Integrating Medical Complexity into Coordinated Entry

Austin/Travis County CoC
TX-503

Requested by Leadership Council August 2025

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***Purpose**: This policy integrates medical complexity into Austin/Travis County's Coordinated Entry system so that those with serious health vulnerabilities are identified, prioritized, and connected to appropriate housing pathways - reducing avoidable suffering and early death.*

***Larger Homelessness Response System Context:** ECHO will lead a process in 2026 to reimagine the Coordinated Entry system that is anticipated to include expanding coordinated entry beyond referrals to permanent housing interventions, but to consider the wholistic resource needs of people experiencing homelessness and how our collective systems can match resources most effectively to those households.*

Within that redesign of CE, we anticipate engaging with additional systems that also provided needed services for people with serious health vulnerabilities. Due to the timing of the Medical Complexity policy recommendations, they are therefore divided into policies recommendations that can take place prior to the larger CE redesign, and recommendations and information that needs to be included in the larger CE redesign (See Implementation Plan).

Policy Highlights

The proposed policy recommendations summarize key adjustments to the Austin/Travis County CoC Coordinated Entry System. These recommendations ensure that the Coordinated Entry system is better equipped to prioritize and support individuals with the greatest health needs, improving both equity and outcomes.

Vulnerability

Recommendation: Adopt an expanded Coordinated Entry vulnerability definition that explicitly recognizes medical complexity and elevated risk of serious harm or death while unhoused as critical components of vulnerability *(See Community Definition of Medical Complexity*). This definition is intended to guide current decision-making and interim policies and to serve as a foundational reference for future assessment and prioritization tools. *(See Implementation Plan: Immediate and Interim Actions).*

Proposed definition: Those least likely to self-resolve their homelessness without formal intervention, *especially those whose medical complexity or environmental risks make remaining unhoused unsafe or life-threatening (See Vulnerability Recommendation).*

Coordinated Assessment

Recommendation: Evolving the Health Outcomes domain of the Coordinated Assessment will capture information needed to determine if someone meets the definition of Medically Complex. This update will ensure that the Health Outcomes domain is asked in a nonjudgemental and trauma-informed way, capturing core and supporting factors of Medical Complexity, and grounding questions in an individual's experience instead of their diagnosis (See Coordinated Assessment Recommendation). This recommendation's implementation largely lives in the Coordinated Entry redesign *(See Implementation Plan: Integration into Coordinated Entry Redesign).*

Prioritization

Recommendation: To ensure that medically complex individuals experiencing homelessness are prioritized for housing through CE, a stepwise implementation approach is recommended. This approach balances the urgency of need with the long-term policy development needed to sustain equitable and effective system change. This includes: (1) a Health Risk By-Name List Override policy for immediate, life-threatening situations and (2) a Health Outcomes Domain tiebreaker incorporated into the prioritization scheme to guide referrals; *(See Implementation Plan: Immediate and Interim Actions).* The use of an integrated data-informed approach to prioritization ((3) the APAT+ model) that combines verified health information with CA information will live within the Coordinated Entry *redesign* *(See Prioritization Recommendation; Implementation Plan: Integration into Coordinated Entry Redesign).*

Systems Alignment

Recommendation: Apply broader systems change to ensure CES policies achieve their intended impact. Key recommendations include stronger structural alignment between housing and healthcare partners, increased staffing capacity to manage high-health-need clients, clearer policies and processes that support earlier identification and coordinated care, and long-term planning to expand medically supportive housing options. In particular, a pre-referral Medical Case Conferencing space and a PSH to SNF Transfer Policy are proposed as interim priorities *(See Implementation Plan: Immediate and Interim Actions).*

Policy Rationale

Over the past year, our community has documented a stark and preventable trend: people with the high health needs are dying while unhoused, and nearly all had Coordinated Assessment (CA) scores too low to ever be referred to housing. Between 2018–2023, more than 1,000 individuals died while experiencing homelessness, and among those who had contact with the system, the median CA score was just 10—well below the threshold for Permanent Supportive Housing (PSH) referral. PSH referrals are typically made for CE participants who've scored between 18-21 on the CA.

This gap is not due to a lack of need. According to ECHO's 2025 State of the Homelessness Response System (HRS) Report, 31% of people served in the system are chronically homeless, and the number of people reporting disabilities continues to rise, reaching 12,755 people—60% of our total unhoused population—in 2024. Yet our Coordinated Entry tool was never designed to identify health risk, functional impairment, or medical complexity; in fact, our CA policy explicitly states that these domains fall outside the scope of the assessment.

While the 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 VI-SPDAT is now widely recognized as an ineffective instrument for determining vulnerability. Multiple independent studies and systematic reviews have identified serious equity implications, weak reliability, poor predictive validity, and inconsistent measurement across its health and wellness domains (Brown et al., 2018; Salim, 2021; SSWR Systematic Review, 2025). Moreover, the tool's original developers have clarified that the VI-SPDAT was never intended to function as an assessment instrument and have formally recommended retiring it in favor of approaches better suited to capturing complex needs.

Because our CA tool does not adequately capture medical risk or functional limitations, individuals with life-threatening conditions often remain invisible within our prioritization process, even as they cycle through emergency departments and are discharged repeatedly back to the street (Appendix, Figures A & B). At the same time, System Improvement Committee's recent policy brief, Recommendations for Housing Options for People with High Medical Needs, highlights that hospitals routinely decline admission for medically complex patients who are considered "at baseline," and shelters often cannot accept individuals who require assistance with Activities of Daily Living (ADLs). This leaves people with the highest health vulnerabilities with no viable options—no hospital bed, no shelter bed, and no pathway through Coordinated Entry to housing.

Our recommendations respond directly to this gap. If adopted, they will formalize our community's commitment to health equity and lay out the groundwork to ensure that medically complex individuals are properly identified, prioritized, and connected to appropriate housing resources.

Coordinated Entry System Primer

A CoC's Coordinated Entry System (CES) is a HUD-mandated system that standardizes access to housing and supportive services for individuals and families experiencing homelessness. Its primary purpose is to ensure that limited resources available in a community are allocated efficiently and equitably by prioritizing those with the highest need in a community.

There are four main components that inform a CES in a community: Access, Assessment, Prioritization, and Referral. Additionally, how a CoC defines vulnerability determines who is being prioritized within a CES.

- **Vulnerability**: In the context of Coordinated Entry (CE), vulnerability is how a community conceptualizes who is most in need of the limited housing resources available. This impacts the information collected through the Coordinated Assessment (CA) and ultimately determines who is being prioritized and referred to housing through CE. Austin/Travis County CoC's definition of vulnerability is *those who are least likely to self-resolve their homelessness without formal intervention*.
- **Access**: Access is the front door to a community's Coordinated Entry System and defines *how and where* people experiencing homelessness connect with the system. A well-designed Access structure ensures that every person receives a consistent, equitable, and streamlined pathway into housing resources. This includes establishing clear physical and virtual access points, integrating outreach teams as mobile access partners, and ensuring that specialized access options exist for populations who cannot safely or appropriately use standard access points. Austin/Travis County CoC operates a No Wrong Door, decentralized access approach allowing individuals experiencing homelessness a wide variety of options for accessing the local CES.
- **Assessment**: The assessment component of CE is where information about service needs, housing history, health, and other factors are collected by service providers from persons accessing the CES. The questions on the Coordinated Assessment, or CA (in Austin, also referred to as the Austin Prioritization Assessment Tool, or APAT), are developed with the definition of vulnerability as a guide. As such, assessment tools must be designed to capture relevant vulnerability indicators. Information

collected on the CA informs several key elements in CE and is explicitly used within the community-developed prioritization process.

- **Prioritization**: Prioritization is the CE component that integrates and aligns all other parts of the Coordinated Entry System. It determines who receives housing referrals by ranking individuals according to the community's defined criteria, ensuring that limited resources are directed to those with the highest need. Because prioritization relies on the quality of information gathered earlier in the process, it is directly shaped by both equitable access and accurate, consistent assessment practices. Effective prioritization serves as the bridge between assessment results and referral decisions.
- **Referral**: Referrals within CE are the component of the system that operationalizes all earlier elements – this is the action step to get an individual housed. Once an individual is prioritized, CE directs referrals to available permanent housing programs within the CoC. A well-functioning referral process is essential for maintaining system flow, strengthening provider accountability, and supporting timely connections to housing and supportive services.

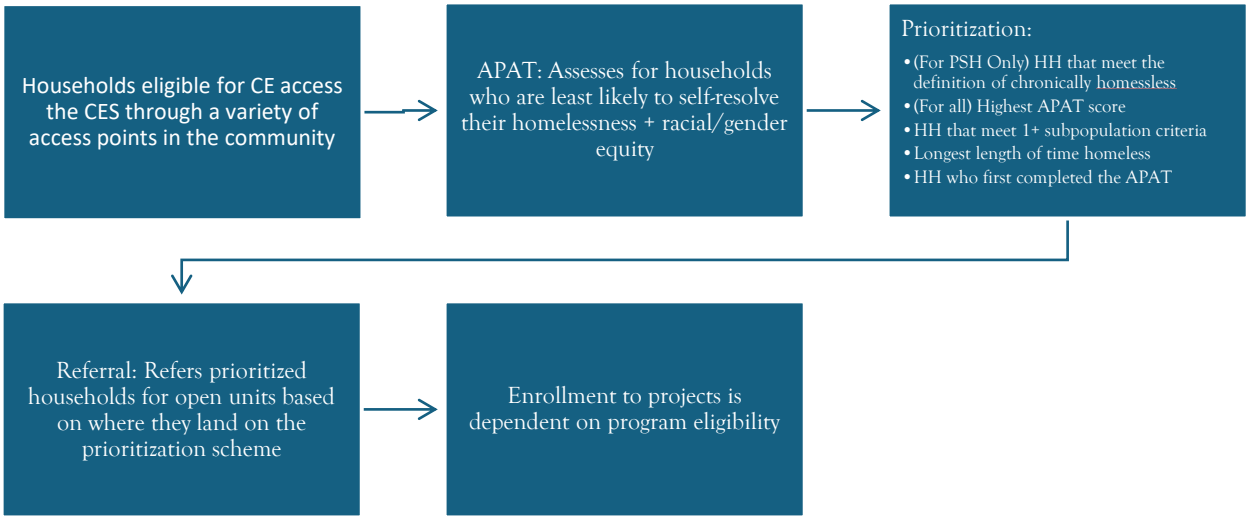

***Figure 1**. Overview of the Austin/Travis County CoC Coordinated Entry System Flow*

To achieve meaningful and measurable impact, it is critical that all components of Coordinated Entry operate in alignment - from defining vulnerability, to assessing for it, to prioritizing clients, and ultimately connecting them to housing. Misalignment across any of these elements can result in delays, inequities, or missed opportunities to serve those at highest risk. Our recommendations coordinate these components, ensuring

that medically vulnerable individuals and other high-need populations are consistently identified, appropriately prioritized, and connected to housing in a timely manner.

Methodology

To develop a community-informed and data-grounded approach to defining and addressing medical complexity, this work drew on multiple complementary methods. It combined interviews with Continuums of Care across the country, extensive local engagement with healthcare providers, Governance Committees, AHAC, and AYC, and quantitative analysis to estimate the scale of medical complexity within the local unhoused population.

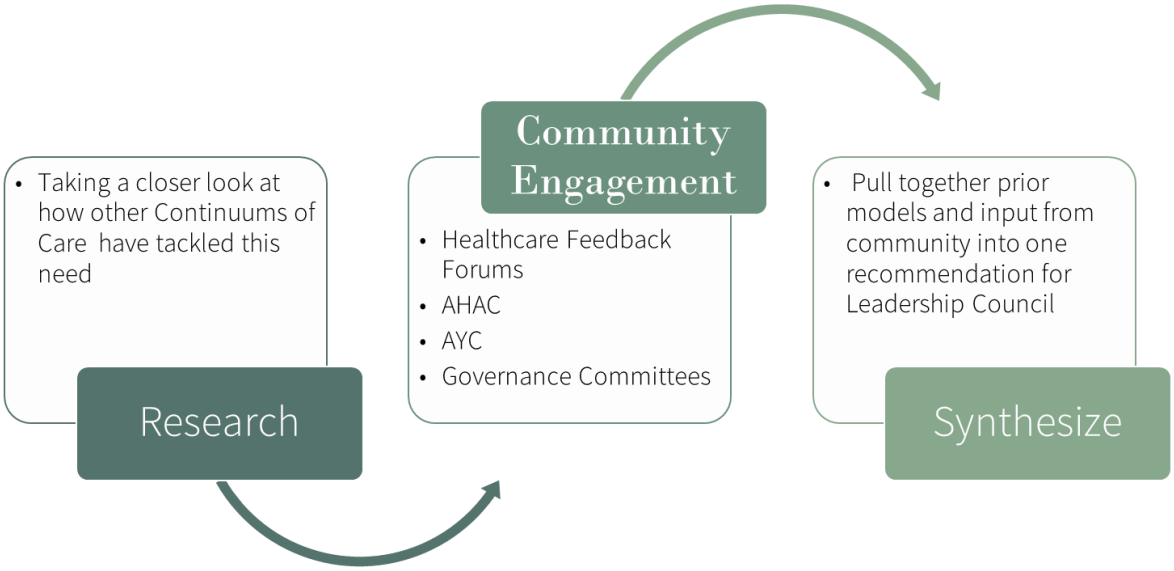

Figure 2. *Scope of Work for the Medical Complexity Project*

National CoC Research

To learn how other communities have integrated medical complexity into their Coordinated Entry policies, ECHO staff conducted a structured outreach and review process. This began by identifying which CoCs have an established policy – reviewing available information online, HUD resources, and utilizing other CoC Collaborative channels. The following communities and subject matter experts were consulted with:

Hennepin, MN	Sonoma County, CA	North Colorado CoC
Ft. Worth, TX	Houston, TX	Chicago, IL
Louisville, KY	Maricopa, AZ	Tucson, AZ
NHCHC	University of Houston	UnitedHealthcare

Once communities were identified, interviews were scheduled to understand their policy frameworks, operational workflows, and planning and implementation processes. The interviews consisted of targeted questions about their policy development, how they were using data to inform their work, and any collaborative partnerships and data-sharing agreements in place. Additionally, these interviews covered which component of Coordinated Entry the policy was implemented under, how each community implemented the policy, and their initial outcomes and evaluations. Interview questions are attached to this document in the appendix for review (Appendix, Semi-Structured Interview A).

Community Feedback

ECHO engaged in a comprehensive, multi-layered community feedback process between October and December 2025.

This feedback process consisted of:

- a multi-session Healthcare Feedback Forum designed to gather structured input from clinical providers across our community; and
- ongoing review and discussion with governance committees responsible for Homeless Response System oversight and policy alignment; and
- dedicated engagement with lived expertise groups such as the Austin Homeless Advisory Council (AHAC) and Austin Youth Collective (AYC).

Together, these perspectives deepened our community's shared understanding of medical complexity and co-developed the framework for how medical complexity should be recognized and incorporated into Coordinated Entry (CE).

Healthcare Feedback Forums

Outreach & Recruitment

ECHO issued a broad invitation to 47 healthcare partners across the Austin–Travis County ecosystem, including hospital systems, primary care providers, behavioral health agencies, EMS, community clinics, and street medicine teams. The invitation encouraged recipients to forward the opportunity to colleagues or networks who work closely with medically complex patients experiencing homelessness: This resulted in a wider

distribution, and thirty new individuals were added to the interest list. Of the 77 healthcare partners outreached to, 56 individuals completed ECHO's engagement survey to determine best times to meet (72%).

Who Participated

Fourteen agencies partnered with ECHO in this time-intensive series (Figure 3).

Figure 3. Partners who contributed their time and energy to the Healthcare Feedback Forum series.

Providers represented the full spectrum of our local health ecosystem – from hospitals and clinics, to outreach, harm reduction, behavioral health, and law enforcement. It is a powerful reflection of how deeply our community is invested in ensuring people with the most complex health needs are given dignified housing and a means to success.

Each individual who participated in the Healthcare Feedback Forum was surveyed on their primary work setting and the lens brought to their work (multiple option select was permitted, max of three). The majority of participants work in a clinic setting (25), mobile outreach (21), street medicine (13), and shelter-based care(10). The lens' brought to these Forums were diverse, with the largest degree of individuals bringing a Case Management/Care Coordination perspective (20), Behavioral Health/Mental Health and Medicine/Clinical Practice (tied at 19) and Social Work and Community Health/Outreach (tied at 15). (Appendix, Figures C and D). Each of our partners bring a different lens with rich and varied perspectives, and most providers wear multiple hats in their work.

Structure of the Engagement Process

The Healthcare Feedback Forum consisted of four sequential 1.5-hour sessions, each designed to build on the previous one. The methodology intentionally layered content so providers could first align on foundational concepts and then contribute directly to policy design. Because health professionals often have very constricted availability for additional

community-based meetings, each session was virtual and offered at three alternate days and times to maximize availability for robust discussions and inclusion.

In all sessions, feedback that collected by taking notes on all spoken feedback, collecting all comments written in Chat, and using polling software. All sessions were recorded as an additional safeguard to ensure no feedback was missed.

Session One: Setting the Foundation

Session One established the foundation for the Healthcare Feedback Forum. Using a combination of presentation and live discussion, the session introduced the project's scope, the CE system, current definitions of vulnerability, and the absence of medical complexity within existing policies. Participants engaged in a resource scarcity exercise ("30 units for 90 patients") to frame the challenge of prioritization. The session also included the first collective brainstorming activity on what medical complexity looks like in practice, which informed the deeper framework-building in later sessions.

Session Two: Building the Definition Framework

There is no universal definition that establishes what is meant by the term *medical complexity*. For our community to reliably identify and prioritize people with complex health needs, it was essential to build a shared understanding of what this term encompasses. Session Two introduced a structured definitional framework for doing this work, consisting of Core Elements, Supporting Factors, and Observable Indicators of medical complexity (See Core/Supporting Factors/Indicators Framework for more).

Building on the thematic analysis from Session One brainstorm on what medical complexity looks like in practice, this session used Menti polling to engage participants in refining each component of the emerging definition. Providers identified which elements felt essential, and uplifted the clinical, behavioral, and functional considerations they rely on to recognize high health needs in practice.

All content considered during this discussion derived directly from Session One's brainstorming, ensuring the framework remained grounded in provider experience. Input from Session Two shaped the development of our community's definition of medical complexity and was later applied to Coordinated Entry in Session Three.

Session Three: Applying the Definition to Coordinated Entry

Session Three focused on how the emerging definition of medical complexity could be applied within the Coordinated Entry system. Facilitators revisited the definitional framework and then used polling to explore how medical complexity could inform the three CE levers: vulnerability, assessment, and prioritization.

Throughout the session, providers engaged in polling and discussion to refine key concepts of the medical complexity definition. Feedback on adaptations to the HRS definition of vulnerability and CE Health Domain questions was collected. Providers also ranked potential approaches that could be used to integrate medical complexity into prioritization.

Session Four: Refining Policy Recommendations

The final session presented draft policy recommendations incorporating all community feedback gathered to date. Providers first reviewed and rated the finalized medical complexity definition, then discussed refinements to the CE vulnerability definition to ensure it accurately reflects health and functional risk.

Building on this foundation, facilitators introduced revisions ("prototype questions") to the APAT Health Domain, developed after Sessions Two and Three using trauma-informed, equity-focused, and plain-language principles. Each proposed question reflected specific themes raised by providers and governance members - including reducing stigma, improving clarity, capturing functional impact, and acknowledging structural barriers to care. Participants were asked to assess whether the draft questions moved us towards the kind of assessment our community needs (1-5 scale). Facilitators gathered feedback on enhancements to the questions.

The session then evaluated the feasibility of multiple prioritization strategies and explored two system-alignment "deep dives": the PSH → SNF/LTC Transfer Protocol and Medical Case Conferencing model. These discussions helped surface considerations for implementation readiness, equity, and cross-system coordination.

Across the session, participants affirmed the core policy directions and offered targeted refinements to strengthen clarity, equity, and operational feasibility.

Austin/Travis County CoC Governance Committees

Throughout November 2025, ECHO Facilitators met with Continuum of Care governance committees (Systems Improvement Committee, Equity Committee, Performance Monitoring Committee, Permanent Housing Committee) and the Coordinated Entry Workgroup to share a presentation on medical complexity and gather input. Of note, ECHO Facilitators could not present to Crisis Response Committee due to zero attendance. These meetings were part of the broader community engagement effort and were designed to ensure that emerging recommendations aligned with input from housing providers and persons with lived experience.

During each committee meeting, staff walked through the same presentation - covering the project background, the problem statement and urgency, the draft definition of medical complexity, and the CE levers and system alignment opportunities under consideration. Committee members were invited to ask questions, raise concerns, and discuss how proposed changes might interact with current practices. These presentations ranged in presentation time, from 30 minutes to 1.5 hours, depending on Committee agenda availability.

