Reducing Family Homelessness in Virginia:

A Report on Rapid Re-Housing Provider Experience and Organizational Impact

Findings from an 18-month Pilot

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for

Virginia Coalition to End Homelessness

National Alliance to End Homelessness

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Contents

Executive Summary

Overview

This report summarizes a participatory, mixed-method evaluation of the impact on the organizations conducting an 18-month pilot to assist high housing barrier (HHB) homeless families in Virginia using a rapid re-housing (RRH) model. The pilot, conducted from July 2013 through December 2014, was designed to facilitate organizations' abilities to employ new and innovative approaches to house HHB families. It involved 11 organizations across five sites in Virginia. Participating organizations included:

- Shelter House, Cornerstone, Facets and New Hope Housing in Fairfax County;
- First Step and Mercy House in Harrisonburg;
- For Kids in Norfolk;
- Housing Families First (formerly Hilliard House), Home Again, and St. Joseph's Villa/Flagler Homeless Services in Richmond; and
- Samaritan House in Virginia Beach.

The structure of the project required that participating organizations first identify HHB families and then enroll them in the pilot. Because the organizations did not have waiting lists of HHB families at the beginning of the project, admission in occurred on a rolling basis, with the first family admitted in July 2013 and the last family in August 2014.

The families served through the pilot differed from one another in many ways; however, the participating organizations identified several characteristics which defined the different subgroups of the populations they served. These characteristics, which correspond to barriers to obtaining and maintaining housing, identified in HHB assessment forms, included:

- No employment history or no credit history.
- Limited or no household income.
- Problems in prior rental history such as past evictions, damages, and/or housing debt.
- Formerly incarcerated individuals or individuals with criminal records.
- Head of household with cognitive disabilities or mental health issues which are undiagnosed or untreated; unrecognized mental illness (for example, severe depression); other medical issues; or physical or mental disability.
- Children with a severe disability, mental or medical illness or cognitive/behavior issues.
- Active substance abuse in parents.
- Low educational attainment.
- Lack of experience with life; life skills gaps/lack of life skills; little to no experience living on one's own.
- Clients who are socially fragile or who lack a support system, for example, recent immigrants who lack social support and are not connected to mainstream services.
- Domestic violence trauma issues, or other post-traumatic stress situations, for example among some recent immigrants.

A brief description of rapid re-housing

There is a growing body of evaluation and research demonstrating that rapid re-housing is an effective means of solving homelessness among families and other populations. The Federal government, including the U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Veterans Affairs (VA), have recently made major investments in rapid re-housing and promote the expansion of rapid re-housing as part of community coordinated systems that quickly assess families and individuals and link them to the best housing option. Opening Doors, the Federal Strategic Plan to Prevent and End Homelessness, calls on communities to retool their homelessness systems to focus on rapidly re-housing families.

National research[1] indicates that people assisted through RRH experience higher rates of permanent housing placement and similar or lower rates of return to homelessness after the assistance ends, compared to those assisted by transitional housing or those who only receive emergency shelter. In and of itself, RRH is not designed to comprehensively address all of a client's service needs or their poverty. Instead, RRH solves the immediate crisis of homelessness, while connecting families or individuals with appropriate community and mainstream resources to address non-housing related service needs and develop long-term supports to maintain housing.

Project impact: families with high barriers to housing can be returned to housing quickly and efficiently through a RRH approach.

Over the course of 18 months, participating organizations served 99 HHB families. Of these, 57 families remained stably housed at their exit from the program and 35 families, who were still participating in the RRH program at the end of the data collection phase in October 2014, were stably housed at that time. Seven left their housing situation and the program.

To achieve these results, on average, organizations provided 15 hours of case management prior to the family moving into housing, and another 17 hours of case management after the family was housed.

[1] The National Alliance to End Homelessness (NAEH) and the Department for Housing and Urban Development (HUD) are two websites that provide a set of excellent research related to understanding Rapid Re-housing and its efficacy as a model. (NAEH: http://www.endhomelessness.org/library)
(HUD: http://portal.hud.gov/hudportal/HUD?src=/recovery/programs/homelessness)

PARTICIPATING FAMILIES' HOUSING STATUS						
Location	Organization	**# of Families served in the pilot**	Stably housed at exit program	Still in program and stably housed	Left program/ living w/ Family	Left program/ status unknown
Fairfax County	Shelter House	**5**		5		
	Cornerstone	**5**		3	1	1
	Facets	**5**	2	2		1
	New Hope Housing	**2**	2			
Richmond	Hilliard House	**17**	10	7		
	Home Again	**11**	11			
	St Joseph's Villa[2]	**4**	2	2		
Harrisonburg	First Step	**10**		10		
	Mercy House	**20**	18	1	1	
Norfolk	For Kids	**9**	6			3
Virginia Beach	Samaritan House	**11**	6	5		
	Total	**99**	57	35	2	5

Due to both the rolling nature of admissions and the short duration of the pilot, data for a key outcome measure for RRH programs – family housing status at 12 months after program exit – is not available. Therefore, this evaluation does not fully address the effectiveness of RRH as a model of ending homelessness and maintaining housing stability. Rather, it provides an analysis of client-level data on housing, income, employment and benefit status during the pilot time frame and documents a range of both client survey and provider interview data on experiences with the RRH model. The evaluation also provides an analysis of other types of assistance which participating organizations believe to be potentially impactful with respect to supporting HHB families.

This evaluation of a RRH pilot in Virginia was participatory in nature and took into account existing evaluation research on RRH and the family-level and organizational outcomes about which participating providers were most concerned. While some of the practitioner's observations are beyond the scope of what homelessness assistance programs, or RRH programs specifically, are designed to address, they reflect an ongoing dialogue in the homelessness field between practitioners' frontline views and the research needed to inform and advance policy to address homelessness in the U.S.

[2] St. Joseph's Villa – Flagler Housing and Homeless Services

1. Introduction

Context

From 2010 to 2014 the Commonwealth of Virginia reduced the number of families experiencing homelessness by 25 percent - from 1,181 family households in 2010 to 883 in 2014[3].

In July 2013, the National Alliance to End Homelessness (NAEH), the Commonwealth of Virginia and the Virginia Coalition to End Homelessness (VCEH) launched an 18-month pilot project, with support from the Freddie Mac Foundation, which aimed to understand whether high housing barrier (HHB) families in Virginia can be served through a rapid re-housing (RRH) model. Funds from the Freddie Mac Foundation were re-granted to eleven participating organizations across five communities in the state: Fairfax County, Harrisonburg, Norfolk, Richmond, and Virginia Beach. This final evaluation report summarizes client-level housing, income, employment and benefit data during the course of the pilot, as well as client survey and provider interview data on their experiences as they transitioned to using a different model of assistance for families focused on RRH. The report assesses the impact experienced by organizations implementing new RRH programs, with respect to both internal operations and external communication with landlords and donors, and provides insights gleaned from organizational assessments and interviews with staff.

Pilot description

RRH is an intervention designed to help individuals and families to quickly exit homelessness and return to permanent housing. RRH assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety); the resources and services provided are typically tailored to the unique needs of the household. The three core components of a RRH program are:

- Housing identification,
- Rent and move-In assistance, and
- Case management and services.

In 2011, the National Alliance to End Homelessness, the Virginia Department of Housing and Community Development, and VCEH developed a partnership which secured grant funding from the Freddie Mac Foundation to support several activities promoting approaches to better serving homeless families through the rapid re-housing model. These activities included an 18-month pilot project supporting 11 provider organizations aiming to understand whether HHB families can be served effectively through the RRH model. The pilot provided funding to eleven homelessness service providers in five Virginia communities to implement the model with a subset of their clients. At the beginning of the pilot, the 11 participating organizations demonstrated varying levels of experience using the RRH model. They implemented pilot-funded activities from July 2013 through December 2014. Success Measures was

[3] Virginia compares favorably to neighboring states and the nation as a whole: according to the 2013 State of Homelessness in America report from the National Alliance to End Homelessness, 20 out of every 10,000 people, nationally, is homeless, while Virginia's rate is just 10 people per 10,000.

contracted to conduct a participatory evaluation for the pilot. Data collection was completed in October 2014; the project concludes with this final report in February 2015.

HHB families are those determined to have severe barriers that could inhibit their access to housing without assistance, such as prior rental history, credit history, income and employment history, disability or substance dependency. This may include families which score a three or higher on a form such as the "NAEH RRH Triage Five-level Scale". However, because there are many ways to define a "high housing barrier" family, at the start of the project the participating organizations each defined "high housing barriers" for their own purposes, taking into account contextual factors which might impact families and organizations at the local level.

VCEH was responsible for evaluating the pilot project, which was designed to be both a capacity building and field-building effort and was the first formal pilot to support RRH work specifically with HHB families in Virginia. Due to the pilot's dual purpose, the sponsoring partners built evaluation for organizational learning into its fabric. Additionally, the pilot served to help identify areas where change is needed, regarding various public and institutional policies, resources, and systems impacting services for the homeless. The evaluation tracked the experience of HHB families served by the pilot, as well as provider and participant feedback on related impacts on organizational staff, resources and service delivery.

Through evaluation of the pilot, VCEH and its partners sought to:

1. Learn about the thoughts and impressions of RRH providers as they implement a RRH program for HHB families; and
2. Learn more about innovations, at the family, organization, and systems levels, that could help significantly reduce family homelessness in Virginia.

Participating Organizations

The organizations implementing the RRH pilot include:

SITE	PARTICIPATING ORGANIZATION
Fairfax County	Shelter House Cornerstone Facets New Hope Housing
Harrisonburg	First Step Mercy House[4]
Norfolk	For Kids
Richmond	Housing Families First (formerly known as Hilliard House) Home Again St Joseph's Villa – Flagler Housing and Homeless Services
Virginia Beach	Samaritan House

Each organization received funding to implement a RRH model with HHB families (as defined by the intake forms used) and began implementing the pilot after July 2013. The individual organization had the flexibility to set its own priorities and determine how to use pilot resources to serve the families it had identified as priority clients. An overview of how the organizations used these funds is provided in the section entitled Benefits to Families on page 29.

