What Gets Measured, Gets Done

A Toolkit on Performance Measurement for Ending Homelessness

July 2008

National Alliance to End Homelessness

Homelessness Research Institute

National Alliance to End Homelessness

The National Alliance to End Homelessness is a nonpartisan, mission-driven organization committed to preventing and ending homelessness in the United States. The Alliance analyzes policy and develops pragmatic, cost-effective policy solutions. We work collaboratively with the public, private, and nonprofit sectors to build state and local capacity, leading to stronger programs and policies that help communities achieve their goal of ending homelessness. We provide data and research to policymakers and elected officials in order to inform policy debates and educate the public and opinion leaders nationwide. Guiding our work is *A Plan, Not a Dream: How to End Homelessness in Ten Years.* This plan identifies our nation's challenges in addressing the problem and lays out practical steps our nation can take to change its present course and truly end homelessness within 10 years.

Homelessness Research Institute

The Homelessness Research Institute at the National Alliance to End Homelessness works to end homelessness by building and disseminating knowledge that drives policy change. The goals of the Institute are to build the intellectual capital around solutions to homelessness; to advance data and research to ensure that policymakers, practitioners, and the caring public have the best information about trends in homelessness, demographics, and emerging solutions; and to engage the media to ensure intelligent reporting on the issue of homelessness.

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Chapter 1

Performance Measurement 101

What Is Performance Measurement and Why Is It Important?

This chapter

- Discusses why performance measurement is important; and
- Introduces the key terms and activities in the performance measurement process.

Overview

Your program serves hundreds of homeless families each year, and you think you are making a difference in people's lives. But how can you find out for sure? Performance measurement helps you better understand and improve your program. **Fundamentally, it is a process that systematically evaluates whether your program is making an impact on the clients you serve and helps to guide efforts to improve results.** Too often program managers view performance measurement only as a reporting requirement for funders or a tactic to gather data for research interests—both are important, but performance measurement can be used to accomplish so much more.

Performance is fundamentally measured by a positive change in the problem you are aiming to address. From a client perspective, change is defined by a measurable improvement in client knowledge, skills, behavior, or condition.

This guidebook is intended to help you think of performance measurement as a program management tool you can use to document and quantify how your work makes a difference. It also allows you to communicate your program's effectiveness to others. Without measuring performance, you don't know whether you should continue with the same program approach or try new ways of helping people who are homeless. This guidebook is intended to help you design a performance measurement system that works for your program; one that provides you with the data you need to improve outcomes for your clients. The approaches in this guidebook can also help your community make informed decisions about resource allocation and evaluate and strengthen its approach to ending homelessness.

Performance Measurement Is Not Limited to Programs

Performance measurement can happen at any level—national, state, community, or program—depending on your perspective and what you plan to do with the information. Performance at all levels is fundamentally a reflection of positive client change, as measured by an improvement in client knowledge, skills, behavior, or condition. National performance is based on the achievements of all persons within the nation, whereas program performance is based on the results of all clients served within a single program. Results can be used at all levels to improve practice and achieve more positive change.

At the *national level*, the National Alliance to End Homelessness might be interested in the national progress or performance in ending homelessness. The federal government, such as the U.S. Department of Housing and Urban Development (HUD), might be interested in the cumulative results of people served by the programs it funds.

At the *state level*, state governments can measure performance of certain programs, funding streams, or special initiatives in the same way. For example, the governor of your state

PERFORMANCE MEASUREMENT LEVELS & CORRESPONDING TOOLS

Level	Sample Performance Measurement Tool
National Level	Research that demonstrates a reduction in chronic homelessness; HUD's Annual Report on its Government Performance and Results Act (GPRA) homelessness goals
State Level	Statewide Report on Homelessness
Continuum of Care (CoC) or System Level	Ten Year Plan Report Cards or CoC application data
Program Level	Program logic models, HUD CoC Annual Progress Reports
Individual (Client) Level	Client accomplishments relative to goals identified in a Case Management Plan

may have a special interest in a recent initiative aimed at providing supportive housing to persons with mental illness. In this case, the state may want to measure the impact of those additional dollars on clients served by programs in the initiative.

Performance measurement at a *system* or *community level* seeks to uncover whether your entire homeless assistance system is working relative to its goals. If it is, what makes it work? If it isn't, what part does not work and how can you fix it? System-wide effectiveness may look at all homeless assistance programs in your community. Or it may focus on a subset of the larger system, for example, the family homeless assistance system.

At the *program level*, you can measure the impact that one program has on its clients. This may be the type of performance measurement with which you are most familiar. It involves looking at program-level outcomes and the changes in the clients that result from participating in the program. An agency might also want to compare its results with other similar programs to gauge how it is doing relative to its peers and how it can improve.

Five Reasons to Measure Performance

People working at all levels should be interested in performance measurement for the following reasons:

1. *To understand whether current activities are working to achieve intended results.* Performance measurement helps you to understand whether what you are doing achieves the results you sought and to ensure that the effect you have on your clients is the intended one.

2 *To drive program improvement and share information on effective practices with others.* Performance measurement also drives program improvement and information sharing—what best practices are all about. If your program is doing something that works well, share it with others.

3 *To ensure a common understanding among all partners, staff, and consumers of what you intend to achieve and how you intend to do it.* Performance measurement helps to ensure that everyone is on the same page in terms of what you are doing and how you intend to do it. This is especially important for partners and funders who are not involved with your program on a day-to-day basis.

4 *To communicate and advocate for community support (e.g., public interest, combating NIMBY, leveraging funding).* You want to be able to communicate your program's effectiveness to others whether you are defending its existence, brokering partnerships, building support, or applying for funding.

5 *To accomplish your goals.* When you add things to a "To Do" list, you are more likely to get them done. The same goes for performance measurement—if you take the time to articulate your program's goals and the steps you need to take to accomplish them, you are more likely to see results. *What gets measured, gets done.*

While each program within a homeless system is working toward its own goals, your system should also have end goals—something each provider is working toward as part of a common mission. In Chapters 4 and 5, we discuss system-level measurement strategies to evaluate and improve performance on community-wide goals. In this chapter, we provide an overview of performance measurement concepts, but focus on setting and managing program performance goals in general.

Key Terms in Performance Measurement

The four key building blocks of performance measurement are **inputs**, **activities**, **outputs,** and **outcomes**. These four terms are diagrammed below.

Inputs

Inputs include resources dedicated to, or consumed by, the program (e.g., money, staff and staff time, volunteers and volunteer time, facilities, equipment, and supplies).

Activities

Activities are what the program does with the inputs to fulfill its mission, such as providing shelter, managing housing subsidies, or providing case management.

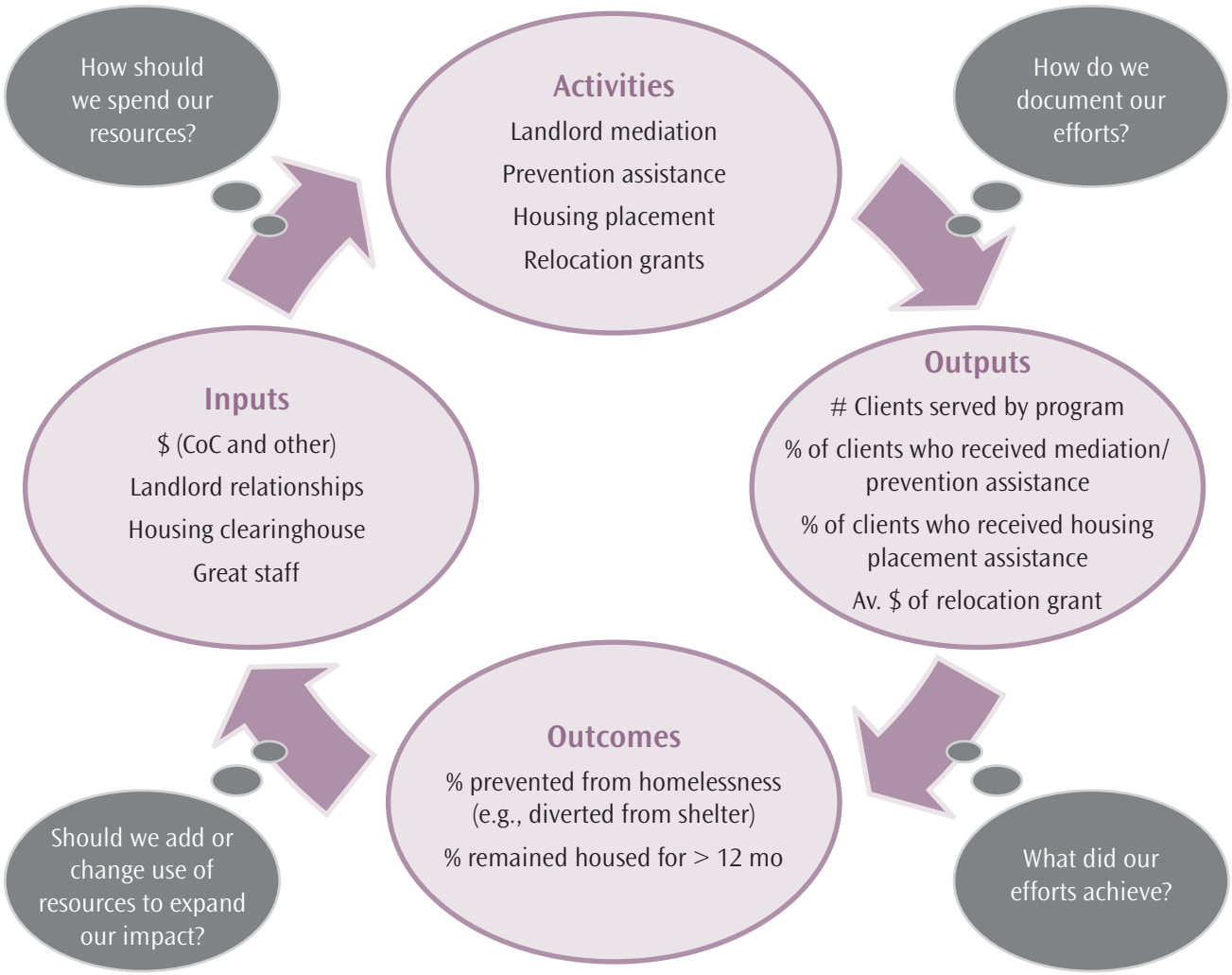
Outputs

Outputs are the direct products of program activities. They are usually presented in terms of the volume of work accomplished (e.g., the number of participants served, the percentage of participants who received rent subsidies and the average subsidy value, or the frequency and intensity of service engagements each participant received). Outputs document what you delivered, so you can exactly replicate or adjust your approach in the future.

Outcomes

Outcomes are benefits or changes among clients during or after participating in program activities. Outcomes may relate to change in client knowledge, attitudes, values, skills, behaviors, conditions, or other attributes. Developing outcomes is not as difficult as you

PERFORMANCE MEASUREMENT FRAMEWORK FOR A PREVENTION PROGRAM



may think. You can quantify a program's outcomes by methodically mapping and describing its results.

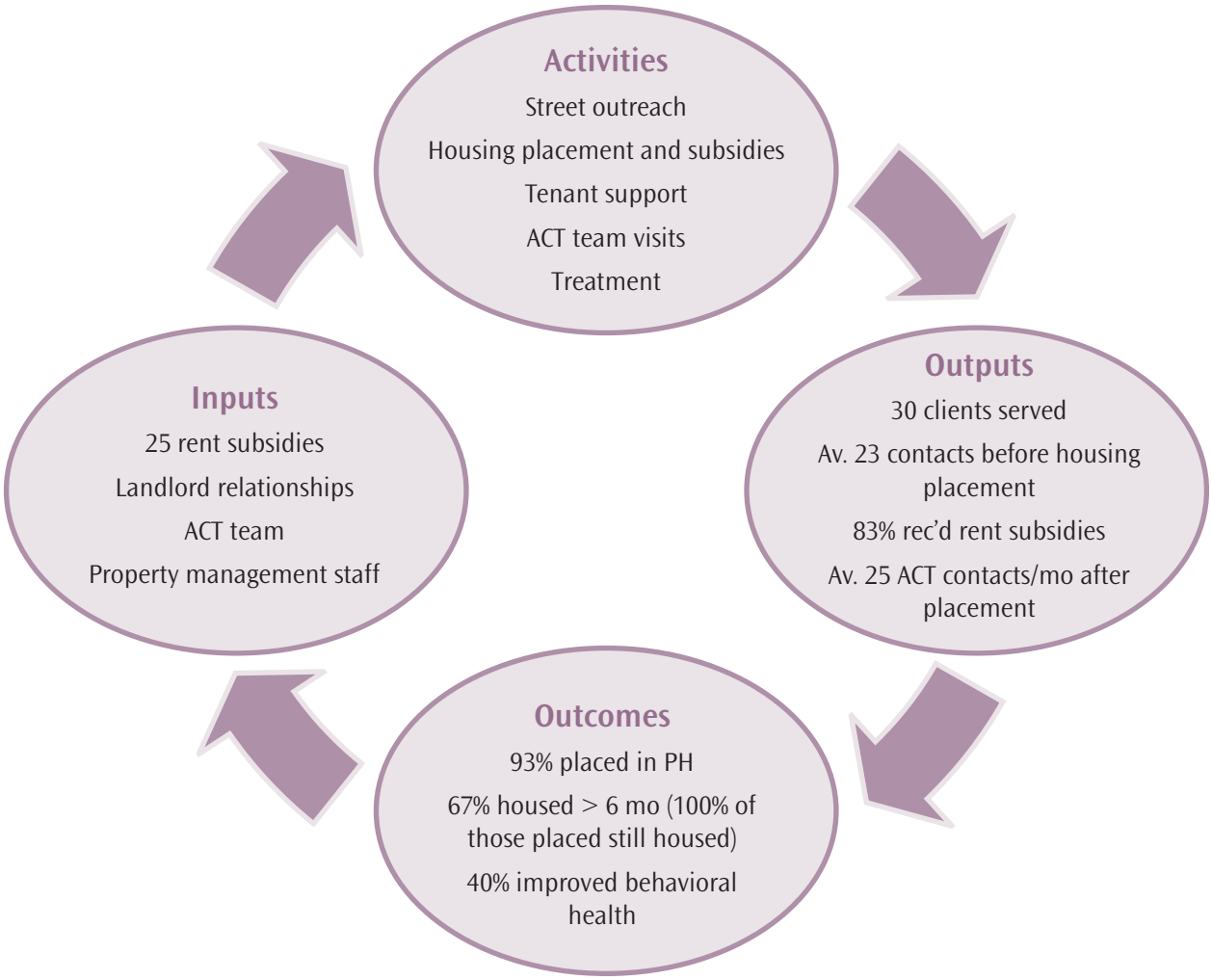
Take For Example…

A Housing First program is just starting to think about the performance measurement process. The program targets homeless persons who have chronic disabilities and long histories of homelessness. Its two primary goals are to help clients:

1. Obtain housing as soon as possible; and
2. Retain housing with a combination of supportive services and rental assistance.