Feedback gathered through these conversations helped inform refinements to the draft recommendations, particularly around feasibility, workflow impact, and the relationship between medical complexity and existing prioritization structures.

Austin Homeless Advisory Council

In December 2025, ECHO facilitators met with the Austin Homeless Advisory Council (AHAC) for a dedicated, nearly two-hour in-person listening session focused on integrating medical complexity into Coordinated Entry. AHAC is composed of individuals with lived experience of homelessness, and the conversation was structured to ensure that their expertise directly shaped how medical vulnerability is defined and applied within CE policy. Facilitators used a presentation to walk members through the draft framework and proposed policy direction, but unlike the healthcare provider sessions, no polling was used. Instead, the engagement relied entirely on open dialogue, experiential feedback, and stories that illustrated how health needs, functional limitations, traumatic events, and systemic barriers affect a person's ability to remain safe, access care, or obtain housing.

Austin Youth Collective

ECHO also met virtually with the Austin Youth Collective (AYC) for a 1.5-hour session focused on the same draft policy recommendations. This engagement included a review of the draft APAT health and functional questions, allowing members to provide detailed feedback on question clarity, relevance, and youth-specific considerations. While Menti was available, the discussion primarily took place through facilitated conversation and real-time notetaking. As with AHAC, the intent of the session was to ensure that youth lived expertise directly informed the development of the medical complexity framework and its integration into Coordinated Entry.

Quantitative Methods: Estimating the Prevalence of Medical Complexity in our Community

Governance committee members requested an estimate of how many people on the community's By-Name List (BNL) may meet the emerging definition of medical complexity.

Because the current APAT does not measure several key elements identified in the community-defined framework—including many supportive factors and observable indicators—an exact estimate is not possible at this stage. However, to generate a *rough approximation* using existing data, ECHO conducted a targeted analysis based on community input.

To do this, ECHO used a stepwise proxy approach, grounded in stakeholder input and aligned as closely as possible with the core elements of the medical complexity definition. During governance meetings and the Healthcare Feedback Forum, facilitators asked participants: "Of the current CE Health Domain questions, which four do you believe are strongest at identifying medical complexity?" Using the questions most consistently selected by stakeholders, ECHO pulled prevalence and demographic data for individuals on the BNL who affirmatively answered those items.

To strengthen this estimate, ECHO also examined the only two questions in the Health Domain not originally part of the VI-SPDAT—the Activities of Daily Living (ADL) question and the end-stage disease question. These items were repeatedly uplifted by healthcare providers, AHAC, AYC, and governance committees as the strongest proxy indicators of medical complexity available in current data and align most directly with the "floor" of the community's medical complexity definition. For these two proxies, ECHO produced:

1. The number of individuals on the BNL meeting the proxy criteria
2. Demographic characteristics (age, race/ethnicity, gender, and veteran status)
3. Patterns within the ADL measure were examined

All analyses were conducted in R using HMIS exports from August 2025. These findings are not intended to represent the full prevalence of medical complexity in the community, but rather to provide a preliminary data snapshot based on the *limited indicators* presently captured in the CE assessment.

Findings

National Continuum of Care Findings

Approaches to Integrating Medical Complexity into Coordinated Entry

Across Continuums of Care (CoCs), research indicates a growing shift toward integrating medical complexity into Coordinated Entry (CE) systems in response to rising unsheltered mortality, equity concerns, and sustained feedback from People with Lived Experience (PLE). In many communities, this work began with an explicit acknowledgment that

commonly used assessment tools—particularly the VI-SPDAT—do not adequately capture differences in medical risk or acuity. PLE advisory groups frequently emphasized that disability status alone does not reflect medical fragility, prompting CoCs to explore alternative or supplemental approaches.

Analysis of community practices identified **three primary strategy types** used to incorporate medical vulnerability into CE. While these strategies are often implemented in combination, they are presented separately below to illustrate distinct system design approaches. For further review, intervention strategies are summarized by community in Table 1.

Strategy Type 1: Formal Review and Medical Case Conferencing

Several CoCs addressed gaps in assessment-based prioritization by establishing **formal review structures** to evaluate medically complex cases that did not score highly through standard CE tools. These structures are commonly referred to as Special Circumstances Committees, CE case review bodies, or medical case conferencing boards.

In these models, requests for escalation on the By-Name List (BNL) are submitted with supplemental clinical or functional information. Review bodies typically include housing providers with experience in Permanent Supportive Housing (PSH) and medical professionals familiar with serving people experiencing homelessness. Decisions are made at a regular cadence using standardized criteria. While escalation affects overall prioritization, individual program eligibility requirements remain in place.

Research indicates that CoCs using this approach view medical case conferencing as a corrective mechanism that preserves assessment standardization while allowing clinical judgment to inform prioritization for high-risk individuals.

Strategy Type 2: Assessment Tool Redesign and Medical Acuity Integration

Other CoCs pursued integration of medical complexity directly within their formal CE assessment tools. These efforts involved either rebuilding existing tools or supplementing them with targeted medical acuity domains.

Assessment-based approaches varied across communities but generally included a dedicated section focused on healthcare and medical vulnerability. Indicators commonly assessed include chronic health conditions, complex care needs, barriers to accessing treatment, acute health impacts of homelessness, and multiple co-occurring conditions. In one CoC, medical acuity was weighted heavily within the prioritization framework, functioning as a primary driver of housing prioritization alongside or ahead of chronicity and length of time homeless.

Implementation timelines for assessment redesign were substantial, reflecting the need for stakeholder engagement, assessor training, pilot testing, reassessment of existing clients, and HMIS reporting modifications. CoCs emphasized the importance of aligning medical indicators with local population health profiles and service capacity.

Strategy Type 3: Data-Informed and Cross-System Prioritization

One CoC incorporated **system-level data** into CE prioritization to identify medical vulnerability beyond self-reported assessment responses. This approach relies on backend integration of data from health systems, emergency services, behavioral health providers, and homeless response systems.

Data-informed strategies included the use of emergency room utilization and documented service engagement patterns to surface individuals experiencing heightened medical risk. CoCs reported that these methods helped identify individuals whose health was deteriorating but who had not been elevated through standard assessment processes.

Research findings suggest that data-informed prioritization reduces reliance on self-report, which can be influenced by access barriers, trauma, and mistrust, and may contribute to more equitable identification of medically complex individuals.

Cross-Cutting Observations and Implementation Considerations

Across all strategy types, CoCs reported common implementation challenges, including:

- Inconsistent documentation of Activities of Daily Living (ADLs)
- Unclear clinical origins or validation of certain medical indicators
- Limited CE and HMIS infrastructure capacity
- The need to align with HUD requirements

Despite these challenges, CoCs consistently described medical complexity integration as a necessary evolution of CE systems to better align housing prioritization with health risk and mortality prevention.

Table 1. Summary of Community Strategies in Incorporating Medical Complexity into CE			
Community / CoC	**Strategy Type**	**Policy or Practice**	**Description**
Sonoma County, CA	Formal Review Structure	BNL Override Policy + Medical Case Conferencing	Reviews cases with high medical risk not captured by assessment scores and determines whether they should be given override clearance on BNL lists
North Colorado BoS	Formal Review Structure	BNL Override Policy + Medical Case Conferencing	Multidisciplinary board reviews medically complex cases for BNL escalation
Chicago, IL	Assessment Tool Integration	Medical Acuity Tool	Medical acuity embedded in CE assessment and heavily weighted in prioritization
Louisville, KY	Medical Case Conferencing	BNL Override Policy + Medical Case Conferencing	Multidisciplinary board reviews medically complex cases for BNL escalation
Hennepin County, MN	Assessment Tool Integration	Medical Acuity Tool (MAT)	Medical acuity embedded in CE assessment and heavily weighted in prioritization
Maricopa County, AZ	Assessment Tool Integration	Medical Acuity Prioritization (MAP)	Medical vulnerability weighted within assessment; conferencing used for service planning
Tucson, AZ	Data-Informed Assessment	Mortality-Driven Assessment Design	Public health and medical examiner data used to redesign assessment
Fort Worth, TX	Medical Case Conferencing	BNL Override Policy	Email-based review process for medical escalations
Houston, TX	Cross-System Data Integration	Health-System Data & HMIS Utilization Flags	Backend data used to identify elevated health risk and individuals frequently utilizing HRS, health, and legal systems.

Community Feedback Findings

Across all engagement streams - healthcare providers, governance partners, and perspectives from those with lived expertise - clear recommendations emerged about how medical complexity presents in practice, the gaps in our current system, and the elements needed to incorporate medical vulnerability into Coordinated Entry.

Healthcare Feedback Forums

Session One Findings: Brainstorm & Initial Themes

Session One introduced the foundational question for this work: *"What does medical complexity look like in our community?"* Providers participated in a broad, open-ended brainstorm that generated a wide range of examples, conditions, functional challenges, and contextual factors reflective of the people they serve. These responses were thematically analyzed and organized into **Table 2**, which summarizes the most common patterns that emerged.

Across this discussion, providers showed strong consensus on two dominant features of medical complexity in practice. **Most responses centered on end-stage or severe chronic diseases**—such as congestive heart failure, uncontrolled diabetes, cirrhosis, and cancer—conditions associated with significant morbidity or risk of death. Equally prominent was an emphasis on **functional impairment**, with participants highlighting mobility challenges, cognitive decline, and reduced ability to complete Activities of Daily Living as core markers of vulnerability.

Providers also identified a range of **contributing factors and disabilities with major impact**, including lack of medication access, unsafe environments, behavioral health conditions, amputation, paralysis, and traumatic brain injury. Taken together, these themes underscored a shared understanding that **medical complexity is not defined by diagnosis alone**, but by the interplay of serious health conditions, functional limitations, and contextual factors that collectively shape a person's risk and stability while unhoused.

These insights formed the foundation for the structured definitional framework introduced in Session Two.

Table 2. Themes from Brainstorm: What Does Medical Complexity Look Like to You?		
End-Stage/Severe Chronic Conditions/ Organ Failure/ Risk of Death	Congestive Heart Failure, End Stage Renal Disease, Diabetes, Cirrhosis, Cancer, Risk of death, Stroke, HIV/AIDS, Palliative care	62
Contributing/Supporting Factors	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;	18
Disabilities with Devastating Impact on ADLs	Amputation; blindness; dementia; mobility issues ; paralysis ; spinal cord injuries; acute accidents resulting in reduced ADLs ; TBI ; IDD	17
Formula to Complexity (Medical + Substance Use + Mental Health?)	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; Maybe more than one chronic medical condition or co-occurring MH or SUD; reliance on medications/procedures to survive	10
Activities of Daily Living (ADLs)	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	9
Mental Health Needs	un/undertreated mental health illness/ mental health / psyc complexity / schizophrenia, acute psychiatric symptoms such as psychosis or catatonia, inability to consent to treatment	8
Health/ Systems Utilization	Re-hospitalized within three months for the same issue ; utilizing the most resources (legal systems mentioned); high hospital/ER usage ; multiple medical providers requiring frequent visits (>1x month?)	6
Substance Use	Substance use: SUD; opioid misuse	3

The Core / Supporting Factors / Indicators Framework

To move from a broad brainstorm to a concrete definition, ECHO Facilitators developed a three-part framework that captures the full range of factors contributing to medical complexity. This structure provided the foundation for all subsequent discussion and helped guide the refinement of the definition throughout the engagement process.

Core Elements: Core Elements are the fundamental criteria that must be true for someone to be considered medically complex. They represent the essential health and functional characteristics at the center of the definition—effectively the floor criteria for inclusion as "medically complex."

Supportive Factors: Supportive Factors are elements that often surround, influence, or compound medical complexity. They reflect nuance and lived context—factors best identified through conversation or observation and not always documented in medical charts. These do not independently determine eligibility but help describe the broader landscape of risk.

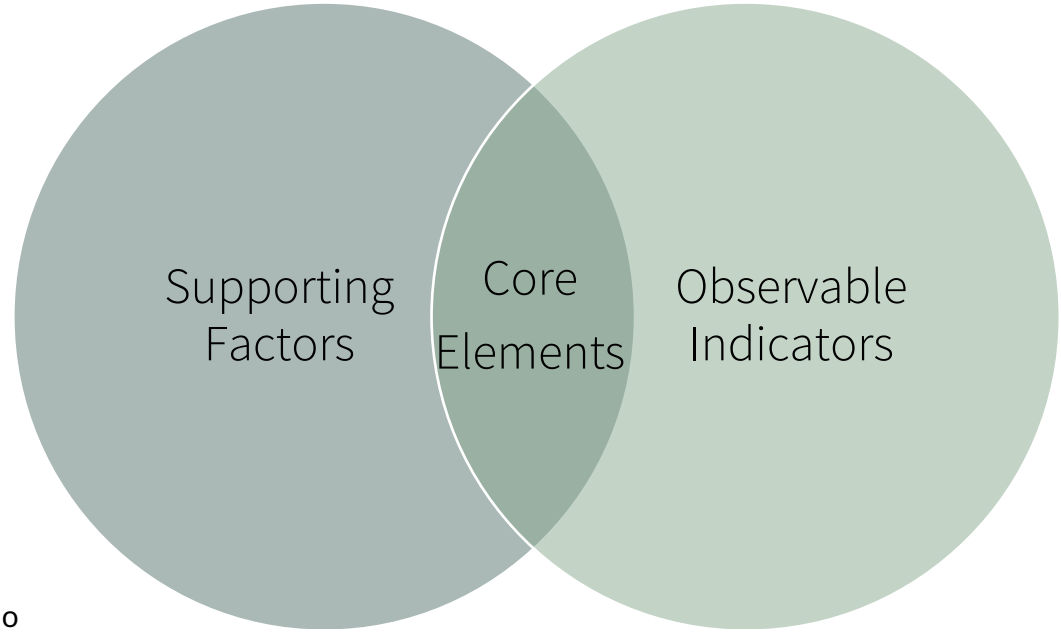

Figure 4A. The Core/ Supporting Factors/Observable Indicators Framework. Core elements are at the center and supporting and observable indicators bolster these foundational elements.

Observable Indicators: Observable Indicators are measurable signs that someone may be medically complex. These data points—often available through medical records, HMIS, or assessment—add context and help identify individuals whose situations warrant closer attention. As with supportive factors, indicators do not define medical complexity on their own; instead, they help surface individuals who may be at heightened risk of a health crisis.

This three-part framework created a clear foundation for the community's definitional work and supported a structured approach to exploring each layer during Session Two.

Session Two Findings: Building the Definition of Medical Complexity

Session Two focused on applying the newly introduced framework to the broad themes identified in Session One. Through facilitated discussion and Menti polling, providers refined which components belonged within each layer of the definition and clarified how medical complexity presents in practice. All options presented were drawn directly from the Session One brainstorm.

Session Two produced the first structured, community-informed version of the medical complexity definition, establishing the elements that would later be tested and refined through application to Coordinated Entry in Sessions Three and Four.

Core Elements

Providers showed strong alignment around what defines medical complexity. **Half of all respondents (50%) identified "a condition that causes serious functional impairment" as the clearest Core Element**, making functional loss the dominant defining feature across all Session Two Forums. Chronic illness was still viewed as central—**29% selected a chronic medical condition** as a required element, and **21% selected a mental health condition** - but providers emphasized that diagnosis alone does not capture medical vulnerability (Appendix, Figures E & F). There was near-unanimous agreement that **healthcare utilization should *not* be required** to meet the definition; **94% of providers indicated utilization should function as an indicator rather than a core criterion.**

Supportive Factors

Providers identified a range of factors that frequently accompany medical complexity and increase risk. These included significant physical limitations (such as amputation, paralysis, or blindness), cognitive or neurological impairment, behavioral health or substance use conditions, difficulty accessing or managing medications, reliance on life-sustaining treatments, advanced age or frailty, and prolonged periods of homelessness or unsheltered living. These factors added important nuance and reflected the layered realities contributing to medical vulnerability. There were no clear supportive factors that outweighed others (the highest selection was 16%) (Appendix, Figure G). Providers noted that this difficulty ranking options reflected the reality that **many supportive factors interact to shape an individual's overall health vulnerability.**

Observable Indicators

Participants also highlighted several measurable signs that can help surface individuals who may be medically complex. Recurrent hospitalizations, recent psychiatric admissions, frequent emergency department visits, and the use of medical devices or treatments such as oxygen or dialysis were seen as strong indicators of underlying instability (Appendix, Figure H). Indicators were understood not as stand-alone criteria, but

as cues that someone may meet the Core and Supportive criteria and may be elevated to life-saving housing interventions within Coordinated Entry.

ADLs as a Cross-Cutting Signal and a System-Level Consideration

ADL limitations appeared across multiple poll responses and emerged as one of the clearest cross-cutting signals of medical complexity. Providers noted that difficulties with bathing, eating, mobility, or managing medications are highly visible in practice, closely connected to safety and autonomy, and often more informative than diagnostic information alone. These impairments appeared across all parts of the framework and became a foundational thread in later discussions on vulnerability, assessment, and prioritization.

As the group explored ADLs, discussion also surfaced the implications for Permanent Supportive Housing (PSH). Providers emphasized that many individuals in our system cannot safely perform daily tasks without support yet still require the stability and protections PSH is intended to offer. Polling reinforced this: **82% of providers indicated that ADL limitations should not exclude someone from PSH**, and instead highlighted supports needed to make PSH viable for these tenants. The most frequently selected supports included **personal or nursing care aides (34%)**, **home health or visiting nurse services (27%)**, and **increased case management intensity (16%)** (Appendix, Figure I & J)

These conversations revealed a key system-level tension. PSH was designed as an independent-living model, not a medically supportive one. Providers expressed concern about the gap between current program expectations and the needs of tenants with substantial functional impairments. This raised an essential question for the community: **Should housing adapt to meet the needs of medically complex individuals, or should eligibility remain tied to current program expectations?**

Although this question extends beyond defining medical complexity, it is a critical area for future system planning. The perspectives raised in Session Two will inform recommendations to Leadership Council as the community evaluates whether and how housing models may need to evolve to support people with high medical needs.

Our Community Definition of Medical Complexity

By the close of Session Two, providers reached consensus on the first community-informed definition of medical complexity. The definition includes three interlocking components:

Individuals with medical complexity are those who:

1. **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.** This is the only core element (floor criteria, or requirement) to be considered medically complex in our community.
2. **Individuals *may* have additional supporting factors** that heighten vulnerability, such as: medication and treatment needs, co-occurring conditions (mental health, substance use, age, pregnancy), functional or cognitive challenges (amputation, paralysis, blindness, dementia, traumatic brain injury, intellectual disability), or exposure to unsafe or destabilizing environments (chronic homelessness, unsheltered exposure, sweeps, violence)
3. ***May* be identified through observable indicators** of severe illness, disability, or healthcare instability (e.g., diagnostic codes, recent hospitalizations, hospital readmissions, use of life-sustaining medical devices or treatments, ADL limitations, psychiatric admissions, or frequent EMS utilization).

This definition reflects the community's shared understanding that medical complexity is **not defined by diagnosis alone**, but by the combination of **functional loss**, **serious health conditions**, and **contextual factors** that together signal heightened risk while unhoused. These elements formed the foundation for the Coordinated Entry policy

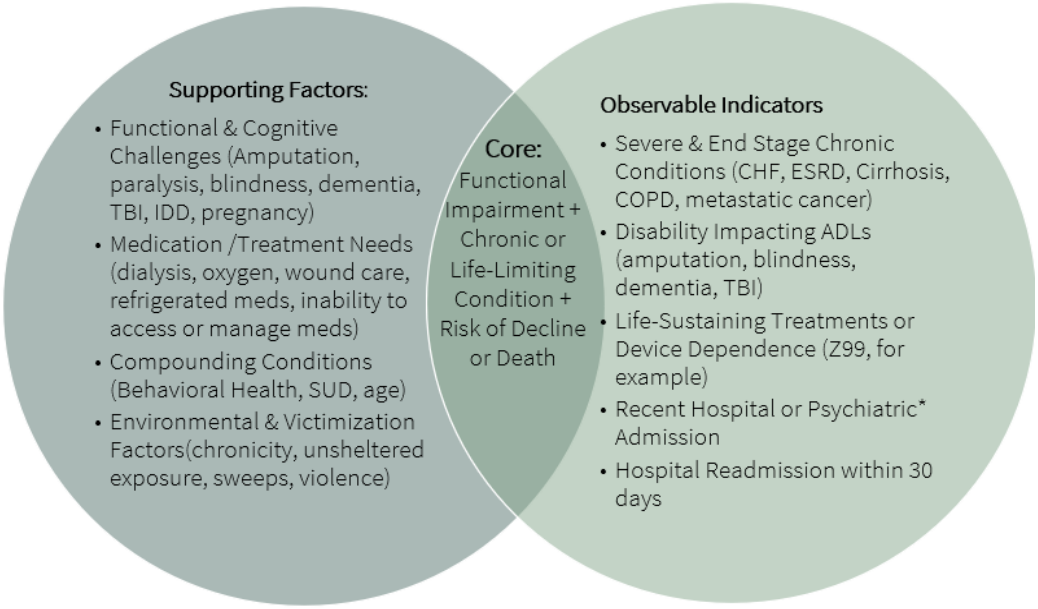

Figure 4B. Application of the Core/Supporting Factors/ Observable Indicators Framework with our community definition of Medical Complexity. Core elements are at the center and supporting and observable indicators bolster these foundational elements.

review and refinement conducted in Sessions Three and Four.

