Montana Continuum of Care Coalition

State Coordinated Entry and Assessment Plan

Foreword

As part of the HEARTH regulations that govern Continuums of Care (CoC) and Emergency Solutions Grant (ESG) funding, the U.S. Department of Housing and Urban Development (HUD) requires all CoCs across the United States to implement a coordinated entry system and process. Coordinated entry, also known as coordinated assessment or coordinated intake, increases the efficiency of a homeless assistance system by standardizing access to homeless services and coordinating program referrals.

Montana's CoC, however, is unique in that it is a statewide continuum consisting of ten somewhat arbitrarily drawn geographic areas (referred to here as districts or communities) that can vary widely in their populations, needs, resources and approaches to local problems.

It is, therefore, necessary to accommodate many variations across districts and local communities are free to design their own version of coordinated entry, but it is important that they conceptualize, document and materialize whatever coordinated entry system best fits their area.

The following "standards" are intentionally imprecise and are meant to be models more than requirements for local planning. They do, however, provide important elements for any successful coordinated entry.

These standards are also subject to change once HUD releases the Notice on the requirements for development and implementation of a coordinated entry process, which was anticipated (but did not appear) during the Summer of 2015.

BACKGROUND

Montana Coordinated Entry Vision Statement: The purpose of a coordinated system is to assist all Montana communities to end homelessness by providing, within existing homeless provider networks, a clear and systematic pattern for helping consumers to quickly access the most appropriate services available.

Principle Components: Across all Montana communities, locally designed and operated coordinated entry systems should strive to provide the following:

1. ***Standardized Access*** for all clients,
2. ***Standardized Assessment*** process for all clients, and
3. ***Coordinated Referral*** *process* for clients to prevention, housing, and/or other related services.

Essential Characteristics:

- Providers are "client focused," and consider all homeless programs as resources that can best achieve the shared goal of ending homelessness if they are leveraged, coordinated and prioritized as a network.
- The system is "client focused" by being accessible, leaving no one behind and accommodating client choice and needs.

- Flexible and customized approaches are based on community needs, resources, and services available
- Transparent and accountable systems that consumers can understand
- Housing focused – our goal is people experiencing housing crises return to permanent housing within 30 days, as set forth in the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009.
- Collaboration focused – system is operated from broad-based consensus, system linkage responsibilities are managed by partnerships with integrity, agencies hold each other accountable and exhibit a willingness to cooperate
- Easy to use – system is not cumbersome to agencies, is also accessible and well-known to the community

First Step:

Before anything else, it is important that all participants be informed of the available programs and services. It is essential that each district inventory their homeless providers, prepare a directory of the organizations with a brief summary of the services they provide (including quantities, e.g. number of beds), basic eligibility criteria and referral contact information.

1. ***STANDARDIZED ACCESS*** for all clients,

Each district needs to decide what "approach" they will take for providing client access to their homeless network, an essential component of any successful coordinated entry system. The four most common methods are:

1. Single point of access
2. Multi-site coordinated
3. 2-1-1 Hotline
4. No Wrong Door

The following table provides general descriptions of these approaches which can be mixed and blended to meet local preferences. For example, Missoula's 2-1-1 system is also a No Wrong Door approach in the sense that a homeless person can present to any homeless provider or other social services organization and be assisted with using the 2-1-1 system or a client may do so from a borrowed cellphone in a park. Or, a multi-site coordinated system that relies upon a limited number willing providers to provide access points can evolve into a no-wrong door where all providers are participating.

