<u>Discussion Paper</u>

Homelessness Performance Reporting Standardization Possibilities

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Introduction

Statement of the problem of public good reporting in this field

The Public Regional Outcomes Standards Board (PROS Board) intends to explore potential regional rules and methods for performance reporting in homelessness. The PROS Board selected this as its first public good "vertical" to explore for the San Diego region because of the persistence of homelessness in the region, the apparent balkanizing of solutions and those seeking solutions in the region, and a seeming acceptance across public funders, private funders, service providers, and even those who have experienced homeless that the region lacks a common lexicon on performance.

Background: Looking at the Regional Picture

Basic Homelessness in San Diego County

San Diego County and its component areas have a variety of ways to try to measure the current state of homelessness. It is a complex topic and will be covered at a basic level here. As complex as the data systems are, they are still imperfect. What is known is that San Diego has a significant problem in the sphere of homelessness. The region consistently ranks among the highest ten communities in the nation in terms of how many people are experiencing homelessness, recently as high as fourth in the nation.[1],[2] Furthermore, the Regional Task Force on Homelessness (RTFH) reported that according to 2017 data, San Diego had the highest or nearly the highest return to homelessness outcomes among West Coast Continuum of Care areas when measured at 6 months (highest rate measured, 13.66%) and 24 months (2nd highest rate, 26.62%, just under Portland Gresham/Multnomah at 26.63%).[3] These data demonstrate that the San Diego region has a significant ongoing problem with helping people get out and stay out of homelessness.

There are several figures relied upon within Continuums of Care to begin to understand the scope of the homelessness problem in the broadest of strokes – point in time count, the annual unduplicated count, housing inventory count, and bed utilization rate.

A primary method for measuring homelessness in a snapshot is through the annual Point in Time (PIT) Count which, as the term implies, is an all hands effort to get an accurate count of sheltered and unsheltered people who lack housing stability at a *single* point in time. This is typically done in late January by well over a thousand staff and volunteers and is a mandated practice followed by Federally recognized Continuums of Care, of which the San Diego region is one. The physical count of unsheltered

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[1] "RTFH-Regional-Unsheltered-Policy-Guidelines_Final-1.Pdf."

[2] "The 2018 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-in-Time Estimates of Homelessness."

[3] "2019 RTFH Annual Report on Homelessness in the San Diego Region"

people was cancelled in 2021 due to COVID-19, though the shelter count was still reported. The physical count was delayed by one month in 2022 and the results are still being compiled at the time of this writing. PIT Counts readily acknowledge that resulting figures represent the best effort at assessing that moment in time and is necessarily a representation of the minimum true count at that point in time and does not attempt to reflect the number of people experiencing homelessness throughout the year.

The tables to follow were published by the Regional Task Force on Homelessness from the last complete reported count in 2020 and report an approximately 6% overall reduction of people who were able to be counted experiencing homelessness on the identified night from 2019. Further breakdowns show reductions in some regions of the County and increases in South and East County. Efforts to improve data collection and specificity are enhanced nearly every year in order to develop a further understanding of who is experiencing homelessness so that services and supports may be developed and deployed based on the region's specific needs. The field is too complex to begin to cover in the scope of this paper. As such, this paper will review some very high level changes over time and provide basic information on the current situation.

While this paper will only review data at a high level, it is important to know the data on people who are homeless are further refined to understand populations by such features as geography, race, ethnicity, potential contributing factors to homelessness, age, or other special populations so that services and support may be tailored based on individual or family circumstances and to help the broader system understand the needs of the community and impact of resources. Examples of further descriptive categories include chronicity of homelessness, duration of homelessness, presence of chronic health conditions, veteran status, youth/ Transition Age Youth, seniors, Domestic Violence survivors, disability status, or those experiencing behavioral health or substance use challenges, to name a few.

As one example to look at change over time, the 2014 Point in Time Count reported 8,506 individuals on the identified night in January, 4521 of whom were sheltered and 3985 who were unsheltered.[4] Compared to the figures represented in the tables for 2020, this represents essentially no change in the number of people who are unsheltered and a 19% reduction in those who are sheltered, or a 10% reduction in the total count. The Regional Task Force on Homelessness website provides access to PIT counts from 2014 through 2021.[5] Earlier reports can be found on the Department of Housing and Urban Development (HUD) website.[6]

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[4] "2014 San Diego Regional Homeless Profile Summary."

[5] "Reports & Data."

[6] "AHAR Reports | HUD USER."

2020 Regional Homelessness Count

	2019	2020	% Change from 2019
UNSHELTERED	4,476	3,971	-11%
SHELTERED	3,626	3,667	+1%
TOTAL HOMELESS	8,102	7,638	-6%

[7]

COUNTY REGION	People Experiencing Homelessness				
	Sheltered	Unsheltered	Total	% by Region	% Change
City of San Diego	2,587	2,283	4,870	63.7%	-4.0%
North County Inland	232	338	570	7.5%	-27.4%
North County Coastal	238	383	621	8.1%	-18.6%
South County	118	369	487	6.4%	13.8%
East County	492	598	1090	14.3%	3.6%
TOTAL	3,667	3,971	7,638	100%	-5.7%

[8]

The above table demonstrates a long standing pattern, that while the majority of people experiencing homelessness are within the City of San Diego, people are experiencing homelessness throughout every region of the county. Further breakdowns by city and unincorporated areas are available in the annual PIT Count reports.[9]

Due to the inherent nature of the challenges of counting individuals who are unsheltered and the limitations of understanding the full scope of the situation based on a given night, the Regional Task Force on Homelessness (RTFH) also reports data gathered throughout the year and then those data are de-duplicated to arrive at an annual count of people served. This information is housed in the central database for the region which the RTFH maintains and which is referred to as the Homeless Management Information System, or HMIS. It is important to note that not all regional providers enter information in the HMIS system. While it is a requirement of agencies receiving many types of Federal funds[10] and some other funders have also adopted HMIS participation as a requirement, it is not universal. The most recent

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[7] "2020-WeAllCount-Report-10.Pdf."

[8] "2020-WeAllCount-Report-10.Pdf."

[9] "Reports & Data."

[10] Including The Department of Housing and Urban Development, Housing for People With AIDS/HIV, Health and Human Services, and the Department of Veterans Affairs

annual performance report covering the period of October 1, 2020 through September 30, 2021 indicates that over 21,000 unduplicated people were served (reported as 21.19k).[11] Since this figure does not include people who have not accessed services or people who accessed services through a resource that does not report information in HMIS, it is almost certainly an underrepresentation of the number of individuals who experienced homelessness during those twelve months, a period complicated by the COVID-19 pandemic.

Among many other data points and much statistical analysis conducted by RFTH and other CoCs, another set of key data points reported is the utilization of available beds of all types at a given time. This should help point to the ability to connect people in need with resources, help begin to inform a gap analysis of which services have inadequate supply, and understand patterns of use, among other things. The Housing Inventory County (HIC) in 2020 is depicted below in a line chart over several recent years.[12] It shows an increase in Permanent Supportive Housing (PSH) with 2020 having the highest inventory in five years. This aligns with the national and regional Housing First Policy, which prioritizes permanent housing without requirements for engagement in services. PSH is earmarked for qualified disabled individuals and the need continues to outstrip supply in San Diego's housing market. Transitional Housing (TH) and Rapid Re-Housing (RRH) have opposite trend lines as RRH tends to replace TH beds. Other Permanent Housing (OPH) and Emergency Shelter (ES) beds have similar slow growth trends, while Safe Havens (SH) continues to be a fairly steady and small number for very hard to serve clients. This helps understand the overall bed availability.

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[11] "Regional Task Force on Homelessness - Community Analysis Dashboard."
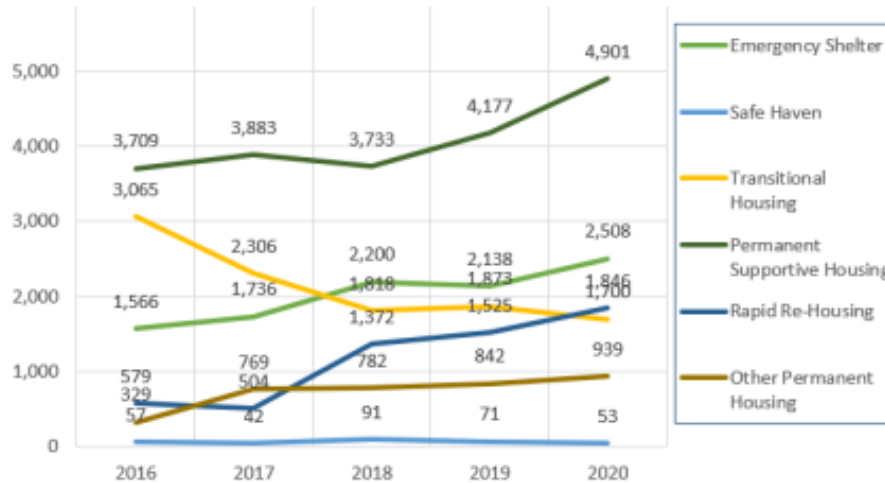
[12] "2020-WeAllCount-Report-10.Pdf."

