

A Toolkit for Resident-Centered Outcomes Measurement

in Affordable Rental Housing



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1 About this Toolkit

Why Housing with Services Matters

Affordable homes enable adults to achieve financial stability and lead healthier lives, equip children to do better in school, and allow seniors to age in place with dignity, among other positive outcomes. When housing is paired with services for residents, these outcomes are even stronger. Services can help break down the barriers created by systemic inequities, and draw support for homes that are a platform for better lives. However, affordable homes are increasingly difficult to find in the U.S. Nationally, a family would need to earn an [hourly wage of \\$20.40](#) to afford a modest one-bedroom apartment, yet the federal minimum wage is only \$7.25. A quarter of all U.S. renters spend more than half (>50%) of their income on rent, and this [rate increases significantly for renters of color](#), who are [disproportionately affected](#) by a long history of racist and flawed housing policies and practices. This reality leaves renters with little money for other bills and almost no room to cover other needs or unexpected expenses.

Increasingly, housing providers, impact investors, capital partners, service providers, and policy makers recognize that by pairing affordable homes with resident services, we can support residents in improving a wide range of outcomes from housing stability to income, employment, education, and health. As this growing range of actors seeks to support housing with services and create accountability for improved outcomes, many lack systems or shared language to guide this work.

Shared language and improved practices can help housing providers and their partners identify what works and build partnerships, policies, and investments to scale it.

This toolkit draws from Stewards of Affordable Housing for the Future (SAHF)'s decade of experience exploring systems of resident services and outcomes measurement in properties serving households with low incomes. While the definition and scope of "resident services" or "service-enriched housing" can vary across providers, our understanding of resident services involves programs that improve life outcomes and well-being for residents, and entail a robust commitment at the enterprise-level that supports on-site staff dedicated to this function. This staff member, often called a "resident services coordinator," provides and connects residents to a wide variety of programs and services at their home and in the community, from community gardening to financial coaching. Depending on resources in the community, the resident services coordinator may host an event or class for a group of residents directly, work with a community partner to bring classes to the property, meet with residents individually to make referrals and connect them with services in the broader community or all of the above. The COVID-19 pandemic revealed how important resident service coordinators can be in helping residents maintain their housing, from connecting residents to rental assistance programs to helping seniors access food and medical care. Yet there are few programs that fund the presence of service coordinators or service delivery in affordable housing outside of [permanent supportive housing](#) for older adults and people with disabilities.

How to Use this Toolkit

The purpose of this toolkit is to provide guidance to affordable housing owners, operators, funders, and partners on approaches to services that are **outcomes-driven, equitable, and resident-centered**.

This toolkit may be particularly useful to:

- Housing and services providers seeking to scale or refine their services programs
- Housing and services providers seeking to add or better integrate outcomes measurement with services
- Funders of housing and services

This toolkit is presented in the order of a cycle of planning and implementation, but is broken into component parts that may also be referenced separately (e.g., there is a resident survey section for those exploring surveys as a measurement tool).

Most sections contain call-out boxes that detail how organizations can put in place equitable, resident-centered practices specifically, as well as useful links for getting started.

The content for this toolkit is informed by and rooted in SAHF's deep practice in this area with its members, as detailed in the following section.

About SAHF and SAHF's Work

Stewards of Affordable Housing for the Future (SAHF) is a policy and practice collaborative of twelve high-capacity, multistate, nonprofit affordable housing providers who collectively own 145,000+ affordable rental homes across the U.S. SAHF's members are committed to producing and preserving affordable rental homes that foster equity, opportunity, and wellness for people of limited economic resources. We focus on pursuing innovation where the scale of the collaborative can have a unique and substantial impact. Our work areas include policy advocacy, energy and water efficiency and decarbonization, financing solutions, and resident health and outcomes.

Our members take a three-part strategy to creating homes that support improved resident outcomes:

1. SAHF members address the root causes, or "[social determinants of health](#)," by increasing the supply of affordable homes and incorporating design practices that support health and well-being, such as trauma-informed design principles.
2. SAHF members have developed a [shared understanding](#) and deep practice of providing quality resident-centered services coordinated through housing, known as resident services.
3. SAHF members are committed to measuring and evaluating the impact of these programs and services, and have established a common [framework of measurement](#).

This three-part approach has provided a framework that helps facilitate partnerships between housing providers and other sectors seeking to improve outcomes for people who live in affordable housing. This framework also seeks to hold actors accountable to engaging residents through equitable, resident-centered approaches and measuring resident outcomes.

SAHF's Resident Services Framework and Resident Outcomes Initiative

Over the past two decades, SAHF members and other affordable housing providers have worked to better integrate, systematize, and evaluate the impact of their resident services programs. SAHF members serve households with very low and extremely low incomes¹ who live in rental homes made affordable through programs such as the Low Income Housing Tax Credit (LIHTC), Section 8, Section 202 Housing for the Elderly and HOME. Given that residents of SAHF member properties often face significant financial constraints and systemic barriers to accessing services that support their housing stability and well-being, SAHF member organizations have long focused on pairing housing with resident services.

Historically, resident services have been provided by resident services coordinators who operated somewhat independently, with low or inconsistent levels of corporate or regional support, and varied standards around training, qualifications, and data collection/reporting. With support from the Kresge Foundation, SAHF launched the Outcomes Initiative in 2012 with a vision of increasing the effectiveness, availability, and financial support of service-enriched housing; and accelerating a fundamental culture and systems change at the practitioner, policymaker, and investor levels. Through iterative conversations with SAHF members (as part of a "Community of Practice") and external partners, the Outcomes Initiative led to the development of two complimentary frameworks for establishing a common approach for systematically implementing and evaluating service-enriched affordable housing:

1. Our [Framework and Guidelines for a System of Resident Services Coordination](#) (Framework for Resident Services) reflects practitioner-driven guidance around a systematic approach to consistently



Measuring the impact of programs and services is an integral component of an effective resident services program, from data collection and analysis to incorporating resident feedback."

engaging residents and coordinating resident-centered services. This approach includes training and capacity building for staff; programs, services, and partnerships; use of data, research, and evaluation; sustainable funding; and other organizational tools necessary to support resident services.

2. Our Resident [Outcomes Initiative Measures](#) detail twenty-five recommended measures for understanding outcomes for residents of service-enriched housing. This list of measures is intended to be both a vehicle for gathering data to tell the story of collective impact, and a resource for the field of commonly-used, vetted measures. With these measures, SAHF and SAHF members are working to move beyond focusing on resident participation and engagement as the primary outcomes for resident services.

Measuring the impact of programs and services is an integral component of an effective resident services program, from data collection and analysis to incorporating resident feedback. However, data collection does not exist in a vacuum, but rather is strengthened when layered within an equitable, resident-centered approach to service-enriched housing. In the broader affordable housing field, there is increasing emphasis by funders, investors, and policymakers on collecting data and evaluating impact. In this process, **it is essential to locate**

1 Very low-income is generally defined as incomes that are less than 50% of the median family income for the area and extremely low-income is defined as incomes that are less than 30% of the median family income for the area.



Photo courtesy of National Church Residences.

“

Data collection does not exist in a vacuum, but rather is strengthened when layered within an equitable, resident-centered approach to service-enriched housing”.

evaluation work within a “resident-centered” system of resident services, as described by our [Framework](#), which outlines how residents can engage with and inform each step of the resident services process. Housing providers – and organizations funding their work – should consider how residents can be co-participants in evaluation and impact measurement, and not simply vehicles for providing data. The diagram on the next page shows how the cycle of data and evaluation fits within, and is bolstered by, the steps of a systems-approach to effective resident services.

How SAHF is Measuring Collective Impact

In 2012, SAHF members began a series of iterative conversations about what they believed to be the key outcome measures in service-enriched affordable housing, leading to our Resident Outcomes Initiative Measures. As owner/operators of rental housing, SAHF members focused on measures that are practical, realistic to collect and meaningful in a housing context.

Collectively, SAHF members agree that the majority of programs and services are geared toward improving outcomes in at least one of the following five categories:

1. **Housing Stability**
2. **Financial Resilience and Stability**
3. **Youth (Development) and Education**
4. **Community Engagement and Safety**
5. **Health and Wellness**

As the field has evolved since 2012, these measures have changed over time.

Each year, SAHF members submit data files to SAHF aligned to framework. SAHF creates data reports for each member and aggregate reports, such as our 2020 report, “[The Impact of Home: Building to Opportunity, Health & Equity](#)”. This report highlights a variety of positive resident outcomes for residents, such as increases in household income, lower rates of housing instability and eviction than comparable populations, higher rates of healthcare access, higher voter registration rates, and positive feelings of safety in residents’ homes. These positive outcomes stem from an approach that leverages existing evidence of what works, engages residents and invests in services that are rooted in the experiences of the community.

Cycle of Impact Measurement in a System of Resident Services Coordination

The diagram below displays each step in the toolkit, with its related step in the [Framework and Guidelines for the System of Resident Services Coordination](#). Ongoing collaboration with residents is a critical element of each step in this process.

STEP 2

Collect Resident, Community and Program Data

Related Framework step: "Assess Community Needs, Resources, Providers" and "Assess Information on Residents"

STEP 3

Clean, Store and Assess Quality of Data

STEP 4

Analyze Data & Create Reports

STEP 5 (A)

Use Data to Prioritize Resident Goals and Inform Internal Decision-making
Related Framework step: "Prioritize Resident Goals and Opportunities" and "Determine Objectives & Indicators for Success"

STEP 5 (B)

Use Data to Establish and Deepen Partnerships / *Related Framework step: "Identify and Establish Partnerships" and "Assess Services & Partnerships"*

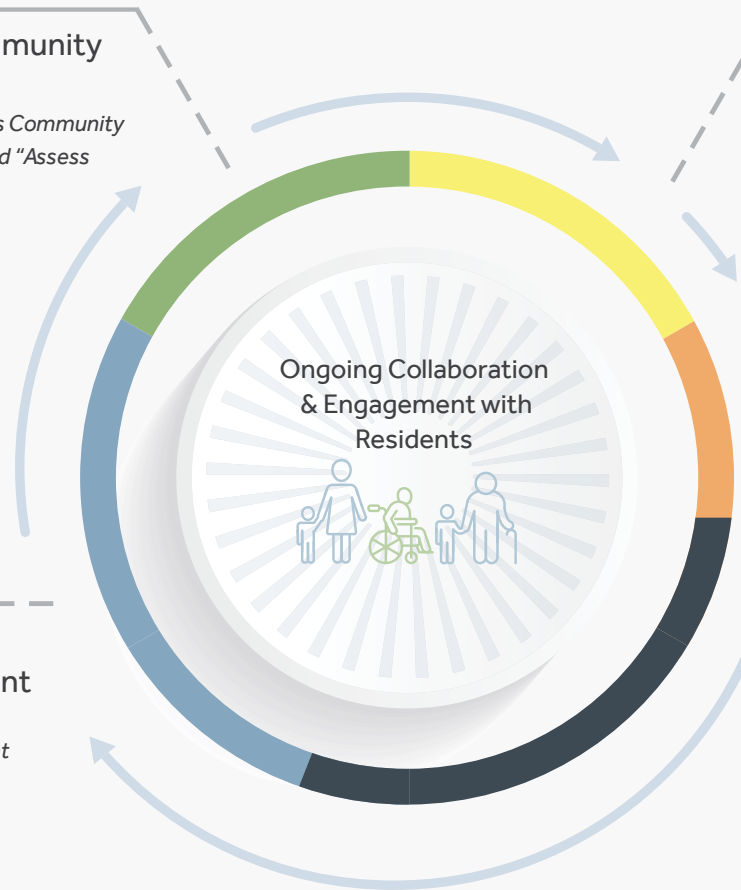
STEP 5 (C)

Use Data to Tell Story of Impact
Related Framework step: "Assess Services & Partnerships" and "Determine and Implement Changes"

STEP 1

Planning & Integrating Outcomes Measurement

Related Framework step: "Organizational Goals for Resident Well-being and Stability"



2

Cycle of Impact Measurement & Evaluation

in Service-Enriched Housing and Equitable, Resident-Centered Approaches

For organizations invested in long-term growth and change, measuring impact is not a one-time exercise. It is ideally a cycle or loop that enables organizations to continually learn from past experiences and put in place more impactful processes and programs. In this way it is similar to a cycle of “[continuous quality improvement](#).” While organizations can work with external consultants, such as researchers, to conduct discrete evaluations, this toolkit is intended more to aid organizations in their internal, ongoing data and evaluation work.

STEP 1 Planning & Integrating Outcomes Measurement

Organizations should take time to plan their cycle of data collection, evaluation and impact measurement. Planning often occurs at the corporate or regional level of the organization. If it occurs at a property level, these plans should be informed by organization-wide or region-wide goals for resident well-being, stability, and resilience. Developing a logic model or theory of change can be a helpful process for organizations to pinpoint their goals (or “north star”) and map out the steps to potentially achieve those goals. The planning process also provides an opportunity for organizations to think creatively about their evaluation work and align data collection with strategic goals and resources. **Appendix A** includes high-level logic models from two housing organizations, as examples.

The following initial questions may provide helpful framing for organizations in the planning process:

Q. What are your goals for resident services and/or resident outcomes? In other words, what are you hoping to achieve? (This could be improved resident health and well-being, economic mobility, financial resilience, increased power and agency, strengthened communities, or any number of other goals for residents, communities, or organizations.)

Q. What resources do you need to work towards this goal? What are intermediate steps you can work towards that will help you meet your goal(s)?

Q. What data or quantitative information do you need to evaluate whether you are progressing towards this goal? (Although challenging, organizations should attempt to differentiate between “nice to have” and “critical to have” data points).

Q. What data do you already have to help you understand the starting point or current circumstances for the communities and residents living in your properties? For example, setting a goal of helping 90% of residents obtain health insurance is not meaningful when current data indicates that 95% of residents are already insured.

Drilling down further, the following questions can help organizations refine or build out their goals, data collection efforts, and intermediate steps:

Q. How will these goals vary for different types of populations served (considering residents’ age, income, race/ethnicity, geography, disability status, and other factors)?

Q. What data do your partners, funders, investors, or regulatory agencies need (and how does their data connect or overlap with yours)?

Q. How often does this data need to be collected, and in what ways?

Q. Whose partnership or buy-in do you need to collect this data? Is it possible to utilize external data sources? How often are those external data sources updated?

Q. How will you contextualize this data and/or examine change over time to evaluate impact?

Q. How burdensome will this data collection be for residents and for staff? Are there ways to lessen the burden of collection while still obtaining meaningful data?

Q. How will your organization work toward building a culture that values data and data-driven inquiry? Is training needed to help staff understand the how and why of data collection?

In this planning and goal setting process, it is also important to consider how the best-laid plans can be thrown off track by forces outside our control. The COVID-19 pandemic forced many organizations to pivot to address urgent needs among their residents, communities and staff. Data collection needs correspondingly may have to change over time as external circumstances change. Although it can be challenging to thread this needle, plans should be flexible enough to accommodate unexpected changes but specific

enough to define the universe of data collection measures, processes and outcomes that point toward organizational goals.



RESOURCE ALLOCATION AND COMMITMENT

Organizations starting or expanding their evaluation work should consider and plan for the resources – financial and otherwise – required to conduct this work well. Funders should also keep in mind the resources organizations need to conduct funder-required evaluation work. This includes corporate-level and perhaps regional staff to handle database management, data cleaning, report writing, analysis and visualization, as well as time investment by frontline staff to incorporate data collection and data use into their day-to-day work. Regular cross-department trainings and data-focused meetings may be necessary. Organizations can start this process utilizing Excel spreadsheets, but in the long-term organizations will benefit from also investing in database systems, analysis and visualization tools and other programs that facilitate data and evaluation work. This planning step should be informed by the financial and other resources organizations are able to commit to their data and evaluation work.



Photo courtesy of NHP Foundation.



MORE RESOURCES

The Stanford Social Innovation Review publishes many helpful articles and resources for nonprofits, such as this [Playbook for Designing Social Impact Measurement](#).



