Minnesota Coordinated Entry System
Policies and Procedures Framework
As of November 2016

Contents

Coordinated Entry System

A Coordinated Entry System ("CES") represents a new approach to coordination and management of a Continuum of Care's housing crisis response system. CES enables CoC providers and homeless assistance staff to make consistent decisions from available information to efficiently and effectively connect people in crisis to interventions that will rapidly end their homelessness. The CES approach also aligns with State of Minnesota goals to transform crisis response systems to improve outcomes for people experiencing a housing crisis.

In 2009, the McKinney-Vento Homeless Assistance Act was amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. Among other actions, the HEARTH Act consolidated several of HUD's separate homeless assistance programs into a single grant program, the Continuum of Care Program, and it codified into law the CoC planning process.

The CoC Program interim rule (24 CFR 578) released by HUD in 2012 requires that CoCs establish and operate a "***centralized or coordinated assessment system***," hereafter referred to as a coordinated entry system. The rule defines coordinated entry as

> ***a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. [Such a] system covers the [CoC's] geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool. (24 CFR part 578.3)***

Both the CoC Program interim rule and the Emergency Solutions Grants (ESG) program interim rule (76 FR part 75953) released in 2011 require that projects operated by recipients and subrecipients of CoC or ESG grant funds must participate in the established coordinated entry process.

Participation Requirements

HUD and VA have recently established guidance that instructs all CoC projects to participate in their CoC's Coordinated Entry system. A CoC project includes any homeless prevention or homeless assistance program regardless of funding source. However, projects that receive HUD funding (CoC Program, ESG, HOPWA) or VA funding (SSVF, GPD, VASH) must further comply with the specific participation requirements as established by the corresponding CoC jurisdiction. The State of Minnesota has established minimum statewide requirements for CES participation for all state funded homeless projects, including those funded by Emergency Services Program (ESP), Family Homeless Prevention and Assistance Program (FHPAP), and Transitional Housing Program. At a minimum CES participation includes the following for all CoCs in Minnesota:

- CoC projects must publish written standards for client eligibility and enrollment determination
- CoC projects must communicate project vacancies (bed and/or unit) to the Coordinated Assessment administrative entity established by CoC leadership
- Persons experiencing a housing crisis must access CoC services and housing using CoC defined access points
- CoC projects must enroll only those clients referred according to the CoC's designated referral strategy
- CoC projects must participate in the CoC's Coordinated Assessment planning and management activities as established by CoC leadership

Coordinated Entry System Design Principles

1. **Adopt statewide standards** but allow flexibility for local customization beyond baseline standard.
2. **Promote client-centered practices** – Every homeless persons should be treated with dignity, offered at least minimal assistance, and participate in their own housing plan. Provide ongoing opportunities for client participation in the development, oversight, and evaluation of coordinated assessment. Clients should be offered choice whenever possible.
3. **Prioritize most vulnerable as the primary factor among many considerations**– Limited resources should be direct first to persons and families who are most vulnerable*. Less vulnerable persons and families will be assisted as resources allow. *Vulnerability will be defined locally.
4. **Eliminate barriers to housing access** – Identify system practices and individual project eligibility criteria which may contribute to excluding clients from services and work to eliminate those barriers.
5. **Transparency** – Make thoughtful decisions and communicate directives openly and clearly.
6. **Exercise continuous quality improvement efforts** – Continually strive for effectiveness and efficiency and agree to make changes when those objectives are not achieved.
7. Promote **collaborative and inclusive** planning and decision making practices.
8. **Diversity** – Respect cultural, regional, programmatic, linguistic, and philosophical differences.
9. **CES data driven** – use data to analyze local housing needs and create a diversity of housing options.
10. **Native American sovereignty** —Work individually with Tribal Nations to acknowledge and honor sovereignty.

Prioritization Standards

The matching process and eventual referral linkage process will take into account a set of prioritization criteria for each project type. The order of client priority on the prioritization list will under no circumstances be based on disability type or diagnosis. CoCs will establish priority for each project type based on the severity of the needs, length of time homeless, or subpopulation characteristics, depending on the specific CoC component type. CoCs that do not adopt and comply with these priority standards must provide documentation that demonstrates different local needs warrant an alternative approach to service strategy prioritization.

