

REGIONAL PLAN TO END HOMELESSNESS

**MARICOPA REGIONAL
CONTINUUM OF CARE**

2018

Continuum of Care Board Co-Chairs

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Executive Summary

The Maricopa Regional Continuum of Care (CoC) represents the Phoenix metropolitan area. The CoC is committed to collaboration and coordination on a regional basis because we know that homelessness does not stop at any one city's borders. Working together towards common goals, we will care for our neighbors and ensure that the county's residents have access to safe, affordable, and stable housing.

The previous plan developed by the CoC was successful by focusing on three key goals:

- Raising awareness and support for coordinated responses to end homelessness;
- Leveraging funding, services, and housing by creating new innovative partnerships and strengthening collaborative relationships; and
- Increasing permanent supportive housing units and rapid re-housing units for individuals and families experiencing homelessness.

While we are proud of our accomplishments thus far, we know that there is still significant work to be done. We are committed to forging a path for the most vulnerable among us and know the real risks faced by our friends living on the streets. We mourn those lost to us in the harsh desert climate of our area and are mindful that one-third of all heat-related deaths in the region are people experiencing homelessness. For our community, ending homelessness is truly a life or death proposition. The

following Plan to End Homelessness is our roadmap towards a day when the community has ample resources and a seamless homeless services delivery system for every individual and family experiencing homelessness.

To continue on the path towards ending homelessness in the region, our priorities are:

- Targeting homeless services through a robust and easily accessible coordinated entry system;
- Delivering homeless services that decrease barriers to housing and determine eligibility based on vulnerability and service needs;
- Strengthening partnerships to create additional housing and freeing housing dollars by leveraging housing resources with Medicaid-billable services; and
- Showing improved system performance year-to-year, to track progress towards overall goal of ensuring that homelessness in the region is rare, brief and non-recurring.

This new plan reaffirms and builds upon the goals made in the previous plan by working to expand housing resources to meet the needs of those experiencing homelessness in our community. The goal is to create a long-term sustainable system that ensures that homelessness in our community is brief, rare, and non-recurring.

Maricopa Regional Continuum of Care

Who is involved in the regional effort to end homelessness?

At the center of this effort to end homelessness in the region is the Maricopa Regional Continuum of Care, coordinated by the Maricopa Association of Governments (MAG).

We are fortunate to have the best and the brightest in our community committed to ending homelessness. Through MAG's stakeholder community, including the region's mayors, city council members, the County Board of Supervisors, and other elected officials, the issue of ending homelessness in our region has been highly prioritized. Funding partners meet regularly to align resources in order to meet regional needs, both with private and public housing resources.

In addition, major healthcare providers have led efforts to address medically vulnerable persons. The area's Regional Behavioral Health Authority commits to and leads community behavioral health initiatives.

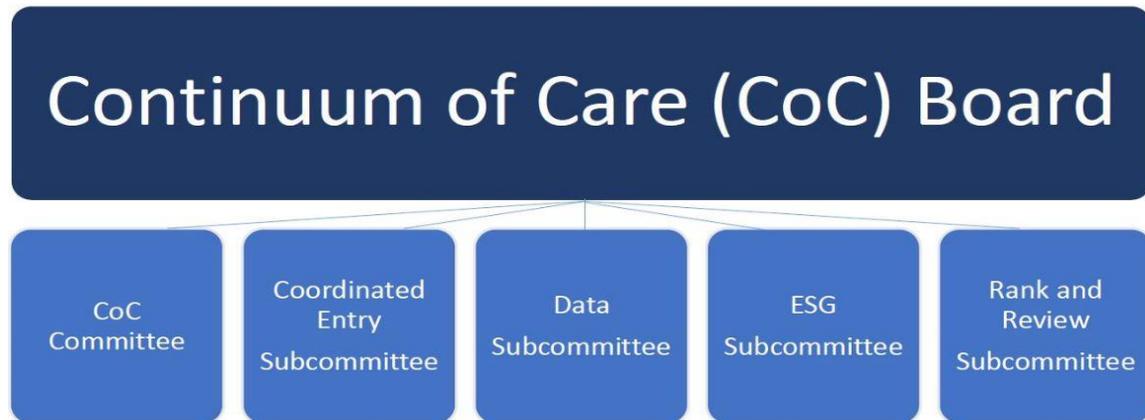


To connect those living on the street with health and housing services, providers such as police, fire, and other first responders partner with street outreach. The criminal justice system also works hand-in-hand with behavioral health and homeless service providers through implementation of innovative programs for the justice-involved population experiencing homelessness.

In addition to the healthcare and justice systems, state child welfare representatives connect youth aging out of the foster care system with resources and oversee the needs of children and youth in the homeless services system. School liaisons work with school-aged children to ensure that education is not interrupted by episodes of homelessness.

The Continuum of Care stands at the center of regional efforts and is led by a diverse and expert governing board, assisted by five key groups, and is reflective of the systems described above.

What is the Maricopa Regional Continuum of Care?



The governing board and the five primary groups are represented by stakeholders in the community that include: formerly homeless individuals, single providers, family providers, youth providers, veterans and veteran advocates, outreach teams, domestic violence advocates, the criminal justice system, the healthcare system, the behavioral health system, the child welfare system, elected officials, the police department, the fire department, Emergency Solutions Grant recipients, Public Housing Authorities, and private funders. The roles of the primary CoC stakeholders are described below.

The CoC Board is the policy-setting and decision-making body for the Maricopa Regional Continuum of Care. The Board develops, annually updates, and follows the governance charter in consultation with CoC (MAG) staff and the Homeless Management Information System lead (CIR). The Board works to strengthen the homeless services system by providing guidance and support to nonprofit homeless services providers and taking appropriate action on the performance of those providers.

The five key groups recommend policies to the CoC Board in the following ways:

The CoC Committee is a collaborative of cross-sector stakeholders providing housing and services to people experiencing homelessness in Maricopa County. The purpose of the Committee is to provide input and recommendations to the Continuum of Care Board and MAG staff, and support communication across groups.

The Coordinated Entry Subcommittee serves to problem-solve issues facing the coordinated entry system and provides policy recommendations to the Continuum of Care Board on principles and guidelines for the system.

The Data Subcommittee provides a forum to review data, provide input and make recommendations to the Continuum of Care Board on policies related to the Homeless Management Information System data collection and use. Using data to inform decisions and planning, the Data Subcommittee contributes expertise to effectively use community data. It is important to the CoC Board that there is consistency about data collection, the definition of data categories and that data transparency exists throughout the CoC. The Data Subcommittee consists of providers, funders, the singles and families coordinated entry leads, and the HMIS lead.

The ESG Subcommittee consults with the CoC Board to foster collaboration and coordination of ESG and CoC-funded services and performance outcomes.

The Rank and Review Subcommittee ensures the objective review of performance metrics, and seeks to maximize HUD CoC funding through rating and reviewing projects recommended for funding. They also analyze the CoC's portfolio of interventions to restructure resources in order to meet regional homeless needs, and provide those recommendations to the Board.

Summary of Homelessness in Maricopa County

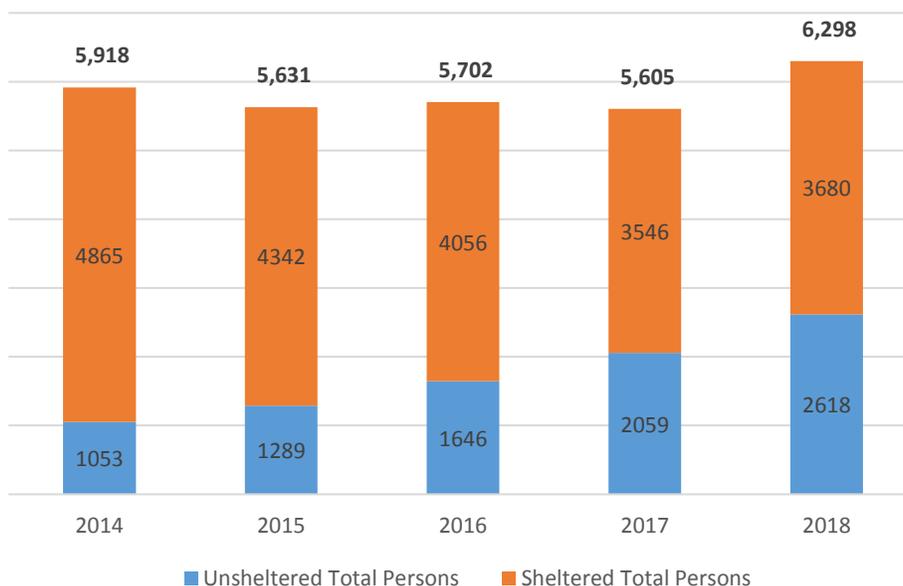
Why is it Important to End Homelessness?

The health of our communities may be measured by the economic well-being of its residents. The cost of homelessness includes costs incurred by law enforcement, the healthcare system, city services like zoning and code enforcement, and the toll it takes on neighborhoods and businesses where people experiencing homelessness may congregate in parks and on the streets. Some communities bear a disproportionate burden, such as when services or encampments are centralized. The greatest concentration of people experiencing homelessness is in the City of Phoenix. However, trends show the unsheltered population increasing in all communities in Maricopa County. Moreover, increases in the County's general population has had an impact on housing availability and costs that exacerbates the issue.

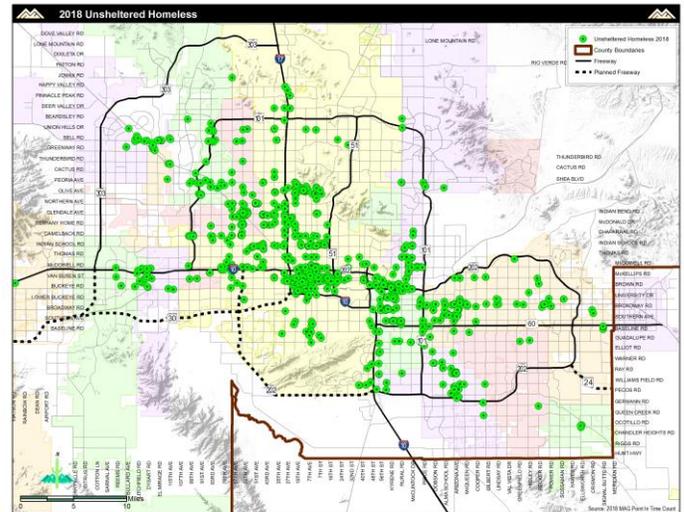
According to the U.S. Census Bureau, between July 1, 2016 and July 1, 2017, Maricopa County gained more than 73,000 people, an increase of more than 200 people per day. The burgeoning population brings challenges associated with absorbing the highest number of new residents in the country. Challenges include rising housing costs and a tight private rental market run by landlords reluctant to rent to vulnerable populations who tend to “fall through the cracks”.

