

The Way Home

Steering Committee

November 2026



This Photo by Unknown Author is licensed under CC BY-SA

Meeting Agenda

Meeting Introduction

- Call to order
- Housekeeping
- Roll call of Steering Committee members

Meeting Business

- Thank you to Outgoing Provider Representatives
- Voting on At-Large Candidates

System Updates

- CoC Lead Agency Updates
- PIT Count Plans
- CE Updates
- Community Plan Update
- Volunteer Houston Opportunities

Meeting Wrap-Up

- Public Comment
- Meeting Adjourn

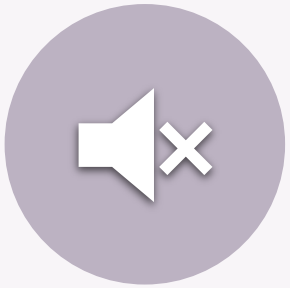
Supporting Materials

- Draft Community Plan

Housekeeping



Partners will not be called during attendance. Partner participation is being monitored through the Zoom webinar platform.



Participants will be muted throughout the meeting. Those wishing to provide a verbal comment may do so once the Chair has opened public comment.



Participants can ask their questions through the Q&A tab found in the menu toolbar.



Participants are encouraged to use Reactions (found in the menu toolbar) throughout the meeting.



This Veterans Day, we recognize the courage, service, and sacrifice of the men and women who have served in the United States Armed Forces. We are grateful for the contributions of our veteran colleagues and their continued impact on our community.

Meeting Business

Items Requiring Vote of the CoC Steering Committee





Thank You, Alexis and Shun!

With heartfelt appreciation for 2.5 years of dedicated service and leadership on the Steering Committee.

Their thoughtful perspectives compassion, and willingness to step forward have strengthened our Board and our system. From shaping Board leadership and supporting nominations to informing key decisions and our next Community Plan, their contributions have made a lasting impact.

Thank you for your leadership, commitment, and service to our community, Alexis and Shun!



THE WAY HOME STEERING COMMITTEE

The Way Home Steering Committee serves as the decision-making body of The Way Home Continuum of Care (CoC), the coordinated Homeless Response System throughout the Greater Houston region, including Harris, Fort Bend, and Montgomery counties of Texas.

PROPOSED RESOLUTION

Resolution No.: Resolution 9. Nomination of Slate of New Members

Date Proposed: Thursday, November 12, 2026

Category: Steering Committee Membership

BACKGROUND

WHEREAS, the Steering Committee of The Way Home Continuum of Care (CoC) serves as the governing board for the regional homeless response system across Harris, Fort Bend, and Montgomery Counties of Texas, providing strategic guidance, oversight, and accountability;

WHEREAS, Steering Committee members represent a broad and diverse cross-section of stakeholders, bringing professional expertise, lived experience, and community-based knowledge to support the CoC's mission of ending homelessness;

WHEREAS, the Nominations Subcommittee and Lead Agency conducted a targeted recruitment process to identify individuals who reflect community needs and priorities, with particular emphasis on representation from the workforce development and criminal justice/reentry sectors, as well as individuals with lived experience of homelessness; and

WHEREAS, the Nominations Subcommittee and Lead Agency reviewed applications, conducted interviews, and recommended a slate of qualified and committed individuals for Steering Committee membership for the December 2026 – November 2028 term.

RESOLVED:

NOW, THEREFORE, BE IT RESOLVED, that the Steering Committee of The Way Home Continuum of Care approves the following individuals to serve as new members for a two-year term beginning December 2026 and ending November 2028:

- Michelle Paul, Capital IDEA Houston
- Liliana Rambo, SERJobs

Adopted by the Steering Committee on: Thursday, November 12, 2026

SIGNATURES:

_____ _____

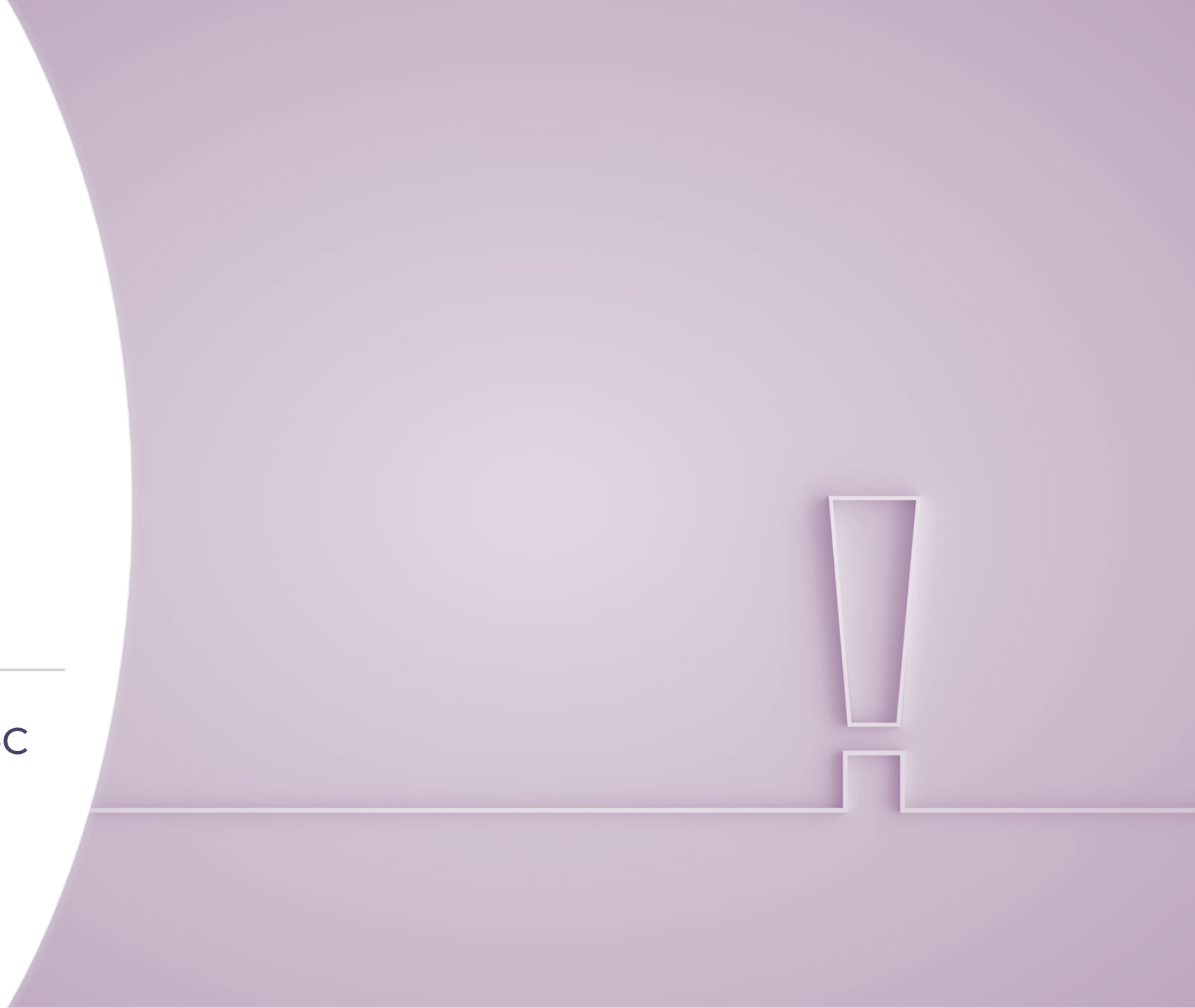
(Vice) Chair, The Way Home Steering Committee Date

_____ _____

Secretary, The Way Home Steering Committee Date

CoC Lead Agency Updates

General Updates for the CoC Steering Committee and Partners of The Way Home



THE WAY HOME · NOVEMBER 2026

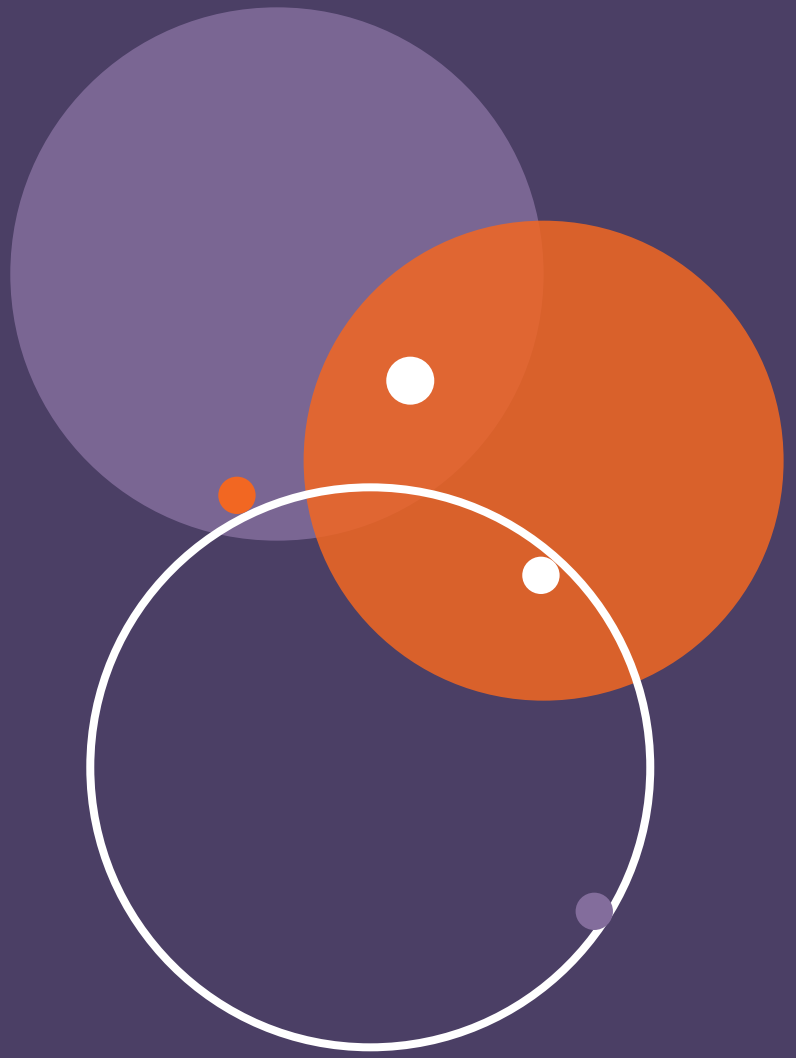
From Individual Programs to a Stronger Continuum

Strengthening Our Continuum of Care

CoC Portfolio, Partner Alignment & 2027 System Priorities

Steering Committee briefing

Presented by the Coalition for the Homeless of Houston/Harris County



Strong individual programs matter. How those programs connect, and what happens to people across them, matters just as much.

