	Permanent Supportive Housing	
Measure #	**Reference #**	**Recommended Performance Measure**
	SYSTEM GOALS	
	Positive Housing Outcomes	
1	1	Number of exits to permanent housing in a year
2	2	Retention for 2 years (measured through returns)
	SYSTEM COMPONENT PERFORMANCE INDICATORS	
	Utilization: Are our investments fully leveraged to provide care?	
3	3	Newly opened project-based permanent supportive housing is at least X% occupied within 90 days of the site receiving a master HAP contract
4	4	Across the entire portfolio of permanent supportive housing in the county, maintain at least X% utilization
5	5	Across the entire portfolio of project-based permanent supportive housing in the county, turnover units are filled within 90 days of the unit becoming available to match
6	6	Across the entire portfolio of tenant-based permanent supportive housing in the county, slots are utilized within 4 months of the resource becoming available to match
7	7	% of CES project-based matches that prioritize people in the Service Planning Area (SPA) near the permanent supportive housing site per CES policy guidance
8	8	Number of permanent supportive housing residents, disaggregated by whether new or existing for reporting period
9	9	*Demographic disaggregation* : Percentage of permanent supportive housing residents, disaggregated by race, ethnicity and gender and by whether new or existing for reporting period
10	10	*Demographic disaggregation:* Percentage of permanent supportive housing residents by prior living location (e.g., IH, unsheltered) and by whether new or existing for reporting period
	Quality of Services: Needed Health, Behavioral Health, and Social Services	
11	11	Number of participants who are referred to a program intended to improve mental health, substance use, physical health, income, or employment
12	12	Percentage of referred participants who are eligible to receive care through a program intended to improve mental health, substance use, physical health, and income
13	13	Percentage of referred, eligible, consenting participants receiving care through a program intended to improve mental health, substance use, physical health, and income
14	14	Number of participants receiving care through a program intended to improve mental health, substance use, physical health, income, or employment
	Positive Housing Outcomes	
15	26	At least X% of tenants retain permanent housing for at least one year, following moving into permanent supportive housing
16	27	At least X% of tenants retain permanent housing for at least two years, following moving into permanent supportive housing
17	28	*Demographic disaggregation* : Percentage of permanent supportive housing tenants who retain housing for at least one year, disaggregated by race, ethnicity and gender
18	29	*Demographic disaggregation* : Percentage of permanent supportive housing tenants who retain housing for at least two years, disaggregated by race, ethnicity and gender
19	30	At least X% of tenants retain permanent housing for more than two years.
20	31	Average number of days from housing match to move-in.
21	32	Percentage of tenants who exit to another permanent destination (Graduation Rate), disaggregated by destinations
22	33	Percentage of tenants who exit to a permanent destination and do not subsequently return to homelessness, disaggregated by observation period (1 year, 2 years, etc.).
	CONTRACT PERFORMANCE INDICATORS	
	Quality of Services: Are residents getting care needed to remain housed and improve their quality of life?	
23	34	Percentage of service participants living in permanent supportive housing who are receiving the regular in-person case management services indicated for their acuity level.
24	35	Percentage of ICMS participants receiving at least two services monthly.
25	36	Percentage of ICMS participants with a 5x5 or other similar, approved assessment completed every 90 days. The 5x5 should assess needs related to physical health, mental health, substance use, activities of daily living, social functioning, and housing status.
26	37	Does the 5x5 assessment accurately capture the tenants' needs?

