

Rolling 12-Month Performance Report for the NY-508 CoC

4/1/2022-3/31/2023

Data taken from HMIS on 4/17/2023

This report is created using HMIS data. It covers homeless service projects who use HMIS within the CoC – Erie, Niagara, Genesee, Orleans, and Wyoming counties. Most of the data/measures in this report are obtained from and matched to HUD Annual Performance Report and System Performance. The intent of this is to: 1. Provide timely feedback to projects to improve their services and to learn from each other, 2. Help funders make funding decisions based upon performance, and 3. To evaluate our CoC's system performance. If you have any questions, please contact the Homeless Alliance of WNY.

*Some of the charts in this report were designed specifically for projects that receive CoC funding so they can compare how they are doing to other CoC-funded projects. These charts assign point values to measures that are used to rank CoC-funded projects and are only posted as a reference for these projects. They do not reflect the ranking for next year's funding competition as these things are subject to change.



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Glossary of Acronyms

CoC: Continuum of Care	SNAP: Supplemental Nutrition Assistance Program (commonly referred to as Food Stamps)
ES: Emergency Shelter	SO: Street Outreach
HMIS: Homeless Management Information System	SSI: Supplemental Security Income
HUD: United States Department of Housing and Urban Development	SSDI: Social Security Disability Insurance
NAEH: National Alliance to End Homelessness	TANF: Temporary Assistance for Needy Families
PA: Public Assistance	TAY: Transition Age Youth Vulnerability Index-Service Prioritization Decision Assistance Tool
PH: Permanent Housing destination	TH: Transitional Housing
PIT: Point In Time	VI-F-SPDAT: Vulnerability Index-Service Prioritization Decision Assistance Tool for Families
PSH: Permanent Supportive Housing for Formerly Homeless Persons	VI-SPDAT: Vulnerability Index-Service Prioritization Decision Assistance Tool for Individuals
RRH: Rapid Rehousing	WIC: Special Supplemental Nutrition Program for Women, Infants, and Children

Cash benefit in this report refers to income such as: Earned income, unemployment insurance, SSI, SSDI, veteran's disability, private disability insurance, worker's compensation, TANF, general assistance, retirement, veteran's pension, pension from former job, child support, and alimony (spousal support).

Non-cash benefit in this report refers to non-cash benefit such as: SNAP, Medicaid health insurance, Medicare health insurance, State children's health insurance, WIC, VA medical services, TANF child care services, TANF transportation services, other TANF-funded services, temporary rental assistance, and Section 8.

Permanent Housing Destination in this report refers to destinations such as: housing owned by client (with or without ongoing subsidy), housing rented by client (with or without ongoing subsidy), permanent supportive housing for formerly homeless persons, living with family or friends with permanent tenure. To reflect 2017 HUD Data Standard updates, **the following are excluded from calculation: foster care, hospital, long term care facility or nursing home, deceased.**

Positive Destination in this report refers to destinations such as: all permanent housing destinations listed above, emergency shelter, transitional housing for homeless persons, staying with family or friends with temporary tenure, Safe Haven, hotel or motel paid by client, foster care, psychiatric facility, substance abuse or detox facility, hospital (non-psychiatric). EXCLUDES jail, places not meant for human habitation, and "other" destinations such as "Client doesn't know", "Client refused", "Data not collected", "No exit interview completed", and "Other".

Permanent Supportive Housing (PSH) Projects

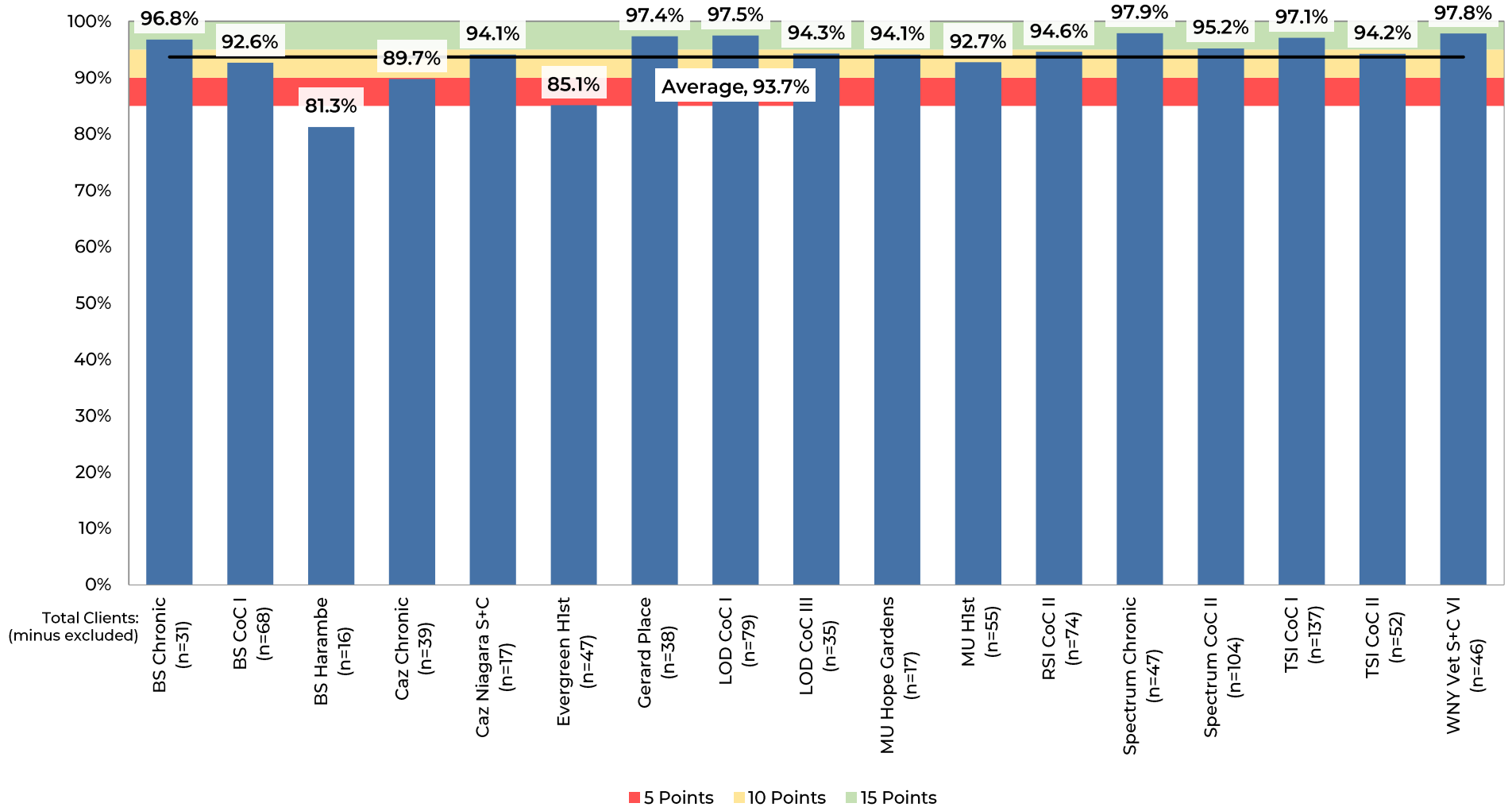
Housing Measures

All charts measuring exits exclude people who passed away during the project stay, those who went to foster care, hospitals or other residential non-psychiatric facilities, long term care facilities or nursing homes.

Remained or Exited to Permanent Housing (PH) Destinations

This measure includes those who remained in the PSH project and those who exited to PH. The local benchmark for this measure is 85% or greater.

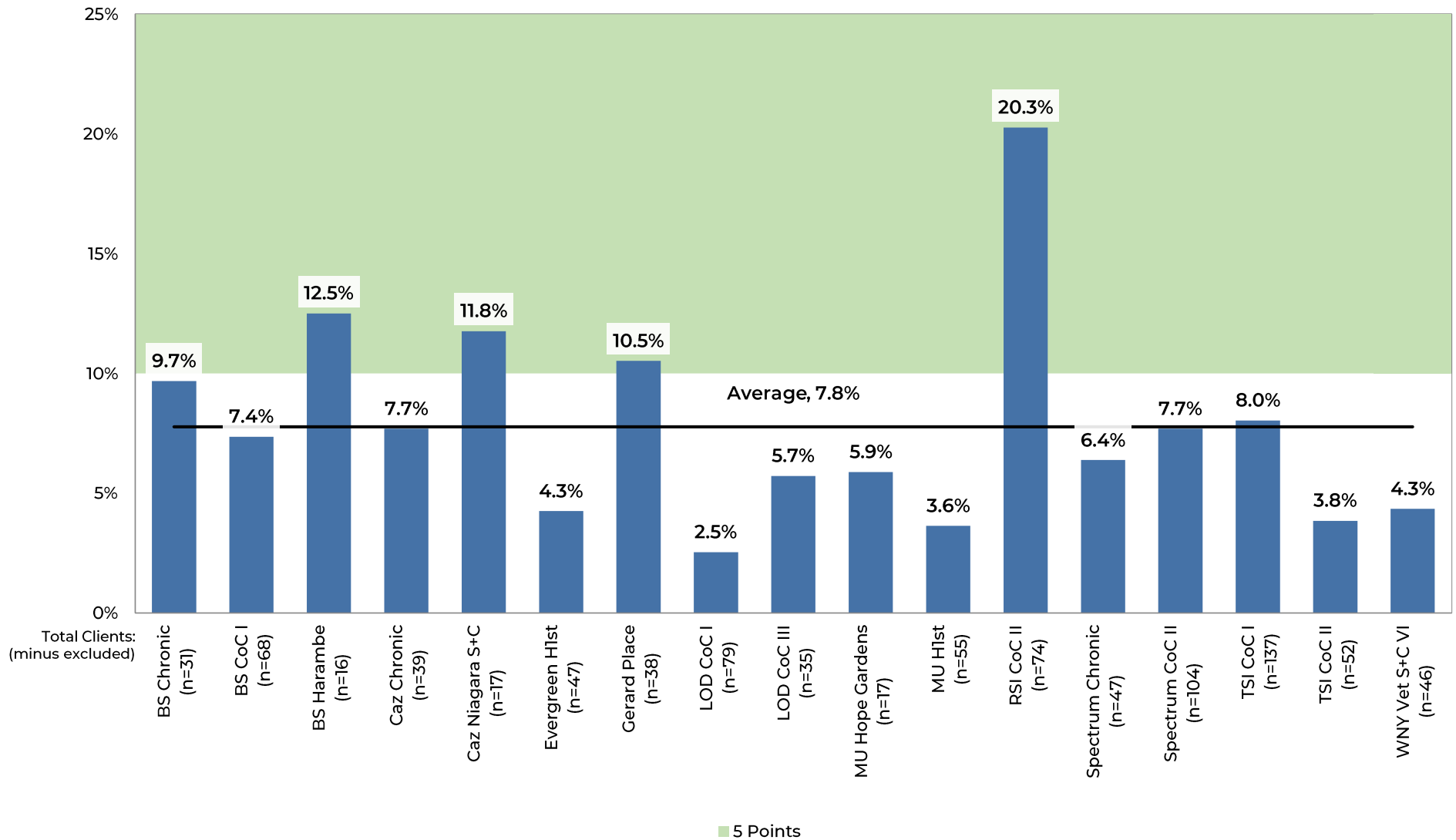
PSH Clients Remained or Exited to PH



Positive Turnover Rates

This measure includes only those clients who left the PSH project and exited to PH based on the total number of clients served. It does not include people who passed away during the project stay, those who went to foster care, hospitals or other residential non-psychiatric facilities, long term care facilities or nursing homes. This measure is a bonus in which projects with a 10% or greater positive turnover rate are awarded additional points on their funding applications.

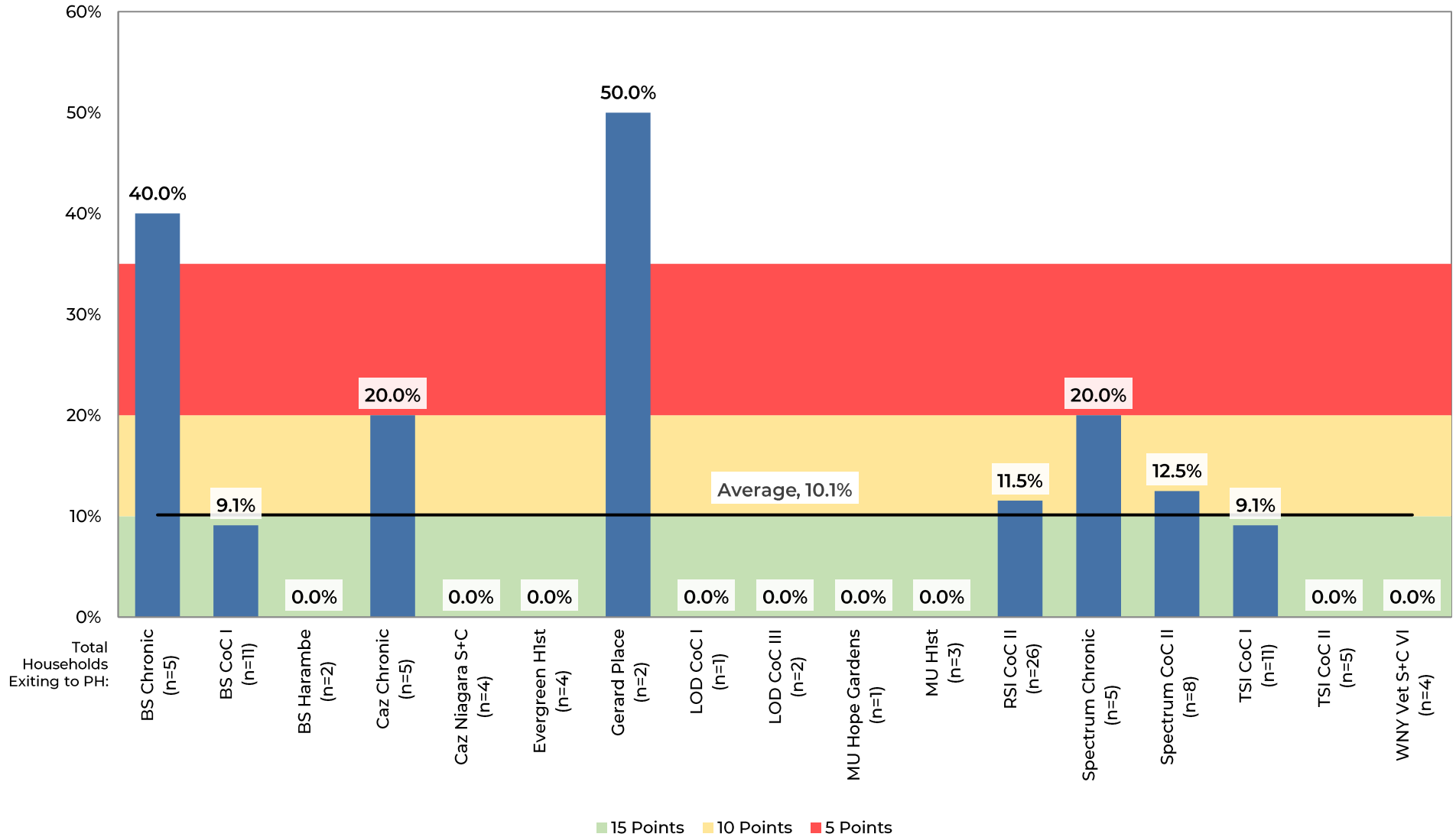
Positive Turnover Rate (PSH)



Returns to Homelessness

This measure looks at those who exited to PH from a service project between 10/1/2021 and 3/31/2023 and returned to homelessness (measured by a new entry date at a service project) within the following six months, beginning on 4/1/2022. This measure reflects our CoC's goal of reducing the number of people who return to homelessness. The local benchmark for this measure is 35% or less.

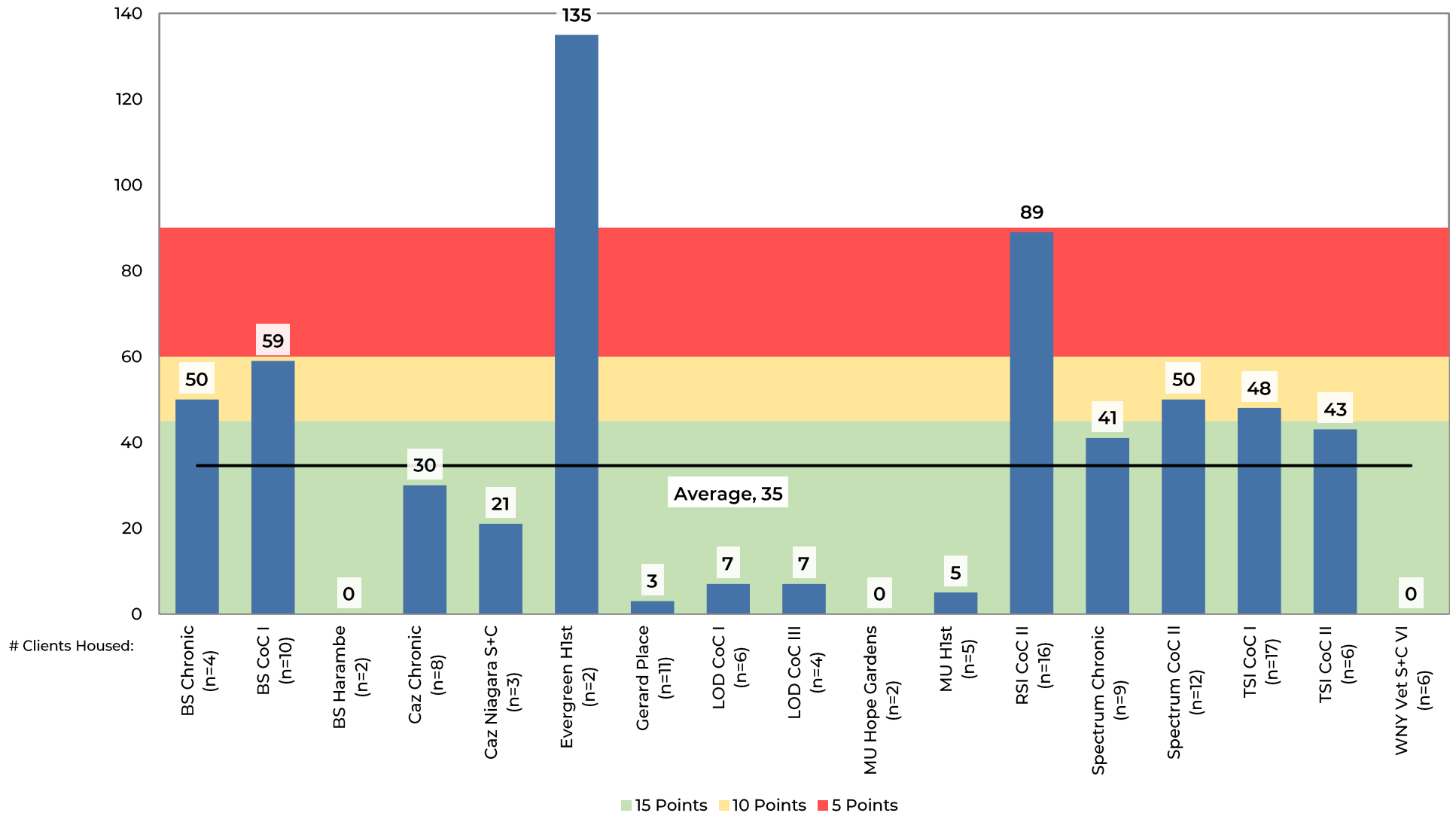
Returns to Homelessness After Exiting to PH (PSH)



Length of Time from Project Entry to Move-In Date

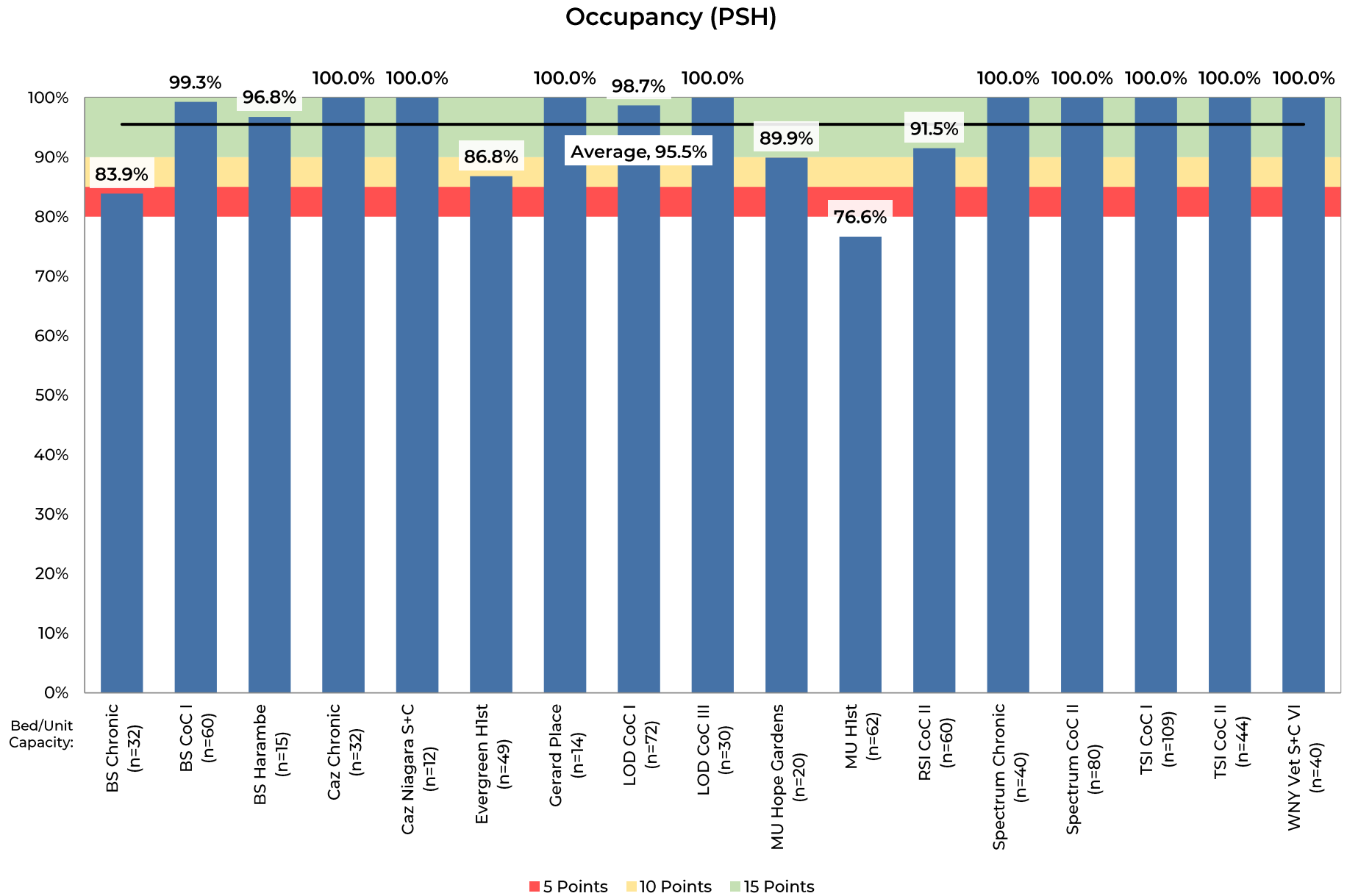
This measure is an average number of days from project entry date to move-in date. The data included in this chart only considers clients with a move-in date during the reporting period. The local benchmark for this measure is 90 days or less.

Days from Entry to Move-In (PSH)



Occupancy Rate

The occupancy rate is measured by calculating how many clients are in each project each night during the reporting period (4/1/2022-3/31/2023), using the project bed/unit capacity. The local benchmark for this measure is 80% or greater.



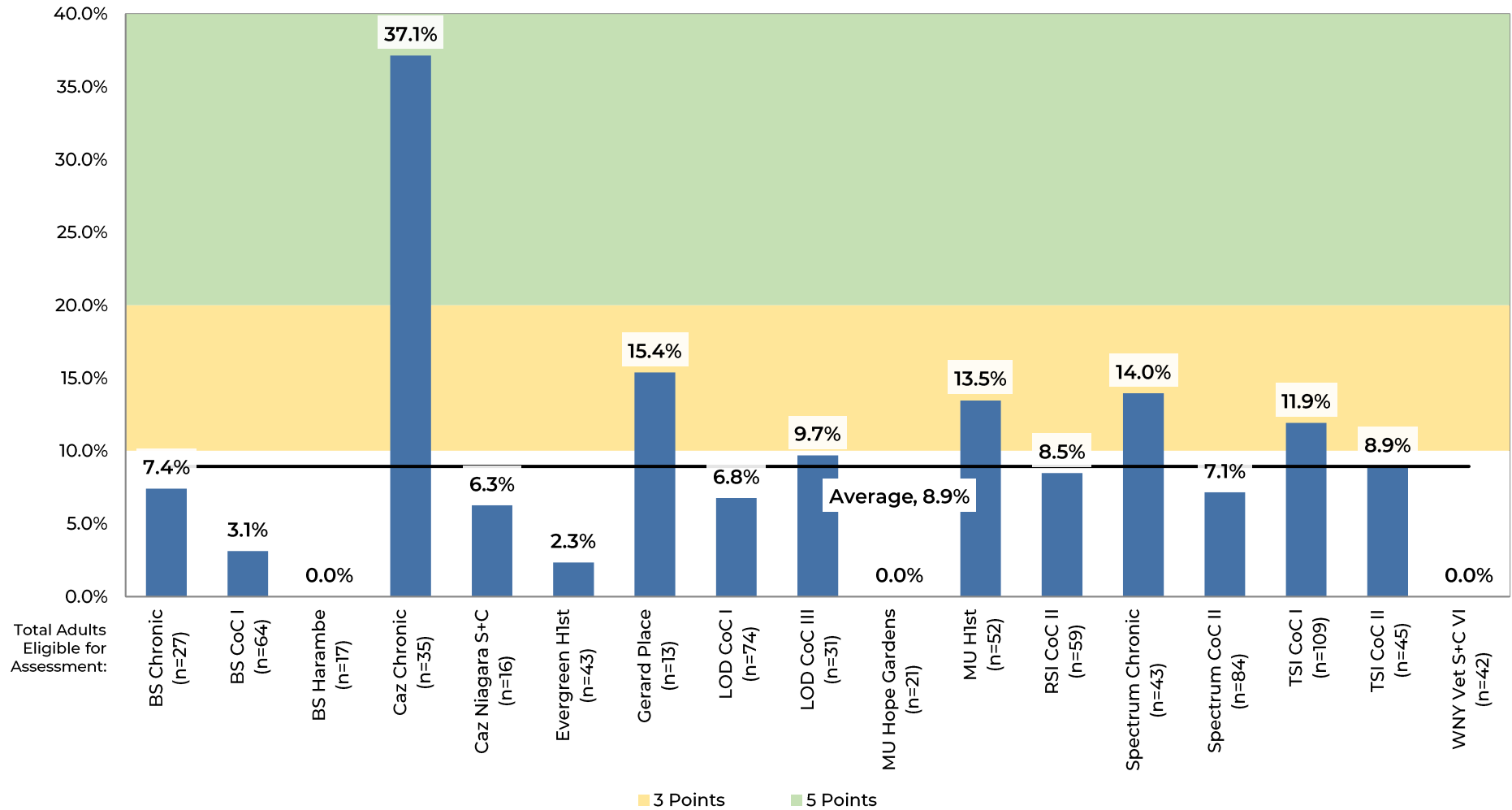
Income Measures

All income measures only include adults that have exited or been in the project for longer than one year, with an annual assessment completed in the +/- 30-day window. Income is measured from client entry into the project to either the latest annual assessment or exit.

Maintained or Increased Earned Income for PSH Participants

This measure includes those adults that have maintained employment and those who have maintained or gained employment and increased their amount of earned income. The local benchmark for this measure is 10% or greater.

