Designing Outcomes Evaluation for Human Services Programs:

A Case Study of the Continuum of Care Supportive Housing Programs

Spring 2005 Systems Synthesis Project
H. John Heinz III School of Public Policy & Management
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Authors:
Kate Bloniarz, J. Khanh D. Bui, Sara A. Chandler
Charlotte Chen, Kelly Coyne, Natalia T. Guevara
Jimyong Lim, Erica Layne Morrison, Jessica D. Strong

Professor Michael Johnson, Faculty Advisor
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Abstract

Outcomes measurement has become increasingly important in assessing the performance of human services programs. Most funders of human services programs, including government agencies, have begun to stress that a meaningful outcomes evaluation framework is crucial to effectively manage their programs. Done correctly, outcomes evaluation can aid program administrators and providers in identifying practices that achieve better outcomes for their consumers and can help direct resources to the most effective interventions. However, it is important that any evaluation of a program, particularly in the human services field, focus on evaluating outcomes that are within the control of the program.

A team of students from Carnegie Mellon University’s H. John Heinz III School of Public Policy and Management developed an outcomes evaluation framework for the Allegheny County Department of Human Services (DHS). The project emphasized providing a methodology for identifying appropriate outcomes versus conducting an evaluation per se. This framework can be applied to any of the human services programs administered by DHS. In order to illustrate the applicability of the framework, the project team applied it to a subset of programs called the Continuum of Care (CoC) programs.

In designing the outcomes-measurement framework, the project team engaged in a multifaceted effort by enlisting DHS staff and service providers in discussions regarding outcomes. Key steps included: by researching best practices in outcomes measurement, by analyzing existing data resources, and by conducting a gap analysis in order to define the indicators that DHS could use for future outcomes measurement.

While defining the outcomes-based framework, the project team identified a variety of challenges that could affect the implementation of the framework. The most significant challenge concerns the inherent difficulty in measuring the true effects of a program or its services on participants, their families, and the larger community. Another significant challenge is how to most effectively identify meaningful program results without substantially increasing the burden on providers or compromising consumer privacy. Finally, the project team noted resource constraints in terms of funding and feasibility.
Executive Summary

Outcomes measurement is an invaluable tool that allows programs to assess the extent to which they have successfully achieved their goals. It was with this in mind that our project team designed an outcomes-based evaluation for the Continuum of Care (CoC) Supportive Housing Services as a case study for other human services organizations. This framework provides human services providers and the Allegheny County Department of Human Services (DHS) with a valuable way to identify best practices and to better serve their consumers. In order to adequately measure success, however, an outcomes measurement framework should consider individual, societal, and administrative goals. Additionally, the success of the framework is dependent on key implementation steps: (1) identifying meaningful and realistic outcomes; (2) creating a logic model that identifies both the short-term and long-term goals of the program, the resources available to the organization, and the ways that the program will achieve the outcomes identified in the first step; (3) identifying indicators that are measurable representations of those goals; (4) determining appropriate data collection methods and ensuring sustainability; and (5) analyzing and reporting findings.

Our project team identified a series of goals based on a thorough analysis of Annual Progress Reports (APRs) completed by service providers and through provider interviews. The team then identified potentially applicable observable measures within the Homeless Management Information System (HMIS) and other information systems. More specifically, the team identified 11 indicators for CoC programs. The indicators identified focused on the HUD goals of achieving residential stability, increasing skills and/or income, and achieving greater self-determination. The indicators help answer the following questions:

- Does the consumer leave to permanent housing?
- Does the consumer stay in the program for the duration?
- For Supportive Services Only programs, are homeless consumers with mental illness placed in supportive housing?
EXECUTIVE SUMMARY

- Do consumers remain in permanent housing for at least 1 year after leaving the program?
- Do consumers have a job when they leave the program?
- Did the consumer receive his/her GED, high school or college diploma, or achieve some other educational milestone while in the program?
- Did the consumer have a higher income when he/she left than when he/she entered the program?
- Does the program help consumers obtain public welfare assistance?
- Do consumers who have mental health or drug and alcohol diagnoses receive appropriate treatment while in the program?
- Do consumers who receive mental health or drug and alcohol treatment while in the program continue to receive such treatment after leaving?
- Do consumers with open cases in Children, Youth and Families (CYF) get their cases closed within 24 months?

In order to move towards an outcomes-based framework, our project team proposes recommendations that fall into three categories: Data, Administrative, and Outcomes. DHS should consider collecting information at more than one point in time. The types of services that are supplied by providers should also be identified. By the same token, DHS should give providers more information about their consumers’ service histories. Follow-up information on all consumers should be collected. APRs should include outcomes-oriented goals and progress should be tracked with HMIS. HMIS should also contain a common assessment tool. DHS should also work towards identifying a Difficulty-of-Service Scale for its consumers. Finally, in order to ensure their success, DHS will need to determine a methodology for comparing across heterogeneous providers and consumers.

Several barriers to outcomes assessment exist in terms of a dearth of affordable housing in Allegheny County, communication challenges, and consumer confidentiality concerns. However, DHS has a variety of internal and external data resources that can be utilized in outcomes measurement.
Introduction

In January 2005, students at Carnegie Mellon University’s H. John Heinz III School of Public Policy and Management met with representatives from Allegheny County’s Department of Human Services (DHS) to define the scope of a project that would allow DHS to measure outcomes for its programs.

The project team decided to create a basic framework for identifying outcomes and then show how this framework can be applied to the Continuum of Care (CoC) programs. This report proposes a set of outcomes and associated indicators for evaluating the CoC programs and addresses how these outcomes and indicators can help guide DHS policy. The flexible outcomes-based evaluation framework described in this report can be applied to other human services program areas, such as child welfare or mental health.

The report consists of the following major sections:

- **Part I: General Framework – A Guide to Outcomes Measurement:** This section presents a methodology for measuring outcomes based on current standards. The methodology consists of identifying broad social services goals and related outcomes for each program, using a logic model to develop measurable indicators, collecting and analyzing available data to measure those indicators, and reporting the findings and ensuring sustainability.

- **Part II: The Current Status of CoC Program Evaluation:** This section describes the programs included under the CoC umbrella and the ways in which these programs report their progress. In addition, this section describes the analyses of the Annual Progress Reports (APRs) submitted by service providers and the interviews conducted with these providers.

- **Part III: Barriers to Success:** This section outlines the environmental and provider-related barriers to outcomes evaluation for CoC programs. While these barriers are significant, a flexible outcomes evaluation methodology can incorporate these concerns.

- **Part IV: Outcomes and Recommendations:** This section details the project’s outcomes and recommendations in terms of both long-term and short-term goals and associated indicators, as well as possible future research directions.
Part I: An Introduction to Outcomes Measurement

The objective in Part I is to identify the key elements required in developing an outcomes-based evaluation for any human services program. This section provides a detailed examination of the fundamental steps involved in creating a successful outcomes-based evaluation that administrators can apply across different program offices. This section defines outcomes measurement, explains the benefits of using outcomes measurement, and examines the key steps in implementing outcomes measurement and logic models.

A. What Is Outcomes Measurement?

Outcomes measurement is “a systematic way to assess the extent to which a program has achieved its intended results.”1

Outcome Measurement and Key Terms

Learning and understanding the common terminology found in the outcomes evaluation literature is important in order to effectively and properly execute an outcomes-based framework. The following are common terms used in this report and found throughout the literature:2

- **Goal**: a broad statement of a program’s ultimate aims

- **Outcome**: the changes in the lives of individuals, families, organizations or the community as a result of the program

- **Indicator**: the specific, measurable metric collected to track whether an outcome has actually been achieved

- **Output**: the services that reach consumers and participants.
B. Why Measure Outcomes for Human Services Programs?

When evaluating programs, many human services providers want to know the effect the program had on participants. For example, have the lives of the participants changed as a result of the program? How have these changes affected the larger community? Outcomes measurement is a tool that enables human services providers to identify, measure, and eventually answer such questions. In *Measuring the Performance of Human Service Programs*, Lawrence L. Martin suggests that in order to properly manage human services programs, administrators must ultimately be able to answer the following questions:

1. Who are the consumers of each program?
2. What are their demographic characteristics?
3. What immediate and long-term needs do consumers seek to address through program participation?
4. What services are consumers receiving?
5. In what amounts are consumers receiving services?
6. What is the level of service quality?
7. What results are being achieved?
8. At what cost are those results being achieved?

Research suggests that most human services programs can easily answer the first five questions. Yet without the knowledge and use of formal measures of outputs and outcomes, program administrators are often unable to answer all eight questions. The use of outcomes measurement provides administrators with a tool designed to help answer such questions, enabling them to better plan and make recommendations for program improvement. Additional benefits of instituting outcomes measurements may accrue to organizations such as DHS.
1. **Improving service provisions by identifying the most effective program interventions or services**

   This is also known as “benchmarking” or “best practices” identification. By comparing performance on key outcomes with the services provided by those programs, both providers and administrators can determine the most cost-effective services and interventions.

2. **Justifying program spending to funders**

   Service providers are usually funded by a variety of sources, including county, state and federal sources, as well as private and philanthropic foundation grants. Since service providers must justify their spending on programs, having an outcomes evaluation process in place will help provide more rigorous justification for these programs.

3. **Helping DHS make decisions on whether to reauthorize contracts with providers**

   Some of the program offices within DHS contract their services with providers. If contracted agencies do not meet a certain level of performance based on their outcomes, DHS could either reduce the funding or choose to not refund the provider in the next contract period.

4. **Determining how the goals and outcomes of the programs fit into larger community goals**

   Ultimately, outcomes evaluation can help human services agencies justify their programs and services within the larger community framework. For example, outcomes evaluation for housing services will help inform community-wide programs to reduce the number of homelessness, such as the Ten-Year Plans to End Homelessness being implemented by over 42 cities and counties around the country. Working within a community framework can also help identify external factors that can affect the outcomes, such as a lack of affordable housing.
C. Steps in Implementing Outcomes Measurement

The Intermediate Development Series, a multi-volume series designed by the National Resource Center for the U.S. Department of Health and Human Services, outlines the key steps and necessary elements in measuring outcomes. The series serves as a valuable and comprehensive reference guide to help community-based organizations create and implement an outcomes measurement plan. Together with literature by Daniel Krause on the subject, the project team identified the following five initial steps in executing an outcomes-based evaluation:

Step 1: Identifying meaningful and realistic outcomes

To identify what is termed as “meaningful and realistic” outcomes by the Intermediate Development Series, it is first important to determine what the program wants to accomplish through the evaluation. Outcomes might include determining a program’s impact on its consumers or on the surrounding community; accurately defining what constitutes a program’s “success”; or deciding whether to continue allocating funding to a specific program.

All organizations set goals for their programs, which may range from being administrative in nature, to focusing solely on the consumers served by the program, or to broader societal goals that reach into the community. An effective outcomes evaluation must therefore define the appropriate level of impact on which the program will be evaluated. Conceptually, these levels may be viewed as three concentric circles, with each circle encompassing a wide range of programmatic goals (Figure 1.1).

One could focus on a number of different outcomes or outputs in developing an outcomes framework. The innermost circle, Administrative Goals, includes the raw data or outputs of a program, such as the number of consumers served, the types of services they receive, and the level of consumer satisfaction with the program. Although outputs are one potential measure of program effectiveness, they are not necessarily associated with good outcomes for consumers. Program administrators who focus exclusively on the extent to which their programs meet administrative targets may not address the larger questions of how their programs affect the lives of the participants.
PART 1: OUTCOMES EVALUATION

The second circle, Societal/Community Goals, includes factors such as improving the quality of life for residents of a certain area, decreasing the number of homeless people living on the street, and improving the resources available for those homeless still on the street. Measuring community goals is difficult because it is hard to attribute large-scale impacts to specific program characteristics. Smaller-scale assessments that focus on a specific, localized population may be more appropriate.

The outermost circle of goals, Individual Goals, is the one that the project team considers in this report. These goals are focused on the individual consumer and broadly attempt to answer the general question, *How does this program help consumers realize their goals?* Consumer goals are qualitative outcomes that can be converted into measurable indicators. Doing so for both short-term and long-term goals is a challenge in all outcomes evaluation efforts. A good outcomes evaluation helps to measure progress in achieving these individual goals for consumers.
PART 1: OUTCOMES EVALUATION

The Intermediate Development Series also suggests that in identifying “meaningful and realistic” outcomes, it is also important to consider who will utilize the outcomes-based evaluation. For an agency such as DHS, it may be most appropriate to conduct the evaluation at the top management level to ensure that the same data is being collected and the same standards are being applied across DHS programs and among providers. Users may include service providers and community stakeholders, in addition to state and federal funders and human service administrators.

Table 1.1 provides a guide to aid DHS in determining who will use the evaluation in order to help further define the evaluation’s purpose or function:

<table>
<thead>
<tr>
<th>Who might use the evaluation?</th>
<th>What do they need to know?</th>
<th>How will they use the results?</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHS</td>
<td>(1) Is the program meeting consumer needs?</td>
<td>(1) To make decisions about modifying the program by comparing results across agencies providing the service</td>
</tr>
<tr>
<td></td>
<td>(2) Who does the program serve?</td>
<td>(2) To make decisions about program funding</td>
</tr>
<tr>
<td></td>
<td>(3) Is the program cost-effective?</td>
<td></td>
</tr>
<tr>
<td>Providers</td>
<td>(1) Has the program achieved its expected outcome?</td>
<td>(1) To justify programs and ensure financial support</td>
</tr>
<tr>
<td></td>
<td>(2) How effective are the current services?</td>
<td>(2) To help with program administration and development</td>
</tr>
<tr>
<td></td>
<td>(3) Should providers focus on developing other types of programs or services?</td>
<td>(3) To identify best practices</td>
</tr>
<tr>
<td></td>
<td>(4)</td>
<td>(4) To aid strategic planning</td>
</tr>
<tr>
<td>Consumers</td>
<td>(1) Is the program meeting consumer needs?</td>
<td>(1) To work on program services with staff</td>
</tr>
</tbody>
</table>

Step 2: Creating a Logic Model

The second key step in developing an outcomes measurement framework is the development of a logic model, which represents “the relationships between program activities and the changes those activities will produce.”
The logic model shows the relationships between the program inputs and ultimately the program outcomes. It is a key component of several program evaluation methods, including outcomes evaluation and cost-benefit analysis.