Sheltered: Housing Inventory Count (HIC)

Bed Inventory the Night of the Count

This chart provides an overview of changes in the number of total beds/units for homelessness-dedicated housing interventions such as Emergency Shelter (ES), Rapid Re-Housing (RRH), Transitional Housing (TH), and Permanent Supportive Housing (PSH).

Source: RTFH, 2020 - We All Count Report

The following chart describes the bed usage on the night of the PIT Count. On a night in January 2000 where nearly 4,000 individuals where observed and counted as unsheltered homeless, one might wonder why bed utilization rates were not higher. This is another demonstration of the complexity of the homelessness services system and the people who are homeless. There are individual factors that contribute to this, including that some people do not want to be in a shelter for a variety of reasons, do not want to engage with the system, or perhaps cannot bring their friend, family, pet, or belongings with them to the available bed. People experiencing homelessness are able to exercise freedom of choice in accepting services at all or which services they accept. There are system issues for this including the ability to align the person's individual eligibility or characteristics up with an available bed (e.g., age, gender, family constellation) or geographic barriers if the bed is in accessible to the individual who is homeless or he or she does not want to leave the area they are familiar or comfortable with. There also may be issues with the coordinated entry system or tracking individuals who have been approved and are awaiting an available housing resource. It could be a reflection of mismatched resources compared to the population's needs. There are countless reasons that may be contributing to some beds within the continuum of care being under-utilized.

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[13] "2020-WeAllCount-Report-10.Pdf."

Utilization Rates the Night of the Count

Utilization rates are based on the total number of beds available in San Diego County and the percentage of those beds that are in use the night of the Point-in-Time Count. The percentages below show a snap shot of how effectively shelter programs are matching people with beds on any given night.

Year	Emergency Shelter	Safe Haven	Transitional Housing	Permanent Supportive Housing	Rapid Re-Housing	Other Permanent Housing
2016	71%	89%	80%	87%	100%	45%
2017	90%	10%	82%	87%	100%	32%
2018	89%	70%	87%	85%	100%	91%
2019	86%	88%	89%	86%	100%	91%
2020	92%	89%	77%	81%	100%	93%
Acceptable Utilization Rates*	75%-105%		80%-105%	85%-105%		

*As determined by HUD's recommended methodology.

[14]

Source: RTFH, 2020 - We All Count Report

Complexity of the Funding Landscape

Much like other aspects of homelessness, the funding picture is complicated.

At the highest level, since 1987 and the adoption of the McKinney Act (later to be expanded to the McKinney-Vento Act with the inclusion of protections for homeless children in education) the Department of Housing and Urban Development is the main Federal agency charged with addressing and funding homelessness services. However, homelessness services overlap with other major areas of public service or the social safety net including education, employment, housing resources, public safety, and more. To illustrate this, in 2019, Beta Data Lab analyzed the landscape and flagged 33 federal programs that identified homeless people as beneficiaries whether as the primary target population or as one of the recipient groups.[15] Similarly, a 2019 California State Audit report on the topic indicated that the State had at least nine agencies administering and overseeing at least 41 different programs to end homelessness yet the State was lacking an overarching oversight body and no single entity was responsible for a comprehensive strategic plan.[16] In addition Federal and State funding, counties, cities, and private funders also contribute to the field. This makes it a challenge to track the funds and the outcomes in aggregate. The landscape is so complicated that there seems to be no single place where information on funding or data is aggregated to get a complete picture, not only at the federal and state levels, but this is also the case at the county or even city levels.

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[14] "2020-WeAllCount-Report-10.Pdf."

[15] "Homelessness Federal Financial Data |U.S. Treasury Data Lab."

[16] "Homelessness in California The State's Uncoordinated Approach to Addressing Homelessness Has Hampered the Effectiveness of its Efforts.Pdf."

A more recent change to homelessness definitions, services, and funding at the federal level occurred in 2009 after the housing bubble burst. In addition to reauthorizing some of the McKinney-Vento homelessness assistance programs, elements were added or changed when the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act was signed into law. This law recognized prevention of homelessness, rapid re-housing, consolidation of housing programs, and new homelessness categories to address changing dynamics and best practices. More specifically, it increased the priority of supporting homeless families with children, focused on developing permanent supportive housing, recognized and granted greater flexibility for rural communities, and greatly expanded prevention services.[17]

COVID-19 brought numerous additional changes and funding sources to the sector with its myriad of impacts on people's health, financial implications, child care needs, and overall public health impacts. This was true at the federal, state, and local levels. San Diego County and its component cities increased their efforts and attention to reduce transmission of COVID and address the increased strains on residents that were risk factors for homelessness. Efforts included the use of and purchase of hotels to provide hundreds of non-congregate shelter beds, the conversion of Golden Hall and the Convention Center into emergency shelters with embedded service providers to help with housing navigation among other needs, grants to support homelessness resources for incorporated cities in the county, and the addition of tent shelters and safe parking lots, to name a few.

Private philanthropy, including faith-based philanthropy and service, have also long played a major role in addressing and serving the homeless population. There are some providers in the county who operate almost exclusively on those funds. During the pandemic, resources increased from these sectors and philanthropic foundations streamlined their processes to grant funds and reduced requirements for reporting to prioritize getting funds, services, and housing to those in need. A recent report indicates that some of these changes may continue.[18]

With a problem as significant as homelessness is in San Diego County and throughout the nation, and given the complex and overlapping sectors that feed into homelessness with its diverse population, needs, experiences, causes, etc., it is hardly surprising that there are so many funding streams and stakeholders. So many aspects of life, community, and government interact in this sphere, and they cannot be disaggregated. It makes it a challenge to identify who is leading the charge and how exactly the charge should be led. It is almost like trying to separate or hierarchically organize requisite biological systems and indicate which takes precedence – the circulatory system or the respiratory system. One cannot survive without blood fueling the body and organs, but if that blood is not oxygenated, it is like having water in the gas tank. The analogies do not stop there, much like in the field of homelessness.

This leaves us with a landscape that cannot be accurately and fully mapped and understood. It is, as stated earlier, a very balkanized landscape of solutions. Dozens of agencies contribute to these services

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[17] "Summary of HEARTH Act."

[18] "Foundations Respond to Crisis."

with their own priorities and lenses. Data that are reported are not always consistent or aggregated to tell one overarching story. Population dynamics and outcomes in the big picture of homelessness in San Diego County cannot be fully understood without cooperation among all those involved.

The Ecosystem of Homelessness Services and Performance Reporting

In order to receive HUD Funding, a self-defined region or collaborative or stakeholders in the field must organize under an umbrella referred to as a Continuum of Care (CoC). San Diego County has done this and is organized under the Regional Task Force on Homelessness (RTFH). RTFH then is responsible for creating and maintaining the HMIS database, also a mandate from HUD, to aggregate required and optional data on all services, providers, and recipients connected to federal funding. The mandate of participation in HMIS creates this most unifying force in the realm of homelessness data in the country. RTFH then must comply with a myriad of reporting and planning requirements in line with federal requirements. Further, these aggregated reports are what RTFH must use to report to federal agencies the statistical state of homelessness needs and services in the region to gain access to federal funds.

Homelessness Data Systems in San Diego

In 2001, Congress mandated the U.S. Department of Housing and Urban Development (HUD) to collect unduplicated data on the population of homeless people for each locality[19] (Center for Social Policy, 2002). Ultimately, by 2004, HUD had overseen the creation of the Homeless Management Information System (HMIS) in order to allow local level data to be collected by providers[20] (HUD, 2021). To ensure participation in this central data system, the most efficient way to reduce duplication and get the most information on the population, ultimately all service providers receiving funding from HUD, the Office of HIV/AIDS Housing, the Health and Human Services (HHS) Department, and the Department of Veterans Affairs (VA) were required to participate in the HMIS system. To further support the development of shared local level aggregate data that is unduplicated, communities and regions were encouraged to join together within natural and logical boundaries to form a Continuum of Care (CoC) which could be cities, one or more Counties, or even at the State Level. As the system developed, it was collective reports from CoCs which were submitted to give a regional, comprehensive picture of the population, needs, and utilization when applying for Federal Funding so that funds were triaged and allocated according to need demonstrated in HMIS. California has 44 CoCs, of which San Diego is one and it is organized under the umbrella of the Regional Task Force on Homelessness (RTFH). RTFH is responsible for maintaining the HMIS system in compliance with Federal Mandates and in a manner that meets the needs of the local CoC, including the Coordinated Entry (CE) system which is intended to support triaging clients and maximizing utilization of available resources with the least disruption or delay.