COC PORTFOLIO

Understanding the Resources We Have Today

The strength of our CoC is not simply how much funding comes into the community. It is how effectively we use those investments together.

Local strategy prioritizes protecting existing Permanent Supportive Housing.

$72.84M

FY2026 CoC Grant Inventory Worksheet

58

Grants for housing, supportive services and system infrastructure

4,957

Beds in the FY2025 application-based working inventory

Locally proposed FY2026 changes, not final HUD awards

- Full project reallocations
- Shifts from Rapid Rehousing and other housing models toward Transitional Housing
- YHDP youth project replacements
- New proposed investments in employment, recovery, behavioral health, outreach and supportive services

The shift toward Transitional Housing is potential. It depends on awards.

Investment → **Housing capacity →** **Services →** **Community outcomes**

OUTCOMES

Measuring What Changes for People

Program level

- Individuals served and services delivered
- Enrollment and completion
- Beds and units funded
- Individual project outcomes

Across the system

- Housing stability over time
- Movement between programs
- Employment, income and recovery outcomes
- Returns to homelessness and length of time homeless
- Long-term stability

What happens to people as they move through our system, and are our collective efforts creating lasting outcomes?

If the proposed shift toward Transitional Housing is awarded, it could potentially affect permanent housing placements, housing retention, returns to homelessness, and length of time homeless, including over the longer term.

PARTNER ALIGNMENT

Strong Partners. Stronger Coordination.

We do not always need to build something new to accomplish something new. Sometimes the opportunity is to better connect and strengthen what we already have.

CFTH, as CoC Lead Agency, coordinates organizations, resources and expertise across The Way Home.

Referral pathways · coordinated services · shared training · technology · operational supports · voluntary partnerships

The goal is not to limit innovation or new organizations.

New organizations are welcomed with a path to learn from established partners, through shared training, peer connections and coordinated referrals.

Shared community outcomes

Organizations of all sizes

Resources

Expertise

THE NEXT 90 DAYS

Listening, Learning, and Identifying Opportunities

Before determining where we can better align as a system, we want to understand where our partners are headed and what they do best.

NOVEMBER 2026	DECEMBER 2026	JANUARY 2027
Connect	**Learn**	**Align**
Begin meetings with CoC-funded agencies. Review strategic plans when available. Understand mission, strengths and priorities.	Continue conversations. Identify common priorities and challenges. See where services and investments intersect. Explore stronger coordination.	Summarize themes. Identify collaboration and shared supports. Connect priorities to 2027 system goals. Report high-level themes to CoC leadership.

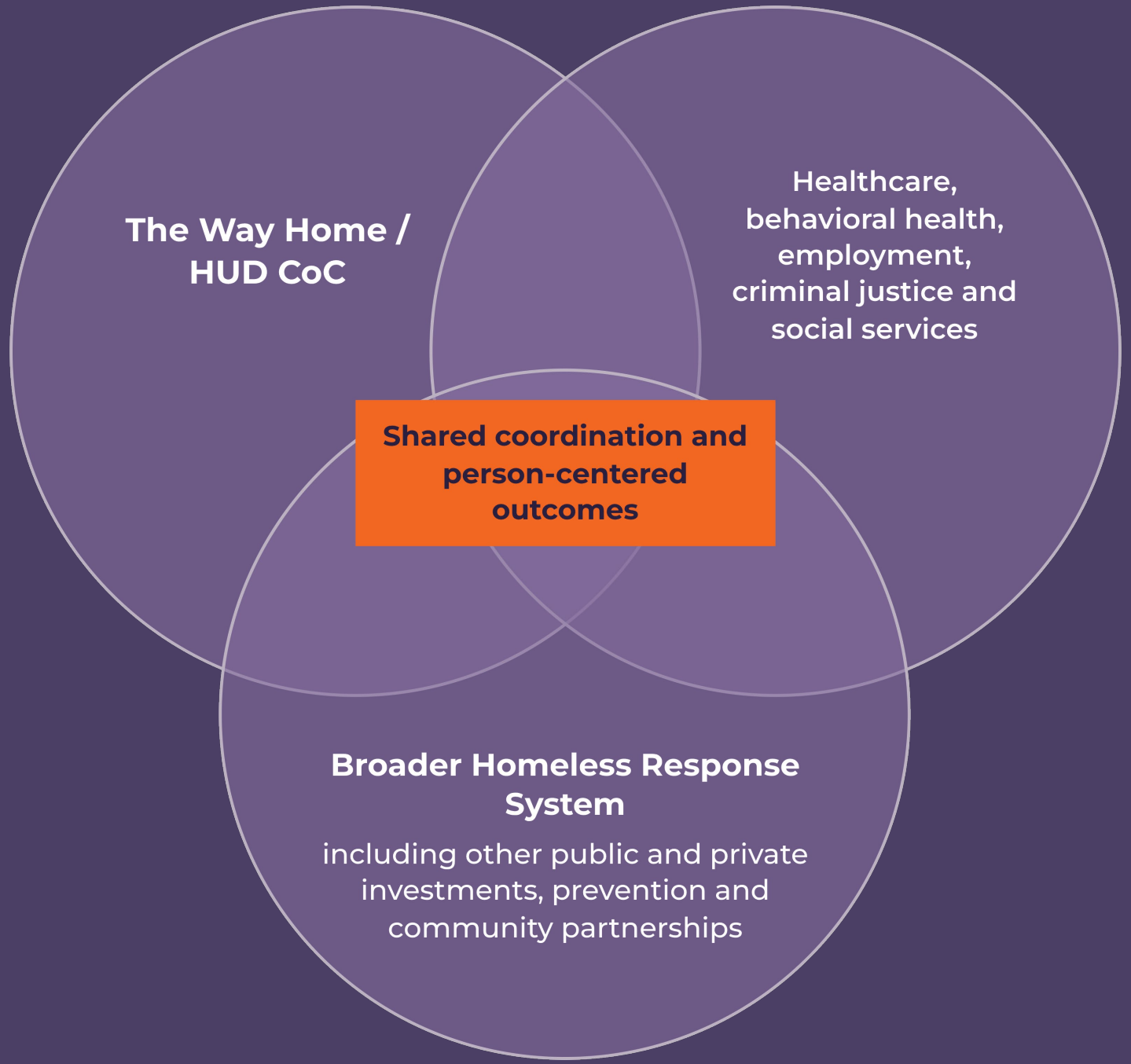
Not monitoring visits, compliance evaluations or funding announcements.

LONGER-TERM OPPORTUNITY

The Way Home Is Part of a Larger Homeless Response System

Experience with providers, shared data, access, prioritization and performance measurement may offer lessons for connecting other community systems.

We have learned a great deal about coordinating a regional response to homelessness. There may be opportunities to apply those lessons more broadly to support our community as a whole.



Building a Stronger Continuum, Together

Over the next few months: understand our partners, where they want to go, and how we can connect the work across our Continuum.

We want to continue building a system where:

- Organizations are recognized for their unique strengths and contributions.
- Partners collaborate and build on existing expertise.
- People experience connected pathways rather than fragmented services.
- Public and private investments are coordinated to improve outcomes.
- The system is accountable for meaningful and lasting results.
- Lessons from The Way Home inform broader community coordination.

Our goal is to spend more time understanding our partners, where they want to go, and how we can better connect the work across our Continuum. We have strong organizations doing important work, and our opportunity is to make sure those efforts add up to the greatest possible impact for the people and communities we serve.

PIT Count Plans

COMMUNITY PARTICIPATION

2027 Point-in-Time Count

FEBRUARY 2027

23–25

23	24	25	26

Harris, Fort Bend and Montgomery counties

Backup date February 26, if needed

Volunteer Registration Opening Soon

Expected later in November 2026.

Staging Locations Needed

Day 2, February 24: west of I-45 / Sam Houston Tollway

Day 3, February 25: east of I-45 / Sam Houston Tollway

Ideal sites open by **6:00 AM**, hold about **50+ volunteers**, offer indoor gathering space and parking, and serve as a central meeting location.

Help spread the word about volunteer registration.

Contact CFTH if your organization could host a staging location.

CE Updates

Coordinated Entry Assessment Updates

STEERING COMMITTEE NOTIFICATION / RESOLUTION 6

Adopted July 23, 2026 • 90-day language adjustment period ended October 21, 2026

ORIGINAL RECOMMENDATION	FINAL IMPLEMENTATION LANGUAGE	REVIEW NOTES
Desired Housing County → Current County	**Current County**	Matches approved recommendation. Hover-over guidance includes expanded definitions and examples.
Are you homeless or do you remain homeless because someone is hurting you?	**Did you become homeless or do you remain homeless because of domestic violence, such as family violence, an abusive relationship, assault, or trafficking?**	Same as approved.
Has someone asked (or forced) you to have sex or sell anything in exchange for something?	**Has someone asked you to have sex, or forced you to do anything, in exchange for something?**	Minor wording refinement. Hover-over guidance includes expanded definitions and examples.
Do you have any tickets with the City of Houston?	**Do you have any tickets with the city of Houston?**	Original wording retained. Hover-over guidance includes expanded definitions and examples.
How many times in the past year have you been arrested or been in jail/prison/juvenile detention?	**Have you been arrested or incarcerated in the past year? If yes, how many times?**	Same as approved. Hover-over guidance includes expanded definitions and examples.
Have you ever been involved in the foster care system?	**When under the age of 18, were you ever in an out-of-home placement?**	Broader than proposed foster-care question. Hover-over guidance includes expanded definitions and examples.
Do you currently have any income?	**Do you have any money coming in right now from any source?**	Same core wording; monthly follow-up not shown. Hover-over guidance includes expanded definitions and examples.
How many times in the past 6 months have you accessed medical services in the ER?	**How many times in the past 90 days, have you received emergency room care or crisis intervention services?**	Minor wording refinement. Hover-over guidance includes expanded definitions and examples.
Recommendation: remove as repetitive	**Have you been homeless in the past?**	Retained following implementation review. Confirmed not asked elsewhere; because it carries prioritization points, retained to preserve identification of potentially vulnerable households.
Addition: Have you been evicted or broken a lease in 7 years?	**Have you been evicted or broken a lease in 7 years?**	Only approved weighted addition. YHSI Committee recommended 1 point.

OUR TECHNOLOGY PARTNERSHIP

CFTH and Fortell

Fix the front door, and everything behind it starts to move.

