

# Western Massachusetts Opening Doors

A Collective Impact  
Framework to Prevent and  
End Homelessness

Western MA Opening Doors sets forth a framework to end homelessness in the region by stating our goal and defining where we are, where we want to go, and how we will get there. Made possible with support from the Commonwealth, the Western MA Network to End Homelessness commissioned this Plan to drive ongoing collective impact work to meet the goals of “Opening Doors: the Federal Strategic Plan to Prevent and End Homelessness.”

DRAFT June, 2015

# Contents

Introduction .....	3
The Vision.....	5
Where We Are: The Homeless Response System.....	6
Parts of the System .....	6
System Coordination.....	7
Where We Are: Baselines .....	10
Homeless Counts .....	10
Point-in-Time Counts for the Region .....	10
Annual Counts for the Region.....	11
Counts of Homeless Subpopulations .....	12
Resources.....	16
Where We Want To Go.....	18
Functional Zero .....	18
Shared Indicators .....	18
The Relationship Between Goal and Indicators.....	19
Population-Specific Goals .....	20
How We Get There: Implementation .....	23
Implementation .....	23
Progress Tracking and Strategic Review .....	23
Appendix A: Network and CoC HEARTH Outcomes Baseline Data .....	25
Appendix B: Data Measurement Tools .....	31

## **Acknowledgements**

---

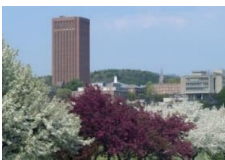
Under contract with the United Way of Pioneer Valley, Simtech Solutions was tasked with developing data integration, analysis and reporting capabilities in order to advance the mission of the Western Massachusetts Network to End Homelessness. This document ultimately reflects a collaborative process that was developed among the Network, Continuum of Care Leads, Waypoint Consulting, and Simtech Solutions. This process drew on the knowledge, history and skills of each of the partners. The document will continue to evolve with additional stakeholder input and as this continues to be a “living document,” we intend to continue this collaboration to meet the goals set forth in this document.

# Introduction

---



The Western Massachusetts Network to End Homelessness came together in 2009 to create collaborative solutions to end homelessness in the region. In that same year, Congress passed the HEARTH Act, which established the VISION that **no one in this country should be without a safe and stable place to call home**, and which charged the federal government to create the first federal strategic plan to prevent and end homelessness. The plan that was created and is updated annually is [Opening Doors: Federal Strategic Plan to Prevent and End Homelessness](#).



The HEARTH Act also set the stage for local communities to transform their homeless response systems from collections of individual programs into a unified crisis response system. Borrowing concepts from effective examples of *collective impact*, the Act creates a framework for multiple local stakeholders to come together with a **common agenda** and a **shared measurement system** to evaluate progress toward implementing that agenda. Collective impact efforts acknowledge that the problems they address are complex and cannot be solved by the actions of individual entities—they are addressed through on-going community learning and problem-solving, driven by data.



Through this plan, the Network embraces the challenge to move from collaboration to collective impact. The Network explicitly commits to the goal of making homelessness **rare, brief, and non-recurring**. We will use shared measures to drive our progress toward this overarching goal, and we will work as a team to get there.

[Western Massachusetts Opening Doors: An Action Framework to Prevent and End Homelessness](#) establishes a framework for the region to rigorously evaluate our ability to provide right interventions at the right time, and to continuously improve the ways we provide services and housing to people in need. The Plan defines **where we are** according to baseline data, **where we want to go** as defined through benchmarks and targets, and **how we will get there** using a data driven, outcome-oriented approach that employs best practices and establishes accountability.

# The Vision

---

The Western Massachusetts Network to End Homelessness explicitly adopts the federal vision, goals and themes set forth in *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*.

## VISION

**No one in Western Massachusetts  
should be without a safe and stable place to call home.**

## MISSION

The region will make homelessness **rare, brief and non-recurring** through a **collaborative, data-driven** approach that is **outcome oriented** and ensures **accountability**.

## *GOALS of Opening Doors Plan*

End veteran homelessness by the end of 2015  
End chronic homelessness by the end of 2017  
End homelessness for families, youth, and children by 2020  
Set a path to ending all types of homelessness

## *THEMES of Opening Doors Plan*

Increase Leadership, Collaboration, and Civic Engagement  
Increase Access to Stable and Affordable Housing  
Increase Economic Security  
Improve Health and Stability  
Retool the Homeless Crisis Response System

# Where We Are: The Homeless Response System

---

Locally, as in the rest of the nation, the homeless response system grew in response to crisis. When unsheltered individuals and families first started appearing in the 1980's, multiple agencies and funders created immediate responses, which resulted in a patchwork of programs designed to provide quick help. As immediate responses became institutionalized, agencies refined individual missions and service specialties, and different funding streams established varying priorities and reporting requirements. The variety can make it difficult for a person in crisis to locate the help they need, and competing compliance requirements feel like a burden to an agency with the core mission of meeting the needs of people in crisis.

This Plan aims to acknowledge all these strands of our system, while pointing the way to knit them together into a single response which is easy to navigate and gets people the help they need when they need it. As a first step, the Plan maps our system.

## Parts of the System

The homeless response system in Western Massachusetts is made up of dozens of programs with multiple funding sources, serving thousands of people each year. In addition to primary governmental funding sources identified for parts of the system below, most individual programs also receive grant funding, and some emergency shelters and transitional housing facilities—particularly those with a faith-based emphasis—are entirely privately funded.

### **OUTREACH AND ENGAGEMENT**

Outreach and engagement is about finding homeless people and helping them to find the resources they need to end their homelessness. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) provides funds for street and shelter outreach for homeless individuals. The U.S. Department of Health and Human Services (HHS) funds health care and services for homeless persons, which includes an outreach component. The Commonwealth of Massachusetts provides a single point of entry for all families experiencing homelessness at Department of Transitional Assistance (DTA) offices, which seek to direct families to appropriate interventions.

### **PREVENTION, DIVERSION AND RAPID REHOUSING**

*Prevention* is services or funding which assist a household experiencing a housing crisis to address the crisis without becoming homeless. *Diversion* assists households at the point they are becoming homeless, and attempts to intervene so that they can avoid literal homelessness. *Rapid rehousing* provides funds and services to assist homeless households re-enter stable housing quickly. Major funding sources for these interventions are the Massachusetts Department of Housing and Community Development (DHCD), the U.S Department of Housing and Urban Development (HUD), and the Veterans Administration (VA).

## **EMERGENCY SHELTER**

Emergency shelter provides an immediate, short-term, safe overnight accommodation for people who would otherwise be on the streets or in a place not fit for human habitation. Some emergency shelter providers serve women and children who are victims of domestic violence. Major funding sources for all emergency shelter are the state of Massachusetts, HUD, and the Federal Emergency Management Agency (FEMA). The federal Administration for Children and Families (ACF) funds emergency shelter for runaway and homeless youth.

## **TRANSITIONAL HOUSING**

Transitional housing is time-limited housing (no more than 2 years) that assists people who have experienced homelessness to achieve stability before moving to permanent housing. A common intervention in the 1990's, this intervention is more limited now and is seen as appropriate for limited populations: youth, victims of domestic violence, and people in the early stages of substance abuse recovery. HUD has been a major funder, but has moved away from funding these projects. The VA is a major funder of transitional housing for homeless veterans.

## **PERMANENT SUPPORTIVE HOUSING**

Permanent supportive housing combines an affordable housing unit with wrap-around services designed to assist a disabled person to maintain stable housing. Major funders of combined programs are HUD and the VA. Many PSH programs are created by agencies which creatively combine funding from housing sources and services sources to provide the mix of housing and services needed to stabilize vulnerable populations. In recent years, there has been experimentation with using Medicaid as a funding source for services. SAMHSA also provides major grant funding the services that support people living in permanent supportive housing.

## **System Coordination**

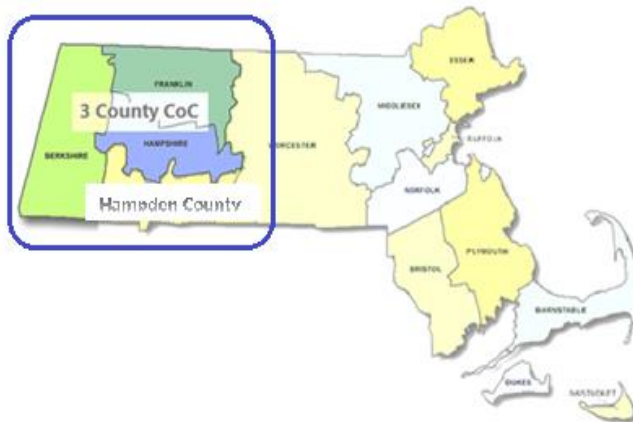
There are different sources and levels of coordination among the multiple providers who serve people experiencing or at risk of homelessness.

## **CONTINUUM OF CARE**

HUD initiated an effort to improve coordination among homeless providers in the early 1990's, when it established the Continuum of Care (CoC) construct. The HUD vision of the CoC is a broad collection of community stakeholders who undertake annual gaps analysis and planning for homelessness services, and apply for funding for housing and services in a coordinated application to HUD. The CoC is both the organizing principle that was an early version of trying to create collective impact, as well as a competitive funding vehicle for the services that make up the core of a system.