The Homelessness Management Information System (HMIS) is the database that has been created and mandated by public funders for use by service providers that receive public funds for well over a decade. The San Diego region is organized as a Continuum of Care with the Regional Task Force on Homelessness as the Lead Agency for the local HMIS. Substantial work goes into often annual updates

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[19] "Homelessness in California The State's Uncoordinated Approach to Addressing Homelessness Has Hampered the Effectiveness of Its Efforts."

[20] "FY-2022-HMIS-Data-Standards-Manual.Pdf."

to the data fields and programming logistics to continue to refine the HMIS system so that it feeds into the most accurate local and Federal data sets. While use of HMIS is not mandated by program providers who do not receive public funds, they are both welcomed and encouraged to participate in HMIS. Other funders, public and private, may themselves stipulate participation in HMIS as a condition of funding. While many providers are part of the HMIS system, most providers also operate their own data systems as HMIS may be a necessary component, but the shared HMIS system is not sufficient to cover the data and service tracking needed for each individual organization. HMIS in San Diego is currently provided through a service agreement between RTFH and Clarity. Organizational service providers may hold their own contract with Clarity to meet their organizational record needs; however, organizations may use any other variety of vendors or programs developed in house to manage this. As mentioned, there are service providers in San Diego that are not required to enter into HMIS. Some of those providers may choose to, others may work with RTFH for some unidirectional or bidirectional information exchange, and others operate fully outside the HMIS system.

Process Overview

Public Stakeholder Meetings in April 2022

In April 2022, the PROS Board convened a series of meetings with public funders, private funders, providers, and those who have experienced homelessness to solicit feedback on opportunities for measurement standardizations. The PROS Board staff invited representatives from across San Diego County.

The goal of these meetings and information gathering sessions was to review issues identified in a working draft of the Discussion Paper and expand on or refine them. The staff anticipated that the stakeholders would identify additional issues; add clarity or depth to issues already identified; collapse or reorganize certain issues; and perhaps indicate that some are not relevant, are out of scope, or should be removed for another reason. Further, the staff sought feedback from stakeholders to help begin prioritizing issues of greatest need and topics that may be most immediately actionable.

This Discussion Paper is a product of the PROS Board staff with additions and shaping by the inputs of the stakeholders with whom we met in April 2022.

Working Groups to Meet May 2022 Onward

This Discussion Paper will help focus the discussions of the working groups based on topic or issue. The staff expects a minimum of two working groups, one to focus on potential measurement standards at the "macro" level of interactions between a service provider and the system of care and a second at the "micro" level of interactions between a service provider and a client. These working groups will discuss the questions presented in this Discussion Paper.

Each working group will conceptualize costs to service providers and benefits to the outcomes of those experiencing homelessness. Conceptualizing costs versus benefits will ensure standard setting efforts are

focused on areas that make the most sense for the homeless while assuring that the costs to the operators are justified.

Where there is consensus that the benefits are highly likely to outweigh costs, working groups will then iteratively discuss potential standards to give the PROS Board staff enough understanding to draft potential rules or methods, which will be published in the form of Exposure Papers. Once regional consensus is reached within a working group on a potential rule or method, then the recommendations of the working group will be submitted to the PROS Board for final adjudication and subsequent publishing. When consensus is not achievable, then the PROS Board will receive multiple recommendations for a rule or method and will debate and vote as the final arbiter for what gets published.

Further detail as to processes in general is available in the PROS Board "Rules of Procedure."

Invitation to Comment

It is critical that the ultimate creation of standards by the PROS Board in any domain of public good be informed by stakeholders and impacted members of the public. Standards where the potential benefit to the overall efficacy of the system and therefore outcomes for the clients do not outweigh the overall costs to operations will be counterproductive. Standards that do not contribute meaningfully to building trust and decision useful information being presented in performance reporting is non-productive.

Feedback from stakeholders and the public is needed in order to shape this process in a useful and meaningful manner. This Discussion Paper will continue to be informed by a series of formal meetings and informal meetings and discussions, direct solicitation of client feedback, survey responses, and perspectives shared during an open comment period. Feedback can be submitted via email at sdprosboard@sdcta.org, online at www.sdcta.org/prosboard, through public meetings, by mail SD PROS Board, 2508 Historic Decatur Road, Suite 220, San Diego, CA 92106, or by phone at 619-234-6423.

Due to the public nature of this work and the commitment to transparency and demonstration of the dialogue, just as the work of the PROS Board will be part of the PROS Board public file available online, the process of the work, including public comments, will also be part of the public file. In order to support the clarity of these communications and to consider them actionable, it is requested that feedback clearly state:

The specific document or work project the comment refers to
The specific section(s) the comments address
The rationale for the comment wherever possible citing specific examples, details, or research
A specific suggestion for a change, addition, or deletion of a standard or concept

Personal individual contact information (address, email, phone number) of those who provide comment will **not** be included in the public file. Please indicate if information provided is personal. Professional and organizational contact information may be included in the public file.

Public comment period for this paper will be 21 calendar days from the Publication Date on the cover page.

Anticipated timeline and work product

A successful result of the Discussion Paper process, stakeholder meetings, and public feedback will lead to the formation of multiple working groups, by topic area, composed of diverse stakeholders, who will further prioritize areas of focus, evaluate the relative costs and benefits of creating a standard or standards in that domain, and the proposal by consensus or draft standard to be put forth to the PROS Board for consideration. If the PROS Board, based on the recommendation of working groups, agrees to the standard(s), they will vote to have them included in Exposure Papers which will then be released for a public comment period. Working Groups will then review public comment and amend or remove standard(s) as needed and re-submit to the PROS Board for a vote on adopting the standard(s) or not.

Standards that are adopted will be made publicly available. Standards that are not adopted will also be reported along with the rationale for why they were not adopted as presented.

It is expected that different standards may be created and approved on different timeframes and that initial standards may begin to be released in late 2022.

Definitions and Scope

As with prior sections, this is not intended to provide a comprehensive overview of definitions within the field of homelessness, homelessness services, or data and outcomes. Rather, the shared definitions are intended to help limit the scope of this current project. As this is the initial effort of the PROS Board's collaborative approach to creating and setting standards in domains of public good, the focus has been narrowed to homelessness services which provide access to beds, (direct or through vouchers) for any duration and any type, or housing. As such, this current effort is not intended to track other critical services in the ecosystem of care which are not immediately attached to provision of beds including but not limited to outreach or supportive services only such as case management, treatment, or job training, to name a few. The following definitions are offered to help define what types of service are in the scope of the current project. These are HUD[21] definitions.

EMERGENCY SHELTER (ES): Any facility, the primary purpose of which is to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless.

TRANSITIONAL HOUSING (TH): A project that has as its purpose facilitating the movement of homeless individuals and families to permanent housing within a reasonable amount of time (usually 24 months). Transitional housing includes housing primarily designed to serve deinstitutionalized homeless individuals and other homeless individuals with mental or physical disabilities and homeless families with children.

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[21] "FY-2022-HMIS-Data-Standards-Manual.Pdf."

SAFE HAVEN (SH): A project that offers supportive housing that 1) serves hard to reach homeless persons with severe mental illness who came from the streets and have been unwilling or unable to participate in supportive services; 2) provides 24-hour residence for eligible persons for an unspecified period; 3) has an overnight capacity limited to 25 or fewer persons; and 4) provides low demand services and referrals for the residents

RAPID REHOUSING (RRH): A permanent housing project that provides housing relocation and stabilization services and short- and/or medium-term rental assistance as necessary to help a homeless individual or family move as quickly as possible into permanent housing to achieve stability in that housing.

PERMANENT (SUPPORTIVE) HOUSING (PSH) (Disability required for entry) - A project that offers permanent housing and supportive services to assist homeless persons with a disability (individuals with disabilities or families in which one adult or child has a disability) to live independently.

OTHER PERMANENT HOUSING (OPH) (No disability required for entry) - A project that offers permanent housing with or without supportive services to assist homeless persons to live independently, but does not limit eligibility to individuals with disabilities or families in which one adult or child has a disability.

Prioritized Discussion Questions

This discussion section is designed to surface issues for further discussion and potential development of regionally accepted standards.

First, the staff of the PROS Board has organized discussion questions into two main sections, one looking at the interactions between a homelessness services recipient and providers and the second looking at the interactions of the provider in the macro-sense with the regional/ systems of care. Within the first section, the discussion questions are organized by the general lifecycle of the service recipient from presentation to screening, intake, consent, assessment, service plan development, and service delivery/ referrals and finally to interruptions of services or completion of services and discharge/ onward referral. At the macro-level of the provider, the discussion questions are organized around initial presentation/ referral/ intake, measurements of the services as a whole, discharge/ referrals, and longitudinal reporting/ tracking.

