MO-604 Continuum of Care

Coordinated Entry System Policy & Procedure Manual

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Overview

The Greater Kansas City Continuum of Care (CoC) for Jackson County, Missouri and Wyandotte County, Kansas (herein referred to as the MO-604) consists of projects and programs that provide housing and supportive services to households experiencing homelessness. The goal of projects and programs funded under the CoC Program is to assist households with attaining and sustaining permanent housing as quickly as possible. CoC funds are currently used to support Permanent Supportive Housing, Transitional to Rapid Rehousing, Rapid Rehousing, and Supportive Services Only projects. Projects receiving Emergency Solutions Grants (ESG), Missouri Housing Trust Funds (MHTF), Supportive Services for Veteran Families (SSVF), and HUD VASH (Veteran Affairs Supportive Housing) are also required, per grant regulations, to engage in the Coordinated Entry System.

The U.S. Department of Housing and Urban Development (HUD) conducts a national competition of CoC programs annually. The Greater Kansas City Coalition to End Homelessness (GKCCEH) is the lead agency responsible for completing and submitting the CoC collaborative application required for the competition on behalf of MO-604. Additional information on the CoC can be found on the HUD website: https://www.hudexchange.info/programs/coc/. More information about CoC funding for both counties within the MO-604 CoC is available on the GKCCEH webpage.

This Policy and Procedure Manual is intended to provide the foundation for decision making related to the MO-604 Coordinated Entry System (CES). This Manual will be reviewed, evaluated, and updated annually or as deemed necessary for improvements to the performance of the CES.

MO-604 HUD Continuum of Care Glossary of Terms & Acronyms
Please click here to view MO-604 HUD Continuum of Care Glossary of Terms & Acronyms.

Introduction to Key Concepts

Coordinated Entry System
Coordinated Entry System (CES) is a consistent, streamlined process for accessing the resources available in the homeless crisis response system as a result of having exhausted all other possibilities prior to entering the homeless system. This systematized approach ensures that the most vulnerable households in the community are prioritized for services in order for resources to be used as efficiently and effectively as possible.

The CES is designed for all geographic areas located in MO-604. It is designed to be easily accessible to households seeking housing or services, and includes a Common Assessment Tool (CAT).

The CES consists of four core elements:

- Access: the engagement point for households experiencing a housing crisis
- Assessment: a CAT is utilized to measure the household's housing needs, preferences, and vulnerabilities
- Prioritization: a process to determine which household will receive the next available housing resource. This process is designed to ensure that households with the highest vulnerability receive the support they need quickly to resolve their housing crisis.
- Referral: the process by which households are referred to available CoC housing resources

Progressive Engagement

The CES is designed to provide intentional pathways through the homeless service system while allowing for the quickest exit to permanent housing. The system employs a phased approach of Progressive Engagement that allows the assessment and service delivery processes to occur over time and only as necessary.

Progressive Engagement is the practice of helping households end their homelessness as rapidly as possible, despite barriers, with minimal financial and support resources. More supports are applied to those households that struggle to stabilize. Progressive Engagement recognizes that there is no way to accurately predict how much help someone may need to end their homelessness and avoid a return to the streets or shelter.

Progressive Engagement prioritizes client choice and provides continual opportunity during the process for a household experiencing homelessness to engage in diversion resources. For example, if an eligible household can be referred to diversion resources for crisis resolution, then they will be referred to such a resource, rather than a housing intervention.

Progressive engagement should also include safety planning through the process if needed.

Diversion

Diversion is focused on assisting the client to examine their resources and options rather than entering the homeless system. Many of the people attempting to complete a housing assessment are experiencing an immediate housing crisis that can be resolved without entry into the CES. This requires CE assessors to be strong problem solvers and understand that their goal is to figure out safe and feasible housing alternatives for people seeking housing assistance.

To maximize the use of homeless system resources, robust diversion must be integrated into the local CES. For all households seeking shelter and/or assessment, diversion should be attempted, regardless of the household's circumstances and without any subjective overrides (ex: thinking that a household cannot be diverted and therefore not even attempting to divert them or support their self-resolution).

A household should only enter the CES once diversion has been thoroughly attempted. If a client cannot be successfully diverted, they should continue to the next step, the CAT. The completion of an assessment is not a guarantee for housing through the CES. Individuals are encouraged to continue to search for alternative housing options.

Post Assessment Diversion

Some households may not meet the prioritization threshold and should instead be referred to emergency and/or other mainstream service providers in the community who can work with them on alternative housing plans. Alternative housing can include applying for affordable housing in the community, increasing income from employment and benefits, and exploring other housing opportunities available through the person's support network.

Housing First

Housing First is an approach that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible and then providing voluntary supportive services. This approach is low barrier, prioritizing client choice in both housing selection and in service participation. The core components of Housing First include:

- **Low barrier admission policies** – Housing program policies should place a minimum number of expectations on participants. They should be designed to "screen-in" rather than "screen-out" applicants with the greatest barriers to housing, such as having little to no income, poor rental history or past evictions, or criminal history.
- **Few to no programmatic prerequisites to housing** – Program participants are offered

permanent housing with no programmatic preconditions such as demonstration of sobriety; completion of drug, alcohol or mental health treatment; or agreeing to comply with a treatment regimen upon program entry.
- **Voluntary, but engaged services** – Supportive services are proactively offered to help clients achieve and maintain permanent housing, but participants are not required to participate in services as a condition of housing.

To review the Housing First policy, click here.

Roles and Responsibilities

Coordinated Entry Governance Committee

The Coordinated Entry Governance Committee (CEGC) consists of members ratified by the MO-604 membership. This entity is the governing body of the CES and oversees the CES planning process. The CEGC is also tasked with ensuring that all CES policies and procedures are in alignment with ESG Program and CoC Program written standards. The CEGC meets regularly to discuss and decide upon improvements and refinements to the current system, policies and procedures, special cases and broader systems change. Meeting dates and times can be found on the GKCCEH website.

Continuum of Care (CoC) Lead

The Greater Kansas City Coalition to End Homelessness (GKCCEH) is the lead agency for one of the Coordinated Entry Supportive Services Only (SSO) grant. GKCCEH serves as the project manager for CES implementation and the overall coordination of Continuum of Care member agencies. In this role, GKCCEH is referred to as the CoC Lead Agency and receives one of the Supportive Services Only (SSO) - Coordinated Entry grants.