Throughout the year, the program's Assertive Community Treatment (ACT) street outreach team engaged 30 persons living on the streets, assessed their housing needs, secured

PERFORMANCE MEASUREMENT FRAMEWORK FOR A HOUSING FIRST PROGRAM



permanent rent subsidies for most of the individuals, and helped place them in housing (generally within 45 days of the initial contact with each person). The program paired the ACT team with its property management staff team to manage the permanent rent subsidies, help clients apply for mainstream benefits, offer overall tenant housing retention and property management support, and check in every day or two. The ACT team also offered more intensive supportive services to help stabilize other behavioral health issues after clients were housed. By the end of the year, 28 (93 percent) clients were placed in permanent housing (PH); all were still living in their housing and 20 (67 percent) had been in housing for at least six months; 15 (50 percent) were involved with supportive services and 12 (40 percent) were showing signs of improved behavioral health. The diagram above illustrates the inputs, activities, outputs, and outcomes of this program.

Outputs vs. Outcomes

Sometimes it may be difficult to distinguish between outputs and outcomes. While an output is typically an activity or action, an outcome is the change in the client as a result of your efforts. Outputs quantify the level and types of activities provided within your system. Outcomes indicate how the need/problem is being affected by your actions and show whether the system works. The box below describes each term in comparison with one another.

Both outputs and outcomes are necessary to measure performance. Outcomes tell you whether your actions made a difference; outputs provide the context to explain your results. Outputs are also necessary to understand how to replicate results.

Think of the outputs as the recipe and the outcomes as the cake. How much of each ingredient do you need for the cake to taste good? How many case management meetings or service engagements did it take to achieve your goal with clients?

OUTPUTS VS. OUTCOMES

An **output** should be:

- Focused on what the client and/or program will do to achieve the outcome.
- Quantified in terms of the frequency and intensity of the activity from the client's perspective.
- Specific to the activity described for the program.
- Feasible.
- Attainable.
- Understandable to someone outside of the program.

An **outcome** should be:

- Focused on what the participant will gain from that program.
- Quantified in terms of the client-level impact with clear targets and methods.
- Specific and attributable to (a result of) that program.
- Meaningful.
- Attainable.
- Understandable to someone outside of the program.

For outcomes and outputs to be measurable, you need to set percentage (%) and/or numerical (#) targets for each objective. You could say, 70 percent of clients will be placed into housing within 18 months of participating in the program, but a target of 70 clients makes this goal more meaningful: 70 percent, or 70 out of 100 clients, will be placed into housing within 18 months. The target (percentage or number) should be set based on past experience or your expectations of what you can accomplish, though you should also set outcome targets that challenge your program staff.

KEY POINTS TO REMEMBER FROM CHAPTER 1

- Done well, performance measurement helps programs tell their stories and can also help drive program improvement.
- Outcomes quantify changes in client behavior related to improved knowledge, skills, behavior, and condition, whereas outputs quantify the level of effort that resulted in the outcomes.
- Fundamentally, performance measurement is about understanding outcomes, but outputs are also important so you can understand how to replicate or alter your results.

RELEVANT RESOURCE

Exhibit 1-1: Performance Measurement 101 "Cheat Sheet."

Exhibit 1-1 provides guidance on how to write outcomes. The tool reiterates the key concepts of performance measurement discussed in this chapter but also describes the thought process behind developing a meaningful and understandable outcome. All exhibits are available at www.endhomelessness.org.

Chapter 2

Outcome Logic Models

A Key Performance Measurement Concept

This chapter

- Provides an overview of logic models and why they are a valuable tool; and
- Explains how to design meaningful measures for your program.

Overview

Logic models are a simple way to summarize your resources (inputs), efforts (activities/outputs), and end results (outcomes). HUD Continuum of Care grantees are required to complete a logic model as part of their project application each year; however, it is worth the time to develop a logic model, even if your funder does not require one. Here's why.

Logic models provide a framework to help you:

- *Organize your thoughts and plans*,
- *Be intentional about your efforts and allocation of resources to support your goals,*
- *Ensure common understanding of goals by all program stakeholders, and*
- *Communicate the purpose and value of your efforts in a brief snapshot.*

Ideally, your program staff—not a grant writer—should define program outcomes and complete a logic model. The logic model should be used as a tool to communicate your program's story, and you want those who know the story best to tell it. You also need your program staff to buy-in to the goals, objectives, and activities outlined in the logic model. If the logic model is your program's to-do list, then you need it to also be your staff's to-do list. And the process of updating your logic model at least annually forces agencies to assess whether they are satisfied with their results and whether they should try new strategies.

Components of a Logic Model

There are different variations of logic models. We use one that is similar to the format prescribed by HUD. There are six key components of a logic model: (1) problem, need, or situation; (2) service or activity; (3) outputs; (4) outcomes; (5) measurement reporting tools; and (6) evaluation process. HUD has moved to a close-ended logic model format, meaning that most of the fields in the logic model must be selected from a list of predefined response categories; however, you can use an open-ended version of the logic model (or an adaption of it) for your own purposes to present your program efforts and end results in a "logical" tabular format. Each of the six logic model components is discussed below. More information on logic models, as well as a sample and blank templates, is provided in Chapter 3 of this guide, ***Building a Performance Measurement System for Your Program***.

Problem, Need, Situation

In this first section of the logic model, you identify the problem that your program is trying to address. Here, you want to succinctly describe and provide evidence of the magnitude of the problem toward which you are working. You should make sure that there is a relationship between the problem and the anticipated impact of your program (e.g., if the program meets its outcomes, will it lessen the need or fix the problem?).

WHAT A LOGIC MODEL LOOKS LIKE

Agency/Program Name				
(1) Problem, Need, Situation				
(2) Service or Activity	(3) Annual Output Goals	(4) Annual Outcome Goals	(5) Measurement Reporting Tools	(6) Evaluation Process
	Short-term			
	Intermediate			
	Long-term			

Service or Activity

Here, describe what your program does with its resources. How are you spending your budget and staff resources? What will you be doing with the program participants (i.e., discuss the activities that will lead to the intended outcome)? Be clear on the frequency and intensity of the activity (one week at summer camp, weekly hour-long counseling sessions, daily parenting classes, after-school tutoring everyday, etc.).

Outputs and Outcomes

Outputs and outcomes go hand in hand—both are necessary to measure performance. In the logic model, you will want to break up your outcomes according to short-term (first month of program involvement), intermediate (annual), and long-term (approximately three years) effects on clients. This will more accurately illustrate the changes that your program has on clients.

The time periods used in logic models may not necessarily correlate with your program's operating year or multiyear funding cycle. That is, the short-term, intermediate, and long-term time frames do not correspond to the first, second, and third years of a grant. Instead, programs should view the time periods in the logic model from the perspective of a *client enrolled in the program*. What will the program do for the client in the *first month* of enrollment/participation? *First year*? Over *three years*? In that sense, programs should be able to report on progress over all three time periods at any point in time by using the experience of clients who have been enrolled during the past one to three years. For purposes of the

logic model, it can be helpful for a program to define the number of clients that it expects to serve during a program year up front. Then the program can consider that group as the universe or denominator for all calculations related to program outcomes.

For Example…

Let's use the example of a job training and education program for persons who are homeless. The program expects to enroll 100 participants over the course of a year. Participants start by taking a job training class. During the first month of the program, staff expect 95 percent of those participants to complete the job training class (the short-term output). A potential outcome for the first month of program involvement is for 93 participants, or 93 percent of the original group, to show improved job skills as a result of completing the class.

Because this program plans to continue working with the subset of clients who completed the class, it has set an intermediate output goal of providing the 95 "graduates" with job placement counseling and job referrals. The intermediate outcome target is for 52 of the clients, 52 percent of all program participants or 55 percent of those who completed the class, to obtain full-time employment as a result of the job placement counseling.

GUIDELINES FOR DEVELOPING SHORT-TERM, INTERMEDIATE, AND LONG-TERM OUTCOMES

Short-term outcomes may reflect the change that the client will experience within the *first month* of involvement in the program, whereas intermediate outcomes articulate the expected change in the client after *one year* of involvement in the program and long-term outcomes focus on a longer time frame, such as *three years,* to illustrate the lasting impact of the program on the client.

Client base = 90 homeless persons with significant barriers to self-sufficiency enroll in a scattered site permanent supportive housing program annually.

SHORT-TERM (FIRST MONTH)

- **Outputs:** What do you expect the client will do during the first month in the program?
  Ninety-five percent, or 85 out of 90 clients, will work with a housing counselor and primary case manager to assess housing needs and appropriate housing placement.
- **Outcomes:** What change will the client experience within the first month of his/her involvement with the program?
  Eighty percent (72) will be placed in permanent stable housing within 30 days. Another 13 percent (12) are placed within 60 days, and 7 percent (6) are not ever successfully housed.

Programs that have very limited client involvement may only have measurable short-term outcomes. Other programs with long-term client involvement may expect little or no impact after only one month of involvement, but may predict more significant intermediate or long-term outcomes. Unless programs anticipate continued client involvement for three years, it may be difficult to track clients long enough to measure long-term outcomes. However, the idea is that the longer someone is involved in your program, the more you should expect for him/her to accomplish. These expectations should be outlined in your logic model. Long-term outcomes may reflect retention outcomes that demonstrate ongoing impact beyond program involvement, such as housing retention for more than 12 months or job retention.

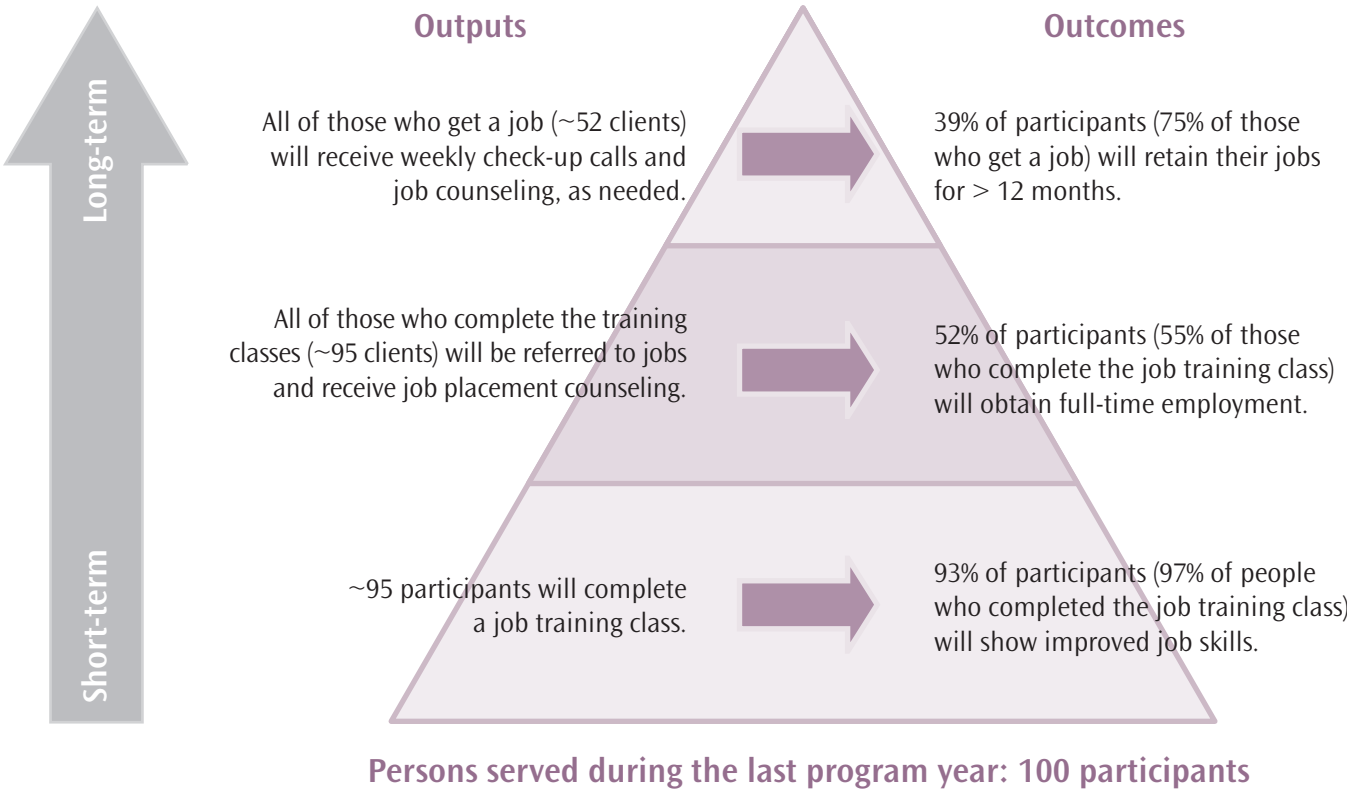
INTERMEDIATE (ANNUAL)

- **Outputs:** Are there any cumulative activities that are better quantified on an annual basis? How will participants interact with the program over the course of one year?
  Eighty-nine percent (80) receive full rent subsidies; 71 percent (64) participate in regular visits with their ACT team.
- **Outcomes:** What change will clients experience within one year of being involved in the program?
  Ninety percent (81) remain in permanent stable housing for at least 6 months; 83 percent (75) remain in permanent stable housing for at least 12 months.

