



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

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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 <i>decrease</i> 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 <i>decreased</i> 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

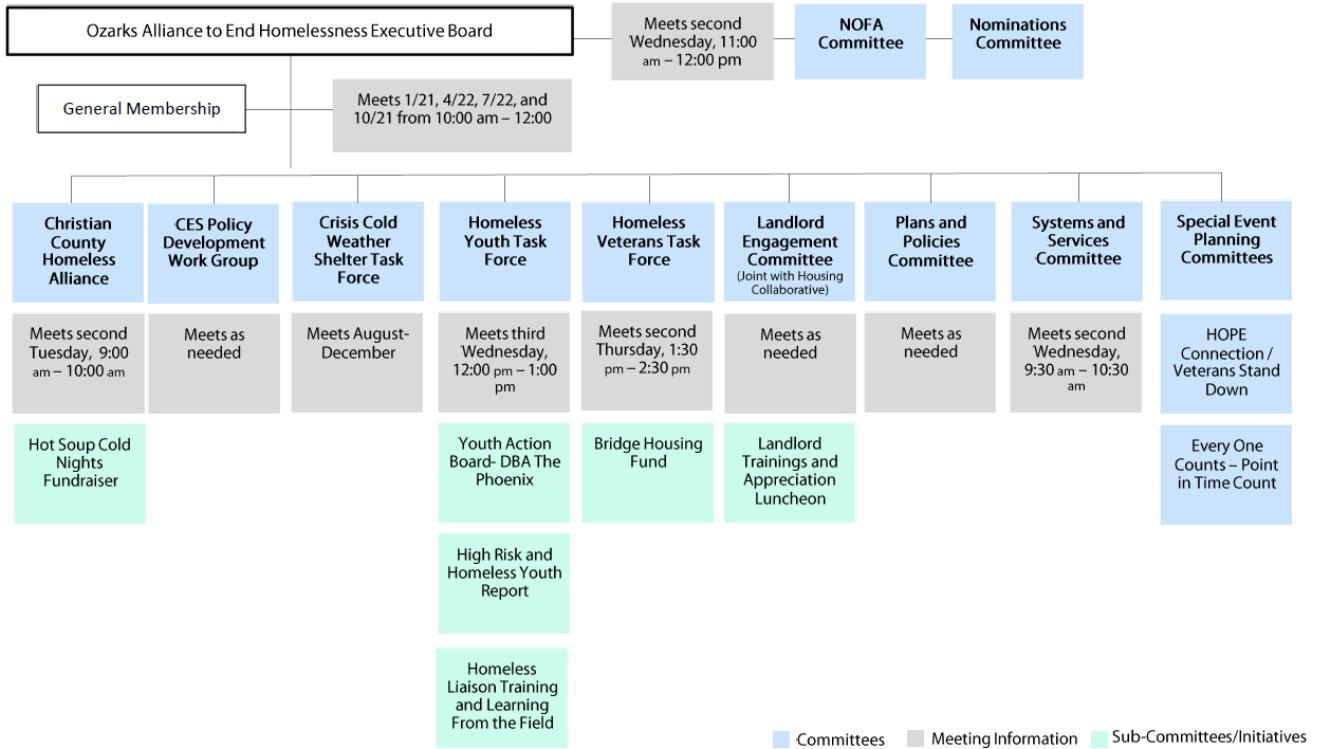
Recommendation		Outcome
On-going staff support for CoC	✓	One FTE position was dedicated to CoC in 2018.
Develop a Coordinated Entry System	✓	CES was formally launched in 2017 and includes a live Prioritization List for housing services.
Develop CoC Training Curriculum	⌚	In progress
Coordinate supportive 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

