A Community Coordinated Entry Procedural Manual
Version 2.1
May 2020

Coordinated Entry is designed to coordinate and prioritize access to housing and homeless programs for households experiencing or at risk of homelessness and ensures clients have the opportunity to be referred to a housing and service prioritization list regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. There is no guarantee that a household will meet a housing provider's final eligibility requirements, be referred to a housing resource, or receive a referral to a particular housing option. Coordinated Entry does not ensure availability of housing resources for all eligible households.

This manual is a living document that may be amended as Coordinated Entry is refined within the Municipality of Anchorage, as other service providers or programs join Coordinated Entry, or as necessary to maintain compliance with federal guidance and regulations governing Coordinated Entry and housing services. Version 2 was written to reflect policy guidance governing the Anchorage Continuum of Care (CoC) and to meet HUD's *Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System* established by CPD-17-01. HUD's compliance deadline is 23 January 2018.

The inevitable growth of Coordinated Entry, coupled with further research into best practices, and feedback from providers and participants will necessitate revision to the Anchorage Coordinated Entry Policies and Procedures. This revision will be tentatively scheduled for a January 2019 update (Version 3). Revisions and policy changes are subject to approval by the Anchorage Coalition to End Homelessness (ACEH). All community or participant suggestions should be forwarded to the Coordinated Entry System Manager.

May 2020 (Version 2.1) updates to section 3.2.3 and 3.2.4 to include Prevention & Diversion Access Points.

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ACRYONYMS

ACEH   Anchorage Coalition to End Homelessness
ADA   Americans with Disabilities Act
AWAIC   Abused Women's Aid in Crisis
BHAP   Basic Homeless Assistance Program
CE   Coordinated Entry
CoC   Continuum of Care
CSS   Catholic Social Services
HMIS   Homeless Management Information System
HUD   US Department of Housing and Urban Development
ICA   Institute for Community Alliances
MOA   Municipality of Anchorage
PSH   Permanent Supportive Housing
ROI   Release of Information
RRH   Rapid Rehousing
SSVF   Supportive Services for Veteran Families
TAY   Transition Age Youth
TC   Transition Coordinator
TH   Transitional Housing
VA   Department of Veteran Affairs
VI-SPDAT   Vulnerability Index-Service Prioritization Decision Assistance Tool

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1.0 CONTINUUM OF CARE BACKGROUND

The Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (HEARTH Act) amended the McKinney-Vento Homeless Assistance Act. Among other changes, the HEARTH Act consolidated the three separate McKinney-Vento homeless assistance programs (Supportive Housing Program, Shelter Plus Care program, and Section 8 Moderate Rehabilitation Single Room Occupancy program) into a single grant program known as the Continuum of Care Program.

The United States Department of Housing and Urban Development (HUD) published the CoC Program Interim Rule in the Federal Register on July 31, 2012. This interim rule governs the CoC programs and is posted on HUD's website.   Included in the requirements outlined in the CoC Program Interim Rule is the mandate that each CoC establish a centralized assessment system, otherwise known as a Coordinated Entry (CE) System. This program is designed to assist households (families, unaccompanied adults, or unaccompanied youth) experiencing homelessness, and to provide the services needed to help such households move into transitional and permanent housing, with the goal of long-term stability.

Alaska is divided into two Continua of Care: Anchorage and Balance of State. The Anchorage CoC encompasses 1,969 square miles: as far north as Eklutna and south to the end of the Whittier Tunnel. It is governed by the Anchorage Coalition to End Homelessness (ACEH). These policies govern the CE Process within the Anchorage CoC. Any project receiving HUH CoC or Emergency Solutions Grants (ESG) funding within the geographic area must comply with CE participation requirements as established by the CoC.

2.0 COORDINATED ENTRY OVERVIEW

CE is meant to effectively target, track, and prioritize individuals and families experiencing homelessness based on highest need. It is defined as "an approach to coordination and management of a crisis response system's resources that allows users to make consistent decisions from available information to efficiently and effectively connect people to interventions that will rapidly end their homelessness."[1]

HUD outlines three main goals for the CE process:

1) To streamline the crisis response system to create equitability and ease for individuals accessing CoC and mainstream resources;
2) To ensure prioritization of individuals with the highest need;
3) To inform the strategic distribution of resources and assist in identification of service gaps through the provision of data and increased community collaboration.

2.1 Guiding Principles

In accordance with CoC and HUD guidance, the Anchorage CE System has committed itself to the observance of certain philosophies and principles. CE harnesses the elements of these principles to meet the goals outlined above. Further, though CE does not have the authority to mandate a participating project's adherence to these standards, it supports the CoC's mission to advance these practices throughout the community by using CE as a platform to monitor and report on projects' practices. Details of evaluation methods are found in Section 11.0 of this manual.

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[1] Coordinated Entry Core Elements, pg. 5

2.1.1. Housing First

CE is meant to adopt a Housing First philosophy as "an approach to homeless assistance that prioritizes rapid placement and stabilization in permanent housing and does not have service participation requirements or preconditions such as sobriety or a minimum income threshold."[2] It assumes that when experiencing a housing crisis, the primary need is stability and safety. Once this is achieved, a household is then able to address other areas of concern.   CE maintains a Housing First approach in all aspects of the system:

➢ Access and Assessment: Persons experiencing homelessness are not screened out of CE nor are they discouraged from completing a CE assessment due to poor credit history, criminal background, lack income or employment. People with addictions to alcohol or substances are not required to cease use or participate in treatment prior to accessing housing and services. Households experiencing or with past experiences of domestic violence are neither prohibited nor discouraged from accessing the CE system.

➢ Prioritization: CE ensures that individuals are prioritized for services solely based on vulnerability and need. Those with highest vulnerability and most severe service need will be identified for assistance through CE.

➢ Referral: CE will base referrals to services on priority, project eligibility requirements and client preference only. Referrals are made without consideration to other preconditions and without establishing "housing readiness."

2.1.2 Fair and Equal Access

CE maintains an individual's right to fair and equal access to services. As such, regardless of where or how a household presents for services the same standardized assessment approach is always used. Further, all households are prioritized and referred through standardized practices and decision-making standards as outlined in this manual. All households are prioritized on one community list which provides referrals to projects participating in CE.

To further ensure fair and equal access to services, applicable civil rights and fair housing laws and requirements are adhered to throughout the assessment, prioritization and referral processes. In compliance with the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, Titles II and III of the American with Disabilities Act, HUD's Equal Access Rule and fair housing provisions found within the CoC Program Interim Rule, all phases of CE are conducted without reference to race, color, religion, sex, national origin, disability, familial status, actual or perceived sexual orientation, gender identity, or marital status.

CE also maintains Fair and Equal Access by ensuring that those fleeing or attempting to flee from domestic violence, dating violence, sexual assault, or stalking are prioritized for the same services regardless of where or how they present for services. Households meeting qualifications for an alternative CE system for victim service providers are prioritized for all services available through the CE system described in this manual.

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[2] Find out from where Kristi obtained this quotation.

2.1.3 Client Centric

CE is dedicated to creating a positive and effective experiencing for individuals requiring services. CE is designed to be easily accessed, understood and navigated by those in need in the community. Further, the Anchorage CE System collects information regarding client preference which is used to inform the referral process. CE does not penalize a household for refusing any specific service referral, nor for refusing to answer any questions within the assessment. CE engages participants in an annual evaluation and adjusts practices as necessary to ensure a client centric approach is maintained.

2.1.4 Data Driven Decision-Making

CE uses data at hand to make informed decisions and adjustments to practice, policies and procedures. CE is continually looking for areas of improvement and bases this growth on objective data and performance measures.

2.1.5 Community Collaboration

CE recognizes the need for the support and input from community service providers to create the most effective system possible. CE relies on continual, constructive participation of service providers, stakeholders, funders, and interested community members. CE always seeks to foster clear, honest, and open communication to remain rooted in a spirit of community collaboration.

2.2 Management

The Anchorage CE System is managed directly by the CoC through ACEH staff and Board. Support from the Municipality of Anchorage (MOA) and United Way of Anchorage, alongside close coordination with the partnering service providers is relied upon for success in tracking, prioritizing, and aligning resources to address the physical, emotional, and social needs of each client.