Most of the organizations served families at levels three and four of the housing barriers five-point scale, a standard assessment form for housing barriers, while a few organizations focused on higher need families assessed at levels four and five. Organizations in Fairfax County used a locally developed assessment form that has a 20-point scale and targeted families between level 11 and 15. Generally, organizations did not serve families who scored at the highest levels on the assessment form through the RRH pilot, but worked to place them in permanent supportive housing[5]. However, because permanent supportive housing is in such short supply, in a few cases where a family qualified for permanent supportive housing but the organization staff thought they might have capacity to maintain stable housing with case management, the family was included in the pilot; it is too early to tell if these families will be successful in RRH over the long term.

[4] The Harrisonburg Redevelopment and Housing Authority, which chairs the local CoC, acted as the lead applicant on the pilot application and fiscal agent for the pilot organizations in Harrisonburg, and was a critical partner to First Step and Mercy House throughout the duration of the pilot.

[5] According to the Interagency Council on the Homeless, Permanent Supportive Housing (PSH or "supportive housing") is for people who need long-term housing assistance with supportive services in order to stay housed. Individuals and families living in supportive housing often have long histories of homelessness and face persistent obstacles to maintaining housing, such as a serious mental illness, a substance use disorder, or a chronic medical problem.

Many of the organizations saw the pilot as an opportunity to diversify the types of families they are able to serve. Others, who intended to work with families at the same barrier levels they typically served, already representative of HHB populations, sought an opportunity to do things differently. The pilot was intentionally designed to allow organizations flexibility in applying the grant funding to facilitate new and innovative approaches. Almost all of the organizations aimed to take advantage of this flexibility to use resources in a different way, either serving a family that they might not otherwise have been able to serve or shifting internal policies to implement new strategies.

The organizations were all encouraged to use the pilot process to learn more about how RRH resources can best serve HHB families and whether their RRH programs could benefit from program modifications for this population. The organizations also expressed a desire to better understand the different barriers families face and identify policy priorities for addressing those barriers to help families successfully maintain stable housing once they were no longer homeless.

2. The Evaluation

Methods

The evaluation was conducted as a participatory, outcome-focused summative evaluation using qualitative and quantitative methods. As a participatory evaluation, the participating organizations and project sponsors contributed to all elements of the evaluation design including identifying outcomes, specifying indicators, and determining lowest burden data collection methods. This work resulted in a draft evaluation framework that was then reviewed by both funders and project participants. The final evaluation framework was completed in September 2013. The evaluation framework reflects the information organizations deemed important for understanding: first, program participants' perceptions and experiences with the pilot and with their housing placement, and second, the level of effort and experiences of providers using RRH with HHB families. A third dimension of the framework focuses on the mainstream systems change, beyond the RRH model, that is needed to create a more integrated set of services, processes and resources in communities to support vulnerable families' return to stability after they are successfully housed.

This mixed-method evaluation relied on both qualitative and quantitative data. Information was collected through a variety of vehicles, including an organizational assessment, an in-person meeting to frame the evaluation; a tracking sheet to capture key data from standard intake processes and ongoing program administrative data; and, a family perception survey developed for the pilot. Descriptions of key evaluation activities are provided below:

- Organizational assessment. An initial assessment was carried out by the evaluators with lead staff from the 11 participating organizations, including reviewing background materials on the organizations. The purpose of the assessment was to introduce and orient the evaluators to the organizations; develop a deeper understanding of the complex relationships that exist among service providers; and provide needed background and input to draft the outcome-oriented evaluation framework. Assessments were carried out in July and August 2013.

- An in-person work session with organizations, VCEH, and the evaluation team. The purpose of this session was to launch the pilot and complete the development of the outcome-oriented evaluation framework. It was held in August 2013.

- Program administrative data. This encompasses quantitative data about the families and program services, from Homeless Management Information Systems (HMIS)[6] and other organizational files. These data include, for example, family size, income level, and debt level, level and type of support provided to the family, date of entry into program, and housing status at end of program.

- Interviews with staff. Qualitative information was collected from staff in an interview format. Conducted by the evaluators, the interviews were designed to gather information on organizational capacities and expenditures related to serving HHB families through the RRH

[6] A Homeless Management Information System (HMIS) is "a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness." Source: HUD Exchange accessed online at: https://www.hudexchange.info/hmis (November 18, 2014).

model, and staff perceptions of what key system issues impacted their work with HHB families. In order to understand change over time, the interviews were conducted twice during the pilot project, the first round conducted during site visits in December 2013 and January 2014 and the second round in October 2014.

- A client-level perception survey. Qualitative information was collected from participating families related to their perceptions and experiences with the RRH program. The survey was administered by case management staff as part of their interaction with the family, and was intended to occur at least twice over the course of the pilot: the first time coinciding with a family's placement in housing and, the second, at least three or four months later. Optimally, organizations were to continue administering the survey at quarterly intervals for the remainder of the project.

Recognizing that several program data points identified in the evaluation framework were already captured by organizations as part of their standard data tracking, Success Measures developed an excel spreadsheet into which organizations could transfer necessary data from their pre-existing Homeless Management Information System (HMIS) or other system. While all organizations serving homeless individuals and families are required to collect a standard set of data called the Universal Data Elements, in Virginia, homeless providers have the option of using HMIS systems designed by various vendors, resulting in some incompatibility among systems. The excel spreadsheet allowed organizations to cut and paste their data into a common spreadsheet for the evaluation. The spreadsheet was also needed because organizations working with domestic violence survivors do not enter client data into HMIS for security reasons. Two of the eleven participating organizations work exclusively with domestic violence survivors, and several others also had domestic violence survivors as clients.

Success Measures made available to all 11 organizations an existing data collection survey regarding income and debt, so that those organizations not tracking income and debt in HMIS would have a vehicle for collecting data; other organizations were given the choice to collect the income and debt data either through the income and debt survey or through their HMIS.

The excel spreadsheet Success Measures developed also provided a way to track the number of contacts organizational staff had with clients and how much time that took, broken into four categories: case management before being housed, case management after being housed, housing location, and other staff supports to the family. This data is intended to assist the organizations to better understand the staff support levels required by HHB families.

Limitations of the data

This report draws on survey and assessment data of provider and participant experience of implementing RRH, as well as client intake and program participation data. Key outcome measures used to evaluate RRH nationwide (e.g. exits to permanent housing, the length of time households are homeless, the length of time households remain in housing once assistance ends, and if the families return to homelessness) are not fully addressed in this report because some of the necessary data collection exceeded the duration of the pilot and therefore was not consistently available for all participating families.

A core objective of the data collection and analysis was to obtain survey data for at least two points in time for each family; the first after the family was housed and, the second, a point in time three or four

months after that, and then continuing on a quarterly schedule for as long as the family remained in the organization's program. Due to inconsistencies in data collection, the first and second points in time vary across families. For example, data available may reflect some families' participation in a RRH program over a period of only three to six months, while for about twenty families it was seven or more months.

In some cases, income and debt and family survey data was collected at more than two points in time over the duration of the pilot. For the purposes of this report, the first and last points of data were included in analysis. In Virginia, there are three versions of HMIS in use. The versions do not easily share data across systems. Additionally, two of the organizations participating in the pilot serve domestic violence survivors, whose data cannot be placed into a centralized data system. This had two implications for this report: first, practitioners had to take an extra step of entering data into the income and debt survey or into the excel spreadsheet, even if they had it already in HMIS; and, second, participating organizations could not provide a number for families returning to homelessness across regions due to different HMIS systems.

Overview of the Evaluation Framework

As a participatory outcome evaluation, the first step in the evaluation process was to work with the organizations to identify a set of client-level outcomes for the pilot. These included outcomes at the client and organization levels:

Organizational level outcomes

RRH is a relatively new intervention being implemented in Virginia. Implementing RRH using the core components required significant shifts in operations, funding mechanisms, and philosophies for homeless service providers accustomed to a shelter-based model. Because of this, pilot organizations were interested in examining the ways the pilot could impact both internal and external organizational operations. Data informing organizational level measures are gleaned from staff interviews, client-level intake data and organizations' HMIS data tracking.

Client-level outcomes

The primary goal of rapid re-housing is to address the immediate needs of a family's housing crisis and, ultimately, end a family's homelessness by supporting their move into permanent housing as quickly as possible. At the time of the report, 92 of 99 pilot program families are in permanent housing. Organizations also identified a set of client-level outcomes, beyond the intended goal of rapid re-housing, in order to examine other possible social and economic benefits of a housing first/RRH approach to HHB families in order to build support for RRH programs among other stakeholders in the system. Organizations felt that these self-identified indicators may show other ways housing contributes to outcomes addressed by other mainstream services and community resources, including employment, health, and education.

The organizations recognized that many of the outcomes they desired to track could not be measured within the time frame and scope of the pilot project, specifically related to long-term housing stability. For this reason, evaluators worked with organizations to identify more specific measures (indicators of change that would best reflect families' progress toward achieving these outcomes), which would be observable during the pilot. These specific measures, including a number of outcomes that were not able

to be captured, are depicted opposite the corresponding outcome in the table on the next page. Data informing client-level measures were drawn from family survey responses and the excel sheet data points reported by organizations.

Systems-level learning areas

The pilot organizations identified linkages with mainstream systems as a core component of the work. However, given the short time frame and limited scope of the pilot, it was determined that these mainstream systems could not be evaluated as part of this project. To incorporate practitioners' experiences with mainstream systems, several open-ended questions were included in the staff interview to better understand organizations' experiences with mainstream systems when serving HHB families. During the course of the evaluation, providers highlighted areas for stronger coordination with other mainstream services providers. Some of the issues they addressed identified key gaps in organization knowledge on up-to-date policies and procedures.

Outcome and Learnings Table – Organization, Client & Systems Level

The outcomes, indicators, and areas for learning in the tables which follow were identified by practitioners in the pilot and reviewed by project partners. A number of outcomes and indicators were identified that went beyond the scope of the project; these have been left in the chart in italics, but no data were collected related to those indicators and outcomes. Additionally, pilot organizations identified a number of areas to investigate related to the mainstream systems. These were identified as beyond the scope of the project at the outset and left in as key areas to consider, as connecting families to mainstream systems is a core part of practitioners' work, even if it is beyond the scope of this pilot.

