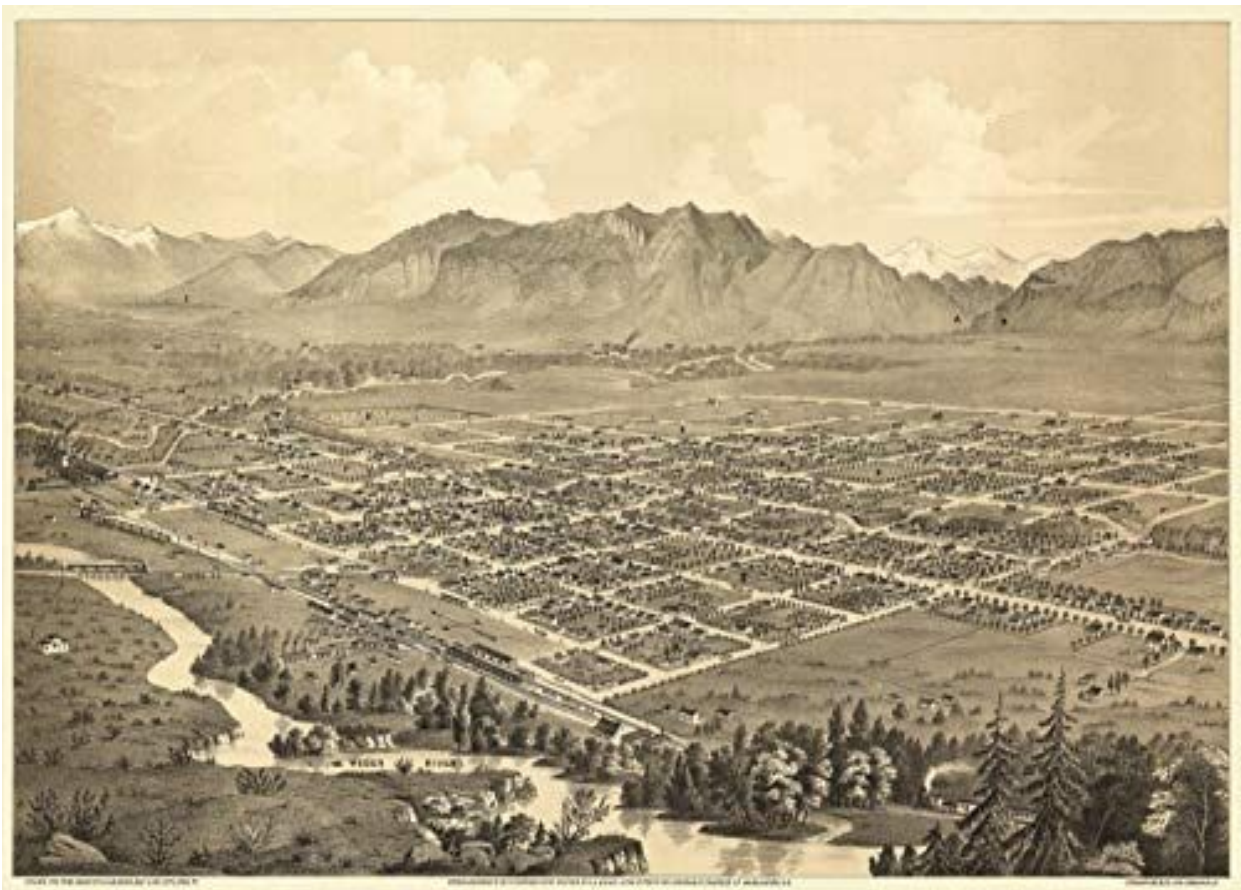# COMMUNITY ASSESSMENT & STRATEGIC PLAN 2019

Improving the Homeless Response System in Weber County

Major Findings

Highlights and recommendations based on community assessment

Homelessness in Weber County is *proportionately higher than* homelessness in Salt Lake County, and has increased at much higher rates from 2014 to 2018 (pp. 5-7).

The gap of affordable housing for extremely-low-income households, combined with increasing rents and decreasing renter income, will likely lead to further increases in homelessness (pp. 7-9).

The loss of a Federal grant for homeless people who experience severe and persistent mental illness left a gaping hole in service that is affecting performance outcomes and will likely lead to recaptured and/or reduced funding (Appendix C, Focus Area 5, Permanent Supportive Housing).

Without an investment in the Weber Homeless Coordinating Committee and improved access to local, homeless system-level data, Weber County will not have the basic tools needed to reverse concerning trends (Appendix C, Focus Area 1 and 2).

Weber County needs to re-orient its system and services to a housing first philosophy and a housing-focused approach (Appendix C, Focus Area 4).

Consistent with national trends, homeless adults without children make up the vast majority of the homeless population and are increasing at faster rates than households with children (pp.5-6).

Of the six applicable system performance measures for Weber County, only Measure 2 (average rates of return to homelessness), moved in a positive direction in the most recent report year. This is most likely a result of the above concerns and insufficient funding (pp. 10-14).

Who We Serve

Insights from homeless individuals in Weber County

JAMES has been homeless on and off for multiple years now. He feels like he is churning through the system repeatedly without any benefit. "You can't get a place to live without a job and you can't get a job if you have a [criminal] record." He knows there are services around to help, but they are so complicated to navigate and punitive in their approach that "it basically robs you of your will to keep trying."

ROBBY is insightful as he shares thoughts about early assessments and working around systemic barriers that discriminate against the homeless. The storage company won't allow people to rent space with the address of a homeless shelter so he uses his sister's. The U.S. postal service won't allow people to get a P.O. box using the shelter address either. He is employed and has enough money saved up for a deposit and first month's rent, only he can't find a unit that will accept his application. He has a non-violent felony on his record from when he was 18 years old. "And landlords won't accept that."

Within the first moments of interaction with **MONICA** it becomes clear she experiences a developmental delay or cognitive disability. She has difficulty keeping up with the focus group conversation. The one question she does offer a direct response to is about safety. "You should give everyone whistles," she says. She then shares that she has been raped 9 times.

Executive Summary

The scope of homelessness in Weber County is more significant than previously realized. Though the population is much smaller than Salt Lake County, Weber County has proportionately higher rates of homelessness, a higher percentage increase of homelessness, and disproportionately lower funding. Weber County hosts 13-16% of the state's homeless population and received 8.9% of state homeless funding in the FY19 allocation round (not including sizeable legislative appropriations; none of which went to Weber County).

Without increased resources, system-level oversight and access to local data, an emphasis on affordable housing for extremely-low-income residents, and housing-oriented services, Weber County may be heading for an even more concerning future; wherein homeless families and individuals suffer the ultimate consequences.

Weber County has long been a community that works hard to prioritize the needs of clients and set aside differences to achieve the best possible outcome. Service delivery components are present and functional, but have not expanded commensurate with need and could use a reorientation to housing first principles and housing-focused services.

A structure for homeless service system-level oversight and coordination is almost entirely absent; it is the clear weakness that limits programmatic optimization and renders system optimization impossible. County government is working on a mechanism for high-level, cross-system coordination; however, before homelessness can effectively be addressed across systems, an investment in the *homeless* services system itself needs to be made.

This plan recommends a Homeless Services System Coordinator be hired to oversee the implementation of this strategic plan and provide backbone support to the WHCC and its subcommittees. The structural framework for the strategic plan includes five recommended focus areas and their objectives, strategies or policies to obtain each key focus area objective, and specific action items for each strategy.[1]

It is a pivotal time to be involved in homeless services and an opportune time to make an impact because we know what works. We don't have to make guesses about how to administer key programs or measure success.

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[1] While findings are consistent with the 2018 Utah legislative audit of homeless services, they are targeted to Weber County. Similarly, while recommended strategies are consistent with the general direction of State and Federal strategic plans, they are also specially tailored to the local community.

Table of Contents

RECOMMENDED FOCUS AREAS

Addressing the gaps and barriers outlined in this recommendation may
be the most crucial for any kind of lasting effort to address homelessness.

Proper data collection, cleaning and end-use must inform each aspect of
the work pursued in the homeless services system.

Cross-system coordination can help expand a sufficient, safe, and affordable
housing stock; and rapidly target those most at risk of homelessness.

A low-barrier, need-based, and highly-coordinated continuum of homeless
services significantly reduces the time it takes to reclaim housing stability.

A sustainable end to homelessness can only be achieved if people are
able to access the tools and resources needed to maintain stability.

A hyperlinked table of all Focus Areas-Objectives-Strategies-Action Items.

Homelessness in Weber County

*An assessment of homeless counts, comparisons, and trends*

Taken together, the data from the PIT and the State Homelessness Data Dashboard tells the story of Weber County homelessness on the rise. Homelessness in Weber County is increasing at faster rates than the rest of Utah combined. Attention for homeless services in Utah remains focused on Salt Lake County, but the data point to a pressing need to attend to rising rates in homelessness in Weber County.

Homeless data set alongside a shortage of affordable housing units, decreasing income and increasing rent cost, tell a cautionary tale should the current trajectory go uninterrupted.

Point-in-time Count (PIT) Data

The Point-in-Time Count (PIT) is comprised of a sheltered and unsheltered count of homeless persons on a single night in January. It includes all homeless service provider agencies in Weber County and not just those that enter data into the Homeless Management Information System (HMIS).[2] The limitation of the PIT is that it only captures a snapshot in time.

According to the State of Utah Annual Report on Homelessness 2018,[3] the Weber-Morgan County LHCC[4] identified 376 total homeless persons on a single night in January 2018.[5] This number marks a 48% increase from 254 total persons counted on a single night in January 2014.[6] As a point of comparison, the Salt Lake County PIT showed a 13% *decrease* from 2014-2018 and the statewide count showed a *decrease* of 6%.
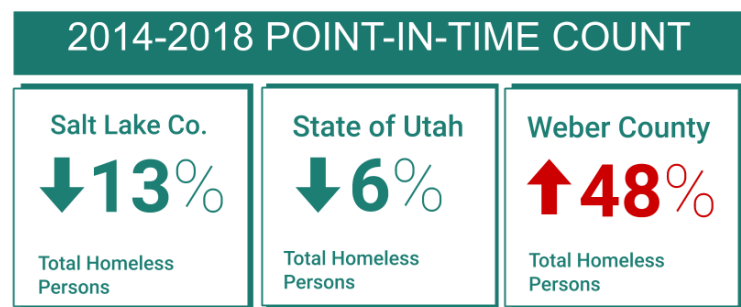
(Fig 1) Sources: Comprehensive Report on Homelessness, State of Utah 2014; State of Utah Annual Report on Homelessness 2018

Of the 376 homeless persons recorded in the Weber County 2018 PIT, 70% are in households of adults without children. The individuals living in households

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[2] HMIS is the shared database used by homeless service providers to collect client-level data and data on the provision of housing and services.
[3] https://jobs.utah.gov/housing/scso/documents/homelessness2018.pdf
[4] Zero homeless persons were counted in Morgan County from 2014 through 2018.
[5] The WHCC reports 6 unsheltered individuals higher than what is reported by the State.
[6] The 2014-2018 timeframe was selected to compare data with the State Homelessness Dashboard

without children had the highest actual difference increase of any household type in Weber County from 2014-2018. This is consistent with state and national trends, but also indicates the need for a more focused response to this subpopulation. Households of adults *with* children made up 25% of those counted in 2018, and households of unaccompanied children make-up 5%. The average family size in 2018 (PIT) for households made up of adult(s) and children in Weber County was 3.4 persons, which was comparable to state averages.

(Fig 2) FAMILY COMPOSITION OF HOMELESS POPULATION

Weber County Headcount (2018 PIT)

● ADULTS W/ CHILDREN   ● UNACCOMPANIED CHILDREN   ● ADULTS WITHOUT CHILDREN
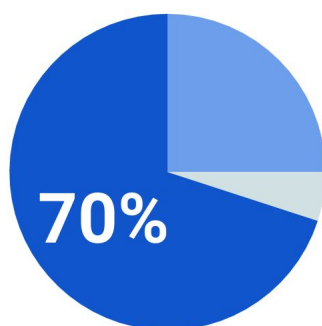
State Homelessness Data Dashboard Data

Where the PIT only captures data for a single night, the State Homelessness Data Dashboard[7] allows users to examine data across any configuration of defined days, months or years from 2014 to the present. While this is a significant advantage, the Data Dashboard also has some limitations; it only captures agencies that enter their data into HMIS (this excludes three agencies and at least one program in Weber), and it cannot currently filter by Local Homeless Coordinating Committee (LHCC) or County.[8]

According to data from the Dashboard, the *annual* unduplicated count of homeless persons in HMIS for Weber County[9] in 2018 was 2,551, compared to 1,533 in 2014; a 66% increase. When Weber County data is put alongside Salt Lake County and statewide data for comparison (Table 1), it becomes clear that Weber County's comparatively higher percentage increase in PIT data is consistent with the HMIS data set. Homelessness in

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[7] https://jobs.utah.gov/housing/homelessness/homelessdata.html
[8] Data were filtered by selecting agencies operating within Weber County. This creates known inaccuracies for three agencies that also provide services outside of Weber County.
[9]Persons served in street outreach, emergency shelter, transitional housing, and rapid rehousing before move-in.

Weber County is increasing at faster rates than it is in Salt Lake County and in the State of Utah as a whole.

(Table 1) % Change of Annual Unduplicated Count in HMIS

	2014	2018	Percentage change 14-18
State of Utah	13,394	15,460	15%
Salt Lake County	9,736	10,807	11%
Weber County	1,533	2,551	66%

Source: State Homelessness Data Dashboard; pulled April 2019

The annual 2018 unduplicated count of total homeless persons in HMIS for Weber County, calculated as a percentage of total County population shows Weber County's rate of homelessness is double that of the state and slightly higher even than Salt Lake County (See Table 2). This comparison will likely come as a surprise to many and should bring pause to political leaders and lawmakers who might discount the need for funding and support in Weber County.

(Table 2) Annual Unduplicated Count in HMIS as % of Total Population

	2018	Total census population (est. 2018)	2018 homeless as % of total population
State of Utah	15,460	3,161,105	.49%
Salt Lake County	10,807	1,152,633	.94%
Weber County	2,551	256,359	1.00%

Source: State Homelessness Data Dashboard; pulled April 2019
Census Population Estimates 2018

Homelessness and Affordable Housing

Research shows a clear link between rent affordability and homelessness. As rents become less affordable, households become cost burdened and more prone to eviction and homelessness. Affordable housing is defined as housing where the total cost, including utilities, is no more than 30% of household income. A December 2018 study shows that when housing costs reach 32% of the median household income, the rate of homelessness rises more sharply.[10]

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[10] Inflection Points in Community-Level Homeless Rates; Glynn, Byrne, and Culhane (2018)

An estimated 44.2% of tenants in Weber County are rent burdened, where their rent costs are ≧ 30% of household income; 34.5% pay ≧ 35% of household income toward rent costs. [11]
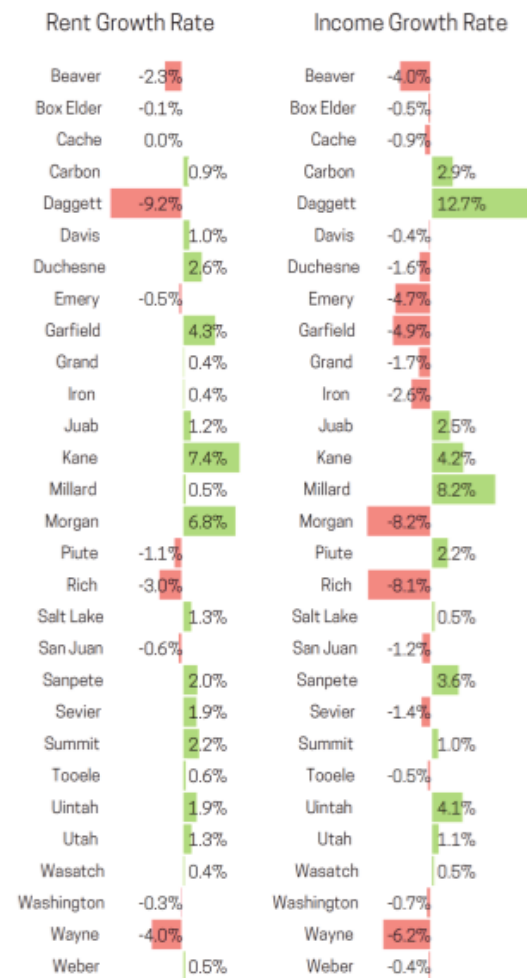
In hourly wages, the average renter is estimated to make $11.48/hour, which is *$6.02 per hour less than* a head of household would need to make to afford a two-bedroom unit at HUD-calculated fair-market-rates (the estimated amount, including utilities, to rent existing rental housing of a modest nature with suitable amenities). Said another way, the average head of household renter would need to work 1.5 full time jobs to cover housing expenses for a two-bedroom unit in Weber County. [12]

To make matters worse, the rent growth rate in Weber County is increasing while the income growth rate is decreasing. Even though the rates are quite small, this trend will further exacerbate renter burden. Constant median rent increased by .5% whereas the income growth rate decreased by .4% from 2009-2016. Weber County is called out in the State Report as a county of particular concern.

The story for Weber County's extremely-low-income (ELI) residents is more problematic. Weber County has a "higher-than-expected" proportion of ELI renter households, making up 27% of the County's total renter population. [13] According to the 2018 State of Utah Affordable Housing Report, 83.1% of ELI households in Weber County are cost burdened and 64.9% are severely cost burdened. [14] An ELI household of four in Weber County would have an annual income of no more than $25,750 (≤30% HUD area median family income [HAMFI]), pricing them out of a 2-bedroom

(Fig 3) Constant Median Rent & Income Growth Rates, 2009-2016

	Rent Growth Rate		Income Growth Rate
Beaver	-2.3%	Beaver	-4.0%
Box Elder	-0.1%	Box Elder	-0.5%
Cache	0.0%	Cache	-0.9%
Carbon	0.9%	Carbon	2.9%
Daggett	-9.2%	Daggett	12.7%
Davis	1.0%	Davis	-0.4%
Duchesne	2.6%	Duchesne	-1.6%
Emery	-0.5%	Emery	-4.7%
Garfield	4.3%	Garfield	-4.9%
Grand	0.4%	Grand	-1.7%
Iron	0.4%	Iron	-2.6%
Juab	1.2%	Juab	2.5%
Kane	7.4%	Kane	4.2%
Millard	0.5%	Millard	8.2%
Morgan	6.8%	Morgan	-8.2%
Piute	-1.1%	Piute	2.2%
Rich	-3.0%	Rich	-8.1%
Salt Lake	1.3%	Salt Lake	0.5%
San Juan	-0.6%	San Juan	-1.2%
Sanpete	2.0%	Sanpete	3.6%
Sevier	1.9%	Sevier	-1.4%
Summit	2.2%	Summit	1.0%
Tooele	0.6%	Tooele	-0.5%
Uintah	1.9%	Uintah	4.1%
Utah	1.3%	Utah	1.1%
Wasatch	0.4%	Wasatch	0.5%
Washington	-0.3%	Washington	-0.7%
Wayne	-4.0%	Wayne	-6.2%
Weber	0.5%	Weber	-0.4%

Source: USCB: American Community Survey, 2009 thru 2016 [Tables B25064 & B25119].
*2017 Constant Dollars.

Source: Fig 24, Utah Department of Workforce Services, State of Utah Affordable Housing Report 2018

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[11] The U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
[12] State of Utah Affordable Housing Report 2018
[13] State of Utah Affordable Housing Report 2018
[14] State of Utah Affordable Housing Profiles 2018

unit at HUD fair market rate (Table 3).

(Table 3) Affordability of a 2 Bedroom Unit for an ELI Household of four - Weber County

Extremely low-income household income	Affordable Rent	2 Bedroom Fair Market Rent	Shortfall
$25,750	$643.75/month	$910/month	$266.25/month

Source: HUD 2019 Income Limits and FMR

Even with the number of affordable housing units in Weber County for ELI households, which is still estimated to be 2,540 units short, not all affordable units that are priced within a certain income group are actually available for that group to rent. Many households with higher incomes will rent units that fall into a lower-income affordability range, making them unavailable. There is an estimated shortfall of 4,095 available units for extremely-low-income households. Weber County is among the three lowest counties statewide for these two measures. Contrast to an estimated surplus of 3,745 affordable units for households between 30-50% HAMFI and a surplus of 6,750 affordable units for households between 50-80% HAMFI, ironically making Weber County among the three highest counties for these measures. (Figure 4.)

(Fig 4) Utah's Deficit of Affordable and Available Housing Units by County

County	Affordable Housing Units			Available Housing Units		
	<30% HAMFI	<50% HAMFI	<80% HAMFI	<30% HAMFI	<50% HAMFI	<80% HAMFI
Beaver	200	235	195	0	50	65
Box Elder	25	1,500	1,295	-395	40	260
Cache	-1,155	1,845	3,350	-2,110	-1,315	120
Carbon	75	675	885	-190	75	175
Daggett	0	0	10	0	4	4
Davis	-2,150	1,505	6,630	-3,475	-2,985	50
Duchesne	9	384	724	-216	-101	64
Emery	140	385	355	-10	145	175
Garfield	80	175	134	-15	25	49
Grand	-10	190	495	-180	-30	150
Iron	-180	1,100	1,750	-915	-260	480
Juab	45	155	175	-70	-15	14
Kane	45	185	274	-30	30	69
Millard	125	355	300	-40	-5	45
Morgan	-10	50	140	-65	-75	-26
Piute	15	29	45	-5	-1	13
Rich	29	44	14	-11	14	9
Salt Lake	-16,575	-4,005	33,715	-21,925	-23,205	270
San Juan	140	460	385	-65	45	95
Sanpete	125	680	595	-280	-90	85
Sevier	0	460	525	-205	-45	75
Summit	40	1,085	1,610	-355	260	490
Tooele	-145	795	2,025	-505	-185	430
Uintah	-100	615	1,430	-255	-115	260
Utah	-4,720	-2,420	10,855	-8,560	-10,655	-2,220
Wasatch	-270	-220	765	-415	-440	20
Washington	-995	-1,005	3,945	-2,100	-2,690	-490
Wayne	35	130	78	0	34	41
Weber	-2,540	3,745	6,750	-4,095	-1,730	640

Source: HUD (2018) 2011-2015 Comprehensive Housing Affordability Strategy [Data]
Note: The three lowest estimates in each income threshold are highlighted in 'Red' and the three highest estimates are highlighted in 'Green'.

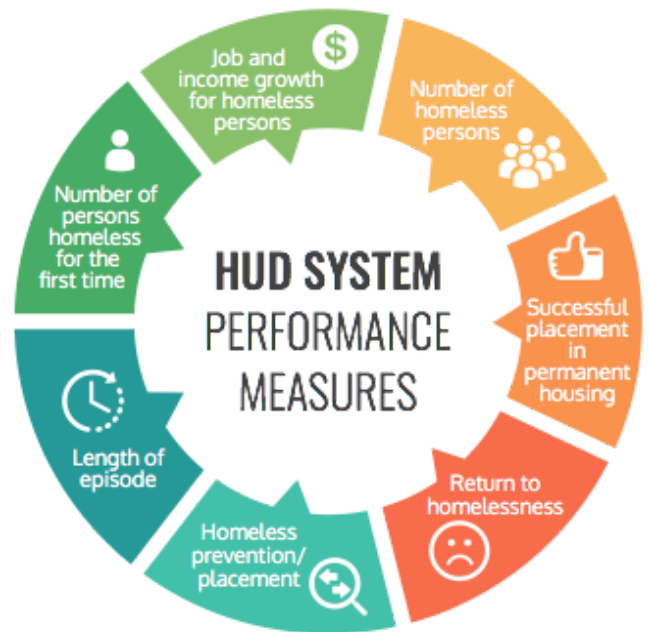Source: Fig 22, Utah Department of Workforce Services, State of Utah Affordable Housing Report 2018

WHCC System Performance

HUD System Performance Measures

HUD System Performance Measures (SPMs) "use data about people's interactions with multiple projects across the homeless system to evaluate whether the system is making homelessness rare, brief, and non-recurring. [It] calculates how long people are homeless in all the projects they receive services from in the system, whether they successfully exit the homeless system to permanent housing, and whether they later return to homelessness after exiting to permanent housing."[15]

The System Performance Measure Report is made up of seven measures:

1. Length of Time Persons Remain Homeless
2. Returns to Homelessness
3. Number of Homeless People
4. Job and Income Growth
5. First Time Homelessness
6. Homeless Prevention
7. Successful Placement in and Retention of Housing

(Fig 5) Source: Utah Department of Workforce Services, 2018 Utah Annual Report on Homelessness

HUD places emphasis on measures: 1, 7, and 2 to evaluate the system on the most effective practices currently known. Taken together, the SPMs help communities look at how they are reducing the number of people becoming homeless (Measures 2 and 5) and helping people becoming quickly and stably housed (Measures 1, 4, and 7).

The following charts visualize the most recent three years of system-level performance for all HMIS- participating agencies in the WHCC. SPM reports were run on the federal fiscal year (FFY) - October 1 to September 30 - to allow national and CoC comparison where
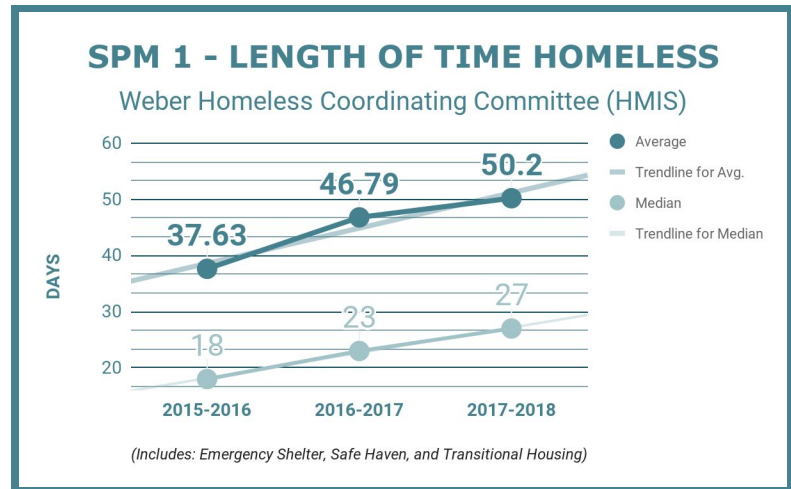
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[15] System Performance Improvement Briefs: Data Quality and Analysis for System Performance Improvement (July 2017)

applicable.

System Performance Measure 1. Length of Time Persons Remain Homeless

Desired Outcome: Reduction in the average and median length of time persons remain homeless.

The trendlines for the average and median length of time people are homeless is moving in the wrong direction, though averages are **significantly lower than National Averages** (50.2 vs. 151 in 2017-2018). Strategies to <u>Make Homelessness Brief</u>, increase affordable housing and permanent housing programs, and target the most vulnerable households first will impact this measure.

SPM 1 - LENGTH OF TIME HOMELESS
Weber Homeless Coordinating Committee (HMIS)

(Includes: Emergency Shelter, Safe Haven, and Transitional Housing)

System Performance Measure 2. Returns to Homelessness

Desired Outcome: Reduction in the percent of persons who return to homelessness.

The percentage of returns to homelessness among those who exited the system to permanent housing destinations is **consistently higher than the national average**, though the most recent year does show a promising decrease for Weber County.