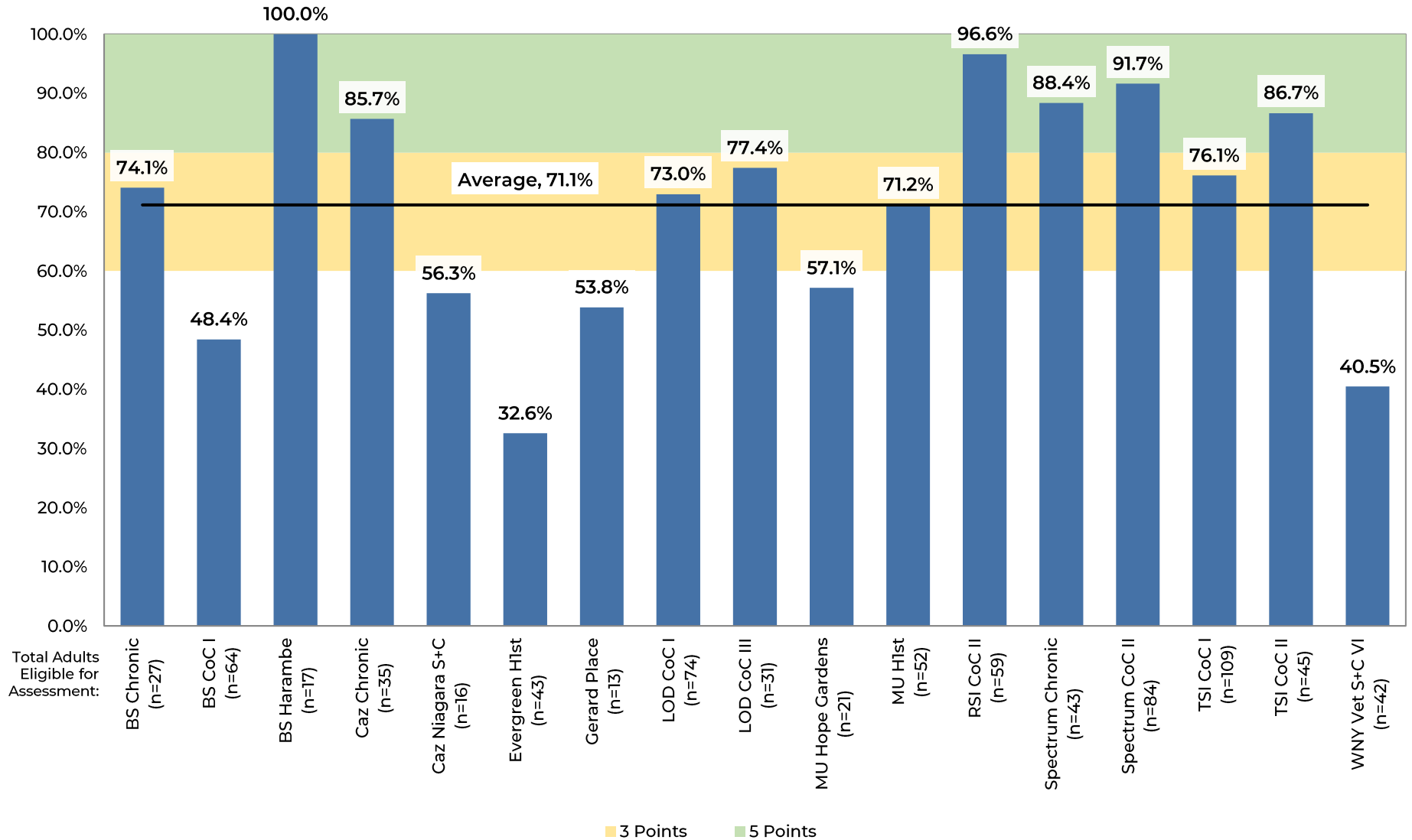
Adults with Maintained/Increased Earned Income (PSH)



Maintained/Increased Any Income for PSH Participants

This measure includes those adults who have increased or retained their cash income from any source, including earned income and benefits (e.g. SSI, SSDI, PA, TANF, etc.). The local benchmark for this measure is 60% or greater.

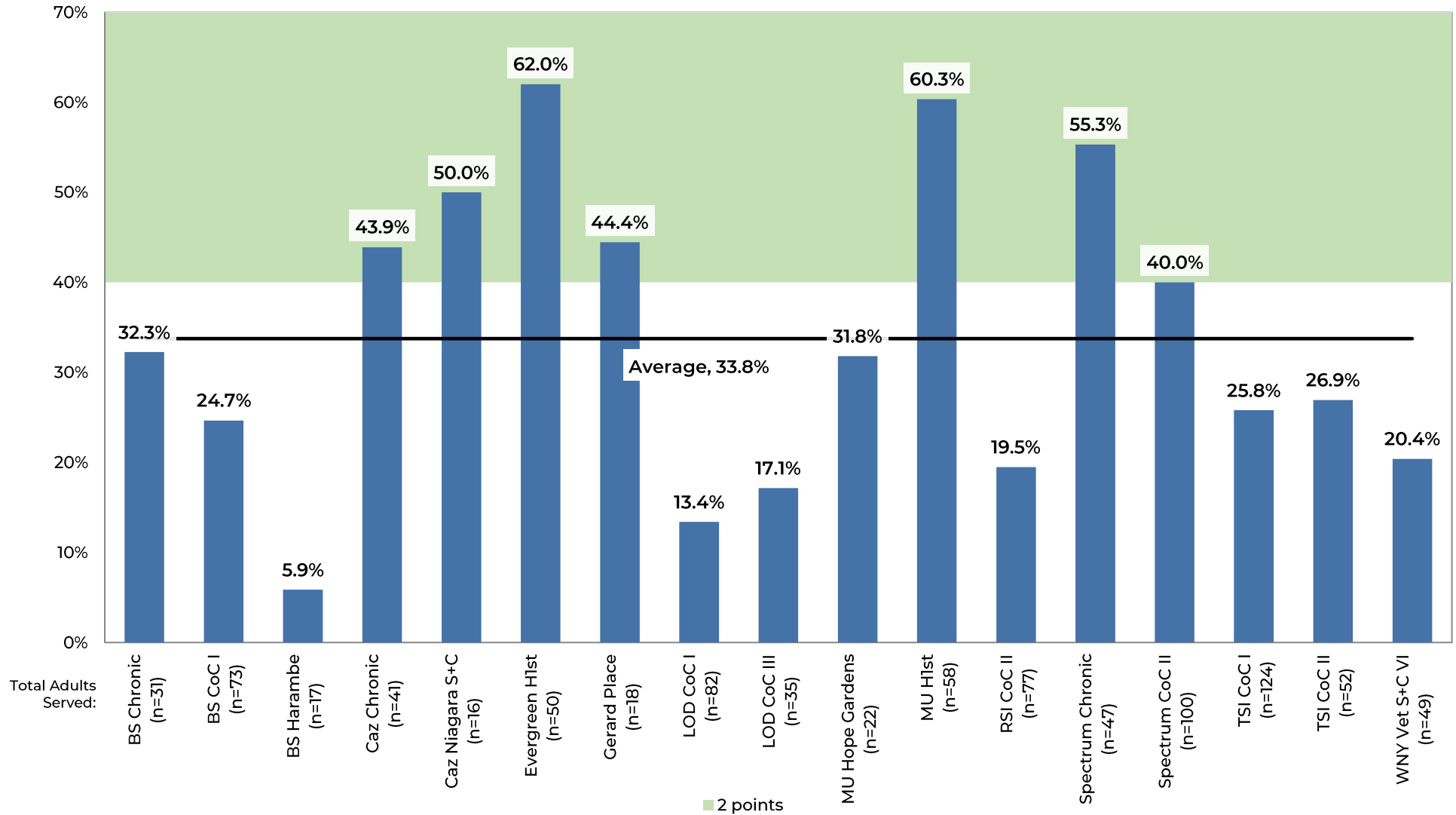
Adults with Maintained/Increased Any Income (PSH)



Percentage of Clients who Entered with Zero Income

Clients without any income have higher barriers to becoming stably housed. This measure shows the percentage of clients with no income at project entry for each RRH project. It demonstrates that these projects are taking the highest need clients. This measure is a bonus in which additional points are awarded on the funding application of projects with 40% or greater of the clients they serve having no income at project entry.

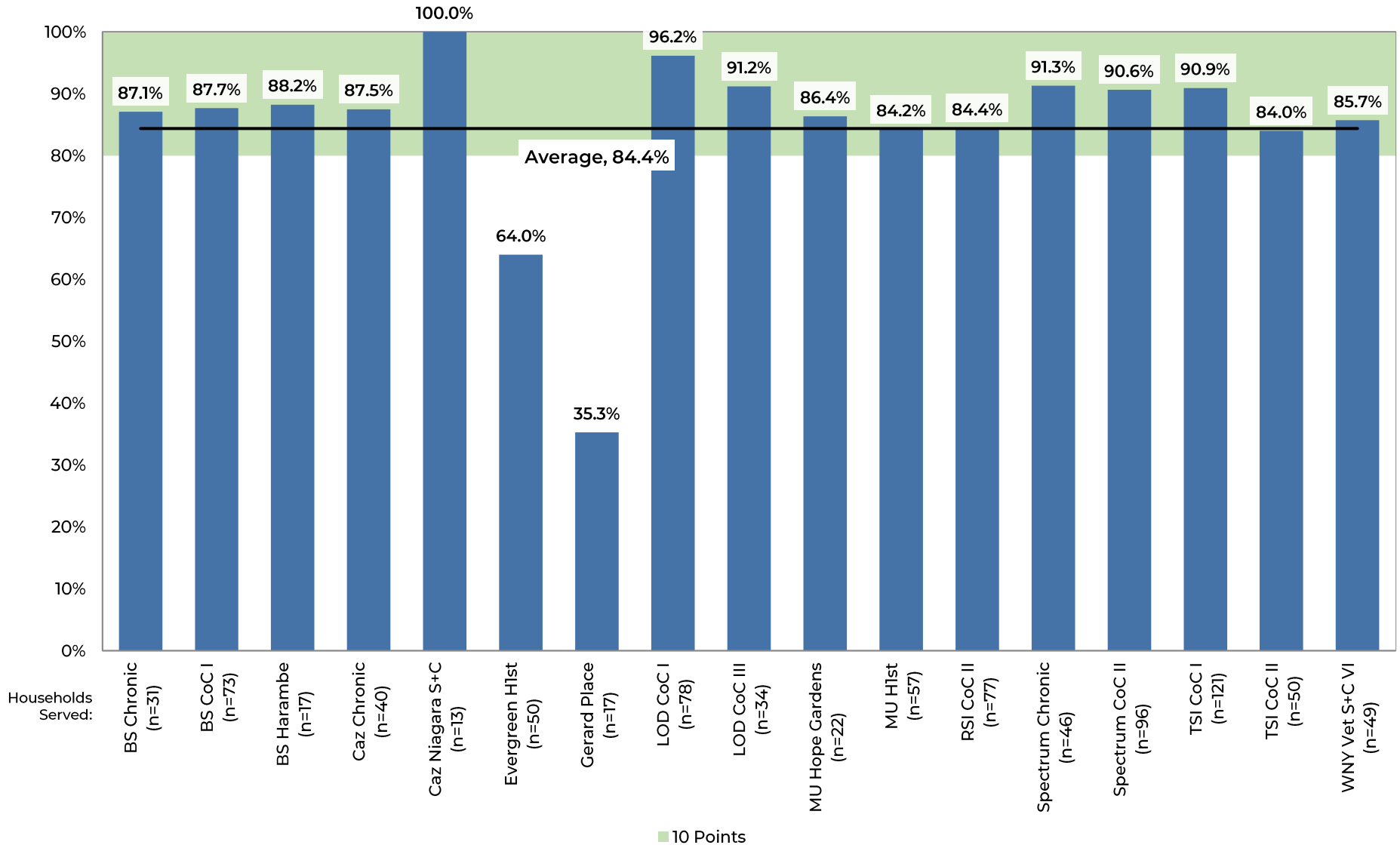
Adults with Zero Income at Entry (PSH)



Percentage of Households with a Member Experiencing Two or More Disabilities

As project entry criteria, all PSH households should have at least one member who experiences at least one eligible disability. However, many of our clients with higher barriers have more than one disabling condition. This measure is to demonstrate that these projects are taking the highest need clients. This measure is a bonus in which additional points are awarded on the funding application of projects with 80% or greater of the households they serve having at least one client who experiences two or more disabling conditions.

Households with Member Experiencing 2+ Disabilities (PSH)

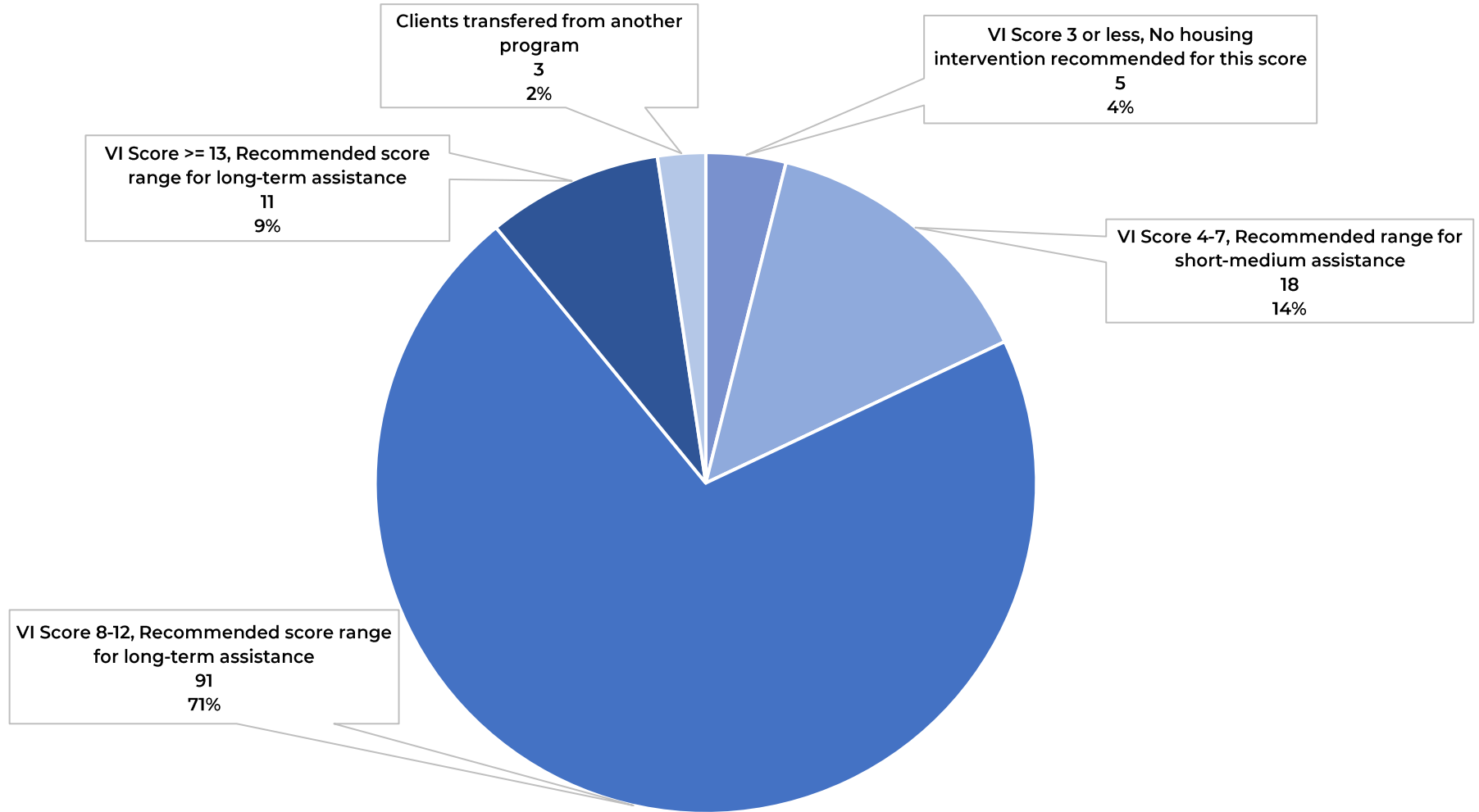


Service High Need Population

New Clients in PSH with a VI Score Recorded in HMIS

This measure indicates the percentage of households that entered into a PSH project with a VI-SPDAT, VI-FSPDAT, or TAY recorded in HMIS. All new households entering a PSH project are required to have a VI-SPDAT, VI-FSPDAT, or TAY. Clients who score 8 or greater are recommended for long-term assistance; this group is broken down further in the chart below to emphasize how many high-scoring clients (scoring 13 or greater) are being served by our CoC.

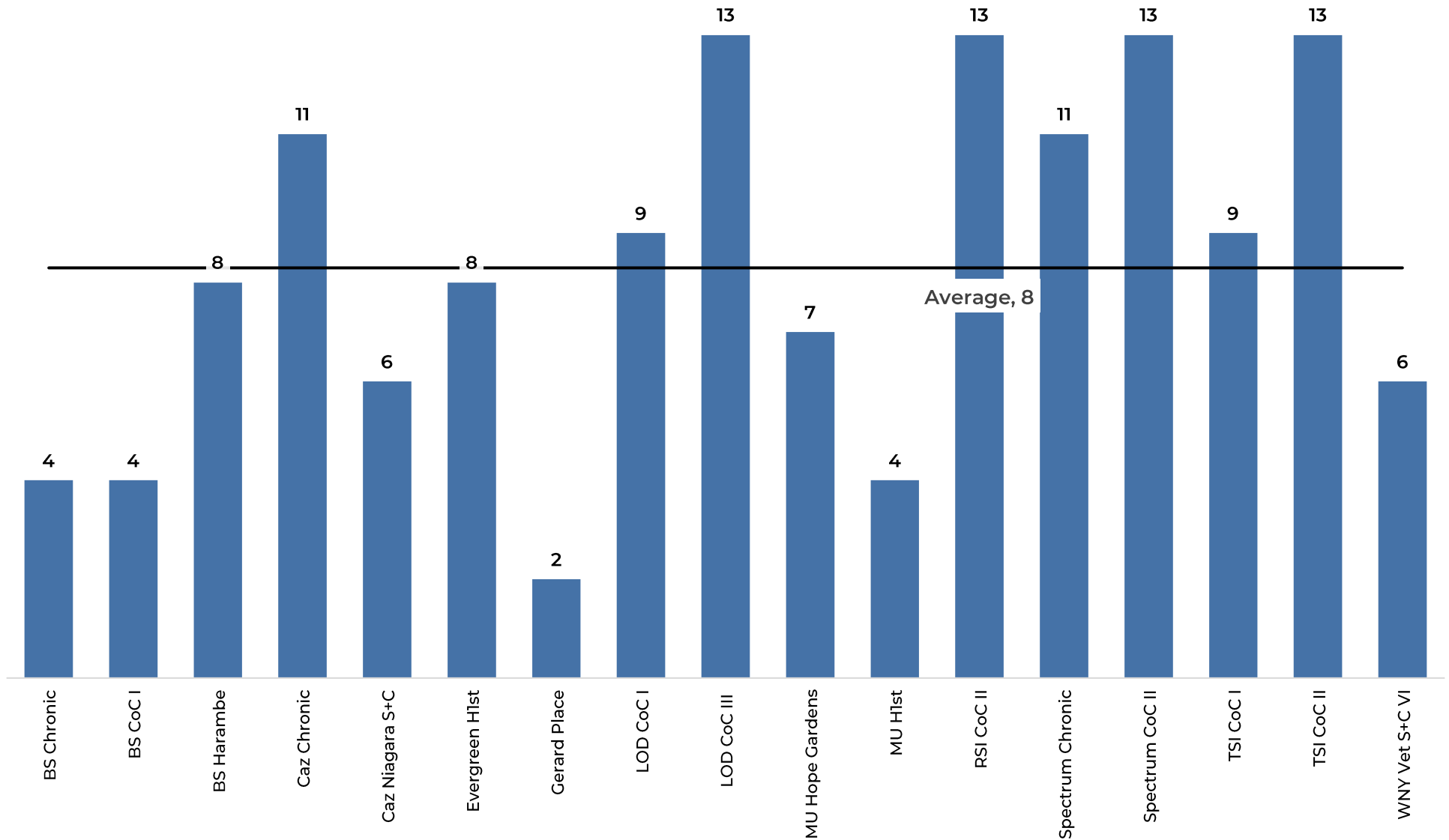
New PSH Households and VI Scores



HMIS Data Quality

All projects that receive CoC or ESG funding are required to use HMIS to facilitate data reporting to their funders. Timely and accurate data entry is necessary to ensure correct data is reported and used in analyses. This measure gives a broad overview as to how timely and accurate each project's data in HMIS is. A total of 13 points can be earned on this measure.

Total Data Quality Points (PSH)



Rapid Rehousing (RRH) Projects

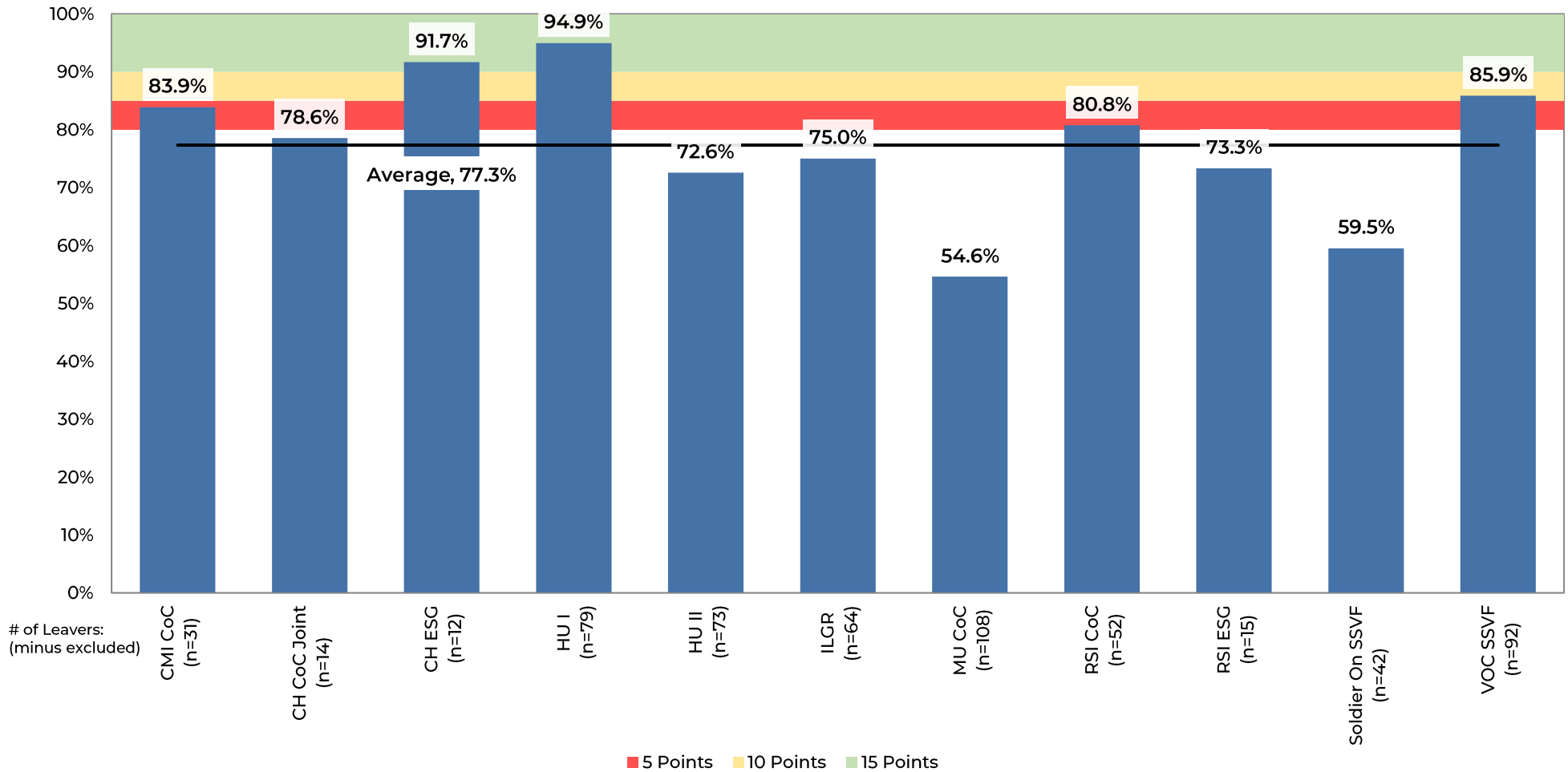
Housing Measures

All charts measuring exits exclude people who passed away during the project stay, those who went to foster care, hospitals or other residential non-psychiatric facilities, long term care facilities or nursing homes.

Exit to Permanent Housing (PH) Destinations

This measure includes only those who left the project and exited to PH. The benchmark for RRH projects is the national benchmark of 80%.

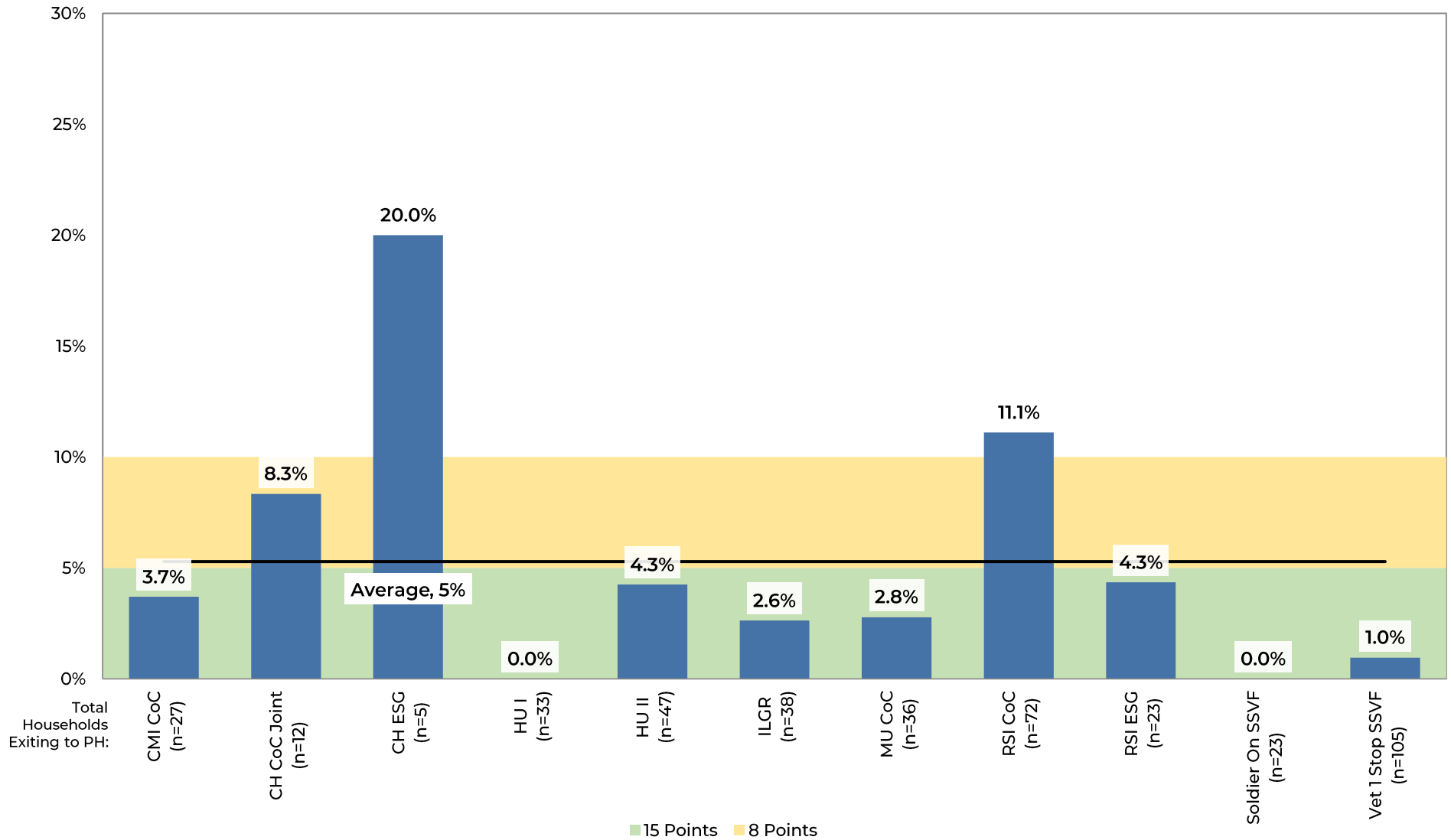
RRH Participants Exited to PH



Returns to Homelessness

The data in this quarterly report looks at those who exited to PH from a service project between 10/1/2021 and 3/31/2023 and returned to homelessness (measured by a new entry date at a service project) within the following six months, beginning on 4/1/2022. This measure reflects our CoC's goal of reducing the number of people who return to homelessness. The local benchmark for this measure is 10% or less.

