Measure H Funding Recommendations Process- FYs 2020-23

Homeless Initiative Policy Summit #4
Interim Housing

Tuesday, October 15, 2019

<u>Summit Report</u>

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Measure H Funding Recommendation Process – FYs 2020-23

Homeless Initiative Policy Summit #4:
Interim Housing

Tuesday, October 15, 2019, 9am-12pm
United Way of Greater Los Angeles
4th Floor Conference Room, 1150 S. Olive Street, Los Angeles CA 90015

Agenda

1. Welcome and Introductions (5 min)

2. Context for Funding Decisions (5 min)

3. Data Overview (5 min)

4. Strategy Evaluation – Interim Results Presentation (25 min)

5. Discussion Questions (1hr 50 min)

   a. What internal and external bottlenecks compromise the homeless services system's ability to optimize Interim Housing's throughput to effectively and efficiently assist homeless individuals and families to transition into stable permanent housing? How can they be addressed?

   b. How can diversion/problem solving be used to help ease the burden on the emergency shelter system? Is use of diversion as a tool to prevent entry into emergency shelter likely to be more effective with some populations/demographics than others?

   c. Deinstitutionalization and non-institutionalization have resulted in homeless populations with complex and highly acute needs. What types of interim housing beds and residential placements are needed to meet the needs of the portion of the unsheltered population that has complex and highly acute needs? How do we increase current capacity to meet these needs?

   d. What factors hinder the unsheltered homeless population from accessing interim housing? How can these barriers be addressed? Can we think about having different types of interim housing that are responsive and attractive to different groups of participants, including those who would like a clean and sober environment or a more structure program?

   e. As the system considers the use of congregate shelters for families, what considerations should we take into account? How can congregate shelters most effectively serve families, including by ensuring that they move quickly into permanent housing?

   f. What are the most promising innovative/new options for interim housing that can expeditiously and effectively get people off the streets? What criteria should we apply as we assess these options?

6. Public Comment (25 min)

7. Overview of Rest of Funding Recommendations Process (5 min)

FY 2020-2023 Measure H Revenue Planning Process
Key Data: Interim Housing

HI Strategies: B7 (Interim/Bridge Housing for those Exiting Institutions) and E8 (Enhance the Emergency Shelter System)

Key Data Points – All Strategies

Strategy	B7-LAHSA		B7-DHS		B7-DPH-SAPC		E8-LAHSA		E8-DHS	
	FY 17/18	FY 18/19	FY 17/18	FY 18/19	FY 17/18	FY 18/19	FY 17/18	FY 18/19	FY 17/18	FY 18/19
Total Funding for interim housing (all sources)	$ 1,646,000	$ 5,690,000	$ 32,764,554	$ 84,373,435	$ 3,176,771	$ 5,919,067	$ 77,117,578	$ 94,639,148	$ 4,953,000	$ 17,990,000
Measure H Funding	$ 1,646,000	$ 5,086,000	$ 9,561,000	$ 16,715,000	$ 1,602,665	$ 4,403,000	$ 45,677,934	$ 60,787,116	$ 4,953,000	$ 17,990,000
Measure H Funding as a % of Total Funding	100%	89%	29%	20%	50%	74%	58%	59%	100%	100%
Total Measure H Unspent	$ 1,485,000	$ 753,000	$ 221	$ 12,000	$ 7,000	$ -	$ 8,028,661	$ 1,977,431	$ 90,868	$ -
Number of persons newly enrolled*	504	540	1,394	774	779	1,331	12,401	13,917	689	830
Number of persons served*	533	691	1,646	1,063	841	1,634	14,586	18,015	952	1163
Number of persons exiting to permanent housing*	70	120	375	221	N/A	N/A	2,489	3,693	263	246

Metrics are for interim housing that is fully or partially funded by Measure H.

Measure H fiscal data for LAHSA is not representative of the full allocation amounts for FY17-18 and FY18-19. The LAHSA Measure H fiscal data only represents the H funding dedicated to programs.