High rates of return to homelessness within 6 months are likely a result of **inadequate supportive services**. Higher rates of returns within 2 years are likely more related to the **lack of affordable housing** and other potential economic or environmental factors.
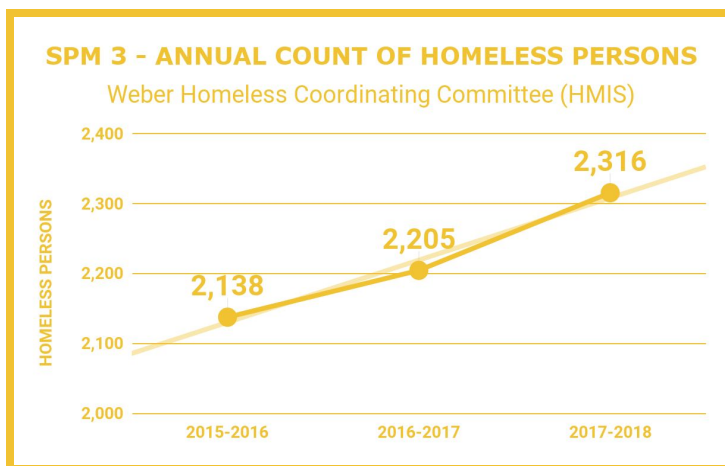
SPM 2 - RETURNS TO HOMELESSNESS

	Returns to Homelessness Within 6 Months of Exit		Returns to Homelessness Within 2 Years of Exit	
	Weber County	National Average	Weber County	National Average
2015-2016	12.0%	9.6%	21.0%	20.1%
2016-2017	12.5%	9.5%	26.0%	20.4%
2017-2018	9.3%	9.1%	20.5%	19.5%

System Performance Measure 3. Number of People Experiencing Homelessness

Desired Outcome: Reduction in the number of persons who are homeless.

SPM 3 shows the **increasing number** of people experiencing homelessness as recorded in HMIS on the federal fiscal year. The trend is **consistent** with both the State Homelessness Data Dashboard and PIT data.

SPM 3 - ANNUAL COUNT OF HOMELESS PERSONS
Weber Homeless Coordinating Committee (HMIS)

HOMELESS PERSONS

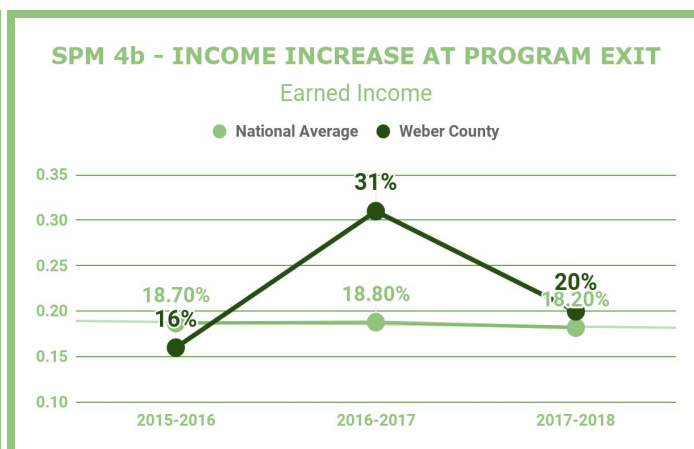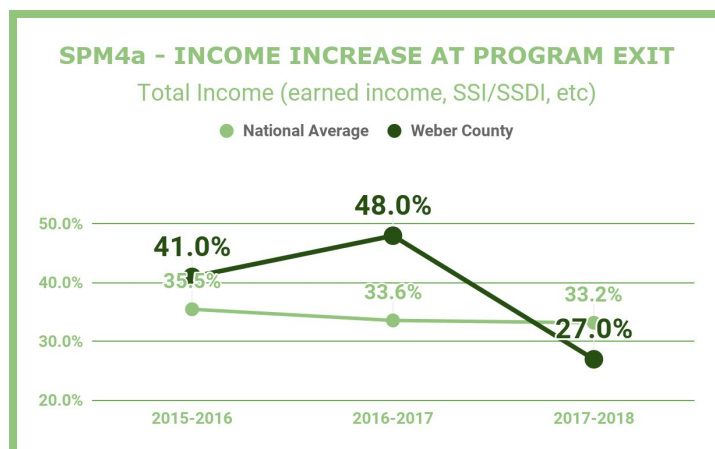|	2015-2016	2016-2017	2017-2018
	2,138	2,205	2,316

## System Performance Measure 4. Employment and Income Growth

Desired Outcome: Increase in the percent of adults who gain or increase employment or non-employment cash income over time.

The following tables show the percent of housing program participants who exited during the reporting period with increased income from the time they entered the program. SPM4a shows the percent of adults with increased *total* income at exit where SPM4b shows the percent of adults with increased *earned* income at exit. The darker line represents WHCC performance and the lighter line represents national averages.

Though prior year performance is generally higher than national averages, the recent **downturn in performance** is concerning; this is likely connected to the loss of federal (CABHI) funding and exorbitant case loads in permanent housing (detailed in <u>Appendix C: Focus Area 5</u>, Make Homelessness Non-Recurring).

SPM4a - INCOME INCREASE AT PROGRAM EXIT
Total Income (earned income, SSI/SSDI, etc)

● National Average   ● Weber County

	2015-2016	2016-2017	2017-2018
Weber County	41.0%	48.0%	27.0%
National Average	35.5%	33.6%	33.2%

SPM 4b - INCOME INCREASE AT PROGRAM EXIT
Earned Income

● National Average   ● Weber County

	2015-2016	2016-2017	2017-2018
Weber County	16%	31%	20%
National Average	18.70%	18.80%	18.20%

System Performance Measure 5. Number of People Experiencing Homelessness for the First Time
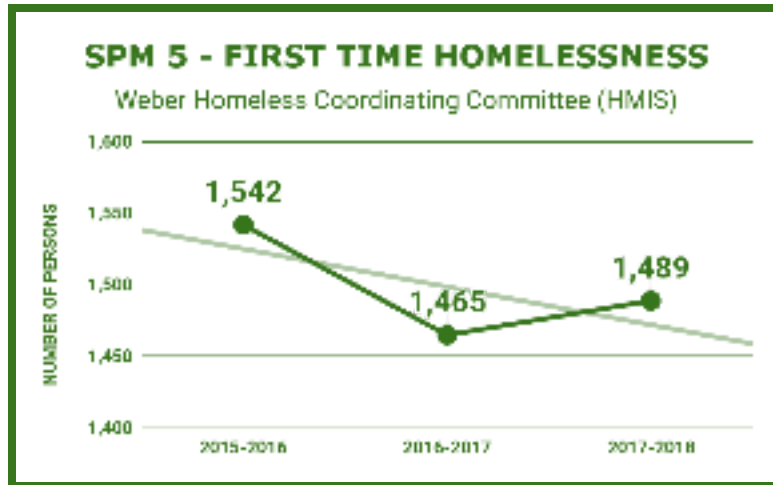
Desired Outcome: Reduction in the number of persons who become homeless for the first time.

The trendline is going in the right direction. However the **17-18 uptick** will need to be watched. See Recommended Focus Area 3 to improve performance on this measure.

System Performance Measure 6. Homeless Prevention and Housing Placement of Persons Defined by Category 3 of HUD's Homeless Definition in CoC Program-funded Projects

Measure 6 is limited to a certain program type that is not currently operating in the WHCC.

System Performance Measure 7a. Successful Placement from Street Outreach

Desired Outcome: Increase in the percent of persons who exit to an emergency shelter (ES), safe haven (SH), transitional housing (TH), or permanent housing (PH) destination from street outreach (SO).

SPM 7a is **difficult to evaluate** due to poor street-outreach-program data-entry practices in Weber County (See Appendix C: Focus Area 2 (HMIS Coverage) and Appendix C: Focus Area 4 (Quick Identification and Engagement). Outcomes should improve somewhat as street outreach becomes more housing-focused in its approach.
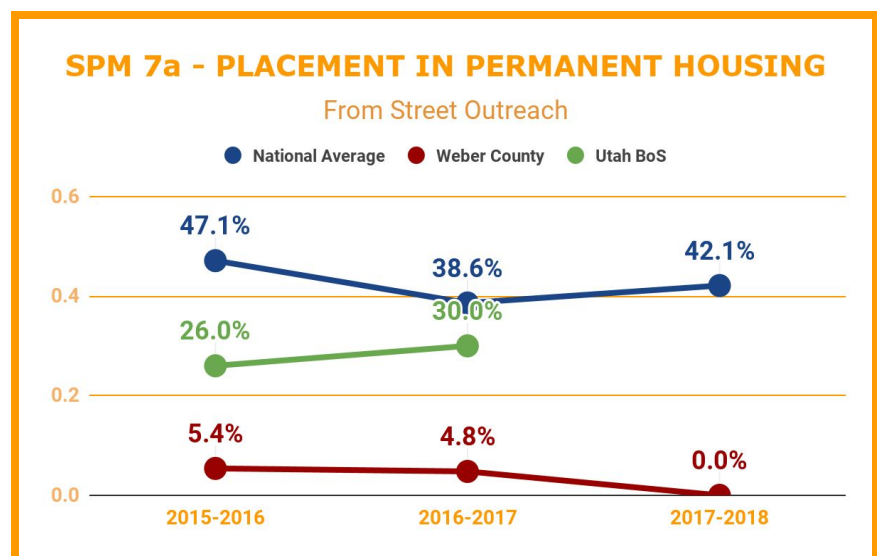
System Performance Measure 7b. Successful Placement In or Retention of Permanent Housing

Desired Outcome: Increase in the percent of persons who exit to or retain permanent housing.

SPM 7b1 looks at successful exits to permanent housing from emergency shelter (ES), transitional housing (TH) and rapid rehousing programs (RRH). WHCC performance is noticeably lower than National averages and Utah BoS performance, but it does appear to be trending **in the right direction**.

SPM 7b2 looks at positive exits from permanent housing programs (other than RRH) or successful retention in a permanent housing program. The most recent **sharp decrease** is of particular concern and is again likely related to the **loss of CABHI funding**. (See Appendix C, Focus area 5, Permanent Supportive Housing for more information.)
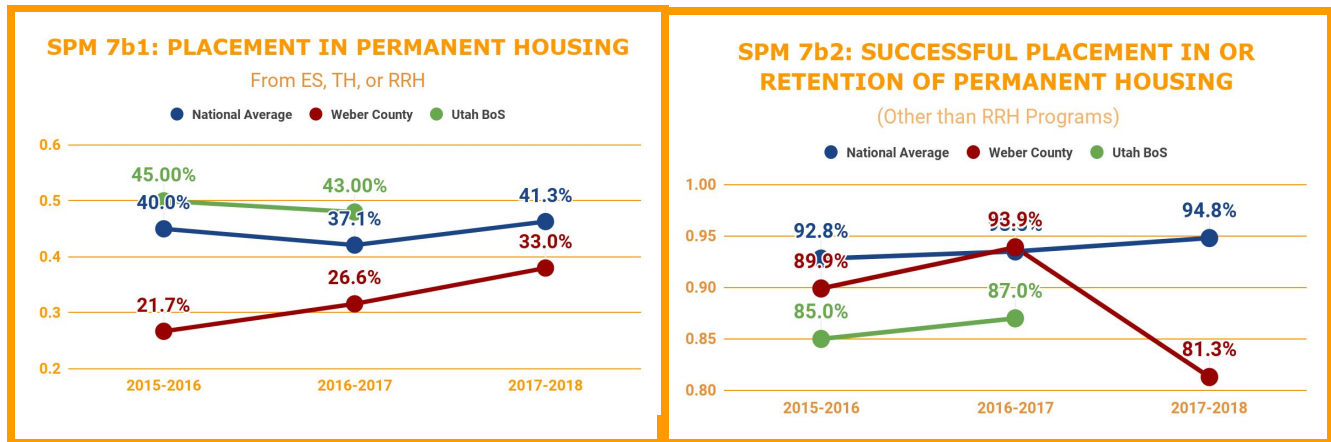
Analyzing Performance

The brief analysis above focuses on trends over time, comparisons to national and BoS performance, and a broader community analysis of gaps and barriers where applicable. The WHCC should conduct a data quality analysis for each of these SPMs; consider additional types of analysis; and use performance data to optimize existing programs and funds and strategically invest new resources. Step Four in the HUD System Performance Improvement Briefs: Data Quality and Analysis for System Performance Improvement walks through each measure with specific suggestions for data quality assessment and suggestions for performance analysis for measures 1, 2, and 7 (p. 8-14). A sample of analysis types and questions are included in a table on page 6 of that brief.

Strategic Plan Introduction

Establishing key terms, historical context, process, and structure

PURPOSE

This Strategic Plan was commissioned by the Weber Housing Authority on behalf of the Weber Homeless Coordinating Committee (WHCC) and funded by the Weber Homeless Trust Fund Board.

It was created to provide direction for the WHCC and facilitate better planning and coordination. Recommendations are based on: policy review, data analysis, literature review, best and emerging practice in the field, and community-specific dynamics in Weber County; bearing in mind that the ultimate beneficiary of improved planning and performance are those individuals and families at risk of, or experiencing, homelessness.

While the gaps and barriers attached to this document are consistent with parts of the 2018 Performance Audit of Utah's Homeless Services,[16] and the recommended strategies are consistent with the general direction of State and Federal strategic plans; the analysis and strategies were specially created for Weber County.

CROSS-SYSTEM COORDINATION

There are a number of local entities in Weber County looking to improve high-level, cross-system coordination. These efforts are timely. The homeless services system is complex enough to require its own *cross-sectoral* decision-making and planning body, but it also overlaps significantly with other systems. The WHCC and its leadership should participate in these high-level coordination initiatives, and ensure a place for homelessness and affordable housing are held at these tables.

The new Weber County Prevention and Prosperity Center of Excellence may be especially valuable to help fill gaps in implementing this strategic plan and connecting the homeless services system with legislative advocacy and public-private partnerships.

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[16] https://le.utah.gov/audit/18_12rpt.pdf

SHARED VISION

The shared vision is to make homelessness rare, brief and non-recurring in Weber County. Through focusing on the system as a whole, improving coordination and oversight and using data and performance to drive decision making, homelessness in Weber County can become rare, brief and non-recurring. Such a vision requires an investment of resource and a new way of thinking; it is not sufficient to assume prior modes of operation can change without adequate provision of training, community leadership, backbone support, and funding.

KEY TERMS & CONCEPTS

HOUSING FIRST

"Housing first is a proven approach, applicable at both the community and program level, in which people experiencing homelessness are connected to permanent housing swiftly and with few to no treatment preconditions, behavioral contingencies, or other barriers. It is based on overwhelming evidence that people experiencing homelessness can more easily address other barriers when their need for safe and stable housing is first met. Study after study has shown that Housing First yields higher housing retention rates, drives significant reductions in the use of costly crisis services and institutions, and helps people achieve better health and social outcomes."[17]

CLIENT-CENTERED SERVICES

Homeless systems and individual service providers should be oriented toward the needs of the client (homeless person seeking service). This means they ensure that policies, strategies and service provision are tailored to the needs of those experiencing homelessness rather than the needs of institutions or agencies. A client-centered system should include client voice, incorporate best practice for service provision, and educate and empower clients.

HOMELESS SERVICES SYSTEM

The homeless services (or housing crisis response) system is the combination of housing and service programming provided for homeless persons and those at risk of homelessness. An effective homeless system is made up of multiple corresponding parts: coordinated entry, homeless prevention, homeless diversion, street outreach (SO),

[17] Housing First Checklist: Assessing Projects and Systems for a Housing First Orientation - usich.gov

emergency shelter (ES), transitional housing (TH), and two types of permanent housing (PH) - rapid re-housing (RRH) and permanent supportive housing (PSH). Each of these parts has a unique set of practices and an important role in quickly responding to and ending homelessness for community members.

A SYSTEMS APPROACH

A systems approach to homelessness organizes each individual service and housing program into a functioning whole. It acknowledges the necessary inter-reliance among program types to achieve community goals, reduce homelessness, and minimize trauma to the people who experience it. An efficient systems approach uses both system and program level performance to drive decision-making at every level.
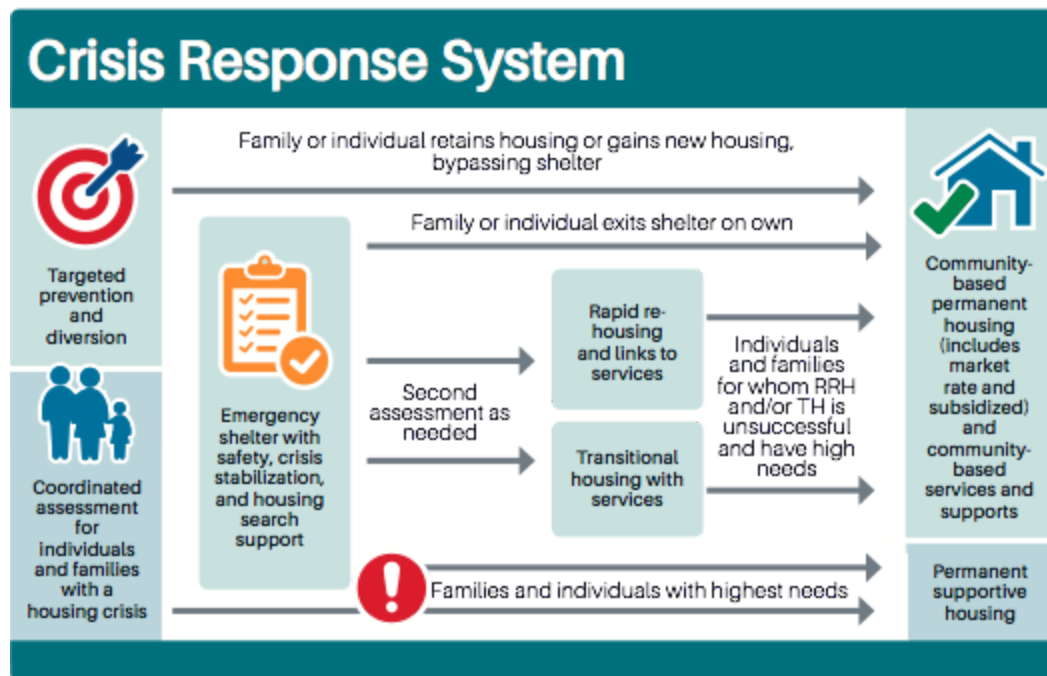
(Fig 6) Department of Workforce Services, Comprehensive Report on Homelessness, State of Utah 2016

CONTINUUM OF CARE

"A Continuum of Care (CoC) is a regional or local planning body that coordinates housing and services funding for homeless families and individuals."[18] Weber County is in the Utah Balance of State CoC (BoS), one of three CoCs in Utah. The geography of the BoS includes 25 of Utah's 29 counties, grouped into 11 local homeless coordinating committees (LHCCs).

Each year individual projects from the 11 BoS LHCCs compete against each other for BoS

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[18] https://endhomelessness.org/resource/what-is-a-continuum-of-care/

ranking and then collaboratively against other CoCs in the nation. The BoS was awarded just over $1.8M in federal funding in the most recent FY 2018 CoC competition, of which $749,155 was awarded to projects in WHCC. Because CoC funds are awarded based on the collaborative BoS score, Weber County funding depends not only on local performance, but on the health and function of homeless service systems *across the entire BoS*.

The Homeless Programs Team in the Housing and Community Development Division (HCDD) of the Department of Workforce Services (DWS) supports the BoS, ensures HUD compliance, and prepares the collaborative application for CoC funding. The geographic expanse of the BoS and unique characteristics of each LHCC make it difficult for supporting staff to implement requirements across all 11 LHCCs. As a result, they rely heavily upon each LHCC to manage local planning and oversight.

HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

The Utah Homeless Management Information System (HMIS) is the database used by homeless service providers to collect client-level data and data on the provision of housing and services to homeless individuals and families (and those at risk of homelessness). Utah has one statewide HMIS implementation inclusive of all three COCs. Client information and services are recorded in a "single client record" which allows providers to track a client's homeless history, view current enrollments, and avoid duplication.

The Housing and Community Development Division (HCDD) is the HMIS Lead for all three of Utah's CoCs. They coordinate with the software vendor and manage the database on behalf of the CoCs. In FY18 the state office was awarded $339,791 in CoC funding to supplement the cost of maintaining the database ($80,640 of that from the BoS).

Utah HMIS is governed by a steering committee made up of representation from each CoC, government organizations that administer homeless program funding, and providers representing specific homeless subpopulations. Service providers from Weber County currently fill two positions on this committee.

WEBER HOMELESS COORDINATING COMMITTEE BEGINNINGS

The current structure of local governance and oversight in Weber County is a remnant of the State Homeless Coordinating Committee's (SHCC) Ten-Year Strategic Plan to End Chronic Homelessness (2004). Around that time, the state was divided into 12 Local Homeless Coordinating Committee (LHCC) areas, chaired by a local elected leader. Weber and Morgan Counties were combined to create the Weber-Morgan LHCC.
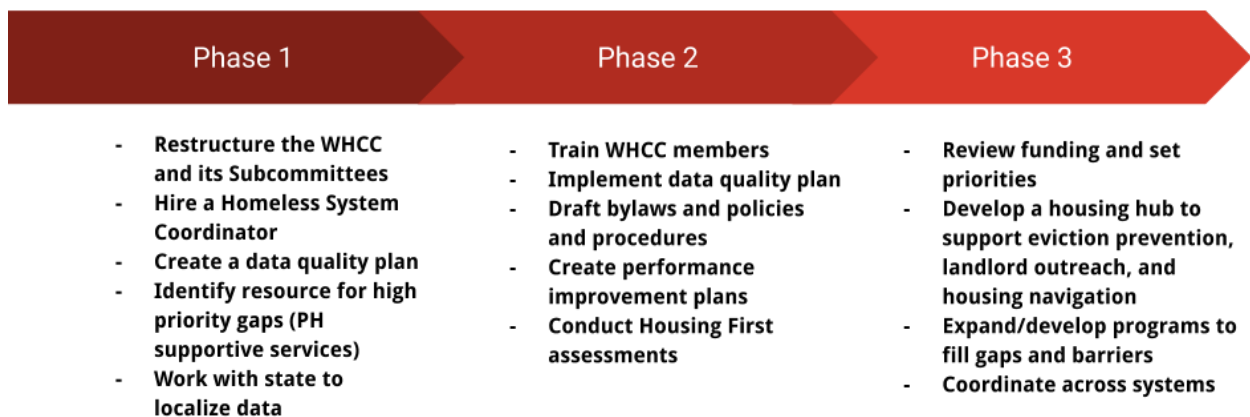
Toward the end of the plan's ten-year term, the State's attention narrowed to the remaining hotbeds of, and tasks required to end, chronic homelessness; specifically: Salt Lake County, emergency shelters, permanent supportive housing development, and fine tuning the measures used to evaluate progress. This narrowing directed energy away from educating and supporting LHCC leadership throughout the state, and by 2014 LHCC structures were largely held together by local chairs - to the extent they were able during the tenure of their political term - and/or a coalition of the willing.

When the State's ten-year plan term came to an end in 2014, the state maintained focus on chronic homelessness for another year and opted not to create a new strategic plan. In the 2019 legislative session, H.B. 342 was passed requiring the SHCC to create a new plan.

IMPLEMENTATION AND MEASURES OF SUCCESS

Strategies in this strategic plan were written to be actionable, while acknowledging the realities of available resource and other constraints. Stakeholders can decide whether or not to adopt it in its entirety. Upon adoption, the community will need to develop an implementation plan with distinct steps, responsible parties and timelines. The following figure, though not exhaustive, gives an example of possible tasks and phases.

(Fig 7) Sample Phases of Implementation

Phase 1	Phase 2	Phase 3
- **Restructure the WHCC and its Subcommittees** - **Hire a Homeless System Coordinator** - **Create a data quality plan** - **Identify resource for high priority gaps (PH supportive services)** - **Work with state to localize data**	- **Train WHCC members** - **Implement data quality plan** - **Draft bylaws and policies and procedures** - **Create performance improvement plans** - **Conduct Housing First assessments**	- **Review funding and set priorities** - **Develop a housing hub to support eviction prevention, landlord outreach, and housing navigation** - **Expand/develop programs to fill gaps and barriers** - **Coordinate across systems**

Each recommended focus area includes specific reports and measures that should be used to gauge success. The HMIS-generated HUD System Performance Measures will be of primary importance, especially measures 1: Length of time persons remain homeless, 2: Returns to homelessness, and 7: Successful placement in and retention of housing.
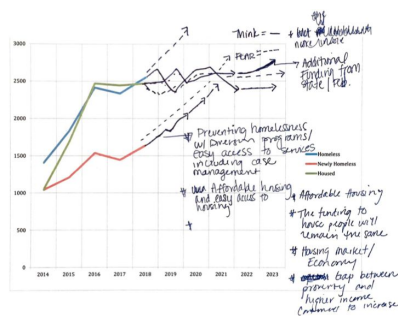
COMMUNITY INPUT

Input for this strategic plan was solicited through a series of six community input meetings. All members and attendees of the Local Homeless Coordinating Committee and Homeless Trust Fund Board were invited to attend these meetings or send a representative.

Agencies who contributed to the creation of this plan include:

- ❏ Catholic Community Services North
- ❏ Homeless Veterans Fellowship
- ❏ Hope Community Health Center
- ❏ Lantern House
- ❏ Ogden City
- ❏ Ogden City Council
- ❏ Ogden City Housing Authority
- ❏ Ogden CAN
- ❏ Ogden Weber Community Action Program
- ❏ Problems Anonymous Action Group
- ❏ United Way of Northern Utah

- ❏ Utah Department of Workforce Services
- ❏ Veterans Administration
- ❏ Weber County Commission
- ❏ Weber County Jail
- ❏ Weber Homeless Trust Fund Board
- ❏ Weber Housing Authority
- ❏ Weber Human Services
- ❏ Weber State University
- ❏ Your Community Connection
- ❏ Youth Futures

Data and input were gathered by using service and system mapping exercises, behavior over time graphs, free-listing, and semi-structured and unstructured interviewing.

EXAMPLES

Input was also solicited from community members with lived experience of homelessness. Information was gathered through five focus groups, including a total of 24 contributors who are either currently experiencing homelessness or who have previously experienced

homelessness and have been housed through local programming. Focus group participants represent a variety of backgrounds, ages, races, disabling conditions, and episodes and lengths of homelessness. Weber Housing Authority and Lantern House assisted by recruiting participants; however, service providers were not allowed to be present during any of the focus groups. Participants were compensated with bus tokens and gift cards generously contributed by the Weber Housing Authority and Lantern House.

STRATEGIC PLAN STRUCTURE

A glance at all strategic plan focus areas, objective, strategies, and action items in a single three-page table can be found in Appendix D.

The strategic plan is made up of five recommended focus areas and their objectives, strategies for accomplishing those objectives, and associated action items.

The five recommended focus areas of the plan are: (1) Improve System Planning and Oversight, (2) Become a Data-Driven System, (3) Make Homelessness Rare, (4) Make Homelessness Brief, and (5) Make Homelessness Non-Recurring.

Each focus area in the plan includes a brief description of the focus area, followed by corresponding strategies and action items.

An analysis of gaps and barriers in Weber County by focus area can be found in Appendix C. It is recommended that the WHCC adopt all strategies and action items put forward in this plan or develop commensurate alternates, rather than picking and choosing in a way that may limit outcomes or create only isolated improvements.

Recommended Focus Area 1

Improve System Planning and Oversight

OBJECTIVE

Build local capacity for system planning and oversight

The strategies in this focus area may be the most crucial for any kind of lasting success. The Weber Homeless Coordinating Committee (WHCC) needs to ensure: implementation of best practice, all parts of the homeless services system work efficiently together, and the needs of unique sub-populations are acknowledged and met. Ultimately, it is vulnerable people in Weber County that are harmed by a failure to put system-level structure in place. The first strategy lists action items to facilitate WHCC reorganization. The second and third strategies address planning and best practice.

✦ Focus Area 1 — At A Glance ✦

GAPS & BARRIERS

❏ Insufficient system-level leadership and advocacy structures
❏ Key stakeholders and decision-makers, including homeless service funders, are absent from the Weber Homeless Coordinating Committee (WHCC)
❏ The WHCC and its subcommittees lack sufficient backbone support
❏ The WHCC does not conduct system-level planning or evaluation

(SEE APPENDIX C FOR MORE INFORMATION)

STRATEGIES & ACTION ITEMS

KEY MEASURES

❏ Overall system performance improvement (HUD System Performance Measures Report)

SUGGESTED RESPONSIBLE PARTIES

STRATEGY   1.1   → WHCC leadership & System Coordinator

STRATEGY   1.2   → WHCC & System Coordinator

ACTION ITEM 1.3.1 → WHCC, System Coordinator & Best Practice Workgroup

ACTION ITEM 1.3.2 → WHCC leadership, System Coordinator & Best Practice Workgroup

ACTION ITEM 1.3.3 → Best Practice Workgroup & System Coordinator

ACTION ITEM 1.3.4 → WHCC & Best Practice Workgroup

STRATEGY 1.1

Reorganize the Weber Homeless Coordinating Committee and its Subcommittees

A reorganized WHCC, with an intentional scope and support structures, could be an effective leadership and decision-making body for homeless services in Weber County.

