HOMELESS SYSTEM OF CARE ANALYSIS OF NEED 2022

QUANTITATIVE AND QUALITATIVE ANALYSIS

PREPARED FOR

Ozarks Alliance to End Homelessness

PREPARED BY

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SPONSORED BY: COMMUNITY FOUNDATION OF THE OZARKS

2022 HOMELESS SYSTEM OF CARE ANALYSIS OF NEED

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2022 HOMELESS SYSTEM OF CARE ANALYSIS OF NEED

HISTORY AND PURPOSE

The Springfield/Greene, Christian, and Webster Counties Continuum of Care (DBA Ozarks Alliance to End Homelessness - OAEH) continually seeks to identify gaps in services and duplications of effort in our community-wide goal of ending homelessness. Annually, the OAEH revises the action plan to ensure our system of care is addressing new and emerging needs of those who are homeless or at risk of becoming homeless, determine the capacity of our service providers to meet the demand, and ensure we have a collaborative system based on Housing First Principles utilizing a Coordinated Entry System.

In May of 2022, the OAEH partnered with the Community Foundation of the Ozarks to sponsor a Homeless Services System of Care Analysis of need. Through this partnership, the OAEH through Community Partnership of the Ozarks contracted with Julie McFarland Consultants (JMC) to conduct a Qualitative and Quantitative review of our system. A team made up of Julie McFarland, Maseta Dorley, and Christopher Andrews completed the following:

1. Quantitative Gaps Analysis - focused on sheltered and unsheltered data, Coordinated Entry System by-name list; HIC (homeless services utilization & bed number data). JMC completed a comparison of similarly sized and positioned Continua of Care and made recommendations based on this data to meet identified needs through research, analysis of data, and a report with recommendations.
2. Qualitative Data Collection - focus groups/discussions/data collection with people experiencing homelessness in the Springfield CoC jurisdiction. JMC conducted 16 focus groups made up of 182 individuals with lived experience. JMC also conducted a community survey to garner information regarding services needed.

The information collected through this study will be incorporated into the 10 Year Plan to End Homelessness and the City of Springfield's Consolidated Plan.

KEY CONCEPTS

The completion of the Homeless System of Care Analysis of Need will give guidance and direction for funding prioritization, program expansion, and system enhancements. To this end, the following key concepts are highlighted from recommendations included in the report and presentation from Julie McFarland Consultants (JMC).

- Expanded Affordable Housing Options: Increasing units and access to affordable housing for individuals with barriers to stability is key to both moving households from shelter and housing services to permanent housing, as well as providing diversion services aimed at those at risk of becoming homeless. This includes greatly expanding Housing Problem Solving Services (aka Shelter Diversion,) Risk Mitigation Funding, Shared Housing, and Respite Housing.

- Best Practice Community-based Supportive Services: Navigating the housing and homeless system is very challenging, especially when experiencing crisis and related trauma. There are critical gaps in access to support that should be prioritized for households experiencing long term homelessness to those at risk of homelessness, or experiencing a housing crisis. This includes Housing Problem Solving (Shelter Diversion), which provides case management, funding to obtain permanent housing, and direct referrals to stabilizing services like Medicaid, healthcare, mental healthcare, and employment.

- Purpose Driven Day Center: People experiencing unsheltered homelessness must have access to basic health, mental health, hygiene, and storage services to aid in obtaining employment, housing, and healthcare. The need is for a day center that focuses on providing showers and laundry (into early evening), locker storage, and low barrier access to health and mental health services. 'Purpose Driven' ensures individuals coming to a center are making progress (however small) toward accessing health, mental health, and housing resources and increased stability.

QUALITATIVE ANALYSIS SUMMARY

The following was provided by Julie McFarland Consultants:

Julie McFarland, Maseta Dorley, and Christopher Andrews were contracted by Community Partnership of the Ozarks as the technical assistance (TA) team conducting a community needs assessment to identify unmet housing, shelter, and service delivery needs and gaps within the homeless response system. The needs assessment focused on quantitative data already available within the community as well as qualitative data centering the human experience in accessing housing and service delivery systems. Information gathered is intended to be used to inform local planning efforts to best utilize available resources to improve housing and service outcomes for people experiencing homelessness. These recommendations offer priorities that may be elevated when future opportunities arise as well, beyond current funding and allocation decisions.

Within this process, the TA team elevated voices of people with recent lived experience with the Springfield area homeless response system, conducting 16 focus groups at 13 locations across the community, ultimately talking with 182 people who are unhoused or were recently unhoused. A survey captured additional partner input about funding priorities from a variety of community partners, and several national and local sources were analyzed to understand demographic and economic data as it relates to and impacts the response to people living unhoused in the three-county area.

Quantitative data related to housing, wages, and the Continuum of Care's (CoC) by-name list was analyzed and can be found separately as a supplement to this written report.

Summary: Similar to communities across the nation, Springfield is struggling to recover from the COVID-19 pandemic and economic losses that impacted many people who have long been on the verge of a housing crisis. Some people find themselves experiencing homelessness for the first time ever. Many people are experiencing homelessness for prolonged periods of time, and COVID-19 made it even more difficult to find housing and supportive services.

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The TA Team heard many powerful themes from people who are unhoused in the Springfield area, as well as from a variety of partners including housing and service providers. There are very clear and tangible opportunities to better support people who are unhoused, resulting in less trauma and hopelessness for those who are unhoused and a reduction in the number of people who are unhoused in the community.

It is undeniable that more affordable, market rate, and creative housing options must be made available to unhoused people. This will continue to be a primary community barrier until more housing is made available. Additional supportive housing resources are also needed to support people with housing and service needs, and a more in-depth research study is anticipated to provide specific estimates regarding these needs. Unless it is a non-congregate model, where people have private, secure space for themselves, additional emergency shelter is not wanted by unhoused people. Safe and affordable housing is what people want and need in order to begin to address additional goals in their life.

If a person is experiencing homelessness in the Springfield area, even if they are staying at a shelter, it is highly likely that they have to haul their personal belongings around all day, every day. Access to showers and laundry is extremely limited, and transportation is inaccessible for many people. In focus group after focus group, people said they have no chance of gaining employment when they show up unshowered, in unwashed clothes, with their bags in tow. In Springfield, it feels impossible to improve your situation when you're exhausted, unshowered, and hauling all of your personal possessions into the same place you are also trying to get a job. The same goes for obtaining housing - there is no chance a property manager will sign a lease with a person in this situation. The lack of ability to meet basic needs has led to widespread hopelessness among people who are unhoused, and has perpetuated a harmful stigma that exists in the community, preventing unhoused people from making progress.

If a person has an eviction or felony charge on their record, regardless of how long ago it occurred, the likelihood they will find housing in the Springfield area and exit their current housing crisis is slim to none. Landlords and property managers quickly and consistently deny people with evictions or felonies, and people then languish in shelter or on the streets. They have no chance to improve their situation.

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The Springfield area has the opportunity to invest in solutions that support people to meet basic needs - housing, laundry, showers, storage - and establish an infrastructure within the housing and service system that offers incentives to landlords to look beyond some barriers, matches people up with roommates when they're interested in sharing space, supports people with move-in costs that are otherwise prohibitive, and offers services that ensure people remain healthy and housed.

Without course corrections around meeting basic needs and increasing housing and supportive services, the number of unhoused people will continue to grow, emergency shelters will bust at the seams, and housing and service providers will inevitably burn out. Communities cannot continue to do the same thing, expecting different results. Springfield must join in the national movement to establish strong support infrastructures for people in a housing crisis and offer what's needed to exit an unhoused situation as quickly as possible.

It also must be stated that there is a well known divide amongst critical leaders in the community that is preventing community progress. The conflict must be addressed before silos can be broken down. Those involved in current conflict all bring critical strengths and brilliance to the table, and where this team could powerfully be working in partnership, they are divided and engaged in negative interactions, which is clearly hindering progress. This conflict is impacting unhoused people more than anyone else - it is resulting in multiple systems being established, a negative community narrative, impacts on system-wide data, and time and energy wasted on activities that do not contribute to progress or an improved homelessness response system.

The recommendations below establish priorities that - if prioritized and invested in - will support the Springfield area in moving the needle to get people off the streets and into safe and long term housing. All community members must be working in tandem in order to make meaningful progress around these priorities.

Efforts can be broken down into four categories, for planning and work group purposes:
1) Basic Needs, 2) Increasing Housing Options, 3) Supportive Services, and 4) Landlord Engagement.

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It is important to note several system strengths and highlights that arose in conversations with community partners before focusing on bottlenecks and gaps. (We are sure we missed a few people who were noted and want to apologize for misspellings or inaccurate agency listings.)

- Specific frontline staff were noted during focus groups as being compassionate and going the extra mile to support people in crisis:
    - Linda Hamer from Burrell Behavioral Health
    - Kendall from The Kitchen
    - Court Social Worker Carol Thompson
    - Gathering Friends: Whitney at Kaleidoscope
    - Christie Love from Connecting Grounds
    - Revive 66: Jenni working on Fridays
    - Heather at One Door
    - Welcoming volunteers at The Venues
    - Former staff of Bill's Place
    - Freeway: the Pastor
    - Michelle, Case Manager at Rancho Motel Shelter
    - Robyn and the current case worker at Safe to Sleep
- Creative, alternative models exist that people like (Eden Village, Revive 66)
- Innovative shelter models exist that people like (The Kitchen shelter, Harmony House)
- One Door is well advertised & known as the housing access site.
- Day centers exist that people like and want more hours/access (Connecting Grounds, Rare Breed, O'Reilly Center for Hope)
- Burrell Behavioral Health services are accessible and meet people in convenient ways (not just office-based - out in the community where people are located)

QUALITATIVE ANALYSIS SUMMARY

Bottlenecks, Gaps, and Recommendations

1. EXPAND HOUSING OPTIONS
2. BASIC NEEDS: Storage, Showers, Laundry, Restrooms
3. LANDLORD ENGAGEMENT & RECRUITMENT
4. SUPPORTIVE SERVICES
5. ELEVATE LIVED EXPERIENCE & EXPERTISE

All quotes are from focus groups conducted in June 2022

1. Expand Housing Options

"Somewhere [we] never have to leave – like Eden Village. Homeless people always have to leave."

- Where there is opportunity to add housing to your local stock, prioritize adding housing units. It is critical to add as many housing units as possible at this point in time. That applies to everything from affordable units, market-rate units dedicated to unhoused people, permanent supportive housing resources, and rental assistance programming.
- Additional housing options should be longer term, at least bridge or interim options (not 30-60 day limited stays), if not permanent options.

"I sleep in a tunnel because I'm not willing to sleep with a group of people because it's dangerous. I don't expect to wake up with my possessions still there. Can't sleep with one eye open. I don't have the preferred solutions, but there's a lack of options."

When asked what additional shelter and housing should look like in the Springfield area, unhoused people want private space where they are safe and personal belongings won't be stolen; where they know they can safely rest and begin the transition from survival mode to future thinking mode. This is not a night-by-night shelter but an option where people can leave their belongings 24/7 and know where they are staying for a period of time. They have a living and sleeping space and a kitchenette, at minimum. This is a trauma-informed model that is being expanded upon nationwide, leveraging federal funding resources as well as state and local funding sources.

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Unhoused people do not want more rooms with cots as shelter; that will not effectively support unsheltered people to move inside. With the exception of the cold weather shelter as an emergency, life-saving option, people are not interested in this type of shelter expansion. They are largely felt to be dehumanizing and unsafe. Any new shelter should focus on private, safe space for households, as they personally identify (families, couples, people with pets, single people, roommates who choose one another).

- These may be hotels, dormitory spaces, or buildings that can be converted to offer private living spaces and shared community spaces.
- It may be an expansion of the local Revive 66 model with longer term stay options and secure storage, or tiny homes as implemented with strong supportive services at Eden Village.
- Look also to The Kitchen Inc. Emergency Shelter local example, offering private apartments to individuals and families.
- Participants of focus groups repeatedly suggested utilizing some of the many "abandos" around town - the abandoned buildings that are centrally located and could help the community meet some of these goals if they were repurposed and used for services and housing.
- HOME ARP can be utilized to acquire and develop NCS for unhoused people.

When asked "What would it take for you to leave where you're at and move into permanent housing?" Participant: "Up front costs, good landlord, good area. All I want is a chance."

Move In costs are a significant barrier that result in people languishing long term in shelter, when a small amount of up-front assistance would have prevented an extended stay and additional trauma.

- Re-establish a robust "Housing Problem Solving" (Shelter Diversion) flexible fund and training program, offering ongoing problem-solving training (Ex: Ed Boyte, national trainer) and flexible assistance that can cover any cost associated with connection to safe housing. This may include expenses like application fees, deposit and first month's rent, and relocation (often transportation) costs to a safe housing option - anything needed that is directly connected to a safe housing option. This was previously established locally sometime around 2017 and needs a refresh and significant expansion. This resource should be flexible, promote creativity and choice, and be accessible to housing provider partners systemwide who are working with people as they are transitioning to safe housing opportunities.

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- National guidance and examples can be provided.
- Look to Supportive Services for Veterans and Their Families (SSVF) locally provided through The Kitchen, Inc. (and Catholic Charities).
- HOME ARP can be utilized to cover move-in and rental costs through Tenant-Based Rental Assistance.

1.a.Tenant Based Rental Assistance:

People are interested in living with friends or roommates, as long as it's their choice. This will also help very few rental options go further, housing more people in limited units. Establish a shared housing infrastructure that helps people match with others interested in shared living spaces identify housing opportunities together and offers ongoing support to mitigate conflict as it arises.

- Options should promote individual living space that locks (ex: a bedroom) and shared community space, which could occur within an apartment with multiple bedrooms as well as single family houses with multiple rooms (SHARE Self Help). This strategy has become a national trend as rentals have become more unaffordable and vacancy rates have reduced.

"People want to volunteer and do the work – sweat equity – for housing."
"A lot of us have skills, we want to build housing! We can be part of the solution."

Expansion of affordable housing options that provides a sweat equity program for eligible participants seeking housing. Example: Habitat for Humanity model in which the design and building of housing involves people who will eventually live there.

- Some people expressed strong interest in sweat equity models during focus groups and asked for opportunities to be part of the solution.
- Include supportive services on-site, within housing programs, including living and tenant skills to help keep the apartment unit. Participants shared experiences of agencies focusing on putting someone in housing, but not offering enough follow-up services to help them survive and keep housing. People asked for more programs, resources and connections to address issues that people experiencing homelessness are dealing with, including medical needs, mental illness and substance abuse.
- HOME ARP can be used to acquire, construct, and rehabilitate rental housing for people who are unhoused.

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2. Basic Needs**: Storage, Showers, Laundry, Restrooms**

"Great job with assessing and head counting all of us. I've been on the streets for 10 months and am never able to do laundry or shower because of the wait list."

"I've had 3 jobs since being homeless and been excused because I'm homeless. I smell - no shower, no laundry."