IMPROVED INTERNAL OPERATIONS	
Organization Level Outcomes	**Interim Measure of Progress**
High barrier families served with existing resources	➢ Total number of HHB families served ➢ Services provided, hours, dollars
Appropriate resource allocation across families served in the pilot	➢ Cash, case management activities, and time spent with each family
Improved understanding, among staff at all levels of the organization, of benefits and realities of RRH model with high barrier families	➢ Staff are able to articulate real success of RRH model
IMPROVED EXTERNAL COMMUNICATIONS	
Organization Level Outcomes	**Interim Measure of Progress**
Improved clarity of message regarding RRH programming to donors, relevant government funders/supporters, and volunteers	➢ Private donors and supporters demonstrate an understanding of why it is important to support RRH
	➢ *Public sector funders demonstrate an understanding of RRH model benefits and the importance of diversified funding with syncing of rules/timing*
	➢ *Volunteer hours*
Improved clarity of message regarding RRH program to landlords resulting in more participation by landlords	➢ *Landlords participate in program in ongoing manner*

STABILITY	
Long-Term Client-Level Outcomes	**Interim Measure of Progress**
Children in families participating in RRH program are more likely to stay in same school over time	➢ Children stay in the same school during RRH program participation
Children in families participating in RRH program stabilize/improve their academic performance	➢ Parents' perception of students' academic achievement; change over time
Income for participating families is sufficient to maintain household expenses	➢ Monthly income; ➢ Employment status ➢ Disability benefits status; ➢ # of families with increased income; ➢ # of families with reduced debt (especially housing debt)
Families are able to stay in housing that meets their needs (located near jobs, transit, child care, etc.)	➢ *Families are housed 12 months after placement in RRH and 6 months after end of program* ➢ *Families feel safe* ➢ *Families find housing convenient to their needs*
SENSE OF WELL-BEING & COMMUNITY	
Long-Term Client-Level Outcomes	**Interim Measure of Progress**
Participating families feel more in control of their living situation and a sense of well-being	➢ Parents report clear goals and a positive change in their ability to manage everyday concerns
Participating families become more connected to the community	➢ Increased connections to other individuals and families in the community and to services

The table below describes areas that pilot organizations identified as important to consider as Rapid Re-housing work moves forward. These areas for exploration were not evaluated and used only as a guide for framing experiences with mainstream services for practitioners during the organization interviews. They are relevant as part of this report only as areas that technical assistance providers and homelessness intermediaries might be able to provide assistance facilitating some of these connections and keeping practitioners up to date on policy changes related to each of the systems partners. It should be noted that organizations identified aspirational outcomes related to changes in their organizational behavior, as well as the changes to external mainstream systems.

AREAS IDENTIFIED FOR LEARNING: SYSTEMS CHANGES	
Aspirational Outcomes	**Suggested Measures**
Families will experience less time in homelessness	➢ *# of days between shelter and permanent housing; duration of homelessness*
Families in the most vulnerable category that participate in RRH will experience fewer returns to homelessness	➢ *Tracking family over time to count any return to homelessness*
Overall family homelessness decreases across the state	➢ *Aggregate state data (recognizing there are other factors such as the economy)*
AREAS IDENTIFIED FOR LEARNING: CHANGES IN BEHAVIOR AND ATTITUDE OF ORGANIZATIONS, INSTITUTIONS, AND FUNDING	
Aspirational Outcomes	**Suggested Measures**
Improved collaboration with mainstream services and resources	➢ *Staff among service providers report increased ease in making connections for families being served*
Timing of complimentary services and funding sources are more in sync to meet re-housing needs in a RRH context	➢ *Staff among service providers, government agencies report increased ability to match families with appropriate services in the appropriate time frame*

3. Organizational Effectiveness (Organization Level Outcomes)

All of the organizations participating in the pilot had some prior experience implementing aspects of RRH programs, but for many this was the first time they had implemented all of the core components, including flexible funding. Implementing RRH with HHB families was a new challenge for many of the organizations making them uncertain of the types of staff support or resources these families would need in order to be successful. The organizations that had experience serving HHB Families looked at the pilot as a way to increase their learning by working with families they had previously considered only eligible for permanent supportive housing or for transitional housing. During initial meetings, the organizations articulated needing to invest in developing new organizational capacities to implement RRH programs for HHB families in particular. They worried that working with HHB families would require more staff time and resources than their organizations could commit. Provided below are some of the organizational outcomes resulting from participation in the RRH pilot, as well as key ways staff support and organizational resources were leveraged to assist HHB families.

Client Intake and Barrier Assessment

When asked about their intake process and whether it had to change for HHB families, organizations indicated that they:

- Completed the intake assessment for HHB families in the same time frame as their other clients (usually 1-3 days of entering the system).
- Used the same assessment process with HHB families as with their other clients, with the typical process being an initial assessment, followed soon after by a meeting with housing-focused staff who would begin to develop a housing plan.
- Used their standard assessment form, but were concerned that this does not adequately capture all the challenges faced by HHB families, and may not adequately weigh the significance of some barriers.
- Were able to maintain their organizational goal of moving families into permanent housing within 30-45 days.

High Housing Barrier Assessments

Organizations felt it was important to acknowledge that there was no one definition of a high housing barrier family. They articulated that high housing barriers differed across geographies, depending on the local context of each place. For this reason, the organizations were asked to assess housing barriers for families by taking into account their local context, but also keeping an explicit focus on barriers related to housing rather than the full gamut of issues a family may be facing.

Each of the organizations was encouraged to use an assessment form they were comfortable with to qualify families as high housing barrier families for the pilot. Most organizations already had forms or were able to modify a form they already used to increase emphasis on housing barriers separate and distinct from other barriers that might be perceived to impact stability. Many of the forms were modeled on the Hennepin County, MN HHB Triage form, or the RRH Triage Form created by the NAEH, both of which

establish five levels of barriers based on the household's housing history and situation. The four organizations in Fairfax County used a form designed by the county and its homeless service providers, which uses a 20-point scale. To determine eligibility for this RRH pilot, the Fairfax County organizations focused on families with a score of 11-15 on their 20-point scale. The other sites focused on families that received a three or four on the NAEH five-point scale.

Additional Triage and Case Management Tools

The organizations' thoughts on the best type of triage tool to use for HHB families and RRH evolved over time in the pilot. In late 2014, as the pilot was concluding, a few organizations began using or considering use of, the Vulnerability Index/Service Prioritization Decision Assistance Tool (VI-SPDAT) and the related Service Prioritization Decision Assistance Tool (SPDAT). The VI-SPDAT, is a triage tool for determining appropriate program planning for homeless individuals and homeless families. The SPDAT is designed to be an ongoing tool which can be completed at numerous points throughout the case management relationship with the household, thereby providing documentation of change pertaining to the following 15 categories:

- Self-Care and Daily Living Skills
- Meaningful Daily Activity
- Social Relationships & Networks
- Mental Health & Wellness
- Physical Health and Wellness
- Substance Use
- Medication
- Personal Administration/Money Management
- Personal Responsibility & Motivation
- Risk of Personal Harm/Harm to Others
- Interaction with Emergency Services
- Involvement in High Risk/Explosive Situations
- Legal
- History of Homelessness & Housing
- Managing Tenancy

Impact of RRH Pilot on Organizations

Internal operations

Organizations were able to quickly serve more, and a broader diversity of, clients

All of the organizations affirmed that participation in the RRH pilot assisted them in achieving their organizational performance goals for the total number of families served per month because they were able to serve families they typically would not have been able to serve or could not previously have served as quickly. Organizations also reported that participation in the RRH pilot lessened the strain on the organization because it shortened the stay in a shelter for some families, thereby freeing up that space for others.

Financial flexibility allowed for the creative application of resources

The organizations affirmed that flexible funding provided an alternative for families who might otherwise have had no option but the shelter, and allowed the organizations more ability and creativity in problem-solving. Especially attractive was the flexibility to support a family based upon its unique situation. A strength of the rapid re-housing model was the ability to be flexible in how much assistance to provide, and how long to provide it for, as well as the ability to fluctuate the amount as needed when a family's situation changed from one month from another. The progressive engagement model encourages that the family and case manager meet monthly to determine the family's financial needs and allocate only the minimum financial supported needed,, with the expectation that the family will progressively need fewer resources. This model also allows for resources to be increased as needed. Several case managers articulated examples when a family would experience a new short-term problem that would require additional resources, i.e., a car would break down, or another unexpected expense would arise, and in order for the event not to become destabilizing, the organization would step in and cover the expense, or would pay a greater portion of the rent that month so the family could cover the additional expense.

Organizations applied flexible funds to cover critical, non-housing related expenses

Nine of the eleven organizations used their RRH financial resources in other ways beyond rent subsidies, including paying prior utility debts, providing utility deposits, subsidizing utility payments, offsetting partial rent arrearages, and paying apartment application fees. Other non-housing related assistance[7] often involved fairly small amounts of money, but, according to the participating organizations, were in fact very important. When asked which financial resources proved most essential in the first months of the pilot, every organization affirmed the important value of these flexible dollars. Organizations appreciated the ability to assist families with a variety of small needs that helped support their transition to stability in their new housing.

[7] Organizations applied flexible funds to cover a variety of non-housing related expenses that they believed were critical to families' well-being. These included expenses related to employment assistance; health care and other social services; personal care; child care and children's extracurricular activities; financial management; household goods and food.

Quick turnover presented opportunities for innovations in service delivery

Several organizations reflected that the shift to RRH challenged them and their partners to consider changes in the timing and delivery of certain programs, such as financial literacy training and budgeting. For example, one organization's partner previously offered eight weeks of voluntary financial literacy classes to families while in the shelter. However, because RRH quickly moves families into permanent housing, families were leaving the shelter before completing the classes, which required the organization to consider alternative ways to deliver the material. Organizations are at various stages of rethinking how to deliver such services. One organization now regularly offers their financial literacy/budgeting and their employment opportunity classes to the broader public, serving the community around their building, as well as to former and current clients. Another is actively considering how to offer training to families on an "as needed" basis; this might require more one-on-one training rather than a classroom setting, which could also better accommodate the broad spectrum of need among the diversity of families.

Staff increased knowledge of housing and family budgeting

Case management staff articulated having developed a new set of skills beyond the typical realm of social work, particularly with respect to improving their understanding of housing and family budgeting. The new emphasis placed on housing, through participation in RRH and other Housing First efforts, has required organizations to consider a different set of skills in new hires; more organizations are now looking for candidates that have prior housing experience. The support organizations provided to families in helping them to negotiate relationships, budget their money and be a good tenant and neighbor, was seen as critical to a family's success in its new housing unit.