STRATEGY DATA

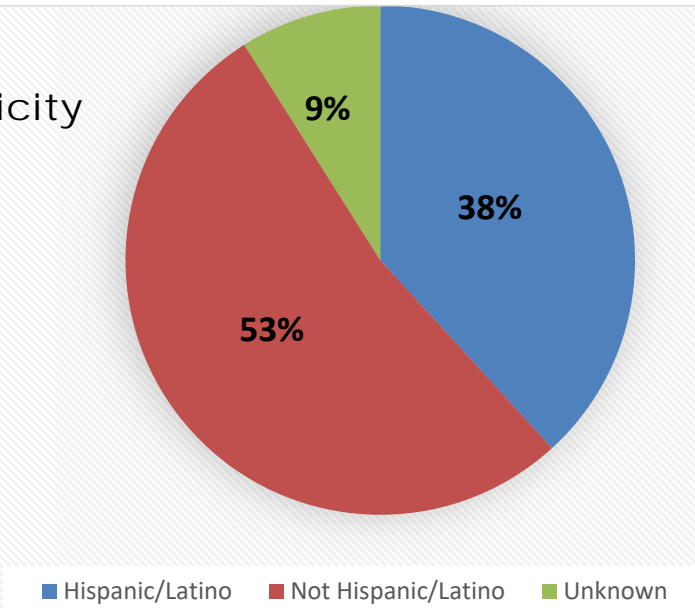|		B7- LAHSA		B7- DHS		B7 – SAPC		E8 – LAHSA		E8 - DHS	
		FY 17/18	FY 18/19	FY 17/18	FY 18/19	FY 17/18	FY 18/19	FY 17/18	FY 18/19	FY 17/18	FY 18/19
Average length of stay for participants still enrolled at end of FY (in days)	All	100	114	99	155	43	65	110	58	176	172
	Individuals	106	112	99	155	43	65	97	71	176	172
	Families	0	0					209	49		
	Youth	43	81					78	44		
Average length of stay for exited participants (in days)	All	74	97	89	141	52	69	82	55	133	151
	Individuals	76	99	89	141	52	69	68	63	133	151
	Families	0	0					113	48		
	Youth	57	69					42	43		
Number of persons who exit to a permanent housing destination	All	70	120	375	221	N/A	N/A	2,489	3,693	263	246
	Individuals	60	109	375	221	N/A	N/A	916	1,097	263	246
	Families	0	0					1,468	2,310		
	Youth	10	11					105	290		
Percentage of individuals who exit to permanent housing	All	19%	22%	38%	38%	N/A	N/A	22%	30%	50%	36%
	Individuals	18%	22%	38%	38%	N/A	N/A	14%	18%	50%	36%
	Families	N/A	N/A					37%	50%		
	Youth	23%	30%					19%	20%		
Number of individuals who exit to non-PH destinations	All	301	420	624	366	N/A	N/A	8,657	8,438	268	445
	Individuals	268	394	624	366	N/A	N/A	5,767	5,008	268	445
	Families	0	0					2,501	2,305		
	Youth	33	26					455	1,160		
Percentage of individuals who exit non-PH destinations	All	81%	78%	62%	62%	N/A	N/A	78%	70%	50%	64%
	Individuals	82%	78%	62%	62%	N/A	N/A	86%	82%	50%	64%
	Families	N/A	N/A					63%	50%		
	Youth	77%	70%					81%	80%		
Number of individuals who exit to homelessness	All	146	151	447	248	107	160	2,566	3,116	157	342
	Individuals	131	128	447	248	107	160	1,665	1,924	157	342
	Families	0	1					775	817		
	Youth	15	22					131	379		
Percentage of individuals who exit to homelessness	All	39%	28%	45%	42%	21%	22%	23%	26%	30%	49%
	Individuals	40%	25%	45%	42%	21%	22%	25%	32%	30%	49%
	Families	N/A	N/A					20%	18%		
	Youth	35%	59%					23%	26%		

Demographic Service Data for Select Homeless Initiative Strategies: FY 2018-19 (July 2018 to June 2019)

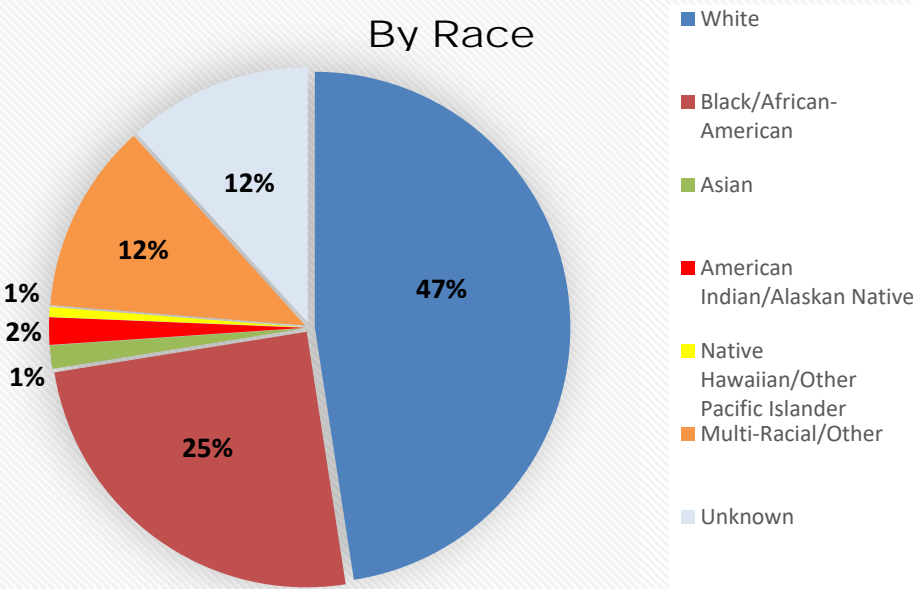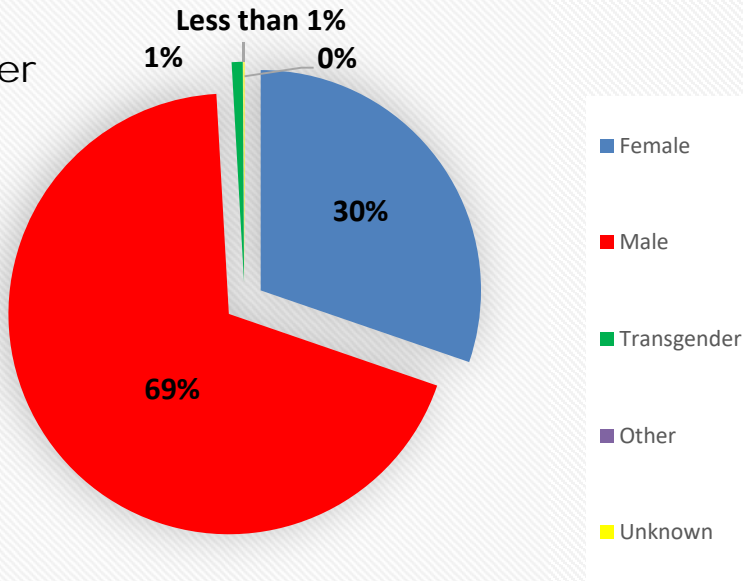## Strategy B7: Interim Housing for Those Exiting Institutions