ACCESS MODEL COMPARISONS

	Single Point of Access	Multisite Centralized Access	Assessment Hotlines	No Wrong Door
Site Location	Centralized	One per population center or at specific high-volume provider locations	Telephone-based	All existing provider locations
Number of Access Points	One	Variable, based on geography (2 to 4)	One Telephone number	Many
Services Offered	Primarily access and assessment; may include triage services, emergency services, or other mainstream services	Primarily access and assessment; may include the services of a co-located provider; may be targeted to one of several subpopulations	Access and often access to an abundance of mainstream services; limited assessment capability	Access, at least limited assessment, referrals, and the standard services of each provider
Operating Authority	Permanent independent access specialists, may be shared staff of a central shelter or other organization	Mobile or permanent independent access specialists or shared staff of co-located providers	Local 211 or other designated hotline agency	Independently operated by each provider

	Single Point of Access	Multisite Centralized Access	Assessment Hotlines	No Wrong Door
Hours of Operation	Hours of the central location	Hours of each access site	Typically 24-hour operation/ 7 days a week	Hours depend on and vary with each provider
Considerations	Highest level of control over implementation and compliance for the CoC; also known as centralized intake	Moderate level of control over implementation and compliance for the CoC; the most adaptable model, sometimes called a hybrid system	211 is the most popular example; may be combined with any of the other models as a pre-screening tool; often must build a relationship with an outside provider	Lowest level of control over implementation and compliance for the CoC; still requires standardized forms and coordinated referrals for all; still answers the guiding question

Excerpted from PowerPoint, HUD Community Planning and Development

Examples/Models

A Single Point of Access approach is probably most workable in urban neighborhoods or, perhaps, small rural communities, where clients can easily walk to or otherwise access a single agency capable of conducting all the intakes, assessments and referrals.

The most developed coordinated entry system in Montana, to date, is in Missoula City/County which adopted the 2-1-1 Hotline approach with a single intake form and data entry system known as "cHris."

Helena is using a no wrong door/multi-site hybrid approach through the "Consented Referral System" initiated by the Safe Schools Healthy Students Initiative in 2000 that "went live" in 2014 and is now operated by the county.

While one or two other communities are looking into eventually using the 2-1-1 option, most communities are at various stages of implementing a No Wrong Door, Multi-site or some combination of the two approaches where all participating providers will agree to use a standard intake tool and procedure and promptly assess for the most appropriate and quickest referral (where more extensive client assessment subsequently occurs).

2. ***STANDARDIZED ASSESSMENT***

Assessment is an iterative (re-occurring) information gathering process that begins with documenting the client's most immediate needs and preferences so that they can be quickly referred to the most appropriate services, but it continues with the referral-receiving organization conducting a more comprehensive needs assessment and preparing a plan for becoming self-sustaining and permanently housed. Some standardized assessment systems go so far as to include screening clients against the eligibility criteria of participating provider programs.

It typically consists of the following components:

- Triage
- Initial intake
- Comprehensive assessment
- Housing plan and strategy
- Updated and revised client information.

The "best practices" of standardized assessment include:

- Document client's homelessness history and housing barriers
- Identify appropriate services
- Document discrepancy between client needs and available resources to meet need
- Respect client preferences
- Capture "just enough" data to meet project needs
- Obtain consent for sharing with providers
- Draft, or at least initiate, a housing plan
- Apply standardized practices at every point

The Intake and assessment tools used by ESG subrecipients in each district provide ready-made options obviating the need to start from scratch. ESG programs are operated by the HRDCs under contracts with the MT Department of Health and Human Services. These intake tools can be tailored (e.g. shortened) in each district to accommodate a consensus of providers or can be used "as is." Not all ESG intakes, however, include questions designed to provide prevention and diversion actions, so be sure to add them if necessary.

The National Alliance to End Homelessness also provides the "Alliance Coordinated Assessment Tool Set," (see attached) that goes beyond the intake data contained in ESG forms to include a multi-level assessment, including:

I. Pre-screening Questions (determines if a domestic violence situation exists)
II. Identifying Questions (collects information needed for the HMIS and similar to most ESG intake tools)
III. Prevention and Diversion Questions to determine their housing or homeless status and if diversion assistance can prevent them from becoming homeless.
IV. Housing Prioritization Tool. Provides a scoring tool to determine if the client should be prioritized for Rapid Rehousing, Transitional Housing or Permanent Supportive Housing.
V. Population Specific Questions. Provides client-focused preferences for HIV/AID, Youth and Substance Abuse services.
VI. Choosing a Referral. Clients eligible for multiple service, they are given the opportunity to express their preferences.
VII. Vulnerability Index. This helps to determine who is eligible for Permanent Supportive Housing and who has been homeless the longest (which may determine priority access).

