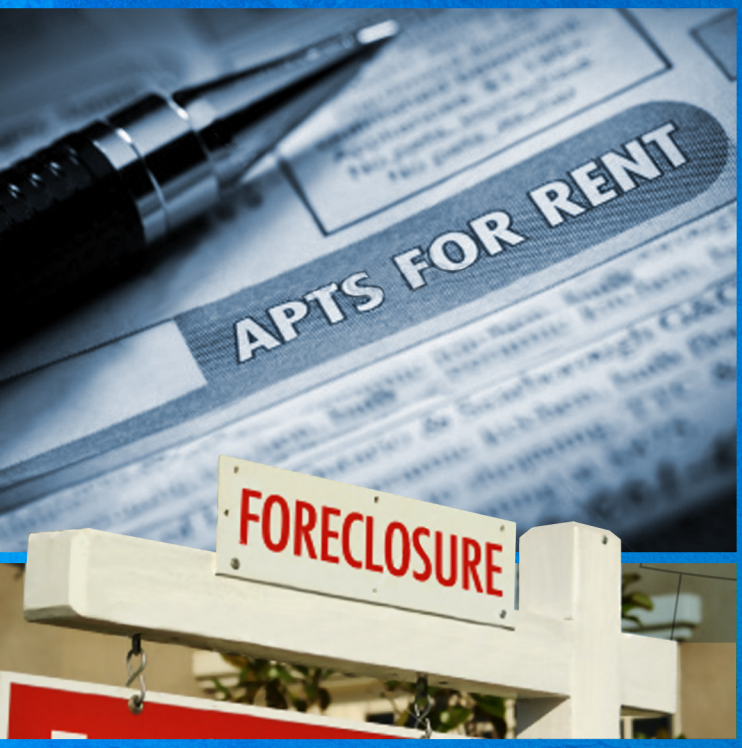
Building Knowledge, Effectiveness, and Capacity:



Advancing Data on Homelessness in Eleven Communities

February 2010

U.S. Department of Housing and Urban Development
Office of Special Needs Assistance Programs

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 were: Meggan Medina, Cara Robinson and Karen DeBlasio. The authors acknowledge the following individuals: Michelle Hayes, Project Director; Kristen Mahoney, Junior Analyst; Jon-Paul Oliva, GIS Analyst; Sam Stewart, graphic designer; and Kim Shifflett, editor.

The authors appreciate the contributions of each community that responded to the request for proposals for the Third Annual Advanced Uses of Homeless Data 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:

- Kevin Breazeale and Matt Berg, City of Philadelphia, Office of Supportive Housing
- Kathleen Shanahan, Homeless Solutions, Dayton, OH and Tracey Norwood, Montgomery County Data Integration and Analysis Department, Montgomery County, OH
- John A. Pandiani, Ph.D., Vermont Mental Health Research and Statistics, The Bristol Observatory and Brian M. Smith, Vermont Department of Mental Health
- David Eberbach and Ehren Stover Wright, Ph.D., Iowa Institute for Community Alliances,
- Des Moines, IA
- Kate Lyons, Coalition for the Homeless of Houston/Harris County and John Rio, Advocates for Human Potential, Houston, TX
- Lianna Barbu, Community Shelter Board, Columbus, OH and Ronald Kadylak, The Alcohol, Drug and Mental Health Board of Franklin County, Franklin County, OH
- Carlos Peraro, Hawaii Public Housing Authority, Homeless Programs Branch, Honolulu, HI and Stephanie On, City and County of Honolulu Department of Community Services, Honolulu, HI
- Mike Lindsay, Allegheny County Department of Human Services and Darren Cerrato, Allegheny County Office of Information Management, Allegheny County, PA
- Darlene Mathews, The Community Partnership for the Prevention of Homelessness, Washington, D.C. and Richard Rankin, Data Remedies
- Abram Hillson, New Jersey Housing and Mortgage Finance Authority, Trenton, NJ and Paul Rossi, Foothold Technology, Inc.

- Dreama Shreve, Appalachian Regional Coalition on Homelessness, Johnson City, TN and Wendy Ramsey, Good Samaritan Bonus Programs

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

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HUD's Office of Special Needs Assistance Programs (SNAPs) applauds the efforts of communities who are utilizing their Homeless Management Information Systems (HMIS) to produce high-quality, innovative program and system-level data. A Homeless Management Information System is a locally administered, electronic data collection system that stores client-level information about people who access the homeless service system. HMIS began as a grassroots effort in the late 1990's to use technology at the community level to improve service delivery, the Continuum of Care (CoC) process, and community homeless planning efforts. Now, several communities are at the forefront of generating valid and reliable data and original research that helps inform homeless service delivery and planning. In each of the past three years, HUD convened an *Advanced Uses of Homeless Data Meeting* (Data Users Meeting) to bring together communities from across the country to share best practices and provided a platform for peer-to-peer networking in an effort to further the field of HMIS. These meetings were extremely successful in establishing and documenting best practices, expanding practitioners' thinking about unique and new uses of HMIS data, and demonstrating inventive partnerships for the facilitation of research on homelessness. The publications resulting from the first meeting, "Demonstrating the Uses of Homeless Data at the Local Level – Case Studies from Nine Communities," and the second meeting, "The Community Perspective: Using Research and Technology to Identify Effective Solutions to Prevent and End Homelessness," have been published and posted at www.hudhre.info.

Drawing from the success of the first two meetings, HUD convened the third annual *Advanced Uses of Homeless Data Meeting* in July 2009. Attendees included local CoC staff, HMIS administrators, researchers, national technical assistance providers, and HUD headquarters staff.

Presenters for the 2009 Data Users Meeting were selected through a competitive process in response to a *Request for Proposals*, asking communities currently using HMIS data or technology in advanced ways to submit a brief description of their innovation for consideration. In its review of these proposals, HUD considered enhancing impact on homeless clients and measuring effectiveness of local homeless programs as strong criteria for consideration. Eleven communities were chosen to present at the meeting. The case studies in this document highlight these best practices from around the country using HMIS data and technology for larger, system-wide planning and decision making. The studies are grouped together by key topic areas, as described below.

Ending Homelessness through Enhanced Prevention

The City of Philadelphia and Dayton/Montgomery County CoC (Ohio) are both utilizing HMIS data to target local prevention programming in efforts to reduce and end homelessness. The City of Philadelphia is using HMIS data to assess the ability of their prevention programs to curb homelessness in high-risk areas. Relying on this data, Philadelphia has demonstrated the cost effectiveness of serving clients through prevention services rather than emergency shelters. This, in turn, has allowed Philadelphia to expand its prevention programming to include job training, ex-offender re-entry, and education resource services. The Dayton/Montgomery County

CoC is using HMIS data to better target families referred for homelessness prevention. HMIS data in Dayton is being used to evaluate clients entering its prevention programs and to provide information to the CoC in its efforts to realign funding priorities and create innovative services.

Understanding Service Use Patterns

The State of Vermont is analyzing HMIS data and information from comparable state databases to expand research on the utilization of medical, veterans, and youth services among the homeless population. Using a powerful statistical method, *Probabilistic Population Estimation*, Vermont has been able to explore patterns of usage without compromising client privacy. This affords state practitioners and policymakers the ability to examine both precursors to homelessness and gaps in service. The State of Iowa is compiling data, through HMIS and individual surveys, on the history of client living situations and migratory patterns. This examination provides information to researchers, policymakers, and practitioners, on clients' prior stability and its associated variables. Fostering this understanding allows more thoughtful decisions to be made regarding a client's needs and, thus, appropriate service allocation. These results are also being aggregated to create a picture of migratory patterns of service usage and their effectiveness in ending homelessness.

Data Matching for the Enhancement of Client Services

Identifying appropriate and adequate services for diverse client needs is a consistent goal across homeless service delivery systems. Communities in Texas and Ohio have designed methods of employing HMIS data to enhance community planning and program decision-making in an effort to match clients and their required level of service. In Houston/Harris County, Texas, researchers are comparing the effectiveness of employment programs that are co-located with other homeless and mainstream services (e.g. health care, education) against those serving the community at-large. This community couples HMIS data with state unemployment and job training program information to demonstrate positive employment outcomes for its homeless-specific programs. Columbus, Ohio has implemented a six-step assessment and entry system for their supportive housing program (Southpoint Place) that identifies eligible clients through HMIS and guides them through an assessment process that prioritizes applicants based on need and program appropriateness. This system has streamlined the application and approval process and, through locally targeted prioritization, has demonstrated the potential to reduce chronic homelessness.

Using HMIS to Generate Point in Time Counts

The State of Hawaii has transformed their Point in Time (PIT) process by more fully utilizing the capacity

of HMIS. Recognizing the limitations of their 2007 PIT process, Hawaii began working with HMIS users, homeless shelter providers, and outreach teams to develop a method of collecting PIT data directly through HMIS. For the sheltered count in 2009, all clients with an existing HMIS record on the night of the survey were given an encounter entry to indicate PIT participation. Outreach agencies administered the unsheltered field count over several nights and blended these numbers with data mined from the statewide HMIS to eliminate duplication. Previously, Hawaii relied on a paid consultant to coordinate their PIT sheltered and unsheltered counts. This new methodology has resulted in significant cost reduction, more comprehensive data, and improved community coordination.

Improving System Effectiveness by Combining Multiple Data Sources

Communities across the country are faced with managing and sorting through multiple data sources to provide a robust picture of programs, services, and clients. Allegheny County, Pennsylvania and Washington, DC have developed innovative methods of combining data sources to improve system effectiveness and efficiency, and to provide comprehensive information for planning and management. The Allegheny County Department of Human Services (DHS) has implemented a data warehouse to create a central repository for all departmental programs (which includes HMIS data). In addition, DHS has been successful in forming partnerships with other county agencies to further enhance their data collection and analysis. Using the comprehensive data set a data warehouse provides, DHS is able to analyze client service usage across multiple systems, which informs funding, planning and policy decisions. *The Community Partnership for the Prevention of Homelessness* (TCP) in Washington, DC manages 145 subcontracts for homeless and housing programs. In order to streamline their management operations, TCP has developed a method of integrating and linking their HMIS and accounting/ housing database. This integration, stemming from the construction of a homegrown system, enhances TCP's capacity to conduct data analysis, reduce the burden of data entry, and prevent duplicate payment errors.

Bringing Non-HUD Funded Providers "Into the Fold"

The State of New Jersey and the Appalachian Regional Coalition on Homelessness (ARCH) in Tennessee have developed partnerships which have successfully brought non-HUD funded providers into their HMIS implementation. Forming these partnerships is a key step in building a comprehensive HMIS that encompasses the entire homeless service delivery continuum. From its inception, the New Jersey Statewide Collaborative has planned carefully for diverse provider HMIS data collection, reporting, and evaluation needs. This embedded flexibility affords the Collaborative the opportunity to expand HMIS partnerships across state agencies and their unique homeless programming. The New Jersey Projects for Assistance in Transition from Homelessness (PATH) program – a community-based, street outreach program funded by the federal Substance Abuse and Mental Health Services Administration (SAMSHA) – is now able to meet its data and reporting needs in

twenty-one counties across the state through HMIS. In rural Tennessee, churches are integral partners in providing services to individuals and families experiencing homelessness. So, when the Appalachian Regional Coalition on Homelessness (ARCH) -- the Northeastern Tennessee CoC -- first began planning for its HMIS, they chose to work hand in hand with a coalition of local pastors to create a joint system for data collection. The resulting HMIS coordinates service provision by linking non-profit providers with faith-based organizations and churches through a collaborative data sharing tool. The inclusion of churches helps ARCH reduce service duplication, track true service costs, and enhance the regional referral network.

Conclusion

Each of the case studies in this document demonstrates the creative ways in which communities are utilizing data on homelessness for enhanced system effectiveness. HUD encourages each CoC to maximize the usefulness of HMIS beyond simply meeting reporting requirements, and will continue to develop best practice case studies (such as these) as models for other communities. Readers are encouraged to model local practices on the methodologies discussed herein and reach out to those persons listed in each case study should they have additional inquiries. Electronic versions of these case studies are available at www.hudhre.info.

Using HMIS Data to Determine the Effectiveness of Prevention Efforts

Introduction

Understanding the effectiveness and efficiency of homeless programs and evaluating the impact and cost-benefit of homeless prevention are priorities for the City of Philadelphia. Through use of their local Homeless Management Information System (HMIS), the City was able to analyze and assess the comprehensive costs of varying models of homeless service delivery. Analysis of client and cost data informs policymakers seeking to realign financing of homeless services and helps to mobilize elected officials' support of innovative programming. Highlighted below are examples of how the City of Philadelphia assessed the impact and cost-benefit of homeless prevention through analysis of HMIS data.

Background

In 2007, under new mayoral leadership, the City implemented a new legislative agenda targeted to reduce homelessness across the city with goals to:

- Target "high crime" areas for neighborhood stabilization services;
- Reduce the rate of new homelessness; and
- Reduce overall demand for and cost of emergency housing.

The City's Office of Supportive Housing (OSH) was directed to assess the effectiveness of existing homeless prevention funding in support of these new legislative goals.