Fortell

AI-powered intake and engagement platform

24/7 Web screening and a phone-based digital agent, with automated HMIS data entry.

CFTH

Local workflow design and oversight

Defines screening rules, tests the tools and monitors data quality with Fortell.

Human oversight remains central

Local policy governs eligibility, prioritization and referrals. HMIS remains the system of record.

THE WAY HOME

Coordinated Entry

HOMELESSNESS PREVENTION WORKFLOW

A coordinated, person-centered approach to connect households at risk of homelessness to available resources.

We're not asking agencies to have an entirely new conversation. We're creating a consistent way to capture the converstations already happening, connect households to resources, and **better measure how our system is responding.**

1 HOUSEHOLD NEEDS HELP

Anyone at risk of homelessness can access Coordinated Entry 24/7.

- **Online Screening** *(Webform)*
- **Phone** (24/7)
- **In-Person** (at agency's discretion)

2 INTAKE & ASSESSMENT

The household completes a brief Coordinated Entry intake and assessment, which collects information about their situation and identifies potential program eligibility.

- Housing situation
- Household needs
- Eligibility screening
- Consent

3 REAL-TIME ENTRY INTO HMIS

The completed information feeds directly into HMIS, and when immediate referral is unavailable, the household is added to the **Homelessness Prevention By-Name List.**

Households unable to be connected within 7 business days will be notified and provided alternative resources.

4 DYNAMIC MATCHING & REFERRAL

The By-Name List is dynamic. Households can be connected to resources in two ways:

Lead Agency Refers
The lead agency reviews the By-Name List and refers households to appropriate programs based on eligibility, priority and availability.

— OR —

Providers Search & Self-Select
Participating Homeless Prevention programs can scan the By-Name List for households that match their eligibility criteria and capacity.

5 HOUSEHOLD CONNECTED TO A PROGRAM

The household is referred to (or self-selected by) an eligible Homelessness Prevention program.

- Agency completes program enrollment
- Confirms eligibility and documentation
- Provides assistance and problem-solving support
- Outcomes are tracked in HMIS

WHY COORDINATED ENTRY WORKS FOR EVERYONE

More than a box to check — Coordinated Entry creates a stronger, more efficient system for households, providers, and funders.

FOR HOUSEHOLDS

- 24/7 access, multiple ways to connect
- A consistent, fair and transparent process
- Assessed for multiple resources with one intake and assessment

FOR PROVIDERS

- Less time on initial screening
- More time for problem-solving
- Multiple pathways to find eligible households that match your program
- Reduced duplication of effort

FOR FUNDERS

- Greater visibility of demand and capacity across all programs and funding streams
- Reduced risk of underutilized funds
- Maximize impact of limited resources
- Strengthen community coordination

The Way Home

PILOT SNAPSHOT

Early Pilot Evidence

≈200

At Risk households completed screening and intake

September–December 2026

Controlled pilot to prepare for public access



Initial monitoring

The memo reports no major operational breakdowns or significant initial data-quality issues.

Preliminary operational evidence

OPTIONAL DEMONSTRATION

Testing access points

Phone-based digital agent

(925) 709-7727

Passcode 6041

Use fictional information only

TWH Homeless Prevention Screener

Open web screener



Update & Next Steps

Purpose of the Community Plan

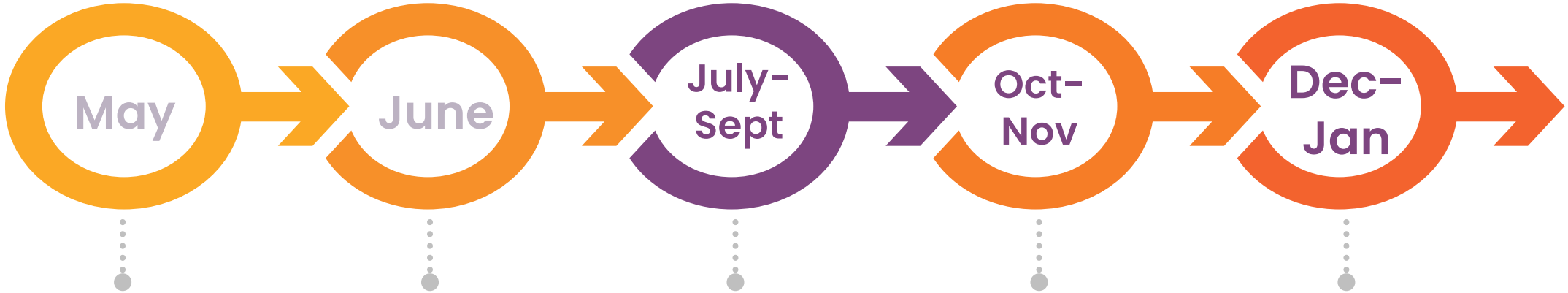
The Way Home is developing its next Community Plan to guide regional efforts to prevent and end homelessness through 2029.

Grounded in community engagement, data, lived expertise, and partner collaboration, the plan will define a shared vision and roadmap for the future.

The Community Plan outlines the goals, strategies, and investments needed to:

- Prevent and reduce homelessness
- Strengthen the homeless response system
- Improve outcomes for individuals and families across the region
- Drive coordinated action across the region

Community Plan Development Anticipated Timeline



Existing Trends & Data Analysis

The University of Houston research team reviewed PIT, HIC, and SPM data to inform the community planning process.

Stakeholder Engagement

Nine stakeholder engagement sessions gathered system-wide input to guide the drafting of the plan.

Drafting

The University of Houston research team, CFTH, and the Steering Committee complete a draft community plan.

Community Feedback

The draft plan is posted for public comment, inviting stakeholders to share feedback.

Plan Adoption

The plan is finalized and voted on for adoption.

Public Comment Engagement



20 Submissions for Public Comment



40+ Community Members Reached

Selected Vision Statement: A Community Moving Together

We will carry forward the collaboration that has changed our community, grounded in a shared commitment to work together. Our next chapter builds on that commitment by preventing housing crises, making help easier to find, and opening more pathways to stable homes. Together, with people who have experienced homelessness helping lead the way, we will build a future of shared responsibility where homelessness is rare, brief, and nonrecurring.

Public Comment Engagement Recommendations

Overall Findings:

- The community expressed that the community plan demonstrates a foundation for future implementation efforts and reflects the needs of the community.
- Additionally, they've provided recommendations to include more often overlooked special population and to improve clarity throughout the plan.

Next Steps and Action Items

We've reviewed the plan for clarity and repetition and are including a more detailed implementation timeline.

We are exploring what additional data is available to add to the plan and add to how the goals connect to special populations.

Implementation and Action Plans

1

Develop Action Plans: Translate the five Community Plan goals into workplans with designated leads, partner responsibilities, resources, timelines, and measurable outcomes

2

Align Community Partners:

Coordinate TWH agencies, public systems, funders, healthcare, housing, and workforce partners around shared priorities, & responsibilities

3

Establish Implementation Milestones:

Set annual benchmarks, identify funding and infrastructure needs, and adapt activities as policies / resources change

4

Evaluate and Adjust: Review progress annually, incorporate frontline and lived-experience feedback, and publicly report outcomes and course corrections

Implementation: System Modeling of Annual Capacity



Expand Modeling

Use Stella M and other tools to project system needs and capacity



Anticipate Funding Changes

Assess how NOFO changes may shift demand for shelter, Transitional Housing, and rapid solutions



Set Annual Targets

Establish service volume, housing capacity, and positive PSH exit targets to improve turnover



Review and Adjust

Update projections and targets annually based on system performance and available resources

The Way Home Volunteer Opportunities

Partners are encouraged to share their volunteer opportunities or needs via The Way Home - Volunteer Houston webpage.

Volunteer Houston helps coordinate these efforts and it's a great place to share your organization and client needs and engagement opportunities.

Public Comment

Speakers will be called upon in the order in which they signed up. Others will be offered an opportunity to speak following.

Please use the “Raise Hand” function and wait to be called upon if you did not sign up to speak prior to the meeting.

When called upon, please introduce yourself and your organization (if applicable).

Duration of comment: 1 minute. This time limit will be identified with a visible timer shared on the screen, followed by the speaker being muted when the time is complete.

Thank you!

Supportive Materials

THE WAY HOME COMMUNITY PLAN (2027 – 2029) DRAFT FOR COMMUNITY FEEDBACK

TABLE OF CONTENTS

Acknowledgements

Executive Summary

Vision Statement

Guiding Principles

Background and Introduction

Homelessness in The Way Home (Community Snapshot)

Goals and Strategies

1. Upstream Prevention & Rapid Crisis Resolution
2. Clear System Entry & Public Navigation
3. Strengthen Outreach, Shelter, and Interim Pathways
4. Increase Housing Exits & Improve System Flow
5. Long-Term Stability & Independence

Special Populations

System Foundations

Implementation and System Modeling

Conclusion

DRAFT

ACKNOWLEDGEMENTS

[To be added.]

EXECUTIVE SUMMARY

The Way Home enters the 2027–2029 planning period with strong partnerships and new challenges. Partners coordinate access to services, share data, connect people to housing, and work with landlords and housing authorities. But rising housing costs, limited affordable housing, changing federal policy, gaps in health care, and more people entering homelessness call for a broader community response.

Beginning in 2012, Greater Houston's partners changed how they work together. They moved from separate programs to a coordinated homeless response system with shared data, common priorities, and a focus on housing. That work helped make The Way Home a national example. The next step is to bring the same coordination to preventing homelessness and addressing the housing, health, and income needs that shape people's stability.

This plan follows the journey of a person or family seeking help. It sets five priorities:

1. Prevent homelessness when possible,
2. Make help easy to find,
3. Respond quickly and safely when homelessness occurs,
4. Help people move into housing faster, and
5. Provide the support they need to stay housed.

The plan also recognizes that preventing and resolving homelessness takes the whole community. The Continuum of Care (CoC), which the U.S. Department of Housing and Urban Development (HUD) recognizes, provides the formal structure for governance and federal funding. The broader response includes local governments, health care providers, employers, schools, justice systems, housing authorities, philanthropy, businesses, faith communities, and other partners.

Together, these partners will measure success by whether fewer people enter homelessness, whether people spend less time homeless, whether critical housing resources are protected and expanded, whether people remain stably housed, and whether systems that contribute to homelessness share responsibility for the solution.

To put the plan into action, partners will establish clear roles, use reliable data, report progress publicly, and draw funding from a wider range of sources. They will support frontline staff and give people who have experienced homelessness a role in decisions. They will also test new approaches, learn from results, and reduce duplicate work so more resources reach people who need help.