Second, each question – in the form of "[w]hat are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to…" – is intended to provoke conversation around the value of a potential regionally accepted standard for that issue. The discussion of the question in and of itself, while it may imply the potential of a regionally accepted standard, does not mean the PROS Board will ultimately issue a standard there. Please note that the staff of the PROS Board, leveraging prior experience in the provision of social services, attempted to elucidate potential benefits and costs to answer the question and also offers other questions to consider so that we share a sense of the benefits and costs of a potential standard before the region commits to designing/ making a standard.

Third and finally, the staff of the PROS Board acknowledge there already exist certain reporting standards or methods that may go beyond the region (e.g., federally mandated requirements, state-level, county-level contractual obligations). The discussion questions are also designed so that the development of regionally accepted standards takes the best of these "extra-regional" requirements and acknowledges the troubles or difficulties they may engender. Ultimately, the development of regionally accepted rules may deviate from these extra-regional requirements, and if that occurs, it is also the hope of the staff of the PROS Board that the parent organization of the San Diego Taxpayers Educational Foundation – the San Diego County Taxpayers Association – would consider advocating for extra-regional changes to reduce the burdens on regional service providers.

Questions at the "Micro"-level of Service Provision and Processes: Interactions between providers and recipients

This category of questions recognizes that a shared data repository is just that – it is shared. This means each program or organization does not have full control over it. It may mean it is not customizable for the needs of each program or organization. It may mean contributing entities cannot pull tailored reports out of it to meet their needs. It may cause certain data points to be collected that are less helpful and other data points to be missed that could have been helpful. There may be privacy or security concerns. The purpose of this category is to understand how stakeholders handle measurements with clients and if it means separate systems need to be used or resources invested (staff, money) to make the one system meet their needs. There is a recognition that service providers do not always have the background in data collection or analysis, nor the IT infrastructure or expertise to build systems, nor the financial capacity to buy or pay for tailored, robust electronic data systems and analysis. Organizations may not be able to enter "additional" data that is important to them into the shared system without others having access to that additional data. All of these and additional reasons prompted this section. Programs and Organizations have more information to collect and document that what goes into a system like HMIS. It begs the question where that information can be entered, used, and analyzed for programs and organizations on a program and entity level. It is critical to learn how entities are handling the information management, what the full scope of options might, and what the practical limitations to exercising those options may be. This may be particularly sensitive to size of the program or organization, access to adequate tools and connectivity when interacting with clients, or limitations of staff time, to name a few of the issues to surface.

Measurements at Homelessness Service Recipient Presentation

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to the use of engagement strategies?</u>

A reasonably common challenge in social services in general and homelessness services, in particular, is related to engagement of clients or potential clients. Though the intention may be good from the funder or the service provider's perspective, it may not always feel that way from the prospective service recipient. This is a near universal problem, and it is important to flesh out some of the reasons for this to inform the system and to improve the system. That is the intention of this section. If providers fail to

engage their audience effectively, they may fail to deliver on the intended outcomes of supporting people dealing with homelessness or beginning to solve the problems of and related to homelessness.

What are the biggest challenges in engaging people in services?

Do you have a way to capture data on who you weren't able to engage in services?

Is there any level of service a person may receive without submitting personal information? If so, please describe what service(s) and if there are any limits on quantity of those services pre-personal information sharing.

Potential Benefits to Outcomes	Potential Operational Costs
- Effective engagement strategies should result in greater access to care. - Effective engagement strategies should result in increased trust and information sharing. - Effective engagement strategies should result in better outcomes. - Effective engagement strategies may translate to improved re-engagement strategies. - Effective engagement strategies may result in fewer lost connections during any waiting periods. - Effective engagement strategies may result in successful network referrals to harder to reach people. - Effective engagement strategies will likely result in increased job satisfaction and likely staff retention which likely further improves outcomes, outputs. - Effective engagement strategies may translate into less time consuming and less costly "customer acquisition."	- Training staff to effectively engage while ensuring compliance with a variety of other operational requirements is challenging, time consuming, and has varying success. - It may be difficult to find staff that are successful at engagement and the other areas of client service delivery. - Workflow issues that prioritize engagement sometimes sacrifice other elements of operations. - Engagement efforts themselves can be time consuming and costly. - Some programs may target populations with very high engagement costs. - Engagement costs can vary significantly with population, geography, situation and, if not understood, can result in inappropriate conclusions being drawn about the efficiency or efficacy of a program or staff. - Hiring diverse staff (language, race, ethnicity, identity characteristics, lived experience), a strategy to increase engagement, can create additional training challenges, intrastaff challenges, and hiring challenges which may all add costs or time.

Measurements at Client Intake

What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to regionally-accepted standards of intake assessments?

> If you are required by contract to conduct intake measurements a certain way, what about those requirements have benefits to client outcomes? What are the costs? Are there any measurements that are not meaningful or incent the wrong organizational or provider behaviors?

Potential Benefits to Outcomes	Potential Operational Costs

Measurements throughout Service Provision (including intake and discharge)

What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to standards of service plan development that assures the leveraging of the Continuum of Care?

> If you are required by contract to develop service plans a certain way, what about those requirements have benefits to client outcomes? What are the costs? Are there any measurements that are not meaningful or incent the wrong organizational or provider behaviors?

Potential Benefits to Outcomes	Potential Operational Costs

What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to utilize San Diego's shared central information system, namely HMIS, for data collection?

Why would service providers maintain proprietary systems for data collection if they had access to HMIS?

Would having a universal, shared information exchange for data collection be helpful? How has or could it be helpful? Are there specific examples?

Can a universal information exchange system serve to capture descriptive information and changes of the population as well as effectively measure meaningful outcomes for various programs and unique individuals?

In what ways does a shared information exchange system cause challenges?

Are there issues with data sharing amongst the CoC/SoC? What issues? How have you resolved them? (Privacy/confidentiality, security, competition, lack of trust, concern over use, timelines, infrastructure set up costs, infrastructure maintenance costs, data accuracy, data consistency)

Are there specific data or elements of shared information exchange system that have contributed to missteps or been inadvertently misleading?

Are you realistically able to customize additional components of a shared information exchange system?

Potential Benefits to Outcomes	Potential Operational Costs
- Service recipients do not need to share their basic information repeatedly and therefore can access services more quickly, increasing the odds of long-term success. - Stored, accurate shared data can help connect a recipient to the right service more efficiently, increasing the odds of long-term success. - Handoffs between staff or agencies should be supported by a shared system and the likelihood of someone falling through the cracks should be reduced. - Even when a person is not actively engaged with the system, they can re-enter the system with a lower barrier to entry, increasing the odds of long-term success.	- Data sharing creates staff training costs, as staff must be properly trained on system use and privacy/ confidentiality. - The deployment of a technical solution to connect proprietary systems to the central informational hub creates operational costs. - Agencies may still need or prefer to have their own systems in addition to the shared system which creates duplication, re-introduces likelihood of error, increases operational costs. - Error or conflict resolution over data between agencies may occur and require staff time to address. - Elements may be required that do not fully or adequately represent the data from the perspective of the provider potentially leading to misinterpretation or misinformed decisions.

- Information retained should be more accurate thereby supporting better service provision.
- Theoretically, funds will be directed in a manner that matches demonstrated need and demonstrated outcomes.
- Knowing that a provider can pull up a complete history of a service recipient allows the provider to tailor the most appropriate services for that recipient. It prevents the costly time needed to complete an incomplete historical profile.
- Data at point of entry from a referral may be able to represent discharge or follow/up data from the referrer resulting in better outcomes tracking and indications of where clients are connecting successfully vs where they are not. Further, if the referral is not successful, reappearance in the system at another provider can help inform both referrer and referral source as well as that current provider and the system, that there was some lapse and may provide all parties with useful information to improve the system of care, facilitated referral process, etc.
- Full commitment to a shared data system may greatly improve accuracy and ability to track longer term or longitudinal outcomes for those that remain in the system through subsequent entries rather than through often time consuming data collection efforts. This can contribute to system improvements based on identification of needs and allocation of resources aimed at improving overall outcomes.
- A shared data system, assuming some shared assessment or intake processes, may also provide a more comprehensive view of each individual/family allowing analysis over time and supporting provision of tailored services to meet the needs of the recipient.
- A shared data system may provide greater ability for continued coordination between providers and possibly contact

- The universal system may not capture the nuances of specific programs or situations requiring resources to correct, explain, or provide additional data or reports.
- Available reports may not be adequate for the service provider or funder requiring customization or parallel tracking and reporting.
- Where the system allows it, different approaches by different agencies may create discrepancies in the data leading to potentially inaccurate conclusions.
- Shared systems can get filled beyond a point of usefulness making it difficult to access the data that is current, correct, or useful; making it difficult to trust; often leading to behavior that exacerbates this situation by each provider starting over rather than being able to build upon existing info.

with the recipient if there is follow-up theoretically resulting in better coordination of care, continuity of services, and effective communication. ● When multiple providers are simultaneously working with a client, a shared system may facilitate that process, thereby improving service delivery and theoretically outcomes.	