In its simplest form, a logic model comprises these phases: Inputs, Outputs and Outcomes, as shown in Figure 1.2:

**Inputs**
- Resources that go into a program, such as:
  - Staff
  - Time
  - Money

**Outputs**
- Services that reach consumers, such as:
  - Services
  - Training
  - Housing Units

**Outcomes**
- Direct changes seen in the consumer, such as:
  - Skill development
  - Behavior changes
  - Improved Decision-making

Figure 1.2: The Logic Model

The logic model is an effective way of relating the resources needed for a program with the ultimate goals that the program hopes to achieve. It enables program administrators to identify what resources they require, the types of services they provide, and the outcomes they would like to see for their consumers. A logic model can help policymakers identify the costs and benefits of a program, develop an outcomes measurement framework, and conduct required audits of the program with respect to administrative requirements.

*Inputs* are defined as resources needed to run the program and could include specific equipment, staff, technology, funding or other resources needed. *Outputs* are the “services that reach people (e.g. groups or agencies) who participate or who are targeted,” and include the amount and types of services provided, the number of consumers served, or whether the consumers are referred to other programs. Outputs could also consist of measures of program spending per participant, the number of consumers who receive a certain type of treatment, or the number of consumers who receive a referral to other programs. *Outcomes* are the “direct results or benefits for individuals, or organizations.” This could include changes in skill development, behavior or decision-making.
PART 1: OUTCOMES EVALUATION

A full logic model is a simple extension of the three aforementioned components to address outcomes over time.\textsuperscript{14}

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
<th>Short-Term Outcomes</th>
<th>Medium-Term Outcomes</th>
<th>Long-Term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>Counseling</td>
<td>Increased Skills</td>
<td>Changes in Behavior</td>
<td>Changes in Social Condition</td>
</tr>
<tr>
<td>Time</td>
<td>Services</td>
<td>Increased Knowledge</td>
<td>Changes in Decision Making</td>
<td>Changes in Economic Condition</td>
</tr>
<tr>
<td>Money</td>
<td>Training</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Step 3: Identifying Indicators for Measuring Program Success**

The third step identified by the Intermediate Development Series is identifying the indicators that most appropriately define the outcomes of the program, as established in Step One. An indicator is “the specific, measurable information collected to track whether an outcome has actually occurred.”\textsuperscript{15} Indicators can also be described as “a bridge between intended goals and the actual data collection process.”\textsuperscript{16}

There are two important things to consider when identifying an indicator. First, indicators should use data that can feasibly be measured within the time and resources available. Second, the indicator should be a meaningful representation of the goal based on data available from administrative records. The indicator should directly relate to the outcome it supports, so that reaching the desired indicator clearly shows success made toward achieving the outcome.

A generic example of an indicator is illustrated below:

**Goal:** Greater self-determination

**Outcome:** Consumers will take responsibility for their health

**Indicator:** 75% of consumers are accessing preventative health care services
PART 1: OUTCOMES EVALUATION

One outcome that would be meaningful for housing-related programs would be whether consumers obtain permanent housing and remain there long-term after leaving the program. An ideal indicator would be to check where the consumers were living six months, a year, and five years after they leave the program. However, it can be difficult and expensive to conduct frequent follow-ups, as funding is often limited or unavailable for evaluation purposes. This creates a tension between spending money on collecting data for meaningful indicators or spending money on the actual programs. Therefore, outcomes evaluation should ideally be conducted with data that is already currently being collected or that would be feasible to collect. Part II of this report focuses more on information sources that DHS already has access to through HMIS and other information systems.

A methodology for identifying target achievement levels for indicators is critical for implementing outcomes measurement. This is a complex task because programs are heterogeneous both in the populations they serve and in the program resources available to service providers. One way to address the heterogeneity of populations is to develop a “Difficulty of Service” scale that would assess the level of service needed for each consumer served by the program. For example, one could imagine a five-point scale that would address the initial state of the consumer upon entering a program, with 5 meaning the consumer exhibited such traits as not socializing with others, poor self-image, multiple physical or mental conditions and/or trouble socializing with others. Scoring a 1 on the scale would indicate that the consumer was responsive to help, showed feelings of self-worth, had few/no physical or mental conditions or was receiving treatment for them, and/or was able to socialize with others.\(^{17}\)

After identifying the Difficulty of Service rating for each program, there are a number of ways to incorporate this into the outcomes evaluation. Outcomes across providers could be compared within similar “difficulty of service” populations. A second method would be to adjust the target level for providers who serve more difficult populations.

There are other important factors to consider when choosing indicators besides the two mentioned above. The Intermediary Development Series provides a helpful checklist, which has been adapted to meet the needs of a human services agency such as DHS.\(^{18}\)
PART 1: OUTCOMES EVALUATION

Indicators Checklist

- Do the indicators make sense with regards to the goals they are intended to measure?
- Are the indicators directly related to the goal?
- Are the indicators specific?
- Are the indicators measurable or observable?
- Can data be collected on the indicators? Is it likely within organizational resources to do so?

Step 4: Determining the Appropriate Data Collection Methods

Data collection may include surveys, interviews, direct observation or document review. These data may already exist within the organization, or data may need to be collected anew. Further, it is important to identify the timeframe that will exist for the collection process, such as quarterly, annually, yearly, or otherwise. The frequency of collecting and measuring data depends on how the data is to be used and the costs associated with collecting that data. Cost is often identified as one of the major considerations in determining how frequently to collect data.\(^{19}\)

Depending on the indicators identified by the program, certain data may need to be collected more frequently. For example, long-term outcomes may require data to be collected at multiple points of time. For human services programs in particular, data collected after the consumer leaves the program can be particularly meaningful in order to gauge the effect the program had on the consumer’s well-being.

There are additional important factors to consider when choosing the proper data collection methods. Below is a checklist provided by the Intermediary Development Series.\(^{20}\)
PART 1: OUTCOMES EVALUATION

Checklist on Data Collection

- How soon would change occur (i.e. immediately, gradually, etc.)?
- Are there milestones that can be measured along the way?
- What is the frequency of contact between DHS program administrators and provider organizations (i.e. weekly, monthly, etc.)?
- When will data be available?
- Are there any “gaps” in data collection between the data currently collected and reported to DHS versus what providers collect?
- Does the plan rely on external sources of data or require collaboration with other agencies? If so, will it be possible to obtain the data?
- Can the approach likely be implemented by using available program resources?
- Does the frequency of data collection match time-points when realistic progress can be expected from participants?
- Are the roles and responsibilities clear for all the staff involved in collecting data?
- Is there staff responsible for managing and monitoring the process to ensure the work is completed on time?

Step 5: Analyzing and Reporting Findings

The final step identified by Daniel Krause consists of analyzing and reporting findings. Descriptive and inferential statistics can be computed on the collected data. Descriptive statistics identify the major features of the data, such as mean and variation. Inferential statistics draw relationships between characteristics of a sample and those of the larger population. Types of inferential statistics include the following:
Hypothesis Testing | A way to determine the probability that a given hypothesis is true
---|---
Confidence Intervals | A range of values that has a high probability of containing the parameter being estimated (i.e. 95% confident)
Probability | To express a subjective judgment about the likelihood, or degree of certainty, that a particular event will occur.

In addition, it is possible to analyze information that is not numerical in nature, such as written comments or suggestions. To do so, it may be helpful to organize the comments into similar categories (such as concerns, suggestions, strengths and so on) and then look for patterns or associations.
D. Key Challenges in Conducting an Outcomes Measurement

There are several common issues that may arise when designing an outcomes evaluation for human services programs. By understanding common challenges experienced when conducting outcomes-based evaluations, administrators might be able to avoid such challenges in the future. Research identifies three common pitfalls:24

1. Failing to relate outcomes to a program’s mission
   Outcomes should be related to the social problem the human services program addresses.

2. Excluding stakeholders from the process
   By excluding key stakeholders from the evaluation process, one risks adopting outcomes that stakeholders find useless or will be unable to properly utilize. The United Way of America indicates that government agencies should view their role as helping service providers develop the outcomes measurement approach that provides the most useful information for that program population in order to avoid impeding implementation.

3. Burdensome reporting requirements
   The final challenge identified by the United Way suggests that the amount of data collecting currently required by many service providers may be overwhelming, particularly given tight fiscal constraints. Outcomes evaluation may pose an additional burden to providers if they are required to collect and report additional information.25

We will revisit these concerns later in the report in the discussion of provider interviews and barriers.
PART II: CONTINUUM OF CARE PROGRAMS

HUD Program Lease Sites
Families Below Poverty

Legend
- HUD Program Lease Sites - Total

Total Below Poverty
- 0 - 48
- 49 - 124
- 125 - 231
- 232 - 398
- 399 - 1070
- 1071 - 11228

Image courtesy of Allegheny County Department of Human Services.
Part II: The Continuum of Care Housing Programs

Part II identifies outcomes for the Continuum of Care (CoC) Supportive Housing Programs in order to illustrate the outcomes evaluation framework presented in Part I. This section describes the CoC programs, identifies the current reporting and outcomes evaluation, presents an analysis the project team conducted of the Annual Progress Reports (APRs) and discusses findings from in-depth interviews with CoC providers. This section then addresses the data resources available at the Department of Human Services (DHS) and how the data can be used to measure outcomes.

The CoC Supportive Housing Programs were established by the United States Department of Housing and Urban Development (HUD). HUD’s stated goals for the CoC address housing and to larger life aspirations. The Allegheny County DHS administers the CoC programs by contracting with a network of providers.

The CoC Supportive Housing Programs are good candidates for using outcomes evaluation. Currently, providers for these programs must specify consumer-oriented goals in their required reporting and report on their progress towards these goals. In addition, starting in 2005, Supportive Housing Program providers will be required to submit logic models for their programs. There is also a strong network of community planning for homelessness services, and there is a new management information system at DHS for collecting information on these programs. With all of these resources, outcomes evaluation has the potential to enable successful strategic planning for the CoC service providers and administering agencies.
A. Outcomes for Housing-Related Programs

Outcomes measurement in housing programs poses a unique challenge: how can one connect housing-related outcomes with outcomes related to other programs the consumer might be participating in? Despite the fundamental importance of housing for consumer outcomes, securing housing is in many ways a secondary objective for most DHS programs. Housing comprises approximately 25% of the DHS budget, yet only approximately 15% of this is for programs where housing is the primary focus.26

Meaningful housing outcomes must be determined within the context of the overarching mission of the program, as housing-related goals may not always be the same as the primary goal. For example, consider goals of the Permanent Housing program with the goals for the Supported Independent Living (SIL) program within the Office of Children, Youth, and Families (CYF). The SIL program serves young adults who are sixteen and older and are in the child welfare system. The SIL program consists of facilities (either apartments or dormitory-style arrangements) that have staff on the premises full-time. The program also includes life-skills training and other services to help youth transition from the CYF program to living on their own.

The goals of the SIL program consists of ensuring their consumers a safe environment while pursuing formal education, employment, or training; and giving them life skills so that when they leave the program they can live independently. The goals for the Permanent Housing program include obtaining housing, obtaining income so they can stay in this housing, and connecting with mainstream services so that the consumer can live more independently. Although the missions of the programs reach different populations and have different success measures, their goals are similar.

In this report, we will address outcomes specifically related to housing as well as outcomes related to other areas of life progress. Although the application of the report is to a set of housing programs, the goals of these programs also include getting connected to services and achieving self-determination. Housing outcomes alone are just one component of measuring program success, even if the program is primarily a “housing” program.
For programs related specifically to housing, one would expect to see even more similarities. All housing programs attempt to provide housing that gives the consumers the support and resources they need in the least restrictive environment possible. When a consumer leaves the housing program, the hope is that he or she has the skills and resources needed to live independently and avoid returning to the program in the future. However, there may be differences among programs in what is considered a “positive” outcome.

Within the Permanent Housing program, for example, consumers are expected to remain in place. An indicator that the consumer left the program could be a negative development if it indicates that the housing situation was not permanent. For the SIL program, all the consumers will age out at some point, and so a positive indicator for housing could entail them moving into an apartment with friends and partaking in a training program. Thus, the particular value of an indicator can convey two different meanings for two different programs.

The project team noticed differences in the meaning of the indicators even within the CoC programs. For women entering a domestic violence shelter, the temporary loss of permanent housing is often part of a larger “positive” outcome: willingly leaving a violent family situation. For other homeless programs, a consumer leaving a program only to end up back in a shelter after a period of time might be considered a “negative” outcome. This underscores the importance of doing rigorous outcomes evaluation individually for each program, because a “negative” outcome for one program and/or consumer population may be a “positive” outcome for another.