The annual Point-in-Time (PIT) Count is a one-night snapshot of homelessness in the region, and can be supplemented with other data sources to provide a better understanding of what is going on in the community. The 2018 PIT Count showed an overall increase from previous years' counts.

Point-in-Time Count Total Persons, 2014-2018



The number of unsheltered individuals and families has continued to rise each year, with a 149% increase since 2014. A map of the 2018 PIT Unsheltered Count depicts the scatter of unsheltered homelessness. As expected, the largest density is in the city of Phoenix, with significant scatter in all directions compared to previous years. Efforts must continue to target the increasing unsheltered population across the region.

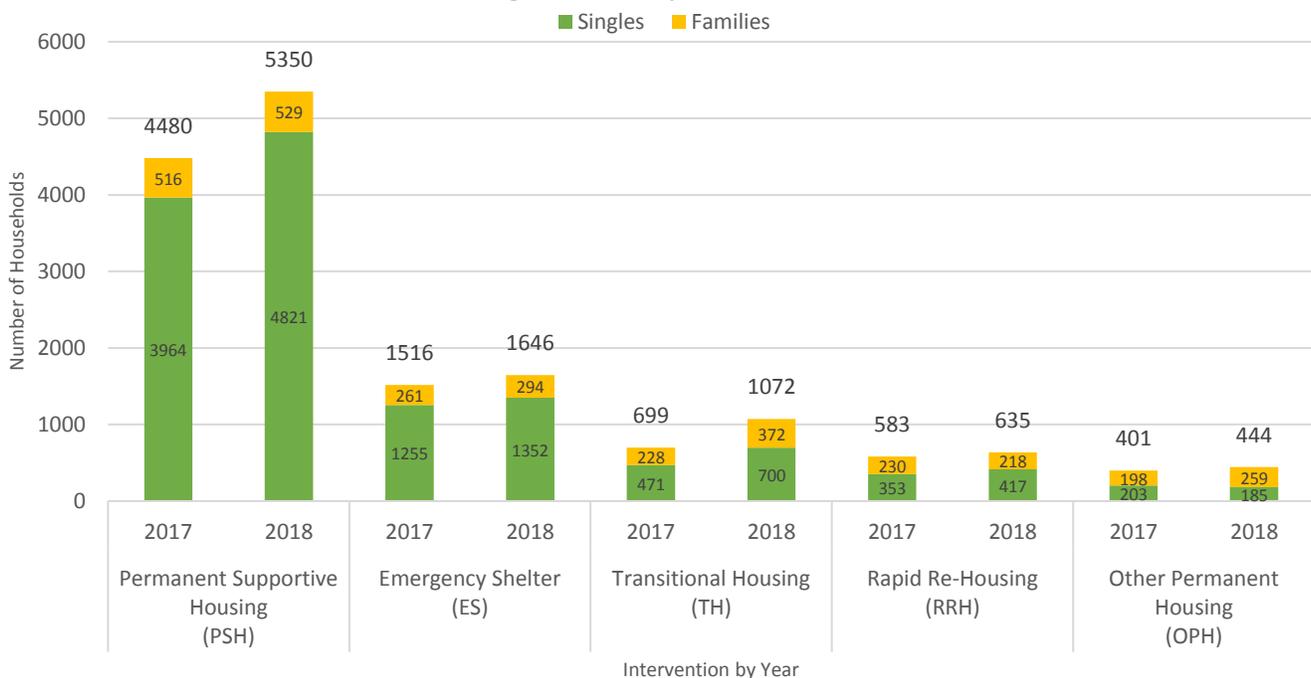


Through focused work on Veteran homelessness, the community now has resources to end homelessness for Veteran families within 30 days, achieving functional zero. To build upon these successes with the veteran population, the community has added resources to pave the way toward similar success for other target populations. The community actively participates in the Built for Zero initiative, a national effort to end veteran and chronic homelessness by using quality data to measure outcomes.

However, there is still a long way to go to provide enough affordable units in Maricopa County; there

is a deficit of 116,080 units for households at or below extremely low income (ELI) thresholds. For every 100 households at or below ELI thresholds, there are 21 affordable and available units. For households at or below 50% of the area median income (AMI), there is a deficit of 119,237 units. There are only 48 affordable and available units per 100 households at or below 50% of AMI, according to the National Low Income Housing Coalition’s March 2017 report.

Housing Inventory Chart, 2017-2018



What is the Impact of the Maricopa Regional Continuum of Care?

- Awarded \$25.89 million from the U.S. Department of Housing and Urban Development's FY 2017 Continuum of Care Program Competition to fund 41 local homelessness programs.
- Provided long-term housing and services. Significantly, 93% of formerly homeless residents in permanent housing programs (not including RRH) exited to permanent housing destinations or retained their housing in FY2017 (SPM Metric 7b.2).
- Provided regional services to ensure that veteran families experiencing homelessness are immediately connected with housing and related services.
- Implemented a monitoring protocol to assess how closely nonprofit providers adhere to HUD compliance, including low-barrier or Housing First model and Coordinated Entry participation, so that the most vulnerable individuals and families have immediate access to housing.
- Achieved success in diversion strategies. In 2017, coordinated entry successfully diverted 1,213 families from entering the homeless services system, with no return for service. For individuals, coordinated entry diverted 439 individuals from the homeless services system (Family Housing Hub and Singles Coordinated Entry 2017 Reports).

Local Initiatives

Maricopa County StandDown

Annually, the StandDown event for veterans experiencing or at risk of homelessness takes place in the Phoenix metropolitan area, providing services such as: direct connection to housing and services, legal services, driver's licenses, Social Security, and Veterans benefits, amongst others.

Built for Zero

The Maricopa Regional Continuum of Care participates in Built for Zero, a national initiative to end veteran and chronic homelessness. The Ending Veteran Homelessness Workgroup and Ending Chronic Homelessness Workgroup meet bi-weekly to review data and strategize system improvements. The CoC submits monthly HMIS data to Community Solutions for the Built for Zero Performance Management Tracker dashboard, which captures monthly inflow, outflow, and active numbers for the chronic and veteran subpopulations.

CoC Youth Workgroup and Youth Action Board

The Maricopa Regional CoC has two groups focused on addressing youth homelessness. The CoC Youth Workgroup meets monthly, bringing together youth providers as well as other community stakeholders to collaborate on improving services for youth experiencing homelessness. The Youth Action Board also meets monthly and is made up of youth with lived experience who provide youth voice, input, and direction for the CoC's work to end youth homelessness in the Maricopa County region.

Outreach Collaborative

Outreach is an important component of the homeless services system. Outreach workers are often the first point of contact for someone experiencing homelessness and play an important role in client engagement. The Outreach Collaborative is made up of outreach workers and law enforcement officers who directly interact with people experiencing homelessness. This group meets monthly to provide updates on outreach initiatives and discuss how to improve coordination of care.

Plan Overview

Ultimate Goal

The Maricopa Regional Continuum of Care will create a system for providing services to individuals and families experiencing homelessness that ensures that homelessness is rare, brief and non-recurring.

Throughout the Plan, various data are referenced from the Homeless Management Information System (HMIS), the Point-in-Time Homeless Street Count, etc. It is important to note that the CoC strives to achieve consistency with data collection as well as the definition of data categories, and that data transparency exists.

Long-Term Goals

Integrate resources and achieve widespread coordination of services across the region.

Increase number of units available.

System Performance Measures (FY 2017)

Rare		Brief		Non-recurring	
Annual count of sheltered homeless persons in HMIS	14,101 persons	Average length of time homeless in Emergency Shelter, Safe Haven, and Transitional Housing	97 days	Returns to homelessness in 2 years	25%
				Successful exits from Street Outreach to Permanent Housing	36%
Number of persons who became homeless for the first time	9,746 persons	Percentage of adult system stayers increasing total income	36%	Successful exits and retention of Permanent Housing	93%

Goal: End Singles Homelessness

Includes Chronic, Veterans, and unaccompanied youth.

Current Data

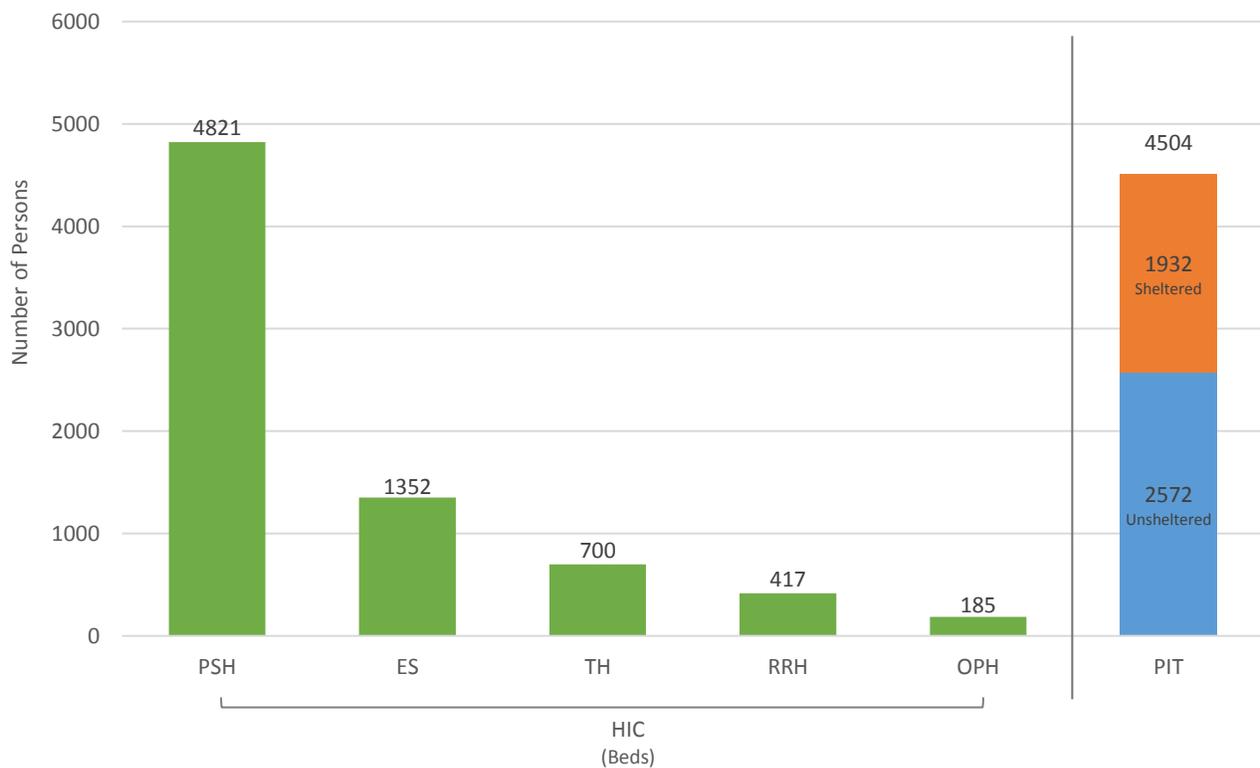


On the night of the 2018 PIT Count, in the region there were

4504

Homeless Singles

2018 Housing Inventory Chart and PIT Count, Singles



Milestones

One Year:

- Strengthen services for singles experiencing homelessness.
- Enhance data partnerships to inform plan to end homelessness for singles, including data needed to determine the need for a progressive engagement policy.
- Address the need for sufficient access points to ensure full geographic coverage of coordinated entry.