ACTION ITEM 1.1.1
Revise WHCC scope and membership.

The WHCC needs to take responsibility for system-level planning and evaluation, including performance improvement, funding strategies and cross-sectoral coordination. WHCC membership should consist of people who have the credibility and experience to drive systems change. A few local community leaders who are already invested in homeless services could be gathered first to help identify and outreach to new members, with strategic support from the Prevention and Prosperity Center of Excellence and logistical support from a System Coordinator (See Action Item 1.1.2).

The revised Weber Homeless Coordinating Committee's mission could be *to provide leadership for the homeless services system in Weber County*.

After onboarding and initially structuring this committee, meeting frequency could be reduced to quarterly, but it should be scheduled at times that allow representatives to approach other bodies, such as the State Homeless Coordinating Committee or legislative committees with up to date information. In its new role, the WHCC could become a sustainable component tied to Weber County Government.

Gaps in strategic representation need to be addressed. For example, it would be advisable to reach out to the Ogden City Mayor's Office for participation. The Mayor is currently the only direct representation for Weber County on the State Homeless Coordinating Committee (SHCC). In that role, the Mayor has the ability to introduce information to state-wide stakeholders and influence state-level homelessness policy and funding that directly affect Weber County. Another group of stakeholders lacking participation is homeless service funders (e.g. the Weber Homeless Trust Fund Board, the Balance of State Continuum of Care, the State Homeless Programs Team, the LDS church, the Wasatch Front Regional Council, and the HUD Salt Lake City Field Office). Finally, it would be valuable to recruit some cross-over membership from parallel decision-making bodies that have related interests or overlapping scopes, such as the Welfare Reform Commission (that oversees the intergenerational poverty initiative) and the Weber Human Services board.

Member agencies need to be represented on the WHCC by someone who has enough authority to make decisions on behalf of the agency. In most cases this would be an executive director, though another executive officer with written decision-making authority could fill their stead. It was also suggested by a member of the homeless services community that both an executive director and a board member attend WHCC meetings on behalf of service provider agencies, while retaining only one vote for each agency. This

could be a beneficial model for furthering education and impact in the community and should be seriously considered as the new committee takes form. Such changes will need to be thoughtfully timed in order to give new participants a clear idea of why WHCC participation is worth their investment.

ACTION ITEM 1.1.2
Hire a Homeless Services System Coordinator.

It is strongly recommended that the WHCC support the hiring of a Homeless Services System Coordinator to provide ongoing backbone support to the WHCC and its subcommittees. That person would need to gain a strong working knowledge of best practice, and have the authority to facilitate day-to-day implementation of the plan. They could support the WHCC chair and provide logistical support to subcommittees and workgroups to ensure movement and compliance in-between meetings. Such a position would bring needed capacity to initiate the implementation of this and future plans.

The term "backbone support" comes from the Collective Impact model, first featured in the Stanford Review for Social Innovation in 2011. A backbone support organization is defined as "an organization [that] requires a dedicated staff separate from the participating organizations who can plan, manage, and support the initiative through ongoing facilitation, technology and communications support, data collection and reporting, and handling the myriad logistical and administrative details needed for the initiative to function smoothly."[19]

United Way of Northern Utah has been working to apply the collective impact model to specific community issues as part of the United Partnerships initiative. They have secured funding to hire Impact Coordinators that would provide backbone support to community-wide committees associated with specific issue areas. One of these areas is housing and homelessness, for which they have dedicated funds for half of a full time employee and are seeking a possible second funding source to make it full. They intend to task this employee to provide backbone support to the WHCC and its subcommittees, and eventually possibly also to a community-wide body focused on affordable housing.

United Way of Northern Utah currently has the structure and knowledge base to train and sustain a backbone support position consistent with emerging research on effective community change. The System Coordinator would need to seek external training on homelessness systems, data, and programs. There has been discussion about this position residing in the newly formed Weber County Prevention and Prosperity Center of

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[19] Stanford Social Innovation Review: Winter 2011, John Kania & Mark Kramer

Excellence, which may be a possibility once the Center of Excellence is fully formed and operating. Wherever the System Coordinator position lives, true backbone support will reinforce WHCC goals and community initiatives over those of any one agency.

Gap funding for this position could be sought from local government, Wasatch Front Regional Council or Ogden City CDBG funds, state homeless funding, Ogden CAN and/or the Weber Homeless Trust Fund among other possibilities. The Weber County Prevention and Prosperity Center of Excellence may also be able to assist WHCC leadership and United Way of Northern Utah to identify gap funding for this purpose.

ACTION ITEM 1.1.3

Form WHCC subcommittees and workgroups.

The inter-agency service coordination that has occasionally taken place at WHCC meetings should now take place at subcommittee meetings and in workgroups. It is recommended that the WHCC create four subcommittees to attend to specific components of this plan and the homeless services system as the WHCC shifts its focus.

Recommended subcommittees:

- ❏ Data
- ❏ Make Homelessness Rare
- ❏ Make Homelessness Brief
- ❏ Make Homelessness Non-Recurring

Each Subcommittee should have an assigned chair, vice-chair and include members in addition to homeless-service providers. Subcommittees will oversee specific action items and performance measures and report directly to the WHCC. Workgroups can be formed under committees as needed to accomplish more specific tasks.

Subcommittee functions, with recommended membership, meeting frequency and assigned action items can be found in Appendix A.

The following organizational chart outlines this possible structure.
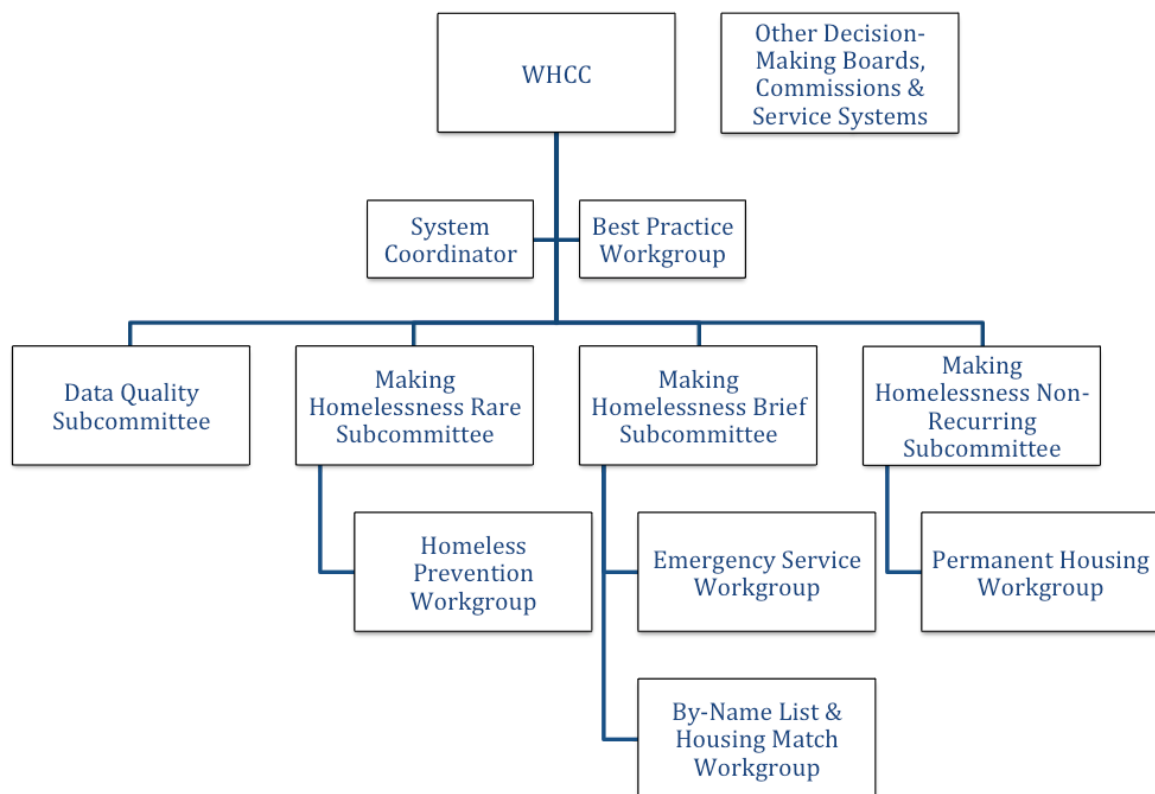
(Fig 8)

ACTION ITEM 1.1.4

Document the new leadership structure with written bylaws and policies.
(See also ACTION ITEM 2.3.2)

This action item is intended to further engage the re-visioning process for the LHCC while simultaneously providing a means for sustainability. At minimum the WHCC and each Subcommittee should have a written: purpose and scope, description of membership and voting membership, membership and leadership selection and succession process, decision-making process, intended use of standard data and reports, and conflict of interest policy. Some communities create an MOU for members of WHCC-like committees, which may be worth consideration. Ideally a system coordinator position could spearhead the process for committee input and drafting.

STRATEGY 1.2

Engage in System-Level Planning and Evaluation

Strategy 1.2 is dependent upon establishing the structure called for in Strategy 1.1 and the data and strategies referenced in the Become a Data-Driven System Focus Area. It indicates the need to look at performance measures and funding, reassess community need on an ongoing basis, and set forward thinking goals. This will primarily take place at the WHCC level, with support from each subcommittee.

ACTION ITEM 1.2.1

Develop system and program performance management plans. (See also FOCUS AREA 2, Become a Data-Driven System)

As the WHCC begins its work as a decision-making, planning and oversight body, it will need to evaluate performance, set goals and track outcomes for the system. This process should be written into a performance management plan that is made publicly available. The WHCC may wish to schedule an initial off-site planning meeting to participate in intensive training and develop the first system performance management plan.

It is recommended that the WHCC also consider whether each Subcommittee should create a performance management plan to coordinate implementation and oversight of their assigned strategies and action items.

A SYSTEM-LEVEL PERFORMANCE MANAGEMENT PLAN

It is recommended that the WHCC use the HMIS-generated HUD System Performance Measures to identify baselines, evaluate benchmarks, and generate community goals and timelines. The WHCC may wish to put particular emphasis on the following three measures, though all 7 have value and should be looked at in combination:

- ❏ HUD System Performance Measure 1: Length of Time Homeless
- ❏ HUD System Performance Measure 2: Returns to Homelessness
- ❏ HUD System Performance Measure 7: Successful Placement in and Retention of Housing

An assessment of Weber County's current performance can be found in WHCC System Performance (p. 10-14). Three years worth of system performance measure reports are in Exhibit 1. The National Summary of Homeless System Performance 2015-2017 could be

used to set initial benchmarks for comparable measures.[20]

PROGRAM-LEVEL PERFORMANCE MANAGEMENT PLANS

Each program type (homeless prevention, street outreach, homeless diversion, emergency shelter, rapid re-housing, transitional housing, and permanent supportive housing) and/or project should have a set of standards and goals associated with the type of assistance provided. Recommendations for the evaluation of certain program types and creation of performance management plans are referenced in Focus Areas 4, Make Homelessness Brief and 5, Make Homelessness Non-recurring. A basic template for a program-type performance management plan could be created by the System Coordinator and discussed and completed in workgroups prior to WHCC submission.

Agencies can use the same system performance measure report out of HMIS to generate program-type, agency, and project-level data and submit it to the WHCC as needed. This is valuable, as long as it is appropriately contextualized, because it shows how individual pieces influence system performance. HMIS-generated annual performance report (APR) and qualitative evaluations should be used for a more in-depth project level analysis.

SUB POPULATIONS

Just as specific program types have their own unique set of approaches, certain subpopulations require specialized attention and interventions to achieve success. Specific subpopulations include youth, veterans, survivors of domestic violence, and chronically homeless individuals and families. Certain subpopulations may have unique characteristics that influence performance. It is recommended that future strategic plans present strategies related to each subpopulation. The WHCC should also review data to identify disproportionately represented groups, such as racial minorities and the LGBTQ+ population to minimize disparity in service that may negatively impact these groups.

ACTION ITEM 1.2.2

Review homelessness funding and establish priorities.

As a part of system planning and evaluation, the WHCC should review existing funding, evaluate whether its current use is most beneficial for the system, explore whether any sources can be increased, and establish community funding priorities.

REVIEWING HOMELESSNESS FUNDING

An awareness of local performance and funding streams, and how these compare with

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[20] National Summary – System Performance Measures 2015-2017 hudexchange.info

other communities will equip leaders to advocate for funding increases. For example, the data showing that Weber County's rate of homelessness to total population is higher than Salt Lake County's should have bearing on WHCC strategy for state homeless funding. The WHCC can look at the prior year allocations proportionate to homeless population and performance to make a case for increased funding.

An outdated WHCC funding profile is included in Exhibit 2 for illustrative purposes. This document could be used as a template for creating an updated profile, though other funding sources may need to be added. It may also be beneficial to include brief funding source descriptions and calculations of available funds received vs. homeless counts and other basic comparative allocation data. Below are sample questions that could help evaluate the current use and function of funding sources.

— QUESTIONS TO EVALUATE CURRENT USE AND FUNCTION OF FUNDING SOURCE —

❏ Who receives these funds within Weber County and for what function? Are they the best suited agency to provide this service?

❏ If there is more than one agency, how do they avoid overlap?

❏ Would it be advantageous to reallocate funds to a single agency rather than spreading it among multiple?

❏ What is the cost per service and cost per successful outcome?

❏ If multiple agencies perform separate functions, is there a function that could be matched to the resource to facilitate higher performance and competitiveness for the funding if applicable?

❏ How does the current provision of these funds influence the client? How might any changes further influence clients?

❏ What additional restrictions are placed on the funding by those who administer it at a state or local level and could those be negotiated to better meet local needs or increase efficiency?

❏ Are any dollars left unspent or recaptured at the end of the grant year?

❏ Are there other funds that are more restrictive that might be better suited for this purpose to allow these funds to be used more flexibly?

❏ Would it be possible to increase funding from this source?

❏ How does Weber County's (or a specific agency's award amount compare to other recipients?

❏ How does the specific use of these funds integrate best practice?

❏ How does the specific use of these funds address the shared vision and

strategic plan for Weber County?

❏ What are the source's reporting requirements?

❏ Could they be streamlined with other reporting requirements to reduce the burden on service providers and the WHCC?

ESTABLISHING FUNDING PRIORITIES

Funding priorities should target projects that: 1) are consistent with best practice, 2) most improve system outcomes, 3) are high-performing, and 4) fill a specific need.

The WHCC could choose to support improvement to low-performing projects that fill a system need or recommend funds be reallocated away from those projects. The following figure lists recommendations from this plan that will require additional funding. Each of these could be evaluated and prioritized based on the four priorities above. The Prevention and Prosperity Center of Excellence could help create a plan to fill more urgent needs while the WHCC is getting organized.

— ADDITIONAL FUNDING NEEDED —

❏ Find another .5 FTE resource to support a systems planner position
❏ Increase the number of case managers for permanent housing (RRH and PSH)
❏ Reintroduce an ACOT team to Weber County
❏ Consolidate and increase street outreach funding
❏ Hire staff to create a hub for eviction prevention, landlord outreach, housing navigation and mediation to be used throughout the system.
❏ Support the development of a permanent supportive housing facility
❏ Expand rapid re-housing programming
❏ Increase housing-focused case management in shelter and street outreach
❏ Expand homeless diversion for households without children

STRATEGY 1.3

Integrate Best Practice into Decision-Making and Service Provision

There is an ever-broadening body of knowledge about what works when it comes to homeless services and systems. Intelligent communities do not reinvent the wheel, but learn from a proven evidence-base. In order for sound decision-making and continued progress there must be basic and continuing education among decision-makers and service providers. Action items in Strategy 1.3 suggest two specific best practices that need to be integrated throughout the system and initial and ongoing training considerations to bring Weber County actors up to speed. Other best practice models are integrated throughout this plan.

ACTION ITEM 1.3.1

Assess and remove barriers to housing first principles as a system and within individual projects.

It is imperative that all parts of the homeless services system are housing-focused. This means any barriers to housing are mitigated and removed, and Housing First principles are fully adopted system-wide. Housing First principles should be reviewed both in written policies and procedures and in practice. It is recommended that the WHCC use two tools to complete this assessment, the Housing First Checklist: Assessing Projects and Systems for a Housing First Orientation and the HUD Housing First Assessment Tool.

The Housing First Checklist[21] was created by the United States Interagency Council on Homelessness (USICH) and is "intended for use by policymakers, government officials, and practitioners alike to help make a basic assessment of whether and to what degree a particular housing program is employing a Housing First approach." The first portion of the checklist reviews core elements of housing first at the program/project level. The second portion of the checklist explores core elements of housing first at the community level. The latter portion should be completed by the WHCC; the WHCC can determine whether it would be beneficial to request answers anonymously prior to engaging in discussion about the basic tenets of Housing First. The WHCC can then identify areas of weakness and brainstorm action steps for improvement to be included in performance management plans. The WHCC can revisit the checklist on a semi-anual or annual basis to identify improvements and/or new barriers since the last review.

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[21] https://www.usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf

The HUD Housing First Assessment Tool,[22] published in 2017 builds upon the checklist and looks at individual projects more in-depth. It is recommended that the WHCC encourage providers to complete these tools and ask the system coordinator to compile answers for WHCC discussion. The Best Practice Workgroup could potentially assist with this process.

ACTION ITEM 1.3.2

Train WHCC members and local decision-makers about the homeless system and best practice models. (See also ACTION ITEM 2.3.1)

A basic knowledge of homeless systems and programs is important for decision-makers to lead effective systems change. The learning content areas listed in this action item constitute basic knowledge that can be formatted and delivered in ways that meet the needs and time constraints of WHCC members. For example, the homeless system simulation game (90 minutes) requires relatively little time input compared to the amount of knowledge and understanding gained for participants. This activity is strongly recommended as it rapidly introduces the working parts of a homeless system and shows how system based decisions directly influence outcomes. For other topics, WHCC leaders can be educated one-on-one as their assignments and schedules demand and presentations on key topics can be integrated into committee meetings over time.

It would be advantageous to encourage local decision makers and WHCC members to attend professional conferences, such as National Alliance to End Homelessness (NAEH) Conferences, which offer several sessions about leadership, planning, use of data and best practice.

— **SAMPLE TRAINING TOPICS FOR WHCC MEMBERS AND LOCAL DECISION MAKERS** —

1. Homeless systems 101
    a. The main components of a homeless service system
    b. Housing first
    c. A systems approach
    d. Coordinated entry and prioritizing resources to the most vulnerable

2. Homeless system simulation game
    a. Identifying how the various parts of the homeless system work together and how system-level decisions impact client outcomes.

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[22] https://www.hudexchange.info/resource/5294/housing-first-assessment-tool/

3. Homeless governance in the State of Utah and Weber County
   a. The role and function of the State Homeless Coordinating Committee, CoC, State Homeless Office and HMIS
   b. The role of the WHCC and its subcommittees
   c. Orientation to the Weber homelessness funding profile and common funding sources

4. Using data to drive strategy and decision-making
   a. Orientation to the WHCC strategic plan
   b. Available reports, tips for analysis and basic use

ACTION ITEM 1.3.3

Support training for service provider boards, management and staff. (See also ACTION ITEM 2.3.1)

Homeless service providers are indeed the local experts in their individual service delivery areas, but overtaxed providers often find it difficult to create time and space to read up on the latest research and practices. Furthermore, it can't always be assumed that new employees will receive consistent training, including those at the executive level. In order to keep a competitive edge for funding and excellence in homeless services in Weber County, there needs to be an emphasis on and investment in training. Executive-level staff and board members could be included in WHCC trainings if they are not already a member.

Training for front-line staff should emphasize evidence-based practices such as housing first, motivational interviewing, critical time intervention, harm reduction, and trauma-informed care. Ongoing norming across assessment tools, standard procedures for coordinated entry, and how to use data to inform service delivery should also be given attention. Finally, it may be worthwhile to include basic training about the system as a whole and the Weber County strategic plan so each individual part can see how it operates within the larger whole to advance agreed upon strategies.

The WHCC Best Practice Workgroup could be responsible to identify needs, develop training schedules, coordinate with neighboring communities and report back to the WHCC. Such coordination has potential to reduce training cost and duplication across agencies. This subcommittee could also identify which agencies plan to attend key conferences and find ways to create an information loop about new content.

ACTION ITEM 1.3.4

Learn from persons with homeless experience.

A key best practice tied to requirements for multiple funding sources is to involve persons with lived experience of homelessness in all aspects of the homeless services system. Utah has been somewhat weak on this requirement and Weber County is no exception. It is recommended that each committee, subcommittee, and agency board be reviewed for consumer membership and participation (not simply attendance). This review could be conducted by the System Coordinator or Best Practice Workgroup.

It is also strongly recommended that a consumer advisory board, open forum, or series of focus groups be held quarterly to gather feedback from persons with lived experience. Participants should represent a variety of experience, including subpopulations and minorities. Program participants should also be consulted for project-level evaluation.

In creating this plan, 5 focus groups with a total of 24 homeless or formerly homeless people were consulted. The insight gained through these focus groups was different than what other community members had to offer and equally valuable. After all, who better than persons with lived experience to troubleshoot problems and identify solutions?

Recommended Focus Area 2

Become a Data-Driven System

OBJECTIVE

Use data to drive planning, decision-making, and evaluation.

Data-driven decision-making requires collecting, cleaning and using data to inform each aspect of the work we do in the homeless services system. Quality data should influence goal setting, resource allocation, and policy and practice improvements. System leaders and service providers often have good intentions to use data, but the unavailability of useful data, poor data quality, unclear delineation of governance and accountability, lack of common measurement and vision, and/or a lack of understanding for the field and what constitutes success can create barriers to effective use.

✦ Focus Area 2 — At A Glance ✦
GAPS & BARRIERS
❏ WHCC and county level reports are not readily available ❏ Decision-makers and service providers lack adequate training ❏ Data quality is not consistently reviewed by the community ❏ Readily available data is unused ❏ Lack of oversight and accountability structures (SEE <u>APPENDIX C</u> FOR MORE INFORMATION)
STRATEGIES & ACTION ITEMS

STRATEGY 2.1 INCREASE THE AVAILABILITY OF USEFUL DATA AND REPORTS page 37
ACTION ITEMS
2.1.1 Work with HCDD to localize, and analyze State and CoC-level reporting. page 38
2.1.2 Create a clearinghouse for WHCC homeless data and information. page 39

STRATEGY 2.2 IMPROVE DATA QUALITY   page 39

    ACTION ITEMS

STRATEGY 2.3 USE DATA IN EVERY COMMUNITY, AGENCY, AND PROGRAM MEETING   page 41

    ACTION ITEMS

KEY MEASURES

- ❏ Data Quality Report Q2-Q7 improved % error rate and timely data entry
- ❏ Increased % HMIS coverage rate
- ❏ Increased utilization rates (pulled from HMIS quarterly and in the annual housing inventory count)

SUGGESTED RESPONSIBLE PARTIES

STRATEGY 2.1 → WHCC leadership & System Coordinator

STRATEGY 2.2 → Data Subcommittee & System Coordinator

ACTION ITEM 2.3.1 → Data Subcommittee & Best Practice Workgroup

ACTION ITEM 2.3.2 → Data Subcommittee & System Coordinator

(SEE APPENDIX A FOR MORE INFORMATION)

STRATEGY 2.1

Increase the Availability of Useful Data and Reports

System performance, and other system tracking data need to be readily available if they are going to be used to drive systems change. The WHCC should advocate for helpful modifications to existing reports, post information in a central location for ongoing use, and request access to data sets that are not yet integrated.

ACTION ITEM 2.1.1

Work with HCDD to localize State and CoC-level reporting to Weber County.

Reports needing regular review, that the HMIS team has graciously provided upon request for this plan, should be made readily available on an LHCC or county-level. The state could also better support the WHCC (and other LHCCs) by using their data analysis and publications expertise to add an easily-understandable layer of analysis to published reports, such as simple rankings or comparisons: across the state, with other communities, over time, and with national averages.

WHCC leadership should work with the Housing and Community Development Division (HCDD) Director and State Homeless Programs Team Manager to explore options. Procedures for making reports available could subsequently be included in the updated HMIS Standard Operating Procedures; something the two representatives from Weber County that sit on the HMIS Steering Committee could work with HMIS staff and other BoS representatives to make happen.

Priority reports that should be made readily available on an LHCC-level include:

- ❏ Homelessness Data Dashboard: System Overview, program type performance and system performance measure tabs; ongoing (HCDD)
- ❏ Coordinated entry reports, monthly (HCDD, appears to operational)
- ❏ HUD System Performance Measure Report, quarterly (pulled from HMIS either by a trusted service provider, system coordinator with HMIS access, or HCDD)
- ❏ Program performance, quarterly (HCDD)
- ❏ Data quality reports, quarterly (HCDD)
- ❏ Point-in-time count (PIT), at least annually and prior to HUD submission (HCDD)
- ❏ Housing-inventory-count (HIC), at least annually and prior to HUD submission (HCDD)

Other information/reports to work with HCD to explore access to:

- ❏ SPDAT reports for case managers (previously under development, but never available)
- ❏ Quarterly spend down reports for State and BoS funding
- ❏ Prior zip code and other mobility analysis
- ❏ Carbon copy of State and BoS monitoring reports
- ❏ Prior state allocations should the WHCC wish to conduct longer-term funding analysis

- ❏ Special compilations of performance data used for State Homeless Funding and CoC competitions, such as those distributed in the February SHCC meeting.
- ❏ Other data sets used to drive SHCC and HCD strategy as they are created and any special analysis conducted by the Workforce Research and Analysis Division

As filters for the data dashboard are being built, the WHCC and HCDD could arrange for HMIS staff or the System Coordinator to run certain reports on a regular basis and post them to the web as a work-around. Information and reports could also be sent to the System Coordinator who can flag information for the WHCC and its subcommittees.

These adjustments and report availability will only serve to strengthen the performance in Weber County, the BoS and the state of Utah.

ACTION ITEM 2.1.2

Create a clearinghouse for WHCC homeless data and information. (See also ACTION ITEM 3.2.2)

Once needed reports are obtained, the WHCC should find a way to link or post this information where it can be repeatedly accessed and used across the community, such as a county website. Publicly available information improves transparency, facilitates the possibility of more frequent use, and even very simply allows for reports passed out during meetings to be accessed by those who are not present. A calendar for WHCC meetings, related community events and training; links to resources (referenced in this plan and otherwise); and system performance management plans could be included as they are available. Efforts to create an online clearinghouse for system and program level data could be combined with efforts to make homeless resource information more readily available for households experiencing, or at risk of, homelessness.

STRATEGY 2.2

Improve Data Quality

Several community members lack confidence in HMIS data quality. The action items under Strategy 2.2 provide concrete ways to build confidence in HMIS data. The first action item recommends the development of a data quality plan and the second highlights a data quality concern specific to domestic violence service providers. Action items in Strategy 2.3 will also support improved data quality over time.

ACTION ITEM 2.2.1

Develop a data quality plan for WHCC adoption.

It is recommended that the WHCC Data Subcommittee analyze recent data quality reports and develop a robust data quality plan for WHCC input and adoption. Those assigned to complete the task should start with the Data Quality section in Appendix C, the supplemental considerations in Appendix B, and the "Action Steps to Improve Data Quality," pages 5-6 in the S*ystem Performance Improvement Briefs: CoC Data Quality.*[23]

The Data Subcommittee will need to refer to pre-existing standards in the Utah HMIS Standard Operating Procedures[24] and apply them as benchmarks where applicable. They should also find ways to support HMIS monitoring activities. Finally, the HUD System Performance Improvement Briefs: *Data Quality and Analysis for System Performance Improvement*[25] may also prove useful.

Once the data quality plan is approved by the WHCC, the Data Subcommittee can take responsibility for oversight between meetings with support from the System Coordinator and HMIS Team.

ACTION ITEM 2.2.2

Support data quality and inclusion for domestic violence service providers.