The evaluation framework described above can be applied to programs where housing is an auxiliary goal as well as programs where housing is a primary goal. The analytical challenge is to select goals and indicators consistent with the primary mission of the program. To illustrate, the ultimate mission of the Office of Children, Youth, and Families is to protect children, preserve families and to assure permanency through providing permanent, safe homes for children. There may be conflicts between a goal of permanent housing and one that encourages family preservation. These conflicts should be addressed in an outcomes measurement framework so that the goals for housing are consistent with the goals for the program as a whole.
PART II: CONTINUUM OF CARE PROGRAMS

B. Continuum of Care Programs

The Continuum of Care (CoC) programs provide critical services for Allegheny County’s homeless by providing housing and services, bringing in approximately $10 million annually.28 DHS has administered grants to providers under the CoC programs since 1996 in Allegheny County, the city of Pittsburgh, the city of McKeesport and the municipality of Penn Hills. The CoC programs stress collaboration with the community and are centerpieces of initiatives such as the Ten-Year Plans to End Homelessness. CoC includes the following Supportive Housing Programs that are covered in this report:29

- **Permanent Housing:** Under HUD eligibility requirements, the Permanent Housing program serves only those consumers with a documented disability. In 2004, the Permanent Housing program in Allegheny County served 201 consumers with a wait list of 147. The funding in 2004 was $3,128,205. There are approximately 19 permanent housing programs administered by 13 providers.

- **Transitional Housing** Transitional housing provides shelter and supportive services for up to 24 months. It is designed to move individuals and families into a more independent housing environment. The DHS Transitional Housing program in Allegheny County served 368 consumers with a waitlist of 122. The funding in 2004 was $4,812,933. There are approximately 25 transitional housing programs, ranging in capacity from ‘1 individual’ to ‘56 individuals and 14 families.’

- **Safe Haven:** The Safe Haven program in Allegheny County serves 22 consumers. This program provides shelter and care to the chronically homeless. There are currently two Safe Haven providers in Allegheny County, and a proposal was recently awarded for a women-only Safe Haven. Funding for Safe Havens in 2004 was $405,144.

- **Supportive Services Only:** Supportive Services Only programs provide assistance such as rental advice and case management to consumers who would otherwise not be served through DHS programs. There are seven Supportive Services Only providers in Allegheny County, and they served 2,656 consumers in 2004. Funding for Supportive Services Only programs was $2,233,147 in 2004.30
Since their creation in the early 1980s, CoC programs are intended to work together as a safety net for the homeless and near-homeless. One primary feature of the safety net is the availability of Safe Havens and engagement centers which serve as an entry point for chronically homeless consumers. Through the Safe Havens and engagement centers, the chronically homeless have access to transitional services and other social services, a process also referred to as “mainstreaming.” Another feature of the programs is to encourage consumers with documented disabilities to move from transitional programs into permanent housing programs.

**Current CoC Goals**

HUD has established the three primary goals for consumers participating in CoC programs: increasing residential stability, increasing skills and/or income, and achieving greater self-determination. The HUD funds are competitively awarded at the federal level, and progress towards these goals helps determine which programs are reauthorized.

All three goals are broad and interdependent. Consumers need income, earned or otherwise, to achieve residential stability without requiring federally-subsidized housing assistance. The goal of greater self-determination links a variety of outcomes that are often the primary mission of the housing-related service providers, from domestic violence victims to the severely mentally ill. The relationship between social services goals and housing outcomes under the ‘housing plus care’ model has been debated throughout the history of the CoC programs. The most obvious manifestation of this is the prioritization of permanent supportive housing for those with documented disabilities, for which Congress has reserved a third of McKinney-Vento Act funds.31

HUD states that “specific performance measures for each of these three goals must be established based on the needs and characteristics of the homeless population to be served.”32 In Allegheny County, provider agencies are encouraged to set reasonable and achievable targets based on their own experiences with consumers. Administrators have typically assisted providers in setting goals, as many self-defined goals are overly ambitious at the beginning of a new program.33
PART II: CONTINUUM OF CARE PROGRAMS

However, these self-identified goals and targets create challenges when comparing agency performance, since there are numerous differences among service providers. The populations served, size of the program, and many other variables affect consumer outcomes. Even when serving similar populations (single men for example), a small provider serving 10 consumers may be able to achieve 100% progress towards a particular goal, while a large provider may only be able to reach 70% for that same goal. The DHS mission of service to all, which encourages providers to adopt more open admissions policies for consumers, also affects the overall achievement levels. Therefore, contracting agencies such as DHS must exercise discretion when allowing providers to set their target levels for standardized goals.

CoC Logic Model

HUD’s 2005 Notice of Funding Availability (NOFA) requires that all Supportive Housing Programs submit a logic model completed by the provider (HUD-96010). The logic model has several steps, similar to those described in Part I of this report. HUD states that the model should take approximately 18 hours to complete. DHS began training providers on the logic model on April 18, 2005.

The steps of the logic model include identifying the problem need or situation (homelessness and need for shelter) and detailing the services administered through the program. Programs should also detail their administrative goals, such as the number of consumers served. These correspond to the inner circle in the “Three Circles of Outcomes Measurement” diagram presented in Part I of this report. These administrative goals are designated by timeframes: short, intermediate or long-term.

HUD-96010 describes outcomes as “the ultimate impact you hope to achieve.” Providers are advised to use proxy outcomes for those that are difficult or impossible to measure. The logic model does not provide details regarding the time sequence of outcomes. Providers are responsible for measurement reporting tools and evaluation.
Current Goal Reporting and Proposal Evaluation for the CoC Programs

Providers outline their program goals each year in the Annual Progress Reports (APRs), which are evaluated by DHS for first-time or renewal grants. Each provider is required to set goals that will measure consumers’ successes under the HUD objectives mentioned above: achieving residential stability, increasing skills and/or income, and achieving greater self-determination. For programs in existence for more than one year, providers are required to list the previous year’s goals, the progress made in meeting those goals during that year, and the restatement or revision of these goals for the upcoming year. The APR also contains the number of beds that the provider maintains for each program and gives the provider an opportunity to communicate with DHS regarding any specific technical problems or training-related issues that arose during the past year. Through the APR process, DHS has the opportunity to provide substantial guidance to providers in setting outcomes-based goals.

DHS conducts monitoring activities on an annual basis, while proposal funding is renewed on a three-year cycle. Renewals are rated on application quality, mainstreaming, community participation and collaboration, and agency performance. Certain programs, such as permanent housing, are considered a higher priority due to the HUD McKinney-Vento funding structure. The current Program Renewal Evaluation heavily emphasizes two components: how well the program does at “mainstreaming” its consumers by connecting them to other services, and how well the program collaborates with the rest of the provider community and the Allegheny Homeless Alliance.

APR goals are evaluated by DHS during several stages. For renewal projects, agencies receive points if they include outcomes-based goals in their APRs. They are also awarded the same number of points for submitting their APRs and any subsequent reports on a timely basis. Ratings for new projects are based on two elements related to goal formulation: whether the work plan “details activities and benefits to be achieved” and whether it “produces measurable results for consumers.”

DHS currently requests monthly APRs from providers. The project team was unable to analyze the monthly APRs in the time provided.
C. APR Analysis

To better understand current reporting requirements and provider-defined goals, the project team analyzed 50 APRs from 29 different service providers, representing all four Continuum of Care (CoC) program areas covered in this report. The APRs spanned from 1997 to 2004 and contained a mix of new and continuing applications. The intent of this analysis was to provide a better understanding of the types of outcomes currently being measured by service providers in order to better inform our development of indicators.

One immediate source of variation concerns administrative goals versus consumer-centric goals. Administrative goals pertain solely to the agency’s ability to provide a service. Consumer-centric goals directly relate to the consumer’s achievement on a stated goal. For example, a goal under greater self-determination stating that “[l]iterature will continue to be made available on how to improve consumer’s health” would be an example of an administrative goal. While consumers may find such information handy, whether or not the provider meets this goal tells DHS little about the provider’s effectiveness in actually helping the consumer. A better example of a consumer-centric goal under greater self-determination might be: “Participants with addiction issues at time of entry to the program will successfully complete treatment and remain abstinent during enrollment in the program.” A consumer-centric goal directly relates to the needs of the consumer and is essential for an outcomes-based evaluation, as it is the consumer’s success that will be measured, not how well the agency itself meets a certain goal.

The project team first looked at the number and nature of the goals (administrative versus consumer-centric) outlined on the APRs. We then conducted a more in-depth analysis on how many of the consumer-centric goals were met, whether the next period’s goals were changed, and why the goals may have changed. A final trend analysis examined the goals associated with each program to determine the range of values included in the goals and progress made, and whether goals were short or long-term.

The majority of goals set under all three objectives were consumer-centric. Over 79% of increasing skills and/or income goals related to the consumer and 78% of greater
self-determination goals were also consumer-centric. Almost 71% of achieve residential stability goals were consumer-centric as well.

The providers of programs in their second year and beyond overwhelmingly reported that they met or exceeded their goals across all three categories on the APRs. Of the forty applications in this group, only five providers were unable to meet some or all of their residential stability goals. Nine providers were unable to meet some or all of their increased skills or income goals, and six did not meet greater self-determination goals. Some interesting findings include discrepancies across HUD objectives: often an organization would meet or exceed goals under one or two objectives and then fall short under a third objective. No organization failed to meet goals under all three HUD objectives.

Since a great majority of the goals listed on the APRs were met or exceeded during the time period, it should come as little surprise that most goals remained the same for the following period. Overall, this analysis indicates that most of the service providers capably define achievable goals, and there appears to be no need for DHS to encourage providers to revise goals downward. It remains unclear whether some goals are met too easily, and providers may need to set more challenging targets. DHS should focus specific attention on providers who struggle to define consumer-centric goals or who fail to meet their initial goals.

The APR analysis influenced our subsequent provider interviews in two ways: it helped define the questions to ask and the types of short-term and long-term goals included in an outcomes-based evaluation. Additionally, as one of the only current data sources collected from providers by DHS, the APRs serve as a valuable reference point for guiding changes to the data submission process.
D. In-Depth Interview Process and Analysis

To better understand how providers set their goals on the Annual Progress Reports (APRs) and how they collect and transmit information, the project team conducted interviews of a subset of the Continuum of Care (CoC) service providers. These meetings with program directors represented as many providers across the widest variety of CoC programs as possible given the time constraints. Twelve providers were selected, but only eight were available to be interviewed. The sessions took place during the month of March 2005 and were conducted in-person or over the telephone. Prior to conducting the interviews, DHS sent providers an introductory e-mail and initiated contact with the program directors. The following provider categories were interviewed:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Number of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitional Housing</td>
<td>2 providers</td>
</tr>
<tr>
<td>Permanent Housing</td>
<td>3 providers</td>
</tr>
<tr>
<td>Safe Haven</td>
<td>1 provider</td>
</tr>
<tr>
<td>Supportive Services Only</td>
<td>3 providers</td>
</tr>
</tbody>
</table>

The interviews were divided into 2 parts: how the agency currently collects, measures, and transmits information about consumers, and what information about consumers the agency would ideally like to know. Ultimately, we hoped these interviews could help DHS improve the process by which it measures successful housing-related outcomes, both through better understanding the needs and limitations of the providers, and understanding how the providers identify the goals of their programs.38

The interviews confirmed that the majority of CoC goals reported on the APRs are determined by the executive directors and program managers. Providers often set goals just once, for the initial proposal. While goals should be reviewed on an annual basis, some providers stated that goals were only reviewed when prompted by a grant renewal.
Most providers stated that they would like more guidance in setting good outcomes-driven goals.

The APRs require that providers identify goals and track progress toward these goals. The project team noted that providers tend to report a wide range of goals that varied in scope and definition. To identify the terminology that the provider was using, the interviewers asked the providers to define four terms that are frequently used in outcomes-based evaluation: *input, goals, indicators and outcomes*.

When asked to provide examples, about half of the providers gave answers that would be consistent with the definition of the term, although there was substantial variation across providers. This demonstrates that providers may have difficulty understanding the terminology used in training and responding consistently to requests for outcomes-oriented goals.

When asked “in an ideal world, what information about your consumers would you like to know?” providers suggested the following:

- Changes in the behavior of the consumer
- Service and case history for the consumer
- The other social services they are receiving
- Who is in their social support network
- Their long-term progress after they leave the program

Also, several providers mentioned the value of knowing the network of services that these consumers use. It was important for provider to know if consumers pursued referrals to other social services programs. Often, the provider does not or cannot provide comprehensive programs that meet all of the consumer’s needs. Consumers are often referred to other community resources. If a consumer does not follow-up with the referral, the provider may not be aware of whether that the consumer is receiving that service.

The project team asked several questions regarding the outcomes that providers report
on their APRs. For the goal of *residential stability*, the outcomes that were important to the providers (aside from those already identified on the APR) included being able to connect the consumer with additional sources of income. Recognizing that some of these consumers may require additional supports, providers want to identify all public welfare programs for which the consumer is eligible and connect them to the application if desired. Providers recognize that a consistent source of income is important in order for the consumer to sustain any type of permanent housing.

If a consumer is enrolled in a transitional program or living at a shelter, the focus of the program is often on securing housing. Providers emphasized that they must also focus on income and employment or schooling: if the consumer cannot secure a consistent source of income before leaving the program, then it is probable that he or she would re-enter another housing program.

Further, providers want to be able to connect their consumers with a social network, ideally their family and friends. This resource is important particularly as the consumer transitions out of the program. Ensuring that the consumer has a support network links consumer goals to those of the community and recognizes the role of external factors on the effectiveness of program services.

For the goal of *increasing skills and/or income*, providers want to know more about issues that consumers encounter in obtaining jobs or schooling. Vocational institutes and junior colleges generally require contact information for enrollment. This could be challenging if the consumer is currently residing in a shelter or in transitional housing. Being aware of these problems can help the provider develop a more comprehensive plan for the consumer.

For the goal of *greater self-determination*, providers focus on the development of life skills as well as increasing the sense of empowerment and confidence. Although providers can recognize when there is a change in these attributes, it is hard to quantify these changes. One provider suggested that changes in behavior could be discussed using the Maslow hierarchy of needs.

In general, there is still variation in how providers define the goals of their program and how they determine what the appropriate indicators are. Furthermore, providers do not
have a good sense of how outcomes evaluation can be used most effectively to guide strategic planning.

