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February 5, 2020

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TRANSMITTING FIVE EVALUATIONS OF HOMELESS INITIATIVE STRATEGIES

On May 3, 2019, the Chief Executive Office (CEO) informed the Board of Supervisors (Board) of its intent to use delegated authority to execute five contracts with competitively-procured independent researchers, each of which would prepare an evaluation report on the effectiveness of key Homeless Initiative (HI) strategies to combat Los Angeles County's homeless crisis. This memo transmits the five completed HI strategy evaluations. Attachment I, provides a brief summary of each evaluation and the full reports are attached as Attachments II through VI. These reports, per the CEO's May 3, 2019 Board correspondence, "identify best practices, evaluate areas where process enhancements may be necessary, and provide HI stakeholders and the Board with information to inform optimal allocations of Measure H resources."

Evaluations in Five Essential Strategic Areas

The five evaluation reports complement but are distinct from the Year Three HI performance evaluation transmitted to the Board on January 6, 2020. Whereas the performance evaluation adopts a broad view of the HI's 51 countywide strategies, assessing their outcomes through a series of inter-dependent quantitative outcome metrics, the attached evaluation reports, combine quantitative analysis and a qualitative focus on process to provide *mixed methods* assessments of specific HI strategies in five key service areas:

Five Independent Evaluations of Homeless Initiative Strategies			
Attachment	**Service Area/ Topic**	**Evaluator**	**Strategies Evaluated**
II	Homelessness Prevention	California Policy Lab / UCLA	A1 and A5
III	Outreach	Resource Development Associates	E6
IV	Emergency / Interim Housing	Health Management Associates	B7 and E8
V	Rapid Re-Housing	Westat	B3
VI	Permanent Supportive Housing	Westat	D7

Setting a New Standard in the Use of Evidence-Based Analysis to Drive County Policy

The five attached strategy evaluations, along with the HI Year Three performance evaluation, together comprise a unified body of inter-related program research that is rare in terms of the collective scope of actionable information being made available to Los Angeles County policymakers and stakeholders. The use of these reports to inform critical deliberations over the allocation of Measure H resources can potentially set a new standard for evidence-based decision-making in areas identified as policy priorities by the Board.

Next Steps

All five strategy evaluators presented key components of their analyses at the Measure H policy summits convened by the HI from September to November of 2019. With the evaluation reports now complete and transmitted to the Board, the evaluators will each present their findings at meetings of the Homeless Policy Board Deputies in the coming weeks. The analyses presented in these reports, as well as in the HI Year Three performance evaluation, will then provide valuable guidance in critical stakeholder deliberations and budgetary discussions to determine how to optimally allocate Measure H resources in fiscal year 2020-21 and beyond. Additionally, these evaluations will inform future modifications to the design and operation of the seven strategies, which together receive the vast majority of Measure H funding.

If you have any questions about the HI strategy evaluations or the Year Three performance evaluation, please contact Max Stevens in the Office of the Chief Information Officer, at (213) 253-5630 or mstevens@ceo.lacounty.gov.

SAH:TJM:WSK
MS:pa

Attachments

c: Executive Office, Board of Supervisors
County Counsel
Sheriff
Children and Family Services
Health Services
Mental Health
Probation
Public Health
Public Social Services
Los Angeles Homeless Services Authority

Homeless Initiative Strategy Evaluations Overview

Following Transmittal of the Year Three Homeless Initiative (HI) Performance Evaluation to the Los Angeles County Board of Supervisors on January 6, 2020, the Office of the Chief Information Officer is now releasing five additional evaluation reports that provide a more detailed examination of specific HI strategies implemented to combat homelessness. Whereas the Performance Evaluation adopts a broad view of the HI's 51 countywide strategies, assessing their outcomes through a series of inter-dependent quantitative outcome metrics, the strategy evaluations adopt a *mixed methods approach* that combines quantitative analysis and a qualitative focus on *process* to assess specific HI strategies in four cornerstone service areas:

- ✓ Prevention
- ✓ Outreach
- ✓ Interim and Emergency Housing
- ✓ Permanent Housing

The strategy evaluations were conducted by independent analysts engaged through competitive procurements. The five reports probe process-related issues as well as outcomes and provide perspective on the functionality of the HI strategies and practical details that would be unavailable otherwise. The analyses presented in these reports will inform deliberations over Measure H resource allocations and guide efforts to enhance HI strategy performance.

Prevention	Evaluator:
HI Strategies A1 and A5	California Policy Lab

Since 2017, the California Policy Lab at the University of California, Los Angeles (CPL/UCLA) has worked jointly with the HI in using predictive methods to construct data-driven tools and processes to *prospectively* identify County service users most at risk of becoming homeless. The development of a rigorous approach to prioritizing those most likely to experience homelessness in the provision of finite preventive resource is a critical component of the Lab's collaborative efforts with the County

CPL's evaluation of the HI's prevention strategies (A1 and A5) leverages the Lab's familiarity with the County's integrated data resources to produce a rigorous assessment of various approaches to homelessness prevention. CPL additionally details the steps the County can take to produce the causal evidence needed to enable and guide more aggressive investment in homelessness prevention in the future, which include ensuring that those at risk of becoming homeless are connected to social services benefits and streamlining the assessment process.

Outreach	Evaluator:
HI Strategy E6	Resource Development Associates

Under HI Strategy E6, the Los Angeles Homeless Services Authority (LAHSA) works jointly with the County Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH) to develop and administer an integrated network of street-based outreach that work jointly to route unsheltered individuals to permanent and interim housing and to connect these persons to supportive services.

Resource Development Associates' (RDA's) evaluation of the E6 outreach network finds that the strategy improves the efficiency with which unsheltered persons are matched to services, while also expanding Coordinated Entry System (CES) points of entry in all eight County Service Planning Areas (SPAs). These

improvements are closely connected to the development of the Homeless Outreach Portal (LA-HOP), a web-based tool built under LAHSA's direction to enhance coordination amongst more than 200 teams currently participating in the E6 network. The evaluators note, at the same time, that system-wide quality measures must be established to ensure a consistent deployment of best practices across the network.

Interim and Emergency Housing	Evaluator:
HI Strategies B7 and E8	Health Management Associates

During the first two years of Measure H, revenues generated through the quarter-cent sales tax have enabled a five-fold increase in HI-affiliated IH placements. Evaluation of the HI's IH strategies is therefore critical to ensure that the resources committed to this area are oriented towards optimizing opportunities, where appropriate, to transition users of these services into Permanent Housing (PH) arrangements and to otherwise prevent exits from IH to unsheltered homelessness.

In assessing HI strategies B7 and E8, Health Management Associates (HMA) cites significant growth in access to interim beds and improved coordination between LAHSA, DHS and DMH as important beneficial effects in this service area. HMA's report also emphasizes the importance of working to mitigate challenges staff at IH providers face in serving high-acuity segments of the homeless population, which contributes to high rates of staff turnover and can negatively affect the continuity of care so essential to the likelihood of favorable service outcomes. HMA also notes that resource allocation discussions must account for barriers that often impede transitions to PH among those with acute mental health and Substance Use Disorder (SUD) challenges.

Permanent Housing	Evaluator:
HI Strategies B3 and D7	Westat

Securing exits from homelessness to Permanent Housing, whether via the provision of rental subsidies or by facilitating self-resolution, is the ultimate objective of the homeless services system and fundamental in determining the success of efforts to reduce homelessness in any setting. The evaluation of PH services affiliated with the HI is divided into two reports both of which are prepared by Westat

Rapid Re-Housing Evaluation: Strategy B3: One of Westat's two PH reports focuses on HI Strategy B3, which seeks to expand Rapid Re-Housing (RRH) services countywide. As reported in the Year Three Performance Evaluation, HI-affiliated RRH placements have grown by more than 180% during this period. While Westat's evaluation underscores this capacity increase, as well as improvements in both the duration from enrollment to move in and the rates at which clients transition from RRH subsidies to non-time-limited PH arrangements, the report also recommends addressing lengthy RRH stays in advance of these transitions, as well as RRH data quality problems, which create difficulties in tracking outcomes and producing full accounts of the effectiveness of these services.

Permanent Supportive Housing Evaluation: Strategy D7: The second of Westat's two PH reports evaluates the HI's Permanent Supportive Housing (PSH) strategy (D7). The report credits the strategy with an improved capacity to sustain the County's expanded PSH inventory and reports that D7 has introduced much-needed flexibility in approaches to funding PSH. Westat describes how D7 intensifies service coordination between PSH personnel at varying levels and locations, but the evaluators also note challenges that emerge in connection with diverse philosophies guiding the operations of different providers. Providers additionally report that the infusion of D7 funds comes with an added layer of case management and administrative responsibilities that at times exacerbate staff burnout and turnover.

Evaluation of Los Angeles County Measure H-Funded Homelessness Prevention Strategies

Till von Wachter, Janey Rountree, Maya Buenaventura, Brian Blackwell, and Dean Obermark

California Policy Lab

December 3, 2019

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Executive Summary

Homelessness prevention programs aim to assist at-risk individuals and families maintain housing stability and reduce the inflows into the homeless services system. In Los Angeles County, the Los Angeles Homeless Services Authority (LAHSA) contracts with homeless service providers to deliver prevention services to families, single adults, and transition-age youth who are imminently at-risk of becoming homeless. "Strategy A1" includes homeless prevention programs for *families* and "Strategy A5" includes homeless prevention programs for *single adults* and *transition-age youth* (TAY). In order to implement prevention under Strategies A1 and A5, LAHSA contracts with homeless service providers to deliver short-term assistance to low-income individuals and families. Service providers then administer a screening survey called the Prevention Targeting Tool (PTT) to determine if clients are experiencing an imminent housing crisis and are eligible for prevention services. Common forms of prevention assistance are short-term financial assistance, housing-conflict resolution and mediation with landlords and/or property managers, housing stabilization planning, and legal assistance. Prevention services are intended to be short-term and are typically provided for up to six months. The goal of prevention is to secure permanent housing through assisted self-resolution of the housing crisis (the participant remains in their current housing or relocates, if needed).

This evaluation covers Measure H[1]-funded LAHSA prevention programs (A1 and A5) for Fiscal Years 2017-18 and 2018-19 (July 1, 2017 to June 30, 2019). We address three primary research questions:

- **Research Question 1: Who is being served by Strategies A1 and A5 and what is their housing status after exit?**
- **Research Question 2: How could Strategies A1 and A5 be improved and how could scarce prevention funding be most efficiently prioritized?**
- **Research Question 3: Does prevention funded through Strategies A1 and A5 directly cause a reduction in inflows to homelessness?**

Under **Research Question 1**, we found that 1,321 single adult households, 1,368 family households, and 112 TAY households received prevention services during the study period. Of those, about 74% were given financial assistance to help resolve a housing crisis, including rental assistance and utility arrears. The remainder (26%) were only given case management. Over a third of prevention clients experienced homelessness in the five years before their enrollment. Sixty-five percent of households are or were CalFresh recipients, and nearly a quarter of households were clients of the Department of Mental Health (DMH) and/or Department of Health Services (DHS). Once clients exited the program, 14.5% returned to homelessness within 12-months. The return rates, however, were very different for households who received financial assistance (5.3%) compared to those that

[1] In response to the homelessness crisis, voters in Los Angeles County passed Measure H, which increases taxes to add an estimated $355 million for homeless services each year.

did not (19.9%). Finally, we examined clients' pathways into and out of prevention services. Nearly half of households who enrolled in prevention move from a doubled-up housing situation with family or friends to an unsubsidized rental.[2]

We supplemented the quantitative analysis under **Research Question 1** with semi-structured interviews with prevention service providers and legal service providers to get a more complete picture of who is being served by Strategies A1 and A5 and how service providers screen individuals and families and administer prevention services. Our interviews show service providers have a generally positive view of A1 and A5 prevention efforts. Providers most frequently pointed to rental arrears or rental assistance as the most beneficial program component, though we also observed frequent usage and widespread support for legal services. Service providers found the prevention program model to be relatively clear, but indicated confusion regarding problem-solving and its role in conjunction with prevention. Providers reported using the Prevention Targeting Tool (PTT) consistently, though that wasn't entirely supported by the administrative data. Legal service providers recommended closer coordination with homeless service providers, including co-location, regularly-scheduled and in-depth case conferences, more swift referrals, training service provider staff to better spot legal issues (or hiring an attorney on staff to spot legal issues), and expanding the universe of organizations permitted to make legal referrals.

Under **Research Question 2**, we identify potential ways to improve the prioritization and efficiency of prevention resources. We found that the accuracy and efficiency of the PTT screening tool could be improved by re-weighting the tool and eliminating certain questions. On average, reweighting and simplification could increase the accuracy between 8% and 34%, while at the same time reducing the number of questions from 30 to 13 for the Families PTT and from 30 to 12 for the Individuals PTT. Since the PTT is a relatively new survey, we performed our analyses on relatively small datasets with positive responses to many questions being rare. As a result, it may be premature to shorten the survey based on our analysis. Instead, we recommended that LAHSA engage in a policy planning process to shorten the survey and then empirically validate the PTT by continuing to collect data and engaging in a continuous improvement process.

We also include an analysis of an underserved population of individuals who are at high-risk of homelessness under **Research Question 2**. Notably, the targeting mechanism for existing A1 and A5 prevention services is largely driven by client self-identification (*i.e.*, clients must seek assistance from a prevention service provider), with further screening taking place via the PTT and related eligibility criteria. This raises the question, however, of whether there are potential clients who are unaware of prevention services or are unable or unwilling to present themselves as being at-risk, who could potentially be identified and

[2] This statistic only includes households for whom enough time has passed to complete a 6-month enrollment in prevention, *i.e.,* households who enrolled at least 6 months prior to the drafting of this report.

served. The use of *predictive analytics* – a field that applies statistical and machine learning methods to administrative data in order to predict future outcomes – provides an opportunity to identify such high-risk, underserved populations. In an effort separate from but related to this evaluation, the California Policy Lab, in partnership with University of Chicago Urban Labs, has been working with the Los Angeles County Chief Information Office and Homeless Initiative to develop a model for predicting homelessness amongst single adults who utilize County services.[3] The lists of high-risk individuals identified by the predictive models can be used for *proactive outreach*. In other words, rather than waiting for clients to self-identify and present themselves to a service provider as being at-risk, as is the case with existing prevention strategies, caseworkers at County agencies or LAHSA service providers could proactively contact clients on the predicted risk list.

We compared the single adults predicted by the models to be at highest risk of homelessness with the clients actually served by A5 prevention services. (There were 5,556 individuals identified by the predictive models and 1,266 A5 prevention clients in Fiscal Years 2017-18 and 2018-19.) We found that only 23 individuals across Fiscal Years 2017-18 and 2018-19 were both identified by the predictive models and enrolled in an A5 prevention project. This should not be taken to suggest that clients served by A5 prevention services are not at high risk of homelessness. More likely, these populations are both at high risk of homelessness but are identified in different ways and should be served at different intervention points. Specifically, the group identified by the model appears to be disconnected from homelessness prevention resources.

Under **Research Question 3**, we sought to estimate whether prevention is directly causing reductions in inflows to homelessness. This type of analysis explores what *would* have happened to prevention clients if they hadn't been served: Would they have successfully self-resolved their housing crisis or would they have fallen into homelessness? One of the ways that researchers estimate what would have happened to individuals or families if they had not participated in a program is by identifying individuals and families who are very similar to program participants but who did not participate in the program, *i.e.*, "comparison" or "control" individuals and families. By comparing the outcomes of a comparison group with the outcomes of the program participants, researchers can get an idea of what would have happened to program participants if they had not participated in the program. In the case of homelessness prevention, all program participants were at imminent risk of losing their housing. Thus, when identifying individuals and families who could serve as comparison individuals, it was important to try to find individuals and families who were also at imminent risk of losing their housing (but who did not receive prevention services). Although the ELP data and HMIS data contains demographic information and service utilization information on individuals and families who could theoretically serve as comparison individuals, the most important characteristic –

[3] von Wachter, T., Bertrand, M., & Pollack, H. (Sept. 12, 2019) "Predicting and Preventing Homelessness in Los Angeles." California Policy Lab. Retrieved from https://www.capolicylab.org/predicting-preventing-homelessness-la/.

imminent risk of losing housing – is not captured in ELP data or HMIS service data. Because we could not identify plausible comparison groups, we could not answer **Research Question 3**.

Acknowledgements

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1. Introduction and Background

While Los Angeles County has successfully navigated homeless individuals into available housing and other services, the homeless population continues to grow as inflow outpaces exits to permanent housing. In 2019, despite the influx of Measure H services, the homeless population in Los Angeles County (as measured by the Greater Los Angeles Homeless Count) grew by 12%.[4] Homelessness prevention programs aim to assist at-risk individuals and families maintain housing stability and reduce the inflows into the homeless services system. Universal prevention addresses social conditions that produce homelessness (*e.g.*, strengthening social safety net programs for all individuals and families, limiting rent increases). Targeted prevention addresses people at special risk (*e.g.*, housing subsidies for people who are determined to be at high risk of homelessness). Targeted prevention programs should be:

- effective (help people to find and maintain stable housing), and
- efficient (allocate assistance to people most likely to benefit).[5]

In Los Angeles County, the Los Angeles Homeless Services Authority (LAHSA) contracts with homeless service providers to deliver prevention services to families, single adults, and transition-age youth who are imminently at-risk of becoming homeless. The Department of Public Social Services also delivers prevention programs to families, but this evaluation only covers Measure H-funded and LAHSA-contracted Strategies A1 and A5 prevention services. (The history of Strategies A1 and A5 is detailed in the following section.)

This evaluation answers three primary research questions:

- Who is being served by Strategies A1 and A5 and what is their housing status after exit?
- How could Strategies A1 and A5 be improved and how could scarce prevention funding be most efficiently prioritized?
- Does prevention funded through Strategies A1 and A5 directly cause a reduction in inflows to homelessness?

[4] LAHSA, "Greater Los Angeles Homeless Count Shows 12% Rise in Homelessness." (June 4, 2019), at https://www.lahsa.org/news?article=558-greater-los-angeles-homeless-count-shows-12-rise-in-homelessness.

[5] Shinn, M. & Cohen, R. (Jan. 2019). "Homelessness Prevention: A Review of the Literature." Center for Evidence-Based Solutions to Homelessness. Retrieved from http://www.evidenceonhomelessness.com/wp-content/uploads/2019/02/Homelessness_Prevention_Literature_Synthesis.pdf.

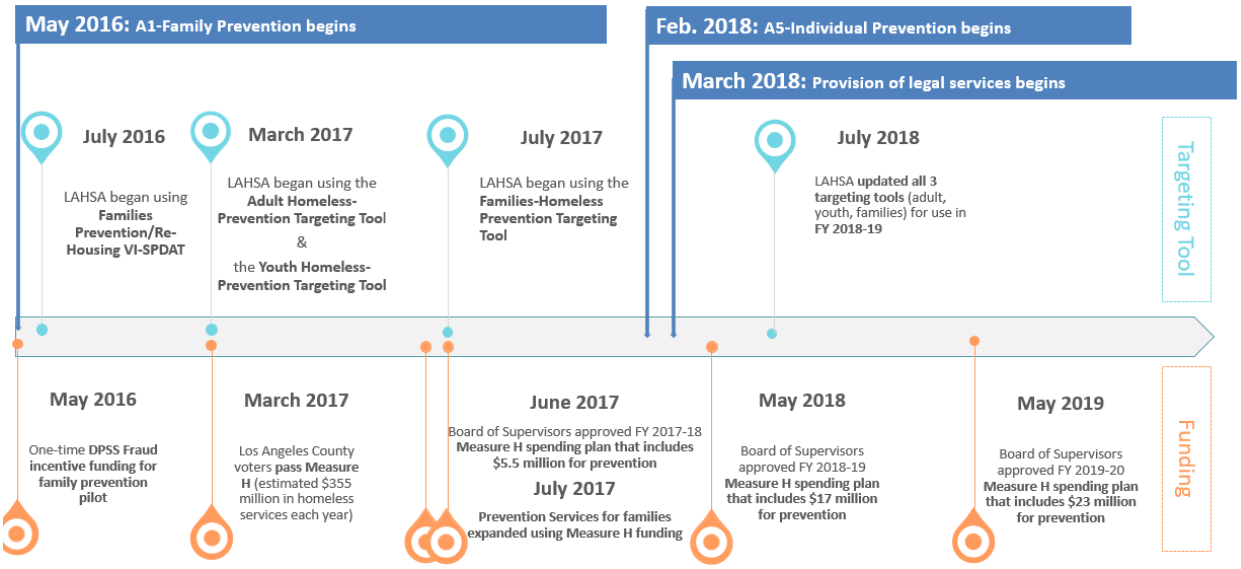
History of A1 and A5 Prevention in Los Angeles County

The Los Angeles County Board of Supervisors ("the Board") launched the Homeless Initiative on August 17, 2015 to combat the homeless crisis in the County. The initial objective of the Homeless Initiative was to develop and present recommended strategies to address the homelessness crisis to the Board. To develop these strategies, the Homeless Initiative conducted 18 policy summits from October 1 to December 3, 2015, convening 25 County departments, 30 cities and other public agencies, and over 100 community partners and stakeholders.[6] Several of the Homeless Initiative's recommended strategies relate to homelessness prevention including: Strategy A1, which addresses homeless prevention programs for families, and Strategy A5, which addresses homeless prevention programs for individuals. The history of A1 and A5 prevention strategies is depicted in Figure 1.1. below. Homeless prevention for families began in May 2016 as a pilot, using one-time DPSS Fraud incentive funding. In response to the growing homelessness crisis, voters in Los Angeles County passed Measure H in March 2017, agreeing to increase their taxes to add an estimated $355 million in homeless services each year.[7] In June 2017, the Board of Supervisors approved a Fiscal Year 2017-18 Measure H spending plan that includes $5.5 million for prevention, and in July 2017, prevention services for families expanded using Measure H funding. In February 2018, A5 prevention for individuals began, and in March 2018, individuals and families enrolled in prevention began receiving legal services (*e.g.*, eviction defense). The Board approved spending plans for Fiscal Years 2018-19 and 2019-20 that included $17 million and $23 million for prevention, respectively.

[6] Los Angeles County Homeless Initiative, "Approved Strategies to Combat Homelessness." (Feb. 2016), at http://homeless.lacounty.gov/wp-content/uploads/2018/07/HI-Report-Approved2.pdf.

[7] Los Angeles County, "The Homeless Initiative," at http://homeless.laCounty.gov/.

Figure 1.1 Los Angeles County Homelessness Prevention Timeline



In order to implement prevention under Strategies A1 and A5, LAHSA contracts with homeless service providers to deliver short-term assistance to low-income individuals and families who are imminently at-risk of homelessness. Common forms of prevention assistance are short-term financial assistance, housing-conflict resolution and mediation with landlords and/or property managers, housing stabilization planning, legal assistance, and/or planning for exit from the program.[8] As a short-term intervention, prevention services are typically provided for up to six months. In addition, providers use a "progressive assistance approach," providing only as much assistance "as is needed to be successful."[9] The goal of prevention is to secure permanent housing placement through assisted self-resolution of the housing crisis (the participant remains in their current housing or relocates, if needed).

Prevention – Eligibility

Eligibility for prevention services depends on (1) homeless status, (2) income requirements, and (3) targeting tool score, as detailed below.

Homeless Status

In order to qualify for prevention assistance, individuals and families must be determined to be at imminent risk of homelessness or fleeing domestic violence.[10] According to HUD's Final Rule on Defining Homeless, an individual or family who will

[8] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 11.
[9] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 44.
[10] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 24.

imminently lose their primary nighttime residence is imminently at-risk of homelessness provided that:

i. Residence will be lost within **14 days** of the date of application for homeless assistance;
ii. No subsequent residence has been identified; and
iii. The individual or family lacks the resources or support networks needed to obtain other permanent housing.[11]

Notably, Los Angeles County adopted a 30-day window for determining imminence, and thus individuals and families who receive a 30-day notice potentially meet the "imminently at-risk of homelessness" requirement.

Income Requirement

Participants must be determined to be income eligible by meeting an income threshold at or below 50% of the Area Median Income (AMI) for Los Angeles County. If a participant is in subsidized housing *and* currently or formerly under a homeless housing assistance program (*i.e.*, Homeless Section 8), they can qualify with income up to 80% of the AMI.[12]

Targeting Tools

LAHSA uses three targeting tools – specific to families, adult individuals, and transition-age youth - to determine eligibility for prevention services. Abt Associates oversaw the targeting tool development process, which included a review of research on risk factors for homelessness and solicitation of feedback from lived experience groups (*e.g.*, Lived Experienced Advisory Group and the Homeless Youth Forum of Los Angeles) and from LAHSA operations committees (*e.g.*, CES Operations Team and the Youth Leadership Team). As detailed in Figure 1.1 above, these targeting tools have gone through revisions, and the current tools were most recently updated in July 2018. The three general categories of questions included in these tools are:

1. Housing status and imminent loss of housing:

[11] Department of Housing and Urban Development (HUD), "Homeless Definition." Retrieved from https://files.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf; 24 C.F.R. Parts 91, 582, and 583. Retrieved from https://files.hudexchange.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf. The traditional HUD definition included a period of 7 days before loss of housing, but HUD adopted a 14-day window in 2011. Congressional Research Services, "The HUD Homeless Assistance Grants: Programs Authorized by the HEARTH Act," (Aug. 30, 2017). Retrieved from https://fas.org/sgp/crs/misc/RL33764.pdf; National Alliance to End Homelessness, "Changes in the HUD Definition of 'Homeless.'" Retrieved from https://www.ncceh.org/media/files/article/NAEH_Definition_of_Homelessness_Analysis.pdf.

[12] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at paras. 24-25.

- Loss of housing means the household will experience literal homelessness – either on the streets or staying in an emergency shelter.
- Imminent loss of current housing must be verified with a "pay or vacate" notice from a landlord or property manager, lease holder, or motel/hotel; ledger record of past due rent; or court paperwork showing the prospective participant is at-risk of losing housing.

2. Vulnerabilities and housing barriers:
    - Gross income
    - Significant loss in income in past 60 days
    - Eviction history
    - Required to register as a sex offender
    - History of literal homelessness
    - Adversity or housing disruptions during childhood
    - Currently involved in child protective services
    - Trauma or event such as death of a family member, separation, divorce, birth of child
    - Recently discharged from an institution
3. Local policy priorities:
    - Individuals who were housed through homeless housing assistance programs
    - History of involvement in the foster care or criminal justice system
    - Disability
    - 55+ years old
    - Residing in permanent supportive housing or living in a unit using a Housing Choice Voucher or under rent control

As detailed in the timeline above (Figure 1.1), LAHSA began using the Families Prevention/Re-Housing Vulnerability Index - Service Prioritization Decision Assistance Tool in July 2016 and the Families-Homeless Prevention Targeting Tool in July 2017. LAHSA began using the Adult Homeless-Prevention Targeting Tool and the Youth Homeless-Prevention Targeting Tool in July 2018. Each question on the targeting tools is assigned a different point value. Families must score 21 out of 42 points to access prevention. Adult individuals must score 19 out of 50 points to access prevention. Youth individuals must score 19 out of 65 possible points to access prevention.[13]

Individuals and families scoring below the thresholds for their population-specific targeting tool are eligible for "Light Touch" services.[14] Light Touch services include "warm handoff" referrals and linkage to other services in another program.[15] (A "warm handoff" means that rather than just providing an individual or family with a name and phone

[13] LAHSA, PowerPoint Presentation: Homeless Prevention Targeting Tools (Mar. 6, 2019).
[14] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 27.4.
[15] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 27.4.

number for another program, the service provider will contact the other program in the presence of the individual or family.)

Prevention Services: Case Management, Direct Services, and Financial Assistance

Prevention consists of a combination of direct services and limited financial assistance (if needed) that case managers typically provide to participants for up to six months.[16] (LAHSA occasionally grants service extension exceptions that allow participants to be assisted through prevention for longer than 6 months.) This assistance is further detailed below.

Case Management and Housing Stabilization Services

Prevention staff provide housing stabilization services to participants in order to promote long-term housing stability. Participants receive housing stabilization services both prior to and after permanent housing is secured. Prevention staff make home visits and have monthly face-to-face meetings with participants in order to create a housing stabilization plan. Housing stabilization services often include assistance in paying rent. This includes budgeting assistance, as well as connections to public benefits, employment programs, free and low-cost goods and services, and other community resources to maximize participants' ability to pay rent. Case managers might also assist participants with lease compliance. For example, case managers might review lease language with clients to promote lease compliance or practice conflict resolution and de-escalation with clients. A participant's preferences and "the degree of engagement between a participant and their case manager" will determine the services, timing, and sequence of referrals.[17]

Housing Identification

On a community level, LAHSA-contracted prevention providers are required to identify housing resources and develop relationships with property owners, landlords, and management companies in their regions to increase availability of permanent housing for prevention participants. Providers conduct unit site visits, catalogue available and appropriate housing units, and review and negotiate leases with landlords.[18]

On an individual level, prevention providers assist participants whose housing cannot be preserved in the housing search and placement process. Along with identifying housing appropriate to the needs, financial constraints, and preferences of participants, prevention providers assist participants in meetings with landlords. Preparation for meetings with landlords includes assistance in understanding the requirements of a lease,

[16] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 28.
[17] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 32.
[18] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 36.

the lease up process, and what is expected of tenants. Prevention providers may also provide financial assistance for application fees and transportation assistance for appointments. When appropriate, prevention providers identify shared housing opportunities for participants, including matching program enrollees as roommates.[19]

Prevention providers support their landlord partners by working collaboratively to address participant lease violations, ensuring that participants pay rent on time, and providing dispute resolution for the landlord and participant.[20]

Rent and Move-in Assistance

Prevention participants may receive direct financial assistance - move-in assistance and/or monthly rental assistance - to help them maintain their housing while working to increase their income. Providers use a "progressive assistance" approach (providing only as much assistance "as is needed to be successful") and ensure that participants are reasonably able to maintain housing once the temporary rental assistance ends.[21] All financial assistance, including rental assistance,

- is subject to the limits described in the Scope of Required Services documents provided to prevention contractors (*e.g.*, rental assistance is limited to six months per twelve-month period and total rental assistance includes the first and last month's rent);
- must never be provided directly to any program participant, but rather must be paid directly to the landlord or other appropriate party;
- must have a signed request from the housing navigation staff and a supervisor/manager within the program; and
- must be provided pursuant to a provider's policies and procedures for how financial assistance is determined, requested, and verified.[22]

Other Financial Assistance

Prevention participants may also receive other financial assistance such as legal fees and moving costs.[23] Eligible categories of financial assistance are detailed in Table 1.1.

Legal Services

As noted above, in March 2018, individuals and families enrolled in prevention began receiving legal services (*e.g.*, eviction defense) from legal service providers. LAHSA contracted with Inner City Law Center, who in turn subcontracted with other legal service

[19] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 36.
[20] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 36.
[21] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 37.
[22] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 15-17.
[23] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 15-17.

providers, to deliver legal services to prevention participants. Each Service Provider Area (SPA) is assigned one or more legal service providers:

- SPA 1 – Neighborhood Legal Services of Los Angeles County/Bet Tzedek
- SPA 2 – Neighborhood Legal Services of Los Angeles County/Bet Tzedek
- SPA 3 – Neighborhood Legal Services of Los Angeles County/Bet Tzedek
- SPA 4 – Inner City Law Center
- SPA 5 – Bet Tzedek
- SPA 6 – Public Counsel
- SPA 7 – Legal Aid Foundation of Los Angeles/Bet Tzedek
- SPA 8 – Legal Aid Foundation of Los Angeles/Inner City Law Center

Legal service providers develop individualized legal services plans for participants to help them obtain and/or preserve housing. Categories of legal services may include:

- Eviction prevention
- Birth certificate advocacy
- Landlord/tenant dispute resolution
- Government benefits
- Reasonable accommodations
- Minor immigration issues
- Dealing with financial debt
- Subsidized housing access
- Professional licenses and identification[24]

The California Policy Lab spoke with Supervising Attorneys from four of the five prevention legal service providers. These attorneys discussed the referral and legal service provision process and their relationships with prevention service providers:

Legal Service Referrals and Intake: Prevention clients are referred to legal service providers by the lead prevention service providers in each SPA ("SPA lead"). A case manager at the SPA lead fills out legal service referral forms and sends them to the SPA's designated prevention legal service provider via email. Referral forms typically include check boxes to indicate the broad category or categories of legal issue(s) that a client faces. For example, there is a check box for "eviction." Referral forms also typically include a brief (approximately three sentence) narrative about the legal issue.

After receiving the referral forms, the legal service provider then schedules an appointment with the client. The referral forms provide some indication of a client's legal needs, but attorneys report that they often identify additional legal needs when they meet with the client for the first time. For example, when a SPA lead refers a client to a legal service provider, the SPA lead typically identifies an urgent need such as a pending

[24] Legal Aid Foundation of Los Angeles, (Jun. 27, 2018), Presentation: Measure H Legal Services. Retrieved from https://www.sbceh.org/uploads/4/5/0/7/45075441/6-27-18_lafla_presentation.pdf.

unlawful detainer or a lease termination notice. During the legal service provider's first meeting with the client, they uncover additional legal needs such as unpaid traffic tickets, unlawful withholding of wages, unlawful denial of employment because of a criminal background, license suspensions that prevent a client from traveling to work, and denial of social security or other entitlements.

Some legal service organizations have a co-location relationship with service providers. In other words, an attorney from the legal service organization will work out of a SPA lead's office one or more times a week, or a representative from a SPA lead will periodically work out of the legal service organization's office. Attorneys report that co-location increases referrals and strengthens the relationship between legal service providers and SPA leads.

Prevention Legal Services: The most common types of cases that legal service providers handle for prevention clients are unlawful detainers and evictions (*i.e.*, clients receive a notice to vacate or demand letter). However, legal service providers also assist clients with other issues, including credit issues and driver's license suspension. One attorney noted that although credit issues and driver's license suspensions may not appear to be directly related to homelessness prevention, addressing credit issues can improve chances of finding new housing and helping someone maintain their driver's license can allow them to keep their job. In general, legal service providers do not provide assistance with family law (aside from domestic violence restraining orders), general criminal law (aside from criminal citation expungement), or personal injury lawsuits. However, if a client does raise these issues, legal service providers are able to provide them with referrals to other organizations that can assist the client with these issues.

While service providers typically work with Measure H prevention participants for up to six months, legal service providers work with clients until their cases are resolved. Attorneys report that there is a lot of variation in the duration of their relationships with clients. Some clients have one legal issue and others have multiple legal issues. Some clients need one-time advice via telephone, others require multiple in-person meetings and representation at court hearings.

Table 1.1. Prevention Assistance

What	When	Why	How
Case Management & Housing Stability Planning	During housing crisis; Prior to and after securing permanent housing	Promote long-term housing stability	• Budgeting • Utilizing public assistance benefits and/or employment programs • Accessing free or low-cost goods/services • Assistance with budgeting and/or money management • Assistance with lease compliance, care of the unit, and conflict with other tenants or the landlord
Housing Identification	If current housing cannot be preserved	Identify opportunities for permanent housing	• Developing relationships with landlords to increase permanent housing opportunities for participants • Identifying units, cataloging unit specifications, reviewing and negotiating leases, conducting unit site visits • Assisting participants in locating appropriate housing that meets their needs and expressed desires • Preparing the participants to understand lease requirements, lease up process, and tenancy expectations • Transportation assistance for appointments • Financial assistance with necessary application fees (see Financial Assistance below) • Ensuring that the rent for the unit is reasonably in reach • Supporting landlord partners (*e.g.*, work with landlords to address participant lease violations; ensure rent paid on time; dispute mediation)
Rent & move-in assistance	During prevention enrollment, generally	Provide assistance needed to identify and/or maintaining stable housing	• Financial assistance – move-in and monthly rent (see Financial Assistance below) • Budgeting support for housing expenses
Financial Assistance	During prevention enrollment, generally	Provide assistance needed to identify and/or maintaining stable housing	• Security Deposit • Rental Assistance • Rental Arrears • Utility Deposit • Utility Assistance • Utility Arrears • Legal Fees • Move-In Expenses (application fee, broker fee, essential furnishing) • Landlord Incentive Fee (up to one month's rent) • Moving Costs • General Housing Assistance (document fees, vocational training and other employment assistance, transportation) • Transportation • Reunification Services
Legal Assistance	Until legal issues are resolved	Prevent homelessness, remove barriers to housing	• Individualized legal services plan that can include assistance with eviction proceedings, expungement of criminal records, birth certificate advocacy, landlord/tenant dispute resolution, government benefits, reasonable accommodations, minor immigration issues, dealing with financial debt, subsidized housing access, and professional licenses and identification.

Diversion/Problem-Solving[25]

"Problem-solving" (also known as diversion or rapid resolution) is an intervention that is related to but distinct from prevention. While it is not the focus of this evaluation, the target population and eligibility criteria for problem-solving are very similar. These similarities have caused some confusion among service providers. As a result, it is worth briefly discussing how problem-solving is intended to work.

Before administering the Prevention Targeting Tool or any other assessment, service providers attempt problem-solving with individuals and families who present with a housing crisis. The goal of problem-solving is to stabilize a participant's current (or new) housing arrangement (either where the participant is currently located, or an alternate, safe and stable housing arrangement) and remove the immediate need for additional homeless services including emergency shelter, rapid re-housing, or transitional housing.[26]

As part of problem-solving, service providers engage individuals and families in one or more deliberate, individualized conversations intended to solve their immediate or near-term housing crisis. During the problem-solving conversation, staff use guided conversation to help individuals and families identify connections within their own networks and outside the homeless system that can assist them in stabilizing their housing situation. For example, an individual who is being evicted might have a relative who could provide them with housing. The problem-solving conversation does not rely on a checklist or form and is the first step in a phased-assessment approach.

Under traditional homeless services approaches, the first meeting with an individual or family seeking assistance would route the family to one or more programs in the community (shelter, transitional housing, rapid re-housing, permanent supportive housing, *etc*.) based on their eligibility for the programs. Problem-solving is "a person-centered approach that trusts that with some help, people may be able to identify resources to help them resolve their housing crisis within their own networks."[27] Common problem-solving activities are active listening, coaching, motivational interviewing, mediation and conflict resolution with families/friends and/or landlords, connection to mainstream resources, housing search assistance, housing stabilization planning, family reunification, *etc*.[28] Problem-solving services are provided for up to 30 days and include a combination of direct services and limited financial assistance (if needed).[29] Appendix A contains details about (1) eligibility for problem-solving and (2) case management and supportive services offered to problem-solving clients.

[25] LAHSA, 2018-2019 Problem-Solving Scope of Required Services.
[26] LAHSA, (Oct. 23, 2017). "CES for Families Operations Manual 2017-2018, version 2.0."
[27] LAHSA, 2018-2019 Problem-Solving Scope of Required Services.
[28] LAHSA, 2018-2019 Problem-Solving Scope of Required Services.
[29] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 11.

Prevention and Problem-Solving

Although problem-solving and prevention are theoretically distinct programs, there are similarities in some of the eligibility requirements. For example, individuals and families under either program can be at imminent risk of homelessness or fleeing domestic violence. In addition, there is overlap in the assistance offered under problem-solving and prevention. Under either program, participants can receive case management, conflict resolution, and referrals to other community resources, as well financial assistance in the form of security deposits, transportation assistance, and utility payments. In addition, until the 2018-2019 timeframe, service providers enrolled both problem-solving clients and diversion clients under the same "Homelessness Prevention" project type in the Homeless Management Information System (HMIS). Table 1.2 below compares problem-solving and prevention with respect to goals, service length, HMIS enrollment, eligibility, and potential services.

Table 1.2. Diversion and Prevention Comparison

	Non-Financial Diversion	Financial Diversion	Prevention	Light Touch
Goals	**Stabilizing current (or new) housing arrangement** (either where the participant is currently located, or an alternate, safe and stable housing arrangement); remove immediate need for additional homeless services including emergency shelter, rapid re-housing or transitional housing		**Securing permanent housing** through assisted self-resolution of housing crisis; participant remains in current housing or, if needed, re-location and assistance moving into a new unit	
Service Length	Up to 30 days		Up to 6 months	1 day
HMIS Enrollment Required?	Yes*	Yes	Yes	Yes
Income	(At or below) 50% AMI**		50% AMI**	50% AMI**
Households	All households (TAY, Single Adults, Families)		All households	All households
Status	Literally homeless, imminently at-risk, fleeing DV		Imminently at-risk, fleeing DV	Imminently at-risk
PTT Score	No score required		19+ (21+ for families)	0-18 (0-20 for families)
Possible Services	Coaching/problem solving, mediation and conflict resolution, connection to other resources, housing search/stabilization assistance	Security deposit, documents/employment/transit costs related to housing, utility assistance, and reunification, in addition to non-financial diversion services	Security deposit, rental assistance/arrears, utility deposit/assistance/arrears, legal fees, move in expenses, documents/employment/transit costs related to housing, and reunification	Referral and linkage to other services in another program with the CES area

*In 2019, LAHSA instructed providers to enroll non-financial diversion clients in HMIS. Prior to that, HMIS enrollment was not required for non-financial diversion. However, some service providers were enrolling non-financial diversion clients in HMIS even prior to 2019.

**If a participant is in subsidized housing AND received homeless housing assistance, they can qualify with income at or up to 80% AMI.

According to LAHSA's 2018-2019 Prevention & Diversion Scope of Required Services, prevention and diversion (now called problem-solving) often work together as a continuum or "progressive assistance approach" to assist an individual or family in a housing crisis. As noted above, before using the Prevention Targeting Tool to determine an individual or family's eligibility for prevention, a service provider must engage the individual or family in a diversion conversation.[30] If the diversion conversation is unsuccessful, then the Prevention Targeting Tool should be administered to determine whether the participant is eligible for prevention services.[31]

Figure 1.2 below illustrates the prevention and problem-solving process flow from entry to exit. The Centralized Referral System - a collaboration between LAHSA and the Los Angeles County Departments of Health Services, Mental Health, and Public Health - facilitates referrals to an appropriate diversion or prevention provider.[32] Referrals are also made through the Coordinated Entry System, a network of service providers seeking to assist people experiencing homelessness or at-risk of becoming homeless. The Coordinated Entry System has multiple access points throughout the County: 211, City & County Offices, and other partners. Once an individual or family is referred to a prevention/problem-solving provider, the provider goes through a standardized intake process.[33] Before completing a Prevention Targeting Tool, the prevention/problem-solving provider should first attempt diversion services.[34] If the individual or family is a good candidate for diversion, then the provider delivers the appropriate diversion assistance. If the individual or family is not a good candidate for problem-solving, then the service providers administers the population-appropriate Prevention Targeting Tool. Individuals and families who meet the income requirements, homeless status requirements, and Prevention Targeting Tool score cutoff detailed above receive prevention assistance. Those who score below the score cutoff receive "light touch."

Providers exit participants from prevention:

- when the participant has completed the primary housing stability goals outlined in their housing stability plan,
- if the participant is unable to resolve instability within six months,
- when the participant relocates to another Continuum of Care,
- if the participant utilizes reunification services or self-resolves their housing crisis,
- if the participant is deemed a risk to the safety of the provider's staff, or

[30] LAHSA, (Dec. 20, 2018). "Memo to LAHSA Funded Diversion Providers, re: Updates to 2018-2019 Scope of Required Services (SRS)."

[31] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 26.2.

[32] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 4.

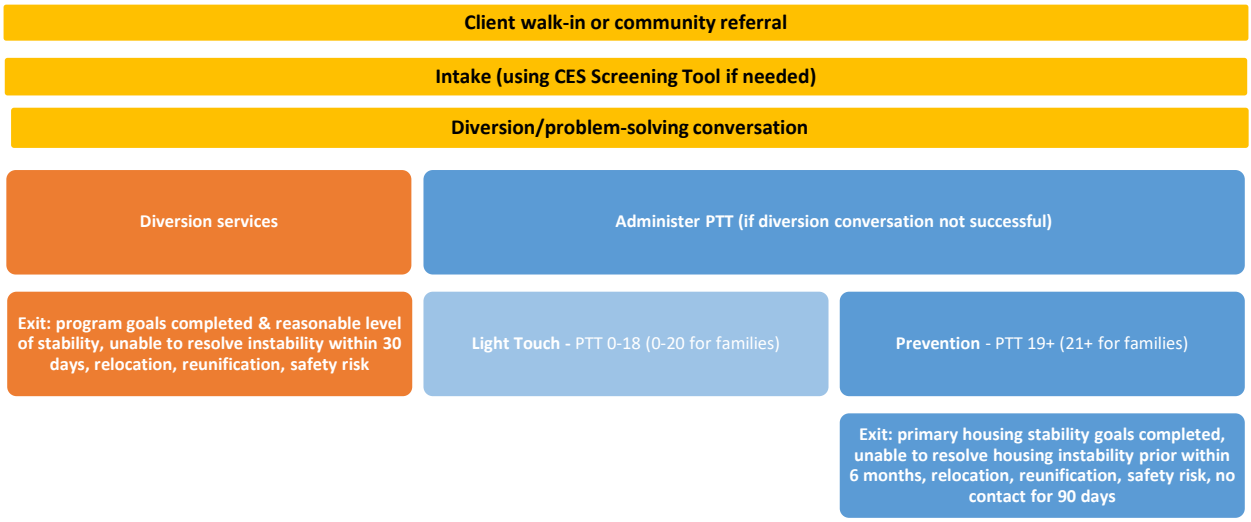
[33] LAHSA, (Oct. 23, 2017). "CES for Families Operations Manual 2017-2018, version 2.0."

[34] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 26.

- if the participant has failed to be in contact for ninety (90) days or more after all due diligence to re-engage with the participant has been taken by the provider.[35]

Participants who lose current housing while enrolled in a prevention program should remain enrolled in prevention, continue to receive prevention services until they are re-housed, and be referred to crisis housing for emergency shelter.[36]

Figure 1.2. Problem-solving and prevention process flow from entry to exit



Prior Studies on Homelessness Prevention Programs

Recent studies in Chicago and New York demonstrate the effectiveness of homelessness prevention programs in those cities, but the studies also highlight the need to ensure that prevention programs are efficient, *i.e.*, target the highest risk families. A prevention program in Chicago provided one-time cash assistance to families who called a hotline and self-identified as being at-risk of homelessness. Callers who were experiencing an eligible crisis received one-time financial assistance up to $1,500. An evaluation of the program found that in the six months following the call, one-time financial assistance reduced shelter entry by 76% for program recipients compared to a comparable control group who were eligible but happened to call on a day when funds were not available. While the program succeeded at reducing shelter entry, homelessness remained a rare outcome among both individuals who received cash assistance (treatment group) and individuals who did not receive cash assistance (control group). 99.5% of the individuals in the treatment group never entered shelter, but 98% of the control group also never

[35] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 4.

[36] LAHSA, (Dec. 17, 2018). "Memo to LAHSA-Funded Prevention Providers, re: Prevention Services if Participant-Household Loses Current Housing from LAHSA."

entered a shelter despite the fact that they were eligible for, but did not receive, financial assistance. While this finding demonstrates that the vast majority of eligible callers were able to resolve their housing crisis by themselves, the prevention program was still cost-effective because cost savings to the shelter system exceeded the cost of running the program. However, study authors noted that the program would be more efficient and cost beneficial if it were more effectively targeted to higher-risk callers.[37]

The Homebase prevention program in New York City offers a variety of homelessness prevention services in community-based settings, including cash assistance, benefits counseling, case management, legal assistance, job placement, and other services. Shinn *et al*. (2013) developed and evaluated a screening model for families in New York City who applied to the Homebase program. This model used demographic, employment, education, housing, disability, criminal justice history, domestic violence history data and other administrative data to predict risk of shelter entry for individuals who applied to Homebase. An evaluation of Homebase found that during a 27-month follow-up period, Homebase reduced the average length of shelter stays by an estimated 22.6 nights when compared to a control group. The average number of nights in a shelter for all Homebase participants (including those with no nights in a shelter) was 9.6 nights and the average number of nights in a shelter for all individuals in the control group (including those with no nights in a shelter) was 32.2 nights. In addition, Homebase reduced the percentage of families who spent at least one night in a shelter from 14.5% to 8.0%.[38] Like the Chicago prevention program, the Homebase program was cost-effective even though it had relatively modest effects. The evaluators of Homebase did, however, conclude that the program would have been even more effective had it been more efficiently targeted. Shinn *et al*. compared the families that the model identified as being at the greatest risk of homelessness with the families that Homebase program staff judged to be eligible for the program. As compared to program staff judgment, the Shinn *et al*. model had substantially higher precision (*i.e.*, correctly predicting shelter entry) at the same level of false alarms (*i.e.*, family that did not enter shelters in the absence of prevention services).[39] Greer *et al*. created a similar model to target individuals for Homebase. Greer *et al*. found that their

[37] Evans, W. N., Sullivan, J. X., & Wallskog, M. (2016). The impact of homelessness prevention programs on homelessness. *Science*, *353*(6300), 694-699. Retrieved from https://science.sciencemag.org/content/353/6300/694/tab-pdf.

[38] Rolston, H., Geyer, J., Locke, G., Metraux, S., & Treglia, D. (2013). Evaluation of Homebase community prevention program. *Final Report, Abt Associates Inc, June*, *6*, 2013. Retrieved from https://www.abtassociates.com/sites/default/files/migrated_files/cf819ade-6613-4664-9ac1-2344225c24d7.pdf.

[39] Shinn, M., Greer, A. L., Bainbridge, J., Kwon, J., & Zuiderveen, S. (2013). Efficient targeting of homelessness prevention services for families. *American journal of public health*, 103(S2), S324-S330. Retrieved from https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2013.301468.

model increased correct predictions by 77% (the model correctly predicted over 90% of shelter entry) and reduced missed cases of future homelessness by 85%.[40]

[40] Greer, A. L., Shinn, M., Kwon, J., & Zuiderveen, S. (2016). Targeting services to individuals most likely to enter shelter: Evaluating the efficiency of homelessness prevention. *Social Service Review*, 90(1), 130-155. Retrieved from https://www.journals.uchicago.edu/doi/abs/10.1086/686466.

2. Study Overview

This evaluation covers Measure H-funded LAHSA prevention programs (A1 and A5) for Fiscal Years 2017-18 and 2018-19 (July 1, 2017 to June 30, 2019). The first goal of this evaluation was to describe who is being served by A1 and A5 prevention, how the PTT is being administered, and what prevention participants' housing status is after exit. The second goal of this evaluation was to detail potential ways to improve the prioritization and efficiency of prevention resources. We examined whether individual answers to questions on the PTT were predictive of housing outcomes. We also explored whether re-weighting the PTT will improve its ability to screen for high-priority prevention clients. In addition, we recommend ways to use the California Policy Lab's existing work on predicting homelessness to target prevention services. The third goal of this evaluation was to determine the causal effect of prevention assistance on housing outcomes. In other words, what *would* have happened to prevention clients if they hadn't been served: Would they have successfully self-resolved or would they have fallen into homelessness? Estimating the causal effect ultimately answers the question of whether prevention services are reducing inflows to homelessness.

Each of these goals corresponds to a research question that guided our analyses. A brief overview of data and methodology used to answer each of these research questions is below. Sections 3, 4, and 5 include more detailed descriptions of the data, methodology, and findings for each research question.

Research Question 1: Who is being served by Strategies A1 and A5 and what is their housing status after exit?

The primary data source used to answer this question was the Homeless Management Information System[41] (HMIS), including service files and PTT data. We also supplemented the analysis with data from the County's Enterprise Linkage Project (ELP), which holds service utilization records from seven County agencies covering health services, benefits payments, law enforcement, and homeless services. We applied descriptive analysis techniques such as grouping, counting, and data visualization to this data to better understand who is being served by Strategies A1 and A5 and what their housing status is after exit. These analyses were not intended to identify causal relationships (*i.e.*, what would have happened in the absence of prevention services), but rather to explore and reveal interesting patterns that could help improve prevention service delivery.

We supplemented this quantitative analysis with semi-structured interviews with prevention service providers. We included information from interviews with 11 service providers, which cover topics such as program administration, eligibility, the PTT, services

[41] HMIS is a web-based application designed to collect information on the characteristics and service needs of recipients of homelessness or homelessness prevention services.

and funding, and defining success. Information gleaned from these interviews provides a fuller picture of who is being served by Strategies A1 and A5.

Research Question 2: How could Strategies A1 and A5 be improved and how could scarce prevention funding be most efficiently prioritized?

Under Research Question 2, we examined whether individual answers to questions on the PTT, the screening tool used to determine eligibility for prevention services, were predictive of housing outcomes. We also explored whether re-weighting questions on the PTT would improve its ability to screen for high-priority prevention clients and whether the PTT could be streamlined by removing questions that are not as effective in identifying clients at highest risk of homelessness.

In an effort separate from but related to this evaluation, the California Policy Lab, in partnership with University of Chicago Urban Labs, has been working with the Los Angeles County Chief Information Office and Homeless Initiative to develop a model for predicting homelessness amongst single adults who utilize County services.[42] Under Research Question 2 of this evaluation, we compare individuals enrolled in A5 prevention with individuals in the ELP data who the County predicts to be at-risk of homelessness. The insights gleaned from this comparison can help the County target prevention resources (both Measure H and non-Measure H) to those at-risk of homelessness who are not currently accessing prevention resources.

Research Question 3: Does prevention funded through Strategies A1 and A5 directly cause a reduction in inflows to homelessness?

Under Research Question 3, we wanted to explore what *would have happened* if individuals and families who were served by A1 and A5 prevention had not received prevention services: Would they have successfully self-resolved their housing crisis or would they have fallen into homelessness? One of the ways that researchers estimate what would have happened to individuals or families if they had not participated in a program is by identifying individuals and families who are very similar to program participants but who did not participate in the program, *i.e.*, "comparison" or "control" individuals and families. By comparing the outcomes of a comparison group with the outcomes of the program participants, researchers can get an idea of what would have happened to program participants if they had not participated in the program. Although we attempted to use ELP and HMIS data to identify comparison group individuals and families, the most important characteristic – imminent risk of losing housing – is not captured in ELP data or HMIS service data. Because we could not identify plausible comparison groups, we could not answer Research Question 3. Nonetheless, we detail our attempts to answer this question and propose options for future impact evaluation in Section 5.

[42] von Wachter, T., Bertrand, M., & Pollack, H. (Sept. 12, 2019) "Predicting and Preventing Homelessness in Los Angeles." California Policy Lab. Retrieved from https://www.capolicylab.org/predicting-preventing-homelessness-la/.

3. Descriptive Analysis: Who is being served by Strategies A1 and A5 and what is their housing status after exit? (Research Question 1)

Key Takeaway: Strategies A1 and A5 have boosted prevention efforts across the County, and providers are practicing prevention in ways consistent with its design. On the other hand, PTT usage is less consistent than expected, and many households appear to receive services that involve little more than case management. Households enrolling in prevention have histories involving both high levels of homelessness and other service usage, suggesting A1 and A5 may have succeeded in serving a high-risk population. After prevention, around 1 in 10 households experiences homelessness, but rates of homelessness are far lower for households that received financial assistance. Almost half of all households who enrolled in prevention move from a doubled-up living situation with family or friends to an unsubsidized rental.

Administrative Data Analysis

Approach and Data

Descriptive analysis uses techniques such as grouping, counting, cross-tabulation, and visualization to explore trends and patterns in data. It sheds light on the mechanisms and inner workings of programs, and, in our case, helps illuminate the "who, what, when, and where" of prevention. Comparing descriptive findings to prevention's model allows us to make inferences about *program fidelity*, or how closely prevention is operating in accordance with its stated theory and design. Though descriptive analysis is often a preamble to causal analysis, it cannot by itself determine causal relationships, and the relationships discussed in this section are best viewed as associative.

Our analysis relies on HMIS data covering prevention enrollments in the Los Angeles Continuum of Care. This data is joined to the Enterprise Linkages Project data for analyses describing prevention clients' service utilization patterns. For the majority of our analyses, we used data covering Fiscal Years 2017-18 and 2018-19, since this period corresponds to the implementation of Strategies A1 and A5. For analyses following the *Historical Prevention Trends* subsection, we filter our data to contain only A1 and A5 prevention enrollments, thus we exclude enrollments tied to other prevention programs like Veterans Affairs Supportive Housing (VASH). Our primary unit of analysis is the household.

Historical Prevention Trends

With the introduction of A1 and A5 programs in Fiscal Year 2017-18, prevention enrollments returned to levels not seen since the beginning of the decade (coinciding with HUD's Homelessness Prevention and Rapid Re-housing Program starting in 2009; see Figure 3.1). 1,038 households were enrolled in A1 and A5 prevention in Fiscal Year 2017-18, constituting 69% of all prevention enrollments recorded in the HMIS. In Fiscal Year 2018-19, A1 and A5 enrollments increased to 1,763 households for 77% of all prevention enrollments. During this same period, we observe steady levels—around 500 per year—of veteran prevention enrollments after the implementation of the Veterans Affairs Supportive Services for Veteran Families (SSVF) program (Figure 3.2).

Figure 3.1

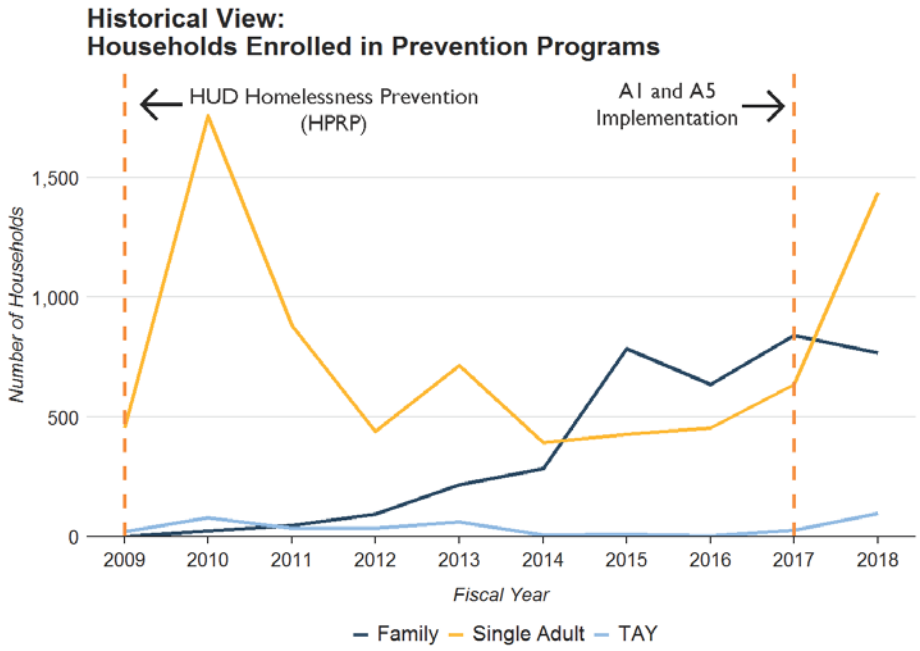
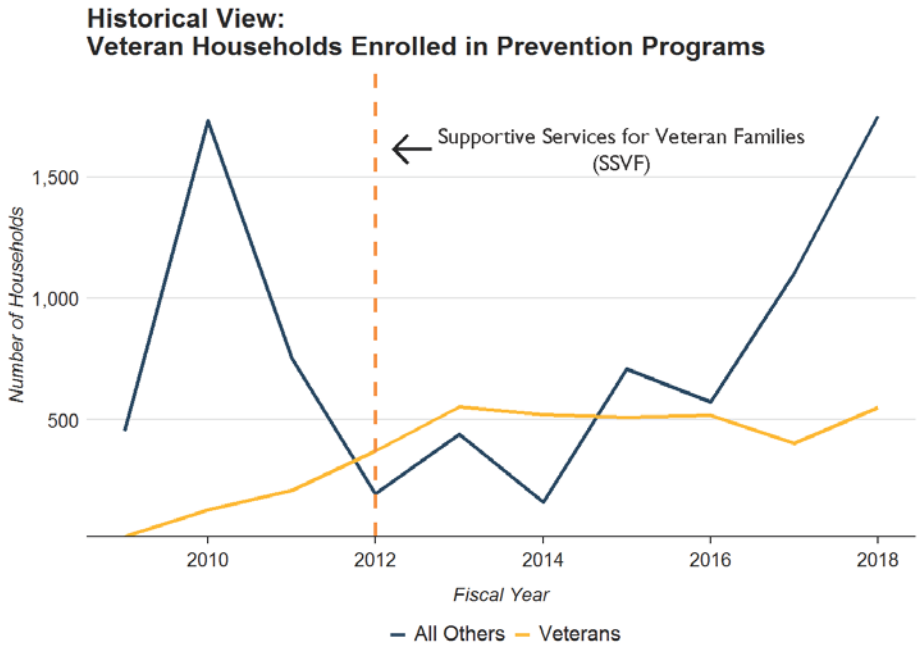


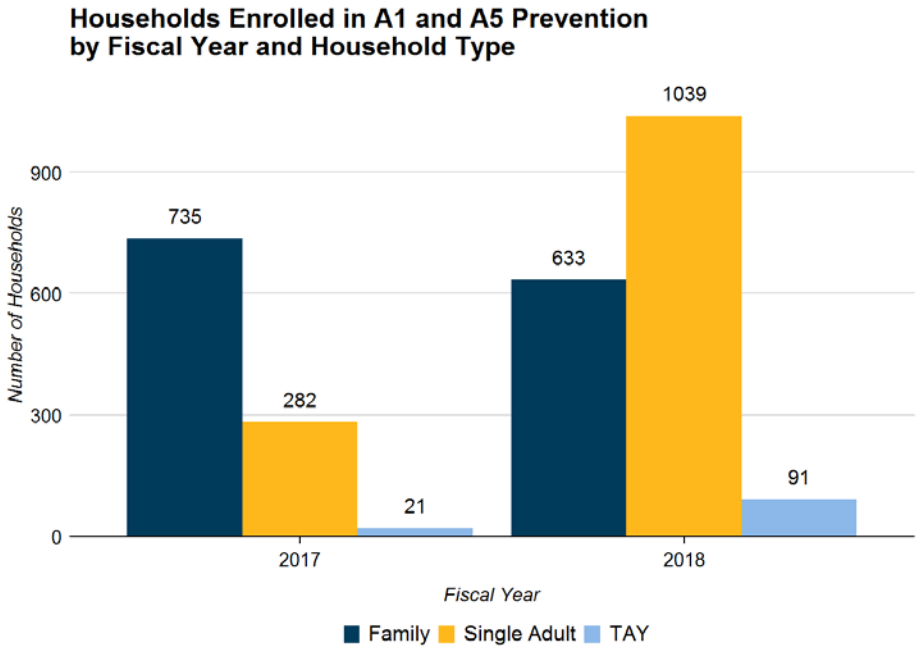
Figure 3.2



A1 and A5 Prevention Trends

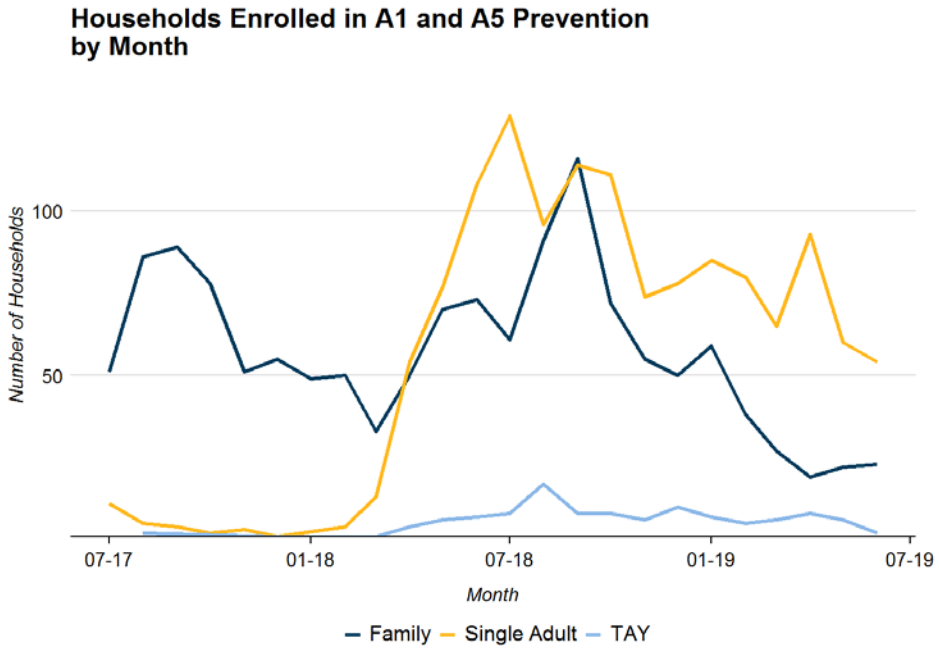
For the remaining analyses, we restricted our data to only A1 and A5 enrollments. 1,321 single adult households, 1,368 family households, and 112 TAY households received prevention during the study period of Fiscal Years 2017-18 and 2018-19. We see a stark increase in single adult enrollments between Fiscal Years 2017-18 and 2018-19, when enrollments rose from 282 households to 1,039 (Figure 3.3). TAY enrollments quadrupled during this time period but remain a small percentage of enrollments (between 2% and 5% per year). Family enrollments decreased slightly. It is important to note that these figures show enrollments of new clients each year and do not show the total prevention caseload as some clients who enrolled in Fiscal Year 2017-18 will remain enrolled in Fiscal Year 2018-19.

Figure 3.3



There's substantial monthly and seasonal variation in enrollments (Figure 3.4). We see enrollments increase sharply around the beginning (July 2018) of Fiscal Year 2018-19 for all household types. This is especially true for single Adult and TAY households, which had very few enrollments until spring of 2018, and this may relate to a later or more gradual implementation of the TAY and single adult programs. Family household enrollments peak in the months just after the beginning of both Fiscal Years (July 2017 and July 2018). On average, there are 57 family, 57 single adult, and 6 TAY enrollments per month.

Figure 3.4



What Happens During Enrollments

Financial assistance—in the form of rental assistance and arrears paid to landlords, utility payments, and other forms of cash assistance—is a major component of prevention services and is designed to help resolve short-term financial difficulties and help clients retain their housing. Financial assistance is rarely if ever paid directly to the client. 1,103 (39%) household enrollments had financial assistance of between $1,001 and $5,000, and 622 (22%) households had financial assistance of over $5,000. However, we observe 735 (26%) households with no record of financial assistance, and another 147 (5%) with financial assistance between $1 and $500 (Figure 3.5).

In analyses that follow, we often distinguish between the 74% of households that received substantial financial assistance ("financially assisted") from those 26% that received small amounts of financial assistance and other services such as case management ("case management only"). These categories reveal interesting differences in enrollment and client characteristics, as well as outcomes.

Examining the service record for prevention enrollments gives a more fine-grained view of the activities that make up an enrollment (Figure 3.6). Case management services are recorded for nearly every enrollment (93%) with any service record. Rental arrears and rental assistance—core tools in prevention's program logic—are recorded in 63% and 52% of enrollments with any service record. We see lower percentages for housing stability plans, referrals, security deposits, and utility payments. Though inconsistent data

entry may lower the percentages for certain service types, the mix of frequent services we observe is consistent with prevention's model.

Figure 3.5

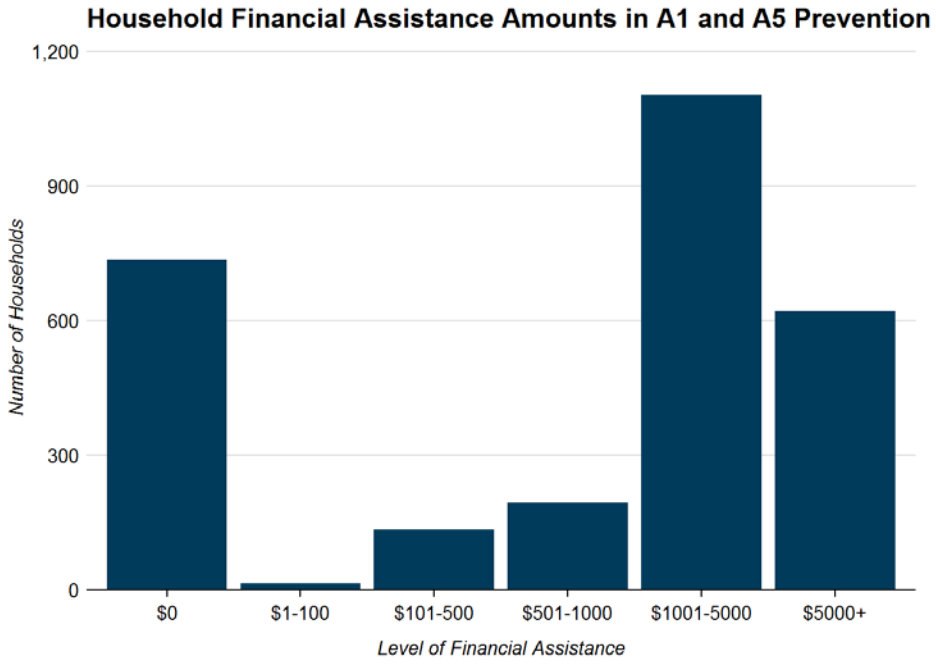
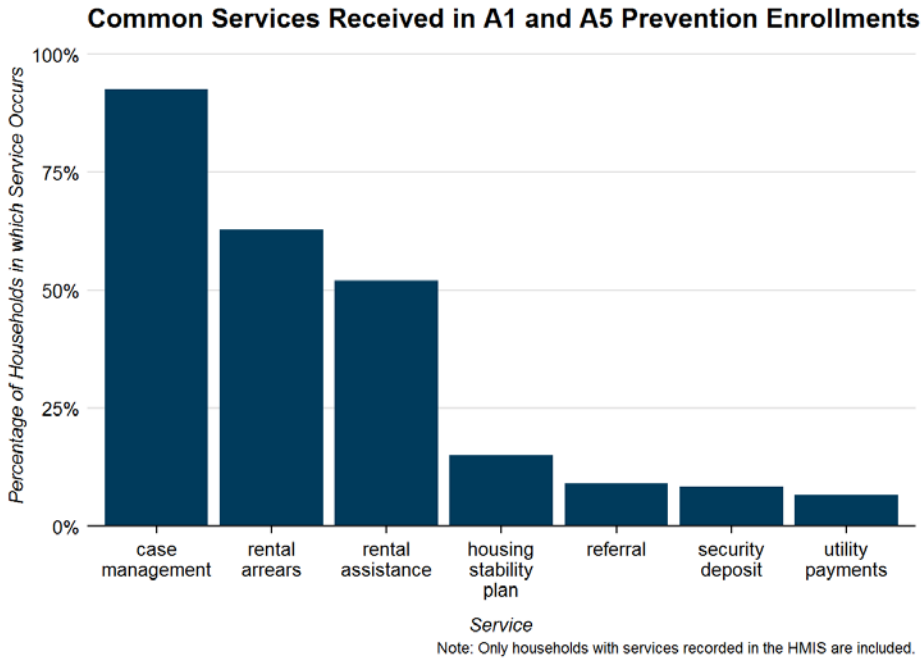


Figure 3.6



Program documentation specifies that prevention enrollments should be under 180 days (6 months). Typical enrollment lengths are in line with this and suggest program fidelity in terms of duration. By any measure, typical enrollments among all households are much shorter than 180 days (Table 3.1). We use three alternative measures of enrollment duration to better understand length and intensity of prevention enrollments. "Enrollment Duration" measures time from project entry to exit. Because client exits are sometimes not entered or entered late, we created "Service Duration," a measure of the time between project entry and the enrollment's last service record. "Financial Assistance Duration" measures the number of months a client receives financial assistance.