Session Three: Applying the Medical Complexity Definition to Coordinated Entry

Session Three focused on testing how the emerging definition of medical complexity could be meaningfully incorporated into Coordinated Entry (CE). Providers began by reviewing the draft definition developed in Session Two and rated it highly overall, **averaging 4 out of 5 stars with no negative ratings**.

Several noted that the only reason they did not select a 5 was the desire to see how the definition functions in practice to ensure it does not create unintended exclusion. With this strong foundational alignment, participants then examined how the Core Elements, Supportive Factors, and Observable Indicators should inform CE's three primary levers: vulnerability, assessment, and prioritization.

Vulnerability

Providers showed clear support for expanding CE's vulnerability definition to reflect medical and functional risk. **Over half of respondents (52%) favored emphasizing health, behavioral health, and functional impairments**, and another **24% prioritized environmental and systemic risk** (Figure 5). Only a small proportion supported keeping the current definition unchanged (14%).

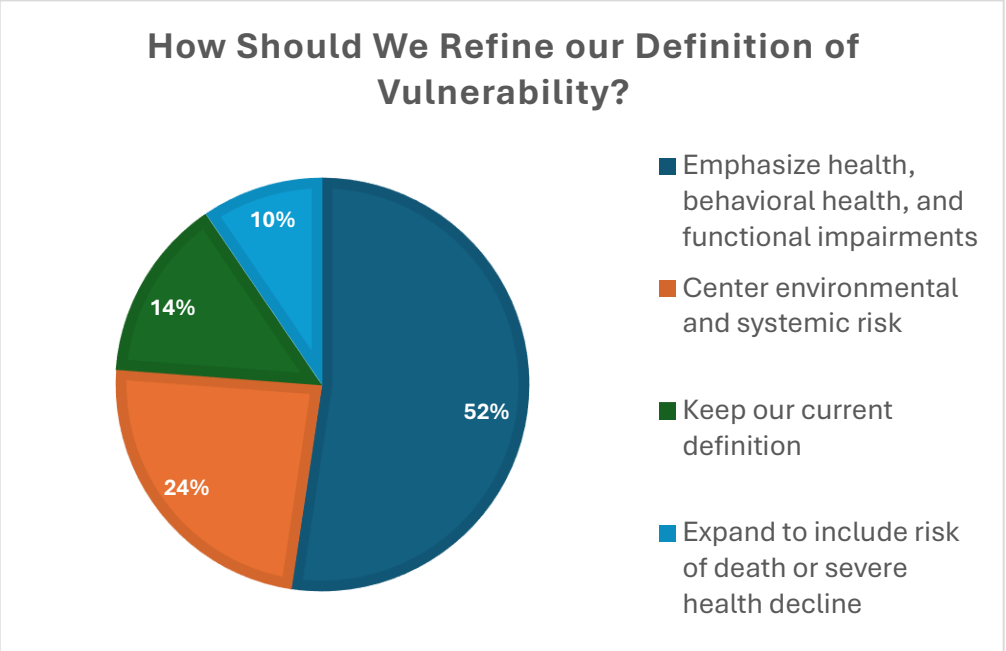

Figure 5. Healthcare provider feedback on how best to incorporate medical complexity into the Continuum of Care definition of vulnerability.

This polling strongly reinforced the need to revise CE's vulnerability construct to align with health needs.

Coordinated Assessment

Providers were asked to give their feedback on present questions in the Coordinated Assessment Health Domain. Three overarching themes were present across all Session three forums, each limiting the tool's ability to capture medical complexity accurately and equitably.

1. **The language is too high-level, clinical, and confusing.**

    a. Providers noted that terms such as *end-stage disease, brain issues, independent living,* and *avoid help* are inaccessible for many people. Some providers also shared that Assessors can sometimes be "robotic", making comprehension more difficult.

2. **Current Questions Assume Health Self-Awareness.**
    a. People may not know they "avoid care"
    b. Someone may have an end stage disease but not identify it or understand their diagnosis.
    c. Substance use may be minimized.
3. **Many questions feel stigmatizing, which could lead to underreporting.**
    a. Overwhelmingly providers warned that questions on mental health, substance use, and violence feel like "trick questions" where individuals might say no in order to not "risk their housing".

Taken together, provider feedback made clear that the CE health domain must undergo significant redesign to accurately identify medical complexity. Questions need to shift toward **plain, accessible language**, reduce reliance on **medical self-awareness**, and avoid **stigmatizing or punitive framing** that discourages honest disclosure. Across sessions, providers emphasized that the health domain should focus on **observable functional impacts**, **concrete indicators of medical need**, and **nonjudgmental wording** that supports accurate assessment without creating fear of losing housing opportunities. These takeaways form the foundation for a more equitable, clinically relevant, and user-centered assessment tool moving forward.

Prioritization

Session Three introduced four prioritization pathways for consideration *(See Supplemental Overview: Prioritization Options)*, with additional polling in Session Four.

When providers ranked four potential approaches to elevating medically complex individuals within Coordinated Entry, the following patterns emerged (Appendix, Figure K):

- **Integrated Medical Complexity Scoring (APAT+)** received the highest number of *first-place rankings*, indicating strong support for a more comprehensive, data-informed model.
- **Health Domain Tiebreaker** was also frequently ranked first, reflecting interest in a straightforward mechanism to elevate medical risk when scores are otherwise equal.

- **Health-Risk BNL Override** received the most *second-place rankings*, suggesting providers view it as a strong near-term option for addressing urgent or acute medical cases.
- **Medically Complex Set-Aside** was most often ranked *third*, signaling interest but also questions about feasibility and design.

Across sessions, providers agreed that **multiple prioritization pathways** will likely be needed to ensure that medically complex individuals are not overlooked within CE.

Session Four: Validating Draft Policy and Aligning System Changes

Session Four served as the capstone of the Healthcare Feedback Forum series. After developing the community definition of medical complexity (Session Two) and exploring its application to Coordinated Entry (Session Three), providers were asked to review, refine, and validate draft policy recommendations across CE vulnerability, assessment, prioritization, and system alignment.

Across all forums, participants expressed strong support for the proposed updates and affirmed that the recommendations reflected the realities they see in the field.

Validation of Draft Policy Direction

Vulnerability Definition

Providers agreed that the revised vulnerability definition better reflects medical fragility, functional impairment, and environmental risk. The updated language aligned with what they felt CE must capture for medically complex individuals.

Assessment (APAT) Prototype Question Feedback

Across the three Session Four forums, participants expressed strong support for the revised APAT Health Domain questions. When asked how well the prototype items move the community toward the kind of assessment needed, **75% rated them a 4 out of 5**, and the remaining **25% rated them a 5 out of 5**; **no respondents selected ratings of 1–3**.

Providers consistently shared that the revised questions feel far more aligned with medical complexity than the current tool—clearer, more functional, easier to understand, and less stigmatizing. At the same time, they emphasized that full confidence will depend on how the questions are piloted, how scoring is ultimately weighted, and how well the final tool integrates into existing assessment workflows.

To inform that next phase of refinement, stakeholders offered detailed feedback across each proposed question. The following table consolidates their major themes, requested adjustments, and common considerations from providers:

Table 3. APAT Prototype Questions developed from Original Feedback & Provider Responses

Prototype Questions (V.1)	What Worked/Refinements Needed / Concerns
Has it been hard to get medical care when you need it — like getting to appointments, getting medicine, or finding a clinic that feels safe?	Clearer than "avoid help"; captures safety, affordability, and access issues. Add ER/ED reliance; ask about having a PCP; clarify that street medicine may be primary care; avoid implying "no access" if person uses ER
No longer any dedicated HIV housing. Bring together with long term disease as HIV is a long-term chronic condition and is fine if medically managed, but can be a risk factor if unstable, untreated, or advanced.	Recognizes HIV as chronic condition
Do you have a long-term health condition that causes strong symptoms or flare-ups — like trouble breathing, chest pain, severe swelling, fainting, or needing urgent care often? (Examples optional: cancer, heart or lung problems, kidney disease, liver disease, long-term infections, HIV/AIDS, diabetes that is hard to control)	Highly supported as a core indicator; symptom-based framing validated Avoid term "strong"; ensure acute but severe symptoms can be captured; consider adding schizophrenia as example; ensure examples don't drive underreporting
Does your health make it hard to do daily tasks — like bathing, using the bathroom, getting food, taking medicine, moving around safely, or taking care of yourself?	Strongest-supported domain; aligns with MC definition Consider removing 9a yes/no gate; ensure people understand ADL limitations as disability
In the past month, which of these have been hard for you because of your health?" (Check all that apply): Moving around - like standing up, walking, or getting in and out of bed (Mobility/Transfers), Getting to the bathroom in time or staying clean (Toileting or continence) , Keeping up with your medicines (medication management), Memory, thinking, or letting people know what you need (Communication/cognition)	Clear, concrete, and function-focused; useful because ADLs can be framed in different ways

Have you had to defend or protect yourself because you felt unsafe while homeless?	Broad, trauma-informed wording appreciated – gets into intersectionality of trauma and homelessness and broad enough to be inclusive or different forms of violence; Downside: Nearly universal experience
In the past year, have you had times when you felt so overwhelmed, scared, or upset that you lost control or felt like hurting yourself?	More trauma-informed than original. Suggestion: Change "lost control" to "your reaction was visible to yourself and others". Removes shame.
Do you deal with stress, trauma, or mental health symptoms that affect you day-to-day?	Less stigmatizing. Hard to distinguish severity; consider examples or scale; doesn't cover lack of insight; too broad; limitations of self-report; explore voluntary/involuntary psych care question
Has anyone - like family, friends, or a doctor - ever told you they were worried about your drinking or drug use?	Less punitive than original question Many lack family/friends/providers; prefer self-identified impact; may benefit from validated screener; consider adding history of overdose; perhaps use CAGE-AID questions
Do you have any long-term disabilities or conditions—like an amputation, paralysis, blindness or low vision, hearing loss, trouble with memory or thinking, or a brain injury?	Strong support; fills major gap
Do you have any treatments or medicines that are hard to keep up with while homeless—like oxygen, dialysis, wound care, or meds that need refrigeration or a set schedule?	Seen as essential indicator Need to explicitly mention securing medications; recognize psychiatric med barriers (medications with side effects that are too much); refine examples
Have you ever been made to move or had your belongings taken from where you were staying?	Highly relevant to risk. Could be universal; consider scale (# of sweeps); specify law enforcement sweeps

These questions were further refined with this feedback, and feedback from Austin Youth Collective. Finalized prototype questions can be found in the Appendix, Table 6.

Prioritization Approaches

Providers endorsed the overall direction of the proposed prioritization pathways and emphasized that **multiple mechanisms** will likely be needed to ensure medically complex individuals are accurately elevated.

System Alignment Deep Dives

Two system-level areas were explored in greater depth:

PSH → SNF/LTC Transfer Policy

Providers supported creating a formal pathway for PSH tenants whose medical needs exceed what PSH can safely provide. Key themes included protecting housing status, clarifying workflows, and improving coordination with healthcare partners.

Medical Case Conferencing

Participants endorsed a structured case conferencing model to support individuals with the highest medical and functional needs. Providers emphasized the need for predictable meetings, cross-system participation, and clear criteria for inclusion.

Governance Committee Feedback

Governance committees reviewed the proposed updates to the medical complexity definition, Coordinated Entry (CE) policy levers, and system alignment recommendations. While timing and agenda constraints meant that not every group was polled on every item, several clear trends emerged across the committees that participated.

Feedback on Current APAT Health Domain

Governance committee members were asked to review the current APAT Health Domain questions and reflect on how well they identify medical need, functional impairment, and barriers to stability. Their feedback aligned closely across committees and highlighted several core issues that limit the tool's accuracy, accessibility, and equity.

1. **Questions Do Not Identify the Real Barriers to Care**
    a. Members noted that questions such as "Do you avoid healthcare?" do not capture why people avoid care. Responses are often driven by cost, insurance gaps, waitlists, or poor past treatment, not lack of need.
    b. As written, the question misrepresents medical risk and overlooks structural barriers.
2. **Questions Rely Too Heavily on Medical Knowledge and Self-Awareness**
    a. People may not know that their ADL challenges count as a health issue or disability.
    b. Individuals may not know they have a progressive illness.
    c. Mental health questions require insight many do not have.

    d. This leads to systematic underreporting and under-identification of medically complex individuals.
3. **Several Questions Feel Stigmatizing or Unsafe to Answer**
    a. Specifically – questions around substance use, mental health, and violence can feel punitive or risky. A few examples that were uplifted: People may fear losing housing opportunities, police involvement or being placed in psychiatric holds.
    b. This discourages honest disclosure – especially among people with trauma histories and mistrust of systems.
4. **ADL Questions Need Clearer Language and Should Capture Equipment Use**
    a. Committees reported that the ADL questions are easy to misunderstand and often minimize real impairment. It's important to provide clarifying examples so people recognize ADLs as more than just personal struggles.
    b. Recommendations included explicitly asking about assistive devices (wheelchairs, walkers, medical equipment) and providing clearer functional examples to avoid misinterpretation, such as asking directly about wheelchairs, walkers, or assistive devices.
5. **The Tool Needs Trauma-Informed Language and Better Assessor Guidance**
    a. Wording should clearly communicate that answers will not jeopardize housing opportunities.
    b. Clear, plain-language questions assessors can read verbatim, and
    c. Assessors need training in cultural competency, trauma-informed communication, and safe framing of health-related questions.

Governance committees agreed that the current APAT Health Domain does not accurately capture health need because the questions are too clinical, rely on self-diagnosis, and often feel unsafe or stigmatizing to answer. Members highlighted the need for clearer ADL questions, language that reflects actual housing instability, and trauma-informed framing. Overall, they stressed that the tool must shift toward plain language, functional impacts, and structural barriers to care.

Feedback on Policy Recommendations

Committees expressed strong support for shifting CE's vulnerability definition to better reflect health, behavioral health, and functional impairment, with **70%** favoring this direction. The remaining **30%** felt the definition should go even further by explicitly incorporating risk of death or severe health decline. Together, these responses reinforce that governance members see health-related vulnerability as central to an equitable CE process.

When considering prioritization options, committees showed greatest interest in two approaches: **APAT+**, which would integrate medical complexity into a more robust scoring model, and a **Medically Complex Set-Aside**, with each receiving **30%** of first-choice responses. The BNL Override and Health Domain Tiebreaker followed, indicating support for both structured and flexible mechanisms to elevate individuals whose medical needs are not well captured by current scoring.

Governance members also weighed in on which system alignment efforts should be pursued first. A clear majority (**59%**) identified **diversifying housing options** as the most urgent priority, followed by establishing a **PSH → Skilled Nursing/Long-Term Care transfer policy** (**24%**) and improving **data sharing between housing and health systems** (**12%**). These responses highlight the committees' recognition that expanding and adapting housing models is foundational to meeting the needs of people with high medical vulnerability.

Finally, committees emphasized the importance of understanding **how many individuals on the By-Name List may meet the community's definition of medical complexity**, a request that directly informed the quantitative analysis included in this report.

Austin Homeless Advisory Council (AHAC)

The Austin Homeless Advisory Council provided critical lived-expertise insights on the medical complexity policy recommendations. Their feedback reinforced many themes raised by healthcare providers while also highlighting barriers, harms, and system gaps uniquely visible to people who have experienced homelessness.

When reviewing present Coordinated Assessment Health Domain questions and proposed policy recommendations, the following themes emerged:

1. Health Care Stigma and Discrimination Shape Access to Diagnosis and Treatment

AHAC members described pervasive stigma and mistreatment in healthcare settings, which directly affects the health outcomes of people experiencing homelessness. Members shared that individuals are judged "by how they look," denied care, or treated poorly because they lack an address. Several described being discharged unsafely, not believed when seeking care, or being treated as lesser than – one person shared they were treated in a hospital hallway and suspected it was because of how the hospital staff saw she was experiencing homelessness.

"Hard to get doctors to see you if you are homeless."
"I don't put shelter addresses on my medical file so I'm not treated like a 'homeless person."

Members emphasized that these experiences contribute to **delayed diagnoses**, including late-stage cancer, unmanaged diabetes, and preventable amputations.

2. Existing CE Health Questions Are Confusing, Stigmatizing, and Incomplete

AHAC members echoed provider concerns about the current CE assessment questions, sharing that several of the current CE health questions use clinical or unclear language, feel condescending, or require medical knowledge that many people do not have.

"People may not know they have conditions or understand the extent."
"The questions come across as condescending."
"Why isn't diabetes listed under end-stage disease?"

Members also raised concerns about **assessor capacity**, noting that many CE assessors are not healthcare providers and may not feel equipped to ask medically involved questions or identify health issues accurately. This led to a broader conversation about **what CE should be able to do**, with several members expressing strong interest in embedding a health component into CE:

"Can part of the CE process be a medical screening? Would help verify people's answers and identify issues people didn't know about previously."

Members emphasized that CE often feels incomplete because it only determines housing eligibility, without connecting people to the care they urgently need:

"At the end of the assessment, it felt anti-climactic — no referrals, just a 'wait and see.'"

They supported exploring ways for CE to connect individuals to clinics, screenings, and other services at the time of assessment, rather than functioning solely as a housing gateway.

3. Strong Support for Case Manager Input and Emergency Override Pathway

AHAC members supported creating pathways that allow case managers to elevate individuals with complex health needs whose situations may not be captured through standard scoring.

"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."

Members stated this approach reflects what other communities have done and compared it to the flexibility seen during COVID-era ProLodges.

Summary

AHAC feedback strongly aligned with the need for a medical complexity framework that addresses functional impairment, health system stigma, and gaps in assessment. Of note, one member did also encourage that pregnancy should be listed as a supporting factor in our community's medical complexity definition. Members supported the proposed changes and reinforced the need for clearer assessment language, earlier identification of medical needs, and system-level support such as home health access.

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

– AHAC Member

Austin Youth Collective (AYC)

The Austin Youth Collective (AYC) provided critical youth-centered insights on how medical complexity and Coordinated Entry (CE) policies should reflect the experiences of young people navigating homelessness.

When reviewing present Coordinated Assessment Health Domain questions and proposed policy recommendations, the following themes emerged:

1. **Defining Medical Complexity: Include Physical, Mental, and Stress-Related Factors**

AYC members recommended expanding the community definition of medical complexity to better reflect physical and neurological conditions and emphasized the importance of mental health and incorporating the debilitating impact of chronic stress. They also requested that the policy list every diagnosis that indicated a person's eligibility to support transparency and understanding.

AYC participants emphasized that medical complexity must encompass a broad range of physical, neurological, and mental health needs. Members specifically uplifted bone and nerve conditions and highlighted that chronic stress can be debilitating and should be recognized within the framework.

"Maybe include people with bone issues or nerve issues."
"Mental health could be a factor considering…"
"Incorporate all the mental things that can contribute to somebody's day."

Youth also expressed a desire for transparency about what conditions fall under medical complexity and recommended that the policy clearly "list it out."

2. **Assessment Questions Should Be Clear, Nonjudgmental, and Relevant to Youth Experiences**

AYC raised concerns that several current APAT health questions feel judgmental, stigmatizing, or overly clinical, particularly around substance use and mental health. They shared that youth may avoid answering honestly if questions appear punitive or tied to criminalization. They recommended reframing these items to focus on how health or substance use impacts stability, rather than implying fault or blame.

"Current questions seem judgmental."
"Not the substance, it's how you use it."
"People who are using won't answer because of the potential consequences of the answer (i.e. police)."

AYC members also highlighted that the APAT's reliance on HUD's formal definition of "housing" does not reflect how youth experience shelter, displacement, or informal living arrangements. They recommended broadening language so questions capture instability such as being forced to leave a friend's place or experiencing a sweep—situations that youth consider housing loss even if HUD does not.

Additionally, youth identified important domains missing from the current health section, including insurance access, which significantly affects health stability and care navigation for young people.

Overall, AYC members responded positively to the direction of the draft APAT questions, noting that the **proposed revisions were clearer and less stigmatizing, but there is still much more work to do**. When asked, on a scale of 1-5, how do these draft questions move us toward the kind of assessment our community needs? One member stated, "Somewhere in the middle, everything within reason. You are asking the right questions - but they can still be written in a way that is more trauma informed."

