

**TRACKING AND EVALUATION ISSUES FOR HOMELESS SERVICE PROVIDERS
IN ALLEGHENY COUNTY, PA**

by

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A main focus for social service agencies that work with homeless individuals is to help their clients achieve housing security. However, social service agencies report that the transient nature of many homeless individuals represents a major obstacle in achieving housing security. This transience leads to a loss of services for many homeless individuals and a return to the streets. This is of public health importance due to the increased risk that homeless individuals face of exacerbated chronic diseases and exposure-related health complications. In order to address this problem, both improved tracking methods and evaluations are needed to increase the effectiveness of providers in helping clients achieve housing security.

This thesis will first discuss innovative methods in tracking and evaluation nationwide to identify opportunities for improvement at the local level in Allegheny County, PA. These nationwide trends will then be compared to local trends, first in Pennsylvania as a whole and then in Allegheny County. This thesis will touch on the 10-year plan currently unrolling in Allegheny County to help end homelessness and how this program integrates tracking and evaluation. To further narrow the focus, this thesis will then discuss an evaluation conducted at Community Human Services Corporation (CHSC) in Pittsburgh, PA as a case study of tracking and evaluation obstacles faced by local homeless service providers.

Finally, after thoroughly reviewing trends nationally and locally, several questions will be offered for Community Human Services and other homeless service providers to ask themselves in regards to tracking and evaluation methods. It is hoped that these questions will

provide a starting point for social service agencies like CHSC to update and revise tracking and evaluation methods while also opening the door for further innovation in tracking and evaluation for Allegheny County.

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1.0 INTRODUCTION

Homelessness continues to pose serious public health problems in the United States. Estimates from the National Law Center on Homelessness and Poverty and the U.S. Department of Health and Human Services state that on any night in America, 600,000 to 800,00 individuals are homeless (National Law Center on Homelessness and Poverty 2007, Thompson 2003). In addition, it is estimated that each year, 1% of the U.S. population will face homelessness for at least one night or that nearly 2-3 million Americans are homeless during a given year (Thompson 2003). People that are homeless face multiple threats to their health and security including direct health consequences of living on the streets such as frostbite, ulcers, and respiratory illnesses including tuberculosis (Kushel, Vittinghoff, Haas 2008, Marks et al. 2000). They also confront risk of assault, hate crimes and discrimination (Leake et al. 2001). In addition, homeless people often lack access to adequate, permanent healthcare resulting in exacerbation of chronic illnesses such as diabetes, asthma, hypertension and chronic heart disease (Kushel, Vittinghoff, Haas 2008). Finally, mental illness and substance abuse disorders pose serious problems for people that are homeless (Eyrich-Garg 2007, Wolff et al. 1997). Approximately 37.1% of the homeless population struggles with a substance abuse disorder (Hunger and Homelessness Survey, 2007). In addition, reports suggest that anywhere between one-quarter to one-third of individuals that are homeless suffer from a serious mental health disorder such as schizophrenia, bipolar disorder or major depression (Folsom et al., 2005). Both

substance abuse disorders and mental illness can greatly impact an individual's judgment. Because of this, persons suffering from either of these conditions are more likely to engage in risky sexual behavior and/or intravenous drug use. These behaviors are associated with a higher incidence of HIV/Aids, and Hepatitis C (Allen et al. 1994). As mentioned above, it is unlikely that homeless individuals will receive adequate healthcare for these conditions, which results in rapid deterioration of the health of homeless individuals that suffer from these conditions.

Although homelessness clearly creates public health problems for both the homeless and the population at large, it is unclear that our efforts to stem homelessness have succeeded. As of 2006, there are more than 40,000 agencies that offer service to the homeless (Mitka 2006). However, it is difficult to ascertain if these services are in any way decreasing the number of homeless individuals (Burt et al. 1999). In fact, the recent mortgage crisis and scare on Wall Street places countless American families at risk of foreclosure and financial instability with some facing homelessness (Johnson 2007). These grim realities raise the question of whether homeless service providers are prepared for a possible increase in the number of homeless. In order to understand their capacity, we must first understand how they measure success and how they keep track of their clients. We need to ask questions like: How do social service agencies themselves measure their progress? Do separate social service agencies have enough support and staff to effectively monitor their programs? How do these programs track the number of individuals they serve and how do they maintain contact with the transient homeless population? All of these questions are integral to ensuring that the health and housing needs of our nation's homeless population are met.

In light of these questions, this paper will first provide a brief introduction and overview to homeless programs nationally with a focus on housing programs. The purpose of this study is

to identify and suggest improved tracking and evaluation of programs that focus on either directly housing homeless individuals or assisting homeless persons in developing skills needed to maintain permanent housing.

As these housing programs are explored, emphasis will be placed on how these programs track individuals that are homeless and how agency personnel evaluate the program's performance. After this overview, the bulk of the paper will focus on homelessness issues in Allegheny County, Pennsylvania giving priority to exploring tracking and evaluation issues. Again, an introduction to local homeless service providers will be given and the environment in which these programs operate will be considered. After a picture of the local situation is developed, this paper will then focus on a specific homeless service provider in Allegheny County, namely Community Human Services, as a case example of evaluation and tracking issues that individual social service agencies face. The information for this section is derived from an evaluation conducted by the Graduate School of Public Health in conjunction with the cooperation and assistance of Community Human Services. With an understanding of the local evaluation and tracking issues, I will look at innovative tracking and evaluation methods among homeless service providers. Based on these innovative practices and the current need in Allegheny County, I will propose a plan for improving tracking and evaluation in Allegheny County at both the service provider level and the county as a whole.

1.1 HOMELESS PROGRAMS NATIONALLY

In looking at homeless services nationally, it is helpful to consider how our current programs evolved. The programs that we have today were created and continue to be adapted and revised

based on our knowledge of the past and our assessment of what has and has not worked. In this section, we will trace the changing paradigms of how social service agencies address the issue of homelessness. These trends, for the sake of brevity, have been grouped into four broad categories: The emergency shelter movement, continuum of care and service-delivery integration, and the supported housing program and consumer preference models.

1.1.1 Emergency Shelters

During the 1980's, the United States saw a rapid rise in the number of individuals that were homeless (Link et al. 1994). In response to the increasing financial burden that the homeless population placed on cities and rural locales nationwide, the federal government enacted the Stewart B. McKinney Homeless Assistance Act in 1987, the first major federal allotment of money specifically designated to assist homeless individuals in finding shelter (Burt et al. 2007, U.S. Public Law 100-77 [1987]). The law required that recipients match federal dollars with a certain percentage of funds, resulting in greater local investment in addressing homelessness issues (Burt et al. 2007).

Initially, these funds were largely directed towards building emergency shelters for the homeless. In 1984, funding to build emergency shelters was less than \$300million, while in 1988, only one year after the McKinney Act passed, funds for emergency shelters skyrocketed to \$1.6 billion (Burt et al. 2007). These Emergency shelters offered short-term shelter options to meet the immediate need for housing (National Coalition for the Homeless 2008). Emergency shelters today are still considered the first line of defense in addressing homelessness, as the immediate need for shelter must be addressed before longer-term solutions can be considered.

The McKinney funds also ushered in a new type of shelter, namely the transitional housing shelter (National Coalition for the Homeless 2008). Transitional housing options, like emergency shelters, are a temporary solution to homelessness. However, transitional housing programs offer longer-term stays for homeless individuals while also providing supportive services (Wong, Park & Nemon 2006). These supportive services are often directed towards achieving ‘housing readiness’ for the homeless individual through case management, treatment and therapy and employment training (Wong, Park & Nemon 2006).

1.1.2 Continuum of Care (CoC) and Integrated Service

Several shifts in the understanding of how to address homelessness occurred during the Clinton Administration (Culhane 1995). Paramount among these new paradigms was the Continuum of Care (CoC) model (Wong, Park & Nemon 2006). This idea was espoused by the Department of Housing and Urban Development (HUD) in response to the uncoordinated, often haphazard efforts that had previously dominated the nation’s response to homelessness (Cisnero 1995). Under the CoC paradigm, a homeless individual is supported from the time they enter an emergency shelter until they find permanent and adequate housing (Culhane 1995).

Emergency shelters, transitional housing and permanent supportive housing are the cornerstone programs for the CoC model (Wong, Park, Nemon 2007). Permanent supportive housing, as the name suggests, is a permanent housing option unlike emergency shelters and transitional housing. Permanent supportive housing targets homeless individuals who are unlikely to successfully achieve permanent housing without intensive support services due to a mental illness, substance abuse disorder or physical disability (Wong et al. 2006). Thus, permanent supportive housing options provide on-site staff to provide supportive services while

also referring individuals to outside supports as needed (Wong et al. 2006, Wong, Park, Nemon, 2007).

Along with the advent of the CoC model, advocates for the homeless also started calling for greater integration of services. These advocates cited the fragmentation of the service-delivery system as an impediment to ensuring that homeless individuals find and maintain affordable, adequate housing (Rosenheck et al.1998). Since many homeless individuals also suffer from other chronic problems such as mental illness, substance abuse and physical health problems, service agencies began partnering to provide more comprehensive services across the continuum of needs (Rosencheck et al. 1998).

These advocates suggest that integrated services not only provide easier access to a broad range of services, but that they also increase the likelihood that homeless individuals will find and sustain permanent housing (Drake et al. 2003). Integration of services is still seen today with homeless service providers either directly offering or partnering with healthcare professionals, therapists, case management and vocational training services to ensure that the vast number of needs represented in the homeless population are met.

1.1.3 Supported Housing Program (SHP)

Due to successes seen in the CoC and service integration approach, the U.S. Department of Housing and Urban Development began allocating grants specifically for regional continuum of care networks starting in 1994 and continuing to the present day (National coalition for homeless veterans, n.d.). These grants are authorized through the McKinney-Vento Homeless Assistance Act and are awarded through the federal Supportive Housing Program (SHP) (U.S. Public Law 100-77 [1987]). The SHP's overall goal is to promote housing development and supportive

services for the homeless nationwide (U.S. Department of Housing and Urban Development 2008). To reach this goal, SHP holds an annual competitive grant application to which regional CoC networks apply. SHP began offering these grants specifically to CoC's in order to encourage inter-agency collaboration and community involvement in the fight to end homelessness. These CoC competitive grants can go to fund local supported housing programs, supportive services and safe havens (U.S. Department of Housing and Urban Development 2008).

Additionally, the federal SHP offers funds for emergency shelters. This money requires that states and/or local jurisdictions submit a consolidated plan that addresses long-term plans to end homelessness regionally (National coalition for homeless veterans, n.d.). The SHP also offers grants to regional CoC's to encourage the use of the Homeless Management Information System (HMIS), which standardized the data collected by homeless service providers nationally (U.S. Department of Housing and Urban Development 2007).

1.1.4 Consumer Preference Programs

Finally, a burgeoning paradigm in offering services for the homeless population is the consumer preference model. This model suggests that the popular paradigms of CoC and service integration possess fundamental flaws if they do not first consider consumer preference (Tsemberis et al. 2003). In this model, service providers that look to offer innovative programs for the homeless should not only consider the opinions of professionals and scientists, but also the opinions of individuals that are currently homeless. Advocates for this model assume that seeking the advice of homeless individuals should be paramount as they know their needs the best (Tsemberis et al., 2003).

This model, unlike the previous models we discussed, does not dictate essential programmatic features to ensure success for the homeless. Rather, this model insists that communities and service agencies engage with individuals that are homeless to discuss their needs as part of programmatic planning. Only by hearing from the intended consumer, advocates argue, does the service agency ensure that they are effectively meeting the needs of their target population (Goering, Paduchak & Durbin 1990). An example of a consumer preference program is the Consumer Preference Supported Housing program at Pathways to Housing, Inc. in New York City. This program focuses on offering housing that directly meets consumer need regardless of consumer adherence to treatment or sobriety status. In this program, consumers are first linked with an apartment of their choice and are then offered individualized supportive services that focus on their own unique needs (Pathways to Housing, n.d., Tsemberis & Eisenberg, 2000).

With the numerous homeless housing options and theories that currently operate, it is important to understand which programs work the best, how outcomes are determined and the costs and effectiveness of these different approaches. Indeed, this is even more important since funders are demanding more outcomes-based approaches and accountability from service agencies that receive funding (Mowbray et al. 1998). As seen from our review of housing options nationally, programmatic goals and theories vary widely as to how homelessness is best addressed. Since the goals of different housing options runs the gamut from providing short-term emergency housing to ensuring permanent housing and sustainability for clients, it makes sense that evaluation options will vary from program to program. However, in the past years, a move has been made to provide more integrated services that address a continuum of needs for clients (Rosencheck et al. 1998, Wong, Park, Nemon, 2007). With this move, some standard

evaluation methods have emerged, which we will cover as we explore evaluation tactics nationally. We will also cover the history of evaluation methods with the homeless population and the emerging trends for evaluations in the present day.

1.2 EVALUATION AND TRACKING METHODS NATIONALLY

Now that we have covered some of the different trends in addressing the issue of homelessness, we come back to some fundamental questions: How do we ensure that we're adequately addressing the needs of the homeless population? In turn, how do funding agencies ensure that social service agencies are using funds in an appropriate manner? Finally, how do individual agencies track their own progress? Evaluations serve to answer all of these questions and are an integral step in assuring that social service agencies are meeting the needs of their clients, are conducting programs in an efficient manner and are using funds appropriately. The type of evaluation used will largely depend on the types of programs offered at an agency, the kinds of questions that the agency wants to answer and the resources and constraints on the agency. With this said, the evaluation of homeless service providers has evolved over time and continues to adapt as services to the homeless population change and grow. In this overview of evaluation methods nationally, I will consider how evaluation of homeless services has changed over time, the current trends in homeless evaluation and tracking and the need for further adaptation of evaluation practices. Both the benefits and the drawbacks of each evaluation strategy will be discussed as well as their applicability to either individual service agencies or larger-scale evaluations carried out at a regional or national level.