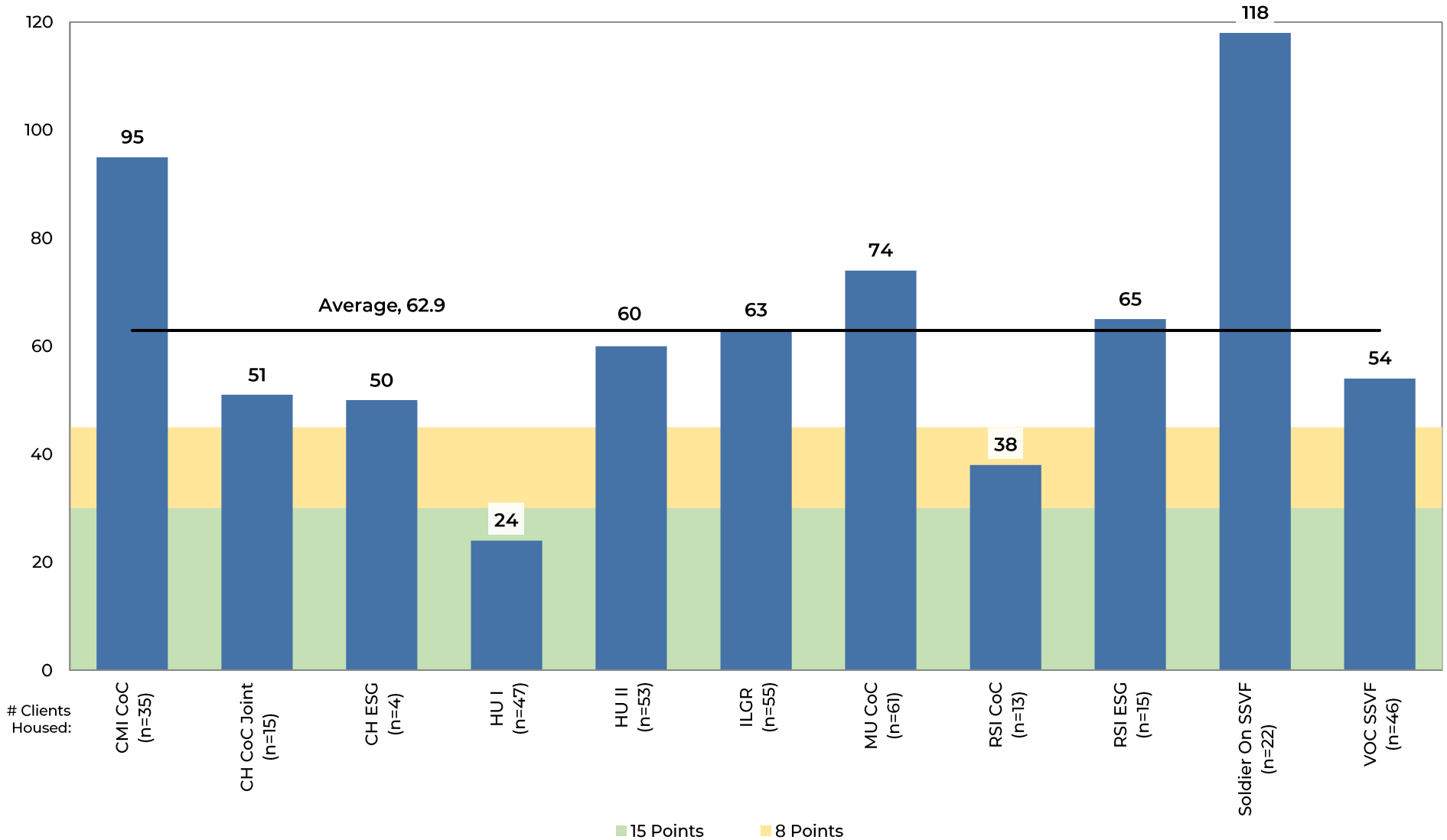
Returns to Homelessness After Exiting to PH (RRH)



Length of Time from Project Entry to Move-In Date

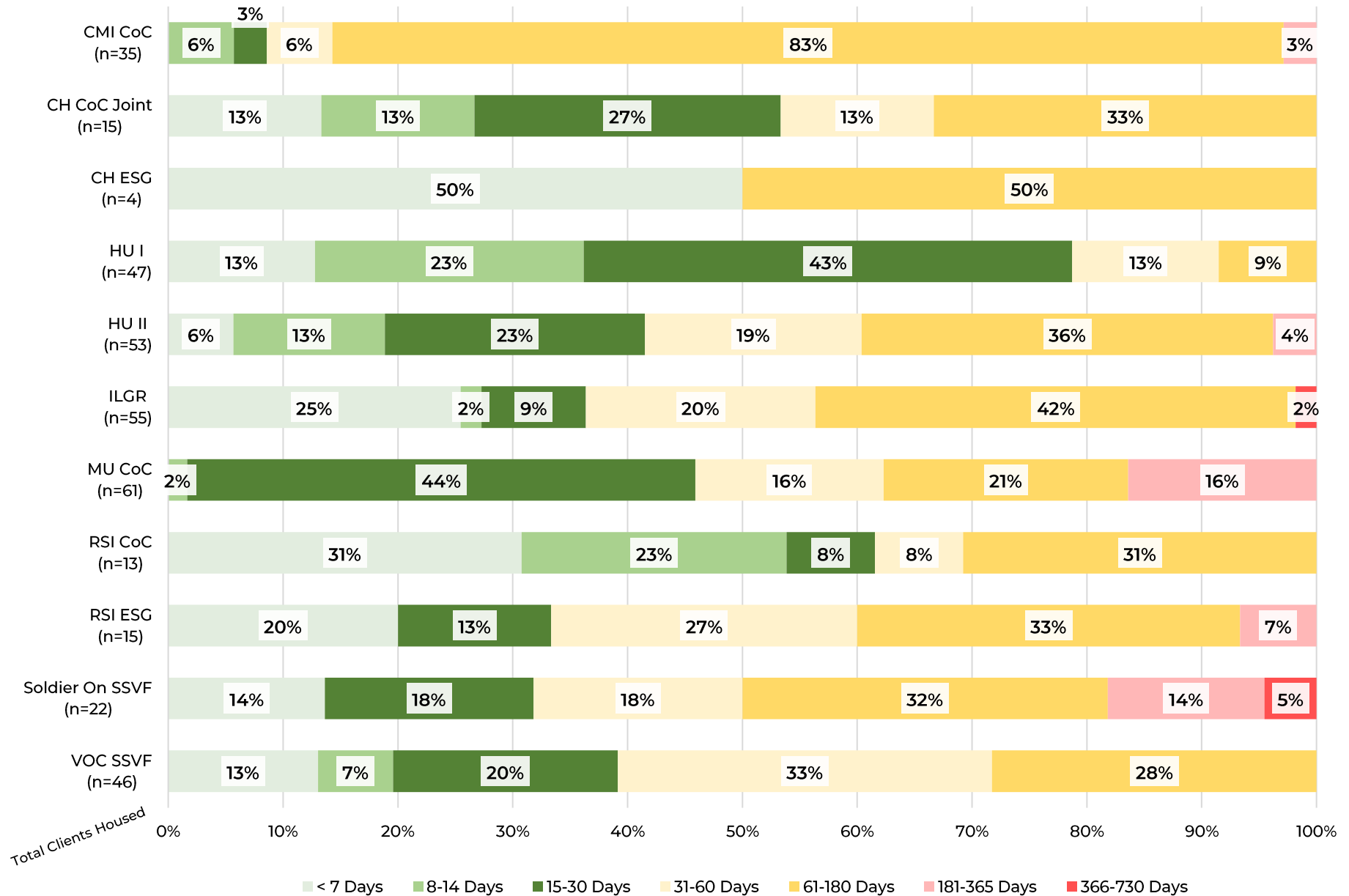
This measure is an average of the number of days from RRH project entry to move-in to PH for those who have an entry date and a move-in date. The NAEH benchmark for this measure is an average of 30 days or less. The local benchmark for this measure is 45 days or less.

Days from Project Entry to Move-In (RRH)



Breakdown of How Long it Takes to House RRH Clients

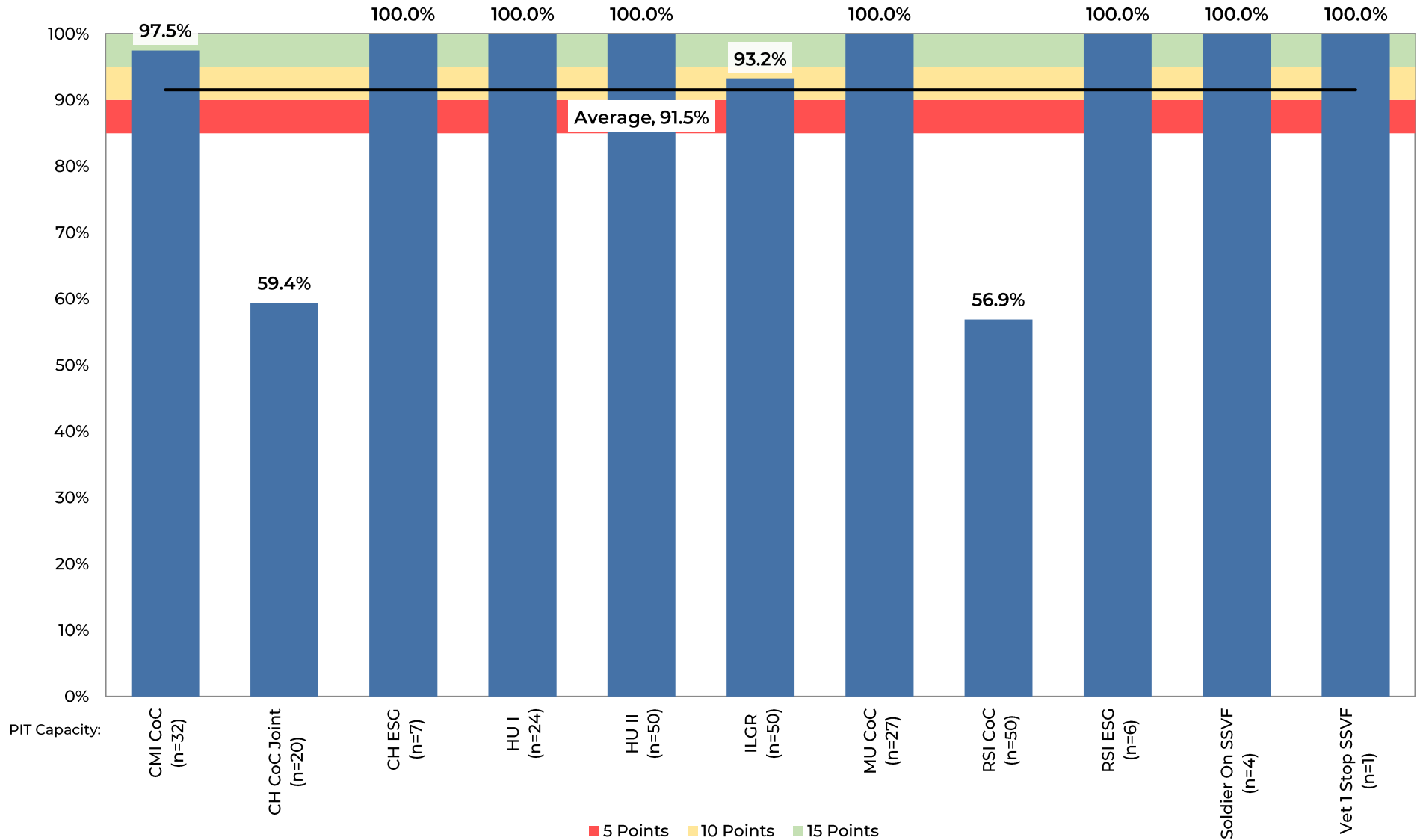
Breaking Down How Long it Takes to House Clients (RRH)



Point in Time Occupancy Rates

For RRH projects, occupancy is measured two ways. The first, shown here, is based on how often during the reporting period each project was “at capacity” by averaging how many clients were enrolled in the RRH project each night. The capacity value is determined using the number of beds the projects reported in their HUD CoC grant application.

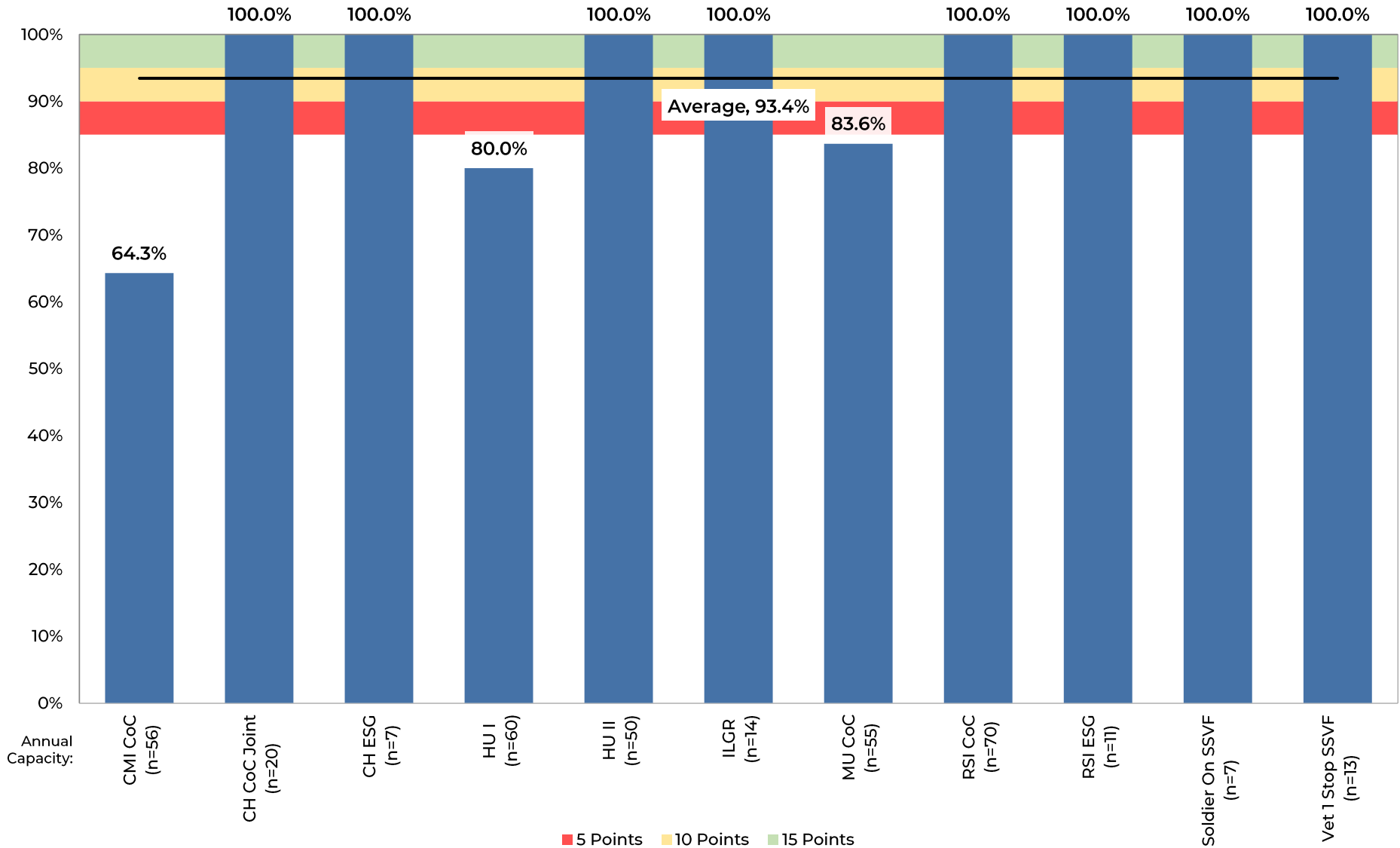
Point in Time Occupancy Rates (RRH)



Annual Occupancy Rates

For RRH projects, occupancy is measured two ways. The second, shown here, is based on how many households were served during the reporting period compared to the number of households the project is estimated to serve over the course of the reporting period. The estimated households served is determined using the number of beds the projects reported in their HUD CoC grant application multiplied by 1.33, as it is expected that there will be some amount of turnover in the households each project serves during the year.

Annual Occupancy Rates (RRH)



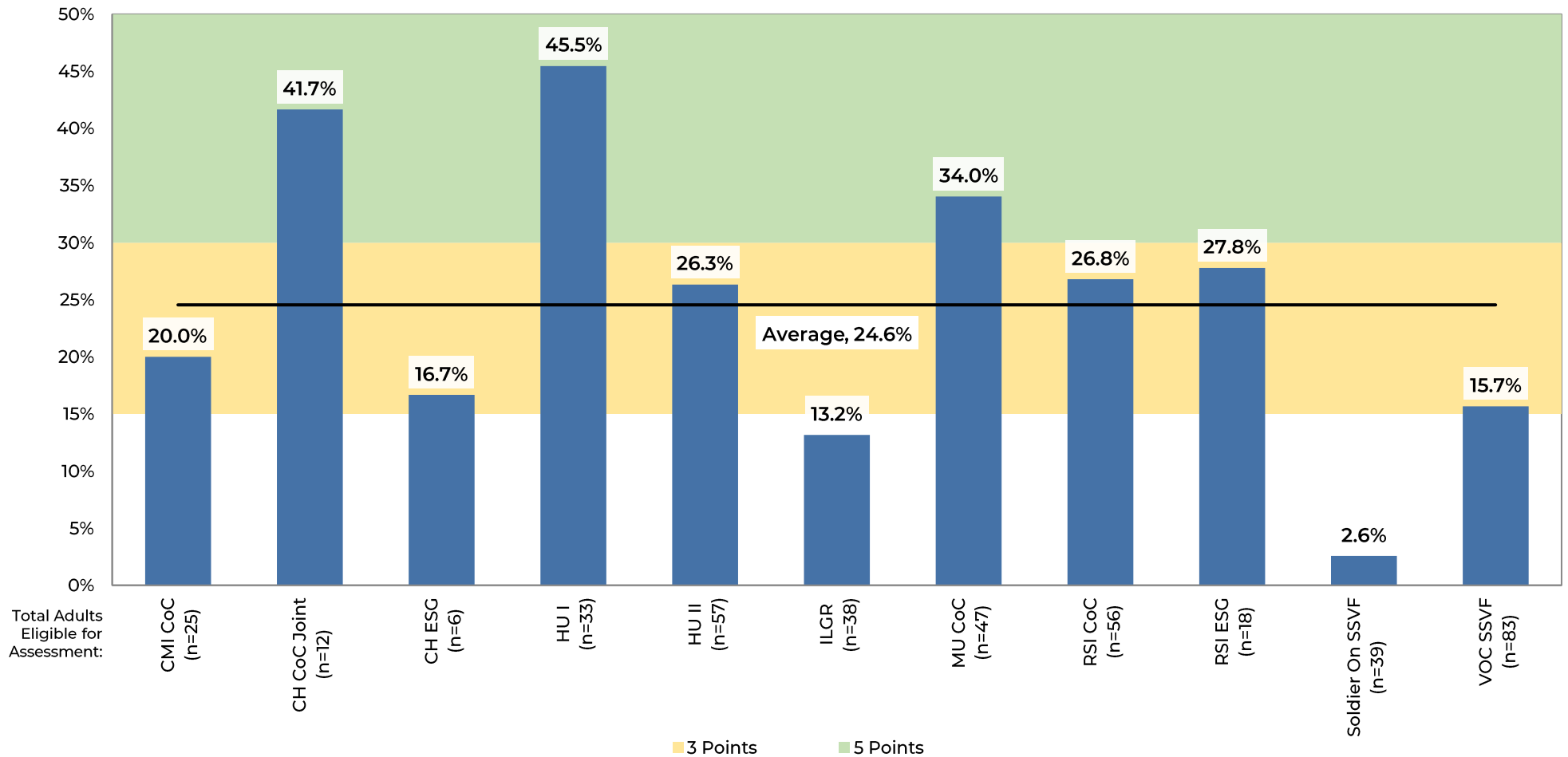
Income Measures

All income measures only include adults that have exited or been in the project for longer than one year, with an annual assessment completed in the +/- 30 day window. Income is measured from client entry into the project to either the latest annual assessment or exit.

Maintained or Increased Earned Income for RRH Participants

This measure includes those adults that have maintained employment and those who have maintained or gained employment and increased their amount of earned income. The local benchmark for this measure is 15% or greater.

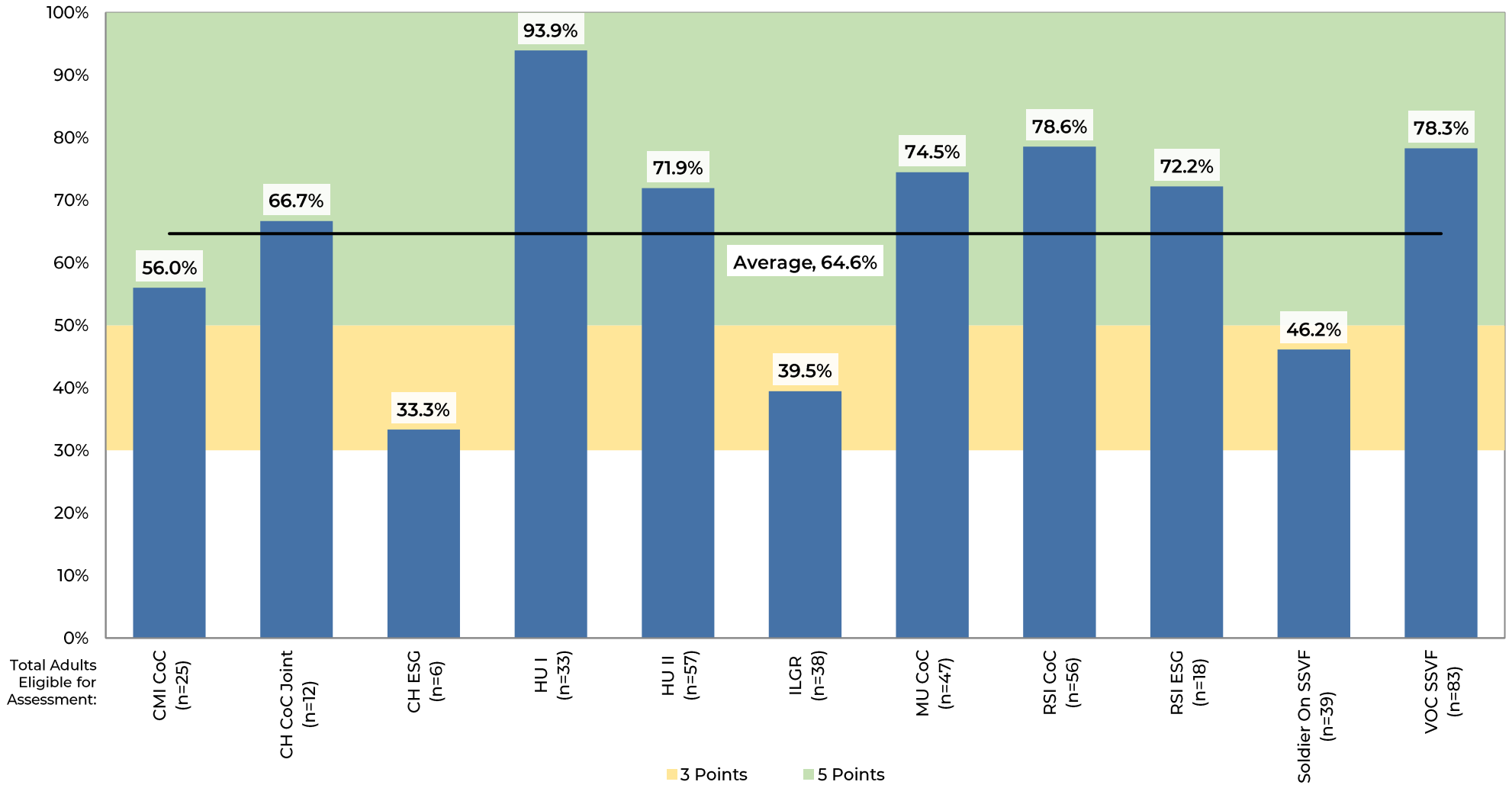
Adults with Maintained/Increased Earned Income (RRH)



Maintained/Increased Any Income for RRH Participants

This measure includes those adults who have increased or retained their cash income from any source, including earned income and benefits (e.g. SSI, SSDI, PA, TANF etc.). The local benchmark for this measure is 30% or greater.

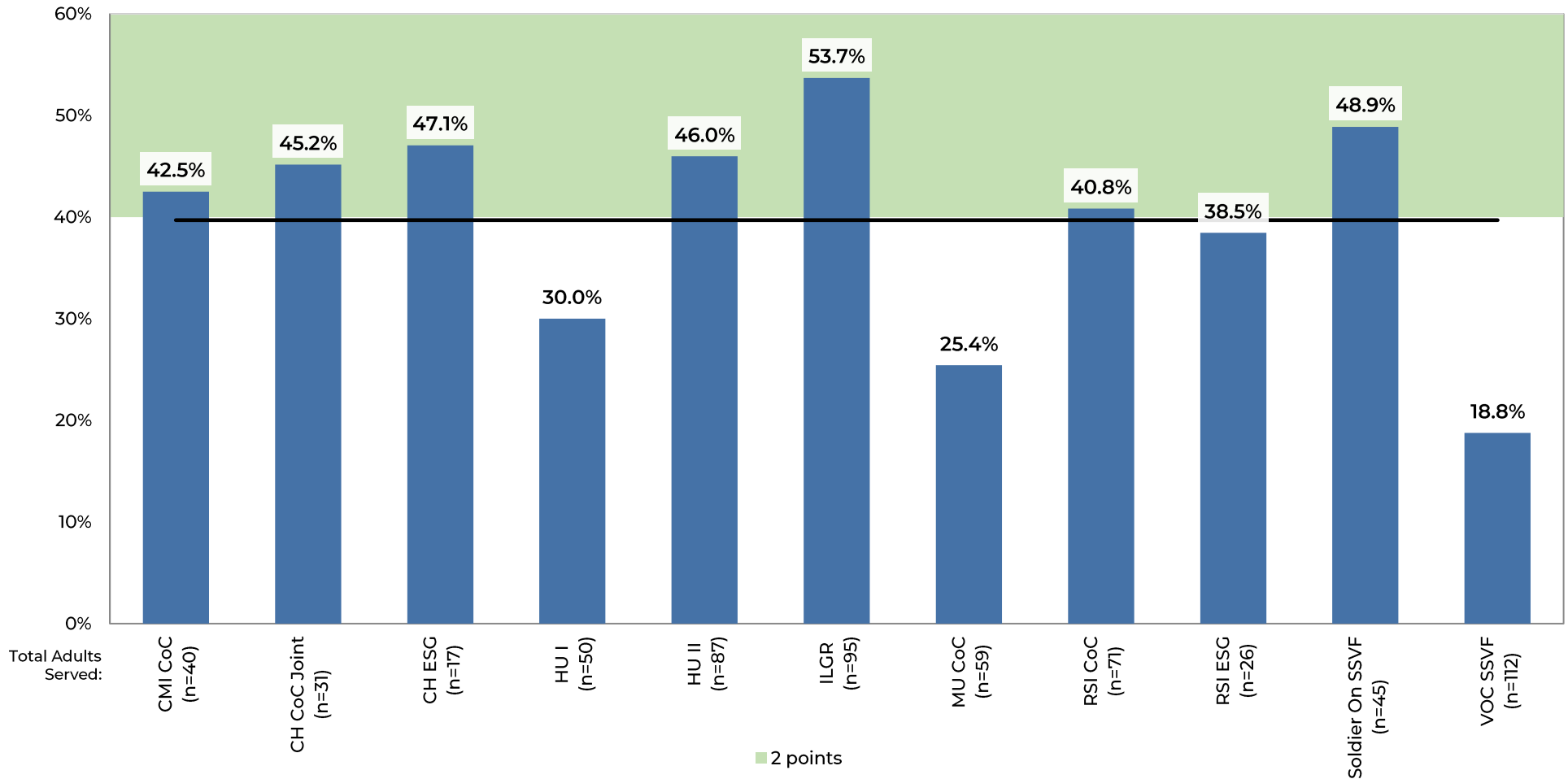
Adults with Maintained/Increased Any Income (RRH)



Percentage of Clients who Entered with Zero Income

Clients without any income have higher barriers to becoming stably housed. This measure shows the percentage of clients with no income at project entry for each RRH project. It demonstrates that these projects are taking the highest need clients. This measure is a bonus in which additional points are awarded on the funding application of projects with 40% or greater of the clients they serve having no income at project entry.