WHAT SUCCESS SHOULD LOOK LIKE BY 2029

- Fewer people enter homelessness, including avoidable entries from priority public systems.
- Chronic homelessness moves toward rare and brief, with faster pathways for people with the longest histories of homelessness and the highest service needs.
- People experience shorter episodes of homelessness and move from outreach, shelter, and Coordinated Entry to safe housing faster.

DRAFT

- Existing housing resources are protected while local, flexible, and alternative housing pathways expand.
- Housing retention remains strong, returns to homelessness decline, and more households have realistic pathways to health and economic stability.
- Public, private, healthcare, philanthropic, and community investments are tied to clear outcomes, and a greater share of flexible resources reaches direct client assistance and client-facing services.
- The community can see what is working, what is not, and where resources or strategy need to shift.

VISION STATEMENT OPTIONS

NOTE: Four (4) draft options to be vetted during the Oct. public comment period and community engagement sessions.

1. Building on what we know: Together, we have shown what a community can accomplish when we work toward a common purpose. We will build on that progress to make homelessness rare, brief, and nonrecurring — shaping solutions with people who have experienced it and creating a region where everyone has a place to call home and the support to stay.
2. A shared future: We envision a region where everyone has a stable home and the opportunity to thrive. The partnerships we have built will carry us forward as we combine community knowledge, firsthand experience, and shared resources to prevent homelessness, make help easier to find, and build lasting stability.
3. Our next chapter: Our community's progress began with a shared commitment to work together. Our next chapter brings that commitment further: preventing housing crises, removing barriers to help, and opening more paths to stable homes. Together, with people who have experienced homelessness helping lead the way, we will build a future where homelessness is rare, brief, and nonrecurring.
4. A place for all of us: We are building a region where all of us can find stability, connection, and a place to call home. We will carry forward the collaboration that has changed our community, use firsthand experience to improve how help works, and share responsibility for preventing and resolving homelessness.

GUIDING PRINCIPLES

These guiding principles serve as our core commitments, guiding policy design, resource allocation, and collaborative action across this plan:

Inclusive Governance & Lived Experience Leadership: Create intentional, compensated pathways for people with lived experience of homelessness to shape priorities, test whether pathways work in practice, participate in governance and evaluation, and help interpret what the data does not show. Lived experience should be part of design, implementation, and course correction.

DRAFT

Person-Centered, Accessible Care: Deliver compassionate, flexible support that respects individual choice and provides swift, direct access to stable housing pathways without burdensome requirements or rigid prerequisites.

Proactive, Trust-Based Community Outreach: Meet unsheltered neighbors where they are through compassionate, continuous, and coordinated field engagement that builds trust and creates direct pathways to housing, healthcare, and stabilization services.

Collective Accountability & Data-Driven Governance: Maintain standardized performance metrics, clear organizational ownership, and transparent reporting to track system outcomes, ensure fiscal stewardship, and drive continuous performance improvement.

Shared Community Responsibility: Homelessness is a community outcome, not solely a CoC program responsibility. The Way Home will work with healthcare, behavioral health, justice, child welfare, schools, housing, workforce, and other systems to establish shared prevention goals, clearer transition practices, and aligned resources where each partner has a meaningful role.

Stewardship Toward Client Impact: Maintain the infrastructure needed for quality, compliance, data integrity, and accountability while reducing unnecessary duplication and directing more flexible community investment toward housing, prevention, stabilization, treatment, income, and other client-facing solutions.

Learning, Adaptation & Innovation: Use HMIS, system modeling, lived experience, research, and pilot results to test new approaches, stop doing what is not producing value, and scale strategies that improve outcomes.

Tri-County Integration & Regional Coordination: Build a regional response that is consistent where it should be and locally tailored where it needs to be. Harris, Fort Bend, and Montgomery partners should use shared data and common expectations while developing county-specific access, outreach, coordination, or service capacity where local conditions require it.

BACKGROUND AND INTRODUCTION

WHY THIS PLAN MATTERS

The Way Home enters the 2027–2029 planning period at a moment of both urgency and transition. Across the country, homelessness response systems are facing rising expectations, changing federal priorities, and increasing pressure to demonstrate measurable progress in reducing homelessness while using limited resources effectively. For The Way Home, this moment calls for a clear community strategy that protects the region's strongest practices while preparing the system to adapt to new policy, funding, and implementation realities.

Recent shifts in federal priorities underscore the need for greater system clarity, accountability, and performance measurement. Communities are being asked to show not only that people are connected to housing, but that systems are coordinated, outcomes are tracked, resources are used strategically, and people are supported in ways that reduce returns to homelessness. This requires more than maintaining existing programs. It requires a shared plan for strengthening the entire pathway from prevention and outreach to coordinated entry, housing placement, supportive services, long-term stability, and independence.

This plan matters because the challenges facing the region cannot be solved by the homeless response system alone. Housing affordability, behavioral health access, income instability,

DRAFT

workforce barriers, institutional discharge practices, public benefits, and transportation all shape whether people become homeless, how long they remain homeless, and whether they are able to stay housed. The Way Home has a central role in coordinating the regional response, but continued progress will require stronger alignment with local governments, healthcare and behavioral health systems, housing authorities, workforce partners, funders, community organizations, and other systems that influence housing stability.

The plan also matters because community members, providers, and partners identified both real strengths and significant implementation barriers. The region has a strong foundation of collaboration, permanent supportive housing, coordinated entry, shared data, housing partnerships, lived experience leadership, advocacy, and disaster response capacity. At the same time, stakeholders described communication gaps, confusing navigation pathways, documentation and referral barriers, limited affordable housing, shortages of specialized care, prevention gaps, funding restrictions, and workforce strain. This plan translates those findings into a focused strategy for 2027–2029.

The 2027-2029 Way Home Community Plan builds on the foundation of previous community plans of the region's homeless response system. Developed through a system-wide needs assessment, the plan affirms the continued importance of housing focused solutions paired with supportive services while recognizing a changing environment marked by funding uncertainty, rising housing costs, limited affordable housing, growing behavioral health, and specialized-care needs. As a result, the plan prioritizes greater system agility, upstream prevention, stability, cross-system accountability, transparency, and long-term financial sustainability. Overall, the plan is designed to preserve effective practices while adapting system structures, partnerships, and investments to meet current and emerging community needs.

THE WAY HOME: A BROADER COMMUNITY STRATEGY

For purposes of this Community Plan, The Way Home is used as the broader regional partnership and shared strategy for preventing and resolving homelessness. The HUD-recognized Continuum of Care (CoC) remains the formal governance, federal funding, compliance, HMIS, and Coordinated Entry structure within that response, but the work of ending homelessness extends beyond programs funded through HUD.

This distinction creates room for local and cross-sector strategies—including Pathways to Independence, local prevention and rapid-resolution investments, healthcare and behavioral health partnerships, workforce and income strategies, affordable housing advocacy, research and system improvement, and other community initiatives—to advance shared outcomes without forcing every solution into a federal program model. The next phase of The Way Home should be federally supported, locally owned, and community accountable.

PLANNING METHODOLOGY

The Way Home developed this Community Plan through a system-wide planning process that combined data analysis, stakeholder feedback, and community engagement. The goal was to understand how people experience the homelessness response system, identify its strengths and challenges, and establish priorities for the next phase of regional action.

Throughout the summer of 2026, The Way Home conducted two system-wide surveys and a series of stakeholder engagement activities to inform the plan's vision and priorities. Input was sought

DRAFT

from a broad range of partners, including homeless service providers, public agencies, nonprofit organizations, healthcare and behavioral health partners, community-based organizations, people with lived experience, frontline staff, funders, local governments, and others connected to housing stability.

More than 400 participants representing over 110 organizations and community groups contributed through surveys, interviews, and engagement sessions. To ensure regional representation across Harris, Fort Bend, and Montgomery counties, feedback was gathered through both in-person and virtual sessions held between June and July 2026. Participants discussed system strengths, implementation barriers, client and provider experiences, and opportunities to improve access, coordination, housing stability, and long-term sustainability.

Survey results and engagement findings were reviewed alongside system data, implementation feedback, and previous planning efforts to identify recurring themes and distinguish broader system challenges from isolated concerns. Common themes included communication and navigation barriers, service-capacity limitations, behavioral health and specialized-care needs, housing affordability, prevention gaps, workforce strain, and the need for stronger accountability across partner systems.

These findings directly informed the Community Plan. Recurring themes identified through the systems strengths and challenges were translated into the plan's strategic goals, priorities, and measures of progress. As a result, the plan reflects both what the data show and what community members, providers, and partners identified as most important for improving the regional response to homelessness.

Additional information on stakeholder engagement, survey findings, and emerging themes can be found in the *Shaping The Way Home Summary Report*.

HOW THIS PLAN SHOULD BE USED

The 2027–2029 Community Plan is both a shared strategy and an implementation guide for The Way Home. It is grounded in data, stakeholder feedback, and ongoing performance monitoring, and is intended to be used as a living tool for decision-making, collaboration, and accountability. Each section builds on the others: the planning context explains why action is needed, the community snapshot identifies key strengths and challenges, and the goals translate those findings into priorities, actions, and measures of success.

The plan's goals are directly informed by system performance data, HMIS trends, survey results, stakeholder engagement, and implementation feedback. Together, these sources highlight where the regional response is working well and where improvements are needed, including communication, navigation, outreach, cross-system coordination, housing access, long-term stability, governance, and sustainability. The goals are designed to address those identified needs and should be understood as interconnected rather than separate initiatives. For example, clearer communication improves navigation, stronger navigation supports housing outcomes, and lasting housing stability depends on access to healthcare, behavioral health services, income supports, workforce opportunities, and coordinated community resources.

This plan also connects The Way Home's homelessness response efforts to broader community initiatives, including the Pathways to Independence framework and other upstream strategies. Many of the factors that contribute to homelessness, such as housing affordability, behavioral health capacity, workforce access, public benefits, institutional discharge practices, and funding

DRAFT

constraints, cannot be addressed by Continuum of Care programs alone. As a result, the plan should be used to guide both internal system improvement and collaborative action with public agencies, healthcare and behavioral health partners, housing providers, employers, funders, and other community stakeholders.

Finally, the Community Plan should serve as a living accountability framework. Its goals, strategies, and performance measures are intended to help partners track progress, evaluate results, and adjust course as conditions change or new challenges emerge. While the plan establishes priorities for 2027–2029, it also recognizes that preventing and ending homelessness requires sustained, long-term commitment from more than just the homeless response system. Its purpose is to preserve what works, address persistent barriers, and align the community around measurable progress toward making homelessness rare, brief, and non-recurring.