1.2.1 Historical Overview of Evaluations among Homeless Service Providers

Prior to the 1960's in the United States, public drunkenness was considered a criminal offense which meant that homeless individuals with an alcohol problem often ended up in the criminal justice system rather than the public health or social service systems (Aaronson, Dienes & Musheno, 1978). During the sixties and seventies, a push for decriminalization of public drunkenness became rampant across the United States, which placed a burden on social service and public health agencies to respond to the needs of the homeless and chronic inebriate (Fagan, Jr. & Mauss 1978). In 1971, the Uniform Alcoholism and Intoxication Treatment Act encouraged states to decriminalize public inebriation and paved the way for rehabilitation and detoxification centers along with halfway houses (Mercier, Fournier & Péladeau, 1992). By 1985, over 33 states adopted this legislation, which led to an increased push for evaluations on these new programs (Mercier, Fournier & Péladeau, 1992). Many of these evaluations compared recidivism and re-lapse rates among “chronic inebriates,” as those with alcohol abuse problems were labeled, under the new decriminalization legislation compared to prior rates when public drunkenness was a criminal offense (Fagan, Jr. & Mauss 1978, Mercier, Fournier & Péladeau, 1992). Although housing and shelters were an integral part of the decriminalization movement, the importance of evaluating housing efforts was often overshadowed by the evaluation of detoxification centers, their readmission rates and recidivism statistics (Finn, 1985).

In the 1980's, however, the homeless population saw a rapid rise in numbers with the characteristics of the ‘typical’ homeless person changing drastically. At this time, social service agencies began to identify that many homeless persons were struggling with either a mental health or substance abuse disorder. In addition, the rise of homeless women began to offset the

previous assumption that only male “inebriates” were at risk of becoming homeless. Due to the changing demographics of the homeless population, new services for the population began to emerge.

During this time, a push for evaluating the outcomes of homeless services for those with chronic mental illness became a top priority. Some of the first published studies conducted with seriously mentally ill homeless individuals showed that the types of services offered in the eighties, such as rehabilitation and halfway houses, were not meeting the needs of their consumers (Bachrach, 1984, Lamb, 1984, Mercier, Fournier & Péladeau, 1992). These initial outcome studies also set the groundwork for using intermediate outcomes, such as recording the number of nights that a consumer reports spending on the street, as a measure for success (Mercier, Fournier & Péladeau, 1992). In addition, there was an increased focus on process evaluations, which looks at the implementation of the program to aid in program monitoring and quality assurance (Mercier, Fournier & Péladeau, 1992, Royse et al., 2006). These process evaluations found that the transience of clients and the program’s adaptability to client needs were both constraints in the program’s success with clients (Mercier, Fournier & Péladeau, 1992).

These initial studies with homeless individuals with a mental illness laid a framework for the types of evaluations still conducted today. In addition, the push for outcomes evaluations has increased due to demand from funders and the public to hold homeless service providers accountable for the public money they receive (Mowbray et al., 1998). Funders will often ask for annual reports that include definite short, medium and long-term outcome success from the agencies they fund. For example, HUD requires that all homeless service agencies receiving federal funding complete annual progress reports as well as delineate their successes in their

annual application for funds (U.S. Department of Housing and Urban Development, 2007a). These outcomes often focus on housing stability, the amount of time spent in the various homeless service programs and other indicators of success such as employment or education advancement (U.S. Department of Housing and Urban Development, 2007a).

However, it is widely recognized that outcomes-based evaluations in homeless service providers do not always adequately represent the success of a program (Culhane et al., 1998, Mowbray, Cohen & Bybee, 1993, Mowbray et al., 1998). The long-term outcome goals, such as placing the client in long-term, permanent housing, may not be reached or may be difficult to measure in a timely fashion due to the transience of the homeless population and the difficulty in tracking clients over long-term periods. Because of these constraints, homeless service providers will often utilize intermediate outcomes as their measure for success (Mowbray, Cohen & Bybee, 1993, Mowbray et al., 1998). Individual homeless service providers or their funders usually determine the intermediate outcomes, but these outcomes are often recorded in a standard form called a performance measurement. Performance measurements record both the types of services received by the client and the goals reached by the client (Culhane et al., 1998). In this way, the agency can suggest that these given ‘inputs’ or services rendered by the agency effectively achieved the given outcomes. However, given that there are many confounding factors, such as the client seeking services from multiple programs, it is not always feasible to attribute the given outcomes to the services.

Although outcomes-based measurements do have some drawbacks, they are still widely used today as standard measurements of the success of agencies and their clients (Mercier, Fournier & Péladeau, 1992, U.S. Department of Housing and Urban Development, 2007a). If used in conjunction with process evaluations, as recommended for a clearer understanding of the

agency's strengths and weaknesses, these evaluations can provide the agency with a snapshot of their strengths, weaknesses, successes and failures (Culhane et al. 1998). Because of this, outcomes-based evaluations and process evaluations still remain the backbone of evaluative strategies for homeless service providers today. In sections 1.2.2-1.2.4, we will further delineate common evaluation strategies based on who or what is being evaluated. In section 1.2.5, we will introduce the logic model as a pictorial map for agencies as they conduct process evaluations.

1.2.2 Accountability to Consumers: Consumer Satisfaction

As noted earlier, the type of evaluation or measurement used depends largely on exactly what you are evaluating. In *Making Homelessness Programs Accountable to Consumers, Funders and the Public*, Culhane et al. (1998) argue that evaluations should be conducted with the consumer, funders and the public in mind. The type of information needed to ensure that the needs of each of these groups are being met varies, as we will discuss.

First, to ensure that an agency is meeting the needs of their clients, arguably one of the most important outcomes, there are two main evaluation strategies: Conducting consumer satisfaction surveys and using qualitative approaches such as focus groups and in-depth interviews (Royse et al. 2006, Ensign & Gittelsohn 1998).

To measure consumer satisfaction, many agencies start by developing a questionnaire for clients. In this strategy, a simple Likert-type questionnaire can be utilized to ensure that the programs and services offered are in line with the needs of the consumers. This type of survey provides valuable information to the agency about where there are gaps in services and what the consumer considers most important to their own success. In order to cut-down on the costs and time of developing their own survey, homeless service providers may choose to utilize a

standardized survey such as the Client Satisfaction Questionnaire (CSQ-8) or adapt a similar survey to their own needs (Royse et al, 2006). However, using a client satisfaction survey is not without its drawbacks. It must be remembered that a person who is homeless faces enormous amounts of stress and anxiety as they try to figure out how to secure housing, let alone food or clothing. Not only this, but as they navigate homeless service provider networks, they are barraged with paperwork in order to even begin receiving services. In this scenario, providers must consider whether or not an additional survey will place an undue burden on their consumers.

If a questionnaire is out of the question or if additional information is sought, qualitative approaches such as in-depth interviews or focus groups with consumers can provide valuable information to homeless service providers about not only client satisfaction. A benefit of this type of approach is that consumers guide the conversation and are able to verbalize their concerns in their own words. In addition, this strategy can be utilized by social service agencies that have major resource and time constraints, but would like at least some feedback from their clients (Greene 1994, Ensign & Gittelsohn 1998, Royse et al. 2006).

It is vitally important for homeless service providers to engage in consumer-based evaluations as these measures address the fundamental question of whether or not the agency is actually meeting consumer needs and creating positive outcomes for consumers.

1.2.3 Accountability to Funders: Program Outcomes and Cost-Effectiveness Analyses

A starting step of being accountable to funders is ensuring that social service agencies are collecting adequate information about their clients and tracking their client's successes over time. In order to ensure that client needs are being met and tracked from the beginning, most

social service agencies conduct some form of intake assessment. These assessments are meant to provide agencies with baseline measures of client housing status, and other pertinent needs. During intake assessments, agencies will often also collect basic client demographic information (Culhane et al., 1998).

Although many agencies were conducting these assessments prior to the introduction of Homeless Management Information Systems (HMIS), after the advent of HMIS, these intake procedures became even more standardized since HMIS requires that certain basic information be collected from every client such as identifying information, previous place of residence, history of alcohol or drug abuse and the types of services being requested. (U.S. Department of Housing and Urban Development 2007a).

Intake assessments provide the baseline measures for future outcomes-based evaluations. To compare the final outcomes to the baseline measurements, social service agencies must record the services that each consumer receives in order to match services with outcomes. The process of recording varies widely between social service agencies, but this process is broadly known as recording performance measures (Culhane et al., 1998). These performance measures typically provide information about the services provided and the direct outcome attained by the consumer. Some agencies use the final outcomes as part of the performance measurement while other agencies record intermediate outcomes associated with particular programs and services (Culhane et al., 1998; Royse et al., 2006).

Program outcomes are measured and reported to funding agencies to ensure accountability of the social service provider to the funder. These outcomes provide funders details on the success of different programs offered by social service agencies, the number of consumers they serve, and the amount of funding they use on different programs. Essentially,

program outcomes allow funders to see a big picture of where their money is going and if it is being used successfully (Culhane et al., 1998, Royse et al. 2006).

Again, the recording of program outcomes and interpretation of these outcomes varies depending on the funding agency and the service provider involved. However, there are a number of funders that have standardized the reporting requirements for homeless service providers. As previously mentioned, the HMIS system utilized by HUD is one such standardized tracking system used by the federal government to see where their money is going and how it is being spent. Other funders, such as the United Way of Allegheny County, require annual or semi-annual reports from funded agencies which include demographic information of those served, the number served and the outcomes (Malone, 2008).

Since these large funders will often have data from several social service agencies, they may choose to conduct more rigorous studies based on the aggregate data. In some instances, funders might follow two different programs over time to see how well these respective programs meet the needs of the consumer (Culhane et al., 1998; Miesher & Galanter, 1996; Clark & Rich, 2003). However, conducting a quasi-experimental or experimental design such as this is time-consuming and costly. Because of this, many funders elect to only look at individual social service data rather than compare data across agencies.

Funders may also conduct cost-effectiveness evaluations based on data given to them from homeless service providers. These cost-effectiveness analyses or evaluations compare different programs for addressing homelessness based on both costs and the desired outcomes. Again, this type of analyses is costly and many social service providers do not have the capacity to collect the amount of information needed in these studies. Because of this, cost-effectiveness evaluations nationally are still rare (Culhane et al. 1998; Culhane et al., 2008).

1.2.4 Accountability to the Public: Systems-Based Outcomes

Finally, social service agencies and their funders must ultimately report to the public progress in meeting the needs of the homeless, the costs of their programs and how these programs are performing as a whole. The information collected and reported to the public is vitally important because it allows the public to hold policymakers accountable for the funds, programs and outcomes seen in federally or locally funded homeless programs.

However, this type of reporting, in which large funding agencies report on the progress of multiple homeless service providers necessitates the development of a comprehensive and standardized tracking system. In order to standardize how federal funds were being used nationally, Congress required that HUD collect homelessness data from local jurisdictions by 2004 (U.S. Department of Housing and Urban Development 2007a, Roman 2003). This requirement resulted in the development of the Homeless Management Information System (HMIS). This system is an attempt to assist Continuum of Care networks and other federal grantees in standardizing information collection at their agencies. Since different agencies possess varying levels of support staff, capacity and funds, HUD offers 11 different HMIS software packages. HUD requires that all CoC networks implement HMIS with the hope that a standardized tracking method will assist agencies in effectively addressing the needs of homeless persons in their community (U.S. Department of Housing and Urban Development 2007a).

Not only are social services asked to collect standardized data in the HMIS system, they are also required to analyze the data and to report trends and outcomes. The type of data collected and the process of analyzing the data will be further explored as we discuss in section 2.0 the local situation in Allegheny County and how HMIS is utilized and implemented locally.

However, it is important to note at this juncture that HMIS has allowed the federal government to collect aggregate data on homeless clients and homeless services in a way that has not occurred prior to this effort. Certainly, different regions maintained their own standardized tracking systems prior to HMIS, but the advent of a standardized system across the country allows the collection and analysis of data on a much larger scale. Culhane & Metraux (1997) argue that this standardized collection of homeless service data will profoundly affect the type and scope of future evaluations. For example, to this day, exact numbers of how many homeless individuals are in the United States still elude us. The most common method for counting homeless individuals is collecting a cross-sectional sample of individuals by conducting point in time counts (Koegel, Burnam & Morton 1996). These counts are conducted nationwide and serve to enumerate the number of homeless individuals on any given night across the United States. However, critics of this method suggest that it significantly undercounts the actual number of homeless individuals since persons in transitional housing or in doubled-up arrangements with friends or family are not counted. As data from HMIS continues to be collected and analyzed, it is possible that we will no longer have to rely on these cross-sectional counts for enumerating the homeless and we can instead utilize information from HMIS on duration of service utilization for individuals to create period-specific, longitudinal counts of the number of homeless individuals receiving services nationwide (Culhane & Metraux, 1997).

1.2.5 Process Evaluations

Although we have largely focused on outcomes evaluations thus far, as mentioned earlier, both outcomes-based evaluations and process-evaluations historically and currently form the backbone of evaluation methods for homeless service providers. Process evaluations focus on

the implementation and follow-through of programs within the agency in contrast to outcomes evaluations, which look at definitive outcomes at the end of a program (Royse et al., 2006).