In practice, CoCs have felt primarily like funding entities. A single entity, the Collaborative Applicant, receives funds from HUD and distributes them to a number of non-profit agencies which carry out programs that provide services and housing to people experiencing homelessness. The HEARTH Act and implementing guidance pushes these entities to work more like the centers of collective impact efforts, by requiring them to report on systemic performance measures, and to work toward the federal *Opening Doors* goals.

There are two CoCs in Western Massachusetts: the Hampden County CoC, (collaborative applicant City of Springfield); and the Three-County CoC, which covers Berkshire, Franklin and Hampshire Counties (collaborative applicant Hilltown Community Development Corporation). The two CoCs are very different in many ways including population, services available and geography (urban / rural), as well as governance structures and involvement in national strategies. Both CoCs are challenged by the requirements that the HEARTH Act imposes to lead a collective impact effort, without sufficient dedicated resources with which to do so.



An important requirement is that each CoC establish a Homeless Management Information System (HMIS), which collects client-level data from multiple providers serving people who are homeless. Unified data standards have created the opportunity for CoCs, and any defined region, to produce unduplicated counts of people experiencing homelessness. The Hampden County CoC meets this requirement through operation of its own HMIS, an online service provided by Social Solutions, Inc. The Three-County CoC meets this requirement by participation in the Commonwealth’s Social Solutions HMIS, which is called ASIST. Both systems are capable of producing many types of aggregate data; however, to truly understand homelessness in the region, data from additional sources—including those providing outreach, community-based case management, and specialized services—would need to be integrated.

### **ENTITLEMENT COMMUNITIES AND CONSOLIDATED PLANS**

Western Massachusetts includes six entitlement communities—Springfield, Chicopee, Holyoke, Westfield, Northampton and Pittsfield—which are required, as part of their planning for HUD Community Development Block Grant (CDBG) funds, to create five-year strategic plans, including plans to address homelessness. Following enactment of the HEARTH Act, these communities must coordinate with CoCs in collecting data, reviewing available resources, and creating local strategies aligned with the federal *Opening Doors* plan. (To access all of the MA Consolidated Plans, click [here](#).) The City of Springfield, as the largest entitlement community in Western Massachusetts, also receives HUD ESG funds and must coordinate this program with the CoC, and describe this coordination in its Consolidated Plan.

### **MASSACHUSETTS FAMILY HOMELESSNESS SYSTEM**

Massachusetts is unique among states in that it has created a statewide homeless response system for families, operated by DHCD in collaboration with DTA. DHCD provides prevention and rapid rehousing services through a network of regional housing authorities, and provides emergency shelter to all eligible families through the centralized Emergency Assistance (EA) program. The state EA program contracts with nonprofit organizations and local hotels to provide shelter beds and services to more than 4000 families experiencing homelessness throughout the Commonwealth. Although the State attempts to shelter families close to their home community, the need for shelter has strained the ability to make local placements and families from anywhere can be placed anywhere. The centralized state control combined



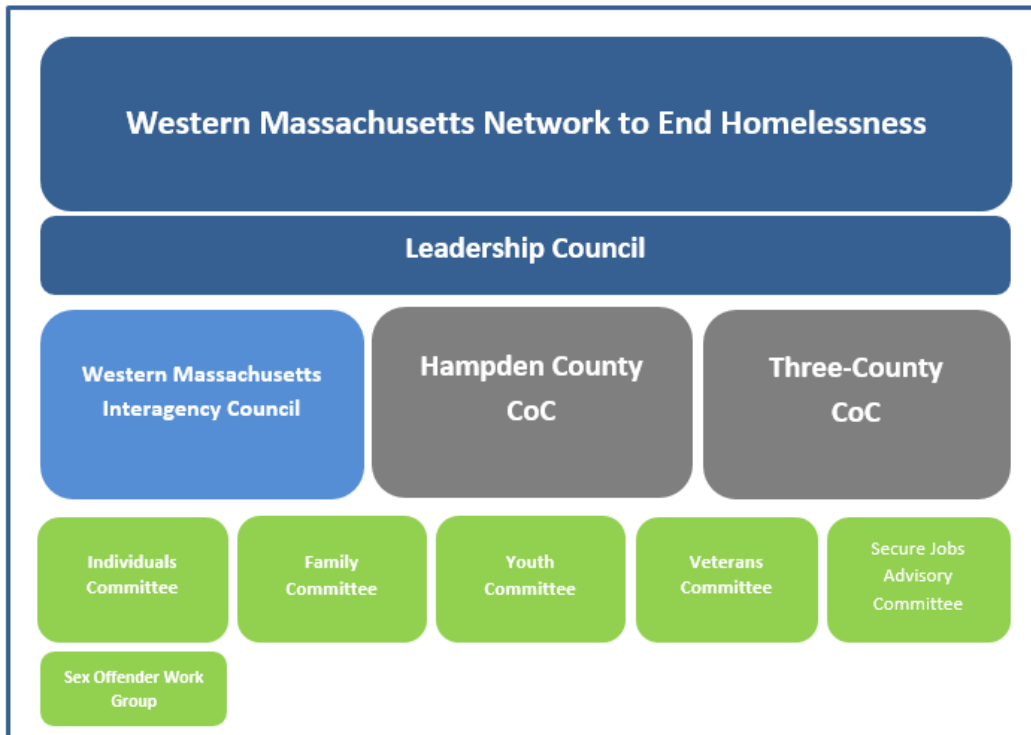
with placement of families away from their home communities make it difficult for local actions to impact levels of family homelessness.

**WESTERN MASSACHUSETTS INTERAGENCY COUNCIL**

The Western Massachusetts Interagency Council includes regional directors of state agencies, who meet regularly to coordinate state system responses to homelessness in our region.

**WESTERN MASSACHUSETTS NETWORK TO END HOMELESSNESS**

The Network was started in 2009 as part of the state’s call for regional coordinating entities that would improve the state’s homelessness response system, particularly for families. This region embraced the charge to improve overall coordination, and created a system that would drive the response to homelessness for all populations and for all four counties of the region. The Network has become the overall coordinating body, with the mission to “create collaborative solutions to end homelessness through a housing first approach that prioritizes prevention, rapid re-housing and housing stabilization.” The Network works closely with the two CoCs and the region’s entitlement communities to advance their goals. In particular, the Network and CoCs have combined efforts to address veteran, chronic, youth and family homelessness through population-specific joint committees.

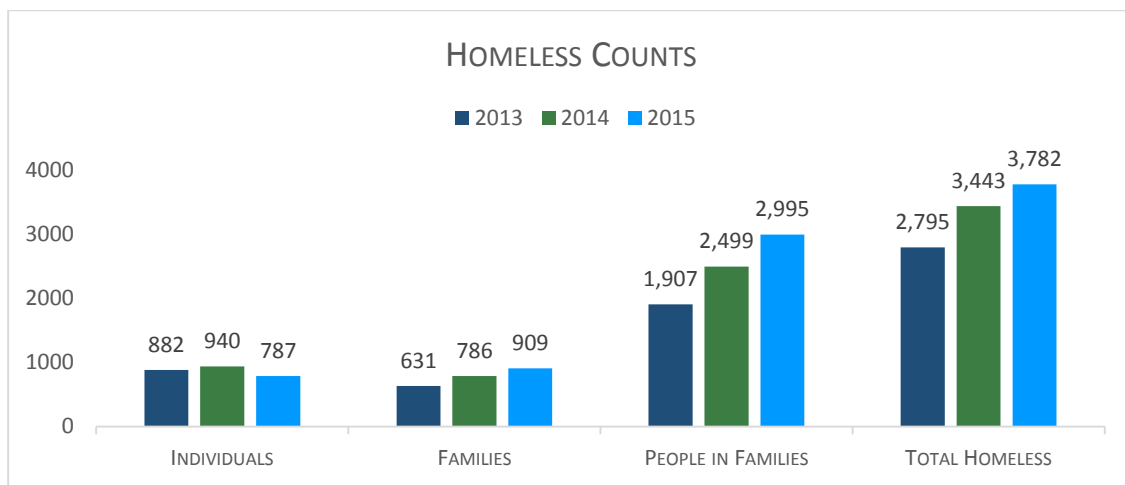


# Where We Are: Baselines

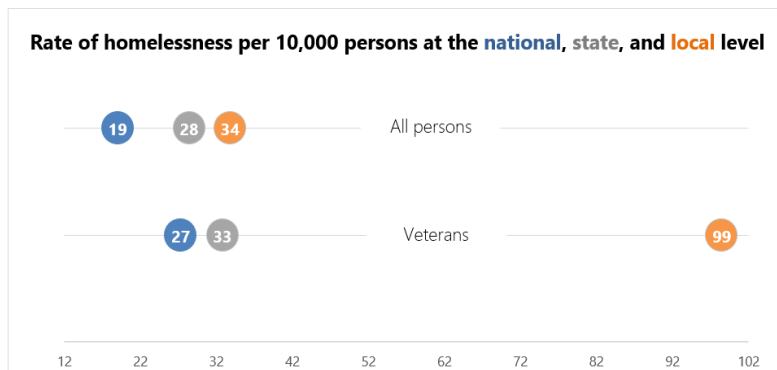
In order to define where we are going and set goals for progress, we need to understand the current data on homelessness. We use two types of counts because we know that the homeless population turns over frequently—homeless people become housed, and other people become newly homeless. CoCs around the country, in accordance with HUD requirements, collect data on homelessness in a standardized way. The [Point-in-Time \(PIT\) Count](#) takes place in the last 10 days of January each year and counts the number of people experiencing homelessness on a given night. The [Annual Homeless Assessment Report \(AHAR\)](#) identifies the number and characteristics of people who experience homelessness over the course of a year.