People who are unhoused need their very basic needs met to focus on employment, housing, and appointments. The Springfield area needs to establish:

- Scattered site storage lockers throughout the community that are secure and available to people 24/7. If necessary, start small and expand over time. Consider clustering storage lockers in smaller groups to limit neighborhood opposition.
- Shower and laundry access. Expand One Door shower and laundry access hours, and establish shower and laundry sites in diverse geographical locations.
- Faith communities may be a partner in this effort given their vast presence throughout the community. A mobile shower unit might be considered (see Denver example) and consistently offered on scheduled days and times at various locations.
- Restroom access throughout the community. One quick solution may be for churches to provide port-a-johns with volunteers assigned to be present, maintain, and sanitize every few hours.

Utilize these sites and opportunities to embed housing-focused services. All efforts should be connected to getting people housed. If service providers can connect with people as they come in for showers, laundry and storage access, it's an opportunity for housing-focused conversations, relationship building, and progress.

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Immediate Next Steps to Address Basic Needs

- Establish a working group focused on basic needs (showers, laundry, storage), inclusive of people who are unhoused.
- Assign working groups to lead the implementation effort for each recommendation. Identify where existing resources exist and are meeting needs, where they can be expanded - capacity & hours (ex: One Door, Rare Breed, churches hosting shelter), and where they need to be created entirely.
- Determine a projected timeframe for project completion.
- Establish an evaluation process for a pulse check on effectiveness, centering the experience of unhoused people. Focus on how you'll know if you're on target 3 months from now, 6 months from now, etc.

"Don't single out different groups – treat everyone the same. I'm a human being, don't treat me like an animal."

Focus groups illuminated how often people are treated as criminals because they do not have a place to sleep. The passing of House Bill 1606 has created elevated concern about the future of funding, and how people who live outside will be treated. The criminalization of homelessness refers to policies, laws, and local ordinances that make it illegal, difficult, or impossible for unsheltered people to engage in the normal everyday activities that most people carry out on a daily basis, or in activities that help make them safer. Springfield community discussions frequently mentioned House Bill 1606 and dire consequences for encampments or simply sitting in a public space while unhoused.

- Given the limited access to showers, restrooms, and drop in centers, individuals who are unhoused have very few options to complete simple activities of daily living throughout the day. Desperate, they may find a space to rest, or access a restroom, and they may be reported to police, which often leads to a fine (that cannot be paid, leading to warrants), and sometimes escalates to an arrest. People anticipate this only getting worse due to House Bill 1606.
- Unhoused people have many ideas and are clear on what they need - especially "safe space to rest." The community needs to organize around this issue, inclusive of unhoused people, and coordinate a response. Statewide, responses are beginning to take shape (some via MHDC) and Springfield should play an active role.

QUALITATIVE ANALYSIS SUMMARY

3. Landlord Engagement and Recruitment

"I'm 46 and got a felony at 17. It's haunting me. I separated from my family and baby because they could get help [housed] and I can't."

When asked "What would it take for you to leave where you're at and move into permanent housing?" Participant: "Understanding landlord that works with my unique situation with 5 kids who have ADHD and may cause damage, but we'll fix it. Just understanding and flexibility."

Landlords and property owners need to be engaged in solutions, with supportive services and incentives established to increase engagement. If a person has a background - an eviction, criminal history, poor credit - regardless of how long ago an incident occurred, they have essentially zero chance of renting a unit in the Springfield area. This is a primary source of bottleneck within the community, coupled with a lack of affordable units. In every focus group conducted, evictions, felonies, and poor credit were cited as a barrier by more than half of unhoused participants.

- Establish a Landlord Liaison Project strategy that includes supportive services for landlords as challenges arise, incentives for leasing with a person formerly experiencing homelessness, and a risk mitigation fund that offers assurance and damage coverage should property damage occur.
- Begin to build communication and relationship between the homeless response system and landlords, and include landlords and property managers in project design to ensure the approach meets their needs.
- Look to Omaha, Nebraska's Metro Housing Collaborative, Seattle / King County's Housing Connector as strong examples.

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4. Supportive Services

"Give a person…services too, on an individual basis. We all have different needs. Budget my money, help me get a job, figure out my benefits."

When asked "What would it take for you to leave where you're at and move into permanent housing?" Participant: "…we get a voucher and it's impossible to find a house. Housing search assistance."

People have no options to get housing search support unless they are connected with a program like Rancho Motel or Safe to Sleep. People cannot find available units, do not have support with landlord conversations or negotiation, and struggle with transportation to get to units for viewings and lease signing. Focus group participants frequently cited the One Door housing resource packet, and for most people it is either outdated or not applicable because of background barriers. It sends people on a "goose chase," often times with no outcomes except wasted time and broken trust.

- Develop a skilled and robust team of Housing Navigators available to people in the housing search process, and closely connected to the Landlord Liaison Project incentives.
- Make these housing-focused services available within all basic needs resources (ex: storage, laundry, showers), so connections can be made with people as they access those resources.

"…be able to get services and charge my phone – I needed that for a week and it would have meant the world to me."

Establish safe space for those who are unhoused to congregate during daytime hours and on weekends through a 7-day per week day program, with housing-focused services embedded.

- A 7-day/week program options that provide a "one-stop shop" for services for unhoused people, especially since most shelters close early in the morning.
- An expansion of what is being provided during limited hours at Connecting Grounds and O'Reilly Center for Hope is critical - people cite these as helpful options but needing expansion (hours and days). Multiple geographic locations are necessary, or shuttles to sites given transportation barriers.

QUALITATIVE ANALYSIS SUMMARY

- Basic needs and housing-focus services should include but not be limited to:
  - Supportive services: mental and medical health, substance abuse support, financial counseling, life skills, tenant education, job support all on-site.
  - Showers, storage, laundry, restrooms.
  - Housing-focused services: housing problem solving, navigation, housing search.
  - Clean clothes for job interviews.
  - Residential address to get jobs and for housing applications (not recognizable government/agency address nor PO Box).
  - Wi-fi access and public outlets to charge phone.
  - Place to go in the daytime for rest (3 ordinances were cited as being recently passed that would result in a misdemeanor or ticket fine).
  - Working/recreational space that people can go to and not be bothered.

5. Elevate Lived Experience

People who have lived experience of homelessness are experts and are needed at every table, from decision making to design to implementation to systems improvement.

- Establish a **Lived Experience Council** with equitable representation, mirroring people experiencing homelessness locally. This should be a diverse group consisting of people with current or fairly recent experience of homelessness.
  - Establish authentic engagement with the Lived Experience Council: Create a working partnership between individuals and providers to inform policy development and improve the services provided.
  - Identify opportunities for people with lived experience to move into decision-making roles, strategic planning, and evaluation.
  - Embed and include this Council in all CoC activities. Communities who have made system changing progress in this area include Austin, Seattle, Chicago, and Boston.
- There must be intentionality within homeless response system efforts to ensure the work is led with equity, which means making space for more diversity and perspectives at every table. Diversity is inclusive of race, ethnicity, exp
- Consider filling roles with front line staff and people w
  Diversity in roles and perspectives is needed at deci
  boards, projects, and committees, and in design, impleme

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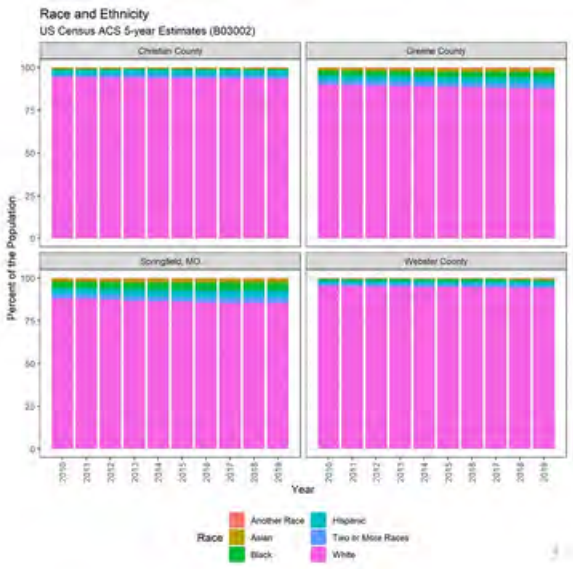
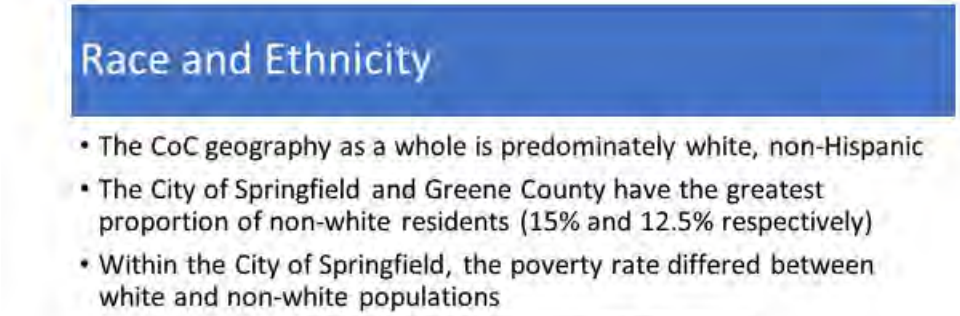
QUANTITATIVE ANALYSIS SUMMARY

Introduction

This report provides an overview of demographic, socioeconomic, and housing data points that may be used to inform and evaluate the needs of low-income households and households at-risk of experiencing homelessness. The report primarily uses data collected through the American Community Survey (ACS), Comprehensive Housing Affordability Strategy (CHAS), and locally collected and reported homeless data.

Demographic and Socioeconomic Data: Race and Ethnicity





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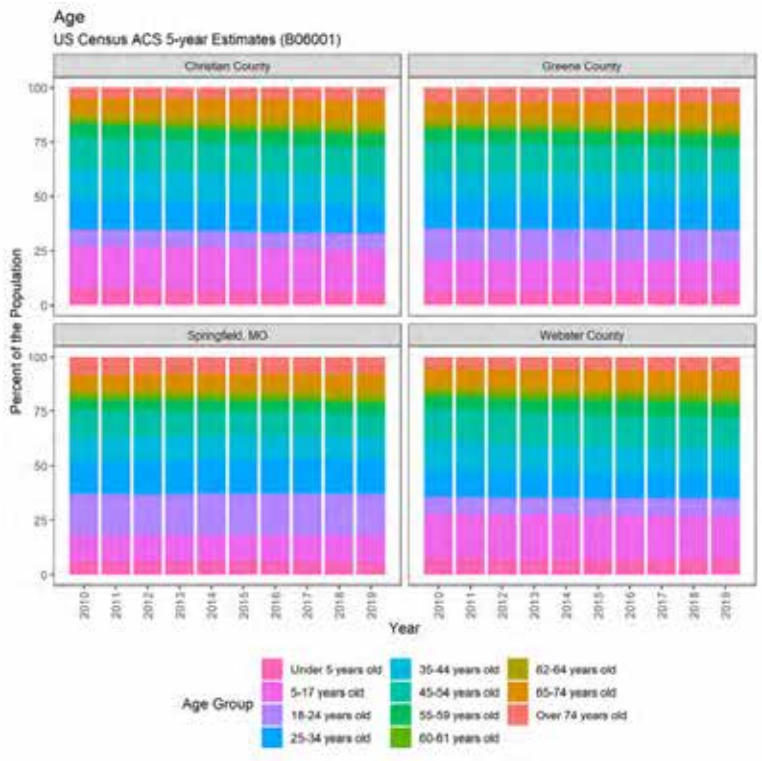
Demographic and Socioeconomic Data: Age

Age



Age

- Median age in 2019 ranges from 33.1 years old (Springfield) to 37.9 years old (Christian County)
- Age distribution has shifted minimally in the past 10 years
- Greatest share of young people under the age of 24 and individuals over the age of 65 are in Greene County

QUANTITATIVE ANALYSIS SUMMARY

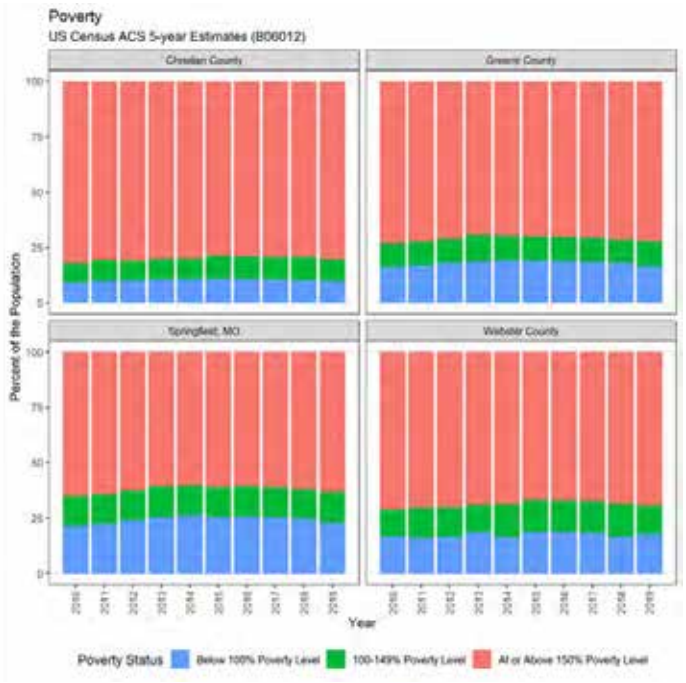
Demographic and Socioeconomic Data: Age

Place	% 65+	% 65+ below Poverty Level	%65+ with Disability	% 65+ Living Alone
Springfield, MO	15.7%	12.3%	41.0%	56.2%
Greene County	16.1%	9.3%	36.5%	48.4%
Christian County	15.2%	7.9%	36.3%	39.5%
Webster County	15.5%	10.8%	40.3%	Data not available

