Northeast & St. Louis County Continuum of Care Coordinated Entry Retreat Summary

September 9, 2026

Coordinated Entry Retreat Summary:

Fifty (50) people from the Northeast Minnesota & St. Louis County Continuums of Care gathered at the biannual Coordinated Entry (CE) Retreat on September 9, 2026 at the Clinton Town Hall in Clinton Township, Minnesota.

Participants included representatives from across the homeless response system (outreach workers, CE assessors, housing navigators, emergency shelter staff, homeless programs staff, CE Priority List Managers, CoC Coordinators, etc.) with the shared goal of building collaboration and working together to improve our regionwide homeless response system.

Participants engaged in small group discussions to more clearly define access gaps for specific subpopulations and best practices for connecting people to community resources. Results from these activities will be used to inform systemwide and program improvements as organizations prepare to respond to upcoming requests for proposals (RFPs) for homeless program funding.

Discussion Topic 1: Housing Access Gaps

Activity summary: CE Retreat participants had small group discussions focused on access gaps for specific subpopulations in our homeless response system. Subpopulations included people with behavioral health needs, people with disabilities, older adults, people with criminal backgrounds, youth and young adults, and

Below is a summary of their responses.

1. What Needs Are Showing Up Right Now

Behavioral Health

- Stigma/mental health
- Clients coming from crisis shelters, jail/prison
- Isolation

- Denial of diagnosis
- Medication compliance

Disabilities

- Access issues
- Identifying disabilities
- No elevators / building accessibility
- Documentation requires access to healthcare
- Several appointments
- Timely access to healthcare

Youth & Young Adults

- Students in college needing help (student loan cap)
- More young parents
- Under age 18 in unsafe environments
- Psychological needs
- HRA guidelines for singles (24 and under enrolled in education)

Criminal Backgrounds

- Programs that will take them
- Need more private landlords
- Work that pays a livable wage
- Higher need for more resources

Older Adults

- Home modification
- Access to affordable care
- Reliable transportation
- Prepared meals
- Better access to waiver services
- Adaptive equipment

Families with Children

- Not enough housing for families

- Rent/deposit funds not great enough to cover cost (double deposits, increased rent amounts)
- People coming from other areas thinking lists are shorter
- Not enough income to pay fair market value but too much to qualify for subsidy

2. How People Access Help and What Gets in the Way

Behavioral Health

- Detox/crisis shelters
- Insurance barriers
- Old habits/patterns
- Follow-through challenges
- Friendly faces and case management matter

Disabilities

- 211 referrals
- Need better connection/communication between providers
- “Go to where people are!”
- ER, free clinic, shelters, 211 outreach
- Transportation
- Passed around between counties

Youth & Young Adults

- First contact: drop-in centers, schools, peer-to-peer, law enforcement
- Connected through hospitals, therapists, social workers
- Barriers: contact issues, parents as barriers

Criminal Backgrounds

- Housing 211
- Housing case managers
- Justice North
- Transportation, tenant selection criteria, mental health barriers, childcare

Older Adults

- Hospital or St. Louis County
- Social workers, case managers, senior linkage line

- Barriers: family dynamics, income, health needs

Families with Children

- Show up at shelters and emergency rooms
- Connected through county case managers, CPS, probation officers, treatment
- Barriers: transportation, unrealistic expectations, miscommunication, failure to follow through, declining services, criminal history, mental health, application fees

3. How People Get Connected to Housing

Behavioral Health

- CE assessments
- Background/barriers
- Not knowing how to congregate live

Disabilities

- Timely access issues
- Walk-in diagnostic assessment process holds up paperwork
- Congregate settings not good for walkers/wheelchairs
- Agencies unable to offer needed services
- Connecting to CADI waivers

Youth & Young Adults

- Stuck: lack of youth housing, no cosigners/credit/rental/criminal history
- Parenting youth: no facilities
- Youth uneducated in county processes; lack of trust
- Working: drop-in centers, case conferencing, Soul House/Safe Harbor, direct cash transfer, texting/social media, school connections