## Homeless Counts

### POINT-IN-TIME COUNTS FOR THE REGION



### COMPARING LOCAL RATE OF HOMELESSNESS TO THE STATE AND NATION (2014)



Calculation of the [rate](#) of homelessness—the number of people who are homeless at a point in time out of every 10,000 people—allows us to compare local levels of homelessness with levels at the state and national level. Western Massachusetts has a higher than average rate of homelessness.

Data sources: National Alliance to End Homelessness State of Homelessness Report, American Community Survey data, and 2014 Point in Time Count.

## ANNUAL COUNTS FOR THE REGION

While it would be ideal to have a true count of people experiencing homelessness there are limitations to the data that require standardized estimating techniques to be used. Some agencies do not receive Federal or state funding which require their usage of the Homeless Management Information System. The data about homeless families, provided by Massachusetts Department of Housing and Community Development (DHCD), has also been of poor quality. Below are the estimates of homelessness in Western Massachusetts over the past three years.

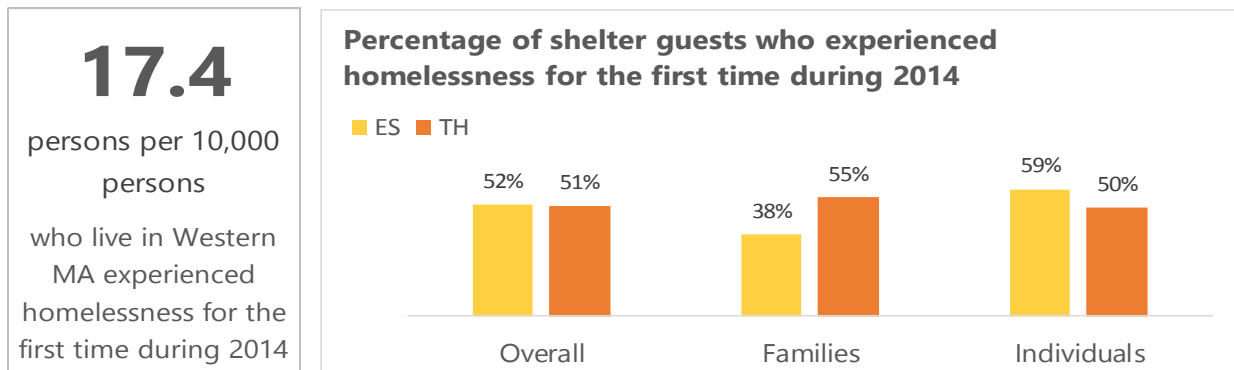
	INDIVIDUALS	PEOPLE IN FAMILIES	TOTAL HOMELESS
2012	1156	1118	2274
2013	1293	1472	2765
2014	1459	1724	3183

Data Source: AHAR

## INCIDENCE OF NEW HOMELESSNESS IN 2014

While the annual count indicates how many people were homeless during any point in a year, **incidence** of homelessness indicates how many people become **newly** homeless over the course of a year. Incidence of homelessness can be a useful gauge for determining how well the region is doing at preventing homelessness.

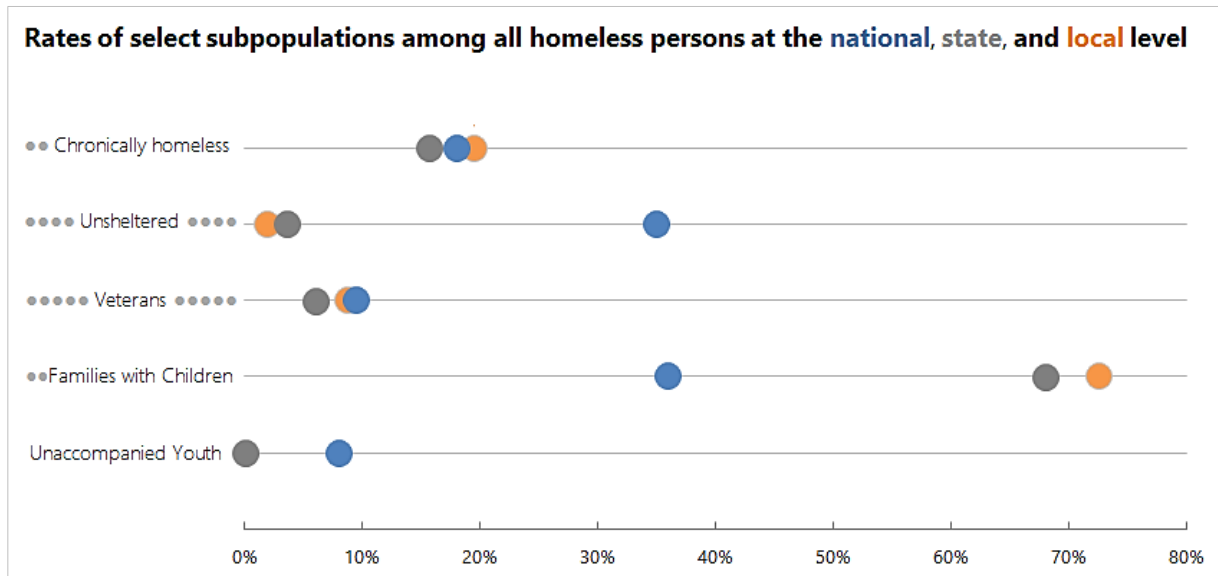
	INDIVIDUALS	FAMILIES	TOTAL FIRST-TIME HOMELESS
2014	1670	577	2247



Data Source: Analysis of HMIS data by Waypoints Consulting

## Counts of Homeless Subpopulations

Different subpopulations of people experiencing homelessness have unique needs or circumstances. The federal framework for preventing and ending homelessness looks at each of these subpopulations separately: veterans, chronically homeless individuals, families with children, and youth. This graph shows the rates of homelessness among subpopulations, compared with state and national data:



Data sources: National Alliance to End Homelessness State of Homelessness Report and 2014 Point in Time Count

At the subpopulation level, there are different factors that lead to different trends in each of the two CoCs in Western Massachusetts. For this reason, subpopulation data is presented by CoC, along with brief descriptions of the factors that cause each CoC to vary from the average regarding that subpopulation.

### VETERANS

	3 COUNTY	HAMPDEN COUNTY	WESTERN MA
2013	244	33	277
2014	256	42	298
2015	217	38	255

Data Source: Annual Point-in-Time Counts

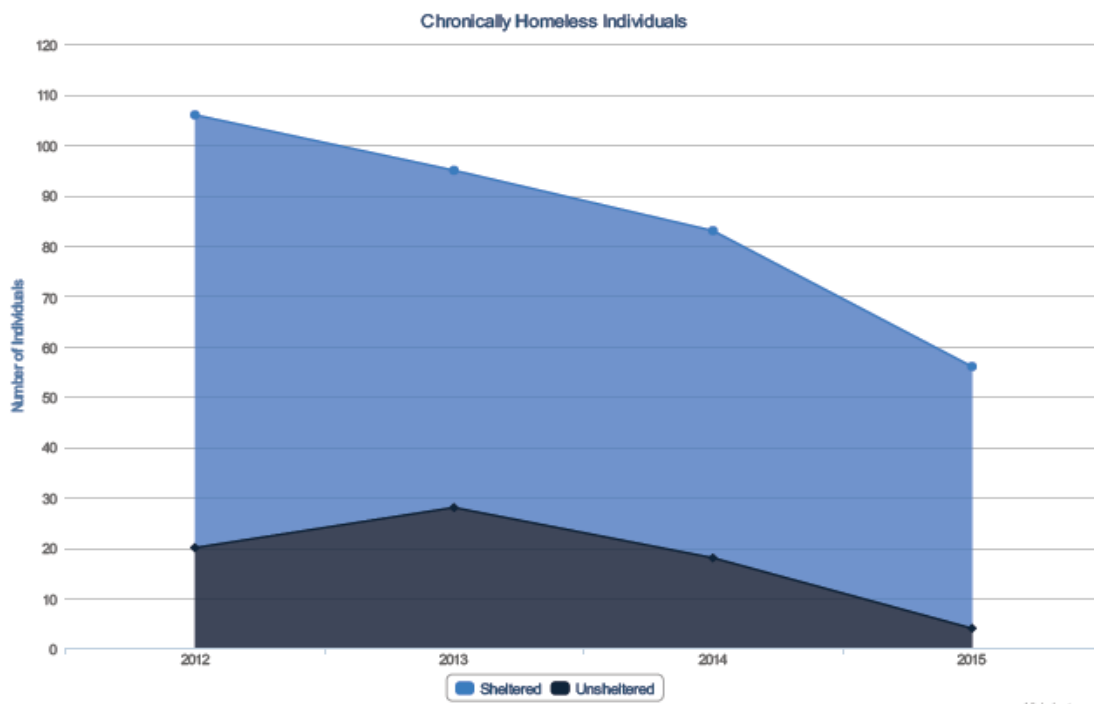
The Three-County CoC contains a regional Veterans Administration Hospital (one of five in the state) and a large non-profit provider with transitional housing and permanent housing programs for veterans. As a result, the CoC attracts veterans from a broader service area, resulting in what is high prevalence of homeless veterans as well as a disproportionately larger share the homeless population that are veterans. The Hampden County CoC has a lower-than-average proportion of homeless veterans.