QUANTITATIVE ANALYSIS SUMMARY

Demographic and Socioeconomic Data: Poverty

Poverty Rate



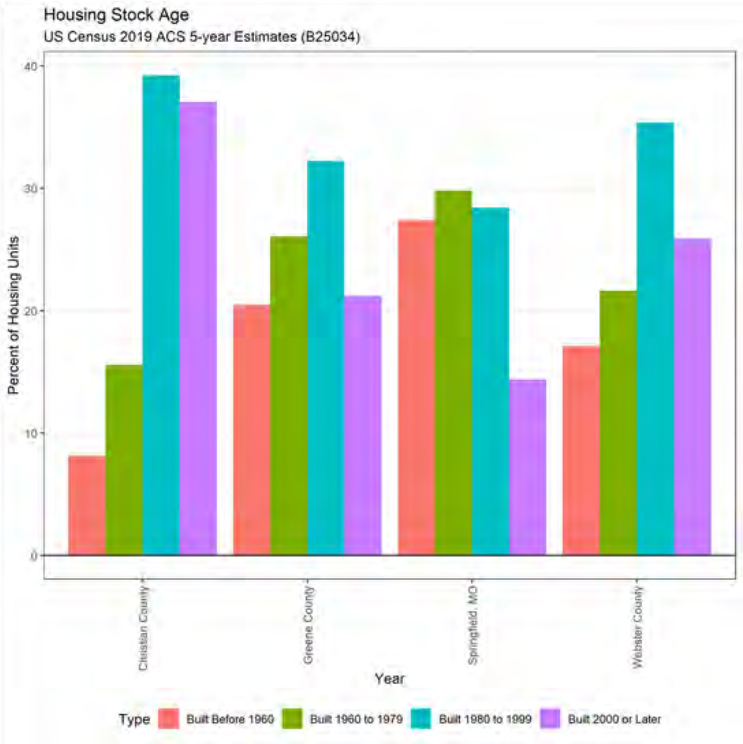
Poverty Rate

- Poverty levels in Springfield and Webster County are the highest within the CoC geography
- Poverty levels have increased slightly in the past ten years – increasing by approximately 1 percentage point in each jurisdiction
- Christian County has the highest share of residents living at or above 150% of the poverty level – though that share has decreased by 2 percentage points in the past ten years

QUANTITATIVE ANALYSIS SUMMARY

Housing Data

Age of Housing



Housing Type

Place	Single Family	2 to 4 Units	5 to 9 Units	10+ Units	Mobile Home/Boat/RV, etc.
Springfield, MO	64.88	6.79	4.97	20.85	2.5
Greene County	73.04	5.47	3.62	14.42	3.46
Christian County	82.66	6	2.13	3.74	5.47
Webster County	79.82	5.14	1.21	2.55	11.28

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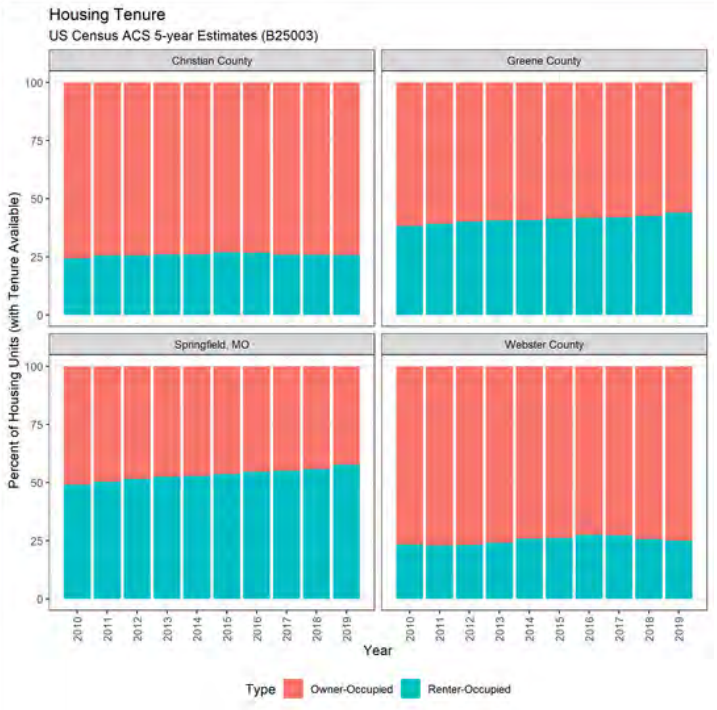
Housing Data

Housing Tenure



Housing Supply

- Housing units in Christian and Webster Counties are relatively new (76% and 61% respectively)
- More than half (57%) of the housing units in Springfield were built before 1980 and may be at risk of lead-based paint
- More than 11% of housing units in Webster County are mobile homes, boats or RVs
- Outside of Springfield, the vast majority of units are single family properties with minimal multi-family housing units
- All jurisdictions have experienced a slight increase in renter units in the past 10 years – most pronounced in Springfield (~16% increase)

QUANTITATIVE ANALYSIS SUMMARY

Housing Data

Unit Size	Fair Market Rent	FMR Housing Wage & (Work Hours)	Median Rent (6/11/22)	Median Rent Housing Wage & (Work Hours)
0 Bedrooms	$591	$11.37 (44)	$683	$13.13 (51)
1 Bedroom	$595	$11.44 (44)	$750	$14.42 (56)
2 Bedroom	$760	$14.62 (57)	$1,000	$19.23 (75)
3 Bedroom	$1,088	$20.92 (81)	$1,350	$25.96 (101)
4 Bedroom	$1,241	$23.87 (93)	$1,500	$28.85 (112)

National Low-Income Housing Coalition Out of Reach 2021 Report
Median Rent 6/1/22 from www.zumper.com (rental cost aggregator)
Housing Wage = minimum wage required to afford rental unit
Work Hours @ Min. Wage = total number of hours required to afford a unit earning minimum wage ($10.30)

Occupation	Total Employment	Median Hourly Wage
Waiters	43,900	$10.05
Fast Food and Counter Workers	61,030	$11.26
Cashiers	68,040	$11.40
Home Health Aides	73,510	$11.73
Retail	72,760	$12.52
Nursing Assistants	34,880	$12.79
Janitors and Cleaners	37,600	$13.45
1-Bedroom Housing Wage (Median Rent)		$14.42
Office Clerks	62,500	$16.31
Customer Service Reps	51,040	$17.25
2-bedroom Housing Wage (Median Rent)		$19.23
Secondary School Teachers	30,850	$22.33
Tractor Trailer Drivers	42,450	$23.20
3-Bedroom Housing Wage (Median Rent)		$25.96
Registered Nurses	71,560	$31.67

National Low-Income Housing Coalition Out of Reach 2021 Report (Occupation data)
Median Rent 6/1/22 from www.zumper.com (rental cost aggregator)
Housing Wage = minimum wage required to afford rental unit

QUANTITATIVE ANALYSIS SUMMARY

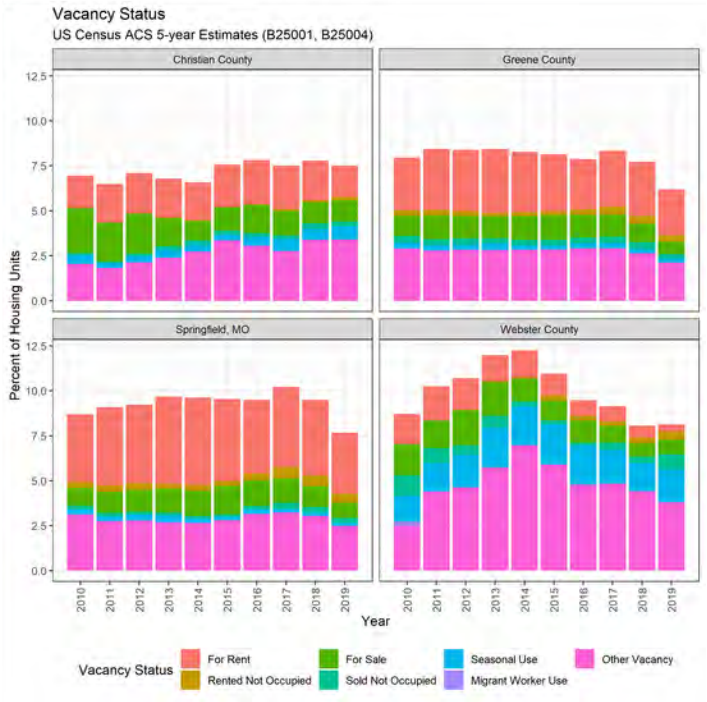
Housing Data

Housing Cost Burden

Place	0-30% Cost Burden	30-50% Cost Burden	>50% Cost Burden	Not Available	% Cost Burdened	Total
Springfield, MO	47,205	11,965	12,580	1,905	33%	73,665
Greene County	85,380	17,680	16,780	2,190	28%	122,025
Christian County	23,520	4,730	2,470	380	23%	31,095
Webster County	10,485	1,895	1,029	109	22%	13,495

CHAS Estimates 2018 5-year Estimates
Housing Cost Burden occurs when a household pays more than 30% of their income to housing costs

Vacancy Rate



QUANTITATIVE ANALYSIS SUMMARY

Housing Data

Housing Demand

- As of June 2022, median rents in Springfield are trending ~$200 more than Fair Market Rents (FMR)
- Rental costs and associated costs are expected to continue to rise due to inflation
- Using FMR as a guide, housing continues to be out of reach for low- and moderate-income households in the metropolitan area; to afford a 2-bedroom unit, an individual would need to work 57 hours at minimum wage ($10.30)
- 1/3 of households in Springfield experience some level of cost burden and between 1/4 and 1/5 of households experience cost burden in Greene, Christian and Webster Counties
- Vacancy rates across all four jurisdictions is generally around 7.5%

QUANTITATIVE ANALYSIS SUMMARY

Homeless System Data

Point in Time (PIT) Count

	2012	2015	2020
Sheltered	**320**	**231**	**352**
Adults Only	243	149	286
Households with Children/Adults	75	77	54
Children Only	2	5	12
Unsheltered	**146**	**175**	**80**
Adults Only	140	171	80
Households with Children/Adults	6	0	0
Children Only	0	4	0

Housing Inventory Count

	2012	2015	2020
Emergency Shelter	197	390	404
Seasonal Shelter	80	0	124
Transitional Housing	422	146	42
Permanent Supportive Housing	103	106	168

QUANTITATIVE ANALYSIS SUMMARY

Homeless System Data

Initial/ Early Recommendations

- To the extent possible, wait for qualitative data collection to make final allocation/spending decisions
- Increase supply of permanent housing for low and moderate income households
- Increase supply of permanent housing with support networks tailored to current homeless and at-risk populations
- Enhance supportive services primarily targeted to those in emergency shelter
- Invest in shared housing options given current occupancy rates

Thoughts/Questions for Discussion

- (Slide 4) High poverty rate among Asian people stands out compared to other communities; other disparities track due to systemic racism
- (Slide 12) Mobile Home (Webster County) / CDBG - in California - have found rising level of at-risk populations in mobile home - used CDBG funding to pay lot lease and utilities
- (Slide 17) Webster County "other vacancies" - what might this be?
- (Slide 18) 7.5% vacancy rate across CoC jurisdictions
    - Shared Housing
- (Slide 21) Shifts from 2012 to 2020 - sheltered data has remained consistent (PH decreased); unsheltered data has decreased (ES increased). Did community focus on decreasing unsheltered? Coincidence?

ATTACHMENT
INSTITUTE FOR COMMUNITY ALLIANCES
CONTINUUM OF CARE
SYSTEM PERFORMANCE MEASURES

FY2021 - Performance Measurement Module (Sys PM)

Summary Report for MO-600 - Springfield/Greene, Christian, Webster Counties CoC

Measure 1: Length of Time Persons Remain Homeless

This measures the number of clients active in the report date range across ES, SH (Metric 1.1) and then ES, SH and TH (Metric 1.2) along with their average and median length of time homeless. This includes time homeless during the report date range as well as prior to the report start date, going back no further than October, 1, 2012.

Metric 1.1: Change in the average and median length of time persons are homeless in ES and SH projects.
Metric 1.2: Change in the average and median length of time persons are homeless in ES, SH, and TH projects.

a. This measure is of the client's entry, exit, and bed night dates strictly as entered in the HMIS system.

	Universe (Persons)		Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Revised FY 2020	FY 2021	Submitted FY 2020	Revised FY 2020	FY 2021	Difference	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
1.1 Persons in ES and SH	1012	1279	47	44	60	16	25	24	30	6
1.2 Persons in ES, SH, and TH	1147	1401	60	56	70	14	28	26	33	7

b. This measure is based on data element 3.17.

This measure includes data from each client's Living Situation (Data Standards element 3.917) response as well as time spent in permanent housing projects between Project Start and Housing Move-In. This information is added to the client's entry date, effectively extending the client's entry date backward in time. This "adjusted entry date" is then used in the calculations just as if it were the client's actual entry date.

FY2021 - Performance Measurement Module (Sys PM)

	Universe (Persons)		Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Revised FY 2020	FY 2021	Submitted FY 2020	Revised FY 2020	FY 2021	Difference	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
1.1 Persons in ES, SH, and PH (prior to "housing move in")	1271	1485	422	405	475	70	137	135	153	18
1.2 Persons in ES, SH, TH, and PH (prior to "housing move in")	1555	1802	424	407	476	69	134	140	160	20

FY2021 - Performance Measurement Module (Sys PM)

Measure 2: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness

This measures clients who exited SO, ES, TH, SH or PH to a permanent housing destination in the date range two years prior to the report date range.Of those clients, the measure reports on how many of them returned to homelessness as indicated in the HMIS for up to two years after their initial exit.

	Total # of Persons who Exited to a Permanent Housing Destination (2 Years Prior)		Returns to Homelessness in Less than 6 Months			Returns to Homelessness from 6 to 12 Months			Returns to Homelessness from 13 to 24 Months			Number of Returns in 2 Years	
	Revised FY 2020	FY 2021	Revised FY 2020	FY 2021	% of Returns	Revised FY 2020	FY 2021	% of Returns	Revised FY 2020	FY 2021	% of Returns	FY 2021	% of Returns
Exit was from SO	11	15	2	4	27%	2	0	0%	0	1	7%	5	33%
Exit was from ES	177	169	23	27	16%	11	5	3%	11	9	5%	41	24%
Exit was from TH	88	68	1	1	1%	1	0	0%	1	1	1%	2	3%
Exit was from SH	0	0	0	0		0	0		0	0		0	
Exit was from PH	169	177	4	11	6%	2	3	2%	5	8	5%	22	12%
TOTAL Returns to Homelessness	445	429	30	43	10%	16	8	2%	17	19	4%	70	16%

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts

FY2021 - Performance Measurement Module (Sys PM)

This measures the change in PIT counts of sheltered and unsheltered homeless person as reported on the PIT (not from HMIS).