By Age
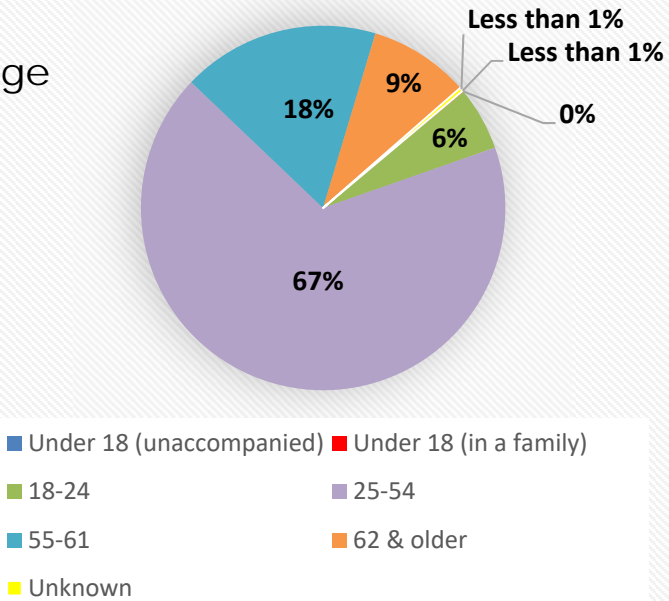
- Under 18 (unaccompanied)
- Under 18 (in a family)
- 18-24
- 25-54
- 55-61
- 62 & older
- Unknown

67%
18%
9%
6%
Less than 1%
Less than 1%
0%

By Ethnicity

- Hispanic/Latino
- Not Hispanic/Latino
- Unknown

38%
53%
9%

By Race

- White
- Black/African-American
- Asian
- American Indian/Alaskan Native
- Native Hawaiian/Other Pacific Islander
- Multi-Racial/Other
- Unknown

47%
25%
1%
2%
1%
12%
12%

By Gender

- Female
- Male
- Transgender
- Other
- Unknown

30%
69%
1%
Less than 1%
0%
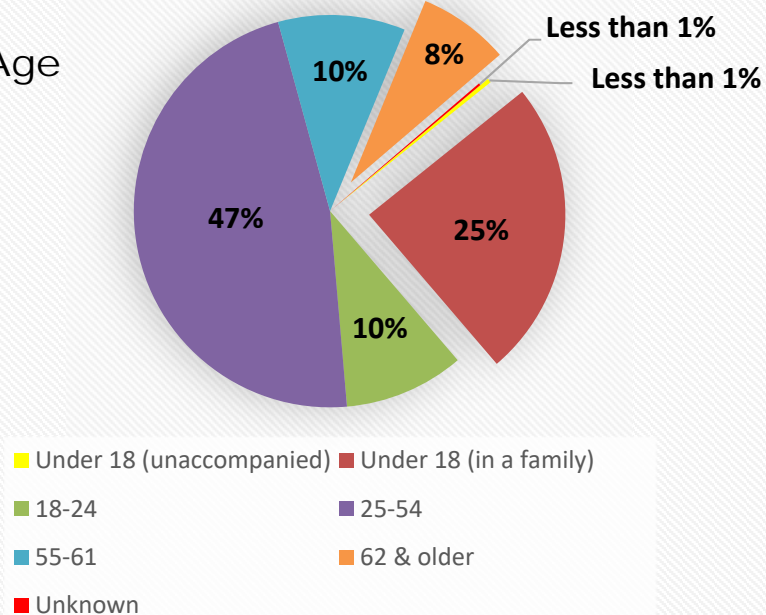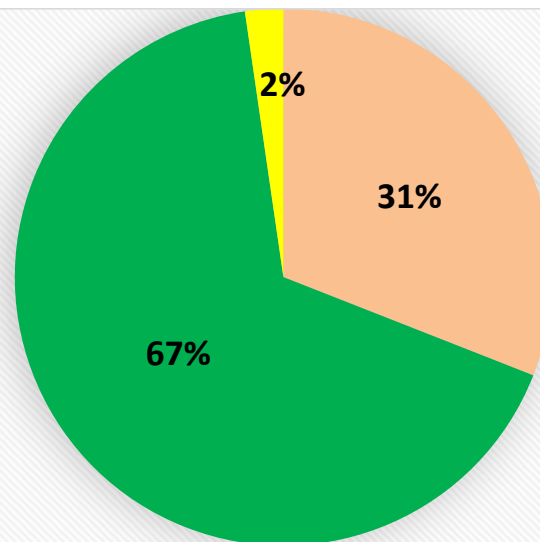
Demographic Service Data for Select Homeless Initiative Strategies: FY 2018-19 (July 2018 to June 2019)
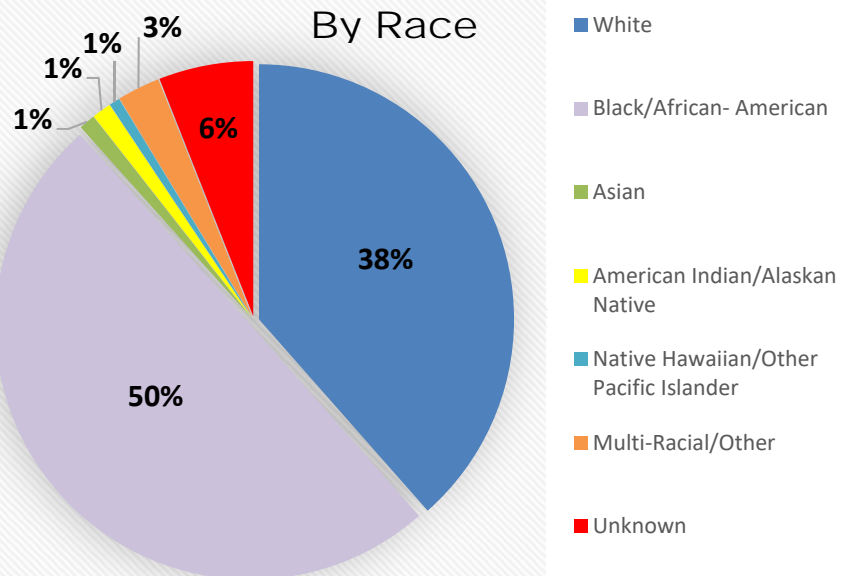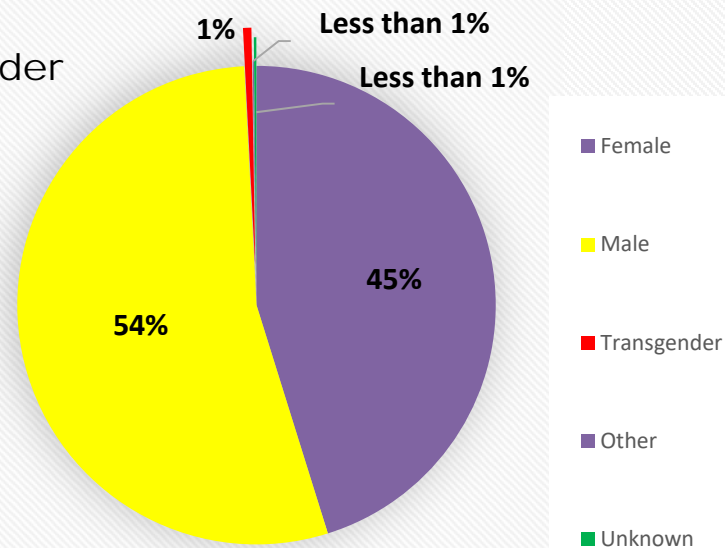
Strategy E8: Emergency Shelter