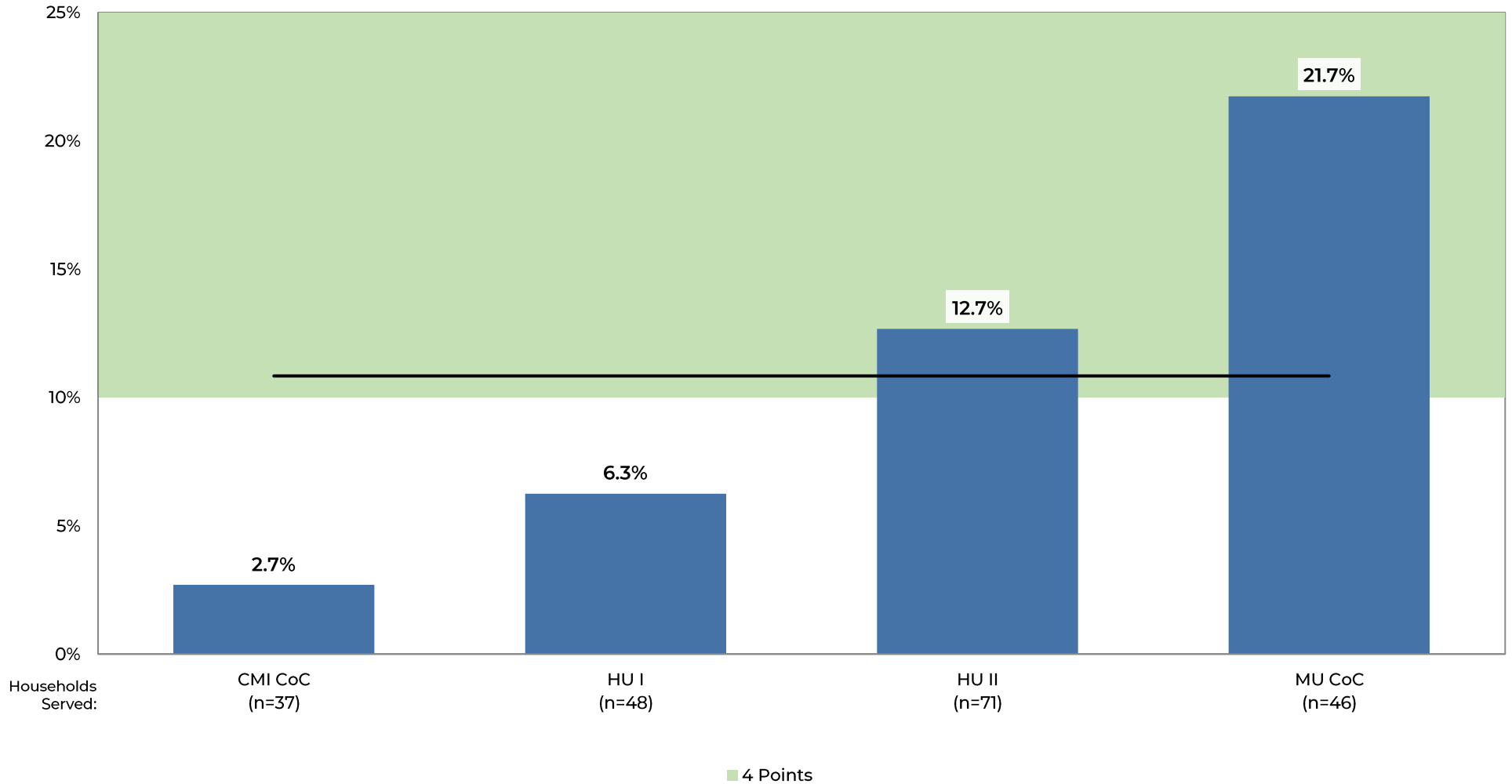
Clients with Zero Income at Entry (RRH)



Percentage of Households Served with Families of 5+

For RRH projects that serve families, finding housing to accommodate larger households can be more difficult. This measure looks at the percentage of households served that have 5 or more members. This measure is a bonus in which additional points are awarded on the funding application of projects with 10% or greater of the households they serve being families of 5 or more.

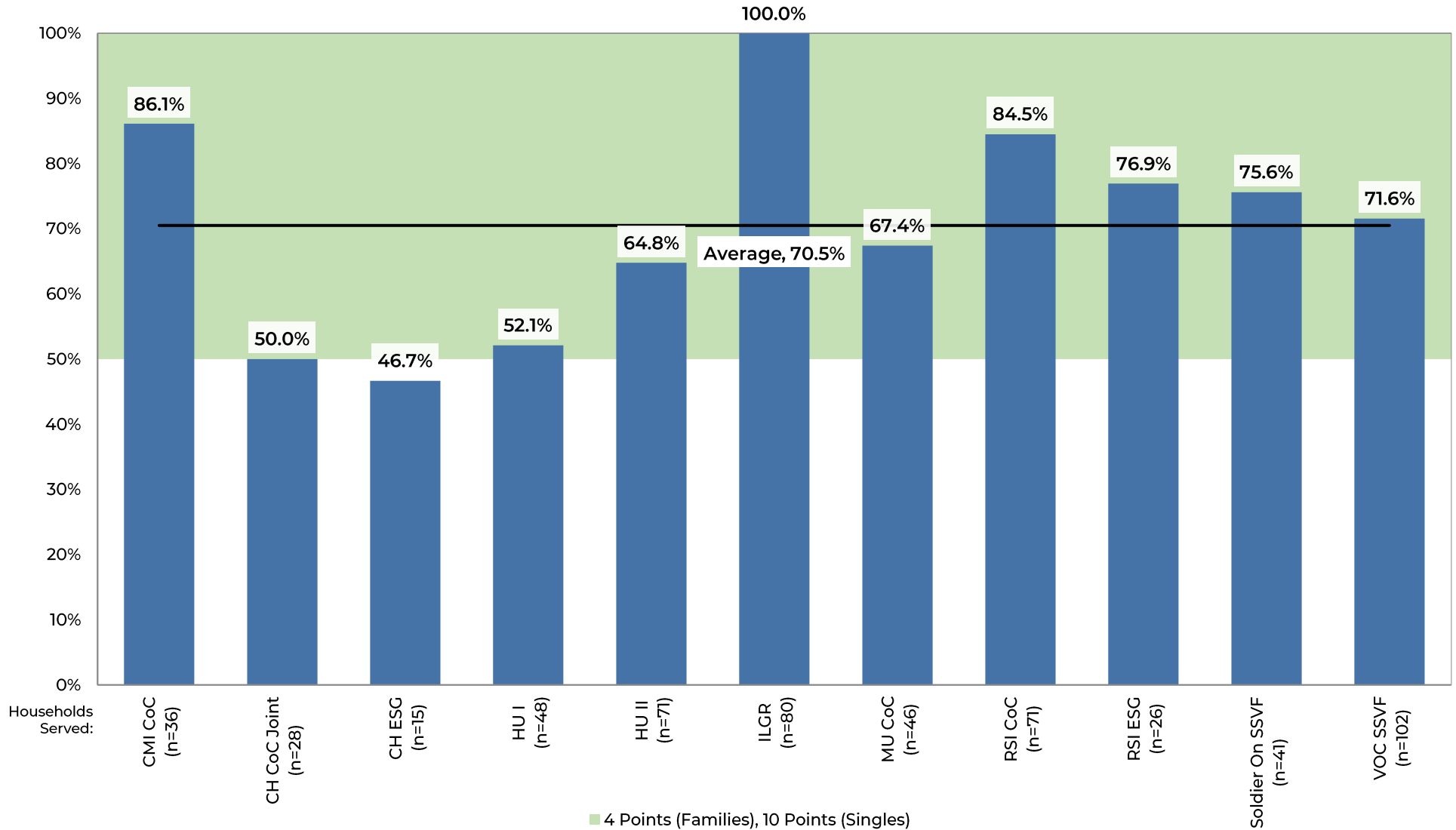
Households with Family Size of 5+



Percentage of Households with a Member Experiencing One or More Disability

As project entry criteria, RRH clients are not required to have a disabling condition. However, many of our clients with higher barriers have one or more disabling conditions. This measure is to demonstrate that these projects are taking the highest need clients. This measure is a bonus in which additional points are awarded on the funding application of projects with 50% or greater of the households they serve having at least one client who experiences one or more disabling conditions.

Households with Member Experiencing 1+ Disability (RRH)

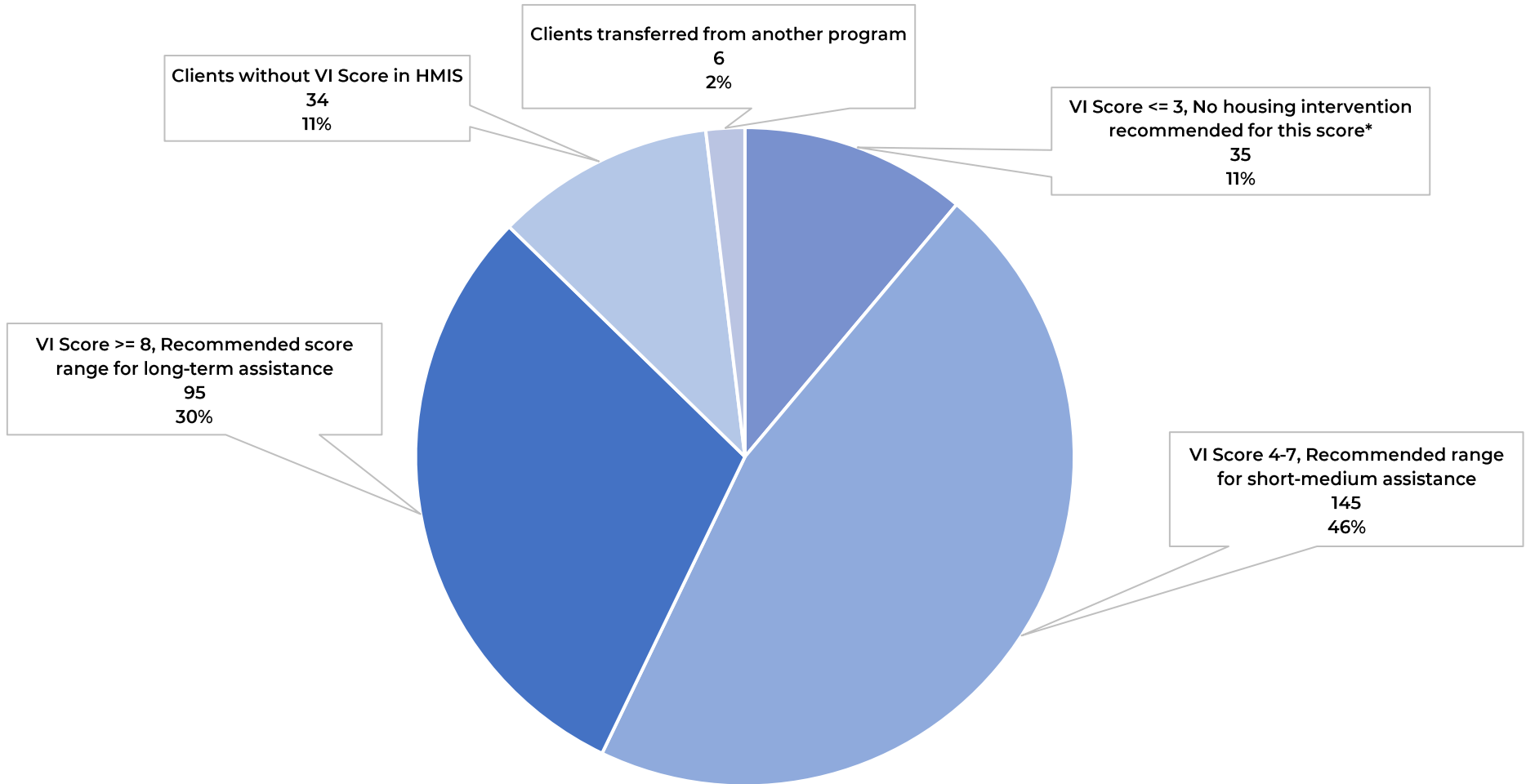


Service High Need Population

New Clients in RRH with a VI Score Recorded in HMIS

This measure indicates the percentage of households that entered into an RRH project during the reporting period with a VI-SPDAT, VI-FSPDAT, or TAY recorded in HMIS. All new households entering an RRH project are required to have a VI-SPDAT, VI-FSPDAT or TAY.

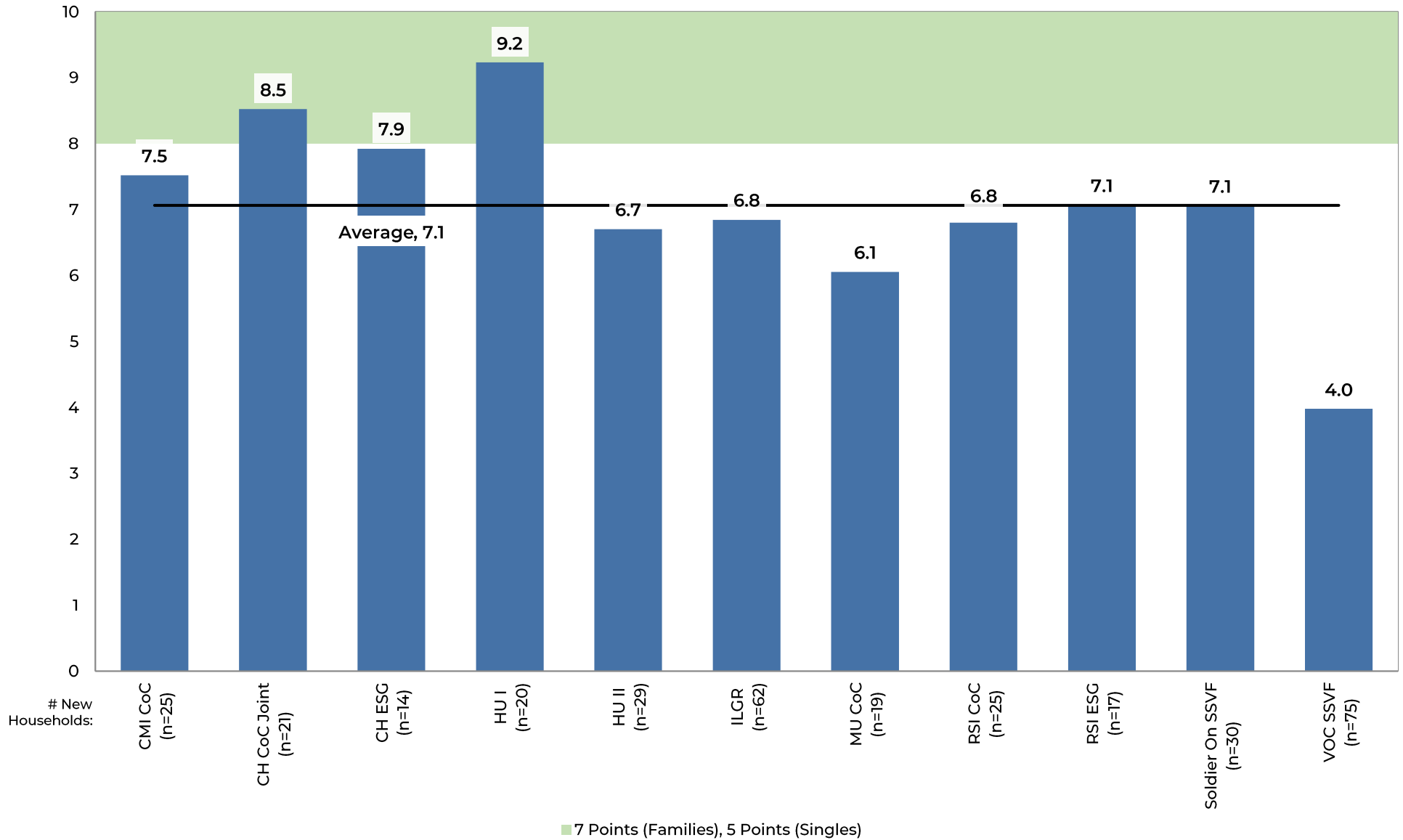
New RRH Households and VI Scores



Average VI Score for Households Served by Each Project

This measure indicates the average score of all households that entered into an RRH project during the reporting period with a VI-SPDAT, VI-FSPDAT, or TAY recorded in HMIS. This measure is a bonus in which additional points are awarded on the funding application of projects serving households with an average VI score of 8 or greater.

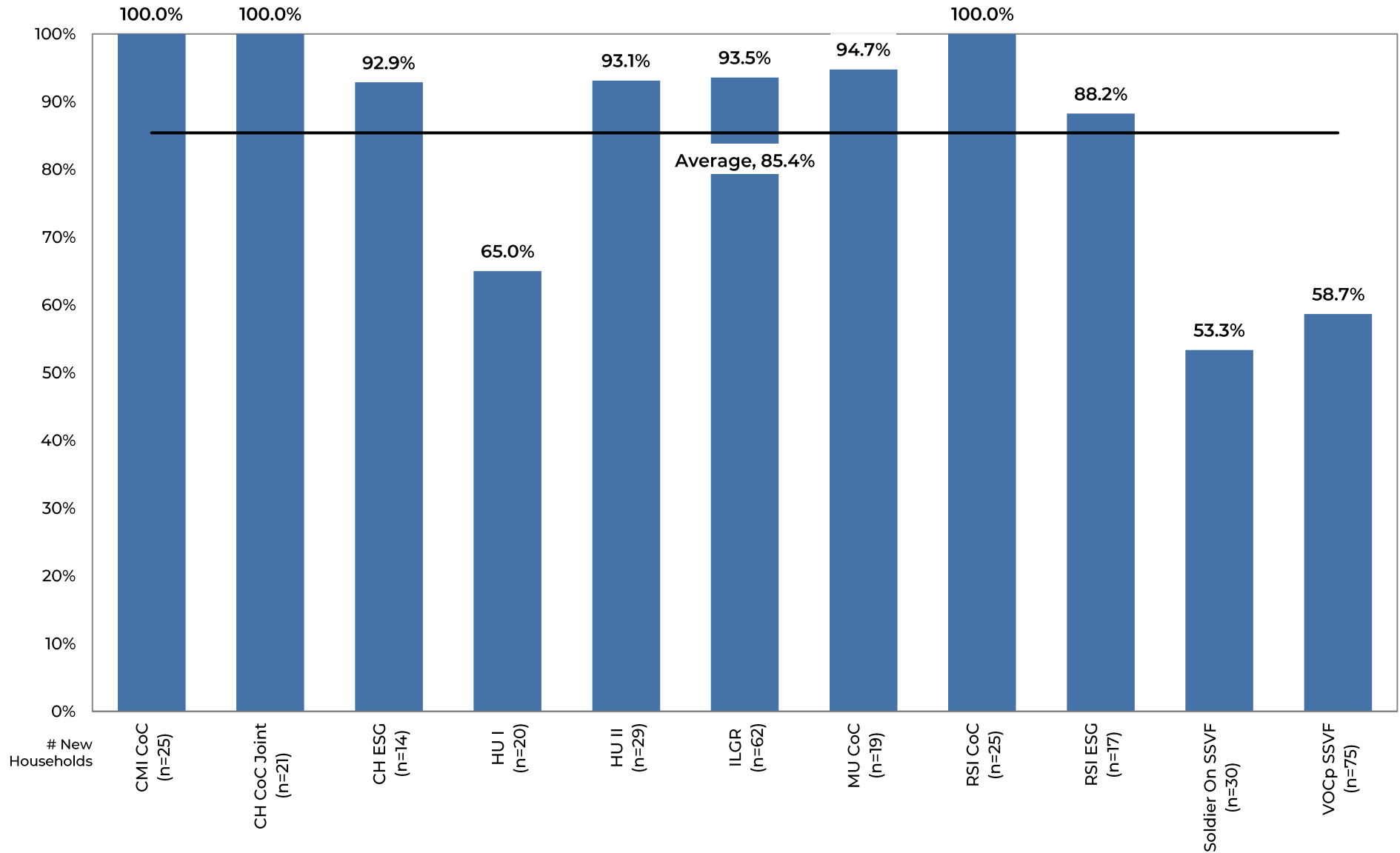
Average VI Score for New Households (RRH)



Percentage of New Households Assessed

This measure indicates the percentage of all new households served during the reporting period who have a VI-SPDAT, VI-FSPDAT, or TAY recorded in HMIS. All new households entering an RRH project are required to have a VI-SPDAT, VI-FSPDAT or TAY.

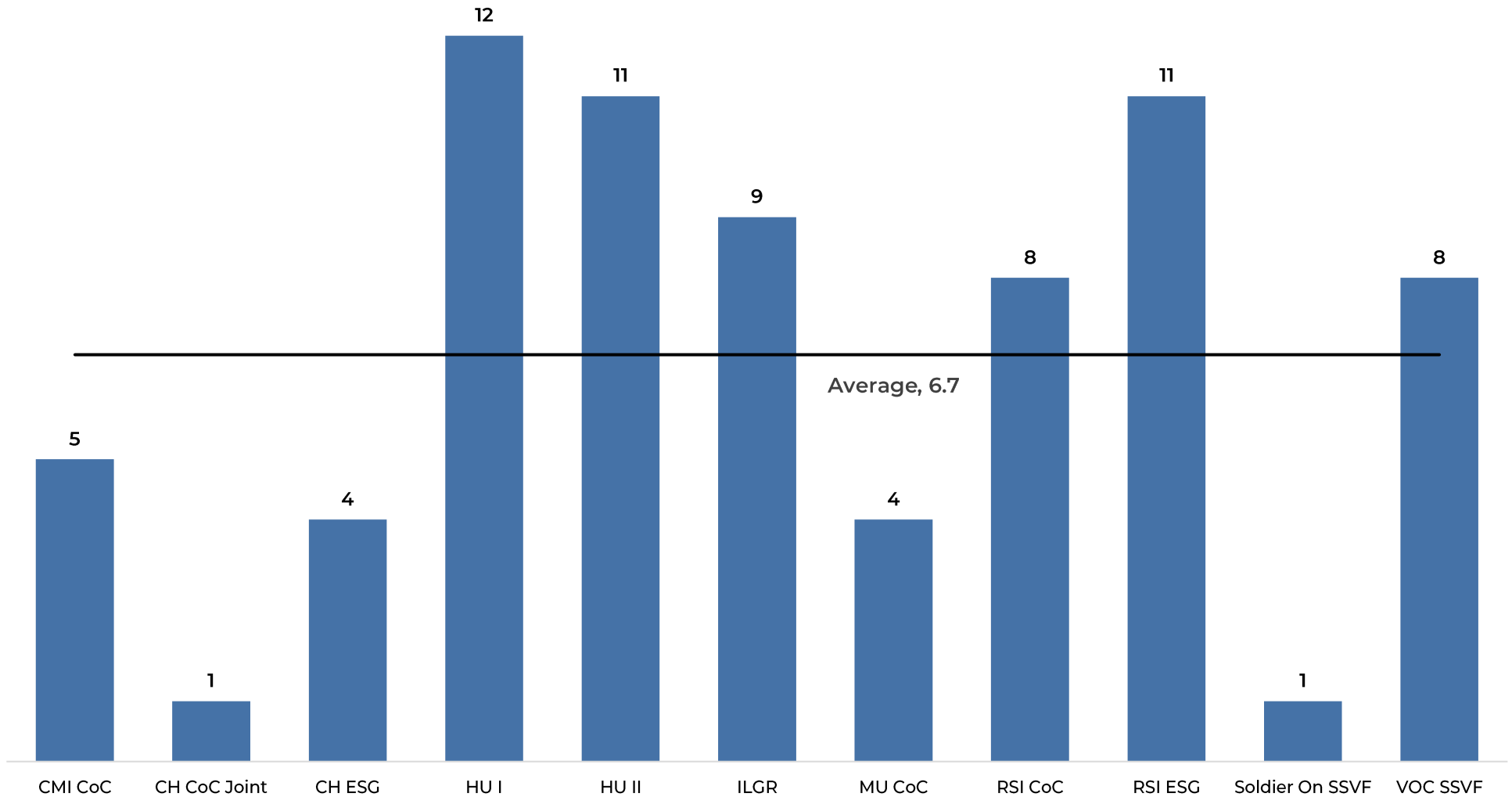
New Households with VI Scores (RRH)



HMIS Data Quality

All projects that receive CoC or ESG funding are required to use HMIS to facilitate data reporting to their funders. Timely and accurate data entry is necessary to ensure correct data is reported and used in analyses. This measure gives a broad overview as to how timely and accurate each project's data in HMIS is. A total of 13 points can be earned on this measure.

