HUD's

HOMELESS ASSISTANCE PROGRAMS

Demonstrating the Uses of Homeless Data at the Local Level:

Case Studies From Nine Communities

September 2007

Office of Community Planning and Development
U.S. Department of Housing and Urban Development

ACKNOWLEDGEMENTS

This document was prepared by Cloudburst Consulting Group, Inc. for the U.S. Department of Housing and Urban Development (HUD) Office of Special Needs Assistance Programs in the office of Community Planning and Development. The primary authors of this document are Michelle Hayes, Karen DeBlasio, Kathleen Freeman, and Kristen Rynning. The authors acknowledge the following individuals: Wendy Sandoz, editor, Dianne Burbank, graphic designer, and Jon-Paul Oliva, GIS analyst.

The authors appreciate the contributions of each community that responded to the request for proposals for the Advanced Data Users Meeting and are grateful to each meeting participant identified below for the presentation materials and reviews of the final case studies they provided. These participants include:

- Barbara Ritter, Michigan Coalition Against Homelessness, Lansing, MI
- Brian Johnson, Hawaii Public Housing Authority and Marika Ripke, University of Hawaii at Manoa
- Michael Shank, Virginia Department of Mental Health, Mental Retardation, and Substance Abuse; and Evan Scully, Homeward, Richmond, VA
- Rockelle Rogers, Family Health Center, Inc. and Melissa Pociask, Housing Resources, Inc., Kalamazoo, MI
- Craig Helmstetter, Wilder Research; and Jamey Burden, Minnesota Housing Finance Agency
- Antoinette Tripplet, City of St. Louis Dept of Human Services; and Deb Little, Municipal Information Systems (MISI), St. Louis, MO
- Michelle Budzek and Molly McEvilley, The Partnership Center, Ltd., Cincinnati, OH:
- Darlene Mathews, The Community Partnership, Washington, D.C
- Kevin Breazeale and Matt Berg, City of Philadelphia Office of Supporting Housing, Philadelphia, PA

The authors are indebted to the Continuum of Care (CoC) coordinators, homeless service providers, and persons served in the numerous homeless programs that contribute daily to promote better understanding of the extent and nature of homelessness in their communities.

Demonstrating the Uses of Homeless Data at the Local Level – Case Studies from Nine Communities

HUD's Office of Special Needs Assistance Programs (SNAPs) recognizes that many communities across the country have Homeless Management Information Systems (HMIS), which have been operational for years and have amassed reliable, high-quality program and system-level data. These communities have been at the forefront of developing innovative ways to use these data to make local CoC and homeless programming decisions. Localized data offers communities a powerful tool to make informed management decisions on resource allocation. With a continued emphasis on HMIS implementation, coupled with increased attention on data quality, many communities are transitioning to broader system-level data uses. The best practices provided here will help communities determine how best to analyze the data they are collecting.

In April 2007, HUD convened the Advanced Homeless Data Users Meeting (Data Users Meeting), to gather forward-thinking and innovative HMIS and CoC professionals from across the country. The meeting prompted a dialogue among these communities with proven, local examples of ways to use homeless-related data generated from analyses of HMIS and/or a combination of HMIS and other data sources and technologies. Participants included local CoC HMIS administrators, researchers, solutions providers, national technical assistance providers, and HUD headquarters staff.

Presenters for the Data Users Meeting were selected via a competitive process. HUD released a Request for Proposals asking communities currently using HMIS data in advanced ways to submit a brief description for consideration. Individuals from nine communities were selected to present at the meeting. The case studies presented in this document demonstrate some of the best practices from around the country for using HMIS data for larger, system-wide decision making. The studies are grouped together by topical area as follows:

Demonstrating the Potential of Aggregate Homeless Reporting

The States of Michigan and Hawaii utilize HMIS data to produce statewide reports documenting characteristics of homeless clients in each state. The *Baseline Data Report from the State of Michigan* is the state's first major publication based on approximately six months of data collected from more than 350 shelters, outreach programs, supportive housing programs, and other homeless service providers. The Hawaii report presents data gathered from clients served by the shelter stipend and outreach programs via the Hawaii State

Homeless Management Information System. The *Homeless Service Utilization Report* is the first of its kind and was developed through a partnership with the University of Hawaii at Manoa. The included case studies highlight these two communities' inaugural efforts to better understand the extent and nature of homelessness in their state. Detailed information on the production of these reports including data analysis methods and the reports' impact in each state is discussed.

Linkages of Homeless with Mainstream Systems

Connecting clients served by homeless programs with the necessary services and resources available from mainstream systems including health and mental health care is the cornerstone of facilitating a client's movement toward a more stable living situation. Merging data collected from homeless and other mainstream systems helps to better link these systems. Two case studies from Richmond, VA, and Kalamazoo, MI, highlight the links between homeless and healthcare information systems to better understand service needs, use patterns, and cost when clients access multiple service sectors. These case studies demonstrate how successful collaboration between the homeless, healthcare, substance abuse, and mental health sectors can inform program development and policy making through data matching.

Assessing Effectiveness of Homeless Prevention

Preventing an individual or family from ever entering the homeless system is a key component of many communities' local plans to end homelessness. Ramsey County, MN, established a pilot project to determine if clients receiving homeless prevention services are able to maintain their housing and not enter the shelter system. Data on each client served by the prevention program is entered into the county's HMIS and this data was used to evaluate the effectiveness of the prevention program. Specifically, the data was used to assess if any of the clients receiving prevention services later were captured in the HMIS in other shelter or housing programs. This case study presents Ramsey County's evaluation methodology, analysis strategies, and findings, and discusses the evaluation's impact on the prevention program.

Maximizing Benefits for Clients and Programs

The ultimate goal of any social service program is to assist clients in meeting their needs by maximizing access to beneficial services. Streamlined access to services for homeless clients is realized by both Cincinnati, OH, and St. Louis, MO, by automating benefit eligibility assessments. Both communities are able to help their clients access services more quickly — Cincinnati through automating the homeless certification process, and St. Louis through electronic benefits eligibility. Case studies on each of these communities highlight the local planning efforts, processes, and results of their local automation processes.

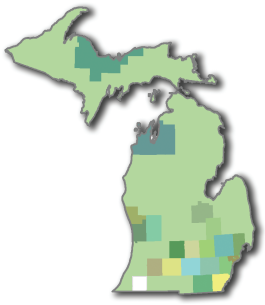
Modeling Performance of Programs

A benefit of collecting longitudinal data on those served throughout the homeless service system is the ability to evaluate program and system-level effectiveness, which in turn can inform local policy decisions and resource allocation. In Washington, DC, the community implemented a Continuum-wide performance measurement system in their local HMIS to monitor program outcomes, expand system reporting capabilities, and improve the validity of data analysis results. Philadelphia, like DC facilitates service coordination and results accountability through broad-based electronic coordinated case planning. This collaborative process, adapted from a proven outcome measurement indicators initiative, enables each community to evaluate the effectiveness of each program and system-level performance. The DC and Philadelphia case studies discuss the local methodology used to move from reporting outputs to a performance-driven reporting system.

Each of the case studies demonstrates how communities use HMIS to more fully understand the extent and nature of homelessness in their own community. As HUD and many other agencies move towards funding data-driven resource planning and effective program models, locally administered HMIS are becoming an increasingly important community resource.

Electronic versions of the case studies are available at www.HMIS.info. HUD encourages each CoC to maximize the usefulness of HMIS beyond simply meeting HUD reporting requirements, and will continue to develop best practice case studies as models for other communities. Readers are further encouraged to model local practices on some of the methodologies discussed herein and reach out to those persons listed in each case study should they have additional inquiries.

The State of Homelessness in Michigan



Many communities across the country continue to struggle with a lack of accurate data on homelessness in their region. Without the necessary data to paint the picture of who is homeless, what services they use, and most importantly what services they need, it is difficult to plan, strategize, and prioritize the allocation of staff, funding, and community resources. The state of Michigan recently took a big step toward addressing this issue by publishing the first ever baseline data report on homelessness.[2] The goal of the baseline report was twofold: to educate the homeless services community and general public, and to serve as a tool for legislators. The report is the first major publication based on approximately six months of statewide Homeless Management Information System (HMIS) data collection. It underpinned the statewide launch of Michigan's 10 Year Plan to End Homelessness.

Homelessness in Michigan

- Population[1]:
  10,095,643
  81% urban
  19% rural
- Annual Estimate:
  79,000

Baseline Data Report

Currently there are more than 350 agencies participating in the Michigan HMIS (MSHMIS). Of those, 250 are required to participate through Emergency Shelter Grant (ESG) contract requirements and must sign off on the accuracy of data entered quarterly. Client data entered into MSHMIS is driven by a consent process, which prohibits record sharing between agencies unless the data has been specifically requested by a caseworker and client consent has been obtained.

Figures for the report were based solely on records entered into MSHMIS that contained known information. Any records that included "null" values or were listed as "unknown" were not included. The report provides population and demographic information on persons experiencing homelessness on a regional and statewide level shows distinct differences between individuals and families experiencing homelessness, including:

- Single mothers with children are the fastest growing subpopulation.
- Fifty-six percent of homeless persons in families are children, most of which are under the age of 10.
- One-third of families are "working poor," while 41 percent of homeless individuals had no income at the time they were entered into the HMIS system.