Table 3.1

Household Median Enrollment and Service Duration in A1 and A5 Prevention

Median Enrollment Duration (Days)	Median Service Duration (Days)	Median Financial Assistance Duration (Months)
101	91	1

We observe large differences in enrollment duration by household type and financial assistance (Table 3.2). Generally, family enrollments are longer than TAY or single adult enrollments. According to our service duration measure, financially assisted enrollments are consistently longer than those involving case management only.

Table 3.2

Household Median Enrollment and Service Duration in A1 and A5 Prevention by Household Type

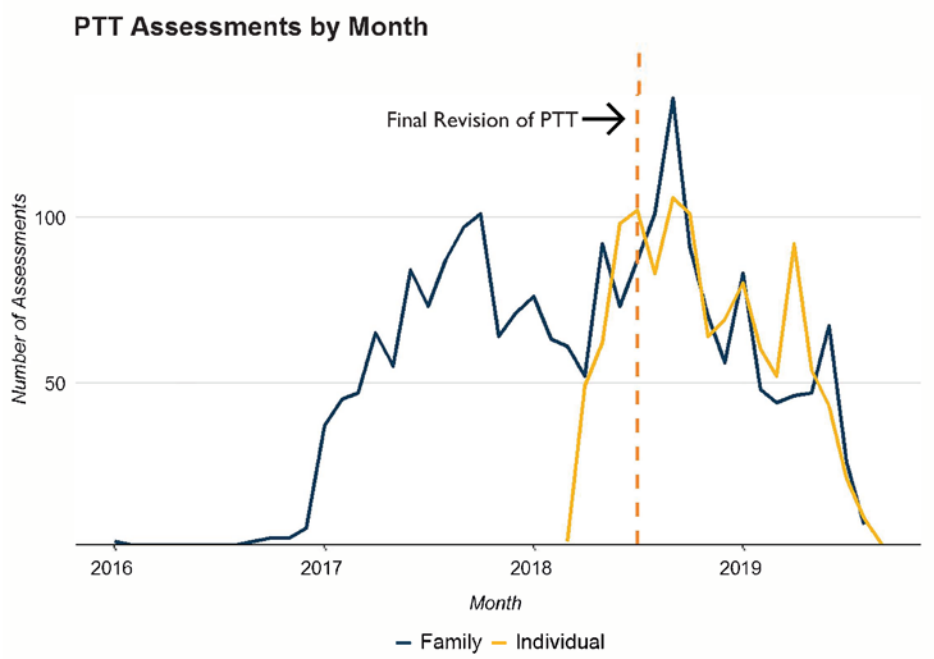
Household Type	Median Enrollment Duration (Days)	Median Service Duration (Days)	Median Financial Assistance Duration (Months)
Case Management Only			
Family	106	90	0
Single Adult	76	50	0
TAY	104	37	0
Financially Assisted			
Family	138	132	3
Single Adult	68	71	3
TAY	88	109	2

Prevention Targeting Tool

The Prevention Targeting Tool (PTT), as described in detail in *Section 1: Introduction and Background*, is a screening tool intended to determine eligibility for prevention. For the purposes of our descriptive analysis, we examined trends in the administration of the PTT, how consistently enrollments involve the usage of the PTT, and whether the PTT threshold appears decisive in determining eligibility.

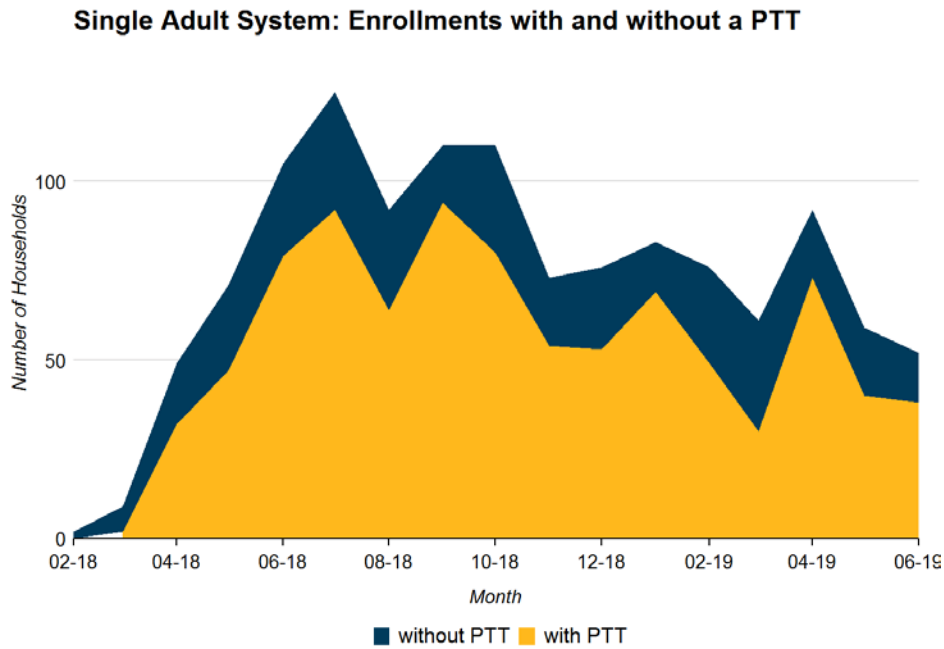
Considering usage of the PTT over time, we see monthly variation in assessment volume, though service providers typically administer between 50 and 100 assessments for families and individuals per month (Figure 3.7). Since the last revision of the instruments in July of 2018, when the instruments took on their current questions and form, providers administer an average of 65 family assessments and 63 individual assessments per month.

Figure 3.7



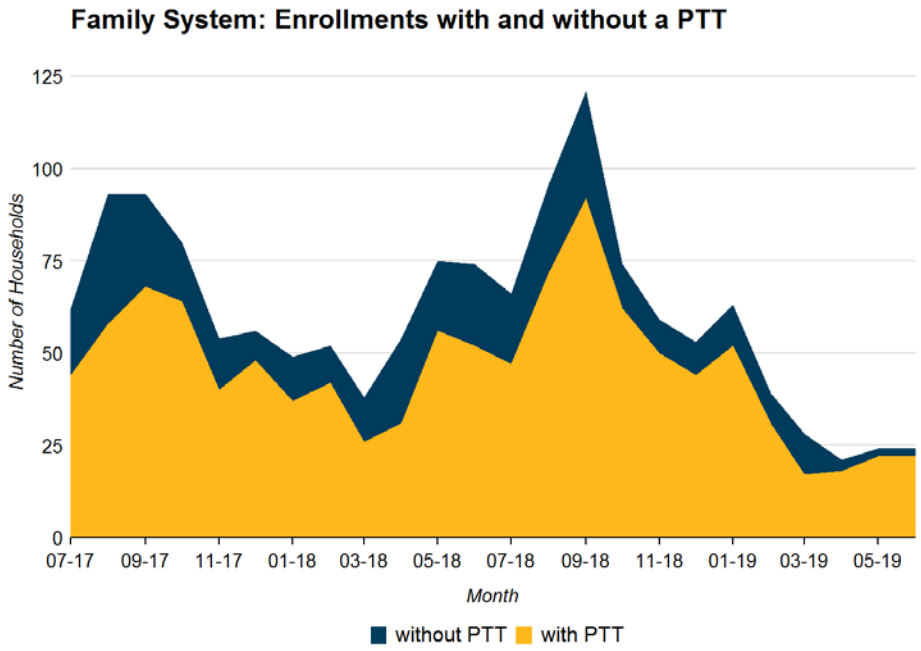
Enrollments somewhat consistently involve the PTT. In the single adult system, 72% of enrollments had a corresponding PTT. The proportion of enrollments with the PTT varies little over time (Figure 3.8).

Figure 3.8



The family system exhibits slightly higher PTT usage—76% of enrollments had a PTT. Moreover, the proportion of enrollments with a PTT has grown over time (Figure 3.9), and, in the last month for which we have data, 92% of enrollments had a PTT.

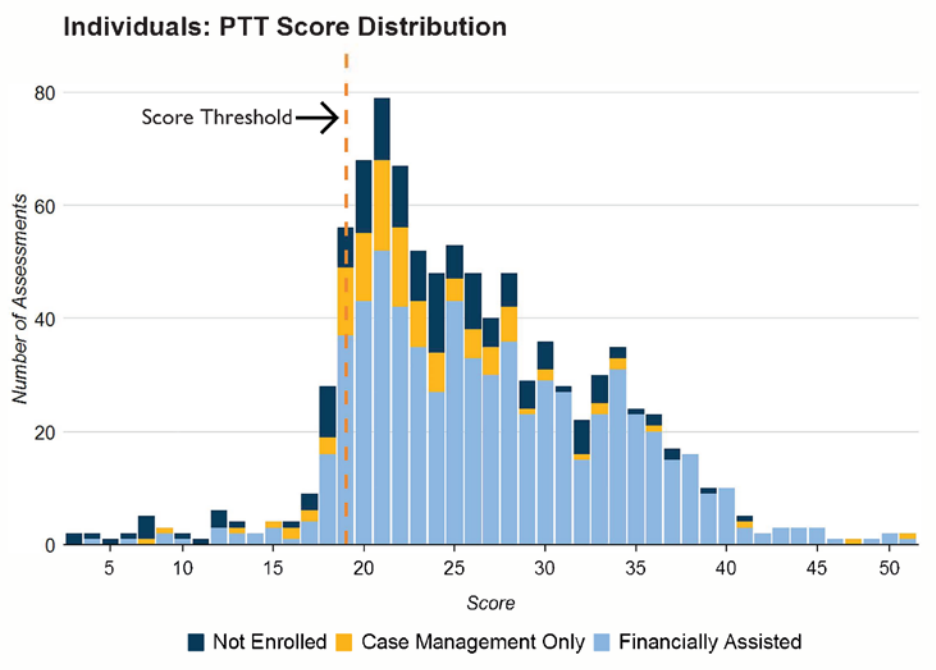
Figure 3.9



The PTT has threshold scores that are meant to establish eligibility for prevention. Individuals in the single adult system should score 19 out of 50 points to access prevention, while families should score 21 out of 42 points. The PTT score distributions for both individuals and families indicate that thresholds do not decisively establish eligibility (Figures 3.10 and 3.11, respectively). Because individuals and families scoring below the thresholds for their population-specific targeting tool are still eligible for "light touch" services,[43] we use three enrollment categories below. Along with our repeatedly used categories of "Financially Assisted" and "Case Management Only," we've included "Not Enrolled," which indicates a PTT was given and recorded, but there was no corresponding enrollment. Score thresholds are shown in orange. If the thresholds were more decisive, we would expect very few prevention enrollments—financially assisted especially—left of the threshold. For individuals (Figure 3.10), we see a mix of all three categories, even at low scores, and a moderate positive relationship between PTT score and financially assisted enrollment. The distribution has few observations below the threshold, suggesting missing data or pre-screening.

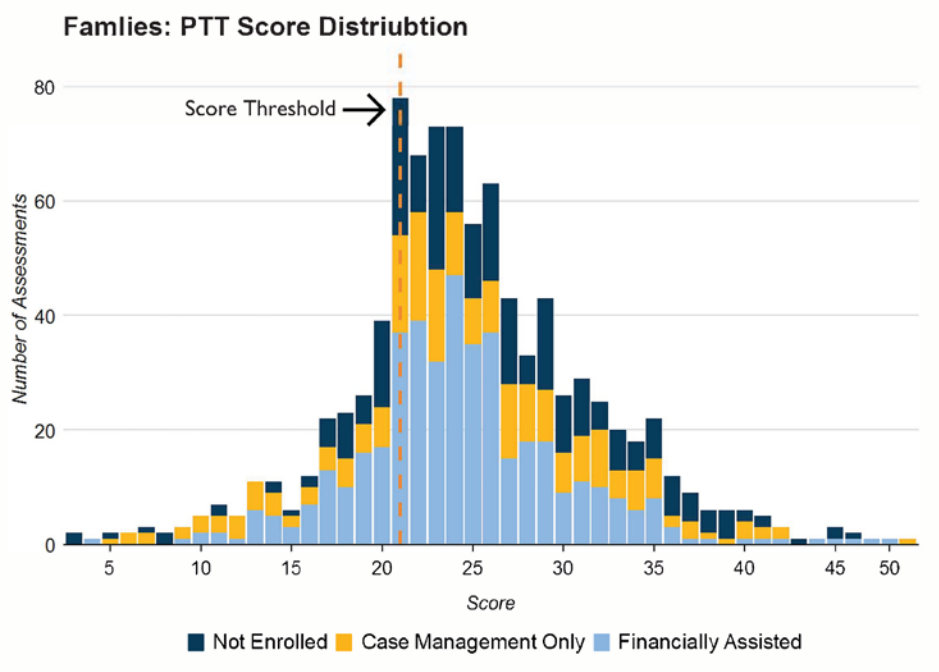
[43] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 27.4.

Figure 3.10



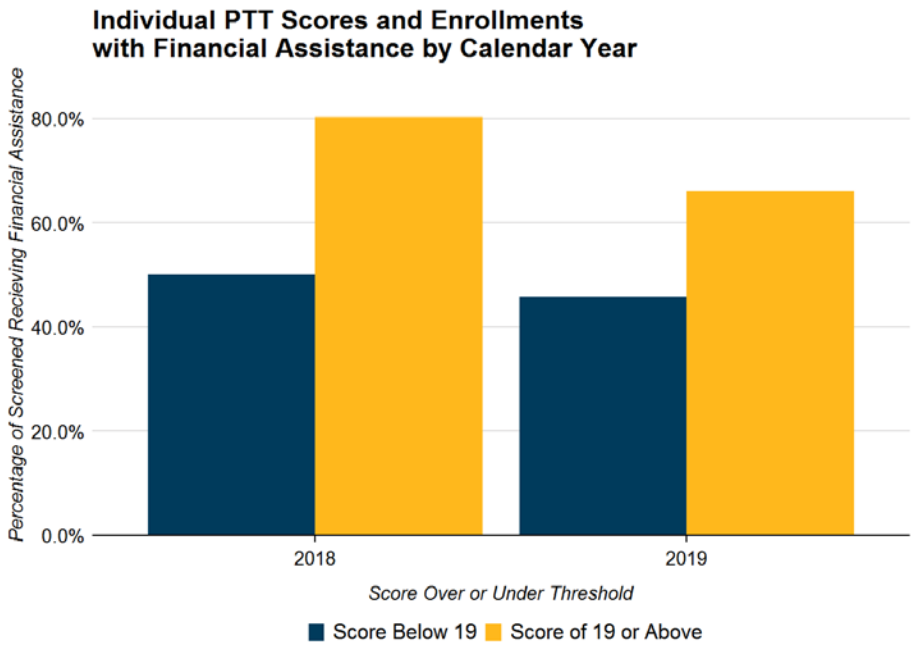
For families, the association between PTT score and enrollment appears weaker (Figure 3.11) and, as with individuals, the threshold does not appear decisive. Moreover, the modal score is 21 – the threshold itself. When the modal score of a screening tool is exactly the same as the eligibility score, it may suggest that those administering the screening tool are trying to direct the scores of clients toward the threshold. This could be explored through further research and interviews with service providers.

Figure 3.11



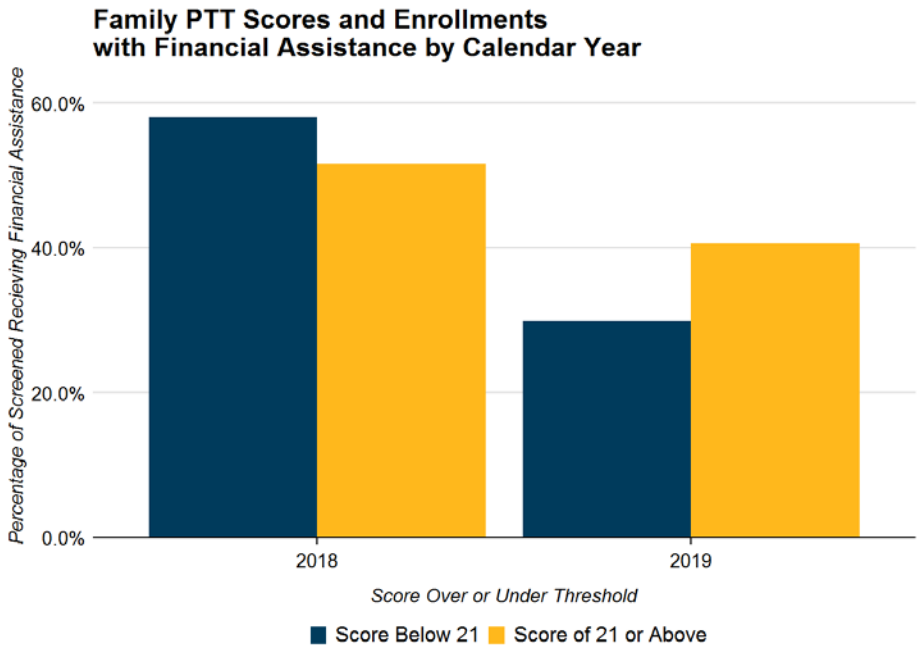
Consolidating scores into above and below threshold groups, we see that individuals with scores above the threshold are more likely to be enrolled in financially assisted prevention. Overall, 74% of individuals with scores above 19 are enrolled compared to 48% with scores below. This varies between years, and we observe that the differential decreases between assessments given in 2018 and 2019 (Figure 3.12).

Figure 3.12



In the family system, we see roughly equal percentages of families above and below the score threshold enrolled in financially assisted prevention (47% vs. 46%). In 2018, providers were slightly more likely to enroll families below the threshold in prevention (Figure 3.13), though this reverses in 2019.

Figure 3.13

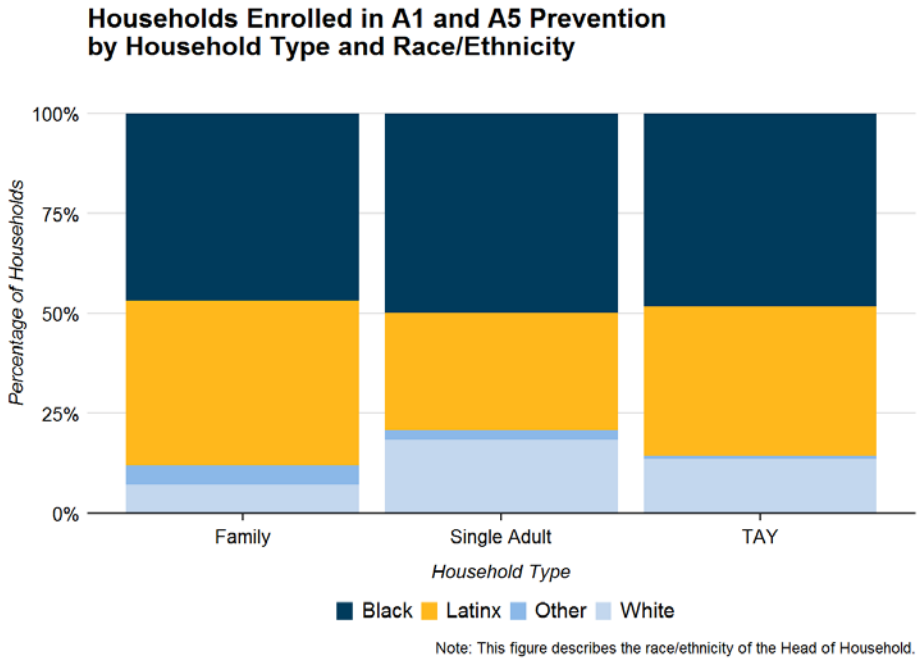


Client Demographics

Approximately half (48%) of all heads of households enrolled in prevention are Black. Latinx households comprise just over a third (36%) of all enrollments. White households make up 13% of enrollments, and households belonging to other races/ethnicities account for the remaining 3% of enrollments.

Looking at household types in the family population (Figure 3.14), we see nearly equal representation of Black and Latinx households (47% and 41%, respectively) and smaller proportions of white (7%) and other race/ethnicity (5%) households. In the single adult population, Black households account for half of enrollments, Latinx households are 29%, white households constitute 18%, and other races/ethnicities are 2%. The TAY population closely resembles the family population except for a larger share of white households and smaller share of other race/ethnicity households.

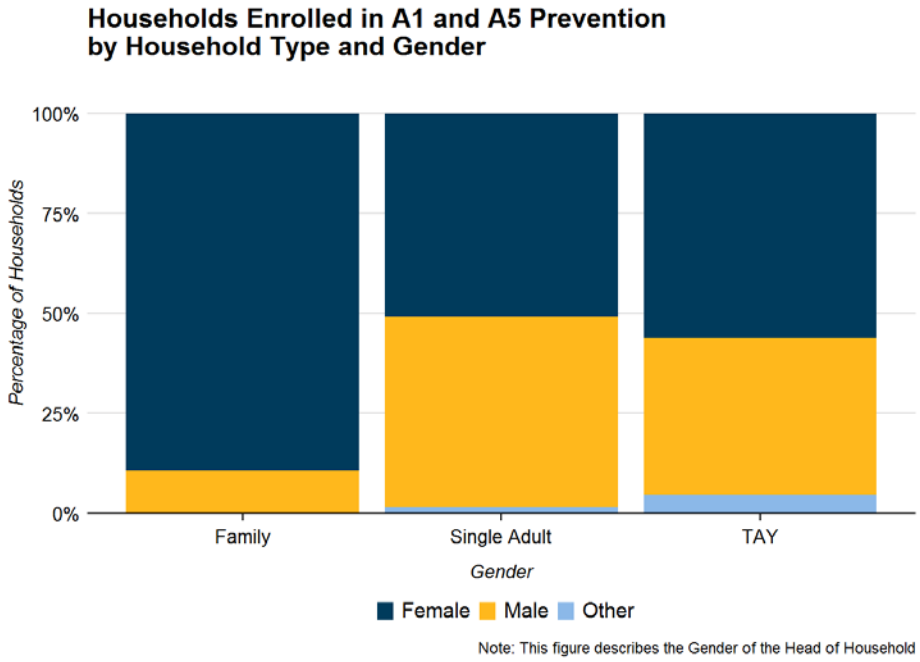
Figure 3.14



70% of all enrollments have a female head of household, 29% have a male head of household, and 1% have a trans head of household, though gender varies widely by household type. Women head 89% of family households, 51% of single adult households, and 56% of TAY households. Men head 11% of family households, 47% of single adult households, and 39% of TAY households. Trans households make up less than 1% of family

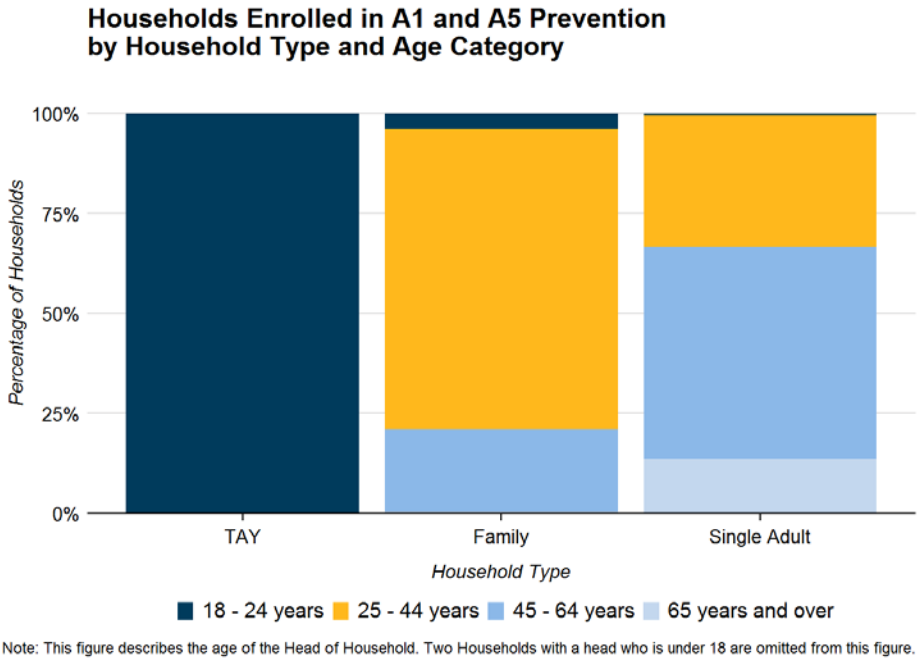
households, 1.5% of single adult households, and almost 5% of TAY households (Figure 3.15).

Figure 3.15



A slight majority (52%) of prevention households are ages 25 to 44. Only 6% of households are ages 18 to 24. Similarly, only 7% of households are ages 65 and over. Over a third (35%) of households are ages 45 to 64. Again, there's substantial variation within household type, and single adult households are much older than family households. Single adult households have a median age of 52 compared to 37 for family households and 22 for TAY households. Moreover, 13% of single adult households are 65 years and older, whereas there are only 5 such households (less than 1%) in the family population (Figure 3.16).

Figure 3.16



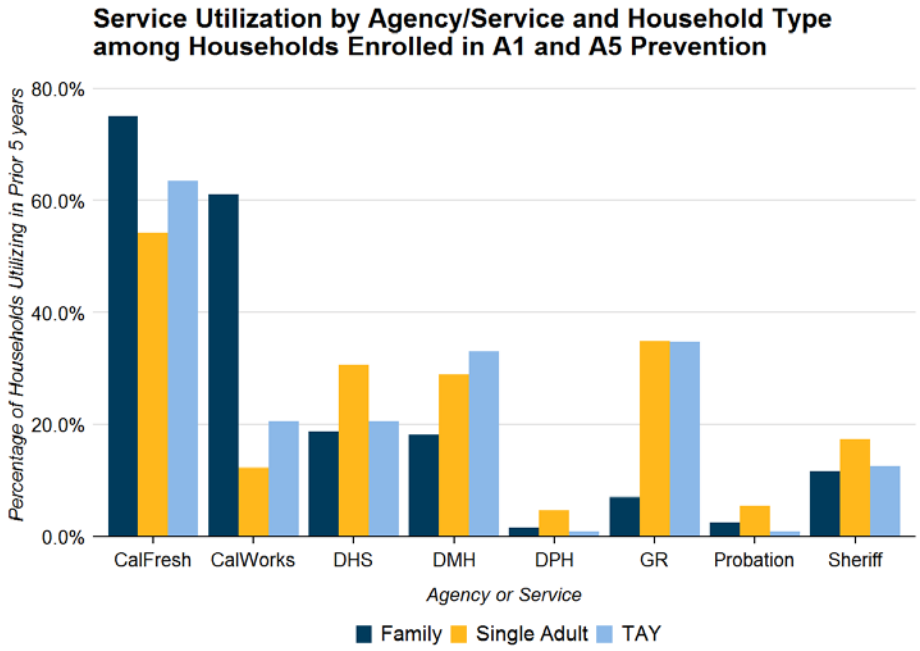
Note: This figure describes the age of the Head of Household. Two Households with a head who is under 18 are omitted from this figure.

Prior Service Utilization and Homelessness

We see high rates of prior service utilization and agency contact among prevention households in the five years preceding their enrollment: 65% of households are or were CalFresh recipients; 36% of households accessed CalWORKs; 24% accessed the Department of Health Services; 24% accessed Department of Mental Health services; 21% accessed General Relief; 14% had a recorded arrest with the Sheriff's Department; and 4% of households were on probation at some time.

Service use among household types shows greater representation of TAY and family households in CalFresh (Figure 3.17). Unsurprisingly, family households are far more likely to have accessed CalWORKS and far less likely to have accessed General Relief. Single adult households have outsized criminal justice involvement (*i.e.*, Probation and Sheriff contact), as well as Department of Health Services access.

Figure 3.17



Underscoring the complex needs and trajectories of prevention clients, we see high rates of prior homelessness. In the five years before their enrollment, 36% of households entered an HMIS project indicating homelessness ("Pct. Any HMIS" in subsequent tables); 20% entered an Interim Housing or Street Outreach project ("Pct. Interim Housing or Street Outreach"); 25% entered a housing project ("Pct. Housing"); and 16% entered some other type of HMIS project indicating homelessness ("Pct. Other").

Depending on household type and the window of time considered (prior year versus prior five years), homelessness rates can be even higher (Tables 3.3 and 3.4). Comparing financially assisted households to case management only households, we see financially assisted households have consistently higher rates of homelessness in the prior five years regardless of household type or homelessness measure (Table 3.4).[44] Considering only the prior year, financially assisted households generally have higher rates of homelessness, but there's some inconsistency for certain household types and homelessness measures (Table 3.3).

[44] These differences are statistically significant in a logistic regression where an indicator for any prior homelessness is regressed on household type and financial assistance or case management only.

Table 3.3

HMIS Homelessness in Prior Year among Households Enrolled in A1 and A5 Prevention

Household Type	Pct. Any HMIS	Pct. Interim Housing or Street Outreach	Pct. Housing	Pct. Other
Case Management Only				
Family	7.8%	3.2%	5.3%	0.9%
Single Adult	18.6%	11.9%	5.2%	6.7%
TAY	30.0%	13.3%	16.7%	10.0%
Financially Assisted				
Family	10.6%	3.6%	6.5%	1.3%
Single Adult	15.1%	8.8%	7.0%	6.1%
TAY	36.6%	19.5%	22.0%	17.1%

[a] Note: Households can belong to multiple categories.

Table 3.4

HMIS Homelessness in Prior 5 Years among Households Enrolled in A1 and A5 Prevention

Household Type	Pct. Any HMIS	Pct. Interim Housing or Street Outreach	Pct. Housing	Pct. Other
Case Management Only				
Family	21.2%	10.6%	16.8%	6.7%
Single Adult	33.1%	23.0%	16.4%	14.9%
TAY	40.0%	26.7%	26.7%	20.0%
Financially Assisted				
Family	31.9%	10.6%	25.5%	9.0%
Single Adult	45.0%	30.3%	30.6%	25.5%
TAY	52.4%	40.2%	32.9%	32.9%

[a] Note: Households can belong to multiple categories.

Homelessness After Prevention

In this subsection, we filter our data to only include enrollments from Fiscal Year 2017-18. This offers a follow-up period in which we could observe homelessness. The majority of our analyses use a 6-month follow-up period because this allows later enrollments time to proceed through prevention and experience homelessness. Using a 12-month outcome window and first examining all enrollments together, we see that 14.5% of households experience homelessness in the 12-months after prevention (Table 3.5).

Table 3.5

HMIS Homelessness in 12 Months among Households Enrolled in A1 and A5 Prevention

Pct. Any HMIS	Pct. Interim Housing or Street Outreach	Pct. Housing	Pct. Other
14.5%	7.8%	7.5%	2.8%

[a] Note: Households can belong to multiple categories.

Turning to a 6-month outcome window, we see generally lower rates because we have applied a smaller outcome window and are shortening the time households have to experience homelessness after exit (Table 3.6).

Table 3.6

HMIS Homelessness in 6 Months among Households Enrolled in A1 and A5 Prevention

Pct. Any HMIS	Pct. Interim Housing or Street Outreach	Pct. Housing	Pct. Other
9.4%	4.5%	5.4%	1.6%

[a] Note: Households can belong to multiple categories.

Financially assisted households are remarkably better off in terms of subsequent homelessness across all measures of homelessness.

Table 3.7

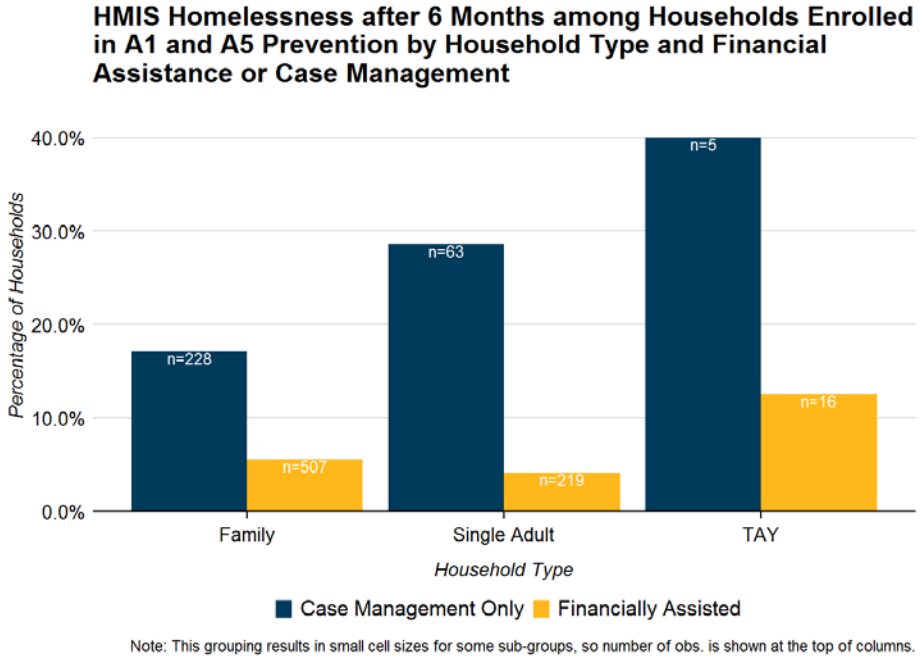
HMIS Homelessness in 6 Months among Households Enrolled in A1 and A5 Prevention by Financial Assistance or Case Management

ServiceType	Pct. Any HMIS	Pct. Interim Housing or Street Outreach	Pct. Housing	Pct. Other
Case Management Only	19.9%	10.8%	12.8%	3.0%
Financially Assisted	5.3%	2.0%	2.4%	1.1%

[a] Note: Households can belong to multiple categories.

Looking at HMIS homelessness outcomes according to household type in combination with financial assistance illuminates large differences in homelessness in the 6 months after prevention (Figure 3.18). Though financial assistance remains associated with much lower rates of homelessness, the differences are larger for single adult and TAY households.

Figure 3.18



Given households' high rates of prior homelessness, we explored whether households that experienced homelessness in the five years prior to their prevention enrollment were more likely to experience homelessness after prevention (Table 3.8). Regardless of prior homelessness or household type, financially assisted households continue to experience subsequent homelessness at much lower rates. Within categories of

financial assistance or case management only, we observe higher rates of post-prevention homelessness among households with a history of homelessness.[45]

Table 3.8

Household HMIS Homelessness in 6 Months After Prevention among Households Enrolled in A1 and A5 Prevention by Household Type, Financial Assistance or Case Management, and Prior Homelessness

Household Type	Prior Homeless Spell	Pct. Any HMIS	Pct. Interim Housing or Street Outreach	Pct. Housing	Pct. Other
Case Management Only					
Family	No	13.1%	7.4%	8.0%	2.3%
	Yes	30.2%	11.3%	24.5%	1.9%
Single Adult	No	27.3%	20.5%	11.4%	2.3%
	Yes	31.6%	10.5%	26.3%	15.8%
Financially Assisted					
Family	No	5.3%	2.1%	2.6%	0.6%
	Yes	6.0%	3.0%	3.0%	1.2%
Single Adult	No	3.3%	1.7%	0.8%	0.8%
	Yes	5.1%	1.0%	2.0%	2.0%

[a] Note: Households can belong to multiple categories. TAY are excluded due to small cell sizes.

Pathways

Household pathways are the combination of households' living situations at enrollment and exit. They offer a view of the varied ways households move through prevention. In these cross-tabulations, we also include homelessness in the 6-months after prevention to explore the association between particular pathways and homelessness.

It is first useful to view living situation at enrollment and destination at exit in separate tables (Tables 3.9 and 3.10, respectively). At enrollment, we see the majority (57%) of households are living with family members in a situation reported as permanent (rather than temporary). A quarter (25%) of households are living in a rental for which they receive some subsidy. The remaining categories all account for less than 3% of enrollments, and some of the rarer situations may reflect data entry errors since they

[45] These differences are statistically significant in a logistic regression where an indicator for any post-prevention homelessness is regressed on household type, financial assistance or case management only, and prior homelessness.

conflict with program eligibility requirements (*e.g.*, those households recorded as being in homeless situations). We observe much higher rates of subsequent HMIS homelessness for households in temporary situations at enrollment, and even greater rates for those in homeless situations. Notably, no households are reported as living in a rental without a subsidy at time of enrollment.[46]

Table 3.9

Living Situation at Enrollment among Households Enrolled in A1 and A5 Prevention

Prior Living Situation	Number	Pct.	Cumulative Pct.	Pct. Any HMIS (6 Months)
Permanently with family	1591	56.8%	56.8%	5.09%
Rental with subsidy	707	25.2%	82.0%	6.79%
Temporarily with family	103	3.7%	85.7%	13.59%
Permanent Housing	74	2.6%	88.4%	12.16%
Permanently with friends	72	2.6%	90.9%	4.17%
Shelter/Homeless	70	2.5%	93.4%	34.29%
Temporarily with friends	67	2.4%	95.8%	20.90%
Hotel	47	1.7%	97.5%	21.28%
Home with subsidy	26	0.9%	98.4%	0.00%
Institution	19	0.7%	99.1%	5.26%
Not Collected	10	0.4%	99.5%	30.00%
Transitional Housing	10	0.4%	99.8%	10.00%
N/A	5	0.2%	100.0%	40.00%

[a] Note: All households are included.

At exit, we see a very different array of living situations (Table 3.10). The most common destination is an unsubsidized rental (46%), followed by missing destination ("N/A")[47] and rentals with a subsidy (21% each). A small proportion of households appear

[46] This finding contradicts experiences some service providers relayed, and it may result from some unknown error in the HMIS data used for the analyses.

[47] Though missing project exit data are a common data quality issue throughout the HMIS, the problem is exacerbated here because this table uses data through July, 2019. For some later enrollments—

to exit directly to a homeless situation, and these households indeed experience very high rates of subsequent HMIS homelessness.

Table 3.10

Destination at Exit among Households Enrolled in A1 and A5 Prevention

Destination	Number	Pct.	Cumulative Pct.	Pct. Any HMIS (6 Months)
Rental	1291	46.1%	46.1%	3.95%
N/A	576	20.6%	66.7%	8.16%
Rental with subsidy	576	20.6%	87.2%	7.64%
Not Collected	136	4.9%	92.1%	11.03%
Shelter/Homeless	42	1.5%	93.6%	57.14%
Temporarily with family	42	1.5%	95.1%	4.76%
Permanently with family	41	1.5%	96.5%	7.32%
Other	30	1.1%	97.6%	36.67%
Permanent Housing	22	0.8%	98.4%	9.09%
Temporarily with friends	12	0.4%	98.8%	25.00%
Institution	8	0.3%	99.1%	37.50%
Home	7	0.2%	99.4%	0.00%
Hotel	7	0.2%	99.6%	57.14%
Permanently with friends	6	0.2%	99.8%	0.00%
Home with subsidy	4	0.1%	100.0%	0.00%
Transitional Housing	1	0.0%	100.0%	100.00%

[a] Note: All households are included. Missingness (N/A) for destination is high in part due to recent program entrances for some households.

like those occurring in the summer of 2019—households would have to rapidly proceed through the program in order have exited. Subsequent Pathways tables subset the data to mitigate the problem of missing information on exit. We separately designate enrollments with entirely missing exit information ("N/A") from those with exit information where no destination was collected ("Not Collected") for a variety of reasons (*e.g.,* client refused).

Returning to pathways, we combine entry and exit living situations, along with group rates of homelessness, to produce the following tabulation of overall pathways (Table 3.11). The most common prevention pathway leads from permanently living with family to living in a market-rate rental property. The second most common pathway is remaining in a subsidized rental. Though the HMIS data do not indicate housing retention, pathways in which households exit to the same situation are suggestive of households keeping their housing. Beyond these top two pathways, all other pathways each account for 5.4% or less of households. The fourth most common pathway—rental with subsidy to rental—suggests some households may have lost preexisting housing subsidies. Though this table provides a high-level view of how prevention is functioning, it masks the important contributions of financial assistance and household type.

Table 3.11

Top 10 Entry/Exit Living Situation Combinations among Households Enrolled in A1 and A5 Prevention

Prior Living Situation	Destination	Number	Pct.	Cumulative Pct.	Pct. Any HMIS (6 Months)
Permanently with family	Rental	906	42.4%	42.4%	3.6%
Rental with subsidy	Rental with subsidy	322	15.1%	57.4%	7.1%
Permanently with family	N/A	116	5.4%	62.8%	9.5%
Rental with subsidy	Rental	104	4.9%	67.7%	1.9%
Permanently with family	Not Collected	76	3.6%	71.2%	11.8%
Permanently with family	Rental with subsidy	64	3.0%	74.2%	4.7%
Rental with subsidy	N/A	36	1.7%	75.9%	11.1%
Permanently with friends	Rental	35	1.6%	77.6%	5.7%
Temporarily with family	Rental	35	1.6%	79.2%	14.3%
Permanent Housing	Rental	19	0.9%	80.1%	0.0%

[a] Note: Households enrolled on or before December 28th, 2018 are included. Missingness (N/A) for destination is 10% for subset of data used to generate table.

Tables 3.12. and 3.13 provide pathways for family and single adult households. Each table groups enrollments according to financial assistance or case management only. Moving from permanently living with family to a rental is the most common pathway by far for all groups except financially assisted single adults, who remain in a subsidized rental at the same rate as they move from permanently living with family to a rental. Looking across tables 3.12 and 3.13, pathways starting in subsidized rentals are more frequent among financially assisted households. Financially assisted households also experience less varied pathways. In both tables, the top 5 pathways account for large cumulative percentages of financially assisted households and much smaller cumulative percentages of case management only households. Single adults who did not receive financial assistance have on average the highest rates of returns to homelessness within 6 months, though the raw numbers are small, which can make the percentages appear more remarkable than they are.

Table 3.12

Family Households Enrolled in A1 and A5 Prevention: Top 5 Entry/Exit Living Situation Combinations by Financial Assistance or Case Management

Prior Living Situation	Destination	Number	Pct.	Cumulative Pct.	Pct. Any HMIS (6 Months)
Case Management Only					
Permanently with family	Rental	99	26.2%	26.2%	4.0%
Permanently with family	Not Collected	40	10.6%	36.8%	5.0%
Rental with subsidy	Rental	19	5.0%	41.8%	0.0%
Permanently with family	Temporarily with family	15	4.0%	45.8%	0.0%
Permanently with family	N/A	14	3.7%	49.5%	21.4%
Financially Assisted					
Permanently with family	Rental	472	59.0%	59.0%	3.0%
Rental with subsidy	Rental	65	8.1%	67.1%	1.5%
Permanently with family	N/A	36	4.5%	71.6%	2.8%
Rental with subsidy	Rental with subsidy	33	4.1%	75.8%	3.0%
Permanently with family	Rental with subsidy	27	3.4%	79.1%	7.4%

[a] Note: Households enrolled on or before December 28th, 2018 are included. Missingness (N/A) for destination is 7% for subset of data used to generate table.

Table 3.13

Single Adult Households Enrolled in A1 and A5 Prevention: Top 5 Entry/Exit Living Situation Combinations by Financial Assistance or Case Management

Prior Living Situation	Destination	Number	Pct.	Cumulative Pct.	Pct. Any HMIS (6 Months)
Case Management Only					
Permanently with family	Rental	40	25.3%	25.3%	7.5%
Permanently with family	N/A	19	12.0%	37.3%	21.1%
Permanently with family	Not Collected	14	8.9%	46.2%	28.6%
Shelter/Homeless	N/A	8	5.1%	51.3%	62.5%
Rental with subsidy	Rental with subsidy	7	4.4%	55.7%	28.6%
Financially Assisted					
Permanently with family	Rental	267	36.8%	36.8%	4.1%
Rental with subsidy	Rental with subsidy	267	36.8%	73.6%	7.5%
Permanently with family	N/A	40	5.5%	79.1%	7.5%
Permanently with family	Rental with subsidy	24	3.3%	82.4%	0.0%
Rental with subsidy	N/A	20	2.8%	85.1%	10.0%

[a] Note: Households enrolled on or before December 28th, 2018 are included. Missingness (N/A) for destination is 12% for subset of data used to generate table.

Qualitative Data Analysis

> ***Key Takeaway***: Service providers have a generally positive view of A1 and A5 prevention. They view rental arrears or rental assistance as the most beneficial program component, though legal services also garnered widespread positive feedback. Service providers found the prevention program model to be clear and easy to follow, but indicated confusion regarding problem-solving and its role in conjunction with prevention. Legal service providers recommended closer coordination with homeless service providers, specifically much speedier referrals and training for providers to spot legal issues faster. They also highlighted that coordination of financial assistance is challenging. A family system focus group indicated additional support for rental arrears, rental assistance, and legal services. The focus group also highlighted a desire to offer greater assistance to doubled-up households.

Approach and Data

To better understand service provider perspectives, we conducted semi-structured interviews with a range of Los Angeles County homelessness service providers and legal service providers. The interviews utilized an open-ended instrument meant to collect broad information related to prevention and problem-solving/diversion program administration, client eligibility, use of and opinions surrounding the Prevention Targeting Tool, and stakeholder notions of program goals and successes. We held 14 interviews with homeless service providers in November and December 2018, five interviews with legal service providers in October and November 2019, and one focus group of homeless service providers on November 7, 2019. All of these data sources inform the conclusions below, but only the structured interviews were coded for analysis.

Our qualitative analysis consisted of an iterative process of interview coding where a coding scheme—a nested collection of concepts—was applied to participants' responses to reveal patterns and build evidence around how prevention looks on the ground. We created our coding scheme using our research questions, while remaining open to emergent themes and insights evident in participants' responses (*i.e.*, using an abductive approach[48]). We present our findings by domain below and include participants' original quotes that illustrate broader themes.

Interviews revealed positive views of A1 and A5. Service providers comprehended the prevention model, and, despite being early in their implementation, discussed practicing many aspects of the program model. Problem-solving/diversion was a source of confusion for most providers. Though providers grasped the framework underpinning problem-solving/diversion, the practical integration of problem-solving/diversion and

[48] Timmermans, Stefan, and Iddo Tavory. "Theory construction in qualitative research: From grounded theory to abductive analysis." Sociological theory 30.3 (2012): 167-186.

prevention eluded most providers. The Prevention Targeting Tool was widely viewed as adequate and helpful, and providers stated they consistently used it. However, they did report informally pre-screening clients, which may explain why relatively few single adults scored below the threshold score for program eligibility.

Service Provider Interviews

Prevention

Providers discussed a range of services occurring during prevention enrollments. They most frequently pointed to rental arrears or rental assistance as the most beneficial program component, though we also observed frequent usage and widespread support for legal services.

> "With the clients going to trial…our attorneys that we work with have been so helpful with updating us on what's going on, like the likelihood of them winning the case, what we can do to help their case. Me personally, I think the **legal services have been amazing."**

Some providers noted a lack of household inflow, especially for the single adult system, but this perception was not universal.

> "We're **not seeing an overwhelming amount of people coming to us for individual prevention** and I think it's because it's very…easy for individuals to go couch surf for quite a while after they lose their units."

When asked to discuss potential improvements, providers offered wide-ranging responses including revision of income requirements, more intensive case management, having onsite legal services, and expansion of prevention funding.

Problem-Solving/Diversion

Providers repeatedly expressed confusion over how to practice problem-solving. Relatedly, they also reported very low usage of problem-solving.

> "To be honest, **we're all getting a little bit confused about diversion.** I don't know if anybody has officially enrolled somebody in diversion, but from what we understand, diversion is to divert them from actually being introduced into the system or prevention."

Some providers viewed problem-solving as a way to avoid expenditures. Several providers discussed problem-solving in terms of what it's not rather than articulating services or activities that would occur during problem-solving.

> "You're also diverting them out of needing... **We're not paying for them. Diversion is also about money at the end of the day**."

Other providers described problem-solving in terms of making households aware of the resources already at their disposal.

> "Diversion is more like, **'Do you have a family member that you can stay with?'** 'Is there something that we can help with?'"

While not all providers viewed problem-solving as a time-intensive program, some indicated it required substantial staff time in the short-term. One provider viewed problem-solving as a recurring process, where households routinely return despite the time investment made upfront.

> "It's a frontend heavy intervention and it's a time commitment…there's no intake paperwork being done… **But you want the client to feel like they're still being helped without bringing them in. You're not saying no.** Sometimes you might be able to divert them for a week and **then they come back and you try it again."**

Prevention Targeting Tool

Across interviews, providers indicated universal usage of the PTT during A1 and A5 enrollments, which conflicts with the findings of our administrative data analysis. Providers also indicated that they engage in an informal pre-screening process that serves as an initial eligibility check. For most providers, this is a quick conversation on households' backgrounds and circumstances before the administration of the PTT.

> "**The first thing we do is just sort of...[an] informal interview**…then, we go right into the Prevention Targeting Tool, you know, to make sure that they do qualify, point-wise, for the program."

We observed high levels of support for the PTT's threshold scores, which most providers felt helped effectively direct prevention resources. Other providers believed that the thresholds were easy to meet for most households.

> "I think that the scoring tool **does a pretty good job weeding out most who could self-resolve.**"

> "Like it's not hard to get a 21 on that Prevention Targeting Tool. If you are a family living in poverty who has had any sort of barriers, **it's not hard to get the score you need to qualify.**"

Some providers shared stories of households just below the score thresholds that would be ineligible for prevention. However, they said such cases were rare, and that LAHSA has been supportive of enrolling such clients despite their PTT scores.

> "**I've had a couple people that are around 18, 18-19.** Those are usually market-rate clients that have just lost their jobs, never been homeless before. So, we've gotten a few of those people. But **typically, it's not really an issue.**"

Legal Service Provider Interviews

Working with Prevention Service Providers

Some legal service organizations report that they regularly work with service providers and have a very good relationship with service providers. One attorney noted that she works with case mangers when she needs help gathering client documents or fingerprints. She also works with case managers to find new housing for her clients if additional time to move out is the best outcome that she can negotiate in an eviction case. Another attorney reported that her organization also regularly works with case managers and that attorneys at her organization are typically in consistent contact with case managers. She noted that co-location with the service provider has strengthened communication and cooperation between her organization and the service provider who refers clients to her organization.

Other attorneys reported that their organizations do not work closely with prevention service providers. Two attorneys noted that when they are unable to preserve a client's housing situation in eviction cases, the clients' case managers have not been helpful in finding new housing for the clients. Another attorney noted that coordination of rental assistance is difficult. In instances when he was able to negotiate for payment of arrearages in order to maintain a client's housing, it has sometimes been difficult to work with service providers to coordinate payment of arrearages (even if the client qualifies for financial assistance through A1 and A5 prevention).

In order to foster communication and cooperation between prevention service providers and legal service providers, some attorneys suggested that co-location should be required. One attorney noted that in the absence of co-location, regularly-scheduled and in-depth case conferences would be beneficial.

Legal Service Providers' Perception of Client Risk Levels

All of the attorneys noted that the prevention clients they serve have very high-risk profiles, *i.e*., in the absence of legal services and other prevention assistance their clients would likely become homeless. One attorney noted that only a fraction of evictions results in actual homelessness. She noted that Measure H-funded legal services are designed to target the eviction cases that could result in homelessness. Another attorney noted that her organization is getting "very, very vulnerable clients" and one challenge has been that some clients resolve one eviction case only to return to the organization with another eviction case.

Legal Service Outcomes

All five of the attorneys interviewed for this evaluation report that Measure H-funded legal services have generally been successful, especially in regards to housing cases

(*i.e.*, eviction and unlawful detainer cases).[49] Attorneys noted that success in these housing cases is critical to preventing homelessness inflows because their prevention clients are at very high risk of homelessness. One attorney noted that even when legal service providers are not able to preserve a client's housing, having an attorney can still result in the best possible legal outcome for a prevention client. For example, an attorney can keep an eviction off of a client's record so that the eviction does not create a barrier to obtaining housing in the future. Attorneys can also negotiate additional time to move out of a unit.

One attorney noted that some prevention clients end up homeless despite legal assistance. For example, some clients enter into a settlement with their landlord that requires them to move out in 90 days. After moving out, clients face barriers to housing such as landlords who will not accept Section 8 vouchers, landlords who do not want tenants with a history of being evicted, or landlords who will not allow pets in the building. For some clients, legal service providers are able to negotiate reduced arrears payments, but the clients do not qualify for financial assistance through Measure-H prevention and have to vacate their units.

Potential ways to improve the legal service referral and intake process

Attorneys noted that it is important to ensure that case managers at SPA leads promptly refer cases to legal service providers. Attorneys reported that they sometimes receive unlawful detainer and eviction cases very late in the life cycle of the case (*e.g.*, one or two days before an eviction trial) and this can make it difficult or impossible to achieve a good case outcome. Sometimes late referrals are the results of a case manager attempting landlord mediation while the unlawful detainer or eviction case is pending. If the mediation fails, the case manager then refers the unlawful detainer or eviction to the legal service provider, but this often happens perilously late in the unlawful detainer or eviction process. It is important that an attorney be involved in unlawful detainers and evictions even in cases where a client's housing cannot be preserved. Because it is very difficult to take an eviction off of an individual's record, it is important that a legal service provider be involved in the case before it is too late to ensure that the record is sealed. Early referrals are also important because landlords and property management companies may involve their own attorneys early on in a lease dispute. This results in the accrual of legal fees. If a tenant has representation early in a dispute, both sides' attorneys can reach a resolution more quickly and prevent accrual of legal fees. Some attorneys noted that it would be beneficial for case managers to receive more training on identifying legal issues. This would help ensure that case managers are flagging urgent legal situations that require immediate legal attention. An additional way to ensure that service providers identify legal

[49] Legal service providers record data about the services they provide to Measure H prevention clients (*e.g.*, legal issue, how many extra days they stayed in their home as a result of legal assistance, monetary benefits), but the California Policy Lab did not have access to this data.

issues early in the client relationship would be for service providers to have a lawyer on staff who would be responsible for legal issue spotting.

One attorney noted that it would be beneficial to create a streamlined process for legal referrals from organizations that are not SPA leads but nonetheless work with populations who are at imminent risk of homelessness and who face eviction. Because these nonprofits are not SPA leads, they have to fill out referral paperwork to first refer the case to the SPA lead, and then the SPA lead reaches out to the individual or family. Oftentimes, it is difficult for the individual or family to travel to the SPA lead's office. If the individual or family is able to travel to the SPA lead's office, the SPA lead has to fill out additional referral paperwork to make the referral to the legal service provider. This process can create barriers to accessing legal services in a timely manner or at all.

Issues Beyond the Scope of Prevention Legal Services

Attorneys noted that while legal assistance has prevented many of their clients from becoming homeless, there are broader societal conditions that lead to homelessness, which are beyond the scope of legal assistance and prevention assistance under Measure H generally. They noted that in Los Angeles, increasingly unaffordable rent and low wages have put low and moderate income Angelenos in a very precarious situation. One rent increase or other unexpected expense can cause an individual to fall into homelessness. One attorney further noted that many individuals and families do not have enough savings to cover a parking ticket, and unpaid parking tickets or other seemingly minor traffic citation fees can snowball into the loss of a car and subsequent loss of a job when an individual no longer has a means of traveling to their job.

Many attorneys noted that landlord issues have prevented their clients from maintaining current housing or finding new housing when current housing cannot be preserved. They noted that some landlords discriminate against their clients who receive Section 8 housing vouchers. Attorneys also noted that some landlords resist third party checks (*e.g.*, rental assistance checks from prevention providers), despite the fact that Assembly Bill 2219 (codified as an amendment to Civil Code § 1947.3) requires a landlord or landlord's agent to allow a tenant to pay rent through a third party.[50] One attorney noted that some clients face other issues like landlords' refusals to make repairs. The solution to

[50] California Assembly Bill 2219 (effective on Jan. 1, 2019). Under Assembly Bill 2219, there is no requirement to accept the rent payment tendered by a third party, unless the third party has provided a signed acknowledgment stating that they are not currently a tenant of the premises for which the rent payment is being made, and that acceptance of the rent payment does not create a new tenancy with the third party.

these scenarios might be the formation of tenant organizations rather than any formal legal action.

One attorney noted that lack of transparency in the unlawful detainer process and tenants' lack of knowledge of the unlawful detainer process can have devastating effects on housing status. For example, many tenants do not realize that if they receive an unlawful detainer complaint and do not file an answer, a default judgement for possession of the property may be entered against them without a court hearing.

Family Prevention Focus Group

A focus group of family coordinated entry system program managers offered additional insights on how prevention functions in the family system. Participants shared a variety of outreach approaches used to inform the community about prevention. Many approaches involved partnering with community organizations to inform local residents about the availability of prevention services. One participant described proactive engagement of landlords, during which the service provider would convey their ability to assist tenants on the brink of homelessness. All participants agreed that word-of-mouth generated numerous referrals.

As with provider interviews, participants indicated that they consistently use the PTT in combination with an informal pre-screening process. Multiple participants described their prevention enrollment decisions as contingent on whether a family could self-sustain following the program. They stated that they were reluctant to enroll clients who presented for prevention due to "money management" issues rather than a singular disruptive event such as job loss. When asked about what prevention resources they deemed most helpful, participants highlighted legal services and financial assistance.

Participants found that doubled-up families sometimes required more assistance than they could provide. One participant shared cases of serving doubled-up families who were on the margin of qualifying for rapid rehousing rather than prevention (but did not qualify for rapid rehousing because they were not literally homeless). In such cases, participants agreed that prevention's six months of services were not adequate to stabilize families.

4. How could Strategies A1 and A5 be improved and how could scarce prevention funding be most efficiently prioritized? (Research Question 2)

> ***Key Takeaway*:** Reweighting and simplifying the PTT could attain increases in accuracy between 8% and 34%, while at the same time reducing the number of questions from 30 to 13 for the Families PTT and from 30 to 12 for the Individuals PTT. However, improving accuracy and operational efficiency are only two of the goals that should be taken into account by a design process for improving the PTT. It is important that any reweighting, removal, or addition of questions also be evaluated with respect to additional goals, such as information gathering, policy priorities, and fairness.

As discussed in *Section 1: Introduction and Background*, recent studies in Chicago and New York demonstrate the effectiveness of homelessness prevention programs in those cities, but the studies also highlight the need to ensure that prevention programs are efficient, *i.e.*, target the highest risk families who would become homeless in the absence of prevention services. LAHSA uses three PTTs—specific to families, adult individuals, and transition-age youth—to determine eligibility for prevention services. These tools were developed through a process that included a review of research on risk factors for homelessness, feedback from groups with lived experience of homelessness, and LAHSA operations committees. This was likely the best available information at the time. However, in an ideal scenario, a screening tool would be empirically validated using data to ensure that the tool is accurately predicting the intended outcome, *i.e.*, risk of homelessness. Empirically validating the screening tool can help ensure that individuals and families at greatest risk of homelessness are being served, rather than those who could resolve their housing crisis without assistance.

Researchers using administrative data to determine which questions could best assess risk of becoming homeless developed the targeting tools used by New York City's Homebase program. As the evaluators of the Homebase tool found, the targeting tool was substantially better at assessing risk of homelessness when compared to program staff judgment.[51] A similar approach to validating the PTT is explored here. As detailed below, we examine whether answers to individual questions on the PTT were predictive of housing outcomes.

[51] Shinn, M., Greer, A. L., Bainbridge, J., Kwon, J., & Zuiderveen, S. (2013). Efficient targeting of homelessness prevention services for families. *American journal of public health*, 103(S2), S324-S330. Retrieved from https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2013.301468.

Correlation between Specific Questions on the Prevention Targeting Tool (PTT) and Housing Outcomes

As noted above, to access prevention, families must score 21 out of 42 points on the Families PTT, adult individuals must score 19 out of 50 points on the Adults PTT, and youth individuals must score 19 out of 65 points on the Youth PTT. One of the important questions to be considered when evaluating the utility of the PTT is its accuracy in assessing risk of becoming homeless. In addition to determining whether the overall PTT score itself is an accurate predictor of homelessness, we can also examine whether individual questions on the PTT are correlated with homelessness—in other words, are "yes" or "no" responses to PTT questions associated with an increase or decrease in the client's risk of becoming homeless in the time period following assessment?

Data and Methodology

Our analysis uses a dataset of PTT assessments for family heads of household and another data set for single individuals. As discussed in the previous section, not all prevention clients were given the PTT, so this set of analyses is restricted to prevention clients who were given the assessment. Our outcome variable was homelessness during the six months following PTT assessment. If an individual was enrolled in an HMIS homeless project in the six months following the PTT assessment date, we considered them to be homeless in that six-month period. If they were not enrolled in an HMIS homeless project in the six months following the PTT assessment date, we considered them to not be homeless in that six-month period. The families PTT dataset consists of N=1,742 assessments between January 1, 2016 and December 31, 2018, while the individuals PTT dataset consists of N=732 assessments between March 1, 2018 and December 31, 2018. We used all PTT observations available during these time periods (including older versions of the PTT and PTT observations from non-Measure H funded prevention).

The following sections of the Families PTT were not included in the dataset provided to the California Policy Lab and were excluded from our analysis:

- Imminent loss of housing (families PTT version 1);
- Currently fleeing domestic violence (families PTT);
- History of prior rental evictions (families and individuals PTTs);
- (Self-reported) history of literal homelessness (families and individuals PTT).

Table 4.1 provides summary statistics for both the families and individuals PTT assessments, along with *percentages of positive responses to individual questions*, broken down by whether or not the client became homeless in the six months following assessment. The summary statistics for the PTT assessments in Table 4.1 provide striking insights into the challenges and vulnerabilities faced by clients seeking prevention services, including:

- 41.1% of families and 69.4% of single individuals reported being lease-holders whose household has received an eviction lawsuit from the property owner or manager;
- 16.7% of families and 5.6% of single individuals reported being doubled up and told by the lease-holder to vacate, and were disproportionately likely to become homeless in the six months following assessment (31.6% of doubled-up families and 14.6% of single individuals);
- 66.7% of families and 75.7% of single individuals reported a household income less than 30% of Area Median Income (AMI), with 64.0% of families and 51.4% of single individuals reporting a sudden and significant loss of income in the last 60 days;
- 43.3% of families and 29.2% of single individuals reported experiencing adversity or housing disruptions during childhood; and
- 38.0% of families and 55.3% of single individuals reported experiencing a major household trauma or event within the last 6 months that directly affected housing stability.

Table 4.1. Summary Statistics for Prevention Targeting Tool Assessments

Prevention Targeting Tool for Families and Adults - Number and Percentage per Category

	Families			Individuals		
	Did Not Become Homeless	**Became Homeless**	**Total**	**Did Not Become Homeless**	**Became Homeless**	**Total**
Summary						
Number of Families Version 1 Assessments	1,096	177	**1,273**		N/A	
Number of Families Version 2/Adult and Youth Assessments	416	57	**473**	650	82	**732**
Score (Mean and Standard Deviation)	21.8 (5.9)	22.6 (6.0)	**21.9 (5.9)**	26.1 (7.1)	25.6 (8.0)	**26.1 (7.2)**
Housing Status						
If DOUBLED UP, the household has been told by the lease holder to vacate the unit. Program staff has verified with lease holder that prospective PRV participant is no longer welcome and must vacate. Prospective participant lacks the resources to secure alternative housing arrangements.	218 (14.4%)	74 (31.6%)	**292 (16.7%)**	29 (4.5%)	12 (14.6%)	**41 (5.6%)**
If LEASE HOLDER, the household has received an Unlawful Detainer ("Eviction") lawsuit by the property owner or manager. An Unlawful Detainer is a formal eviction action that is filed in justice court. Program staff has verified with property owner/manager that prospective PRV participant has received notice to vacate. Prospective participant lacks the resources to secure alternative housing arrangements.	617 (40.8%)	100 (42.7%)	**717 (41.1%)**	459 (70.6%)	49 (59.8%)	**508 (69.4%)**
Currently fleeing or attempting to flee domestic violence, dating violence, sexual assault, or other dangerous or life-threatening conditions that relate to violence against any household member.		N/A		9 (1.4%)	2 (2.4%)	**11 (1.5%)**
Staying in a hotel in which adult is paying out of pocket, but can no longer sustain in the unit due to costs. Agency staff have verified with adult costs of increase in hotel, debt to cost ratio, applicable after a certain amount of days paying out of pocket. Prospective participant lacks the resources to secure alternative housing arrangements.	65 (4.3%)	20 (8.5%)	**85 (4.9%)**	4 (0.6%)	3 (3.7%)	**7 (1.0%)**

Table 4.1. Summary Statistics for Prevention Targeting Tool Assessments (*Continued*)

Prevention Targeting Tool for Families and Adults - Number and Percentage per Category

	Families			Individuals		
	Did Not Become Homeless	**Became Homeless**	**Total**	**Did Not Become Homeless**	**Became Homeless**	**Total**
Imminent Loss of Current Housing						
Have failed to respond to the Unlawful Detainer notice within 5 days of the court hearing or have received a court ruling with a date the person must move out. Or, lease holder (or motel/hotel management) has mandated prospective participant must leave within 24 hours.	17 (4.1%)	10 (17.5%)	**27 (5.7%)**	22 (3.4%)	4 (4.9%)	**26 (3.6%)**
Have been served an Unlawful Detainer requiring court response or have an already determined court date. Or, lease holder (or motel/hotel management) has mandated prospective participant must leave within 48 hours.	36 (8.7%)	8 (14.0%)	**44 (9.3%)**	51 (7.8%)	16 (19.5%)	**67 (9.2%)**
Have received a 3-day pay or quit notice with more than one month of rent owed. Or, lease holder (or motel/hotel management) has mandated prospective participant must leave within 3 days.	285 (68.5%)	24 (42.1%)	**309 (65.3%)**		N/A	
Have received a 3-day pay or quit notice with less than one month of rent owed. Or, lease holder (or motel/hotel management) has mandated prospective participant must leave within 1 week.	64 (15.4%)	8 (14.0%)	**72 (15.2%)**	107 (16.5%)	28 (34.1%)	**135 (18.4%)**
Have received a 30-day Notice to vacate or experiencing a housing crisis that will lead to an expected loss of housing within 1 month. Or, lease holder (or motel/hotel management) has mandated prospective participant must leave within 1 month.	51 (12.3%)	14 (24.6%)	**65 (13.7%)**	37 (5.7%)	15 (18.3%)	**52 (7.1%)**
Household Annual Gross Income Amount						
Income is less than 30% of Area Median Income (AMI) for household size	1,015 (67.1%)	150 (64.1%)	**1,165 (66.7%)**	483 (74.3%)	71 (86.6%)	**554 (75.7%)**
Income is between 31-50% of AMI for household size	316 (20.9%)	43 (18.4%)	**359 (20.6%)**	104 (16.0%)	6 (7.3%)	**110 (15.0%)**
Within the last 60 days, adult has experienced sudden and significant loss of income, including loss of employment and/or cash benefits AND/OR experienced an uncontrollable and significant increase in non-discretionary expenses	986 (65.2%)	132 (56.4%)	**1,118 (64.0%)**	329 (50.6%)	47 (57.3%)	**376 (51.4%)**

Table 4.1. Summary Statistics for Prevention Targeting Tool Assessments (*Continued*)

Prevention Targeting Tool for Families and Adults - Number and Percentage per Category

	Families			Individuals		
	Did Not Become Homeless	**Became Homeless**	**Total**	**Did Not Become Homeless**	**Became Homeless**	**Total**
Other Questions						
Adult experienced adversity or housing disruptions during childhood. Examples of childhood adversity could include homelessness, placement in foster care, eviction, refugee or immigrant to the U.S., or frequent moves (>3 in 1 year)	648 (42.9%)	108 (46.2%)	**756 (43.3%)**	190 (29.2%)	24 (29.3%)	**214 (29.2%)**
Current involvement with Adult Protective Services (APS) or Child Protective Services	85 (5.6%)	22 (9.4%)	**107 (6.1%)**	17 (2.6%)	7 (8.5%)	**24 (3.3%)**
Recently (within last 6 months) experienced a major household trauma or event that directly affects ability to secure or maintain housing. Examples of trauma or event include death of family member, separation or divorce from adult partner, birth of a new child.	555 (36.7%)	109 (46.6%)	**664 (38.0%)**	364 (56.0%)	41 (50.0%)	**405 (55.3%)**
Recently (within last 6 months) discharged from an institution after stay of any length. Examples of institutions include hospital, jail, prison, psychiatric hospital or substance abuse treatment facility.	169 (11.2%)	37 (15.8%)	**206 (11.8%)**	144 (22.2%)	17 (20.7%)	**161 (22.0%)**
History of involvement in the foster care or criminal justice system.	68 (4.5%)	11 (4.7%)	**79 (4.5%)**	282 (43.4%)	33 (40.2%)	**315 (43.0%)**
Adult has a disability (i.e., a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment)	108 (7.1%)	14 (6.0%)	**122 (7.0%)**	373 (57.4%)	56 (68.3%)	**429 (58.6%)**
Currently residing in a unit using a Housing Choice Voucher (HCV) or under rent-control	86 (5.7%)	13 (5.6%)	**99 (5.7%)**	0 (0.0%)	0 (0.0%)	**0 (0.0%)**

The analyses of PTT questions significantly correlated with homelessness were performed using logistic regression, a statistical technique used to model the probability of a certain event happening (here, the event is becoming homeless in the six-month outcome period).[52] When using regression modeling techniques to test for associations, including covariates can improve the accuracy of the model. In this analysis, we included covariates such as (i) the amount of financial assistance received; (ii) demographics including age, race, gender, household size, and veteran status; (iii) SPA and fiscal year; (iv) prior living situation and HMIS homeless history; and (v) ELP service utilization history. Table 4.2 lists the questions we found to have statistically significant correlations at the $p < .05$ level with homelessness in the six months following assessment.

