ORANGE COUNTY CONTINUUM OF CARE

COORDINATED ENTRY SYSTEM EVALUATION

An independent evaluation of effectiveness, efficiency, equity, and opportunities to strengthen Orange County's Coordinated Entry System.

SEPTEMBER 2026



PREPARED FOR
Orange County Continuum of Care
with support from the Samueli Foundation

PREPARED BY
Element Consulting Group, LLC

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Contents

Acknowledgements 5
Letter to CoC Stakeholders 7
A Message from the Office of Care Coordination 9
Evaluation Guide 11
How the Report Is Organized 11
Guidance for Different Readers 12
Companion Materials 13
Evaluation Overview 15
Project Context and Purpose 15
What is a "Coordinated Entry System"? 16
OC Coordinated Entry System Overview 17
Evaluation Approach 18
Evaluation Summary 19
Key Findings 20
Recommendations and Innovation Opportunities 26
Moving Forward 30
Section 1: Evaluation Framework 31
1.1 Rating Framework 31
Section 2: Evaluation Methodology 33
2.1 Documentation Review 33
2.2 HMIS and Administrative Data Analysis 33
2.3 Unit of Analysis and Deduplication 35
2.4 Limitations and Caveats 35
Section 3: System Design 37
3.1 Key Findings — Design Compliance 37
3.2 Discussion and Interpretation 45
3.3 Recommendations (REC) 46
Section 4: CES Function 1 — Access 48
4.1 Key Findings — Access Compliance 49
4.2 Discussion and Interpretation 56
4.3 Recommendations 57
Section 5: CES Function 2 — Assessment 59
5.1 Key Findings — Assessment Compliance 60
5.2 Discussion and Interpretation 73

5.3 Recommendations 75
Section 6: CES Function 3 — Prioritization 77
6.1 Key Findings — Prioritization Compliance 78
6.2 Discussion and Interpretation 86
6.3 Recommendations 88
Section 7: CES Function 4 — Referral 90
7.1 Key Findings — Referral Compliance 91
7.2 Discussion and Interpretation 105
7.3 Recommendations 107
Section 8: Direct Financial Assistance 110
8.1 Key Findings – Direct Financial Assistance 110
8.2 Discussion and Interpretation 110
8.3 Recommendations 110
Section 9: Data Management and Resource Availability 111
9.1 Key Findings - Data Management and Resource Availability 111
9.2 Discussion and Interpretation 113
9.3 Recommendations 113
Section 10: Advancements, Innovations and Experiences 115
10.1 Advancements and Innovations by CES Function 115
10.2 Experiences and Outcomes 117
10.3 Innovation Opportunities (IO) 122
10.4 CES Mapping Process: Root Cause Analysis and Administrator-Prioritized Improvements 125
Section 11: Looking Forward; Homeless Population Projections 127
11.1 Emerging Federal Policy Direction and Implications for the Orange County System 127
11.2 Projections and Assumptions 128
11.3 System Flow 132
11.4 Projected Gaps 133
11.5 Drivers of System Gaps and Pathways to Improvement 136
11.6 Recommendations 139
Section 12: Conclusion 141
12.1 Cross-System Priorities 141
12.2 Complete List of Recommendations 144
12.3 Subpopulation-based Recommendations 153
12.4 Immediate Action Recommendations 157

Appendix A: Compliance Rating Detail by Evaluation Dimension 159
Appendix B: Technical Modeling Documentation 164
Model Limitations and Caveats 164
Capacity Projections 165
Homelessness Prevention Projections 168
Diversion Projections 169
Street Outreach Projections 170
Emergency Shelter Projections 171
TH Projections 174
RRH Projections 176
PSH Projections 177
Appendix C: List of Tables and Figures 180
Appendix D: CES Pain Points and Root Causes Matrix 183
Appendix E: Recommendation Responsibility and Investment Matrix 186
Appendix F: Glossary 191
Acronyms and Terms 191
Governance and Operational Roles 195



Acknowledgements

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The evaluation was guided by a project **Core Team** that supported project planning, stakeholder engagement, interpretation of findings, and development of recommendations. Core Team members included:

- **Element Consulting Group evaluation team:** Tom Albanese, Lianna Barbu, Tanesha Travis, Brooke Spellman, Heather Stratman, and Caroline Roddey
- **Lived Experience Advisors:** Nichole Gideon and Paul Kaiser
- **County of Orange Office of Care Coordination:** Doug Becht, Zulima Lundy, Timothy Kirkconnell, and Daniel Garcia
- **OC CoC and community leadership:** Dr. Shauntina Sorrells; Nishtha Mohendra, CoC Board Co-Chair; Andrew Crowe, CES Steering Committee Chair; Aubrey Sitler, CoC strategic planning consultant

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Letter to CoC Stakeholders

Dear Orange County Continuum of Care Partners and Stakeholders:

At its core, a Coordinated Entry System is about something quite simple: when someone in our community is experiencing homelessness and asks for help, can they find a clear path to the right support and, ultimately, to housing?

The answer to that question matters deeply. For many people experiencing homelessness, CES is the front door to our homelessness response system. How easy that door is to find, what happens when someone walks through it, how decisions are made, and whether the system ultimately connects people to what they need can shape the course of someone's life.

That is why we undertook this evaluation.

We wanted Orange County to have an independent and comprehensive understanding of how our Coordinated Entry System is working today — not based solely on policy or process, but on the experiences of the people who use it, the people who operate it, and the many organizations and systems that intersect with it every day.

What emerged is a report that gives us both reason for confidence and reason for urgency.

There is much to build upon. Across Orange County, there are deeply committed people doing difficult work, strong partnerships, valuable data capabilities, and promising practices. This evaluation reflects the voices and experiences of people with lived experience of homelessness, frontline staff, CES operators, housing and service providers, County and CoC leaders, data partners, and partners from systems that intersect with homelessness. We are incredibly grateful for the candor, time, and expertise so many people brought to this process.

The evaluation also identifies places where our current system is not working as well as it could or should. Some of those challenges are operational. Others are about capacity, coordination, accountability, data, resources, or the way our broader homelessness response system is organized.

Importantly, these are not challenges that belong to one organization, one agency, or CES alone. That distinction matters.

CES can and must improve- but CES cannot, by itself, solve the conditions that constrain it. A stronger Coordinated Entry System therefore requires us to improve both the front door and the broader system behind that door.

It would be easy to read a report like this and focus on who owns a particular problem. We hope Orange County will instead focus on what it will take to solve it. The opportunity before us is not to assign blame, but to understand where people are getting stuck, where our systems are not connecting as they should, and what each of us can do differently to create a homelessness response system that works better for the people who depend on it.

The Samueli Foundation supported this evaluation because we believe deeply in Orange County's ability to learn, adapt, and work differently when there is a shared challenge. We have seen what is possible when philanthropy, government, nonprofit organizations, healthcare, behavioral health, housing, workforce, and other community partners bring their respective resources and expertise to the same table. This work requires that same kind of collective commitment.

And this report cannot be the end of the work.

The findings and recommendations provide us with mechanisms and tools for what comes next: immediate improvements where change can happen now, a sustained quality-improvement effort for CES, and longer-term work to strengthen the systems surrounding it. Some recommendations will require relatively straightforward changes. Others will require difficult conversations, new partnerships, clearer accountability, additional capacity, and sustained investment over time.

The opportunity now is to translate these results into a shared and prioritized roadmap — one with clearer ownership, measurable actions, and ongoing opportunities for stakeholders and people with lived experience to help shape and assess progress. What that roadmap ultimately looks like cannot be determined by any one organization or group. It will require the collective ownership of the CoC, County, providers, people with lived experience, and the many systems and partners that intersect with homelessness.

We should expect that. Systems this complex do not change through a single organization, report, meeting, or funding cycle. They change when people decide together that better is possible — and then stay at the table long enough to build it.

As co-leads of this evaluation, our hope is that every person reading this report will consider not only what the findings mean for CES, but what they mean for their own organization, system, and role in Orange County.

Where can you help remove a barrier? Where can your organization better coordinate with another? What information or resources can you bring to the table? Where do responsibilities need to be clearer? And, most importantly, what would need to change for a person experiencing homelessness to find help more easily, experience the system with dignity, receive assistance that meets their needs, move into housing more successfully, and remain housed?

Those are the measures that ultimately matter.

This evaluation gives Orange County an opportunity to look honestly at where we are, recognize what we already have to build upon, and make thoughtful choices about where we go next.

Now, the work belongs to all of us.

With appreciation,

Dr. Shauntina Sorrells
Co-Lead, Orange County CES Evaluation Strategy

Nishtha Mohendra
Co-Lead, Orange County CES Evaluation Strategy

A Message from the Office of Care Coordination

Connecting individuals, families, veterans, transitional aged youth and survivors of domestic violence experiencing or at risk of homelessness to housing, shelter, and supportive resources is the most important interventions a Continuum of Care (CoC) can provide. In Orange County, our Coordinated Entry System (CES) serves as a critical access point to these resources, helping connect those most vulnerable to the services and housing opportunities they need to resolve or prevent their homelessness.

The Office of Care Coordination is incredibly grateful to the Samueli Foundation and Element Consulting Group for their leadership and support in making this comprehensive evaluation of Orange County CoC's CES possible.

Over the past decade, Orange County's homeless services system has grown significantly, helping thousands of people exit homelessness. Throughout this growth, CES has played a critical role in connecting people to the housing and services that have helped them end their homelessness. Often through subpopulation specific interventions and approaches aimed to addressing their unique barriers and challenges. At the same time, the CES has struggled to evolve at the same pace as the broader homeless services system and the growing demand for assistance.

As the CES Lead and CoC Collaborative Applicant, the Office of Care Coordination has heard the concerns and critiques of the Orange County CoC's CES over the years. The Office of Care Coordination welcomes this opportunity to work alongside Element Consulting Group, the Orange County CoC, community partners and system leaders to examine the system and identify meaningful opportunities for improvement.

This evaluation goes well beyond the mandates and regulations established by the U.S. Department of Housing and Urban Development (HUD) for a CES or its Lead. Element Consulting Group used this opportunity to examine CES within the broader context of Orange County's homeless services system, exploring the many interconnected components that influence how people access housing, shelter, and resources from other components of the System of Care: Behavioral Health, Community Corrections, Healthcare, Housing, and Benefits and Support Services. The result is a comprehensive assessment that provides our community with both a roadmap for improvement and an opportunity to consider new approaches.

The recommendations and innovative opportunities identified in this report also serve as an important reminder: **the success of CES is a shared responsibility.** Implementing the more than 30 recommendations and innovative opportunities outlined in this report will require active participation from partners across the Orange County CoC, including CES administrators, the CoC Board, housing developers and property managers, access points, supportive service providers, and many others.

As you read this report, we ask that you consider not only what can be improved, but also **where you can contribute to that improvement.** This report will be formally introduced to the Orange County community in sessions occurring in September and October, which will serve as a springboard for implementation. Through this process, leads and participating organizations will be identified for each recommendation, and we will begin developing a shared path forward.

The Office of Care Coordination, the Orange County CoC Board and others involved in this effort will be reaching out to individuals and organizations to participate in these efforts. However, we also encourage you to **tag yourself in and invite others.** The greater the participation, commitment, and collaboration across our community, the greater our ability to translate these recommendations and innovations into meaningful improvements for the people we serve.

The Office of Care Coordination also recognizes that many of these efforts will take time. Meaningful systems change does not happen overnight, and some recommendations will require sustained effort, collaboration, and adjustment before their full impact can be realized. Maintaining that commitment and momentum will be essential to our collective success.

Finally, the Office of Care Coordination extends our sincere appreciation to everyone who contributed their time, expertise, and perspective to this evaluation. The Office of Care Coordination is equally grateful to the many professionals, volunteers and organizations across Orange County who dedicate themselves every day to helping our most vulnerable neighbors end their homelessness and achieve safe, stable, and dignified housing.

This report represents an important step forward. As our co-leads point out: Now the work of turning its recommendations into action belongs to all of us.

On behalf of the OCC Team,

Doug Brecht
Director of Office of Care Coordination
County Executive Office, County of Orange

Evaluation Guide

This report is designed to support both understanding and action. It is also a technical report intended to comprehensively document the evaluation approach and findings. As such, it should be used as a reference and alongside additional supporting material, described below, that have been produced to support understanding and action among CoC stakeholders and key partners.

Readers may review the full report from beginning to end or focus on the sections most relevant to their roles. The Executive Summary provides the clearest overview of the evaluation's purpose, approach, principal findings, and recommended direction. The detailed sections that follow present the supporting evidence, stakeholder perspectives, compliance determinations, equity findings, recommendations, and innovation opportunities.

I updated the description to match the report's current structure, including the expanded Section 12 and all six appendices. I also replaced references to an "Executive Summary" with the report's actual **Introduction and Evaluation Summary** content.

How the Report Is Organized

- **Evaluation Overview** describes the purpose and scope of the evaluation, the OC CES and its current operating context, summarizes the evaluation approach, and presents the principal compliance, performance, stakeholder-experience, and equity findings. This opening section also summarizes the recommendations and innovation opportunities and identifies priorities for moving forward.

- **Sections 1–2: Evaluation Framework and Methodology** explain the evaluation areas, rating framework, data sources, documentation review, stakeholder-engagement methods, unit of analysis, deduplication approach, and limitations and caveats necessary for interpreting the findings. The methodology also distinguishes ratings based on HUD requirements, adopted OC CoC standards, or the evaluation team's expert assessment.

- **Sections 3–9: CES Design, Core Functions, and Supporting Infrastructure** present detailed findings and recommendations related to overall system design; access, assessment, prioritization, and referral; direct financial assistance; data management; and resource availability. As applicable to each topic, these sections integrate compliance findings, quantitative performance measures, stakeholder experiences, equity considerations, discussion and interpretation, and recommended actions.

- **Section 10: Advancements, Innovations and Experiences** examines opportunities to strengthen CES functioning beyond minimum compliance. It summarizes participant and stakeholder experiences across CES functions, presents nine Innovation Opportunities, and describes findings from the CES mapping process, including identified pain points, root causes, and administrator-prioritized improvement ideas.

- **Section 11: Looking Forward; Homeless Population Projections** examines emerging federal policy direction and models projected homelessness, service demand, system capacity, and resource gaps under status quo and moderately improved operating

scenarios. It considers system flow, prevention and diversion, emergency shelter, transitional housing, rapid rehousing, permanent supportive housing, and the operational and resource changes needed to improve future outcomes.

- **Section 12: Conclusion** brings the findings together into cross-system priorities and provides the report's complete set of 38 compliance and performance recommendations and nine Innovation Opportunities. It also organizes recommendations by subpopulation and geography and identifies eight recommendations requiring immediate action.

- **Appendices:**

    - **Appendix A: Compliance Rating Detail by Evaluation Dimension** provides the complete item-level compliance ratings for CES design, access, assessment, prioritization, referral, and data management and resource availability.

    - **Appendix B: Technical Modeling Documentation** presents the assumptions, definitions, methods, limitations, and detailed calculations supporting the projections in Section 11.

    - **Appendix C: List of Tables and Figures** provides a consolidated reference to the report's tables and figures.

    - **Appendix D: CES Pain Points and Root Causes Matrix** documents the 28 pain points identified through CES process mapping across nine process areas and connects them to the underlying root causes.

    - **Appendix E: Recommendation Responsibility and Investment Matrix** compiles all 38 recommendations and nine Innovation Opportunities and identifies the entity responsible for next-step action and the estimated relative level of investment associated with each item.

    - **Appendix F: Glossary** defines the principal acronyms, terms, and governance and operational roles used throughout the report.

Guidance for Different Readers

CoC leadership and governing bodies should begin with the Evaluation Overview and Sections 11 and 12. These sections highlight the most consequential findings, projected system and resource gaps, immediate corrective actions, longer-term governance and capacity needs, and decisions requiring CoC-wide direction, oversight, or partnership. Appendix E provides an additional implementation-focused view of responsible entities, next steps, and relative investment needs. Leaders may then consult Sections 3–10 and Appendix A for the evidence supporting individual findings and recommendations.

CoC members, CES administrators and operators, access points, and housing and service providers should begin with the Evaluation Overview and the detailed sections most relevant to their responsibilities. Sections 3–9 clarify applicable requirements and standards, implementation and workflow concerns, performance results, participant and provider experiences, equity

considerations, and recommended operational changes. Section 10 presents additional opportunities for system improvement, while Section 12 and Appendix E show how individual actions fit into the broader implementation framework.

Data, evaluation, and continuous-quality-improvement partners should review Sections 1 and 2, the performance and equity analyses in Sections 3–9, and the technical documentation in Appendices A and B. Section 10 describes additional opportunities involving real-time system management and HMIS data quality, while Section 12 and Appendix E identify the related recommendations, responsibilities, and investment considerations.

Community members, people with lived experience, and cross-system partners may begin with the companion materials below, and the Evaluation Overview, followed by Sections 10, 11, and 12. These sections explain how CES performance depends on broader partnerships involving affordable housing, healthcare, behavioral health, aging, workforce development, child welfare, income and benefits, local governments, philanthropy, and other community systems. They also identify opportunities for partners to expand resources, improve referral and service pathways, align investments, contribute to implementation and oversight, and help prevent or resolve homelessness more effectively.

The findings should be understood as an interconnected set rather than as isolated ratings or recommendations. Compliance and operational improvements can make CES more accessible, equitable, consistent, and efficient, but CES cannot independently create the housing, financial assistance, and services needed to meet community demand.

Likewise, additional resources will not achieve their full impact without effective access, assessment, prioritization, referral, data management, governance, and accountability. Immediate corrective action, continuous quality improvement, and longer-term system and resource development should therefore move forward together.

All partners should use the companion materials below to further organize ***Findings into Action***.

Companion Materials

Dissemination of evaluation results will be supported by companion materials being developed for different audiences and implementation purposes. These materials will be issued as part of September and October 2026 briefing and planning sessions and will be updated as the CoC moves from evaluation to implementation:

- **CES Evaluation CoC Partner Summary** — A concise summary for CoC leaders, system staff, providers, and partners that begins to translate ***Findings into Action***.
- **CES Evaluation Community Summary** — An accessible overview for interested community members, including ways they can support turning ***Findings into Action***.
- **CES Improvement Plan and Roadmap** (to be developed collaboratively with CoC partners) — Prioritized actions, responsible parties, anticipated timeframes, dependencies, and progress measures for implementing the recommendations.

- **CES Evaluation Framework** (to be developed collaboratively with CoC partners) — Indicators, data sources, review frequency, responsibilities, and processes for ongoing CES monitoring, evaluation, quality assurance, and continuous improvement.

Together, the report and companion materials establish a foundation for shared learning, decision-making, implementation, and accountability. They should be treated as living resources that guide immediate action while supporting sustained improvements in how Orange County prevents and resolves homelessness.



Evaluation Overview

Project Context and Purpose

The Orange County Continuum of Care (OC CoC), with financial support from the Samueli Foundation, engaged Element Consulting Group, LLC (ECG) to conduct a comprehensive, independent evaluation of the Orange County Coordinated Entry System (OC CES). The evaluation was conducted on behalf of the OC CoC and in partnership with the County of Orange Office of Care Coordination (OCC), which serves as the CES Lead. The work was guided by a project Core Team and a CES Evaluation Advisory Group, with input from people with lived experience, CES operators, providers, system partners, CoC leadership, and cross-sector stakeholders.

The purpose of this evaluation is to assess how effectively, efficiently, and equitably the OC CES connects people experiencing housing crises to appropriate housing and services across Orange County.

The evaluation examines CES compliance with HUD and CoC requirements, the experience and outcomes of people and providers using the system, and opportunities to strengthen CES performance and functioning as a coordinated, person-centered, and data-informed access and referral system.

CES Compliance. The extent to which OC CES policies, procedures, and practices align with HUD requirements and locally adopted CoC standards across the core CES functions of system design, access, assessment, prioritization, referral, direct assistance, and data management.

CES Effectiveness and Experiences. The impact and performance of CES overall and for different subpopulations, including individuals, families, survivors of domestic violence, Veterans, transition-age youth, and people across Orange County's Service Planning Areas (SPAs).

CES Advancements and Innovations. Opportunities to improve CES policies, workflows, data use, coordination, and resource alignment, especially for populations and geographies experiencing disproportionate barriers.

The findings and recommendations in this report are provided as part of the final phase of ECG's OC CES evaluation support. This final phase is intended to move beyond evaluation and reporting and immediately support implementation of corrective actions and improvements, including the development and initiation of a CES performance and quality improvement workplan, implementation approach, and oversight structure.

The goal is to help the OC CoC translate evaluation findings into practical system improvements, clearer accountability, and an ongoing framework for continuous CES monitoring, learning, and improvement.

It is important to note the evaluation does not analyze specific funding streams, expenditures, program costs, or funding allocations, as those questions are being addressed by the CoC through a separate fiscal-mapping project with Homebase. Findings from both efforts should be considered together by the CoC when making future resource and investment decisions, as is also planned and laid out in the CoC Board's Strategic Plan.

Finally, a comprehensive, person-centered evaluation requires people with lived experience (PLE) to help design, implement, interpret, and review the evaluation—not merely participate as research subjects. This approach reflects a core principle of ECG's work and is reinforced by the lived experience of homelessness of one of our team members.

To operationalize this principle for this evaluation, ECG recruited and compensated two PLE Advisors to serve as members of both the ECG Evaluation Team and the project Core Team, along with three additional compensated PLE Advisors who also served on the Evaluation Advisory Group. Advisors and evaluation participants ("PLE Storytellers") were compensated consistent with OC CoC policies. Advisors helped guide the evaluation approach, interpret and validate emerging findings, and shape priorities and recommendations related to CES access, communication, assessment, accountability, and person-centered practices.

As the CoC moves into review and implementation planning, ECG will continue to encourage and seek the fullest possible involvement of people affected by housing insecurity and homelessness to help develop solutions that are meaningful, equitable, practical, and lasting as evaluation recommendations are turned into actionable improvements that are meaningful, equitable, and lasting.

What is a "Coordinated Entry System"?

A **Coordinated Entry System (CES)** is the process a community uses to help people experiencing or at risk of homelessness access available housing and services in a consistent, transparent, and equitable way. The U.S Department of Housing and Urban Development (HUD) requires each community that receives federal homelessness assistance funding to operate a CES so that people across each community can readily access local homelessness prevention and assistance services.

HUD requires each Continuum of Care (CoC) to establish and operate a CES that covers the full CoC geographic area, is accessible to all eligible populations, uses standardized access, assessment, prioritization, and referral processes, includes written policies and procedures, protects participant choice and privacy, and prioritizes people with the greatest needs and vulnerabilities for appropriate assistance.

At a minimum, CES includes four core functions:

ACCESS, where people experiencing a housing crisis are initially screened and connected to resources to immediately resolve the crisis or connect to available shelter, interim housing, transitional housing, outreach services (if needed), and rehousing assistance.

ASSESSMENT, where people who don't otherwise quickly resolve their housing crisis are further assessed for needed and desired housing and services, including program eligibility and prioritization factors.

PRIORITIZATION, where households eligible for housing assistance and options available via CES are prioritized for limited resources based on HUD requirements and locally adopted criteria.

REFERRAL, where eligible and prioritized households are matched or referred to available housing and supportive service opportunities, typically with support from either the referring or receiving provider.

CES is not intended to function as a waiting list. Its broader purpose is to provide a coordinated, person-centered response to housing crises—connecting households as quickly as possible to the appropriate level of housing assistance and supportive services across systems. CES also helps communities assess whether available housing and service resources are sufficient, accessible, and aligned with the needs of people experiencing a housing crisis.

OC Coordinated Entry System Overview

The OC CES is organized by subpopulation rather than as a single undifferentiated CES and queue. Separate CES pathways or registries exist for **individual adults, families, Veterans, survivors of domestic violence, and transition-age youth (TAY).** These pathways are intended to account for different eligibility rules, safety considerations, service needs, housing resources, and partner systems. OCC administers the CES registries for **Veterans and TAY**, while third-party contracted providers have historically operated the **individual, family, and domestic violence survivors CES** functions.

Orange County is currently transitioning management of the Family CES, Individual and domestic violence survivors CES to a new contracted operator, expected to assume responsibility this fall (PATH began full operations of the CES as of September 1, 2026). During the transition period, OCC operated those CES functions on an interim basis to maintain continuity of assessment, prioritization, matching, and referral activities.

In Orange County, CES currently functions primarily as the pathway for matching eligible households experiencing homelessness to homeless-dedicated housing resources that are accessed through CES, including Permanent Supportive Housing (PSH), Rapid Rehousing (RRH), and other limited housing opportunities. While OC CES policies reference prevention, diversion, and broader system coordination, the operational focus of CES is largely on identifying households who meet prioritization requirements for dedicated permanent housing units, placing them on the applicable registry or by-name list, and matching them to available housing openings as they become available.

As designed, a household's first contact with the homelessness response system, a call to 211, or walking into a shelter operating as an Access Point or connecting with street outreach program staff, is the first CES-specific step identified as a **general crisis contact.** The Access Point conducts a **Crisis Needs Assessment (CNA)** or a **Bed Reservation Assessment,** a short intake screening that asks about the participant's background, shelter preference and accessibility needs.[1] System policy and written Access Point responsibilities identify this point as an opportunity for diversion, helping a household resolve their crisis without entering shelter, but this is not a formalized or consistently tracked step and is left to each Access Point to operationalize, train staff, and monitor diversion. When diversion succeeds, the household typically never appears in CES data at all.

If the household is enrolled in a shelter, outreach, or transitional housing program, they become part of the CES pipeline. They are expected to also receive a **Housing Needs Assessment (HNA)**

[1] OCC clarified that the CNA has not been implemented and records showing a CNA are erroneous.

asking about the household's housing preference and accessibility needs and a **Current Living Situation Assessment (CLSA)** that must be updated every 90 days. This assessment drives the placement of the household on the Community Queue, the system's prioritized waiting list for referral to permanent supportive housing (PSH), rapid rehousing (RRH), and other homeless dedicated housing resources accessed via CES. By design, the CNA happens at intake and the HNA and CLSA follow.

Orange County's CES has a more limited scope and function than coordinated entry systems in other communities. It focuses primarily on matching households experiencing homelessness to dedicated housing resources. Because Orange County's CES is largely match-focused, its performance depends more heavily on the availability of dedicated housing, provider participation in CES, the quality and consistency of housing navigation and individualized support, and housing providers' post-match policies and practices.

In communities with more developed and comprehensive coordinated approaches, CES plays a critical role coordinating both "front door" Access Points for prevention and diversion to help households avoid homelessness and via actively coordinating the "back door" by ensuring currently homeless households are connected to available housing, service supports, and resources.

Evaluation Approach

The OC CES Evaluation used a mixed-method, equity-driven approach combining quantitative data analysis, qualitative stakeholder engagement, policy and workflow review, system mapping, and review of CES documentation.

> For purposes of this evaluation, **"equity-driven"** means intentionally using data and the experiences of people most affected by homelessness to identify and address disparities in access, treatment, and outcomes—particularly for groups that have historically faced discrimination or systemic barriers.

Quantitative analysis covered the October 1, 2024, through September 30, 2025, period and included HMIS and administrative data files provided by Orange County United Way, the HMIS Lead, and OCC. The primary target population for quantitative analysis was 15,913 unique heads of household enrolled in 125 Street Outreach (SO), Emergency Shelter (ES), or Transitional Housing (TH) programs using the OC HMIS[2] during the evaluation period.

Qualitative engagement included interviews, focus groups, survey responses, CES mapping discussions, and Advisory Group feedback. Engagement gathered perspectives from people with lived experience, frontline staff, CES operators, housing providers, Victim Service Providers, Veteran service partners, youth providers, city and public housing authority representatives, behavioral health partners, HMIS/211 staff, and other system-interfacing partners. The evaluation also incorporated input from CES mapping sessions to identify pain points, root causes, and

[2] Using the 2025 Housing Inventory Count information, HMIS coverage is 94% system-wide, not including the DV projects that are not allowed to participate in HMIS. All housing projects participate in HMIS, 99% of emergency shelters and 35% of transitional housing projects.

improvement ideas that could inform both near-term corrective action and longer-term system redesign.

The evaluation team also examined prior CES evaluation findings. A detailed review was conducted by OCC staff at the request of the evaluation team to ensure proper understanding of efforts made following the evaluation and related results. The process of starting the evaluation by examining past and current evaluation and system monitoring data is essential to both this evaluation and our team's recommendations for ongoing CES monitoring and improvement.

The evaluation used two complementary rating approaches: compliance ratings and implementation functioning ratings. Compliance ratings assess individual items and overall CES functions using a three-tier scale of **Compliant, Partially Compliant, or Noncompliant.** For this report, the term "compliance" does not always indicate compliance with a specific HUD requirement. Each item was rated against an explicit HUD requirement or an established OC CoC standard or performance benchmark when one existed. Where no such requirement, standard, or benchmark existed, the evaluation team assigned the rating based on its expert assessment of the available evidence, including document review, HMIS and administrative data, stakeholder input, and accepted CES practices. *Accordingly, findings based on evaluator expert opinion should not be interpreted as determinations that the CoC or OCC violated a HUD requirement*.

Implementation functioning ratings provide a separate assessment of how effectively each CES function operates in practice, using ratings of **High Functioning, Moderately Functioning, or Low Functioning**. These ratings consider factors such as the consistency of implementation across providers and geographic areas, the clarity of workflows, data quality, delays, and barriers to participant access. Additional information about both rating approaches, including rating thresholds and equity-analysis criteria, is provided in **Section 1.1, Rating Framework**. Item-level compliance ratings and their bases are presented in **Appendix A, Compliance Rating Detail by Evaluation Dimension**.

Evaluation Summary

Overall, the evaluation found that the OC CES has important strengths and a solid foundation for improvement.

- The system has comprehensive written policies, established subpopulation-specific pathways and operational procedures, strong nondiscrimination and privacy protections, and an HMIS infrastructure capable of supporting robust reporting and continuous improvement. Stakeholders consistently identified committed and capable staff across the system, while people with lived experience emphasized the significant difference made by responsive, knowledgeable caseworkers. The Veteran coordination model provides a particularly strong example of effective by-name-list management, case conferencing, coordinated communication, embedded outreach, and end-to-end navigation. No consistent racial or ethnic disparities were identified across the system, and the PSH match-acceptance rate met the CoC's established target.

At the same time, the evaluation found significant implementation weaknesses that prevent the CES from achieving the best possible results with its current resources.

- CES reaches only a limited share of households enrolled in street outreach, emergency shelter, and transitional housing;

- Assessments are frequently incomplete, compressed, or outdated; prioritization relies primarily on length of homelessness rather than a fuller consideration of vulnerability and housing fit; and
- Only 7.7 percent of assessed households received a housing referral during the evaluation period. Of the housing matches made, 40.5 percent resulted in a confirmed move-in.

Across principal evaluation areas, findings point to the need for both immediate corrective action and longer-term system improvement. The compliance review identified gaps across system design, access, assessment, prioritization, and referral, while data management emerged as a comparative strength. Stakeholder feedback—especially from people with lived experience—highlighted difficulties locating and understanding CES, inconsistent communication and navigation support, repeated documentation requests, limited transparency, and uncertainty before and after a housing match. Equity concerns were concentrated among particular populations, geographic areas, and stages of the CES process rather than reflected in consistent system-wide racial disparities.

Together, these findings support the need to strengthen access and assessment coverage, modernize prioritization, improve match quality and post-match support, formalize continuous quality improvement and accountability, deepen cross-system coordination, and better align housing and service capacity with community need.

Key Findings

Across all program types, the OC CES served 26,259 unique persons during the evaluation period. **The OC CES coverage rate is 77 percent of the system's beds and 52 percent of the system's programs.** The OC CES operates within a structural housing supply deficit with limited to no formal coordination and access protocols with critical service and healthcare supports. No amount of operational improvement within a homeless crisis response system can overcome these constraints. Consequently, proactive strategies that both increase access to sustainable housing and ensure access to all supports a household may need to avoid or resolve homelessness and remain stably housed is both paramount and essential context for interpreting this report.

> **CES can improve how households are identified, assessed, prioritized, matched, and supported through housing referral processes, but it cannot by itself create the permanent housing inventory, prioritized access to other stabilization options (e.g., assisted living), and supportive services needed to meet the level of demand presenting to and entering the crisis response system.**

Within that constraint, the evaluation found significant implementation gaps that reduce system effectiveness below what the current resource level can support. The CES assessment function reaches only 35 percent of the target population. The prioritization function places all households assessed for housing needs on a single list without differentiating by acuity or need, only length of time homeless. The list does differentiate by the CES participant SPA, city ties and other eligibility requirements. **Among households in SO/ES/TH assessed by CES, only 7.7 percent receive a housing referral (Section 5); of the housing matches that are made, only 40.5 percent convert to a confirmed move-in (Section 7).**

One of the most important findings of this evaluation is the system-wide **6:1 inflow-to-permanent housing exit ratio**. The OC CES absorbs nearly six new households experiencing or at-risk of

homelessness for every one household it resolves through a permanent housing exit. HP, Services Only and Coordinated Entry together account for a substantial share of the system-wide totals; when both entries and exits are restricted to the CE-assessed permanent housing pathway program types (excluding HP, Services Only, and CE from both sides), the ratio rises to 13:1, indicating that CES-specific throughput is materially tighter than the system-wide figure alone suggests. Additionally, figures should be read with caution as they focus solely on permanent housing exits and it do not capture households who exited to Unknown or Other destinations, which may reflect self-resolution through non-dedicated resources outside CES's visibility.

The evaluation findings point to three simultaneous overarching needs.

> **First**, the OC CoC should **correct CES compliance and implementation gaps** identified in this report so the existing system functions as fairly, consistently, and efficiently as possible.
>
> **Second**, the OC CoC should continue to **better align existing housing, service, prevention, and mainstream system resources** that homeless systems generally and CES specifically depends on to prevent or resolve homelessness at scale. Without progress on both fronts, CES improvements will increase transparency and efficiency but will not be sufficient to close the gap between community need and available housing solutions.
>
> **Third**, to progress as a system and grow to the scale needed and beyond over-taxed emergency responses, OCC must **address overarching governance structure** needs to ensure engagement, support, and clear accountabilities exist across all CoC members, including the County of Orange and each of the major local authorities investing in housing solutions (Anaheim, Irvine, Santa Ana, and Garden Grove), as well as healthcare, aging, workforce, child welfare, and other critical partners.

Compliance Summary

The OC CES was evaluated against HUD requirements, CoC Program regulations, the OC CES Policies and Procedures Manual, and evaluator opinion across **51 compliance items**. ECG applied an overall compliance rating based on the number of items rated Fully Compliant divided by the total number of items rated for that function, expressed as a percentage. Under this formula, a compliance rate of 90 percent or greater yields a rating of Compliant, 75 to 89 percent yields Partially Compliant, and less than 75 percent yields Noncompliant, consistent with the **Rating Framework** defined in Section 1. Using this formula, the OC CES was rated Noncompliant across five of six rated functions, with only Data Management reaching Partially Compliant.

Table ES-1 — Compliance Summary by Function

Function	Compliant	Partially Compliant	Non-Compliant	Total	Rate	Rating
System Design	3	2	0	5	**60%**	**Noncompliant**
Access	6	4	1	11	**55%**	**Noncompliant**
Assessment	5	4	2	11	**46%**	**Noncompliant**

Prioritization	1	6	1	8	**13%**	**Noncompliant**
Referral	2	8	2	12	**17%**	**Noncompliant**
Data Management	3	1	0	4	**75%**	**Partially Compliant**

Six items across four functions were rated noncompliant and are recommended (REC) for corrective action. Items marked as "**Immediate Action**" are highlighted as they fall within the current delegated authority and capacity of OCC as CES lead.

- **Access:** The CES coverage rate of 14 percent, the proportion of households with an Emergency Shelter (ES), Street Outreach (SO), or Transitional Housing (TH) program enrollment that also received a CNA during the evaluation period, is substantially below the threshold for a functioning access system. **(REC-8 through REC-11)**
- **Assessment:** The Disabling Condition Form requires disability-type disclosure and the CES Policies and Procedures do not include the required disability-related language limitations, in violation of HUD requirements. **(REC-12 — Immediate Action)**
- **Assessment:** The HNA coverage rate measures the proportion of households with ES, SO, or TH program enrollments that also received a CES HNA during the evaluation period. Of 15,913 unique heads of household with a qualifying program enrollment, 5,588 received a HNA, a coverage rate of 35 percent. **(REC-13)**
- **Prioritization:** No evidence of a homelessness prevention prioritization process was found in the current CES P&Ps. Prevention assistance is reported to be allocated on a first-come, first-served basis, with no risk-based criteria determining who receives prevention resources ahead of others. **(REC-19)**
- **Referral:** Housing match timeliness benchmarks, evaluated against the actual median days, are not met for permanent supportive housing (PSH) or rapid rehousing (RRH). PSH Match-to-Determination averaged 58 days with a median of 49 days against the 45-day target. RRH Match-to-Determination averaged 26 days with a median 15 days, a near-miss against the OC CES established 14-day target. **(REC-25)**
- **Referral:** Evidence indicates CES-participating agencies are screening out participants based on perceived barriers. Stakeholder interviews, PLE focus groups, and process review indicates ill-fitting, underprepared matches, documentation issues, and providers and city representatives describing efforts to actively work around CES rather than through it. **(REC-26 — Immediate Action)**

Stakeholder Engagement Summary

Data sources for the stakeholder feedback and qualitative findings in the report consist of 69 survey responses, 11 interviews, and 12 focus groups, including 7 focus groups with 74 participants representing People with Lived Experience (PLE). A bottom-up analysis was conducted to identify recurring themes and patterns that were not predefined by the evaluation team.

The most consistent patterns across sources were:

- **Access.** Stakeholders described a hard-to-find front door: 48 percent of survey providers disagreed that people know how to access CES, and PLE typically reached the system through word of mouth, family, jail, or chance rather than 211. Providers reported access points declining because the role is unfunded, and the HUD literal-homelessness definition excluding couch-surfing youth and doubled-up families.
- **Assessment & prioritization.** Prioritization changes in recent years shifted the system from reliance on intensive vulnerability assessments to now resting largely on length of time homeless; providers generally saw this as not only more objective, but also blunt and ineffective for clinically urgent, youth, and survivor cases. They named being 'doc-ready' (that is, having all documents needed for move-in, not just being in the queue) as the real gate.

  Many PLE described uncertainty about how CES works, including the purpose of the housing assessment, how information collected during the assessment is used, and what documentation is needed throughout the process. Participants frequently reported gathering documents without understanding how those documents contributed to housing eligibility, prioritization, or readiness for housing opportunities. They expressed confusion about what it means to be "doc ready" and why certain documents are required for specific housing resources, especially voucher-based programs.

  Participants (across all types) also expressed a desire for clearer communication about the overall housing process, including what to expect after completing an assessment, the roles of different providers, and the steps that occur between assessment and housing placement. This lack of understanding contributed to confusion and uncertainty about how to successfully navigate the system.
- **Referral & matching.** CES match meetings were widely described as efficient but missing a human layer; a large share of matches do not convert to housing placement (60 percent) and PSH units sat vacant for months. PLE experienced and other stakeholders affirmed significant barriers between referral, matching, and enrollment, resulting in repeated matches, missed housing opportunities, and prolonged periods of homelessness. People with lived experience frequently described a referral and matching process that lacked transparency and predictability. PLE participants often did not understand how housing matches were made, why they were referred to specific programs, or what factors determined whether a housing opportunity would ultimately result in enrollment.

  A key challenge identified by a cross-section of participants were housing matches often made before eligibility requirements and documentation readiness had been fully confirmed through the assessment, referral, and case conferencing processes. As a result, individuals were frequently referred to or matched with housing opportunities only to later learn that they did not meet program eligibility requirements, lacked required documentation, or were otherwise unable to move forward with enrollment. PLE participants described these experiences as discouraging and confusing, particularly when they believed they had secured a housing opportunity only to have it fall through later in the process.

  Many participants reported multiple matches are frequently required before successfully enrolling a person in a housing program. Each unsuccessful match often resulted in additional waiting periods, repeated document collection efforts, challenges with compliance and funding/partner confidence, and continued uncertainty for PLE about their

housing status – and the resulting stress and compounding difficulties such experiences created for them.

PLE participants also described limited support in understanding or completing the steps required after a match was made, including obtaining documentation, addressing eligibility barriers, communicating with housing providers, and navigating housing search requirements associated with voucher programs.

- **Cross-system coordination.** Coordination with other systems drew the weakest survey response (21 percent agree it is sufficient), with behavioral health named the top need; funding, data, and confidentiality rules were described as not lining up, so coordination often runs on relationships and workarounds.

Several subpopulations merit additional, dedicated stakeholder feedback to inform implementation of CES evaluation findings and recommendations. In particular, Seniors (21 percent of the target population), people returning from incarceration, gender-diverse and LGBTQ+ individuals, limited English proficiency households, and at-risk (not yet literally homeless) households were not the subject of targeted qualitative engagement in this evaluation and current findings for these populations are based on administrative data only.

Performance Findings Summary

Across the four core CES functions evaluated below, data shows a system that is formally structured and well-documented but does not yet translate design into consistent household-level outcomes: coverage remains low at the point of entry, assessments are often rushed or stale, prioritization does not differentiate by acuity, and only a small share of assessed households ultimately receive a housing referral. The findings below summarize the most significant performance results by function; full compliance ratings, equity findings, and stakeholder evidence supporting each are presented in Sections 5 through 8.

- **Access.** CNA coverage declined 47 percent over the evaluation year, from 335 unique participants in October 2024 to 178 in September 2025, likely driven by the ongoing shift of access points from open to closed status. The South SPA accounts for only 3 percent of all CNAs despite being a distinct geographic service area.
- **Assessment.** Of 5,588 households with a HNA, 42 percent received their assessment on the same day as program enrollment, before initial crisis stabilization could occur. Fourty-seven percent of BNL households have not been reassessed within the last 180 days. Three-quarters of chronically homeless and disabled households with a HNA, 3,734 of 4,109, received no housing unit referral during the evaluation period.
- **Prioritization.** The BNL contains over 3,600 households, but prioritization is based solely on length-of-time homeless, which does not differentiate by clinical acuity, housing type fit, or documentation readiness. Thirty-six percent of BNL placements expired due to inactivity. Youth (TAY) are placed on the BNL at 53 percent, 12 percentage points below the 65.5 percent system average.
- **Referral.** Of the 1,195 OCC match records, 550 (46.3 percent) were accepted and 482 (40.5 percent) resulted in a confirmed move-in. PSH acceptance (57.9 percent) meets the ≥50 percent CoC target; RRH acceptance (31.0 percent) falls materially below the ≥60 percent target. The 22 percent system-wide return-to-homelessness rate exceeds all program-type targets. Only 431 of the 5,588 SO/ES/TH-HNA-holding households (7.7 percent) received a

housing referral at all; system-wide, across all referral sources, 816 households received a referral during the period. This gap is not explained by program-level CES participation: referral rates are comparable between CES-participating and non-participating ES/TH programs (10.4 percent versus 11.9 percent). The gap is concentrated among the 70 percent of this population reached only through Street Outreach (6.3 percent referred), a segment for which CES-participation status is not determinable from available data (Section 2.4).

Equity Findings Summary

No consistent racial or ethnic disparities were identified at the system level. Equity concerns are concentrated in specific functions and subpopulations, as summarized in the table below.

Table ES-2 — Equity Summary: Significant Disparities Identified

Subpopulation	Metric	Finding	Flag
South SPA	CNA and HNA coverage	CNA: 9% vs 21% Central SPA HNA: 36% vs 45% North SPA	**Significant**
Veterans	CNA coverage	11% vs 21% non-veteran	**Flag for Monitoring**
South SPA	Time to housing	147 days vs 94-days average	**Significant**
DV Survivors	Time to housing	142 days vs 94-days average	**Significant**
Black/AA and Asian/AA	Time to housing	109 days vs 94-day average	**Significant**
Disabled participants	Assessment-to-referral	36 days vs 28-days non-disabled participants	**Significant**
Youth / TAY	Assessment-to-referral	40 days vs 35-days average and non-youth	**Flag for Monitoring**
North SPA	Assessment-to-referral	42 days vs 35-days average	**Significant**
Youth / TAY	BNL placement rate	53% vs 66% non-youth	**Flag for Monitoring**
NHPI and Asian/AA	Referral acceptance rate	NHPI 88% denial rate Asian/AA 59% denial rate	**Flag for Monitoring**
Veterans	Referral acceptance rate	38% vs 46% system average and 48% non-vets	**Flag for Monitoring**

PLE interactions with CES varied significantly based on the quality and consistency of support they received, impacting their sense of dignity, trust, and fairness throughout the process. Participants consistently described positive experiences when they had access to a caring, responsive, and knowledgeable caseworker who provided clear communication, guidance,

and ongoing support. These relationships helped participants navigate complex processes, understand expectations, and remain engaged while pursuing housing opportunities.

Conversely, PLE participants also frequently reported inconsistent communication, staff turnover, lost documentation, repeated requests for information, and uncertainty about who was responsible for supporting them. Many described having to repeatedly explain their circumstances to new staff, contributing to frustration and a lack of trust in the general system. Participants who recalled or knew they were being assisted by coordinated system with a "community queue" understood it as the only or primary means by which they receive assistance to resolve their homelessness and secure housing.

Participants also shared experiences of feeling judged, dismissed, or stigmatized because of their homelessness, substance use, mental health challenges, or personal circumstances that make it appear as though there's a lack of follow-through or commitment to next steps. These interactions often left individuals feeling blamed for their situation, reluctant to ask questions, and less likely to engage with services. In addition, some participants perceived favoritism or unequal treatment, leading to concerns about the fairness and transparency of homeless assistance and of the CES processes.

Recommendations and Innovation Opportunities

This evaluation identified **38 recommendations for Improvement (REC-1 through REC-38)** including corrective actions for non-compliant findings and **9 Innovation Opportunities (IO-1 through IO-9)**. The IOs are strategic opportunities requiring CoC Board action rather than CES Lead operational implementation. Eight recommendations are flagged for **Immediate Action** as they fall within the current delegated authority and capacity of OCC as CES lead. See Appendix E for a full implementation matrix identifying the responsible entity and estimated investment level for each Recommendation and Innovation Opportunity.

Section 3: System Design	
REC-1	**Severity-of-Need Assessment & Prioritization** — Utilize standardized severity-of-need factors for assessment and prioritization purposes consistent with requirements in HUD Notice CPD-17-01.
REC-2	**Document Readiness & Matchable Status** — Build document-preparation support into the process earlier, and track "in queue" vs. "matchable" (document-ready) status in HMIS.
REC-3	**Responsible Provider & Warm Handoff** — Formalize a responsible-provider model and case-conferencing protocol covering match acceptance through enrollment.
REC-4 IMMEDIATE	**VA SSVF Participation Terms** — Clarify and formally document VA Supportive Services for Veteran Families (SSVF's) Program role in OC CES.
REC-5	**CQI Framework** — Formalize a Continuous Quality Improvement (CQI) framework with a defined review cycle and protocol for developing and updating the CES P&Ps and staff training materials.

Section 3: System Design	
REC-6	**Stakeholder Input Mechanisms** — Establish formal, transparent mechanisms for stakeholder input, feedback, and policy development. (related to REC-35)
REC-7	**Governance Roles & Decision Rights** — Clarify governance roles, decision-making authority, and escalation pathways across CES entities.

Section 4: CES Function 1 — Access	
REC-8	**Coverage Expansion Plan** — Develop a CES Coverage Expansion Plan (35% coverage within 12 months, 50% within 24) with focus on Street Outreach programs and implement some form of structured CNA at first contact.
REC-9	**Access Point Sustainability Plan** — Stabilize and expand access point capacity, prioritizing the South SPA and Street Outreach programs, with stable funding, incentives, monitoring, training, and contingency planning.
REC-10	**Prevention & Diversion Component** — Build a formal homelessness prevention and diversion component into the CES access model.
REC-11	**Referral Connection Tracking** — Track referral-to-CNA connection rates to identify where households drop out at entry.

Section 5: CES Function 2 — Assessment	
REC-12 IMMEDIATE	**Disabling Condition Form Fix** — Remove the disability-type field from the Disabling Condition Form.
REC-13	**HNA Completion Timeliness** — Set a 90%-within-30-days completion target for the HNA.
REC-14 IMMEDIATE	**HNA Instrument Review** — Review whether the HNA instrument captures enough information for accurate housing matches.
REC-15 IMMEDIATE	**Survivor & TAY Assessment Review** — Conduct a targeted HNA-adequacy review for DV survivors and TAY populations.
REC-16	**CLSA Reassessment Alerts** — Automate CLSA reassessment alerts before households hit the 90-day cutoff.
REC-17	**S3 Cohort Referral Review** — Review all 3,734 high-need households with a completed HNA but no housing referral (S3 cohort).

Section 6: CES Function 3 — Prioritization	
REC-18 IMMEDIATE	**PSH Prioritization Language Fix** — Correct PSH prioritization language on temporary transitional housing while a permanent unit is identified.
REC-19	**Prevention Prioritization Protocol** — Create a separate, risk-based Homelessness Prevention Prioritization Protocol.
REC-20 IMMEDIATE	**Shelter Prioritization Correction** — Remove length-of-homelessness criteria from Emergency Shelter prioritization.
REC-21	**Prioritization Model Refinement** — Refine prioritization to weigh vulnerability and clinical urgency alongside length of homelessness. Update the HNA to account for any updates to this model.
REC-22	**Street Outreach HNA Gap** — Close the ~70% HNA coverage gap for Street Outreach participants.
REC-23 IMMEDIATE	**Participant Grievance Process** — Establish means for confidential reporting of CES participant concerns and grievances. Ensure evaluation findings inform updates to CES monitoring practices and feedback mechanisms.
REC-24	**BNL Expiry Investigation** — Investigate the 36% BNL expiry rate and build a pre-expiry outreach protocol.

Section 7: CES Function 4 — Referral	
REC-25	**Timeliness Improvement Plan** — Launch a Timeliness Improvement Plan to bring match-to-move-in timelines into compliance.
REC-26 IMMEDIATE	**Provider Screen-Out Investigation** — Investigate provider screen-out practices that violate CoC participation requirements. Ensure any findings inform updates to CES monitoring practices.
REC-27	**Subpopulation Denial Rate Review** — Investigate high decline/denial rates among Veteran, NHPI, and Asian/AA households.
REC-28	**RRH Performance Workgroup** — Convene an RRH Performance Workgroup to correct program underperformance.
REC-29	**HNA-to-Referral Review Interval** — Add a minimum review interval between HNA completion and referral issuance.
REC-30	**Return-to-Homelessness Response** — Address the 22% system-wide return-to-homelessness rate with stability check-ins and post-placement supports.
REC-31	**Standardized Eligibility Registry** — Standardize housing-provider application requirements through a shared eligibility registry.

REC-32	**Pre-Referral Eligibility Communication** — Establish a process for communicating provider eligibility requirements to CES staff before referrals are made.
REC-33	**Performance Benchmark Transparency** — Publish and regularly review performance benchmarks for referral and housing outcomes.

Section 8: Direct Financial Assistance	
REC-34	**Direct Financial Assistance Function** — Build a Direct Financial Assistance function with defined eligibility, disbursement, and fiscal controls.

Section 9: Data Management and Resource Availability	
REC-35	**Year-Round Feedback Mechanism** — Establish a year-round, structured provider and participant feedback mechanism.
REC-36	**Resource Alignment Strategy** — Develop a Resource Alignment and Capacity Management Strategy to address the system's 6:1 inflow-to-exit ratio.
REC-37	**Capacity & Utilization Metrics** — Establish formal metrics to monitor system capacity and housing resource utilization.
REC-38	**Landlord & Provider Engagement** — Strengthen housing provider and landlord engagement to expand available housing opportunities.

Section 10: Advancements, Innovations and Experiences (Innovation Opportunities)	
IO-1	**Dynamic BNL Management** — Implement dynamic BNL management using real-time data to adjust prioritization as needs change.
IO-2	**Progressive Engagement Model** — Adopt a progressive engagement model: phased triage/crisis assessment at contact, full HNA 7–14 days later.
IO-3	**Real-Time System Dashboard** — Build a real-time system dashboard and standardized public eligibility profiles for housing programs.
IO-4	**Culturally Responsive Navigation** — Develop subpopulation-based, culturally responsive housing navigation.
IO-5	**Independent Complaint Mechanism** — Establish a confidential, third-party complaint mechanism independent of CES operational staff.

IO-6	**Mainstream Resource Integration Plan** — Build a Mainstream Resource Integration Plan linking CES to CalAIM, BHSA, child welfare, workforce, aging, and affordable housing systems.
IO-7	**DFA Buildout** — Stand up the full Direct Financial Assistance function: diversion, rapid placement, and landlord engagement funds.
IO-8	**Training Update Protocol** — Require staff training materials to be updated within a set timeframe after every policy or tool change.
IO-9	**HMIS Data Quality Plan** — Launch a structured HMIS data quality improvement plan targeting equity and reporting fields.

Moving Forward

The OC CES has genuine strengths to build on. The data infrastructure is sound and HMIS is configured for comprehensive reporting. Stakeholders across all groups identified commitment, capable individual staff, and a genuine desire to improve the system. The findings of this evaluation are intended to support and accelerate that improvement.

The path forward requires parallel action on three tracks:

First, the OC CoC should **correct CES compliance and implementation gaps** identified in this report so the existing system functions as fairly, consistently, and efficiently as possible.

Second, the OC CoC should continue to **better align existing housing, service, prevention, and mainstream system resources** that Orange County's systems with homeless-dedicated resources generally, and that CES specifically, depend on to prevent or resolve homelessness at scale. Without progress on both fronts, CES improvements will increase transparency and efficiency but will not be sufficient to close the gap between community need and available housing solutions.

Third, to progress as a system and grow to the scale needed and beyond over-taxed emergency responses, the OC CoC should **address overarching governance structure** needs to ensure engagement, support, and clear accountabilities exist across all CoC members, including the County of Orange and each of the major local authorities investing in housing solutions (Anaheim, Irvine, Santa Ana, and Garden Grove), as well as healthcare (including CalAIM and BHSA), aging, workforce, child welfare, and other critical partners.

Section 1: Evaluation Framework

On behalf of the Orange County Continuum of Care (OC CoC), Element Consulting Group, LLC (ECG) has conducted a comprehensive evaluation of the Orange County Coordinated Entry System (OC CES) with data review spanning October 1, 2024, through September 30, 2025. This evaluation was conducted in accordance with HUD Notice CPD-17-01 and the HUD Coordinated Entry Management and Data Guide, which establishes requirements for CoC-administered coordinated entry systems, and is guided by a comprehensive CES Evaluation Plan developed by ECG to structure and facilitate evaluation.

The evaluation examines whether the OC CES equitably, efficiently, and effectively resolves housing crises; whether CoC housing and service interventions are more efficient and effective because of CES; and whether the CES helps individuals, families, and survivors of domestic violence connect with ***available*** housing and services they need.

Evaluation Areas

Three areas of evaluation are used to provide a comprehensive evaluation of the OC CES:

- **CES Compliance:** Examines the status of the CES regarding compliance with HUD requirements and CoC CES standards.
- **CES Experiences & Outcomes:** Examines the impact the CES has overall and on different subpopulations regarding system access, service quality, capacity, and system performance.
- **CES Advancements & Innovations:** Examines where adjustments and innovations are needed to assure compliance and improve CES efficacy for all populations, with attention to disproportionately affected populations.

1.1 Rating Framework

All findings in this report are assessed using two complementary rating approaches, consistent with the OC CES Evaluation Plan developed for this project by Element Consulting Group.

Compliance Ratings assess the degree to which CES policies, procedures, and practices align with HUD requirements and locally adopted standards.

- Overall, at the **CES function level** (design, access, etc.), a rating of **Compliant** requires 90 percent or greater compliance with no material disparities across geography or priority populations. **Partially Compliant** indicates 75 to 89 percent compliance with isolated variation, documentation gaps, or emerging equity signals. **Noncompliant** indicates less than 75 percent compliance, persistent disparities, or routinely misapplied processes. For items where a percentage compliance was not appropriate to compute, the evaluation team assessed and determined the level of compliance based on other available data.
- Each **CES functional item** was rated against an objective factor where one existed, either an explicit HUD compliance requirement or a performance goal or benchmark established by the OC CoC. Where no such metric was available, the evaluation team made a compliance determination based on a relative assessment

of the evidence gathered through documentation review, HMIS data analysis, and stakeholder engagement, applying the same three-tier framework described above.