Each CoC must define a minimum VI-SPDAT score or score range associated with referrals to CoC resources such as RRH, TH, or PSH.

1. Individuals and families will be referred to ***Rapid Re-Housing*** according to the following prioritization criteria:
   At least **75%** of available RRH resources must be filled with individuals or families that score for RRH based on the VI-SPDAT as determined by each CoC. CoCs may enact more rigorous standards.
2. Individuals and families will be referred to ***Transitional Housing*** according to the following prioritization criteria:
   At least **75%**[1] of available TH units within a CoC must be filled with households that score for

[1] CoC should justify variances to the 75% threshold (either above or below) using local data to support the

TH based on the VI-SPDAT **AND** meet the criteria of at least one of the priority groups identified below:

- ***Youth –*** All individuals between the ages of 15-24 who present as a household. This can include unaccompanied youth (household size of one), and multiple youth who are seeking assistance together.
- ***Youth Parents –*** Women and men between the ages of 15-24 who are the parent of at least one child and are seeking assistance with that child(ren).
- ***Domestic Violence survivors –*** Individuals and families with at least one person who identifies a domestic violence experience as the primary reason causing their housing crisis.
- ***Persons being released from correctional facilities*** and were homeless before entering prison/jail
- ***Pregnant women -*** Women who are pregnant, regardless of their age or whether they have any additional children.
- ***Persons in the early stages of AOD addiction recovery -*** Individuals and families with at least one person who recently began receiving services to assist in their recovery from alcohol or other drug addiction. This can include (but is not limited to) people who were recently released from a treatment center or other institution.
- ***Veterans (choosing Grant and Per Diem - GPD)***

3. Individuals and families will be referred to ***Permanent Supportive Housing*** according to specific prioritization protocols as defined by each CoC which must include the following attributes:
    - Chronic homelessness as defined by HUD
    - Long-Term-Homeless as defined by State of MN
    - longest history of homelessness
    - most severe service needs as determined by the VI-SPDAT score

Low Barrier Policy

The term "low barrier" refers to minimal eligibility and enrollment obstacles resulting in homeless persons being engaged and enrolled in homeless assistance projects regardless of perceived barriers such as lack of income, lack of sobriety, presence of criminal records, or historical non-compliance with program requirements. No client may be turned away from crisis response services or homeless designated housing due to lack of income, lack of employment, disability status, domestic violence status, or substance use unless the project's primary funder or local government jurisdiction requires the exclusion or a previously existing and documented neighborhood covenant/good neighbor agreement has explicitly limited enrollment to clients with a specific set of attributes or characteristics. Funders restricting access to projects based on specific client attributes or characteristics will need to provide documentation to the CoC providing a justification for their enrollment policy.

CoC projects offering Prevention and/or Short-Term Rapid Rehousing assistance (i.e. 0 – 6 months of financial assistance) may choose to apply some income standards for their enrollment determinations.

difference.

Fair and Equal Access

All CoCs will ensure fair and equal access to CES system programs and services for all clients regardless of actual or perceived race, color, religion, national origin, age, gender identity, pregnancy, citizenship, familial status, household composition, disability, Veteran status, sexual orientation, or domestic violence status. To ensure fair access by individuals with disabilities, physical and communication accessibility barriers must be addressed by appropriate accommodation within each Coordinated Entry System. Each CoC's written policies and procedures must establish protocols for fair and equal access to CoC housing and services.

If an individual's self-identified gender or household composition creates challenging dynamics among residents within a facility, the host program should make every effort to accommodate the individual or assist in locating alternative accommodation that is appropriate and responsive to the individual's needs.

Emergency Services

Defined access points must provide directly or make arrangements through other means to ensure universal access to crisis response services for clients seeking emergency assistance at all hours of the day and all days of the year. Each CoC must document their planned after-hours emergency services approach. After hours crisis response access may include telephone crisis hotline access, coordination with policy, emergency medical care.