Figure 1   Coordinated Entry Policy Making Hierarchy

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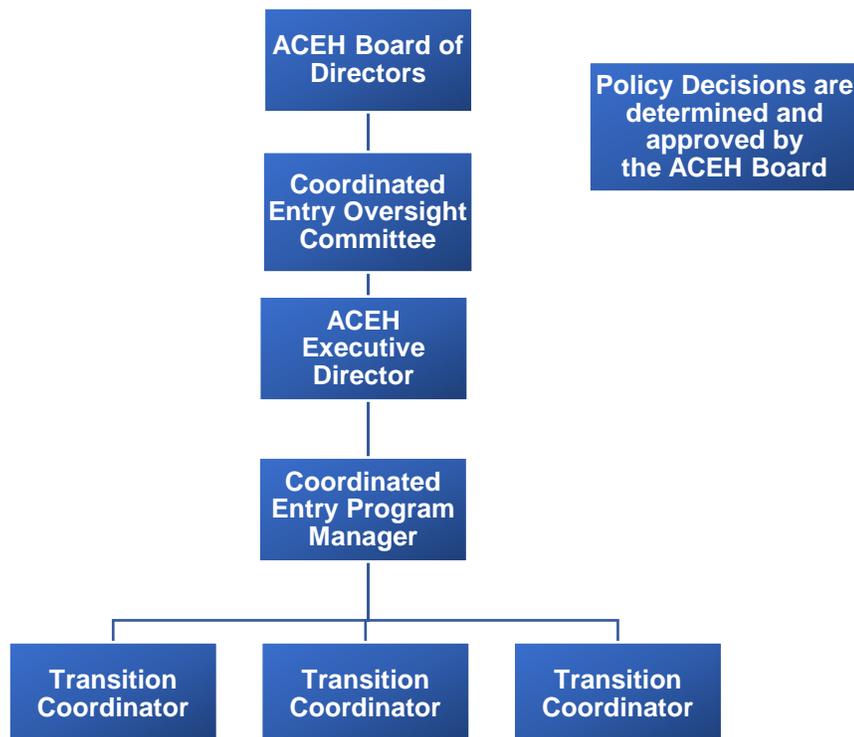
2.2.1 Anchorage Coalition to End Homelessness

The Anchorage Coalition to End Homelessness (ACEH) oversees the coordination and administration of all aspects of CE. ACEH identifies potential funding sources and orchestrates the appropriate methods to obtain funding. ACEH is responsible for the management and reporting of Homeless Management Information System (HMIS) data, developing and managing the CE System, and serving as the CoC's planning body during the annual Notice of Funding Available (NOFA) process. ACEH also monitors all subrecipients of CoC funds to ensure compliance with grant, HUD, and CE requirements.

2.2.2 Oversight Committee

The Oversight Committee is a subcommittee of the ACEH Board whose mission statement is "To provide oversight and direction around all parts of the Coordinated Entry System in Anchorage to assure individuals are connected with services to end homelessness." Specifically, the Oversight Committee participates in the policy decision making process by reviewing, revising, and creating CE policies. All creations, revisions, or recommendations are submitted to the ACEH Board for final approval. The Oversight Committee is comprised of ACEH Board members, CE Program staff, ICA staff and other key community partners.

2.2.3 Program Manager

The Program Manager oversees the day to day operations of the CE process. The Program Manager oversees the Transition Coordinators (TCs) and ensures a close connection between CE Program staff and participating agencies is maintained. The Manager organizes large meetings or workshop events including assessment packet or database trainings as needed.

The CE Manager also partakes in the oversight of client level data on the Prioritization List. Removal from the prioritization list is completed by the Program Manager along with oversight of data quality monitoring completed by the TCs. The Program Manger monitors compliance with client confidentiality standards. The Program Manager works closely with the Institute for Community Alliances (ICA) for technical guidance and participates in the HMIS Advisory Board to assist with HMIS policy review and revision.

The Program Manger is responsible for creating procedural practices compliant with both the standards in this document and the CoC's mission to ensure efficient operation of the CE Process. The Manager works closely with program staff and participating projects to ensure that procedures in place meet the needs of both the agencies involved and the clients served. The CE manager also assists in the development of policies, in conjunction with the Oversight Committee and the CoC. The manager maintains communication with ICF, the CoC's assigned HUD technical advisor, to ensure program compliance and for guidance in ongoing development. The Program Manager is responsible for reports and communication back to the ACEH Board.

2.2.4 Transition Coordinators

The Anchorage CoC has three Transition Coordinators (TCs): High Acuity, Mid Acuity and Access.

TCs are primarily responsible for managing the referrals of households from their subpopulation to housing providers in the community, and facilitating weekly or bi-weekly case conferencing meetings. Through community case conferencing meetings, TCs work in tandem with participating agencies to connect clients to available housing as quickly as possible. TCs develop and maintain a comprehensive understanding of the community players associated with homelessness, build strong relationships with each agency, and proactively engages with housing providers and cooperating agencies to find suitable

solutions for clients. TCs ensure that clients are referred to appropriate housing programs according to placement on the Prioritization List, client preference, and eligibility requirements of the program. TCs follow up with providers to assess client housing progress. TCs prepare clients and housing providers for next steps necessary to ensure a smooth transition; this may involve some direct-care services to assist specifically with the move into housing. TCs are not case managers.

TCs assist in data management by both training assessors and monitoring data quality. TCs are responsible for conducting trainings on the Initial Assessment Phase and Housing Services Assessments for all assessors supporting CE. TCs also monitor the data entered into HMIS by CE assessors to ensure data completeness and quality.

TCs serve as facilitators between the CE Manager and participating projects. TCs work closely with community providers to identify the needs of their subpopulation and gaps in the services available. TCs work with community partners and the Program Manager to identify and implement innovative ways to engage service providers within their designated sector to ensure wrap around services for households on the Prioritization List.

2.3 Homeless Information Management System

HMIS is a database used to capture client level data regarding households experiencing homelessness and is subject to HUD requirements.   HMIS is used by most housing and homeless service providers in the Anchorage community outside of their engagement with the CE System. As such, it proves a useful tool for the sharing and management of community data. For these purposes, the Anchorage CoC has opted to utilize HMIS for the purposes of the collection and maintenance of CE data.   The Anchorage CE process stores all assessment data in HMIS and uses the database for the creation of the Prioritization List.

2.3.1. HMIS Vendor and Administrator

Mediware Information Systems is the HMIS software vendor for the Anchorage and BoS CoCs. ICA is the system administrator designated to manage HMIS throughout the state.

As system administrator, ICA provides technical support to the CE process. ICA creates and maintains reports related to CE, including the Prioritization List. ICA provides training on data collection and entry to CE assessors and works closely with TCs to monitor data quality.   ICA remains up to date on HUD requirements for data collection and ensures that the database is equipped to meet those standards. ICA works with CE Program staff to identify and implement ways to further utilize HMIS to streamline the assessment, prioritization, and referral process. ICA also assists with managing and analyzing of aggregate data to assist CE and the Anchorage CoC in making informed and data-driven decisions.

As the system administrator serving all HMIS users throughout the state, ICA's role and scope is wider than outlined in this document. Additional information regarding ICA in Alaska is available online: http://www.icalliances.org/alaska/

3.0 PROCESS FLOW

Figure 2   CE Process Flow

Step 1

Step 2

Step 3

Step 4

Step 5

Step 6

ACCESS

Client connects with CE through access points or outreach teams.

INITIAL ASSESSMENT/PRE-SCREENING

Access points ensure eligibilty and screen for safety. Prevention and Diversion is discussed with eligible households.

HOUSING SERVICES ASSESSMENT

Those who can't be served by Prevention and Dicersion services are assessed for housing and related services.

PRIORITIZATION

Households are prioritized for assistance based on need and vulnerability. Priorization list is reviewed and managed by TC.

CASE CONFRENCING

Prioritization list is reviewed by service providers. When CoC housing interventions are limited, providers work to identify alternate resources and ways to assist indidividuals at the top of the list.

REFERRAL

Referrals based on priority and program eligibilty are made. Staff outreach individuals to inform of referral and assist with paperwork preparation process and move into housing.