By Age

- 10%
- 8%
- Less than 1%
- Less than 1%
- 25%
- 10%
- 47%

Legend:
- Under 18 (unaccompanied)
- Under 18 (in a family)
- 18-24
- 25-54
- 55-61
- 62 & older
- Unknown

By Ethnicity

- 2%
- 31%
- 67%

Legend:
- Hispanic/Latino
- Not Hispanic/Latino
- Unknown

By Race

- 1%
- 1%
- 1%
- 3%
- 6%
- 38%
- 50%

Legend:
- White
- Black/African- American
- Asian
- American Indian/Alaskan Native
- Native Hawaiian/Other Pacific Islander
- Multi-Racial/Other
- Unknown

By Gender

- 1%
- Less than 1%
- Less than 1%
- 45%
- 54%

Legend:
- Female
- Male
- Transgender
- Other
- Unknown

HMA COMMUNITY STRATEGIES

L.A. COUNTY INTERIM HOUSING AND EMERGENCY SHELTER SERVICES EVALUATION
POLICY SUMMIT PRESENTATION

October 15, 2019

WWW.HEALTHMANAGEMENT.COM

EVALUATION OBJECTIVES

O1
Establish what the available data and performance evaluation results suggest are the strategy's best practices.

O2
How persons on the ground define effectiveness. Are their characterizations consistent with what the data show?

O3
Describe how specific funding sources affect the administration of a strategy and the capacity of strategy leads to deploy available resources effectively.

O4
How does the administration of non-H-funded services and benefits differ from the administration of those funded with H dollars?

HMA COMMUNITY STRATEGIES

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RESEARCH QUESTIONS

+ **RQ1:** How do the DHS, DPH/SAPC and LAHSA B7 services differ in practice?

+ **RQ2:** What difference do bed rates make to operations?

+ **RQ3:** How does the provision of interim and emergency services differ by subpopulation and what are the challenges encountered in serving different groups?

+ **RQ4:** What is the quality of collaboration with DMH, DCFS, LASD and Probation?

+ **RQ5:** What is the process and challenges experienced by hospitals in securing housing through B7 for inpatients/clients as required by SB-1152 Hospital Patient Discharge Process?

+ **RQ6:** What is the potential for interim/emergency shelters to implement recovery-oriented principles into their environment and service delivery?

+ **RQ7:** What are the most difficult barriers to making transitions from interim housing and emergency shelter to permanent housing?

+ **RQ8:** What difference do bed rates make to interim housing and emergency shelter outcomes?

+ **RQ9:** To what extent do those discharged from institutions to interim housing and needing physical health, mental health or substance abuse services receive referrals and services?

+ **RQ10:** What are the differences among subpopulations in return to homelessness, permanent housing, and length of stay in interim housing?

HMA COMMUNITY STRATEGIES

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QUALITATIVE DATA COLLECTION AND ANALYSIS

KEY INFORMANT INTERVIEWS	
+ DHS + H4H Program Implementation Manager	+ H4H Director of Interim Housing + H4H Director of Access, Referrals, and Engagement
+ CEO + HI Principal Analysts	+ CEO Senior Analyst + CEO Principal Analyst
+ LAHSA + Interim Housing Placement Coordinator	+ Crisis Housing Coordinators + Manager of System Components
+ DMH: Mental Health Clinical Program Head	

+ Shelter Staff (program directors, clinical & interim housing leads)
   + First To Serve (SPA 7)- crisis and bridge
   + Weingart (SPA 4)- crisis and bridge
   + Illumination Foundation (SPA 3)- recuperative care
	+ LA Family Housing (SPA 2)- crisis and bridge
	+ PATH Hollywood (SPA 4)- interim/ bridge
	+ Path W Washington (SPA 6)-interim/ bridge

+ Hospitals
   + LAC USC Senior Clinical Social Worker
   + Harbor UCLA Clinical Social Worker Supervisor
	+ DHS Director of Patient and Social Support Services

+ Others
   + Brilliant Corners
   + NHF (recuperative care)
	+ *ODR (upcoming)*
	+ *SAPC (upcoming)*

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▌ **THEMES** FROM QUALITATIVE DATA

+ **Differences in services among DHS, LAHSA, DPH/SAPC**
    + DHS providing recuperative care/stabilization housing
        + Higher acuity population
        + Flexible use of Measure H funds
        + Provide more intensive case management, additional services
    + LAHSA generally serving lower-acuity patients
        + Some issues with needing to re-assign individuals based on re-assessment of acuity levels
        + Some enhanced bridge housing with licensed clinical case managers.
+ **Bed rates**
    + Higher bed rates would allow for enhanced services, staffing
    + All providers stated that while bed rates have increased, they are still not sufficient considering acuity of clients, and requested bed rates between $80 and $100 per night
    + Higher bed rates necessary for: increased staffing (most mentioned), expanded services (workforce development, enhanced case management, health/ mental health services), facility costs, security, and food
    + Increased bed rates could improve shelter operations particularly during non-traditional hours— currently a lack of licensed staff on site after hours to manage crises

HMA COMMUNITY STRATEGIES

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▌ **THEMES** FROM QUALITATIVE DATA CONT.