Homelessness in Philadelphia, Pennsylvania

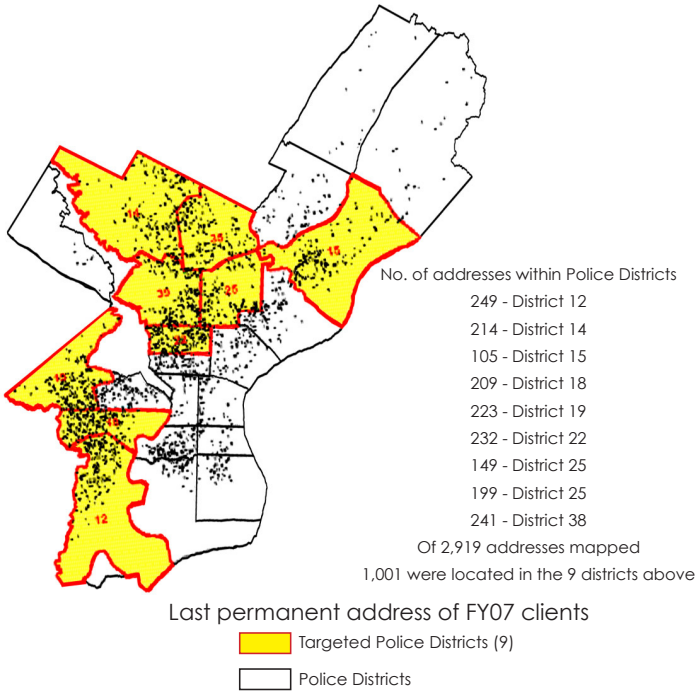
- Population: 1,447,395[1]
- Homeless Point in Time Count (2009): 6,409

1 2008 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

Description of Data and Research Questions

To address the first priority of targeting "high crime" areas for neighborhood stabilization services, data was combined from the City's long standing HMIS (e.g. last known permanent address) with police homicide data. Data was mapped to identify city neighborhoods with high rates of crime, high rates of clients entering homelessness for the first time, and promising areas for cross-systems collaboration. As demonstrated in Figure 1, many recently homeless clients appear to be leaving areas afflicted with high rates of crime. As a result, the city developed a new homeless prevention program, the Homeless Retention Program (HRP), to target those areas identified through the analysis. HRP provides rent, mortgage and utility assistance in these neighborhoods. As presented in Figure 2, HRP provides residents with a flexible award of up to $1,500 for rent, mortgage or utility arrearages in one twelve month period. In 2008, the HRP program assisted 319 households with an average award of $1,185.

Figure 1: Cross-Systems Mapping



This map demonstrates the geographic distribution of the last permanent address of persons experiencing homelessness. The yellow districts are those targeted by the City of Philadelphia for high-crime rates.

Figure 2: Funding distribution for the HRP (2008)

Assistance Category	#of Awards	Total Category Awards
Rental Arrearage Grants	213	$261,582
Mortgage Foreclosure Grants	91	$102,610
Single Adults (21 persons)	21	$24,344
Families (238 persons)	70	$78,265
Utility Arrearage Grants	15	$13,923
Total Grants Awarded	**319**	**$378,115**

To further determine the efficacy of City programs in preventing or reducing the rate of new homelessness, OSH also analyzed the HMIS data from prevention beneficiaries of the Emergency Relocation Program (ERP). The ERP provides rapid assistance to consumers who experience homelessness due to building emergencies, such as fires and properties determined unfit, with the objective of preventing entry into emergency shelter. The ERP also provides assistance to the American Red Cross in responding to building disasters, fires and other situations calling for the evacuation of residents. Consumers experiencing such emergencies can apply for security deposits on rental properties, limited hotel stays and food assistance. The program has no income limits and has the capacity to provide eviction intervention and utility assistance for persons throughout the city. Figure 3 shows the funding distribution of the ERP in 2008. Eviction prevention, relocation assistance, and Philadelphia Housing Authority eviction prevention are the largest areas of relocation program funding. In 2008, a total of 654 households were helped with an average award of $711.

Figure 3: Funding distribution for the ERP (2008)

Relocation Case Type	Award Totals	Households
Building Emergency	$10,611	13
Domestic Violence	$6,127	10
Eviction Prevention	$141,714	182
Fire Emergency	$49,504	71
Homeless Prevention	$25,323	38
Hotel Payment	$4,928	12
Nursing Home/Relocation	$3,711	9
Other	$1,908	6
PHA Eviction Prevention	$84,001	126
Relocation Assistance	$117,383	158
Special Needs	$8,864	13
Transitional Housing	$590	1
Unfit Living Situation	$10,335	15
Grand Total	**$465,005**	**654**

Effectiveness of Prevention Programs

Homeless prevention and shelter cost data was compared to answer the following research questions:

- Are homeless prevention programs effective in preventing new homelessness?
- What is the cost benefit of homeless prevention programs?

As Figure 4 demonstrates, the cost per day for emergency shelter is $9.50 to house a single individual and $14.50 to shelter a family. If a single client stays the average of 180 days in emergency shelter, the city is paying $1,710. If a family stays the average of 240 days, the city pays a total of $3,480.

Figure 4: Emergency Shelter Cost Per Person (2008)[1]

Cost Per Person	Families	Singles
Average Length of Stay	240	180
Cost Per Day	$14.50	$9.50
# of Persons Housed per Year	5000	7000
Total Cost of Shelter Programs	$17,400,000	$11,970,000

To what extent are prevention programs successful in keeping clients out of emergency shelters? OSH predicts that about 30% of the consumers receiving prevention assistance would require emergency shelter without it. Through an analysis of HMIS data, OSH has been able to determine that of the 654 households receiving ERP grants in 2008, only 1.7% required emergency shelter within 12 months of grant assistance. Of the 319 households receiving HRP grants in 2008, only 2% required emergency shelter within 12 months of grant assistance.

Cost-Benefit of Prevention Programs

Between July 2007 and June 2008, ERP awarded 654 households a total of $465,304 in grants (an average grant award of $711 per household). During the same period, HRP awarded 319 households a total of $378,115 in grants (an average of $1,185 per household). Of the households served by ERP and HRP for the period of July 2007 through June 2008, 1,611 were members of family households and 217 were single adult households. To provide emergency shelter for 1,611 family members for 30 days at a rate of $27 per day/per person (Figure 5) would have cost the City of Philadelphia approximately $1,304,910. To provide emergency shelter for 102

1 This data was provided by City of Philadelphia's Office of Supportive Housing.

single adults for 30 days at a rate of $28 per day/per person would have cost $85,680. The total cost to provide emergency shelter for all these individuals for one month would have been $1,390,590.

Figure 5: Emergency Shelter Cost Per Bed (2008)[2]

Cost Per Bed	Families	Singles
# of Annual Beds	1739	1165
Daily Cost Per Bed	$27	$28
Total Cost to Shelter	$17,400,000	$11,900,000

Therefore, with an investment of $843,419, the City of Philadelphia potentially saved $547,171 by preventing these individuals from entering emergency shelter for just 30 days. To provide emergency shelter for the 1,828 individuals for the average length of stay of 210 days at the average daily rate of $27 would have cost the city $10,364,760.

More realistically, if just 30% of these individuals had entered shelter for an average stay of 210 days, the cost to the city would have been $3.1 million -- almost 5 times the amount invested in prevention.

Impact and Anticipated Benefits

Philadelphia continues to use the information gathered through the evaluation of the ERP and HRP programs to realign and reassess the distribution of homeless funding and service delivery. This has resulted in new practices and strategies being implemented, including:

- Coordination of efforts between social service departments through the new PhillyStat[3] process.
- Establishment of additional homeless prevention programs in job training, ex-offender re-entry, and educational resources.

In Fiscal Year 2010, OSH has broadened the scope of homeless prevention with funding through the American Reinvestment and Recovery Act Homelessness Prevention and Rapid Re-Housing Program. Programs awarded funding for this initiative will be required to capture client level demographic and assistance data in HMIS. Geographic data will again be mapped to determine the greatest areas of need within the city and to facilitate partnerships with other city agencies to target necessary resources and services.

2 This data was provided by City of Philadelphia's Office of Supportive Housing.

3 PhillyStat is a data management tool used by all agencies in the City of Philadelphia to enhance operations and deliver services.

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Introduction

Dayton/Montgomery County, Ohio has a number of prevention and rapid re-housing efforts underway. Montgomery County was one of five sites selected to participate in a state-funded Family Homelessness Prevention Pilot (FHPP) in late 2007 and was one of 23 sites selected nationally to receive a Rapid Re-Housing Demonstration Program grant through the 2008 CoC competition. The following case study focuses on preliminary analysis of HMIS data from the Family Homelessness Prevention Pilot. This data was used to shape the community's successful CoC Rapid Re-Housing Proposal and to develop targeting criteria for their Homelessness Prevention and Rapid Re-Housing Program (HPRP).

Background

In January, 2008, the Ohio Department of Development (ODOD), in partnership with the Ohio Department of Job and Family Services' Office of Family Stability, began to implement the Family Homelessness Prevention Pilot Program (FHPP). This statewide initiative is funded with resources provided through the Ohio Housing Trust Fund and Temporary Assistance for Needy Families (TANF). The FHPP provides limited direct assistance and intensive home-based case management services for Ohio households facing imminent homelessness. In Dayton/Montgomery County, the Dayton YWCA administers this program. To qualify for assistance in the pilot program, targeted families are required to have one or more dependent children, incomes at or below 200% of the federal poverty level, be living in or in need of subsidized housing, and be imminently at risk of homelessness.

Homelessness in Dayton/ Montgomery County, Ohio:

- Population: 534,626[1]
- Homeless Point in Time Count (2009): 861

1 2008 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

Targeting Prevention Resources

Each of the five FHPP sites throughout the state developed their own assessment tools to determine which families met the criteria for program eligibility. The Dayton YWCA site used a standardized matrix of risk factors (Figure 1) -- embedded in the HMIS -- as the primary strategy for assessment. Each factor in this approach is weighted according to evidence-based research on the risk of imminent homelessness. The total point value ranges from 0-30 possible points.

Figure 1: Dayton YWCA Prevention Pilot Screening Matrix

Risk Factor	Means of Verification	Score
Prior stay in an emergency shelter	HMIS/shelter record	**3 points**
Young parent under 24 years of age	Drivers license, or other identification	**3 points**
Young children under 6 years old in household	Birth certificates	**2 points**
Infant in home or currently pregnant	Birth certificates/ medical report	**2 points**
Extremely low income (less than 67% of poverty line)	Pay stubs or benefit statements	**2 points**
Loss of benefits or employment	Sanction letter or lay-off notification	**2 points**
Paying over 40% of income for rent	Income/rent ratio	**1 points**
Unable to secure any other temporary or permanent housing if evicted due to lack of income, saving, or credit	Income or bank statement or self report	**2 point**
Prior eviction/pattern of housing instability	history of previous addresses and length of residence	**2 point**
No "family or friend" temporary housing options	statements and history of prior "doubling up"	**1 point**

Figure 1 (continued)

Risk Factor	Means of Verification	Score
Significant personal barriers to housing stability 1. Substance abuse 2. Mental health issues 3. Criminal history/legal problems 4. Little or no employment history 5. Low educational achievement 6. Documented disability or medical conditions 7. Domestic violence in home 8. Child Welfare concerns, Children Services Board involvement, 9. Lack of child care prevents employment 10. Eviction due to housekeeping/negative behaviors	Self verification, court records, state systems verification, educational records, disability letter, eviction letter	**1 Point per each factor Maximum personal factors is 10 points**
		Total Risk Factor Points

Families falling below a 12 point cumulative score were deemed to have resources sufficient to enable them to remain in their housing without assistance. Families scoring above 25 points were identified as having barriers or a need for services exceeding the scope of the program. Those families whose score fell between 12 and 25 points were deemed eligible and appropriate for the pilot.

All families selected for the FHPP received home-based case management for 3-6 months and no more than $1,000 in financial assistance. The general case load for case managers affiliated with this initiative was 15 families.

The Dayton/Montgomery County HMIS provided the FHPP with detailed, client-level demographics, risk characteristics at entry, prevention assistance received, referrals and services from partner agencies, and a self-sufficiency matrix that was completed at program entry, program exit, and 3 and 6 months after program exit.

Impact and Anticipated Benefits

An independent research firm conducted a statewide evaluation of the Family Homelessness Prevention Pilot. Initial data from this evaluation revealed that 247 families (89%) had a positive housing outcome (defined as obtaining permanent housing, remaining in permanent housing or moving in with family/friends). Based on the initial success of the pilot, the Ohio Department of Development (ODOD) committed to:

- Allocate state Housing Trust Fund dollars for prevention programs targeting clients at risk of homelessness;
- Continue the Family Prevention Pilot Program beyond the original funding period (with the help of Recovery Act Funds); and
- Examine "lessons learned" across the sites to guide future funding and next steps for the evaluation component.

Of the 92 families originally enrolled in Dayton/Montgomery County, 54 have exited successfully and 38 families remain in the program. Initial analysis of local data from the Family Homelessness Prevention Pilot has been used to:

- Evaluate the effectiveness of the screening matrix over time in targeting prevention efforts;
- Refine the screening matrix for use as a standardized assessment process throughout the community (one of the major recommendations of the community's 10-Year Plan); and
- Target new Homelessness Prevention and Rapid Re-housing (HPRP) resources.

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Introduction

Communities are consistently seeking ways to understand service utilization among their homeless populations and across service sectors. Understanding how homeless clients interact with medical and other public services affords providers, policymakers, and advocates the opportunity to demonstrate need and target programs more effectively. The Vermont Department of Mental Health and the Bristol Observatory have partnered to produce a series of studies aimed at formulating a comprehensive picture of homeless service utilization including use of hospitals, mental health and substance abuse services and prior involvement in protective custody for various subpopulations. Through this partnership, the State has been able to better measure access to care, service system integration, and treatment outcomes.

Methodology and Description of Data

Through application of innovative statistical methods, including Probabilistic Population Estimation, studies have been able to demonstrate the utility and cost-effectiveness of various service configurations. Probabilistic Population Estimation allows for anonymous extracts from administrative databases to be analyzed using minimal identifiers[1]. Using this method, data from three separate databases was analyzed to better understand service usage within and between systems. These data systems included: the Vermont Balance of State Continuum of Care HMIS database (including PATH, HUD Homeless and non-HUD-funded providers in rural Vermont); all state-funded rural mental health and substance abuse programs; and Uniform Hospital Discharge. Each extract included the date of birth and gender of all service recipients and other data relevant to program-specific concerns (e.g. diagnoses, criminal offenses, and volume of service utilization). Each data set also includes dates and locations of service. The cross data set analysis has produced several results that provide insight into service sector utilization in multiple service sectors across Vermont. A number of these are highlighted in the sections below.

1 Probabilistic Population Estimation is a statistical procedure that uses date of birth information in one data set in conjunction with knowledge of the distribution of dates of birth in the general population to determine the number of people represented in the original. For more information please contact John A. Pandani, Ph.D. Contact information is available on the last page of this case study.