RESIDENT-CENTERED APPROACH

Including Resident Voice in Design

Organizations should consider how they can involve residents in the planning and design stage of the evaluation process. One lens or framing for this work is the [Participatory Action Research \(PAR\)](#) framework, which is a “collaborative approach to research that involves all stakeholders throughout the research process, from establishing the research question, to developing data collection tools, to analysis and dissemination of findings.” For example, when designing a resident survey, organizations should ask resident leaders to “beta-test,” or provide feedback on, the design and wording of questions. Residents may be able to provide invaluable insights on whether certain questions don’t make sense, if there are alternative ways to ask a question to gain more meaningful information, or if the survey design is confusing or too long. Residents can also indicate whether there are certain concepts or areas in which they would like to provide feedback or insights on a survey that are not included. The concept of “[human-centered design](#)” may also be a useful framework, which promotes iterative or recurring feedback loops with clients to test programs at all stages of the “design” process, from prototype to pilot to final product. Residents may also be able to provide insights on the best timing of survey administration and process (for example, residents may prefer paper surveys over online surveys, or vice versa). Depending on the nature of the survey, organizations could also consider utilizing resident leaders or volunteers to administer, distribute and/or promote the survey to other residents, similar to the resident “[health champions](#)” or “health ambassadors” concept but “survey” or “data” ambassadors.

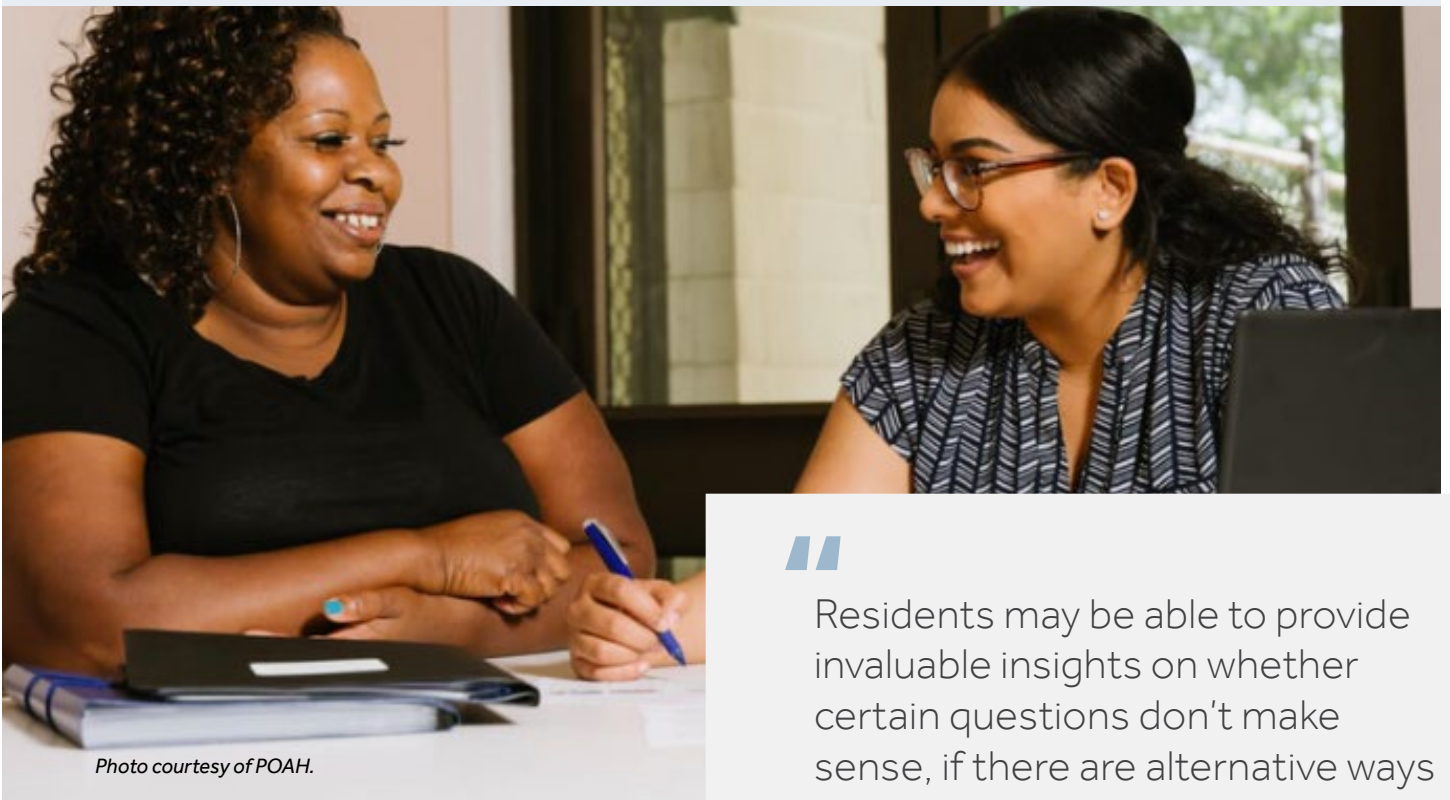


Photo courtesy of POAH.



Residents may be able to provide invaluable insights on whether certain questions don’t make sense, if there are alternative ways to ask a question to gain more meaningful information.”



STEP 2

Collect Resident, Community and Program Data

COLLECT COMMUNITY DATA

Information about the surrounding community is important to collect for at least two reasons. First, where the property's residents are similar to the surrounding community, neighborhood-level data can supplement and complement the body of data that is received directly from residents. For example, examining health indicators from the RWJF & NYU [City Health Dashboard](#) for a neighborhood can help housing providers better understand the health needs of residents without necessitating new, potentially intrusive data collection (up to a point – no community is homogenous in its health conditions and needs). Second, it is critical to understand the availability and quality of resources in the surrounding neighborhood, town, or city. A property with many K-12 children in a rural or resource-poor area may benefit from afterschool/summer programming; whereas a property near a strong youth provider, such as a YMCA or United Way, may be better served through referrals or more targeted services. A "community" can be precisely defined by various geographic boundaries, such as zip codes, or defined by community members in more amorphous ways, triangulating between bus routes, walkable distances, well-known local institutions, etc. "[Community asset mapping](#)," or resource mapping, is a way to understand how residents define their neighborhood and community.

COLLECT PROGRAM OR SERVICE DELIVERY DATA

Organizations should have a comprehensive understanding of how programs, services, or interventions are provided in properties, by service coordinators. There are different ways in which organizations track this information – some track

FRAMEWORK FOR RESIDENT SERVICES CONNECTION

For more context, check out the "Assess Community Needs, Resources, Providers" step on page 11. Prior to implementing resident services at a property, a "community scan" can help organizations determine how resident services may support or improve property performance and, if so, how to structure and fund resident services coordination at a particular property. An example can be found [here](#).

simply whether or not certain programs are offered over a certain period of time, such as a year; others track the specific number of times programs are held or offered; while others track the specific number of times a service coordinator interacts with each resident or family.

Program and service delivery information tends to fall within four buckets, all generally considered "outputs":

1. the types of programs or services being coordinated or offered, such as financial stability programs;
2. the intensity or duration of programs, such as weekly or monthly;
3. resident participation, uptake or engagement, measured as attendance or number of contacts;
4. the entity providing the program, such as the resident services coordinator or a community partner.

Regardless of the ways in which this information is tracked, it is important for organizations with more than a handful of properties to be able to think about program delivery in a quantifiable way, rather than simply relying on qualitative, narrative information about program delivery. While informative, narrative information is very difficult to aggregate at a portfolio-wide level or for a group of properties.



Putting numbers on this topic may also bring to light issues or complexities that be obscured in narrative reporting. For example, tracking program delivery by community partners can be an indicator of the broader community's investment and involvement in a property and its residents. Tracking and quantifying program participation, uptake or engagement is also critical to understanding whether programs are aligning with and addressing residents' priorities, interests and needs. Even high quality programs that are provided at inconvenient times or days will not be impactful. **Appendix B** provides a hypothetical report on program delivery.

COLLECT RESIDENT OR HOUSEHOLD DATA

It is also critical for organizations to understand resident priorities, needs, opportunities, and assets in order to tailor programs and services to the unique circumstances of each community and assess the impact of those programs and services. Organizations often layer quantitative data with qualitative information to best understand residents and solicit their input (more formally known as "mixed methods" evaluation, discussed on next page).

Housing providers typically collect information about residents and households in four primary ways:

1. Property Management & Certification Data.

This data can take two forms: (1) Household data provided to property management staff as part of the initial certification or annual recertification process² and (2) tenancy and housing stability data that is collected by property management, such as move-in and move-out dates, move-out reasons, lease violations, rent payment, arrears, etc. Certification and recertification data points may include *income*, *employment status*, and

FRAMEWORK FOR RESIDENT SERVICES CONNECTION

For more context, check out the "Assess Information on Resident Opportunities, Priorities and Assets" step on page 15. This step describes how a "Resident Opportunities and Priorities Assessment" can help staff understand how to tailor programs and services to residents and communities. This assessment spans multiple steps in this toolkit, including collecting data, cleaning and storing data, creating reports and using reports to prioritize resident needs.

demographics. Data collection requirements and fields vary by property subsidy type. It is important to note that for residents of properties that do not have subsidies or income restrictions, this information may not be collected regularly. This data is typically stored in a property management and/or asset management software system, such as Yardi or RealPage's OneSite.³

2. Voluntary Resident Data. This data is collected across properties, or portfolio-wide, through surveys, interviews, assessments, meetings, and/or focus groups to better understand the needs, opportunities, and resources of residents and assess overall impact. This may include data on resident goals, needs, satisfaction, engagement, and/or outcomes. Pages 12-21 cover this in more depth.

3. Program Participant Data. Resident data is collected from those enrolled in a specific program/intervention, often located at a specific property or a few properties, to assess the impact of this program/intervention. Due to the

² This the process by which property management verifies that tenants meet income or other eligibility requirements, which varies by property subsidy/assistance types.

³ Property management and resident services staff should coordinate on the best ways to access and review this data, whether it's in the form of a regularly-pulled report or an automatically-updated electronic dashboard (such as Salesforce or Power BI). However, any data that is gathered through the Enterprise Income Verification (EIV) system comes with specific statutory and regulatory limits on its use. For example, disclosure of tenant-specific EIV information to service coordinators is not allowed unless the service coordinator is present during the interview and assisting the tenant with the recertification process, even with a consent form. More information about EIV regulations can be found in HUD Handbook 4350.3 Chapter 9.

myriad of programs that may be offered on-site, this type of data collection is generally only conducted for more intensive, structured, and/or grant-funded programs. This may involve “pre/post” assessments and outcomes tailored to this program or service. For example, a rigorous afterschool program may assess students’ reading and math proficiency at the program start and end to determine academic gains.

- 4. Partner Data.** Housing providers may be able to obtain data from community service providers/partners to help facilitate conversations about how residents are being served by the partner and how the partner is improving outcomes for residents. Data sharing agreements are often utilized to facilitate this type of data sharing. More information about using data in partnerships can be found in Step 5(B).

Mixing Data Collection Methods (“Mixed Methods”)

This toolkit focuses primarily on quantitative information gathered from resident surveys and assessments, rather than more **qualitative**

information gathering. However, qualitative information about residents is also extremely valuable for organizations to gather. This may take the form of focus groups or community meetings across a handful of properties, or a series of interviews with specific residents, or open-ended, free-form questions at the end of a survey. This qualitative information can be helpful to better plan what quantitative information should be collected by survey (and in what ways), helpful for contextualizing or explaining survey results, breaking down complex issues, providing residents with opportunities to elaborate on important or nuanced issues, and other purposes. Qualitative information is also extremely helpful for sharing individual stories of impact with external audiences, as well as capturing the feelings, emotions, complexities and nuances of residents’ lived experiences that are impossible to fully capture via survey. Sometimes the most effective evaluation method involves layering qualitative and quantitative information in an iterative process, allowing one to inform the other like two pieces of a puzzle.



Photo courtesy of The Community Builders.



MORE RESOURCES

Housing providers may be able to obtain administrative data about residents, with the appropriate data sharing agreements in place. CLPHA’s [Housing Is](#) site has various resources on this topic, such as this [template](#). For example, some school jurisdictions have created [data sharing collaboratives](#) in which educational data is shared with a variety of local social service organizations serving youth. In this case, nonprofits working with youth can evaluate the impact of their programs on student achievement without having to collect new data from participants. However, the complexity of creating and maintaining these types of collaboratives make them rare. School district agencies are almost universally reluctant to provide student-specific information to external entities due to privacy concerns. A commonly-used privacy threshold is providing aggregated data for groups of at least 10 or more individuals. However in order to evaluate school-level outcomes, the housing provider must then have at least 10 students at any particular school.

However, surveys are necessary to capture a broader range of resident voices in a consistent way over time, recognizing that focus groups or interviews may only represent views of residents with the time, energy or desire to participate. Anonymous surveys may also capture situations or feelings that residents may feel reluctant to express publicly to staff, neighbors or third-party facilitators. Focus groups or community meetings may not adequately capture the voices of residents who are more reserved, new to the community, non-English speakers, or are otherwise hesitant to speak out. It can also be easier to translate a survey to multiple languages than hiring or identifying a translator for a focus group.

VOLUNTARY RESIDENT SURVEYS & ASSESSMENTS: WHO, WHEN & HOW?

Across properties and communities, some housing providers conduct voluntary resident surveys to gather information for three primary purposes:

1. To assess individual priorities, goals and needs, enabling coordinators to follow up with necessary interventions, referrals or services specific to certain individuals;
2. To design and provide programs and services that fit the priorities, goals and needs of groups of residents, taking into account community and organizational resources;
3. To evaluate the impact or effectiveness of programs, services and partnerships over time and tell the story of organizational impact across the portfolio to internal and external audiences.

Each of these purposes may lead to different survey and assessment types, formats and methods. Next we've outlined key considerations and limitations.

Who: Anonymous vs Identifiable Surveys

Surveys can be anonymous or ask for identifiers, such as names and/or unit numbers, and we see both approaches used by high-capacity housing providers. Each approach has its benefits and limitations.

- **Benefits of anonymous surveys:** As some residents may be concerned that their

SAHF INSIGHT

While resident surveys are an important tool for understanding resident needs and program impacts, they must be based on a foundation of trust with residents. When residents do not understand why they are being surveyed or where their information is going, it can feel extractive and intrusive. This can lead to lower survey uptake and general feelings of distrust. The "resident-centered approach" call-outs throughout this report provide ideas on how to build trust with residents, how to center them in the cycle of evaluation, and other strategies (also compiled in a tip sheet in Appendix F). There are various resources on this topic, such as the [AAMC Center for Health Justice's Principles of Trustworthiness](#).

survey answers will be provided to property management and may negatively impact their housing status, such as losing their voucher eligibility, survey anonymity may foster more honest answers among survey respondents. Particularly for questions about resident satisfaction with the property and/or staff, anonymity may help residents feel more comfortable with answering candidly. Non-identifiable information also requires less data protection than personally-identifiable information (PII). Appendix E contains more information about data privacy.

- **Benefits of identifiable surveys:** Service coordinators can follow up with specific residents to address their needs or build on opportunities/assets. In addition, by tracking resident-specific responses in a data system, organizations can undertake longitudinal analysis and measure outcomes/impact among the same or continuous residents over time.

One middle of the road approach is to administer an anonymous resident satisfaction survey and a separate, identifiable survey/assessment of resident needs and outcomes.



The most effective, long-term solution for improving response rates is building trust with residents."

Who: Considering Bias in Survey Responses

Housing providers who administer outcomes surveys are often only able to do so at properties with resident services, unless an organization can utilize property management staff to assist with survey administration. SAHF members' staff work diligently to boost survey response rates, while also respecting residents' right and agency to not complete the survey if that is their preference. SAHF member organizations recognize that survey results are biased by the reality that residents with more time, bandwidth, and/or trust with management are more likely to take the survey than others. Thus, residents with perhaps the highest need for services may be least likely to complete a voluntary survey. While incentives for survey completion help, there is general consensus that the most effective, long-term solution for improving response rates is building trust with residents, such that residents understand why they are being asked for their information and feel like they are part of the process. When organizations share data results back with residents and invite their interpretation and engagement with the analysis, that also builds trust with residents. As one director summarized their work broadly, "progress moves at the speed of trust."

When: Timing and Frequency of Collection

While annual or biannual surveys are the most common approach, organizations should consider the following questions when deciding when and how often to administer a survey to residents:

Q. How likely is it that the information will change from year to year? Some data points, such as banking status or health insurance status, are unlikely to change for most residents from one year to the next. For this kind of data, a survey administered every other year or every third year may be sufficient.