3. Prioritization: Interest in Integrating the BNL Override Into APAT+

AYC members were supportive of prioritization approaches that allow medically complex individuals to be elevated even when traditional scoring does not capture their circumstances. They expressed interest in combining elements of the BNL Override Policy with APAT+ (the integrated data model option for prioritization), noting that an approach blending discretion and data could better reflect the diverse needs of our community.

4. Systems Alignment: Some Work Should Proceed Through Governance, but Much Can Move Faster

Youth participants recognized that certain system changes—such as formal CE pathways and prioritization structures—will need to move through Leadership Council. However, they also emphasized that many of the systems alignment recommendations, particularly

operational or coordination-focused improvements, could be pursued outside of governance structures and implemented more quickly. They encouraged ECHO to move forward on actionable items without waiting for full governance deliberation where appropriate.

Summary
AYC members emphasized including physical, neurological, mental health, and stress-related factors in the medical complexity definition. They noted that current CE health questions feel judgmental or misaligned with youth realities—especially around substance use, mental health, and informal housing—and supported clearer, function-focused revisions that include missing domains like insurance access. Youth also favored integrating the BNL override into APAT+ and encouraged advancing system alignment work that does not require full governance approval.

Quantitative Findings: Estimating Medical Complexity Using Existing CE Data

To approximate how many people on the By-Name List (BNL) may meet the community's definition of medical complexity, ECHO analyzed the strongest indicators available within the current CE Health Domain. While these indicators do not reflect the full definitional framework, they provide useful insight into the patterns of functional impairment and serious illness in the population.

1. Using the Four Questions Most Often Identified by Healthcare Providers and Governance Members Produces a Very Small, Narrow Cohort

ECHO Facilitators asked healthcare providers and members of Governance Committees to select what they believe to be the top four existing APAT questions that best measure medical complexity. The top four were:

- Progressive end-stage disease (Question 8)
- ADL impairment (Question 9a)
- Difficulty maintaining housing due to mental health (11a)
- Mental health or brain issues affecting independent living (11b)

A brief analysis was conducted to observe demographic trends for those who affirmatively answered all of these questions (Figure 6). Not pictured, this group, which is 3.6% of the BNL, represents 7.4% veterans and has an average APAT score of 13.4.

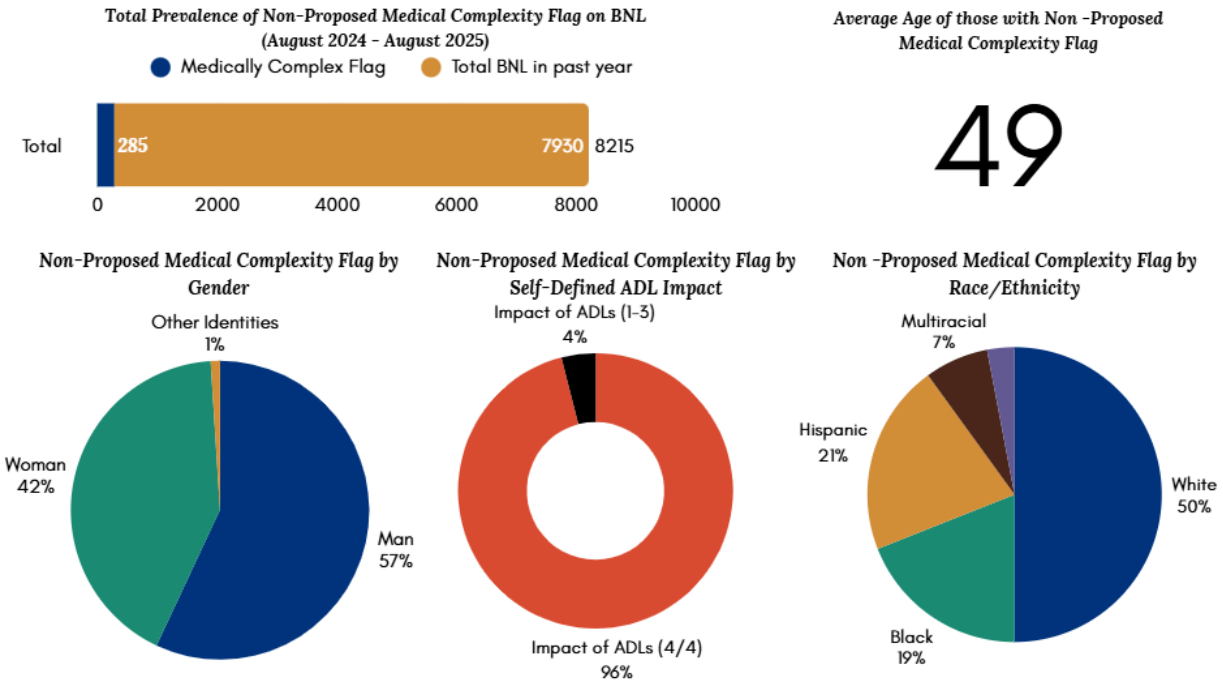

Figure 6. Prevalence and demographic data of our first pass Medical Complexity flag that we do not propose due to demographic misalignment with community priorities.

This distribution results in a very narrow proxy, capturing only a small subset of individuals with high health needs and yielding demographic patterns that differ significantly from the broader unhoused population (32% Black, 29% Hispanic, 25% White, 5% multiracial; *State of the HRS Report, 2025*). Notably, two of the four questions in this proxy (11a and 11b) originate from the VI-SPDAT, a tool that has been shown nationally to reinforce inequitable scoring patterns and inflate prioritization for White individuals. Given these concerns and the misalignment with our community's racial equity commitments, we explored an alternative proxy more consistent with the core elements of the medical complexity definition.

2. A More Aligned Proxy (ADLs + End-Stage Disease) Produces a Larger and More Representative Group

Because the community definition centers **functional impairment** and **serious health conditions**, ECHO analyzed a second proxy using only:

- End-stage/progressive disease (Question 8), and
- ADL impairment (Question 9)

These two items are also the only questions in the Health Domain not inherited from the VI-SPDAT, making them uniquely positioned to reflect the core elements of medical

complexity without the inequitable scoring patterns associated with VI-SPDAT–derived items. A brief analysis was conducted to observe prevalence and demographic trends for those who affirmatively answered both of these questions (Figure 7). Not pictured, this group, which is 16% of the BNL, represents 7.8% veterans and has an average APAT score of 11.8.

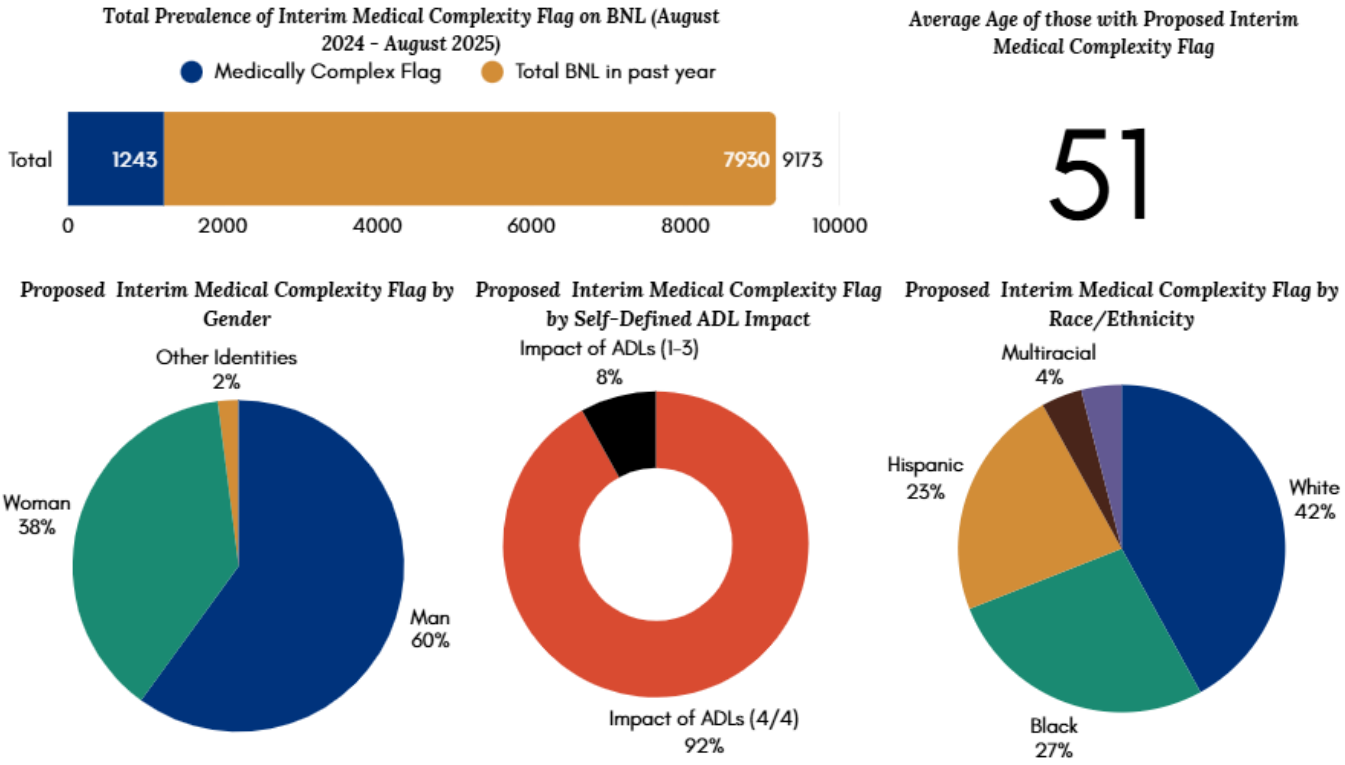

Figure 7. Prevalence and demographic data for a Medical Complexity flag that is proposed as an interim solution, prior to larger community redesign, to mitigate risk of death.

When replicated across the **full BNL (15,103 individuals)**, the results were consistent:

- **1,990 individuals (13%)** met this proxy
- Demographic and scoring patterns were nearly identical

While limited, this proxy more closely aligns with the definition of medical complexity (See: Community Definition of Medical Complexity) and reflects the demographic composition of our unhoused population more accurately.

3. Functional Impairment Is a Dominant Signal of Medical Complexity

Of note, analysis of the ADL item revealed that **functional impairment is not a marginal issue—it is the predominant health-related challenge in the population**:

- **7,915 of 15,103** individuals on the full BNL (**52%**) report **4/4** ADL impairment (Figure 8).
- **4,484 of 7,930** individuals assessed in the last year (**56%**) report **4/4** impairment.

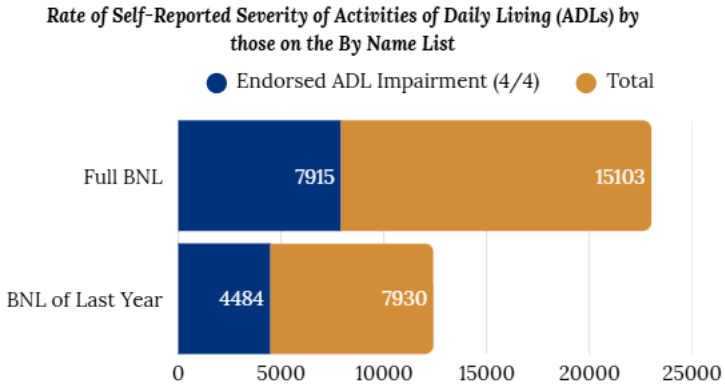

Figure 8. Rate of self-reported Activities of Daily Living on the full by name list (total) and within the past year (08/2024 – 08/2025).

This means that **more than half of people assessed experience major limitations in their ability to complete essential daily activities** - a level of impairment strongly associated with heightened risk of medical decline, hospitalization, and housing instability. Functional impairment clearly emerges as a **central indicator of medical complexity** and underscores the need for CE policy to elevate functional status as a core component of prioritization.

Further, functional impairment has emerged as one of the strongest signals of increased health-related vulnerability available in existing CE data, and can be used as an interim flag for medical complexity to mitigate risk of early death.

Policy Recommendations

This section outlines the full set of policy recommendations necessary to meaningfully incorporate medical complexity into Austin/Travis County's Coordinated Entry system. These recommendations are intentionally comprehensive, reflecting both immediate system gaps identified through the Medical Complexity Project's engagement with people with lived experience, healthcare partners, and homelessness response system providers, as well as the longer-term structural changes required to sustainably identify and prioritize individuals at highest risk of serious harm or death while unhoused.

While not all recommendations can or should be implemented simultaneously, this section establishes the policy rationale, design principles, and end-state goals that will guide both near-term actions and the ongoing Coordinated Entry redesign. The

accompanying Implementation Plan distinguishes which actions can be taken immediately to reduce harm and which should be embedded within the formal CE redesign process.

While ECHO Leadership has indicated that full implementation will likely occur within that larger redesign process, we are preserving the original recommendations and implementation framework here to honor community input and maintain a clear, data-informed roadmap for moving this work forward.

Community Definition of Vulnerability

Vulnerability is the mechanism a CoC uses to determine who is most in need of its limited housing resources, shaping both the information collected through the Coordinated Assessment and the way housing opportunities are allocated. Austin/Travis County's current definition of vulnerability does not explicitly account for individuals who are medically vulnerable, leaving a critical gap in how the system identifies and prioritizes those with the highest risks.

Nationally, CoCs are increasingly expanding their definitions of vulnerability to incorporate physical and behavioral health as part of broader efforts to address medical complexity within CE. Stakeholders across the Austin/Travis County community echoed this shift, expressing broad consensus that the current definition should be expanded to explicitly include physical and behavioral health needs. Updating the definition offers a clear path to strengthen equity, improve targeting of scarce resources, and align with emerging best practices across the country.

Recommendation

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*.

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.

Additionally, our Coordinated Assessment (CA) tool was not originally designed to capture health risk, functional impairment, or medical complexity; in fact, current CA policy explicitly excludes these domains. **Expanding the definition of vulnerability to include medical complexity will therefore require corresponding updates to the Coordinated**

Assessment Policy. For details on its proposed implementation, see Implementation Plan *(see Implementation Plan: Immediate & Interim Actions).*

Coordinated Assessment

Across all engagement groups, there was broad agreement that the current APAT Health Domain does not accurately or equitably identify medical complexity. Much of the section still reflects the original VI-SPDAT, a tool that OrgCode (its creators) now advise communities to discontinue due to validity concerns and inequitable scoring patterns. This context shaped participants' feedback and reinforced the need for significant redesign.

Five cross-cutting themes emerged:

1. **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.
2. **Questions Rely Too Heavily on Medical Self-Awareness**
   - Many individuals do not know their diagnoses, 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.
3. **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.
4. **ADL 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.
5. **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.

To better identify and prioritize people who meet the community's definition of medical complexity, the Coordinated Assessment must be updated to capture the core and supporting factors associated with heightened medical complexity.

Strengthening this section will enable Coordinated Entry to more accurately identify individuals with significant functional limitations or serious health conditions and ensure that their needs are appropriately accounted for in the housing referral process.

The accompanying graphic illustrates which domains of medical complexity are currently

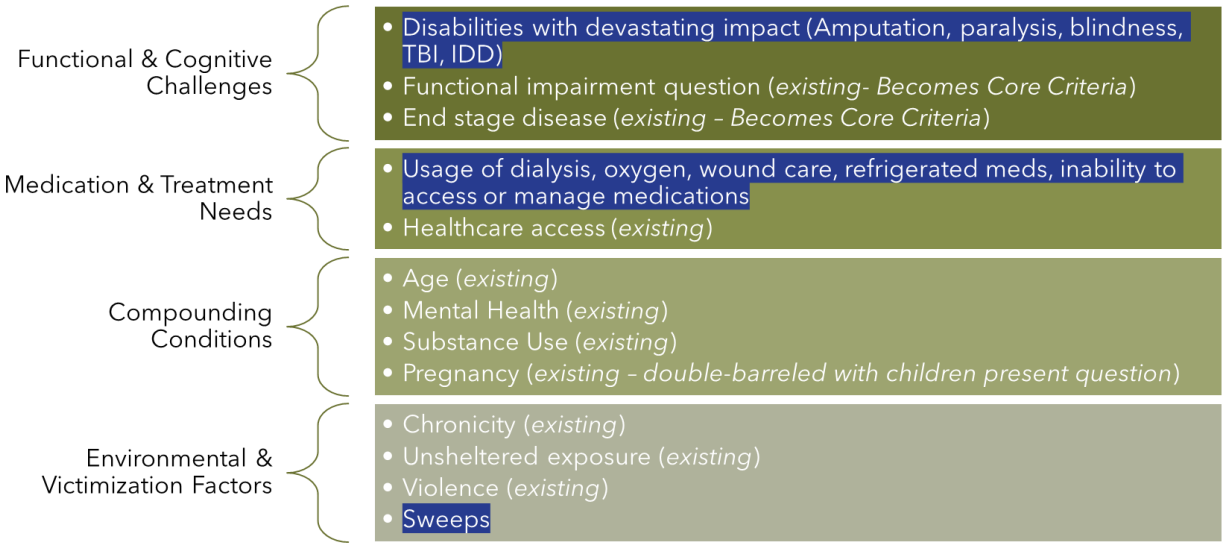

Figure 9. Breakdown of each of the Supporting Factors that are identified in our community definition of Medical Complexity. Areas in green are questions that exist already in present Coordinated Assessment, with elements highlighted in blue that are missing entirely. All questions must be evolved to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

represented in the APAT and which are missing entirely. Three key factors identified by stakeholders—such as disabilities with devastating impact, treatment needs, and systemic risk exposure (e.g. sweeps) —are absent from the existing tool. Their absence contributes to the systemic under-identification of medically complex individuals.

Two additional areas also require revision:

Age as a Health Indicator: Age is a well-established predictor of mortality, functional decline, and medical vulnerability among people experiencing homelessness. Although age is collected as demographic information, it is not represented within the Health Domain, where it would provide critical context for assessing medical risk.

Pregnancy and Postpartum Status: The APAT currently includes a double-barreled item combining pregnancy/breastfeeding status with questions about children in the household (Q5). Pregnancy and postpartum status carry significant health risks and should be treated as a distinct supporting factor, not embedded within a question inquiring about household characteristics. Separating these concepts and placing pregnancy-related health risk within the Health Domain would improve identification of medically complex individuals.

Policy Recommendation: Redesign of the Health Domain

To better identify and prioritize individuals who meet the community's definition of medical complexity, the Coordinated Assessment must be substantially revised. This report recommends initiating a Coordinated Assessment redesign process that:

- Replaces VI-SPDAT–derived items with trauma-informed, plain-language questions aligned with core and supporting elements of medical complexity;
- Incorporates all medical complexity elements currently absent from the APAT, including functional impairment, treatment dependence, devastating disabilities, pregnancy and postpartum risk, age-related medical vulnerability, and systemic risk exposures (e.g., sweeps).
- Establishes clear assessor guidance, scripts, and training requirements to ensure consistent, equitable administration.

A refined prototype question set is included in the Appendix as a starting point for the CE redesign (see **Appendix, Table 6**). Final question language, scoring, and workflows should be developed in the CE Redesign and validated through a dedicated design phase involving assessors, clinicians, housing providers, and people with lived expertise *(see **Implementation Plan: Integrating Medical Complexity into Redesign**)*.

We also propose opportunities to mitigate harm of the present assessment during the Interim period through the implementation of a BNL Override Policy and a Medical Complexity Flag integrated into our existing prioritization using the only two APAT questions that are not VI-SPADT *(see **Implementation Plan: immediate & Interim Actions**)*.

Prioritization

A Layered Framework for Incorporating Medical Complexity into Prioritization

To ensure that individuals experiencing homelessness who meet the definition of medically complex are prioritized for housing, a stepwise approach to implementing policies within the prioritization component of Coordinated Entry is recommended. This approach balances immediate urgency and long-term policy refinement, allowing the Austin/Travis County Community to strategically update its processes while being able to respond in real-time to those who are at critical health risk.

The steps below are not intended to replace one another. Instead, they work together to address medical risk at different points in the system. Step one creates an immediate pathway to respond to urgent health risk, step two strengthens how health factors are used within existing prioritization, and step three reflects a longer-term shift toward integrating housing and health data within Coordinated Entry. **Together, this layered framework allows the system to respond to immediate need while continuing to build toward a more precise and equitable approach over time through the larger CE redesign.**

Step One: Health-Risk BNL Override

The immediate implementation of a Health-Risk BNL Override policy would allow Austin/Travis County CoC CES to rapidly respond to individuals at imminent health risk but involves minimal modifications to the existing CE workflows, allowing the system to respond rapidly to urgent health needs while maintaining overall system flow and equity *(see Implementation Plan: Immediate and Interim Actions)*.