[52] Regression analysis adds value to the purely descriptive presentation of factors in Table 4.1. One advantage of the regression framework is that the regression takes into account whether some predictive factors are highly correlated and which of the factors remain relevant once that correlation is taken into account.

Table 4.2. PTT questions significantly correlated with homelessness

	Question	Odds Ratio and 95% CI	Explanation
Families PTT	If DOUBLED UP, the household has been told by the lease holder to vacate the unit. Program staff has verified with lease holder that prospective PRV participant is no longer welcome and must vacate. Prospective participant lacks the resources to secure alternative housing arrangements.	2.47 (1.57, 3.91)	Twice as likely to become homeless
	If LEASE HOLDER, the household has received an Unlawful Detainer ("Eviction") lawsuit by the property owner or manager. An Unlawful Detainer is a formal eviction action that is filed in justice court. Program staff has verified with property owner/manager that prospective PRV participant has received notice to vacate. Prospective participant lacks the resources to secure alternative housing arrangements.	2.01 (1.35, 3.01)	Twice as likely to become homeless
	Income is between 31-50% of AMI for household size* (*reference level is 30% or less than AMI)	0.62 (0.41, 0.95)	Almost half as likely to become homeless
	Recently (within last 6 months) experienced a major household trauma or event that directly affects ability to secure or maintain housing. Examples of trauma or event include death of family member, separation or divorce from adult partner, birth of a new child.	1.78 (1.28, 2.47)	Almost twice as likely to become homeless
Individuals PTT	Have been served an Unlawful Detainer requiring court response or have an already determined court date. Or, lease holder (or motel/hotel management) has mandated prospective participant must leave within 48 hours.	3.07 (1.13, 8.33)	Three times as likely to become homeless
	Have received a 3-day pay or quit notice with less than one month of rent owed. Or, lease holder (or motel/hotel management) has mandated prospective participant must leave within 1 week.	4.67 (2.4, 9.09)	Almost five times as likely to become homeless

Our analysis of PTT questions that are significantly correlated with homelessness provides additional insight into factors that increase baseline risk of homelessness, with baseline risk being the risk faced by the "average" prevention client. In other words, prevention clients who answer "yes" to these questions are more vulnerable, on average, than those prevention clients who answer "no." Therefore, PTT questions that we did not find to be significantly correlated with homelessness may still make those prevention clients vulnerable compared with some other lower-risk baseline, such as an average resident of Los Angeles County.

It is also important to note that the above analyses were performed on relatively small datasets, with positive responses to many PTT questions being relatively rare. (This

is especially true in the case of the individuals PTT, where less than half as many observations were available as compared to the families PTT). Estimates of correlations between questions and outcomes are necessarily imprecise, as is evidenced by the wide confidence intervals[53] in the above tables. We should not conclude, for instance, that any PTT questions shown to be not statistically significant in the above analyses bear no relationship to homelessness in reality. The lack of statistical significance is not positive evidence for the absence of a relationship; instead, lack of statistical significance indicates that more data is required in order to estimate a precise effect.

In addition, the above analyses were performed using a six-month outcome window[54] for homelessness following assessment in order to maximize the number of available observations and the precision of the estimates. Policymakers may be more interested, however, in outcomes tracked over a longer period, such as 12, 18, or 24 months. We recommend that the analyses be rerun after a longer time period has elapsed.

Can the PTT be Improved?

When considering revisions to the PTT, it is important to consider multiple objectives, including:

(1) **Accuracy**: How accurately is the PTT identifying clients who are at high risk of becoming homeless?
(2) **Operational efficiency**: Could the PTT be made shorter without sacrificing accuracy?
(3) **Information gathering**: Is the PTT gathering information that is important for client service delivery and/or research into risk factors for homelessness?
(4) **Policy priorities**: Does the PTT help advance the policy priorities and goals of LAHSA and other key stakeholders?
(5) **Fairness**: Does the PTT help ensure fairness and equity in the distribution of prevention resources?

Decisions about revising the PTT would take the above objectives, and perhaps additional objectives, into account. In this evaluation, however, we will demonstrate how a data-driven methodology can provide specific and robust information relevant to objectives (1) and (2).

[53] A confidence interval is the range of values likely to contain the true value.

[54] Since the PTT has only been administered consistently in the last two years, we chose a six-month outcome window in order to maximize the usable number of observations. Similarly, we have chosen not to restrict the dataset to assessments for Measure H programs in order to maximize the amount of usable data and the resulting precision of the estimates.

Evaluating the Accuracy of the PTT

The accuracy of the PTT can be evaluated by comparing PTT scores with actual homelessness outcomes—specifically, clients' enrollment in HMIS homeless projects in the six months following assessment. By comparing scores with actual outcomes, we can generate evaluation metrics that provide insight into the performance of the tool. One common evaluation metric is the *Area under the Receiver Operating Curve* (AUC for short), a measure of the ability of a risk score to distinguish between high-risk and low-risk clients. The AUC is a decimal number between 0 and 1. A risk score with an AUC of 0.50 does no better at prediction than random coin flipping, while a risk score with an AUC of 1.00 makes perfect predictions. As a general rule of thumb, an AUC between 0.60 and 0.70 is regarded as acceptable, while an AUC of 0.70 or greater is regarded as good or excellent.

One factor that complicates our evaluation of the accuracy of the PTT score is that a certain percentage of those assessed by the PTT received financial assistance during their A1 or A5 enrollment—a factor which is not incorporated into the PTT score itself. In order to avoid unfairly penalizing the PTT score for failing to take into account the reduction in risk associated with receipt of financial assistance, we evaluate the PTT score separately for those clients who received financial assistance and for those who do not.

Table 4.3 shows model evaluation metrics for the families and individuals PTT scores. Although the individuals PTT achieves an AUC of 0.62 within the subset of financially assisted clients, the other AUC scores range from 0.50 to 0.57, which is not a significant improvement on random guessing.

Table 4.3. Model evaluation metrics for the PTT score

PTT Type	Received Financial Assistance	AUC
Families	Yes	0.57
	No	0.53
Individuals	Yes	0.62
	No	0.50

Data-Driven Methods for Improving the Accuracy and Operational Efficiency of the PTT

By applying statistical techniques to the datasets of PTT assessments and corresponding homelessness outcomes for the assessed clients, we explored the possibility of revising the PTT to maximize accuracy and improve operational efficiency. More specifically, we addressed the following questions:

- Can the accuracy of the PTT be improved by reweighting questions with a score between 0 and 10?
- Can the operational efficiency of the PTT be improved by removing questions?

Using the families PTT (N=1,742) and individuals PTT (N=732) questions, we ran a simulation which fitted a series of *constrained least squares* models. The constrained least squares algorithm chooses question weights in order to maximize accuracy. For each question, the algorithm provided us with a number between 0 and 10. If the algorithm assigned a value of 0 to the question, then the question was not correlated with risk of homelessness. If the algorithm assigned a value of 10 to a question, then the question was very strongly correlated with risk of homelessness. We removed questions assigned a value of 0 from our hypothetical PTT. If a question was assigned a value of 1, then answering yes to the question would contribute 1 point to the total PTT score. If a question was assigned a value of 10, then answering yes to the question would contribute 10 points to the total PTT score. The resulting hypothetical PTT consisted of a series of questions scored between 1 and 10 to produce a final total risk score. As detailed above, we used the *AUC* metric to evaluate the accuracy of the current individuals PTT and families PTT. We also evaluated the hypothetical PTTs that we created using the *AUC* metric. Table 4.4 shows the total number of questions on our hypothetical PTTs and the evaluation metrics for our hypothetical PTTs.

Table 4.4. Total number of questions and accuracy metrics for hypothetical PTTs created using constrained least squares models

PTT Type	Total Number of Questions Included (with 95% Confidence Intervals)	Received Financial Assistance	AUC (with 95% Confidence Intervals)[55]
Families	13 (10, 15)	Yes	0.69 (0.61, 0.76)
		No	0.63 (0.59, 0.69)
Individuals	12 (9, 15)	Yes	0.67 (0.57, 0.77)
		No	0.67 (0.56, 0.77)

Results Suggest Potential for Gains in Accuracy and Efficiency

The results show the potential for striking improvements in both accuracy and operational efficiency, using only a subset of the PTT questions currently being collected. On average, reweighting and simplifying could attain increases in accuracy between 8% and 34%, while at the same time reducing the number of questions from 30 to 13 for the families PTT and from 30 to 12 for the individuals PTT.

The results are intended to provide an illustration of potential gains in accuracy and operational efficiency through a *process* that incorporates data-driven methods and should not be interpreted as an explicit recommendation. Improving accuracy and operational efficiency are only two of the objectives that should be taken into account by a design process for improving the PTT. It is important that any reweighting, removal, or addition of questions also be evaluated with respect to additional objectives, such as information gathering, policy priorities, and fairness.

[55] We used a technique called *bootstrapping* (repeating our simulation 1,000 times) in order to estimate 95% confidence intervals.

Using Predictive Analytics to Efficiently Target Prevention Services

> ***Key Takeaway*:** We compared the single adults in Los Angeles County predicted by statistical models to be at highest risk of homelessness with the clients actually served by A5 prevention services. We found that only 23 individuals across Fiscal Years 2017-18 and 2018-19 were both identified by the predictive models and enrolled in an A5 prevention project. This suggests that there is a large number of high-risk County clients who are not currently connected to prevention resources and who could be reached by mainstream County departments. In addition, the high-risk individuals identified by the predictive models have much higher rates of mental health, physical health, and substance use issues, as well as histories of homelessness and criminal justice system involvement, when compared to the prevention clients served through A5 prevention.

Under Research Question 2, we also included an analysis of an underserved population of individuals who are at high-risk of homelessness. The targeting mechanism for existing A1 and A5 prevention services is largely driven by client self-identification (*i.e.*, clients must seek assistance from a prevention service provider), with further screening taking place via the PTT and related eligibility criteria. This raises the question, however, of whether there are potential clients who are unaware of prevention services, or are unable or unwilling to present themselves as being at-risk, who could potentially be identified and served. The use of *predictive analytics*—a field that applies statistical and machine learning methods to administrative data in order to predict future outcomes—provides an opportunity to identify such high-risk, underserved populations.

The California Policy Lab, in partnership with University of Chicago Urban Labs, has been working with the Los Angeles County Chief Information Office and Homeless Initiative to develop predictive analytics for identifying individuals and families at high risk of homelessness. The project applies statistical and machine learning techniques to approximately 10 years of linked administrative data from six County departments (Department of Health Services, Department of Mental Health, Department of Public Health-Substance Abuse Prevention and Control, Department of Public Social Services, Probation, and Sheriff), in addition to HMIS data, in order to identify, from among the approximately 6.5 million people who have had contact with County agencies, which clients are most at-risk of new homeless spells. In the most recent proof-of-concept results, the top 3,000 highest-risk single adults identified by the models—drawn from the population of 1.9 million single adults with County service histories—were approximately 27 times more

likely to experience a new homeless spell than the average Los Angeles County service utilizer, and approximately 48 times more likely to experience first-time homelessness.[56]

The lists of high-risk individuals identified by the predictive models can be used for *proactive outreach*. In other words, rather than waiting for clients to self-identify and present themselves to a service provider as being at-risk, as is the case with existing prevention strategies, caseworkers at County agencies could proactively reach out to their clients on the predicted risk list and potentially offer existing prevention resources or newly designed ones. This approach could potentially prevent hundreds or thousands of new homeless spells each year.

Although our predictive modeling is still in progress, we have consistently observed acute mental health, physical health, and substance use issues as well as histories of homelessness and criminal justice system involvement amongst adults predicted by the models to be at highest risk of homelessness. [57] In this section, we compare the single adults predicted by the models to be at highest risk of homelessness with the clients actually served by A5 prevention services to see how they might be similar or different.

Data

We use a data set containing N=1,266 single adults enrolled in A5 prevention across Fiscal Years 2017-18 and 2018-19. For those same fiscal years, we analyzed the top 3,000 single adults at highest risk of a new homeless spell according to the predictive models for HMIS homelessness. The resulting dataset, which we will refer to as the "Risk List," included N=5,556 single adults (with N=444 appearing on the risk list in both years).

[56] von Wachter, T., Bertrand, M., & Pollack, H. (Sept. 12, 2019) "Predicting and Preventing Homelessness in Los Angeles." California Policy Lab. Retrieved from https://www.capolicylab.org/predicting-preventing-homelessness-la/.

[57] Because we have not yet completed predictive modeling for families at-risk of homelessness, the analysis is restricted to single adults and A5 prevention services.

Figure 4.1. Overlap in Prevention Clients and Individuals on Predictive Analytics Risk List

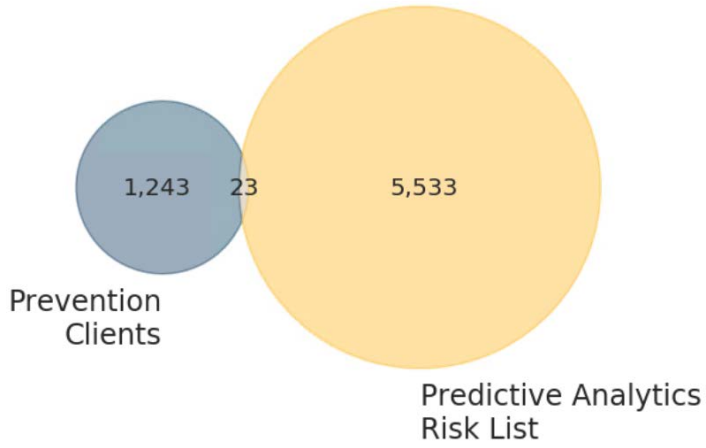


Figure 4.1 shows that **only 23 individuals** across Fiscal Years 2017-18 and 2018-19 were observed to be *both* on the Risk List *and* enrolled in an A5 prevention project. This suggests that there is a large number of high-risk County clients who are not currently connected to prevention resources. This should not be interpreted to mean that A5 clients are not high risk, but this does indicate that these are two separate groups who may need different identification strategies and different intervention points.

Prior Homelessness and Homelessness Outcomes for A5 Prevention Clients vs. Risk List Clients

Figure 4.2, below, shows that although a significant percentage of A5 prevention clients were previously homeless in the last five years (42.6%), a much higher percentage of the Risk List were previously homeless (86.5%), with much higher rates of enrollment in prior shelter and street outreach. A5 prevention clients were more likely to have prior enrollment in permanent supportive housing, permanent housing, or rapid re-housing (27.4% vs. 9.3% for Risk List clients). This reflects the importance of PTT questions, which prioritize individuals with prior enrollments in subsidized housing.

Figure 4.2. Prevention Clients and Individuals on Risk List, Homelessness in Prior Five Years

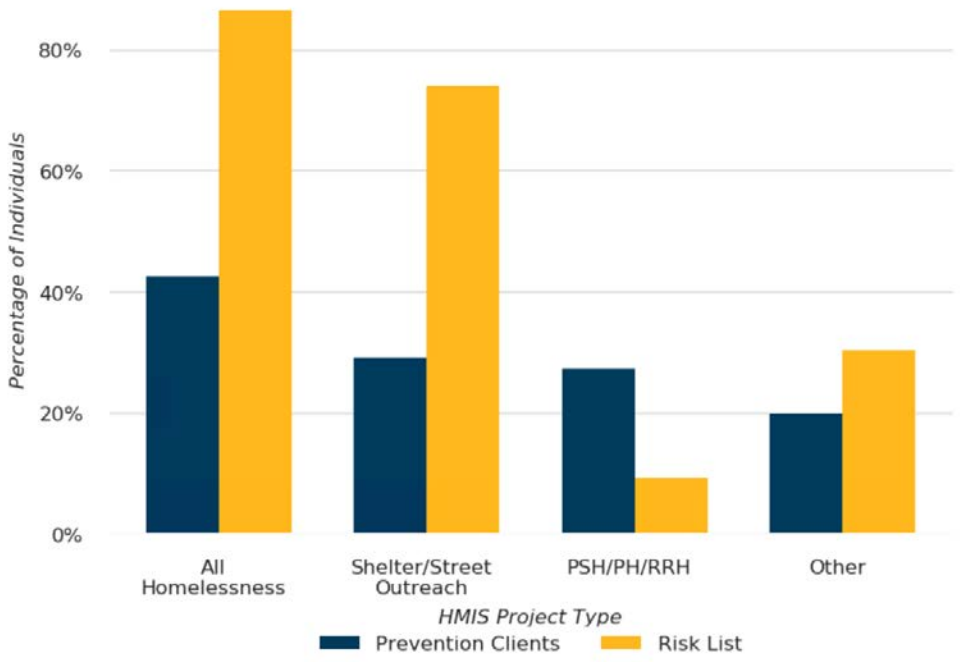
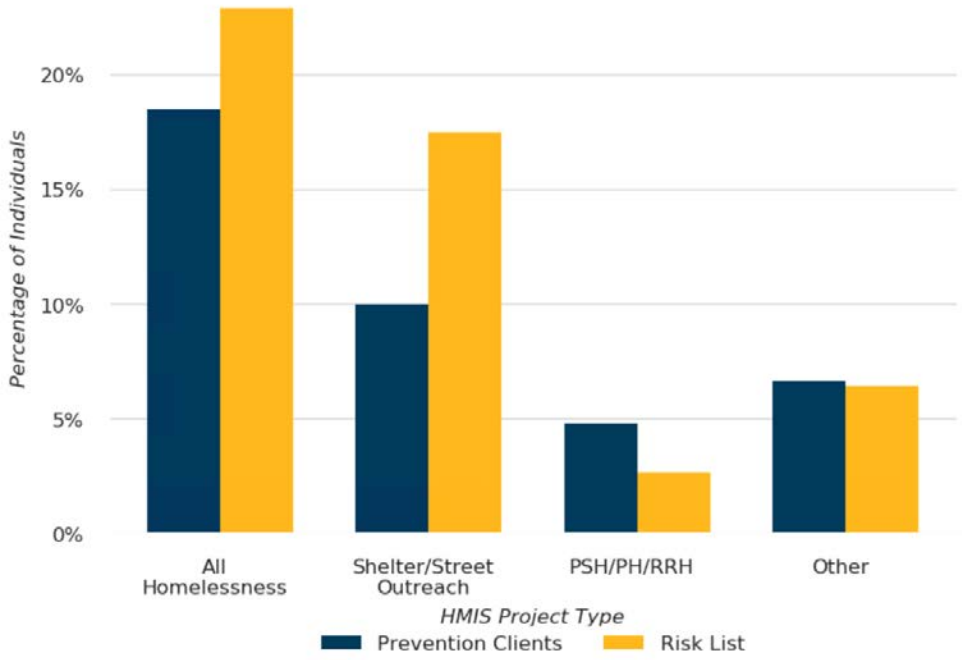


Figure 4.3, below, compares the risk of homelessness in the outcome period for the two groups, restricted to Fiscal Year 2017-18 to allow a 12-month outcome window. The two groups are at similar risk of new homeless spells, with 18.5% of A5 prevention clients becoming homeless in the 12 months following project enrollment and 22.9% of Risk List clients becoming homeless in the Fiscal Year 2017-18 outcome window. Risk List clients are more likely to utilize shelter or street outreach (17.5% vs. 10.0% for A5 prevention clients) and are slightly less likely to become enrolled in permanent supportive housing, permanent housing, or rapid re-housing (2.7% vs. 4.8%).

Figure 4.3. Prevention Clients and Individuals on Risk List, Homelessness in 12 Months Post-Enrollment or in 12 Month Outcome Window (Fiscal Year 2017-18 only)



Health, Mental Health, and Substance Use Issues amongst Individuals on Risk List

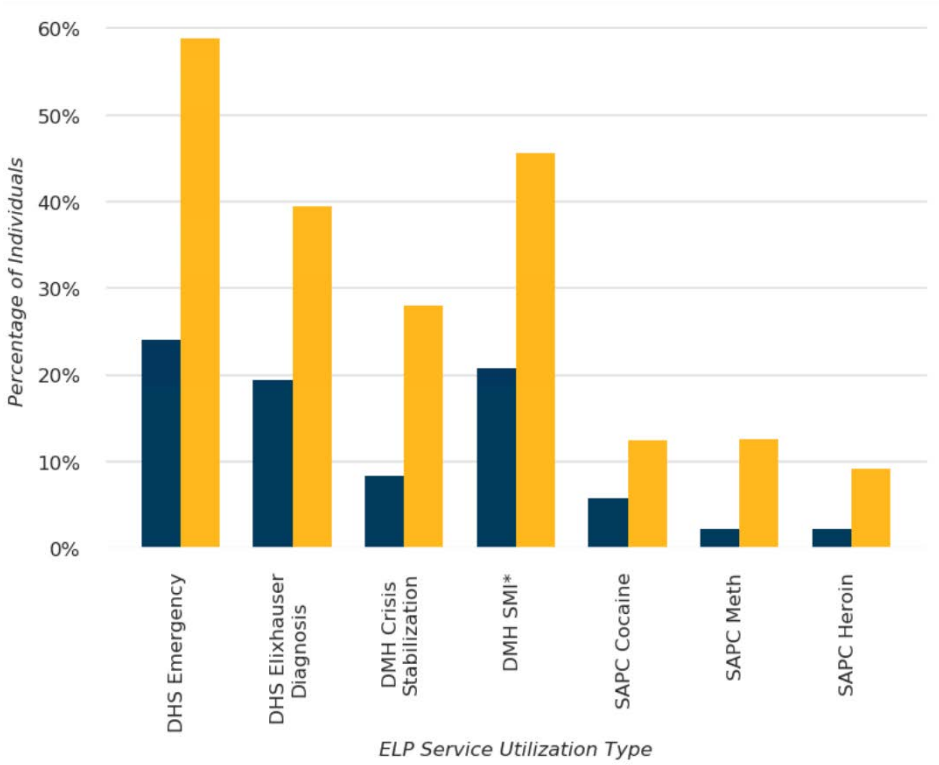
As reflected in Figures 4.4 through 4.6 below, when compared to A5 prevention clients, individuals on the Risk List are much more likely to exhibit acute health, mental health, and substance use issues, including:

- emergency room visits in Department of Health Services hospitals;
- medical diagnoses from the Elixhauser Comorbidity Index, comprising 31 conditions associated with patient mortality;[58]
- crisis stabilization episodes in Department of Health Services or Department of Mental Health facilities;
- diagnoses of Serious Mental Illness (SMI) and Department of Mental Health facilities (prior to calendar year 2016);
- enrollment in a Department of Public Health-Substance Abuse Prevention and Control treatment program with primary area of dependency being crack/cocaine, methamphetamines, or heroin.

[58] Menendez, M. E., Neuhaus, V., Van Dijk, C. N., & Ring, D. (2014). The Elixhauser comorbidity method outperforms the Charlson index in predicting inpatient death after orthopaedic surgery. *Clinical Orthopaedics and Related Research*, 472(9), 2878-2886. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4117875/.

Risk List clients are much more likely to have prior histories of homelessness according to the General Relief flag (70.8% vs. 36.3%) and CalFresh flag (82.5% vs. 40.2%) maintained in Department of Public Social Services benefit receipt data, and are much more likely to have had a prior arrest since calendar year 2016 for a misdemeanor (66.2% vs. 9.0%) or a felony (15.5% vs. 0.9%).

Figure 4.4. Prevention Clients and Individuals on Risk List, Key Risk Factors Reflected in ELP Service Utilization in Prior Five Years: Health, Mental Health, and Substance Abuse



Note: "SAPC" refers to Los Angeles County Substance Abuse Prevention and Control.

Figure 4.5. Prevention Clients and Individuals on Risk List, Key Risk Factors Reflected in ELP Service Utilization in Prior Five Years: Prior Homelessness According to DPSS Flags

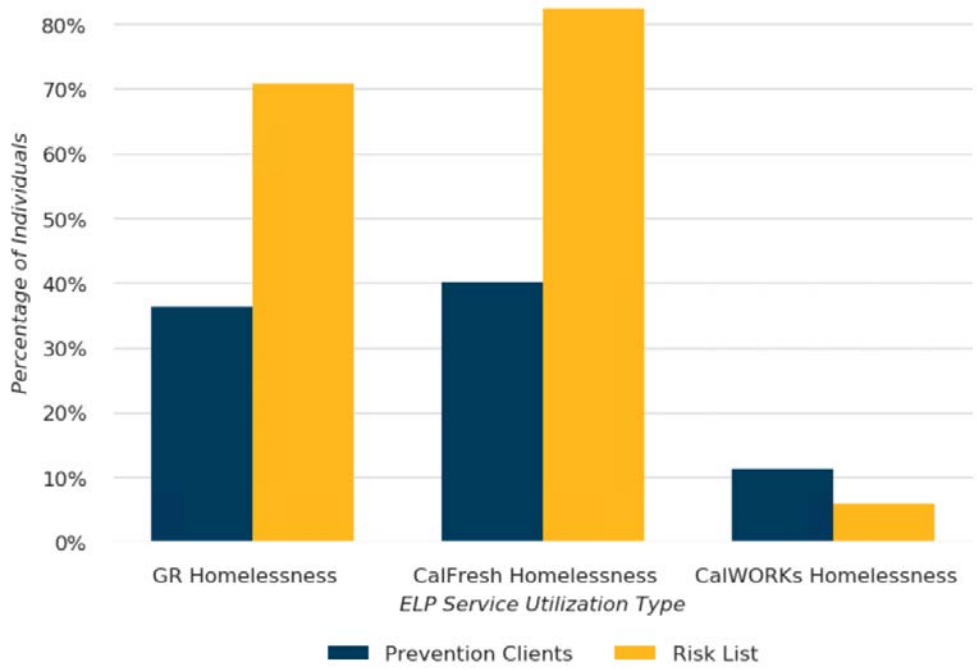
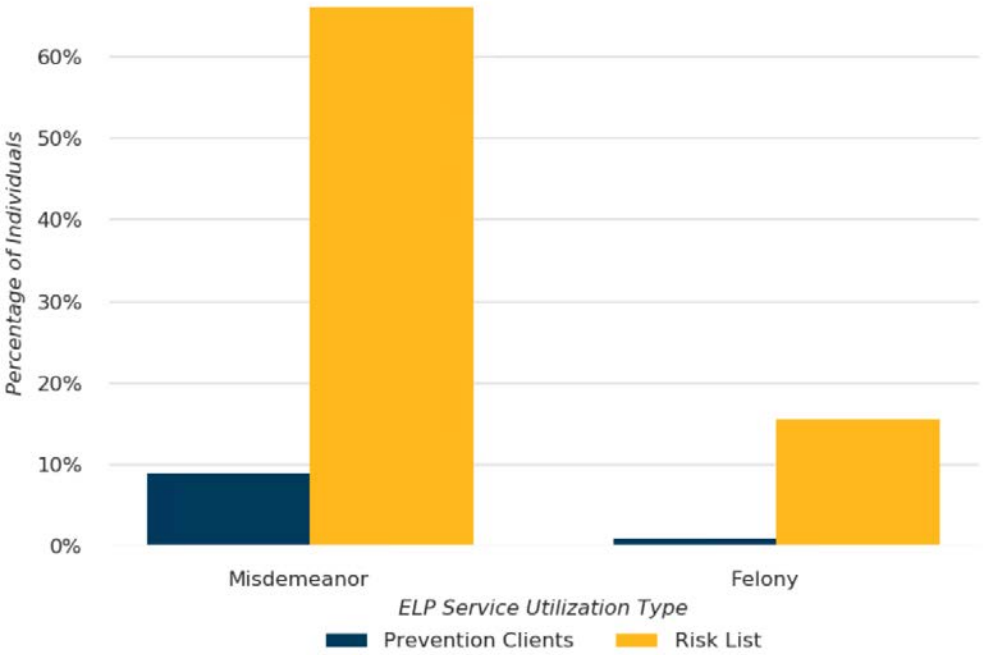


Figure 4.6. Prevention Clients and Individuals on Risk List, Key Risk Factors Reflected in ELP Service Utilization in Prior Five Years: Sheriff Arrest Charge Codes



Special Considerations for Designing Outreach and Prevention for County Service Utilizers at High Risk of Homelessness

The use of predictive analytics provides an important opportunity for identifying a population of individuals at high risk of new homeless spells who are not currently connected to existing prevention services. An intervention targeted at the top 3,000 highest-risk single adults could (if it works perfectly) prevent approximately 660 new homeless spells annually—a number that could potentially increase as the accuracy of the predictive models is improved with further research and development. The clients on the Risk List, however, have much higher rates of mental health, physical health, and substance use issues, as well as histories of homelessness and criminal justice system involvement, when compared to the prevention clients served through A5 prevention. The goal of traditional prevention services under A5 is to secure permanent housing through case management and potentially financial assistance. Traditional prevention services offered through the Coordinated Entry System are appropriate for individuals who are facing imminent loss of housing due to financial shocks. In contrast, clients on the Risk List are likely to need more intensive case management and access to interventions that address mental health issues, substance use disorders, and other issues. Because the population currently served by A5 prevention appears to have a different set of needs than Risk List clients (County service utilizers at highest risk of homelessness), a distinct prevention program or set of programs may need to be developed for Risk List clients.

5. Causal Analysis: Does prevention funded through Strategies A1 and A5 directly cause a reduction in inflows to homelessness? (Research Question 3)

> ***Key Takeaway:*** Because we could not retroactively identify plausible comparison groups, we could not estimate whether prevention is directly causing any reduction in inflows to homelessness. However, we offer some research design options that would allow for future impact evaluation.

Under Research Question 1, we describe prevention participants' housing status after exit, *i.e.*, what happened after individuals and families received prevention services. Under Research Question 3, we wanted to explore what *would have happened* if these individuals and families had not received prevention services: Would they have successfully self-resolved their housing crisis or would they have fallen into homelessness? As noted in *Section 1: Prior Studies on Homelessness Prevention Programs*, recent studies in Chicago and New York highlight the need to ensure that prevention programs are efficient, *i.e.*, target the highest risk families. In evaluating homelessness prevention programs, it is important to rigorously assess both effectiveness and efficiency and to not conflate the two. In other words, a homelessness prevention program that appears to be highly effective because enrollees do not experience homelessness in the outcome window might be inefficient if it targets people who are at very low risk. Consider the finding from *Section 3: Descriptive Analysis* of this report which shows that 14.5% of A1/A5 prevention clients served in Fiscal Year 2017-18 became homeless in the 12 months subsequent to enrollment. One cannot use this statistic to make inferences about the effectiveness of the program. Although 86.5% of clients did not become homeless, it is impossible to know whether this was due to the impact of the program, or if they would have successfully self-resolved in its absence. Similarly, the 14.5% rate of post-enrollment homelessness for A1/A5 prevention clients is considerably higher than the rate of homelessness among individuals in the ELP (*i.e.*, individuals who have accessed Los Angeles County services) which is less than 1%. It would not be valid to conclude, however, that A1/A5 prevention *increases* clients' risk of homelessness, since A1/A5 prevention clients have a much higher level of baseline risk than average Los Angeles County service users. To differentiate between effectiveness and efficiency, evaluators need to measure outcomes against a counterfactual—what would have happened without access to the prevention program.

We were unable to identify a comparison group using administrative data

One of the ways that researchers estimate the "counterfactual" - what would have happened to individuals or families if they had not participated in a program - is by comparing program participants with individuals or families who are very similar to program participants but who did not participate in the program, *i.e.*, a "comparison" or "control" group. By comparing the outcomes of this comparison group with the outcomes

of the program participants, researchers can estimate the impact of the program. The gold standard for this type of analysis is a randomized control trial, in which people who meet program eligibility requirements are randomly assigned to a treatment group (which receives program services) or a control group (which does not receive program services). Notably, the Homebase program was evaluated using a randomized control trial.[59] By randomizing individuals or families who meet program eligibility requirements to the treatment group or control group, researchers can ensure that outcomes of the participants and the comparison group are not attributable to anything other than participating in the program.

Randomization is not always feasible or advisable. When participation in a program is not randomized, then researchers need to estimate the impact of a program via an *observational study*, in which a control group is artificially identified in observational data (*e.g.*, administrative data such as ELP data or HMIS data). Treatment and control groups must not differ in some important, unobserved aspect that makes either group more or less likely to experience the outcome of interest (here, the outcome of interest is homelessness in the outcome period). In the case of A1 and A5 homelessness prevention, all program participants were at imminent risk of losing their housing. Thus, when identifying individuals and families who could serve as comparisons, it was important to try to find individuals and families who were also at imminent risk of losing their housing but who did not receive prevention services. Although the ELP data and HMIS data contain demographic information and service utilization information on individuals and families who could theoretically serve as comparisons, the most important characteristic – imminent risk of losing housing – is not captured in ELP data or HMIS service data. Thus, a plausible comparison group could not be identified using ELP or HMIS data.

Below, the research team describes two strategies it explored for observing a control group. While neither worked, we think the descriptions are useful for future planning. We conclude by offering a strategy for an impact evaluation of homelessness prevention in the near future.

Regression Discontinuity Design

An alternative way to measure the impact of a program is "regression discontinuity design." Under this method, the effect of prevention would be estimated by comparing individuals at the cut score (*i.e.*, "treatment" individuals who qualified for A1/A5 prevention because they met a minimum PTT score) with individuals just below the cut score (*i.e.*, "control" or "comparison" individuals who did not qualify for A1/A5 prevention because they scored just below the minimum score). Theoretically, the treatment and control individuals would be very similar in terms of risk of future homelessness, but there would be a very slight difference of one point in PTT score. A prerequisite for this design

[59] Rolston, H., Geyer, J., Locke, G., Metraux, S., & Treglia, D. (2013). Evaluation of Homebase community prevention program. *Final Report, Abt Associates Inc, June*, *6*, 2013.

would be that providers consistently administer the PTT and enter PTT scores for all individuals and families who apply for A1/A5 prevention services into the HMIS. Another prerequisite would be that a strict cutoff score be used to determine whether or not an individual or family receives prevention services. As discussed in Section 3, these prerequisites were not met during the time period evaluated here, likely because the tools were so new to service providers. Thus, we could not measure the impact of A1 and A5 prevention using regression discontinuity design.

A causal comparison of prevention participants who received financial assistance with prevention clients who did not receive financial assistance was not plausible

We also considered comparing participants enrolled in the "prevention" project type who received financial assistance with participants enrolled in the "prevention" project who did not receive financial assistance. (However, many service providers enrolled both *problem-solving/diversion* clients and *prevention* clients under the same general "prevention" project type in the HMIS. Thus, we cannot discern many *problem-solving/diversion* clients from *prevention* clients.) In other words, rather than estimating the impact of being enrolled in prevention, we would estimate the effect of receiving financial assistance as opposed to receiving case management only. However, the mechanism by which clients were assigned financial assistance is unclear. In order for the comparison between financially assisted and non-financially assisted clients to be valid, these clients would have to be at the same or very similar risk of future homelessness at the time of prevention enrollment. We found that individuals and families who did not receive financial assistance were more likely to be doubled-up and suspected that there were other characteristics not captured in the data that differentiated financially assisted and non-financially assisted clients.

Designing a Causal Analysis

For the reasons detailed above, we could not estimate the impact of prevention on homelessness outcomes. We offer some research design options that would allow for future impact evaluation. We recognize that a randomized control trial may not be possible because policymakers and service providers are often reluctant to screen individuals for prevention and then withhold services from individuals or families who qualify for prevention but who are randomly assigned to a comparison group. Thus, we propose two options that would not require randomization by service providers. First, regression discontinuity design (described above) would be possible if two criteria are met in the future: (1) providers consistently administer the PTT and enter PTT scores for all individuals and families who apply for prevention services into the HMIS, and (2) a strict cutoff score be used to determine whether or not an individual or family receives prevention services.

Second, prevention services targeted through the use of predictive analytics and delivered through a proactive outreach model – as described in Section 4 of this report – provide an opportunity for rigorous causal evaluation while avoiding some of the ethical and logistical concerns around traditional randomization at the case-worker level. For example, we could estimate the causal effect of reaching out to individuals on the list of high-risk County services utilizers. We would generate a list of individual County service utilizers who are at the highest risk of becoming homeless. We would then randomly select half of these highest-risk individuals for inclusion on an outreach list. Individuals on the outreach list would be connected to prevention services. We would then estimate the impact of being included on the outreach list by comparing homelessness outcomes for high-risk individuals included on the outreach list and high-risk individuals not included on the outreach list. In short, we could implement a randomized research design without the need for caseworkers to divert clients or withhold services at the point of contact. This option would not estimate the impact of A1 and A5 prevention on homelessness inflows, but it would estimate the impact of connecting high-risk County service utilizers with prevention services on homelessness inflows.

6. Report Summary and Key Takeaways

While Los Angeles County has successfully navigated homeless individuals into available housing and other services, the homeless population continues to grow as inflow outpaces exits to permanent housing. In 2019, despite the influx of Measure H services, the homeless population in Los Angeles County (as measured by the Greater Los Angeles Homeless Count) grew by 12%.[60] Homelessness prevention programs funded by Measure H aim to help at-risk individuals and families maintain housing stability and reduce the inflows into the homeless services system. This evaluation seeks to answer several important question about Measure-H funded prevention, including (1) who is being served and how, (2) how can those services be improved, and (3) is prevention reducing inflows to homelessness?

LAHSA contracts with homeless service providers to deliver prevention services to families, single adults, and transition-age youth who are imminently at-risk of becoming homeless. Prevention services last for up to six months and may include short-term financial assistance, mediation with landlords, housing stabilization planning, and legal assistance. The California Policy Lab evaluated Measure H-funded LAHSA prevention programs in Fiscal Years 2017-18 and 2018-19 (July 1, 2017 to June 30, 2019).

The California Policy Lab found that 1,321 single adult households, 1,368 family households, and 112 transition-age youth households received prevention during the study period. Of those, about 74% were given financial assistance, including rental assistance and utility arrears. The remainder (26%) were given case management. Over a third of prevention clients experienced homelessness in the five years before their enrollment. Once clients exited the program, 14.5% returned to homelessness within 12 months. The return rates, however, were very different for households who received financial assistance (5.3%) compared to those that did not (19.9%). Almost half of all households who enrolled in prevention move from a doubled-up living situation with family or friends to an unsubsidized rental. During interviews, service providers had a generally positive view of prevention. Providers most frequently pointed to rental arrears or rental assistance as the most beneficial program components, though we also observed frequent usage and widespread support for legal services.

The California Policy Lab identified potential ways to improve the prioritization and efficiency of prevention resources. As noted above, to determine if clients are experiencing an imminent housing crisis and are eligible for prevention services, service providers administer a screening survey called the Prevention Targeting Tool (PTT). We found that re-weighting the PTT and eliminating certain questions could increase the accuracy between 8% and 34%, while at the same time reducing the number of questions from 30 to

[60] LAHSA, "Greater Los Angeles Homeless Count Shows 12% Rise in Homelessness." (June 4, 2019), at https://www.lahsa.org/news?article=558-greater-los-angeles-homeless-count-shows-12-rise-in-homelessness.

13 for the Families PTT and from 30 to 12 for the Individuals PTT. The California Policy Lab also explored whether single adult County service utilizers who were predicted to be at high risk of homelessness in Fiscal Years 2017-18 and 2018-19 were being served by Measure H-funded prevention services during those years. We found that only 23 of the 5,556 single adult County service utilizers who were predicted to be at highest risk of homelessness were enrolled in Measure-H funded prevention. This should not be taken to suggest that clients served by A5 prevention services are not at high risk of homelessness. More likely, these populations are both at high risk of homelessness but were identified in different ways and have different observable risk factors. Specifically, the group identified by the predictive models appears to be disconnected from homelessness prevention resources and could benefit from proactive outreach by mainstream County departments.

The California Policy Lab also attempted to estimate whether prevention is directly causing reductions in inflows to homelessness. This type of analysis explores what *would* have happened to prevention clients if they hadn't been served: Would they have successfully self-resolved their housing crisis or would they have fallen into homelessness? Because we could not retroactively identify plausible comparison groups, we could not estimate whether prevention is directly causing any reduction in inflows to homelessness.

Policy Recommendations

Homelessness prevention is a relatively new program with scarce evidence to inform policy decisions and investments. While this evaluation furthers knowledge of prevention and those at-risk of homelessness, it does not answer all important questions. Nonetheless, the research team offers the recommendations below for consideration. We believe these suggestions would improve the impact of Measure-H funded prevention.

As noted above, the homelessness return rates were very different for households who received financial assistance (5.3%) compared to those that did not (19.9%). Although we could not establish a causal relationship between financial assistance and homelessness outcomes, providers most frequently pointed to forms of financial assistance as the most beneficial prevention program components. We thus recommend exploring ways to reduce administrative barriers to financial assistance. Options for reducing barriers may include educating landlords about their legal obligation to accept third-party checks, exploring ways to simplify documentation requirements (*i.e.*, the documents that a participant must submit in order to receive financial assistance), and encouraging service providers to provide financial assistance to all qualifying clients.

During interviews, service providers found the prevention program model to be relatively clear, but indicated confusion regarding problem-solving and its role in conjunction with prevention. In addition, in analyzing data for this evaluation, it was difficult for the research team to distinguish between prevention and problem-solving clients in administrative data. Additional training on the differences between prevention and problem-solving and when and how each should be used may be helpful to staff. To improve future research and evaluation, we recommend that administrative data clearly distinguish between prevention and problem-solving clients. We also recommend standardizing the way providers track services under each of these programs.

Legal service providers recommended closer coordination with homeless service providers, including co-location, regularly-scheduled and in-depth case conferences, more swift referrals, training service provider staff to better spot legal issues (or hiring an attorney on staff to spot legal issues), and expanding the universe of organizations permitted to make legal referrals. Legal service providers also noted that a public education campaign regarding how to respond to unlawful detainer complaints would be beneficial.

The accuracy and efficiency of the PTT screening tool could be improved by re-weighting the tool and eliminating certain questions. However, it may be premature to shorten the survey based on our analysis, and we recommended that LAHSA engage in a policy planning process to shorten the survey and then empirically validate the PTT by continuing to collect data and engaging in a continuous improvement process. Such efforts would require providers to consistently record PTT data, whether or not a person qualifies

for prevention services. Although, providers reported using the PTT consistently, this wasn't entirely supported by the administrative data.

As noted above, we found that only 23 individuals across Fiscal Years 2017-18 and 2018-19 were both identified as highest-risk County service utilizers by the predictive models and enrolled in Measure H-funded prevention. This should not be taken to suggest that prevention clients are not at high risk of homelessness. More likely, these populations are both at high risk of homelessness, but the group identified by the predictive models appears to be disconnected from homelessness prevention resources. Thus, high-risk County utilizers could benefit from proactive outreach. Because the population currently served by A5 prevention appears to have a different set of needs than County service utilizers at highest risk of homelessness, a distinct prevention program or set of programs should be developed for these individuals.

The California Policy Lab described prevention participants' housing status after receiving prevention services, but we were not able to estimate whether prevention is directly causing any reduction in inflows to homelessness. In particular, we were not able to ascertain that financial assistance helped to reduce homelessness. An estimation of the impact of prevention on inflows is vital to tackling homelessness in Los Angeles County. In order to estimate the impact of prevention on inflows, the County should consider options for future evaluations that could estimate the impact of prevention and its components on inflows.

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Appendix A: Problem-Solving Eligibility and Services Offered to Problem-Solving Clients

Problem-Solving – Eligibility

Eligibility for problem-solving depends on (1) homeless status and (2) income requirements, as detailed below.

Homeless Status

In order to qualify for problem-solving, individuals and families must be determined to be homeless or at imminent risk of homelessness or fleeing domestic violence (Categories 1, 2, & 4) per HUD's Final Rule on Defining Homeless (24.CFR parts 91,576 and 578).

Income Requirement

Participants must be determined to be income eligible by meeting an income threshold at or below 50% of the AMI for Los Angeles County. If a participant is in subsidized housing and currently or formerly under a homeless housing assistance program (*i.e.*, Homeless Section 8) with income up to 80% of the AMI, they can also qualify.

Problem-solving Services: Case Management and Supportive Services

Problem-solving consists of a combination of direct services and limited financial assistance (if needed) that case managers provide to participants for up to 30 days.[61]

Case Management

Problem-solving participants receive assistance with a range of activities, based on their needs, including:

- an initial conversation to explore their current situation and possible non-traditional alternatives;
- mediation and/or dispute resolution with their current or previous landlord, family, or friends; and/or
- referrals to mainstream services or other community resources.[62]

[61] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, at para. 18.
[62] LAHSA, 2018-2019 Problem-Solving Scope of Required Services.

Financial Assistance

Problem-solving participants may also receive limited financial assistance in the form of:

- security deposit;
- transportation (*e.g.*, automobile repair);
- grocery/food cards; and
- utility payment.[63]

[63] LAHSA, 2018-2019 Prevention & Diversion Scope of Required Services, Appendix IV, p. 20.

ATTACHMENT III

Los Angeles County Chief Executive Office—Research & Evaluation Services

Homeless Initiative Strategy E6: Countywide Outreach System

Implementation Evaluation

Prepared by:
RESOURCE DEVELOPMENT ASSOCIATES, December 2019

Los Angeles County Chief Executive Office—Research & Evaluation Services

Homeless Initiative Strategy E6: Countywide Outreach System

Implementation Evaluation

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RESOURCE DEVELOPMENT ASSOCIATES (RDA) developed this report under contract with the LA County Chief Executive Office.

RDA 2019

About RDA

RESOURCE DEVELOPMENT ASSOCIATES (RDA) is a consulting firm based in Oakland, California, that serves government and nonprofit organizations throughout California as well as other states. Our mission is to strengthen public and nonprofit efforts to promote social and economic justice for vulnerable populations. RDA supports its clients through an integrated approach to planning, grant writing, organizational development, and evaluation.

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Executive Summary

Context & Purpose for This Evaluation

In response to the humanitarian crisis of homelessness in Los Angeles County, in 2015 the Board of Supervisors (BOS) established the Los Angeles County Homeless Initiative (HI) within the Chief Executive Office (CEO). During the subsequent year, a collaborative planning process involving community and government partners resulted in a set of 47 Board-approved strategies reaching across sectors to provide a continuum of upstream (preventative), downstream (curative), and systems-level services and programs for persons experiencing or at risk of experiencing homelessness. In 2017, county voters approved a quarter-cent sales tax increase through Measure H, providing funding to expand implementation of these strategies through the HI.

Several of the approved strategies aim to create a more coordinated system of care, including Strategy E6: Countywide Outreach System. The intent of Strategy E6 is to create a coordinated and integrated network of street-based homeless outreach teams to identify, engage, and connect unsheltered individuals to interim and/or permanent housing and supportive services. The Los Angeles Homeless Services Authority (LAHSA) and other County agencies and departments began Strategy E6 implementation during the 2017/2018 fiscal year (FY 17/18).

HOMELESSNESS IN LA COUNTY

Homelessness in Los Angeles County reached crisis levels during the past decade. Between 2009 and 2019, the number of people living without shelter increased 54% from 28,644 to 44,214 people.

Although performance data show the County has housed more people experiencing homelessness than ever before, people are falling into homeless-ness at rates faster than the County can serve or house them.

PROCESS EVALUATION

A process evaluation studies the implementation for a program, network, or system. It answers *who*, *what*, *when*, and *where* questions. It also answers the question *how do inputs, activities, and outputs work together?*

The CEO's Research and Evaluation Services unit contracted with Resource Development Associates (RDA) to evaluate Strategy E6 implementation. The purpose of this process and implementation evaluation is to measure and describe the extent to which LA County has 1) implemented E6 activities as intended and 2) achieved E6 objectives. The Los Angeles Homeless Services Agency (LAHSA), the Department of Health Services (DHS), and the Department of Mental Health (DMH) formed the core E6 leadership team to collaboratively design and implement a regional system for outreach with the following key objectives:

1) Develop a robust and centralized data infrastructure to dispatch and track outreach activities and support cross-team collaboration	2) Expand outreach coordination within each Service Planning Area (SPA) and across the whole County through new Outreach Coordinator positions	3) Implement multidisciplinary outreach teams (MDT) to better meet the public service needs of unsheltered individuals
4) Expand community-based outreach personnel Countywide as well as entry points into the homeless system of care	5) Reach the hardest-to-serve individuals and those who frequently experience the highest levels of need	6) Assess and connect individuals to services that support their wellness, independence, and access to housing

Evaluation Methodology

RDA's rigorous evaluation design applies a mix of quantitative and qualitative methods grounded in community values, subject-matter expertise, and decades of public sector research experience. This evaluation's research framework incorporates three layers of analysis—systems-level, program-level, and individual-level—and outlines sets of questions within each of these frames. The evaluation team utilized the following mixed-methods data collection approaches and sources:

QUALITATIVE METHODS

1. Structured interviews with nine Strategy leadership and program managers

2. Structured focus groups with 95 outreach staff representing all County service areas and all types of outreach teams

3. Review of quarterly reports, LA County Point-in-Time (PIT) Counts, and other programmatic documents

4. Research of homeless outreach best and evidence-based practices

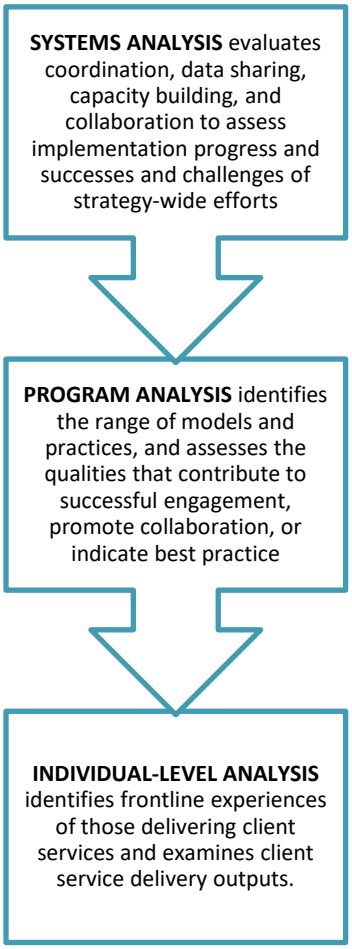
QUANTITATIVE METHODS

1. Data cleaning and descriptive analysis of 5M+ individual records from the homeless management information system (HMIS)

2. Analysis of aggregated outreach request data from the County's Homeless Outreach Portal (LA-HOP) outreach request data

3. Survey of leadership (n=68) measuring perceptions of system collaboration

4. Survey of frontline staff (n=200) evaluating overall strategy implementation, data utilization, and E6 culture



What is Homeless Outreach?

Homeless outreach is the face-to-face interaction with people who are experiencing homelessness in the streets, under freeways and bridges, in temporary motels or shelters, at meal and service sites, in libraries and public spaces, and wherever else a person may be located.[1] Effective homeless outreach involves a multi-pronged approach to service delivery, including a) providing direct services on-location, as opposed to inside the walls of an office or clinic; b) establishing and maintaining supportive relationships and connections with clients who may be disconnected or alienated from mainstream services, including homeless-specific services; c) addressing clients' real or perceived problems through access to needed treatment or supportive services; and d) educating clients about the resources, services, and supports available to them.[2] This framework for engaging with persons experiencing homelessness is well studied and a documented best practice. Outreach is an important component within the County's plan to help

[1] San Diego County, *Homeless Outreach Worker (HOW) Best Practices*, February 2018. Accessed from: https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/TRL/TRL%20Section%202/HOW_BestPractices.pdf
[2] Canadian Observatory on Homelessness, *Outreach,* 2019. Accessed from: https://www.homelesshub.ca/solutions/emergency-response/outreach

people prevent or end their experiences with homelessness, but it is only one of 51 strategies aimed at combating this crisis. Homeless outreach workers cannot end or resolve peoples' experience with homelessness; they cannot coerce people into services; they cannot move or force people to move away from publicly accessible spaces; and they cannot open shelter beds, build affordable housing, or facilitate pathways indoors when housing is unavailable.

Key Evaluation Findings

The RDA evaluation team systematically processed, categorized, and interpreted primary qualitative and quantitative data as well as secondary administrative data and documents to triangulate the key findings below. Results fall into four overarching themes: 1) System Coordination & Collaboration, 2) Outreach Practices, Training, & Staff Culture, 3) Data Sharing & Technology, and 4) Client Service Delivery.

System Coordination & Collaboration

OUTREACH PRIOR TO E6

Veteran staff and leadership characterized homeless outreach before E6 as disorganized, inefficient, and under-resourced. Documents suggest the County funded 10 teams with only 20 individual staff, although many individual cities and County agencies provided their own outreach services.

Before E6, requests for services frequently overlapped and resources deployed inefficiently. There was no means to coordinate by geography or by quantified need. Additionally, the County lacked the ability to understand the capacity, quantity, or availability of various outreach resources.

Finding 1. A high-functioning and collaborative leadership partnership between LAHSA, DHS, and DMH adopted a *systems change* approach to implementing new structures, processes, and dynamics in order to coordinate and direct the 200 teams delivering Strategy E6 homeless outreach services across the County.

Before E6, the structure and deployment of outreach across Los Angeles County represented the dynamics of an *unorganized system,* absent of a strategy to guide clear interactions between actors or parts, and lacking pathways for individuals to move forward or through it.[3] In contrasting *organized systems*, leaders plan and coordinate the activities of multiple teams or parts. Complex systems are adaptive; actors learn and co-evolve as they interact with one another and respond to changes in their environment.[4] *Systems change* interventions seek to transform complex behavioral patterns among actors and parts by changing the underlying system dynamics, structures, and conditions.[5] Given the scale of the unsheltered population, and the 10% increase from 2017 to 2019, and the complex dynamics between agencies, organizations, actors, and parts, Strategy E6 needed to adopt a *systems change* approach to develop a functional, organized, multi-sector network with capacity for a proportional and effective crisis response.[6]

A collaborative partnership between the LAHSA, DHS, and DMH lead the ongoing implementation of Strategy E6. Together with the HI, each of these three County departments lends its own expertise to

[3] Olson, E., and G. Eoyand. "Facilitating Organization Change: Lessons from Complexity Science." *Jossey-Bass/Pfeiffer*, 2001.
[4] Hargreaves, M. "Evaluating System Change." *Mathematica Policy Research, Inc.,* 2010.
[5] Eoyang, G. "Human Systems Dynamics: Complexity-based Approach to a Complex Evaluation." *Systems Concepts in Evaluation, American Evaluation Association,* 2007.
[6] 2017 unsheltered total of 40,082; 2019 unsheltered total of 44,214 (Los Angeles County Point-In-Time Count, LAHSA)

provide thought leadership, develop strategy, oversee and direct services, and provide continuous quality improvement to the network of providers and outreach staff. The leadership team attends monthly and quarterly collaboration meetings to identify and resolve on-the-ground issues in real time, monitor resource allocation, and identify opportunities for improvement. This leadership team also consolidated reporting for funders and community stakeholders. Each E6 agency oversees specific outreach teams:

AGENCY	TEAM	STAFF	DESCRIPTION
LAHSA	Homeless Engagement Teams (HET) & Coordinated Entry Teams (CES)	189.0 FTE	Generalist teams make initial contact with new clients and maintain regular engagement with ongoing clients through proactive outreach. Some teams operate with special populations (e.g., youth or veterans).
	Homeless Outreach and Proactive Engagement (HOPE)	15.0 FTE	Teams overseen by both LAHSA and the City of LA, consist of generalist outreach staff, Los Angeles Police Department (LAPD) staff, and LA Sanitation & Environment (LASAN) staff to serve clients impacted before and during encampment resolutions.
	Homeless Outreach Services Teams (HOST)	16.0 FTE	Generalist outreach staff collaborate with cities' law enforcement agencies to approach outreach using best practices.
DHS – Housing for Health	Multidisciplinary Teams (MDT) & Public Spaces Teams	330.0 FTE[7]	Five specialists representing physical health, mental health, substance use, case management, and peer support comprise the MDTs. Public Spaces teams maintain a visible and accessible presence in the County's public spaces, such as parks, plazas, or other gathering places.
DMH	Homeless Outreach and Mobile Engagement (HOME) Teams	125.5 FTE	Specialist teams provide psychiatric support, outreach, and intensive case management to persons experiencing homelessness with serious mental illness (SMI). Supports generalist teams as needed.

Finding 2. The new regional coordination structure developed by E6 leadership forms the central backbone of E6, with SPA coordinators rapidly liaising outreach requests and effectively deploying teams. This structure efficiently matches available resources to the observed needs of outreach clients.

Outreach coordinators in each SPA are responsible for providing tailored coordination for outreach services. A team of 19 full-time coordinators review, assess, and assign requests to specific teams at the SPA and sub-regional levels. This ensures resources deploy to the locations that are most needed. The data system automatically records the lifecycle of each request, including coordinators' assignments to specific teams, teams' actions to address each request, and the results of their actions.

Finding 3. Implementing the E6 network of over 200 outreach teams to connect persons experiencing unsheltered homelessness with the Coordinated Entry System and field-based services made every location in LA County a possible entry point into the homeless service system.

[7] 44 MDTs receive funding through Measure H, and 16 do not. 20 Public Spaces teams receive Measure H funding.

Prior to Strategy E6, there was no centralized way to collect or report the number of outreach staff or teams. E6 implementation enabled a centralized pathway for reporting and tracking outreach teams and staff. In addition to the outreach teams funded through blended and other sources, Measure H funds added new (or provided funding for continuing) generalist, multidisciplinary, and specialist outreach teams to the E6 network. There are now 200 teams under this strategy, of which more than half receive Measure H funding.

Strategy E6 plays a pivot role in the Coordinated Entry System (CES), which is a standardized process by which individuals and families experiencing or at-risk of homelessness can rapidly access, be assessed and prioritized for, and connect with appropriate housing resources and services. Within each of the eight SPAs, generalist, specialist, and multidisciplinary staff work in parallel to assess clients for service and housing needs, including administering the CES assessment tool. By ensuring the vast network of Countywide outreach teams are able to administer this tool, and by deploying these teams throughout all SPAs and regions, Strategy E6 made every location a possible entry point into the homeless service system.

Finding 4. The investment in collaborative planning strengthened outreach partnerships that enable the outreach system to flex to meet the service and care coordination needs of people experiencing unsheltered homelessness across LA County.

LA County did not have formal, centralized homeless outreach teams containing staff from multiple disciplines prior to Measure H and Strategy E6 implementation, but MDTs now provide a range of health services, intensive case management, peer support, and housing navigation on-location to clients out on the street. These teams provide a unique approach to addressing the cross-cutting needs of people experiencing homelessness while they are living unsheltered on the streets.

Finding 5. Measure H funds facilitate Strategy E6 coordination, enabling outreach teams across LA County—including teams that do not receive Measure H funds—to effectively coordinate as one organized system delivering street-based client services.

Measure H funded 19 Coordinator positions system-wide, which facilitated a new layer of coordination that is central to the outreach system's effective functioning. These positions monitor outreach requests and deploy the appropriate resources to resolve these requests. As a result, most frontline staff shared that an individual team's funding source does not impact the overall coordination, facilitation, and delivery of most client services. Some LAHSA teams receive Measure H funds and some do not; some DHS teams receive Measure H funds and some do not; no DMH teams receive Measure H funds; yet, the outreach teams coordinate as one singular, centralized system.

Finding 6. Collaboration pathways between homeless-serving agencies, law enforcement, and sanitation departments need to continue to be developed, refined, and strengthened. Without strong communication protocols with the E6 network, responses to safety and sanitation concerns at encampments can negatively impact client progress toward stability and housing.

The number of encampments is increasing with the number of people experiencing unsheltered homelessness across the County. Responding to encampment health and safety issues falls under the purview of a number of public services, including law enforcement and sanitation workers, who have become increasingly visible actors within the homeless outreach system. During events responding to these health and safety concerns, close collaboration between outreach, police, and sanitation workers is crucial to providing trauma-informed services to the people living in the affected areas. However, despite certain outreach teams being Measure-H funded collaborations between homeless-serving agencies and law enforcement with existing communication protocols, outreach teams across all SPAs report that the communication they receive from law enforcement can be inconsistent and lack a trauma-informed approach.

Similarly, E6 staff across the County shared that there are established communication protocols between sanitation agencies and outreach stakeholders, and that sanitation workers are supposed to provide advance notification of upcoming encampment clean-ups. However, outreach teams shared that sanitation agencies do not consistently follow the established protocols, which can result in teams being unable to support clients during encampment response events.

Data Sharing & Technology

Finding 7. LA-HOP is an innovative technology solution that enables efficient outreach request tracking; facilitates dynamic, street-based outreach response; and promotes improved E6 system coordination.

LAHSA directed efforts to develop an easy-to-use web-based tool for requesting homeless outreach services. In July 2018, LAHSA launched LA-HOP to facilitate the consolidation and coordination of homeless outreach requests. Since launching, LA-HOP has received over 10,000 unique requests. For the first time, County leadership can access this volume of data to drive homeless policy and decision making, whereas before, information about street-based homelessness was static, available only once per year, and frequently delayed by months. This new technological solution allows Strategy E6 to mobilize and coordinate outreach resources in proportion to emerging regional needs, and more effectively align the E6 outreach system with best practices. Not only does LA-HOP make Countywide outreach more accountable to people experiencing street-based homelessness, it increases accountability for all community stakeholders concerned about this crisis.

Finding 8. Strategy E6 improved system-wide data quality in HMIS by expanding access to this common tool, implementing data entry standards, and requiring frontline workers to document client services. However, the County does not have a process to monitor data quality or gain insight into further coaching or training needs to improve system-wide data capacity.

LA County uses a centralized HMIS to track contacts, services, and housing details and referrals for people experiencing homelessness. Prior to E6, many outreach teams used HMIS to document outreach services and activities, although some teams did not track data or services systematically. Other teams did not have access to the County's HMIS or were not required to use it. Strategy E6 implementation expanded access to this one documentation system across all outreach teams under all County departments. Despite expanded HMIS access, improved standards, and increased training, some E6 stakeholders reported that data capacity building is inconsistent across the E6 network and that there are discrepancies in data and documentation quality. Both frontline staff and E6 leadership shared that protocols—or adherence to protocols—for quality or timely entry of case notes varies by department, provider, team, or individual.

The evaluation team learned that Strategy E6 does not have system-wide measures for data quality assurance to ensure agencies, providers, teams, and staff follow consistent standards and protocols for documenting outreach services and activities. Without measures to monitor data quality, Strategy leadership cannot gain insight into HMIS coaching or further training needs to improve efficient documentation, data fluency, and quality client services.

Finding 9. E6 staff and leadership report that outreach data sharing practices for client care coordination adhere to privacy protection laws, but E6 leadership has not assessed the need for infrastructure improvements such as security controls for client data confidentiality and maximizing efficient referral tracking across disciplines.

All E6 staff receive training in client data privacy laws and report following these guidelines for sharing data while also finding ways to access information necessary for care coordination among teams. A core function of homeless outreach is to connect clients with needed services and resources, and systematic documentation and data monitoring practices are important to delivering efficient and high-quality services. However, conversations with frontline staff indicated that HMIS does not maximize efficiency for reliably tracking external service referrals and linkages. This makes it more difficult for E6 staff to coordinate and manage client care among teams. Many staff noted that although they experience frustration with HMIS limitations, they find other ways to coordinate care through case conferences, emails, phone calls, and team meetings. More than one E6 staff member suggested they use informal—or unauthorized—methods to access the information they need to do their job. A "doing whatever it takes" culture combined with imperfect data sharing platforms creates risk for client confidentiality.

Outreach Practices, Training, and Staff Culture

Finding 10. Countywide, Strategy E6 outreach workers employ both proactive (routine, scheduled) and reactive (response-oriented) strategies to engage as many people experiencing homelessness with services as possible. A benefit of this approach is prevention and early intervention of issues before they can escalate to other taxing and avoidable impacts on public systems.

Strategy leadership allocated E6 funding among SPAs according to the level of unsheltered need in order to distribute outreach resources across the County's many hot spots, geographies, and regions. Across all SPAs, Strategy E6 employs a two-pronged approach to conducting street-based outreach that includes the following proactive and reactive strategies:

PROACTIVE OUTREACH PROCESS

1. Staff visit clients on a planned, recurring schedule
2. Staff support clients in transition to ongoing engagement activities (such as developing personal wellness or housing goals and assessing needs)
3. Staff conduct clients' assessments, including the Coordinated Entry assessment, and provide services and referrals as needed
4. When possible, staff connect clients to interim housing or placement programs
5. Staff document activities in HMIS

REACTIVE OUTREACH PROCESS

1. Community member requests services in LA-HOP
2. System routes request to correct SPA
3. Coordinator assigns request to appropriate team
4. Team initiates at least two attempts to provide outreach services to clients
5. Staff provide services as during proactive outreach
6. Staff document activities in HMIS and close the LA-HOP request

These complementary approaches enable the E6 outreach network to connect and engage as many people experiencing homelessness with services as possible, while creating a direct pathway for members of the general public to request outreach on behalf of their unhoused neighbors.

Finding 11. System-wide trainings and learning collaboratives onboard new staff, support a client-centered culture, and help align outreach practices to best and evidence-based approaches.

Outreach workers from every department or agency under E6 participate in systematic, comprehensive, and required training on several evidence-based, self-care, and best outreach practices during a five-day orientation series that leadership offer twice a year to onboard new hires. Staff also attend monthly learning collaboratives as well as learning sessions on special topics. These training opportunities enable outreach workers to employ a range of approaches and practices to engaging clients. Many people who are living on the streets have experienced trauma, so they naturally approach new relationships with a good deal of caution. In addition, many people experiencing homelessness carry institutional trauma and mistrust of government systems, so a necessary first step in establishing a productive outreach relationship is to build trust with the client and understand the principles of trauma-informed services.

RDA reviewed the extant literature on best practices for homeless outreach, and various sections within this evaluation report illustrate that Strategy E6 has implemented outreach services that align with most best practices recognized by experts from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), United States Interagency Council on Homelessness (USICH), and the US Department of Housing and Urban Development (HUD). This report describes many best and evidence-based practices implemented by Strategy E6: [8]

Outreach Practice	Described in Evaluation Section:	
Coordinated Entry	Finding 3	System Coordination & Collaboration
Collaboration with Non-Traditional Partners	Finding 6	
Hot Spotting	Finding 7	Data Sharing & Technology
Data Sharing	Finding 8	
A Systematic, Documented Approach	Finding 8	
High Quality Data	Finding 8	
Housing First	Finding 11	Outreach Practices, Training, & Staff Culture
Diverse Approaches	Finding 11	
Person-Centered Services	Finding 11	
Motivational Interviewing	Finding 11	
Harm Reduction	Finding 12	
Warm Handoffs	Finding 15	Client Service Delivery

Finding 12. The absence of system-wide quality measures to ensure all providers and teams implement best practices is a barrier to consistent quality across the system. This gap emerges despite the system's approach to training in best and evidence-based practices. As a result, some E6 agencies, providers, and individual staff do not buy-in to implementing all best outreach practice models.

Some Strategy leadership voiced concerns that not all teams are implementing the principles of established outreach best practices, noting a range of organizational cultures among contracted providers, varying levels of professional experiences, and different personal experiences that inform their approaches to service delivery. A provider may attend an E6 training and translate practices back to their own organization or team in a way that fits their culture or service model, particularly with harm reduction approaches to working with homeless and at-risk populations, and there is no systemic accountability structure E6 leadership can leverage to encourage fidelity to best practices. As a result, individual staff members have different levels of buy-in; for example, staff noted inconsistent use of a harm reduction model across the E6 system. Despite extensive trainings on best practices, Strategy E6 has no system-wide quality measure to ensure training, retention, and consistent implementation of these practices. Assessing implementation quality is critical to understanding training opportunities and adherence to established system-wide approaches to providing client services.

[8] USICH, *Practices that Work: The Role of Outreach and Engagement in Ending Homelessness: Lessons Learned from SAMHSA's Expert Panel.* From https://www.usich.gov/resources/uploads/asset_library/Outreach_and_Engagement_Fact_Sheet_SAMHSA_USICH.pdf

Finding 13. Established best practices for continuous care during client transitions are not well coordinated with Strategy E6, causing system gaps. During transitions between the community, institutions, and care providers, system gaps lead to negative consequences and outcomes for persons experiencing homelessness.

There are established best practices for care coordination and case management for persons experiencing homelessness that are not well coordinated with Strategy E6, creating system gaps that can lead to negative outcomes during vulnerable client transitions between providers or levels of care. While short-term outreach often does not include case management, the housing shortage means that E6 clients are engaged in outreach services for months at a time, during which staff perform ad hoc case management, evidenced by the 9,000 case management activities E6 staff logged between FY 17/18 and FY 18/19. E6 stakeholders reported that institutions struggle to communicate the enrollment, intake, or discharge status of E6 clients to outreach staff via HMIS, which contributes to care coordination gaps. For example, when a person experiencing homelessness is booked into and then released from jail without an opportunity to connect or re-connect with E6 staff or services, that person may be more likely to experience a recidivating event. Other examples include challenges connecting with a new care teams, avoidable or repeat hospitalizations, and challenges adhering to rules or retaining permanent housing.

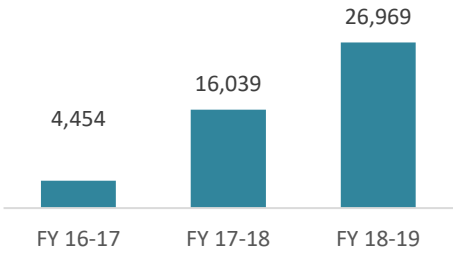
Finding 14. Regional differences in outreach travel times do not inform staff productivity targets. As a result, staff report a mismatch between their workloads and the tasks required to perform their job responsibilities and serve clients within normal working hours.