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to standards that ensure data input into any regional system is trustworthy, reliable, and useful?</u>

If data are intended to report on inputs (e.g., dollars invested), processes (e.g., type of service provided), outputs (e.g., number of shelter bed nights provided), and outcomes (e.g., number of individuals who maintain the same or better level of shelter stability at discharge) as well as general features of the population (e.g., demographics, factors contributing to homelessness, chronicity of homelessness, etc), a lack of trust in the data by a service provider will potentially prevent its use and thus reduce the provider's ability to tailor services to the recipient. There are many complexities that occur in the provision of services, collection of data, and entry of data. It is of the utmost importance that resources are provided, barriers reduced, training provided, definitions are agreed upon, and systems are in place to support the reliability of the data entered. This section is intended to elucidate the current state of the data in HMIS, or other data systems, from a variety of stakeholders with respect to trustworthiness, accuracy, and reflection of near real-time information.

This question speaks to the desire to have the data that are collected be useful to multiple parties. This requires considerable thought and collaboration. It is all too common that, inadvertently, the collection of certain data or the drive towards certain targets may inadvertently incent decisions and operations which may not be in the best service of the client or overall mission. As a fictional example, let us say reducing time people are on the waitlist for housing is a goal. It is an understandable goal if it means they have "successfully" moved off the waitlist. However, policies or practices may be developed or evolve to meet that goal in less ideal ways. A program may implement a policy that if staff have no response from the person on the waitlist within one day, they are removed. That does not represent a successful outcome for that person but it represents a success for that program if reducing people or time on the waitlist is the measured data point. That would be a difficult response time to hold someone to who is struggling with homelessness and on a waitlist for services who likely does not have as ready or reliable access to email, phone, mail, and transportation among other possible challenges.

This question is also attempting to get at what people, programs, and funders see as informative data about their success. It is critical to recognize how variable that can be based on environment, program type, population served, continuum of care resources, unique needs of clients, missions of funders, etc. One funder may prioritize access to shelter, even shelter for one night, for as many as are in need without the expectation that service recipients will walk the path towards greater housing stability. Success for

that funder looks very different than for the funder that has the vision of ending homelessness in the San Diego region and moving every overnight sheltered person into case management and towards increasingly permanent housing stability. From the service provider perspective, one program may generally focus on front end engagement and increasing continuity of contact with chronically homeless people struggling with serious mental illness or addiction. For that program, increased number of contacts with a service recipient may be success even if they are not housed. For another program, nothing short of sustained stability in permanent supportive housing with fewer emergency contacts to the Housing program and regular contacts to their peer support partner, case manager, counselor, etc., would be success. High contact at the point of engagement is success in one program and not necessarily success in another program. Clients in homelessness programs for people struggling with addiction, depending on the priorities and rules of the program, may view only negative drug tests as success whereas other programs view a reduction in the number of drugs as success, or simply engagement with the testing process regardless of results as a success. These things are far better understood by stakeholders than by academics. Academics can then take information shared by stakeholders and help try to design useful data points and analysis to point to true efficacy of a program based on its specific space in the sector.

If data entry and reports lag, that impacts the ability for decisions to be made in a timely manner and support nimble operations, targeted resource allocation, and even treatment team treatment efficacy and coordinated care at the level of the client-staff interaction. If information that is or feels unnecessary is collected and entered, it impacts the customer experience, the staff experience, and the ability of the program to report in a helpful manner or the funders to make informed decisions. It can also be a waste of financial resources. If a provider thinks certain data should be collected due to how informative or useful it could be, but they do not collect it because of other requirements taking priority, barriers to data collection or entry, or due to an expectation of only uniform data elements being presented, the entire system misses out.

This is arguably one of the most important question on which to gather broad and deep thoughts from stakeholders. If in the end we have uniform, timely, trustworthy data that is not meaningful and specific enough to provide valuable insight, we have missed the forest for the trees. One of the challenges will be identifying exacting data that has some ability to allow meaningful comparisons between programs or for participants (improvement over time) that can be tailored enough to the unique features of the program, allowing necessary or appropriate carve outs while not dismissing data or outcomes that may be less favorable.

This question begins to address the holy grail. In an ideal world, we will have trustworthy data that is meaningful, not burdensome and allows for any interested party to compare like programs on an apples to apples basis. The more tailored data is between programs, the more data likely needs to be collected by providers and from service recipients and the less funders (or service providers or recipients) can efficiently and effectively gain decision useful information from reports. The reports will all look very different. Information will not be in a reasonably expected order. Comparative analysis will be difficult or impossible. The reader will wonder if the information presented is a complete an accurate representation or one where data was selected to highlight successes over shortcomings. There is a level of uniformity of data reporting that may also be helpful for providers and clients. If diverse funders require a uniform data set, training and systems can be easier, workflow can be more efficient, and clients do not have to

share different information, variations on a theme, to satisfy different funder reporting requirements. This is a complex area that requires finding the right balance which can only be discerned from feedback from and conversation between stakeholders.

What enhances and detracts from data usefulness, if you are accessing from a centralized system?

What facilitates quality assurance in data?

Is it necessary for an organization to have its own data tracking and charting system in addition to a shared information exchange? Why or why not?

Are there benefits to having multiple systems in which to enter data? Why or why not?

Are there disadvantages or costs (fiscal, burdensome to staff or service recipients, complexity for direct staff, costly QA or IT staffing needs, etc) to having multiple systems in which to enter data?

Is there funding or technical assistance to support these expenses? Please describe.

Do you have formalized data collection processes – intake, assessment, discharge, follow up?

Do you have data that demonstrates a change from one point in time to another (intake to discharge or discharge to follow up)?

Are you able to extract decision useful data and reports from your own system?

What it the most useful data you collect (receive as a funder, provide as a client) and why?

Is there data collected that seem extraneous or not useful?

Do you feel there is data that particularly effectively communicates outcomes? What data does this?

Do you feel there is data you collect/receive/provide that is particularly misleading or unhelpful/not representative?

Do you feel there is data that effectively communicates efficiency or meaningfully captures a cost per unit? What data communicates this?

Is data collected and accessible in a timeframe in which it is useful for decision making?

Providers – Do you have to collect different data for different funders?

Funders – Do you receive vastly different reports from different providers? Does that make it more or less difficult to gauge efficacy?

Potential Benefits to Outcomes	Potential Operational Costs

- Knowing that a provider can pull up a trusted history of services for a current recipient allows the provider to tailor the most appropriate services for that recipient. It prevents the costly time needed to complete an incomplete historical profile.
- Efficiency of service providers can result in more time spent on services.
- Trustworthy data can support more effective and efficient service connection.
- Accurate data may enhance service recipient trust in the system and/or provider.
- Trusted data may enhance funding in the needed and beneficial areas creating a better system of care and opportunity to access needed services and supports.
- A system that is trustworthy may engender greater responsiveness or partnership from other benefit systems.
- Data at point of entry from a referral may be able to represent discharge or follow/up data from the referrer resulting in better outcomes tracking and indications of where clients are connecting successfully vs where they are not. Further, if the referral is not successful, reappearance in the system at another provider can help inform both referrer and referral source as well as that current provider and the system, that there was some lapse and may provide all parties with useful information to improve the system of care, facilitated referral process, etc.
- Useful data can improve service delivery.
- Useful data can track meaningful outcomes and communicate them to all stakeholders including funders thereby increasing funding for successful programs or gaps in services.
- Useful data may be shared with service partners.
- Useful data (and effectively communicating its use) may serve to engage service recipients and encourage complete data disclosure.