Perhaps the hardest outcomes for providers to achieve on behalf of their consumers is securing affordable housing. This is often not a result of inadequate service, but of regional structural impediments to affordable housing. Most consumers have very limited and/or vulnerable sources of income that make them less desirable to landlords and realtors, and some consumers have other issues such as bad credit. Furthermore, aside from public housing, most of the properties that these consumers can afford are in communities that may not be conducive to their life goals.

When asked how they determined their goals, providers articulated three common themes. First, goals are informed by their program objectives. Second, the goals are defined by the mission and vision of the organization. Third, goals are dictated by their funding priorities. Providers felt that the priorities of the community are often driven by funders, although they would prefer to develop their programs based on their understanding of community needs. Many providers conduct community needs assessments (either formally or informally) and would like to communicate that information to funders before a community-wide agenda is established. The Ten-Year Plan to End Homeless provides one vehicle for this communication.

In general, providers felt that the three goals defined by HUD adequately capture the services that these programs provide, but that the goals do not capture the significance of the relationships and trust built up between providers and consumers and the importance of these relationships to the consumers’ outcomes.

Another issue related to defining goals for the homeless population is that providers tailor programs and treatment plans to individual consumers. Individual service plans track the needs of the consumer along with their goals and accomplishments. The provider works with the consumer to define personal goals that will help him/her achieve sustainability. Because these goals vary widely and success is primarily defined by the consumer, it is hard to compare outcomes across populations. This presents a problem of standardization for the providers. When reporting outcomes to DHS, providers are concerned about how they identify the successes of their consumers. Although some consumers may not secure permanent housing right away, they may receive services and
support that increases the chance that they will secure housing in the future. Not every consumer is at the same stage of development, and a poor outcome for one consumer may be a good outcome for another. Under the current reporting system, there is little guidance for how to standardize reporting of these successes across consumers.

Standardizing reporting of success is a particular problem. If evaluated on a case-by-case basis, the case manager can evaluate the successes of each consumer based on the consumer’s self-defined goals and milestones. For example, a case manager may view two cases as having the same degree of success, even though one entails a consumer obtaining housing and another entails a consumer consistently using silverware. Case managers are confused about how they would aggregate these two successful outcomes.

One suggestion reporting outcomes across consumers is to develop a “Difficulty of Service” scale for consumers. This scale would reflect the amount of resources a provider would need to expend to help that consumer reach the next level of functioning. This scale should be used when considering funding decisions because it would recognize that providers who do work with consumers at one end of the “Difficulty of Service” scale should be held to different standards than providers with consumers at the other end.

Once a service plan is agreed upon with the consumer, all of the providers interviewed stated that they make an effort to follow-up with the consumers. Some providers are more formal about this than others. For example, some programs whose consumers are permanent residents require daily “check-in.” All other providers try to abide by DHS requirements by checking-in at least once a month in person and once a week by phone. This standard is sometimes hard to meet because consumers sometimes miss appointments or do not return calls. Providers try to meet with consumers, but because of large caseloads, it may not be feasible to place 20-30 calls per week until contact is made.

One of the providers stated that they try to maintain a long-term relationship with the consumers they serve even after the consumer leaves the program. When a consumer exits the program, they ask permission to follow-up with the consumer in three months, six months and a year. This is an informal conversation to see if the consumer is “safe.” Providers believe that the information that they collect should and can be more effec-
Part II: Continuum of Care Programs

Responsively communicated and utilized to meet community needs. Although providers understand the value and benefit of an outcomes-based evaluation system, it requires balancing the time required for entering data with the time it takes away from directly serving consumers. Providers suggested that they need more administrative support and training so they can effectively participate in the process.

Providers feel that any additional evaluation requirements should:

- Give the provider feedback on how they are doing which can be used to improve the quality of their programs;
- Help the staff have a clearer understanding of what constitutes success, both individually and collectively;
- Help the providers communicate information to consumers that would inform their decisions to seek services; and
- Help the providers communicate to funders how the money they are investing is making a difference in people’s lives.
E. Data Availability

A major component of the project team’s analysis concerned the availability of reliable and relevant data. Without complete and correct data, outcomes cannot be measured. As a result, the project team used multiple methods to identify the various data resources available, determine how these resources can be utilized for outcomes measurement, and identify challenges the Department of Human Services (DHS) may encounter in terms of information gathering and reporting that could impact outcomes measurement efforts.

The richest data source for evaluating outcomes for the Continuum of Care (CoC) housing programs is the Homeless Management Information System (HMIS) at DHS. HMIS is a web-based application mandated by HUD that captures information on homeless individuals and families that use residential or other homeless assistance services. The system has four major purposes: to provide an unduplicated count of homeless persons receiving services; to analyze community progress in reducing homelessness; to improve delivery of housing and services by examining sub-populations experiencing chronic homelessness; and to examine characteristics of homeless persons via demographic information, patterns of homelessness, and use of services.40

Because HMIS has the capacity to integrate data from all homeless service providers in the community while capturing basic descriptive information on every person served, it is a valuable resource for communities.40 Given this importance, the project team commenced its study on data availability by thoroughly examining the HMIS in place at DHS.

HUD has identified the following three objectives in support of its mandate:

- To apply “the power of technology” to the daily operations of providers;
- To coordinate housing and service providers more effectively in order to improve service delivery to consumers; and
- To “[o]btain and report critical information about the characteristics and service needs of homeless persons.”41
The project team focused largely on the third HUD objective: obtaining and reporting critical information. By establishing a repository of relevant information, an HMIS can assist provider coordination efforts by allowing providers to see where consumers have previously received homeless services and the types of homeless services received.

In order to implement its goals, HUD mandates that localities capture basic demographic data (e.g. consumer name, race, ethnicity, gender, veteran’s status, and SSN). Although HUD originally prescribed a methodology for providers on how they should gather this information, it subsequently removed that methodology in order to minimize the burden on providers and to allay consumer confidentiality concerns. Therefore, providers can gather information by any means they see fit. This may pose a challenge in ensuring that the information used for analysis is consistent across providers.

HMIS provides DHS with a mechanism of gathering information that can be used for outcomes measurement. The DHS system stores a significant number of data elements that are not required under the federal mandate, such as a more detailed assessment. As a result, the DHS system provides great potential for effective outcomes evaluation. In addition, DHS framed the data elements in a manner that encourages consistent answers.
F. Data Resources Available for Outcomes Measurement

In addition to HMIS, DHS has a variety of other data resources available for use in outcomes measurement. While HMIS is potentially a rich source of information, it may be desirable to identify services that consumers receive via other program offices. The available data resources fall into two main categories: information collected by DHS or contracted providers, and external information that DHS could collect in the future and use to track outcomes.

Internal Data Sources

A number of internal data sources exist within DHS. The data warehouse is the primary source of information and consists of information from a variety of DHS feeder systems. For example, the Electronic Client and Provider System (eCAPS), which houses HMIS, also tracks the consumer and service information for the Office of Behavioral Health (Mental Health and Drug and Alcohol Services) and the Office of Mental Retardation. The Office of Children, Youth and Families (CYF) has its own information system, as does the Area Agency on Aging. The information from eCAPS, the CYF mainframe, and the Aging mainframe is populated into the DHS data warehouse.

Ad-hoc queries can be performed on the data warehouse in order to provide reports on consumers who receive services from more than one program office and to track utilization over time. However, there are limits on the amount of information available in the data warehouse and what this information can be used for. In particular, federal and state laws contain provisions designed to protect the privacy of individuals undergoing drug and/or alcohol treatment.

Federal regulations allow qualified personnel to use drug and alcohol treatment records in program evaluation without first obtaining the consumer’s consent as long as the records do not directly or indirectly identify the patient(s) who are undergoing treatment. However, a state is permitted to promulgate regulations offering additional protections. Pennsylvania has a confidentiality provision prohibiting the disclosure of patient records to government entities unless the program receives the patient’s consent and the disclo-
sure is necessary in order for the patient to receive benefits. Providers thus view such provisions as limiting the amount of information that can be shared with other program offices and providers.

There is also some information collected by CoC providers that supplements the data in HMIS. In particular, some agencies conduct either formal or informal follow-up assessments with consumers who leave the program. Some providers also collect information on consumers that they do not submit to HMIS, such as case notes and detailed service information. Case histories and service information varies across providers and would be difficult to systematically gather at the DHS level. However, if DHS were to encourage providers to complete follow-up assessments, the providers could submit this information through HMIS. HMIS already has a set of fields for follow-up assessments but the completion of a follow-up assessment is not currently required.

Finally, DHS conducts a twice-yearly point-in-time survey of homeless persons in shelters and on the street. This survey collects data such as age, gender, family structure, duration of the current spell of homelessness, and disability status. The point-in-time survey is useful for identifying regional trends in homelessness but would not be used for outcomes measurement since the data are aggregate rather than individual in nature.

**External Data Sources**

There are also external data sources that could be used for outcomes measurement. The Pennsylvania Department of Public Welfare has information on consumers receiving welfare benefits such as Temporary Assistance to Needy Families (TANF), Supplemental Security Income (SSI), and food stamps, and this information is captured in the DHS data warehouse. Many DHS consumers also appear in this data set.

Although this data is probably too restricted or may not add value for outcomes evaluation for the CoC programs, DHS may want to investigate using such data if DHS implements outcomes evaluation for other programs.
How Could the Data Be Used?

There are two levels at which DHS could use available data to measure outcomes and inform planning and strategy. The first is at the micro level: case coordination, determining eligibility, and measuring indicators. The second level is the macro level: using the information to coordinate strategic planning efforts between DHS and providers. Outcomes can help DHS identify best practices and efficiencies in service provisions or could help providers identify which of their program elements are the most effective.

Providers and DHS staff have indicated that data in HMIS, bring largely self-reported by consumers, can result in incorrect or incomplete information regarding case and service histories. Thus, providers may attempt to enroll consumers in programs for which they are not eligible for or refuse service to otherwise eligible applicants. Not knowing the consumer’s service history can also lead to redundant services and treatment. In particular, providers can have a difficult time corroborating a mental health or drug and alcohol diagnosis for the CoC programs where a documented disability is required.

Making the existing data in eCAPS available to providers when they enter in consumer information would help ameliorate some of the problems listed above. eCAPS was set up to allow users to see information for the Office of Mental Retardation, the Office of Behavioral Health, and the Office of Community Services, but this capability is currently unavailable. There are confidentiality concerns about sharing this information, particularly with the Drug and Alcohol programs and the shelters that serve victims of domestic violence. Dealing with these issues should be given priority so that the system can begin to benefit providers. For example, the Drug and Alcohol information could be restricted so that other providers could only see whether a consumer had been in a program, but see no details about the treatment. Domestic violence shelters could be excluded completely from providing data on their consumers. Ultimately, there are ways to address the concerns about this kind of information sharing in order to allow better case coordination, eligibility identification, and more complete case histories.

These internal data could also be used for outcomes measurement. One potential use for this data would be monitoring the status of a consumer’s participation in a housing program or use of other non-CoC services. However, a consumer may stop receiving men-
Outcomes evaluation for housing services or drug and alcohol services for a variety of reasons. Thus, it may not be a bad outcome for a housing program if their consumers re-enter other housing programs, or if they get connected to mental health or other services they need. Since we do not know why a consumer actually seeks additional services, it is not clear how this information can help an agency determine the extent to which a consumer actually benefits from the services provided.

Outcomes measurement might also help identify other services that consumers receive while they are in a CoC program. One important goal of the CoC programs is to get people connected to other services that can help them. Getting consumers connected to other programs is a good outcome, as long as any comparisons were across similar types of consumers.

The point-in-time survey would probably find its most appropriate use in helping determine policy and identify areas of need across the program office. The point-in-time survey could be used to help define DHS’s prioritization of programs that are submitted to HUD through the CoC programs. It may also help the providers with their strategic planning.
PART III: BARRIERS
Part III. Barriers to Outcomes Assessment for the Continuum of Care (CoC) Housing Programs

Despite the numerous benefits of moving to outcomes evaluation, implementation poses a number of challenges. Part III discusses these challenges in two parts. First we consider barriers to the implementation of outcomes evaluation, such as consumer privacy concerns. Second, we discuss barriers to meeting target goals for providers, including limitations imposed by various external factors. For example, conditions in the local housing and political environment may prevent some providers from reaching the same consumer outcome goals as other providers. The latter constitutes a challenge for measuring outcomes consistently across providers. Both are addressed in the recommendations presented in Part IV.
A. Barriers Faced by Providers in Implementing Outcomes-Based Evaluation

Interviews with providers pointed to common problems and obstacles. Providers spoke of challenges that hinder their ability to implement outcomes-based evaluation, including:

- No common language
- Issues of confidentiality
- Lack of adequately trained staff and volunteers for HMIS entry
- Poor funding and/or lack of money
- Lack of information across agencies
- Inaccurate or falsely provided information from consumers
- Technology not up-to-date
- Little evaluation of collected data

We examine these issues in detail below.

1. No common language

Program directors were asked during the interview process to define the following terms: “input,” “goals,” “indicators,” and “outcomes,” which are common terms used in outcomes-based evaluation. Some providers had different conceptions of these terms. The definitions provided during the interviews generally did not reflect those definitions used internally by DHS (please see attached Glossary of Terms).

Human services administrators may generate erroneous evaluations if they incorrectly understand the terminology used. One executive director indicated that “we would greatly benefit from help defining the outcomes.”

Aside from differences in how providers used these terms, there was a lack of continuity between how providers classified consumers’ needs. As mentioned in the interview analysis, there are few common metrics for reporting a consumer’s progress.
A lack of common language limits the ability of providers to benchmark program development and improvement. Without better training and development of a common language for evaluation among program administrators, it will be difficult for DHS to assess the efficiency, quality and effectiveness of its contracted programs.