Homelessness in Vermont

- Population: 621,270[1]
- Homeless Point in Time Count (2009): 1,587

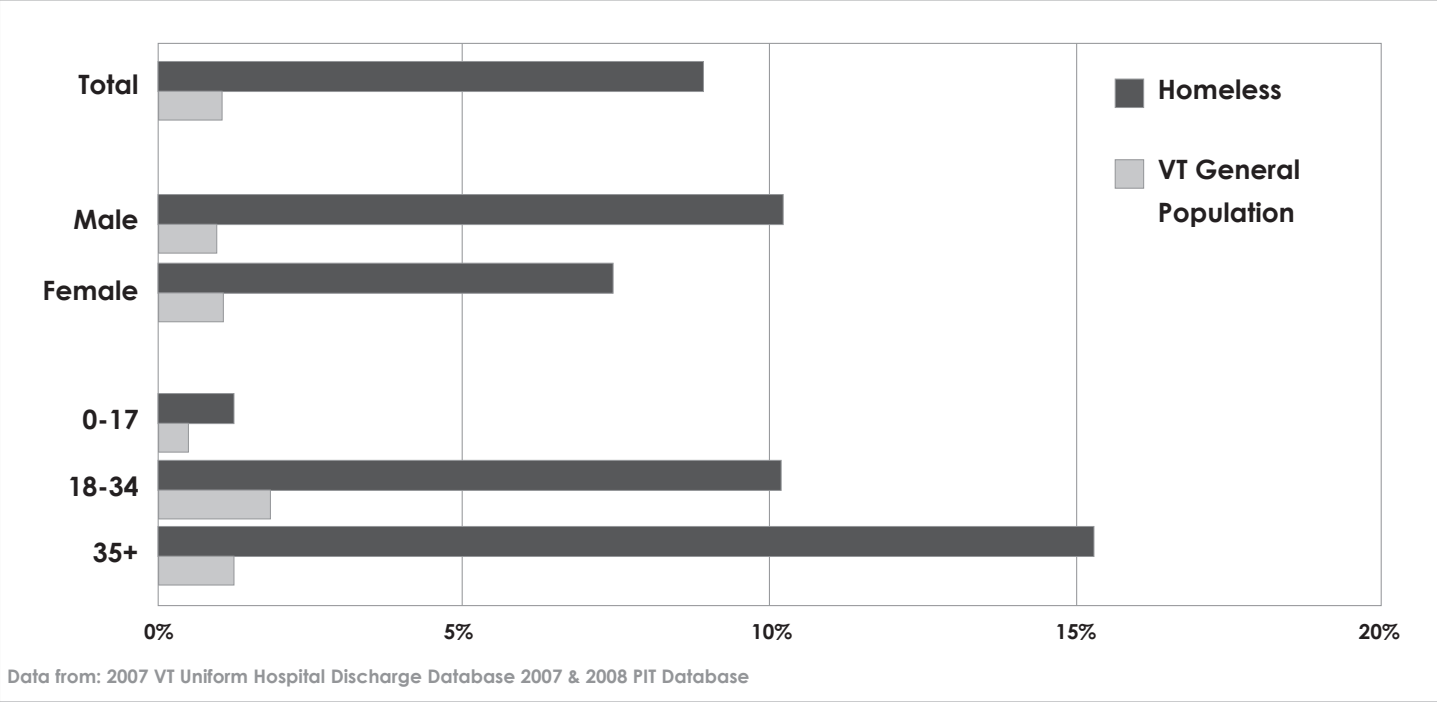
1 2008 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

Analysis and Results

Emergency Room (ER) Utilization

Across the nation, homeless individuals and families lacks access to adequate health care. As a result, many seek help from hospital emergency rooms for physical health, mental health, and substance abuse conditions. The Vermont project used data from HMIS and the Uniform Hospital Discharge dataset to make service comparisons. Figures 1 and 2 compare emergency room utilization by the state's homeless population with the general population. Figure 1 focuses on emergency room visits for physical health concerns. Figure 2 (next page) focuses on emergency room visits for mental health (MH) and/or substance abuse (SA) issues.

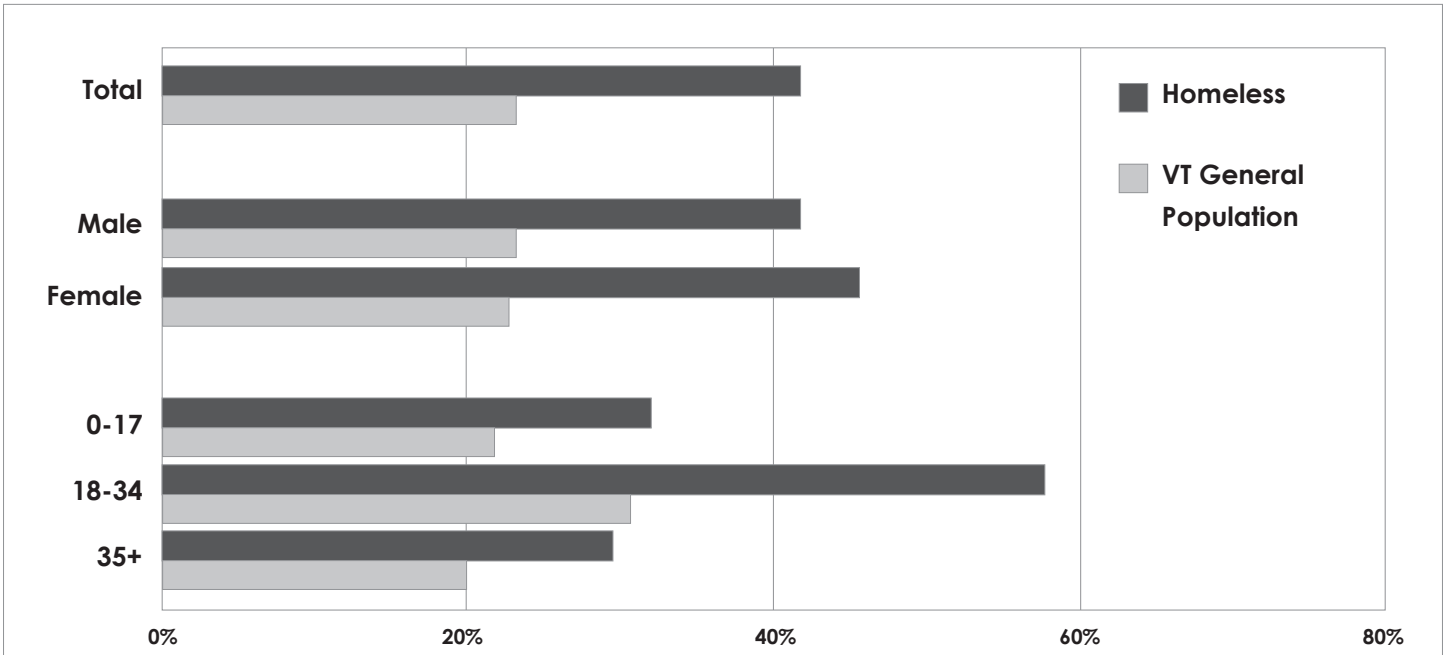
Figure 1: Comparison of Use of Emergency Room for Physical Health Services[1]



Data from: 2007 VT Uniform Hospital Discharge Database 2007 & 2008 PIT Database

1 For Figures 1 and 2, the numbers ("n") represented on these graphs are the same as the total population and homeless count numbers listed on the first page of this case study.

Figure 2: Comparison of Use of Emergency Room for MH/SA Services[1]



Data from: 2007 VT Uniform Hospital Discharge Database 2007 & 2008 PIT Database

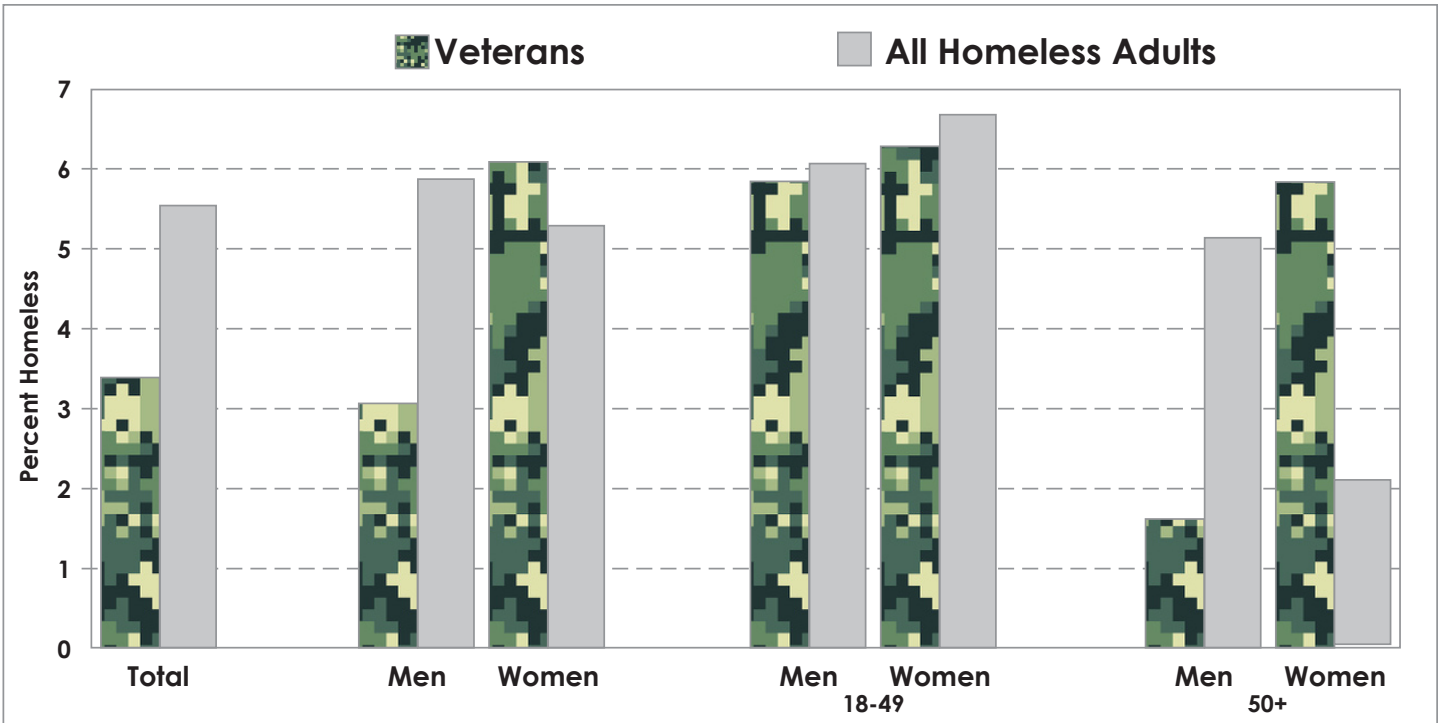
1 For Figures 1 and 2, the numbers ("n") represented on these graphs are the same as the total population and homeless count numbers listed on the first page of this case study.

As each figure demonstrates, Vermont's homeless population is much more likely than other Vermont residents to utilize the emergency room for physical health and mental health/substance abuse conditions. That utilization gap is wider for mental health/substance abuse conditions.

Homelessness Among Veterans and Others with Outpatient MH/SA Services

Homeless veterans are afforded access to mental health and substance abuse care and services at Veterans Administration (VA) facilities. Many veterans suffer conditions related to their military service. The Vermont project used data from the Vermont Department of Mental Health, Vermont Veterans Administration, and HMIS to assess service utilization at VA facilities for outpatient mental health and substance abuse services. Figure 3 demonstrates outpatient treatment for mental health and substance abuse services among Vermont's homeless veterans as compared to all homeless adults.

Figure 3: Comparison of Homeless Vets Use of MH/SA Services[1]



1 Homeless Veterans n=2412

As Figure 3 demonstrates, homeless veterans are less likely than other homeless adults to access mental health/ substance abuse services. Among older men, veterans are much less likely to use services than other homeless men. Among women, female veterans are much more likely to receive services than other homeless females in the same age group.

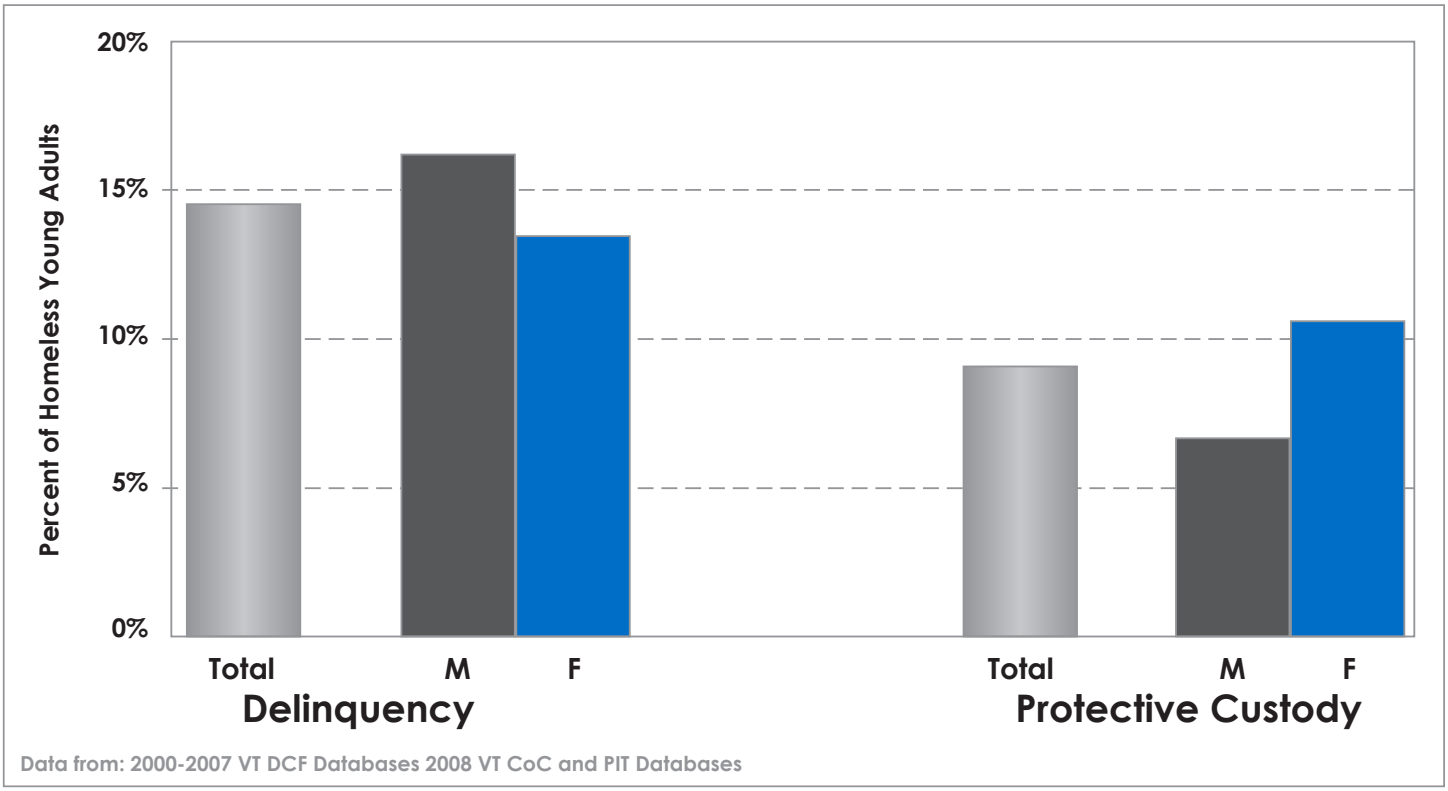
Homeless with Previous State Custody

Often children and youth who spend time in state custody experience unstable living environments that do not prepare them for a successful transition to adulthood. Resources and networks that provide stability are generally lost. The Vermont project aimed to understand the relationship between homeless young adults[2] and past participation in state custody. Data from the Vermont Department of Children and Families and HMIS was used.