[1] 2006 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

[2] For a full coy of the report visit: http://www.mihomeless.org/Homeless%20Summit%20Report.pdf

Comparative data was generated to allow advocates, policy makers, and the public to compare the characteristics of the various subpopulations of the homeless. A sample table from the report is included below:

CROSS POPULATION COMPARISON TABLE

Adult Characteristics	Families	Singles	Chronic	Overall Homeless	At-Risk
Single Female Head of HH	59%	NA	NA	NA	37%
Two Parent HH	16%	NA	NA	NA	35%
Employed at Intake	32%	18%	15%	24%	38%
Documented Eviction	33%	15%	10%	23%	36%
Average Income (at intake)	$867.06	$452.90	$395.50	$592.99	$819.33
Monthly Income Less than $500	36%	69%	75%	59%	37%
Presence of Disability of Long Duration	19%	62%	100%	46%	22%
First Time Homeless	56%	39%	0%	46%	NA
1 or 2 Times Homeless in Past	34%	36%	0%	35%	NA
Homeless Multiple Times and/or Long Duration	10%	27%	100%	21%	NA
GED or High School Diploma (No College)	39%	43%	41%	41%	17%
At Least Some College of Technical School	25%	23%	22%	24%	25%
Reported They Were Veterans	4%	12%	14%	9%	5%

What the Report is NOT

Michigan HMIS staff decided to produce and publish the report knowing they had neither multiple years' worth of data, nor 100 percent of their service providers entering data into the HMIS. The report is NOT a full picture of homelessness in the state of Michigan. While the report does provide an estimate of number of individuals experiencing homelessness in the state, it does NOT attempt to determine homeless prevalence rates. These things will all come in time as the data improve and the number of providers using the system increases.

While the report's authors acknowledge these issues, they also explain that they published the report in an attempt to "inform the public and set the stage for change." Perhaps this will set the stage not only in Michigan, but in other communities across the country. After all, some data is better than no data at all. Communities waiting for higher-quality data or better HMIS coverage before they analyze the data, risk the possibility that their data will never be used for anything more than required reporting.

Impact

Although recently released, the report has been the basis for a number of improvements and changes to the service delivery system in the state of Michigan. Since publication of the report:

- Data entry in the rural Continuum of Care (CoC) systems more than doubled.
- Multiple CoCs are publishing their own version of the report.
- Thirteen new agencies have joined the statewide implementation.
- Linkages have been strengthened with other State agencies. The Department of Human Services (DHS) and the Department of Community Health (DCH) have signed pledges to end homelessness.
- The commitment to use the data to support advocacy and planning has been kept. Leadership has promised that the HMIS would not be a "black hole" where data disappeared never to return. Further, the graphs and tables used in the statewide report may be populated for any agency or CoC at the touch of a button allowing localities to compare themselves to state trends.

In addition to the benefits already recognized, MSHMIS staff believes more anticipated benefits will be recognized in the future including:

- Overall improved data quality. Providers realize that the information entered into the System will be useful to agencies, continuums, and the State in addressing the needs of homeless persons.
- Increased utilization by more communities/providers will result in accurate and stable estimates.
- With close to full participation, changes seen in the data will accurately reflect changes in the homeless population.
- A defined picture of rural homelessness.
- Ethnicity data that is accurate and reflects the whole state.
- Accurate data on children experiencing homelessness.
- Mature data with actual numbers for calculation of care system uses and burdens across health, emergency services, jail, etc.

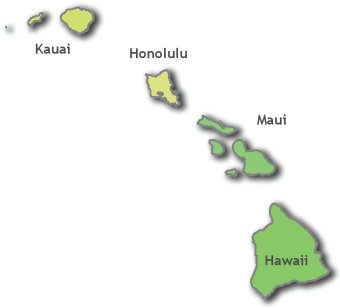
"We are finding there are homeless individuals and families in every part of the state. Our response must be delivered in the same manner."

–S. Harrison, Director, Office of Supportive Housing and Homeless Initiatives, Michigan State Housing Development Authority (MSHDA)

For More Information, Contact:

Barbara Ritter
Project Director
MI Coalition Against Homeless
106 South Washington Square, Suite 300
Lansing, MI 48933
britter@mihomeless.org

Homeless in Hawaii- From the Streets to Camps to the Shelter System



Like many other HMIS professionals, staff from the Hawaii Public Housing Authority (HPHA) knew they had valid, reliable data available in the HMIS, but were unsure how best to use it. Through a strategic partnership with the University of Hawaii at Manoa, they created the first-ever statewide report on homelessness and found that every day, more than 6,000 men, women, and children in the state of Hawaii are homeless.

Homelessness in Hawaii

- Population[1]: 1,285,498
  71% urban
  29% rural
- Homeless Point in Time Count as of 1/07: 6,061
- Annual Estimate: 18,624

Hawaii's Homeless Service Utilization Report

The *Homeless Service Utilization Report*[2] (Utilization Report) was published during Hawaii's Homeless Awareness Week in November 2006. The primary intent of the report was to enable state- and county-level policy makers, program managers, and advocates to better understand the individuals and families who use federal- and state-funded homeless services. Data from this report has helped improve plans to end homelessness and educated the local community about: How many people use services annually? What are the needs of those served? Have new initiatives resulted in measurable changes? A sample chart from the report is shown on the next page.

The report produced following a Memorandum of Understanding (MOU) between the HPHA and the Center on the Family at the University of Hawaii at Manoa, provides a snapshot of the homeless population in Hawaii. The report dispels some of the myths that often surround the public perception of homelessness in Hawaii, including homeless persons are unemployed, most come from the mainland, most are mentally ill, and are lazy and do not want to work. In contrast, the analysis found that of those served:

- 58% of those that received shelter services were male.
- 33% were children aged 17 or younger, and children under 5 comprised 13%.
- 56 % were either long-term Hawaii residents or lifetime residents, while 20% had lived in Hawaii for one year or less.
- 78% were high school graduates or the equivalent (GED), including 7% who had earned a college degree.
- 77% of households were single individuals or couples with no children. 89% of single-parent households were headed by a female adult.
- Prior to shelter entry, 44% of households were living unsheltered and 29% were living in institutional settings (e.g. prisons or hospitals).
- 27% reported being homeless for less than a month, almost half reported being homeless for one to 11 months, and 26% reported being homeless for a year or longer.

"We had all this data and we weren't using it to make CoC plans and decisions."

–Brian Johnson- Hawaii State HMIS Manager

[1] 2006 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

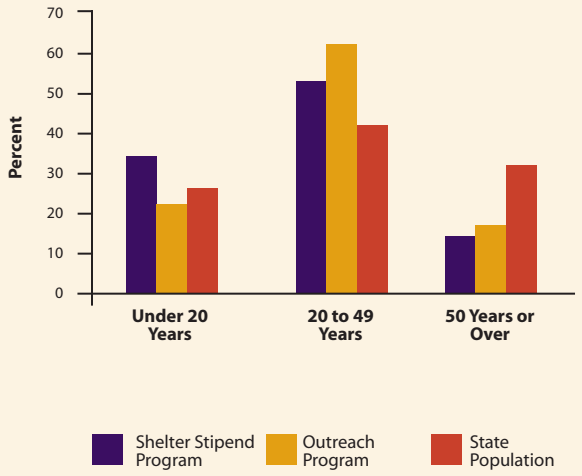
[2] For a full copy of the report visit: http://uhfamily.hawaii.edu/publications/brochures/HomelessServiceUtilization2006.pdf

The tables presented below illustrate how staff were able to analyze and present HMIS data in a useful format.