Longer Term:

- Identify and secure funding stream(s) to support increasing the number of units needed to achieve functional zero.
- Create a system that integrates jails, hospitals and other systems of care into the coordinated entry system using data-based solutions.

Action Items

Short-Term

Priority	Short-Term Strategy	Lead	Completion Date Goal
1	<ul style="list-style-type: none"> • Strengthen services for singles experiencing homelessness. <ul style="list-style-type: none"> ○ Formally define and communicate “diversion” strategies and establish baseline outcome data. <ul style="list-style-type: none"> ▪ Use diversion training from a national expert to inform community provider practices and policies. ▪ Review diversion plans and tools used by other communities. ▪ Formalize diversion across the community. ○ Explore technology solutions for making system more transparent and integrate with HMIS. <ul style="list-style-type: none"> ▪ Explore a secure website for by-name list access. ▪ Increase use of “mobile-enhanced” HMIS for outreach efforts. ○ Strengthen process by which singles are connected with benefits or workforce connections to increase income to achieve sustainability. <ul style="list-style-type: none"> ▪ Ensure providers are using the referral tab in HMIS ▪ Figure out a way to compare data across St. Joe the Worker, Goodwill Industries, AWEE, DES, Maricopa County and Phoenix Workforce Connections ▪ Explore opportunity for a SOAR dedicated program in the community. ○ Improve integration of existing community resources into singles system i.e. CAP offices, navigation, and housing resources. 	CE Lead, Singles Providers, CoC Committee	2019
2	<ul style="list-style-type: none"> • Enhance data partnerships to inform plan to end homelessness for singles, including data needed to determine the need for a progressive engagement policy. <ul style="list-style-type: none"> ○ Set threshold goals for the system to include exits to Permanent Housing, length of stay, and returns to homelessness. ○ Collect and evaluate data on a regional and sub-regional basis. Focus on where individuals are engaged with the system, how many are assessed, and how many are housed. ○ Use data to align funding needs and existing resources to end homelessness. ○ Formally define and communicate “diversion” strategies and establish baseline outcome data. ○ Document what all providers do for diversion (i.e., St. Vincent de Paul travel aid assistance). 	HMIS Lead, CE Lead, Data Subcommittee	2019
3	<ul style="list-style-type: none"> • Address the need for sufficient access points to ensure full geographic coverage of coordinated entry. 	CE Lead, CE Subcommittee	2019

Long-Term

Priority	Long-Term Strategy	Lead
1	<ul style="list-style-type: none"> • Identify and secure funding stream(s) to support increasing the number of units needed to achieve functional zero. <ul style="list-style-type: none"> ○ Seek new partnerships to bring governmental and non-governmental resources to support units for housing individuals experiencing chronic homelessness. 	CoC Board
2	<ul style="list-style-type: none"> • Create a system that integrates jails, hospitals and other systems of care into the coordinated entry system using data-based solutions. <ul style="list-style-type: none"> ○ Fully integrate other systems of care into coordinated entry and determine a process by which individuals may access coordinated entry through a wide-range of access points. ○ Explore enhanced data shares across these systems, specifically medical providers, to inform solutions and improve coordination of care. 	Coordinated Entry Providers and CE Subcommittee
3	<ul style="list-style-type: none"> • Increase community awareness of mission and leverage community partners for support. For example, employing marketing strategies through the Coalition. • Strengthen landlord relations and solicit future landlord participation in programs through tax incentives or other models. • Require landlord retention training for scattered site programs to maintain existing landlord relationships. 	All

Goal: End Chronic Homelessness

Current Data



On the night of the 2018 PIT Count, in the region there were

974

Chronic Homeless Persons

Actively Homeless



Monthly data reported to Community Solutions from HMIS.

Milestones

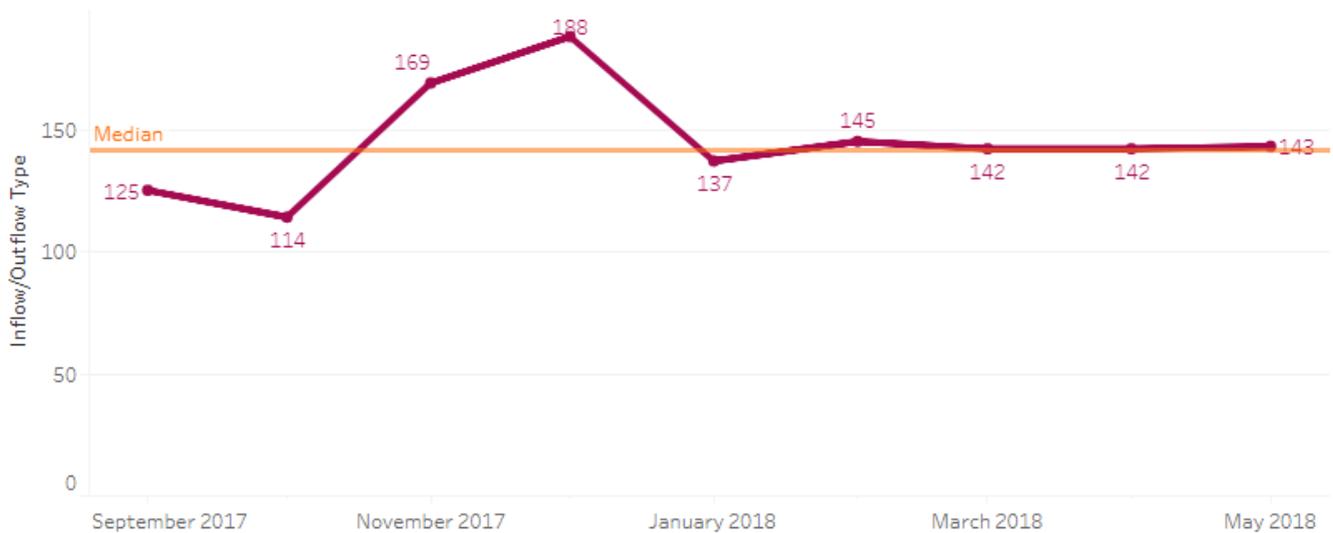
One Year:

- Evaluate data and trends to come up with ideas for interventions that would adjust the numbers (inflow/outflow). Test data-informed change ideas to target interventions towards impact.
- Enhance outreach, navigation, and housing resources by onboarding to Coordinated Entry.
- Develop, through a gaps analysis, the number of units required to reach functional zero.

Longer Term:

- Identify and secure funding stream(s) to support increasing the number of units needed to achieve functional zero.
- Connect chronic homeless in jails, frequent users of hospitals and other systems of care into the coordinated entry system.

Housing Placements for Chronic



Community Solutions' data dashboard definition of "Housing Placements" includes both Housing Placements and Positive Exits to Housing.

Action Items

Short-Term

Priority	Short-Term Strategy	Lead	Completion Date Goal
1	<ul style="list-style-type: none"> • Evaluate data and trends to come up with ideas for interventions that would adjust the numbers (inflow/outflow). Test data-informed change ideas to target interventions towards impact. <ul style="list-style-type: none"> ○ Establish a mechanism within HMIS to identify people aging into chronicity or at-risk of chronic status. <ul style="list-style-type: none"> ▪ Explore the other part of the chronic definition for people who qualify through multiple instances of homelessness, and people who are aging into chronicity but do not have a disability ○ Identify and quantify how many housing unit openings we have available each month. ○ Community-wide diversion training to potentially reduce inflow. 	Ending Chronic Homelessness Workgroup, HMIS	2019
2	<ul style="list-style-type: none"> • Increase onboarding of providers and existing housing resources to Coordinated Entry. <ul style="list-style-type: none"> ○ Identify existing housing resources that currently are not connected to coordinated entry and onboard to Coordinated Entry to expand our housing pool. ○ Enhance outreach and navigation's commitment to working off the by-name list. ○ Onboard additional navigation resources and integrate CAP resources into Coordinated Entry. 	Ending Chronic Homelessness Workgroup, Coordinated Entry	2019
3	<ul style="list-style-type: none"> • Develop, through a gaps analysis, a value for the number of units required to reach functional zero. <ul style="list-style-type: none"> ○ Develop a course of action through data-driven processes to reach functional zero specifically for the subpopulation of chronically homeless veterans. 	Focus Strategies, Ending Chronic/Veteran Homelessness Workgroups	2019

Long-Term

Priority	Long-Term Strategy	Lead
1	<ul style="list-style-type: none"> • Identify and secure funding stream(s) to support increasing the number of units needed to achieve functional zero. <ul style="list-style-type: none"> ○ Seek new partnerships to bring governmental and non-governmental resources to support units for housing individuals and families experiencing chronic homelessness. 	CoC Board
2	<ul style="list-style-type: none"> • Connect chronic homeless in jails, frequent users of hospitals and other systems of care into the coordinated entry system using data-based solutions. <ul style="list-style-type: none"> ○ Identify chronic homeless in jails, frequent users of hospitals and other systems of care. ○ Fully integrate other systems of care into coordinated entry and determine a process by which individuals and families may access coordinated entry through a wide-range of access points. 	Coordinated Entry Providers and CE Subcommittee

Successes

Priority	Long-Term Strategy	Lead	Completed Goal
1	<ul style="list-style-type: none"> • Set the policies and procedures for the ten benchmarks on the Community Solutions scorecard for a quality by-name list. <ul style="list-style-type: none"> ○ Established a policy from the by-name list that specifies the number of days of inactivity (within 30 days) at which a person’s status will be changed to ‘inactive.’ ○ Regional coverage and coordination of outreach through the Outreach Collaborative, with pilot projects to connect high priority individuals with outreach if they recently exited from shelter. 	Ending Chronic Homelessness Workgroup, Outreach Collaborative	2018
2	<ul style="list-style-type: none"> • Determined the inflow, outflow, and active numbers of chronic homelessness to calculate the need for units dedicated to chronic homeless persons. This data is submitted to Community Solutions from HMIS on a monthly basis. 	Ending Chronic Homelessness Workgroup, HMIS	2018