	January 2020 PIT Count	January 2021 PIT Count	Difference
Universe: Total PIT Count of sheltered and unsheltered persons	540	583	43
Emergency Shelter Total	414	479	65
Safe Haven Total	0	0	0
Transitional Housing Total	38	38	0
Total Sheltered Count	452	517	65
Unsheltered Count	88	66	-22

Metric 3.2 – Change in Annual Counts

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

	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
Universe: Unduplicated Total sheltered homeless persons	699	1168	1419	251
Emergency Shelter Total	561	1034	1295	261
Safe Haven Total	0	0	0	0
Transitional Housing Total	150	151	141	-10

FY2021 - Performance Measurement Module (Sys PM)

Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

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

	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
Universe: Number of adults (system stayers)	70	65	74	9
Number of adults with increased earned income	2	4	10	6
Percentage of adults who increased earned income	3%	6%	14%	8%

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

	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
Universe: Number of adults (system stayers)	70	65	74	9
Number of adults with increased non-employment cash income	16	19	26	7
Percentage of adults who increased non-employment cash income	23%	29%	35%	6%

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

	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
Universe: Number of adults (system stayers)	70	65	74	9
Number of adults with increased total income	18	22	32	10
Percentage of adults who increased total income	26%	34%	43%	9%

FY2021 - Performance Measurement Module (Sys PM)

Metric 4.4 – Change in earned income for adult system leavers

	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
Universe: Number of adults who exited (system leavers)	65	67	59	-8
Number of adults who exited with increased earned income	6	8	7	-1
Percentage of adults who increased earned income	9%	12%	12%	0%

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

	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
Universe: Number of adults who exited (system leavers)	65	67	59	-8
Number of adults who exited with increased non-employment cash income	12	13	12	-1
Percentage of adults who increased non-employment cash income	18%	19%	20%	1%

Metric 4.6 – Change in total income for adult system leavers

	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
Universe: Number of adults who exited (system leavers)	65	67	59	-8
Number of adults who exited with increased total income	17	20	18	-2
Percentage of adults who increased total income	26%	30%	31%	1%

FY2021 - Performance Measurement Module (Sys PM)

Measure 5: Number of persons who become homeless for the 1st time

Metric 5.1 – Change in the number of persons entering ES, SH, and TH projects with no prior enrollments in HMIS

	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
Universe: Person with entries into ES, SH or TH during the reporting period.	600	1024	1294	270
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	125	170	173	3
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)	475	854	1121	267

Metric 5.2 – Change in the number of persons entering ES, SH, TH, and PH projects with no prior enrollments in HMIS

	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
Universe: Person with entries into ES, SH, TH or PH during the reporting period.	860	1264	1494	230
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	187	231	205	-26
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.)	673	1033	1289	256

FY2021 - Performance Measurement Module (Sys PM)

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

This Measure is not applicable to CoCs in FY2021 (Oct 1, 2020 - Sept 30, 2021) reporting period.

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

	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
Universe: Persons who exit Street Outreach	214	219	361	142
Of persons above, those who exited to temporary & some institutional destinations	15	15	30	15
Of the persons above, those who exited to permanent housing destinations	20	20	27	7
% Successful exits	16%	16%	16%	0%

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

FY2021 - Performance Measurement Module (Sys PM)

	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
Universe: Persons in ES, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing	754	1189	1432	243
Of the persons above, those who exited to permanent housing destinations	318	355	476	121
% Successful exits	42%	30%	33%	3%

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

	Submitted FY 2020	Revised FY 2020	FY 2021	Difference
Universe: Persons in all PH projects except PH-RRH	119	116	106	-10
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	108	106	97	-9
% Successful exits/retention	91%	91%	92%	1%

FY2021 - SysPM Data Quality

MO-600 - Springfield/Greene, Christian, Webster Counties CoC

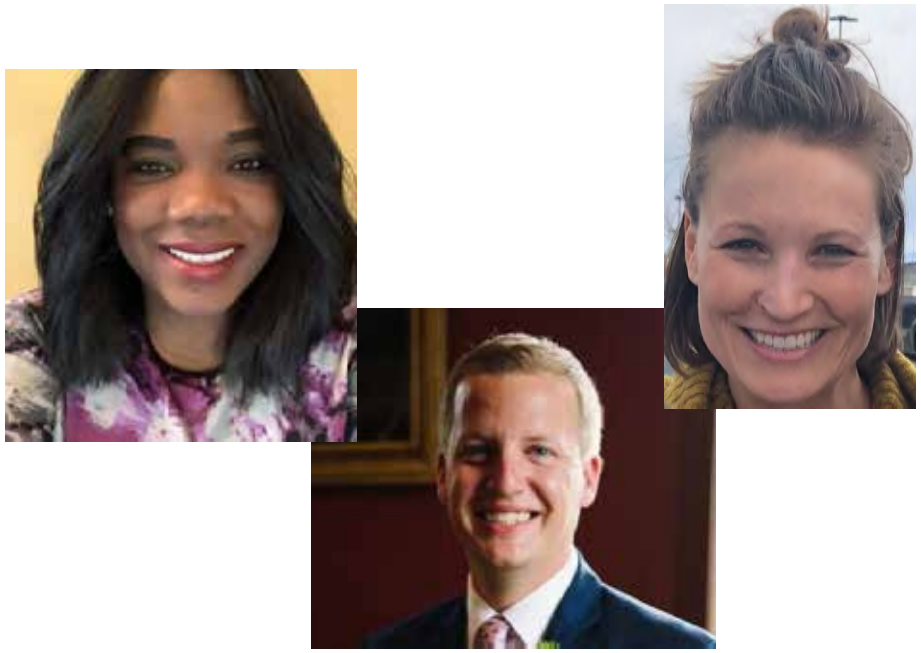
	All ES, SH			All TH			All PSH, OPH			All RRH			All Street Outreach		
	Submitted FY2019	Submitted FY2020	FY2021	Submitted FY2019	Submitted FY2020	FY2021	Submitted FY2019	Submitted FY2020	FY2021	Submitted FY2019	Submitted FY2020	FY2021	Submitted FY2019	Submitted FY2020	FY2021
1. Number of non-DV Beds on HIC	190	179	372	42	42	42	157	168	183	155	142	222			
2. Number of HMIS Beds	169	166	346	42	42	42	121	98	91	155	142	222			
3. HMIS Participation Rate from HIC (%)	88.95	92.74	93.01	100.00	100.00	100.00	77.07	58.33	49.73	100.00	100.00	100.00			
4. Unduplicated Persons Served (HMIS)	944	1034	1297	181	151	143	136	142	115	420	460	560	181	294	432
5. Total Leavers (HMIS)	830	946	1168	140	121	116	36	42	27	214	223	342	146	236	376
6. Destination of Don't Know, Refused, or Missing (HMIS)	158	253	181	0	2	12	0	7	2	19	7	4	19	103	58
7. Destination Error Rate (%)	19.04	26.74	15.50	0.00	1.65	10.34	0.00	16.67	7.41	8.88	3.14	1.17	13.01	43.64	15.43

ATTACHMENT
JULIE MCFARLAND CONSULTANTS
COMMUNITY PRESENTATION SLIDES

Springfield, MO Area CoC
City Council Presentation

July 26, 2022

Project Team



Maseta Dorley, MDM Global Consulting, LLC

Julie McFarland, Julie McFarland Consulting, LLC

Chris Andrews, Mountain Top Consulting, LLC

Key Questions of this Needs Analysis

- When it comes to homeless response, what are the greatest needs of the Springfield area community/CoC?
- What types of resources would people experiencing homelessness access that don't currently exist, or lack capacity to meet demand?
- What do people experiencing homelessness locally have to say about the above questions?
- How does the Springfield area community compare to similar communities when it comes to homelessness response?

Before We Move to Needs…

A few highlights on system strengths:

- Specific frontline staff were noted during focus groups as being compassionate and going the extra mile to support people in crisis
- Creative, alternative models exist that people like (Eden Village, Revive 66)
- Innovative shelter models exist that people like (The Kitchen shelter, Harmony House)
- One Door is well advertised & known as *the* housing access site
- Day centers exist that people like and want more hours/access (Connecting Grounds, Rare Breed, O'Reilly Center for Hope)
- Burrell behavioral health services are accessible and meet people in convenient ways (not just office-based)

Methodology

Quantitative Data Analysis

Analysis focused on housing needs and risk of homelessness and a comparison of similarly sized and positioned CoCs to understand how other CoCs are meeting needs.

Focus Groups

182 people experiencing homelessness were engaged in conversations about their experiences and what types of resources they would like to see prioritized within the Springfield area CoC. 13 sites hosted 16 focus groups and people were compensated $25 for participating.

Community Survey

Partners working within the homelessness response system were asked for input on questions about system strengths, gaps, and priorities.

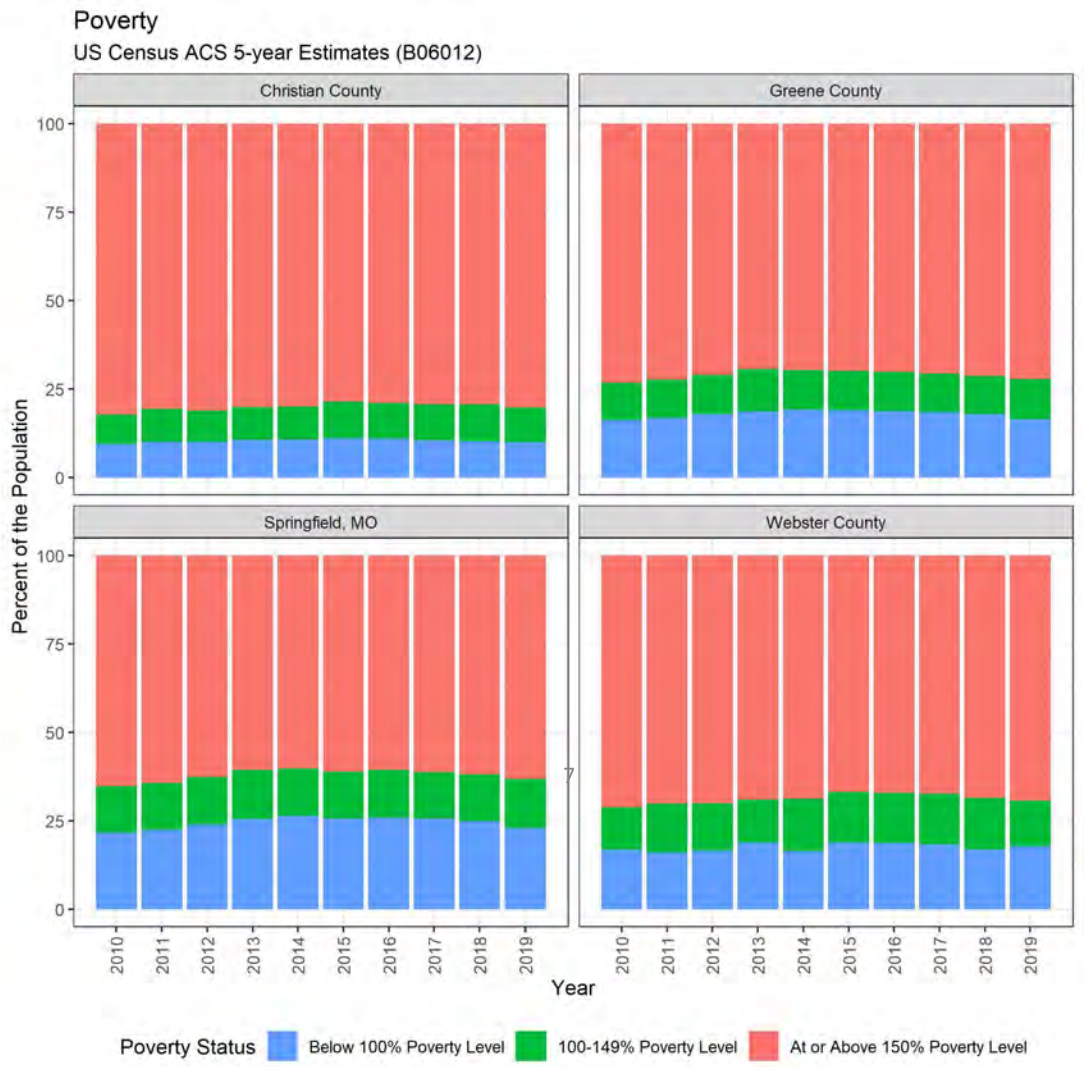
Quantitative Data

Data collected through the American Community Survey (ACS), Comprehensive Housing Affordability Strategy (CHAS), and locally collected and reported homeless data

Overarching Themes

- Approximately ⅓ of Springfield households are living at or below 150% of poverty level
- ⅓ of households in Springfield are cost burdened
- An individual would need to work 75 hours/week @ minimum wage in order to afford median two bedroom apartment

Poverty Rate



Cost of Housing

Unit Size	Fair Market Rent	FMR Housing Wage & (Work Hours)	Median Rent (6/11/22)	Median Rent Housing Wage & (Work Hours)
0 Bedrooms	$591	$11.37 (44)	$683	$13.13 (51)
1 Bedroom	$595	$11.44 (44)	$750	$14.42 (56)
2 Bedroom	$760	$14.62 (57)	$1,000	$19.23 (75)
3 Bedroom	$1,088	$20.92 (81)	$1,350	$25.96 (101)
4 Bedroom	$1,241	$23.87 (93)	$1,500	$28.85 (112)

National Low-Income Housing Coalition Out of Reach 2021 Report
Median Rent 6/1/22 from www.zumper.com (rental cost aggregator)
Housing Wage = minimum wage required to afford rental unit
Work Hours @ Min. Wage = total number of hours required to afford a unit earning minimum wage ($10.30)

Cost of Housing

Occupation	Total Employed	Median Hourly Wage
Waiters	43,900	$10.05
Fast Food and Counter Workers	61,030	$11.26
Cashiers	68,040	$11.40
Home Health Aides	73,510	$11.73
Retail	72,760	$12.52
Nursing Assistants	34,880	$12.79
Janitors and Cleaners	37,600	$13.45
1-Bedroom Housing Wage (Median Rent)		$14.42
Office Clerks	62,500	$16.31
Customer Service Reps	51,040	$17.25
2-bedroom Housing Wage (Median Rent)		$19.23
Secondary School Teachers	30,850	$22.33
Tractor Trailer Drivers	42,450	$23.20
3-Bedroom Housing Wage (Median Rent)		$25.96
Registered Nurses	71,560	$31.67

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Webster County	10,485	1,895	1,029	109	22%	13,495

CHAS Estimates 2018 5-year Estimates
Housing Cost Burden occurs when a household pays more than 30% of their income to housing costs

Qualitative Data

16 Focus Groups over 2.5 days ; 182 participants

Focus Group Locations

- O'Reilly Center for Hope
- Rancho Motel *(Catholic Charities of Southern Missouri)*
- Vets Coming Home (3)
- The Kitchen Inc. Rare Breed *(Youth Center)*
- The Salvation Army Harbor House
- Harmony House *(domestic violence shelter)*
- Eden Village
- Meal Sites:
  - Grace United Methodist
  - The Venues Downtown (2)
- Victory Mission
- Safe to Sleep
- Revive 66 *(The Gathering Tree and Eden Village)*
- The Kitchen, Inc. Shelter *(micro sites)*

Bottlenecks & Gaps

1. Expand Affordable Housing Options
2. Landlord Engagement & Recruitment
3. Meet Basic Needs
4. Supportive Services
    - Daytime Space, Housing Problem Solving, Housing Navigation, Housing Retention
5. Lived Experience Council

Expand Affordable Housing Options

- **Interest in creative and alternative solutions -** shared housing, tiny homes with services, larger houses for multiple people wanting to live in community together - as long as people have their own individual space that locks, and sweat equity opportunities.