2 For the purposes of this study, young adults is defined as persons between the ages of 18-24.

Figure 4 illustrates the percentage of homeless young adults who have a history in delinquency and/or protective custody.

Figure 4: Comparison of Homeless History with Delinquency and Protective Custody



Data from: 2000-2007 VT DCF Databases 2008 VT CoC and PIT Databases

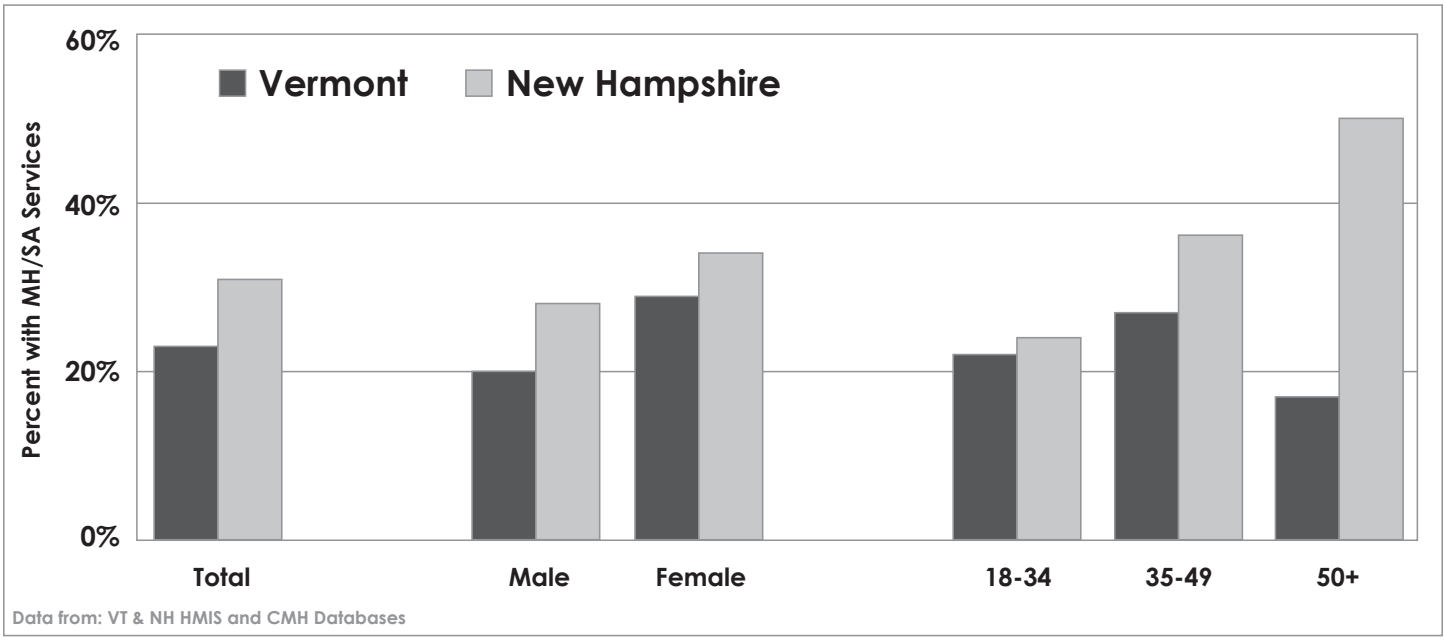
This figure illustrates that almost fifteen percent of homeless young adults have been in state custody for delinquency and approximately nine percent have been in protective state custody.

Cross State Comparison: Vermont and New Hampshire

Many states share responsibility for serving transient homeless clients. To foster collaboration and design effective service delivery systems, it is important to understand service utilization across each state. The Vermont project is partnering with the State of New Hampshire to begin work on formulating cross-state

comparisons in an effort to facilitate regional networks. An example of this work is demonstrated in Figure 5. Using data from Vermont's and New Hampshire's HMIS and Mental Health databases, Figure 5 outlines the percentage of homeless clients receiving mental health and/or substance abuse services. Overall, Vermont's homeless populations are significantly less likely to receive mental health/substance abuse services than

Figure 5: Cross-State Comparison of Use of MH/SA Services



homeless persons in New Hampshire. This difference is greatest among adults aged 50 years and older.

Impact and Anticipated Benefits

Information provided through this approach is being used by the Vermont Agency of Human Services' Interagency Council to End Homelessness to monitor caseload size, participation in non-HUD funded programs, and treatment outcomes. In turn, this data informs related policy decisions. In addition, the study's methodology has the potential to address confidentiality concerns of domestic violence, HIV, and other special needs populations.

Many communities struggle to balance the need for research which describes and examines vulnerable populations with the need for client confidentiality. The Vermont research approach helps alleviate these concerns because it does not require any personally identifying information to formulate useful and statistically rigorous information for policymakers.

In the near-term future, Vermont plans to expand this project to include further analysis including:

- In-State Regional Comparisons: Examining the relationship between geographic location and service delivery is helping to design a statewide service delivery system.
- Cross-State Comparisons: Expanding on the partnership with New Hampshire, Vermont hopes to continue comparative analysis across states to understand both states' effectiveness in providing services and to inform policy decisions through multi-state program evaluation.
- Precursors to Homelessness: As explored in the data analysis regarding previous services to homeless young adults, identifying causes of, or precursors to, homelessness is a key component of preventive programming and the creation of effective, targeted policies.
- Changes Over Time: Analyzing how Vermont's homeless population accesses services over time can help determine effective service delivery and policies.

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Introduction

Communities across the nation are continuously looking for ways to better understand the migratory pathways of their homeless citizens. Understanding the history of a person's housing, financial, and social situation assists in the development of more effective individual client plans and community-level initiatives. In addition, understanding the movements of clients between geographic locations (rural to urban, urban to suburban) helps communities facilitate networks of service delivery across jurisdictions.

In 2008, the State of Iowa was asked to participate, with Michigan and Nevada, in a HUD Homeless Management Information System (HMIS) study examining the movement of homeless clients through the homeless service delivery system. This initial migration study used HMIS data to assess the reported zip code of respondents' last stable housing situation in conjunction with the locations of places where services were received.

Building on initial participation in this research, the Iowa Institute for Community Alliances designed a second study integrating HMIS data with client interviews. This study, called the Enhanced Homeless Migration Study, complemented the initial analysis with detailed client history not typically collected in HMIS data networks. This included reporting on intermediary locations between last "successful" housing and shelter, as well as details on social and family support networks. The primary intent of this study was to track the movement of clients and create detailed migration narratives that documented life situations associated with the client's last reported stable housing circumstance, as well as subsequent housing history. Through understanding the patterns of homeless migration and the point at which a client's stability declines, communities become better able to target services, funding, and programming.

Homelessness in Iowa

- Population: 3,002,555[1]
- Homeless Point in Time Count (2009): 3,568

1 2008 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

Background

Iowa's interest in enhanced housing stability data and information grows out of a mobility study that employed the "zip code of last permanent address" data element and the "zip code where services were rendered" in order to determine from where and how far people traveled to receive services. Planners and providers sought a more robust understanding of client migration patterns and the reasons underlying those life changes. There was also a high level of concern regarding the reliability of the "zip code of last permanent address" data element in research analysis.

By conducting intensive interviews, the Enhanced Homeless Migration Study sought to examine the last "successful" housing situation of homeless clients. Building on the required data standard, "zip code of last permanent address," the study analyzed the path of and changes in a client's housing situation. Understanding these patterns could allow communities the opportunity to expand the current understanding of client migration and to describe factors that contribute to housing stability. Furthermore, the interaction between successful housing and associated life factors were examined to paint a picture of successful interventions, service models, and resource allocations that fostered stable living.

Methodology

Iowa's study of homeless household migration combined HMIS data and data from a supplemental self-sufficiency survey. The HMIS data set of the preceding year served as the primary data source and the universe from which a representative, random sample was drawn. This study sampled clients from both emergency shelter and transitional housing providers. A total of 400 randomly selected clients -- 200 clients from 2009 and 200 clients from 2008 – were interviewed between June and December of 2009.

Data analyzed included:

- Locations of client housing prior to or in between homeless episodes
- Changes in client stability in key life areas
- Client access to stabilizing resources

The questions explored included:

- From where do people in need of services come?
- Are these households moving from rural homes to urban areas in pursuit of services?
- What factors lead to instability?

- Where should resources be targeted to provide the most effective and speedy path to residential stability and self-sufficiency?
- What causes people to choose a destination and what causes them to move on?
- How accurate is the last permanent zip code measure?

A self-sufficiency survey with the sampled population served as a second primary data source. Through this detailed interview, the sampled population was encouraged to provide their narrative history from the point of last stable residence to the current location. The survey instrument utilized in Iowa examined a client's self-sufficiency in multiple life areas during their last stable housing situation. Several of the areas included:

- Education: level of and satisfaction with education
- Community: relationships and networks with others
- Mental Health: level of symptoms/condition
- Health: level and type of care needed
- Health Care: medical coverage/service type
- Family Relations: type of relationship with family

There were a total of sixteen to eighteen[1] questions in the survey regarding life area resources. Each life area was assigned a score between one and five using an ordinal scale. Figure 1 (below) summarizes this scale.[2]

Figure 1: Self-Sufficiency Scale

LIFE AREA		1	2	3	4	5
Income	No Change	None	Inadequate	Needed help	Sufficient	Saving
Employment	No Change	None	Unstable	Insufficient	Adequate	Fulfilling +benefits
Family Relationship	No Change	Hostile.	Draining	Absent	Stable	Supportive

1 Two additional questions if children are present in household.

2 Only a sampling of the total life areas is included in this table for the purposes of illustrating the scale.

Figure 1 (continued)

LIFE AREA		1	2	3	4	5
Safety	No Change	Danger	Some Risk	Cautious	Usually safe	Always safe
IF CHILDREN WERE PRESENT						
Childcare	No Change	No access	Unstable	Limited	Affordable	Educational
Education	No Change	Not enrolled	Not attending	Often miss	Generally go	Never miss

Scores for all clients were aggregated for each stage of housing stability, and analyzed for statistically significant correlations between housing stability and life area categories (e.g. income, employment, transportation). Final outcomes from this study are still being compiled and analyzed as of the date of this publication.

Impact and Anticipated Benefits

The Iowa Institute of Community Alliances is already reaping many benefits from the Enhanced Homeless Migration Study. Preliminary data analysis has assisted in clarifying the progression of homeless clients and the effectiveness of the services they encounter. As this analysis continues, the Iowa Institute anticipates further benefits of the study, which include:

- Predicting what services are most likely to help homeless households in specific situations through the development of representative narratives and associated needs.
- Helping local communities make funding decisions for existing programs by analyzing their effectiveness in promoting client stability.
- Designing planning and funding for future programming based on gaps in service.
- Finalizing decisions regarding Regional Service Delivery Networks that might enhance service delivery across jurisdictions and within established migration pathways.
- Creating a system of migration data collection to serve as a model in other rural areas across the United States.

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Introduction

The Gulf Coast Workforce Investment Board (GCWIB) initiated a research and demonstration project to address the needs of homeless job seekers and to help the Houston/Harris County community to address the challenge of reducing homelessness. The Board's administrative agent, the Houston-Galveston Area Council (HGAC) contracted with Service of the Emergency Aid Resource Center for the Homeless (SEARCH) Inc. to develop and operate a Workforce Solutions office, a One-Stop career center in Midtown. This innovative project was designed to test the effectiveness of serving people experiencing homelessness in one of the largest workforce investment areas in the country by co-locating employment and homeless service programs. This case study focuses on the analysis of both HMIS and workforce development systems data to compare two sets of clients: those receiving job services at the research and demonstration site (which was co-located with other homeless services) and those receiving services at traditional One-Stop Career Centers - providing employment services only. The Coalition for the Homeless of Houston/Harris County -- the homeless system manager that administers the local HMIS, leads the Continuum of Care, and orchestrates the community's 10-Year Plan to address homelessness -- also actively partnered in the study.

Background

In an effort to enhance employment outcomes for Houston's homeless populations, Workforce Solutions Midtown is uniquely located on the first floor of a four-story building that houses a number of other homeless assistance programs including transitional and permanent housing. The job center is co-located with additional services including showers, laundry, daily lunch, health care and a variety of vocational and educational support services. This co-located program design is

Homelessness in Houston/ Harris County, Texas

- Population: 4,515,490[1]
- Homeless Point in Time Count (2009): 7,286

1 2008 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov. This estimate includes Fort Bend County, which is also part of the Houston/Harris County CoC.

intended to attract and serve job seekers who are homeless. The approach at the Workforce Solutions center includes:

- identifying employment goals;
- identifying barriers to employment;
- locating resources and funding to meet the jobseekers' needs;
- providing a familiar, welcoming environment; and
- providing services to address on-going needs.