A designated housing specialist on staff helped build relationships with landlords

Most, if not all, of the organizations adjusted their staff roles so that the role of housing locator was specialized within one position rather than having all case managers responsible for that role in their caseloads. This specialization allowed staff to build stronger relationships with landlords. Several organizations affirmed that with a single staff person focused as housing specialist, landlords were more comfortable knowing whom to call if a problem arose with a client. This also provided landlords with an internal advocate who would represent their perspective, while a case manager might be more likely to represent the client's perspective if the organization became involved in resolving problems.

Increased organizational supports mitigated the effects of staff burnout

Many staff reported that case managers with a large HHB family caseload often experienced burnout. Most found that it worked well to provide each case manager with a mix of HHB families and non-HHB families, so that the stress did not become overwhelming for the case manager. One or two organizations found that a unique case manager could thrive with an entire portfolio of HHB families, but that was not the norm. Most organizations also instituted increased staff supports in the form of additional supervisory meetings with case managers, or increased frequency of staff group meetings to review cases, so that case managers had a peer support system in place. This increased creative problem-solving, and reduced the stress and isolation of community case management where each staff was increasingly on their own out at the client's housing.

Staff improved overall confidence in working with HHB clients

Organizations' staff indicated that participation in the RRH pilot enabled them to view both HHB families and the services they offer in a new light. They were more confident, at the end of the pilot that RRH can work for HHB families. In particular, organizations stressed that the flexible money and ability to provide more intensive case management were critical to ensuring families' well-being; for some, participation in the pilot convinced them that RRH can work for most families if both these conditions – flexible funding and intensive case management support – are met. Some organizations reported that the flexibility allowed in the pilot enabled them to take risks and consider the broader potential of options.

External communications

Organizations conducted more creative outreach to identify willing landlords

To identify potential landlords, organizations scour the paper and Craig's List, contact prior landlords to see if they have new openings, and try to identify small landlords through their faith congregation partners. Organizations' success in recruiting landlords seemed to be influenced by whether an organization has a dedicated housing specialist with the time to do outreach to individual landlords and groups of landlords. One fairly recent approach was to have exploratory conversations to build relationships with landlords before actually having a specific family in need of housing. Other approaches included holding educational workshops for landlords at luncheons and other meetings to address fair housing and perceptions of preferential treatment given to these families. Several organizations discussed coordinating their efforts to facilitate regional outreach to landlords, rather than each organization doing its own outreach.

Financial flexibility and timely payments were critical for gaining landlord support

Rapid access to deposit checks is critical. Organizations found that they were more successful in recruiting landlords when they could provide rent deposits immediately at the time of leasing. They believe that landlords are more willing to take high-risk families if the organization can provide payment the day that the landlord commits to a family becoming a tenant. One organization, whose internal policies and procedures require a board member's and executive director's signature, causing a delay of several days, acknowledged this may hinder the ability to secure some landlords' participation; another organization referenced a specific landlord of a larger property who refused to participate because although the family could provide a signed lease quickly the organization could not deliver a deposit check in less than 30 days. Another organization was unable to utilize a local public rent deposit fund for RRH clients because the fund has a 30-day turnaround for a deposit check.

Other factors that organizations identified as appealing to landlords were the guarantee of rent payment, even if just for a few months; the ability to fill vacancies quickly; and the willingness to pay the last month's rent up front, or to pay a double deposit. The additional money is valuable to landlords because, should eviction become necessary, it takes two months to evict a tenant. If the organization can pay two months up front, the risk of non-payment later is decreased.

Small property owners were more amenable to working with HHB families

Small local property owners are more flexible than large property management companies. HHB families don't generally meet the eligibility criteria for large multifamily properties owned by private corporations. Even at those properties funded with tax credits or some HUD programs, where the property management company is national or regional, there are inflexible credit standards or other criteria that would exclude HHB families. Public housing authorities could be an option based on eligibility criteria, but many have such prohibitively long waiting periods that only one of the five pilot sites saw public housing authorities as a realistic possibility.

Prior housing-related debts were difficult for landlords to ignore

Case management staff articulated in the interviews that they often felt it was important to differentiate between housing debt and other debt, because landlords were more likely to overlook other types of debt, such as medical bills, than any housing-related arrearages. For this reason, organizations were likely to direct resources towards eliminating housing-related debt for HHB families.

Prior housing damage was one reason clients faced housing-related debt. Staff identified Virginia's treatment of housing damage as contributing to landlords' reluctance to accept families with this type of housing-related debt. The state law does not differentiate between types of damages incurred at a property. For example, the same penalty is applied to a property that has incurred interior or structural damage as to a property where the previous tenant may simply have left behind personal belongings or furniture. This is a concern, given that some HHB clients may have been fleeing a domestic violence situation at the time of departing from their previous household. Staff suggested that simply differentiating between the two levels of housing arrearages could make a difference in landlords' decision making and improve housing opportunities for HHB clients; such a change would need to be made through state law.

Organizations maintained consistent messaging with donors

Prior to the pilot, some organizations with a strong individual donor base, expressed some concern that a reduction in shelter use and an increase in housing through the RRH model, might cause difficulty in keeping their donors engaged to support families. One organization expressed fear that fewer photo opportunities at the shelter during the holidays might limit their fundraising capacity. Staff interviews addressed messaging to donors and volunteers and, by the end of the pilot, revealed that all organizations felt that they had found ways to clearly express to their stakeholders, donors, and volunteers the value of moving families to permanent housing and that all families served continue to be their clients, whether temporarily in the shelter or in their own housing unit through RRH. No organization experienced any measurable shift in donor support during the relatively short period of the pilot, and most believed they would experience an increase over time due to being able, through RRH, to serve more families and show increased numbers of successfully housed families. Additionally, recognizing the many benefits that flexible funding from the pilot provided, several organizations noted that they have begun to request flexible funding as a component of their proposals and have seen support for this among their donor communities.

Staff-Reported Challenges for Implementation

In most cases, organizations' effectiveness in working with HHB families far exceeded their initial expectations and the RRH pilot led the organizations to discover both new and different ways of doing things. However, throughout the course of the pilot, organizations also articulated a number of implementation concerns, based on their experience and knowledge regarding both the RRH model and working with HHB families. While some of these concerns were not addressed in the scope of the pilot, and cannot be addressed through a RRH approach, organizations identified these issues as related to case management or mainstream services provided to HHB families.

These concerns, each discussed in further detail below, included:

- Tracking staff time
- Short-term assistance
- Funding constraints or complexities beyond the scope of the pilot
- Perceived separation of housing-related issues from other barriers

Tracking staff time

All of the organizations provided their client families with case management, as well as housing locator help. The organizations also provided families with advocacy assistance in applying for mainstream benefits, including disability assistance, when eligible. Most of the organizations had funding for a staff person who could provide job locator/employment assistance; those who could not offer this resource internally did so through partner organizations.

At the start of the pilot, the participating organizations planned to employ a staff-to-client ratio that would treat HHB families as equivalent to two non-HHB families. In reality, the organizations found that, on average, HHB families required two to four times as much time as non-HHB families. The additional time was needed at every step of the process, both before and after the family is housed. Organizations also reported that their case management staff needed to adjust the way they interacted with the family, as well as the amount of interaction. These issues are further discussed as follows.

Overall case management for HHB clients can be intensive and time consuming

Across the board, organizations indicated that staff time providing case management to HHB clients was more intensive and time consuming than providing case management for families with fewer barriers. This is indicated by the fact that staff used more time than they had allotted (equivalent to two non-HHB families) and staff's reported perception that they needed to do a lot of "hand holding" for their clients, related to issues staff considered to be a lack of overall life experience or cognitive limitations among some clients. Staff reported the need for modeling relationships with others, for example with landlords, and modeling conversations and speaking up for the client in meetings. Staff also had to instruct clients how to connect to additional community supports, such as local food pantries; child proofing their home and what to do in case of emergency; and managing the daily upkeep of a household, particularly for those clients who had no prior experience living on their own. Staff described their relationships with clients as being more nurturing and reassuring, helping to calm clients when panicked, and helping them to build confidence. The topic of how much time these families would require, and whether the type of staff support they would need would be different from what other families receive, was addressed in staff

interviews with all 11 organizations. Nine of the eleven organizations were able to consistently track and report on the number of contacts and amount of time that staff spent with the HHB families participating in the pilot.

HHB families require intensive case management before being housed

When asked to compare how much time the staff spends with a HHB family before placement in housing, compared to non-HHB families, all organizations indicated that it took significantly more time for both face-to-face meetings and frequent phone conversations. Given that the organizations were able to place their HHB families in housing within the same 30-45 days they used for placement of other families; this means a more intense time commitment prior to housing. Organizations reported case management hours provided before the family was housed as two to three times what other families received, with an average of 15 hours. The data tracked in this pilot showed the average number of contacts by case managers prior to the family being housed as 14.8 contacts, which case managers believed from experience to be three to four times greater than the number of contacts other families received. This number of contacts can be stressful for staff, given that these organizations are getting HHB families housed in the same time frame as other RRH families. Cognitive difficulties, undiagnosed mental illness, and/or lack of life skills can all impact the head of household's ability to complete tasks without staff guidance. In staff interviews, organizations reported spending more time face-to-face, focusing on a more basic level to help families complete discrete tasks, accompanying the family to complete tasks, and meeting more frequently for longer periods of time.

Housing locator role for HHB families takes significant staff time

Organizations in the pilot tracked the hours used in the Housing Locator role separate from hours used for case management. In this way, it was possible to clarify the number of hours needed for housing placement and case management separately. While all 11 organizations reported being able to place these HHB families into a housing unit within the same 30-45 day time frame as other lower-barrier families, organizations did indicate that the housing location process took more hours and required extensive support. Among the nine organizations that reported how much contact their housing locator had with the families in the pilot, and how much time was spent, the average was ten contacts by the housing locator, with an average total number of hours just over 6.6 hours. In the interviews, staff observed that it was more likely in the case of HHB clients than other clients that staff or volunteers needed to accompany the family at each step of the process in order to assure tasks related to securing housing were accomplished.