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3.1 Access

3.1.1 Access Points

Access Points (APs) are physical locations within the city of Anchorage where a household may present for assessment and services.   AP organizations are equipped to administer the standardized assessment tool and to make adequate referrals or diversions based on the assessment outcome and resources currently available. All APs utilized in the Anchorage CoC are wheelchair accessible and have access to large-print material through the ACEH website. At all times, at least one AP has access to language interpretation; the AP with these services is identified to clients via CE marketing. The Anchorage CoC and CE System is currently working to identify how to provide auxiliary aides for communication to at least one designated AP.

The Anchorage CE permits separate APs based on subpopulation: adults with children, adults without children, unaccompanied youth, or victims/survivors of domestic violence. Households may be served at any AP for which they qualify.   Some APs may be equipped to assess households from any subpopulation. A current list of APs, available hours, directions, and dedicated subpopulation (if applicable) is always posted on the ACEH website. If a household presents at an AP dedicated to serve an alternate subpopulation, the AP at which they present assists the household in connecting with the appropriate AP for assessment and services.

All APs undergo standardized training to ensure that no matter which location conducts a household 's assessment, the same approach and decision-making criteria will be used. Standardized practices used by all APs are outlined in Section 5.0 of this manual.

3.1.2 Geographic Coverage

Though the Anchorage CE System encourages in-person assessments to capture the most accurate information, phone assessments are also available to ensure that those in need of services throughout the entire geographic region may have easy and efficient access to CE.

At present, all physical APs are located within the city of Anchorage, while the Anchorage CoC extends much further.   As such, marketing of CE in outlying communities encourages households to connect with Alaska 2-1-1.   Alaska 2-1-1 supports the Anchorage CE system by completing Initial Assessments to appropriately triage clients. Alaska 2-1-1 directly provides prevention and diversion services; those households who cannot be assisted through means of Prevention or Diversion are scheduled for a phone Housing Services Assessment with a designated AP.   Clients within the city of Anchorage may also call Alaska 2-1-1 for assistance in accessing CE.

3.1.3 Outreach

Currently, there are no ESG or CoC funded street outreach programs within the Anchorage CoC. The Anchorage CE system has, however, coordinates with various entities to ensure that those who are not regularly accessing housing services are connected to CE.   VA and mental health outreach workers attend the community case conferencing meetings to ensure that the individuals with whom they work are connected into the system.   The Anchorage CE is currently working with the MOA and the creation of a new crisis intervention team to capture clients who have high use of emergency services, but are not engaged with housing supports or resources.

3.2 Initial Assessment

Upon initial engagement with clients, CE Access Point staff complete the Initial Assessment phase. The Initial Assessment is a quick questionnaire meant to both assess households for safety concerns and to triage clients to the most appropriate services. Grievance policies and procedures are also reviewed with a household at this time.   Safety is always of primary concern for assessors and will be the first service offered to as household when necessary. Those who could benefit from Prevention or Diversion services are engaged in conversations regarding both their natural supports and community resources. Those who cannot be served through prevention and diversion services move to the second phase of assessment – the Housing Services Assessment.

This Initial Assessment also ensures that only those whose regular residence is within the MOA are prioritized for assistance through the Anchorage CE System. Any household in need of assistance whose regular residence is outside of the MOA is assisted in connecting with appropriate services in the BoS Continuum.

Though information may be collected regarding these areas during the Initial Assessment phase, no household will be denied services based on reference to race, color, religion, sex, national origin, disability, familial status, actual or perceived sexual orientation, gender identity, or marital status.

3.2.1 Grievance Review

Upon initial access with the Anchorage CE system, households are informed of CE's fair and equal access policies and non-discrimination policies.   Clients are provided information outlining how to file a grievance due to the violation of these rights. Procedures addressing this process are outlined in Section 10.0 of this manual.

3.2.2 Domestic Violence and Safety Planning

The immediate safety of a household is always a primary concern and is assessed during the Initial Assessment phase. If a household indicates that safety concerns are present, the assessor assists the household in identifying safe, natural supports in the community. Connections to Abused Women's Aid in Crisis (AWAIC) or other victim service providers are also provided, as necessary.

Connecting with a victim service provider is always the choice of the client, and the client is not penalized if they refuse a referral. If a household would like to accept a referral, they have the choice as to when they would like to complete the rest of their CE assessment – either prior to connecting with the victim service provider, or at a later time.

Further, if a client presents who is fleeing or attempting to fleeing domestic violence (DV), stalking, dating violence, or sexual assault and does not want to share their information in HMIS, the client has multiple options. These households may complete the process for an unshared CE assessment with the AP with whom initial engagement is established; these processes are outlined in Section 6.2.1. The household can also receive a comparable CE assessment that is entered into AWAIC's database managed by the contractor Social Solutions. AWAIC manages a closed database in which comparable assessment information is entered into the system. AWAIC is responsible for the collection, management, client prioritization and reporting of data entered into their private database. Clients who are prioritized through the DV process will also be placed, in a deidentified manner, on the Prioritization List described in this manual to ensure that those participants are prioritized for all services available through the CE process.

3.2.3 Prevention

During the Initial Assessment Phase, APs assess a household's eligibility and appropriateness for homeless prevention programs and services. Prevention efforts are designed to keep households in a place that they themselves already rent or own, therefore preventing homelessness. Clients who are currently housed and at risk of losing their housing are encouraged to call a Prevention and Diversion Access Point (PD AP). If a client calls a different AP and is identified as needing prevention services, they will be connected to a PD AP. Including prevention screening and assistance in the Initial Assessment Phase ensures that information is collected on an as-needed basis and saves households who can benefit from prevention services from completing a more intensive assessment.

The PD AP asks specific questions to determine if prevention is the best intervention for the household. Prevention services can include providing resources through the ESG program run by the ADRC, referrals to mainstream community resources, or assisting a household in connecting with their natural support system.

Households who fall into this category but cannot be prevented from meeting literal homelessness are eligible to complete the Housing Services Assessment.

3.2.4 Diversion

Clients who do not meet HUD's definition of literal homelessness are encouraged to reach out to the Prevention and Diversion AP (PD AP) run by Alaska 2-1-1 and the ADRC. If a client who reached out to a traditional access point is found not to be literally homeless, diversion efforts will be made along with a connection to the PD AP. Diversion efforts are designed to assist households who have already left their previous housing situation (rent or own) but are not experiencing HUD's definition of literal homelessness. Common situations in which this occurs is when a household is staying with family or living in a hotel. Including diversion screening and assistance in the Initial Assessment Phase ensures that information is collected on an as-needed basis and saves households who can benefit from diversion services from completing a more intensive assessment.

At the PD AP, specific questions are asked during this phase to determine if diversion is the best intervention for the household. Diversion services can include referrals to mainstream community resources or assisting a household in connecting with their natural support system.

Households who fall into this category but cannot be diverted from becoming literally homeless are eligible to complete the Housing Services Assessment.

3.3 Housing Services Assessment

The Housing Services Assessment is conducted on households meeting literal homelessness within the MOA, or whose primary residence is within the MOA. A household is still eligible for Anchorage CE prioritization when outside of the MOA if the intention is to return to the MOA for long-term residency (Ex. A household who is literally homeless while participating in treatment in BoS, who resided in Anchorage prior to treatment, and who intends to return to the MOA upon completion). Further, households who cannot be assisted through prevention and diversion services available, and who will be entering homelessness on the same night they present for services may also complete a Housing Services Assessment. All clients receive the same assessment approach, regardless of at which AP they present.

All clients have the right to refuse any questions asked during the assessment without penalization. Clients are made aware that withholding information may hinder CE from most accurately prioritizing or referring a household to services, however, their right to do so is maintained. In these cases, clients are prioritized as accurately as possible based on the information provided.

The Housing Services Assessment is stored within HMIS; live data entry is always encouraged when completing assessment to ensure households are prioritized as efficiently as possible. If an assessor is unable to complete live-data entry, they may complete a hard copy of the assessment which is always available on the ACEH website. The paper and electronic versions of the Housing Services Assessment are identical and are comprised of four main sections: Release of Information, HMIS Data Elements, the Standardized Assessment Tool, and Preference Questions. A self-sufficiency matrix is also completed by families with minor dependents who are interested in a referral to the Family Community Housing Project (FCHP).