Criminal Backgrounds

- 211, HRA
- Barriers: checking mail, phone number changes, appeals, bills

Older Adults

- CE, case managers, in-person interaction
- CADI waivers, time it takes, technology/internet, transportation

Families with Children

- CE/211 working to connect people with case managers
- Stuck due to funding loss, lack of housing, landlords prioritizing short-term rentals
- Not enough income to pay FMR but too much to qualify for subsidy

4. Resources Needed to Get and Stay Stable in Housing

Behavioral Health

- TACT, therapy, ARMHS, Peer Recovery Specialists
- Bus passes, benefits/county

Disabilities

- Barriers show up after housed
- Needs too high (caring for disabled child)
- More than 1-hour supports; inconsistent services
- Fixed income (30% rent burden)
- Don’t want to give up Social Security income

Youth & Young Adults

- Transportation to jobs/appointments
- Off-hour jobs
- Childcare availability
- Access to safe community spaces
- Under-insured
- Working: Go Marti, reproductive health

Criminal Backgrounds

- Transportation
- Case management
- Peer support specialists
- Advocacy

Older Adults

- CADI case managers
- Social services
- Medical transportation

- Disability specialists/employment counselors
- Rides

Families with Children

- Consistent mailing address (critical for follow-through, verifications, and housing opportunities)

5. Partnerships Needed to Improve Access and Stability

Behavioral Health

- Need for case management, crisis providers, behavioral health supports.

Disabilities

- Political will / culture of care
- Healthcare (discharge planning)
- County leadership
- State-funded mobile care medics

Youth & Young Adults

- Connecting landlords to youth
- Funding
- Master lease entity
- Legal age partnerships
- Supports for undocumented youth

Criminal Backgrounds

- MNChoices
- Probation officers
- Landlords
- Honest communication

Older Adults

- Family
- St. Louis County
- Tribal Enrollment
- MAC-V
- Social workers and case managers advocating at the state level

Families with Children

- Increased funding (state and federal)
- Volunteer programs
- Access to public health nurses and professional resources

6. Cross-Cutting Themes Across All Subpopulations

Across all six groups, providers consistently named:

- Transportation barriers
- Documentation and healthcare access delays
- Limited housing stock (especially 1-bedrooms, youth housing, and family units)
- Not enough income to pay FMR but too much to qualify for subsidy
- Need for stronger cross-agency communication
- Trust issues and difficulty navigating county systems
- Technology barriers (phones, internet, checking mail)
- Waitlists and slow processes
- Need for more private landlords and flexible tenant selection criteria
- Importance of warm handoffs, case management, and friendly faces

Discussion Topic 2: Community Resources

Activity summary: CE Retreat participants had small group discussions focused on how they connect people to community resources, what's effective, and what needs improvement. A summary of those discussions is below.

How providers connect people to community resources:

Overall, participants described using a hands-on, relationship-based approach to connecting people with community resources. Common practices include:

- **Direct support and warm handoffs:** Calling providers with clients, calling on behalf of clients, attending appointments, helping complete applications, walking through eligibility and documentation requirements, and making sure clients know to call their case manager/outreach worker/assessor back after attempting to connect to a resource so they don't get lost in the process.
- **Meeting people where they are:** Outreach, meeting clients in the community, removing transportation barriers, and helping navigate systems step-by-step.
- **Transportation solutions:** Providing rides when possible, helping clients access transportation options, Go Marti (Grand Rapids).
- **Resource navigation and education:** Goal planning, helping clients understand processes, educating about eligibility, and providing guidance on what to expect.
- **Tools and materials:** Landlord lists, housing applications, mental health resources, Ready to Rent lists, printed handouts, QR codes, and any resource lists relevant to the client's needs and situation.
- **Connecting to basic needs:** Food shelves, clothing, hygiene items, WIC, primary care and dental care, government benefits, and referrals to trusted organizations.
- **Networking and collaboration:** Case consultation, SSP meetings, interagency referrals, weekly CE meetings, and maintaining strong relationships with partner organizations.