HHB families require intensive case management after being housed

In the initial staff interviews early in the pilot, most organizations expressed concern that HHB families would require more time from their case managers than lower-barrier families, which is why most planned for a reduced staff-to-client ratio in the pilot. In the follow-up staff interviews in October, each organization was asked what their experience had been in case management time required by these families. All said that these families seemed to require more time than other families do. Among the organizations that tracked the number of contacts, and number of hours spent with the HHB clients, the organizations found that the amount of time required of the case manager after the family was placed into permanent housing was, on average, more than 15.6 hours. Additionally, the number of contacts a

family had with their case manager after being housed averaged 17 contacts in the pilot, which case managers in the interviews said was two to three times the number of contacts case managers had with other families. An organizational challenge is to structure a case management model that would not be overly burdensome for staff but that could be flexible enough to serve families as their needs fluctuate.

HHB clients required a deep level of employment, advocacy, and other assistance

Nine of the eleven participating organizations kept track of how much "other support" staff provided to HHB families, beyond housing location and case management support. Examples included resume writing and other job search and job preparedness support, advocacy around benefits application and receipt, advocacy to secure benefits and services for children. All of the 11 organizations articulated that a priority was to determine if there were any mainstream benefits or services a family was eligible for that they were not currently receiving and, if so, to assist them with the application and determination process. Overall, among the nine organizations that tracked and reported on the support provided by "other staff" separate from case management and housing locator support, they reported an average of eighteen contacts over an average of 23.5 hours. .

Short-term assistance

Nearly all of the organizations participating in the pilot had prior experience with some form of RRH, though not necessarily using the recommended core components or best practices of effective RRH programs. To a large extent, the organizations reported that they embraced the RRH model because they support getting families into permanent housing as quickly as possible. However, staff at ten of the eleven organizations initially expressed concern using RRH for HHB families because they feared that the brief time period during which families are offered assistance would be insufficient to families' needs: they worried that some families would require longer-term support because their housing barriers are often coupled with other significant barriers, or because they are extremely low-income households and/or have limited potential for increases in income. While data on the length of time that families received housing subsidies was not sufficient to determine the median or average length of support, four organizations provided at least some of their participating families with rental subsidies for more than six months, while the other seven organizations provided subsidies for six months or less. State and Federal funding for RRH permit up to 24 months of assistance, but these organizations appeared to have either budgetary limits on the length of support they would provide a client or organizational philosophical constraints that kept them from providing longer-term support.

Providers' perceptions of short-term assistance improved over time

In the initial round of interviews early in the pilot, a number of the organizations believed HHB clients would need a higher level of rent subsidy than other families because, first, it might take them longer to reach self-sufficiency and, second, they were generally starting at a lower income level than other families. Many organizations in those initial interviews stated that they believed many of the HHB families would probably be better served with permanent supportive housing, and were skeptical that RRH could work for those families. In the second round of interviews near the end of the pilot, the organizations were asked the same set of questions about their perception of what their clients needed in level of subsidy and length of support and many changed their initial concerns to a more positive view of short-term assistance. When asked their opinion about whether a longer rent subsidy would have resulted in better

outcomes for their clients, a number of organizations reported that they did not believe so, that their families were stably housed as a result of the level of support they had received. Some observed that for many families, the staff worried that a longer term of subsidy could cause complacency or dependency. Some organizations did note in the interviews that longer-term assistance might incentivize clients to maintain the relationships with their case manager(s) and several organizations felt that these HHB families could benefit from longer-term case management support than what other families receive. These organizations believed that once the financial relationship was completed it was more difficult to maintain the case management relationship. Many of the organizations also expressed the opinion that, in their experience, HHB families were more likely to benefit from flexibility in the rent subsidy to help address episodic financial difficulties and that their ability to use the flexible funds to increase the level of rental support one month or another due to a financial emergency helped the family remain financially stable, and thus stably housed. When asked, the staff acknowledged that this same flexibility would be of benefit to non-HHB families in their RRH program as well.

RRH may require a shift in the way families receive other supports

During the pilot the organizations learned about the higher level and more intense type of case management support some HHB families need, but that this home-based support could be accessed by the family after they are permanently housed. Initially, organizations worried that the shift to living in an apartment, would take families away from the built-in support network provided by organization staff and peers in a shelter or a transitional housing setting. Organizations explored ways to deliver services to families in their own units rather than in the "captive audience" setting of a shelter and found through experience that HHB families are actually able to receive services and remain housed using the RRH model.

Funding constraints or complexities beyond the scope of the pilot

Fiscal year cycle of funding is misaligned with ongoing needs of families

A large hindrance overall for organizations, not specific to this pilot, is how dollars committed/received from funders fit within the organization's annual budget and fiscal year cycle. In the initial interviews, some organizations discussed anticipating significant challenges to serving families in the final two months of their fiscal year because they might run out of the flexible funds that could support a family moving into permanent housing and the resources available for the rental subsidy; they feared this would result in families being forced to stay in shelter until a new fiscal year begins and new resources secured.

A source of multi-year funding or other ways to access supplemental funds late in the fiscal year could alleviate this issue for organizations.

Geographic restrictions limit client support

Organizations identified the geographic restrictions of their funding as an additional challenge. For example, some funding they received from their local government could only be utilized within county lines and could not be used to assist a family to move to a different county.

Organizations struggled to balance flexibility and fairness in allocating financial assistance to families

Organizations also discussed in the interviews how to design their programs to balance predictability and a sense of fairness with flexibility to address the unique situation and needs of each family. Several articulated that it might be simpler to administer, and explain, a program designed to provide each family a fixed amount of rental and financial assistance for a fixed number of months. Such an approach, they felt however, would not be sufficiently client-focused. While in the final round of interviews some organizations that designed a flexible program, using progressive engagement to determine month by month how much assistance a family needed, had expressed concern about the resulting lack of predictability in budget, other organizations that designed their programs more toward predictability articulated frustration when they feared they might not be able to help families when new emergencies arose which might be small, but possibly destabilizing for the family if not addressed. One family may take $8,000 in rental assistance subsidy financial resources paying down old housing debt, while another may only require $3,000 in short-term rental subsidy. Some organizations wrestled with this, with some staff wondering how fair or equitable it is to give different families different levels and types of support. Organizations also wrestled with the reality that it is easier to budget for a program that can calculate in advance that each family served will receive a certain fixed amount, e.g., if the organization receives $30,000 and each family receives $3,000, then the organization knows it can serve 10 families. While easier to budget, providers overall felt that type of program would not meet the needs of some families, and may spend more than needed on other families.

This is an issue that depends on organizational culture, and as organizations continue to implement RRH with HHB families they should continue to have discussions about these concerns and how to balance flexibility and fairness for the greatest impact for the families. Most of the organizations in this pilot felt that the flexibility was critical so that their families received the level and type of support that worked best for them. Recognizing that even among the HHB families, the level of need is on a spectrum, these organizations felt that they can best serve their families if they have the ability to design the financial support along the spectrum as well. Some HHB families can succeed with only a few months of financial support and case management because the nature of their crisis, while deep, can be relatively quickly addressed. Other HHB families may need longer-term support (four to six months, or even nine to twelve months) while they work on ways to improve their employment situation and become financially stable, or may need additional financial assistance several months later when a new problem arises.

Perceived separation of housing-related issues from other barriers

RRH is designed primarily to end a family's homelessness and resolve a housing crisis, using a housing first approach that assumes that every household is ready to be rapidly re-housed without needing to become "housing-ready." At the beginning of this pilot at least eight of the eleven organizations expressed concern with the concept of using RRH with HHB families, fearing that the magnitude of the families' problems would require a longer-term intervention and higher level of support than what the organizations' current case management models provided. Several thought HHB families were better served with transitional housing, or permanent supportive housing, but recognized that those resources were disappearing and/or limited. Some of these organizations' staff also expressed skepticism in the first interviews that an assessment tool focused on housing could be successfully utilized with this

population, feeling that non-housing issues were key to addressing the families' long term stability and, therefore, needed to be in focus during the initial assessment and planning of support to a family. This seems to be a frustration with their current assessment tools, and a lack of experience implementing significant case management with HHB families within a housing first model. In the interviews at the end of the pilot, these organizations still articulated some frustration with their assessment forms, and the need for their staff to balance housing and non-housing issues in their assessment and the development of plans with families. However, overall, organizations were more comfortable with the concept of using RRH with HHB families than at the beginning of the pilot.

While housing is the main focus, some practitioners were concerned about meeting other needs.

An exclusive focus on housing in the family assessment process was of concern to several organizations in the initial round of interviews. While a housing focus did encourage some to develop a better understanding of housing-related barriers and the resources useful for addressing them, organizations stressed that the assessment tools do not adequately address other issues that, once a family is placed in housing, impact their stability, whether in the short- or long-term. For example, organizations pointed out that the assessment tools do not adequately address things like mental health; an individual's fear or anxiety about living on their own or living alone; an individual's capacity to manage day-to-day responsibilities; children's needs; family support; and issues of trust. These organizations worked in the pilot to complement the housing barrier assessment tool with other assessment tools that focused on non-housing issues, because they believe that, while housing should be a primary focus, it should not be the exclusive focus. During the time frame of the pilot two or three organizations began exploring what the VI-SPDAT might provide, hoping it would balance the full spectrum of issues their client families face when homeless.

4. Benefits to Families (Client-Level Outcomes)

Demographic Profile and Services Overview

Homelessness is a circumstance that results from a wide array of factors and affects a diverse group of people. Accordingly, there is no one type of homeless person or family, nor is there one type of high housing barrier family. Families who participated in this RRH pilot differed from one another in many ways. A core goal for the organizations participating in the pilot was to better understand the types of barriers HHB homeless families face and how to design a program with the flexibility and resources needed to serve the myriad of families.

Key characteristics of families served

Coming into the pilot, organizations assumed that most households they would serve would be single women with children, with low incomes and high debt. In the first round of staff interviews, organizations described observing what they believed to be undiagnosed mental illness or cognitive problems among their clients. Some organizations described their HHB clients as falling just below eligibility for permanent supportive housing, or as candidates for transitional housing.

All of the organizations also observed in the final round of interviews that they served some families at such low-income levels that were it not for participation in the pilot, they feared these families would have no other viable options for leaving the homeless shelter or accessing permanent housing.

The information provided below presents a brief snapshot of the HHB clients who participated in the pilot.