3.3.1 Release of Information
All households engaged in the CE Process are asked to sign a Release of Information (ROI) that allows for continuum-wide sharing. Signing the ROI allows for the client's information to be shared within HMIS and allows for community partners to coordinate services for the household through community case conference meetings. Households who do not wish to sign the ROI remain eligible for assessment and prioritization through CE. Procedures surrounding the assessment and prioritization of "unshared records" can be found in Section 5.2.1 of this manual.

3.3.2 HMIS Data Elements
The Housing Services Assessment collects all HMIS Universal Data Elements (UDEs) along with other data elements identified by the CoC. Assessments are updated to match adjustment to HUD and CoC data requirements.   Data elements include client demographic information, information on disability status (without requiring the disclosure of specific diagnoses), history with homelessness, income, health insurance, native corporation affiliation, and history with domestic violence.

3.3.3 Standardized Assessment Tool
The Anchorage CE System has adopted the use of the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) as created by OrgCode Consulting, Inc. Currently, Anchorage uses separate versions of the VI-SPDAT to capture the difference in the vulnerability and needs of three subpopulations:

1) The adult VI-SPDAT is utilized for individuals older than 24 without minor dependents.   Multiple adults presenting as a single household can be housed together, though they are assessed and prioritized separately.
2) The TAY-VI-SPDAT is utilized for transitional aged youth (TAY) who are aged 18-24 and do not have minor dependents.   Multiple TAY presenting as a single household can be house together, though they are assessed and prioritized separately.
3) The family VI-SPDAT is utilized for households with minor dependents. Multiple adults and minors can make-up a household; only the head of household needs to complete the VI-SPDAT.

At present, the Anchorage CoC has not approved any other variation in assessment for any other subpopulation. Recent funding awards for DV providers, however, have mandated the creation of a DV CE System. Which assessment tool will be used by this system, and whether it will vary from what is listed above, is yet to be determined.

3.3.4 Preference Questions

Client preference questions are captured at the end of the assessment to ensure that the Anchorage CE system maintains a client-centric approach to services. Questions are asked to ascertain if there are certain types of resources with which a client would prefer to engage or avoid. Questions asked in this portion of the assessment are updated as the variety of services receiving referrals through CE grows. Preference questions may also be used to indicate gaps or areas for growth within the social service network. Preference questions are not used for prioritization and do not affect placement on the list. A client may update their preference questions during regular AP operating hours.

3.3.5 Self Sufficiency Matrix

The Self-Sufficiency Matrix is an optional part of the family assessment that is used to identify a household's independence in various areas of life. A certain score on this matrix is used as an eligibility standard for the privately funded FCHP. As FCHP constitutes a great portion of family referrals and housing placements, the matrix has been included in the assessment phase to streamline the referral process for speedy transition from homelessness to housing. This matrix is not required by CE nor does it affect a household's prioritization. A household who refuses to complete this assessment will not be denied CE services.

3.4 Prioritization

Regardless of which version of the assessment tool is completed, all households are placed on the same prioritization list, in a consistent manner. The Anchorage CoC has adopted prioritization standards for all subpopulations based on client vulnerability. Information collected during the assessment phase is used in tandem with information gathered through community partnerships to identify those clients most in need of services. The Anchorage CE System has identified three orders of priority:

> 1) Composite Vulnerability Score

> 2) Time Homeless

> 3) Time on Prioritization List.

Though information may be collected regarding these areas during the Housing Services Assessment, no household will be prioritized based on race, color, religion, sex, national origin, disability, familial status, actual or perceived sexual orientation, gender identity, or marital status.

3.4.1. Composite Vulnerability Score

The Composite Vulnerability Score is composed of normalized VI-SPDAT scores and additional layers of vulnerability as identified by the community. Households may receive additional vulnerability points based on criteria of additional layers of vulnerability. These points are added to the normalized VI-SPDAT score to calculate the Composite Vulnerability Score, which serves as CE's first order of priority.

Additional Layers of Vulnerability:

Additional layers of vulnerability have been identified by the Oversight Committee and approved by the ACEH Board. Processes for identifying and tracking how households will receive additional vulnerability points remain under revision; this manual will be updated to reflect these procedures once finalized and approved. Areas identified and current statuses are listed below:

    i.   Chronic Status – calculated by assessment data via HMIS

ii. High Use of Emergency Services – information of high utilization of EMS, APD and AFD is gathered by community partners in tandem with the municipality. This information is used to flag high utilizers in HMIS. Final process remains under revision by the CoC and community partners.

iii. High Systems Involvement – use of systems and institutions across subpopulations. This could include Department of Corrections, Department of Juvenile Justice, Office of Children Services, Child in Transition, Alaska Psychiatric Institute, substance abuse treatment facilities, etc. Policies to identify "frequent fliers" is under revision by the CoC and community partners.

iv. Being primarily Unsheltered vs. Sheltered – calculated by HMIS; final process is under revision by the CoC and ICA.

3.4.2 Length of Time Homeless

Length of time homeless is captured by the number of months a family has been experiencing homelessness over the last three years. When two or more households are scored with the same Composite Vulnerability Score, the household whose number of months in a homeless situation in the last three years is the greatest is given priority.

3.4.3 Length of Time on Prioritization List.

In the circumstance that two or more households with the same Composite Vulnerability Score also have experienced homelessness for the same amount, priority is given to the household who accessed CE the earliest.

3.5 Community Case Conferencing

Community case conferencing meetings are facilitated by TCs to assess current client information and identify gaps in a household's plan, anticipate future needs, and discuss available housing options. Cooperating agencies that attend coordination meetings will review the prioritization list with the TCs and CE manager and make housing decisions based on eligibility, prioritization, client preference, assessment data, and bed/unit availability. Community case conferencing meetings are also used to identify households prioritized as highly vulnerable on the prioritization list, who may not qualify for services taking referrals through CE. Agencies participating in community case conferencing meetings work together to identify means to connect highly vulnerable households to mainstream resources.

Community case conferencing meetings are comprised of participating housing and social service providers. Providers receiving referrals directly through the CE process are expected to attend these meetings. Many agencies participating case conferencing, however, do not accept referrals directly from CE but attend to work alongside and collaborate with the CE system. These agencies may be community drop in centers, mental health providers, community case managers, housing or employment advocates, or other agencies that provide supportive services. The participation of such agencies is vital to ensure that the population being served receives appropriate wraparound supports necessary for stability and self-sufficiency.

3.5.1 Emergency Medical Elevation

In extreme circumstances, clients at risk of imminent death if housing is not provided can be moved to the top of the prioritization list. Requests for Medical Elevation can be requested by community providers during the community case conferencing meetings. Potential elevation will be reviewed and supported

by medical documentation and/or client notes.   Elevation of a client is done at the discretion of the TC and CE Manager. Consensus from community providers, however, is sought. Extreme funding needs to support the elevated status may be taken to the ACEH Board. Emergency medical interventions in which a client is elevated to the top of the prioritization list will be document and reported to the ACEH Board during the next Board meeting.

3.6 Referral

The referral process is designed to ensure that the most appropriate housing intervention is offered to a household. The referral process considers vulnerability, severity of service need, length of time homeless, project eligibility requirements, and client preference.   Households are referred in a "top-down" manner, with the highest prioritized household who is eligible for the available intervention receiving a referral into the program. Program eligibility is identified, to the extent possible, by TCs through the data collected in the Housing Services assessment and other data shared in HMIS or case conferencing.   Once identified, the referral is communicated by the TC to the receiving agency to initiate referral outreach.   Standards for referrals are found in Section 4.0 of this document.

A housing agency receives one referral per open unit to ensure that the highest prioritized household has access to the opening. Similarly, if multiple housing placements have concurrent openings, a household will only receive a referral to one agency to ensure strategic use of funds allowing for as many households as possible to be served at any given time.

3.6.1 Outreach

Upon receiving a referral, the housing provider is responsible for conducting intensive outreach to engage a client for a minimum of two weeks. The housing provider's outreach team collaborates with partner agencies during community case conferencing meetings. Continued case conferencing occurs, as necessary, outside of set meetings.   Information to assist in both locating and effectively engaging a client is communicated.   The TC and partnering agencies work collaboratively with the housing agency to identify creative means to outreach and engage clients who are difficult to locate or serve.

