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Slide 2 – Housing 101 for Victim Service Providers

Hello and thank you for joining us today for Part 8 of Violence Free Minnesota's Housing 101 for Victim Service Providers series on the Coordinated Entry process. My name is Princess Awa-Ada Kisob. I am a board member of Violence Free Minnesota, and I will be your host for this session. Here we will cover what coordinated entry is and some of the unique considerations it presents for survivors and victim service providers. A lot of the information in this session has been pulled directly from publicly available resources which will be noted in our resource page for this series on our website.

Domestic and sexual violence advocates have an important role to play in the implementation of the coordinated entry system in your communities. This session will be of primary interest to advocates and other direct service providers who are helping survivors find affordable housing, and more ably navigate that system. But everyone working in a victim service program may benefit as well. As with other aspects of the affordable housing network of programs and services,

coordinated entry was not designed with survivors of violence in mind. But with the advocacy of VSPs, it is possible to work with your local Continuum of Care to design a system that is more responsive to the specific needs of people fleeing violence.

If you are not familiar with the Continuum of Care, please view Part 4 of this series.

Slide 3 – Introduction to Coordinated Entry

We've learned that a Continuum of Care, or CoC, is a regional or local planning group to coordinate housing and services funding for families and individuals who are unhoused.

HUD requires that each CoC establish a coordinated entry process to assist people experiencing houselessness to access housing options. There are special considerations for people fleeing violence, that we will emphasize in this session.

Slide 4 – What is Coordinated Entry?

The US Department of Housing & Urban Development, or HUD, which is the primary federal funder of low-income housing, requires each Continuum of Care,

or CoC, to utilize a Coordinated Entry system, or CES, to prioritize those with the highest need. The system is intended to provide people with fair and equal access to housing, while also prioritizing the needs of the most vulnerable households with the greatest service needs, especially given scarce affordable housing options in most communities.

HUD has designated 4 categories of homelessness for intervention. HUD Category 4 includes people who are fleeing or attempting to flee domestic violence, sexual assault, or trafficking. We covered this more specifically in previous sessions of this series. For now, it's important to note that survivors are designated specifically in federal policy as a subpopulation in need of services to acquire and maintain safe, stable, and affordable housing.

Prior to the implementation of the coordinated entry model, people experiencing houselessness would need to contact each provider individually to inquire about availability of services. Access was random and somewhat haphazard. HUD's intention in establishing the CES was to streamline access to services, ensure that the most vulnerable people received priority, and to centralize data collection to identify community needs.

While the idea behind prioritizing the most vulnerable people into housing is commendable, and was designed to minimize access based on favoritism or prejudice, communities continue to struggle with how to fairly and equitably implement CE. In this session we will describe how CE is implemented along with strategies victim service provider agencies can use to improve safety and access for survivors. We will also provide the CE Access Points link in the resource page for anyone interested in accessing the CE.

Slide 5 – Core Elements

The core components of coordinated entry are:

- establishing access points for people to enter the system;
- use of a standardized assessment method of gathering information about the individual person or family's circumstances, needs, preferences and barriers to housing;
- identification and prioritization of the most vulnerable people with the greatest need;
- and referral to available housing options and supportive services.

We’ll talk about each of these.

Slide 6 – Points of Access

Access refers to how people experiencing a housing crisis learn that coordinated entry exists, and how to access crisis response services. The first contact that most people experiencing a housing crisis will have with the crisis response system is through a coordinated entry access point, though survivors may more often do so through a domestic violence shelter or other victim services program.

Access points are the places–either virtual or physical–where a household in need of assistance accesses the coordinated entry process. This can include the following examples:

- a central location within the geographic area covered by the Continuum of Care, or Coc
- a 211 or other hotline system that screens and directly connects callers to housing service providers in the area;
- a “no wrong door” approach in which a household can present at any provider serving unhoused people in the geographic area;

- a specialized team of workers that provides assessment services at provider locations within the CoC; or
- a regional approach in which "hubs" are created within smaller geographic areas.

CoCs may also create unique access points and assessment protocols for special subpopulations, including people fleeing violence. It's important to note that each CoC has its own distinctive approach to designing and operating the CE. While there is a strong desire and collaborative effort to coordinate among these CoCs, it's important to acknowledge that there are unique procedures and practices specific to each one.