Implementation Functioning Ratings assess how effectively each CES function operates in practice. **High Functioning** indicates consistent implementation across providers and geographies, with clear workflows and effective data systems. **Moderately Functioning** indicates generally sound operations with intermittent gaps, inconsistencies, or data quality issues requiring corrective action. **Low Functioning** indicates inconsistent or unclear workflows with frequent delays and significant barriers to participant access.

For ***Equity Analysis***, a **5-percentage-point disparity threshold** is applied throughout this report. Any group outcome that differs from the system average by 5 or more percentage points is flagged for further examination, for percent-based measures. For all other measures a 10 percent disparity threshold is applied.

A disparity flag does not constitute a confirmed inequity; it signals the need for deeper investigation of contributing factors, including potential structural or procedural causes, before a determination is made. The following equity dimensions are disaggregated in most applicable metrics, based on data availability:

- **CES Subpopulation:** ICES (Individuals), FCES (Families), SCES (DV Survivors), VET (Veterans), Transition Age Youth (TAY, Youth)
- **Race and ethnicity:** Black, African American or African, Hispanic/Latina/e/o, Multi-racial, White. The counts for other racial subgroups were too low to assess.
- **Household (HH) type:** Single Adult (Individuals), Family (with children)
- **Age:** TAY (all Household members are under 25)
- **Veteran:** Households with a Veteran member; Households without a Veteran member
- **Survivors of Domestic Violence:** Households that are actively fleeing domestic violence
- **Disabling condition:** Households that include someone with a known disabling condition
- **Service Planning Area (SPA)** and **geographic variation** (North, Central and South SPA)



Section 2: Evaluation Methodology

This evaluation employed a mixed-method, equity-driven evaluation design, consistent with the OC CES Evaluation Plan, including: documentation review and HMIS data analysis; process mapping, and qualitative stakeholder engagement via remote and in-person interviews, focus groups and survey.

2.1 Documentation Review

Governance and policy documentation were reviewed to assess CES design compliance with HUD requirements. Materials reviewed included the current OC CES Policies and Procedures Manual, CoC Program Written Standards, ESG Program Written Standards, participation agreements, and assessment tool documentation. Findings from documentation review are incorporated throughout this report in the compliance sections for each CES function.

See **Appendix F** for a full definition of governance and operational roles across CES entities.

2.2 HMIS and Administrative Data Analysis

Quantitative analysis was conducted using seven HMIS data files exported from the Orange County HMIS system. All files cover data recorded from October 1, 2024 through September 30, 2025, except for the Match Inventory file provided by OCC, which spans July 2024 through March 2026. For the data analysis. data was restricted to activity during October 2024 – September 2025. Table 3-1 summarizes the data sources.

Table 2-1 — HMIS and OCC Data Files Used in Analysis

Data File Name	Records	Description of Records	Key Variables Used	Metrics Supported
All Enrollment Data	85,364	Individual program-enrollment records: a client can have multiple enrollment records across the evaluation period. The 85,364 records span 37,192 unique clients. This file includes all project types recorded system-wide in HMIS and includes CES-participating and non-participating programs.	Project start/exit, destination, demographics, SPA	Coverage, inflow: exit, exit outcomes
All Households	15,913	Unique heads of household (deduplicated by Client ID) with a qualifying SO/ES/TH enrollment starting during the evaluation period. CE, Services Only, HP, RRH, PSH project types are excluded from this count. By CES participation, 8 percent are participating, 8.2 percent are not CES participating, 83.6 percent are SO households (undeterminable) and 0.2 percent have no match.	Household ID, project type code, head of household flag, SPA, demographics	Target population; CNA and HNA coverage rates; assessment progression (CNA→HNA); demographic and SPA disaggregation

Data File Name	Records	Description of Records	Key Variables Used	Metrics Supported
Individual & Family Assessments	10,483 (10,316 HNA / 167 CNA)	Assessment records from the CES Individual and Family assessment instruments, spanning 7,705 unique clients. 9,375 assessments were recorded as "Individual CES Assessment" and 1,108 as "Family CES Assessment." A client may have more than one HNA on record if reassessed during the period.	Assessment level, assessment date, client ID	HNA completion, time to assessment, housing preferences
Bed Reservation Assessments	11,230 (5,534 CNA / 5,696 HNA)	CES-administered assessment records collected through the Bed Reservation process, spanning 5,496 unique clients.	Assessment level, assessment date, modality, location	CNA coverage, CNA monthly trend, CNA→HNA progression
Referrals	25,044	Combines two distinct CES queues: 13,610 records (54 percent) are Bed Reservation queue referrals, and 11,431 records (46 percent) are CES queue referrals. Because a household can generate multiple referral records across both queues during the evaluation period, this figure reflects referral events, not unique households referred. Of these 25,044 records, a subset of 936 referral records (816 unique households) represent referrals to a Housing Opportunity.	Referral date, status, queue, program destination, denial reason	Referral status, denial analysis, BNL queue activity
Current Living Situation	20,309	CES-administered living-situation update. Records spanning 9,765 unique clients, an average of roughly two updates per client over the period. The two most common recorded situations are unsheltered locations (10,255 records) and emergency shelter (9,094 records); 9,594 records (47 percent) were active as of the data extraction.	Living situation category, information date	Literal homelessness classification
CE Events	2,137	CES referral-event records spanning 1,738 unique clients, predominantly referrals to ES (990), PSH (570), and RRH (420). By result: 940 (44 percent) successful/client accepted, 672 (31 percent) client rejected, 459 (21 percent) provider rejected, and 66 with no result recorded.	Event type, referral result, event date	CE referral acceptance rates by program type
Shelter and Housing Opportunities	1,354	Program-opening records spanning ES (464), RRH (438), PSH (345) and PH-Housing Only (90), openings (17 other program openings).	Opening status, program type,	Housing opportunity fill rates, vacancy by SPA

Data File Name	Records	Description of Records	Key Variables Used	Metrics Supported
			SPA, opening date	
Match Inventory (OCC)	1,195	Provided directly by OCC; it tracks CES-based match-level outcomes (acceptance, denial, move-in) for households matched to housing resources.	Date of match, result, housing type, move-in date, HMIS ID	Referral acceptance, denial, match timeliness

2.3 Unit of Analysis and Deduplication

The unit of analysis throughout this report is the households, not the individual. Household identifiers were derived by linking Assessment Enrollment IDs to the All Enrollment file via Enrollment ID. Head-of-Household records were identified using the Entry Screen Head of Household field. For Households with multiple assessment or enrollment records, the most analytically relevant record was selected per metric, for example, the first Housing Needs Assessment (HNA) per participant for HNA-to-referral time, and the first referral in the evaluation period for BNL analysis. The SPA designation was derived from the city of last residence prior to program entry.

2.4 Limitations and Caveats

This evaluation's findings should be interpreted alongside the following limitations:

- **System coverage gap.** The Housing Inventory Chart shows that **CES participation covers 77 percent of available beds and only 52 percent of the entire CoC's programs**. This report's findings describe CES-connected pathways, **not the full county homeless response system.**
- **CES-participation status not available for Street Outreach.** This evaluation's scope is CES-participating programs and pathways. For Emergency Shelter, Transitional Housing and housing programs CES-participation status is documented. No comparable participation designation was provided for Street Outreach. As a result, this evaluation cannot determine what share of Street Outreach-enrolled households were served by a CES-participating outreach team. This is a material scope gap: approximately 70 percent of the SO/ES/TH-HNA population's first crisis-system contact was through Street Outreach.
- **Victim Service Provider (VSP) data are outside HMIS.** VSPs are not permitted to participate in HMIS and instead use a comparable, non-HMIS database. DV survivor metrics throughout this report reflect only survivor activity visible through HMIS-participating pathways and likely undercount total SCES system contact.
- **Small subpopulation cohorts limit disparity determinations.** Several subpopulations analyzed throughout this report, including American Indian or Alaska Native (AI/AN), Native Hawaiian or Pacific Islander (NHPI), Asian/Asian American, and TAY in some specific metrics, were too small in cohort size to support a formal disparity determination, even where descriptive findings are reported. These findings should be read as directional, not conclusive.

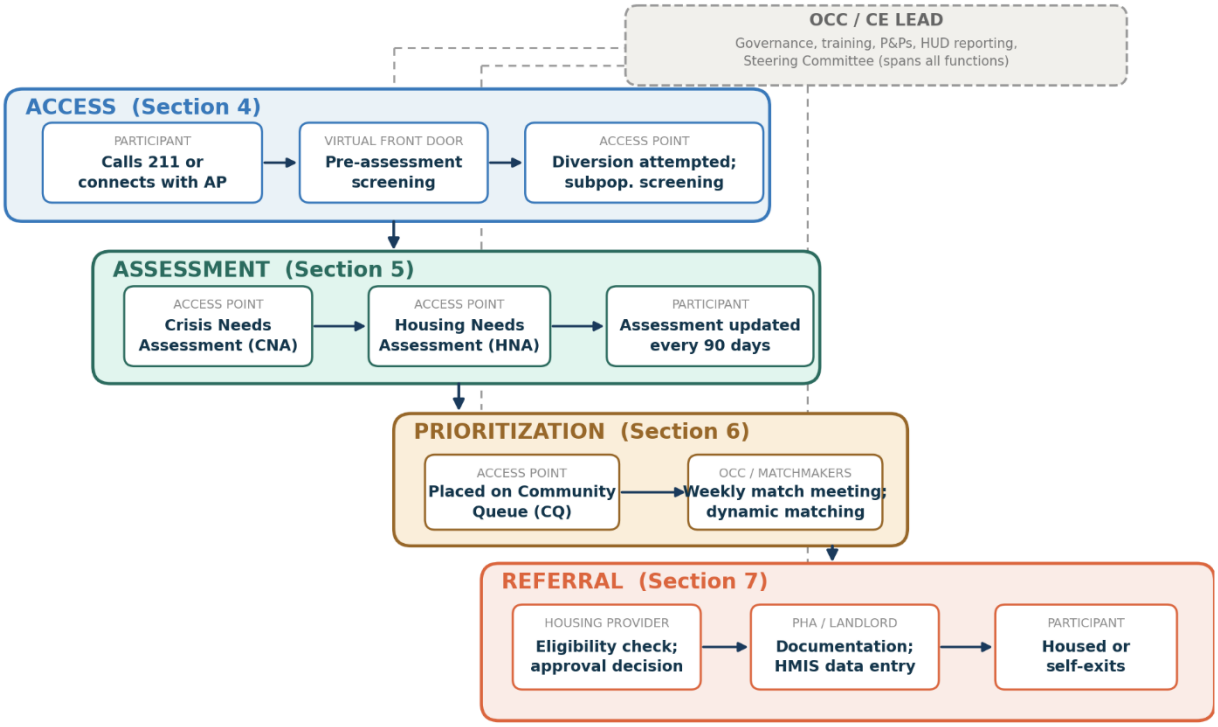
- **Exit destinations outside this evaluation's scope.** This evaluation's exit outcome and return-to-homelessness metrics are built from HUD's Stella P module, which categorizes exits by destination type. A meaningful share of exits fall into "Unknown" or "Other" destination categories, and this evaluation does not attempt to characterize what happened to those households after they left the system. Some of these exits are almost certainly households who resolved their housing crisis through a resource CES does not track and was never designed to track, non-homeless dedicated resources outside the CoC-funded system. The evaluation has no visibility into these outcomes and cannot quantify how many exits they represent. This limitation means the successful exit rates presented are likely conservative, they capture confirmed positive outcomes through CES-dedicated pathways, not the full universe of households who successfully resolved their homelessness by other means.
- **Scope of resource analysis.** Consistent with the approved evaluation scope, the evaluation team examined resource availability from an operational capacity and system-performance perspective. The team compared current and projected demand with available housing and service capacity, identified geographic and population-level gaps, and assessed how resource constraints affect CES access, referrals, housing placement, and system flow.

  The evaluation team did not conduct a comprehensive fiscal inventory or analyze specific funding streams, expenditures, program costs, or funding allocations. Homebase is leading that work through a separate fiscal-mapping project. The teams aligned the two efforts to avoid duplication: this evaluation identifies capacity and performance needs, while Homebase examines how funding flows through the homelessness response system. The CoC and its partners should consider findings from both projects when making future investment decisions.
- **Individual access points and housing providers were not evaluated.** The evaluation team did not directly examine individual provider practices to assess whether providers adhered to CES requirements and expectations.
- **The reentry population is understated in available data.** Prior living situation data shows only 44 participants entering CES directly from jail or prison, which almost certainly undercounts true justice-involved presence in the system, since most individuals cycle through other settings before accessing the homelessness system.
- **Several subpopulations merit additional, focused engagement** to inform implementation of CES evaluation findings and recommendations. In particular, Seniors (21 percent of the target population), people returning from incarceration, gender-diverse and LGBTQ+ individuals, limited English proficiency households, and at-risk (not yet literally homeless) households were not the subject of targeted qualitative engagement in this evaluation and current findings for these populations are based on administrative data only.
- **OCC provided Match Inventory and HMIS-based Referrals measure different points in the referral process and are not directly comparable.** Where the two sources diverge, this report presents both and identifies the source.

Section 3: System Design

The first area of focus for this evaluation is on the documented overall design of the CES. **System Design** encompasses the written policies, governance structures, participation standards, and cross-system coordination frameworks that define how the CES is structured and administered. Figure 1 shows the current design of the OC CES.

Figure 3-1 — OC CES Design



System Design is evaluated through documentation review of CES governance and operational materials and the inflow-to-permanent-exit ratio, which measures the relationship between the number of households entering the crisis response system and the number achieving a permanent housing exit, including exits to permanent housing without further program enrollment or support. This cross-cutting indicator reflects the throughput capacity of the CES.

3.1 Key Findings — Design Compliance

Documentation review found the OC CES Policies and Procedures Manual (P&P) to be largely comprehensive and consistent with HUD CPD-17-01 requirements, though critical deficiencies exist. The P&P addresses affirmative marketing, non-discrimination and Equal Access requirements, subpopulation-specific pathways, and privacy protections for DV survivors. Of the five design items rated, three were rated Compliant and two were rated Partially Compliant, yielding **a compliance rate of 60 percent** and an overall Design rating of **Noncompliant**.

3.1.1. Inflow-to-Permanent Exit Ratio

The inflow-to-permanent exit ratio is a cross-cutting system capacity indicator measuring the volume of households entering the crisis response system relative to the volume achieving a permanent housing exit during the same period. While a ratio of 1:1 would represent perfect throughput, one housing exit for every new entry, not every household exits to permanent housing through a CES-coordinated pathway as some households self-resolve their crisis or access other solutions that meet their needs (e.g., assisted living). Ratios well above 1:1 indicate that the system is accumulating unhoused households faster than it is resolving them through permanent housing exits specifically.

During the evaluation period, **34,595 unique households entered a crisis response (inclusive of HP) or housing program** while **5,997 households exited to permanent housing destinations through any program type**, yielding a **system-wide inflow-to-permanent exit ratio of 6:1** (Table 3-1). For every one household that achieved a permanent housing outcome, nearly six new households entered the crisis response system.

The 5,997 exits include all program types, not only CES-pathway exits. HP (18.8 percent) and Services Only (22.1 percent) together account for 40.9 percent of exits. HP exits represent households stabilized before entering literal homelessness, a meaningful system outcome, but a different process from CE assessment and referral. **When both entries and exits are restricted to the same CE-assessed pathways (excluding HP, Services Only and Coordinated Entry from both sides of the calculation), the system-wide ratio rises from 6:1 to 13:1 (26,968 entries / 2,030 exits).** The Family ratio of 1.2:1 also reflects the significant role of HP for families. This ratio also does not capture households who exit to Unknown or Other destinations that may reflect self-resolution through non-dedicated resources outside CES's visibility.

Table 3-1 — Inflow-to-Permanent Exit Ratio by Quarter

Category	New Entries	Permanent Exits	Inflow to Permanent Exit Ratio
Q1 (Oct-Dec 2024)	9,368	1,473	6.36
Q2 (Jan-March 2025)	9,849	1,644	5.99
Q3 (Apr-June 2025)	9,301	1,432	6.50
Q4 (July-Sept 2025)	6,077	1,448	4.20
System Total	**34,595**	**5,997**	**5.77**

Quarterly ratios remained largely consistent through the first three quarters of the evaluation year at approximately 6:1. The Q4 ratio of 4:1 reflects a meaningful decline in new entries, likely driven by seasonal patterns and data timing, rather than a sustained improvement in housing outcomes.

Equity Considerations

The household type breakdown reveals a striking disparity. The single adult system operates at a **7.7:1 ratio** (Table 3-2)**,** meaning for every housing exit, more than seven new single adults enter the crisis system. The family system, by contrast, operates at near-equilibrium at 1.2:1, reflecting the combined effect of a smaller entry volume and likely a proportionally larger inventory of family-appropriate permanent housing resources.

The SPA-level ratio variation also warrants attention. The South SPA's lower ratio (2.3:1) reflects a smaller entry volume in that geography, not a higher rate of shelter-to-permanent-housing placement. The "Data Not Collected" SPA category, representing 3,593 households (10percent of entries) with no recorded city of prior residence carries the worst ratio at 9.4:1. Based on the CES design, these households may be family households that can access any SPA, countering the better result for specifically family households identified above.

Table 3-2 – Inflow-to-Permanent-Exit Ratio

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: No Disparity (≤5pp) | Emerging (5–10pp) | Significant (>10pp).							
Resource: Inflow to Permanent Exit Ratio							
Resource	Inflow to Permanent Exit Ratio	Black / African American	4.2	5.8	-28%	No Disparity	Low — Track
Resource	Inflow to Permanent Exit Ratio	Hispanic / Latino	6.1	5.8	5%	No Disparity	Low — Track
Resource	Inflow to Permanent Exit Ratio	White	5.8	5.8	0%	No Disparity	Low — Track
Resource	Inflow to Permanent Exit Ratio	Multi-racial	3.9	5.8	-33%	No Disparity	Low — Track
Resource	Inflow to Permanent Exit Ratio	People with Disabilities	5.6	5.8	-3%	No Disparity	Low — Track
Resource	Inflow to Permanent Exit Ratio	Youth (Under 25)	3.7	5.8	-36%	No Disparity	Low — Track
Resource	Inflow to Permanent Exit Ratio	Veterans	1.9	5.8	-67%	No Disparity	Low — Track
Resource	Inflow to Permanent Exit Ratio	DV Survivors	4.4	5.8	-24%	No Disparity	Low — Track
Resource	Inflow to Permanent Exit Ratio	Singles	7.7	5.8	33%	Significant	Medium — Monitor Closely
Resource	Inflow to Permanent Exit Ratio	Families	1.2	5.8	-79%	No Disparity	Low — Track
Resource	Inflow to Permanent Exit Ratio	North SPA	6	5.8	3%	No Disparity	Low — Track
Resource	Inflow to Permanent Exit Ratio	Central SPA	6.7	5.8	16%	Significant	Medium — Monitor Closely
Resource	Inflow to Permanent Exit Ratio	South SPA	2.3	5.8	-60%	No Disparity	Low — Track
Resource	Inflow to Permanent Exit Ratio	Data Not Collected SPA	9.4	5.8	62%	Significant	Medium — Monitor Closely

Table 3-3 below presents, in addition to the above table, equity findings for the Inflow-to Permanent-Exit ratio across key demographic dimensions. For each subgroup, two assessments were conducted: performance relative to the system average, and performance relative to the subgroup's direct counterpart—for example, veterans compared to non-veterans, or TAY compared to non-TAY. Comparing subgroups to their direct counterparts, rather than only to the system average, surfaces disparities that can be masked when a large dominant group pulls the system average toward its own rate. Disparity flags reflect the larger of the two gaps: No Disparity indicates no meaningful difference in either comparison; Flag for Monitoring indicates an emerging gap that warrants tracking; Equity Concern or Significant indicates a gap large enough to require active attention and corrective action.

For this metric, a lower ratio indicates better system throughput. Groups with higher ratios face greater relative pressure between new entries and housing exits and are flagged accordingly.

Table 3-3 – Inflow-to-Permanent Housing Exit Ratio Equity Assessment

Dimension	Finding	Disparity Flag
Race / Ethnicity	Hispanic/Latino subpopulation is slightly above the system average (6.0:1). The most pronounced negative counterpart gap is the AI/AN ratio (6.8:1). However, the subpopulation is significantly smaller than the rest of the subpopulations (51 permanent exits) and a disparity assessment is difficult to make. Black/AA (4.2:1), Asian/AA (4.6:1), NHPI (4.2:1), and Multiracial (3.9:1) ratios are below it. "Other/Unknown" ratio (23.8:1) reflects a data quality concentration, not a population-level finding.	**No Disparity**
Household Type	Single adults face a dramatically worse ratio (7.7:1) than the system average and relative to families (1.2:1). Families are near equilibrium partly due to Homelessness Prevention exits; single adults, who represent 94 percent of all entries, absorb the structural housing supply deficit	**Significant**
Veteran Status	Veterans are near equilibrium (1.9:1), the best ratio of any binary subgroup, while non-veterans ratio (5.4:1) closely tracks the system average. Veteran-dedicated resources produce meaningfully different outcomes for this population.	**No Disparity**
Disability Status	Participants with a disabling condition are near the system average (5.6:1). Non-disabled participants have a notably better ratio (3.1:1). This likely reflects that non-disabled households are more likely to exit on their own before entering the CES pipeline. Disabled households, who predominantly require PSH, face a supply-constrained pathway (a large cohort of participants are missing this data element).	**Flag for Monitoring**
DV Survivor Status	DV survivors have a modestly better ratio (4.4:1) than non-DV survivors (4.9:1). Both groups are below the system average (a large cohort of participants are missing this data element).	**No Disparity**
Youth / TAY	TAY participants have a better ratio (3.7:1) than non-youth (5.9:1). TAY's lower ratio likely reflects a combination of shorter homelessness episodes and a higher proportion of RRH exits, rather than greater availability of permanent housing specifically for youth.	**No Disparity**
Geography (SPA)	North SPA (6.0:1) and Central SPA (6.7:1) ratios are near or above the system average. South SPA ratio (2.3:1) is the lowest ratio. Households with no SPA on record have the worst ratio (9.4:1), compounding the data quality gap identified across sections – some of these are households are likely families that are not assigned to a SPA.	**Flag for Monitoring**

3.1.2. Stakeholder Feedback

Data sources for the stakeholder feedback and qualitative findings in the report consist of one survey with 69 responses, 11 interviews, and 12 focus groups, including 7 focus groups with 74

participants representing people with lived experience (PLE). Those are described here as they relate to both how CES is designed and how it operates. Later sections incorporate additional key stakeholders feedback relevant to CES functionaity.

Strengths and Positive Practices

Stakeholders identified several practices of sufficient strength to merit deliberate protection and expansion.

- **The effective caseworker.** PLE consistently described a responsive, consistent caseworker as the most impactful element of their CES experience — one they characterized as life-changing. This relationship-based navigational support is itself a system asset that depends on staff retention and manageable caseloads.
- **The veteran coordination model.** Multiple non-veteran providers named the veteran CES pathway as the most effective component of the county's coordinated entry system. Its effectiveness was attributed not to dedicated vouchers alone but to an operational model built around a by-name list with real case conferencing, a match notification process that notifies every party connected to a veteran simultaneously, a Community Resource Center functioning as a single point of contact, VA outreach embedded in community shelters, and co-enrollment with RRH services to support successful placement. The model does have documented gaps — veterans are not always identified at non-veteran access doors, and warm handoffs are not automatic at every program boundary — but it remains the clearest working example of what a coordinated, end-to-end CES pathway looks like. However, the veteran CES largely exists outside of the OC CES, as the OC CES Veteran Registry.

> "Whatever the county's doing with veterans, they're doing better than anyone else, as far as I can tell… and the emergency-shelter CES pilot was extraordinarily impressive. They're a very proactive group, very equity-minded, and they use their data with great power." - Housing developer focus group participant

- **The CES 2-for-1 pilot and co-located service fairs.** The OCC formalized a 2-for-1 Match Policy in November 2025, establishing OCC-approved criteria under which a Housing Provider may request that two households from the Community Queue be matched to a single unit, a Primary and a Secondary, as a safeguard against application failure. Requests are limited to units vacant and move-in ready for at least 15 days, or newly opened properties needing to meet an occupancy target within 60 days and require OCC approval on every submission. This policy was implemented at the beginning of 2026, at the current time is no longer operational and no successful 2 for 1 match was completed during the pilot timeframe. Providers report that insufficient information was shared to fully operationalize the pilot.

  Frontline staff praised co-located 'same-day solutions' fairs and access points (the Costa Mesa model 'the Hub') that let participants reach many partners at once.

- **Match meetings, SPA administrators, and data culture.** Weekly match meetings, case conferencing, office hours, and provider trainings were identified as critical connective tissue. SPA administrators received consistent praise for their responsiveness. Stakeholders credited CES Leadership (OCC and contracted-provider staff who administer CES's day-to-

day operations; see Appendix E) with meaningful transparency and a proactive, equity-conscious approach to data use.

System Challenges and Opportunities for Improvement

Provider and leadership respondents raised the following systemic concerns:

- **Document readiness and matchability.** Participants placed in the queue are often not document-ready at the point of match, causing delays and failed placements. Stakeholders recommended building document preparation support into the CES process earlier and making a clear distinction in the system between households that are "in the queue" and those that are "matchable" or document ready.
- **Post-match navigation.** A "responsible provider" and warm-handoff protocol after match acceptance is largely absent. Stakeholders recommended developing a more explicit case-conferencing policy and protocol to support successful placement after match.
- **Data visibility at the leadership level.** Housing developers reported that Orange County leadership and the CoC board could not access data on failed matches or vacancy duration. Stakeholders recommended making these indicators visible and operationalizing 2-for-1 matching practices rather than relying on ad hoc requests.
- **Prioritization model.** Respondents recommended revisiting the dynamic-match vote structure and exploring tiered queues organized by housing type and acuity, alongside length of homelessness.
- **Access infrastructure.** Stakeholders cited a need to fund and expand access points, simplify the 211 front door, and add self-referral options.
- **Communication with participants.** The queue process is not clearly communicated to participants in plain language. Several PLE respondents described confusion about what the queue meant, what documentation they were gathering it for, and what happened after their assessment. Reducing caseworker turnover and caseloads was also cited as a prerequisite for more consistent participant communication.
- **Cross-system alignment.** Stakeholders identified the need for better alignment of funding, data systems, and confidentiality requirements across BHSA, CalAIM, and HMIS, and called for a more empowered governance table where policy can be made transparently and efficiently.

At least one major provider reported disengaging from county CES due to persistent unresolved operational concerns. This represents a material risk to system-wide coverage and should be addressed through governance improvements (see REC-3, REC-6, and REC-7).

Governance and Accountability

A recurring theme across stakeholder sources was uncertainty about how to influence system policy and limited confidence in existing feedback pathways. CES Leadership respondents specifically cited:

- Uncertainty about where to bring forward improvement recommendations
- The absence of a clearly defined forum for discussing system design changes

- Multi-layer approval requirements, silos and bureaucracy that slow implementation of operational improvements
- Concern about overstepping organizational boundaries when raising issues

Several CES Leadership suggested that more structured feedback loops between CES operators, HMIS administrators, access points, and County leadership would meaningfully improve communication and responsiveness (see REC-5 and REC-6).

Continuous Quality Improvement

CES Leadership described several active quality improvement activities:

- Tracking match acceptance rates.
- Reviewing reasons for unsuccessful referrals.
- Monitoring referrals that remain unresolved beyond 90 days.
- Reviewing feasibility and resource constraints through leadership and steering committee discussions.
- CES Leadership indicated that discussions with housing authorities continue regarding implementation challenges and referral practices.

While these activities reflect meaningful monitoring, stakeholders indicated that findings do not consistently translate into formal policy change. The absence of a structured CQI framework with defined improvement cycles, response protocols, and accountability mechanisms limits the system's ability to translate data into action (see REC-5 and REC-6).

Roles and Responsibilities

Although CES Leadership generally viewed CES operations positively, responses suggested some ambiguity regarding:

- Responsibility for housing provider relationships versus access point oversight.
- Authority to modify policies or procedures.
- Escalation pathways for operational concerns.

Change Management and System Redesign

CES Leadership characterized the system as having a relatively low tolerance for major changes. While County leadership was described as receptive to feedback, respondents indicated that implementing policy or operational changes is often difficult and slow.

CES Leadership expressed concern about potential organizational changes associated with future CES administration and the operational burden such transitions could create.

3.1.3. Partial Compliance Items

1. Prioritizing and referring households consistent with HUD's severity-of-need requirements

The current OC CES written standards organize prioritization around homelessness status, chronicity (length of time homeless), and disability presence but do not establish a structured severity-of-need assessment and prioritization mechanism incorporating HUD-specified factors.

This represents a design-level gap, the existing standard does not meet the substantive content HUD requires.

The CES P&Ps establish four prioritization categories - chronically homeless households, households with a chronic disability, households without a disability, and households at risk of homelessness - and the ESG Written Standards confirm that prioritization factors are intended to direct limited resources to the most vulnerable households first.

The written standards do not incorporate HUD's **severe service needs assessment and prioritization component**. HUD guidance (CPD-17-01) requires that the coordinated entry process derives an indicator of risk, vulnerability, or need based on seven categories, including one for locally determined needs, that, along with case conferencing and other information, is used to ensure people with more severe service needs and higher levels of vulnerability are prioritized ahead of those with less severe needs, to the maximum extent feasible. Often, this is operationalized in the form of an assessment that is scored, then combined with other information and used dynamically to continually prioritize an ever changing pool of eligible households for the next available opening.

Permitted assessment factors include functional impairments requiring a significant level of support, high utilization of crisis or emergency services, the extent to which a household, particularly youth and children, is unsheltered, vulnerability to illness, death, or victimization, risk of continued homelessness, and other factors determined locally. This assessment component does not need to take the form of a point-based scale.

2. VA SSVF participation

It is not clear from available documentation whether VA SSVF programs are required to participate in the OC CES. The terms of SSVF participation in HMIS, which is required by the VA, should be clarified and documented through direct engagement with VA partners (see REC-4).

3.1.4. Full Compliance Items

The following three items were rated Fully Compliant:

1. The OC CES has a comprehensive Policies and Procedures document addressing all required design elements - scope, partner roles, system mechanisms, governance structures, and documentation requirements - reviewed for completeness against HUD CPD-17-01.
2. CES is affirmatively marketed to ensure all people experiencing homelessness, across all subpopulations and geographies, are aware of and able to access the system. Marketing materials are available in accessible formats including multilingual resources and materials for individuals with limited English proficiency. This assessment is based on the evaluation team's limited review, the actual implementation of these requirements were not assessed as they were out of the scope of the evaluation.
3. Non-discrimination and Equal Access requirements are appropriately designed across CES functions and participating providers, including explicit protections for gender identity, sexual orientation, disability, and all other protected characteristics under the Anti-Discrimination Policy. A documented grievance and anti-retaliation process is in place. This assessment is based on the evaluation team's limited review, the actual implementation of these requirements were not assessed as they were out of the scope of the evaluation.

COMPLIANCE RATING: NONCOMPLIANT (<75%)

The OC CoC should revise the CES P&Ps and the CoC and ESG Written Standards to incorporate a formal severity-of-need assessment and prioritization consistent with HUD requirements. Documentation confirming or establishing the terms of SSVF participation should be completed and incorporated into the CES P&Ps.

3.2 Discussion and Interpretation

The OC CES is formally structured to meet HUD design requirements. Written standards, non-discrimination policies, and subpopulation-specific pathways are in place, and the 60 percent compliance rate reflects a substantively complete system at the design level. However, one of the two Partially Compliant findings, the absence of a formal severity-of-need scoring component, is a gap in the policies and written standards. Addressing it requires revising the system policies and standards, while the operational and resource-level gaps identified elsewhere in this section require investments beyond documentation review.

The missing severity-of-need assessment and prioritization component has direct consequences for how the system's scarcest resource, permanent housing, gets allocated. As the inflow-to-permanent exit ratio below demonstrates, the OC CES resolves only a fraction of the households entering the crisis response system in any given period. When demand substantially outstrips supply, the mechanism used to decide who is served first becomes the primary determinant of equity in outcomes. HUD's severity-of-need requirement exists precisely for this scenario: it directs CoCs to ensure that, to the maximum extent feasible, people with more severe service needs and higher vulnerability are prioritized ahead of those with comparatively lower need.

Without a standardized assessment mechanism incorporating functional impairment, crisis service utilization, unsheltered status, and vulnerability to harm, the OC CES has no formal, auditable basis for demonstrating that its limited housing resources are reaching the households who need them most, independent of whatever informal practices may occur in case conferencing or provider-level decision-making. This finding connects directly to the Assessment function (Section 5), where the current HNA instrument captures only housing interest rather than a structured vulnerability profile, and to Prioritization (Section 6), where the practical effect of this design gap on who actually advances through the system is most directly observable.

The inflow-to-permanent exit ratio of 6:1 is the quantitative anchor for understanding that gap. The system is absorbing nearly six new households experiencing homelessness for everyone it resolves. Even if every HUD compliance requirement were fully met and every best practice implemented within the existing footprint, the structural deficit in permanent housing supply would prevent the system from achieving meaningful improvement.

The single adult system, which represents 94 percent of system entries, operates at a 7.7:1 ratio. There is no operational or procedural change within CES that can close a gap of this magnitude without a corresponding increase in affordable permanent housing availability. The CES is designed to prioritize access to a scarce resource; it cannot generate the resource itself. The absence of severity-of-need scoring compounds this dynamic specifically within the single adult population, where competition for the limited housing supply is most acute and the cost of an unstructured prioritization process is highest.

Two additional features of the data merit attention in the system design context. First, the quarterly ratio was essentially stable across the first three quarters of the year, suggesting the capacity gap is structural and not improving. Second, the South SPA, which has the most constrained access infrastructure and lowest Crisis Needs Assessment (CNA) coverage rate, shows the lowest inflow-

to-permanent exit ratio (2.3:1). This appears to reflect that the South SPA has a proportionally different program mix relative to total entries, rather than superior housing placement performance. The interpretive risk of reading sub-group ratios in isolation without understanding program type composition is significant and should be addressed in future reporting by presenting program-type-adjusted ratios alongside the headline figures.

The stakeholder evidence reinforces the structural reading. The veteran pathway, which is the one CES sub-system that functions near-optimally, works because it has both a coordinated intake process and dedicated, mission-specific housing resources (SSVF and HUD-VASH vouchers) which are coordinated via the CoC CES alongside VA-led CE processes and by-name list management. The absence of an equivalent resource dedicated to single adults experiencing non-veteran chronic homelessness is the defining constraint on system performance.

3.3 Recommendations (REC)

REC-1: The OC CoC should revise the CES P&Ps and the CoC and ESG Written Standards to incorporate a formal severity-of-need assessment and prioritization component consistent with HUD's **Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System (CPD-17-01)**,[3] which outlines the requirements for CES and related obligations for CoCs and recipients of CoC Program and ESG Program funding.

The revised standards should define how severe service needs and vulnerability are assessed across the areas listed in the Notice, including functional impairment requiring significant support, high utilization of crisis services, unsheltered status (with particular attention to youth and children), vulnerability to illness, death, or victimization, and risk of continued homelessness, are incorporated into prioritization decisions, to ensure that the most vulnerable households are prioritized ahead of those with comparatively lower need. As noted in Section 3.1.3, this does not require a numeric point-based tool; a structured assessment that consistently differentiates risk, vulnerability, or need across the factors above satisfies the intent.

While HUD no longer requires a particular order of priority be used for HUD funded PSH[4], the severity-of-need scoring is no longer a HUD compliance requirement, its absence from the CES model is a design-level gap that propagates through every downstream function. The evaluation team recommends that the OC CoC prioritize households with the most severe service needs, including chronic homeless and long-term homeless, and adopt the severity of service needs as an explicit, scored marker for prioritization decisions. Length of time homeless should be incorporated as one factor among several, alongside severity of service needs, and should account for length of time in TH as well as time literally homeless.

[3] https://www.hud.gov/sites/documents/17-01cpdn.pdf

[4] In July 2016, HUD issued Notice CPD-16-11, which encouraged CoCs to incorporate into their written standards a recommended order for prioritizing eligible households for CoC-funded permanent supportive housing (PSH), emphasizing people experiencing chronic homelessness and those with the longest histories of homelessness and most severe service needs. The notice also addressed the use of coordinated entry, standardized assessment, and a prioritized waiting list to support PSH referrals. On November 21, 2025, HUD issued Notice CPD-25-06, formally withdrawing CPD-16-11 and the earlier CPD-14-12 for all CoC Program recipients. Although CoCs are no longer subject to the specific federal priority sequence recommended by CPD-16-11, they must continue to establish written standards for prioritizing assistance and comply with applicable regulations, grant requirements, nondiscrimination protections, and project eligibility or dedication requirements.

HUD's policy change gives the Orange County CoC both the responsibility and an opportunity to reassess and clearly document a locally appropriate, data-informed, and equitable prioritization framework through REC-1. This revision should be coordinated with the Prioritization function findings (Section 6) and should be reflected consistently across both the CES P&Ps and the written standards to maintain alignment.

REC-2: The OC CoC should build document preparation support into the CES process earlier, prior to match, rather than relying on document readiness to surface as a barrier at the point of referral. This should include establishing a clear system-level status distinction between households that are "in the queue" (placed on the BNL but not yet document-ready) and "matchable" (document-ready and eligible for referral), tracked in HMIS, so that access points and matchmakers can prioritize document-readiness support for households approaching matchable status.

REC-3: The OC CoC should formalize a "responsible provider" model, including defined responsibilities, and warm-handoff protocol that designates clear ownership of each household from match acceptance through enrollment. This should include a structured case-conferencing policy specifying when conferencing is required, who participates, and what triggers escalation, addressing the currently absent post-match navigation function identified later in the report.

REC-4: The OC CoC should clarify and formally document in the CES P&P the terms of VA programs participation in the OC CES, including SSVF, GPD and HCHV.

REC-5: The OC CoC should formalize a **Continuous Quality Improvement (CQI) framework** that receives all CES feedback loops and data collection, ensures performance data, stakeholder feedback, system outcomes, and the results of this evaluation are systematically reported out, reviewed and translated into action. The framework should define: a structured improvement review cycle (minimum quarterly); a clear process for elevating findings to policy decisions; opportunities for system improvement and actionable improvement plans; designated accountability for follow-through and improvement plans; and a mechanism for communicating outcomes of improvement efforts back to stakeholders. The inflow-to-permanent housing exit ratio and CNA coverage rate should be core standing indicators in the CQI framework.

The CQI framework should also include a defined protocol for updating the CES Policies and Procedures and monitoring their implementation and updating staff training materials following policy or instrument changes, with a required completion timeline and tracking mechanism to ensure consistent implementation across access points.

REC-6: The OC CoC should establish formal, transparent mechanisms for stakeholder input and policy development. Current pathways are perceived as unclear or ineffective by both operators and providers. Structured mechanisms should include: a defined process for submitting and tracking improvement recommendations; a regular stakeholder input cycle tied to the CQI framework; and a public-facing summary of how recommendations are reviewed and resolved. Inclusive feedback mechanisms should also address the perspective of PLE beyond the focus group format.

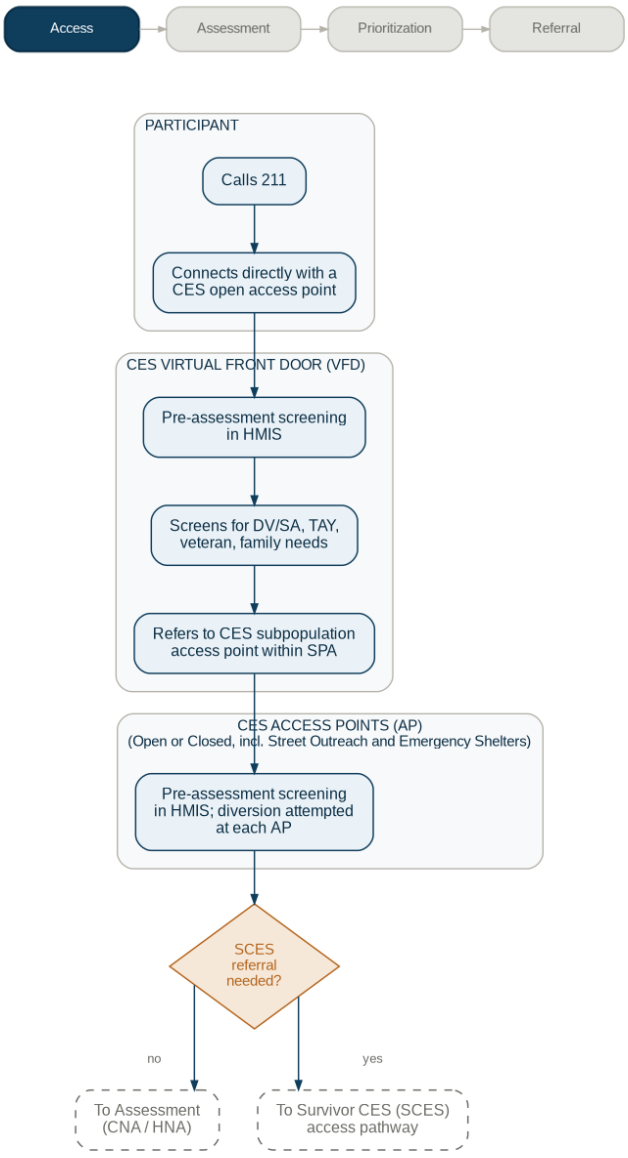
REC-7: The OC CoC should clarify governance roles, decision-making authority, and responsibility for system changes across all CES-affiliated entities. Role ambiguity, particularly around housing provider relationships, access point oversight, and policy modification authority, creates delays and reduces accountability. A governance map with clearly defined roles, escalation pathways, and decision rights should be documented and disseminated to all CES-affiliated organizations. CoC board meetings should be structured to enable substantive policy discussion, not only information reporting.

Section 4: CES Function 1 — Access

Access is the initial point of engagement with the CES, encompassing all pathways through which individuals and households experiencing or at risk of homelessness come into contact with an access point and receive a standardized screening or assessment. The evaluation of Access examines geographic coverage, timeliness of assessment, equity of access, and compliance with design standards.

The Access function is evaluated primarily through the CNA, which is the standardized crisis screening administered at the point of first contact with the CES. Coverage metrics in this section measure CNA reach within the target population.

Figure 4-1 — CES Access Design



OCC has indicated that the CNA is not an assessment the CoC intentionally directs Access Points to use, and that where a "Crisis Needs Assessment" assessment type appears in HMIS, it may in some cases reflect a data-entry selection made in error rather than the deliberate administration of a distinct crisis-screening instrument. This finding affects coverage rates as well as how the corresponding CNA→HNA progression analysis in Section 6 should be interpreted: the coverage rates below may reflect an artifact of the HMIS assessment-type field rather than a consistent record of purposeful crisis screening. The findings that follow are presented as derived directly from the HMIS data, with this caveat noted for reader interpretation. This caveat concerns the reliability of CNA-labeled HMIS records as a measurement tool, it does not diminish the underlying need for a structured crisis needs assessment function at first contact.

4.1 Key Findings — Access Compliance

Documentation review found the OC CES access design to be compliant with HUD requirements. Policies address geographic coverage across all three SPAs, the 'no wrong door' principle, subpopulation-specific access pathways, DV confidentiality protocols, 24/7 crisis access through the Virtual Front Door, and non-discrimination requirements. Of 11 Access compliance items rated, 6 were rated Compliant, 4 were rated Partially Compliant, and 1 was rated Noncompliant. This yields a **compliance rate of 55 percent**, placing Access in the **Noncompliant** range overall.

4.1.1. Noncompliant Item 1 — CES Coverage

The single noncompliant item concerns CES coverage. The CES coverage rate measures the proportion of households with an Emergency Shelter (ES), Street Outreach (SO), or Transitional Housing (TH) program enrollment that also received a CNA during the evaluation period. Of the 15,913 unique heads of household with a qualifying program enrollment between October 1, 2024, and September 30, 2025, **2,229 received a CNA, a coverage rate of 14 percent** (Table 4-1). This means **86 percent of households enrolled in crisis response programming had no CNA on record.** The 14 percent coverage rate falls materially below the standard for an accessible CES, which should be above 90% (see REC-8-9). This figure is subject to the CNA-reliability caveat noted above.

When HNAs are included, 6,356 households (40 percent) received at least one form of CES assessment. This broader figure reflects households who entered the prioritization process through the HNA pathway, often bypassing the CNA entirely[5]. The meaning and implications of this pattern are addressed in Section 5.

[5] The 14% CNA coverage rate and the 40% assessment rate reflect different population definitions. The CNA coverage rate is the compliance-evaluated metric for the Access function. The 40% figure encompasses all assessment types and is presented for context.

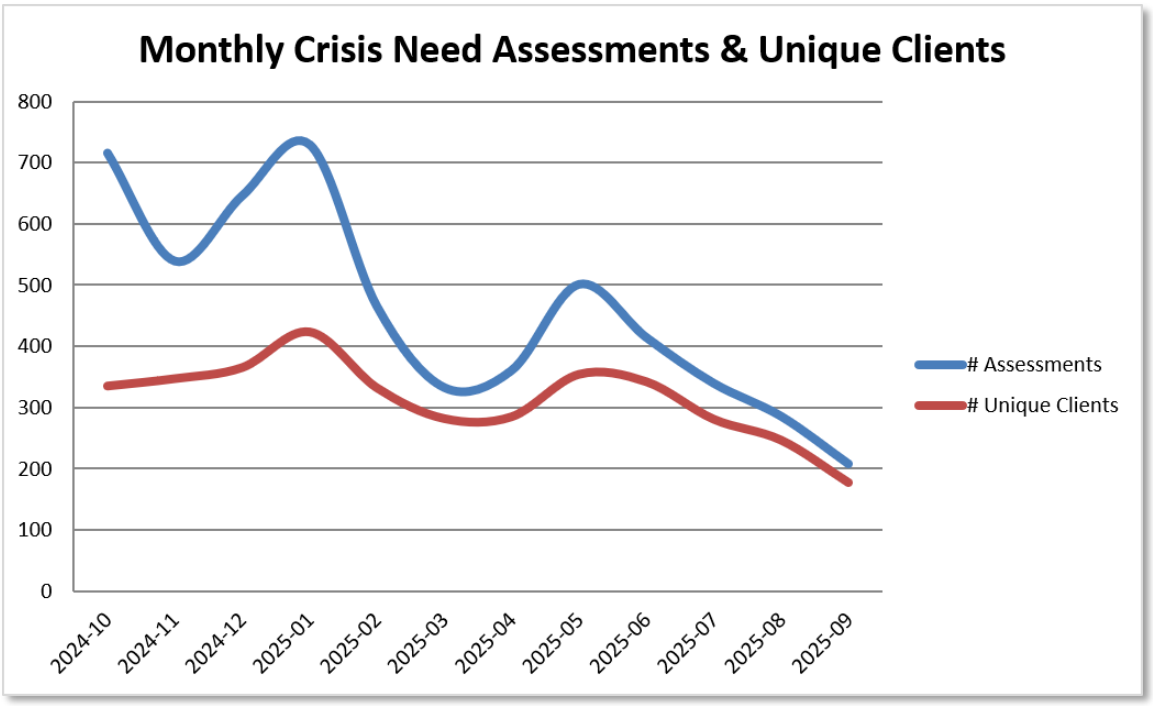
Table 4-1 — CES CNA Coverage Rates

Category	Total Household Enrollments	Households Assessed	Coverage Rate
System Total	**15,913**	**2,229**	**14%**
Single Adult	15,357	2,100	14%
Family	556	129	23%
Street Outreach	12,342	1,411	11%
Emergency Shelter	3,435	803	23%
Transitional Housing	105	13	12%

Monthly Distribution

CNA volume declined materially over the evaluation period. Among all CNA participants, unique participants assessed per month fell from **335 in October 2024 to 178 in September 2025, a 47 percent decrease** (Figure 4-2).

Figure 4-2 — CES CNA Monthly Distribution



Volume peaked in January 2025 at 423 unique participants before declining through the remainder of the period. On average, participants received **2.4 CNAs** during the timeframe, reflecting recurring crisis screenings as households cycle through shelter placements. The large majority of CNAs, **75 percent, were conducted in person**, with the remainder conducted by phone (22 percent) or virtually (1 percent).

The sustained decline in monthly CNA volume over the evaluation year is consistent with stakeholder reports of access points switching from open to closed and staffing constraints. Figure

5-3 maps the access points within the County and indicates which are open versus closed (serving only their own participants).

4.1.2. Geographic Distribution

The Central SPA accounts for the largest share of CNA activity (55 percent), followed by the North SPA (39 percent). The South SPA accounts for only three percent of all CNAs. Viewed as coverage rates, the pattern is pronounced: the Central SPA achieves a 20.9 percent coverage rate, more than **twice the 7.2 percent rate** recorded in the South SPA (Table 4-2). This geographic disparity in coverage rates is consistent with the concentration of access point capacity in the northern and central areas of the county, as reflected in Figure 4-3. It is not explained by population size alone and additional demographic analysis of sub-regional characteristics within Orange County was not completed. However, the South SPA's smaller target population (814 households) would be proportionally easier to cover if access point capacity existed.

The 3,172 households (20 percent of the target population) with no SPA on record represent a data quality gap and are effectively invisible to geographic coverage monitoring.

Figure 4-3 — Geographic Distribution of Access Points (AP) (purple = closed AP; orange = open AP)

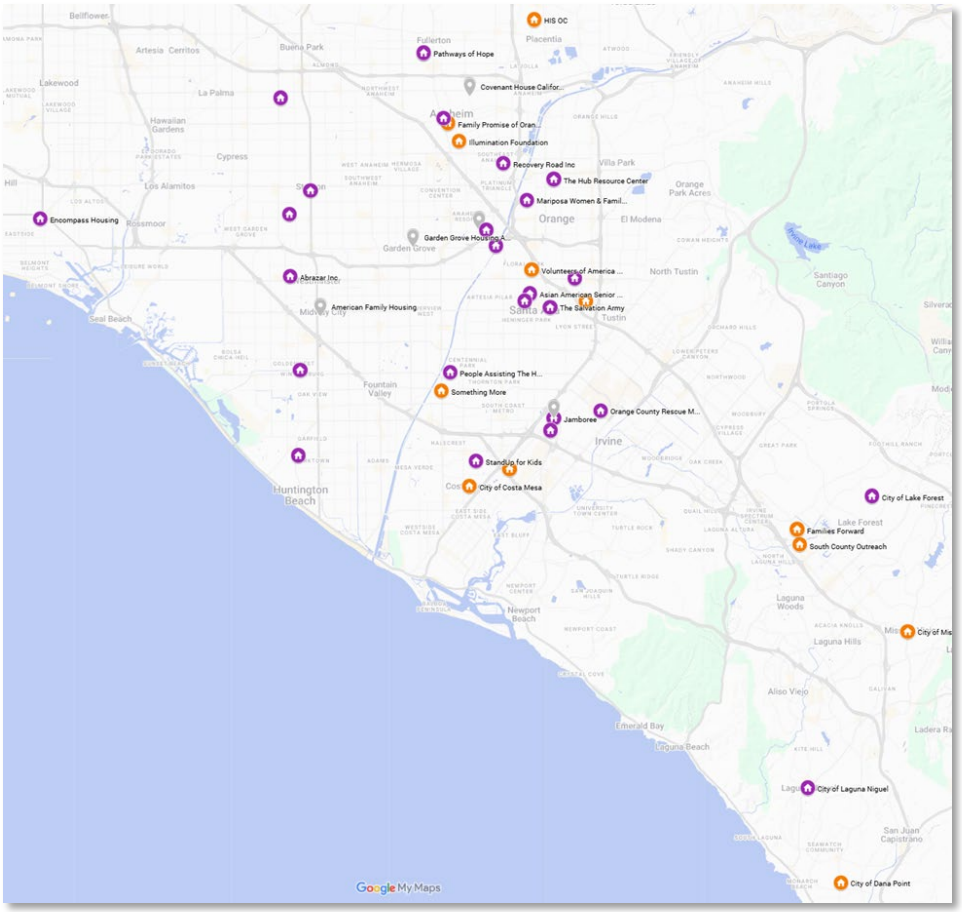


Table 4-2 — Geographic Distribution of CES CNAs

SPA	# of Households Assessed	% of Total	Total Household Enrollments	Coverage Rate
North SPA	867	39%	6,066	14%
Central SPA	1,224	55%	5,861	21%
South SPA	59	3%	814	7%
Data Not Collected	79	4%	3,172	3%
System Total	**2,229**	**100%**	**15,913**	**14%**

Equity Considerations

While racial and ethnic disparities in CNA coverage were not identified (Table 4-3), the geographic inequity between the South SPA and other SPAs represents a structural access barrier. Stakeholders confirmed that geographic variation in housing opportunities also disadvantages southern county residents, compounding the access gap.

Table 4-3 — CES CNA Coverage Rates

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: No Disparity (≤5pp) | Emerging (5–10pp) | Significant (>10pp).							
Access: CES Coverage Rate							
Access	CES Coverage Rate	Black / African American	15%	14%	1%	No Disparity	Low — Track
Access	CES Coverage Rate	Hispanic / Latino	15%	14%	1%	No Disparity	Low — Track
Access	CES Coverage Rate	White	15%	14%	1%	No Disparity	Low — Track
Access	CES Coverage Rate	Multi-racial	22%	14%	8%	No Disparity	Low — Track
Access	CES Coverage Rate	Asian or Pacific Islander	14%	14%	0%	No Disparity	Low — Track
Access	CES Coverage Rate	People with Disabilities	22%	14%	8%	No Disparity	Low — Track
Access	CES Coverage Rate	Youth (Under 25)	13%	14%	-1%	No Disparity	Low — Track
Access	CES Coverage Rate	Veterans	11%	14%	-4%	No Disparity	Low — Track
Access	CES Coverage Rate	DV Survivors	23%	14%	9%	No Disparity	Low — Track
Access	CES Coverage Rate	Singles	14%	14%	0%	No Disparity	Low — Track
Access	CES Coverage Rate	Families	23%	14%	9%	No Disparity	Low — Track
Access	CES Coverage Rate	North SPA	14%	14%	0%	No Disparity	Low — Track
Access	CES Coverage Rate	Central SPA	21%	14%	7%	No Disparity	Low — Track
Access	CES Coverage Rate	South SPA	9%	14%	-6%	No Disparity	Low — Track

Table 4-4 below presents, in addition to the above table, equity findings for the CNA Coverage across key demographic dimensions. For each subgroup, two assessments were conducted: performance relative to the system average, and performance relative to the subgroup's direct counterpart, for example, veterans compared to non-veterans, or TAY compared to non-youth. Comparing subgroups to their direct counterparts, rather than only to the system average, surfaces disparities that can be masked when a large dominant group pulls the system average toward its own rate. Disparity flags reflect the larger of the two gaps: No Disparity indicates no meaningful difference in either comparison; Flag for Monitoring indicates an emerging gap that warrants

tracking; Equity Concern or Significant indicates a gap large enough to require active attention and corrective action.