Total Data Quality Points (RRH)



Transitional Housing (TH) Projects

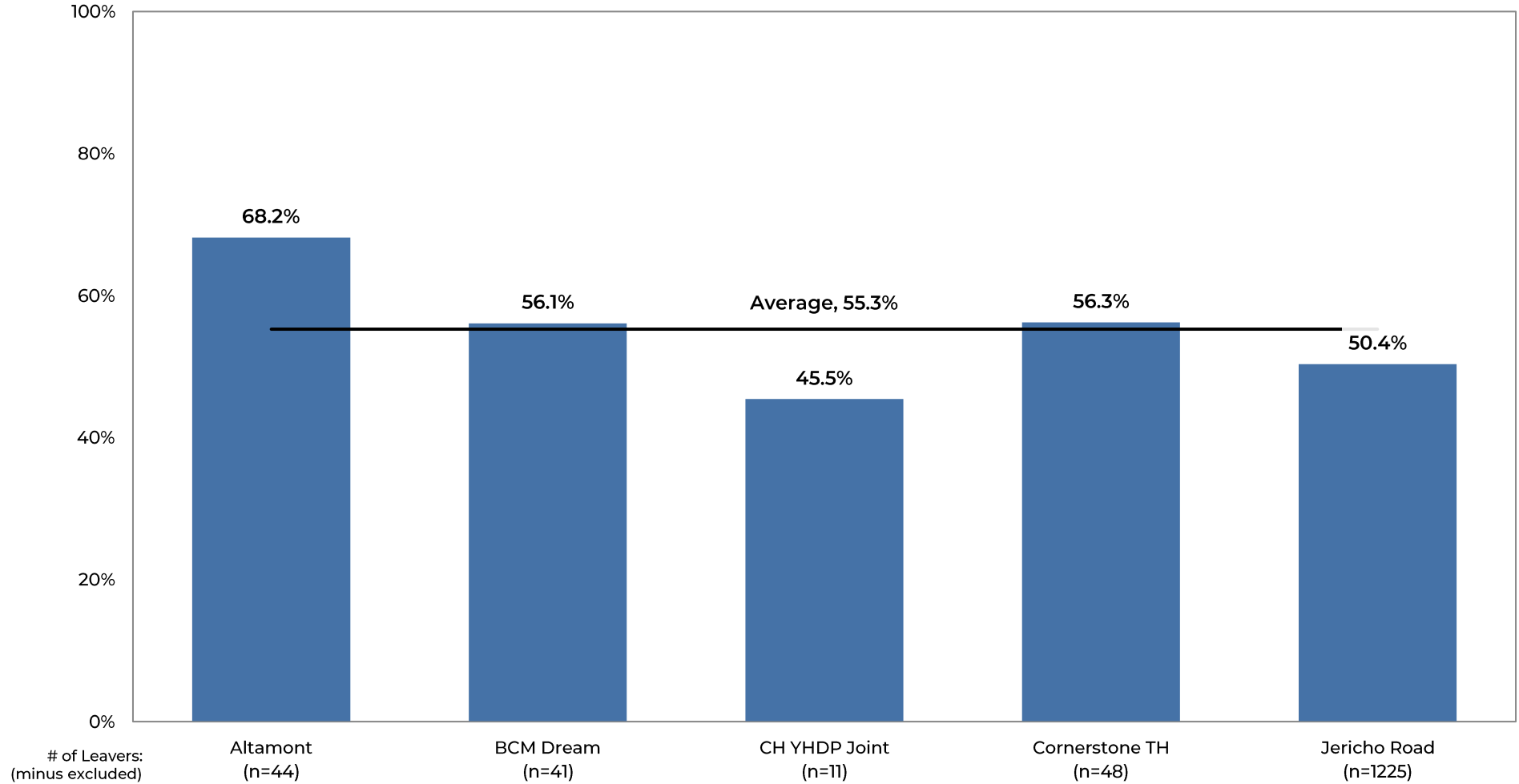
Housing Measures

All charts measuring exits exclude people who passed away during the project stay, those who went to foster care, hospitals or other residential non-psychiatric facilities, long term care facilities or nursing homes.

Exit to Permanent Housing (PH) Destinations

This measure includes only those who left the project and exited to PH.

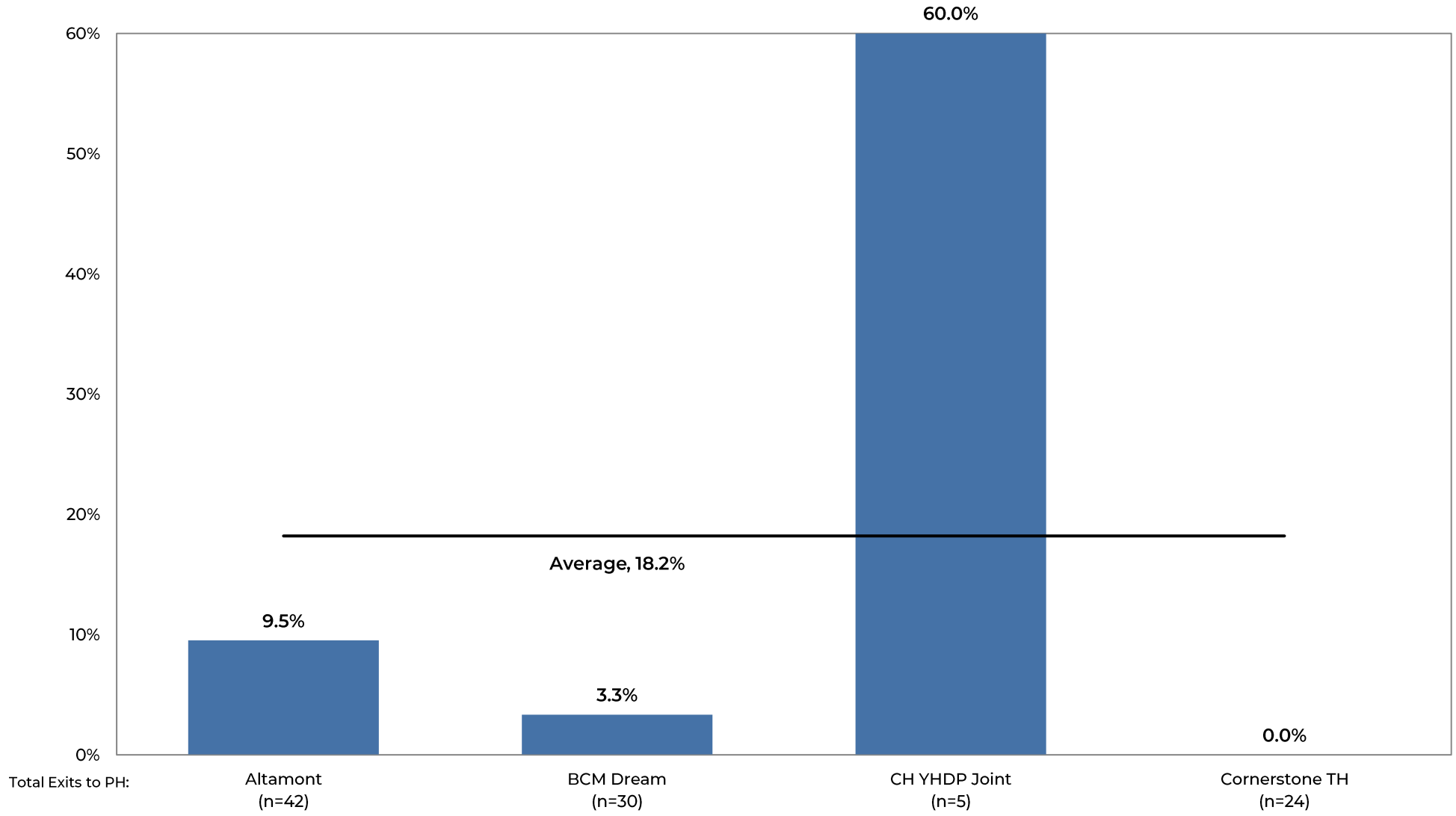
TH Clients Exited to PH



Returns to Homelessness

The data in this quarterly report looks at those who exited to PH from a service project between 10/1/2021 and 3/31/2023 and returned to homelessness (measured by a new entry date at a service project) within the following six months, beginning on 4/1/2023. This measure reflects our CoC's goal of reducing the number of people who return to homelessness.

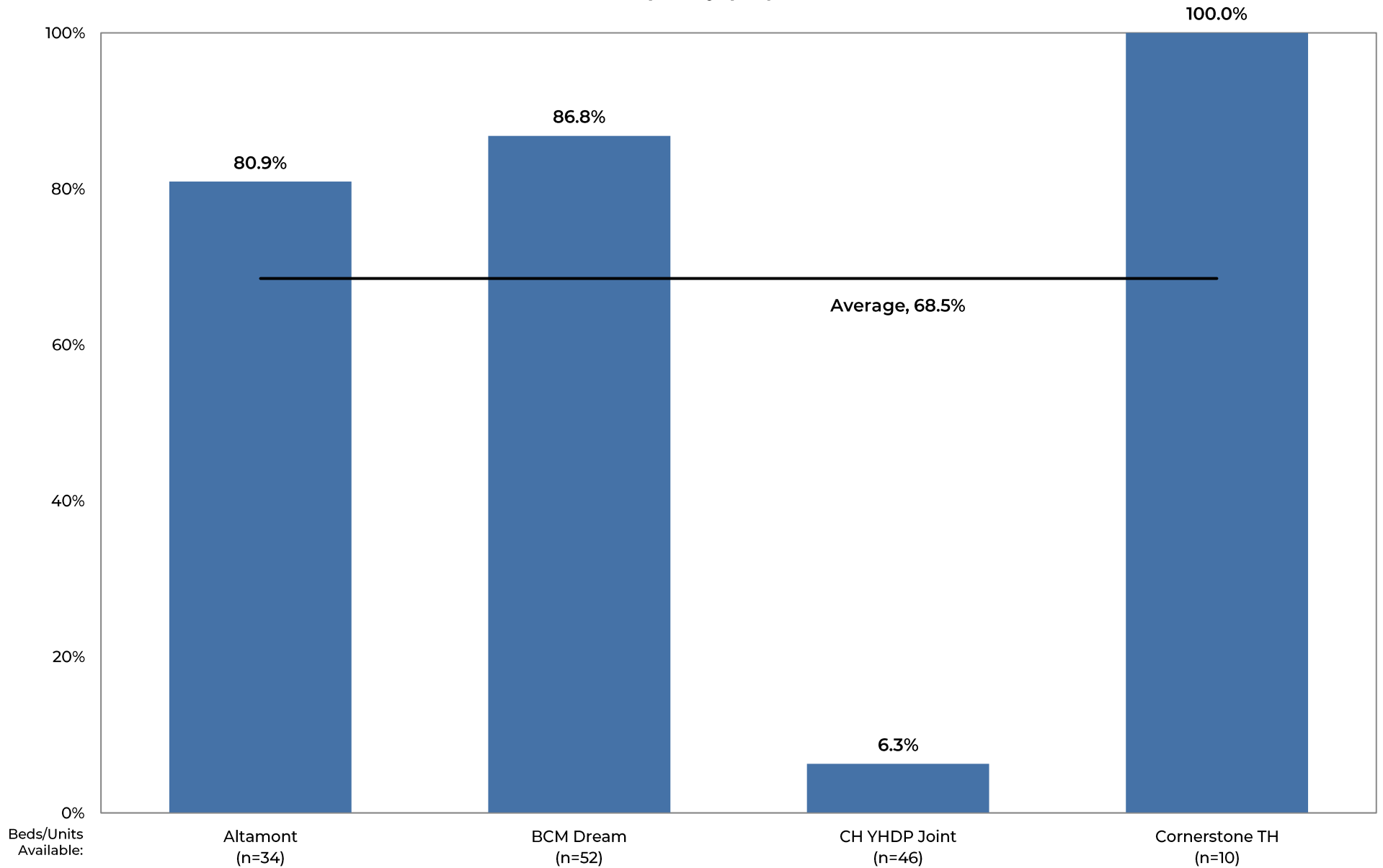
Clients Returning to Homelessness After Exiting to PH (TH)



Occupancy Rate

The occupancy rate is measured by calculating how many individuals are in each project each night during the reporting period (4/1/2022-3/31/2023) and using the project bed/unit capacity.

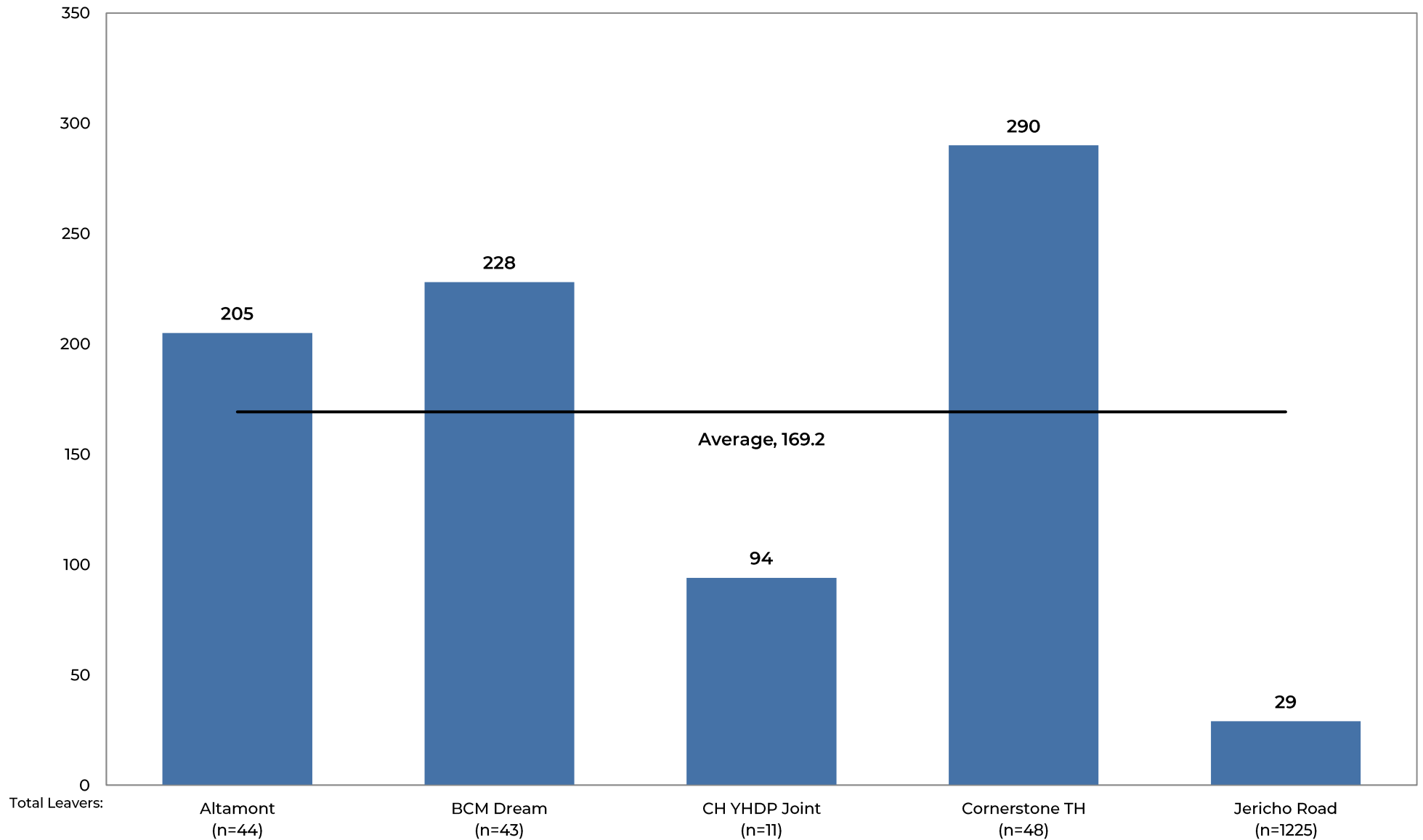
Occupancy (TH)



Length of Time Person Remains Homeless

The HUD goal is to reduce the length of time a person experiences homelessness. HUD system measurements are based on the length of stay at Transitional Housing. This measure is the average length of stay in TH projects among clients who exited the project within the reporting period.

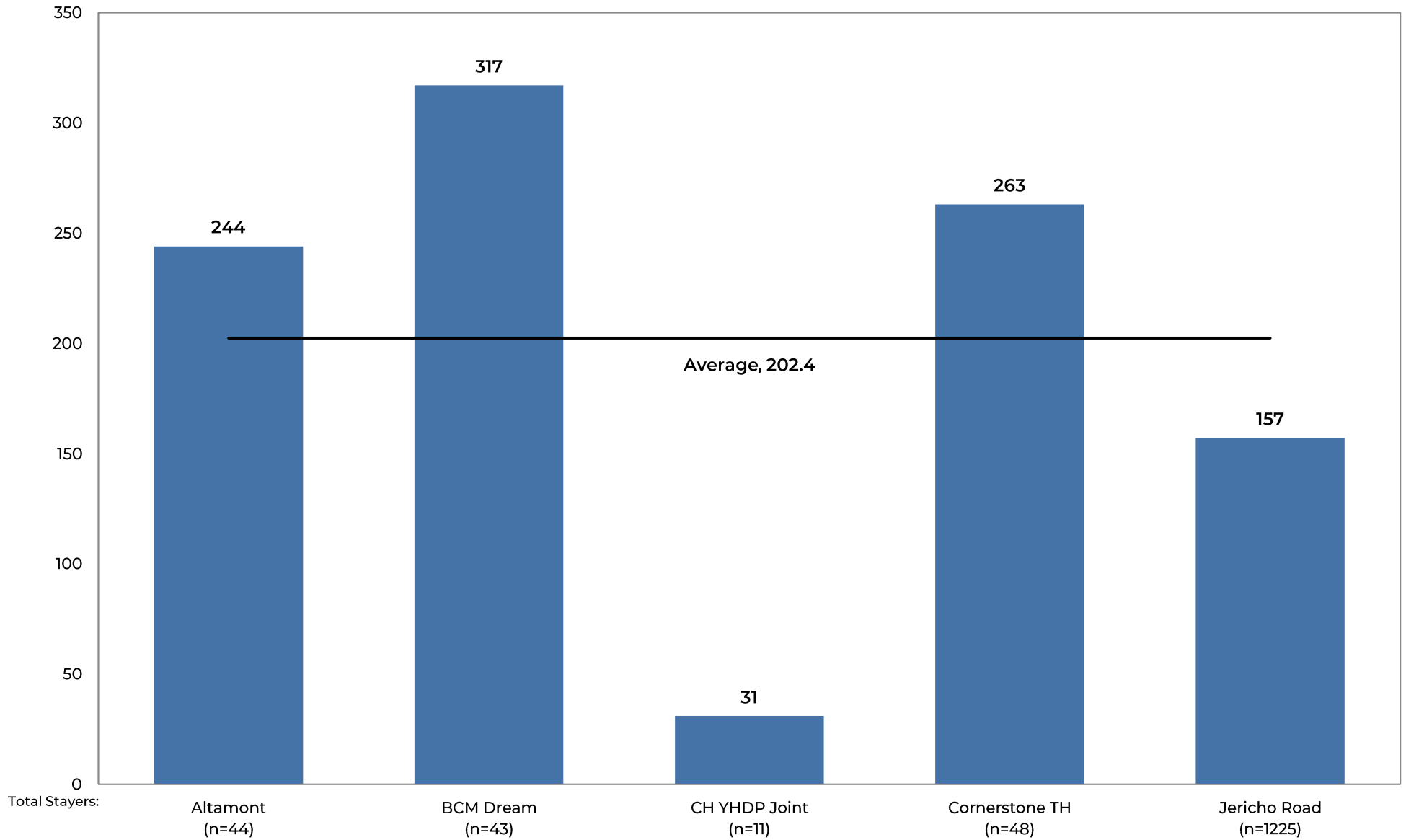
Average Length of Stay for TH Leavers



Length of Time Person Remains Homeless

This measure is the average length of stay in Transitional Housing projects among clients who were active clients who did not exit the project within the reporting period.

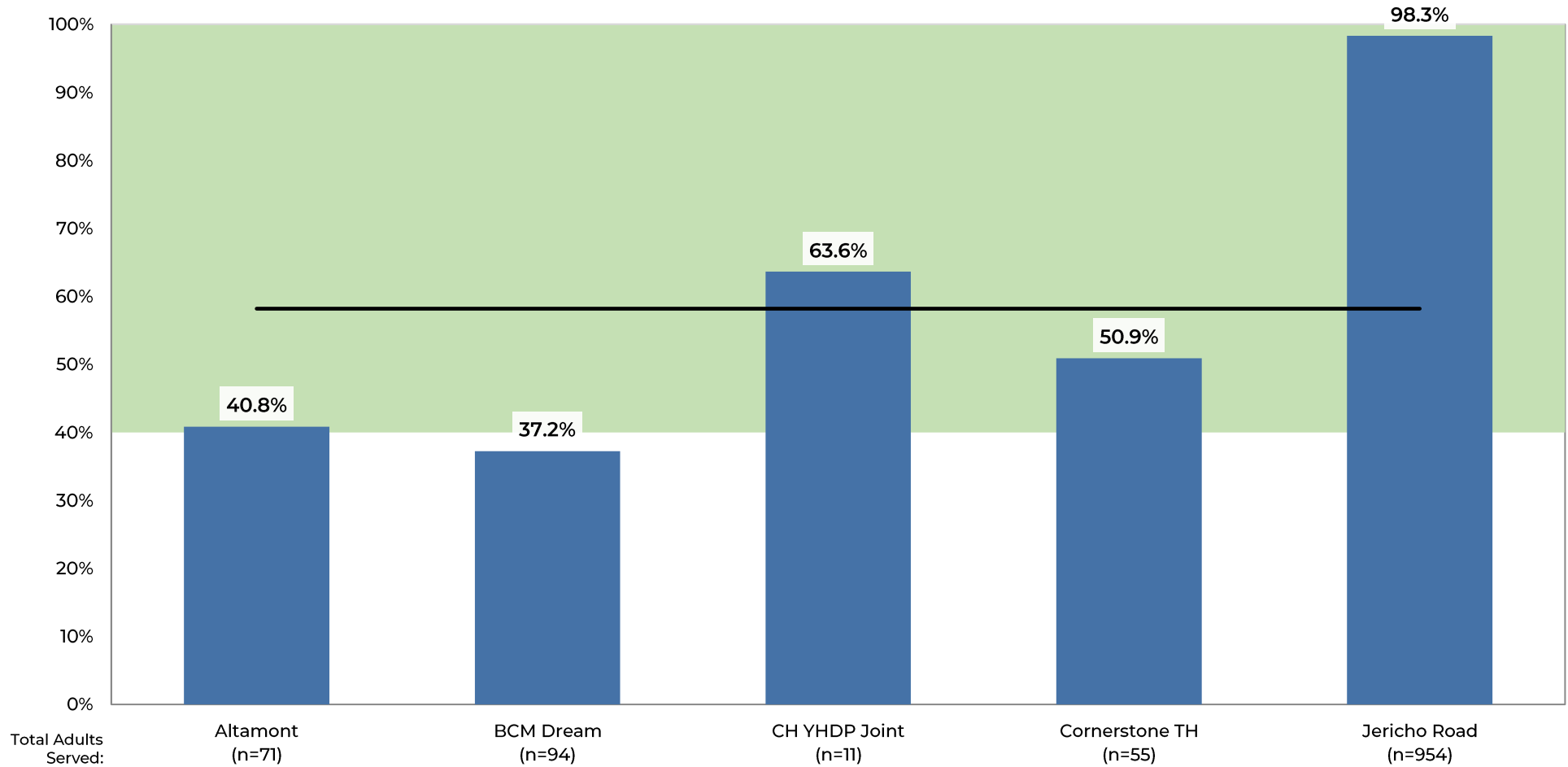
Average Length of Stay for TH Stayers



Percentage of Clients who Entered with Zero Income

Clients without any income have higher barriers to becoming stably housed. This measure shows the percentage of clients with no income at project entry for each RRH project. It demonstrates that these projects are taking the highest need clients. This measure is a bonus in which additional points are awarded on the funding application of projects with 40% or greater of the clients they serve having no income at project entry.

Clients with Zero Income at Entry (TH)



Emergency Shelter and Street Outreach (ES & SO) Projects

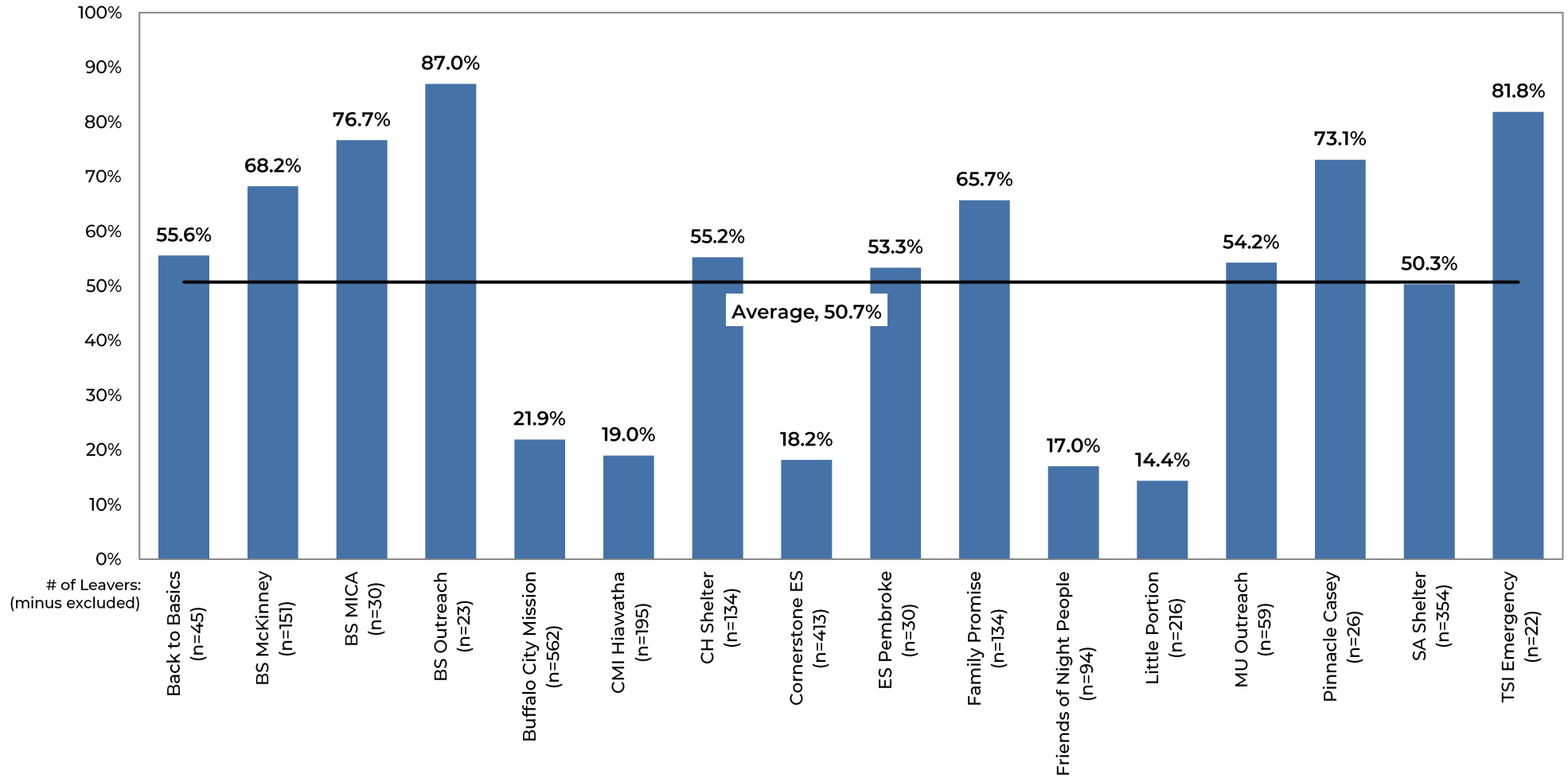
Housing Measures

All charts measuring exits exclude people who passed away during the project stay, those who went to foster care, hospitals or other residential non-psychiatric facilities, long term care facilities or nursing homes. The number of project leavers is included in some of the charts to show the total number of exits from each project.

Exit to Permanent Housing (PH) Destinations

This measure includes only those who left the project and exited to PH.