Landlord Engagement & Recruitment

- **Community Campaign** focused on stigma + need
- **Incentives** (ex: Lease Up Bonus, Retention Bonus, Risk Mitigation Fund)
- **Shared Housing Options** including matching services and conflict resolution

BASIC NEEDS: Shower, Storage, Laundry, Restrooms

- **Scattered site storage lockers** throughout the community that are secure and available to people 24/7
- **Shower, bathroom and laundry access.** Expand One Door shower and laundry access hours, and establish shower and laundry sites in diverse geographical locations.

Supportive Services

Daytime Space

- **Safe space for unhoused people to utilize during daytime hours and on weekends,** including supportive services like mental & medical health, employment support, life skills, and showers, storage, restroom, mail, wi-fi access, phone outlets

Systemwide Housing Problem Solving

- **Supportive Services** to identify safe housing alternatives
- **Training and ongoing space** for staff to be continuously supported and effective in this creative approach
- **Robust flexible funds to cover anything related to a housing resolution**; this is more cost effective than long shelter stays and/or continued engagement multiple crisis systems (hospitals, EMTs, police)

Supportive Services

Housing Navigation – from housing search to move in

- **Housing Navigation Team** supports the housing search process with people who are unhoused. Services should last until a person moves in. Navigator team should be inclusive of people with lived experience.
- **Flexible Funds** to cover application fees, move in costs
- Navigation team needs to be in the field (ex: shelters, outreach) like Burrell
- **Housing retention services** to ensure people who are housed can stay housed

Establish A Lived Experience Council

- **Equitable representation mirroring people experiencing homelessness locally:** A diverse group consisting of people with current or fairly recent experience of homelessness

- **Establish authentic engagement:** create a working partnership between individuals and providers to inform policy development and improve the services provided

- Identify opportunities for people with lived experience to move into **decision-making roles, strategic planning and evaluation.**

CoC-specific recommendations for the next year

- Debrief your NOFA
- Analyze your BNL and update quarterly so you have live data that's better than PIT to base decisions
- Evaluate who you have $$ committed to for RRH over next few years, and start to peel that $$ back and put it into PSH. Utilize HOME ARP to invest in rental assistance with supports.

THANK YOU!

ATTACHMENT
JULIE MCFARLAND CONSULTANTS
CONTINUUM OF CARE
COMPARABLE COMMUNITIES

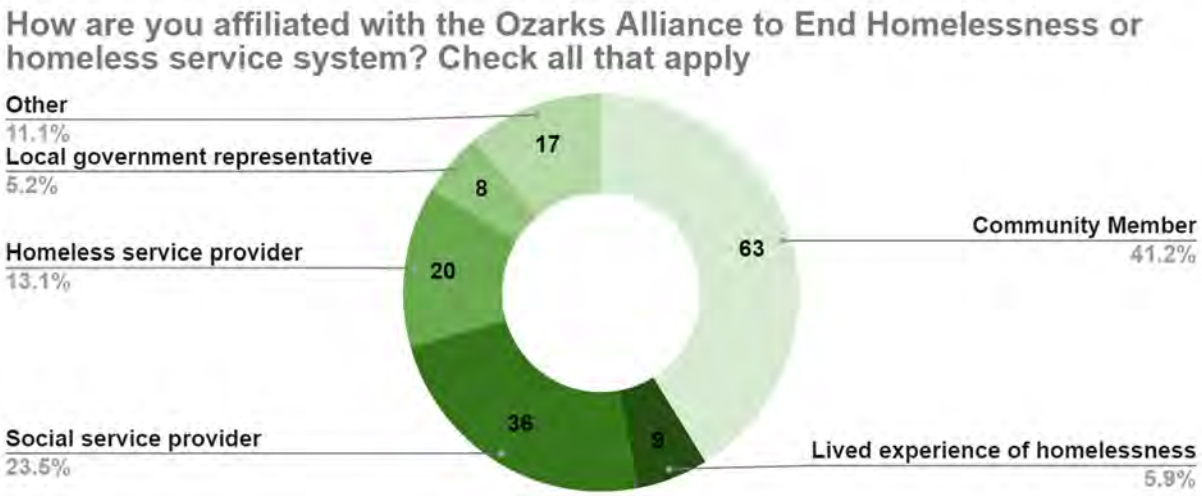
			Permanent Supportive Housing		RRH (Permanent)	
Similar Sized Cities	CoC Number	Total CoC Award	PSH $ Amount	PSH % Share	RRH (P) $ Amount	RRH (P) % Share
Springfield, MO	MO-600	*$ 1,204,821*	*$ 435,620*	*36%*	*$ 516,195*	*43%*
Salt Lake, City, UT	UT-500	$ 9,778,026	$ 8,495,733	87%	$ 626,515	6%
Grand Rapids, MI	MI-506	$ 7,593,643	$ 3,453,314	45%	$ 1,092,009	14%
Knoxville, TN	TN-502	$ 1,474,219	$ 711,800	48%	$ 371,025	25%
Mobile, AL	AL-501	$ 4,056,865	$ 2,457,527	61%	$ 370,706	9%
Fort Lauderdale, FL	FL-601	$ 12,121,768	$ 10,195,897	84%	$ 569,696	5%
Aurora, IL	IL-517	$ 2,336,609	$ 1,716,215	73%	$ 447,658	19%
Eugene, OR	OR-500	$ 4,135,613	$ 2,828,863	68%	$ 1,052,702	25%
Akron, OH	OH-506	$ 5,767,496	$ 2,595,901	45%	$ 1,104,451	19%
Santa Rosa, CA	CA-504	$ 4,162,516	$ 3,017,499	72%	$ 347,971	8%
Springfield, MA	MA-504	$ 6,470,022	$ 3,027,978	47%	$ 1,355,183	21%
Savannah, GA	GA-507	$ 3,563,992	$ 3,013,142	85%	$ -	0%
Syracuse, NY	NY-505	$ 11,386,529	$ 7,962,071	70%	$ 2,088,710	18%
Salem, OR	OR-504	$ 1,270,807	$ 364,377	29%	$ 822,929	65%

ATTACHMENT
OZARKS ALLIANCE TO END HOMELESSNESS
2021 COMMUNITY SURVEY RESULTS

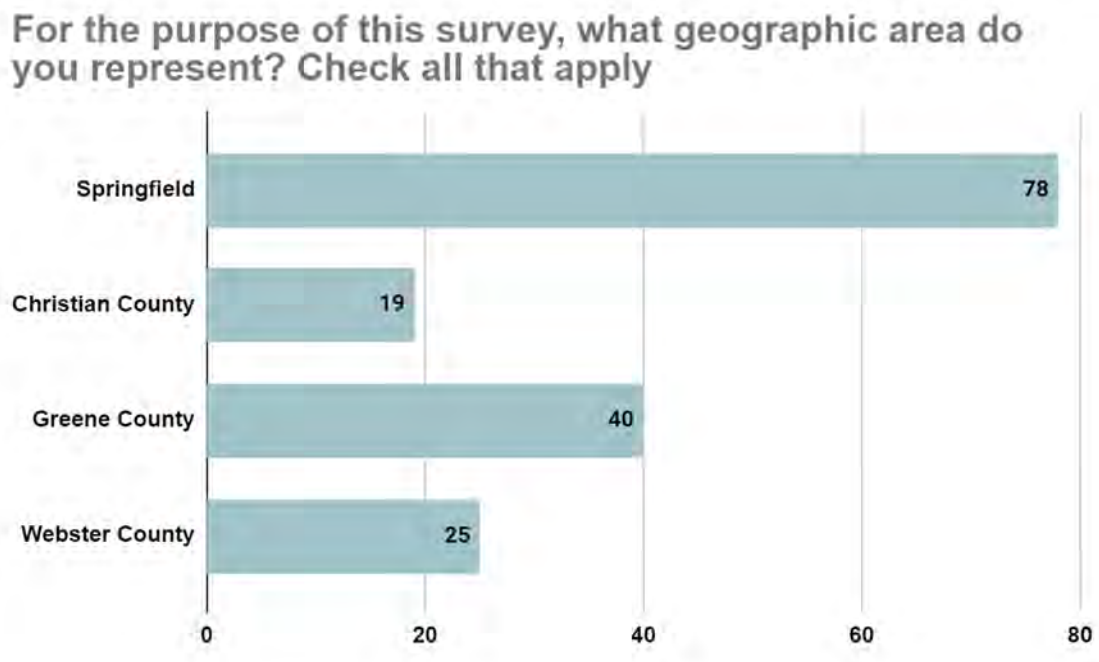
Ozarks Alliance to End Homelessness System Survey Results

105 Respondents

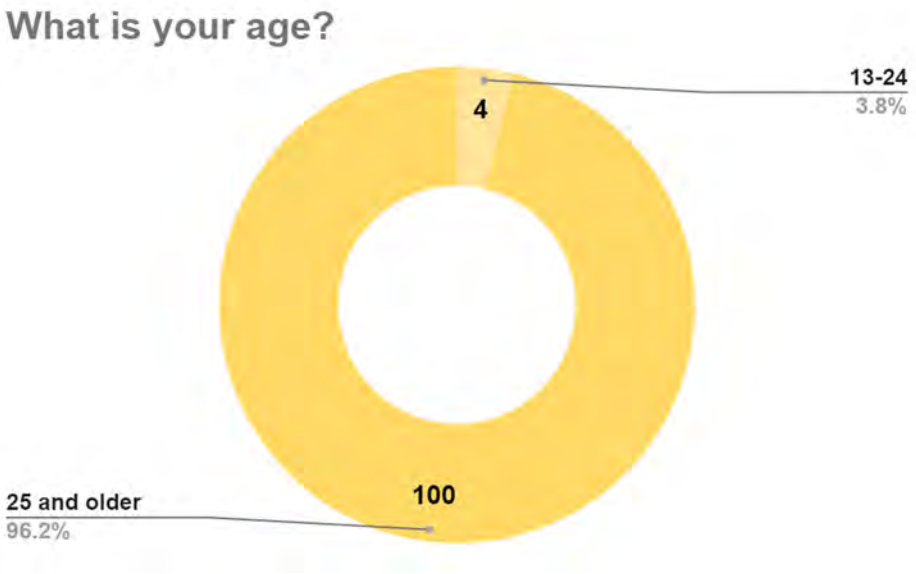
Question 1



Question 2



Question 3



Question 4

What factors do you currently contribute to homelessness in our community?

Common Themes:

- Lack of safe and affordable housing
- Lack of accessible housing
    - Previous evictions, felonies, credit scores
- Untreated health / mental health
- Substance Use
- Low wages
- Unemployment
- High poverty rate (25% below federal poverty level)
    - Generational poverty
- Lack of financial direction / budgeting resources
- Not enough support from community leaders

Question 5

What do you think is the most difficult part about obtaining housing?

Common Themes:

- Lack of safe affordable housing
- Lack of accessible housing
    - Previous evictions, felonies, credit scores, housing history
- High cost of rent
    - Including high deposits or required payments before moving in
- Not enough beds / housing options through the Coordinated Entry System
- Low wages
- Money owed to City Utilities (will not rent to those with outstanding balances)

Question 6

How could current homeless services be improved AND what barriers do you think prevent this?

Common Themes:

- Timely access to mental health treatment
    - Barriers: low staffing, insurance/payment, transportation
- Long term case management from multiple providers
    - Barriers: transportation, low staffing, cost, no way to contact clients, wait times
- Trust from community stakeholders and buy-in from community members
    - Barriers: negative past experiences, financial liability
- Extended hours for services (weeknights, weekends)
    - Barriers: money, staffing
- Making getting IDs more accessible
- More quality, transitional housing options and emergency shelter beds
    - Barriers: funding, availability, stigma
- More collaboration across the system between service providers
- More access points to the Coordinated Entry System
    - Barriers: funding, staffing, finding interested agency
- More resources in Christian County and Webster County (shelters, food pantries)
    - Barriers: more rural and less localized, funding, awareness
- Space to allow safe camping, rather than breaking up camps
    - Barriers: finding location, trust, funding
- Increased street outreach
    - Barriers: staffing, funding, stigma, trust

Question 7

How would you define the success of our community's response/service system for people experiencing homelessness?

Common Themes:

- Shorter waiting lists and waiting times for transitional housing
- Consistent, immediate responses to housing crises with flexible ways to meeting the needs of the community
- More community awareness of the problem

Question 8

What do you see as our community's strengths related to addressing homelessness?

Common Themes:

- Faith communities' willingness to help
- Collaboration between agencies
- Willingness to explore and adopt best practices
- Working towards widespread awareness
- Volunteers
- The Coordinated Entry System
- Current outreach services such as The Connecting Grounds

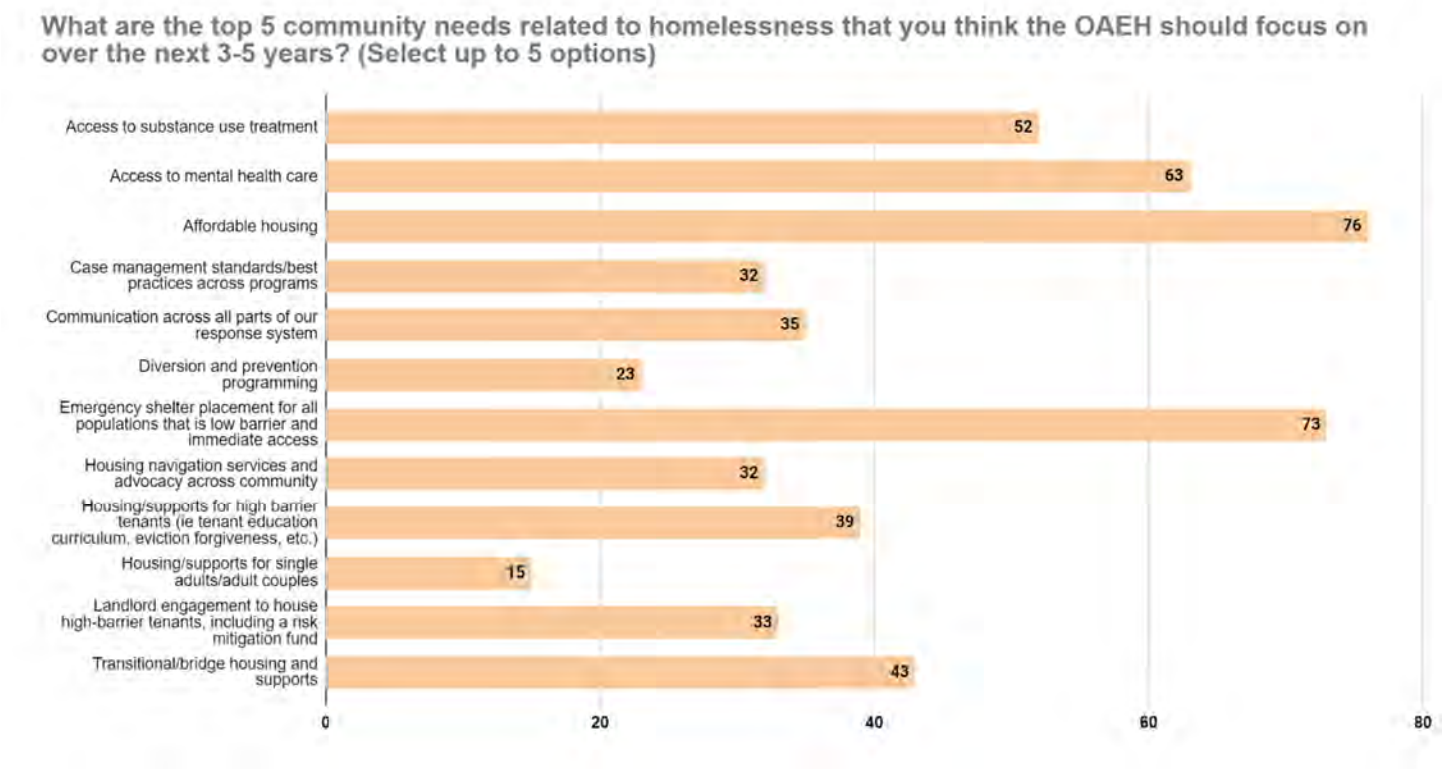
Question 9

What do you see as our community's weaknesses related to addressing homelessness?