HOW THE STRATEGY FOLLOWS THE CLIENT JOURNEY

The 2027–2029 plan follows the experience of a person or family seeking help: connection to early crisis resolution, understandable access, immediate support, housing, and lasting stability.

Goal	Intended result
1 Improve upstream prevention and rapid crisis resolution	Housing crises are resolved early and avoidable entries to homelessness decline.
2 Clear system entry and public navigation	People can find help and reach the next appropriate step.
3 Strengthen outreach shelter and interim pathways	People receive safe, accessible crisis support connected to housing.
4 Increase housing exits and improve system flow	People move into suitable permanent housing faster.
5 Long term stability and independence	People remain housed with health, income, and community supports.

The journey should be evaluated by the experiences of people who use it. At each stage, implementation should assess whether access was clear, referrals led to meaningful help, responses respected choice and safety, and housing or support matched what the person actually needed. Those questions should be part of implementation reviews, not an afterthought.

Our commitments

- People shape their own goals and receive accessible, compassionate support that respects choice and safety.
- People with lived experience have compensated roles in planning, governance, evaluation, and course correction.

- Partners share responsibility for outcomes and use clear decision rights, reliable data, and transparent reporting.
- Regional expectations account for different access and capacity in Harris, Fort Bend, and Montgomery counties.
- Resources support effective services and direct assistance, alongside the infrastructure needed for quality and accountability.
- We test approaches, learn from results, and adjust when a strategy is not working.

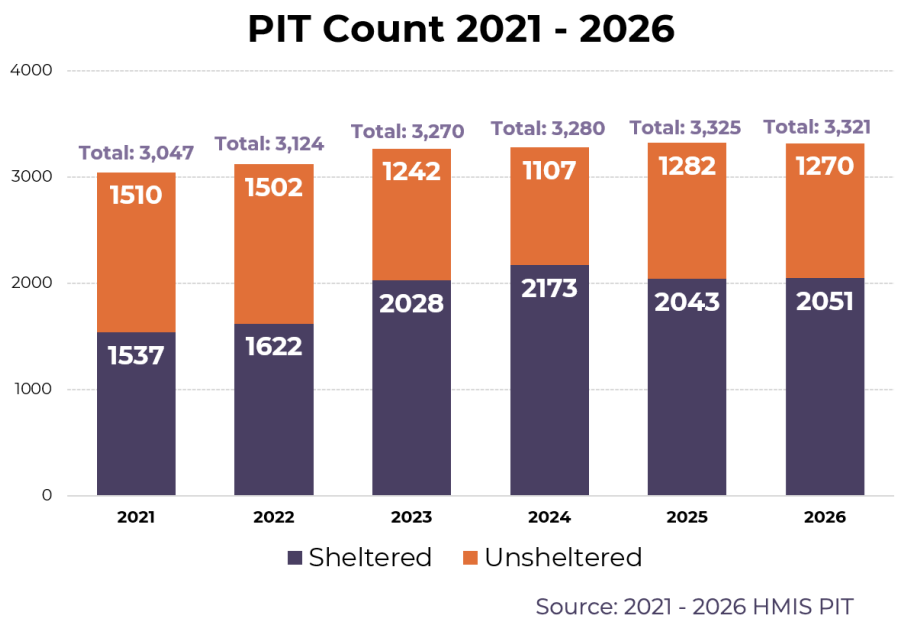
HOMELESSNESS IN THE WAY HOME - COMMUNITY SNAPSHOT

WHAT THE DATA TELLS US

Reviewing the state of homelessness and the system in the past 5 years and looking at the emerging trends from the Point-In-Time Count (PIT), Housing Inventory Count (HIC), and the System Performance Measures (SPMs) provide a foundation for this plan. This data was key to informing the stakeholder and community engagement process.

Point-In-Time Count

From 2021 to 2026, the overall Point-In-Time (PIT) count has stayed relatively stable year to year, increasing at an average of 2% each year and by 9% overall. Over half of our homeless population is made up of sheltered individuals (59%).



Source: 2021 - 2026 HMIS PIT

Housing Inventory Count

Permanent supportive housing dominates the housing inventory across 2020 to 2025, with a steep increase of 146% in inventory from 2020 to 2025. Rapid re-housing and emergency shelter units also saw a modest increase of 9.5% and 10.7% respectively, while transitional housing units stayed stable near 660 units.

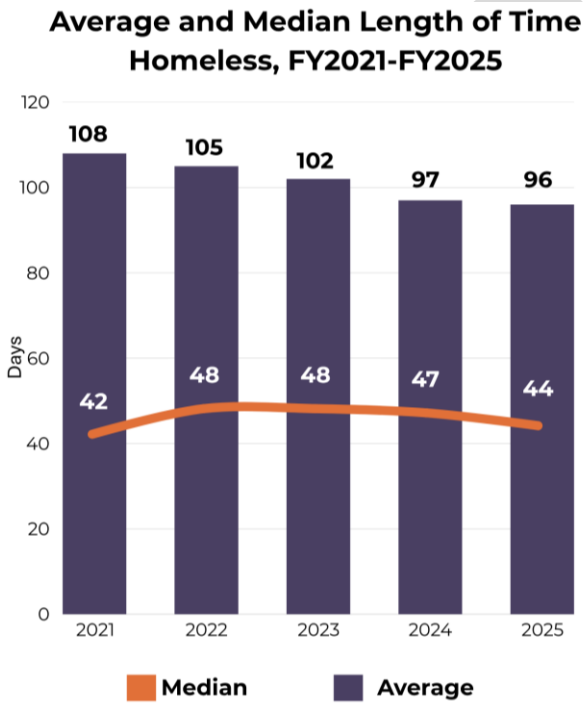
Single Adults and Youths

Program	2020 Units	2025 Units	Goal	Change (#)	Change (%)	% of Goal (2025)	Gap to Goal (2025)	Gap Change
ES	1,050	937	1,570	-113	-10.76%	59.68%	633	Widened by 22%
TH	658	662	625	4	0.61%	105.92%	-37	Fully Closed
RRH	650	712	1,500	62	9.54%	47.47%	788	Closed by 7%
PSH	3,125	7,710	5,025	4,585	146.72%	153.43%	-2,685	Fully Closed

Families

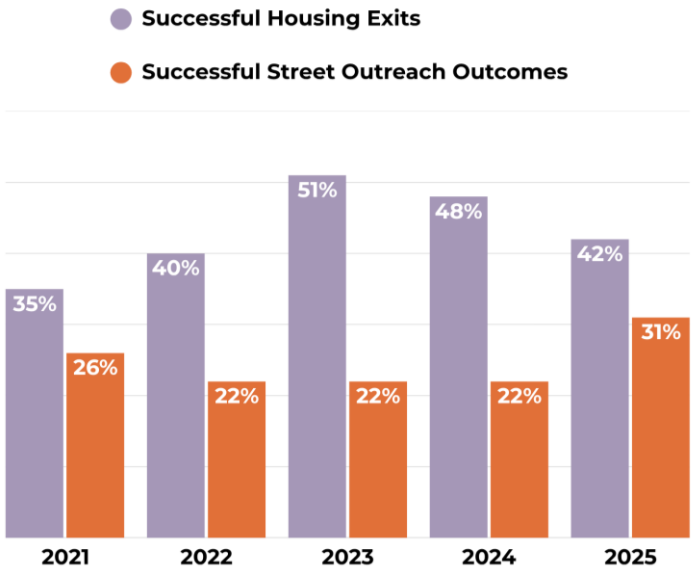
Program	2020 Units	2025 Units	Goal	Change (#)	Change (%)	% of Goal (2025)	Gap to Goal (2025)	Gap Change
ES	400	504	160	104	26.00%	315.00%	-344	Fully Closed
TH	120	31	100	-89	-74.17%	31.00%	69	New Gap Created
RRH	170	658	485	488	287.06%	135.67%	-173	Fully Closed
PSH	415	1691	290	1276	307.47%	583.10%	-1401	Fully Closed

System Performance Measures



From Fiscal Year (FY) 2021 to FY 2025, the average length of time experiencing homelessness among people enrolled in emergency shelter, safe haven, or transitional housing programs decreased from 108 to 96 days, while the median remained relatively stable at 42 to 44 days.

Across this same time period, housing outcomes were mixed. Successful exits from emergency shelter, safe haven, transitional housing, and rapid rehousing to permanent housing increased from 35% in FY2021 to 42% in FY2025, but declined from a high of 51% in FY2023. Successful street outreach outcomes increased to 31% in FY2025 after remaining at 22% from FY2022 through FY2024.



Successful Outcomes by Program Pathway, FY2021-FY2025

Permanent housing outcomes remained a consistent system strength, with 95%-96% of participants retaining housing or exiting to another permanent destination throughout the five-year period.

Note: System Performance Measure data were available for FY2021–FY2025, unlike the Point-in-Time and Housing Inventory Count trends presented in this report, which were available from 2021 to 2026.

CURRENT SYSTEM STRENGTHS & OPPORTUNITIES

The Way Home's 2027–2029 priorities build on a strong foundation of regional collaboration across Harris, Fort Bend, and Montgomery counties. Through coordinated planning, shared crisis response, and partnerships among public agencies, healthcare systems, housing authorities, and more than 130 nonprofit organizations, our community has demonstrated the value of working as a unified system. This foundation includes a strong Coordinated Entry process, integrated HMIS data infrastructure, established housing partnerships, and a robust network of Permanent Supportive Housing programs that have helped connect thousands of people to permanent housing.

These strengths provide the tools, relationships, and infrastructure needed to meet emerging challenges. Stakeholder feedback consistently affirmed the value of regional collaboration, shared data, housing partnerships, frontline expertise, and lived experience leadership while also identifying opportunities to strengthen how people access and move through the system.

Building on these strengths, stakeholders identified three key opportunities to further strengthen the homelessness response system:

1. Expand housing options by developing additional pathways for people with different levels of support needs, including options for households ready for greater independence while maintaining access to services.

2. Strengthen cross-sector referrals and coordination by improving information sharing, increasing transparency, and creating more user-friendly tools that connect people to the right services more quickly and effectively.
3. Improve access and navigation by clarifying eligibility requirements, strengthening coordination among access points, and reducing the time between referral and connection to housing and services.

This approach preserves the system's strongest assets while making The Way Home easier to navigate, more responsive to community needs, and better positioned for long-term sustainability.