Regardless of the access point, everyone should be assessed using the same tools, methodology, and referral processes across the CoC, and each must have the same access to resources.

Advocates should be aware that survivors do not necessarily need to be in shelter or on the street to qualify for help under HUD's Category 4 definition of homeless. Many survivors are still living with the person who has harmed them, but if they are trying to leave, they still meet the definition. Some coordinated

entry staff do not understand this, and might take the position that the person is not homeless, or at least is voluntarily homeless. Advocates armed with the correct information can help ensure that the survivor receives the appropriate services from coordinated entry.

Slide 7 – Access: HUD Requirements

HUD has established several required access elements for every coordinated entry plan.

They include:

- Full coverage of the entire geographic area covered by the Continuum of Care.
- Outreach to ensure that people living on the streets are prioritized for assistance.
- A plan to connect people experiencing a housing crisis to emergency services, including domestic violence crisis services. It must also have a way for people to access emergency services outside of the standard operating hours. This requirement is challenging everywhere, because many communities lack sufficient shelter space to meet the demand, and it may be a particular

challenge for rural communities that might not have 24/7 access to emergency services.

- HUD also requires a marketing plan that ensures nondiscriminatory access for all eligible people.
- A standardized access process is also required, including access by certain subpopulations, such as people fleeing violence.
- The plan must include safety planning for people fleeing or attempting to flee violence, and
- Privacy and confidentiality provisions for obtaining participant consent to use their information for purposes of assessment and referral.

<u>Slide 8 – Access for People Fleeing Violence</u>

All staff at coordinated entry points of access are required to be trained and alert to the possibility that someone has experienced violence, has fled, or is trying to flee.

A provider in an agency that does not routinely work with survivors of violence may or may not be fully equipped to respond.

We also know that a survivor's decision to disclose violence is complex--the decision to tell this individual, this information at this moment in time--is complicated, and survivors who do not have a relationship with the person providing access to CE may not choose to disclose. Opportunities for disclosure must be frequent, welcoming, and non-judgmental by trained staff. Providers at all points of access must do all they can to create a welcoming environment that invites disclosure, such as displaying materials about help for people fleeing violence, creating physical space that promotes privacy out of eye or earshot of others, and so on. Advocates can work with provider agencies to help create a safe and confidential environment.

How providers are positioned to determine whether someone has experienced violence is critical. Specialized points of access can be important, but everyone must have adequate training and support to identify whether someone is at risk of further violence.

When someone discloses that they are fleeing, or attempting to flee violence, the assessor is required to provide support and services and, if not a victim service provider, to offer a referral.

Slide 9 – Access for People Fleeing Violence

If the CoC chooses to create a separate coordinated entry process for people fleeing domestic violence, that process must be developed in coordination with local victim service providers and must adhere to the same requirements as the broader coordinated entry process, with the exception that it is targeted to households fleeing violence. Any separate process must ensure that victims of domestic violence have equal access to services and housing programs serving unhoused people that are available to those using the primary access point.

The special point of access for survivors can include a physical location, a virtual access point, such as a hotline or web-based platform, or a hybrid of the two. Whatever model is used it's important that survivors have the ability to quickly access the CES from any location where the person feels safe.

Slide 10 – Assessment Requirements

Assessment is the process of gathering information about the household's experience to match them with the most appropriate and helpful services possible. It involves collecting and documenting information about the person's

vulnerability as defined by the Continuum of Care, or CoC's, assessment tool or process.

The assessment process determines how people are prioritized and referred to housing and other supportive services. It includes gathering information about the person's overall goals and preferences, but should begin by asking about immediate needs, such as asking whether the person is safe at the moment, in need of emergency medical services, food and so on, and if appropriate, connecting them with immediate help. Assessment will include learning about and evaluating the person's vulnerabilities and barriers to housing.

If the CoC uses a designated access point for people fleeing violence, it can add or delete irrelevant questions as applicable. However, it must have written policies and procedures for documenting its criteria for uniform decision-making.

