MID-WILLAMETTE VALLEY HOMELESS ALLIANCE

MOVING TO END AND PREVENT HOMELESSNESS

2025-2030 Strategic Plan

Adopted April 10, 2025

www.MWVHomelessAlliance.org

Mid Willamette Valley Homeless Alliance
2025-2030 Strategic Plan

Table of Contents

Introduction *3*

The Alliance in 2030 ..... *4*

Timeline and Methodology *5*

Local Data Highlights *7*

2023 Regional Needs Assessment: **7**

2023 LSA Data **8**

2020-2024 Housing Inventory Count **9**

Strategic Plan *10*

Mission: **10**

Vision: **10**

Purpose: **10**

Values: **10**

Goals and Objectives: **11**

Implementation Plans *12*

2025-2030 Strategic Plan Dashboard *27*

Conclusion *29*

Appendix *29*

History of the Alliance **29**

Acronyms and Definitions **33**

Introduction

The Mid-Willamette Homeless Alliance (Alliance) serves as the Continuum of Care for Marion and Polk County, Oregon. The Alliance is a collaborative organization engaging in a community-wide commitment to coordinate, leverage, and align efforts and resources to end prevent homelessness.

Recognized by the U.S. Department of Housing and Urban Development (HUD) in December 2019 as the Marion-Polk region's Continuum of Care (CoC), the Alliance does not provide direct services. Rather, it focuses on community wide planning and coordination, e.g., aligning services, implementing a strategic plan, collecting and analyzing data, evaluating project and system performance, maximizing and allocating resources, facilitating cross-system collaboration, and bringing youth, chronic, and Veteran homelessness to functional zero through Built for Zero system improvement strategies. The Alliance is also responsible for compiling a single community application for federal Continuum of Care dollars that is submitted to HUD. A detailed history of the Alliance can be found in the appendix of this report.

To guide this work, the Alliance has developed this strategic plan. This plan was developed between February 2024 and April 2025 with input from dozens of members of the CoC over the course of many meetings, workshops and surveys and was informed by many key organizational documents.

The goal of this strategic planning process was to:

(1) clarify the Alliance's vision, mission, and values;

(2) set high-level strategic goals to guide the Alliance's overall work;

(3) select key metrics that demonstrate success towards reaching those goals; and

(4) create implementation plans to guide the daily work of the Alliance staff, board and committees.

The Alliance in 2030

This strategic plan describes how the Alliance staff, committees and community partners will work together to end and prevent homelessness and achieve the four goals developed during the April 2024 board retreat. This is a living document, designed to be updated annually as the Alliance makes practical progress towards its goals through defined objectives and actions.

By implementing this plan, the Alliance will have:

1. Increased understanding of the homelessness crisis in our community by improving data collection and developing a community messaging strategy.

2. Improved the coordinated system of care and services by:

    a. Strengthening our (1) region's service providers and (2) homeless response system.

    b. Assessing our community's need for shelter and housing and developing a plan to increase shelter and housing options across our region. This plan will include details on meeting the needs of special populations and will demonstrate progress towards improving the following outcomes:
        i. Reduction in the average and median length of time persons remain homeless.
        ii. Reduction in the percent of persons who return to homelessness.
        iii. Reduction in the number of persons who are homeless.
        iv. Increase in the percentage of adults who gain or increase income.
        v. Reduction in the number of persons who become homeless for the first time.
        vi. Reduction in the percentage of Category 3 people who return to homelessness.
        vii. Increase in percentage of people who exit street outreach to permanent housing, temporary destinations (except street), and some institutional destinations.
        viii. Increase in percentage of people who exit to or retain permanent housing.

    c. Building community capacity to prevent homelessness by sharing best practices, supporting and improving existing efforts, increasing case management in affordable housing and voucher programs, incentivizing landlord participation, and engaging our community's systems in prevention work.

3. Maximized the resources available to end and prevent homelessness by seeking new resources, using current resources efficiently, and leading the Alliance resource allocation processes through a data-driven and values focused lens.

4. Increased participation in the Alliance by assessing gaps in representation and creating a proactive engagement plan as well as creating spaces for people to genuinely engage and be part of creating solutions.

Timeline and Methodology

The timeline below describes the strategic planning activities conducted:

- February 2024: Overview of Strategic Planning process presented at board meeting.
- March 2024: Surveys sent to the Alliance Board of Directors, Collaborative Committee and Backbone to garner input on progress toward 2021 strategic plan goals, committee roles, and values. Survey results analyzed and presented at the March 2024 Alliance board meeting. (55 survey responses)
- April 2024: Full day strategic planning retreat for the Alliance Board and Backbone. (30 participants)
- May 2024: Draft strategic plan presented to the Alliance Executive Director for review. Revisions from the Executive Director incorporated and the revised strategic plan was sent to Alliance Board members for review.
- June and July 2024: Meetings held with individual Alliance board members to garner input on the draft plan. Revised strategic plan presented to the Collaborative Committee and Backbone for input. Further input from committee members gathered via emails, individual meetings, and a survey (24 survey responses).
- August 2024: Presentation of revised strategic plan to a combined meeting of the Alliance Board and Collaborative Committee. Workshop conducted to develop list of potential action items for the implementation plans. (45 participants)
- September to December 2024: Meetings with Alliance staff members, Backbone, Collaborative Committee, and Healthy and Safety Committee held to develop, review and revise implementation plans.
- January 2025: Revised strategic plan with implementation plans sent to board to review and input.
- April 2025: Strategic plan with implementation plans presented to the Alliance staff and Board.
- April 2025: Implementation begins

To inform the values, goals, objectives and implementation plans in this strategic plan, primary and secondary information from the following sources were used:

- MWVHA 2021 Strategic Plan – July 2021
- MWVHA Coordinated Community Plan to End Youth Homelessness – March 2022
- MWVHA Plan to Serve Individuals and Families Experiencing Homelessness with Severe Needs – October 2022
- MWVHA Housing Inventory Count – January 2023
- MWVHA All In Regional Plan – March 2023

- MWVHA OR-504 2023 LSA visualization in Stella P – Excerpts of Summary Daa – September 2023
- MWVHA Regional Needs Assessment – November 2023
- MWVHA Collaborative Committee Meeting notes – November 2023
- MWVHA CoC Governance Chater- updated December 2023
- MWVHA Board Strategic Planning Survey – conducted March 2024
- MWVHA Collaborative Committee and Backbone Member Survey – conducted March 2024
- MWVHA Data Quality Management Plan – March 2024
- MWVHA Strategic Planning Feedback Survey – July 2024
- MWVHA HMIS Assessment – July 2024
- MWVHA's workplan submitted to Willamette Health Council – July 2024
- MWVHA's Emergency Order Project Monitoring Report, August 2024
- MWVHA's OR-504 Housing Inventory Count, Summary by year 2020-2024
- Salem/Marion, Polk Counties' FY2024 Continuum of Care application to the US Department of Housing and Urban Development – October 2024
- MWVHA's HMIS and CE renewal and expansion grant applications submitted October 2024
- MWVHA Local Long-Term Rental Assistance Plan
- MWVHA's OR-504 Data Quality Management Plan
- MWVHA's Committee Charters

In total, the development of this plan included input from over 130 organizational stakeholders and was informed by two dozen organizational documents:

- 79 responses to surveys on values, goals, objectives and implementation plans
- 45 participants at August 2024 workshop (Alliance Board and Collaborative Committee)
- 37 individual meetings with board members, committees members, MWVHA staff and consultants to garner input on the plan
- 30 participants at the April 2024 full day retreat with the Alliance Board and Backbone
- 24+ organizational documents
- 8 presentations at committee meetings (Collaborative, Backbone, Health & Safety)
- 3 workshops with the MWVHA staff team

Local Data Highlights

2023 Regional Needs Assessment:

The Alliance must conduct an annual gaps analysis of the homeless needs and services available within our geographic area. Below are highlights from the most recent regional needs assessment:

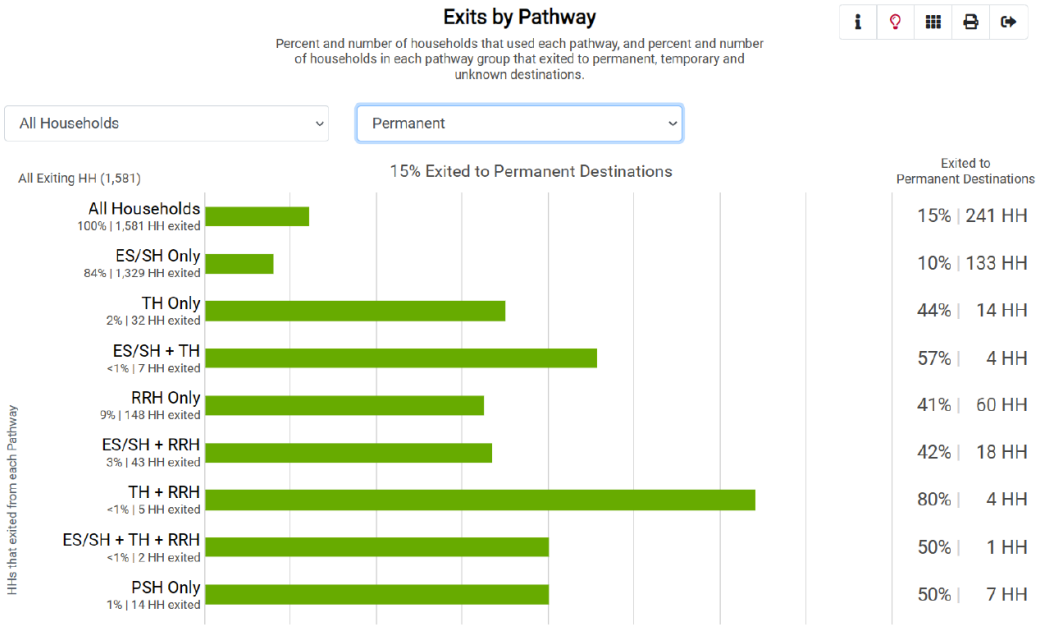
- From July 2022 to June 2023, more than 4,400 Marion-Polk residents were assessed as homeless in need of housing. Of that number: 67% were adults, 29% were children (under 18), and 4% were ages unknown.
- As of August 14, 2023, there were 4,778 people in Coordinated Entry (CE). Of those, 967 were identified as chronically homeless at the time of the most recent assessment.
- A total of 146,589 housing units are needed in the Willamette Valley by 2040, this includes 8,972 housing units for the homeless.
- A two-bedroom fair market rate rental in Marion County and Polk County costs about $1,245/month, which requires a renter to earn $23.94/hour (or $49,800/year) to afford. A renter earning minimum wage would have to work 1.7 full-time jobs to afford a local two-bedroom apartment at fair market rate (FMR).
- There were more than 1,400 evictions in Marion and Polk Counties in 2023. 80% were due to nonpayment.
- Of the 4,424 people assessed as homeless in need of housing in the Marion County and Polk County region during 2022-2023, 49% reported having a mental health disorder, more than one-third (38%) had a physical disability, more than one-third (37%) had a chronic health condition, more than one-in-four (27%) reported having one or both an alcohol use disorder or drug use disorder, and 24% had a developmental disability.
- In 2022-23 there were 280 unaccompanied youth and young adults younger than 25 years of age experiencing homelessness, 68 of whom were parenting.
- 2022-2023 Coordinated Entry data shows that 15% of Marion-Polk homeless families (91 families) were chronically homeless.
- During the 7/1/22-6/30/23 year, 230 Veterans experienced homelessness.
- Of the 3,100 adults (18+ yrs.) assessed, 1,404 (45%) were fleeing domestic violence at the time of their assessment. Of the children (<18 yrs.) assessed, 129 were fleeing domestic violence.
- Of the 4,424 Marion-Polk residents assessed for homelessness from July 1, 2022, through June 30, 2023, 750 were 55 years of age or older.

2023 LSA Data

The table below offers highlights on the demographics and system performance measures from the most recent Longitudinal Systems Analysis (LSA) report. This report contained information on 2,589 people across 1,936 households.

Demographics:	System Performance Data:
Of the 2589 people: • 21% children (0-17) • 14% young adult (18-24) • 61% adults (25-64) • 7% older adults (65+) • 5% unknown • 77% white • 77% were a household of 1 person • 14% veterans • 38% domestic violence survivor	Of the 1,936 households: • 134 days homeless (average cumulative days homeless) • 17% exits to permanent destinations for Adults only households • 59% exits to permanent destinations for Adults & Child households • 16% exits to permanent destinations for Child only households • 3% return after exits to permanent destinations

The table below, also from the most recent LSA report shows that the highest percentage of exits to permanent destinations involve transitional housing (TH) – either TH only (44%), Emergency Shelter / Safe Haven (ES/SH) + TH (57%); or TH + Rapid Rehousing (RRH) (80%).

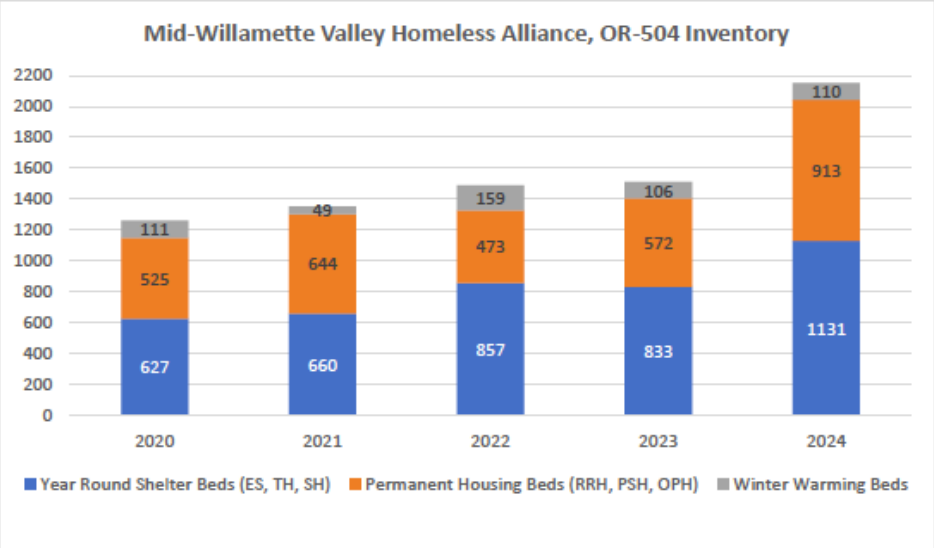


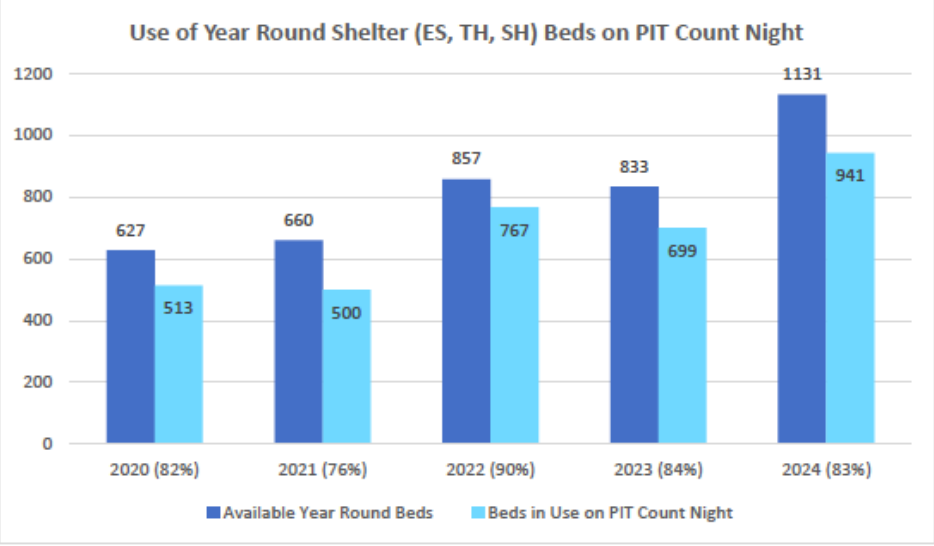
2020-2024 Housing Inventory Count

With the 2023 Regional Needs Assessment showing 4,424 people in our region in desperate need of shelter, what is our region's capacity to meet that need? The 2024 Housing Inventory Count shows that our region's inventory is 2,154, meeting only 49% of the need.