As part of the research and demonstration project highlighted here, SEARCH agreed to conduct an evaluation of the initiative and sub-contracted with Advocates for Human Potential to provide an independent evaluation of the career office. The evaluation was designed to compare jobseekers that accessed services at the Workforce Solutions Midtown office with other jobseekers experiencing homelessness that accessed services from more typical One-Stop Career Centers in other parts of Houston.

By comparing data from the workforce investment system and the local Homeless Management Information System (HMIS), the evaluation sought to:

- Describe any differences in the homeless population using the Workforce Solutions Midtown site, when compared to those using more traditional One-Stop Career Centers;
- Describe the range of services used by participants in the Workforce Solutions Midtown and how these might differ from a traditional One-Stop program; and
- Compare success rates for key project outcomes associated with each setting.

Methodology

Working with staff at SEARCH, the Coalition and HGAC, evaluators identified two representative cohorts (groups) who were homeless and used a workforce development program during the 18-month study period (from April 1, 2006 to September 30, 2007). Key characteristics of these two cohorts are summarized below:

- Cohort 1 – Homeless adult men and women seeking job assistance at the Workforce Solutions Midtown who were also receiving homeless assistance services at SEARCH. SEARCH staff were trained in using the HUD definition of homelessness and verified that clients met that definition. A total of 358 homeless persons were identified for Cohort 1.

- Cohort 2 – Persons who self-identified as homeless to staff during the process of seeking employment assistance from other Workforce Solutions offices in Harris County and who were not registered in the countywide HMIS (i.e. not receiving homeless assistance services). A total of 1,430 homeless persons were identified as members of Cohort 2.

Four data sets were used in this study. These included data from Work In Texas (WIT); The Workforce Information System of Texas (TWIST); Texas Unemployment Insurance (UI); and Houston's Homeless Management Information System (HMIS). The WIT, TWIST, and HMIS sources provided demographic, service, and housing outcomes for the homeless population; while the UI source provided data on employment, income and job retention outcomes. These same UI wage records were used as the primary data source for tracking employment in the quarter following program exit. If UI records for the quarter following exit showed earnings greater than zero, an individual was considered employed. Each individual record was assigned a unique identifier to protect the confidentiality of job seekers participating in the study.

Analytic Approach for Quantitative and Qualitative Data

Simple descriptive statistics (examining distribution and frequency of key variables) formed the basis of the study's analysis and provided summaries about the study population, services utilized, and results achieved. Analytical tests were performed to document the association and differences across cohorts between pre-entry and post-exit income and employment.

In addition to the quantitative analysis, a series of key informant interviews were conducted to hear directly from key project staff and customers involved in the research and demonstration project. Questions were designed to ascertain the utilization and efficacy of services in achieving desired outcomes. This data was analyzed for identification of recurrent themes, as well as to enrich the understanding of findings based on insights into the unique perspective of participating individuals.

Results

While there were four times as many job seekers in Cohort 2 (N=1430) than in Cohort 1 (N=358), the characteristics of each group (described in Figure 1 below) were very similar. The mean age was 43 years old with a range from 17 to 77 years old. About 65% of participants were male and 35% female; 63% were African American, 31% Caucasian and 5.9% reported "Other." In the "Other" category were people of multiple races, Asians, Native Americans and Pacific Islanders. Both cohorts included clients with a history of criminal offenses. Figure 1 (next page) synthesizes selected demographic characteristics of both cohorts.

Figure 1: Homeless Job Seekers in Cohorts 1 and 2 in Houston/Harris County

		Cohort 1: Homeless Customers Receiving Workforce Solutions Services + SEARCH Homeless Services (N=358)		Cohort 2: Homeless Customers Receiving Workforce Solutions Services Only (N=1430)	
Demographics		N	%	N	%
Age	Mean (range: 17.3 – 77.8)	358	43.9 (mean)	1407	43.1 (mean)
Gender	Male	242	67.8	920	64.4
	Female	115	32.2	508	35.6
	Total	357	100.0	1428	100.0
Race	White	100	29.6	404	31.1
	Black	222	65.7	814	62.7
	Other	16	4.7	81	6.2
	Total	338	100.0	1299	100.0
Ethnicity (Hispanic)***	Yes	29	8.9	183	14.6
	No	296	91.1	1073	85.4
	Total	325	100.0	1256	100.0
Last Grade Completed**	Middle to high school grades	36	10.1	223	15.6
	GED/HS grad	197	55.2	686	48.0
	Some college/Credential/Voc skills	96	26.9	379	26.5
	Associate/College or higher degree	28	7.8	141	9.9
	Total	357	100.0	1429	100.0
Offender Status	Yes	64	56.6	272	64.6
	No	49	43.4	149	35.4
	Total	113	100.0	421	100.0

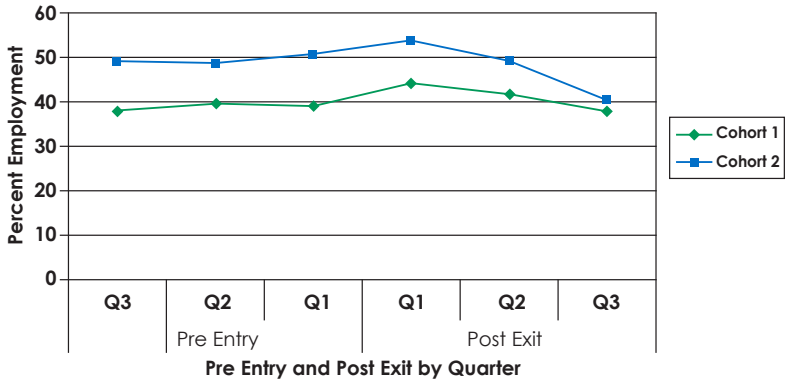
** $p < .05$ *** $p < .01$

In addition to comparing the descriptive characteristics of each cohort, the SEARCH study examined comparative use of supportive services provided. Job seekers at all of the Workforce Solutions offices, including those at Midtown, were able to access 48 core services, depending on their individual need. The customers at Midtown had access to additional services offered by SEARCH's job bank and resource center -- uniquely co-located with the Workforce Solutions office.

For purposes of this evaluation, services were categorized across both cohorts into seven overarching "service clusters," including assessment services, counseling/case management, employment planning, job linking and searching, training and job preparation, concrete job support services and miscellaneous services. Job seekers in Cohort 1 used more services overall than their counterparts in Cohort 2. Notably, the most frequently used service on average by Cohort 1-- concrete job support services -- were hardly used by anyone in Cohort 2.

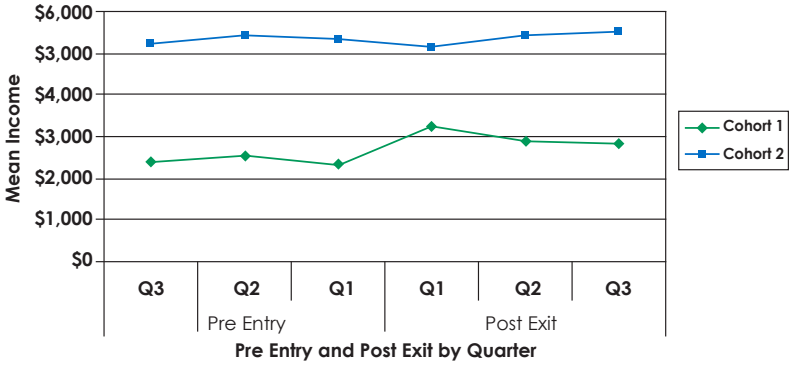
In examining employment rates *prior* to program entry across a 9-month period, Cohort 2 had a higher percentage of employed persons than did Cohort 1 (62% v. 54%, respectively). With this difference in mind, employment trends following program exit for each Cohort were examined to determine if any difference would carry through into the post-program results (Figure 2). There was an identifiable trend in both programs towards improved employment as participants exited the program (i.e. the difference between Quarter 1 pre-entry and Quarter 1 post-exit), indicating that the workforce services may have affected employment positively. Both programs showed similar longer-term results (i.e. a slight increase in the first three post-exit months followed by decline in the ensuing six post-exit months). This decline, however, appeared steeper in Cohort 2 -- indicating that SEARCH may have been more effective in helping participants maintain employment over time.

Figure 2: Percent Employment Across Pre Entry and Post Exit Quarters



Parallel to the pre-enrollment employment data, the income earned prior to program entry across three quarters was higher for persons in Cohort 2 than those in Cohort 1, $19,240 and $9,005, respectively. The pattern for post-exit income, however, did not mirror the pattern seen for employment. When post-exit earnings were examined, the combined 9 month post-exit income for Cohort 2 significantly increased from pre-program income (Figure 3). Comparing Quarter 1 pre-income earnings to Quarter 1 post-exit earnings, there was a trend toward improved income for Cohort 1. Mean wage earnings appeared to remain relatively stable over time while the average earnings for Cohort 2 appeared to gradually increase or at least did not decrease as seen in employment.

Figure 3: Mean Income Across Pre Entry and Post Exit Quarters



Impact and Anticipated Benefits

In this evaluation of the provision of workforce services for homeless job seekers, evaluators matched HMIS data with mainstream systems data to analyze the income and employment outcomes of two cohorts of homeless participants in workforce development programs. Cohort 1 sought career services at a demonstration project (Workforce Solutions Midtown), enhanced by co-location with other homeless services, and Cohort 2 sought career services from more traditional One-Stop Career Centers throughout Houston.

A key finding from this study was that homeless clients not only expressed the desire to work, but sought services, entered employment and sustained their job earnings. Other lessons learned from this study include:

- A sub-group of job seekers who are homeless (represented by Cohort 1) may need specialized, intensive services from an experienced homeless service provider.
- Typical One-Stop Career Centers serve a segment of the homeless population (represented by Cohort 2) in Houston/Harris County, but it seems to be a population with a greater record of previous employment and earnings even before seeking assistance.
- Almost 1,500 job seekers in Cohort 2 are not benefiting from Continuum of Care services in Harris County. This provides an opportunity for greater collaboration between the workforce and homeless assistance systems.

This comparison study in Houston/Harris County demonstrates clearly how a community can analyze the effectiveness of local programs by linking HMIS data with mainstream services data. The resulting analysis can then be used to enhance linkages between homeless and mainstream programs and/or design and develop more effective service systems.

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Introduction

In 2008, the community of Columbus, Ohio updated and adopted the *Rebuilding Lives Plan* (originally written in 1999), a comprehensive and interrelated set of strategies to decrease the number of people who experience homelessness. The revised plan contained eleven new strategies; among them was the development of a Unified Supportive Housing System (USHS). USHS is being developed as a collaborative effort between the Alcohol, Drug and Mental Health Board of Franklin County (ADAMH), the Columbus Metropolitan Housing Authority (CMHA), and the Community Shelter Board (CSB). The new system will target single adults, couples and families with children who have at least one adult household member who has a chronic disabling condition and may also experience long-term homelessness. This case study focuses on the use of data extracted from the HMIS and community mental health data system to help identify and select those clients with the greatest need for entry into permanent supportive housing units in the community.

Description of Innovative Project

USHS is a community collaboration intended to coordinate efforts to place the most vulnerable of the community's homeless population into the most appropriate supportive housing. It is an unprecedented collaboration in Columbus among three of the entities that come into the closest contact with people experiencing homelessness. A central aspect of this collaboration is the innovative use of data to accomplish the goals of the overall system. HMIS data is routinely matched with ADAMH and CMHA data to identify the most vulnerable individuals and families for referral to supportive housing.

The goals of the new system include:

- Simplifying and strengthening the current permanent supportive housing system.
- Increasing the number of clients served.
- Increasing resources to serve a larger client population.

Homelessness in Columbus/ Franklin County, Ohio

- Population:

  Franklin County – 1,129,067[1]

  City of Columbus - 743,364

- Homeless Point in Time Count (2009): 1,380

1 2008 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

- Increasing client and provider access to supportive housing units.
- Matching clients with the right services and the right housing for their needs.
- Encouraging clients to reach their greatest level of independence.

Three projects are planned to pilot this new system. Full implementation will be based on the results of these three pilots. This case study focuses primarily on the "Southpoint Place Lease-Up Project," the first pilot started under this initiative. The other two pilot projects, the "Move-Up" project and "Commons at Buckingham Lease-Up Project" will begin in 2010.

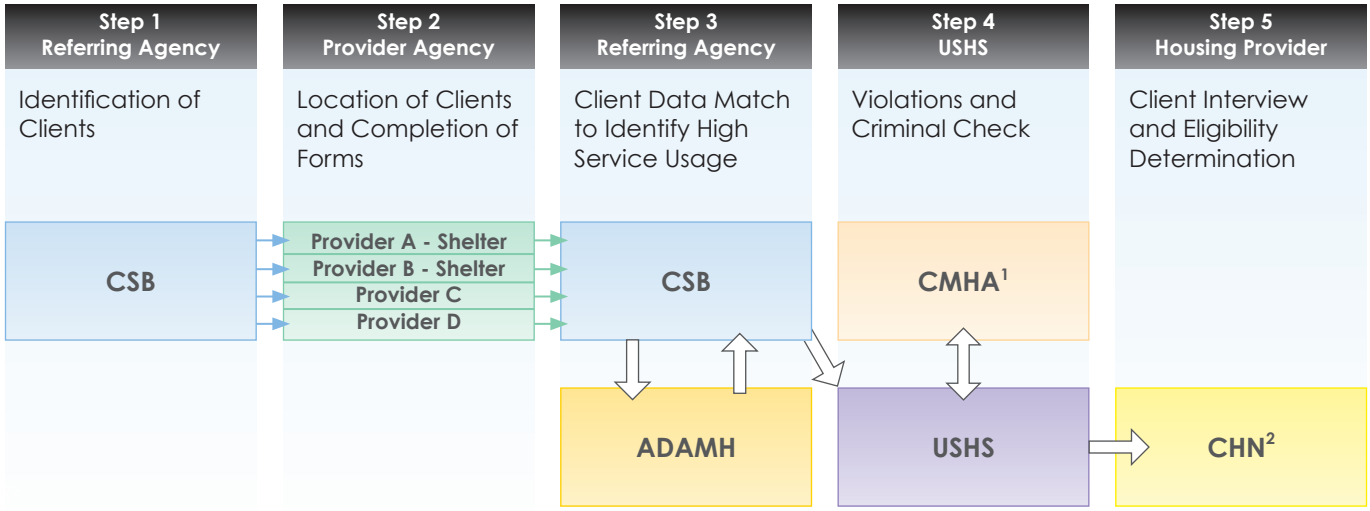
The Southpoint Place Lease-Up Project tested a centralized client assessment, eligibility and admission process for permanent supportive housing units (Figure 1 next page). The goal of the process was to quickly and efficiently identify the clients most in need of housing placement. Southpoint Place is an 80 unit permanent supportive housing development that opened in August 2008 with 25 units targeted for chronically homeless single adults and 15 set aside for ADAMH clients using the mental health system.