Domestic violence (DV) service providers who receive Federal homeless funding are restricted from entering any identifying information into HMIS for those they serve. However, DV service providers are also required to have an HMIS comparable database if they receive any CoC or ESG funding. This comparable database should allow DV service providers, such as Your Community Connection (YCC), to pull de-identified raw data and reports with the same specifications and formulas used by HMIS.

Current Federal reporting requirements only direct these data be integrated with other community data once a year through the annual PIT and HIC, but communities are strongly encouraged to find ways to lawfully include DV data in their local planning and decision-making processes.

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[23] https://www.hudexchange.info/resources/documents/coc-data-quality-brief.pdf

[24] https://utahhmis.org/about/governance/
[25] https://www.hudexchange.info/resources/documents/Data-Quality-and-Analysis-for-System-Performance-Improvement-Brief.pdf

Studies show that as many as 57% of all homeless women report domestic violence as the immediate cause of their homelessness. Another study of homeless women with children found that 80% had previously experienced domestic violence.[26] The frequency of homeless persons who have experienced or are actively experiencing domestic violence and the frequency of those who experience domestic violence experiencing housing instability is too significant to ignore. Data that may help decision-makers better serve this subpopulation need to be integrated into local analysis and reporting where possible.

It is recommended that the WHCC conduct or request skilled county or university staff to conduct a review of the comparable database used by YCC, ensure it meets compliance standards as an HMIS-comparable database, support funding solutions to address weaknesses and identify ways information from that database could be lawfully integrated into community planning and decision-making efforts. The WHCC may wish to explore similar possibilities with other non-HMIS participating providers should those providers continue to refuse participation in HMIS.

STRATEGY 2.3

Use Data in Every Community, Agency, and Program Meeting

The community must begin introducing data into all aspects of the homeless services system. From consumer input and individual client SPDAT scores to system performance reports, each meeting held to review community progress, connect resources, share information and direct future action should include some kind of data to substantiate claims and inform results.

At minimum, each body that meets should ask the following questions: What assumptions are our discussions and decisions based upon? Can they be substantiated with data? What reports are available that relate to the topics we are discussing? Are there trends or outcomes we should examine before correcting course? How will we measure the impact of any changes made? Is there information that could better inform our meeting objective?

The following action items are consistent with, and cross-referenced to, action items in the

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[26] The Intersection of Domestic Violence and Homelessness
https://safehousingpartnerships.org/sites/default/files/2017-05/SHP-Homelessness%20and%20DV%20Inforgraphic_1.pdf

Improve System Planning and Oversight Focus Area. Their emphasis here is a deliberate part of becoming a data-driven system.

ACTION ITEM 2.3.1

Provide training based on system and program level performance.
(See also ACTION ITEMS 1.3.2 and 1.3.3)

The training referenced in 1.3.2 and 1.3.3 should include application-oriented training about system and program level data and performance. The focus is not so much how to read the reports (though that may be helpful in some settings), as it is how to use them. Homeless service provider executive staff, management, and board members may benefit from a separate training or peer learning forum. Reports the WHCC should have familiarity for are listed in Action Item 2.1.1. Reports that are readily accessible and should be trained to for agencies and programs follow:

- ❏ Annual Performance Reports
- ❏ Monitoring Reports
- ❏ Coordinated Entry Report
- ❏ Each of the community-level reports, broken down to an agency level

    *Front-line service staff should have some familiarity with client-level SPDAT data

ACTION ITEM 2.3.2

Include a detailed policy for data use in written policies and procedures.
(See also ACTION ITEM 1.1.4)

Consistent with Action Item 1.1.4, it is strongly recommended that the written by-laws and policies and procedures for the WHCC and each subcommittee detail how data and reports will be used, including source and frequency. Once these have been developed, there should not be any question about where data are sourced or how frequently data are reviewed and by whom. These written documents should be reviewed for accuracy on a consistent basis, but no less than once every two years. Once these policies are developed, WHCC and subcommittee minutes could periodically be reviewed to evaluate compliance. The measures of success sections throughout this Strategic Plan provide a road map. It is also recommended that the WHCC explore possible goals for local homeless service funders and provider agencies to incorporate similar expectations.

Recommended Focus Area 3

Make Homelessness Rare

OBJECTIVE

Reduce the number of persons who experience homelessness in Weber County

Communities with a sufficient, safe and affordable housing stock; strong cross-system coordination; and the ability to quickly identify and target those most at risk of homelessness can reduce the number of persons who experience homelessness. It requires a high-level, coordinated response across multiple systems of care.

Note: Homeless prevention programming should not be prioritized above, or divert resource away from, any part of the homeless crisis response system.

✦ Focus Area 3 — At A Glance ✦

GAPS & BARRIERS

- ❏ Weber County lacks an affordable housing strategy
- ❏ Homeless diversion programming generally excludes households without children
- ❏ Weber County lacks apparent resource for landlord mediation, eviction prevention, and housing navigation.
- ❏ Information and support to resolve housing instability is difficult to locate
- ❏ Homeless prevention and low-income resources could be targeted to households at higher risk of homelessness.
- ❏ High-level coordination between the homeless system and agencies/initiatives that target support to low-income people needs improvement.

(SEE APPENDIX C FOR MORE INFORMATION)

STRATEGIES & ACTION ITEMS

KEY MEASURES

- ❏ System Performance Measure 2: Returns to Homelessness - A reduction in the % of persons who return to homelessness.
- ❏ System Performance Measure 5 : A decrease in the number of persons who become homeless for the first time (HMIS)
- ❏ Secondarily: Data from other systems that count homelessness could be referenced to triangulate trends. (eg. school district homeless data, IGP, etc.)

SUGGESTED RESPONSIBLE PARTIES

STRATEGY 3.1 → WHCC & community leaders

STRATEGY 3.2 → Make Homelessness Rare Subcommittee & System Coordinator (in coordination with the Make Homelessness Brief Subcommittee)

STRATEGY 3.3 → Make Homelessness Rare Subcommittee & System Coordinator (in coordination with the Make Homelessness Brief Subcommittee)

(SEE APPENDIX A FOR MORE INFORMATION)

STRATEGY 3.1

Develop a Weber County Affordable Housing Plan

In light of data referenced in the State of Utah Affordable Housing Report, there is need to increase affordable housing for extremely-low-income households. Solutions will have direct impact on all aspects of the homeless service system. The process to develop a strategic plan for affordable housing should be coordinated with the homeless services system, but it is ultimately separate and distinct in its scope and participant expertise.

ACTION ITEM 3.1.1

Support the creation of an Affordable Housing Commission to develop a strategic plan for affordable housing.

It is recommended that the WHCC support the formation of a group of community leaders to look at affordable housing need and solutions in Weber County. This body would analyze gaps, barriers and impediments to fair, safe, and affordable housing on a county and municipal level; and dynamically track existing and new units (and their affordability) in the community. Ideally county and municipal governments, economic development experts, land developers, landowners, transportation officials, affordable housing advocacy organizations, financers, the State Housing and Community Development Division, and housing authorities should be part of the conversation. Together this group could review existing data and generate local strategies to influence development, consolidated planning, legislation, and other policies to meet community need.

STRATEGY 3.2

Reorient Homeless Prevention Models

Current homeless prevention efforts can be enhanced by expanding homeless diversion to all household types, making information and resources more available to those experiencing a housing crisis; using local data to prioritize high-risk households, and improving coordination with mainstream resources and programs (Strategy 3.3).

ACTION ITEM 3.2.1

Expand diversion programming to fill service gaps.

Homeless diversion assists individuals and families actively seeking shelter to pause crisis thinking and consider safe and creative alternatives to shelter entry. The light-touch intervention often draws upon a household history, strengths and pre-existing social networks. Shelter diversion is not a denial of shelter services, but a discussion considering all available options and which would be best for the household. Where homeless diversion is considered to be a more effective use of homeless prevention funding, it is recommended that efforts to prevent homelessness first be directed toward homeless diversion programming and filling the service gap for adult households without children.

The community will need to identify a funding source that could be reallocated or newly obtained to support diversion for this population and determine whether it is most effective to expand this service with existing staff at shelter sites or create a consolidated point of contact or some combination of the two. Ideally these considerations would be discussed in a meeting including representation from the Make Homelessness Rare and Make Homelessness Brief Subcommittees, emphasizing a rapid connection to homeless diversion for all newly homeless households and seamless follow-through to housing-focused case management for those who are unable to be diverted.

ACTION ITEM 3.2.2

Create a hub for homeless prevention information and assistance.
(See also ACTION ITEMS 2.1.2, 4.1.3, and 5.2.3)

It is recommended that the WHCC help create a community-wide hub for eviction and homeless prevention information and support for community members at risk of homelessness. Further development and implementation considerations should be discussed with the Make Homelessness Rare and Make Homelessness Brief Subcommittees and brought before the WHCC for input and support.

Should something like this be implemented, it would need to be fully integrated with coordinated entry, including associated policy and procedure additions. It would be worth considering whether this type of service hub could provide diversion services, deposit assistance and/or support other efficiencies at the front door and at other points of the coordinated entry process.

Ogden CAN is currently developing pilot programs with IGP, the Ogden School District, and both housing authorities to include several of these services and may be able to play a role in expanding provision to at-risk and homeless individuals and families on behalf of the community. The newly formed Weber Prevention and Prosperity Center of Excellence is well positioned to work with Ogden CAN in support of high-level coordination needed for this and other Make Homelessness Rare Action Items. Both organizations may be able to fill different gaps and/or help locate one or more physical locations as this action item takes shape.

The hub for eviction and homeless prevention information and assistance could be created in two to three phases:

1) Create a user-friendly website with guidance and resource for persons experiencing housing instability. Post consolidated information in public places frequented by low-income people, such as libraries, social service buildings, community centers, and food assistance centers. Information should include emergency assistance providers, such as shelters, and ways to access coordinated entry assessments without the requirement of shelter entry. Making information readily available to those who need it gives a step up to households with lower barriers that could avoid entering the homeless system when equipped with the right information. It can also help connect higher-barrier households with appropriate support structures. This would be a low cost, broadly available resource.

2) Support the creation of a physical hub for information and support. At its most basic level, such a hub would provide access to low-cost resources that should be made generally available and not require passage through a program or service provider, such as access to computers and phones, updated lists of available units with contact, screening and application details, lists of felon-friendly landlords, and referral and connection to existing services, such as free legal clinics, mainstream benefits and other available programming. Printed tools such as worksheets from the HUD Housing Search Assistance Toolkit could also be considered for inclusion.

3) Expand access to eviction prevention, landlord outreach and mediation, housing counseling, and housing location assistance. Staff could work with the Affordable Housing Commission to track available affordable units and reduce barriers to access. Staff could use a similar approach to homeless diversion to find low-cost, light-touch, and creative ways to retain stable housing.

The first section of the HUD Housing Search Assistance Toolkit offers potential models, funding and staffing ideas that could be considered in this action item. There are several

other models worth noting, such as the model developed in Waterloo by Lutherwood Housing Services or Housing Opportunities Made Equal in Cincinnati.

ACTION ITEM 3.2.3

Use local data to target higher-risk households.
(See also ACTION ITEM 5.2.3)

Traditional homeless prevention programs, where clients are assisted with housing or other financial assistance prior to seeking shelter, should be evaluated for efficacy and considered for reallocation where applicable. Those that continue programming should ensure client selection is data-driven to have the very best chance of serving a household that would have actually become homeless were it not for the assistance.

National predictive data from other communities in the nation consistently indicate the single best predictor of eventual homelessness is having previously stayed in a homeless shelter.[27] Targeting this population first could create a baseline standard for all prevention assistance funding. Programs may also wish to target households who have previously experienced homelessness in the past 2-3 years and who are fleeing domestic violence,[28] as these two variables were noted with frequency among those who experienced literal homelessness the last time a prevention study was conducted in Utah.[29] There are of course other studied predictors that could be considered if these filters end up being too broad. Any additions should be adopted from a reputable evidence-base or determined based on local shelter and outreach data.

Providers should not worry about selecting households perceived as being at too great a risk level as "there does not appear to be a "peak risk level" beyond which homelessness prevention services cannot have an impact. In fact, programs that serve people who are at higher risk of homelessness often have larger effects, as indicated by the larger differences in homelessness rates between people who do and do not get services as risk level

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[27] Center for Evidence Based Solutions, Homeless Prevention, A Review of the Literature, Jan 2019, Shin and Cohen
http://www.evidenceonhomelessness.com/wp-content/uploads/2019/02/Homelessness_Prevention_Literature_Synthesis.pdf
[28] "Domestic violence...has had inconsistent relationships to homelessness in other studies."= Efficient Targeting of Homelessness Prevention Services for Families, Shin, et. al.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3969118/
[29] Homeless Prevention Technical Assistance: Implementing a Random Trial of Homelessness Prevention in Utah; Utah Department of Workforce Services and the Urban Institute
https://www.va.gov/HOMELESS/ssvf/docs/Utah_Homelessness_Prevention_Study_Technical_Assistance_Guide_2014.pdf

increases (Shin and Cohen)." It should also be noted that high performing programs will likely see a decrease in stable housing outcomes as a result of serving higher-risk households; this is anticipated and merely another example of outcome data needing to be compared in conjunction with other data sets, such as household risk and SPM 5 (the number of first time homeless) to be properly contextualized.

Whatever the standard, once agreed upon, it should be brought before the WHCC and adopted as part of the local coordinated entry system.

STRATEGY 3.3

Improve Coordination with Systems and Initiatives Serving Low-Income and Vulnerable People

The homeless services system alone cannot effectively prevent and end homelessness. There are however many other community touch points that provide services to persons at risk of (and experiencing) homelessness. There are myriad mainstream federal, state, and local programs and initiatives that target low-income people in Weber County that could be better coordinated. Organizations such as the newly formed Center for Excellence and the United Way of Northern Utah with their United Partnership Council are working on broad level coordination and will likely create a structure to better facilitate linkages with the homeless services system, other sectors, and other systems of care in the future. The role of the WHCC is to represent homelessness as a part of these higher-level coordinations, educate partner agencies about housing instability and its effects on all aspects of a low-income individual's life, and encourage ways to prioritize eligible clients for assistance based on housing instability.

If informed and coordinated, these other programs and initiatives can help make significant progress, not only toward reducing the number of persons who experience first-time homelessness in Weber County, but also to help make homelessness brief and non-recurring.

ACTION ITEM 3.3.1

Use community resources not specifically targeted to homelessness ("mainstream resources and programs") to target individuals and families most at risk of homelessness.

Resources, programs and special initiatives (including, but not limited to those that target low-income households) could train staff about housing instability and intentionally target their own supports to eligible households at greater risk of homelessness. They could even use a similar prioritization method to Action Item 3.2.3. DWS emergency assistance and child care, health prevention, behavioral health, education, the Intergenerational Poverty Initiative, agencies such as OWCAP and Cottages of Hope, and others listed in the following figure[30] should be included in this effort. Doing so could actually reduce cost to many sister systems and initiatives and improve pathways to housing for their highest users.

Mapping Connections between Mainstream Resources and Programs and Homelessness Services

Prevention, Identification & Early Intervention		Tailored Services & Housing Solutions
Mainstream Programs	Coordinated Entry and Assessment	**Housing**
• Public Housing Authorities		• Rapid Re-Housing
• Multifamily/Section 8 Housing		• Affordable Housing
• HOME Grantees		• Supportive Housing
• Medicaid		• Transitional Housing
• Hospitals and health care providers		
• Supplemental Security Income (SSI)		**Education & Employment Supports**
• Social Security Disability Insurance (SSDI)		
• Temporary Assistance for Needy Families (TANF)	Emergency/ Crisis Response	**Health & Behavioral Health Services**
• Head Start and Early Head Start		
• Child Welfare Agencies		
• Public School Districts	Shelters	**Social Service Supports**
• WIOA Planning Committees		
• Community Development Block Grants		• Temporary Assistance for Needy Families
• Community Services Block Grants	Transitional Housing	• Supplemental Security Income/Social Security Disability Insurance
• Supplemental Nutrition Assistance Programs		• Women, Infants and Children Benefits and Services
• Domestic Violence Service Providers	Outreach & First Responders	
• Women, Infants and Children Benefits and Services (WIC)		

United States Interagency Council on Homelessness

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[30] The figure can also be found at
https://www.usich.gov/resources/uploads/asset_library/Coordinated_Entry_Brief.pdf

ACTION ITEM 3.3.2

Improve efforts to prevent people from entering homelessness as they transition from other systems

Higher-level coordination across systems should not only facilitate processes to prioritize at-risk residents, but also ensure any transitions from one system to another are well-planned and do not negatively impact housing stability. This recommendation includes the entities listed in Action Item 3.3.1 and extends to providers of residential or institutional care, such as hospitals, jails, the state mental hospital, residential treatment facilities, assisted living and skilled nursing facilities. Each of these systems also needs to have a basic awareness of homelessness and housing instability and how it directly impacts their own system outcomes. Ideally one of the umbrella organizations could work to create a countywide policy for discharge planning for broad adoption. Ideally those who regularly facilitate discharge planning could also participate in homeless diversion training or have access to a centralized homeless diversion specialists.

Where applicable, maintaining primary supportive services through the specialized care system, rather than the homeless services system, may be preferable to maintain the proper expertise to stabilize especially vulnerable populations.

Efforts to improve discharge planning will require a close look at data to more effectively gauge the scope of and needed response to discharge to homelessness.

Recommended Focus Area 4

Make Homelessness Brief

OBJECTIVE

Reduce the average length of time persons experience homelessness

Once an individual or household becomes homeless, the path to housing stability is often layered and complicated. A highly coordinated continuum of homeless programming can significantly reduce the time it takes to reclaim housing stability. Among other things, this requires quick identification and engagement of those who are homeless; access to low-barrier, housing-focused emergency services; and that the coordinated entry system is operating as efficiently as possible.

✦ Focus Area 4 — At A Glance ✦

GAPS & BARRIERS

- ❏ General homeless service information is difficult to find
- ❏ Coordinated entry inefficiencies and limited scope
- ❏ Loss of CABHI funding and ACOT team
- ❏ Street outreach teams lack capacity
- ❏ Law enforcement and street outreach coordination is minimal
- ❏ Housing-focused case management needs evaluation
- ❏ Landlord outreach and housing location assistance could be streamlined

(SEE APPENDIX C FOR MORE INFORMATION)

STRATEGIES & ACTION ITEMS

STRATEGY 4.1 ENHANCE THE COORDINATED ENTRY PROCESS	PAGE 54

ACTION ITEMS

| 4.1.1 Use referenced tools to evaluate local coordinated entry policy and practice. | page 54 |
| 4.1.2 Adopt a 'Universal system management' approach. | page 55 |

KEY MEASURES

- ❏ System Performance Measure 1: Length of Time Persons Remain Homeless (HMIS) - reduce average and median lengths
- ❏ System Performance Measure 7a: Successful Placement in Temporary and Permanent Housing from Street Outreach - increase in the % who exit to an ES, SH, TH, or PH destination.
- ❏ System Performance Measure 7b.1 Successful Placement in Permanent Housing from ES, SH, TH, and RRH. - particular emphasis on increased successful placements from ES, SH, and TH.
- ❏ Coordinated Entry System Reports (HMIS)
  - ❏ New VI-SPDATs (pre-screens) conducted, compared to the total number of households that newly engaged in street outreach or entered emergency shelter fourteen or more days ago.
  - ❏ Average days from prescreen to SPDATand prescreen to placement
  - ❏ Percent placed with SPDAT score
  - ❏ Program placement from top 25% acuity

SUGGESTED RESPONSIBLE PARTIES

STRATEGY 4.1 → Make Homelessness Brief Subcommittee & System Coordinator (Action Item 4.1.3 in coordination with the Make Homelessness Rare Subcommittee)

STRATEGY 4.2 → Make Homelessness Brief Subcommittee & System Coordinator

STRATEGY 4.3 → Make Homelessness Brief Subcommittee & System Coordinator (Action Item 4.3.2 in coordination with the Make Homelessness Rare Subcommittee)

STRATEGY 4.1

Enhance Coordinated Entry to Ensure Pathways to Permanent Housing are as Rapid and Efficient as Possible

A rapid and efficient pathway to permanent housing will look different for different households. The role of the homeless services system and coordinated entry is to to speed this process and prioritize the most vulnerable individuals and families for assistance while facilitating faster housing and referrals for those who are less in need of a housing program intervention.

ACTION ITEM 4.1.1

Use referenced tools to evaluate and revise local coordinated entry policy and practice.

The Make Homelessness Brief Subcommittee should use the tools referenced below and the HMIS-generated Coordinated Entry Report to evaluate the coordinated entry process and create a performance management plan.

The Subcommittee will want to pay special attention to implementing a Housing First orientation (see also ACTION ITEM 1.3.1) and housing-focused services, the administrative structure and logistics of coordinated entry, and the existing prioritization list and housing-match process, including SPDAT assessment consistency.

Making homelessness brief requires a housing-focused approach. The housing-focused case management self-assessment portion of the NAEH Emergency Shelter Learning Series asks the following questions that are just as applicable to the system as they are to emergency shelter providers : 1) Are all our services focused on helping participants obtain and sustain housing as quickly as possible? 2) Do we have appropriate staffing and job descriptions to provide housing-focused, rapid exit services? 3) Do our staff know how to provide case management that is focused on creating a housing plan and helping participants develop and achieve housing-focused goals to exit [homelessness] quickly? 4) Are participants assisted to create a rapid exit housing plan with staff within one week of entering shelter [or street engagement]? and 5) Does our agency embrace housing-focused

messaging - throughout its environment, activities and policies?

Coordinated entry administration requires some investment on behalf of the community. Potential conflict and capacity need to be considered. For example, could one of the local governments or another somewhat neutral entity offer leadership or administrative staff to support this process? A system coordinator position could add capacity to this Subcommittee. Additional funding could be sought through the BoS competition to help fund coordinated entry work, though this would require advance conversation with the BoS to determine how such an application would fit within their funding priorities.

Tools to help evaluate and improve the coordinated entry process:

- ❏ The HUD Coordinated Entry Self-Assessment:
  hudexchange.info/resources/documents/coordinated-entry-self-assessment.pdf
- ❏ NAEH Coordinated Entry Evaluation Tools:
  endhomelessness.org/resource/coordinated-entry-evaluation-tool
- ❏ And NAEH provided sample participant surveys from other communities:
  endhomelessness.org/resource/coordinated-entry-community-samples-resource-library
- ❏ HUD System Performance Improvement Briefs: Strategies for System Performance Improvement
  hudexchange.info/resources/documents/Strategies-for-System-Performance-Improvement-Brief.pdf

ACTION ITEM 4.1.2

Adopt a 'Universal system management' approach to the prioritization list and housing-match process.

The community prioritization list should be a dynamic, up to date platform that gives a sense of how many homeless people have housing program needs.

A Universal System Management approach to coordinated entry was delineated as a specific model by OrgCode to differentiate among various common approaches to client prioritization and housing match. The name of the approach is less important than its intent and characteristics. According to DeJong,

> "This is the best approach for addressing multiple priorities at once, making the housing process more efficient, and taking as much subjectivity out of the process as possible while leveraging HMIS. ...the community collects an inventory of all of the eligibility requirements for each [PSH and RRH program]. The community can then be clear, for example, that their top

priority for offering a PSH unit is a person who meets the definition of chronic homelessness, who is tri-morbid, who has been homeless for three or more years, and who has a VI-SPDAT score of 13 or higher. This will then generate a list of just those people that meet that group for the top priority. Assuming all of the documentation is in order for each of those people, the list can be provided to PSH providers that serve that group that have a vacancy... In this approach, the emergency side of the system (shelters, outreach, drop-ins) are responsible for getting people document ready and putting them on a list, and housing providers are responsible for taking people off the list. There can also be fail safes of assigning people if they are not picked within a certain period of time. And it can generate specific lists for every type of PSH, RRH, TH or any other type of housing intervention that exists in your community. Gone are the days of case conferences and trying to chase people down.

This approach also comes with some problems that need to be resolved. It can be difficult for a community to establish and agree upon priority groups. It can be cumbersome to learn every single eligibility detail for every single housing program, in large part because many providers have unwritten rules. It can be difficult for well intentioned service providers to let go of advocating for specific people to the point where it actually circumvents why coordinated entry is so necessary."

The following link outlines the other two approaches DeJong is distinguishing from: http://www.orgcode.com/3_main_approaches_to_coordinated_entry

The Balance of State has already identified PSH and RRH prioritization standards, using a combination of the highest SPDAT score and applying any program-specific requirements. If the cleaned up prioritization list continues to have so many high-scoring households, it may be worth considering additional prioritization categories based on need, such as tri-morbidity or total length of homelessness. This would need to be discussed with the Balance of State, but could likely be put into the coordinated entry policies and procedures local addendum to avoid requiring adoption from the entire BoS and Mountainlands CoCs.

ACTION ITEM 4.1.3

Consider streamlining and jointly resourcing housing navigation & landlord outreach activities to rapidly house homeless households. (See also ACTION ITEM 3.2.2)

Streamlining housing search and landlord outreach activities has the potential to add significant capacity to homeless service providers. Such services could potentially be co-located with similar community-wide efforts to track affordable housing within the community and to make homelessness rare and non-recurring. See 3.2.2 for further reference to a possible centralized model within the community.

Both the Make Homelessness Rare and Make Homelessness Brief Subcommittees could jointly consider this option. They should also consider partially-centralized and decentralized options, such as increased funding for housing search within housing program staff while centralizing landlord outreach and unit tracking.

STRATEGY 4.2

Quickly Identify and Respectfully Engage Persons Experiencing Homelessness

In an effort to reduce trauma, speed the pathway to housing stability, and increase the system's capacity to serve more people in need, the homeless services system in Weber County needs to be equipped to proactively identify newly homeless people and respectfully engage them with housing-focused services.

ACTION ITEM 4.2.1

Use client input to expand coordinated entry outreach and inreach.

It is recommended that information for accessing homeless and housing resources be made more available to the target population. To date, some of the most obvious resource postings on the web consist of lists of agencies without a clear pathway of who to contact for what. This should be revisited with input from persons with lived experience to ensure there is an easy way to access helpful information. Posting information in libraries, food

access points, community centers, schools and service sites could be valuable for those who do not have computer access. Non-homeless service providers and employees who work at places frequented by homeless persons, such as librarians, should be given information and invitations to participate in planning and training.

The value of public education is multi-fold, but has been shown to be particularly valuable in suburban areas and municipalities without service hubs. In these areas a friend, family member or church group may be the first to identify individuals at the time they become homeless. Low input forms of public education could be explored. For example, the point-in-time count can be used to increase public education about homelessness. Volunteer events could include an educational component, and housing-related events, such as landlord outreach open houses, could be announced through broady public forums whenever possible.

The Make Homelessness Brief Subcommittee likely needs to revisit the entire outreach plan in the WHCC localized addendum.

ACTION ITEM 4.2.2

Ensure street outreach teams have the capacity for routine outreach such that all unsheltered persons are known by name and connected to housing and services as quickly as possible.

Street outreach teams need to have enough capacity to engage and case manage unsheltered homeless clients to facilitate service engagement, particularly for those clients with disabling conditions. Street outreach should be *low-barrier* and *housing-focused* and the system should not require persons to enter emergency shelter in order to access needed housing and service programming. Outreach workers should collectively know *all* unsheltered homeless persons by name, connect them with emergency services and shelter, and support them through the coordinated entry process. Street outreach staff need to be be dedicated professionals to attain these expectations. A more accurate picture of the scope of unsheltered homelessness also needs to be explored.

It is recommended that the community evaluate street outreach practices and identify resource to coordinate and expand street outreach activities to this end. This could be done through the reinstatement of an ACOT team or by consolidating and increasing existing street outreach efforts and funding sources. HMIS should be used in a consistent manner across all outreach programs to improve data collection and gain a better understanding of the scope of unsheltered homelessness in Weber County.

ACTION ITEM 4.2.3

Work with municipalities and their police departments to coordinate street outreach and advocate for policies and practices that do not criminalize homelessness.

Because of common biases assigned to homeless people, it is especially important for communities to ensure that local laws and law enforcement activities reflect best practice over common myths. The WHCC should coordinate with county and municipal law enforcement to provide education and advocate for Crisis Intervention Team (CIT) training and basic homeless education. Law enforcement, with the proper skills and information, can be a highly valuable partner to quickly identify homeless persons, particularly in smaller municipalities without a service hub.