Q. Can the survey be administered to a portion of your portfolio, on a rotating basis? If the survey is administered to some portion of the portfolio each year, such as a third or half of properties, this reduces the burden on properties and residents while ensuring that the organization is utilizing portfolio-wide data that is less than 2-3 years old at any given point.

Q. What are the expectations of your funders, partners, senior leadership, or other stakeholders? Data collected within the past 2-3 years may be acceptable for reporting purposes; outside of that time frame, it may be considered too old to be useful or actionable.

Q. How important is it to your strategic goals to capture information from almost every tenant in every cycle?

Organizations that ask residents to complete the survey in tandem with their annual subsidy recertification have higher survey completion rates, such that each resident is surveyed on a rolling basis through the year. This enables more of a “case management” approach to using data to target interventions/ services to specific residents. However, this approach may give the impression to residents that their survey responses are related to or may impact their housing status. Conversely, a survey given to all residents at the same time, detached from the certification process, will mitigate this fear and may generate more honest responses. Response rates may be lower with this approach, but gathering information from a large enough portion of residents may be sufficient for informing property-wide programming, partnerships, funder reporting and other purposes. A sample size is “large enough” when it is representative of or resembles the overall population. There are various sample size calculators online that allow users to calculate statistically sufficient sample sizes from overall population size and preferred margins of error (see example below). However in practice, many organizations set response rate targets

for all properties that are based in what has been achievable in the past.

Q. What is your comfort level with sampling? If the intent of the survey is less to target resident-specific interventions and more to inform population-level program delivery and evaluate impact, gathering information from a sample of residents may be sufficient, depending on whether the sample is representative of the larger population. Some organizations have experimented with sampling techniques, in which residents or properties are randomly chosen from the rent roll and then targeted for surveys, to obtain a more representative sample; however, this can be challenging in practice. This assumes that the majority of residents who have been targeted for survey completion will actually complete the survey. Incentives may be necessary in this scenario (see “Tips” on page 16).

How: Online versus Paper Surveys

A survey may take the form of an online survey that is emailed or advertised to residents and/ or a paper survey that is mailed or otherwise handed out to each resident (community events, meetings, and parties can be good opportunities for service coordinators to promote and hand

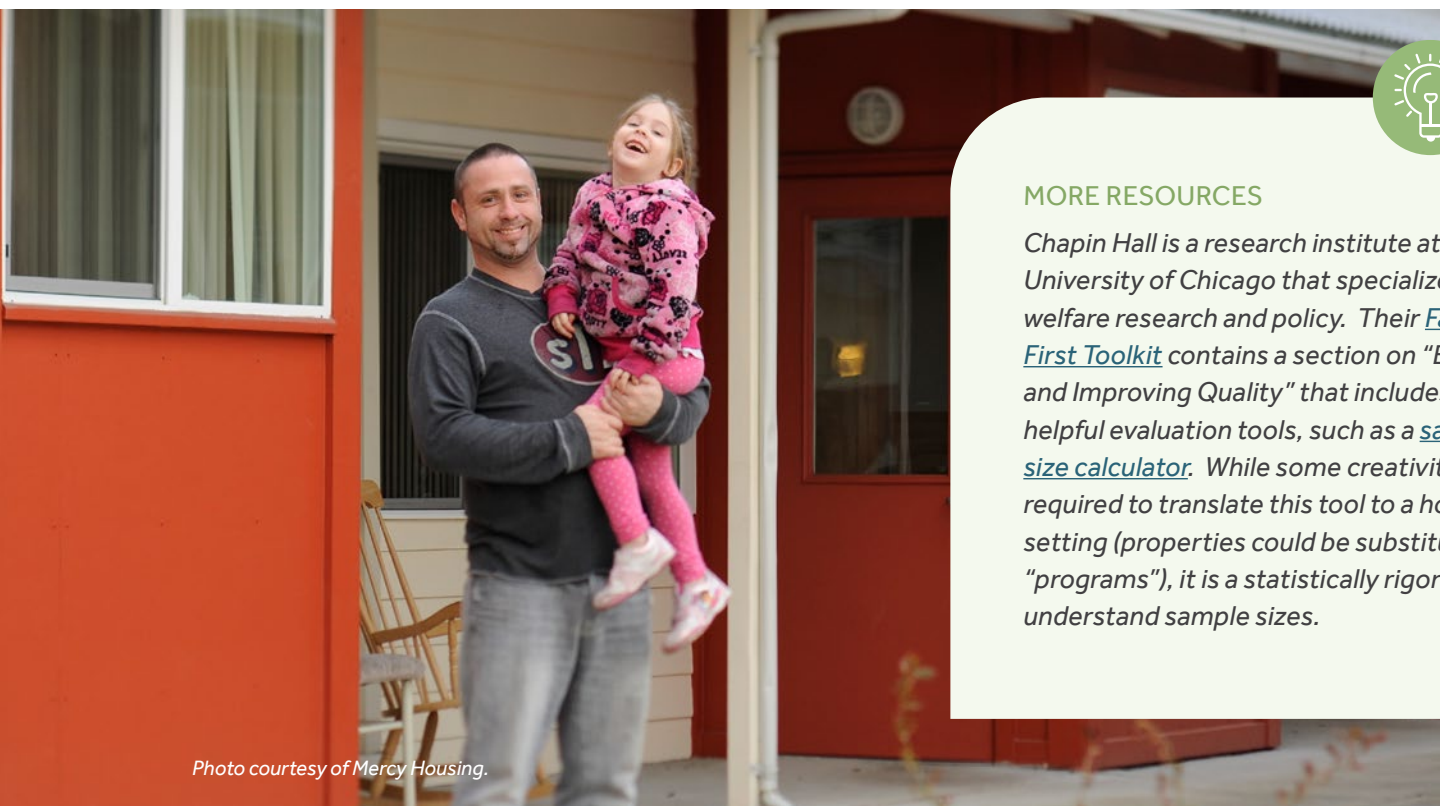


Photo courtesy of Mercy Housing.



MORE RESOURCES

Chapin Hall is a research institute at the University of Chicago that specializes in child welfare research and policy. Their [Family First Toolkit](#) contains a section on “Evaluating and Improving Quality” that includes many helpful evaluation tools, such as a [sample size calculator](#). While some creativity is required to translate this tool to a housing setting (properties could be substituted for “programs”), it is a statistically rigorous way to understand sample sizes.

out paper surveys). Although online surveys are more efficient and flexible, response rates can be hampered by residents' lack of internet access, owners' lack of active email accounts, language barriers, and other technical difficulties. Residents may also be wary of clicking on unfamiliar links or providing sensitive information electronically. Paper surveys may feel "tried and true" to some residents, particularly older residents. However, they are often burdensome for staff to enter the results into a database, and do not allow for "skip logic," which creates shorter surveys by enabling residents to skip over questions that are not applicable to them, or other validation rules that steer residents towards providing certain types of information (for example, preventing residents from putting "Yes" for "Age"). Some tools that organizations utilize to administer online surveys are Survey Monkey, Google Forms, Qualtrics, and some survey tools that are built into social service data platforms, such as AASC Online.

How: Interview-Style Surveys

Alternatively, some housing providers encourage and expect resident services coordinators to meet in-person with residents and ask survey questions with a more conversational, interview-style approach. Some organizations encourage resident services coordinators to partner with property management staff, who then jointly ask residents to meet with the coordinator before or after they complete their annual recertification (the "rolling" surveys mentioned previously). Service coordinators can also administer surveys in-person to residents independent of the certification process.

This approach is more feasible in properties with higher levels of resident services staffing, where staff have time to meet one-on-one with each household regularly and undertake the engagement necessary to encourage those meetings. Properties with seniors and/or special needs populations may have public funding sources for service coordination staff that allow them to meet regularly with residents. In these settings, coordinators often use assessments, such as the Activities of Daily Living tool, to identify needs and develop individual

service plans and provide referrals. This is a "case management" approach that orients services more around individual, specific needs than population-wide or group-wide needs. For coordinators who are administering in-person, interview-style surveys to assess building-wide needs and opportunities as well as develop programming, considering the property holistically is important.

How: Third-Party Survey Administration

Lastly, some housing providers have experimented with hiring/contracting with external firms to conduct resident surveys. External firms may have more expertise on the right questions to ask and how to obtain representative samples of residents. Survey firms may also be able to provide comparable benchmarking data for the broader industry, thus helping organizations better understand their survey results. However, external firms are more likely to rely on emailed/electronic surveys, and resident trust can be a huge barrier to response rates. Residents are not likely to trust an email or link from an unknown company. Cost can be a prohibitive barrier to an engagement with an external firm as well.

VOLUNTARY RESIDENT SURVEYS & ASSESSMENTS: WHAT TO ASK?

There is a large body of knowledge and expertise around effective survey design; some resources are provided on page 17. This toolkit does not attempt to re-create that work but instead provide tips on surveying in an affordable, multifamily housing setting. We generally see six buckets of questions that are included in resident surveys:

- 1. Demographics & Identifiers:** This includes questions about respondents' race/ethnicity, gender identity, age, or other characteristics, as well as potential identifiers such as property type, name, or unit number (depending on whether survey is anonymous). Appendix E on resident data privacy provides more information about protecting data with personally-identifiable information (PII).

TIPS FOR BOOSTING SURVEY RESPONSE RATES

A commonly asked question across the field is how to boost survey response rates. This is not a unique problem to housing providers – even polling firms that specialize in this area are also having trouble these days. As Nate Silver at the blog *FiveThirtyEight* puts it: “Even polls that make every effort to contact a representative sample of voters now get no more than 10 percent to complete their surveys — down from about 35 percent in the 1990s.”* That said, here are some ideas for how to try to boost response rates:

- **Incentives:** While offering a monetary incentive to every resident who completes a survey may not be feasible, there are other ways to provide incentives. Residents who complete a survey could be entered into a raffle or giveaway for the chance to win a prize. Service coordinators can hand out paper surveys and/or share the link at community events with food, activities, or giveaways that have the dual purpose of supporting community engagement and promoting survey completion. Lastly, organizations can provide incentives to staff, such as service coordinators, to reach certain

response rate thresholds, which gives staff autonomy to utilize the outreach strategies that might work best for their communities.

- **Multimodal approaches:** Depending on the population surveyed, it may be helpful to utilize multiple modes of delivery, including (but not limited to) mailing paper copies to residents, providing paper copies in community spaces and/or at community events, emailing survey links to residents, advertising QR codes to the online survey on community bulletin boards or in community newsletters, providing surveys in multiple languages, and utilizing any engagement or program with residents as an opportunity to promote the survey. Door hangers for every unit containing copies of the survey and QR codes to the online version are an effective way to spread the word about a survey.
- **Building trust:** We have heard from housing providers that staff who are able to build relationships and trust with residents over time are better able to foster buy-in to the survey. Residents who understand how their data will be protected and used may be more comfortable with completing a survey. Sharing data back with residents is another avenue to building trust.

* <https://fivethirtyeight.com/features/is-the-polling-industry-in-stasis-or-in-crisis/>

2. Resident Priorities, Goals & Needs: This includes questions about resident priorities, goals and need for various programs & supports, as well as how to leverage community assets and opportunities. For example, these questions may include, “Which of the following programs are you most interested in attending?” (with checklist provided) or “What times of day work best for you to attend programs or events?” This could also include questions about resident need for services/ interventions broadly, such as “Do you need help accessing food or groceries?” or “Do you need help accessing the internet and/or learning

to use devices or tools?” Lastly, surveys can ask about how residents feel about community resources, such as “How would you rate the quality/reliability of your neighborhood [school, library, health clinic/hospital, park, etc.]?”

3. Participation/Engagement: This includes questions that assess residents’ attendance at or engagement with programs or services (e.g., “Have you attended a community life event in the past year?”). Alternatively, some housing providers maintain databases that track specific resident or household attendance at events and/or meetings with staff, thus precluding the need to ask this in

a survey. In a logic model (see Appendix A for examples), the number of events held and/or residents participating are typically considered “outputs,” which are different from “outcomes.” While resident engagement is critical to measure, and a necessary building block to achieving outcomes, it is not an outcome in and of itself if it does not lead to improvements in resident well-being.

- 4. Short-term Outcomes:** This pertains to questions that assess residents’ well-being or progress in a short or immediate-term horizon. Achieving short-term outcomes can be important stepping stones or pathways to improved long-term outcomes. For example, these questions may include: “Do you have health insurance?” or “Do you have a checking or savings account?”
- 5. Resident Satisfaction:** These questions could be grouped with short-term or long-term outcomes, but are an important category in and of themselves. Resident satisfaction with the property/community, which includes feelings of safety, is a prerequisite to deeper resident engagement and trust. This includes questions about how residents are experiencing life at the property, residents’ satisfaction with the built environment of the property, and whether they have positive or negative interactions and engagement

with staff and programs. For example, these questions may include, “Would you recommend this property to others?” or “How satisfied are you with this property, on a scale of 1-5?” In addition to informing resident services, this information can help asset management and property management teams understand and budget for residents’ commonly expressed wants and needs.

- 6. Long-term Outcomes:** This includes questions that assess residents’ long-term health, well-being, stability, security, agency, economic mobility, and other outcomes. For example, this can include questions about financial stability, such as “Do you have enough savings to be able to cover a financial emergency?” or physical health, such as “For how many days during the past 30 days was your physical health not good?” It can also include tracking indicators over time, such as changes in assets, income, credit scores, lease violations, ER visits and hospitalizations, etc. Using data on long-term outcomes to inform decision-making can be challenging and must be contextualized with the reality that many factors influence residents’ long-term well-being, beyond the control of a resident services system/program. However it is still meaningful and important to understand how residents are faring in a holistic, long-term way, however your organization defines the scope of that inquiry.



Photo courtesy of POAH.

MORE RESOURCES

There is an extensive body of research on how to design surveys in ways that lead to accurate and reliable results. A few online resources include [this brief](#) from the Pew Research Center, [this blog](#) from survey platform Qualtrics, and [this article](#) from the Duke Global Health Institute.



Across all categories, but particularly in the categories of resident engagement, satisfaction and priorities, organizations often include a few open-ended, free-form questions to capture more nuanced, complex resident perspectives and input. Due to the time investment required to read each answer individually, these answers are most useful for property-specific resident services or other staff. However corporate-level staff can also “code” qualitative responses, identifying key words, phrases and related terms. This coding can be low-tech, using manual tools and Excel, or high-tech, using a software program. An emerging area in tech is the development of machine learning to code and predict language.

For all of the questions in a survey, some organizations find it helpful to collaborate with regional staff or property staff in choosing which questions to include. Property staff can provide insights into how certain data points will be useful to their day-to-day work, or useful to certain local partners, or perhaps how residents will receive/react to certain questions. While it can be challenging to standardize survey tools across properties when site staff are included in the process, it can also engender buy-in and engagement with the survey in the long-term. Some housing providers have a set of questions that are standardized across all service-enriched properties, while allowing regions or properties to add on questions that are applicable to their needs. Corporate-level staff can provide regions with a bank of questions from which to choose, or work with them to design their own tailored questions.

Guiding Questions for Survey Design

The following are a list of guiding questions that organizations could ask internally to help determine which questions or measures are most critical to include on a resident survey or assessment:

Q. Do the measures/questions in this survey link or connect to a goal for resident services or resident well-being, as defined in your logic model, theory of change, or strategic plan?

Some mission-driven housing providers choose to establish goals around specific outcome areas,

SAHF INSIGHT

Program participation (or enrollment, attendance, or completion) is a critical stepping stone to improved outcomes, but for most programs it is not a positive outcome in and of itself. Participation is a very important data point to understanding whether a program or service is aligning with a community’s priorities, interests and needs. Organizations should have a system to track and evaluate program delivery and uptake, as described in the “Collect program or service delivery data” section. However, participation does not speak to the quality or content of the program or service. For example, a popular tutoring program with staff who are not well trained or equipped may not improve educational outcomes. A tablet lending program for seniors may not improve social connectedness or other outcomes if the seniors do not understand how to use all of the features of the device. Tracking and evaluating participation should be married with evaluating other desired outcomes for programs and services.

such as health & wellness, housing stability, or economic mobility, recognizing that with limited, finite resources they must prioritize services. There should be a clear throughline connecting your data collection to your activities/programs and your goals [two sample logic models are included in Appendix A]. Without this orientation towards high-level goals or objectives, surveys may become over time a mish-mash of questions that meet varying funder demands, partner needs, researcher requests, and/or specific staff person interests or curiosities, all of which may be important but necessitate longer surveys with more resident and staff time investment. However, there may be times when adding questions to meet the needs of key funders, leaders or other stakeholders is unavoidable. In these instances, organizations

could consider shorter, one-off “pulse surveys” that capture specific topical issues, rather than adding permanent questions to an annual/biannual survey.

