

Calgary, Alberta, Canada

North star: “Guiding the fight against homelessness” and “We envision the day when homelessness is rare, brief, and non-recurring — perhaps an episode in someone’s life, but never a condition that defines one’s life.”

Population: 1,491,900 (2024)
Point in time count (2024):
Total individuals - 2,782

KPIs

- People no longer experiencing homelessness
- People housed
- People diverted from emergency shelter to immediate housing services
- Additional KPIs set by provincial government
- Reductions in public services
 - Emergency room visits
 - Court appearances
 - Emergency medical services (EMS) uses
 - Hospital stays
 - Police interactions
 - Incarcerations

The [Calgary Homeless Foundation](#) (CHF) uses a Homeless Management Information System (HMIS) to develop KPIs that measure progress toward community goals. It also helps monitor if services are being deployed most efficiently and effectively towards the desired outcome and to identify and triage immediate service needs.

Structure

In Calgary, government ministries and a network of agencies known as Calgary’s Homeless-Serving System of Care serve people experiencing homelessness.

CHF is a nonprofit hub that has been leading and coordinating efforts to end homelessness. However, in December 2024 the provincial government announced that this model will soon change.

CHF has been serving as a central system planner, funder and data-driven decision-maker to improve housing and support services for vulnerable populations. Under this model, the foundation and six other organizations have acted as local hubs and received a lump sum of government money, which they distribute to smaller organizations in their area. This system uses real-time data-driven insight to track homelessness trends through pooled data of all clients served.

Under the provincial government’s new plan, funding distribution will shift from nonprofit hubs to the government, which will distribute the funding in the form of government grants.

Program highlights

[The Alberta Recovery Model](#) is recovery-oriented system of care with a coordinated network of personalized, community-based services for people at risk of or experiencing addiction and mental health challenges. It provides access to a full continuum of services and support from prevention and intervention to treatment and recovery. The Alberta Recovery Model was developed by the Government of Alberta and is administered by Recovery Alberta, one of four public health ministries in Alberta.

Denver, Colorado

North stars: “A region where everyone has a safe, stable place to call home”

Population (2024): 3,245,276
Counties: 7
Point in Time Count (2023):
Total Individuals – 14,281

KPIs

Metro Denver Homeless Initiative (MDHI) reports on the following measures in an annual [State of Homelessness](#) report:

- People experiencing homelessness via Point in Time count
- Number of people assessed and prioritized for housing via Coordinated Entry
- Youth experiencing housing instability via McKinney-Vento
- Tracking racial disparities and causes of homelessness using HMIS
- Tracking select economic and housing market indicators

MDHI focuses on real-time quality data which means they can account for everyone experiencing homelessness by name in each population. This Quality By-Name List (BNL) helps the program understand the scope of homelessness in each subregion, describes the inflow and outflow on an ongoing basis, and helps measure progress towards ending it. MDHI also partners with [Community Solutions](#) to certify data, assuring 100% data reliability.

Regional goals

By end of year 2024:

- 9/9 subregions achieve quality data for Veterans
- 4/9 subregions achieve functional zero for Veterans
- 33% reduction in the number of Veterans actively experiencing homelessness across 9 sub-regions
- Build out data infrastructure in HMIS to support all subpopulations (families, youth, single adults, chronically homeless)

By end of year 2027:

- Have quality all singles data in 9/9 subregions
- Have quality data for youth in the region
- Have quality data for families in the region
- Have reached functional zero in all subregions for Veterans
- Have 4 subregions ended homelessness for at least one of the following subpopulations (all singles, chronic singles, families)

Structure

The [Metro Denver Homeless Initiative](#) (MDHI) is a regional continuum of care (CoC) encompassing seven counties and 40 municipalities. MDHI coordinates CoC applications and reporting for the continuum through the support of a membership organization, which facilitates several committees to involve interested and affected parties including a Coordinating Committee with broad participation, a Community Design Team for coordinated entry partners, and a Youth Work Group for providers serving youth. MDHI’s efforts broadly align with the [Community Solutions Built for Zero methodology](#) for achieving functional zero for specific subpopulations via targeted, data driven investments.

Program highlight

The Denver region achieved functional zero for veteran homelessness using the Built for Zero methodology, a data-driven approach aimed at ending homelessness by creating systems that prevent, detect, and rapidly resolve homelessness for specific populations. MDHI transitioned its HMIS software, enabling better data customization and integration with the VA's system. MHDH established subregions, [updated its HMIS](#) to allow for better collaboration and integration, and set time-bound population-specific data quality goals.