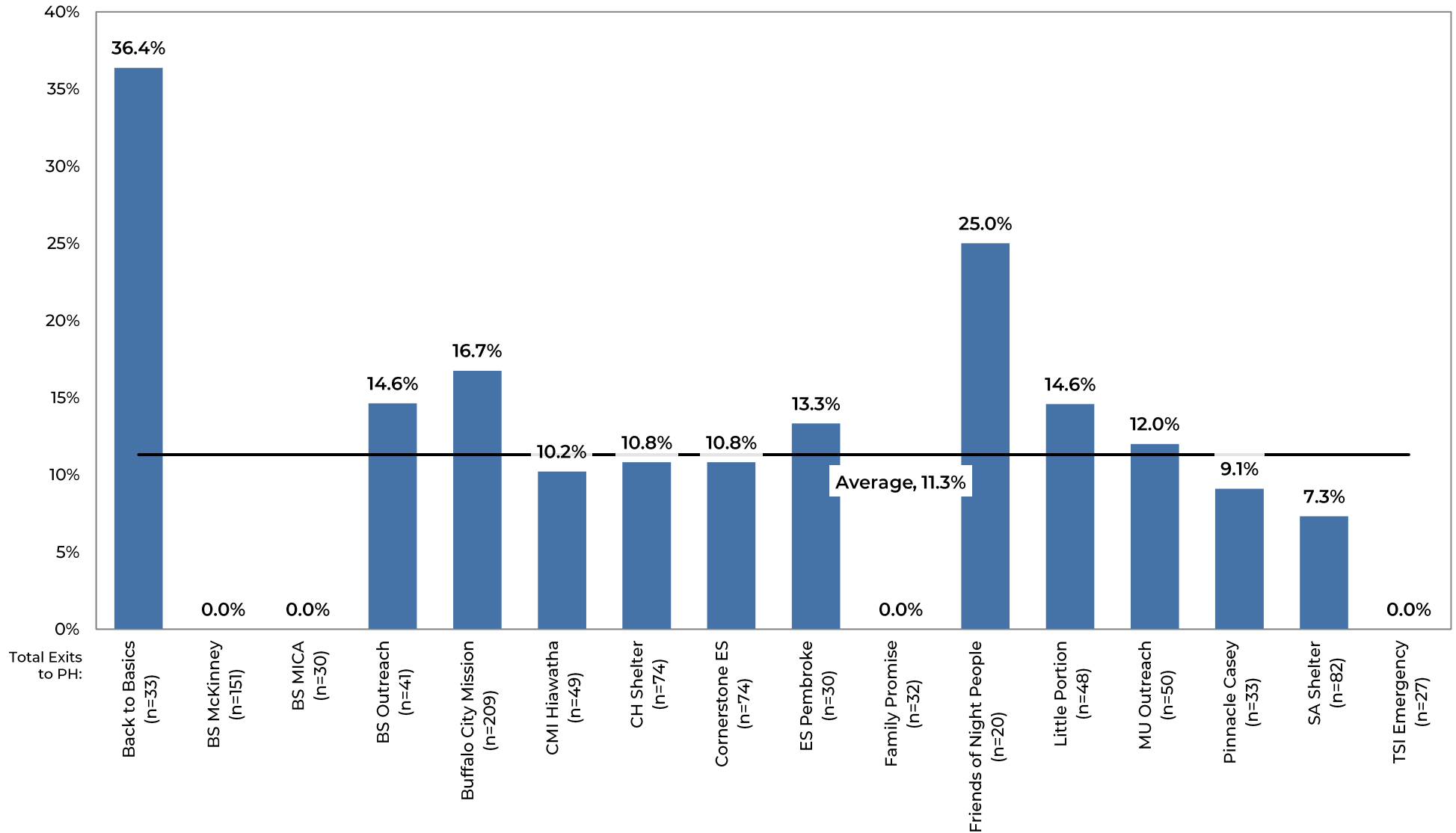
ES & SO Clients Exits to PH



Returns to Homelessness

The data in this quarterly report looks at those who exited to PH from a service project between 10/1/2021 and 3/31/2023 and returned to homelessness (measured by a new entry date at a service project) within the following six months, beginning on 4/1/2022. This measure reflects our CoC's goal of reducing the number of people who return to homelessness.

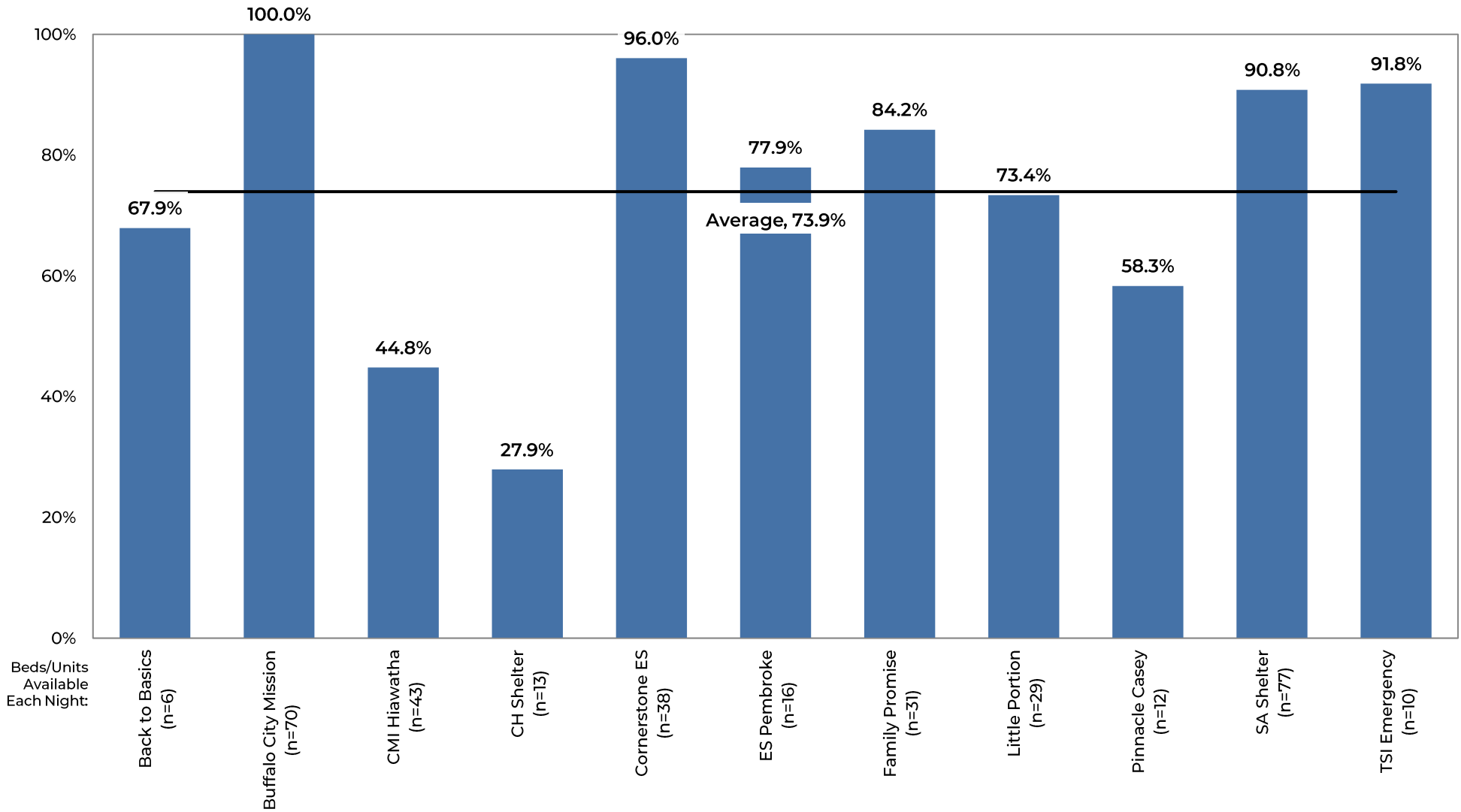
Returns to Homelessness After Exiting to PH (ES & SO)



Occupancy Rate

The occupancy rate is measured by calculating how many individuals are in each ES project each night during the reporting period (4/1/2022-3/31/2023) and using the using the project bed/unit capacity.

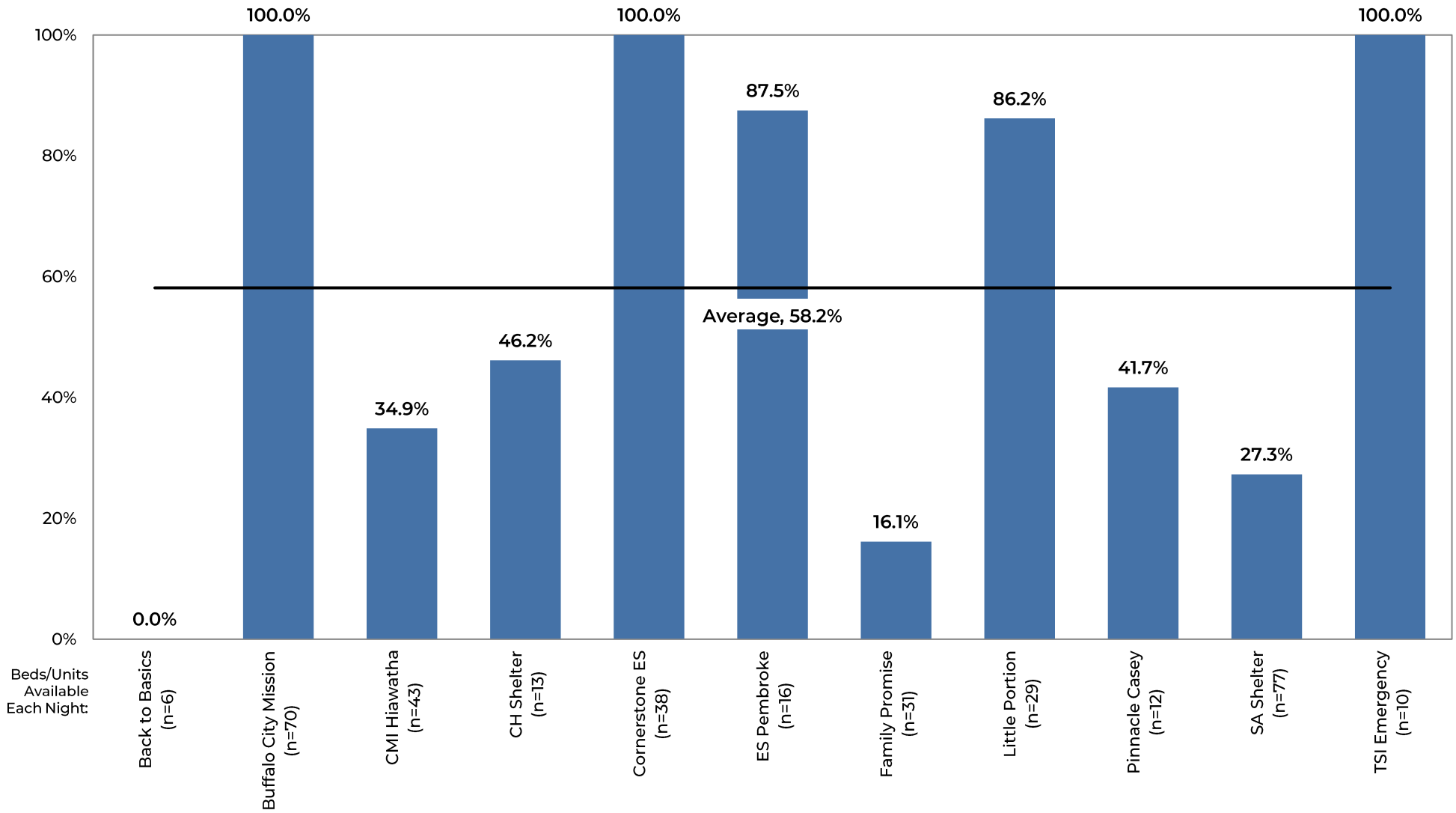
Occupancy (ES)



Occupancy Rate on the Last Day of the Reporting Period

This occupancy rate is measured by determining how many households were active in each ES project on the last night of the reporting period (3/31/2023) and comparing that to the project bed/unit capacity.

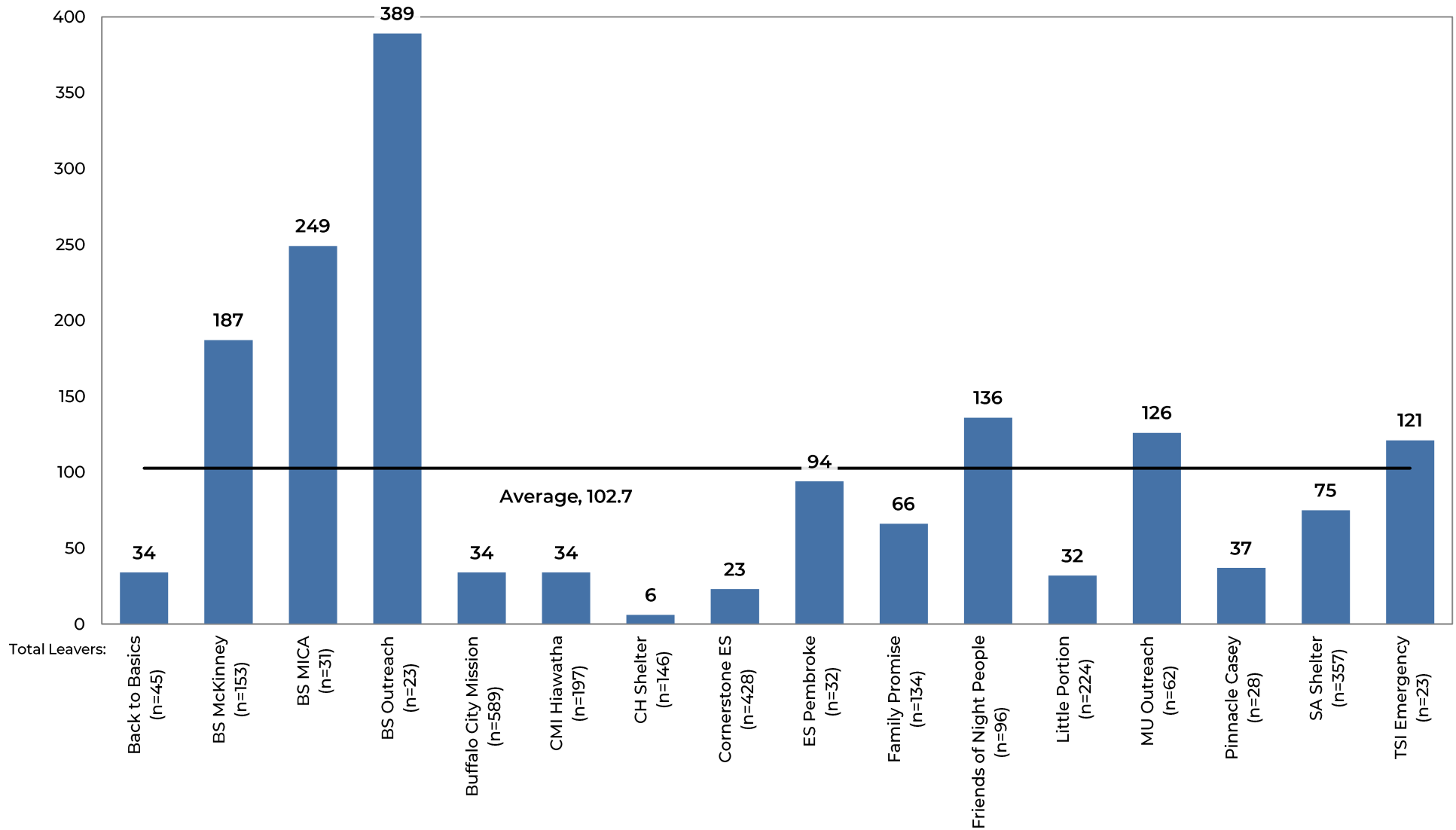
Occupancy on the Last Day of the Reporting Period (ES)



Average Length of Time Person Remains Homeless

The HUD goal is to reduce the length of time a person experiences homelessness. HUD system measurements are based on the length of stay at Emergency Shelters.

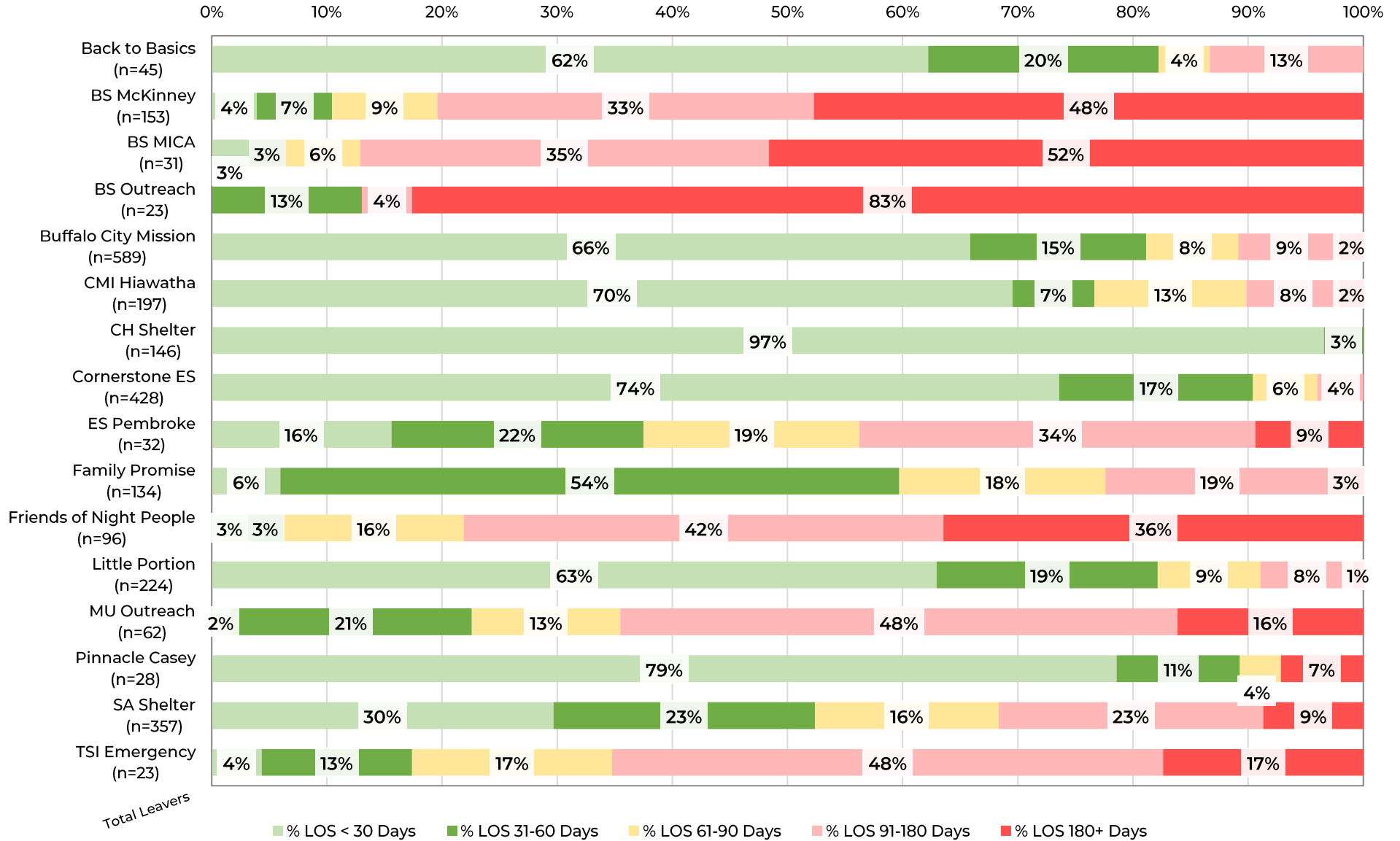
Average Length of Stay for Leavers (ES & SO)



Length of Stay for all Leavers

The chart before showed the average length of stay in each project for clients who leave, whereas this chart details how long all clients are staying in each of the projects.

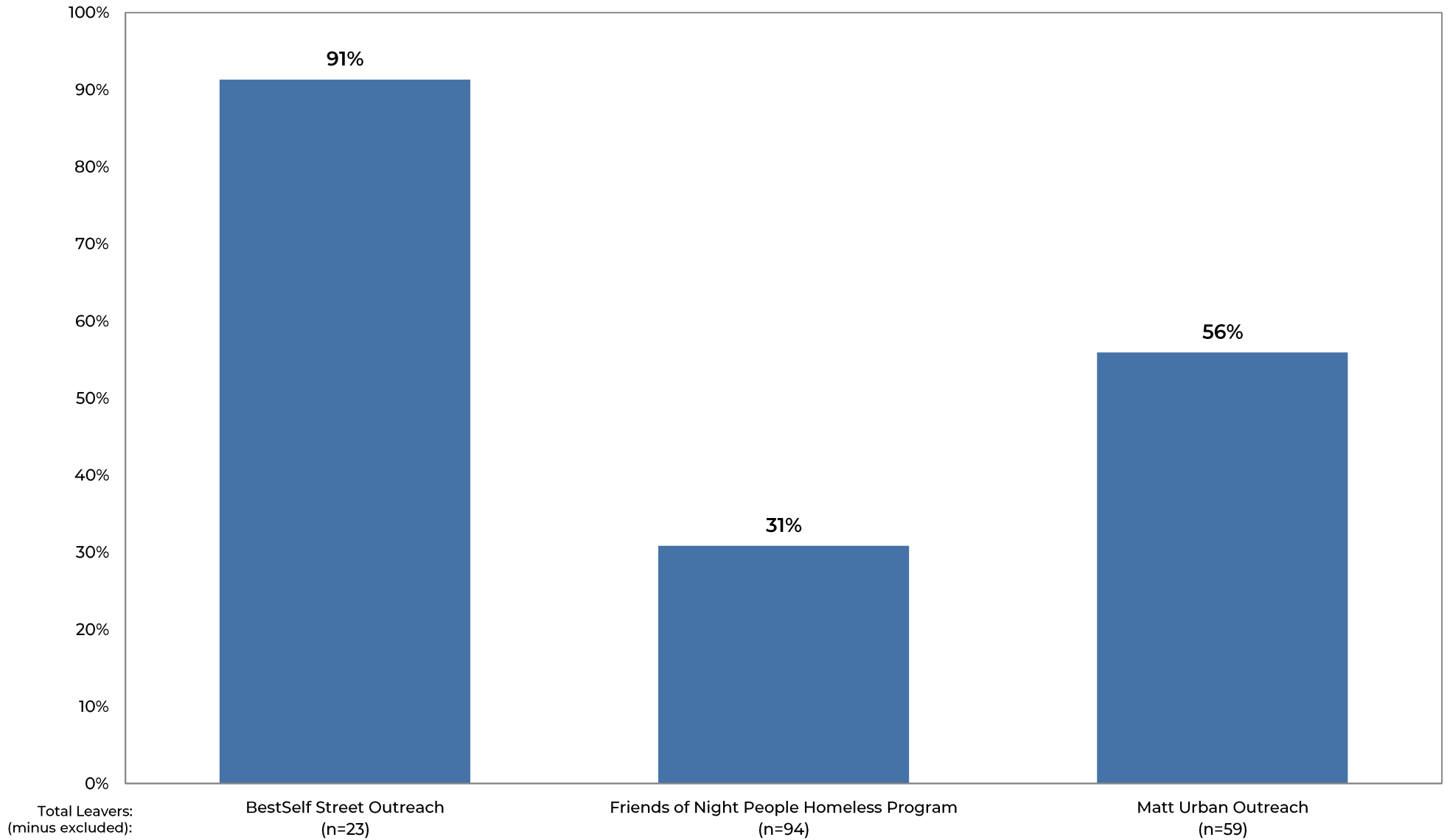
Length of Stay for Leavers (ES & SO)



Exit to Positive Destinations (Outreach Only)

Positive Destinations include all permanent housing destinations, emergency shelter, transitional housing for homeless persons, staying with family or friends with temporary tenure, Safe Haven, hotel or motel paid by client, foster care, psychiatric facility, substance abuse or detox facility, hospital (non-psychiatric).

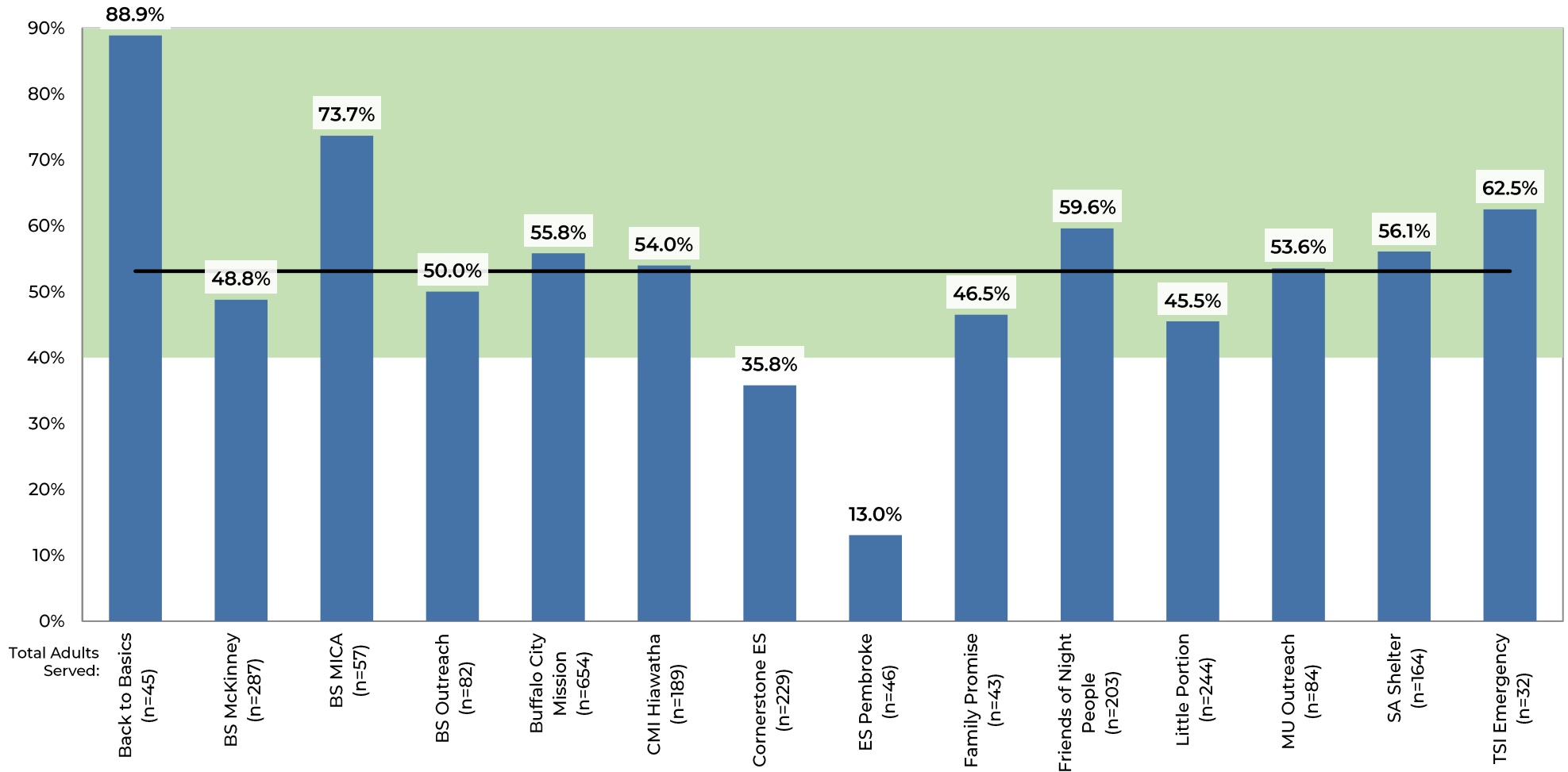
Outreach Clients Exits to Positive Destinations



Percentage of Clients who Entered with Zero Income

Clients without any income have higher barriers to becoming stably housed. This measure shows the percentage of clients with no income at project entry for each RRH project. It demonstrates that these projects are taking the highest need clients. This measure is a bonus in which additional points are awarded on the funding application of projects with 40% or greater of the clients they serve having no income at project entry.

Clients with Zero Income at Entry (ES & SO)



Projects in this Report

PSH	RRH	TH
BestSelf Chronic Homeless Program (BS Chronic)	CMI CoC RRH (CMI CoC)	Altamont Veterans Program Buffalo (Altamont)
BestSelf CoC I (BS CoC I)	Compass House CoC Joint RRH (CH CoC Joint)	Buffalo City Mission Dream TH (BCM Dream)
BestSelf Harambe House (BS Harambe)	Compass House ESG RRH (CH ESG)	Compass House YHDP Joint RRH (CH YHDP Joint)
Cazenovia Chronic Homeless Program (Caz Chronic)	Hispanos Unidos RRH I (HU I)	Cornerstone-Transitional (Cornerstone TH)
Cazenovia Niagara Falls S+C (Caz Niagara S+C)	Hispanos Unidos RRH II (HU II)	Jericho Road Community Health Center – VIVE (Jericho Road)
Evergreen Housing First (Evergreen H1st)	ILGR RRH (ILGR)	
Gerard Place PSH for Families (Gerard Place)	Matt Urban CoC RRH (MU CoC)	
LOD CoC I (LOD CoC I)	Restoration Society CoC RRH (RSI CoC)	
LOD CoC III (LOD CoC III)	Restoration Society County ESG RRH (RSI ESG)	
Matt Urban Hope Gardens (MU Hope Gardens)	Soldier On SSVF RRH (Soldier On SSVF)	
Matt Urban Housing First (MU H1st)	Veterans One Stop Center SSVF RRH (VOC SSVF)	
Restoration Society CoC II (RSI CoC II)		
Spectrum Chronically Homeless PSH I (Spectrum Chronic)		
Spectrum CoC II (Spectrum CoC II)		
TSI CoC I (TSI CoC I)		
TSI CoC II (TSI CoC II)		
WNY Veterans Housing Coalition S+C VI (WNY Vet S+C VI)		

Projects in this Report cont.