OR-504 Housing Inventory Count (HIC)
Summary by Year, 2020-2024 (The Annual HIC is based on the date of the PIT Count.)

People staying here are considered homeless. (Locations for Sheltered PIT Count)		People in these programs are considered housed, with subsidies.
ES = Emergency Shelter	**TH = Transitional Housing**	**PH = Permanent Housing**
• Warming Shelters • Year Round Shelters	• Specific populations • No individual lease • Up to 24 months (Includes Safe Haven)	• Facility-based programs • Voucher-based programs
• Night-by-Night Shelters • Duration Shelters		• Rapid Rehousing (RRH) • Permanent Supportive Housing (PSH) • Other Permanent Housing (OPH)





Strategic Plan

Mission:

To develop an evidence-based system of services, including stable housing, designed to meet the unique and complex needs of adults, youth, children, and families in Marion and Polk counties who are at risk of or are experiencing homelessness.

Vision:

Our vision is that the Mid-Valley becomes a community of belonging where everyone has access to housing and healthcare, has the opportunity to heal, and is treated with dignity and respect while their safety and basic needs are met.

Purpose:

End and Prevent Homelessness

Values:

The Alliance furthers its mission in light of the following values:

- **Collaboration:** *We engage organizations across many sectors and people with lived experience to find and develop solutions to our community's most pressing housing/healthcare crises. We intentionally include voices and perspectives from underrepresented communities to ensure more comprehensive and effective solutions.*
- **Stewardship:** *We are responsible for ensuring that the resources of the Alliance are used strategically and transparently in our collective pursuit to end and prevent homelessness.*
- **Inclusion:** *We seek to create a community that cultivates belonging by designing a Continuum of Care that actively includes people of all walks of life.*
- **Compassion:** *We want to relieve human suffering. When one person in our community is at-risk of or experiencing displacement, we are committed to meet them where they are at and offer options.*
- **Leadership:** *We take bold steps forward, leading the way to community-defined and evidenced-based solutions to end and prevent homelessness.*
- **Commitment:** *We are committed to this work until every person in our community's basic needs are met.*
- **Adaptability:** *We adapt our work to fit the needs in our community, we are nimble, and we are constantly adjusting our approach to match emerging trends.*

Goals and Objectives:

Therefore, over the next five years, the Alliance will make measurable progress to:

#1 Understand our community: **Through local quantitative and qualitative data the Alliance continually seeks to understand the causes of the crises faced by our community members.**

1.1 Quantitative Data: Improve participation in HMIS (or a comparable database for domestic violence service providers) to improve accuracy and quality of local quantitative data.
1.2 Quantitative Data: Ensure the PIT Count is routinized and robustly conducted.
1.3 Qualitative Data: Gather qualitative data (e.g. town halls, listening sessions, surveys) from all sectors of our community, especially underrepresented groups (e.g. youth, seniors, tribal nations), to assess the qualitative impact of the homeless crisis.
1.4 Analyze data and share it with our communities, Alliance stakeholders, decision makers and funders.

#2 Develop and improve the coordinated system of care and services.

2.1 Strengthen our region's service providers and the homeless response system.
2.2 Expand service providers' ability to offer everyone a safe place to sleep and a path to stable housing.
2.3 Build community capacity to prevent homelessness.

#3 Maximize resources: The Alliance maximizes resources that support ending and preventing homelessness through solicitation, leverage, and strategic investments.

3.1 Seek new resources to end and prevent homelessness.
3.2 Coordinate existing funding streams (CoC, ESG, SSVF, GPD, DHS/YEHP, OHCS, IHA, CDBG, HOME) to make more efficient and effective use of resources.
3.3 Secure resources that support service integration and wrap around supports (e.g. services that increase income and/or employment skills).
3.4 Leverage resources for CoC partners by serving as the CoC's fiscal agent, providing CoC coordination, and fostering collaborative partnerships.
3.5 Support homeless services provider participation in the HRSN program.
3.6 Lead the Alliance resource allocation process through a data-driven and values focused lens.

#4 Increase participation in the Alliance: Because homelessness touches every corner of our community, we need vast representation from across our region to solve it.

4.1 Reach out to all parts of our region to increase Alliance participation from cities, counties, tribal nations, public health departments, nonprofit service providers, mental health providers, healthcare providers, schools, faith communities, those with lived experience, youth and young adults, community members, culturally specific organizations, and more.
4.2 Create spaces for people to genuinely engage, gain understanding about our community's needs and services, and be part of creating community solutions.

Implementation Plans

Purpose of the implementation plans:
The following implementation plans are organized by goal. Each goal has objectives, action items, lead staff or committee identified to support the work, and a timeline. These plans will guide staff and committee work and lead the coordinated accomplishment of the plan's goals and objectives. These implementation plans should be updated annually, reflecting new action items based on work achieved in the previous year. Note that some of the action items lack an identified "Lead Alliance Staff" member. This is due the limited staff capacity of the Alliance. These items can be assumed by committees, if willing and able, or can be paused while the infrastructure of the Alliance grows.

Goal #1 Understand our community: Through local quantitative and qualitative data the Alliance continually seeks to understand the causes of the crises faced by our community members.

Objectives	Actions	Lead Alliance Staff / Committee Support	Time
1.1 **Quantitative Data:** Improve participation in HMIS (or a comparable database for domestic violence service providers) to improve accuracy and quality of local quantitative data	1.1.1 Implement "Data Quality Management Plan" which includes regular training and technical assistance for HMIS users*: • New User training, offered monthly • Provide regular training from domestic violence service providers to ensure the best interpretation of data from comparable databases, annually • Refresher training, as needed • Reports training (how to run data quality reports and correct errors), offered annually • ROI and Visibility Training, offered annually • Office hours for HMIS user questions and training, offered monthly • One-on-one technical assistance to HMIS users, as needed	HMIS Specialist and HMIS Analyst	Ongoing
	1.1.2 Operate the HMIS Help Desk • Provide guidance on required fields and address questions regarding data entry protocols • Implement the help desk ticket submission process	HMIS Specialist and HMIS Analyst	Ongoing
	1.1.3 Measure performance of training efforts: • Training participation and assessment	HMIS Specialist and HMIS Analyst	Annually

**Required by HUD*

	• Data Quality Audits • Agency performance reports • Monitor system performance measures	P&E Committee	
	1.1.4 Gather feedback from a wide range of partners to inform the "Data Quality Improvement Plan," inform monthly training topics, and guide the work of the HMIS User Workgroup • Conduct surveys, interviews, and offer feedback forms to HMIS users and domestic services providers to solicit feedback • Attend community meetings (e.g. Salem Provider Meeting, Collaborative Committee, Coordinated Entry Committee) where HMIS users are present to exchange ideas and solicit feedback • Proactively engage culturally specific groups to inform service delivery and develop culturally relevant and linguistically responsive tools • Increase representation on the HMIS User Workgroup	HMIS Specialist and HMIS Analyst P&E Committee HMIS Committee CE Committee	Annually
	1.1.5 Educate service providers regarding security and privacy standards of HMIS data, including survivors of domestic violence and VAWA transfers *	HMIS Specialist and HMIS Analyst	Annually
	1.1.6 Implement the HMIS Assessment workplan based on the ICA HMIS assessment, critical to securing resources and understanding our community's need	HMIS Specialist and HMIS Analyst	2025
	1.1.7 Update the "Data Quality Management Plan" and relevant policies and procedures incorporating a focus on data completeness and accuracy during assessment and intake processes*	HMIS Specialist and HMIS Analyst P&E Committee HMIS Committee CE Committee	Annually
	1.1.8 With increased HMIS quality and accuracy, examine trends to inform decision makers on program effectiveness, especially for underserved (e.g. Who is and who is not getting housed?)* • PE Committee Review annual SPM and LSA data • Make data driven funding and programmatic recommendations to the board • Inform the Alliance resource allocation process	HMIS Specialist and HMIS Analyst P&E Committee HMIS Committee CE Committee	Annually