Process evaluations seek information from program staff to assess what works and doesn't work with programs, what difficulties are encountered in the day-to-day running of a program and if the programs actually address the needs and problems they are supposed to address. However, for small social service agencies that do not have an excess of time, personnel or resources for evaluations, the idea of doing a process evaluation can seem overwhelming. Recently, however, the logic model has been introduced as a compact, fairly straightforward tool to use in conducting process evaluations (Kaplan & Garrett, 2005, Mulroy & Lauber 2004, Julian, Jones & Deyo 1995).

Logic models provide a pictorial representation or map of how programs are supposed to interact and what ultimate outcomes are expected from these programs. They allow the service provider to instantly see the essential components of a program and desired outcomes (Mulroy & Lauber 2004). Logic Models usually have several core elements including: Who the program serves, assumptions underlying the program, inputs or resources needed, activities used by the program and finally the outputs and outcomes. These core elements are evident in the sample logic model shown in figure 1 below as used in the Program Evaluation course taught by Dr. Rafael Engel in the spring of 2008 at the University of Pittsburgh.

PROGRAM LOGIC MODEL “Definition of Problem” Program Name					
For Whom	Assumptions	Inputs	Activities	Outputs	Outcomes
	Why is there a problem? What is the best way to address the problem?			Service Completion:	Intermediate Outcomes: Ultimate Outcome:

Figure 1. Framework for Program Logic Model

It is vitally important to include exactly whom the program is meant to serve. Sometimes this becomes clouded since many homeless service providers want to help as many individuals as possible. However, identifying exactly who is meant to benefit from the program not only avoids confusion while conducting a logic model, but also clarifies the issue for the agency.

Assumptions include two parts: 1) The reason that the agency believes the problem is occurring. For the purposes of this paper, the problem is homelessness and 2) What the agency believes is the most effective way to address the problem. Often these assumptions are not verbalized and including this section in the logic modeling process allows staff to become cognizant of their own theories about the causes of homelessness and the best way to address homelessness.

Next, a list of all the inputs needed to carry out the various programs meant to serve the target group is drafted. This list should be as extensive and exhaustive as possible. After all inputs are included, a list of activities offered by the agency to meet the needs of the identified

group is formed. The activities include all the programs offered by the agency to assist the target group in meeting their goals.

Finally, the outputs and outcomes are then listed. The outputs are everything that the agency does to carry out their programs. These should have a measurable component linked with them. For example, an output for many service providers would be the # of intakes that they complete in a specified period of time if intakes are included as one of their activities. Also included in the outputs is what the agency identifies as a service completion. The service completion includes all necessary steps that the consumer must complete in order to graduate from the program.

The last component of a logic model is the outcomes section. Usually, short-term, intermediate and long-term outcomes will be identified. These outcomes list the goals that should be accomplished if clients successfully complete the given set of activities. For a homeless service provider, a short-term or intermediate outcome might be to increase the client's knowledge about housing options with the ultimate outcome being that there would be a decrease in the number of homeless individuals.

As stated before, logic models are a useful tool for service providers to use in understanding agency goals and providing a map for how programs and outcomes are linked. While conducting process evaluations, service providers should consider using logic modeling as a blueprint for considering implementation and quality issues associated with the program.

2.0 HOMELESSNESS IN ALLEGHENY COUNTY

With an understanding of homeless programs and evaluation tactics nationally, we now turn to consider the programs offered to address the needs of the homeless locally and the current methods for tracking and evaluating homeless service providers in Allegheny County.

First, however, we need to consider the burden of homelessness in Allegheny County. According to a report provided by the Department of Human Services, there were a total of 1,308 homeless individuals in Allegheny County counted for the year 2008 (Allegheny County Department of Human Services, 2008). This data is derived from the Allegheny Point-in-time count. This count takes place annually during one night in January. Trained observers count the number of individuals either in emergency shelters or on the streets during a specified period of time. The number of homeless individuals in 2008 did not change significantly from the 2006 and 2007 Point-in Time Counts, which respectively recorded 1, 297 and 1, 380 homeless people (Allegheny County Department of Human Services, 2008). Although Point-in-time counts are used widely to estimate the number of homeless individuals in a given area, critics suggest that this technique leads to low estimates due to difficulties in finding and identifying homeless individuals (Link et al. 1994). Given the constraints of point-in-time counts, Allegheny County also measures the number of individuals served annually through homeless services providers. During the fiscal year 2006-2007, collective reporting of unduplicated clients from 100 homeless

service programs showed that they served 10,912 adults and 4,736 children that were homeless or in danger of becoming homeless (Allegheny County Continuum of Care, 2007).

Among the homeless adult population in Allegheny County, 19% of individuals reported that they had a serious mental illness while 24% reported that they abused substances including alcohol or illegal drugs (Allegheny County Department of Human Services, 2008). Similar counts from the 2007 Point-in Time estimate showed that 40% of homeless adults had a mental illness and 12% struggled with Drug and Alcohol abuse (Allegheny County Department of Human Services, 2008). In 2008, self-reports also showed that 7% of homeless individuals suffered from domestic violence and 4% of the homeless reported that they were HIV positive (Allegheny County Department of Human Services, 2008). Although the information collected during the point in time surveys show extreme variance from year to year, it still provides useful information about the health and welfare of Allegheny County's homeless population. These reports show that besides housing needs, many homeless individuals need multiple services such as healthcare, mental healthcare and drug and alcohol services.

Providing services for the homeless is an expensive undertaking in Allegheny County. Housing programs by themselves cost the county almost 12 million dollars in the fiscal year 2006-2007 with an additional \$2million contributed from matching funds (Allegheny County Department of Human Services, 2008). In addition, supportive services, such as rental assistance and case management cost a little under \$2 million in FY 2006-2007. All told, the Allegheny County Department of Human Services receives over \$19 million annually from federal, state and local sources to provide programs and services that focus on finding and providing housing for homeless individuals (Allegheny County Department of Human Services, 2008). Given the extensive funds needed to ensure sustainable housing for individuals that are

homeless in Allegheny County, it is easy to understand why the county has made ending homelessness a priority.

Allegheny County has taken several region-wide steps to address the problem of homelessness. First, in 2003 a network of public and private entities in Allegheny County was formed to create a systematic, collaborative effort to address homelessness in Allegheny County (Allegheny County Homeless Alliance, 2005). This network named itself the Allegheny County Homeless Alliance and it continues to strive for providing comprehensive, continuum of care programs for homeless individuals in the region. The network ranges from small non-profits to larger entities such as the Allegheny County Department of Human Services.

In 2005, the Allegheny County Homeless Alliance with the assistance of Allegheny County, the city of Pittsburgh, the city of McKeesport and the municipality of Penn Hills published a 10-year plan to end homelessness in Allegheny County called *Ending Homelessness Now: Creating New Partnerships for Change* (n.a., 2005). This local effort reflects national trends in developing 10-year plans to end homelessness. The Allegheny County plan lays out eight recommendations of how to end homelessness in the region with distinct objectives and outcomes specified for each recommendation. The 10-year plan shows a further collaboration of local service providers, government agencies and funders in the interest of addressing homelessness issues (n.a., 2005). These specified outcomes and objectives are further delineated in Section 2.2.2 along with a discussion on local tracking and evaluation efforts.

In addition, Allegheny County has created a local Continuum of Care (Allegheny County CoC). The Allegheny County CoC is a collaborative network of over 44 homeless service providers in Allegheny County that collectively offer over 100 programs to address the complex issues of the local homeless population (U.S. Department of Housing and Urban Development,

n.d.). This local CoC is also part of a larger, regional network called the Mid-Atlantic Regional HMIS (MARHMIS). The MARHMIS supports the region in creating standardized reporting using the Homeless Information Management System (HMIS) as discussed in further detail in Section 2.2.1.

The creation of the Allegheny County CoC not only improves delivery and integration of services for the homeless in Allegheny County, it also opens up federal funding streams for local homeless service providers. In Allegheny County, federal monies funneled through the SHP fund emergency shelters, supportive housing programs, safe havens and shelter + care (U.S. Department of Housing and Urban Development, n.d.). In addition, the County receives money from state, local and private sources that further support temporary housing programs like transitional housing and bridge housing. Federal, state, local and private funds also provide the opportunity for the County to offer supportive services for the homeless population in the form of case management and rental assistance. Given the breadth of housing options and supports, it is important to further clarify the details of each program to ensure a full understanding of their differences and similarities. Before continuing, it should be noted that all reported information below comes from the Allegheny County CoC. The CoC provides the most comprehensive data about what individual social service agencies are doing in Allegheny County, however, it is possible that certain agencies were overlooked, particularly if they have not applied for funding federal funding through the SHP.

2.1 HOUSING PROGRAMS OFFERED LOCALLY

In addition to creating these region-wide networks to address homelessness, individual service providers continue to offer various housing options for homeless individuals in Allegheny County. These services provide the backbone for getting homeless individuals off the street and into safe housing. Allegheny County also provides supportive services such as case management or rental subsidies. Although these supportive services do not directly offer housing options to individuals, they are often an interlinking step in assisting homeless individuals in finding either temporary or permanent housing solutions. The services and goals of these housing and supportive service programs vary widely, so a brief analysis of each type of housing and support option is offered below to provide a snapshot of the programs currently offered in Allegheny County.

2.1.1 Emergency Shelters

Emergency shelters primarily offer temporary accommodations for individuals that are currently homeless and need shelter immediately. Generally, these shelters are only open during evening hours and residents vacate the premises during the day. Also, these shelters are time-limited, meaning that residents at these shelters must find other housing options in a specified period of time, typically 30 days.

There are 16 emergency shelters in Allegheny County with a total of 202 beds for individuals and 162 beds for families (Allegheny County Continuum of Care Fact Sheet , 2007). In addition, the County opens additional shelters during severe weather emergencies to ensure that everyone can get off the streets and into safe, warm housing for the night.

2.1.2 Temporary Housing

Temporary housing programs are more complex than Emergency shelter options. Generally, temporary housing is a short-term solution for homeless individuals that provides full-day residence for a year or longer. As the name suggests, temporary housing is not a permanent solution. These programs are meant to *transition* consumers into finding and sustaining permanent housing. In this way, many temporary programs offer additional supports and training such as case management, vocational training, and drug and alcohol rehabilitation along with many others.

In Allegheny County, there are three housing options that fall under the category of temporary housing. The first program is known as Transitional Housing. The other two temporary programs are called Bridge housing and Safe Havens. The program aspects of each will be discussed more below.

2.1.2.1 Transitional Housing

Transitional housing programs in Allegheny County offer temporary housing for individuals and families with a goal of finding a permanent housing within 24 months. These transitional programs often offer in-house supports to assist with gaining the necessary skills to live independently. Although supportive services vary from agency to agency, common supportive services include case management, drug and alcohol rehabilitation, vocational training and financial literacy trainings.

Transitional housing in Allegheny County is largely funded by HUD. In 2006-2007, there were 25 transitional housing programs in Allegheny County, which collectively served 451 adults and 329 children (Allegheny County Continuum of Care).

2.1.2.2 Bridge Housing

Bridge housing, by definition, is a link for consumers that are in temporary housing, but wish to find sustainable, long-term housing. Bridge programs offer residents a place to stay for up to 12 months while they search for permanent housing arrangements. Bridge housing programs often offer supportive services to assist consumers in developing the necessary skills to find and sustain permanent housing. The supportive services offered in Bridge Housing settings largely replicate the services offered in transitional housing and include case management, housing referrals, vocational training and financial planning assistance.

Allegheny County offers 13 Bridge Housing Programs. The PA Department of Public Welfare provides the funds to operate these programs. In 2006-2007, Bridge Housing providers in Allegheny County served 271 adults and 206 children. In addition, PennFree Bridge Housing, a one-year Bridge Housing program supported by state funds, offered services for 224 adults and 140 children in FY 2006-2007. PennFree Bridge Housing is offered to individuals that have substance abuse problems with either drugs and/or alcohol. The PennFree Bridge Housing option is offered by seven social service agencies throughout Allegheny County (Allegheny County Continuum of Care).

2.1.2.3 Safe Havens

Safe Haven programs in Allegheny County offer supportive housing options to individuals that are homeless and have a severe mental illness. These Safe Havens, unlike Bridge Housing, do not have a specified cut-off time when residents must find other housing options. Safe Havens must provide all residents with either private or semi-private accommodations. Similar to Bridge Housing, Safe Havens are seen as a transitional arrangement

that prepares residents for permanent housing options by providing supportive services and training.

In Allegheny County, during 2006-2007, there were 3 Safe Havens operating. Collectively, they served 47 adults. (The Department of Housing and Urban Development, 2008; Allegheny County Continuum of Care, 2007).

2.1.3 Permanent Housing

The ultimate goal of any transitional housing service such as Bridge Housing or Safe Havens is to find a permanent housing option for consumers. Some consumers will find and maintain permanent housing on their own, while other consumers may need continued support throughout their lifetime. In order to assist the latter, Allegheny County offers permanent supportive housing options with services for people with physical disabilities and/or people with a severe mental illness or co-occurring mental illness and substance abuse problems. Supportive services offered at many of these programs include intensive case management, vocational training, drug and alcohol rehabilitation, life skills training and counseling (U.S. Department of Housing and Urban Development, 2008).

Allegheny County offers 20 permanent supportive housing options for people with disabilities. In 2006-2007, permanent housing assisted 445 adults and 300 children (Allegheny County Continuum of Care, 2007).

2.1.4 Rental Assistance

Rental assistance is a monetary form of support for those that are homeless or near homeless. Rental assistance funds can be used to pay past-due utilities, rent, security deposit, or mortgage arrearage. In 2006-2007, \$815, 307 were spent on rental assistance for 978 adults and 840 children.

According to the Allegheny County CoC fact sheet (2007), only one member of the Allegheny County CoC offers rental assistance to homeless or near-homeless individuals; the Urban League of Pittsburgh (Allegheny County Continuum of Care 2007).