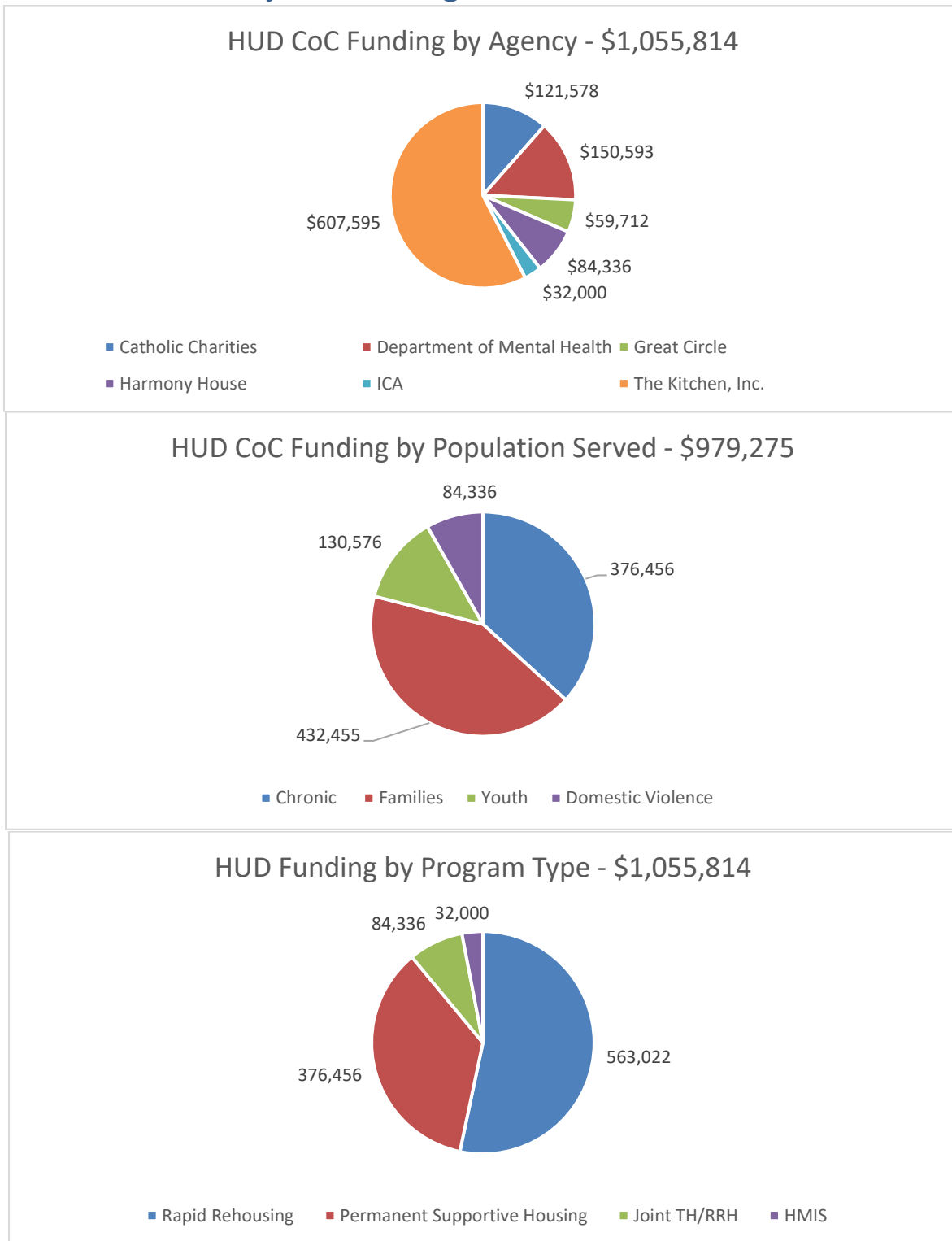


Ozarks Alliance to End Homelessness
 Continuum of Care for Springfield/Greene, Christian, and Webster counties
 2021 Committee Information www.cpozarks.org/endhomelessness
 All meetings held virtually until further notice



February 22, 2021

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?

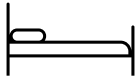
Every year, communities document the number of people experiencing homelessness on a single night. On one night in January 2021 . . .