Common Themes:

- Lack of affordable housing locations
- Lack of widespread awareness
- Funding limitations
- Community view of homelessness
    - Stigmatization of homelessness
- Lack of shelter beds
- Limited hours of resources (weekdays only)
- Lack of involvement with local government
- Lack of low-barrier services
- No day shelters
- Authorities breaking up camps

Question 10



Top 5:

1. Affordable housing (73.8%)
2. Emergency shelter placement for all populations that is low barrier and immediate access (70.9%)
3. Access to mental health care (61.2%)
4. Access to substance use treatment (50.5%)
5. Transitional/bridge housing and supports (41.7%)

ATTACHMENT
OZARKS ALLIANCE TO END HOMELESSNESS
2021 STATE OF THE CONTIUUM OF CARE
(STRATEGIC PLANNING)

COMMUNITY PARTNERSHIP

Working Together to Build Strong Communities

Ozarks Alliance to *End* Homelessness

Strategic Planning document 2022 - 2025

2

Springfield/Greene, Christian, and Webster counties Continuum of Care

cpozarks.org/endhomelessness

Table of Contents

Ozarks Alliance to End Homelessness Overview

Our *Community's* Continuum of Care

The federal Continuum of Care Program was established in 2009 through an amendment to the McKinney-Vento Homeless Assistance Act. The Springfield/Greene, Christian, and Webster Counties Continuum of Care, DBA the Ozarks Alliance to End Homelessness, was created soon thereafter. Community Partnership of the Ozarks is proud to coordinate this dynamic initiative, which has grown from the first two partners (The Kitchen, Inc. and the City of Springfield) to over 30 partners today that represent people with lived experience, non-profits, local government, advocacy groups, and others. Collectively, The Alliance brings over $1 million in HUD funding to our community for housing and supportive services.

A Continuum of Care is designed to:

- *Promote community-wide commitment to the goal of ending homelessness*
- *Quickly rehouse individuals and families experiencing homelessness*
- *Promote access to and effective utilization of mainstream programs*
- *Optimize self-sufficiency among individuals and families experiencing homelessness*

Advocates *Faith Partners* *Housing Providers* *Law Enforcement* *Mental/Physical Health*

In 2017, The Alliance received federal technical assistance to restructure its leadership. Through that process, The Alliance increased its collaboration with cross-sector partners to develop a truly system-level response to homelessness. Broad system representation on the Executive Board and committees allows The Alliance to implement a community-wide approach to ensure that homelessness is rare, brief, and one time.

Despite these efforts to improve our community's collective response to homelessness, on any given night more than 500 people are still experiencing homelessness in Springfield/Greene, Christian, and Webster counties. While several factors can contribute to homelessness and housing instability, the over-arching cause of homelessness is a lack of safe, decent, and affordable housing.

Executive Summary

"Success will be measured by having consistent, immediate responses to housing crises with flexible ways to meet the needs of the community" – Community Feedback Survey, July 2021

This strategic plan is based on review of data from the Homeless Management Information System (HMIS) and public input from service providers, people experiencing homelessness, and the community.

- Information from HMIS was reviewed to understand who is served in our homeless service system, how they are served, and gaps that exist in care.
- Public input was collected during community feedback surveys and OAEH Listening Sessions.

Data analysis and public input pointed to three goals for the Ozarks Alliance to End Homelessness: to make homelessness rare, make homelessness brief and one-time, and increase community education and engagement around homelessness. This document is designed to be a working document and will be updated to reflect specific objectives, outcomes, and progress towards these goals as action planning and implementation are completed during spring of 2022 with OAEH Committees.

Acknowledgment

The Ozarks Alliance to End Homelessness is governed and lead by an Executive Board that is intentionally structured to include cross-sector representation from systems of care, the communities we serve, and City of Springfield Leadership. The Executive Board has designated voting seats for representation from people with lived experience, the City of Springfield, Christian County, Greene County, Webster County, and appointees from the Mayor of Springfield. Additional Executive Board members are recruited from other social service systems including Healthcare and Mental Healthcare, Legal Services, Law Enforcement, housing developers, and advocates for the homeless. Current voting membership includes:

Sabrina Aronson, Burrell Behavioral Health (Mental Health)
Bob Atchley, City of Springfield (Local Government)
Jody Austin, Springfield Greene County Health Department, Mayor's Appointee (Healthcare) **
Jennifer Cannon, Gathering Friends for the Homeless (Advocate)
Elisa Coonrod, Community Member (Advocate)
Kelly Harris, Council of Churches* (Faith Based Partner/Emergency Shelter and Housing Provider/Federal Funding Recipient)
Holly Hunt, Great Circle (Youth Services Provider/Emergency Shelter Provider/Federal Funding Recipient)
Wyatt Jenkins, BKD and Greene County Representative
Tim Knapp, Missouri State University - Sociology Department
Jim O'Neal, Community Member
Sgt. Mike Lucas, Springfield Police Department (Law Enforcement)
Alyssa Spradlin, Webster County Representative (Faith Based Partner)
Maura Taylor, Catholic Charities of Southern MO(Emergency Shelter and Housing Provider/Federal Funding Recipient)
John Walker, Christian County Homeless Alliance
Lee Wiley, Community Member (Lived Experience)
Katrena Wolfram, Housing Authority of Springfield (Affordable Housing Developer)
Missey Hayward, Springfield First Community Bank, Mayor's Appointee

** Chair* ***Vice-Chair*

The Past

Progress Report on Previous Strategic Planning Goals

10 Year Plan to End Homelessness (2009)

The following section documents progress made on goals identified in the previous Ozarks Alliance to End Homelessness' Strategic Plan.

Key

✓ Specific Goal Met (Does not indicate that recommendation is not still a community need)

⌛ Progress towards goal is on-going

✕ No system level progress toward goal has been made

A. System Level Initiatives

Recommendation		**Outcome**
Centralized Housing Resources	✓	Coordinated Entry System launched in 2017
Homeless Risk Assessment	✓	Coordinated Entry System, which includes prioritization based on vulnerability, launched in 2017
HMIS Participation	✓	Per 2021 HIC, 90% of beds utilize HMIS or comparable database
Community Education and Outreach	⌛	In Progress
Staff Support to the CoC	✓	One FTE position was dedicated to the CoC in 2018.
Homeless Court	⌛	In Progress

B. Homeless Prevention Initiative

Recommendation		Outcome
Prevent new individuals/families from becoming homeless	✓	Over the last reporting year, 78% of people served across all programs were experiencing homelessness for the first time. This is a *decrease* from FY2019, when 83% of people were experiencing homelessness for the first time (Measure 5, Metric 5.2)
Reduce number of episodically homeless	✓	Our annual sheltered count shows that over the last reporting year, the number of people experiencing sheltered homelessness over the entire year has *decreased* from 902 individuals to 699 individuals. (Measure 3, Metric 3.2)
Create streamlined intervention system	✓	O'Reilly Center for Hope was opened in 2020
Ensure safe, affordable housing is available	⌛	In Progress
Promote a dynamic job market	⌛	In Progress

C. Shelter Services

Recommendation		Outcome
Create additional emergency shelter beds	✓	In 2009, 120 year-round emergency shelter beds and 30 seasonal beds were reported on our Housing Inventory Count. In 2021, 548 year-round emergency shelter beds and 130 seasonal beds were reported. Despite this increase, our community still faces a critical shortage of emergency shelter beds. By checking this off, does it state that we have no need for additional beds? We know this is still a critical need.
Increase scattered site transitional housing	✗	In 2009, 563 year-round transitional housing beds were reported on our Housing Inventory Chart. In 2021, 42 year-round transitional housing beds were reported. This is due primarily to a federal shift away from funding transitional housing programs.
Increase shelter programs for targeted populations	✓	Since 2009, emergency shelters for women, pregnant women, families, and additional Crisis Cold Weather Shelter beds have been created. Again, does this say we are meeting all needs?

D. Supportive Services

Recommendation		Outcome
Increase access to job training	⌛	In Progress
Create holistic system with measurable goals/outcomes	⌛	In Progress . Progress has been made on this goal with the launch of the Coordinated Entry System and regular review of System Performance Measures, but more work is needed, specifically around the development of case management minimum standards.

E. Healthcare

Recommendation		Outcome
Support Regional Health Commission and address gaps	✓	Development of MSU Care and healthcare partnerships with MSU Care and Springfield/Greene County Health Department through the O'Reilly Center for Hope and OAEH Executive Board.

Community Recommendations from Corporation for Supportive Housing(2016)

In 2016, the Alliance worked with Corporation for Supportive Housing (CSH) through HUD-funded technical assistance to strategically address homelessness in our community. This process included community sessions on the following topics:

- Alignment with the Federal Plan to End Homelessness
- Addressing Permanent Housing Needs
- Local Response to Unsheltered Homelessness
- Prioritizing of Local Funding Resources

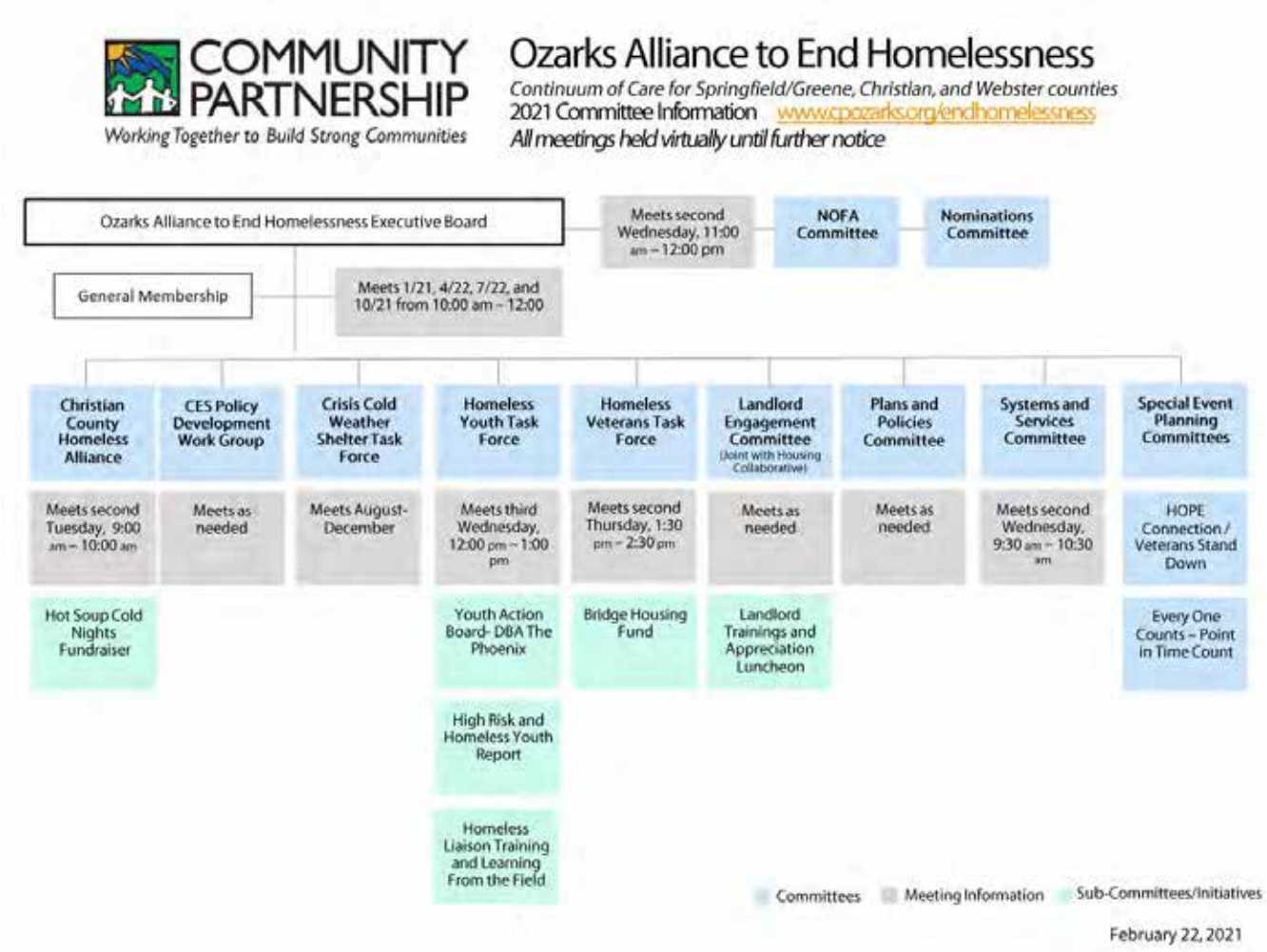
A full report of Community Recommendations is available at www.cpozarks.org/endhomelessness. A summary of system level recommendations and current status is below.