Staff from all SPAs reported that productivity targets set for outreach staff do not accommodate travel times for normal business activities, including the time it takes to find hard-to-reach clients and travel times to provide client services or provide rides between appointments, or the travel time to attend required administrative meetings. Staff who work in more remote areas of the County expressed greater frustration with meeting their productivity target expectations. Staff report that they document many outreach tasks and activities, but not travel time, which is often a large portion of their workday. Because staff travel times are not reported systematically, data are unavailable to inform productivity targets or shed light on regional travel differences among SPAs.

Client Service Delivery

Finding 15. Frontline outreach staff are serving more people experiencing homelessness than ever before, forming real human connections to help individuals achieve greater safety and stability, overcome personal barriers, and successfully navigate complex public systems.

Unique Individuals Served, Contacted, or Referred by Measure H-funded E6 teams



RDA received administrative data for E6 services funded through Measure H, including most generalist and multidisciplinary teams at LAHSA and DHS, but none of the teams under DMH or those funded through other sources. As a result, values represent only a portion of service outputs from across the outreach network. However, the trends is unmistakable. Outreach staff in LA County are contacting more people experiencing unsheltered housing crises than ever before, more people are engaging with public systems of care to receive the services they need, and more people are connecting to housing resources and supports. The number of clients served by Measure H-funded outreach steadily increased as implementation ramped up. In FY 16-17, prior to Measure H, outreach teams had some type of contact or provided some type of service to fewer than 5,000 individuals across Los Angeles County. In FY 18/19, year two of Measure H implementation, Measure H-funded teams connected with six times that many people (n=26,969).

E6 teams provide direct support services and resources, connections to external services and resources, and support to obtain important documentation and identification. Staff meet with clients to develop individual service and support plans, provide them with transportation to and from important appointments, and frequently accompany them to ensure they connect with their care teams and external providers. E6 teams provide case management and care coordination services, which is especially important for persons with complex physical health, mental health, and/or substance use needs. If they cannot address clients' needs in the field, staff refer them to other providers or County agency and provide "warm handoffs" for referred services. Warm handoffs are a best practice and central to homeless outreach, improving client service linkages, increasing trust in new providers, and improving outcomes.

Staff expressed deeply personal commitments to use individualized approaches to "meet clients where they are at" and help them walk the path towards better outcomes, including securing housing. A core strength of Strategy E6 is the deliberate effort to staff teams with individuals with lived experiences and backgrounds that match the County's unsheltered populations. Nearly half of all outreach staff claim some personal lived experience with homelessness, and across the board, E6 staff closely reflect the County's homeless population in terms of race and ethnicity.

EXAMPLES OF E6 SERVICES

- Face-to-face or phone contact
- Goal planning
- Provision of food & water
- Hygienic & basic supplies
- Emergency response
- Administration of first aid
- Motel/hotel vouchers
- Appointment scheduling assistance or accompaniment
- Transportation to or from appointments or vouchers
- CES assessment
- On-location counseling
- Family reunification
- Assistance with IDs, documents
- Assistance enrolling in public benefits
- Referrals to external services such as substance abuse or mental health treatment

Recommendations

RDA offers the following system-wide, program and practice, and client service delivery recommendations to improve efficiency and impact. Recommendations flow from the evaluation team's triangulation of primary qualitative, primary survey, and secondary qualitative data, as well as research on evidence-based and best practices in homeless outreach service delivery.

A. Align access to "flexible funds" for clients by establishing policies for all outreach teams that improve equitable access to resources across the outreach system (Finding 5).

Unequal access to resources that support client health and safety, such as flexible funds that cover expenses like administrative fees or hotel stays, causes imbalances among teams. Staff noted that staff and contracted providers under LAHSA or DHS follow looser requirements than DMH staff.

B. Continue to establish, refine, and strengthen collaboration protocols between homeless-serving, law enforcement, and sanitation agencies to support client service continuity as well as trauma-informed responses to public safety concerns (Finding 6).

Strengthening and reinforcing collaboration protocols (e.g. MOUs) with law enforcement, as well as continuing to offer training to law enforcement and sanitation agencies, can provide role clarity for each actor within this system, define trauma-informed escalation pathways for crisis situations involving clients, and enhance understanding about the purpose and function of outreach. Strong collaboration protocols between these partner agencies can prevent avoidable trauma and support ongoing engagement in homeless outreach services.

C. Continue to educate community stakeholders about the purpose and function of homeless outreach, including providing more nuanced information to LA-HOP requestors (Finding 7).

SPA Outreach Coordinators and E6 leadership noted that targeted promotion and education campaigns about LA-HOP and the system of outreach could address misperceptions about the role and function of outreach and help the community learn about the outreach system.

D. Implement HMIS data and documentation quality measures across E6 providers to identify ongoing training needs, build staff data capacity, and ensure consistently high-quality data (Finding 8).

Because stakeholders report inconsistent quality with HMIS data entry, Strategy leadership should consider implementing continuous quality improvement efforts and standard data quality assurance processes to ensure all providers are following consistent standards and protocols for using HMIS.

E. Assess client data sharing infrastructures, including tools for documenting service referrals and linkages, to gain insights about opportunities to improve system-wide efficiency (Finding 9).

An assessment of referral tracking tools would help determine which outreach data tools meet standards for efficiency, expediency, and client confidentiality. One suggestion is to explore the feasibility of

implementing a community health record across public services to automate provider notifications and referral tracking.

F. Support coordinated E6 practice trainings with coaching for E6 outreach staff and implement a fidelity or quality measure to ensure continuous improvement for delivering evidence-based and best practices (Finding 12).

Changing behaviors and beliefs is slow, steady work. Similarly, training without continuous monitoring and improvement efforts results in declining quality. The centralized, structured E6 orientations, learning collaboratives, and trainings reinforce best and evidence-based practices across the vast network of providers, but it is equally important to implement fidelity measures in order to ensure consistent service delivery that results in the expected client outcomes.

G. Fold CTI models and institutional in-reach (or pre-release planning) partnerships into Strategy E6 to support care coordination. This will help ensure that vulnerable individuals exiting institutions have warm hand-offs to coordinated entry services and that individuals moving into permanent housing have the support they need to stay housed (Finding 13).

Hospitals admit and discharge homeless patients every day, but there is currently no way for hospital staff to notify the homeless outreach service system that a vulnerable individual is heading back onto the streets. When law enforcement arrests and books into jail someone experiencing homelessness, that individual will still be homeless when they are released. Expanding HMIS access to hospitals, law enforcement agencies, and other institutional partners would support care coordination among these entities. Effective interagency crossover care makes possible best practices such as CTI, an empirically-supported intensive case management model developed specifically to prevent recurring experiences with unsheltered homelessness.

H. Track outreach travel time and ensure staff targets account for job-required travel (Finding 14).

E6 does not ask staff to track travel time for essential job functions, like the provision of client services. Enabling staff to provide travel time information and ensuring staff targets account for job-required travel will improve transparency between frontline staff and Strategy leadership and address concerns about unfair productivity targets, especially among staff who work in less dense areas of the County that require more time spent driving.

Considerations for the Next Phase of E6 Implementation

Because implementation of Strategy E6 is still in a formative stage, efforts to date have emphasized establishing effective collaborative partnerships, defining communication pathways and protocols, and promoting best practices across the Countywide system of homeless outreach. In the next phase of implementation, Strategy E6 leadership should continue to institutionalize and refine systems-level structures that support service quality, assure alignment between theories and practices, and sustain long-term influence and impact. This includes considering formal tools and structures to support Strategy E6 governance, including a charter, a unified mission statement, and/or a theory of action.

Strategy E6 is a systems change initiative that targets a deeply entrenched problem. To create and influence sustainable change at the systems and policy levels, E6 will need to ensure alignment across stakeholders, disciplines, viewpoints, and approaches to doing the work of homeless outreach. While Strategy leadership demonstrate strong internal partnerships that enable effective system-wide collaboration, Strategy E6 does not have an explicit theory of action or governance agreement to support a cohesive vision or sharpen planning and implementation efforts. These tools increase shared understanding of the problem that needs to be solved; the intended impact or outcome; the forces for change; external influences and risks; and the evidence basis for practices that lead to impact. Shared governance tools sustain system-wide culture and reinforce the practices that result in beneficial client outcomes. In the next phase of implementation, it will be important to codify the means to establish and hold partners accountable to a common goal and ensure the considerable investment in Strategy E6 stays on course.

Evaluation Report

Introduction

Background

In response to the humanitarian crisis of homelessness in Los Angeles County, in 2015 the Board of Supervisors (BOS) established the Los Angeles County Homeless Initiative (HI) within the Chief Executive Office (CEO). During the subsequent year, a collaborative planning process involving community and government partners resulted in a set of 47 Board-approved strategies reaching across sectors to provide a continuum of upstream (preventative), downstream (curative), and systems-level services and programs for persons experiencing or at risk of experiencing homelessness. In 2017, County voters approved Measure H, a $^1/_4$ percent sales tax increase, to implement these strategies through the HI.[9]

Several of the approved strategies aim to create a more coordinated system of care, including Strategy E6: Countywide Outreach System. With oversight from the HI, the Los Angeles Homeless Services Authority (LAHSA) and other County agencies and departments set out to implement integrated networks of multidisciplinary, street-based homeless outreach teams to identify, engage, and connect unsheltered individuals to interim and/or permanent housing and supportive services. The CEO's Research and Evaluation Services unit contracted with Resource Development Associates (RDA) to conduct an evaluation of the implementation of Strategy E6.

Strategy E6 is one of the strategies within *E: Create a Coordinated System.* The strategies that comprise this domain are intended to "maximize the efficacy of current programs and expenditures" by creating a "coordinated system which brings together homeless and mainstream services." Within this framework, the HI plan intended *Strategy E6: Countywide Outreach System* to develop and deploy a "network of multidisciplinary, integrated, street-based teams to identify, engage and connect, or re-connect, homeless individuals to interim and/or permanent housing and support services." Because Strategy E6 has "the greatest impact within the short- and medium-term," the HI selected it for the first wave of strategy implementation and evaluation.

Process and Implementation Evaluation Goals

This process evaluation, or implementation evaluation, is a formative study that seeks to measure whether Los Angeles County has implemented Strategy E6 activities as intended and measure the outputs and immediate results of implementation. This type of evaluation answers *who*, *what*, *when*, and *where* questions, such as:

[9] Measure H also added four more strategies to the original 47 for a total of 51.

- Who receives services from Strategy E6?
- What has occurred during implementation of Strategy E6?
- When and where did these activities occur?
- What are the barriers/facilitators to implementation of program activities?

RDA's research aims to discover the extent to which Strategy E6 implementation achieved the County's goals, described in Figure 1 on the following page.

Figure 1: Goals for the Implementation of Strategy E6

Develop a robust and centralized data infrastructure to dispatch and track outreach activities and support cross-team collaboration	Expand outreach coordination within each Service Planning Area (SPA) and across the whole County through new Outreach Coordinator positions	Implement multidisciplinary outreach teams (MDT) to better meet the public service needs of unsheltered individuals
Expand community-based outreach personnel Countywide as well as entry points into the homeless system of care	Reach the hardest-to-serve individuals and those who frequently experience the highest levels of need	Assess and connect individuals to services that support their wellness, independence, and access to housing

Structure of this Report

This report first describes the overall research approach, methods used for data collection and analysis, and an overview of Strategy E6 within the County's Homeless Initiative. The following section describes the evaluation results and findings. The report concludes with a summary of recommendations that the County may consider to improve the E6 system. Additional appendices provide more detailed information about key documents, plans, data, and figures that support the research conducted within this evaluation.

Figure 2: Structure of this Report

Methodology	✓ Describes how the team carried out the evaluation research ✓ Lists all sources of data, analytic approaches, and limitations
Homeless Initiative & Strategy E6	✓ Explains the role of E6 in the County's continuum of services ✓ Documents how and when Strategy E6 was implemented
Evaluation Results	✓ Presents key evaluation findings based on the analysis of data ✓ Provides evidence and explains the significance of findings
Recommendations	✓ Presents areas suggested areas for system improvement ✓ Describes steps to implement some recommendations

Evaluation Methodology

This process evaluation seeks to understand whether the implementation of Strategy E6 has achieved the intended goals, to uncover E6 system successes and challenges, and identify strengths and barriers.

Research Framework

RDA's rigorous evaluation design applies a mix of quantitative and qualitative methods grounded in community values, subject-matter expertise, and decades of public sector research experience. This evaluation's research framework incorporates three layers of analysis—systems-level, program-level, and individual-level—and outlines sets of questions within each of these frames. Taken holistically, this formative evaluation will provide the County with actionable knowledge for future policy decision making regarding Strategy E6. Appendix B details the full list of research questions and accompanying modes of data collection.

Figure 3: Evaluation Research Framework & Key Questions

SYSTEMS ANALYSIS: Evaluates coordination, data sharing, capacity building, and collaboration to provide useful data about implementation progress, successes, and challenges of strategy-wide efforts. Findings support Strategy-wide improvements to optimize the efficacy and efficiency.

To what extent are outreach partners effectively coordinating?	What are barriers and facilitators of effective coordination?	What specific structural changes or resources would further optimize the system?	To what extent do data sharing practices increase overall effectiveness?

PROGRAM ANALYSIS: Identifies the range of models and practices and assesses the qualities contributing to successful engagement, promote collaboration, or indicate best practice. Findings focus on referrals, service coordination, and direct client services to inform program improvement.

What practices and models of outreach are being implemented?	How do perceptions of effectiveness and existing practices align?	What additional resources or tools do staff need to fulfill their job responsibilities?	How do staff assess, record, and monitor clients' service needs?

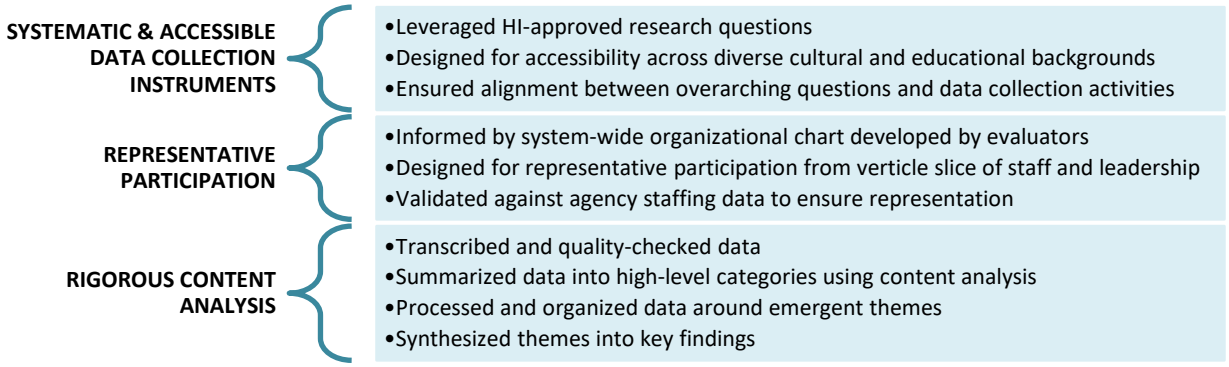
INDIVIDUAL-LEVEL ANALYSIS: Identifies frontline experiences of those delivering client services and examines client service delivery outputs. Findings facilitate connections between systemic and programmatic factors and individual experiences with outreach.

Who has accessed or engaged in outreach services?	Do clients experience greater access to services and resources as a result of engaging with outreach teams?	What practical changes will ensure Strategy E6 services reach the intended population?

Qualitative Methods

RDA evaluators engaged in primary data collection with a diverse group of Strategy E6 stakeholders to obtain qualitative insights about their experiences with the implementation of the E6 outreach network and also conducted a document review of pertinent E6 reports, publications, and internal documents. The evaluation team triangulated these qualitative data with quantitative and administrative data to assess E6 implementation and provide recommendations. The section below describes the specific qualitative data sources, collection methods, and analytic approaches utilized.

Figure 4: Qualitative Research Approach



RDA's research included the following qualitative data collection methods and sources:

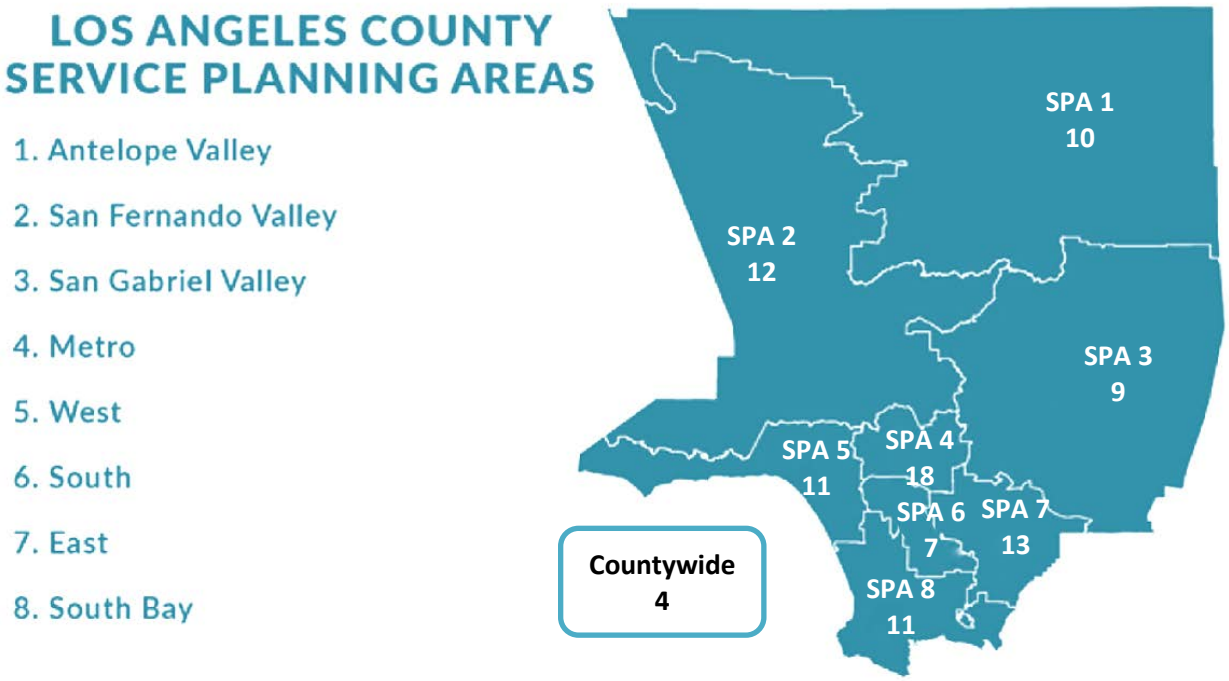
- **Key Informant Interviews.** The evaluation team conducted nine phone interviews with E6 leadership, program managers, and analysts from LAHSA, Department of Mental Health (DMH), Los Angeles County Executive Office's Homeless Initiative (HI), and Department of Health Services (DHS) to assess stakeholder experiences with E6 program design, program launch, and ongoing implementation. Conversations focused on lessons learned, facilitators of success, and barriers to implementation.
- **Focus Groups.** The evaluation team conducted seven focus groups with a total of 95 E6 staff members representing outreach teams across all SPAs. These focus groups included one session with SPA coordinators and six with frontline outreach staff. Participants responded to structured questions designed specifically for this evaluation, including questions about system-wide implementation, team dynamics, outreach practices, perceptions of client outcomes, and data utilization and management practices. With support from the E6 leadership team, the evaluators recruited focus group participants and aligned data collection activities with scheduled E6 staff trainings to ensure representative participation across a diverse pool of positions, teams, SPAs, and organizations. [10]

[10] At the time of writing, the evaluation team had planned, but not yet conducted, a final focus group with only outreach staff who also have lived experiences with homelessness. During the condensed timeframe for this evaluation, RDA faced challenges conducting primary research with persons currently experiencing homelessness and scheduled this additional data collection activity to vet, confirm, and further nuance the findings presented in this draft report.

- **Document Review.** The evaluation team reviewed quarterly reports, LA County Point-In-Time Counts (PIT), E6 presentation materials, and other programmatic documents including staffing lists and descriptions of service activities.
- **Best Practice Research.** The evaluation team researched best practices within the field of homeless outreach and service provision among vulnerable populations experiencing homelessness, and also studied evidence-based practices from relevant research literature.

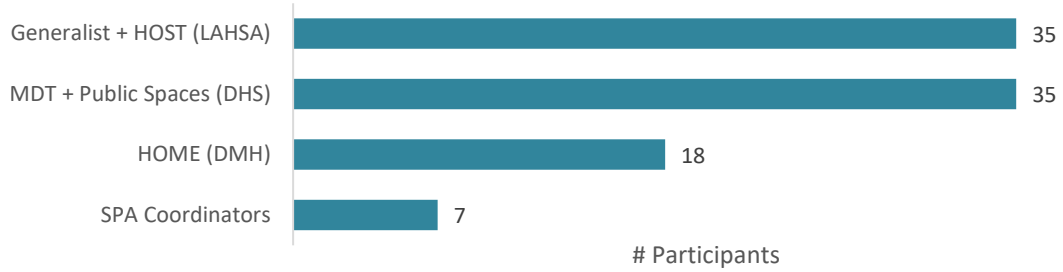
A wide range of positions, teams, community-based organizations (CBOs), and agencies attended these data collection activities. The figure below lays out the County's eight SPAs, and lists the number of E6 outreach staff that participated in focus groups for this evaluation.

Figure 5: Staff Focus Group Participation, by SPA (n=95)



The following chart illustrates staff participation in this evaluation's data collection.

Figure 6: Focus Group Participants, by Team Type (n=95)



Quantitative Methods

In addition to primary data collection, the evaluation team analyzed relevant administrative (quantitative) data to triangulate and nuance findings that emerged from qualitative research activities. This evaluation focused on key administrative data elements from the County's Homeless Management Information System (HMIS) and Homeless Outreach Portal (LA-HOP), as well as internal E6 programmatic data descriptions. In addition, RDA developed and administered two primary survey instruments: one for Strategy leadership and one for frontline staff. This section describes the specific quantitative data sources and analytic approaches.

Figure 7: Secondary Administrative & Quantitative Data Elements

HMIS	LA-HOP	E6 Data Definitions
•Client Demography •Services, Referrals, & Linkages •System Exits	•Number of Outreach Requests •Days until Request Close	•E6 Service Definitions •E6 Programs

RDA obtained de-identified HMIS data from the HI, then cleaned, analyzed, and aggregated data elements to describe E6 service outputs over time as well as the number and characteristics of E6 clients served. The evaluation team leveraged the following methods to analyze and synthesize findings:

- **Data Preparation and Quality Assurance.** The evaluation team cleaned and merged data across multiple tables, then scoped these data to include only E6 services using LAHSA's E6 service definitions and program list. The team manually corrected most data entry errors (e.g. spelling inconsistencies, incorrect time or date entries) and dropped outlying instances and duplicates.
- **Descriptive Statistics.** The evaluation team used descriptive analytic techniques to summarize client demographic characteristics, types of services received, service characteristics, and preliminary housing outcomes.
- **Inferential Statistics.** The evaluation team used a difference-in-means analysis to analyze any extant relationship between the provision of all E6 services, taken together, and system exits.[11] This statistical test compares the means of multiple independent groups to determine whether or not they are statistically significant. For this evaluation, the team constructed the test to determine whether any meaningful difference exists between a) the average E6 service engagement rates for clients who exited into housing, and b) the average E6 service engagement rates for clients who did not exit into housing.

In addition to secondary administrative data, RDA developed two survey instruments to collect primary quantitative data from both Strategy E6 leadership and frontline outreach staff. The evaluation team analyzed aggregated survey data and data specific to each SPA, then folded themes into relevant findings.

[11] One-way ANOVA tests the presence of a statistically significant difference between means of multiple unrelated groups.

Figure 8: Primary Survey Data

Leadership Collaboration Survey (n=68)	Outreach Staff Survey (n=200)
•Instrument leveraged multiple validated collaboration survey instruments to measure levels of collaboration across E6 leadership and agencies •Respondents included E6 Strategy leads, MDT leads, SPA outreach coordinators, LAHSA and DMH program managers, and other managers	•Instrument collected perspectives of frontline staff to evaluate overall strategy implementation, data utilization and management, and E6 team culture •Respondents included frontline outreach staff from all representative E6 agencies, team types, and SPAs

Limitations

The following limitations impacted data analysis and findings developed for this report.

- **Limited Timeframe of Secondary Data.** Secondary data sources span different time periods. Wherever possible, the evaluation team leveraged the most recent data available. Frequently within formative implementation studies like this, no comparable baseline dataset yet exists inform comparisons or conclusions.
- **Limited Client Demographic Variables.** To conduct this study, RDA requested data containing a diverse set of client demographic descriptors to analyze service provision and receipt. However, the individual-level dataset received contained gender data only and no other variables. This limited RDA's ability to analyze and report service outputs in relationship with demographic characteristics such as race, ethnicity, age, sexual orientation, chronicity, etc. Instead, RDA leveraged publicly available demographic reports on Measure H-funded E6 clients.
- **Service Output Data for Only Measure H-funded E6 Teams.** The service and referral data provided to RDA only included services provided by Measure H-funded E6 teams, and not the full range of homeless outreach teams in Los Angeles County. As a result, this study's quantitative analyses excludes work done by non-Measure H funded teams, including DMH outreach.
- **Varied Data Quality.** The evaluation team observed discrepancies within HMIS data, including varied usage of service nomenclature and descriptions. Although RDA corrected obvious errors and excluded outliers and duplicates from the analysis, qualitative data collected during this evaluation demonstrate that HMIS data quality and consistency are common challenges that limit the accuracy of service and administrative outputs.
- **Small Sample Sizes.** Participants represented a portion of the County's E6 staff. Because small sample sizes can yield unreliable or misrepresentative insights, wherever possible RDA combined secondary and primary data sources to develop more meaningful and accurate results.
- **Reliability of Self-reported Data.** Participants self-reported most primary data collected for this evaluation in surveys, focus groups, and interviews. Time lapses and recall discrepancies can lead to under- or over-reporting, and there is always a possibility that participants present themselves falsely or misrepresent their beliefs. To address this, evaluation findings present only themes that emerged across data collection rather than from just one or two reports.

Measuring Impact and Outcomes in the Future

A process evaluation studies the implementation for a program, network, or system. It answers *who*, *what*, *when*, and *where* questions. It also answers the question *how do inputs, activities, and outputs work together?* In short, process evaluation answers the question *how does the Strategy work?* while outcome evaluation, or impact evaluation, answers the question *does the Strategy work?* A full exploration of Strategy E6 outcomes, such as moving into stable housing and long-term housing retention, is outside the scope of this formative study. However, RDA conducted preliminary statistical testing to determine the feasibility of future efforts to study relationships between E6 outreach service engagement (dosage) and exits to stable housing (outcomes). RDA conducted a one-way ANOVA to determine if service engagement rates are significantly different between E6 clients in two distinct groups: E6 clients that ultimately moved into stable housing (n=1,651) and E6 clients that remained homeless (n=3,531). Using HMIS service data, the team developed a 'service dosage' dependent variable for E6 clients who received two or more E6 services spanning at least one month.

The test examined whether the average (mean) service dosages for these two groups demonstrate a statistically significant difference. Preliminary results of this test reflect that future efforts to study E6 services, for example impact or outcome evaluation, could provide meaningful insights into any relationships between E6 services and beneficial client outcomes like moving into stable housing. To do so effectively, future impact studies should examine different types of services that E6 clients receive (for example, differentiating between services intended to support successful move-ins and services that address immediate safety or emergency needs in the field) and also account for clients' vulnerability scores and/or prioritization in coordinated entry. Because the shortage of shelter and affordable units functions as a bottleneck to attaining housing across the County, future research that examines the impacts of Strategy E6 should account for the different prioritizations for housing that span the population of persons experiencing unsheltered homelessness in Los Angeles County.

Overview of the Homeless Initiative and Strategy E6

Over the past decade, the number of people experiencing homelessness in Los Angeles County reached crisis levels, particularly for people living without shelter. Between 2009 and 2019, the number of persons experiencing unsheltered homelessness on a single night anywhere in the County increased 54% from 28,644 to 44,214 persons. This is a statewide crisis that acutely affects California's largest metropolitan region. In 2018, California was home to nearly half of all people experiencing unsheltered homelessness in the United States (89,543 persons across the country), and nearly half of the state total (44%) were living somewhere without shelter in LA County (39,396 persons).[12,13] In 2019, the County's unsheltered population rose another 12% meaning more people across the County's many geographies—including urban, suburban, and desert regions—are living without access to indoor shelter and are, instead, living in tents, cars, RVs, or other places not meant for habitation. Although data show the County is successfully housing more people than ever before, people are falling into homelessness at rates faster than the County can serve and house them. This context underscores the importance of recent planning and implementation efforts to address the crisis.

Homeless Initiative: Approved Strategies to Combat Homelessness

In August 2015, the Los Angeles County Board of Supervisors (BOS) commissioned the Homeless Initiative (HI) to develop a plan to combat the Countywide crisis. That year, the HI conducted 18 policy summits on nine topics, bringing together 25 County departments, 30 of the County's 87 cities, other public agencies, and over 100 community-based partners, organizations, and stakeholders. These summits resulted in a strategic plan to address the growing crisis of people experiencing homelessness. In February 2016, the BOS approved 47 coordinated strategies to develop and implement the systems and partnerships needed to carry out this response. [14] In March 2017, Los Angeles County voters approved Measure H, a quarter percent sales tax increase to fund the implementation of these approved strategies, with oversight from the HI. The funding supports the County's efforts to address and prevent homelessness in the following domains: A) Prevent Homelessness, B) Subsidize Housing, C) Increase Income, D) Provide Case Management Services, E) Create a Coordinated System, and F) Increase Affordable & Homeless Housing.

Strategy E6 is one of the strategies within *E: Create a Coordinated System.* The strategies that comprise this domain are intended to "maximize the efficacy of current programs and expenditures" by creating a "coordinated system which brings together homeless and mainstream services." Within this framework, the HI plan intended *Strategy E6: Countywide Outreach System* to develop and deploy a "network of multidisciplinary, integrated, street-based teams to identify, engage and connect, or re-connect, homeless individuals to interim and/or permanent housing and support services." Because Strategy E6 has "the greatest impact within the short- and medium-term," the HI selected it for the first wave of strategy implementation and evaluation.

[12] HUD Office of Community Planning and Development, The 2018 Annual Homeless Assessment Report (AHAR) to Congress Part 1: Point-in-Time Estimates of Homelessness, Dec 2018. https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf
[13] LAHSA Greater Los Angeles Homeless Count: 2009, 2018, and 2019 Results. Accessed from: https://www.lahsa.org/
[14] The first set of recommended strategies totaled 47, and the Measure H ordinance added four more for a total of 51.

What is Homeless Outreach?

Homeless outreach in LA County "aims to locate, identify, and build relationships with people experiencing homelessness who are unsheltered and/or street-based to engage them for the purpose of providing immediate support, linkages to services, and connections with housing navigation resources aimed at ending homelessness." It is the face-to-face interaction with people who are experiencing homelessness in the streets, under freeways and bridges, in libraries and public spaces, and wherever else a person may be located.[15] Effective homeless outreach involves a multi-pronged approach to service delivery, including a) providing direct services on-location, as opposed to inside the walls of an office or clinic; b) establishing and maintaining supportive relationships and connections with clients who may be disconnected or alienated from mainstream services, including homeless-specific services; c) addressing clients' real or perceived problems through access to needed treatment or supportive services; and d) educating clients about the resources, services, and supports available to them.[16]

This framework for engaging with persons experiencing homelessness is well studied. The United States Interagency Council on Homelessness (USICH) partnered with several other federal agencies to identify and publish the following best practices for homeless outreach and engagement initiatives (Figure 9).[17]

Figure 9: USICH Core Elements of Effective Street Outreach

Coordinated Service Delivery	"Housing First" Focus	Person-Centered & Trauma-Informed Approaches	Safety & Harm Reduction Emphasis
•Coordinates among various providers and agencies for comprehensive coverage across entire community •Connects clients to coordinated entry into housing placement using HMIS and a vulnerability assessment	•Connects clients to stable housing with support services when matched •Promotes any connections to shelter or housing when sought by the client •Does not impose preconditions to refer to housing resource when requested	•Focuses on an individual's strengths and resourcefulness •Makes repeated offers of assistance as necessary to engage •Endeavors to be respectful and responsive to the beliefs, practices, culture, and other needs of clients	•Implements protocols to ensure safety of all individuals seeking assistance •Promotes non-judgmental and non-coercive provision of all services and resources •Accepts that not all individuals will be open to assistance initially

Homeless outreach is the central topic examined within this report, but it is important to note that outreach is only one component within a continuum of strategies and initiatives that, when implemented together, aim to combat this humanitarian crisis. In and of itself, outreach alone can neither resolve nor end unsheltered homelessness in Los Angeles County.

[15] San Diego County, *Homeless Outreach Worker (HOW) Best Practices*, February 2018. Accessed from: https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/TRL/TRL%20Section%202/HOW_BestPractices.pdf
[16] Canadian Observatory on Homelessness, *Outreach,* 2019. Accessed from: https://www.homelesshub.ca/solutions/emergency-response/outreach
[17] USICH, *Core Elements of Effective Street Outreach to People Experiencing Homelessness,* June 2019: https://www.usich.gov/resources/uploads/asset_library/Core-Components-of-Outreach-2019.pdf

SPOTLIGHT: THE PURPOSE AND FUNCTION OF HOMELESS OUTREACH

The purpose of homeless outreach is to provide face-to-face services at the locations where people are experiencing homelessness; its function is to establish supportive human relationships that foster ongoing service engagement, provide or facilitate access to needed services and resources, and, whenever possible, support clients in moving into stable housing. This framework for engaging with persons experiencing homelessness is a documented best practice for engaging vulnerable, unhoused, and difficult-to-reach individuals who need services and supports.

RDA's conversations with Los Angeles County stakeholders and decision-makers demonstrate that community members frequently misunderstand the purpose and function of homeless outreach. Outreach is a very important component within the County's plan to help people prevent or end their experiences with homelessness, but it is only one of 51 strategies aimed at combating this crisis. The plan includes eight strategies to subsidize housing and make it more affordable, six strategies to increase incomes for persons experiencing or at risk of homelessness, and six strategies to increase the inventory of affordable and homeless-specific housing. For Strategy E6, the housing shortage creates a bottleneck restricting how many people successfully find a pathway off the streets.

As much as outreach workers try to make a difference in the lives of people experiencing homelessness on the streets, under freeways and bridges, in temporary motels and shelters, at meal and service sites, in libraries and public spaces, and in any other unsheltered areas of Los Angeles County, there are things homeless outreach cannot do. For example, outreach cannot coerce people into services; it cannot move or force people to move away from publicly accessible spaces; and it cannot open shelter beds, build affordable housing, or facilitate immediate pathways indoors when there are not accessible housing options.

> *"One of the biggest counterproductive issues we deal with is that general constituents across the County think we have a magic wand. If they report street-based homelessness through the LA-HOP portal, they think the next day that person won't be on the street. Folks are very uneducated on what outreach does or can and cannot do." -E6 Leadership*

The implementation and effectiveness of other HI strategies, such as increasing the supply of housing and rental subsidies, impact what outreach can help homeless clients achieve; but community understanding of the purpose and function of outreach impact their perceptions of E6 effectiveness.

As discussed in later sections of this report, implementing more outreach teams and the online request system increased visibility of the County's response to homelessness. For many public stakeholders, outreach may be the only visible part of the County's broad continuum of initiatives and strategies. It is not surprising, then, that when frustrated residents witness peoples' ongoing suffering on the streets and in their neighborhoods, they might misattribute this to be a failure of outreach, or they might believe there are too many outreach workers who have nothing to do. These misperceptions loom over the impactful efforts of Strategy E6: the trusting relationships outreach workers build with clients, the ongoing client engagement E6 staff maintain, and the connections to necessary services that prevent issues from escalating until they become taxing to public systems.

> *"We need more compassion from elected officials as far as understanding how or what homelessness is really about – the outreach, impact, trust, desire to make things happen, and change." -E6 Staff*

Stakeholders who participated in this study expressed concern that misperceptions about outreach may threaten continued Strategy E6 funding, which is not within the scope of this research to evaluate. However, both frontline staff and leadership identified a need to expand education and share more information about the purpose of homeless outreach. This evaluation aims to provide valuable insight about outreach in Los Angeles County, describe outputs and immediate outcomes of Strategy E6 implementation, and provide recommendations to improve system coordination and outreach practices across the Countywide system.

Outreach Prior to Strategy E6

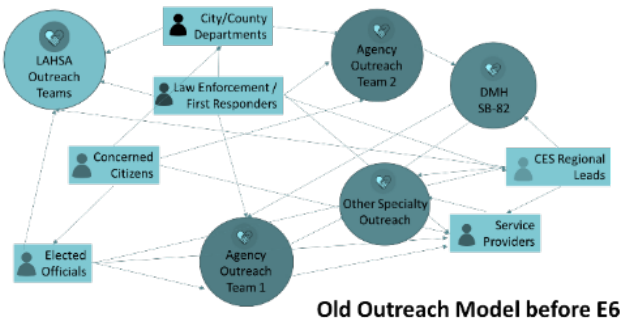
The primary purpose of this evaluation is to understand the relevant outputs and immediate outcomes of Strategy E6 efforts implemented at the systems-, program- and individual client-level. Some of the learnings will emerge as successes and some as challenges that will need to be resolved to fully implement Strategy E6 and to understand its impact. RDA researched the structure and deployment of homeless outreach services before and after implementation to demonstrate the extent to which Measure H funds and Strategy E6 have transformed homeless outreach across the County.

> *It was a convoluted system. Typically, an elected [official's] staff member would send out an email asking for outreach to respond to a constituent complaint. Multiple agencies would send staff since there was no way to see if someone had already responded.*
>
> *-E6 Leadership*

Before the County implemented Strategy E6, veteran staff and leadership generally characterized the system of outreach as disorganized, inefficient, and under-resourced. While precise counts of all homeless outreach teams and staff prior to E6 implementation are impossible, documentation suggests that the County only funded about 10 teams containing about 20 individual staff to conduct homeless outreach. Leadership reported that in addition to these County teams, cities and agencies funded their own outreach teams, but that they worked in silos and lacked infrastructure to communicate or coordinate services. In response to local crises and community-driven complaints, city officials, County department leaders, and elected officials mobilized outreach responses. Requests for outreach services came into multiple departments or teams simultaneously via the same political connections. This led to inefficient and redundant deployment of outreach resources; staff lacked the ability to coordinate so multiple teams would see each other responding to the same request. E6 leadership recalled that incoming requests for outreach would come through various simultaneous means, including emails, 2-1-1 calls, direct phone calls, text messages, etc.

Prior to E6 implementation, there was no means to coordinate outreach resources geographically or in relationship to quantified regional needs. Veteran outreach staff recounted long travel times when responding to outreach requests in another region or SPA, because requests came in and staff deployed without regard to location. The old "system" was inefficient and uncoordinated. Additionally, as mentioned above, the County lacked comprehensive information about the capacity, quantity, or availability of outreach staff across the County's cities and departments. Without a centralized inventory of full-time equivalent staff (FTE), Strategy leadership and veteran outreach staff recalled that outreach resources were spotty and disorganized. For example, the most impacted urban areas of the County, such as Skid Row

Figure 10: Leadership Illustration of Homeless Outreach Prior to Strategy Implementation



Old Outreach Model before E6

and downtown LA, had high concentrations of outreach staff but other hot spots in the County had comparatively little, or none at all.

It was not just the number of staff or teams that were difficult to quantify; staff that oversaw homeless outreach prior to Strategy E6 shared there was not adequate data to quantify how many services outreach staff provided or the number of people they contacted. Departments and teams used different systems to track and monitor their services, or did not use a system at all. The lack of shared tools for centralized data collection and management contributed to service duplication, inconsistent outreach methods and practices, competition for resources, and service gaps across the County.

Strategy E6 Implementation

Strategy E6 is one of the eleven strategies selected for the first phase of HI implementation because of its potential for impact in the short- and medium-term. The process officially commenced in June 2016, and a stakeholder-engaged planning process for Strategy E6 implementation began in October 2016. This process involved leadership from the HI, LAHSA, DHS, and DMH.

> *Before E6, we couldn't answer anything about outreach. We didn't know how many teams there were or how many people were being helped.*
>
> *-E6 Leadership*

The HI plan contained minimal descriptive or prescriptive language to guide implementation, recommending that LAHSA, "in conjunction with relevant County agencies and community-based organizations, develop and implement a plan to leverage current outreach efforts and create a Countywide network of multidisciplinary, integrated street-based teams to identify, engage and connect, or re-connect, homeless individuals to interim and/or permanent housing and supportive services."

The plan listed the collaborating partners and agencies (Table 1), calling for: a) at least one multidisciplinary team per Service Planning Area (SPA); b) specialization in transition-age youth (TAY), veterans, victims of domestic violence, and families; c) a "telephone hotline" to connect teams with service and housing coordinators; d) emulation of a local outreach model with intensive case management services; and, e) awareness of domestic violence protocols.

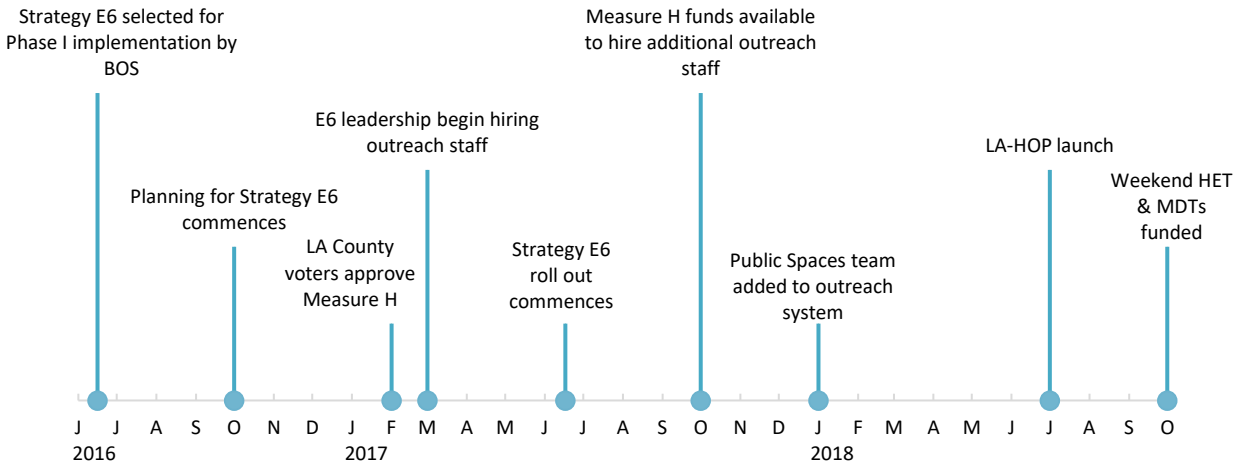
Table 1: Strategy E6 Collaborating Departments and Agencies, as Described in the HI Plan

LAHSA *Lead Agency*	Health Services	Mental Health	Probation	Public Health	Social Services	Sheriff & Fire	City of LA & any of the other 87 cities	United Way

Ultimately, LAHSA, DHS, and DMH formed the core of the E6 leadership team and, working together, leaders from each of these agencies designed a regional system to conduct outreach services. The system they designed incorporated innovative technological tools and a mix of generalist, multidisciplinary, and specialty teams to address the most pressing needs facing people experiencing street-based homelessness. As of September 2019, over 100 outreach teams funded through Measure H and nearly 100 more funded through other (or blended) sources spanned the County's eight SPAs. Among these 200

outreach teams, at least 60 are multidisciplinary (MDTs). Measure H also funded the development and implementation of a public-facing online ticketing portal to coordinate and deploy outreach resources above and beyond the "hotline" described in the initial plan. As described in detail throughout this report, the E6 system in place today exceeds the HI plan's minimal requirements. Over a short period of a few years, Strategy E6 leadership scaled the capacity of the outreach system to cover the County's expansive geography and hot spots of persons experiencing homelessness. The following figure outlines additional implementation milestones for Strategy E6.

Figure 11: Strategy E6 Implementation Timeline



Key Evaluation Findings

The RDA evaluation team systematically processed, categorized, and interpreted primary qualitative and quantitative data as well as secondary administrative program data and documents to triangulate the key findings presented below. This process evaluation identifies system outputs and formative implementation results at the systems-, program-, and individual client-level. Some findings indicate implementation successes and strengths, and others indicate barriers to implementation and opportunities for system improvement. Evaluation results fall into four overarching themes:

1) *System Coordination & Collaboration*
2) *Outreach Practices, Training, & Staff Culture*
3) *Data Sharing & Technology*
4) *Client Service Delivery*

System Coordination & Collaboration

Coordination and collaboration are two of the most critical elements to any social sector systems change initiative, because effective interagency partnerships and relationships ultimately define system-wide dynamics between leadership, formal and informal partners, participating agencies, teams, and individual staff. The following section describes findings relating to system-wide factors.

Finding 1. A high-functioning and collaborative leadership partnership between LAHSA, DHS, and DMH adopted a *systems change* approach to implementing new structures, processes, and dynamics in order to coordinate and direct the 200 teams delivering Strategy E6 homeless outreach services across the County.

Before E6, the structure and deployment of outreach across Los Angeles County represented the dynamics of an *unorganized system,* absent of a strategy to guide clear interactions between actors or parts, and lacking pathways for individuals to move forward or through it.[18] In contrasting *organized systems*, leaders plan and coordinate the activities of multiple teams or parts. Complex systems are adaptive; actors learn and co-evolve as they interact with one another and respond to changes in their environment.[19] *Systems change* interventions seek to change complex behavioral patterns among actors and parts by changing the underlying system dynamics, structures, and conditions.[20] Given the scale of the unsheltered homelessness crisis in Los Angeles County and the 10% increase between 2017 and 2019, and the complex dynamics between agencies, organizations, actors, and parts, Strategy E6 needed to adopt this *systems change* lens in order to develop a functional, organized, multi-sector network with the capacity for a proportional and effective crisis response.[21]

[18] Olson, E., and G. Eoyand. "Facilitating Organization Change: Lessons from Complexity Science." *Jossey-Bass/Pfeiffer*, 2001.
[19] Hargreaves, M. "Evaluating System Change." *Mathematica Policy Research, Inc.,* 2010.
[20] Eoyang, G. "Human Systems Dynamics: Complexity-based Approach to a Complex Evaluation." *Systems Concepts in Evaluation, American Evaluation Association,* 2007.
[21] 2017 unsheltered total of 40,082; 2019 unsheltered total of 44,214 (Los Angeles County Point-In-Time Count, LAHSA)

A collaborative partnership between the LAHSA, DHS, and DMH lead the ongoing implementation of Strategy E6. Together with the HI, each of these three County departments lends its own expertise to provide thought leadership, develop strategy, oversee and direct services, and provide continuous quality improvement to the network of providers and outreach staff. The leadership team attends monthly collaboration meetings to identify and resolve on-the-ground issues in real time, monitor resource allocation, and identify opportunities for improvement. Also, E6 leadership consolidated reporting to funders and community stakeholders. In general, specific departments support specific outreach team types, described below in Table 2.

Table 2: E6 Agencies & Outreach Team Types

AGENCY	TEAM	STAFF	DESCRIPTION
LAHSA	Generalist Homeless Engagement Teams (HET) & Coordinated Entry Teams (CES)	189.0 FTE	Generalist teams make initial contact with new clients and maintain regular engagement with ongoing clients through proactive outreach. Some teams operate with special populations (e.g., youth or veterans).
	Homeless Outreach and Proactive Engagement (HOPE)	15.0 FTE	Teams overseen by both LAHSA and the City of LA, consist of generalist outreach staff, Los Angeles Police Department (LAPD) staff, and LA Sanitation & Environment (LASAN) staff to serve clients impacted before and during encampment resolutions.
	Homeless Outreach Services Teams (HOST)	16.0 FTE	Generalist outreach staff collaborate with LAPD to approach outreach using best practices. HOST Regional teams include generalist outreach staff working in collaboration with other city police departments.
DHS – Housing for Health	Multidisciplinary Teams (MDT) & Public Spaces Teams	330.0 FTE[22]	Five specialists representing physical health, mental health, substance use, case management, and peer support comprise the MDTs. Public Spaces teams maintain a visible and accessible presence in LA County's public spaces, such as parks, plazas, or other gathering places.
DMH	Homeless Outreach and Mobile Engagement (HOME) Teams	125.5 FTE	Specialist teams provide psychiatric support, outreach, and intensive case management to persons experiencing homelessness with serious mental illness (SMI). Supports generalist teams as needed.

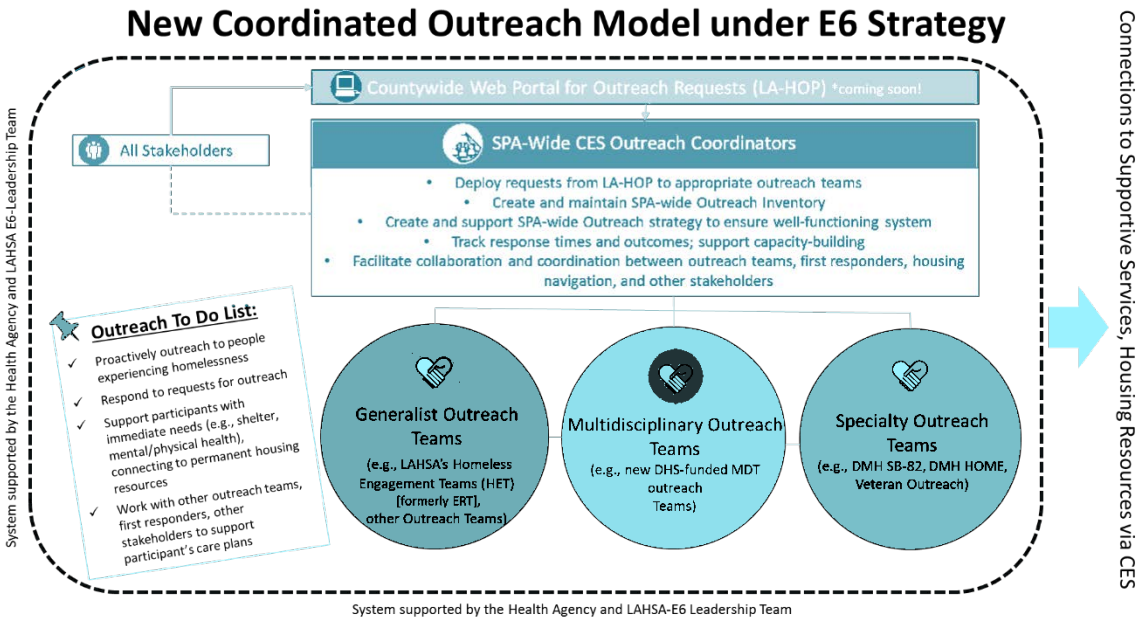
RDA implemented a survey instrument for E6 leadership to measure levels of collaboration among the E6 leadership and other leaders and managers, including MDT leads, SPA outreach coordinators, program managers, and senior leaders from other County departments. These leadership stakeholders demonstrate strong clarity of purpose, with 85% agreeing that E6 leadership are motivated and inspired, and 82% agreeing that E6 invests the right amount of time in implementation and coordination efforts. Even more (90%) agree that their organization benefits from participation in Strategy E6.

Both leadership and frontline staff consistently remarked that the outreach structures impacting people experiencing homelessness in Los Angeles County are now more streamlined across agencies than ever

[22] 44 MDTs receive funding through Measure H, and 16 do not. 20 Public Spaces teams receive Measure H funding.

before, because all agencies now use *one system structure;* a common client data management system is the pillar to consistent processes, documentation protocols, and communication across departments. This structure facilitates coordinated care and service delivery for people experiencing unsheltered homelessness anywhere in the County, regardless of their particular conditions or needs. The new structure is notably different from the uncoordinated silos that existed before E6. The shared ownership between LAHSA, DHS, and DMH results in all E6 agencies using the same interdisciplinary training protocols, onboarding procedures, and external reporting. The network of outreach staff, training protocols, and communication processes reflect strong coordination among these departments. Figure 12 is a slide from a 2018 presentation delivered by Strategy leadership, illustrating their vision for a coordinated outreach system model.

Figure 12: Leadership Illustration of Strategy E6 Coordinated Outreach Model



Strategy E6 partner agencies also now demonstrate *improved system dynamics;* leadership partners institutionalized collaborative decision-making and oversight for the entire E6 system, as well as unified staff training and protocols for service delivery and documentation. The scope of collaboration expands beyond these three departments and includes stakeholder participation by law enforcement, sanitation, various CBOs, hospital systems, universities, cities and their elected officials, parks and recreation, public works, and other actors. This level of coordination and collaboration mirrors the kind of network mobilization that is common during disaster or emergency response. Because patterns of activity at one level within a system influence—and

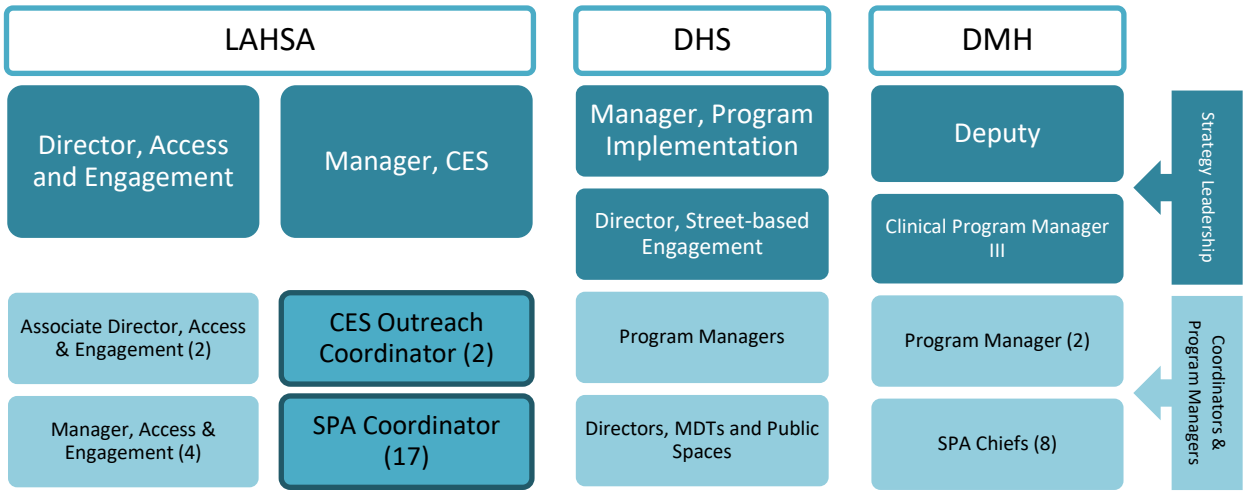
> *E6 created a structure. We now have team leads, MDTs, boots on the ground, and specialty services. It created a structure for each SPA to meet, collaborate, and to provide assistance. Before, we didn't have any of that and no team was obligated to work together.*
>
> *-E6 Outreach Staff*

are influenced by—patterns at other levels, systems change efforts are both scalable and replicable.[23] The Strategy E6 approach to fostering systems change is a model that can be replicated upstream within other parts of the County's homeless service system and policy decision-makers, and it can also be replicated in other regions, systems of care, or public health crises.

Finding 2. The new regional coordination structure developed by E6 leadership forms the central backbone of E6, with SPA coordinators rapidly liaising outreach requests and effectively deploying teams. This structure efficiently matches available resources to the observed needs of outreach clients.

Strategy E6 leadership leveraged Measure H funding to add an important layer to address the sprawling geographic region it is responsible for serving. Los Angeles County's 4,300 square miles are divided into eight Service Planning Areas (SPAs) to allow County departments to better match services to the specific needs of the residents in each of these areas. Outreach coordinators in each SPA are responsible for providing tailored coordination for outreach services within their specific geographic areas. E6 leadership and coordinators divided some larger SPAs into sub-regional quadrants to further refine service delivery to clients.

Figure 13: Strategy E6 Leadership and Coordination Structure



The SPA outreach coordinators, in combination with the new Los Angeles Homeless Outreach Portal (LA-HOP), form an effective system for monitoring and resolving outreach requests on a broad scale. A team of 17 full-time SPA coordinators review, assess, and assign requests to specific teams at the SPA and sub-regional levels. The system automatically records the lifecycle of each request, including coordinators' assignments to specific teams, teams' actions to address each request, and the results of their actions. This record provides valuable data about process and time required to find and initiate client contact, as

[23] Von Bertalanffy, L. "General Systems Theory." *Main Currents in Modern Thought*, vol. 11, 1955, pp. 75-83

well as the outcomes of requests. LAHSA customized dashboards that summarize LA-HOP data for monitoring and quality assurance of outreach coordination. These real-time data enable the allocation of outreach resources when and where they are needed most, at both the coordination and leadership layers. This dual approach to coordination maximizes efficiency as well as entry points into the homeless service system.

Finding 3. Implementing the E6 network of over 200 outreach teams to connect persons experiencing unsheltered homelessness with the Coordinated Entry System and field-based services made every location in LA County a possible entry point into the homeless service system.

Prior to Strategy E6, there was no centralized way to collect or report the number of outreach staff or teams existed. Implementation enabled a centralized pathway for reporting and tracking outreach teams and staff. In addition to the outreach teams funded through blended and other sources, Measure H funds added new (or provided funding for continuing) generalist, multidisciplinary, and specialist outreach teams to the E6 network. There are now 200 teams under this strategy, of which more than half receive Measure H funding. At the time of writing, Strategy E6 has deployed 34 generalist teams, 44 multidisciplinary teams, and 31.5 specialist teams using Measure H funds. [24] All of the 200 teams receive training in outreach best practices to contact and engage people experiencing street-based homelessness, then either address those needs on-location or provide links to other service providers through referrals and follow-up supports that help clients form connections with external providers.

Strategy leadership allocated Measure H funds to teams in each SPA according to the level of need, based on the Point-In-Time unsheltered count. Within each of the eight SPAs, and in some cases across the entire County, generalist, specialist, and multidisciplinary staff work in parallel coordination to assess clients for service and housing needs, including administering the County's standard assessment for Coordinated Entry. For this evaluation, RDA developed a system-wide organizational chart to describe the entire network, including leadership, coordination, program management, and the division of teams funded by Measure H as well as those funded through blended or other sources (see Appendix F).

BEST PRACTICE: Coordinated Entry

The primary goal of coordinated entry is for housing resources and services to be allocated as effectively and fairly as possible, and that the entry process be accessible no matter where or how people first connect with the homeless service system. Most communities lack the resources needed to meet all the needs of all people experiencing homelessness, which can result in severe hardships for individuals and families; coordinated entry systems (CES) help communities prioritize assistance based on vulnerability and severity of need.

Strategy E6 is the front door to coordinated entry in Los Angeles County. All E6 frontline staff receive training to administer the CES assessment tool, so the deployment of outreach teams Countywide dramatically expanded access to the homeless service system.

Strategy E6 is an important part of the County's Coordinated Entry System (CES). CES is a standardized process by which individuals and families experiencing or at-risk of homelessness can rapidly access, be

[24] Generalist teams refer to the HETs and specialty teams include Public Spaces, HOST, and C3 teams.

assessed and prioritized for, and connect with appropriate housing resources and services. The U.S. Department of Housing and Urban Development (HUD) and the State of California have long recognized the necessity of CES for effectively matching the most intensive available resources to the people with the highest needs. Both HUD and State funding require local homeless service systems to establish and operate a local process for coordinated entry, and in Los Angeles County, E6 outreach staff receive training to administer the CES assessment and prioritization tool called the VI-SPDAT. By ensuring the vast network of Countywide outreach teams are able to administer this tool, and by deploying these teams throughout the County's SPAs and regions, Strategy E6 made every location a possible entry point into the homeless service system.

Finding 4. The investment in collaborative planning strengthened outreach partnerships that enable the outreach system to flex to meet the service and care coordination needs of people experiencing unsheltered homelessness across LA County.

The establishment of MDTs is a cornerstone of Strategy E6 implementation. MDTs address a range of client needs including physical health care, social services and case management, mental health, substance use, and housing navigation, overseen by the DHS – Housing for Health unit. These teams provide a unique approach to addressing the cross-cutting needs of people experiencing homelessness while they are living unsheltered on the streets. Contracted CBOs staff the MDTs, with each representing five different disciplines including physical health, mental health, substance use, generalist support, and peer support. Outreach staff frequently spotlighted the specialized expertise provided by these MDT staff members throughout data collection. Staff across SPAs agree that these interdisciplinary MDTs have the expertise needed to provide and link clients to needed services, particularly among staff who provide outreach services in SPAs 1, 3, 5, and 8.

Los Angeles County did not have formal, centralized homeless outreach teams containing staff from multiple disciplines prior to Measure H and Strategy E6 implementation, but MDTs now provide a range of health services, intensive case management, peer support, and housing navigation on-location to clients out on the street. This prevents clients from having to report to an office or clinic for treatment or support, which can be a barrier to service engagement for those who are hardest to serve.

These teams "meet people where they are at," both literally and as far as their health needs take them. MDTs, as well as all E6 outreach staff, keep clients engaged in services by providing person-centered services that support their wellness and safety. Outreach staff who participated in this evaluation reflected that the strong partnerships among the generalist, multidisciplinary, and specialty teams are essential to maintaining ongoing engagement. Both staff and leadership reported that leadership adds more teams to the E6 system, such as the recent additions of the weekend teams and public spaces teams, as outreach

> *This is a good approach. You have folks to address specialties like mental health, substance use, and physical health. Our medical staff is amazing. They make clients feel so at home.*
>
> *-E6 Outreach Staff*

needs emerge throughout the County. These team additions strengthen the overall effectiveness of the Strategy by maintaining capacity for a proportional crisis response and visibility within the community.

Finding 5. Measure H funds facilitate Strategy E6 coordination, enabling outreach teams across Los Angeles County—including teams that do not receive Measure H funds—to effectively coordinate as one organized system delivering street-based client services.

As discussed above, Measure H funds facilitated a new layer of coordination that is central to the outreach system's effective functioning. As a result, most frontline staff shared that an individual team's funding source does not impact the overall coordination, facilitation, and delivery of most client services. Some LAHSA teams receive Measure H funds and some do not; some DHS teams receive Measure H funds and some do not; and no DMH teams receive Measure H funds. Still, the E6 systems coordinates as a singular, centralized system. RDA's conversations with E6 stakeholders demonstrate that Strategy E6 implementation achieved its intentional design to a) effectively coordinate a centralized system for all homeless outreach across the County, b) deploy a coordinated mix of interdisciplinary teams, c) provide teams, specialties, and staff that are proportional to the need within each SPA (vis-a-vis the unsheltered PIT count), and d) standardize use of one central database for outreach service documentation and case management information.

> *E6 coordinates all outreach across the County despite funding mechanisms they are using, and it doesn't impact outreach resources.*
>
> *-E6 Leadership*

On the other hand, some teams within the E6 system have more flexibility to leverage flexible funding resources to serve clients. Frontline workers reflected that contracted community providers and LAHSA-employed HET staff have greater flexibility to use these client resources than DMH HOME team staff, due to different accounting requirements and restrictions. HOME team members reported stricter scrutiny for using flexible funds to do things for a client such as paying for a night in a motel or the fees to obtain their identification. This creates asymmetrical access to resources that are vital to all E6 clients, and can lead clients to prefer engaging only with the teams that have more discretion. These differences negatively impact staff morale, and some staff expressed feeling less able to meet clients' immediate and felt needs than other teams.

Finding 6. Collaboration pathways between homeless-serving agencies, law enforcement, and sanitation departments need to continue be developed, refined, and strengthened. Without strong communication protocols with the E6 network, responses to encampment safety and sanitation concerns can negatively impact client progress toward stability and housing.

The number of encampments is increasing with the number of people experiencing unsheltered homelessness across the County. Encampments are informal dwellings that are frequently unsafe for residents, disconnected from public utilities like power and water, lack adequate sanitation, and can pose threats to the health of both residents and the people nearby. These issues are under the purview of a number of public services, including law enforcement and sanitation agencies. Staff of these agencies have become increasingly visible actors within the homeless outreach system.

BEST PRACTICE: Collaboration with Non-traditional Outreach Partners

The effectiveness of homeless outreach often benefits from collaboration with non-traditional partners such as law enforcement, jails, prisons, hospitals, and other health care providers, to identify and connect individuals to care, address safety and sanitation concerns, and minimize unnecessary criminalization.

Although the implementation of collaborative outreach teams improved partnerships with law enforcement and sanitation, there are opportunities to continue to improve collaboration protocols and develop more consistent trauma-informed approaches to serving this population during essential safety and sanitation efforts.

While the County is working to establish more effective protocols for collaboration, E6 staff report that communication with both law enforcement and sanitation agencies is inconsistent. When E6 teams receive notice in advance of an encampment response, they can provide proactive outreach at the location, communicate directly with the clients about the upcoming actions, store important belongings, IDs, documents, and cellphones, and support these individuals in more effectively preparing for the upcoming action and preventing avoidable trauma. On the other hand, when they do not receive sufficient notice, E6 staff cannot provide proactive outreach prior to an encampment response. As a result, staff report that the affected individuals may not be prepared or understand what is happening. Staff across all SPAs reported that sanitation crews have either confiscated or thrown away clients' personal belongings and important documents, damaging the relationships and trust they have worked so hard to build. The negative impact of this is significant, because it reverses client progress toward safety, stability, and housing.

During encampment response events, close collaboration between outreach, police, and sanitation workers is crucial to providing trauma-informed services to the people living in the affected areas. However, this can be difficult to achieve when each municipality in LA County has difference enforcement and sanitation protocols for encampments. Data collected for this evaluation reflect that E6 staff across all SPAs believe these protocols need to continue to be established and refined.

Following RDA's data collection activities, in October 2019 the City of Los Angeles implemented a new collaboration protocol for encampment response events. Additionally, Measure H funds the outreach workers within the nine HOST teams, which are specialized collaborations between homeless-serving agencies and law enforcement to support coordination during responses to encampment health and safety concerns. Consistently strong and trauma-informed collaboration protocols for encampment responses can reduce crisis situations and enhance understanding about the purpose and function of outreach.

> *We are often dealing with systems that have conflicting information and don't coordinate. [The agency] sometimes sends notifications when they are going to sweep clients, and sometimes they do not. All of our work with clients can get thrown up in the air.*
>
> *-E6 Outreach Staff*

Data Sharing and Technology

Technologies that enable more effective data sharing are systems-level improvements that support effective coordination and communication efforts between actors, stakeholders, and partners. These findings describe the strengths and challenges of Strategy E6 implementation relating to data sharing practices and infrastructure.

Finding 7. LA-HOP is an innovative technology solution that enables efficient outreach request tracking; facilitates dynamic, street-based outreach response; and promotes improved E6 system coordination.

In the early stages of implementation, E6 leadership recognized the need for technological infrastructure to support the efficient deployment of outreach teams and resources in response to community requests. After exploring other options LAHSA directed efforts to develop an easy-to-use web-based tool for requesting homeless outreach services. In July 2018, LAHSA launched the Los Angeles Homeless Outreach Portal (LA-HOP) to facilitate the consolidation and coordination of homeless outreach requests from anywhere in the County. Anyone with internet access via a smartphone or computer can easily use this innovative request portal. LA-HOP also serves as a front door to publicly available information about the County's homeless services, initiatives, and funding, including information about Measure H funds. LA-HOP also contains a staff directory. The portal answers frequently asked questions that address common community concerns, such as '*What do outreach workers do?*' or *'How long does it take to help?'*

Users navigate to the website and fill out a simple form to request outreach services either for themselves or for another individual in need. LA-HOP utilizes an agile ticketing platform (JIRA) to track each request and, based on the address a user inputs, routes the request to the correct SPA in real time. After the user submits their request, they receive automatic status updates about their request. First, a SPA coordinator reviews and assigns it to the appropriate team. Then, the assigned outreach team makes at least two attempts to find, make contact with, and engage that individual in services. The service requestor receives updates at each of these steps in the outreach process.

Since launching, LA-HOP has received over 10,000 outreach service requests. This volume of new data is more than leadership initially anticipated, and enables County decision-makers to drive homeless policy using real information that was never available before. All stakeholder groups that participated in this evaluation, including people from all levels of staff and leadership, identified LA-HOP as a critical success of Strategy E6 implementation that improved service coordination and increases the available information about homelessness on the streets. Before LA-HOP, quantitative information about street-based homelessness was largely static, with most data available only once per year, and delayed for months after the homeless PIT survey on a single night. Unfortunately, homelessness is not a static

> *The coordination piece has impacted our ability to provide information to policy makers about what homelessness really looks like on the streets of LA County… We are able to provide detailed information about most of the larger encampments and the tenor of neighborhoods within the County, offering tremendous value as far as policy setting.*
>
> *-E6 Leadership*

phenomenon. People experiencing homelessness, especially people who are living on the streets or in other places not meant for habitation move around frequently for their own safety, to avoid conflict escalation, to prevent confiscation or theft, or out of fear of law enforcement. Before LA-HOP, a resident of LA County could walk down almost any street to observe this crisis, but the County had no way to pinpoint emerging hot spots or respond adequately to the dynamic and changing needs of people living on the streets.

BEST PRACTICE: Hot-spotting

Hot-spotting is the practice of geographically identifying concentrations of high-need individuals experiencing homelessness, allowing providers to better mobilize and coordinate services.

Prior to E6 outreach teams served critical hot spots like Skid Row, and teams continue to serve these high-need areas. However, data from LA-HOP enables E6 to identify and deploy outreach resources to emerging hot spots in other regions. This system provided the County's first comprehensive data to track changing hot-spots, enabling teams to provide both proactive and reactive services where they are needed.