CURRENT SYSTEM CHALLENGES

While our regional foundation is strong, stakeholder feedback and system data point to a homelessness response system that has become increasingly difficult to navigate for many of the people it is intended to serve. Community members, providers, and people with lived experience consistently described barriers that affect every stage of the housing journey, from preventing homelessness and finding help to moving into housing and maintaining long-term stability. These challenges informed the five strategic goals of this Community Plan and highlight where change is most needed.

In the community engagement workshops stakeholders identified four overarching barriers:

1. Difficult and Fragmented Pathways to Help: People often encounter unclear entry points, inconsistent information, outdated resources, repeated paperwork, rigid eligibility requirements, and incomplete referrals. Together, these issues create delays, administrative fatigue, and a system that can be difficult for both clients and providers to navigate.
2. Insufficient Housing, Services, and Stabilization Resources: The region lacks enough affordable and specialized housing options, timely behavioral healthcare, medical respite, flexible financial assistance, and other supports needed to move people out of homelessness and keep them housed. Low wages, rising rents, benefit cliffs, and limited prevention resources further increase housing instability.
3. Disconnected systems and Uneven Shared Responsibility: Healthcare, behavioral health, criminal justice, child welfare, housing, workforce, and other systems are not consistently aligned around prevention, transitions, referrals, or discharge planning. People may be passed between organizations or leave institutions without an effective housing plan, placing additional and often unfunded pressure on the homelessness response system.
4. Limited System Capacity, Accountability, and Sustainability: Restricted funding, workforce burnout, unclear ownership, fragmented governance, and inconsistent performance accountability limit the system’s ability to adapt and implement improvements. These challenges make it difficult to sustain effective programs, respond to changing conditions, and ensure responsibility for outcomes is clearly held.

Ultimately, these findings demonstrate that preventing and ending homelessness requires more than housing placement alone. The challenges identified by stakeholders span prevention, system access, crisis response, housing, and long-term stability. Together, they provide the rationale for the five goals of this Community Plan and outline the areas where coordinated community action can produce the greatest impact over the next three years.

DRAFT

COMMUNITY PLAN GOALS

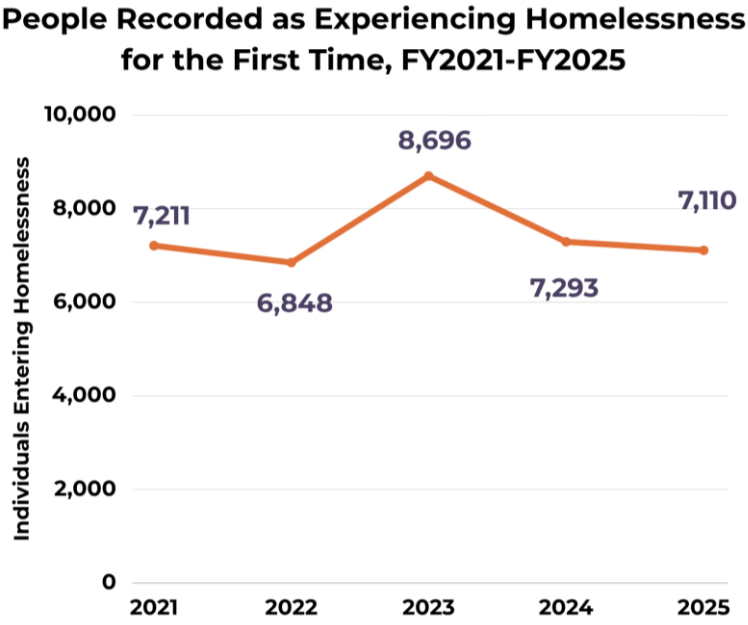
2027–2029 STRATEGIC GOAL FRAMEWORK	
Goal 1	Upstream Prevention & Rapid Crisis Resolution
Goal 2	Clear System Entry & Public Navigation
Goal 3	Strengthen Outreach, Shelter, and Interim Pathways
Goal 4	Increase Housing Exits & Improve System Flow
Goal 5	Long-Term Stability & Independence

GOAL 1: UPSTREAM PREVENTION & RAPID CRISIS RESOLUTION

Vision & 2029 Outcome: Brief housing crises are resolved quickly at the front door through light-touch financial assistance, landlord mediation, and targeted diversion—reserving intensive long-term subsidies for individuals with complex needs.

Core Context & Narrative: Without immediate problem-solving at initial contact, short-term financial stumbles turn into prolonged unsheltered episodes. Rapid resolution prevents inflow into literal homelessness, reduces time spent in crisis, and preserves system capacity.

Prevention must also address system-driven inflow. Hospitals, behavioral health systems, criminal justice, child welfare, schools, and other public systems should not be treated only as referral partners after a housing crisis has already occurred. The plan should establish shared outcomes, changed practices, and resource commitments that reduce avoidable entries into homelessness. Shown in Figure X, 7110 people experienced homelessness for the first time, emphasizing the importance of preventing housing instability from escalating into homelessness and reducing the flow of new households into the homeless response system.



DRAFT

Figure X. The number of individuals experiencing homelessness for the first time decreased from 7,293 in FY24 to 7,110 in FY25.

KEY STRATEGIES

Strategy	Implementation activities	Proposed lead and partners	Timing	Progress indicator
1.1 Flexible Upstream & Diversion Funding	Prioritize and direct flexible funding toward immediate resolution barriers (document recovery, application fees, move-in costs, utility support, transportation) and develop shared rapid problem-solving guidance.	Access Point Providers, Outreach Teams, CFTH Program Team	Year 1 (Ongoing)	% of households successfully diverted from homeless system entry
1.2 Landlord Mediation & Problem-Solving	Embed landlord mediation and family reunification specialists directly at access points and shelters.	Access Point Providers, Shelter Staff, Landlord Liaison Teams	Year 1 – Year 2	Increase in rapid diversion resolutions prior to emergency shelter entry.
1.3 Coordinated Entry Triage & Assessment Optimization	Evaluate Coordinated Entry (CE) assessment tools and refine triage protocols and prioritization rules to accurately differentiate light-touch diversion from intensive Permanent Supportive Housing (PSH) subsidies.	CE Workgroup, Evaluation Team, Housing Providers	Year 1	Decreased average days from initial crisis contact to the next appropriate intervention, safe resolution, or housing pathway.
1.4 Shared Prevention & Cross-System Partnerships	Work with priority public systems including healthcare, behavioral health, justice, child welfare, school, and other public-system partners to establish shared prevention goals, strengthen transition and warm-handoff practices, clarify escalation pathways, and align resources where appropriate.	CFTH Leadership, CoC Board, Public-System Partners, Local Government, Prevention/Access Providers	Year 1 - Year 3	Number of priority systems with formal shared prevention goals or protocols in place; increase in successful cross-system transitions; reduction in avoidable entries to homelessness from public systems where shared data is available.

GOAL 2: CLEAR SYSTEM ENTRY & PUBLIC NAVIGATION

Vision & 2029 Outcome: Anyone experiencing or at risk of homelessness—as well as community partners, faith-based groups, and first responders—can easily find, understand, and access transparent front doors into the homelessness response system without dead ends or administrative confusion.

Core Context & Narrative: Unclear access points force vulnerable neighbors into word-of-mouth navigation, long wait times, and administrative fatigue. Establishing simple, multi-channel public communications and standard provider directories ensures immediate, transparent connections.

Figure X presents a lived-experienced perspective on challenges in navigating the homelessness response system.

This goal is about more than better information. A no-wrong-door system means a person should not have to understand funding streams, program acronyms, or agency boundaries to get help. Every participating access point should take responsibility for helping the person reach the next appropriate step, even when another organization ultimately provides the service.

> With the paperwork, you have to wait. Things like documentation, finding a job, etc. is overwhelming and a barrier. Took an extra month just to navigate that adult space as a youth.

KEY STRATEGIES

Strategy	Implementation activities	Proposed lead and partners	Timing	Progress indicator
2.1 Public Awareness & Messaging	Launch a multi-lingual public awareness campaign and unified messaging framework across 2-1-1 Texas, front-door agencies, and public partners.	CFTH Communications, Public Affairs, 2-1-1 Texas, Community Partners	Year 1 – Year 2	Campaign launch; measured improvement in public understanding of where to seek help and accuracy of access-point inquiries.
2.2 Transparent Central Resource Directory	Launch and maintain a centralized, real-time public resource directory of entry points, eligibility criteria, and services. Establish formal ownership workflows for monthly directory updates and maintenance.	CFTH Communications, Public Affairs, Homeless Response System (HRS) Team	Year 1	Public directory launch; quarterly audit showing >95% provider contact accuracy.
2.3 Standardized Provider Operations Hub	Create a standardized provider-facing repository and operations hub to align current system standards, policies, procedures, and training tools.	Homeless Response System (HRS) Team, CoC Provider Network	Year 1	Live provider hub; % of participating access points actively utilizing current system guidance and shared intake expectations.
2.4 Performance Dashboards & Reporting	Publish visual, plain-language annual reports, and live community dashboards detailing system performance, inflow, and housing outcomes.	CFTH Data & Evaluation Team, CoC Board	Year 1 (Ongoing)	Annual publication of public community impact report and live dashboard updates.
2.5 No-Wrong-Door Referral Standard	Adopt a no-wrong-door service standard at access points with shared expectations for warm handoffs, referral response times, referral closure, and escalation when a person	CFTH HRS Team, Coordinated Entry, 2-1-1 Texas, Access Point Providers, Community Partners	Year 1 - Year 2	Increase in completed and closed-loop referrals; reduction in unresolved or repeated referrals; decreased median time from request for help to next appropriate connection; participant-

Strategy	Implementation activities	Proposed lead and partners	Timing	Progress indicator
	cannot connect to the next appropriate step.			reported ease of navigation where feasible.

GOAL 3: STRENGTHEN OUTREACH, SHELTER, AND INTERIM PATHWAYS

Vision & 2029 Outcome: Unsheltered neighbors and people in emergency shelter receive immediate, person-centered stabilization, healthcare, ID recovery, and crisis support that bridges them directly into permanent housing.

Core Context & Narrative: This priority represents a critical stage that meets immediate human needs while preparing individuals for long-term housing stability. Rather than moving directly from prevention to housing exits, this priority ensures the system addresses the quality, accessibility, and coordination of the crisis response while people are experiencing homelessness—reaching unsheltered individuals across geographic gaps, embedding healthcare, and making shelter pathways dignified and person-centered. Below, Table X represents the reach of street outreach client enrollment and engagement over time, providing an indicator of the system's ability to connect individuals experiencing homelessness to services and supports.

Outreach, shelter, and interim settings are crisis interventions not destinations. Their success should be judged by whether people are safer, connected to the right next step, and moving toward permanent housing, not simply by the number of contacts, beds, groups, or services delivered.