The annual competition for Federal homelessness funding awards direct points for communities being able to show they have applied strategies to reduce the criminalization of homelessness. Accordingly, the community may also wish to consider developing a specific plan to reduce the criminalization of homelessness. The National Law Center on Homelessness and Poverty developed the Housing Not Handcuffs Initiative, a supplemental Fact Sheet, and policy recommendations that would be helpful resources to facilitate education and planning. The WHCC could also refer to Martin v. Boise for the 2018 9th Circuit Court of Appeals affirmation about criminalizing conduct that is an unavoidable consequence of being homeless.

STRATEGY 4.3

Ensure Emergency Services are Client-Centered, Low-Barrier and Housing-Focused

Once a homeless client has been engaged, access to emergency services need to be low-barrier. Initial shelter and outreach engagements should include a rapid assessment of immediate and urgent needs to determine whether the person is in immediate danger or at unusually high risk. Shelter intake assessments should include homeless diversion discussions to divert households who may be able to avoid the effects of literal homelessness altogether. Within one week of intake or engagement each client should be

assisted to create a housing plan and know where to access housing information that is not contingent upon waiting for an appointment or assessment.

ACTION ITEM 4.3.1

Use referenced tools to improve emergency shelter

It is recommended that emergency shelters engage in shelter evaluation and further transition to a low-barrier, housing-focused approach. The National Alliance to End Homelessness has put forward an Emergency Shelter Learning Series that could help with evaluation and action planning. It includes educational webinars, self-assessments, action plans, and a shelter outcome metrics form. Shelters should also evaluate client access to information that would facilitate rapid self-resolution of homelessness. It may be worth creating an ad hoc working group or learning collaborative of shelter directors and key staff to implement this action item.

According to the National Alliance to End Homelessness, the five keys to effective emergency shelter are: a housing first approach, safe and appropriate diversion, immediate and low-barrier access, housing-focused rapid exit services, and data to measure performance (see figure below). These five keys are applicable across all types of emergency shelter, though there may be additional considerations for unique populations. For example, youth homeless shelters should include a strong emphasis on family reunification while DV shelter average lengths of stay may be longer on average and should be compared to other DV shelter averages.

ACTION ITEM 4.3.2

Create self-accessible resources and information to facilitate homeless exit plans and self-resolution. (See also ACTION ITEM 3.2.2)

This is part of a recurring theme to make information accessible to people who could benefit from it. It is generally believed that the majority of homeless people find their own resolutions to homelessness without a specific housing intervention. In order to potentially increase the number of people who are able to do this and reduce the length of time it takes, housing-focused informational resources should be made publicly available and advertised.

This information should be streamlined and listed online as well as in physical locations, like emergency shelters and other common service hubs. It could include service referral information, available community classes, and pre-existing resources (such as the *HUD*

Housing Search Assistance Toolkit: Conducting the Housing Search Resources). The provided tools are "designed to help clients with their housing search, particularly those who are searching on their own." It could also facilitate more rapid connections to employment support, economic assistance programs, child care and other community services.

THE FIVE KEYS
TO EFFECTIVE EMERGENCY SHELTER

HOUSING FIRST APPROACH

Align shelter eligibility criteria, policies, and practices with a Housing First approach so that anyone experiencing homelessness can access shelter without prerequisites, make services voluntary, and assist people to access permanent housing options as quickly as possible.

SAFE & APPROPRIATE DIVERSION

Provide diversion services to find safe and appropriate housing alternatives to entering shelter through problem-solving conversations, identifying community supports, and offering lighter touch solutions.

IMMEDIATE & LOW-BARRIER ACCESS

Ensure immediate and easy access to shelter by lowering barriers to entry and staying open 24/7. Eliminate sobriety and income requirements and other policies that make it difficult to enter shelter, stay in shelter, or access housing and income opportunities.
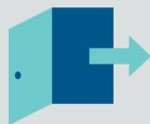
HOUSING-FOCUSED, RAPID EXIT SERVICES

Focus services in shelter on assisting people to access permanent housing options as quickly as possible.

DATA TO MEASURE PERFORMANCE

Measure data on percentage of exits to housing, average length of stay in shelter, and returns to homelessness to evaluate the effectiveness of shelter and improve outcomes.

National Alliance to
End Homelessness

Recommended Focus Area 5

Make Homelessness Non-Recurring

OBJECTIVE

Reduce returns to homelessness

While housing is what ends homelessness, a sustainable end can only be achieved if people are able to access the tools and resources needed for stability. Service provision should be individualized enough to scale the response to an individual's need, include mainstream and community-based supports, and facilitate meaningful daily activities that promote stability and community integration.

This section will consider housing retention, with special consideration for the most vulnerable housing program participants.

✦ Focus Area 5 — At A Glance ✦

GAPS & BARRIERS

❏ An absence of facility-based permanent supportive housing
❏ Inaccessible clinical support and other linkages for clients with disabilities
❏ Loss of the ACOT team
❏ Insufficient training and inordinate caseloads for case managers who serve high-acuity clients.
❏ Insufficient RRH program adjustments and linkages for higher-acuity clients

(SEE APPENDIX C FOR MORE INFORMATION)

STRATEGIES & ACTION ITEMS

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ACTION ITEMS
5.1.1 Prioritize funding for additional PSH case managers.   page 64
5.1.2 Scale RRH caseloads, length of assistance, and case manager training to client need.   page 64
5.1.3 Evaluate RRH and PSH programming and create performance management plans.   page 65

STRATEGY 5.2 ENSURE COMMUNITY SUPPORTS ARE AVAILABLE   PAGE 66

ACTION ITEMS

STRATEGY 5.3 INCREASE THE FLOW AND AVAILABILITY OF PERMANENT HOUSING **PAGE 68**

ACTION ITEMS

KEY MEASURES

- ❏ System Performance Measure 2: Returns to homelessness - reduce total returns to homelessness
- ❏ System Performance Measure 4: Job and income growth- increased % of person who increase income at program exit.
- ❏ System Performance Measure 7b.1: Successful Placement in Permanent Housing from ES, SH, TH, and RRH (with emphasis on placements from RRH)
- ❏ System Performance Measure 7b.2: Successful Placement and Retention of Permanent Housing

SUGGESTED RESPONSIBLE PARTIES

STRATEGY 5.1 → Make Homelessness Non-Recurring Subcommittee & System Coordinator

STRATEGY 5.2 →Make Homelessness Non-Recurring Subcommittee & System Coordinator (in coordination with the Make Homelessness Rare Subcommittee)

STRATEGY 5. →Make Homelessness Non-Recurring Subcommittee & System Coordinator (Action Item 5.3.3 in coordination with the Make Homelessness Rare Subcommittee)

(SEE APPENDIX A FOR MORE INFORMATION)

STRATEGY 5.1

Increase the Utilization and Quality of Permanent Housing Programs

The first step to meet community need for permanent housing is to maximize the capacity of existing resources. Maximization in this sense does not refer only to the number of program participants, it must also include maximizing quality and success. This will require additional funding for supportive services in both PSH and rapid-rehousing program types if the funding allocated for housing assistance is to function at capacity. Certain strategies such as outsourcing housing location could be helpful to increase existing case manager capacity, but it is not enough on its own. In addition to changing caseloads, practices across permanent housing programs should be evaluated and performance management plans created to ensure local programming is drawing upon the evidence-base for administering permanent housing programs.

ACTION ITEM 5.1.1
Prioritize funding for additional PSH case managers to create a maximum 1:18 case manager to client ratio.

There is a clear and immediate need to increase case management for permanent supportive housing programming in Weber County. WHCC leadership and community decision-makers need to move quickly to find and allocate additional resource for PSH case management and avoid the recapture of PSH housing funds. This action item could be partially combined with item 5.2.1 if the community chooses to improve PSH caseloads by reintroducing an ACOT team.

ACTION ITEM 5.1.2
Scale RRH caseloads, length of assistance and case manager training to match participant need.

Rapid rehousing can help fill gaps in PSH, but only if the program is nimble enough to be scaled to match client need. As higher-acuity clients are selected for RRH, caseloads need to be decreased, the length of assistance needs to be increased (even maximized) and case manager training should include evidence-based practices for serving persons with disabilities. This will require additional funding.

Rapid rehousing has proven to be a highly successful and cost efficient program when administered well, especially when compared to the older transitional housing model and even for participants with higher needs and more significant barriers to stable housing. However, if high need clients are to be served effectively through rapid rehousing, the program needs to be intentionally tailored to this end.

Under CoC and ESG funding sources it is allowable to provide rental assistance and

supports to clients for up to 24 months. CoC funding also allows for an additional six months of supportive services after clients have received the maximum 24 months of housing assistance. If higher-acuity clients are going to meet success in rapid rehousing (which is especially necessary due to the PSH backlog), the community should expect a longer average number of months of assistance to positive exit and the possibility of clients needing to be rehoused to a new unit within that same time. Regardless of the PSH stock in the community, it would do RRH programs well to more readily be able to scale services to client need.

Similar to permanent supportive housing, case manager to program participant ratio should be commensurate with client need and participants should have a direct pathways to clinical support, programs that assist clients to increase income, supported employment, and mainstream PHA-administered housing subsidies as needed.

ACTION ITEM 5.1.3
Use referenced tools to evaluate RRH and PSH programming and create WHCC performance management plans.

RRH

The core components of rapid re-housing, performance benchmarks, program standards and tools for evaluation and improvement can be found in the two following National Alliance to End Homelessness technical assistance products. It is recommended that rapid rehousing providers use these tools to evaluate programming and develop a RRH performance management plan that incorporates components of the housing first self assessment to present to the WHCC.

- ❏ Rapid Re-Housing Performance Benchmarks and Program Standards
  http://endhomelessness.org/wp-content/uploads/2016/02/Performance-Benchmarks-and-Program-Standards.pdf
- ❏ Rapid Re-Housing Performance Evaluation and Improvement Toolkit
  http://endhomelessness.org/wp-content/uploads/2016/06/rrh-evaluation-and-improvement-toolkit.pdf

PSH

The Substance Abuse and Mental Health Services Administration (SAMHSA) Evidence-Based Permanent Supportive Housing Toolkit provides a clear set of standards and recommendations for the effective creation, implementation and evaluation of permanent supportive housing. PSH providers should review these materials and join together in qualitatively evaluating their programs and reviewing performance data to set

new goals and generate performance management plans that incorporate components of the housing first self assessment to present to the WHCC.

- ❏ SAMHSA PSH Evidence Based Toolkit

    https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510

STRATEGY 5.2

Ensure Community Supports are Available and Commensurate with Client Need

Housing assistance and case management through PH programs are imperative, but they alone are typically not enough for long-term stability. PH participants also need access to community-based and clinical supports that require linkages to mainstream resources and programs outside of the housing program itself. Linkages to mainstream resources and poverty-focused initiatives provide an added layer to a household's safety net and can effectively make the difference to move participants to self sufficiency.

ACTION ITEM 5.2.1
Improve pathways to clinical treatment, supported employment and other services tailored for persons with disabilities.

Pathways to services tailored for persons with disabilities need to be made accessible throughout the homeless services system, including and especially once people are placed in housing. In some cases clients will need to access mobile crisis services, such as the newly-created Mobile Crisis Outreach Team (MCOT). Supported employment and individual placement and support (IPS) services are helpful tools whereby persons with disabilities are assisted in finding and maintaining employment (Weber Human Services has some programming already available, but whether the availability meets the scope of need among homeless and formerly homeless persons and the way those resources are accessed need to be solidified.)

Access to behavioral health treatment and health prevention activities appear to be similarly disconnected from permanent housing participants at present. The reintroduction of an ACOT team that could assist clients who experience severe and persistent mental illness and/or substance use disorder, from homelessness to long-term stable housing could be especially beneficial. An assessment of the scope of need

throughout the homeless services system compared to availability and a refresher of pathways to access may be something that WHCC leadership and the newly formed Prevention and Prosperity Center of Excellence could work together to quickly address.

ACTION ITEM 5.2.2

Review and improve access to programs that could increase a formerly homeless persons ability to gain employment and income supports. (See also ACTION ITEM 3.3.1)

In addition to those supports tailored to persons with disabilities, there are several mainstream resources and programs that homeless and formerly homeless households could access to improve housing stability. These programs include, but may not be limited to: WIOA, SNAP, WIC, early childhood care and education, SSI, SSDI, TANF and Medicaid (See the figure in Action Item 3.3.1).

Each mainstream program could be assessed to determine how many homeless and formerly homeless participants are on the program and what barriers may be limiting participation. In some instances it may be beneficial to provide training to specific mainstream resource and program staff who could become familiar with, and offer services to, formerly homeless persons as part of their workload. Those staff could attend relevant homelessness trainings and perhaps even be responsible for targeting DWS programming to households in permanent housing programs. Ideally these staff would become especially skilled at working with this population and recognize the unique needs of homeless persons with disabling conditions.

ACTION ITEM 5.2.3

Prioritize homeless prevention resources for persons who have previously experienced homelessness. (See also ACTION ITEMS 3.2.2 and 3.2.3)

Prioritizing homeless prevention resources, in addition to mainstream resources, can provide an added safety net for people currently housed in and seeking to exit permanent housing programs. As referenced in 3.2.2, prioritizing the strategies laid out in the Make Homelessness Rare Focus Area to this population would prove beneficial.

STRATEGY 5.3

Increase the Flow Through and Amount of Permanent Housing

In order for permanent housing programs to be fully utilized, community leaders should also take a look trends in the flow and availability of vouchers and units. Are there moving on (aka moving up) strategies that could be implemented or improved to improve the flow out of permanent housing programs and reduce returns to homelessness simultaneously?

Moving on strategies are those strategies that "[enable] stable tenants of permanent supportive housing who no longer need on-site services to move to a private apartment with rental support and aftercare". Housing rental assistance can be tenant, project, or sponsor based. Project-based PSH can be a helpful tool to preserve PSH housing units long into the future and provide a specially designed facility and service model for clients. Weber County currently does not have any project-based PSH.

ACTION ITEM 5.3.1

Develop a project-based PSH facility to expand the continuum of available housing in Weber County and house vulnerable families and individuals.

Weber County has enough chronically homeless households to benefit from an increased number of units for permanent supportive housing. One conspicuously absent form of PSH in the community is single-site, project-based PSH. Single-site, project-based permanent supportive house has pros and cons as does any service delivery model, but is certainly worth exploring based on the current dynamics of the Weber County homeless services system. While it would be a mistake to reassign more than a handful of current PSH scattered-site vouchers to project-based vouchers, it is possible to designate some existing vouchers and apply for additional project-based vouchers. A few of the benefits and concerns of this type of PSH model, as outlined by SAMHSA in the their Evidence-based PSH Toolkit, are stated below:

SINGLE SITE

Services and housing can be co-located, which is convenient for many. Not always integrated; location choices can be limited for tenants. A sense of community develops within site. Some programs restrict tenant choice and freedom. Neighborhood resistance might be encountered. Living in designated special-needs housing can be stigmatizing.

PROJECT BASED

Ensures long-term availability and affordability of 20, 30, 40 years or more. Development is a lengthy and complicated process. Landlord is already aware of service needs of tenants and may be more understanding and supportive if a crisis arises and less likely to

enter eviction proceedings if something goes wrong. Depending on market conditions, creating housing can be more expensive

In the case of Weber County the complete lack of co-located housing and services for homeless persons and the tight housing market that make physical units difficult to find further lend a case to the benefit of project-based PSH. Creators would have to carefully and creatively consider ways to minimize common challenges with single site, project based developments, such as integration and stigmatization. It is recommended that the WHCC leadership and community-based decision-makers find a way to support the process Ogden City and Weber Housing Authorities have already started to site and develop permanent supportive housing in the community with a modest number of units.

ACTION ITEM 5.3.2
Increase rapid re-housing programming.(See also ACTION ITEM 5.1.2)

Rapid rehousing programming is cost-effective and scalable when housing units can be located. Increased rapid re-housing should consider appropriate case loads and not attempt to put funding into housing assistance without balancing caseloads.

> [Rapid re-housing] has been demonstrated to be effective in getting people experiencing homelessness into permanent housing and keeping them there. By connecting people with a home, they are in a better position to address other challenges that may have led to their homelessness, such as obtaining employment or addressing substance abuse issues. The intervention has also been effective for people traditionally perceived to be more difficult to serve, including people with limited or no income and survivors of domestic violence. Research demonstrates that those who receive rapid re-housing assistance are homeless for shorter periods of time than those assisted with shelter or transitional housing. Rapid re-housing is also less expensive than other homeless interventions."[31]

ACTION ITEM 5.3.3
Employ effective exit and move-on strategies for permanent housing.

Effective move-on strategies facilitate positive and stable exits for clients, ensuring they are connected with needed community supports and income prior to exit. They can also improve the flow through limited PSH units within the community. While the term is most commonly used in reference to PSH, similar principles hold true for RRH, especially when serving higher acuity clients. For example, when RRH programs are serving chronically homeless households, it would likely be in that household's best interest to create a

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[31] https://endhomelessness.org/ending-homelessness/solutions/rapid-re-housing/

pathway to continued mainstream housing subsidies, employment support and ongoing healthcare.

Housing authorities have been effective at facilitating this connection for PSH participants and could consider the possibility of improving pathways for high-need RRH clients or increasing mainstream voucher preferences for homeless households. PSH participants who are in master leased units could also benefit from housing search assistance. All PH programs could consider ways to better access section 42 and other subsidized units within the community as original placements for program participants and help participants consider cost saving options such as shared housing, utility assistance and so on. Providers may also consider using program funds to temporarily continue case management to ease the transition to housing independence.

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32. Homeless Coordinating Committee Executive Summary, FY19 Allocation Plan for Homelessness Funding https://www.utah.gov/pmn/files/394415.pdf

33. REPORT TO THE UTAH LEGISLATURE Number 2018-12, A Performance Audit of Utah's Homeless Services December 2018 Office of the LEGISLATIVE AUDITOR GENERAL State of Utah, https://le.utah.gov/audit/18_12rpt.pdf

34. Rapid Rehousing (National Alliance to End Homelessness) https://endhomelessness.org/ending-homelessness/solutions/rapid-re-housing/

Appendices & Exhibits

APPENDICES

EXHIBITS

ACKNOWLEDGEMENTS

Subcommittees

Functions, Membership, and Assignments

(See Also ACTION ITEM 1.1.3)

Appendix A outlines each of the proposed Subcommittees and the Best Practice Workgroup, with a suggested: function, membership, assigned parts of the Strategic Plan, and meeting frequency. This could serve as a starting place for discussion and development.

NOTES FOR ALL SUBCOMMITTEES

The WHCC and System Coordinator have implied responsibility for all parts of the Strategic Plan assigned to Subcommittees. Each Subcommittee should report progress and bring concerns, resource needs, and system-wide decisions to the WHCC. The Homeless Services System Coordinator will provide backbone support to each Subcommittee. Each Subcommittee should also have an assigned chair, ideally a community leader that could lend their expertise to get the subcommittees running, and a vice-chair. (see Action Item 1.1.1 and 1.1.2 for more information about the role of the WHCC and System Coordinator).

DATA SUBCOMMITTEE

FUNCTION: Take responsibility for gaps, barriers, measures, and strategies to improve data quality and support the WHCC to become a data-driven system.

Create and oversee the ongoing management of a robust data quality plan, oversee planning activities relating to the annual point-in-time count (PIT) and housing-inventory-count (HIC), review PIT and HIC data for accuracy before HUD submission, review the system performance measure report for quality prior to each review by the WHCC, identify additional uses for these data and share responsibility for becoming a data-driven system. Any concerns regarding report access, data quality, or HMIS function should be reported to the WHCC. Over time this subcommittee could shift its focus from data quality management to WHCC-directed research and evaluation.

Over time the scope of the Data Subcommittee could expand to develop strategies for research and analytics, working closely with the Utah HMIS Steering Committee for necessary approvals.

MEMBERSHIP: County and city government staff that deal with data systems, HMIS steering committee representatives from Weber County, BoS Board Executive Committee representatives from Weber County, the Weber County PIT Lead, an Intermountain Healthcare Alliance representative, two or more Weber State University faculty members or graduate students in data and social research related fields such as management information systems, sociology, and/or social work, and a DV services data representative. It would be useful to ensure representation from Lantern House as the largest user in Weber County and street outreach agencies as a program type that has specific data entry concerns (these agencies are already represented in the prior list). It may also be worthwhile to include representation from the Utah Domestic Violence Coalition as discussion about de-identified DV data integration arise.

STRATEGIC PLAN ASSIGNMENTS: All action items under strategies 2.2 and 2.3, and possible support for Strategy 2.1. (See also APPENDIX B)

PERFORMANCE MEASURES: Data quality and joint analysis for all SPMs (Measures 1-7), decreased errors in Q2-7 in the HMIS Data Quality Report, and increased % HMIS coverage, increased % bed utilization. HMIS monitoring reports could also be used to identify specific concerns.

MEETING FREQUENCY: The Subcommittee may wish to meet monthly to get started, but would likely meet quarterly ongoing.

MAKE HOMELESSNESS RARE SUBCOMMITTEE

FUNCTION: Take responsibility for gaps, barriers, measures, and strategies to make homelessness rare and make recommendations to the WHCC.

Coordinate closely with the Make Homelessness Brief Subcommittee to develop coordinated entry procedures for homeless prevention, and the Make Homelessness Non-recurring Subcommittee to focus prevention efforts on people who have had prior episodes of homelessness. Work through the WHCC to coordinate activities with non-homeless service providers and other poverty-focused community initiatives. This Subcommittee may wish to add a homeless prevention workgroup to meet more regularly

and focus on specific client cases to avoid case staffing in the Subcommittee meetings. The Subcommittee may eventually wish to merge with, or hold combined meetings with the Make Homelessness Non-Recurring Subcommittee.

In addition to working on the action items listed in the Make Homelessness Rare and Make Homelessness Non-Recurring Focus Areas, the committee should review the following information:https://www.usich.gov/news/resource-roundup-preventing-housing-crises-and-homelessness.

MEMBERSHIP: All agencies with homelessness prevention funding or one-time assistance services, agencies that work with households at risk of homelessness, school districts, jails, hospitals, senior services, assisted care facilities, community action agencies.

STRATEGIC PLAN ASSIGNMENTS: All action items in Strategies 3.2 and 3.3., and shared responsibility for action items in Strategy 5.2.

PERFORMANCE MEASURES: SPM2-Returns to Homelessness, SPM5-First Time Homelessness, and eventually SPM6-Homeless Prevention. *Secondarily*, this Subcommittee could consider using data from other systems that count homeless persons to triangulate trends.

MEETING FREQUENCY: Quarterly to monthly

MAKE HOMELESSNESS BRIEF SUBCOMMITTEE

Function: Take responsibility for gaps, barriers, measures, and strategies to make homelessness brief and make recommendation to the WHCC.

This subcommittee is primarily responsible for the coordinated entry system, ensuring the quickest and safest pathways are in place for housing stability. This includes integrating homeless prevention policies into coordinated policies and procedures, quickly identifying homeless people, providing emergency services, conducting assessments, and making connections to resources and housing. This subcommittee will not staff specific cases. To function properly it will need to form workgroups to focus on specific populations or tasks, such as: an emergency services workgroup to focus on the quality provision of emergency services and specific cases as needed, and a by-name list and housing-match workgroup (formerly the Coordinated Entry Subcommittee) to continue the work of prioritizing households for housing and connecting them to services.

MEMBERSHIP: Local government representation, emergency service program directors

(Lantern House, YCC shelter, Youth Futures shelter and outreach, Weber Housing Authority outreach), Homeless Veterans Fellowship, coordinating/referral agencies, Ogden City Police Department, 211 director, neighboring LHCC representation, property managers, agencies that have information to help validate SPDAT assessment data upon consent, one to three researchers/evaluators (this could be members of the Data Subcommittee) to map client pathways, track intervention effect on length of time homeless, and analyze inter-rater reliability and coordinated entry SPDAT data.

STRATEGIC PLAN ASSIGNMENTS: All action items found in Strategies 4.1, 4.2, and 4.3.

PERFORMANCE MEASURES: SPM1. Length of Time Persons Remain Homeless, SPM7a-Successful Placement in temporary and permanent housing from Street Outreach, and SPM7b1-Successful Placement in Housing from **ES**, **SH**, **TH**, and RRH.

This Subcommittee should also use Coordinated Entry Report performance indicators including: New VI-SPDATs (pre-screens) conducted compared to the total number of households that are engaged in street outreach or entered emergency shelter fourteen or more days ago, average days from prescreen to placement, percent placed with SPDAT score, and program placement from the top 25% acuity.

MEETING FREQUENCY: Initially monthly to get established, eventually quarterly to monthly

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MAKE HOMELESSNESS NON-RECURRING SUBCOMMITTEE

Function: Take responsibility for gaps, barriers, measures, and strategies to make homelessness non-recurring and make recommendations to the WHCC.

This subcommittee will take responsibility for housing stability within the community, coordinating heavily with the Make Homelessness Rare Subcommittee to target prevention resources and with the Make Homelessness Brief Subcommittee should any barriers to permanent housing program entry affect their ability to make placement in PH programs. This Subcommittee may want to eventually combine with and/or hold joint meetings with the Make Homelessness Rare Subcommittee. The subcommittee could form a permanent housing workgroup to oversee program quality and troubleshoot cases in RRH and PSH programs. Staffing should take place in workgroups rather than Subcommittee meetings.

Membership: Rapid Rehousing and Permanent Supportive Housing program directors, one or two clinically licensed members from Weber State University Department of Social

Work and or Weber Human Services, a representative from health prevention, Department of Workforce Services, representatives from employment services and mainstream benefit programs.

STRATEGIC PLAN ASSIGNMENTS: All action items found in Strategies 5.1, 5.2, and 5.3 (Strategy 5.2 and Action Item 5.3.3 in coordination with the Make Homelessness Rare Subcommittee).

PERFORMANCE MEASURES: SPM2-Returns to Homelessness, SPM 4-Job and Income Growth, SPM 7b1-Successful Placement in Housing from ES, SH, TH, and **RRH**, and SPM 7b2-Successful Placement in and Retention of Permanent Housing (excluding RRH).

MEETING FREQUENCY: Quarterly to monthly

BEST PRACTICE WORKGROUP

The Best Practice Workgroup is not a Subcommittee, but a Workgroup of the WHCC, fulfill specific tasks under the WHCC.

FUNCTION: Support best practice through ongoing training.

Identify initial training needs and propose a schedule to the WHCC, including unmet training needs the WHCC could assist to meet. The workgroup would ensure direct service staff are equipped with skills to provide evidence-based, housing-focused case management, including trauma-informed care, housing first, motivational interviewing, critical time intervention, and harm reduction. They would encourage conference participation and community sharing among agency leadership where possible. They could coordinate training efforts within the larger service community, regional LHCCs and non-homeless service providers that may have overlapping needs. In addition to supporting service providers, the workgroup may wish to support system-wide best practice implementation (such as Housing First) and coordinate occasional training in WHCC meetings.

MEMBERSHIP: A small, rotating group of four to five members, including at least one licensed social worker or social work faculty. Ideally, this work group would include one or two homeless service providers who manage direct service staff, and a representative from one or two other organizations that manage large training needs such as the Department of Workforce Services or Weber Human Services.

STRATEGIC PLAN ASSIGNMENTS: All Action Items found in Strategy 1.3 (in coordination with the system coordinator, WHCC, and WHCC Leadership), Action Item 2.3.1 (as needed in coordination with the Data Subcommittee)

PERFORMANCE MEASURES: N/A

MEETING FREQUENCY: This workgroup will need to have one or two initial meetings to establish need and develop a list of recommendations to bring to the WHCC. Subsequent meetings could be infrequent and as needed.

