**Minnesota Coordinated Entry System**

**Policies and Procedures**

As of July 23, 2015

**Participation Requirements**

HUD and VA have recently established guidance that instructs all CoC projects to participate in their CoC’s Coordinated Assessment system.  Any project that receives HUD funding (CoC Program, ESG, HOPWA) or VA funding (SSVF, GPD, VASH) must comply with the participation requirements as established by the corresponding CoC jurisdiction.  The State of Minnesota is in the process of establishing minimum statewide requirements for Coordinated Assessment participation for all state funded homeless projects.  While official guidance from the State is not likely until later in 2015, at a minimum Coordinated Assessment participation will include 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 Design Principles**

1. **Adoptstatewide standards** but allow flexibility for local customization beyond baseline standard.
2. **Promoteclient-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 barriersto 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** – Acknowledge and honor tribal sovereignty; respect cultural, regional, programmatic, linguistic, and philosophical differences.
9. **Use CE data** to analyze local housing needs and create a diversity of housing options.

**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 (e.g.

1. Individuals and families will be referred to ***Transitional Housing*** according to the following prioritization criteria:

* At least **75%[[1]](#footnote-1)** of available TH units within a CoC must be filled with households that score for 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)***

1. 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**

CoC providers will make enrollment determinations on the basis of limiting barriers to enrollment in services and housing. No client may be turned away from crisis response services or homeless designated housing due to lack of income, lack of employment, disability status, or substance use unless the project’s primary funder 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.

**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, or sexual orientation.

If an individual’sself-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.

[Further details of this policy are pending review by safety advocates]

**Standardized access and assessment**

All defined access point providers must administer the Minnesota Coordinated Entry System (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.

**Referral criteria**

All CoCsmust 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.

**ReferralProcess**

CoCs must establish written protocols 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. Clients must be provided the ability to enroll in CoC component types that are less intensive, but not more intensive, than the CES referral choice offered. The applicability and accuracy of VI-SPDAT score ranges 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
* Planning resources (e.g. HB101, DB101, DLL)

**Inclusivity of subpopulations**

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

**Referral Rejection Policy**

Both CoC providers and program participants may denyor 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 projectsand 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 apreliminary 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 associated 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 and prioritization protocols. The list of resources must be updated annual andbe publicly available.

**Assessor training**

CoCs must develop and make available capacity building training courses or instruction for all CES assessors. Training topics must address effective client engagement techniques, interviewing skills, collection of quality data, and maintenance of CES records and processes.

**Data Sharing**

All CoCs will follow the Data Sharing policies developed by the HMIS Advisory Task Force and Data Sharing planning group(as yet undetermined as of the date of this document)

**HMIS**

Each CoC will use the HMIS designated by the CoC to manage data related to CES operations. At a minimum data collected and managed in HMIS must include the following:

* ***Assessment Dates.*** Dates that each stage of the client assessment is completed:
  + Initial Triage/Diversion;
  + Client Intake/Assessment;
  + Comprehensive/Housing Assessment;
* ***VI-SPDAT score*** (if applicable). The VI-SPDAT as determined by the administration of the VI-SPDAT tool;
* ***CES Referral Determination***. The service strategy referral as determined by the Comprehensive Assessment:
  + Rapid Re-Housing
  + Transitional Housing
  + Permanent Supportive Housing
* ***CES Placement***. The provider name and CoC component type of the final disposition for each referred client.
* ***Reason for Denial***. If the CES referral sources denies or rejects a referral, the reason for the referral must be noted in HMIS. See Policy regarding referral rejection

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.

**Monitoring and Reporting of CES**

All CoC’s must adhere to a state-defined monitoring and reporting plan for CES. The State-defined monitoring process will reporton performance objectives related to CES utilization, efficiency and effectiveness.

The State of Minnesota CES Reporting Requirements will include the following elements to be reported annually by each CoC:

* Narrative description of the status of CES implementation, barriers and challenges experienced, and plans for expansion and improvements in the future
* CES performance indicators will include the following:
  1. Number of persons and individuals receiving CES services
  2. Number seeking assistance/referred to CES
  3. Number completing initial triage/diversion screen
  4. Number completing client intake/assessment
  5. Number completing comprehensive/housing assessment

1. Demographics and attributes of persons/households receiving CES assistance (from 1d above)
2. Number of persons and individuals by VI-SPDAT score
3. Number of persons and individuals receiving CES referrals to the following
   1. Self-Resolve
   2. Rapid Rehousing
   3. Transitional Housing
   4. Permanent Supportive Housing
   5. All other
4. Destination of persons and individuals to each service strategy as a result of CES referral
   1. Rapid Rehousing
   2. Transitional Housing
   3. Permanent Supportive Housing
   4. All other
5. Length of time from completion of CES comprehensive/housing assessment to program entry
   1. Average length of time from assessment to referral for each component type
   2. Average length of time waiting on prioritization list for each component type
6. Number of persons who waited for each CoC component type for greater than 30 days

**Evaluation**

The State of Minnesota 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. Areas of inquiry will include the following:

**Implementation**

* What has been the experience of CoCs with the CES design process?
* What refinements and adjustments have CoC staff adopted in the process of managing their CES approach?

Management

Outcomes

Future Refinements

1. CoC should justify variances to the 75% threshold (either above or below) using local data to support the difference. [↑](#footnote-ref-1)