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



26 Veterans were homeless



517 Individuals were staying in an emergency shelter *



77 Families with children were homeless



66 Individuals were unsheltered



158 Children were homeless (under 18)

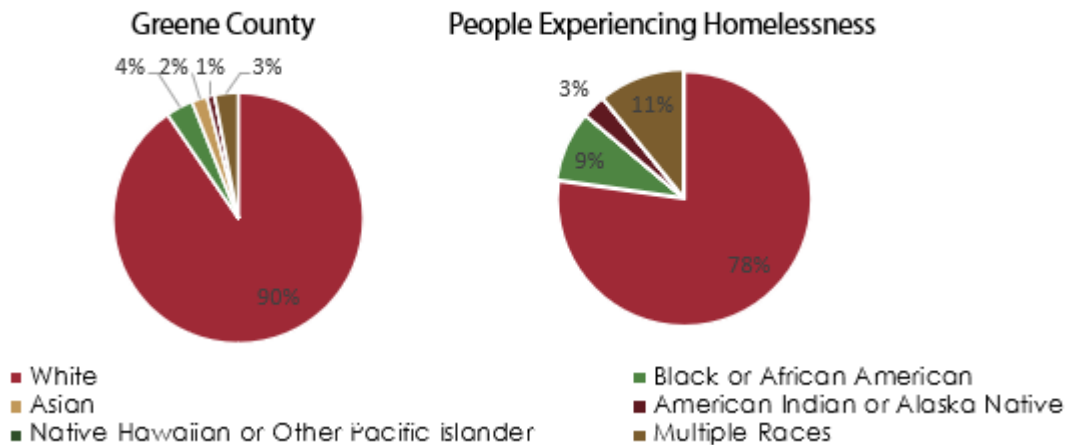
** Of people who were sheltered . . .*

73 were in Crisis Cold Weather Shelters
158 were in hotel placements due to COVID vulnerability



30 Youth were homeless (age 18-24)

Racial Demographics



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 <i>stayed the same</i> 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., <i>the same</i> 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 <i>decreased</i> 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 <i>increase</i> 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 <i>decrease</i> 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 <i>increased</i> over the last reporting year from 39% to 42%. Successful exits/retention from permanent supportive housing programs has <i>decreased</i> over the last reporting year from 97% to 91%.

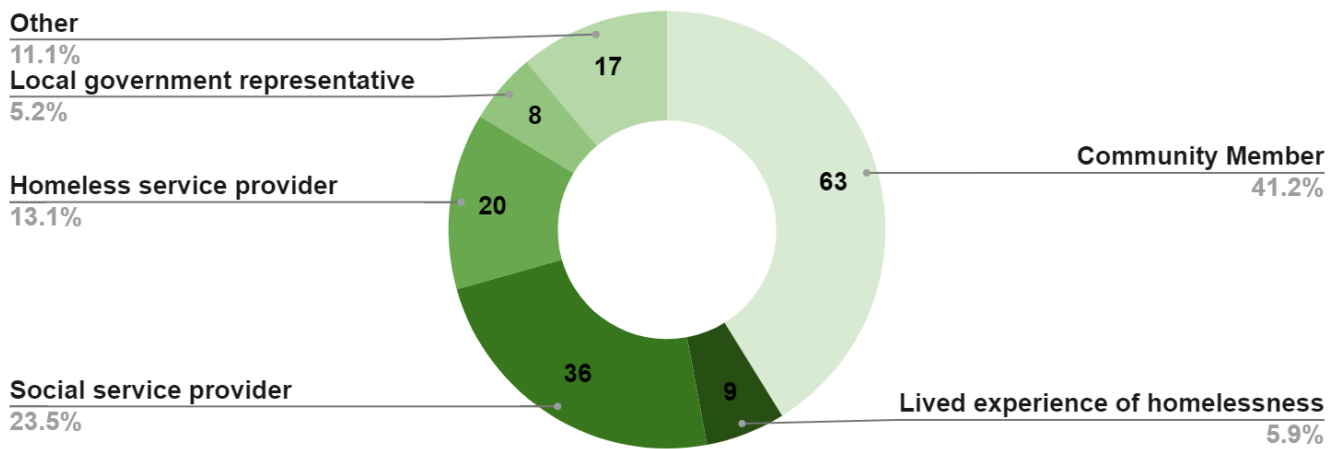
*includes Emergency Shelter, Safe Haven, Transitional Housing, and Permanent Supportive Housing Programs