2.1.5 Case Management

Case management services are often offered in conjunction with transitional housing options or permanent supportive housing. However, some agencies offer case management services as a way to help consumers find housing even if the agency itself does not offer housing options on-site. Case management supports the consumer in developing self-sufficiency to prepare them for living on their own. As part of case management, consumers are asked to set goals around the categories of life skills, financial management, home maintenance and vocational preparation.

The PA department of Public Welfare Homeless Assistance Program as well as HUD offers funds for case management services. Currently, there are three agencies in Allegheny County that offer case management services under the auspices of the PA Department of Welfare. These three agencies served 741 adults and 542 children in the FY 2006-2007 (Allegheny County Continuum of Care 2007).

2.2 LOCAL EVALUATION AND TRACKING METHODS

Given the breadth of housing and support options for homeless individuals and families in Allegheny County, the process of evaluating and tracking these programs and the consumers they serve can seem daunting. Add to this the fact that homeless service providers receive monetary support from various funders with different requirements for reporting and tracking, and you can quickly see how complex tracking both homeless service providers and their consumers can become.

In an attempt to standardize reporting and tracking among homeless service providers nationwide, the U.S. Department of Housing and Urban Development (HUD), required all CoC's receiving funding through the SHP to submit standardized data by 2004. HUD provided the Homeless Information Management System (HMIS), a data-tracking software program, to assist in this request (Roman 2003). The Allegheny County CoC has adopted these HMIS standards and has also taken additional steps to integrate tracking and evaluations locally. The 10-Year plan to end Homelessness in Allegheny County not only offers a blueprint for ending homelessness, it also provides specific outcomes and objectives in order to evaluate progress towards this goal. To gain a clearer picture of local evaluation and tracking methods, we will discuss both HMIS and the 10-year plan to end homelessness as they relate to tracking and evaluation in Allegheny County.

2.2.1 HMIS

As mentioned in previous sections, Allegheny County has created a countywide Continuum of Care to further integrate homeless service delivery and to seek funds from the federal Supportive

Housing Program. In 2000, Congress sanctioned HUD to collect data on homelessness from jurisdictions across the nation by 2004. To meet this requirement, HUD required all CoC's to track clients and service provider data through the Homeless Management Information System (HMIS). This system allows users to choose different HMIS software programs that work best for their needs, while collecting standard data regardless of the program chosen. In this way, the federal government can collect standardized data about where their money is going, whom they are reaching and what outcomes are achieved.

The requirement for all CoC's to use HMIS is enforced through the CoC competitive application that all CoC's must fill out in order to apply for funds from the federal SHP. As part of their grant requirements, Continuum of Care organizations must provide an annual progress report (APR) using data from HMIS as well as report on technical standards to ensure consumer privacy. In addition, all emergency shelters in Allegheny County that receive federal funding through an emergency shelter grant (ESG) must also report data from HMIS via the Integrated Disbursement Information System (IDIS) (U.S. Department of Housing and Urban Development 2007a).

Requirements from HUD specify that all agencies using HMIS must report universal data including demographics, patterns of use among the homeless population. (See Appendix A) Additionally, all agencies that receive funding from the federal SHP must complete the Program-specific portion of HMIS, which documents assessments, service use and outcomes (See Appendix B). These program-specific measures use indicators such as the types of service received and the outcomes achieved to assess agency success in helping the client (U.S. Department of Housing and Urban Development 2007a). For housing programs, agencies must record the type of housing that the client is offered and also must record the reason that a client

eventually leaves the program as indicators of the stability and permanence of the housing options for these clients (U.S. Department of Housing and Urban Development 2007a).

According to HUD, the HMIS system is meant to assist local CoC's in not only planning and delivering integrated services for consumers, but also serving as an evaluation tool to study outcomes and effectiveness of programs. In keeping with this goal, HUD released the 2007 report on HMIS, which includes a goal of increasing evaluation tools by collecting more information about outcomes from programs receiving SHP funding (U.S. Department of Housing and Urban Development 2007a).

2.2.2 10-Year Plan to End Homelessness

In addition to adopting HMIS to assist in integrating data, Allegheny County has also developed a 10-year plan to end homelessness. This plan is part of a national program sponsored by the United States Interagency Council on Homelessness (U.S. Interagency Council on Homelessness, n.d.). The Council encourages communities, counties and states nationwide to develop comprehensive plans to end homelessness within ten years.

In 2005, the Allegheny County Homeless Alliance published *Ending Homelessness Now: Creating New Partnerships for Change*. It provides eight recommendations (highlighted in order) to combat homelessness:

- *Recommendation 1: To reduce the number of homeless individuals and families entering the system by (1) educating individuals and families on the warning signs of homelessness (2) educating community/social services agencies and organizations on these warning signs so they are better positioned to intervene early with their consumers to avert homelessness and(3) providing county-wide information on how to access resources and assistance in a timely way to avoid a housing crisis.*

- *Recommendation 2: To increase the affordable housing supply that is accessible to the chronically homeless and homeless over the next ten years by 1000 units and preserve existing low-income housing units where feasible.*
- *Recommendation 3: To develop, implement and maintain, as long as there is a demonstrated need, a comprehensive approach to ending chronic homelessness through three major components. They are: an Engagement Center System, Harm Reduction Housing and expansion of Housing First Programs.*
- *Recommendation 4: To improve how homeless consumers are accessing and receiving housing and or supportive services through the network.*
- *Recommendation 5: To co-locate homeless services within designated regional centers where a variety of community-related programs and opportunities for resource dissemination, volunteering and socialization, regardless of housing status, is the focal point.*
- *Recommendation 6: To develop short-term and long-term Public Awareness and Education Programs on Homelessness.*
- *Recommendation 7: Establish a central repository for financial contributions from private sources. Annually distribute these funds through the homeless network based upon performance, quality of program and responsiveness to identified needs in the continuum of care.*
- *Recommendation 8: To advocate for comprehensive health and behavioral health services that are accessible, reliable and effective for people experiencing homelessness (n.a., 2005).*

Of particular import for this paper is the fact that many of these recommendations necessitate the collaboration of social service agencies throughout the county. In recommendation five, the plan calls for an integration of social service programs into one location to form a comprehensive engagement center. The recommendation proposes a central facility where both homeless and non-homeless consumers can come to receive information

about housing, employment, SSI, food stamps, medical assistance and other social service needs. In order to successfully implement this plan, standardized tracking and evaluation would be paramount (n.a., 2005).

In light of this, the 10-year plan also addresses tracking and evaluation issues. In recommendation eight, the plan calls for an assessment of how data is being collected and what the data means. They also call for a review of the health survey data that was used to collect information about health needs from homeless individuals in 2002. This review would evaluate the instrument itself to establish its validity and reliability (n.a., 2005).

These are certainly important steps in the fight to end homelessness. However, I would argue that in order for Allegheny County to effectively address homelessness, it must first ensure that services provided meet client needs, that services lead to desired outcomes and that clients are not “lost” in the process of seeking services due to tracking barriers. It must also make certain that homeless service providers in the County have the supports and resources needed in order to effectively collect data and carry out thorough evaluations. As we will discuss in the next section, individual social service agencies still face barriers in collecting data from clients and evaluating the outcomes of their services.

3.0 COMMUNITY HUMAN SERVICES

Community Human Services Corporation (CHSC) is a local non-profit in Pittsburgh, PA. It is housed in South Oakland near the University of Pittsburgh. CHSC was established in 1970 in response to the transience and instability felt in the Oakland community as residents either left Pittsburgh completely or migrated out to the suburbs (Community Human Services Corporation, n.d.). Concerned citizens went door to door seeking other residents who would help in the revitalization of the community. This small group of residents began meeting informally in a drop-in center to share their visions for the community (Community Human Services Corporation, n.d.). Eventually, this group of citizens gave rise to the non-profit Community Human Services Corporation.

Today, CHSC has expanded to include programs that meet a wide variety of needs in the South Oakland community. These programs include health services, mental health services, youth programming in the form of summer camps, and early childhood assistance and family assistance in the Family Foundations Early Head Start program. In addition, CHSC has operated Wood Street Commons since 1986 (Community Human Services Corporation, n.d.). Wood Street Commons is located in downtown Pittsburgh and is a multi-functional site that includes 258 Single Room Occupancy beds for low-income adults and families in Allegheny County. This building also houses various social services, a nursing station, computer lab and library (chscorp.org).

CHSC offers various social services to residents around the city, but of particular import for this paper are its Homeless Assistance Programs. The team at CHS that runs homeless services is called the Supportive Outreach Team. This team offers services that include case management, behavioral health treatment, permanent supportive housing, supportive counseling and various other resources. The Supportive Outreach Team has three major components: Operation Save-A-Life (OSAL), Families United Program and the Supportive Relocation Program (SRP). Operation Save-A-Life is a peer outreach program in which formerly homeless individuals, staff of CHSC and community members go to the streets to offer food, medical care and referrals to homeless individuals (chscorp.org). The Families United Program is a permanent, supportive housing program offered to homeless families and individuals and persons with disabilities. This program assists clients in gaining self-sufficiency by offering intensive case management, household supports, financial literacy training, vocational assistance and education opportunities (Community Human Services Corporation, n.d.).

The third component, the Supportive Relocation Program, was the main focus for the evaluation carried out by a team of students from GSPH under the guidance of Dr. Jaros, BCHS departmental chair at GSPH, and Mac McMahon, director of homeless services at CHSC. The Supportive Relocation Program (SRP) is funded through the Supportive Housing Program grants from HUD (Community Human Services Corporation, n.d. U.S. Department of Housing and Urban Development, 2008). This service provides case management for homeless individuals around housing location, financial stability and one-time rental subsidies. The goal of the program is to transition homeless persons into stable, permanent housing. To be considered for this program, homeless individuals must show proof of income to ensure that they will have enough money to support housing for the long-term. If an individual applies for the program but

does not have stable income, they are referred to an outreach program in CHS where case managers help to identify income possibilities, including but not limited to employment opportunities, SSI or disability (Community Human Services Corporation, n.d.).

Mac McMahon noticed from tracking tools that many clients were either not completing the program or were lost to contact at some point during the application process for SRP. This trend concerned Mac since the SRP program is meant to be one of the final steps at CHS for consumers in moving towards permanent, stable housing. Since this is the ultimate goal of the program, Mac felt that more clients should be successfully completing SRP and partnered with the Graduate School of Public Health to conduct an evaluation of the program based on data from their tracking tool.

3.1 SUPPORTED RELOCATION PROGRAM: EVALUATION

In order to assist CHS with an evaluation of their SRP, Dr. Kenneth Jaros invited several students to help conduct the evaluation. These students included Lisa Greco, Mohammed Ngegba and myself. Tammy Thomas, the Coordinator of Community Programs at GSPH, also sat in on initial meetings to encourage further partnership between GSPH and CHSC. This team from GSPH met several times with Mac McMahon and other employees in the Homeless Assistance Program throughout the spring semester of 2008. It was decided through these meetings that the students would conduct an evaluation by examining the tracking tools used by the SRP program after all identifying information about clients was removed. In addition, based on conversations with Mac about the ultimate goals of the SRP, the students would draft a logic model to assess if the current programs at SRP were meeting the stated goals and outcomes.

Both of these evaluation strategies will be discussed more below. Also, in order to fully understand the programmatic elements of SRP, a flow chart of the different routes that a client can follow through the program was developed to serve as background information for the evaluation.

3.1.1 Flow Chart

Flow charts map out the functions of a program and are useful in assuring that gaps in program flow can be identified through graphic representation (Kaplan & Garrett 2005). Although the flow chart was not originally conducted in the evaluation between GSPH and CHSC, as a part of this thesis the flow chart will help to illuminate how clients navigate through the Supportive Relocation Program.

Figure 2 shows a representation of client flow through SRP. As noted in the flow chart, clients can be terminated at any step along the process if they cannot be contacted or do not provide the necessary documentation. The flow chart starts with a client turning in a hard copy application to the SRP program. At this point, eligibility is determined based on the finances of the client (they must be able to prove that they can support permanent housing) and if they meet the HUD definition of homelessness. Once the application is submitted, an interview is set up with the client. At the interview, the client supplies documentation to prove income and any other required paperwork. Once the interview is completed and all documentation is received, CHSC staff members meet to discuss the client and formally approve the client for SRP. These meetings take place weekly and the client is informed by telephone of their approval after this meeting. After formal acceptance into the program, the client is assigned a case manager that helps them search for permanent housing, they are encouraged to attend a voluntary banking and

budgeting class and they are eligible for first month's rental assistance if needed once permanent housing is found. After the client moves into a permanent residence, they can continue to meet with a case manager for three more months to ensure continued stability or they can reject further case management services. Either way, once permanent housing is found, the client is considered a successful graduate of SRP.