Homeless Management Information System (HMIS) Lead

GKCCEH has been designated to operate the Homeless Management Information System (HMIS). As the HMIS Lead Agency, GKCCEH ensures CES has access to the HMIS and functionality for the collection, management, and analysis of data on participants served by coordinated entry.

CES Supportive Services Only (SSO) Projects

Supportive Services Only (SSO) projects allow recipients to provide supportive services, such as conducting outreach and providing referrals to necessary services to households experiencing homelessness. These project recipients receive referrals through the CES. Often these staff members are working with persons on the by-name list (BNL) who have been prioritized and are preparing for a housing opening. These duties include, but are not limited to, locating households, document collection, and service connection.

Guiding Principles/Core Values

The following guiding principles and core values have been identified to guide system changes to promote a more effective crisis response system, help structure planning and management efforts, and ensure that there is a common understanding of system goals and priorities.

1. **Transparency:** Operating in such a way that it is easy for others to see what actions are performed and the rationale for making decisions are clearly communicated
2. **Equity and Inclusion:** There is a long history of systemic inequalities in housing policies and practices in Kansas City. Our community is therefore committed to racial equity, cultural humility, and including those who might otherwise be excluded such as the LGBTQIA+

individuals, people with disabilities, immigrants, and other marginalized groups.

3. **Housing-focused Interventions:** The system is designed to help those in a housing crisis achieve and maintain stable, permanent housing. At every point in the service delivery system, engagement with service providers should focus on supporting housing-focused interventions and activities which mitigate future housing instability, including but not limited to connections to healthcare and behavioral health support, case management, employment, income, and benefits.
4. **Data-driven Decision-making:** Collecting data, analyzing it, and basing decisions on insights derived from the information. This process contrasts sharply with making decisions based on gut feeling, instinct, tradition, or theory.
5. **Learning as a Cultural Practice:** Curiosity is valued. Stakeholders both seek, share, & apply new knowledge, and are engaged in ongoing dialogue and educational opportunities.
6. **Equitable, Low-barrier Access:** Every person in need of housing has the same opportunity, regardless of eligibility or perceived barriers (behavioral, situational, etc.), to access housing and related services. The system is designed to support each household with only the type and amount of support required to address their housing crisis and focused on meeting the needs of the most vulnerable households first.
7. **Client-centered, Strengths-based, and Trauma-informed Approaches:** Every effort is made to meet households in need of services “where they are” in a non-authoritative, accessible, and culturally appropriate way. A trauma sensitive culture is created by providing safe, nonjudgmental, collaborative and relational interactions. Client voices and perspectives are centered in decision-making. Services are client-directed in that each household is supported with the appropriate level of assistance to empower them to arrive at their own, self-determined solutions.
8. **Nimble Responsiveness:** The system is governed by a body afforded the flexibility to be decisive and react to changes in the environment in a strategic and timely fashion. When appropriate, participating programs should leverage tools and waivers to eliminate unnecessary processes and paperwork to maximize efficient service delivery.

Accountability

Accountability refers to the outcomes and measurements that enable the CoC to know if all expectations are being met, and if the CES is operating effectively.

The Coordinated Entry Governance Committee (CEGC) works in conjunction with GKCCEH CES staff to solicit feedback at least annually from participating projects and from households that participated in coordinated entry during that time period. Feedback may be solicited in the following ways:

- Surveys designed to reach either the entire population or a representative sample of participating providers and households;
- Focus groups of 5 or more participants that approximate the diversity of the participating providers and households; or
- Individual interviews with participating providers and enough participants to approximate the diversity of participating households.

The feedback period is from August through October and outcomes are reported to the CoC membership in the month of November. A random selection of participants for the reporting period are selected to participate in a feedback session. Feedback session types range from in-person or phone interviews, focus group sessions, or online or paper surveys.

In addition, at each CEGC meeting, time is allowed for public comment during which those wishing to provide feedback may do so. Feedback received during public comment will be evaluated and

may be used to make updates to the CES process.

Privacy

Collecting and sharing personal and protected information is a necessary aspect of helping persons to resolve their housing crisis. However, the collection and disclosure of participant data among CoC providers affiliated with the CES must always be managed in a way that ensures privacy, provides participants with choice about what and how to share their information, and does not result in repercussions when participants choose not to disclose or share data. Participants have the ability to have their personal identifiable information de-identified if they choose. Maintaining the confidentiality of participants' sensitive information is an important way of gaining trust from project participants and ensuring vulnerable populations are protected from potential harm resulting from the collection and disclosure of sensitive information about their lives.

CoC funded agencies must participate in HMIS, unless they are a victim service or legal service provider who must collect data in a comparable database. HMIS is a secure and confidential database operated by trained representatives which allows agencies and community providers to work together to make sure assistance needed is received in a timely manner. The use of HMIS allows the CoC to get an accurate count of all people experiencing homelessness or who are at-risk of homelessness in the MO-604 service area. Additionally, the use of HMIS allows for the coordination and documentation of services provided. All HMIS users must receive confidentiality training and sign strict agreements to protect the participant's personal information and limit its use appropriately. Any person or agency that violates this agreement may lose their access rights and may face penalties including legal action.

Access

Equitable Access

All populations and subpopulations (chronically homeless individuals, veterans, adults with children, LGBTQIA+, youth, and survivors of domestic violence, dating violence, sexual assault, stalking, and trafficking) in the MO-604's geographic area must have fair and equal access to the coordinated entry process, regardless of where or how they present for services. All access points must be accessible for persons with disabilities, including those who use wheelchairs and those who are least likely to access homeless assistance. Upon request, access points must provide appropriate and reasonable accommodations for persons with disabilities and/or limited English proficiency so they can participate equally in the CES. This includes, but is not limited to, qualified language interpreters, auxiliary aids, and adaptive communication devices.

This CES must also comply with the nondiscrimination provisions of federal civil rights laws as applicable, including the following:

- Fair Housing Act;
- Section 504 of the Rehabilitation Act;
- Title VI of the Civil Rights Act;
- Titles I and II of the Americans with Disabilities Act; and
- HUD's Equal Access and Gender Identity Rules

Access Points

Access refers to how households experiencing a housing crisis are able to learn about the CES and housing-related services. Access points are the places where households in need of assistance can access the CES. Access points include designated agencies, outreach teams, and virtual access.