The Future

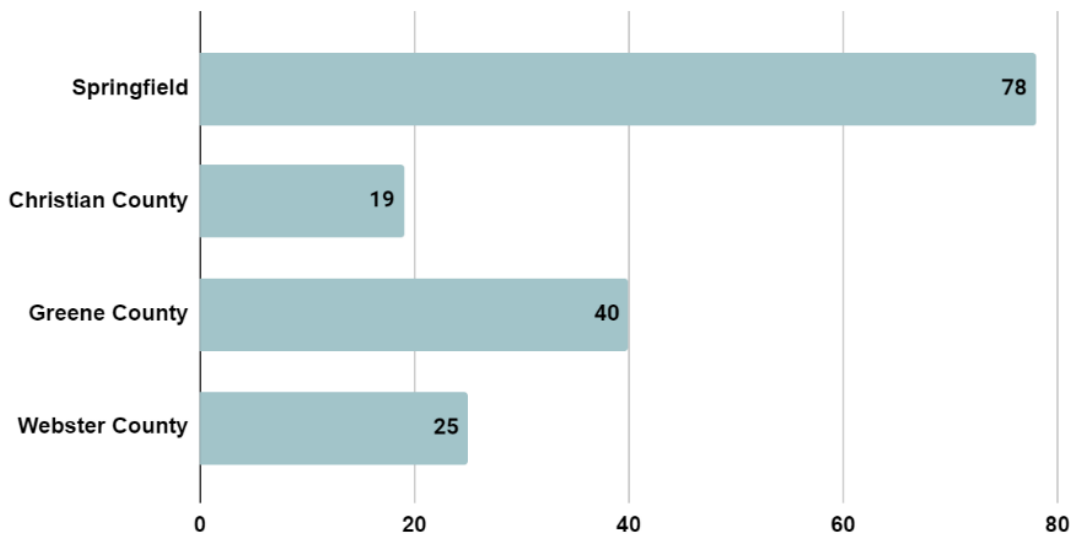
Community Feedback for this Plan

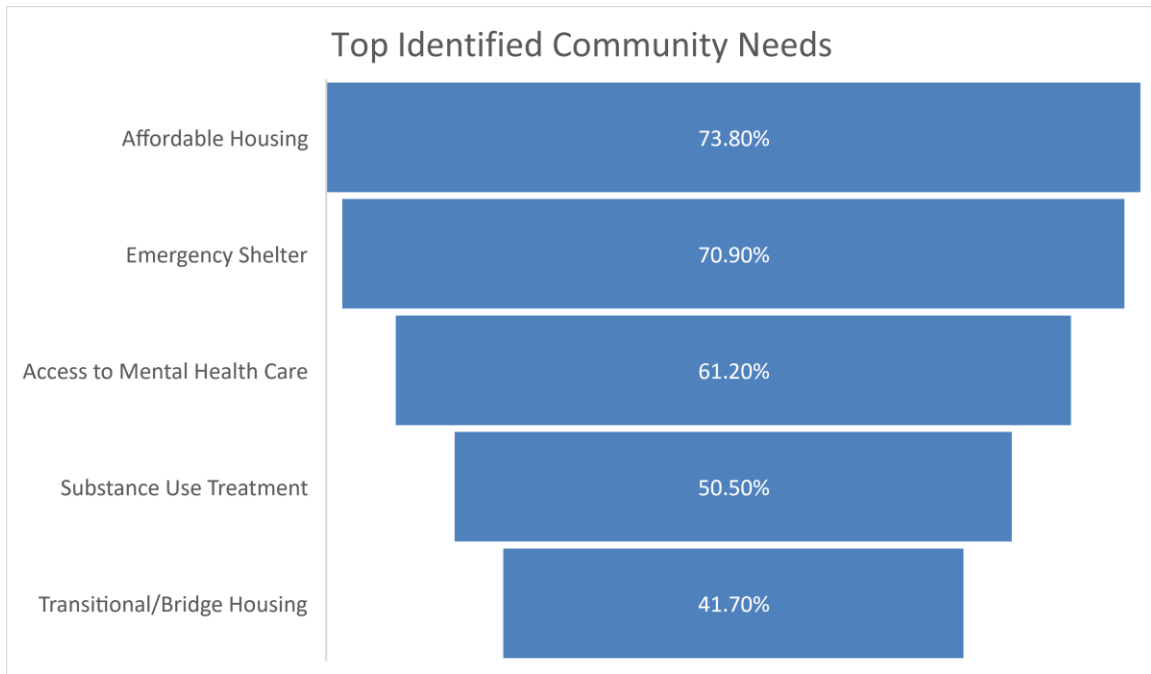
In July of 2021, the OAEH conducted a System Survey to gather community feedback on the local response system for people experiencing homelessness. 115 community members, social service providers, and local government representatives completed the survey. An additional listening session was held at the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