+ **Challenges in serving subpopulations**
    + Medical recuperative- recuperative care providers stated that because clients are such high acuity, they can be "hardest to house," may need longer LOS to stabilize

    + TAY-providers serving TAY mentioned a need for more services (e.g. family/ parenting support, financial literacy) tailored to this age group

    + SUD- providers discussed needing more time to build rapport and engage clients in order to get them housing ready

    + Operational Challenges:
        + Multiple funding sources, some with different restrictions. However, providers report providing services as needed by carefully planning funding allocations
        + Some issues with initial acuity assessment resulting in in appropriate placement. However, this is generally addressed fairly quickly with staff ability to identify appropriate housing.

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10/10/2019

THEMES FROM QUALITATIVE DATA CONT.

+ **Collaboration – County Departments, Providers**

  + All DHS, LAHSA, DMH department staff identified the regular, ongoing, and highly collaborative interaction resulting from Measure H initiative as one of the key strengths of the program.
    + Regular meetings at leadership level
    + Opportunity to regularly discusses individual cases and problem-solve
    + Implementation of shelter standards mentioned by majority of informants as key indicator of effective collaboration
    + Development of consistent intake forms for DHS/DMH

  + All shelters mentioned strong communication channels with DHS and LAHSA with opportunity to discuss individual cases and problem-solve at case level.

  + Providers and department staff identified training provided by DHS and LAHSA as effective for service provision to various subpopulations.

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THEMES FROM QUALITATIVE DATA CONT.

+ **Collaboration – Hospitals/DHS**

  + Strong referral pathways from public hospitals to Housing for Health/Recuperative Care/Stabilization Housing
    + One hospital has dedicated team of homelessness staff focused on working with this population for assessment and referral. Team partially funded by hospital operational budget.
    + Another hospital reported no dedicated team, but all staff have experience with and are comfortable with working with homeless population and unique needs.
    + DHS-funded staff on site at hospitals. Hospital staff have access to DHS CHAMP system and there is protocol for initiating referral process in CHAMP system by hospital staff
    + Staff report reduction in ED visits, inappropriate length of stays

  + Opportunity to strengthen referral networks with private hospitals

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THEMES FROM QUALITATIVE DATA CONT.

+ **Challenges transitioning to permanent housing**

  + Top barrier identified was lack of permanent housing capacity—bottleneck leads to slow bed turnover in interim housing
  + Difficult to achieve care continuity in scattered site permanent housing—challenges with CES matching based on availability and eligibility rather than client needs
  + Clients in interim housing not necessarily next in line for permanent housing resources—a strategy is needed for those in beds to be prioritized for permanent housing in order to improve throughput
  + Transition to permanent housing must include supportive services such as workforce readiness training, financial literacy, budgeting, "life skills"
  + Clients with mental health, SUD needs in particular face anxiety over transition, lack of social support
  + Many shelter staff cited inaccurate VI-SPDAT scoring as a barrier for CES match, although also indicated this is generally addressed as soon as identified.

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THEMES FROM QUALITATIVE DATA CONT.

+ **Potential to implement recovery-oriented principles**

  + Shelters already using a Housing First model – focused on harm reduction.
  + Since Measure H, have started focusing more on trauma-informed care.
  + Some shelters have recuperative/stabilization and emergency shelter beds – staff trained to provide more intensive case management
  + LAHSA initiating Learning Communities to share best practices – can improve program functioning, provide opportunity for enhanced training
  + Recognition that shelter providers are willingly taking on challenge of providing more beds – shelter providers motivated to work collaboratively with LAHSA to address the issue and work with more complex cases.

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THEMES FROM QUALITATIVE DATA CONT.

+ **Program challenges**
    + Working with multiple funding sources is a challenge administratively.
    + Shelter staff stated that some clients come in without an ICMS worker, but need access to services
    + Clients with chronic conditions face an additional layer of challenges when transitioning to permanent housing
    + High rates of staff turnover creates issues with care continuity for clients, progress towards housing readiness
    + Lack of public awareness of length of process creates frustration for clients when waiting for placement
    + Top issue identified with DHS was working to find placements for clients in need of a higher level of care—however, interviewees acknowledged this is mainly due to a dearth of skilled care settings that will accept H4H clients due to young age, BH issues, and lack of funding

+ **Challenges with data systems**
    + HMIS and CHAMP do not communicate; data from other departments (e.g., DMH, SAPC) not easily accessible
    + Inputting data into multiple systems is a burden for providers, increases error

HMA COMMUNITY STRATEGIES

THEMES FROM QUALITATIVE DATA CONT.

+ **Program Successes**

    + Significant increase in all interim beds as a result of Measure H
    + Increased outreach and accessibility to shelters
    + Low-barrier shelters
        + 24-hours
        + Allow pets
        + Storage for belongings
    + Cross-department collaboration to address the homelessness issue is highly successful
    + Establishment of shelter standards was a key milestone
    + Ability to hire more clinical staff, train more staff in working with challenging populations
    + Department staff able to closely collaborate with and provide TA to shelter providers
    + Expansion of services to ensure those moving from interim housing have needed supports
    + Fewer serious client complaints

HMA COMMUNITY STRATEGIES

THEMES FROM QUALITATIVE DATA CONT.