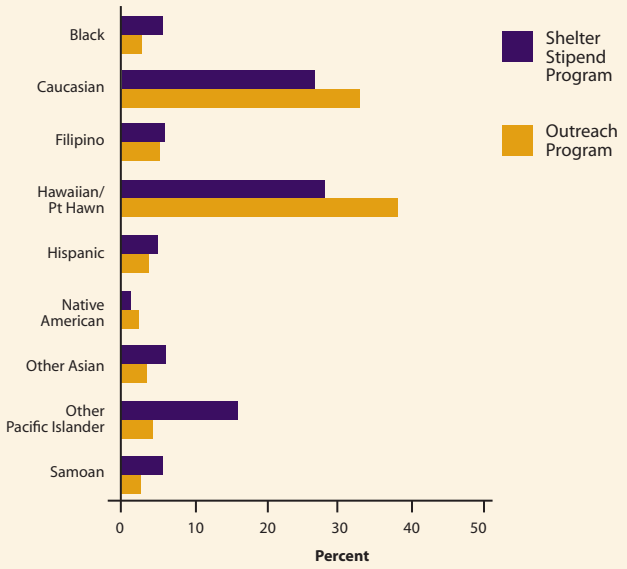
CROSS POPULATION COMPARISON TABLE

	Hawai`i County		Kaua`i County		Maui County		C&C of Honolulu		State	
	#	%	#	%	#	%	#	%	#	%
Foster Care History										
Yes	25	9%	0	0%	103	14%	215	8%	343	9%
No	262	91%	32	100%	652	86%	2451	92%	3397	91%
Total	287	100%	32	100%	755	100%	2666	100%	3740	100%
Veteran Status										
Yes	15	5%	1	3%	63	8%	388	14%	467	12%
No	276	95%	31	97%	693	92%	2328	86%	3328	88%
Total	291	100%	32	100%	756	100%	2716	100%	3795	100%
Hawai`i Residence										
1 year or less	48	17%	5	16%	145	19%	553	21%	751	20%
More than 1 year, less than 10 years	69	25%	5	16%	161	21%	636	24%	871	24%
10 years or more	159	58%	21	68%	444	59%	1459	55%	2083	56%
Total	276	100%	31	100%	750	100%	2648	100%	3705	100%
Labor Force Participation										
Not in labor force/ unemployed	215	75%	12	38%	450	60%	2009	75%	2686	72%
Part-time employment	23	8%	8	25%	98	13%	287	11%	416	11%
Full-time employment	49	17%	12	38%	204	27%	372	14%	637	17%
Total	287	100%	32	100%	752	100%	2668	100%	3739	100%
Educational Attainment										
Less than high school	64	24%	8	29%	159	22%	575	22%	806	22%
High school diploma or GED	139	52%	10	36%	353	48%	1294	49%	1796	49%
Some college	51	19%	10	36%	147	20%	585	22%	793	22%
College degree or more	13	5%	0	0%	69	9%	165	6%	247	7%
Total	267	100%	28	100%	728	100%	2619	100%	3642	100%

Ages of Individuals Served by Shelter Stipend Programs and Outreach Programs Compared to State Population



Ethnicity if Individuals Served by Shelter Stipend Programs and Outreach Programs



Impact

Although the Utilization Report was the first of its kind, the housing authority HPHA has already realized enormous benefits they attribute to the published report, including:

- Increased funding – Funding for the HPHA's homeless services budget was doubled following release of the statewide utilization report.
- The planning and resource allocation process has been revised to reflect a better understanding of the homeless population as promoted by the report.
- Data collection methods on special populations — such as children and special-needs adults — are being altered to promote access to more comprehensive, useful data.

This is just the beginning of the benefits HPHA staff anticipate to come out of the better understanding the Utilization Report provides policy makers, service providers, and the general public. They plan to produce this report annually in partnership with the University of Hawaii's Center on the Family.

For More Information:

Brian Johnson
Hawaii State HMIS Manager
Hawaii Public Housing Authority
1002 N. School St.
Honolulu, HI 96817
808-832-5930
Brian.johnson@hcdch.hawaii.gov

Marika Ripke
Project Director
University of Hawaii at Manoa
2515 Campus Rd. Miller Hall 103
Honolulu, HI 96822
808-956-4132
marika@hawaii.edu

Linking Homeless and Mainstream Data Systems for Cost Avoidance Analysis

What is the utilization and cost of providing inpatient psychiatric and healthcare services to homeless adults in the Richmond/Henrico/Chesterfield/ Hanover Counties CoC?

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (VDMHMRSAS) partnered with the local HMIS administering organization, Homeward, to assess cost of inpatient psychiatric services for persons who are homeless with mental health disabilities. Homeward implements HelpNet, a central intake web-based case management system that documents bed availability and usage for clients served for over 40 local homeless programs. Minimal data from Helpnet (de-identified client and enrollment date) was merged with local psychiatric hospital and other data to determine the cost of inpatient care for a homeless adult with psychiatric disabilities and the costs that could be offset by utilizing a housing first approach to intervene with clients prior to hospital admission.

Using a sophisticated analytic strategy, data on 7,649 adults who sought homeless services from 2003 through June 2006 from Helpnet Homeless Community Information Systems (HCIS) were merged with inpatient hospital utilization data from 2001 through March 2006 from the Virginia Health Information Database (VHI) and the VDMHMRSAS Community Consumer Submission (CCS) database. Prior to merging client records, memoranda of understanding guiding the uses and disclosures of client information were put in place. Local policy analysts matched client records using social security numbers, which were "hashed" through an algorithm to produce a unique, but anonymous, client identifier.

DATA SOURCES		
HCIS	7,649 Richmond-area individuals enrolled in homeless services[2]	- Demographics - Dates of enrollment
VHI	231,275 Richmond-area individuals in inpatient hospital care (21,225 in inpatient psyhicatric care)	- Demographics - Dates of enrollment - Diagnosis
CCS	33,507 people enrolled Richmond-Area Behavioral Healthcare (MH and SA services)	- Demographics - Dates of enrollment - Diagnosis

Data from several studies using the data sources listed above is presented in this document

Homelessness in Richmond/ Henrico/ Chesterfield/ Hanover Counties CoC

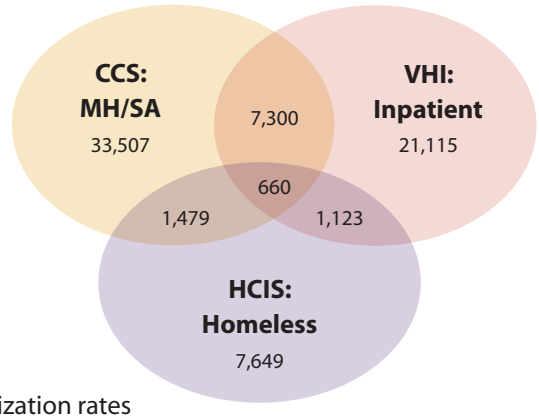
- Population[1]: 882,155: 84% urban 16% rural
- Homeless Point in Time Count as of Jan 25, 2007: 1,158 shelter and 149 unsheltered
- Annual estimate 4,600-6,900

[1] 2006 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

[2] HCIC: 9,218 records less 1,439 missing or invalid SSNs less 130 duplicate entries (from 1/1/03 to 6/30/06)

The "Revolving Door" Phenomena

Of the homeless with inpatient stays, they were most likely to be hospitalized for mental health issues followed by substance abuse, respiratory illness, trauma and infections. Most (54%) had an average of less than 2 admissions each during this three-year period. A small proportion (17%), however, averaged more than 10 admissions each and accounted for 44% of the total number of admissions among all the HelpNet patients (see below).

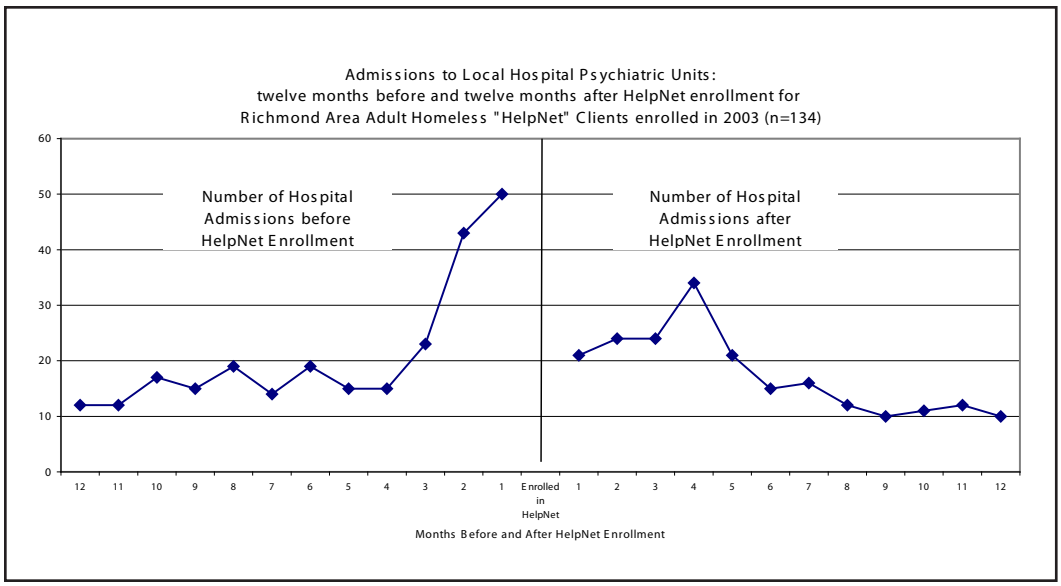


Further review of homeless clients' hospital usage found higher hospitalization rates immediately precede and follow enrollment in homeless services. A very similar pattern is found for the subset of clients (n=49) for whom the post-enrollment admissions were actually readmissions to the hospitals' psychiatric wards. In fact, their utilization made up the bulk of total admissions (72% pre-enrollment and 67% post-enrollment). The statistics for homeless individuals in the greater-Richmond area are even worse. The utilization rate of inpatient psychiatric care by the entire cohort of HelpNet adults is twenty times that of the general population, resulting in huge costs for inpatient care for homeless clients.

This "revolving door" phenomenon of repeated hospital admissions reveals psychiatric healthcare needs that are not being met in the community. For these individuals, homelessness may be both a contributing cause and the resulting consequence of these recurring hospitalizations.