LONG-TERM (THREE YEARS)

- **Outputs:** Are there three-year benchmarks for program activities? How do you expect that the participants will interact with the program at the three-year point?
  Eighty-one percent (73) continue to receive full rent subsidies; 56 percent (50) participate in weekly visits with their ACT team; and 30 percent (27) enrolled in a supported employment training program.
- **Outcomes:** What is the long-term (three-year) impact of being involved with the program (is the client still involved?)? Is there a long-lasting impact?
  Sixty-five percent (59) remain in permanent stable housing for at least 30 months; 15 percent (14) increased earned income by at least 30 percent from program entry.

Finally, the program plans to provide follow-up support to clients who obtain full-time employment. As a long-term output, the program will reach out to the 52 clients who are working full-time through weekly check-up calls and as-needed job counseling to help clients retain their jobs. The long-term outcome expectation for the program is for 39 of the 52 clients who obtained full-time employment to retain their jobs for at least 12 months. Based on the characteristics and circumstances of their clients, these targets are realistic yet challenging for program staff. See the graphic below for an illustration of how to diagram this iterative outcome process for clients in a program. (Hint: start at the bottom of the pyramid.)



Measurement Reporting Tools and Evaluation Process

In this section of the logic model, you specify the reporting tools, processes, and methods that you will use to track progress against outcomes outlined in the logic model. Specifically, you identify the measurement tools, how you maintain the data, frequency of data collection, methods for retrieving the data, issues related to data collection, the process to analyze the information, and how you will use the results to improve performance. If the short, intermediate, and long-term outcomes require similar tracking methods, then the reporting tools and evaluation process may be consistent across all outcomes.

Your Homeless Management Information Systems (HMIS) (or equivalent administrative database) is an invaluable source of information to track program and community performance related to homelessness.

MEASURING PROGRESS

Reporting Tools

- Measurement tools (e.g., grades)
- Where data are maintained (e.g., client-level database—HMIS; case files—at program site)
- Frequency of data collection (e.g., end of term)
- Methods for retrieving data (e.g., need to obtain consent from students and parents to collect grades from school; persons involved in collecting data)

Evaluation Process

- Clarify issues related to data collection.
- What will you do to process and analyze the information?
- How will you use the results to improve program performance?

It is fine for a program to only have a short-term outcome if it has only a brief or one-time interaction with clients. For example, if your program provides a six-week budgeting class to homeless women, your entire interaction with these clients ends after six weeks. Therefore, it is unreasonable to expect the program to project long-term outcomes for these clients. However, programs that offer one-time or short-term assistance may still be able to articulate intermediate and long-term outcomes, if they are careful to specify what they can track versus what they believe based on rigorous research or other sources.

Prevention assistance programs provide another example of a program with short-term client involvement. In the short term, programs may report the percentage of households who avoided homelessness immediately following the housing crisis. Intermediate or long-term outcomes might relate to preventing homelessness for the household over time; however, it is not likely that the program will keep in touch with the households to verify that they are still housed. Instead, housing stability might be inferred by tracking whether the household reappeared in community-wide shelter HMIS records over a specified period.

The prevention program example also illustrates an earlier point—that outcomes should be able to be closely attributed to the program. Many other factors could have influenced the household and kept them from experiencing homelessness, and there is no way of knowing for sure whether that household would have ever become homeless without the assistance. Thus, it may not be appropriate for a prevention program to attribute three-year housing stability to a $1,000 emergency assistance grant.

To truly demonstrate that the intermediate or long-term client outcomes are a result of participating in the program (no matter what the program type), you would need a controlled experiment that randomly assigned people to either the program or to a comparison group that did not receive the program. However, random assignment research is not feasible for most programs, so performance measurement offers a proxy that can suggest the relationship between the activities of the program and the clients' outcomes and provide a basis for other more rigorous research, if desired.

Process Measures and Other Types of Outcomes

We already mentioned that outputs and outcomes go together—you need to measure both to make conclusions about program or system performance and how to improve or replicate it. But how should you determine what outputs and outcomes to consider? What are the most meaningful measures for your program? Are there other types of measures that might be helpful?

If outcomes show if the system works…outputs are needed to understand how to replicate results.

Outcomes indicate how the need or problem you are addressing is being affected by your actions, while *outputs* quantify the level and types of activities provided within your system. We've already discussed both of these concepts from the client perspective. Now let's take it one step further; you can also measure your program's *efficiency* as another dimension of performance, and you can use client outcomes as *interim benchmarks* of progress or as *direct measures of status* toward meeting system-level end goals. These measurement options are called Process or Efficiency Measures, Interim Outcomes, and System Impact Outcomes, respectively.

Process Measures (Program Outputs)

Process measures quantify your program's efficiency and help you to manage daily operational performance. They indicate system functionality on a daily basis (number of clients served, nightly occupancy, vacancy or turnaway rates, case manager-to-client ratios, placement rates, etc.) and can reveal problems in the homeless system. For example, if the permanent supportive housing programs in your system have a 50 percent vacancy rate, you may need to examine referral mechanisms, eligibility and acceptance criteria, or program policies that result in eviction.

However, process measures *do not* tell if the program is meeting its goals. They are indicators and, therefore, are not actually outcomes. They do not measure a change in the client, the program, or the system, but instead are a measurement tool used to support important management purposes.

Numbers of permanent supportive housing units constructed offer another example of a process measure or program/system output. Developing new housing units may be an important part of implementing a chronic homelessness initiative and, therefore, an important measure to track. If the housing units have not been developed, then that may help explain why chronically homeless individuals remain on the streets. However, having new housing units does not tell you whether the units are occupied or whether clients are successful in that housing; therefore, the number of housing units developed is not an outcome measure.

Interim Outcomes

Interim outcomes are benchmarks of progress. They measure the *way clients need to change* in order to meet their goals. For example, if the end goal of your program is to place clients

in housing and help them to maintain that housing for at least six months, interim outcomes could include the number of clients placed in permanent supportive housing or the number of clients who have increased their income or obtained subsidies to afford market rents during a specified period of time. Interim outcomes suggest whether your efforts are on the right track. If not, they provide an opportunity to make adjustments before acknowledging that you did not meet your end goal. Think of interim outcomes as milestones that clients meet along the way to meeting their goals. But remember, interim outcomes are still *outcomes;* therefore, they must show a change in the client as a result of your program's actions.

Impact Outcomes

Whereas interim outcomes measure a change in the client at an interim benchmark, impact outcomes measure *sustained* change. Impact measures document whether you are meeting your goals and making a difference in the problem you are targeting. They do this by providing quantifiable indicators of the change in the problem (e.g., fewer people are living on the streets or experiencing chronic homelessness; fewer people are presenting with a housing crisis; more people are being prevented from entering the system; people are staying homeless for shorter periods of time; etc). They help determine if you need to continue actions, expand current efforts (add resources to the current system), tweak current efforts, or fundamentally change the structure and approach of your homeless system. They could also be used to evaluate whether past actions (adding money or changing strategies) helped address the issue and to communicate the overall system's success (such as, when justifying funding requests). Think of them as direct indicators of progress toward goals.

COMMON PROBLEMS WITH LOGIC MODELS

- Logic model does not effectively communicate need, or the problem/need is not compelling.
- Proposed outcomes will not make a meaningful impact on need.
- Need is related to one population, but outcomes target another.
- Logic model never clearly states the activities that will be provided to the target population.
- Outcomes do not reflect a change in clients' skills, behavior, or condition.
- Outputs and/or outcomes are not quantified or measurable (need percentages and/or numbers).
- Outputs and outcomes do not correspond (time frames are inconsistent, activities do not relate to results).
- Short-, intermediate, and long-term outcomes are all the same even though activities/outputs differ.
- Long-term outputs and outcomes show the cumulative number of services provided or people served, rather than the cumulative involvement or impact achieved.
- It is unclear whether proposed outcome is better than what would have happened without program.
- Measurement strategies aren't sufficient to prove that the program achieved results.

However, impact outcomes are not perfect—while they do tell you the outcome of your efforts, they do not tell you why what you did worked, or how it worked. You need to use process measures and other outputs to explain the "why" and "how" pieces of the puzzle. Additionally, impact results take time to show up, so people often use interim outcomes to suggest impacts.

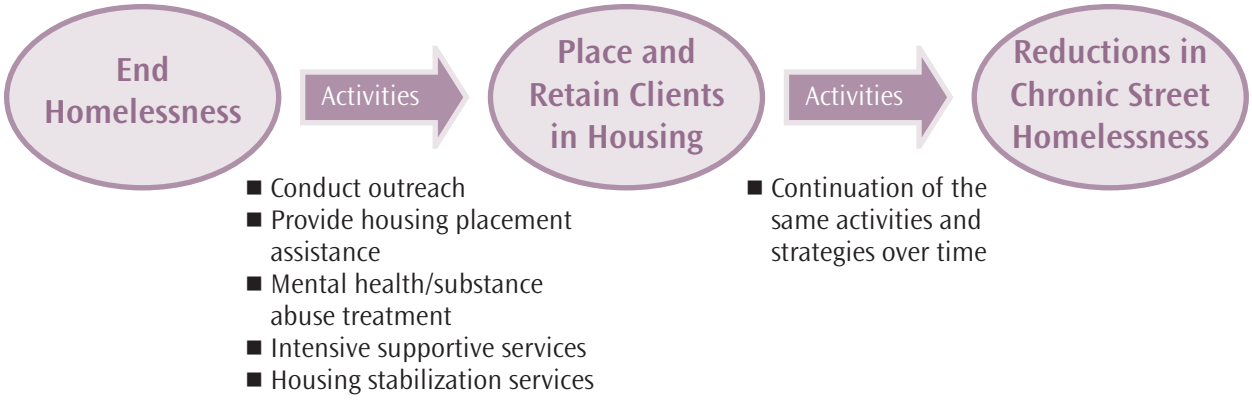
Selecting Meaningful Measures

We differentiate between process measures, interim outcomes, and impact outcomes to show how important it is to select meaningful measures for your program. You want to tell your program's story, but you also want to make sure that what you're doing is having the intended effect and that your program is operating as efficiently as possible.

Below is a simple illustration of what we have just discussed. When you are thinking about your program's inputs, activities, and outputs in relation to your end goal, think about what you want to know about your program's efforts in terms of those resources. For example, do you want to know if the training program you recently implemented resulted in reduced time spent on data entry for intake workers (a process measure)? Are you looking for evidence that your program is making strides toward reducing chronic homelessness (impact measure) by providing weekly mental health and substance abuse services (outputs) to clients who recently moved into permanent housing (an interim outcome)?

Let's try a more detailed example. A collaboration of agencies is working toward ending chronic homelessness by moving people who are living on the streets into permanent supportive housing and helping them to retain that housing. The program's ultimate goal is to end chronic homelessness. To meet this goal, one program conducts outreach to homeless persons living on the streets and builds trust through continued contact and housing placement advocacy and assistance. The outreach program aims to move the homeless persons into permanent housing within 30 to 60 days of initial contact, though some clients will take much longer. Once clients are placed in appropriate housing, the outreach partner transitions the relationship to a partner agency that uses mobile case management teams to provide regular mental health and substance abuse treatment, as well as intensive case management to clients. A third agency manages rent subsidies and landlord–tenant relationships.

The collaboration's *activities* are conducting outreach, providing housing placement assistance, mental health and substance abuse counseling, and supportive services and managing rent subsidies. A *process measure* might relate to securing housing units and/or subsidies for the future program participants or maintaining a 1:12 case management ratio for the intensive case management program. The program's *short-term outcome* is the num-



ber of clients placed in housing by the program. An appropriate *intermediate or long-term outcome* for this program could be the length of time clients stay in housing after they have been placed. Looked at another way, an intermediate outcome could be the number of clients who stayed in housing for at least six months. These programmatic outcomes could also be referred to as *interim outcomes*, since they are indicators or benchmarks of progress toward meeting the identified need or problem. The *impact outcome* is a reduction in the number of chronically homeless people, which is a demonstrated reduction in the identified need or problem.

This example illustrates the importance of looking at the entire performance measurement puzzle—activities, outputs, outcomes—to ensure that you have reasonable methods to measure each of these components. In addition to the core components described in the first portion of this chapter, you may also want to include *process measures, interim outcomes,* and *impact outcomes.* Process measures help you manage your program, but do not tell results. Interim and impact outcomes tell you whether you are meeting your goals but do not tell you why or how you got there. You need to look at activities, outputs, and outcomes to put everything together. The bottom line is that your program should determine what it wants to know before attempting to develop its performance measurement framework.

KEY POINTS TO REMEMBER FROM CHAPTER 2

- Performance measurement requires considerable planning and forethought.
- Logic models can help you clearly articulate how your resources and efforts and their corresponding client outcomes cumulatively build to address the identified community problem over time.
- Establishing a solid infrastructure for collecting data, such as an HMIS, can help ensure that you have the data you need to calculate your program outcomes.
- Process measures document whether you implemented your program as you intended and can be used to understand if there are other ways to achieve your program goals more efficiently.
- Look at the outcomes within the context of all the outputs and the community environment to validate the interpretations that are being made. Ensure that staff have reviewed your data and outcomes before publicly releasing anything—this will help maintain their buy-in and make sure that the conclusions are reasonable. Appropriately note the limitations of your data and analysis. The end result of your efforts should be a system to help you understand your results and improve them.

Chapter 3

Building a Performance Measurement System for Your Program

How to Design a System and Build It from Scratch

This chapter provides

- An overview of performance measurement at the program level;
- Sample measures by program type;
- Methods to define program measurement targets; and
- Strategies to track, analyze, and use program results.

Overview

Performance measurement is a process that systematically evaluates whether your program's efforts are making an impact on the clients you serve. Although *you* may be able to see the difference your work makes through daily interactions with clients or the high morale of your staff, performance measurement is about communicating that difference to others by looking at the big picture. In other words, while you know that Sally and Joe may be successful, performance measurement allows you to understand and communicate whether all of your clients are as successful as they are.