CSB developed the following criteria to create a pool of applicants eligible for the 25 chronic homeless units:

1. All active outreach clients (individuals living on the streets or places not meant for human habitation) receive first priority. Active outreach clients are identified through HMIS data as those individuals who have entered but not exited an outreach program.
2. Active shelter clients identified in the HMIS data which more specifically indicates either:
    a. Cumulative length of shelter stay in emergency shelters that exceeds 300 days over the last three years; or
    b. Four or more shelter stays during the last three years with a cumulative length of stay that exceeds 120 days.

The pool of potential candidates was selected based on the above criteria and distributed to emergency shelters and outreach providers, who contacted clients to determine their level of interest in moving to Southpoint Place. Prospective tenants filled out Indication of Interest (IOI) and Release of Information (ROI) forms, along with associated documentation (proof of identity, certificate of disability, proof of income, etc.), and submitted these to CSB.

Figure 1: Southpoint Place Identification and Selection Process Homeless Housing Candidates

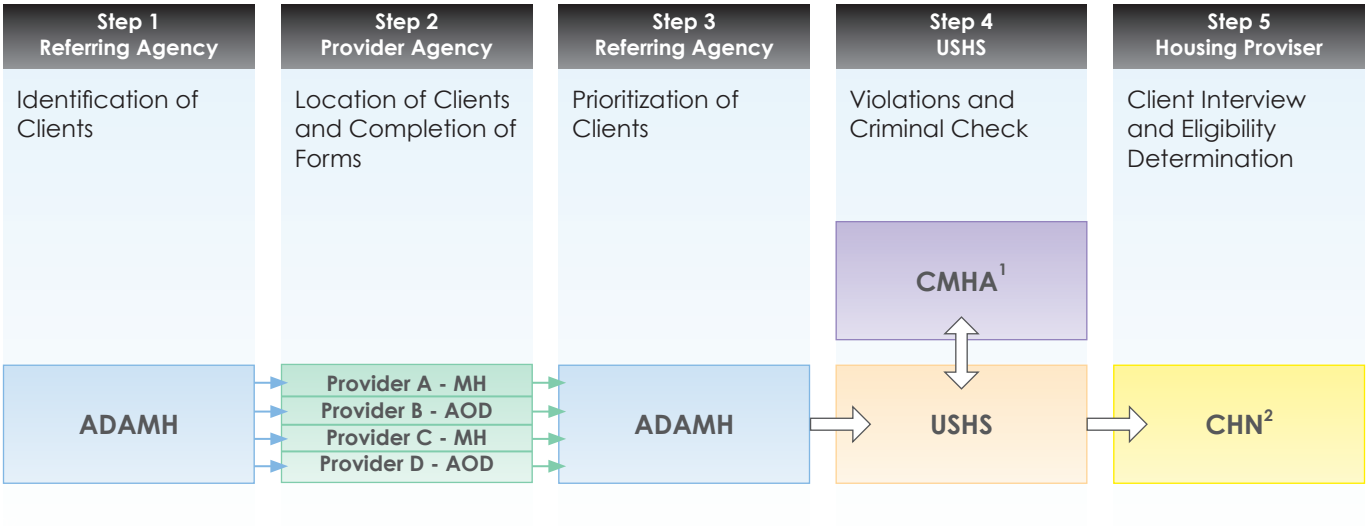


1 Data is matched to the Columbus Metropolitan Housing Authority (CMHA) database to check for a criminal history or previous violations in public housing.

2 Community Housing Network (CHN) is a nonprofit organization that provides property management services at Southpoint Place.

CSB then provided the client data to ADAMH, where staff matched it against their own database system, the Multi-Agency Community Services Information System (MACSIS). The MACSIS database combines outpatient and inpatient payment information for the Ohio Department of Mental Health, and the Ohio Department of Alcohol & Drug Addiction Services. This system compiles behavioral healthcare services data for both Medicaid paid and non-Medicaid paid services. Each client in the pool received a "high", "some", or "none" designation based on the level of services received in the previous 12 months. "High" utilization was a designation given to clients who, compared to the rest of the pool of applicants, were in the top 25% of service utilization. "Some" utilization was given to those clients who received fewer services than the top 25%, but still some services in the previous 12 months. The "none" designation was given to those that had no ADAMH service utilization in the previous 12 months. Based on these designations, scoring was attached to each client in the pool based on their service utilization level. An additional score was given to clients based on the extent of their disabilities (i.e., clients with a multiple disability diagnosis received a higher score than those that had a dual disability diagnosis). Because all of these units were targeted specifically to chronically homeless adults, all clients were also screened to meet the federal definition for chronic homelessness. Based on all of the information above, CSB prioritized potential tenants based on their extent of homelessness, disability score (multiple/dual/single diagnosis) and mental health service utilization in the preceding 12 months.

Figure 2: Southpoint Place Identification and Selection Process Non-Homeless Housing Candidates



1 Data is matched to the Columbus Metropolitan Housing Authority (CMHA) database to check for a criminal history or previous violations in public housing.

2 Community Housing Network (CHN) is a nonprofit organization that provides property management services at Southpoint Place.

Matching HMIS data with ADAMH data was the most important element of this approach. A study conducted by CSB and ADAMH showed a high percentage match between the population served in permanent supportive housing and the population served by ADAMH. For calendar year 2008, the data match between the two organizations showed that 63% of clients served in supportive housing had been involved in the mental health system in the 12 months prior to the analysis, and 82% had received mental health services in their lifetime.

For the 15 units at Southpoint Place reserved for non-homeless, disabled ADAMH clients, the process for developing and prioritizing a pool of applicants had distinct goals unique to the mental health system (Figure 2). ADAMH's priority for these units was to relieve the inpatient hospital bed crisis in Franklin County. The goal was to develop a system to move people through the housing continuum from a more service intensive environment to one that was less so, depending on a client's individual need. Candidates were identified from residential facilities working closely with case managers and resident managers. The ADAMH pool of eligible candidates was prioritized based on residential status, length of time in residency, and recommendation by the service provider.

Once both the CSB and ADAMH clients were identified and prioritized, USHS completed the process of screening clients into housing. Background and credit checks were conducted and the potential pool of clients was checked against the local public housing authority database for eligibility. This step helped make the housing provider's work more efficient once client files were received. Then, USHS forwarded the client

files to the housing provider for final interviews and approvals. USHS maintained communication with the housing provider, emergency shelters, outreach and residential programs to expedite the housing process. The process from initial receipt of the client's file to the time when the client moved into Southpoint Place was approximately 45 days.

Impact and Anticipated Benefits

While evaluation of the Southpoint Place Lease-Up Pilot is still underway, several observations can be made about ways in which the processes developed under this pilot might serve the larger supportive housing system.

Those observations include:

- Data matching across systems can effectively identify possible tenants for new project lease-up where individuals (and families) can be placed in the units most appropriate for their needs.
- HMIS-based data matching can accelerate housing placement for long-term and chronically homeless clients in shelter or on the streets.
- Centralized admission provides a workable strategy for increasing simplicity and efficiency in the tenant selection process.

Initial results also show that inpatient hospitalization costs for current Southpoint Place tenants is lower than costs for these same individuals prior to living in supportive housing. In addition, more clients are now using ADAMH outpatient services as a result of their initial engagement with the services offered at Southpoint Place. Overall, this approach appears to be fairly effective in reducing the community's cost of care for these clients.

Columbus is continuing to build on this pilot project to create a more streamlined and efficient approach to permanent housing placement. In this effort, the community is actively pursuing several other related strategies:

- While Southpoint Place demonstrated the benefits of having a pro-active referral process for filling units as opposed to waiting passively for clients to "sign up" for housing vacancies, the community will be working to develop its process for future lease-up challenges -- both in these units and other new projects.
- USHS will be working to develop a "client vulnerability assessment" tool and an inventory/vacancy management system for all supportive housing.

- As part of the Move-up Pilot, which will be starting in the beginning of 2010, USHS will be developing a "tenant assessment" tool for use in identifying tenants in supportive housing that are ready to move to more independent housing in the community

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Using HMIS to Generate Sheltered and Unsheltered Point-in-Time Counts (PIT)

Introduction

Two Continuums of Care (CoC) comprise the State of Hawaii's homeless planning system. The Honolulu CoC encompasses the City and County of Honolulu, and the Hawaii Balance of State CoC is comprised of the remaining three rural counties of Maui, Kauai, and Hawaii. In the past, the Point in Time (PIT) counts for both CoCs have been produced with the aid of contracted consultants, which have cost the State of Hawaii and City and County of Honolulu approximately $50,000 biennially. In order to save scarce resources, the State decided to use a different data collection methodology for its 2009 PIT count with the permission of the U.S. Department of Housing and Urban Development (HUD), primarily based on the use of its Homeless Management Information System (HMIS) to conduct both the sheltered and unsheltered counts. This case study focuses on the methodology used to create a sheltered and unsheltered count using the State's HMIS.

Description of Innovative Method for Data Collection

Hawaii's Statewide HMIS contains both sheltered and unsheltered data. The sheltered module contains intake, exit and supportive services data for clients served in emergency shelters, transitional housing and permanent supportive housing. The unsheltered module encompasses intake, encounter and exit data for clients served by Hawaii's outreach programs. Utilization rates for Hawaii's HMIS are 98% for sheltered providers and 95% coverage for all outreach providers. Previous unsheltered counts were performed on a single night by agency staff and community volunteers receiving a stipend, and were coordinated by a contracted consultant who handled all the data input and analysis for the count. For the 2009 PIT count, the State of Hawaii's Homeless Programs Branch used a new methodology that relied on the HMIS for both the sheltered and unsheltered counts.

Homelessness in Hawaii

- Population[1]:

  City and County of Honolulu: 905,034

  Rural Counties of Maui, Kauai, and Hawaii: 383,047

  Statewide: 1,288,198

- Homeless Point in Time Count (2009): 5,782

1 2008 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

For the sheltered PIT count, shelter providers ensured that all clients sleeping in their facilities on January 23rd were entered into the HMIS. Domestic violence shelters provided a manual count of their client and subpopulation data that was later combined with the HMIS sheltered data. The State exported and grouped the data from all shelter providers to produce an aggregate count. Client intake data taken on the survey night was queried to produce an extensive report containing all HUD-required subpopulation data.

The unsheltered count, while more complicated than the sheltered count, provided an innovative method for conducting counts on people who do not traditionally access the shelter system. Using standardized surveys outreach agencies conducted interviews of homeless individuals over the course of a five day period, beginning with the day after the sheltered count. Many of the unsheltered clients had previous engagements with outreach staff and, therefore, were already entered into HMIS, which made the required data readily accessible. Outreach staff, combined with volunteers, asked each person encountered, "Where did you spend the night of January 23rd?" (referring the night of the sheltered count). If the individual spent that evening outside of a shelter, the survey continued in order to identify the household makeup (singles, couples and families), as well as other characteristics that might determine chronic homeless status. Two separate survey instruments were used, depending on whether the individual was "single" or "part of a household." For all clients currently active in the HMIS, the survey was linked to their record as an outreach encounter and all relevant subpopulation data was updated on the intake form. Surveys for those households not already in HMIS were tallied manually and unduplicated in an Excel spreadsheet.

Impact and Anticipated Benefits

Two primary outcomes emerged from using this methodology to conduct sheltered and unsheltered counts in Hawaii. First, comparing the 2009 PIT count to previous counts, providers felt more comfortable with the accuracy of the numbers with the new methodology. Outreach providers, in particular, felt that previous counts underestimated the percentage of chronically homeless persons for the unsheltered count. On the Island of Oahu, for example, the PIT count in 2007 claimed that only 6.2% of the unsheltered were chronically homeless compared to almost 33% in the 2009 PIT count. Also, in past counts, the consultant was not able to capture some subpopulation data, including disability and veteran status, which would have provided a more accurate analysis of the unsheltered population. In the 2009 count, however, outreach providers made sure to enter and/or update this data in the HMIS, which provided a more robust picture of the subpopulation data. Clearly, having outreach providers play a greater leadership role in the 2009 count was also significant.

The second key outcome from implementing the PIT count through HMIS was significant cost savings for the State of Hawaii. Previously, the combined cost of contracted consultants, volunteer stipends, and giveaway items totaled approximately $50,000. The 2009 count, in contrast, resulted in no additional cost to the State by using State-funded staff, shelter and outreach personnel, volunteers, and donated giveaway items.

The State of Hawaii plans to implement its PIT count annually, and to obtain all subpopulation information reported in the CoC NOFA through both the unsheltered and sheltered counts. This past year, the unsheltered survey form was filled out and submitted by hand, but in the future, the State will seek to embed the form in the HMIS for all populations (singles, couples and families). This will enable surveyors to enter information directly into the system and pull client files of those already entered in HMIS to populate relevant additional fields for the survey. Survey forms could then be unduplicated and aggregated to produce a comprehensive report with total numbers of people and subpopulation data for reporting purposes. In the sheltered module, the state is considering adding an element that will allow providers to "check off" those who were in a shelter on the night of the Point in Time count. Adding these elements to the HMIS will further strengthen the data collection process, allowing for a more efficient and effective PIT count.