Measures of success:

a. 100% of required local, state, and national reports (APRs, CAPERs, LSA, SPMs, etc.) submitted on time.*

a. 95% data completeness of Universal Data Elements as tracked via APR, CAPER and Data Quality report.*

**Required by HUD*

Goal #1 Understand our community – continued

Objectives	Actions	Lead Alliance Staff / Committee Support	Time
1.2 Quantitative Data: Ensure the PIT Count is routinized and robustly conducted	1.2.1 Develop new PIT Count methodology that can be implemented routinely and produces accurate, reliable and equitable data*	Alliance Contractors PIT Count Workgroup	Jan. 2025
	1.2.2 Engage community partners and volunteers in implementing the PIT Count, bring forward list of potential partners to the Collaborative Committee for review to ensure those serving special population are represented (e.g. survivors of domestic violence, veterans, youth and young adults)*	Administration and Communications Specialist Alliance Contractors PIT Count Workgroup	Jan. 2025
	1.2.3 Evaluate new PIT Count method and make recommendations for improvement (e.g. Utilize Plan, Do, Study, Act cycle to ensure continuous improvement)	Alliance Contractors PIT Count Workgroup	Spring 2025
	1.2.4 Analyze and share PIT Count data to highlight key needs and trends, create a report template for annual updating and adapting and include highlights in annual gaps analysis report*	Administration and Communications Specialist Alliance Contractors PIT Count Workgroup	Spring 2025
	1.2.5 PIT Count process is updated and repeated annually* • Utilize HMIS data in ongoing PIT Count methodology	Executive Director PIT Count Workgroup	Annually

Measures of success:

a. Able to submit sheltered (annually) and unsheltered (bi-annually) PIT Count*
b. Standard method for sharing PIT Count data and trends with the community is developed

**Required by HUD*

Goal #1 Understand our community – continued

Objectives	Actions	Lead	Time
1.3 **Qualitative Data:** Gather qualitative data (e.g. town halls, listening sessions, surveys) from all sectors of our community, especially underrepresented groups (e.g. youth, seniors, tribal nations), to assess the qualitative impact of the homeless crisis.	1.3.1 Develop learning objectives and question list for qualitative data collection. Vet questions with representatives from special populations (e.g. Backbone, domestic violence service providers, culturally specific organizations (CSOs), rural groups, and more).	Health and Homeless Systems Liaison	Annually
	1.3.2 Gather secondary qualitative data from listening sessions conducted by other partners (e.g. Community Health Assessment, Community Health Improvement Plan, DOT survey, Willamette Health Council, Community Action), analyze and incorporate into annual needs assessment		
	1.3.3 Develop list of target audiences for qualitative data collection, with a focus on underrepresented groups (e.g. The Drop Inn, Youth Era, C@P, Punks with Purpose, Arches)		
	1.3.4 Identify existing meetings in the community that may be willing to host a listening session (e.g. neighborhood association meetings, Salem Housing Authority's Friday Street Outreach, Community Violence Reduction Initiative, Salem Provider Network, Salem Peace Walks, Community Business and Education Leaders collaborative)		
	1.3.5 Ask community partners to lead a listening session at an upcoming meeting and gather primary qualitative data from sessions.		
	1.3.6 Conduct at least one annual listening session at an Alliance Collaborative Committee meeting		
	1.3.7 Conduct 5-10 key informant interviews, focusing on groups not represented in community listening sessions		
	1.3.8 Qualitative data is collected from sources above, as available, analyzed and themes are incorporated into annual needs assessment / gaps analysis*		

Measure of success:

a. # of listening sessions or key informant interviews conducted (facilitated by the Alliance or community partners), highlighting # of underrepresented groups participating in listening sessions

**Required by HUD*

Goal #1 Understand our community – continued

Objectives	Actions	Lead Alliance Staff / Committee Support	Time
1.4 **Analyze data and share** it with our communities, Alliance stakeholders, decision makers and funders.	1.4.1 Determine what data is needed to have a clear picture of the homeless crisis in our community: • Initial data set developed by Alliance staff and then reviewed by PE Committee and HS Committee. Data set to include, at least, the outcomes of HUD's System Performance Measures (SPM). • After agreement on the data set is achieved, ensure annual needs assessment/gap analysis updates this data each year. • Prior to the commencing of the next need assessment, garner input from Alliance partners on previous gaps analysis (e.g. strengths, weaknesses, usefulness).	Executive Director PE Committee HS Committee	2025
	1.4.2 Using 1.4.1 as a lens, review and vet available primary and secondary quantitative data (e.g. HMIS, PIT Count, LSA, SPM, Voices of Youth count, CHA, CHIP, Oregon ESSENCE) and qualitative data (e.g. key informant interviews, listening sessions).	Executive Director PE Committee HS Committee	2025 and annually
	1.4.3 Create a standard data set to guide CoC messaging regarding the state of homelessness in our community.	Executive Director PE Committee HS Committee	2025 and update annually
	1.4.4 Share data in annual needs assessment / gap analysis report* broadly: • In multiple modalities (e.g. press releases, website, social media, presentations, videos that combine stories with the data); • With diverse audiences (e.g. service providers, community, media, local government, business associations, neighborhood associations, Speak Up events, youth serving organizations); and • With the Alliance Board of Directors to inform CoC decision making.	Administration and Communications Specialist All committees	2025 and update annually

Measures of success:

a. Standard set of quantitative and qualitative data is developed
b. Complete annual needs assessment (AKA gaps analysis), incorporating quantitative and qualitative data*
c. Number of times the annual needs assessment (or gaps analysis) report is viewed increases annually

**Required by HUD*

Goal #2: Develop and improve a coordinated system of care and services

Objectives	Actions	Lead Alliance Staff / Committee Support	Time
2.1 Strengthen our region's service providers and the homeless response system.	2.1.1 Develop collaborative strategies to build skills and reduce turnover rate in case managers and outreach workers (e.g. trauma informed care training, mentoring), especially those with lived experience: • Centralize resources and provide regular training for our region's service providers (Source: FY2024 Continuum of Care Application for list of required trainings)* • Adapt HUD required trainings to include trauma informed principles • Provide training on safety and dynamics of interpersonal violence • Provide feedback to the Alliance on how to increase efficiencies in the CoC system to decrease burden on case managers/outreach workers • Offer burnout prevention for social services staff training (most recently offered by Marion County)	Executive Director Collaborative Committee	Ongoing
	2.1.2 Provide real-time data to service providers about shelter capacity across the CoC: • Train HMIS Users to access real-time shelter capacity data in HMIS • Regularly remind partners to update HMIS data so that real-time data is accurate • Provide quarterly reminders (e.g. via email, at community meetings) to partners about how to access real-time data	HMIS Analyst and HMIS Specialist	Ongoing
	2.1.3 Annually assess and improve the Coordinated Entry (CE) system functionality* for partners: • Conduct a comprehensive evaluation of current CE system: Evaluate data accuracy, training, access sites, assessments, prioritization, referrals, By Name List management, case conferencing, pulls for available units, duplication of processes, policies and procedures, coordination between DV confidential CE list and general CE list, and review CE practices through a racial equity lens (e.g. Does the By Name housing list equitably represent populations experiencing homelessness) • Disseminate evaluation findings to stakeholders and the broader community, promoting transparency and accountability • Create a detailed workplan to improve the CE system • Implement workplan • Monitor progress quarterly • Revise workplan annually	CE Program Manager Alliance Contractors CE Committee	2025-2026 Then ongoing
	2.1.4 Strengthen and expand CE assessors' services in order to serve our entire region and special populations*: • Determine the need for CE assessors and access sites (e.g. general vs. specialized) • Create a plan to expand assessor capacity and the number of access sites (e.g. CEs at Chariots, train McKinney Vento Liaisons to be CEs) to meet the identified need	CE Program Manager CE Committee	Ongoing