- Designated agencies: Certified CE assessors are located at designated organizations throughout the CoC's geographic region. These agencies include organizations that provide services such as victim-related, emergency assistance, legal, housing, etc.
- Street outreach: Most outreach workers are certified CE assessors to allow easy access to the CES while meeting the client where they are.
- Virtual access: Households seeking services are able to access the CES virtually by calling United Way 2-1-1. United Way will connect eligible households to a certified CE assessor.

Victim Service Providers (VSP)

Certified CE assessors are located at local victim service providing organizations to ensure survivors of domestic violence also have access to the CES. VAWA contains strong, legally codified confidentiality provisions that limit VSPs from sharing, disclosing, or revealing victims' personally identifying information (PII), including entering information into shared databases like HMIS. To protect clients, VSPs must enter required client-level data into a comparable database that is comparable to and complies with all HMIS requirements. The process for domestic violence survivors receiving a CAT by a VSP can be found here.

Street Outreach

Street outreach programs are designed to engage unsheltered people at non-traditional settings such as campsites, public parks, bus or train stations, exit or entrance ramps to roads and highways, abandoned buildings, or under bridges. Outreach workers may also engage people at drop-in centers, libraries, and other various locations frequented by households experiencing homelessness. Outreach providers should meet people where they are, both geographically and emotionally.

Street outreach teams include community agency providers and dedicated volunteer groups to meet the common goal of ending homelessness. Outreach teams value input from all parties that play an integral role in the mission of ending homelessness. They recognize the need for housing-focused outreach efforts and harm reduction outreach. In response, the Coordinated Outreach, Resources, and Engagement (CORE) was established with the goal of coordinating outreach efforts and bridging our most vulnerable households to services, including housing opportunities, medical and behavioral health services, etc. For more information on how to participate, please review MO-604's outreach policy and procedures, click here.

Training and Quality Assurance

CE Assessors are qualified to engage people experiencing homelessness and administer the CE assessment tool to enroll them into the Coordinated Entry System and be placed on the (BNL). MO-604 consists of assessors dispersed through the community based on access point and population specific needs. All CE assessors must report to an agency that is in good standing with the CoC.

Persons interested in becoming a CE assessor must complete the following steps:

1. Submit an Assessor Interest Form to be reviewed by the lead agency CE staff. Interest forms will be reviewed by the CEGC as needed.
2. CE staff will communicate with approval/denial status and inform of next steps. This decision is based on the community's need for more assessors and whether the applicant's position is appropriate for being a CE assessor.
3. Applicants will participate in required training including, but not limIted to, HMIS training, CE assessment tool training, and domestic violence training.
4. Upon training completion, the applicant will receive their CE Assessor certification.

Inability to perform CE Assessor responsibilities and duties may result in the revocation of one's CE Assessor certification. Reasons for revocations of one's assessor rights may include, but are not limited to:

1. Not adhering to CE Assessor Role and Expectation Agreement;
2. Not conducting a minimum of 1 assessment every 90 days;
3. Substantiated allegations of discriminatory practices;
4. Unfair, subjective, and/or dishonest application of any defined processes and standards.

To ensure reliable application of the tool, all assessments may only be administered by certified CE assessors. CE Assessors are required to complete annual trainings in order to continue administering the assessments.

Assessment

Assessment is the process of gathering information about the person presenting to the crisis response system. It includes documenting information about the barriers a person faces to being rapidly rehoused and any characteristics that might make the person more vulnerable while homeless. The assessment process must also appropriately triage the person by asking about immediate needs, accurately evaluating the person's vulnerability and barriers to housing, and providing information to support accurate referrals.

Eligibility

In order to serve those with the greatest need using limited resources, eligibility for Coordinated Entry is based on the following criteria:

- HUD's Category 1: Literally homeless: Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
    - Has a primary nighttime residence that is a public or private place not meant for human habitation; **or**
    - Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); **or**
    - Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

- HUD's Category 4: Fleeing/attempting to flee domestic violence*: Any individual or family who:
    - Is fleeing, or is attempting to flee, domestic violence;
    - Has no other residence; and
    - Lacks the resources or support networks to obtain other permanent housing

    **Note: "Domestic Violence" includes dating violence, sexual assault, stalking, and other dangerous or life-threatening conditions that relate to violence against the individual or family member that either takes place in, or him or her afraid to return to, their primary nighttime residence (including human trafficking).*

- In addition to the primary eligibility requirements, due to the disproportionate inflow versus outflow into the CES, only households who meet one or more of the following criteria are able to be

enrolled into CE at this time:

- Chronically homeless (an individual with a disability who has been “literally homeless” for at least 12 months OR at least 4 episodes of homelessness totaling 12 months of time “literally homeless” over the past 3 years).
- Veteran
- Youth
- Family
- HIV/AIDS diagnosis
- Survivors of domestic violence, sexual assault, dating violence, stalking, or human trafficking

Households who do not meet these eligibility criteria should be assisted through diversion.

Standardized Assessment Process

MO-604 has incorporated a standardized assessment process across its CES. The same assessment process is used at each access point and across all populations, including the use of a Common Assessment Tool (CAT). The CAT collects sufficient information to assist making consistent prioritization decisions and facilitates access to housing and supportive services across MO-604’s service area.

It should be noted that the assessment process under the CES collects only enough information to determine a person’s need for housing and supportive service projects. The purpose is to identify strengths and barriers for resolving the person's homelessness quickly. The information collected during the assessment influences how a person is prioritized amongst others on the BNL.

Common Assessment Tool

A Common Assessment Tool (CAT) is administered as a part of the Coordinated Entry Assessment process. A CAT is a triage tool that provides a standardized way of measuring the vulnerability of households experiencing homelessness to determine which households should be prioritized first for housing assistance. The CAT produces a score that can be compared with other households experiencing homelessness. The CAT score is just one piece of information used in a larger prioritization scheme.

MO-604 currently utilizes the *Vulnerability Index Service Prioritization Decision Assistance Tool* (VI-SPDAT) version 2. Three versions of the VI-SPDAT are used based on subpopulation - single adults, families, and youth. The following should be considered:

- Couples without children in the household will be assessed separately with the single adult VI-SPDAT.
- Families with a youth head of household will be assessed with the family VI-SPDAT.
- Two youth presenting as a couple will be assessed separately with the youth VI-SPDAT.