If no contact has been made, housing providers are authorized to take a new referral after two weeks of outreach to avoid the possibility of empty units or unused leasing dollars in the community. To streamline the referral and outreach process, TCs may perform the full two-week outreach period for households at the top of the Prioritization List prior to an anticipated housing opening. Once the agency communicates availability, referrals are made for individuals who have already been outreached and located. This process eases the burden on the housing providers and assists in the speedy transition from homelessness into housing.

Client Outreach and Removal from Prioritization List
In the event that a household is not located after the allotted two-week outreach period, the household does not lose placement on the Prioritization List.   If, however, a household is outreached for over four weeks with no contact, the household is removed from the Prioritization List.   This four-week outreach period may be completed by one entity, or could be the cumulative total of multiple agencies' outreach efforts (ex. If a housing agency completes the designated two-week outreach period, a TC could complete a subsequent two weeks of outreach).   In the event a household is outreached for over two weeks but less than four, the client will remain on the prioritization list. In these circumstances, the household will not be referred to another housing agency until they have been re-engaged with the system.

Due to restrictions of data sharing, CE is unable to provide personally identifying information when referring an unshared record to a housing agency, as there has been no consent to share this information.   In these circumstances, the unshared household is outreached by the AP who originally collected the assessment data.   As, however, APs are not equipped to complete intensive outreach, this process relies on making phone contact with the client.   Clients are responsible for providing up to date phone and message lines through which contact can be made.   Households who do not share their information receive the full two-week outreach period established in this document.

3.6.2 Documentation Collection and Eligibility

Once a client is located through the outreach process, the housing agency will continue engagement and assist in documentation collection.   The housing agency will provide regular updates during the community case conferencing meetings, and outside of the meetings to the TC.   Community providers will work together to best support the client and housing provider in obtaining necessary documentation. Each housing agency is responsible for the collection and maintenance of documentation showing a household's project-level eligibility.

3.6.3 Client Preference and Refusal

Preference questions gathered during the assessment phase are used to ensure that a household does not receive a referral to a service with which they do not want to engage. In the event preference questions do not provide all information necessary to make a referral in line with client desires, a client may refuse the referral with no penalty. In these circumstances the client remains prioritized for services and is eligible receive future referrals.

4.0 REFERRAL STANDARDS

4.1 CoC Funded Housing Agencies

All CoC-funded housing units are required to accept referrals directly through the CE Process.   The three main types of service interventions funded through the CoC are Permanent Supportive Housing (PSH), Transitional Housing (TH), and Rapid Rehousing (RRH). Referral standards for each are outlined below.

4.1.1 Permanent Supportive Housing

The Anchorage CoC has adopted the Orders of Priority as outlined in Notice CPD-16-11 (July 25, 2016) for all PSH beds.   As such, all PSH beds receive referrals from the CE Prioritization list in a top-down manner, ensuring those with the highest need and vulnerability receive access to the necessary services.

 All dedicated PSH beds receive the highest prioritized household meeting program-specific eligibility and the chronic homeless definition.   In the event that all households meeting chronic homelessness in the community have been served, CE will provide referrals from the top of the CE Prioritization list, ensuring that those with highest need and length of time homeless are served.

At present, the Anchorage CoC does not have any non-dedicated PSH beds. If the Anchorage CoC were to fund a non-dedicated PSH project in the future, that project will receive highest prioritized and eligible households, regardless of chronic homelessness status.

4.1.1.1 CoC Funded PSH and Low-Income Tax Credit Housing

In the instance that a CoC-funded PSH program receives funding through multiple sources, CE will work with the specific project to ensure that the CE process allows for compliance with CoC and HUD

requirements, along with the requirements of other funding sources.   At present, the RurAL CAP PSH program 325 is the only program whose secondary funding requires specific considerations in CE procedures.

To meet low-income tax credit compliance, 325 is required to offer its housing to the overall public when openings become available. Based on this requirement, 325 must open the application period to any willing applicant in Anchorage, but gives preference to clients prioritized and referred through the CE Prioritization List. Further, low-income tax credit compliance also requires a lengthy documentation collection process which must be fully completed prior to a household being found eligible for the program. In adherence to the goal of housing households quickly and ensuring that available housing services do not go unused in the community, CE has adopted a process to allow 325 provide an "open application" period.

Unlike other housing referrals, at the time of availability CE provides 325 ten referrals to every one opening in the project. Referrals are made in accordance with the standards outlined in Section 4.1.1 of this manual.   325 staff outreach all ten referrals to communicate that the referral process has begun. During this process, additional assessments and IRS documentation collection occurs; households can be found ineligible for the project if documentation cannot be verified, if the household does not score vulnerable enough per 325's secondary vulnerability assessment, or through criminal background screenings.   If during the two-week outreach period many households are found ineligible for the project or cannot be found via outreach, 325 is provided ten additional referrals for the opening.

Clients referred to 325 may also receive an additional referral to another housing agency if available during the 325 outreach and engagement period.   This ensures that a household is not skipped over for a referral to a placement for which they qualify. During these circumstances, the additional agency to which a client is referred remains in close contact with the TC and 325 outreach staff.   Case conferencing occurs outside of the weekly or bi-weekly community case conferencing meetings to ensure updates on progress, documentation collection, housing needs, and client preference are clearly communicated.

4.1.2 Transitional Housing
CoC funded TH projects receive referrals to units directly through the CE list. Referrals to TH are made in a top-down manner, based on eligibility standards and client preference.

4.1.3 Rapid Rehousing
Historically, there have not been CoC funded RRH projects within the Anchorage CoC. As such, standardized referral policies have not yet been established. The most recent HUD NOFA process, however, resulted in the Anchorage CoC being awarded funds for RRH. These funds have been allocated to a local DV provider and will be incorporated into the Anchorage DV CE process.

4.2 ESG Funded Services
All ESG funded services receive referrals through CE based on their eligibility requirements. ESG programs that serve literally homeless clients receive clients from traditional CE and ESG prevention programs that serve at risk of homeless clients receive referrals from PD APs.

4.3 BHAP Funded Services
The Alaska Housing Finance Corporation (AHFC) provides BHAP funding to a variety of agencies throughout the Anchorage CoC. As part of the funding agreement, AHFC states that all BHAP recipients must participate within the Anchorage CE System. The extent of participation remains at the discretion

of the agency. CE welcomes all BHAP funded programs to receive referrals through the prioritization list, however, there is no requirement that this occurs and no process has been formalized. This manual will be updated as procedures are standardized.

4.4 Department of Veteran Affairs

4.4.1 Veteran Affairs Supportive Housing

Veteran Affairs Supporting Housing (VASH) vouchers do not receive direct referrals from the CE Prioritization list, nor do representatives of the Department of Veteran Affairs (VA) input data into HMIS. Representatives from VA do, however, attend outreach meetings. VA representatives work in collaboration to assist other programs serving veterans and assist in the mitigation of duplicative efforts between veteran and non-veteran service providers. The VA also utilizes CE to ensure that all identified veterans captured on the Prioritization List are outreached and prioritized for VASH vouchers through the VA's internal process.

4.4.2 Supportive Services for Veteran Families

The VA provides Supportive Services for Veteran Families (SSVF) funding to Catholic Social Services to provide supportive services such as case management, and limited financial assistance to veterans and veteran families experiencing homelessness. As part of the funding agreement, the VA states that the recipient must participate within the Anchorage CE System. Though participation is mandated by the funding, to what extent the program participates remains at the discretion of the recipient. CSS works with CE to identify the best manner for SSVF to be incorporated into the CE System. While SSVF is open to receiving referrals through CE, formalization of this process is still under review. This manual will be updated as procedures are standardized.

4.5 Privately Funded Housing Services

4.5.1 Family Community Housing Project

Providence Alaska has provided funding to create the FCHP.   FCHP assists families with minor dependents experiencing homelessness in Anchorage. Similar to an RRH project, FCHP provides time-limited financial assistance, along with 12 months of case management services.   FCHP takes referrals directly from the Prioritization List based on a VI-SPDAT score of 4-8. Further eligibility criteria for the program includes a Self-Sufficiency Matrix score of 45 or higher.   Referrals to this program are based on the adopted orders of priority, with consideration of additional eligibility criteria.