FAMILY CHARACTERISTICS						
	All	Fairfax	Harrisonburg	Norfolk	Richmond	Virginia Beach
Total number of families served	**99**	17	30	9	32	11
Average family size	**3.27**	3.5	3.0	3.4	3.7	2.7
Unemployed or employed part-time	**46**	8	11	4	20	3
Disability designation	**10**	1	4	0	3	2
Median household income per month[8]	**-**	$1,027	$1,070	$373	$1,450	$850

In the second round of staff interviews, organizations were asked to reflect on some of the family dynamics or characteristics they observed in their work which presented challenges to working with HHB families. Case management staff articulated the importance of understanding the complexity and diversity of circumstances that may contribute to a family experiencing homelessness. There were several characteristics staff consistently identified as representative of the different subgroups of the populations

[8] This data represent median reported household income among families in each community, taken at the point of intake. A comparison of income change over time is available on page 33.

they served, which correspond to the items identified as housing barriers in the HHB assessment forms. These included:

- Head of household with cognitive disabilities or mental health issues which are undiagnosed or untreated; unrecognized mental illness (for example, severe depression); other medical issues; or physical or mental disability.
- Children with a severe disability, mental or medical illness or cognitive/behavior issues.
- Active substance abuse in parents.
- No employment history or no credit history.
- Problems in prior rental history such as past evictions, damages, and/or housing debt.
- Low educational attainment resulting in limited household income.
- Lack of experience with life; life skills gaps/lack of life skills; little to no experience living on one's own.
- Clients who are socially fragile or who lack a support system, for example recent immigrants who lack social support and are not connected to mainstream services.
- Domestic violence trauma issues, or other post-traumatic stress situations, for example, among some recent immigrants.
- Formerly incarcerated individuals or individuals with criminal records.

In the second organizational interviews done in October 2014, organizations reported having observed in the past year an overall increase in the number of families facing such challenges and remarked that families seeking their services today, face more difficult circumstances than those they served in years prior. The organizations attribute this overall change to Virginia's success in reducing overall homeless numbers through RRH and diversion and prevention programs, which have been more effective in housing families with fewer challenges. This means that the families making up the homeless population these organizations now serve is increasingly disproportionately comprised of harder-to-serve, higher-barrier populations. Their ability to serve these types of families using RRH within the flexible structure of the pilot appears to be successful so far, and hopefully can inform the ongoing structure of RRH programs in Virginia.

Key services provided to families

The RRH pilot provided two types of assistance to participating families:

- Case management and services: Through staff and partnerships, the organizations provided case management, housing locator assistance, and other staff support such as employment assistance. Staff also helped to facilitate families' connection to mainstream resources, to ensure housing stability once RRH assistance ends. This included connecting households to benefits they may be eligible for but were not receiving.
- Financial assistance: The pilot also provided financial assistance, which took three general forms:
    1. Rental assistance, ongoing payment of some portion of the monthly rent.

2. Other housing related assistance, to expedite the ability to get into a housing unit or to maintain the unit, such as payment of past rent or utility arrearages, payment of double security deposit, episodic assistance with utility payments.
3. Other support, to improve stability, such as paying for child care, car repairs, transit passes, work-related license renewals, or work skill certifications.

The RRH pilot allowed organizations the flexibility to identify priorities based on their clients' needs and to allocate resources in ways that would most effectively assist families. The assistance provided to families is described below.

TYPE OF FINANCIAL ASSISTANCE		
	# of Families	Percent
Rental Assistance	99	100%
Other Housing-Related Assistance	70	71%
a. Utility debt, deposit or assistance	51	52%
b. Security deposit, application fee, etc.	33	33%
Other Assistance[9]	47	47%

While actual expenditures for other types of assistance were not large in terms of dollar amounts, the diversity of assistance provided to families was extremely important to their success in the RRH pilot. This is further discussed in the section entitled Impact of RRH Pilot Organizations on page 19.

Short-Term Benefits of the RRH Pilot on Families

This section reflects responses to the survey administered to families participating in the RRH pilot. Overwhelmingly, families reported improvements in overall stability and well-being after being placed in housing. However, it is important to note that the family-level outcomes discussed in this section reflect the varying lengths of time that families participated in a RRH program. As discussed in Methods, beginning on page 10, family survey data included in this report reflect two points in time during the pilot: the first after a family was placed in stable housing, and the second, as early as three months but potentially up to ten months later. Thus, family responses represent different lengths of time in the pilot program.

Families housed

During the course of the 18-month pilot project, 92 of 99 HHB families, across the five sites, were successfully housed through a RRH program. At the close of the data collection phase in October 2014, 57

[9] Here, other assistance includes families who received financial assistance to support taking a class, getting a license reinstated, or the purchase of clothes. Other types of financial assistance received by families is discussed in the section entitled Impact of RRH Pilot on Organizations, on page 19.

HHB families had successfully completed a RRH program and remained stably housed, and 35 HHB families were still participating in a RRH program and stably housed.

PARTICIPATING FAMILIES' HOUSING STATUS

Location	Organization	**# of Families served in the pilot**	Stably housed at exit program	Still in program and stably housed	Left program/ living w/ Family	Left program/ status unknown
Fairfax County	Shelter House	**5**		5		
	Cornerstone	**5**		3	1	1
	Facets	**5**	2	2		1
	New Hope Housing	**2**	2			
Richmond	Hilliard House	**17**	10	7		
	Home Again	**11**	11			
	St Joseph's Villa[10]	**4**	2	2		
Harrisonburg	First Step	**10**		10		
	Mercy House	**20**	18	1	1	
Norfolk	For Kids	**9**	6			3
Virginia Beach	Samaritan House	**11**	6	5		
	Total	**99**	57	35	2	4

Stability

Families' household income moderately increased once placed in stable housing

Across all five sites, median household income among families participating in RRH increased once the families were placed in stable housing.[11] In many cases, families' household debt changed over time. This was often a result of case managers working with families to achieve debt consolidation; reduction of interest; and a concerted effort to pay down debt while in the RRH program. Change in household income and debt is described in the table which follows.

[10] St. Joseph's Villa – Flagler Housing and Homeless Services

[11] Income increases were evident when taking into account individual household's gross income, as well as the average and median income for each site. Median household income increases across the five sites varied from as little as $44 per month up to about $800 per month.

INCOME AND DEBT CHANGE OVER TIME						
	All	Fairfax	Harrisonburg	Norfolk	Richmond	Virginia Beach
Total number of families	99	17	30	9	32	11
Median household income per month[12]						
Start		$1,027	$1,070	$373	$1,450	$850
End		$1,853	$1,114	$618	$1,625	$1,061
Median Household debt[13]						
Start		$20,037	$5,876	$ 2,100	$2,108	-
End		$14,000	$4,720	--	--	-

Families demonstrated an ability to balance their household income and expenses fairly well. Among the 57 families who responded to the survey twice, 29 indicated that they felt capable of having sufficient monthly income to maintain basic household expenses, and another 11 reported that they were even more likely than before, after having been in stable housing for at least three months, to have income sufficient to maintain their basic expenses.[14]

Of the 59 families who responded to questions about tracking expenses, 43 reported having experience with tracking their expenses. Of these, 16 reported a positive change between the first and second time they responded to the survey, reporting in the later survey that they had experience tracking expenses when in the previous survey they had not.

Families were also asked their experience with having money left over at the end of the month: 57 provided responses to this question in both the first and second survey. Among the 57 families who responded to this question, 12 reported positively in both the first and second survey that they had the ability to have money left over at the end of the month; an additional 15 reported a positive change in their ability to have money left over at end of the month.

[12] This data represent median reported household income among families in each community, for the first and last point in time at which the data were collected. First and last points vary across families.

[13] Complete data on household debt was not available from some organizations.

[14] A total of 88 families were administered the family survey. Sixty-three of these families were administered the survey at least twice. Not all families responded to every survey question, thus the total number of responses per questions varies.

Parental perception of children's social and emotional well-being and academic performance remained stable or improved

The family survey asked the head of household to consider their children's well-being academically, socially and emotionally, compared to three months prior. For the first round of surveys, the comparison was made between parents' perceptions of their children's well-being prior to being in the RRH program (or prior to becoming homeless) and immediately after the family was housed. For the later round of surveys, which may have been done any time from three months to six months after the family was housed, the comparison was between when the family was first placed in housing and several months after.[15]

Among families who responded to the survey twice, parents reported that their children's academic, social and emotional well-being either remained the same or improved. For all cases in which academic performance and well-being remained the same, parents had already indicated their child was doing well at the point the family survey was first administered.

The table below provides further detail on parents' responses regarding children's wellbeing.

CHILDREN'S ACADEMIC, SOCIAL AND EMOTIONAL WELL-BEING

Survey Question: How is your child doing in school now compared to 3 months ago?

	Total # of Children	Better	About the same	Worse
First survey				
Academically	108	47	54	7
Socially	105	37	60	8
Emotionally	115	53	52	10
Second Survey				
Academically	70	27	41	2
Socially	71	27	43	1
Emotionally	64	22	40	2

Among those who reported having seen improvement in children's academic performance, parents' reasons included reduced stress due to increased personal and family stability; consistency in care from, and the presence of, parents and caregivers; improvements to social support among children's peers; and, in a few cases, diagnosis of learning or cognitive disabilities, behavioral problems or mental illness.

Parents attributed children's social and emotional well-being to both their and their children's reduced emotional distress and anxiety, primarily resulting from placement in stable housing or parents' securing

[15] Not all families responded to the family survey twice. Among those who responded twice to the survey, not all families responded to every question. For this reason, the total number of families (in turn, the number of children for which the question was answered) varies.

employment. Parents also reported being better able to attend to their children's needs once these stressors were reduced, often a result of keeping a regular work schedule that allowed them to be home with their children at night. Parents identified stable housing and a supportive social environment, for example, participation in after school activities, as predictive factors influencing their children's social and emotional improvements or academic success. They also commented that children's ability to build or maintain their own social networks and support improved once placed in stable housing, particularly when children did not have to switch schools.

Change in schools occurred primarily as a result of moving to stable housing, which parents saw as beneficial to their children

During the pilot, families were asked to indicate whether their children changed schools within the last three months. Of the 60 families that responded to the question of whether or not their children had changed schools in the prior three months, 22 answered yes. Of those, twenty were due to a move because of housing, the other two were natural transitions between levels of school (i.e. elementary to middle school or middle school to high school). Although parents would rather not have had their children change schools, the majority of parents (18 of 20) indicated that they were satisfied with the change and said it was because the overall reason for the change, moving into housing and improving overall family stability, would be beneficial to their child.