Safety Planning

Each CoC must provide necessary safety and security protections for persons fleeing or attempting to flee family violence, stalking, dating violence, or other domestic violence situations.

Safety planning guidelines and examples of trauma-informed approaches to care coordination will be fully developed via a partnership with Minnesota Coalition for Battered Women (MCBW) in 2017.

Standardized Access and Assessment

All defined access point providers must administer the Minnesota CES Assessment Process as defined by the Interim Decision Group. The assessment process must be standardized across each participating CoC, with uniform decision-making across all assessment locations and staff. If access points or assessment processes are conducted or managed by providers who do not receive HUD, State of Minnesota, or local county funds, those providers must still abide by assessment standards and protocols defined by the CoC. CES will operate using a client-centered approach, allowing clients to freely refuse to answer assessment questions and/or refuse referrals.

To ensure transparency in client care coordination and decision making, all CES participants receiving a comprehensive assessment and referral to a CoC project must be offered written documentation of the assessment results and referral. This "receipt" of CES assessment and referral process should include a description of the CES screening and assessment results and indicate the CES participant's prioritization for the referral intervention being offered.

Referral criteria for all CoC projects

All CoCs must define referral criteria for all projects within the CoC's geographic area. Referral criteria

must identify all the eligibility and exclusionary criteria used by program staff to make enrollment determinations for referred persons or households. Established guidelines must describe acceptable time frames for reviewing and communicating referral decisions (i.e. whether the potential program participant is either accepted or denied enrollment). If a potential client is not offered enrollment, the reason for rejection must be clearly communicated and documented in HMIS. The referral criteria must be published at least annually and support the identification of and connection to appropriate housing and services for all assessed clients.

Referral Process

CoCs must establish written protocols in accordance with HUD guidelines for referrals that explicitly identify the VI-SPDAT score or score range associated with referrals to each CoC component type including PSH, TH, RRH, and self-resolve strategies. CoCs shall adopt locally specific prioritization criteria and referral protocols based on local CoC capacity, inventory and availability of CoC housing and services. The referral process shall be standardized and consistently administered; however, the prioritization of housing and services will vary over time due to fluctuating participant demand, changes in availability of CoC housing and services, and dynamic client needs and preferences.

Clients must be provided the ability to enroll in CoC component types that are less intensive than the CES referral choice offered. The applicability and accuracy of VI-SPDAT score ranges may vary among CoCs based on local CoC design, resource availability, and funder requirements. Prioritization processes and tools will be assessed and updated annually by each CoC based on analysis of actual score prevalence rates and available CoC inventory.

When offering referral options to clients, the following information shall be provided:

- information about the referred housing providers and housing types using resources such as web pages, CoC inventory information, and HB101
- Referral Rejection Policy
- Right to choose options less intensive than the CES referral offered
- Guidance about possible impact associated with accepting, rejecting, or changing the project type recommended for the household by the CES assessment and prioritization process

Inclusivity of subpopulations

All subpopulations including chronically homeless individuals and families, Veterans, youth, persons and households fleeing domestic violence, transgendered persons, and refugees and new immigrants must be provided equal access to CoC crisis response services regardless of the characteristics and attributes of their specific subpopulations.

Referral Rejection Policy

Both CoC providers and program participants may deny or reject referrals from the defined CES access point, although service denials should be infrequent and must be documented in HMIS or other comparable system with specific justification as prescribed by the CoC. The specific allowable criteria for denying a referral must be established by the CoC, must be shared with each project and client, and be reviewed and updated annually. All participating projects and client must provide the reason for service denial, and may be subject to a limit on number of service denials. Aggregate counts of service denials,

categorized by reason for denial, must be reported by the CoC annually.

At a minimum, project's referral rejection/denial reasons must include the following:

Client/household refused further participation (or client moved out of CoC area)
Client/household does not meet required criteria for program eligibility
Client/household unresponsive to multiple communication attempts
Client resolved crisis without assistance
Client/household safety concerns. The client's/household's health or well-being or the safety of current program participants would be negatively impacted due to staffing, location, or other programmatic issues.
Client/household needs cannot be addressed by the program. The program does not offer the services and/or housing supports necessary to successfully serve the household.
Program at bed/unit/service capacity at time of referral
Property management denial (include specific reason cited by property manager)
Conflict of interest.