Goal: End Veteran Homelessness

Current Data

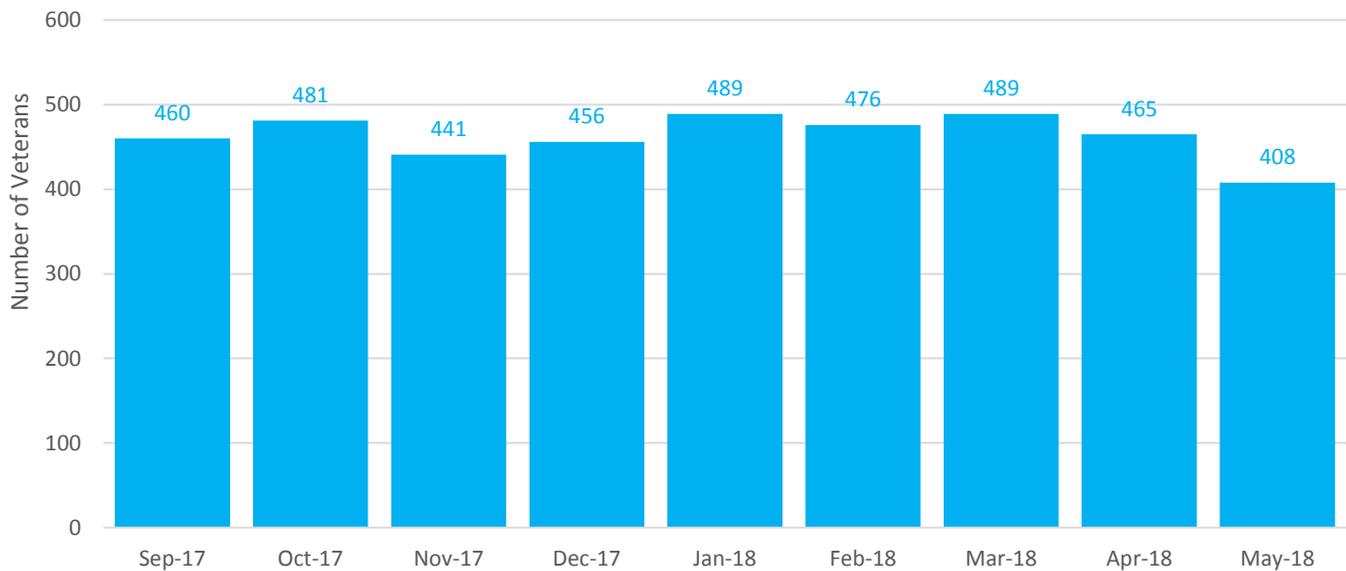
On the night of the 2018 PIT Count, in the region there were

413

Homeless Veterans



Actively Homeless



Monthly data reported to Community Solutions from HMIS.

Milestones

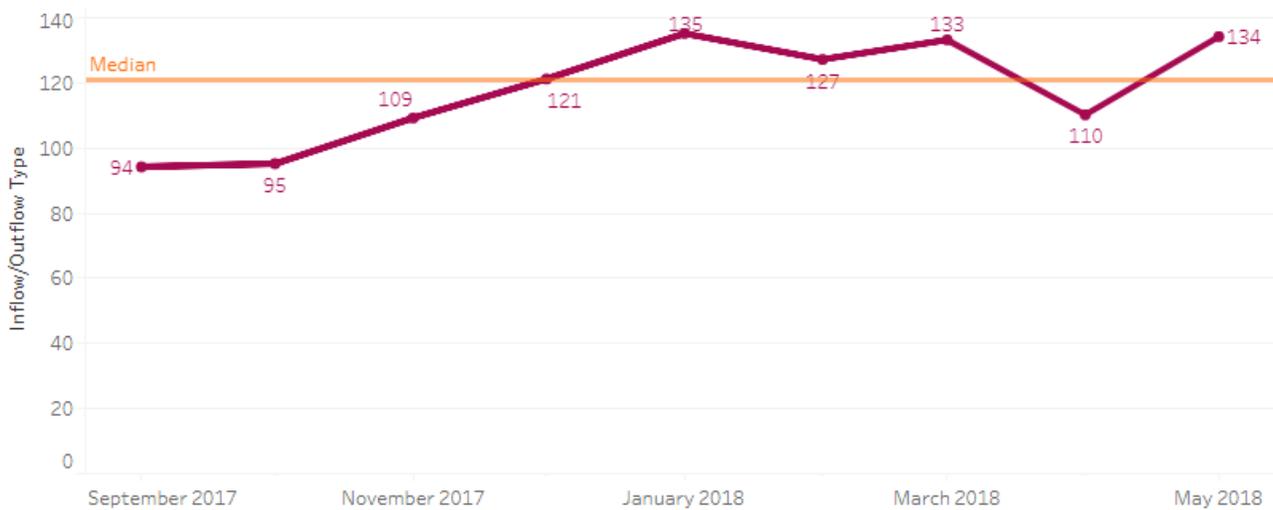
One Year:

- Effectively manage significant changes to the Grant Per Diem program to appropriately target interventions to the veteran population.
- Reduce the number of chronic veterans on the community by-name and the number of all veterans experiencing homelessness by testing “change ideas” geared towards reducing bottlenecks in the homeless services system.

Longer Term:

- Reach functional zero for veterans experiencing homelessness using HUD prioritization strategies that populate the by-name list.
- Engage other systems of care, including medical and behavioral health systems, using HMIS.
- Address employment needs of veterans experiencing homelessness by partnering with employment and training resources.

Housing Placements for Veteran



Community Solutions' data dashboard definition of "Housing Placements" includes both Housing Placements and Positive Exits to Housing.

Action Items

Short-Term

Priority	Short-Term Strategy	Lead	Completion Date Goal
1	<ul style="list-style-type: none"> Effectively manage significant changes to the Grant Per Diem program to appropriately target interventions to the veteran population. <ul style="list-style-type: none"> Continue to work to integrate the changes to the GPD program to target interventions to the veteran population. Work to ensure the GPD referral process makes most effective use of the resource. 	Ending Veteran Homelessness Workgroup (with VA)	2019
2	<ul style="list-style-type: none"> Test “change ideas” to remove bottlenecks in the homeless services system to reduce the number of veterans experiencing chronic homelessness and all veterans experiencing homelessness in the region. 	EVHW (with VA)	2019
3	<ul style="list-style-type: none"> Work to increase prevention and diversion efforts to reduce the inflow of veterans to the homeless services system. <ul style="list-style-type: none"> Increase diversion efforts, particularly for veterans planning to relocate to the region by education on housing costs and service availability in the region. Stress “come with a plan” to those veterans looking to relocate to the Phoenix area. Participate in the SSVF Rapid Resolution Pilot Project to identify and test best practices for resolving homelessness before individuals and families access the homeless services system. 	EVHW (with VA and CE Leads)	2019

Long-Term

Priority	Long-Term Strategy	Lead
1	<ul style="list-style-type: none"> Reach functional zero for veterans experiencing homelessness using HUD prioritization strategies that populate the by-name list. <ul style="list-style-type: none"> Prioritize veterans experiencing chronic homelessness so that every veteran experiencing chronic homelessness is housed within 90 days. Develop additional resources to ensure adequate housing options for all veterans experiencing homelessness. 	EVHW (with VA)
2	<ul style="list-style-type: none"> Engage other systems of care, including medical and behavioral health systems, using HMIS. <ul style="list-style-type: none"> Develop policies and procedures to link the data and information from other systems of care to the information inputted into HMIS systems. 	Ending Veteran Homelessness Workgroup (with VA)
3	<ul style="list-style-type: none"> Address employment needs of veterans experiencing homelessness by partnering with employment and training resources. 	Ending Veteran Homelessness Workgroup (with VA)

Successes

	Priority	Lead	Completed Goal
1	<ul style="list-style-type: none"> • Effectively managed significant changes to the Grant Per Diem program to appropriately target interventions to the veteran population. <ul style="list-style-type: none"> ○ Involve GPD providers in the Ending Veteran Homelessness Workgroup to ensure continuous feedback on status of GPD changes. ○ Ensure integration of GPD units with coordinated entry system including VI-SPDAT assessment for every veteran in a GPD bed. 	Ending Veteran Homelessness Workgroup (with VA)	2018
2	<ul style="list-style-type: none"> • Accelerated housing placements to reduce veterans on the list identified as experiencing chronic homelessness by increasing positive housing placements from 23 per month to 33 per month. 	EVHW (with VA)	2018
3	<ul style="list-style-type: none"> • Maintained a sustainable quality by-name list. <ul style="list-style-type: none"> ○ Work with the VA to enter veteran data into the Homeless Management Information System for coordinated entry which will include eligibility status and housing placements. • Create policies to identify, assess, and house all veterans experiencing homelessness within 90 days. • Achieved 100% data quality with “balanced” data increasing confidence in the community By-Name List. 	EVHW (with VA, HMIS Leads and CE Leads)	2018

Goal: End Family Homelessness

Current Data

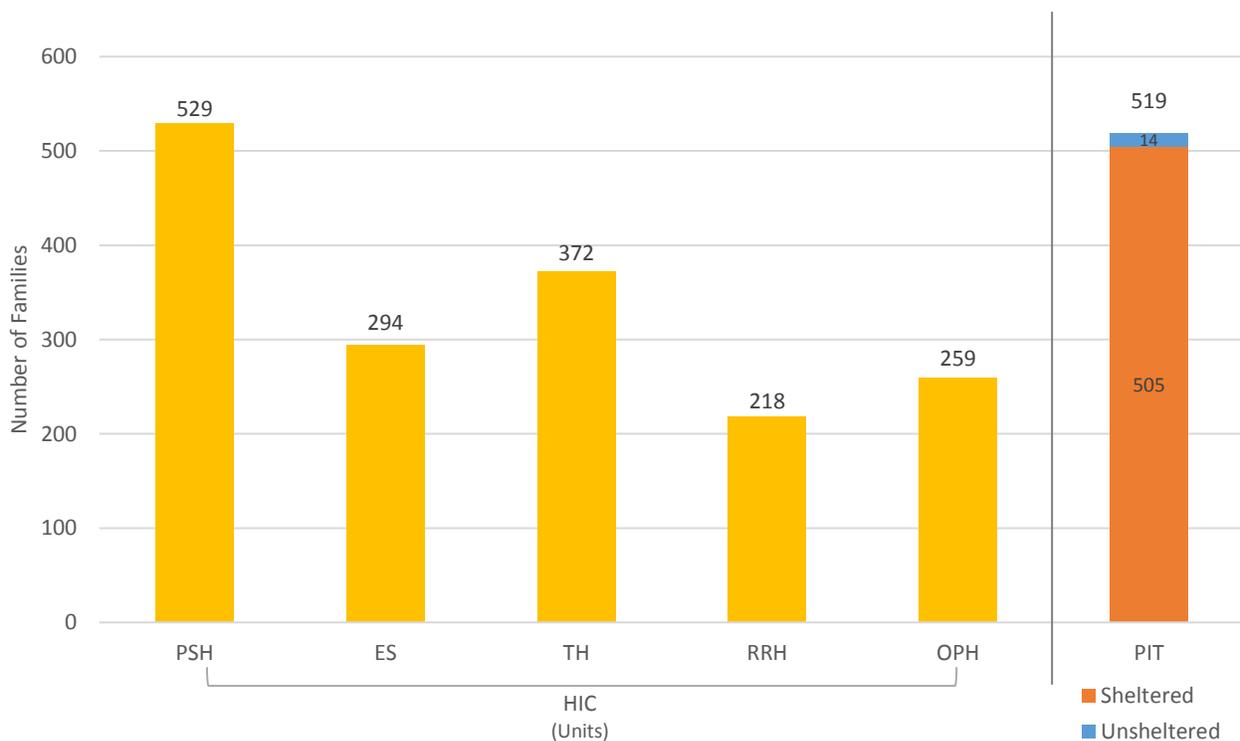


On the night of the 2018 PIT Count, in the region there were

519

Homeless Families

2018 Housing Inventory Chart and PIT Count, Families



Milestones

One Year:

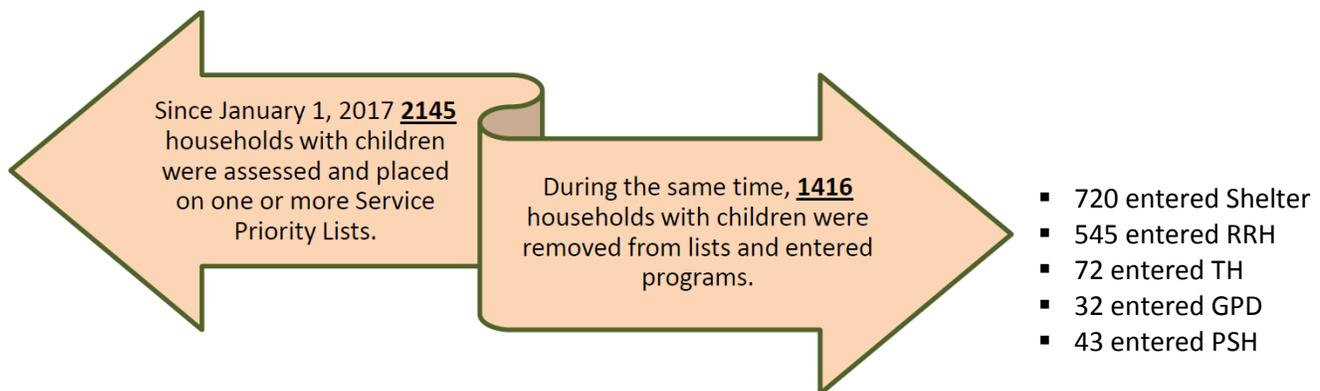
- Prioritize and intensify diversion services for families experiencing homelessness.
- Enhance data partnerships to inform plan to end homelessness for families and to determine the need for additional housing resources. .
- Map community resources to transition successful exits to permanent housing.

Longer Term:

- Align resources with acuity assessment scores and need determined by gaps analysis, emphasizing the need for more non-restrictive PSH designated for families.
- Connect with sustainable community supports to transition successful exits to Permanent Housing, including faith-based and behavioral health resources.
- Develop strategies to strengthen infrastructure and partnerships to prevent recidivism.
- Develop, assess and determine effective move on strategies for families in PSH, where appropriate, when stability is achieved.
- Address the need for sufficient access points to ensure full geographic coverage of coordinated entry

Family Housing Hub Program Report (Oct 1., 2017 – Dec. 31, 2017)

From Assessment to Assistance



Action Items

Short-Term

Priority	Short-Term Strategy	Lead	Completion Date Goal
1	<ul style="list-style-type: none"> • Prioritize and intensify diversion services for families experiencing homelessness. <ul style="list-style-type: none"> ○ Formally define and communicate “diversion” strategies and establish baseline outcome data. ○ Implement community training (including all front line staff) on diversion to encourage families to use their existing resources to resolve their homelessness. <ul style="list-style-type: none"> ▪ Ensure equal treatment for those receiving diversion resources. ▪ Develop ongoing learning collaborative. ○ Evaluate the outcomes of Coordinated Entry and diversion techniques. ○ Connect families with benefits or workforce connections to increase income to achieve sustainability. ○ Expand geographic coverage of Coordinated Entry system and a 24/7 phone system for families. 	CE Lead, Family Providers, CoC Committee	2018
2	<ul style="list-style-type: none"> • Enhance data partnerships to inform plan to end homelessness for families and to determine the need for additional housing resources. <ul style="list-style-type: none"> ○ Explore technology solutions for making system more transparent and integrate with HMIS. ○ Set threshold goals for the system to include exits to Permanent Housing, length of stay, and returns to homelessness. ○ Develop data to inform funding needs and existing resources to end family homelessness, including history of foster care or homelessness as a child. 	HMIS Lead, CE Lead, Data Subcommittee	2018

Long-Term

Priority	Long-Term Strategy	Lead
1	<ul style="list-style-type: none"> • Align resources with acuity assessment scores and need determined by gaps analysis, emphasizing the need for more non-restrictive PSH designated for families. <ul style="list-style-type: none"> ○ Use current Standards of Excellence to assist with informing the development of best practices. 	HMIS Lead, CE Lead, Data Subcommittee, CE Subcommittee
2	<ul style="list-style-type: none"> • Connect with sustainable community supports to transition successful exits to Permanent Housing, including faith-based and behavioral health resources. <ul style="list-style-type: none"> ○ Map community supports and resources. ○ Implement long-term, extensive services for Rapid Re-housing to prevent recidivism. 	Family providers, CoC Committee
3	<ul style="list-style-type: none"> • Address the need for sufficient access points to ensure full geographic coverage of coordinated entry. 	Family providers, CoC Committee
4	<ul style="list-style-type: none"> • Implement community information strategy so that clients and public understand there is limited capacity, for example through a flyer that details a process map. 	Family providers, CoC Committee

Goal: End Youth Homelessness

Current Data

On the night of the 2018 PIT Count, in the region there were

415

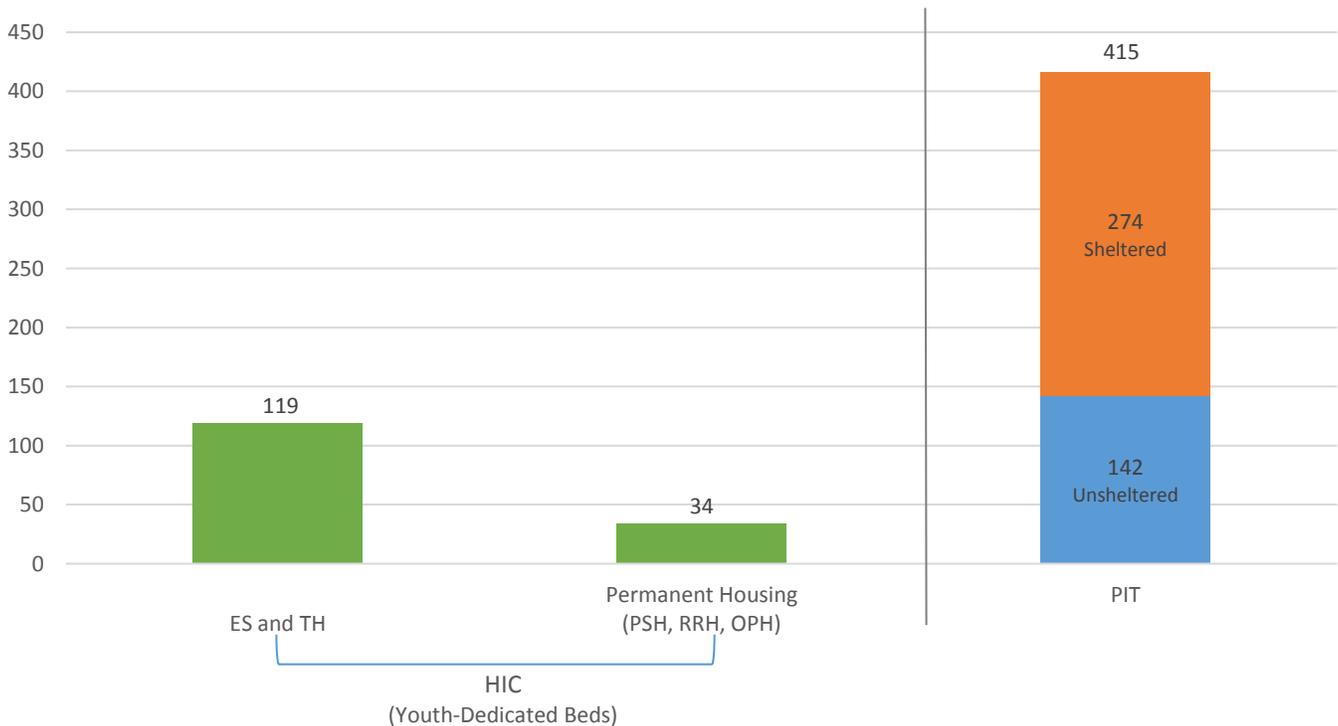
Unaccompanied Homeless Youth

(This does not include Parenting Youth Households.)

Note: HUD defines Youth as persons under the age of 25.



2018 Housing Inventory Chart and PIT Count, Unaccompanied Youth



Milestones

One Year:

- Identify and define unique needs of youth, and improve service delivery to youth populations.
- Develop a dashboard for tracking youth experiencing homelessness.
- Identify an appropriate coordinated entry integration strategy for youth.
- Explore the use of the TAY VI-SPDAT for youth assessment.
- Convene a Youth Action Board monthly to guide the direction of youth work.
- Review the work from the systems-wide analysis project and build upon identified opportunities for youth.
- Explore dedicated diversion funds for youth.