This technological solution allows Strategy E6 to mobilize and coordinate outreach resources to emerging regional needs, and more effectively align the E6 outreach system with best practice. LA-HOP enabled more effective and expedient provision of outreach services. This makes Countywide outreach more accountable to people experiencing street-based homelessness, but also, LA-HOP increased accountability and responsiveness with all community stakeholders concerned about this crisis. For this evaluation, individual-level data from LA-HOP were unavailable to RDA for analysis, but LAHSA calculated that the average number of days to complete a request can vary between 3-23 days, depending on the number of outreach attempts.[25] While many factors impact the length of time required to close out a request, E6 leadership shared that some community stakeholders expect that submitting a request to LA-HOP will lead to an immediate resolution to a concern they have about someone experiencing homelessness in the community, and that they are misunderstanding one crucial reality about homeless outreach—finding, making initial contact with, and building the trust necessary to engage an individual in services takes time. LA-HOP is a technological innovation that facilitates efficient and expedient service coordination, but neither efficient systems nor homeless outreach itself can resolve an individual's homelessness. Technology cannot change the purpose, function, or process of conducting homeless outreach; however, LA-HOP is facilitating better information about the emerging needs for homeless outreach services, better system coordination, and better information to drive policy-making across the County.

> *I like having LA-HOP. It gives me information about certain parks and areas to address where a larger encampment might be. We get hot spot information through there.*
>
> *-E6 Outreach Staff*

Finding 8. Strategy E6 improved system-wide data quality in HMIS by expanding access to this common tool, implementing data entry standards, and requiring frontline workers to document client services. However, the County does not have a process to monitor data quality or gain insight into further coaching or training needs to improve system-wide data capacity.

[25] LAHSA excluded outliers using a standard deviation of five.

Like many communities in California, LA County uses a centralized homeless information management system (HMIS) product called Clarity, by BitFocus. This HMIS product is a web-based tool for tracking contacts, services, and housing details and referrals for people experiencing homelessness. It meets the technical data standards set forth by HUD for Continuums of Care (CoC), which requires outreach programs that receive CoC funds to document activities in HMIS to standardize service data.

Prior to E6, many outreach teams did not use HMIS to document outreach services and activities. Most teams were not required to use it, such as teams that received private or local funding rather than CoC funding. Without a consistent and shared approach to data management, there was no way to a) monitor ongoing needs for the unsheltered population across the County, b) ensure efficient outreach resource deployment, or c) track outreach services Countywide. Strategy E6 implementation expanded access to this one documentation system across all outreach teams under all County departments. The E6 network-wide adoption of HMIS enabled a systematic, consistent approach to documenting outreach services and activities which aligns with recognized best practices.

BEST PRACTICE: A Systematic, Documented Approach

Employing a systematic and consistent approach to documenting outreach services reduces the chances of overlooking people in need of homeless outreach or duplicating effort.

Strategy E6 expanded HMIS access to all outreach teams, and as a result all E6 outreach staff document their activities and client outcomes in one centralized data management system. A benefit of Strategy E6 implementation is that LA County now has the ability to track, monitor, and report on homeless outreach services in a systematic and accessible way. However, conversations with stakeholders reveal that despite the E6 system's universal access to HMIS, data entry practices are not consistent across all E6 staff. Additionally, HMIS cannot monitor client service referrals and linkages in a reliable way.

BEST PRACTICE: High Quality Data

Having reliable and complete data at the client level allows communities and homeless-service agencies to better monitor their progress and hold themselves accountable to identify and help people experiencing homelessness.

E6 frontline staff input the data that enable system-wide reporting on service delivery. This is necessary for effective monitoring, evaluation, and quality assurance. Strategy implementation dramatically increased the volume of data inputs, but there are not quality assurance measures at the systems-level to ensure all staff and teams adhere to consistent standards.

Veteran staff reported that prior to E6, teams that used HMIS had inconsistent practices for documenting their outreach activities. Since the implementation of E6, leadership developed data management standards and documentation requirements for more outreach services across all E6 teams, providers, and agencies. As described in Finding 11, all E6 staff receive formal training to document their E6 activities in HMIS. They also receive training to understand the connections between thoroughly documenting and reviewing a client's case notes, conducting the County's standard vulnerability and service needs assessment (VI-SPDAT), and the County's CES.[26] The efforts to consolidate data entry for homeless outreach services into one system and leverage system-wide data for CES are achievements of E6 implementation that align with recognized best practices.

[26] The VI-SPDAT (Vulnerability Index - Service Prioritization Decision Assistance Tool) is a survey administered both to individuals and families to determine risk and prioritization when providing assistance to homeless and at-risk of homelessness persons.

However, despite expanded HMIS access, improved standards, and increased training, some E6 stakeholders reported that data capacity building is inconsistent across the E6 network and that there are discrepancies in data and documentation quality. Staff from SPAs 1, 2, 6 and 8 reported feeling well supported to use HMIS to track their activities and client outcomes, but staff from SPAs 4 and 7 reported that they felt less supported. Over one third of E6 staff (37%) do not find HMIS "easy to use" which indicates issues with data quality and front-end functionality. LAHSA reports working with the HMIS vendor to improve and enhance the user experience.

Both frontline staff and E6 leadership shared that HMIS data entry protocols—or adherence to them—varies by department, provider, team, or individual. Inadequate or untimely documentation causes system inefficiencies, such as duplication of effort when an outreach worker provides a service but does not record it, or missed opportunities to provide prevention or early intervention for urgent issues when an outreach worker does not document a client's need. Additionally, an individual staff member's fluency and familiarity with documentation can decrease client success in moving out of homelessness by impacting their access to or prioritization for housing resources.

At the time of writing, Strategy E6 did not have system-wide measures for data quality assurance (QA) to ensure E6 agencies, providers, teams, and staff follow consistent standards and protocols for documenting outreach services and activities. Without measures to monitor data quality, Strategy leadership cannot gain insight into HMIS coaching or further training needs to improve efficient documentation, data fluency, and quality client services.

Finding 9. E6 staff and leadership report that outreach data sharing practices for client care coordination adhere to privacy protection laws, but E6 leadership has not assessed the need for infrastructure improvements such as security controls for client data confidentiality and maximizing efficient referral tracking across disciplines.

All outreach staff receive training in client data privacy laws, including HIPAA and 42CFR, and staff report that they follow these guidelines for sharing data while also finding ways to access information necessary for care coordination between teams. A core function of homeless outreach is to connect clients with needed services and resources, and as discussed in Finding 8 above, systematic documentation and data monitoring practices are important to delivering efficient and high-quality services. However, RDA's conversations with frontline staff across all SPAs elevated common themes indicating HMIS does not maximize efficiency for reliably tracking external service referrals and linkages. This makes it more difficult for outreach staff to coordinate and manage client care between teams. Specifically, outreach workers identified the following wish list items to improve care coordination:

- **Messaging.** Staff report that HMIS does not enable messaging between care teams. Staff believe that the ability to send, receive, and track messages with other providers or E6 outreach workers in HMIS would improve timely communication, facilitate faster care coordination, and improve delivery of necessary services.
- **Housing Match Alerts.** Staff report that they do not receive system notifications when a client is matched to a housing resource, although leadership noted that this feature is enabled in HMIS. If a housing resource opportunity is time-limited and requires the client to submit a complete application within a specific number of days, the outreach worker loses valuable time to support the client in gaining access to permanent housing. Additionally, if the worker does not receive timely notification of the housing match, they also lose valuable time to coordinate the warm handoffs that support successful move-ins and housing retention during client transitions into permanent housing.
- **Access for Institutional Partners.**[27] As discussed later within this report, there are not consistent care coordination pathways during client transitions from institutions like hospitals and jails. While privacy concerns or laws may inhibit institutional access to HMIS, E6 staff noted this system-wide gap in communication. When a jail releases a person experiencing homelessness back onto the streets, that person is more likely to fall through the cracks and experience a recidivating event or re-arrest. When a hospital discharges a person experiencing homelessness and that person's care team cannot facilitate a transition back into community services, that person is less likely to connect or reconnect with public systems and is more likely to require further emergency services or hospitalizations. This report discusses this challenge in more detail in Finding 13.

BEST PRACTICE: Data Sharing

Sharing data between generalist and specialists enables multidisciplinary teams to provide more effective wraparound services to individuals experiencing homelessness. Additionally, at the systems level, the ability to merge datasets to identify and track the most vulnerable clients allows systems of care to better meet clients' unique needs.

The Strategy's broad expansion of HMIS has enabled many teams to effectively share client information and provide effective care coordination. While many staff find ways to get access to the client information they need to provide quality client services, not all staff agree that information is easily accessible from other teams. The Strategy's leadership have not conducted a thorough assessment of data sharing infrastructure, which could support stronger data sharing practices.

Effective January 1, 2018, Assembly Bill 210 (AB 210) authorized counties to establish homeless adult and family MDTs to facilitate interdepartmental information sharing to break down silos between collaborating departments; share important information to support care coordination; improve care continuity between homeless, housing, and other supportive service providers; and decrease duplication in service delivery.[28] Before the passing of AB 210, existing State law did not clarify the authority to data share data between

> *I think once you can log into [a central data hub] and see what you need, AB 210 will be much more effective. We really wanted this to be the answer, but this hasn't taken off the way we intended.*
>
> *-E6 Leadership*

[27] Strategies D2, D4, D5, and B7 provide care coordination and discharge services from institutional partners, but there is a need to strengthen collaboration with those strategies.

[28] LA County HI, *Assembly Bill 210: Information Sharing for Homeless Adults and Family Multidisciplinary Teams,* June 2018: https://homeless.lacounty.gov/wp-content/uploads/2018/09/AB-210-Fact-Sheet-6.20.2018.pdf

County departments and homeless service providers for persons experiencing homelessness, resulting in service duplication or fragmentation. Fundamentally, AB 210 authorizes data sharing which would otherwise be prohibited by State law, without impacting compliance with federal privacy laws like 42 CFR and HIPAA. Strategy E6 implementation facilitated the development of DHS MDTs, but leadership did not express clarity on how AB 210 has impacted data sharing in the field for all E6 teams. Robust data sharing infrastructure is essential to efficiently coordinating services between providers in real time, but HMIS does not efficiently track emergency services or service referrals in real time, as described above.

Many E6 staff shared that they find workarounds to these HMIS limitations, consistent with their "doing whatever it takes" culture (Finding 11). At the same time, half of outreach staff (49%) feel they cannot easily obtain client data from other outreach teams. Some E6 teams, such as DHS MDTs, receive training in the DHS data system called CHAMP for tracking housing and benefits referrals to external providers until a warm handoff occurs, but MDT staff noted that documenting across two systems in parallel is not optimal or efficient.[29] Not all E6 teams can access CHAMP, and therefore not all E6 teams can track CHAMP-related referrals and linkages effectively.

E6 teams rely on imperfect data sharing platforms to deliver care coordination as seamlessly as possible, and many staff noted that although they experience frustration with HMIS limitations, they find other ways to coordinate care through case conferences, emails, phone calls, and team meetings. More than one E6 staff member suggested to RDA that they use informal—or unauthorized—methods to access the information they need to do their job, and RDA observed that a "doing whatever it takes" culture combined with imperfect data sharing platforms creates risk for client confidentiality.

AB 210 requires communities to assess data sharing infrastructure to ensure data are complete, accurate, up-to-date, and include reasonable administrative safeguards that ensure confidentiality and data availability to prevent unauthorized or inappropriate sharing. In November 2019, HI leadership shared that the County was soft launching phase two of AB 210 implementation: a system called the County Homeless information Portal (CHIP) that will enable users to query current and past service histories for individuals or families experiencing homelessness. This system is scheduled for full deployment in early 2020.

[29] Health Services Los Angeles County, *Whole Person Care – Los Angeles (WPC-LA)*, accessed from: https://bit.ly/2Nm1nrH

Outreach Practices, Training, and Staff Culture

An effective system has strong shared values and practices, promotes a culture of learning and continuous improvement, and encourages stakeholders to develop core competencies, refine their skills, and create opportunities for impactful client services. Training reinforces practices, practices define culture, and culture influences efficacy within a system. The findings in this section describe training models, practices implemented in the E6 network, alignment with best practices in the field, and overall staff culture.

Finding 10. Countywide, Strategy E6 outreach workers employ both proactive (routine, scheduled) and reactive (response-oriented) strategies to engage as many people experiencing homelessness with services as possible. A benefit of this approach is prevention and early intervention of issues before they can escalate to other taxing and avoidable impacts on public systems.

As noted earlier in this report, Strategy leadership allocated E6 funding among SPAs according to the level of unsheltered need in order to distribute outreach resources across the County's many hot spots, geographies, and regions. Across all SPAs, Strategy E6 employs a two-pronged approach to conducting street-based outreach that includes both proactive and reactive strategies. Teams conducting proactive outreach visit clients on a planned, recurring schedule to provide ongoing services and maintain frequent contact. During these visits, outreach staff assess and address client issues as they arise, including health concerns and first aid, documentation or paperwork challenges, etc. Proactive outreach is essential for prevention and early intervention for issues that might otherwise have devastating impacts for clients, such as avoidable hospitalizations or lapses in crucial public benefits such as SSI and Medi-Cal.

Reactive outreach complements the proactive approach by responding to new and emerging needs of people experiencing homelessness. Despite the Strategy's broad reach into the community, there are individuals not yet connected to outreach staff, the homeless services continuum, or other services they may need. During the implementation of Strategy E6, LAHSA identified a need to reach above and beyond the HI plan; instead they developed a web-based outreach request portal called the Los Angeles Homeless Outreach Portal, known simply as LA-HOP. The system is easily accessible to anyone with a smart phone or computer connected to the internet. If a County resident or stakeholder observes an individual with acute or concerning needs, they can request outreach services on behalf of that individual by completing a simple form, regardless of their location in the County. The system routes incoming outreach requests to the correct SPA, and within two to four days, an outreach team will initiate an effort to locate and provide services to that individual.

As a part of this evaluation, RDA developed an outreach process flow map to describe how teams reach out to and engage people experiencing unsheltered homelessness in the community, under both proactive and reactive methods (Appendix E). These complimentary approaches enable the E6 outreach network to connect and engage as many people experiencing homelessness with services as possible, while creating a direct pathway for members of the general public to request outreach on behalf of their unhoused neighbors.

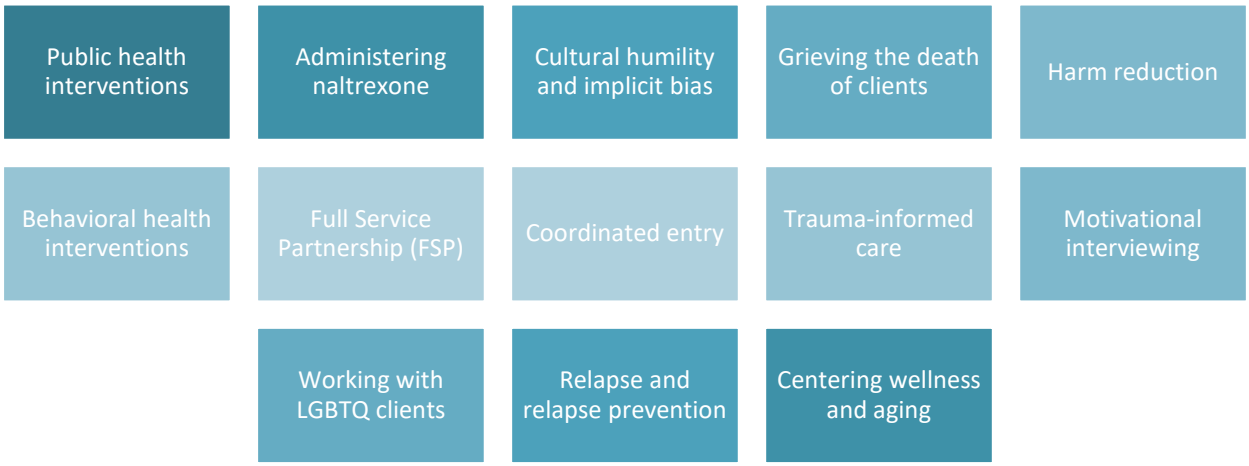
Finding 11. System-wide trainings and learning collaboratives onboard new staff, support a client-centered culture, and help align outreach practices to best and evidence-based approaches.

Outreach workers from every department or agency under E6 participate in systematic, comprehensive, and required training on several evidence-based, self-care, and best outreach practices during a five-day orientation series that leadership offer twice a year to onboard new hires. Each Strategy E6 lead presents topics during these weeklong trainings, as do political leaders and representatives, data analysts and researchers, legal scholars and practitioners, health care administrators, law enforcement officers, housing staff, and people with lived experiences of homelessness.

> *We get trained in different tools and tactics, like harm reduction, and we get appropriate supervision hours toward doing that. The interdisciplinary approach is really effective.*
>
> *-E6 Outreach Staff*

> *Good outreach meets clients where they are at. It doesn't encourage one cookie-cutter template of how to approach the work.*
>
> *-E6 Outreach Staff*

In addition, between October 2018 and June 2019, E6 staff had opportunities to attend 52 different learning collaboratives and other specialized skill-building opportunities above and beyond the onboarding orientation week. Strategy leadership maintains a consolidated and centralized calendar for interdisciplinary trainings to build and refine outreach worker skills across Strategy E6. Staff attend the monthly learning collaboratives as well as frequent sessions on special topics. Appendix G includes a full list of trainings offered between October 2018 and June 2019. Previous offerings have included topics across disciplines, such as:



These training opportunities enable outreach workers to employ a range of approaches and practices to engaging clients. From the very first contact with a client, E6 workers stressed the importance of "meeting people where they are at," both literally and metaphorically. Many people who are living on the streets have experienced trauma, so naturally approach new relationships with a good deal of caution. In addition, many people experiencing homelessness carry institutional trauma and mistrust of government systems, so a necessary first step in establishing a productive outreach relationship is to build trust with

the client and understand the principles of trauma-informed services. Trust building is essential to maintaining engagement with this populations, and outreach workers from all SPAs report pride in their abilities to tailor trauma-informed approaches to each client's unique personalities, needs, and personal motivations.

For this evaluation, RDA reviewed the extant literature on best practices for homeless outreach, and various sections within this report illustrate that Strategy E6 has implemented outreach services that align with most best practices recognized by experts from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), USICH, and HUD. This report describes many best and evidence-based practices implemented by Strategy E6, as listed in below.[30]

Table 3: Model & Evidence-based Outreach Practices Implemented by Strategy E6

Outreach Practice	Described in Evaluation Section:	
Coordinated Entry	Finding 3	System Coordination & Collaboration
Collaboration with Non-Traditional Partners	Finding 6	
Hot Spotting	Finding 7	Data Sharing & Technology
Data Sharing	Finding 8	
A Systematic, Documented Approach	Finding 8	
High Quality Data	Finding 8	
Housing First	Finding 11	Outreach Practices, Training, & Staff Culture
Diverse Approaches	Finding 11	
Person-Centered Services	Finding 11	
Motivational Interviewing	Finding 11	
Harm Reduction	Finding 12	
Warm Handoffs	Finding 15	Client Service Delivery

In addition to the best practices described in other findings, Strategy E6 has successfully implemented the following best and evidence-based practices.

BEST PRACTICE: Person-Centered Services

Person-centered services emphasize an individual's strengths and resources, mobilizing support and treatment plans around that individual's own unique preferences and needs. This approach never assumes an individual's needs in order for that individual to drive their own decision-making or problem-solving process.

Across conversations with staff and leadership from all SPAs, RDA repeatedly heard that E6 staff are implementing person-centered approaches to delivering homeless outreach services because they are willing to "meet clients where they are at" to help them achieve their personal goals.

[30] USICH, *Practices that Work: The Role of Outreach and Engagement in Ending Homelessness: Lessons Learned from SAMHSA's Expert Panel,* accessed https://www.usich.gov/resources/uploads/asset_library/Outreach_and_Engagement_Fact_Sheet_SAMHSA_USICH.pdf

BEST PRACTICE: Diverse Approaches

Having diverse, person-centered, and robust outreach in non-traditional settings increases the chances of reaching and building trust with more people experiencing homelessness. Not all people are the same, and there is no one approach to engaging persons experiencing homelessness that will work for everyone. Both E6 leadership and staff reflected that a hallmark of the shared E6 culture is "doing whatever it takes" with grit and determination to help their clients succeed, as well as commitment to the teamwork necessary.

E6 staff demonstrate pride in their abilities to tailor their approaches to the unique needs and motivations of each individual client, increasing their chances of successfully maintaining engagement and providing better services to that individual.

EVIDENCE-BASED PRACTICE: Motivational Interviewing

Motivational interviewing (MI) is a collaborative, evidence-based, person-centered approach to engaging with clients intended to elicit and strengthen internal motivation to change. This approach is useful for interacting with persons experiencing homelessness, as well as any vulnerable population that may be experiencing complex care needs involving substance use, mental illness, or trauma. SAMSHA describes MI to be rooted in an understanding of how difficult it can be to change learned behaviors, which are frequently essential to survival on the streets.

To support this approach to delivering client services, all E6 staff receive training in Motivational Interviewing (MI) to promotes behavioral changes by tapping into clients' own motivations to improve their lives. Strategy E6 requires all new staff to receive this training during orientation. Each E6 client completes an individual services and supports plan focusing on how to leverage their own strengths to achieve their own self-directed goals.

EVIDENCE-BASED PRACTICE: Housing First

According to Sam Tsmbersis, credited with founding the Housing First approach, this model is simple: provide housing first, and then combine that housing with supportive services. The National Alliance to End Homelessness (NAEH) describes this approach as consistent with what most people experiencing homelessness want and seek help to achieve. Housing First is the practice of connecting people with permanent, rather than time-limited, housing as quickly as possible, believing everyone is "housing ready," not making housing a contingency of service compliance, and removing as many restrictions and barriers to housing resources as possible. This principle stems from the evidence demonstrating that housing is an effective intervention for persons experiencing homelessness that leads to improved outcomes in nearly every area, including health, stability, and safety. Because of this, housing homeless and vulnerable individuals frequently process to be cost-effective for public systems.

E6 staff are dedicated to housing their clients as quickly as possible and spend a great deal of time supporting them in this effort. Despite this hard work, the lack of available shelter and housing resources—or lack thereof—frequently limits what outreach workers can do in relation to helping their clients obtain housing.

During the course of data collection for this evaluation, frontline E6 staff also suggested several other practices that are essential to the delivery of effective homeless outreach. Table 3 below lists these emerging best practices as described by the Strategy E6 outreach staff who do this work across Los Angeles County every day.

Table 4: Emerging Best Practices Identified by E6 Outreach Workers

Data & Documentation	• Conduct a CES assessment for every new client once rapport has been established • Use mobile technologies to document in real time, to the greatest extent possible • Complete HMIS documentation within 24 hours
High-Functioning Teams & Partnerships	• Foster authentic and organic collaboration among teams • Value collective impact through partnership • Facilitate regular SPA-specific meetings to strengthen collaboration • Hold team conferences or huddles every morning to coordinate outreach activities • Prioritize team safety and look out for team members in the field • Schedule dedicated time to be out in the field vs. documenting activities
Service & Referral Coordination	• Do 'whatever it takes' and meet clients where they are • Use a structured case conferencing and care coordination protocol • Provide personal, warm handoffs for each referred service • Integrate data from LA-HOP to inform decisions and strategies about daily tasks • Keep clients' documents safe and secure so they are accessible when needed

Training and Turnover

E6 stakeholders at all levels reported that organizations and agencies within the Strategy sustain high levels of staff turnover, although RDA could not obtain administrative data to analyze and quantify these patterns. Because this was a recurring theme in conversations with both E6 staff and leadership, RDA probed to understand the nature of turnover on-the-ground. Staff provided several explanations for the turnover, including the lower pay scale for outreach positions and the secondary trauma frontline workers frequently experience in the field. The intense nature of conducting homeless outreach with vulnerable populations is not the right fit for everyone, and as the system creates and fills new positions, some new hires may choose to move into other careers or fields.

In response, Strategy E6 leadership increased the frequency of staff training to provide onboarding and training support for new hires on an ongoing basis. Data from the E6 staff survey indicate this is successful; three quarters of respondents agree that E6 welcomes new hires and effectively orients them to the outreach system. A unified culture empowers the frontline staff, who need sustainable self-care practices as well as support from leadership in order to continue engaging in this difficult work. Nearly 80% of E6 staff survey respondents agreed that the E6 agencies empower frontline workers by encouraging their participation and input in Strategy decisions that impact the way they do their jobs and deliver client services. As detailed in Appendix G, orientation includes self-care practices for sustaining difficult work.

On the other hand, E6 leadership reflected that turnover is a normal condition of systems change processes. Because many E6 partner agencies underwent structural reorganizations during implementation, many staff moved around to fill the newly created positions, and then their vacated positions needed filling as well. Strategy E6 implementation is still new, and leadership anticipate that the

passing of time will moderate perceptions of staff turnover. Some stakeholders even observed that the frequency and quality of trainings is a double-edged sword; as frontline staff learn new practices and skills, more opportunities become available for them to move into higher positions either within E6 or outside it. Although staff turnover has the potential to interrupt client relationships, the regular and frequent training schedule supports a culture of high quality practices across the E6 system.

Finding 12. The absence of system-wide quality measures to ensure all providers and teams implement best practices is a barrier to consistent quality across the system. This gap emerges despite the system's comprehensive approach to training best and evidence-based practices. As a result, some E6 agencies, providers, and individual staff do not buy-in to implementing all best outreach practice models.

Early in their tenure, new E6 staff attend intensive, week-long trainings on evidence-based and best practices, but some Strategy E6 leadership voiced concerns that not all teams are implementing the principles of established outreach best practices, noting a range of organizational cultures among contracted providers, varying levels of professional experiences, and different personal experiences that inform their approaches to service delivery. A provider may attend an E6 training and translate practices back to their own organization or team in a way that fits their culture or service model, particularly with harm reduction approaches to working with homeless and at-risk populations.

Although E6 leadership report substantial management shadowing to ensure consistent service delivery, Strategy E6 has no system-wide quality measure to ensure training retention and consistent practice of demonstrated approaches to working with people experiencing homelessness in the field. Assessing implementation quality is critical to understanding training opportunities and adherence to established system-wide approaches to providing client services. The following examples demonstrate two challenges in the implementation of outreach best practices within Strategy E6:

- **Harm Reduction.** Personal attitudes or organizational biases against harm reduction strategies for working with clients who are actively using substances can impact that client's access to housing resources through CES. Specifically, if the client perceives that the outreach worker is judging their substance use, they may not feel comfortable disclosing their personal information or health history. If the client does not feel comfortable disclosing details of their history that could indicate higher vulnerability, such as previous hospitalizations, inpatient stays, or detox services, they may not receive an appropriate

BEST PRACTICE: Harm Reduction

Harm reduction is an approach to providing services to vulnerable populations that aims to reduce the risks and harmful effects of substance use and addictive behaviors, practiced through non-judgmental and non-coercive methods, resources, and supports. It emphasizes changes that support their own goals rather than judging their substance use.

E6 outreach staff practice varying levels of fidelity to the harm reduction model. Many staff are proud of their harm reduction practices, including distribution of clean needles and naltrexone, but others expressed skepticism about its effectiveness, especially if their own personal journey to recovery has roots in values that clash with this best practice.

vulnerability score on the VI-SPDAT, and, consequently, not receive adequate prioritization for certain supportive housing resources.

> *We have pushback from LAPD. I know we all want to work together... They are paid from the same tax dollars as us, and they should have that trauma-informed training.*
>
> *-E6 Outreach Staff*

- **Non-traditional Partner Training.** Law enforcement and sanitation workers from the City of LA and other cities across the County may not be formal E6 partners, but they do partner with E6 teams and work the frontlines. E6 staff repeatedly stressed that their experiences with law enforcement officers and sanitation workers do not reflect consistent trauma-informed and harm reduction approaches to interacting with people experiencing homelessness. Outreach staff want to partner more effectively with these agencies, in particular the City of LA, and want those partnerships to be centered around evidence-based practices for working with this population in order to more effectively address the homelessness crisis and help people engage in the services that can help them finding pathways out of homelessness, rather than promoting mistrust and fear.

Finding 13. Established best practices for continuous care during client transitions are not well coordinated with Strategy E6, causing system gaps. During transitions between the community, institutions, and care providers, system gaps lead to negative consequences and outcomes for persons experiencing homelessness.

Although other HI strategies provide care coordination and discharge services from institutional partners, there is a need to strengthen collaboration with those strategies to close system gaps. These gaps can lead to negative outcomes during vulnerable client transitions between providers or levels of service.[31]

Traditional outreach is short-term and does not include case management. However, because the Countywide housing shortage means that E6 clients are engaged in outreach services for months or even years, E6 staff perform ad hoc case management, evidenced by the 9,000 case management activities logged in HMIS between FY 17/18 and FY 18/19. E6 stakeholders reported that institutions struggle to communicate the enrollment, intake, or discharge status of E6 clients to outreach staff. For example, when a person experiencing homelessness is booked into and then released from jail without an opportunity to connect or re-connect with E6 staff or services, that person may be more likely to experience a recidivating event. Other examples include challenges connecting with a new care teams, avoidable or repeat hospitalizations, and challenges adhering to rules or retaining permanent housing. The following may be folded into other HI Strategies but are not well coordinated with Strategy E6.

- **Critical Time Intervention.** E6 staff do not currently receive training on the evidence-based practice Critical-Time Intervention (CTI). CTI is a time-limited service model that mobilizes support for clients during periods of vulnerable transitions, such as when they are exiting an institution or moving into

[31] E6 leadership noted that discharge planning is within the purview of other strategies: Strategy D2 Expand Jail In Reach; Strategy D4 Regional Integrated Re-entry Networks – Homeless Focus; Strategy D5 Support for Homeless Case Managers; and Strategy B7 Interim/Bridge Housing for those Exiting Institutions.

permanent housing. When implemented to fidelity, providers facilitate care continuity during these transitions by accompanying clients to meetings with new providers, following up with clients before, during, and after the transition, and ensuring the client maintains ties to their existing support system while building new supports. Although E6 provides training on important aspects of the CTI model, including warm handoffs, care coordination, and client engagement, outreach staff are not currently receiving training specific to this evidence-based practice.

❖ **Institutional In-Reach.** The Strategy's two-pronged approach to conducting outreach proactively and reactively reaches a broad range of the population experiencing unsheltered homelessness, but there are more opportunities to catch individuals who are exiting institutions like jails and hospitals before they fall into—or back into—homelessness. There is currently a systemic gap at the point a homeless individual is discharged or is released from a prison, jail, hospitalization, inpatient treatment, or other institution. Outreach staff shared that there is currently no mechanism by which institutional staff can notify homeless outreach when an individual is about to be released without an exit destination or known address. There is an opportunity during this transition to provide services and linkages that might prevent relapse or a recidivating event, but without a way to receive a notification, E6 staff cannot do pre- or post-release intervention. This leaves a critical gap in care for individuals who may struggle to connect or re-connect with services on their own.

EVIDENCE-BASED PRACTICE: Critical Time Intervention

Critical Time Intervention (CTI) is a time-limited evidence-based practice that mobilizes case management support for vulnerable individuals during periods of transition. It facilitates community integration and continuity of care by ensuring clients have enduring ties to their support system during these critical periods, The primary focus is housing stability, (e.g. adhering to rules) to prevent homelessness for people experiencing mental illness during transitions between care providers. The model includes intensive case management, resource navigation and linkages, stabilization in housing, celebration and validation, and fostering collaboration among different providers within a client's care team.

Documentation provided to RDA does not reflect that Strategy E6 currently offers training on CTI, and conversations with stakeholders do not demonstrate that this model is being implemented. However, E6 does train and implement some principles of the model. Instead of CTI, staff receive training on strengthening coordination, maintaining ongoing client engagement, and making referrals and linkages through warm handoffs. Individual staff, teams, or agencies may be implementing CTI.

BEST PRACTICE: Institutional 'In-reach'

Institutional 'in-reach' is the delivery of services to people who will be exiting from institutions like prisons, jails, and hospitals. This practice can prevent people from falling through the cracks, recidivating, or experiencing another emergency health crisis.

While this evaluation cannot determine whether or not any form of pre-release planning is happening across LA County's many institutions, there is currently a systemic gap in homeless outreach services at the point an individual exits an institution. This leaves a critical gap in care for individuals who may struggle to re-engage with services on their own and are more likely to recidivate or experience another hospitalization.

Finding 14. Regional differences in outreach travel times do not inform staff productivity targets. As a result, staff report a mismatch between their workloads and the tasks required to perform their job responsibilities and serve clients within normal working hours.

Staff from all SPAs reported that productivity targets set for outreach staff do not accommodate travel times for normal business activities, including the time it takes to find hard-to-reach clients and travel times to provide client services or provide rides between appointments, or the travel time to attend required administrative meetings. Staff who work in more remote areas of the County expressed greater frustration with meeting their productivity target expectations, particularly for staff in SPAs 1, 3, and 7.

> *We try to find a way to make the higher-ups happy with their numbers vs. helping a client. You might be with a client all day. That's the work. If that's what it takes then that's what it takes.*
>
> *-E6 Outreach Staff*

Nearly all outreach staff, including coordinators and those working in more dense and urban areas of LA County, report needing to work extra hours some days to fulfill their daily job responsibilities, such as returning a County vehicle and/or completing client documentation. RDA learned it is common for staff to spend an entire day in the field with a single client because of the time it takes to travel to the client's location and/or transport them to appointments. Several staff noted that required staff trainings can take place long distances from their home office, and that after a full eight-hour day, they still need to return the outreach vehicle before being finished. As a result, many E6 staff report feeling "stretched" trying to fulfill both their client and documentation responsibilities, and that their workloads are unfair and difficult to attain. Staff document their many outreach tasks and activities, but they do not document travel time; this is frequently a large part of their workday. Because staff travel times are not reported systematically, data are unavailable to inform productivity targets or shed light on regional travel differences between SPAs.

> *For our SPA, we have two meetings a week just for staff to attend… I'm looking at 4 hours of travel because of the distance and that's an entire day lost.*
>
> *-E6 Outreach Staff*

Client Service Delivery

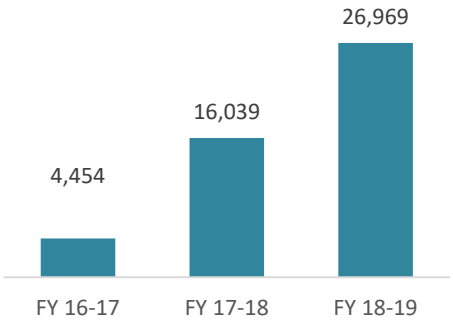
Client service delivery is the cornerstone of homeless outreach. This section describes the delivery of client services and the range of things that outreach workers do for their clients.

Finding 15. Frontline outreach staff are serving more people experiencing homelessness than ever before, forming real human connections to help individuals achieve greater safety and stability, overcome personal barriers, and successfully navigate complex public systems.

For this evaluation, RDA received administrative data from HMIS for only E6 outreach teams funded through Measure H, including most generalist and multidisciplinary teams at LAHSA and DHS, but none of the teams funded through other sources. As a result, the values provided on the following pages represent a portion of service outputs from across the entire E6 network. The trends, though, are unmistakable. Homeless outreach in Los Angeles County is contacting more people experiencing unsheltered housing crises than ever before, more people are engaging with public systems of care to receive the services they need, and more people are connecting to housing resources and supports.

Clients. The evaluation team analyzed Strategy E6 HMIS records for FYs 16/17, 17/18, and 18/19.[32] As Figure 14 illustrates, the number of clients served by Measure H-funded outreach steadily increased during this three-year period as teams established and Strategy implementation ramped up. In the year prior to Strategy E6 implementation, FY 16/17, homeless outreach teams documented contacts and services with fewer than 5,000 humans across Los Angeles County; and last year in FY 18/19, Measure H-funded teams connected with six times that many people (n=26,969). RDA analyzed publicly-available demographic information on E6 clients from the HI's quarterly reports, and compared these data with demographic information from the 2019 PIT count for the LA County Continuum of Care (LAC CoC).[33, 34]

Figure 14: Unique Individuals Served, Contacted, or Referred (Measure H-funded teams only)



The following Figure 15 and Figure 16 demonstrate that last year, Strategy E6 teams served clients with genders and ages that reflect the County's overall unsheltered population.

[32] The evaluation team received data from FY 15/16 also, but data entered during this year was, for the most part, insubstantial. Because one-time County HI funds started in 16/17 and Strategy E6 implementation funding from Measure H began in FY 17/18, it would not make sense to contrast data after implementation with earlier values. This evaluation considers data from FY 16/17 to be the baseline prior to Measure H and Strategy E6 implementation.
[33] RDA compared quarterly report information on E6 services in FY 18/19 to the published 2019 PIT data for the Los Angeles County Continuum of Care, which does not include Pasadena, Glendale, or Long Beach.
[34] Individual-level indicators such as race, ethnicity, age, and other sub-population identifiers were unavailable for analysis within the HMIS data received for this study. However,

Figure 16: Gender - E6 Clients (FY 18/19) and LA CoC's Unsheltered PIT Count (2019)

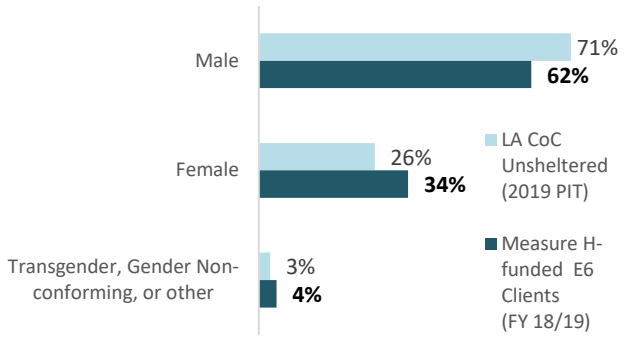
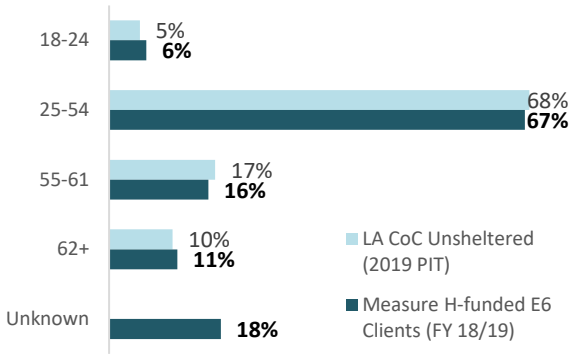
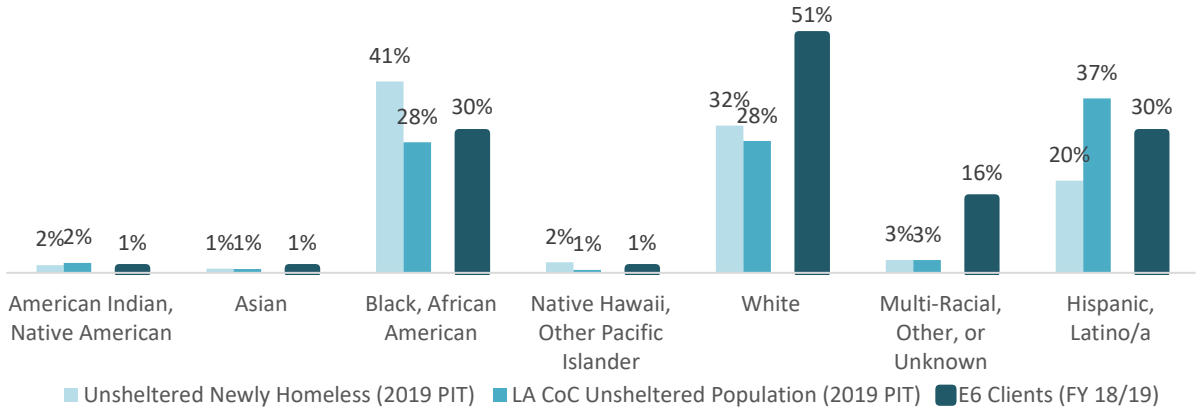


Figure 16: Age - E6 Clients (FY 18/19) and LA CoC's Unsheltered PIT Count (2019)



However, the data within Figure 17 suggest a need to more closely examine emerging needs for homeless outreach services among people experiencing homelessness for the first time. In particular, the PIT data demonstrate that black residents of LA County may be falling into homelessness faster than before, which also suggest a need to target E6 services among this subpopulation moving forward. In addition, the administrative service data from HMIS suggest that more E6 clients identify as white than the rest of the unsheltered population—*but*—more E6 clients also identify as multi-racial or are categorized as "unknown" or "other" than the rest of the County's unsheltered population. These differences indicate that it could prove useful to conduct further analysis of individual demographic factors among E6 clients.

Figure 17: Race/Ethnicity – E6 Clients (FY 18/19), Newly Homeless (2019 PIT), & LA County's Unsheltered PIT Count (2019 LAC CoC)

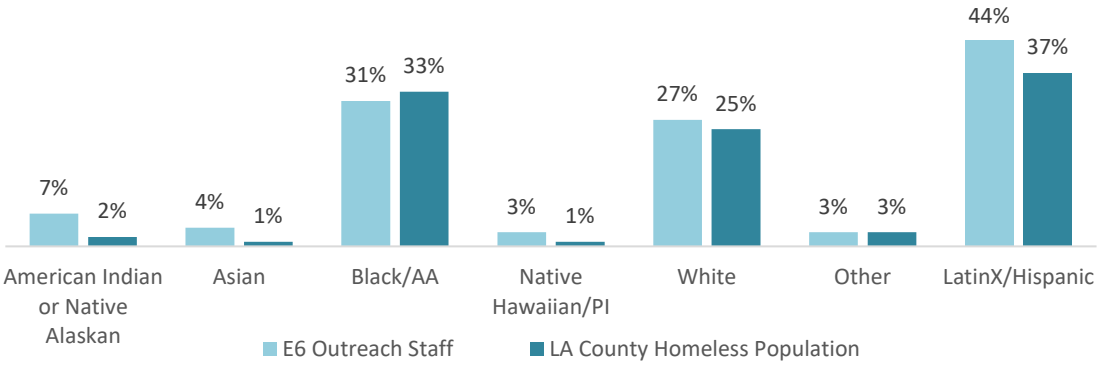


Service Providers. A core strength of Strategy E6 is the deliberate effort to staff teams with individuals with lived experiences and backgrounds that match the County's unsheltered populations. Nearly half of all outreach staff claim some personal lived experience with homelessness, and across the board, E6 staff closely reflect the County's homeless population in terms of race and ethnicity.[35,36] This effort to ensure the staff network has cultural fluency that resonates with clients' own experiences supports the effective

[35] Staff demographic data from a 2018 survey conducted by LAHSA
[36] Data from the 2019 Los Angeles County Homeless County Demographic Survey.

development of trusting relationships that ultimately support people in achieving their own safety, wellness, stability, and housing goals. Figure 18 shows how closely the E6 outreach network reflects the unsheltered population in terms of race and ethnicity.

Figure 18: Race & Ethnicity of E6 Outreach Staff & LA County Homeless Population



Because of the way LAHSA collects and reports mental health and substance abuse data on homeless clients, it is difficult to compare the self-reported experiences of E6 staff with the unsheltered population, but the data reflect that staff have backgrounds that help them connect with their clients: 40% of staff self-report personal experience with mental health issues and 38% with a history of substance abuse.[37]

Services & Referrals. Outreach workers do not simply "make contact" with highly vulnerable individuals on the streets, they provide a wide range of direct support services, connections to resources and external services, emergency food and water, hygiene supplies and first aid, assistance getting identification, and public benefits. They meet with their clients to develop an individual service and support plans; they provide them with transportation to and from important appointments; and they frequently accompany them to ensure they connect with their care teams and external providers (Figure 19).

Figure 19: Examples of Outreach Services, Resources, and Items Provided to E6 Clients

"Human" Contact	Food & Water	Hygiene & Basic Supplies	Emergency Response & First Aid
Motel/Hotel Vouchers	Transportation	Appointments	CES Assessment
Counseling	Family Reunification	Assistance with IDs & Public Benefits	Referrals to External Services

[37] LAHSA reports a 25% rate of diagnosed SMI among the County's homeless population, and a 15% rate of diagnosed substance use disorder. These definitions are narrower than those used in the staff survey.

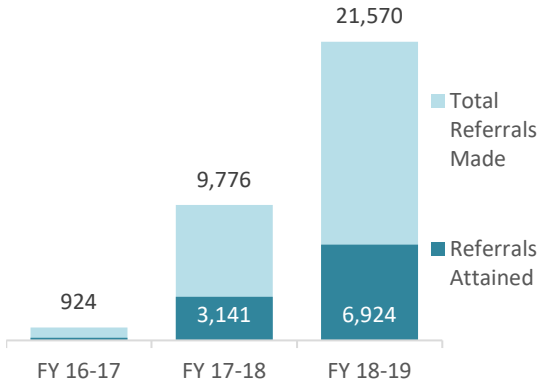
E6 teams provide case management and care coordination services, which is especially important for persons with complex physical health, mental health, and/or substance use needs. Outreach workers serve as the front door to CES and the County's housing resources, but for most clients they also serve as the front door to a wide range of other County services and programs, including physical health services, behavioral and substance abuse services, housing, and public benefits assistance. When the team cannot meet a client's service needs directly in the field, they make referrals to an external provider or County agency. E6 outreach staff provide "warm handoffs" for referred services, frequently driving and also accompanying clients to important appointments to help create a bridge, increasing the chances the client will form a trusting relationship with the new provider. Warm handoffs are a best practice and a core part of homeless outreach, improving client service linkages, increasing trust in new providers, and benefitting individual outcomes.

BEST PRACTICE: Warm Handoffs

Warm handoffs increases the trust people have in the transfer of their care to new providers or in new settings. Warm handoffs occur when an individual moves into permanent housing and still receives repeated visits with their outreach worker, or when the outreach worker accompanies them to an appointment with a healthcare professional.

E6 outreach staff receive training to provide warm handoffs to ensure clients link up with the services they need and to foster trust in the new provider or setting. The rates of service linkages demonstrate that many E6 workers are engaging in this best practice to support their clients' relationships with other community-based and County providers.

Figure 20: External Service Referrals Made & Attained (Measure H-funded teams only)



Over the last two years, Measure H-funded outreach teams made 30,000 service referrals for clients based on assessed needs. The data show that E6 clients ultimately linked up to those referred services one third of the time, but as described earlier in this report, many staff express concerns with the quality of data that track referrals in HMIS. As a result, the overall rates of service linkages may be under-reported. Staff expressed deeply personal commitments to build the trust needed to help clients walk the path towards better outcomes, including securing housing. Living unsheltered can cause physical and social isolation, and lead clients to despair, so frontline outreach workers use customized, diverse approaches to "meet clients where they are at" and maintain trust to help them move forward with their individual goals. A large majority of staff (90% of survey respondents) believe they are personally benefitting their clients, and 90% also agree their entire outreach team is impacting their clients' lives.

The journey to securing housing can be long and arduous because there are many prerequisite tasks to even get onto the community queue. First, a client needs to complete a CES assessment and disclose personal information about their level of need and vulnerabilities, which does not always happen upon first contact. Outreach staff sometimes need to make several subsequent visits in order to build the trust necessary to complete the CES VI-SPDAT assessment. Then, if they don't have current identification, the outreach worker will help them get an ID, which frequently requires them to get a copy of the client's

birth certificate. Working with state agencies to process and obtain identification and documents is not usually very fast. During this window, teams provide ongoing client outreach to maintain engagement so clients can reach their goals.

Many clients understand there is a shortage of housing resources and that they may have to wait long periods for a housing match, but E6 staff shared that they feel deeply appreciated by their clients for maintaining engagement and providing ongoing support during this period. Many clients have not connected with services in a long time, and some clients have never navigated public systems before. In both cases, the process can be both daunting and complex, and E6 outreach staff help them through the process of coordinating with various County, state, and federal agencies to obtain identification, enroll in public benefits, access resources, and connect with service providers to help them successfully achieve better health, safety, and long-term stability including housing retention.

Service Details. Because of the limitations outlined in the methodology section of this report, RDA did not have Strategy-wide data from which to draw conclusions about the quality, degree, or responsiveness of Strategy-wide service output data. That said, the figures in Appendix H show very clearly that over the first three years of Strategy E6 implementation, Measure H-funded outreach teams dramatically increased every type of contact, service, and referral provided to clients. These figures combine services and referrals in a few broad categories:

1. *Housing Referrals & Linkage Rates:* referrals and links to 2-1-1, access centers, DHS Housing for Health, housing navigation, and bridge, crisis, permanent, transitional, and rapid re-housing.
2. *Housing Services in the Field:* vouchers for short-term hotel stays, housing search and placement services (replaced by external referrals), and housing stability planning.
3. *Direct Support Services & Supplies in the Field:* emergency supplies such as food, water, and hygiene kits, transportation vouchers or actual rides to and from appointments, information about services, and any "contact" which could include any type of human-to-human interaction between people experiencing unsheltered homelessness and E6 staff.
4. *Case Management Services:* case management meetings, care coordination services such as accompanying clients to appointments or scheduling assistance, and assistance obtaining identification and documents and enrolling in public benefits.
5. *Health & Behavioral Health Services & Referrals:* emergency health services or first aid in the field, referrals to physical health providers, and field services or referrals to mental health services and substance use services or treatment.

Resources External to Strategy E6

Throughout this evaluation project, stakeholders shared their perspectives on a broad range of factors that are external to the E6 outreach system but related to other public safety net services systems impacting people experiencing unsheltered homelessness. E6 is the deliberate focus of this report's key findings, in alignment with the purpose of the evaluation. However, the intensity and frequency of feedback received about other systems indicated the need to incorporate a section of considerations for non-outreach related data. Inherently, homeless outreach interconnects with all other components of an effective continuum of safety net and housing services. This section highlights those areas that arose as significant concerns impacting effective outreach services for E6 clients.

Housing

Stakeholders underscored the impact of Countywide shortages for all types of affordable housing and shelter resources. This lack prevents people from successfully exiting from homelessness, creating a bottleneck in the outreach system where staff must continue to engage clients who cannot see a clear or expedient path indoors. This shortage of housing resources creates several interrelated challenges that impact the perceived effectiveness of outreach, namely because it prevents E6 clients from being able to achieve the intended housing outcomes. E6 stakeholders identified four distinct needs for housing:

1. **Shelter Beds & Temporary Housing (Interim Housing).** Staff underscored the impact of interim housing shortages in some areas of the County. Specifically, there may be a challenge siting or allocating shelter resources in the places that most need them even if there are enough beds across the entire region. Although leadership noted the County is working with providers to open many more interim housing sites in the City of LA, E6 staff from across the County frequently shared that when beds become available, they are not located in the areas that clients need them. Geographic accessibility to outreach staff is a key strength of the E6 system, but the available shelter beds and temporary housing resources from other parts of the homeless services continuum do not match the geographic accessibility of outreach staff. When a shelter bed becomes available, staff reported that the bed is frequently in another community that is far away from where their client currently lives and outside their comfort zone. This challenge with the homeless service continuum is not directly related to Strategy E6, but it does limit what outreach staff can do to help their clients move off the streets. Additionally, staff reported that their clients frequently cite concerns with shelter safety and habitability, accessibility for persons with disabilities, and pet policies. These restrictions on traditional shelters are barriers that prevent some clients from moving indoors to temporary environments.

> *This whole program started with no housing resources. We don't have housing or shelters. These programs are great, we can hire more people, but we don't have beds.*

2. **Population-specific Housing Options.** Outreach staff shared that there are insufficient housing resources for culturally-specific groups or subpopulations of people experiencing homelessness. For example, seniors, TAY, people with substance use disorders, people recovering from physical illness, people with disabilities, undocumented immigrants, and registered sex-offenders all have specific housing needs and there are unique best practices defined for each of these groups. Many of the existing shelters and other housing opportunities have policies that create unwelcoming environments for one or more of these groups, or even ban one or more groups explicitly. The lack of culturally-specific housing options for these subpopulations does not align with the County's Housing First policy.

[We need] more doors for youth to walk into. Youth really fall through the cracks and it's hard to tell which TAY are homeless. Also individuals with physical illness. I found two people dead in the street and in the park. They need to be prioritized.

3. **Resources for Clients with Moderate Vulnerability or CES Scores.** In CES, clients experiencing homelessness are assessed for their vulnerability. All E6 outreach staff play a role in conducting the CES assessment or they connect clients to someone who can, but many staff expressed frustration that this system creates a barrier to accessing affordable housing resources. Although it is possible some frontline staff don't understand the nuance of the County's CES, the prioritization based on vulnerability is widely regarded as a challenge for their clients, with the potential to increase or prolong housing insecurity and instability, and, in the worst of cases, lead to housing crises. Some staff shared instances of witnessing County residents become homeless because they did not meet eligibility criteria for certain prevention or housing resources until the met the threshold for "literally homeless." Among many staff, there is a sense that a CES which prioritizes only the most vulnerable is illogical because everyone who is homeless is in need.

The whole system, the approach of trying to house the most vulnerable, is not working Countywide. Prioritizing undermines people's perceptions of who should get what. CES is a barrier… If you score between 8 and 11, there's nothing.

4. **All Types of Affordable Housing.** It almost goes without saying that the lack of affordable housing is the number one barrier to resolving homelessness. This reverberates across the continuum of homeless services and impacts E6 staff serving clients actively awaiting a housing match. As clients engage with outreach staff and identify case plan goals, outreach staff shared that their clients frequently grow frustrated as they learn there may not be a clear pathway indoors. Even though outreach staff are contacting more people experiencing unsheltered homelessness every year, the lack of system exits create a bottleneck in the pathway out of

When someone does want shelter, you might not have the capacity to help them. What we deal with is the moral injury of it all.

homelessness. When housing resources are scarce, outreach teams must find other ways to incentivize clients to stay service-engaged and help them understand that ongoing engagement may be their best hope for security, safety, and, hopefully housing.

Mental Health Services

DMH is a key member of Strategy E6 leadership; while they do not receive Measure H funding, DMH outreach teams are fully integrated into the E6 structure. All teams collaborate closely with DMH outreach, which provides a large array of community-based mental and behavioral health services to people experiencing homelessness across LA County.

Outreach workers need access to more mental health resources, such as licensed clinicians and Full Service Partnership (FSP) wraparound services for clients experiencing acute mental health issues. The stress of homelessness can lead to or exacerbate mental health challenges, and E6 outreach staff across all SPAs frequently encounter individuals experiencing mental health issues on the streets. Although E6 staff receive training in effective practices for engaging these individuals and bringing in support from MDTs or DMH teams when necessary, they also reported that engaging these individuals is a frequent challenge. Additionally, E6 staff also reported difficulty accessing trained mental health providers when they need them, such as licensed clinicians with competency serving homeless individuals in the field. They also noted that because the County's FSP slots are filled to capacity, they either need additional licensed clinicians and FSP slots or more alternatives for wraparound services for clients experiencing acute mental health challenges or SMI.

[The] biggest barriers for clients who have SMI is that they won't engage with you. You will barely be able to identify their name. For DMH, our best line of defense is FSP programs. They [DMH] don't have the capacity to do what clients need [because] they are understaffed and overworked.

Recommendations

RDA offers the following system-wide, program and practice, and client service delivery recommendations to improve efficiency and impact. Recommendations flow from the evaluation team's triangulated analyses of primary qualitative, primary survey, and secondary qualitative data, as well as research on evidence-based and best practices in homeless outreach service delivery.

A. Align access to "flexible funds" for clients by establishing policies for all outreach teams that improve equitable access to resources across the outreach system (Finding 5).

As discussed in Finding 5, unequal access to client resources that support health and safety, such as the varying rules that govern staff use of flexible funds for things like fees to obtain documentation or overnight stays in a hotel, causes imbalance between teams. This issue arose for DMH and HET teams, who are County employees, and staff noted that the providers who work for community-based organizations that contract under LAHSA or DHS have looser requirements or enforce requirements in a more relaxed way.

Because unequal access to resources that are vital to clients limits how effectively staff feel they can meet clients' needs, it can lower morale and lead to disengagement. Strategy leadership should consider aligning restrictions for these funds or more broadly communicate the reasons behind the differences.

B. Continue to establish, refine, and strengthen collaboration protocols between homeless-serving, law enforcement, and sanitation agencies to support client service continuity as well as trauma-informed responses to public safety concerns (Finding 6).

The formal and informal communication protocols between homeless outreach teams and non-traditional outreach partners are still emerging in Los Angeles County as these disparate agencies learn how to more effectively collaborate. Strengthening and reinforcing collaboration protocols (e.g. MOUs) among the formal E6 partnerships with law enforcement, as well as continuing to offer training to law enforcement and sanitation agencies across the County, can provide role clarity for each actor within this system, define trauma-informed escalation pathways for crisis situations involving E6 clients, and enhance understand about the purpose and function of outreach.

Strong collaboration protocols provide role clarity for actors, define trauma-informed escalation pathways for crisis situations involving E6 clients, and enhance understanding about the purpose and function of outreach. Outreach staff want to partner more effectively with these agencies, and want those partnerships centered on evidence-based practices for working with this population. Delineating steps that each actor should take, and when they should take them, will support clients' continued engagement in E6 services to help them find pathways out of homelessness, rather than promoting mistrust and fear.

C. Continue to educate community stakeholders about the purpose and function of homeless outreach, including providing more nuanced information to LA-HOP requestors (Finding 7).

SPA Outreach Coordinators and E6 leadership noted that targeted promotion and education campaigns about LA-HOP and the system of outreach could address misperceptions about the role and function of outreach and help the community learn about the outreach system. One example of a public-facing messaging strategy is to provide more information about the process and time it takes to find and contact people experiencing homelessness, as well as the nature and purpose of outreach. Although the system provides answers to these questions, community members may not read the documentation or emails. Arming community stakeholders with better information about the outreach process can help address widespread misperceptions about outreach.

D. Implement HMIS data and documentation quality measures across E6 providers to identify ongoing training needs, build staff data capacity, and ensure consistently high-quality data (Finding 8).

Training without ongoing quality improvement efforts and coaching leads to declining quality over time. Because stakeholders report inconsistent quality within HMIS data entry, and because a third of E6 staff do not find HMIS easy to use, Strategy leadership should continue working with the vendor to improve the user experience, but also should consider implementing continuous quality improvement efforts and standard data quality assurance (QA) processes to ensure all E6 providers are following consistent standards and protocols for using HMIS. QA processes, when combined with ongoing coaching, reinforce best practices, support consistently high-quality client services, and reduce duplication of effort.

E. Assess client data sharing infrastructures, including tools for documenting service referrals and linkages, to gain insights about opportunities to improve system-wide efficiency (Finding 9).

A focused examination of Countywide referral tracking tools would help Strategy leadership assess the degree to which current outreach data tools meet standards for efficiency, expediency, and client confidentiality. Although many E6 staff report they find "ways" to access the information they need from other teams, many also suggested improvements to HMIS to increase ease-of-use and system-wide capacity for care coordination. Because staff do not receive notifications when clients connect with referred services, they have no way to know for certain if or when that happens. Therefore, linkage data from HMIS are unreliable. Although the County's CHIP pilot (AB 210 portal) may address these concerns, the County should monitor and assess its features, or, explore the feasibility of implementing a community health record across public service disciplines to automate provider notifications and referral tracking.

F. Support coordinated E6 practice trainings with coaching for E6 outreach staff and implement a fidelity or quality measure to ensure continuous improvement for delivering evidence-based and best practices (Finding 12).

Changing behaviors and beliefs is slow, steady work. Similarly, training without continuous monitoring and improvement efforts results in declining quality. The centralized, structured E6 orientations, learning

collaboratives, and trainings reinforce best and evidence-based practices across the vast network of providers, as do the management shadowing and coaching efforts, but it is equally important to implement fidelity measures in order to ensure consistent service delivery that results in the expected client outcomes.

G. Fold CTI models and institutional in-reach (or pre-release planning) partnerships into Strategy E6 to support care coordination. This will help ensure that vulnerable individuals exiting institutions have warm hand-offs to coordinated entry services and that individuals moving into permanent housing have the support they need to stay housed (Finding 13).

Hospitals admit and discharge homeless patients every day, but there is currently no way for hospital staff to notify the homeless outreach service system that a vulnerable individual is heading back onto the streets. In addition, when law enforcement arrests and books into jail someone experiencing homelessness, that individual will still be homeless once released. These are system gaps that disproportionately affect the most vulnerable individuals; individuals who are also the most likely to require and over-utilize emergency services. RDA suggests that Strategy leadership explore partnerships with other County agencies that are already providing pre-release assessment and planning services (e.g. Whole Person Care), agencies that have the ability to partner with the homeless service system to conduct in-reach or pre-release planning (e.g. Probation), and local health systems to find ways to provide early intervention for vulnerable homeless clients exiting from other institutions. CTI is an empirically-supported intensive case management model developed specifically to prevent recurring experiences with unsheltered homelessness in people who have experienced chronic homelessness, mental illness, or substance use challenges. This is a time-limited model that emphasizes mobilizing and strengthening client support during critical transitions between levels of care.

H. Track outreach travel time and ensure staff targets account for job-required travel (Finding 14).

Driving around Los Angeles County takes a lot of time. As mentioned on page 37, E6 does not ask staff to track travel time for essential job functions like the provision of client services or returning a County vehicle after a required meeting. Without the systematic data collection on travel, productivity targets cannot effectively account for the realities of travel in LA County, or regional differences between SPAs. Enabling staff to provide travel time information and ensuring staff targets account for job-required travel will improve transparency between frontline staff and Strategy leadership and address concerns about unfair productivity targets, especially among staff who work in less dense areas of the County that require more time spent driving.

Consideration for the Next Phase of E6 Implementation

Because implementation of Strategy E6 is still in a formative stage, efforts to date have emphasized establishing effective collaborative partnerships, defining communication pathways and protocols, and promoting best practices across the Countywide system of homeless outreach. In the next phase of implementation, Strategy E6 leadership should continue to institutionalize and refine systems-level structures that support service quality, assure alignment between theories of change and outreach

practices, and sustain long-term influence and impact. The Annie E. Casey foundation suggests several core competencies for systems-change initiatives to influence social change and drive impact; Strategy E6 leadership have already established or developed most of these core competencies. In the next phase of implementation, leadership should consider establishing formal tools and structures to support Strategy E6 governance, including a charter, a unified mission statement, and/or a theory of action.

Strategy E6 is a systems change initiative that targets a deeply entrenched problem. To create and influence sustainable change at the systems and policy levels, E6 will need to ensure alignment across stakeholders, disciplines, viewpoints, and approaches to doing the work of homeless outreach. While Strategy leadership demonstrate strong internal partnerships that enable effective system-wide collaboration, Strategy E6 does not have a theory of action or governance agreement to support a cohesive vision or sharpen planning and implementation efforts. These tools increase shared understanding of the problem that needs to be solved; the intended impact or outcome; the forces for change; external influences and risks; and the evidence basis for practices that lead to impact. [38] Shared governance tools sustain system-wide culture and reinforce the practices that result in beneficial client outcomes. In the next phase of implementation, it will be important to codify the means to establish and hold partners accountable to a common goal, and ensure considerable investments stay on course.