Some CoCs have opted to use an off-the shelf tool for their assessments. A common tool is the Vulnerability Index-Service Prioritization Decision Assistance Prescreen Tool, or VI-SPDAT. This tool has specifically been found to be a poor fit for determining vulnerability, and to be a poor predictor of future homelessness. It has also been shown to be racially biased. Some communities around the

country continue to use VI-SPDAT, and others have modified it somewhat, though these modifications have not been tested.

HUD also requires that an assessment process respect participant autonomy regarding information sharing. Participants must be informed that they do not have to answer any questions or provide any information they choose not to share, and that the decision not to share information will not be used to deny services. Sometimes the lack of response can limit the available options, and the assessor must take care to thoughtfully and respectfully communicate the impact of this decision, and work within the parameters of what the person has shared to find an optimal solution. Coordinated entry staff cannot turn people away for declining to provide information and cannot prevent them from accessing the coordinated entry system in the future.

The CoC must provide a minimum of one training annually for providers, and document training protocols for assessors to follow.

Coordinated entry staff are also prohibited from screening out people for assistance based on perceived barriers such as domestic violence, a prior eviction, or substance abuse.

A CoC's coordinated entry process must have policies and protocols in place to ensure that assessment information is collected, stored, and handled in accordance with HUD and Violence Against Women Act confidentiality standards.

Slide 11 – Assessment Challenges

While the effort to ensure that access to housing options based on favoritism, prejudice or chance is necessary, it's important to recognize that using a tool or checklist alone to do this can't effectively assess or rank people, based on reducing their life experience to a score, no matter how well-intentioned.

One of the concerns about assessment tools that try to arrive at a vulnerability score is that this approach is deficit-based. The idea is that those with the highest points are then prioritized into more immediate, and/or longer-term and more supported, housing options. The person is left with trying to make themselves look as pitiful as possible in order to achieve a high vulnerability score. Some CoCs report people denying themselves access to food or other basic needs to increase their score.

Some evidence suggests that relying on survivors' expertise in the assessment process may provide a more accurate understanding of how to maintain their

safety and stabilize their housing, given that survivors are more knowledgeable about the complex interplay of their vulnerabilities and needs. Systems that seek to improve the fit between an individual's vulnerability and their housing placement may find it more beneficial to rely on survivor-defined vulnerabilities as opposed to using a score sheet in a pre-determined assessment tool. Best practice suggests that moving toward a needs-base assessment, rather than a deficit-based assessment, and survivor-identified vulnerabilities over system-defined vulnerabilities, can produce better results.

Common assessment tools look at factors such as exposure to elements due to living outdoors, which can leave out harm due to living with domestic violence or trafficking. Some advocacy organizations have concluded that coordinated entry systems don't understand the unique needs of survivors of violence, and some have decided not to send people through that process.

Advocates can have an impact on the assessment process. First, it's important to learn about how coordinated entry works in your community and work with survivors to help them access the CES in a way that is most helpful for them. If your agency is involved with the Continuum of Care, you can try to engage them

in conversation about how to realistically approach assessment from the standpoint of survivors. If you have not yet engaged with your CoC, Part 4 of this series will give you some ideas.

Slide 12 – Stages of Assessment

Coordinated Entry assessment is not a single, time-limited event. Assessment can take place over time, with numerous opportunities to work with a survivor as circumstances change, and as the survivor feels the need to share more information. Advocates can facilitate continued engagement with the Coordinated Entry staff for the benefit of the survivors they are working with.

We've already talked about the need for an immediate assessment for emergency intervention. For example, if someone who connects with coordinated entry is fleeing, or attempting to flee violence, they should be offered resources to address their safety needs, and/or referred to an outside resource if not provided at the access point. This initial triage can also identify other emergency needs such as emergency medical care or food. These immediate needs should be attended to before going further.

Diversion or prevention refers to the process of working with people to identify whether they have resources in their own support system to keep them from having to access the coordinated entry system. Advocates should be aware that this may not solve the person's housing problem and may be only a temporary solution, and the advocate should talk with the survivor about this. The person can still access the coordinated entry system, but there could be implications for how temporary arrangements with people in a survivor's personal support system could affect how their situation is viewed by the CES. If a solution is not realistic for the survivor, such as a temporary stay on a relative's couch, the survivor should say so.