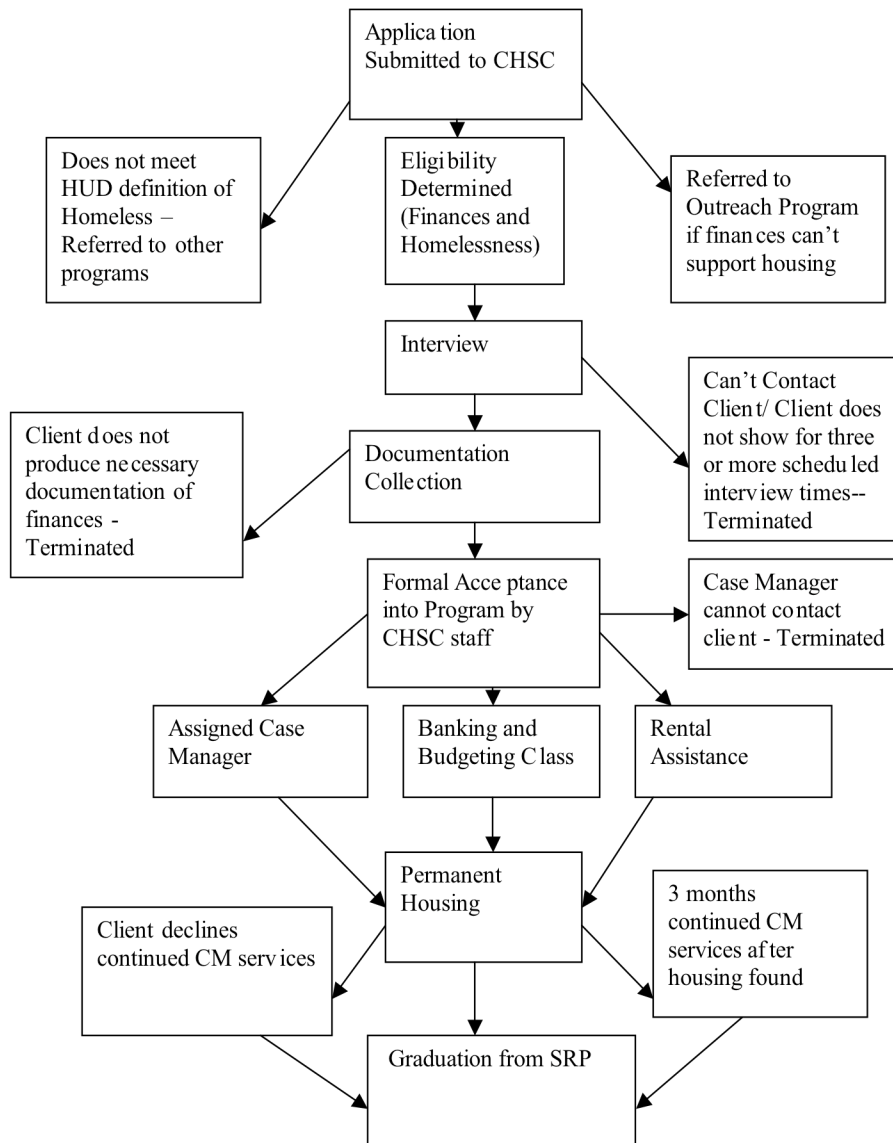


Figure 2. SRP Participant Flow Chart

3.1.2 Logic Model

Logic models in the past several decades have gained popularity as a tool for organizations to plan, manage and evaluate their programs (Kaplan & Garrett 2005, Cooksy, Gill & Kelly, 2001). Logic models provide users with a pictorial ‘map’ of program resources, activities and outcomes. This map shows links between the theory behind the program activities and the outcomes they are meant to achieve (Kaplan & Garrett 2005). Logic models have several uses, including planning new programs, managing ongoing programs and evaluating how programs work.

In order to further the evaluation of the SRP at Community Human Services, the GSPH team decided to develop a logic model based on interviews with Mac McMahon. Laying out a graphic display of the SRP elements and their intended goals not only allowed everyone to see how activities and outcomes fit together, it also ensured that everyone at the table had a clear understanding of the programmatic elements to reduce confusion in the entire evaluative process. Once the logic model was complete, a final review of the product with Mac McMahon uncovered some missing pieces and resulted in the formation of the following logic model:

PROGRAM LOGIC MODEL "Homeless Population in Pittsburgh" Program: Community Human Services: Supportive Relocation Program					
For Whom	Assumptions	Inputs	Activities	Outputs	Outcomes
<ul style="list-style-type: none"> - Homeless Population (based on HUD def'n of Homelessness) -In Allegheny County - Must be able to provide proof of income so that housing is sustainable 	<p>Why is there a problem?</p> <ul style="list-style-type: none"> - Poor financial knowledge among the homeless population -Little or no stable income - Initial barriers to finding housing: Time Upfront costs Knowledge <p>What is the best way to address the problem?</p> <ul style="list-style-type: none"> - Provide Case Management Services - Provide financial help with First month's rent and security deposit -Provide financial literacy training 	<p>Staff for:</p> <ul style="list-style-type: none"> - Case Management -Financial Training -Intake Operations -Database Management - Supervisory roles -\$\$\$ -Space to Work - Transportation for Case manager and client -Referral agencies (within CHS and without) - Education materials for banking and budgeting class 	<ul style="list-style-type: none"> - Intake - Provide \$ for 1st months rent and security deposit - Provide case management for assistance in finding housing - Provide financial training - Provide referrals to other needed resources - Exit Interview 	<ul style="list-style-type: none"> - # of Intakes completed - # of financial trainings offered - # of clients that attend financial trainings -Amount of \$ provided per year for first month's rent -Amount of \$ provided per year for security deposit -# of hours that the case manager spends with clients -# of referrals provided - # of exit interviews <p>Service Completion Homeless person successfully finds housing, provides proof of income, and moves into stable housing.</p>	<p>Intermediate Outcomes:</p> <ul style="list-style-type: none"> - Increase in financial knowledge among homeless persons. - Increase Homeless persons ability to obtain stable income -Decrease barriers to finding housing (time, upfront costs, knowledge) <p>Ultimate Outcome:</p> <ul style="list-style-type: none"> - Decrease in # of homeless persons in Allegheny County

Figure 3. Program Logic Model: Supportive Relocation Program

With the assistance of the logic model depicted in Figure 2, the GSPH team was able to more fully understand the underlying assumptions or theories that guided the practice of employees in the SRP. These theories included what the SRP team identified as causes for continued homelessness such as little or no stable income, poor financial knowledge and upfront barriers to obtaining housing such as knowledge, costs and time. In order to address these barriers, the SRP team sees activities such as providing first month rental subsidies, increasing financial literacy and providing case management services as the most effective method to

address these issues. Not only did the logic model provide a clearer understanding of the SRP staff's theories and expectations, it also provided a constant reminder about how programs were supposed to work so the evaluation team could see if the data showed where there were gaps in services or, on the other hand, where program activities resulted in expected outcomes.

3.1.3 Data Analysis

With an understanding of how SRP employees believed their programs should work in order to assist clients to the fullest extent, the GSPH evaluation team turned to looking at the data spreadsheets provided to them by Mac McMahon. As a personal tool for tracking clients in SRP, Mac keeps an excel spreadsheet with information about client's application to the program, staff's follow-up attempts, when the client is accepted into the program or referred to a different program and when the client graduates from the program. This spreadsheet was provided to the GSPH evaluation team with all identifying data removed. The spreadsheet followed 250 clients that submitted applications to the SRP from August 2006 to March 2008.

Since one of Mac's major concerns about the program was the number of clients that are either 'lost to follow-up' or simply never complete the program, the evaluation team decided to first look at the clients who never complete the program and what the reported reasons were for incompleteness. Out of the 250 clients in the spreadsheet, reasons for completion or incompleteness were listed for 210 clients. Reasons for leaving the program included graduation (fulfilling all requirements of the program and successfully finding and maintaining permanent housing), termination, case manager unable to contact the applicant, applicant refused to participate, applicant was not actually homeless and applicant did not have enough stable income to support

permanent housing. The number of individuals or families that fell into each category is listed in Table 1 below:

Table 1. Reasons for Leaving SRP

<u>Reasons for Leaving SRP</u>	<u>Count</u>
Active	36
Unable to Reach/Locate	29
Client Could not Wait to be Processed	1
Refused to Participate	38
Income too Low	9
No Longer Interested	2
No Proof of Homelessness	1
Not Homeless	29
No Homeplan	2
Moving out of County	1
Over 30 Days	1
Graduated	37
Terminated	24
Total Count	210

As seen from Table 1, 37 out of 210 clients successfully graduated from SRP, which means that SRP has an approximate graduation rate of 18 percent. The percentage of clients that were listed as “Refused to Participate” in the excel spreadsheet was also 18% (38/210) with an additional 14% (29/210) listed as “Unable to Contact.” About 14% (29/210) of the applicants were not actually homeless and were referred to other programs that would suit their needs better. Finally, 24 out of the 210 (11%) of applicants were terminated without an additional reason for termination given.

Given that only 18% of clients successfully graduated from SRP from Aug. 2006 to March 2008, the evaluation team decided to look at factors that they hypothesized might cause such a large number of participants ending up in the “Unable to Contact” or “Refused to Participate” columns. One of the major factors that the evaluation team identified as a possible contributor to termination was the time-efficiency of the application process. Simply by scanning the spreadsheet, the evaluation team could see that many applicants waited over a month from the time they applied to the program to when they were accepted. Given the transience of the homeless population, it would be safe to assume that a large number of applicants might not still reside at the same address/phone number, etc. that they gave when they first applied. In fact, many applicants might not have stable contact information even when they apply to the program.

In order to address the timeliness issue, the evaluation team calculated the Net Work Days between each applicant’s first contact with SRP and their successful completion of the interview, acceptance into the program and graduation/termination date. The team decided to use Net Work Days as it eliminates weekend and holidays so the team could get a clear understanding of how many actual ‘work days’ passed between client’s application and the

various goal marks in the program. The team then averaged all individual client data by adding up total Net Work Days and dividing by the number of clients to get an overall picture of how long client's waited to complete various aspects of SRP.

First, the team found that on average, 27 net work days passed between client's application date to successful completion of the interview. At this interview, a team member from CHS informs clients of the expectations of the programs, the criterion that each client must meet to enroll in the program and how the program itself is run. If clients have proof of homelessness or income, they provide this documentation at the interview or the team member makes a note of missing documentation still needed before acceptance into the program is granted.

If all documentation is provided at the interview, the team member that completed the interview then presents the client's scenario at the next team meeting, which occurs weekly, and the entire SRP team decides whether to grant the client acceptance into the program. Ideally, acceptance should occur rapidly after interview completion as long as all documentation is received. If accepted, the client is assigned a case manager to assist them in finding housing suitable for their needs. The evaluation team found that from the client's interview to their acceptance, an average of 8 net work days, or over a week, elapsed. In addition, the team found that from the application date to the acceptance date, an average of 35 net work days passed. Given that net work days does not include weekends, this means that clients wait on average almost 7 weeks before they hear of they are accepted into the program.

Finally, the evaluation team measured the length of time between application to the program and either graduation or termination of the client. This was seen as a crude measure for how effectively case managers are in contacting the client and helping them receive the needed

services in a timely manner. Based on the data, it seemed that the longer a client remained in the program, the more likely it was that they were missing contacts with the case manager rather than The average number of net work days that elapsed between client application and official leaving of the program was 91 days. The evaluation team noticed, however, that there was a staff turnover of case managers and that the new case manager seemed to assist clients in leaving the program in a more time efficient manner. As shown in figure 4, the team found that the average length of time that clients spent in the program if they were assigned to case manager 1 vs. case manager 2, was 96 net work compared to 33 net work days in the program. It should be noted, however, that more of case manager 2's clients are still active since case manager 2 is still working with SRP while case manager 1 no longer works at SRP. Since case manager 2 has more active clients, it is possible that the number of net work days these active clients spend in the program will skew case manager 2's numbers as these clients either graduate or are terminated from the program.

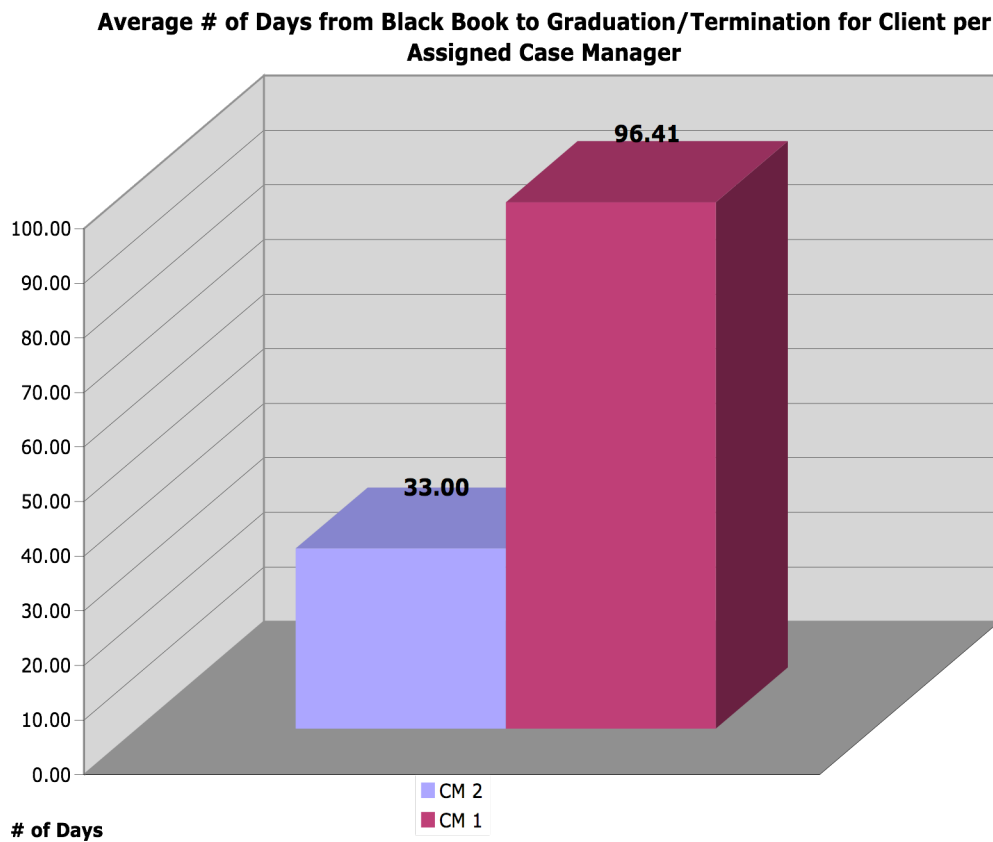


Figure 4. Client’s Average Length in SRP per assigned Case Manager

As seen from this analysis of SRP’s data, particularly the number of net work days from client’s application to client’s acceptance into the program, a major factor that may contribute to a large number of clients being lost to follow-up is the length of time that it takes for clients to actually gain acceptance into the program. One of the possible causes for the drawn-out timeline of the application process is the fact that the application and some of the subsequent communications are paper-based. The applicant sends a paper application to CHS by either sending it in the mail or hand-delivering it to CHS offices. After the in-person interview is completed, a letter is sent to the applicant that notifies them of their pending status and gives a

list of any additional application materials that are needed. Since the homeless population is notoriously transient, it is possible that many applicants do not have a stable enough address at which to receive mailings and may not realize the status of their application, thereby seeking help from other sources or moving to another area without notifying CHS. However, this is a hypothetical cause and effect and would need further evaluation to help ascertain its accuracy.