Longer Term:

- Maximize use of the existing resources to improve service delivery to youth and implement new practices based on gaps identified through HMIS data and innovative strategies informed by the short-term action items.
- Identify and secure new funding sources for youth housing.
- Expand Youth Workgroup to region-wide stakeholders and connect regional work with national efforts to end youth homelessness

Action Items

Short-Term

Priority	Short-Term Strategy	Lead	Completion Date Goal
1	<ul style="list-style-type: none"> • Identify and define unique needs of youth, and improve service delivery to youth populations. <ul style="list-style-type: none"> ○ Continue to improve access and engagement strategies for identifying and connecting youth to services/resources through Outreach and Coordinated Entry. ○ Identify youth hotspots using outreach and provider data. ○ Increase scope of youth providers using HMIS. ○ Identify trends and needs based on HMIS and PIT data. ○ Encourage innovative strategies for addressing the needs of youth experiencing homelessness. 	Youth Workgroup, Youth Action Board, HMIS, MAG	2019
2	<ul style="list-style-type: none"> • Develop a dashboard for tracking youth experiencing homelessness. <ul style="list-style-type: none"> ○ Identify required data elements to input into HMIS. ○ Incorporate non-HMIS data as needed. 	Youth Workgroup, HMIS	2019
3	<ul style="list-style-type: none"> • Identify an appropriate coordinated entry integration strategy for youth. <ul style="list-style-type: none"> ○ Identify how youth are impacted by the coordinated entry prioritization strategy. ○ Incorporate youth-specific assessments at access points. ○ Develop protocols for warm hand-off to youth services. 	Youth Workgroup, CE Leads, CE Subcommittee	2019
4	<ul style="list-style-type: none"> • Explore the use of the TAY VI-SPDAT for youth assessment. 	Youth Workgroup, CE Subcommittee	2019
5	<ul style="list-style-type: none"> • Convene a Youth Action Board monthly to guide the direction of youth work. 	Youth Workgroup, Youth Action Board	2019
6	<ul style="list-style-type: none"> • Review the work from the systems-wide analysis project and build upon identified opportunities for youth. 	Youth Workgroup, Focus Strategies, HMIS, MAG	2019
7	<ul style="list-style-type: none"> • Explore dedicated diversion funds for youth. 	Youth Workgroup, Other Funders, CoC Board	2019

Long-Term

Priority	Long-Term Strategy	Lead
1	<ul style="list-style-type: none"> • Maximize use of the existing resources to improve service delivery to youth and implement new practices based on gaps identified through HMIS data and innovative strategies informed by the short-term action items. <ul style="list-style-type: none"> ○ Develop connection with schools, juvenile justice, and foster care and identify ways to share data and coordinate services. ○ Connect with sustainable community supports to transition successful exits to Permanent Housing and ensure that the data is documented on HMIS. 	CoC Committee, Youth Workgroup
2	<ul style="list-style-type: none"> • Identify and secure new funding sources for youth housing. 	CoC Board
3	<ul style="list-style-type: none"> • Expand Youth Workgroup to region-wide stakeholders. <ul style="list-style-type: none"> ○ Engage new partners in geographic areas where youth congregate. • Connect regional youth homelessness work with national efforts to end youth homelessness. <ul style="list-style-type: none"> ○ Align with federal benchmarks and criteria. ○ Explore opportunities to send youth to national conferences. 	CoC Board, Collaborative Applicant, Youth Workgroup

Successes

Priority	Success	Lead	Completed Goal
1	<ul style="list-style-type: none"> • The Maricopa Regional Continuum of Care submitted an application for HUD's FY 2017 Youth Homelessness Demonstration Program (YHDP) competition. 	Youth Workgroup, YHDP Planning Team, Youth Action Board, MAG, HMIS	April 2018

Goal: Strengthen the System for Ending All Homelessness

Data indicate that there are not yet enough resources to end homelessness in Maricopa County. For example, units for singles are not prevalent enough to address the issue of homelessness among this population of 4,504 singles identified in the 2018 Point-in-Time Count in Maricopa County. Specifically, the chronic population – which heavily consists of singles – has increased substantially from 2016 to 2018. In addition, families and youth also face homelessness without sufficient resources and the overall unsheltered count has been rising since 2014.

Before reaching conclusions on actions to take regarding homelessness in Maricopa County, it is important to first acknowledge that the data from the Homeless Services system represent only a portion of homelessness in the county. There are many other county systems that encounter homeless individuals and families who actually do not make contact with the Homeless Services system, and are never included in the Homeless Management Information System. Some examples of these other county systems include:

- The criminal justice and jail system;
- The healthcare system (AHCCCS, hospitals, etc.);
- The behavioral health system;
- Fire and police.

As such, the goal must not simply to be to reduce the numbers of homeless individuals and families outlined throughout this plan to end homelessness, but also should be to integrate the other systems that frequently interact with homelessness. This represents a very pressing data need: a comparison of hospital, healthcare, and criminal justice coding compared to HMIS records to determine how many homeless individuals and families are not reaching the system. Only after achieving this goal will Maricopa County have a more accurate and representative idea on the true needs of the system, and be able to work to help those in our society who are most vulnerable.



Partnerships with ESG recipients and other funding sources are key to our efforts to end homelessness. Partnership includes aligning outcomes, serving on application review panels, and coordinating the adoption of funding priorities by the CoC Board.

Milestones

One Year:

- Leverage CoC resources by seeking new partnerships with funders, affordable housing developers, landlords, faith community, healthcare providers, and other partners.
- Continue to build a fully functional coordinated entry system.
- Partner with the funding community to ensure common outcomes and consistent program delivery.
- Conduct a systems analysis to identify strengths and areas of improvements and make recommendations for right-sizing interventions.

Longer Term:

- Develop and implement a strategy for right-sizing interventions.
- Integrate other systems of care into the coordinated entry system.
- Create additional permanent housing in the region.
- Identify prevention funds.

System Performance Measures

Category	System Performance Measures	FY 2016	FY 2017	Change from FY 2016 to FY 2017
Rare	Number of Homeless Persons (in HMIS)	15,271 persons	14,101 persons	-7.7% (change in persons)
	Number of Persons who Become Homeless for the First Time	10,099 persons	9,746 persons	-3.6% (change in persons)
Brief	Length of Time Homeless (Average days in ES/SH/TH)	101 days	97 days	-4.0% (change in days)
	Employment and Income Growth (Percentage of Adult System Stayers Increasing Total Income)	22% (531 persons)	36% (778 persons)	+14.0% (change in percent), +46.5% (change in persons)
Non-Recurring	Returns to Homelessness (Percentage in 2 years)	24% (1,258 persons)	25% (1,420 persons)	+1.0% (change in percent), +12.9% (change in persons)
	Successful Exits from Street Outreach	25% (373 persons)	36% (495 persons)	+11.0% (change in percent), +32.7% (change in persons)
	Successful Exits and Retention from Permanent Housing	95% (5635 persons)	93% (5945 persons)	-2.0% (change in percent), +5.5% (change in persons)

Action Items

Short-Term

Priority	Short-Term Strategy	Lead	Completion Date Goal
1	<ul style="list-style-type: none"> • Create Affordable Housing <ul style="list-style-type: none"> ○ Create additional permanent housing in the region. ○ Remove barriers to affordable housing. 	All	2019
2	<ul style="list-style-type: none"> • Coordinate CE services regionally and continue to build a fully functional Coordinated Entry system. <ul style="list-style-type: none"> ○ Refine coordinated entry prioritization strategy to serve those most vulnerable. ○ Ensure coordination between coordinated entry leads. ○ Guard against silos within the coordinated entry system. ○ Review assessment tools and protocols to incorporate information that comprehensively determines need. ○ Use HMIS to measure outcomes of Coordinated Entry and diversion. ○ Develop and implement a monitoring and evaluation process: establish benchmarks, set specific outcomes with associated timelines ○ Consider an RFP process to administer Coordinated Entry. 	CoC Board, CE Leads, CE Subcommittee	2019
3	<ul style="list-style-type: none"> • Right-size interventions and find common language to achieve goals. <ul style="list-style-type: none"> ○ Develop and implement a strategy for right-sizing interventions. ○ Maximize the use of all current resources and invest where there is the greatest demand. ○ Align resources determined by system analysis. 	All	2019
4	<ul style="list-style-type: none"> • Leverage CoC resources by seeking new partnerships and find common language to achieve goals. <ul style="list-style-type: none"> ○ Develop partnerships with funders, affordable housing developers, landlords, faith community, healthcare providers, and others ○ Provide opportunities for new partners to engage in CoC meetings, CoC membership, and education and training events. ○ Review current matrix of participants; solicit lead within sectors where representation is lacking within the CoC; this includes PHA and housing developers. ○ Develop formal PHA housing workgroup. ○ Focus on having robust, cross-sector representation at the table. 	CoC Board, CoC Committee, Collaborative Applicant	2019

Short-Term Work Completed

Priority	Short-Term Strategy	Lead	Completed Goal
1	<ul style="list-style-type: none"> • Conduct a systems analysis to identify strengths and areas of improvements and make recommendations for right-sizing interventions. <ul style="list-style-type: none"> ○ Develop timelines for securing contractor and completing system analysis. ○ Facilitate RFP process to secure a consultant to conduct system analysis. 	CoC Board, CE Leads, CE Subcommittee	2018
2	<ul style="list-style-type: none"> • Partner with the funding community to ensure common outcomes and consistent program delivery. <ul style="list-style-type: none"> ○ Serve on ESG funding process to collaborate on common goals. 	ESG Subcommittee, Collaborative Applicant	2018

Long-Term

Priority	Long-Term Strategy	Lead
1	<ul style="list-style-type: none"> • Integrate other systems of care into the coordinated entry system. <ul style="list-style-type: none"> ○ Seek partnerships and engage with jails and corrections, mental health, hospitals, and other systems that serve those experiencing homelessness. 	Coordinated Entry Subcommittee, CE Lead, Collaborative Applicant
2	<ul style="list-style-type: none"> • Identify prevention funds and coordinate with DES, CAP offices and other sources to secure and prioritize prevention funds for all populations. 	CoC Board, ESG Subcommittee
3	<ul style="list-style-type: none"> • Ensure supportive services continue after program exit (up to six months) to ensure long-term housing success. 	All

Coordinated Entry Visioning Sessions

The Maricopa Regional Continuum of Care's Coordinated Entry Subcommittee hosted stakeholders for a workshop to explore ideas about how the current coordinated entry system can be enhanced and identify opportunities for new approaches including investment, partnerships, and collaboration to address homelessness in Maricopa County.

Meeting Details

Date Held: April 24, 2018

Place: Maricopa Association of Governments, 302 N 1st Avenue, Saguaro Room

Time of Meeting:

- 10:00 a.m. to 12:00 p.m., Singles Coordinated Entry System
- 1:00 p.m. to 3:00 p.m., the Family Coordinated Entry System

Attendees: 51 individuals including representatives of cities, the County, homeless services providers, CoC Board members, Coordinated Entry leads and access points, funders, and CoC staff.

Purpose:

1. Conduct a high-level review of the coordinated entry system (CES) organized by the Maricopa Regional Continuum of Care
2. Facilitate dialogue among leaders to discuss opportunities and strategies to improve the CES
3. Inform the next steps for the work of the Coordinated Entry Subcommittee to update the CES to be more effective and efficient to reduce homelessness across Maricopa County

Summary:

The meeting began with a presentation of the purpose and function of the CES. In small group discussions, stakeholders worked to identify strengths of the CES and opportunities to improve. Reconvening with the larger group, attendees debriefed on work completed in the smaller groups.

Small group discussions were convened first around outreach, engagement, and access by households experiencing homelessness. During the second round of small group discussions, groups focused on prioritizing, matching, and assisting households experiencing homelessness.