Performance measurement is all about telling your program's story succinctly but effectively. ***And don't forget, performance measurement should help you better understand and improve your program.***

Performance measurement can happen at any level—national, state, system, program, and individual. The level you decide to measure depends on your perspective and what you plan to do with the information. At the *program level*, you can measure the effects that one program has on its clients. It involves looking at data on clients served by your program alone and measures the change in the clients as a result of participating in the program. Program outcome results can also be used as a tool for benchmarking progress against other similar programs.

This chapter focuses on *program-level* performance measurement only. You can find more information on system-level measurement in Chapter 4, ***Performance Measurement as a Management Tool for Your Community,*** and Chapter 5, ***Measuring Big Change***.

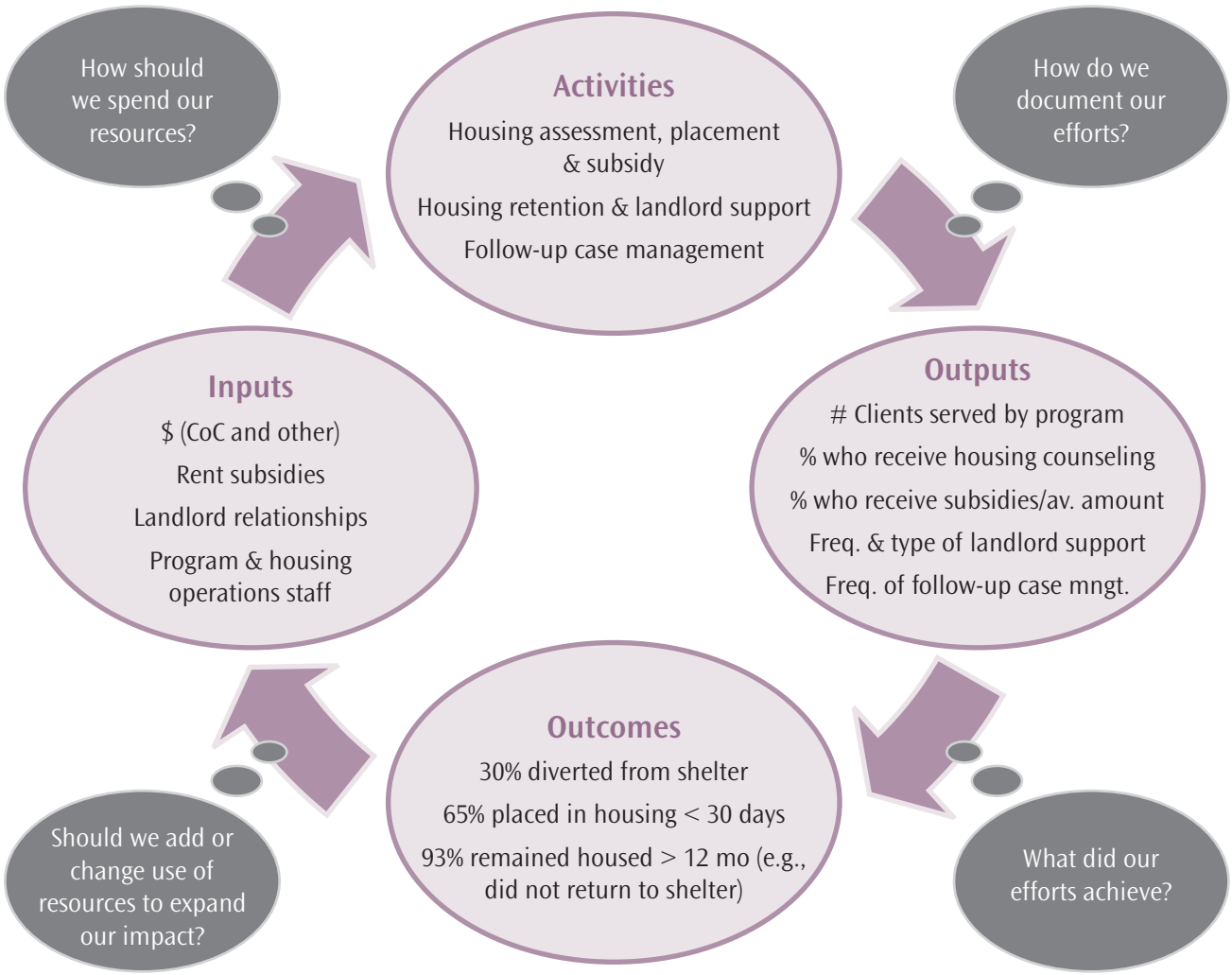
Chapter 1 introduced four key terms: inputs, activities, outputs, and outcomes. These are illustrated in the diagram on the next page.

Performance measurement is a process—a continuous cycle—in which all four of these components are related to one another. When thinking through the performance measurement process for your program, there are some things to consider before putting the puzzle together:

- *Program Design.* If you haven't already, now's the time to articulate the client needs that your program is trying to address and your program's goals.
- *Performance Measurement Framework.* If you're starting from scratch, start backwards with the outcomes, followed by determining the activities you think you need to achieve those results. If you're starting with an existing program, then work through current practice to document what you are currently doing and its impact. Revise current practice if you are not satisfied with the results you document.

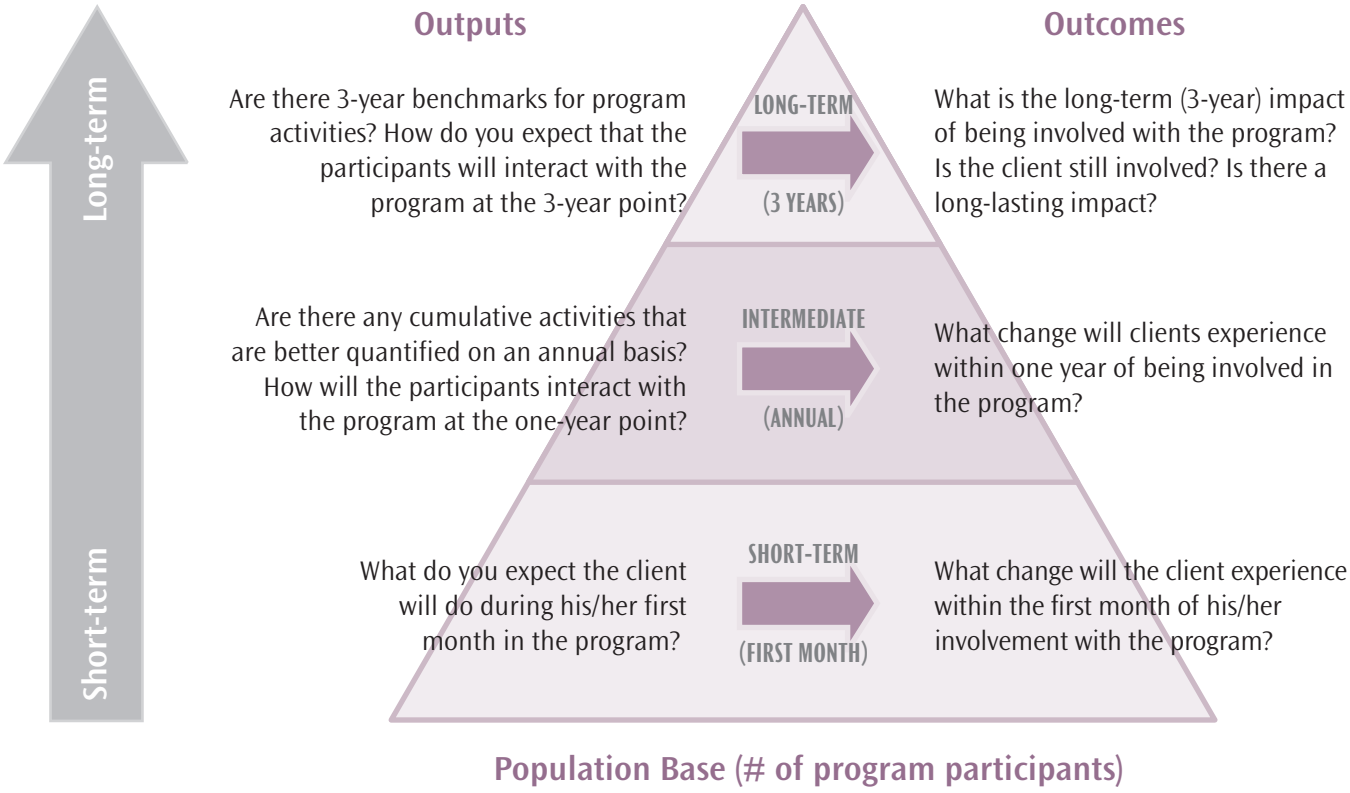
Inputs, activities, outputs, and outcomes are the building blocks of the performance measurement process and therefore are your starting points. It's not easy; stepping back from the day-to-day work of running a program to view the big picture is difficult. It's about changing your perspective and viewing the clients, staff, case management plans, housing placements, and other successes your program achieves in a new light.

PERFORMANCE MEASUREMENT FRAMEWORK FOR A RAPID REHOUSING PROGRAM



Developing Performance Measures

It's helpful to think about performance measures in terms of the changes that clients will experience as a result of your program's efforts over different time frames. For example, HUD's logic model requires grantees to define separate short-, intermediate, and long-term outcomes. Short-term outcomes measure the change that the client will experience within the *first month* of his/her involvement in the program. Intermediate outcomes measure the change in the client after *one year* of involvement in the program. Long-term outcomes measure change over a longer time frame, approximately *three years*, illustrating the lasting impact of the program on the client. See Chapter 2 for more information on defining program outcomes for different time frames.



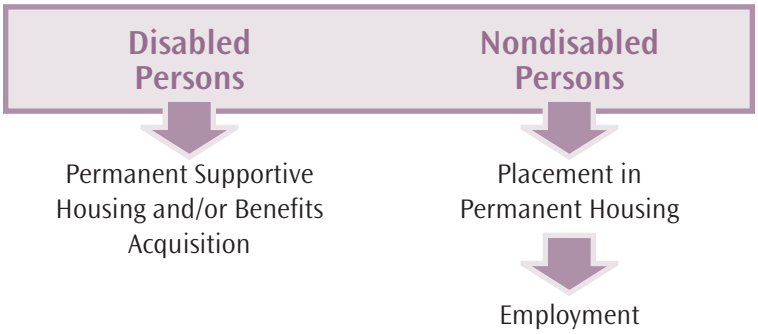
Developing performance measures for your program forces you to answer two critical questions:

1. How do I convert program activities into measurable outcomes?
2. What do I need to calculate outcomes?

We'll discuss each of these questions separately.

Developing the Measurement Structure

The first step in converting program activities into outcomes is to *identify the target population for the outcome*. Certain goals may only apply to a subpopulation (e.g., persons with disabilities). Others may only apply to those who have achieved earlier goals, such as



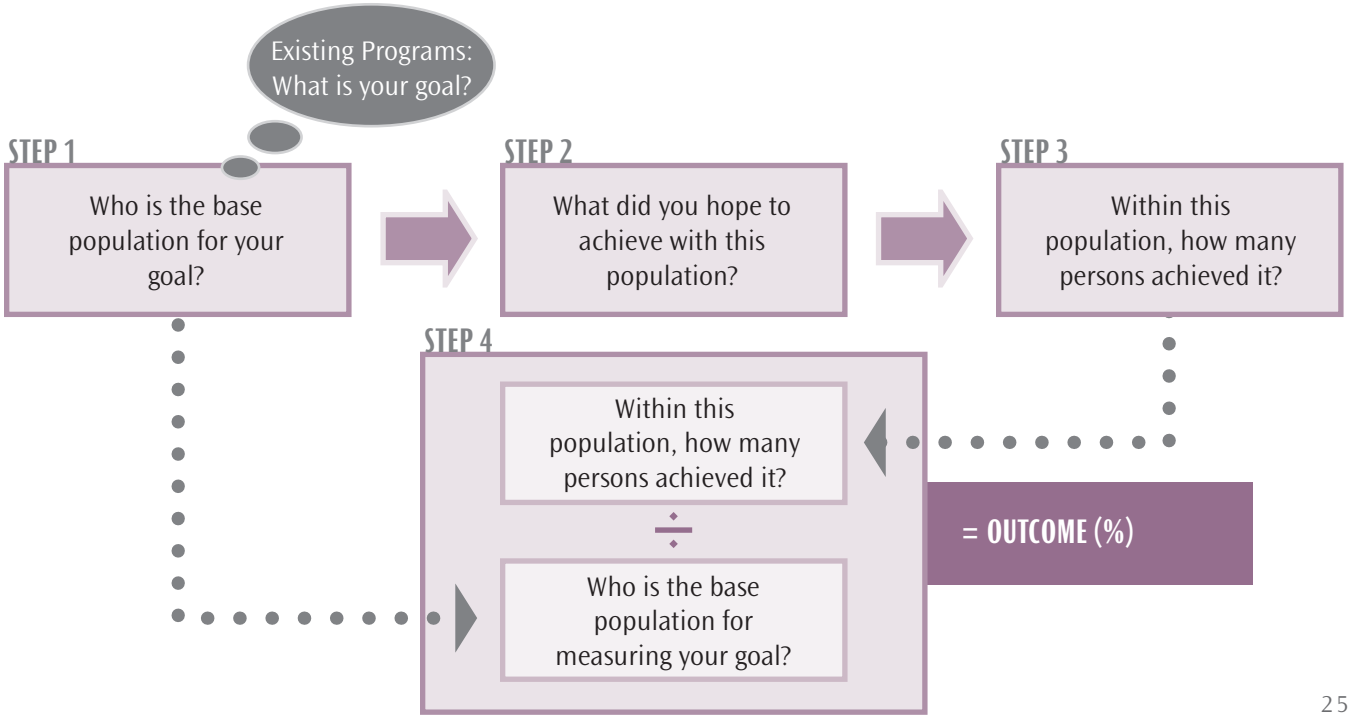
completing a training program, securing housing, or staying in the program for at least six months.