[38] Connell, J. and Kubisch, A. *Applying a Theory of Change Approach to the Evauation of Comprehensive Community Initiatibes"* Accessed from: http://www.dmeforpeace.org/sites/default/files/080713%20Applying+Theory+of+Change+Approach.pdf

Appendices

Appendix A E6 Staff Positions & Funding Sources

Table 5: E6 Agencies, Staff Positions, & Funding

Agency	Position	Staff	Measure H Funding
CEO-HI	Staff Analyst, E6	0.25 FTE	None
LAHSA	Director, Access & Engagement	1.0 FTE	Full
	Associate Director, Access & Engagement	2.0 FTE	Full
	Manager, Access & Engagement	2.0 FTE	Full
	HOPE Manager, City of LA	1.0 FTE	Partial
	Manager, Measure H & City of LA	1.0 FTE	Partial
	Manager, CES Access	1.0 FTE	Full
	CES Outreach Coordinator	2.0 FTE	Full
	SPA Outreach Coordinators	17.0 FTE	Full
	Generalist Teams: SPAs 5, 6, & 8	46.0 FTE	Full
	Generalist Teams: SPAs 1, 3, & 7	54.0 FTE	Full
	Generalist Teams: SPAs 2 & 4	89.0 FTE	Full
	HOST & HOST Regional Teams	16.0 FTE	Full
	HOPE Teams	15.0 FTE	Partial
DHS – Housing for Health	Manager, Program Implementation	1.0 FTE	Full
	Director, Street-Based Engagement	1.0 FTE	Full
	Program Manager: SPAs 1 & 2	1.0 FTE	Full
	Program Manager: SPA 3	1.0 FTE	Full
	Program Manager: SPA 4	1.0 FTE	Full
	Program Manager: SPAs 5 & 6	1.0 FTE	Full
	Program Manager: SPAs 7 & 8	1.0 FTE	Full
	Multidisciplinary Teams (MDTs)[39]	44 Teams	Full
		16 Teams	None
	Public Spaces Teams	20 Teams	Full
DMH	Countywide Deputy	1.0 FTE	None
	Program Manager IV	2.0 FTE	None
	SPA Chief	8.0 FTE	None
	HOME Teams	125.5 FTE	None

[39] At the time of publication, DHS reported that between the 80 MDTs and Public Spaces teams, there are approximately 300 FTEs

Appendix B Evaluation Research Questions and Data Sources

Table 6: Evaluation Research Questions and Primary & Secondary Data Sources

		Key Question *** Questions were adapted for specific methods, e.g. Focus Groups with Frontline Staff*	Interviews (Key Informants)	Focus Groups: Prog. Mgrs	Focus Groups: Staff	Survey	Document Analysis	PIT	HMIS	LA-HOP
How do *systems-level factors* impact the effective coordination of outreach services?										
CURRENT	I.	How is the network of outreach resources deployed, structured, and funded?	X	X			X			
	II.	What key considerations impact the structure, dispatch, or deployment of outreach resources? (e.g. geography, request volume, expertise required; funding sources)	X	X			X			
ASSESSMENT	I.	To what extent is E6 being implemented as planned?	X	X	X		X			
	II.	To what extent do the structure, data sharing practices, and collaboration processes increase overall effectiveness of the strategy?	X	X	X	X	X			
	III.	To what extent are outreach partners effectively coordinating within SPAs and across the County?	X	X	X	X	X			
	IV.	What are the barriers and facilitators of effective coordination?	X	X	X	X	X			
	V.	How do different funding sources and respective restrictions affect outreach coordination?	X	X						
	VI.	How does the relationship between system demand (unsheltered population needs and resident requests for service) and system capacity (including the capacity of CEO-HI leads for E6) impact efficiency and optimization?	X	X	X		X	X	X	X
+/Δ	I.	What specific structural changes or resources would further optimize the system?	X	X	X					
How do *program-level factors* impact the effective coordination of outreach services?										
CURRENT	I.	What practices and models are outreach partners implementing?	X	X	X		X			
	II.	How do Measure H-funded practices differ from practices funded through other means?	X	X	X		X			
	III.	What do direct service staff understand to be their job responsibilities?			X					
	IV.	How do staff assess, record, and monitor clients' service needs?		X	X				X	
	V.	How do staff refer clients to supportive services, such as public benefits, housing navigation, etc. and track referrals?		X	X		X		X	
ASSESSMENT	I.	What is the alignment between perceptions of effectiveness and existing practices?	X	X	X		X			
	II.	How do direct service staff and County staff define effectiveness within this strategy?	X	X	X					
	III.	What do direct service staff and County staff understand to be best or promising practices in coordinating outreach?	X	X	X					
	IV.	To what extent do outreach partners successfully collaborate with each other and partners to address clients' needs?	X	X	X	X				
	V.	What are the barriers to, and facilitators of, interagency collaboration?	X	X	X	X	X			
	VI.	What are the impacts of multidisciplinary vs. generalist teams? (MDT/AB 210)	X	X	X		X		X	
+/Δ	I.	What additional resources or tools do staff need to fulfill their job responsibilities?		X	X					
	II.	If expanded across the system, what best or promising practices would improve system-wide outreach service delivery and coordination?	X	X	X					

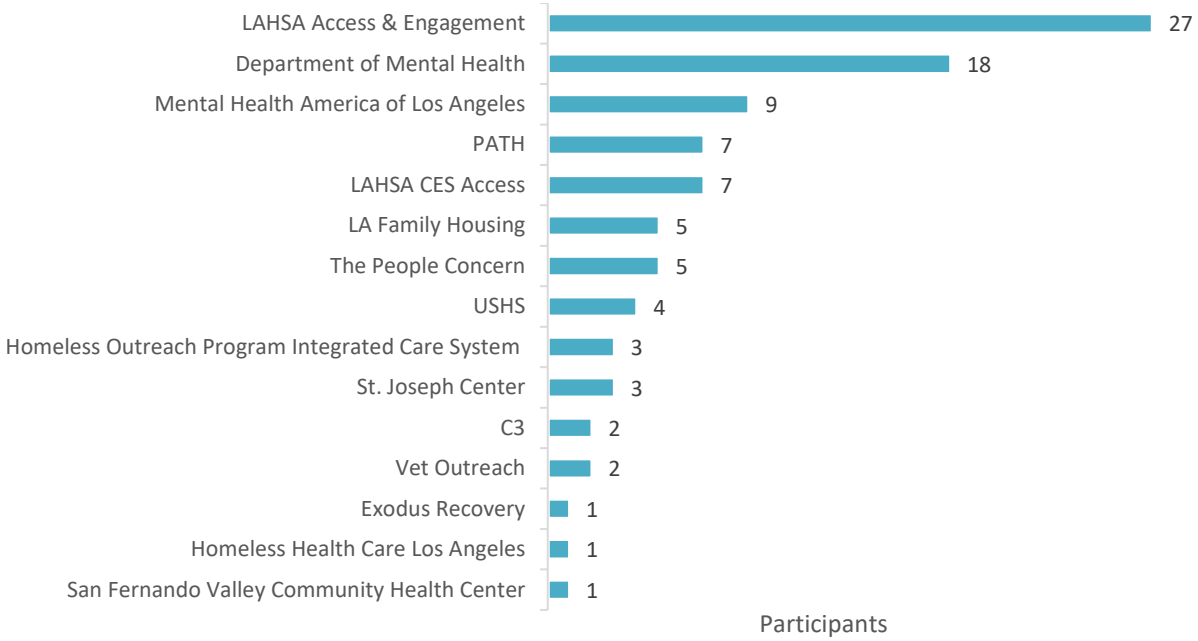
		Key Question ** Questions were adapted for specific methods, e.g. Focus Groups with Frontline Staff	Interviews (Key Informants)	Focus Groups: Prog. Mgrs	Focus Groups: Staff	Survey	Document Analysis	PIT	HMIS	LA-HOP
How do *individual client services and/or experiences* align to Strategy E6 objectives?										
CURRENT	I.	Who has accessed or engaged outreach services?					X	X	X	
	II.	What outcomes do clients expect or hope to achieve as a result of engaging in outreach?			X					
	III.	Are these outcomes being tracked and achieved?			X		X		X	
ASSESSMENT	I.	Under this strategy, to what extent do clients who engage in services reflect population trends among the unsheltered population?						X	X	X
	II.	How do barriers to achieving positive outcomes (e.g. access to healthcare or interim housing, etc.) impact clients' experiences?			X					
	III.	Do clients experience greater access to services and resources as a result of engaging with outreach teams?			X				X	
+/Δ	I.	What improvements, practice adjustments or further resources do clients need in order to achieve the success they expect to achieve as a result of engaging in outreach?			X					
	II.	What practical changes will ensure Strategy E6 services reach the intended populations?			X					

Appendix C Focus Group Participation

Table 7: E6 Positions & Teams That Participated in RDA Focus Groups (n=95)

Positions	Teams
• Addiction Specialist II • Case Manager • Community Health Worker • Data Quality Specialist • Housing Navigator • Intermediate Typist Clerk • Marriage & Family Therapist • Mental Health Specialist • Mental Health Clinician • Outreach Specialist • Peer Case Manager • Personal Service Contractor • Program Manager • Psychiatric Social Worker I & II • Registered Nurse • SPA Coordinator • Substance Use Specialist • Supervisor • Team Lead • Veteran Outreach Coordinator	• Generalist • HOME • HOST • Housing Navigation • MDT • DMH HST • Supportive Services for Veteran Families • Public Spaces • C3

Figure 21: Focus Group Participation by Agency (n=95)



Appendix D Strategy E6 Outreach Service & Referral Definitions

Table 8: HMIS Definitions for Services Provided by E6 Outreach Staff

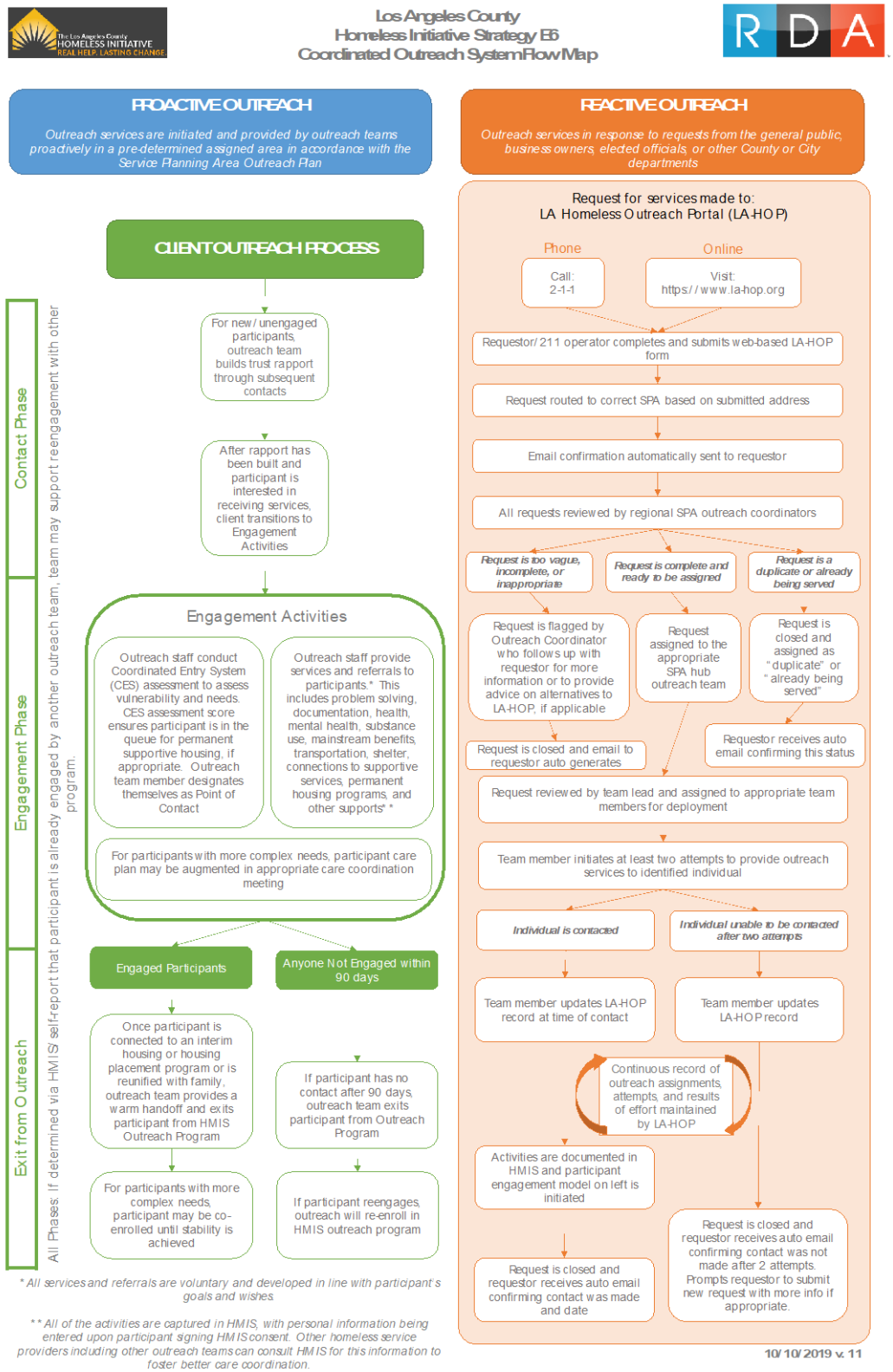
Contact	Provide any interaction with a street-based homeless individual. • *Contacts range from a brief conversation about needs to a service referral* • *Every interaction/service/referral provided must be logged as a contact in addition to the service and/or referral logged.*
Food & Drink	Provide food or drink and/or assist in obtaining food or drink (e.g., meal cards)
Basic & Hygiene Items	Provide basic hygiene items (e.g., toothpaste, shampoo, socks) and/or assist in obtaining necessary items (e.g., 99 cent store card, clothing vouchers, etc.)
Motel/Hotel Vouchers	Provide individual with a motel/hotel voucher
Appointments	Schedule and/or assist to schedule an appointment for services (e.g. Medi-Cal appointments, case management appointments) • *This may include accompanying an individual to an appointment*
Mental Health	Conduct a psychosocial assessment, risk assessment, mental status exam and/or clinical intervention(s)
Physical Health	Conduct a physical evaluation/assessment and/or health intervention(s)
Substance Use Counseling	Conduct a substance use assessment and/or substance use intervention(s)
Document Assistance	Assist in obtaining vital, other documentation (e.g., birth certificate, ID, social security card, income verification)
Transportation	Provide client transportation and/or assist client in obtaining transportation (e.g. bus tokens, rideshare)
Family Reunification	Assist in reconnecting an individual with family members through phone contact and/or face to face contact in an effort to resolve their homelessness
Benefits Assistance	Assist with establishing or increasing benefits (e.g., General Relief, Social Security Income, CAPI, CalFresh, Medi-Cal) • *Activities include assisting with the application process, (e.g., accompaniment to appointments, completion of required documents and follow up appointments, benefits advocacy)*
Emergency Response	Contact 911 or other emergency responder(s) to assist a street-based homeless individual with a health and/or mental health emergency

Table 9: HMIS Definitions for Referrals to External Services

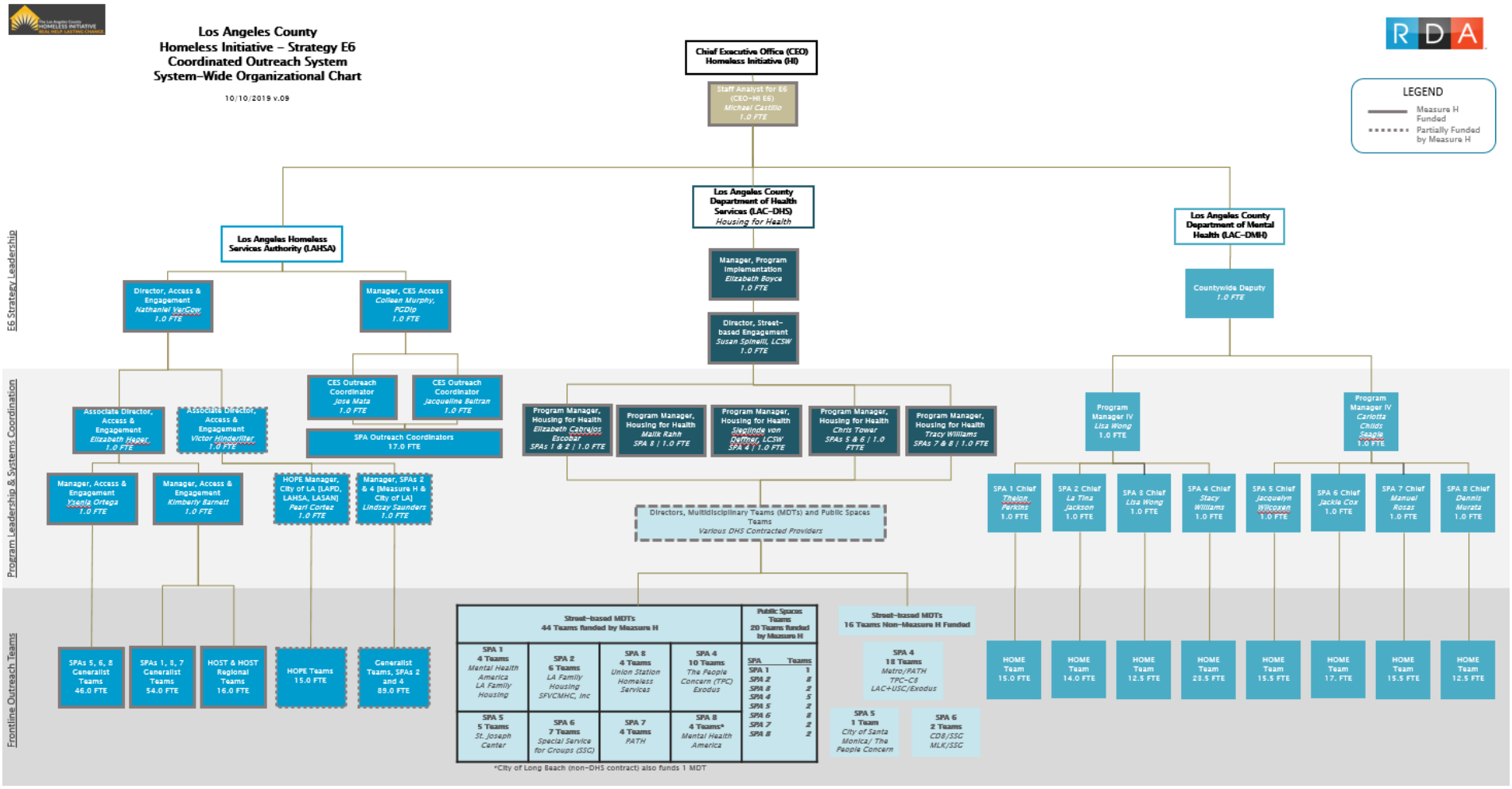
Access Center	Referral to a Homeless Access Center
Crisis Housing	Referral to short term, 24-hour emergency shelter • *Beds are provided on a first-come, first-serve basis, based upon availability*
Bridge Housing	Temporary/interim housing that facilitates access to permanent housing • *Beds are prioritized for individuals with high acuity in CES who are either matched or unmatched or for persons exiting institutions*
Recuperative Care	Referral to temporary housing that provides health oversight and a location to work with individuals to get permanent housing
Motel/Hotel Vouchers	Referral for the provision of a motel/hotel voucher
Residential Care Facility	Referral to short or long-term residential care facility • *e.g. independent living program, board and care facility, skilled nursing facility*
Residential Substance Use Treatment	Referral to a residential substance use treatment program • *e.g., detox program, in-patient substance use treatment program*
Employment Services	Referral for employment-based skill building, pre-employment work experience and/or job placement programs
Education Services	Referral for academic instruction and/or education-based training

Legal Services	Referral for legal services • *e.g., homeless court, legal aid, expungement programs*
Substance Use Services	Referral for outpatient substance use services • *e.g., substance use counseling, Medication Assisted Treatment including Methadone, Suboxone, needle exchange, 12-Step meetings*
Mental Health Services	Referral to mental health services that provide treatment for people experiencing mental health and/or co-occurring disorders • *e.g., Department of Mental Health*
Primary Care	Referral for physical health care with a primary health care clinic
Specialty Care	Referral for specialized physical health care and/or treatment • *e.g., dental services, vision care, specialized Medi-Cal care, HIV services*
Benefits	Referral for the purposes of benefit establishment • *e.g., General Relief, CalFresh, Medi-Cal, VA*
CBEST	Referral to the Countywide Benefits Establishment Team (CBEST) for benefit establishment
Permanent Housing	Referral to a program that provides permanent housing • *e.g., Housing for Health Intensive Case Management Services (ICMS), Rapid Rehousing, Veteran Affairs Supportive Housing (VASH), and Housing Opportunities for Persons with AIDS (HOPWA). Project-Based Supportive Housing program*

Appendix E Strategy E6 Outreach Process Flow Map



Appendix F Strategy E6 System-Wide Organizational Chart



Appendix G E6 Staff Training Detail

Table 10: E6 Staff Trainings October 2018 – June 2019

Date	Training Type/Course Name
OCTOBER	
18-Oct	Street-based Engagement (E6) Learning Collaborative. HEART: Protecting People and Their Pets
DECEMBER	
10-14-Dec	**LAHSA & The Health Agency Street-based Engagemt. Collaborative Training & Orientation Week**
JANUARY	
17-Jan	Street-based Engagement (E6) Learning Collaborative -Public Health for Outreach Teams
FEBRUARY	
21-Feb	Street-based Engagement (E6) Learning Collaborative -An Introduction to Vivitrol
MARCH	
5-Mar	Stages of Change: Helping People Change Behavior
6-Mar	Housing First: An Evidence-Based Approach for Ending Homelessness
7-Mar	Foundations of Motivational Interviewing 1
12-Mar	Introduction to Case Management
13-Mar	Foundations of Motivational Interviewing 1
14-Mar	Practical Counseling Skills
19-Mar	Hoarding Part I: Buried in Treasures
20-Mar	Hoarding Part II: Buried in Treasures
21-Mar	Working with the Chronically Homeless
21-Mar	Street-based Engagement Learning Collaborative 1) Universal Homeless Verification 2) AB 210
22-Mar	Moving On: Supporting Clients through Transition
26-Mar	Stages of Change: Helping People Change Behavior
27-Mar	Art of Person-Centered Documentation
28-Mar	Understanding Special Needs
APRIL	
9-Apr	Decompensation and Relapse: A Proactive Lens
10-Apr	Non-Coercive Approaches to Conflict Management
11-Apr	Foundations of Motivational Interviewing 2
18-Apr	Street-based Engagement (E6) Learning Collaborative. Grieving on the Streets: Compassion and Community for Outreach Workers Coping with the Death of Clients
23-Apr	Introduction to Case Management
24-Apr	Practical Counseling Skills
25-Apr	Trauma and Its Aftermath 1
30-Apr	Working with the Chronically Homeless
MAY	
1-May	Foundations of Motivational Interviewing 2
2-May	Trauma and Its Aftermath 1
7-May	Art of Person-Centered Documentation
8-May	LGBTQ: Becoming an Ally to the Community
9-May	Overview of Major Psychiatric Disorders & Medication: DSM 5
14-May	Hoarding Part I: Understanding Compulsive Hoarding
15-May	Housing-Based Case Management
16-May	Understanding Mental Health Recovery

16-May	Street-based Engagement (E6) Learning Collaborative 1) DMH Adult FSP Overview 2) Domestic Violence on the Streets: Overview and Resources
21-May	Understanding Special Needs
22-May	Trauma and Its Aftermath 2
23-May	Managing Impact of Job Related Stress for Staff
28-May	Motivational Interviewing for Supervisors
29-May	Trauma informed-Care Part 2 (Modified on 5.2.19)
30-May	Housing-Based Case Management
JUNE	
4-Jun	Decompensation and Relapse: A Proactive Lens
5-Jun	Foundations of Motivational Interviewing 1
6-Jun	Meeting the Challenge of Working with People who have Borderline Personality Disorder
10-14-Jun	**LAHSA & The Health Agency Street-based Engagemt. Collaborative Training & Orientation Week**
18-Jun	Trauma and Its Aftermath 1
19-Jun	Foundations of Motivational Interviewing 2
20-Jun	Non-Coercive Approaches to Conflict Management
25-Jun	Motivational Interviewing for Supervisors
26-Jun	Housing First: An Evidence-Based Approach for Ending Homelessness
27-Jun	Suicide Assessment and Prevention
28-Jun	Wellness and Aging in Supportive Housing

Appendix H Client Service Outputs

Figure 22: Housing Referrals and Linkages (Measure H-funded teams only)

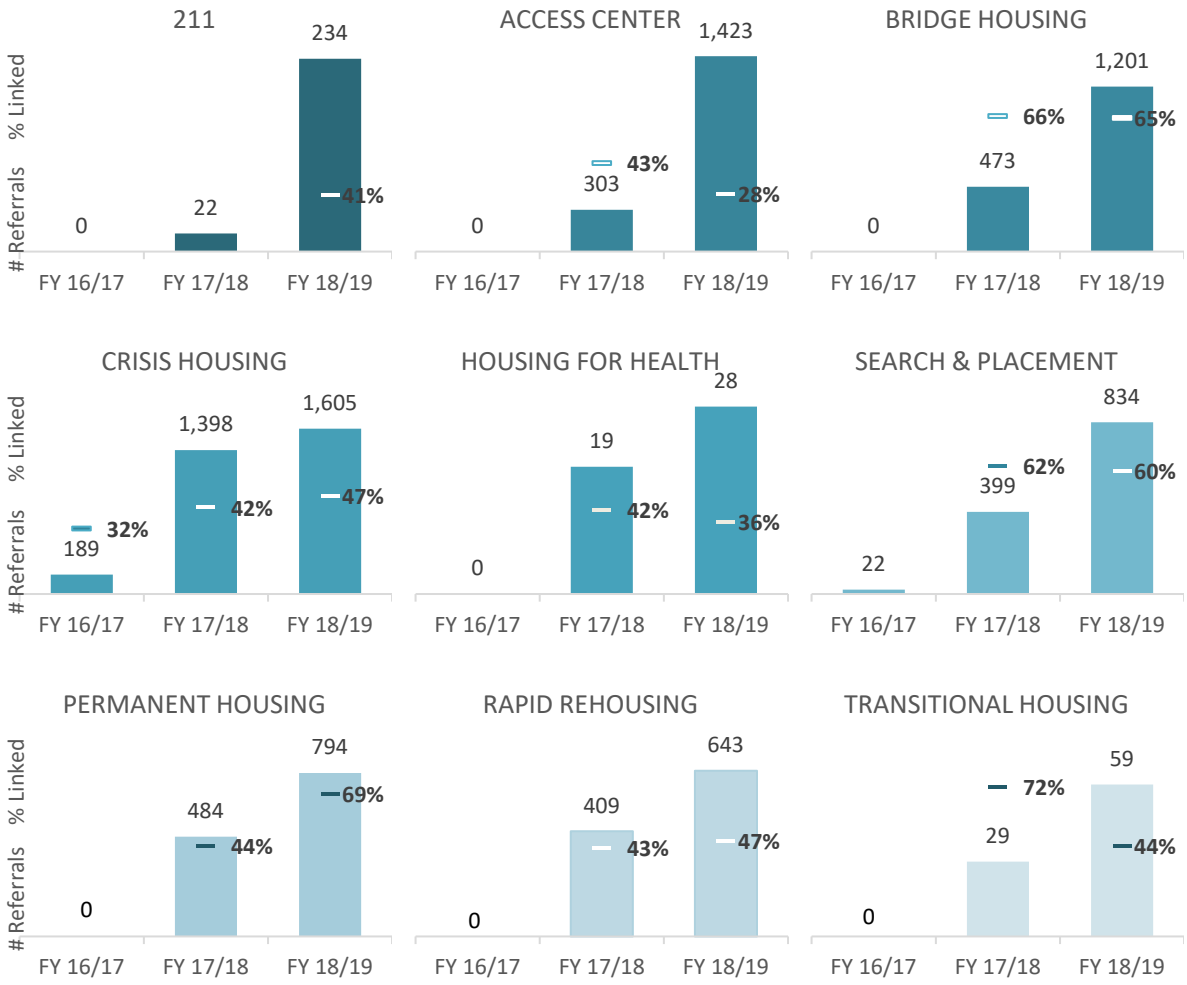


Figure 23: Housing Services in the Field (Measure H-funded teams only)

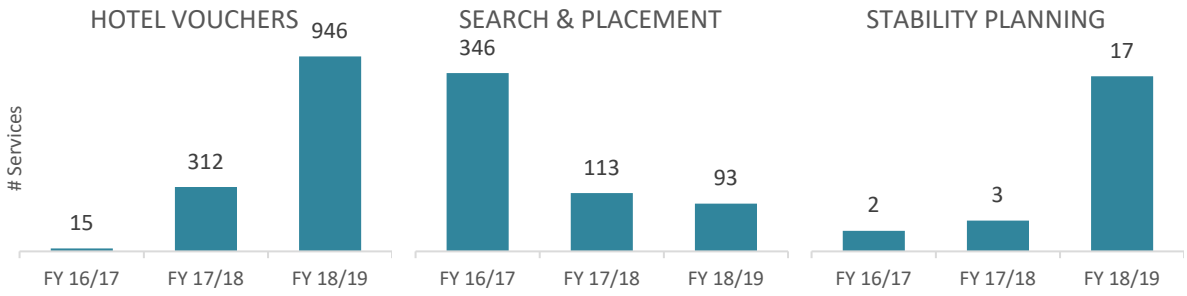


Figure 24: Direct Support Services and Supplies (Measure H-funded teams only)

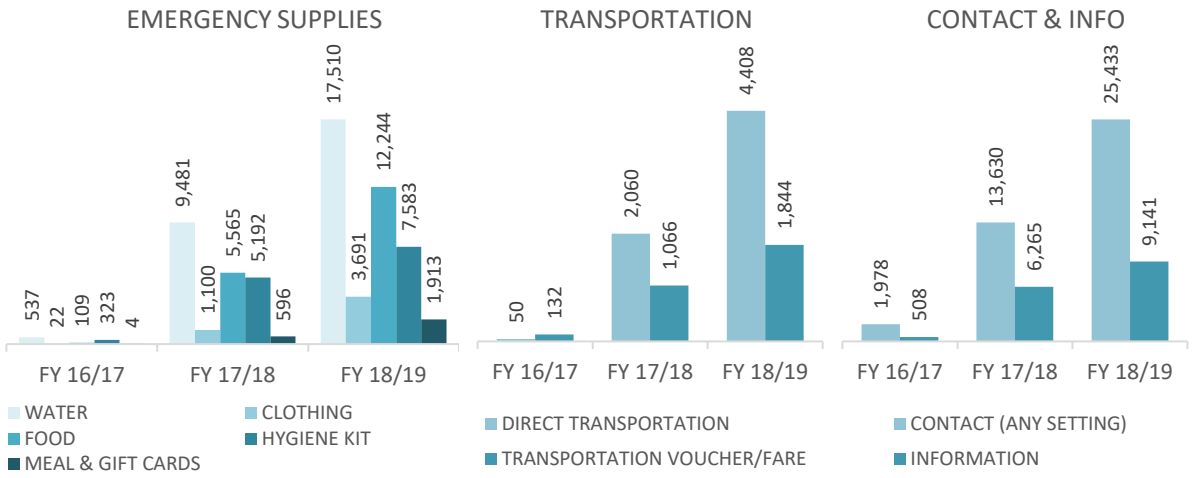


Figure 25: Case Management Services (Measure H-funded teams only)

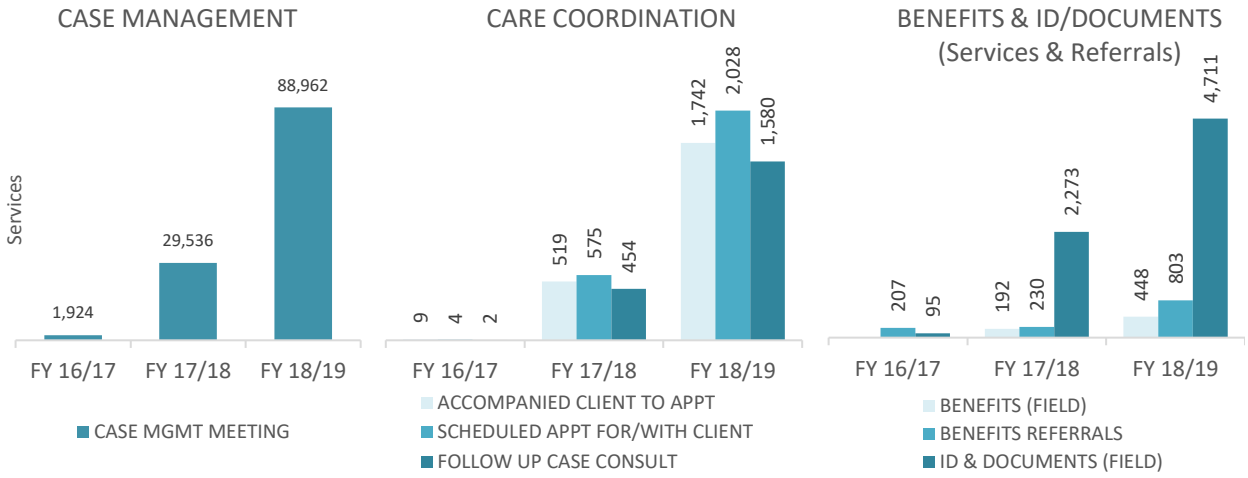
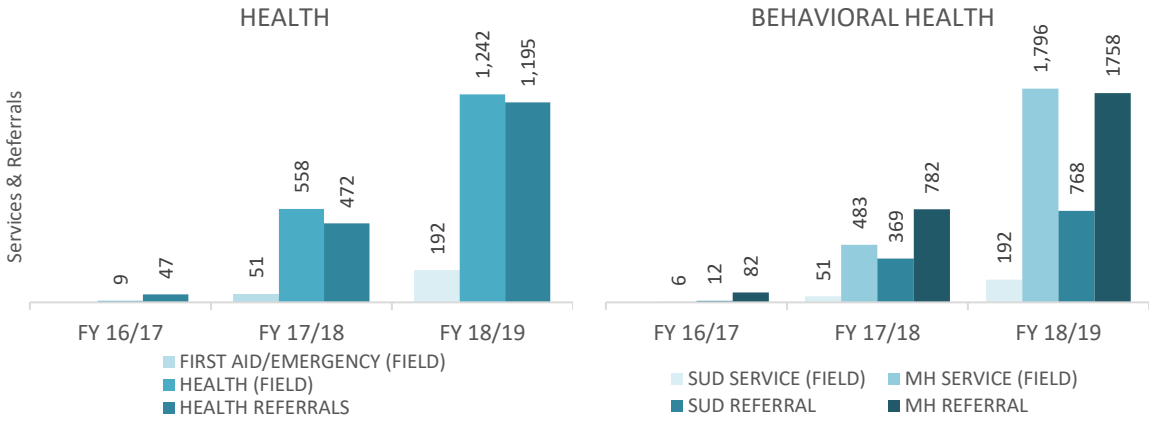


Figure 26: Health and Behavioral Health Services and Referrals (Measure H-funded teams only)



ATTACHMENT IV

HEALTH MANAGEMENT ASSOCIATES
HMA COMMUNITY STRATEGIES

Evaluating the Effectiveness of Los Angeles County's Strategies to Expand and Enhance Interim Housing and Emergency Shelter Services

Draft Report

PREPARED FOR
CHIEF EXECUTIVE OFFICE, LOS ANGELES COUNTY

NOVEMBER 25, 2019

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Table of Contents

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  - Chief Information Office: Max Stevens
  - Homeless Initiative: Phil Ansell, Elizabeth Ben-Ishai, Michael Castillo, Ashlee Oh
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  - Jeff Proctor, Steven Rocha
- Los Angeles County Department of Mental Health
  - Lise Ruiz
  - Countywide Housing, Employment and Education Resource Development Division

We would also like to thank all the county agencies and direct service providers who are working tirelessly to address homelessness.

Executive Summary

Background

In 2016, the Los Angeles County Board of Supervisors approved 47 coordinated strategies to combat homelessness, which were developed under the leadership of the Office of the Homeless Initiative (HI) established in the County's Chief Executive Office (CEO) in August 2015. Measure H, approved by the Los Angeles County (LA County) electorate in March 2017, generates an estimated $355 million in annual funding for 10 years for the HI with the goal of connecting 45,000 individuals and families to permanent housing in five years and preventing homelessness for 30,000 more.[1]

In 2018, the Los Angeles Homeless Services Authority (LAHSA) Point-In-Time (PIT) count reported its first decrease in the PIT homeless population in four years, with 52,765 individuals and family members experiencing homelessness.[2] Between the 2018 and 2019 PIT counts, LAHSA reported preventing and ending homelessness for more people in LA County than ever before: 5,643 people were prevented from entering homelessness, 21,631 people were placed in homes, and 27,080 experienced other exits to housing. However, as documented by the 2019 PIT count, homelessness increased by 12% to 58,936 individuals in 2019. LA County continues to struggle with a large homeless population, roughly three-quarters of which, according to the 2019 PIT count, is unsheltered, with approximately 11,000 people living in tents or encampments and approximately 16,000 people living in cars, vans, or RVs/campers.

Purpose

The purpose of evaluating the HI's interim housing strategies is to produce information that will facilitate these strategies in meeting their underlying objective to expand and enhance interim/bridge housing for those exiting institutions (Strategy B7) and enhance the emergency shelter system (Strategy E8), to determine best practices and areas in need of improvement, and to clarify how persons working directly with the homeless population define and understand program effectiveness and the degree to which this understanding is consistent with performance data. Additionally, this report examines differences in administration of various homelessness services funding sources and their impact on service provision.

Evaluation Objectives and Research Questions

Objectives

In procuring this HI strategy evaluation, as well as four others, the CEO specified four overall objectives to be addressed in the analyses:

Objective 1. To establish what the available data and performance evaluation results suggest are the strategy's best practices and to identify practices and processes in need of being re-visited and re-worked.

Objective 2: To reveal how persons working directly with the homeless population in the strategy define effectiveness and characterize the practices that the data suggest either bolster or impede strategy

[1] https://homeless.lacounty.gov/about/

[2] The PIT count reflects number of people who meet the HUD standard for homelessness on a typical night in Los Angeles County.

performance. Are their characterizations consistent with what the data show? If not, how do they understand the divergence?

Objective 3: To describe how specific funding sources affect the administration of a strategy and the capacity of strategy leads to deploy available resources effectively. To the extent that funding source restrictions create challenges in optimizing available resources, what are they and are there steps that can be taken to minimize them?

Objective 4: To detail instances in which strategy leads provide both services with Measure H funds and similar services not funded with these revenues. How does the administration of non-H-funded services and benefits differ from the administration of those funded with H dollars? What are the practical implications of this difference? Does the difference suggest non-H-funded homeless services would benefit from adopting practices specific to the H-funded portion of the same services and/or vice versa? How much does the answer to this question depend on the non-H funding sources and restrictions involved?

Additional Research Questions

In addition, specific research questions to evaluate Strategies B7 and E8 include:

Research Question 1: How do the Department of Health Services (DHS), the Department of Public Health (DPH)/Substance Abuse Prevention and Control (SAPC), and the Los Angeles Homeless Services Authority (LAHSA) B7 services differ in practice?

Research Question 2: How do bed rates affect interim housing shelter operations and outcomes?

Research Question 3: How does the provision of interim housing services differ by subpopulation and what are the challenges encountered in serving different groups? What are the operational challenges associated with the following types of services falling under strategies B7 and E8: DHS – Medical Recuperative, Psychiatric-Recuperative, Stabilization, DPH-SAPC Beds; LAHSA – Crisis, Bridge, Women's, Transitional Housing for Domestic Violence Survivors?

Research Question 4: What is the quality of collaboration with the Department of Mental Health (DMH), Department of Children and Family Services (DCFS), Los Angeles County Sheriff's Department (LASD), and Probation? What do each of these agencies do to support interim housing efforts and what is the significance and impact? Can coordination be improved or enhanced, and if so, how?

Research Question 5: What is the process and what challenges do hospitals face securing housing through B7 for inpatients/clients as required by the SB-1152 Hospital Patient Discharge Process? What is the potential role for Recuperative Care services for enhancing linkages from hospitals to interim housing?

Research Question 6: What is the potential for interim shelters to implement recovery-oriented principles into their environment and service delivery and how might that impact overall integration of services across sectors? (An example of recovery-orientation implementation is use of a person-centered assessment and planning process that incorporates the strengths and goals of individuals served and case management to support effective transition between treatment and service sites).

Research Question 7: What are the most difficult barriers to making transitions from interim housing to permanent housing?

Research Question 8: What are the differences among subpopulations (e.g., various sociodemographic groups, baseline substance use and mental health conditions) in outcomes including return to homelessness, permanent housing, and length of stay (LOS) in interim housing?

Methods and Data Sources

HMA used a mixed methods approach for this evaluation. The primary objectives and research questions address program process and implementation, and most of the methods were qualitative in nature, specifically document review and in-depth interviews with program staff from LAHSA, DHS, DMH and other organizations contracted to provide interim housing services.

Data were collected through 25 key informant interviews conducted with County agency staff, shelter provider staff, and hospital staff from July through October 2019. We also reviewed program documentation including the LA County Homeless Initiative Quarterly Reports. For the quantitative components of this report, CEO made de-identified client-level data available to us from the Homeless Management Information System (HMIS) and from DHS's CHAMP system. Aggregate data on number of individuals served by DMH and SAPC were also shared with us by CEO for illustrative purposes.

Data Analysis

For qualitative data, detailed notes taken during each interview were examined using specialized qualitative data methods. Interviews were also recorded as back-up and confirmation of notes. Codes were developed to reflect each research question and analysis was conducted by question, with key themes identified, and illustrative examples highlighted.

HMIS Data Sample

The HMIS sample constructed for this analysis included adult heads of household enrolled in either emergency or transitional housing, with entry date on or after July 1, 2017, and with valid exit date following July 1, 2017. (See Appendix D for details on sample selection.) HMIS data primarily track persons receiving interim housing services through LAHSA, with relatively little overlap with services provided through DHS (described below). The total sample size for analysis was 20,574 adults.

Demographic variables were defined as per the "HMISSCVSpecifications6_11" data dictionary. Analysis included bivariate comparisons in mean differences (using one-way ANOVA for multiple group comparison) and categorical differences (using chi-square) in exit to permanent housing, length of stay (LOS), and exit to homelessness, among the following subpopulations: ethnicity, race, gender, veteran status, domestic violence, substance abuse problem, mental health problem, and Coordinated Entry System (CES) score, which uses the Vulnerability Index-Service Prioritization Decision-Assistance Tool to assign a score to determine the best type of permanent housing solution.

CHAMP Data Sample

The DHS/CHAMP sample constructed for this analysis included all unique individual cases included in the Interim Housing datafile with check-in date on or after July 1, 2017, and a valid check-out date. All de-

duplicated records were included in the analysis sample. The total sample size for analysis was 3,489 persons. CHAMP data track persons receiving recuperative and stabilization housing services predominantly through DHS.

Analysis included bivariate comparisons in mean differences (using one-way ANOVA for multiple group comparison) and categorical differences (using chi-square) in exit to permanent housing and length of stay among the following subpopulations: ethnicity, race, gender, veteran status, and housing type.

Summary of Results

Differences in interim housing services among agencies

Interim housing service provision among agencies is differentiated by the populations targeted, specifically their physical and behavioral health needs. DHS, for example, primarily provides recuperative care and stabilization housing for individuals requiring assistance with physical ailments, while LAHSA provides shelter services for persons not needing assistance with physical ailments and/or daily living. In practice, services provided are similar, including intensive case management with the goal of moving individuals to permanent housing.

Bed Rates

Providers expressed appreciation that bed rates have increased since the inception of Measure H. However, bed rates, currently reported from $44 to $135 per night depending on housing type, were considered too low by providers and other key stakeholders. Providers recommended a rate increase for both interim and recuperative care housing. Shelters experience operational challenges during non-traditional hours and increased bed rates would allow for hiring of licensed staff to be on site after hours. Additionally, because most clients have a number of complex needs, higher bed rates would allow an expansion of services, such as workforce development, enhanced case management, and on-site health and mental health services. Key stakeholders did not necessarily speak to the tension between higher bed rates and the possible reduction in persons served that would result, although we discuss this below in the Recommendations section.

Differences in services among subpopulations

Shelter providers discussed challenges in serving specific sub-populations, including LGBTQ, transition-aged youth (TAY) and domestic violence survivors. Those serving TAY expressed a need for more services that are TAY-specific, including employment support, family/parenting support and financial literacy. Those serving LGBTQ individuals (including TAY) expressed a need for more clinical mental health services. Domestic violence victims require services such as trauma-informed care. Some standard practices such as diversion as a first-line strategy for domestic violence victims are inappropriate, given victims often share friends and family with their abusers, and they cannot rely on their own social network for safety. Those serving immigrant, monolingual, and Limited English Proficient clients expressed challenges with a lack of culturally appropriate services, particularly in the Asian/Pacific Islander communities.

Collaboration among County agencies and providers

The regular, ongoing, and highly collaborative interaction among key agencies, including DHS, LAHSA, DMH, and the HI, resulting from Measure H, is one of the key strengths of the program. A key indicator

of successful collaboration is the development of shelter standards of care that were implemented by DHS, LAHSA, and DMH in September 2019. Prior to Measure H, consistent standards across shelter types and agencies did not exist. The sheer increase of beds as a result of Measure H prompted the recognition that standards were crucial to consistent and high-quality service provision

Process and challenges for hospitals

County hospitals have well-established referral pathways to DHS for Recuperative Care/Stabilization Housing, with DHS-funded staff on site who, along with certain hospital staff working with the homeless population in emergency departments, have direct access to the DHS CHAMP data system. However, some private hospitals are located in areas without many recuperative care providers. This was specifically mentioned for Service Planning Area (SPA) 6. Both types of hospitals have focused efforts on identifying and referring homeless individuals. There is great opportunity to link individuals to interim housing through Recuperative Care, though challenges with long wait times, particularly for private hospitals, remain an obstacle.

Potential to implement recovery-oriented principles

The expansion of interim housing beds due to the infusion of Measure H funding gives shelter providers significant potential to incorporate recovery-oriented principles such as a person-centered and strengths-based approaches into their programs. Most of the shelters are already applying a Housing First approach and focusing on harm reduction in addition to recovery support. Providers have received training from LAHSA in trauma-informed care models, which can be further strengthened through LAHSA's Learning Collaborative and sharing of best practices.

Challenges transitioning to permanent housing

The number one barrier to transitioning to permanent housing that key informants identified is the lack of permanent housing capacity in the County. Another commonly mentioned set of barriers stems from difficulties faced by clients with high mental health and/or substance use acuity levels in living independently.

Subpopulation differences in outcomes

Significant differences were observed in the demographics and health status profiles of those examined for this evaluation in the duration of their stays in interim housing, in exiting to permanent housing (PH), and in exiting to homelessness. In both the HMIS sample (persons receiving predominantly LAHSA-funded interim housing services) and CHAMP sample (persons receiving recuperative care and stabilization housing through DHS), whites (23%) were the least likely to exit to permanent housing among racial groups, and females (29% of HMIS sample and 26% of CHAMP sample) were more likely than males (26% of HMIS sample and 23% of CHAMP sample) to exit to permanent housing. In the HMIS sample, veterans were more likely to exit to PH than non-veterans (34% versus 23%).

Additional subpopulation differences among those with substance use problems, mental health problems, and those with high versus lower CES scores were found in all three outcomes. Those flagged in HMIS with substance abuse problems were less likely than those with no substance use problems to exit to permanent housing and more likely to exit interim housing to homelessness. Those flagged with a mental health problem had a longer length of stay (LOS) than those without a mental health problem, and, similar

to those with a substance abuse problem, were more likely to exit to homelessness. Looking at combined mental health and substance abuse problems, those with a substance abuse problem only and those with co-occurring substance abuse and mental health problems were the least likely to exit to permanent housing, and those with co-occurring problems were most likely to exit to homelessness.

A somewhat different pattern was found for CES acuity score (which is based on a wide range of factors including substance abuse problems, mental health problems, history of homelessness, risk of harm, history of trauma, and other social functioning indicators). Those in the highest acuity category (score of 8+) were more likely that those in the less acute categories (0-3 or 4-7) to exit to permanent housing; however, this same group was also the most likely to exit to homelessness.

Best practices and processes in need of improvement

Several best practices were identified as a result of this evaluation. These include:

- The overall increase in interim beds is a significant accomplishment, as are the increased outreach and strong referral processes, which have resulted in improved access to shelters.
- The referral process from County DHS hospitals to Recuperative Care is seamless and efficient.
- Several "low barrier" strategies including 24-hour shelters, harm reduction policies for those with SUDs, accommodations for pets, and storage for belongings were all identified as best practices in terms of increased access to interim housing.

Additionally, several processes and areas needing improvement were identified, including:

- Lack of continuity of care—i.e., continuation of services provided by a consistent staff/counselor across housing venues— is a key area in need of improvement. Maintaining relationships with clients is critical to the support provider staff can provide in helping clients transition through levels of interim housing towards the goal of permanent housing.
- The referral process, access to CES in private hospitals, and lack of recuperative care providers in some SPAs is a significant challenge to identifying appropriate housing upon hospital release.

Definition of program effectiveness

Most key informants interviewed for this evaluation recognize that the most important objective of interim housing is to move individuals to permanent housing. Multiple data sources, including both quantitative performance metrics and qualitative data in case files, are reviewed regularly to assess program effectiveness and identify programmatic issues with respect to transitions to PH.

Funding Sources, Restrictions, and Administration: Effects on service provision in practice

Multiple funding sources have different eligibility requirements, certification requirements for staff, performance targets, reporting requirements, and bed rates, which is a significant challenge for program administration. While acknowledging the challenges incurred with multiple funding sources, shelters provide the same level of services for all clients. Respondents described complicated funding policies at the administrative level to ensure consistent services. More streamlined funding processes and requirements would be beneficial and would result in significant reduction of administrative burden.

Recommendations

Based on our evaluation, we have identified a set of recommendations for enhancing the ongoing work for Strategies B7 and E8. These recommendations are based on input from key informants as well as HMA's assessment of key areas of focus. Key recommendations include the following:

Services

Key informants interviewed for this evaluation suggested enhancing service provision in multiple areas. However, given funding limitations of Measure H, any increase in services in one strategy or service area would likely result in a decrease in funding for other strategies/services. Given the centrality of the interim shelter strategies to the County's overall coordinated approach to homelessness – a degree of importance that is further amplified by current permanent housing shortages the County should seek to identify or generate additional resources for key services to be made available through or in coordination with interim housing providers, including the following:

- Employment services can be provided at shelter sites and focused on employment opportunities that offer a living wage and increase self-sufficiency. Providing incentives for employment services providers could increase their commitment to working with the homeless population.
- Community-based clinical and physical health services can be made available to better meet the needs of high acuity persons in the interim housing system. This is particularly the case for clients in need of SUD treatment services, which are lacking at shelter sites.
- Increase the allowable LOS at shelters, especially for high-acuity clients. Measure H has resulted in increased services for those exiting institutions, and this has increased the number of complex, high-acuity clients entering the interim shelter system. The challenge at this level is to set shelter stay durations in a way that extends stays for certain groups using these services but also minimizes bottlenecks in moving new clients from the street to shelters. While finding the right balance could be difficult, longer LOS will help maximize the likelihood of successful transitions from interim to permanent housing.

Staffing

- While shelter providers have successfully scaled up since Measure H was implemented, it is important to ensure they have the support and resources needed to continue to grow and expand.
- Target funding to provide intake, counseling, and case management staff during the evening hours and hire problem-solving specialists.
- Assess salary rates for staff based on experience needed to work with acute populations. If funding is not available to hire more experienced staff, alternative staffing models, such as regional professionals who rotate sites, should be explored.

Referral/Intake Process

- Develop a process that will allow real-time assessment of all open beds, particularly in emergency shelters. Streamline communication between interim housing and emergency shelters so that immediate and direct referral to emergency housing can be made in the event individuals show up to interim housing sites without bed availability.

- Examine strategies to increase the accuracy of initial assessments. This may include re-examining and revising the assessment instrument. Often clients may not adequately comprehend the questions in the CES intake survey, resulting in inaccurate scoring. Provide additional training to CES and other intake staff on interfacing with clients to determine acuity levels during the intake process.
- The referral process from private hospitals to both DHS and the CES should be strengthened. Provision of CES staff on site at hospitals (potentially funded by the hospitals themselves) could make the referral process faster and more efficient.

Continuity of Care

- Develop protocols to allow the same case manager to work with clients throughout the continuum — from interim to permanent housing — to support clients for at least a 3-month period after placement in permanent housing. This will alleviate the need for permanent housing staff to devote time to developing trust with clients and increase the likelihood of successful stays in permanent housing. This could be accomplished through interdisciplinary teams, like what occurs in Strategy E6.

Collaboration

- Enhance collaboration with and participation by SAPC. Other departments are working collaboratively, but service provision could be improved with more intensive involvement of SAPC staff, both at the leadership level and the shelter provider level.[3]
- Build on the successful collaborative effort to develop shelter standards to move toward more consistent standards across departments in other areas, including contract requirements, performance metrics, and reporting requirements, particularly across DHS, LAHSA, and DMH. Continue to explore other areas to streamline forms and processes required by various agencies.

Bed Rates

- Explore ways to increase bed rates above the current rates for interim beds, and recuperative care/stabilization housing beds. The higher rates will allow for additional services, more experienced staff, and can ultimately shorten the LOS with more intensive services in a shorter period. of time.

Funding Sources

- Identify ways to streamline the processes and requirements of multiple funding sources. For example, new state money allows alignment with Measure H, and this funding source can be administered with requirements that are consistent with LAHSA requirements.

[3]HMA made multiple attempts to contact and interview SAPC staff but were unable to do so. Thus, findings related to SAPC services and perspectives on Measure H interim and emergency housing are lacking for this evaluation.

Background

In 2016, the Los Angeles County Board of Supervisors approved 47 coordinated strategies to combat homelessness after extensive community input including stakeholder focus groups and interviews (See Appendix A: "Approved Strategies to Combat Homelessness"). The process was led by Phil Ansell, director of the County's Homeless Initiative (HI), and engaged community-based organizations, city and county department leads, philanthropy, and most importantly, individuals who have experienced homelessness. The full action plan now includes 53 interconnected strategies developed by more than 100 community groups, 30 cities, and key county leadership.

Measure H, approved by Los Angeles County (LA County) voters in March 2017, generates $355 million in annual funding for 10 years for the Los Angeles County Homeless Initiative over ten years, with the goal of connecting 45,000 individuals and families with permanent housing in five years and preventing homelessness for 30,000 more.[4] Measure H is funding a variety of social services, mental health services, addiction treatment, outreach, and enhanced supportive services[5].

In 2018, the Los Angeles Homeless Services Authority (LAHSA) Point-In-Time (PIT) count reported its first decrease in the PIT homeless population in four years, with 52,765 individuals and family members experiencing homelessness.[6] Between the 2018 and 2019 PIT counts, LAHSA reported preventing and ending homelessness for more people in LA County than ever before: 5,643 people were prevented from entering homelessness, 21, 631 people were placed in homes, and 27,080 experienced other exits to housing. However, as documented by the 2019 PIT count, homelessness increased by 12% to 58,936 individuals in 2019. Los Angeles County continues to struggle with a large homeless population, roughly three-quarters of which, according to the 2019 PIT count, is unsheltered, with approximately 11,000 people living in tents or encampments and approximately 16,000 people living in cars, vans, or RVs/campers.

Programs and services administered through Measure H are varied, extensive, and involve multiple County agencies. While performance measures are tracked and reported regularly for each of the Measure H housing strategies, the complexity of service delivery and the multiple agencies and stakeholders involved requires a more in-depth evaluation to fully understand program functioning and need for program improvement. Fortunately, the Los Angeles Homeless Services Authority (LAHSA), which oversees these funds, implemented the Coordinated Entry System (CES) and Homeless Management Information System (HMIS) which provide a significant amount of data on how people enter and exit homelessness.

[4] https://homeless.lacounty.gov/about/

[5] Additionally, the U.S. Department of Housing and Urban Development (HUD) allocated $109,398,295 to the Los Angeles Continuum of Care (LA CoC) for 2017 - an increase of nearly $5 million from the previous year. The HUD Homeless Assistance Grant Awards include $13.5 million for 11 new permanent supportive housing projects (PSH) providing 828 new permanent housing units. The overall award, with renewals, covers more than $97 million for Permanent Supportive Housing.

[6] The PIT count reflects number of people who meet the HUD standard for homelessness on a typical night in Los Angeles County.

Purpose

The purpose of evaluating the HI's interim housing strategies is to produce information that will facilitate these strategies in meeting their underlying objective to expand and enhance interim/bridge housing for those exiting institutions (Strategy B7) and enhance the emergency shelter system (Strategy E8), to determine best practices and areas in need of improvement, and to clarify how persons working directly with the homeless population define and understand program effectiveness and the degree to which this understanding is consistent with performance data. Additionally, this report examines differences in administration of various homelessness services funding sources and their impact on service provision.

Evaluation Objectives and Research Questions

Objectives

In procuring this HI strategy evaluation, as well as four others, the CEO specified four overall objectives to be addressed in the analyses:

Objective 1. To establish what the available data and performance evaluation results suggest are the strategy's best practices and to identify practices and processes in need of being re-visited and re-worked.

Objective 2: To reveal how persons working directly with the homeless population in the strategy define effectiveness and characterize the practices that the data suggest either bolster or impede strategy performance. Are their characterizations consistent with what the data show? If not, how do they understand the divergence?

Objective 3: To describe how specific funding sources affect the administration of a strategy and the capacity of strategy leads to deploy available resources effectively. To the extent that funding source restrictions create challenges in optimizing available resources, what are they and are there steps that can be taken to minimize them?

Objective 4: To detail instances in which strategy leads provide both services with Measure H funds and similar services not funded with these revenues. How does the administration of non-H-funded services and benefits differ from the administration of those funded with H dollars? What are the practical implications of this difference? Does the difference suggest non-H-funded homeless services would benefit from adopting practices specific to the H-funded portion of the same services and/or vice versa? How much does the answer to this question depend on the non-H funding sources and restrictions involved?

Additional Research Questions

In addition, specific research questions to evaluate Strategies B7 and E8 include:

Research Question 1: How do the Department of Health Services (DHS), the Department of Public Health (DPH)/Substance Abuse Prevention and Control (SAPC), and the Los Angeles Homeless Services Authority (LAHSA) B7 services differ in practice?

Research Question 2: How do bed rates affect interim housing shelter operations and outcomes?

Research Question 3: How does the provision of interim housing services differ by subpopulation and what are the challenges encountered in serving different groups? What are the operational challenges associated with the following types of services falling under strategies B7 and E8: DHS – Medical Recuperative, Psychiatric-Recuperative, Stabilization, DPH-SAPC Beds; LAHSA – Crisis, Bridge, Women's, Transitional Housing for Domestic Violence Survivors?

Research Question 4: What is the quality of collaboration with the Department of Mental Health (DMH), Department of Children and Family Services (DCFS), Los Angeles County Sheriff's Department (LASD), and Probation? What do each of these agencies do to support interim housing efforts and what is the significance and impact? Can coordination be improved or enhanced, and if so, how?

Research Question 5: What is the process and what challenges do hospitals face securing housing through B7 for inpatients/clients as required by the SB-1152 Hospital Patient Discharge Process? What is the potential role for Recuperative Care services for enhancing linkages from hospitals to interim housing?

Research Question 6: What is the potential for interim shelters to implement recovery-oriented principles into their environment and service delivery and how might that impact overall integration of services across sectors? (An example of recovery-orientation implementation is use of a person-centered assessment and planning process that incorporates the strengths and goals of individuals served and case management to support effective transition between treatment and service sites).

Research Question 7: What are the most difficult barriers to making transitions from interim housing to permanent housing?

Research Question 8: What are the differences among subpopulations (e.g., various sociodemographic groups, baseline substance use and mental health conditions) in outcomes including return to homelessness, permanent housing, and length of stay (LOS) in interim housing?

Methods and Data Sources

The primary objectives and research questions address program process and implementation, and methods included both qualitative data, including document review and in-depth interviews with program staff from LAHSA, DPSS, DHS, shelter provider staff, and hospital staff, and quantitative, secondary data from the LAHSA HMIS and DMH CHAMP databases. Table 1 presents a list of specific research questions, and their associated methods and data sources.

Table 1. Objectives, Methods and Data Sources

Objective/Research Question	Method	Data Source
O1: Establish what the available data and performance evaluation results suggest are the strategy's best practices	Document Review	HI program documents: • 2016 Strategies • 2018 Evaluation Report • HI Quarterly Reports

	In-depth Interviews	County agency staff Strategy leads Direct service providers Policy Summit notes
O2: How persons on the ground define effectiveness	In-depth Interviews Document Review	County agency staff Direct service providers HI Performance Reports
O3: Describe how specific funding sources affect the administration of a strategy	In-depth Interviews	Strategy leads County agency staff Direct service providers
O4: How does the administration of non-H-funded services and benefits differ from the administration of those funded with H dollars?	In-depth Interviews	Strategy leads County agency staff Direct service providers
RQ1: How do the DHS, DPH/SAPC and LAHSA B7 services differ in practice?	Document Review In-depth Interviews	County agency staff
RQ2: What difference do bed rates make to operations and outcomes?	In-depth Interviews	Direct service providers
RQ3: How does the provision of interim housing services differ by subpopulation and what are the challenges encountered in serving different groups?	In-depth Interviews	Direct service providers Policy Summit notes
RQ4: : What is the quality of collaboration with DMH, DCFS, LASD and Probation?	In-depth Interviews	County agency staff Strategy leads Direct service providers
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?	In-depth Interviews	DHS staff County hospital staff Private hospital staff
RQ6: What is the potential for interim shelters to implement recovery-oriented principles into their environment and service delivery?	In-depth Interviews	Direct service providers
RQ7: What are the most difficult barriers to making transitions from interim housing to permanent housing?	In-depth Interviews	County agency staff Direct service providers Policy Summit notes
RQ8: What are the differences among subpopulations in return to homelessness, permanent housing, and length of stay in interim housing?	Quantitative Analysis	HMIS data CHAMP data

Data Collection

New data collected were qualitative in nature. We also obtained and analyzed secondary, quantitative data from administrative data sources.

Qualitative Data Collection

We conducted a total of 25 in-depth, semi-structured interviews with county agency staff, direct service providers, and hospital staff between July and October 2019. Table 2 lists the department and provider staff interviewed by position title. See Appendix B for a complete list of all individuals interviewed. The process began with the CEO contact, Max Stevens, emailing one primary contact at DHS, DMH, and LAHSA, introducing the HMA project manager, Charles Robbins. HMA then scheduled introductory/fact finding meetings with each lead to explain the evaluation and request information including names of additional staff. We then selected in-depth interview participants, ensuring representation from each county agency. Shelter providers were selected to represent most of the Service Planning Areas (five of the eight SPAs were represented), large and smaller shelters, geographic diversity, and shelters targeting specialty populations.[7]

In addition, HMA staff attended the Homeless Initiative Policy Summit #4: Interim Housing on October 15, 2019, where multiple department and shelter provider staff had an opportunity to discuss their perspectives on several similar issues. Notes from this summit are also included in the qualitative component.

We developed semi-structured interview guides to address all objectives and research questions listed above. Interview guides were unique to different types of respondents, with one guide for County staff, one for provider staff, and one for hospital staff (see Appendix C for interview guides).

Mr. Robbins and Dr. Riehman led the in-person interviews, with Rathi Ramasamy attending and taking detailed notes. The interviews were recorded. Interviews were scheduled at times and locations that were convenient to participants and lasted 45 minutes to one hour.

Table 2. Key Informant Interviews

KEY INFORMANT INTERVIEWS	
DHS	+ H4H Director of Interim Housing + H4H Director of Access, Referrals, and Engagement + H4H Program Implementation Manager
CEO	+ CEO Senior Analyst + CEO Principal Analyst + HI Principal Analysts

[7] HMA made multiple attempts to contact and interview SAPC staff but were unable to do so. Thus, findings related to SAPC services and perspectives on Measure H interim and emergency housing are lacking for this evaluation.

LAHSA	+ Crisis Housing Coordinators + Manager of System Components + Interim Housing Placement Coordinator
DMH	+ Mental Health Clinical Program Head
Shelter Staff (program directors, clinical & interim housing leads)	+ LA Family Housing (SPA 2)- crisis and bridge + PATH Hollywood (SPA 4)- interim/ bridge + Path W Washington (SPA 6)-interim/ bridge + First To Serve (SPA 7)- crisis and bridge + Weingart (SPA 4)- crisis and bridge + Illumination Foundation (SPA 3)- recuperative care + Center for the Pacific Asian Family (SPA 4)- interim/ bridge + Haven Hills (SPA 2)- interim/ bridge + Los Angeles LGBT Center (SPA 4)- crisis, interim/ bridge
Hospitals	+ DHS Director of Patient and Social Support Services + LAC USC Senior Clinical Social Worker + Harbor UCLA Clinical Social Worker Supervisor + MLK Hospital VP, Population Health + Huntington Memorial Hospital, Director of Care Coordination
Others	+ Brilliant Corners + NHF (recuperative care)

Quantitative Data Collection

Quantitative data included HMIS data provided by LAHSA, CHAMP data provided by DHS, and aggregate DMH and SAPC administrative data prepared by CEO's research unit. HMA developed a list of data requests and submitted this to the County CEO contact. The quantitative HMIS and DHS/CHAMP data are individual level, de-identified data.

Data Analysis

Qualitative Data Analysis

For qualitative data, detailed notes taken during each interview were examined using specialized qualitative data analysis methods. Interviews were also recorded as back-up and confirmation of notes. Codes were developed to reflect each research question and analysis was conducted by question, with key themes identified, and illustrative examples highlighted.

Quantitative Data Analysis

The quantitative analysis focused on two questions assessing the client experience: 1) What are the differences among subpopulations in return to homelessness, permanent housing, and LOS in interim housing? 2) To what extent do those discharged from institutions to interim housing and needing physical health, mental health or substance abuse services receive services?

HMIS Data Sample

The HMIS sample constructed for this analysis included adult heads of household enrolled in either emergency or transitional housing, with entry date on or after July 1, 2017, and with valid exit date following July 1, 2017 (see Appendix D for details on sample selection). HMIS data primarily tracks persons receiving interim housing services through LAHSA, with relatively little overlap with services provided through DHS (described below). The total sample size for analysis was 20,574 adults.

Demographic variables were defined as per the "HMISSCVSpecifications6_11" data dictionary. Analysis included bivariate comparisons in mean differences (using one-way ANOVA for multiple group comparison) and categorical differences (using chi-square) in exit to permanent housing, LOS, and exit to homelessness, among the following subpopulations: ethnicity, race, gender, veteran status, domestic violence, substance abuse problems, mental health problems, and Coordinated Entry System (CES) score, which uses the Vulnerability Index-Service Prioritization Decision-Assistance Tool (VI-SPDAT) to assign a score to determine the best type of permanent housing solution.

- Ethnicity
  - Non-Hispanic/Non-Latino, Hispanic/Latino, Other (Client doesn't know, client refused, data not collected)
- Race
  - White, Black/African American, Mixed Race (assigned if more than one category was identified), Other (American Indian/Alaska Native, Native Hawaiian/Other Pacific, Race-none)
- Gender
  - Female, Male, Transgender (Trans Female-Male to Female, Trans Male-Female to Male)/Non-conforming, Other (Client doesn't know, client refused, data not collected)
- Veteran status
  - Veteran, Non-Veteran, Other (Client doesn't know, client refused, data not collected)
- Disability status
  - Mental health disability, No mental health disability
  - Substance abuse disability, No substance abuse disability
  - Mental health problems only, Substance abuse problems only, Mental health and substance abuse problems, No mental health/substance abuse problems
- CES score
  - 0-3, 4-7, 8+

Client experience outcome variables included total number of days in the program across all years (calculated as total days across all stays), exit to permanent versus non-permanent housing, and exit to homelessness. Exit to permanent housing was defined as any of the following values for 'Destination' in the Exit data file: 3-permanent housing (other than RRH) for formerly homeless persons; 10-rental by client, no ongoing housing subsidy; 11-owned by client, no ongoing housing subsidy; 20-rental by client, with other ongoing housing subsidy; 21-owned by client, with ongoing housing subsidy; 22-staying or living with family, permanent tenure; 23-staying or living with friends, permanent tenure; 26-moved from one HOPWA funded project to HOPWA PH; 27-moved from one HOPWA funded project to HOPWA TH; 28-rental by client, with GPD TIP housing subsidy; or 29-residential project or halfway house with no

homeless criteria. Exit to homelessness was defined as 'Destination' = 16-place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway stations/airport or anywhere outside).

CHAMP Data Sample

The DHS/CHAMP sample constructed for this analysis included all unique individual cases included in the Interim Housing datafile with check-in date on or after July 1, 2017, and a valid check-out date (See Appendix D for details on de-duplication of CHAMP data file). All de-duplicated records were included in the analysis sample. CHAMP data track persons receiving recuperative and stabilization housing services predominantly through DHS. The total sample size for the analysis was 3,489 persons.

Analysis included bivariate comparisons in mean differences (using one-way ANOVA for multiple group comparison) and categorical differences (using chi-square) in exit to permanent housing and LOS among the following subpopulations: ethnicity, race, gender, veteran status, and housing type.

- Ethnicity
  - Non-Hispanic/Latino White, Hispanic/Latino, Other/Unidentified
- Race
  - White, Black/African-American, Mixed Race, Other/Unidentified
- Gender
  - Female, Male
- Veteran status (Served in Armed Forces)
  - Veteran, Non-Veteran, Unknown
- Housing type
  - Stabilization, Recuperative

Information on the mental health, SUD and domestic violence statuses of clients in our DHS sample was not available for this analysis.

Client experience outcome variables included total number of days in the program across all years (calculated as total days across all stays), total number of program stays (calculated as total number of check-in dates), and exit to permanent versus non-permanent housing (Interim_Housing_Exit_Reason = 'Move to Permanent Housing'). There was no indicator for exiting to homelessness, thus this outcome is not analyzed for the CHAMP data.

Summary of Results

Results are organized by research question, with all relevant qualitative and quantitative data presented. We present first the results for the specific research questions. We then present results for the overall program evaluation objectives, to which the research question results contribute.

Differences in interim housing services among agencies

Interim housing service provision among agencies is differentiated by the populations targeted, specifically their physical and behavioral health needs. DHS, for example, primarily provides recuperative care and stabilization housing for individuals requiring assistance with physical ailments, while LAHSA provides shelter services for persons not needing assistance with physical ailments and/or daily living.

Stabilization housing consists of room and board, case management, transportation to appointments, and support in getting ready to be permanently housed. Recuperative Care housing adds a layer of medical and mental health oversight, including services such as wound care, response to health emergencies, and other medical assistance needed. LAHSA shelter services also include case management services similar to those provided by DHS, though again working with a population with less acute health needs. LAHSA's enhanced bridge housing also has licensed clinical care management staff.

As described by DHS and LAHSA staff, case management services provided in practice are similar across populations and shelter types, with the primary focus on case management to move individuals to permanent housing, regardless of acuity level.

DMH provides shelter beds and services for individuals requiring mental health services or existing institutions, or who may have co-occurring mental health and substance use disorders. SAPC provides beds for recovery services, typically for about 90 days, after which time individuals are often referred to DHS for further housing needs.

The referral process among DHS, LAHSA, and DMH is well coordinated, with daily communication to determine appropriate placement among those referred from all sources. The coordinated referral and placement system is further strengthened by co-located DHS and DMH staff. Several key informants noted that there are some issues with inaccurate initial acuity level assessment, but that these are fairly quickly identified, and individuals are re-assessed for more appropriate placement.

Bed rates

Shelter staff expressed appreciation for the fact that bed rates have increased since the inception of Measure H. However, almost all shelter staff indicated that the current bed rates are still not sufficient to provide the level of service they feel clients need, particularly because the clients they are serving have complex needs. Shelter staff who could recall their current bed rates reported rates between $44 and $82 per night and stated that bed rates between $80 and $100 would be optimal. County staff indicated that they were aware of this desire for higher bed rates.

A higher bed rate could be leveraged to better serve clients by allowing for enhanced services and staffing, particularly having licensed staff on site. Several shelter key informants stated that they experience operational challenges during non-traditional hours, and higher bed rates would allow them to hire licensed staff to be on site after hours to manage crises. Staff also expressed that because most clients have a number of complex, co-occurring needs, they would benefit from an expanded portfolio of services including workforce development programs, enhanced case management, on-site health and mental health services to ensure ease of access, and "life skills" training including financial literacy. Higher bed rates could also help support facility costs, security, and food.

Differences in services among subpopulations and challenges serving subpopulations

Several challenges unique to serving specific subpopulations were identified. Medical recuperative care providers stated that because their clients have such high acuity levels requiring assistance with daily living, they can be "hardest to house" and sometimes needed a longer length of stay to stabilize than a client without any medical issues. Key informants indicated that it was difficult for clients to focus on connecting with housing resources and managing their medical issues at the same time.

Shelter staff serving Transitional Age Youth (TAY) expressed a need for more services that are TAY-specific. While TAY need many of the same services as other clients experiencing homelessness, such as employment support, family/ parenting support and financial literacy, TAY experience these challenges in a different way and would benefit from service delivery tailored to their age group. During the policy summit, stakeholders also expressed challenges that TAY face with safety while in shelters with all other age groups. While shelters have generally adopted a harm reduction approach to substance use disorder, stakeholders stated that environments in which TAY are exposed to other clients' substance use could be harmful for them. For clients with substance use disorder, key informants stated that more time was needed to build rapport and engage them in services to get them ready for housing

Providers serving domestic violence victims indicated an additional layer of challenges due to the level of trauma their clients have faced. Shelter staff expressed concern that survivors of domestic violence are not prioritized in the system and stated that their clients are in particular need of trauma-informed care. Key informants emphasized that some standard practices such as diversion as a first-line strategy are inappropriate for domestic violence survivors—victims often share friends and family with their abusers, and they cannot rely on their own network for safety. They also indicated that domestic violence is likely underreported in HMIS data, as victims may not clearly understand the question on the CES intake survey, "Are you fleeing because you are in danger?"

Shelter providers serving LGBTQ individuals expressed a need for more staff with a clinical background in order to provide more mental health services. Providers also requested that the homeless system of care prioritize the LGBTQ population by protecting resources for them.

Key informants serving immigrant, monolingual, and Limited English Proficient clients expressed challenges with a lack of culturally appropriate services for these populations, particularly in Asian/Pacific Islander communities. Shelter staff serving these clients stated that monolingual clients faced a great deal of difficulty accessing resources simply because it is so hard for them to navigate the system. Key informants specifically offered the example of the VI-SPDAT assessment only being offered in English and Spanish, making it extremely difficult to accurately complete for monolingual clients speaking any other language. Key informants also stated that there is a lack of resources for undocumented immigrants experiencing homelessness, particularly in more remote areas of the county.

Key informants also expressed a few operational challenges in working with specific subpopulations. Almost all shelter key informants indicated that they are receiving funding from multiple sources, many with different restrictions, requirements and objectives that may apply to different populations. However,

they stated that this did not impact service delivery and is generally not detected from the perspective of the clients, but mainly creates some administrative burden in terms of reporting and paperwork.

Collaboration among County agencies, providers

The regular, ongoing, and highly collaborative interaction among key agencies, including DHS, LAHSA DMH and the HI, resulting from the Measure H initiative, is one of the key strengths of the program. Regular monthly meetings among the lead agencies (DHS, DMH, LAHSA, CEO's office) offer leadership the opportunity to discuss high level issues around funding, spending, and broader program issues. Quarterly meetings involving additional agencies such as DCFS, LASD, and Probation are also held. LAHSA has conducted several trainings for law enforcement on the referral system for LAHSA and DHS. One key informant noted that collaboration with probation tends to occur with individual shelter providers to identify individuals appropriate for placement under B7.

High Quality of Collaboration: According to one key informant, 'the level of coordination and collaboration is unlike anything I have ever seen in the county.'

A key indicator of successful collaboration is the development of shelter standards of care that were implemented in September 2019 by DHS, LAHSA, and DMH. Prior to Measure H, consistent standards across shelter types and agencies did not exist. The sheer increase of beds as a result of Measure H prompted the recognition that standards were crucial to consistent and high-quality service provision. The development of standards also included participation by DPH, who developed the facilities standards component. Key informants also mentioned the development of a universal housing referral form used by DHS, DMH, and LAHSA, as an indicator of successful collaboration.

Several key informants and individuals attending the Policy Summit noted that despite substance use disorders being a major issue for many individuals, SAPC participation is lacking at the leadership and programmatic level. Some shelter providers recommended that SAPC provide substance abuse services on-site. It was also noted that some agencies such as DHS, DMH and DPH collaborate very well because they are under one umbrella; however, structural issues within other agencies such as DPSS and DFCS make it more difficult for those staff to easily collaborate. One key informant noted that for some agencies, including the sheriff's office and probation, involvement in addressing issues of homelessness is relatively new, and the idea has 'taken hold unevenly in some agencies.'