**Required by HUD*

	• Vet potential CE assessors through a trauma informed lens • Offer comprehensive training and ongoing technical support to new and existing CE assessors • Incorporate training for CE assessors on domestic violence and the cycle of abuse • Implement CE refresher trainings and offering regular check ins with CE service provider staff • Explore updating or replacing the CE assessment tool, VI SPDAT • Explore online CE assessment for self-completion • Increase accessibility of CE assessments for rural communities, people with disabilities and those with limited English proficiency • Regularly solicit feedback from CE assessors, clients, partners, culturally specific organizations, and more in order to inform CE training and processes		
	2.1.5 Establish a communication plan across the CoC during a crisis (e.g. Shigella Outbreak, wildfires, heat, cold, air quality). • Identify potential crises that need immediate communication across the CoC • Reach out to partners (e.g. Marion County Health and Human Services, Polk County, cities, school districts, healthcare agencies) for a copy of their crisis communications plans and review for alignment and partnership (e.g. what messages do we share from others vs. create on our own) • Establish process for development of crisis communications materials, customize by type of crisis • Create process and timeline for dissemination of crisis communications materials • Using the information from the process above, revise the CoC's Infectious Disease Prevention and Response Policy*, as appropriate	Health and Homelessness Systems Liaison HS Committee	2025
	2.1.6 Develop the MWVHA's capacity to convene health, housing, and homeless services partners to strengthen cross-sector collaboration, coordination, and service integration leading to better health and related outcomes for the populations served.* • Hire a full-time (1.0 FTE) Health Liaison to run the Health & Safety Committee and coordinate the MWVHA's new body of work related to health, housing, and homeless services coordination/integration at the systems level • Develop and post an RFP to hire a consultant with relevant subject matter expertise to map the current state of health, housing, and homeless services coordination/integration in the region, identify gaps, and develop a set of actionable recommendations for improvement • Execute consultant contract • Based on consultant findings and recommendations and in consultation with the Health & Safety Committee, the Health Liaison will develop a process to invest WHC funds in projects/initiatives that advance regional health, housing, and homeless services coordination/integration aims • The Health Liaison will work with the Health & Safety Committee to implement the above fund investment process and provide regular updates to the MWVHA Board of Directors and other key stakeholders	Health and Homelessness Systems Liaison HS Committee	2025

**Required by HUD*

	• The Health Liaison will work with the Health & Safety Committee and other community stakeholders to plan and execute community convenings that support stronger connections between health, housing, and homeless services providers • The Health Liaison will partner with Willamette Health Council (WHC) and PacificSource to keep MWVHA partners informed on the new Health-Related Social Needs housing benefit for Oregon Health Plan members, and track developments that may impact the MWVHA's potential future role in this space		2025-27
	2.1.7 Increase collaboration with and between public housing authorities.* • Develop a list of key questions to determine how the Alliance can support collaboration among public housing authorities • Conduct interviews with staff from each public housing authority and regional service providers • Identify themes across interviews and create list of collaboration options • Gather representatives from public housing authorities to discuss collaborative options and create an action plan	Executive Director Collaborative Committee Salem Housing Authority	TBD

Measures of success:

a. # of people attending trauma informed trainings and/or social services burnout prevention trainings
b. # of people that attend training HUD required trainings (e.g. domestic violence, safety planning and confidentiality protocols, Emergency Transfer Plan, Equal Access Final Rule, Gender Identity Final Rule, mainstream benefits available for program participants)*
c. Assess the # of CE assessors needed, in general and in underserved communities, annually and make a plan to meet the need* (# assessors needed / # of actual assessors)
d. Establish a goal for the "CE referral to assessment completion rate" and create a plan to meet it
e. Assess racial disparities along six service points (entry into HMIS, Coordinated Entry Assessment, referral to housing, entry into programs, housing move-in date and housing retention) Data source: Race and Ethnicity V4.0*
f. Plans created (e.g. crisis communication plan; plan to integrate healthcare, housing and domestic violence services; plan to increase public housing authority collaboration)

**Required by HUD*

Goal #2: Develop and improve a coordinated system of care and services – continued

Objectives	Actions	Lead Alliance Staff / Committee	Time
2.2 Expand service providers' ability to offer everyone a safe place to sleep and a path to stable housing:	2.2.1 Increase the continuum of shelter and housing options available to meet an individual's needs: • Assess the amount of currently available shelter options, using 2024 Housing Inventory County as a reference point. • Compare availability to need and determine gaps (Sources to review: Annual regional needs assessment/gaps analysis, Housing Inventory Count, PIT Count, LSA data, HMIS data) • Create plan to address the gaps: ○ Plan components may include: proactively seek funding to expand shelter options as determined by need, expand Long-Term Rental Assistance, align Coordinated Community Plan to End Youth Homelessness with overall plan, engage with public housing authorities on affordable housing development • Using this plan, inform funding decisions, partnerships, advocacy and more. • Revise annually Shelter and housing options: safe parking, emergency shelter (e.g. congregate, hotels, hotel vouchers, shelters dedicated to youth/young adults), confidential/domestic violence shelter, low-barrier shelters, seasonal shelters, transitional housing (for adults, families, and youth/young adults), rapid rehousing, permanent supportive housing, other permanent housing, community based long-term care, and affordable housing.	Executive Director HMIS Specialist	TBD
	2.2.2 Increase services, shelter and housing options for special populations: • Assess the services available for and designed to serve special populations: (a) Collaborate with the region's 14 school districts and their McKinney-Vento liaisons to share and analyze data and expand case management capacity. (b) Assess the needs of domestic violence survivors, make a plan to sustain current services and grow to meet the need. (c) Assess access to supportive services and mainstream resources through a racial equity lens. • Compare availability of services, shelter and housing to need and determine gaps • Create plan to address the gaps, starting with updating Coordinated Community Plan to End Youth Homelessness (e.g. update workplan with what has been accomplished to date, what is still outstanding, identify additional resources needed) • Using this plan, inform funding decisions, partnerships, advocacy and more. Special populations: Chronically homeless, Youth and Young adults, Families, Veterans, Medical respite/discharge, Physical/mental disabilities, Domestic violence survivors, LGBTQIA+, Culturally specific populations, Seniors, Rural	Health and Homelessness Systems Liaison	TBD
	2.2.3 Per the FY2024 Consolidated application, annually assess the Alliance's progress toward achieving the desired outcomes of HUD's System Performance measures*:	HMIS Data Analyst	2026

**Required by HUD*

	• Use LSA and Stella P to identify pathways most in need of improvement • Expand duration shelters and implement more robust case management housing navigation, health care and mental health services • Coordinate with case management for people who enter rapid rehousing programs with stays at emergency shelter • Expand rental assistance for RRH clients through LTRA with a goal of exiting to permanent housing when possible, freeing up services for new households • Incorporate innovative ways to house youth and young adults exiting from the streets and shelters (e.g. YHDP Transitional Housing Rapid Rehousing Project, Youth Voucher Housing for youth exiting foster care system)		

Measures of success:

g. Set a goal for occupancy rate for year-round facility-based beds, including specific goals for emergency shelter, transitional housing and permanent housing, track annually*

h. Create a plan for how the Alliance will increase HMIS bed coverage rate to at least 85% (HUD defined metric). Current rates: Emergency Shelter = 76%, Transitional Housing = 37% and Permanent Supportive Housing = 40%.