Houston, Texas

North star: “Ensure homelessness is rare, brief and nonrecurring”

Population: 2,319,119 (2024)
Counties: 3
Point in Time Count (2024):
Total individuals - 3,280

KPIs

- Length of time homeless
- Returns to homelessness
- Number of homeless persons
- Increased income
- First time homeless
- Exits from street outreach
- Exits to permanent housing destinations
- Exits to or retention of permanent housing

Houston, Texas has developed a north star to inform the specific actions and strategies included in their [5-year Community Plan to End Homelessness](#). Coalition staff and consultants use KPIs to determine service gaps and new resources and strategies to work towards the goals and priorities defined in the plan.

Structure

Houston's local homeless response system is a collective of more than 100 partners called [The Way Home](#) a regional Continuum of Care (CoC) that receives federal funds to administer homelessness response. It includes homeless service agencies, local governments, public housing authorities, the local Veterans Affairs office, and other nonprofits and community stakeholders. It encompasses Harris, Fort Bend, and Montgomery counties, Texas.

The Way Home has committed to ending homelessness in the greater Houston region and has defined “Ending homelessness” to mean preventing it when possible and ensuring homelessness is rare, brief, and one-time when not preventable.

[The Coalition for the Homeless of Houston/Harris County \(CFTH\)](#), a nonprofit, is the lead agency to The Way Home which coordinates community strategies to address homelessness.

Since its inception in 2011, The Way Home has achieved a 63% reduction in homelessness in the greater-Houston area, and more than 32,000 people have been housed. This is done through a coordinated system using real time data to track progress and address program and service gaps.

Program highlights

Housing First: The Way Home bases its programs on a Housing-First model. HUD defines “Housing First” as “an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.”

Lot size reform: In 1998, a policy change in Houston reduced the city's minimum-lot-size requirement and enabled development of over 34,000 town houses from 2007 to 2020. In 2013, the policy was expanded to cover nearly the entire city. Paired with Houston's reduced requirements for building setback and heights, the minimum lot sizes enabled more housing development throughout the city.

King County, Washington

North star: “Bring unsheltered people inside in a way that meets their needs for safety, stability and healing, as quickly as possible to prevent death and further harm”

Population (2023): 2,262,713
Counties: 1
Point in Time Count (2023):
Total Individuals – 16,868

KPIs

King County looks at the following KPIs to assess the baseline number of households accessing the homelessness response system and the number of households entering the homelessness response system. With these baseline numbers, the program then tracks KPIs across their [Five-Year Plan \(2023-2028\)](#).

- Number of households accessing the system
- Number of households entering the system
- Number of households exiting to permanent housing
- Returns to homelessness at 6-, 12- and 24-months post-program exit
- Number of temporary and permanent housing units in the system
- Throughput of temporary and permanent housing units in the system
- Utilization of temporary and permanent housing units in the system

Where possible, these measures are further broken down by:

- Household type: Single adults, families with children, and youth and young adults
- Race and ethnicity
- Program type: Emergency shelter/housing, transitional housing, day center, safe haven, rapid-rehousing, diversion, safe parking

A Path Forward goals

In its [Five-Year Plan \(2023-2028\)](#), the region has set the following goals across system levels, each with a list of prioritized “key actions” further outlined (beginning on page 29):

- Every service provider has the resources to implement best practices and can recruit and retain necessary staff
- All service providers can coordinate response with better data capacity, every sub-region has services, and all disproportionately impacted sub-populations are served
- Multiple systems of care can coordinate to ensure supportive transitions and leverage every opportunity to prevent homelessness

Structure

The [King County Regional Homelessness Authority](#) (KCRHA) serves as the continuum of care for King County and the dozens of cities within it. A partnership between City of Seattle and King County, KCRHA was created in 2019 with the aim of regionalizing homeless services, creating a consistent strategy across cities and reducing administrative burden by centralizing the greater Seattle area’s homelessness response funding under a single authority. In August 2024, the City and county approved a revised Interlocal Agreement, consolidating the agency’s implementation and

governing boards into a single entity composed primarily of elected officials with the goals of streamlining oversight, and enhancing transparency, coordination, and accountability.

Program highlight

KCRHA collaborates with state and local jurisdictional partners and organizations in the [Encampment Resolution Initiative](#), which focuses resources on specific prioritized encampments, offering permanent housing placement opportunities as sites are being cleared. In King County, the program has placed 90% of residents in targeted camps into housing.