HELPNET CLIENT HOSPITAL ADMISSION RATES

HelpNet Patients admitted 2002-2004	N	% of Clients	Average # of Admissions	Total Admissions	% of Admissions
HelpNet patients admitted in 1 of 3 years	289	54%	1.69	491	22%
HelpNet patients admitted in 2 of 3 years	159	29%	4.63	737	34%
HelpNet patients admitted in 3 of 3 years	93	17%	10.34	962	44%
Total HelpNet Patients	**541**	**100%**	**4.05**	**2,190**	**100%**



Cost Analysis

Five hundred forty one (18%) of these adults were found to have a total of 2,190 psychiatric admissions during this period at an estimated cost in excess of $8 million (and over $3.5 million in 2004 alone). On average, roughly $9,000 is spent for each of these homeless adults to spend 15 days per year in psychiatric units of local hospitals. For a subset (29%) that have three or more admissions in a year's time, that average cost rises to $21,000. A supportive housing model designed for these individuals is described as an alternative to this costly "revolving door" system of care. This study strongly suggests that funds currently supporting the repeated rehospitalization of homeless adults with mental illness could be much more wisely invested in providing them with permanent housing and supportive services.

Limitations

The greater-Richmond community has made significant efforts to better coordinate services for its homeless residents, and the HelpNet database has, for the first time, allowed the review of overlapping caseloads in the larger services system. While this study utilized enrollment into HelpNet as documentation of a homeless episode, it is unknown whether the enrollment date signifies a first episode or simply an administrative intake of persons already homeless. Caution should therefore be used in interpreting the relationship between inpatient events and initial entry into homelessness.

As both HelpNet and VHI are administrative databases, data entry mistakes may limit the accuracy of the findings. Limitations may also include the absence of additional homeless persons not enrolled into HelpNet, or incorrect data that prohibited matching with VHI hospital records. While efforts were made to insure correct record matching (such as age, race, and gender in addition to the unique identifier), matching administrative data sets may also produce some false positives.

Reallocation of Resources

Regardless of the limitations discussed above, the data demonstrate that a significant number of homeless adults in the greater-Richmond area are not receiving the community mental health care they need to avoid rehospitalizations. The likely result is extended or repeated episodes of homelessness punctuated by costly episodes of inpatient hospital stays. Homeward, the Virginia InterAgency Council on Homelessness (VIACH), Virginia Supportive Housing, and a number of partners from the public and private sectors have proposed an alternative approach based on successful *housing-first* models of supported housing demonstrated in San Francisco, New York, and Washington, DC.

Planning has been initiated and funds are being sought for a *housing-first* program in the Richmond area for 40-60 homeless adults who frequently utilize hospitals and other community resources. In collaboration with Homeward, VIACH, and a broad representation of private and public sector partners, VSH is coordinating a housing-first program in Richmond that combines the housing models of Direct Access to Housing (DAH) and Pathways and provides the intensive services of the Program for Assertive Community Treatment. This supportive housing program is estimated to cost less than what is currently being spent for this population's inpatient psychiatric care alone.

This project demonstrates how a successful collaboration between the homeless, healthcare, substance abuse and mental health sectors can inform program development and policy making through data matching. Minimal data from the HMIS (consumer and enrollment data) was compared with local psychiatric hospital and other data to determine the amount of money spent each year for a homeless adult with psychiatric disabilities, the number of days spent in local hospitals and the costs that could be offset by utilizing a housing first approach to intervene before clients were admitted to the hospital.

For more information contact:

Evan Scully
HCIS Director, Homeward
408 West Franklin St.
PO Box 5347
Richmond, VA 23220
804-343-2045 x18
Escully@homewardva.org

Michael Shank
Community Support Services
Virginia Depart of MH, MR, and SA
PO Box 1797
Richmond, VA 23218
804-371-2480
Michael.shank@co.dmhmrsas.virginia.gov

Using Homeless Data Systems in HealthCare and Human Service Agencies

Homeless services staff in Portage/Kalamazoo City and County CoC in Michigan recently integrated their local homeless data into the statewide Homeless Management Information System (HMIS). Client data is entered into the HMIS to generate an accurate picture of the homeless population in Kalamazoo for Continuum of Care (CoC) planners and policy makers as part of Michigan's 10 Year Plan to End Homelessness. The local healthcare provider, who provides emergency and prescription assistance to homeless clients is now contributing data to the Michigan HMIS. The Family Health Center, a federally qualified health center (FQHC)[2] , is a "safety net" provider whose purpose is to enhance primary medical care for underserved populations. This case study presents information about implementing HMIS in a FQHC.

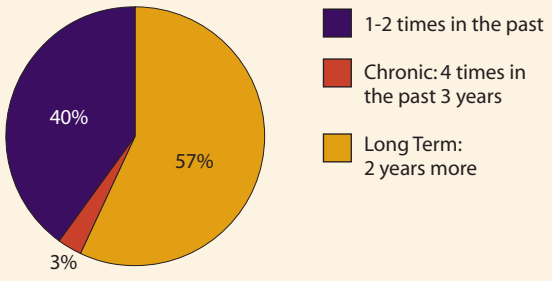
Homelessness in Portage/ Kalamazoo City and County CoC

- Population[1]: 358,117 80% Urban 20% Rural
- Homeless Point in Time Count as of 1/07: 614 Individuals

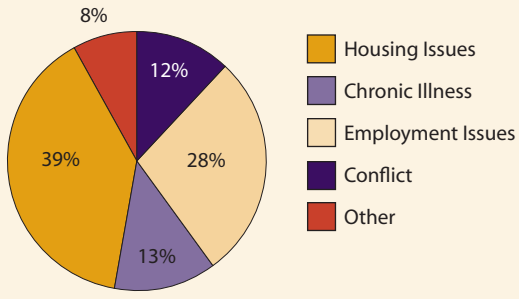
Using HMIS in the Family Health Center

The primary reason for implementing Michigan's HMIS in the Family Health Center is to enable staff administering the Emergency Prescription Assistance Program (EPAP) to quickly determine other community services that might be accessed simultaneously by the client. The EPAP, which is funded locally by the United Way, provides medical assistance to clients who do not have a primary care doctor and are in need of an emergency prescription. Many clients of the EPAP program might not currently be experiencing homelessness at the time they utilize this program, but might be at risk of becoming homeless or might be in an unstable housing situation. For those that are homeless, staff administering the EPAP can inquire about the extent and reason for homelessness (as displayed below), and use the HMIS to understand the array of other agencies and services the client might need.

EXTENT OF HOMELESSNESS



REASON FOR HOMELESSNESS

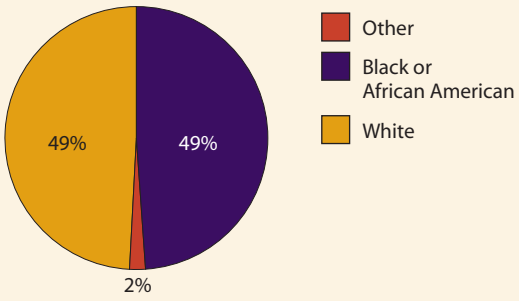


[1] 2006 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

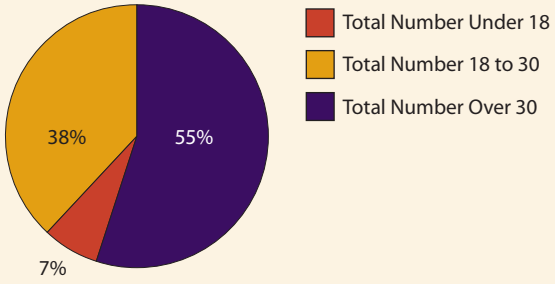
[2] For more information on Federally Qualified Health Centers please go to: http://www.cms.hhs.gov/MLNProducts/downloads/fqhcfactsheet.pdf

Data on EPAP clients enhances the complete picture of homelessness in Kalamazoo through identification of persons who may not otherwise have entered the system through other access points (i.e., homeless shelters). According to agency staff, an average of 20-30 new clients a month have entered into the system through the EPAP program since the Family Health Center began using HMIS. By combining HMIS with the EPAP, the demographics of persons served can be documented as shown below.

RACE



AGE CATEGORIES



Defining Business Processes and Integrating HMIS

Implementation of the HMIS in the Family Health Center and the Healthcare for the Homeless (HCH) program is relatively new, and staff are still working to integrate the system into their daily activities. When the project began, most viewed this as a simple task; caseworkers and agency staff would meet with clients to gather the information needed for HMIS. However, they found that this was not always possible. At HCH, for example, caseworkers originally planned to collect information as a client sat in the waiting room. But in many cases, there was not enough time while the client was was waiting to collect the information. To address this challenge, the necessary information was added to the intake questions asked by the doctor when the client is first seen. By integrating HMIS data collection into their daily processes, the agency has taken a big step in ensuring the data will be collected accurately and in a timely manner.

Impact

Implementing HMIS in the Family Health Center has led to several immediate benefits including:

- Increased use of HMIS by other organizations including Health Care for the Homeless (HCH).
- The CoC was able to demonstrate that the amount of money allocated to prescription assistance exceeded the demand. This resulted in the United Way redirecting funds to utility assistance, another much-needed service for the Family Health Center's clients.
- The City of Kalamazoo used the data generated from HMIS to make funding and resource allocation decisions on affordable housing.

Because of the success in impementing the HMIS in the Family Health Center and HCH the CoC is looking to include other service agencies in the HMIS, including the CoC's drop-in centers and faith-based organizations not currently participating in the HMIS..