+ **Suggestions/ recommendations (from interviewees)**

    + Top recommendation- increase permanent housing stock

    + Reevaluate LOS regulations—some clients may need more time, services and supports to transition to and stay in permanent housing successfully; however, must be balanced to not exacerbate bottleneck

    + A need for interdisciplinary care teams (like E6) throughout continuum

    + Ongoing training for providers through learning communities, possibly attendance at other professional meetings

HMA COMMUNITY STRATEGIES

QUANTITATIVE ANALYSIS

+ **Quantitative analysis will focus on the following research questions:**

    + To what extent do those discharged from institutions to interim housing and needing physical health, mental health or substance abuse services receive referrals and services?

    + What are the differences among subpopulations in return to homelessness, permanent housing, and length of stay in interim housing?

+ **Data Sources**

    + HMIS

    + CHAMP

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▌QUANTITATIVE ANALYSIS

- **Subpopulations**
  - Gender, Race/Ethnicity
  - Veteran status
  - Individual v. Family
  - Disability status
    - Mental health and substance use key focus area
  - CES score
- **Measures Of Client Experience**
  - Time in interim housing
  - Number interim housing stays
  - Exit status – positive v. negative exit
  - Aggregate data on mental health and substance use services

HMA COMMUNITY STRATEGIES

▌QUANTITATIVE ANALYSIS

- **Sample:**
  - HMIS
    - Adults enrolled in either emergency or transitional housing (Project Type = 1 or 2), with entry date from January 1, 2016 through present.
    - Exclude those in winter shelters only
    - Exclude those who are not identified as Head of Household
    - **Total number unique individuals for analysis = 37,334**
    - Total sample for analysis may decrease depending on missing data
  - CHAMP
    - Include all individuals
    - Currently de-duplicating file to determine total number unique individuals

HMA COMMUNITY STRATEGIES

QUANTITATIVE ANALYSIS

+ **Analysis Plan:**
    + Compare differences in client experience measures by subgroups
        + Bivariate and multivariate models with group comparisons, and controlling for additional demographic/risk factors
    + Compare number of individuals receiving mental health and substance use disorder services identified from aggregated tables from DMH, SAPC, with total number of those identified in HMIS data as having MH/SA disability

HMA COMMUNITY STRATEGIES

NEXT STEPS & QUESTIONS

HMA COMMUNITY STRATEGIES

Interim Housing Summit Participants*

Participant	Agency
Alexis Boothby	Union Station Homeless Services
Andrea Marchetti	Jovenes Inc
Ashlee Oh	Homeless Initiative
Charles Robbins	Health Management Consulting
Debra Gatlin	Los Angeles Homeless Services Authority Lived Experience Advisory Board
Deon Arline	Department of Public Social Services
Elizabeth Ben-Ishai	Homeless Initiative
Erika Hartman	Downtown Women's Center
Gail Winston	Department of Children and Family Services
Graceline Shin	Department of Public Health
Jeff Proctor	Los Angeles Homeless Services Authority
Juataun Mark	Department of Health Services
Kara Riehman	Health Management Consulting
Katina Holliday	Serenity Recuperative Care
Kris Freed	LAFH
Lezlie Murch	Exodus Recovery (SUD)
Libby Boyce	Department of Health Services
Lise Ruiz	Department of Mental Health
Maria Barahona	Haven Hills
Max Stevens	CEO Research
Meg Barclay	City of Los Angeles
Michael Castillo	Homeless Initiative
Natalia Torregrosa	United Way of Greater LA
Pamela Crenshaw	Los Angeles Homeless Services Authority Lived Experience Advisory Board
Patima Komolamit	Center for the Pacific Asian Family
Peter Espinoza	Department of Health Services, Office of Diversion and Reentry
Phil Ansell	Homeless Initiative
Simon Costello	LA LGBT Center
Steve Lytle	Bell Shelter – The Salvation Army
Tara Reed	Abt Associates
Tescia Uribe	PATH
TuLynn Smylie	The People Concern
Will Lehman	Los Angeles Homeless Services Authority

*The above list does not include members of the public who attended the Summit.

Measure H Funding Recommendation Process-
FYs 2020-23

Homeless Initiative Policy Summit #4
Interim Housing

Tuesday, October 15, 2019

Key Points:

1. **For clients who require a higher level of care, consider opportunities for placement in facilities other than interim housing.** This could include Board and Care and Skilled Nursing Facilities. The County and partners can collaborate to explore funding options and creative solutions to make these facilities more accessible to people experiencing homelessness.

2. **Explore additional options for interim housing that support client choice.** While low-barrier, harm reduction-oriented programs have flourished within our system, some clients want and need separate sober-living facilities (not just a floor or segment of a facility) to maintain their sobriety and expedite transition into permanent housing.

3. **Pursue options for increasing access to a range of supportive services for participants in shelters.** For some clients, the supports currently available do not meet their needs. Such needs could be met with onsite staff or, potentially, by utilizing teams of clinicians from several disciplines that serve multiple facilities operating within a region.

4. **Enhance collaboration between interim housing providers and mental health and substance use disorder services.** While some shelters are effectively collaborating with agencies providing these services, others struggle to help their clients access needed supports. Services should be available to all clients, regardless of the funding source for their beds.

5. **Improve staff training to support better client outcomes and staff retention.** Expectations of interim housing staff are very high, but training and experience are limited due to the level of funding interim housing providers are receiving. Hiring more people with lived experience can help providers to better meet their clients' needs.

Interim Housing Policy Summit Notes
(Discussion questions in bold)

After a presentation on interim evaluation results by Health Management Associates, participants made the following comments:

- Bed rates have increased but are still too low. Providers need higher rates in order to enhance services and provide round-the-clock staff.
- Providers face the continued challenge of housing high acuity clients. The clients' lengths of stay in interim housing are increasing.
- Many challenges in transition to permanent housing.
- Top barrier: Lack of permanent housing, creating a bottleneck in the system and slow turnover rates in interim housing.
- 90 days is not enough time to be in interim housing before moving into Permanent Supportive Housing (PSH); clients need at least 6 months in interim housing to set them up for success in PSH.
- For future data collection:
  - o Look at age (and pay attention to patterns with youth specifically).
  - o Analyze data for Domestic Violence (DV) providers specifically, since DV survivors are in unique circumstances.