i. Analyze voucher use by special populations (e.g. X% of vouchers in use by special populations, goal is Y%)

j. Progress is achieved toward desired outcomes of HUD's System Performance Measures:*

Measure 1: Length of Time Persons Remain Homeless

Desired Outcome: Reduction in the average and median length of time persons remain homeless

Measure 2: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness within 6, 12, and 24 Months

Desired Outcome: Reduction in the percent of persons who return to homelessness

Measure 3: Number of Homeless Persons

Desired Outcome: Reduction in the number of persons who are homeless

Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

Desired Outcomes: Increase in the percentage of adults who gain or increase income

Measure 5: Number of Persons who Become Homeless for the First Time

Desired Outcome: Reduction in the number of persons who become homeless for the first time

Measure 6: Homelessness Prevention and Housing Placement of Persons Defined by Category 3 of HUD's Homeless Definition in CoC Program-funded Projects

Desired Outcome: Reduction in the percentage of Category 3 people who return to homelessness

Measure 7: Successful Housing Placement

Desired Outcome: Increase in percentage of people who exit street outreach to permanent housing, temporary destinations (except street), and some institutional destinations

Desired Outcome: Increase in percentage of people who exit to or retain permanent housing

**Required by HUD*

Goal #2: Develop and improve a coordinated system of care and services – continued

Objectives	Actions	Lead Alliance Staff / Committee	Time
2.3 Build community capacity to prevent homelessness:	2.3.1 Examine best practices in prevention, share broadly with community partners and create plan for local implementation. • For example, share practical examples for how other CoC's implement the National Alliance to End Homelessness Prevention Guide's five basic homelessness prevention principles: crisis resolution, client choice respect and empowerment, provide the minimum assistance necessary for the shortest time possible, maximize community resources, and the right resources to the right people at the right time.	Executive Director	TBD
	2.3.2 Support community-wide efforts to prevent homelessness: • Create list of currently available prevention resources and educate CoC service providers • Assess gaps between availability of and need for prevention resources (e.g. assistance with expenses (medical, car repair, eviction prevention, utilities, rent, childcare, transit); assistance accessing benefits; displaced worker programs; self-sufficiency programs), especially for special populations • Identify resources to fill the gap • Secure resources, implement and evaluate	Executive Director	TBD
	2.3.3 Increase availability of case management for people in affordable housing units or using housing vouchers: • Assess number of people in affordable housing/using vouchers that are not receiving case management • Identify available and needed resources to support expanding case management • Identify potential safety risks (e.g. domestic violence, substance abuse) • Identify service providers capable to assume increased case management responsibilities • Secure resources and implement	Executive Director	TBD
	2.3.4 Educate, support, and provide incentives to landlords to keep or make housing affordable: • Identify best practices in landlord incentives and customize list for local implementation • Secure resources to support implementation • Create an outreach and education plan to inform landlords of available incentives • Implement plan and evaluate	Executive Director	TBD

**Required by HUD*

	2.3.5 Engage our community's systems (childcare, service integration, education, healthcare) in preventing homelessness: • Share information about proven homeless prevention models broadly with community partners, organizations, government agencies, community members and more • Increase utilization of supportive services in combination with housing supports to prevent homelessness with a focus on increasing access to prevention services for special populations	Executive Director HS Committee Collaborative Committee	TBD

Measures of success:

l. # of households provided with eviction prevention resources

m. # of landlords engaged in the homeless services system (e.g. housing RRH clients)

n. Increase case management for people in affordable housing or on vouchers (e.g. LTRA program)

Goal #3 Maximize resources: The Alliance maximizes resources that support ending and preventing homelessness through solicitation, leverage, and strategic investments.

Objectives	Actions	Lead Alliance Staff / Committee	Time
3.1 Seek new resources to end and prevent homelessness.	3.1.1 Conduct a comprehensive search of local, state and federal funding streams that are aligned with the Alliance's purpose to end and prevent homelessness 3.1.2 Strategically apply to funding opportunities, focusing on opportunities that increase access to resources for special populations 3.1.3 Track success	Executive Director	Annually
3.2 Coordinate existing funding streams to make more efficient and effective use of resources.	3.2.1 Examine existing funding streams (CoC, ESG, SSVF, GPD, DHS/YEHP, OHCS, IHA, CDBG, HOME) for opportunities to increase coordination and leverage 3.2.2 Present potential coordination options to partners (e.g. service providers, regional public housing authorities) 3.2.3 Implement as appropriate	Executive Director	Annually
3.3 Secure resources that support service integration and wrap around supports (e.g. services that increase income and/or employment skills).	3.3.1 Conduct a comprehensive search of local, state and federal funding streams that support service integration and wrap around supports 3.3.2 Evaluate the most strategic lead applicant for identified funding streams: • If the Alliance is the most strategic lead applicant, solicit service providers as co-applicants • If a service provider is the ideal lead applicant, offer letters of support, data, etc.	Executive Director	Annually
3.4 Leverage resources for CoC partners by serving as the CoC's fiscal agent, providing CoC coordination, and fostering collaborative partnerships.	3.4.1 Create a fact sheet that describes how the Alliance can support service provider's acquisition of resources 3.4.2 Educate service providers on available support 3.4.3 Provide support to service providers as requested 3.4.4 Track resources obtained by service providers where the Alliance served as fiscal agent or collaborative partner	Executive Director Administration and Communication Specialist	Annually
3.5 Support homeless services	3.5.1 Invite PacificSource to present to HS Committee and the Alliance Board of directors on the HRSN program and its implementation	HHS Liaison	2025

**Required by HUD*

provider participation in the HRSN program	3.5.2 Educate service providers about how to bill Medicaid for supportive housing services 3.5.3 Annually evaluate the participation of service providers in the HRSN program 3.5.4 Create a plan to increase participation, as appropriate 3.5.5 Examine service provider's utilization of HRSN dollars to inform utilization of local dollars to support populations not eligible for HRSN funding	HS Committee	
3.6 Lead the Alliance resource allocation process through a data-driven and values focused lens*	3.6.1 Review all NOFOs and RFPs through its values of collaboration, stewardship, inclusion, compassion, leadership, commitment and adaptability and the data in the annual needs assessment/ gaps analysis 3.6.2 Works to ameliorate barriers to applying to the Alliance resource allocation process for culturally specific organizations and other organizations representing special populations 3.6.3 Create a process for measuring grantee and Alliance performance to determine system-wide gaps in services, deficiencies in performance, and inform allocation of resources 3.6.4 Alliance conducts annual monitoring of individual grantees to (1) ensure compliance; (2) track grantees progress toward deliverables; and/or (3) create improvement plans as appropriate	Executive Director HMIS Specialist Alliance Board	Ongoing

Measures of success:

a. Amount of funds secured by the Alliance to end and prevent homelessness
b. # of homeless services providers participating in HRSN program
c. Increase # of culturally specific organizations and others serving special populations that respond to Alliance RFPs
d. System for measuring grantee and Alliance performance is created and updated annually to inform allocation of resources

**Required by HUD*

Goal #4: Increase participation in the Alliance: Because homelessness touches every corner of our community, we need vast representation from across our region to solve it.