Table 4-4 — CNA Coverage Equity Assessment

Dimension	Finding	Disparity Flag
Race / Ethnicity	Coverage rates range from 13.6 percent (NHPI) to 21.8 percent (Multiracial). No consistent disparity pattern identified across the major racial/ethnic groups.	**No Disparity**
Household Type	Families have higher CNA coverage (22.8 percent) than single adults (13.7 percent). This reflects the proportionally smaller Family CES population, a structurally different CES for families and better access to resources, rather than inequitable treatment within the same pathway.	**No Disparity**
Veteran Status	Veterans have lower coverage (10.5 percent) than non-veterans (20.8 percent). This gap warrants monitoring, though the large "Data Not Collected" proportion (32.3 percent) limits confidence in the veteran rate. Note: this pattern reverses in HNA coverage (Table 5-4), where veterans outperform non-veterans, suggesting veterans bypass CNA and access CES through a direct HNA pathway rather than the standard crisis screening door.	**Flag for Monitoring**
Disability Status	Participants with disabling conditions have higher coverage (21.6 percent) than those without (18.3 percent), consistent with prioritization practices.	**No Disparity**
DV Survivor Status	DV survivors have modestly higher CNA coverage (23.8 percent) than non-DV survivors (20.8 percent). Positive counterpart gap; VSP pathways appear to be functioning effectively at the crisis screening level.	**No Disparity**
Youth / TAY	TAY coverage (12.6 percent) is slightly below the overall rate (14.0 percent). The counterpart gap is negligible.	**No Disparity**
Geography (SPA)	South SPA coverage (8.5 percent) is less than half the Central SPA rate (20.9 percent). This represents a meaningful geographic equity gap driven by access point capacity, not overall population characteristics. Further examination may be needed	**Significant**

4.1.3. Stakeholder Feedback

People with Lived Experience— Strengths

Participants' experiences with the CES access process varied significantly based on the quality and consistency of support they received. Participants consistently described positive experiences when they had access to a responsive and knowledgeable caseworker who provided clear communication and ongoing guidance through the intake process. These relationships helped participants navigate complex processes, understand expectations, and remain engaged.

People with Lived Experience — Challenges

Most participants did not describe accessing CES through a clearly identified community entry point such as 211. Instead, participants most often entered the system through informal pathways, including referrals from family members, friends, service providers, outreach workers, hospitals, law enforcement, or correctional settings. Many participants reported not knowing where to go for help or what CES was until someone already familiar with the system connected them. Several described reaching housing services only after repeated attempts, a significant crisis event, or a chance encounter with a service provider. **These experiences suggest that the formal access structure is largely invisible to the population it is designed to serve.**

Provider and Leadership Feedback — Strengths

CES Leadership interview participants generally described Orange County CES as attempting to provide broad system access and cited the benefits of a "no wrong door" approach. CES Leadership noted that CES enrollment and demographic representation occur across geographic areas and that demographic differences largely mirror underlying regional population differences. Community outreach efforts were described as occurring through community events, provider forums, social media, and public-facing resources such as FAQs.

CES Leadership also described coordination between providers and referral routing processes intended to connect households to available access points.

Provider and Leadership Feedback — Challenges

Stakeholders described concerns regarding the visibility, availability, and accessibility of Coordinated Entry points throughout the community. **Nearly half (48 percent) of provider survey respondents disagreed that people experiencing homelessness know how to access CES services.** Providers also expressed concerns that access functions are often under-resourced or unfunded, making it difficult to maintain a robust network of access points.

A consistent theme across provider and leadership interviews was the declining availability of open access points, particularly within the Family CES (FCES) system. Multiple participants attributed this trend to insufficient funding, staffing shortages, and growing caseloads. CES Leadership reported instances where referrals could not be assigned because no open access point was available and indicated that in some locations a single staff member may manage dozens of simultaneous referrals.

Specific operational barriers described included:

- Calls to access points going to voicemail with no follow-up
- Frequent participant phone number changes disrupting contact
- Referrals being routed to access points that had moved to closed status
- Uncertainty among referring agencies about whether households ultimately connected with assigned providers

CES Leadership also identified geographic variation in housing opportunity availability, noting that northern and central regions appear to have more housing options than the south, a pattern consistent with the geographic coverage disparity documented above.

Additionally, stakeholders noted that HUD eligibility requirements can create access barriers for certain populations, particularly couch-surfing youth and doubled-up families whose housing

instability may not meet the federal definition of literal homelessness despite significant need. Specifically for youth, stakeholders noted the lack of access and geographic coverage for youth-focused services.

CES Leadership generally believed CES reaches households experiencing chronic homelessness effectively due to prioritization practices but expressed concern that households at risk of homelessness receive insufficient attention due to limited prevention resources.

4.1.4. Partial Compliance Items

1. Access Model Best Practices

The CES access model incorporates mobile street outreach, virtual access options, and a 24/7 crisis entry point, reflecting alignment with most national best practice components. However, diversion screening and housing problem-solving, a structured, inquiry-based process to explore alternatives to crisis system entry, are not integrated into the model as a distinct access phase (see REC-10).

2. Homelessness Prevention Documentation and Referral

The OC CES P&P documents that prevention and diversion services are a critical component of CES and directs households at risk of homelessness to access prevention referrals through 211. The ESG Written Standards similarly establish a risk assessment process intended to prioritize households at greatest risk of housing loss. At the policy level, this item is compliant. However, two implementation gaps were identified: it is not clear from available documentation whether ESG-funded prevention assistance is being deployed as described, and despite the existence of a risk assessment tool, prevention assistance is reported to be allocated on a first-come, first-served basis rather than according to assessed risk level.

3. Access Implementation Alignment with Design

Access functions were found to be only partially implemented in alignment with CES design and HUD requirements across access points. System and policy-level barriers, including inconsistent definitions, variation in access point capabilities, and funding constraints, create more immediate negative consequences for unsheltered, youth, and justice-involved populations. Access point capacity itself was identified as a near-term structural risk: agencies reported that participation in Coordinated Entry can feel administratively burdensome and resource-intensive, and that increasing process complexity may be reducing provider engagement and undermining the collaborative function Coordinated Entry is intended to serve.

4. Geographic and Subpopulation Consistency of Access Practices

The extent to which access practices are implemented consistently across geography, subpopulation, and access point was also rated Partially Compliant. Geographic access is sharply uneven, consistent with the SPA-level coverage disparities documented in Table 4-2, including geographic variation in access point capacity, and declining open access point availability. Access also varies meaningfully by population: Victim Service Provider (VSP) participants enter through three closed, confidential phone-based access points rather than the open front door used by the general population, and survivors and re-entry populations frequently cannot use the standard open access point at all. While these closed-pathway protections exist for legitimate confidentiality and safety reasons, they represent a structurally different, and in practice less visible, access experience for these subpopulations compared to the general intake process.

4.1.5. Full Compliance Items

The following items were rated Fully Compliant:

1. CES design meets all federal and state access-related requirements (HUD CPD-17-01). The CES covers the entire geographic area claimed by the OC CoC.
2. The CES is easily accessed by individuals and families seeking housing or services. The access points cover and are accessible throughout the entirety of the geographic area of the CoC.
3. The CES design ensures a 'no wrong door' approach across all SPAs and subpopulations, including VSPs. However, VSPs noted that at one point of the CES implementation they were asked to become front-door access points which they were not ready to do. Once this requirement was removed, the CES did not go back to the VSPs to ask for their participation.
4. The design of access pathways supports equitable access across all geographies and populations, including those in underserved SPAs.
5. The CES design includes accessible, culturally/linguistically appropriate, and DV-safe access pathways.
6. The access hours are sufficient, including 24/7 crisis access through the Virtual Front Door. Crisis services operate with few barriers, independent of the operating hours of the system's intake and assessment processes.

> **COMPLIANCE RATING: NONCOMPLIANT (<75%)**
>
> The 14 percent CNA coverage rate is substantially below the threshold for a functioning CES access system. While no racial or ethnic disparity in coverage was identified, a meaningful geographic equity gap exists in the South SPA, and the absolute coverage level is insufficient to ensure equitable access to resources for the populations the system is designed to serve.

4.2 Discussion and Interpretation

As noted in Section 4's introduction, the CNA-based findings carry an open caveat regarding data reliability (per OCC feedback). The subgroup and geographic patterns discussed in this section, by household type, SPA, and over time, are drawn from the same CNA data source and should be read subject to that same caveat. The 14 percent CNA coverage rate is the defining Access function finding. However, the CNA does not function as a strict ceiling on downstream functions. A substantial share of households reach later CES stages without ever completing a CNA.

The single-adult pathway is the primary driver of this finding. Single adults constitute 96 percent of the target population (15,347 of 15,913 households) and have a CNA coverage rate of 13.7 percent. Families, while representing only 4 percent of the target population, achieved a substantially higher coverage rate of 22.8 percent, suggesting that access infrastructure is proportionally more developed for the Family CES pathway than for the individual pathway.

The geographic pattern compounds this concern. The South SPA, which has the lowest access point density and the fewest housing opportunities, also has the lowest CNA coverage rate at 7.2 percent. Households in the South SPA are therefore least likely to be screened, least likely to be referred, and served by the most constrained local housing supply. This convergence of access, capacity, and resource gaps in the same geographic area represents a structural equity concern that design-level policy alone cannot address.

The 47 percent decline in monthly CNA volume over the evaluation year, from 335 unique participants in October 2024 to 178 in September 2025, signals that the access problem is not stable; it is deteriorating. If this trend continues at the same rate into the next evaluation period, CNA activity could fall below 100 monthly unique participants systemwide. The stakeholder evidence strongly suggests this decline is driven by supply-side factors, the closure of access points, insufficient funding, and staffing constraints, and/or diminishing utility of the CNA as a distinct step, consistent with OCC's reported concern that CNA administration may not reflect an intentionally used assessment, rather than reduced demand from the target population.

The 2.4 average CNAs per participant indicates that the participants who do access CNA services often do so multiple times, reflecting repeated shelter entries and street homelessness episodes over the evaluation period. This pattern is consistent with revolving shelter utilization and underscores the absence of a stable housing pathway for many assessed participants.

4.3 Recommendations

REC-8: The OC CoC should develop a CES Coverage Expansion Plan with a target of 35 percent coverage within 12 months and 50 percent within 24 months. The plan should establish mandatory CES CNA protocols at all Access Points and define accountability mechanisms for programs that fail to link households to CES. Regardless of the OCC-reported data-entry issue, some form of structured crisis needs assessment at first contact remains a necessary system function. The plan should formalize the CNA, or a clarified equivalent crisis-screening instrument, as an intentional, trained, and consistently administered step in HMIS, so that assessment-type data reliably reflects purposeful screening. Clarifying this distinction is a prerequisite to accurately measuring coverage against the expansion targets above. Single adults represent the largest unserved group and should be the primary focus of expansion efforts. Because Street Outreach drives the bulk of the coverage gap (84 percent of the target population, 30 percent HNA coverage), expansion progress should be tracked separately by program type against the baseline established in this evaluation.

REC-9: The OC CoC should stabilize and expand open access point capacity, with priority given to the South SPA where coverage rates are critically low. The root cause of the access point closure trend, insufficient funding and staffing, must be addressed at the system level. An Access Point Sustainability Plan should be developed that includes:

- Minimum geographic coverage standards by SPA.
- Capacity monitoring for open access points.
- Stable funding mechanisms for agencies serving as access points.
- Incentives for agencies serving as open access points.
- Training for access points on diversion and Housing Problem-Solving.
- Formalize and publicly track CES-participation status for Street Outreach programs. Street Outreach comprises 84 percent of the SO/ES/TH target population but has the lowest HNA coverage rate of any program type (30 percent, compared to 65 percent for Emergency Shelter).
- Contingency plans when access point capacity falls below established thresholds.

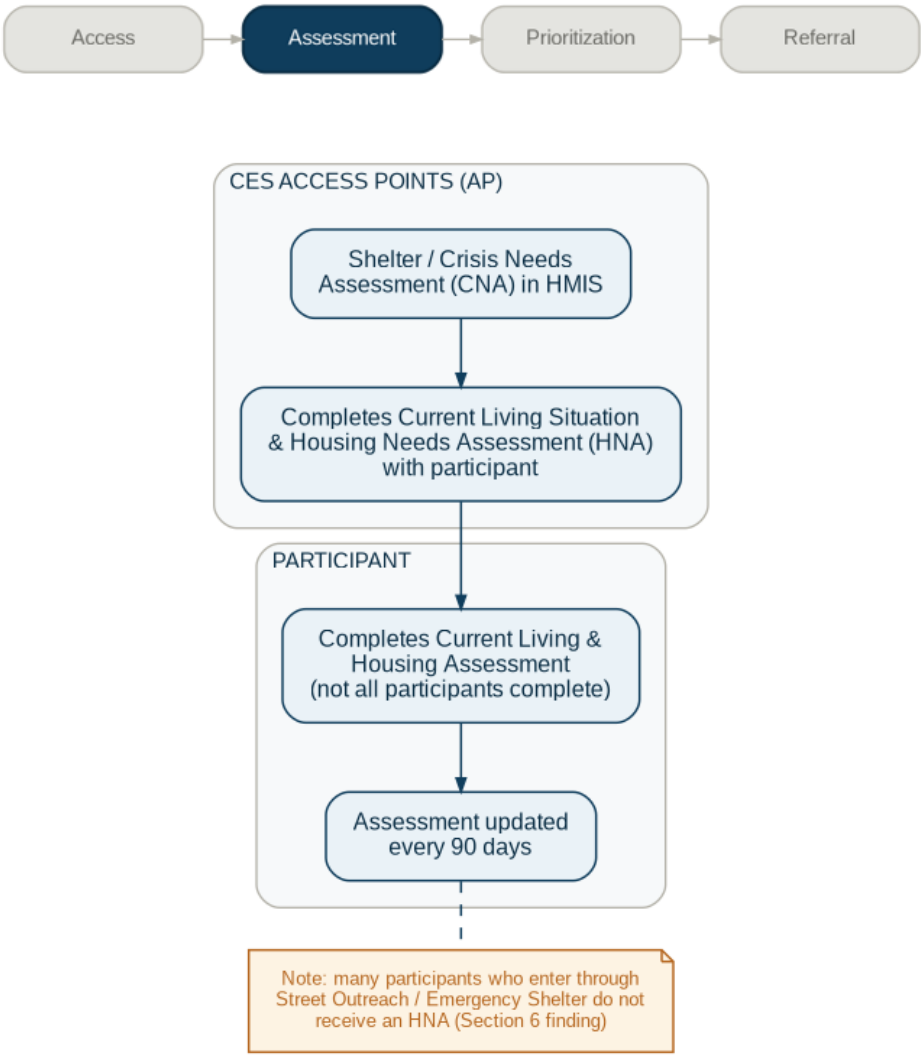
REC-10: A homelessness prevention and diversion component should be developed and integrated into the OC CES access model. The current CES P&P references homelessness prevention and problem-solving at the point of crisis assessment. However, a formalized diversion protocol with clear eligibility criteria, trained staff, and outcome tracking is absent from implementation, as well as coordination with other community-based prevention resources. Dedicated homelessness prevention funding and programming are also essential for reducing crisis system demand. Prevention and diversion represent a material structural gap in the current design.

REC-11: The OC CoC should implement a referral connection tracking protocol to determine whether households successfully engage with assigned access points following referral. Stakeholders described systemic uncertainty about connection rates, including unanswered calls and referrals to closed access points. Monitoring the proportion of referrals that result in a completed CNA would provide actionable data on system attrition at the point of entry and enable targeted interventions to reduce dropout.

Section 5: CES Function 2 — Assessment

Assessment is the standardized, participant-centered process through which the Coordinated Entry System identifies participant housing needs, vulnerabilities, barriers, preferences, and required services in order to support prioritization and referral decisions. The OC CES uses a phased approach: an initial CNA administered at the point of system entry, followed by a HNA and Current Living Situation Assessment (CLSA) administered through the CES system while the person is enrolled in a crisis response program. This section evaluates HNA coverage, assessment timeliness, assessment currency (90-day update rate), scoring alignment between documented vulnerability and housing referral activity, as well as stakeholder experiences.

Figure 5-1 — CES Assessment Design



5.1 Key Findings — Assessment Compliance

Of 11 Assessment compliance items rated in the Master Matrix, 5 were rated Compliant, 4 were rated Partially Compliant, and 2 were rated Noncompliant. This produces a **compliance rate of 45.5 percent**, placing the Assessment function in the **Noncompliant** range. Assessment is operating below standard across multiple dimensions, including coverage, tool quality, and assessment currency.

5.1.1. Noncompliant Item 1 — Disability Disclosure

The assessment process cannot require disclosure of a specific disability type or clinical diagnosis. Information about disabling conditions may only be gathered for the purpose of determining program eligibility and making appropriate referrals. The OC CES Disabling Condition Form currently requires disclosure of the type of disability, and the CES Policies and Procedures do not include the required disability-related language limitations. In addition, the Disabling Condition Form is required for the person to added to the BNL and this requirement is inconsistent with HUD HMIS requirements (see REC-12).

5.1.2. Noncompliant Item 2 — HNA Coverage

The second Noncompliant item is HNA coverage. The HNA coverage rate measures the proportion of households with ES, SO, or TH program enrollments that also received a CES HNA during the evaluation period. Of **15,913 unique heads of household** with a qualifying program enrollment between October 1, 2024, and September 30, 2025, **5,588 received a HNA, a coverage rate of 35 percent** (Table 5-1). This means 65 percent of crisis response system–enrolled households have no HNA and therefore no access to the CES prioritized housing placement process (see REC-13).

Within Emergency Shelter, coverage also varies by whether the enrolling program is CES-participating: 77.3 percent for households enrolled at a CES-participating shelter program, compared to 53.5 percent at a non-participating shelter program (transitional housing shows a similar participation-linked pattern but its small sample size, 93 households, limits generalization).

Table 5-1 — CES HNA Coverage Rate by Subgroup

Category	Total Household Enrollments	Households with a HNA	Coverage Rate
System Total	**15,913**	**5,588**	**35.1%**
Single Adult	15,357	5,372	35.0%
Family	556	216	38.8%
North SPA	6,064	2,699	44.5%
Central SPA	6,070	2,451	40.4%
South SPA	844	300	35.5%

Coverage is highly uneven by program type. Emergency shelter (entry/exit type) households have a HNA coverage rate of **65 percent**, while Street Outreach households have a coverage rate of **30 percent** (Table 5-2). This gap is particularly significant given that Street Outreach represents approximately **84 percent of the 15,913 unique households** in the target population, meaning the majority of the target population is concentrated in the program type with the lowest assessment coverage.

Table 5-2 — CES HNA Coverage Rate by Program Type

Program Type	Total Household Enrollments	Households with a HNA	Coverage Rate
Street Outreach	13,433	4,011	29.9%
Emergency Shelter (Enty/Exit (E/E))	2,330	1,526	65.5%
Emergency Shelter (Night by Night (NBN))	57	21	36.8%
Transitional Housing	93	30	32.3%
System Total	**15,913**	**5,588**	**35.1%**

The HNA coverage rate measures whether a household received an assessment at any point during the evaluation period, not whether that assessment was administered through the qualifying SO/ES/TH enrollment itself: HNAs are recorded under a separate Coordinated Entry enrollment in virtually all cases (98.1 percent), reflecting a distinct Access Point touchpoint.

5.1.3. Geographic Distribution

The North and Central SPAs together account for 92 percent of all HNAs, reflecting the geographic concentration of access point capacity in those areas. The South SPA, while achieving its highest assessment rate of any assessment type (35.5 percent vs. 7.2 percent CNA coverage), accounts for only 5 percent of system HNAs. The South SPA's HNA coverage rate (35.5 percent) is substantially higher than its CNA coverage rate (7.2 percent), suggesting that some households in the South SPA are reaching the HNA pathway without going through the CNA first, consistent with the pattern of CNA bypass documented in Section 4.

Table 5-3 — Geographic Distribution of CES HNAs

SPA	Households with a HNA	% of Total	Coverage Rate
North SPA	2,699	48%	44.5%
Central SPA	2,451	44%	40.4%
South SPA	300	5%	35.5%
Data Not Collected	138	2%	-
System Total	**5,588**	**100%**	**35.1%**

Equity Considerations

While no cross-demographic disparity has been identified within the assessed population, the absolute coverage rate of 35 percent is insufficient regardless of its distribution. The equity finding that HNA coverage rates are broadly consistent across subgroups means that underservice is systemic and population-wide, not targeted at specific groups (Table 5-4).

Table 5-4 — CES HNA Coverage Rate

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: ☑ No Disparity (≤5pp) | ⚠ Emerging (5–10pp) | ● Significant (>10pp).							
Assessment: Housing Assessment Completion Rate							
Assessment	Housing Assessment Completion Rate	Black / African American	39%	35%	4%	☑ No Disparity	Low — Track
Assessment	Housing Assessment Completion Rate	Hispanic / Latino	35%	35%	0%	☑ No Disparity	Low — Track
Assessment	Housing Assessment Completion Rate	White	39%	35%	4%	☑ No Disparity	Low — Track
Assessment	Housing Assessment Completion Rate	Multi-racial	57%	35%	22%	☑ No Disparity	Low — Track
Assessment	Housing Assessment Completion Rate	People with Disabilities	55%	35%	20%	☑ No Disparity	Low — Track
Assessment	Housing Assessment Completion Rate	Youth (Under 25)	38%	35%	3%	☑ No Disparity	Low — Track
Assessment	Housing Assessment Completion Rate	Veterans	55%	35%	20%	☑ No Disparity	Low — Track
Assessment	Housing Assessment Completion Rate	DV Survivors	60%	35%	25%	☑ No Disparity	Low — Track
Assessment	Housing Assessment Completion Rate	Singles	35%	35%	0%	☑ No Disparity	Low — Track
Assessment	Housing Assessment Completion Rate	Families	39%	35%	4%	☑ No Disparity	Low — Track
Assessment	Housing Assessment Completion Rate	North SPA	45%	35%	10%	☑ No Disparity	Low — Track
Assessment	Housing Assessment Completion Rate	Central SPA	40%	35%	5%	☑ No Disparity	Low — Track
Assessment	Housing Assessment Completion Rate	South SPA	36%	35%	1%	☑ No Disparity	Low — Track

Table 5-5 below presents, in addition to the above table, equity findings for the HNA Coverage across key demographic dimensions. For each subgroup, two assessments were conducted: performance relative to the system average, and performance relative to the subgroup's direct counterpart.

Table 5-5 — CES HNA Coverage Equity Assessment

Dimension	Finding	Disparity Flag
Race / Ethnicity	Coverage ranges from 35.1% (Hispanic/Latino) to 57.0% (Multiracial). Hispanic/Latino participants (35.1%) are below the White Non-Hispanic rate (39.1%), the only racial/ethnic group with a meaningful negative counterpart gap.	● **No Disparity**
Household Type	Families have modestly higher HNA coverage (38.8%) than single adults (35.0%), a positive counterpart gap.	● **No Disparity**
Veteran Status	Veterans coverage (55.1%) outperforms non-veterans (51.3%), a positive counterpart gap that directly reverses the CNA pattern (Table 4-4), confirming that veterans bypass CNA and access the system through a direct HNA pathway.	● **No Disparity**
Disability Status	Participants with a disabling condition outperform (55.2%) those without (48.0%). Positive counterpart gap consistent with CES prioritization directing highest-vulnerability households toward assessment.	● **No Disparity**
DV Survivor Status	DV survivors outperform (60.4%) non-DV survivors (52.8%). Positive counterpart gap; VSP-specific assessment pathways are functioning effectively at the HNA level.	● **No Disparity**
Youth / TAY	TAY coverage (37.8%) is above non-youth (35.0%), a modest positive counterpart gap. Unlike the CNA finding where TAY were slightly below the system average, TAY participants have a small coverage advantage in HNA.	● **No Disparity**

Dimension	Finding	Disparity Flag
Geography (SPA)	South SPA HNA coverage (35.5%) is below North SPA (44.5%) and Central SPA (40.4%). The South SPA gap narrows considerably relative to CNA but remains the most consistent geographic disparity across both assessment types.	**Flag for Monitoring**

5.1.4. Timeliness of Assessment

Time from enrollment to HNA completion is measured as the number of days from the household's qualifying CES program enrollment (ES, SO, or TH) to their first HNA. Of 5,588 households with a HNA, **5,020 (90 percent)** had a HNA completed on or after the enrollment date. The remaining 568 households had a HNA date preceding their program enrollment, which may reflect prior assessment activity, system re-entry, or data recording inconsistencies rather than an assessment completed before a crisis episode.

Among the 5,020 households with a sequentially valid HNA: the **mean is 41 days** and the **median is 4 days** from enrollment to first HNA. The large gap between these two figures indicates a heavily right-skewed distribution: most households received their HNA very quickly after enrollment, but a smaller group waited far longer, and those long waits pull the average upward without affecting the typical (median) experience. Table 5-6 demonstrates this pattern.

Table 5-6 — HNA Timeliness by Program Type

Program Type	# of Valid Pairs (HNA ≥Start)	Average Days (Valid Pairs)	Same-Day (0 days)	91+ Days	Coverage Rate
Street Outreach	3,685	41	45%	18%	30%
Emergency Shelter (EE)	1,298	42	33%	17%	65%
Emergency Shelter (NBN)	18	21	6%	6%	37%
Transitional Housing	19	66	11%	21%	32%
System Total	**5,020**	**41**	**42%**	**18%**	**35%**

The 42 percent same-day completion rate and the 18 percent 91-days-plus rate represent opposite concerns. Same-day completions suggest that the assessment is administered at initial enrollment contact, before the household has had an opportunity to articulate their circumstances. Assessments completed on the first day of enrollment are unlikely to capture the depth of housing need, vulnerability, and barrier information that should inform prioritization decisions. Conversely, 91-plus day completions mean that a household has been enrolled in a crisis program for three or more months before receiving any formal housing assessment, representing a prolonged period of housing need going unaddressed within the CES framework.

For an optimally timed assessment, completion within approximately 7 to 30 days of enrollment, after initial stabilization but before crisis circumstances evolve significantly, would better balance timeliness with quality. Under current implementation, only 26 percent of households complete their HNA within 30 days of enrollment, excluding same-day completions.

Equity Considerations

From the HNA completion timeliness perspective, no disparity was identified for the subpopulations analyzed (Table 5-7). HNAs are completed earlier than the system average for Black/African American, Youth and Veteran subpopulations.

Table 5-7 — CES HNA Timeliness

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: ☑ No Disparity (≤5pp) | ⚠ Emerging (5–10pp) | ● Significant (>10pp).							
Assessment: Time from Access to Assessment							
Assessment	Time from Access to Assessment	Black / African American	35	41	-15%	☑ No Disparity	Low — Track
Assessment	Time from Access to Assessment	Hispanic / Latino	41	41	-1%	☑ No Disparity	Low — Track
Assessment	Time from Access to Assessment	White	45	41	8%	☑ No Disparity	Low — Track
Assessment	Time from Access to Assessment	Multi-racial	45	41	7%	☑ No Disparity	Low — Track
Assessment	Time from Access to Assessment	People with Disabilities	43	41	3%	☑ No Disparity	Low — Track
Assessment	Time from Access to Assessment	Youth (Under 25)	32	41	-22%	☑ No Disparity	Low — Track
Assessment	Time from Access to Assessment	Veterans	34	41	-17%	☑ No Disparity	Low — Track
Assessment	Time from Access to Assessment	DV Survivors	39	41	-5%	☑ No Disparity	Low — Track
Assessment	Time from Access to Assessment	Singles	41	41	0%	☑ No Disparity	Low — Track
Assessment	Time from Access to Assessment	Families	42	41	1%	☑ No Disparity	Low — Track
Assessment	Time from Access to Assessment	North SPA	39	41	-5%	☑ No Disparity	Low — Track
Assessment	Time from Access to Assessment	Central SPA	43	41	4%	☑ No Disparity	Low — Track
Assessment	Time from Access to Assessment	South SPA	42	41	0%	☑ No Disparity	Low — Track

Table 5-8 below presents, in addition to the above table, equity findings for the HNA Timeliness across key demographic dimensions. For each subgroup, two assessments were conducted: performance relative to the system average, and performance relative to the subgroup's direct counterpart.

Table 5-8 — CES HNA Timeliness Equity Assessment

Dimension	Finding	Disparity Flag
Race / Ethnicity	Black/AA participants (35.3 days), Asian/Asian American (28.8 days), AI/AN (25.7 days) and Hispanic/Latino participants (40.8 days) are assessed faster than White Non-Hispanic participants (44.7 days), a positive finding. The NHPI subpopulation has an average of 56.4 days but a disparity assessment cannot be determined due to the low subpopulation census (46 participants).	● **No Disparity**
Household Type	Single adults (41.4 days) and families (41.7 days) are assessed at virtually identical averages. Counterpart gap: 0.3 days.	● **No Disparity**
Veteran Status	Veterans are assessed faster (34.3 days) than the system average and non-veterans (41.8 days). This is a positive counterpart gap consistent with the dedicated veteran assessment pathway.	● **No Disparity**
Disability Status	Participants with a disabling condition are assessed at nearly the same average (42.5 days) as the system average. No meaningful counterpart gap vs. non-disabled participants (35 days).	● **No Disparity**
DV Survivor Status	DV survivors are assessed slightly faster (39.4 days) than non-DV survivors (40.2 days).	● **No Disparity**

Dimension	Finding	Disparity Flag
Youth / TAY	TAY participants are assessed faster (32.3 days) than the system average and their non-youth counterparts (41.8 days). This is a positive equity finding.	**No Disparity**
Geography (SPA)	SPA-level timeliness is closely clustered: North 39.5 days, Central 42.9 days, South 41.5 days. No meaningful geographic disparity in time to HNA. South SPA's faster rate likely reflects smaller volume rather than a structural advantage.	**No Disparity**

5.1.5. 90-Day Re-Assessment Update Rate

The 90-day assessment update standard requires that households on the By-Name List (BNL) maintain a current assessment, defined as a HNA and CLSA completed within the preceding 90 days, to ensure that prioritization and referral decisions are based on current information. The household is automatically removed from referral to housing opportunities if there is no updated CLSA.

HNA Update Analysis

The evaluation applied an adjusted number of 4,692 households, excluding 896 whose first and only assessment occurred in Q4 of the evaluation period (July–September 2025) and for whom the 90-day update window had not yet lapsed as of the September 30, 2025 evaluation end date. From the 4,692 households, 1,571 households were removed as they exited the system's programs within the 90-day timeframe, leaving 3,121 households for the denominator.

Of the 3,121 households in the adjusted denominator, **17 percent have a current HNA under the 90-day standard** (Table 5-9). Applying a 120-day window to account for scheduling flexibility, **29 percent** have a subsequent assessment on record. Both figures are substantially below the 90 percent standard.

Table 5-9 — HNA Recency Distribution (Adj. Denominator n=3,121)

Days Since Last Assessment	# Households with a HNA	% of Denominator	Status
< 90 days (current)	521	17%	✓ At or below 90% target
90–119 days	379	12%	⚠ Just overdue
120–179 days	742	24%	⚠ Moderately overdue
180–364 days	1,479	47%	✗ Significantly overdue
Adjusted Total Denominator	**3,121**	**100%**	

The median time since the last HNA across the full adjusted denominator is 187 days and the mean is 179 days. Almost half of BNL households, 1,479 of 3,121 (47 percent), have not been reassessed in six or more months. For this cohort, housing vulnerability and clinical needs may have changed materially since the last assessment, directly undermining the equity and accuracy of current prioritization and referral decisions. This is a systemic process failure affecting the majority of the BNL population.

Equity Considerations

From the HNA reassessment rate within 120 days perspective, no disparity was identified for the subpopulations analyzed (Table 5-10). Participants are reassessed at slightly lower rates if they are White or in the South SPA but not at a level that would indicate a disparity. Multi-racial, Veterans and Family households are reassessed at slightly higher rates within 120 days.

Table 5-10 — HNA Reassessment Timeliness

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: ☑ No Disparity (≤5pp) | ⚠ Emerging (5–10pp) | ● Significant (>10pp).							
Assessment: Rate of Re-Assessment w/in 120 days							
Assessment	Rate of Assessment w/in 120 days	Black / African American	29%	29%	1%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Hispanic / Latino	30%	29%	1%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	White	28%	29%	-1%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Multi-racial	41%	29%	12%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	People with Disabilities	30%	29%	1%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Youth (Under 25)	30%	29%	1%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Veterans	32%	29%	3%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	DV Survivors	31%	29%	2%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Singles	29%	29%	0%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Families	36%	29%	7%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	North SPA	29%	29%	1%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Central SPA	29%	29%	0%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	South SPA	25%	29%	-4%	☑ No Disparity	Low — Track

Table 5-11 below presents, in addition to the above table, equity findings for the HNA Reassessment Timeliness across key demographic dimensions. For each subgroup, two assessments were conducted: performance relative to the system average, and performance relative to the subgroup's direct counterpart.

Table 5-11 - HNA Reassessment Timeliness Equity Assessment

Dimension	Finding	Disparity Flag
Race / Ethnicity	Reassessment rates range from 14% (AI/AN) to 41% (Multiracial). However, the AI/AN subpopulation is small, and a disparity assessment cannot be made.	● **No Disparity**
Household Type	Families are reassessed at a higher rate (36%) than the system average. Counterpart comparison: Families (36%) vs. Single Adults (29%).	● **No Disparity**
Veteran Status	Veterans are reassessed at a higher rate (32%) than the non-Veterans (29%), the system average and single adults, consistent with more structured case management in the veteran pathway.	● **No Disparity**
Disability Status	Participants with a disabling condition are reassessed at a higher rate (30%) than those without (25%).	● **No Disparity**
DV Survivor Status	DV survivors are reassessed at a higher rate (31%) than non-DV survivors (25%).	● **No Disparity**
Youth / TAY	TAY participants are reassessed at a slightly higher rate (30%) than the non-TAY population rate (29%).	● **No Disparity**

Dimension	Finding	Disparity Flag
Geography (SPA)	South SPA rate (25%) is below the system average and below Central (29%) and North (29%) SPAs rates. The counterpart gap is modest and does not indicate a geographic disparity in reassessment practices.	**No Disparity**

CLSA Update Analysis

The evaluation applied an adjusted denominator of 3,121 households: the 5,588 SO/ES/TH households with an HNA, excluding 896 whose first and only assessment occurred in Q4 of the evaluation period (for whom the 90-day window had not yet lapsed as of September 30, 2025) and 1,571 who exited all programs before the 90-day update window elapsed.

Of the 3,121 households in the adjusted denominator, **34 percent have a current CLSA under the 90-day standard** (Table 5-12). Applying a 120-day window to account for scheduling flexibility, **45 percent** have a CLSA update on record. Both figures are substantially below the 90 percent standard. Notably, 598 households (19 percent) have no CLSA record at all on or after their first HNA. The higher CLSA rates (over the HNA rates) reflect the system's policy emphasis on homeless status and length of time homeless.

Table 5-12 - CLSA Recency Distribution (Adj. Denominator n=3,121)

Days Since Last Assessment	# Households with a HNA	% of Denominator	Status
< 90 days (current)	1,063	34%	✓ Well below 90% target
90–119 days	325	11%	⚠ Just overdue
120–179 days	466	15%	⚠ Moderately overdue
180–364 days	669	21%	✗ Significantly overdue
No CLSA on/after first HNA	598	19%	✗ Never updated
Adjusted Total Denominator	**3,121**	**100%**	

The median time for a CLSA since the last HNA is 110 days and the mean is 125 days. Among households with any post-HNA update, consecutive CLSA records are a median of 39 days apart, and 72 percent of update intervals fall within 90 days, though this reflects only the households with a second update to measure, not the full population, some of whom have just one update on record and no further contact.

Equity Considerations

From the CLSA reassessment rate within 120 days perspective, a disparity was identified for the Veteran subpopulation (Table 5-13). Participants are reassessed at slightly lower rates if they are Hispanic, Youth or in the North SPA but not at a level that would indicate a disparity. Black/African American, White, People with Disabilities, DV Survivors and South SPA households receive a CLSA reassessment at slightly higher rates within 120 days.

Table 5-13 - CLSA Reassessment Timelines

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: ☑ No Disparity (≤5pp) | ⚠ Emerging (5–10pp) | ● Significant (>10pp).							
Assessment: Rate of Re-Assessment using CLS Assessment w/in 120 days							
Assessment	Rate of Assessment w/in 120 days	Black / African American	47%	45%	3%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Hispanic / Latino	42%	45%	-2%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	White	47%	45%	2%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Multi-racial	43%	45%	-2%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	People with Disabilities	47%	45%	2%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Youth (Under 25)	39%	45%	-5%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Veterans	31%	45%	-14%	● Significant	Low — Track
Assessment	Rate of Assessment w/in 120 days	DV Survivors	48%	45%	3%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Singles	44%	45%	0%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Families	46%	45%	2%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	North SPA	43%	45%	-2%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	Central SPA	45%	45%	0%	☑ No Disparity	Low — Track
Assessment	Rate of Assessment w/in 120 days	South SPA	56%	45%	12%	☑ No Disparity	Low — Track

Table 5-14 below presents, in addition to the above table, equity findings for the CLSA Reassessment Timeliness across key demographic dimensions. For each subgroup, two assessments were conducted: performance relative to the system average, and performance relative to the subgroup's direct counterpart.

Table 5-14 - CLSA Reassessment Timeliness Equity Assessment

Dimension	Finding	Disparity Flag
Race / Ethnicity	Reassessment rates range from 29% (AI/AN) to 48% (NHPI). However, both subpopulations are small, and a disparity assessment cannot be made.	● **No Disparity**
Household Type	Families are reassessed at a slightly higher rate (46%) than the system average. Counterpart comparison: Families (46%) vs. Single Adults (44%).	● **No Disparity**
Veteran Status	Veterans are reassessed at lower rate (31%) than the non-Veterans (45%), the system average and single adults.	● **Significant**
Disability Status	Participants with disabling conditions are reassessed at a higher rate (47%) than those without (37%).	● **No Disparity**
DV Survivor Status	DV survivors are reassessed at a higher rate (48%) than non-DV survivors (44%).	● **No Disparity**
Youth / TAY	TAY participants are reassessed at a slightly lower rate (39%) than the non-TAY population rate (45%).	● **Flag for Monitoring**
Geography (SPA)	South SPA (56%) is above the system average and above Central (45%) and North (43%) SPAs rates. The South SPA volume however is less than 15% of either the North or Central SPA.	● **No Disparity**

5.1.6. Assessment Consistency

Three metrics examine the relationship between documented household vulnerability and receipt of a formal housing unit referral. For this metric, **"referral" is defined as receipt of a Housing Opportunity referral** (RRH, PSH, PH-Housing Only, or PH-Housing with Services) through the CES Queue.

Metric 1 — Chronically Homeless (CH) Households

Of 2,470 CH-designated households with a HNA, **266 (10.8%) received a Housing Opportunity referral** in the evaluation period. The remaining **2,204 CH households (89.2%) had no housing unit referral** on record (Table 5-12).

Metric 2 — Households with a Disabling Condition

Of 4,064 households with a HNA and a recorded disabling condition, **367 (9.0 percent) received a Housing Opportunity referral**. The remaining **3,697 (91.0 percent) had no housing unit referral** on record.

Metric 3 — CH or Disabled Households Without Any Referral

Of 4,109 households that are either CH-designated or have a disabling condition, **3,734 (90.9 percent) received no Housing Opportunity referral** in the evaluation period. These households represent the highest-priority segment of the assessed population, chronically homeless, disabled, or both, and the overwhelming majority have no housing unit referral connecting them to a permanent housing opportunity.

Table 5-15 — Assessment Consistency and Housing Opportunity (HO) Referral

Metric	# of Households with a HNA	# of Households Referred	% of Households with a HNA	% Referred
S1 - CH + Disability + HO Referral	2,425	258	4.6%	10.6%
S1 - CH only + HO Referral	45	8	0.1%	17.8%
S2 - Disability + HO Referral	1,639	109	2.0%	6.7%
Neither CH/Dis + HO Referral	1,479	56	1.0%	3.8%
Total with HO Referral	**5,588**	**431**	**7.7%**	**7.7%**
Metric	**# of Households with a HNA**	**# of Households NOT Referred**	**% of Households with a HNA**	**% NOT Referred**
S3 - CH + Disability, No HO Referral	2,425	2,167	38.8%	89.4%
S3 - CH only, No HO Referral	45	37	0.7%	82.2%
S3 - Disability only, No HO Referral	1,639	1,530	27.4%	93.3%
Neither CH/Dis, No HO Referral	1,479	1,423	25.5%	96.2%
Total without HO Referral	**5,588**	**5,157**	**92.3%**	**92.3%**

The 3,734 households in S3 not referred may reflect a combination of resource constraints (insufficient housing units available), documentation gaps (households assessed but not yet document-ready for referral), or process failures (assessed households not being actively managed on the BNL). These causes require investigation and are addressed in the recommendations below.

5.1.7. Stakeholder Feedback

People with Lived Experience

PLE reported inconsistent communication, staff turnover, lost documentation, repeated requests for information, and uncertainty about who was responsible for supporting them. Many described having to repeatedly explain their circumstances to new staff, contributing to frustration and diminished trust. These experiences reflect implementation inconsistencies that create unequal access even within the assessed population.

PLE shared experiences of feeling judged, dismissed, or stigmatized because of their homelessness, substance use, mental health challenges, or personal circumstances that make it appear as though there's a lack of follow-through or commitment to next steps. These interactions often left individuals feeling blamed for their situation, reluctant to ask questions, and less likely to engage with services.

PLE described limited understanding of how the CES assessment functions, including the purpose of the HNA, how information is used after completion, and what documentation is required throughout the process. Many described uncertainties about what happens after completing an assessment, the roles of different providers within the system, and the steps that occur between assessment and housing placement. Participants frequently reported collecting documents without understanding how those documents contributed to housing eligibility, prioritization, or readiness for a housing opportunity. Participants expressed a desire for clearer communication about the overall housing process.

Provider and Leadership Feedback — Strengths

CES Leadership generally affirmed that the assessment captures minimum information necessary to establish housing interest and facilitate placement within CES. Stakeholders noted that assessment information supports current prioritization processes and that case conferencing and HMIS data supplement assessment information during matching discussions. Monthly access point case reviews and ongoing cross-agency case discussions were identified as mechanisms to review enrollment histories, denials, and household circumstances.

Provider and Leadership Feedback — Challenges

Widespread confusion about "doc-readiness" was reported across stakeholders, including confusion about why specific documents are required for particular housing types, especially voucher-based programs. Across stakeholder groups, there was widespread recognition that being "doc-ready", rather than simply being enrolled in the queue, serves as a critical threshold for accessing housing opportunities.

Providers identified a need for greater community-wide understanding of the CES and reported that participants are often not informed that the documents they are gathering may ultimately support a housing voucher or housing referral. Providers consistently noted that verified disability

documentation and chronic homelessness documentation are often what make an individual eligible for referral or matching.

Multiple CES Leadership respondents described the assessment as insufficiently comprehensive to fully capture household vulnerability, clinical acuity, safety concerns, and other factors that may affect housing needs and inform the type, level and intensity of support needed. Specific concerns included:

- Reliance on minimum required data elements rather than a broader housing vulnerability profile
- Inadequate capture of clinical acuity, safety concerns, and service needs relevant to housing stability, particularly for survivors of violence, transition-age youth, and individuals with significant medical or behavioral health needs
- Dependence on access point staff to conduct supplemental assessment activities outside the formal CES assessment process
- Variability in documentation expectations across housing providers and public housing authorities (PHAs), including reports that at least one housing authority excluded chronically homeless households from certain units
- Absence of standardized application requirements and universal forms across PHAs and housing providers

CES Leadership noted that housing needs and household circumstances frequently change, but assessment updates occur on a periodic schedule rather than when needs change. Several respondents suggested that more timely updates could reduce inappropriate referrals and improve alignment between Household needs and housing opportunities.

Assessment Fidelity Monitoring

CES Leadership reported limited systematic review of assessment outcomes or long-term success rates. One participant referenced survey findings indicating some households return to CES multiple times after prior matches, raising questions about whether the assessment adequately captured initial intervention appropriateness, particularly for RRH placements. Current fidelity monitoring relies primarily on monthly access point reviews, enrollment notes and denial reviews, and case-level discussions, without a formal quality review process or outcome-linked feedback loop.

5.1.8. Partial Compliance Items

1. Assessment Design Alignment with HUD Standards

The CES P&P establishes a standardized assessment process. However, this item was rated Partially Compliant in connection with the broader content gap identified at the system design level (Section 3): the written standards do not incorporate HUD requirements related to prioritization that require a standardized severity-of-need assessment component. **The assessment design is procedurally sound but does not operationalize the substantive prioritization content HUD expects.**

2. Assessment Tool Compliant with HUD Requirement

The CES assessment tool is low-barrier, trauma-informed, and participant-centered in its structure. However, the tool has moved from a detailed vulnerability-and-needs assessment to a format that primarily captures housing interest and basic demographic information. While this

approach reduces burden and avoids screening-out practices, it does not adequately assess household needs, barriers, clinical vulnerabilities, current acuity, or housing-specific risk factors necessary to inform appropriate housing intervention matching. This item was rated Partially Compliant because the design intent meets HUD standards but the scope is insufficient for accurate prioritization and matching decisions.

3. Assessment Sufficiency

Implementation-level evidence indicates that the current assessment does not adequately serve all subpopulations it is intended to reach. Survivor-focused providers (SCES) reported that the assessment is too short to capture the depth of vulnerability needed to safely match the highest-need survivors to appropriate survivor housing. Various housing providers, including Victim Service Provider (VSP) staff, reported receiving referrals for participants whose assessed needs do not match what the receiving program is able to safely serve, the same underlying issue surfacing at the point of referral: the assessment captures housing choice and preference rather than a working profile of need, acuity, and other information essential to an efficient and successful placement. Transition-age youth (TAY) participants similarly described the assessment as shallow and characterized the broader system as oriented toward families and couples rather than single youth. This item was rated Partially Compliant because the assessment functions adequately for the general population but does not reliably capture the information necessary to protect and appropriately place higher-vulnerability survivor and youth participants.

4. Assessment Frequency and Currency

The 90-day reassessment standard requires that BNL households maintain current assessments. At 17 percent compliance (90-day window) and 29 percent compliance (120-day window) for the HNA and 34 percent compliance (90-day window) and 44 percent compliance (120-day window), measured against the CLSA, the OC CES falls materially below the standard. Prioritization and housing referral decisions are being made for a significant portion of BNL households on assessment data that is six months or more out of date.

5.1.9. Full Compliance Items

The items that were deemed to be in full compliance with the CES requirements are:

1. The participants are informed of the ability to file a nondiscrimination complaint.
2. The assessment design protects participant privacy and prohibits using assessment to screen people out due to perceived barriers.
3. The assessment process protects participant autonomy, including the right to refuse questions, choose housing type and location, and maintain their priority placement status regardless of refusals.
4. Staff are trained and certified to administer CES assessment tools.
5. Assessments are implemented consistently across all SPAs and access points using approved tools and protocols.

COMPLIANCE RATING: NONCOMPLIANT (<75%) The Disabling Condition Form is not compliant with HUD requirements. 35 percent of CES-enrolled households have a linked HNA record; the remaining 65 percent do not. Of the assessed households, 29 percent have received a subsequent HNA and 44 percent received a CLSA when allowing 120 days for scheduling flexibility, below the ≥90 percent standard. Of the highest-priority assessed households (chronically homeless or disabled), 91 percent have no housing unit referral on record.

5.2 Discussion and Interpretation

Disability disclosure — a compliance requirement with immediate action implications. The Disabling Condition Form's current requirement to disclose the *type* of disability violates HUD's explicit prohibition on requiring clinical diagnosis or disability-type information for the purposes of CES screening or assessment. This a requirement HUD established specifically to prevent households with stigmatized or complex disabilities from being screened out of, or deterred from accessing, the coordinated entry process. The practical consequences extend beyond the legal compliance gap itself, it is a deterrent to honest and complete participation for individuals with behavioral health, substance use, or other stigmatized conditions, the same populations who are disproportionately likely to be chronically homeless and most in need of the assessment pathway. Any data collected under these conditions for households who withheld or misrepresented disability information is also less reliable as a basis for prioritization.

Additionally, the Disabling Condition Form should not be required for a person to continue to be reported with a disabling condition in HMIS and included on the by-name list (BNL), as this is inconsistent with HUD HMIS requirements and best practices for tracking people on a BNL, pre-program referral and enrollment. The Disabling Condition Form should be updated to remove the disability type field, and the P&P should be updated to reflect HUD disability disclosure requirements, including consistency with HMIS requirements.

The Assessment function faces a compound failure across all three stages of the assessment lifecycle: initial coverage, timely completion, and ongoing currency.

Stage 1 (post CNA) — Coverage. Among the 15,913 households enrolled in ES, SO, or TH programs during the evaluation period, 5,588 (35 percent) have a HNA. The 10,325 households without a HNA, the majority unsheltered and served through SO programs, have no access to the CES prioritized housing placement process. They are not on the BNL and are not subject to the 90-day update standard. They cycle through SO and ES programs with ongoing housing needs that go unaddressed within the CES framework.

Stage 2 — Timeliness. Of the 5,020 households with a HNA dated after their program enrollment, the distribution of timing is problematic at both extremes. The 42 percent same-day completion rate suggests many assessments are administered immediately at intake, before the household can accurately characterize their housing history and needs. Assessment at this point in a person's crisis experience may capture distress and confusion rather than a reliable vulnerability profile. At the opposite end, the 18-plus percent of households with HNA completions 91 or more days after enrollment represent a significant delay, a household enrolled in crisis housing for three or more months before their first formal assessment. An optimal completion window of 7 to 30 days post-enrollment, with a more comprehensive assessment tool, would better serve both accuracy and timeliness goals. Only 26 percent of HNA completions fall within this window, excluding same-day assessments.

Additionally, the current HNA instrument is structured as a housing interest and preference form rather than a comprehensive housing needs and vulnerability assessment. It does not systematically capture clinical acuity, safety concerns, service dependencies, or documentation status, factors that directly determine a household's ability to utilize a housing opportunity once offered. The result is that the assessment serves as a queue entry mechanism rather than a planning document, and that the real assessment work occurs informally through case conferencing and provider-specific processes outside the HMIS system.

HNA Adequacy for Subpopulations. Beyond the general finding that the HNA instrument captures housing interest rather than vulnerability, the evidence indicates this insufficiency has disproportionate and safety-relevant consequences for specific subpopulations. Survivor-focused providers reported that the assessment is too short to capture the depth of vulnerability required to safely match the highest-need survivors to appropriate survivor housing, meaning the instrument's general shallowness is not merely a data quality concern in this context but a potential safety risk.

Transition-age youth participants described a parallel but distinct problem: the assessment and the broader system are oriented toward families and couples, leaving single youth inadequately served by a tool and process not designed with their circumstances in mind. Housing providers and housing authority stakeholders reported receiving referrals that were a poor match for available housing and services, lacked sufficient document, or were otherwise difficult to locate and navigate through the match to lease-up process.

These findings point to the same root cause, an assessment instrument built for throughput and general housing interest rather than population-specific vulnerability, but the consequences differ in kind. For survivors, the risk is an unsafe match; for TAY, the risk is a system that structurally does not fit their housing pathway. For people with significant barriers and service needs, the risk is continued unsheltered homelessness and the many risks that come with being unsheltered. This distinguishes the issue from the broader assessment quality discussion above and warrants a dedicated, more urgent response (see REC-14/15).

Stage 3 — Currency. The median of 187 days since last HNA across the 3,121-household adjusted BNL denominator, with 47 percent exceeding 180 days since reassessment, means housing prioritization and referral decisions are routinely being made on information that is six or more months old. Household circumstances, like income, health status, housing history, documentation status, and safety concerns, may change materially over this period.

Measured against the CLSA, 34 percent of still-active BNL households are current, and the median household's most recent update is 110 days old. Among households with any post-HNA update, consecutive CLSA records are a median of 39 days apart, and 72 percent of update intervals fall within 90 days. The failure mode is therefore not slow updating by connected households; it is complete contact loss. Nineteen percent of the still-active households has no CLS record whatsoever after their first HNA.

The absence of a current assessment directly undermines the equity and accuracy of every prioritization and referral decision made on their behalf.

The referral gap. The assessment scoring analysis reveals that 91 percent of the highest-priority assessed population, chronically homeless and disabled households, has no housing unit referral on record. Even within the assessed population, the formal housing referral system reaches only 7.7 percent of HNA participants. This finding bridges the Assessment and Referral functions and

underscores that assessment completion alone does not translate into housing access. Being assessed and being matched are separated by a gap that the data shows is rarely closed.

5.3 Recommendations

REC-12: The OC CoC should immediately revise the Disabling Condition Form to remove the disability-type field. HUD prohibits requiring disclosure of a specific disability type or clinical diagnosis as part of coordinated entry screening or assessment; information about disabling conditions may only be gathered for the purpose of determining program eligibility and making appropriate referrals. The revised form should confirm the presence of a disabling condition without specifying type. Concurrently, the CES Policies and Procedures should be updated to include the required disability-related limitations language consistent with HUD guidance. The policy should also clearly state that the Disabling Condition Form is not required to be present for the person to be included in HMIS as having a disabling condition and, by extension, the BNL.

These two actions, form revision and P&P update, are discrete, bounded, and do not require system redesign or significant resources. Completion should be targeted within 30 days and confirmed in writing to the CES Steering Committee. Once the revised form is in use, a brief staff communication should clarify the updated disclosure standard to ensure consistent implementation across all access points and assessing programs.

REC-13: The OC CES should establish a HNA completion target of 90 percent of newly enrolled SO/ES/TH households within 30 days of enrollment, replacing the current pattern of same-day and 91-plus day completion. The target should be implemented as a program-level performance standard, with quarterly reporting to the CES Steering Committee. HMIS should track enrollment-to-HNA days as a standing metric alongside coverage rates.

REC-14: The OC CoC should conduct a structured review of the current HNA instrument and assessment workflow to determine whether the tool captures sufficient information to support accurate housing intervention matching and service supports, both immediate and ongoing. The review should consider whether the instrument should be expanded to incorporate vulnerability scoring, clinical acuity indicators, documentation readiness, navigation and support needs, and safety assessments, particularly for survivors, TAY, and medically complex subpopulations. The review should also examine whether informal supplemental assessment activities conducted outside the formal CES process can be standardized and incorporated into the HMIS record.

REC-15: The OC CoC should conduct an immediate, targeted review of HNA adequacy for survivor and transition-age youth (TAY) populations, separate from the broader instrument review in REC-14. For survivors, the review should determine whether a supplemental, SCES-administered assessment is needed to safely characterize need before a housing match is proposed and should establish a protocol requiring SCES sign-off or consultation before a survivor referral is finalized to a non-DV survivor-specific program. For TAY, the review should assess whether the current instrument and surrounding system design, including housing type availability and program eligibility criteria, adequately serve single youth, who may be structurally disadvantaged by a system oriented toward families and couples.

REC-16: The OC CoC should implement an automated HMIS notification system alerting CES staff and BNL managers when a household's CLSA is approaching 75 days since last update, 15 days before the 90-day standard, to allow time for outreach and scheduling. OCC confirmed automated emails are already generated, and they will look at the timeframe for these emails. We also

recommend HMIS-based alerts, not just email notification. Program-level reassessment currency targets should be set, with performance monitored and reported quarterly. A supplemental mechanism should be developed to enable timely out-of-cycle reassessment when significant household circumstances change, rather than waiting for the next scheduled update window.