Q. How does your organization track resident participation in or engagement with programs, services, or interactions with staff?

Some housing providers maintain data systems that track specific resident or household participation in programs and events, or overall attendance at events, or specific interactions or contacts with coordinators. For those without a data tracking system of this kind, providers can ask about resident participation in programs by survey (or track participation in Excel). Achieving sustained and robust resident engagement and participation is a critical building block to creating programs and services that can generate improved life outcomes for residents.

Q. Are there a mix of short-term and long-term outcomes in this survey?

Surveys should have a blend of both short-term and long-term outcomes in order to capture both immediate impacts and long-term progress for residents. Questions around resident access to services, resources, and supports can be considered more short-term outcomes. Examples of these questions might include: “Do you [the resident] have a routine or primary care provider?” or “If you have a young child in the household, do they have access to a high-quality childcare or early education provider?” Short-term outcomes are necessary ingredients for improved long-term outcomes and provide site staff with opportunities to provide targeted interventions/supports.

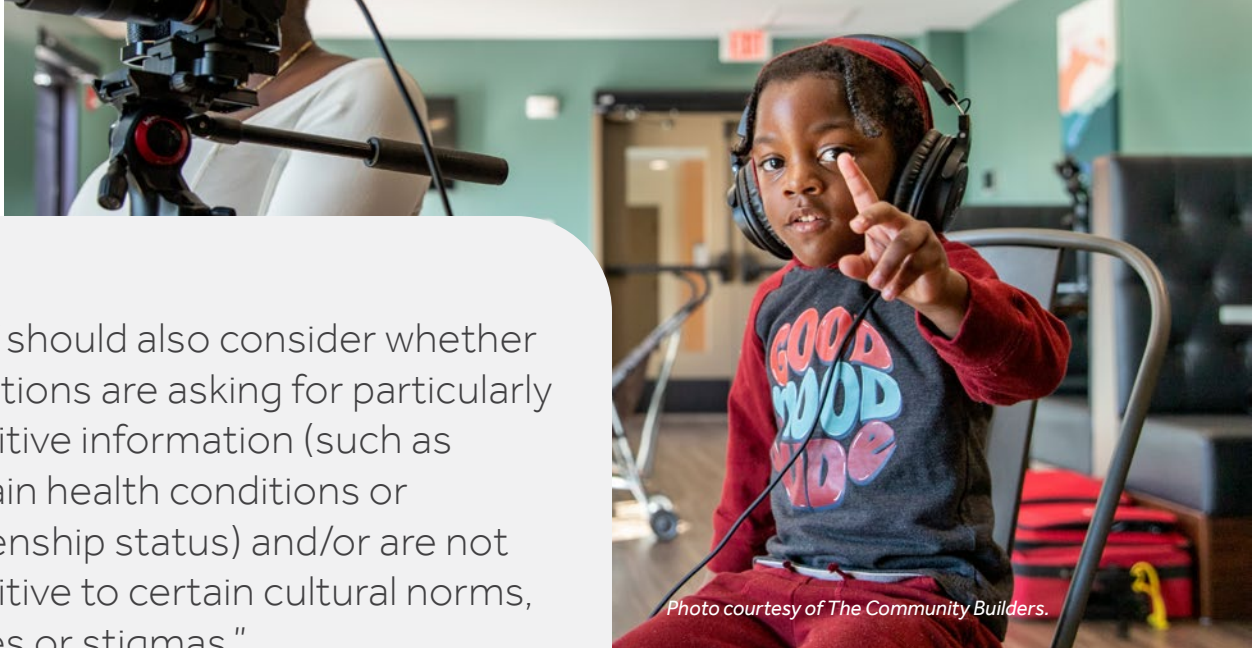
Long-term outcomes attempt to measure or assess lasting improvement through indicators such as those related to a resident’s health, well-being, stability, economic mobility, etc. It is equally important to include at least some measures of long-term outcomes in resident surveys, even if aspirational, in order to gauge whether programs/interventions are having a true impact on well-being in the long term.

Q. Is this measure actionable for site-level staff or program design?

In addition to balancing short-term and long-term outcomes, consider including some measures or questions that lend themselves to direct follow-up by service coordinators or help leadership understand whether programs need to be changed, expanded, or improved. For example, if specific residents indicate that they do not have health insurance, the coordinator can follow up with them to identify and address any barriers to obtaining insurance. This facilitates buy-in to the survey from both a staff and resident perspective, since residents see immediate results from the survey, and helps coordinators feel like they are making tangible, real differences in residents’ lives. Additionally, some measures can help leadership understand how to best modify or expand programs on an ongoing basis to meet resident needs. For example, if a high rate of residents at a property are without internet access, this suggests that more systemic interventions are necessary, such as working with local internet service providers to secure low-cost plans or investigating mesh Wi-Fi solutions.

Q. Is this measure validated by research and evidence?

A survey question is generally considered to be most effective if it is both accurate (the question directly relates to the substance of the issue you’re trying to measure) and reliable (the question generates the same results every time the question is asked of the same residents, whether positive or negative). For some outcome measures of interest to affordable housing providers, researchers have determined (or “validated”) the most effective ways to phrase the question and answer options to maximize accuracy/validity and reliability. For example, the CDC Behavioral Risk Factor Surveillance System (BRFSS) asks a series of validated questions about a person’s physical and mental health. Utilizing this phrasing may generate more reliable results than simply asking residents how they feel at any particular moment in time. Use of validated measures can also allow comparison/benchmarking against broader datasets. However,



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Staff should also consider whether questions are asking for particularly sensitive information (such as certain health conditions or citizenship status) and/or are not sensitive to certain cultural norms, values or stigmas.”

researchers often recommend or validate a series of questions on a particular issue (or an assessment), which may not be feasible to include in its entirety due to space and time constraints on a comprehensive survey. When pulling specific questions from a validated tool, it's important to consider how the questions are meant to work in tandem together. Using one question out of a tool may limit the validity of the question; however this should be balanced with the overall survey burden.

Q. Will residents be able to understand this question/measure and feel comfortable providing honest information? Is the survey question culturally responsive/appropriate?

It is important to consider the survey language from the perspective of the residents and identify any words or phrases that may not make sense to this population. Organizations should beta-test or pilot survey language with a select group of residents to prevent any misinterpretations. When translating surveys to other languages, it is also helpful to beta-test a translation with specific residents who speak that language to identify any translations that are confusing or not colloquially accurate. This can also help identify any missing information/questions that may be useful to include, such as resident concerns or interests. Staff should also consider whether questions are asking for particularly sensitive information (such as certain health conditions or citizenship status) and/or are

not sensitive to certain cultural norms, values or stigmas. For example, people are often reluctant to talk about mental illness or poor mental health due to [pervasive, societal stigma about this issue](#).

Q. Which measures/outcomes are particularly important in an affordable housing context?

While all the social determinants of health are important, housing providers should consider how to leverage the areas in which they have expertise and infrastructure, such as measures of housing stability, including eviction prevention and aging in place for seniors. Move-out data is an underutilized data resource for organizations working to move the needle on housing stability and reducing “negative” or involuntary exits. For example, affordable housing provider [Homeport Ohio reports](#) that “residents who stay with Homeport longer report a positive reason to move out, such as buying a home.” The [Eviction Lab](#) is also a useful resource for comparable eviction statistics in the broader non-subsidized rental market. In addition, it may be helpful for organizations to survey residents who are moving out of a property in more depth, beyond collecting a simple move-out reason, in order to understand whether residents are leaving for more positive or negative reasons. For example, an organization could ask a resident who recently left, “Has moving out of the property had a positive impact on you or a negative impact on you (or neither)?”

Q. Is this measure obtainable through property management?

In an effort to reduce data collection burdens for residents and staff, organizations should consider how to utilize data that is already being collected by property management staff to evaluate resident outcomes and impact of services. This might include measures such as household or resident income, earned income, full-time student status, and assets (to evaluate financial stability/resilience programs); housing tenancy data, lease violations, one-rent payments, arrears and move-out reasons (to evaluate housing stability programs); and demographics (to examine any disparate impacts). For example, organizations could pull earned income values

from a property management software program (such as Yardi, OneSite, or MRI) in lieu of asking residents if they are employed, thus saving survey space for other topics.

APPENDIX D

List of SAHF Resident Outcomes Initiative Measures provides many resources for publicly-available, or benchmarking data sources. There are also subscription-based platforms that aggregate, visualize and layer various external data sets in user-friendly ways, such as [PolicyMap](#), [MySidewalk](#) or [Metopio](#), among others.



RESIDENT-CENTERED APPROACH

Minimizing Survey Burden

Numerous [organizations](#) have detailed the ways in which marginalized, underserved, or oppressed communities have been over-surveyed by the research community, in ways that are extractive and do not return immediate dividends to the community that provided information. While it is important for housing providers to survey residents or otherwise collect data to provide appropriate, responsive, and impactful programs, it is equally important to consider how to survey in the least burdensome, least invasive ways possible. There are various ways in which organizations can limit the burden of data collection on residents. Organizations can consider reducing the frequency or length of surveys (such as moving from annual to biannual surveying), exploring alternative data sources (such as utilizing comparable community-level, publicly available data), or engaging in data sharing arrangements with community partners or public agencies (such as the local department of education). Lastly, organizations should consider compensating residents for their time completing the survey, monetarily or in some other way that recognizes the value of their personal information, insights, knowledge, and time.



STEP 3

Clean, Store and Assess Quality of Data



DATA SYSTEMS

Voluntary resident data is often recorded in an electronic service coordination data management system, either in real time or after survey results are received. These systems include, but are not limited to, Efforts to Outcomes (ETO), Apricot, AASC Online, Family Metrics, and Salesforce. For a few housing providers, this service coordination system is integrated with property management software, so data sources can be combined and data duplications/redundancies are reduced. Integrated software systems also facilitate the creation of cross-department, organization-wide analysis. For example, organizations can more easily examine whether residents who report high satisfaction with the property (data collected through surveys) are more likely to stay longer at the property and/or more likely to pay their rent on-time (data collected through property management and stored separately). Smaller organizations can also use Excel effectively to store and track this information. Having a database is not a prerequisite to starting the journey to measuring and evaluating resident impact.



RESIDENT-CENTERED APPROACH

Protecting Resident Data

Housing organizations are increasingly considering how to best ensure that resident-specific, personally identifiable data is secure. **Appendix E** on resident data privacy provides more information on this topic. Other helpful online resources include National Neighborhood Indicators Project (NNIP)'s [Resource Guide to Data Governance and Security](#), and the global [Fair Information Practice Principles](#).

MORE RESOURCES

This [memo](#) and [webinar](#) provide more information on commonly used data management systems across the SAHF members and [CORES organizations](#).

DATA CLEANING & QUALITY ASSURANCE

Quality Assurance (QA) practices are a key, critical piece of any effective system of evaluation and impact measurement. The validity and reliability of the overall analysis hinges on the accuracy of the inputted data. As the saying goes, “junk in, junk out.” QA practices may include regularly running reports to identify systemic data entry errors or misinterpretation, randomly spot-checking records, assessing the completeness of records across staff and properties, and cross-checking data accuracy across systems. Additionally, a critical piece of quality assurance involves the practice of developing a data-informed and data-driven culture across the organization. Staff who understand the importance and purpose of data collection are more likely to take care to input accurate and complete information for residents and households. Sharing the results of data collection efforts with staff and creating space to have conversations about the analysis can be helpful to incentivize collection among staff, particularly if results are tied to actions by leadership, partners and/or funders. Providing regular training and resources for staff, such as recorded tutorials or written manuals, on how to accurately and efficiently enter data are important. Lastly, it may be helpful to establish threshold expectations around data entry in job descriptions in order to ensure staff and management are on the same page in terms of the importance of data.

STEP 4

Analyze Data and Create Reports

Organizations should have the ability and capacity to create a query or run a report on every data point in their resident software system, if they have one. If data exists in a system that cannot be pulled out in an aggregate, usable format (such as an Excel file), organizations should think critically about why they have it and whether they need it moving forward. In creating analysis, visualizations and reports, organizations should consider the following guiding questions:

1. Who is the audience for this analysis?

Audiences may include external stakeholders, such as partners, policymakers, funders, and the general public, as well as internal audiences, such as residents and corporate-level or site-level staff. Different audiences will interpret analyses in different ways and will utilize reports differently. Data analysis and reports should be shared back with residents in appropriate ways; the “Sharing Data and Engaging Residents in Interpretation” call-out provides more information on this.

2. What is the best format or method for reporting to your audience(s)?

Internal staff: For corporate or site-level staff, electronic dashboards can be an effective way to

report aggregate information back in real time, in a way that reduces the burden on a data analyst or analytics team to generate and tailor reports at regular intervals. There are various dashboard tools available now, such as Power BI, Tableau, and Salesforce. However, even in the absence of an electronic dashboard, regular Word/PDF reports are critical for staff to understand and use real-time data. Corporate-level staff may find it help to meet and review any reports or dashboards before they are shared with staff across the organization, in case there is helpful context or analysis that should be added or explained. When sharing reports with site-level staff, it can be helpful to marry distribution with regularly scheduled meetings to discuss the data and next steps. This can be an opportunity to check for data entry errors if statistics do not seem accurate to staff, and for staff to hear from each other on how they can use data in their everyday work.

External audiences: Multimedia web pages are an increasingly popular way to report on high-level statistics in ways that capture audiences through photos, videos, infographics, and text. Online sites allow for integrated videos, high-res photos, and interactive charts. One example of this is The Community Builder’s [2021 Impact report](#). However, static PDF reports may be better for some audiences, particularly for longer, content-heavy reports. Some readers prefer to print out longer PDF’s and save them for off-line reading. BRIDGE Housing’s 2021 [Who Lives in BRIDGE Housing report](#) is an example of a longer, traditional PDF report.

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For staff, electronic dashboards can be an effective way to report aggregate information back in real time.”



Photo courtesy of Mercy Housing.



RESIDENT-CENTERED APPROACH

Disaggregating Data

In their analysis, organizations should work toward disaggregating outcomes by population characteristics, particularly race and ethnicity, to identify disparate outcomes for different groups. Positive outcomes for the population as a whole may mask disparities in outcomes for residents of color or other subpopulations (or vice versa – some programs may be more impactful or effective for certain residents of color). Interpretation of disparities can be challenging because correlation is not causation – people of color are impacted by unjust systems that can negatively impact outcomes, independent of the effects or non-effects of the program in question. Analysis that examines change over time from a baseline for specific groups, perhaps compared to similar groups who did not participate in programming or were not offered resident services broadly, may help to reveal the disparate impacts of specific programs. If the sample size (number of residents for whom data is available) is large enough, statistical techniques such as multivariate regression and propensity score matching can attempt to “control for” the effects of race or other resident characteristics, allowing the analyst to compare similar residents against each other. If it is appropriate to include outcomes by race/ethnicity in external reporting, providing context is crucial. As [this playbook](#) from Enterprise and FrameWorks points out:

“Discussions about the role of race in policy issues often go astray. Deficit-based ideas about people of color are regularly reinforced in mainstream American media and culture. As a result, many people readily recall, repeat, and believe these ideas, arriving at opinions that place blame for negative outcomes on the people of color who experience them. This situation calls on advocates to be ready to provide compelling, alternative ways to understand the problem. Other situations call for advocates to be ready to talk differently about solutions in order to ward off fatalism. ... The strongest frame [message] begins with ...the idea that economic and community vitality requires that people have the resources they need to participate and contribute. FrameWorks recommends that advocates ...[provide] an explanation of how structural racism creates and maintains disparities, taking care to highlight points where an intervention can change outcomes.”

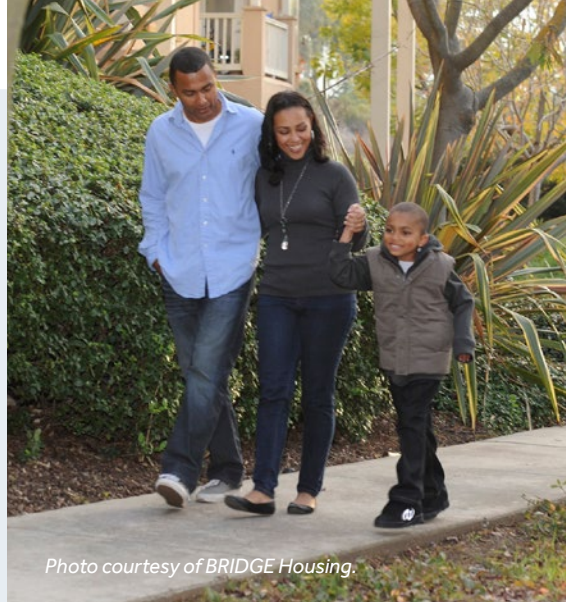


Photo courtesy of BRIDGE Housing.