Data Quality

Special Considerations and Data Quality Report Summaries

Action Item 2.2.1 *Develop a data quality plan for WHCC adoption.*

SUPPLEMENTAL CONSIDERATIONS FOR DATA QUALITY

These considerations are intended as a supplement to the "Action Steps to Improve Data Quality," pages 5-6 in the S*ystem Performance Improvement Briefs: CoC Data Quality.*[32]

DATA QUALITY KEY TERMS	DEFINITIONS
COMPLETENESS	The degree to which all required data is known and documented. Coverage and utilization are both forms of completeness.
Coverage	The degree to which all homeless assistance providers within a CoC's geography enter all homeless clients into HMIS. Providers include those funded by the CoC and ESG Program, federal partner agencies, foundations, and private organizations.
Utilization	The degree to which the total number of homeless beds within the HMIS are recorded as occupied divided by the total number of homeless beds within the CoC's geographic coverage area.
ACCURACY	The degree to which data reflects the real-world client or service.
TIMELINESS	The degree to which the data is collected and available when it is needed.
CONSISTENCY	The degree to which the data is equivalent in the way it is collected and stored.

Source: System Performance Improvement Briefs: CoC Data Quality, April 2017

[32] https://www.hudexchange.info/resources/documents/coc-data-quality-brief.pdf

COMPLETENESS

Three years worth of data quality reports are summarized in tables below and included in Exhibit 3 of this plan. If helpful, each agency could be asked to pull the same report on an agency or program level which could be compiled into a spreadsheet to pinpoint data quality errors. This should be carried out *in the spirit of community improvement and mutual support*, recognizing that the nature of some program types may make it more difficult to collect certain data elements. That does not mean those service providers get a free pass, rather it should be a reminder that the dynamics of service provision should inform data quality and performance targets; agencies need to be *called-in,* not called-out in the beginning phases of improving data quality.

HMIS COVERAGE

There are at least two known agencies that provide homeless services that could, but choose not to participate in HMIS. It could benefit the community to work with these organizations either to increase HMIS coverage (there would need to be additional consideration given here in terms of how it may affect CoC performance) or to generate comparable data to integrate in certain community reports (similar to recommendations for DV data in Action Item 2.2.2). The Youth Futures Street Outreach program should also be entering information into HMIS, but is not currently.

Individual programs should be reviewed to ensure all parts of a service delivery model within an agency are set up as a single program rather than split among several types that may operate outside the designated system performance measure or falsely inflate outcomes.

As important as it is to ensure HMIS coverage includes all homeless programs, it is equally important that programs not targeted to homeless people are not entering data into HMIS. It would be worth a quick review of all HMIS agencies and programs to determine whether this is the case.

UTILIZATION

Utilization rates should be reviewed at least annually by the WHCC and quarterly by the System Coordinator or Data Subcommittee, who could distill additional information to the WHCC as needed. It is important to recognize the difference between bed and unit utilization, especially for programs that serve families. It is possible for unit utilization to be 100% and bed utilization to be much lower; it is also possible that the number of year-round beds (the denominator) is inflated and requires adjustment.

ACCURACY

In addition to the steps in the Data Quality Brief, the Data Subcommittee may wish to consider ways to work with the Make Homelessness Brief Subcommittee and Best Practice Workgroup to validate and improve the accuracy of SPDAT inter-rater reliability and coordinated entry data. The WHCC should support the HMIS team's annual monitoring and encourage specific strategies to check data accuracy.

TIMELINESS

The Subcommittee should be sure to refer to the Utah HMIS Standard Operating Procedures for timeliness standards. The SNAPS Data TA Strategy to Improve Data and Performance sets a target of 3-5 years for the majority of CoCs to have projects directly enter data within 2 hours for crisis response and project start/project exit; and PSH projects to directly enter data within 24 hours.

CONSISTENCY

The HUD-generated HMIS Data Standards, 2017 HMIS Data Dictionary, and 2017 HMIS Data Standards Manual provide the framework for standardized collection across systems. Agencies should also follow the protocols outlined in the Utah HMIS Standard Operating Procedures, which are currently being updated. Any HMIS procedures lacking clarity should be brought to the HMIS Steering Committee for evaluation. Consistency for administering SPDAT assessments, other assessments and coordinated entry processes will also need consideration.

SUMMARY OF 2015-2017 HUD DATA QUALITY REPORTS

The following tables display three-year comparisons for 5 data quality measures in the HUD Data Quality Report. The actual reports give greater detail, including in some cases a breakdown by program type. This summary could be used alongside the most recent report detail as helpful.

Q2. - Personally Identifying Information Percentage of Error Rate			
	2015-2016	2016-2017	2017-2018
Overall Score	13.7%	19.43%	16.84%

Q3. University Data Elements - % Data Error

	2015-2016	2016-2017	2017-2018
Veteran Status	2.65%	0.12%	0.46%
Project Entry Date	0.84%	0.33%	0.37%
Relationship to Head of Household	2.38%	0.51%	0.28%
Client Location	36.12%	2.82%	1.00%
Disabling Condition	27.75%	6.01%	2.55%

Q4. Income and Housing Data Quality - % Data Error

	2015-2016	2016-2017	2017-2018
Destination	45.62%	5.07%	6.60%
Income and Sources (at start)	39.17%	21.46%	13.79%
Income and Sources (annual assessment)	79.17%	96.61%	98.73%
Income and Sources (at Exit)	57.48%	21.51%	11.01%

Q5. Chronic Homelessness

	2015-2016	2016-2017	2017-2018
Total % of records unable to calculate chronic homelessness	0%	0.40%	1.24%

Q6. Timeliness of Record Entry

	2015-2016	2016-2017	2017-2018
% of Records entered in 7 or more Days	44%	18%	18%

GAPS AND BARRIERS

By Focus Area

FOCUS AREA 1
Assessment of Gaps and Barriers to Improve System Planning and Oversight

The Weber Homeless Coordinating Committee (WHCC) meets every other month. The scope and purpose of the WHCC is undocumented and somewhat unclear at this time. It is chaired by a Weber County Commissioner and is primarily made up of membership from a single stakeholder group: local homeless service providers. Local service provider representatives attending the WHCC vary significantly in level of authority. While there are some executive-level participants, there are also front-line staff who are unable to fully represent or make decisions on behalf of their agency.

The perspective and coordination of service providers is crucial to any homeless planning and coordination process, but their perspective alone is insufficient. An effective decision-making and oversight body for the homeless services system must be made up of decision makers representing a variety of stakeholder groups - including persons with lived experience of homelessness - who receive an adequate base level education about a healthy homeless services system and the local dynamics driving that system. Several key stakeholder groups appear to be missing and sufficient training is absent.

Upon review of WHCC attendance since January 2017 there appear to be several stakeholder groups that are underrepresented or entirely absent.

Examples of the types of organizations that could be represented on the WHCC (some may be better suited for participation on a specific subcommittee):

❏ Nonprofit homelessness service providers
❏ Domestic violence service providers
❏ Faith-based organizations
❏ Local government staff/officials

❏ Local businesses
❏ Advocacy organizations
❏ Public housing agencies
❏ School districts
❏ Social services providers
❏ Mental health agencies

- ❏ Hospitals and clinics
- ❏ Universities and researchers
- ❏ Affordable housing developers
- ❏ Law enforcement
- ❏ Workforce initiative
- ❏ Organizations serving veterans
- ❏ Homeless or formerly homeless individuals
- ❏ Entities that fund homeless services
- ❏ CDBG/HOME/ESG entitlement jurisdictions
- ❏ Mental health service organizations
- ❏ Substance abuse service organizations
- ❏ Disability service organizations
- ❏ Youth service organizations
- ❏ Financial institutions
- ❏ Agencies that serve survivors of human trafficking
- ❏ LGBTQ advocacy organizations
- ❏ Health prevention organization

It is extremely difficult for service providers to objectively evaluate and self-govern the system they play such a key role in. This puts undue strain on the service provider and creates a conflict of interest when community-driven decisions may not be to the advantage of their own agency. A higher level of functioning requires dedicated, human capacity at the system-level; someone who can do the system-level work between meetings. Prior attempts at filling this gap have come in a variety of forms including, at times, a local political leader taking a more involved role. However, the turnover in political office and steep learning curve coupled with the stress of other responsibilities make this untenable.

The County Commission provides administrative support to the WHCC and has a staff person who efficiently sends out agendas and takes meeting minutes. Ideally, this administrative support would continue.

The WHCC has two active groups that could be considered subcommittees (though they are not formally documented as such): 1) the Case Manager Group where case managers receive ongoing training and 2) the Coordinated Entry Subcommittee that prioritizes and matches currently homeless persons to housing. The case manager group provides a helpful service and could further focus to become an intentional part of implementing this plan. Coordinated entry is a significant system component and will be explored more in depth in the Make Homelessness Brief Focus Area. In short, the current Coordinated Entry subcommittee's scope has become too narrow to plan and implement comprehensive coordinated entry and their current level of performance shows need for significant improvement. Some of the same barriers affecting the WHCC, such as lack of backbone support, similarly inhibit Coordinated Entry processes.

WHCC meetings provide a forum for service providers to share updates about their agencies and community events. Rarely do the meetings include the use of data or community-level planning and evaluation. This strategic plan attempts to address each of those gaps.

Without cross-sectoral representation and community and agency-level authority, the WHCC will not be in a position to drive community initiatives or advocate for funding and policy that has direct impact on those we serve.

FOCUS AREA 2
Assessment of Gaps and Barriers to Become a Data-Driven System in Weber County

CURRENT ATTITUDE TOWARD AND USE OF DATA

Attitudes toward using data at the *community-level* are generally positive. Stakeholders would like to see this happen, but either data is inaccessible on a usable level or the community lacks an awareness of what is available and the knowledge base to use it. The lack of community governance structures and clearly delineated roles and responsibilities, including a formal arrangement of the role and responsibilities of the HMIS team in relation to LHCCs, exacerbate this problem exponentially.

Most stakeholders have not received adequate training about the homeless services system as a whole, best practice, what data are available for use, and what constitutes success. Performance indicators need to be evaluated in the context of overall system goals and best practice. For example, community leadership should be aware that prioritizing the most vulnerable persons (a best practice) may make it difficult to attain stable housing or increase income and those performance indicators will be affected.

The current extent of community-level data use consists of an oral report of the point-in-time count numbers to the WHCC each year and a review of the Coordinated Entry Data Summaries by the current Coordinated Entry Subcommittee, which is occasionally orally reported to the WHCC also. The point-in-time count report is acknowledged, but rarely used to drive community action planning. (And while point-in-time count data is a valuable source of information, it is limited in scope and should not be the only source of information used to gauge the scope of homelessness or inform planning.) Coordinated Entry Reports are generated by the State HMIS team from LHCC-level data on a monthly basis. In 2016 these Reports were used regularly by the Weber Coordinated Entry Group and community members worked hard to ensure

accuracy. However, these reports were not generated at all in 2017 and for most of 2018. Sometime since November 2018 the monthly summary report was made available for July 2018 forward. The WHCC Coordinated Entry Lead quickly recognized the need for cleanup and is in the process of leading the coordinated entry group to make local corrections so she can evaluate potential errors in report formulas that would need to be addressed with the HMIS team.

Upon initial assessment it appears as though coordinated entry performance has also suffered during the time these reports were not available. This is an excellent example of how using data to drive performance can positively influence outcomes. When service providers can see the results of their efforts they are able to evaluate approaches and correct course where needed. Basic attitudes toward the use of data and daily practices need to shift in order for Weber County's homeless system to become truly data-driven.

The general feeling about using homeless data among *service providers* in Weber County is that they know it's there and would like to use it, but lack confidence in HMIS-generated report quality. Agency-level use of data varies significantly across organizations. Most service providers are certain to use data points in presentations to boards and in grant writing, but may not have a good understanding for which indicators are linked to specific outcomes and which interventions directly influence those outcomes. Some agencies may even have a sense of these connections and share information with mid-level management on a consistent basis, but it is rare for managers to use data in meetings with front line staff to evaluate performance and improve services.

HCDD GENERATED REPORTS AND ACCESSIBILITY

The Homeless Programs Team, located in the Housing and Community Development Division of the Utah Department of Workforce Services, has made significant improvements to data access in the past year alone. They have generated a filterable data dashboard, committed to releasing PIT and HIC data more quickly, and refreshed coordinated entry reporting. HMIS staff are willing to pull needed reports upon contact and have supplied several reports to inform the creation of this plan. Despite these advancements, more needs to be done if local communities are going to govern their own homeless systems.

Reports that are generated on a state and CoC level are not automatically published regularly (or filterable) on an LHCC and/or County level. The State's Homelessness Data Dashboard is a good example of the latter. It is an incredible tool, but because it cannot be filtered by LHCC or county, there is no immediate way to gather accurate information for

WHCC use. The dashboard does afford the option to filter by agency, but this too is problematic because at least three Weber County based agencies also provide services outside the LHCC area. To illustrate: Youth Futures now operates a youth shelter in Ogden and in St. George, YCC supports TANF-Rapid Rehousing in Davis County, and Homeless Veterans Fellowship provides SSVF throughout the State of Utah.

The DWS Homelessness Data Dashboard currently includes a tab for HUD System Performance Measures on a CoC level that would ideally be filtered by LHCC. It also has tabs for Emergency Shelter and Transitional Housing Performance. This is immensely helpful, but it does not yet include rapid rehousing and permanent supportive housing performance data. The WHCC should advocate for resource for the state to build these additional tabs while adding the ability to filter program performance by LHCC and/or county.

PIT and HIC data are made publicly available in the State's Annual Homeless Report and are helpfully broken down by LHCC and County, but they, the HIC in particular, lack enough detail for LHCCs to evaluate accuracy, which would ideally be done prior to HUD submission. If the BoS were able to generate these reports on an LHCC-level prior to the BoS submitting them to HUD they could ask communities to verify counts. This would help avoid issues such as the misinformation for unsheltered homelessness in Weber County that was printed in the State of Utah Annual Report on Homelessness 2018. (State reports are a helpful source of information, but Weber and other local communities would benefit from an additional layer of comparative analysis in these reports if possible.)

Agencies that already enter data into HMIS have the advantage of being able to pull HMIS reports on their own.

An untapped resource among service providers is Service Prioritization Decision Assistance Tool (SPDAT) assessment data. Coordinated entry assessors and case managers have been entering SPDAT data for multiple years, and while the HMIS team had previously made plans to generate a report based on these data, it was either never completed or local providers are unaware of how to use it. Various breakdowns of SPDAT data could help inform agency leadership and case managers of: client progress over time, service linkages that need improvement, clients who need a more intensive intervention, and areas for additional case manager training.

DATA QUALITY

Data quality is defined by HUD as "an umbrella term that refers to the reliability and comprehensiveness of a community's data and encompasses several concepts." HUD

defines: completeness, coverage, utilization, accuracy, timeliness, and consistency; which are used as categories to evaluate data quality in Weber County.

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COMPLETENESS -

The degree to which all required data is known and documented. Coverage and utilization are both forms of completeness.

Data completeness among HMIS-participating agencies is evaluated through data quality reports. These reports convey calculated data errors and missing or incomplete values. Three years worth of system-level data quality reports were generated by the HMIS team and attached to this plan. These reports are included in Exhibit 3. Three years worth of data quality reports should allow the Data Subcommittee, with input and approval from the WHCC, to establish baselines and set goals for data quality improvement.

HMIS COVERAGE -

The degree to which all homeless assistance providers within a CoC's geography enter all homeless clients into HMIS. Providers include those funded by the CoC and ESG Program, federal partner agencies, foundations, and private organizations.

HMIS coverage in Weber County is relatively good, though there are some gaps. Currently there is one victim service provider agency (YCC) precluded by law from entering personally identifying information into HMIS, two known agencies and at least one program not entering data into HMIS that could be (Family Promise and the Ogden Rescue Mission, and (Youth Future's street outreach program. All organizations graciously offer data for the annual point-in-time and housing-inventory-count, giving those reports 100% coverage. Two possible additional gaps in HMIS coverage are the possibility that programs that actually function as an extension of another program are set up separately in HMIS and that programs that are not targeted only to homelessness are entering data.

UTILIZATION -

The degree to which the total number of homeless beds within the HMIS are recorded as occupied divided by the total number of homeless beds within the CoC's geographic coverage area.

Utilization rates require additional attention. As of the 2018 Housing Inventory Count, utilization rates in Weber County averaged 88%. Utilization rates are not currently reviewed by the WHCC and contributing data may include inaccuracies as a result.

ACCURACY -

The degree to which data reflects the real-world homeless individual or service.

Data accuracy tends to be more concerning than data completion because it can be more difficult to identify whether data in the system matches reality. Qualitative evaluation of programs compared with performance reports and matching HMIS records to in-house files can be helpful. Data accuracy checks were not performed as part of this strategic plan.

TIMELINESS -

The degree to which the data is collected and available when it is needed.

The timely input of data into the system is obviously important for report accuracy. Assuming providers enter accurate dates of service, timeliness of entry can be evaluated through the data quality report. The Utah HMIS policy is for agencies to "enter or upload information into the UHMIS database within five working days of seeing the client," though 24 hours is preferred where possible. The same section within the Utah HMIS Standard Operating Procedures states that certain components of street outreach and emergency shelter data entry can be entered within a 10 business day window. It is also suggested that all agencies create a "client record verification/audit procedure" to be exercised at least quarterly.[33] Standard agency practice for data quality and record verification was not reviewed as a part of this strategic plan.

CONSISTENCY -

The degree to which the data is equivalent in the way it is collected and stored.

Consistency in data collection and recording is what allows for comparison within program types. Similar to accuracy, parts of consistency can also be difficult to measure without direct observation. For example, the way in which staff administer questions or assessments and interpret the results may vary significantly. This requires attention especially when it comes to SPDAT assessments that are used to prioritize households for housing, where there is some evidence of inconsistent and inflated scoring.

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The basic structure for a highly functional Homeless Management Information System, per HUD specification and State leadership, are in place, but the community needs to take

[33] Utah HMIS SOP 9-3-14_approved
https://www.dropbox.com/s/ss70u04mbxvjxcu/Utah%20HMIS%20SOP%209-3-14_approved.doc?dl=0

ownership for what information is being put into the system and what they hope to get out of the system. The current dynamic is not only a garbage in, garbage out scenario. It's a garbage in game of blind hot potato. Communication and oversight functions need to be defined so that quality data can become broadly accessible and utilized.

FOCUS AREA 3
Assessment of Gaps and Barriers to Make Homelessness Rare in Weber County

AFFORDABLE HOUSING

As referenced in the introduction, the state of affordable housing in Weber County is troubling. Weber County lacks a coordination and planning body to review data and create a strategic plan to address the gaps and barriers to safe and affordable housing, especially for those households that are considered to be extremely-low-income. The long term costs to the community, not to mention the homeless services system, for not getting in front of this need will be significant.

Having said this, several independent organizations in Weber County have begun to coalesce around the need to evaluate and support improved access to affordable housing. For example, Ogden (CAN) is in the process of creating a Housing Needs Assessment for Ogden City and the East Central Neighborhood. They are also working with the Ogden School District and the Weber Intergenerational Poverty Initiative to pilot a program for households with children that will: assist with housing search, provide rental counseling, offer tenant rights training, and develop a housing advocacy webpage. Weber Housing Authority, Ogden City Housing Authority and Ogden CAN are discussing the possibility of submitting an application for a HUD Mobility Demonstration grant application this year that would increase voucher assistance funding for households that could move from low to moderate income neighborhoods. These initiatives could become a precursor for other much needed services tied to homeless prevention and coordinated entry in Weber County.

HOMELESS PREVENTION

The efficacy of homeless prevention is difficult to measure. This is because few at risk households will actually experience homelessness. We can't know for certain if someone who is assisted through prevention programming would have become homeless without prevention assistance. As a result, even when a household retains housing we don't know if we actually *prevented* an episode of homelessness. This problem has a tendency to skew

success rates and increase cost per positive outcome (preventing homelessness) significantly, especially when compared to interventions applied during periods of literal homelessness. In most prevention programs, resource is being used with little to no success at achieving its intended purpose, i.e. preventing homelessness.

Without a broader evidence-base, communities should be careful not to prioritize homeless prevention programming over other proven models, especially if they don't have the ability to carefully evaluate those efforts and make a contribution to the evidence-base. Existing homeless prevention programming should be carefully evaluated and highly targeted to maximize the possibility for success.

 The following are selected key lessons from a reputable recent homeless and eviction prevention study,:

- ❏ Embark on this journey only if your community has the solid base of a well functioning, homeless crisis response system and strong allies and partners beyond the homeless crisis response system.
- ❏ Before embarking on "upstream" prevention, a community must offer diversion across all populations. This will ensure that the people who are most vulnerable to immediate homelessness are being served ahead of those whose risk of literal homelessness is in the future. The additional benefit is that the expertise and skills used by diversion can be applied to "upstream" prevention.Additionally, a CoC [or LHCC] primarily or exclusively composed of homeless assistance providers should not undertake this work alone.
- ❏ Homelessness and eviction prevention should be viewed as a range of potential interventions along a spectrum from highly targeted to broad.
- ❏ Review data to determine greatest needs and potential for impact.[34]

TANF homeless prevention dollars, currently awarded to YCC to serve households in Weber, Davis, and Morgan Counties, is a specific program that could better target higher risk households. However, where this form of TANF funding will only support families for up to four months, and national averages suggest successful assistance for homeless households takes an average of 5 months, it will require that funders be educated and pathways to longer-term assistance be created where needed. Other community resource, such as emergency rental assistance administered by the Weber Housing Authority, could

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[34] Unlocking Doors to Homelessness Prevention: Solutions for Preventing Homelessness and Eviction, March 2018; Poppe; https://static1.squarespace.com/static/59e4bd08d7bdce1e8a5b15bb/t/5ac2302d03ce648731d78cfd/1522675761270/Eviction++Homelessness+Prevention+Research+Report_FINAL_33018.pdf

similarly use data to prioritize funding for higher risk households.

Homeless diversion is a kind of homeless prevention that takes place at the time a homeless individual or family is seeking shelter. Homeless diversion is a light touch, relatively low-cost to cost-savings intervention. It helps homeless individuals pause their current crisis as they are seeking shelter and consider what pre-existing safety nets may be available for them to draw upon. Good diversion programming is driven by mediation principles and can be effective even for high-barrier households. A successful program may have a 25-30% diversion rate, which tends to be significant when compared to the cost of an average shelter stay. Existing homeless diversion in Weber County includes homeless diversion for youth and families at Lantern House, YCC, and Youth Futures. Much of this is funded through TANF dollars, under which only households with children or youth are eligible. This has created a gap in funding and service for households made up of single individuals or adults only.

Ideally, the light-touch, strengths-based mediation approach used in homeless diversion would be available at other points in time for households experiencing housing instability and homelessness.

Access to information for persons at risk of homelessness is somewhat limited and difficult to find. Even if someone who is at risk of eviction is able to track down 211 as a resource, the list of referrals is limited to contact information for a few property managers and housing authorities. This is a clear gap. Several communities outside of Utah have developed a program or center that offers eviction prevention, landlord mediation, and housing navigation services. This is often built in as part of a community's coordinated entry process.

FOCUS AREA 4
ASSESSING GAPS AND BARRIERS TO MAKE HOMELESSNESS BRIEF IN WEBER COUNTY

All of the major components of a homeless service delivery system, from the time a person becomes homeless to the time they regain housing stability, are basically present and functional in Weber County. There are however several parts that could use improvement to increase efficiency and reduce the overall length of time people experience homelessness.

COORDINATED ENTRY

HUD defines coordinated entry as "a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs." Effective coordinated entry pools all community resources together and prioritizes and assigns clients to these resources based on need. It requires a massive shift in how agencies think about their programming and their responsibility to homeless people in the community (not just those within their agency walls). It should promote self-resolution where possible and prioritize those with the highest acuity. It requires a client-centered approach and the highest level of coordination among service providers.

The coordinated entry system in Weber County developed more quickly than most in the state, and many nationally. However, it appears there are several issues limiting further development and keeping it from operating at an optimum level. Not the least of these is a seemingly limited understanding of the scope of coordinated entry. The current group that meets to manage the coordinated entry process manages the client prioritization list and matches clients to available housing programs. This is an important part of the coordinated entry process, but only one piece. A true coordinated entry system would develop client-centered pathways from housing crisis to housing stability, including homeless prevention, quickly identifying homeless persons, connecting them to emergency services, engaging them in housing-focused case management and connecting them with housing programs and other supports as needed. The coordinated entry process requires a system-level vantage point that is highly coordinated with overlapping service systems and homeless prevention processes.

Coordinated entry data and meeting observation hint at several inefficiencies in the current management of the client prioritization list and match-to-housing program process: 1) a stagnant and outdated list that is likely missing unsheltered and high needs individuals that might have previously been engaged by the CABHI team (e.g. unsheltered homeless individuals or those in the Lantern Housing "nightlies" program), 2) housing programs not selecting clients at the top of the list as units become available, 3) possible assessment score inflation, and 4) minimal engagement and offering of services to those for whom housing may not be available.

Lantern House has taken the responsibility to oversee the coordinated entry process without any new resource. They have done an excellent job working with community partners to get it off the ground and operating, but there are again capacity limits to what

unfunded service providers can do and potential conflicts when it comes to directing community-level action that affects other agencies. The coordinated entry committee was recently taken over by a staff who has previous coordinated entry experience in another County. She is qualified with an understanding of how to assess and prioritize households and could continue to lead that group, but may also benefit from support from a System Coordinator or similar position to add non-conflicted oversight and authority.
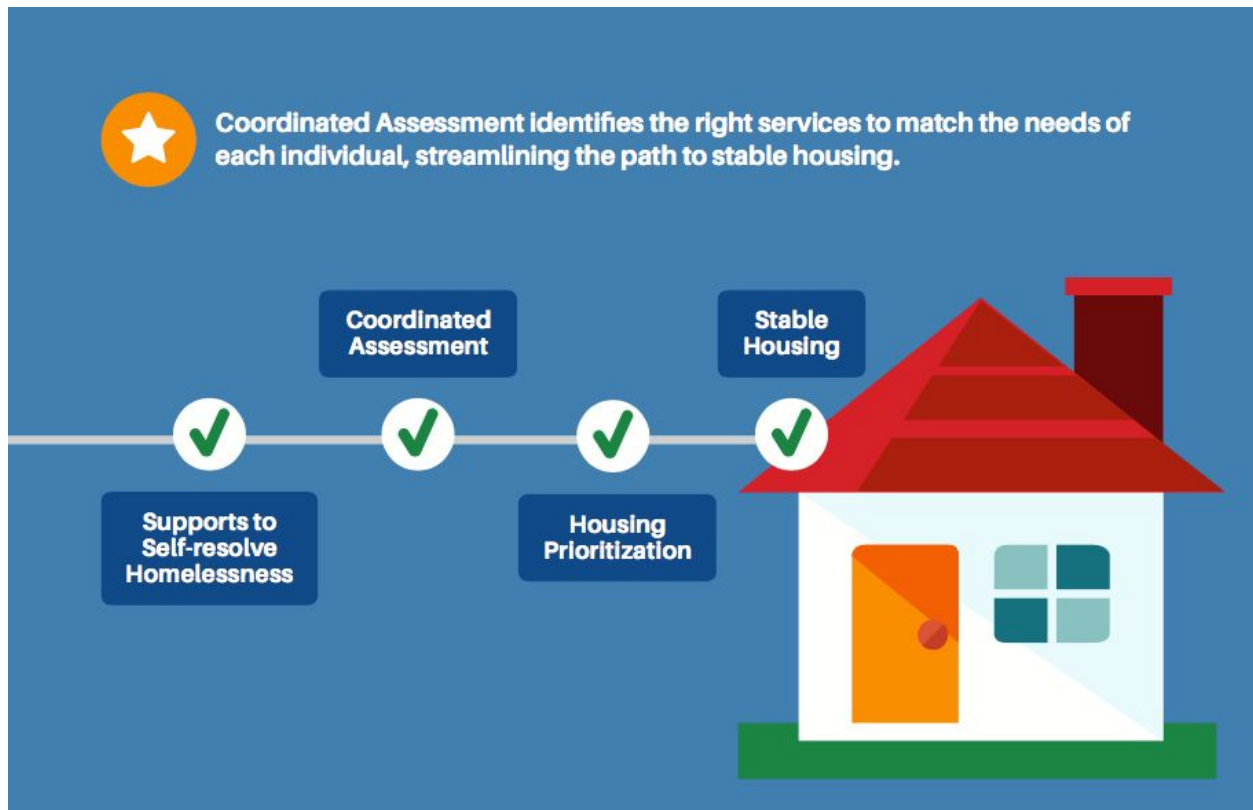
(Comprehensive Report on Homelessness - State of Utah 2016)

LANDLORD OUTREACH AND HOUSING LOCATION

While those who provide outreach to, and continually engage landlords are efficient with the resource available to them, this is an area lacking resource. In most cases a case manager with a higher-than-recommended caseload has little choice but to let the participant seek their own housing or support the search from a distance. Alternatively, some case managers may find one or two complexes they can work with and make repeated referrals there. This can be problematic for households with disabilities for whom, according to the evidence-based practice for PSH, individuals will ideally live in units typical of the community, without clustering people with disabilities. Such practices are purely a function of time constraint. Rarely do case managers have time to even consider outreaching to, engaging and educating new landlords.