Next, *determine what you want to achieve with this population.* For some programs, this may be explicitly stated in your program goals already [e.g., the goal of our program is to retain clients in permanent stable housing for at least six months]. For others, it may be more difficult to tease out depending on your program's activities.

The third step is to *determine how many people within this population achieved the goal (or the number that you expect to achieve the goal if you are in the planning stages).* The number of persons who achieved the goal you set divided by the total number of persons in your target population is your outcome.

For example, let's assume that your program's goal is to help clients maintain permanent stable housing for at least six months. Your base population is the number of clients that are in your program and have had the opportunity to be in housing for at least six months, which means that when you are reporting, you would exclude people who are enrolled in your program but have been there less than six months. For this example, let's say 40 people have been enrolled for at least six months or have already exited during this program year. If 10 clients are still enrolled and stayed more than six months, and another 10 had stayed more than six months before they left, then 20 clients, or 50 percent of the base population, have achieved your stated outcome. You can report that 50 percent of your base clients maintained their housing for at least six months. This example is illustrated on the following page using the same calculation format provided below.

OUTCOME CALCULATION



HOUSING STABILITY EXAMPLE

If you don't have program results to analyze, start by estimating what you think will happen, and then document results moving forward to calculate actual outcomes. Adjust measurement targets and/or program strategy depending on your results.

Each outcome calculation will need a specific method to track performance at the client level. Whenever possible, use HMIS to help define your performance measures. Each HMIS data element has a set of response categories attached to it. You can use these to create standardized definitions of the terms you use in your performance measures.

For example, your HMIS includes the standard response choices for "Destination After Program Exit." If your program or community is measuring the percentage of clients who leave the program for permanent stable housing, then you should decide in advance which of the potential destination responses count as "permanent stable housing." In this example, "permanent stable housing" includes: *permanent housing; room, apartment or house that you rent;* or *apartment or house that you own.*

BEWARE OF AMBIGUOUS CONCEPTS!

Performance measures often include ambiguous concepts, such as "permanent stable housing," "employment," "increasing skills," "accessing services," "becoming more self-sufficient," and so forth. If you plan to use terms like these, make sure to define what they mean in terms of your data collection and use. The definitions you create should make sense in your community. Establishing definitions will make it easier to consistently record results and strategies and communicate results to other stakeholders, key funding partners, other providers, and the community.

These three options are shown in bold among the list below of potential responses for the "Destination After Program Exit" field in the HMIS.

Emergency shelter	**Apartment or house that you own**
Transitional housing	Staying/living with family
Permanent housing	Staying/living with friends
Substance abuse facility or detox center	Hotel or motel voucher
Hospital (nonpsychiatric)	Foster care home or group home
Jail, prison, or juvenile detention center	Place not meant for human habitation
Room, apartment, or house that you rent	Other
Don't know	Refused

You can follow this type of process to decide how you will measure all of your selected performance measures using your HMIS. For instance, you can use the income fields to track changes in household income over time.

Setting Meaningful Outcome Targets for Your Program

For outcomes to be measurable, you have to set percentage and/or numerical targets for each objective. For example, you could say "Safe Shelter will place a majority of clients into permanent stable housing in 2008." While that might be your goal, it's more meaningful to actually set targets. By setting targets, you are clear about your expectations, and you are more likely to challenge your staff to exceed expectations. A better performance measurement target is "Safe Shelter will place 75 percent of clients (30 individuals) into permanent stable housing in 2008."

But how do you decide what your target should be? *First, gain an understanding of past program participants' performance on your measures.* Even if you've never formally adopted performance measures in the past, a good place to start is to compare current clients with a potential performance measure. For example, let's use the example in the paragraph above. Safe Shelter is an emergency shelter program currently working with 40 homeless clients with severe substance abuse issues who are interested in recovery. Staff are providing case management, peer recovery support, linkage to supportive services, life skills classes, and other services specifically focused on helping clients maintain housing after placement. Perhaps in the past, Safe Shelter was successful in placing approximately 60% of clients in permanent housing.

Second, determine if there's a need to change based on the frequency and intensity of the service or activity. Adjust your targets based on any recent or imminent changes in your program. Is anything planned that may improve your ability to achieve your outcomes, such as pending availability of rent subsidies for clients who exit your program? Is anything planned that may reduce the likelihood of achieving your planned outcomes?

Third, determine if you need to adjust your targets to reflect what's feasible for the current or future subpopulation(s) served by the program. As we've discussed, you can look at past clients' performance on a potential measure to identify reasonable targets, but if current clients differ from past clients in ways that may impact their outcomes, you may need to

TIPS FOR USING HMIS FOR PERFORMANCE MEASUREMENT

You can calculate outcomes consistently for all clients if, and only if:

- Staff are collecting the required information at entry and exit for each client.
- Staff are recording this information into the HMIS in a timely fashion.
- Clients are enrolled in programs that make sense for aggregating client results.

COMMON PROBLEMS WITH THE PERFORMANCE MEASUREMENT PROCESS

- The goals of the program are poorly articulated and/or may not flow from client needs.
- The program never clearly states what it is doing with the client population.
- Outputs and outcomes don't correspond (e.g., activities don't relate to results).
- HMIS lacks the capacity to quantify outputs (#) and outcomes (%) consistently.
- Outcomes are really outputs, and don't reflect a change in client knowledge, values, attitudes, skills, behaviors, conditions, or other client attributes.
- Outcomes are unrelated to program goals.
- Short, intermediate, and long-term outcomes are all the same even though the activities/outputs differ.
- Measurement strategies are faulty and unable to prove that program achieved results.

adjust your targets. Back to Safe Shelter: while the program historically placed 60 percent of clients in permanent housing, the program has identified several landlords who are more willing to rent apartments to your client population. Thus, you may be able to raise your target to 65 or 70 percent.

Fourth, set targets that challenge your program staff to reach to achieve the goal. While you don't want to be unrealistic, you still want to challenge your staff to meet the target. At Safe Shelter, if staff are confident that at least 28 of the current 40 clients will move to permanent housing, a target of 70 percent (28 clients) is too low. In fact, staff may consider 28 clients as their baseline—something against which they can measure progress. Instead, program staff may choose to use 75 to 80 percent (30 to 32 clients) as their outcome target.

Tips for Achieving Your Outcomes

- Track your efforts and results all year using HMIS. Achieving outcomes can be a progression, and monitoring this progression requires HMIS data that are collected at different intervals. Don't be surprised by your outcomes at the end of the program year; periodically review your progress by running HMIS queries and establishing interim benchmarks. You can start by determining your *baseline*. The baseline should be your starting point against which you will track your program's ability to improve its results. A baseline is critical for evaluating change and monitoring performance.

  Then, develop interim outcomes and associated time periods against which to measure your progress. For example:
  - Short-term outcomes: What change will the client experience within *the first month* of his/her involvement in the program? How will you measure this?
  - Intermediate outcomes: What change will the client experience within *one year* of being involved in the program? How will you measure this?
  - Long-term outcomes: What is the *long-term* (e.g., three-year) impact of the program on clients? Has it been sustained? How will it be measured?

- Periodically review results and progress toward goals. We have already discussed how performance measures tell your program's story to others and help you to communicate results. However, they may be trying to tell you something too! Don't ignore the messages. If your outcomes are consistent with your goals, keep doing what you've been doing. If you're doing better than expected, it's time to assess whether you need to adjust your targets. If you're doing worse than expected, determine whether there are unexpected circumstances that might have affected your results. Ask yourself: are you doing what you planned? Do you need to try to modify your efforts? Do you need to adjust your targets?
- Compare your results to other programs. Look inside and outside of your community to programs serving like populations in like environments or adjust for client differences to allow for program-to-program comparison. (See Chapter 4 for more on risk adjustment.)

Sample Measures by Program Types

Outcome measures can, and should, differ depending on the type of program you run. In this section, we provide examples of sample performance measures for different program types. As a resource for this chapter we provide a sample completed logic model for an emergency shelter, as well as two blank logic model templates for other residential program types. You can learn more about logic models and how to complete them in Chapter 2.

SAMPLE PERFORMANCE MEASURES BY PROGRAM TYPE

Program Type	Description	SAMPLE Program Outcomes
Prevention	Supportive services, financial assistance, advocacy, and mediation to mitigate factors leading to imminent homelessness.	% diverted from shelter (i.e., they would have become homeless otherwise) due to prevention assistance
Central Intake	Center that functions as the central point of intake for persons accessing the homeless system. Includes prevention assistance, assessment, housing counseling, and placement into appropriate housing.	% assessed and placed into appropriate housing within 1, 3, and 5 days *(could also be paired with prevention outcomes)*
Mobile Outreach	Street-based, mobile outreach teams that address basic needs and seek to move people off the streets.	% placed into housing (ES, TH, Safe Haven, or PH) as a result of the program's efforts % (of service-resistant) engaged by team % linked to appropriate community services

SAMPLE PERFORMANCE MEASURES BY PROGRAM TYPE (CONTINUED)

Program Type	Description	SAMPLE Program Outcomes
Drop-in Center	Site-based engagement center that provides basic services and assists clients in accessing services.	% placed into housing (ES, TH, Safe Haven, or PH) as a result of the program's efforts % (of service-resistant) engaged by team % linked to appropriate community services
Emergency Shelter	Safe, clean place to stay for persons in need of shelter with a strong focus on immediate placement into housing and linkage to services.	% exited to PH < 30 days (and do not present for shelter again within 12 or 24 months) % with histories of living on the streets who remained in ES or other housing % (who stay longer than 3 days) connected with a primary case manager % applied for mainstream benefits for which they appeared eligible
Rapid Re-housing	Immediate housing assessments and housing placement and retention support, including: housing referrals; one-time relocation assistance and/or partial or full rent subsidies; landlord support; co-signing assistance; credit counseling; retention-focused case management and/or property management.	% placed in PH < 7 or 30 days (may be shared outcome with ES) % remained housed for at least 6 months % remained housed for at least 12 months % remained housed for at least 24 months
Transitional Housing	Project-based, time-limited housing with supportive services. Projects are often targeted to specific subpopulations.	% exited to PH (within specified time frame) % increased earned income (or obtained and/or retained employment) % increased their self-sufficiency
Permanent Supportive Housing	Scattered-site permanent housing linked with supportive services to help residents maintain housing.	% remained in PSH > 1 year or exited to other PH % improved mental health or substance addictions % secured entitlement benefits
Employment Training Program	Job search assistance program that provides a wide range of employment services from basic resume writing to job training programs and childcare.	% maintained or increased employment income
Legal Services to Prevent Homelessness Program	Legal rights education, legal representation, and education for shelter staff and other service providers.	% whose eviction is prevented or who are otherwise diverted from shelter (i.e., they would have become homeless otherwise) due to legal assistance

ES = emergency shelter; TH = transitional housing; PH = permanent housing; PSH = permanent supportive housing.

Methods to Track, Analyze, and Use Program Results

As we've said before, HMIS is an invaluable tool to track progress and analyze your results. At the program level, any administrative database that records client-level data can serve the same purpose, but consistent data response categories from one program to another are important to be able to compare performance of like programs. However, system analysis requires HMIS and the ability to examine the outcomes of persons across different programs.

Whether you use an HMIS or an agency-specific system, a client-level administrative database has several advantages over manual data collection systems.

1. *Administrative data can be easily analyzed to gain a more accurate description of your program's population and their outcomes. Manual data systems lend themselves to anecdotal examples of clients and their success.* Stories about individual clients are important, but data are needed to prove a program's success. In fact, the best way to use your data is to contextualize it with stories about individual clients and successes

WHAT IS HMIS?

An Homeless Management Information System is a computerized data collection tool specifically designed to record and store client-level, system-wide information over time on the characteristics and service needs of homeless persons.

- An HMIS is typically a Web-based software application that local homeless communities implement to enter and share client-level data across agencies about homeless persons served in shelters or other homeless service agencies.
- HMIS records and stores:
  - Client intake information, such as demographics, basic assessment of needs, and bed utilization;
  - Services and information and referral (I & R) resources;
  - Case management, including the ability to plan, schedule, and follow up on the delivery of services and track changes in clients over time; and
  - Performance goals and outcomes.
- HMIS allows for the aggregation of client-level data across homeless service agencies to generate unduplicated counts and service patterns of clients served.
- HUD's National Data and Technical Standards establish baseline standards for participation, data collection, privacy, and security for HMIS users.
- Participation in the local HMIS is a requirement for most HUD McKinney-Vento funded programs.

For more information on HMIS, go to www.hmis.info

COLUMBUS, OHIO HMIS-BASED OUTCOMES

The Community Shelter Board (CSB) in Columbus, Ohio analyzed HMIS shelter usage patterns and destinations for clients in the adult emergency shelter and were able to report the percentage of Successful Housing Outcomes for this population. They defined a "successful housing outcome" as a "distinct exit to 'permanent' or 'transitional' housing, excluding exits to family or friends."

Then, CSB uses annual Program Outcomes Plans to measure performance of individual programs. Success in achieving performance standards during the contract period, along with other factors, informs funding decisions in the next contract period.

achieved in your program. Or, use your data to correlate program outcomes with client characteristics. Stories capture your audience's attention; data keep it.

2. *Databases allow client information to be analyzed in multiple ways, which may identify new information about client differences and the relationship of those differences to performance.* Manual data are much more onerous to analyze than data stored in a database. For instance, manual data might be used to report on outcomes, but administrative data can be easily manipulated to understand whether outcomes vary by client gender, age, disability, family structure, or other factors.
3. *A community database provides a way for programs to track client activity beyond the program's time frame.* It may not be feasible for your program to keep in touch with clients after program exit; however, you can infer longer-term client outcomes based on whether the client interacts with other programs following his/her exit from your program. For instance, if you place a client in permanent housing, and he presents for emergency shelter three months later, then you know that he did not maintain his housing beyond that three-month time frame.