2. Lack of adequately trained staff and volunteers for HMIS entry

Program directors commonly mentioned a lack of training of both staff and volunteers for properly utilizing HMIS for data entry. One executive director stated, “We haven’t been using HMIS yet, because the program administrators haven’t been trained and there are computing needs.” Thus, some providers chose not to fully utilize HMIS since they lack staff or volunteers adequately trained to use the system.

Many of the provider agencies noted that they are currently understaffed. With the lack of staff, many agencies choose not to enter data into the HMIS because it is a lower priority than other administrative needs. One provider indicated, “Staffing is always a challenge for us. We are pretty consistently understaffed and that won’t get better over the next six months.”

Given a provider’s natural focus on providing services to their consumers, many agencies do not have time to collect and enter data for purposes of evaluation. The director at one provider agency stated, “There isn’t a lot of free time available for data entry. . . HMIS is a cumbersome system, and doesn’t allow you to run reports.” For another agency, chronic understaffing provides a continuous problem for data entry. They state, “Having time to collect information and the ability to do something with it has gotten pretty difficult.”

3. Poor funding and/or lack of money

A lack of money and funding has caused many agencies not to fully utilize HMIS or not to participate in outcomes evaluation. The executive director of a provider agency indicated that a key challenge they face is the lack of money to measure outcomes or perform follow-ups with their consumers. The agency quoted, “We don’t really have the money to do a formal follow-up.” Another director added, “We haven’t been using HMIS yet . . . and we can’t afford a full-time person.”
PART III: BARRIERS

For many providers, HMIS data collection is perceived as an unfunded mandate. “The HUD financial payments do not fully fund the program, and we have trouble making the match. HMIS is therefore just an added cost for us.” In addition, they indicated that, “HUD doesn’t increase our subsidy each year or when renewal comes around, so we aren’t receiving the same funding as when we entered the Continuum [of Care].” Consequently, many provider agencies would rather fund an additional caseworker rather than hire a data entry worker.

4. Technology not up-to-date

Some agencies indicated that their inability to enter data into HMIS and their inability to perform evaluations resulted from outdated equipment. One director indicated that they currently have a “technology issue.” This provider must use a dial-up connection to access the Internet. Thus, the provider must enter data later in the evening when it is less likely to interfere with telephone calls received during the daytime.

The issues above are exacerbated by the fact that providers have seldom found a way to interface effectively between HMIS and other management information systems currently in use. For example, a program director indicated, “HMIS is not tied into either the computer system the program uses for intake, nor is it related to the payment system.” Because HMIS cannot replace existing provider databases, at least several providers interviewed entered data in HMIS separately. This information is often entered in one or more other databases maintained by the provider organization.

5. Issues of Confidentiality

In tracking consumer outcomes, it is difficult to strike the appropriate balance between protecting consumer privacy and permitting the disclosure of personal information for evaluation. HUD has articulated standards designed to protect the confidentiality of personal information while allowing for reasonable, responsible, and limited use and disclosure of data. However, program directors repeatedly mentioned issues of confidentiality that hindered their ability to provide certain information to DHS. In addition to the HUD regulations, there are also other federal regulations, such as HIPAA, and state regulations that regulate the collection and transmission of human services data. This hinders the ability of the providers to verify information on their consumers with other providers.
According to one executive director, “Our problem lies in how to collect data without having confidentiality problems. We would like to share certain information regarding our consumers with DHS, but we are unsure how to do so without betraying our consumer’s identity.” Another interviewee indicated that HMIS is poorly servicing their agency due to these confidentiality issues. The director stated, “Because of the confidentiality issues, there is not a lot for which we can use HMIS.”

Given the tension between providers, it is vital for DHS and providers to identify elements of concern and to work together toward a solution. If data is made available to providers, it will need to be vetted thoroughly to ensure that it complies with the HUD standards regarding consumer confidentiality. The standards allow providers to coordinate services, and so it is definitely feasible that DHS could make certain data elements available to providers to help with service coordination.

This challenge is similar to that DHS encounters with data collection in the Point-in-Time surveys. Mental health and other sensitive issues are not consistently represented or reported by consumers and/or providers. Therefore, the information provided is not able to be used accurately for measuring outcomes.

### 6. Inaccurate or Falsely Provided Information from Consumers

One risk of measuring outcomes concerns a potential lack of accuracy resulting from inaccurate or falsely provided data from consumers. Such data could skew evaluation results. Almost all of the provider agencies indicated that the data recorded and entered could be falsely provided to them or could be inaccurate. According to one provider agency: “Currently, HMIS asks some questions on the intake [form] that aren’t really ‘get-table.’ The questions around mental health diagnoses and treatment are usually more complex than a consumer at intake can really describe.” The director further indicated that some consumers may falsify their data in order to receive services. The same agency noted, “It is hard to get certain people to disclose information, and there is no guarantee that it is accurate or truthful. There may be consumers that know how to give a story in order to fit the eligibility requirements.”

A second executive director concurred regarding the challenges faced in gathering accurate data for outcomes evaluation. The director indicated that “it is becoming difficult to
get any answers about anything. Even with HIPAA, homeless people are less inclined to answer or tell truths. The more questions we ask, the less info we are getting. It burdens the relationship.”

Privacy concerns may be one cause of inaccurate responses. However, it is also possible that the consumer desires a particular service or is unsure how to interpret the question. All methods of data collection introduce error. In this case, errors could be minimized by carefully tailoring the questions providers ask consumers and determining which questions are most likely to evoke inaccurate responses. DHS may wish to consider collaborating with providers in order to define a successful outcome as within a given range if the indicator is one that consumers are likely to provide inaccurate data on (e.g. mental health diagnoses).

7. Little evaluation of collected data

The agencies that currently collect data and use HMIS are unable to actually review and evaluate the data collected. The director of one of the agencies indicated, “In an ideal world, I’m not sure I’m ready to think about more information. It’s about what the information we have tells us. We collect a lot of information on our shelter residents. But we really haven’t looked at that information to figure out how to change our program.”

The reality is that many providers feel that they have few spare resources for program analysis. This may be an area of opportunity for DHS or other researchers to help providers analyze their data with the goal of informing their program administration.
The complex nature of housing services yields difficulties in measurement and evaluation. For implementation, DHS will have to address several difficulties faced by providers such as organizational capacity and technology issues.

As noted, the reasons for the low HMIS utilization rates varied among providers. Generally, providers noted technological, confidentiality, and/or financial issues. Several providers do not actively use HMIS as of the date of this report. Since HMIS is a prime resource for outcomes evaluation, the low utilization rate may reduce the effectiveness of outcomes measurement. This area is of concern because a lack of reliable data hinders the effectiveness of an outcomes measurement framework. For example, the percentage of consumers who have a high school diploma may be a valid indicator in terms of assessing the likelihood that those consumers will be able to increase income upon exiting a program. However, if only 5% of providers complete educational assessments, this measure becomes far less reliable.

B. Local Barriers
Outcomes evaluation sets ‘target’ goals for consumer outcomes. However, there may be many reasons why providers fail to meet these targets other than lower service quality. Factors in the local environment may be reflected in consumer outcomes. One of the goals of effective outcomes evaluation is to delineate as clearly as possible challenges towards serving diverse populations.

The availability of affordable housing influences the goal attainment of providers in meeting goals under the CoC. Based on the project team’s interviews with providers and the Ten-Year Plan to End Homelessness, safe and affordable housing for low-income consumers are difficult to find within Allegheny County. Both the consumer and provider find it difficult to secure quality housing in safe areas. Providers, who lease units from landlords under the HUD Supportive Housing Program and Pennsylvania’s Department of Public Welfare (DPW) Homeless Assistance Program, report that it is difficult to locate units that will accommodate their consumers.

According to the 2003 report, “A Study of Affordable Housing: Supply and Demand Allegheny County” commissioned by the Allegheny County Executive’s Office, there is a crisis in affordable housing for Allegheny County households earning below 30% of median household income.47 For households under 50% of median income, there are additional concerns about affordable housing that are exacerbated by the phenomenon of “renting down,” where higher income residents occupy the available low-income housing stock, decreasing its availability for those in the lower income brackets.

The ability to house consumers quickly may vary with provider location. Most low-income housing is concentrated in Pittsburgh, not in suburban Allegheny County. Housing units for households at 50% of median income also face a shortage within the City of Pittsburgh, although there is a surplus of housing outside the city.48 The Ten-Year Plan noted that homeless providers and developers are willing to partner to develop new housing opportunities, but they are struggling to meet the match requirements and raise the funds needed to begin the development.49 Providers of permanent housing services must spend valuable time focusing on fundraising instead of providing services to consumers.

In addition to housing location, the requirements for appropriate permanent housing depend on the consumer population. Housing units that will accommodate special popula-
tions, such as individuals with a physical disability, are also difficult to locate. Allegheny County has many older units that are not accessible for persons with physical disabilities. There is no central source for locating units which are accessible in the free market. There may be an opportunity to coordinate across city-wide housing resources to coordinate and combine information on affordable and accessible housing units. As a result, housing sources do not sufficiently address this need and have presented consumers and service providers with challenging efforts to secure permanent affordable housing.\(^{50}\) Similarly, housing issues are coupled with the need for consumers to access supportive services. Persons with HIV/AIDS face specific needs in terms of accessible housing located near supportive services.\(^{51}\) Therefore, the ability of organizations to ensure permanent housing options will be more challenging when servicing this population.

Several other characteristics will influence consumers’ abilities to find affordable housing and achieve residential stability. One such example is family size: since it is more difficult for large families to find affordable housing, these consumers may utilize transitional and emergency services with greater duration and frequency. According to one provider, women with large families fleeing domestic violence stay many more days on average in emergency shelters due to the shortage of available housing options.\(^{52}\)

Other barriers consumers face include histories of bad credit or criminal convictions. These were emphasized as consistent problems in the 2004 HUD CoC Proposal Narrative.\(^{53}\) In Pennsylvania, source of income is not a protected class for renting, so consumers who have income from public welfare programs may be denied housing.\(^{54}\) For all of these reasons, outcomes will vary among populations served, location, and other factors.

*How can one evaluate provider outcomes within the context of these varied challenges?*  This is a relevant critique when one considers moving towards more outcome-oriented goals. Arguably, provider agencies have much more control over administrative outputs than consumer outcomes.

Consumer outcomes targets must accommodate changes based on the larger environment, beyond the providers’ control. Transitional programs are heavily dependent upon the performance and availability of other programs in meeting their goals. Changes in
permanent housing provisions will impact the ability of transitional services to meet their goals.

Achieving program goals may depend on broad community factors outside of the providers’ control, such as economic and employment trends or the overall housing market. The local economy, employment opportunities, and availability of benefits all impact providers’ abilities to meet the goal of increasing consumer income and/or skills. For transitional housing programs in particular, the majority of the goals are accomplished through referrals to other services (“mainstreaming”).

Because the homeless services system is relatively small, it can be overwhelmed by small changes in other systems such as corrections and foster care. For example, Allegheny County has worked extensively on facilitating care from correctional facilities. However, recognition should be given to the fact that even with extensive strategic planning, the ability of homelessness services to maintain consistent consumer outcomes while withstanding changes in the larger environment is limited. This would be particularly true if there are substantive changes to the public housing subsidy programs such as HUD Section 8 and the HUD voucher program.

Variables that influence consumer outcomes are not always service-related, nor can differences between populations served always be captured in simple benchmark groupings of the population served. However, we recommend some approaches to dealing with variability in populations served. Factors in the larger environment need to be recognized through appropriate analysis. With respect to the larger problems of increasing the supply of affordable, accessible units that are located near service providers, DHS should try to work with other agencies that provide housing, such as the Allegheny County Housing Authority. There is also an opportunity for this kind of community-wide collaboration around housing strategy in the Allegheny County 10 Year Plan to End Homelessness. Whatever the mechanism, coordinating across agencies will help address the dearth of appropriate low-income housing.
Part IV. Outcomes, Indicators and Recommendations for DHS

This section discusses the outcomes for consumers in the CoC programs, related indicators, and metrics for measuring these indicators. This section will also include recommendations for DHS in adopting an outcomes-based evaluation framework.
A. Outcomes and Indicators

The project team identified a number of short- and long-term outcomes for the Continuum of Care (CoC) programs through the Annual Progress Report (APR) analysis, interviews with providers, and discussions with DHS staff. These outcomes all fall within the broad goals identified by HUD: achieving residential stability, increasing skills and/or income, and increasing self-determination for the consumers. It is important to examine both short- and long-term goals because looking only at what is achieved in the short-term may not capture the effect of the program over time. Consumers may be doing well while in the program, but programs would also like for the consumer to be successful after leaving the program.

Indicators can provide much valuable information. However, alone, they cannot enable an evaluation to be performed unless providers specify a target achievement level for each outcome. Since most providers identified a target goal for the percentage of consumers achieving the outcome, the next step for DHS and the CoC provider is to put this information in perspective. Did the expected target match the actual result? Setting “the right number” is a frequent challenge and often becomes an iterative process with the target changing over time.

The project team has focused on using existing data elements to build the outcomes measurement framework wherever possible. However, the team considered various tradeoffs between the cost/resource savings inherent in utilizing existing information versus the objective to capture the best information possible for outcomes measurement. HUD desires to eventually institute an APR system driven by HMIS data to measure performance of CoC programs. As a result, it may become necessary to add new outcome indicators in the future.

The project team identified a series of short- and long-term outcomes based on the APR analysis and provider interviews. These were selected based on four characteristics: whether they represent the stated mission of the program, whether providers listed some variant of the outcome on their APRs, whether the outcomes-related indicators are measurable, and whether they were consumer-centric. After examining and ranking these indicators, the team specified observable measures within HMIS or other information systems that can determine whether providers are successful in achieving the given outcome.
We feel that these goals represent the range of outcomes that are the most important for consumers of the CoC programs. They are not exhaustive, but they do represent the most important outcomes that providers and DHS staff identified, and they are also representative of the best consumer-focused outcomes as seen on the APRs. These outcomes measure functionality in a variety of areas that providers agreed are important for making sure that their consumers do well.