Sense of Well-Being and Community

Families' social support networks remained relatively unchanged

In development of the overall evaluation framework, the organizations identified a strong social support network as a key factor of families' long-term success; they believed that families with a social support network would fare better in stabilizing after being housed. While the pilot was not able to track this factor over a period of time sufficient to show a difference between families with a social support network and those without, the family survey captured families' perceptions of whether or not they felt they had a support network.

Families' responses to the survey indicate an almost even split among those who entered the program feeling they had a social support network and those that didn't. The table below provides further detail on clients' responses regarding a social support network.

SENSE OF WELL-BEING & COMMUNITY

Survey Question: Please indicate if you feel each is mostly true or mostly not true at this time.

	# of Families	Mostly true	Mostly not true	Positive Change	Negative Change
First survey					
I have a social network I can rely on	85	42	43		
Second survey[16]					
I have a social network I can rely on	60	31	29	13	9

Case management staff said that they recognize housing location as a key factor that may contribute to the strength or deterioration of a family's social support network; for example, if a family is placed in housing far from relatives or friends, or in an unfamiliar neighborhood, it can be difficult to cultivate or maintain social connections. Housing locators attempted to identify units convenient to public transportation and families' work and support networks, but it was not always possible.

Families' perceptions of housing convenience and safety changed little over time

In the development of the evaluation framework, participating organizations articulated that housing convenient to a family's work, childcare and/or school, and affordable transportation would improve their long-term stability. They also believed it was important that the housing be in a place the family felt safe. For these reasons the family survey included questions about whether the family believed their home was in a convenient location and an area where they felt safe.[17]

Families' perceptions of safety and convenience did not change significantly over time. Among families who responded to the survey twice, the majority experienced no change at the time of the second survey, from the positive attitude they had indicated at the time of the first survey. A small number of families – three or less – experienced a negative change in their perception of their housing convenience to affordable transportation or their children's childcare or school. Eight families reported a negative change in their perception of their housing convenience to work.

The table which follows provides further detail on clients' responses regarding housing convenience and safety.

[16] The count of families responding "Mostly true" or "Somewhat true" in the second survey includes those who indicated a positive or negative change in their perception from the first survey.

[17] As articulated above, a goal of the project was to administer the survey to families for at least two points in time. Some families responded to the survey only once, and not all families answered every question in the survey. For this reason, the total number of responses vary by question.

HOUSING CONVENIENCE AND SAFETY

Survey Question: Please indicate the degree to which each of the following is true. My home is:

	Total # of Families	Completely or mostly true	Somewhat true	Mostly or Completely untrue
First Survey				
In a safe area	87	61	23	3
A place where my children are safe	79	63	13	3
Convenient to affordable transportation	84	69	8	7
Convenient to work	66[18]	50	10	6
Convenient to my child(ren)'s child care or school	79	63	12	4
	Total # of Families	Positive Change	No Change[19]	Negative Change
Second Survey				
In a safe area	55	1	52	2
A place where my children are safe	54	1	50	3
Convenient to affordable transportation	57	3	52	2
Convenient to work	43	5	30	8
Convenient to my child(ren)'s child care or school	61	2	56	3

Reasons for a decrease in satisfaction may include an actual change in job or the placement of a child's school or child care, or may include the perception that, at first, housing itself is an improvement from the shelter, with families' evaluation of housing tending to be positive soon after being housed. Over time, as families adjust to their living situation and begin work or other routines, they may encounter inconveniences that were not immediately apparent – such as the time it takes to get to school, work, or other destinations. Additionally, though housing locators often housed families in units with access to public transportation, traveling by bus can often be difficult or time consuming depending, for example, if someone is traveling with heavy grocery bags or with small children, or needs to take more than one bus to reach a destination.

Of the 85 families that responded to a question of whether they hope to change their housing situation in the near future, 40 (47%) answered Yes, 34 responded No, and 2 were not sure. Of the 59 that responded to this survey question for at least two points in time, 23 (39%) still hope to change their housing situation, and an additional 16 (27%), who previously indicated no desire to change later hoped to change their housing situation in the near future. Among those who indicated a desire to change their housing situation, the primary reasons were to secure more affordable housing or to improve the quality or size of their home.

[18] An additional 24 responded to the question on convenient to work by indicating 'Not Applicable'.

[19] "No Change' indicates no change from the family's previously indicated perception, whether positive or negative, from the time of the first survey.

A vast majority of families (81% of 83 who responded in the first survey after moving into their unit) reported having a clear sense of goals for the future of their family. Of the 59 families that responded to this question at least twice, 51 (86%) had no change in their positive response, and an additional 4 had a significant positive change in their response; 3 responded with a significant negative change, and 1 responded with no change to their negative response about whether or not they had a clear vision of what they wanted their family's future to look like.

Perceived Challenges for HHB families in a RRH Program

The review of client-level outcomes for HHB families participating in the RRH pilot revealed clear benefits for families, and contributions to family stability and well-being, particularly improved financial circumstances and reduced emotional distress among family members. Through their experience in the pilot working with HHB families, case management staff also noted other contextual conditions, which, although beyond the RRH pilot scope, they felt were important factors that could impact some families' long-term stability after their participation in a RRH program. Recognizing that these factors are beyond the scope of what the pilot, and the RRH model generally, is designed to address, they are possibly relevant to help families gain further stability after being housed. These factors, each discussed in greater detail in the sections that follow, included:

- Mental health
- Lack of life skills and experience
- Housing affordability
- Childcare
- Income and accessing mainstream resources

Mental health

In interviews conducted with case management staff, the mental health issues among their HHB clients were cited as key factors that could impact families' stability after participation in a RRH program. While only 10 percent of the families served in the pilot had a diagnosed mental illness which resulted in them receiving benefits, the providers believed that many more families appeared to have undiagnosed or untreated mental illness or cognitive difficulties that could impair their long-term stabilization if not recognized and addressed. In many cases, the providers were concerned that these issues were unnoticed or, were not properly diagnosed, at the point of intake. Two organizations emphasized the importance of altering their program design to access mental health assessments for all family members, on an as-needed basis during the intake process or when developing a plan with a family, which they believed could enhance the families' well-being during and after their participation in the RRH pilot. [20]

[20] If not covered by a client's preexisting benefits, mental health assessments can bring significant financial cost. One organization cited a $900 mental health assessment fee as being prohibitive for homeless families, and yet critical. Several organizations used privately raised funds to pay for the assessment, others worked with community health partners to gain access to assessments for their clients. It would be beneficial if Virginia were able to identify some way to secure a priority for assessment, and waive or reduce the fee, for homeless individuals and families.

Three case managers identified mental health issues among children in a handful of their families, and discussed how this can cause an increase in required time away from work by the head of household, which can impact income and, therefore, ability to maintain housing. As mentioned earlier, in the few cases where a parent reported that their child's academic performance and social/emotional behavior was worse after being placed in housing, these instances were also those where a child's mental illness or behavioral problem later became evident. As these issues were addressed, parents reported seeing improvements.

Case management staff identified school psychologists as important resources, because they often the performed the mental health assessments for children which led to diagnoses of behavioral issues, such as attention deficit disorder (ADD). Similarly, two organizations mentioned that it was helpful to have someone – for example, a child services coordinator – who was focused on working with children when in shelter, prior to housing, and who could bring children's perspectives to the plan of action. A person in this role could also work with the case manager when further assistance was needed with regard to accessing services for children. Organizations stressed that simply addressing the needs of the entire family – not just the head of household, on which initial assessments often focus – is critical to ensuring a family's long-term stability.

Lack of life skills and experience

Case management staff observed that some clients' lack of overall life skills and lack of experience living on one's own were additional issues some HHB families face, which may have resulted in longer and more intensive case hours with that client. This issue was present among, but was certainly not limited to, domestic violence survivors. In some cases, case managers observed that clients expressed anxiety over the prospect of living on one's own, having never before lived apart from family or others. In other cases, clients had prior experience living alone, but case managers felt that they may still have been ill-prepared to manage upkeep of a home or were lacking general knowledge of how to be a good tenant and neighbor. When case managers identified either a lack of life skills or increased anxiety about living independently, they would need to make adjustments in staff support to assist clients with being responsible tenants, managing budgets and household tasks, interacting with landlords and neighbors, and other educational topics.

Housing affordability

The cost of housing was an important consideration in all five sites of the RRH pilot and reported by all eleven organizations. All of the families participating in the pilot project were provided financial assistance in the form of short-term rent subsidies. Each organization structured the amount of subsidy and length of support based upon their local community housing situation and the needs of the families. Organizations were encouraged to use a progressive engagement model where monthly reviews between the case manager and household would adjust a plan for how much support was needed.

Child care

Many organizations pointed out the importance of long-term affordable dependable child care to their HHB clients, particularly given the number of appointments parents must attend to which they cannot, or prefer not, to bring children. Some organizations perceived part of the problem to be that child care services are not adequately targeted to and funded for the homeless. In one instance an organization used the flexible funding provided by the pilot to secure child care services for their clients when other resources were not available. Organizations also identified the frustrating reality that the waiting lists for child care subsidies/slots are jurisdictionally restricted, meaning a move across jurisdictional lines can remove the family from their spot on the list and drop them to the bottom of the waiting list in the new jurisdiction.

Income and accessing mainstream resources

Participating organizations identified issues related to clients' ability to obtain work and access mainstream benefits as critically important to the success of their clients' long-term stability after being rapidly re-housed. In particular, staff identified job training as a key factor that may be needed for clients to increase earnings. In addition, staff focused often on working with clients to secure quality employment that paid a living wage, acknowledging that very low-income populations struggle to meet housing costs when earning the minimum wage, even when working two or three jobs at a time.

5. Conclusion

Over the course of an 18-month period, the RRH pilot aimed to facilitate organizations' abilities to employ new and innovative approaches to house HHB families. The pilot came on the heels of the Commonwealth of Virginia's recent success in significantly reducing the overall percentage of people experiencing homelessness. Nationally, organizations working to address homelessness had begun to examine the viability of RRH to assist HHB families because RRH offers potential to place families in stable housing at less cost than long-term stays in shelters or transitional housing. Additionally, it has demonstrated higher rates of permanent housing placement and similar or lower rates of return to homelessness after assistance ends compared to those assisted by transitional housing or who only receive emergency shelter.