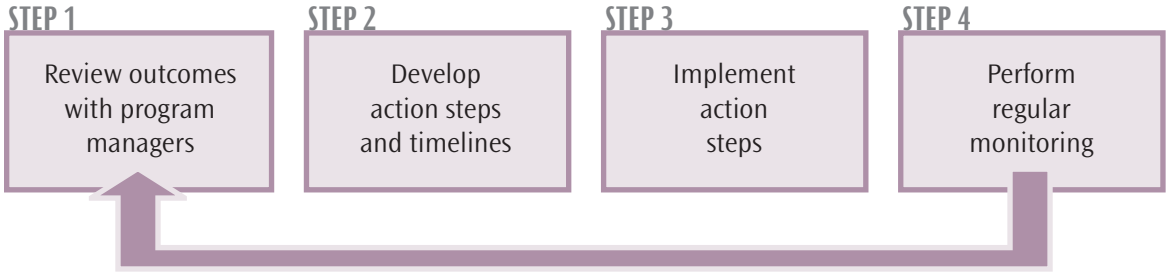
However, before you get knee-deep in running queries and analyzing data, there are a few things you need to remember:

1. To use HMIS, you need good data quality. This means you need *client identifiers to de-duplicate data* and *entry and exit dates for all clients.*
2. Your data may not be perfect, but the more you dig into your data, the better you will know them. It's important to identify the holes so you know how to fix them. If you wait until the data are perfect to use them, they will never be of sufficient quality to use.
3. HMIS data tell your program's story, and program staff are the authors of that story. If program staff understand why it's important to have high-quality data (and see that you actually use that data), they will be more invested in getting it right the first time. Remember—everyone in your program is working toward the same goals, so they want to get the story right.

If your program isn't entering data into HMIS, or has just begun to enter data, don't panic. You probably have several other measurement tools available to your program: case files, shelter and service inventory data, point-in-time street count data, primary data collection (client and/or program interviews), and mainstream administrative data. All of these data sources support performance measurement.

Using Results to Drive Program Improvement

Performance measurement is often initiated to report program performance to current and potential funders. Equally important, if not more, is the opportunity to use program results to better understand the program's strengths and limitations and to make systematic changes that can improve client outcomes. A four-step process is outlined below.



STEP 1: Review Outcomes with Program Managers

The program director and managers should review results to understand program performance.

- Break the outcomes down to understand the underlying forces and what results suggest about each program:
- What are we doing right? What activities contributed to our ability to meet/exceed our benchmarks?
- Where do we need to improve? What activities fell short of producing the desired outcomes?
- What else might be contributing to our outcomes? How can we influence or mitigate these external forces to further our positive outcomes?

STEP 2: Develop Action Steps and Timelines

The goal of this step is to reinforce the good and adjust the bad. For outcomes that were achieved or exceeded, staff should continue to support the activities that led to positive performance. For outcomes that were not achieved, staff should allocate resources differently and/or support different types/levels of activities.

STEP 3: Implement Action Steps

Obtain buy-in by sharing information with other staff. You can't implement what you don't understand; program directors, managers, and front-line staff must understand the reasons for making changes in program operations. Information sharing promotes the idea that "we are all in this together," and that program directors, managers, and front-line staff can learn from one another. It's not a one-way (top-down) process. Then, there should be agreement on the steps to implement action steps. It may be easier to adjust program practices incrementally, and a methodical rollout of changes will allow agencies to gauge how changes are influencing results.

STEP 4: Perform Regular Monitoring

Reviewing outcomes should be a year-round activity. It is also important to review the impact of program changes on outcomes to determine whether the desired effect was obtained. You will need to monitor progress on regular intervals, but you will also need to periodically assess client demographics and needs. If client needs shift, then program practices may also need to be adapted.

SEARCH (HOUSTON, TX) AGENCY-WIDE PERFORMANCE MEASUREMENT SYSTEM

The Service of the Emergency Aid Resource Center for the Homeless (SEARCH) in Houston, Texas recently began an agency-wide assessment of performance measurement systems within each funded program. The result of this process was to create a framework for using outcomes to inform future program operations. The agency looked at performance measures created by each funded program to define agency-wide benchmarks, ongoing program monitoring standards, and agency goals.

SEARCH has faced the following key challenges during this process:

1. Data quality impacted the agency's ability to analyze program performance.
2. Activities for some programs (outreach, drop-in services) do not have an immediate outcome.
3. Program staff do not fully understand performance measurement, evaluation, and quality improvement.

In order to realign the agency's practices to achieve desired performance, staff engaged in a process similar to the one discussed in this section.

KEY POINTS TO REMEMBER FROM CHAPTER 3

- Establishing a program measurement system can help all program stakeholders—staff, board members, funders, and clients—to better understand the program's core purpose, strategies to achieve its goals, and current and anticipated results.
- Without a clear measurement structure, stakeholders probably lack a common understanding of the program and, therefore, will not all be working in the same way toward the same goal.
- Most importantly, understanding program results and the efforts that contributed to them, as well as those that were less effective, can drive program improvement and enhance each program's ability to better serve people who are homeless.

RELEVANT RESOURCES

Exhibit 3-1: Sample Program Logic Model

This exhibit illustrates how to use a logic model to describe an emergency shelter's efforts and outcomes.

Exhibit 3-2: Blank One-Year Logic Model Template

This exhibit includes a template for a simple one-year format that can be used by agencies to outline their own programs.

Exhibit 3-3: Blank Multiyear Logic Model Template

The multiyear format allows agencies to enter goals for the last fiscal year, actual results for that year, and revised goals for the current fiscal year based on the previous year's experience.

All exhibits are available at www.endhomelessness.org.

Chapter 4

Performance Measurement as a Management Tool for Your Community

Using Results to Manage or Change a Homeless System

This chapter

- Explains how to use program measures to inform resource allocation (e.g., giving out money) in order to address homelessness in your community more effectively;
- Discusses the concept of risk adjustment and how to consider program results within the context of the characteristics of clients to compare more fairly the results of one program with those of another program; and
- Describes how to set community targets for performance by program type.

Overview

Many communities throughout the country have adopted strategies to improve local efforts to end homelessness. At a time when homelessness is pervasive, communities struggle with how to allocate limited resources. More often, community decision makers are looking to program outcomes to inform, if not drive, local funding decisions. Program outcomes articulate program strengths and the extent to which programs can make an impact on the clients they serve, and outcomes provide a basis for comparing similar programs with one another.

This chapter describes several approaches for using program outcomes to manage homeless systems. In addition, program outcomes can be used to change systems by setting new community-wide expectations for different types of programs and establishing an incentive for programs to change the ways in which they do business. However, comparing program results throughout a system and awarding dollars on that basis does not come without risks. If differences in the clients served by programs are not accounted for, then comparing results may not be a fair assessment of program accomplishments, and this type of resource allocation approach may actually deter programs from serving those who are most challenging and most in need. Therefore, this chapter also discusses the concept of risk adjustment, which is a process to level the playing field for programs that serve different types of clients.

Using Performance Measurement for Resource Allocation

Local governments and private funders have always had to make tough funding decisions. Now, through HUD's McKinney-Vento Continuum of Care grant process, other community stakeholders are in a similar position. The CoC grant application process requires that a local decision-making entity review and rank applications for homeless assistance funding. Typically demand for resources far exceeds the amount available, so criteria for ranking proposals have to be developed. Many communities have turned to program performance as a key ranking factor. This means that local stakeholders need to be able to compare program results to understand performance.

First, you must decide what results you want to compare. What performance measure is appropriate? Chapter 3 provides some suggestions of performance measures for different program types, but that chapter focuses on how programs can develop measures themselves. For system comparison, all like programs must be compared against the same measure and must be able to report on those results. This means that the community or funder needs to define the performance measure up front, and programs need to be asked to collect data from the beginning that will allow them to report on the selected measure(s).

HUD has established three core performance measures for the program types that it funds.

- Permanent Housing Programs: The percentage of clients who remain stably housed for at least six months.

- Transitional Housing Programs: The percentage of clients who exit the program to permanent housing.
- All programs: The percentage of clients who increased their earned income.

Communities ranking programs for the HUD CoC application will want to consider program performance relative to HUD's performance goals, but they may want to consider other goals too. And communities may have or want to establish different expectations or measures for other funding sources.

The model is easiest to understand by following a hypothetical example of a community that adopted a Ten Year Plan to End Homelessness in 2005. At that time, the community established desired outcomes for each of the residential program types in its homeless system, as shown below.

> If we have limited dollars, let's fund the programs that are most effective.

At the beginning of the Ten Year Plan implementation, the community reviewed the outcomes of each program relative to its goals and identified its high-performing programs and its low-performing programs. For example, the community funds three emergency shelter programs that all serve similar populations; however, the shelters' rates of placement in permanent housing within 30 days ranged from 30 percent to 80 percent. Since all three programs serve a similar population, the community was very interested in understanding why the results varied so significantly.

Programs	Goal	Measure
Emergency Shelters	Facilitate immediate placement in appropriate permanent housing within 30 days of entry into shelter.	70% of clients who exit to PH within 30 days of program entry
Transition in Place Housing	Help people remain stable in permanent housing for at least 24 months, transitioning to economic self-sufficiency or a mainstream rent subsidy within that time frame.	80% remaining in program or housing for > 12 months from program entry 70% remaining in program or housing for > 24 months from program entry 55% who gain economic self-sufficiency in < 24 months
Permanent Supportive Housing	Help people remain stable in housing using supportive services to address disabilities that may jeopardize housing stability.	80% remaining in PSH > 12 months (and > 24 months) from program entry 60% who gain social and emotional self-sufficiency each year enrolled

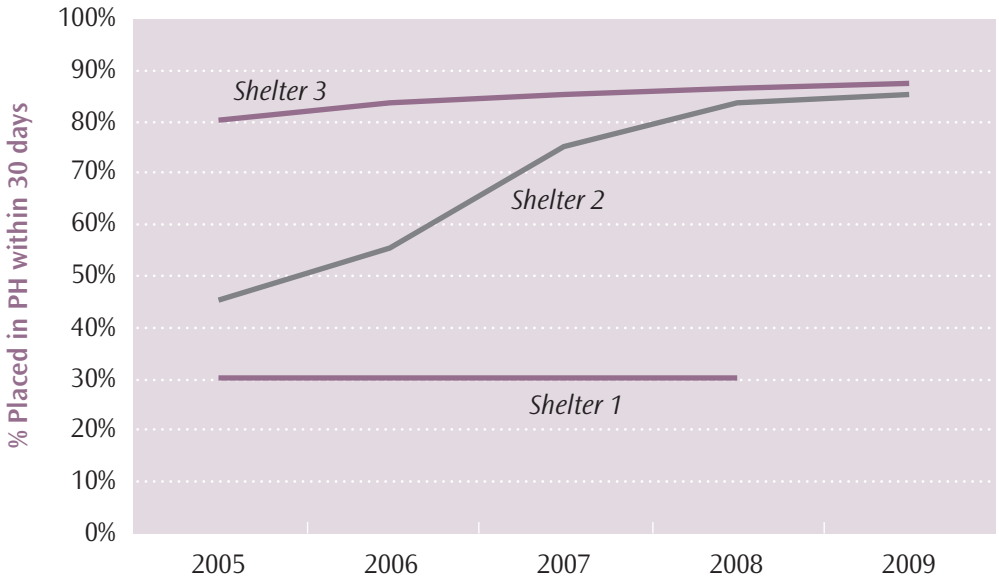
The community determined that Shelter 3 had adopted a new approach to housing assessment and placement that appeared very promising. Unfortunately, Shelter 3's approach also appeared to cost more for each client served. The community asked Shelter 3 to document its innovative approach, and community stakeholders agreed to monitor results of all three programs at least annually to determine if Shelter 3 was able to sustain its outcomes. Simultaneously, the community talked with Shelters 1 and 2 about their disappointing permanent housing placement rates. Both programs had ideas for improvements that they agreed to implement for 2006. Since Shelter 3's approach was still relatively new and appeared expensive, the community did not think that it was appropriate to ask Shelters 1 and 2 to adopt the practices in use by Shelter 3. Instead, these two programs were provided ample opportunities to improve results using their own strategies.

PH PLACEMENT OUTCOMES

	2005
Shelter 1	30%
Shelter 2	45%
Shelter 3	80%

The community reviewed results one year later in 2006. (See the chart above.) In 2006, Shelter 3 showed sustained results, whereas Shelter 1 had not improved at all. Shelter 2 did demonstrate improved placement rates, but they were not nearly as successful as Shelter 3. As a result of the 2006 findings, the community decided that it was time to replicate the Shelter 3 housing placement approach in the other shelters. It worked with Shelter 3 to develop and implement a training program and provided Shelter 3 with additional grant dollars to fund staff to mentor shelter staff at Shelters 1 and 2. It also modified the grant budgets for Shelters 1 and 2 to pay more for the enhanced approach and held trainings with staff from Shelters 1 and 2 on how to implement the new approach. Finally, the community warned that homeless grant funds would be awarded based in large part on performance beginning with the 2009 funding applications. Thus, if

EMERGENCY SHELTER PROGRAM HOUSING PLACEMENT OUTCOMES



Shelters 1 and 2 were not successful in improving their outcomes within a two-year period (by the time of their 2008 outcome results), then they were at risk of losing their grant funding.

From 2006 through 2008, the community also worked with all three programs to calculate and discuss outcome results on a quarterly basis. Even with all of the additional funds and support, Shelter 1 was unable to achieve higher results. Further inquiry revealed that the program staff did not agree with the approach being advanced by Shelter 3 and had not been willing to implement it. However, Shelter 2 did effectively adopt the new intervention and showed increasingly successful housing placement outcomes. After the 2008 outcomes were reviewed, the community decided not to fund Shelter 1 in 2009, and instead it expanded the programs at Shelters 2 and 3.

This example points out several very important points that help to summarize this approach.

1. The community sets performance expectations for different program types and clearly states how performance will be measured.
2. Program staff understand expectations, and they can manage their programs to achieve desired results. Thus, community measurement is likely to drive better community performance.
3. When results are communicated regularly, rather than once per year, programs have an opportunity to use results to improve performance, so performance measurement is as much about technical assistance as resource allocation.