In practice, a Health-Risk BNL Override policy allows healthcare and HRS providers in the Austin/Travis County CoC to identify individuals experiencing homelessness who are in an imminent health crisis. The provider will submit an Override Request form to ECHO Staff, who would determine if the client meets the baseline criteria outlined in the policy for escalation consideration.

Once the client information is verified, ECHO staff would inform the Community Review Team (CRT) (whose makeup is inclusive of HRS providers, PLE, and healthcare providers from the Austin/Travis County CoC/Community) and the identified client would be reviewed for BNL escalation. If the request is approved, the client would escalate to the top of the BNL to be referred to the first permanent supportive housing (PSH) unit available that the individual is eligible for.

If the override request is denied by the CRT, the client would remain in their current position on the BNL. The CRT would make every attempt to connect this client to additional healthcare and supportive services in the community to try to meet their needs while they are experiencing homelessness.

The Health-Risk BNL Override policy is designed to supplement existing and future Coordinated Entry (CE) policies, rather than serve as a comprehensive strategy for ensuring that medically complex individuals are fully supported within the CES. Its purpose is to provide an immediate mechanism for elevating individuals who are experiencing medical deterioration while homeless, without requiring changes to the broader CE framework. Because this policy can be implemented independently of larger policy revisions, it offers a timely, targeted response for clients facing imminent health risks,

ensuring the system can act quickly while longer-term CE policy updates continue to develop. This policy is drafted and welcomes feedback and further review (see Supplemental Materials, Form 1).

Step Two: Health Domain Tiebreaker

A critical second layer introduces the Health Domain Tiebreaker, refining the current CE prioritization scheme by using health-related factors captured on the APAT to distinguish between individuals with comparable CA scores. This policy can be implemented in one of two ways:

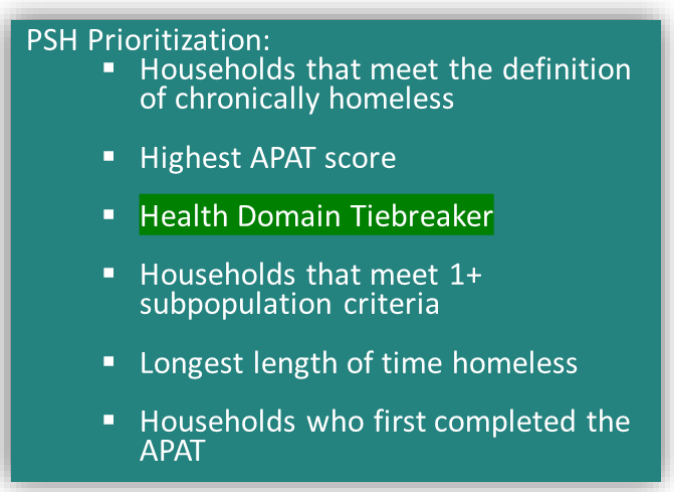

Figure 10. The PSH Prioritization above highlights the HUD requirement of Chronicity for PSH units and shows the series of community-defined tiebreakers that are considered when working through a PSH referral. The recommended Health Domain Tiebreaker is highlighted for clarity.

1. **Existing Health Domain:** Uses the indicators currently incorporated into the Health Domain section of the APAT. This option enables immediate policy implementation with minimum system change and allows for consistency in current workflows *(see Implementation Plan: Immediate and Interim Actions)*.
2. **Evolved Health Domain:** Enhances the current health domain by incorporating additional Supporting Factors as health indicators (see Community Medical Complexity Definition), allowing for a more precise identification of individuals with higher medical complexity. This approach may better capture those who are medically complex but requires updates to questions and their corresponding scores *(see Implementation Plan: Integrating Medical Complexity into the CE Redesign)*.

Example:

- **Household A:** CH, APAT score = 14, Health Domain score = 3 → *lower priority*
- **Household B:** CH, APAT score = 14, Health Domain score = 6 → *prioritized for housing*

In this scenario, both households are chronically homeless and have identical APAT scores, indicating similar overall vulnerability. The Health Domain tiebreaker is applied to distinguish between them: Household B has a higher health score, reflecting greater medical or behavioral health needs, and is therefore elevated in the prioritization queue to receive housing more quickly. This ensures that limited resources are directed to those at greatest risk of medical deterioration.

This policy is included in Step 2 because it can be applied with minimal changes to existing CE processes and workflows, allowing the system to refine prioritization without major operational disruptions. When using the **evolved APAT section**, the Health Domain incorporates additional indicators of physical and behavioral health, allowing for a more precise identification of clients with higher medical complexity. Applying the tiebreaker in this context will require adjustments to Health Domain questions and their respective scores, staff training, and new workflows to accommodate the expanded data collection. In contrast, using the **existing Health Domain section** achieves the same prioritization function with minimal changes to system processes or staff responsibilities, allowing for immediate implementation while maintaining alignment with current CE operations.

Step 3: Integrated Medical Complexity Scoring (APAT+)

The final prioritization layer incorporates APAT+ — a smarter iteration of the existing prioritization process — to embed a shared housing–health lens within Coordinated Entry. Implementation of APAT+ requires establishing formal data-sharing agreements with healthcare partners, addressing general equity concerns related to access to healthcare and representation in the data, and developing a structured implementation plan in the larger CE redesign *(see Implementation Plan: Integrating Medical Complexity into the CE Redesign)*. These prerequisites ensure that health data is integrated securely, ethically, and consistently into Coordinated Entry before the system can begin using it to refine prioritization and elevate individuals with medical complexity.

In practice, the Coordinated Assessment would continue to screen for core elements of medical complexity and capture supporting factors, while over time the system would evolve to layer in verified health data from partners, such as hospital readmissions, EMS calls, or ICD-10 codes. **These health indicators would be represented in HMIS as a simple numeric flag, which could function as a tiebreaker, a score adjustment, or a trigger for case review. The intent is to create a verified health signal — an external data point that elevates individuals with the highest medical risk — without importing full medical records or adding assessment burden.** Once securely transmitted to HMIS, the data integrates with CE's prioritization logic. This allows the system to act earlier and coordinate more effectively with healthcare partners. It also enables real-time

responsiveness to medical complexity, ensuring that individuals at highest risk are identified and elevated promptly.

While information collected through the Coordinated Assessment (CA) continues to serve as the foundation for prioritization, APAT+ provides a structured mechanism to identify and elevate medically vulnerable clients proactively, enabling the system to intervene before crises occur and ensuring that scarce housing resources are allocated to those at greatest health risk.

There are three main ways this modifier could be operationalized, ranging from the simplest to a more complex, integrated approach.

Option 1: Health Modifier as a Tiebreaker

When two or more clients are prioritized for a PSH unit, the system will check for a medical complexity flag or modifier. If present, the household will rise in priority for open units; if a flag does not exist for the client, existing tiebreakers within the prioritization scheme will apply.

Figure 11. APAT+ would integrate Supporting Factors (See Figures 4A, 4B) through the Coordinated Assessment with Observable Indicators, which would be integrated through a singular numeric flag from healthcare partners that could be used to inform prioritization. This numeric flag would be in alignment with the community Medical Complexity definition and would be a scaled representation of health acuity. To do this, data sharing agreements and data infrastructure with health partners would need to be in place to connect numeric data with HMIS.

Option 2: Health Modifier Incorporated into APAT Score

Each client's CA score is adjusted by a medical weighting factor based on the intensity of the numeric flag. For example, a standard APAT score of 12 might become 15 if the client has a high-risk medical flag (e.g., frequent hospitalizations, critical diagnosis). Adjustments can be additive (+3) or percentage-based (×1.25).

Option 3: Health Modifier as an Override Trigger

When defined criteria are met (e.g., ≥3 hospital readmissions in 30 days, life-threatening diagnosis, active crisis contact), the flag triggers immediate case review or referral

override, bypassing the BNL. The override trigger would be elevated to the Community Review Team to assess and manage.

To address possible healthcare access equity concerns, identified inequities will be reviewed systematically, and a targeted mitigation plan will be developed, tested, and refined to ensure that medically vulnerable individuals—particularly those from historically underserved populations—are accurately recognized and prioritized within Coordinated Entry. Possible equity concerns are likely to be addressed through a counter-lever developed within HMIS. This approach ensures that APAT+ reflects true need rather than systemic access gaps, promoting equitable allocation of housing and supportive services.

Policy Recommendation: Stepwise Implementation Approach

Thia layered approach to incorporating medical complexity into the prioritization component of Coordinated Entry balances immediate action with long-term system refinement. Step 1 implements a Health-Risk BNL Override to rapidly elevate clients in imminent medical crisis with minimal workflow changes. Step 2 introduces a Health Domain tiebreaker within APAT to distinguish between clients with comparable vulnerability scores, using either existing indicators for immediate implementation or an evolved set for greater precision. Step 3 leverages APAT+ to integrate verified health data into HMIS, enabling proactive identification of medically vulnerable clients, real-time responsiveness, and equity-focused prioritization. **This structured, phased approach ensures the system can respond immediately to urgent health risks, refine prioritization over time, and allocate scarce housing resources to those at greatest medical risk.**

Step 1 (BNL Override) is proposed as an Interim solution, as is a modified version of Step 2, (Health Domain Tiebreaker) (see ***Implementation Plan: Integrating Medical Complexity into the CE Redesign***).

Step 3 (APAT+) is being rolled into the larger CE redesign *(see **Implementation Plan: Integrating Medical Complexity into the CE Redesign**).*

Systems Alignment

Policies alone cannot achieve their intended impact without a broader system capable of supporting medically complex individuals through every stage of housing and care. Even the strongest definitions, assessment tools, and prioritization mechanisms will fall short if the surrounding infrastructure - contracts, staffing, coordination pathways, and housing options - cannot respond to the needs being identified. To ensure that policy changes translate into real outcomes, the community emphasized the importance of strengthening four interconnected areas: structural alignment, staffing capacity, policy and process infrastructure, and long-term system planning.

1. Structural Alignment

To embed medical complexity into the system in a meaningful way, foundational structural supports must be aligned across housing and healthcare partners. This includes:

- **Aligning local government contracts with new prioritization criteria**, ensuring that provider deliverables and performance measures support the identification and inclusion of people with medical complexity.
- **Building a dedicated CE referral pathway to Emergency Shelter for medically complex people**, creating a rapid stabilization option for individuals who cannot safely remain unsheltered while awaiting housing.
- **Enabling data-sharing across housing and healthcare systems**, so that observable indicators - such as diagnoses, hospitalizations, readmissions, life sustaining treatments and medical device usage, or other indicators of functional impairment - can be integrated into assessment and prioritization workflows.

These structural shifts create the conditions for consistent implementation and reduce systemic fragmentation.

2. Strengthening Staffing Capacity

Community feedback highlighted that housing programs frequently lack the staffing depth needed to support tenants with high health needs. To close this gap, recommendations include:

- **Expanding Health Care Collaborative and SOAR staffing** to improve access to primary and behavioral health care, strengthen in-home support, and increase system capacity for benefits assistance, disability documentation, and coordinated health care.

- **Embedding robust peer support roles within PSH teams**, recognizing that peers often serve as critical and trusted relational bridges for individuals with complex needs.
- **Cross-training housing staff on medical complexity**, ensuring that teams can recognize early signs of decline, escalate concerns appropriately, and navigate new pathways such as medical case conferencing or transfer reviews.

These investments help ensure that individuals with significant functional or medical challenges receive consistent, informed support once housed.

3. Policy & Process Infrastructure

Several operational policies are necessary to support earlier identification, coordinated care, and safe transitions across levels of care:

- **Permanent Supportive Housing → Skilled Nursing / Long-Term Care Transfer Protocol**
  Establishing a structured pathway prevents avoidable evictions, reduces unsafe discharges to homelessness, and protects resident autonomy by ensuring that individuals whose needs exceed PSH capacity are connected to clinically appropriate settings. This policy will be drafted in partnership with the PSH Health Care Collaborative, the Transitions of Care team, and other supportive housing health care providers *(see Implementation Plan: Immediate and Interim Actions)*.
- **Pre-/Post-Referral Medical Case Conferencing**
  A coordinated cross-sector staffing – to include health care street teams, outreach teams, and navigation — triggered by service providers who have identified troubling indicators of health

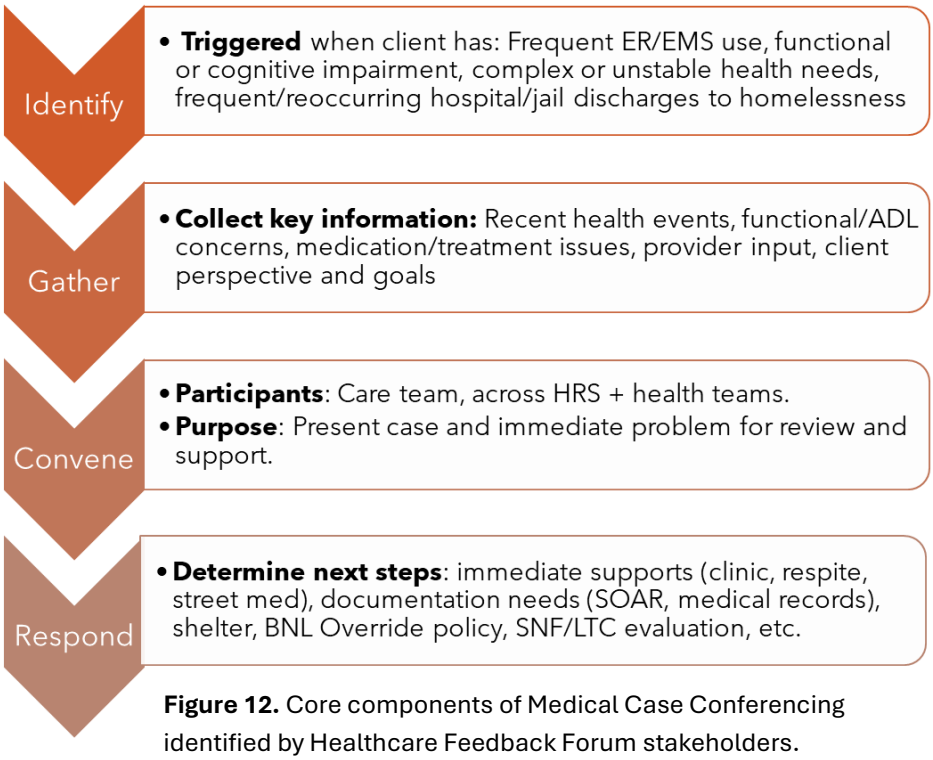

Figure 12. Core components of Medical Case Conferencing identified by Healthcare Feedback Forum stakeholders.

decline such as frequent ER use, functional decline, or unstable health. This space would support accurate assessment, early stabilization planning, and improved communication between outreach, navigation, and healthcare teams. The development of this space would take concerted community buy in to mitigate any concerns around data sharing and would need to be aligned with City outreach meetings. This space could elevate individuals that meet criteria for the BNL Override, medical respite, SOAR, or an emergency shelter bed, for example *(see Implementation Plan: Immediate and Interim Actions)*.

- **Provider Input Form for Underreporting on CE**
  This mechanism Coordinated Assessors to elevate relevant observational information that may not surface in the CE assessment, offering an essential safeguard against under-identification due to stigma, misunderstanding, or limitations of self-report. This policy is drafted and welcomes feedback and further review (see Supplemental Materials, Form 2). Information collected through this form will inform ongoing Coordinated Entry redesign efforts by helping the community better understand how medical complexity and functional risk show up when current assessment tools fall short. These data will support learning about how provider observations can thoughtfully supplement assessment responses and be embedded into the system over time *(see Implementation Plan: Immediate and Interim Actions)*.

Together, these processes strengthen continuity of care, reduce system churn, and ensure that key health information informs referral and housing decisions.

4. Future Planning & System Capacity Development

Sustainable implementation of medical complexity policies requires expanding the types of housing and care options available in the community. Key areas of long-term planning include:

- **Developing new housing models**, such as transitional housing, LTC partnerships, reentry housing, recovery housing, shared housing, or hospice-aligned housing for individuals with life-limiting illness.
- **Pursuing braided funding models** that combine healthcare, housing, and supportive service dollars to create scalable, medically supportive housing pathways.

These forward-looking strategies are essential for building a continuum that can meet the needs of people whose health conditions exceed what traditional PSH was designed to support.

Implementation Plan

Because the Coordinated Entry redesign is a multi-phase, year-long process, the following implementation strategy distinguishes between actions that can be implemented immediately to reduce preventable harm and those that must be intentionally incorporated into the broader CE redesign to ensure durability, equity, and system alignment.

While ECHO Leadership has indicated that full implementation will likely occur within that larger redesign process, we are preserving the original recommendations and implementation framework here to honor community input and maintain a clear, data-informed roadmap for moving this work forward.

I. Immediate and Interim Actions to Reduce Harm During the CE Redesign Process

Recognizing the length and complexity of the CE redesign timeline, the following actions are recommended for implementation in the near term. These steps are designed to reduce immediate harm, generate implementation learning, and complement—not pre-empt—the broader redesign.

1. **Adopt Updated Coordinated Entry Vulnerability Definition**

Adopt an expanded Coordinated Entry vulnerability definition that explicitly recognizes medical complexity and elevated risk of serious harm or death while unhoused as critical components of vulnerability. This action establishes a shared, system-wide understanding of vulnerability that reflects community-identified risk and documented outcomes. Additionally, as our current CA policy explicitly excludes identification of health or safety risk domains in our assessment, **expanding the definition of vulnerability to include medical complexity will therefore require corresponding updates to the Coordinated Assessment Policy.**

> ***Proposed Definition of Vulnerability****: Those least likely to self-resolve their homelessness without formal intervention, especially those whose medical complexity or environmental risks make remaining unhoused unsafe or life-threatening*

This definition is intended to guide current decision-making and interim policies and to serve as a foundational reference for future assessment and prioritization tools. The specific mechanisms for measuring and applying this definition may continue to evolve over time; however, adopting the definition now ensures that individuals with life-threatening health needs are not excluded from consideration while longer-term system changes are underway.

2. **Implement a Health-Risk By-Name List (BNL) Override Policy**

A Health-Risk BNL Override provides an immediate, structured pathway to elevate individuals experiencing imminent or life-threatening medical risk. This policy can be implemented with minimal workflow disruption and paired with evaluation or sunset provisions aligned with CE redesign milestones. If approved by Leadership Council, this policy change could be operational within 60 days. This policy is drafted and welcomes feedback and further review (see Supplemental Materials, Form 1).

3. **Provider Input Form**

While Coordinated Entry health questions remain largely derived from the VI-SPDAT, there is a risk that individuals with serious medical complexity or functional impairment may not be fully reflected in their assessment scores. As an interim measure, the Provider Input Form can be used to support limited score adjustments within Coordinated Entry when documented health needs are not adequately captured through self-reported assessment responses.

This approach allows CE scores to more accurately reflect observable health risk and functional impairment using existing processes, without altering the assessment tool itself. It is intended as a temporary harm-reduction measure while longer-term assessment and prioritization updates are developed. This policy is drafted and welcomes feedback and further review (see Supplemental Materials, Form 2).

4. **Create Interim Health Domain Tiebreaker with Medical Complexity Flag:**

Develop Medical Complexity flag based on our two existing APAT questions that most align with the Core Criteria of the Medical Complexity community definition:

    1. ADLs Question
    2. Progressive End Stage Disease (proxy for chronic condition)

If both are answered affirmatively, individual is flagged in HMIS as Medically Complex and this flag is used as a tiebreaker after APAT Score and Chronicity for PSH referrals. This is only an interim solution; once the larger redesign is complete, we recommend updating

this flag to be more representative of our community definition of medical complexity, and not limited to progressive end stage disease (see Supplemental Materials, Form 3).

5. **Establish a Medical Case Conferencing Process**

Creating a formal medical case conferencing mechanism—either as a pilot or standing process—allows healthcare and 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.

6. **Initiate Development of a PSH → Skilled Nursing / Long-Term Care Transfer Protocol**

Developing a formal transfer protocol protects housing stability for Permanent Supportive Housing tenants whose medical needs exceed what PSH can safely provide. This work addresses a critical system gap and can proceed independently of CE redesign timelines. 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.

II. Integrating Medical Complexity into the Coordinated Entry Redesign

The following components outline shared design and operational considerations intended to support consistent identification and response to medical complexity within future Coordinated Entry iterations. While these elements do not require changes to the formal CE redesign scope, they are intended to inform redesign deliverables, implementation planning, and cross-team operational decision-making.

1. **Medical Complexity as a Community Priority, Not a Subpopulation**

Medical complexity is not a discrete subpopulation within the Homelessness Response System. Rather, it is a **cross-cutting, data-informed community priority** that reflects elevated risk of serious harm or death and can affect individuals across multiple demographic and programmatic groups.

Individuals experiencing medical complexity may include—but are not limited to—youth, older adults, people with disabilities, individuals with chronic or terminal illness, people with behavioral health conditions, people fleeing domestic violence, individuals cycling through the carceral system, veterans, and people experiencing chronic homelessness. **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.