Implementation Recommendations

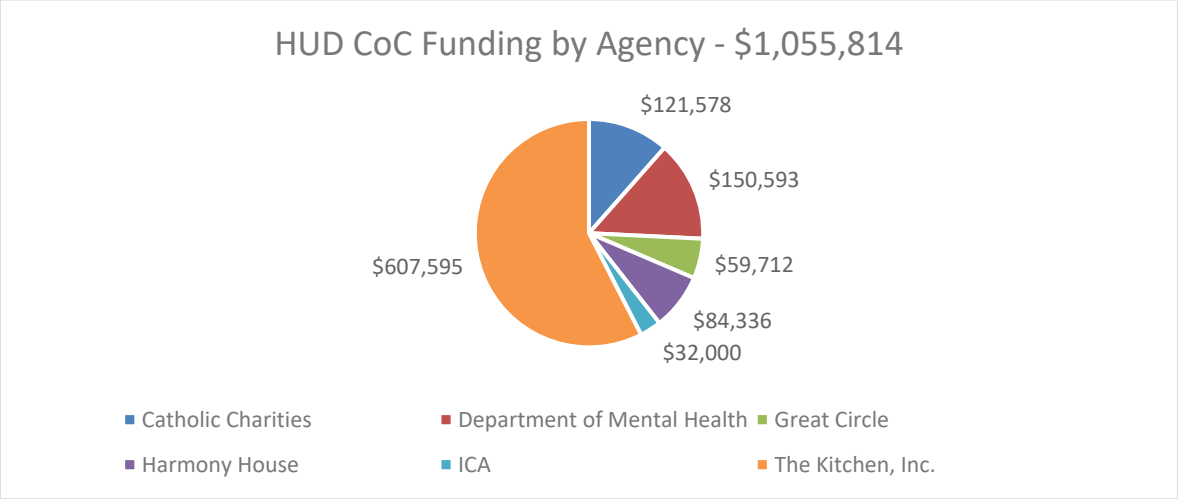
Recommendation		**Outcome**
On-going staff support for CoC	✓	One FTE position was dedicated to CoC in 2018.
Develop a Coordinated Entry System	✓	CES was formally launched in 2017 and includes a live Prioritization List for housing services.
Develop CoC Training Curriculum	⌛	In progress
Coordinate supportive service standardization	⌛	In progress
Establish funding collaborative to end homelessness	⌛	In Progress – Emergency Shelter Work Group was created in August 2020
Attend Peer Learning Calls	⌛	In Progress
Develop a CoC Communications Plan	✗	Will be a focus of 2022 Strategic Plan
Set goals to house sub-populations	✗	Will be a focus of 2022 Strategic Plan
Moving On Initiative	✗	Will be a focus of 2022 Strategic Plan
Implement Diversion Strategies	✓	Diversion programming is integrated into One Door assessment process
Landlord Engagement	⌛	In Progress in partnership with CPO's Housing Collaborative

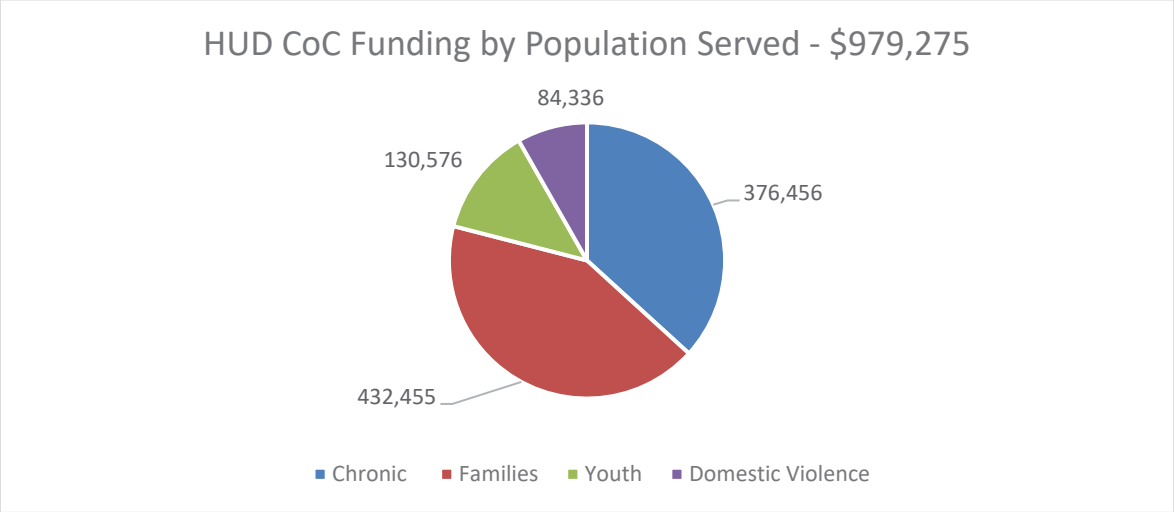
The Present

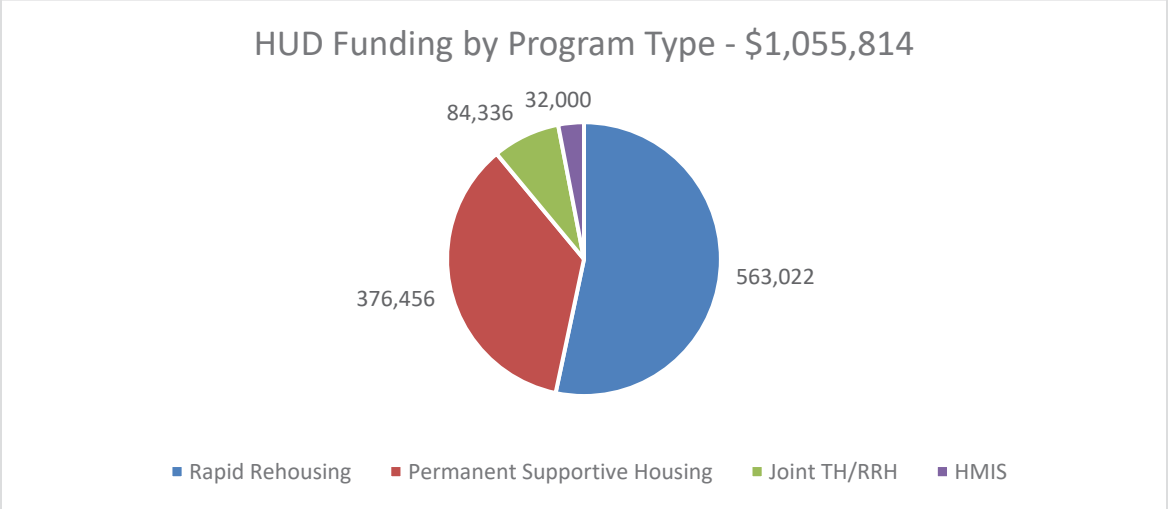
OAEH Structure and Committees



FY2020 HUD CoC Project Funding Overview







Additionally, the City of Springfield is awarded approximately $30,000 annually through a HUD CoC Planning Grant.

System Overview

Who is experiencing homelessness in our community?

Every year, communities document the number of people experiencing homelessness on a single night. On one night in January 2021 . . .

583 Individuals were experiencing homelessness (55% male, 45% female)

517 Individuals were staying in an emergency shelter *

66 Individuals were unsheltered

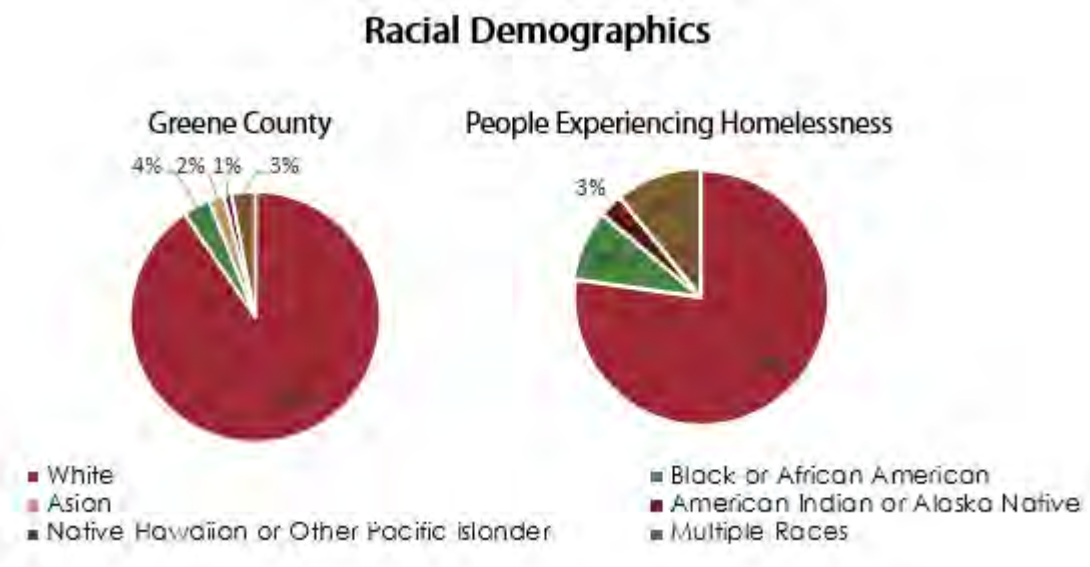
** Of people who were sheltered . . .*
73 were in Crisis Cold Weather Shelters
158 were in hotel placements due to COVID vulnerability

26 Veterans were homeless

77 Families with children were homeless

158 Children were homeless (under 18)

30 Youth were homeless (age 18-24)



More information is available at www.cpozarks.org/endhomelessness or at https://icalliances.org/mo-pit-dashboard.

How is our community addressing homelessness?

HUD uses a set of defined measures to determine our community's progress in meeting the needs of people experiencing homelessness – not only in obtaining housing, but in supporting them in sustaining it. Our progress on these measures impacts federal funding allocations. The numbers below are based on Federal Fiscal Year 2020 (10/2/2019-9/30/2020).

Measure		**Outcome**
Length of time people remain homeless	✓	Over the last reporting year, the number of days people experienced homelessness before getting housed *stayed the same* at 60 days. (Measure 1, Metric 1.2).
Extent that people who were permanently housed return to homelessness	✓	Over the last reporting year, 3% of households that exited to permanent housing situations returned to homelessness within 6-12 months., *the same* as FY 2019 (Measure 2a).
Number of people experiencing homelessness	✓	Our annual sheltered count shows that over the last reporting year, the number of people experiencing sheltered homelessness over the entire year has *decreased* from 902 individuals to 699 individuals. (Measure 3, Metric 3.2)
Employment Income and Growth	✓	Over the last reporting year, 26% of adults who stayed in a housing program increased their total income. This is an *increase* from FY 2019, when 24% of adults increased income (Measure 4, Metric 4.3).
Number of people experiencing homelessness for the first time	✓	Over the last reporting year, 78% of people served across all programs* were experiencing homelessness for the first time. This is a *decrease* from FY2019, when 83% of people were experiencing homelessness for the first time (Measure 5, Metric 5.2)
Successful placement in or retention of Permanent Housing	✓ ✗	Exits from shelter and rapid rehousing programs to permanent housing *increased* over the last reporting year from 39% to 42%. Successful exits/retention from permanent supportive housing programs has *decreased* over the last reporting year from 97% to 91%.

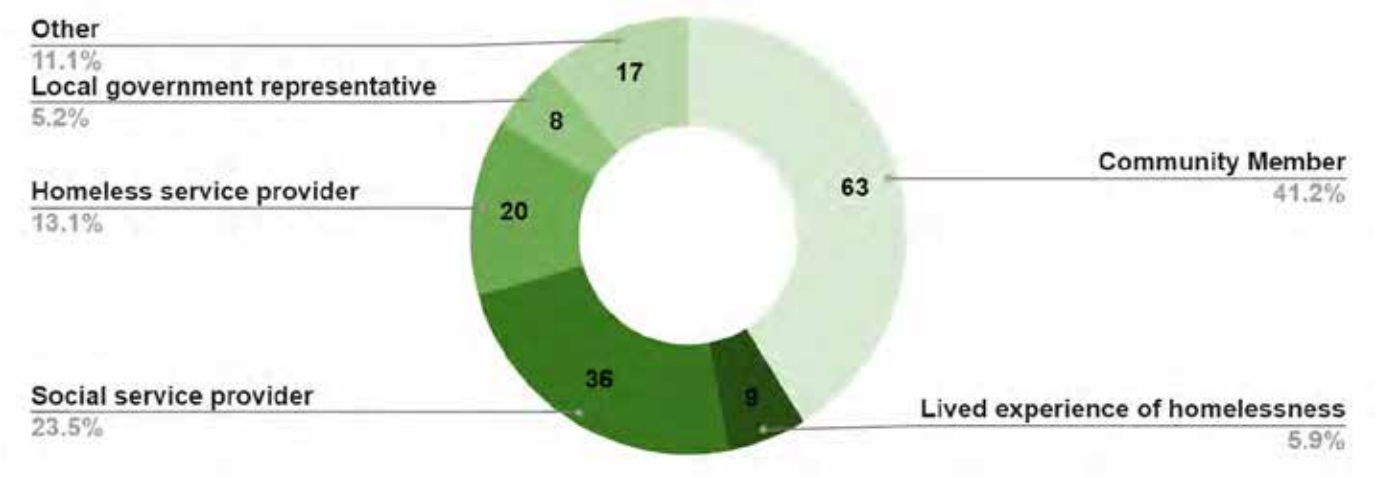
*includes Emergency Shelter, Safe Haven, Transitional Housing, and Permanent Supportive Housing Programs