Initial assessment helps prioritize the person for specific housing services, such as emergency shelter, rapid rehousing, transitional housing and permanent supportive housing. These are the main programs people are referred to through coordinated entry, though some CoCs might have limited access to other housing programs. Talk with survivors about these programs, eligibility requirements and their interest in participating.

Eligibility screening involves gathering the information necessary to determine the potential participant's eligibility for admission to a particular project. For example, programs designed specifically to serve survivors of violence require that they meet HUD's definition of Category 4 homelessness, which includes people fleeing, or attempting to flee violence. Please see Part 4 of this series, if you need a more detailed definition of Category 4 homelessness.

Coordinated entry staff will document the survivor's Category 4 status. The survivor can self-certify by signing a statement that they are fleeing violence. Alternatively, a staff member or volunteer of a victim service provider agency assisting the survivor can do so.

Next, a comprehensive assessment builds on previous assessment strategies. This could include updating or confirming information from a prior assessment, creating an individualized housing plan with someone, or case-conferencing, which includes multiple providers discussing an individual's situation to more deeply assess their needs and identify potential resources. Any process that includes discussing an individual's situation by name, or with any information that

could potentially identify them, can only take place with a written, time-limited release of information, as described in Part 6 on Survivor Confidentiality.

Finally, a next-step or moving on assessment re-evaluates program participants who have been stably housed for some time and who are ready for less intensive housing or services, perhaps even an exit to self-sufficiency. This can also be used when new information about a person is revealed during enrollment in a project and the new information suggests a different service strategy might be warranted.

Slide 13 – Prioritization

HUD requires that the Continuum of Care, or CoC, use the information gathered in coordinated entry to prioritize houseless persons for access to housing and supportive services. The CoC must establish specific, written criteria for prioritization.

The scoring and other processes used by the CoC most often use multiple considerations such as length and number of times unhoused, nature and severity of disability, age, high use of emergency services such as emergency room and psychiatric facilities, vulnerability to victimization and others. As with

the VI-SPDAT that we've already described, no specific assessment tool, single scoring or other prioritization method has been proven to reliably predict what will end houselessness for a specific person. Assessment tools that generate a prioritization score are a good place to start, but additional factors need to be considered such as individual participant's circumstances and the way they respond to challenges in their lived experience. For example, someone might be eligible for Permanent Supportive Housing but respond just as successfully to a less intensive intervention such as Rapid Rehousing.

CoCs must establish written policies and procedures for the process by which the CoC staff will make prioritization decisions for each project type, for example, Rapid Rehousing or Permanent Supportive Housing, and the criteria used for prioritization decisions. HUD does, however, prohibit prioritization based on protected class.

Finally, prioritization criteria and processes should be evaluated on an ongoing basis to make sure they are not excluding any people or groups. This is extremely important as new assessment methods emerge and as the field learns more about their effectiveness in predicting who is most helped by what interventions.

Slide 14 – Prioritization Pitfalls

Across Minnesota, the need for housing far exceeds the supply. While we must continue to prioritize increasing the supply of safe, affordable housing, in the meantime the Continuum of Care is tasked with the difficult decision of deciding how to distribute scarce resources among multiple, similarly disadvantaged households.

How to make this determination is obviously controversial and is part of what led to the push for developing scoring tools in the first place. HUD, along with community partners, desires to create a system that is fair, equitable, non-discriminatory, and that ensures that the people with the greatest need are offered services first. Using some sort of scoring tool was seen as a relatively quick way of obtaining targeted information related to the person's life situation and housing needs. We now realize, however, that scoring tools – even if they were accurate in determining vulnerability – do not solve this problem. If three families all have the same score, and only one housing unit is available that all three might likely benefit from, the agency or community is still left with the problem of how to prioritize who receives the help. For example, an immigrant

family with a child with a disability, fleeing a violent situation, with high medical debt and an eviction on their record can be in competition with a Native family where the adult has a physical disability requiring special care, struggling to parent several children, fleeing violence and in danger of living on the streets. This is an impossible choice, yet it is one that the CES is asked to make every day.

Some communities around the country have used the Danger Assessment to help prioritize need. The Danger Assessment was not designed for this purpose. It can reliably predict who might be in danger of severe injury or homicide but does not predict whether that person is safer in their home as opposed to somewhere else. Experts recommend instead targeted conversations with survivors focused on housing stability and safety.