- Data quality requires audit trails, timeliness expectations and tracking, and other mechanisms to reduce errors.
- Extensive training of staff is required initially and ongoing to support their ability to enter data in a timely, accurate, consistent manner.
- Required data may change over time requiring additional training and or system upgrades to remain up to date – whether in a shared system, an organization specific system or both.
- Staff may feel a disproportionate amount of time is spent on data leading to turnover disrupting service provision, impacting quality, and increasing operational costs.
- Accuracy tends to improve with real time or near real time documentation which requires additional training and proficiency increasing costs and reducing employee pool.
- To establish trust, costly and time consuming Data Quality Assurance systems are necessary to test the data routinely.
- A shared monitoring/audit system is likely needed to develop and maintain a mutual sense of trust in data entered by every participating entity which requires costs to set up, administer, and adhere to at a systems level and on the part of each organization.
- Understanding and developing useful data collection is time consuming and costly.
- Collecting useful data in addition to required data can be time consuming and costly.
- This generally requires dedicated and specific data and quality assurance and improvement staff.
- When staff feel there is excessive focus on data, it can lead to turnover impacting service quantity, quality, and costs.
- Usefulness is not universal and the process to get to what is useful and agreeable or to determine who enters what required data can be a point of conflict

- Useful data and effectively communicating its use) may serve to help retain staff and motivate them to collect quality data throughout the course of services and possibly even at follow up.
- Useful data may help staff feel positive about their work and support their ongoing commitment to service delivery and quality data.
- Uniform data sets allow the opportunity to gain efficiencies if data is shared and save staff time and reduce errors.
- Uniform data sets allow for reduced training costs because costs might be shared or borne by an overall system administrator. Costs may be reduced for staff that move between programs or agencies.
- Uniform data sets may require less time and repetition from recipients allowing quicker access to services.
- Uniform data sets may allow comparisons across programs or comparison within programs over periods of time, between staff, between programs, etc.
- Uniform data sets can help understand the population as a whole including its needs, what works, and what hasn't worked.
- Uniform data sets can help make comparisons between regional populations and apply lessons learned or allocate funds.
- Uniform data sets or reports may reduce operational overhead freeing up more time for services.
- Uniform data sets can improve ability to measure outcomes and track longitudinal outcomes.

that, if resolvable, will take resources to resolve.
- Some useful data may be very difficult to get for a variety of reasons (accessibility-communication, willingness of the client, ability/knowledge of the client, accessibility – situational/time/technology) and the cost-benefit needs to be evaluated.
- A lot of information is client reported and subject to fluctuate for a variety of reasons which may make it difficult to trust that the data is accurate, complete, or useful and the provider may spend a lot of time wading through information in order to commit to useful data.
- Uniform data sets may not be sufficient data requiring additional costs to collect additional data.
- Uniform data sets may not present a complete picture leading to inadequately informed decisions.
- It is possible that uniform data sets introduce bias in interpretation based on idiosyncrasies of the programs or data collection processes.
- Programs may need to collect additional data to directly address misrepresentation created by the uniform data set.
- If uniform data is unnecessary or unhelpful, or perceived as such, it can lead to staff turnover.

Measurements at Client Discharge/ Exit

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to regionally-accepted standards of discharge/ exit measurements?</u>

> If you are required by contract to conduct discharge measurements a certain way, what about those requirements have benefits to client outcomes? What are the costs? Are there any measurements that are not meaningful or incent the wrong organizational or provider behaviors?

Potential Benefits to Outcomes	Potential Operational Costs

Questions at the "Macro"-level of Service Coordination, Improvement, and Measurement: The "System"

Measurements of System Capacity and Performance

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment of real-time tracking of space availability and active participation in the Continuum of Care?</u>

In the domain of homelessness, access is critical. Homelessness is, at its core, an issue of accessibility. Accessibility to safe, reliable shelter. It is of course impacted by a myriad of contributing factors, personal, economic, political, etc. Therefore, when someone presents to the system of care in need of shelter, access and maximizing effective utilization of available resource is critical.   This section focuses on elements related to access to resources.

Programs have various requirements and sometimes legal, financial, environmental, or programmatic restrictions on who they can serve. Unless there is no demand, ideally each program and the system will work to maximize their service provision or the utilization of their resources. This section is focused on how each provider manages their systems and coordination with others to achieve this goal. Underlying these questions is the premise that if a safe bed is available for the night in one program, and there is another person on a waitlist or otherwise turned away who is eligible – or at least not prohibited from intermingling due to any reason (age, active substance use, safety, etc) – there is a clear coordinated effort to connect the person in need with the available resource, even on an interim basis. For example, a veteran waiting for an available slot at a transitional shelter specifically for veterans may be better served by spending a brief period of time in another transitional program intended to serve single adults and then transferring to the veteran-specific program when available, than by waiting on a waitlist or by remaining in night by night shelters. This clearly requires a coordination of care, facilitation of transfer, awareness of alternative program requirements and exceptions that may be made in cases like this to enhance

crossover capacity. It is critical to understand what elements are in place or could be safely maximize utilization within the system.

How do you track availability of beds?

How close to real time is intake staff able to see bed availability?

Is there a system that allows coordination across providers to ensure maximum utilization?

How is the wait list managed?

Is there ongoing contact with people while on a waitlist?

Is there a triaging system for access? If so, please describe.

If there is a triaging system, is it automated?

If there is a triaging system, how was it developed?

If there is a triaging system, how often is its structure reviewed and by whom?

How are rules for length of stay established?

Potential Benefits to Outcomes	Potential Operational Costs
- A coordinated system of access to care should result in maximizing and optimizing utilization of needs to available resources. - Such a system should enhance mutual awareness within the system of care of other resources to best support the various needs of recipients. - Such a system should help identify gaps in services and channel funds towards those gaps. - Effective waitlist management strategies should result in fewer people in need falling through the cracks. - Such a system should allow for focus on triaging greatest need and/or best match as appropriate. - Such a system should support research on efficacy of different strategies – prioritizing based on best match vs	- A coordinated system requires shared data hub and inherent costs mentioned in previous sections. - A coordinated system may mandate ineffective strategies, like possibly assigning inappropriate matches resulting in poor outcomes for the recipient as well as the provider. - Managing a waitlist or helping facilitate a warm handoff with a population that can be hard to track and communicate with can be very challenging and costly. - Tracking internal availability may require one system and an ancillary system (or translation for interoperability) to report into a shared system, which requires additional staff time, opportunity for error, and potential issues if tracking is not real time.

prioritizing based on greatest need, for instance.	

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to "best practices," evidence-based practices, and/or continuous quality improvement in service quality?</u>

This question needs very little introduction. When stakeholders think about effectiveness of service, they may or may not think that it is expressed in terms of data and reporting, but they likely think of service quality and all that goes into selecting the type of service, training of staff to deliver that service, and then the further down the line functions of Quality Assurance and Continuous Quality Improvement to test if the service was delivered as intended and then how it is impacting the desired outcome and/or how it can be improved. The following sections under service quality aim to gather information related to this.

Like most industries, human services, inclusive of services focused on homelessness are ever-changing and complicated. Most industries have professional collaboratives, learning communities, shared working groups and other similar things to support the sharing of good ideas and lessons learned, the development of emerging concepts or service improvements, and mutual support and potentially pooling of resources. These tend to be indicators of a healthy system. This section is intended to gather information on the collaborations that exist, the benefits and challenges, and the involvement of individuals or entities in the bigger picture of homelessness – a landscape that is absolutely bigger and more complex than any one entity can effectively manage.

Do you participate in collaboratives or topic related working groups? Which ones? Is it helpful? How and how not? Is it a requirement?

Do you partner with other agencies for continuum of care?

Do you share data, client info, funding info? How? Where? Is it helpful? How? What could make it better, more helpful, or easier?

Where do you see coordination and collaboration work best? Worst?

How do you work with partners to maximize utilization across the system?

Do you track the need, referral to, and outcomes of linkage efforts to additional services or next step services? How?

Do you have a release of information process that allows you to coordinate with other service providers?

How do we build trust that the service modality and planned service is of high quality?

How have you chosen what services you offer?

Do you utilize evidence-based interventions? Please describe.

How do we build trust that the service is in fact delivered with high quality and adherence?

What QA system do you use for service quality?

What outcomes do you report on that best represent true service quality? Outputs?

What training do you provide staff to ensure quality delivery of service? At hire? Continuing ed?

How do we build trust in the commitment to ongoing quality?

Do you have a QI or CQI process? Please describe.

Do you have forums in which you gather opinion/satisfaction/suggestion info from service recipients? What? How? Benefits? Challenges?

Are people with lived experiences employed by your organization?

Are there outputs or outcomes that you report on that you feel may inadvertently misrepresent service quality? What? Why/How?

Are there conferences, trainings, memberships, associations you participate in towards ensuring up to date awareness and relevance of services?

What are the feedback systems or ways you can demonstrate incorporation of feedback, data analysis into your planning, training, operations, etc.

Do you collect input from your staff as to the processes, what's working, and room for improvement? How? How often? Who collects the info? What is the process for reviewing the info?