Objectives	Actions	Lead Alliance Staff / Committee	Time
4.1 Reach out to all parts of our region to increase Alliance participation from cities, counties, tribal nations, public health departments, nonprofit service providers, mental health providers, healthcare providers, schools, faith communities, those with lived experience, youth and young adults, community members, culturally specific organizations, and more.*	4.1.1 Identify gaps in Alliance engagement: • Create complete list of people and organizations currently engaged in the Alliance's work (Sources: FY2024 CoC Application and MWVHA committee membership lists) • Using a racial equity and data driven lens, identify gaps in representation and engagement in order to ensure invitation and inclusion of Alliance participation is reflective of the community • Ensure schools and youth serving organizations are well represented both in Salem and in rural areas (e.g. school counselors, McKinney Vento Liaisons, teachers, social workers, The Gate, The Kroc, YMCA, Boys & Girls Clubs, Youth Era, Job Corp) • Create list of potential organizations and people to recruit with a focus on board and committee membership becoming more representative of our community in race/ethnicity, geography and special populations. 4.1.2 Create outreach plan • Determine appropriate method for engaging identified list of people and organizations 4.1.3 Implement outreach plan 4.1.4 Annually evaluate results and revise	Executive Director Collaborative Committee	Annually
4.2 Create spaces for people to genuinely engage, gain understanding about our community's needs and services, and be part of creating community solutions.	4.2.1 Develop opportunities to increase community understanding of and engagement in ending and preventing homelessness (e.g. informal gatherings of service providers, subcommittees of the Collaborative Committee, existing community meetings, annual Alliance summit of the year's accomplishments and future goals) 4.2.2 Using a racial equity lens, create messages and activities for these opportunities to promote genuine engagement around community needs/services and solutions 4.2.3 Implement and evaluate	Executive Director Collaborative Committee	Annually

Measure of success:

a. # of individuals or organizations engaged in Alliance work increases
b. # of individuals or organizations representing special populations (e.g. youth, young adults, BIPOC, survivors of domestic violence) engaged in CoC work increases*

**Required by HUD*

2025-2030 Strategic Plan Dashboard

	Baseline~	2025	2026	2027	2028	2029
Goal 1: Understand our community:						
a. 100% of required local, state, and national reports (APRs, CAPERs, LSA, SPMs, etc.) submitted on time*	100%					
b. 95% data completeness of Universal Data Elements as tracked via APR, CAPER and Data Quality report*	XX%					
c. Able to submit sheltered (annually) and unsheltered (bi-annually) PIT Count*	Yes					
d. Standard method for sharing PIT Count data and trends with the community is developed	NA					
e. # of listening sessions or key informant interviews conducted (facilitated by the Alliance or partners), highlighting # of underrepresented groups participating in listening sessions (# of sessions / # of groups)	# / #					
f. Standard set of quantitative and qualitative data is developed	NA					
g. Complete annual needs assessment (AKA gaps analysis), incorporating quantitative and qualitative data*	11/2023					
h. # of times the annual gaps analysis / needs assessment report is viewed increases annually	NA					
Goal 2: Develop and improve the coordinated system of care and services						
a. # of people attending trauma informed or social services burnout prevention trainings	#					
b. # of people that attend training HUD required trainings (e.g. domestic violence, safety planning and confidentiality protocols, Emergency Transfer Plan, Equal Access Final Rule, Gender Identity Final Rule, mainstream benefits available for program participants)*	#					
c. Assess the # of CE assessors needed, in general and in underserved communities, annually and make a plan to meet the need* (# assessors needed / # of actual assessors)	# / #					
d. Establish a goal for the "CE referral to assessment completion rate" and create a plan to meet it.	XX%					
e. Assess racial disparities along six service points (entry into HMIS, Coordinated Entry Assessment, referral to housing, entry into programs, housing move-in date and housing retention) Data source: Race and Ethnicity V4.0*	# / #					
f. Plans created (e.g. crisis communication, healthcare/housing integration, housing authority collaboration)	NA					
g. Set a goal for occupancy rate for year-round facility-based beds, including specific goals for emergency shelter, transitional housing and permanent housing, track annually*	X% ES X% TH X% PH					
h. Create a plan for how the Alliance will increase HMIS bed coverage rate to at least 85% (HUD defined metric).	76% ES 37% TH 40% PH					
i. Analyze voucher use by special populations (e.g. X% of vouchers in use by special populations, goal is Y%)	X% / Y%					
j. Demonstrate improvement toward the desired outcomes of HUD's System Performance Measures:						
j.1. Reduction in the average and median length of time persons remain homeless						

**Required by HUD*

j.2. Reduction in the percent of persons who return to homelessness						
j.3. Reduction in the number of persons who are homeless						
j.4. Increase in the percentage of adults who gain or increase income						
j.5.Reduction in the number of persons who become homeless for the first time						
j.6. Reduction in the percentage of Category 3 people who return to homelessness						
j.7. Increase in percentage of people who exit street outreach to permanent housing, temporary destinations (except street), and some institutional destinations	10% ES 44% TH 50% PH					
j.8 Increase in percentage of people who exit to or retain permanent housing						
k. # of households provided with eviction prevention resources	#					
l. # of landlords engaged in the homeless services system (e.g. housing RRH clients)	#					
m. Increase case management for people in affordable housing or on vouchers (e.g. LTRA)	# FTE					
Goal 3: Maximize resources:						
a. $ secured by the Alliance to end and prevent homelessness	$					
b. # of homeless services providers participating in the HRSN program	#					
c. Increase # of culturally specific organizations and others serving special populations that respond to Alliance RFPs	#					
d. System for measuring grantee and Alliance performance is created and updated annually to inform allocation of resources	NA					
Goal 4: Increase participation in the CoC:						
a. # of individuals or organizations engaged in CoC work increases	XX					
b. # of individuals or organizations representing special populations (e.g. youth, young adults, BIPOC, survivors of domestic violence) engaged in CoC work increases*	XX					

~Note about baseline data: Due to transition in Alliance leadership, not all baseline data was able to be gathered before the publication of this document.

NA = not applicable or not started yet

**Required by HUD*

Conclusion

A strategic plan is a powerful tool. It clarifies vision, reveals values, sets goals, and spurs action. This plan reflects the desire of the Mid-Willamette Valley Homeless Alliance and its partners to move the needle on its purpose to ***end and prevent homelessness***. Dozens of community stakeholders provided input on the vision, values, goals, objectives and actions in this plan. To that end, this plan is a living document. As the implementation plans begin to unfold, the plan should be reviewed and updated annually. When it becomes clear which data points are valuable for the Alliance to track its success, the data dashboard should be updated as well. Some of the work in this plan is aspirational and will require the Alliance to build its infrastructure to accomplish it and/or more community partners will need to take the lead.

Appendix

History of the Alliance

The Mid-Willamette Homeless Initiative (MWHI) began in 2016 as a collaborative effort by the cities of Salem and Keizer and Marion and Polk counties. During 2016-17, a task force and eight subcommittees worked diligently on a strategic plan to identify and launch proven strategies to reduce homelessness in the Marion-Polk county region. Task force members included business and community leaders with expertise in social services, housing, public safety, and business. After the task force produced its strategic plan and dissolved in February 2017, Marion County and the cities of Salem, Keizer, Monmouth and Independence, in cooperation with the Mid-Willamette Valley Council of Governments, formed a steering committee and pooled funds to hire a Homeless Program Coordinator to continue the task force's work, which included an in-depth review of the region's participation in the Rural Oregon Continuum of Care (CoC). That work was completed in early 2019. In April 2019, the steering committee began focusing on the effort to form a regional CoC.

Jurisdictions throughout the two-county area provided supporting resolutions, which were submitted with a governance charter, organizational structure, and other documentation required by the U.S. Department of Housing and Urban Development (HUD) to request recognition as a Continuum of Care. In less than two weeks, HUD approved the request and formally recognized the Alliance as the Marion-Polk region's Continuum of Care (CoC).

Prior to being officially recognized by HUD, representatives of the soon-to-be CoC were invited to participate in a national institute and become one of 70 communities (at the time) signed on to the Built for Zero initiative. Kaiser Permanente sponsored the effort, and the Alliance agreed to participate in semi-annual training and monthly technical assistance for the next five years.

The first meeting of the Mid-Willamette Valley Homeless Alliance board of directors was held in February of 2020, followed by the first set of committee meetings in March of 2020. Adapting to the COVID pandemic, all CoC meetings were held virtually for the next two years, and many committees continue to use Zoom as a way to provide geographic access and eliminate travel time.