2. **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 (See Medical Complexity definition). Assessment tools, prioritization methodologies, and matching processes should demonstrate how they capture and respond to this definition, rather than reopening or re-litigating it during redesign. Redesign outputs should explicitly map how proposed assessment questions, prioritization logic, or referral workflows align with the core elements of this definition.

3. **Assessment Design Requirements Related to Health and 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, below:

   - Chronic, life-limiting, or serious health conditions (inclusive of chronic medical, behavioral health, or substance use conditions)
   - Functional impairment (trouble with daily activities of living)
   - Co-occurring conditions (mental health, substance use, age, pregnancy)
   - Disabilities with devastating impact (amputation, paralysis, blindness, dementia, traumatic brain injury, intellectual disability)
   - Medication and treatment needs
   - Exposure to unsafe or destabilizing environments (chronic homelessness, unsheltered exposure, sweeps, violence)

These elements are all further defined in our community's definition of medical complexity (see Definition of Medical Complexity). Question design should be trauma-informed, accessible, and grounded in lived experience rather than clinical self-diagnosis.

4. **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.

This information will be used to identify system bottlenecks, inequities, and design gaps related to the identification and prioritization of individuals with complex medical needs, and to inform redesign recommendations grounded in lived experience and cross-system expertise.

5. **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.

6. **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.

7. **Conditional Referral Pathways and Resource Matching**

As part of CE redesign, the Medical Complexity flag could inform conditional referral logic that supports appropriate matching to available interventions, including but not limited to:

- Permanent Supportive Housing with enhanced supports
- Medical respite
- Recovery-oriented housing
- Long-term care or skilled nursing pathways
- Other health-integrated housing models developed through system alignment efforts.

This ensures that identification of medical complexity leads to meaningful action, rather than solely influencing position on a housing queue. Redesign plans should identify which existing or planned interventions can be activated through medical complexity indicators, even where capacity is limited.

8. **Alignment with Systems Beyond Coordinated Entry**

The CE redesign should explicitly account for downstream system interfaces that affect medically complex individuals, including healthcare, long-term care, and supportive housing capacity. CE improvements alone are insufficient without parallel alignment across these systems.

As part of CE implementation planning, responsible teams should identify and name key external dependencies that affect outcomes for medically complex individuals and document relevant assumptions, constraints, or points of friction within existing referral and discharge pathways. Where gaps or misalignments are identified, implementation planning should include a strategy for shared partnership and coordinated action, clarifying engagement needs and roles across housing, healthcare, and related systems.

Summary

Together, these implementation steps align urgency with accountability. By advancing near-term actions to reduce preventable harm and embedding Medical Complexity into the conceptual foundation of Coordinated Entry, the community commits to a system that responds to health risk when it appears and is structurally equipped to serve individuals with the highest health needs over time.

Supplemental Materials

Form 1. Austin/Travis County CoC Coordinated Entry: Health Risk By-Name-List Override Policy *(DRAFT)*

Purpose

The Health Risk By-Name List (BNL) Override policy is an emergency prioritization mechanism for Coordinated Entry (CE) participants experiencing acute medical crises or rapid health deterioration, whose lack of housing creates an immediate and serious risk to their life or long-term health.

This document outlines guidelines established to assist in determining:

- Household eligibility for an override consideration
- The protocol for the override submission process
- The protocol for the prioritization of approved overrides

In instances where a household would not be prioritized for Permanent Supportive Housing (PSH) expediently using Austin/Travis County's existing prioritization process, community providers actively working with the household should employ this override policy when immediate health risks necessitate expedited consideration.

Eligibility for Override Consideration

Households must meet the following criteria to be eligible for the Health-Risk BNL Override policy:

- Open CE enrollment
- Recent CA (within last six months to ensure client has exhausted all prioritization options through the standard process)

An Austin/Travis County direct service provider can submit an override request if a household includes at least one individual experiencing *significant functional impairment caused or exacerbated by one or more chronic, life-limiting, or serious health conditions, including medical, behavioral health, and/or substance use disorders,* ***resulting in an elevated risk of health decline or death.***

Evidence of these conditions may be observed through the following indicators:

1. Medication & Treatment Needs
    a. The requirement of a durable medical device
    b. Medical treatment that requires portable oxygen

    c. Terminal phase of a chronic or acute illness
2. Functional or Cognitive Challenges
    a. Amputation
    b. Blindness
    c. Paralysis
    d. Dementia
    e. Traumatic Brain Injury (TBI)
    f. Intellectual/Developmental Disability (IDD)
3. Exposure to Unsafe or Destabilizing Environments
    a. Sweeps
    b. Violence
    c. Exposures that result in potentially devastating health outcomes
4. Co-Occurring Conditions
    a. Mental Health
    b. Substance Use Disorder
    c. Pregnancy
    d. Aged 55+

Documentation Requirements for Override Requests

When requesting an override, the provider submitting the BNL Override Request form are also required to submit sufficient documentation of the participant's circumstances that warrant the override to **rehousing@austinecho.org**. Submission requests not accompanied by the below-mentioned documentation will not be considered for escalation.

Required Documentation

1. Proof of Chronic Homelessness, if applicable
2. Provider Statement of Need
    a. The statement of need should include the following information:
        i. Evidence that illustrates the client's severe health decline and how an imminent housing opportunity could be life-saving.
        ii. Relevant background information about the participant and the provider's observations
        iii. Reasons that other housing options or standards processes are not best suited for the participant

Recommended Documentation

1. Documentation from a medical provider including diagnosis information, medical requirements, and prognosis letter.
2. Letters from additional service providers or community members that document their observations of the participant.

Override Submission Request Process

The direct service provider working with the participant is responsible for initiating the override request process. The provider must submit the BNL Override Request Form and collect and submit all required documentation and submit it to the Coordinated Entry team at ECHO at **rehousing@austinecho.org**. The CE Team is responsible for determining if the submitted documentation meets the minimum requirements and is sufficient to move forward within the override process. The CE Team will communicate with the requesting provider if any documentation needs to be added or adjusted to move forward in the process.

Documentation *must* include:

- Proof of Chronicity
- Provider Statement of Need

Additionally, the CE team will confirm the participants open CE enrollment in HMIS and that the date of the participants most recent CA is within 6 months of the override request. The CE team will review the provider documentation and HMIS data and communicate next steps with the requesting provider within 3 business days.

Override Decision Process

Overrides decisions are made by a committee of seven (7) CoC service providers and one (1) ECHO Staff member. Service providers may include PSH providers, RRH providers, Shelter or TH providers, Victim Service providers, medical service providers or mental health service providers. All committee members must have an active HMIS user agreement. No more than 2 override committee members may be from the same agency.

Members of the Override Committee have a 6-month term limit. Once a member's term has expired or they otherwise leave, ECHO is responsible for recruiting and selecting committee members. Former committee members may apply, and current committee members may request extension of their term. If more providers volunteer for the committee than spots are available, ECHO will select the provider type that is least represented in the current makeup of the committee. ECHO will make every effort to maintain a diverse provider profile within the makeup of the committee.

Requests that meet all documentation requirements will be sent to the Override Committee. The Override Committee is a closed reviewal body that reviews all requested overrides and votes on approval or denial of the request based on their experiences and clinical expertise. If the request is approved, the client will override the current prioritized BNL to be referred to the first PSH unit they are eligible for.

If the override request is denied by the Override Committee, the participant would remain in their current position on the BNL. The Override Committee would then make every attempt to connect this client to additional healthcare and supportive services in the community to try to meet their needs while they are experiencing homelessness.

Prioritization for Approved Overrides

Once an override request has been approved, the participant will be prioritized for the first available PSH unit they are eligible for. They will be prioritized above all other CE participants, to include all sub-populations. ***This policy does not supersede project eligibility.*** Participants must be eligible for the project that requests a referral to be referred.

If there are multiple approved overrides waiting for a referral, ECHO will prioritize these participants with the standard prioritization process.

Form 2. Provider Input Form *(DRAFT)*

Provider Input Form

Purpose and Use

The **Provider Input Form** allows Coordinated Assessors to document **observable health, functional, or safety concerns** that may warrant additional review when CA responses do not fully reflect risk. This may occur when a person is unable to fully participate in the assessment, underreports needs, or experiences chronic health conditions that are not well captured through self-report alone. Providers should be mindful that cultural differences, language barriers, and trauma responses may affect presentation.

While Coordinated Entry health questions remain largely derived from the VI-SPDAT, there is a risk that individuals with serious medical complexity or functional impairment may not be fully reflected in their assessment scores. As an interim measure, the Provider Input Form can be used to support limited score adjustments within Coordinated Entry when documented health needs are not adequately captured through self-report.

This form:

- Does **not** require medical or psychiatric training
- Does **not** provide diagnoses
- Does **not** replace the Coordinated Assessment
- Documents **observable information only**
- Will inform the Coordinated Entry Redesign

This is not a crisis assessment. If the client is having a medical emergency, please call 911 or go to the nearest hospital to seek care.

Section 1: Client Information

Clarity ID : _____

APAT Score : _____

Date of most recent APAT: _____

Date of Provider interaction: _____

Section 2: Provider Information

Provider Name: _____
Organization: _____
Role: ☐ Outreach ☐ Shelter ☐ Navigation ☐ Case Management ☐ Other: _____

Provider Relationship to Individual

- ☐ Single interaction
- ☐ Multiple contacts over time (3-5 interactions total)
- ☐ Ongoing case management or navigation (5+ interactions or ongoing)

Approximate length of time you have known this person:
☐ Single interaction ☐ Days ☐ Weeks ☐ Months ☐ Years

Section 3: Reason for Provider Input

(Check all that apply)

- ☐ Individual was **unable to complete** all or part of the Coordinated Assessment
- ☐ Assessment responses appear **inconsistent with observable functioning**
- ☐ Client appears to be at **elevated health, mental health, or safety risk** not reflected in APAT score
- ☐ Provider has **additional observable context** relevant to CE review

Section 4: Capacity and Observed Barriers to Participating in the Coordinated Assessment

Based on observation during the interaction. Select all that apply; no diagnosis is required. If you are unsure, or if the behavior was not observed during your interaction, please do not select the box.

During the assessment interaction, did the person appear **unable to fully participate** due to any of the following?

- ☐ Disorientation to place, time, or situation
- ☐ Difficulty understanding or responding to basic questions
- ☐ Speech that was difficult to follow or understand (e.g., rapid, disorganized, hard to track, or not connected from sentence to sentence)
- ☐ Extreme agitation, distress, or inability to remain present

- ☐ Actively responding to internal stimuli (e.g., talking to or reacting to voices or people not present; expressing beliefs that are clearly inconsistent with the surrounding environment)
- ☐ Appeared intoxicated or in an altered state that could affect assessment accuracy
- ☐ Fell asleep, lost consciousness, or required repeated redirection
- ☐ Marked immobility, very limited movement, or little to no speech for extended periods (e.g., remained still, stared, or did not respond despite repeated attempts to engage)
- ☐ Other observable barrier that affected ability to complete the Coordinated Assessment: _____
- ☐ No concerns observed

Was the Coordinated Assessment able to be completed?
☐ Yes ☐ No

If yes, was the assessment paused, shortened, or completed with assistance due to these observations?
☐ Yes ☐ No

Regarding client capacity to complete or not complete the assessment, please share your observations and any concerns that you feel may not be reflected in the Coordinated Assessment.

Section 5: Additional Observable Indicators of Medical Fragility or High Health Risk

Sections below capture additional context beyond assessment participation, even if the Coordinated Assessment was completed. Please limit to only what you observed during the interaction.

Did you observe any of the following?

A. Functional & Mobility Limitations

- ☐ Uses wheelchair, walker, cane, or requires physical assistance
- ☐ Difficulty standing, transferring, walking, or maintaining balance

- ☐ Difficulty using hands or arms (gripping, carrying, writing)
- ☐ Difficulty managing belongings, documents, or medications
- ☐ One or more limb amputations or major loss of limb function
- ☐ Prosthetic use with observed difficulty functioning
- ☐ Requires assistance from others to move safely
- ☐ Mentioned recent/frequent fall(s)
- ☐ Other significant physical impairment observed: _____
- ☐ No functional limitations observed

If the individual reported **no difficulty or underreporting of troubles with daily activities (Questions 9a & 9b in APAT)**, but you observed challenges, briefly describe what you saw (1–2 sentences):

B. Breathing, Cardiac, or Medical Fragility

These observations may be consistent with serious heart or lung conditions such as heart failure or COPD, but no diagnosis is required.

- ☐ Shortness of breath at rest or with minimal activity
- ☐ Labored breathing, wheezing, persistent coughing, or visible breathing distress
- ☐ Visible swelling in legs, ankles, or feet
- ☐ Extreme fatigue with minimal exertion
- ☐ Complaints of chest tightness or heaviness
- ☐ Uses oxygen or other medical devices that are difficult to manage while unhoused
- ☐ Not Observed

C. Vision, Sensory, or Cognitive Impairment

- ☐ Reported blindness or severe vision loss
- ☐ Appeared unable to see surroundings, forms, or obstacles
- ☐ Required assistance navigating space

- ☐ Memory impairment, confusion, or difficulty retaining information
- ☐ Not Observed

D: Medical Devices or High-Risk Health Management Needs

Select any that were observed during your interaction or that the client mentioned in conversation.

- ☐ Uses oxygen, catheter, ostomy bag, feeding tube, or other medical device
- ☐ Device appeared unmanaged, broken, lost, or difficult to maintain while unhoused
- ☐ Requires refrigeration, electricity, or sterile conditions for care and/or medications
- ☐ Reported recent complications or infections related to medical care / difficulty accessing treatment (within past month)
- ☐ Reported recent hospitalization / readmission to care / Skilled nursing stay (within past month)

If the client reported **no difficulty** in areas above, but you observed limitations, briefly describe what you observed (1–2 sentences):

Section 6: Time-Sensitive Safety or Health Concerns

Based on your interaction **today**, do you have concerns that this person is experiencing a time-sensitive or escalating health or safety risk that may require urgent attention?

- ☐ Yes — concern appears urgent or worsening
- ☐ Yes — concern present, but not clearly urgent
- ☐ Unsure
- ☐ No immediate concern observed

If yes or unsure, what contributed to your concern? *(Check all that apply.)*

- ☐ A noticeable decline or change compared to recent interactions
- ☐ Symptoms or behaviors that appeared new, worsening, or unstable

- ☐ Recent medical, psychiatric, or substance-related crisis with limited recovery
- ☐ Functional limitations that appeared to prevent the person from meeting basic needs **today**
- ☐ Risk related to current conditions (e.g., extreme weather, infection, injury)
- ☐ Other time-sensitive concern observed: _____

Reminder: This is not a crisis assessment. If the client is having a medical emergency, please call 911 or go to the nearest hospital to seek care.

Section 7: Additional Context (Optional)

Please share any additional **observable information** that may help Coordinated Entry more accurately understand this person's risk or needs:

Provider Attestation

I am documenting **observable information** to support accurate Coordinated Entry decision-making. I am not providing a medical or psychiatric diagnosis.

Provider Signature: _____
Date: _____

Form 3: Prioritization Tiebreaker Amendment *(DRAFT)*

This amendment will outline the recommended changes to the Austin/Travis County CoC prioritization standards for Permanent-Supportive Housing (PSH) and Rapid Rehousing (RRH). This policy amendment will immediately uplift medically complex households through the Coordinated Entry (CE) prioritization process with minimal system or workflow alterations.

Background

Through consultations with Austin/Travis County CoC healthcare providers and data analysis, ECHO staff have been able to identify two (2) questions in the Disparate Health Section on the current version of the Austin Prioritization Assistance Tool (APAT) that are the most closely aligned with the definition of medical complexity and reflect the demographic composition of our unhoused population more accurately. Those questions are:

1. (8) Are you currently living with a progressive end stage disease? Examples include, but are not limited to, End Stage Renal Disease, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and Cancer.
2. (9A) Do you have a medical condition or a health concern that affects your activities of daily living (ADLs)? For example, do you have trouble with eating, showering, using the restroom, taking the bus, or moving due to your health?

These two items are also the **only questions in the Health Domain not inherited from the VI-SPDAT**, making them uniquely positioned to reflect the core elements of medical complexity without the inequitable scoring patterns associated with VI-SPDAT–derived items.

An analysis of CE participants who completed a Coordinated Assessment in the last year (8/2024 – 8/2025) identified:

- **1,243 of 7,930** individuals (**16%**)
- **Race/Ethnicity:** 42% White, 27% Black, 23% Hispanic, 4% multiracial
- **Gender:** 60% male, 38% female
- **Veterans:** 7.8%
- **Age:** Mean 51; median 52; most ages 55–64
- **ADLs:** 92% report **4/4** impact
- **APAT score:** Mean 11.8 (median 12)

- **Health score:** Mean/median 5

When replicated across the **full BNL (15,103 individuals)**, the results were consistent:

- **1,990 individuals (13%)** met this proxy
- Demographic and scoring patterns were nearly identical

Proposal

ECHO staff are formally recommending the inclusion of an additional tiebreaker into the CE prioritization process.

The current PSH prioritization process is as follows:

1. Chronically Homeless Households
2. Highest CA Score
3. Households who meet one (1) or more of the HUD-recognized sub-populations (Active Duty US Military Veteran, Household with Minor Children, Unaccompanied Youth, or Chronic Homelessness)
4. Highest length of time homeless
5. First completed CA

The proposed PSH prioritization process is as follows:

1. Chronically Homeless Households
2. Highest CA Score
3. **Medically Complex (MC) Flag**
4. Households who meet one (1) or more of the HUD-recognized sub-populations (Active-Duty US Military Veteran, Household with Minor Children, Unaccompanied Youth, or Chronic Homelessness)
5. Highest length of time homeless
6. First completed CA

In practice, this recommendation will allow for medically complex CE participants to immediately be prioritized at a higher rate than they currently are through the existing prioritization process. For example:

- **Household A:** CH, APAT score = 14, MC Flag = No → *lower priority*
- **Household B:** CH, APAT score = 14, MC Flag = Yes → *prioritized for housing*

In this scenario, both households are chronically homeless and have identical APAT scores, indicating similar overall vulnerability. The MC Flag tiebreaker is applied to distinguish between them: Household B possesses a MC Flag, reflecting greater medical

or behavioral health needs, and is therefore elevated in the prioritization queue to receive housing more quickly. If in this example, both households being reviewed do not have an MC Flag (or both DO have an MC Flag) then the next step would be to consider subpopulations, and so on. This process ensures that limited resources are directed to those at greatest risk of medical deterioration.

Supplemental Overview: Prioritization Options

As part of Session Three of the *Integrating Medical Complexity into Coordinated Entry* series, several prioritization approaches were presented to explore how medical complexity could be incorporated into Coordinated Entry (CE). These options focus on how assessment data is translated into action through prioritization, with the goal of ensuring individuals at highest risk of severe health decline or death are not missed within existing CE processes.

Option One: Health Domain Tiebreaker
This option maintains the existing APAT structure and uses the Health Domain (Section 2: Disparate Health Outcomes) more intentionally within prioritization. When households have identical APAT scores, the Health Domain score is used as a tiebreaker—applied after chronic homelessness and total APAT score, but before subpopulation status or date of assessment. This approach adds a medical-complexity lens without altering overall scoring or equity weighting. It is simple to implement, highly feasible, and assumes assessment questions have been adapted to better reflect medical complexity.

This prioritization option becomes more meaningful once the health domain questions are adapted to capture all components of the Medical Complexity definition. This will be addressed in the Coordinated Entry redesign.

Option Two: Health-Risk By-Name List Override
The Health-Risk By-Name List Override functions as a safety valve for acute medical crises. This option introduces a process to elevate individuals who show imminent health risk and clinical deterioration that could be remedied by expedient housing. The override triggers case review and expedited referral consideration. This approach prevents medically complex individuals from waiting extended periods between assessments and requires defined criteria and health-system communication, but minimal restructuring of Coordinated Entry.

Option Three: Medically Complex Set-Aside
This option establishes a dedicated sub-queue within PSH for individuals who meet the community definition of medical complexity. A portion of PSH units (for example, one out of every eight, completely hypothetical) would be reserved for this group, while selection

within the sub-queue would still follow existing prioritization. It assumes the development of a medical complexity flag, clear eligibility criteria, and coordination with housing providers. To be clear, the housing that would be dedicated in this sub-queue would not provide more enhanced services or be different from traditional PSH, by our present housing inventory, though this could be a point for future development and consideration.

Option Four: Integrated Medical Complexity Scoring (APAT+)
APAT+ embeds medical complexity directly into Coordinated Entry by integrating core elements of medical complexity, supporting factors, and observable indicators into prioritization (See Medical Complexity framework). Coordinated Entry would continue to screen for medical complexity during assessment while incorporating verified health indicators—such as diagnoses, hospital readmissions, or crisis contacts—transmitted securely by health partners as a numeric indicator in HMIS. This strengthens prioritization by enabling earlier action, better coordination, and responsiveness to health risk without increasing assessment burden.