## CHRONICALLY HOMELESS INDIVIDUALS

	3 COUNTY	HAMPDEN COUNTY	WESTERN MA
2013	93	95	188
2014	112	83	195
2015	78	69	147

Data Source: Annual Point-in-Time Counts

The City of Springfield has had a long-standing focus on ending chronic homelessness. Since 2007, the community plan *Homes Within Reach: A Ten-Year Plan to End Long-Term Homelessness* has driven progress toward this goal. The community has created 250 new units of permanent supportive housing, development of a comprehensive homeless resource center, and made a community-wide commitment to a Housing First model. The City has seen the rate of chronic homelessness drop by 50% since 2007, and trend analysis indicates that is on track to end chronic homelessness by 2016.

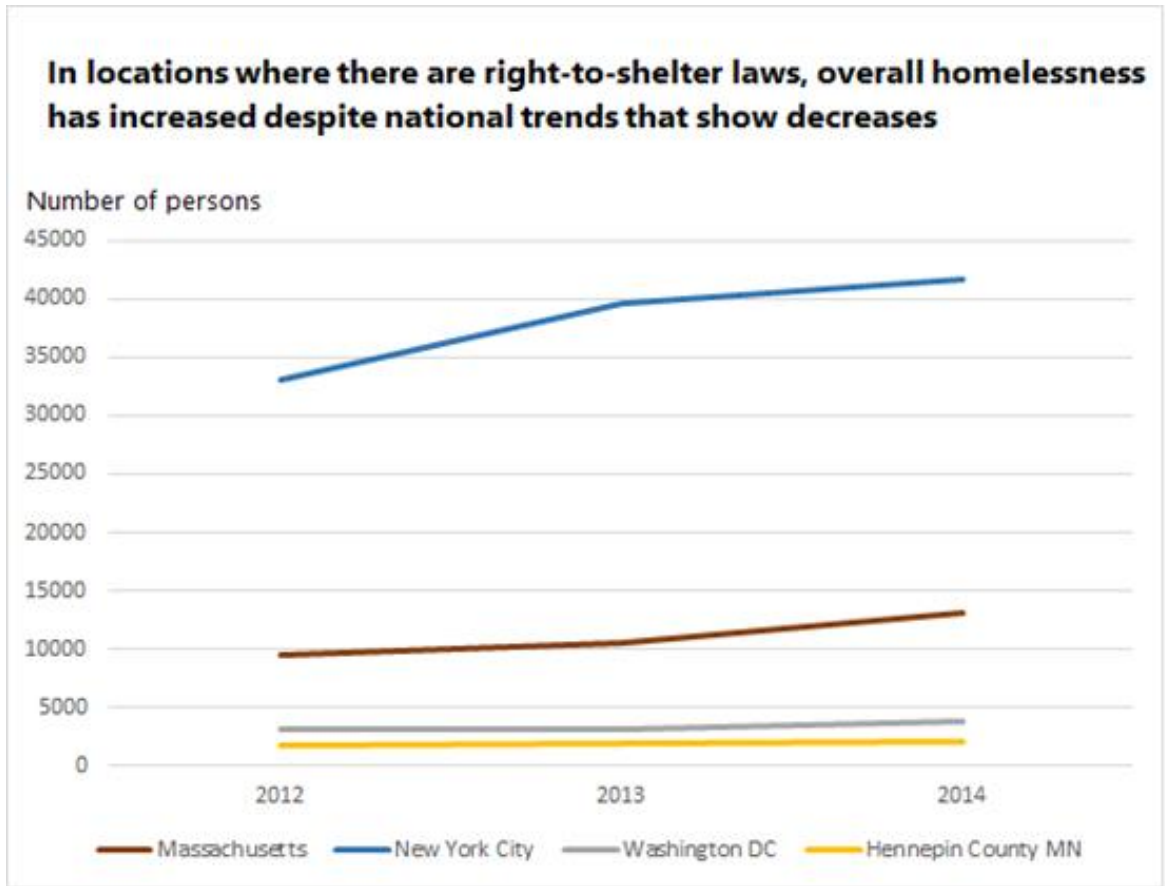


## FAMILIES

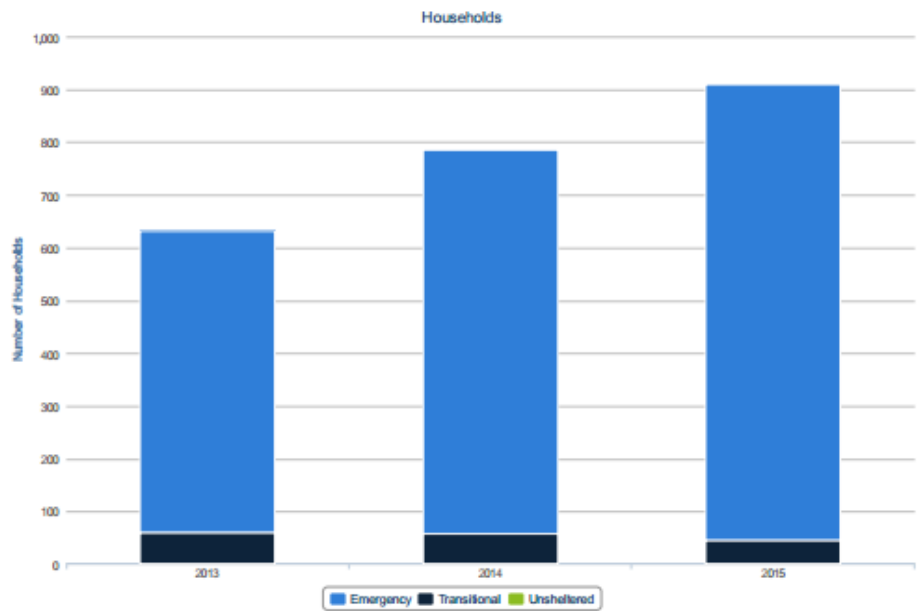
	3 COUNTY	HAMPDEN COUNTY	WESTERN MA
2013	71	560	631
2014	84	702	786
2015	122	756	909

Massachusetts as a whole has very high rates of family homelessness. In Western Massachusetts, homeless counts do not find unsheltered homeless families, but there are high numbers of families in

emergency shelter and overflow shelter motels. The state is unique in that it provides emergency shelter to every eligible family that applies.



Numbers of homeless families have been rising in Western Massachusetts and statewide, even as numbers of homeless families are decreasing nationally. The large number of homeless families is the primary factor why Western Massachusetts has a much higher-than-average rate of homelessness per 10,000 people.



## YOUTH HOMELESSNESS

	3 COUNTY	HAMPDEN COUNTY	WESTERN MA
2015	52	287	339

Beginning in 2015, HUD has required CoCs to begin separating data regarding homeless youth—those who are 24 and under, and the initial year’s data is provided above. An important characteristic regarding the counted youth is that 280 of the youth identified were parents, and had a total of 325 young children with them. The majority of these very young families were in the family shelter system.

Prior to 2015, HUD required CoCs to count unaccompanied youth—those under 18 and not with their parents. Finding these youth has always been a challenge because many do not want to be found and do not access traditional shelter providers. In both 2014 and 2015, Western Massachusetts CoCs participated in statewide outreach efforts to better identify homeless youth and survey them about their needs. The [Massachusetts Youth Count 2014](#) reports on this effort.

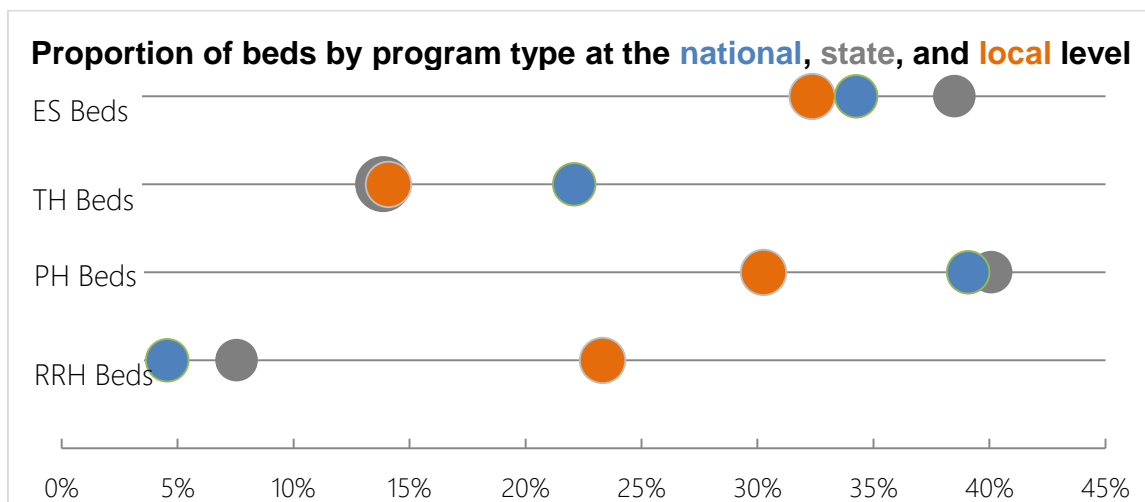
# Resources

## HOMELESS SYSTEM RESOURCES

Western Massachusetts has approximately 4,400 beds dedicated to homeless persons in a variety of program types: emergency shelter, transitional housing, permanent supportive housing, and rapid rehousing 'slots'. Emergency shelter beds comprised 32% of all beds while permanent and rapid rehousing beds comprised about 54% of all beds.