3. What is the story for each chart or statistics?

In other words, how much explanation is needed?

There is increasing emphasis on providing context and explanation to accompany any data visualization, chart, or graphic. Context could include the number of residents or households the chart represents, or “sample size,” any underlying data integrity or reliability issues, how to interpret the results (e.g., describing the results in a sentence), and broadly why the chart

might be relevant or important to the audience. “Data storytelling” is a growing area of interest with many [online resources](#). Step 5 (C) provides more information on this. Different audiences can take away different insights from statistics; however, providing context can help set the stage for how one could interpret the chart and provides an avenue or gateway into the chart for those for whom data charts or graphics might seem intimidating or not in their area of expertise.

STEP 5 (A)

Use Data to: Prioritize Resident Goals and Inform Internal Decision-Making

Now is the time to put your data to use! Steps 5(A)-(C) detail the various ways in which data can be used to effect change. These steps can take place concurrently or iteratively; we have broken them into three sections for ease of understanding.

Data can be used at different levels of the organization for a variety of internal purposes.

- **Data to provide direct support to residents:** Resident service coordinators can review survey information to determine whether assistance and referrals for specific residents or families are appropriate. For example, a service coordinator might reach out to families with small children who indicated that their children are not enrolled in preschool to identify and help address barriers to enrollment. A coordinator might help make referrals to workforce training programs for those who indicate they are unemployed and searching for work.
- **Data to prioritize programs and services offered:** Resident data can be used to prioritize which programs or services to offer at a property for groups of residents, contextualized with qualitative resident information and the housing organization's knowledge of resources (both internal and external, such as local, regional, or national partners). For example, high rates of social isolation or loneliness across the property might warrant more community-building or social activities. Prioritization is a dynamic process that involves ongoing engagement with residents, assessment of resident priorities and partner capacity, and review of available resources. Providing a realistic timeframe of when any new programs will be launched can also help residents feel heard and foster survey buy-in.
- **Data to set benchmarks, objectives, or goals for collective success:** Resident data can be used at the property level, regional level, and/or organizational level to set quantitative benchmarks for success. For example, a property or region with low rates of residents with health insurance (e.g., 60% insured) might decide to set a goal of reaching 80% of residents insured within five years. This helps align staff on a common goal and objective, and helps hold staff at all levels accountable to reaching that goal. Data can also be used to assess the effectiveness of specific programs and/or community partners, using mutually-decided quantitative goals.



Using data to inform decisions can reinforce a virtuous cycle of organizational buy-in to data collection, quality assurance and reporting processes."



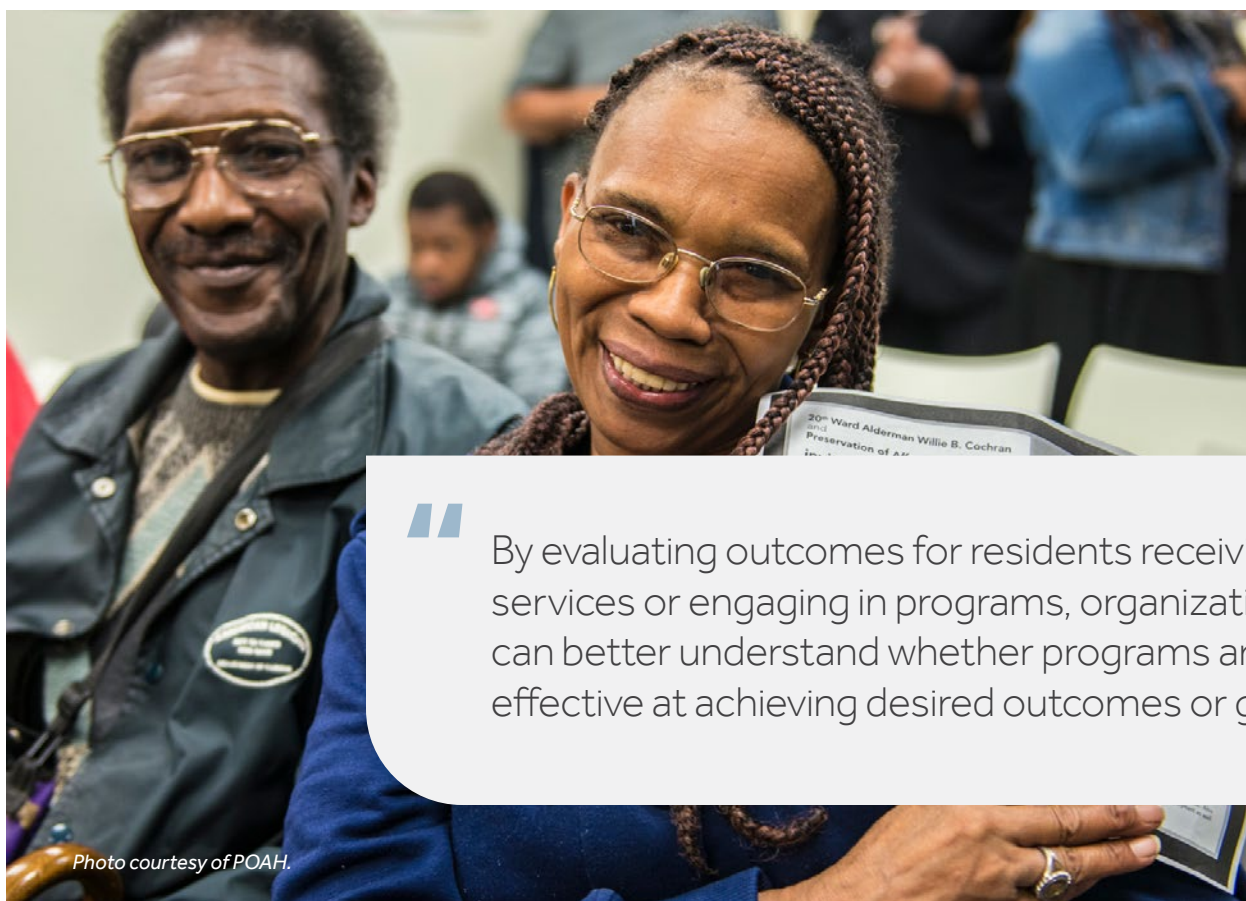
FRAMEWORK FOR RESIDENT SERVICES CONNECTION

The Property Services Plan step on page 18 of the Framework outlines the proposed programs, services, staffing, and partnership model for a property, based on quantitative and qualitative information about resident priorities, assets and needs, as well as community resources.

- **Data to learn and improve practice:**
By evaluating outcomes for residents receiving services or engaging in programs, organizations can better understand whether programs are effective at achieving desired outcomes or goals, and if not, consider how to change course. Changes could involve modifying the program design or model, increasing program dosage or intensity, allocating more resources or staffing, exploring ways to increase resident uptake or targeting specific groups for enrollment, or even making the hard decision to end an ineffective program. This is related to the

concept of continuous quality improvement, in which programs and services are continually evaluated so that staff can determine whether changes should be made to improve efficacy and quality. Data can also be used to guide organizational decision-making beyond specific programs, such as decisions on resident services staffing models, trainings, policies and practices, and other portfolio-wide decisions.

In the long term, using data to learn, improve practice and guide organizational decision-making may be the most challenging part of the evaluation and impact measurement process. It can be hard to identify the pathways to use data to guide decisions, and when data results are contradictory to what management or leadership assumes intuitively to be true, it can be difficult for staff to trust the validity of the data. However, using data to inform decisions can reinforce a virtuous cycle of organizational buy-in to data collection, quality assurance and reporting processes. Leaders and managers who use data to drive decisions will invest more in data systems, staffing, and infrastructure that generates reliable, high-quality data and analytics.



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By evaluating outcomes for residents receiving services or engaging in programs, organizations can better understand whether programs are effective at achieving desired outcomes or goals.”



RESIDENT-CENTERED APPROACH

Sharing Data and Engaging Residents in Interpretation

Service coordinators can support greater resident agency and voice by sharing aggregated data back with residents and involving them in the collection and analysis process. For example, sharing survey results with residents presents an opportunity to “ground truth” the analysis with residents and gauge its validity. Residents may be able to point out inconsistencies or biases in data results that stem from residents not understanding a question, interpreting it differently from staff or feeling not comfortable with providing honest answers. **Residents may also simply appreciate knowing more about their fellow residents and may feel validated if they see themselves reflected in the data.** In the long run, data may also empower residents to create or co-create their own solutions with staff. For example, data may reveal that residents have shared concerns or priorities that can be addressed by the community collectively, such as younger residents who can help elderly residents shovel their sidewalks or parents unable to find affordable childcare who can create communal/informal childcare arrangements.

Housing providers have experimented with various ways in which to share aggregated survey results and analysis back with residents. The organization [Data You Can Use](#) has created a model called [Data Chats](#) that convenes small groups of residents to meet and talk about data, with an emphasis on collaboration and interpretation. As another example, one organization utilized the concept of [Data Walks](#) and organized a “data festival” that included thematic stations. Each station had posters with data results and some sort of related activity to demonstrate the theme. For example, the health station presented health-related survey results and allowed residents to take their pulse after engaging in an aerobic activity. Residents were divided into groups and moved around to all of the stations, getting a stamp when they participated in a station. At the end of the evening, residents who had

all stamps were entered into a raffle. Staff also set up a feedback board at the event where residents could write any feedback about the survey, the results, or the process as a way to capture and validate residents’ perspectives. While this was an intensive, one-off event, other housing providers have created practices around facilitating less intensive, more frequent share-outs. Some organizations request that each service coordinator share data with residents once a year while allowing coordinators to choose the method that works best for them and their residents.

It is important to consider ways to share analyses that are asset-based and not deficit-based. Simply highlighting the persistent needs of the community can be demoralizing, and even unproductive. Even statistics that point to a problem can be flipped to emphasize the positive over the negative; for example, 75% of residents are non-smokers, versus 25% of residents are smokers. Additionally, it may be more effective to highlight a few key findings or statistics from a survey, rather than trying to cover every survey question result. Providing analysis in multiple formats – handouts, posters, presentations, even games – can help residents with different learning styles to absorb information.

Lastly, and perhaps most importantly, organizations should also consider how the property or broader organization plans to act on the results of the survey. Will the survey results lead to any changes? For example, if the survey shows a high need for financial counseling and employment services, the service coordinator could indicate that they will look for and coordinate with community resources to bring these programs to the property (if that is a commitment the organization is able and willing to make). However, it is important for staff to be realistic about what is doable and feasible, as well as timing. Providing a realistic timeframe for when a new program can be launched helps communicate to residents that a plan is in place, but that change can’t happen overnight. Communicating the intermediate steps of a long-term change, and any obstacles to change, can be helpful in assuring residents that their voices have been heard.

STEP 5 (B)

Use Data to: Establish and Deepen Partnerships

Affordable housing providers often partner with local, regional, or national organizations who may have expertise, staff, and/or funding to support specific programs or outcome areas. Rather than trying to be the experts in financial stability, and health, and education, and everything else, housing providers often focus on how to best position housing as the conduit, connector, or platform that links together various partners across the social services sector. Sometimes, data can be used to attract partners and demonstrate the alignment of missions and focus areas. Through collective data collection, sharing, and analysis, housing providers and mission-aligned partners can work collectively towards achieving positive, quantifiable outcomes and impact measurement.

Considerations or key elements for forming outcomes-driven partnerships with non-housing entities include:

- **Understanding the time horizon or timeline of deliverables for each party.** Housing providers often work in longer time horizons than other partner organizations. Housing providers make 15+ year commitments to serving residents in a specific community, and it can take years for a project to move from the planning stage to “lease-up,” or when residents are moving into the property. Funders and housing providers should communicate about realistic timing for when place-based programs or interventions should begin. Additionally, partners should enter engagements with the understanding that construction timelines can change for projects due to unforeseen delays, and partners should build in appropriate flexibility in timelines for project deliverables and reporting.
- **Breaking down jargon.** Different social sectors have different acronyms, labels, and commonly-used phrases – it is important to create spaces in which partners have dedicated time to talk about any language or jargon that is being lost in translation. For example, a housing provider

knows that “resident services” and “service-enriched housing” are generally the same thing, but that “permanent supportive housing” is different.

- **Determining goals or benchmarks for success at the start.** Mutually-determined, quantifiable goals can help to drive the partnership forward and can help partners gauge their progress towards success. Establishing realistic time horizons and understanding systemic limitations is important. While funding partners may have goals and accountability to show progress in relatively short timeframes, it may take a few years for a new partner or program to build trust/engagement with residents and put in place the building blocks that lead to improved resident outcomes. Establishing and reviewing benchmarks can help create accountability and offer opportunities for program refinement to continue to build to positive long-term outcomes.
- **Understanding community needs, assets, and interests.** It is critical to understand resident needs and characteristics, community assets, neighborhood history, and other context to design programs that have resident buy-in. Understanding residents will also help contextualize any outcomes data collected through the partnership. However, sometimes tailoring programs or interventions to the needs and interests of specific communities can have the trade-off of limiting an organization’s ability to scale programs across properties or regions, thus precluding any aggregate or cross-property analysis to understand broader impact. This is a fundamental tension for housing providers, in that programs scaled across multiple sites may not perfectly align with what each community needs or wants. Many organizations encourage properties to align programs to the needs of that particular, unique group of residents, while also encouraging uptake of effective models and best practices across the field. Partners should discuss where they want to live within this spectrum. One approach we have seen among housing providers is an attempt to scale evidence-based or vetted program models at sites where it is appropriate.



FRAMEWORK FOR RESIDENT SERVICES CONNECTION

The “Identify and Establish Partnerships with Community Providers” step on page 18 describes the process for identifying and vetting partners from a broader, more qualitative perspective.

- **Creating processes and protections for data sharing.** Data sharing can take many forms – aggregate statistics or reports can be shared for high-level learning; de-identified resident-specific data can be shared for cross analytics; or identifiable resident-specific data can be shared for data matching and analysis projects, in which multiple data sets can be combined to form a more complete picture of residents. For the latter paths, data sharing agreements and protections should be created to ensure that resident privacy is protected and secured.
- **Creating defined avenues or spaces for communication and shared learning.** Partners should set aside time specifically to check in and share learnings as the project advances. Periodic review of qualitative and quantitative output and outcomes data can help build understanding and identify issues. It is important for leadership or management to set the tone and create an environment in which staff feel comfortable sharing challenges or struggles, as well as successes and progress. It can be helpful to have a staff person specifically in charge of handling the meeting coordination, scheduling, and agenda planning that is necessary to bring together busy staff at various organizations.



SAHF INSIGHT

Establishing a true baseline for evaluating the impact of services in affordable housing can be difficult, since typically there is a relatively small pool of either (a) newly constructed properties each year, or (b) or properties with a new resident services program/staff in affordable housing portfolios. When services are put in place at properties that have been recently rehabbed or constructed, investors and funders may be eager to put services in place immediately to facilitate the collection of baseline data and start to evaluate impact. However, it is important for housing providers and funders to communicate about realistic timing for when place-based programs or interventions should begin. Time should be allocated in the process for staff to get to know residents and understand resident and community needs, priorities and assets, in order to tailor programs to specific communities. By short-changing this first step, organizations may end up with programs that do not align with residents' interests or do not have resident buy-in.