In the event of a service denial or participant rejection the following steps must be followed:

1. Any referral provisionally reviewed by participating agencies and a preliminary enrollment determination made must be communicated back to the CES manager, assessment and referral provider, or client advocate within **3 business days**.
2. All referral requests that result in a denial must be reviewed by the CES manager, assessment and referral provider, or client advocate designated by the CoC.
3. If a referral is returned to the housing referral coordinator or designee, the HMIS record must be updated to reflect the reason for the denial.
4. The CoC project denying the referral must notify the CES manager, assessment and referral provider, or client advocate within a specified amount of time determined by the CoC. Further communication must include a detailed written justification of the referral denial provided within **3 business days**. The written justification of service denial must also be shared with the client.
5. A provider who denies three sequential referrals will be required to participate in a case conferencing meeting with the CES manager, assessment and referral provider, or client advocate designated by the CoC.
6. A client who denies three sequential referrals will be required to participate in a case conferencing meeting with the CES manager, assessment and referral provider, or client advocate designated by the CoC.

Outreach

All CoC outreach activities, projects, initiatives must be integrated with the CoC's CES design, serving as an engagement resource or designated access points for CoC resources, services, and housing.

Stakeholder Inclusion

CoCs will support the implementation, expansion, and ongoing operation and evaluation of Coordinated Entry Systems by regularly convening stakeholder input and feedback opportunities. CoC must develop a plan to collect stakeholder feedback at least annually and will engage participants from all CoC component types, referral sources, residents and participants of homeless services and programs,

funders of homeless response systems, and mainstream system providers.

Full Coverage

The full geography of the CoC must be covered by CES services including access to crisis response services, assessment of clients, and referral options.

Privacy Protections

CES operations and staff must abide by all State of Minnesota-defined privacy protections as defined by the HMIS Advisory Committee. Client consent protocols, data use agreements, data disclosure policies, and any other privacy protections offered to program participants as a result of each client's participation in HMIS will be the same as CES.

List of Resources

Each CES operator will maintain a list of all available CoC resources, including each project's eligibility criteria. The list of resources must be updated annual and be made publicly available.

CES Training

CoCs must develop and implement an annual CES training plan to ensure all participating CES partners are knowledgeable of CoC-specific CES participation and performance expectations, are following statewide guidelines and protocols for CES operations, and strive to achieve national best practices and promising approaches for the most effective coordinated entry system. Needs or gaps in training effectiveness will be assessed annually as part of each CoC's evaluation of CES processes.

Elements of **locally-specific training** shall include the following:

- CES access points and access protocols
- CES assessment tools, processes and uses of assessment information to coordinate client care
- General eligibility requirements for all CoC projects
- Prioritization standards and protocols for how client's placement on prioritization lists (i.e. waiting lists) will be managed
- Referral processes and protocols (rather than specific referral policies which will likely be more standardized across the state).
- Data collection, data management, data sharing and reporting requirements and responsibilities

Elements of standardized approaches across all CoCs in Minnesota will be reinforced **by state-level training and capacity building opportunities** to include but not limited to the following:

- Effective strategies for VI-SPADT assessment, score analysis, and referral determinations
- Effective client engagement techniques for challenging, difficult to engage clients (e.g. motivational interviewing, trauma-informed care, Housing First approaches)
- Trauma-informed care throughout the CES system
- Assessment practices and approaches that honor the lived experience of the specific culture or subpopulation accessing emergency services
- Co-occurring issues of substance use disorders, mental illness, physical disability, chronic health conditions, and sexual assault and family violence.
- Domestic and sexual violence 101, exploring dynamics of violence and how violence impacts a

person's executive decision making and functioning
Information specific to working and immigrant/refugee and undocumented people and families as it relates to domestic and sexual violence
Strategies for culturally competent CES practices and mitigating historical inequities among racial, ethnic, and cultural minorities
Maintaining high quality data collection and reporting practices
Strategies for maintaining client confidentiality and privacy while coordinating care among multiple CoC partners
Linkage of CES practices to achieving HUD's CoC system performance measures

Training on topics related to culturally appropriate engagement, assessment practices and programming should be designed and conducted by members of communities representing the specific culture or subpopulation impacted.