27	38	Based on the tenants' assessment, are the needs identified in the assessment leading to a connection to services that meet those needs? What are the tenants' experiences of the service connection?
28	40	Percentage of ICMS participants with all required ICMS documentation completed, including permanent housing updates, appropriate opt-in forms, and current consent.
29	41	Percentage of ICMS participants living in permanent supportive housing with a Housing Acuity Assessment completed every 90 days.
30	42	Percentage of ICMS participants with an Individualized Care Plan updated at least every 90 days. Plans should be based on participant needs and barriers, and should document participant goals and the steps to achieve them.
31	43	Percentage of tenants in permanent supportive housing who complete their annual recertification and remain eligible for their rent subsidy
	REQUIRED SERVICES	
	Quality of Services: Are residents getting care needed to remain housed and improve their quality of life?	
32	44	Eligible permanent supportive housing participants are enrolled in MediCal
33	45	Tenants living in project-based permanent supportive housing have access to onsite community building and enrichment activities beyond case management
34	46	Tenants have access to annual surveys or listening sessions that ask about quality of services they receive and quality of their lives (separate surveys for Property Management & service providers)
35	47	Tenants have access to a housing retention process to resolve issues and prevent loss of housing
	Interim Housing	
	#	**Recommended Performance Measure**
	SYSTEM GOALS	
	Quality of Services: Needed Health, Behavioral Health, and Social Services	
36	1	Percentage of interim housing participants, disaggregated by permanent housing referral status (e.g., are clients in the queue, matched, or housed through the time-limited subsidy, permanent supportive housing, or other appropriate permanent housing destination)
	Positive Housing Outcomes	
37	2	Number of people who move into permanent housing as defined as exits to permanent destinations, moves into TLS, and moves into PSH.
38	3	Average days from IH enrollment to permanent housing move-in
	SYSTEM COMPONENT PERFORMANCE INDICATORS	
	Are our investments fully leveraged to provide care?	
39	4	Average length of stay (LOS) in interim housing, disaggregated by active and exited participants as well as by LOS time bins
40	6	Interim housing maintains at least x% occupancy (aggregated across all sites)
41	7	*Demographic disaggregation* : Percentage of interim housing participants, disaggregated by race, ethnicity and gender
	Positive Housing Outcomes	
42	8	At least x% of participants exit to permanent housing destinations (with a breakdown of housing destinations, such as but not limited to, licensed residential care facilities, in a home with friends and family, permanent supportive housing, rentals using time-limited subsidy, non-subsidized apartment etc.)
43	9	Increase in percentage of participants exiting to permanent housing destinations year over year
44	10	*Demographic disaggregation:* Percentage of interim housing exits, disaggregated by race, ethnicity and gender (with a breakdown by exit destination)
45	11	Percentage of Participants who are document ready (i.e., have both their identification and social security card uploaded into HMIS)
	Quality of Services: Needed Health, Behavioral Health, and Social Services	
46	12	Number of participants who are referred to the Interim Housing Outreach Program (IHOP; onsite health, mental health, and substance use services)
47	13	Number of referred participants who are assessed for the Interim Housing Outreach Program eligibility (IHOP)
48	14	At least x% of IHOP-enrolled participants receive a baseline IHOP assessment within 45 days of referral
49	15	At least x% of IHOP-enrolled participants receive appropriate services (medical, occupational therapy and/or behavioral health) within 60 days of IHOP enrollment
50	16	Number of participants who are referred to a program intended to improve mental health, substance use, physical health, income, or employment
51	17	Percentage of referred participants who are eligible to receive care from a program intended to improve mental health, substance use, physical health, or income

52	18	Percentage of referred, consenting, eligible participants who are receiving care through a program intended to improve mental health, substance use, physical health, or income
53	19	Number of participants receiving care through a program intended to improve mental health, substance use, physical health, income, or employment
54	33	Number of participants referred to a bed funded to serve high-acuity participants from a bed funded to serve low-acuity participants
55	34	Percentage of participants referred to a bed funded to serve high acuity participants from a bed funded to serve lower acuity participants who are clinically-assessed as eligible for that bed
56	35	Percentage of referred, eligible participants who were moved to a bed funded to serve high-acuity participants from a bed funded to serve lower acuity participants
57	36	Number of participants who move to a bed funded to serve high acuity participants from a bed funded to serve low acuity participants
58	37	Number of participants with clinically-assessed high acuity needs in beds funded to serve lower acuity needs who receive appropriate care without moving beds
59	38	Number of interim housing participants in beds funded to serve high-acuity participants
	CONTRACT PERFORMANCE INDICATORS	
	Are our investments fully leveraged to provide care?	
60	39	Interim housing maintains at least x% occupancy (site-level)
	Interim Housing: Are participants receiving quality assistance to prepare for permanent housing	
61	40	At least x% of enrolled participants have completed a CES assessment within 120 days of enrollment, with a goal of decreasing the number of days associated with this performance target year over year
62	41	At least x% of enrolled participants have their Social Security card or receipt of order & Social Security Number uploaded into HMIS within 90 days of enrollment
63	42	At least x% of enrolled participants have their ID uploaded within 45 days of enrollment
	Positive Housing Outcomes	
64	43	No more than x% of people exit to unsheltered or locations “not acceptable for human habitation”
65	44	At least x% of people exit to known destinations (excludes "client prefers not to answer" "data not collected"
66	45	Decline in percentage of participants released to unknown locations year over year
67	46	Permanent Supportive Housing opportunities are declined within 2 days of match or applications are completed within 7 days of match notification
	REQUIRED SERVICES	
	Quality of Services: Needed Health, Behavioral Health, and Social Services	
68	47	Eligible interim housing participants are enrolled in MediCal

	Street Outreach	
	#	**Recommended Performance Measure**
	SYSTEM GOALS	
69	1	Decrease the number of people experiencing unsheltered homelessness by x%
70	2	Increase the number of people moving into permanent housing from unsheltered settings by x%
71	3	Increase the rate of people moving into interim housing from unsheltered settings by x%
72	4	Average days from Street Outreach to moves into permanent housing as defined as exits to permanent destinations, moves into TLS, and moves into PSH.
73	5	Average days from Street Outreach to enrollment into Interim Housing
74	6	Which factors predict permanent-housing entry and retention among people served by outreach teams, including entry point, interim-housing duration, and provider?
	SYSTEM COMPONENT PERFORMANCE INDICATORS	
75	7	Number of Individuals Served by Street Outreach programs, disaggregated by new and continuing
76	8	Number of individuals who ended their stay in street outreach program or have moved into permanent housing
77	9	How does the system assess the quality of engagement? Is the quantity of services/contacts associated with better outcomes? How do participants assess the quality of services?
	Are teams effectively engaging people in need?	
78	10	*Demographic disaggregation:* Percentage of all individuals disaggregated by engagement status who are connected or re-connected to ongoing services by an outreach team, by race, ethnicity, and gender