	HOUSEHOLDS WITH CHILDREN	HOUSEHOLDS WITHOUT CHILDREN	ONLY CHILDREN HOUSEHOLDS	TOTAL
EMERGENCY SHELTER (ES)	1,048	369	4	1,421
TRANSITIONAL HOUSING (TH)	167	444	8	619
PERMANENT HOUSING (PH)	375	954	0	1,329
RAPID RE-HOUSING (RRH)	1,024	0	0	1,024

The federal strategy of “retooling the crisis response system” refers to reworking the mix of resources dedicated to assisting people to resolving housing crisis. Over years, there has been a recognition that a crisis response to homelessness resulted in emergency shelter and transitional housing units that had a tendency to become a long-term solution. An over-emphasis on these interventions can result in increased homelessness, as people get trapped and experience long stays in homelessness. Recent thinking emphasizes prevention, rapid rehousing and permanent supportive housing, with the understanding that these interventions should decrease the need for shelter. In comparison to the rest of the nation, Western Massachusetts has significant resources dedicated to rapid rehousing, which reflects state funds used to assist homeless families transition out of shelter.





## **Mainstream and Community Housing Resources**

While the most obvious and accessible housing resources for persons experiencing homelessness are the HUD-funded ESG and CoC resources that are provided as part of the homeless response system, these are only a portion of the housing resources available. Included among the *Opening Doors* strategies are the recommendation that affordable housing units be targeted to people experiencing or at most risk of homelessness. The following are mainstream and community housing resources can be part of the solution to housing homeless people:

### **PUBLIC HOUSING AUTHORITIES**

Communities throughout Western Massachusetts have local public housing authorities (PHAs), quasi-governmental agencies that provide housing to low-income individuals and families through federal and state programs. Key programs include public housing owned and operated by the PHA, and Section 8 Housing Choice Vouchers, which provide rent subsidies for tenants renting in the private market. PHAs can be a partner in ending homelessness by: creating priorities for people experiencing homelessness, operating prevention programs that help public housing tenants avoid homelessness, providing unit set-asides to be used for homeless individuals or families, and using the section 8 project-based program to create permanent supportive housing for chronically homeless individuals or families. [The PHA Guidebook to Ending Homelessness](#) is an excellent resource describing PHA strategies.

### **HOME-FUNDED TENANT-BASED RENTAL ASSISTANCE**

The federal HOME Partnerships Investment Program provides annual allocation to entitlement cities and to states to use to increase affordable housing opportunities. HOME funds can support rental subsidies for homeless persons, which can be used in two key ways to assist people experiencing homelessness: 1) combined with supportive services as permanent supportive housing; and 2) as bridge funds to provide a rental subsidy while a person is on a wait list for an affordable housing program.

### **PRIVATELY OWNED SUBSIDIZED HOUSING**

Each privately-owned subsidized housing complex maintains its own wait list, and these tend to be shorter than PHA wait lists. Through the New Lease Program, owners commit deeply subsidized units to families exiting the state's emergency shelter system.

### **PRIVATELY-OWNED HOUSING: LANDLORD INCENTIVES**

It can be easy to overlook purely private housing as a resource for people experiencing homelessness, but in Western Massachusetts, there are both affordable units (especially the limited supply of single-room-occupancy (SRO) or other less-desirable housing types) and households with some income but with barriers to renting on the private market. Programs throughout the country provide landlord incentives to overcome barriers.

# Where We Want To Go

---

Our community is in agreement that no one in Western Massachusetts should be without a safe and stable place to call home. We recognize that “ending homelessness” can be a confusing goal, because we know that people will continue to experience housing crises, and that individual people and families will continue to become newly homeless. We are adopting the following descriptor for what we want to accomplish:

## Functional Zero

Our Network will make homelessness rare, brief, and non-recurring. The federal government is expressing this concept as functional zero. The definition of this status is that, on a monthly basis, our system is able to house the average number of households that become newly homeless each month.

## Shared Indicators

A collective impact initiative is based on many actors working toward a shared vision and using shared indicators to show progress toward that vision. HUD has charged CoCs with measuring and reporting progress toward indicators it has established as a result of research and best practices for making homelessness rare, brief and non-recurring. All indicators are applied to the system as a whole—that is, at a minimum at the CoC level, but potentially also at the regional level. Some indicators are also applied to specific programs, in order to understand how individual programs contribute to the system as a whole. An important key to understanding these indicators is seeing that they work as a package.

Currently, each CoC collects Housing Management Information System (HMIS) data on many programs. All programs funded by the CoCs or through the Emergency Solutions Grant program are required to participate in HMIS (with the exception of providers of services to victims of domestic violence, which are prohibited from using HMIS). HMIS data specifications are established by HUD in order to lead to a data set that can provide information on the mandated indicators.

CoCs are responsible for encouraging providers funded with other sources to use HMIS, and non-HUD federal agencies are now encouraging or requiring grantees to use HMIS. The goal is to create sufficient data to be able to understand community progress toward shared indicators. As a result, more and more agencies are using HMIS. However, many funding sources have their own electronic reporting systems, which may not be compatible with HMIS and some entities do not wish to participate in HMIS and do not receive funding from any source that requires use of HMIS. As our collective impact grows, we hope that more of our partners will see the benefit of shared data and indicators. With the right technology, including data warehousing and a data integration platform, the region can look at data across multiple systems to better serve individuals and to better understand our collective impact.

As we move toward shared measurement, we start with the data we have, and our current ability to analyze the data. Our Network has recently taken a big step forward regarding analysis through acquiring the tool AgencyDash, which enables us to pull from our HMIS to run automated reports on our chosen indicators. Previously, we had only been able to undertake analysis through a labor-intensive process,

which limited the frequency with which we did so. AgencyDash is a data warehouse platform that can be leveraged to measure system-level performance and other indicators.

## The Relationship between Goal and Indicators

The table below ties together the goal of “rare, brief, and non-recurring” with the HUD performance indicators. While the performance measurements are described below, it will be up to the CoCs and the Network to establish local targets and to integrate reporting into a continual evaluation and improvement process to measure success.

GOAL	INDICATORS
“RARE, BRIEF, AND NON-RECURRING”	<ul style="list-style-type: none"> <li>• Reduced Number of Homeless Persons</li> </ul>
“RARE”	<ul style="list-style-type: none"> <li>• Reduced Number of Persons who Become Homeless for the First Time</li> </ul>
“BRIEF”	<ul style="list-style-type: none"> <li>• Reduced Length of Time Persons Remain Homeless</li> <li>• Successful Placement from Resulting from Outreach &amp; Engagement</li> <li>• Successful Placement in Permanent Housing</li> </ul>
“NON-RECURRING”	<ul style="list-style-type: none"> <li>• Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness</li> <li>• Employment and Income Growth for Persons in CoC-Funded Programs</li> <li>• Successful Retention of Permanent Housing</li> </ul>

## Population-Specific Goals

The overall goal to make homelessness rare, brief, and non-recurring can be divided into sub-goals, which are specific to subpopulations, have their own time-frames, and have specific agencies and resources associated with each.

### VETERAN HOMELESSNESS

The federal goal is to end veteran homelessness by the end of 2015. Our local goals are:

	2015 PIT BASELINE	GOAL FOR 2016 PIT
HAMPDEN COUNTY COC	38 (22 in ES; 17 in TH)	0 unsheltered; 0 in emergency shelter; No more than 10 veterans in TH and each has a housing plan
THREE-COUNTY COC	220 (30 in ES, 190 in TH)	0 unsheltered; 0 in emergency shelter; Every veteran in TH has a housing plan

#### Potential Strategies:

- Create a by-name list of homeless veterans and assign each one to a Housing Navigator who will continue to work with the veteran until housed
- Identify the number of veterans to be housed and set a target for how many to be housed each month
- Use veterans to undertake outreach to veterans in emergency shelter or who are unsheltered
- Identify non-VA-eligible veterans and refer to CoC programs/Housing Navigators
- Ensure that community has widespread knowledge of where to refer a veteran for emergency housing assistance, and ensure that SSVF and VASH programs are working smoothly to assist veterans to obtain housing quickly
- Increase proportion of SSVF placements to permanent housing
- Increase proportion of VASH placements to permanent housing
- Increase number of VASH placements that maintain housing or exit to their permanent housing
- Develop new veteran housing
- Convert transitional housing to permanent housing
- Create preferences for veterans in housing programs, including PHAs

### CHRONICALLY HOMELESS INDIVIDUALS

The federal goal is to end chronic homelessness by the end of 2017. Our local goals are:

	2015 PIT BASELINE	GOAL FOR 2018 PIT
HAMPDEN COUNTY COC	78	0
THREE-COUNTY COC	69	TBD

*Potential Strategies:*

- Create a by-name list of chronically homeless individuals and assign each one to a Housing Navigator who will continue to work with the veteran until housed
- Identify the number of chronically homeless individuals to be housed and set a target for how many to be housed each month
- Broadly implement a Housing First model
- Increase the number of PSH units that prioritize to chronically homeless individuals
- Create new PSH units for chronically homeless individuals using CoC funds
- Leverage PHA, HOME funds, or state resources to create new PSH for chronically homeless individuals
- Use a Moving Up/Moving On strategy to help people who are in PSH but no longer need intensive services to move to other affordable housing
- Identify ways to use Medicaid dollars to fund supportive services for chronically homeless individuals to be placed into affordable housing units