San Antonio, Texas

North stars: “Ensure everyone has a place to call home” and “Significantly and efficiently reduce homelessness”

Population (2024): 2,319,119

Counties: 2

Point in Time Count (2024):

Total Individuals - 3,398

KPIs

The following are baseline metrics developed by [Close to Home](#), the CoC lead agency for San Antonio and Bexar County.

- People experiencing homelessness
- People experiencing unsheltered homelessness
- Returns to homelessness from positive housing exits from the homeless response system
- People experiencing homelessness for the first time
- Positive housing exits from the homeless response system

2025 Alliance to House Everyone One-Year Action Plan Strategic Objectives

Additional KPIs were developed for eight strategic objectives outlined in its [2025 One-Year Action Plan](#). Each of the 2025 Strategic Objectives are evaluated using one or more of these baseline metrics. Additionally, each objective includes key performance indicators (KPI) critical to understanding the impact of actions taken in support of the objectives in 2025.

- Prevent Homelessness and Reduce Inflow
- Expand Housing Options and Accelerate Housing Placements
- Strengthen Homeless Response & Services for Youth & Young Adults
- Improve Coordination & Access to Domestic Violence Services
- Improve Access to Healthcare Services
- Strengthen Street Outreach Coordination
- Effectively Address Equity and Accessibility
- Strengthen System and Program Capacity

Example:

Strategic Objective - Prevent Homelessness and Reduce Inflow

Baseline KPI

- Number of households and individuals experiencing homelessness for the first time
- Number of first-time homeless households and individuals enrolled in a prevention program

2025 KPI

- Complete a coordinated prevention analysis with the City of San Antonio (COSA), Bexar County, and the United Way

Structure

Since 2016, [Close to Home](#) has been HUD's Continuum of Care (CoC) lead agency for San Antonio and Bexar County and is the backbone nonprofit organization providing funding, education and accountability to organizations that address homelessness and housing insecurity in the region. Close to Home secures and distributes funding for direct service providers in the housing and homelessness sectors and provides guidance to improve local policies and programs.

The [Alliance to House Everyone](#) is the HUD Continuum of Care (CoC) group of approximately 50 organizations that collaborate to address homelessness in the Bexar County region. With the support and direction of the lead agency, Close to Home, the Alliance to House Everyone convenes to share information, provide training opportunities, recommend coordination strategies, and address service gaps or resource needs. As the CoC lead, Close to Home supports the Alliance to House Everyone by securing funding, providing guidance, and improving local policies and programs. Together, Close to Home and the Alliance work toward reducing homelessness.

Program Highlight

[Haven for Hope](#), a 22-acre, 1,600-person shelter in San Antonio. The facility serves 85% of the city's total homeless population and offers opportunities for individuals to have a safe place to sleep indoors, hot meals, shower and laundry services, and access to numerous community resources.

Upstate South Carolina

North star: “To prevent, reduce and end homelessness through the coordination of agencies in our communities.”

Population: 1,585,3999 (2023)

Counties: 13

Point in Time Count (2023):

Total individuals – 1,669

KPIs

- Length of time homeless
- Returns to homelessness
- Number of homeless persons
- Increased income
- First time homeless
- Exits from street outreach
- Exits to permanent housing destinations
- Exits to or retention of permanent housing

Implementing and maintaining a Homeless Management Information System (HMIS) allows the Upstate South Carolina program to compete more effectively for federal funding to support the work of preventing homelessness. Their KPIs are determined by data points captured in HMIS which allows for better management of client data, coordinated services, helps guide resource allocation, and streamline service delivery.

Structure

The Upstate Continuum of Care serves the 13 counties in Upstate South Carolina and is made up of more than 80 agencies. The nonprofit [United Housing Connections](#) is the lead agency in the CoC's efforts throughout 13 counties and is the collaborative applicant for the HUD CoC Program Grant.

HMIS in South Carolina is integrated for a more inclusive approach that enhances the ability to refer those needing services all over the state.

In 2023, the Upstate CoC began the process of developing a Diversity, Equity and Inclusion Committee that reinforces its “dedication to creating and maintaining an environment that is inclusive of all persons.

Program Highlights

Upstate South Carolina’s regional coordination focuses primarily on funding and data sharing. Individual counties and cities have recently [announced](#) their own [initiatives](#) focused on connecting individuals to housing and shelter closer to their communities.

The City of Spartanburg, in acknowledging the rise in the presence and complexity of homelessness and the ongoing challenges that arise with it within the past few years, created the Homeless Engagement and Response Team (HEART). The HEART team operates with the following goals of reducing the number of homelessness by 10%, successfully refer at least 75% of homeless residents to resources within Spartanburg, and to engage in at least 12 educational opportunities with the community within the next year.