As experts in the field of domestic violence and housing have grappled with this issue, some have arrived at the conclusion that prioritization is not possible. Some are promoting the idea that once Category 4 eligibility is established, and survivors have expressed in targeted conversations their self-defined vulnerabilities and needs; that housing opportunities and services should be offered on a first-come-first-served basis. We're not promoting a specific solution

here, but we mention this idea to spark your thinking and invite further conversation.

Information on assigning priority, and Danger Assessment in the housing context and more will be available on the resource page connected to this session.

Slide 15 – Components of Prioritization

Given the challenges of accurately determining a person's vulnerability and the need to make the difficult decision of deciding which household will be offered a scarce resource, it's important to take a moment and recognize the difficult task that the CES is undertaking. This is a hard job and requires engagement from the entire Continuum of Care, or CoC, partners, especially victim service providers, and should involve conversations with survivors.

Using the prioritization standards and coordinated entry policies and procedures the CoC developed, the entity is tasked with prioritizing, reviews information collected during assessment and determines the person's priority level. Usually this involves some kind of scoring process, though ideally the CoC will include additional information, such as can be gathered from a targeted conversation

related to housing. This information is evaluated alongside the CoCs prioritization standards.

Many CoCs maintain a priority list. This generally lists people either by name or by identifier, including their score or ranking level if it exists, and/or placement date. It might include other priorities such as domestic violence, high risk of mortality or heavy use of medical services.

If the priority list is held in a shared database, such as the Homeless Management Information System, or HMIS, it will be necessary to use a different mechanism for people fleeing violence. VSPs are barred from entering information into any type of shared document. This can be overcome by creating a second list that uses a code identifier for people whose names cannot be shared. It is essential that this second list use an identifier only, and that no personally identifying information be included.

Some CoCs will choose to maintain a centralized list that includes all known houseless persons throughout the CoC. Others maintain separate priority lists by subpopulation, such as survivors of violence. If the CoC maintains separate

priority lists for different subpopulations, it must enable people to be cross-referenced among all prioritization processes.

The priority list also is meant to ensure that all project vacancies are filled through coordinated entry prioritization and referral processes. Agreement by providers in the CoC to follow prioritization in making and accepting referrals is intended to ensure fairness, transparency, and consistency in providing services to all people in need.

Case conferencing is also sometimes used to aid in prioritization of potential program participants. We've already referenced its use in the initial assessment phase. This is a process where a number of providers discuss the circumstances of particular households to determine how best to serve them. As previously stated, any process that includes discussing an individual's situation by name, or with any information that could potentially identify them, can only take place with a written, time-limited release of information.

However, the list is maintained and managed, it should ensure that all project vacancies are filled through the established processes. All providers in the CoC

should agree to follow the process to promote fairness, transparency and consistency.

Slide 16 – Referrals

The fourth core element of coordinated entry is referral, the process used by a coordinated entry system to offer people available housing and supportive service options. The referral process must be guided by an intentional protocol that follows the Continuum of Care's, or Coc's, prioritization standards.

We won't cover everything HUD requires about referral in this 101 training, but here are some of the fundamental requirements.

HUD's guidance for coordinated entry specifies that in referral, the person with the highest priority and most vulnerability is offered housing and supportive services first. As we've already noted, this process is challenging and the resources the CES has available to help make this determination are not necessarily reliable indicators.

The CoC's CE process and participating projects must continually strive to identify and lower barriers to project entry, using a Housing First model. The CE process is prohibited from screening people out based on perceived barriers.

For example, people who have a history of domestic violence cannot be screened out for a program for which they are otherwise eligible. CE staff cannot choose to refer survivors only to programs operated by a VSP. Survivors need to have the option of working with a mainstream program if a vacancy in that program becomes available and the survivor is otherwise eligible for the program.

Next, all beds and services available at participating projects funded by the CoC program or through Emergency Services Grants, or ESG, programs must be filled through the CES. HUD encourages CoCs to maintain an inventory list, updated at least annually, of all housing and supportive services projects that can be accessed through referrals from the CE process.