During the assessment process, specific questions are asked to determine if the person is experiencing or fleeing from domestic violence. For those who identify that they are experiencing or fleeing domestic violence, the standardized, evidence-based Lethality Assessment Program (LAP) is completed. The LAP screening is a strategy to prevent intimate partner homicides and serious injuries. All CE assessors are required to complete the LAP training, where they learn how to provide domestic violence education and safety plan.

De-Identified CES Process for Non-Victim Service Agencies

All households accessing the CES have the option to de-identify their personal identifying

information. Households may opt to de-identify their information for safety or other privacy reasons. This option is most commonly used for households fleeing or attempting to flee domestic violence.

If a household would like to be de-identified, the CE Assessor would complete the following steps:

1. Complete the CAT on paper with the client's identifying information and detailed notes on the paper copy only.
2. The CE assessor then assigns the head of household a de-identifier (ex: GKCCEH, KC091621).
    a. First Name: Agency
    b. Last Name: Assessor's initials + assessment date (format: MMDDYY)

    Note: If the assessor completes more than one assessment on the same day, simply add another # to the client's "last name" (ex: GKCCEH, KC0916211)
3. Assign X, X as the de-identifier for all family members.
    a. First name: X
    b. Last Name: X

    Note: You will have to create a new client for each family member - do not select a client already in HMIS under "X, X" as this will link the wrong de-identified family member(s) to your client.

    Date of birth: For all members of the household, select "partial: month/year" and enter the information. This allows us to know if a household is eligible for youth programs.
4. Enroll client into the Coordinated Entry project in HMIS under their de-identifier
5. Upload the paper copy of the assessment to GKCCEH staff at this link: https://app.smartsheet.com/b/form/7173298709854bbcaf8201bc0c719b24

Provisional CES Assessment

Occasionally there are circumstances where, after multiple attempts, a client is unable to complete the CES enrollment for various reasons (ex: mental health or substance use) but is vulnerable, in need of housing, and has expressed a desire to get into housing. However, a client's inability to provide information should not prevent them from being able to access housing through Coordinated Entry. In these situations, a provisional assessment may be completed. The CES assessor should get the client's consent to put information into HMIS and then complete the CAT to the best of their ability based on the information they are able to get from the client. The client's status and the process followed should be documented in the narrative of the assessment. The CES assessor should then bring this client up at the next Prioritization meeting to case conference. The assessor is encouraged to invite other service providers that are familiar with the client to this Prioritization meeting or to gather additional information from these providers beforehand to present during the case conferencing.

If the client is unable to provide written or verbal consent, CE enrollment will be completed on paper and de-identified information will be input into HMIS. If later on the client has the capacity to complete the CES enrollment, it will replace the provisional CE enrollment. Provisional assessments should be rare and these cases are subject to review by the Coordinated Entry Manager.

CES Enrollment Expiration and Revision

A household's situation can change considerably over time, and therefore after six months a household's CES enrollment will expire. For the household to get back onto the BNL, they will need to complete another CE enrollment. If a household's situation changes significantly before the enrollment has expired, then a household is able to complete a new CES enrollment. Examples of significant changes can include but are not limited to: a new diagnosis, increased severity of a current diagnosis/medical condition, change in homeless living situation, a new situation of victimization, pregnancy, a change in household composition, etc. If a provider or staff member believes the initial CAT was not accurate, the provider or staff member is able attend a prioritization

meeting to advocate on behalf of the client.

Inactive Status

The inactive policy is a critical component of maintaining a real-time BNL as well as a robust coordinated entry system. To ensure an efficient assessment and referral process, it is important to ensure that the coordinated entry system navigators and outreach teams have the ability to contact and connect with households as soon as a housing opportunity is available. Without this policy, the coordinated entry process can experience delays in its referral procedures due to the time spent searching for households in the community who they have not been able to reach through multiple attempts.

If a household has had no contact - including phone, email, social media, and in-person contact - with any coordinated entry access points, system navigators, outreach and they have had no services or documented shelter stays for the past 90 days, the household will be moved to inactive status. If a household on inactive status makes contact with the homeless system including outreach workers, drop-in centers, shelters, meal lines, etc, they are moved from the inactive list to the active list and are eligible to be referred to housing openings. At this point the household may need to be reassessed if their situation has changed significantly. See the previous section for examples of situations that could warrant a new CES enrollment. To view the inactive policy in full, click here.

Participant Autonomy

The CE enrollment process must allow people presenting to the crisis response system to refuse to answer assessment questions and to reject housing and service options offered without suffering retribution or limiting their access to assistance:

- If, while conducting a CE Enrollment, a certified CE assessor encounters a person who refuses to answer questions, the assessor must inform the person of the possible impact of not providing all requested information, which may include, but is not limited to, referrals to inappropriate resources and incorrect placement on the BNL;
- The assessor must make every effort to assess and resolve the person's housing needs in spite of missing information; and
- The person's refusal to answer any questions must not be taken into consideration during future assessments or referrals.

Additionally, any person placed on the BNL must be allowed to maintain their place on the list after rejecting service options that are offered.

Data Collection Process

CE Assessors must adequately inform persons they assess of the coordinated entry data collection process, including what data will be requested, how and with whom that data will be shared, and the person's rights regarding the use of their data. The assessor is responsible for obtaining either a signed or verbal Release of Information (ROI) that allows data to be entered into HMIS. The CE enrollment, including the common assessment tool, is integrated into HMIS. Completing the enrollment places a household on the BNL to be prioritized for available housing project openings. Assessors are highly encouraged to enter information into HMIS in real-time while completing the CE enrollment. If the assessor needs to complete a paper copy of the CE enrollment, then the information should be entered into HMIS within 48 hours. Once entered, the enrollment information, including the assessment score, appears on the BNL to be used for prioritization purposes.

Prioritization

Managing the By-Name List

The BNL is a list inclusive of all households who have received a CAT and are enrolled in the CE program. GKCCEH CE staff is charged with managing the BNL, including determining the level of priority for households on the BNL. The BNL includes the household's name or unique identification number, assessment score, homelessness history, LAP screening, household type (veterans, families, youth, single adults), service connections, and impairments/disabilities.