Also attached is the Missoula City/County's tool for Community Housing Information and Referral System (cHris) utilizing the community's 2-1-1 program. The tool collects the following information:

I. Basic demographic information,
II. Housing Information
III. Financial Resources, Social Supports, and Youth Factors,
IV. Housing Stability and Housing Transitions
V. Service Use (past access to local services)

Also attached is a typical ESG intake tool (HRDC IX, Bozeman).

3. ***COORDINATED REFERRAL***

Referral is simply the placement process that refers clients for enrollment in appropriate housing and services. Coordinated referral involves all providers in the community using a single process to ensure that every person, regardless of how or where they enter the process, receives the fastest and most appropriate referral possible.

Basic Components:

- **Standardized.** Functions identically for all clients.
- **Efficient.** Matches the recommended type of intervention to a project offering the appropriate services.
- **Effective.** Leads to the enrollment of the client in a project offering the appropriate assistance.

Ideal Components:

- **Participation.** Achieves participation and compliance from all providers.
- **Informed.** Real-time information on the availability of beds and services offered by appropriate projects is available and used.
- **Comprehensive.** Transfers all the data that funders require and most of the data needed by service providers.

- **Electronic.** Uses electronic referral (e.g., HMIS) to transfer information.

Eligibility Criteria
While Continuums of Care are required to establish eligibility criteria as part of their coordinated referral activities, the MT CoC is deferring eligibility decisions to local communities and the provider programs that operate under their own eligibility requirements.

Because, however, there are more homeless persons than resources in any community, local coordinated entry referral processes are encourage to consider how prioritizing can lead to greater efficiencies or effectiveness in ending homelessness. Prioritizing can include targeted subpopulations, system process and performance measures.

The National Ending Homeless Priority Goals adopted by the US Interagency Council on Homelessness and in the Opening Doors document are:

- Veterans (2015)
- Chronic homelessness (2017)
- Families, youth and children (2020)

Assuming local data supports these same priorities, a local coordinated entry policy should consider incorporating the following:

- Persons most vulnerable to becoming homeless should be referred to a local community action agency or other organization that provides budget and credit counseling, emergency assistance (food, clothing, medical care), cash assistance (utility payments, rent assistance) and eviction/landlord assistance.
- All veterans are immediately referred to SSVF and/or any veteran not served by VA or SSVF program is given priority.
- Any person escaping violence is given a priority for immediate and safe housing.
- Permanent Supportive Housing vacancies are prioritized for chronically homeless who have been homeless the longest. (At this time, this is a local prerogative, but the MT CoC must consider adopting this as a statewide standard to conform with HUD Notice CPD-14-012 which "strongly encourages" adopting a standard that prioritizes Permanent Supportive Housing for homeless individuals and families with the most severe needs, i.e. chronic homelessness.)
- ESG prioritized for families who have been homeless the longest.

Coordinated Entry Process Priorities
Statewide "process" priorities are being deferred to local CoC groups, but a statewide "process standard" might be adopted in the future. Local CoCs, therefore, are encouraged to consider the following:

- Adopt policies outlining the acceptable reasons a client referred to a project can be rejected or denied by that project.
- Referral and waitlist management
    - Referral to the most appropriate provider(s) should be done using an intake evaluation and prioritization assessment. See Bozeman Risk and Eligibility Assessment.
    - Each provider can determine and manage their own waitlist management
- Real-time knowledge of inventory and capacity

- When possible, providers entering data into HMIS should consider sharing their data so real-time inventory and capacity can be readily seen. This will require necessary forms and agreements to be filled out with the HMIS Administrator.