STEP 5 (C)

Use Data to: Tell Story of Impact

Storytelling is often the missing link of data collection and evaluation. What story or narrative is the data telling us, or not telling us (is there a story you thought the data would show that it is not)? As explained by the nonprofit [Data You Can Use](#): “no data without stories; no stories without data.” Storytelling is just as important for internal audiences within the organization as external audiences. Sharing reports and analysis with internal stakeholders helps to build a culture of data and data-driven decision-making, as staff better understand the use and role of the data they have been collecting, inputting, and correcting. Organizations should assess the impact of specific programs or services occurring within their portfolio, as well as their overall impact, in order to determine whether changes in program design, staffing, or resource allocation need to happen (as described in Step 5(A)). Framing this conversation as a data-informed story, rather than statistics with no context, is important to facilitate understanding and collaborative decision-making when changes are warranted. For example, a data-informed story might conclude as follows: “Despite a strong commitment to this program by staff, academic

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Storytelling is also important for sharing data with external audiences, particularly in areas that are prone to misinterpretation.”

outcomes for youth participating in this program overall declined by XX percentage points over the past two years. However, when we disaggregated the data we saw that outcomes for middle school boys in particular improved over this time period. This community has also struggled with learning loss resulting from pandemic school closings. How can we make changes that improve outcomes for youth participating in this program?”

Storytelling is also important for sharing data with external audiences, particularly in areas that are prone to misinterpretation. In creating reports for external audiences, housing providers often include some statistics in annual impact reports and/or create comprehensive reports about the impact of their service-enriched housing every few years, as funding allows. This often takes the form of a PDF report that is layered with photos, infographics, maps, and text to create a visually interesting and engaging medium.



RESIDENT-CENTERED APPROACH

No Data without Stories

The most effective data storytelling marries quantitative analysis with relevant case studies, narrative stories of the lived experiences of residents, historical or topical context, photos and maps, or other context that explains why the data results matter. When audiences can associate a person or family with a statistic, it helps to paint a picture of the data (people are notoriously [bad at understanding big numbers](#)). The case study or story explains why

this matters and the statistics explain the magnitude or scale of the impact. Sometimes, generating more explanatory, contextualized data reports less frequently can be more effective than churning out data reports at frequent intervals with little context provided. However, organizations must balance the value of obtaining resident stories with the value of respecting resident privacy. Residents should understand that participating in any story-gathering project is completely voluntary, and should understand when, how and why their stories will be presented to external audiences or the public at large.



Photo courtesy of POAH.

“

It is critical for organizations to revisit their plans every few years and consider what they have learned.”

STEP 1 REPEAT

Planning Outcomes Measurement

Organizations should revisit their impact measurement and evaluation plan holistically every few years, taking into account changes in the organization’s structure, goals and priorities; changes in resident needs and priorities; and developments in the field broadly. Some organizations take advantage of strategic planning to revisit their evaluation and impact work. Periodically, organizations should conduct a “data audit” to inventory all the data points, measures, and indicators that are collected on residents and households across the organization. This will allow organizations to evaluate whether there is data being collected that is not regularly included in reports or that is not used to inform decision-making. This data can then be removed from the collection process.

Over time, SAHF members have collectively decided to drop certain measures from our Outcomes Initiative Measures that have proven to be impractical to collect, not meaningful for analysis, or raise other issues. As an example, SAHF previously collected the percentage of students who advanced to the next grade as an indicator of academic achievement. However, this measure proved too challenging to collect from parents, quickly dated, did not vary significantly from year to year, and was highly dependent on school district policies on grade advancement. Therefore, many SAHF members stopped collecting this data. While changes to data collection and collection processes should not be taken lightly, it is critical for organizations to revisit their plans every few years and consider what they have learned and how to incorporate those lessons learned into new plans moving forward.

3 Resources

APPENDIX A

Sample Organization Logic Models

Below are example logic models for resident services from two organizations: APAH and Community Housing Partners.

Logic Model – Across All Pillars



APAH Resident Services

Mission: Provide assistance to residents and help them eliminate barriers to obtaining self-sufficiency.

Resources (Inputs)	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes
Resident Services Staff	1. Housing Stability	# of residents	Reduced rate of delinquency & eviction	Stability - Length of Time at APAH (for appropriate cohort)
Volunteers	2. Economic Mobility	# of residents accessing resources through APAH	Reduced rates of food insecurity among residents	Mobility – what happens to residents after they leave APAH (for appropriate cohort); home ownership, income, higher education, etc.
Apricot CRM	3. Health, Wellness, & Senior Support	# of referrals made for external resources	Increased resident satisfaction, residents feeling of safety and security	Self-Sufficiency / Self-efficacy
APAH Staff Support	4. Children, Youth, & Families	% Participation in RS Activities	Fostering a Sense of Community and Belonging among residents	Agency & Self-Advocacy
Government Assistance	Community Engagement (throughout all 4 pillars)			
Grant Funds				
Donations				
Partnerships (e.g., THRIVE)				

CHP Resident Services Logic Model

Goal: Increase the length and quality of life for CHP residents.					
Objectives: 1) Increase educational attainment 2) Improve healthy behaviors and access to care 3) Improve housing and economic security 4) Improve community and social connectedness					
Program level outcomes:					
Inputs	Interventions	Outputs	Short Term Outcomes	Long Term Outcomes	Impact
CHP Residents CHP Community Spaces RS Site & Corporate Staff Regional/ Local Partners, Volunteers, and resources CHP Executive and Board Support Cross Collaboration with CHP Departments	Service Enriched Housing with Four Core Programming Interventions: 1. Education 2. Health 3. Economic Stability 4. Community Building and Engagement	# of Program Participants Units of Service by program Monthly Committed Partner Resource CHP dollars invested	Access to educational opportunities for youth increases Assistance to adults pursuing educational opportunities increases Access to onsite health education and health screenings Access to exercise opportunity increases Food Security increases Resident Stability increases	Adverse childhood experiences decrease Health and well-being self-reports improve Physical activity increases School mobility of children decreases Sense of community (social connectedness) increases Social-emotional skills of children improve	Seniors comfortable and safely age in place. Academic proficiency scores increase Crime rate decreases Employment rate increases Graduation rate increases School readiness improves



RESIDENT
SERVICES



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APPENDIX B

Mock Program Delivery Data Report

Below is an example of how an organization could potentially track the delivery of programs and services across its portfolio. In this report, the first six columns (through “provider”) would be standardized, drop-down answers in a data system, which allows for comparison and aggregation across many sites. The last three columns would be used as free-form, open text fields, which allows the site-specific staff person entering the information to provide more details. This is one way of many an organization could track and aggregate their program delivery information. This type of quantitative tracking may not be necessary for organizations with smaller portfolios, such as those with fewer than 10-15 properties.

MOCK PROGRAM & SERVICES DELIVERY REPORT: 1/1/2018-12/31/2018

Property Name	RSC Name	Impact Area	Program Category	Dosage	Provider	Avg # Participants	Date(s)/ Range	Details
Sunset Village	Jane Doe	Community Engagement	Community Meetings	Every Few Months	RSC	40	11/1/2018	Rehab info community meeting
Sunset Village	Jane Doe	Community Engagement	Donations	Occasional/ Annual	RSC	32	Nov-Dec 2018	Winter coats drive
Sunset Village	Jane Doe	Community Engagement	Community Safety	Every Few Months	RSC	15	2018 Quarterly	Neighborhood safety mtgs with MPD
Sunset Village	Jane Doe	Community Engagement	Potlucks/ Community Meals	Occasional/ Annual	RSC	52	12/21/2018	Christmas potluck
Sunset Village	Jane Doe	Financial Stability	Financial Coaching	Weekly	Community Partner	8	Jan-Jun 2018	Ernst & Young weekly coaching
Sunset Village	Jane Doe	Financial Stability	Credit Building/ Credit Repair	Weekly	Community Partner	14	Jan-Jun 2018	Ernst & Young credit building classes
Sunset Village	Jane Doe	Financial Stability	Benefit Screening	Weekly	RSC	22	Ongoing 2018	Part of ongoing interviews
Sunset Village	Jane Doe	Financial Stability	Tax Prep/EITC Education	Occasional/ Annual	Community Partner	28	March-April 2018	VITA tax filing
Sunset Village	Nancy Adams	Health & Wellness	Physical Fitness & Exercise	Weekly	Community Partner	12	April-Nov 2018	Sunset Yoga classes
Sunset Village	Nancy Adams	Health & Wellness	Healthy Living	Monthly	RSC	19	Ongoing 2018	Healthy cooking classes
Sunset Village	Nancy Adams	Health & Wellness	Healthy Living	Monthly	RSC	13	Ongoing 2018	Mindful eating classes

APPENDIX C

Abbreviated Table of SAHF Resident Outcomes Initiative Measures

This table summarizes the key benefits and value of collection for each SAHF measure (“short-term” and “long-term” being subjective and overlapping characteristics). More explanation for each column provided on next page.

Program Area	Outcome Measures	Short-term	Long-term	Bench-marking Available	Housing-specific	PM Source
Financial Stability & Resilience	% of households whose gross income increased		X	X		X
	% of households whose income from employment increased		X	X		X
	% increase in median income from employment		X	X		X
	% of employed residents	X	X	X		X
	% of residents who had no job last year and now have a job	X	X	X		X
	% of households who report increased assets		X	X		X
	% of unbanked households	X		X		
Housing Stability	Median duration of residence		X	X	X	X
	% of households who moved out for negative reasons (such as eviction or poor health)		X		X	X
	% of households who moved out for positive reasons (such as purchasing a home or no longer needing rental assistance)		X		X	X
	% of households with in-unit internet access and access to a computer	X		X		
Youth & Education	% of 3 and 4-year-old children enrolled in Pre-K, Preschool, Head Start, or other early education program	X		X		
	% of young adults who graduate from high school	X	X	X		X
	% of residents who complete higher education or earn a secondary degree		X	X		
Community Engagement & Safety	% of residents that said they feel safe in their building	X	X		X	
	% of residents that said they feel safe in their neighborhood	X	X			
	% of residents eligible to vote who are registered to vote	X		X		
Health & Wellness	% of residents reporting that their general health is good/poor		X	X		
	% of residents reporting that poor physical health kept them from doing their usual activities such as self-care, work, or recreation in the last 30 days		X	X		
	% of residents reporting that their mental health was not good in the last 30 days		X	X		
	% of residents using a hospital ER one or more times in 12 months	X	X			
	% of residents with a usual place of care where they receive routine primary care services	X		X		
	% of residents who visited a healthcare provider for a routine checkup in the last 12 months	X		X		
	% of residents enrolled in health insurance and type of insurance	X		X		
	% of residents or households who report experiencing food insecurity	X	X	X		

Short-term

These are measures that indicate short-term progress towards longer-term positive outcomes, that have the benefit of often being directly actionable by service coordinators, in terms of connecting residents with benefits and resources, or working to break down barriers to access.

Long-term

These measures point towards longer term positive outcomes, progress or growth, in terms of improved health, financial stability, educational advancement, community engagement, etc.

Benchmarking Available

These are measures that have external/secondary data available for benchmarking purposes (i.e., to understand how residents compare to others with similar characteristics and/or in the same geographic areas).

Housing-specific

These measures are specific to a housing context, in that they are directly related to a key outcome of housing stability and can only be collected by affordable housing providers.

PM source

These measures are generally collected by property management (PM) staff through the certification/recertification process for subsidized renters; and thus can be reliably obtained through PM software and do not require new collection from residents.

APPENDIX D

List of SAHF Resident Outcomes Initiative Measures with Details

Below is a more detailed list of the SAHF Resident Outcomes Initiative Measures with the specific survey question or indicator; the rationale for why SAHF and SAHF members feel it is important; and any secondary data source that can provide a local or population-specific benchmark to better contextualize resident data. SAHF members collaboratively arrived at this list of measures but these are not the only possible outcome measures to evaluate impact. The National Neighborhood Indicators Project maintains a list of [data sources](#) utilized by their partners.

PROGRAM/SERVICE AREA: FINANCIAL STABILITY & RESILIENCE

- **Percent of households whose gross income increased**
 - *Indicator/Survey Question:* Gross household annual income (\$)
 - *Rationale:* Income is a key element of financial stability and economic mobility. The Urban Institute report, "[Boosting Upward Mobility: Metrics to Inform Local Action](#)," draws from the [U.S. Partnership on Economic Mobility](#)'s work and specifies two main components of financial well-being: income and financial security. Specific to income, the report states: "Families need a base level of income to meet basic needs and costs related to working. Higher incomes are associated with higher academic achievement and educational attainment, better physical and mental health, and fewer behavioral problems in children." Income values can also be pulled from property management software, thus reducing the reporting burden on residents.
 - *Secondary Benchmarking Resource:* The [HUD Picture of Subsidized Housing](#) provides average income values for all households in HUD-subsidized properties, by subsidy type and various geographies (such as census tracts). This is relevant since HUD subsidies have varying income targets. The Census Bureau American Community Survey also provides median household income values for every census tract.
- **Percent of households whose income from employment increased**
 - *Indicator/Survey Question:* Gross household or resident annual income from employment (\$)
 - *Rationale:* Income from employment specifically, or "earnings," is a key element of financial stability and economic mobility. Changes in earned income can result from gaining employment, transitioning to employment with higher wages, and/or increasing hours worked. Income from employment values can also be pulled from property management software, thus reducing the reporting burden on residents.
 - *Secondary Benchmarking Resource:* The Annual Social and Economic Supplement to the Current Population Survey (March CPS), administered every year in March, is a well-vetted source for federal income data. The battery of income-related questions can be used to ascertain annual income by source. The Survey of Income and Program Participation (SIPP) core income questions can be used to ascertain income data monthly.⁴

4 As stated in the US Partnership for Economic Mobility report "Measuring Mobility from Poverty" (2018).

- **Percent increase in median income from employment**
 - *Indicator/Survey Question:* Gross household or resident annual income from employment (\$)
 - *Rationale:* This is another way to calculate change in earnings. See above for more for information.
 - *Secondary Benchmarking Resource:* See above for more information.
- **Percent of employed residents**
 - *Indicator/Survey Question:* Gross household annual income from employment (\$)
 - *Rationale:* Employment is a key element of financial stability and economic mobility. However, SAHF recognizes that an increasing body of evidence posits the importance of employment that pays a living wage and provides upward growth. SAHF does not currently have a measure in our framework on the types or industries of resident jobs due to the complexity of this type of data; however, this is an issue we are exploring and encourage other housing providers to consider.
 - *Secondary Benchmarking Resource:* The Bureau of Labor Statistics publishes monthly and annual figures on employment, unemployment, and labor force participation. However, SAHF members typically do not identify residents who are actively looking for work and able to work, which makes comparisons with BLS employment rates more challenging. Using the labor force participation rates, specifically out of the “civilian, non-institutional population” may be a more apt comparison.
- **Percent of residents who had no job last year and now have a job**
 - *Indicator/Survey Question:* Employment status
 - *Rationale:* This is another way to analyze employment data, identifying residents who have recently gained employment.
 - *Secondary Benchmarking Resource:* See notes for “percent of employed residents” indicator.
- **Percent of households who report increased assets**
 - *Indicator/Survey Question:* Total household financial assets (\$). SAHF does not provide parameters on what constitutes an “asset” because for the majority of SAHF member residents, their total assets are the equivalent of their savings in a bank account, and occasionally retirement accounts. Residents do not typically have physical assets, equity, or investments.
 - *Rationale:* The Urban Institute report, “[Boosting Upward Mobility: Metrics to Inform Local Action](#),” states: “Savings can help families weather destabilizing events like a period of unemployment or unexpected expenses. Building assets and savings can also help families work toward homeownership, which is a critical step in reducing the [Black-white wealth gap](#). Asset values can also be pulled from property management software, thus reducing the reporting burden on residents.”
 - *Secondary Benchmarking Resource:* The Census Bureau American Community Survey provides data on household net worth, including financial assets and other sources of wealth.
- **Percent of unbanked households**
 - *Indicator/Survey Question:* Do you [the resident] have a bank checking or savings account?
 - *Rationale:* This measure is more of a short-term outcome that can be directly impacted by a service coordinator, who can help residents address obstacles to opening a bank account. This measure recognizes that it is impossible for residents to accumulate assets and savings without first having a bank account.
 - *Secondary Benchmarking Resource:* The [Prosperity Now \(formerly CFED\) Scorecard](#) publishes rates of unbanked residents at the city or county level, among many other important financial indicators.