Community Feedback - Singles Session

Topic 1: Outreach, Engagement and Access by Households Experiencing Homelessness

Strongest Aspects of Singles CES:

- Case conferencing
- Diversion
- By-Name List
- Multiple navigation providers
- Prioritization
- Special needs
- Shared resources
- Housing match
- Data & technical capacity
- Other

Small group exercise #1: Think of people you have known or worked with who have been homeless. How could CES better meet their needs for quick resolution of their housing crisis? How could CES be more effective and efficient?

Access:

- Telephonic access to real people
- Access to transportation through resources at MAG
- Regional approach/share data—people want to stay in their communities where they are already connected
- More intentional collaboration with law enforcement
- Increase of outreach advocates to assist those experiencing homelessness in multiple sectors and underserved communities such as child welfare, criminal justice, mental health, and West Valley

Assessment:

- Immediate assessment at first contact 24/7

Marketing:

- Increased awareness of CE process through education/training (clarity on roles and expectations of CE and entry points)

Data:

- Through data integration, connect varied systems to achieve:
1) No wrong door access; 2) better prioritization; and 3) more efficient referrals

Engagement:

- Keep individuals from By-Name List engaged to ensure he/she can be located when their housing opportunity presents itself
- Interim resource connection (between assessment and housing match) to stay connected to system and HMIS
- Continued engagement from outreach to referral with improved communication with community and increased effort/capacity
- More programs with low-barrier options for shelter

Diversion:

- Leverage public/private partnerships for funding toward diversion and prevention
- Build a common diversion program

Prioritization:

- Prioritize with impact on multiple systems, in mind (i.e., jail, geography, and depth of need-mental health status)
- Triage-physical wait times need improvement appropriate triage, including 24/7 hotline, marketing to the entire community, and using a tool other than the VI-SPDAT

Topic 2: Prioritization, Matching and Assisting Households Experiencing Homelessness

Strongest Aspects of Singles CES:

- Data
- Person-centered
- Access
- Staff openness
- Outreach
- Collaboration
- Knowledge and communication
- Other

Small group exercise #2: think of people you have known or worked with who have been homeless. How could the CES better meet their needs for quick resolution of their housing crisis? How could the CES be more effective and efficient?

Prioritization:

- Identifying organizations where the strength matches the needed activity (e.g., using the strength of CRN to manage data for prioritization/match)
- Evaluate current prioritization outcomes; prioritization informed by data and best practices
- Data warehousing/integration to identify high cost utilizers to increase access to varied funding dollars
- Data integration to improve prioritization and improve communication and messaging
- Prioritizing prevention for youth at risk of homelessness
- Exploration of additional tools to better gauge vulnerability for prioritization
- More balanced approach to prioritization than just chronic/high acuity to avoid creating more future chronic homeless
- Find the pains of the cities (hot spots) and use our CE to be a solution, in turn add their housing stock
- Inter-agency case conferencing for all on BNL for all interventions

Matching:

- On-boarding non CoC housing resources
- Work off the BNL and not who is document-ready

Access:

- Population specific entry points (DV, veterans, SMI)
- Access to coordinate entry (e.g., West Valley)
- Education for social service agencies and faith-based services in the community in regard to CE access points and how they work

Assisting:

- Secure emergency shelter for persons prioritized for housing such that they are more easily engaged by navigators (i.e., effective bridge housing)

Diversion:

- Recognize CAP programs as a proactive opportunity for diversion
- A clear and commonly adopted operational definition of diversion leading to a community of providers who are consistently and effectively implementing the best diversion strategies
- Establishing a definition of those that fall in between “divertible” and “housing” –resources for those people

Other:

- Need better system measures to tell us how the system is function as a whole—are we using our full capacity of resources—more than just diversion, but includes diversion
- Create a client portal in HMIS (mobile app or web-based) after they already are in the system that allows the client to update contact info, contact providers, and provide feedback
- Sales pitch for CE

Community Feedback - Families Session

Topic 1: Outreach, Engagement and Access by Households Experiencing Homelessness

Strongest Aspects of Families CES:

- Single entry
- Diversion
- Triage & assessment
- Quality staff
- Mobile outreach
- Other

Small group exercise #1: Think of people you have known or worked with who have been homeless. How could CES better meet their needs for quick resolution of their housing crisis? How could CES be more effective and efficient?

Access:

- Hot-line that covers county 24/7 to increase access
- More accessibility and flexibility with access point times and locations/and assisting with barriers with transportation

Engagement:

- Increased role of shelters serve as navigators plus additional navigators for street homeless

Assisting:

- Need for low-barrier shelter options/more flexible eligibility criteria

Topic 2: Prioritization, Matching and Assisting Households Experiencing Homelessness

Strongest Aspects of Families CES:

- Diversion
- Resource-matching
- Simple/standardized

Small group exercise #2: think of people you have known or worked with who have been homeless. How could the CES better meet their needs for quick resolution of their housing crisis? How could the CES be more effective and efficient?

Access:

- 24/7 regional access w/kiosks and mobile hot-spots
- On-board more agencies with CE to be access points
- Improve access hours and assessment process to ensure it meets the unique needs of each family we are serving
- Adding 24/7 access with multiple entry points (East & West) with additional staff beyond FHH (include youth and use universal triage tools)
- Schools could become entry points
- Expand locations, hours of operations, capacity & staffing to have immediate access valley-wide
- Partner with schools for access sites as a resource
- “Move data not people” –no wrong door, multiple entry points, with multiple providers doing diversion and assessment, look at number of hours/day & number of days/week that access is available

Diversion:

- Diversion training available for all community providers so that we can offer that service to all clients
- Diversion funds
- Closer partnership w/Child Welfare System (reducing inflow at the source)

Assessment:

- Ensuring appropriate intervention through accurate scoring and verification of self-reported information (collaboration between CE and providers)

Prioritization:

- Transparency in prioritization list
- Create case conferencing for families
- Street outreach prioritized for any open shelter beds – day by day

Assisting:

- Expanding housing opportunities w/landlord incentives and education

Other:

- Better system data so we know if we are fully using our housing capacity/two measures: bed utilization rate 95% or above system-wide; length of time from initial assessment to move-in 60 days or less
- Communication/advertisement and engaging all communities/education to understanding the system & effectiveness

Special Thank You

Broad community input was integral to this 2018 Plan to End Homelessness and the workings of the Continuum of Care. We would like to thank those who have volunteered to serve on groups central to the operations of the Continuum of Care.

Continuum of Care Board

Allie Bones, *Arizona Coalition to End Sexual and Domestic Violence*
Diana Yazzie Devine, *Native American Connections, Inc.*
Sergeant Rob Ferraro, *City of Tempe Police*
Moises ‘Moe’ Gallegos, *AZ Head Start Association*
Tad Gary, *Mercy Care*
Scott Hall, *Maricopa County Human Services Dept.*
Kevin Hartke, *Vice-Mayor City of Chandler, Board Co-Chair*

Bruce Liggett, *Maricopa County Human Services Dept.*
Darlene Newsom, *UMOM*
Dawn Noggle, *Maricopa County Correctional Health Services*
Amy Schwabenlender, *Human Services Campus, Board Co-Chair*
Tamara Wright, *Dept. of Veterans Affairs*

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Kathy Di Nolfi, *A New Leaf*
Alfred Edwards, *Arizona Department of Economic Security*
Blythe Fitzharris, *Mercy Care*
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Linda Mushkatel, *Lodestar Day Resource Center*
Ty Rosensteel, *Crisis Response Network*
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Sara Sims, *Phoenix Elementary School District*
Barbara Sloan, *The Salvation Army*
Stephanie Small, *City of Glendale*
Stefanie Smith, *Native American Connections*
Charles Sullivan, *Arizona Behavioral Health Corporation*
Jacki Taylor, *Save the Family, Committee Chair*
Keith Thompson, *Phoenix Shanti Group*
Kim Van Nimwegen, *City of Tempe*
John Wall, *Arizona Housing Inc.*
Brandi Whisler, *Circle the City, Committee Vice Chair*
Andrea Williams, *Southwest Behavioral & Health Services*

Coordinated Entry Subcommittee

Rachel Barber, *CASS*
Joshua Crites, *AHCCCS*
Elizabeth Da Costa, *Community Bridges*
Dana Martinez, *A New Leaf*
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TJ Reed, *Crisis Response Network*

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Jennifer Page, *Mercy Care*

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Charles Sullivan, *Arizona Behavioral Health Corporation*
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ESG Subcommittee

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Riann Balch, *City of Chandler*

Anissa Blair, *City of Phoenix*

Betsy Long, Alfred Edwards, and Adriane Clark,
Arizona Department of Economic Security

Rachel Milne & Scott Hall, *Maricopa County*

Liz Morales & Deanna Grogan, *City of Mesa*

Christine Wetherington, *Valley of the Sun United Way*

Rank and Review Subcommittee

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Renee Ayres-Benavidez, *City of Glendale*

Andrea Bell, *Mercy Care*

Anissa Blair, *City of Phoenix*

Adriane Clarke, *Arizona Department of Economic Security*

Laura Guild, *Arizona Department of Economic Security*

Ending Veteran Homelessness Workgroup, Ending Chronic Homelessness Workgroup, CoC Youth Workgroup, and Standing Strong for Families

Coordinated Entry Visioning Sessions (participating organizations)

A New Leaf

Arizona Behavioral Health Corporation

AZ Department of Economic Security

AZ Health Care Cost Containment System (AHCCCS)

AZCEND

Central Arizona Shelter Services (CASS)

City of Chandler

City of Glendale

City of Goodyear

City of Mesa

City of Peoria

City of Surprise

City of Tempe

City of Tolleson

Community Bridges, Inc.

Crisis Response Network (HMIS)

HOM, Inc.