Potential Benefits to Outcomes	Potential Operational Costs
- This should result in clients having access to the best available services for their specific needs. - Collaboration can result in the sharing of best practices as well as lessons learned. - Effective CoC may result in the best mix of access and outcome. - CoC may result in shared accountability and commitment to high quality. - This potentially means a shared data system with previously discussed benefits to outcomes or access. - High quality, "proven" services should result in positive outcomes. - Commitments to these things should mean a well trained and capable staff providing services and the remediation of staff that are not performing adequately. - With a robust QA and CQI process, lack of positive outcomes should be identified fairly quickly and effort put into rectifying the problems or improving the outcomes. - This can be a positive feedback loop where well trained staff feel valued and invested, deliver quality services in an effective manner, recipients benefit and have positive outcomes, and staff continue to feel positive about their work and remain dedicated. This should result in less turnover and a satisfied workforce. - Best practice assessment measures should facilitate full and complete assessment	- It requires staff time to participate in collaboratives. - It is possible that participation in the COC/CE may be set up in a fashion that does not direct the referrals most efficaciously thereby costing resources and potentially impacting outcomes. - There may be a resource draw on data, data correction, or coordination involved in this participation. - Collaboratives may not be helpful or operate as intended leading to wasted resources. - This may mean choosing evidence-based practices which often come with high training costs, both initial and ongoing. This can be especially cost prohibitive if it is not a train-the-trainer model or other sustainable model. - At times, evidence based practices are very specific and any deviation puts at risk one's ability to say they utilize an evidence based practice. However, some modifications are often necessary to accommodate specific circumstances or applications. - Evidence Based practices often delay full deployment of new hires. - Time consuming and sometimes costly quality assurance efforts are necessary to evaluate quality. - Additional costs, skills, and data collection are required to have a more

which will include accurate identification of strengths, needs, contributing factors to current challenges and generally point the provider in the right direction for services to help achieve the client's goals. ● Measurement tools ideally will help track progress or lack of progress allowing for refinement of services or reassessment, as needed.	robust Continuous Quality Improvement program. ● Getting point B data can be challenging and time consuming. Sometimes evaluation is difficult without point B data. ● Gathering satisfaction feedback from the population can be challenging and time consuming. ● Engagement of staff in the QA and CQI processes is generally important to maximize learning and improvement and also to have adequate labor, but it takes staff away from service delivery and typically is less compelling to staff and can reduce employee satisfaction. ● Commitment to quality requires commitment to ongoing learning in the field which requires time and investment in conferences, trainings, professional collaborative/organizations, research, etc. ● Robust QA and CQI processes take time to develop and implement, ensuring meaningful data is collected and analyzed, implemented, and analyzed again. It often requires fine tuning over time. Yet consistent data points are also imperative to support the process. It is complicated and takes time and foresight to build into something meaningful and not something that can be developed or provide benefit in a short period of time. There is a lot of investment before a robust CQI process is in place.

Measurements of Movements Intra-System

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to successfully referring a service recipient to a follow-on regional agency with appropriate services and reporting such successful referrals?</u>

How do we account for the difference between attempted referral and failed referral due to system structure or internal policies?

Potential Benefits to Outcomes	Potential Operational Costs

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to standards of case management?</u>

Is there an appropriate "case load" for case management?

Is there an appropriate length of time for case management with a single client?

Potential Benefits to Outcomes	Potential Operational Costs

Measurements of Movements Extra-System: Into and Out of the System

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to standards of outreach performance reporting?</u>

Potential Benefits to Outcomes	Potential Operational Costs

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to accurate reporting of presented and referred recipients, as well as reporting those who had to exit to the street due to lack of space availability?</u>

If you are required by contract to report volume of potential clients and/or referrals certain way, what about those requirements have benefits to client outcomes? What are the costs? Are there any measurements that are not meaningful or incent the wrong organizational or provider behaviors?

Potential Benefits to Outcomes	Potential Operational Costs

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to reporting service recipients' statuses at some fixed time after exit, assuming the provider is a participant in HMIS pursuant to any rules developed by the PROS Board?</u>

> If you are required by contract to report longitudinal information in other ways, what about those requirements have benefits to client outcomes? What are the costs? Are there any measurements that are not meaningful or incent the wrong organizational or provider behaviors?

Potential Benefits to Outcomes	Potential Operational Costs

Future Opportunities for Regional Standard Setting

In this initial setup of regionally accepted standards in the provision of homelessness services, we will necessarily have to prioritize the issues and leave for another time other opportunities for standard setting. This section details items for future consideration.

Questions at the "Micro"-level of Service Provision and Processes: Interactions between providers and recipients

Measurements at Homelessness Service Recipient Presentation

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to regionally-accepted standards of initial screening?</u>

> If you are required by contract to conduct screening measurements a certain way, what about those requirements have benefits to client outcomes? What are the costs? Are there any measurements that are not meaningful or incent the wrong organizational or provider behaviors?

Potential Benefits to Outcomes	Potential Operational Costs

Measurements at Client Intake

Measurements throughout Service Provision

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to standards of cultural competency?</u>

This is a topic that, like engagement, is where clients may be won or lost, and successful outcomes for everyone may be achieved or squandered. The populations served are diverse and the staff providing services are also diverse. There are unavoidable elements like linguistic diversity that must be addressed, but other cultural factors play as much, if not more of a role in successful engagement and interventions as well as culturally respectful agreed upon goals. These can vary greatly. This section aims to gather information about how programs handle this level of complexity, how it impacts their training, workflow, outcomes, etc.

How do you ensure your services are culturally responsive?

What are examples of changes you have made or seen in order to continue to evolve in the context of cultural humility and responsiveness

In what ways do you support access for people with different language needs

In what ways to you support access for different communication styles (deaf, not able to read or write)

Are there specific challenges in serving your population from a cultural perspective

What efforts are made to match cultural make up of clients to cultural make up of staff

What ongoing trainings are conducted related to cultural considerations

How do you tailor your services to the unique needs of San Diego's geographic location and international border

Potential Benefits to Outcomes	Potential Operational Costs
- Training and representation should generally translate to more effective engagement and service provision which should, theoretically result in improved outcomes. - Diversity among staff tends to enhance awareness and cultural humility in a manner that exceeds the results of training alone. This better prepares staff as a whole to effectively understand, engage, and serve clients.	- It can be challenging and costly to effectively recruit and retain a sufficiently diverse staff. - Diversity among staff can create additional operational costs in training/communicating/interacting in different ways, resolving internal conflicts, fostering a culture of appreciation for diversity, paying additional stipends for linguistic diversity, understanding and allowing for the the added time it takes to work in a second

- This may enhance the employment opportunities for service recipients down the line as employees with lived experiences. - This makes it more likely that services or policies can be adapted with cultural accommodations in mind. - An awareness of diversity likely also points to ongoing evaluation of the newest considerations – cultural or service related – and a willingness of the organization to be nimble and evolve based on evolving needs.	language or to work in multiple languages (e.g., serving in Spanish and documenting in Spanish for the client and in English for the record/data). - Additional training carries costs in order to train to adequately serve your population. - Costs may be incurred for translation of materials, cultural consultations and adaptations to the environment, language lines, etc.

Measurements at Client Discharge/ Exit

None

Questions at the "Macro"-level of Service Coordination, Improvement, and Measurement: The "System"

Measurements of System Capacity and Performance

What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to standards of workforce management and quality?

California and San Diego have identified homelessness as a serious issue and have increasingly been investing funds, developing affordable housing, and supporting services towards ending homelessness. There are risks in assuring quality outcomes for service recipients when they are not served by a qualified and well trained workforce, as such a workforce is effective at connecting to people in need, effectively engaging those individuals and families, and continuing to support their stability (Mullen and Leginski, 2010).

The CEO of a large homelessness service provider in California recently shared in an interview that she had to hire seven recruiters to try to fill 340 vacancies out of 1,100 positions and, subsequent to the enhanced recruiting department, it is still taking an average of four months for her organization to fill any given position (Tobias, 2022). This data was reported for a period before a recent increase in funding which will create more employment positions, likely lengthening the average time to fill.

Recent trends in employment have been well documented and even prompted the coining of the term, The Great Resignation. Records have been set in recent years for job openings, hires, and quits in many sectors (Bureau of Labor and Statistics, 2022). The Social Service field has not been exempt and, in fact, like service industries, have been harder hit in some cases. The positions often carried greater health risk

with respect to COVID and also often are relatively low wage and relatively high stress. According to the Bureau of Labor and Statistics, the average annual wage in the private sector of Emergency and other relief services in San Diego County was $47,528 for 1845 private sector employees (2022). This translates to approximately $22.85 per hour. However, in a recent article on the topic, most organizations reported a pay range of $16-18 per hour for frontline service workers which the employers see as often not a living wage in California for jobs that can be very challenging – emotionally, physically, and mentally (Tobias, 2022). Due to the high cost of living, this effectively means much of the work force may be under similar stressors related to their housing stability. For many reasons, the field is susceptible to high turnover which impacts the entire system. Not the least of which are the recipients who may receive a new case worker every few months. This impacts the ability to build trust and rapport and reliably access the supportive services case management is intended to provide for people whose stability is so often tenuous.

Many staff in this field are motivated to help others and some have shared experiences and struggles similar to those of the clients they choose to serve. There is a great deal of literature in the social service field about the benefits of having staff members providing services and planning services who have lived experiences, that is, who have to some degree lived the life of the client. This practice tends to make the workplace more equitable and humanize work activities and services. Quality tends to improve as the policies and practices are informed in planning, real time, and retrospectively by those that understand the challenges and benefits. All staff tend to benefit from this lived knowledge within the workforce in their awareness in ways beyond what has been accessible simply through trainings or theoretical discussion and application. Community engagement almost invariably improves with inclusion of the population at hand, partly due to human nature and also due to increased trust, community reach, social capital, legitimacy or credibility, and a greater sense of community ownership. All of this necessarily improves service quality and likely supports improved outputs and outcomes. (Byrne, 2017)

Being an individual with lived experience can also bring unique challenges. Depending on where the employee is in their personal journey, they may still be struggling with some of the same challenges, or be relatively new in their stability, sobriety, etc. Many individuals with lived experience have mental health challenges including but not limited to trauma, often times multiple trauma, exposure which may impact their functioning or how they manage different stressors or triggers. In this field, these staff may also have less workforce experience or less recent or stable employment experience which sometimes means more training and support is required to help them succeed. This can especially be so as it relates to the technical skills required to perform the job be those literal computer fluency or writing/communication skills expected for the role.