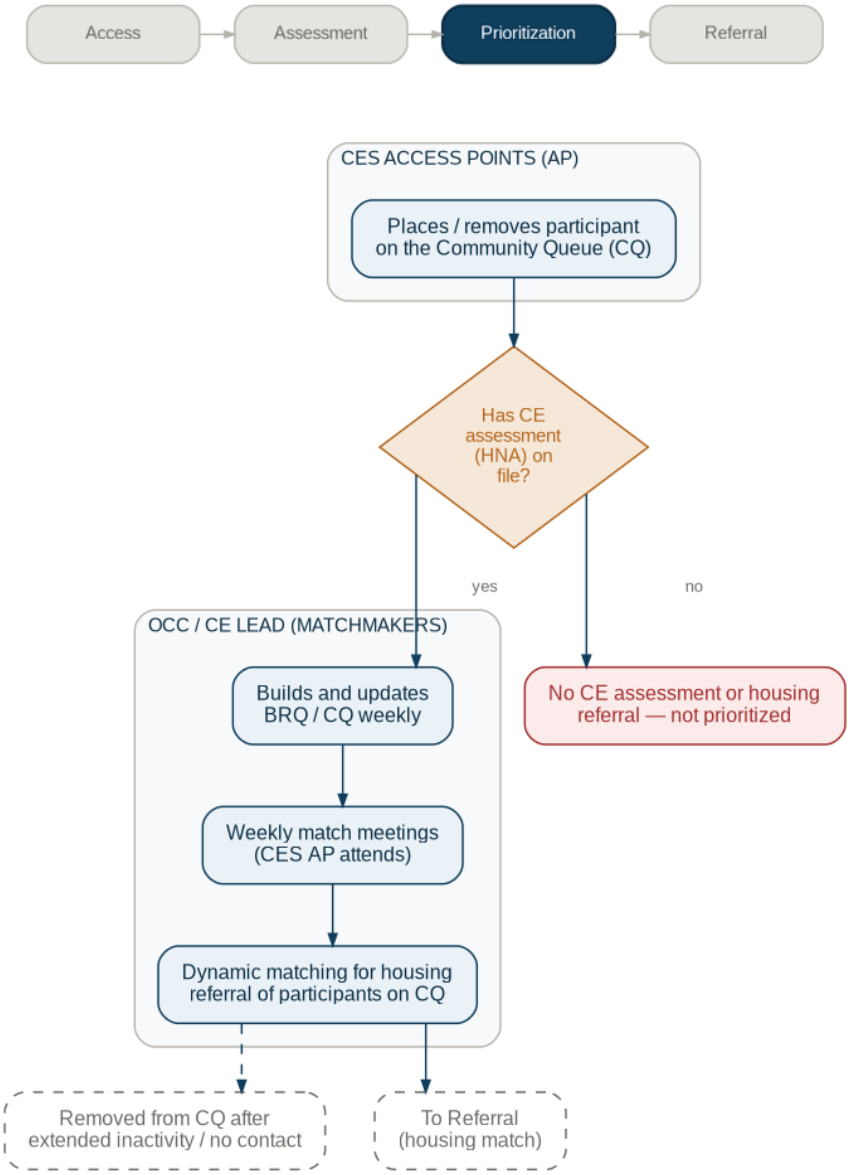
REC-17: Conduct a structured review for all 3,734 households identified as chronically homeless or having a disabling condition who completed a HNA but received no housing unit referral (S3 cohort). For each household, the absence of referral should be categorized as: (a) appropriate based on clinical or resource-based judgment, (b) a documentation or process gap, or (c) an unaddressed resource constraint. Where no clinical reason for non-referral is identified and resources exist, referral should be issued. Priority should be given to households in S3 who have also not been reassessed within 90 days. This review should be completed within 90 days and results reported to the CES Steering Committee.



Section 6: CES Function 3 — Prioritization

Prioritization is the system-level process by which households are ranked for CoC-managed assistance, ensuring that scarce housing and service resources are allocated transparently, equitably, and consistently, with the highest-need households receiving first access. The OC CES implements prioritization through centralized By-Name Lists (BNL), also referred to as the Community Queue (CQ), managed at the system and subpopulation levels and derived from HMIS and comparable databases. This section evaluates placement on the prioritization list, list management practices, timeliness from assessment to housing, BNL turnover, and equity of prioritization outcomes.

Figure 6-1 — CES Prioritization Design



6.1 Key Findings — Prioritization Compliance

Of 8 Prioritization compliance items rated in the Master Matrix, 1 was rated Compliant, 6 were rated Partially Compliant, and 1 was rated Noncompliant. This produces a **compliance rate of 12.5 percent**, placing Prioritization in the **Noncompliant** range. The concentration of Partially Compliant ratings, 6 of 8 items, is the highest concentration of any function evaluated and reflects systemic gaps in written standards, assessment workflow, list management, and alignment between prioritization policy and available resources.

6.1.1. Noncompliant Item 1 — Homelessness Prevention Prioritization

The CES P&Ps are required to describe the process by which people will be prioritized for referrals to homelessness prevention services. No evidence of a homelessness prevention prioritization process was found in the current CES P&Ps. Prevention assistance is reported to be allocated on a first-come, first-served basis, with no risk-based criteria determining who receives prevention resources ahead of others. This represents a direct noncompliance with a required P&P element (see REC-19).

6.1.2. Prioritization Placement Rate

The prioritization placement rate metric examines the progression of households through the CES assessment pathway. Of the 2,229 ES/SO/TH households with a CNA during the evaluation period, **1,461 (66 percent) progressed to a HNA** and were thereby placed on the BNL (Table 6-1). The South SPA recorded a higher CNA-to-HNA progression rate (79 percent) compared to the North SPA (73 percent) and Central SPA (60 percent), though the South SPA's smaller CNA volume (72 participants) limits the reliability of direct comparison with higher-volume SPAs.

Table 6-1 — CNA→HNA Progression Rate by SPA

SPA	# of Households with a CNA	# of Households Progressed to a HNA	Progression Rate
North SPA	852	619	73%
Central SPA	1,244	746	60%
South SPA	72	57	79%
System Total	**2,229**	**1,461**	**66%**

However, **4,127 households (26 percent of the 15,913 target population) completed a HNA with no CNA on record** (Table 6-2), entering the BNL directly without a crisis screening. Of these, 71 percent came through Street Outreach, indicating that the outreach pathway commonly bypasses the CNA and proceeds directly to a HNA. This pathway-level inconsistency means two households on the same BNL may have arrived through fundamentally different intake processes.

Table 6-2 — Disaggregation of Participants by their Assessment

Group	# of Households	% of 15,913
Both CNA and HNA	1,461	9%
HNA only (no CNA)	4,127	26%

Group	# of Households	% of 15,913
CNA only (no HNA)	768	5%
No CNA or HNA	9,557	60%
System Total	**15,913**	**100%**

From the available data, it is also unclear who receives a HNA (and thus is placed on the BNL) and the reasoning behind the households that do not receive a HNA.

The vast majority of ES/SO/TH program participants, over 9,500 households (60 percent), have no assessment of any kind and are therefore not on the BNL and not eligible for prioritized referral to housing or services. This is the direct consequence of the 14 percent CNA coverage rate (OCC clarified that the CNA has not been implemented in the CES and the use of it is an HMIS data entry error) and 35 percent HNA coverage rate documented in Sections 5 and 6.

Equity Considerations

No disparity was identified in BNL placement rates across most subpopulations analyzed (Table 6-3). DV Survivors, Families, and North and South SPA participants are placed on the BNL at slightly higher rates than the system average. The **Youth (TAY) subpopulation is an exception**, placed on the BNL at a rate 13 percentage points below the system average. Youth placement should be monitored closely, particularly given the parallel finding in Section 5 that the current assessment instrument does not adequately capture sub-population specific housing and service needs and vulnerabilities and the stakeholders' feedback about the lack of access and geographic coverage for youth services.

Table 6-3 — Prioritization List Placement

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: ☑ No Disparity (≤5pp) | ⚠ Emerging (5–10pp) | ● Significant (>10pp).							
Prioritization: Prioritization List Placement Rate							
Prioritization	Prioritization List Placement Rate	Black / African American	68%	66%	3%	☑ No Disparity	Low — Track
Prioritization	Prioritization List Placement Rate	Hispanic / Latino	65%	66%	-1%	☑ No Disparity	Low — Track
Prioritization	Prioritization List Placement Rate	White	66%	66%	1%	☑ No Disparity	Low — Track
Prioritization	Prioritization List Placement Rate	Multi-racial	69%	66%	3%	☑ No Disparity	Low — Track
Prioritization	Prioritization List Placement Rate	People with Disabilities	67%	66%	2%	☑ No Disparity	Low — Track
Prioritization	Prioritization List Placement Rate	Youth (Under 25)	53%	66%	-13%	● Significant	Medium — Monitor Closely
Prioritization	Prioritization List Placement Rate	Veterans	64%	66%	-2%	☑ No Disparity	Low — Track
Prioritization	Prioritization List Placement Rate	DV Survivors	73%	66%	8%	☑ No Disparity	Low — Track
Prioritization	Prioritization List Placement Rate	Singles	65%	66%	-1%	☑ No Disparity	Low — Track
Prioritization	Prioritization List Placement Rate	Families	77%	66%	12%	☑ No Disparity	Low — Track
Prioritization	Prioritization List Placement Rate	North SPA	73%	66%	8%	☑ No Disparity	Low — Track
Prioritization	Prioritization List Placement Rate	Central SPA	60%	66%	-6%	☑ No Disparity	Low — Track
Prioritization	Prioritization List Placement Rate	South SPA	79%	66%	14%	☑ No Disparity	Low — Track

Table 6-4 below presents, in addition to the above table, equity findings for the Prioritization List Placement across key demographic dimensions. For each subgroup, two assessments were

conducted: performance relative to the system average, and performance relative to the subgroup's direct counterpart.

Table 6-4 — Prioritization List Placement Equity Assessment

Dimension	Finding	Disparity Flag
Race / Ethnicity	BNL placement rates range from 58% (Asian/Asian American) to 69% (Multiracial). The Asian/Asian American subpopulation is too small at 76 participants for a disparity assessment. The other racial/ethnic groups are very close to the system's average. No racial disparity identified.	**No Disparity**
Household Type	Families are placed on the BNL at a higher rate (77%) than single adults (65%), a meaningful positive counterpart gap reflecting more streamlined family assessment-to-BNL pathways and the proportionally smaller family population.	**No Disparity**
Veteran Status	Veterans are placed slightly below the system average (64%) and the non-veterans (66%). The counterpart gap is negligible.	**No Disparity**
Disability Status	Participants with disabling conditions are placed at a slightly higher rate (67%) than those without (64%), a modest positive counterpart gap.	**No Disparity**
DV Survivor Status	DV survivors are placed above the system average (73%) and above non-DV survivors (64%), a positive counterpart gap.	**No Disparity**
Youth / TAY	TAY participants are placed below the system average (53%) and the non-youth population (66%). However, the TAY subpopulation is small at 70 and as such, no disparity assessment can be made.	**Flag for Monitoring**
Geography (SPA)	South SPA (79%) and North SPA (73%) have higher placement rates than Central SPA (60%). This may reflect differences in program-type composition.	**No Disparity**

6.1.3. Priority List Wait Time

Time from BNL placement to permanent housing exit is measured from the date of HNA completion to the ES/SO/TH program exit date to permanent housing. For the evaluation period, **590 households with a HNA were housed**, with an average of **119 days** (median 102 days) from BNL placement to housing. **46 percent of housed households were housed within 90 days** of BNL placement (Table 6-5). The remaining 54 percent waited longer than 90 days, with **23 percent waiting more than 180 days**.

Table 6-5 — Priority List Wait Time

Days Since Last HNA	# of Households Housed	% of Households Housed
< Same Day	4	0%
1–90 days	269	46%
91–180 days	182	31%

Days Since Last HNA	# of Households Housed	% of Households Housed
181–365 days	135	23%
Total	**590**	**100%**

A notable finding from Table 6-6: the majority of housed households (71 percent) did not have a concurrent ES/SO/TH program enrollment at the time of housing exit. The absence of a concurrent program enrollment for this group warrants further investigation to determine whether these households were enrolled in other program types, had lapsed enrollments, or represent a data recording pattern in HMIS.

Table 6-6 — Priority List Wait Time by Program Type

Program Type	# of Households Housed	Average Days
Coordinated Entry (CE)	420	118
Emergency Shelter (ES-EE)	138	130
Street Outreach (SO)	17	84
Transitional Housing (TH)	14	97
Other	1	0
Total	**590**	**119**

Equity Considerations

No disparity was identified in wait time on the priority list across subpopulations analyzed (Table 6-7). Black/African American, Multi-racial, Youth, Veteran, and Family households were housed faster than their counterparts, on average.

Table 6-7 — Priority List Wait Time

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: ☑ No Disparity (≤5pp) | ⚠ Emerging (5–10pp) | ● Significant (>10pp).							
Priority List Wait Time							
Prioritization	Priority List Wait Time	Black / African American	110	119	-8%	☑ No Disparity	Low — Track
Prioritization	Priority List Wait Time	Hispanic / Latino	123	119	3%	☑ No Disparity	Low — Track
Prioritization	Priority List Wait Time	White	122	119	3%	☑ No Disparity	Low — Track
Prioritization	Priority List Wait Time	Multi-racial	102	119	-14%	☑ No Disparity	Low — Track
Prioritization	Priority List Wait Time	People with Disabilities	120	119	1%	☑ No Disparity	Low — Track
Prioritization	Priority List Wait Time	Youth (Under 25)	113	119	-5%	☑ No Disparity	Low — Track
Prioritization	Priority List Wait Time	Veterans	98	119	-18%	☑ No Disparity	Low — Track
Prioritization	Priority List Wait Time	DV Survivors	123	119	3%	☑ No Disparity	Low — Track
Prioritization	Priority List Wait Time	Singles	124	119	4%	☑ No Disparity	Low — Track
Prioritization	Priority List Wait Time	Families	101	119	-15%	☑ No Disparity	Low — Track
Prioritization	Priority List Wait Time	North SPA	118	119	-1%	☑ No Disparity	Low — Track
Prioritization	Priority List Wait Time	Central SPA	119	119	0%	☑ No Disparity	Low — Track
Prioritization	Priority List Wait Time	South SPA	120	119	1%	☑ No Disparity	Low — Track

Table 6-8 below presents, in addition to the above table, equity findings for the Priority List Wait Time across key demographic dimensions. For each subgroup, two assessments were conducted: performance relative to the system average, and performance relative to the subgroup's direct counterpart.

Table 6-8 — Priority List Wait Time Equity Assessment

Dimension	Finding	Disparity Flag
Race / Ethnicity	Wait times range from 94 days (Asian/Asian American) to 123 days (Hispanic/Latino, DV Survivors). The Asian/Asian American subpopulation is very small at 27. No group is more than 4 days above the average. No racial disparity in wait time.	**No Disparity**
Household Type	Families are housed 23 days faster (101 days) than single adults (124 days), likely reflecting the smaller population and proportionally more available resources.	**No Disparity**
Veteran Status	Veterans are housed faster (98 days) than the system average and the non-veteran average (125 days). This is consistent with the dedicated VA resources.	**No Disparity**
Disability Status	Participants with disabilities wait slightly longer (120 days) than those without (115 days).	**No Disparity**
DV Survivor Status	DV survivors wait 6 days longer (123 days) than non-DV survivors (117 days). Counterpart gap is negligible and does not constitute a disparity.	**No Disparity**
Youth / TAY	TAY participants are housed 6 days faster (113 days) than the system average and the non-youth population (120 days). Modest positive counterpart finding.	**No Disparity**
Geography (SPA)	Wait times are consistent across SPAs (118–120 days). No geographic disparity in time from BNL placement to housing once in the pipeline.	**No Disparity**

6.1.4. By-Name-List Size and Composition

The BNL or Community Queue (CQ) currently contains over 3,600 households. The composition and volume of the CQ reflect a structural misalignment between the households enrolled in the system and the housing resources realistically available to serve them.

The CQ includes households experiencing literal homelessness and households at risk of homelessness. Under the current prioritization policy, which ranks primarily by length of time homeless, at-risk households will not, by definition, accumulate homeless time nor advance toward the top of the list and will not receive a housing referral under current criteria. Their continued presence on the BNL inflates the queue and obscures the proportion of households with a realistic near-term pathway to housing.

BNL turnover during the evaluation period reflects **7,701 total placements** (Table 6-9), across 6,788 unique households, a broader population than the 5,588 SO/ES/TH households with an HNA discussed in Section 5, since Community Queue placements include households from all referral pathways, not only the SO/ES/TH target population. Of these placements:

- 3,712 (48 percent) resulted in "Completed" status. The "Completed" status means that the participant enrolled in *some* program (not necessarily the one initially referred to).
- 2,789 (36 percent) expired due to inactivity exceeding 90 days.
- 1,200 (16 percent) remain active at period end.

The overall turnover rate (proportion reaching a resolved outcome) was 84 percent; the completion rate (proportion of all placements reaching "Completed" status, which may or may not have resulted in housing) was 48 percent.

Table 6-9 — CES BNL Turnover

BNL Outcome	# of Referrals	% of Referrals	# of Households	% of Households
Completed	3,712	48%	3,371	50%
Expired	2,789	36%	2,404	35%
Active	1,200	16%	1,013	15%
Total	**7,701**	**100%**	**6,788**	**100%**

The 36 percent expiry rate—meaning that more than one in three BNL placements removed for inactivity rather than resolved through housing or services—is a significant system performance concern. The median time on the queue before expiry was **144 days** and the mean was **167 days**. Households are automatically removed from the BNL on day 90 with no engagement or updates. The median and average above show that households had their CES enrollment updated or some type of activity was logged to restart the 90 day inactivity timer before the household was removed from the BNL. This finding is directly connected to the assessment currency gap documented in Section 5: the expiry mechanism is functioning as a default removal process rather than a managed, outreach-supported transition.

6.1.5. Stakeholder Feedback

People with Lived Experience

Individuals who were aware they were participating in a system with a Community Queue understood it as the primary, and often only, means by which they could receive assistance to resolve their homelessness and secure housing. However, most participants could not explain how prioritization decisions were made, how their position on the queue was determined, or what they could do to improve their chances of a housing match.

PLE reported that they were rarely provided with information about the steps, timelines, or criteria involved in the process. Confusion about what documentation they needed, and what happened between assessment and housing placement was widespread. Participants expressed a desire for clearer communication about the overall process and their individual standing.

Many participants expressed concerns with their treatment as they were assisted by providers and in the process of securing housing via CES, with almost all indicating they were provided no opportunity to address their concerns. Various individuals also reported receiving threatening phone calls after submitting complaints, being excluded from meetings, and being deprioritized

from housing following complaint activity. This finding is particularly serious as a documented grievance process that is actively undermined through retaliatory conduct at the point of use, is not functioning as designed, regardless of its compliance-level policy documentation. This finding should be investigated and addressed with urgency (see REC-23).

Provider and Leadership Feedback - Strengths

CES Leadership generally described the prioritization process as consistently applied and relatively transparent, attributing this to its reliance on objective, HMIS-documented factors: chronic homelessness status, disability status, and length of current homelessness episode. The single-factor model was viewed by many providers as defensible and less susceptible to manipulation than previous assessment-based methods.

Provider and Leadership Feedback — Challenges

Bluntness of the length-of-homelessness model. Providers widely described the current prioritization model as blunt, ranking households by duration of homelessness rather than housing fit, clinical urgency, safety risk, or complexity of need. Stakeholders reported that this approach can disadvantage individuals who require intensive engagement or specialized services despite significant vulnerability, particularly youth, survivors of violence, and individuals with acute medical or behavioral health needs. These are exactly the populations for whom the lack a severity-of-need scoring component, has the most direct consequences.

Providers serving these populations noted that prioritization does not always align with the level of risk or urgency experienced by participants and does not account for support needs to successfully transition into housing, including with non-CES resources (e.g., BHSA or CalAIM funded services).

BNL composition and resource alignment. Several CES Leadership questioned whether the current prioritization structure aligns with the resources actually available in the system. Specific concerns included: the heavy emphasis on chronic homelessness and disability status in a system with insufficient PSH supply; the large number of at-risk households enrolled in the CQ despite having no realistic path to referral; and the contribution of this population to queue inefficiency and management burden.

6.1.6. Partial Compliance Items

1. Prioritization Design — Written Standards

The CES P&P establishes prioritization criteria organized around chronic homelessness, disability, and length of homelessness. However, the written standard contains a policy error regarding PSH eligibility: the P&P currently states that a household qualifies if it *"met the criteria for chronically homeless prior to entering a government-funded transitional housing program,"* which does not reflect the HUD-permitted allowance for temporarily housing accepted participants in transitional housing while a permanent unit is identified.

The HUD FAQ on CPD-14-012 states: *"HUD has determined that after an individual or family has been accepted into a program but before an appropriate unit has been identified, a household may stay with a friend or family or in a hotel or motel without losing their eligibility for the permanent supportive housing program in which they have already been accepted. HUD would also allow a CoC to temporarily house the participant in an available transitional housing bed while a permanent housing unit is identified. This allowance is only permitted in the circumstances*

described here and does not apply to persons enrolled in transitional housing that were considered chronically homeless prior to entry into the program."

The written standard should be corrected to accurately reflect HUD guidance (see REC-18).

2. Scarce Resource Allocation to Greatest Need

The prioritization process places the highest priority on households with the longest homelessness history and CH/disability status. However, service need is not tested through the current assessment process (Section 5), meaning the "greatest need" determination is operationally limited to duration and categorical status. This item is Partially Compliant because the design intent aligns with HUD requirements but the assessment instrument does not produce the service-need information required to fully implement that intent.

3. Emergency Shelter Prioritization Criteria

The CES P&Ps apply length-of-homelessness prioritization to all program types, including ES. HUD guidance distinguishes between interventions that require prioritization by severity of need (PSH, RRH) and those, such as ES, that should not be prioritized only based on length of homelessness, as doing so further extends the duration of homelessness episodes for those not yet at the top of the list. The current policy should be corrected to remove singular use of length-time-homelessness criteria from ES prioritization. Instead, CES leadership and partners should work collaboratively to establish an equitable shelter prioritization model based on local data and input from key stakeholders, most especially people with lived experience (see REC-20).

4. Consistent Implementation of Prioritization Criteria

Prioritization is consistently applied according to documented criteria - chronically homeless status, disability, and length of homelessness. The CES P&Ps include the factors used in prioritization decisions and these factors are applied uniformly. However, the prioritization criteria do not consider participant vulnerability, as HUD requires, creating a Partially Compliant status: **implementation is consistent, but what is being implemented consistently is insufficient to identify the highest-need households in a clinically meaningful sense.**

5. BNL Management Practices

BNL management protocols are HMIS-compliant with appropriate security protections and removal procedures for inactive or ineligible households. The CES P&P documents conditions under which participants maintain their BNL position when rejecting referral options. However, the policy of enrolling and maintaining all assessed households on the BNL, including those at risk of homelessness who are not eligible for homeless assistance will not be prioritized for housing resources, results in a queue of over 3,600 households that does not accurately reflect the literal homeless population in need of a path to housing. Sound technical management of an operationally unsound list is Partially Compliant.

6. Literal Homelessness at Time of Prioritization

All households referred to ES, SO, PSH, TH, and RRH are literally homeless at the time of prioritization, consistent with HUD requirements. However, the CQ also includes households at risk of homelessness who are enrolled but will not receive referrals to housing programs under current prioritization criteria. Their continued BNL enrollment is Partially Compliant: the literally homeless referral standard is met, but the inclusion of at-risk households in the same queue creates a structural misalignment between list membership and referral eligibility.

6.1.7. Full Compliance Items

The item that was deemed to be in full compliance with the CES requirements covered the prioritization process requirement to include non-discrimination protections and a documented grievance/appeals process for households who believe they were unjustly prioritized or denied.

The CES P&P and Anti-Discrimination Policy include non-discrimination protections, a documented grievance process, and an anti-retaliation policy. Grievance procedures are required to be communicated at intake. All complaints are required to be addressed in a timely and fair manner per policy. While the policy-level grievance framework is compliant, implementation-level evidence indicates that participants have reported retaliatory conduct following complaint submission. Policy compliance and implementation functioning must be evaluated separately; this item is fully compliant at the design level but Low Functioning at the implementation level.

> **COMPLIANCE RATING: NONCOMPLIANT (<75%)**
>
> 1 of 8 compliance items is fully met. 6 items are Partially Compliant, reflecting systemic gaps in written standards, assessment workflow, list management, and resource alignment. The grievance process, the only Compliant item, is undermined at the implementation level by reported retaliatory conduct toward complainants.

6.2 Discussion and Interpretation

The 12.5 percent compliance rate is the lowest of any function evaluated and reflects a prioritization system that is structurally present but operationally misaligned across nearly every dimension. The issues identified here form a connected causal chain that begins in System Design and Assessment and terminates in a prioritization framework that cannot produce the outcomes HUD requires.

The causal chain begins in **Section 3**, where the written standards were found to lack a severity-of-need scoring component. That design gap means the prioritization function has never been given the instrument it needs to operationalize "greatest need" in a clinically meaningful way. The primary sorting criterion, length of time homeless, is administratively defensible and easy to verify, but it ranks endurance of crisis above severity of vulnerability. A youth who has been homeless 30 days and is at acute safety risk ranks below a middle-aged adult who has been homeless 400 days with stable functioning. The current model was not designed to distinguish between them.

The **Section 5** assessment findings compound this directly. The HNA instrument captures housing interest and preference rather than a structured vulnerability profile. When the assessment does not produce clinical acuity, safety risk, or service-need data, prioritization by service need is not operationally possible regardless of what the written standards say, and the written standards currently do not say it either. The result is that both the policy and the instrument systematically exclude the information needed to prioritize correctly and ensure proper transitional supports are both identified and available.

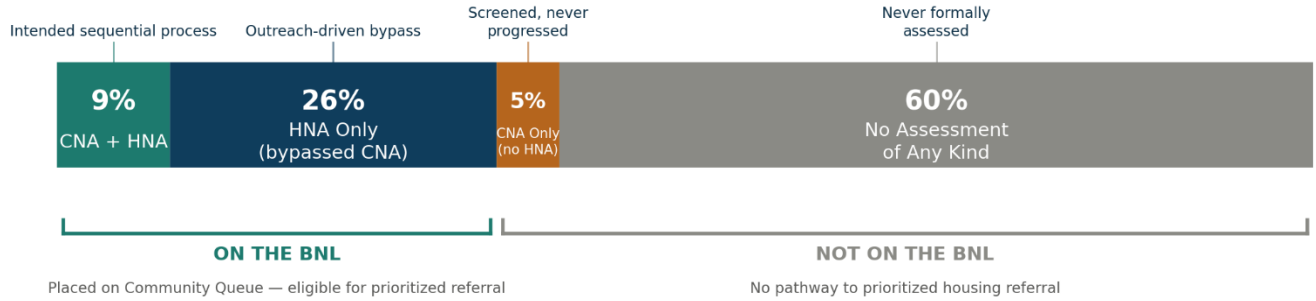
The **inflow-to-permanent housing exit ratio of 6:1 and 7.7:1** for single adults defines the resource context in which this prioritization model operates. For every household that achieves a housing exit, nearly six new households enter the system. In this environment, prioritization is not a process management function, it is the primary mechanism determining which households among a very large competing population will receive one of a very small number of available housing opportunities. The cost of getting that mechanism wrong is proportionally very high. The current

model, which relies primarily on time and categorical status rather than vulnerability and need, does not minimize that cost.

Assessment pathway inconsistency creates unequal access to prioritization. The data reveals three structurally different pathways onto the BNL, each producing a different quality of intake record for the households that arrive through it.

- Households with both a CNA and HNA (9 percent of the target population) entered through the intended sequential process.
- Households with a HNA only (26 percent), the majority of them via Street Outreach, bypassed the CNA entirely and were placed on the BNL without a crisis screening on record.
- The remaining 65 percent of the target population received no assessment of any kind and are not on the BNL at all.

Figure 6-2 – Pathways onto the BNL



The question this raises is whether the BNL, as currently composed, reflects an equitable prioritization of households or an artifact of which provider a household happened to encounter first. A household that enters through an ES program has a 65 percent chance of receiving a HNA and joining the BNL. A household that enters through Street Outreach has a 30 percent chance. The prioritization system cannot be equitable if access to the list itself is determined by program type rather than household need.

The BNL's current size and composition deepen this problem. A queue of over 3,600 households, including at-risk households who will not receive a referral under current criteria, is not a prioritization list in the functional sense. It is a tracking list from which a small number of referrals are periodically drawn. The 36 percent expiry rate confirms that removal from the list for inactivity is as common an outcome as completion. Some inactivity may also be related to system exits to other stable destinations, even if unknown. Households are waiting on a list for a median of 144 days before expiry, and many are waiting far longer. The 47 percent of BNL households with no assessment update in 180 or more days (Section 5) are making housing placement decisions based on information about people whose circumstances have materially changed.

The participant experience findings add a dimension that data alone cannot capture. PLE did not understand the prioritization process, were rarely told how it worked, and in some cases reported being threatened or penalized for attempting to use the formal complaint process. A system that is formally compliant at the policy level but produces intimidation at the point of use has a compliance problem that requires immediate investigative action.

6.3 Recommendations

REC-18: The OC CoC should immediately correct the PSH prioritization eligibility language in its policy to accurately reflect HUD's permitted allowance for temporarily housing accepted program participants in transitional housing while a permanent unit is identified. The correction is a discrete policy edit. The revised policy should be formally adopted by the CoC Board and distributed to all participating providers.

REC-19: The OC CoC should develop a formal Homelessness Prevention Prioritization Protocol, separate from the existing CES BNL, with its own eligibility criteria, risk-based prioritization framework, and designated BNL. Prevention assistance should be allocated based on assessed risk of housing loss, not first-come, first-served. This protocol should be incorporated into the CES P&P as a dedicated section and operationalized with a separate prevention-specific CQ. Households at risk of homelessness should be enrolled in the prevention queue, not the general CQ, which is designed for literally homeless households. They should simultaneously be supported with Housing Problem-Solving at any access points by trained and certified staff.

REC-20: The OC CoC should revise the CES P&P to remove singular use of length-time-homelessness criteria from ES prioritization. HUD guidance distinguishes between interventions that should be prioritized by acuity (PSH, RRH) and crisis-response resources such as ES that generally should be immediately accessible for people with no safe alternative. Applying length-of-homelessness criteria for at-risk populations may incent households into the crisis response system. Instead, CES leadership and partners, including people with lived experience, should devise ES prioritization policies that account for the participants' acuity, available ES options and include negotiated local preferences.

This revision should be coordinated with the severity-of-need scoring revision in REC-1 (Section 3) to ensure alignment across the prioritization framework.

REC-21: The OC CoC should evaluate and refine the current length-of-homelessness–based prioritization model to incorporate participant vulnerability, clinical urgency, housing-fit, and service support needs alongside duration. This need not take the form of a point-based scale, a structured assessment capturing these factors is sufficient. This includes reviewing whether the dynamic-match vote structure produces the intended prioritization outcomes; examining whether tiered queues organized by housing type and acuity would improve match quality and reduce referral failure rates; and implementing a structured case conferencing protocol to supplement list-based ranking with provider-level clinical knowledge.

This recommendation should be developed in direct coordination with the assessment instrument review in REC-14 (Section 5), as vulnerability-based prioritization requires vulnerability data that the current HNA does not produce.

REC-22: The OC CoC should address the gap in HNA coverage for Street Outreach participants, approximately **70 percent of whom have no HNA** and are therefore not placed on the BNL. Outreach workers should be equipped and trained to complete or facilitate HNA completion for all literally homeless participants at or shortly after contact. Given that SO represents 84 percent of the target population and 70 percent of SO participants lack a HNA, this represents the single largest coverage gap between the population experiencing homelessness and the prioritized population for housing resources. Outreach-to-HNA completion should be established as a performance standard and tracked quarterly.

REC-23: The OC CoC should immediately investigate reports that PLE received threatening communications after submitting complaints and were excluded from meetings or deprioritized from housing following complaint activity. The grievance and anti-retaliation policy is the only Fully Compliant item in the Prioritization function; retaliatory conduct at the point of use represents a serious implementation failure that directly undermines that policy's purpose. In light of this finding, the OC CoC should establish a confidential third-party complaint channel that reduces the risk of retaliation. Results should be reported to the CoC Board within 30 days.

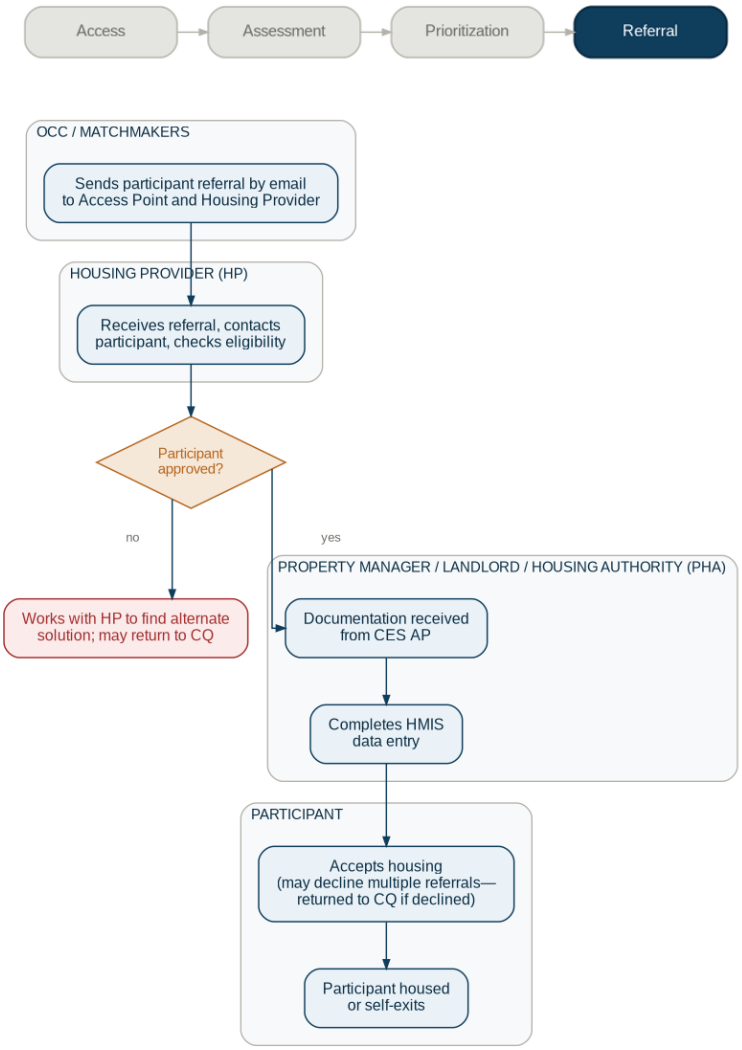
REC-24: The OC CoC should investigate the high BNL expiry rate (36 percent) to determine whether expiring households are being actively contacted and supported prior to removal. BNL managers should track and report the number of households contacted versus unreachable in the 90-day period before expiry, and a formal outreach protocol should be established for households approaching expiry.

The investigation should also examine whether the expiry rate is related to the assessment currency gap (Section 5, REC-16 and REC-17): the CLSA data confirms that a household with no CLSA update in 90 days is automatically removed from referral eligibility, and 19 percent of still-active BNL households have no CLSA update on record at all. Coordinating reassessment outreach with pre-expiry contact could address both issues with a single workflow.

Section 7: CES Function 4 — Referral

Referral is the coordinated, standardized process through which prioritized households are matched and referred to participating housing and service projects with available vacancies. The referral function requires that participating projects fill vacancies through the CES, do not screen out households based on perceived barriers, and comply with Fair Housing requirements. This section evaluates referral acceptance and denial rates, housing match timeliness, housing outcomes, and equity across race, geography, and housing type.

Figure 7-1 — CES Referral Design



Data sources: Two data files assess referral results and are used in parallel throughout this section. They measure different events and are not directly comparable.

The **OCC-provided Match Inventory** tracks unit-level housing opportunity matches for PSH, RRH, TH-RRH, and TBV program types. The evaluation timeframe produced 1,195 records with definitive outcomes (excluding 6 pending or unknown records).

The **HMIS Referrals file** tracks all CES referral transactions in HMIS. During the evaluation period, 816 unique households received 936 housing referrals across all referral sources. Of these, 431 households were part of the 5,588-household SO/ES/TH HNA population evaluated in Section 5.

Where findings differ between sources, both are reported and the source is identified. Where they converge, the finding is treated as confirmed.

7.1 Key Findings — Referral Compliance

Of 12 Referral compliance items rated, 2 were rated Compliant, 8 were rated Partially Compliant, and 2 were rated Noncompliant. This produces a **compliance rate of 17 percent** (items fully compliant), placing Referral in the **Noncompliant** range.

7.1.1. Noncompliant Item 1 — Referral Acceptance Timeline

The OC CES establishes referral acceptance timeline benchmarks of 45 days (Match to Determination) for PSH and 14 days for RRH. Neither benchmark was met during the evaluation period. PSH Match-to-Determination averaged 58 days (median 49 days) against the 45-day target. RRH Match-to-Determination averaged 26 days (median 15 days), a near-miss against the 14-day target. This item is rated Noncompliant (see REC-25). Full timeliness analysis is presented in Section 7.1.5.

7.1.2. Noncompliant Item 2 — Screening-Out Prohibition

CES-participating agencies are prohibited from screening potential participants out of assistance based on perceived barriers to housing or services. Evidence from stakeholder interviews, PLE focus groups, and process review indicates this standard is not being consistently met. The match meeting process, while operationally efficient, lacks the human accountability layer needed to ensure that matches advance to enrollment. PLE frequently reported being left without communication after a match was made, including one participant who waited seven months for a single document to be uploaded. Housing providers reported ill-fitting or underprepared matches, documentation issues, and providers and city representatives describing efforts to actively work around CES rather than through it. This item is rated Noncompliant and is flagged for immediate corrective action (see REC-26).

7.1.3. Timeliness of Assessment to Referral

Time from HNA to first housing referral is measured as days between the household's first HNA date and the Housing Opportunity referral date. During the evaluation period, 816 unique households received 936 Housing Opportunity referrals through the CES Queue, across all referral sources; of these, 431 households were part of the 5,588-household SO/ES/TH HNA population evaluated in Section 5. Of the 936 referrals, 774 valid HNA-to-referral pairs were identified where the household's HNA preceded or coincided with the referral date. The system mean is **35 days** and **64.2 percent of referred participants received their referral on the same day as their HNA**, indicating that for most participants who reach the referral stage, the interval between assessment and referral is effectively zero. This does not by itself mean the entire CES pathway occurred in a single session. A more restrictive check, program enrollment, HNA completion, and housing referral all occurring on the same calendar day, is only measurable for the SO/ES/TH population, where enrollment is defined. Within that population's 413 households with a valid HNA-to-referral

pair, 58 (14 percent) had all three events on the same day, meaning the full CES pathway, from crisis-program entry to a housing match decision, was compressed into a single day for this subgroup. This subgroup's referral acceptance rate (38 percent) is well below the system average.

To test whether this gap reflects program-level CES participation, the evaluation cross-referenced each SO/ES/TH-HNA household's first qualifying enrollment against CES-participation status for ES/TH programs. Referral rates were comparable regardless of participation status: 10.4 percent of households first enrolled in a CES-participating ES/TH program received a housing referral, compared to 11.9 percent of households first enrolled in a non-participating ES/TH program. Program-level CES participation status for ES/TH does not, on its own, explain the low overall referral rate.

The gap is instead concentrated among the 3,921 households (70 percent of the SO/ES/TH-HNA population) whose only qualifying enrollment was SO, who were referred to housing at less than half the rate of ES-enrolled households (6.3 percent, compared to 10.4–11.9 percent for ES/TH-enrolled households). This evaluation could not determine what share of SO-enrolled households were served by a CES-participating outreach team. Within the bounds of this evaluation's CES-participating scope, the referral gap for this population is better explained by the outreach-to-assessment handoff than by formal program-level participation status.

The implications of this pattern are addressed in Section 7.2.

Equity Considerations

From the timeliness of the assessment to referral perspective, two significant disparities are identified for the subpopulations analyzed (Tables 7-1 and 7-2). The North SPA participants show average times that exceed significantly the system average of 35 days. Participants with a disabling condition receive referrals 8 days slower than their non-disabled counterparts. These disparities should be monitored closely going forward to assess root causes.

Table 7-1 — Timeliness of Assessment to Referral

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: ☑ No Disparity (≤5pp) | ⚠ Emerging (5–10pp) | ● Significant (>10pp).							
Referral: Time from Assessment to Referral							
Referral	Time from Assessment to Referral	Black / African American	19	35	-44%	☑ No Disparity	Low — Track
Referral	Time from Assessment to Referral	Hispanic / Latino	35	35	0%	☑ No Disparity	Low — Track
Referral	Time from Assessment to Referral	White	40	35	13%	⚠ Emerging	Low — Track
Referral	Time from Assessment to Referral	Multi-racial	21	35	-40%	☑ No Disparity	Low — Track
Referral	Time from Assessment to Referral	People with Disabilities	36	35	4%	☑ No Disparity	Low — Track
Referral	Time from Assessment to Referral	Youth (Under 25)	40	35	13%	⚠ Emerging	Low — Track
Referral	Time from Assessment to Referral	Veterans	23	35	-36%	☑ No Disparity	Low — Track
Referral	Time from Assessment to Referral	DV Survivors	35	35	-1%	☑ No Disparity	Low — Track
Referral	Time from Assessment to Referral	Singles	35	35	0%	☑ No Disparity	Low — Track
Referral	Time from Assessment to Referral	Families	32	35	-8%	☑ No Disparity	Low — Track
Referral	Time from Assessment to Referral	North SPA	42	35	20%	● Significant	High — Immediate Action
Referral	Time from Assessment to Referral	Central SPA	36	35	3%	☑ No Disparity	Low — Track
Referral	Time from Assessment to Referral	South SPA	26	35	-26%	☑ No Disparity	Low — Track

Table 7-2 below presents, in addition to the above table, equity findings for the Timeliness of Assessment to Referral across key demographic dimensions. For each subgroup, two assessments

were conducted: performance relative to the system average, and performance relative to the subgroup's direct counterpart.

Table 7-2 — Timeliness of Assessment to Referral Equity Assessment

Dimension	Finding	Disparity Flag
Race / Ethnicity	Black/AA (19.4 days), NHPI (17.5 days) and Multiracial (21.1 days) participants receive referrals substantially faster than White Non-Hispanic participants (39.5 days). Hispanic/Latino participants (35.3 days) are at the system average. The AI/AN subpopulation shows the highest referral time at 55.7 days, however, the subpopulation size is very low, 11 referrals, and as such no disparity assessment can be made.	**No Disparity**
Household Type	Single adults (35.4 days) and families (31.9 days) have a 3-day difference in the referral time with families being referred slightly faster than single adults.	**No Disparity**
Veteran Status	Veterans receive referrals 12.4 days faster (22.5 days) than the system average, consistent with a better resourced system. Non-veterans (37.8 days) are referred 15 days slower, in average, than veterans.	**No Disparity**
Disability Status	Participants with a disabling condition receive referrals near the system average (36.3 days). Non-disabled participants are referred 8 days faster, at 28 days.	**Significant**
DV Survivor Status	DV survivors receive referrals at the system average rate (34.7 days) and non-DV survivors slightly slower at 36.1 days, not a meaningful counterpart gap.	**No Disparity**
Youth / TAY	TAY participants wait 4.7 days longer (39.6 days) than the system average. Non-youth are referred approximately 5 days faster.	**Flag for monitoring**
Geography (SPA)	North SPA participants wait 7 days longer (42.4 days) than the system average and 16 days longer than South SPA participants (26.4 days), the largest geographic counterpart gap in this table. North SPA's longer referral time suggests the delay accumulates between assessment and referral issuance rather than in the assessment process itself.	**Significant — North SPA**

7.1.4. Referral Results

Two data sources are available to assess the referral results.

OCC-Provided Match Inventory

OCC provided a data file that tracks the housing matches since 2024, outside the HMIS. This data was restricted to activity during October 2024 – September 2025. Of 1,189 definitive Match Inventory records within the evaluation timeframe, 550 referrals (46.3 percent) were accepted, falling below the 50 percent target (Table 7-3). 367 referrals (30.8 percent) were declined by the participant, representing the single largest outcome category and the primary driver of below-target acceptance. Provider or PHA denial accounted for 115 referrals (9.7 percent) and 147 participants (12.4 percent) were unresponsive.

Table 7-3— Match Inventory Outcome Distribution, OCC Data

Outcome	# of Match Counts	% Outcomes	Status
Accepted	550	46%	✓ Near target
Participant Declined	367	31%	Primary barrier — largest single group
Participant Unresponsive	147	12%	—
Provider/PHA Denied	115	10%	—
Other	10	1%	—
Pending (excluded)	6	—	—
Total	**1,189**	**100%**	—

Of the 550 accepted matches, 482 (88 percent) resulted in a confirmed move-in, but those represent only 40.5 percent of all 1,189 match records. By program type, 57.6 percent of **all** PSH match records (630 total) have a move-in date, compared to only 21.5 percent of **all** RRH match records (520 total).

The low overall move-in rate is driven by RRH's 31 percent acceptance rate, 69 percent of RRH referrals are declined or denied before a move-in is ever possible (Table 7-4). Participants in RRH declined housing at a 48 percent rate (247 out of 520 matches), confirming stakeholder feedback about RRH being an inadequate option. RRH referrals are the primary driver of the below-target system acceptance rate. PSH acceptance (57.9 percent) meets the ≥50 percent target, however, the target itself is low; RRH acceptance (31 percent) falls materially below the ≥60 percent target.

Table 7-4 — Referral Acceptance Rate by Housing Type, OCC Data

Housing Type	# of Match Counts	# Accepted	Acceptance Rate	Acceptance Target	Status	# of Move-Ins	Move-In Rate
PSH	630	365	58%	≥50%	✓ Meets target	363	58%
RRH	520	161	31%	≥60%	✗ Well below target	112	22%
TH-RRH	25	18	72%	—	—	1	4%
TBV	14	6	43%	—	—	6	43%
Total	**1,189**	**550**	**46%**	**—**	—	**482**	**41%**

HMIS Referrals Data

Using HMIS data to assess referrals, 816 unique households received 936 housing referrals during the evaluation period, across all referral sources. Of 936 Housing Opportunity referrals in HMIS, **473 (50.5 percent) were accepted**, meeting the ≥50 percent system target. **235 referrals (25.1 percent) were declined by the participant** and 169 (18.1 percent) were denied by the provider or housing authority (Table 7-5).

Table 7-5— Match Inventory Outcome Distribution, HMIS Data

Outcome	# of Referral Counts	% Outcomes	Status
Accepted	473	51%	✓ On target
Participant Declined	235	25%	Primary barrier — largest single group
Provider/PHA Denied	169	18%	—
Pending (excluded)	57	—	—
Total	**936**	**100%**	—

Disaggregating the housing types and their acceptance rates, using this dataset RRH referrals acceptance rate shows very close to the target goal, and the PSH referrals acceptance rate is lower than goal (Table 7-6).

Table 7-6 — Referral Acceptance Rate by Housing Type, HMIS Data

Housing Type	# of Referral Counts	# Accepted	Acceptance Rate	Acceptance Target	Status
PSH	482	217	45%	≥50%	✗ Below target
RRH	339	197	58%	≥60%	✓ Near target
Other PH	116	59	51%	—	—
Total	**936**	**473**	**51%**	—	—

The OCC Match Inventory and HMIS Referrals data are related but distinct sources that measure different points in the referral process. The HMIS Referrals file recorded a higher RRH completion rate than the OCC because "Completed" in HMIS means a referral resulted in some enrollment, not necessarily in the RRH program the participant was referred to. A participant referred to RRH who enrolled in Emergency Shelter would show as Completed in HMIS. The OCC Match Inventory, by contrast, tracks whether a participant accepted a specific housing unit through the full match process, which is a stricter and more meaningful measure of RRH placement performance. For this reason, the OCC figure (31.0 percent) is the primary source for acceptance rate analysis in this section.

Equity Considerations

From the referral acceptance rate perspective, no significant disparity was identified for the subpopulations analyzed (Tables 8-7 and 8-8), except for the Youth and Veteran subpopulation, dependent on the data source used. However, the number of youth referred was very small at 4 and as such no disparity assessment can be conducted for this subpopulation. Some emerging disparities are noted for the North SPA participants that have lower acceptance rates and these subpopulation acceptance rates should be monitored closely. Referral acceptance rate also shows low for the Native Hawaiian and Pacific Islander (NHPI) subpopulation, at 88 percent denial rate (7 out of 8 referrals) using the OCC data at 100 percent (8 referrals, all denied) using HMIS data and for the Asian/Asian American subpopulation at 59 percent denial rate (16 out of 27 referrals) using the OCC data and 54 percent denial rate (15 out of 28 referrals) using HMIS data. Cohort size is low for these subpopulations and as such a disparity cannot be assessed. For these

subpopulations, the participant denial rates are high compared to the system average and drive the lower acceptance rate.

Table 7-7 — Referral Acceptance Rate, OCC Data

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: ☑ No Disparity (≤5pp) | ⚠ Emerging (5–10pp) | ● Significant (>10pp).							
Referral: Referral Acceptance Rate - OCC Provided Data							
Referral	Referral Acceptance Rate	Black / African American	48%	46%	2%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	Hispanic / Latino	60%	46%	14%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	White	52%	46%	6%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	Multi-racial	46%	46%	-1%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	People with Disabilities	51%	46%	5%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	Youth (Under 25)	25%	46%	-21%	● Significant	Medium — Monitor Closely
Referral	Referral Acceptance Rate	Veterans	38%	46%	-9%	⚠ Emerging	Low — Track
Referral	Referral Acceptance Rate	DV Survivors	60%	46%	14%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	Singles	46%	46%	-1%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	Families	53%	46%	7%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	North SPA	39%	46%	-7%	⚠ Emerging	Low — Track
Referral	Referral Acceptance Rate	Central SPA	47%	46%	1%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	South SPA	55%	46%	9%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	All SPA	47%	46%	1%	☑ No Disparity	Low — Track

Table 7-8 — Referral Acceptance Rate, HMIS Data

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: ☑ No Disparity (≤5pp) | ⚠ Emerging (5–10pp) | ● Significant (>10pp).							
Referral: Referral Acceptance Rate							
Referral	Referral Acceptance Rate	Black / African American	55%	51%	5%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	Hispanic / Latino	49%	51%	-2%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	White	52%	51%	1%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	Multi-racial	57%	51%	7%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	People with Disabilities	49%	51%	-2%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	Youth (Under 25)	53%	51%	3%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	Veterans	33%	51%	-18%	● Significant	Medium — Monitor Closely
Referral	Referral Acceptance Rate	DV Survivors	62%	51%	11%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	Singles	48%	51%	-3%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	Families	69%	51%	19%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	North SPA	48%	51%	-2%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	Central SPA	46%	51%	-5%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	South SPA	64%	51%	14%	☑ No Disparity	Low — Track
Referral	Referral Acceptance Rate	All SPA	67%	51%	16%	☑ No Disparity	Low — Track

Table 7-9 below presents, in addition to the above tables, equity findings for the Referral Acceptance Rate across key demographic dimensions. For each subgroup, two assessments were conducted: performance relative to the system average, and performance relative to the subgroup's direct counterpart.

Table 7-9 — Referral Acceptance Rate Equity Assessment

Dimension	Finding	Disparity Flag
Race / Ethnicity	Acceptance rates are broadly distributed across racial/ethnic groups. Two small-sample findings warrant monitoring: NHPI participants have an 88 percent denial rate (7 of 8 referrals denied, OCC data) and Asian/AA participants have a 59 percent denial rate (16 of 27 referrals). Cohort sizes are too small for a formal disparity determination, but the pattern is notable. Participant-driven denials, not provider denials, are the primary driver for both groups.	**Flag for Monitoring**
Household Type	In the HMIS data families have a substantially higher acceptance rate (69%) than singles (48%). The OCC data shows a very similar acceptance rates between the two subpopulations. This gap reflects program-type composition rather than differential treatment.	**No Disparity**
Veteran Status	In the OCC data veterans have a 38% acceptance rate vs. 46% system average and 48% rate for non-veterans. In the HMIS data the gap is more significant: veterans (33% HMIS) vs. non-veterans (54%). Veterans' denial rate is driving the lower acceptance rates. This pattern is consistent across both data sources and warrants monitoring.	**Flag for Monitoring**
Disability Status	In the HMIS data participants with a disabling condition have an acceptance rate near the system average (49% HMIS) but a lower rate than their non-disabled counterparts (66%). In the OCC data the rates are reversed, 51% of participants with a disabling condition accepted a referral vs 45% of the non-disabled participants.	**No Disparity**
DV Survivor Status	DV survivors have higher acceptance rates (59% HMIS / 56% OCC) than the system average and their non-DV counterparts.	**No Disparity**
Youth / TAY	OCC data shows a 50% youth acceptance rate. HMIS data shows 53% acceptance vs the non-youth 51% rate, but both cohorts are very small and thus unreliable.	**No Disparity**
Geography (SPA)	The North and Central SPAs have lower acceptance rates (48% HMIS / 39% OCC for North and 46% HMIS / 47% OCC for Central) than the South SPA (64% HMIS / 55% OCC). The South SPA, however, has only 1/3 of the referrals that each the North and Central SPAs have.	**No Disparity**

7.1.5. Housing Match Timeliness

Housing match time is measured across three intervals from the OCC Match Inventory data: Date of Match to Date of Determination (M→Det), Date of Match to Move-In Date (M→MI), and Date of Determination to Move-In Date (Det→MI). Performance benchmarks are drawn from the OC CoC Housing Times and Rates reference document.

The only target that PSH meets is the Determination-to-Move-in of less than 30 days (actual: 24-day average / 6 days median) indicating that once a match determination is made, the physical move-in

process occurs promptly. The delay accumulates between the initial match and the determination decision. For RRH, all three benchmarks are either missed or near-missed, with Match-to-Move-In at 77 days average against a 44-day target, 75 percent over benchmark. The Match to Determination is a near-miss (15 days versus a 14-day target) (Table 7-10).

Table 7-10 — Housing Match Performance vs. CoC Benchmarks

Housing Type	Metric	Target	Actual (Avg/Median)	Status
PSH	Match→Determination	≤45 days	58/49 days	✗ Not met
PSH	Determination→Move-In	≤30 days	24/6 days	✓ Met
PSH	Match→Move-In	≤75 days	98/80 days	✗ Not met
RRH	Match→Determination	≤14 days	26/15 days	⚠ Near miss
RRH	Determination→Move-In	≤30 days	63/48 days	✗ Not met
RRH	Match→Move-In	≤44 days	77/60 days	✗ Not met

Equity Considerations

From the housing placement timeliness perspective, disparities are identified for the Black/African American, DV Survivors and South SPA participants where the time to the housing placement is significantly higher than the system's average (Table 7-11). For these subpopulations, the root causes should be identified and then further monitored. For the South SPA, both the M→Det and Det→MI targets are higher than the system's average. For the Black/African American and DV Survivors subpopulations the Det→MI average and mean are higher than for the other racial/ethnic/experience subgroups and drive the slower housing.

Table 7-11 — Time to Housing Placement

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: ☑ No Disparity (≤5pp) | ⚠ Emerging (5–10pp) | ● Significant (>10pp).							
Referral: Time to Housing Placement (days)							
Referral	Time to Housing Placement (days)	Black / African American	109	94	16%	● Significant	Medium — Monitor Closely
Referral	Time to Housing Placement (days)	Hispanic / Latino	89	94	-5%	☑ No Disparity	Low — Track
Referral	Time to Housing Placement (days)	White	94	94	0%	☑ No Disparity	Low — Track
Referral	Time to Housing Placement (days)	Multi-racial	74	94	-21%	☑ No Disparity	Low — Track
Referral	Time to Housing Placement (days)	People with Disabilities	95	94	1%	☑ No Disparity	Low — Track
Referral	Time to Housing Placement (days)	Youth (Under 25)	34	94	-64%	☑ No Disparity	Low — Track
Referral	Time to Housing Placement (days)	Veterans	79	94	-16%	☑ No Disparity	Low — Track
Referral	Time to Housing Placement (days)	DV Survivors	142	94	51%	● Significant	High — Immediate Action
Referral	Time to Housing Placement (days)	Singles	101	94	7%	☑ No Disparity	Low — Track
Referral	Time to Housing Placement (days)	Families	56	94	-40%	☑ No Disparity	Low — Track
Referral	Time to Housing Placement (days)	North SPA	72	94	-23%	☑ No Disparity	Low — Track
Referral	Time to Housing Placement (days)	Central SPA	99	94	5%	☑ No Disparity	Low — Track
Referral	Time to Housing Placement (days)	South SPA	147	94	56%	● Significant	High — Immediate Action
Referral	Time to Housing Placement (days)	All SPA	79	94	-16%	☑ No Disparity	Low — Track

Table 7-12 below presents, in addition to the above tables, equity findings for the Time to Housing Placement across key demographic dimensions. For each subgroup, two assessments were conducted: performance relative to the system average, and performance relative to the subgroup's direct counterpart.