For More Information, Contact:

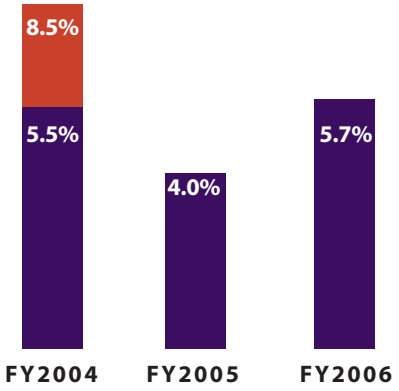
Dr. Rockelle Rogers
Medical Director
Family Health Center, Inc.
117 W. Paterson
Kalamazoo, MI 49007
269-349-2641
rockelle.rogers@fhckzoo.com

Melissa Pociask
Operations Coordinator
Housing Resources, Inc.
Kalamazoo, MI 49007
269-382-0287 Ext. 125
melissa@housingresourcesinc.org

Evaluating the Effectiveness of Homeless Prevention

The 1993 Minnesota Legislature established the Family Homelessness Prevention and Assistance Program (FHPAP) to assist families with children, youth/unaccompanied youth, and single adults who are homeless or are at imminent risk of homelessness. Funds are appropriated to county projects for a broad range of activities aimed at preventing homelessness, as well as minimizing and eliminating repeat episodes of homelessness. Each project designs its own service delivery system to achieve these goals, using approaches that are realistic at the local community level.

Percentage of stays in shelter* after receiving Family Homeless Prevention and Assistance Program services in St. Paul/Ramsey County CoC



** Not including domestic violence shelters*
*** 12 month outcomes not available for 2005 and 2006*

Ramsey County, an FHPAP regional grantee, teamed with Wilder Research Center to examine its prevention program effect on housing stability for the county's low income and formerly homeless clients. Since it is often difficult to follow-up directly with clients once their needs have been served, the group developed a proxy methodology to analyze the program. They pulled data from the Homeless Management Information System (HMIS) and from two local adult shelters, and focused specifically on a key outcome of non-returns[2] to shelter.

Homeless in St. Paul/ Ramsey County CoC

- Population[1]: 798,186 99% Urban 1% Rural
- Homeless Point in Time Count as of 1/07: 1,294

Impact

The program supports ongoing innovation and development of a comprehensive system to address homelessness, with an emphasis on prevention. All grantees of the two-year competitive grant program are required to use Minnesota's HMIS to collect household data and submit complete reports to the Minnesota Housing Finance Authority.

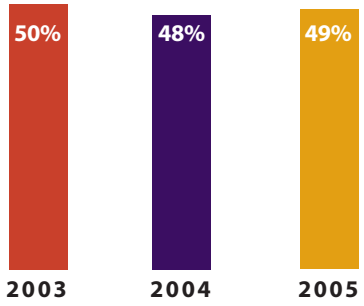
Using a de-duplication and matching key, the St.Paul/Ramsey County CoC's and Wilder Research Center compared the records from the network of homeless prevention and

[1] 2006 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

[2] Analysis was based on matches between FHPAP and HMIS emergency shelter clients regardless of type of prevention or assistance provided. Some clients received intervention during shelter stay and/or had a history of prior shelter stay and returned to shelter after intervention, while others had no prior recorded history of shelter stay and received prevention intervention but experienced a subsequent shelter stay.

assistance providers (nearly 900 households) with the records from emergency shelter providers within the region (approximately 4,000 households). Because the HMIS shows shelter providers[3] to have high bed coverage, the research team was confident that the data they were assessing was complete and accurate. However, they purposefully excluded domestic violence and street homeless programs, which enabled them to specifically define the conditions under which they could declare their findings.

Percentage of all adults in shelter* with more than one stay per year in the St. Paul/Ramsey County CoC



** Not including domestic violence shelters*

Findings and Implications for Future Research

Looking at outcomes over a three-year period[4], the St. Paul/Ramsey County CoC-Wilder team identified that less than 6 percent accounted for households who experienced a shelter stay within six months of receiving FHPAP intervention. For 2004, less than 10 percent of clients experienced a subsequent shelter stay within 12 months.

This promising analysis is one of just a few examples of service jurisdictions attempting to examine the effect one program has on another. In this case, results of the program's impact are clear. When the post-service shelter stays of FHPAP clients are compared with recidivism rates within the general homeless population in Ramsey County, it is clear emergency shelter services having a positive impact on clients. With recidivism of adults in the general population at 48 percent in 2004 and less than 10 percent of prevention-assisted clients presenting, or re-presenting, to emergency shelter, the analysis indicates a solid, effective prevention program. As a result of this, the Minnesota legislature recently doubled the funding for of FHPAP.

A further study is planned in fiscal year 2008 utilizing statewide FHPAP data. The Minnesota Housing Finance Agency currently is planning to implement "post-program shelter stays" to help monitor the statewide outcomes of FHPAP. Additionally, State agencies are considering using this method to help evaluate the success of the state's plan to end long-term homelessness.

For More Information:

Craig Helmstetter
MN HMIS Project Director
Wilder Research
1295 Bandana Blvd. Suite 210
St. Paul, MN 55108
651-647-4616
cdh@wilder.org

Jamey Burden
MN Family Prevention Program Manager
Minnesota Housing Finance Agency
400 Sibley St. Suite 300
St. Paul, MN 55101
651-296-9839
Jamey.burden@state.mn.us

[3] Shelter data included all adult and family shelters located in Ramsey County (400 beds). Domestic Violence shelters and street homeless programs were not included in the analysis.

[4] FYs 2004, 2005, 2006

Increasing Access to Mainstream Resources for Homeless

Homelessness in St. Louis City CoC

- Population[1]: 347,181 100% Urban
- Homeless Point in Time Count as of 1/07: 1,386

In their 10-year plan to end chronic homelessness, the City and County of St. Louis acknowledged an essential need for "improved coordination among service providers to ensure every chronically homeless person has seamless access to services." Officials recognize linking individuals with welfare, healthcare, mental healthcare, substance abuse treatment, and veterans' assistance programs is an essential step in helping clients exit homelessness. Utilizing the Homeless Management Information System (HMIS) to conduct presumptive eligibility screening for mainstream benefits is a strong example of a Continuum of Care (CoC) expanding the usefulness of existing data sources to facilitate a client's move toward self-sufficiency.

The CoC of St. Louis City elected to create a special assessment tool within their locally administered HMIS to assist case managers in identifying those most likely to qualify for mainstream benefits. From data entered into the HMIS, the system analyzes a client's cash and non–cash benefits, the existence of any disabling conditions, age, veteran status, and 10 newly defined data elements before displaying a summary of mainstream benefits for which household members may qualify. HMIS users are prompted to indicate if the client is being referred to the identified service(s) and a printed report is produced summarizing the data considered for determining eligibility, listing the location of the office where application for services can be made, and specifying what documents will be required.

Screening for Presumptive Eligibility

To develop the assessment tool providers were surveyed to identify the array of benefits for which most clients qualify. An in-depth assessment of the eligibility requirements (i.e. income guidelines, disability status, family size, etc) for state and federal mainstream benefits informed the development of the eligibility tool. It is important to note the tool screens for *presumptive eligibility*, that is, benefits a client may be eligible to receive and provides detailed information on documentation requirements, benefit office locations, and hours of operation. Clients are required to visit the specific agency to apply for the benefit. An example referral page is shown on page two:

REFERRAL CONTACT(S): SOCIAL SECURITY DISABILITY INCOME (SSDI)

Social Security Administration

St. Louis City

717 North 16th Street, Suite 100
St. Louis, Missouri 63103
800-772-1213

4365 Chippewa Street
St. Louis, Missouri 63103
800-772-1213

St. Louis County

Telephone 800-772-1213
TTY 800-325-0778

3rd Floor Clayshire Building
8151 Clayton Road
St. Louis, Missouri 63117

3890 South Lindbergh Blvd., Suite 220
St. Louis, Missouri 63127

Documents to Take

Social Security Number
Birth Certificate
Information about Doctors, Hospitals, Clinics & Institutions, and Dates of Treatment
List of Medications

The eligibility assessment tool was designed to be user friendly. Once an intake is completed, the case manager is able to complete a presumptive eligibility assessment to determine for which benefits the client may be eligible. Local policy requires assessments be completed within seven days of shelter arrival.

Impact

The presumptive eligibility assessment tool is a recent addition to the HMIS and the St. Louis City CoC expects to recognize several benefits as a result of screening for eligibility. These anticipated benefits include:

- Quantifying the number of clients linked to mainstream services/support;
- Identifying support services most effective in helping to stabilize clients;
- Decreases in the number of individuals cycling through emergency shelter; and
- Identifying and addressing barriers to accessing mainstream services.