With respect to the larger problems of increasing the supply of affordable, accessible units that are located near service providers, DHS should try to work with other agencies that provide housing, such as the Allegheny County Housing Authority. There is also an opportunity for this kind of community-wide collaboration around housing strategy in the Allegheny County 10 Year Plan to End Homelessness. Whatever the mechanism, coordinating across agencies will help address the dearth of appropriate low-income housing for DHS populations.

All the measurable areas of importance that providers identified for consumers are included in these indicators. It is important to note, however, that indicators related to self-determination are hard to measure since they are subjective and qualitative in nature. This is evident in many of the self-determination outcomes listed on the APRs, which were often based on the individual service plans. Since these vary by consumer, they are difficult to standardize across providers and programs.

The indicators the project team selected are identified and described as follows:
PART IV: INDICATORS & RECOMMENDATIONS

Goal: Achieve Residential Stability, Short-Term

1. **Outcome:** Consumer leaves to permanent housing

   **Indicator:** Does the consumer leave to permanent housing?

*Importance of the Indicator*

The stated goal of the Continuum of Care (CoC) Supportive Housing programs is to help consumers live as independently as possible. All providers interviewed indicated that helping their consumers move into permanent housing is a primary goal of the program. This is especially important for non-permanent housing programs. However, for the permanent housing program, it may be inappropriate to talk about “moving” consumers into permanent housing, since they are already in a stable, long-term housing environment.

There is some inherent arbitrariness about what elements are defined as a “good” housing situation. Certain providers felt that the housing element “Permanent: Moved in with Family or Friends” in particular does not represent what they feel to be a good permanent housing situation. It is also important to ensure that the housing situation truly is permanent: that the consumers remain in that housing situation or move to a better one for a pre-determined length of time (for example, one year).

*Data Elements*

HMIS elements

a. **Program:** Has Consumer exited the program?
b. **Program:** Reason for leaving
c. **Program:** Destination
d. **Program:** Is this permanent (more than 90 days)?

*How to Measure It*

*If* ‘Has Consumer exited the program?’ = [Yes],

*And* ‘Reason for leaving’ = [Completed Program, Reached Maximum Time Allowed in Project, or Left for a Housing Opportunity Before Completing Program]

*And* ‘Destination’ = [Permanent - Moved in with family or friends, Other Subsidized House or Apartment, Safe Haven, Public Housing, Section 8, Shelter Plus Care, Home subsidized house or apartment, Rental house or apartment, Other supportive housing, Home Ownership]
And ‘Is this permanent?’ = Yes
Then consumer has left to permanent housing

Are Additional Data Needed?

As long as providers complete the above fields in HMIS, this indicator should be relatively straightforward to record.

2. Outcome: Consumer stays in program for entire duration

Indicator: Does the consumer stay in program for the duration (if not permanent housing)?

Importance of the Indicator

Although completion of the program is not always associated with good outcomes for the consumers, it may proxy for consumer status upon program completion. Consumers who complete the program will probably be more likely to achieve independence when out of the program. However, one concern about this indicator is that it may miss consumers who improve their situation and no longer require the services provided by the Continuum of Care.

Data Elements

HMIS elements

b. Program: Has Consumer exited the program?
c. Program: Reason for leaving
c. Program: Program Type

How to Measure It

If ‘Program Type’ <> Permanent, Then
If ‘Has Consumer exited the program?’ = [Yes],
And ‘Reason for leaving’ = [Completed Program or Reached Maximum Time Allowed in Project]
Then consumer has stayed in the program for the duration
Are Additional Data Needed?

This indicator attempts to measure whether consumers stay in the program for as long as they need. Perhaps a better measurement of this indicator would be to use elements in HMIS about whether the program staff agrees with the consumer’s decision to leave the program.

3. Outcome: Consumers will be connected with other social services as needed

Indicator: For Supportive Services Only programs, homeless consumers with disabilities will be placed in Supportive Housing.

Importance of the Indicator

This indicator applies only to the Supportive Services Only (SSO) programs, but it is one that can in principle be derived from data elements stored in HMIS. SSO programs do not provide housing, but they do often refer consumers who could benefit from other programs in the Continuum. If the providers of SSO programs can identify consumers with disabilities who may be eligible for other programs, they should refer these consumers to these other programs.

Data Elements

HMIS elements

a. Program: Special Needs
b. Program start and end dates for other Supportive Housing programs

How to Measure It

If ‘Special Needs’ = [Mental Illness, Alcohol Abuse, Drug Abuse, HIV/AIDS, Developmental, or Physical]

At some later point, consumer enters Permanent Housing, Transitional Housing, Safe Haven, or Shelter+Care program

Then homeless consumers with disabilities are placed in supportive housing

Are Additional Data Needed?

Although one can track whether the consumer in SSO has needs that may make them
eligible for Supportive Housing, this does not mean that there are programs with vacancies. It also does not ensure that the consumer will meet all of the eligibility criteria, particularly for the Safe Haven or Transitional Housing programs. Data on whether the consumer re-enters a DHS housing program will be captured in HMIS.

Goal: Achieving Residential Stability, Long-Term

4. Outcome: Consumers remain in permanent housing

Indicator: Do consumers remain in permanent housing for at least 1 year after leaving the program?

Importance of the Indicator

This indicator represents an extension of the short-term housing indicator listed above, but it is perhaps even more important. Providers believe that this indicator really measures program effectiveness: if consumers can live independently, and continue to do so, then the program has done its job. Although some programs may do a good job in finding permanent housing for their consumers, it is more important that they help consumers develop the skills and resources so that they can continue to live independently.

Data Elements

HMIS elements

b. Program: Was Follow-Up Attempted?
c. Program: Was Contact Made?
c. Program: Status of Living Arrangement
d. Program: Program End Date

How to Measure It

If ‘Was Follow-up Attempted?’ = [Yes]
And ‘Was Contact Made?’ = [Yes]
And ‘Status of Living Arrangement’ = [Permanent - Moved in with family or friends, Other Subsidized House or Apartment, Safe Haven, Public Housing, Section 8, Shelter Plus Care, Home subsidized house or apartment, Rental house or apartment, Other supportive housing]
PART IV: INDICATORS & RECOMMENDATIONS

Then consumer remained in permanent housing after leaving the program

Are Additional Data Needed?

Measuring long-term indicators is extremely important. Although HMIS does not require follow-up assessments for consumers, some providers indicated that they did do their own follow-up. Other providers have stated that they encounter former consumers frequently at other programs, and so a sort of ad-hoc follow-up occurs. Despite the expense and technical difficulty, we recommend that DHS seriously consider collecting follow-up data in a more formal and comprehensive manner, especially for housing and income measures. It also appears that HMIS does not collect information about when the follow-up occurred, so currently the follow-up capability does not capture how long the consumer remains in permanent housing.

Goal: Increasing Skills and/or Income, Short-Term

5. Outcome: Consumers secure employment upon exiting the program

Indicator: Do consumers have a job when they leave the program?

Importance of the Indicator

Many providers indicated that getting their consumers stable employment would be a very good outcome for their consumers, since it provides both income and self-determination. We would like to identify those consumers who do not have a job at entry and have a job upon exiting the program.

Data Elements

HMIS elements

a. Financial Assessment-Initial, Working Copy, and Exit: Does consumer have income?

b. Financial Assessment-Initial, Working Copy, and Exit: Income Source Section

How to Measure It

If ‘Does consumer have income?’ = [Yes] at exit

And ‘Income Source Section’: [Consumer_Inc_Source_ID] = ‘Employer’
And

(If ‘Does consumer have income’ = [No] at entry

Or

‘Does consumer have income’ = [Yes] at entry

And ‘Income Source Section’: [Consumer_Inc_Source_ID] /=/ ‘Employer’ at entry)

Then consumer has a job when they leave the program

Are Additional Data Needed?

HMIS requires a rather substantial initial assessment, but does not currently require any updated assessments during the program. That creates a problem in trying to measure indicators that represent some change between when the consumer entered and when they left. We would recommend that providers be encouraged to complete periodic updates, by just entering information on a couple of important fields, throughout the duration of the program. There is an exit assessment that providers must fill out, but if consumers leave the program abruptly, this may not get completed. It also does not have information about what changes the consumer has had in his/her life since he/she has been in the program

6. Outcome: Consumer increases skill level while in program

Indicator: Does consumer get his/her GED, high school or college diploma, or other educational milestone while in the program?

Importance of the Indicator

This indicator is similar to the preceding one. Helping consumers obtain more education or training increases the skill set of the individual and makes it more likely that he/she will be able to move into a less restrictive environment and live independently.

Data Elements

HMIS elements
PART IV: INDICATORS & RECOMMENDATIONS

b. Education Assessment-Initial, Working Copy, and Exit: Is Consumer in school now?
c. Education Assessment-Initial, Working Copy, and Exit: Highest education level achieved

How to Measure It

Two indicators:

If ‘Is consumer in school now’ = [No] at initial assessment
And ‘Is consumer in school now’ = [Yes] at working copy or exit assessment

If ‘Highest education level achieved’ at initial assessment
Is less than ‘Highest education level achieved’ at working copy or exit assessment

Then consumer achieved educational milestone

Are Additional Data Needed?

This indicator suffers from the same difficulty as indicator (5): if providers do not regularly submit updated consumer status information, it will be impossible to track improvements in consumer well-being throughout the program. The exit assessment does not ask questions about education level or schooling.

7. Outcome: Consumer increases income upon leaving program

Indicator: Did the consumer have a higher income when he/she left the program than when he/she entered?

Importance of the Indicator

This indicator is a measure of a program’s effectiveness at getting consumers connected to services and job supports, which will increase successful outcomes for consumers. This indicator is a proxy for other measures, such as paid work or training, public assistance programs, or other sources of income.

Data Elements
HMIS elements

   a. Financial Assessment-Initial, Working Copy, and Exit: Does Consumer have income?

How to Measure It

If sum of all consumer income source amounts

Is greater at program exit or working copy than at program entry

Then consumer has higher income at exit than at entry

Are Additional Data Needed?

In order to track any improvements, data is needed from at least two points in time during the program to measure this indicator. If the providers feel that they can reliably fill in the exit assessment because their consumers aren’t very likely to leave the program suddenly, then we can rely on the exit assessment. Otherwise, it might be more appropriate to require some periodic updates of the assessment during the time that the consumer is in the program.

8. Outcome: Consumer will be connected with other social services as needed

   Indicator: Does the program help consumers get TANF, Section 8, SSI, SSDI, Food Stamps, Medicaid, Head Start, or other public welfare?

Importance of the Indicator

Aside from programs that give financial benefits, which will be largely captured in Indicator 7, there are other public programs that can assist consumers. Gaining access to these programs, particularly Medicaid, if the consumer has a disability or mental illness, as well as the rental assistance programs will increase the probability that consumers will be able to move into housing without support but still be able to get the help they need.

Data Elements

HMIS elements

   a. TANF Benefit Amount
b. Other eCAPS data sources TBA

How to Measure It

If ‘Benefit amount’ at initial assessment

Is greater than ‘Benefit Amount’ at working copy or exit assessment

Then consumer gets connected to additional social services

Are Additional Data Needed?

Because some of this data is stored in eCAPS and providers have stated that they are more likely to enter information into eCAPS than in the HMIS module, sufficient data may exist for measuring this indicator. However, it is highly likely that the same problem will still exist: the providers enter in this kind of data only once, at the initial assessment.

Goal: Greater Self Determination, Short-Term

9. Outcome: Consumers will improve health status while in program

Indicator: Do consumers who have mental health or drug and alcohol diagnoses get treatment when in the program?

Importance of the Indicator

Many providers say that this goal is crucial to successful outcomes, but that it is the most difficult to achieve and could be misleading to use as an indicator. In particular, some of the Safe Haven providers state that they try to use enticement to get consumers to start attending mental health or drug and alcohol counseling, rather than coercion. For this reason, it is difficult to assess whether a program is doing a good job or not on this outcome. It is hard to identify who would need treatment and it is not at all clear whether the supportive housing or Safe Haven programs can change this outcome.

It would also be problematic to compare this outcome across providers and program types, since different populations are going to be more receptive to attending mental health or drug and alcohol programs than others.

Data Elements
PART IV: INDICATORS & RECOMMENDATIONS

HMIS elements

a. Program: Special Needs

eCAPS elements

b. Consumer active and receiving services from Office of Behavioral Health (OBH): Drug and Alcohol

c. Consumer active and receiving services from OBH: Mental Health

How to Measure It

If ‘Special Needs’ = [Mental Illness, Alcohol Abuse, or Drug Abuse]

And consumer active and receiving services during program stay

Then consumers having mental health or drug and alcohol diagnoses obtain treatment while in the program

Are Additional Data Needed?

Some of the treatment data may be available within HMIS. If not, there will definitely be privacy concerns related to accessing the Drug and Alcohol treatment information, since this data is very constrained. Ideally, the CoC provider would have information on what kinds of treatments their consumers are receiving while they are in the program, and this information could be stored in HMIS in a routine way. Although eCAPS captures whether a consumer receives services for Mental Health and Drug and Alcohol, if the providers of these services do not submit their service authorizations in a timely manner then the eCAPS data can be out of date.

Goal: Greater Self Determination, Long-Term

10. Outcome: Consumers will maintain health status upon exiting the program

Indicator: Do consumers who receive Mental Health (MA) or Drug & Alcohol (D&A) treatment while in the program continue to get MH/D&A services after leaving?
Importance of the Indicator

This goal is crucial to achieving long-term outcomes. Some consumers, particularly ones with a mental health or drug or alcohol problem in the past, may be clean and sober in the program, but once they return to a neighborhood setting they may find it hard to maintain their sobriety. Some providers stressed the importance of this outcome, saying that it is one of the reasons they see consumers return to homeless programs after successfully leaving another program.