Table 7-12 — Time to Housing Placement Equity Assessment

Dimension	Finding	Disparity Flag
Race / Ethnicity	Black/AA (50 moved-in) and Asian/AA (10 moved-in) participants (109 days each) take 15 days longer than the 94-day system average and 15 days longer than the White Non-Hispanic to move-in. This is driven by longer Determination-to-Move-In times, suggesting post-match barriers rather than pre-match process differences. However, the Asian/AA participant cohort size is too small for a formal disparity determination.	**Significant**
Household Type	Families (56 days) are housed 38 days faster than the system average and approximately 45 days faster than single adults (101 days). This reflects both more efficient family placement processes and resource availability.	**No Disparity**
Veteran Status	Veterans (78 days) are housed 16 days faster than the system average and approximately 19 days faster than the non-veteran counterpart, consistent with the dedicated veteran housing resources.	**No Disparity**
Disability Status	Participants with a disabling condition (95 days) are housed near the system average nut lower than their non-disabled counterparts (86 days).	**No Disparity**
DV Survivor Status	DV survivors (142 days) take 48 days longer than the 94-day system average, a 51 percent counterpart disadvantage. This is driven by longer Determination-to-Move-In time, suggesting the delay occurs specifically in post-match housing search and unit access rather than upstream.	**Significant**
Youth / TAY	TAY participants (34 days) are housed 60 days faster than the system average, by far the best timeliness result of any subgroup.	**Flag for Monitoring**
Geography (SPA)	South SPA (147 days) takes 53 days longer than the system average and 75 days longer than North SPA (72 days), the largest geographic counterpart gap in this table. Central SPA (99 days) is near average. South SPA's longer placement time is particularly notable. The bottleneck appears to be in post-match housing unit availability and landlord engagement rather than in CES workflow.	**Significant — South SPA**

7.1.6. Housing Outcomes and Returns to Homelessness

Exit outcome data drawn from HUD's Stella P module and HMIS data extract (for SO) shows that the overall rate of exits to permanent destinations is 21 percent of all exits (973 permanent exits out of 4,590 total exits). By program type, ES exits to permanent housing stand at 15 percent against a 30 percent target, and Street Outreach exits to permanent housing stand at 2 percent against a 20 percent target. For RRH, the success rate shows 54 percent against an 80 percent target rate. Overall, no program type meets its successful exit rate target, the rates of success are lower than projected goals (Table 7-13). Length of stay in ES averages 120 days against a 30-day target and Street Outreach length of participation averages 42 days compared to a 65-day target.

The Return to Homelessness outcome data drawn from HUD's Stella P module shows that overall, the 6-month return-to-homelessness rate for Households that exited within the previous 12 months is 22 percent, far exceeding the 10 percent target for ES programs and the 7 percent target for permanent housing programs. The ES return rate is 25 percent, PSH returns to homelessness are 42 percent and RRH returns are at 7 percent (Table 7-13).

Table 7-13 — Housing Outcomes and Returns to Homelessness

Program Type	Successful Exit Rate Target	Successful Exit Rate	Average Length Target	Average Length	Return Rate Target	Return Rate
ES	≥30%	15%	≤30 days	120 days	≤10%	25%
SO	≥20%	2%	≤65 days	42 days	≤10%	N/A
TH	≥75%	57%	≤180 days	N/A	≤10%	5%
RRH	≥80%	54%	N/A[1]	N/A[1]	≤7%	7%
PSH	≥95%	N/A[6]	N/A[1]	N/A[1]	≤7%	42%

The PSH return-to-homelessness rate of 42 percent must be interpreted alongside PSH's design as permanent housing. Participants in PSH rarely exit voluntarily; exits typically occur due to eviction, program termination, or participant choice, meaning the denominator of PSH exits is a small, high-risk subset of the PSH population rather than all PSH participants. The 42 percent return rate reflects the experience of this subset, not of the PSH-enrolled population as a whole. Nonetheless, the rate is substantially above the 7 percent target and warrants review of exit circumstances and post-exit support availability for this population.

For SO there is no return target established. The latest System Performance Measures (SPM) report shows SO with a 20 percent return to homelessness rate, a comparable rate with ES, but given the volume of participants served by SO compared to the ES volume, this result is positive.

Equity Considerations

From the housing placement success and returns to homelessness perspective, no disparities are identified (Tables 7-14 and 7-15). In general, all subpopulations are exiting with similar success rates and return to homelessness at similar rates.

[6] Goal was not established, data was not available to calculate metric or cohort too small.

Table 7-14 — Successful Exit Rate

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: ☑ No Disparity (≤5pp) | ⚠ Emerging (5–10pp) | ● Significant (>10pp).							
Referral: Successful Exit Rate							
Referral	Successful Exit Rate	Black / African American	28%	21%	7%	☑ No Disparity	Low — Track
Referral	Successful Exit Rate	Hispanic / Latino	22%	21%	1%	☑ No Disparity	Low — Track
Referral	Successful Exit Rate	White	19%	21%	-2%	☑ No Disparity	Low — Track
Referral	Successful Exit Rate	Multi-racial	19%	21%	-2%	☑ No Disparity	Low — Track
Referral	Successful Exit Rate	People with Disabilities	17%	21%	-4%	☑ No Disparity	Low — Track
Referral	Successful Exit Rate	Youth (Under 25)	46%	21%	25%	☑ No Disparity	Low — Track
Referral	Successful Exit Rate	Veterans	42%	21%	21%	☑ No Disparity	Low — Track
Referral	Successful Exit Rate	DV Survivors	21%	21%	0%	☑ No Disparity	Low — Track
Referral	Successful Exit Rate	Singles	15%	21%	-6%	⚠ Emerging	Medium — Monitor Closely
Referral	Successful Exit Rate	Families	50%	21%	29%	☑ No Disparity	Low — Track

Table 7-15 — Return to Homelessness Rate

CES Function	Metric / Indicator	Population Group	Group Outcome Rate (%, #)	System Average (%,#)	Variance (pp)	Disparity Flag	Severity
Variance (col F) auto-calculates. Disparity Flag (col G) auto-populates: ☑ No Disparity (≤5pp) | ⚠ Emerging (5–10pp) | ● Significant (>10pp).							
Referral: Return to Homelessness Rate							
Referral	Return to Homelessness Rate	Black / African American	18%	22%	-4%	☑ No Disparity	Low — Track
Referral	Return to Homelessness Rate	Hispanic / Latino	22%	22%	0%	☑ No Disparity	Low — Track
Referral	Return to Homelessness Rate	White	23%	22%	1%	☑ No Disparity	Low — Track
Referral	Return to Homelessness Rate	Multi-racial	22%	22%	0%	☑ No Disparity	Low — Track
Referral	Return to Homelessness Rate	People with Disabilities	25%	22%	3%	☑ No Disparity	Low — Track
Referral	Return to Homelessness Rate	Youth (Under 25)	10%	22%	-12%	☑ No Disparity	Low — Track
Referral	Return to Homelessness Rate	Veterans	14%	22%	-8%	☑ No Disparity	Low — Track
Referral	Return to Homelessness Rate	DV Survivors	22%	22%	0%	☑ No Disparity	Low — Track
Referral	Return to Homelessness Rate	Singles	25%	22%	3%	☑ No Disparity	Low — Track
Referral	Return to Homelessness Rate	Families	6%	22%	-16%	☑ No Disparity	Low — Track

7.1.7. Resource Utilization and CES Participation

The 2025 Housing Inventory Chart (HIC) was used to assess the efficient utilization of available resources and CES Participation. All PSH beds are included in the CES but lower participation rates are recorded for ES/RRH/TH programs.

Table 7-16 — Utilization and CES Participation Rates

Program Type	Total Beds - All	Utilization - All	Total Beds - CES Participating	Utilization - CES Participating	CES Participation Rate
Emergency Shelter	3,162	87%	2,159	91%	68%
Other Permanent Housing	2,403	96%	2,108	98%	88%
Permanent Supportive Housing	3,123	91%	3,123	91%	100%
Rapid Re-Housing	681	100%	516	100%	76%
Transitional Housing	959	72%	68	54%	7%
Overall Utilization	**10,328**	**90%**	**7,974**	**93%**	**77%**

The HIC shows **77 percent of available beds participate in the CES**[7], with strong utilization rates across most program types. ES utilization (91 percent) exceeds the 70 percent CoC target. PSH utilization (91 percent) is near the 95 percent target. TH utilization (54 percent) falls substantially below the 80 percent target, though the participating TH inventory is small (68 beds), limiting the interpretation of this shortfall. All PSH beds participate in CES; lower participation rates are recorded for ES, RRH, and TH.

7.1.8. Stakeholder Feedback

People with Lived Experience

PLE experienced and other stakeholders affirmed significant barriers between referral, matching, and enrollment, resulting in repeated matches, missed housing opportunities, and prolonged periods of homelessness. PLE frequently described a referral and matching process that lacked transparency and predictability. PLE participants often did not understand how housing matches were made, why they were referred to specific programs, or what factors determined whether a housing opportunity would ultimately result in enrollment.

PLE noted multiple housing matches and continued uncertainty about their housing status and the resulting stress and compounding difficulties such experiences created. PLE described these experiences as discouraging and confusing, particularly when they believed they had secured a housing opportunity only to have it fall through later in the process. Some PLE perceived favoritism or unequal treatment, leading to concerns about the fairness and transparency of homeless assistance and CES processes.

PLE also described limited support in understanding or completing the steps required after a match was made, including obtaining documentation, addressing eligibility barriers, communicating with housing providers, and navigating housing search requirements associated with voucher programs.

Provider and Leadership Feedback - Strengths

CES Leadership generally affirmed that referral policies are understood and that many housing providers follow CES referral expectations. Some respondents described strong partnerships among CES stakeholders and ongoing training opportunities intended to support implementation.

Respondents reported that OCC leadership tracks referral outcomes, including accepted matches and reasons matches do not proceed.

Provider and Leadership Feedback – Challenges

CES match meetings were widely described as efficient but missing a human layer; a large share of matches do not convert to enrollment (46% acceptance rate, 53% denial rate and only 40% move-rate), PSH units sat vacant for months.

A key challenge identified by a cross-section of participants was that housing matches were often made before eligibility requirements and documentation readiness had been fully confirmed through the assessment, referral, and case conferencing processes. As a result, individuals were frequently referred to or matched with housing opportunities only to later learn that they did not

[7] CES participation was provided by OC OCC.

meet program eligibility requirements, lacked required documentation, or were otherwise unable to move forward with enrollment.

Many participants reported multiple matches are frequently required before successfully enrolling a person in a housing program. Each unsuccessful match often resulted in additional waiting periods, repeated document collection efforts, challenges with compliance and funding/partner confidence.

CES Leadership identified several factors contributing to unsuccessful matches:

- Housing opportunities not matching household needs.
- Insufficient affordable housing supply.
- Inconsistent housing navigation support.
- Delays within housing authority processes.
- Varying landlord engagement efforts.
- Unknown or inconsistent provider eligibility requirements.

Several CES Leadership expressed concern that access points and CES administrators often lack visibility into housing authority screening requirements before referrals are made. This can result in referrals that later fail due to provider-specific criteria that were not known during matching.

CES Leadership reported concerns regarding:

- High denial rates.
- Repeat referrals for the same households.
- Households remaining matched to opportunities for extended periods without housing outcomes.
- Referral outcomes and housing placement rates

One participant stated that a housing outcome rate near 50% appeared low and suggested expectations closer to 75%, while others viewed current performance as understandable given existing logistical challenges.

A growing concern identified by stakeholders is the shift of access points from open to closed status. As more providers operate as closed access points, the effective CES participation rate decreases in functional terms even while the formal HIC participation rate remains stable. This trend, documented in Section 4, directly limits the reach of the referral function.

Housing Provider Compliance

CES Leadership provided mixed feedback on provider adherence to CES referral policies. Barriers included data quality issues, staff turnover, training retention challenges, high workload, and new providers' unfamiliarity with CES processes. While some CES Leadership believed providers generally comply with policies, others indicated inconsistent adherence among certain housing providers.

7.1.9. Partial Compliance Items

1. Resource availability.

The types and volume of resources managed through CES are constrained by available funding. The CES participation rate is 77 percent, and more access points are operating as closed rather than open, limiting the effective referral pool available to the system.

2. CES participation requirement and referring agency recruitment.

The CES design requires that 100 percent of referrals to CoC-managed resources come through the CES in ways accessible to all populations, including those served by VSPs. This design requirement is documented in the P&P. However, the CES does not actively recruit additional referring agencies, and an increasing proportion of access points are operating as closed rather than open access points. The effective reach of the referral pipeline is therefore narrowing even as the formal participation requirement remains in place.

3. Participant autonomy.

The CES referral process ensures participant autonomy, it is not coercive or discriminatory and includes an annually updated resource list. However, the resource list is not current, and housing choice options and navigation support are limited in practice, constraining the meaningful exercise of the autonomy the policy provides.

4. Acceptance and denial rates.

Housing placement rates partially meet CoC targets. PSH acceptance (58 percent, OCC) meets the ≥50 percent target; RRH acceptance (31 percent, OCC) falls materially below the ≥60 percent target. Denial rates are within acceptable thresholds for PSH but exceed them for RRH.

5. Application completion and match quality.

Rates of housing application completion, average matches required per successful placement, time to move-in, and the proportion of assessed participants whose need is met through referral are all below standard. The 40 percent overall move-in rate reflects material attrition between referral issuance and successful placement.

6. Recidivism rates.

Return-to-homelessness rates exceed targets for ES (25 percent vs. ≤10 percent target) and PSH (42 percent vs. ≤7 percent target). RRH returns (7 percent) meet the target.

7. Project utilization.

Utilization rates meet the CoC target for ES (91 percent vs. ≥70 percent target) but fall short for TH (54 percent vs. ≥80 percent target). PSH utilization (91 percent) is near its 95 percent target.

7.1.10. Full Compliance Items

The following items were rated Fully Compliant:

1. The CES design meets federal and state referral-related requirements and includes a uniform, coordinated referral process for all beds, units, and services available at participating projects within the CoC's geographic area.
2. Referrals are managed consistently across all geographic areas, subpopulations, and staff managing referrals, when accounting for differences related to distinct resource types.

COMPLIANCE RATING: NONCOMPLIANT (<75%)

2 of 12 (17%) compliance items are fully met. Two items are Noncompliant - referral acceptance timeliness and the screening-out prohibition - both requiring immediate corrective action. The majority of performance metrics related to matches and referrals are only partially met. The driver for the non-compliance is the RRH program.

7.2 Discussion and Interpretation

The referral function is the point in the CES pipeline where the structural deficits identified in upstream functions converge into observable housing outcomes. The performance in this area reflects not a single performance failure but a cascade that begins at the assessment stage, deepens through the referral process, and resolves, for the majority of assessed households, in no housing placement at all.

The most important contextual fact for interpreting any referral metric is this: of 5,588 households with a HNA during the evaluation period, **only 431 (7.7 percent) received a housing referral** (see Table 5-12 as well). System-wide, 816 households received a referral across all sources. The referral function's performance data, acceptance rates, denial rates, timeliness benchmarks, describes the experience of this 7.7 percent. The remaining 92.3 percent of assessed households, and the 65 percent of enrolled households without any HNA at all, are not visible in referral metrics because they never reached the referral stage. This is not a referral function failure in isolation; it is the cumulative effect of the access gap (Section 4), the assessment coverage gap (Section 5), and the prioritization gaps (Section 6) operating in sequence.

The same-day referral pattern. The finding that 64 percent of referred participants received their housing referral on the same day as their HNA warrants direct attention. While same-day processing reflects operational efficiency, it also means that for most participants, the assessment that is supposed to drive the housing match decision, identifying housing type, clinical need, geographic preference, documentation status, and service requirements, and the referral decision are made in a single session without the time needed to assess fit carefully. The assessment is designed to inform the referral; when both occur simultaneously, neither function can serve its intended purpose.

The high participant-decline rate for RRH (48 percent of participant-driven decisions, OCC data) is consistent with referrals made without adequate assessment of whether the specific opportunity fits the household's needs, geography, and preferences. This finding should be read alongside the Section 5 Discussion on same-day HNA completion (42 percent of HNAs completed the same day as enrollment, system-wide). The pattern of compressing sequential steps into single sessions runs through both the assessment and referral stages of the CES pipeline.

These are two separate compression points affecting different populations. The 42 percent figure describes the full assessed population, while the 64 percent figure describes only the small subset who reach referral, and they are not concentrated in the same households: only 58 households (12.5 percent of referred households with a valid pair) experienced enrollment, assessment, and referral on the same day.

RRH performance. The RRH program's performance shortfall is the primary driver of Referral non-compliance. OCC data shows a 31.0 percent acceptance rate against a ≥60 percent target. Match-to-Move-In averages 77 days against a 44-day target. The high participant-decline rate for RRH (48 percent, OCC) suggests that offered RRH opportunities are frequently misaligned with participant

needs, geographic preferences, or housing readiness. RRH is an intervention that requires active housing search, landlord engagement, and post-placement support when the subsidy is available; but when these elements are inconsistently resourced, the program produces referrals that fail at the move-in stage rather than stable housing exits.

These numbers indicate structural program challenges related to fidelity of the RRH implementation to national best practice standards and benchmarks.[8]

Veteran referral disparities and Participant Declines. The veteran referral acceptance gap, 38 percent vs. 46 percent system average, and a 62 percent denial rate vs. 53 percent average, is the most unexpected finding in this section given the veteran resources available, the near-equilibrium inflow-to-permanent exit ratio (1.9:1) and strong HNA coverage (55 percent). The pattern suggests that the veteran housing inventory is not well-matched to veterans' specific needs.

The finding that participant-declined rates, rather than provider denials, are the primary driver of low acceptance for some subpopulations is important to further assess. A high participant-declined rate does not necessarily indicate a preference against housing; it may indicate that the housing units offered are geographically mismatched, that the match process is not culturally responsive, the housing is not of good quality, or that households require additional outreach and support to navigate the acceptance process. Provider denial rates for the same subpopulations are comparable to or below the system average, ruling out provider discrimination as the primary cause.

Race-based, DV survivor and South SPA placement delays. Black/AA and Asian/AA participants' delay in housing (109 days), 16% higher than the 94-day system average, driven by longer Determination-to-Move-In times, suggests post-match barriers rather than pre-match process differences. The 142-day average time to housing placement for DV survivors, 48 days above the 94-day system average, is the most acute equity finding in this section. DV survivors enter the system at relatively high rates and with relatively strong referral acceptance, making the placement delay anomalous. The bottleneck is in post-match housing search rather than upstream pipeline stages, suggesting that survivor-specific barriers - safety planning, geographic restrictions for confidentiality, unit availability in acceptable locations, landlord willingness - are adding significant time after the match is made.

South SPA's 147-day placement average (56 percent above system average), despite its low volume, converges with the survivor finding: both point to housing inventory gaps that the CES referral process alone cannot resolve.

Housing outcomes and the feedback loop. The overall 22 percent return-to-homelessness rate, more than double the most lenient program target (10 percent for ES), is a system stability failure that points back to the accuracy of the assessment process and the fidelity of program implementation. When households return to homelessness after placement, it suggests the housing intervention was either mismatched to their needs, insufficiently supported by resources or timely connection to resources, or both. The connection between same-day assessment-and-referral, mismatched housing opportunities, and high return rates is not coincidental. The RRH return rate meeting its target (7 percent) while RRH acceptance and move-in

[8] National Alliance to End Homelessness, Rapid Re-Housing Performance Benchmarks and Program Standards (February 2016), https://endhomelessness.org/wp-content/uploads/2016/02/Performance-Benchmarks-and-Program-Standards.pdf. Tom Albanese, principal of Element Consulting Group, LLC, was a contributing author of these national standards.

rates fall far below target is itself a notable pattern: the households that do successfully move into RRH tend to remain housed, while the majority who are referred but do not move in may include those who would benefit most from additional navigation support before and after placement.

A note on exit destinations outside this evaluation's scope. This evaluation's exit outcome and return-to-homelessness metrics are built from HUD's Stella P module, which categorizes exits by destination type. A meaningful share of exits fall into "Unknown" or "Other" destination categories, and this evaluation does not attempt to characterize what happened to those households after they left the system. Some of these exits are almost certainly households who resolved their housing crisis through a resource CES does not track and was never designed to track, non-homeless dedicated resources outside the CoC-funded system. The evaluation has no visibility into these outcomes and cannot quantify how many exits they represent.

What can be observed, though not quantified with precision, is that a portion of these households do not return to the homelessness response system within the measurement window. Non-return is a directionally positive signal: it does not confirm a household achieved stable housing, but it is also not consistent with a rapid cycle back into crisis. **This limitation means the successful exit rates presented in this section are likely conservative, they capture confirmed positive outcomes through CES-dedicated pathways, not the full universe of households who successfully resolved their homelessness by other means.**

7.3 Recommendations

REC-25: The OC CoC should develop and implement a Timeliness Improvement Plan to bring housing match timelines into compliance with established benchmarks within 90 days. The plan must address both the PSH Match-to-Determination and Match to Move-in intervals for both PSH and RRH. For each benchmark, the plan should identify the specific stage where delays accumulate, designate a responsible party accountable for resolving delays at that stage, and set monthly milestones for improvement. OCC should report progress against all six timeliness benchmarks, M→Det, M→MI, and Det→MI for both PSH and RRH, to the CES Steering Committee monthly until all benchmarks are met for two consecutive quarters.

REC-26: The OC CoC should immediately investigate and address evidence that CES-participating agencies are screening potential participants out of assistance based on perceived barriers, in violation of CoC participation requirements. OCC should conduct a structured review of denial reasons in the OCC Match Inventory to identify providers with above-average provider-denial rates and cross-reference these against program eligibility documentation. For providers where denial patterns suggest barrier-based screening, OCC should initiate a formal compliance review and require a written corrective action plan within 30 days. In parallel, OCC should establish a clear, accessible mechanism for participants and referring providers to report suspected screening-out practices confidentially. Results of the review, including the number of providers reviewed, corrective actions taken, and denial rate trends, should be reported to the CoC Board within 60 days. This recommendation should be read alongside Section 6 — grievance retaliation, as both reflect systemic accountability gaps at the provider-participant interface.

REC-27: The OC CoC should investigate the drivers of high participant-declined and denial rates among Veteran, NHPI and Asian/AA households through dedicated focus groups and case record review. For each population, findings should distinguish whether the decline is driven by geographic mismatch, unit quality concerns, cultural misalignment, documentation barriers, or

insufficient navigation support. A formal corrective action plan with measurable targets should be developed within 90 days of investigation completion and reported to the CES Steering Committee.

REC-28: RRH program performance requires targeted corrective action. RRH is not seen as a permanent housing path, is not implemented optimally and does not follow RRH best practices. Stakeholders identified housing shortages, inconsistent housing navigation practices, varying provider requirements, and administrative delays as common barriers to successful placement.

The OC CoC should convene an RRH Performance Workgroup to review: fidelity of RRH implementation against national best practices; landlord engagement and unit sourcing strategies; housing match appropriateness criteria; post-match navigation support; and the low housing acceptance rate. A structured review of referral denials and unsuccessful matches may help identify opportunities to improve housing placement rates and reduce time from referral to housing. Findings should inform tenancy support service deployment priorities.

The workgroup should establish updated quarterly performance targets for acceptance rate, Match-to-Move-In timeliness, and move-in rate, and report progress to the CES Steering Committee. Given the RRH program's role as the system's primary rapid-exit intervention, its underperformance has system-wide consequences.

REC-29: The OC CoC should examine and address the same-day HNA-to-referral pattern (64 percent of referred participants). The current practice of completing assessment and issuing a housing referral in a single session does not allow sufficient time to assess housing fit, confirm documentation readiness, and identify post-placement support needs before a referral is made. The CoC should develop a protocol establishing a minimum review interval between HNA completion and referral issuance, sufficient to confirm eligibility, document readiness, and housing type fit, with an exception process for participants who are genuinely ready for same-session referral.

This pattern should be examined in connection with the same-day enrollment-to-assessment compression documented in Section 5 (42 percent of HNAs completed the same day as program enrollment). The review interval established above should be evaluated alongside a corresponding minimum interval between program enrollment and HNA completion (see REC-13), since addressing either compression point in isolation would leave the other capable of producing the same single-session outcome.

The CoC should establish explicit accountability for who is responsible for carrying a household from match determination to enrollment and housing, and what constitutes a documented referral failure vs. a legitimate denial.

REC-30: The OC CoC should address the 22 percent system-wide return-to-homelessness rate. For the majority of returns, driven by ES exits to a permanent destination with no CES housing referral on record, the OC CoC should pair rapid exit resources for lower-need ES households with a lighter-touch stability check-in protocol, to identify households at risk of return before a crisis recurs. An analysis of return patterns by housing type, time since placement, and geographic area should identify the highest-risk profiles for return. Separately, for households that do receive a CES-coordinated placement, the OC CoC should invest in post-placement housing stability supports anchored to the actual move-in date.

For DV survivors specifically, where time to housing placement is 51 percent above average and driven by post-match barriers, targeted housing navigation and safety-planning support should be deployed between match determination and move-in, closing the pre-placement gap, with post-placement stability support following as a separate, subsequent phase of the same case plan.

REC-31: The OC CoC should work with housing providers and public housing authorities to standardize application requirements, documentation expectations, and supplemental forms across the referral network. The variation in provider requirements is a primary contributor to referral failures and participant confusion. A centralized, publicly accessible eligibility requirements registry, documenting each participating program's requirements, screening criteria, and unit availability, should be developed and maintained by OCC, with quarterly updates required from all participating providers.

REC-32: The OC CoC should establish a process for communicating provider eligibility requirements and screening practices to CES staff before referrals are generated. Stakeholders consistently reported that access points and CES administrators lack visibility into provider-specific requirements, resulting in referrals that fail after the match has been made. This communication gap contributes to participant frustration, delays, and wasted resources. A structured and centralized process for pre-referral eligibility check, whether through HMIS documentation, a provider eligibility portal, or a standardized pre-referral communication protocol, should be implemented system-wide to improve match quality and reduce unsuccessful referrals.

REC-33: The OC CoC should establish, communicate, and regularly review clearly defined performance benchmarks for all referral and housing outcome metrics. Several stakeholders expressed uncertainty about the basis for current targets and whether they reflect system realities. Benchmarks should be published, reviewed annually against performance data, and adjusted in consultation with providers and CoC leadership. Performance against benchmarks should be reported quarterly through the CES Steering Committee with explanations of variance and corrective action when targets are not met.

Section 8: Direct Financial Assistance

Direct financial assistance is the CES-coordinated function through which flexible financial resources are deployed to resolve housing crises, including short-term assistance for rent, deposits, utilities, move-in costs, and problem-solving funds. Direct financial assistance is a best practice function of the CES that should be integrated with assessment, prioritization, and referral to support both diversion from homelessness and rapid housing placement for households already experiencing homelessness.

8.1 Key Findings – Direct Financial Assistance

Direct Financial Assistance is absent from the OC CES implementation.

The absence of this function has direct implications for both the Access, Prioritization and Referral functions: households that could be diverted from homelessness through targeted financial assistance are instead entering the full CES queue. Households referred to RRH or PSH may face delays in move-in due to the absence of flexible financial supports for deposits and move-in costs.

8.2 Discussion and Interpretation

The absence of a coordinated direct financial assistance function from the OC CES represents a structural gap with implications across multiple CES functions. First, without a diversion protocol supported by flexible financial resources, households entering crisis situations that could be resolved with modest financial assistance (such as a missed rent payment or security deposit) are instead entering the full CES queue and competing for scarce permanent housing resources. Second, households referred to RRH, which has a high decline rate, may be declining offers or experiencing delays in part because move-in costs and deposit assistance are not reliably available through a coordinated mechanism.

If direct financial assistance is available system-wide, the operational implementation appears to be decentralized across individual programs rather than coordinated through the CES.

8.3 Recommendations

REC-34: The OC CoC should develop and implement a Direct Financial Assistance function for the CES with defined eligibility criteria, a standardized disbursement process, fiscal controls, and HMIS outcome tracking. This function should be integrated with the assessment process so that households presenting at access points with short-term financial needs can be diverted from the full CES queue through targeted, time-limited assistance, as part of both homelessness prevention services for people imminently at-risk for literal homelessness and rapid resolution services for those currently literally homeless.

Section 9: Data Management and Resource Availability

Data Management and Resource Availability is a cross-functional evaluation domain that assesses whether the OC CES is supported by the data infrastructure, performance monitoring practices, stakeholder consultation mechanisms, and resource base necessary for sustained and equitable system operations. Unlike the five preceding function evaluations, this section does not assess a specific CES process step; it assesses the conditions that enable all five functions to perform effectively. Two sub-domains are evaluated: Data Management, which covers HMIS privacy, consent, and data governance; and Resource Availability, which covers resource sufficiency (capacity), stakeholder consultation, HMIS reporting capability, system performance, and overall system governance.

9.1 Key Findings - Data Management and Resource Availability

Of 4 compliance items rated, 3 were rated Compliant and 1 was rated Partially Compliant, with 0 Noncompliant. This produces a **compliance rate of 75 percent**, placing the overall rating at the lower threshold of **Partially Compliant**.

9.1.1. Stakeholder Feedback

Provider and Leadership Feedback - Strengths

Stakeholders identified the HMIS infrastructure and data availability as meaningful system assets. OCC leadership was credited with maintaining accessible, real-time data on referral outcomes, match activity, and enrollment history that supports operational decision-making. The use of disaggregated data to identify equity concerns was described positively by multiple stakeholders.

Provider and Leadership Feedback - Challenges and Concerns

Provider feedback identified three recurring concerns relevant to this section. First, providers described limited ability to access data about their own referred participants' outcomes after match, including whether a referred participant moved in, was denied, or was referred elsewhere, creating information gaps that impede case management continuity. Second, the absence of a functioning feedback channel between annual evaluation cycles was described as a structural gap, with multiple providers noting that concerns about CES operations had no clear path to resolution outside of the formal evaluation process. Prior CES evaluations (e.g., 2024 evaluation conducted by Homebase) have not been used as designed to serve as a baseline and guide near- and mid-term improvements. Third, stakeholders described limited visibility into resource availability, specifically, which housing opportunities are currently open, how long they have been vacant, and how opportunity availability compares across program types and geographies, limiting providers' ability to set realistic expectations with participants.

9.1.2. Partial Compliance Items - Stakeholder Consultation and Continuous Improvement

1. Stakeholder Consultation and CQI

The CES P&Ps establish a formal stakeholder consultation requirement. The Lead Agency is required to solicit feedback from CES households and participating agencies through annual feedback surveys and focus groups, covering all domains of the coordinated entry process.

Findings from these activities are to be reviewed by a committee of relevant stakeholders, meeting at least annually, to recommend and implement system changes. All evaluation data is de-identified to protect participant and provider privacy.

This item was rated Partially Compliant because the policy framework for consultation is comprehensive and well-documented, but implementation-level evidence identified a significant gap: providers consistently reported they do not have an effective avenue to raise concerns, provide ongoing feedback, or track whether their input was received and acted upon. The evaluation's own provider survey and interview data, collected through the formal evaluation process, surfaced concerns that providers described as having had no other outlet within the current CES feedback structure. A policy that requires annual feedback but does not provide a functioning channel for providers to submit and track input between evaluation cycles is partially, not fully implemented. Also, the absence of a structured inter-cycle feedback mechanism means that operational concerns accumulate between annual reviews rather than being addressed in real time.

9.1.3. Full Compliance Items - Data Management

Documentation review confirmed that the OC CES meets all HUD requirements for participant data privacy, consent management, and HMIS governance. Three compliance items were reviewed and all three were rated Fully Compliant.

The CES P&Ps require assessors to obtain household consent to disclose information prior to or at the point of assessment. Where verbal consent is obtained in unavoidable circumstances, a signed CES Authorization Form must be uploaded to the participant's HMIS profile within 30 calendar days. Participants who do not consent are not denied services, consistent with HUD's prohibition on conditioning access to services on data collection consent (except where Federal statute requires collection as a condition of program participation).

All HMIS users are required to sign an HMIS User Agreement, which includes the obligation to inform each participant that their information will be entered into HMIS and to explain the terms of the OC HMIS Participant Consent Form. A wet or digital signature is obtained from each participant whose personally identifiable information (PII) is entered into the system.

Victim Service Provider (VSP) staff are not permitted to participate in HMIS due to the confidentiality requirements of survivor services. VSPs partnering with CES are required to use a comparable database, ensuring that privacy protections extend to the survivor pathway without requiring HMIS participation.

The following items were rated Fully Compliant:

1. Participant consent to share and store information in HMIS is obtained and documented at assessment, consistent with HUD requirements. Services are not denied where consent is withheld.
2. All HMIS users are informed of privacy rules associated with collection, management, and reporting of participant data through the HMIS User Agreement.
3. HMIS is configured and managed to ensure adequate privacy protections of all participant information per the HMIS Data and Technical Standards, including appropriate VSP accommodations through a comparable non-HMIS database.

COMPLIANCE RATING: PARTIALLY COMPLIANT 75–89%

Data privacy and consent requirements are fully met across all three Data Management compliance items. The single Partially Compliant finding, stakeholder consultation and CQI, reflects a functioning-level gap in the implementation of an otherwise complete policy framework. The cost sustainability item was not evaluable in this cycle due to data access constraints.

9.2 Discussion and Interpretation

Section 9 serves as a cross-functional area across all five CES function evaluations. The Data Management findings are uniformly positive: the OC CES meets all HUD requirements for data privacy, consent, and HMIS governance. These are genuine strengths and represent a functional data infrastructure that supports both operational management and system evaluation.

Establishing a critical path informed by available data to guide system resource development is critical to ensure CES keeps pace with both unmet current and growing future demand and reduce the current documented 6:1 inflow-to-permanent housing ratio. Plans should address near, mid and long-term system capacity needs, with goals established as part of a comprehensive stakeholder consultation and planning process. Broader efforts to align CoC and CES operations and goals with adjacent public sector systems and resources to facilitate access to mainstream and ongoing supports are also critical and addressed in Section 10.

The stakeholder consultation finding is operationally significant because it creates a systemic information failure. When providers cannot raise concerns between annual evaluation cycles, issues compound rather than being addressed in real time. The result is visible in this evaluation: concerns about match quality, screening practices, documentation burden, access point closures, and referral process gaps were all raised by providers in evaluation interviews, suggesting they had been accumulating without a resolution pathway. A formal **inter-cycle feedback mechanism** is a low-cost intervention that would materially improve the CoC's ability to identify and respond to operational problems before they affect outcomes for participants.

9.3 Recommendations

REC-35: The OC CoC should establish a formal, structured provider and participant feedback mechanism that operates throughout the year, not only during the annual evaluation cycle. The mechanism should include: a defined submission pathway for operational concerns and improvement suggestions; a documented review process with designated staff responsibility; a response timeline commitment; and a public-facing record of how submitted feedback was reviewed and what action was taken. Feedback from providers should be tracked across evaluation cycles so that recurring issues are identifiable even if individual submissions do not produce immediate resolution. PLE should have a dedicated input pathway separate from provider channels, accessible through existing community touchpoints such as CES focus groups, access point contacts, and participant satisfaction surveys administered at assessment.

REC-36: The OC CoC should develop a **Resource Alignment and Capacity Development Strategy** that translates the system's quantified capacity gap into a structured plan for housing inventory development, reallocation, and funding decisions. The strategy should address: the

documented 6:1 inflow-to- permanent exit ratio and what intervention mix would be required to achieve equilibrium; geographic resource distribution across SPAs, with particular attention to the South SPA's access point and housing inventory deficits; subpopulation-specific resource requirements, including PSH and RRH; and a projection of funding, development, and partnership activity required to close identified gaps over a 3-year horizon. The strategy should be reviewed and updated annually alongside the CES evaluation cycle and reported to the CoC Board as part of its planning process.

REC-37: The OC CoC should establish formal performance metrics to monitor system capacity and housing resource utilization. Metrics should include inflow-to-permanent exit ratios, housing opportunity utilization rates and vacancy duration. Regular monitoring of these indicators will provide early warning of capacity constraints and support more proactive system management.

REC-38: Strengthen Housing Provider and Landlord Engagement Strategies. The OC CoC should strengthen housing provider and landlord engagement efforts to expand the pool of available housing opportunities and reduce placement delays. Stakeholders identified affordable housing shortages, inconsistent housing navigation practices, and limited visibility into available opportunities as contributors to lower housing placement rates. Enhanced coordination with landlords, housing authorities, and housing providers may improve resource availability and system throughput.



Section 10: Advancements, Innovations and Experiences

The OC CES Evaluation Plan directs the evaluation to identify where the OC CES has incorporated innovative and best practices and to note additional opportunities to innovate. This section distinguishes between compliance-required improvements identified throughout this report and advancements and innovations the CES should be considering. It also examines the experience of staff, participants, and system partners across each CES function.

The evaluation found that many of the challenges facing the OC CES are not the result of absent policies or fundamentally flawed system design. Rather, they stem from the interaction between increasing demand, limited housing resources, operational capacity constraints, and inconsistent implementation across system partners. As a result, the most promising opportunities for advancement are those that improve system efficiency, increase transparency, strengthen coordination, and better align resources with participant needs.

The innovations described in Section 10.3 represent opportunities for continuous improvement, but also require more significant CoC and County level examination of current homeless system governance and accountabilities vis-à-vis other public systems and funding streams and should be considered alongside the compliance and performance findings presented throughout this report.

10.1 Advancements and Innovations by CES Function

This section documents where the OC CES has incorporated current best practices, where gaps exist relative to those practices, and where innovation is possible. Items are organized by CES function and assessed on a Functioning scale (High / Moderate / Low / N/A).

Access Function

Evaluation Question	Findings	Status
Does the CES access design address connections with mainstream systems — including healthcare (CalAIM), child welfare, VA, and prevention services — as part of the access model?	No formal integration with mainstream systems is documented in the CES access design. No MOUs, referral protocols, or documented coordination with CalAIM, the Behavioral Health Department, child welfare, or workforce development systems were identified. The VA partnership is the exception. No equivalent agreement exists for any other mainstream system.	Low Functioning

Assessment Function

Evaluation Question	Findings	Status
Does the CES appropriately differentiate assessment types (crisis, diversion, housing, move-on) and integrate diversion throughout?	The P&P establishes a structured sequence: triage and diversion should precede shelter connection and a CNA, which should precede the HNA completion. This design appropriately distinguishes between a CNA and a HNA and acknowledges diversion as a distinct step. In practice, however, the design differentiation does not translate to sequential implementation. CNA and HNA are administered concurrently in the majority of cases, and	Moderately Functioning

Evaluation Question	Findings	Status
	diversion activities are not documented as a distinct step in HMIS. The model as designed reflects differentiation; the model as implemented collapses that differentiation into a single session, limiting the deliberate pause in which diversion and problem-solving can occur with a stabilized household. Move-on assessment is incorporated into the current assessment design.	
Does the CES incorporate diversion and problem-solving screening as a distinct and documented phase of the assessment process, with outcome tracking?	Diversion is not incorporated as a distinct, documented phase of the CES assessment process. While the P&P references diversion and problem-solving as activities that should occur at the point of crisis contact, no standardized diversion screening tool and no defined diversion protocol with specific inquiry components. The practical result is that diversion may occur informally at the provider level, depending on individual staff skill and inclination, but cannot be measured, monitored, or quality-assured at the system level. Without tracked diversion attempts and outcomes, the CoC cannot quantify how many households could have been stabilized without entering the CES queue, or whether diversion is being offered consistently across access points and subpopulations.	Low Functioning

Prioritization Function

Evaluation Question	Findings	Status
Does the CES incorporate best practices for prioritization — including dynamic list management, real-time matching, and structured case conferencing to support placement decisions?	The current model does not incorporate the best practices most directly associated with effective prioritization: structured case conferencing, real-time matching based on household vulnerability and housing type fit, or dynamic list management that adjusts priority when household circumstances change between assessments. List management is dynamic only with respect to length-of-homelessness accumulation. No formal case conferencing protocol exists. The match meeting process, while operationally efficient, does not constitute structured case conferencing in the clinical sense: it does not systematically weigh vulnerability, service match, housing type appropriateness, or post-placement stability risk.	Low Functioning

Referral Function

Evaluation Question	Findings	Status
What is the extent of the referral role (limited to referral, or follow -up to see if referral was accepted/declined, support	There is no structured, funded post-match navigation function that carries the household through from match determination to enrollment, document completion, and move-in. The absence of this function contributes directly to the high match-failure and participant-unresponsive rates.	Moderately Functioning

Evaluation Question	Findings	Status
for referral through process)?		
Does the CES incorporate real-time vacancy management, standardized acceptance criteria, and proactive matching workflows?	No standardized acceptance criteria or real-time vacancy management system exists. Housing providers maintain varying and often unpublished eligibility requirements; CES staff frequently lack visibility into those requirements before referrals are made, resulting in predictable match failures. Opportunity to develop more functional vacancy tracking/management approach utilizing HMIS.	Moderately Functioning
Does the design supports referrals to mainstream system resources	Referrals to mainstream system resources beyond PBV and VA are absent. No referral pathway connects CES participants to CalAIM housing stabilization services, child welfare housing resources, or income support programs at the point of housing match.	Moderately Functioning

10.2 Experiences and Outcomes

While compliance and performance metrics provide important information regarding system functioning, they do not fully capture how CES is experienced by participants, providers, access points, housing partners, and system administrators. Understanding these experiences is critical because participant engagement, provider implementation, and stakeholder collaboration directly influence CES outcomes.

This section synthesizes themes from interviews, focus groups, surveys, and stakeholder engagement activities conducted during the evaluation. The findings provide insight into how CES is experienced in practice, including barriers to access, assessment and referral challenges and opportunities for improvement. Together, these perspectives help contextualize the quantitative findings presented throughout this report and identify areas where operational changes may improve both participant outcomes and system effectiveness.

Access Function

Evaluation Question	Findings	Status
To what extent are access staff, referring agencies, and community members aware of how to connect people to the CES?	In general, CES staff and referring agencies are aware of how to connect people to the CES, and monthly outreach activities represent a meaningful improvement. Community-level awareness, however, remains significantly limited. PLE across all seven focus groups reached CES through informal pathways - word of mouth, family, jail, hospital, or sheer persistence - rather than a clear, accessible public entry point. The front door that exists is narrowing: providers confirm that access points have shifted toward closed status (serving only participants in their own programs) because the access point role was never stably funded, and that 211 is too general to reliably route people experiencing homelessness to the right service.	Low Functioning

Evaluation Question	Findings	Status
Are people satisfied with their experience accessing the CES?	People struggle to find the CES front door. Experiences of dignity, responsiveness, and clarity in the access process vary significantly depending on the access point and the caseworker encountered. A caseworker who is knowledgeable, responsive, and consistent is the single most commonly described factor in a positive access experience, and also the most frequently identified source of frustration when unavailable or overloaded. Participants rarely described accessing CES through a designated access point; most described reaching services through indirect, unpredictable pathways that depended on persistence or a chance encounter with a knowledgeable provider. The concentration of positive access experiences around individual staff relationships, rather than system design, indicates that access quality is not reliably reproducible at scale.	Low Functioning
Is the CES access process efficient — minimizing burden on households and providers relative to the benefit provided?	A persistent trend toward closed access points is limiting the effective accessibility of the CES for participants in crisis. Agencies that serve as access points describe growing administrative burden without corresponding funding, creating a disincentive to maintain open-door status. The result is a system whose formal coverage is broader than its operational coverage.	Low Functioning
How does access volume, utilization, and timeliness vary by SPA, subpopulation, and race/ethnicity?	No significant and consistent access equity disparity was identified across racial or ethnic groups.	High Functioning

Assessment Function

Evaluation Question	Findings	Status
Do participants, providers, and funders understand the assessment process?	Most stakeholders appear to understand the assessment process. However, some think VISPDAT is still in use, indicating that transition communication was incomplete. More substantially, providers across multiple stakeholder groups describe the current HNA as capturing housing preference rather than housing need, limiting its utility as a clinical planning tool.	Moderately Functioning
Do end users (people experiencing/at-risk of homelessness, referring agencies, housing resource providers) are satisfied with the assessment process	Various participants spoke to the need for a better community-wide understanding of CES; the sheltered-provider team and LEAC confirmed the gap from the other side and that participants are often never told the documents they are gathering lead to a voucher. Often, referrals are made without attention to acuity and level of needs participants have, resulting in mismatch	Moderately Functioning

Evaluation Question	Findings	Status
(communication, information tracking about the status, understanding of next steps, etc)	between level of need, referral support needs, and capacity/services offered by receiving housing provider.	
Is the assessment process trauma-informed, culturally responsive, and experienced positively by participants?	**Policy level, medium-to-high severity.** The single-factor prioritization model produces recurring, documented harms for people with complex clinical needs and for specific subpopulations, including transition-age youth, DV survivors, and individuals with significant behavioral health needs, whose circumstances are not well captured by length-of-homelessness criteria or by the current HNA instrument. The assessment process does not systematically incorporate trauma-informed screening, safety planning, or cultural responsiveness protocols beyond the general anti-discrimination framework. For survivors specifically, this represents a safety concern.	Low Functioning
Is the assessment process efficient — minimizing duplicate assessments, staff and participant burden, and time-to-assessment while maintaining quality?	The concurrent administration of CNA and HNA is operationally efficient and reduces participant burden in terms of time and touchpoints. The efficiency gain, however, comes at the cost of assessment quality: same-session administration eliminates the deliberate separation between crisis stabilization and full HNA that would allow a more accurate picture of the household's vulnerability and housing readiness.	Moderately Functioning
Are there disparities in assessment outcomes (scoring, referral rates) by race, ethnicity, gender, or disability?	No significant and consistent assessment equity disparity was identified across racial or ethnic groups.	High Functioning

Prioritization Function

Evaluation Question	Findings	Status
Do participants, providers, and funders understand the prioritization criteria and process?	**Policy level, medium-to-high severity.** All providers and system stakeholders understand the current prioritization criteria. The model is administratively transparent and does not rely on subjective scoring. Stakeholders, however, widely request more transparency in the process, specifically in how individual households are ranked relative to each other, how long they can expect to wait, and what factors may accelerate or delay a match. Several providers have requested revisions to the dynamic-match vote structure as a near-term priority.	Moderately Functioning
Do end users (people experiencing/at-risk of homelessness, referring	PLE almost universally could not explain how prioritization works and reported that they were rarely provided information about steps, timelines, or criteria. Post-BNL-	Low Functioning

Evaluation Question	Findings	Status
agencies, housing resource providers) are satisfied with the referral process (communication, information tracking about the status, understanding of next steps, etc)	placement communication was described as largely absent. Critically, evidence documents that participants reported receiving threatening phone calls after filing complaints about CES processes and being excluded from meetings or deprioritized from housing following complaint activity. This is a serious implementation failure that extends beyond the functioning domain: it represents potential violation of the anti-retaliation protections in the CES P&P and requires immediate investigation independent of the functioning assessment.	
Is the prioritization process efficient — with minimal wait time between assessment and list placement, clear communication to Households, and timely matching to available resources?	The process is efficient in that all participants with a HNA are placed on the prioritization list. However, this process defeats the purpose of a "prioritization list". Participants with not enough homeless time will be left unreferred until they accumulate sufficient homeless time. Participant vulnerability is not considered.	Moderately Functioning
Are there disparities in prioritization outcomes by race, ethnicity, or geography?	No significant and consistent prioritization equity disparity was identified across racial or ethnic groups.	High Functioning

Referral Function

Evaluation Question	Findings	Status
Do participants, providers, and funders understand the referral process and how to track referral status?	All stakeholders understand the referral process. CES data management focuses on match queue outcomes, limiting visibility into what happens after a match is made. Housing developers and providers described being unable to access data on failed matches, unit vacancy duration, or the status of households matched to their programs, information gaps that directly impair their ability to manage their housing portfolios and vacancies and engage proactively with the CES.	Moderately Functioning
Extent to which end users (people experiencing/at-risk of homelessness, referring agencies, housing resource providers) are satisfied with the referral process (communication that a referral/"match" has been	PLE who were 'just matched' were not provided with the opportunity to see the assigned unit and did not know their move-in date. One participant waited seven months for a single document to be uploaded. Housing providers expressed growing concern about ill-fitting matches, documentation issues, and the absence of a post-match navigation function. Several providers described efforts to actively work around the CES rather than through it, citing growing rather than declining	Low Functioning

Evaluation Question	Findings	Status
made, information tracking about the status, understanding of next steps, support provided to pursue next steps, etc)	frustration with the referral process. This represents a material risk to CES participation rates and system coverage.	
Is the referral process efficient — minimizing time between matching and move-in, reducing duplicative communication, and enabling timely housing placement across all project types?	The referral process is not as efficient as it should be. Approximately half of participants do not move in after a referral is made. For RRH specifically, time from match to move-in substantially exceeds the CoC's own benchmark. The absence of a post-match navigation function and the information gap between OCC match records and housing provider eligibility requirements are the primary operational drivers of this inefficiency.	Moderately Functioning
Are there disparities in referral outcomes (acceptance, denial, time-to-placement) by race, ethnicity, or geography?	No significant and consistent referral equity disparity was identified at the system level.	High Functioning

Cross-functional

Evaluation Question	Findings	Status
Are CES resources (ES, TH, RRH, PSH, HP) sufficient relative to modeled system demand?	The system modeling results show that CES resources (ES, TH, RRH, PSH, HP) are not sufficient relative to the modeled system demand and significant gap exists for all program types.	Low Functioning
Is HMIS configured and used in a way that enables comprehensive system performance reporting — including APR generation, SPM reporting, disaggregated equity analysis, and Stella P modeling inputs?	HMIS is configured for comprehensive reporting including APR, SPM, disaggregated equity analysis, and Stella P modeling inputs.	High Functioning
Is CES implementation contributing to improvement in HUD SPMs?	It is not entirely clear how the CES implementation contributes to SPM improvements. However, the SO project implementation, with a significant number of enrollment records showing same-day entry/exit dates have a negative effect on the SO performance, inflating the number of households served and deflating the successful outcomes.	Moderately Functioning
Does OC CES equitably, efficiently, and effectively resolve homelessness across	No evidence of significant and consistent disparities	High Functioning

Evaluation Question	Findings	Status
the CoC — including for all subpopulations and geographies — as evidenced by disaggregated performance data?		
Does the OC CES advance and leverage mainstream resources — including CalAIM, VA services, child welfare, workforce supports, and affordable housing — to extend the impact and sustainability of CES?	No evidence of mainstream resource involvement, except PBV and VA.	Low Functioning

10.3 Innovation Opportunities (IO)

Several innovation opportunities emerge from the quantitative and qualitative findings of this evaluation. These are presented as forward-looking advancements rather than compliance corrections. The evaluation suggests that future CES improvements should focus on operational refinement, resource alignment, data-informed decision-making, and participant-centered system design. While increased housing resources remain essential to improving outcomes, many opportunities identified through this evaluation can be pursued independently of new housing inventory and system improvements and have the potential to greatly improve overall system functioning, quality, and performance within existing resource constraints.

These IOs are presented as strategic and structural advancements rather than day-to-day operational changes. Implementation of most IOs requires CoC Board action, cross-system partnership agreements, or resource allocation decisions that fall within the CoC's governance and policy-making authority, distinct from, and beyond the scope of, the CES Lead's (OCC) operational responsibility for administering CES on the CoC's behalf.

IO-1: Implement a dynamic BNL management approach using real-time data to adjust prioritization for Households whose needs change between assessments. The current static BNL model is not producing current, accurate prioritization. Technology-supported dynamic reassessment processes could substantially reduce information lag and improve match quality without requiring a structural change to the prioritization model.

IO-2: Implement a progressive, phased engagement model for assessment. A phased assessment approach, completing triage/diversion assessment and a shortened crisis assessment immediately and scheduling a full HNA within 7 to 14 days would allow the HNA to occur after initial crisis stabilization rather than concurrent with it. This approach is more likely to produce accurate vulnerability profiles, reduces same-day-assessment-and-referral compression, and creates a structured opportunity for diversion before a household is formally entered into the CES queue.

IO-3: Implement a real-time system management dashboard providing CES staff, providers, and CES leadership with unified visibility into assessment currency, referral status, pending matches, housing opportunity availability, vacancy duration, and queue aging metrics. Concurrently, develop standardized, publicly accessible eligibility profiles for all participating housing programs that allow CES staff to confirm household eligibility before a referral is made, eliminating the most common source of preventable match failure.

IO-4: Develop of a culturally responsive housing navigation function, subpopulation-based. The data establishes that participant-declined rates for certain subpopulations are the primary driver of low housing acceptance. Culturally specific housing navigators who work with households through the matching process, provide language-accessible communication, are culturally matched to the populations they serve, and understand community-appropriate housing options, represent an evidence-informed intervention for this pattern.

IO-5: Establish a confidential, third-party participant complaint and feedback mechanism that is structurally independent of the CES operational staff. A confidential external complaint pathway that is accessible without requiring disclosure of the complainant's identity to CES staff, is necessary to provide genuine anti-retaliation protection and to restore confidence in the grievance process.

IO-6: Develop and implement a **Mainstream Resource Integration Plan** to formalize connections between the CES and mainstream systems, including CalAIM, child welfare, workforce development, income and benefits systems, older adult services, and affordable housing pipelines that currently operate in parallel without active coordination.

CalAIM / Healthcare

The plan should assess which CES-enrolled households are Medi-Cal beneficiaries eligible for Enhanced Care Management (ECM) and Community Supports housing services and establish a referral pathway between CES and Managed Care Plans. In January 2026, an additional Community Support Service, transitional rent, is available for SMI/SUD clients and provides rental subsidy for up to 6 months. This service could potentially provide both a launch pad into permanent housing opportunities as well as ensure the necessary services are extended to the client with the assistance of CalAIM. The Healthcare Agency, Behavioral Health Department, should be an integrated stakeholder to support these referral pathways.

Beyond CalAIM, the plan should also formalize coordination with Federally Qualified Health Centers (FQHCs), medical respite programs, and specialty behavioral health services, each of which serves a significant portion of the CES population and can support housing stabilization if formally integrated into post-placement care planning.

Income and benefits enrollment

The plan should establish a systematic connection between CES and benefits enrollment support, including SSI/SSDI advocacy through the SOAR program, General Relief, and CalWORKs for eligible families. For many CES participants, particularly those with disabilities who are unable to pursue employment, income benefit enrollment is the foundational stabilization intervention, without which housing subsidies cannot be utilized or sustained. Benefits enrollment should be offered as a standard referral at the point of HNA completion.

Child welfare and youth services

The plan should establish cross-system protocols for coordinated housing placement for youth exiting foster care and families involved with the child welfare system, consistent with McKinney-Vento and AB 12 requirements.

Workforce development

The plan should establish formal protocols with OC Workforce Development Board and it's network of partners and One Stop Centers to ensure coordinated access to employment and workforce support services.

Older adult services

The plan should establish formal coordination with IHSS, Area Agency on Aging, Adult Protective Services, and senior housing programs, whose resources are not currently integrated into the CES referral network but needed for an aging homeless population.

Affordable housing

The plan should formalize the CoC's engagement with local housing authorities and affordable housing developers to ensure CES prioritization needs inform unit set-asides and preference structures. The VA partnership, identified as the one functioning mainstream integration model in the OC CES, should serve as the operational template for what structured, accountable mainstream coordination achieves.

A designated leadership table or joint committee reporting to the CoC Board and Commission to Address Homelessness should formalize partner roles, map resources and responsibilities, establish written referral and escalation protocols, develop a braided-funding/data/services framework, and review progress through shared performance measures. Orange County's VA partnership can serve as an operational model for structured, accountable cross-system coordination. For additional discussion see section 12.1. Cross-System Priorities.

IO-7: Develop and implement a **Direct Financial Assistance** function, as described in Section 8. Implementation would represent a significant structural advancement available to the system within the current policy and technology infrastructure. The function should encompass at minimum: a flexible diversion fund available at the point of crisis contact to support households who can be stabilized with one-time assistance; a rapid housing placement fund providing security deposits, first-month rent, and move-in costs for BNL households matched to RRH or market-rate units; and a landlord engagement or risk mitigation fund that compensates participating landlords for vacancy periods, damage beyond normal wear, and potentially the added administrative costs of CES participation. Each component should be designed with explicit eligibility criteria, anti-discrimination protections, equity monitoring, and outcome tracking in HMIS.