As seen in this brief data analysis, the need for effective and thorough tracking and evaluation is paramount to ensuring that homeless programs provide the best possible care for their clients. Only through constant assessment of program outcomes and impacts can an agency know if its services are reaching those that need them and if they are having the expected impact. In light of this, it is important to examine some innovative and promising practices in homeless tracking and evaluation in order to provide further ideas for tracking and evaluation at homeless service providers in Allegheny County.

4.0 INNOVATIVE TRACKING AND EVALUATION: PHILADELPHIA, PA

For this next section, we will examine innovative tracking and evaluation processes in Philadelphia, PA. Philadelphia was chosen as a model city for this paper due to its successes with using innovative programs to assist homeless people in finding adequate, permanent housing. In fact, Philadelphia is nationally known as an exemplar city for its ability to get homeless people off the street and into housing (Fagan 2004, Rose 2007). In the mid-nineties, over 800 people slept on the streets of Philadelphia on any given night, whereas in 2004 less than 300 people were on the streets on any given night, a reduction of over 50% (Rose 2007). There has recently been a resurgence in the number of street homeless, with 600 people on any given night sleeping on the streets in 2007 (Rose, 2007). However, many still view Philadelphia as a success story in its reduction of the number of homeless and its multidisciplinary tactic to achieve this goal.

In this section, we will focus on two innovative strategies to track the homeless and evaluate success in the city of Philadelphia. The first will focus on tracking systems set up at the city-wide level to assist in creating accurate tallies of the number of homeless and the services they use, while the second success story will focus on an individual social service agency and its innovative methods for tracking and evaluating program performance.

4.1 WEBFOCUS

In 2003, the city of Philadelphia was awarded an Innovative use of Technology Award for its adaptation of WebFOCUS, an Internet based tracking and reporting system, for use with the Homeless population in Philadelphia. The Office of Mental Health and Mental Retardation in the City of Philadelphia wanted to use an internet-based system because it not only allowed users to create useful reports with little training or effort, but it also allowed an array of social service agencies to be linked into the same reporting system. In this way, a social service agency can see if a hard to reach client is receiving services from other providers linked into the WebFOCUS system. Initially, this program was adopted for use within the Office of Mental Health and Mental Retardation, but it has since expanded to tracking clients reached through Homeless Outreach programs in Philadelphia (Information Builders, n.d.).

Dutch Klugman, the director of Research and Information Management in the Office of Mental Health and Mental Retardation, used WebFOCUS to create a tracking system called Homeless Outreach that monitors use of services among the homeless population contacted by outreach workers in Philadelphia. Using WebFOCUS for this tracking purpose allows users to update information about clients from anywhere with internet access, while also allowing reports to show frequency of use and links between clients served by homeless service providers and other social services within the City of Philadelphia. With multiple service providers using the same reporting system, data is not only easier to access and understand, it also can be used to track clients throughout a complex system (Information Builders, n.d.).

In order to implement WebFOCUS, the city of Philadelphia applied for a state technology grant in order to purchase the software rights for WebFOCUS. The popularity and success of WebFOCUS at the Office of Mental Health and Mental Retardation is creating an expansion of

its use to other social service providers in the city including mental health residential providers and crisis response teams. WebFOCUS is used in conjunction with the HMIS system to provide comprehensive and up-to-date information about the City's homeless population (Information Builders, n.d.).

4.2 PROJECT H.O.M.E.

Project H.O.M.E. (Housing, Opportunities for Employment, Medical Care, Education) is a non-profit organization in Philadelphia dedicated to empowering the homeless in their search for housing and living their fullest in society. The organization also is a strong voice for advocacy and addressing the underlying causes of homelessness in Philadelphia (Project Home, n.d., Coughy et al., 1999). The organization was co-founded in 1989 by Sister Mary Scullion and Joan Dawson McConnon to help address the large number of street homeless that were struggling to survive through the winter months in Philadelphia. Project H.O.M.E. started as a severe weather emergency shelter and has since expanded into a continuum of care for homeless individuals that offers supported housing, employment assistance, education and medical care for the homeless. They currently offer 447 housing units and three businesses including a café, thrift shop and catering company that are run by formerly homeless individuals (Project Home, n.d.).

With their expansion and growth, Project H.O.M.E. has throughout their tenure ensured that their programs are making a difference and meeting the needs of the homeless in their neighborhood. Some of the evaluations run by PROJECT H.O.M.E. are typical outcome evaluations required by funding agencies such as the U.S. Department of Housing and Human Services (Coughy et al., 1999). However, as they have grown and expanded, Project H.O.M.E.

has participated in more innovative evaluation strategies including an ethnographic research report on the nature and evolution of leadership within Project H.O.M.E (Hall, 2005). In all of their evaluation and tracking strategies, however, Project H.O.M.E. has utilized the resources and knowledge of trained evaluators and professionals outside of their agency. This emphasis on recruiting outside help has lessened the financial and personnel demand that these evaluations usually take on a social service agency. We will look in-depth at the planning portion of an evaluation strategy recently implemented at Project H.O.M.E. as a marker for how other social service agencies can address evaluation needs within their organization.

4.2.1 Strategic Plan for 2005-2010

In 2005, Project H.O.M.E. outlined their strategic vision for the coming five years. Strategic plans are meant to provide a guideline for how organizations will operate and what they will achieve through their programs. These plans are important in that they offer a guideline for what the organization expects to achieve and how they will measure their achievement. As mentioned in the evaluation section, planning is essential in order for effective evaluations to occur. If planning is not undertaken at the beginning of a project, the data needed to conduct a thorough evaluation may be overlooked. In addition, setting goals and objectives at the outset assists evaluators in addressing if these goals were met (Scullion, Mc Connon & Davis 2005).

In order for a strategic vision to be effective for an organization, it must provide specific goals, objectives and expected outcomes. These will provide the framework for evaluations in the future. It is also necessary to involve as many key stakeholders as possible to ensure that all sides of an issue are discussed and that feasible objectives are set. In both of these areas, Project

H.O.M.E. has excelled with the creation of their strategic plan called Vision of H.O.M.E., strategic plan 2005-2010.

First, Project H.O.M.E. outlined 9 overall goals for the years 2005-2010. These goals include:

- 1. Significantly reduce and strive to eliminate street homelessness by deepening and strategically expanding programs and services*
- 2. Expand and enhance education and employment initiatives that empower program participants and broaden opportunities for increased income.*
- 3. Create an environment that promotes the physical health of residents and staff*
- 4. Maximize Project H.O.M.E.'s leadership position on homelessness, affordable housing and poverty issues to benefit the communities we serve.*
- 5. Promote health, safety and sustainability in the St. Elizabeth/Diamond Street community, and further economic development of the Ridge Avenue commercial corridor.*
- 6. Build and maintain the organizational strength and capacity to operate current and future programs and services.*
- 7. Effectively communicate the impact, viability, and success of Project H.O.M.E. programs and services.*
- 8. Manage all physical assets in a cost-effective and efficient manner for the health and safety of all residents and employees.*
- 9. Maintain and expand the financial resources and viability of Project H.O.M.E* (Scullion, Mc Connon & Davis 2005).

As seen from this list, these goals are broad ideas of what the organization hopes to achieve from 2005-2010. Even though these goals are broad, they each address specific evaluation points within Project H.O.M.E. For example, goal one speaks to evaluating how the organization meets the needs of the homeless through programs and services while goal 8 speaks to how the agency manages financial resources and ensures the safety of all residents and employees. These two goals, both equally important, will most likely lead to evaluation strategies that will address very different functions of the agency. In this way, these goals are comprehensive and provide the framework for multiple forms of evaluation.

After the goals are outlined, each goal is split into objectives and outcomes. The objectives each delineate what strategies the agency will use to meet their goals. The outcomes for each objective give specific and measurable guidelines for how the agency will know that the objective is met. For example, goal one, *significantly reduce and strive to eliminate street homelessness by deepening and strategically expanding programs and services*, is split into five different objectives. One of these five objectives is to deepen the level of engagement with outreach coordination clients. If the agency successfully implements this objective, the strategic vision states that the following outcomes should be met:

- Increase the numbers of chronically homeless OCC clients who are placed in housing to 65%; and linked with behavioral health services to 50% by 2010.
- Increase the numbers of episodically homeless OCC clients who are placed in housing to 35% by 2010.
- Increase the percentage of OCC clients who are linked with jobs and employment to 15% by 2010 (Scullion, Mc Connon & Davis 2005).

These outcomes are specific and measurable to ensure that when evaluators look at the program's outcomes, they will see if the goals that the agency set were actually met. By detailing the expected outcomes during planning phases, an agency can ensure that the evaluation of the program is not only less time consuming and difficult, but that it will also provide meaningful data on the successes and advancement of the agency mission and goals.

It is also important to note that Project H.O.M.E. involved many different stakeholders in the planning process to ensure that the goals and objectives of the agency are in compliance with the needs of the community. For this strategic plan, Project H.O.M.E. sought input from local community organizers, trustee members, employees in the different programs of Project H.O.M.E. and residents that use the services provided by Project H.O.M.E. By bringing a wide array of voices to the table, Project H.O.M.E. ensures that the services provided and their expected outcomes are in keeping with all stakeholder expectations (Scullion, Mc Connon & Davis 2005).

5.0 KEY QUESTIONS FOR CHSC

Finally, as a culmination of the information provided in this paper, it is time to consider how to move forward with this information. Since no two homeless service providers are exactly alike, it seems fitting that this section focus on the unique circumstances at CHSC and how they can think about tracking and evaluation for the future. The questions posed here are meant as a starting point for CHSC as they are constantly looking to improve their tracking and evaluation efforts in order to best serve their clients. These questions will focus on both the information gleaned from the evaluation conducted by GSPH students and CHSC staff and also the best practices as represented by Project H.O.M.E. and WebFOCUS in Philadelphia.

Questions based on GSPH evaluation:

Since staff at CHSC identified the number of clients being ‘lost to contact’ as a major focus of concern, the first set of questions focuses on tracking and evaluation around this concern.

- What do CHSC staff members see as a target graduation rate for the SRP program?
- What do CHSC staff members see as a target guideline for how long the intake process should take from application date to acceptance date?
- After acceptance, how long do CHSC staff members think clients should remain in program?

- Are there standard guidelines in place for how/when a client should be terminated? (I.e. A certain number of contact attempts? A certain period of time passes without hearing from the client?)
- How do staff members determine when a client should be terminated? (I.e. A certain number of failed contact attempts, a certain period of time without contact? Etc.?)
- Do staff members feel that there are problems with the current program application and client flow through the program? If so, would it be possible to conduct further evaluations on these concerns?
- Are there any client feedback opportunities currently in place? Would client feedback be helpful in future evaluations at CHSC?

Questions based on Best Practices:

This thesis focused on Philadelphia as a model for homeless service evaluation and tracking due to their history of success in this area and recent innovative tracking methods such as WebFOCUS. This next set of questions will focus on if/how CHSC staff could see these changes being implemented both at the agency level and at a larger system level in Allegheny County. This section will also ask questions about resources and needs felt at CHSC.

- What resources does CHSC currently have for tracking and evaluation?
- Are the current resources enough for tracking and evaluation needs?
- How could partnerships, such as those created by Project H.O.M.E. with local universities, be used to further CHSC's evaluation and tracking needs?

- At a systems-level, does CHSC feel that the homeless network of providers share enough information about tracking and evaluation? How could this system of communication be improved?
- If a web-based reporting system were implemented in Allegheny County, what resources or supports would CHSC need to implement new tracking strategies?
- Would a web-based system, where social service agencies could track clients across systems be helpful to CHSC in assisting homeless clients? How would it be helpful?

Again, as stated above, these questions are meant to be a starting block for CHSC as they conduct future evaluations and are in no means exhaustive. Since social service providers, such as CHSC, are constantly changing to meet the needs of clients, so too must tracking and evaluation strategies. In order to effectively track clients and evaluate programs, it is sometimes necessary to first sit back and ask exactly what goals and resources will be effecting evaluation and tracking while also brainstorming about innovative ways to update these strategies.

6.0 CONCLUSION

Throughout this paper, I have discussed both national and local efforts to improve tracking and evaluation of homeless service programs and the clients they serve. This effort is vitally important because homelessness still poses a major problem in our country. Estimates suggest that 600,000 to 700,000 individuals are homeless on any given night in America (National Law Center on Homelessness and Poverty). These individuals face multiple problems including health issues, mental health problems and potentially, death (Kushel, Vittinghoff, Haas 2008). However, in our efforts to ease the risks to this population, we must first understand how effective our programs are in addressing these complex problems. In order to effectively evaluate the programs and their successes, we must also implement thorough tracking systems that will supply the data needed. This paper discusses both the history of tracking and evaluation efforts and current methods to conduct evaluations such as consumer satisfaction surveys, process evaluations and logic modeling and finally, outcomes-based evaluations.