4.6 Emergency Services.

Currently in Anchorage, no emergency service takes direct referrals from the CE System.   As such, participation in CE is not a requirement to access emergency shelter beds or other emergency services. Households accessing emergency services outside of the CE operating hours are eligible to complete a

Some shelters do, however, use the CE list to identify households who are unsheltered to provide outreach services to fill vacancies.   In these circumstances, if another household were to present at the shelter requesting services, that household's ability to be served would not be contingent upon already having been prioritized through CE.

4.7 Mainstream Resources

At present, resources not required to accept referrals through CE have not opted to do so in a standardized manner. CE assists households in connecting with mainstream resources via referrals through AP staff, or as a result of community case conferencing. CE recognizes that building strong

relationships with mainstream resources is necessary to ensure that households receive all the supports and services necessary to move towards stability and self-sufficiency. CE plans to continue to engage and meet with mainstream resources to explore how a stronger relationship can be built. This manual will be updated upon the formalization of any referral process.

5.0 DATA COLLECTION

Data collection for the CE process is completed by trained assessors from designated APs.   Data is stored within HMIS under the 602 Anchorage Continuum of Care project or under an agency's UNSHARED Anchorage Continuum of Care Project.   The standards and procedures outlined in this section apply only to HMIS data collection as it relates to these specific projects.

5.1 Assessment Data Collection Training

All assessors collecting documentation on behalf of the CE process complete training prior to having HMIS access to Anchorage Continuum of Care projects. Annual trainings are required for continued access to these projects. Some assessors may be required to complete additional trainings throughout the year to ensure compliance with data quality standards. Additional trainings may also be requested by assessors if felt necessary.

Trainings are provided by both TCs and ICA staff.   Trainings completed by TCs focus on CE Policies and Procedures, including the grievance procedures; Assessment administration, including adopted variations for dedicated subpopulations; client confidentiality standards; and uniform decision-making standards adopted by the CoC. ICA trainings emphasize how to use the database and store data within HMIS, including proper protocol for client confidentiality standards.   TC and ICA trainings may occur concurrently or at separate times. If occurring separately, assessors complete both trainings prior to being granted access to the HMIS Anchorage Continuum of Care projects.

The CE Program Manager maintains a comprehensive list of all assessors and date of training completion. It is the responsibility of the Program Manager to track annual update training needs and to communicate these needs to TCs, ICA, and assessors in a timely manner.

5.2 Assessment Collection and HMIS Data Entry

All data collected through the CE assessment process is input and stored in HMIS. In accordance with the CoC, the Anchorage CE System encourages live data entry where possible. In the event that live data entry is not possible, CE assessors input data into HMIS within three (3) business days. Once information is stored in HMIS, CE does not require the retention of hard-copies of assessments; assessment storage and retention rates are at the discretion of the participating agency.   If retained, assessments are to be stored in a locked drawer and are shredded when disposed.

In order to properly collect and store data consistently and to ensure that all individuals are properly placed on the prioritization list, assessors always follow the steps listed below. These steps are consistent for live data entry, and paper assessment. If necessary, further detail on specific steps is available in the How-To Guides on ICA's website.

To note: These steps are only followed for households who are willing share their data with the Anchorage Sharing Group. Households who do not wish to share their data complete the steps in Section 5.2.1 of this manual.

1) Discuss the ROI with the client and obtain a signature. Instructions for obtaining an ROI are found in Section 7.0 of this manual.
2) Under the assessor's parent provider, clients are searched for by name. If the client does not already have an existing HMIS profile, the assessor creates a new profile for the client. If a profile is already in existence for the client, assessors ensure that the profile is shared with the Anchorage Sharing Group.
3) Assessors change their HMIS EDA to the 602 Anchorage Continuum of Care Anchorage to complete a Housing Provider Assessment.
4) Under the 602 EDA, assessors create an "entry" within HMIS.   All data in the entry assessment is completed and updated. Sometimes, data from previous assessments auto-populates into the new CE entry; assessors always re-ask questions that have previous answers to ensure their accuracy. Assessors never skip questions in the assessment, living the "Data Not Collected" option null.   "Client Refused" or "Client Doesn't Know" options are available for use when appropriate.
5) Assessors upload the signed ROI into HMIS in the ROI section of HMIS and track its expiration date. Further instructions for this step are found in Section 7.2 of this manual.

5.2.1 Unshared Records

If a client refuses to have personal data shared with the Anchorage Sharing Group, the client retains the right to be prioritized through the Coordinated Entry List and to be served by Continuum projects.   For this to be completed, assessors follow the steps listed below.

1) Complete the ROI to indicate that client does not want to share their data with the Anchorage Sharing Group.
2) Search for the client by name in HMIS under their parent provider to see if the client has an existing record in the system. If the assessor has access to an <u>unshared</u> client record in HMIS the assessor continues with steps 3-5. If the client has an HMIS ID previously shared in the system or if the assessor cannot find an ID for the client, a new closed record is created. Additionally, if a client has a previously shared record in the system, the assessor also completes the steps found in Section 7.2.5 of this document.
3) Assessors change their EDA access to their agency's unshared CoC project. The name of this project is always the name of the agency followed by UNSHARED Anchorage Continuum of Care Coordinated Entry System. For example, Catholic Social Services assessors have access to a project named Catholic Social Services UNSHARED Anchorage Continuum of Care Coordinated Entry System, while Covenant House assessors have access to Covenant House Alaska UNSHARED Anchorage Continuum of Care Coordinated Entry System.   <u>Assessors never complete a CE HMIS entry under the 602 Provider for an unshared record.</u>
4) Under the unshared EDA, assessors find the unshared client record and create a CE entry within HMIS.   All data in the entry assessment is completed and updated. Sometimes, data from previous assessments auto-populates into the new CE entry; assessors always re-ask questions that have previous answers to ensure their accuracy. Assessors never skip questions in the assessment, leaving the "Data Not Collected" option null.   "Client Refused" or "Client Doesn't Know" options are available for use when appropriate.
6) Assessors upload the ROI in the system, and indicate that the release does not grant permission for sharing in the client's alias field. Further instructions for this step are found in Section 7.2.1 of this manual.

7) Assessors pull regular reports of unshared records and provide deidentified information to TCs for placement on the prioritization list.

5.2.2 Disability Status

In accordance with HUD standards, the Anchorage CE Housing Assessment process does not require the disclosure of any specific disabilities or diagnoses. If, however, a client provides such information the self-report data can be documented in HMIS in the notes section of the HUD Disability Verification.

Housing providers that require the documentation of a specific disability for the purposes of eligibility are responsible for gathering that documentation within the policies and procedures of their own organization.

5.3 Additional Data Entry

It is recognized that the Housing Services Assessment may not produce the entire body of information necessary to determine appropriate client prioritization. As such, there are data points which are collected outside of the Housing Services Assessment.   Some of these additional data points are collected for the purposes of prioritization, while others are used to assist in determining eligibility and appropriate referrals to participating projects.

5.3.1 Additional Layers of Priority

There are often difficulties with self-reporting due to lack of insight or withheld information. Due to this, the Anchorage CoC has adopted additional layers of priority as outlined in Section 3.4.1 of this manual.   These additional layers of priority are meant to be more objective in nature and do not rely on self-report. While some of these additional data points are calculated by information within HMIS, others are data points must be collected from various community partners.

Data points collected from community partners are stored in the CE HMIS entry under an assessment identified by "TCs ONLY" in its title. This assessment may only be updated by a TC, the Program Manager, or another individual specifically designated by the Program Manager. Assessors never update this assessment as it is dependent on information collected outside of the client interview.

5.3.2 Veteran Status and Eligibility

In coordination with the VA, any self-report of veteran status is verified and updated by Transition Coordinators outside of the Initial Assessment and Housing Services Assessment. The VA provides additional information to ascertain a household's eligibility for various projects serving veterans. Eligibility information is updated by TCs under the TCs ONLY assessment within the CE HMIS entry. This information is later used to provide appropriate referrals to projects within the community.