The first CoC Strategic Plan was approved in June of 2020 and was built off of the MWHI plan, incorporating HUD system performance measures. Based on a new Gaps Analysis, the CoC 5-Year Strategic Plan was approved in July of 2021. Committee action plans were developed to achieve specific goals.

In mid-2020, the Alliance was identified as one of three collective impact initiatives supported by the Community, Business, and Education Leaders (CBEL) Consortium and received $50K per year for three years to support the CoC's work.

In late 2020, the Alliance submitted a collaborative application and secured $5.5M in Covid relief funds through Oregon Housing and Community Services (OHCS) to support 23 different projects provided by ten different organizations for the next two years.

In February 2021, the Alliance hosted its first summit with 109 online participants representing 63 organizations.

In April 2021, the Alliance board receives a report from Willamette University PACE students, summarizing eight months of study assessing diversity, equity, and inclusion in the CoC.

In July 2021, the Alliance board expanded its agency membership to include PacificSource Community Solutions.

In 2021, the Alliance created a youth action board and secured a two-year $3.6M HUD Youth Homelessness Demonstration Program (YHDP) grant and developed a Coordinated Community Plan to End Youth Homelessness (approved in March 2022). The region continues to receive $1.8M annually to support priority projects identified in the plan.

In September 2021, the Alliance submitted its first required Consolidated Application in response to the HUD Notice of Funding Opportunity for Continuum of Care Program. The application was 172 pages long.

In early 2022, the Alliance added two board seats for a total of three voting members with lived experience in homelessness. In 2023, a fourth seat was added for a representative from the youth action board.

In February 2022, the Alliance hosted its second annual summit, with a focus on equity. More than 200 people participated in the online event.

In March 2022, the Alliance approved the Coordinated Community Plan to End Youth Homelessness; the plan was subsequently approved by HUD in April 2022.

In June 2022, the Alliance board approved a list of priority projects to be funded by HUD under the YHDP grant.

In October 2022, the Alliance board approved a Plan to Serve Individuals and Families Experiencing Homelessness with Severe Needs.

In late 2022, the Alliance updated all committee charters, based on recommendations from each committee.

In January 2023, Oregon Governor Tina Kotek declared a state of emergency due to homelessness, launching a call to action and releasing state funding to prevent 8,750 households from becoming homeless, rapidly rehouse 1,200 households, and create 600 new low-barrier shelter beds across the state.

In April 2023, the Alliance board approved its local ALL IN plan, in response to the Governor's executive order. Subsequently approved by the state, the plan provided the basis for the initial $10M to the Alliance to rapidly rehousing 150 unsheltered households and create 79 new low-barrier shelter beds. In total through 2024, the Alliance received more than $27M to sustain and expand emergency order efforts.

In 2023, a number of committees brought significant projects to the Alliance board. In January, the Performance & Evaluation Committee delivered its first annual report to the CoC board. In April, the Diversity, Equity, and Inclusion Subcommittee presented an Equity Lens for board approval. In May, the HMIS Users Workgroup presented the CoC's first HMIS Data Quality Management Plan for

board approval. The CoC board also approved standards for Rapid Rehousing and Permanent Supportive Housing service delivery in 2023.

In mid-2023, the Alliance became its own HMIS Lead Agency, after Oregon Housing and Community Services stepped away from the role.

In May 2023, the Alliance hosted 140 people at an Affordable Housing Conference held at the Salem Convention Center.

In June 2023, the Alliance hired its first executive director, shifting from a consultant-only model to an employee as director. The Alliance board paused the scheduled bi-annual revision of the 5-Year Strategic Plan to allow time for the new director to assess current conditions.

In the fall of 2023, Mid-Willamette Valley Community Action Agency gave notice of its intent to move away from its roles as the HMIS coordinating organization and the Coordinated Entry management organization. The Alliance secured HUD technical assistance to guide the transition to the Alliance assuming those roles directly, rather than through a memorandum of understanding with another entity.

In November 2023, the Alliance board expanded its agency membership to include Willamette Health Council, bringing the number of board members to 25 (18 voting members; 7 non-voting members).

In January 2024, Governor Kotek extended the state of emergency due to homelessness, issuing Executive Order (EO) 24-03. The Alliance had met its goals for EO 23-02 and established a new set of goals for the coming year.

In April 2024, the Alliance board participated in a day-long strategic planning retreat, setting the foundation for a new strategic plan.

In June 2024, the Alliance board approved a Long-Term Rental Assistance Plan, supported by $5.3M in state funding.

In July 2024, the Alliance board revised its organizational chart by making the Health & Safety Subcommittee a committee that reported directly to the board. By charter, this provided staff support to the committee.

In September 2024, having accepted Performance & Evaluation Committee member resignations, appointed a Performance & Evaluation Task Force.

In November 2024, the Alliance accepted the resignation of its executive director, effective December 31, 2024, and began planning for an interim director.

In December 2024, the Alliance board approved revisions to the LTRA Plan.

In January 2025, Governor Kotek extended the state of emergency due to homelessness, issuing Executive Order (EO) 25-01.

Acronyms and Definitions

- APR: Annual Performance Report
- Backbone: Youth Action Board of the MVWHA
- CAPER: Consolidated Annual Performance and Evaluation Report
- CE: Coordinated Entry
- CHA: Community Health Assessment
- CHIP: Community Health Improvement Plan
- CoC: Continuum of Care
- EO: Executive Order
- ES: Emergency Shelter
- HMIS: Homeless Management Information System
- HRSN: Health Related Social Needs
- HHS: Health and Homeless Systems Liaison
- HS: Health and Safety Committee
- HUD: United States Department of Housing and Urban Development
- LSA: Longitudinal Systems Analysis
- LTRA: Long Term Rental Assistance
- MWVHA: Mid-Willamette Valley Homeless Alliance
- NOFO: Notice of Funding Opportunity, specifically the CoC Program NOFO
- PE: Performance & Evaluation Committee
- PH: Permanent Housing
- PIT Count: Point in Time Count
- RFP: Request for Proposal
- RRH: Rapid Re-Housing

- SPM: System Performance Measures. HUD's System Performance Measures are best practice for tracking desired outcomes towards reducing homelessness. They include seven measures and each has a correlated desired outcome:
    - Measure 1: Length of Time Persons Remain Homeless
        - Desired Outcome: Reduction in the average and median length of time persons remain homeless
    - Measure 2: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness within 6, 12, and 24 Months
        - Desired Outcome: Reduction in the percent of persons who return to homelessness
    - Measure 3: Number of Homeless Persons
        - Desired Outcome: Reduction in the number of persons who are homeless
    - Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects
        - Desired Outcomes: Increase in the percentage of adults who gain or increase income
    - Measure 5: Number of Persons who Become Homeless for the First Time
        - Desired Outcome: Reduction in the number of persons who become homeless for the first time
    - Measure 6: Homelessness Prevention and Housing Placement of Persons Defined by Category 3 of HUD's Homeless Definition in CoC Program-funded Projects
        - Desired Outcome: Reduction in the percentage of Category 3 people who return to homelessness
    - Measure 7: Successful Housing Placement
        - Desired Outcome: Increase in percentage of people who exit street outreach to permanent housing, temporary destinations (except street), and some institutional destinations
        - Desired Outcome: Increase in percentage of people who exit to or retain permanent housing
- Special Populations: Chronically homeless, Youth and Young Adults, Families, Farmworkers, Veterans, Medical respite/discharge, persons with physical/mental disabilities, survivors of Domestic violence, survivors of human trafficking, LGBTQIA+, Culturally specific populations, Seniors, Rural communities
- Stella P: Stella Performance is a data visualization of the Longitudinal Systems Analysis (LSA) dataset to help communities understand how their homeless response system has been performing on critical performance measures.
- TH: Transitional Housing
- VI SPDAT: Vulnerability Index – Service Prioritization Decision Assistance Tool
- WHC: Willamette Health Council