Human Services Campus

Lodestar Day Resource Center

Maricopa Association of Governments

Maricopa County

Maricopa County Correction Health

Mercy Care

Native American Connections

Phoenix Elementary School District

Phoenix Shanti

Salvation Army

Save the Family

Southwest Behavioral and Health

US Vets

UMOM

Valley of the Sun United Way

For questions, please contact:

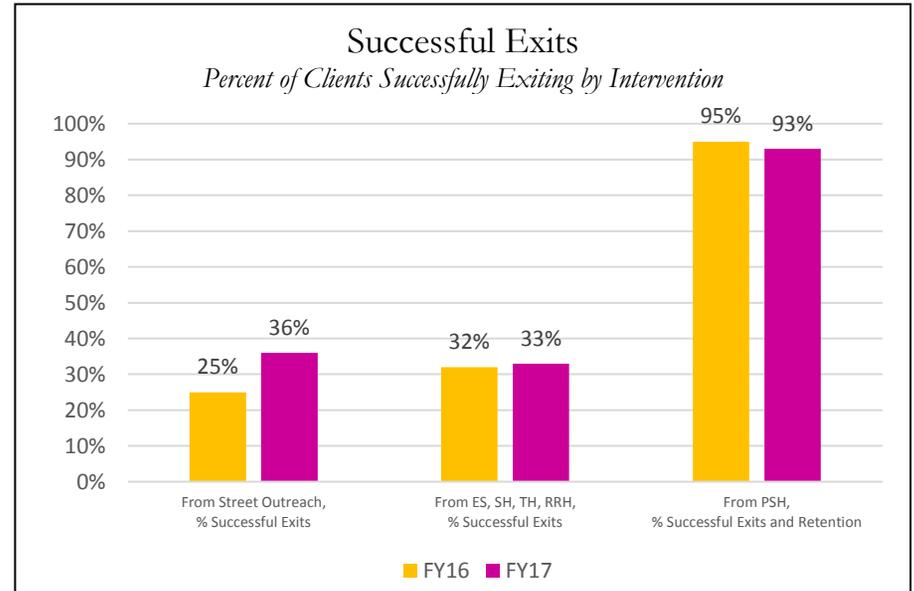
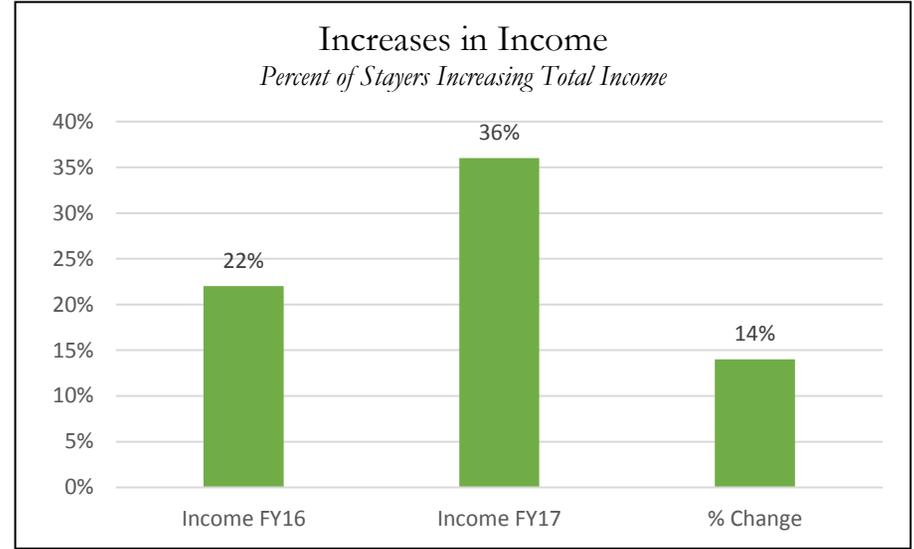
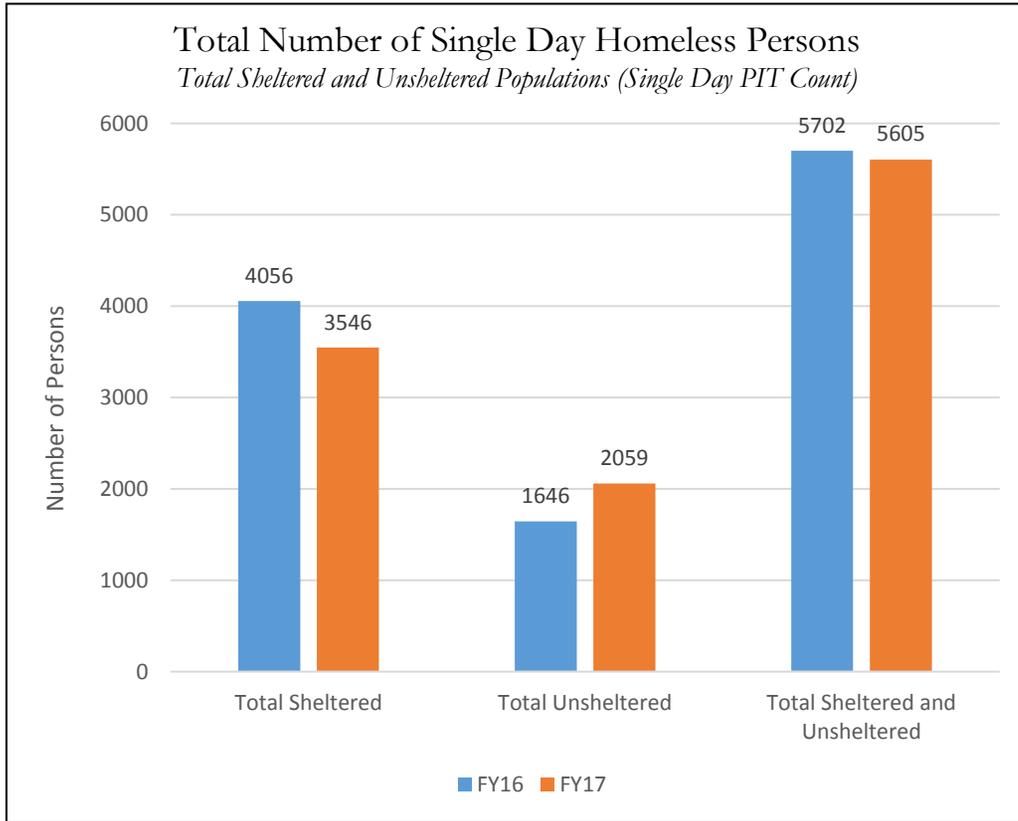
Kinari Patel at kpatel@azmag.gov

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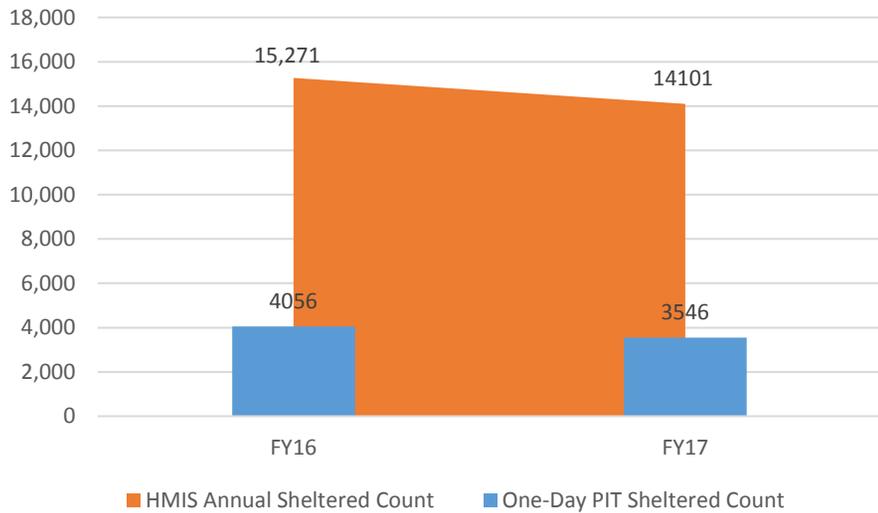
Appendix: System Performance Measures Dashboard

Maricopa County Continuum of Care System Performance Measures FY 2016 and FY 2017



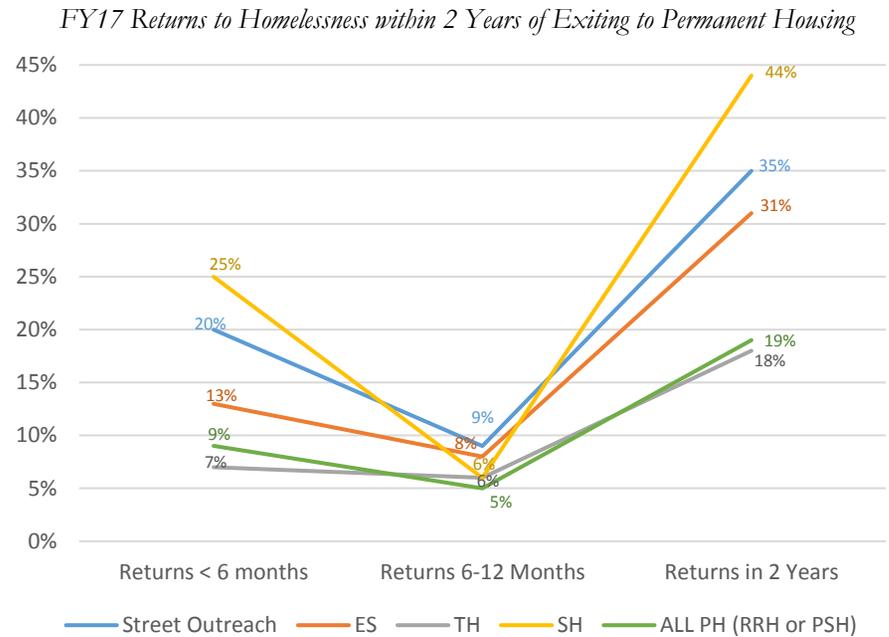
Total Number of Sheltered Homeless Persons

Annual HMIS Data and PIT Sheltered Count



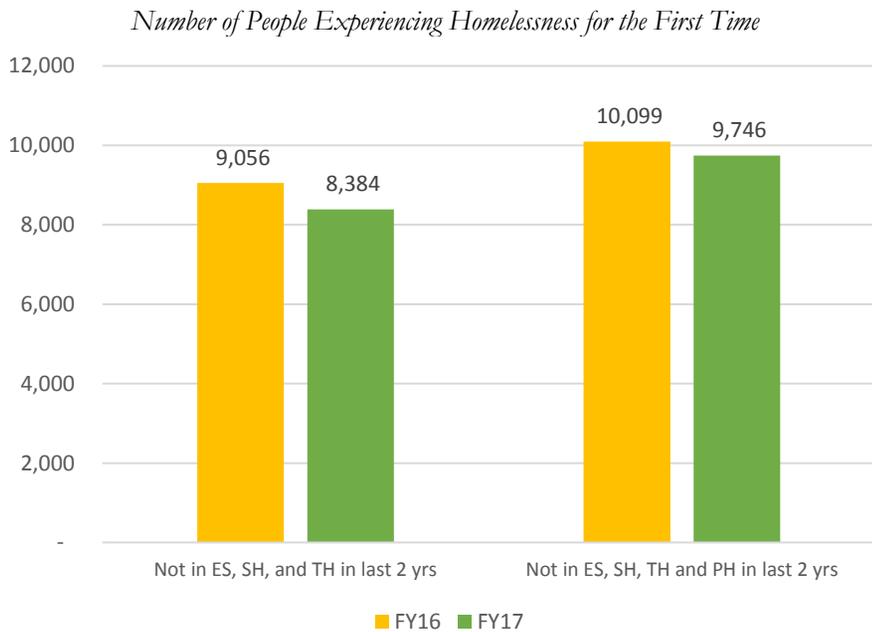
Returns to Homelessness

FY17 Returns to Homelessness within 2 Years of Exiting to Permanent Housing



First Time Homeless

Number of People Experiencing Homelessness for the First Time



Length of Time Homeless

Average Number of Days Homeless by Intervention