What internal and external bottlenecks compromise the homeless services system's ability to optimize Interim Housing's throughput to effectively and efficiently assist homeless individuals and families to transition into stable and permanent housing? How can they be addressed?

Need for effective deployment of supportive services and staff training
- Intensive Case Management Services (ICMS) case managers are sometimes matched to clients who are very far away from them geographically; lots of time spent in transit. LAHSA and DHS are looking at ways to address this.
- Providers recommend onsite supports from nurse practitioners, psychiatrists/DMH.
- Lack of staff training on crisis de-escalation, cultural competency, and LGBT issues/needs; lack of training contributes to high turnover rates among staff.
- Lack of connection to adequate wrap-around services.
- Lack of job connections for seniors and people with disabilities.
- Need to improve and increase employment services as a way to increase throughput (especially for low acuity clients who aren't eligible for any housing resources).
  - o Need connection to higher quality jobs.
  - o Consider offering incentives for housing based on engagement in work programs.
  - o Co-locate WorkSource centers' employees at interim housing sites.
- Need for childcare services and education services for those in interim housing.
- Need to increase partnerships with other agencies.

Challenges of prioritizing and placing clients in Interim Housing (IH)
- Need to prioritize IH placement for those attached to a permanent housing (PH) resource.
- Burden of proving oneself eligible for interim housing is usually placed on the client, which is a challenge.
- Lack of housing options for people with mid-range acuity scores; may need to look outside the voucher system for these individuals/families.
- Lack of innovative thinking; need to explore alternative shelter spaces. For example, Downtown Women's Center looked into turning their day center into interim housing at night.

Client choice, safety, and special populations
- Unsafe conditions in interim housing, especially for youth and transgender women; many young people first come into contact with drugs at shelters.
- Women tend to remain without stable housing for longer than men.
- Challenge of high volume of people in interim housing still actively using substances.
  - DMH and partners are looking at opportunities for client choice, including options for people who want to keep using and those who want sober living environments.

Challenges of placing clients in permanent housing
- Landlord refusal to accept rental subsidies (even when they are within rental subsidy standards) is a barrier to moving people out of IH to PH. (Implementation of SB 329 effective January 2020 could mitigate this problem.)

Administration
- Rigid funding requirements; need more flex funding available to clients for their various needs.
- Need to hire more people with lived experience at interim housing to provide support and walk with clients through their journey. Roles could include house manager, coach, etc.
- Different sites are funded at different rates, but are all doing the same thing.

How can diversion/problem-solving be used to help ease the burden on the emergency shelter system? Is use of diversion as a tool to prevent entry into emergency shelter likely to be more effective with some populations/demographics than others?

Populations for whom diversion can be effective
- Diversion for youth can be very effective; many can self-resolve with connections to jobs/some assistance.
- Need more financial assistance for people who are already employed, but are still experiencing homelessness.
- Diversion seems more effective in the family system, which has a single point of entry.

Populations/situations for whom problem-solving may not be appropriate

- There are some people who aren't good candidates for diversion; however, we need to look at resources from other systems before sheltering.
- Problem-solving may not be particularly helpful at shelters that tend to serve single adults who are chronically homeless and don't have many options.
- Need to stop trying to divert DV survivors from coming into shelters; they are at the shelters because they truly have no other options. Family and friends are often connected to the abuser, so are not viable options.
- Service providers need to be trained in assessing the lethality of a DV situation, and then be able to provide wrap-around services.

Implementing effective problem solving

- Problem-solving must be well-resourced.
- LAHSA will pilot placing problem-solving specialists at high volume interim housing sites starting in November.
- In family reunification cases, need to consider the living conditions the person will be returning to before providing financial assistance to support the reunification; consider whether or not the person is likely to become homeless again based on those living conditions.
- Talk to clients more about looking into shared housing before going into a shelter; otherwise, they may be homeless for a long time.
- Explore client cost-sharing for motel stays.
- Staff through the system need to be problem-solvers, not just the problem-solving specialists at the front-end of the system.
- Homeless service system should not be the first call that people make when they need help; we should be the last call/last resort, once people have exhausted mainstream resources.
- Need to increase follow-up for those who have been diverted.
- LAHSA states that it is planning to do special DV training for providers.

Communications, prevention, and other comments

- Elected officials need to be able to educate their team about how the system works and what the best approach is to messaging.
- Homeless prevention seems underfunded and there is a lack of transparency/public info about prevention services.
- Greatest challenge with prevention is determining who will actually become homeless.
- Need to prioritize matching people to LA City's new A Bridge Home sites.
- Concern about high percentage of turnover for staff, whose caseloads are way too big.
- Need to improve policing at PSH sites.

Deinstitutionalization and non-institutionalization have resulted in homeless populations with complex and highly acute needs. What types of interim housing beds and residential placements are needed to meet the needs of the portion of the unsheltered population that has complex and highly acute needs? How do we increase current capacity to meet these needs?

Challenges facing high acuity clients
- Not enough interim housing for high acuity clients.
- Need to distinguish between people who began experiencing homelessness due to their high acuity needs vs. people who develop high acuity needs as a result of experiencing homelessness over time.
- Need more recuperative care beds.

Alternative care options for high acuity clients
- Board & Care facilities could be used for interim housing.
  - Having interim housing beds at Board & Care facilities could help channel more funding to those facilities.
- Need to advocate for SSI rate to increase statewide, as it has not increased substantially in decades and creates a challenge for Board & Care costs. Low payment rate for Board and Care threatens this important resource for the most vulnerable.
- Could we better utilize Skilled Nursing Facilities (SNFs)? Some clients in interim housing actually need SNFs.
  - However, they are expensive, most are privately operated, and they can and often do turn homeless clients away.
  - Medicaid doesn't cover the full cost. Client could be in SNF for life, so providers are reluctant to take them if they will not be reimbursed appropriately.
- Could we create a homeless service system SNF? May need additional funding.