Data Elements

HMIS elements
- Program: Special Needs
- End date of program

eCAPS elements
- Consumer active and receiving services from OBH: Drug and Alcohol
- Consumer active and receiving services from OBH: Mental Health

How to Measure It

If ‘Special Needs’ = [Mental Illness, Alcohol Abuse, or Drug Abuse]
And consumer active and receiving MH/D&A services during program stay
And consumer active and receiving MH/D&A services after program exit
Then consumer continues to receive Behavioral Health treatment after leaving the program

Are Additional Data Needed?

As long as the data warehouse has information about the types of services the consumer was receiving, it should be easy to collect this information. It is hard to assess causality with this outcome, because if a consumer no longer receives MH services after leaving the CoC program, it could be because they no longer need it, or it could indicate that they are not getting the help they need.
11. Outcome: Consumers leave the CYF system

**Indicator:** Do consumers with open cases in CYF get their cases closed within 24 months?

*Importance of the Indicator*

Certain providers, particularly domestic violence shelters and facilities that serve families, indicated that this was an important goal for their consumers to work towards, and that getting their cases closed marked a significant step in a move towards self-determination. This goal would not apply to all consumers, and probably would not be applicable to some entire programs.

*Data Elements*

HMIS elements
- b. Start date of program
- c. End date of program

CYF mainframe elements
- b. Case status: open or closed?

*How to Measure It*

*If* ‘Case status’ = [Open]

*And*

‘Case status’ = [Closed] two years after program end date

*Then* the consumer had their CYF case closed within two years

*Are Additional Data Needed?*

Additional data are probably not necessary, although the two-year timeframe is somewhat arbitrary. This is another indicator, however, where the outcome is determined by many other factors that the program may not be able to control. It may not be appropriate to use this indicator extensively unless the program has a strong component addressing family reunification.
B. Overall Recommendations

To move towards an outcomes-based framework, DHS should implement some or all of the following recommendations so that outcomes can be tracked consistently, be used to identify best practices, and allow for comparisons across providers. The recommendations are categorized into three main areas:

- Data Collection Recommendations
- Administrative Recommendations
- Outcomes Recommendations

Data Collection Recommendations

1. Collect Information at More Than one Point in Time

In order to better measure whether the providers and their programs successfully meet goals specified by HUD for its Continuum of Care (CoC) services, DHS should modify its data collection mechanisms. Currently, HMIS requires a substantial initial assessment, and then tracks some of the program specific information, and then asks a number of questions when the consumer exits.

Although HMIS allows the providers to update their consumer assessment during the program stay, HMIS does not require providers to do so. Relying solely on exit assessments may not be appropriate because some consumers leave the program suddenly, and providers may not be able to conduct the assessment. Therefore, the exit assessment in HMIS is quite limited. Most of the indicators listed above require information collected at more than one point in time because they represent improvements in the consumer’s functioning and well-being. There are a few elements that are important to collect at more than one point in time during the program stay and ideally afterwards:

- Income Source and Amount
- Education Level, and whether the consumer is in school or training
- Benefits and Support from Public Programs
- Involvement with Mental Health or Drug and Alcohol Services and Physical Health Services
PART IV: INDICATORS & RECOMMENDATIONS

2. Identify What Types of Services are Supplied by Providers

Additionally, expanded data collection is necessary to track the types of services provided to consumers. HMIS should provide a list of program services as well as the services administered to each consumer. This will enable DHS and providers to see how other providers have handled similar cases. Reports on service metrics and ‘outputs’ will be valuable in assisting providers to complete reporting on the HUD logic models which are now required. Ultimately, this service list can be used to identify best practices.

3. Collect Follow-up Information on Consumers

Key outcomes for the CoC programs include whether consumers gain access to permanent housing and whether they have gained the skills to live independently in that housing. It is hard to measure these outcomes without conducting some kind of follow-up with the consumer, which would probably take the form of a telephone call either six months or one year after the consumer’s exit. The problem is that long-term follow-up is often infeasible: it is time-intensive, particularly for the providers with smaller staffs, and the consumers can be difficult or impossible to reach.

Some providers also stated that they would be interested in knowing what their consumers say about them if someone else did the follow-up. It may be worthwhile to institute a pilot project to try to determine where consumers were a year after the program ended and how they felt about the program.

Administrative Recommendations

4. APRs Should Include Outcomes-Oriented Goals, and Progress Should be Tracked Via HMIS

Annual Progress Reports (APRs), currently completed by providers, include a mix of administrative and consumer-centric goals. Providers should be trained on how to iden-
tify consumer-centric goals similar to the indicators listed above. Perhaps the indicators on APRs could be the same across all providers, but the targets set by individual providers. If the APRs are standard across providers, progress towards these goals could be measured by HMIS and performance on meeting the goals could be compared across providers. This could also help inform program renewals.

It may also be appropriate to provide intermediate feedback to the providers, either through a routine or ad-hoc query mechanism, on how the programs are doing with respect to their goals. Many providers feel that HMIS does not add value to their operations. If providers had reports summarizing consumers progress, this perception might change. Even providing a tool to run descriptive summaries in HMIS could increase the utility of HMIS for providers.

5. Use a Common Assessment Tool Based on HMIS

Most of the providers interviewed stated that HMIS was partially duplicative of the information systems that they were already using. In particular, HMIS asks a number of mental health diagnosis and history questions in the initial assessment that the providers are often not yet able to answer. Some providers suggested that if fewer mental health questions were asked at the beginning, they could use HMIS as an intake assessment. Often providers must build a relationship with the consumers before they can get the consumer into mental health or drug and alcohol treatment, and may not even be able to do an assessment. Additionally, the team’s research indicates that a common assessment tool can be valuable in outcomes assessment, particularly if all the providers are trained on a common system such as HMIS. Insuring that providers collect the same information at intake will provide consistency across providers in measuring outcomes.

6. Give Providers More Information about Their Consumers’ Service Histories

HMIS is scheduled to eventually allow providers to see the case histories of the consumers within the other housing programs. The project team suggests that providers also be given at least limited information about the services consumers may have received in the other program offices.
There are compelling reasons why providers should be able to access limited consumer service histories. First, since CoC programs require the enrollees to have a diagnosed disability, giving the providers some information about their previous mental health or drug and alcohol treatment would aid in determining which consumers may be eligible for the Continuum of Care. Second, some providers say that the most frustrating element about HMIS is the fact that all the data is self-reported, and consumers may be unwilling or unable to provide the level of detail required by HMIS.

However, this is an area where confidentiality and consumer privacy concerns will need to be considered. Programs with specific confidentiality concerns, such as Drug and Alcohol programs or Domestic Violence shelters, will need to be dealt with separately. We recommend that DHS detail policy concerns, while seeking to find technical solutions that enable sensitive information or legal conflicts to be addressed (such as storing consumer codes at the provider level rather than reporting names and SSN for domestic violence). Alternatively, DHS may restrict or eliminate this information entirely for designated programs.

**Outcomes Recommendations**

*7. Identify a Difficulty-of-Service Scale for Consumers*

Another vital part of program evaluation for DHS and its providers is the ability to have an initial base of assessment for their consumers. Accordingly, it is our recommendation that DHS further investigate the development of a “Difficulty of Service” ranking for consumers. This ranking would ideally provide a common base or starting point for assessing the difficulty of serving the consumer. Not only will this give program staff a better starting point for developing plans of action, but it will also allow for providers to compare their consumers across other programs. The common assessment described above could be used to determine where the consumers fall in the Difficulty-of-Service ranking. Providers can seek strategic planning resources to better assess if what they are doing is working relative to other provider programs that deal with consumers with the same “Difficulty of Service” ranking. DHS will be in a good position to provide that
data following full HMIS implementation.

The project team recommends that DHS collect information from providers regarding consumer populations that have difficulty securing housing. This could be a component of the Difficulty-of-Service scale. For example, providers of family services have difficulty placing large families due to affordable housing availability in the community. These consumer characteristics may not be directly related to the success of the services. However, they influence consumer outcomes. Through the Homeless Alliance, DHS can be a voice for identifying common needs in housing across consumer groups.

8. Determine a Methodology for Comparing Across Heterogeneous Providers and Consumers

The most challenging component of instituting outcomes measurement is figuring out what to do with the outcomes. It is tempting to want to compare performance across providers immediately. Yet providers often have different resources at their disposal and are dealing with different populations.

One method of addressing variation in the consumer populations can be addressed somewhat by a Difficulty-of-Service scale, where the challenges in serving certain consumer populations are considered in comparing consumer outcomes. A second alternative is to compare across populations, by specifying distinct target levels within common consumer outcomes. For example, one provider may want a minimum of 60% of its consumers to transition into permanent housing, while another provider may set its minimum threshold for this indicator at 40%. A third method to minimize differences between populations would be to just compare types of programs, such as comparing across all of the women-only permanent housing providers.

Differences in provider resources and program philosophy will complicate any effort to address heterogeneity in consumer populations through standardized indicators. These differences are harder to address, and warrant further study. Any temptation to immediately compare performance on outcomes and make drastic funding decisions should be tempered until differences in providers are accounted for.
Follow-up with Providers on the Feasibility of the Recommendations

We spoke with several providers who offered comments after reviewing proposed indicators and recommendations. Providers expressed a desire to know more about consumer outcomes. Tracking some or most of the data recommended was important for evaluating program efficacy and unmet consumers’ needs. Additionally, one provider suggested that information on the quality of housing, availability of physical health services and access to legal services would be helpful in accessing consumer progress and stability. Measuring the affordability of housing, through comparison of housing expenditures and consumer’s income level, would reflect residential stability.

Providers were most concerned about implementing mental health and drug and alcohol indicators. Despite the importance of these issues to consumer outcomes, providers want to respect consumer confidentiality. Providers may not be able to identify consumers needing this assistance, ensure that they receive appropriate treatment, or assess the appropriateness and/or success of the treatment. First, consumers have varying levels of self-identification. Providers rely on the consumers’ self-identification and can seldom address discrepancies between provider/professional perceptions of consumer needs and consumer self-conceptions. Second, the distinction between formally received services and informal support is not well-defined. Informally received services may be the only ones available and cannot be formally communicated or tracked. Third, few homelessness/housing providers have experience in substance abuse and/or mental health. Individual mental health diagnoses are not necessarily available to shelter/housing providers. Nor are providers trained to evaluate what might constitute appropriate treatment for a given diagnosis. Coordinated training and communication with mental health, drug and alcohol services, and CYF program staff for training may be appropriate.

Finally, providers noted that follow up with consumers was difficult or impossible. Contact information for providers is quickly outdated, and consumers may not want to interact again with program staff. This is a formidable challenge for feasibility, and DHS may want to consider alternatives, such as a formal consumer study or data analysis to identify service reentry.
C. Future Research Directions

Outcomes measurement will likely become more important for DHS in managing housing programs such as the Continuum of Care for two reasons. First, federal reporting requirements hold providers increasingly responsible for tracking consumer outcomes and/or proxy outcomes for their programs. New requirements for the logic model in the Continuum of Care are one such instance of increasing accountability for consumer outcomes. Second, there is concern regarding the future federal funding climate for social service programs. This concern motivates agencies such as DHS to develop methodologies to guide funding considerations based on associated social impacts.

The systematic implementation of outcomes evaluation requires increased information gathering for some providers. This project has identified 11 outcomes that are critical for outcomes evaluation in the social services of housing plus care, over half of which exist currently in HMIS. However, aside from several reviews by participating providers, this project does not consider the feasibility across all providers in the context of HMIS implementation.

Future research should address the role of management information system implementation in the Continuum of Care. There may be a need for descriptive summary reporting tools in HMIS to help provider managers make better decisions regarding resource allocation and program strategy. Serious management analysis of the role of information technology in the work processes of resource-limited providers would examine short-term and longer-term benefits for the Allegheny County network of homelessness service providers. How, specifically, could providers with limited staff and expertise use IT in an efficient manner to help guide the management of their programs?

Additionally, future research might consider how DHS could best evaluate program outcomes using the analytical capabilities provided by HMIS. The systematic collection of meaningful indicators within a logic model framework enables more sophisticated social policy analysis. While we have recommended several processes by which DHS could evaluate outcomes across providers, the most important steps of implementation and benchmarking would be conducted in the future. Social benefit-cost analysis for programs, such as those in the Continuum of Care, could be effective in understanding whether programs achieve their goals in the most efficient way.
Endnotes


2 Ibid., 6.


5 Ibid.


8 Thanks to Stephanie Wilson of the Heinz Endowments and the Heinz School for discussing outcomes evaluation with the project team.

9 Ellen Taylor-Powell et al., “Planning a Program Evaluation” (Program Development and Education: G3658-1, University of Wisconsin Cooperative Extension, 1996), 4. Also available online at http://cecommerce.uwex.edu/pdfs/G3658_1.PDF.


11 The University of Wisconsin provides a helpful online tutorial on creating an effective logic model. See Ellen Taylor-Powell et al., Enhancing Program Performance with Logic Models (University of Wisconsin-Extension, 2002), http://www1.uwex.edu/ces/lmcourse/.

12 Ibid.


14 Ibid.


16 Ibid., 21.

17 Adapted from “Operation Safety Net,” Mercy Hospital administrator in discussion with authors, April 18, 2005.


19 Martin and Kettner, Measuring the Performance of Human Service Programs, 102.


21 Krause, Effective Program Evaluation, 84.


24 Martin and Kettner, Measuring the Performance of Human Service Programs, 102.

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26 Kate Bloniarz, “Housing Demand and Supply” (Unpublished report for Allegheny County DHS, 2005), 1.