How providers find out about resources:

Participants often utilize tools such as 211, county websites, Resourceful, HB101, other organizations (e.g. YMCA, CAP agencies, Salvation Army, United Way), and peer networks. They also learn through:

- Networking with coworkers and community partners
- Meetings (Case conferencing, Self-sufficiency coalition, CoC meetings)
- Events (Trainings, retreats like this ☺, Community connect events, community events, resource fairs)
- Trainings
- Word of mouth
- Online searches

- Networking with other agencies
- County Departments – OMG we **miss** triage @ SLC!

Gaps identified included:

- Eligibility criteria and intake processes
- Turnover leading to loss of institutional knowledge
- Limited awareness of resources outside one's immediate service area
- Lack of a comprehensive, up-to-date community directory
- Inconsistent information sharing with new staff
- Outdated landlord lists
- Limited understanding of non-housing resources
- Youth not knowing what exists or how to access it

Some participants suggested that it would be helpful to create a resource list for the entire Northeast region.

Mismatch between available resources and what people need:

- **Mental health services:** Long waitlists, limited access despite advertised availability, ARMHS waitlists and not enough ARMHS workers to meet the need, and services not being utilized.
- **Housing:** Shortage of 1-bedroom units, long waitlists, limited shelter options, limited warming shelters, and lack of alternative options when clients are evicted from or burn bridges with an agency.
- **County systems:** Difficulty reaching staff, inconsistent guidance, being referred to the wrong department, lack of in-person access, challenges obtaining verifications, voicemail-only foster care lines, paperwork burdens.
- **Transportation and hours of operation:** Food shelves and services open only during work hours; mobile food banks with limited hours; rural transportation barriers.
- **Documentation and benefits:** HRA verification issues, benefits eligibility confusion, "benefits cliff" prevents people from increasing their income, insurance barriers, and lack of ID assistance.
- **General access issues:** After-hours needs, lack of warming shelters, limited outreach, clients struggling to follow through, frustration with long processes (youth), lack of phones or minutes, legal help through Justice North isn't enough to meet people's needs.
- **Level of care:** There are people who have a higher level of care than the services that are available.

How to reduce duplication and avoid sending people in circles:

Participants emphasized that duplication happens when communication breaks down. Strategies that work include:

- **Warm handoffs and clear communication:** Calling with clients, documenting what has already been tried, and giving clients direct contact information.

- **Case conferencing and shared information:** Case consultation meetings, SSP meetings, and up-to-date HMIS documentation so others can see what people have already done or tried to do.
- **Better coordination with county and partner agencies**: Clear steps for resolution, improved communication, and knowing partner resources before making referrals.
- **Centralized or unified information:** A central information center, shared resource lists, and consistent language across agencies.
- **Releases of information and cross-agency collaboration:** Allowing providers to work together more effectively. Providers collaborating with each other to take the burden off of clients and helping to connect the dots.
- **Staffing and capacity:** More navigators, increased salaries, reduced caseloads, and funding for long-term services.

What resources or supports do you wish people knew more about?

- Employment supports
- Food resources
- United Way
- Personal hygiene resources
- Insurance helpers
- Youth-specific healthcare apps
- County benefits (including what they *can't* do)
- ARMHS and mental health services
- Foster care supports
- Resourceful (Aunt Bertha)
- Go Marti
- Free clinics
- Recovery meetings
- Housing education and required documentation
- Priority List Manager / CE processes
- MAC-V (veteran supports)
- Tribal and urban offices
- Rental assistance programs, including help resolving HRA debts
- Peer support specialists and community health workers
- Non-housing resources for people who may not meet housing program eligibility or who need more supports