Training offerings will be made available remotely (via iTV), posted online, with comprehensive transcripts made available following the completion of live training events. Sample assessor scripts or engagement language will be made available as guides for effective and best practice assessment practices.

Data Sharing

All CoCs shall comply with the data sharing policies developed by the HMIS Advisory Task Force and Data Sharing planning group.

Some participating CES providers will need to opt out of data sharing practices to comply with the explicitly expressed requests of clients who wish not to share their information or in cases where providers are prohibited from participating in HMIS or sharing client information (e.g. victim service providers serving households fleeing domestic violence). In these instances coordinated entry protocols will need to accommodate management of prioritization lists using masked or encoded identifiers of applicable households.

HMIS and Data Collection

Each CoC will use the HMIS designated by the CoC to manage data related to CES operations. At a minimum data collected from CES participants and managed in HMIS must include all data necessary to generate an accurate and complete CES Management Report (see Appendix A for a draft version of this report).

CES Management Report data will be derived from the HUD-defined Universal Data Elements (UDEs), select Project-Specific Data Elements (PSDEs), and additional data elements from the of MN HMIS Question Bank.

CoCs are encouraged to access the official MN HMIS Question Bank to review approved questions and response categories for consideration in local data collection requirements. Any additional data collection requirements beyond the baseline set established by IDG in official policy must be drawn from the official MN HMIS Question Bank.

CoCs may independently explore and utilize other HMIS functions and services in support of CES operations (e.g. Referral Point)

Mainstream Services

Each CoC must implement a screening protocol to assess each client's potential eligibility for the following mainstream resources or services:

- Housing
- Medical benefits
- Nutrition assistance
- Income supports

Assessment Tool

Each CoC will develop a universal assessment tool for use in managing the client intake, assessment, and referral process. The standard tool may be customized by each individual CoC project with additional program-specific assessment questions and response categories necessary to address the unique aspects and needs of individual programs. All assessment tools will use the VI-SPDAT question and scoring paradigm to assist with documenting clients' needs and prioritizing services

Assessment Process

CoCs will employ a progressive assessment approach. Progressive assessment stages the asking and sequencing of assessment questions such that prospective program participants are asked only those questions directly related to service enrollment and prioritization decisions necessary to progress the participant to the next stage of assessment or determine a referral to a service strategy.

Prioritization

The State of Minnesota has determined that an effective coordinated entry process ensures that people with the greatest needs receive priority for any type of housing and homeless assistance available in the CoC, including PSH, rapid rehousing (RRH), and other interventions. When interventions are not immediately available or accessible in a CoC, or if a client prefers interventions located in another Minnesota CoC, the client may be placed on multiple prioritization lists in different CoCs for the same CoC component type. Recognizing that some projects may have locally restrictive residency requirements, the CES workgroup will work with CoCs to define a protocol by March 2017 to accommodate movement between CoCs that matches CES capacity and design. It is understood that there may be locally restrictive residency requirements within CoCs to CES in the meantime.

Monitoring and Reporting of CES

All CoC's must adhere to the State-defined ***CES Monitoring and Reporting Plan***. The State-defined ***CES Monitoring and Reporting Plan*** will include requirements for reports on performance objectives related to CES utilization, efficiency and effectiveness. The specific ***CES Monitoring and Reporting Plan*** will be published by the CES IDG and updated on an annual basis.

The Minnesota ***CES Monitoring and Reporting Plan*** will include the following narrative and management report sections to be submitted annually by each CoC:

1. *Narrative*. A narrative description of the status of CES implementation during the reporting

period. The narrative must be no longer than 1-page in length and identify the CoC's experience of barriers and challenges related to implementation and management of Coordinated Entry, and identify plans for expansion and improvements in the upcoming reporting period.