6.0 DEACTIVATION AND REMOVAL FROM LIST

6.1 Deactivation

Households who have not had HMIS activity within 90 days are deactivated from the Prioritization List. This ensures that the prioritization, case conferencing, and referral process remains focused on those in the community who are actively in homeless situation and in need of services. Households are reactivated, without need for reassessment, as soon as new HMIS activity is recorded.   Lists of those who have been deactivated are provided at regular intervals to service providers in the Anchorage Sharing Group who do not enter data into HMIS. This includes, but is not limited to, street outreach, shelters, and drop-in centers. Information on households identified as in contact with these service

providers and still in need of prioritization is provided to the Program Manager. The Program Manager ensures that HMIS activity is recorded for reactivation. Agencies with more stringent confidentiality standards (Ex. DV providers) will inform their clients of reactivation process, and encourage any household who would like to remain prioritized to contact the nearest AP.   Households may remain deactivated for up to one year.

6.2 Removal

Removals from the prioritization list occurs when an exit is provided in association to a household's CE HMIS entry.   HMIS exits for CE are always completed by the Program Manager; no other entity is permitted to complete a CE HMIS exit without prior approval from the Program Manager.   Exits always capture as much data available at the time of removal from the list. CE captures reason for exit, client destination, whether a client was housed through CE, and which agency housed the client, if applicable. Removal from the Prioritization List can happen for a limited number of reasons:

> Housed – removal from the Prioritization List and a cease in prioritization for services occurs whenever a household obtains housing.   Households are removed in this manner whether they are housed through CE, housed through another community resource, or self-resolved.

> Relocation – services available through CE are reserved for households whose primary residence is within the MOA. Households who relocate outside of the community are removed from the Prioritization List.

> Institutionalization – after institutionalization for over 90 days households lose HUD's homeless status. As all services currently connected to traditional CE require literal homelessness as a minimum requirement. Households who lose literal homeless status are removed from the Prioritization List and referred to a PD AP as appropriate.

> Inability to locate – subsequent to four or more weeks of unsuccessful outreach a household is removed from the Prioritization List. Agencies are unable to assist a household that cannot be located and therefore removal from the list occurs.

> Request for Removal – in accordance with a client-centric approach, CE does not require a household to continue participation if the household is no longer interested in being prioritized for services.

> Death – deceased households are removed from the Prioritization List.

> Expired ROIs – upon expiration of a release on information, a household is always closed from the Prioritization List to ensure that client confidentiality standards are upheld.

> Inaccurate ROI – Inaccurate ROIs are considered a data error and communicated back to assessors. Inaccurate ROIs also are a violation of client confidentiality standards which requires the notification of the Privacy Officer located at the assessor's agency.

> Ineligible for CE – ineligibility refers to when a client is ineligible for CE at the point of assessment. Clients closed due to ineligibility are considered data error which is communicated back to TCs and may result in additional training. Clients who are eligible for services at the point of assessment, but later become ineligible for CE are exited for other reasons listed here (ex. Obtained housing).

Duplicate Referrals – duplicate referrals are considered a data error and are communicated back to assessors when they occur. Duplicate referrals are the only circumstance that an entry is deleted entirely from the system. This ensures that the number of households tracked as served through CE is not inflated.

Inactive – households who have remained deactivated for one year or longer are removed from the Prioritization List.

Households are not removed from the list for any reason outside of the above. A household is never removed from the Prioritization List or denied services due to race, color, religion, sex, national origin, disability, familial status, actual or perceived sexual orientation, gender identity, or marital status. Further a household is never removed from the prioritization list due to perceived barriers to housing or severity of service need.

Any household removed from the Prioritization List is always eligible for re-assessment and prioritization by CE, pending minimum eligibility standards are met. There is no limit to the number of times a household may be re-prioritized for services after being exited from the CE list.

7.0 CLIENT CONFIDENTIALITY

7.1 Interagency Data Sharing Agreement

The Interagency Data Sharing Agreement is the data sharing and confidentiality agreement signed by all agencies participating in the Anchorage Sharing Group. The Interagency Data Sharing Agreement allows for participating agencies to share client level data with all other participating agencies in the Anchorage Sharing Group via either HMIS and/or case conferencing. Though many agencies participating in both aspects of this agreement, some agencies only participate in one form of sharing (ex. Participating in community case conferencing meetings without entering data into HMIS). Regardless of the extent of participation, any agency engaged with the Anchorage Sharing Group must have read, agreed to, and signed the Interagency Data Sharing Agreement. This agreement outlines confidentiality standards and requirements approved by the CoC and is accordance with HUD requirements and ICA Policies and Procedures. No agency is permitted to attend case conferencing meetings, nor may they share data with the Anchorage Sharing Group in HMIS prior to signing this agreement. All agencies actively participating in the Anchorage Sharing Group are posted on the ACEH website.

7.2 Release of Information

Prior to a client's information being shared with the Anchorage Sharing Group, a client must first sign the CoC HMIS ROI. This document outlines what information will be shared, how it will be shared, the time-frame associated with the release and the process and conditions of revoking consent. Clients who do not wish for their information to be shared are still prioritized for services through CE; details for these procedures are found in Section 5.2.1 of this document.

7.2.1 ROI Tracking in HMIS

To ensure that all households prioritized through the CE process have provided proper consent, all releases obtained are uploaded into HMIS for storage and tracking. All are ROIs are saved under a CoC-wide naming convention and expiration tracking conventions:

ROI Naming Convention: HMIS ROI, followed by the date (beginning with the year), followed by client initials. For example, if John Doe completed a release of information on January 20th, 2018 his ROI would be saved as follows: **HMIS ROI 2018.01.20 JD.**
ROIs uploaded for client who have not agreed to share their data follow the same naming convention.

Expiration Tracking: An ROI's expiration date is updated in the client's alias field on the client profile.   Updating the expiration date on the client profile ensures that all users with access to the HMIS ID can easily identify if the client has an active release. The expiration convention used in the alias field is similar to the naming convention, however, it does not include the client initials: HMIS ROI, followed by date (beginning with the year) of expiration. If a client has an alias listed in HMIS, the expiration date always comes first and is separated from the client's alias by a semi-colon. For example, if John Doe's ROI expires on January 20th, 2018, and he also an alias of John Smith, his alias field would be populated as follows: **HMIS ROI 2018.01.20; John Smith.**

Indication of No Sharing – If a client chooses not to share their data, this is indicated in the alias field on the client profile.   Updating the alias field in this way ensures that all users with access to the HMIS ID can easily identify if the client has not consented to sharing. The convention used for unshared records is HMIS ROI UNSHARED. If a client has an alias listed in their client profile, the indication of an unshared record always come first and the alias second. The two are separated by a semi colon. For example, if John Doe has an alias of John Smith and he has not consented to sharing, his alias field would be populated as follows: **HMIS ROI UNSHARED; John Smith.**

7.2.2 Guardian Consent for Adults

Assessors always ask whether a client has an appointed guardian when obtaining consent on an ROI. Whether a guardian has been appointed for the client is <u>always</u> indicated on the release. If the yes/no question regarding a guardian is left blank the release is considered invalid and the client's information is not shared.   If a legal guardian has been appointed for an adult client, the guardian must sign the ROI prior to any information regarding the client being shared.

7.2.3 Households with Minors

If a household with a minor presents for services, permission to share and prioritize the minor's information must be obtained from the legal guardian. A minor is not permitted to provide consent for data sharing. In these situations, consent to share both the guardian's and the minor's information is obtained through on release. This occurs by including the minor's name and date of birth on the designated section of the release pertaining to the guardian. In these circumstances, in which consent to share information pertaining to multiple people is obtained through one ROI, the ROI is uploaded into the HMIS profile of every individual to whom the release pertains.   The expiration date is also tracked in the alias field of all affected clients.

Currently, no minors unaccompanied by their legal guardian are prioritized through the Anchorage CE process. Unaccompanied minors experiencing homelessness are referred to the Office of Children Services for intervention. If the Anchorage CE process identifies a way to prioritized unaccompanied minors, this manual will be updated.