Comparing Like to Like: Risk Adjustment

While the previous section references the ability of communities to compare results of programs, this approach may also create a disincentive for programs to serve clients who are less likely to achieve desired outcomes. One way to mitigate this concern is to adjust program results based on the type of clients a program serves; the process of accounting for differences in client populations that are served by different programs is called *risk adjustment*.

For instance, you might lower your expectations for programs that serve people with chronic disabilities, which would mean that you could multiply their results by a percentage (e.g., actual program outcomes × 125 percent = adjusted outcomes) to account for the additional barriers their clients face. Alternatively, you could adjust a program that serves higher-functioning families by multiplying their results by a percentage less than 100 (e.g., actual program outcomes × 90 percent = adjusted program outcomes.) The percentages, referred to as *risk adjustment factors*, allow program results to be compared with one another even if their populations are different.

The following example compares results for two programs to illustrate why it is important to consider client outcomes within the context of client characteristics. The program

outcomes reflect *the percentage of clients that increased their employment income during the year.*

In the first row of the figure below, both Program A and Program B include all clients in their calculations. In Program A, 61 percent of clients increased their earned income, while in Program B only 23 percent did. Therefore, it appears that Program A is significantly more successful than Program B. However, in the next two rows, the results are calculated separately for disabled and nondisabled clients. Separating the results recognizes that disabled clients face many more barriers obtaining employment than nondisabled clients. Additionally, increasing income may not be the primary goal for disabled clients, who may instead be focusing on increasing benefit income, building independent living skills, obtaining volunteer work, or participating in other community or supportive service activities.

PROGRAM A	PROGRAM B	COMBINED OUTCOME RESULTS BY POPULATION
All Clients (n = 100)	All Clients (n = 300)	
61% (61) gained emp. income	**23%** (70) gained emp. income	
Disabled Clients (n = 10)	Disabled Clients (n = 250)	Disabled Clients (n = 260)
10% (1) gained emp. income	**12%** (30) gained emp. income	**12%** (31) of disabled clients gained emp. income
Nondisabled Clients (n = 90)	Nondisabled Clients (n = 50)	Nondisabled Clients (n = 140)
67% (60) gained emp. income	**80%** (40) gained emp. income	**71%** (100) of nondisabled clients gained emp. income

As illustrated in the figure, when the disabled clients were separated from the nondisabled clients in these two programs, results are much more comparable though Program B is actually more successful than Program A. For instance, Program A increased employment income for 10 percent of its disabled clients while Program B increased employment income for 12 percent. Similarly, Program A increased employment income for only 67 percent of its nondisabled clients while Program B increased employment income for 80 percent. These results may lead the CoC or other funding entity to further investigate Program B's approach. How have they increased employment income for 40 out of 50 nondisabled clients? Are there best practices or promising strategies that could be applied to other programs here?

You do not want to encourage "creaming" to ensure strong results. Risk adjustment helps communities avoid that problem. You can use risk adjustment techniques to adjust results

on the basis of client characteristics, such as demographics; family size; disability status; client history, such as past evictions or criminal background; or client functionality or their level of engagement in the program and commitment to change.

However, risk adjustment requires expertise and a fair amount of planning before use. Keep in mind the following points:

- You may need to engage a researcher or other expert to assist in the development of risk adjustment factors.
- Communities need to determine which characteristics affect client outcomes, so there is an appropriate rationale for adjusting results on the basis of those characteristics.
- To adjust for client differences, programs need to collect consistent data on clients to use during analysis of results.
- Even if you don't formally adjust results, acknowledge that different programs may have different outcome expectations based on differences in clients targeted and/or served.

Setting Community Targets and Learning from Practice

This section describes three ways to use program performance to manage and improve systems. The first uses program performance to establish community standards and to encourage peer-to-peer learning. The second uses program results to understand which clients thrive at different programs and to use those lessons to triage or direct clients where

STATE OF ARIZONA SELF-SUFFICIENCY MATRIX

The State of Arizona partnered with the Virginia G. Piper Charitable Trust to develop the Arizona Self-Sufficiency Matrix (SSM). The matrix is a case management assessment tool that includes 13 domains related to self-sufficiency. The case manager uses the tool to assess a client on each of the domains in the SSM at program entry and again at exit. Results are recorded in the HMIS. The HMIS calculates the changes in self-sufficiency for each client based on subtracting the composite self-sufficiency score at program entry from that at exit. The State of Arizona and the Maricopa County CoC have been able to determine reasonable expectations for changes in self-sufficiency by program type and have used the results to identify which programs are more or less effective overall and with specific subpopulations. This has also led to CoC-level discussions about referring clients at intake to programs where they will be most successful.

Interestingly, the State of Michigan has adopted the SSM as a risk adjustment tool, so client outcomes can be compared based on their self-sufficiency score at program entry. Programs that serve a higher proportion of clients with lower self-sufficiency at entry may not be expected to achieve the same outcomes as those that serve persons with higher self-sufficiency.

they will be most successful. The third strategy uses program results to shape system planning, that is, to think about how the system as a whole should function to better address homelessness.

Establishing Community Targets and Fostering Peer-to-Peer Learning

Once a community has reasonable evidence to understand what performance can be expected by different program types in relation to different client characteristics, the community can set targets for performance by program type, such as the targets for employment for different subpopulations suggested by the example illustrated in the risk adjustment section. Further, the section on resource allocation discussed the phenomenon that measuring expectations and regularly communicating results can result in improved performance. Thus, communities may improve program performance in part by defining and communicating what programs should be achieving. For instance, if previous analysis reveals that local permanent supportive housing programs are successful at maintaining resident housing stability for at least 12 months, then the community may want to set a community benchmark for permanent supportive housing stability.

> ***Example of Permanent Housing Stability Standard:*** *90 percent of residents placed in permanent supportive housing programs are expected to remain stably housed for at least 12 months. (Note: stably housed needs to be defined as part of the community standard. For instance, permanent stable housing could be defined as remaining in the same permanent supportive housing program, the same physical housing unit, or any permanent supportive housing program.)*

Then, permanent supportive housing programs that exceed the local benchmark, 90 percent in this example, can be recognized as high-performing, and those that fail to meet the benchmark can work with the community to understand why they did not meet the target and to develop strategies to improve.

If performance measurement is viewed as a strategy to drive program improvement, then measuring results presents a real opportunity to encourage peer-to-peer learning. High-performing programs can literally be paired with lower-performing programs to mentor and help identify strategies that work to achieve desired client outcomes. Alternatively, communities can work with high-performing programs to understand the practices that contribute to their success. These lessons or practices can be translated into technical assistance materials that can be used to train lower-performing programs.

Triage Strategies: Matching Clients with Interventions

Program performance is a result of many different factors, including the types of clients the program serves. Risk adjustment was introduced earlier to help adjust program results on the basis of client characteristics to allow fair comparison of results across programs. Yet, the concept of risk adjustment should not suggest that all programs should work with

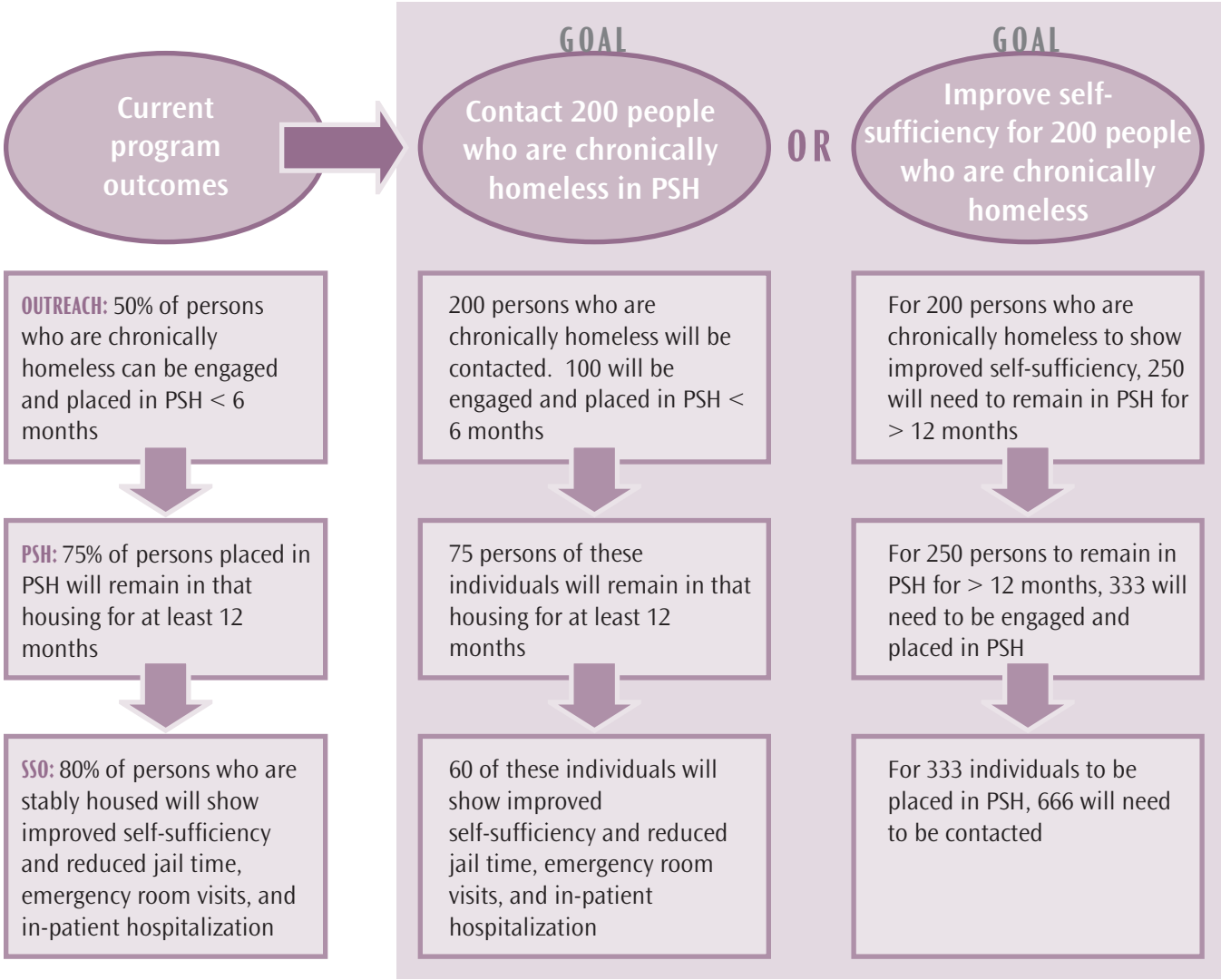
the same types of populations. In most cases, some programs will work better with some populations than others. For instance, one agency may offer mental health services in addition to its homeless programs, and they may have the agency culture and staff skills that make them best suited to work with clients with mental illness. Another program may be very effective at engaging runaway youth, and another at working with those with long-time substance addictions. By analyzing client outcomes in relation to client characteristics, the agencies and community planners can identify if a program is particularly successful with particular subpopulations. Armed with this information, programs can decide whether they want to build on that success by specializing on a particular population or whether they want to train staff or adjust program practices to improve their ability to serve other populations. The community as a whole can also respond to these decisions by understanding program strengths and referring people who are most appropriate and likely to be most successful in each program.

Using Performance Data for System Planning

All of the material presented in this section relates to how the CoC can use performance information to improve system results, such as by managing how dollars are spent or managing how clients flow to various programs. Yet, there is another dimension of system planning that can be achieved with good information about program performance.

The chart below illustrates how a good understanding of program outcomes can translate into system planning. The first column shows a hypothetical community's current program outcomes for outreach programs, permanent supportive housing programs, and supportive service only (SSO) programs that are all working with people who are chronically homeless. Based on these outcomes, the community can develop estimates of the level of effort required to meet certain community goals. The second column shows the expected outcome if the community sets a goal for the outreach program to contact 200 persons who are chronically homeless and living on the streets. The third column shows how many people each program would need to work with if the community wanted to achieve housing stability and improved self-sufficiency for 200 people who are chronically homeless.

This process can be extended to all populations or program types. It represents an attempt by the community to understand how programs fit together to build a system that ends homelessness and the system's cumulative outcomes. Chapter 5 of this guidebook discusses how to evaluate the overall system to determine if the system-level goals are being met.


Current program outcomes
GOAL
Contact 200 people who are chronically homeless in PSH
OR
GOAL
Improve self-sufficiency for 200 people who are chronically homeless
OUTREACH: 50% of persons who are chronically homeless can be engaged and placed in PSH < 6 months
200 persons who are chronically homeless will be contacted. 100 will be engaged and placed in PSH < 6 months
For 200 persons who are chronically homeless to show improved self-sufficiency, 250 will need to remain in PSH for > 12 months
PSH: 75% of persons placed in PSH will remain in that housing for at least 12 months
75 persons of these individuals will remain in that housing for at least 12 months
For 250 persons to remain in PSH for > 12 months, 333 will need to be engaged and placed in PSH
SSO: 80% of persons who are stably housed will show improved self-sufficiency and reduced jail time, emergency room visits, and in-patient hospitalization
60 of these individuals will show improved self-sufficiency and reduced jail time, emergency room visits, and in-patient hospitalization
For 333 individuals to be placed in PSH, 666 will need to be contacted

KEY POINTS TO REMEMBER FROM CHAPTER 4

- Compare program results on specified community measures to understand which programs are most successful to help inform resource allocation and program improvement. For instance, successful programs can share their practices with less successful programs.
- Use risk adjustment techniques to adjust results on the basis of client characteristics, client history, or client functionality before you begin comparing program results. Engage experts to develop risk adjustment strategies and communicate results appropriately.
- Set targets for performance by program type, such as permanent supportive housing programs. You may improve program performance in part by defining and communicating what programs should be achieving based on the unique populations that programs serve and approaches used.

RELEVANT RESOURCES

Exhibit 4-1: Program-Level Reporting

This sample report describes how one community has established outcomes for each program type for purposes of comparing and using program results across agencies to make decisions about how to allocate and manage system resources. The report also includes sample report results for one agency as part of the community's strategy to communicate program results quarterly to agencies so they have an opportunity to improve them.