Measure H has also resulted in a closer collaborative relationship between DHS, LAHSA, and shelter providers. Several DHS staff and shelter providers noted that the close collaborative relationship offers the opportunity to regularly discuss individual cases and engage in problem-solving at the client level. Also noted was the importance of training provided by DHS and LAHSA to shelter providers. LAHSA is currently developing Learning Communities with providers to encourage sharing of best practices.

Process and challenges for hospitals

The process for hospital referral for strategy B7 is similar for county hospitals and private hospitals interviewed, although access to DHS recuperative care housing differs. The county hospitals have well-

established referral pathways to DHS for recuperative care/stabilization housing, with DHS-funded staff on site who, along with many hospital staff working with the homeless population in emergency departments, have direct access to the DHS CHAMP data system. The county hospitals have a specific protocol for initiating the referral process for homeless individuals directly in CHAMP. One hospital has a dedicated team of homeless staff – the Homeless Task Force – focused on working with this population for assessment and referral. This team is partially funded by the hospital's operational budget. Another county hospital reported no dedicated homeless team, but all staff have experience with and are comfortable working with the homeless population and their unique needs.

In private hospitals, staff do not have access to CHAMP and rely on direct communication with DHS staff to identify potential recuperative care beds for their patients. One key informant noted that referral to DHS recuperative care/stabilization housing is prioritized for the county hospitals, and while their preference would be DHS housing, most often DHS is not able to accommodate patients referred from private hospitals. Another private hospital informant was completely unfamiliar with the DHS referral process, had never referred to DHS, and was not aware that they might have access to DHS recuperative care beds.

Role of recuperative care for linking from hospitals to interim housing: "So maybe they go into recuperative care, but then if they are willing and able to kind of move through the rest of the process to get into some other like transition or permanent supportive housing, they'll do that and their team really serves as housing navigators."

In both the county and private hospitals, identification of potentially homeless individuals begins immediately after, and sometimes before, the actual intake process. One county hospital staff described how their Homeless Task Force goes into the emergency department (ED) waiting room and looks for individuals who appear to be homeless, including those with a lot of belongings or suitcases with them. Another public hospital staff described checking the hospital's tracking system proactively to identify homeless individuals prior to them being referred to her for assistance. For all county hospitals, determination of potential housing needs is a routine part of the intake and release process. The CHAMP system allows referring staff to quickly and easily identify whether an individual is already in the system or whether a new referral initiation is needed. Once the referral process is initiated in CHAMP, DHS sends a Recuperative Care staff person to the hospital to interview the patient, review records, and determine whether the patient requires Recuperative Care or other appropriate housing. This then leads to the overall process of moving individuals to permanent housing.

One informant observed that the hospital setting is a key location for identification and referral of homeless individuals. Some homeless individuals go to the ER to find a place to sleep for the night. She also described how many individuals spend time on the hospital campus because they have no other place to go during the day. Another staff indicated that word has spread about their Homeless Task force, and in some cases individuals without health problems show up at the ER for housing services.

Potential to implement recovery-oriented principles

Because of Measure H and the expansion of interim housing beds, shelter providers have significant potential to incorporate recovery-oriented principles into their programs. These principles include using a person-centered, strengths-based approach to recovery that focuses on empowerment, peer support, respect, and individual responsibility.[8] Shelters are already applying a Housing First approach and focus on harm reduction in addition to recovery support. Providers have received training from LAHSA in trauma-informed care models, which can be further strengthened through the Learning Collaborative and sharing of best practices. All B7 and E8 shelters are required to provide case management services that include a wide array of person-centered services.

However, challenges to this person-centered approach were identified. Several participants in the Policy Summit specifically noted that the focus on harm reduction has made it difficult for individuals who are interested in sober living and recovery. With the increased size of interim housing facilities, individuals are exposed to other individuals who use substances, making it more difficult to achieve and maintain their own sobriety. Recommendations included allowing and designating some facilities as sober living facilities, in which an individual can choose to be assigned to this type of facility.

Another challenge includes the need for more experienced and highly trained staff to work with complex cases. Many providers do not have sufficient funds to hire staff with the level of experience required for this population. At a minimum, more training for existing staff should be provided to increase their skill set and ability to work with individuals with complex needs.

Challenges transitioning to permanent housing

Lack of permanent housing in the County was the most frequently cited barrier to transitioning to permanent housing identified by key informants. Both County agency staff and shelter staff agreed that a lack of permanent housing resources creates a bottleneck, leading to slow bed turnover in interim housing.

Another frequently cited barrier was the difficulty for clients with high acuity level needing assistance with daily living, and those with mental health and/or substance use problems, to gain skills needed to live independently. Key informants emphasized the importance of supportive services such as workforce readiness, financial literacy, and budgeting classes as crucial for clients to be able to maintain housing once they transitioned. However, key informants also stated that workforce development and job training programs are often still insufficient due to the high cost of living in Los Angeles, as even a full-time minimum wage job might not be sufficient to maintain housing stability.

Because CES matching is based on availability and eligibility rather than client needs, key informants also stated that it is difficult to achieve care continuity in scattered site permanent housing. Clients often build rapport with service providers in shelters, and it can be a challenge to transition to a different location with new staff. Key informants also discussed the importance of community, and the fear that many clients grapple with once moving into permanent housing and losing the social support they had relied on

[8] https://www.apa.org/monitor/2012/01/recovery-principles

from other clients in shelter. This was a commonly mentioned challenge particularly for clients with mental health and substance use disorder needs.

In terms of CES prioritization, key informants stated that clients in interim housing are not necessarily next in line for permanent housing resources. One key informant expressed a need for a strategy to prioritize those in beds for permanent housing to improve throughput in the system.

Differences among subpopulations in outcomes

We examined differences in outcomes among various client subpopulations related to exits to permanent housing (PH), returns to homelessness, and LOS in interim housing. We first present results for the HMIS sample, which includes those in interim housing served predominantly by LAHSA. We then present results for the population receiving Recuperative Care and Stabilization Housing through DHS and tracked in the DHS CHAMP data system.

HMIS Sample

Table 5 presents the demographic, health status, and outcomes for the entire HMIS sample analyzed. Most were Non-Hispanic/Non-Latino (72%) with about 27% Hispanic/Latino. Over 50% were Black/African-American, followed by 38% White. Almost 60% were male and about 11% were veterans.

Almost 30% of the sample had experienced domestic violence upon entry to the program, 43% had a mental health problem, almost 20% had a substance abuse problem, and almost 14% presented with co-occurring mental health and substance abuse problems. Almost one-quarter of the sample had exited to permanent housing, 8% exited to homelessness, and the average length of stay was 99 days.

Table 3. Demographics, Health Status, and Outcomes

Sample Demographics	Number	Percent
Total	**20,574***	
Ethnicity		
Non-Hispanic/Non-Latino	13,820	72.0
Hispanic/Latino	5,513	26.8
Other	241	1.2
Race		
White	7,886	38.3
Black/African-American	10,773	52.4
Mixed	426	2.1
Other	1,489	7.2
Gender		
Female	7,984	38.8
Male	12,252	59. 6

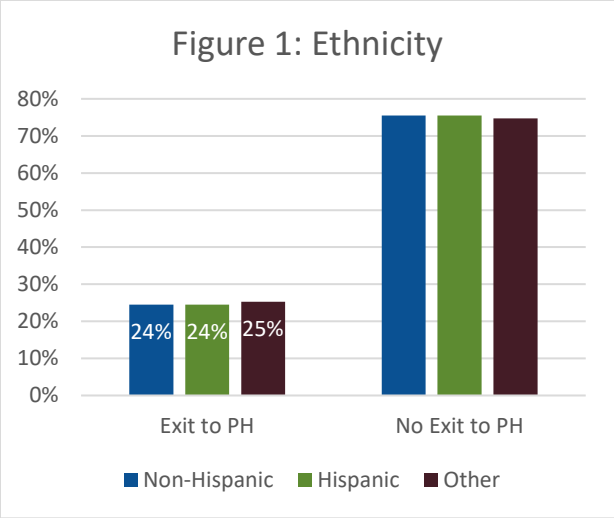
Transgender/Non-conforming	270	1.3
Unknown/Refused	68	0.3
Veteran Status		
Veteran	2,300	11.2
Non-Veteran	17,926	87.1
Other/Unknown	348	1.7
		Health Status
	Number	**Percent**
Domestic Violence		
Experienced DV	6,106	29.7
No DV	14,468	70.3
Mental Health Problem		
Yes	8,851	43.0
No	11,723	57.0
Substance Abuse Problem		
Yes	3,987	19.4
No	16,587	80.6
Mental Health and Substance Abuse Problem		
Substance abuse only	1,135	5.5
Mental health only	5,999	29.2
Both SA and MH	2,852	13.8
No MH or SA	10,588	51.5
		CES Score
0-3	1,989	16.2
4-7	4,826	39.4
8+	5,430	44.4
		Client Experience Outcomes
Exit to Permanent Housing	**Number**	**Percent**
Yes	5,020	75.5

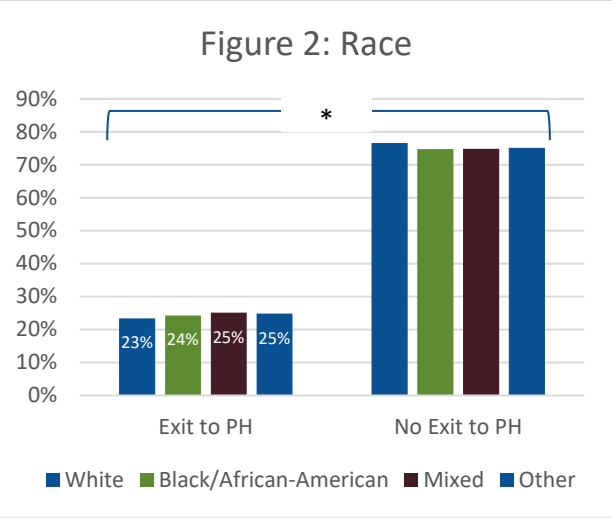
No	15,534	24.5
Exit to Homelessness		
Yes	1,618	7.9
No	18,956	92.1
Length of Stay (Days)	99.3	109.5

* Some variables have missing values so do not total to 20,574.

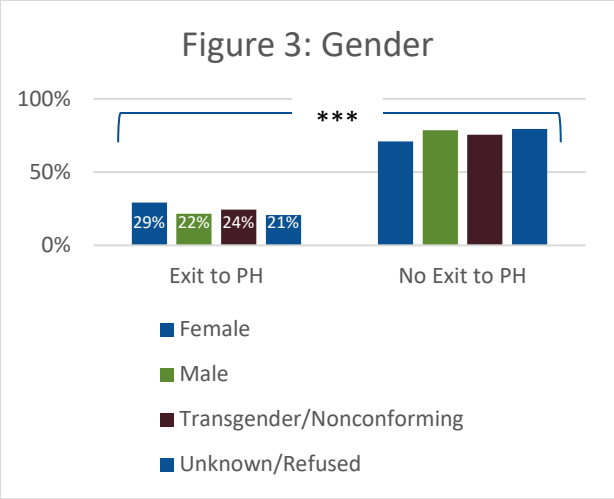
Exit to Permanent Housing

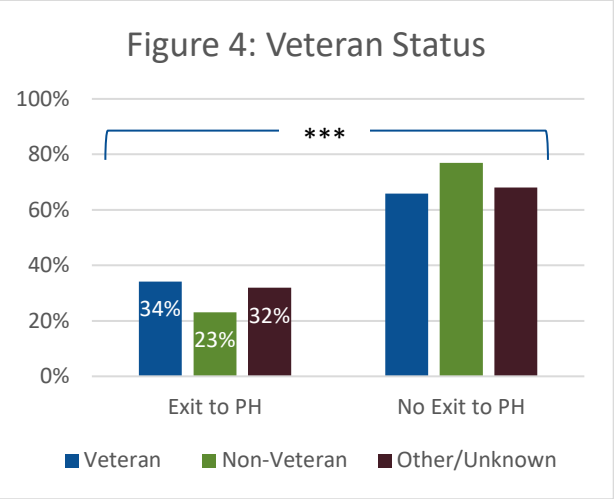
Figures 1 to 4 show differences in the demographic subpopulations in exit to permanent housing. There were no significant differences among ethnic groups in exit to PH, but there were significant differences by race, gender, and veteran status. Whites were the least likely to exit to PH (23% compared to 24% and 25% of Black and mixed race, respectively). Females were more likely than males to exit to PH (29% versus 21.5%), and veterans were more likely than non-veterans to exit to PH (34% versus 23%).



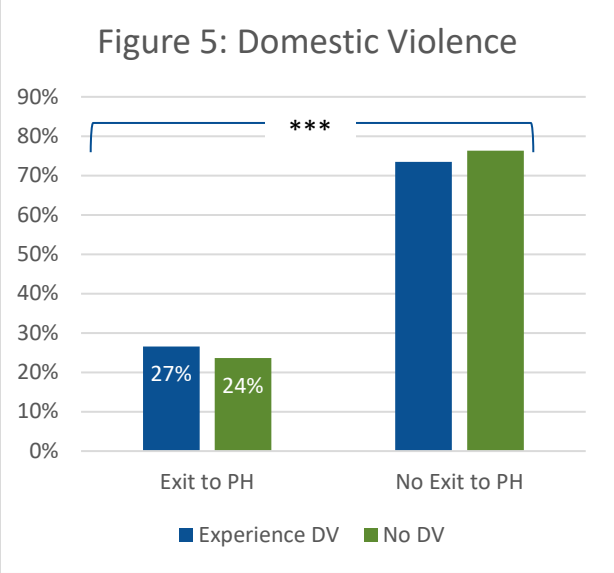


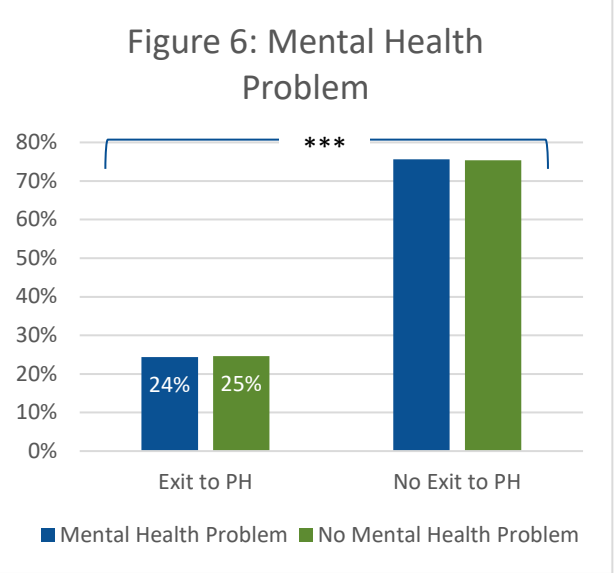
*p<0.05
** p<0.00
*** p<0.000

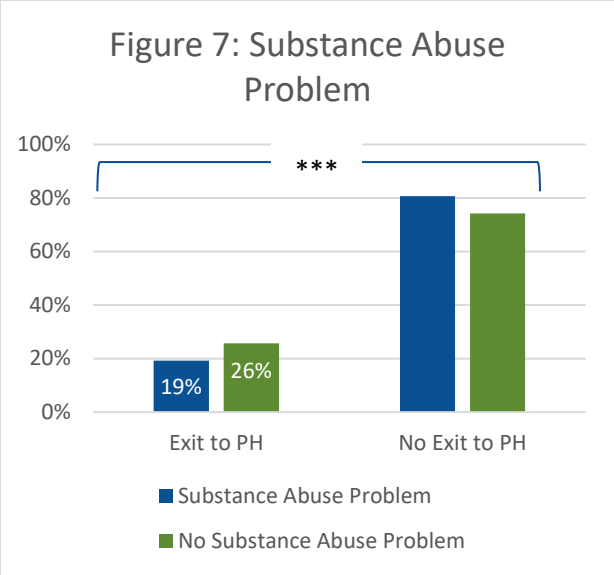


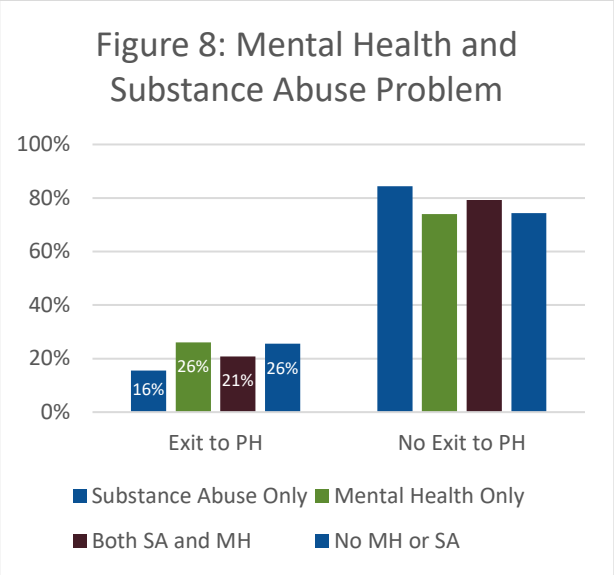


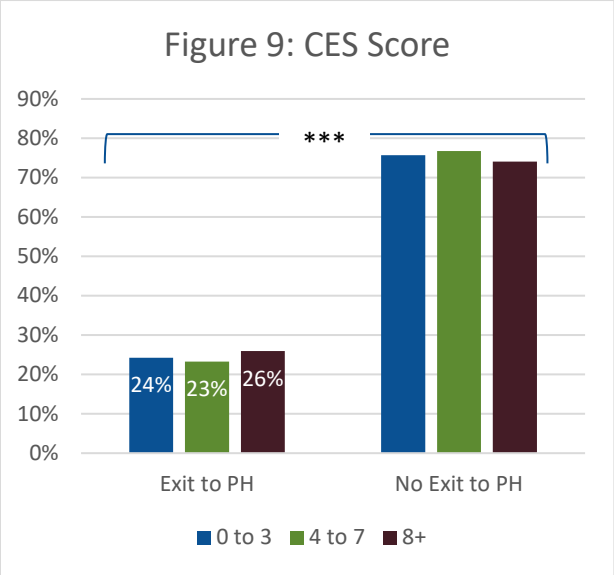
Figures 5 to 9 show that significant differences among subpopulations in exiting to PH were also found for those with domestic violence, substance abuse problems, and co-occurring mental health and substance abuse problems, while no differences were found among those with only mental health problems. Individuals experiencing domestic violence, those without substance abuse problems, and those with mental health only or no mental health problems were more likely to exit to PH. Those with the highest CES score were most likely to exit to PH (26% compared to 24% of those in the lowest and 23% of those in the mid-range groups).











Figures 10 to 18 show subpopulation comparisons for LOS. There were no differences in LOS by ethnicity, but significant differences were found in the other demographic subgroups. Those with mixed race had the longest LOS (107 days) compared to 'other' and whites who had the shortest LOS (91 and 96 days, respectively). This may be reflective of whites and 'other' being less likely to exit to PH (it is possible these groups terminate the program early, prior to finding PH).

Figure 10: Ethnicity LOS

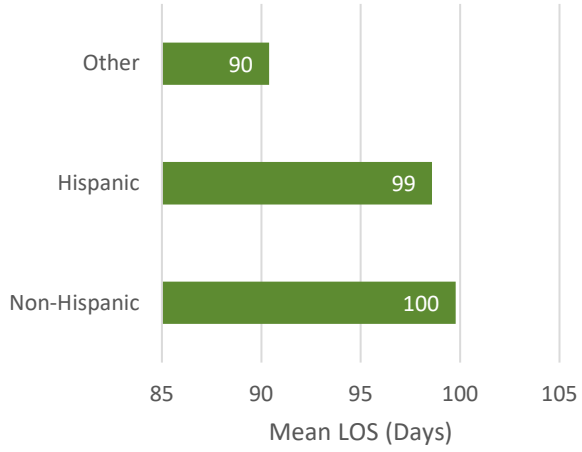


Figure 11: Race LOS

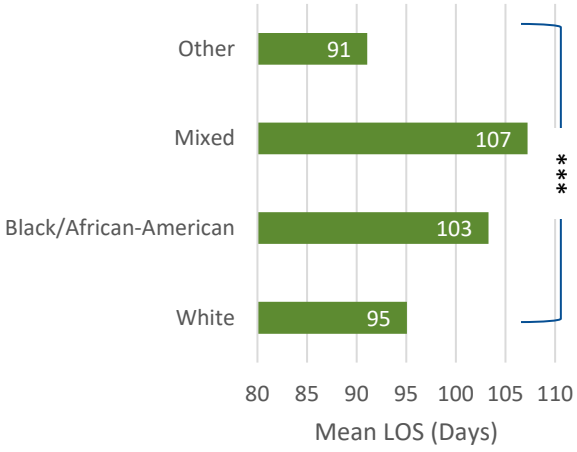


Figure 12: Gender LOS

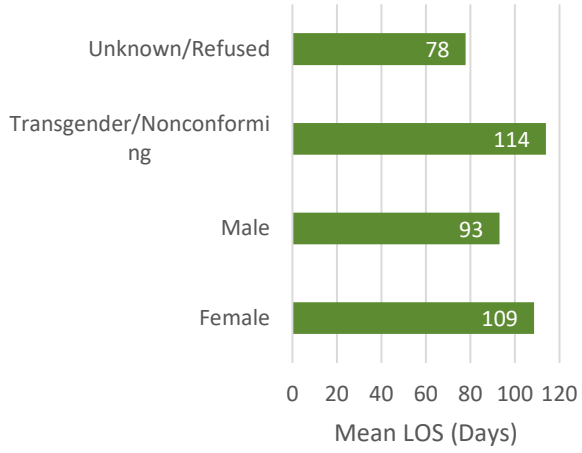
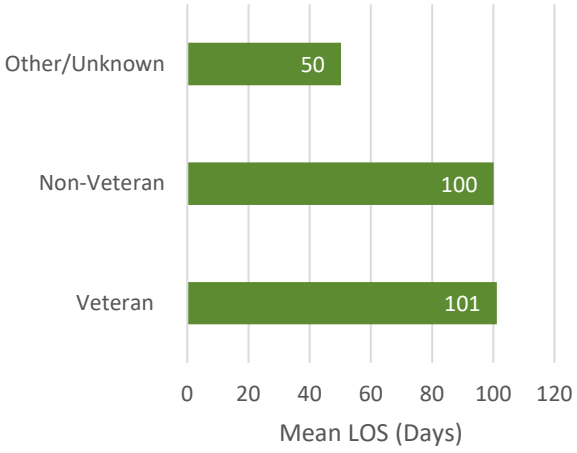


Figure 13: Veteran Status LOS



Among the health status subgroups, those experiencing domestic violence had a significantly longer LOS (109 days compared to 95 days for those with no domestic violence history), and those with mental health problems compared to those without had longer LOS (106 versus 94 days, respectively). There was no difference in LOS for those with substance abuse versus those without substance abuse problems. Looking at the combined mental health and substance abuse grouping, however, those with co-occurring mental health and substance abuse problems and those with mental health problems only had the longest LOS (106 days for both). CES score was also associated with LOS, with those in the most severe category remaining the longest (118 days).

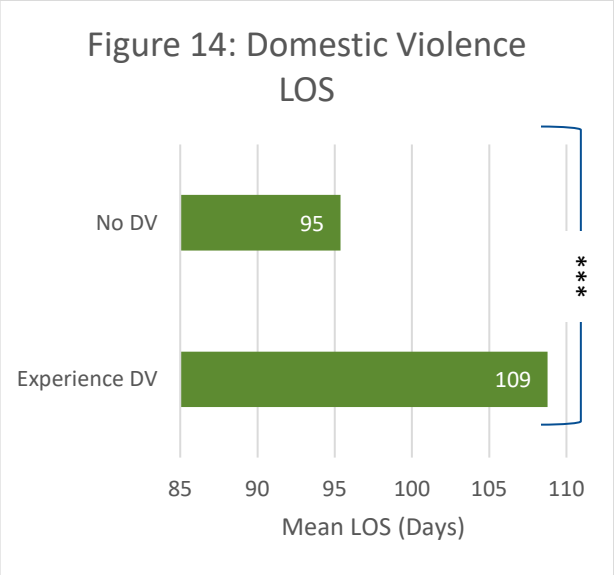


Figure 14: Domestic Violence LOS
No DV
95
Experience DV
109
***
85
90
95
100
105
110
Mean LOS (Days)

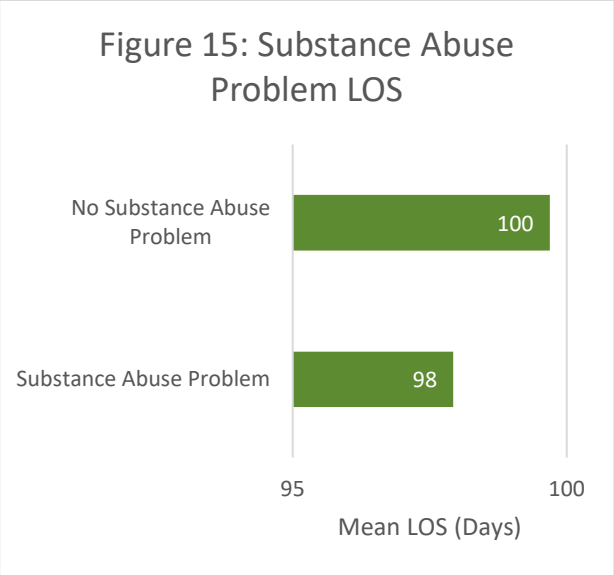
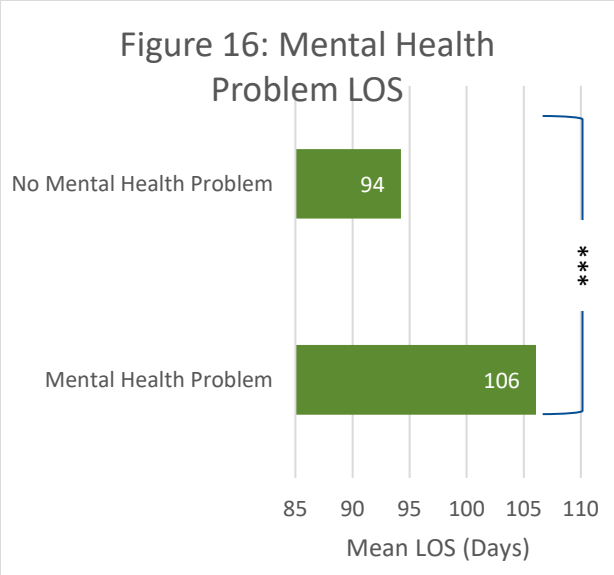
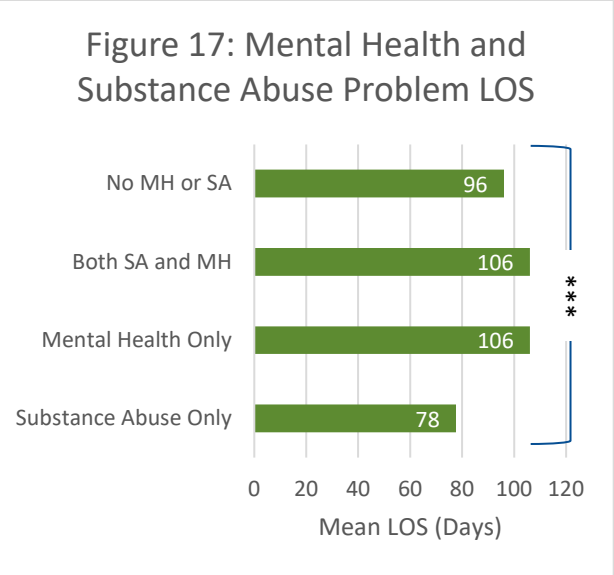
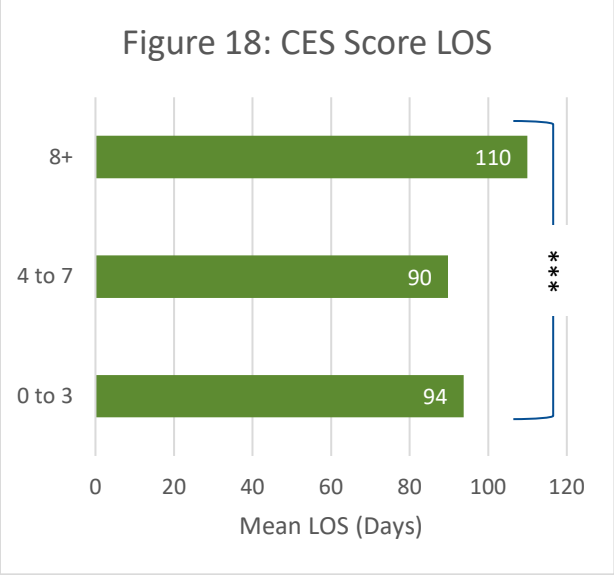


Figure 15: Substance Abuse Problem LOS
No Substance Abuse Problem
100
Substance Abuse Problem
98
95
100
Mean LOS (Days)



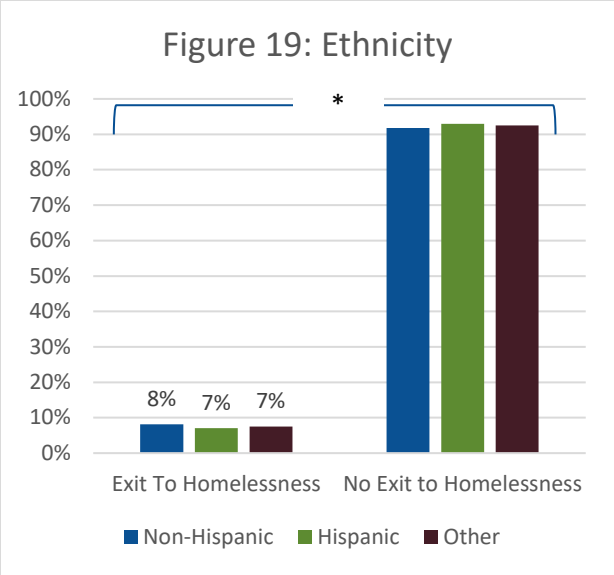


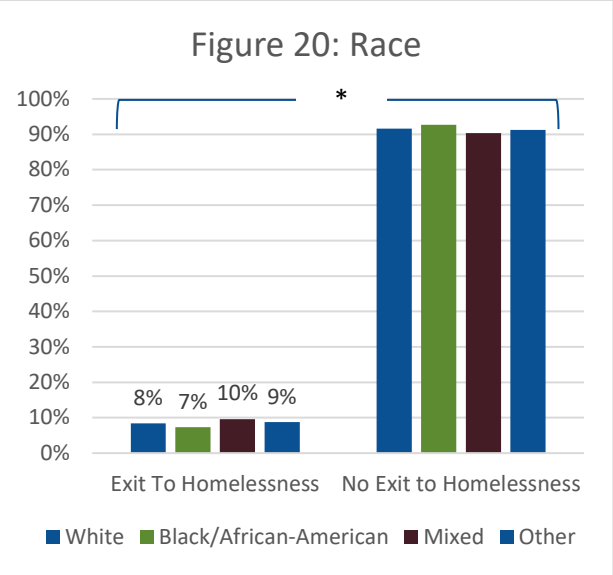


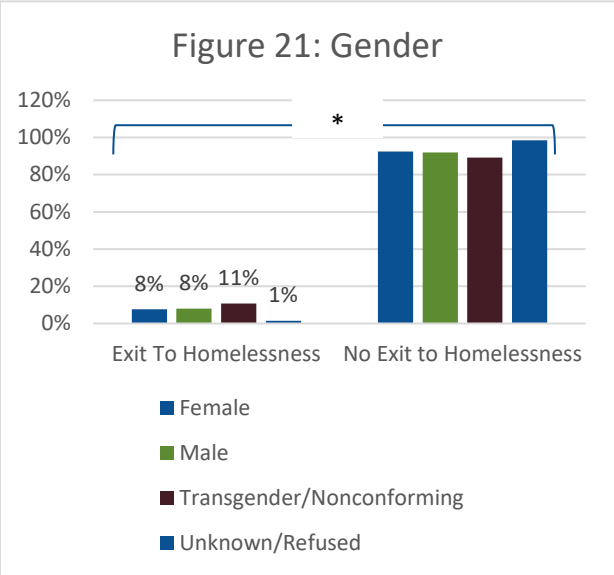
Exit to Homelessness

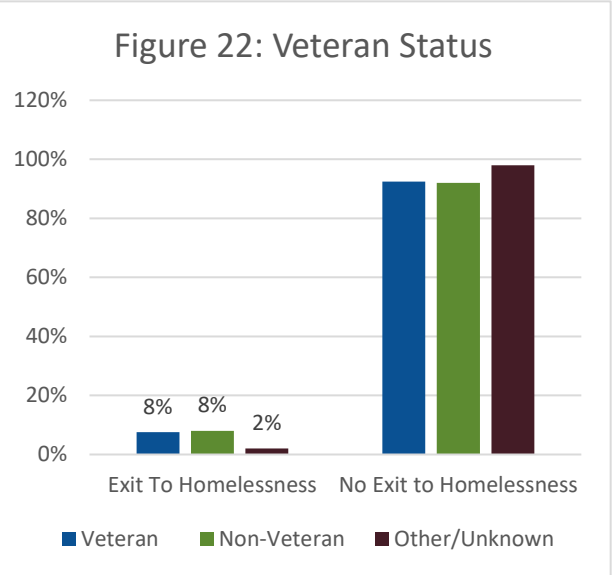
As illustrated in Figures 19 to 27, significant differences in exit to homelessness were found across all subgroups. Non-Hispanic/Non-Latinos, and those with mixed race were more likely than their comparison groups to exit to homelessness. Transgender/non-conforming individuals (11%) were significantly more likely to exit to homelessness compared to females and males (8% in each group).

There was a significant difference in the veteran group, but this may be driven by those with unknown status, with only 2% compared to 8% of those identified as veterans or non-veterans exiting to homelessness.









Those experiencing domestic violence (8%), those with mental health problems (9%) and those with substance abuse problems (11%) were more likely than their counterparts to exit to homelessness. Those with co-occurring mental health and substance abuse problems (11%) were more likely than the other categories to exit to homelessness. Those in the most severe CES category (8%) were twice as likely to exit to homelessness compared to the low and mid-range groups.

Figure 23: Domestic Violence

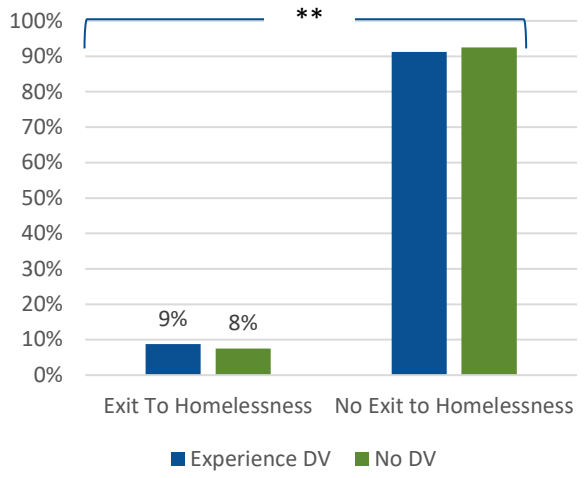


Figure 24: Mental Health Problem

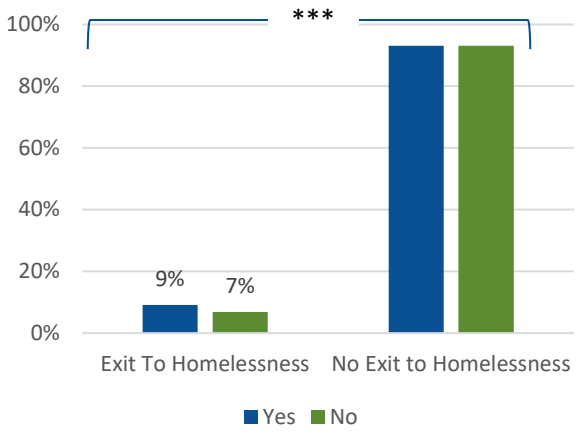


Figure 25: Substance Abuse Problem

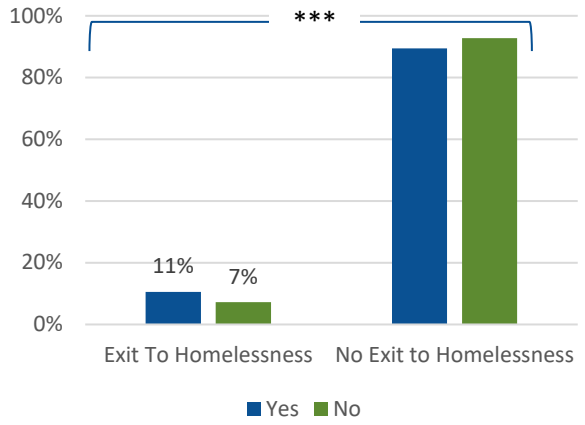


Figure 26: Mental Health and Substance Use Disorder

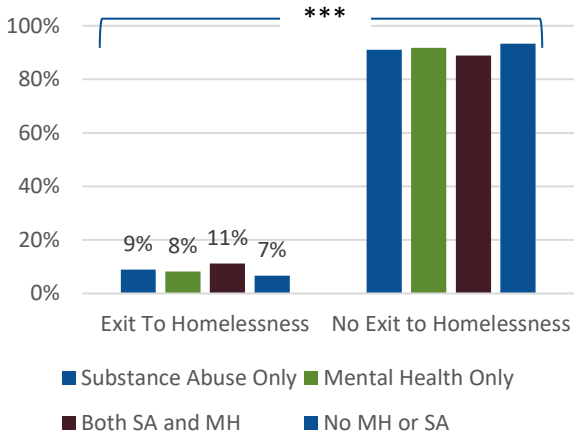
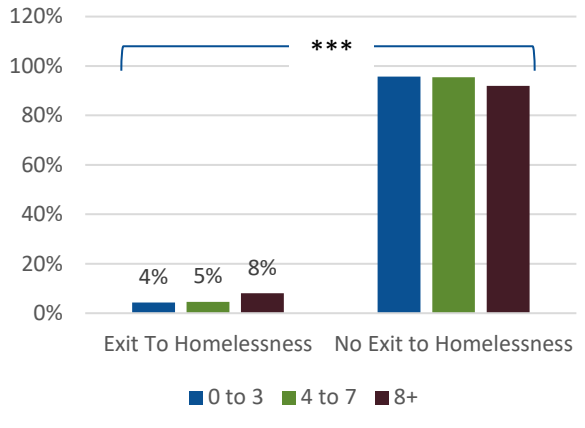


Figure 27: CES Score



Summary for HMIS sample

Analysis indicates significant differences in all outcomes among various subpopulations; however; interpretation of these differences may be difficult. Exit to permanent housing is a positive outcome, but this is often accompanied by a longer length of stay. This is an example where longer LOS may be indicative of a positive outcome if individuals remain in a temporary shelter longer but end up in PH rather than non-PH living situations. Similarly, the significantly longer LOS for those with the highest acuity level may indicate that they are staying longer because they need to, compared to those with low acuity. However, data also indicate that for a subset of those with high acuity, exiting to homelessness is more likely, compared to those with lower acuity. Thus, individuals with high acuity are more likely to exit to homelessness, but if they stay in a program, they stay longer and are more likely to move to PH. The same is not true for those with co-occurring mental health and substance abuse problems, where they are the least likely to exit to PH and the most likely to exit to homelessness.

CHAMP Sample

The CHAMP data available to us did not include information on health status, thus analysis was more limited for examining subgroup differences. In addition, these data did not include information on whether individuals exited to homelessness, so we focus only on exit to PH and LOS. Table 6 presents the demographic information and outcomes for the CHAMP sample analyzed. Like the HMIS data, most of the sample were Non-Hispanic, White at 63%. White and Black/African-Americans were at about equal proportions (39 and 38%, respectively), with almost 70% male. Most individuals were in stabilization housing (65%) compared to those in Recuperative Care (36%). Like the HMIS population, 24% exited to PH, and the average LOS among those who had exited was 139 days, 40 days longer on average than in the HMIS population.

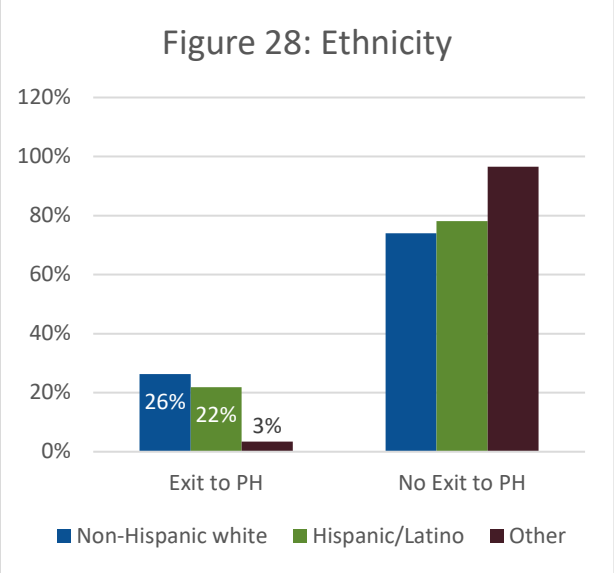
Table 4. Sample Demographics

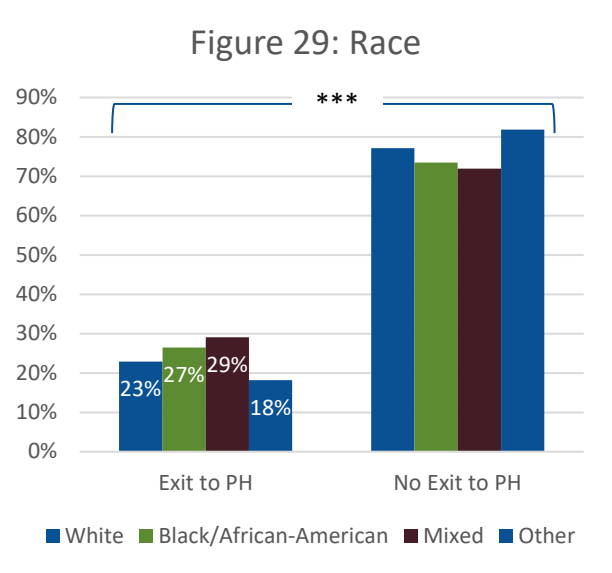
Sample Demographics	Number	Percent
Ethnicity		
Non-Hispanic/Non-Latino	2,202	63.1
Hispanic/Latino	1,140	32.7
Other	147	4.2
Race		
White	1,352	38.8
Black/African American	1,309	37.5
Mixed	267	7.6
Other	561	16.1
Gender		
Female	1,111	31.8
Male	2,378	68.2

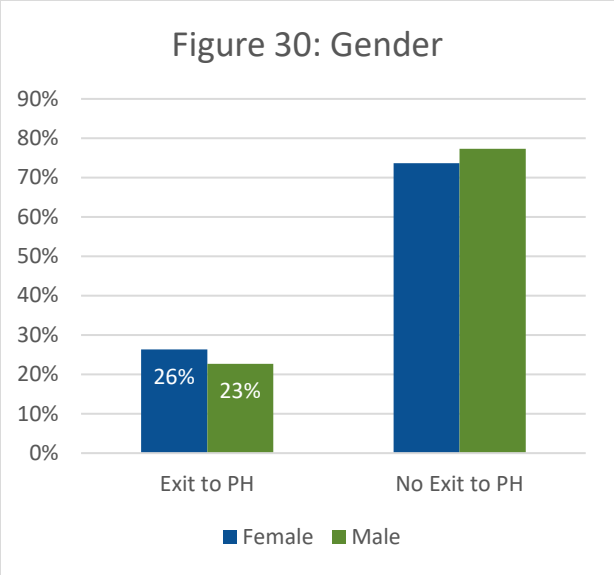
Veteran Status		
Veteran	109	3.1
Non-Veteran	3,265	93.6
Unknown	115	3.3
Housing Type		
Stabilization	2,228	63.9
Recuperative	1,261	36.1
Exit to Permanent Housing		
Yes	833	23.9
No	2,656	76.1
Length of Stay	138.9	129.4

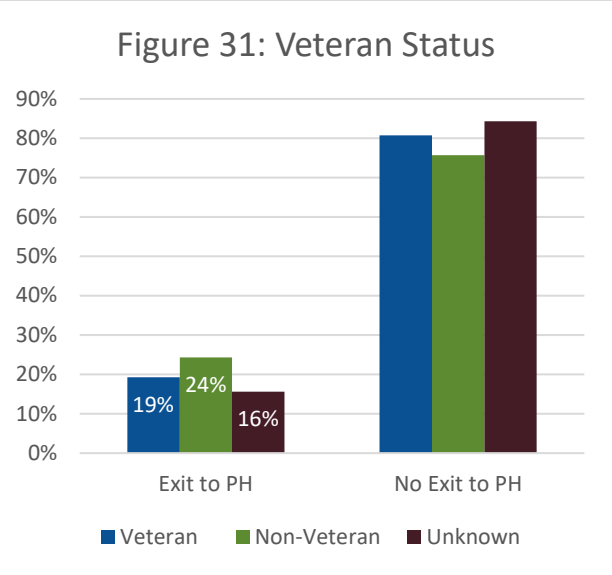
Exit to permanent housing

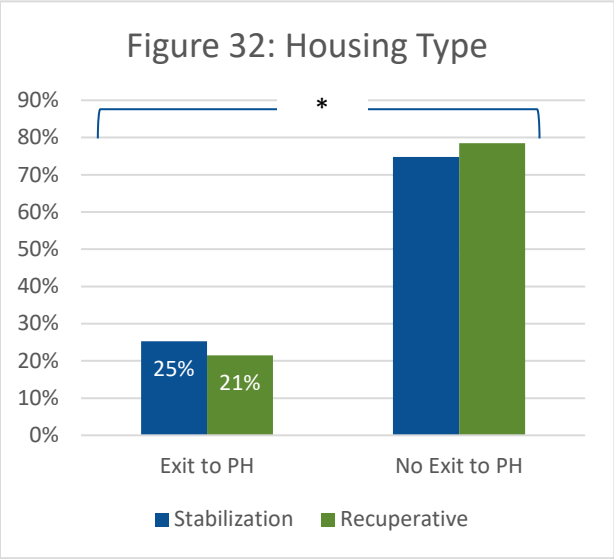
Figures 28 to 32 show differences by demographic subgroup, with significant differences across all demographic variables in both outcomes. Among those in recuperative care/stabilization housing, Non-Hispanic/Non-Latinos were more likely to exit to PH than Hispanic/Latinos.











This differs from the HMIS population, for which no significant difference in ethnicity was observed. Like the HMIS population, whites were the least likely to exit to PH (23% compared to 27% of Black/African-Americans and 29% of mixed race). Females were also more likely to exit to PH than males (26% versus 23%) as was found in the HMIS population, although CHAMP data does not track transgender/nonconforming status. Those in stabilization housing were more likely to exit to PH than those in recuperative care (25% versus 21%).

Length of Stay

LOS differed across all demographic groups as well. Non-Hispanic/Whites had a longer LOS (146 days) compared to Hispanic/Latinos (131 days). Those with mixed race and African-Americans had longer LOS than Whites (149, 147, and 135 days, respectively). This also mirrors the HMIS population data. Males and non-veterans had longer LOS compared to their counterparts, and those in stabilization housing had longer LOS then those in recuperative care.

Figure 33: Ethnicity

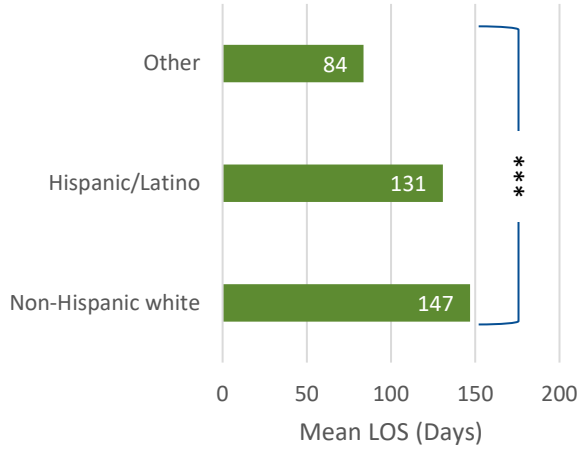


Figure 34: Race

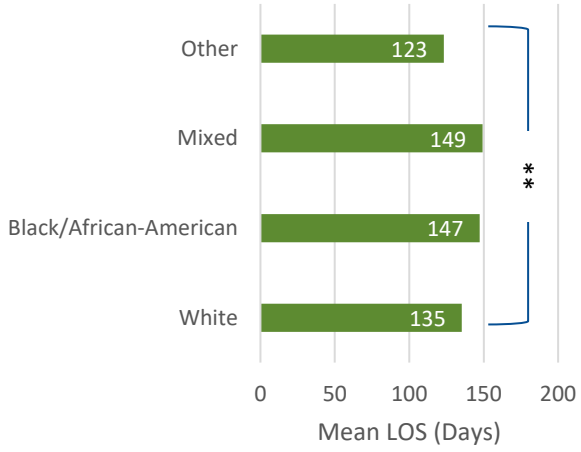


Figure 35: Gender

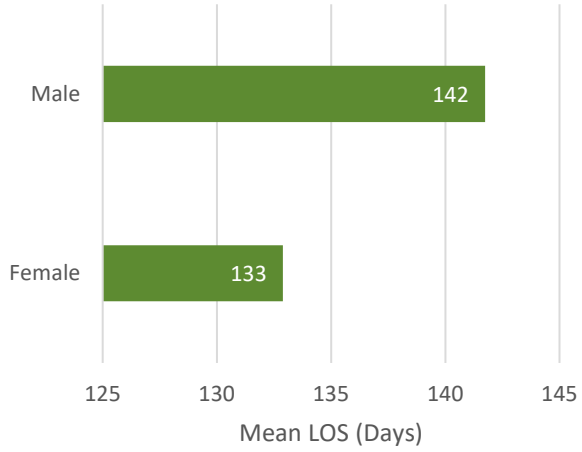


Figure 36: Veteran Status

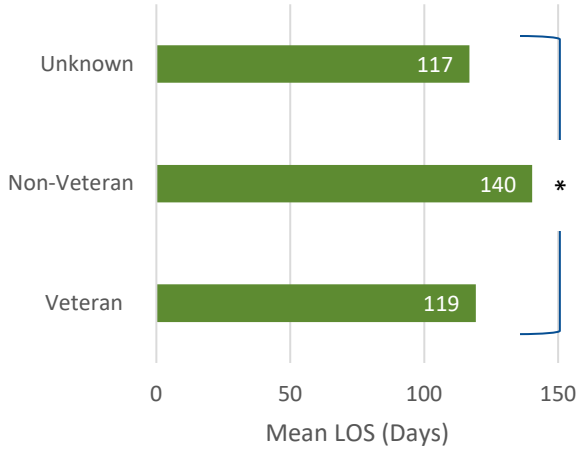
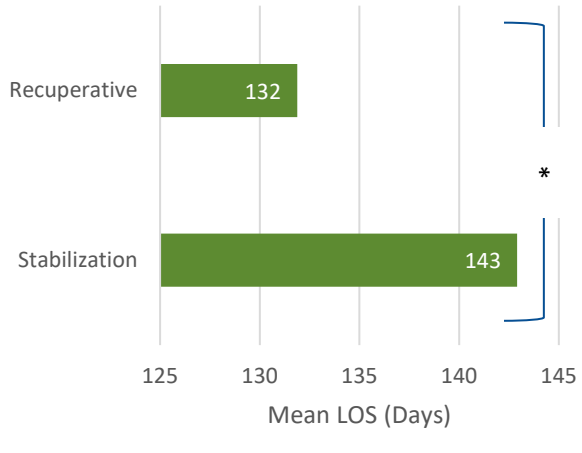


Figure 37: Housing Type



Summary for CHAMP sample

Similar differences across demographic subgroups were seen among those in stabilization housing/recuperative care compared to the HMIS emergency and transitional shelter population, although patterns across the two outcome variables differs. Unfortunately, we are not able to assess other subgroup comparisons in the CHAMP data.

Best practices and processes in need of improvement

Since Measure H has been implemented, several successes and potential best practices have emerged from the available data and performance evaluation results. Key informants pointed to the overall increase in interim beds as a significant success, as well as increased outreach and strong referral processes resulting in increased access to shelters. County hospital key informants described the referral process to DHS beds as very smooth and were able to easily communicate with Housing-For-Health staff in the event of any issues and resolve them quickly. Several "low barrier" strategies including 24-hour shelters, harm reduction policies for substance use disorder, accommodations for pets, and storage for belongings can be considered best practices for increasing access and are strong examples of shelters using Measure H funds to reimagine service delivery to meet clients where they are. Increased funding has also allowed shelters to hire more clinical staff, provide a much more expanded portfolio of services to clients and co-locate services such as health care to increase access. Funding has also enabled more opportunities for professional development such as trainings for staff in working with challenging populations. County key informants indicated fewer client complaints since the implementation of Measure H.

As noted previously, Measure H has been a driver of unprecedented collaboration across the county. Informants most frequently mentioned the establishment of universal shelter standards as a key milestone exemplifying this collaboration. Shelter key informants characterized the level of collaboration and communication with County agencies as very strong and expressed that they felt supported by DHS and LAHSA.

While several successes and identified best practices point to a generally positive trajectory for Measure H, key informants also identified several challenges. Lack of care continuity across the continuum of housing resources came up as a challenge frequently, and several key informants expressed the importance of maintaining relationships with clients as they transition through levels of housing to maintain progress. Shelter staff stated that some clients have been referred to shelter without an identified Intensive Case Management Services (ICMS) worker but needed access to services that they could not connect with through any other avenue. High rates of staff turnover were also cited as a key challenge with maintaining care continuity and could stymie clients' progress towards housing readiness.

When considering the unique needs of subpopulations experiencing homelessness, key informants discussed a need for more nuanced consideration of the challenges certain clients might face when transitioning to permanent housing, such as clients with chronic conditions who must maintain access to certain services to maintain their housing.

For clients exiting hospitals, while public hospitals relayed extremely positive experiences with the referral process to DHS recuperative care beds, private hospitals indicated a lack of awareness of and difficulty with referring their patients to those beds. Because private hospital staff do not have access to HMIS, key informants expressed frustration with trying to verify where patients were in the CES process and connecting them with CES resources. Key informants also identified a lack of skilled care as a top issue, specifically a dearth of skilled care settings willing to accept Housing-For-Health clients due to their young age, co-occurring behavioral health issues, and lack of funding.

Key informants also identified several challenges with data systems, particularly the challenges of working with different data systems. Not only do different data systems seem to place a burden on providers to enter data multiple times (which also increases errors), the lack of communication between HMIS and CHAMP seems to create difficulties with getting a complete story for each client. Key informants also stated that data from other departments such as DMH and SAPC is not easily accessible.

Definition of program effectiveness

Definitions of program effectiveness vary depending on role, type of involvement in the program, and consideration of individual-level, program-level, and/or system-level assessment. However, the majority of key informants recognize that the ultimate goal of interim housing is to move individuals to permanent housing. Many key informants look to data related to performance metrics reported and published quarterly such as time from entry to permanent placement, type of exit (negative versus positive), time from referral to placement, and vacancy rate as indicators of success. Individuals also recognize the importance of looking historically at data to see improvements – even small and gradual improvements are important over time.

Maintaining individuals in interim housing as long as needed until permanent housing is available is also a key indicator of success; however, LOS as a measure of effectiveness on its own may be incomplete. Longer LOS may be viewed as a negative indicator, in that this indicates more time in a non-permanent versus permanent housing situation, as well as indicating less capacity to move unhoused individuals off the street. However, longer length of stay can also be a positive indicator in that individuals remain housed rather than exiting back to homelessness. Most key informants felt that the approved length of stay, particularly for recuperative care and stabilization housing, should be lengthened.

Many key informants note that qualitative data, in addition to the numbers/quantitative data, helps them assess program effectiveness. For example, some individuals noted that reviewing client incident reports has shown a decrease in serious shelter incidents, which is an important outcome. Both agency and shelter provider staff also examine qualitative data in individual case notes to identify individual-level and program-level issues that need to be addressed.

ASSESSING PROGRAM EFFECTIVENESS: "We started monitoring evening activity, seeing an increase in incident reports at night and on the weekends. We learned there is not a lot for people to do at night. We didn't have case managers, so now we have staggered schedules of programs and case managers, we created social programming for the evening, and we have seen a decreased in the number of incidents."

At the individual level, key informants consider many factors when assessing program effectiveness – Were physical health problems addressed? Was substance use reduced? Did clients increase interpersonal relationships while in shelter? Did clients become more self-sufficient? Did they learn life skills that will assist them in maintaining permanent housing? Were clients satisfied with services? Individual success stories are considered important indicators by many and are included in the quarterly reports.

At the program level, all agency and shelter staff report reviewing data on at least a weekly basis (for some measures such as bed rates they review daily) and utilizing data to identify problems and make program improvements. One key data-informed program improvement was time from referral to placement. DHS noticed that agencies were taking a long time to vet individuals. Once identified as a problem, they changed protocols to the process for receipt of referral, response, time to placement, and expectations of providers to accept clients. As a result, the referral-placement timeframe was reduced from two weeks to three days.

Funding Sources, Restrictions, and Administration: Effects on Service Provision in Practice

County agencies have multiple funding sources to support B7 and E8 beds, with different types of restrictions imposed from each source. DHS funding for recuperative care/stabilization housing comes from a variety of sources, including Measure H, state funds, their standard operating budget, the Office of Diversion and Reentry, as well as additional funding sources that pre-dated Measure H. Medi-Cal funds through Health Homes and Whole Person Care are also utilized to various extents by County agencies and shelter providers.

LAHSA derives significant funds from Measures H for shelter services, with additional funds from the city, other County sources, state funding, and DPSS funding. LAHSA is able to use Measure H funding to drive programming for the rest of the funding sources. According to one LAHSA staff, the city is willing to align their dollars with Measure H, making the contract and service provision process more streamlined.

Among shelter providers interviewed, many serve various subpopulations and provide both B7 and E8 services and services through other funding sources. For example, some providers have funds from the Office of Diversion and Reentry (through AB109 funds) to support those exiting jails. Others receive city funding as well as funding directly from health plans and private hospitals.

Overall informants noted significant challenges involved with different funding sources in terms of eligibility requirements, certification requirements for staff, performance targets and reporting requirements, and bed rates. Several respondents noted challenges in funding provided by family-serving agencies such as DPSS, which tends to have the most restrictions. One respondent noted key barriers with DPSS funding, which has a much lower bed rate than DHS, stringent eligibility criteria that is challenging for most clients, and unfunded mandates for service provision.

Measure H funds are much less restrictive than other funding sources, particularly funding from the city, DPSS, and HUD. The limitations on LOS and very specific eligibility criteria for some funding sources makes it challenging to provide consistent and quality care to all clients. One shelter respondent noted that working with DHS funds through B7 is much more flexible than hospital funding in terms of LOS. Hospitals often pay for only 7 days, while DHS allows a much longer LOS through Measure H funds.

While acknowledging the challenges incurred with multiple funding sources, shelters provide the same level of services for all clients. Respondents described complicated funding policies at the administrative level to ensure consistent services, including utilizing more restrictive funding first, so those dollars are used as efficiently as possible, allowing more leeway with less restrictive sources (e.g., E8 funds) for use with those not meeting the restrictive eligibility criteria.

Despite restrictions on DPSS funds, LAHSA fully utilizes those funds by leveraging Measure H funds to ensure they meet DPSS requirements.

Tracking various funding sources is handled at the administrative level, with complex record-keeping and financial tracking. Shelter respondents noted that billing also differs across funding sources, which is difficult for the finance unit to maintain.

All respondents endorse streamlined funding sources as the ideal given the complexity of different funding restrictions, bed rates, and standards they currently manage. However, many respondents also recognize that the extent of the homelessness problem requires multiple strategies and funding sources to be able to serve all clients in need.

Recommendations

Based on our evaluation, we have identified a set of recommendations for enhancing the ongoing work for Strategies B7 and E8. These recommendations are based on input from key informants as well as HMA's assessment of key areas of focus.

Services

Key informants interviewed for this evaluation suggested enhancing service provision in multiple areas. However, given funding limitations of Measure H, any increase in services in one strategy or service area would likely result in a decrease in funding for other strategies/services. Given the centrality of the interim housing shelter strategies to the County's overall coordinated approach to homelessness – a degree of importance that is further amplified by current permanent housing shortages the County should seek to identify or generate additional resources for key services to be made available through or in coordination with interim housing providers, including the following:

- Employment services can be provided at shelter sites, with a focus on employment opportunities that offer a living wage and increase self-sufficiency. Providing incentives for employment services providers could increase their commitment to working with the homeless population.

- Community-based clinical and physical health services can be made available to better meet the needs of high acuity persons in the interim housing system. This is particularly for clients in need of SUD treatment services, which are lacking at shelter sites.
- For TAY, provide additional counseling and family therapy that is appropriate for this age group. Additionally, consideration should be made to increase the number of TAY-specific shelter sites/beds and increase funding for TAY drop-in centers.
- Identify ways to access and pay for licensed nursing home facilities. This may require focused effort to build relationships with these facilities, particularly by DHS. Funding could be allocated at the state/Medicaid level.
- Engage health plans to support services provided in the shelter/recuperative care setting. Many health plans recognize the need to address social determinants of health. The timing may be right to approach plans with specific requests for assisting the homeless population.
- Increase the allowable LOS at shelters, especially for high-acuity clients. Measure H has resulted in increased services for those exiting institutions, and this has increased the number of complex, high-acuity clients entering the interim shelter system. While increased LOS may cause more bottlenecks in moving individuals from the street to shelters, this will ensure that individuals in shelters exiting to permanent housing have a great chance of success.
- Assess the need for case management on a case-by-case basis. Many individuals may not need intensive services, and for those who do not, they may be moved through the shelter system to permanent housing more quickly.
- More services that are culturally and linguistically appropriate are needed to address the specific needs of various subpopulations, particularly for the Asian/Pacific Islander (API) population. Los Angeles County has the highest API population outside of Asia, and there are already existing services across the county that could be brought directly to the shelter sites. This also includes translating the VI-SPDAT into API languages.
- Building on the momentum of universal shelter standards, establish and enforce specific recuperative care quality standards, aligned with NHCHC standards or another identified evidence-based standard.
- The DV population is significant – 30% of those in HMIS have experienced DV upon entry to the shelter system. Prioritize the DV population and examine ways that service delivery might need to be reimagined for this population. Diversion as an initial focus is not appropriate for this population, so time spent on this is an inefficient use of resources.
- Replicate the development of additional “Safe Landing” full-service interim housing projects.
- Explore the utilization of host homes, apartment share, shared housing, sober living, and board and care facilities. Explore the homeless services skilled-nursing facility model.

Staffing

- While shelter providers have successfully scaled up since Measure H was implemented, it is important to ensure they have the support and resources needed to continue to grow and expand.
- Target funding to provide intake, counseling, and case management staff during the evening hours and hire problem-solving specialists.

- Assess salary rates for staff based on experience needed to work with acute populations. If funding is not available to hire more experienced staff, alternative staffing models, such as regional professionals who rotate sites should be explored.
- At a minimum, all staff, regardless of experience level, should receive training on working with a population with complex needs. This could be accomplished through developing a staffing 'boot camp' that is available to all new staff. The Learning Communities can also serve as a means for enhancing staff training. Funding set aside specifically for staff training could support this effort.
- Address shelter staff burnout, recognizing that this is a highly stressful job that requires greater focus on staff self-care.

Referral/Intake Process

- Develop a process that will allow real-time assessment of all open beds, particularly in emergency shelters. Streamline communication between interim housing and emergency shelters so that immediate and direct referral to emergency housing can be made in the event individuals show up to interim housing sites without bed availability.
- Examine strategies to increase the accuracy of initial assessments. This may include re-examining the assessment instrument. Often clients may not adequately comprehend the questions in the CES intake survey, resulting in inaccurate scoring. Provide additional training to CES and other intake staff on interfacing with clients to determine acuity levels during the intake process.
- Identify ways to reduce paperwork required at intake. The CES intake process is lengthy and can result in delays and bottlenecks. Examine data to determine wait times from initial referral to a CES intake and actual intake. Identify ways to reduce the wait time.
- Identify strategies to reduce the lag time between referral to ICMS provider and initial contact. Flexible hours for ICMS staff may enhance the ability to meet clients where they are within a short period of time. Ensure that ICMS staff come to where clients are located, and this protocol is consistently followed.
- The referral process from private hospitals to both DHS and the CES should be strengthened. Provision of CES staff on site at hospitals (potentially funded by the hospitals themselves) can make the referral process faster and more efficient.
- Proactively engage private hospitals to provide informational resources on both DHS and LAHSA-funded shelter as well as private recuperative care options. The Hospital Association of Southern California is a key partner in engaging with private hospitals.

Continuity of Care

- Develop protocols to allow the same case manager to work with clients throughout the continuum—from interim to permanent housing—to support clients for at least a 3-month period after placement in permanent housing. This will alleviate the need for permanent housing staff to devote time to developing trust with clients and increase the likelihood of successful stays in permanent housing. This could be accomplished through interdisciplinary teams, similar to what occurs in Strategy E6.
- Services to support the transition to permanent housing should include training on how to budget, how to be a successful employee, and links to supportive services once in permanent housing.

Collaboration

- Enhance collaboration with and participation by SAPC. Other departments are working very collaboratively, but service provision could be improved with more intensive involvement of SAPC staff, both at the leadership level and the shelter provider level.
- Continued collaboration among all stakeholders is needed to address the ongoing political pressure and negative press about the homelessness issue in Los Angeles.
- Build on the successful collaborative effort to develop shelter standards to move toward more consistent standards across departments in other areas, including contract requirements, performance metrics, and reporting requirements, particularly across DHS, LAHSA, and DMH. Continue to explore other areas to streamline forms and processes required by various agencies.

Data

- Utilize existing data to model the entire homelessness continuum and develop accurate targets. This will assist in determining funding needs and priorities.
- Develop more realistic outcomes for performance metrics. Expectations for movement to permanent housing may be too high, given the lack of housing availability, as well as the need for greater LOS in interim housing to ensure the successful transition.
- Explore options for better data integration that is automated, or possibly utilization of one system across agencies.
- It would be beneficial to track and report, at a minimum, referral for mental health and substance use services, and if possible, services actually received. These data could provide insight into what additional services may be needed for homeless individuals identified with these problems.

Bed Rates

- Explore ways to increase bed rates above the current rates for both interim beds and recuperative care/stabilization housing beds. The higher rates will allow for additional services, more experienced staff, and can ultimately shorten the LOS with more intensive services in a shorter period of time.

Funding Sources

- Identify ways to streamline the processes and requirements of multiple funding sources. For example, new state money allows alignment with Measure H, and this funding source can be administered with requirements that are consistent with LAHSA.
- Engage in advocacy around identifying sustainable funding sources. Engage with health plans, Medicaid, and Medicare for reimbursable services provided.

Conclusion

Measure H has had a significant positive impact on interim housing shelter services and bed availability. Cross-agency collaboration has ensured that appropriation of Measure H dollars and implementation of programs has been done through a purposeful and transparent process. This has included intensive efforts to coordinate with and support shelter providers to ensure the appropriate placement of

individuals within interim housing, as well as movement to permanent housing. Standards of care have been implemented, best practices are being shared, provider training has increased, and serious incidents have been reduced. Given the severe limitations in available permanent housing, a focus for future efforts can include improving efficiencies in the intake and referral process generally, and for hospitals specifically, as well as increased ability to identify housing availability in real time. Although certain challenges remain, the momentum of Measure H is making a difference in the lives of homeless individuals and families in Los Angeles County.

Appendices

Appendix A. Los Angeles County Strategies to Combat Homelessness

Appendix B: Key Stakeholder Interviews

Date	Interviewee	Title	Agency
7/29/2019	Max Stevens	Principal Analyst	LA County CEO
7/30/2019	Michael Castillo	Senior Analyst	LA County CEO
7/30/2019	Elizabeth Ben-Ishai	Principal Analyst	LA County CEO
8/1/2019	Ashlee Oh	Principal Analyst	LA County CEO
8/1/2019	Libby Boyce	Program Implementation Manager	DHS Housing for Health
	Juataun Mark	Director of Interim Housing	
8/1/2019	Justin Dae	Real Estate Acquisitions Manager	Brilliant Corners
8/1/2019	Vicki Nagata	Director of Access, Referrals, and Engagement	DHS Housing for Health
8/1/2019	Wade Trimmer	Executive Director of Housing and Homeless Services	National Health Foundation
8/7/2019	Raquel Zeigler	Crisis Housing Coordinator	LAHSA
	Sofia Peralta	Crisis Housing Coordinator	
8/12/2019	Andrew Hill	Interim Housing Placement Coordinator	LAHSA
8/12/2019	Whitney Lawrence	Director of Policy and Planning	DHS Housing for Health
8/12/2019	Tonja Boykin	Chief Operating Officer	Weingart Foundation
8/13/2019	Kelsey Madigan	Director of Interim Housing For Individuals	LA Family Housing
8/22/2019	Elizabeth Saldana	SVP of Operations	Illumination Foundation
	Christina Martinez	Director of Medical Care Coordination	
	Cindy Villasenor	Associate Manager of Case Management	
8/22/2019	Awade Khan-Variba	Program Manager	PATH Hollywood
	Stephen Feichter	Senior Director, Metro LA Programs	
8/23/2019	Tiffany Shirley	Director of Family Services	PATH W Washington
	Elizabeth Jimenez	Associate Director of Family Programs	

8/28/2019	Christina Barajan	Contract and Compliance Manager	First to Serve Vernon
	Michelle Bush	Director of Programs	
	Rene Ohta	Program Manager	
	Wendy Gaston	Clinical Director	
9/5/2019	Lise Ruiz	Program Manager	DMH
9/25/2019	Charmaine Dorsey	Director Of Patient And Social Support Services	DHS
9/19/2019	Veronica Turner	Clinical Social Worker Supervisor II	Harbor UCLA
10/1/2019	Jeff Proctor	Manager of System Components, Acting Associate Director of Performance Management	LAHSA
10/2/2019	Julie Pan	Senior Clinical Social Worker	LAC USC
10/22/2019	Maria Barahona	Compliance Director	Haven Hills
10/22/2019	Jorge Reyno	VP, Population Health	MLK Hospital
10/22/2019	Patima Kolomat	Shelter Program Director	Center For The Pacific Asian Family
10/23/2019	Marcia Penido	Director of Care Coordination	Huntington Memorial Hospital
	Laura Raya	Community Coordinator	
	Heather Heilmann	Manager of Health Navigation	
11/6/19	Kris Nameth	Associate Director of Programs	Los Angeles LGBT Center

Appendix C. Interview Guides

Evaluating the Effectiveness of Los Angeles County's Homelessness Strategies – Interim and Emergency Housing

Interview Guide – County Staff

Thank you for participating in this interview. The purpose of the interview is to find out more about your perspective on the County's Homelessness Strategies for Strategy B7 and E8 – Emergency and Interim Housing. The interview will last about one hour, and we will be asking your thoughts on a variety of questions, including how effective are program activities in which you are involved in meeting the overall goals of the County's strategies, program best practices, challenges, and areas for improvement.