PROGRAM/SERVICE AREA: HOUSING STABILITY

- **Median duration of residence**
 - *Indicator/Survey Question:* Move-in and move-out dates
 - *Rationale:* Duration of residence (or “length of stay”) is a key outcome of affordable housing, although analysis can be complex. Longer durations of residence may be a positive outcome for seniors who would like to “age in place” and avoid institutional care. Shorter durations of residence may be a positive outcome for families who are working toward building assets and moving to unsubsidized rental housing or homeownership. SAHF’s analysis has also indicated that the availability and affordability of other rental housing in the surrounding neighborhood is a strong contributor to duration of residence.
 - *Secondary Benchmarking Resource:* HUD’s [Picture of Subsidized Housing](#) database provides data on “average months since moved in” for all households in HUD-subsidized properties, by subsidy type and various geographies (such as census tracts). HUD’s “Length of Stay in Assisted Housing” report (2017)⁵ is also a helpful resource on understanding the factors that influence duration of residence.
- **Percent of households who moved out for negative reasons (such as eviction or poor health)**
 - *Indicator/Survey Question:* Move-out reason
 - *Rationale:* Avoiding negative move-outs, particularly evictions and households on the path to eviction, is a key outcome for affordable housing. Most SAHF members provide programs that aim to support housing stability for residents and prevent evictions. While many factors influence eviction rates, including local policies and court systems, SAHF members work to avoid and reduce evictions whenever possible.
 - *Secondary Benchmarking Resource:* The [Census Bureau American Housing Survey](#) asks renters about their ability to pay rent and remain in their homes. In terms of actual court-ordered evictions, [The Eviction Lab](#) at Princeton University started in 2017 to compile eviction data and records from jurisdictions across the U.S. to create national eviction rate data and analyze disparities and trends between populations and geographies.
- **Percent of households who moved out for positive reasons (such as purchasing a home or no longer needing rental assistance)**
 - *Indicator/Survey Question:* Move-out reason
 - *Rationale:* For individuals and families who have identified homeownership as a goal, SAHF members work to support them with asset building and coaching services to reach that goal. More broadly, many SAHF members provide financial counseling, coaching, employment services, and other programs that help working-age residents increase their income and potentially reach an income level at which they no longer need rental assistance.
 - *Secondary Benchmarking Resource:* The [Census Bureau American Housing Survey](#) asks respondents who moved during the past two years their reason for leaving their previous residence. There is not a homeownership reason specifically, but many reasons are similar to the move-out reasons that SAHF members collect.
- **Percent households with in-unit internet access**
 - *Indicator/Survey Question:* Does your household have regular access to the internet at home?

5 “Length of Stay in Assisted Housing.” U.S. Department of Housing and Urban Development, Office of Policy Development and Research. October 2017

- **Rationale:** SAHF added this measure to our framework two years ago, recognizing the necessity of internet access to enable residents to fully participate in an interconnected world. The COVID-19 pandemic has highlighted the extent to which our systems have evolved to rely upon in-home high-speed internet for access to food, healthcare, education, employment, and opportunities to remain connected and fight social isolation. Internet is [essential for a healthy home](#) and we believe it should be considered a utility in affordable housing programs. This is also a short-term measure that service coordinators may be able to directly impact by identifying barriers to access (cost, lack of knowledge about options, etc.). SAHF made the strategic decision to not ask about the type of internet access (e.g., high-speed, broadband, dial-up, etc.), which is common in other survey questions on this topic. Although having high-speed internet is critical now, SAHF felt that potential resident confusion about what constitutes “high-speed” or “broadband” would impede our ability to understand the survey results. How “high-speed” is defined is also a moving target (the FCC defines high-speed as a minimum connection speed of 25 Mbps for downloads and 3 Mbps for uploads, which some argue is too slow for practical use). This poses a challenge to putting definitions on that label.
- **Secondary Benchmarking Resource:** The Census Bureau American Community Survey asks a [series of three questions](#) about internet and device access. The second related question is, “At this house, apartment, or mobile home – do you or any member of this household have access to the internet?” The ACS asks respondents to differentiate between internet they pay for and internet they access but do not pay for. SAHF does not ask about this for the sake of simplicity, and also recognizing that if residents access but do not pay for internet, it is most likely provided by the property owner, which is something the SAHF member/owner would know.
- **Percent households with access to a computer**
 - **Indicator/Survey Question:** Does your household have a computer, laptop, or tablet that you use to access the internet at home?
 - **Rationale:** In addition to having internet access, it is critical for residents to have access to a “fully capable device” that enables full participation in the internet, beyond smartphone use. Particularly for more intensive work, such as educational and employment activities, having a computer or tablet is critical. SAHF also feels that this question is important to pair with the first question on internet access in order to identify residents who have internet (“Yes” to first question), but do not have a computer or tablet (“No” to second question), as these residents most likely access the internet through their smartphone and most likely do not pay for broadband in their units (using a monthly data plan instead).
 - **Secondary Benchmarking Resource:** The Census Bureau American Community Survey asks a series of three questions about internet and device access. The first related question is, “At this house, apartment, or mobile home – do you or any member of this household own or use any of the following types of computers: desktop or laptop; smartphone; tablet or other portable wireless computer; some other type of computer.”

PROGRAM/SERVICE AREA: YOUTH & EDUCATION

- **Percent of 3-year old and 4-year-old children enrolled in Pre-K, Preschool, Head Start, or another early education program**
 - **Indicator/Survey Question:** If your child is 3-4 years old, are they enrolled in preschool, Pre-K, Head Start, or another early education program?
 - **Rationale:** Extensive [research](#) indicates the value of enrollment in a (high-quality) preschool/Pre-K program. This is also a short-term measure that service coordinators can directly

impact by working with parents to provide information about options and identify barriers to enrollment (cost, transit, etc.). Potentially, stronger understanding about preschool enrollment can also help organizations identify opportunities for creating co-located childcare facilities/centers in their properties.

- **Secondary Benchmarking Resource:** The [Census Bureau American Community Survey](#) provides rates of early education enrollment at the census tract level and other small area geographies. The Annie E. Casey Foundation KIDS COUNT data center provides rates of early education enrollment at the state-wide level for low-income families (<200% Federal Poverty Level).
- **Percent of young adults who are enrolled in postsecondary education**
 - **Indicator/Survey Question:** Resident full-time student status (as of time of interview or tenant certification)
 - **Rationale:** Educational attainment is a [strong predictor](#) of economic mobility. This measure also helps SAHF and SAHF members identify “disconnected” young adults (18-24 years) who are not enrolled in school or working. Service coordinators can work with these young adults to connect them with programs, trade schools, job fairs, GED programs, etc. Additionally, this measure can be pulled from property management software, thus reducing the reporting burden on residents.
 - **Secondary Benchmarking Resource:** The [Census Bureau American Community Survey](#) provides data on enrollment in college and graduate school. The survey does not differentiate between types of colleges/postsecondary education.
- **Percent of residents who complete higher education or earn a postsecondary degree**
 - **Indicator/Survey Question:** What is the highest level of education you have completed?
 - **Rationale:** As previously stated for the “enrolled in postsecondary education” indicator, educational attainment is a strong predictor of economic mobility. Service coordinators can help connect residents with secondary/higher education opportunities. This measure is also very important to contextualizing financial stability and resilience data (e.g., income, assets, employment) in order to understand the impact of service-enriched housing.
 - **Secondary Benchmarking Resource:** The Census Bureau American Community Survey provides data on educational attainment. They provide the following [categories](#): regular high school diploma; GED or alternative credential; Less than one year of college credit; one or more years of college credit, no degree; associate’s degree; bachelor’s degree; master’s degree; professional degree; doctorate degree.

PROGRAM/SERVICE AREA: COMMUNITY ENGAGEMENT & SAFETY

- **Percent of residents who feel safe in their building**
 - **Indicator/Survey Question:** How safe do you feel in your building?
 - **Rationale:** SAHF members believe that building trust with residents and creating safe environments is a critical and foundational aspect of their work. People of color in the U.S., particularly Black residents, often do not feel safe in their communities. A 2020 Gallup survey [found](#) that only 60% of Black Americans, compared to 84% of White Americans, feel safe walking alone at night in the city where they live. In addition, the Pew Research Center also found that “Black adults were roughly twice as likely as Whites to say crime is a major problem in their local community (38% vs. 17%).” This measure is one that SAHF member staff can directly impact by working to create safe environments for residents in physical ways, such as installing

better lighting or limiting building access points, and in less tangible ways, such as coordinating the development of community safety groups and leading conflict resolution and mediation programs, among other programs. SAHF members also work with residents to better understand how they define safety and what methods they prefer to create safe environments, recognizing that some common tools, such as video cameras, have often historically been used to perpetuate systems of bias and discrimination against people of color.

- **Secondary Benchmarking Resource:** To SAHF's knowledge, there are no secondary datasets that capture this concept of perceptions of safety on an ongoing, disaggregated basis. The [CDC Youth Risk Behavior Surveillance System \(YRBSS\)](#) asks high school students: "During the past 30 days, on how many days did you not go to school because you felt you would be unsafe at school or on your way to or from school?" There are also various surveys, such as the Gallup survey cited in the rationale section, that measure this periodically at a U.S.-wide level. The FBI Uniform Crime Reporting Program reports crime levels at the city and county level across the U.S. However, crime rates can vary widely by neighborhood and perceptions of safety are not always directly correlated with actual crime rates.
- **Percent of residents who feel safe in their neighborhood**
 - **Indicator/Survey Question:** How safe do you feel in your neighborhood?
 - **Rationale:** Understanding how safe residents feel in their neighborhoods is important for contextualizing the prior measure. If residents report feeling unsafe in their building but safe in the surrounding neighborhood, that is a warning sign for the property. Additionally, understanding whether residents feel safe in the neighborhood is important to assessing whether residents will connect with or utilize resources in the community.
 - **Secondary Benchmarking Resource:** As stated for the "percent of residents that said they feel safe in their building" indicator, there are few secondary data sources for this measure.
- **Percent of residents eligible to vote who are registered to vote**
 - **Indicator/Survey Question:** Are you registered to vote?
 - **Rationale:** Community engagement can be a hard concept to measure – residents find community in a variety of settings and in ways that go beyond simple survey questions⁶. When considering that many of the communities that SAHF members serve have been, and continue to be, excluded from civic engagement and denied equal voting rights, SAHF members look to civic engagement and participation as a measure of community engagement. Many SAHF members provide opportunities and programs for residents to become civically engaged, such as locating polling sites at their properties, conducting 'Get Out the Vote' drives with local partners, providing transportation to the polls, and coordinating resident advocacy on local issues that matter to the community.
 - **Secondary Benchmarking Resource:** The [Census Bureau American Community Survey](#) provides data on voter registration for various subpopulations. Nonprofit organizations can also request voter registration rolls for specific jurisdictions from the local board of elections or voter registrar office to aid 'Get Out the Vote' efforts.

⁶ "Readers may notice that questions about residents knowing their neighbors or feeling connected with neighbors are absent from this list. Understanding community cohesion is important, but this is a difficult concept to measure. However, Raj Chetty's new research on the value of cross-class friendships in driving economic mobility may spur housing providers to focus more on this concept and outcome area."

PROGRAM/SERVICE AREA: HEALTH & WELLNESS

- **Percent residents reporting their general health is good, fair or poor**
 - *Indicator/Survey Question:* Would you say that in general your health is... [Excellent, Very Good, Good, Fair, Poor, Unsure, Prefer not to answer]
 - *Rationale:* Programs and services can help improve residents' general health and quality of life. For example, physical activity classes can help keep seniors mobile and active. Improving residents' health is an important long-term outcome. Additionally, this question is easy for residents to understand, easy to translate into foreign languages, and easy to interpret.
 - *Secondary Benchmarking Resource:* This question is identical to question C01.01 in the [CDC Behavioral Risk Factor Surveillance Survey \(BRFSS\)](#), an annual U.S.-wide survey. Survey data can be downloaded and disaggregated by income and age, among other household characteristics (isolating low-income seniors, for example).
- **Percent residents reporting that poor physical health kept them from doing their usual activities in the last 30 days**
 - *Indicator/Survey Question:* During the past 30 days, for about how many days did poor physical health (which includes physical illness and injury) make it hard for you to do your usual activities, such as self-care, work, or recreation?
 - *Rationale:* This question is similar to a question from the CDC BRFSS but focuses on "physical health" and "usual activities" in order to assess the degree to which residents' poor physical health prevents them from doing usual activities, or going about their daily lives. Those who report frequent poor physical health days are at higher risk of mortality, more commonly use health care, and have lower health-related quality of life.⁷ Resident services staff can make referrals to healthcare providers in the community or bring clinics/providers onsite to provide services.
 - *Secondary Benchmarking Resource:* This question is similar to questions C02.03 and C02.01 in the [CDC Behavioral Risk Factor Surveillance Survey \(BRFSS\)](#), an annual U.S.-wide survey. Survey data can be downloaded and disaggregated by income and age, among other household characteristics (isolating low-income seniors, for example). Additionally, the [City Health Dashboard](#), sponsored by the RWJ Foundation and NYU Langone Health, provides small area estimates for a similar measure for download (only includes 750 cities with populations of 50,000+).
- **Percent residents reporting that their mental health was not good in the last 30 days**
 - *Indicator/Survey Question:* Now thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good?
 - *Rationale:* A growing [evidence base](#) details how some communities, particularly disinvested, low-income communities, can experience long-lasting toxic stress and trauma. Mental health is often overlooked when evaluating the health of a community, yet it is an important indicator

⁷ As per the [City Health Dashboard](#): Dominick KL, Ahern FM, Gold CH, Heller DA. Relationship of health-related quality of life to health care utilization and mortality among older adults. *Aging clinical and experimental research*. 2002;14(6):499-508. Taylor RM, Gibson F, Franck LS. A concept analysis of health-related quality of life in young people with chronic illness. *Journal of clinical nursing*. 2008;17(14):1823-1833.

of economic hardship and overall well-being. People who report many poor mental health days may have difficulties in their daily life and are more likely to engage in risky health behaviors that are linked to chronic diseases.⁸

- **Secondary Benchmarking Resource:** This question is identical to question C02.03 in the [CDC Behavioral Risk Factor Surveillance Survey \(BRFSS\)](#), an annual U.S.-wide survey. Survey data can be downloaded and disaggregated by income and age (isolating low-income seniors, for example). Additionally, the [City Health Dashboard](#), sponsored by the RWJ Foundation and NYU Langone Health, also provides small area estimates of this measure for download (only includes 750 cities with populations of 50,000+).
- **Percent of residents using a hospital ER/ED one or more times in 12 months**
 - **Indicator/Survey Question:** In the last 12 months, have you been to the hospital emergency room for an illness, injury, or disease?
 - **Rationale:** Frequent visits to a hospital emergency department are an indicator of poor health and/or a lack of access to routine healthcare.
 - **Secondary Benchmarking Resource:** The CDC National Center for Health Statistics publishes periodic reports on U.S.-wide health and their [Data Finder](#) tool provides U.S. rates of ED visits by certain populations, such as households below the federal poverty level (FPL). However, SAHF has not been able to identify a comparison data source for smaller area geographies.
- **Percent of residents with a usual place of care where they receive routine primary care services**
 - **Indicator/Survey Question:** Do you have a usual place of care where you receive routine primary care services?
 - **Rationale:** This is a short-term outcome that is a critical first step to improving a resident's long-term health. Primary care physicians can screen for potential health problems before they become severe, and help lower ER/ED use for routine care.⁹ This measure can also be directly impacted by a service coordinator, who can help connect residents with affordable, culturally competent providers in their area.
 - **Secondary Benchmarking Resource:** This question is similar to question C03.02 in the [CDC Behavioral Risk Factor Surveillance Survey \(BRFSS\)](#): "Do you have one person you think of as your personal doctor or health care provider?" Survey data can be downloaded and disaggregated by income and age (isolating low-income seniors, for example). This is also similar to the CDC National Health Interview Survey question: "Is there a place that you usually go to when you are sick or need advice about your health?"
- **Percent of residents who visited a healthcare provider for a routine checkup in the last 12 months**
 - **Indicator/Survey Question:** Have you visited a healthcare provider for a routine checkup in the past 12 months?
 - **Rationale:** This is a short-term outcome that is important for long-term health, particularly for seniors. Service coordinators can have a direct impact on this measure by identifying and addressing barriers to getting a check-up, such as cost or transportation. As per the [City Health Dashboard](#): "Preventive care is an important aspect of clinical care that could save an estimated 100,000 lives in the U.S. per year if it reached everyone. Preventive services include

8 As per the City Health Dashboard: Liu Y, Croft JB, Wheaton AG, et al. Association between perceived insufficient sleep, frequent mental distress, obesity and chronic diseases among US adults, 2009 behavioral risk factor surveillance system. BMC Public Health. 2013;13:84. Strine TW, Balluz L, Chapman DP, Moriarty DG, Owens M, Mokdad AH. Risk behaviors and healthcare coverage among adults by frequent mental distress status, 2001. Am J Prev Med. 2004;26(3):213-216.