Street Outreach Enrollment and Service Engagement by Fiscal Year

Year	Clients Enrolled	Clients Actively Served	Percentage of Enrolled Clients Served
2021	2,531	2,379	94%
2022	3,465	3,249	94%
2023	2,702	2,321	86%
2024	2,910	2,305	79%
2025	2,470	2,041	83%
2026*	429	347	81%

Table X. Most street outreach clients remain actively engaged in services after enrollment, with engagement increasing from 79% in FY24 to 83% in FY25.

KEY STRATEGIES

Strategy	Implementation activities	Proposed lead and partners	Timing	Progress indicator
3.1 Regional Outreach & County-Based Supports	Expand and coordinate regional outreach using county partner input, HMIS/outreach data, and system modeling to identify gaps in coverage, and determine where dedicated	Outreach Workgroup, Fort Bend and Montgomery County Leads, Regional Service Providers, CFTH	Year 1 – Year 2	Adoption of County-specific coverage plans; reduction in documented geographic service gaps; increase in successful connections to shelter, services, or housing from Fort Bend and

DRAFT

Strategy	Implementation activities	Proposed lead and partners	Timing	Progress indicator
	coordination, access points, or service capacity would make the biggest difference. Continue aligning CoC and non-CoC outreach teams across the region.	HRS Team, Community/Faith Partners		Montgomery Counties, as well as unincorporated Houston/Harris County.
3.2 Shelter Capacity, Healthcare & Person-Centered Care	Upgrade emergency shelter accessibility. Embed mobile health, behavioral health, and ID recovery into interim settings. Adopt CoC-wide trauma-informed, harm-reduction, and person-centered standards.	Emergency Shelter Providers, Specialized Health Partners, CFTH Training Team	Year 1 – Year 2	Increase in shelter-to-permanent-housing exits; systemwide adoption of person-centered care standards; positive participant-reported safety, accessibility scores.
3.3 Crisis-to-Housing Flow	Track client movement from outreach, shelter, and interim settings to the next appropriate step, including time to connection, permanent housing exits, returns, and geographic capacity gaps. Use results to adjust deployment and investment.	CFTH HRS/Data Teams, Outreach and Shelter Providers, Coordinated Entry, County Partners	Year 1 - Year 3	Reduced time from crisis contact to next appropriate step; improved positive exits/permanent housing connections; documented course corrections based on flow data.

GOAL 4: INCREASE HOUSING EXITS & IMPROVE SYSTEM FLOW

Vision & 2029 Outcome: People move from outreach, shelter, and Coordinated Entry into permanent housing faster, with fewer administrative delays and a broader set of housing pathways matched to need.

Core Context & Narrative: Houston's housing response cannot rely only on making existing referral processes more efficient. The community must protect the PSH, RRH, and other housing capacity it already has while preparing for a tighter federal and affordable-housing environment. That means reducing match-to-move-in delays, sharing verified documentation where appropriate, strengthening clinical supports for people with complex needs, and using system modeling to guide landlord, housing authority, developer, philanthropic, and local-government strategies that preserve and expand housing options. Tables X and Y identify current housing and service gaps across intervention types, highlighting areas where additional capacity and targeted investments may be needed to improve system flow and support timely transitions into permanent housing.

KEY STRATEGIES

Strategy	Implementation activities	Proposed lead and partners	Timing	Progress indicator
4.1 Streamlined Handoffs & Document Reuse	Adopt standardized referral workflows in HMIS with automated status tracking. Complete privacy/legal assessment and pilot a secure HMIS document-sharing vault to eliminate duplicate paperwork.	HMIS Team, Homeless Response System Workgroups, CoC Provider Network	Year 1 – Year 2	% reduction in referral and match-to-move-in processing time; reduction in duplicate documentation requests where legally/operationally feasible.
4.2 Integrated Clinical & Behavioral Health Care	Establish multidisciplinary case conferencing and consultation pathways for clients with complex behavioral/medical needs (high acuity participants). Formalize healthcare/MCO care-integration funding partnerships.	Specialized Health Partners, Healthcare Networks, Housing Case Managers	Year 2	% of high-acuity housing participants connected to appropriate physical/behavioral health care; housing retention rate for participants receiving integrated clinical support.
4.3 Protect & Expand Housing Pathways	Use system modeling and gap analysis to protect existing PSH/RRH capacity, strengthen housing authority and landlord partnerships, test shared or other flexible housing models, and inform affordable-housing advocacy and local investment.	CoC Board, Housing Authorities, Housing Providers/Developers, Landlord Networks, Local Government, Philanthropic Partners	Year 1 – Year 3	Existing dedicated capacity preserved where feasible; net increase in viable housing pathways; documented progress against modeled housing gaps and match-to-move-in timelines.
4.4 Regional Housing Accelerator & Innovation Partnerships (Concept to test – Not yet a commitment)	Complete a feasibility and partner scan for a regional housing accelerator or innovation fund that could combine catalytic public/private/philanthropic capital, policy support, and innovation to unlock affordable or supportive housing opportunities. If viable, structure at least one pilot partnership or financing pathway.	CoC Board, CFTH Leadership, City/County, Housing Authorities, Philanthropy, Private Capital, Developers, Community Partners	Year 1 - Year 3	Feasibility completed; external capital/resources leveraged; projects, units, or new housing pathways advanced if a pilot is launched.

Housing capacity and gaps

These preliminary tables describe current capacity and estimated need. They must be validated before they are used to set investment priorities. Annual households served and housing units measure different kinds of capacity; comparisons should retain clear units and periods.

Single Adults & Youth			
Program	Current capacity as of September 1 2026	Estimated need	Estimated gap
Emergency Shelter	1,255	~1000	(~255)
Diversion	391 HH in 2025	2000 HH served/yr	~1600
Prevention	1508 HH in 2025	1575 HH served/yr	~75
Transitional Housing	543	~4500 split as appropriate/possible with funding	~3100
Rapid Rehousing	855	~4500 split as appropriate/possible with funding	~3100
Permanent Supportive Housing	4,407	~5000	~500

Families			
Program	Current capacity as of September 1 2026	Estimated need	Estimated gap
Emergency Shelter	157	~180	~20
Diversion	118 HH in 2025	320 HH served/yr	~200
Prevention	778 HH in 2025	815 HH served/yr	~25
Transitional Housing	22	22	None
Rapid Rehousing	262	480	~220
Permanent Supportive Housing	561	500	(~60)

GOAL 5: LONG-TERM STABILITY & INDEPENDENCE

Vision & 2029 Outcome: People who move into housing have realistic pathways to remain housed, improve health and income, and reconnect to community supports as their needs change. The system reduces returns to homelessness without assuming that employment alone can close the gap between income and housing costs.

Core Context & Narrative: Stability extends beyond move-in day and beyond a referral to employment or benefits. Rising rents, low wages, benefit cliffs, healthcare costs, transportation, childcare, disability, recovery, and changing public benefits can all destabilize housing. The community response should combine income and benefits strategies with health, recovery, education, and flexible post-housing supports while also using data and advocacy to identify structural gaps that individual case management cannot solve. Figure X shows the percentage of individuals returning to homelessness within two year, reinforcing that successful housing placements must be paired with ongoing supports.

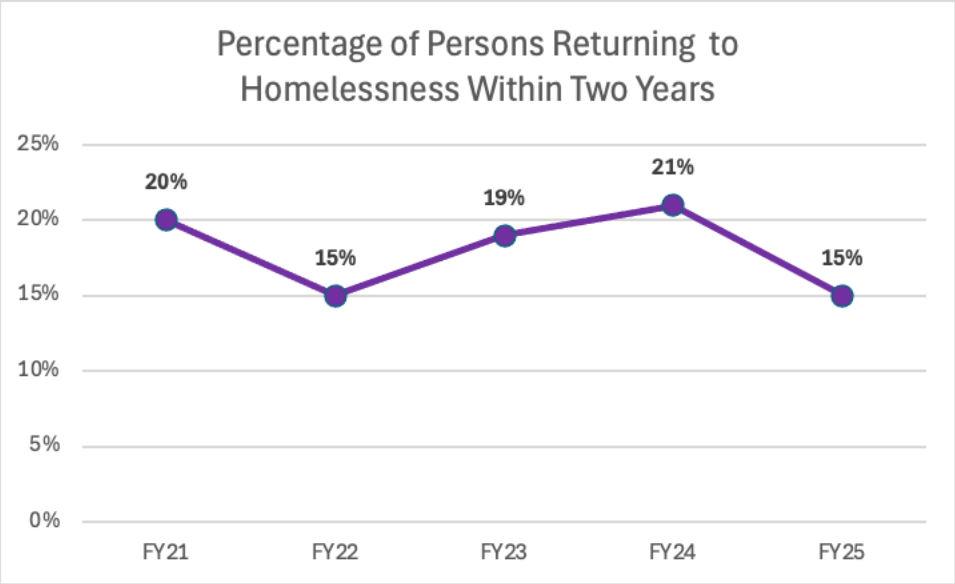


Figure X. The percentage of persons returning to homelessness within two years declined from 21% in FY24 to 15% FY25, the lowest level reported during the past 5 years.

KEY STRATEGIES

Strategy	Implementation activities	Proposed lead and partners	Timing	Progress indicator
5.1 Economic Mobility, Education & Benefits	Build direct employment, education, benefits, and economic-mobility pathways that reflect participant goals and local labor-market realities. Include benefits-cliff counseling, employer partnerships, and practical supports that affect participation.	CFTH Income Team, Employment Partners, Education Partners, Benefits/SOAR Partners, Employers	Year 1 - Year 3	Increase in participants connected to income/benefits/employment/education pathways appropriate to their goals; track income and employment retention rates where applicable without using employment alone as the measure of stability.

Strategy	Implementation activities	Proposed lead and partners	Timing	Progress indicator
5.2 Post-Housing Support & Early Re-Engagement	Develop voluntary post-housing supports, flexible step-down financial assistance, and clear early re-engagement pathways for households at transition points before a housing crisis becomes a return to homelessness.	Housing Providers, CFTH Program/HRS Teams, Community Support Partners	Year 1 - Year 3	12-month returns to homelessness; housing retention; number/percent of households successfully re-engaged before housing loss where measurable.
5.3 Health & Community Stability Supports	Strengthen practical connections to healthcare, behavioral health, substance use/recovery, transportation, childcare, legal, education, and other supports that materially affect housing stability.	Healthcare/Behavioral Health Partners, Housing Providers, Community-Based Organizations, MCOs	Year 1 - Year 3	Improved connection and engagement rates with identified community support; housing retention rates for participants with complex needs (households receiving specialized wrap-around services); reduced service gaps identified through case review and data.
5.4 Structural Gaps, Advocacy & Partnership Solutions	Use system data (HMIS), lived experience, and partner input to identify where wages, benefits, housing costs, or community resources remain insufficient and pursue policy, funding, or partnership solutions beyond individual service navigation.	CoC Board, CFTH Leadership/Public Affairs, Local Government, Philanthropy, Workforce/Benefits Partners	Year 1 - Year 3	Annual priority agenda informed by system data and lived experience; documented policy, funding, or partnership changes that address identified stability gaps.