Permanent Supportive Housing, or PSH, is almost always the most effective resource for highly vulnerable people with high service needs. But its lack of availability should not result in people languishing in shelters or on the streets without other assistance. If no PSH resources are available, the highest need or

highest prioritized persons should be offered other appropriate resources the CoC has available. This approach should be used as much as possible with Transitional Housing and Rapid Rehousing as well.

The CoC should incorporate a person-centered approach into its referral policies and procedures, including the following:

- Ensuring potential program participants have choices regarding location and type of housing, level and type of services, and other project characteristics.
- Being clear with potential participants about where they are being referred, entry and eligibility requirements, and what services will be provided.
- And in the rare instance when a person is rejected by a project, having a process to support the person in identifying and accessing another suitable projects.

Slide 17 – Referrals

Once a potential program participant is identified for a housing referral, the Continuum of Care, or CoC, notifies that person. If the participant is a survivor or

is not included in any by-name list, the referring agency will be notified so they can inform the person of the offer.

The CE process may initiate the collection of information to confirm the person's eligibility for the project, but that decision will ultimately be made by the potential housing service provider.

If the participant accepts the referral, they will be linked with the housing service provider. The provider will do a screening to confirm eligibility. If for any reason the person is not eligible for the program, and cannot move forward with the referral, the person should not lose their spot on the priority list. Sometimes the participant will choose not to accept the referral, and, rarely, the program will decide not to move forward with the participant. Neither of these should affect the person's standing on the priority list.

The entity managing the referral process should have a list of all the resources currently available. This means that a mechanism must be established for housing service providers to regularly update their information, including geographic area covered, eligibility requirements and services provided. The CoC should develop a

process by which projects notify the CES contact about housing and supportive services availability when a vacancy opens.

The CoC's referral process should also account for occasions when a referral is rejected by the potential participant, or when the provider from the CES declines to accept the potential participant for services. There can be several reasons that precipitate a rejection.

Sometimes the program participant decides the option offered does not address their needs; for example, if the needs of a Category 4 household, that is, someone fleeing or attempting to flee violence, are not accounted for or may not be met by a mainstream provider. In that case, the referral might not be appropriate or might not be something they want. Or the provider agency could decide the person is not a good fit for some reason, for example, an internal issue such as an unexpected staffing problem.

In these situations, coordinated entry should work with the person to clarify their needs and continue to seek options for them. The person should not lose their place on the list.

The warm hand-off for a successful referral means that the referring entity, probably the CES, should follow up with the provider that accepted the referral to make sure that it was successful. This can prevent people from falling through the cracks if something isn't working out. And if not, a more appropriate placement can be sought.

Slide 18 – In Summary….

Coordinated entry is a very important, key step in helping survivors access safe and affordable housing. It's also complex and in this series, we can only touch on the basics.

We've also talked about the challenges, and even the aspects of coordinated entry that might have flawed assumptions about the needs of people experiencing a housing crisis. Everyone involved in the process of helping people find affordable housing has a huge, almost insurmountable task.

This is the last part of Violence Free Minnesota's series on housing. Throughout the series we've covered affordable housing models, the Continuum of Care and its funding opportunities, survivor confidentiality related to housing and more.

We’ve talked about the deep, devastating lack of affordable housing in Minnesota and around the country. We know that some available housing options are either not affordable, or don’t meet the needs of survivors.

We’ve learned that housing systems were not designed to meet the needs of survivors, yet opportunities exist for VSPs to engage with community partners, promote systems change, and seek funding opportunities to expand options for survivors.

We hope we’ve given you some ideas for how to improve access for survivors in your communities, and that we’ve inspired you to get involved locally, or on a state or federal level, to promote better options for everyone.

Slide 19 – Resources

Several victim service providers and coalitions have developed tools that can be used to help you with ideas for engaging with your Continuum of Care and Coordinated Entry System. Technical assistance is available from the Domestic Violence and Housing Technical Assistance Consortium and others. These resources are available on the resource pages attached to this session.

Slide 20 – Gratitude

Thank you for taking the time to review this session on coordinated entry. This is the final session; all the previous sessions are available on the VFMN website along with resources you may access for additional information.

We want to thank everyone who had a part in developing this series. Their names are listed on the VFMN website. And we hope we have inspired you to engage with your local housing providers and Continuum of Care, and with your elected officials to work toward safe and affordable housing for all.

Slide 21

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