**FAMILIES**

The federal goal is to end family homelessness by the end of 2020. Our local goals are:

	2015 PIT BASELINE		GOAL FOR 2021 PIT
HAMPDEN COUNTY COC	787 households	2,628 persons in hh	TBD
THREE-COUNTY COC	122 households	367 persons in hh	TBD

*Potential strategies:*

- Advocate for CoCs to be able to analyze DHCD HMIS homeless family data, both to better understand the population and to establish baselines and targets regarding this population
- Continue to address the gap between household incomes and housing costs through expansion of the Secure Jobs Connect program

**YOUTH**

For purposes of planning, youth homelessness applies to unaccompanied young people, and not children under the care of a parent or guardian. HUD as well as [The MA Commission on Homeless Youth](#) is targeting unaccompanied youth under the age of 25. The federal goal is to end youth homelessness by the end of 2020. Our local goals are:

	2015 PIT BASELINE	GOAL FOR 2021 PIT
HAMPDEN COUNTY COC	43	TBD
THREE-COUNTY COC	0	TBD

*Potential strategies:*

- Continue to undertake annual youth counts and analyze data about youth who become homeless
- Incorporate Runaway and Homeless Youth (RHY) data into HMIS

- Create strategies to connect with LGBTQ youth, who are over-represented in the homeless population
- Consider research regarding risk and protective factors for young Latinas, who enter the homeless family shelter system at a disproportionate rate, and identify interventions targeted to this population
- Expand appropriate housing interventions for homeless youth, with an emphasis on connecting youth to education, employment, and health care
- Create interventions targeted to youth aging out of foster care or being released from the juvenile justice system

**SET A PATH TO ENDING ALL TYPES OF HOMELESSNESS**

The federal goal is to set a path to ending all types of homelessness. This goal involves transforming the homeless response system so that it responds with housing not shelter. It emphasizes increasing resources dedicated to prevention and rapid rehousing.

	2015		2020	
	Prevention slots	Rapid rehousing slots	Prevention slots	Rapid rehousing slots
HAMPDEN COUNTY COC		1954		
THREE-COUNTY COC				

*Potential strategies:*

- Explore all possible sources of prevention and rapid rehousing funds, including consideration of conversion of other funding sources
- Consider community fundraising event(s) to raise annual funds for these critical resources
- Implement coordinated entry to homelessness system to quickly direct people in crisis to needed resources

**Note on Baseline data:** Baseline data for January 2015 has been generated or aggregated wherever possible. Some of the baseline data will be updated prior to the launch of the plan.

# How We Get There: Implementation

---

Knowing baselines and ultimate goals are key first steps, but they must be combined with interim targets — set locally after reviewing current performance and comparison with national benchmarks for high - achieving communities—as well as ongoing learning and strategizing about how to meet the ultimate goals. The region will meet its goals through a collaborative, data driven approach that is outcome oriented and ensures accountability.

Critical drivers for progress will be the existing population-specific committees, which will review baseline data and national benchmarks to create local CoC interim targets, and will monitor progress toward goals. The committees will be accountable to both the Network and the CoCs.

## Implementation

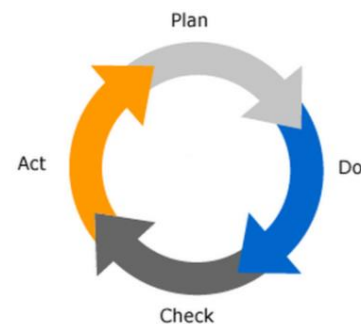
Implementation of the plan will consist of:

- Committee identification of local targets, with Network leadership approval
- Generation of data to track progress toward meeting goals
- Committee and Network leadership regular review of data
- Committee and Network leadership identification of barriers to achieving goals
- Developing processes to improve outcomes where necessary and appropriate
- Designating responsible parties to take action accordingly
- Effecting change through ongoing communication and feedback between committees and leadership

During implementation and in accordance with HUD requirements, HEARTH outcomes data will be generated regularly using [Simtech Solutions](#) tools and reports.

## Progress Tracking and Strategic Review

The Network Leadership Committee is responsible for holding the vision and ensuring accountability for the Plan. The Leadership may also pursue advocacy on those issues that remain as barriers to implementing the plan. Implementing the Opening Doors plan should occur not only in the context of rich dialogue and feedback within Committees, but according to a regular meeting and reporting schedule.



- Annually: Leadership Council reviews key indicators, ideally against the backdrop of community indicators
- Biannually: Leadership Council and Steering Committee review select commitments, indicators, targets and outcomes
- Quarterly: Network Committees and CoC Membership and/or Performance Committees review all relevant measures with a focus on HEARTH metrics & CoC reporting

- Monthly: Data quality and performance reports are part of every committee meeting. Data quality is reviewed in a manner that is consistent with the CoC data quality plan. Take down numbers are reviewed to track progress towards goals. Additional reports to measure performance will be developed and reviewed as required by HUD.

Instituting a regular review and assessment schedule, coupled with defining action steps and designating parties responsible for implementing them, will create the foundation for ongoing monitoring, evaluation, and continuous improvement. Specific schedules, reports, goals and benchmarks will be defined by the committees upon implementation and will consider additional priorities and requirements.



# Appendix A: Network and CoC HEARTH Outcomes Baseline Data

## HUD System Performance Measures

### Measure 1 Length of Time Persons Remain Homeless

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

Data Report Completed

#### 1.1 Average and Median Length of Stay

Client Universe: ES and SH guests

Reporting Period: 2014

	3 County CoC			Hampden CoC			Western MA		
	Total	FAM	IND	Total	FAM	IND	Total	FAM	IND
	n=1265	n=261	n=1004	n=2284	n=1401	n=883	n=3549	n=1144	n=2405
Average LOS (in days)	<b>57</b>	74	53	<b>163</b>	333	56	<b>126</b>	274	55
Median LOS (in days)	<b>38</b>	56	34	<b>85</b>	365	20	<b>54</b>	365	27

#### 1.2 Average and Median Length of Stay

Client Universe: ES, SH, TH guests

Reporting Period: 2014

	3 County CoC			Hampden CoC			Western MA		
	Total	FAM	IND	Total	FAM	IND	Total	FAM	IND
	n=1810	n=374	n=1436	n=2419	n=928	n=1491	n=4229	n=1302	n=2927
Average LOS (in days)	<b>100</b>	84	104	<b>168</b>	332	66	<b>139</b>	261	85
Median LOS (in days)	<b>68</b>	65	68	<b>92</b>	365	23	<b>77</b>	365	45

<b>Measure 2</b>	<b>The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness</b>
Desired Outcome	Reduction in the percent of persons who return to homelessness
Data Report	TBD. High rate of missing data yields results that are not valid nor reliable

<b>Measure 3</b>	<b>Number of Homeless Persons</b>
Desired Outcome	Reduction in the number of persons who are homeless
Data Report	Completed. Annual counts adjusted using HUD-approved extrapolation factors to account for beds not covered by HMIS.

### 3.1 Point in Time Count of Homeless Persons

Client Universe: ES, SH, TH guests

Reporting Period: 2014

	3 County CoC			Hampden CoC			Western MA		
Program Type	Total	FAM	IND	Total	FAM	IND	Total	FAM	IND
Total number of persons	753	247	506	2690	2,252	434	3443	2,499	940
Unsheltered	29	0	29	64	35	0	93	35	29
Chronic homeless persons	153	41	112	673	520	83	826	561	195
Veterans	256	na	na	42	na	na	298	na	na
Unaccompanied youth	0	na	na	4	na	na	4	na	na

### 3.2 Annual Count of Sheltered Persons

Client Universe: ES, SH, TH guests

Reporting Period: 2014

Program Type	3 County CoC			Hampden CoC			Western MA		
	Total	FAM	IND	Total	FAM	IND	Total	FAM	IND
ES	1162	260	902	2268	884	1384	3430	1144	2286
SH	0	0	0	11	0	11	11	0	11
TH	652	117	535	126	29	97	681	146	535
<b>Grand Total</b>	<b>1814</b>	<b>377</b>	<b>1437</b>	<b>2405</b>	<b>913</b>	<b>1492</b>	<b>4122</b>	<b>1290</b>	<b>2832</b>

<b>Measure 4</b>	<b>Employment and Income Growth for Homeless Persons in CoC Program-funded Projects</b>
Desired Outcome	Increase in the percent of adults who gain or increase employment or non-employment cash income over time
Data Report	Not completed as part of baseline data since this metric is exclusive to CoC-funded programs rather than being a systems level measure.

<b>Measure 5</b>	<b>Number of Persons who Become Homeless for the First Time</b>
Desired Outcome	Reduction in the number of persons who become homeless for the first time
Data Report	Completed.