Funding/resource constraints and challenges
- Given level of funding for interim beds, providers are hiring people with limited experience; yet, they are expected to know everything.
- Need funding to hire people with lived experience to work onsite and just talk to/provide support to participants.
- Need funding for facilities modification and access to support for those who need assistance with Activities of Daily Living (ADLs).
- Need every single partner that has resource to come to the table, even if we don't historically have a relationship with them or come from different perspectives on service provision.

Client supports and coordination of care
- Need more support and follow up with clients in PSH so they don't fall out of the system. For high need clients, transition to PSH can be difficult, and not all projects have sufficient support available.

- Suggestion for regional team support approach for interim housing – This could be something like a Multidisciplinary Team (MDT) to support interim housing. Could be one for each SPA, available by phone and for in-person visits. (Majority of people in the room raised their hand in agreement that this would be helpful.)
- Shelters need to be better equipped to link clients to DMH. Bell Shelter has a strong relationship with DMH case managers, who are able to provide continuous care. At Bell Shelter, support services are strong both for clients that are in DMH-funded beds and those who are not in DMH-funded beds.
- Not all have same experience as Bell Shelter. Need to increase system flexibility so that DMH providers are not limited to only working with people in DMH beds.
- Need to more clearly define ICMS case managers' role; right now, many are supporting clients while they are in shelters and offer continued support through the PSH process.
- Rather than form regional teams, we need to increase on site supports and services, but resources are limited.

Other challenges/options
- Need to divert lower acuity clients from shelters, find low-cost fast options. This will increase throughput and allow beds to be dedicated to the sickest clients.
- Before people exit interim housing, they need life skills classes, such as classes on cooking, cleaning, budgeting, and taking care of themselves, and be prepared for other needed activities, such as doing monthly check-ins with service providers.

What factors hinder the unsheltered homeless population from accessing interim housing? How can these barriers be addressed? Can we think about having different types of interim housing that are responsive and attractive to different groups of participants, including those who would like a clean and sober environment or a more structured program?

Shelter operations
- System has done a great job shifting to low barrier, harm-reduction services. However, with sites opening that serve 100+ people with varied needs, this doesn't work for everyone.
- Need more flexibility in the system, including ability to offer sober living environments. Entire facility needs to be sober, not just a floor or wing.
- Consider requiring participation in AA or NA for people to be able to stay in sober housing.
- Need local beds, geographically distributed throughout the county. Clients shouldn't have to move across the County, including to Skid Row, to get interim housing.
- For people exiting institutions, it takes a few days to figure out where they can be placed based on their needs/whether they can maintain themselves in an unlicensed facility. This time lag is challenging when there is an urgent need for shelter.
- Clients should be granted extensions to their stays in interim housing facilities while they are waiting for PSH or rapid re-housing placement, if they have already been

matched. If discharged to the street, they may encounter challenges/provider may have difficulty finding them.

Shelter hours
- Shelters need to have 24/7 access and/or afterhours intakes; having shelters maintain normal business hours is not working.
- Safe Landing programs should help alleviate this; will provide 24/7 intakes.
- Agencies are understaffed; shelters need night staff other than security guards. Staffing ratios at shelters should stay the same even through the night.
- People are getting thrown out of shelters (especially in SPAs 4 and 6) by security in the middle of the night; need service providers there to provide crisis intervention.

Perceptions of shelters and shelter variations
- People living on the streets have a lot of fear about what shelters are like, often based on rumors about what they are like; for example, some believe, "People get killed in shelters."
  - To address this, outreach teams could give clients tours of shelters (without them having to commit to taking a bed).
- Transitional housing for youth is not funded under strategies E8 or B7. The goal of this type of interim housing is to exit young people to independence, not to PSH.

Reasons why people experiencing homelessness may not want to enter interim housing
- Teenage boys are often turned down from family shelters/interim housing.
- Many providers are not accepting pets and emotional support animals.
- People in encampments may not want to leave their communities.
- Interim housing presents a challenge for couples, as a facility may not have beds for both people.
- Curfews discourage some from entering shelters.
- Not allowing alcohol/substance use also presents a challenge in shelters; some people leave their things in the shelter and end up staying outside all night to use substances, especially those who are alcohol dependent.
- People who are actively using drugs are fearful of entering interim housing; need more collaboration with DMH and SAPC.

What are the most promising innovative/new options for interim housing that can expeditiously and effectively get people off the streets? What criteria should we apply as we assess these options?

- Host Home model - volunteers hosting a young person in their home for up to 6 months
- Pet daycare
- Sober vs. not sober spaces
- Asking mega churches if they will shelter people at night
- Nighttime intakes at shelters

Public Comments

- People are entering into PSH too quickly, and then there are insufficient supportive services in PSH; people need mental health services.
- Need to focus on helping people heal on the inside (spiritually, emotionally, etc.). Services should be culturally rooted, delivered in a culturally competent manner.
- Need to hire people from various backgrounds within the homeless service system. Standardize terminology used (shelter, emergency housing, etc. mean different things for different organizations). Need housing options for people who are obese, registered sex offenders, and sex workers. Concern about shelter staff who have to work around animals even though they have allergies. Educate the public on vouchers; let people know that allowing someone to couch surf could jeopardize their voucher.
- Seniors are scared of shelters and they are the last place that senior, black, disabled women would want to go.
- Need funding to fill in geographic and population-specific gaps. Measure H funding not available to support capital funds needed to build new shelter.
- We are asking amazing questions and we are going in the right direction. We also need people who have worked in emergency shelters sitting at the table. SPAs 4 and 6 have additional needs. Safe Landing triage centers are needed in hospitals.
- The National Association of Mental Illness educates family members on how to live with, accommodate, and support someone suffering from mental illness. We could do something similar. We need to truly walk with people who are homeless through their struggle
- We need to better utilize open beds at sober living houses.