IO-8: The OC CoC should establish a standing protocol requiring that staff training materials be updated within a defined timeframe following any change to CES policies, procedures, or assessment tools. Training synchronization with P&P updates has historically lagged, contributing to inconsistent implementation across access points, including providers who reported believing the VI-SPDAT was still in use at the time of this evaluation. Given the volume of policy corrections and instrument updates recommended in this report, a systematic training update process, with defined timelines, delivery accountability, and completion tracking, is essential to consistent implementation of those changes.

IO-9: The OC CoC should implement a structured HMIS data quality improvement plan targeting the fields most critical to equity analysis, coverage monitoring, and system performance reporting. Data quality gaps identified during this evaluation directly limited the reliability of subgroup findings and in some cases prevented linkage between related records entirely. Priority fields for improvement include: Veteran Status (32 percent Data Not Collected in the target population), Disabling Condition (35 percent Data Not Collected), City of Prior Residence / SPA (20 percent of

target population unassigned to a geographic area), Race and Ethnicity (8 percent Other/Unknown). Separately, the HNA-before-enrollment-date anomaly affecting 10 percent of assessed households should be reviewed to determine whether it reflects data entry timing errors, assessment-before-intake workflows, or a system configuration issue. The data quality plan should establish field-level completion targets, assign data stewardship responsibility by program and access point, include regular HMIS data quality reports to CES leadership, and connect data quality performance to provider participation agreements.

10.4 CES Mapping Process: Root Cause Analysis and Administrator-Prioritized Improvements

As described in the Evaluation Methodology (Section 2), qualitative engagement included CES mapping sessions with CE Administrators (CEAs) designed to trace pain points to underlying root causes and generate improvement ideas beyond what individual interviews and focus groups surface. Two structured artifacts resulted: a pain point-to-root-cause matrix developed collaboratively during the mapping sessions (Appendix: CES Pain Points and Root Causes Matrix), and an Impact-versus-Effort prioritization matrix developed independently by CEAs to rank the resulting improvement ideas.

10.4.1 Root Cause Analysis

The mapping process identified 28 distinct pain points across nine process areas, eligibility and documentation requirements, housing opportunity mismatch, staff turnover, timing, participant engagement, communication, participant-opportunity mismatch, information gaps, and data quality, and traced each to one or more of nine root causes. The full pain point-by-root-cause matrix is presented in the appendix; Table 10-1 summarizes the concentration of root causes across all 28 pain points.

Table 10-1 Root Cause Concentration Across CES Mapping Pain Points

Root Cause	# Pain Points Linked
Volume Issues	13
Training Issues	10
Effective Management of Complex Processes	9
Resource Constraints	8
System Issues	6
Process Design & Uniformity	3
People Issues	2
Data Issues	2
Policy Constraints	2

Three findings corroborate and sharpen conclusions presented elsewhere in this report. First, volume and training issues are the most widespread root causes, present across nearly every pain point category, consistent with the caseload and staffing concerns raised in Section 4 and Section

8 stakeholder feedback, and reinforcing REC-9's call for stable access point funding and REC-5's staff training protocol. Second, five pain points were linked to three root causes simultaneously, extended Community Queue wait time, the tension between prioritizing RRH by vulnerability versus sustainability, participant information gaps at referral, and two related data timeliness gaps (ICES record maintenance and vacancy reporting), which the mapping team characterized as requiring cross-functional rather than single-point fixes, directly supporting this evaluation's own finding that referral-stage failures (Section 7) accumulate across functions rather than originating in one. Third, the RRH vulnerability-versus-sustainability tension identified independently through this process is the same tension underlying REC-21's call to incorporate vulnerability and housing fit into the prioritization model and REC-28's RRH corrective action recommendation.

10.4.2 Administrator-Prioritized Improvement Ideas

Following the mapping sessions, CEAs independently sorted the resulting improvement ideas onto an Impact-versus-Effort grid, producing a self-generated priority view that complements this evaluation's own recommendations (Table 10-2).

Table 10-2 CEA Impact-versus-Effort Prioritization

	Hard to Solve	Easy to Solve
High Impact	• Evaluate RRH referral balance and dynamic match process, including RRH access for TAY (REC-21, REC-28) • Build a PSH opportunity inventory for Families, Survivors, and TAY (REC-36, IO-6) • Develop compensation/incentive structures for CES partner agencies (REC-9) • Remove at-risk (Category 2) households from the general Community Queue or create a separate registry (REC-19) • Build shared, real-time visibility into housing availability across the county (IO-3)	• Promote existing training and survey partners for training gaps (IO-8) • Engage PSH developers on subpopulation-specific eligibility criteria (IO-6) • Monitor recidivism trends more closely to evaluate long-term placement success (REC-30)
Low Impact	• Onboard additional open access points (REC-9) • Data sharing with healthcare providers (IO-6)	• Structured onboarding for new access point staff (IO-8) • Capture additional eligibility criteria, such as high-cost health utilization, in HMIS (IO-9)

Section 11: Looking Forward; Homeless Population Projections

This section presents the results of the system dynamics modeling using Stella P data. **This modeling is illustrative, not predictive.** Its purpose is to demonstrate how small, incremental improvements can meaningfully change system performance and capacity to serve more people in crisis, not to forecast what will actually happen in Orange County's homelessness response system over the coming years. Given the current level of political and economic uncertainty, including potential shifts in federal homelessness policy and funding (see *Emerging Federal Policy Direction*, below), any attempt to project actual future outcomes would carry a false sense of precision. The model should be read as a structured "what if" exercise, a way to see the relative size and direction of different levers, not as a prediction of where the system will be in 2031.

With that framing in mind, the modeling projects crisis services demand, capacity, and unmet need across a six-year period from 2026 through 2031, using 2025 as the baseline year. The modeling identifies project type gaps, simulates the impact of performance improvements and examines:

- System inflow and outflow rates
- System bottlenecks
- Effectiveness of the intervention mix (prevention & diversion, RRH, PSH, shelter and transitional interventions)
- Supply-demand alignment by project type

For Homeless Prevention (HP), the capacity increase can be unlimited and only dependent on the resources available to expand the program; consequently, no modeling was performed on this program type. Given the anticipated federal policy shift away from RRH and PSH programs as primary interventions (see Emerging Federal Policy Direction, below), quantified capacity gap projections for RRH and PSH are unlikely to be achievable without a significant investment of local resources, and for this reason a gap is not quantified for these programs. These constraints remain critical to system performance and are addressed qualitatively in the System Flow section.
The Technical Documentation Appendix provides the information on the modeling assumptions, inputs, and methodology.

11.1 Emerging Federal Policy Direction and Implications for the Orange County System

Federal homelessness policy is expected to undergo a significant strategic shift as early as next year, with Housing and Urban Development (HUD) signaling a reorientation away from RRH and PSH as primary interventions and toward an expanded role for TH. Under this emerging direction, TH would serve as the principal program model for households exiting ES, with investment in RRH and PSH reduced as program priorities and funding structures are realigned. It is important to note that this analysis does not incorporate any assumptions related to this anticipated strategic change.

The modeling presented throughout this report therefore reflects current system configuration and incremental performance improvement. The projections should be interpreted as a baseline for what is achievable within the existing program framework, not as a forecast under a restructured federal policy and funding environment. Changes to the program types within the Orange County's

homelessness response system would affect system performance in ways that cannot be fully captured by the current model. RRH and PSH capacity levels directly influence the rate at which households exit ES to stable housing, the average length of stay (ALOS) in ES, and the overall ES gap. Any confirmed shifts in federal capacity assumptions should be incorporated into future iterations of this analysis as that information becomes available.

11.2 Projections and Assumptions

Using the available data from the U.S. Census, the historical information on several key population and housing statistics were obtained:

- Orange County population
- Number of renter households[9]
- Gross median rent[1]
- Population severely cost burdened (paying over 50 percent of their income towards rent)[10]

The model projects changes in total population, the rate of severely cost-burdened households, and the resulting size of the renter population experiencing severe cost burden. Historical trends are used to estimate future rates of severe cost burden.

The Orange County population projection[11] is using the 2026 – 2031 numbers from the California Department of Finance Demographic Research Unit (Table 11-1).

Table 11-1: Projected Population Change

Current and Projection Years	2025	2026	2027	2028	2029	2030	2031
Projected Population	3,149,507	3,166,588	3,164,963	3,164,498	3,164,476	3,165,150	3,169,076

Overall Orange County-area rents rose 1.5 percent in the past year but the Fair Market Rent increased by over 4 percent. The 2026 2-bdr Fair Market Rent is $2,903 and the median gross rent is estimated at $2,545. According to the Matthews Q1 2026 Orange County Multifamily Market Report[12], vacancy stands at approximately 4.3 percent, one of the lowest among major U.S. markets, reflecting strong occupancy despite elevated housing costs, and indicating slower leasing velocity compared to historical norms. The low vacancy is partially due to limited available inventory and affordability constraints that are reducing renter turnover. Property owners have prioritized occupancy over aggressive rent increases. The National Apartment Association projects rent growth moving toward 2 percent annually. Using the above, the modeling assumes an annual 2 percent increase, resulting in average asking rents of $2,800 by 2031 (Table 11-2).

Table 11-2: Projected Median Rent Increase Rate

Parameter	2025	2026	2027	2028	2029	2030	2031
Median Rent Increase Rate	1.1%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

[9] U.S. Census Bureau, *American Community Survey 1-Year Estimates, 2019-2024: Selected Housing Characteristics (Table CP04)*, Orange County, CA. Available at: data.census.gov.
[10] U.S. Census Bureau, *American Community Survey 1-Year Estimates, 2019-2024: Housing Costs for Renters (Table B25140)*, Orange County, CA. Available at: data.census.gov.
[11] California Department of Finance. (n.d.). *Projections*. Demographic Research Unit. https://dof.ca.gov/forecasting/demographics/projections/
[12] Bridge, M. (2026, April 20). *Orange County, CA multifamily market report: Q1 2026*. Matthews Real Estate Investment Services. https://www.matthews.com/insights/orange-county-multifamily-q1-2026

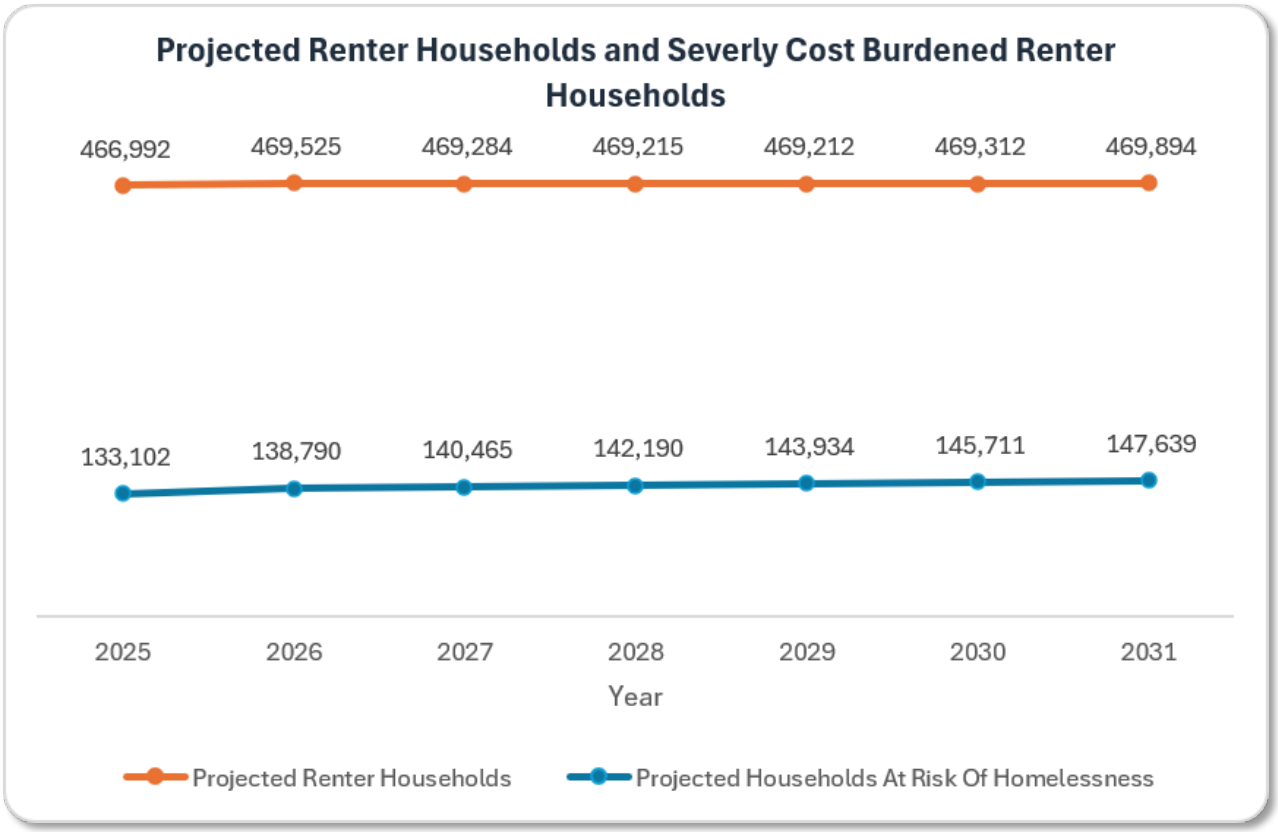
Over 54 percent of Orange County renter households already spend more than 30 percent of their income on rent and utilities. Looking ahead, the share of renter households experiencing severe cost burden (paying more than 50 percent of income toward rent) is projected to rise from 28.5 percent in 2025 to 31.42 percent by 2031 (Table 11-3). Although there was a temporary decline in 2024, rates have since resumed an upward trajectory, and current economic conditions do not indicate a reversal of this pattern. The model assumes that renters who are severely cost burdened represent the population most at risk of experiencing homelessness.

Table 11-3: Change in the Rate of Households Severely Cost Burdened

Current and Projection Years	2025	2026	2027	2028	2029	2030	2031
Cost Burdened	28.50%	29.56%	29.93%	30.30%	30.68%	31.05%	31.42%

The projected increase in the rate of households severely cost burdened leads to a projected **increase in the population at risk of homelessness from approximately 133,100 to 147,600 households**, an 11 percent increase (14,500 households) over the modeling period (Figure 1).

Figure 1: Projected Renter Households and Severely Cost Burdened Renter Households

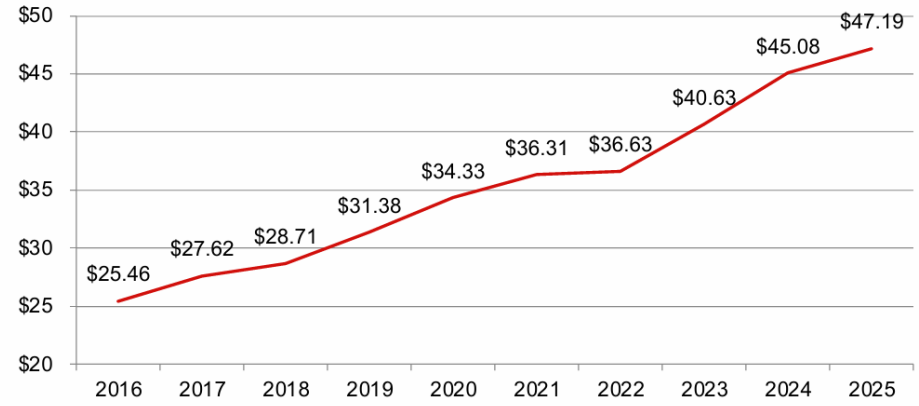


High housing affordability concerns and a severe housing supply shortage continue in Orange County. According to the 2026 Orange County Community Indicators[13] report, the hourly wage needed to afford a one-bedroom in Orange County increased from $45.08 in 2024 to $47.19 in 2025 (Figure 2). This 4.7 percent year-over-year increase comes after increases of 10.9 percent in 2023

[13] Orange County Business Council. (2026). *2026 Orange County Community Indicators Report*. https://ocbc.org/3d-flip-book/2026-community-indicators-report/

and 11.0 percent in 2024. A minimum wage worker (making $16.50 per hour) would need to work 114 hours per week to afford a one-bedroom apartment.

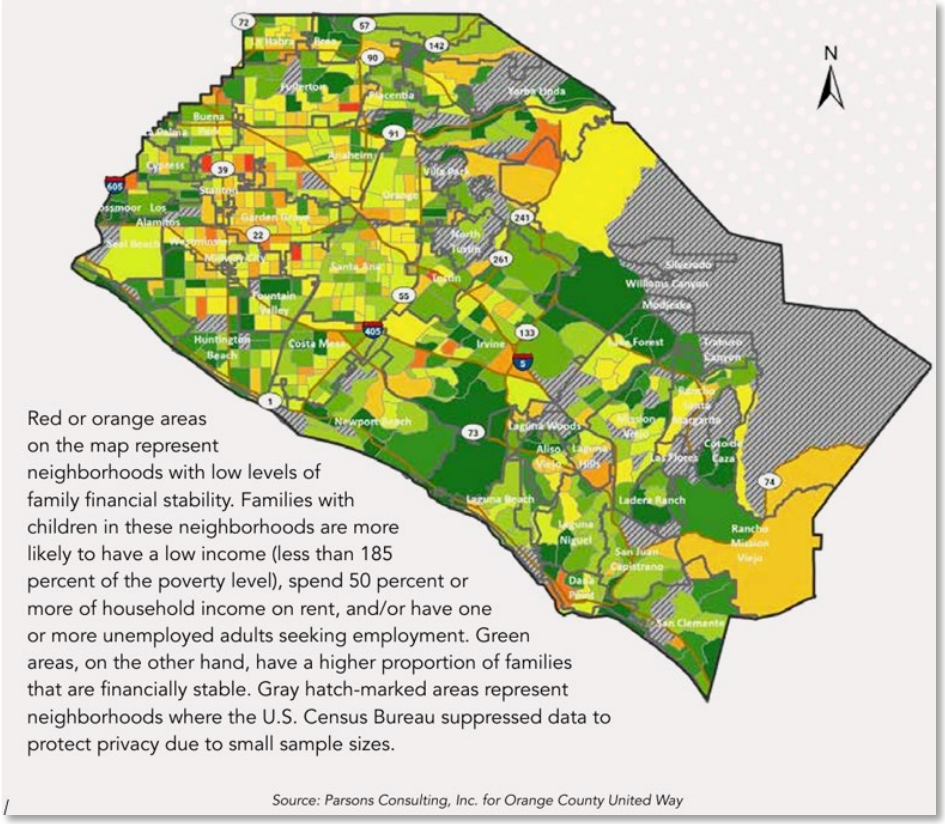
Figure 2: Hourly Wage Needed to Afford a 1-bdr Unit



Sources: Community Indicators Report analysis of Fair Market Rent data from the U.S. Department of Housing and Urban Development using the methodology of the National Low Income Housing Coalition.

The same report shows that 18.9 percent of Orange County neighborhoods have low levels of family financial stability, and they are concentrated in the North and Central SPAs (Figure 3). This geographic concentration also informs resource allocation priorities for prevention and diversion investment, discussed further in the Recommendations section below.

Figure 3: Geographic Distribution of Neighborhoods based on Family Financial Stability



The next step in the modeling process was to project the population expected to experience homelessness during the modeling period. This projection incorporates findings from the United States Government Accountability Office (GAO) July 2020 report, *Better HUD Oversight of Data Collection Could Improve Estimates of Homeless Population*.[14]

Based on this research, the model assumes that **for every $100 increase (or decrease) in median household rent, the homelessness rate correspondingly increases (or decreases) by approximately 9 percent** meaning that rising rents translate directly and predictably into rising ES demand. As noted in the GAO report: "Specifically, a $100 increase in median rental price was associated with about a 9 percent increase in the estimated homelessness rate. For instance, in a CoC with a homelessness rate of 16 individuals per 10,000, a $100 increase in household median rent would have an associated increase to about 17.4 individuals per 10,000. In analyzing the relationship between rental prices and homelessness, we chose to model household median rental prices rather than the cost to obtain a new unit of housing, which might be somewhat higher than the median. Although the cost for a new mover to find housing would more closely reflect the experience of those attempting to exit homelessness, we chose to use household median rent prices because such a model more accurately reflects the experience of people for whom increasing rent is a factor that causes them to become homeless."

The GAO elasticity estimate was calibrated to Orange County (rents are higher than most other US locations) using a locality adjustment factor. This factor was derived by comparing, for each year from 2019 through 2025, the actual historical number of households experiencing homelessness[15] against the number calculated using the unadjusted GAO formula for that year; the resulting annual ratios were then averaged across the 2019–2025 period to produce a single calibration factor applied throughout the projection. Applied to Orange County's projected rent trajectory, this adjusted estimate projects that the total number of households experiencing literal homelessness **will grow from approximately 21,700 in 2025 to 29,175 by 2031, an increase of 34 percent** (Table 4). The conversion of the projected population experiencing homelessness into households used the current average number of individuals per household experiencing homelessness, derived from Stella P (1.2).

Table 11-4: Projected Homelessness Rate Change and Households Experiencing Homelessness

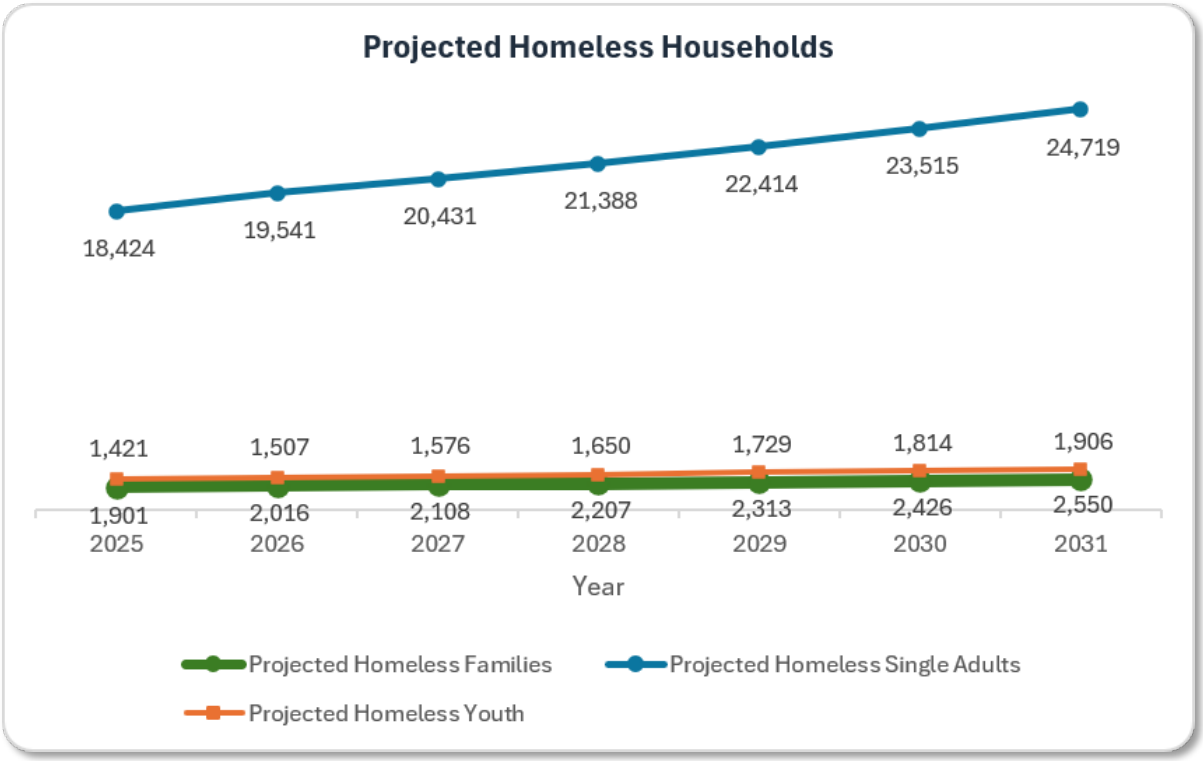
Year	Projected Rent Increases (Relative to the Prior Year)	Projected Median Gross Rent	Projected Homelessness Rate Change (Rent-Based Changes)	Projected Homeless Households
2025	1.10%	$ 2,510	2.46%	21,746
2026	2.00%	$ 2,561	4.52%	23,064
2027	2.00%	$ 2,612	4.61%	24,115
2028	2.00%	$ 2,664	4.70%	25,244
2029	2.00%	$ 2,717	4.80%	26,455
2030	2.00%	$ 2,772	4.89%	27,755
2031	2.00%	$ 2,827	4.99%	29,175

[14] U.S. Government Accountability Office, *Homelessness: Better HUD Oversight of Data Collection Could Improve Estimates of Homeless Population*, GAO-20-433. Report to the Chairwoman, Committee on Financial Services, House of Representatives. Washington, D.C.: GAO, July 2020. Available at: gao.gov/products/gao-20-433.

[15] California Interagency Council on Homelessness. (2025). *CA System Performance Measures, statewide and by Continuum of Care (CoC)* [Data set]. California Open Data Portal. https://data.ca.gov/dataset/ca-system-performance-measures-statewide-and-by-coc

Subsequently, the projected number of households is disaggregated into key subpopulations - individual adults, families, and youth (age 24 and under) - based on the existing distribution within the Orange County CoC. **These estimates represent the projected population requiring accommodation within the Orange County's homelessness response system over the modeling period (Figure 4).**

Figure 4: Projected Households Experiencing Homelessness by Subpopulation



11.3 System Flow

The modeled homelessness response system operates as a continuum in which households move through HP services, crisis response interventions, and housing programs such as RRH and PSH. System performance is determined by the interaction between inflow (households entering or at risk of entering homelessness), system capacity across program types, and the rate at which households exit to stable housing.

Inflow into the Homelessness Response System

Households enter the homelessness response system through multiple pathways. HP and diversion programs act as mechanisms for reducing inflow by stabilizing at-risk households. However, the majority of households are unable to access HP due to lack of capacity, and diversion services are not standardized nor tracked and ultimately contribute to system inflow. Additional inflow occurs from households already experiencing unsheltered homelessness.

Emergency Shelter as the Primary Entry Point

ES serves as the primary crisis response intervention for households entering the homelessness response system. ES capacity is dynamically influenced by both inflow (recidivist or returning and

non-recidivist or first-time homeless households) and outflow (exits to TH[16], RRH, PSH and other permanent housing). When monthly inflow exceeds available ES point-in-time capacity, unmet demand manifests as an ES gap, reflected in unsheltered homelessness or overcrowding within the system.

TH and RRH Interventions

TH and RRH function as intermediate permanent housing pathways that facilitate movement out of ES. These programs increase the system's exits and number served by shortening ES stays and freeing beds for new entrants. RRH, in particular, operates as an effective placement intervention due to higher rates of exit to permanent housing (ALOS[17] homeless is, however, higher for the RRH participants than TH participants). Capacity constraints in TH and RRH directly limit the rate at which households can exit ES, thereby increasing pressure on ES capacity (see Projected Gaps section).

PSH as a System Constraint

PSH and Other Permanent Housing serve households with the highest levels of need, particularly those experiencing chronic homelessness. Because households typically remain in PSH for long periods, turnover is low and openings are limited (table A-4). Limited PSH availability restricts the ability of high-need households to exit ES, TH, RRH or unsheltered homelessness, resulting in prolonged system engagement and reduced overall flow efficiency.

System Bottlenecks and Feedback Effects

Constraints in downstream capacity, particularly in RRH and PSH, create upstream impacts across the system. Currently, 88 percent of ES exits occur without downstream program assistance, which undermines the stability of exits and feeds a pattern of returns to homelessness following exit from ES. Also, limited exits from ES reduce bed availability, increasing lengths of stay and contributing to unmet ES demand. Similarly, insufficient HP and diversion capacity increases inflow into ES, further exacerbating pressure on ES and downstream programs. These dynamics create feedback loops in which capacity limitations in one part of the system propagate across other components. This is a system burdened by too many structural failures occurring simultaneously.

11.4 Projected Gaps

Against this backdrop, the analysis identifies the following persistent, dynamic, and interdependent structural gaps: HP and diversion capacity is under-funded and insufficient to address need and reduce inflow; ES capacity is insufficient to address need resulting in increased unsheltered homelessness, and permanent housing capacity (TH, RRH, PSH, or other PH exits) is lacking severely and causing increases in the time people remain unhoused.

[16] Exits to TH are not classified as permanent housing outcomes under HUD data standards. The ES capacity discussion in this section should be read with that distinction in mind. In November 2025, HUD issued a Notice of Funding Opportunity that shifts federal Continuum of Care funding away from permanent housing programs and toward transitional housing programs, moving funding away from PSH and RRH toward TH. This evaluation's discussion reflects that evolving federal funding landscape rather than an assertion that TH exits are equivalent to permanent housing exits.
[17] According to Stella P, RRH households spend, on average, 422 days in the program, out of which 301 homeless in ES and the rest permanently housed, while TH households participate in the program for an average of 254 days (TH is considered a homeless state, similar to ES).

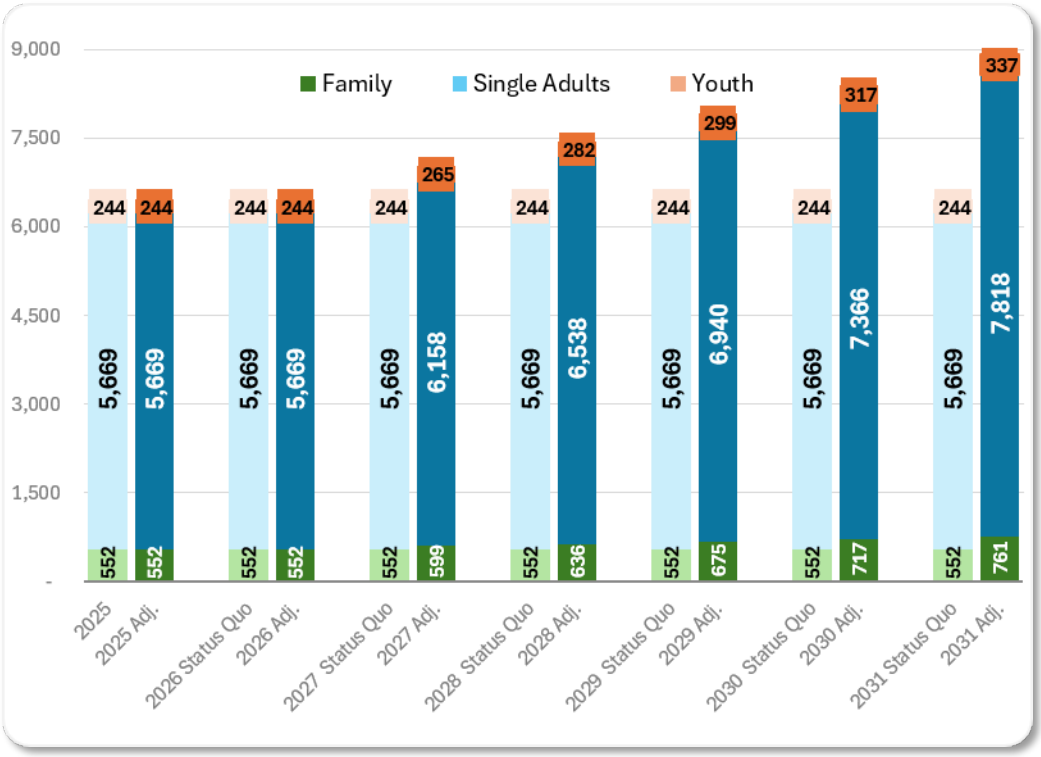
Gaps in Services and Areas of Unmet Need

This section examines projected service gaps by program type, first for ES, then TH, with RRH and PSH addressed qualitatively given the federal policy uncertainty discussed above. Two scenarios are compared throughout: a **status quo scenario**, which holds current capacity and performance flat, and an **adjusted scenario**, which layers in the small, incremental improvements described earlier in this report (modestly expanded HP capacity, small capacity increases, and improved bed utilization). A summary of the scenarios and results are described below. The modeling assumptions used for each scenario and the modeling process is documented in the **Technical Methodology Appendix**.

Emergency Shelter Projections

Under the adjusted scenario, the number of **households served in ES programs is projected to grow from approximately 6,400 in 2025 to 8,900 by 2031, an increase of approximately 38 percent** (Figure 5). This growth reflects the system's improved ability to serve more of the households who need ES, driven by **higher bed utilization and modest capacity increases**.

Figure 5: Households Projected to be Served in ES, Status Quo vs Adjusted Scenarios



The adjusted scenario would enable the community to serve approximately 31 percent of people estimated to become homeless by the end of the modeling period in 2031, leaving roughly 69 percent unable to access ES due to capacity limitations (Table 5). In contrast, approximately 78 percent of people in 2031 are expected to be unserved under the status quo scenario, driven by demand growth outpacing static capacity. It should be noted that these gap percentages measure ES capacity against total projected homeless households. Since households that are not served in ES may access other system components, including TH, RRH and PSH, or may remain unsheltered,

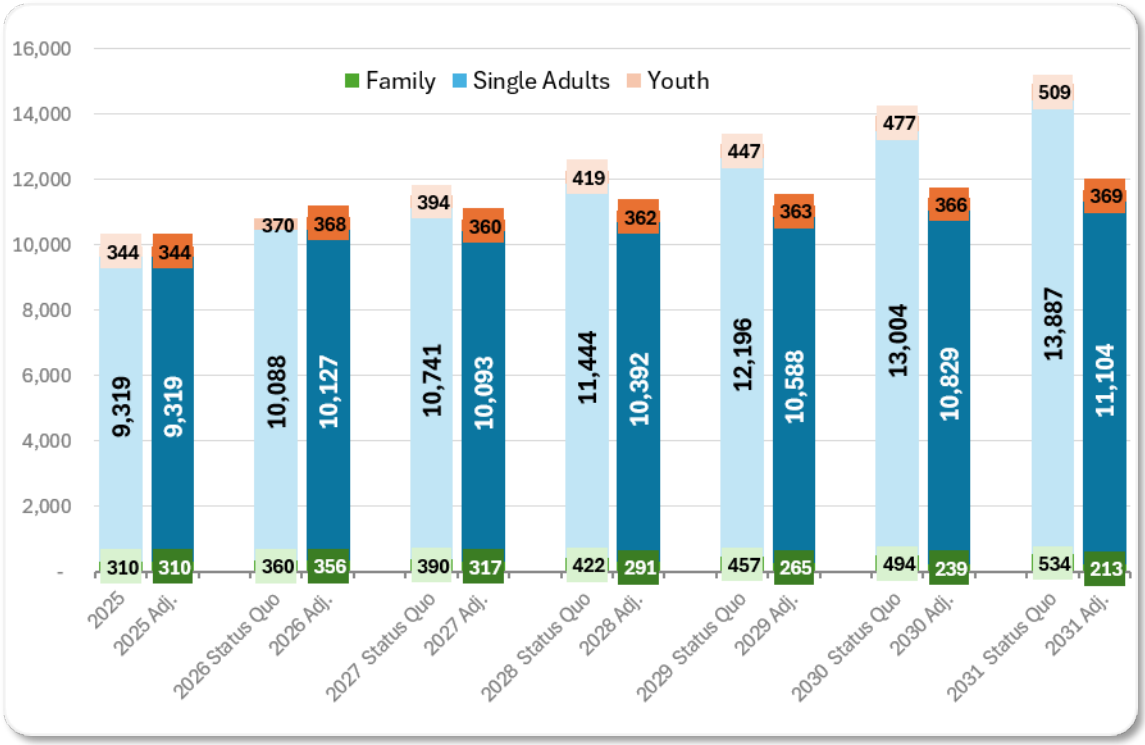
the gap represents the upper bound of unmet ES need. Increasing access to ES for underserved populations will require improving outflow from ES by expanding housing resources and facilitating access to mainstream housing options, strengthening upstream interventions that divert households from ES entry, and/or **expanding ES capacity for underserved populations.**

Table 5: Households Projected to Experience Homelessness and Sheltered Homelessness

Year	Projected Homeless Households	ES Total Served - Status Quo	% Served in Shelters, Status Quo	ES Total Served - Adjusted	% Served in Shelters, Adjusted
2025	21,746	6,465	30%	6,465	30%
2026	23,064	6,465	28%	6,465	28%
2027	24,115	6,465	27%	7,023	29%
2028	25,244	6,465	26%	7,456	30%
2029	26,455	6,465	24%	7,914	30%
2030	27,755	6,465	23%	8,400	30%
2031	29,175	6,465	22%	8,915	31%

Under the adjusted scenario, while still high, the ES gap will narrow by over 2,000 beds. This improvement is achieved by assuming the "adjusted system" has enhancements and investments that increase bed utilization and improve program performance.

Figure 6: Projected ES Gap, Status Quo vs Adjusted Scenarios

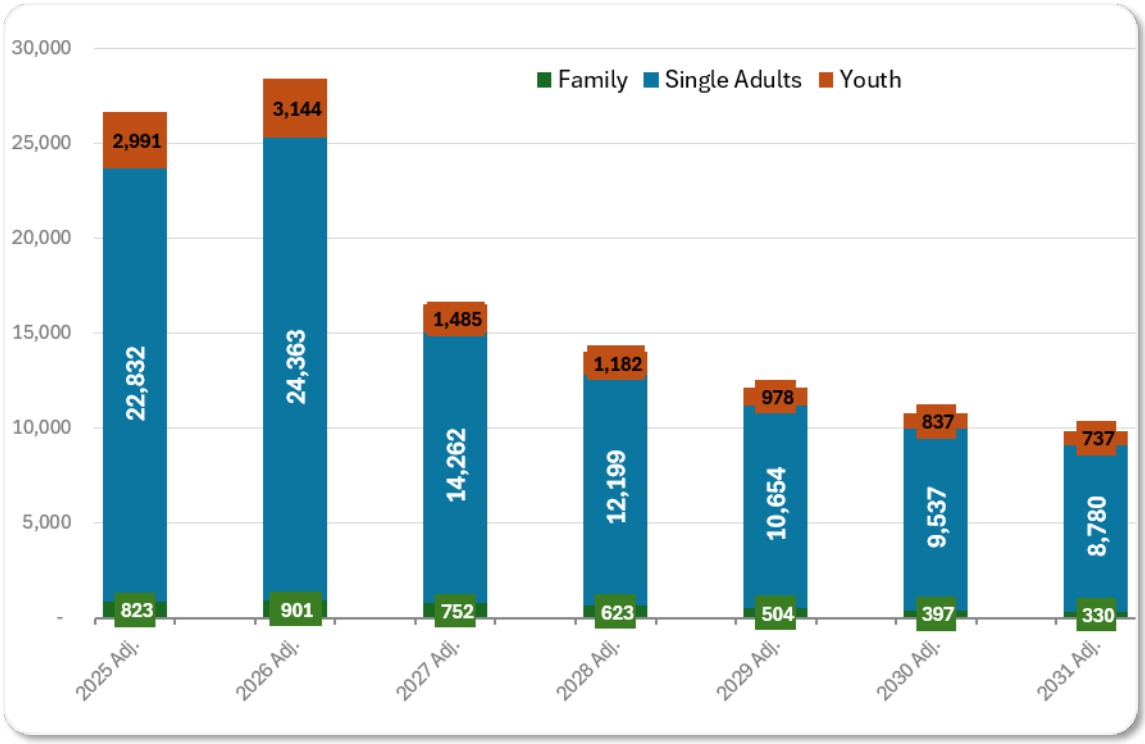


Transitional Housing Projections

The adjusted scenario assumes enhancements will be made to significantly improve utilization of TH, which is currently very underutilized, along with investments to add a small amount of TH capacity. The adjusted scenario would reduce the gap in TH need by over 63% (Figure 7). The

baseline unit gap appears much higher than is needed, because there is an underlying assumption that current inventory is being used to meet local needs. In reality, a significant part of the TH gap can be met by actually using existing TH capacity.

Figure 7: Projected TH Gap, Adjusted Scenario



11.5 Drivers of System Gaps and Pathways to Improvement

The system's performance depends on three levers:

1. **Reducing inflow through HP and diversion;**
2. **Ensuring crisis response capacity that meets demand; and**
3. **Expanding housing exit pathways through TH, RRH, and PSH (and other positive exits, including non-homeless dedicated resources, not modeled here).**

Strengthening HP and diversion through coordinated and targeted interventions reduces demand for ES, while increasing RRH and PSH capacity improves the system's number served and alleviates congestion. Conversely, constraints in these areas result in increased ES demand, longer lengths of stay, and higher levels of unsheltered homelessness.

The current system's constraints are driven by the following factors:

- Increased inflow from cost-burdened households coupled with limited HP and diversion capacity
- Insufficient ES and TH capacity to meet demand for crisis services

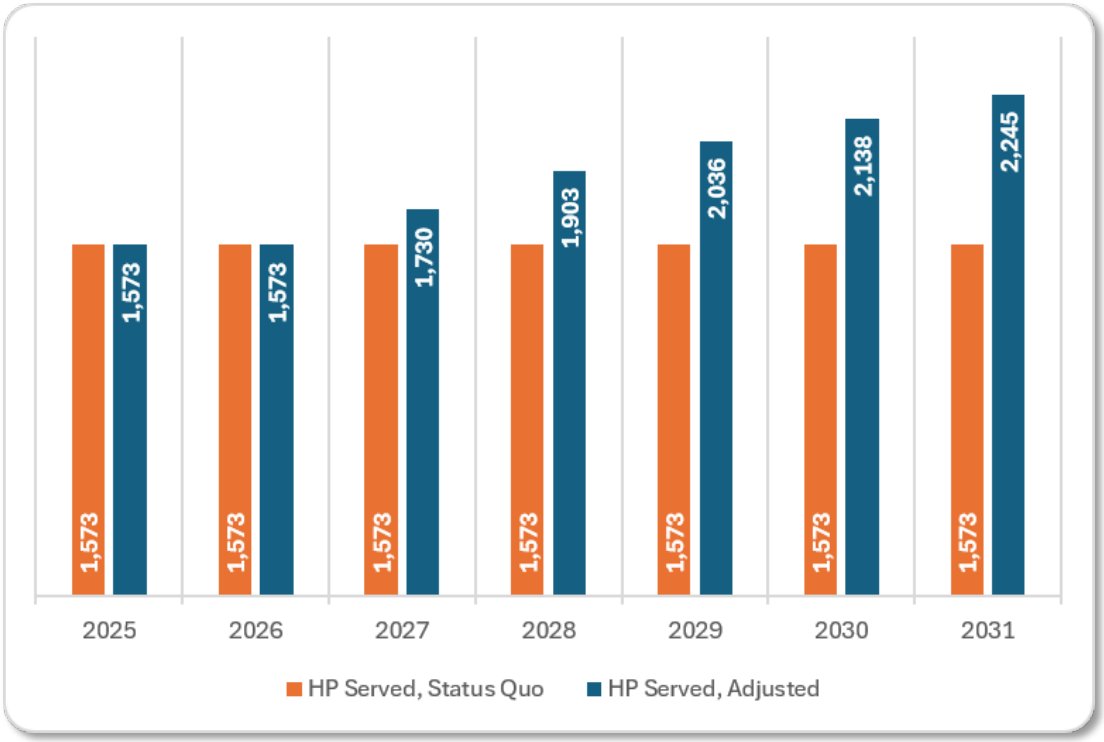
- Constrained exits to permanent housing, driven by limited affordable housing and limited RRH and PSH capacity

Upstream and Downstream Program Alignment

The ES's ability to meet demand and move households toward stable housing is fundamentally shaped by its capacity and what happens both upstream and downstream of ES entry. Upstream interventions that target people with greater inherent risk for homelessness (e.g., as LA County is now doing) coupled with other coordinated HP and diversion efforts that target people facing immediate, material risk can directly reduce the number of households that need ES in the first place. Downstream programs, TH, RRH and PSH determine how quickly households can exit ES and whether they achieve lasting housing stability. When upstream capacity is insufficient, ES inflow (demand) grows beyond the system's ability to absorb it. When downstream capacity is constrained, ES lengths of stay increase and bed turnover slows, further compressing available capacity. Figures 8 and 9 illustrate how targeted improvements in each of these program areas, modeled under an adjusted scenario, translate into meaningful gains in households served across the continuum.

Figure 8 illustrates the impact of expanded HP capacity on the number of households served. HP reduces ES inflow by stabilizing households before a housing crisis requires emergency intervention, with gains that compound over time as fewer households cycle into the system. The gap between the status quo and adjusted scenarios reflects the degree to which upstream investment can impact the entire continuum. Even modest investments in HP reduce ES demand over time as every household stabilized before reaching the ES door relieves pressure across the entire system.

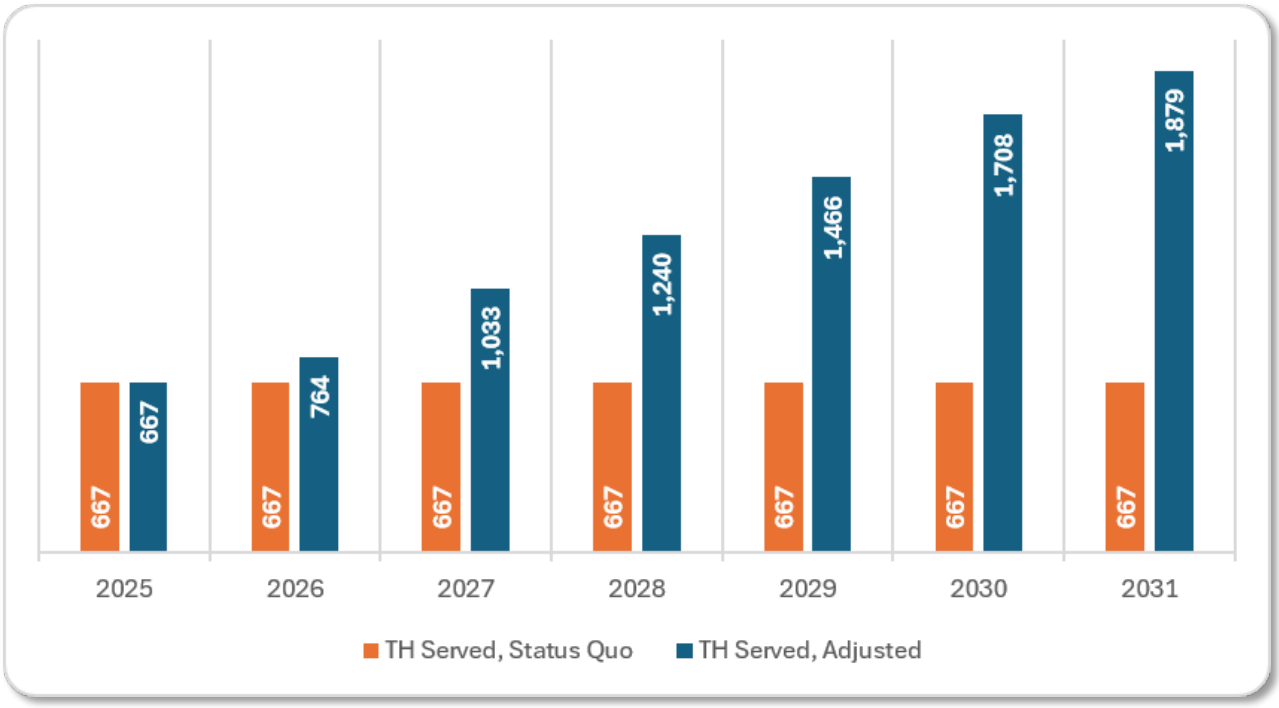
Figure 8: Projection of Households Served by HP, Status Quo vs Adjusted Scenarios



Currently TH programs show an underutilization of available capacity, based on the 2025 HIC. TH utilization ranges from 18 percent for youth to 66 percent for families (RRH and PSH show good utilization based on the 2025 PIT count numbers reported).

Figure 9 shows the number of people projected to be served in the status quo scenario compared with the effect of improving TH utilization and incrementally expanding TH inventory by a small amount over the modeling period. TH creates structured exits from ES for households requiring a longer stabilization period, freeing ES beds for new entrants and improving overall the system's number served.

Figure 9: Projection of Households Served by TH, Status Quo vs Adjusted Scenarios



Projected Outcomes

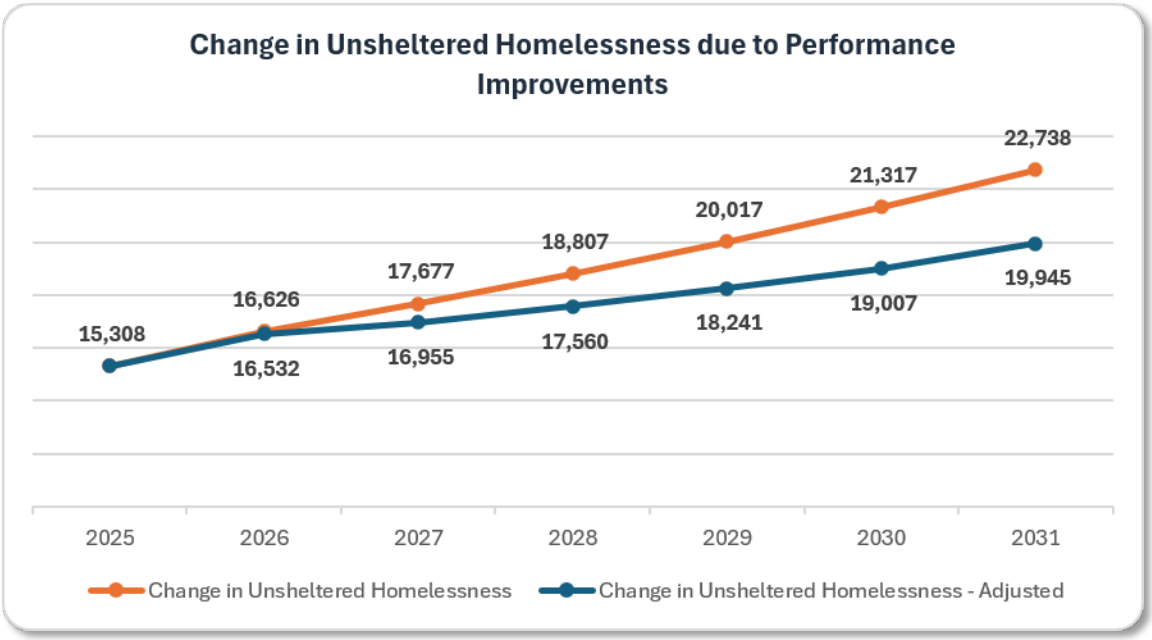
Implementation of the investments in HP, diversion, and TH and performance improvements described to increase utilization and performance of existing ES and TH programs are projected to reduce unmet need, particularly the number of households experiencing unsheltered homelessness.

Because neither scenario includes significant investments in the homeless system, the community is expected to see increases in unsheltered homelessness in both scenarios; however, the modest improvements envisioned in the adjusted scenario could slow the increase in unsheltered homelessness by 2,800 households (Figure 10) by 2031:

- **No action:** Without system changes, **unsheltered homelessness is projected to increase by 49 percent,** rising from approximately 15,300 households needing services annually (2025) to approximately 22,700 households by 2031, as rising housing cost burden drives growth in demand that outpaces static system capacity.
- **Performance, capacity and utilization improvements:** Implementing modest

improvements to HP, ES and TH capacity and bed utilization is projected to **slow the increase in unsheltered homelessness. With these improvements, the number of households projected to experience unsheltered homelessness is estimated to increase by 30 percent,** a 19 percentage point difference vs. the status quo scenario. This reflects the gains achievable through operational improvements and limited infrastructure additions.

Figure 10: Change in Unsheltered Homelessness, Status Quo and Adjusted Scenarios



11.6 Recommendations

1. Expand Homelessness Prevention and diversion capacity to reduce system inflow. The modeling demonstrates that upstream investment produces compounding returns: every household stabilized before reaching the ES door relieves pressure across the entire continuum. It should be noted that typically even very well targeted prevention activities require serving multiple households to avoid homelessness for one household. However, targeting techniques and strategies are rapidly improving across the U.S. and are being deployed to identify and assist households with immediate material or inherent risk, often building on CES partnerships and access points. Embedding these locations with staff trained in housing problem-solving and with access to flexible financial assistance are core features of expanded, coordinated HP. Related studies now document the much lower costs involved preventing versus resolving homelessness.

With the at-risk population projected to grow from approximately 133,100 to 147,600 households by 2031, current HP capacity addresses only a small fraction of projected need. Prevention and diversion investments should be prioritized as the most cost-effective lever for reducing ES demand, with resources targeted toward the severely cost-burdened renter households the model identifies as the population most at risk of entering homelessness, with particular geographic priority given to the North and Central SPAs, where family financial stability is lowest (Figure 3). In parallel, diversion services should be standardized and consistently tracked, as current practice is neither, limiting both effectiveness and the ability to measure it.

2. Improve Transitional Housing utilization before pursuing capacity expansion. TH utilization currently ranges from 18 percent for youth to 66 percent for families, based on the 2025 HIC, a significant volume of existing, funded capacity going unused while ES demand exceeds supply. Before new TH investment is considered, the causes of underutilization should be identified and addressed, whether they stem from referral pathway gaps, eligibility restrictions, program requirements that deter participation, or misalignment between unit configuration and household composition. Restoring existing TH capacity to full utilization represents the fastest and least costly capacity gain available to the system and takes on added importance given the anticipated federal reorientation toward TH as the principal program model for households exiting ES.

3. Update the model as federal policy direction is confirmed. The projections in this report reflect the current system configuration and do not incorporate the anticipated federal shift away from RRH and PSH toward an expanded TH role. Because RRH and PSH capacity directly influence ES exit rates, lengths of stay, and the overall ES gap, any changes to federal program priorities or funding structures should trigger a model update. The CoC should treat this analysis as a living baseline, refreshed as federal guidance, funding notices, and local capacity decisions materialize, rather than as a static forecast.

4. Discontinue same-day entry/exit records in Street Outreach. HMIS data shows that a substantial majority of street outreach records (over 12,000, approximately 68 percent of all SO records) are same-day entry/exit records. This practice should be discontinued. Same-day records negatively impact system performance measures and do not accurately represent the population served or the depth of outreach engagement. Recording contacts as enrollments inflates apparent service volume while masking the true length and intensity of outreach participation, complicating both performance measurement and capacity planning. Outreach contacts should be recorded consistent with HUD HMIS guidance distinguishing contacts, engagements, and enrollments, with enrollment reserved for households receiving ongoing outreach services.

5. Reduce direct exits from Emergency Shelter without downstream program support. Currently, 88 percent of households exiting ES do so directly, without assistance from downstream programs (TH, RRH, or PSH). This group has substantially higher returns to homelessness than those who leave ES with supports. Expanding both “rapid exit” assistance involving housing problem-solving and flexible financial assistance, similar to HP and diversion, along with downstream program connections at shelter exit, through improved coordinated entry prioritization, stronger ES-to-RRH/TH referral pathways, and progressive engagement practices, would convert a larger share of shelter exits into stable housing outcomes and reduce the recidivist inflow that consumes ES capacity in subsequent years.

Section 12: Conclusion

This section brings together the evaluation's 38 priority activity recommendations and 9 innovation opportunities, organized first by cross-system priority and then by the subpopulations for whom specific actions are most consequential. A single recommendation may appear in more than one subpopulation section where it addresses issues affecting multiple groups.