79	11	*Length of service disaggregation* : Percentage of enrolled (contacted)and engaged (connected/re-connected to services) individuals who experience differing number of days between enrollment date (contact) and engagement date (connection) (less than 30 days; 30-90 days; 91 days to six months; six months to one year; longer than one year)
	Are teams providing people with needed case management, health, behavioral health, and social	
80	14	Percentage of enrolled (contacted) individuals who receive life sustaining support (i.e., food, water, hygiene, clothing, etc.)
81	15	Number of individuals referred to a specialized mental health or substance use outreach team (e.g. field medicine, specialized psychiatric treatment or care)
82	16	Number of individuals who receive ongoing services from a specialized mental health or substance use outreach team
83	17	Number of individuals who are referred to program intended to improve mental health, substance use, or income
84	18	Percentage of referred participants who are eligible to receive care through a program intended to improve mental health, substance use, physical health, and income
85	19	Percentage of referred, eligible individuals who *r* eceive care through a program intended to improve mental health, substance use, physical health, and income
86	20	Number of participants receiving care through a program intended to improve mental health, substance use, physical health, and income
87	30	Percentage of referred individuals who are engaged (connected) in specialized mental health or substance use treatment services provided by an outreach team,disaggregated by sheltered and unsheltered status
88	31	Percentage of individuals connected (engaged) with two or more specialized outreach or care teams who experience enrollment gaps no longer than X days
89	32	Number of individuals who are engaged by specialized field based treatment programs
90	33	Number of clinical encounters recorded by each specialized outreach team per month
91	34	Length of time between being referred to and receiving care from a specialized outreach team, disaggregated by time bins.
92	35	*Demographic disaggregation:* Percentage of referred individuals who are connected to specialized mental health or substance use treatment services provided by an outreach team, disaggregated by race, ethnicity, and gender
	Connections to Specific Housing Resources	
93	36	Number of individuals on the by-name list at a specific encampment site
94	37	Percentage of people on the by-name list who were placed into interim housing on the day of the operation
95	38	Percentage of people on the by-name list who were not placed into interim housing on the day of the operation
96	39	Number of individuals not on the by-name list at the specific encampment site
97	40	Percentage of people not on the by-name list who were placed into an alternative interim housing program on the day of the operation (dependent on housing resource availability)
98	41	Of those not placed into interim housing on the day of the operation, percentage of people not on the by-name list who are connected or re-connected to outreach services within a week of the operation
	Regional Coordination	
99	42	Regularly updated, public resource showing: - Most recent point-in-time count of geographic distribution of unsheltered homelessness (Data source: PIT count) - Encampment data: Locations with five or more people experiencing unsheltered homelessness (Data source: HMIS) - Frequency of contacts from an outreach team, disaggregated in three ways: (1) In response to a request for service (LA-HOP) and Emergency Centralized Response Center (ECRC) (2) With sufficient frequency to infer response to major events (e.g., disease outbreak, natural disaster) (3) Through proactive engagement, to serve people known and enrolled in outreach services
100	43	Percentage of instances in which a specialized care outreach team or MDT is deployed within 48 hours of a referral
101	44	Average number of times per week that each encampment (defined as five or more people) is visited by outreach teams
102	45	Average number of times per week that each engaged (connected) individual receives in-person services
	CONTRACT PERFORMANCE INDICATORS	
103	46	Number of individuals with whom teams initiate contact as demonstrated by a new street outreach enrollment

104	47	At least x% of all contacted individuals are engaged (connected or re-connected to ongoing services)
105	48	Percentage of engaged (connected) individuals who have ID uploaded in HMIS
106	49	Percentage of engaged (connected) individuals who have a social security card uploaded in HMIS
107	50	Percentage of engaged (connected) individuals who have their CES assessment completed and score indicated in HMIS, in line with CES Policy and guidance
108	51	Percentage of engaged (connected) individuals who are referred to and are active in the interim housing community queue
109	52	At least x% of engaged (connected) individuals successfully attain an interim housing resource (inclusive of crisis and/or bridge housing) *This measure is dependent upon the availability of housing resources*
110	54	At least x% of engaged (connected) individuals are permanently housed *This measure is dependent upon the availability of housing resources*
111	55	*Demographic disaggregation:* Percentage of engaged (connected) individuals who attain an interim housing placement and percentage who are permanently housed, disaggregated by race, ethnicity, and gender
	REQUIRED SERVICES	
112	56	Percentage of referrals that are "closed loop," meaning service providers inform the referring entity or individual when an individual has been connected to services or couldn't be connected