For More Information, Contact:

Antoinette Triplett
Manager Homeless Services
City of St. Louis Dept. of Human Services
634 North Grand
St. Louis, MO 63103
5933-5933-5933
tripletta@stlouiscity.com

Deb Little
Director Client Services
Municipal Information Systems, Inc.
2665 Scott Ave. Suite C
St. Louis, MO 63103
1-800-536-6474
dlittle@misi.org

Electronic Homeless Certification

Documentation of homelessness is critical for eligibility to access U.S. Department of Housing and Urban Development (HUD)-funded housing and service programs. HUD has defined criteria that clients must meet to be eligible for homeless services. Historically, Continuum of Care (CoC) programs have documented client eligibility status on paper, which have been stored in a file cabinet. With guidance from their HUD Field Office, a CoC can use their HMIS to simplify the documentation process for front line staff.

Homelessness in Cincinnati/Hamilton County, OH

- Population[1]: 331,285 100% Urban
- Homeless Point in Time Count as of 1/07:1,046
- 2006 Actual CoC Unduplicated Count of Persons Served: 9,448

Homeless Certification and HMIS

HUD requires all persons served in CoC-funded programs to have documentation of homelessness contained within their files. Gathering documentation that meets HUD program and monitoring requirements is time consuming and challenging (see page 3). Documentation is often found to be incomplete or inaccurate during HUD monitoring. HUD's new Monitoring Guide requires the field office to issue a finding when homelessness documentation is not contained in all files reviewed.

The information necessary to establish a client's eligibility can be collected in most HMIS applications. The Cincinnati/Hamilton County CoC uses a homegrown web-based HMIS application called VESTA, developed in conjunction with the CoC by The Partnership Center, Ltd. (PCL). During development providers requested their HMIS include the ability to certify homelessness electronically. As a result, PCL staff automated the paper eligibility assessment to an electronic process in the HMIS. The system officially began as an implementation of the Family Shelter Partnership Program in 1999 and was rolled out to the entire community by 2002. By 2006 the HMIS system had 100 percent participation by eligible CoC providers.

The HMIS includes a homeless certification process that allows a VESTA user to certify a client's homeless status electronically. Once certified, an electronic "certificate" is then attached to the client's electronic HMIS record. The certificate moves through the HMIS system with the client; as the client exits from emergency shelter and moves to transitional housing, the certificate remains attached to their record. This allows clients to access services and housing they made need, and allows providers to meet HUD monitoring requirements.

The electronic homeless certification provides a minimal amount of information to identify the client; it does not identify the certifying program or worker, which could reveal sensitive information about the client. Instead, it simply identifies the status that makes the client eligible for services (e.g. on the street, in emergency shelter, etc.). This certification system does not

[1] 2006 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

circumvent the rules surrounding eligibility. Rather it implements them consistently across the CoC, while simplifying compliance.

Impact

Cincinnati's project is unique. It is the first HMIS to electronically provide certified documentation of homelessness. Agencies are motivated to participate in HMIS so their clients can access the CoC's homeless certification process. Widespread consumer recognition of the importance of certification encourages providers to "opt-in" to the database system. Subsequently, Cincinnati achieved a 100 percent participation rate in the HMIS among street outreach programs, emergency shelters, transitional housing programs, permanent housing, services only programs, Health Care for the Homeless (HCH) health care for the homeless, and faith-based providers.

PCL staff also believe that using a more rigorous certification process has led to programs serving only qualified clients. In the past, many clients accessed both transitional housing and permanent housing programs even though they did not meet the HUD definition of homelessness; some, for example, came from tenuously housed situations, prisons, or detox facilities. Though those clients may need housing, they do not meet HUD's definition of homeless.

Importantly, as the doors closed to "technically non-homeless" persons being served in transitional and permanent housing through the homeless certification process, access to these programs has improved for individuals from the streets and the sheltered communities. Thus PCL and CoC agencies believe the use of homeless certification has lead, in part, to the decline in the homeless numbers in the Cincinnati community.

Replication

Though the Cincinnati system was designed from the ground up to certify homelessness and generate appropriate corresponding documentation and reports, it is possible for other HMIS systems to generate similar certification reports using advanced reporting protocols. Theoretically, HMIS systems could generate documentation of homelessness for most clients. After entering the data required at intake, there is enough information in most cases to make a definite determination of homelessness, or to determine what documentation of homelessness would be required.

Determining whether a client/family is homeless according to HUD standards is based primarily on current and past intake data. Specifically two fields specified as Universal Data Elements in the HMIS Data and Technical Standards: Program Type Code and Residence Prior to Program Entry. For any given date and any given client (or household), based on existing information, an HMIS should be able to either certify homelessness or identify why the client does not meet the criteria. HMIS-generated certification in a client file can meet HUD's requirement for documentation of homelessness, if coordinated with the HUD Field Office in advance.

DOCUMENTATION OF HOMELESSNESS REQUIREMENT		
Situation	**Documentation – required by HUD[2]**	**How VESTA is used to certify homelessness**
Persons living on the street or in short-term emergency shelter	Information should be obtained to indicate that the participant is living on the street or in short-term emergency shelter. This may include names of organizations or outreach workers who have assisted them in the past, whether the client receives any general assistance checks and where the checks are delivered, or any other information regarding the participant's activities in the recent past that might provide documentation. If unable to verify that the person is living on the street or in short-term emergency shelter, the participant or a staff person may prepare a short written statement about the participant's previous living place. The participant should sign the statement and date it.	Street Outreach – Outreach workers enter individuals on the streets as soon as they encounter them with as much information as they have to generate a certificate. Information is updated as they engage with the client. Certification lasts 3 months from initial contact and may be renewed by the Outreach worker. Emergency Shelter – an intake into an emergency shelter automatically generates a homeless certificate. Certification is valid from intake to exit. Emergency High Volume (Drop Inn) Shelter – A bed night at a drop-in shelter automatically generates a homeless certificate. Drop Inn clients use a scan card to document each bed night. Certification is valid for 30 days from the client's last bed night at the shelter.
Persons coming from transitional housing for homeless persons	Written verification should be obtained from the transitional housing staff that the participant has been residing at the transitional housing facility. The verification should be signed and dated by the referring agency personnel. Written verification also should be obtained that the participant was living on the streets or in an emergency shelter prior to living in the transitional housing facility (see above for required documentation for emergency shelter), or was discharged from an institution or evicted from a private dwelling prior to living in the transitional housing and would have been homeless if not for the transitional housing (see below for required documentation for eviction from a private dwelling).	Transitional Housing – an intake into a transitional housing program automatically generates a homeless certificate if the client had an existing certification from an outreach or emergency shelter program at the time they entered the program. Certification is valid from the date of intake into the Transitional Housing program and expires on the date of exit. For clients who do not have existing certificates (e.g. those being evicted or coming from a short term stay at an institution) VESTA permits the worker to document how the client meets the eligibility criteria and generates a homeless certification based on this data (see below).
*Persons being evicted from a private dwelling	Evidence of formal eviction notice should be obtained indicating that the participant was being evicted within a week before receiving homeless assistance. Information should be obtained on the participant's income and efforts made to obtain housing, and why, without the homeless assistance, the participant would be living on the street or in an emergency shelter. If the participant's family is evicting, a statement describing the reason for eviction must be signed by the family member and dated. In other cases where there is no formal eviction process, persons are considered evicted when they are forced out of the dwelling unit by circumstances beyond their control. In those instances, a signed and dated statement should be obtained from the participant describing the situation. The grantee/	For clients who do not have an existing certification from an outreach or emergency shelter program, VESTA allows workers to document that they have a copy of the eviction notice, letter from a family member, or signed statement from the client in the client's paper file. This both reminds the worker of exactly what the HUD requirement for documentation is and generates a homeless certificate based on this documentation.

[2] http://www.hud.gov/offices/cpd/homeless/library/shp/shpdeskguide/dgb.cfm#anchor197076

Situation	Documentation – required by HUD[2]	How VESTA is used to certify homelessness
	recipient must make efforts to confirm that these circumstances are true and have written verification describing the efforts and attesting to their validity. The verification should be signed and dated.	
*Persons from a short-term stay (up to 30 consecutive days) in an institution who previously resided on the street or in an emergency shelter	Written verification should be obtained from the institution's staff that the participant has been residing in the institution for less than 31 days and information on the previous living situation. See above for guidance.	VESTA allows workers to document that they have the required verification from the institution's staff in the client's paper file and generates a homeless certificate based on this documentation.
*Persons being discharged from a longer stay in an institution	Evidence should be obtained from the institution's staff that the participant was being discharged within the week before receiving homeless assistance. Information should be obtained on the income of the participant, what efforts were made to obtain housing, and why, without the homeless assistance, the participant would be living on the street or in an emergency shelter.	VESTA allows workers to certify that documentation is available in the client's paper file and generates a homeless certificate based on this documentation.
*Persons fleeing domestic violence	Written verification should be obtained from the participant that he/she is fleeing a domestic violence situation. If a participant is unable to prepare verification, the grantee/recipient may prepare a written statement about the participant's previous living situation for the participant to sign and date.	VESTA allows workers to certify documentation is in the client's paper file and generates a homeless certificate based on this documentation.