Summary
Together, these options illustrate a range of ways medical complexity could be reflected in Coordinated Entry prioritization—from minimal refinements within current workflows to more integrated, data-informed approaches. Each option represents a different balance of feasibility, system change, and responsiveness to health risk, offering the community multiple pathways to ensure housing reaches those most at risk of severe decline or death while experiencing homelessness.

For a more detailed look at these prioritization options, please see the Prioritization Recommendations section.

Appendix

Section 1 - Household/History of Homelessness				
1	Frequent unsheltered homelessness	Where do you sleep most frequently? (Choose One: Shelters, Transitional Housing, Safe Haven, Outdoors, Other, Refused)	"Outdoors" = 1 point	5 points total
2	Length of current homelessness	How long has it been since you lived in permanent stable housing?	1 year or more = 1 point	
3	Number of times experiencing homelessness	In the last three years, how many times have you been homeless?	4 times or more = 1 point	
4	Advanced age	Staff Question: Does the household currently contain at least one member age 50 or older?	"Yes" = 1 point	
5	Minor children	Staff Question: Does the household currently contain at least one child under the age of 18 (not awaiting custody after housing). And/or is anyone in the household pregnant and/or breastfeeding?	"Yes" = 1 point	

Section 2 - Disparate Health Outcomes				
6	Healthcare access	When you are sick or not feeling well, do you avoid getting help?	"Yes" = 1 point	7 points total
7	HIV/AIDS	If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you?	"Yes" = 1 point	
8	End Stage Diseases	Are you currently living with a progressive end stage disease? Examples include, but are not limited to, End Stage Renal Disease, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and Cancer.	"Yes" = 1 point	
9a	Activities of Daily Living	Do you have a medical condition or a health concern that affects your activities of daily living (ADLs)? For example, do you have trouble with eating, showering, using the restroom, taking the bus, or moving around in general due to your health?	If yes, move on to 11b	
9b		On a scale from 1-4, with 1 being it does not affect your ADLs at all and 4 being that it completely impacts or impairs your ADLs, how much difficulty do you have eating, showering, using the restroom, taking the bus, or moving around due to your health?	4 = 1 point	
10a	Violence	Have you been attacked or beaten up since you've become homeless?	If either "Yes" = 1 point	
10b		Have you threatened or tried to harm yourself or anyone else in the last year?		
11a	Mental health	Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of a mental health issue or concern?	If either "Yes" = 1 point	
11b		Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help?		
12	Substance Use	Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?	"Yes" = 1 point	

Section 3 - Potential Barriers to Housing				
13	Education	What is the highest grade or level of school you have completed?	Less than high school completion or equivalent = 1 point	9 points total
14	Foster Care	Have you ever been in foster care—that is, placed in a foster home, another relative's home, a group home, or in some other out-of-home placement?	"Yes" = 1 point	
15	Juvenile Justice	Have you ever been sentenced to spend time in jail, prison, a juvenile detention center, a residential facility, or other correctional facility prior to the age of 18?	"Yes" = 1 point	
16	Criminal History	Have you ever been denied access to employment and/or housing due to your criminal background? Or have you ever opted out of applying for employment and/or housing due to your background?	"Yes" = 1 point	
17a	Rental History	Have you ever had a rental lease in your name?	If yes, move on to 17b	
17b		If yes, do you have any negative rental history within the last 10 years?	"Yes" = 1 point	
18	Raised in a Multi-Generational Household	When you were growing up, did you usually have members from multiple generations in your household (more than two, like grandparents or grandkids)?	"Yes" = 1 point	
19	Gender or Sexual Identity	Have you ever been afraid to seek services, or denied services due to your sexual identity, and/or gender identity?	"Yes" = 1 point	
20	Sex Work	Have you ever had a neighbor and/or law enforcement assume, without evidence, that you were a sex worker?	"Yes" = 1 point	
21	Gentrification	Did any of the responses [to 21a or 21b] include any of the July 2020 ZIP codes (78701; 78702; 78717; 78721; 78723; 78725; 78728; 78741; 78744; 78748; 78749; 78752; 78753; 78754;78757; 78613; 78641, or "East Austin")?	"Yes" = 1 point	
21a		Were you born and raised in Austin? If so, which Zip Code or Neighborhood did you grow up in?		
21b		If you have ever been permanently housed in Austin, what was the last zip code of that housing?		

Table 4. Complete APAT Questions and scoring as of December 2025.

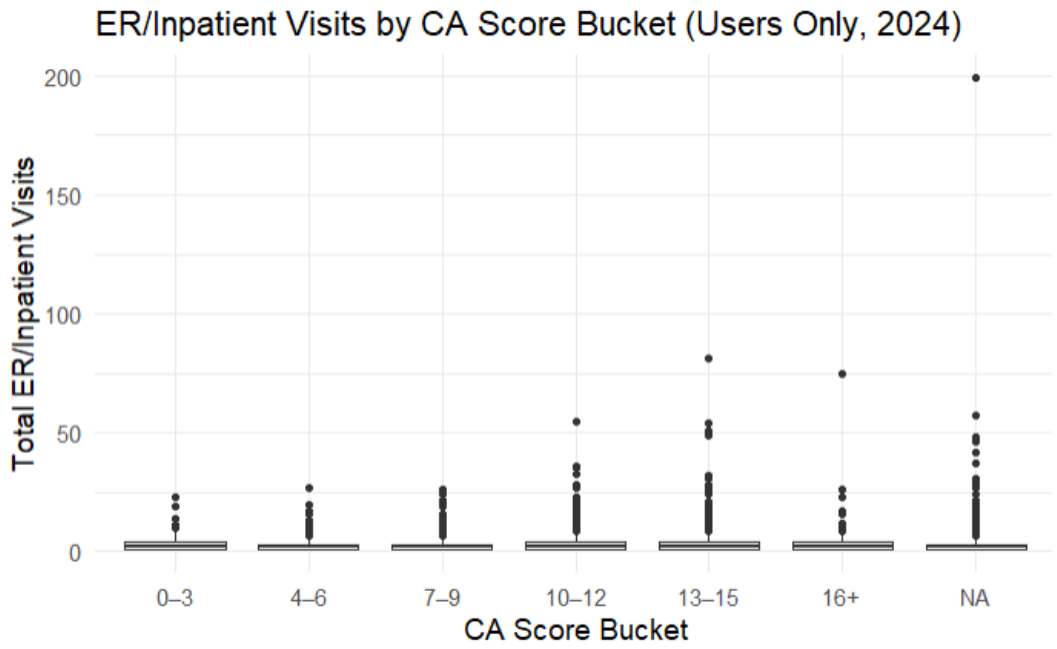

Figure A. ER and inpatient visit counts from January 2024 to January 2025 for individuals in HMIS and corresponding CA score. High hospital utilization is seen across score buckets.

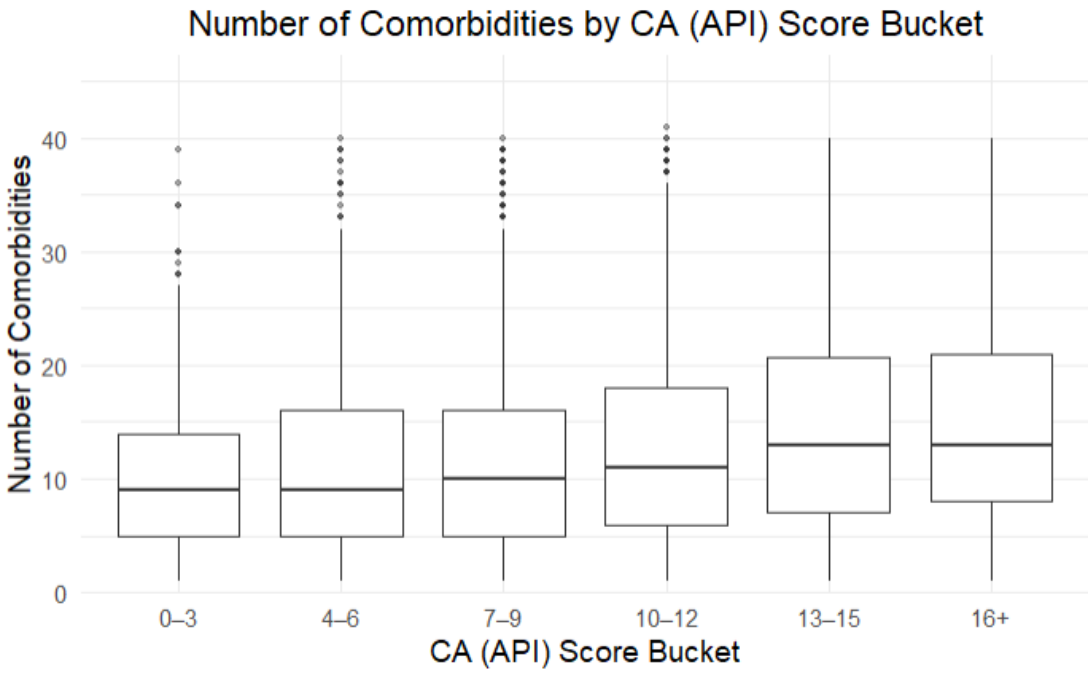

Figure B. Number of medical conditions individuals in HMIS have, per available records, from January 2024 to January 2025 and corresponding CA score. People with high comorbidities are found at every CA score level.

Semi-Structured Interview A: National Continuum of Care Interview Questions

Planning:

What prompted your community to integrate medical complexity into your CES?

How are you defining medical complexity? How did you land on that definition?

How did you come up with the questions or indicators that you are using to measure medical complexity?

Data Collection:

How are you verifying the information being reported? Self-report, provider documentation, etc.

Are you able to use data from hospitals, clinics, or other healthcare providers? If so, how are able to access this healthcare data, and from there, how do you integrate it into CE?

Partnerships & Data Sharing:

Which health system partners were most critical in developing and maintaining this process? How were you able to cultivate those relationships?

How are you addressing HIPAA or other data-sharing barriers? MOUs, other data-sharing agreements – Ask if they could share the language they used.

Prioritization:

How is medical complexity factored into your prioritization process? Via assessment questions, listed within the prioritization standards, other (weighting questions?)

Does medical complexity ever allow a participant to "jump the line" on your BNL? What is the process for that? What are the limitations to that?

Are you looking at the impact of prioritizing medical complexity alongside demographic breakdowns? In our community, there is a concern that prioritizing medical complexity will disproportionally benefit white folks because folks of color are not as likely to access health care when they need it. Was this a similar concern for your community, and if so, did you build in any racial equity counterweights? Tell me about that.

Implementation:

What training do your CE assessors go through to ask sensitive medical questions? Or do you integrate healthcare providers directly into CE to ask these questions? Tell me more about how this works.

What changes did you need to make to your HMIS workflows?

How long did it take from planning to implementation?

Outcomes & Evaluation

What outcomes have you seen since integrating medical complexity into your system?

How are you measuring effectiveness?

Have you seen any unintended consequences?

Other:

Tell me about lessons learned. What worked well? What challenges have you run into and what would you do differently?

How were you able to get community/provider buy-in?

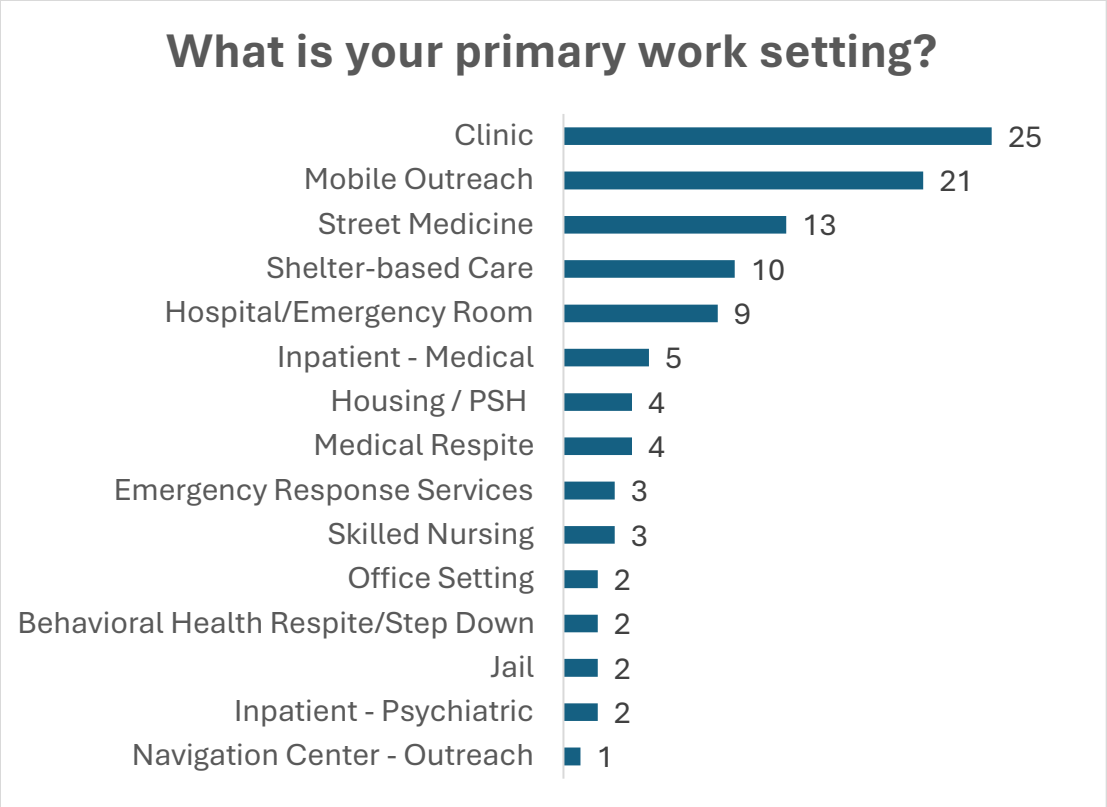

Figure C. Healthcare Feedback Forum providers are surveyed on their primary work setting. Total number of participants was 53. Participants could choose a max of three options.

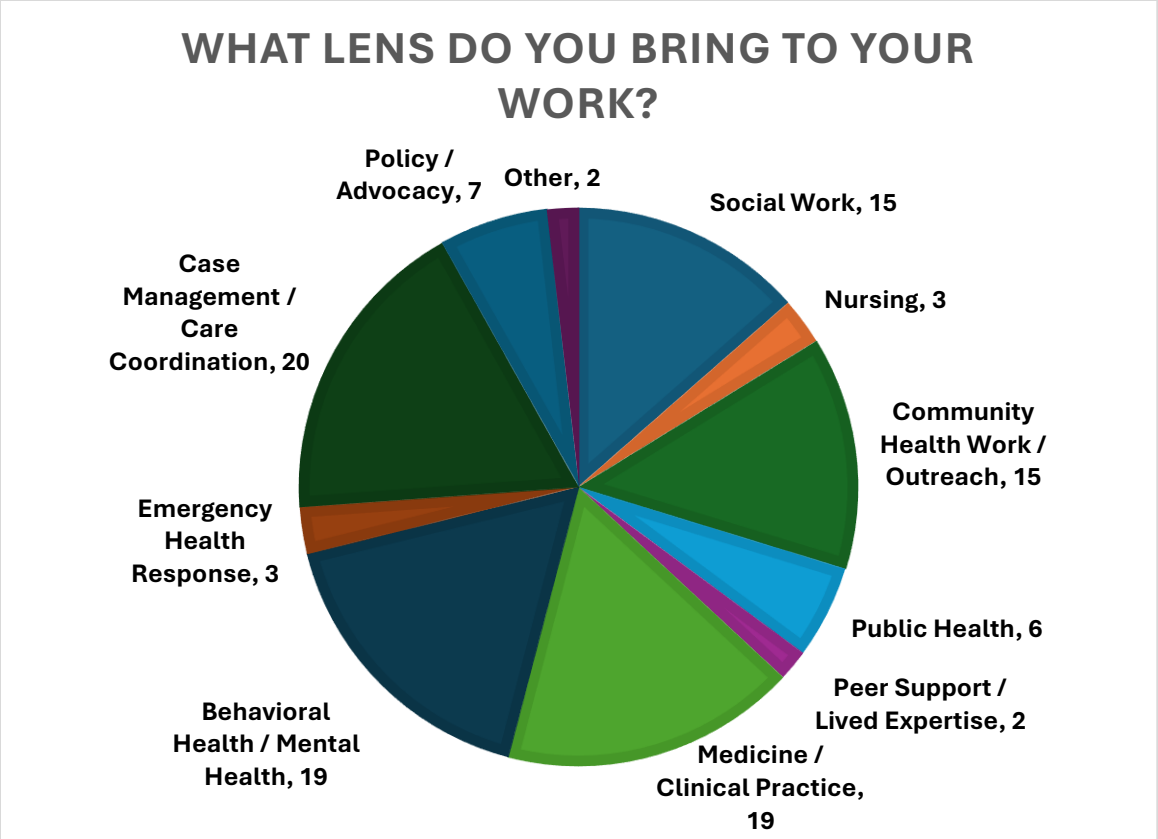

Figure D. Healthcare Feedback Forum providers are surveyed on the primary lens they bring to their work. Total number of participants was 53. Participants could choose a max of three options.

Health Section	Proposed Question
6 - Healthcare Access	Has it been hard to get medical care when you need it – like getting to appointments, getting medicine, or finding a clinic that feels safe?
7 - HIV/AIDs	*No longer any dedicated HIV housing. Bring together with long term disease as HIV is a long-term chronic condition and is fine if medically managed, but can be a risk factor if unstable, untreated, or advanced.*
8 - Serious Illness/ End Stage Diseases	Do you have a long-term health condition that causes strong symptoms or flare-ups – like trouble breathing, chest pain, severe swelling, fainting, or needing urgent care often? (Examples optional: cancer, heart or lung problems, kidney disease, liver disease, long-term infections, HIV/AIDS, diabetes that is hard to control)
9a - ADLs	Does your health make it hard to do daily tasks – like bathing, using the bathroom, getting food, taking medicine, moving around safely, or taking care of yourself?
9b - ADL Scale	In the past month, which of these have been hard for you because of your health?" (Check all that apply): Moving around - like standing up,

	walking, or getting in and out of bed (Mobility/Transfers), Getting to the bathroom in time or staying clean (Toileting or continence) , Keeping up with your medicines (medication management), Memory, thinking, or letting people know what you need (Communication/cognition)
10a – Violence	Have you had to defend or protect yourself because you felt unsafe while homeless?
10b – Harm to Self or Others	In the past year, have you had times when you felt so overwhelmed, scared, or upset that you lost control or felt like hurting yourself?
11a – Mental Health	**Do you deal with stress, trauma, or mental health symptoms that affect you day-to-day?**
11b – Mental Health	*Proposal: Merge with 11a – one combined mental health question and weight*
12 – Substance Use	*Has anyone - like family, friends, or a doctor - ever told you they were worried about your drinking or drug use?*
NEW Supporting Factor: **Disabilities with devastating impact** (Amputation, paralysis, blindness, TBI, IDD)	*Do you have any long-term disabilities or conditions—like an amputation, paralysis, blindness or low vision, hearing loss, trouble with memory or thinking, or a brain injury?*
NEW Supporting Factor: **Medication & Treatment Needs** (Usage of dialysis, oxygen, wound care, refrigerated meds, inability to access or manage medications)	*Do you have any treatments or medicines that are hard to keep up with while homeless—like oxygen, dialysis, wound care, or meds that need refrigeration or a set schedule?*
NEW Supporting Factor: **Sweeps & Systemic Risk**	*Have you ever been made to move or had your belongings taken from where you were staying?*

Table 5. Prototype APAT Health Domain questions developed to support robust discussion and guide refinement of the assessment.