After this background information, the paper focused on local issues with implementing effective evaluation and tracking methods. Community Human Services Corporation was used as a case study in the resource constraints and limitations that many local homeless service providers face as they attempt to track clients in their program and evaluate the effectiveness of their programs. Many of these constraints are intimately linked to financial and personnel constraints in implementing evaluations and tracking methods. Not only are financial and

personnel constrains an issue for homeless service providers, they are also an issue for larger, aggregate studies of homelessness based on County-level information. Although much of this information is now generated through the HMIS reporting system required by HUD for all CoC's, the information is not often used to provide reports on County accomplishments in homeless service delivery or gaps in services still felt throughout the county. To address some of these missing pieces, I ended this paper with a set of questions focused on how to improve tracking and evaluation at homeless service providers such as CHSC. These questions are meant as a starting point for thinking about how to address some of the constraints felt at individual homeless service providers.

As evidenced throughout this paper, tracking and evaluation are key components in assuring that our knowledge of homelessness increases, our programs effectively serve the homeless population and the money for homeless services is utilized in a responsible way. By furthering the sophistication of evaluation and tracking efforts with the homeless, we can ensure that our efforts to end homelessness today are not in vain, but are in fact providing the best care possible to the homeless clients we serve.

APPENDIX A

UNIVERSAL DATA ELEMENTS FOR HMIS

Section 1: General Overview and Data Collection Standards

The U.S. Department of Housing and Urban Development's (HUD) Homeless Management Information System (HMIS) Data and Technical Standards (the HMIS Standards) were published in the Federal Register on July 30, 2004 with an effective date of August 30, 2004. The HMIS Standards define requirements for implementation of HMIS including:

- Data elements and definitions;
- Participation requirements for homeless service programs;
- Privacy standards for data collection, uses and disclosures;
- Security standards for protection of client information; and
- Technical standards for the storage and removal of data.

The HMIS Standards apply to all recipients of HUD McKinney-Vento Act program funds including:

- Emergency Shelter Grant (ESG);
- Supported Housing Programs (SHP);
- Shelter plus Care (S+C);
- Section 8 Moderate Rehabilitation for Single Room Occupancy (SRO); and
- Housing Opportunities for Persons with AIDS (HOPWA) projects that target homeless persons.

HUD also encourages participation of other federal and non- federal programs that serve

homeless persons. HUD created the HMIS Standards for five main reasons:

- To understand the extent and scope of homelessness (who, how many, service use/needs) by collecting client data in a uniform, consistent, and accurate manner across programs by:
 - Providing clear and precise meanings for the types of information collected by local homeless assistance providers; and
 - Ensuring that providers are collecting the same types of information consistently.
- To help further standardize reporting across federal programs and other programs that provide homeless services.
- To help protect client confidentiality and the storage, use and disclosure of client data through uniform privacy and security provisions.
 - Set high baseline standards for all users of HMIS data; and
 - Provide important safeguards for personal information collected from all homeless clients.
- Plan for the reduction/ending of homelessness with uniform, longitudinal data by which to make effective programming decisions to reduce or end homelessness.

The HMIS Standards have the potential to greatly streamline reporting requirements and permit analysis of how programs are working together to address homelessness. The specific data elements and data collection requirements are outlined in the HMIS Standards. There are two types of data elements:

Universal Data Elements

Chart A: Universal Data Elements	
Universal Data Elements	Response Categories
Name	Example: John David Doe Jr.
Social Security Number	-- _ / _ / -- _ _ (e.g., 123 45 6789) 1 = full SSN reported. 2 = Partial SSN reported. 8 = Don't know or don't have SSN. 9 = Refused.
Date of Birth	_ _ / _ _ / _ _ _ _ _ (e.g., 08/31/1965)
Ethnicity and Race	Ethnicity: 0 = Non-Hispanic/Latino. 1 = Hispanic/Latino. Race: 1 = American Indian or Alaska Native. 2 = Asian. 3 = Black or African American. 4 = Native Hawaiian or Other Pacific Islander. 5 = Other.
Gender	0 = Female. 1 = Male.
Veterans Status	0 = No.

Universal Data Elements Universal Data Elements Response Categories

<p>1 = Yes. 8 = Don't Know. 9 = Refused.</p>	
<p>Disabling Condition</p>	<p>0 = No. 1 = Yes. 8 = Don't Know. 9 = Refused.</p>
<p>Residence Prior to Program Entry Length of Stay in Pervious Place</p>	<p>1 = Emergency Shelter (including a youth shelter, or hotel, motel, or campground paid for with emergency shelter voucher). 2 = Transitional Housing for Homeless persons (including homeless youth). 3 = Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab). 4 = Psychiatric hospital or other psychiatric facility. 5 = Substance abuse treatment facility or detox center. 6 = Hospital (non-psychiatric). 7 = Jail, prison or juvenile detention facility. 10 = Room, apartment, or house that you rent. 11 = Apartment or house that you own. 12 = Staying or living in a family member's room, apartment, or house. 13 = Staying or living in a friend's room, apartment, or house. 14 = Hotel or motel paid for without emergency shelter voucher. 15 = Foster care home or foster care group home. 16 = Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside). 17 = Other. 8 = Don't know. 9 = Refused. 1 = One week or less. 2 = More than one week, but less than one month. 3 = One to three months 4 = More than three months, but less than one year. 5 = One year or longer.</p>

Universal Data Elements Universal Data Elements Response Categories

<p>Zip Code of Last Permanent Address Zip Data Quality Code</p>	<p>____ (e.g., 12345) 1 = Full Zip Code Recorded. 2 = Don't Know. 3 = Refused.</p>
<p>Program Entry Date</p>	<p>--/--/---- (e.g., 01/30/2004)</p>
<p>Program Exit Date</p>	<p>--/--/---- (e.g., 01/31/2004)</p>
<p>Person ID Number*</p>	<p>A PIN must be created, but there is no required format as long as there is a single unique PIN for every client served in the CoC and it contains no personally identifying information.</p>
<p>Program ID Number*</p>	<p>10 –digit FIPS code identifying geographic location of provider.</p>
<p>Household ID Number*</p>	<p>A Household ID number must be created, but there is no required format as long as the number allows for identification of clients that receive services as a household.</p>

Program-Specific Data Elements Response Category

<p>Total monthly income.....</p>	<p>13 = Child support 14 = Alimony or other spousal support 15 = Other source 16 = No financial resources </p>	<p>-----.00 -----.00 -----.00 -----.00 -----.00 -----.00 \$-----.00</p>
<p>Non-Cash Benefits</p>	<p>1 = Food Stamps or money for food on a benefits card 2 = MEDICAID health insurance program 3 = MEDICARE health insurance program 4 = State Children’s Health Insurance Program 5 = Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC) 6 = Veteran’s Administration (VA) Medical Services 7 = TANF Child Care Services 8 = TANF transportation services 9 = Other TANF-funded services 10 = Section 8, public housing, or other rental assistance 11 = Other Source</p>	
<p>Physical Disability</p>	<p>0 = No 1 = Yes</p>	
<p>Developmental Disability</p>	<p>0 = No 1 = Yes</p>	
<p>HIV/AIDS</p>	<p>0 = No 1 = Yes</p>	
<p>Mental Health Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently</p>	<p>0 = No 1 = Yes 0 = No 1 = Yes</p>	

Program-Specific Data Elements Response Category

<p>Substance Abuse Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently</p>	<p>1 = Alcohol Abuse 2 = Drug abuse 3 = Dully diagnosed 0 = No 1 = Yes</p>
<p>Domestic Violence If Yes, When experience occurred</p>	<p>0 = No 1 = Yes 1 – Within the past three months 2 = Three to six months ago 3 = From six to twelve months ago 4 = More than a year ago 8 = Don't Know 9 = Refused</p>
<p>Services Received (Date) Service Type</p>	<p>__/__/____ (e.g., 01/31/2004) 1 = Food 2 = Housing placement 3 = Material goods 4 = Temporary housing and other financial aid. 5 = Transportation 6 = Consumer assistance and protection 7 = Criminal justice/legal services 8 = Education 9 = Health Care 10 = HIV/AIDS-related services 11 = Mental Health care/counseling 12 = Substance abuse services 13 = Employment 14 = Case/care management 15 = Day Care</p>

Program-Specific Data Elements Response Category

<p>16 = Personal enrichment 17 = Outreach 18 = Other</p>	
<p>Destination Tenure Subsidy Type</p>	<p>1 = Emergency Shelter (including a youth shelter, or hotel, motel, or campground paid for with emergency shelter voucher). 2 = Transitional Housing for Homeless persons (including homeless youth). 3 = Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab). 4 = Psychiatric hospital or other psychiatric facility. 5 = Substance abuse treatment facility or detox center. 6 = Hospital (non-psychiatric). 7 = Jail, prison or juvenile detention facility. 10 = Room, apartment, or house that you rent. 11 = Apartment or house that you own. 12 = Staying or living in a family member's room, apartment, or house. 13 = Staying or living in a friend's room, apartment, or house. 14 = Hotel or motel paid for without emergency shelter voucher. 15 = Foster care home or foster care group home. 16 = Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside). 17 = Other 8 = Don't Know 9 = Refused 1 = Permanent 2 = Transitional 8 = Don't Know 9 = Refused 0 = None 1 = Public Housing 2 = Section 8 3 = S+C</p>

Program-Specific Data Elements Response Category

<p>4 = HOME Program 5 = HOPWA Program 6 = Other housing subsidy 8 = Don't Know 9 = Refused</p>	
<p>Reasons for Leaving</p>	<p>1 = Leaving for a housing opportunity before completing program 2 = Completed program 3 = Non-payment of rent/occupancy charge 4 = Non-compliance with project 5 = Criminal activity/destruction of property/violence 6 = Reached maximum time allowed by project 7 = Needs could not be met by project 8 = Disagreement with rules/person 9 = Death 10 = Unknown/disappeared 11 = Other</p>
<p>Employment If currently working, number of hours worked in past week. Employment Tenure If client is not currently employed, is the client looking for work.</p>	<p>0 = No 1 = Yes ___ hours 1 = Permanent 2 = Temporary 3 = Seasonal 0 = No 1 = Yes</p>
<p>Education Received vocational training or apprenticeship certificates</p>	<p>0 = No 1 = Yes 0 = No 1 = Yes</p>

Program-Specific Data Elements Response Category

<p>Highest level of school completed</p> <p>If client has received a high school diploma, GED or enrolled in post-secondary education, what degree(s) has the client earned</p>	<p>0 = No schooling completed</p> <p>1 = Nursery school to 4th grade</p> <p>2 = 5th grade to 6th grade</p> <p>3 = 7th grade to 8th grade</p> <p>4 = 9th grade</p> <p>5 = 10th grade</p> <p>6 = 11th grade</p> <p>7 = 12th grade, no diploma</p> <p>8 = High school diploma</p> <p>9 = GED</p> <p>10 = Post-secondary school</p> <p>0 = None</p> <p>1 = Associates Degree</p> <p>2 = Bachelors</p> <p>3 = Masters</p> <p>4 = Doctorate</p> <p>5 = Other graduate/professional degree</p>
<p>General Health Status</p>	<p>1 = Excellent</p> <p>2 = Very good</p> <p>3 = Good</p> <p>4 = Fair</p> <p>5 = Poor</p> <p>6 = Don't Know</p>
<p>Pregnancy Status</p> <p>Due date</p>	<p>0 = No</p> <p>1 = Yes</p> <p>__/__/____ (e.g., 01/31/2004)</p>
<p>Veteran's Information</p> <p>Military service eras</p>	<p>1 = Persian Gulf Era (August 1991 – Present)</p> <p>2 = Post Vietnam (May 1975 – July 1991)</p> <p>3 = Vietnam Era (August 1964 – April 1975)</p> <p>4 = Between Korean and Vietnam War (February 1955 – July 1964)</p>

Program-Specific Data Elements Response Category

<p>Duration of active duty Served in a war zone If yes, name the war zone If yes, number of months in war zone If yes, received hostile or friendly fire Branch of the military Discharge Status</p>	<p>1950) 1940)</p> <p>5 = Korean War (June 1950 – January 1955) 6 = Between WWII and Korean War (August 1947 – May 1950) 7 = World War II (September 1940 – July 1947) 8 = Between WWI and WWII (December 1918 – August 1940) 9 = World War 1 (April 1917 – November 1918) ___ months 0 = No 1 = Yes 1 = Europe 2 = North Africa 3 = Vietnam 4 = Laos and Cambodia 5 = South China Sea 6 = China, Burma, India 7 = Korea 8 = South Pacific 9 = Persian Gulf 10 = Other ___ months 0 = No 1 = Yes 1 = Army 2 = Air Force 3 = Navy 4 = Marines 5 = Other 1 = Honorable 2 = General 3 = Medical</p>
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Program-Specific Data Elements Response Category

<p>4 = Bad conduct 5 = Dishonorable 6 = Other</p>	
<p>Children's Education If yes, name of the child's school If yes, type of school If not enrolled, last date of enrollment If not enrolled, identify problems in enrolling child</p>	<p>0 = No 1 = Yes _____ (e.g., Lone Pine Elementary School) 1 = Public school 2 = Parochial or other private school __/____ (e.g., 01/2004) 1 = None 2 = Residency requirements 3 = Availability of school records 4 = Birth certificates 5 = Legal guardianship requirements 6 = Transportation 7 = Lack of available preschool programs 8 = Immunization requirements 9 = Physical examination records 10 = Other</p>