GKCCEH CE staff have the ability to pull the BNL and sort the list based on the community-identified priorities. GKCCEH CE staff also has the ability to regularly review and update the BNL as needed. GKCCEH CE staff works with victim service providers to ensure prioritization includes those deidentified survivors who are not entered into HMIS.

Community Priorities

Due to the limited amount of resources available in CES, we focus on prioritizing the most vulnerable households for housing opportunities offered through the CES and work to divert the other households. Similar to the triage desk in an emergency department of a hospital, a CES assesses the conditions of the people who are in need and prioritizes them for assistance. Our primary goal when prioritizing households is preserving human life.

The CES is not intended to be a solution for all people experiencing homelessness, and thus, community priorities are used to distribute the limited resources according to vulnerability to death. These community priorities guide the decision making process, but are not comprehensive and there may be outliers. For example, a household may score in the PSH range, but be an appropriate RRH referral.

Households are placed in the priority pool based on the community-identified priorities and housing availability. The community-identified priorities are outlined below:

Community Priorities

MO-604 prioritizes households in an effort to mitigate the household members' vulnerability to death and prioritizes the populations identified above for the following reasons, among others:

- Veterans - Veterans are overrepresented in the homeless population, especially those facing unresolved mental health concerns such as post-traumatic stress disorder (PTSD), substance use disorder, and the co-occurrence of these issues. Because of their service, communities across the country have prioritized ending homelessness among veterans first.
- Chronically homeless - Research from HUD has suggested that length of time homeless increases vulnerability due to limited connection to services, challenges to addressing physical and mental health issues, exposure to the elements.

- High lethality risks due to interpersonal violence - Domestic violence inherently indicates risk to serious injury and/or death. Research shows that certain abusive behaviors indicate increased risk to victims. Thus, fleeing or attempting to flee domestic violence (intimate partner violence, sexual assault, stalking, human trafficking, and youth in dangerous living situations) is included as a priority.

MO-604 acknowledges that these three populations are not mutually exclusive. Households may fall into more than one category at a time.

Community priorities are identified by the CEGC with feedback from the community and informed by HUD's guidance. Priorities are assessed annually by the CEGC.

Using the By-Name List to Fill Vacancies

In addition to making sure households with the highest priority are first to be offered housing opportunities, the BNL is used to ensure that all housing project vacancies are filled through the CES.

If the most appropriate resource for an individual (PSH, RRH, TH-RRH) is not available, the highest prioritized household should be offered other available resources if appropriate. For example, when a person is prioritized for PSH but only RRH is available, that household may be placed in RRH as a bridge or temporary placement without it negatively affecting their PSH eligibility. Eligibility documentation for the PSH opening must be met at entry into the program being used as a bridge.

Caution should be made to ensure not to refer a household to a resource that could negatively impact their prioritization for the resource they are best suited for. For example, a TH program should not be used as a temporary option for someone who is intended to be prioritized for PSH without first adequately informing the household of the impact that entering a TH program can have on their eligibility (loss of chronically homeless status) for a PSH program.

Referral Chart

Housing Type	Vulnerability Factors	Housing Type	Vulnerability Factors
PSH	● Assessment score (11+) ● Unsheltered Homelessness ● Chronic Homelessness ● Length of Time Homeless ● High LAP ● # of HUD Disabling Conditions	**RRH & TH-RRH**	● Assessment Score (7+) ● Unsheltered Homelessness ● Chronic Homelessness and/or High LAP ● Length of Time Homeless

Generally, the more of these vulnerability factors a household has, the higher the household is prioritized. A household's CAT score determines eligibility for housing type, but does not solely impact ranking. Those with the highest number of risks will enter the priority pool and be case-conferenced at the community's prioritization meeting. Case conferencing allows for exploration of the impact of the vulnerability factors and determination of the most appropriate referral for a household.

Because other certain factors (such as chronicity and disabling conditions) characterize such large portions of the homeless population, every referral could potentially be filled by households that fit those criteria. Because of this, HUD issues funding for specific populations, such as domestic violence populations, veterans and youth to ensure those populations are also served. We also consider these specific earmarked funds to be examples of fulfilling our community's priorities.

Referral

Referral Requirements

Projects participating in the coordinated entry system are expected to identify and lower barriers to project entry, and are prohibited from screening persons out based on perceived barriers. Such barriers include, but are not limited to:

- too little or no income
- active or a history of substance use disorders
- domestic violence history
- resistance to receiving services
- the type or extent of disability-related services or supports needed
- history of eviction or poor credit
- lease violations or history of not being a leaseholder
- a criminal record including registered sex offense
- lack of vital documentation

Notification of Vacancies (from housing providers)

All CES participating housing projects will accept referrals exclusively through the CoC's defined coordinated entry process.

Housing projects are responsible for notifying CES staff of upcoming vacancies by providing availability projections. Availability projections will be provided to CES staff at the Housing Solutions meetings. Availability projections help to facilitate prompt referrals, improve resource utilization and reduce vacancy rates.

The housing project will notify CES staff of current vacancies through a submission of a referral request via the Referral Request form located here. The request must include specific details of the vacancy, including the agency and project name, contact person, type of housing assistance provided, quantity of referrals requested, unit size, location, and any funder-defined eligibility requirements.

Housing projects are strongly encouraged to not ask for more than 5 referral requests per week depending on the agency's capacity and available housing stock.

Notification of Referral (from GKCCEH)

Upon receiving the Referral Request form from the housing project, CES staff will send a referral to the housing project within 5 business days based on the CoC's community priorities.

Housing projects will receive referrals via email with the following information if available and applicable:

- housing program to which the participant is being referred to
- participant HMIS ID
- method(s) of contact
- agency/social service connections
- status of verification of homelessness and disability documentation
- other relevant information

Referral Time Standards

The housing project should make initial contact with the household within 2 business days of receiving the referral notification. The project should attempt all contact information listed in HMIS and in the referral email. It is important to make contact with the referral quickly in the event there is a change in the referral's primary method of contact (i.e. a phone getting disconnected).