QUICK IDENTIFICATION AND ENGAGEMENT

Consumer focus groups reported difficulty finding information about where to seek homeless services and other resources. Several felt there was a lack of publicly available information and some suggested creating easier pathways to gather this information on the web as well as posting information at resource locations that are frequented by low-income and homeless populations, such as libraries and food access points.

The extent of need for street outreach, a program type where providers outreach to unsheltered homeless people on the streets, in Weber County is difficult to define. This is due in part to the minimal outreach activities that currently exist in the county and lack of HMIS coverage/problematic data entry practices for those that do.

Street outreach to unsheltered adults was previously provided by the interdisciplinary Cooperative Agreement to Benefit Homeless Individuals (CABHI) team, an interdisciplinary team based on the Assertive Community Outreach Treatment (ACOT) model. The CABHI team, overseen by Weber Human Services, included trained clinicians and was specifically designed to serve homeless persons with a substance use disorder, severe and persistent mental illness or both. The Federal grant term for this team ended in 2018 and has created a significant gap in services in Weber County. In their stead, there is one funded .5 FTE street outreach worker remaining at Weber Housing Authority and a unfunded street outreach program covered by rotating staff and private donors through Youth Futures.

These outreach initiatives have some communication, but are largely uncoordinated and may be lacking a housing-focused orientation.

The 2018 unsheltered point-in-time count identified 36 persons sleeping on the streets for a single night in January. The Weber Housing Authority street outreach program recorded 55 unduplicated client enrollments from July 2018 - March 31, 2019.

The Youth Futures outreach program provided just under 18 average hours of staff time per week in 2018. Over that year the Youth Futures team recorded 3,576 encounters with adults and 479 with youth. Unfortunately we do not have enough information de-duplicated these numbers by client. The Youth Futures Outreach team encounters were not tracked in HMIS per HMIS team instruction, which also means we can't de-duplicate clients across the Youth Futures and Weber Housing Authority Programs. This again makes it difficult to tell the real scope of unsheltered homelessness, but the little we do know indicates need for a closer look. Certainly the data collection process for street

outreach in HMIS should be revisited as a way of gaining a more accurate picture.

HOUSING-FOCUSED EMERGENCIES SERVICES

Once households have been engaged on the streets, they should be linked to coordinated entry, emergency shelter, and other available information and resources to end homelessness in the community.

Like street outreach programs, emergency shelters have a key role in making homelessness brief. By taking a client-centered, low-barrier, and housing-focused approach, emergency shelters can rapidly provide a higher level of support to more vulnerable homeless individuals and encourage self-resolution among less vulnerable clients where possible.

There are currently five emergency shelter programs operating in Weber County: Lantern House, Ogden Rescue Mission, Youth Futures, Your Community Connection and Family Promise. The 2018 annual housing inventory count reported 416 emergency shelter beds in total, but comprehensive ongoing performance data is more difficult to ascertain across all shelters. The only programs among these that currently enter data into HMIS are Lantern House and Youth Futures. The Rescue Mission and Family Promise do not receive any funds that require entry, while Your Community Connection operates as a DV shelter and is prohibited from entering any personally identifying client data into HMIS by law. Having said this, where Lantern House provides 70% of the shelter beds in the community, we can still infer some information about the population who enters shelter while we work to improve data coverage and reporting for the three non-participating shelters.

Taking a housing-focused approach in emergency shelter will require a shift in philosophy and programming. Emergency shelters will need to train staff to become more housing-focused in their approach and equip them with tools such as housing barrier assessments and housing plan templates. Programming would need to be shifted to clients based on earlier support and need, while promoting self-resolution where possible. It is unclear how present these practices are across all shelters, but consumer focus groups stated they did not feel they had direct access to information that would help them personally resolve their homelessness nor did they feel that people with extremely high needs were identified early to avoid added risks associated with their vulnerabilities.

Historically, most of the services at Lantern House have been focused on longer-term residents that are able to keep certain rules to maintain their position in a case managed bed. This may effectively extend the length of time people experience homelessness and deter service from the most vulnerable shelter clients. To their credit, Lantern House has

begun taking measures to better serve the "nightlies" population, but more could be done to target those with the highest needs and focus greater energy on housing-focused activities closer to the time of shelter entry. Due to the relatively high volume of persons served at Lantern House, these recommended shifts will likely require additional funding.

FOCUS AREA 5

Assessment of Gaps and Barriers to Make Homelessness Non-Recurring in Weber County

A vital form of making homelessness non-recurring is to ensure housed clients have commensurate intensity and quality wrap around services based on need. Those with particularly complicated co-occurring diagnoses for example, will have difficulty maintaining housing without access to specialized service and treatment options. At present there appear to be some systemic problems impacting the client's ability to access these resources once placed in permanent housing.

There are two main types of permanent housing programs offered as a part of most homeless service systems; permanent supportive housing and rapid re-housing.

PERMANENT SUPPORTIVE HOUSING (PSH)

Permanent supportive housing is a model of housing assistance that "combines low-barrier affordable housing, health care, and supportive services to help individuals and families lead more stable lives."[35] It is the most intensive and expensive housing intervention available. However, when used for highly vulnerable and chronically homeless households it actually creates a cost savings to the community and a possible pathway for participants to live a fulfilling, independent life. For this reason it is important that every community have access to PSH *and* that participants for PSH are carefully selected based on verified need.

As of January 2018 Weber County reported 126 total units of PSH. Of these, 62 PSH units (inclusive of 5 units for households with children) are designated for disabled veterans; and 64 units (inclusive of 7 units for households with children) are designated for chronically homeless households. A Chronically Homeless household is a household that is currently homeless for whom the head of household (with or without dependents) is struggling with a documented disability and has experienced homelessness for at least a year continuously - or at least 4 separate times in the past 3 years totalling 12 months

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[35] National Healthcare for the Homeless Council, https://www.nhchc.org/policy-advocacy/issue/permanent-supportive-housing/

worth of homelessness.

The *veteran-designated* PSH beds in Weber County come from two funding sources: the HUD-Veteran Affairs Supportive Housing (VASH) Program sourcing 54 units and State Homeless Funding sourcing eight units. The VASH program is administered locally by the Ogden City Housing Authority, with supportive services provided by VA medical center staff. Participants must be eligible for VA medical services and homeless by federal definition, with preference given to those who meet the definition for chronic homelessness. The eight state-funded PSH beds for veterans are administered by Homeless Veterans Fellowship (HVF). HVF has the flexibility to house those veterans that the VASH program cannot due to their stricter housing authority and VA requirements. HVF is planning to repurpose two to four transitional housing beds over the next year to increase PSH beds for this subset of the homeless veteran population. This particular repurposing is encouraged to meet that more specific need, and should be monitored to see if increased flexible PSH beds for veterans would be beneficial. Otherwise, it appears as though the general need for PSH for veteran's is well met through these two programs. In fact, the VASH program consistently operates at less than 100% utilization for lack of eligible participants. To illustrate, the 2018 Housing Inventory Count showed a utilization rate of 70% for the VASH program (current utilization rates are closer to 85%).

The 64 units of competitive, CoC-funded permanent supportive housing deserve a separate look. These beds are administered by Ogden City Housing Authority and Weber Housing Authority. Weber Housing Authority currently provides all supportive services, though this model will no longer be compliant with State Homeless Funding requirements and Ogden City Housing Authority recently submitted an application to provide services for their own program beds. Many of these PSH beds originated from an old CoC model called shelter plus care, wherein funding applicants could request money for housing subsidy, but they had to provide a 100% match of supportive services. Originally this was supplied through interagency agreements with St. Anne's Center, Weber Human Services and Roads to Independence, but without a specific funding source to support these agencies in their work, or a lead service coordinator to oversee consistency among them, the services became more difficult to administer and program outcomes decreased. As a result, both housing authorities shifted supportive service responsibility to the Weber Housing Authority. As both programs adopted coordinated entry and began prioritizing clients based on need, it became apparent quite quickly that the severity of need among program participants would require better training, much smaller caseloads, and clinical level support if clients were going to maintain their housing.

In 2014 the State of Utah submitted an application for CABHI funds to the U.S. Department of Substance Abuse and Mental Health Services Administration. This funding was subsequently awarded and allowed Weber Human Services to develop an interdisciplinary ACOT team founded on evidence-based practice. The ACOT team can serve up to 50 people at a time and provided case management and supports for a large number of PSH clients.

Due to the effectiveness of CABHI-ACOT, the PSH program administered by Ogden Housing Authority was able to leverage 24 vouchers into serving 42 individuals over the course of one year. In the three years the ACOT team was operational, both housing authorities were freed up to consider whether the number of PSH units in the community was enough and each worked toward creating a plan for project-based permanent supportive housing to increase the overall stock of PSH and add a centralized service delivery option that could be more advantageous for certain clients.

In 2018 the CABHI grant term ended, taking with it clinical level support and effective client to case manager caseloads. PSH programs, although still recognizing the need to increase overall units, are scrambling to figure out how to match supportive services in order to utilize existing PSH vouchers. As of the writing of this plan, a solution has not been identified to fill this gap. According to the two housing authorities that administer non-veteran-dedicated PSH in Weber County, as of January 2019 there was only a 54% utilization rate in the combined programs, or 26 unused PSH vouchers out of a total of 56 available for households without children[36]. While the ability to secure new housing units in a tight market has some influence and should be considered in its own right, the capacity to provide sufficient supportive services for those who enter the current program is the more urgent problem. It is likely PSH funding will be left unspent and recaptured at the end of the current grant year.

While the overall homeless population has increased over the last several years, the community has not added any PSH beds since 2012. The need for permanent supportive housing in Weber County appears to remain constant. Due to the severity of needs among participants, the turnover rate in permanent supportive housing is typically quite low. It is estimated nationally at 15%, which is consistent with what providers report locally and would equate to about 8 beds in Weber County annually. This makes it especially difficult to meet the scope of need over so many years of increasing homelessness without added inventory.

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[36] Note: 56 beds for households without children differs slightly from 57 referenced above. This is due to the dynamics of natural turnover and metering funds across a grant year.

The HUD Data Quality Report for Weber County for Federal fiscal year 17-18 indicates a 207 unduplicated headcount of chronically homeless clients. Coordinated entry data report that 176 of the 232 people assessed in the past six months would benefit from permanent supportive housing. Even if this number represents some score inflation, the frequency of people scoring in this range is likely still significant.

According to the SAMHSA Evidence-Based Practice Permanent Supportive Housing Toolkit, the recommended caseload for permanent supportive housing is 10-20 clients per full time case manager. In January, during a time of 54% utilization, the caseload for Weber County's only full-time PSH case manager for households without children was 30 clients. If this case manager were to assume responsibility to fill all available PSH openings for households without children they would have to maintain a caseload of 56 persons, 36 people beyond the evidence-based higher range, which they were already 50% over as of January 2019. Such an increase would most certainly render the case manager incapable of assisting clients to find units and almost assuredly tank positive outcomes on these programs, which would simultaneously jeopardize funding.

Not only did the CABHI-funded ACOT team provide a substantial amount of case management for PSH, but the interdisciplinary nature and location within Weber Human Services created a natural pathway to specialized support for program participants. The natural connections to ensure treatment options and services, such as supported employment, disappeared almost entirely. The PSH case manager described "feeling helpless" to support participants to the level needed. Regardless of whether the need for PSH services is met through an ACOT team or additional, trained case managers, these linkages specialized to persons with disabilities must be in place.

RAPID REHOUSING (RRH)

This PSH bottleneck adversely influences other parts of the homeless services system, especially rapid rehousing. Without enough PSH to meet the demand, rapid rehousing programs have no choice but to select clients from the top of the housing prioritization list who would be better served through PSH programming. This dynamic pushes the same challenges experienced by PSH programs into RRH programs, but without some of the natural benefits that come with an evidence-based program tailored to serve clients with complex histories and disabling conditions (i.e. rapid rehousing is time limited and often less connected to resources for persons with disabilities).

Rapid rehousing is a type of permanent housing that offers 1) housing identification, 2) short term (up to 3 months) or medium term (up to 24 months) rent and move-in

assistance, 3) and housing-focused case management. It places participants into housing units in the community with a minimum one-year lease in their name to promote rapid stabilization and community integration The amount of rental assistance and supportive services is scalable based on client need. The following three figures illustrate each of the three core components of a rapid rehousing program.

RAPID REHOUSING CORE COMPONENT #1

RAPID REHOUSING CORE COMPONENT #2

(Source: National Alliance to End Homelessness Rapid Re-Housing Works)

The following accounting of available RRH units are averaged based on how many units might be in play at any given time in the community. These unit counts may vary over time due to the varying length of assistance per household and how agencies choose to meter funds over the course of the grant year.

In Weber County there are four different sources of rapid rehousing at play:

1) Supportive Services for Veteran Families (SSVF)

A Federal program that provides both homeless prevention and rapid rehousing. It is designated for veterans and administered locally by Homeless Veterans Fellowship (HVF). HVF provides this service to all counties within Utah, excepting Salt Lake County, and Southern Idaho. They serve an average of 21 households with rapid rehousing in Weber County at any given time and again generally appear to be meeting local need among homeless veterans.

2) TANF-Rapid Rehousing"

A specific type of Temporary Assistance for Needy Families (TANF) programming used for rapid rehousing and administered by YCC to Weber, Moran and Davis Counties. TANF-rapid rehousing can target youth and households with children with these funds. YCC currently serves an average of 18 households with rapid rehousing at any given time).

TANF-rapid rehousing demands unique consideration in that it is not set up in a way that facilitates average need or best practice. Participants are required to meet certain employment requirements to participate and be in a position to resolve their financial crisis within 4 months. This can be problematic for a rapid rehousing program for families where national averages indicate the average number months of assistance to positive exit is 5 months and 9-12 months for survivors of domestic violence.

Stringent program requirements also make it difficult to provide adequate support to clients at the top of the housing prioritization list which often pressures program administrators to cherry pick clients with fewer barriers who produce positive program outcomes, but who would also be much more likely self-resolve their homelessness. This program type will require creative solutions among decision-makers to administer it in a way that is both cost effective and consistent with the community's overarching goals.

3) CoC-Funded Rapid Rehousing

Awarded through the annual Federal CoC competition, CoC-funded RRH currently makes up an average 31 units in the community at any given time. These units are administered by Lantern House (22 units) and Your Community Connection (17 units). Of the total 31 units of CoC-funded RRH, 8 units are dedicated for youth under the age of 25, 13 are dedicated to households with children, and 10 are dedicated to households without children. The youth units have been difficult to fill and both programs administering youth beds are exploring the possibility of targeting these programs to a different sub-population.

4) ESG/State-Funded Rapid Rehousing

Accounts for another 10 units of rapid rehousing. ESG rapid rehousing follows very similar, though not identical, rules to CoC funded RRH and can serve a mix of households with or without children. This program is currently administered by Lantern House.

The amount of available funding for rapid re-housing is not only not enough to adequately scale it to client need, but not enough to meet the ongoing need in Weber County.

— Strategic Plan At a Glance —

Vision: Homelessness is Rare, Brief and Non-Recurring in Weber County

FOCUS AREA 1	
Improve System Planning and Oversight	
Objective: Build local capacity for system planning and oversight.	
STRATEGY	ACTION ITEM
1.1 *Reorganize the Weber Homeless Coordinating Committee and its Subcommittees*	**1.1.1** Revise WHCC scope and membership.
	1.1.2 Hire a Homeless Services System Coordinator.
	1.1.3 Form WHCC subcommittees and workgroups.
	1.1.4 Document the new leadership structure. (See also 2.3.2)
1.2 *Engage in System- Level Planning and Evaluation*	**1.2.1** Develop performance management plans. (See also Focus Area 2)
	1.2.2 Review funding and establish priorities.
1.3 *Integrate Best Practice into Decision-Making and Service Provision*	**1.3.1** Remove barriers to housing first as a system and within individual projects.
	1.3.2 Train WHCC members and local decision-makers. (See also 2.3.1)
	1.3.3 Support training for service providers. (See also 2.3.1)
	1.3.4 Learn from persons with homeless experience.
FOCUS AREA 2	
Become a Data Driven System	
Objective: Use data to drive planning, decision-making, and evaluation.	
STRATEGY	ACTION ITEM
2.1 *Increase the Availability of Useful Data and Reports*	**2.1.1** Work with HCDD to localize State and CoC-level reporting to Weber County.
	2.1.2 Create a clearinghouse for WHCC homeless data and information. (See also 3.2.2 and 4.3.2)
2.2 *Improve Data Quality*	**2.2.1** Develop a data quality plan for WHCC adoption.
	2.2.2 Support data quality and inclusion for domestic violence service providers.
2.3 *Use Data in Every Community,*	**2.3.1** Provide system and program performance training. (See also 1.3.2 and 1.3.3)

Agency, and Program Meeting	2.3.2 Include a detailed policy for data use. (See also 1.1.4)

<table>
<tr><td colspan="2" align="center">FOCUS AREA 3
Make Homelessness Rare</td></tr>
<tr><td colspan="2" align="center">Objective: Reduce the number of persons who experience homelessness in Weber County.</td></tr>
<tr><td>STRATEGY</td><td>ACTION ITEM</td></tr>
<tr><td>3.1 Develop Weber County Affordable Housing Plan</td><td>3.1.1 Support the creation of a Weber County Affordable Housing Commission to develop a strategic plan for affordable housing.</td></tr>
<tr><td rowspan="3">3.2 Reorient Homeless Prevention Models</td><td>3.2.1 Expand diversion programming to fill service gaps.</td></tr>
<tr><td>3.2.2 Create a hub for homeless prevention information and assistance.
(See also 2.1.2, 4.1.3, and 5.2.3)</td></tr>
<tr><td>3.2.3 Use local data to target higher-risk households. (See also 5.2.3)</td></tr>
<tr><td rowspan="2">3.3 Improve Coordination with Systems and Initiatives Service Low-Income and Vulnerable People</td><td>3.3.1 Use community resources to target individuals and families most at risk of homelessness.</td></tr>
<tr><td>3.3.2 Improve efforts to prevent people from entering homelessness as they transition from other systems.</td></tr>
</table>

<table>
<tr><td colspan="2" align="center">FOCUS AREA 4
Make Homelessness Brief</td></tr>
<tr><td colspan="2" align="center">Objective: Reduce the average length of time persons experience homelessness.</td></tr>
<tr><td>STRATEGY</td><td>ACTION ITEM</td></tr>
<tr><td rowspan="3">4.1 Enhance the Coordinated Entry Process</td><td>4.1.1 Use referenced tools to evaluate and revise local coordinated entry policy and practice.</td></tr>
<tr><td>4.1.2 Adopt a 'Universal system management' approach to housing prioritization.</td></tr>
<tr><td>4.1.3 Consider streamlining and jointly resourcing housing navigation & landlord outreach activities to rapidly house homeless households. (See also 3.2.2)</td></tr>
<tr><td rowspan="3">4.2 Quickly Identify and Respectfully Engage Persons Experiencing Homelessness</td><td>4.2.1 Use client input to expand coordinated entry outreach and inreach.</td></tr>
<tr><td>4.2.2 Ensure street outreach teams have the capacity for routine outreach.</td></tr>
<tr><td>4.2.3 Coordinate street outreach and advocate for policies that do not criminalize homelessness.</td></tr>
<tr><td rowspan="2">4.3 Ensure Emergency Services are Client-Centered, Low-Barrier and Housing-Focused</td><td>4.3.1 Use referenced tools to evaluate emergency shelter.</td></tr>
<tr><td>4.3.2 Create self-accessible resources and information to facilitate homeless exit plans and self-resolution. (See also 3.2.2)</td></tr>
</table>

FOCUS AREA 5
Make Homelessness Non-Recurring

Objective: Reduce returns to homelessness.

STRATEGY	ACTION ITEM
5.1 *Increase the Utilization and Quality of Permanent Housing Programs*	**5.1.1** Prioritize funding for additional PSH case managers.
	5.1.2 Scale RRH caseloads, length of assistance, and case manager training to match participant need.
	5.1.3 Use referenced tools to evaluate RRH and PSH programming and create performance management plans.
5.2 *Ensure Community Supports are Available and Commensurate with Client Need*	**5.2.1** Improve pathways to clinical treatment, supported employment and other services tailored for persons with disabilities.
	5.2.2 Review and improve access to programs that could increase a formerly homeless persons ability to gain employment and income supports. (See also 3.3.1)
	5.2.3 Prioritize homeless prevention resources for persons who have previously experienced homelessness. (See also 3.2.2 and 3.2.3)
5.3 *Increase the Flow Through and Availability of Permanent Housing*	**5.3.1** Develop a project-based PSH facility to expand the continuum of available housing in Weber County and house vulnerable families and individuals.
	5.3.2 Increase rapid rehousing programming.
	5.3.3 Employ effective exit and move-on strategies for permanent housing. (See also 3.1.2)

Exhibit 1 - SPMs

HMIS System Performance Measures: Measure 1
10/1/2015 to 9/30/2016

ClientTrack™

Report Criteria:

The following criteria have been utilized to filter the <u>initial universe</u> of data for each row and determining each client's specific date range to review. Data from other organizations or programs will be utilized for calculating LOT data.

Organizations:	All Organizations
Programs:	Multiple
CoC:	No Filtering on CoC
Include:	Persons in ES, SH and TH

Measure 1: Length of Time Persons Remain Homeless

Metric 1a: This measure is of the client's start, exit, and bed night dates strictly as entered in the HMIS system

	Previous FY Universe	Current FY Universe	Previous FY Average LOT Homeless	Current FY Average LOT Homeless	Difference	Previous FY Median LOT Homeless	Current FY Median LOT Homeless	Difference
Persons in ES, SH and TH		2,066		37.63			18.00	

HMIS System Performance Measures: Measure 1
10/1/2016 to 9/30/2017

ClientTrack™

Report Criteria:

The following criteria have been utilized to filter the <u>initial universe</u> of data for each row and determining each client's specific date range to review. Data from other organizations or programs will be utilized for calculating LOT data.

Organizations:	All Organizations
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Measure 1: Length of Time Persons Remain Homeless

Metric 1a: This measure is of the client's start, exit, and bed night dates strictly as entered in the HMIS system

	Previous FY Universe	Current FY Universe	Previous FY Average LOT Homeless	Current FY Average LOT Homeless	Difference	Previous FY Median LOT Homeless	Current FY Median LOT Homeless	Difference
Persons in ES, SH and TH		2,128		46.79			23.00	

HMIS System Performance Measures: Measure 1
10/1/2017 to 9/30/2018

ClientTrack™

Report Criteria:

The following criteria have been utilized to filter the <u>initial universe</u> of data for each row and determining each client's specific date range to review. Data from other organizations or programs will be utilized for calculating LOT data.

Organizations:	All Organizations
Programs:	Multiple
CoC:	No Filtering on CoC
Include:	Persons in ES, SH and TH

Measure 1: Length of Time Persons Remain Homeless

Metric 1a: This measure is of the client's start, exit, and bed night dates strictly as entered in the HMIS system

	Previous FY Universe	Current FY Universe	Previous FY Average LOT Homeless	Current FY Average LOT Homeless	Difference	Previous FY Median LOT Homeless	Current FY Median LOT Homeless	Difference
Persons in ES, SH and TH		2,231		50.20			27.00	

Exhibit 1 - SPMs

ClientTrack™

Report Criteria:

The following criteria have been utilized to filter the <u>initial universe</u> of data for each measure. Data from other organizations or programs may be utilized for comparison data.

Organizations: *All Organizations*

Programs: *Multiple*

CoC: *Utah Balance of State CoC*

Measure 2a and 2b: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness within 6 to 12 months (and 24 months in a separate calculation)

	Total Number of Persons who Exited to a Permanent Housing Destination (2 Years Prior)	Number Returning to Homelessness in Less than 6 Months (0 - 180 days)	Percentage of Returns in Less than 6 Months (0 - 180 days)	Number Returning to Homelessness from 6 to 12 Months (181 - 365 days)	Percentage of Returns from 6 to 12 Months (181 - 365 days)	Number Returning to Homelessness from 13 to 24 Months (366 - 730 days)	Percentage of Returns from 13 to 24 Months (366 - 730 days)	Number of Returns in 2 Years	Percentage of Returns in 2 Years
Exit was from SO	1	1	100.00%	0	0.00%	0	0.00%	1	100.00%
Exit was from ES	179	34	18.99%	10	5.59%	12	6.70%	56	31.28%
Exit was from TH	42	2	4.76%	0	0.00%	5	11.90%	7	16.67%
Exit was from PH	136	6	4.41%	2	1.47%	3	2.21%	11	8.09%
TOTAL Returns to Homelessness	358	43	12.01%	12	3.35%	20	5.59%	75	20.95%

Measure 3.2: This measures the change in annual counts of sheltered homeless persons in HMIS.

	Previous FY	Current FY	Difference
Universe: Unduplicated Total sheltered homeless persons		2138	
Emergency Shelter Total		2095	
Transitional Housing Total		53	

ClientTrack™

Metric 4.1 - Change in earned income for adult system stayers during the reporting period

	Previous FY	Current FY	Difference
Universe: Number of adults (system stayers)		29	
Number of adults with increased earned income		0	
Percentage of adults who increase earned income		0%	

Metric 4.2 - Change in non-employment income for adult system stayers during the reporting period

	Previous FY	Current FY	Difference
Number of adults with increased non-employment cash income		3	
Percentage of adults who increased non-employment cash income		10%	

Metric 4.3 - Change in total income for adult system stayers during the reporting period

	Previous FY	Current FY	Difference
Number of adults with increased total income		3	
Percentage of adults who increased total income		10%	

Exhibit 1 - SPMs

ClientTrack™

Metric 4.4 - Change in earned income for adult system leavers

	Previous FY	Current FY	Difference
Universe: Number of adults who exited (system leavers)		51	
Number of adults who exited with increased earned income		8	
Percentage of adults who increase earned income		16%	

Metric 4.5 - Change in non-employment cash income for adult system leavers

	Previous FY	Current FY	Difference
Number of adults who exited with increased non-employment cash income		14	
Percentage of adults who increased non-employment cash income		27%	

Metric 4.6 - Change in total income for adult system leavers

	Previous FY	Current FY	Difference
Number of adults who exited with increased total income		21	
Percentage of adults who increased total income		41%	

ClientTrack™

Measure 5: Number of Persons who Become Homeless for the First Time

Metric 5.1: This measures the change in active persons in ES, SH, and TH projects with no prior enrollments in HMIS.

	Previous FY	Current FY	Difference
Universe: Person with entries into ES, SH or TH during the reporting period		2038	
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their start during the reporting year		496	
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e., number of persons experiencing homelessness for the first time)		1542	

Metric 5.2: This measures the change in the number of persons entering ES, SH, TH, and PH projects with no prior enrollment in HMIS.

	Previous FY	Current FY	Difference
Universe: Person with entries into ES, SH, TH, or PH during the reporting period		2243	
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their start during the reporting year		550	
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e., number of persons experiencing homelessness for the first time)		1693	

Measure 6: Homeless Prevention and Housing Placement of Persons defined by category 3 of HUD's Homeless Definition in CoC Program-funded Projects

Metrics 6a.1 and 6b.1: This metric has been combined into one table to measure the returns to ES, SH, TH, and PH projects after exits to permanent housing destinations within 6 and 12 months (and 24 months in a separate calculation).