Additional examination of the following sub-populations is needed to contribute to further inform step planning:

- **Seniors.** Seniors are the second-largest identifiable subpopulation after single adults (age 55+, 3,410 participants or 21% of the target population; age 62+, 1,698 participants or 11% of the target population). Recommendation IO-6 includes connection to IHSS, Area Agency on Aging, and senior housing programs.
- **Reentry Population.** Prior living situation shows only 44 participants entering from jail or prison and almost certainly this number is an undercount. Most people do not transition directly from jail to street outreach, they cycle through other settings first. The exit data confirms the justice-involved population is a meaningful presence in the system (383 exits to jail or prison during the evaluation period)
- **Gender Diverse and LGBTQ+ Population.** LGBTQ+ youth are nationally estimated to represent 20–40 percent of the unaccompanied youth homeless population, and gender-diverse individuals face well-documented barriers in shelter settings.
- **Language Access / Limited English Proficiency (LEP) Population.** The evaluation mentions Spanish-language materials as a compliance strength but does not analyze whether Spanish-speaking or other LEP households have different access rates, assessment completion rates, or housing outcomes. Given that Hispanic/Latino is the largest racial/ethnic subgroup (42 percent of the target population), language access is an equity dimension distinct from race/ethnicity alone.
- **At Risk of Homelessness Population.** The evaluation notes that at-risk households are present on the BNL and that prevention referral is first-come, first-served rather than risk-based. Additional stakeholder feedback and assessment is needed to inform improvements to coordinated, targeted prevention resources via access points and other sources and to align with related efforts OCC is engaged in to develop homelessness prevention approaches.

12.1 Cross-System Priorities

The following recommendations address structural conditions that affect all CES participants and must be resolved before subpopulation-specific interventions can be fully effective.

System Governance and Coordination

Current resources and responsibilities individuals and families need to avoid or resolve homelessness and remain stably housed are distributed and often siloed across multiple agencies, funding streams, data systems and service networks. Distribution itself is not the problem; many functions must remain with the entities legally and operationally responsible for them. The gap is

the absence of a more singular governance process that ensures separate systems operate toward common goals and function as one coordinated response for the people they jointly serve.

Braided funding does not mean combining all dollars into one pool. It means using each funding source for the costs it can legally and effectively support, while using a ***cross-system governance structure*** to ensure that outreach, housing navigation, tenancy support, clinical care, and long-term stabilization function as one system for the client. This allows CoC funds to anchor coordinated entry, HMIS, rapid rehousing, permanent supportive housing, and other HUD-eligible functions; HHAP funds to support flexible regional capacity and housing pathways; CalAIM to support eligible care management, medical respite, community supports, transitional rent and other services; BHSA to support behavioral health treatment, interim and long-term housing, and supportive services, including during critical transition periods; and workforce, benefits, aging, child welfare, and housing agencies to contribute resources within their respective authorities, but in a coordinated, systematic manner.

Governance is what connects those contributions into a coherent strategy and system of supports and related information systems and data sharing that work for people, rather than a collection of parallel programs with different requirements, enrollment pathways, and care coordination barriers.

Orange County already has much of the institutional architecture needed to support this approach in both the CoC Board, serving as the central homeless-system strategy implementing and operational body, and the County Commission to Address Homelessness, serving as the chief convener across departments, cities, public housing authorities, health plans, providers, and other system partners.

However, clarifying and potentially re-setting roles and accountabilities is needed, particularly as the evaluation points to multiple instances where enhanced and intention integration with service supports from other systems and sources (e.g., CalAIM) are not being leveraged or access via CES. Existing and forthcoming HHAP regional planning requirements and the CoC committee structure provide a foundation for aligning roles, funding, performance expectations, and implementation across systems.

Successful implementation of the recommendations in this evaluation and parallel coordination with other related CoC strategic initiatives underway depends first on ensuring system governance is optimized.

This approach would move Orange County from episodic coordination and parallel initiatives toward an integrated regional system in which major housing and stabilization functions are singularly governed, even when funding and delivery remain distributed. The result should be clearer accountability, more effective use of available resources, and a more complete pathway from CES access through housing placement and long-term stability.

The existing VA partnership—identified as the strongest functioning mainstream integration model in Orange County and based on the national VA-required “One Team” approach—can serve as an operational example of how shared goals, defined roles, dedicated resources, and accountable coordination across public and private partners can improve access and outcomes. An examination of this model by leadership may serve to inform next steps.

Severity-of-Need Assessment (REC-1)

While HUD no longer prescribes prioritization for CoC Program funded PSH, HUD still requires assessment that accounts for severity of service needs as part of CES prioritization functions. This is a design-level gap that propagates through every downstream function. The evaluation team recommends that the OC CoC follow HUD requirements and prioritize households with the most severe service needs, including chronic homeless and long-term homeless, and adopt the severity of service needs as an explicit approach for assessing and prioritizing people for assistance.

Length of time homeless should be incorporated as one factor among several, alongside severity of service needs, and should account for length of time in TH as well as time literally homeless. Until vulnerability and clinical acuity are formally incorporated into the prioritization model, the system cannot ensure that the scarcest housing resources reach the households with the greatest need. This is the single highest-leverage policy correction available to the OC CoC.

CNA Coverage Expansion (REC-8, REC-9)

At 14 percent of the target population, the CAN reaches too few households to function as a genuine system front door. Expanding coverage to 35 percent within 12 months and 50 percent within 24 months, adding open access points with priority in the South SPA, is a prerequisite for meaningful improvement in all downstream functions. Some form of structured crisis needs assessment at first contact remains a necessary system function. The plan should formalize the CNA, or a clarified equivalent crisis-screening instrument, as an intentional, trained, and consistently administered step in HMIS, so that assessment-type data reliably reflects purposeful screening.

*HNA Coverage and Timeliness (REC-13, **REC-14**)*

Thirty-five percent HNA coverage means 65 percent of households in the crisis response system are invisible to the prioritization and referral functions. Achieving 90 percent HNA completion within 30 days of enrollment requires both access point investment and instrument redesign to incorporate vulnerability scoring, clinical acuity indicators, documentation readiness, and safety assessment.

Prioritization Model Reform (REC-21)

Replacing the length-of-homelessness-only prioritization model with one that is dynamic and consistent with HUD requirements to incorporate severity of service needs factors, along with clinical urgency and housing type fit is the most consequential operational change available to the system. This need not take the form of a point-based scale, a structured assessment capturing these factors is sufficient and it directly addresses the finding that 3,734 chronically homeless and disabled households with completed HNAs received no housing referral.

Continuous Quality Improvement and Governance (REC-5, REC-6, REC-7, REC-35)

Without a formal CQI framework and functioning governance and feedback mechanisms, the compliance and performance gaps documented in this report will continue to accumulate between evaluation cycles rather than being identified and corrected in real time.

HMIS Data Quality (IO-9)

Data quality gaps, including the DV survivor, disabling condition, veteran status, and SPA assignability, limit the reliability of equity monitoring across all functions.

12.2 Complete List of Recommendations

This list is a compilation of all 38 numbered recommendations (REC-1 through REC-38) and all 9 innovation opportunities (IO-1 through IO-9) presented throughout the report, organized by the section in which each first appears. The IOs reflect CoC-level strategic and governance opportunities rather than actions within the CES Lead's operational authority. For each item's responsible entity and estimated investment level, see Appendix E.

Part 1 — Compliance & Performance Recommendations (REC)

Section 3: System Design

REC-1: The OC CoC should revise the CES P&Ps and the CoC and ESG Written Standards to incorporate a formal severity-of-need assessment, as required per HUD Notice CPD-17-01 and consistent with best practices. The revised standards should define how severe service needs and vulnerability, including functional impairment requiring significant support, high utilization of crisis services, unsheltered status (with particular attention to youth and children), vulnerability to illness, death, or victimization, and risk of continued homelessness, are incorporated into prioritization decisions, to ensure that the most vulnerable households are prioritized ahead of those with comparatively lower need. This revision should be coordinated with the Prioritization function findings (Section 6) and should be reflected consistently across both the CES P&Ps and the written standards to maintain alignment.

REC-2: The OC CoC should build document preparation support into the CES process earlier, prior to match, rather than relying on document readiness to surface as a barrier at the point of referral. This should include establishing a clear system-level status distinction between households that are "in the queue" (placed on the BNL but not yet document-ready) and "matchable" (document-ready and eligible for referral), tracked in HMIS, so that access points and matchmakers can prioritize document-readiness support for households approaching matchable status.

REC-3: The OC CoC should formalize a "responsible provider" model and warm-handoff protocol that designates clear ownership of each household from match acceptance through enrollment. This should include a structured case-conferencing policy specifying when conferencing is required, who participates, and what triggers escalation, addressing the currently absent post-match navigation function identified later in the report.

REC-4: The OC CoC should clarify and formally document in the CES P&P the terms of VA SSVF participation in the OC CES.

REC-5: The OC CoC should formalize a Continuous Quality Improvement (CQI) framework that receives all CES feedback loops and data collection, ensures performance data, stakeholder feedback, system outcomes, and the results of this evaluation are systematically reported out, reviewed and translated into action. The framework should define: a structured improvement review cycle (minimum quarterly); a clear process for elevating findings to policy decisions; opportunities for system improvement and actionable improvement plans; designated accountability for follow-through and improvement plans; and a mechanism for communicating outcomes of improvement efforts back to stakeholders. The inflow-to-permanent housing exit ratio and CNA coverage rate should be core standing indicators in the CQI framework.

The CQI framework should also include a defined protocol for updating the CES Policies and Procedures and monitoring their implementation and updating staff training materials following

policy or instrument changes, with a required completion timeline and tracking mechanism to ensure consistent implementation across access points.

REC-6: The OC CoC should establish formal, transparent mechanisms for stakeholder input and policy development. Current pathways are perceived as unclear or ineffective by both operators and providers. Structured mechanisms should include: a defined process for submitting and tracking improvement recommendations; a regular stakeholder input cycle tied to the CQI framework; and a public-facing summary of how recommendations are reviewed and resolved. Inclusive feedback mechanisms should also address the perspective of PLE beyond the focus group format.

REC-7: The OC CoC should clarify governance roles, decision-making authority, and responsibility for system changes across all CES-affiliated entities. Role ambiguity, particularly around housing provider relationships, access point oversight, and policy modification authority, creates delays and reduces accountability. A governance map with clearly defined roles, escalation pathways, and decision rights should be documented and disseminated to all CES-affiliated organizations. CoC board meetings should be structured to enable substantive policy discussion, not only information reporting.

Section 4: CES Function 1 — Access

REC-8: The OC CoC should develop a CES Coverage Expansion Plan with a target of 35 percent coverage within 12 months and 50 percent within 24 months. The plan should establish mandatory CES CNA protocols at all Access Points and define accountability mechanisms for programs that fail to link households to CES.

Regardless of the OCC-reported data-entry issue, some form of structured crisis needs assessment at first contact remains a necessary system function. The plan should formalize the CNA, or a clarified equivalent crisis-screening instrument, as an intentional, trained, and consistently administered step in HMIS, so that assessment-type data reliably reflects purposeful screening. Clarifying this distinction is a prerequisite to accurately measuring coverage against the expansion targets above. Single adults represent the largest unserved group and should be the primary focus of expansion efforts. Because Street Outreach drives the bulk of the coverage gap (84 percent of the target population, 30 percent HNA coverage), expansion progress should be tracked separately by program type against the baseline established in this evaluation.

REC-9: The OC CoC should stabilize and expand open access point capacity, with priority given to the South SPA where coverage rates are critically low. The root cause of the access point closure trend, insufficient funding and staffing, must be addressed at the system level. An Access Point Sustainability Plan should be developed that includes:

- Minimum geographic coverage standards by SPA.
- Capacity monitoring for open access points.
- Stable funding mechanisms for agencies serving as access points
- Incentives for agencies serving as open access points.
- Training for access points on diversion and Housing Problem-Solving.
- Formalize and publicly track CES-participation status for Street Outreach programs. Street Outreach comprises 84 percent of the SO/ES/TH target population but has the lowest HNA

coverage rate of any program type (30 percent, compared to 65 percent for Emergency Shelter).

- Contingency plans when access point capacity falls below established thresholds.

REC-10: A homelessness prevention and diversion component should be developed and integrated into the OC CES access model. The current CES P&P references homelessness prevention and problem-solving at the point of crisis assessment. However, a formalized diversion protocol with clear eligibility criteria, trained staff, and outcome tracking is absent from implementation, as well as coordination with other community-based prevention resources. Dedicated homelessness prevention funding and programming are also essential for reducing crisis system demand. Prevention and diversion represent a material structural gap in the current design.

REC-11: The OC CoC should implement a referral connection tracking protocol to determine whether households successfully engage with assigned access points following referral. Stakeholders described systemic uncertainty about connection rates, including unanswered calls and referrals to closed access points. Monitoring the proportion of referrals that result in a completed CNA would provide actionable data on system attrition at the point of entry and enable targeted interventions to reduce dropout.

Section 5: CES Function 2 — Assessment

REC-12: The OC CoC should immediately revise the Disabling Condition Form to remove the disability-type field. HUD prohibits requiring disclosure of a specific disability type or clinical diagnosis as part of coordinated entry screening or assessment; information about disabling conditions may only be gathered for the purpose of determining program eligibility and making appropriate referrals. The revised form should confirm the presence of a disabling condition without specifying type. Concurrently, the CES Policies and Procedures should be updated to include the required disability-related limitations language consistent with HUD guidance. The policy should also clearly state that the Disabling Condition Form is not required to be present prior to the person being added to the BNL. These two actions, form revision and P&P update, are discrete, bounded, and do not require system redesign or significant resources. Completion should be targeted within 30 days and confirmed in writing to the CES Steering Committee. Once the revised form is in use, a brief staff communication should clarify the updated disclosure standard to ensure consistent implementation across all access points and assessing programs.

REC-13: The OC CES should establish a HNA completion target of 90 percent of newly enrolled SO/ES/TH households within 30 days of enrollment, replacing the current pattern of same-day and 91-plus day completion. The target should be implemented as a program-level performance standard, with quarterly reporting to the CES Steering Committee. HMIS should track enrollment-to-HNA days as a standing metric alongside coverage rates.

REC-14: The OC CoC should conduct a structured review of the current HNA instrument and assessment workflow to determine whether the tool captures sufficient information to support accurate housing intervention matching and service supports, both immediate and ongoing. The review should consider whether the instrument should be expanded to incorporate vulnerability scoring, clinical acuity indicators, documentation readiness, navigation and support needs, and safety assessments, particularly for survivors, TAY, and medically complex subpopulations. The review should also examine whether informal supplemental assessment activities conducted outside the formal CES process can be standardized and incorporated into the HMIS record.

REC-15: The OC CoC should conduct an immediate, targeted review of HNA adequacy for survivor and transition-age youth (TAY) populations, separate from the broader instrument review in REC-14. For survivors, the review should determine whether a supplemental, SCES-administered assessment is needed to safely characterize need before a housing match is proposed and should establish a protocol requiring SCES sign-off or consultation before a survivor referral is finalized to a non-DV survivor-specific program. For TAY, the review should assess whether the current instrument and surrounding system design, including housing type availability and program eligibility criteria, adequately serve single youth, who may be structurally disadvantaged by a system oriented toward families and couples.

REC-16: The OC CoC should implement an automated HMIS notification system alerting CES staff and BNL managers when a household's CLSA is approaching 75 days since last update, 15 days before the 90-day standard, to allow time for outreach and scheduling. OCC confirmed automated emails are already generated, and they will look at the timeframe for these emails. We also recommend HMIS-based alerts, not just email notification. Program-level reassessment currency targets should be set, with performance monitored and reported quarterly. A supplemental mechanism should be developed to enable timely out-of-cycle reassessment when significant household circumstances change, rather than waiting for the next scheduled update window.

REC-17: A structured review should be conducted for all 3,734 households identified as chronically homeless or having a disabling condition who completed a HNA but received no housing unit referral (S3 cohort). For each household, the absence of referral should be categorized as: (a) appropriate based on clinical or resource-based judgment, (b) a documentation or process gap, or (c) an unaddressed resource constraint. Where no clinical reason for non-referral is identified and resources exist, referral should be issued. Priority should be given to households in S3 who have also not been reassessed within 90 days. This review should be completed within 90 days and results reported to the CES Steering Committee.

Section 6: CES Function 3 — Prioritization

REC-18: The OC CoC should immediately correct the PSH prioritization eligibility language in its policy to accurately reflect HUD's permitted allowance for temporarily housing accepted program participants in transitional housing while a permanent unit is identified. The correction is a discrete policy edit. The revised policy should be formally adopted by the CoC Board and distributed to all participating providers.

REC-19: The OC CoC should develop a formal Homelessness Prevention Prioritization Protocol, separate from the existing CES BNL, with its own eligibility criteria, risk-based prioritization framework, and designated BNL. Prevention assistance should be allocated based on assessed risk of housing loss, not first-come, first-served. This protocol should be incorporated into the CES P&P as a dedicated section and operationalized with a separate prevention-specific CQ. Households at risk of homelessness should be enrolled in the prevention queue, not the general CQ, which is designed for literally homeless households. They should simultaneously be supported with Housing Problem-Solving at any access points by trained and certified staff.

REC-20: The OC CoC should revise the CES P&P to remove singular use of length-time-homelessness criteria from ES prioritization. HUD guidance distinguishes between interventions that should be prioritized by acuity (PSH, RRH) and crisis-response resources such as ES that generally should be immediately accessible for people with no safe alternative. Applying length-of-homelessness criteria for at-risk populations may incentivize households into the crisis response

system. Instead, CES leadership and partners, including people with lived experience, should devise ES prioritization policies that account for the participants' acuity, available ES options and include negotiated local preferences. This revision should be coordinated with the severity-of-need scoring revision in REC-1 (Section 3) to ensure alignment across the prioritization framework.

REC-21: The OC CoC should evaluate and refine the current length-of-homelessness–based prioritization model to incorporate participant vulnerability, clinical urgency, and housing-fit considerations alongside duration. This includes reviewing whether the dynamic-match vote structure produces the intended prioritization outcomes; examining whether tiered queues organized by housing type and acuity would improve match quality and reduce referral failure rates; and implementing a structured case conferencing protocol to supplement list-based ranking with provider-level clinical knowledge. This recommendation should be developed in direct coordination with the assessment instrument review in REC-14 (Section 5), as vulnerability-based prioritization requires vulnerability data that the current HNA does not produce.

REC-22: The OC CoC should address the gap in HNA coverage for Street Outreach participants, approximately **70 percent of whom have no HNA** and are therefore not placed on the BNL. Outreach workers should be equipped and trained to complete or facilitate HNA completion for all literally homeless participants at or shortly after contact. Given that SO represents 84 percent of the target population and 70 percent of SO participants lack a HNA, this represents the single largest coverage gap between the population experiencing homelessness and the prioritized population for housing resources. Outreach-to-HNA completion should be established as a performance standard and tracked quarterly.

REC-23: The OC CoC should establish a participant grievance process and means for confidential reporting of CES participant concerns and grievances. Evaluation findings should inform updates to CES monitoring practices and feedback mechanisms. OCC should also immediately investigate reports that PLE received threatening communications after submitting complaints and were excluded from meetings or deprioritized from housing following complaint activity. The grievance and anti-retaliation policy is the only Fully Compliant item in the Prioritization function; retaliatory conduct at the point of use represents a serious implementation failure that directly undermines that policy's purpose. In light of this finding, the OC CoC should establish a confidential third-party complaint channel that reduces the risk of retaliation or other neutral means for assuring protection of client rights and due process. Results should be reported to the CoC Board within 30 days.

REC-24: The OC CoC should investigate the high BNL expiry rate (36 percent) to determine whether expiring households are being actively contacted and supported prior to removal. BNL managers should track and report the number of households contacted versus unreachable in the 90-day period before expiry, and a formal outreach protocol should be established for households approaching expiry. The investigation should also examine whether the expiry rate is related to the assessment currency gap (Section 5, REC-16 and REC-17): the CLSA data confirms that a household with no CLSA update in 90 days is automatically removed from referral eligibility, and 19 percent of still-active BNL households have no CLSA update on record at all. Coordinating reassessment outreach with pre-expiry contact could address both issues with a single workflow.

Section 7: CES Function 4 — Referral

REC-25: The OC CoC should develop and implement a Timeliness Improvement Plan to bring housing match timelines into compliance with established benchmarks within 90 days. The plan

must address both the PSH Match-to-Determination and Match to Move-in intervals for both PSH and RRH. For each benchmark, the plan should identify the specific stage where delays accumulate, designate a responsible party accountable for resolving delays at that stage, and set monthly milestones for improvement. OCC should report progress against all six timeliness benchmarks, M→Det, M→MI, and Det→MI for both PSH and RRH, to the CES Steering Committee monthly until all benchmarks are met for two consecutive quarters.

REC-26: The OC CoC should immediately investigate and address evidence that CES-participating agencies are screening potential participants out of assistance based on perceived barriers, in violation of CoC participation requirements. OCC should conduct a structured review of denial reasons in the OCC Match Inventory to identify providers with above-average provider-denial rates and cross-reference these against program eligibility documentation. For providers where denial patterns suggest barrier-based screening, OCC should initiate a formal compliance review and require a written corrective action plan within 30 days. In parallel, OCC should establish a clear, accessible mechanism for participants and referring providers to report suspected screening-out practices confidentially. Results of the review, including the number of providers reviewed, corrective actions taken, and denial rate trends, should be reported to the CoC Board within 60 days. This recommendation should be read alongside Section 6 — grievance retaliation, as both reflect systemic accountability gaps at the provider-participant interface.

REC-27: The OC CoC should investigate the drivers of high participant-declined and denial rates among Veteran, NHPI and Asian/AA households through dedicated focus groups and case record review. For each population, findings should distinguish whether the decline is driven by geographic mismatch, unit quality concerns, cultural misalignment, documentation barriers, or insufficient navigation support. A formal corrective action plan with measurable targets should be developed within 90 days of investigation completion and reported to the CES Steering Committee.

REC-28: RRH program performance requires targeted corrective action. RRH is not seen as a permanent housing path, is not implemented optimally and does not follow RRH best practices. Stakeholders identified housing shortages, inconsistent housing navigation practices, varying provider requirements, and administrative delays as common barriers to successful placement.

The OC CoC should convene an RRH Performance Workgroup to review: fidelity of RRH implementation against national best practices; landlord engagement and unit sourcing strategies; housing match appropriateness criteria; post-match navigation support; and the low housing acceptance rate. A structured review of referral denials and unsuccessful matches may help identify opportunities to improve housing placement rates and reduce time from referral to housing. Findings should inform tenancy support service deployment priorities.

The workgroup should establish updated quarterly performance targets for acceptance rate, Match-to-Move-In timeliness, and move-in rate, and report progress to the CES Steering Committee. Given the RRH program's role as the system's primary rapid-exit intervention, its underperformance has system-wide consequences.

REC-29: The OC CoC should examine and address the same-day HNA-to-referral pattern (64 percent of referred participants). The current practice of completing the assessment and issuing a housing referral in a single session does not allow sufficient time to assess housing fit, confirm documentation readiness, and identify post-placement support needs before a referral is made. The CoC should develop a protocol establishing a minimum review interval between HNA completion and referral issuance, sufficient to confirm eligibility, document readiness, and

housing type fit, with an exception process for participants who are genuinely ready for same-session referral.

This pattern should be examined in connection with the same-day enrollment-to-assessment compression documented in Section 5 (42 percent of HNAs completed the same day as program enrollment). The review interval established above should be evaluated alongside a corresponding minimum interval between program enrollment and HNA completion (see REC-13), since addressing either compression point in isolation would leave the other capable of producing the same single-session outcome.

The CoC should establish explicit accountability for who is responsible for carrying a household from match determination to enrollment and housing, and what constitutes a documented referral failure vs. a legitimate denial.

REC-30: The OC CoC should address the 22 percent system-wide return-to-homelessness rate. For the majority of returns, driven by ES exits to a permanent destination with no CES housing referral on record, the OC CoC should pair rapid exit resources for lower-need ES households with a lighter-touch stability check-in protocol, to identify households at risk of return before a crisis recurs. An analysis of return patterns by housing type, time since placement, and geographic area should identify the highest-risk profiles for return. Separately, for households that do receive a CES-coordinated placement, the OC CoC should invest in post-placement housing stability supports anchored to the actual move-in date.

For DV survivors specifically, where time to housing placement is 51 percent above average and driven by post-match barriers, targeted housing navigation and safety-planning support should be deployed between match determination and move-in, closing the pre-placement gap, with post-placement stability support following as a separate, subsequent phase of the same case plan.

REC-31: The OC CoC should work with housing providers and public housing authorities to standardize application requirements, documentation expectations, and supplemental forms across the referral network. The variation in provider requirements is a primary contributor to referral failures and participant confusion. A centralized, publicly accessible eligibility requirements registry, documenting each participating program's requirements, screening criteria, and unit availability, should be developed and maintained by OCC, with quarterly updates required from all participating providers.

REC-32: The OC CoC should establish a process for communicating provider eligibility requirements and screening practices to CES staff before referrals are generated. Stakeholders consistently reported that access points and CES administrators lack visibility into provider-specific requirements, resulting in referrals that fail after the match has been made. This communication gap contributes to participant frustration, delays, and wasted resources. A structured and centralized process for pre-referral eligibility check, whether through HMIS documentation, a provider eligibility portal, or a standardized pre-referral communication protocol, should be implemented system-wide to improve match quality and reduce unsuccessful referrals.

REC-33: The OC CoC should establish, communicate, and regularly review clearly defined performance benchmarks for all referral and housing outcome metrics. Several stakeholders expressed uncertainty about the basis for current targets and whether they reflect system realities. Benchmarks should be published, reviewed annually against performance data, and adjusted in consultation with providers and CoC leadership. Performance against benchmarks should be

reported quarterly through the CES Steering Committee with explanations of variance and corrective action when targets are not met.

Section 8: Direct Financial Assistance

REC-34: The OC CoC should develop and implement a Direct Financial Assistance function for the CES with defined eligibility criteria, a standardized disbursement process, fiscal controls, and HMIS outcome tracking. This function should be integrated with the assessment process so that households presenting at access points with short-term financial needs can be diverted from the full CES queue through targeted, time-limited assistance, as part of both homelessness prevention services for people imminently at-risk for literal homelessness and rapid resolution services for those currently literally homeless.

Section 9: Data Management and Resource Availability

REC-35: The OC CoC should establish a formal, structured provider and participant feedback mechanism that operates throughout the year, not only during the annual evaluation cycle. The mechanism should include: a defined submission pathway for operational concerns and improvement suggestions; a documented review process with designated staff responsibility; a response timeline commitment; and a public-facing record of how submitted feedback was reviewed and what action was taken. Feedback from providers should be tracked across evaluation cycles so that recurring issues are identifiable even if individual submissions do not produce immediate resolution. PLE should have a dedicated input pathway separate from provider channels, accessible through existing community touchpoints such as CES focus groups, access point contacts, and participant satisfaction surveys administered at assessment.

REC-36: The OC CoC should develop a Resource Alignment and Capacity Management Strategy that translates the system's quantified capacity gap into a structured plan for housing inventory development, reallocation, and funding decisions. The strategy should address: the documented 6:1 inflow-to- permanent exit ratio and what intervention mix would be required to achieve equilibrium; geographic resource distribution across SPAs, with particular attention to the South SPA's access point and housing inventory deficits; subpopulation-specific resource requirements, including PSH and RRH; and a projection of funding, development, and partnership activity required to close identified gaps over a 3-year horizon. The strategy should be reviewed and updated annually alongside the CES evaluation cycle and reported to the CoC Board as part of its planning process.

REC-37: The OC CoC should establish formal performance metrics to monitor system capacity and housing resource utilization. Metrics should include inflow-to-permanent exit ratios, housing opportunity utilization rates and vacancy duration. Regular monitoring of these indicators will provide early warning of capacity constraints and support more proactive system management.

REC-38: Strengthen Housing Provider and Landlord Engagement Strategies. The OC CoC should strengthen housing provider and landlord engagement efforts to expand the pool of available housing opportunities and reduce placement delays. Stakeholders identified affordable housing shortages, inconsistent housing navigation practices, and limited visibility into available opportunities as contributors to lower housing placement rates. Enhanced coordination with landlords, housing authorities, and housing providers may improve resource availability and system throughput.

Part 2 — Innovation Opportunities (IO)

Forward-looking advancements identified in Section 10, distinct from the compliance-required recommendations above.

Section 10: Advancements, Innovations and Experiences

IO-1: Implement a dynamic BNL management approach using real-time data to adjust prioritization for Households whose needs change between assessments. The current static BNL model is not producing current, accurate prioritization. Technology-supported dynamic reassessment processes could substantially reduce information lag and improve match quality without requiring a structural change to the prioritization model.

IO-2: Implement a progressive engagement model for assessment. A phased assessment approach, completing triage/diversion assessment and a shortened crisis assessment immediately and scheduling a full HNA within 7 to 14 days, would allow the HNA to occur after initial crisis stabilization rather than concurrent with it. This approach is more likely to produce accurate vulnerability profiles, reduces same-day-assessment-and-referral compression, and creates a structured opportunity for diversion before a household is formally entered into the CES queue.

IO-3: Implement a real-time system management dashboard providing CES staff, providers, and CES leadership with unified visibility into assessment currency, referral status, pending matches, housing opportunity availability, vacancy duration, and queue aging metrics. Concurrently, develop standardized, publicly accessible eligibility profiles for all participating housing programs that allow CES staff to confirm household eligibility before a referral is made, eliminating the most common source of preventable match failure.

IO-4: Develop a culturally responsive, subpopulation-based housing navigation function. The data establishes that participant-declined rates for certain subpopulations are the primary driver of low housing acceptance. Culturally specific housing navigators who work with households through the matching process, provide language-accessible communication, are culturally matched to the populations they serve, and understand community-appropriate housing options, represent an evidence-informed intervention for this pattern.

IO-5: Establish a confidential, third-party participant complaint and feedback mechanism that is structurally independent of the CES operational staff. A confidential external complaint pathway, accessible without requiring disclosure of the complainant's identity to CES staff, is necessary to provide genuine anti-retaliation protection and to restore confidence in the grievance process.

IO-6: Develop and implement a Mainstream Resource Integration Plan to formalize connections between the CES and mainstream systems, including CalAIM, child welfare, workforce development, income and benefits systems, older adult services, and affordable housing pipelines that currently operate in parallel without active coordination.

IO-7: Develop and implement a Direct Financial Assistance function, as described in Section 8. Implementation would represent a significant structural advancement available to the system within the current policy and technology infrastructure. The function should encompass at minimum: a flexible diversion fund available at the point of crisis contact to support households who can be stabilized with one-time assistance; a rapid housing placement fund providing security deposits, first-month rent, and move-in costs for BNL households matched to RRH or market-rate

units; and a landlord engagement fund that compensates participating landlords for vacancy periods, damage beyond normal wear, and administrative costs of CES participation. Each component should be designed with explicit eligibility criteria, anti-discrimination protections, equity monitoring, and outcome tracking in HMIS.

IO-8: The OC CoC should establish a standing protocol requiring that staff training materials be updated within a defined timeframe following any change to CES policies, procedures, or assessment tools. Training synchronization with P&P updates has historically lagged, contributing to inconsistent implementation across access points, including providers who reported believing the VI-SPDAT was still in use at the time of this evaluation. Given the volume of policy corrections and instrument updates recommended in this report, a systematic training update process, with defined timelines, delivery accountability, and completion tracking, is essential to consistent implementation of those changes.

IO-9: The OC CoC should implement a structured HMIS data quality improvement plan targeting the fields most critical to equity analysis, coverage monitoring, and system performance reporting. Data quality gaps identified during this evaluation directly limited the reliability of subgroup findings and in some cases prevented linkage between related records entirely. Priority fields for improvement include: Veteran Status (32 percent Data Not Collected in the target population), Disabling Condition (35 percent Data Not Collected), City of Prior Residence / SPA (20 percent of target population unassigned to a geographic area), Race and Ethnicity (8 percent Other/Unknown). Separately, the HNA-before-enrollment-date anomaly affecting 10 percent of assessed households should be reviewed to determine whether it reflects data entry timing errors, assessment-before-intake workflows, or a system configuration issue. The data quality plan should establish field-level completion targets, assign data stewardship responsibility by program and access point, include regular HMIS data quality reports to CES leadership, and connect data quality performance to provider participation agreements.

12.3 Subpopulation-based Recommendations

12.3.1 Single Adults

Single adults represent 94 percent of all SO/ES/TH entries and drive the system's most severe performance gaps. The single-adult inflow-to-permanent exit ratio of 7.7:1 defines the resource ceiling within which every other single-adult finding must be understood.

Key findings: Inflow: permanent housing exit 7.7:1 • CNA coverage 14% • Priority List Wait time 124 days • Successful exit rate 15% • Return-to-homelessness 25%

- **REC-8, REC-9:** Access expansion and South SPA investment
- **REC-13:** HNA completion target of 90% within 30 days of enrollment
- **REC-20:** Remove length-of-homelessness criteria from Emergency Shelter prioritization
- **REC-21:** Vulnerability-based prioritization model
- **REC-30:** Post-placement stability supports to address the 25% return-to-homelessness rate
- **REC-36, IO-7:** Resource alignment strategy and Direct Financial Assistance function
- **IO-1:** Dynamic BNL management for timely priority adjustments

12.3.2 Families

Families operate in a near-equilibrium sub-system at 1.2:1 inflow-to-permanent exit ratio. Family outcomes are consistently stronger than system averages across most metrics. However, family access has been narrowing, and child welfare coordination is absent.

Key findings: Inflow: permanent housing exit 1.2:1 • CNA coverage 23% • Time to housing 56 days (fastest) • Successful exit 50% • Return rate 6%

- **REC-9:** Maintain and expand open Family CES access points with stable funding
- **REC-10:** Homelessness prevention and diversion integration
- **REC-15:** Immediate review of HNA adequacy for families with domestic violence involvement
- **REC-19:** Homelessness Prevention Prioritization Protocol
- **IO-6 (Child welfare):** Coordinated housing placement protocols consistent with McKinney-Vento and AB 12
- **IO-6 (Income and benefits):** CalWORKs enrollment support as a standard referral for eligible families

12.3.3 Veterans

Veterans demonstrate the highest-functioning pathway in the OC CES: 1.9:1 inflow-to-permanent exit ratio, the highest HNA coverage of any subgroup (55 percent), and a 98-day wait time. However, two significant referral disparities require investigation.

Key findings: Inflow: permanent housing exit 1.9:1 • CNA coverage 11% • HNA 55% • Acceptance Rate 33% • Denial rate 67%

- **REC-4:** Formalize VA SSVF participation terms in the CES P&P
- **REC-27:** Investigate the veteran referral acceptance gap through case record review
- **IO-6 (VA):** Document the veteran pathway as the operational template for mainstream coordination

12.3.4 Transition-Age Youth (TAY)

Youth downstream outcomes are strong (34-day time to housing, 46 percent successful exit, 10 percent return rate), but access to the pipeline is disproportionately restricted. Youth face barriers at specific points: access to resources dedicated to the population and lack of geographic coverage, entry to the prioritization list and acceptance of housing matches.

Key findings: BNL placement 53% vs 66% average • Acceptance Rate 25% vs 46% • Denial rate 75% • Time to housing 34 days (fastest — positive)

- **REC-15:** Immediate review of HNA adequacy for TAY, including housing type availability and program eligibility criteria, to assess if it adequately serves TAY
- **REC-21:** Vulnerability-based prioritization incorporating youth-specific risk factors
- **REC-27:** Investigate youth referral acceptance gap (25% acceptance rate)
- **IO-4:** Culturally responsive housing navigation with youth-specific navigators
- **IO-6 (CalAIM):** Enhanced Care Management for Medi-Cal-eligible TAY

- **IO-7:** Direct Financial Assistance with low-barrier eligibility criteria for TAY circumstances

12.3.5 Domestic Violence Survivors

DV survivors demonstrate strong upstream outcomes but experience the most severe post-match delay of any subgroup. The time-to-housing disparity is driven by post-match barriers: safety planning, geographic restrictions, and unit availability in locations compatible with survivor safety.

Key findings: CNA 24% • HNA 60% (highest) • Acceptance 60% (positive) • Time to housing 142 days vs 94-day average

- **REC-15:** Immediate review of HNA adequacy for survivor populations
- **REC-29:** Post-match navigation support between match determination and move-in for survivors
- **REC-30:** Post-placement stability supports incorporating survivor-specific services
- **IO-4:** Culturally responsive navigation with dedicated survivor navigators
- **IO-9:** HMIS data quality improvement targeting the DV survivor field

12.3.6 Chronically Homeless Individuals

The evaluation found that 91 percent of CH and disabled households with completed HNAs, 3,734 of 4,109, received no housing unit referral during the evaluation period. This is the most consequential single performance finding in the report.

Key findings: 11% of CH households referred • 9% of disabled households referred • 91% (3,734) with no HO referral • PSH acceptance 58% (meets target — the upstream pipeline is the bottleneck)

- **REC-17:** Structured review of all 3,734 households to identify and clear actionable barriers to referral
- **REC-21:** Vulnerability-based model making clinical acuity an effective differentiator
- **REC-28:** RRH corrective action plan for the 31% acceptance rate
- **REC-31:** Standardize pre-referral eligibility and documentation requirements
- **IO-1:** Dynamic BNL management ensuring CH households receive timely priority adjustments
- **IO-7:** Direct Financial Assistance for households who could exit through targeted intervention

12.3.7 Hispanic and Black / African American Participants

No significant disparity was identified for Hispanic/Latino participants in access metrics. One flag for monitoring was identified in HNA coverage. The Hispanic/Latino population is the largest racial/ethnic subgroup (42.3 percent of the target population).

No broad racial disparity was identified in system access or coverage for Black/AA participants. Black/AA participants show better-than-average inflow-to-permanent exit ratios and faster assessment-to-referral times. One significant disparity was identified at the housing placement stage, driven by longer post-match processing times.

Key findings for the Hispanic subpopulation: Inflow: permanent housing exit 6:1 (above average) • HNA coverage 35%

- **REC-13:** HNA completion target implementation closing the coverage gap proportionally
- **IO-4:** Culturally responsive navigation with Spanish-language navigators
- **IO-9:** Race/ethnicity data quality improvement

Key findings for the African American subpopulation: Inflow: permanent housing exit 4.2:1 (positive) • Assessment-to-referral 19.4 days (faster — positive) • Time to housing 109 days vs 94-day average

- **REC-29:** Post-match navigation support reducing Determination-to-Move-In delays
- **REC-31:** Standardize application requirements to reduce post-match documentation burden
- **IO-4:** Culturally responsive housing navigation with culturally matched navigators

12.3.8 South SPA

The South SPA is the most consistent geographic equity concern in the evaluation, appearing as an Equity Concern or Flag for Monitoring in every function assessment. The access and placement gaps are driven by access point capacity constraints and housing inventory limitations, not population characteristics.

Key findings: CNA coverage 9% vs 21% Central SPA • HNA coverage 36% vs 45% North SPA • 3% of all CNAs • Time to housing 147 days vs 94-day average

- **REC-8:** CES Coverage Expansion Plan with explicit South SPA targets
- **REC-9:** Prioritize open access point investment in South SPA
- **REC-36:** Resource Alignment Strategy with geographic disaggregation identifying South SPA housing inventory deficit
- **IO-3:** Real-time dashboard with vacancy duration by SPA and geographic distribution of available opportunities
- **IO-6 (Affordable housing):** CoC engagement with housing authorities to ensure South SPA needs inform unit set-asides

12.3.9 People with Disabilities

Disabled participants show higher CNA and HNA coverage than non-disabled participants, consistent with prioritization practices. However, a significant CNA-to-HNA progression delay was identified, and 3,734 CH/disabled HNA holders received no housing referral.

Key findings: CNA 22% vs 18% (positive) • HNA 55% vs 48% (positive) • CNA→HNA: 54 days vs 45 average • 3,734 CH/disabled with no HO referral

- **REC-12:** Remove disability-type disclosure from the Disabling Condition Form
- **REC-14:** HNA instrument review to capture disability-related service needs and housing modification requirements
- **REC-17:** Structured review of the 3,734 CH/disabled cohort
- **REC-31:** Standardize pre-referral eligibility checks; disability verification requirements are a recurring barrier
- **IO-6 (CalAIM):** Enhanced Care Management and Community Supports for Medi-Cal-eligible disabled individuals

- **IO-6 (Income and benefits):** SSI/SSDI advocacy through SOAR as a standard referral at HNA completion

12.4 Immediate Action Recommendations

Regardless of subpopulation or system-level sequencing, eight recommendations require immediate action. These address active compliance obligations, participant safety, and fundamental system integrity. They can and should be initiated within 30 days of this report's adoption.

REC	Required Action	Responsible Party
REC-4	Clarify and formally document in the CES P&P the terms of VA SSVF participation in the OC CES.	OCC / CES Lead
REC-12	Remove disability-type disclosure from the Disabling Condition Form and requirement of disability documentation pre-prioritization or pre-referral.	OCC / CES Lead
REC-14/ REC-15	Conduct immediate review of HNA adequacy for DV survivors and TAY populations. In conjunction with this review, address the HNA adequacy for all populations.	OCC / CES Lead
REC-18	Correct the PSH prioritization eligibility language to accurately reflect HUD's permitted allowance for temporarily housing accepted program participants in Transitional Housing while a permanent unit is identified.	OCC / CES Lead
REC-20	Correct the CES P&Ps to remove length-of-homelessness criteria from Emergency Shelter prioritization.	OCC / CES Lead
REC-23/ REC-26	Establish means for confidential reporting of CES participant concerns and grievances. Investigate reports of threatening communications and retaliation against PLE who filed complaints, leading to barrier-based screen-out practices.	OCC / CES & Collaborative Applicant Lead



Appendix A: Compliance Rating Detail by Evaluation Dimension

This appendix presents every item rated for compliance (Compliant / Partially Compliant / Noncompliant), organized by CES Function.

CES Design

Key Evaluation Question	Rating
Does the OC CES have a comprehensive Policies & Procedures document that addresses all required CES design elements - scope, partner roles, mechanisms, governance, and documentation requirements?	**Compliant**
Are all required entities (CoC Program, ESG, VA SSVF) participating in OC CES with current participation agreements or MOUs in place?	**Partially Compliant**
Do CoC and ESG Written Standards provide guidance for evaluating, prioritizing, and referring individuals and families per HUD requirements - and are they consistent with CES design?	**Partially Compliant**
Is CES affirmatively marketed to ensure all people experiencing homelessness - across all subpopulations and geographies - are aware of and able to access the system?	**Compliant**
Are non-discrimination and Equal Access requirements consistently implemented across all CES functions and participating providers, including protections for gender identity, sexual orientation, and disability?	**Compliant**

Access

Key Evaluation Question	Rating
Does the CES design meet al l federal and state access-related requirements (HUD CPD-17-01)? Does the CES cover the entire geographic area claimed by the OC CoC?	**Compliant**
Is the CES easily accessed by individuals and families seeking housing or services? Do the CoC's access points cover and are accessible throughout the entirety of the geographic area of the CoC?	**Compliant**
Does the CES design ensure a 'no wrong door' approach across all SPAs and subpopulations, including VSPs?	**Compliant**
Does the design of access pathways support equitable access across all geographies and populations, including those in underserved SPAs?	**Compliant**
Does the CES design include accessible, culturally/linguistically appropriate, and DV-safe access pathways?	**Compliant**

Key Evaluation Question	Rating
Does the CES access model includes mobile outreach, virtual access options, low-barrier entry design, and diversion-integrated intake? Is street outreach linked to the coordinated entry process such that that persons encountered by street outreach workers are offered the same standardized process as persons who access coordinated entry through site-based access points?	Partially Compliant
Are the CoC's written CE policies and procedures document availability of homelessness prevention services and the process by which persons are prioritized for referrals to homelessness prevention services?	Partially Compliant
Are access hours sufficient, including 24/7 crisis access through the Virtual Front Door? Crisis services operate with as few barriers to entry as possible, independent of the operating hours of the system's intake and assessment processes?	Compliant
Are access functions implemented in alignment with CES design and HUD requirements across all access points?	Partially Compliant
Extent to which access practices are implemented consistently across all geographic areas, subpopulation and access points	Partially Compliant
What is the coverage rate of CES access - what proportion of people experiencing homelessness are accessing the CES?	Noncompliant

Assessment

Key Evaluation Question	Rating
Does the assessment design comply with HUD requirements and CoC-adopted written standards?	Partially Compliant
Does the CES design use a standardized, HUD-compliant comprehensive assessment tool?	Partially Compliant
Do CES P&Ps state that participants informed of the ability to file a nondiscrimination complaint?	Compliant
Does assessment design protect participant privacy, and prohibit using assessment to screen people out due to perceived barriers?	Compliant
Does the assessment process protect participant autonomy, including the right to refuse questions, choose housing type and location, and maintain their priority placement status regardless of refusals?	Compliant
Do the CES P&Ps CoC establish that the assessment process cannot require disclosure of specific disabilities or diagnosis? Information may only be obtained for purposes of determining program eligibility to make appropriate referrals.	Noncompliant

Key Evaluation Question	Rating
Does the assessment process support assessment throughout CoC, in ways that are accessible to all populations (including those served by VSPs)	Partially Compliant
Are staff trained and certified to administer CES assessment tools?	Compliant
What is the assessment completion rate, and how long does it take from access to housing needs assessment?	Noncompliant
How often are assessments updated, and what is the rate of disengagement/removal from the BNL?	Partially Compliant
Are assessments implemented consistently across all SPAs and access points using approved tools and protocols?	Compliant

Prioritization

Key Evaluation Question	Rating
Does the prioritization design comply with HUD requirements and CoC-adopted written standards?	Partially Compliant
Does prioritization design ensure that scarce resources are allocated to those with the greatest need?	Partially Compliant
Are CES P&Ps clearly distinguishing between the interventions that will not be prioritized based on severity of service need or vulnerability, such as entry to emergency shelter, and those that will be prioritized, such as permanent supportive housing (PSH)?	Partially Compliant
Does the prioritization process include non-discrimination protections and a documented grievance/appeals process for households who believe they were unjustly prioritized or denied?	Compliant
Are CES P&Ps describe the process by which persons will be prioritized for referrals to homelessness prevention services?	Noncompliant
Is prioritization implemented consistently for all populations, with the highest-need household identified as 'next eligible' each time? Is prioritization based on a specific and definable set of criteria that are documented, made publicly available? Do CES P&Ps include the factors and assessment information with which prioritization decisions are made?	Partially Compliant
Are By-Name List management practices HMIS-compliant, with appropriate security protections, regular list maintenance, and removal of inactive or ineligible households? P&Ps document conditions under which participants maintain their place on the BNL lists when the participant rejects referral options?	Partially Compliant
Metrics related to prioritization: placement rate on the CQ; time that people wait on a prioritization list. These metrics were not evaluated as no performance benchmark has been established for them.	N/A

Key Evaluation Question	Rating
Are 100% of participants referred to ES, SO, PSH, TH, and RRH literally homeless at time of prioritization?	**Partially Compliant**

Referral

Key Evaluation Question	Rating
Does the design meet federal and state referral-related requirements? Does the CES process include uniform and coordinated referral process for all beds, units, and services available at participating projects within the CoC's geographic area for referral to housing and services?	**Compliant**
What types of resources are managed through CES (shelter, deeper housing interventions) and are they limited by funding types?	**Partially Compliant**
Does the CES design require and document that 100% of referrals to CoC-managed resources come through the CES, in ways that are accessible to all populations (including those served by VSPs)? Extent to which the CES recruited referring agencies.	**Partially Compliant**
Does the CES referral process ensure participant autonomy, including an annually updated resource list, genuine choice in housing type and location, and protection from coercive or discriminatory referral practices?	**Partially Compliant**
Do CES participating agencies do not screen potential project participants out of assistance based on perceived barriers related to housing or services?	**Noncompliant**
Are referrals managed consistently (when accounting for differences related to distinct resource types), across all geographic areas, subpopulations and staff managing referrals	**Compliant**
Are referral acceptance timelines met? (PSH: matches accepted ≤45 days; RRH: ≤14 days)	**Noncompliant**
Are housing placement rates meeting CoC targets? (PSH ≥50% match rate; RRH ≥60%)	**Partially Compliant**
Are denial rates within acceptable thresholds? (PSH ≤50%; RRH ≤40%)	**Partially Compliant**
What is the rate of completion of the housing application process, average # of matches needed to fill a resource; time to move-in, rate of move-in, time to fill a resource, rate of people assessed for various interventions that get their need met through referrals.	**Partially Compliant**
Are recidivism rates within targets? (PSH ≤7%; RRH ≤7%; ES ≤10%; SO ≤10%; TH ≤10%)	**Partially Compliant**
Is project utilization meeting CoC targets? (ES ≥70%; PSH ≥95%; TH ≥80%)	**Partially Compliant**

Data Management & Resource Availability

Key Evaluation Question	Rating
Do the CES P&Ps include protocols for obtaining participant consent to share and store participant information for purposes of assessing and referring participants through the coordinated entry process? If the participant refuses to allow their data to be shared, the participants continues to receive services, unless Federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information (PII) as a condition of program participation.	**Compliant**
Does the CES informs all users of HMIS about the privacy rules associated with collection, management, and reporting of client data?	**Compliant**
When using an HMIS or any other data system to manage coordinated entry data, does the CoC ensures adequate privacy protections of all participant information per the HMIS Data and Technical Standards?	**Compliant**
Does the OC CES conduct regular, inclusive consultation with providers, participants, and funders on system performance and are findings systematically used to drive continuous improvement?	**Partially Compliant**

Appendix B: Technical Modeling Documentation

Model Limitations and Caveats

The following section consolidates the limitations applicable to the quantitative model presented. These caveats apply across all projection years and program types and should be read in conjunction with the specific methodology sections above.

Demand projection methodology. The GAO elasticity estimate was calibrated to Orange County using a locality adjustment factor (1.3; see *Capacity Projections*), which does not fully eliminate the risk that local market conditions, population mix, policy environment, or changes in system interventions (rental assistance, eviction prevention, ES diversion, capacity shifts) may cause the relationship to behave differently than assumed.

This calibration reflects observed historical relationships between rent and system utilization from 2019–2025, a period that includes atypical conditions such as pandemic-era eviction moratoriums and emergency rental assistance funding; to the extent these interventions affected historical service levels, the resulting factor may not fully generalize to future years absent similar interventions.

The model also uses median rent as a proxy for housing cost pressure; households seeking new housing typically face above-median market rents, which may cause the model to understate demand. Projections should be interpreted as directional estimates rather than precise forecasts and are best used to understand relative changes in system demand under varying housing market conditions.

Rent growth assumptions. A precise annual gross median rent forecast for Orange County, year-by-year through 2031, does not exist. The model assumes rent growth of approximately 2 percent. Actual rent trajectories, particularly given current macroeconomic volatility, federal policy changes, and the constrained housing pipeline, may diverge materially from these assumptions.

Capacity projection limitations. No capacity change projections are included for RRH and PSH. Changes to ES, HP and TH capacity, whether from funding shifts, provider exits, or federal policy changes, may materially alter projected system performance differently than modeled.

HMIS coverage and representativeness. This model scales HMIS-derived performance metrics (exit rates, ALOS, recidivism) to approximate full system activity using coverage adjustment factors. This approach assumes that HMIS-participating providers are broadly representative of the full system in terms of outcomes, an assumption that may not hold if non-participating providers serve systematically different populations or operate under different performance standards.

Scenario design. The model evaluates two scenarios: status quo and adjusted (incremental improvements). The adjusted scenario reflects moderate, internally consistent assumptions about performance gains over time. It does not model structural system redesigns, large-scale capacity additions, or the effects of federal funding restructuring. The scenario should not be interpreted as a target or a prediction, but as an illustration of what is achievable under incremental improvement conditions.

Youth subpopulation disaggregation. Youth populations are disaggregated from family and single adult inventories. The ALOS for parenting youth used the young adults ages 18–24 as a proxy, as

this group represents the majority of youth program participants and provides a stable basis for estimation. The proxy introduces some imprecision in youth-specific projections.

Feedback loop simplification. The model captures the primary system feedback dynamics, like downstream capacity constraints increasing ES lengths of stay, recidivism returning households to the system, but does not fully replicate every interaction between program types. In particular, the effect of PSH capacity constraints on TH and RRH occupancy, and the secondary effect on ES inflow, is approximated, rather than explicitly modeled.

Capacity Projections

During the modeling years, the projections assume no changes in the capacity of all program types. All components of the homelessness response system influence the system's ability to meet demand and appropriately serve households experiencing a housing crisis.

- HP programs reduce inflow into the homelessness system by providing services to households at risk of housing loss. These programs do not operate with fixed bed capacity; instead, they function through "housing slots" or unit-based assistance, with overall capacity determined by available financial and staffing resources.
- SO programs engage unsheltered households and facilitate pathways either directly to housing or into ES. These programs do not have fixed capacity and operate using "service slots" based on available financial and staffing resources.
- ES capacity directly determines the system's ability to accommodate households experiencing immediate housing crises.
- TH provides time-limited housing for households requiring a longer stabilization period and serves as an exit pathway from ES. TH bed and unit availability influences ES capacity by enabling movement out of ES and freeing beds for new entrants.
- RRH programs provide a permanent housing pathway for households exiting homelessness and are a primary mechanism for reducing ES length of stay. Like HP programs, RRH operates through "housing slots" or unit capacity determined by available financial and staffing resources. Increased RRH capacity supports turnover in ES beds.
- PSH provides long-term housing and supportive services for households experiencing chronic homelessness and/or disability. PSH capacity creates sustained exit pathways from the homelessness system and contributes to ongoing turnover in ES capacity.

Definitions

- **System capacity/inventory:** The number of beds, slots, or units for each system component at the end of the baseline year and projections about how that inventory will change over time.
- **Utilization rates:** The percentage of inventory occupied by households.
- **Initial population:** The number of households in each system component at the start of the modeling period.
- **Inflow:** The number of households entering homelessness each year including the impact of strategies to prevent people from becoming homeless.
- **Length of stay:** The average number of days households spend in each system component.

- **Unit turnover rates:** The percentage of units/slots that become available for new occupants each year.

Modeling Assumptions

The model evaluates two scenarios across all project types:

- **Status Quo Scenario:**
  Projections assume a status quo environment, with no changes to program capacity, system performance, or outcome rates over the modeling period.
- **Adjusted Scenario:**
  Projections incorporate performance changes, including adjustments to outcome rates.

System Initial and Future Capacity Assumptions

Baseline year capacity assumptions were derived from the 2025 HIC, supplemented with additional data on HP and SO using the OC HMIS data. Where applicable, youth beds and units were disaggregated from family and single adult inventories to estimate a distinct youth capacity and utilization rate, encompassing parenting youth, young adults ages 18–24, and child-only households. (Table A-1).

Table A-1: Baseline Year System Capacity by Subpopulation

Baseline Year System Capacity	Unit/Slots	Families	Single Adults	Youth
Prevention and Diversion	Slots	299	205	82
Street Outreach	Slots	32	2,025	89
Emergency Shelter	Beds/Units	174	2,539	52
Transitional Housing	Beds/Units	244	263	51
Rapid Rehousing	Slots	114	282	12
Permanent Supportive Housing+Other	Units	621	3,449	14

Demand Projection Methodology

The demand model relies on the relationship identified in the 2020 United States Government Accountability Office (GAO) analysis linking median rent increases to homelessness rates, specifically, a 9 percent increase in the homelessness rate per $100 increase in median rent. This elasticity was estimated nationally and may not apply uniformly to Orange County's local market conditions, population mix, or policy environment, as well as changes in homelessness system interventions such as rental assistance, eviction prevention programs, ES diversion strategies, or changes in system capacity.

The GAO's national elasticity estimate was calibrated to reflect Orange County's local conditions. For each year from 2019 to 2025, the actual historical number of households served was divided by the number of households predicted for that year using the unadjusted GAO formula, producing an annual ratio of actual-to-predicted outcomes. These seven annual ratios were then averaged to produce a single locality adjustment factor (1.3), which was applied to the GAO elasticity estimate throughout the modeling period. This approach calibrates the national elasticity relationship to Orange County's observed historical trends rather than relying on the national estimate in isolation (Table A-2).

Table A-2: Projected Homelessness Rate Change and Households Experiencing Homelessness

Year	Projected Rent Increases (Relative to the Prior Year)	Projected Median Gross Rent	Projected Homelessness Rate Change (Rent-Based Changes)	Projected Homeless Households
2025	1.10%	$ 2,510	2.46%	21,746
2026	2.00%	$ 2,561	4.52%	23,064
2027	2.00%	$ 2,612	4.61%	24,115
2028	2.00%	$ 2,664	4.70%	25,244
2029	2.00%	$ 2,717	4.80%	26,455
2030	2.00%	$ 2,772	4.89%	27,755
2031	2.00%	$ 2,827	4.99%	29,175

Initial Population and System Utilization

The model incorporates inputs for the initial population of households experiencing unsheltered homelessness and households receiving services within the system. Utilization rates were derived for each program type and subpopulation using 2025 HIC capacity (Table A-1) and corresponding PIT counts. Initial population within each program type was then calculated as the product of capacity and the applicable utilization rate.

