Monthly Objectives	
Plan Objectives	**Actual Outcomes**
Housing exit plan for shelter long stayers.	**Case Conferencing taking place bi-weekly. 152 HH with shelter stays over 100 days - 46% enrolled in housing program.**
Increase housing placements	**39 Housing Placements in December**
Increase access to OHP assisters in shelter, access centers and outreach	**We are beginning to assess how to incorporate OHP assisters into our upcoming access center contracts**
Plan for 2025 Point In Time Count	**The Point in time count occurred in January, preliminary results indicate a single digit increase in unsheltered homelessness from the previous**
Challenges	
Continued barriers to accessing health, behavioral health, and substance use treatment for unsheltered and sheltered individuals	
People are staying longer in shelter waiting for refferals to housing programs through Coordinated Entry. This reduces access to shelter and increases the length of time that people experience unsheltered homelessness as they wait for shelter beds. The may be exacerbated by upcoming	
Staff retention and professional development in provider organizations continues to create challenges and delay the full utilization of contracted capacity system-wide. A stable and skilled workforce is neccary to deliver quality services in all program areas.	
Beaverton does not have an access center offering access services, while work is continuing to be done, the city has not yet identified where an access center can be placed. This leaves the city without access services until at least then.	
Highlights	
During the week of January 19th, Washington county had two separate inclement weather shelter activations while conducting the point in time count. While the workload was immense, shelters served an average of 31 humans and 1 pet per night.	
Shelter Longstayer case conferencing has begun for households that do not yet have a housing program enrollment, thereby allowing them to make progress on their housing plans.	
We have developed a partnership with mental health teams to coordinated emergency bed availability for clients the mental health team encounters that is in need of an immediate bed. Results and impact will be assessed over the coming months.	
Needs from the State (policy, additional assistance…)	
Health system alignment: Improved access to medical services. For example, a rapid response team or direct contact within ODHS would help our system manage urgent health needs especially for elderly and disabled participants in our homeless services system.	
Health system alignment: More flexibility in Medicaid eligibility determinations. This would allow engagement services from Behavioral Health system for eligible members who are not yet qualified for Medicaid services.	
Health system alignment: Higher needs elderly participants who can not live independently, even with enriched supportive services. Our system lacks adequate access or availability to long-term care facilities and of these kinds of health system 'beds'.	