	Total Number of Persons who Exited to a Permanent Housing Destination (2 Years Prior)	Number Returning to Homelessness in Less than 6 Months (0 - 180 days)	Percentage of Returns in Less than 6 Months (0 - 180 days)	Number Returning to Homelessness from 6 to 12 Months (181 - 365 days)	Percentage of Returns from 6 to 12 Months (181 - 365 days)	Number Returning to Homelessness from 13 to 24 Months (366 - 730 days)	Percentage of Returns from 13 to 24 Months (366 - 730 days)	Number of Returns in 2 Years	Percentage of Returns in 2 Years
TOTAL Returns to Homeless-ness	0		NaN		NaN		NaN	0	NaN

Metric 6c.1 - Change in exits to permanent housing destinations

	Previous FY	Current FY	% Difference
% Successful Exits		NaN	

Metric 6c.2 - Change in exit to or retention of permanent housing

	Previous FY	Current FY	% Difference
Universe: Cat. 3 Persons in all PH projects except PH-RRH who exited after moving into housing, or who moved into housing and remained in the PH project		4	
Of the persons above, count those who remained in PH-PSH projects and those who exited to permanent housing destinations		4	
% Successful exits/retention		100.00%	

Measure 7: Successful Placement from Street Outreach and Successful Placement in or Retention of Permanent Housing

Metric 7a.1 - Change in exits to permanent housing destinations

	Previous FY	Current FY	% Difference
Universe: Persons who exit Street Outreach		37	
Of the persons above, those who exited to permanent housing destinations		2	
Those who did not [not reported]		35	
% Successful Exits		5.41%	

Metric 7b.1 - Change in exits to permanent housing destinations

	Previous FY	Current FY	% Difference
Universe: Persons in ES, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing.		1,964	
Of the persons above, those who exited to permanent housing destinations		426	
Those who did not [not reported]		1,538	
% Successful Exits		21.69%	

Metric 7b.2 - Change in exit to or retention of permanent housing

	Previous FY	Current FY	% Difference
Universe: Persons in all PH projects except PH-RRH		99	
Of the persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations		89	
Those who did not [not reported]		10	
% Successful exits/retention		89.90%	

Report Criteria:

The following criteria have been utilized to filter the <u>initial universe</u> of data for each measure. Data from other organizations or programs may be utilized for comparison data.

Organizations: *All Organizations*

Programs: *Multiple*

CoC: *Utah Balance of State CoC*

Measure 2a and 2b: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness within 6 to 12 months (and 24 months in a separate calculation)

	Total Number of Persons who Exited to a Permanent Housing Destination (2 Years Prior)	Number Returning to Homelessness in Less than 6 Months (0 - 180 days)	Percentage of Returns in Less than 6 Months (0 - 180 days)	Number Returning to Homelessness from 6 to 12 Months (181 - 365 days)	Percentage of Returns from 6 to 12 Months (181 - 365 days)	Number Returning to Homelessness from 13 to 24 Months (366 - 730 days)	Percentage of Returns from 13 to 24 Months (366 - 730 days)	Number of Returns in 2 Years	Percentage of Returns in 2 Years
Exit was from SO	7	0	0.00%	0	0.00%	1	14.29%	1	14.29%
Exit was from ES	196	46	23.47%	21	10.71%	17	8.67%	84	42.86%
Exit was from TH	14	0	0.00%	1	7.14%	0	0.00%	1	7.14%
Exit was from PH	206	7	3.40%	10	4.85%	7	3.40%	24	11.65%
TOTAL Returns to Homelessness	423	53	12.53%	32	7.57%	25	5.91%	110	26.00%

Measure 3.2: This measures the change in annual counts of sheltered homeless persons in HMIS.

	Previous FY	Current FY	Difference
Universe: Unduplicated Total sheltered homeless persons		2205	
Emergency Shelter Total		2151	
Transitional Housing Total		67	

Metric 4.1 - Change in earned income for adult system stayers during the reporting period

	Previous FY	Current FY	Difference
Universe: Number of adults (system stayers)		35	
Number of adults with increased earned income		1	
Percentage of adults who increase earned income		3%	

Metric 4.2 - Change in non-employment income for adult system stayers during the reporting period

	Previous FY	Current FY	Difference
Number of adults with increased non-employment cash income		2	
Percentage of adults who increased non-employment cash income		6%	

Metric 4.3 - Change in total income for adult system stayers during the reporting period

	Previous FY	Current FY	Difference
Number of adults with increased total income		3	
Percentage of adults who increased total income		9%	

Metric 4.4 - Change in earned income for adult system leavers

	Previous FY	Current FY	Difference
Universe: Number of adults who exited (system leavers)		42	
Number of adults who exited with increased earned income		13	
Percentage of adults who increase earned income		31%	

Metric 4.5 - Change in non-employment cash income for adult system leavers

	Previous FY	Current FY	Difference
Number of adults who exited with increased non-employment cash income		8	
Percentage of adults who increased non-employment cash income		19%	

Metric 4.6 - Change in total income for adult system leavers

	Previous FY	Current FY	Difference
Number of adults who exited with increased total income		20	
Percentage of adults who increased total income		48%	

Measure 5: Number of Persons who Become Homeless for the First Time

Metric 5.1: This measures the change in active persons in ES, SH, and TH projects with no prior enrollments in HMIS.

	Previous FY	Current FY	Difference
Universe: Person with entries into ES, SH or TH during the reporting period		2050	
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their start during the reporting year		585	
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e., number of persons experiencing homelessness for the first time)		1465	

Metric 5.2: This measures the change in the number of persons entering ES, SH, TH, and PH projects with no prior enrollment in HMIS.

	Previous FY	Current FY	Difference
Universe: Person with entries into ES, SH, TH, or PH during the reporting period		2280	
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their start during the reporting year		650	
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e., number of persons experiencing homelessness for the first time)		1630	

Measure 6: Homeless Prevention and Housing Placement of Persons defined by category 3 of HUD's Homeless Definition in CoC Program-funded Projects

Metrics 6a.1 and 6b.1: This metric has been combined into one table to measure the returns to ES, SH, TH, and PH projects after exits to permanent housing destinations within 6 and 12 months (and 24 months in a separate calculation).

	Total Number of Persons who Exited to a Permanent Housing Destination (2 Years Prior)	Number Returning to Homelessness in Less than 6 Months (0 - 180 days)	Percentage of Returns in Less than 6 Months (0 - 180 days)	Number Returning to Homelessness from 6 to 12 Months (181 - 365 days)	Percentage of Returns from 6 to 12 Months (181 - 365 days)	Number Returning to Homelessness from 13 to 24 Months (366 - 730 days)	Percentage of Returns from 13 to 24 Months (366 - 730 days)	Number of Returns in 2 Years	Percentage of Returns in 2 Years
TOTAL Returns to Homeless-ness	0		NaN		NaN		NaN	0	NaN

Metric 6c.1 - Change in exits to permanent housing destinations

	Previous FY	Current FY	% Difference
Universe: Cat. 3 Persons in SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing		1	
Of the persons above, those who exited to permanent destinations		1	
% Successful Exits		100.00%	

Metric 6c.2 - Change in exit to or retention of permanent housing

	Previous FY	Current FY	% Difference
Universe: Cat. 3 Persons in all PH projects except PH-RRH who exited after moving into housing, or who moved into housing and remained in the PH project		2	
Of the persons above, count those who remained in PH-PSH projects and those who exited to permanent housing destinations		2	
% Successful exits/retention		100.00%	

Measure 7: Successful Placement from Street Outreach and Successful Placement in or Retention of Permanent Housing

Metric 7a.1 - Change in exits to permanent housing destinations

	Previous FY	Current FY	% Difference
Universe: Persons who exit Street Outreach		42	
Of the persons above, those who exited to permanent housing destinations		2	
Those who did not [not reported]		40	
% Successful Exits		4.76%	

Metric 7b.1 - Change in exits to permanent housing destinations

	Previous FY	Current FY	% Difference
Universe: Persons in ES, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing.		2,030	
Of the persons above, those who exited to permanent housing destinations		539	
Those who did not [not reported]		1,491	
% Successful Exits		26.55%	

Metric 7b.2 - Change in exit to or retention of permanent housing

	Previous FY	Current FY	% Difference
Universe: Persons in all PH projects except PH-RRH		99	
Of the persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations		93	
Those who did not [not reported]		6	
% Successful exits/retention		93.94%	

Andrea Watkins Beadles

ClientTrack™

The following criteria have been utilized to filter the <u>initial universe</u> of data for each measure. Data from other organizations or programs may be utilized for comparison data.

Organizations: *All Organizations*

Programs: *Multiple*

CoC: *Utah Balance of State CoC*

Measure 2a and 2b: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness within 6 to 12 months (and 24 months in a separate calculation)

	Total Number of Persons who Exited to a Permanent Housing Destination (2 Years Prior)	Number Returning to Homelessness in Less than 6 Months (0 - 180 days)	Percentage of Returns in Less than 6 Months (0 - 180 days)	Number Returning to Homelessness from 6 to 12 Months (181 - 365 days)	Percentage of Returns from 6 to 12 Months (181 - 365 days)	Number Returning to Homelessness from 13 to 24 Months (366 - 730 days)	Percentage of Returns from 13 to 24 Months (366 - 730 days)	Number of Returns in 2 Years	Percentage of Returns in 2 Years
Exit was from SO	2	2	100.00%	0	0.00%	0	0.00%	2	100.00%
Exit was from ES	306	39	12.75%	16	5.23%	20	6.54%	75	24.51%
Exit was from TH	25	0	0.00%	0	0.00%	1	4.00%	1	4.00%
Exit was from PH	204	9	4.41%	12	5.88%	11	5.39%	32	15.69%
TOTAL Returns to Homelessness	537	50	9.31%	28	5.21%	32	5.96%	110	20.48%

Measure 3.2: This measures the change in annual counts of sheltered homeless persons in HMIS.

	Previous FY	Current FY	Difference
Universe: Unduplicated Total sheltered homeless persons		2316	
Emergency Shelter Total		2267	
Transitional Housing Total		57	

ClientTrack™

Metric 4.1 - Change in earned income for adult system stayers during the reporting period

	Previous FY	Current FY	Difference
Universe: Number of adults (system stayers)		41	
Number of adults with increased earned income		3	
Percentage of adults who increase earned income		7%	

Metric 4.2 - Change in non-employment income for adult system stayers during the reporting period

	Previous FY	Current FY	Difference
Number of adults with increased non-employment cash income		8	
Percentage of adults who increased non-employment cash income		20%	

Metric 4.3 - Change in total income for adult system stayers during the reporting period

	Previous FY	Current FY	Difference
Number of adults with increased total income		11	
Percentage of adults who increased total income		27%	

Metric 4.4 - Change in earned income for adult system leavers

	Previous FY	Current FY	Difference
Universe: Number of adults who exited (system leavers)		82	
Number of adults who exited with increased earned income		16	
Percentage of adults who increase earned income		20%	

Metric 4.5 - Change in non-employment cash income for adult system leavers

	Previous FY	Current FY	Difference
Number of adults who exited with increased non-employment cash income		11	
Percentage of adults who increased non-employment cash income		13%	

Metric 4.6 - Change in total income for adult system leavers

	Previous FY	Current FY	Difference
Number of adults who exited with increased total income		22	
Percentage of adults who increased total income		27%	

Measure 5: Number of Persons who Become Homeless for the First Time

Metric 5.1: This measures the change in active persons in ES, SH, and TH projects with no prior enrollments in HMIS.

	Previous FY	Current FY	Difference
Universe: Person with entries into ES, SH or TH during the reporting period		2159	
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their start during the reporting year		670	
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e., number of persons experiencing homelessness for the first time)		1489	

Metric 5.2: This measures the change in the number of persons entering ES, SH, TH, and PH projects with no prior enrollment in HMIS.

	Previous FY	Current FY	Difference
Universe: Person with entries into ES, SH, TH, or PH during the reporting period		2406	
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their start during the reporting year		731	
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e., number of persons experiencing homelessness for the first time)		1675	

Measure 6: Homeless Prevention and Housing Placement of Persons defined by category 3 of HUD's Homeless Definition in CoC Program-funded Projects

Metrics 6a.1 and 6b.1: This metric has been combined into one table to measure the returns to ES, SH, TH, and PH projects after exits to permanent housing destinations within 6 and 12 months (and 24 months in a separate calculation).

	Total Number of Persons who Exited to a Permanent Housing Destination (2 Years Prior)	Number Returning to Homelessness in Less than 6 Months (0 - 180 days)	Percentage of Returns in Less than 6 Months (0 - 180 days)	Number Returning to Homelessness from 6 to 12 Months (181 - 365 days)	Percentage of Returns from 6 to 12 Months (181 - 365 days)	Number Returning to Homelessness from 13 to 24 Months (366 - 730 days)	Percentage of Returns from 13 to 24 Months (366 - 730 days)	Number of Returns in 2 Years	Percentage of Returns in 2 Years
Exit was from PH	3	1	33.33%	0	0.00%	0	0.00%	1	33.33%
TOTAL Returns to Homeless-ness	3	1	33.33%	0	0.00%	0	0.00%	1	33.33%

Metric 6c.1 - Change in exits to permanent housing destinations

	Previous FY	Current FY	% Difference
% Successful Exits		NaN	

Metric 6c.2 - Change in exit to or retention of permanent housing

	Previous FY	Current FY	% Difference
% Successful exits/retention		NaN	

Measure 7: Successful Placement from Street Outreach and Successful Placement in or Retention of Permanent Housing

Metric 7a.1 - Change in exits to permanent housing destinations

	Previous FY	Current FY	% Difference
Universe: Persons who exit Street Outreach		262	
Those who did not [not reported]		262	
% Successful Exits		0.00%	

Metric 7b.1 - Change in exits to permanent housing destinations

	Previous FY	Current FY	% Difference
Universe: Persons in ES, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing.		2,127	
Of the persons above, those who exited to permanent housing destinations		701	
Those who did not [not reported]		1,426	
% Successful Exits		32.96%	

Metric 7b.2 - Change in exit to or retention of permanent housing

	Previous FY	Current FY	% Difference
Universe: Persons in all PH projects except PH-RRH		128	
Of the persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations		104	
Those who did not [not reported]		24	
% Successful exits/retention		81.25%	

Exhibit 2

Weber Morgan Funding Resources: Updated 3/20/14

WEBER-MORGAN 2013-14 Funding Resources Distribution & Demographics

	CDBG (2013)	CDBG (2014)	CSBG (2014)	TANF 2014	CoC 2012	EEN (2014)	*QEAF (2013)	*QEAF (2014)	PAIITF (2014)	CNH (2014)
OGDEN	948,191	955,708								
Huntsville	61,508									
OWCAP			269,014							
St. Anne's Ctr.				100,000	30,000		32,981		105,000	
Share Inc							1,726			
HA of Ogden City					184,638					
Ogden Group Home (TURN)										
Ogden Homeless Vets									45,000	
Washington Terrace										
Weber County										
Weber County H.A.	320,000				231,026				35,000	
Weber Human Services										
orizon Station @Pleasar										
YCC Transitional Hsng					68,363				10,000	
WEBER-MORGAN										
TOTAL	1,329,699		269,014	100,000	484,027	30,000	34,707	0	90,000	105,000

*QEAF - Qualified Emergency Food Agencies Fund

Weber-Morgan	2010 census pop.	total fund resources	total funding resources	% of per capita	# of indiv. In poverty	poverty rate	% pop.rcvng. reduced lunches	# of homeless	# of chronic homeless	Food Stamps recipients
Morgan	9,469	0.34%			436	4.60%	17.30%	0	0	398
Weber	231,236	8.37%	$5,623,966	8.10%	28,582	12.36%	46.60%	1,203	128	41,647
TOTALS	240,705	8.71%	$5,623,966	8.10%	$23.36	29,018	-	1,203	128	42,045

Exhibit 2

	ESG (2013)	SSBG 2013	EITC (2014)	HOPWA	S+C (2012)	QWHLF.TBRA	QWHLF	HOME	HOME 2014	PATH	SAMHSA.FY12/13	EEMA.30	EEMA.31	SSVF	TOTALS
								328,652	362,416						2,594,967
															61,508
															269,014
															367,981
															1,726
	100,000			45,000			1,000,000								1,229,638
							108,789								108,789
														326,000	371,000
		87,687									69,037				69,037
												80,851	71,330		239,868
					28,464					41,039	376,000				614,490
															417,039
							590,000								590,000
															78,363
															0
	100,000	87,687	0	45,000	28,464	0	1,698,789	328,652		41,039	445,037	80,851		326,000	5,623,966

	% pop. roving food stamps	# pop. recvng food stamps	WIC	unemp. rate	# unemp. insurance
	4.20%	59		5.80%	226
	18.01%	6,988		7.60%	11,178
	17.47%	7,045		-	11,404

Exhibit 2

Key Code:

Code	Code
CDBG--Community Development Block Grant	PAHTF--Pamela Atkinson Homeless Trust Fund
CSBG--Community Services Block Grant	CNH--Critical Needs Housing
TANF--Temporary assistance for Needy Families	SSBG--Social Services Bolck Grant
EFN--Emergency Food Network	EITC--Earned Income Tax Credit
COC--Continuum of Care--HUD funding vehicle	HOPWA--Housing Opportunities for Persons with AIDS
QFAF--Qualified Emergency Food Agencies Fund	HUD S+C--HUD Shelter + Care funding
ESG--Emergency Solutions Grant	OWHLF--Olene Walker Housing Loan Fund
OWHLF-TBRA--Tenant-based rental assistance disbursed by OWHLF	
HOME--A grant program from HUD to States and units of general local government to increase home ownership and housing opportunities for low- and very low-income Americans.	
PATH--Projects for Assistance in Transition from Homelessness--Dept of Health and Human Services administered by Center for Mental Health Services--a component of SAMHSA	
SSVF -- Supportive services for Veteran Families--outreach, case mgmt, assistance	
VASH--Veterans Affairs Supportive Housing--similar to HCV with case mgmt	
FEMA--Federal Emaergency Management Agency--State set-aside funds for emergency food and shelter	
SAMHSA--Substance abuse and Mental Health Services Administartion--grant	
HCV--Housing Choisce Voucher --tenant based sect 8 voucher--moves with tenant	
Sect 8 units--Housing Authority used some Sect 8 to permanently subsidize specific units--subsidy stays with unit	
Mod Rehab--program ended in 1991--Some SRO and family units still in stock and eligible for annual renewal of Housing Authority contracts	
GPD-Grant per Diem--VA program that reimburses service providers for housing/support-- VA contracts for number of beds a service provider is able to submit for reimbursement	
USDA Rural Rental--subsidized units for very low, low, and moderate income individuals.	

Exhibit 3

10/1/2015 to 9/30/2016

ClientTrack

Report Criteria

Organizations:	Family Promise - Ogden, Homeless Veterans Fellowship, Juvenile Justice Services, State of Utah, Department of Human Services, Lantern House (St. Anne's Center), Ogden Housing Authority, Problems Anonymous Action Group, Rescue Mission - Ogden, Weber County Housing Authority, Weber Human Services, Your Community Connection, Youth Futures Shelter Home
Programs:	Multiple

Q1. Report Validation Table

Total Number of Persons Served	5210
Number of Adults (age 18 or over)	3982
Number of Children(under age 18)	1221
Number of Persons with Unknown Age	7
Number of leavers	4695
Number of adult leavers	3613
Number of adult and head of household leavers	4038
Total Number of Stayers	515
Number of Adult Stayers	369
Number of Veterans	387
Number of Chronically Homeless Persons	297
Number of youth under age 25	829
Number of parenting youth under age 25 with children	41
Number of Adult Heads of Household	3713
Number of child and unknown-age heads of household	437
Heads of households and adult stayers in the project 365 days or more	24

Q2. Personally Identifiable Information (PII)

Data Element	Client Doesn't Know / Refused	Information Missing	Data Issues	% of Error Rate
Name (3.1)	0	0	0	0.00%
Social Security Number (3.2)	553	21	115	13.22%
Date of Birth (3.3)	5	3	2	0.19%
Race (3.4)	13	24		0.71%
Ethnicity (3.5)	11	9		0.38%

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Gender (3.6)	0	0		0.00%
Overall Score				13.78%

Q3. Universal Data Elements

Data Element	Error Count	% of Error Rate
Veteran Status (3.7)	138	2.65%
Project Entry Date (3.10)	44	0.84%
Relationship to Head of Household (3.15)	124	2.38%
Client Location (3.16)	1499	36.12%
Disabling Condition (3.8)	1446	27.75%

Q4. Income and Housing Data Quality

Data Element	Error Count	% of Error Rate
Destination (3.12)	2142	45.62%
Income and Sources (4.2) at Start	1731	39.17%
Income and Sources (4.2) at Annual Assessment	19	79.17%
Income and Sources (4.2) at Exit	2321	57.48%

Q5. Chronic Homelessness

Entering into project type	Count of total records	Missing time in institution (3.917.2)	Missing time in housing (3.917.2)	Approximate Date started (3.917.3) DK/R/missing	Number of times (3.917.4) DK/R /missing	Number of months (3.917.5) DK/R/missing	% of records unable to calculate
ES, SH, Street Outreach	0			0	0	0	0.00%
TH	0	0	0	0	0	0	0.00%
PH (all)	0	0	0	0	0	0	0.00%
Total	0						0.00%

Q6. Timeliness

Time for Record Entry	Number of Project Start Records	Number of Project Exit Records
0 days	1025	766
1-3 Days	1053	874
4-6 days	267	264
7-10 days	150	193

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11+ days	444	2598

Q7. Inactive Records: Street Outreach & Emergency Shelter

Data Element	# of Records	# of Inactive Records	% of Inactive Records
Contact (Adults and Heads of Household in Street Outreach or ES - NBN)	1	0	0.00%
Bed Night (All clients in ES - NBN)	0	0	0.00%

Organizations:	Family Promise - Ogden, Homeless Veterans Fellowship, Juvenile Justice Services, State of Utah, Department of Human Services, Lantern House (St. Anne's Center), Ogden Housing Authority, Problems Anonymous Action Group, Rescue Mission - Ogden, Weber County Housing Authority, Weber Human Services, Your Community Connection, Youth Futures Shelter Home
Programs:	Multiple

Q1. Report Validation Table

Total Number of Persons Served	3310
Number of Adults (age 18 or over)	2338
Number of Children(under age 18)	969
Number of Persons with Unknown Age	3
Number of leavers	2585
Number of adult leavers	1853
Number of adult and head of household leavers	2204
Total Number of Stayers	725
Number of Adult Stayers	485
Number of Veterans	281
Number of Chronically Homeless Persons	239
Number of youth under age 25	711
Number of parenting youth under age 25 with children	15
Number of Adult Heads of Household	2202
Number of child and unknown-age heads of household	458
Heads of households and adult stayers in the project 365 days or more	59

Q2. Personally Identifiable Information (PII)

Data Element	Client Doesn't Know / Refused	Information Missing	Data Issues	% of Error Rate
Name (3.1)	0	0	0	0.00%
Social Security Number (3.2)	520	11	92	18.82%
Date of Birth (3.3)	1	2	2	0.15%
Race (3.4)	7	18		0.76%
Ethnicity (3.5)	1	7		0.24%

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Gender (3.6)	0	0		0.00%
Overall Score				19.43%

Q3. Universal Data Elements

Data Element	Error Count	% of Error Rate
Veteran Status (3.7)	4	0.12%
Project Entry Date (3.10)	11	0.33%
Relationship to Head of Household (3.15)	17	0.51%
Client Location (3.16)	75	2.82%
Disabling Condition (3.8)	199	6.01%

Q4. Income and Housing Data Quality

Data Element	Error Count	% of Error Rate
Destination (3.12)	131	5.07%
Income and Sources (4.2) at Start	600	21.46%
Income and Sources (4.2) at Annual Assessment	57	96.61%
Income and Sources (4.2) at Exit	474	21.51%

Q5. Chronic Homelessness

Entering into project type	Count of total records	Missing time in institution (3.917.2)	Missing time in housing (3.917.2)	Approximate Date started (3.917.3) DK/R/missing	Number of times (3.917.4) DK/R /missing	Number of months (3.917.5) DK/R/missing	% of records unable to calculate
ES, SH, Street Outreach	1788			1	4	3	0.34%
TH	49	0	0	0	0	0	0.00%
PH (all)	184	0	2	0	0	0	1.09%
Total	2021						0.40%

Q6. Timeliness

Time for Record Entry	Number of Project Start Records	Number of Project Exit Records
0 days	1081	1042
1-3 Days	1105	896
4-6 days	250	201
7-10 days	139	89

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11+ days	422	357

Q7. Inactive Records: Street Outreach & Emergency Shelter

Data Element	# of Records	# of Inactive Records	% of Inactive Records
Contact (Adults and Heads of Household in Street Outreach or ES - NBN)	0	0	0.00%
Bed Night (All clients in ES - NBN)	0	0	0.00%

Report Criteria

Organizations:	Catholic Community Services - N. Utah, Family Promise - Ogden, Homeless Veterans Fellowship, Juvenile Justice Services, State of Utah, Department of Human Services, Lantern House (St. Anne's Center), Ogden Housing Authority, Problems Anonymous Action Group, Rescue Mission - Ogden, Weber County Housing Authority, Weber Human Services, Your Community Connection, Youth Futures Shelter Home
Programs:	Multiple

Q1. Report Validation Table

Total Number of Persons Served	3255
Number of Adults (age 18 or over)	2401
Number of Children(under age 18)	852
Number of Persons with Unknown Age	2
Number of leavers	2347
Number of adult leavers	1908
Number of adult and head of household leavers	1944
Total Number of Stayers	908
Number of Adult Stayers	493
Number of Veterans	261
Number of Chronically Homeless Persons	207
Number of youth under age 25	566
Number of parenting youth under age 25 with children	25
Number of Adult Heads of Household	2243
Number of child and unknown-age heads of household	268
Heads of households and adult stayers in the project 365 days or more	157

Q2. Personally Identifiable Information (PII)

Data Element	Client Doesn't Know / Refused	Information Missing	Data Issues	% of Error Rate
Name (3.1)	0	0	1	0.03%
Social Security Number (3.2)	426	7	80	15.76%
Date of Birth (3.3)	0	2	5	0.22%
Race (3.4)	10	31		1.23%

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Ethnicity (3.5)	2	17		0.58%
Gender (3.6)	0	0		0.00%
Overall Score				16.84%

Q3. Universal Data Elements

Data Element	Error Count	% of Error Rate
Veteran Status (3.7)	15	0.46%
Project Entry Date (3.10)	12	0.37%
Relationship to Head of Household (3.15)	9	0.28%
Client Location (3.16)	25	1.00%
Disabling Condition (3.8)	83	2.55%

Q4. Income and Housing Data Quality

Data Element	Error Count	% of Error Rate
Destination (3.12)	155	6.60%
Income and Sources (4.2) at Start	368	13.79%
Income and Sources (4.2) at Annual Assessment	155	98.73%
Income and Sources (4.2) at Exit	214	11.01%

Q5. Chronic Homelessness

Entering into project type	Count of total records	Missing time in institution (3.917.2)	Missing time in housing (3.917.2)	Approximate Date started (3.917.3) DK/R/missing	Number of times (3.917.4) DK/R /missing	Number of months (3.917.5) DK/R/missi ng	% of records unable to calculate
ES, SH, Street Outreach	1544			4	8	5	0.52%
TH	36	0	0	0	0	0	0.00%
PH (all)	278	0	8	0	7	6	5.40%
Total	1858						1.24%

Q6. Timeliness

Time for Record Entry	Number of Project Start Records	Number of Project Exit Records
0 days	1115	1156
1-3 Days	985	676
4-6 days	189	79

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7-10 days	119	72
11+ days	366	364

Q7. Inactive Records: Street Outreach & Emergency Shelter

Data Element	# of Records	# of Inactive Records	% of Inactive Records
Contact (Adults and Heads of Household in Street Outreach or ES - NBN)	0	0	0.00%
Bed Night (All clients in ES - NBN)	0	0	0.00%

Acknowledgements

Special thanks to community leaders and homeless service provider agencies in Weber County that so generously offered their time and support, the people with lived experience of homelessness who participated in focus groups, Lantern House and Weber Housing Authority for their contributions to the focus groups, the Weber Homeless Trust Fund Board for funding this project, and the following individuals who offered time, talent, and support in the creation of this plan:

Kendall Wilcox

Margaret Ann Wilcox

Liliane and Lorin Barker

Paige and Alex Barker Johnson

Jami Baayd

Kimberlee Michaud

and David Shuler