BIBLIOGRAPHY

- Aaronson, D.E., Dienes, C.T. & Musheno, M.C. (1978). Changing the public drunkenness laws: The impact of decriminalization. *Law and Society Association, 12*(3), pp. 405-436.
- Allegheny County Continuum of Care (2007). Fiscal Year 2006-2007 Fact Sheet.
- Allegheny County Department of Human Services (2008, June 25). *Homelessness in Allegheny County*. Grantmakers of Western Pennsylvania.
- Allegheny County Homeless Alliance (2005). Allegheny County Homeless Alliance Quaterly Report. Accessed 11/2/08 from http://www.alleghenycounty.us/uploadedFiles/DHS/Basic_Needs/Housing_and_Homelessness/SupSvcsCurrent.pdf
- Allen, D.M., Lehman, S.J., Green, T.A., Lindegren, M.L., Onorato, I.M., Forrester, W. (1994). HIV infection among homeless adults and runaway youth, United States, 1989-1992. *AIDS, 8*(11), pp. 1593-1598.
- Bachrach, L.L. (1984). Research on services for the homeless mentally ill. *Hospital and Community Psychiatry, 35*(9), pp. 910-914.
- Burt, M.R., Aron, L.Y., Douglas, T., Valente, J., Lee E. & Iwen, B. (1999). Homelessness: Programs and the people they serve- findings of the national survey of homeless assistance providers and clients. *Urban Institute*.
- Burt, M., Aron, L.Y., Lee, E. & Valente, J. (2007). Helping America's homeless: Emergency shelters or affordable housing? *The Urban Institute*. Last accessed 11/1/08 from www.urban.org/pubs/homeless/chapter1.html
- Cisnero, H.G. (1995). Legacy for a reinvented HUD: charting a new course in changing and demanding times. *Cityscape: A Journal of Policy Development and Research, 1*(3), pp. 145-152.
- Clark, C. & Rich, A.R. (2003). Outcomes of homeless adults with mental illness in a housing program and in case management only. *Psychiatric Services, 54*, pp. 78-83.
- Cooksy, L.J., Gill, P., Kelly, P.A. (2001). The program logic model as an integrative framework for a multimethod evaluation. *Evaluation and Program Planning, 24*, pp. 119-128.

- Coughey, K., Feighan, K. Lavelle, K., Olson, K., DeCarlo, M., Medina, M. (1999). Project H.O.M.E.: A comprehensive program for homeless individuals with mental illness and substance use disorders. *Alcoholism Treatment quarterly*, 17(1/2), pp. 133-148.
- Culhane, D.P. (1995). Federal plan to address homelessness recognizes size, complexity of problem. *Housing Research News*, 3(1), pp. 1-3.
- Culhane, D.P. & Metraux, S. (1997). Where to from here? A policy research agenda based on the analysis of administrative data. *Understanding Homelessness: New Policy and Research Perspectives*. Fannie Mae Foundation
- Culhane, D.P., Eldridge, D., Rosenheck, R., Wilkins, C. (1998). Making homelessness programs accountable to consumers, funders, and the public. 1998 National Symposium on Homelessness Research. Accessed on 11/20/08 from: <http://aspe.hhs.gov/homeless/symposium/4-account.htm>
- Culhane, D.P., Gross, K.S., Parker, W.D., Poppe, B. & Sykes, E. (2008). Accountability, cost-effectiveness, and program performance: Progress since 1998. School of Social Policy Practice, Department Papers, University of Pennsylvania.
- Drake, R.E., Becker, D.R., Bond, G.R., Mueser, K.T. (2003). A process analysis of integrated and non-integrated approaches to supported employment. *Journal of Vocational Rehabilitation*, 18, pp. 51-58.
- Econsult Corporation (2007). Project H.O.M.E.'s economic and fiscal impact on Philadelphia neighborhoods.
- Ensign, J. & Gittelsoh, J. (1998). Health and access to care: Perspectives of homeless youth in Baltimore City, U.S.A. *Social Science & Medicine*, 47(12), pp. 2087-2099.
- Eyrich-Garg, K.M., Cacciola, J.S., Carise, D., Lynch, K.G., McLellan, A.T. (2008). Individual characteristics of the literally homeless, marginally housed, and impoverished in a US substance abuse treatment-seeking sample. *Social Psychiatry and Psychiatry Epidemiology*, 43, pp. 831-842.
- Fagan, Jr. & Mauss (1978). Padding the revolving door: An initial assessment of the uniform alcoholism and intoxication treatment act in practice. *Social Problems*, 26(2), pp. 232-246.
- Fagan, K. (2004, June 21). *Philadelphia's homeless efforts praised*. The San Francisco Chronicle.
- Finn, P. (1985). Decriminalization of public drunkenness: Response of the health care system. *Journal of Studies on Alcohol*, 46(1), 1985.

- Folsom, D.P., Hawthorne, W., Lindamer, L., Gilmer, T., Bailey, A., Golshan, S., Garcia, P., Unutzer, J., Hough, R. & Jeste, D.V. (2005). Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system. *American Journal of Psychiatry*, 162, pp. 370-376.
- Franke, M. & Herb, M (2007). The \$25,000 pyramid: Financial management for HMIS grantees. HMIS Grant Administration & Project Management Training Power Point. Last accessed from the World Wide Web on 11/20/08 at <http://www.hud.gov/offices/cpd/homeless/hmis/>
- Goering, P., Paduchak, D. & Durbin, J. (1990). Housing homeless women: A consumer preference study. *Hospital & Community Psychiatry*, 41, pp. 790-794.
- Greene, J.C. (1994). *Qualitative program evaluation: Practice and promise*. Handbook of Qualitative Research, Columbia University.
- Hall, K. (2005). *Until all of us are home: The process of leadership at Project H.O.M.E.* University of Pennsylvania.
- Hunger and Homelessness Survey (2007). A status report on hunger and homelessness in America's cities: A 23-city survey. Last accessed on 10/1/08 from <http://www.usmayors.org/HHSurvey2007/hhsurvey07.pdf>
- Information Builders (n.d.). Web-based reporting enhances Philadelphia's social services. Last accessed 11/10/08 from <http://www.informationbuilders.com/applications/philly.html>
- Johnson, A. (2007, Dec 13th). Mortgage crisis inflicts collateral damage: Marriages, families, tax revenues fall victim to wave of foreclosures. *MSNBC*. Accessed 11/1/08 from <http://www.msnbc.msn.com/id/22246203/>
- Julian, D.A., Jones, A. & Deyo, D. (1995). Open systems evaluation and the logic model: Program planning and evaluation tools. *Evaluation and Program Planning*, 18(4), pp. 333-341.
- Kaplan, S.A. & Garrett, K.E. (2005). The use of logic models by community-based initiatives. *Evaluation and Program Planning*, 28, pp. 167-172.
- Koegel, P., Burnam, M.A. & Morton, S.C. (1996). Enumerating homeless people. *Evaluation Review*, 20(4), pp. 378-403.
- Kushel, M.B., Vittinghoff, E., Haas, J.S. (2001). Factors associated with the health care utilization of homeless persons. *JAMA*, 285(2), pp. 200-206.
- Lamb, H.R. (1986). The homeless mentally ill. A task force report of the American Psychiatric Association. Washington, D.C.: American Psychiatric Association.

- Malone, K. (2008, July 2). United Way forcing agencies to compete to get full funding. *Pittsburgh Post-Gazette*. Accessed 11/3/08 from <http://www.post-gazette.com/>.
- Marks, S.M., Taylor, Z., Burrows, N.R., Qayad, M.G., Miller, B. (2000). Hospitalization of homeless persons with tuberculosis in the United States. *American Journal of Public Health, 90*(3). pp. 435-438.
- Miesher, A., & Galanter, M. (1996). Shelter-Based Treatment of the Homeless Alcoholic. *Journal of Substance Abuse Treatment, 13*, pp. 135-40.
- Mercier, C., Fournier, L. & Péladeau, N. (1992). Program evaluation of services for the homeless: Challenges and strategies. *Evaluation and Program Planning, 15*, pp. 417-426.
- Mitka, M. (2006). Chronic homeless in intervention spotlight. *JAMA, 295*, pp. 2344-2345.
- Mowbray, C.T., Bybee, D., Collins, M.E. & Levine, P. (1998). Optimizing evaluation quality and utility under resource constraints. *Evaluation and Program Planning, 21*(1), pp. 59-71.
- Mowbray, C.T., Cohen, E. & Bybee, D. (1993). The challenge of outcome evaluation in homeless services: Engagement as an intermediate outcome. *Evaluation and Program Planning, 16*(4), pp. 337-346.
- Mulroy, E.A. & Lauber, H. (2004). A user-friendly approach to program evaluation and effective community interventions for families at risk of homelessness. *Social Work, 49*(4), 2004.
- n.a. (2005). *Ending Homelessness Now: Creating New Partnerships for Change*. Ten Year Plan, Allegheny County, PA.
- National Coalition for Homeless Veterans (n.d.). *HUD Continuum of Care brochure*. Accessed 11/12/08 from <http://www.nchv.org/docs/HUD%20CoC%20brochure%209.14.04.pdf>
- National Coalition for the Homeless. (2008). *McKinney/Vento Act. Fact sheet no.18*. National Coalition for the Homeless, Washington, D.C. Last accessed 11/1/08 from <http://www.nationalhomeless.org/publications/facts/mckinney.html>
- National Law Center on Homelessness and Poverty (2007). 2007 annual report: Changing laws, changing lives, lawyers working to end homelessness. Accessed 11/21/08 from the World Wide Web at http://www.nlchp.org/view_report.cfm?id=285
- Pathways to Housing (n.d.) Accessed 11/17/08 from www.pathwaystohousing.org
- Project Home (n.d.). Accessed 11/20/08 from www.projecthome.org
- Roman, N. (2003). Tracking the homeless: An overview of HMIS. NHI, *Washington News and Views*, Issue #132.

- Rose, J. (2007, April 26). Philadelphia's homeless rates rises anew. All Things Considered, National Public Radio. Last Accessed on the on 11/21/08 from <http://www.npr.org>.
- Rosencheck, R., Morrissey, J., Lam, J., Calloway, M., Jounhsen, M., Goldman, H., Randolph, F., Blasinsky, M., Fontana, A., Calsyn, R. & Teague, G. (1998). Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness. *American Journal of Public Health*, 88(11), pp. 1610-1615.
- Royse, D., Thyer, B.A., Padgett, D.K. & Logan, T.K. (2006). Program evaluation, an introduction, fourth edition. Thomson Brooks/Cole.
- Scullion, S.M., McConnon, J.D. & Davis, C.S. (2005). Vision of H.O.M.E.: Strategic plan 2005-2010. Project Home. Accessed 11/1/08 from <http://www.projecthome.org>.
- Thompson, T. (2003). *Ending chronic homelessness: Strategies for action*. U.S. Department of Health and Human Services. Last accessed from the World Wide Web at <http://aspe.hhs.gov/hsp/homelessness/strategies03/>
- Tsemberis, S.J. & Eisenberg, R.F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services*, 51, pp. 487-493.
- Tsemberis, S.J., Moran, L., Shinn, M., Asmussen, S. M. & Shern, D.L. (2003). Consumer preference programs for individuals who are homeless and have psychiatric disabilities: A drop-in center and a supported housing program. *American Journal of Community Psychology*, 32(3/4), pp. 305-316.
- U.S. Department of Housing and Urban Development (n.d.). *McKinney-Vento Homeless Assistance Act*. Last accessed 10/12/08 from <http://www.hud.gov/offices/cpd/homeless/lawsandregs/mckv.cfm>
- U.S. Department of Housing and Urban Development (n.d.) Continuum of Care Homeless Assistance Programs. Pittsburgh/McKeesport/Allegheny. Accessed 11/2/08 from <http://www.hud.gov/offices/cpd/homeless/local/index.cfm?st=pa&coc=600>
- U.S. Department of Housing and Urban Development (2007). HUD field office feedback on SHP self-monitoring, handout 2. Accessed 11/2/08 from <http://www.hmis.info/Resources/884/Handout-2---HUD-Field-Office-Feedback-on-SHP-Self-Monitoring.aspx>
- U.S. Department of Housing and Urban Development 2007a. *Report to Congress: Sixth progress report on HUD's strategy for improving homeless data collection, reporting and analysis*. Washington, D.C.

- U.S. Department of Housing and Urban Development (2008). *Supportive Housing Program Desk Guide*. Accessed 11/20/08 from <http://www.hudhre.info/index.cfm?do=viewShpDeskguide>
- U.S. Interagency Council on Homelessness (n.d.) Ten-Year Plans. Accessed 11/12/08 from <http://www.ich.gov/slocal/index.html>
- Wenzel, S.L., Leake, B.D., Gelberg, L. (2001). Risk factors for major violence among homeless women. *Journal of Interpersonal Violence*, 16(8), pp. 739-752.
- Wolff, N., Helminiak, T.W., Morse, G.A., Calsyn, R.J., Klinkeberg, W.D., Trusty, M.L. (1997). Cost-effectiveness evaluation of three approaches to case management for homeless mentally ill clients. *American Journal of Psychiatry*, 154(3), pp. 341-348.
- Wong, Y.I., Park, J.M. & Nemon, H. (2006). Homeless service delivery in the context of continuum of care. *Administration in Social Work*, 30(1), pp. 67-94.
- Wong, Y.I., Hadley, T.R., Culhane, D.P., Poulin, S.R., Davis, M.R., Cirksey, B.A., Brown, J.L. (2006). *Predicting staying in or leaving permanent supportive housing that serves homeless people with severe mental illness*. U.S. Department of Housing and Urban Development.