The Future

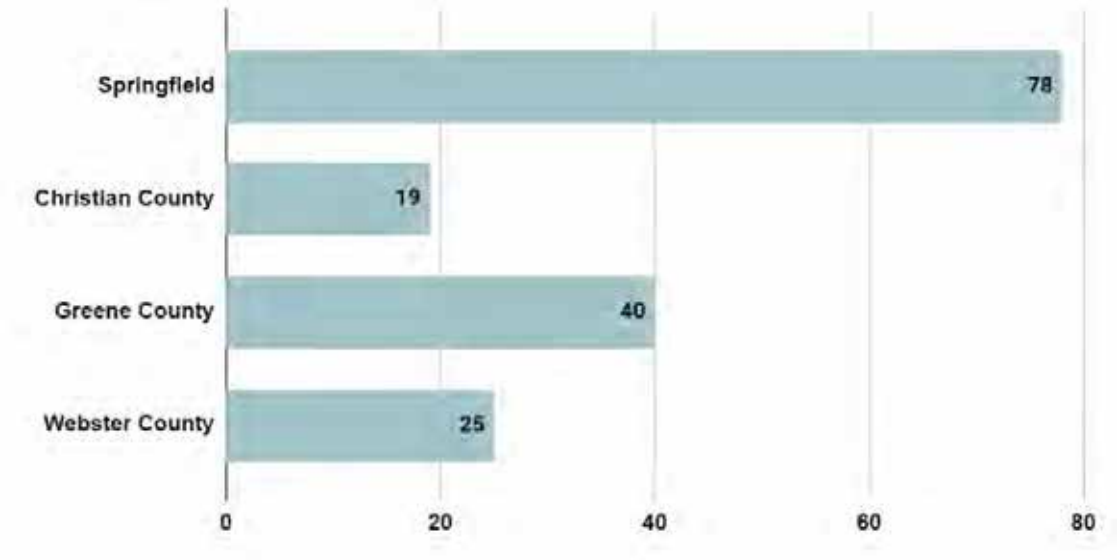
Community Feedback for this Plan

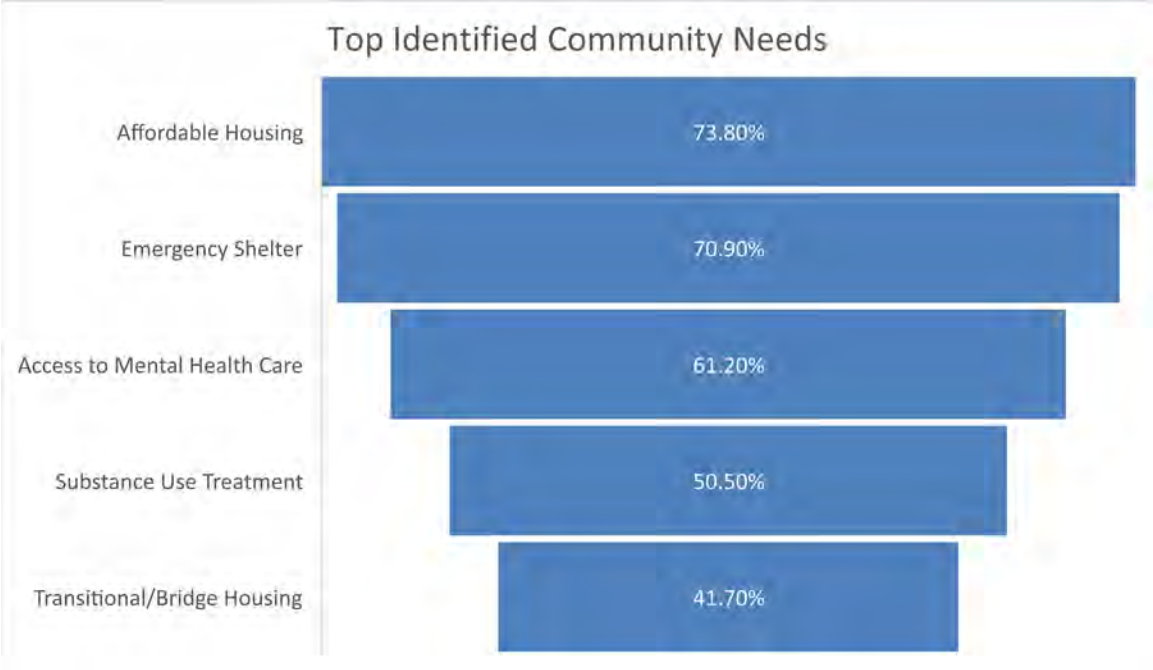
In July of 2021, the OAEH conducted a System Survey to gather community feedback on the local response system for people experiencing homelessness. 115 community members, social service providers, and local government representatives completed the survey. An additional listening session was held at the OAEH General Membership meeting on July 22, 2021 to guide the prioritization and development of goals.

How survey respondents were affiliated with the Ozarks Alliance to End Homelessness (includes duplicate numbers)



Geographic area survey respondents represented (includes duplicate numbers)





Local strengths respondents identified related to addressing homelessness:

- Collaboration between agencies (including Coordinated Entry System)
- Willingness to explore/adopt best practices
- Increased community awareness and efforts around this
- Civic engagement with volunteers and faith community
- Outreach initiatives

Local weaknesses respondents identified to addressing homelessness:

- Lack of affordable housing
- Lack of widespread community awareness and community stigmatization of homelessness
- Funding limitations
- Lack of day and overnight shelters
- Limited availability of resources that are low barrier and available outside of normal business hours only
- Lack of local government response

Strategic Goals

Make Homelessness Rare

Outcomes

 Reduce number of people experiencing homelessness

 Reduce number of people experiencing homelessness for the first time

 Increase employment and income

Strategies

- Increase availability of safe, decent, and affordable housing
- Increase resources and connectivity in surrounding counties
- Increase collaboration across system between service providers
- Increase timely access to mental health treatment
- Increase access to employment and benefits

Make Homelessness Brief and One-time

Outcomes

 Reduce length of time people experience homelessness

 Increase successful placement in and retention of housing

 Reduce returns to homelessness

Strategies

- Remove barriers to services (increase access and reduce program prerequisites)
- Increase low barrier emergency shelter beds and transitional housing options
- Increase street outreach initiatives
- Develop system-wide curriculum and best practices for case management
- Leverage local, state, and federal resources (specifically ARPA funds)
- Increase landlord engagement
- Increase number of SOAR certified staff

Increase community education and engagement around homelessness

Outcomes

Improve system level coordination and engagement

Increase community awareness of homelessness and community support for service providers

Further develop the O'Reilly Center for Hope as a shared community tool for resources

Strategies

- Engage with new system level partners
- Develop annual training curriculum for direct service providers on best practices
- Develop OAEH Communications Plan to share about the work of the OAEH with general public

Appendix

Committee Action Plans

Action plans will be added here as they are developed by OAEH Committees.

FY2020 Performance Measure Summary Report

Measure 1: Length of Time Persons Remain Homeless

This measures the number of clients active in the report date range across ES, SH (Metric 1.1) and then ES, SH and TH (Metric 1.2) along with their average and median length of time homeless. This includes time homeless during the report date range as well as prior to the report start date, going back no further than October, 1, 2012.

Metric 1.1: Change in the average and median length of time persons are homeless in ES and SH projects.
Metric 1.2: Change in the average and median length of time persons are homeless in ES, SH, and TH projects.

a. This measure is of the client's entry, exit, and bed night dates strictly as entered in the HMIS system.

	Universe (Persons)		Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Revised FY 2019	FY 2020	Submitted FY 2019	Revised FY 2019	FY 2020	Difference	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
1.1 Persons in ES and SH	871	951	45	45	47	2	22	23	25	2
1.2 Persons in ES, SH, and TH	1039	1086	56	60	60	0	25	28	28	0

b. This measure is based on data element 3.17.

This measure includes data from each client's Living Situation (Data Standards element 3.917) response as well as time spent in permanent housing projects between Project Start and Housing Move-In. This information is added to the client's entry date, effectively extending the client's entry date backward in time. This "adjusted entry date" is then used in the calculations just as if it were the client's actual entry date.

	Universe (Persons)		Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Revised FY 2019	FY 2020	Submitted FY 2019	Revised FY 2019	FY 2020	Difference	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
1.1 Persons in ES, SH, and PH (prior to "housing move in")	1103	1170	312	359	422	63	105	117	137	20
1.2 Persons in ES, SH, TH, and PH (prior to "housing move in")	1216	1287	298	362	424	62	105	121	134	13

Measure 2: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness

This measures clients who exited SO, ES, TH, SH or PH to a permanent housing destination in the date range two years prior to the report date range.Of those clients, the measure reports on how many of them returned to homelessness as indicated in the HMIS for up to two years after their initial exit.

After entering data, please review and confirm your entries and totals. Some HMIS reports may not list the project types in exactly the same order as they are displayed below.

	Total # of Persons who Exited to a Permanent Housing Destination (2 Years Prior)		Returns to Homelessness in Less than 6 Months			Returns to Homelessness from 6 to 12 Months			Returns to Homelessness from 13 to 24 Months			Number of Returns in 2 Years	
	Revised FY 2019	FY 2020	Revised FY 2019	FY 2020	% of Returns	Revised FY 2019	FY 2020	% of Returns	Revised FY 2019	FY 2020	% of Returns	FY 2020	% of Returns
Exit was from SO	7	11	1	2	18%	0	2	18%	1	0	0%	4	36%
Exit was from ES	160	177	21	23	13%	6	11	6%	8	6	3%	40	23%
Exit was from TH	52	88	2	1	1%	0	1	1%	3	0	0%	2	2%
Exit was from SH	0	0	0	0		0	0		0	0		0	
Exit was from PH	168	169	11	4	2%	6	1	1%	12	3	2%	8	5%
TOTAL Returns to Homelessness	387	445	35	30	7%	12	15	3%	24	9	2%	54	12%

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts

This measures the change in PIT counts of sheltered and unsheltered homeless person as reported on the PIT (not from HMIS).

	January 2019 PIT Count	January 2020 PIT Count	Difference
Universe: Total PIT Count of sheltered and unsheltered persons	492	540	48
Emergency Shelter Total	368	414	46
Safe Haven Total	0	0	0
Transitional Housing Total	43	38	-5
Total Sheltered Count	411	452	41
Unsheltered Count	81	88	7

Metric 3.2 – Change in Annual Counts

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

	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
Universe: Unduplicated Total sheltered homeless persons	1076	902	699	-203
Emergency Shelter Total	913	737	561	-176
Safe Haven Total	0	0	0	0
Transitional Housing Total	175	175	150	-25

Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

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

	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
Universe: Number of adults (system stayers)	68	78	70	-8
Number of adults with increased earned income	4	4	2	-2
Percentage of adults who increased earned income	6%	5%	3%	-2%

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

	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
Universe: Number of adults (system stayers)	68	78	70	-8
Number of adults with increased non-employment cash income	19	17	16	-1
Percentage of adults who increased non-employment cash income	28%	22%	23%	1%

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

	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
Universe: Number of adults (system stayers)	68	78	70	-8
Number of adults with increased total income	20	19	18	-1
Percentage of adults who increased total income	29%	24%	26%	2%

Metric 4.4 – Change in earned income for adult system leavers

	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
Universe: Number of adults who exited (system leavers)	67	70	65	-5
Number of adults who exited with increased earned income	12	12	6	-6
Percentage of adults who increased earned income	18%	17%	9%	-8%

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

	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
Universe: Number of adults who exited (system leavers)	67	70	65	-5
Number of adults who exited with increased non-employment cash income	13	13	12	-1
Percentage of adults who increased non-employment cash income	19%	19%	18%	-1%

Metric 4.6 – Change in total income for adult system leavers

	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
Universe: Number of adults who exited (system leavers)	67	70	65	-5
Number of adults who exited with increased total income	24	24	17	-7
Percentage of adults who increased total income	36%	34%	26%	-8%

Measure 5: Number of persons who become homeless for the first time

Metric 5.1 – Change in the number of persons entering ES, SH, and TH projects with no prior enrollments in HMIS

	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
Universe: Person with entries into ES, SH or TH during the reporting period.	1008	827	600	-227
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	162	150	125	-25
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)	846	677	475	-202

Metric 5.2 – Change in the number of persons entering ES, SH, TH, and PH projects with no prior enrollments in HMIS

	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
Universe: Person with entries into ES, SH, TH or PH during the reporting period.	1239	1053	860	-193
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	198	184	187	3
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.)	1041	869	673	-196

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

This Measure is not applicable to CoCs in FY2020 (October 1, 2019 – September 30, 2020) reporting period.

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

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

	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
Universe: Persons who exit Street Outreach	117	140	214	74
Of persons above, those who exited to temporary & some institutional destinations	21	23	15	-8
Of the persons above, those who exited to permanent housing destinations	16	15	20	5
% Successful exits	32%	27%	16%	-11%

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

	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
Universe: Persons in ES, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing	1071	945	754	-191
Of the persons above, those who exited to permanent housing destinations	355	368	318	-50
% Successful exits	33%	39%	42%	3%

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

	Submitted FY 2019	Revised FY 2019	FY 2020	Difference
Universe: Persons in all PH projects except PH-RRH	123	122	119	-3
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	120	118	108	-10
% Successful exits/retention	98%	97%	91%	-6%

Glossary

Annual Homeless Assessment Report (AHAR): HUD report to the U.S. Congress that provides nationwide estimates of homelessness, including demographics, service use patterns, and capacity to house people. Report is based on data the OAEH submits to HUD from the Coordinated Entry System, Point in Time, and Housing Inventory Counts.

Case Conferencing: Twice monthly meetings with housing providers to refer people to housing programs from the Prioritization List.

Chronic Homelessness: Specific definition of homelessness based on length of time someone has experienced homelessness (over one year or repeatedly) and a disabling condition (mental illness, substance use disorder, or physical disability).

Continuum of Care (CoC): Federally mandated local planning body tasked by HUD with oversight of federal funding for homeless services and system level coordination of a community's response to homelessness. Locally, DBA as Ozarks Alliance to End Homelessness.

Coordinated Entry System (CES): Federally mandated process to manage referrals to housing programs across a community; facilitated by Community Partnership's One Door program. This process ensures that everyone needing assistance has equal access to housing resources.

Crisis Cold Weather Shelter (CCWS): Supplemental overnight emergency shelter system operating during the winter season (November through March).

Diversion: Intervention to immediately address needs to prevent a household from accessing the emergency shelter system.

EHV: New long-term tenant based rental assistance allocated to Public Housing Authorities through the American Rescue Plan Act; requires an MOU with the CoC.

Emergency Shelter: Facility whose primary purpose is to provide temporary shelter (generally 90 days or less).

FYI: Long-term tenant based rental assistance to at-risk young adults aging out of foster care. Funding is administered through Public Housing Authorities and requires an MOU with the CoC.

Homeless: Individual or family who lacks a fixed, regular, and adequate nighttime residence (e.g., living in emergency shelter, transitional housing, or somewhere not meant for human habitation).

Homeless Management Information System (HMIS): A local information technology system used to collect client-level data and data on the provision of housing and services to households experiencing or at risk of homelessness. Each Continuum of Care (CoC) is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.

Housing First: National best practice philosophy of offering housing assistance that prioritizes meeting basic needs (housing, food) first before addressing other needs (employment, budgeting, etc.) Also emphasizes client choice in determining housing assistance.

Housing Inventory Count (HIC): Single night inventory of beds in a CoC dedicated to serve people experiencing homelessness; documented on a single night in January.

HUD (US Department of Housing and Urban Development): Cabinet department that administers programs that provide housing and community development assistance while working to ensure that everyone has fair and equal opportunities for housing. Federal oversight of the CoC program.

HUD-VA Supportive Housing (VASH): Joint housing program through HUD and the VA that serves Veterans. It pairs rental assistance vouchers administered by Public Housing Authorities with supportive services and case management through the VA; takes referrals from the Coordinated Entry System.

Ozarks Alliance to End Homelessness (OAEH): Local Continuum of Care, aka "The Alliance."

Point-in-Time Count (PIT): Federally mandated initiative and report that counts and collects demographic information on people experiencing homelessness (sheltered and unsheltered) on a single night at the end of January.

Permanent Supportive Housing: Type of housing assistance that pairs long-term rental payments with case management and services to serve the most vulnerable people experiencing chronic homelessness.

Prioritization List: Local list of households who reported experiencing homelessness in the last 90 days; used to make referrals to housing programs based on highest need.

Rapid Rehousing: Type of housing assistance that provides short-term (up to two years) rental payments and services.

Sheltered: Individuals staying in emergency shelter or transitional housing.

Supportive Services for Veteran Families (SSVF): Federal grant administered by the Department of Veterans Affairs to prevent and end Veteran homelessness by providing housing assistance and supportive services to very low-income Veteran families. Locally, awarded to The Kitchen, Inc. and operated as their Home At Last program. Takes referrals from the Coordinated Entry System.

Unsheltered: Individuals staying on the streets, in an encampment, in their car, or other place not intended as housing (includes housing without utilities).

VI-SPDAT (Vulnerability Index- Service Prioritization Decision Assistance Tool): Survey administered to people through the Coordinated Entry System to assess their need for housing assistance.