SPECIAL POPULATIONS

The Way Home recognizes that homelessness does not impact all populations equally. Special populations are groups that may experience homelessness due to unique circumstances or

barriers and may require tailored resources, services, and pathways to prevent or resolve their homelessness. The community assessment identified Youth & Young Adults, Veterans, Families with Children, Survivors of Domestic Violence, Criminal Justice Reentry, and people experiencing chronic homelessness as special populations. To ensure each population has access to the services and supports needed to address their unique circumstances, the 2027-2029 Community Plan embeds strategic priorities for these populations within the system-wide framework at every stage of the response system.

Special Population	Chronic	Veterans	DV Survivors	YYA (<18, 18-25)	Older Adults (65+)	Total PIT Count
2024	494 (15%)	213 (6%)	439 (13%)	696 (21%)	211 (6%)	**3280**
2025	440 13%)	195 (6%)	516 (16%)	763 (23%)	201 (6%)	**3325**
2026	712 (21%)	244 (7%)	576 (17%)	766 (23%)	171 (5%)	**3321**

Population-specific work should be visible in the measures, not isolated in a separate program lane. Each goal should disaggregate outcomes where data and privacy rules permit and identify targeted strategies when the general system pathway is not producing effective results for a population.

People with lived experience from the populations most affected should help review the strategies and measures intended for them, particularly where safety, trust, disability, age, family structure, or prior system involvement changes how the general pathway works in practice.

The long-term aim remains to make chronic homelessness rare and brief while protecting and strengthening pathways for Veterans, youth and young adults, families with children, survivors of domestic violence, people returning from institutions, and others whose needs require specialized approaches.

SYSTEM FOUNDATIONS: WHAT MUST BE IN PLACE

The five goals depend on shared infrastructure, reliable resources, and people who can carry out the work. These foundations support every stage of the journey.

Governance and Shared Accountability: Clarify decision rights, ownership, and escalation across the CoC Board, CFTH, providers, local governments, funders, and adjacent systems. Each goal should have an implementation home within existing workgroups where possible. Partners should know where unresolved barriers go for a decision.

Data Research and Learning: Use HMIS, system modeling, lived experience, and research to identify where people get stuck and which changes improve results. IH3 at the University of Houston and other research partners can support selected questions, evaluation, and interpretation. Community leaders retain responsibility for priorities and implementation.

Funding and Stewardship: Diversify local, healthcare, philanthropic, and private investment alongside federal resources. Establish a baseline for selected investments across direct assistance, client-facing services, and necessary infrastructure. Reduce duplication where feasible and reinvest flexible savings near the people receiving help while protecting quality and fiscal controls.

Shared Tools and Provider Support: Identify where shared services, joint procurement, common tools, or coordinated compliance, training, and reporting can reduce duplicative administrative

burden while strengthening quality. Build a stronger provider network with more time and flexible resources available for housing, prevention, stabilization, treatment, navigation, and other client-facing work.

Workforce and Lived Experience Leadership: Support realistic caseloads, supervision, training, and retention. Create compensated roles for people with lived experience to shape priorities, review implementation, and interpret data. Record where their participation changes a decision.

Communications and Public Accountability: Explain what investments support, what outcomes change, and where course correction is needed. Publish clear information that helps people find services and partners understand their responsibilities.

IMPLEMENTATION & ACCOUNTABILITY FRAMEWORK

START WITH CLEAR RESPONSIBILITY

Cross-System Workgroup Alignment: Each strategic goal should have a clear implementation home, using existing workgroups and partner structures wherever possible rather than creating new layers by default. CFTH and community co-leads should bring together the partners needed to move the work, including county-specific partners when implementation needs differ across Harris, Fort Bend, and Montgomery Counties.

Escalation Pathways: Partners should understand where decisions sit and how unresolved barriers are elevated. Clear escalation pathways can help the system resolve inter-agency conflicts, policy bottlenecks, and implementation delays without relying on informal relationships alone.

DEVELOP AND REVIEW WORKPLANS

Within six to nine months of plan adoption, each goal area should develop an implementation workplan that identifies priority activities, responsible partners, timelines, required resources, milestones, risks, and measures of success. Where a 2029 target has not been established, the first workplan should define the baseline, target, owner, and reporting cadence.

Workplans will also establish a reporting framework that outlines how progress will be tracked, evaluated, and communicated. Workplans should remain living implementation tools that can adapt to changes in policy, funding, evidence, and community needs without requiring changes to the overall Community Plan.

Each workplan should also include a compensated lived-experience review, at least one participant-experience measure, and clear criteria for determining whether pilot strategies should be scaled, modified, or stopped.

USE MODELING TO GUIDE DECISIONS

System modeling will be used as an ongoing decision-support tool rather than a static gap analysis. At least annually, The Way Home should model system inflow, housing and shelter inventory, utilization, length of stay, housing exits, returns to homelessness, unit turnover, and known funding changes to identify where capacity constraints are emerging and where investments can generate the greatest improvement in system outcomes. This approach aligns with the plan's emphasis on data-driven governance, continuous learning, and using system modeling to inform resource allocation and strategic priorities.

DRAFT

Scenario planning should test how the system performs under different conditions, including reductions in federal housing resources, expansion of local prevention efforts, changes in shelter or interim housing capacity, shifts in housing inventory, or improvements in discharge practices from healthcare, behavioral health, criminal justice, child welfare, and other partner systems. Findings should be used to inform funding decisions, housing and policy advocacy, program design, implementation planning, and public reporting.

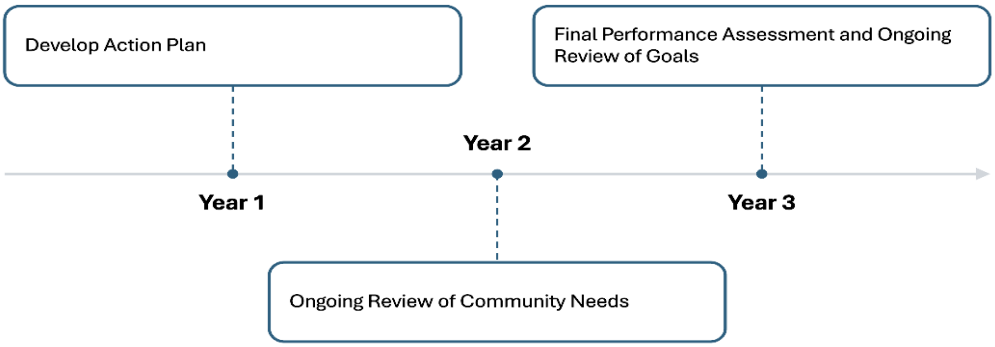
Where data capacity allows, system modeling should also highlight meaningful differences across Harris, Fort Bend, and Montgomery Counties. Regional planning should account for variations in housing markets, service availability, population needs, and access pathways rather than assume uniform conditions across the homeless response system. External data sources, including regional housing instability research, may be incorporated alongside HMIS, PIT, HIC, System Performance Measures, and local partner data to provide a more complete picture of housing risk, unmet need, and pressures that exist both inside and outside the formal homeless response system.

REPORTING, EVALUATION & CONTINUOUS IMPROVEMENT

Progress toward strategic goals will be reviewed on an ongoing basis and incorporated into an annual update process to assess outcomes, identify opportunities for improvement, and ensure alignment with evolving community needs and system priorities.

Annual reporting should distinguish between activity and impact. Reporting should distinguish completed activities from measurable changes in participant experience and system outcomes.

System modeling, performance data, lived experience, and community feedback should be used to assess progress and inform course correction. At least annually, the system should evaluate inflow, capacity, utilization, length of stay, housing exits, returns to homelessness, resource turnover, and anticipated funding changes to identify where investments and implementation strategies should be adjusted.



Research partners such as IH3 at the University of Houston may support selected research, modeling, scenario testing, and evaluation questions as an independent learning partner. The CoC Board, CFTH, and community partners will remain responsible for priorities, implementation, and decisions.

YOUR PLACE IN THE PLAN

This plan depends on people across the region. The following participation pathways are proposed for confirmation during implementation.

Community members	What the plan means and how to contribute
People with lived experience	Help test whether pathways are understandable, respectful, and effective. Participate through compensated review, design, and leadership roles. Share feedback through safe, accessible channels.
Providers and frontline staff	Help refine workflows and standards, keep service information current, identify barriers, and use shared data to improve handoffs and support.
Public agencies and elected officials	Align resources and transition practices where your agency can affect housing stability. Help resolve policy and capacity barriers, and review shared outcomes.
Funders, businesses, and housing partners	Support viable housing pathways, flexible assistance, and services tied to clear results. Help test models and address identified resource gaps.
Residents, faith communities, and community organizations	Use verified service information, support community partnerships, and help people connect with appropriate assistance. Follow progress and contribute through approved opportunities.

CONCLUSION

The Way Home's progress has never come from one program or one funding stream. It has come from partners agreeing to work as a system, share data, align resources, and stay focused on whether people are actually moving out of homelessness. The next chapter of The Way Home must build on that discipline while expanding who shares responsibility for the outcome.

This plan does not assume that the CoC Program can solve housing affordability, behavioral health capacity, wages, benefits, institutional discharge, or every other condition that contributes to homelessness on its own. It does expect the community to be clear about who owns what, where resources are missing, what outcomes each partner is responsible for, and when the system needs to change course.

The future is not just more programs. It is a smarter, more aligned response that can see where people get stuck, understand what investments are producing results, reduce unnecessary administrative burden, and direct more community resources toward housing, prevention, stabilization, treatment, income, and long-term independence. By 2029, The Way Home should know more, move faster, duplicate less, and invest more directly in solutions.

The Way Home's last major leap was from separate programs to a coordinated system. The next frontier is from a coordinated homeless response system to a broader community strategy for housing stability—one that shares responsibility earlier, learns faster, brings new partners and capital to the table, and keeps the experience of people using the system at the center. That is the next version of The Way Home.