28 Bloniarz, “Housing Demand and Supply,” Appendix B.

29 The information of each program covering consumers served, wait lists, and funding is derived from the report on DHS Housing by Kate Bloniarz. Ibid.

30 Allegheny County Department of Human Services, “2004 CoC Proposal,” Received February 7, 2005, Exhibit 1 and CoC Project Performance - Housing and Services Section M.

31 Dennis P. Culhane, “New Strategies and Collaborations Target Homelessness” Housing Facts and Findings. Volume 4, Issue 5. Available at: http://www.fanniemaefoundation.org/programs/hff/v4i5-strategies.shtml. While permanent housing is important, this continuation of this shift in funding priorities could jeopardize transitional services that help populations for which temporary shelter is most appropriate. An example is women moving from domestic violence situations, who need short-term shelter combined with services.


33 Barbara Poppe, Community Shelter Board, Columbus/Franklin County, Ohio in discussion with the authors, April 20, 2005. David Foster, HUD SHP administrator for Western WA, in discussion with the authors, March 30, 2005.


35 United States Department of Housing and Urban Development, Program Outcome Logic Model (HUD-96010, 2005), ii. Also available online at http://www.hudclips.org/sub_nonhud/cgi/pdfforms/96010.pdf.

36 “Renewal Application Form,” (Excel spreadsheet obtained from Lara Sebolt on February 8, 2005). A perfect score on A2 and C1 (collaboration with other agencies and the Homeless Alliance) and B1 and B2 (connecting consumers to other services) would both result in 20 points each.

37 Allegheny County Department of Human Services, “Evaluation Form Instructions 2004,” received from Lara Sebolt on February 8, 2005, Section D5, page 3. The objectivity of the evaluation process is described in Allegheny County DHS, “2004 CoC Proposal,” Section K.

38 See Appendix 1 for complete interview write-up.


40 Ibid., 45888.

41 Ibid.

42Ibid., 45901.
43 Ibid., 45888-89.
47 Angela M. Foster and David Y. Miller, “A Study of Affordable Housing: Supply and Demand Allegheny County” (Graduate School of Public and International Affairs, University of Pittsburgh, February 2003), iii. The supply of affordable housing in Allegheny is generally sufficient for households at 50-80% of median income. Comparisons of the ratio of available low income units to households, Allegheny did relatively well in available affordable housing when benchmarked against ‘comparable’ cities (Cleveland and Seattle, for example) in the mid-1990s.
48 Ibid.
50 Ibid.
52 Women’s Center and Shelter of Greater Pittsburgh, in discussion with the authors, February 17, 2005.
54 Angela Williams Foster, in discussion with the authors, March 18, 2005.
57 Adapted from “Operation Safety Net,” Mercy Hospital administrator in discussion with authors, April 18, 2005.
References:


----------. Data Model for the Homeless Management Information System. Received from David Gross on March 26, 2005.


REFERENCES


REFERENCES


Selected Annotated References:

**Resources from U.S. Department of Housing and Urban Development:**


This guide provides several methods for identifying, counting, and collecting data about homeless people who are not in shelters. It describes steps for conducting a count of unsheltered homeless people, why it is important to count unsheltered people, and the challenges faced in data collection.


This article examines Continuum of Care (CoC) for homeless people with case studies of 25 counties throughout the United States. This research evaluates local homeless assistance network and services in terms of program integration and performance.

**Additional Resources and Commentary on Homelessness Social Services:**


This website introduces the Homeless Management Information Systems (HMIS) system. It briefly discusses the motivations for HMIS implementation, its process, and challenges.


This report discusses the insufficiency of HUD’s budget for supporting the low – income families. Based on the nationwide survey through the branches of National Association of Community Action Agencies, it presents most crucial needs for low – income families’ housing.
Data, IT and Management:


This article depicts the theoretical framework for policy systems, based on an actual policy system used for elderly services planning. This article provides basic definitions like policy system, policy analysis, program analysis etc. while analyzing a case study for designing policy support system.

Outcomes-based Program Evaluation Resources:

*Articles:*

Adapting Evaluation Measures for Hard to Reach Audiences
[http://ag.arizona.edu/fcs/cyfernet/evaluation/adapeval.pdf](http://ag.arizona.edu/fcs/cyfernet/evaluation/adapeval.pdf)

This guide addresses issues to consider when working with vulnerable populations. Topics include obtaining consent, how to conduct interviews with children, modifying surveys for those with low literacy skills, and respecting culture when conducting evaluation.

A Brief Introduction to Sampling

This overview of sampling describes basic concepts, including sample size, response rate, and sampling error. The guide is designed for psychologists in particular, but it uses social service-related examples. It may be a bit academic for some, but it contains useful information and links to other resources.

Evaluation Handbook
[www.wkkf.org/Pubs/Tools/Evaluation/Pub770.pdf](http://www.wkkf.org/Pubs/Tools/Evaluation/Pub770.pdf)

This handbook, published by the W.F. Kellogg Foundation, provides a framework for thinking about evaluation as a relevant and useful program tool. Written primarily for project directors, it is a useful resource for those working in collaboration with community-based organizations.

Evaluation Strategies for Human Services Programs

This guide provides an overview of basic principles of program evaluation design. Topics covered include types of evaluation, developing a logic model, resources needed, organizational readiness and capacity to undertake evaluation, evaluation design, and common pitfalls encountered in evaluation. The content is broadly applicable to a broad range of human service programs.
Everything You Wanted to Know About Logic Models But Were Afraid to Ask
http://www.insites.org/documents/logmod.htm

This brief article provides an excellent overview of logic models -- what they are, their purpose(s), and how to develop them.

Guiding Principles for Evaluators

These standards for evaluators and conducting evaluations were developed by an American Evaluation Association Task Force.

Logic Model Development Guide
http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf

This online handbook published by the W.K. Kellogg Foundation provides a comprehensive guide to developing logic models, complete with exercises and checklists.

NPower Program Evaluation Toolkit

Developed by NPower, a technology technical assistance provider to nonprofit organizations, this evaluation toolkit provides a general overview of the various steps in conducting program evaluation, including developing a logic model, planning an evaluation, data collection, and data analysis.

Survey Response Options
http://dataguru.org/ref/survey/responseoptions.asp

This handy guide is helpful in constructing survey response scales. It provides options for wording of three-point, four-point, five-point, and seven-point scales. It is particularly useful in pinpointing the language you are looking for and ensuring that there is sufficient difference between scaled responses.

Using Existing Records in Evaluation
http://ag.arizona.edu/fcs/cyfernet/cyfar/Exisrec5.htm

This article provides an excellent overview of existing records as data collection tools -- what they are and how to use them. It covers the pros and cons of relying on existing records. The article concludes with a very helpful reference section that includes a number of sources for federal and nationwide statistics and other external data of use to evaluators.
Books:


List of Appendices

Appendix A: Interview Instrument
Appendix B: Example of a “Difficulty of Service” scale
Appendix C: Glossary of Key Terms and Definitions
Appendix D: Glossary of Acronyms
Appendix A – Interview Guide Template

Housing Outcome Interview Guide - Interviews for Service Providers

Organization Name: __________________________
Person interviewed: __________________________
Title: __________________________
Date: __________________________
Interviewer(s): __________________________

We are students from the Heinz School at Carnegie Mellon, getting our degrees in Master’s of Public Policy. For our capstone project, we are working with the Allegheny County Department of Human Services (DHS). We are interested in how they collect and analyze data related to the provision of housing services, specifically within the Bureau of Hunger and Housing Services. Ultimately, our research aims to help DHS improve how it measures successful housing-related outcomes.

This interview should take between 30-60 minutes, and focuses on two main themes: (1) information your agency now collects about its consumers through the HMIS and APRs, and (2) information you would ideally like to see collected.

To make sure that we are on the same page, it would be helpful if you can define the following terms we will be using during this interview. In the context of program evaluation, can you define the following terms and provide an example...

<table>
<thead>
<tr>
<th>When conducting evaluations, what is an…</th>
<th>Definition Offered</th>
<th>Example of how it is used</th>
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<tbody>
<tr>
<td>Input</td>
<td></td>
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<tr>
<td>Goal</td>
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<td>Indicator</td>
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<td>Outcome</td>
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</tbody>
</table>
In an ideal world, what information about your consumers would you collect to help you do your job better (ie, inform your program development, strategic planning, resource allocation, etc)?

What information would you like to know about your consumers after they leave your programs (six months from now, a year…)? Ignore reasons for not having that information now, like privacy concerns, cost, feasibility, etc.

PLEASE REFER TO LAST PAGE FOR ADDITIONAL QUESTIONS RELATING TO SPECIAL POPULATIONS INCLUDING CHILDREN, DISABILITIES, HIV/AIDS, MENTAL ILLNESS.

Now that we better understand what information about your client would be helpful for your program planning and development, we are going to ask you more specific questions about what the information you currently collect for the Department of Human Services with the Homeless Management Information Systems (HMIS) and the Annual Progress Report (APR).

On the Annual Progress Report, three types of goals are mentioned:

(1) residential stability;

(2) increased skills and/or income, and

(3) greater self-determination.

With these in mind, what kinds of outcomes would you like to see for your consumers with regards to residential stability?

What kinds of outcomes would you like to see for your consumers with the second goal of increasing skills and/or income?

What kinds of outcomes would you like to see for your consumers with the third goal of self-determination?
In your opinion, which goals are easiest to achieve (or are achieved most often)?

Which ones are hardest to achieve (or are achieved least often)?

Who in your organization determines the goals listed on the Annual Progress Reports?

How are these goals determined?

Do you feel these goals (referring to the goals you report on the APR) adequately capture the range of services your agency provides with Continuum of Care funds from DHS?

If not, what is missing?

What is the process involved in making individual service plans for your consumers?

Follow-up: How do you check-in with the clients to make sure that the service plans are being followed?

Might be redundant: How is “success” for the consumer defined?

1. How is it tracked?

2. How is it measured?
Aside from the information you report on the APR, we understand that the Department of Human Services also requests you collect data for the Homeless Management Information System. For example, you are asked to report information regarding client demographics, where they go after they leave your program, etc. Recognizing this...

How is the Homeless Management Information System currently being used by your agency?

Follow-up: Does it impact your ability to meet your mission?

Follow-up: If not, how is it not serving you?

What information for HMIS is pretty easy to capture?

What data is most difficult to capture and/or track?

Are there other kinds of data you collect that is not recorded in the HMIS (ie, follow-up surveys)?

Follow-up: How do you collect that data?

Follow-up: Would you be willing to provide that data to DHS at some point in the future?

Are there challenges you foresee in implementing/tracking/measuring these outcomes?
ADDITIONAL QUESTIONS RELATING TO SPECIAL POPULATIONS INCLUDING CHILDREN, DISABILITIES, HIV/AIDS, MENTAL ILLNESS.

If a program includes a large number of children: What kind of outcomes would you like to know about the children in your program? I.e., have they been taken out of the welfare system and placed with their parents, did their education remain uninterrupted, etc.

If a program includes people with disabilities: What kinds of outcomes would you like to know about those consumers with disabilities? I.e., did they remain on Medicaid, did they continue to receive treatment/therapy, etc?

If a program includes people with HIV/AIDS: What kinds of outcomes would you like to know about those consumers with HIV/AIDS? I.e., do they continue to have access to their medications, etc.

If a program includes people with mental illness: What kinds of outcomes would you like to know about those consumers with mental illness?
Appendix B – Example of “Difficulty-of-Service” Scale

A difficulty-of-service scale can be used by all providers, regardless of consumer population, to assess consumers upon intake. The scale helps standardize provision of services across heterogeneous populations and gives a way of benchmarking consumer improvement upon exiting the program.

Level 5:
Reclusive
Poor self-image
Multiple physical problems
Drug/Alcohol issues
Severe mental illness
Social isolation

Level 4:
Protective/guarded personality
Selective conversations
Attempts at hygiene
Accepts medical and/or social care
Chronic problems identified
Recovery efforts began

Level 3:
Sociable
Seeks health care
Knowledge of services available
Expresses needs
Seeks housing
Modest rehab success

Level 2:
Offers to volunteer
Struggles with self needs and a desire to attain a place in society
Relates to authority

Level 1:
Self-fulfillment
Responsive to help
Serves as example/mentor for others
Good hygiene
Feelings of Self-worth
Sober, remains in treatment program
Appendix C - Glossary of Key Terms and Definitions

As adapted from the Intermediary Development Series, entitled Measuring Outcomes:58

Data collection: “Deciding how information utilized will be collected”

Goal: “A broad statement of a program’s ultimate aims”

Indicator: “The specific, measurable metric collected to track whether an outcome has actually been achieved”

Inputs: “Resources and contributions needed”

Logic model: “Representing the relationships between program activities and the changes those activities will produce”

Outcome: “The changes in the lives of individuals, families, organizations or the community as a result of the program”

Outcomes measurement: “A systematic way to assess the extent to which a program has achieved its intended results”

Output: “The services that reach clients and participants”
Appendix D - Glossary of Acronyms

AFDC: Aid to Families with Dependent Children
APR: Annual Progress Report
CoC: Continuum of Care
CYF: Children, Youth, and Families
DPW: Pennsylvania Department of Public Welfare
DHS: Allegheny County Department of Human Services
eCAPS: Electronic Client And Provider System
HMIS: Homeless Management Information System
HUD: United States Department of Housing and Urban Development
MH/D&A: Departments of Mental Health and Drug and Alcohol at the Allegheny County Department of Human Services
NOFA: Notice of Funding Availability
OBH: Office of Behavioral Health at the Allegheny County Department of Human Services
SHP: Supportive Housing Programs
SSI: Supplemental Security Income
SSO: Supportive Services Only at the Allegheny County Department of Human Services
TANF: Temporary Assistance to Needy Families