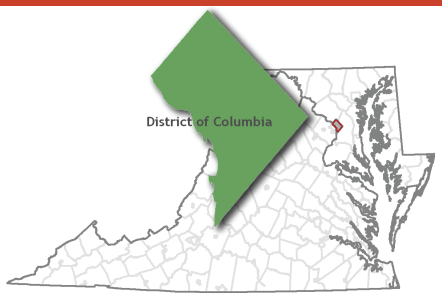
*These circumstances apply to transitional and permanent supportive housing programs only; circumstances are not applicable to outreach or emergency shelter as certificates are generated based on other factors; services-only programs are not able to generate homeless certificates.

For More Information:

Michelle Budzek
President
The Partnership Center, Ltd.
2260 Park Ave. Suite 402
Cincinnati, OH 45206
513-891-4016 Ext. 11
mbudzek@partnershipcenter.net

Molly McEvilley
VESTA Database Administrator
The Partnership Center, Ltd.
2260 Park Ave. Suite 402
Cincinnati, OH 45206
513-891-4016 Ext. 38
mmcevilley@partnershipcenter.net

Using Agency Data for Program Monitoring and Performance Measurement



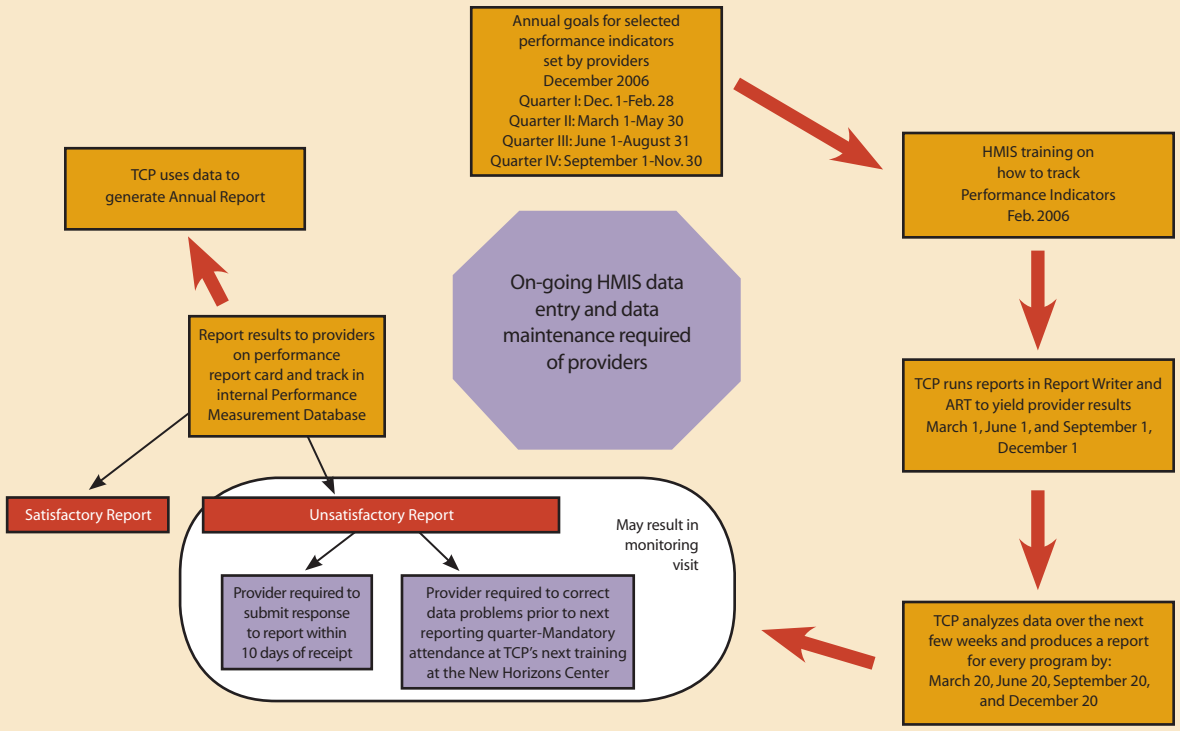
Across the country community leaders and human service providers are beginning to recognize the importance of documenting program outcomes. More and more resources are being allocated based on performance — programs are asked to define who they will serve, how they will serve them, and what they expect the outcomes of those services to be. In many cases, funding levels are dictated in large part by how successful they are at meeting their goals. Several Continuums of Care (CoC) across the country, including the District of Columbia (DC) CoC are using data collected via the Homeless Management Information System (HMIS) to monitor program performance on a daily, monthly, and yearly basis. The Community Partnership in DC has spearheaded an effort to design a performance measurement system to monitor program outcomes, expand their reporting capabilities and improve data analysis for the CoC. In 2005, the Partnership began to use the CoC's HMIS to evaluate program performance and to rate and rank programs for the CoC NOFA process.

Homelessness in Washington DC

- Population[1]: 581,530 100% Urban
- Homeless Point in Time Count as of 1/07: 5,757

ANNUAL PERFORMANCE PLAN

Reporting Flow Chart (Fiscal Year 2007)



Please note satisfactory reports will be sent to Program Directors and Agency Administrators only.
Unsatisfactory Reports will be sent to the Executive Director, Program Director and Agency Administrator.

[1] 2006 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

Staff from the Community Partnership worked to develop core performance indicators for each program adapted from the Department of Health and Human Services Assistant Secretary of Planning and Evaluation[2]. There are mandatory indicators for all programs with additional self-sufficiency indicators for a subset of programs on substance abuse, mental illness, education, and employment.

Every locally funded program is required to submit an Annual Performance Plan at the beginning of each contract year. Every quarter the Community Partnership analyzes each programs progress in meeting their annual goals set forth in their performance plan. Each program then receives a *Performance Report Card* that analyzes their progress in meeting their annual goals.

Impact

The ability to use HMIS data for more than required reporting is a tremendous asset to the CoC. The DC Performance Measurement System has enabled CoC staff to collect data on each program's performance and monitor progress toward individual program and broader community goals. As shown above, the Annual Performance Plan is a well-defined, structured way in which to hold providers accountable and ensure everyone clearly understands what is expected. The Community Partnership expects use of this system to determine the following:

- *Shelter Usage* - Assist with determining shelter usage patterns on a quarterly and biannual basis.
- *Utilization Rates* -Determine shelter utilization and identify shelters that may be overburdened or under-utilized.
- *Planning and Resource Allocation* – Access longitudinal data (trend data) that will provide them with the necessary data for CoC planning, resource allocation, and will assist with CoC-wide needs assessments.

An additional benefit of the system already found is the creation of the *Dashboard* report. This report, conducted during the winter months, serves as a great planning tool to determine patterns of use of winter beds and overflow seasonal beds. It helps determine where to best concentrate efforts to increase shelter coverage during the winter months.

Rating and Ranking for Funding Purposes

The performance measurement system was developed for the purpose of rating and ranking programs for funding purposes. In order to ensure that renewal programs perform at high standards, the CoC developed a quantitative and qualitative ranking process that judges programs according to fair standards.

[2] Detailed information about the HHS Core Performance Indicators for Homeless Programs can be found online at: http://aspe.hhs.gov/hsp/homelessness/perf-ind03/index.htm

The Ranking Process

Quantitative HMIS Ranking

Through the Qualitative Ranking process each renewal program is analyzed based on a set of core performance indicators identified in HUD's Annual Progress Report (APR) as measures of success. Program information is generated from the HMIS. Each program is scored on three measures:

1. *Occupancy* -the rate at which the program was utilized by homeless consumers;
2. *Income* - the amount of income (including employment and/or mainstream benefits) obtained while in the program; and
3. *Length of stay* - for *Transitional Housing Programs* — the number of positive client destinations at exit; and for *Permanent Housing Programs*—the ability to retain clients for more than six months as a measure of stability.

Qualitative Advisory Ranking

Each renewal program and new applicant participates in the CoC application process, through which they have the opportunity to vote on the ranking of renewal programs and the inclusion of new programs. Each program has the opportunity to advocate for their program's place in the CoC. Additionally, each new program requesting inclusion in the application is given the opportunity to introduce their proposal to the community. Each agency is offered the opportunity to vote on ranking order. The aggregate results of this vote are the Community Advisory Ranking.

Project Priority Review Committee (PPRC)

Both the Quantitative HMIS and Qualitative Advisory Rankings are sent to the Project Priority Review Committee (PPRC) for consideration. The PPRC is the final decision-making body that determines which programs will be included in the application. The PPRC is composed of community stakeholders that do not have applications in the CoCNOFA process. The PPRC considers federal funding priorities and local CoC needs when determining which programs are included in the application.

For More Information:

Darlene Mathews
Community Partnership
801 Pennsylvania Avenue, SE, Suite 360
Washington, DC 20003
(202) 543-5298
dmathews@community-partnership.org

Using Technology to Facilitate Homeless Service Coordination and Results Accountability

The City of Philadelphia, Department of Social Services (DSS), Office of Supportive Housing, along with 10 other providers are relying on the local Homeless Management Information System (HMIS) to improve service delivery and facilitate results accountability among the provider community. The collaborative identified areas of service that needed improvement including: clients accessing services across multiple systems with several case managers working independently; missing client data that could have supported the client's self-sufficiency planning; and the potential loss of critical information. The collaborative agreed that ignoring these issues would lead to inefficient and ineffective service delivery, and ultimately would effect the number of homeless individuals in the community.