If the initial attempt to contact the referral is unsuccessful, the housing project must continue to attempt to contact the household 3 separate times on each known contact method (phone, email, social media, etc) and should also, at minimum, make 3 unique attempts to reach the household within 10 business days. Unique attempts include, but are not limited to, conferencing the referral at the community's outreach meeting, contacting other service providers, searching in additional databases (ex: Vine Link/Casenet/Kasper), visiting known locations that the referral frequents, etc.

If contact is lost at any point in this process prior to the household being housed, an additional 3 attempts to reach the household should be made within 10 business days. Housing projects should conference any referrals they cannot contact at the Housing Solutions meeting.

If contact cannot be established or re-established within 10 business days, the housing project should return the referral (see below). If the housing project has reason to believe that contact can be re-established soon or if there are particular circumstances where the housing project needs longer to make contact with the participant, this should be noted in the Active Referrals Update form.

Returning Referrals

Returning referrals should only occur when appropriate and remain as limited as possible. However, there are situations when a referral could be returned.

Participant Declined Referrals

A client-centered approach and participant choice are guiding principles of Coordinated Entry and should be applied consistently throughout the Coordinated Entry process. As such, participants are allowed to reject any housing projects or housing options offered to them without repercussion. If a participant chooses to decline a housing referral, the housing project staff should ask follow-up questions about why they are declining the referral and if there are any accommodations the housing provider could make for the participant to accept the referral. However, if the participant does decline the housing referral, the housing project should communicate this on the referral in HMIS and complete the Return to List form located on the GKCCEH website. The housing project should be specific about the reason the participant declined the referral so that it can inform subsequent referrals. The participant will be placed back on the BNL until the next appropriate housing opportunity is available.

Provider Declined Referrals

These returns should only occur when appropriate and remain as limited as possible. The housing project should make every effort to work with the participant in their housing project. Providers can decline referrals in the following circumstances:

- The household does not meet the program's eligibility criteria
- The program is at capacity and is not able to accept referrals
- The household is missing and the referral time standards has been exceeded
- Other justifications as specified by the program, and approved by CES staff *(Please note: Prior engagement and/or behaviors with a housing program is not typically an eligible reason for returning a referral.)*

If a referral does not qualify for the housing project because they are not in an eligible state of homelessness (Category 1 or 4), then the housing provider should communicate this on the Active Referral Update sheet, update the referral status on HMIS, and exit the participant from Coordinated Entry in HMIS.

In all other circumstances, the housing project should case conference the referral at the Housing Solutions meeting. If the issue cannot be resolved, the housing project should complete the Return to List form, documenting the reason for the return and all efforts made to work with the participant. Please note that submission of this form does not confirm that the client was returned. The housing

project will receive a follow-up email confirming the return or requesting further information. Once the return is confirmed, the housing project should update the referral status on HMIS. If the housing project is needing a new referral, they should request a new referral by completing the Referral Request form. The participant will then be returned to the BNL until the next appropriate housing opening.

If a referral is returned, CES staff will attempt to contact the participant to ask any questions and/or make a final attempt to contact the participant before moving them to inactive status on the BNL.

Post Referral

Once a referral has been accepted and enrolled in the housing project, a target move-in date of 30 days should be established and communicated to the client. If the 30 day target move-in date cannot be met due to an unforeseen barrier, the housing provider is expected to problem solve with the members of the Housing Solutions team.

The housing project staff is also expected to provide active, supportive, and intentional engagement with the client to get them into housing as quickly as possible. The housing project should adjust the level of engagement with the referral depending on the client's individual needs, ability to locate housing units, and connection to other service providers. It is the responsibility of the housing provider to provide active updates on the client's housing placement status.

Victim Service Agency Referrals

Per HUD, victim-services providers that are recipients or subrecipients under the CoC and ESG program are required to collect client-level data consistent with HMIS data collection requirements, but they must not directly enter data into an HMIS. To protect clients, victim-service providers must enter required client-level data into a comparable database that complies with HMIS requirements. They may use CoC and ESG program funds to establish and operate a comparable database. Information entered into a comparable database must not be entered directly into or provided to an HMIS. Victim-service providers must provide aggregate data to the CoC for reporting purposes.

Our community is in the process of implementing a victim-service provider HMIS which will mirror MO-604's system. There is a current process in place outside of HMIS for referrals to victim-service providers that is subject to change upon implementation of a victim-service provider HMIS.

Coordinated Entry Events

The Coordinated Entry Event element is designed to capture key referral and placement events, as well as the results of those events. The housing provider should record the appropriate result for the event to their respective project when known. All Coordinated Entry events must result in one of the following:

1. Successful referral: client accepted - If a client was referred to an opening in a continuum project and subsequent follow up with the client or provider indicates the client was accepted into the project opening.
2. Unsuccessful referral: client rejected - If a client was referred to an opening in a continuum project and subsequent follow up with the client or provider indicates the client decided to reject the referral to the project.
3. Unsuccessful referral: provider rejected - If a client was referred to an opening in a continuum and subsequent follow up with the client or provider indicates the client referral was rejected by the provider.

HMIS Data Entry Timeliness Standards

Timely data entry into HMIS is essential for the CoC's data quality and for CES staff to know about the progress of referrals. Delayed and inaccurate data affects the housing project and the CoC's system-wide performance measures. As such, data entry points should be recorded in HMIS **within 2 business days** of the event.

Please note, it is imperative the data reflects the referral's true story regardless of negative outcomes.

In addition, the housing project staff are expected to complete the updates on the bi-weekly active referral updates sheet within 5 business days.

Once a referral is housed, the housing provider has 2 business days to record the move-in date in the "one time" field and exit the referral from CE. Please note, the "one time" field is only available under case manager and system admin roles.

Discharge Summary Form

To improve community data and ensure sustainable housing outcomes for program participants, a discharge summary form must be completed for each program participant that is exited from a housing program. The discharge summary form can be found here.

A copy of the discharge summary form must be printed off and included in the program participant's file.

This form is under review for VSPs to comply with VAWA.

Meetings

Housing Solutions

Housing solutions meetings focus on housing program's open referrals with the goal to coordinate swift communication among providers, address barriers to housing placement, determine next steps and targeted housing dates for the clients, and ultimately decrease the length of time it takes from referral to housing placement. This portion of the meeting is specific to the housing program and providers with clients referred to that respective program. A portion of the meeting is to troubleshoot client cases, discuss general barriers for clients, and discuss potential clients that need to be transferred to a different housing program type. The goals of these meetings are to:

1. To ensure holistic, coordinated, and integrated assistance across providers for all persons experiencing homelessness in the community; and those who have been referred to housing programs.
2. To review progress and barriers related to each individual's housing goal;
3. To identify and track systemic barriers and strategize solutions across service providers;
4. To clarify roles and responsibilities and reduce duplication of services.