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The Benefits of System Integration: Allegheny County Department of Human Services Data Warehouse

Introduction

The Allegheny Department of Human Services (DHS) is the lead agency for human service programs in the Pittsburgh, Pennsylvania region. With a $1 billion annual budget, DHS consists of several different agencies including: Department of Children, Youth and Family; Area Agency on Aging; Office of Behavioral Health; and the Office of Community Services. These agencies have a large and diverse client base and provide a wide array of human services in this region. In early 2001, the Director of DHS's Office of Information Management saw a need to create a central repository of human services data that would allow DHS agencies to track client demographic and service data across all DHS program offices. This case study provides the background behind the development of the data warehouse using the CoC's HMIS as the backbone. It discusses both its practical application, and the benefits already recognized by agencies participating in this innovative data integration project.

Background

To comply with federal directives, and with the support of the local foundation community, DHS internally developed and put into production a Homeless Management Information System (HMIS) in early 2005. Allegheny County's HMIS is a comprehensive system with 100% participation from all county funded homeless providers[1] within Allegheny County. Allegheny County's approximately 2,000[2] homeless clients are entered directly into HMIS by more than 40 providers spanning over 100 homeless programs, including, but not limited to: emergency shelter, transitional housing, permanent supportive housing, supportive services only programs and Safe Haven programs. The HMIS also collects data for every chronically homeless client currently on the street, as well as clients of Allegheny County's Severe Weather Emergency Shelter. HMIS client and service level data is a direct internal source of data for the Allegheny County DHS Data

1 Non-DV homeless providers; DV providers do not enter client data into the HMIS.

2 This figure refers to the clients served over the course of a year, which differs from the "snapshot" referred to in the Point in Time number.

Homelessness in Allegheny County, Pennsylvania

- Population: 1,215,103[1]
- Homeless Point in Time Count (2009): 1,418

1 2008 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

Warehouse. Other internal sources populating the DHS Data Warehouse include: child welfare, behavioral health, developmental disability, aging services, employment and training, and several low income services such as low income energy assistance and medical assistance transportation. The DHS Data Warehouse also collects data from external sources including: Allegheny County Jail, Adult and Juvenile Probation, Allegheny County's Medical Examiner, city and county housing authorities, and the Pennsylvania Department of Public Welfare (including TANF, general assistance, food stamps and Medical Assistance). Historical data from all operating applications is also included, which allows data analysis to go back further than the inception of the DHS Data Warehouse itself.

All operating systems included in the DHS Data Warehouse supply extracts on a regular basis to update the warehouse. A complex algorithm is run on all client information to unduplicate clients common to two or more operating systems. By incorporating historical data from sources both internal and external to DHS, a multi-dimensional picture of DHS clients and their cultural surroundings is created. Authorized stakeholders make use of the various analytical tools to extract and analyze data. The data is displayed in several formats including aggregate unduplicated counts, client-specific, provider-specific and/or program-specific reports, and data by geographic location. The tools used to access the data include:

- Cognos Cubes - Displays aggregate client and service data in cross-tabs, tables, or graphs and allows users to slice and dice data for quick answers. It also provides trend analysis in specified increments.
- Cognos ReportNet - Provides a framework that allows users to drag and drop various data elements to build reports.
- SQL Queries - Generates complex ad-hoc reports straight from the DHS Data Warehouse.
- ArcMap - Displays data visually by geographic location through the creation of GIS maps.

Why Create a Data Warehouse?

There are three core reasons why the DHS Data Warehouse is beneficial to the Department and its human services partners:

1. The DHS Data Warehouse is unique in combining historical data from sources both internal and external to DHS. The breadth and depth of the data collected and housed in the data warehouse allows many stakeholders to access valuable information. The information informs needs assessments, resource allocations and policy decisions. Compiled together, these have resulted in improved outcomes for clients receiving human services.

2. The vast amount of data in the data warehouse allows stakeholders to look at individuals as a whole, not just the dimension for which DHS provides services. Additionally, the DHS Data Warehouse is working towards tracking individuals in related groups, including families and households. This will enable stakeholders to look at clients by yet another perspective.

3. The DHS Data Warehouse allows information to be tracked and stored electronically. Previously, data was tracked manually on paper, or on disconnected spreadsheets, and in some cases data was not tracked or available at all.

In addition to the advances described above, the DHS Data Warehouse continues to provide positive benefits for many stakeholders involved in human service delivery in Allegheny County. These community-level benefits include:

- Aggregate provider and service data from the DHS Data Warehouse is made available to the public through an application developed by DHS called HumanServices.Net. DHS clients and families are using information on this web site to make critical decisions regarding services for themselves and/or their family members.

- The DHS Data Warehouse enables planners to use data with greater confidence. For instance, enhancements in the client matching algorithm have substantially improved the unduplicated identification of clients in multiple information systems. In calendar year 2005, for example, the DHS Data Warehouse reported 250,000 clients served, with 26% of teenage children served in child welfare also served by the mental health system. In calendar year 2006, the data warehouse more reliably reported serving 181,000 clients, with 44% of teenage children served both by child welfare and mental health systems.

- Educational and research institutes rely on the DHS Data Warehouse to assist in studies and research projects as a single point of data collection rather than going to many sources and piecing data together. To date, institutional users have included: RAND Corporation, the Center for Disease Control, Carnegie Mellon University, the University of Pittsburgh, Funders in Criminal Justice and the U.S. Department of Justice.

Impact and Anticipated Benefits

Given HUD's increased emphasis on permanent supportive housing and decreased emphasis on supportive services, Allegheny County's number one priority in 2008 was securing new Shelter Plus Care (S+C) units. Their challenge in securing S+C units in the past was identifying appropriate funding sources to address HUD's dollar-for-dollar matching service requirement. The Data Warehouse helped create a solution for this requirement.

In direct partnership with the Allegheny County Department of Mental Health Services, Community of Care Behavioral Health Organization (CCBH) and the Allegheny County Office of Community Services staff used the data warehouse to match HMIS data against data for both the Department of Mental Health and CCBH. Comparative results from this analysis demonstrated that:

- Forty percent of Allegheny County's homeless persons were also receiving Drug and Alcohol services.
- Sixty percent of Allegheny County's homeless persons had, at one time, been enrolled in the mental health system.

Relying on these findings, these services partners were able to:

- Identify $4.4 million dollars in matching mental health services over the past five years.
- Secure 51 single S+C units for chronically homeless individuals and 50 new S+C units for families (representing a 15% direct increase in units available for homeless clients in Allegheny County).

Using GIS mapping technology and HMIS data, Allegheny County was able to illustrate the direct success of homeless programs and the need to grow the CoC infrastructure. As a consequence of these efforts, the local foundation community established a $500,000 annual fund committed to addressing the HUD matching funds requirement, as well as to directly compensate for the loss of service funds resulting from the community's shifting emphasis toward housing.

In a similar vein, HMIS data is now actively shared with the Allegheny County Homeless Advisory Board to secure support and approval for emerging CoC priorities, including increased permanent housing, expanding "housing first" models and establishing additional facility-based Safe Haven programs.

Finally, Allegheny County is utilizing DHS data to inform quarterly HMIS outcomes and peer support meetings that use data-based documentation to drive analysis of ways in which programs are meeting or exceeding HUD performance benchmarks and local dialogue on enhancing outcomes.

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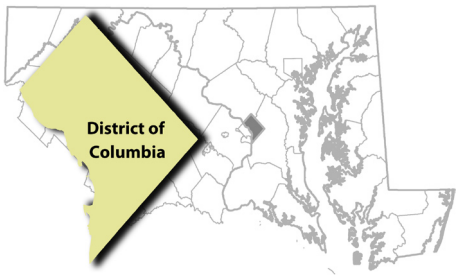
Introduction

The Community Partnership for the Prevention of Homelessness (TCP) is an independent, non-profit corporation coordinating the District of Columbia's Continuum of Care (CoC) on behalf of the city. TCP successfully manages a large and complex homeless portfolio using three key tools: comprehensive housing services; responsible fiscal controls; and an integrated data system. Through the creation of an integrated data system, a unique information technology solution, these three divisions are seamlessly joined, enabling effective and efficient implementation of innovative program designs. This case study examines both how TCP integrated a client-based case management system with its financial system and how this integration has helped to insure cost effective, timely and high-quality service delivery. Integrating two data systems has also led to a deeper understanding of the financial benefits of rapid re-housing compared to providing emergency shelter for homeless clients.

Background

As the needs of the District of Columbia's CoC and local policy priorities have changed, so have the services provided by The Community Partnership for the Prevention of Homelessness. To best meet the needs of homeless clients, TCP has increasingly focused on providing permanent housing and homelessness prevention assistance for special needs and extremely poor populations. Each month, TCP issues as many as 1,200 checks to provide one-time emergency rental assistance payment for clients on the brink of becoming homeless, to pay for bridge-subsidy funding for families in community-based transitional housing, and to help subsidize long-term permanent housing for persons with disabilities for whom independent rental payment is not feasible. In addition to these housing services, TCP manages a subcontract portfolio that funds over 145 homeless services programs, utilizing eight different funding streams, each with its own set of regulations.



Homelessness in Washington, DC

- Population: 591,000[1]
- Homeless Point in Time Count (2009): 6,606

1 2008 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

Linking HMIS Data with Financial Data

Given the size and scope of the programs administered by TCP, staff sought to design an integrated management information structure to manage programs and collect meaningful data. They did so by integrating and linking the CoC's HMIS and TCP's financial systems - the SAGE Micro Information Product (MIP) accounting database. In 2008, TCP enlisted the help of an outside consultant to develop a check request data system linking accounting and HMIS information for each housing program. The intended goals for this system were to:

1. Develop uniform methods to issue large numbers of checks quickly, efficiently, and transparently.
2. Link HMIS information with accounting information to determine whether new programmatic initiatives were more cost effective then shelter.
3. Map distribution of prevention funding to assess whether certain parts of the city were requiring more assistance, and to ensure that permanent housing programs are not over-concentrating clients in any single area of the city.

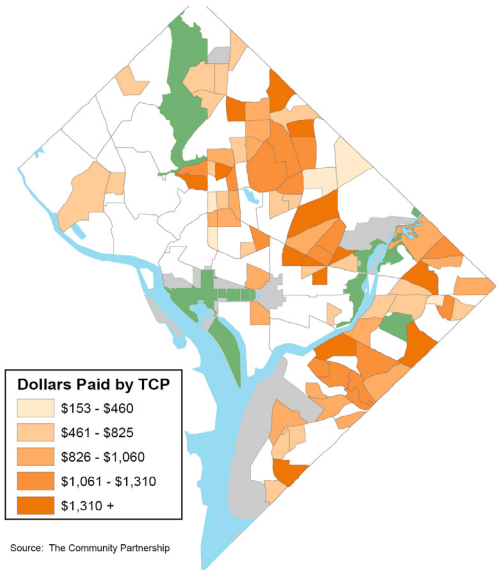
From an analytical perspective, this integrated system – combining client level information collected in the HMIS and accounting data on program costs – allows staff to determine the true cost of a program on a client by client basis. Cost information is used to place clients in most appropriate interventions. From a programmatic perspective, the system also allows TCP to determine concentration of clients served by geographic area within the city (Figure 1). Finally, from an organizational perspective, this integrated system provides fiscal controls to ensure that programmatic, client and accounting information are seamlessly joined.

Description of Data Used

In order to create this new system integrating both HMIS and financial information, staff used the following variables:

- Client Name
- HMIS ID
- Client Address
- Landlord Address
- Landlord Contact Information
- Amount of Subsidy

Figure 1: Shelter Plus Care Participants Mapping to Determine Cost Concentration

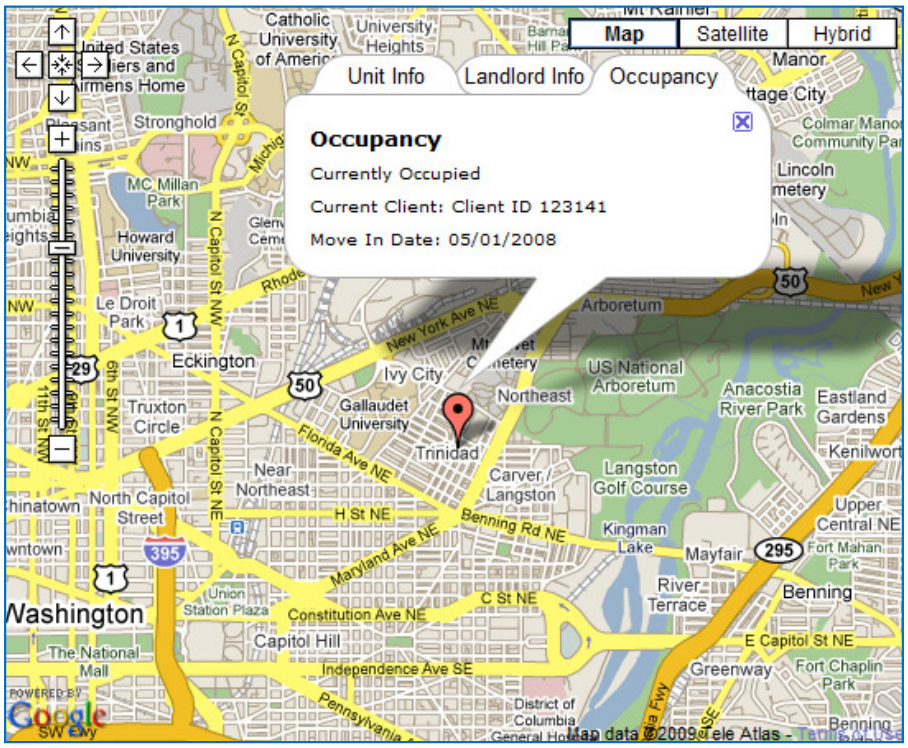


- Client Contribution
- Housing Program Utilized
- Date of Entry and Exit

The data system developed is based on an enhanced Microsoft Access system. Information from both the local HMIS and financial system is imported into Access. The integrated system then produces check requests, using a uniform method for completing the landlord payment process for over 1,200 clients. As the system is updated every month with new clients, different rental amounts, and closed cases, the information is seamlessly downloaded back into the MIP accounting system.