This evaluation of the RRH pilot in Virginia was participatory in nature and took into account existing evaluation research on RRH and the family-level and organizational outcomes participating providers were most concerned about. While some of the practitioners' concerns are beyond the scope of what homelessness assistance programs, or RRH programs specifically, are designed to address, they reflect a set of client-level outcomes practitioners considered important for the target population, beyond the goal of being re-housed. This final evaluation summarized the experience of 11 participating organizations in five sites in Virginia, and the HHB families they served, as they transitioned to implementing RRH with HHB families.

Of the 99 HHB families served in the pilot, 92 families, across the five sites, remained successfully housed through a RRH program. At the close of the data collection phase in October 2014, 57 HHB families had successfully completed a RRH program and remained stably housed, and 35 HHB families were still participating in a RRH program and stably housed. Parents reported improvements to their and their children's stability and well-being after being placed in housing, including improved financial circumstances and reduced emotional distress and anxiety.

Among organizations implementing RRH programs, staff gained a greater understanding of the challenges presented by working with HHB families and recognized the diversity of subpopulations which comprise HHB populations. Working with HHB families proved more time intensive on average with staff providing more face-to-face time and needing to assist clients more intensively in securing housing, employment and/or benefits. Clients were provided with more case management, both before being housed and after being housed, which the RRH approach (if structured to include community case management with reasonable staff-to-client ratios) can support. Flexible funding proved crucial to the organizations' efforts, for both filling resource gaps for families and improving relationships with landlords. Participation in the pilot enabled staff to develop new skills and competencies and to view their clients, and the services provided to them, in a new light. As a result of the pilot, some organizations have begun to identify new ways to provide services that are better customized to client needs.

During the course of the pilot, organizations identified a number of other contextual factors, beyond the pilot scope and which fall outside the parameters that a RRH model is designed to address, which they perceived as important to families' long-term stability in housing. Organizations identified policy

challenges and systems level inefficiencies which they perceived as hindrances to their families' well-being, which, if addressed, would better support families moving out of homelessness through RRH as well as other programs, and possibly improve the prevention of homelessness. These important connections to mainstream services, including up-to-date information on key policies, is an important next step for continuing to expand RRH in Virginia.

This evaluation focused on implications for the organizations implementing a RRH program with HHB families. The next steps in determining the full outcomes of this pilot would be to track the indicators identified by NAEH, particularly related to housing tenure. Tracking this information would provide the data to show whether or not a family's homelessness was resolved in a permanent way.

Appendices

DEMOGRAPHIC PROFILE & SERVICES OVERVIEW

	Total	Fairfax	Harrisonburg	Norfolk	Richmond	Virginia Beach
Total number of families served	**99**	**17**	**30**	**9**	**32**	**11**
Family size:						
Range	2 to 6	2 to 6	2 to 6	2 to 6	2 to 6	2 to 6
Average	3.27	3.5	3	3.4	3.7	2.7
# of families with:						
Employed head of household at intake	59*	10*	19	5	16	9
Unemployed head of household at intake	40	7	11	4	16	2
*(*One family had two employed adults)*						
Disability status - # of families with:						
Benefits designation	10	1	4	0	3	2
Benefits application submitted/pending	6					
Median household income:						
At intake		$1,027	$1,070	$373	$1,450	$850
At exit/final data collection		$1,583	$1,114	$618	$1,625	$1,061
Median household debt:						
At intake		$20,037	$5,876	$1,215		
At exit/final data collection		$14,000	$4,720	$2,100	$2,108	
High housing barrier (HHB) score:						
Median		17	3	3	4	-
Range		12 to 24	1 to 4	2 to 4	3 to 4	-
# of families receiving:						
Rental assistance	99	17	30	9	32	11
Other financial assistance, including:	69	16	20	8	25	
Utility debt	51	9	18	5	19	-
Security deposit	33	3	18	5	7	-
Application fee for housing	20	3	2	4	11	-
30-day bus passes	13	3	1	6	3	-
Other items (tuition, clothes, etc.)	47	10	18	3	16	-
Employment assistance	63	14	23	8	18	-

STAFF SUPPORT SERVICES OVERVIEW

	Total	Fairfax	Harrisonburg	Norfolk	Richmond	Virginia Beach
Case Management and Other Staff Support						
Case management before client housed						
Average # of contacts	14.84	22.84	6.95	3.14	26.43	-
Average hours	14.99	26.57	7.08	4.86	21.43	-
Case management after client housed						
Average # of contacts	17.03	39.5	2.91	19.3	6.425	-
Average hours	15.64	20.32	2.46	34.26	5.51	-
Housing Locator support						
Average # of contacts	10.04	14.85	4.58	11.88	8.85	-
Average hours	6.63	12.9	3.55	6.13	3.93	-
Other staff support						
Average # of contacts	18.89	27.67	10.01	11.14	26.73	-
Average hours	23.58	44.47	11.06	9	29.79	-
Average length of participation in program (months)		6 to 9	NA	6	3 to 6	6 to 9

PARTICIPATING FAMILIES' HOUSING STATUS

Location	Organization	**# of Families served in the pilot**	Stably housed at exit program	Still in program and stably housed	Left program/ living w/ Family	Left program/ status unknown
Fairfax County	Shelter House	**5**		5		
	Cornerstone	**5**		3	1	1
	Facets	**5**	2	2		1
	New Hope Housing	**2**	2			
Richmond	Hilliard House[21]	**17**	10	7		
	Home Again	**11**	11			
	St Joseph's Villa[22]	**4**	2	2		
Harrisonburg	First Step	**10**		10		
	Mercy House	**20**	18	1	1	
Norfolk	For Kids	**9**	6			3
Virginia Beach	Samaritan House	**11**	6	5		
	Total	**99**	57	35	2	5

[21] Housing Families Fist (formerly Hilliard House)

[22] St. Joseph's Villa – Flagler Housing and Homeless Services

DISABILITY STATUS AT TIME OF INTAKE TO HOMELESS SERVICES				
Location	Organization	**# of Families served in the pilot**	Receiving disability benefits	Application Submitted/ Pending
Fairfax County	Shelter House	**5**	1	2
	Cornerstone	**5**	0	
	Facets	**5**		1
	New Hope Housing	**2**	0	0
Richmond	Hilliard House[23]	**17**	2	
	Home Again	**11**	0	0
	St Joseph's Villa[24]	**4**	1	1
Harrisonburg	First Step	**10**		2
	Mercy House	**20**	4	
Norfolk	For Kids	**9**	0	0
Virginia Beach	Samaritan House	**11**	2	
	Total	**99**	10	6

[23] Housing Families First (formerly Hilliard House)

[24] St. Joseph's Villa – Flagler Housing and Homeless Services

AVERAGE # OF CONTACTS AND AMOUNT OF CM TIME PRIOR TO HOUSING				
	Total # Families	**# Families w/ data**	**# of contacts**	**Average Hours**
Fairfax				
Cornerstones	5	4	16	12.5
Facets	5	4	28.6	28.4
New Hope	2	1	24.5	35
Shelter House	5	5	22.25	30.38
Total	**17**	**14**	**22.84**	**26.57**
Harrisonburg				
First Step	10	10	3.4	3.05
Mercy House	20	20	10.5	11.11
Total	**30**	**21**	**6.95**	**7.08**
Norfolk				
For Kids	9	7	3.14	4.86
Richmond				
Flagler	4	NA	NA	NA
Hilliard House	17	17	15.95	15.95
Home Again	11	11	36.91	26.91
Total	**32**	**28**	**26.43**	**21.43**
Virginia Beach				
Samaritan House	**11**	NA	NA	NA
Total	**99**	**70**	**14.84**	**14.99**

AVERAGE # OF CONTACTS AND AMOUNT OF CM TIME AFTER FAMILY WAS HOUSED				
	Total # Families	**# Families w/ data**	**# of contacts**	**Average Hours**
Fairfax				
Cornerstones	5	5	11.8	11.8
Facets	5	5	66.2	27.05
New Hope	2	2	1	6
Shelter House	5	4	79	36.44
Total	**17**	**14**	**39.50**	**20.32**
Harrisonburg				
First Step	10	8	2.5	1.88
Mercy House	20	13	3.31	3.04
Total	**30**	**21**	**2.905**	**2.46**
Norfolk				
For Kids	9	7	19.3	34.26
Richmond				
Flagler	4	4	21.25	45.75
Hilliard House	17	17	8.94	8.47
Home Again	11	11	3.91	2.55
Total	**32**	**28**	**6.425**	**5.51**
Virginia Beach				
Samaritan House	**11**	NA	NA	NA
Total	**99**	**70**	**17.03**	**15.64**

AVERAGE # OF CONTACTS AND AMOUNT OF TIME BY HOUSING LOCATOR				
	Total # Families	**# Families w/ data**	**# of contacts**	**Average Hours**
Fairfax				
Cornerstones	5	4	13.5	9.63
Facets	5	4	3.5	5
New Hope	2	1	6	10
Shelter House	5	5	36.4	26.95
Total	**17**	**14**	**14.85**	**12.90**
Harrisonburg				
First Step	10	NA	NA	NA
Mercy House	20	19	4.58	3.55
Total	**30**	**21**	**4.58**	**3.55**
Norfolk				
For Kids	9	8	11.88	6.13
Richmond				
Flagler	4	4	8.25	20.25
Hilliard House	17	17	3.53	3.53
Home Again	11	11	14.17	4.33
Total	**32**	**32**	**8.85**	**3.93**
Virginia Beach				
Samaritan House	**11**	NA	NA	NA
Total	**88**	**75**	**10.04**	**6.63**

AVERAGE # OF CONTACTS AND AMOUNT OF TIME BY OTHER STAFF*				
	Total # Families	**# Families w/ data**	**# of contacts**	**Average Hours**
Fairfax				
Cornerstones	5	5	6	8
Facets	5	3	10.67	13.08
New Hope	2	1	20	26
Shelter House	5	4	74	103.8
Total	**17**	**14**	**27.67**	**44.47**
Harrisonburg				
First Step	10	9	10.67	9.61
Mercy House	20	20	9.35	12.5
Total	**30**	**30**	**10.01**	**11.06**
Norfolk				
For Kids	9	7	11.14	9
Richmond				
Flagler	4	3	15.67	21.67
Hilliard House	17	17	11.06	8.12
Home Again	11	NA	NA	NA
Total	**32**	**20**	**26.73**	**29.79**
Virginia Beach				
Samaritan House	**11**	NA	NA	NA
Total	**88**	**71**	**18.89**	**23.58**

**Other staff could include child advocate, job assistance, legal assistance, etc.*