ES & SO	CV RRH
Back to Basics (Back to Basics)	BestSelf Buffalo City CV ESG RRH (BS Buffalo CV)
BestSelf McKinney (BS McKinney)	Catholic Charities Buffalo City CV ESG RRH (CC Buffalo CV)
BestSelf MICA (BS MICA)	Catholic Charities Niagara Falls CV ESG RRH (CC Niagara CV)
BestSelf Street Outreach (BS Outreach)	Compass House Buffalo City CV ESG RRH (CH Buffalo CV)
Buffalo City Mission (Buffalo City Mission)	Hispanos Unidos Buffalo City CV ESG RRH (HU Buffalo CV)
CMI Hiawatha ES (CMI Hiawatha)	Housing Opportunities Made Equal Buffalo CV ESG RRH (HOME Buffalo CV)
Compass House Emergency Shelter (CH Shelter)	ILGR Genesee NYS CV ESG RRH (ILGR Genesee CV)
Cornerstone-Emergency (Cornerstone ES)	ILGR Orleans NYS CV ESG RRH (ILGR Orleans CV)
Eagle Star-Pembroke ES (ES Pembroke)	ILGR Wyoming NYS CV ESG RRH (ILGR Wyoming CV)
Family Promise (Family Promise)	Restoration Society Inc. Tonawanda CV ESG RRH (RSI Tonawanda CV)
Friends of Night People Homeless Program (Friends of Night People)	Salvation Army Buffalo City CV ESG RRH (SA Buffalo CV)
Little Portion Friary Shelter (Little Portion)	Salvation Army Niagara NYS CV ESG RRH (SA Niagara CV)
Matt Urban Outreach (MU Outreach)	Spectrum Buffalo City CV ESG RRH (Spectrum Buffalo CV)
Pinnacle Casey House Teen Shelter (Pinnacle Casey)	Spectrum Erie County CV ESG RRH (Spectrum Erie CV)
Salvation Army of Buffalo - Emergency Family Shelter (SA Shelter)	
TSI Emergency Housing Service (TSI Emergency)	

CV Rapid Rehousing (CV RRH) Projects

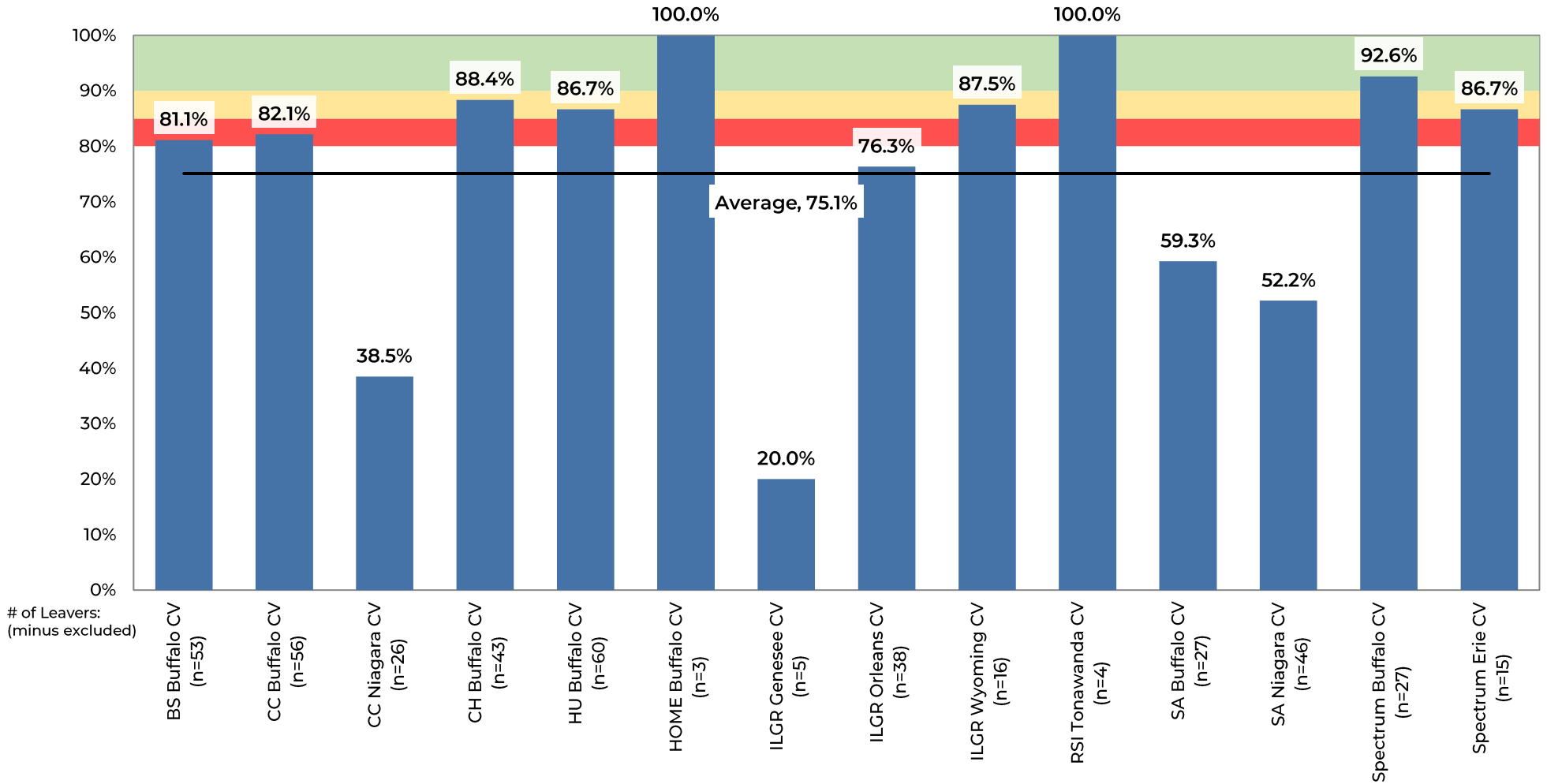
Housing Measures

All charts measuring exits exclude people who passed away during the project stay, those who went to foster care, hospitals or other residential non-psychiatric facilities, long term care facilities or nursing homes.

Exit to Permanent Housing (PH) Destinations

This measure includes only those who left the project and exited to PH. The benchmark for CV RRH projects is the national benchmark of 80%.

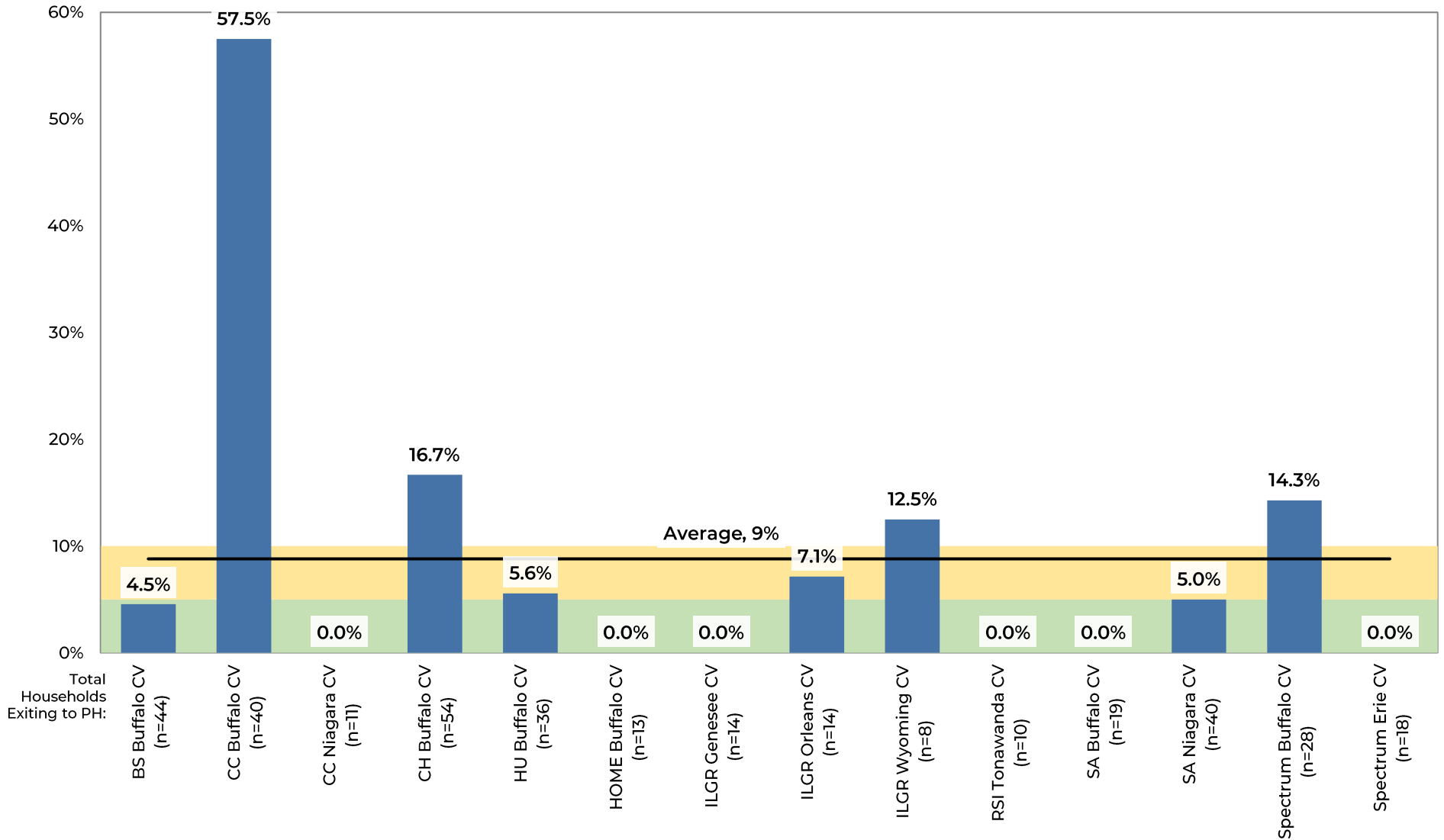
CV RRH Participants Exited to PH



Returns to Homelessness

The data in this quarterly report looks at those who exited to PH from a service project between 10/1/2021 and 3/31/2023 and returned to homelessness (measured by a new entry date at a service project) within the following six months, beginning on 4/1/2022. This measure reflects our CoC's goal of reducing the number of people who return to homelessness.

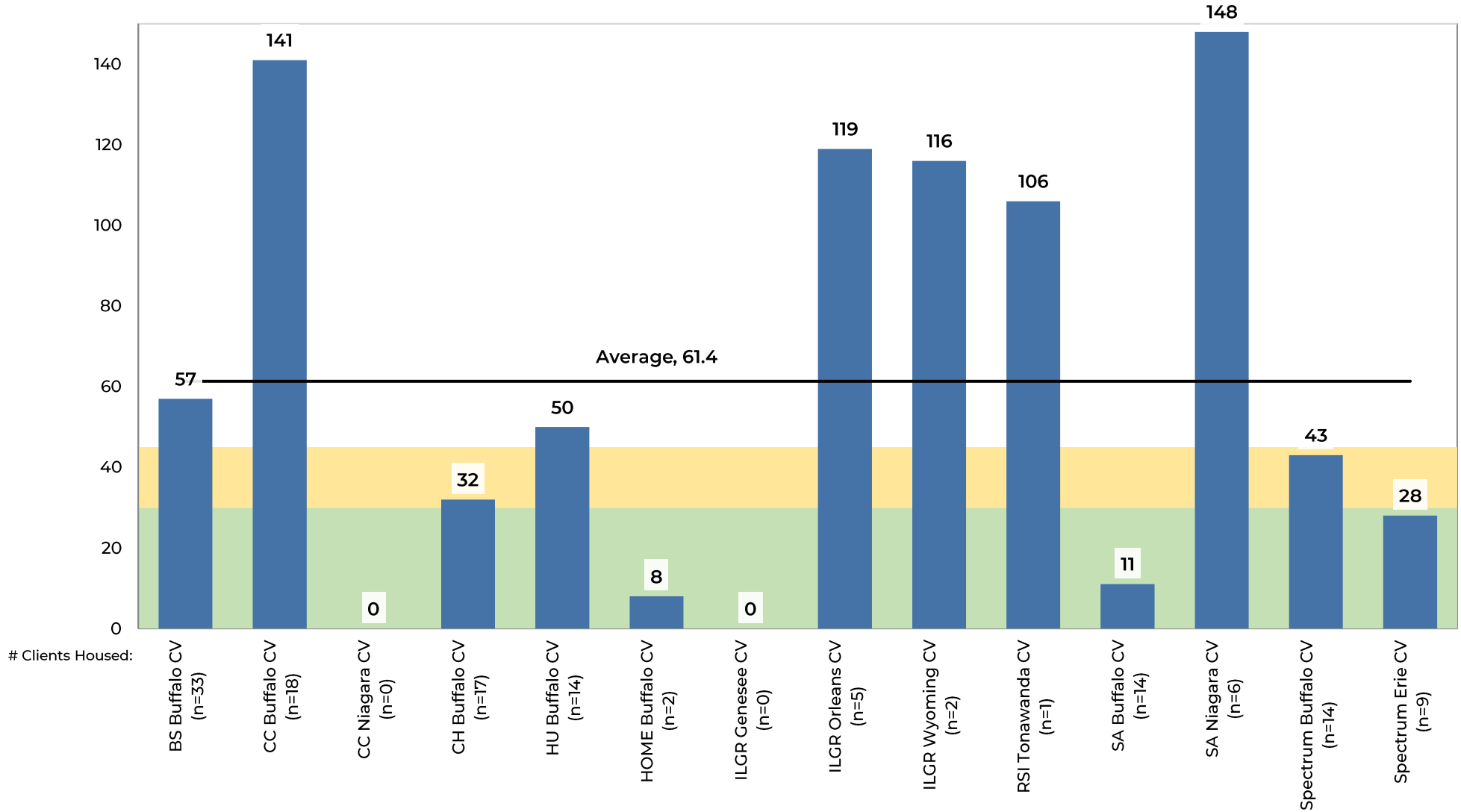
Returns to Homelessness After Exiting to PH (CV RRH)



Length of Time from Project Entry to Move-In Date

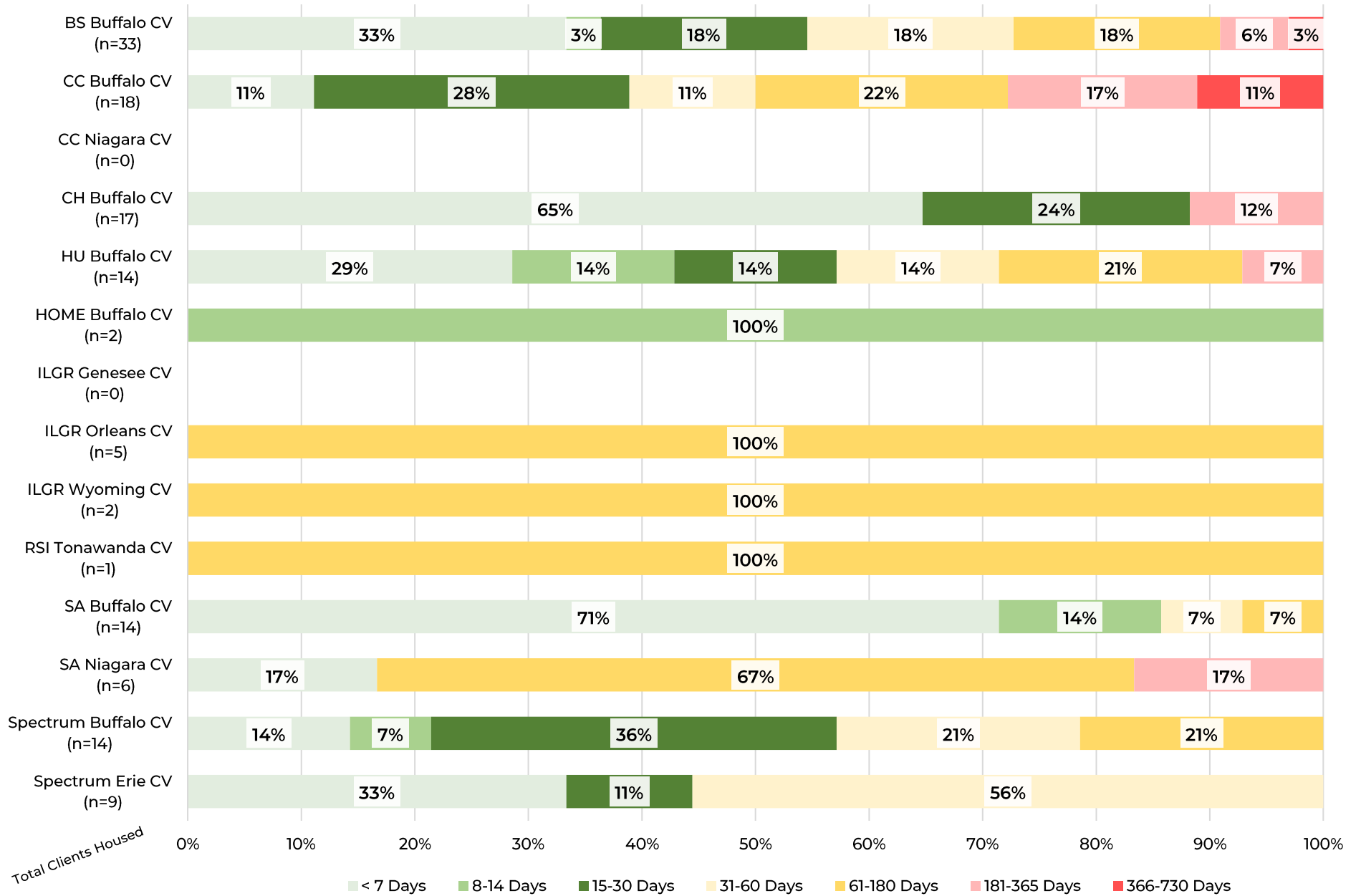
For CV RRH projects, this measure is an average of the number of days from CV RRH project admission to move-in to permanent housing for those who have an entry date and a move-in date. The NAEH benchmark for this measure is an average of 30 days.

Average # of Days from Project Entry to Move-In (CV RRH)



Breakdown of How Long it Takes to House CV RRH Clients

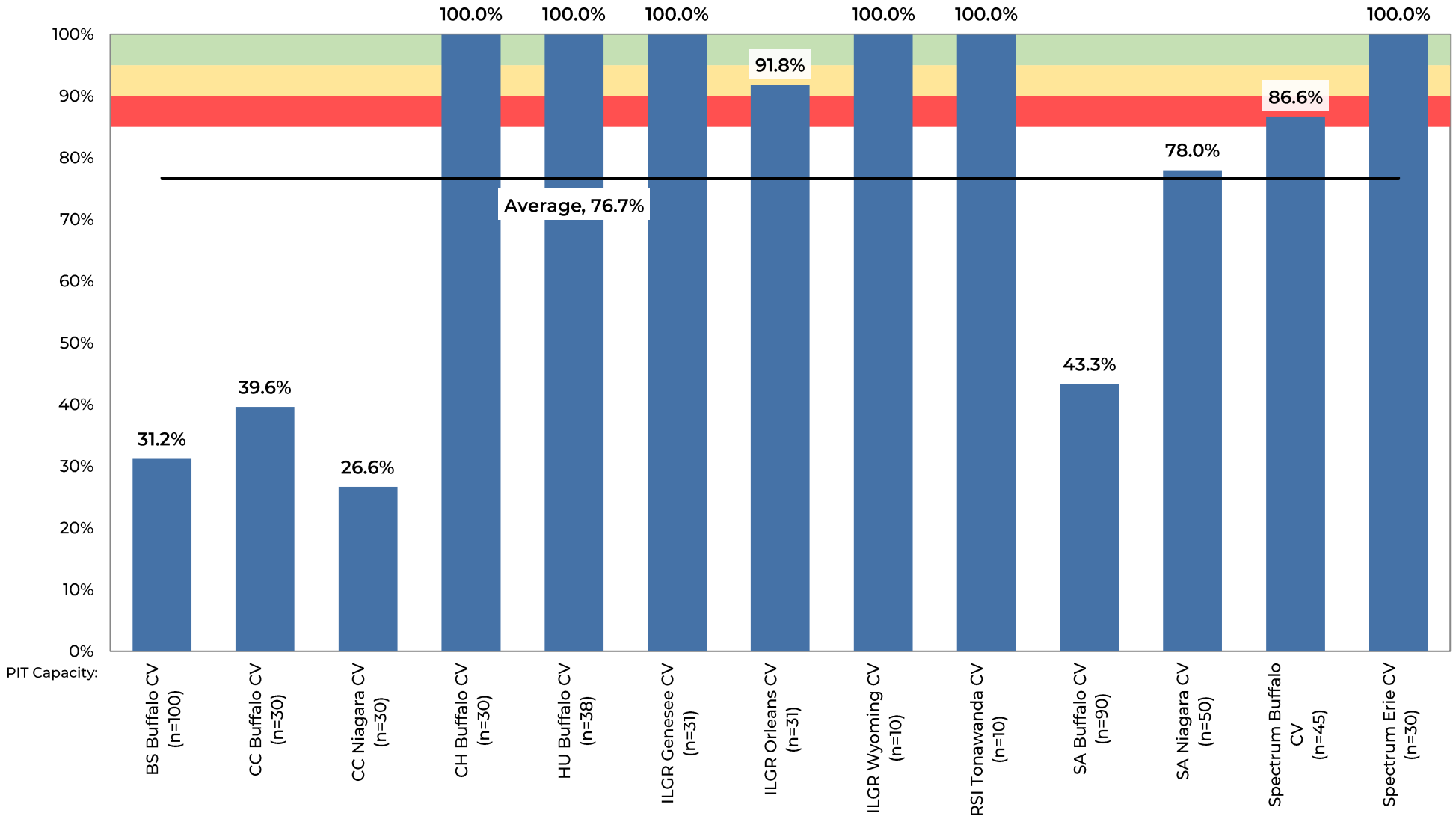
Breaking Down How Long it Takes to House Clients (CV RRH)



Point in Time Occupancy Rates

For RRH projects, occupancy is measured two ways. The first, shown here, is based on how often during the reporting period each project was “at capacity” by averaging how many clients were enrolled in the RRH project each night. The capacity value is determined using the number of beds the projects reported in their HUD CoC grant application.

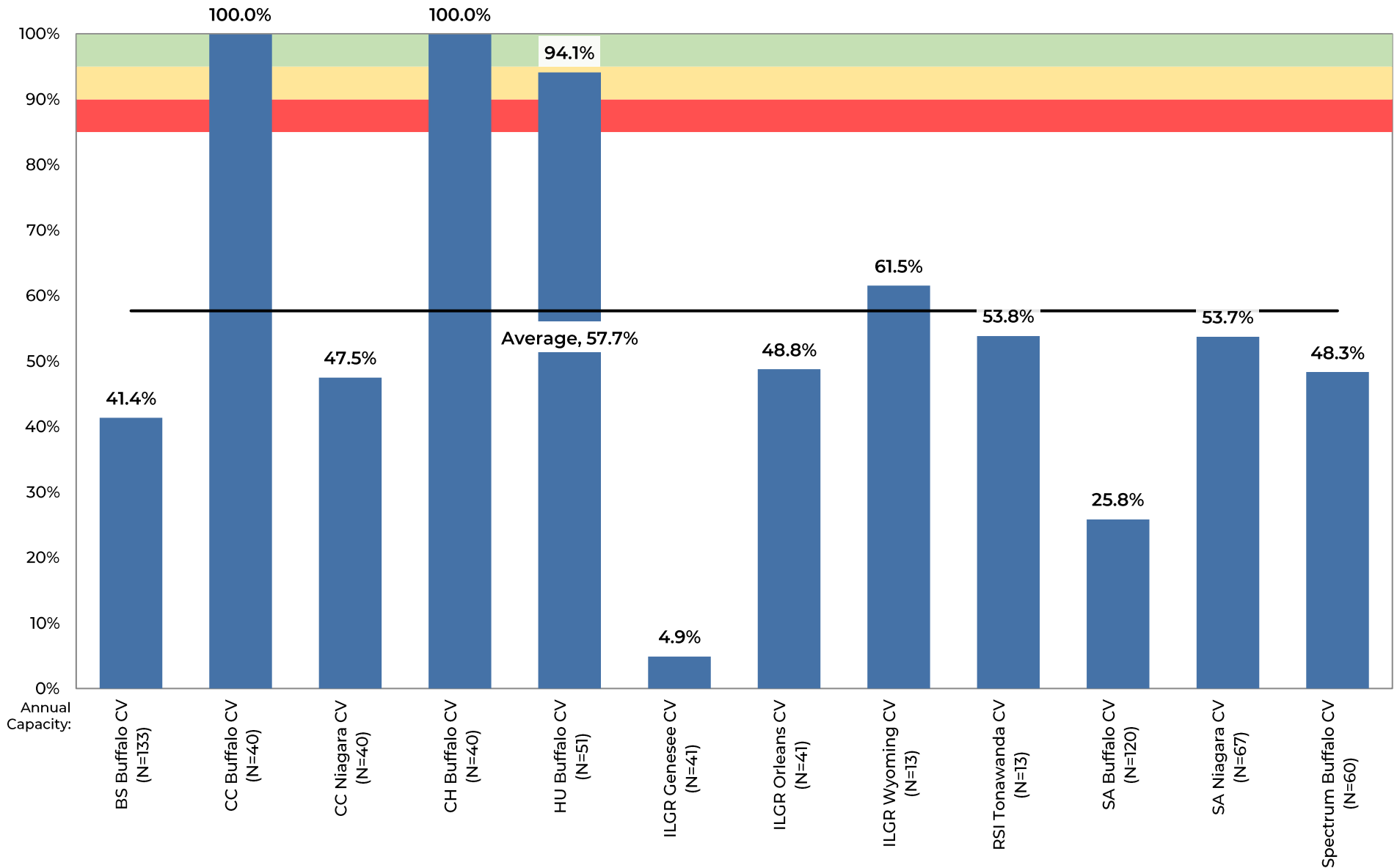
Point in Time Occupancy Rates (CV RRH)



Annual Occupancy Rates

For RRH projects, occupancy is measured two ways. The second, shown here, is based on how many households were served during the reporting period compared to the number of households the project is estimated to serve over the course of the reporting period. The estimated households served is determined using the number of beds the projects reported in their HUD CoC grant application multiplied by 1.33, as it is expected that there will be some amount of turnover in the households each project serves during the year.