Exhibit 4-2: System-Level Reporting

This sample system-level report illustrates system-level results on 13 outcomes related to clients enrolled in case management programs.

All exhibits are available at www.endhomelessness.org.

Chapter 5

Measuring Big Change: How Will We Know When We End Homelessness?

Understanding and Implementing System-Level Performance Measurement

This chapter

- Provides an overview of performance measurement at the system level, and
- Discusses system outcomes that might be included in a Ten Year Plan and strategies to measure progress on these outcomes.

Overview

While each program within a homeless system is working toward its own goals, your system should also have end goals—something each provider is working toward as part of a common mission. Community or system goals are often articulated in a community's Ten Year Plan to end homelessness. Whether it is to keep people from sleeping on the streets or to provide permanent housing for those most in need, your goal(s) should be directly related to the problem(s) you are trying to solve. System-level performance measurement emphasizes the *shared* mission of all the system's parts and measures the system's ability to achieve its *shared* goals. If it does, what makes it work? If it doesn't, what part of the system does not work as expected and how can you fix it? System-wide effectiveness may look at all homeless assistance programs in your community, or it may focus on a subset of the larger system—for example, the family homeless assistance system. System goals may also relate to certain types of clients—for example, severely disabled persons or parenting teens. System measurement is closely related to program performance, because systems are comprised of programs; however, system measurement also accounts for the effectiveness of the relationships between programs and the cumulative impacts.

Let's consider the example of a community that sets a goal to shorten the period of time that people spend homeless to less than 30 days. The community may have three shelter programs, each of which is successful at exiting clients in approximately 30 days; however, if people bounce from one program to another to another, the average length of time that people spend homeless across all programs may exceed 90 days—falling far short of the community's goal. Therefore, this example reveals why it is so important to look beyond program performance in order to understand the cumulative performance of the system.

All of the elements of a homeless system (prevention, outreach, shelter, permanent housing, rapid re-housing, services, etc.) should fit together to meet common goals. Although systems may evolve organically to meet needs and help people who are homeless, systems are generally stronger if there is an articulated plan of how programs interrelate and what they are intended to accomplish together.

Chapter 2 introduces the concepts of interim and impact outcomes. *Interim outcomes* and *impact outcomes* describe changes in the system at different periods of time. Interim out-

WHAT IS THE GOAL OF YOUR HOMELESS SYSTEM?

- To prevent homelessness?
- To immediately re-house people when they experience homelessness?
- To address the factors that led to people's homelessness so they can locate and remain in housing on their own?
- To increase people's self-sufficiency so they will remain housed?

You have to know your system's goal before you can see if the system is working.

INTERIM VERSUS IMPACT OUTCOMES

Interim Outcomes are benchmarks of progress that measure the way clients or their circumstances need to change in order to meet the system's end goal.

➤ *Thirty percent of chronically homeless people who were contacted on the streets moved into permanent supportive housing within a year of the initial contact.*

Impact Outcomes are direct measures of status on end goals.

➤ *We achieved a 25 percent reduction in chronic homelessness during the past year.*

comes indicate change along the way and at the system level can be used to indicate progress toward your system's end goals.

For example, let's say that your system's goal is to reduce chronic homelessness. How would you measure progress toward that goal? You could calculate *the number of chronically homeless clients who originally came from the streets who were moved into permanent supportive housing (via emergency shelter, Safe Haven, or directly from the streets) and retained that housing for at least 6 months, 12 months, and 24 months.* You could also measure a reduction in recidivism: *fewer chronically homeless clients return to shelters or are observed by street outreach teams after placement in housing than in the past.* While both of these outcomes provide an indicator of progress toward reducing chronic homelessness, neither tells the extent of the impact. Instead, they illustrate a change in client behavior that is necessary to achieve your goal. They suggest impact, but they are only interim outcomes. Impact itself is measured by a *sustained reduction in the incidence of chronic homelessness*. Since impact outcomes are often harder to measure and take longer to demonstrate, many communities use interim outcomes to imply impacts.

System Measures and Ten Year Plans to End Homelessness

Performance measurement is an integral part of a Ten Year Plan to end homelessness. Many Ten Year Plans outline past efforts to combat homelessness and provide different strategies or innovative solutions to tackling homelessness issues going forward. To understand if the new strategies are more effective, communities must measure progress toward interim and impact outcomes.

Examples of impact outcomes that may be identified in Ten Year Plans include:

- Declines in the incidence of homelessness,
- Reductions in the lengths of time that people spend homeless or in temporary housing,

BROWARD COUNTY, FLORIDA — TEN YEAR PLAN STRATEGIES

In Broward County, Florida's Ten Year Plan, strategies to end homelessness are divided into nine subject areas: Data, Systems Prevention, Emergency Prevention, Street Outreach, Treatment and Services, Discharge Planning, Rapid Re-housing, Shortening the Time People Spend Homeless, and Permanent Supportive Housing. Each area has an oversight committee and specific objectives. Each objective identifies action steps that are associated with responsible parties, outcome measures, funding sources, and target dates.

A number of the objectives outlined in this Ten Year Plan include detailed action steps and measurable outcomes. For example, the plan includes an overarching goal of ensuring that eligible clients receive mainstream benefits in a timely manner. The performance measures identified include the establishment of a baseline average timeline for clients who receive benefits (such as food stamps, unemployment, TANF, SCHIP), to increase the number of people receiving benefits, and to expedite their receipt.

- Prevention of first-time homelessness, and
- Elimination of or reductions in repeat occurrences of homelessness.

Note that homelessness prevention and reduction in recidivism may be impact outcomes if they are the end goal of the plan or effort, but they may also be interim outcomes required to reduce the overall incidence of homelessness.

The scope of the Ten Year Plan will dictate whether some or all of these impact measures apply. Ten Year Plans to end homelessness that target specific client populations, such as a Ten Year Plan to end *chronic homelessness*, would measure impact by declines in the incidence of chronic homelessness. A Ten Year Plan focused on *the Housing First approach* or rapidly re-housing those in need would measure impact by a reduction in the length of homelessness. A broad-reaching Ten Year Plan might seek measurable impacts on all of these.

Data to Measure System Impact

To measure progress against plan goals, you need good quality data that are collected consistently across the parts of your system. Without quality data, you cannot illustrate success (or failure).

As we have said before, HMIS is an invaluable tool to track progress and analyze your results. At the system level, HMIS data allow communities to examine the outcomes of persons across different programs. If you are relying on HMIS data, you need to ensure that you have good data quality. In particular, you need a high level of providers contributing data to the HMIS; each provider must enter complete identifiers for each client to allow all of the client records to be de-duplicated on the backend; and each provider must record accurate residential entry and exit dates for each residential stay as well as

dates of service for each major service transaction.

Besides HMIS, there are a number of other data sources available at the system-level to track outputs and outcomes for the system:

- Shelter and service inventory data;
- Point-in-time street counts;
- Client and program interviews and other primary data collection;
- Mainstream administrative data; and
- Documentation of system efforts, such as evidence of discharge planning agreements.

All of these sources support system-level performance measurement. Depending on your community, you may have all or only a few of these resources available to you. There are a couple of caveats you should keep in mind while using data to conduct system-level performance measurement:

1. **System analysis may require a lag in time even beyond clients' completion of programs.** For example, measuring recidivism requires a certain period of time (e.g., 12 months) after program exit in which a return to the system may occur. It is up to your community to develop definitions and business rules around performance measures to ensure that you set the proper parameters for your measures.
2. **If your HMIS or other administrative system only includes data from a subset of programs, the system analysis will provide an incomplete picture.** For example, a perceived decline in recidivism may only reflect absence from participating providers as opposed to a large number of clients who have not re-appeared in the system.

USING HMIS DATA TO TRACK PERFORMANCE

If your community has a high percentage of its homeless providers entering data about the clients they serve into the HMIS, these data can be easily analyzed to generate regular point-in-time counts or reports to understand homelessness in your community.

- How many people are homeless today? How many were homeless on an average day this quarter as compared with the same quarter last year?
- How many different people experienced homelessness over the last year as compared with the year before?
- Are new people becoming homeless; or are the same people still in the system because they are staying extended periods of time in shelter or homeless programs; or are people exiting homelessness, but becoming homeless again sometime later?

This analysis can help you track progress on your goals, and it can also help inform whether you need to work on prevention (closing the "front door," so new people do not become homeless), getting people out of the system into housing (opening the "back door"), or helping people who exit the homeless system to remain stably housed.

Measuring Interim Outcomes at the System Level

Now that we've talked about impact outcomes, let's talk more about interim system outcomes that might suggest whether the system is working for people who are homeless. Often it makes sense to examine traditional program measures, such as placement in permanent housing, across the whole system to gauge interim success. For instance, you may

COLUMBUS, OHIO — PERFORMANCE MEASUREMENT SYSTEM WITH HMIS-BASED PROGRAM STANDARDS

The Community Shelter Board (CSB), a nonprofit umbrella homelessness organization in Columbus, OH, was created in 1986 to respond to the growing needs of homeless people in Franklin County. CSB is a nonprofit intermediary, funding shelter, supportive housing, and related services and also planning and coordinating services. CSB developed a performance measurement system in 2003 and began tracking key indicators that provided program managers with information about outcomes. This system helped CSB understand their programs and make adjustments that led to reductions in family homelessness. CSB tracks a number of performance measures using data from their HMIS. The chart below presents the performance measures that CSB tracks for different programs, including transitional housing and permanent housing.

Measure	Prevention	Outreach	Emergency Shelter	Resource Specialist	Direct Housing	Permanent Supportive Housing
Number Served	✓	✓	✓	✓	✓	✓
Successful Housing Outcomes	✓	✓	✓	✓	✓	
Average Length of Stay			✓			
Recidivism	✓	✓	✓	✓	✓	
Movement			✓			
Successful Income Outcomes			✓			✓
Direct Client Assistance Utilization		✓		✓	✓	
Occupancy			✓			✓
Housing Stability						✓
Housing Retention						✓

CAMDEN COUNTY — TEN YEAR PLAN BENCHMARKS

The Camden County Ten Year Plan is built on the foundation of a Proposed Plan of Work chart. The objectives are broken up into six categories: Prevention, Shelter, Affordable Housing, Supportive Services, Employment/Income Maintenance, and Advocacy. Within each category, Camden listed action steps, parties responsible for implementation, a time frame, performance measures, and what was to be accomplished in the next 12 months. A number of strategies begin at the macrolevel, such as establishing a better working relationship with public agencies that determine financial benefits for the homeless with specific performance measures. For this strategy, the outcome measure is to have 12 homeless persons with increased income and 24 additional homeless persons receiving mental health counseling by January 2007. Camden County identified a way to use microlevel outcomes as benchmarks of success for macrolevel endeavors.

analyze HMIS data to see the percentage of people who exit homelessness for permanent housing, as of the last program they used. Therefore, while someone may move from emergency shelter to transitional housing and then to permanent housing, across all programs they are eventually successful in exiting homelessness to permanent housing. The number of programs the person uses or length of time that it takes to return to permanent housing may be measures of efficiency in reaching the end goal.

Let's look at another example. Take a community where 95 percent of people obtain and retain employment for 12 months or more based on support from the homeless assistance system's employment-focused programs. However, the data may reveal that, on average, people get three jobs before they retain one for 12 months of more. Therefore, Sue may take a job-counseling class, find a job, lose it the next month, get support from a different job program to find another job that she ends up losing a couple months later, and finally get a third job while she's enrolled in a transitional housing program that she ends up keeping for at least 12 months. It may be that the transitional housing program was more effective at placing Sue in the right type of job or provided a stable living environment that helped her retain it. But it may also be true that employment retention is incremental, and that her employment success was a reflection of all three programs and the process that she had to go through to learn how to be successful in full-time employment. Ultimately, Sue was successful in achieving stable employment, but the community must use the data to probe further to understand whether the three-step employment outcome is an efficient route to stable employment or whether other strategies could achieve the same goal more efficiently.

If by evaluating the results of the interim analysis a community concludes that the system is not working as efficiently as it should, it may want to consider *which programs are working best or least well.* The community can use program comparison methods discussed in Chapter 4 to compare program results and manage and improve system results.

KEY POINTS TO REMEMBER FROM CHAPTER 5

- Communities must set goals and consider how they expect each part of the system to contribute to these goals.
- Interim outcomes can be used to understand how parts of the system or the overall system are affecting client knowledge, skills, behavior, or condition, as an intermediate gauge of overall system impact.
- Impact outcomes help the community determine whether the homeless system is making a difference relative to its goals and provide powerful data that can be used by the community to communicate its successes.
- Both types of outcomes can be used to help a community decide whether to continue actions, expand current efforts (by adding resources to the system), tweak current efforts, or fundamentally change the structure and approach of the homeless system. They also help communities understand whether past actions (e.g., adding resources or expanding a segment of the system) helped to address needs.

RELEVANT RESOURCES

Exhibits 5-1, 5-2, and 5-3 are tools you can use to help your community develop a system-level performance measurement strategy:

Exhibit 5-1: Measuring Progress on the Ten Essentials to Ending Homelessness

This exhibit provides sample performance measures for monitoring progress on the National Alliance's Ten Essentials to Ending Homelessness. The table provides sample outcomes for the various strategies that communities might employ in their Ten Year Plans. We also encourage you to refer to the *Ten Essentials: A Guide to Ending Homelessness* (http://www.naeh.org/section/tools/essentials) for more information on creating and implementing a Ten Year Plan to end homelessness.

Exhibit 5-2: How to Calculate a System Outcome

Exhibit 5-2 illustrates the technical process for calculating system measurement results, using the example of measuring a homeless system's effectiveness at increasing client incomes.

Exhibit 5-3: Sample Performance Measurement Framework

A performance measurement framework is an overview of the outcomes you expect from each part of your homelessness system, as well as the system overall. This exhibit includes a hypothetical example for a sample community.

All exhibits are available at www.endhomelessness.org.

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