As Figure 2 demonstrates, the data systems application allows for street addresses to be downloaded from HMIS for easy mapping. The HMIS Client ID also allows for accounting information to be tracked back to specific clients to produce cost information by client.

Figure 2: Mapping HMIS Housing Data



Impact and Anticipated Benefits

The Community Partnership for the Prevention of Homelessness has demonstrated how an integrated data system combining client, payment and address information may facilitate a community's process for transitioning from shelter-based services to housing-based services. From a local management perspective, integrating client and financial information has substantially enhanced the community's capacity to manage large housing programs for special needs populations. Integrating these technologies has also enhanced the community's strategic and analytic capabilities.

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Benefits of a State and Local HMIS Collaborative

Introduction

The New Jersey Statewide Homeless Management Information System (NJHMIS) Collaborative is a unique technology partnership among state agencies and local communities. The Collaborative is coordinated by the New Jersey Housing and Mortgage Finance Agency (HMFA), and includes the New Jersey Department of Human Services (DHS), the New Jersey Department of Community Affairs (DCA) and 20 Continuums of Care (CoC) local homeless planning communities. Through this partnership, the State of New Jersey has been able to increase participation in NJHMIS and leverage data from many disparate human service agencies, both HUD-funded and non HUD-funded. This case study highlights the core elements of this partnership and the impact it has had on the agencies providing services to homeless and at-risk clients in New Jersey.

Background

The NJHMIS Collaborative provides robust data management and reporting capacity for housing and service organizations serving homeless, disabled, low-income and at-risk populations. As in most CoCs, HUD is not the only agency providing funding to programs throughout the state. Each funding agency has unique monitoring, data collection, and reporting requirements. In many cases, this leads to data entry duplication and strain on already limited staff resources. The NJHMIS provides a technological solution to reduce duplicative data collection and provides an opportunity for various state agencies to use the NJHMIS to gather data and report on client progress.

In addition to data collected for HUD reporting purposes, the NJHMIS contains data needed for the New Jersey DHS Division of Family Development (DFD) to monitor shelter and prevention funds allocated to agencies, counties, or the entire state. The collaborative system also allows the DHS Division of Mental Health Services (DMHS) to produce Quarterly Contract Monitoring Reports and the Annual Report Survey needed for the Project for Assistance in Transition from Homelessness (PATH), a federally-funded program.

Homelessness in New Jersey

- Population: 8,682,661[1]
- Homeless Point in Time Count (2009): 7,918

1 2008 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

HHS Project for Assistance in Transition from Homelessness (PATH) and NJHMIS

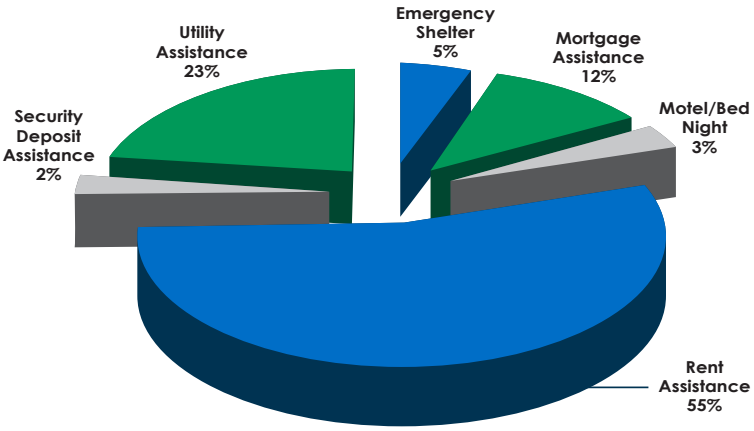
PATH, a program funded by the federal Department of Health and Human Services (HHS) targets individuals with serious mental illness living on the street or in places not meant for human habitation. Most PATH funds are allocated to support outreach workers who actively engage and enroll these difficult to serve clients in needed services. There is frequent duplication both in the client base and in the information collection process for case managers who may be funded both through HHS and HUD to conduct homeless outreach programming. To address this issue, the NJHMIS Collaborative developed a plan to include PATH providers in the NJHMIS and facilitate participation in NJHMIS by PATH outreach workers[1].

As a consequence of the innovation documented here, all agencies receiving PATH funds in all 21 New Jersey counties now participate in the NJHMIS. Outreach workers in these programs are now entering comprehensive data on clients engaged on the street and those enrolled in the PATH program, including tracking of service linkages resulting from engagement or enrollment in the program. As a result, PATH programs are able to run reports both on aggregate numbers of clients in outreach and their linkages to homeless services. All of this data is needed to report out on the Quarterly Contract Monitoring Report (QCMR) required of all PATH program grantees.

Using HMIS to Track and Analyze Expenditures

In addition to PATH providers using the NJHMIS, other state-funded Support Services for the Homeless (SSH) programs use the system as well (Figure 1). These programs have successfully implemented NJHMIS and have been able to use NJHMIS data to analyze expenditures and make decisions regarding resource allocation.

Figure 1: SSH-Funded Agencies: Expenditures by Cost Type



The NJHMIS tracks expenditures for all SSH-funded agencies' including those providing emergency shelter, motel/bed nights, rent assistance, mortgage assistance, utility assistance, and security deposit assistance. The NJHMIS allows both the state Division of Family Development and locally-based CoCs to run quarterly reports to track the level of resources expended in each of these program areas. Agencies can then produce reports as soon as 10 days following the end of a quarter.

1 It may be helpful to note that since this study was initiated SAMSHA has announced a new directive requiring PATH providers to use HMIS for client services documentation.

The ability to gather information in a timely manner helps both state agencies and local CoCs to effectively monitor resources and make informed policy changes based on valid, reliable data.

Impact and Anticipated Benefits

The NJHMIS provides user organizations from multiple state systems with the ability to track both mission-critical and administrative data while facilitating one-time, point-of-service data entry. This cross-systems collaboration has resulted in a variety of system-wide benefits and has positively impacted the agencies involved by providing:

- Centralized collection of information on services provided to homeless and persons and those at-risk of becoming homeless.
- Compilation of information that can be used for multiple reporting requirements.
- Increased cost efficiencies and reduced burden on program staff in participating CoCs and agencies required to collect common information.
- Increased commitment of State fiscal and human resources for ongoing HMIS system management and training.
- Uniformity in reporting measures through utilization of a single standard HMIS system.
- Strengthened needs assessment processes required of all local jurisdictions.
- Increased reliability of data for evaluation and assessment of mainstream housing and social service systems.

As the system continues to expand and grow, NJHMIS staff anticipate that participating agencies will see even more benefits as a result of this unique approach to data collection and data sharing.

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Facilitating Data Collection and Reporting for Faith-Based Homeless Programs

Introduction

Provision of homeless services in rural communities can be challenging due to limited funding, broad geographic span, and lack of access to care. The Appalachian Regional Coalition on Homelessness (ARCH) Continuum of Care (CoC), located in northeastern Tennessee, consists of eight rural counties and three small cities (Bristol, Johnson City, Kingsport) covering 2,900 square miles. The area has a population of almost 500,000 with only twenty HUD-funded agencies providing homeless assistance services. To enhance the local capacity to meet the needs of the homeless, faith based providers play a critical role in meeting the gap between demand and capacity. Through a partnership between ARCH and the local faith based coalition, a working relationship has formed to create a shared, online data management system that allows diverse, community-based agencies -- including shelters, food banks and churches -- to coordinate service delivery.

Background

Prior to funding of the ARCH CoC in 2003, a network of faith based organizations served as the local social safety net. Beginning in 1996, a coalition of local pastors formed to discuss ways to better coordinate service delivery to both ensure a high level of effectiveness and help as many individuals and families as possible without duplicating limited assistance. To address their concerns, the pastors' coalition devised a common web-linked database to track the services they were providing to their community members.

In 2003, when the ARCH CoC was convened, its members were aware of the data management network and approached the pastors to create a coordinated HMIS solution. This would expand the existing group of churches and benevolent agencies (e.g. food pantries) to include direct homeless service organizations (e.g. shelters, permanent housing agencies). The existing web-linked database served as the foundation for the ARCH CoC HMIS. The ARCH CoC and the local churches agreed to collaborate in data collection and analysis.

Homelessness in Northeastern Tennessee

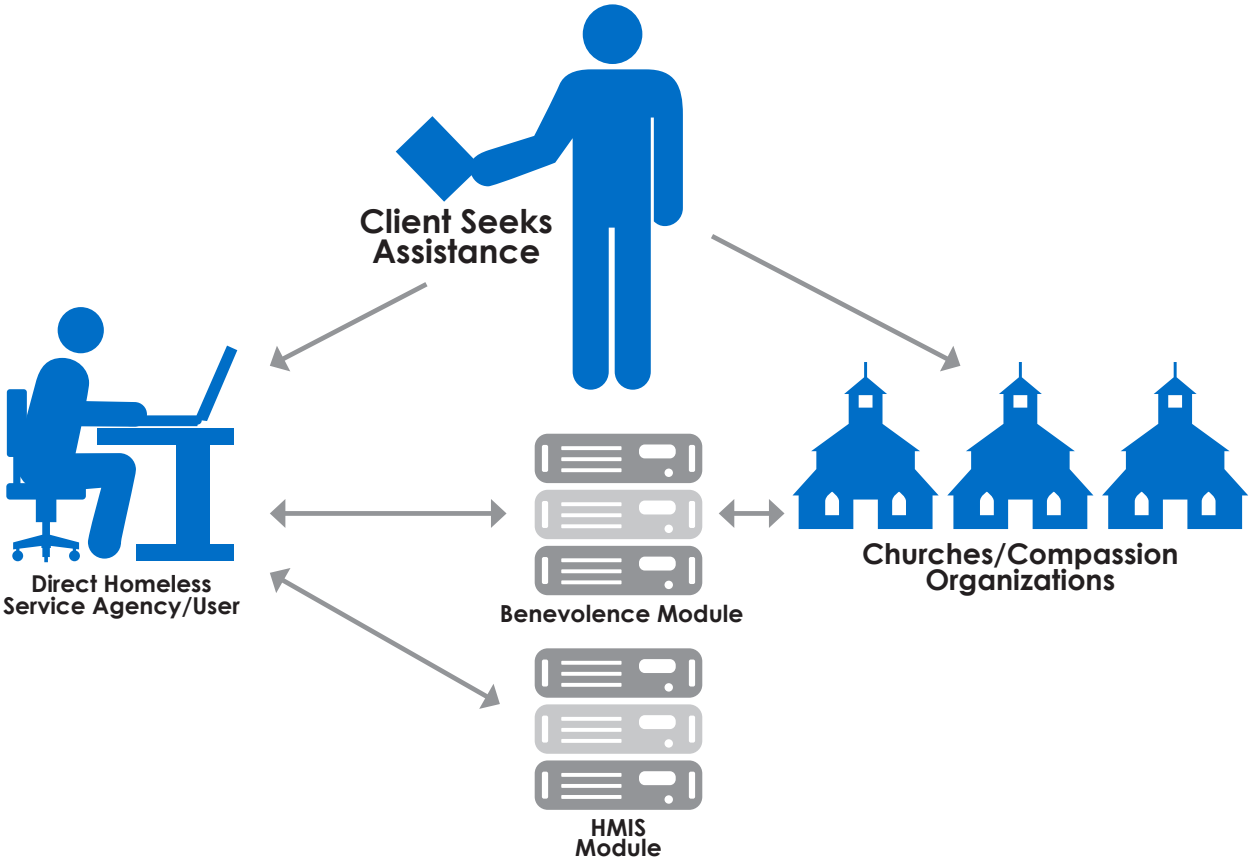
- Population: 498,188[1]
- Homeless Point in Time Count (2009): 840

1 2008 Population Estimates, U.S. Census Bureau; www.factfinder.census.gov

Combined Data Management System

Working together, the CoC and the pastors' coalition created a shared, online data management system that allows diverse, community-based agencies -- including shelters, food banks and churches -- to track service delivery. The information system tracks data by two agency types: 1) direct homeless service organizations and 2) benevolence agencies (i.e. faith-based organizations and churches). Each group is able to record expenditures and service delivery frequency through the network with the enhanced capability for HUD-funded organizations to meet the HMIS requirements. Figure 1 illustrates the flow of data through the combined data system.

Figure 1: Operation of the ARCH data entry system



Description of Data Use

The ARCH CoC utilizes the combined data management system in a variety of ways, most notability in reducing the provision of duplicative services through coordinated case management. The ARCH CoC has found that 75% of clients were seeking duplicative services and 45% were regularly receiving assistance from

more than one agency. The integrated system assists agencies to develop effective case management plans to ensure clients are not provided duplicative services or referred to agencies that have previously provided support. The shared information system helps the CoC to streamline service provision as the same clients are not seeking help across agencies for the same service (i.e. May's utility bill). Additionally, agencies have access to a real-time bed registry showing system-wide bed availability, type of beds available, and staff contact information for those providers. The shared case management and service tracking system allows the community to help preserve and extend service capacity at provider agencies and, ultimately, allows the community to serve clients more effectively and efficiently.

Impacts and Anticipated Benefits

Based on the strong foundation of interagency collaboration between direct homeless service and benevolence agencies in the ARCH CoC, the community has implemented a data management system that has positively impacted the region in a number of ways. The following are key outcomes agencies in the region have experienced:

- Reduced service duplication, allowing agencies to be more efficient and effective with limited funds.
- Enhanced analysis on cost/value of services, including leverage and match.
- Increased assessment of agency strengths and weaknesses from a data-driven perspective.
- Improved service delivery through regional collaboration and real-time referral systems.

In the future, the ARCH CoC plans to:

- Improve coverage by getting hospitals, jails, local state prisons, and foster care systems to participate in the data-sharing network.
- Cross-reference data in the system with all Point in Time surveys[1].
- Develop virtual single point of entry into the homeless system with a common intake form to be used across the region.

1 ARCH currently cross-references sub-populations such as Veterans, but leaders believe that a more accurate count could be obtained by doing this in a more comprehensive way.

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