Table 6: APAT Prototypes developed from Original Feedback & Provider + AYC Responses

Original Questions	Prototype Questions (V.1)	Prototype Questions (V.2)
When you are sick or not feeling well, do you avoid getting help?	Has it been hard to get medical care when you need it — like getting to appointments, getting medicine, or finding a clinic that feels safe?	Has it been hard to get medical care when you need it — like getting to appointments, getting medicine, finding care that feels safe, or relying on the emergency room for care?
If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you?	*No longer any dedicated HIV housing. Bring together with long term disease as HIV is a long-term chronic condition and is fine if medically managed, but can be a risk factor if unstable, untreated, or advanced.*	*Agreement here, rolled into chronic condition question.*
Are you currently living with a progressive end stage disease? Examples include, but are not limited to, End Stage Renal Disease, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and Cancer.	Do you have a long-term health condition that causes strong symptoms or flare-ups — like trouble breathing, chest pain, severe swelling, fainting, or needing urgent care often? (Examples optional: cancer, heart or lung problems, kidney disease, liver disease, long-term infections, HIV/AIDS, diabetes that is hard to control)	Do you have an ongoing or serious health condition that causes symptoms or flare-ups — like trouble breathing, chest pain, fainting, swelling, or needing emergency care often? (Examples optional: cancer, heart or lung problems, kidney disease, liver disease, long-term infections, HIV/AIDS, diabetes that is hard to control)
Do you have a medical condition or a health concern that affects your activities of daily living (ADLs)? For example, do you have trouble with eating, showering, using the restroom, taking the bus, or moving around in general due to your health?	Does your health make it hard to do daily tasks — like bathing, using the bathroom, getting food, taking medicine, moving around safely, or taking care of yourself?	*Recommend just screening everyone with following question, drop this one.*

On a scale from 1-4, with 1 being it does not affect your ADLs at all and 4 being that it completely impacts or impairs your ADLs, how much difficulty do you have eating, showering, using the restroom, taking the bus, or moving around due to your health?	In the past month, which of these have been hard for you because of your health?" (Check all that apply): Moving around - like standing up, walking, or getting in and out of bed (Mobility/Transfers), Getting to the bathroom in time or staying clean (Toileting or continence) , Keeping up with your medicines (medication management), Memory, thinking, or letting people know what you need (Communication/cognition)	Agreement with this question as drafted in prototype 1.
Have you been attacked or beaten up since you've become homeless?	Have you had to defend or protect yourself because you felt unsafe while homeless?	Have you had to defend or protect yourself because you felt unsafe where you were staying while experiencing homelessness?
Have you threatened or tried to harm yourself or anyone else in the last year?	In the past year, have you had times when you felt so overwhelmed, scared, or upset that you lost control or felt like hurting yourself?	In the past year, have you had times when you felt so overwhelmed, scared, or upset that you felt unsafe or thought about hurting yourself?
Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of a mental health issue or concern?	Do you deal with stress, trauma, or mental health symptoms that affect you day-to-day?	Do you have mental or emotional symptoms that keep coming back and make everyday things harder — like very high or very low moods, confusion, intense anxiety, or hearing or seeing things others don't?
Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help?	*Proposal: Merge with 11a – one combined mental health question and weight*	*Agreement.*

Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?	Has anyone - like family, friends, or a doctor - ever told you they were worried about your drinking or drug use?	Have you ever felt like your use of alcohol or drugs made it harder to stay safe, manage your health, or get through daily life?
N/A	Do you have any long-term disabilities or conditions—like an amputation, paralysis, blindness or low vision, hearing loss, trouble with memory or thinking, or a brain injury?	Do you have any long-term disabilities or conditions that significantly affect your daily life — like an amputation, paralysis, blindness or low vision, hearing loss, trouble with memory or thinking, or a brain injury?
N/A	Do you have any treatments or medicines that are hard to keep up with while homeless—like oxygen, dialysis, wound care, or meds that need refrigeration or a set schedule?	Do you have any medicines or treatments that are hard to keep up with where you're staying — like oxygen, dialysis, wound care, injections, medicines that need refrigeration or a strict schedule, or medications that are hard to take safely while unhoused?
N/A	Have you ever been made to move or had your belongings taken from where you were staying?	Have you ever been forced to move or had your belongings taken as part of a sweep or cleanup where you were staying?

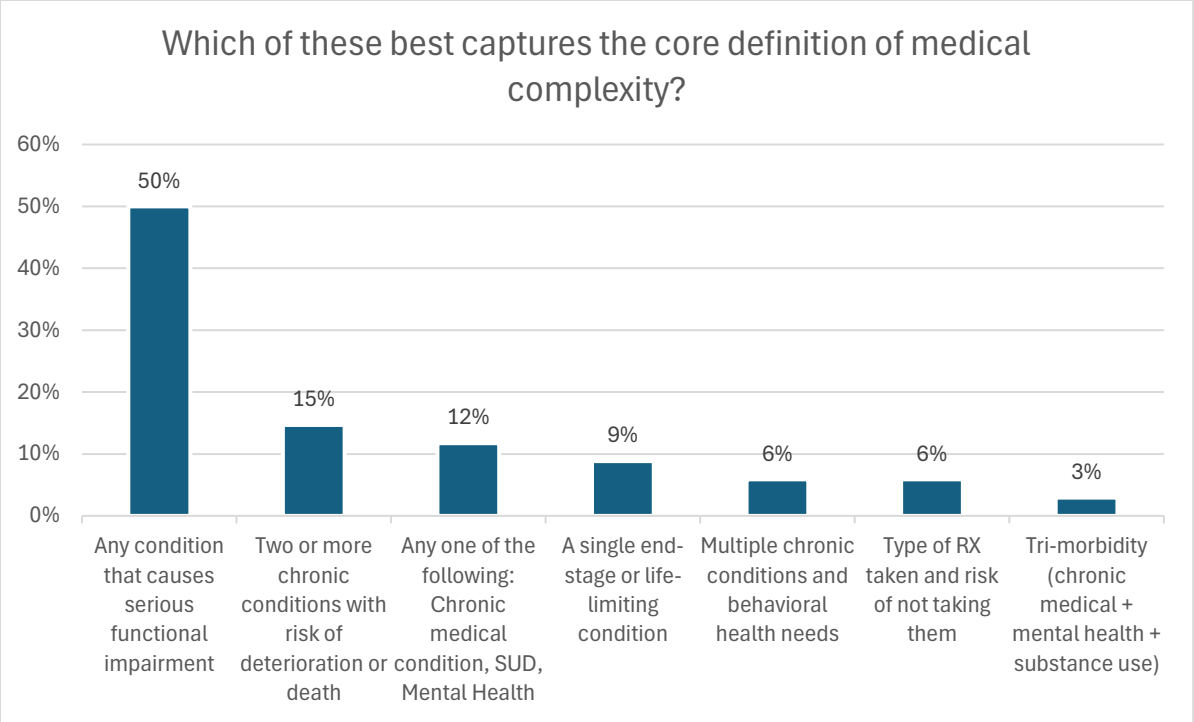

Figure E. Healthcare Feedback Forum, Session Two. Using ideas pulled from the first brainstorm session on Medical Complexity (Session One), providers were instructed to select only one choice to illuminate strongest components for the Core Elements of Medical Complexity.

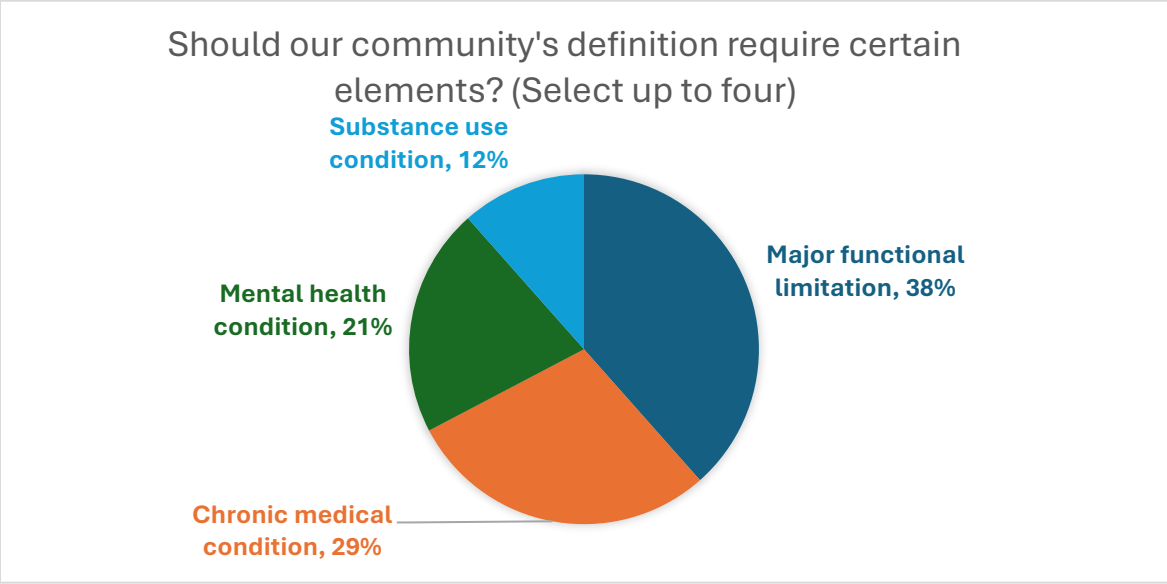

Figure F. Healthcare Feedback Forum, Session Two. This was a secondary way of elucidating response from healthcare providers on what should be considered in core

elements. Unlike the prior poll, providers were able to select up to four (all) of these responses.

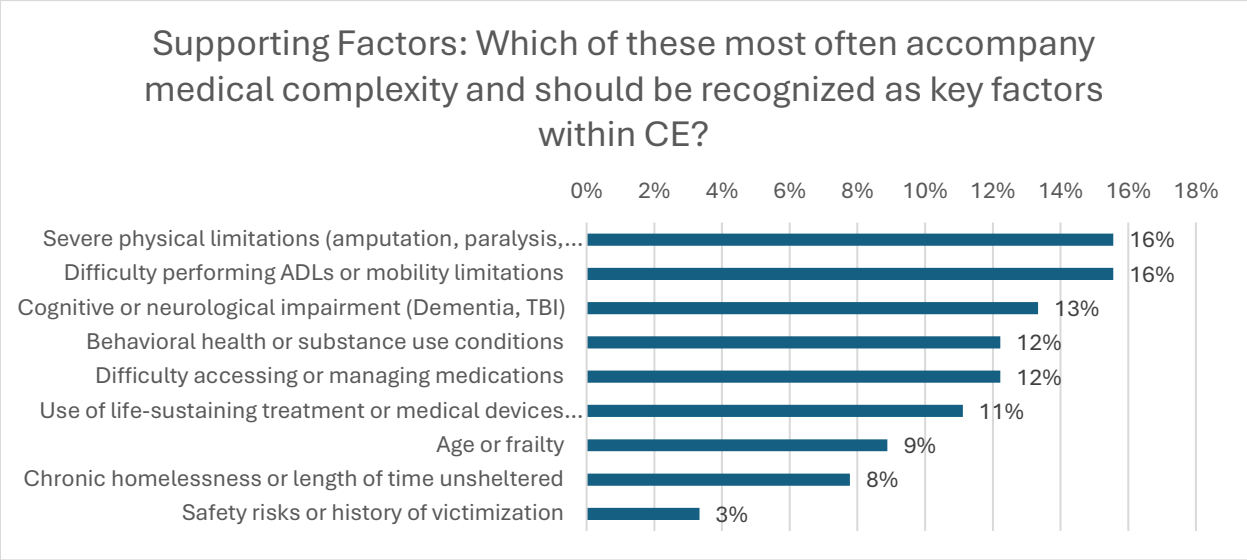

Figure G. Healthcare Feedback Forum, Session Two. Using ideas pulled from the first brainstorm session on Medical Complexity (Session One), providers were instructed to select only up to four choices to uplift strongest Supporting Factors of Medical Complexity.

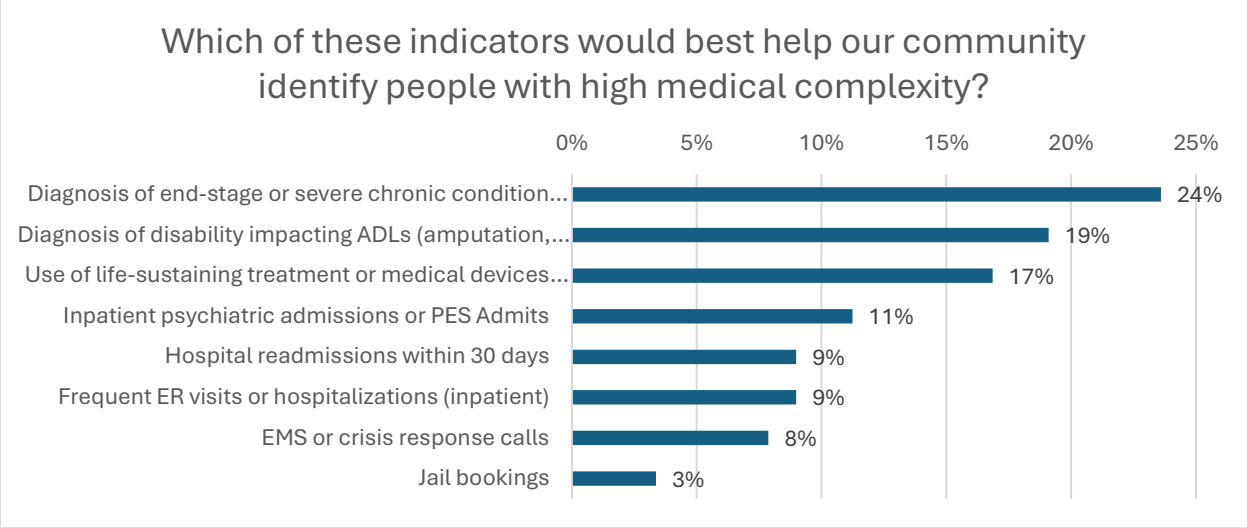

Figure H. Healthcare Feedback Forum, Session Two. Using ideas pulled from the first brainstorm session on Medical Complexity (Session One), providers were instructed to select only up to four choices to uplift strongest Observable Indicators of Medical Complexity.

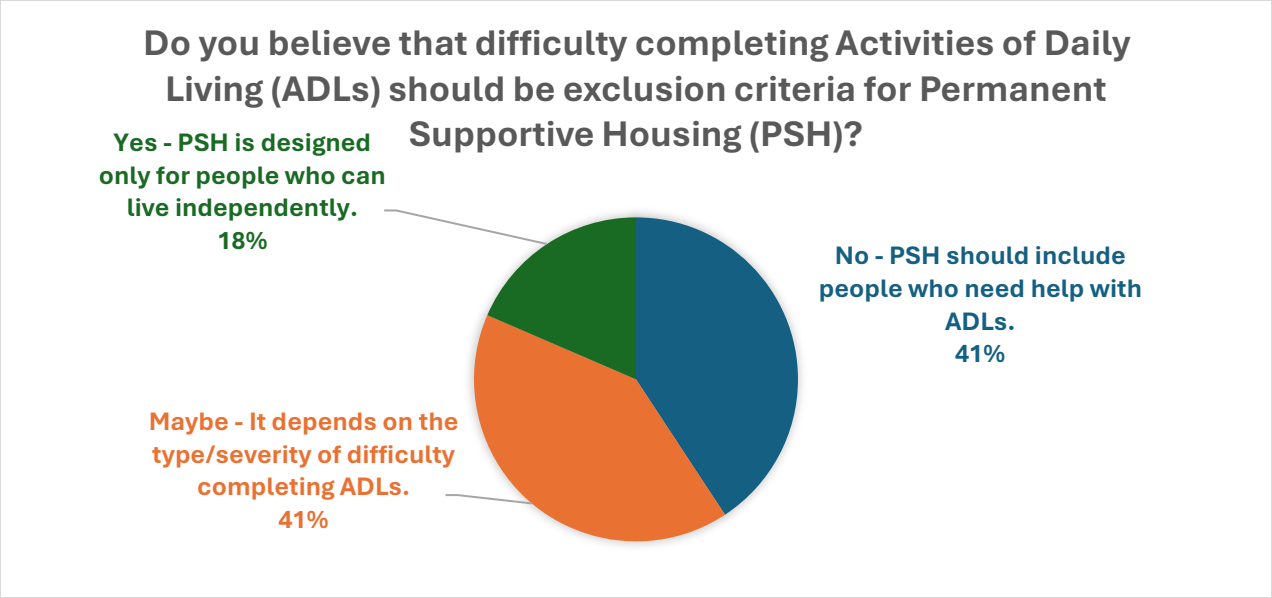

Figure I. Healthcare Feedback Forum, Session Two. As functional impairment emerged as a central component of the medical complexity definition, participants discussed its implications for Permanent Supportive Housing (PSH). This question created space for providers to consider the relationship between functional impairment and PSH eligibility, inviting reflection on whether the model as designed can meet the needs of medically complex individuals.

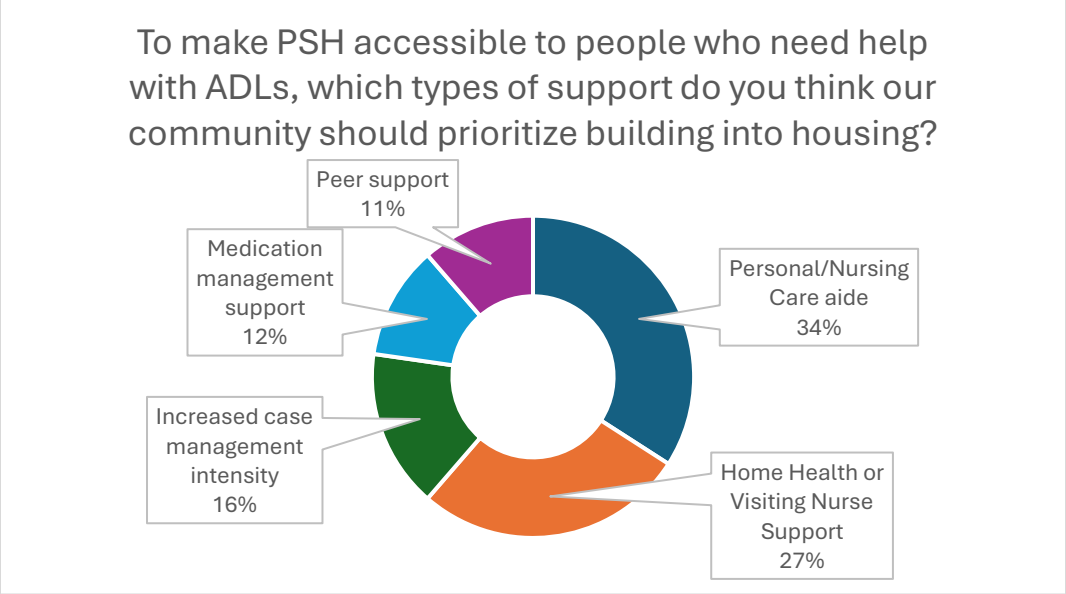

Figure J. Healthcare Feedback Forum, Session Two. Providers identified the supports needed to make PSH accessible to people with ADL limitations. Priorities included personal or nursing care aides (non-medical daily living support) and home health or

visiting nurse services (skilled clinical care). These considerations extend beyond the scope of the definition but are relevant for future recommendations to Leadership Council.

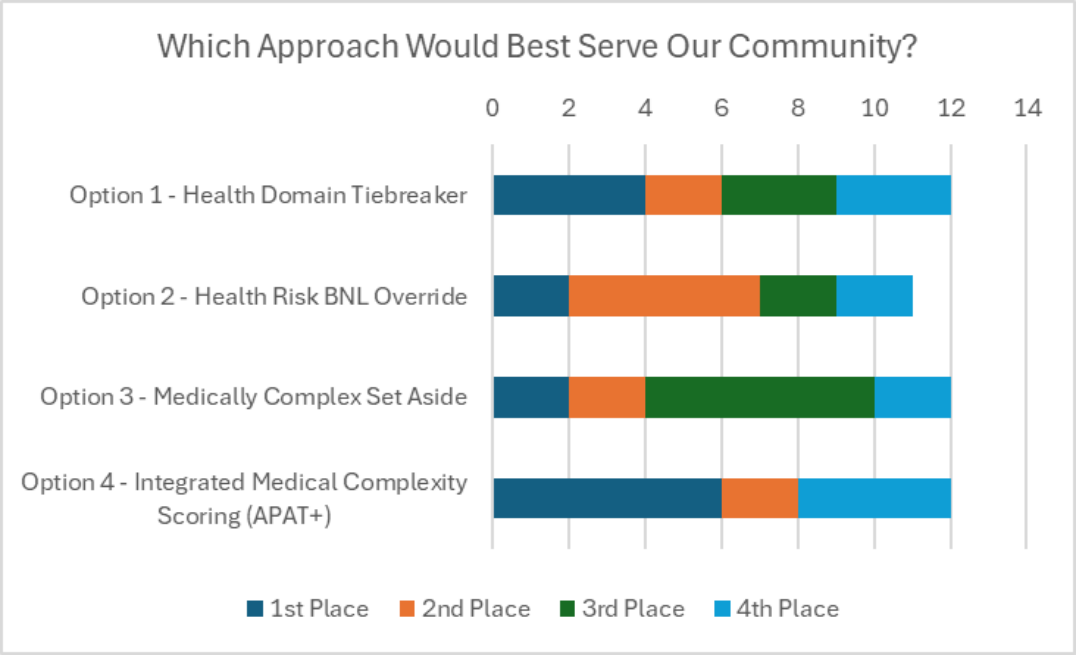

Figure K. Healthcare Feedback Forum, Session Three. Providers were asked to rank their prioritization preferences for integrating medical complexity into Coordinated Entry, from first choice to last choice.