### 5.1 Number of Persons Experiencing Homelessness for the First Time

Client Universe: ES, SH, TH guests

Reporting Period: 2014

Program Type	3 County CoC			Hampden CoC			Western MA Network		
	Total	FAM	IND	Total	FAM	IND	Total	FAM	IND
ES	681	260	421	1198	184	1014	1773	430	1343
SH	0	–	–	0	0	0	0	0	0
TH	322	81	241	37	1	36	349	80	269
<b>Grand Total</b>	<b>1003</b>	<b>341</b>	<b>662</b>	<b>1235</b>	<b>185</b>	<b>1050</b>	<b>2122</b>	<b>510</b>	<b>1612</b>

### 5.2 Number of Persons Experiencing Homelessness for the First Time

Client Universe: ES, SH, TH, PH guests

Reporting Period: 2014

Program Type	3 County CoC			Hampden CoC			Western MA Network		
	Total	FAM	IND	Total	FAM	IND	Total	FAM	IND
ES	816	260	421	1198	184	1014	1773	430	1343
SH	0	–	–	0	–	0	0	0	0
TH	538	81	241	37	1	36	349	80	269
PH	32	11	21	94	58	36	125	67	58
<b>Grand Total</b>	<b>1035</b>	<b>352</b>	<b>683</b>	<b>1329</b>	<b>243</b>	<b>1086</b>	<b>2247</b>	<b>577</b>	<b>1670</b>

<b>Measure 6</b>	<b>Homelessness Prevention and Housing Placement of Persons Defined by Category 3 of HUD's Homeless Definition in CoC Program-funded Projects</b>
Desired Outcome	Only CoC applicants that have exercised the authority and been approved by HUD to serve Category 3 are required to complete Measures 6a, 6b, and 6c.
Data Report	Not applicable.

<b>Measure 7a</b>	<b>Successful Placement from Street Outreach</b>
Desired Outcome	Increase in the percent of persons who exit the streets to ES, SH, TH, or PH.
Data Report	No data available.

<b>Measure 7b</b>	<b>Successful Placement in or Retention of Permanent Housing</b>
Desired Outcome	Increase in the percent of persons who exit to or retain permanent housing
Data Report	Completed.

**7b.1 Increase in the percent of persons who exit to permanent housing: Positive Exits**

Client Universe: ES, SH, TH guests and RRH participants who exited during the year

Reporting Period: 2014

Program Type	3 County CoC			Hampden CoC			Western MA Network		
	Total	FAM	IND	Total	FAM	IND	Total	FAM	IND
ES	197	46	151	131	0	131	323	46	277
SH	0	0	0	0	0	0	0	0	0
TH	184	32	152	16	2	14	200	34	166
RRH	0	0	0	67	67	0	67	67	0
<b>Grand Total</b>	<b>381</b>	<b>78</b>	<b>303</b>	<b>214</b>	<b>69</b>	<b>145</b>	<b>590</b>	<b>147</b>	<b>443</b>

Program Type	3 County CoC			Hampden CoC			Western MA Network		
	Total Exits	Positive Exits	Unknown	Total Exits	Positive Exits	Unknown	Total Exits	Positive Exits	Unknown
ES	885	197	375	1204	131	937	2029	323	1268
SH	0	0	0	3	0	0	0	0	0
TH	503	184	86	61	16	45	558	200	124
RRH	0	0	0	66	66	0	66	66	0
<b>Grand Total</b>	<b>1388</b>	<b>381</b>	<b>461</b>	<b>1334</b>	<b>213</b>	<b>982</b>	<b>2653</b>	<b>589</b>	<b>1392</b>

<b>Rate per Exit Type</b>		<b>27%</b>	<b>33%</b>		<b>16%</b>	<b>74%</b>		<b>22%</b>	<b>52%</b>
---------------------------	--	------------	------------	--	------------	------------	--	------------	------------

**7b.2 Increase in the percent of persons who retain permanent housing**

Client Universe: PH participants

Reporting Period: 2014

	3 County CoC			Hampden CoC			Western MA Network		
Exit Status	Total	FAM	IND	Total	FAM	IND	Total	FAM	IND
Leaver									
Stayer									
<b>Grand Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

*DISCLAIMER:* Ideally these system-level performance measures would be generated automatically and in near real-time with the assistance of software. This will help the region to better quantify the impact of the work being done over time. Current restrictions on access to client-level data that is being imposed by the Massachusetts Department of Housing and Community Development (DHCD) will prevent most of these measures from being performed in an automated manner. As a result, the figures in this Exhibit A: Network and CoC HEARTH Outcomes Baseline Data are either derived from the annual HUD Point in Time (PIT) homeless census or were generated by Andrea Miller from Waypoint Consulting using data she had access to via her separate contractual relations with the Springfield/Hampden County and Three County Continuum of Care.

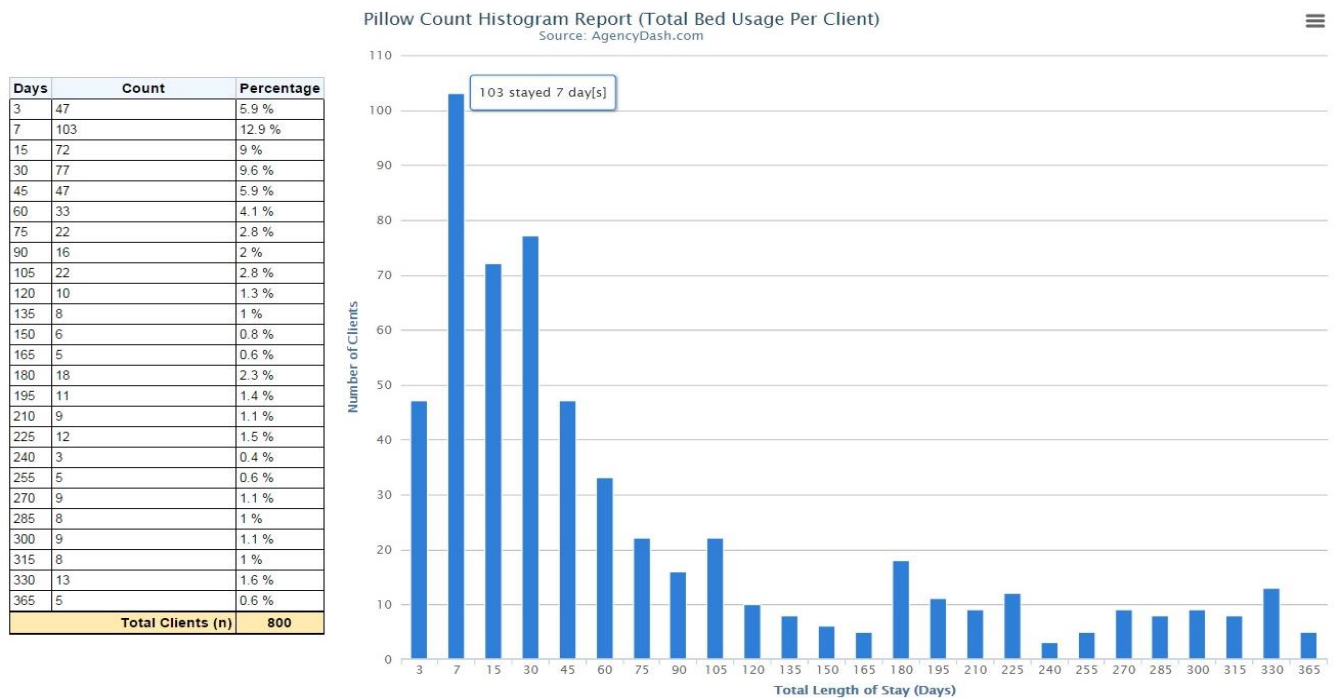
Due to the timing of the anticipated release of the plan, these baseline figures were also generated prior to the May 8, 2015 release by HUD of the formal programming specifications for these measures. With this in mind, it is to be understood that these figures are preliminary in nature.

## Appendix B: Data Measurement Tools

**Prevention** –A primary objective for prevention is to reduce the total number of people who end up becoming homeless in the first place. The image below demonstrates how the “Total Number of New Clients” can be pulled from reports such as this HMIS Annual Performance Report (APR). Ideally this number should decline from one reporting period to the next.

**Rapid Rehousing** projects are designed to move people to stable housing as soon as possible. The primary measure to use to assess these projects is #1 – *Length of Time Persons Remain Homeless*. The quality of the placement and the supportive services that lead to sustained housing (ie TPP) are measured with #2 - *The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness* and #4 - *Employment and Income Growth for Homeless Persons in CoC Program-funded Projects*.

Below is a sample Length of Stay Histogram which provides the supporting details for measure #1. This was generated using data from the *Friends of the Homeless* men’s individual emergency shelter in Springfield for May 15, 2014 to May 14, 2015. This same measure can and should be run for all individual emergency shelters within the region. The primary objective being to reduce the average and median length of time people remain homeless in the region.



**Ongoing Shelter Operations** support people while they are homeless and the primary objective is to reduce the length of stay. There is a National benchmarks 30 day shelter stays. However, Hampden County is committed to housing people by 20 days. Reports that can be of assistance in doing so include the [Chronic Homeless Audit](#), the [Housing Prioritization Report](#), the [AHAR Readiness Report](#), and [Daily Census and Meals Served Trend Analysis](#).