9 The Importance of Having a Primary Care Doctor, by the Cleveland Clinic

vaccinations and cancer screenings, and help medical providers detect chronic and infectious diseases early and provide treatment. People with lower incomes and those without health insurance are less likely to use preventive services.”

- **Secondary Benchmarking Resource:** This question is similar to question C03.04 in the [CDC Behavioral Risk Factor Surveillance Survey \(BRFSS\)](#), an annual U.S.-wide survey: “About how long has it been since you last visited a doctor for a routine checkup?” (Answer options: within past year, within past two years, within past five years, five or more years ago, never, refused, don’t know/unsure). Survey data can be downloaded and disaggregated by income and age (isolating low-income seniors, for example). The [City Health Dashboard](#), sponsored by the RWJ Foundation and NYU Langone Health, also provides small area estimates of this measure *for seniors* for download (only includes 750 cities with populations of 50,000+).
- **Percent residents enrolled in health insurance and types of insurance**
 - **Indicator/Survey Question:** Do you have health insurance? If so, what type is it?
 - **Rationale:** This measure is important for service coordinators to identify residents with barriers to obtaining insurance, such as working-age residents who do not qualify for Medicaid or immigrants who may need help navigating the healthcare system. As per the [City Health Dashboard](#): “People without health insurance may have limited access to health care, delay pursuing treatment, and experience poorer health compared to those with health insurance. ... Disparities persist in insurance coverage: racial/ethnic minorities and people in lower income brackets are less likely than the general population to be insured.”
 - **Secondary Benchmarking Resource:** The [City Health Dashboard](#), sponsored by the RWJ Foundation and NYU Langone Health, provides small area estimates of this measure for download (only includes 750 cities with populations of 50,000+).
- **Percent of residents or households who report experiencing food insecurity**
 - **Indicator/Survey Question:** In the last 12 months, was there a time when the food you bought just didn’t last and you didn’t have money to buy more?
 - **Rationale:** Food insecurity is a significant and growing problem among families and seniors. Hunger is particularly [damaging](#) for children’s development and is a barrier to adult participation in other programs and services. This question is one part of the [Hunger Vital Sign](#) screener, developed by Children’s HealthWatch and based on the U.S. Household Food Security Survey Module. In October 2015, the American Academy of Pediatrics recommended that pediatricians screen all children for food insecurity. In May 2017, the Centers for Medicare & Medicaid Services incorporated the Hunger Vital Sign™ in the Accountable Health Communities Screening Tool.
 - **Secondary Benchmarking Resource:** The USDA publishes data from its [U.S. Household Food Security Survey Module](#).

APPENDIX E

Resident Data Privacy Tip Sheet

It is increasingly important for housing providers to consider how to protect resident privacy and ensure that any resident-specific, personally-identifiable data is secure. This tip sheet includes laws and best practices for resident services and other staff to consider, in consultation with their organization's internal legal counsel. Another great resource on this topic is the National Neighborhood Indicator Project (NNIP)'s [Guide to Data Governance and Security](#).

FEDERAL & STATE STATUTORY REQUIREMENTS

In the absence of comprehensive federal legislation on consumer data privacy¹⁰, various states have passed laws protecting resident privacy (California, Virginia, Utah, Colorado, and Connecticut). Of these, only the Colorado Privacy Act applies to nonprofit organizations, and it only applies nonprofits that meet certain size thresholds¹¹. Provisions in the Colorado law overlap significantly with the good practices section below. However, as momentum grows in this area, more comprehensive state and federal privacy legislation may be on the horizon, and these laws may provide blueprints for future legislation.¹²

WHAT IS PERSONALLY-IDENTIFIABLE INFORMATION (PII) AND WHY DOES IT MATTER?

PII is information that can be used to distinguish an individual's identity, either alone or when combined with other identifying information that is linked to a specific individual. Examples of PII include name, date of birth, home address or geolocation information; driver's license or social security numbers; education, financial, or legal records; or IP address. Resident-specific data that includes PII requires a higher level of protection and security, and thus organizations should distinguish between data with and without PII.

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD) REGULATORY REQUIREMENTS

Housing providers with HUD-assisted properties must comply with HUD data privacy requirements, which include storing personally-identifiable information (PII) on secure networks and systems; encrypting PII on computers; and transferring PII via secure file transfer protocol (FTP). There are also specific regulatory limits on information gathered through the Enterprise Income Verification (EIV) system. EIV uses data matching with other federal agencies to verify tenant employment, income and other information at the time of recertification, to reduce errors in subsidy payments. Disclosure of EIV information to Service Coordinators is not allowed unless the Service Coordinator is present during the interview and assisting the tenant with the recertification process. More information can be found in HUD Handbook 4350.3 Chapter 9.

10 There are federal laws regarding privacy for certain types of data, such as FERPA and HIPAA. However unless an organization has a formal partnership with a school district or healthcare entity ("covered entity") in which data is shared, these laws are unlikely to apply to a housing provider's day to day work.

11 Thresholds include the processing of personal data for more than 100,000 Colorado residents in a calendar year.

12 The bipartisan American Data Privacy and Protection Act ("ADPPA") was introduced in Congress in June 2022.

GOOD PRACTICES IN DATA PRIVACY

Beyond meeting regulatory requirements, there are various ways organizations can work on improving their practice in protecting resident privacy. One global framework for this is the [Fair Information Practice Principles](#). Examples include:

1. **Transparency through Privacy Notices:** Organizations should disclose to residents the ways in which their information is collected and used. Privacy notices should be clear, short, and enable residents to comprehend an organization's privacy practices. They should indicate a) what information is collected and for what purpose(s), b) how that information may be shared, and c) how residents can limit data sharing or otherwise exercise their rights.
2. **Consent:** Opt-in consent is an affirmative act that signals a resident's unambiguous, voluntary, specific, and informed consent. Opt-in consent is particularly important for collecting sensitive data, such as racial/ethnic origin; mental or physical health data; or children's data.
3. **Access rights:** Residents should be able to access, correct, delete, and transfer their personal data.
4. **Minimization and retention:** Organizations should only collect data in a way that is consistent, relevant, and limited to the purpose(s) specified, and keep data for no longer than is necessary for the purpose specified. Organizations should also have practices in place to ensure that data is accurate, which is easier with more limited volumes of data.
5. **Partner & Vendor Management:** Organizations need to identify the data privacy and security risks created by partnerships and vendor relationships, and extent to which they can be managed through contracts and non-contractual, ongoing oversight. Contractual controls should include limiting vendors' ability to use and share data except as needed to provide services, ensuring that vendors safeguard data appropriately, and requiring vendors to provide notification of any data breach.
6. **Security Procedures & Protocols:** Organizations should have written data security procedures that should include:
 - Periodically reviewing threats and vulnerabilities to data, including before any new projects;
 - Classifying data (e.g., PII versus sensitive data) to ensure proper storage and protection;
 - Limiting access to PII and sensitive data, including through the use of access controls;
 - Encrypting data and destroying data when no longer required;
 - Enabling multi-factor authentication on all devices, for all users;
 - Backing up critical organizational data in a disconnected or off-site system;
 - Training employees on data security.
7. **Incident Response Preparedness:** Cyber incidents or data breaches can happen to any organization. An Incident Response Plan should be created that describes the critical data systems in use and how the organization will respond if any one of those systems are compromised or inaccessible. This should include systems in place to notify affected individuals of any security incident.

APPENDIX F

Resident-Centered Approaches Tip Sheet

Below is a compendium of all the resident-centered, equitable approaches we have listed throughout this toolkit. This is not intended to be an exhaustive list, but rather a starting point for how to think about centering residents and incorporating resident voice and agency in all aspects of data collection, evaluation and impact measurement work.

INCLUDING RESIDENT VOICE IN DESIGN

Organizations should consider how they can involve residents in the planning and design stage of the evaluation process. One lens or framing for this work is the Participatory Action Research (PAR) framework, which is a “collaborative approach to research that involves all stakeholders throughout the research process, from establishing the research question, to developing data collection tools, to analysis and dissemination of findings.” For example, when designing a resident survey, organizations should ask resident leaders to “beta-test,” or provide feedback on, the design and wording of questions. Residents may be able to provide invaluable insights on whether certain questions don’t make sense, if there are alternative ways to ask a question to gain more meaningful information, or if the survey design is confusing or too long. Residents can also indicate whether there are certain concepts or areas in which they would like to provide feedback or insights on a survey that are not included. The concept of “human-centered design” may also be a useful framework, which promotes iterative or recurring feedback loops with clients to test programs at all stages of the “design” process, from prototype to pilot to final product. Residents may also be able to provide insights on the best timing of survey administration and process (for example, residents may prefer paper surveys over online surveys, or vice versa). Depending on the nature of the survey, organizations could also consider utilizing resident leaders or volunteers to administer, distribute and/or promote the survey to other residents, similar to the resident “health champions” or “health ambassadors” concept but “survey” or “data” ambassadors.

MINIMIZING SURVEY BURDEN

Numerous organizations and entities have detailed the ways in which marginalized, underserved, or oppressed communities have been over-surveyed by the research community, in ways that are extractive and do not return immediate dividends to the community that provided information. While it is important for housing providers to survey residents or otherwise collect data to provide appropriate, responsive, and impactful programs, it is equally important to consider how to survey in the least burdensome, least invasive ways possible. There are various ways in which organizations can limit the burden of data collection on residents. Organizations can consider reducing the frequency or length of surveys (such as moving from annual to biannual surveying), exploring alternative data sources (such as utilizing comparable community-level, publicly available data), or engaging in data sharing arrangements with public agencies (such as the local department of education or child welfare agency). Lastly, organizations should consider compensating residents for their time completing the survey, monetarily or in some other way that recognizes the value of their personal information, insights, knowledge, and time.

PROTECTING RESIDENT DATA

Housing organizations are increasingly considering how to best ensure that resident-specific, personally identifiable data is secure. Whereas in decades past, securing hard copies of personal records was important, now the priority is ensuring that electronic records are stored in secure, encrypted programs and

that data is used and shared in secure ways. Appendix E on resident data privacy provides more information on this topic. Other helpful online resources include National Neighborhood Indicators Project (NNIP)'s Resource Guide to Data Governance and Security, and the global Fair Information Practice Principles.

DISAGGREGATING DATA

In their analysis, organizations should work toward disaggregating outcomes by population characteristics, particularly race and ethnicity, to identify disparate outcomes for different groups. Positive outcomes for the population as a whole may mask disparities in outcomes for residents of color or other subpopulations (or vice versa – some programs may be more impactful or effective for certain residents of color). Interpretation of disparities can be challenging because correlation is not causation – people of color are impacted by unjust systems that can negatively impact outcomes, independent of the effects or non-effects of the program in question. Analysis that examines change over time from a baseline for specific groups, perhaps compared to similar groups who did not participate in programming or were not offered resident services broadly, may help to reveal the disparate impacts of specific programs. The diagram below provides a simplified visual explanation of this type of analysis. Understanding where people started can help you understand where they are now. If the sample size (number of residents for whom data is available) is large enough, statistical techniques such as multivariate regression and propensity score matching can attempt to “control for” the effects of race or other resident characteristics, allowing the analyst to compare similar residents against each other. If it is appropriate to include outcomes by race/ethnicity in external reporting, providing context is crucial. As this playbook from Enterprise and FrameWorks points out:

“Discussions about the role of race in policy issues often go astray. Deficit-based ideas about people of color are regularly reinforced in mainstream American media and culture. As a result, many people readily recall, repeat, and believe these ideas, arriving at opinions that place blame for negative outcomes on the people of color who experience them. This situation calls on advocates to be ready to provide compelling, alternative ways to understand the problem. Other situations call for advocates to be ready to talk differently about solutions in order to ward off fatalism. ... The strongest frame [message] begins with ...the idea that economic and community vitality requires that people have the resources they need to participate and contribute... FrameWorks recommends that advocates ...[provide] an explanation of how structural racism creates and maintains disparities, taking care to highlight points where an intervention can change outcomes.”

SHARING DATA AND ENGAGING RESIDENTS IN INTERPRETATION:

Service coordinators can support greater resident agency and voice by sharing aggregated data back with residents and involving them in the collection and analysis process. For example, sharing survey results with residents presents an opportunity to “ground truth” the analysis with residents and gauge its validity. Residents may be able to point out inconsistencies or biases in data results that stem from residents not understanding a question, interpreting it differently from staff or feeling not comfortable with providing honest answers. Residents may also simply appreciate knowing more about their fellow residents and may feel validated if they see themselves reflected in the data. In the long run, data may also empower residents to create or co-create their own solutions with staff. For example, data may reveal that residents have shared concerns or priorities that can be addressed by the community collectively, such as younger residents who can help elderly residents shovel their sidewalks or parents unable to find affordable childcare who can create communal/informal childcare arrangements.

Housing providers have experimented with various ways in which to share aggregated survey results and analysis back with residents. The organization Data You Can Use has created a model called Data Chats that convenes small groups of residents to meet and talk about data, with an emphasis on collaboration and interpretation. As another example, one organization utilized the concept of Data Walks and organized a

“data festival” that included thematic stations. Each station had posters with data results and some sort of related activity to demonstrate the theme. For example, the health station presented health-related survey results and allowed residents to take their pulse after engaging in an aerobic activity. Residents were divided into groups and moved around to all of the stations, getting a stamp when they participated in a station. At the end of the evening, residents who had all stamps were entered into a raffle. Staff also set up a feedback board at the event where residents could write any feedback about the survey, the results, or the process as a way to capture and validate residents’ perspectives. While this was an intensive, one-off event, other housing providers have created practices around facilitating less intensive, more frequent share-outs. Some organizations request that each service coordinator share data with residents once a year while allowing coordinators to choose the method that works best for them and their residents.

It is important to consider ways to share analyses that are asset-based and not just deficit-based. Simply highlighting the persistent needs of the community can be demoralizing, and even unproductive. Even statistics that point to a problem can be flipped to emphasize the positive over the negative; for example, 75% of residents are non-smokers, versus 25% of residents are smokers. Additionally, it may be more effective to highlight a few key findings or statistics from a survey, rather than trying to cover every survey question result. Providing analysis in multiple formats – handouts, posters, presentations, even games – can help residents with different learning styles to absorb information.

Lastly, and perhaps most importantly, organizations should also consider how the property or broader organization plans to act on the results of the survey. Will the survey results lead to any changes? For example, if the survey shows a high need for financial counseling and employment services, the service coordinator could indicate that they will look for and coordinate with community resources to bring these programs to the property (if that is a commitment the organization is able and willing to make). However, it is important for staff to be realistic about what is doable and feasible, as well as timing. Providing a realistic timeframe for when a new program can be launched helps communicate to residents that a plan is in place, but that change can’t happen overnight. Communicating the intermediate steps of a long-term change, and any obstacles to change, can be helpful in assuring residents that their voices have been heard.

NO DATA WITHOUT STORIES

The most effective data storytelling marries quantitative analysis with relevant case studies, narrative stories of the lived experiences of residents, historical or topical context, photos and maps, or other context that explains why the data results matter. When audiences can associate a person or family with a statistic, it helps to paint a picture of the data (people are notoriously bad at understanding big numbers). The case study or story explains why this matters and the statistics explain the magnitude or scale of the impact. Sometimes, generating more explanatory, contextualized data reports less frequently can be more effective than churning out data reports at frequent intervals with little context provided. However, organizations must balance the value of obtaining resident stories with the value of respecting resident privacy. Residents should understand that participating in any story-gathering project is completely voluntary, and should understand when, how and why their stories will be presented to external audiences or the public at large.

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STEWARDS OF AFFORDABLE
HOUSING FOR THE FUTURE 



Photo courtesy of The Community Builders.

Stewards of Affordable Housing for the Future

Stewards of Affordable Housing for the Future (SAHF) is a nonprofit collaborative of 12 multi-state nonprofit affordable housing providers who own more than 145,000 affordable rental homes. SAHF's mission is to advance the creation and preservation of healthy, sustainable affordable rental homes that foster equity, opportunity, and wellness for people of limited economic resources.

SAHF Members

BRIDGE Housing, CommonBond Communities, Community Housing Partners, Homes for America, Mercy Housing, National Church Residences, NHP Foundation, National Housing Trust, Preservation of Affordable Housing, Retirement Housing Foundation, The Community Builders, and Volunteers of America.