Annual Occupancy Rates (CV RRH)



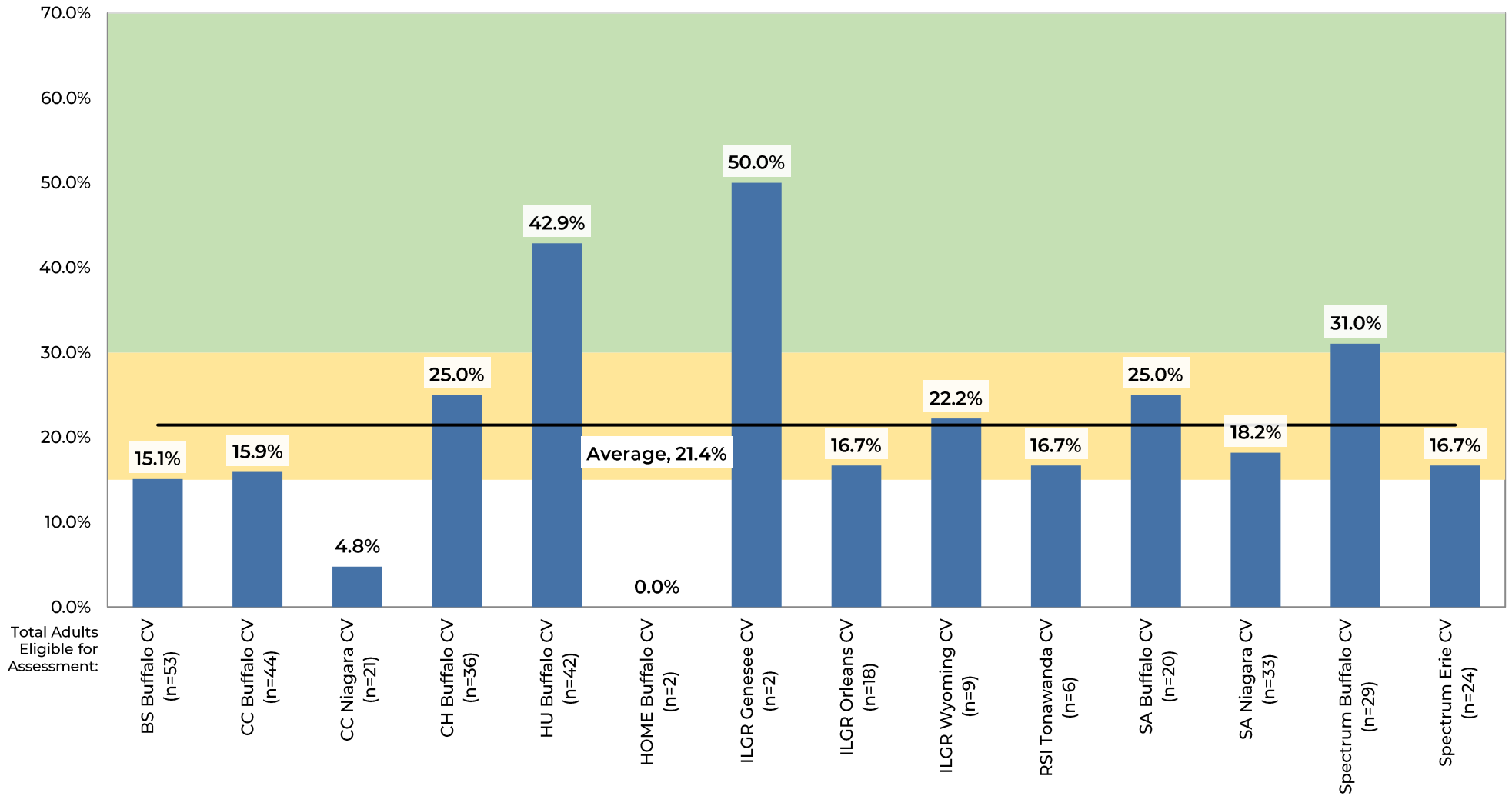
Income Measures

All income measures only include adults that have exited or been in the project for longer than one year, with an annual assessment completed in the +/- 30 day window. Income is measured from client entry into the project to either the latest annual assessment or exit.

Maintained or Increased Earned Income for CV RRH Participants

This measure includes those adults that have maintained employment and those who have maintained or gained employment and increased their amount of earned income.

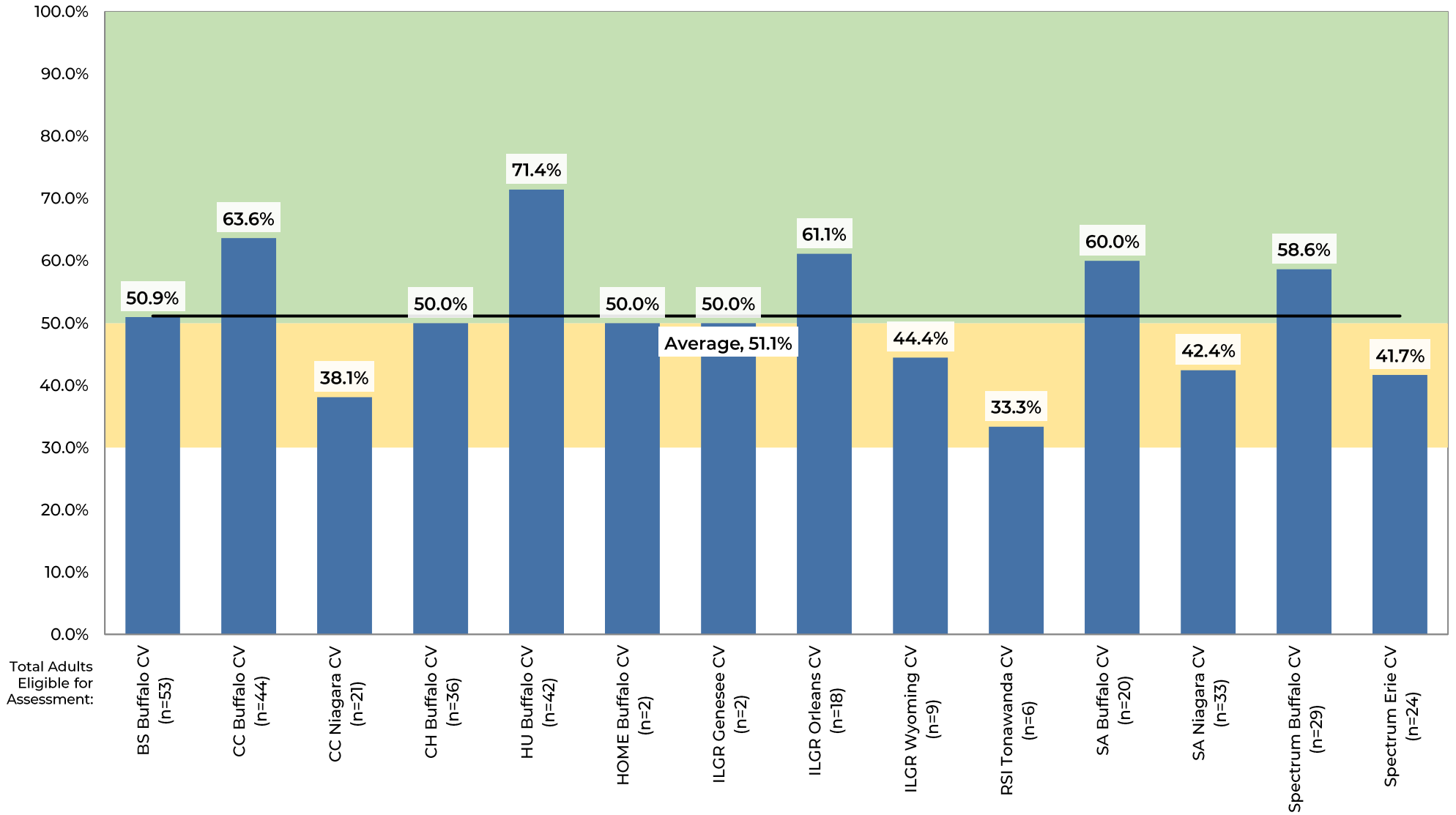
Adults with Maintained/Increased Earned Income (CV RRH)



Maintained/Increased Any Income for CV RRH Participants

This measure includes those adults who have increased or retained their cash income from any source, including earned income and benefits (e.g. SSI, SSDI, PA, TANF etc.).

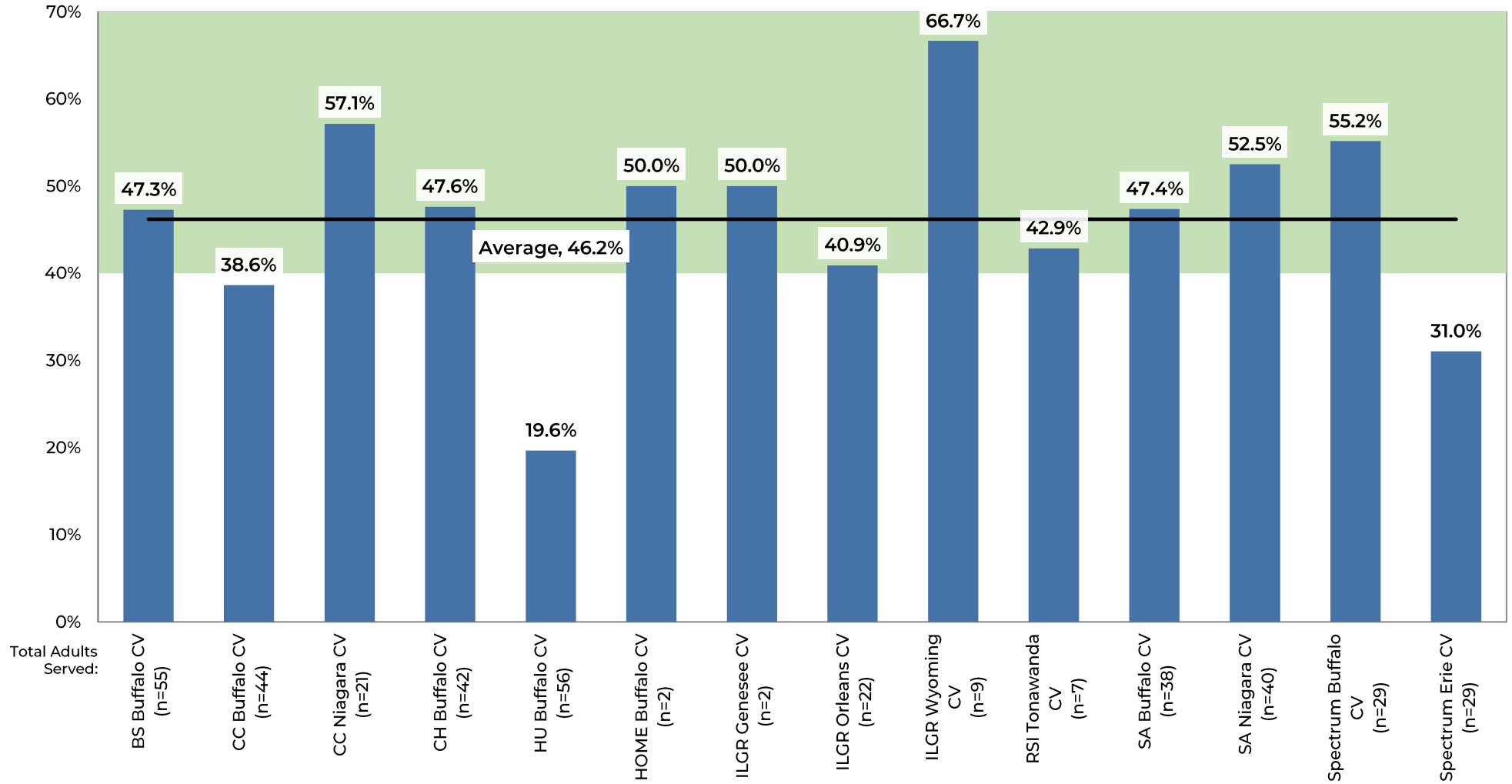
Adults with Maintained/Increased Any Income (CV RRH)



Percentage of Clients who Entered with Zero Income

Clients without any income have higher barriers to becoming stably housed. This measure shows the percentage of clients with no income at project entry for each RRH project. It demonstrates that these projects are taking the highest need clients. This measure is a bonus in which additional points are awarded on the funding application of projects with 40% or greater of the clients they serve having no income at project entry.

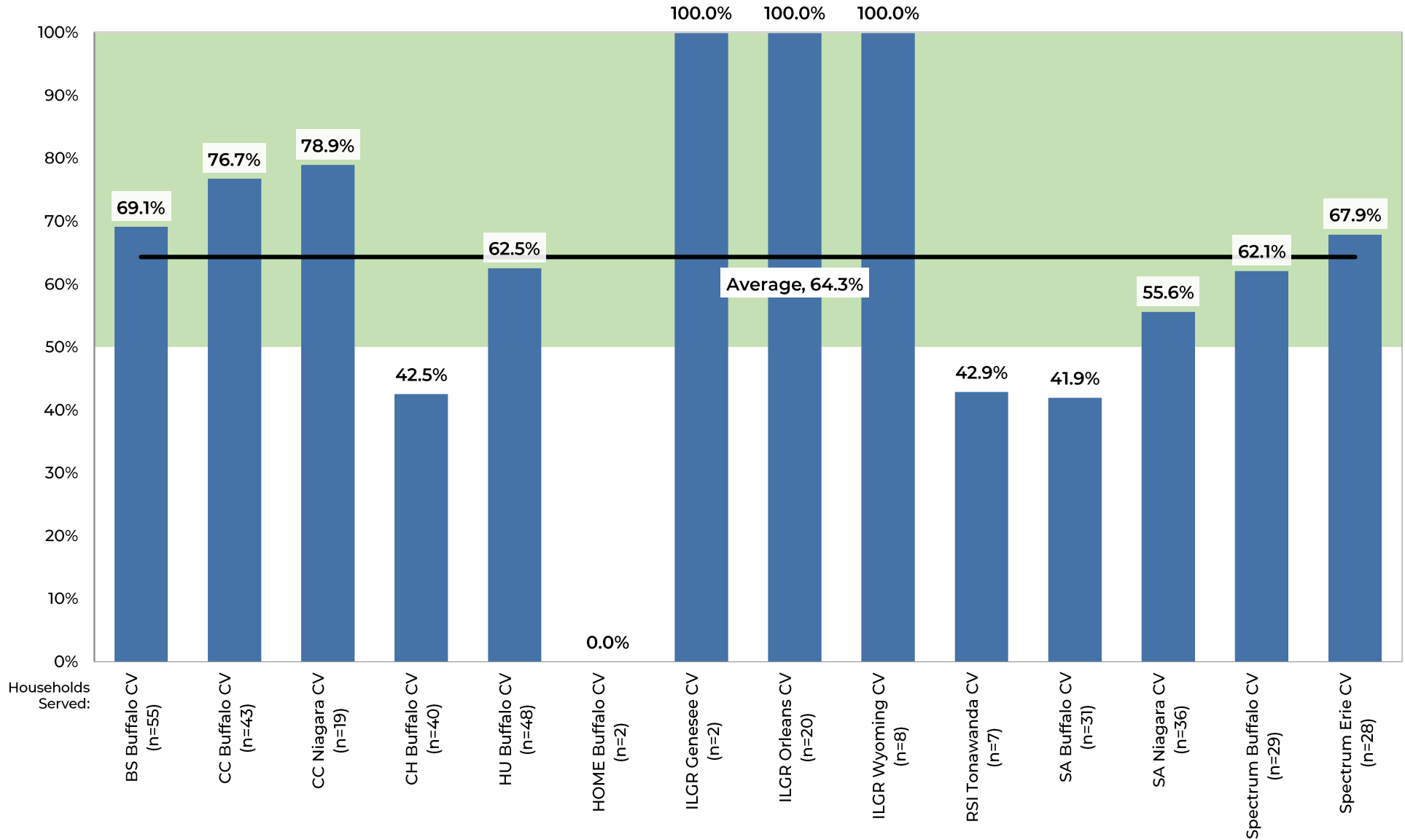
Clients with Zero Income at Entry (CV RRH)



Percentage of Households with a Member Experiencing One or More Disabilities

As project entry criteria, RRH is not required to have a disabling condition. However, many of our clients with higher barriers experience one or more disabling condition. This measure is to demonstrate that these projects are taking the highest need clients. This measure is a bonus in which additional points are awarded on the funding application of projects with 50% or greater of the households they serve having at least one client who experiences one or more disabling condition.

Percentage of Households with a Member Experiencing 1+ Disability (CV RRH)

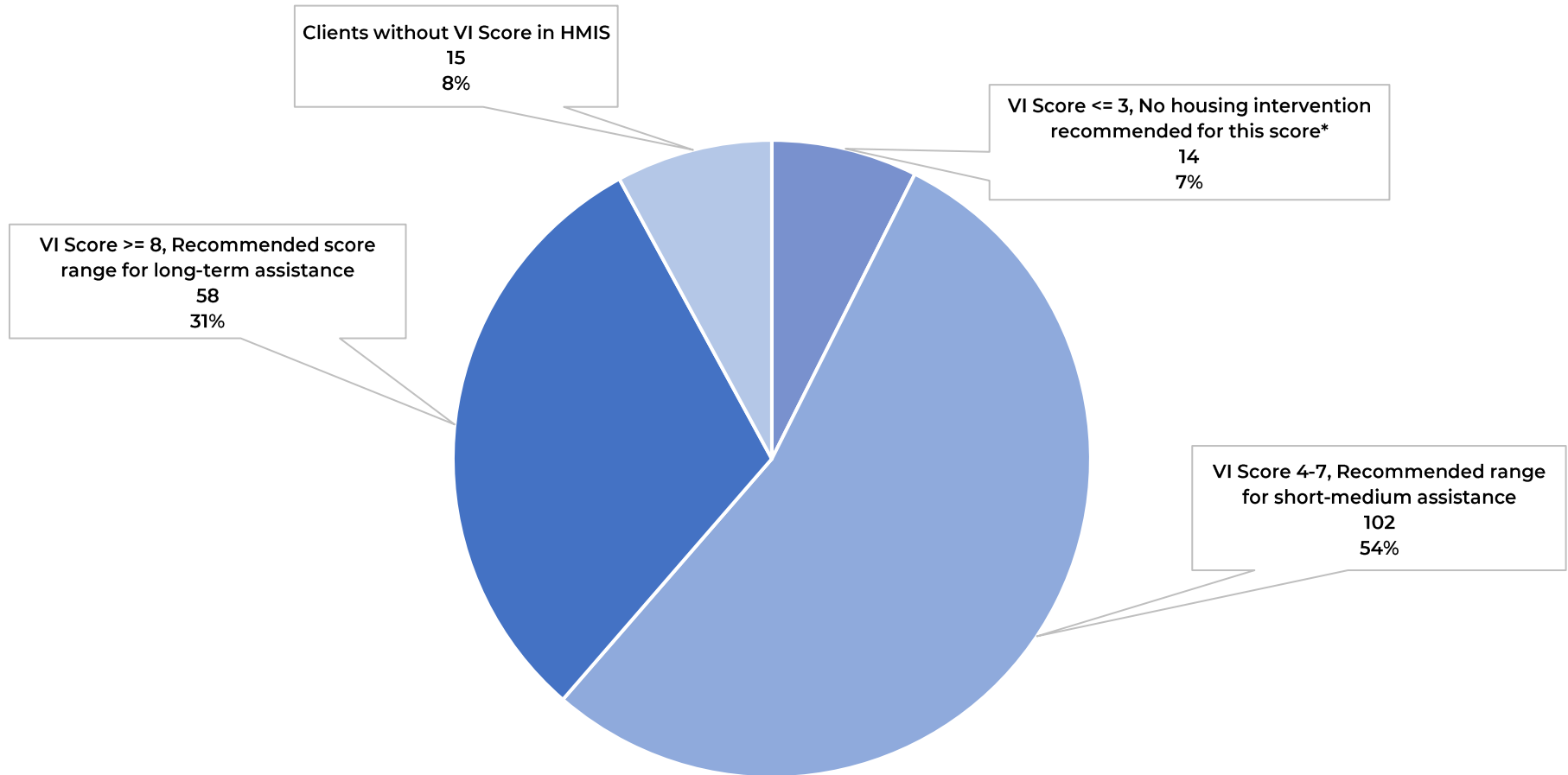


Service High Need Population

New Clients in CV RRH with a VI Score Recorded in HMIS

This measure indicates the percentage of households that entered into a CV RRH project during the reporting period with a VI-SPDAT, VI-FSPDAT, or TAY recorded in HMIS. All new households entering a CV RRH project are required to have a VI-SPDAT, VI-FSPDAT or TAY.

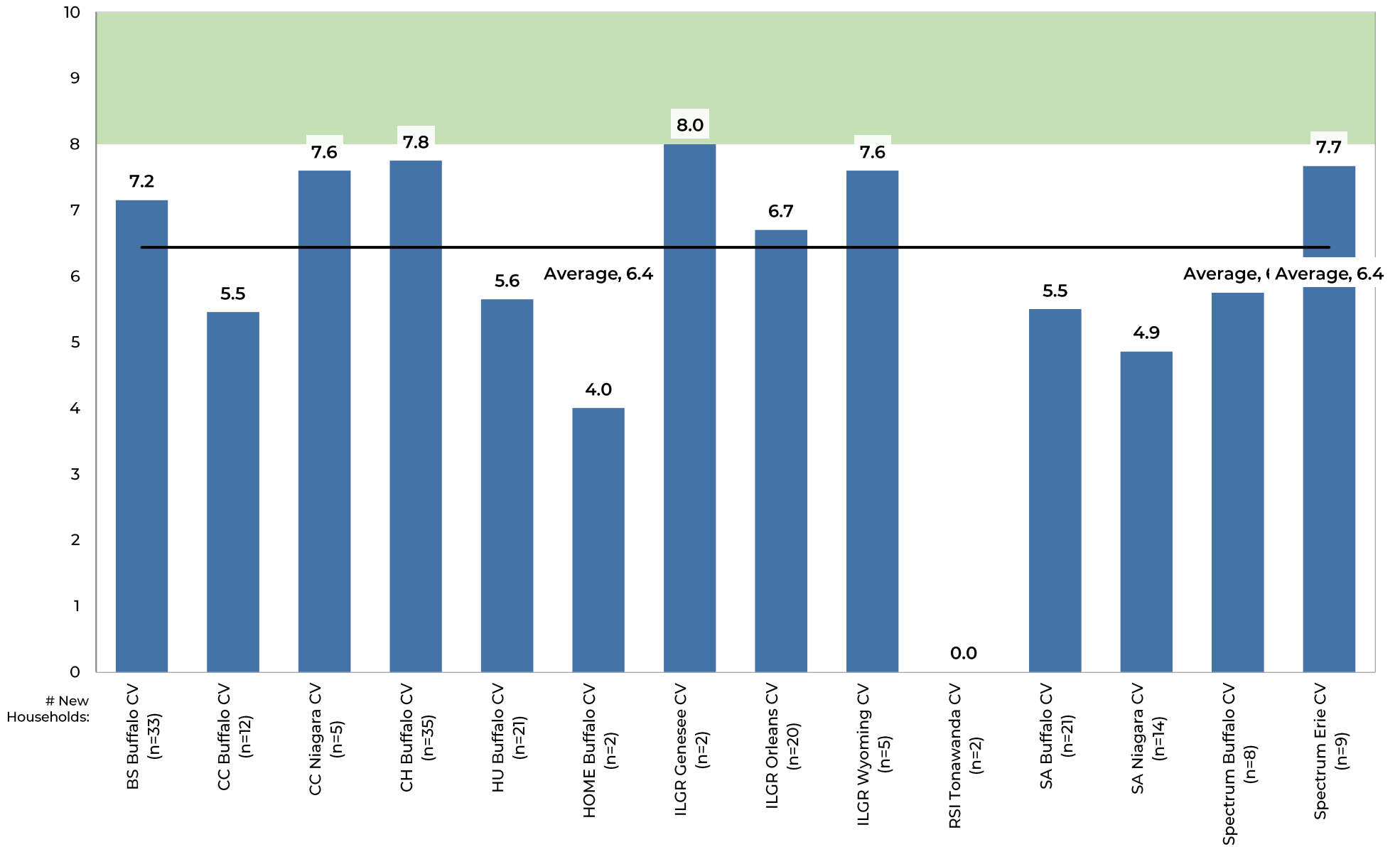
New CV RRH Households and VI Scores



Average VI Score for Households Served at Each Project

This measure indicates the average score of all households served in a CV RRH project with a VI-SPDAT, VI-FSPDAT, or TAY recorded in HMIS.

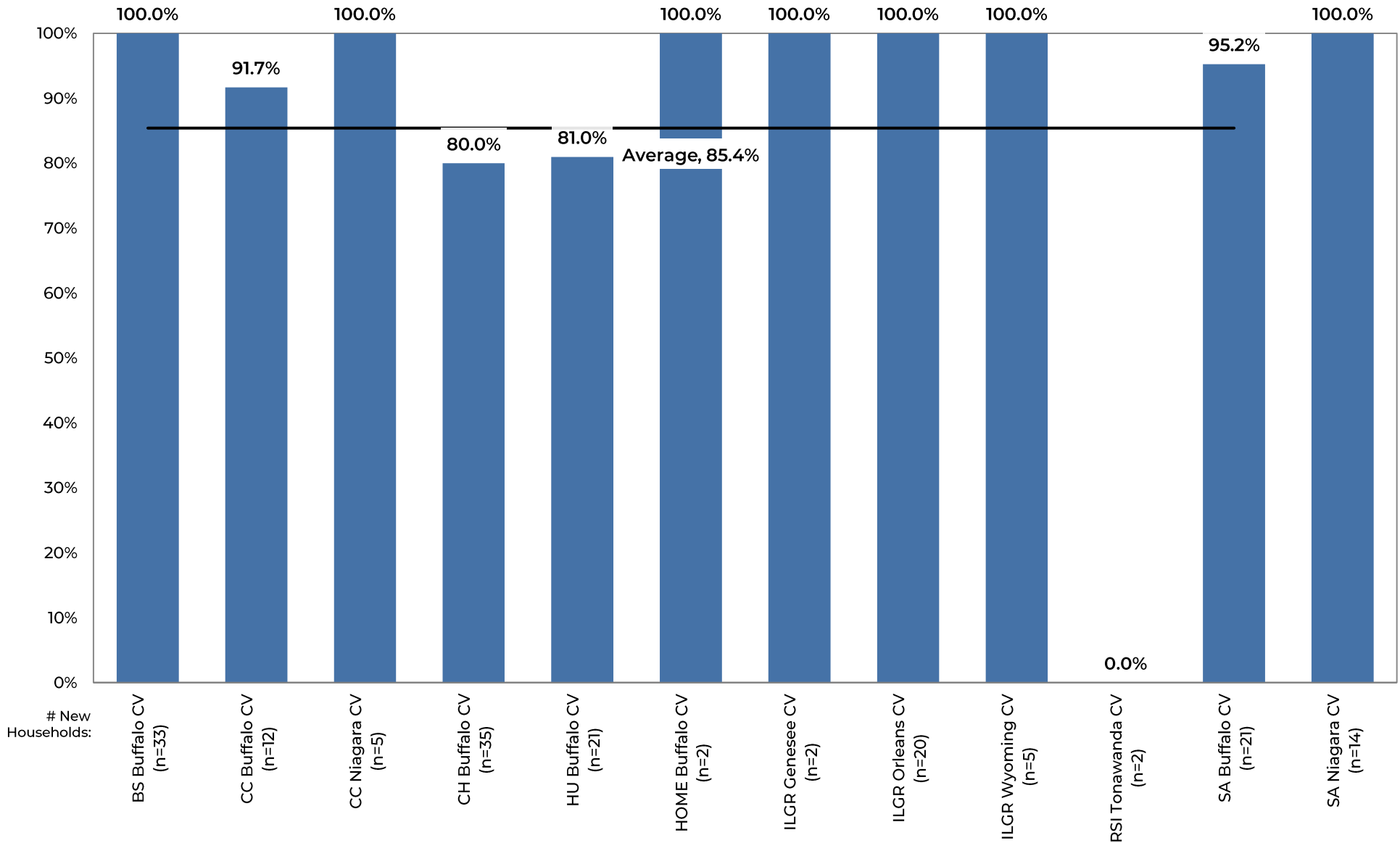
Average VI Score for New Households (CV RRH)



Percentage of New Households Assessed

This measure indicates the percentage of all new households served during the reporting period who have a VI-SPDAT, VI-FSPDAT, or TAY recorded in HMIS.

New Households with VI Scores (CV RRH)



HMIS Data Quality

All projects that receive CoC or ESG funding are required to use HMIS to facilitate data reporting to their funders. Timely and accurate data entry is necessary to ensure correct data is reported and used in analyses. This measure gives a broad overview as to how timely and accurate each project's data in HMIS is.

HMIS Data Quality (CV RRH)