The model uses the PIT-based method for the initial population, as this correctly represents who occupies the ES beds at the start of the projection period.

Table A-3 summarizes the initial population and system utilization assumptions used in the model.

Table A-3: Initial Population for Baseline Year and System Utilization Assumptions

Program Type / Population Type	Initial Population			Utilization		
	Family	Adult	Youth	Family	Adult	Youth
Unsheltered Homelessness	-	3,885	162		100%	100%
Emergency Shelter	151	2,209	45	87%	87%	87%
Transitional Housing	160	72	9	66%	28%	18%
Rapid Rehousing	231	348	29	203%	123%	244%
Permanent Supportive Housing+Other	577	3,221	13	93%	93%	93%

Estimated Average Length of Program Stay or Participation

ALOS (or program participation) was estimated by subpopulation using Stella P data. For the youth population, the ALOS for young adults ages 18–24 was used as a proxy, as this group represents the majority of youth program participants and provides a stable basis for estimation (Table A-4).

Table A-4: Estimated ALOS by Subpopulation

Average Length of Stay or Program Participation	Families	Single Adults	Youth
Emergency Shelter	138	233	83
Transitional Housing	264	147	139
Rapid Rehousing	223	327	324

Unit/bed Turnover

Unit turnover was estimated differently by program type to reflect variation in program structure and length of stay. For HP, SO, and RRH, turnover was calculated as the inverse of the average length of program participation (365 divided by the average length of participation, in days).

For ES, TH, and PSH, turnover was estimated using a calculated exit rate that uses observed exits from HMIS-participating programs, as reported in Stella P. Exit counts were adjusted to account for HMIS participation rates to approximate full system activity, and turnover was calculated as total adjusted exits divided by overall system capacity. This approach reflects the longer and more variable length of stay in these programs and provides a stable estimate of annual program turnover (Table A-5).

Table A-5: Estimated Unit Turnover by Subpopulation and Program Type

Baseline Year Unit Turnover	Families	Single Adults	Youth
Prevention and Diversion	2.68	2.68	2.68
Street Outreach	4.45	4.45	4.45
Emergency Shelter	1.49	1.44	10.22
Transitional Housing	1.38	2.48	2.63
Rapid Rehousing	1.64	1.12	1.13
Permanent Supportive Housing	0.01	0.05	0.00

Returns to homelessness (Recidivism)

Returns to homelessness by subpopulation using Stella P returns to homelessness data (Table A-6). Returns to homelessness are defined as the share of households exiting the system within the prior 12 months who return to the homelessness system within six months of exit. Reported return rates were disaggregated to account for youth populations embedded within family and single adult categories. As part of this process, a distinct return rate was calculated for the youth population.

Table A-6: Estimated Return Rates by Subpopulation and Program Type

Household Returns by Project Type	Families	Single Adults	Youth
Emergency Shelter	10%	27%	10%
Transitional Housing	3%	5%	9%
Rapid Rehousing	5%	9%	4%
Permanent Supportive Housing	0%	0%	0%
System Returns	**6%**	**25%**	**10%**

Homelessness Prevention Projections

- **Capacity:** Annual serving capacity is calculated based on the number of available "program slots" and the average length of program participation. Capacity reflects the total number of households that can be served within a given modeling year.
- **Net Inflow:** Net inflow represents the annual number of new households entering the program. It is calculated by excluding households already enrolled at the beginning of the modeling year (initial population), thereby capturing only newly served households.

- **Population Served (Families/Singles/Youth):** The total number of households served during the modeling year, disaggregated by subpopulation (families, single adults, and youth). This measure includes both the initial population and households entering through net inflow, assuming full utilization of available program slots.
- **Exits (Families/Singles/Youth):** The annual number of households exiting the program within the modeling year, based on projected program participation durations and exit timing.
- **Unsuccessfully Served:** The annual number of households for whom the intervention does not result in housing stabilization. These households are assumed to remain at risk of homelessness and may subsequently enter the CES and seek ES.

Modeling Input Parameters for HP

The model incorporates a series of input parameters designed to reflect incremental improvements in performance over the projection period (Table A-7). These parameters include changes in system utilization, capacity and exit rates. Across the modeling years, these factors are adjusted to reflect gradual operational improvements. These assumptions represent a realistic, moderate improvement scenario in which performance improves incrementally, leading to decreases in the number of households becoming homeless and a better alignment between HP capacity and demand over time.

Table A-7: Modeling Input Parameters for HP

Parameter	2025	2026	2027	2028	2029	2030	2031
Capacity Increase in Homelessness Prevention	0%	0%	10%	10%	7%	5%	5%
Increase in Demand for Homelessness Prevention	0%	0%	0%	0%	0%	0%	0%
Improvement Rate for Prevention Success Rate for Families	79%	1%	4%	4%	0%	0%	0%
Improvement Rate For Prevention Success Rate for Singles/Youth	79%	1%	2%	2%	2%	0%	0%

Diversion Projections

- **Households likely to become homeless:** The annual number of households projected to experience homelessness and therefore potentially enter the diversion assistance system. This measure includes:
    - Households that were unsuccessfully served by HP, defined as those who did not achieve housing stabilization through HP interventions;
    - Households unable to access HP services due to capacity limitations, calculated as the difference between the projected at-risk population and the number of households served (net inflow) in HP programs;
    - Households already experiencing homelessness at the start of the modeling year (i.e., the initial population), including those who are unsheltered or residing in ES or TH, are excluded from the inflow projection.

Diversion Negative Outcomes

- **Undiverted Households:** The annual number of households for whom diversion efforts are unsuccessful (i.e., negative diversion outcomes), using a conservative positive diversion rate. This includes:
    - Households unsuccessfully served by HP; and
    - Households not served by HP due to capacity constraints and not already experiencing homelessness.
- **The Undiverted Households cohort represents the population that requires assistance within the homelessness response system during the modeling year(s).**

Modeling Input Parameters for Homelessness Diversion

The model incorporates a couple of input parameters designed to reflect incremental improvements in performance over the projection period (Table A-8), specifically increased success of diversion activities. Across the modeling years, these factors are adjusted to reflect gradual operational improvements. These assumptions represent a realistic, moderate improvement scenario in which performance improves incrementally, leading to decreases in the number of households becoming homeless.

Table A-8: Modeling Input Parameters for Diversion

Parameter	2025	2026	2027	2028	2029	2030	2031
Improvement Rate for Family Diversion	0%	1%	5%	5%	5%	5%	5%
Improvement Rate for Singles/Youth Diversion	0%	1%	3%	3%	3%	3%	3%

Street Outreach Projections

- **Population Served:** The annual number of households served is calculated based on program capacity ("slots"), multiplied by 365 days and divided by the average length of program participation (in days).
- **Successful Outcomes:** The annual number of households exiting to sheltered settings, including ES and TH, using data from the latest HUD System Performance Measures report.
- **Successful Housing Outcomes:** The annual number of households exiting directly to permanent housing, including PSH and RRH, using data from the latest HUD System Performance Measures report.
- **Households achieving Successful Outcome and Successful Housing Outcomes represent demand for downstream system capacity during the modeling year, including ES, TH, RRH, and PSH programs. ES placements (ES/TH) represent short-term accommodation demand, while permanent housing outcomes (RRH/PSH) represent demand for housing inventory and subsidies.**

Modeling Input Parameters for SO

The model incorporates a series of input parameters designed to reflect incremental improvements in capacity and performance over the projection period (Table A-9). Across the modeling years, these factors are adjusted to reflect gradual operational improvements. These

assumptions represent a realistic, moderate improvement scenario in which performance improves incrementally.

Table A-9: Modeling Input Parameters for SO

Parameter	2025	2026	2027	2028	2029	2030	2031
Capacity Change for Street Outreach	0%	0%	5%	5%	5%	5%	5%
Rate of Change in Demand for Unsheltered Services	0%	0%	0%	0%	0%	0%	0%
Improvement Rate in Successful Outcome	19%	3%	10%	7%	5%	5%	5%
Improvement Rate in Successful Housing Outcome	2%	1%	5%	5%	5%	5%	5%

In addition, SO assumptions incorporate an adjustment ratio to account for the unsheltered individuals that are not captured in HMIS. The ratio obtained by dividing the HMIS-based unsheltered people at the beginning of the review period to the unsheltered people counted during the most recent PIT count provides the estimated HMIS coverage (56 percent) and the adjustment factor to assess the true extent of the unsheltered homelessness in Orange County.

Finally, the HMIS data provided shows that a significant number of street outreach records are same day entry/exit (68 percent). Only approximately 4,800 unique individuals during the reporting timeframe had participation of 1 day or more. Consequently, the average length of participation in the modeling was adjusted by removing the 0-day participation individuals.

Emergency Shelter Projections

- **ES Capacity Assessment:** ES capacity is evaluated across two dimensions:
  - Total Capacity: The capacity to serve all households, including both the initial population (households in ES at the start of the modeling year) and net inflow during the year; and
  - Capacity for New Entries: The capacity available to serve incoming households during the modeling year, including both new and returning (recidivist) households.
- **Annual serving capacity:** Defined as occupied capacity (capacity multiplied by utilization) multiplied by the annual turnover rate (365 divided by the ALOS, in days).
- **Entries into ES:** ES entries are modeled across two primary cohorts:
  - Returning households: Households exiting the system during the prior 12 months and re-entering homelessness within 6 months of a prior episode. Baseline return levels are derived from Stella P system data. In subsequent years, entries associated with returners are calculated based on available capacity for new entries and the total number of program exits from homelessness programs in the prior modeling year multiplied by the projected rate of return for the population.
  - Newly Homeless (or Newly Identified) Households: Households entering ES without a recent history of homelessness. These include:
    - *Unsuccessfully Diverted Households*: Households that did not achieve stabilization through diversion or HP efforts; and

    - *Unsheltered Households*: Households entering ES from an unsheltered living situation.
    - The number of newly homeless households served is calculated by comparing projected demand to available capacity. Entries are capped at available capacity when demand exceeds supply or allowed to meet full demand when capacity is sufficient.
- **Gap Calculation:** The model assumes that returning households will gain access to ES "first". Remaining capacity is then allocated to newly homeless households. ES demand from newly homeless households is compared against available capacity to determine the annual **household-level service gap** (unmet demand) or surplus capacity.
- **Conversion to Unit (Bed) Gap:** The household-level service gap is converted into an equivalent unit (bed) capacity gap by translating households unserved into required ES units using ALOS, dividing by 365 days and adjusting for expected utilization rates. This produces an estimate of the concurrent bed capacity required to meet unmet demand.
- **Exits from ES:** Annual exits are calculated using a stock-flow identity in which exits are equal to annual entries adjusted for changes in the sheltered population. Specifically, exits are derived as the number of households entering ES during the modeling year plus the net change in the initial sheltered population between consecutive years.
- **Positive Exits:** Positive exits represent the subset of total exits in which households transition to stable or permanent destinations. These are calculated using projected positive exit rates by population group and applied to the ES exits by population group.

Modeling Input Parameters for ES Facilities

The model incorporates a series of input parameters designed to reflect incremental improvements in system performance over the projection period (Table A-10). These parameters include changes in system utilization and modest improvements in capacity, exit rates and returns to homelessness. Across the modeling years, these factors are adjusted to reflect gradual operational improvements rather than structural system changes. For example, utilization rates increase over time, indicating more efficient use of available capacity, while positive exit rates improve, reflecting stronger housing placement outcomes and system flow. Collectively, these assumptions represent a realistic, moderate improvement scenario in which system performance improves incrementally, leading to increased participants served and a more effective alignment between ES capacity and demand over time.

Table A-10: Modeling Input Parameters for ES

Parameter	2025	2026	2027	2028	2029	2030	2031
Improvement in ALOS for Sheltered HHDs	0%	0%	0%	0%	0%	0%	0%
Utilization Rate Families - EMERGENCY SHELTER	87%	87%	90%	91%	92%	93%	94%
Utilization Rate Singles - EMERGENCY SHELTER	87%	87%	90%	91%	92%	93%	94%
Utilization Rate Youth - EMERGENCY SHELTER	87%	87%	90%	91%	92%	93%	94%
Change in ES Capacity for Families	0%	0%	5%	5%	5%	5%	5%
Change in ES Capacity for Singles	0%	0%	5%	5%	5%	5%	5%
Change in ES Capacity for Youth	0%	0%	5%	5%	5%	5%	5%
Improvement Rate in ES Recidivism for Exited HHDs	0%	0%	1%	1%	1%	1%	1%
Improvement Rate in ES Positive Exit Rates	0%	0%	3%	3%	3%	3%	3%

Estimated annual inflow into emergency shelters

Annual inflow into ES represents the number of households entering ES during a given year, including both first-time entrants and returning households. Projections for future years incorporate expected population growth and increases in demand for ES services, estimated through the HP and diversion models, then constrained by available capacity. This approach reflects how inflow actually operates: returners enter based on prior system behavior; all new entries are limited by available HP and diversion, as well as ES bed capacity.

Inflow estimates are presented under two scenarios: (1) a baseline (status quo) scenario reflecting current system conditions, and (2) an adjusted scenario that assumes system improvements, including reductions in front-end demand for ES by increasing HP and diversion capacity and success rates, and ES improved bed/unit utilization, capacity and exit rates. Table A-11 summarizes projected annual inflow by modeling year.

Table A-11: Projected Annual Inflow by Modeling Year, Status Quo vs Adjusted Scenarios

Year	Inflow Status Quo			Inflow Adjusted		
Population Type	Family	Adult	Youth	Family	Adult	Youth
2025	400	3,460	199	400	3,460	199
2026	400	3,460	199	400	3,460	199
2027	400	3,460	199	435	3,759	216
2028	400	3,460	199	462	3,990	229
2029	400	3,460	199	490	4,236	244
2030	400	3,460	199	520	4,496	258
2031	400	3,460	199	552	4,772	274

Projected Number of households experiencing sheltered homelessness

The projected number of households experiencing sheltered homelessness represents the total number of households served in ES facilities over the course of a year. This is calculated as the sum of the projected initial sheltered population at the start of each modeling year (i.e., those currently enrolled in ES on the first day of the period) and the estimated annual inflow into ES during the year.

Estimates are presented under two scenarios: (1) a baseline scenario reflecting current system conditions, and (2) an adjusted scenario that assumes improved utilization of available ES capacity, resulting in changes to the number of occupied beds at the beginning of each modeling year and the overall system number served (Table A-12).

Table A-12: Projected Annual Number Served by Modeling Year, Status Quo vs Adjusted Scenarios

Year	ES Served Status Quo				ES Served Adjusted			
Population Type	Family	Adult	Youth	Household	Family	Adult	Youth	All Households
2025	552	5,669	244	6,465	552	5,669	244	6,465
2026	552	5,669	244	6,465	552	5,669	244	6,465
2027	552	5,669	244	6,465	599	6,158	265	7,023
2028	552	5,669	244	6,465	636	6,538	282	7,456
2029	552	5,669	244	6,465	675	6,940	299	7,914
2030	552	5,669	244	6,465	717	7,366	317	8,400
2031	552	5,669	244	6,465	761	7,818	337	8,915

TH Projections

- **TH Capacity Assessment:** TH capacity is evaluated based on the program's ability to serve both the initial population and new households entering during the modeling year.
    - Total Capacity: The capacity to serve all households, including the initial population (households in TH at the start of the modeling year) and new entries; and
    - Capacity for New Entries: The capacity available for incoming households during the modeling year.
- **Annual serving capacity in TH:** Estimated as the sum of projected program exits and the net change in occupied capacity between modeling years. Projected exits are calculated by applying the turnover rate to occupied TH capacity (capacity multiplied by utilization). The net change in occupied capacity is defined as the difference between next-year and current-year occupied capacity.
- **Demand for TH:** Demand for new TH entries is estimated based on projected upstream system flows, including exits from ES and transitions from unsheltered homelessness. These projections are informed by pathway distributions derived from Stella P, reflecting observed patterns of movement into TH.
- **Entries into TH:** New TH entries are estimated using a demand-based approach in which projected upstream flows, specifically from ES and unsheltered populations, are allocated to TH based on observed entry shares derived from Stella P. Projected entries are then constrained by available program capacity. When projected demand exceeds capacity, entries are capped at the level of available capacity, and the remaining demand is classified as unmet need.

- **Initial Population:** The initial population represents households residing in TH at the start of the modeling year. This population occupies existing capacity and reduces the number of available slots for new entries.
- **Gap Calculation:** Projected demand for TH is compared against available capacity for new entries to determine the number of households served and the number of households unable to access TH (i.e., unmet demand).
    - Unmet demand represents households that must either remain in upstream system components (e.g., ES or unsheltered) or seek alternative housing pathways.
- **Exits from TH:** Total exits are calculated as the annual number of households with a projected program exit date within the modeling year. Exit projections are based on program capacity, utilization rates, and ALOS.
- **System Impact (Downstream and Upstream):**
    - Downstream Impact: TH exits contribute to movement into permanent housing or other system components, influencing the system's number served.
    - Upstream Impact: Limited TH capacity may constrain exits from ES, thereby reducing ES bed turnover and increasing ES demand.

Modeling Input Parameters for TH

The model incorporates a series of input parameters designed to reflect incremental improvements in performance over the projection period (Table A-13). These parameters include changes in capacity, system utilization and exit rates. Across the modeling years, these factors are adjusted to reflect gradual operational improvements. These assumptions represent a realistic, moderate improvement scenario in which performance improves incrementally, leading to an increase in participants served and a better alignment between TH capacity and demand over time.

Table A-13: Modeling Input Parameters for TH

Parameter	2025	2026	2027	2028	2029	2030	2031
Improvement in ALOP for TH HHDs	0%	0%	0%	0%	0%	0%	0%
Utilization Rate Families - TRANSITIONAL HOUSING	66%	66%	71%	76%	81%	86%	90%
Utilization Rate Singles - TRANSITIONAL HOUSING	28%	28%	48%	58%	68%	78%	88%
Utilization Rate Youth - TRANSITIONAL HOUSING	18%	18%	38%	48%	58%	68%	78%
Change in TH Capacity for Families	0%	0%	5%	5%	5%	5%	5%
Change in TH Capacity for Singles	0%	0%	5%	5%	5%	5%	5%
Change in TH Capacity for Youth	0%	0%	5%	5%	5%	5%	5%
Improvement Rate in TH Positive Exit Rates	0%	0%	3%	3%	3%	3%	3%

RRH Projections

- **RRH Capacity Assessment:** RRH capacity is evaluated based on the program's ability to serve both the initial population and new households entering during the modeling year.
    - Total Capacity: The capacity to serve all households, including the initial population (households enrolled in RRH at the start of the modeling year) and new entries; and
    - Capacity for New Entries: The capacity available for incoming households during the modeling year.
- **Annual serving capacity:** Defined as occupied capacity (capacity multiplied by utilization) multiplied by the annual turnover rate (365 divided by the ALOS, in days). This represents the number of households that can be served annually given program capacity and average duration of assistance.
- **Demand for RRH:** Demand for new RRH entries is estimated based on projected upstream system flows, including exits from ES, TH, and transitions from unsheltered homelessness. These projections are informed by pathway distributions derived from Stella P, reflecting observed patterns of movement into RRH.
- **Entries into RRH:** New RRH entries are estimated using a demand-based approach in which projected upstream flows, specifically from ES, TH and unsheltered populations, are allocated to RRH based on observed entry shares derived from Stella P. Projected entries are then constrained by available program capacity. When projected demand exceeds capacity, entries are capped at the level of available capacity, and the remaining demand is classified as unmet need.
- **Initial Population:** The initial population represents households enrolled in RRH at the start of the modeling year and is calculated as program capacity multiplied by the utilization rate. This population occupies existing capacity and reduces the number of available slots for new entries.
- **Gap Calculation:** Projected demand for RRH is compared against available capacity for new entries to determine the number of households served and the number of households unable to access RRH (i.e., unmet demand).
    - Unmet Demand: Represents households that are unable to access RRH and must either remain in upstream system components (e.g., ES or TH) or seek alternative housing pathways.
- **Exits from RRH:** Total exits are calculated as the annual number of households with a projected program exit date within the modeling year. Exit projections are based on program capacity, utilization rates, and average length of participation.
- **System Impact (Downstream and Upstream):**
    - Downstream Impact: RRH exits contribute to transitions into permanent housing stability and reduce returns to homelessness when successful, influencing long-term system outcomes.
    - Upstream Impact: RRH capacity directly affects the number of participants served in upstream components (SO, ES and TH). Increased RRH capacity facilitates faster exits from ES and TH, improving bed turnover and reducing system congestion.

Modeling Input Parameters for RRH

The model incorporates a series of input parameters designed to reflect incremental improvements in performance over the projection period (Table A-14). Across the modeling years, these factors are adjusted to reflect gradual operational improvements. These assumptions represent a realistic, moderate improvement scenario in which performance improves incrementally. For RRH, no changes in capacity are projected due to changes in federal policy. The higher calculated utilization rate is preserved throughout the modeling timeframe.

Table A-14: Modeling Input Parameters for RRH

Parameter	2025	2026	2027	2028	2029	2030	2031
Improvement in ALOP for RRH HHDs	0%	0%	0%	0%	0%	0%	0%
Utilization Rate Families - RAPID REHOUSING (RRH)	203%	203%	203%	203%	203%	203%	203%
Utilization Rate Singles - RAPID REHOUSING (RRH)	123%	123%	123%	123%	123%	123%	123%
Utilization Rate Youth - RAPID REHOUSING (RRH)	244%	244%	244%	244%	244%	244%	244%
Change in RRH Capacity for Families	0%	0%	0%	0%	0%	0%	0%
Change in RRH Capacity for Singles	0%	0%	0%	0%	0%	0%	0%
Change in RRH Capacity for Youth	0%	0%	0%	0%	0%	0%	0%
Improvement Rate in RRH Positive Exit Rates	0%	0%	3%	4%	5%	4%	4%

PSH Projections

- **PSH Capacity Assessment:** PSH capacity is evaluated based on the program's ability to serve both the initial population and new households entering during the modeling year.
    - Total Capacity: The capacity to serve all households, including the initial population (households enrolled in PSH at the start of the modeling year) and new entries; and
    - Capacity for New Entries: The capacity available for incoming households during the modeling year.
- **Annual serving capacity for new households:** Defined as occupied capacity (capacity multiplied by utilization) multiplied by the annual turnover rate. Due to the long-term nature of PSH, turnover (exits) is typically low, resulting in highly constrained capacity for new entries.
- **Demand for PSH:** Demand for new PSH entries is estimated based on projected upstream system flows, including exits from ES, TH, and RRH, as well as transitions from unsheltered homelessness. These projections are informed by pathway distributions derived from Stella P.
- **Entries into PSH:** New PSH entries are estimated using a demand-based approach in which projected upstream flows, specifically from ES, TH and unsheltered populations, are allocated to PSH based on observed entry shares derived from Stella P. Projected entries

are then constrained by available program capacity. When projected demand exceeds capacity, entries are capped at the level of available capacity, and the remaining demand is classified as unmet need.

- **Initial Population:** The initial population represents households enrolled in PSH at the start of the modeling year. This population occupies the majority of PSH capacity due to long lengths of stay, significantly limiting availability for new entries.
- **Gap Calculation:** Projected demand for PSH is compared against available capacity for new entries to determine the number of households served and the number of households unable to access PSH (i.e., unmet demand).
    - Unmet Demand: Represents households eligible for and in need of PSH who are unable to access available units. These households typically remain in upstream system components (e.g., ES, TH) or continue experiencing unsheltered homelessness, often with high service needs.
- **Exits from PSH:** Total exits are calculated as the annual number of households with a projected program exit date within the modeling year. Exit projections are based on program capacity, utilization rates, and turnover rate. Given the permanent nature of PSH, exit rates are typically low relative to other program types.
- **System Impact (Downstream and Upstream):**
    - Downstream Impact: PSH exits are limited but, when they occur, may transition households to other permanent housing situations or independent living.
    - Upstream Impact: PSH capacity is a critical constraint on system flow. Limited PSH availability restricts the ability of high-need households to exit ES, TH, or unsheltered homelessness, contributing to longer lengths of stay, reduced ES turnover, and increased system congestion.

Modeling Input Parameters for PSH

The model incorporates a series of input parameters designed to reflect incremental improvements in performance over the projection period (Table A-15). These parameters include changes in system utilization and exit rates. Across the modeling years, these factors are adjusted to reflect gradual operational improvements. These assumptions represent a realistic, moderate improvement scenario in which performance improves incrementally, leading to increased serving capacity and a better alignment between PSH capacity and demand over time. For PSH, no changes in capacity are projected due to changes in federal policy.

Table A-15: Modeling Input Parameters for PSH

Parameter	2025	2026	2027	2028	2029	2030	2031
Improvement in ALOP for PSH HHDs	0%	0%	0%	0%	0%	0%	0%
Utilization Rate Families - PERMANENT SUPPORTIVE HOUSING (PSH)	93%	93%	94%	95%	96%	96%	96%
Utilization Rate Singles - PERMANENT SUPPORTIVE HOUSING (PSH)	93%	93%	94%	95%	96%	96%	96%
Utilization Rate Youth - PERMANENT SUPPORTIVE HOUSING (PSH)	93%	93%	94%	95%	96%	96%	96%
Change in PSH Capacity for Families	0%	0%	0%	0%	0%	0%	0%
Change in PSH Capacity for Singles	0%	0%	0%	0%	0%	0%	0%
Change in PSH Capacity for Youth	0%	0%	0%	0%	0%	0%	0%
Improvement Rate in PSH Positive Exit Rates	0%	0%	3%	3%	3%	3%	3%

Appendix C: List of Tables and Figures

This appendix lists all 47 numbered tables and 7 numbered figures presented throughout the report, in the order they appear.

List of Tables

Table #	Caption	Section
Table ES-1	Compliance Summary by Function	Executive Summary
Table ES-2	Equity Summary: Significant Disparities Identified	Executive Summary
Table 2-1	HMIS and OCC Data Files Used in Analysis	Section 2
Table 3-1	Inflow-to-Permanent Exit Ratio by Quarter	Section 3
Table 3-2	Inflow-to-Permanent Exit Ratio	Section 3
Table 3-3	Inflow-to-Permanent Exit Ratio Equity Assessment	Section 3
Table 4-1	CES CNA Coverage Rates	Section 4
Table 4-2	Geographic Distribution of CES CNAs	Section 4
Table 4-3	CES CNA Coverage Rates	Section 4
Table 4-4	CNA Coverage Equity Assessment	Section 4
Table 5-1	CES HNA Coverage Rate by Subgroup	Section 5
Table 5-2	CES HNA Coverage Rate by Program Type	Section 5
Table 5-3	Geographic Distribution of CES HNAs	Section 5
Table 5-4	CES HNA Coverage Rate	Section 5
Table 5-5	CES HNA Coverage Equity Assessment	Section 5
Table 5-6	HNA Timeliness by Program Type	Section 5
Table 5-7	CES HNA Timeliness	Section 5
Table 5-8	CES HNA Timeliness Equity Assessment	Section 5
Table 5-9	HNA Recency Distribution (Adj. Denominator n=3,121)	Section 5
Table 5-10	HNA Reassessment Timeliness	Section 5
Table 5-11	HNA Reassessment Timeliness Equity Assessment	Section 5
Table 5-12	CLSA Recency Distribution (Adj. Denominator n=3,121)	Section 5
Table 5-13	CLSA Reassessment Timeliness	Section 5
Table 5-14	CLSA Reassessment Timeliness Equity Assessment	Section 5
Table 5-15	Assessment Consistency and Housing Opportunity (HO) Referral	Section 5
Table 6-1	CNA→HNA Progression Rate by SPA	Section 6
Table 6-2	Disaggregation of Participants by their Assessment	Section 6

Table #	Caption	Section
Table 6-3	Prioritization List Placement	Section 6
Table 6-4	Prioritization List Placement Equity Assessment	Section 6
Table 6-5	Priority List Wait Time	Section 6
Table 6-6	Priority List Wait Time by Program Type	Section 6
Table 6-7	Priority List Wait Time	Section 6
Table 6-8	Priority List Wait Time Equity Assessment	Section 6
Table 6-9	CES BNL Turnover	Section 6
Table 7-1	Timeliness of Assessment to Referral	Section 7
Table 7-2	Timeliness of Assessment to Referral Equity Assessment	Section 7
Table 7-3	Match Inventory Outcome Distribution, OCC Data	Section 7
Table 7-4	Referral Acceptance Rate by Housing Type, OCC Data	Section 7
Table 7-5	Match Inventory Outcome Distribution, HMIS Data	Section 7
Table 7-6	Referral Acceptance Rate by Housing Type, HMIS Data	Section 7
Table 7-7	Referral Acceptance Rate, OCC Data	Section 7
Table 7-8	Referral Acceptance Rate, HMIS Data	Section 7
Table 7-9	Referral Acceptance Rate Equity Assessment	Section 7
Table 7-10	Housing Match Performance vs. CoC Benchmarks	Section 7
Table 7-11	Time to Housing Placement	Section 7
Table 7-12	Time to Housing Placement Equity Assessment	Section 7
Table 7-13	Housing Outcomes and Returns to Homelessness	Section 7
Table 7-14	Successful Exit Rate	Section 7
Table 7-15	Return to Homelessness Rate	Section 7
Table 7-16	Utilization and CES Participation Rates	Section 7
Table 10-1	Root Cause Concentration Across CES Mapping Pain Points	Section 10
Table 10-2	CEA Impact-versus-Effort Prioritization	Section 10

List of Figures

Figure #	Caption	Section
Figure 3-1	OC CES Design	Section 3
Figure 4-1	CES Access Design	Section 4
Figure 4-2	CES CNA Monthly Distribution	Section 4

Figure #	Caption	Section
Figure 4-3	Geographic Distribution of Access Points (purple = closed AP; orange = open AP)	Section 4
Figure 5-1	CES Assessment Design	Section 5
Figure 6-1	CES Prioritization Design	Section 6
Figure 6-2	Pathways onto the BNL	Section 6
Figure 7-1	CES Referral Design	Section 7

Appendix D: CES Pain Points and Root Causes Matrix

This matrix was developed collaboratively with CE Administrators (CEAs) during CES process mapping sessions conducted as part of this evaluation's qualitative engagement (see Evaluation Methodology, Section 2). It documents 28 pain points identified across nine CES process areas and traces each to one or more of nine underlying root causes. A summary of this matrix and its implications is presented in Section 10.4.

Pain Point	People Issues	Volume Issues	Training Issues	Process Design & Uniformity	Data Issues	Effective Mgmt of Complex Processes	System Issues	Policy Constraints	Resource Constraints	Root Causes
Eligibility & Documentation Requirements										
Additional eligibility criteria (high cost health users)			●							1
Lack of clearly established eligibility criteria						●	●			2
City ties requirements. HMIS info not comprehensive							●			1
Housing authority — not clear what they are looking for							●			1
Property Manager using 3rd party compliance							●			1
Lack or Mismatch of Housing Opportunities										
Decrease of housing opportunities, no consistency		●							●	2
FCES — opportunity gap for larger vs smaller families		●							●	2
Delays in participant identifying housing		●							●	2
Landlord issues									●	1
Staff Turnover										

Pain Point	People Issues	Volume Issues	Training Issues	Process Design & Uniformity	Data Issues	Effective Mgmt of Complex Processes	System Issues	Policy Constraints	Resource Constraints	Root Causes
Housing provider or PM turnover	●	●								2
Staff turnover at AP and caseload reasonableness	●	●								2
Timing Problems										
Time participants are waiting on the CQ		●						●	●	3
Length of time available in RRH								●	●	2
Participant Engagement Challenges										
Participant unreachable						●				1
HP delays on determination			●			●				2
Participant housing decline						●	●			2
HP participant denial						●	●			2
Communication Problems										
AP leaves match meeting early, no case conferencing participation			●			●				2
VET — breaking silos between general population and specific VET programs			●			●				2
Communication breakdown			●			●				2
Participant Mismatch for Opportunity										
AP accepts match that is no longer appropriate for participant		●							●	2
Checking with client on the spot, AP not prepared		●	●							2

Pain Point	People Issues	Volume Issues	Training Issues	Process Design & Uniformity	Data Issues	Effective Mgmt of Complex Processes	System Issues	Policy Constraints	Resource Constraints	Root Causes
RRH prioritization: most vulnerable vs sustainability		●				●			●	3
Gaps in Participant Information & Documentation										
Participant information gaps and changing info on CQ			●	●						2
Participant information gaps at referral (interest, eligibility)		●	●	●						3
CQ documentation gaps (CH, disability doc, vital documents)		●		●						2
Data Quality Problems										
ICES — maintaining accurate data for large # of people and APs		●	●		●					3
Vacancy not reported timely		●	●		●					3
Total Pain Points Linked per Root Cause	**2**	**13**	**10**	**3**	**2**	**9**	**6**	**2**	**8**	

Appendix E: Recommendation Responsibility and Investment Matrix

This appendix compiles all 38 recommendations and 9 Innovation Opportunities into a single implementation-planning matrix, identifying the entity responsible next step actions:

- CoC Board (CoC): Next step(s) require Board-level review and potential action.
- CoC Collaborative Applicant Lead (OCC-CA) with other CES Leadership: Next step(s) require OCC action as Collaborative Action (e.g., policy review, procedural/operational changes)
- CoC CES Lead (OCC-CES): Next step(s) require OCC action as CES Lead and are within current scope.
- CoC HMIS Lead (UW-HMIS): Next step(s) require UW action as HMIS Lead and are within current scope.

A description of each entity is included in **Appendix F**.

An estimated relative level of investment required to implement each is also included. Investment levels use a four-tier relative scale **($ to $$$$) reflecting the scale of effort and related resources** involved rather than specific dollar figures, as precise cost estimates are outside the scope of this evaluation. Currently available CoC Program funding (planning grant) and other sources used to operate CoC functions, including CES, was not evaluated.

Symbol	Label	Interpretation
$	Minimal Investment	No significant new funding required, primarily staff time, policy or procedural changes.
$$	Small Investment	Modest new resources (e.g., targeted staff time, minor HMIS/system configuration, or limited training/materials development).
$$$	Large Investment	Substantial new resources (e.g., new staff positions, technology or dashboard development, or new multi-agency coordination infrastructure).
$$$$	Significant Investment	Major new resources (e.g., new program funding streams, capital investment, or system-wide infrastructure buildout).

	Section 3: System Design	Responsible Entity	Estimated Investment Level
REC-1	Severity-of-Need Assessment & Prioritization — Utilize standardized severity-of-need factors for assessment and prioritization purposes consistent with requirements in HUD Notice CPD-17-01.	OCC-CA/CES	$$

Section 3: System Design		Responsible Entity	Estimated Investment Level
REC-2	Document Readiness & Matchable Status — Build document-preparation support into the process earlier, and track "in queue" vs. "matchable" (document-ready) status in HMIS.	OCC-CES	$$
REC-3	Responsible Provider & Warm Handoff — Formalize a responsible-provider model and case-conferencing protocol covering match acceptance through enrollment.	OCC-CA/CES	$$
REC-4 IMMEDIATE	VA SSVF Participation Terms — Clarify and formally document VA SSVF's role in OC CES.	OCC-CES	$
REC-5	CQI Framework — Formalize a Continuous Quality Improvement (CQI) framework with a defined review cycle and protocol for updating staff training materials.	OCC-CA/CES	$
REC-6	Stakeholder Input Mechanisms — Establish formal, transparent mechanisms for stakeholder input and policy development.	CoC	$$
REC-7	Governance Roles & Decision Rights — Clarify governance roles, decision-making authority, and escalation pathways across CES entities.	CoC	$

Section 4: CES Function 1 — Access		Responsible Entity	Estimated Investment Level
REC-8	Coverage Expansion Plan — Develop a CES Coverage Expansion Plan (35% coverage within 12 months, 50% within 24) with focus on Street Outreach programs and implement some form of structured CNA at first contact.	CoC	$$$
REC-9	Access Point Sustainability Plan — Stabilize and expand access point capacity, prioritizing the South SPA and Street Outreach programs, with stable funding, incentives, monitoring, training, and contingency planning.	CoC	$$$
REC-10	Prevention & Diversion Component — Build a formal homelessness prevention and diversion component into the CES access model.	CoC	$$$
REC-11	Referral Connection Tracking — Track referral-to-CNA connection rates to identify where households drop out at entry.	OCC-CES	$

Section 5: CES Function 2 — Assessment		Responsible Entity	Estimated Investment Level
REC-12 IMMEDIATE	Disabling Condition Form Fix — Remove the disability-type field from the Disabling Condition Form.	OCC-CES	$
REC-13	HNA Completion Timeliness — Set a 90%-within-30-days completion target for the Housing Needs Assessment (HNA).	OCC-CA/CES	$

Section 5: CES Function 2 — Assessment		Responsible Entity	Estimated Investment Level
REC-14 IMMEDIATE	HNA Instrument Review — Review whether the HNA instrument captures enough information for accurate housing matches.	OCC-CES	$
REC-15 IMMEDIATE	Survivor & TAY Assessment Review — Conduct a targeted HNA-adequacy review for DV survivors and TAY populations.	OCC-CES	$
REC-16	CLSA Reassessment Alerts — Automate CLSA reassessment alerts before households hit the 90-day cutoff.	UW-HMIS	$$
REC-17	S3 Cohort Referral Review — Review all 3,734 high-need households with a completed HNA but no housing referral (S3 cohort).	OCC-CES	$$

Section 6: CES Function 3 — Prioritization		Responsible Entity	Estimated Investment Level
REC-18 IMMEDIATE	PSH Prioritization Language Fix — Correct PSH prioritization language on temporary transitional housing while a permanent unit is identified.	OCC-CES	$
REC-19	Prevention Prioritization Protocol — Create a separate, risk-based Homelessness Prevention Prioritization Protocol.	OCC-CA/CES	$
REC-20 IMMEDIATE	Shelter Prioritization Correction — Remove length-of-homelessness criteria from Emergency Shelter prioritization.	OCC-CA/CES	$
REC-21	Prioritization Model Refinement — Refine prioritization to weigh vulnerability and clinical urgency alongside length of homelessness.	OCC-CA/CES	$
REC-22	Street Outreach HNA Gap — Close the ~70% HNA coverage gap for Street Outreach participants.	CoC	$$
REC-23 IMMEDIATE	Participant Grievance Process — Establish means for confidential reporting of CES participant concerns and grievances. Ensure evaluation findings inform updates to CES monitoring practices and feedback mechanisms.	OCC-CA/CES	$$
REC-24	BNL Expiry Investigation — Investigate the 36% BNL expiry rate and build a pre-expiry outreach protocol.	OCC-CES	$

Section 7: CES Function 4 — Referral		Responsible Entity	Estimated Investment Level
REC-25	Timeliness Improvement Plan — Launch a Timeliness Improvement Plan to bring match-to-move-in timelines into compliance.	OCC-CA/CES	$
REC-26 IMMEDIATE	Provider Screen-Out Investigation — Investigate provider screen-out practices that violate CoC participation requirements.	OCC-CA/CES	$
REC-27	Subpopulation Denial Rate Review — Investigate high decline/denial rates among Veteran, NHPI, and Asian/AA households.	OCC-CA/CES	$

Section 7: CES Function 4 — Referral		Responsible Entity	Estimated Investment Level
REC-28	RRH Performance Workgroup — Convene an RRH Performance Workgroup to correct program underperformance.	CoC	$
REC-29	HNA-to-Referral Review Interval — Add a minimum review interval between HNA completion and referral issuance.	OCC-CES	$
REC-30	Return-to-Homelessness Response — Address the 22% system-wide return-to-homelessness rate with stability check-ins and post-placement supports.	CoC	$$
REC-31	Standardized Eligibility Registry — Standardize housing-provider application requirements through a shared eligibility registry.	CoC	$$
REC-32	Pre-Referral Eligibility Communication — Establish a process for communicating provider eligibility requirements to CES staff before referrals are made.	OCC-CES	$
REC-33	Performance Benchmark Transparency — Publish and regularly review performance benchmarks for referral and housing outcomes.	UW HMIS & OCC-CA	$

Section 8: Direct Financial Assistance		Responsible Entity	Estimated Investment Level
REC-34	Direct Financial Assistance Function — Build a Direct Financial Assistance function with defined eligibility, disbursement, and fiscal controls.	CoC	$$$$

Section 9: Data Management and Resource Availability		Responsible Entity	Estimated Investment Level
REC-35	Year-Round Feedback Mechanism — Establish a year-round, structured provider and participant feedback mechanism.	OCC-CA/CES	$
REC-36	Resource Alignment Strategy — Develop a Resource Alignment and Capacity Management Strategy to address the system's 6:1 inflow-to-exit ratio.	CoC	$
REC-37	Capacity & Utilization Metrics — Establish formal metrics to monitor system capacity and housing resource utilization.	OCC-CA	$
REC-38	Landlord & Provider Engagement — Strengthen housing provider and landlord engagement to expand available housing opportunities.	CoC	$$$

Section 10: Advancements, Innovations and Experiences (Innovation Opportunities)		Responsible Entity	Estimated Investment Level
IO-1	Dynamic BNL Management — Implement dynamic BNL management using real-time data to adjust prioritization as needs change.	OCC-CA/CES	$$

Section 10: Advancements, Innovations and Experiences (Innovation Opportunities)		Responsible Entity	Estimated Investment Level
IO-2	Progressive Engagement Model — Adopt a progressive engagement model: phased triage/crisis assessment now, full HNA 7–14 days later.	CoC	$$
IO-3	Real-Time System Dashboard — Build a real-time system dashboard and standardized public eligibility profiles for housing programs.	CoC	$
IO-4	Culturally Responsive Navigation — Develop subpopulation-based, culturally responsive housing navigation.	CoC	$$
IO-5	Independent Complaint Mechanism — Establish a confidential, third-party complaint mechanism independent of CES operational staff.	CoC	$
IO-6	Mainstream Resource Integration Plan — Build a Mainstream Resource Integration Plan linking CES to CalAIM, child welfare, workforce, aging, and affordable housing systems.	CoC	$$
IO-7	DFA Buildout — Stand up the full Direct Financial Assistance function: diversion, rapid placement, and landlord engagement funds.	CoC	$$$$
IO-8	Training Update Protocol — Require staff training materials to be updated within a set timeframe after every policy or tool change.	CoC	$
IO-9	HMIS Data Quality Plan — Launch a structured HMIS data quality improvement plan targeting equity and reporting fields.	CoC	$

Appendix F: Glossary

This glossary defines the abbreviations, acronyms, and terms used throughout this report as they apply to the OC CES evaluation.

Acronyms and Terms

Abbreviation	Full Term	Definition as Used in This Report
AB 12	Assembly Bill 12 (California Fostering Connections to Success Act)	State law extending support to foster youth; referenced regarding coordinated housing placement protocols for families involved with the child welfare system.
AI/AN	American Indian or Alaska Native	Race/ethnicity subgroup disaggregated in equity assessments throughout this report.
APR	Annual Performance Report	HUD-required program-level performance report; referenced as a function HMIS is configured to generate.
BHSA	Behavioral Health Services Act	California state legislation referenced by stakeholders regarding cross-system funding and data alignment with CES.
BNL	By-Name List	The centralized, prioritized list of all known literally homeless households used to manage referrals to housing. In Orange County, this is more narrowly confined and referred to as the Community Queue (CQ), and also includes households at risk of homelessness. The OC CES operates two by-name registries, a Veteran Registry and a TAY Registry.
CalAIM	California Advancing and Innovating Medi-Cal	California's Medicaid delivery system reform initiative, identified as a priority target for mainstream resource integration with CES.
CE	Coordinated Entry	Used in reference to CE Events data and CE-assessed exit pathways.
CES	Coordinated Entry System	Orange County's centralized system for assessing, prioritizing, and referring people experiencing homelessness to housing and services; the subject of this evaluation.
CH	Chronically Homeless	HUD-defined status combining long-term or repeated homelessness with a disabling condition; used as a prioritization and scoring category.
CLSA	Current Living Situation Assessment	The CES assessment completed after program enrollment (and typically after the CNA) and alongside the HNA. failure to update the CLSA within 90 days triggers automatic removal from housing referral eligibility.
CNA	Crisis Needs Assessment	The standardized crisis screening administered at initial CES access, the first phase of the CES assessment process.

Abbreviation	Full Term	Definition as Used in This Report
CoC	Continuum of Care	The federally designated regional planning body responsible for coordinating homelessness services; here, the Orange County CoC (OC CoC).
CPD-17-01	HUD Notice CPD-17-01	HUD guidance establishing coordinated entry requirements for CoC-administered systems; the primary compliance framework applied in this evaluation.
CQ	Community Queue	See BNL.
CQI	Continuous Quality Improvement	A structured process for translating performance data and stakeholder feedback into system changes; identified in this report as absent from current CES governance.
Det→MI	Determination to Move-In	The interval between a housing match determination decision and a household's move-in date.
DV	Domestic Violence	Used to describe survivors of domestic violence and the specialized SCES access pathway.
ES	Emergency Shelter	Crisis housing program type; disaggregated in this report as ES-EE (Entry/Exit) and ES-NBN (Night-by-Night).
ESG	Emergency Solutions Grant	HUD funding source with its own Written Standards.
FCES	Family Coordinated Entry System	The CES pathway serving households with children.
FQHC	Federally Qualified Health Center	Community health provider identified as a target for mainstream system coordination with CES.
HIC	Housing Inventory Chart	Annual HUD-required inventory of all beds and units in the CoC's homeless response system, used to assess CES resource participation rates.
HMIS	Homeless Management Information System	The data system used to record client-level homelessness services information; the primary source for quantitative analysis in this report.
HNA	Housing Needs Assessment	The CES assessment completed after program enrollment (and typically after the CNA) that places a household on the BNL and informs referral. Typically in conjunction with the CLSA.
HO	Housing Opportunity	A housing unit or resource (RRH, PSH, PH-Housing Only, or PH-Housing with Services) available for referral through the CES Queue.
HP	Homelessness Prevention	Program type intended to stabilize households at risk of homelessness before shelter entry.
HUD	U.S. Department of Housing and Urban Development	The federal agency that funds and regulates CoC-administered homelessness programs and establishes CES requirements.

Abbreviation	Full Term	Definition as Used in This Report
ICES	Individual Coordinated Entry System	CES subpopulation/pathway serving single adults.
IHSS	In-Home Supportive Services	California program identified as a target for coordination with older adult CES participants.
IO	Innovation Opportunity	A forward-looking system advancement identified in Section 10, distinct from a compliance-required recommendation (REC).
LEP	Limited English Proficiency	Population identified as needing tailored CES language access accommodations and materials.
M→Det	Match to Determination	The interval between a housing match and the determination decision.
M→MI	Match to Move-In	The interval between a housing match and a household's move-in date.
NHPI	Native Hawaiian or Pacific Islander	Race/ethnicity subgroup disaggregated in equity assessments throughout this report.
OC CoC	Orange County Continuum of Care	The Continuum of Care responsible for administering the OC CES and this evaluation.
OCC	Office of Care Coordination	The entity that leads and coordinates the CES in Orange County.
P&P	Policies and Procedures	The CES Policies and Procedures Manual governing system design, standards, and operations.
PBV	Project-Based Voucher	A housing subsidy tied to a specific unit; referenced as a mainstream referral resource alongside VA.
PH	Permanent Housing	Permanent housing destination or program type without a defined length of stay.
PHA	Public Housing Authority	Entity administering housing vouchers and units referenced throughout the Referral function.
PLE	People with Lived Experience	Individuals who have directly experienced homelessness, engaged as a distinct stakeholder voice through focus groups and survey in this evaluation.
PSH	Permanent Supportive Housing	Long-term subsidized housing with services for households experiencing chronic homelessness or high service needs.
REC	Recommendation	A numbered, compliance-driven recommendation issued throughout this report (e.g., REC-1).
RRH	Rapid Rehousing	Short-term rental assistance and housing navigation intervention intended to move households quickly to permanent housing.
SCES	Survivor Coordinated Entry System	CES pathway serving survivors of domestic violence through Victim Service Providers (VSPs).

Abbreviation	Full Term	Definition as Used in This Report
SO	Street Outreach	Program engaging unsheltered individuals and connecting them to the CES.
SOAR	SSI/SSDI Outreach, Access, and Recovery	Program supporting disability benefits advocacy, referenced as an income and benefits integration opportunity.
SPA	Service Planning Area	Geographic subdivision of Orange County (North, Central, South) used for geographic equity analysis throughout this report.
SPM	System Performance Measure	HUD-defined metrics used to assess CoC-wide system performance.
SSI/SSDI	Supplemental Security Income / Social Security Disability Insurance	Federal disability benefit programs referenced in income and benefits integration recommendations.
SSVF	Supportive Services for Veteran Families	VA-funded program whose CES participation terms were found in this evaluation to require clarification and documentation.
Stella P	HUD Longitudinal Systems Analysis module	HUD data module used as the source for various data analysis including exit outcome and returns-to-homelessness findings in this report.
TAY	Transition-Age Youth	CES subpopulation of households in which all members are under age 25.
TBV	Tenant-Based Voucher	A portable housing subsidy tracked as a housing type in the Match Inventory data.
TH	Transitional Housing	Time-limited housing program type; also referenced as TH-RRH, a hybrid transitional housing/rapid-rehousing model.
VA	U.S. Department of Veterans Affairs	Federal agency partnering on veteran-specific CES pathways and housing resources.
VASH	VA Supportive Housing	Veteran-dedicated permanent supportive housing voucher resource.
VET	Veteran	CES subpopulation with a household member who has served in the U.S. Armed Forces.
VI-SPDAT	Vulnerability Index – Service Prioritization Decision Assistance Tool	Legacy assessment tool referenced by stakeholders as still believed to be in use, indicating incomplete transition communication to the current HNA/CNA instruments.
VSP	Victim Service Provider	A non-HMIS-participating agency serving DV survivors within the CES.

Governance and Operational Roles

The following table defines the respective governance, operational, and coordination roles of entities involved in the OC CES.

Entity	Role
CoC Membership	The broad group of organizations and individuals participating in a Continuum of Care, representing the community's housing and homelessness response partners, public systems, service providers, people with lived experience, advocates, and other interested stakeholders. CoC membership provides community input, supports coordinated planning, and selects the CoC Board through an established governance process. It is broader than the CoC Board, which serves as the CoC's designated decision-making and oversight body.
CoC Board	Governance, policy adoption, and oversight body for the Orange County Continuum of Care. Adopts CES policies and written standards, receives compliance and performance reporting, and holds ultimate accountability for the CoC's HUD-required coordinated entry process.
CoC Collaborative Applicant (OC Office of Care Coordination (OCC))	The eligible organization designated by the CoC Board to coordinate and submit the CoC's consolidated application for HUD CoC Program funding and to apply for CoC planning funds on the CoC's behalf. The Collaborative Applicant commonly provides administrative and planning support to the CoC and may perform other responsibilities assigned through the CoC's governance charter or written agreements. It supports the CoC's work but does not replace the CoC Board as the community's governing and decision-making body.
CoC CES Lead (OCC)	The eligible organization designated by the CoC Board responsible for the operational and implementation side of coordinated entry, administering access points and overseeing assessment, prioritization, and referral processes, and carrying out the policies the CoC Board adopts. According to CES Policies and Procedures, the CES lead agency's responsibilities include: • Facilitating referrals between CES for Individuals, Families and Survivors. • Collecting CES data to report to HUD. • Providing support to CES Access Points and Housing Providers participating in CES.
CoC HMIS Lead (OC United Way)	The eligible organization designated by the CoC Board to administer the Homeless Management Information System underlying CES data collection and reporting. Responsible for data system infrastructure, user access, and data quality standards, distinct from OCC's responsibility for how that data is used operationally within CES.
CoC CES Steering Committee	The operational body to which CES performance, corrective action plans, and benchmark progress are reported on a regular cadence. Functions as the working-level monitoring and coordination forum between OCC's day-to-day operations and CoC Board governance.
CES Leadership	The OCC staff and contracted-provider staff responsible for the day-to-day administration of individual CES functions and registries. This includes:

Entity	Role
	• OCC program staff who administer the Veterans and TAY CES registries directly. • Contracted-provider administrators who have historically operated the Individual, Family, and DV CES functions, managing assessment, prioritization, matching, and referral activity within their assigned population (PATH begun to fully operate the CES as of on September 1, 2026). • SPA-level administrators who oversee access point coordination, match meetings, and provider communication within their geographic area. CES Leadership is the term used throughout this report's qualitative findings (stakeholder interviews and focus groups) to refer collectively to the program- and SPA-level administrators, the people directly managing CES operations day to day.
Commission to Address Homelessness	The County's chief cross-system convener, bringing together County departments, cities, public housing authorities, health plans, providers, and other system partners whose work intersects with homelessness response but who sits outside the CoC's direct funding and operational structure.

Providers	CES-participating agencies that deliver direct services, operating access points, conducting assessments, accepting referrals, and enrolling households in housing and services programs. Accountable to both OCC and the CoC Board for compliance with CES policies and standards. Providers include:
	• **The CES Virtual Front Door (VFD)** is contracted by the CES lead to develop and manage a VFD infrastructure, including the operation of a centralized information and referral process for connecting eligible households to a CES Access Point. The CES VFD's responsibilities include:
	  ○ Facilitating referrals to CES Access Points for eligible households.
	  ○ Screening for sub-population specific service needs, including Survivors, TAY, Veterans, and family
	  ○ status.
	• **CES Access Points** are homeless service providers in the community that serve as entry points into CES as well as offer additional assistance via referrals and other services to help support households experiencing a housing crisis. Access Points include mobile street outreach teams, navigation centers, emergency shelters and supportive services agencies. CES Access Point responsibilities include: (but not limited to)
	  ○ Connect eligible households with CES through a standard assessment process.
	  ○ Offer additional services and resources to support with housing crisis needs.
	  ○ Represent the household's needs in CES.
	  ○ Submit a new/updated Current Living Situation Assessment, at minimum, every 90 days or the

Entity	Role
	○ household will be automatically removed from being referred to any housing opportunities. ○ Maintain accurate and timely data in HMIS, as outlined in the annual CES Participating Agency Agreement form, or a comparable database for survivors. • **Matchmakers** are CES Administrators that manage the CES prioritization and referral process. Matchmakers work collaboratively with Access Points and housing providers to support a successful referral process while prioritizing the most vulnerable households. Matchmaker responsibilities include: ○ Facilitating referrals for shelter, housing, and supportive services resources, including survivor- ○ specific CoC, ESG, and HHAP funded resources. ○ Facilitating referrals between CES for Individuals, Families and Survivors. ○ Providing support to CES Access Points and Housing Providers participating in CES. • **Housing Providers** are CES participating agencies that provide resources for people at risk of homelessness or experiencing homelessness. Housing Provider resources include shelter, supportive services, homeless prevention assistance, rapid rehousing, permanent supportive housing and other permanent housing. All CoC, ESG, and HHAP funded programs are required to participate in CES as Housing Providers. Housing Providers are required to enter any resources in HMIS every Friday by 12pm, Pacific Standard Time, when resources are available to ensure that those resources are available for matching the following week when there is a Housing Provider Match Meeting taking place. Any resources entered after this time may not receive a referral placement the following week. Housing Provider responsibilities include: ○ Notifying CES through HMIS or a comparable database for survivors when a program has an ○ opening and is able to accept referrals. ○ Clearly communicate eligibility requirements for available resources. ○ Accept referrals for the available resources exclusively through CES. ○ Maintain accurate and timely data in HMIS, as outlined in the annual CES Participating Agency ○ Agreement, or a comparable database for Survivors.
External Partners	Systems and organizations adjacent to but outside CES's direct governance, including healthcare and behavioral health (e.g., CalAIM/BHSA-funded services), workforce development, aging services, child welfare, criminal justice, and housing authorities. Engagement occurs through referral relationships, data-sharing agreements, or cross-system coordination structures rather than CES policy authority.