7.2.4 Households with Multiple Adults

Each adult in a household always completes an ROI to indicate personal consent. One client may never sign on a behalf of another adult client, unless legal guardianship has been appointed.

7.2.5 Revocation

Clients who agree to data sharing and are prioritized in a shared manner through CE always maintain the right to later revoke this agreement. Revocation results in the shared HMIS CE entry being closed and in all case conferencing of the individual ceasing. Clients who would like to remain in CE but no longer consent to data sharing are reassessed so that information can be transferred from the shared CE project to an unshared CE project. During reassessment, assessors follow the steps laid out in Section 5.2.1 of this manual.

CoC-wide Policies and Procedures for the management of revoked sharing is currently under review. The Anchorage CE System currently follows the procedures outlined in this section. Upon the implementation of a CoC-wide policy, the CE system will adjust the procedures in this section to ensure compliance.

Clients understand at the point of original consent to share that revocation only pertains to future sharing and that any data previously shared within HMIS will remain open to the Anchorage Sharing Group. In these circumstances it is the responsibility of CE to properly communicate to participating agencies that sharing has been revoked and to ensure that no future data is shared through the CE system. After CE communicates a revocation to participating agencies, it is the responsibility of each agency to protect client confidentiality and to ensure that their agency does not enter any further data into the client's shared record.

To ensure proper communication of revocation takes place the steps list below occur. These steps only pertain to the revocation of releases in relation to CE. CE is does not manage the communication surrounding the revocation of sharing by clients who are not prioritized through the CE system.

1) The agency who receives the request for revocation contacts the CE Program Manager within one business day.
2) The Program Manager closes the client's CE HMIS entry to ensure that the client is no longer placed on the shared prioritization list.
3) The Program Manager communicates the revocation to all TCs to ensure that the client is no longer discussed during community case conferencing meetings.
4) The Program Manager communicates the revocation to the agency with whom consent was originally given to ensure that the ROI end date is appropriately updated in the HMIS.
5) The Program Manager indicates "Revoked ROI" in the Alias Field of the client's profile to indicate to all agencies with access to the shared HMIS record that no future data will be added to this record.
6) As necessary, agencies create new, closed HMIS profiles for any future data entry pertaining to the client. Agencies are aware that a new profile needs to be created when "Revoked ROI" is seen in the client's alias field.

8.0 DATA MONITORING

To most effectively prioritize and refer households to services, accurate data regarding the household must be collected. Poor data quality does not allow CE to make informed decisions regarding a household's needs, leading to ineffective referrals. Further, in order to meet the goal of data-driven decision making, the CE System needs to ensure that the data collected through the system is complete

and accurate. As such the CE system has implement quality control measures to monitor data collected. The procedures outlined in this section apply only to HMIS data collected through the CE process.

8.1 Data Quality Control Measures

All new entries being placed on the prioritization list are monitored by TCs for data completeness, accuracy, and appropriate compliance with confidentiality standards.   TCs pull data completeness reports through ICA on a regular basis to review new households placed on the Prioritization List. TCs review the report not only for completeness, but also for accuracy identified by congruence between answers. Any entries found with missing information or incongruent answers are sent back to the original assessors for correction. Assessors are expected to respond to the TC within five (5) business to communicate that errors have been corrected.   If an assessor finds themselves unable to correct the error within the allotted timeframe, the assessor communicates an identified plan to make corrections to the TC.

Failure to communicate back to the TC, or a consistent inability to fully and accurately complete an assessment will result in corrective action through CE. Corrective action may include, but is not limited to, conversations with the assessor's supervisor, required additional training, or a revocation of permission to complete CE assessments resulting in removal of access to the Anchorage Continuum of Care HMIS projects.

8.1.1 Compliance with Client Confidentiality Standards

The Anchorage CE values client confidentiality and takes every measure to ensure that a client's right to privacy is always respected.   In accordance with ICA Policies and Procedures, the Anchorage CE System expects each HMIS participating agency to have a designated Chief Privacy Officer.   The Anchorage CE System works with each agency's Privacy Officer, or a designated point of contact, for each instance an assessor fails to abide by client confidentiality standards.

Concurrent with data completeness and accuracy reviews, TCs also audit records to ensure that client confidentiality standards have been met. If a client record is found without a properly completed ROI, the TC communicates this finding to the Program Manager who follows procedures to closer the CE Entry.   Further, the Program Manager communicates the breach in confidentiality to both the assessor, the Privacy Officer at the assessor's agency. It is expected that the Privacy Office will follow all internal protocols regarding breaches of confidentiality.

Repetitive failure to comply with confidentiality practices will result in corrective action through CE. Corrective action may include, but is not limited to, conversations with the assessor's supervisor, conversations with the assessor's Chief Privacy Officer, required additional training, or removal of access to the Anchorage Continuum of Care HMIS projects resulting in a revocation of permission to complete CE assessments.

9.0 GRIEVANCE PROCEDURES

The Anchorage CE System maintains each household's right to be prioritized for service without discrimination based on race, color, religion, sex, national original, disability, familial status, actual or perceived sexual orientation, gender identity or marital status. The Anchorage CE System also maintains a household's right to file a grievance form if they feel that any of their rights have been violated through the CE System. Grievances may be filed due to reports of discrimination, violation of fair and

equal access, disagreement with prioritization placement or project qualification, or due to general complaints and concerns.

Grievance Forms are available and may be submitted at participating projects. Forms are also available on the ACEH website, and may be submitted directly to ACEH via email. If submitted first to a participating project, the project forwards the submittal to ACEH within two business days. Grievance forms are reviewed by the TC designated to serve the household's subpopulation. If a grievance is regarding a TC it is reviewed by the Program Manager.

Any form submitted regarding disagreement of prioritization placement results in the TC completing a review of the household's CE Housing Services Assessment to ensure all information is accurate and that no errors have been made. A review of Prioritization Policies with the client may also take place. Grievances regarding project-specific eligibility also result in a similar review of the household's project application along with the project's eligibility criteria. A representative from the specific project may also be present if deemed necessary and appropriate. In both these cases, the TC contacts the household within two business days of receiving the grievance to schedule a review.

All other grievances are reviewed by the TC who decides upon any corrective action within the boundaries of the position. A review of the findings will be communicated back to the household, any affected participating projects, and the CE Program Manager within five business days. It is the responsibility of the household to provide an active phone number or message line by which this communication may occur.

If a client remains dissatisfied with the finding of the TC, a request for case conferencing can be submitted. Forms to request case conferencing are located and submitted in the same manner as grievance forms. Grievance case conferencing occur within five business days of the request. Grievance case conferences include a minimum of three separate representatives from three separate participating agencies. The findings of the grievance case conferencing team are reported back to the client within two business days.

All Grievances, Case Conferencing Reviews, and results are submitted to the ACEH Board of Directors by the CE Program Manager via the upcoming CE Board Report.

10.0 MARKETING

The Anchorage CE system makes every effort to ensure individuals in the community experiencing homelessness or a housing crisis are aware of the services provided through CE. The Anchorage CoC markets throughout all communities within the MOA's geographic area. Marketing communicates to potential clients how and where to connect with CE. APs designated to serve specific subpopulations and APs with extra accommodations to communicate with individuals with a disability or Limited English Proficiency are clearly indicated through marketing. Marketing always includes inclusive language and a non-discrimination clause. All participating agencies are expected to advertise their involvement with CE. At minimum, participating agencies post fliers/posters provided by the CoC meeting the requirements listed above.

The Anchorage CE System also works to identify further marketing opportunities to ensure that places the CE clientele frequents also advertise the CE process. This may include bus stops, libraries, businesses, medical facilities, or other identified places.

11.0 ANNUAL EVALUATION

To improve program effectiveness, and to ensure adherence to guiding principles, the Anchorage CE process is committed to the completion of annual evaluations. The specifics of this process remain under review.

Evaluation planning will ensure that all aspects of CE (assessment, prioritization, and referral) will be reviewed with input from both clients and participating agencies. At minimum, evaluation will focus on effectiveness, efficiency, non-discrimination compliance, adherence to guiding principles and protection of client's personal information and privacy. Once established, this manual will be updated to include frequency, and methods of evaluation. Plans to incorporate findings into future CE planning, policies and procedures will also be included.

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