Meeting Frequency: 1st and 3rd Monday of each month. Please note, if there is a 5th Monday in the month, a meeting will not be held.

Attendance: As per local NOFO policy requirements, all COC funded agencies must attend at least 80% of all Housing Solutions meetings. Further details in regards to Housing Solutions attendance can be found here.

- Programs must have at least one designated agency representative at Housing Solutions meetings in order to be counted for attendance.

- Changes to the designated representative(s) must be done by registering on the Coordinated Entry section of the GKCCEH website. This portion of the site is password protected; CE providers may get the password from CES staff.
- All designated Housing Solutions meeting participants must sign a confidentiality statement regarding use and disclosure of client data shared during the sessions. This document must be signed when the participant is appointed and renewed annually.
- Funded programs must begin attending by the start of their grant period.

Prioritization

Prioritization focuses on preparing clients in our priority pool for upcoming referrals, ensuring their prioritized housing pathway is appropriate and the client is prepared for housing placement if and when a referral is made. As receiving agencies receive and work on referrals from the BNL and acquire new information that requires updates to be made to a person's CAT or about the prioritization of a person, they can report that to CE staff at these meetings.

Meeting Frequency: 2nd and 4th Monday of the month.

Attendance:

- Meetings are interactive and require active participation for them to be effective. Ideal participants have ready access to client-level information, knowledge of status of households on referral with their respective agency, familiarity with community resources, and the confidence and willingness to actively problem-solve, contribute to the meeting, and receive value from the meeting, e.g., outreach workers, housing program direct service staff, CE assessors, community health partners.

Meeting Guidelines:

- CES staff will send out meeting reminders the Friday prior to each Monday meeting, with instructions and/or meeting links.
- CES staff will facilitate meetings, but may have speakers lead portions of meetings.
- Meetings will consist of updates on outstanding referrals, reporting on housing openings, and making referrals to openings. In addition, concerns or updates about persons on the list or currently in programs may be discussed.
- If a housing provider is concerned about the housing placement of anyone in their programs, this meeting is a safe place where they can discuss the situation, and the team can offer ideas, input, or resources to assist with the housing retention of clients.
- CES staff will occasionally provide an educational or informational opportunity to meeting attendees. Topics will vary, and recommendations for topics should be directed to CES staff. These training topics will be quick, taking no more than 15-30 minutes of the meeting.
- The virtual meetings should only be attended by individuals that have completed the privacy and security training provided by HMIS staff, and attendance will be kept for these meetings as well to confirm that all persons in attendance are covered by such training.

Privacy Guidelines:

- The BNL holds personal information about people experiencing homelessness. This information needs to be held in the strictest of confidence.
- Everyone attending the meetings must be registered CaseWorthy users that have engaged in the privacy and security training provided by HMIS staff.
- If the privacy and security training hasn't been completed, the individual must fill out an MOU prior to the meeting, which includes their supervisor's signature. The MOU will be given to the CES staff person maintaining the BNL and facilitating the meetings.

- Lists should be kept strictly confidential and always shredded when no longer in use. Please don't even take the list outside of the meetings if not needed. CES staff always shred the lists.
- The full list is released only to CES staff to ensure confidentiality.

Retention/Transfer

A CES should not only work to connect the highest need, most vulnerable households in the community to housing, but also ensure households are able to remain stably housed. Housing retention and transfer processes have been put in place to ensure we remain attentive to the needs of program participants.

Housing Retention

Housing Retention supports program participants with the goal of maintaining their current housing, thereby preventing an additional episode of homelessness or requiring one to relocate to a new unit. This committee recommends creative ideas and solutions to help households connect to services including, but not limited to medical, employment, behavioral health and substance use to ensure they comply with their lease and rental subsidy program requirements to ensure they can maintain housing.

Program participants are brought to Housing Retention as a result of being staffed on multiple occasions in Housing Solutions meetings and still struggling to stably maintain housing despite trying the suggestions given by providers. It is determined in real-time at the Housing Solutions meeting if the program participant will be required to attend Housing Retention. If required to attend, the program participant and their current provider must be present at the next Housing Retention meeting.

The provider is required to continue working with the program participant for a minimum of 60 days after the initial Housing Retention meeting. This ensures the program participant has a sufficient amount of time to implement the steps suggested to them by the Housing Retention committee.

After all options are exhausted, the Housing Retention committee may suggest transferring the program participant from their current program to another. Please see more information about transfers below.

The Housing Retention committee is composed of CoC-funded agency representatives and non-CoC-funded agency representatives recruited by the CEGC.

Transfers

A sound and successful CES must allow for transfers between programs to better meet the preferences and needs of a household and to ensure households are able to successfully meet and sustain their housing goals. A key component to any transfer process is an ongoing assessment of a household to determine whether the levels of service are appropriate or need to be increased.In some instances, a household may need to transfer to another program within the CES for a myriad of reasons including, but not limited to, changes to family composition, the defunding of an agency or program, or criminal record for state-mandated restrictions.

It is important to recognize transfers from one program to another can prove disruptive to program participants' lives and that this should only be undertaken in the most serious of circumstances and when all other avenues of resolution have been explored and documented.

It's important to note that no transfer, regardless of the circumstances, is guaranteed. For guidance, please review the "GKCCEH Transfer Form".

The Transfer committee is composed of CoC-funded agency representatives and non-CoC-funded agency representatives recruited by the CEGC.

Permanent Supportive Housing (PSH) Transfers

When a current household must transfer to another program within the same program model (PSH to PSH) the household will be prioritized via the CES. The housing provider should complete the Transfer Request Form detailing the need for the household to be transferred and submit it to CES staff. CES staff will review the request and schedule a Program Transfer Review meeting with the person making the request and the panel of reviewers selected by the CoC to collaborate in making those determinations. The Program Transfer Review meeting will be scheduled within 14 days from when the request is submitted. The transfer panel will be comprised of CoC members with no vested interest in the outcome of the transfer. A decision will be made during the Program Transfer Review meeting or no later than 5 business days after the Program Transfer Review meeting if additional information and/or documentation is needed. In cases where additional information is needed, CE staff will inform the housing provider(s) of the decision. If the transfer is approved, the household will be placed back on the BNL and a new program match will be made.