Regardless of the reason(s), high turnover typically negatively impacts service delivery in efficiency and often in quality. It creates a revolving door for training (service delivery, technology and data collection, familiarity with services and the continuum of care, subject matter expertise) as well as client relationship development, an imperative in this field (Rios, 2018).

This section attempts to gather information about practices related to employee hiring, training, benefits, satisfaction, and retention.

Do you hire people with lived experiences?

Employee retention – administrative support, intake, case manager, clinician, management?

Describe measures taken to support staff safety?

Can you provide any information as to how your Average salary/benefits compares with similar organizations in similar markets?

Can you provide your staff Turnover rate?

Please describe institutional efforts intended to provide Staff support.

Please describe Training for client facing staff. Onboarding, ongoing, additional training opportunities.

Has your organization participated in workplace climate surveys, employee satisfaction efforts, or similar. If so, please describe.

Potential Benefits to Outcomes	Potential Operational Costs
- Effective retention results in a competent healthy workforce. - Effective retention is a good recruitment strategy via employee referrals - both of which lead to lower staff vacancies, less time lost to training, less burden due to cross coverage of high caseloads, etc. - Strong retention allows for enduring relationships, the time to build relationships and trust, and a knowledgeable workforce that can leverage their own relationships to get things done on behalf of the client. - Consistent workforce likely means fewer mistakes and the opportunity for higher level trainings. - Retention and promotion opportunities create a motivated workforce and retain institutional knowledge within the field leading to a higher caliber and well functioning system. - Effective retention implies staff are well taken care of in one or more ways - pay, safety, benefits, intangibles including	- Retention implies higher carrying costs for experienced and knowledgeable employees so that they don't leave and receive compensation commensurate with their skills and experience. - Many times contracts are written without an allowance for cost of living increases or wage adjustments so they can be difficult to manage without improvements in efficiencies or alternative additional funding streams. - It can be difficult to recruit people to work in this challenging field and may require additional costly incentives. - Retaining a diverse, experienced workforce has unique challenges in the higher wages for linguistic diversity or the often additional training and support required to recruit and retrain a diverse workforce. - Retaining a workforce with lived experience has unique challenges in the often additional training and support

- morale/belonging/sense of purpose/sense of efficacy/being cared for - which allows them to focus more on quality service delivery than obstacles or challenges in their workplace, workflow, etc.
- This tends to improve the true understanding, awareness, sensitivity, and efficacy of all staff who are then more able to engage and help recipients.
- People with lived experience tend to be more able to engage intended recipients and may have better client retention, more effective communication, and better outcomes.
- People with lived experience have an inherent credibility which sometimes make clients or other community members more forthcoming, sometimes affording better access to clients initially or in follow up efforts.
- This expertise on staff or leadership tends to help inform the entire program and organization from reducing structural barriers, to improvements in workflow, to other process and policy improvements making the service more welcoming and user friendly.
- People with this expertise can often solve problems before they happen or help resolve them once they have occurred.
- Effective retention results in a competent healthy workforce.
- Effective retention is a good recruitment strategy via employee referrals - both of which lead to lower staff vacancies, less time lost to training, less burden due to cross coverage of high caseloads, etc.
- Strong retention allows for enduring relationships, the time to build relationships and trust, and a knowledgeable workforce that can leverage their own relationships to get things done on behalf of the client.
- Consistent workforce likely means fewer mistakes and the opportunity for higher level trainings.
- Retention and promotion opportunities create a motivated workforce and retain institutional knowledge within the field

- required to recruit, train, and retain individuals with lived experience.
- Hiring people with lived experiences can be challenging for a variety of reasons including required clearances to be an employee at many of the agencies.
- People with lived experiences have often been exposed to one or more traumas and may be triggered by elements of the work and may require certain accommodations or specialized support.
- There can at times be conflict between employees with lived experiences and employees without them, or the institution, which may be very difficult to resolve to mutual satisfaction.
- Many people with lived experiences have additional challenges which, while making them qualified for the role, also present additional challenges (e.g., having a mental health diagnosis or substance use history).
- It can be difficult to find people who both have lived experiences and can manage the complexity and/or technology of these positions.
- Retention implies higher carrying costs for experienced and knowledgeable employees so that they don't leave and receive compensation commensurate with their skills and experience.
- Many times contracts are written without an allowance for cost of living increases or wage adjustments so they can be difficult to manage without improvements in efficiencies or alternative additional funding streams.
- It can be difficult to recruit people to work in this challenging field and may require additional costly incentives.
- Retaining a diverse, experienced workforce has unique challenges in the higher wages for linguistic diversity or the often additional training and support required to recruit and retrain a diverse workforce.
- Retaining a workforce with lived experience has unique challenges in the often additional training and support

leading to a higher caliber and well functioning system. • Effective retention implies staff are well taken care of in one or more ways - pay, safety, benefits, intangibles including morale/belonging/sense of purpose/sense of efficacy/being cared for - which allows them to focus more on quality service delivery than obstacles or challenges in their workplace, workflow, etc.	required to recruit, train, and retain individuals with lived experience.

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to receiving feedback from service recipients?</u>

In recent years, there has been a commonly adopted phrase in social services, "Not about us without us." The idea is that service planning and intervention should not happen without being heavily informed by the intended recipient of the service. While well intentioned, without the perspectives of those served, administrators, funders, governments, and do gooders will necessarily miss some elements at best and be well off the mark at worst. Services planned with input from recipients tend to gain higher engagement initially and throughout and to attain greater success – and that success is more likely to be meaningful from all perspectives. In much the same way that business collect voice of customer input to improve their products, customer service, delivery or service, etc, this is the same principle in the field of social services. This section is intended to gain information about how this is incorporated in the field of homelessness.

Do you participate in forums in which opinion/satisfaction/suggestion info is gathered from service recipients? What? How? Benefits? Challenges?

Is there a grievance and appeal process for clients? Please describe.

Are service recipients or former service recipients involved in your planning?

Potential Benefits to Outcomes	Potential Operational Costs

<u>What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to regular financial auditing?</u>

What financial auditing practices are required/do you require and by who?

How are the financial controls and practices tested?

Who is in charge of preparing your financials?

Are you audited by an independent external body? How often?

Has an external auditor or a funder conducting an audit expressed any areas of concern with respect to your financials or your financial controls in the most recent 3 years?

Do your funders evaluate your financial controls? Have they expressed any concern in the most recent 2 years?

Potential Benefits to Outcomes	Potential Operational Costs
- Resources should be spent according to accepted practice and documented policy and procedure which should result in judicious use of funds and minimize misuse of funds, thereby ensuring funds are being spent in the manner the organization has intended. - These practices should demonstrate strong management and controls to funders making the organization eligible for contracts, donations, etc. - An organization with strong financial systems and controls may have similarly well structured operational controls and systems to support quality service delivery, staff practices, etc. - Financial reports will follow a fairly standard format and, therefore, be readily understood by anyone proficient in reading these documents which is likely to support funding – or weed out ineffectively managed organizations, both potentially benefit recipients. - These systems lend themselves to outside, independent audits which means more eyes on the organization at different points, generally a factor that supports quality and integrity.	- Making, training, using and enforcing these systems takes considerable set up and ongoing time to maintain which brings additional cost. - Smaller organizations may have difficulty with this overhead. - It is conceivable that an organization with limited resources may spend too much of their finite resources on these elements at the expense of time and energy spent on the service delivery, planning, and other aspects of quality. - Staff that can feel burdened by data and administrative paperwork directly related to service provision may feel particularly overburdened by this type of less tangibly related administrative work, leading to non-compliance, inadequate compliance (both of which can risk negative judgment in an audit), or turnover.

• Detailed and accurate financial reporting allows analysis of the costs efficiency and possibly cost efficiency against efficacy if there quality service and outcomes data also exists. These are metrics of interest to funders which can help secure additional or ongoing funds for services.	

Measurements of Movements Intra-System

What are the benefits to outcomes for homeless service recipients and the operational costs to the service provider with a verifiable commitment to successfully referring a service recipient to a follow-on regional agency with appropriate services?

How do we account for the difference between attempted referral and failed referral due to system structure or internal policies?

Potential Benefits to Outcomes	Potential Operational Costs

Measurements of Movements Extra-System: Into and Out of the System