## Planning and Operational Tools

Central to planning and operationalizing efforts to end homelessness is the capacity to know who in the community is homeless. As people tend to access multiple services, there is often a lack of clarity about a client's path towards housing – which service provider is doing what based on a particular understanding of the client and the resources that are available to that particular provider. Through guidance, as well as new system level performance measures, HUD is requiring a community wide, collaborative approach. Fundamental to this approach is creating a list of people – by name – who need housing and to then prioritize these people for housing. HUD has issued guidance regarding such prioritization. HUD guidance to communities is that prioritization for limited Permanent Supportive Housing units should be based on chronic homelessness status, then length of homelessness and finally, to include scoring from assessments such as the VI-SPDAT. Details including an analysis and recommendations on how to implement this approach is detailed in: [Tools and Techniques to Prioritize Clients for Limited Housing Resources](#).

Communities that participate in the various national campaigns, such as the Mayor's Challenge to End Veteran Homelessness and the Zero: 2016 Campaign, are generating these lists to help manage the housing placement process. Below is a report for Boston which integrates data from a variety of HMIS sources to generate a single list for the community to focus on. As this requires client-level information,

### Housing Prioritization Report

SimtechSolutions, Inc.

Report Start: 03/01/2012  
 Report End: 02/28/2015  
 Activity in last: 90 days  
 Leaver/Stayer: Stayer  
 Veteran Status: Yes  
 Ran By: Barber, Eddie

Organization: All Organizations  
 Project: All Projects  
 Disabled Status: Yes  
 Min. Total Bed Nights: 365  
 Min. # of Episodes: 4  
 Dataset: Boston CH Study v7

#### List of clients

#	First Name	Last Name	Organization	Program	Date of Birth	Age	Gender	Disabled?	Vet?	Episodes	Total Bed Nights
1			Pine Street Inn	Outreach - Outreach Van		55	Male	Yes	Yes	4	1872
2			Homeless Services	Long Island Shelter		57	Male	Yes	Yes	1	1558
3			Pine Street Inn	Mens Inn		65	Male	Yes	Yes	2	1378
4			Pine Street Inn	Mens Inn		58	Male	Yes	Yes	1	1086
5			19	Shattuck Emergency Shelter		54	Male	Yes	Yes	1	1086
6			Homeless Services	Long Island Shelter		61	Male	Yes	Yes	1	1084
7			Homeless Services	Woods Mullen Shelter		67	Male	Yes	Yes	1	1077
8			Homeless Services	Long Island Shelter		64	Male	Yes	Yes	1	1065
9			Homeless Services	Long Island Shelter		56	Male	Yes	Yes	1	1060
10			Homeless Services	Long Island Shelter		68	Male	Yes	Yes	2	1034
11			Pine Street Inn	Outreach - Project NeighBOR		60	Male	Yes	Yes	1	1009
12			Pine Street Inn	Mens Inn		64	Male	Yes	Yes	2	1004
13			Homeless Services	Long Island Shelter		63	Male	Yes	Yes	1	988
14			Pine Street Inn	Mens Inn		58	Male	Yes	Yes	3	952
15			19	Shattuck Emergency Shelter		53	Male	Yes	Yes	1	891
16			Homeless Services	Long Island Shelter		50	Male	Yes	Yes	10	872
17			Homeless Services	Woods Mullen Shelter		81	Male	Yes	Yes	3	839
18			Homeless Services	Long Island Shelter		54	Male	Yes	Yes	1	822
19			Pine Street Inn	Mens Inn		61	Male	Yes	Yes	5	760
20			Pine Street Inn	Outreach - Outreach Van		70	Male	Yes	Yes	10	738
21			Pine Street Inn	Mens Inn		66	Male	Yes	Yes	5	710
22			Homeless Services	Long Island Shelter		59	Male	Yes	Yes	4	705
23			Homeless Services	Long Island Shelter		64	Male	Yes	Yes	2	704
24			Homeless Services	Long Island Shelter		60	Male	Yes	Yes	6	673
25			Homeless Services	Woods Mullen Shelter		68	Male	Yes	Yes	2	671
26			Homeless Services	Long Island Shelter		64	Male	Yes	Yes	5	668
27			Pine Street Inn	Mens Inn		53	Male	Yes	Yes	2	587
28			Pine Street Inn	Mens Inn		56	Male	Yes	Yes	1	517
29			Homeless Services	Woods Mullen Shelter		68	Male	Yes	Yes	5	401



Simtech Solutions is unable to run similar prioritization reports for Western MA until data sharing agreements are updated to allow for this work to occur.

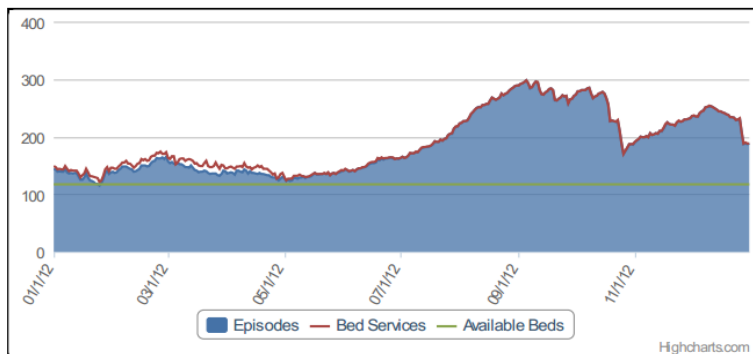
### Process Controls

These reports are only valid if the data that they are run off of is valid. Therefore, there must be policies and procedures in place to ensure accuracy and completeness of the data. There are various committees that are active within the two CoCs that comprise the Western MA region. The plan is a call to action for these committees, and stakeholders, to work towards implementing both practices and systems in order to foster accountability, increase collaboration, and ensure that the limited community resources are being allocated wisely. For this initiative to be successful there is work to be done at every level – from staff at agencies providing services; the CoCs; the Network; and the State.

Governance includes the defining of roles within both governance agreements and HMIS Policies and Procedures will need to clearly define roles and responsibilities to ensure accountability. A primary focus of the guidance (which is specifically asked for within the HUD NOFA application) should be on the ongoing data quality monitoring. This monitoring requires various levels of oversight ranging from a region-wide HMIS Administrator, a designated agency-lead, the project manager, and the frontline staff. This quality assurance process is supported by tools such as the [Data Quality Summary Report](#), the [Missing Data Report](#), the [Overlapping Episodes Report](#), and other reporting tools. Having real-time data that can be trusted will position the region to have an unprecedented level of coordination while improving outcomes through data-driven decisions-making. Below are examples of two such reports that can be used to help ensure the validity of the data.



### Data Quality Summary Report

#### Emergency Program



Data Element	Total Clients (n)	Don't Know / Refused	%	Missing	%
First Name	1028	0	0%	0	0%
Last Name	1028	0	0%	0	0%
SSN	1028	47	5%	2	0%
Date of Birth	1028	5	0%	2	0%
Race	1028	119	12%	1	0%
Ethnicity	1028	6	1%	1	0%
Gender	1028	1	0%	1	0%
Veteran Status	1004	32	3%	11	1%
Disabling Condition	1028	38	4%	13	1%
Prior Residence	1004	25	2%	11	1%
Prior Zip	1004	23	2%	0	0%
Housing Status-Entry	1028	6	1%	13	1%
Destination	944	462	49%	20	2%

## Chronic Homeless Status Audit

 Meets HUD Definition, not flagged as Chronic	 Does Not Meet HUD Definition, flagged as Chronic
--	--

Client Information			Data Derived Chronic Status				
#	First Name	Last Name	Marked as Chronic in HMIS	Flagged as Disabled?	Has a stay of 365+ consecutive days	Number of Stays	Meets the HUD Chronic Definition
1	Hoyt	Bond	Yes	Yes	No	1	No
2	Dara	Olson	No	Yes	Yes	1	Yes
3	Scarlet	Ochoa	No	Yes	No	2	No

### Additional Planning Tools

There are additional tools being made available through various resources to support communities working to address homelessness:

- **Gaps Analysis Tool** – this tool was developed by both the Veteran’s Administration and Community Solutions to help communities quantify the gaps in housing that must be filled in order to house all homeless veterans in a region
  - [Springfield’s Gaps Analysis Tool](#)
  - [Three County Gaps Analysis Tool](#)
- **Coordinated Assessment and Housing Placement (CAHP) Systems** – these systems are “a client-centered process that streamlines access to the most appropriate housing intervention for each individual or family experiencing homelessness”.
  - *Homelink* – this currently free tool is being used in Springfield to support their efforts as part of the Zero: 2016 initiative. The prioritization for housing in Homelink is largely driven off of client’s scoring on the VI-SPDAT assessment.
  - *Coordinated Housing Operations and Managed Placement System (CHOMPS)* – this CAHP system was developed by Simtech Solutions. CHOMPS is integrated with HMIS, the security model allows for participation by Veteran’s Administration (VA) staff, includes a housing match component to determine eligibility for housing, and it was developed in a manner that complies with the [Federal regulations for prioritizing homeless people for housing](#).
- [Vulnerability Index & Service Prioritization Decision Assistance Tool](#) (VI-SPDAT) – “is a pre-screening, or triage tool that is designed to be used by all providers within a community to quickly assess the health and social needs of homeless persons and match them with the most appropriate support and housing interventions that are available.”

[Supportive Housing Opportunities Planner](#) (SHOP) developed by the USICH to help “communities identify the specific set of strategies, such as increasing the prioritization of existing turnover units and creating new supportive housing, needed to achieve the goal (of ending chronic homelessness) in 2017 or earlier.”