Homeless in Philadelphia, Pennsylvania

- Population[1]: 1,517,550 100% Urban
- Homeless Point in Time Count as of 1/07:Emergency Shelter: 3,266 Transitional Housing: 3,927 Unsheltered: 447 Total: 7,640
- Annual Estimate: 14,500

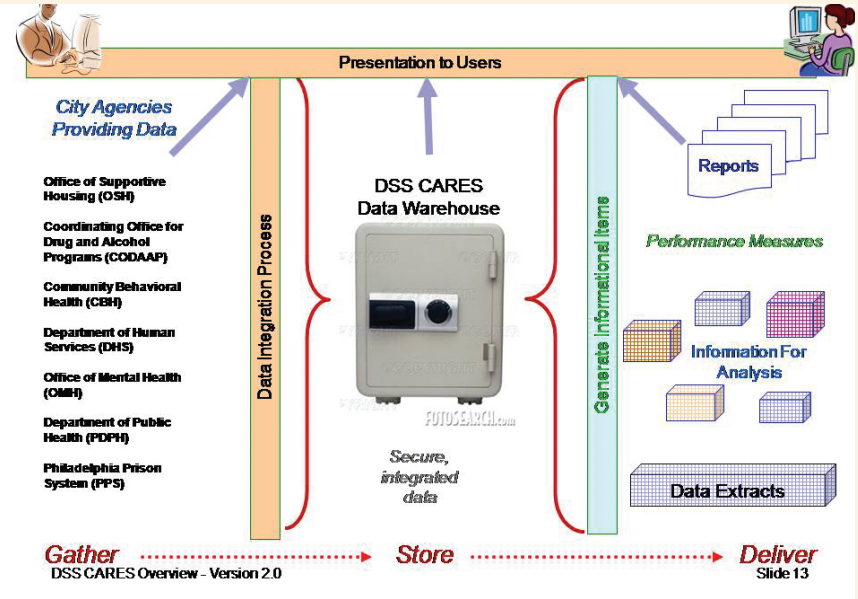
Using Technology to Facilitate Service Coordination and Results Accountability

The City of Philadelphia believes technology should be used to integrate practice, and thus has invested significant resources into the DSS CARES (Cross Agency Response for Enhanced Service) data system. DSS CARES has emerged as an integral part of Philadelphia's effort to integrate data, practice, and policy to streamline the use of funding and staffing resources. The data entered into CARES meets the specifications of HMIS and Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, and is client consent driven with written revocation protocols. The integrated system provides a comprehensive picture for child welfare and other human services professionals working with the same client, to "view" data from any city department.

The Philadelphia provider collaborative team adopted a practice foundation that builds on the existing principles of six different social service organizations and federal standards.

[1] 2006 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

CARES INFORMATION INFRASTRUCTURE



The principles provide a holistic foundation for case coordination among the various service organizations. Now, clients and case managers can create an integrated plan that is meaningful and achievable with the appropriate supports in place.

PRACTICE PRINCIPLES

- Client focused
- Family Centered
- Strengths-based
- Trauma Informed
- Culturally based
- Culturally appropriate
- Continuous across all domains of a person's life

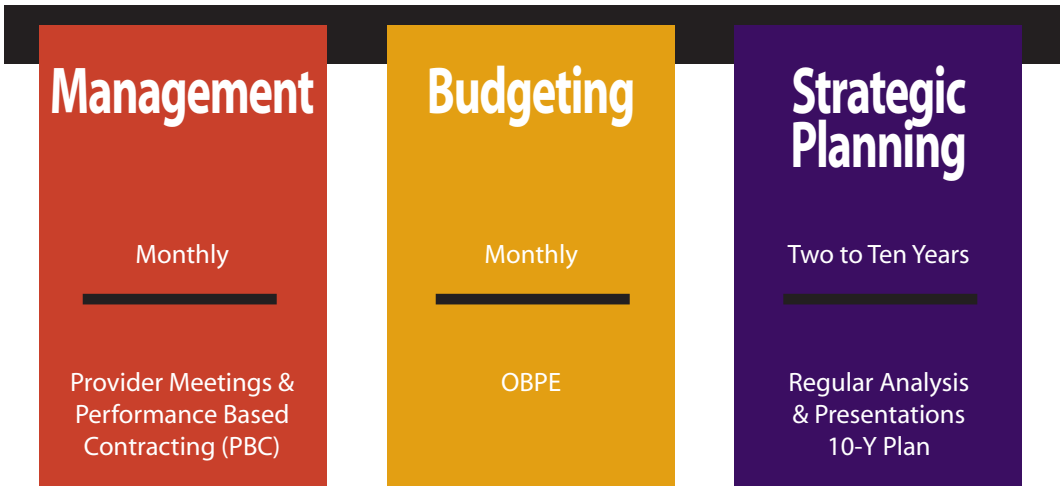
FEDERAL STANDARDS

- Adoption and Safe Families Act
- Community Support Program (CSP)
- Children & Adolescent Service System Principles (CASSP)
- National Institute of Drug & Alcohol (NIDA)
- Person-Centered Planning
- McKinney-Vento Homeless Assistance Act

The technical backbone of DSS CARES integrates data from many sources for viewing but does not include a data entry front end. The read-only client-level data from various administrative systems is accessed in real-time and provides a critical "lens" through which to see basic service data pulled from each of the city department's databases. It should be noted that clinical information is not accessible.

How DSS CARES Data is Used

DSS CARES also identifies other case workers or staff from city departments and subcontracted agencies who are working with the client. The system allows online coordination meetings to be set up with, and on behalf of, the clients. It also allows for cross-agency data sharing and comprehensive assessment in a manner that guards the client's confidentiality and ensures the security of the data.



DSS CARES provides for cross agency service analysis that can identify target populations and target population trends over time, and follow cohorts of clients across time periods to study their prior service and recidivism rates. The analytic capacity can also stratify target populations by a variety of cross-sectional parameters; "mine" the information in real-time to develop unique insights into populations and programs; develop effective prevention and intervention strategies; analyze trends in service delivery across agencies and service categories; and perform drill-through analysis of services and clients across agencies, service categories, program, time periods, etc.

Philadelphia's Office of Budget and Program Evaluation (OBPE) also uses data from DSS CARES to support their program evaluation efforts. Coupled with the Friedman Model for Developing Consumer-Focused Results, the City can monitor program goals and measures as they are integrated into day-to-day management processes. The Friedman Model uses seven questions (as shown to the right) for program performance designed to help managers understand their program's purpose and measurements of success.

SEVEN QUESTIONS FOR PROGRAM PERFORMANCE

1. Who are the clients/customers?
2. How can we measure if our clients/customers are better off?
3. How can we measure if we are delivering services well?

"Four Quadrant" Exercise

4. How are we doing on the most important of these measures?
5. Who are the partners with a role to play in doing better?
6. What works, what could work, to do better?
7. What do we propose to do?

"Turn the Curve" Exercise

Impact

In determining appropriate program performance measures, the city concluded that all of their measures needed to demonstrate three primary characteristics:

- Data Power: accurate and timely information on the measure must exist;
- Proxy Power: the measure must accurately reflect reality; and
- Communicative Power: the measure must be easily understood by "Joe Public."

Using the adopted measures, "score cards" were developed and published for similar programs – thus leading the way for establishing realistic targets and discussion forums on performance improvement strategies. A sample score card is shown below:

Headline Performance Measure Score Card
FY07 Quarter 1

I. Family Shelters

Measures	ACTS	Jane Doe	John Doe	Mr. Blue	Mr. Woodstock
# of Households Served	70	25	119	66	89
# of Household Members	172	95	459	140	270
# received Cs Mgmt Svcs	37	1	45	42	40
# with Svc Plans	50	5	100	48	66
# with Svc Plans dev < = 30 days	8	0	49	21	19
# increased income	19	4	50	21	29
# of First time households	6	5	18	18	17
# discharged to appropriate housing	21	1	12	1	16
Average Length of Stay					
% discharged to appropriate housing	30%	4%	10%	2%	18%
% with increase income	27%	16%	42%	32%	33%
% with Svc Plans	71%	20%	84%	73%	74%
% with Svc Plans dev < = 30 days	11%	0%	41%	32%	21%
% receiving Case Mgmt Svcs	53%	4%	38%	64%	45%
Overall Score	35%	10%	44%	34%	37%

The implementation of DSS CARES also has been a catalyst for changes in management and policy. Beginning in July 2007, Emergency Shelter and Transitional Housing contracts began to include both performance measure targets and requirements for integrated practice protocols. DSS has established a resource policy group to consider practice implications of research opportunities using DSS CARES, and the City of Philadelphia has incorporated performance measures into the budgeting and planning process of all Social Service Department offices with planned expansion to other departments by fiscal year 2008.

For More Information:

Kevin Breazeale
Assistant Deputy Director
City of Philadelphia
Office of Supportive Housing
1401 JFK Blvd. MSB Suite 1030
Philadelphia, PA 19102
215-686-7130
Kevin.breazeale@phila.gov

Matthew Berg
Information Technology, Manager
City of Philadelphia
Office of Supportive Housing
1401 JFK Blvd. MSB Suite 1030
Philadelphia, PA 19102
215-686-7184
matthew.berg@phila.gov