2. *CES Management Report*. An HMIS-generated CES management report covering the 12-month period coinciding with the State's fiscal year (ie. July 1 to June 30). The *CES Management Report* will include the following performance indicators:
    1. Number of individuals receiving CES services
        a. Number of families and individuals completing initial triage/diversion screen
        b. Number of families and individuals completing client intake/assessment
        c. Number of families and individuals completing comprehensive/housing assessment
    2. Demographics and attributes of persons/households receiving CES assistance
    3. Number of persons and individuals by VI-SPDAT score
    4. Number of persons and individuals receiving CES referrals to the following
        a. Self-Resolve
        b. Rapid Rehousing
        c. Transitional Housing
        d. Permanent Supportive Housing
        e. All other
    5. Destination of persons and individuals to each service strategy as a result of CES referral
        a. Rapid Rehousing
        b. Transitional Housing
        c. Permanent Supportive Housing
        d. All other
    6. Length of time from completion of CES comprehensive/housing assessment to program entry
        a. Average length of time from assessment to referral for each component type
        b. Average length of time waiting on prioritization list for each component type
    7. Number of persons who waited for each CoC component type for greater than 30 days

The following schedule identifies specific CoC reporting requirements, including required data, report structure, and submission deadlines:

CoC CES Evaluation Component	Format	Reporting Period	Due Date
CoC Annual Report	Narrative & CES Management Report	July 1 – June 30	August 30
CoC Quarterly Report	Narrative & CES Management Report	a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. October 30 b. January 30 c. April 30 d. July 30
CoC Stakeholder feedback – CoC partners	Narrative report incorporating data from surveys, questionnaires, or focus group meetings	July 1 – June 30	August 30
CoC Stakeholder feedback - participants in CE	Narrative report incorporating feedback from client focus groups, participant advisory groups, surveys, or questionnaires	July 1 – June 30	August 30

CES Statewide Evaluation

The CES leadership team will conduct a comprehensive system evaluation of CES to ensure that both qualitative and quantitative information are collected and used to identify opportunities for continuous system improvements. Results of the statewide evaluation of CES operations will be shared with funders and policy makers. Areas of inquiry may include the following:

1. ***CES Coverage***
    a. Which CoC projects are participating? What does ***participation*** mean – listing vacancies, accepting referrals?
    b. Are all geographic areas of the CoC covered by CES processes? (non HMIS)
2. ***System Gaps***
    a. What is the actual demand for CoC crisis response services?
    b. Is demand effectively managed by the available resources and CoC assets?
    c. What is the distribution of referrals by project type?
    d. What are rates and reasons for referral rejections?
3. ***Triage & Diversion Screening Efficiency***
    a. How long does a screening call last? Is duration tied to outcome? (non HMIS)
    b. Are virtual (phone) screenings more/less effective than in-person screenings?
    c. What information gets asked? Gets collected/entered into HMIS? Is all the collected information necessary for care coordination? (non HMIS)
4. ***Assessment Process***
    a. Is participant assessment data complete, accurate, timely for referral process?
    b. Is assessment process respectful of participant preferences, culturally appropriate, trauma informed? (non HMIS)
    c. When referred, do participants get accepted/enrolled?
    d. When referred, do participants accept referral options?
    e. Length of time from referral to placement in PH?
    f. Are prioritized populations being successfully referred and enrolled in available housing and services?
    g. Any assessment information collected that is not readily used to inform case planning or care coordination? (non HMIS)
5. ***Access Consistency***
    a. Does the relationship between referrals and eligibility vary in terms of presenting program participant's race, household size, age or gender of children, or geography (such as rural vs. urban)?
    b. If the CoC has established different access points for singles, families, survivors of domestic violence, and youth, are those subpopulations experiencing variance in rates of referral and enrollment when compared to

other groups?

c. Do rates of return to homelessness vary by program participant characteristics or site?

Appendix A – CES Management Report Template (DRAFT version 11.11.16)