Transfers from Permanent Supportive Housing programs to Rapid Rehousing programs are not allowed.

Rapid Rehousing (RRH) to Permanent Supportive Housing (PSH) Transfers

Rapid re-housing is a model for helping individuals and families who are experiencing homelessness to obtain and maintain permanent housing, and it can be appropriate to use as a bridge to other permanent housing programs. Program transfers may be made from rapid re-housing to permanent supportive housing so long as the household met, at RRH program entry, the eligibility criteria for the program they are transferring to under the specific program guidelines and the requirements for the Permanent Supporting Housing project in the Notice of Funding Availability (NOFA) for the year the project was awarded. RRH to PSH transfers are able to occur in instances where the household being transferred met the chronically homeless definition when enrolled in the RRH program. Additionally, it is understood RRH programs, in order to house households from the list more quickly, may be utilized as “bridge” housing. In the event the transfer request is initiated due to a household’s need for additional support, the transferring agency will not be penalized. To ensure the rationale for such transfers is reasonable, the CAT score will be a factor in decision-making.

When a current household must transfer from an RRH to a PSH program, the household will be prioritized via the CES. The housing provider should complete the Transfer Request Form detailing the need for the household to be transferred and submit it to CES staff. CES staff will review the request and schedule a Program Transfer Review meeting with the person making the request and the panel of reviewers selected by the CoC to collaborate in making those determinations. The Program Transfer Review meeting will be scheduled within 14 business days from when the request is submitted. The transfer panel will be comprised of CEGC members with no vested interest in the outcome of the transfer. A decision will be made during the Program Transfer Review meeting or no later than 5 business days after the Program Transfer Review meeting if additional information and/or documentation is needed. In such cases where additional information is needed, the CES staff will inform the housing provider(s) of the decision. If the transfer is approved, the household will be placed back on the BNL and a new program match will be made. This cohort will be prioritized according to the CE Prioritization Policy.

By their nature, rapid re-housing programs are flexible to meet the needs of participants, with a host of voluntary supportive services. As the level of care is to be consistent within the community among RRH providers, transfers from one RRH program to another will not be considered between different agencies with RRH programs.

Transfers Due to Grant De-funding or Reallocation

When a transfer request is made due to a program's loss of funding, it is understood the program participant's stability should remain the primary goal. The expectation is that prior to requesting a transfer, programs will explore and document other opportunities and strategies where possible, to move participants onto other appropriate housing subsidies and supportive services. Should these measures prove unsuccessful, program staff should notify CES staff no later than 6 months prior to the program's end date.

Emergency Transfer

It is the role of the Greater Kansas City Coalition to End Homelessness (GKCCEH), the Continuum of Care Lead Agency for Jackson and Wyandotte counties, to ensure that appropriate policies and procedures are in place to protect the safety of clients, particularly within CoC MO-604, including ESG-Funded programs. This policy/procedure addresses safety of individuals who are experiencing or have experienced domestic violence, dating violence, sexual assault, and/or stalking.

In accordance with the Violence Against Women Act (VAWA) and other entities, CoC MO-604 allows individuals affected by domestic violence, dating violence, sexual assault, and/or stalking to request an emergency transfer from their current unit to another unit. The ability to request a transfer is available regardless of sex, gender identity, or sexual orientation. While the ability of Housing Programs (HP) within CoC MO-604 to honor such requests for individuals currently receiving support may depend upon unit availability, CoC MO-604 encourages programs to creatively consider all possible options to increase individuals' safety. To learn more about the emergency transfer policy and to request an emergency transfer, please visit GKCCEH's policy page located on their website.

Grievance Procedure

All households served by the CoC have the right to file a complaint or grievance if they feel they have been treated unjustly by the CES or by any program or agency within MO-604's CoC.

MO-604 has a formal client grievance procedure to ensure that clients' complaints are dealt with quickly and fairly. Clients are given a copy of the grievance procedure and a client grievance form at program intake. Staff at CoC and ESG funded agencies should explain clients' rights to them and how the grievance procedure works, including that a staff member will help them complete the form and file the grievance if needed.

A client should first discuss a grievance with whomever the grievance is against (ie. service provider, agency) and work to resolve grievances informally between the parties involved. When the grievance is about CES, the CES representative for the agency should be involved in the conversation if possible. If the grievance is still not resolved through the agency's formal process, the client should submit a formal grievance to the CoC Lead Agency (GKCCEH) following the process outlined below. To submit a grievance, please complete a Grievance Submission form here.

Agencies that have a grievance are able to complete the same form, and the grievance will follow the same procedure as detailed below.

Grievance Procedure Steps:

1. Client completes grievance form and submits to CoC Lead Agency (the CES representative at the agency serving the client is responsible for assisting client with the form if necessary).
2. CoC Lead Agency reviews grievances, to investigate in an attempt to substantiate the claims, and routes grievances to the review committee, a subcommittee of the CEGC.
3. The committee then reviews grievance forms and any additional information and works to resolve grievances with clients. The entity will confer with the CoC Lead Agency and other CoC partners as necessary.
4. Committee facilitator will then provide a written response to the grievance within twenty (20)

business days of the review. Copies of the response will be forwarded to the CoC Lead Agency within ten (10) business.

5. If a client is not satisfied with response to grievance, the program participant will be invited to participate in a case conference with staff from CoC Lead Agency, Grievance Review Committee, and other CoC partners as necessary.
6. If client is not satisfied with results of the case conference, client can then file grievance with the appropriate funding body, following the grievance procedure of that body (ie. HUD, MHDC, etc.).

Anti-Retaliation Policy

MO-604 provides agencies and clients who wish to file a grievance the opportunity to do so without retaliation from the party accused or any representative associated. Retaliation includes, but is not limited to: harassment, intimidation, violence, program dismissal, refusing to provide services, use of profane or derogatory language to or in reference to the complainant, or breach of contract. The CoC will take immediate steps to stop retaliation and prevent its recurrence.

Other Related Policies

MO-604 Continuum of Care Policies