Your responses will be kept confidential. We will not use your name in any reports. We will be taking detailed notes, as well as recording the interview. We may include quotes in our report, but these won't be attributed to any individual. The report will be a summary of themes across multiple interviews we are conducting with County staff and providers of housing and shelter services.

Do you have any questions before we begin?

[Interviewer state individual's name, agency, date, and if known, position title]

<u>General</u>

1. What is your position title?
2. What is your role within the agency for the interim/emergency shelter homelessness program(s) in LA County? How long have you been in this position?

<u>Program Services and Implementation</u>

3. Please describe the services addressing homelessness provided through your department's programming in which you are involved.
4. What are the funding sources for the services?
    a. (If H and other funding sources) Do you see differences among these funding sources in how they support services addressing homelessness? If yes, please describe. What are the challenges in having multiple funding sources? Would the program benefit from more streamlined funding? How?

   b. Are there restrictions on what services can be provided with the current funding sources? Do these restrictions impact how effectively the program is run? If yes, how?
5. What do you see as the strengths of the program as it is currently being implemented?
6. What are some of the challenges in implementing the program?
7. What are some areas for improving program functioning?
8. What are the key differences between the services provided by DHS, LAHSA, DMH and DPH-SAPC?
9. What do you see as the most difficult challenge(s) in individuals experiencing homelessness making the transition from interim/temporary shelter to permanent housing? What suggestions would you have for how your agency can support improvements to this process?

Program Data Tracking and Performance Measurement

10. Can you describe how program activities and outcomes are tracked? How are data tracked and entered? What are some of the challenges with this/these data systems? If multiple data systems – how are these systems integrated? Do DHS, LAHSA, DMH, and DPH/SAPC share data to establish, track and respond to outcomes for the system of programs addressing homelessness in LA County? Do you have suggestions about how this can best be accomplished?
11. How do you define program effectiveness? What tells you how well the program is working?
    a. Have you used data to make programmatic changes? Can you provide some examples?

Collaboration

12. Can you describe how the various agencies/departments – DHS, LAHSA, DMH, and DPH/SAPC – collaborate in the implementation of their programs and services addressing homelessness? Are there formalized structures in place that support interagency collaboration? Do you have suggestions for how collaboration could be further developed to improve efficiencies in use of funds and improve outcomes from programs funded?
13. How are strategies B7 and E8 integrated with other strategies currently being implemented? Where are there opportunities for improved integration and efficiencies?
14. Do you feel the annual budget allocation process is appropriate? Would you make any adjustments to the process? Do you feel the current allocation is fair?
15. How does your agency/department collaborate/coordinate with hospitals and the criminal justice system/jails in working with the homeless population? How can coordination be improved?

Final Question

16. Can you identify one or two things in the County that are working well and one or two things that are not working well to effectively and efficiently provide interim/shelter services for homeless individuals and families?

Evaluating the Effectiveness of Los Angeles County's Homelessness Strategies – Interim and Emergency Housing

Interview Guide – Shelter Staff

Thank you for participating in this interview. The purpose of the interview is to find out more about your perspective on the County's Homelessness Strategies for Strategy B7 and E8 – Interim and Emergency Housing. The interview will last about one hour, and we will be asking your thoughts on a variety of questions, including how effective are program activities in which you are involved in meeting the overall goals of the County's strategies, program best practices, challenges, and areas for improvement.

Your responses will be kept confidential. We will not use your name in any reports. We will be taking detailed notes, as well as recording the interview. We may include quotes in our report, but these won't be attributed to any individual. The report will be a summary of themes across multiple interviews we are conducting with County staff and providers of housing and shelter services.

Do you have any questions before we begin?

[Interviewer state individual's name, agency, date, and if known, position title]

<u>General</u>

1. What is your position title?
2. What is your role within this organization? How long have you been in this position?
3. Does your organization provide interim/bridge housing, or emergency shelter, or both?
4. Do you provide recuperative care?
5. Do you contract with DHS, LAHSA, or both? Any others?
6. How long has your organization been contracting with the County to provide interim/bridge housing?

<u>Program Services and Implementation</u>

7. Please describe the services addressing homelessness provided through your organization. What population(s) do you serve? Do you have any special focus on or special programs for specific populations? Please tell me about your agency's reasons for and approach to serving this/these specific population(s).
    a. Do you think the services you provide to address the needs of your population are sufficient? What additional services would your population benefit from?

Have you looked into starting to provide any additional services? What would be needed for you to do this?

8. Please describe your process for (1) receiving and accepting or denying referrals; and (2) your process for enrolling new clients.
    a. Do you have any recommendations for how the referral process could be improved?
9. What are the funding sources you receive?
    a. (If H and other funding sources) Do you see differences among these funding sources in how they support services addressing homelessness? If yes, please describe. What are the challenges in having multiple funding sources? Would the program benefit from more streamlined funding? How?
    b. Are there restrictions on what services can be provided with the current funding sources? Do these restrictions impact how effectively the program is run? If yes, how?
    c. If you provide recuperative care, how is that funded?
10. What is the bed rate you receive through the various funding sources?
    a. Is this funding sufficient? What would be an optimal bed rate?
11. What do you see as the strengths of your program as it is currently being implemented?
12. What are some of the challenges in implementing your program?
13. What are some areas for improving program functioning?
14. What do you see as the most difficult challenge(s) in individuals experiencing homelessness making the transition from interim/temporary shelter to permanent housing? What suggestions would you have for how your agency can support improvements to this process?

<u>Program Data Tracking and Performance Measurement</u>

15. Can you describe how program activities and outcomes are tracked? How are data tracked and entered? What are some of the challenges with this/these data systems? Do you submit data through CHAMP, HMIS, or both systems? If both, what are some suggestions for streamlining the data collection process?
16. How do you define program effectiveness? What tells you how well your program is working? How often to you review your data?
    a. Do you follow a process for implementing improvements because of regular program performance data review? Have you used data to make programmatic changes? Can you provide some examples?

<u>Collaboration</u>

17. Can you describe how your organization collaborates with DHS/LAHSA? What suggestions do you have for improving communication and collaboration with these agencies?

Final Question

18. Thinking about the Measure H strategies and activities overall, can you identify one or two things in the County that are working well and one or two things that are not working well to effectively and efficiently provide interim/shelter services for individuals and families experiencing homelessness?

Evaluating the Effectiveness of Los Angeles County's Homelessness Strategies – Interim and Emergency Housing

Interview Guide – Hospital Staff

Thank you for participating in this interview. The purpose of the interview is to find out more about your perspective on the County's Homelessness Strategies for Strategy B7 –Interim and Emergency Housing - as it relates to the release of homeless patients from institutional settings, including hospitals. The interview will last about one hour, and we will be asking your thoughts on a variety of questions, including the effectiveness of the referral and release process, best practices, challenges, and areas for improvement.

Your responses will be kept confidential. We will not use your name in any reports. We will be taking detailed notes, as well as recording the interview. We may include quotes in our report, but these won't be attributed to any individual. The report will be a summary of themes across multiple interviews we are conducting with County staff and providers of housing and shelter services.

Do you have any questions before we begin?

[Interviewer state individual's name, agency, date, and if known, position title]

<u>General</u>

1. What is your position title?
2. What is your role within this organization? How long have you been in this position?
3. What is your role in activities related to referral and release of homeless individuals from the hospital setting?

<u>Referral Process</u>

4. Please describe how you identify homeless patients receiving care in your hospital.
    a. Does this differ for ER patients who are not admitted and admitted patients?
5. Does the hospital have dedicated funding to a staff position for identifying and referring homeless patients upon release?
6. Please describe the process for referring patients who are homeless to appropriate care settings.
    a. How many providers do you work with? How have you identified these providers?
    b. Have you seen an increase in the number of private recuperative care providers since Measure H was implemented?

   c. Are you familiar with the referral process for DHS housing?
   d. Do you have contractual arrangements with recuperative care providers? With DHS? With private providers?
7. How do you determine level of need/acuity level for those being released in terms of whether they will need recuperative care housing versus regular housing?
8. What happens when you cannot find appropriate housing for individuals upon release?
   a. Can you describe any instances when patients have remained in the hospital longer than necessary due to unavailability of housing? How often does this happen?
9. Have you seen a reduction in inappropriate stay length since Measure H has been implemented in 2016?
10. Do you track where homeless individuals have been released in your electronic health records?
11. Have you seen a reduction in returns to the ER/hospital since Measure H has been implemented? Do you regularly track and report this?
12. What are the challenges in identifying appropriate housing?
13. What are the challenges with the referral process?
    a. Do you have any recommendations for how the referral process could be improved?
14. What additional resources would be helpful in assisting you in identifying and referring homeless patients to appropriate housing upon release?

Appendix D. Detailed Sample Selection Criteria for HMIS and CHAMP Data

Steps in Data Selection Process for HMIS

1. Merge the following data files, matched by PersonalID
    a. Project_Out
    b. Enrollment_Out
    c. Exit
    d. Disabilities_Out
    e. Health-and-DV_Out
2. Select sample based on parameters outlined below

Sample Selection for HMIS

1. 'ProjectType' = 1 – Emergency Shelter or 2 – Transitional Housing
2. Entry date on or after July 1, 2017
3. Exclude if only associated with a Winter Shelter (winter shelters identified by name)
4. Individual identified as a Head of Household – 'Relationship to HofH' = 1
5. Exit data valid/non-missing – 'ExitDate' has valid response and occurs prior to August 15, 2019 (date of data pull)

Final sample size = 20,574 unique individual records

Sample Selection for CHAMP

Based on a conversation with Kevin Flaherty from DHS, we de-duplicated the data file based on the following decision rules:

1. For duplicate records with identical data EXCEPT for number days homeless – select the record with the larger number days homeless.
2. For duplicate records with the same check-in date but different check-out date, select the record with the longest length of stay and assume the record with the earlier exit date is incorrect.

Sample selection criteria include:

1. Entry date on or after July 1, 2017.
2. Exit data valid/nonmissing – 'Interim_Housing_Exit_Date' has valid response

Final sample size = 3, 489 unique individual records

ATTACHMENT V

Westat

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Evaluation of Los Angeles County's Strategies to Expand and Enhance Rapid Re-Housing Services for Multiple Populations

Draft Report

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Executive Summary

A. Background

Rapid re-housing (RRH) provides time-limited rental assistance coupled with supportive services to help people experiencing homelessness access housing quickly. In Los Angeles County, RRH as funded through Strategy B3, is one of the original strategies developed by the Los Angeles County Homeless Initiative (HI). The Strategy was approved by the Board of Supervisors in February 2016 and expanded in July 2017 through Measure H, a ballot initiative in Los Angeles County to generate funding to prevent and combat homelessness. RRH consists of three core components: housing identification, rental and move-in assistance, and case management and services.

B. Evaluation Description and Methods

Westat, a national research organization, in collaboration with California-based consultant Katharine Gale, has contracted with Los Angeles County's Chief Executive Office (CEO) to evaluate the implementation and client-level outcomes of RRH under Strategy B3. The evaluation, conducted between June and November 2019, involves the analysis and collection of data from multiple methods and sources, including document review; individual interviews with administrators, RRH program managers and landlords, and housing location intermediaries; and focus groups with direct line staff and RRH participants. In addition, analyses were conducted using administrative data from the Homeless Management Information System (HMIS) maintained by the Los Angeles Homeless Services Authority (LAHSA) and the Department of Health Services' (DHS) Comprehensive Health and Management Platform (CHAMP). While these administrative data were not originally collected for research purposes and are limited in their reliability and completeness, they provide a basis for a descriptive understanding of the characteristics, length of time served, time from entry to move-in to housing, and exits to permanent housing for the 20,668 households served after Strategy B3 implementation. They also permit comparison of characteristics and outcomes of those served following Strategy B3 implementation with the 8,768 households served prior to B3 implementation. Prior RRH funding sources included Supportive Services for Veteran Families (SSVF) funding, Emergency Solutions Grants (ESG) and Continuum of Care (CoC) funding, First Five funding from the state of California, as well as funding from the LA County Department of Public Social Services (DPSS), and more limited city and county general funds.

C. Findings

Strategy B3 has led to more people being served through RRH in Los Angeles County and has provided a larger quantity of more flexible resources than were previously available to meet the needs of RRH participants. Expanded resources also led to a broader set of populations receiving RRH. Moreover, there appear to be improvements in the extent to which people move into housing, the time it takes to move in, and the rates at which people exit to permanent housing without a subsidy following move-in.

At the same time, those served following Strategy B3 implementation appear to remain enrolled slightly longer before exiting compared with those served prior. Moreover, among those with

documented move-in dates, their patterns of exit destinations show key differences. The most significant differences are that those served following Strategy B3 compared to those served prior are more likely to exit to permanent housing without a subsidy (44% v. 30%) but less likely to exit to permanent housing with a subsidy (32% v. 54%); they are also somewhat more likely to exit to an unknown (12% v. 10%) or other (2% v. less than 1%) destination. Due to inconsistencies in the administrative data, these quantitative findings may reflect real changes in RRH operations and outcomes or alternatively may be artifacts resulting from differences in the quality and completeness of data over time and across providers. Additionally, outcomes are not yet known for a substantial portion of those served following Strategy B3, who have not yet exited the program.

There is considerable variability in the way in which RRH has been implemented following Strategy B3. This variability introduces the potential for inequity in service receipt among RRH participants and poses challenges to systematic evaluation of RRH operations under Strategy B3. These findings are described in greater detail below.

Population Served. Expanded resources through Strategy B3 have provided RRH to a greater number of people and a broader set of populations. Over twice the number of participants were served in the three years following Strategy B3 implementation (July 1 2016 – June 30, 2019), compared to the 2-year time period prior (July 1, 2014 – June 30, 2016) to Strategy B3 implementation (20,668 compared to 8,768). In addition, administrative data suggest that the composition of the population served following Strategy B3 implementation is different in a number of ways from those served prior to Strategy B3 implementation. Those served following Strategy B3 compared to the earlier cohort reflect a greater proportion of transition aged youth (7% versus 3%) and females (55% versus 44%), and a smaller relative proportion of single adults (57% versus 61%) and veterans (18% versus 43%). Despite these changes, the total numbers of adults and males served is still larger than it was prior to Strategy B3, while the total number of veterans served is unchanged. The shift in populations likely also has created a shift in the service needs of the participants served, with the biggest difference being higher rates of domestic violence (22% versus 17%) and developmental disabilities (10% versus 7%) in the post-implementation cohort, and lower rates of participants with substance abuse (7% versus 9%), physical disabilities (22% versus 26%), chronic health conditions (25% versus 27%), and mental health conditions (30% versus 32%).

Outcomes. Administrative data suggest that compared to those served previously, the population served after Strategy B3 implementation show improvements in the documented rates at which households move into housing (50% compared to 41%) and the time it takes to move in (an average of 98 days compared to 109 days). At the same time, among those who move into housing, those served after Strategy B3 appear to remain enrolled longer before exiting compared with those served prior. Those served after Strategy B3, compared to those served prior, were more likely to be enrolled for more than 12 months (25% compared to 4%) and less likely to be enrolled for six months or less (44% compared to 77%). This pattern is the same for those who have no recorded move-in date.

Those served after Strategy B3 exit to stable and unstable housing destinations at different rates than those served prior to Strategy B3 implementation. Among those with a record of having moved into housing, those served after Strategy B3 are more likely than those served before Strategy B3 to exit to permanent housing without a subsidy (44% v. 30%). They are, however, less likely to exit to permanent housing with a subsidy (32% v. 54%) and more likely to exit to an unknown (12% v. 10%) or other (2% v. less than 1%) destination.

These findings need to be interpreted with caution given inconsistencies in the data; substantial proportions of those served exited the program without a documented move into housing during enrollment. Those records lacking move-in data encompass both households that never moved into housing and households that moved into housing but are missing a move-in date. It is therefore not clear whether findings represent real changes in outcomes after Strategy B3 implementation versus changes in quality and completeness of the data, or inconsistent approaches to tracking move-ins and exits across providers and over time. Further, outcomes are not yet known for 32% of those served after Strategy B3, who either remain in the program or have no recorded exit.

Resource Availability and Flexibility. Strategy B3 offers a larger quantity of more flexible resources than were previously available. It provides RRH assistance for up to 24 months in duration, with broadened income restrictions to 50 percent Area Median Income (AMI) from the 30 percent AMI required by Emergency Solutions Grant funding, and covers move-in costs not previously covered, as well as furniture assistance and landlord incentive fees. It also includes the ability to serve people experiencing homelessness in Los Angeles County by supporting them to obtain housing outside the county, where housing may be more affordable.

Guidance, Training, and Collaboration. Guidance and training from LAHSA, though initially delayed, has increased over time through a variety of mechanisms and has offered clearer expectations for RRH operations. Collaborative learning is reportedly strong within and across RRH agencies and providers through LAHSA's learning communities, although the type and degree of collaboration around service delivery appears to vary by provider and Service Planning Area (SPA).

Provider Discretion. Despite LAHSA's guidance and training, RRH implementation varies widely and appears to be largely based on provider discretion, as well as factors such as when in the budget cycle a participant enters the program. Providers have discretion in the nature, duration, and amount of both financial assistance and case management provided, as well as how they approach housing location. In addition, households are often referred to RRH through the coordinated entry system (CES), but the prioritization and matching of participants is left to the discretion of the providers, with some consideration of the vulnerability assessment score. As a result, there is a lack of transparency regarding how providers determine who to prioritize for RRH enrollment. Similarly, providers appear to vary in whether they expect households to satisfy requirements beyond LAHSA's eligibility criteria, such as requirements to have income or employment, before being enrolled.

D. Challenges in Implementing RRH

Providers face a variety of challenges in implementing RRH. These are listed below, along with some of the strategies that have been tried to address them. In some cases, these strategies have resulted in new challenges, which are also described.

Lack of Standardized Policies Around RRH Prioritization and Implementation. As described above, the implementation of RRH is left to the discretion of the providers and the resulting variability is exacerbated by a lack of standardized policies around prioritization for RRH within CES. LAHSA has considered plans to standardize the CES process across all SPAs, prioritizing and matching to RRH the highest acuity participants (who are not matched to permanent supportive housing [PSH] or another deeper resource). These plans, however, were evolving as this evaluation

was underway, amid provider concerns that prioritizing high acuity participants would exclude those of lower acuity who could benefit from RRH and do not now qualify for other resources, prioritize those who have a lower likelihood of retaining the housing, and make it difficult for providers to serve those they believe could benefit from RRH. Training and technical assistance offered by LAHSA that could ultimately lead to greater consistency in RRH practice requires a significant investment in time and resources by both providers and the system, exacerbated by staff turnover requiring additional trainings.

The current lack of prioritization standards has a particular impact on family providers, who believe they are expected to serve all families. This perceived expectation reportedly results in over-enrollment and/or high caseloads. In addition, the family system is expected to provide crisis housing for all families that are not immediately rehoused. Families who participated in our focus groups expressed strong concerns about the quality and safety of the available crisis housing, and confusion about whether staying in crisis housing was a prerequisite to receive RRH assistance.

Difficulty Securing Sustainable Housing and Engaging Landlords. It is reportedly difficult to find affordable housing in the tight and costly Los Angeles County market and engage landlords in renting to RRH participants. Strategy B3's flexibility in allowing providers to house people experiencing homelessness in Los Angeles County in other more affordable geographic areas outside of the county was noted as helpful, particularly by providers that border other counties. Other strategies perceived by providers as improving landlord engagement and helping to find and keep sustainable housing include one-time incentives for landlords, an increased focus on shared housing as a strategy, and specialized housing location services. While useful, these strategies also bring new challenges that require new solutions. Use of one-time incentives has helped secure units but has led to competition among housing programs for housing slots as well as reportedly attracting some landlords who engage in illegal or unethical practices, such as charging large fees. Shared housing requires participants to navigate roommate relationships, often requires additional case management support, and is not feasible for all participants. Challenges to specialized housing location and retention efforts thus far include difficulties holding units for shared housing and identifying landlords willing to participate in RRH programs. The Shallow Subsidy program, recently implemented, is perceived as potentially helpful in sustaining housing, but has generated early concerns that the program has restrictive eligibility and may provide insufficient support, although there is not yet sufficient data to evaluate this concern.

Staff Turnover. There is reportedly a high rate of staff turnover, due to the challenging nature of the work itself and high availability of jobs in the field. Challenges of the work that may contribute to turnover include frustrations brought on by difficulties inherent in the position and high caseloads, as well as staff concerns that they are unable to provide the assistance needed to successfully stabilize participants in housing, particularly those with higher needs.

E. Recommendations

The recommendations below are provided to address these challenges.

- ✓ **Improve Program and Provider Consistency.** Enhanced provider consistency in RRH delivery would permit a stronger evaluation of program implementation and outcomes and might lead to improved client outcomes, transparency, and equity of access. Although RRH is intended to be implemented on a case-by-case basis, the

quality of assistance should not depend on where and when participants access services. Continued training and guidance, tied closely to the program requirements and expectations, may help to improve consistency within and across provider organizations. In addition, system administrators' efforts to standardize the way in which CES operates across Service Planning Areas (SPAs) and to systematize the prioritization and matching process, should help provide greater consistency in who receives RRH. Using data to monitor implementation of these procedures and assess whether differences in outcomes relate to differences in vulnerability scores should help administrators of RRH programs to guide and communicate about the process. Moreover, by involving persons from all levels and perspectives in RRH (program managers, case managers, participants, landlords) in planning and decision-making around RRH/Strategy B3, administrators can facilitate buy-in as well as avert possible additional challenges in the decisions that are made.

- ✓ **Enhance Landlord Cultivation.** Navigating the private housing market was described by many as a central but difficult component of the RRH program model. As efforts to engage landlords proceed, it will be worth gathering targeted information on what has worked to date and what barriers have been encountered by providers and housing location and retention specialists. Efforts are needed to standardize landlord incentives so that all programs have similar tools and those receiving RRH through Strategy B3 are not at a disadvantage relative to those with other subsidies. Putting in place practices that mitigate perceived risks among landlords may also be helpful. These may include further increasing available incentives, offering risk mitigation funds, and developing and implementing best practices for RRH providers around communicating with landlords from the outset when RRH participants move into housing through the end of RRH assistance.

- ✓ **Address Staff Turnover.** Strategies to retain staff should be a priority given the reportedly high turnover. It may be helpful to increase salaries as well as ensure that caseload mixes afford staff the capacity to adequately support their participants. Where possible, it may also be helpful to give staff alternative resources to offer RRH candidates who are lower priority, including problem-solving (diversion) resources.

- ✓ **Improve and Clarify the Relationship between Crisis Housing for Families and RRH.** Families in RRH that we interviewed believed that they were required to stay in crisis housing while working on finding housing through the RRH program. While some crisis housing was provided in motels, some of it was through shelters or other forms of temporary congregate housing. Families had significant concerns about these places; they found them uncomfortable, overcrowded, unsafe, and seemingly arbitrarily regulated by the agencies providing them. The relationship between the requirements of these programs and the RRH program was not clear and created confusion for families. Crisis housing is outside the scope of this evaluation; however, efforts appear warranted to clarify whether families must stay in crisis housing to receive RRH assistance.

- ✓ **Monitor and Improve Data Quality and Track and Report Outcomes Including by Time in Program and Acuity.** Available administrative data have a number of inconsistencies and quality concerns that limit interpretability of findings for this report and the potential usefulness of data to providers and the system moving forward. Our

inability to reconcile inconsistent findings and to distinguish missing data from a move-in not occurring highlights the need to place greater attention on enhancing the completeness and quality of the data to guide program decisions. Relatedly, concerns were raised by providers that RRH is being used more for people of higher acuity, who may not be successful. We did not see evidence to support the perceived increases in acuity, although this was another area where data were limited. Tracking the impact of the programs for clients served and being able to distinguish trends and differences in population outcomes from anecdotal experience is critical, especially if RRH will be offered to those with higher needs.

List of Acronyms

AHAR	Annual Homeless Assessment Report
AJCCs	America's Job Centers of California
AMI	Area Median Income
CBEST	Countrywide Benefits Entitlement Services Team
CEO	Chief Executive Office
CES	Coordinated Entry System
CHAMP	Comprehensive Health and Management Platform
CoC	Continuum of Care
DCFS	Department of Children and Family Services
DHS	Department of Health Services
DPSS	Department of Public Social Services
DV/IPV	Domestic Violence/Intimate Partner Violence
ESG	Emergency Solutions Grant
FHSP	Flexible Housing Subsidy Pool
FSCs	Family Solutions Centers
GPD TIP	Grant and Per Diem Program Transition in Place
HACLA	Housing Authority of the City of Los Angeles
HI	Homeless Initiative
HJC	Housing and Jobs Collaborative
HMIS	Homeless Management Information System
HOH	Head of Household
HPI	Homeless Prevention Initiative
HPRP	Homeless Prevention and Rapid Re-Housing Program
LACDA	Los Angeles Community Development Authority
LAHSA	Los Angeles Homeless Services Authority
PATH	People Assisting the Homeless
PH	Permanent Housing
PSH	Permanent Supportive Housing
RFP	Request For Proposals
RRH	Rapid Re-Housing
SNAP	Supplemental Nutrition Assistance Program
SPA	Service Planning Area
SRS	Scope of Required Services
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSVF	Supportive Services for Veteran Families
TANF	Temporary Assistance for Needy Families
TAY	Transition Age Youth
VA	Veterans Administration
VASH	Veterans Affairs Supportive Housing
VI-SPDAT	Vulnerability Index – Service Prioritization Decision Assistance Tool
WIC	Supplemental Nutrition Program for Women, Infants, and Children

Section I. Introduction

A. Background

Rapid re-housing (RRH) provides time-limited rental subsidies to people experiencing homelessness, along with supportive services, with the goal of helping them to access housing quickly. In Los Angeles County, RRH as funded through Strategy B3, is one of the original strategies approved by the Los Angeles County Homeless Initiative (HI) in February 2016 (Los Angeles Chief Executive Office, Los Angeles County Homeless Initiative, 2016). The primary goal of Strategy B3 is to expand the availability of RRH for multiple populations. Initially funded through a one-time $26 million investment of state and county funds,[1] Strategy B3 received an infusion of additional ongoing funds through the passage in July 2017 of the county's ballot initiative to prevent and combat homelessness, Measure H, with increasing investment over the past 3 fiscal years that has led to continued expansion in the number of RRH programs operating during this time period (Los Angeles County Homeless Initiative, (2019a).

This report provides the findings from a mixed-methods evaluation of the implementation and client-level outcomes of RRH under the strategy. The evaluation, conducted by Westat, a national research organization, in partnership with California-based consultant Katharine Gale, was funded by Los Angeles County's Chief Executive Office (CEO) to shed light on the practices and procedures under the strategy and to inform policy decisions around the future use of Measure H revenue.

This report begins with an overview of the background and evaluation methodology in Section I, followed by the key findings in Section II related to the operation of the initiative, including funding and growth, training and guidance, and collaboration around implementation, and the nature of financial assistance and supports provided through RRH. In Section III, the report then describes what is known thus far about how participants are identified and enrolled and the characteristics and outcomes of participants served, followed by a set of conclusions and recommendations in Section IV.

B. Evaluation Purpose and Methods

This evaluation aims to answer the following overarching question:

> *How has Strategy B3 affected the operation and outcomes of rapid re-housing in Los Angeles County?*

Table 1 outlines specific questions encompassed within this question, mapped onto the methods of data collection and data sources.

[1] $10 million in funding for single adults had been approved by the Board of Supervisors on October 13, 2015 prior to the one-time allocation of an additional $26 million under the strategy approved by the HI in February of 2019. These included $8 million in one-time Homeless Preventive Initiative (HPI) funds was approved in February of 2019 ($5 million of which were allocated to serve families and $2 million of which were earmarked for transition age youth [TAY]). Additional funds came from $11 million in one-time SB 678 funding and $7 million in one-time AB 109 funding.

Table 1. Specific evaluation questions and methods to address them

Methods	Analysis of extant records		Interviews		Focus groups	
Sources	Documents /quarterly data	Admin data	Agency administrators	Program directors	Front line staff	RRH participants
How has Strategy B3 affected the operation of Rapid Re-Housing in Los Angeles County?						
Have there been changes in:						
Nature of funding sources (variations in requirements and restrictions by type)	✓		✓	✓		
Training and guidance provided around RRH implementation	✓		✓	✓	✓	
Nature of financial assistance (structure, timeline, amount)	✓		✓	✓	✓	✓
Services and supports received (Amount and nature of case management)	✓		✓	✓	✓	✓
Housing location and navigation	✓		✓	✓	✓	✓
How participants are identified and enrolled, and the characteristics of the populations served through rapid re-housing?	✓	✓	✓	✓	✓	✓
What are the key challenges that providers and administrators face in implementing RRH?			✓	✓	✓	
What are the client-level outcomes of RRH, including length of stay in rapid re-housing, and exits to non-subsidized and other permanent housing Do these differ from those of RRH prior to Strategy B3 implementation?	✓	✓				
How are outcomes influenced by provider approaches to RRH implementation, and individual differences within and across populations?			✓	✓	✓	✓
What are the sources of variation in these findings?						
How do the operations, implementation challenges, and outcomes of RRH vary by provider, service planning area (SPA), or population served?	✓	✓	✓	✓	✓	✓

Our evaluation methods are summarized in Exhibit 1 and described further in Appendix A. We reviewed documents to understand how Strategy B3 evolved over the implementation time period and to inform the development of the data collection protocols and analytic plan. We collected data

on the status, operation, and client service and housing experiences through multiple methods, including extracting extant administrative data, key informant interviews with government agency administrators and directors of service and housing agencies administering RRH, and focus groups with frontline staff and RRH participants in several of these agencies. A sample of 13 housing providers was selected to maximize representation of providers serving all populations (families, single adults, and youth) across all SPAs, with 13 director interviews, and four staff and five participant focus groups with a total of 53 participants conducted in the three largest SPAs (2, 4, and 6). Qualitative data from the documents, interviews, and focus groups were coded through iterative analysis, aided by an analysis software program, NVivo, to identify key themes. Quantitative administrative data, extracted from the Homeless Management Information System (HMIS) maintained by the Los Angeles Homeless Services Authority (LAHSA) and the Department of Health Service's (DHS) Comprehensive Health and Management Platform (CHAMP), were used to describe the population with respect to (1) sociodemographics and needs; (2) enrollment and length of time served; and (3) client-level outcomes, including time to obtaining housing and exits to permanent housing. Administrative data also permitted comparison of characteristics and outcomes of the 20,668 households served following Strategy B3 implementation with the 8,768 households served prior to Strategy B3 implementation. Prior RRH funding sources included Supportive Services for Veteran Families (SSVF) funding, Emergency Solutions Grants (ESG) and Continuum of Care (CoC) funding, First Five[2] funding from the state of California, as well as funding from the LA County Department of Public Social Services (DPSS), and more limited city and county general funds.

Exhibit 1. Summary of key evaluation methods

Document Review • Review of strategic planning documents, budgets, aggregate data, and other agency records
Interviews and Focus Groups • Individual interviews with key administrators (N = 18) and housing program managers from all SPAs (N = 13) • Four focus groups with 5-12 direct line staff (Total of 29 participants) in the three largest SPAs (2, 4, and 6) • Five focus groups with 2-8 RRH participants (Total of 24 participants) in SPAs 2, 4, and 6 • Four interviews with key informants around housing navigation/location (two landlords, People Assisting the Homeless [PATH] LeaseUp Program, and Brilliant Corners)
Administrative Data • Sample: All households served through RRH since Strategy B3 implementation (July 1, 2016) and 2 years prior (July 1, 2014 – June 30, 2016) • Data sources: HMIS and CHAMP

[2] First Five California is an initiative to bring services to young children (ages 0-5) and their families in the state of California. The initiative is funded through revenue generated by a state sales tax on cigarettes.

Section II. Understanding the Operation of Rapid Re-Housing Under Strategy B3

A. History and Funding

RRH is a short- to medium-term rental assistance and supportive services intervention designed to help people experiencing homelessness move quickly from homelessness into permanent housing (United States Interagency Council on Homelessness [USICH], 2016). The primary goal of RRH is to help individuals and families quickly exit homelessness and return to permanent housing with a reasonably high expectation of being able to maintain it after the program is over. RRH consists of three core components: (1) housing identification, (2) rental and move-in assistance, and (3) case management and services. This evaluation examines how the various components of RRH have been implemented under Strategy B3.

Figure 1 illustrates the timeline of Strategy B3, which has been implemented in stages. Los Angeles County's DHS's Housing and Jobs Collaborative (HJC) was the first Strategy B3-funded RRH program, which funded RRH for single adults in January of 2016. LAHSA subsequently began administering RRH for families and TAY later that year. In July of 2017, LAHSA's administration of RRH funds for single adults began (Los Angeles County Homeless Initiative, 2019b). Figure 1 depicts a timeline of the strategy. In the early stages, the agencies leading the strategy (DHS and LAHSA) focused on partnering with the cities to expand the availability of RRH, using both city and county funds. With increased availability of funding through Measure H, the focus has shifted to expanding RRH for multiple populations and to new efforts to standardizing the quality of implementation as well as introducing new RRH pilots and initiatives tailored to the needs of RRH participants that have emerged over the course of the strategy implementation (Los Angeles County Homeless Initiative, 2019b). The introduction of Strategy B3 brought $26 million in new one-time funding and additional annual revenue through Measure H, which has been awarded in increasing allotments thus far (Los Angeles County Homeless Initiative, 2019a): $57 million (FY 2017-2018), $73 million (FY 2018-2019), and $86 million (FY 2019-2020).

Figure 1. Timeline of implementation of strategy B3

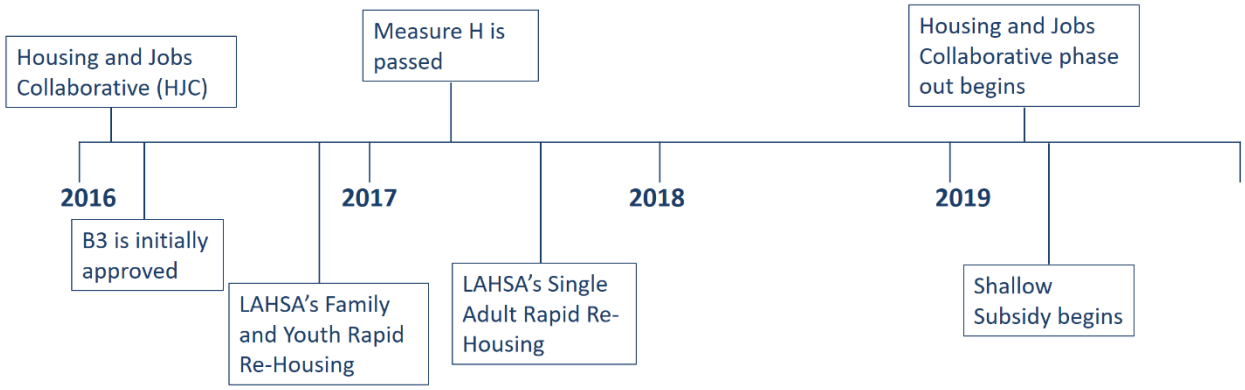
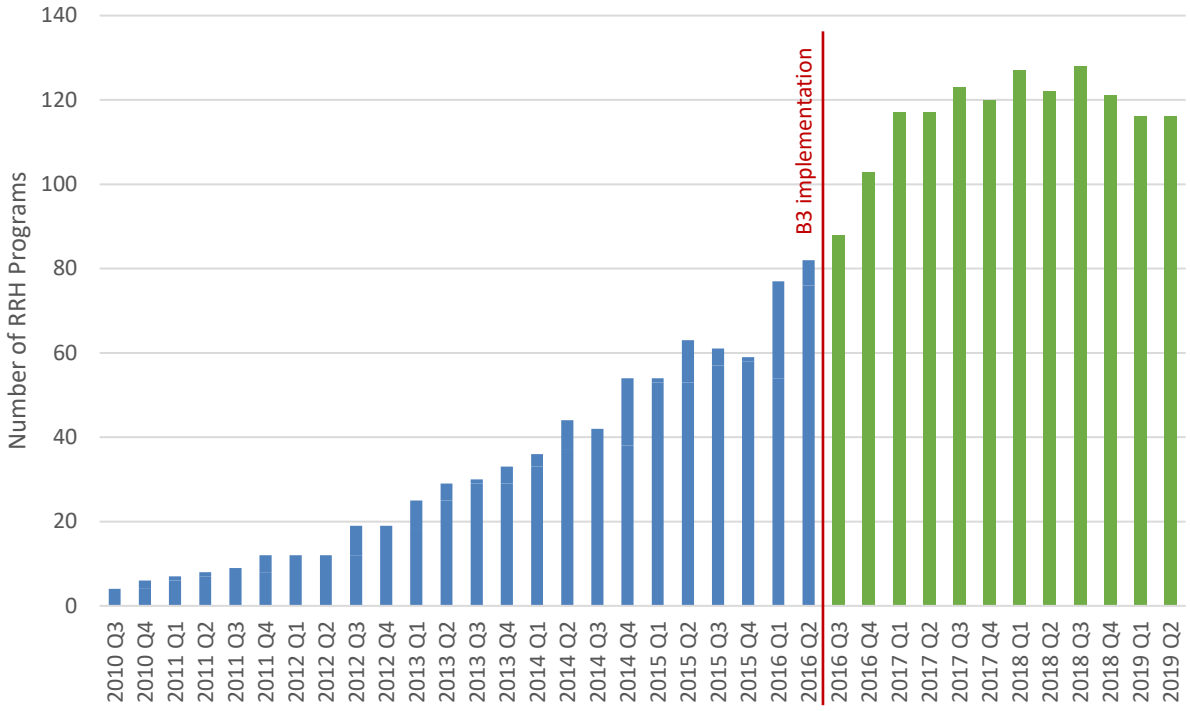


Figure 2 illustrates this growth, depicting the number of RRH programs[3] serving participants in the region between 2010 and 2018, as documented in HMIS.

Figure 2. Rapid rehousing programs in operation 2010-2019



Following implementation of Strategy B3 from July 1, 2016 until July 1, 2019, analysis of the HMIS/CHAMP data indicate that 20,668 households were served in RRH during the 3 years of implementation, as compared with 8,768 served in the 2 years prior to Strategy B3 implementation.

Below we describe our findings regarding the operation of RRH and client outcomes under Strategy B3, including

1. The availability and sufficiency of funding;
2. Training, guidance, and support provided around implementation;
3. Collaboration around the strategy occurring within and between housing providers and other agencies;
4. What constitutes RRH: financial assistance, case management, housing identification and navigation support;

[3] RRH programs depicted are all projects of type 13 documented in HMIS during this timeframe. It is possible for a single agency to operate multiple projects.

5. How participants are identified and enrolled in RRH programs, and the characteristics of those served; and

6. Client-level outcomes, including length of stay in RRH, and exits to permanent housing.

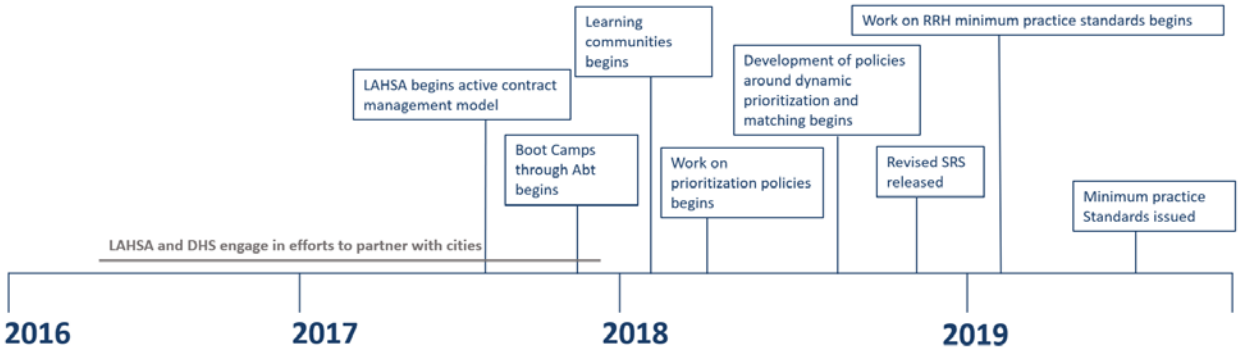
B. The Availability and Sufficiency of Funding

Strategy B3 offers more resources and more flexible resources than were previously available, and therefore, can serve greater numbers of people. The overwhelming perception of program managers interviewed was that there is more assistance on a larger scale than was available prior to the strategy. In general, Strategy B3 was perceived as relatively more flexible, providing assistance for a longer duration, and having broader eligibility compared with other current and prior funding sources, including Department of Public Social Services (DPSS), Continuum of Care (CoC), Emergency Solutions Grant (ESG), and Homeless Prevention and Rapid Re-Housing Program (HPRP) funding. Strategy B3 allows coverage of costs not previously covered , such as move-in costs, furniture assistance and landlord incentive fees. RRH under Strategy B3 also includes the ability to house people experiencing homelessness in LA County outside the county, where housing may be more affordable. In addition, its income restrictions are more generous than ESG funds; ESG funds restrict recertification to households with 30% of the area median income (AMI) whereas Strategy B3 has broadened income restrictions to 50% AMI, thus allowing more people to be served within the program, and for people to stay in the program longer despite income changes.

C. Training, Guidance, and Collaboration

Guidance and training around implementation have evolved over time. Providers noted that initially limited guidance was offered around implementing RRH under Strategy B3. For example, new guidelines were issued for assistance duration and the appropriate target population as the strategy was already being rolled out. As illustrated in Figure 3, over time, guidance and training has improved. LAHSA has added trainings and provided more formal guidance around standards and best practices to standardize implementation. LAHSA has updated the most recent Scope of Required Services (SRS) to be more specific than earlier iterations, including the definition of RRH, the nature of case management and progressive engagement, the role of problem solving/diversion, and the processes for assessing and identifying participants and determining their eligibility for the program. Minimum practice standards are currently under development, but have not yet been rolled out. LAHSA's current RRH coordinator also provides one-on-one technical assistance to providers on an as-needed basis. While this help was lauded by many providers, it came late in their implementation of the program.

Figure 3. Training and guidance around strategy B3 implementation



Formal trainings from LAHSA that are currently in place include a 2-day boot camp training for new frontline staff and program managers that provides introductory information on how to apply RRH best practices. LAHSA's "learning communities," begun in 2018, allow providers to exchange information and resources on a range of topics (e.g., information on available local resources to help participants, understanding leases and preventing evictions, and progressive engagement). Overall, many interviewed noted that expectations are clearer, more training support is provided, and more consistency in guidance is now available than when the expansion was launched, but there is still a very broad range of implementation and understanding of the expectations, which we discuss further below.

One challenge to the training and technical assistance is the resources and time that need to be devoted to it, by providers as well as the system at large. In particular, turnover in staff results in an ongoing, fairly significant investment of time and resources to continue to train new staff. Six months was the estimate to get new staff trained sufficiently and comfortable doing the job. In addition, staff must travel to attend the boot camp trainings and the learning communities, which can be a significant investment in travel time for some providers given the wide expanse of the county.

Collaborative learning around RRH implementation is occurring across RRH providers, while the type and degree of collaboration by providers around service delivery varies by provider and SPA. LAHSA's learning communities provide vehicles for collaborative learning, as providers across SPAs come together to share resources and receive shared guidance around implementation. The SPA-level organization of the Coordinated Entry System (CES) means that collaboration around client identification and enrollment is organized within SPAs and by population. Providers reported collaborating with a variety of other service providers within their SPA in order to link participants to needed services beyond rapid rehousing assistance (e.g., child care, employment assistance). Providers that rely more heavily on other service providers for resources such as employment services and mental health services report collaborating more than providers that can refer to in-house programs.

Within providers, there is staff-level collaboration between case managers and other staff, including housing navigators. In some cases, participants noted a need for better communication between case managers and other staff within and across organizations, including better communication with housing navigators who liaison with landlords and/or more involvement by case managers in

monitoring housing situations and advocating for them with the house managers in family crisis housing.

D. What Constitutes RRH: Financial Assistance, Case Management, Housing Identification, and Navigation Support

Strategy B3 provides more financial assistance for a longer period of time with greater flexibility. As noted earlier, financial assistance under Strategy B3 can be provided for a longer duration, with fewer eligibility restrictions, and with more flexible coverage of costs than other prior and current funding sources. For example, it covers financial assistance for up to 24 months, compared to earlier programs with 4 and 18 month caps.

Different Provider Approaches to RRH Rental Assistance

- One size fits all as a starting point
- Step-down approaches (e.g., decrease each month by 10% or each quarter by 25%; or 100% rental assistance for 4-6 months followed by monthly or quarterly reductions)
- Using a tool that considers income, rent, and assessment scores to determine monthly payments
- Case by case, based typically on case manager determination in consultation with participant

Program managers and frontline staff noted appreciation of the ability to tailor the financial assistance better to individual needs. In addition, having fewer restrictions in eligibility than funding sources such as ESG and DPSS, and having resources plus the subsidy to cover furniture assistance, transportation, application fees, utility bills, and other one-time needs related to move-in is perceived to be helpful by all (program managers, frontline staff, and participants).

Despite the increase in duration of the financial assistance, some providers and RRH participants are concerned that it can still be insufficient in some cases. Some providers and recipients perceive that the longer term assistance still may not meet the needs of all participants. For example, some households currently served in RRH have received more than 2 years of rental assistance and are not yet able to pay full rent. Others may stabilize and become independent and able to pay the rent, but have a sudden change in circumstances close to the end of their financial assistance which requires an increase in financial assistance and an extension of the assistance. Some participants expressed that even when they were working, their income was insufficient to cover their rent. Additionally, program managers and frontline staff worry that the financial assistance may not be enough to begin with given the housing market, will be insufficient to allow participants to stabilize in housing, or will leave participants with enough income to stay in housing but in a state of food insecurity. Some families echoed that the cost of rent left them with insufficient resources to cover their children's basic needs, like food or clothing. Other participants indicated that the funding at their particular program does not cover all costs, such as rental application fees and transportation subsidies, which can lead to missed opportunities to secure housing.

Some approaches to addressing these issues were described by program managers and administrators. An extension beyond 24 months is available upon request through LAHSA for those who need it. Providers also noted that some participants have qualified for and transitioned to a higher level of service, such as permanent supportive housing under Strategy D7. Finally, LAHSA

has introduced a new Shallow Subsidy program to provide a smaller amount of extended assistance, which is described further below.

There is not yet a systematic approach to determining the nature of financial assistance. The nature of the RRH financial assistance (duration, amount, and what is encompassed) provided to each client is determined by the provider organization, but is also influenced by the time of year the assistance is provided. Most providers report that the assistance is determined on a case-by-case basis, per LAHSA's SRS. However, assistance provided also appears to vary considerably by provider. The method for determining the rental subsidy amount is not always clear or consistent with participants' needs, according to both staff and participants. In addition, participants varied in how well they understood what to expect in duration and amount of assistance, some understanding the program to be very short, others believing it lasts a year or more with an ability to extend, and some understanding it as very flexible and undetermined.

In addition, the availability of funding in a provider's budget, especially at the end of the year, influences the amount and duration of financial assistance offered. As the fiscal year nears its end, some program managers reported that RRH provider organizations often have less funding available and only enroll people for short-term assistance because providers lack confidence they will have the funding to carry over or because they need to meet enrollment metrics. This reportedly results in less assistance than they may have provided the same client at an earlier time in the budget cycle. Similarly, some program managers and staff noted the difficulty in determining how much financial assistance is needed and to predict how much will be needed in the future by a particular client. This has reportedly been challenging from a budgetary and planning perspective, and several interviewees emphasized a need for stronger coordination between the housing providers' services and finance staff.

Similar to financial assistance, the nature of case management (amount, supports, caseloads) varies by provider as well as by population served. Program managers were consistent in their reports of what the minimum amount of case management should be and both participants and program managers and staff across our interviews and focus groups shared similar descriptions of the services to which case managers connect participants. However, beyond these two dimensions, case management varied considerably across provider and population served.

The size of caseloads varied by both provider and population, with the lowest caseloads (at approximately 20:1) for youth and highest for families, which were generally reported as being around 40:1 but could be as high as 60:1.

RRH provider organizations varied in the duration of case management they provided and whether and for how long it continued after rental assistance ended. Some reported it ended a set number of months after move-in and others reported it could continue for a longer period of time, even after the financial assistance ends.

Case Management

Minimum of one meeting per month (consistent with the SRS)

Connection with other services (Countywide Benefits Entitlement Services Team Program, child care, mental health services, and, in some cases, employment services).

Vary by provider and population:

- **Caseload size**
- **Amount and duration of case management provided**
- **Specific types of hands-on services**
- **Home visiting**

Finally, program managers, frontline staff, and participants were variable in their reporting of the extent to which case managers provided other services. Home visits were rare, although a few program managers did report providing monthly case management through home visits to some of their participants. In addition, some providers and their participants described case managers working on budgeting, credit and financial planning, and housing plans, as well as providing orientation to the participant's new neighborhood, including information about where potentially helpful local services could be found. Case management support appeared higher for youth than for other populations, with more of a focus on increasing income through employment and vocational assistance. Although differences varied by provider, providers' descriptions of services suggested more of a focus on connecting families to services, with for example linkage to Countywide Benefits Entitlement Services Team (CBEST) and child care services noted by a number of family providers.

Participants described varying experiences of the quality of case management received and outstanding unmet needs. Some participants in our focus groups reported having had a lot of case management support with the process, but others indicated their case manager was unavailable or doesn't help or listen, or "is new and doesn't know anything." In some cases, participants currently had a responsive case manager but reported less positive experiences with prior RRH case managers.

Areas with which participants noted they would like additional assistance include finding employment or vocational training assistance and child care, services not consistently accessed through housing providers. In particular, some youth participants in the focus groups stated that they were required to have a job to be enrolled in RRH, but that they had to find the job independently and would have found assistance helpful. There was some perception among providers that youth and families may need longer durations of assistance and more case management than single adults.

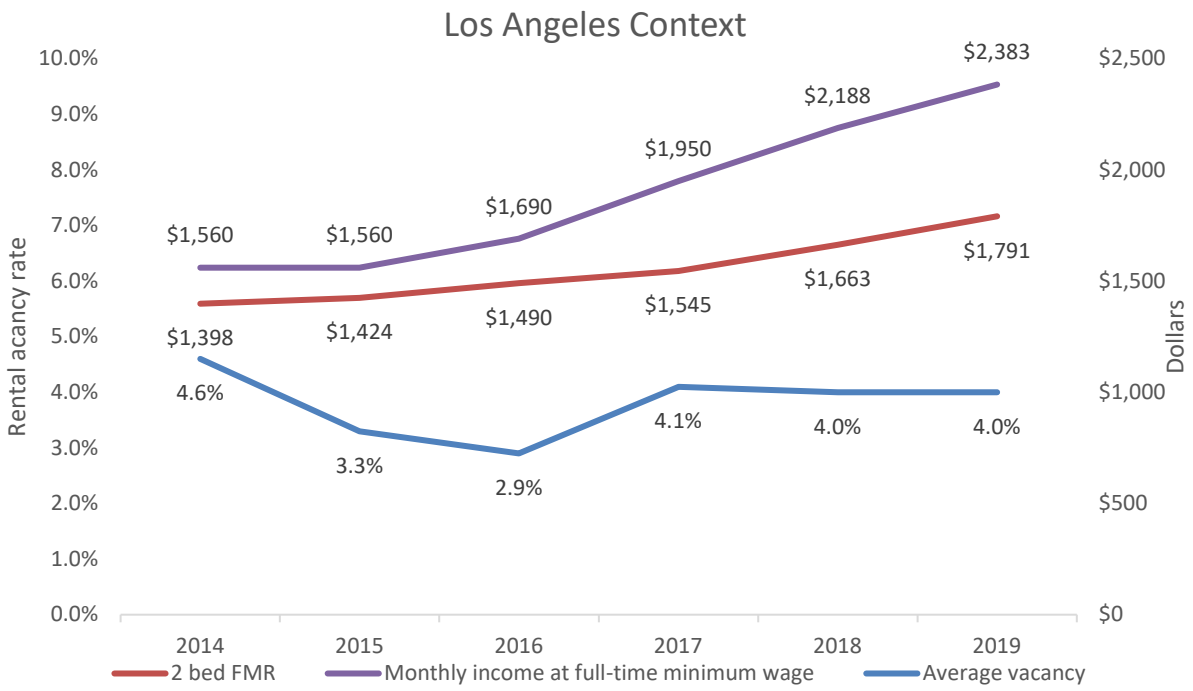
Turnover among case managers and direct service staff is high and affects the operation of RRH in a number of ways. A number of case managers and supervisors interviewed had been in their role for less than a year. Among frontline staff focus group participants, the majority (65%) had been in their positions for 2 years or less. Factors believed to contribute to high turnover among frontline staff are the high availability of jobs in the field coupled with some frustrations brought on by difficulties with the position and high caseloads. Difficulties included serving high acuity participants who staff perceive to need more support than they can offer, the inability to provide financial assistance to the numbers in need or when participants do not stabilize in housing, the inability to provide the needed level of case management support, changing implementation guidelines, and agencies not adhering to staff recommendations regarding participants' level of need for financial assistance.

Providers and participants report difficulty finding housing with the limited availability of affordable units. As a result of the tight housing market and high housing costs in Los Angeles County, staff report that it is getting harder for people to find housing and the time to find housing is growing. Program managers and staff reported that time to finding housing depends on a variety of factors, including the client's housing barriers (such as eviction and credit history), as well as whether the participant has income and is willing and able to share housing, which can expedite the housing location process. Program managers and staff also indicated that it is often necessary to work with participants to adjust their expectations around the type and location of housing they can afford after RRH assistance expires; in some cases, participants may find it necessary to move to a less central location or one further from their preferred area of residence to be able to find

affordable housing. Participants reported housing search times that varied from less than a month to a full year.

To provide context, Figure 4 below displays the vacancy rates, and the cost of housing relative to minimum wage earnings in Los Angeles County. The data show that over the past 5 years, overall vacancy rates (not just those within the affordable housing range) hit a low of 2.9 percent in 2016, but have increased to about 4 percent in the last 3 years. Both income and housing costs have increased, though the ratio of the minimum wage to the cost of housing has increased.

Figure 4. Vacancy rates, fair market rent, and minimum wage monthly income (2014-2019)



Analysis of administrative data on participants served through the RRH program after Strategy B3 implementation (July 1, 2016 - July 1, 2019) indicate that the average time from enrollment in RRH to move-in was 109 days (but this measure ranged widely, from less than a week to more than a year). This is longer than the average time to move-in following implementation of Strategy B3, which was 98 days (a small but statistically significant difference), although it is not clear what factors may be contributing to this difference. It is also important to acknowledge that variations in this time frame could be driven by variations in provider practices around the timing of enrollment relative to housing location as discussed further below.

Staff and client roles in housing location vary across provider and population served. There are two overarching approaches among providers supporting participants' housing location efforts: Having separate staff to do the housing location (some with specialized staff devoted specifically to identifying units and building landlord relationships) and having case managers assume the housing location role and assist participants with the housing search. It is unclear how these different models impact client outcomes.

According to both staff and participants interviewed, expectations vary both within and across providers around the role of the participant in the housing search process, as does the corresponding level of support case managers or housing navigators provide. Some participants find the housing themselves and bring it to the provider when they are ready to sign the lease. Others are given light support, such as a list of housing locations from the provider. In many cases, participants have help from a housing navigator or case manager, who may identify potential housing opportunities and accompany them to view units. Across populations, youth appear to need and receive more housing location support than other populations, including help screening possible housing and meeting with and talking to landlords. Youth providers sometimes have master lease housing and offer youth placements in that housing, or alternatively identify housing options in the community to which youth are referred. Overall, participants interviewed from all three populations perceived the housing search as difficult, and help with housing navigation to be useful.

RRH requires working with private landlords. Engaging landlords and securing and keeping housing in a tight rental market is one of the biggest challenges reported by program managers, frontline staff, and participants. Landlord reluctance to accept RRH participants as tenants is, in part, due to the limited duration of the rental assistance, reluctance to accept third-party checks, and the competitive housing market. Landlords also note a perceived risk around accepting tenants with housing barriers; similarly, participants indicate that the stigma of homelessness makes it difficult for them to find a landlord willing to rent to them.

Fostering good relationships with private landlords, therefore, has become an important activity for providers administering RRH. Through Strategy B3, in addition to the rental assistance, providers have resources to offer landlords incentives such as a one-time "signing" fee or providing 1 month's rent to hold a unit. However, the greater availability of funding for RRH assistance, as well as the new incentives, have brought new challenges. One provider indicated "we've created a bit of a monster," as some landlords expect one-time incentives on an ongoing basis. Different housing programs also offer competing incentives, and landlords are aware of the relative benefits that come with tenants with different sources of housing support. For example, one interviewee noted that rental subsidies through the Flexible Housing Subsidy Pool (FHSP) come with longer holding fees than other types of subsidies. Growth in available rental assistance and incentives create several unintended consequences such as competition for housing slots within and across providers and attraction of some landlords who engage in illegal or unethical practices, such as charging large fees, refusing to repair units, and finding ways to move a client out once the subsidy expires in order to get a new move-in.

Two landlords were interviewed about their perspectives on housing tenants with RRH assistance. Both work with PATH's LeaseUp program (described below) and primarily rent to single adults who are referred through housing agencies. The landlords stressed how they value the role that case managers play, and that knowing there is case manager support provided is a more important consideration in renting to a tenant than financial incentives, although these are also considered helpful. Both landlords communicate frequently with tenants' case managers and perceive this communication as essential to addressing tenant issues when they arise. At times, the landlords apprise the case managers when tenants need support. One of the landlords who primarily provides shared housing arrangements reported initiating frequent communication with case managers and taking on more of a case management role over time. This reportedly included assessing tenants' employment and financial plans at the time of application, matching them to compatible roommates, providing job referrals once they are housed, and instituting housing arrangements intended to

mitigate disputes between tenants. The landlord became engaged in these activities after experiencing tenant issues early in the program, including receiving threats from tenants and witnessing disputes between tenants that resulted in police involvement.

The landlords interviewed also reported a need for ongoing case manager involvement as needed during the tenants' transitions off of RRH assistance. One landlord noted that it is not uncommon for tenants to be unemployed when their assistance expires; in these situations, the landlord works with the case managers to arrange to relocate tenants unable to pay rent rather than formally evict them. The other landlord reported challenges around not being informed when a tenant transitions off of assistance, especially when the tenant subsequently experiences difficulties paying rent or other tenant issues. This landlord indicated that it would be helpful to have a roadmap for who to call or how to proceed if difficulties arise after a tenant graduates the program.

In addition to communication and responsiveness, the landlords recommended other strategies that may be useful in engaging other landlords, including providing more rental assistance or compensation for the added time needed to manage properties with high-need tenants, and providing resources (e.g., holding fees, risk mitigation, and compensation for gaps in unit occupancy) to offset the perceived risk around relaxing standard screening criteria for rental applications.

Strategies and solutions are under development to increase the pool of sustainable affordable housing. Shared housing and a shallow subsidy program are two strategies intended to provide more sustainable opportunities to house people, especially after the RRH financial assistance is completed. Additionally, specialized housing location and retention efforts through PATH's LeaseUp Program and Brilliant Corners Housing Location and navigation services are an additional strategy to expedite housing location and facilitate long-term housing stability.

Shared housing is cited often by providers as one solution to the problem of finding and keeping sustainable affordable housing, particularly for youth and single adults. Providers and landlords perceive that participants are more likely to be able to retain shared housing long term. However, this approach has its own challenges: It does not lend itself to certain housing location approaches such as the use of large-scale holding agreements, which have been used to hold a large number of units vacant while matching them to RRH participants, but have been found to remain open for too long when awaiting placement of multiple disparate people into a single housing location. It also requires participants to navigate roommate relationships; it may require additional case management support to help mediate roommate issues; and it is not a solution for everyone given that some participants are unwilling or unable to live in shared housing arrangements.

The Shallow Subsidy program was developed by LAHSA, and a request for proposals for the program was issued in July 2018 and awarded to the Salvation Army in January 2019. The goal of the program is to provide financial help to RRH tenants who are no longer in need of case management services and whose financial assistance is expiring, but who are unable to afford market rate housing. The Salvation Army received an annual investment of $12 million from February 2019 through June 2021, to begin implementation in April 2019. The program offers a security deposit (if needed) and a monthly amount of $300 for a one-person household or $500 for a multi-participant household for up to 5 years. RRH tenants eligible for the subsidy must meet all of the following criteria: Be waitlisted for subsidized or affordable housing, be currently housed and exiting RRH within 120 days, have income under 50 percent AMI, be paying 60 percent or more of their total income towards their current rent, and not be in need of intensive case management or other long-term service (LAHSA, 2018). The Shallow Subsidy program was in its early implementation during our evaluation and program managers interviewed had limited experience with actually using it. However, early concerns raised are that the program has restrictive eligibility that means many participants may not qualify, and that it may provide insufficient monthly amounts, particularly for families.

PATH and Brilliant Corners are two non-profit community organizations that operate specialized housing location and retention efforts. PATH, a housing and homeless services provider, operates the LeaseUp program, a resource that provides information about available units for eligible housing and homelessness programs involved with CES, including RRH and other housing programs. PATH's housing location program acts as a liaison between landlords and case managers throughout the housing location and retention process. Brilliant Corners is DHS's community-based fiscal intermediary, responsible for administering local rental subsidies for DHS and providing housing acquisition services to subsidy recipients. Several program managers mentioned currently accessing PATH's LeaseUp program for housing location and finding the resource helpful. Brilliant Corners housing acquisition services have been provided for RRH participants since Strategy B3 implementation, but the focus has since shifted to provision of services for other subsidy types.

The effectiveness of these programs has not been systematically examined, but future housing navigation efforts could benefit from a review of information on their work to date, information gathered through their landlord engagement efforts, as well as the challenges encountered. One challenge identified thus far has been holding units for shared housing and matching them to tenants in a timely manner, as it is reportedly difficult to identify and match disparate RRH participants to shared housing units. Another barrier is

Housing Location and Retention Efforts

PATH LeaseUp

- **Provider support in working with landlords, identifying vacancies and matching participants, understanding incentives**
- **Zillow-like platform for case managers to access pre-vetted units for tenants**
- **Landlord support, including Landlord Advisory Board, relationships with apartment associations, outreach and landlord education workshops, risk mitigation funds, a mediation coordinator to work with landlords and case managers to resolve issues that arise**

Brilliant Corners Housing Acquisition Services:

- **Landlord outreach, incentives, matching of tenants**
- **Unit holding agreements to retain large number of units and link clients to them**
- **Tenancy support services including assisting clients in housing selection and move in, and providing supports to prevent evictions**

identifying landlords willing to participate in the programs. Related to this, some providers are reportedly hesitant to share or publicize information on participating landlords, because such landlords are a limited resource.

Section III. Identification, Characteristics and Outcomes of RRH Participants

A. Identification and Enrollment in Rapid Re-Housing, and Characteristics of Populations Served

Participants identified and enrolled in RRH programs are reportedly generally assessed and tracked in CES at or prior to enrollment, although in same cases assessment comes afterwards. Potential participants may be identified and referred through a range of sources and are enrolled directly by the providers. The process whereby participants are identified and enrolled differs by population and by SPA. Populations differ in the number and type of referral sources, the pathways through CES, and the degree to which systems coordination and matching is already in place. Referrals into RRH come from a range of sources including CES, community partners, outreach workers, hospitals, and participants self-presenting. While single adults seem to be referred through the widest range of referral sources, CES for youth appears to be more coordinated and centralized, with matching to RRH providers occurring at the SPA-level in some cases.

For families, the process of identification and referral poses unique challenges. Unlike other populations, families are referred through the Family Solutions Centers (FSCs), a countywide network of homeless service providers that provided a centralized point of access for families in need of crisis services. In addition to connecting with other needed services, the FSCs connect families with temporary as well as permanent housing placements. The reported expectation is that, in the absence of an alternative housing resource, all families should be enrolled in an RRH slot if they are unable to be diverted. This results in a higher number of families enrolled than can be served.

All participants to be served through RRH are expected to complete a standardized vulnerability assessment (the VI-SPDAT, Family VI-SPDAT, or Next Step Tool for Youth) and to be connected to CES if they did not come through CES prior to their referral. This was confirmed by a number of focus group participants who reported calling 211 and completing assessments through CES, or doing an assessment after contacting the RRH provider. At present, however, CES across the populations functions as a source of referrals for RRH and a way to standardize initial screenings and systematically store data on intake information and vulnerability scores but not yet as a method of systematically prioritizing participants or matching them to RRH slots.

Prioritization and matching of participants to RRH are left to the discretion of the providers. Per the SRS, RRH provider organizations are required to assess whether a client is a "fit" for RRH and to consider the vulnerability assessment score. However, they are not required to rely solely on the score in making the determination; consequently, there is a lack of transparency regarding how the organizations determine who to prioritize for enrollment in the programs. Some program managers indicated that participants are served on a first come first served basis, whereas others indicated they try to serve everyone simultaneously or use a wait list and enroll participants when there is space available on caseloads.

Participants who are eligible for RRH under LAHSA's criteria (e.g., documented as homeless under HUD Categories 1 and 4 and under 50% AMI) may be required to meet additional requirements

from providers before being offered enrollment in the program. Client participants in focus groups noted requirements they believed they had to meet, including having income, being employed, having already identified housing and being ready to sign a lease, or being eligible for mental health services. It is unclear whether these perceived requirements are in fact enrollment requirements. What is clear is that there are differences across program managers and case managers in what they describe as the level of needs participants have in their programs as well as the extent to which they have income and employment. These client differences may be due to differences in how participants are recruited and enrolled. Due to time constraints in data availability and incomplete data about income and other characteristics, we were not able to examine differences in characteristics of participants served by provider; however, this may be something that can be pursued by LAHSA as it examines refinements it might make.

The administration of RRH is challenged by the lack of policies around prioritization for RRH and corresponding lack of standardization within CES. Challenges center around the lack of a system to determine how many participants can be served, the lack of consistency and transparency in who is prioritized for the limited resource, and a lack of consensus among stakeholders on how best to make such determinations. There are reportedly more people eligible for the programs than there are available resources, and no policy of establishing slots and openings to address this problem. Family providers, in particular, believe there are explicit or implicit expectations to serve all families, reportedly resulting in over-enrollment and/or high caseloads.

LAHSA has considered plans to standardize the CES process across all SPAs, prioritizing and matching the highest acuity participants to RRH (who are not matched to PSH or another deeper resource). Specifically, at the time of data collection, an operational manual was under development to standardize CES processes across the SPAs, and LAHSA had convened an advisory group to inform implementation of prioritization and matching to RRH. However, these plans have met with resistance and were evolving at the time of data collection. In our interviews, program managers repeatedly raised objections to the plan to prioritize and match to RRH resources based on high assessment scores. They worried that such a policy would make the resource less available for those of lower acuity who they feel are likely to benefit from it and do not qualify for other resources. They also were concerned that participants with high acuity would be less likely to be able to retain the housing, and concerned that system-wide matching will mean they are unable to serve existing participants of their agency for whom they believe their services may be most appropriate.

Providers and administrators also perceived that there already has been a shift in the acuity of the participants served under Strategy B3, which several providers reported was originally targeted to those of low to moderate acuity and later expanded under LAHSA's direction. While some providers and administrators indicate that those of higher acuity have also succeeded in RRH, others expressed concern that they may have a hard time maintaining housing once the assistance expires.

Analysis indicates that assessment scores are missing for 47 percent of those receiving RRH since the implementation of Strategy B3, and for 85 percent of those served in RRH in the 2 years prior. Due to large amounts of missing data on vulnerability scores in the HMIS, it is difficult to assess whether or not vulnerability has shifted over time or whether scores are related to retention.

Families' long stays in crisis housing while waiting for RRH are exacerbated by the uneven and, at times, poor quality of the temporary placements. As noted, families who go through

CES and whose needs cannot be addressed through problem solving or diversion[4] are to be offered crisis housing either in group settings or hotels. While this evaluation does not cover crisis housing, families' use of crisis housing is intertwined with the RRH program's efforts to rehouse them. Families may stay, and several reported that they believed they *must* stay, in these settings until rehoused, a process that can take many months. The families reporting these experiences sometimes had resided in hotels for a portion of their time awaiting RRH assistance and had spent the remaining time in group or shelter settings that they perceived to be uncomfortable, overcrowded, unsafe, and seemingly arbitrarily regulated by the agencies providing them. Lack of alignment between the requirements of the RRH program and of the crisis housing added to families' dissatisfaction. Providers and administrators interviewed did not indicate that staying in crisis housing was an eligibility requirement for RRH, although they did report that it is challenging to find shelter for all of the families in need while they are waiting for housing placements.

After Strategy B3 has been implemented, the size of the population served through RRH has increased considerably and there have been slight shifts in the demographics of the population. As noted earlier, over two times the number of households were served in the three years following Strategy B3 implementation, compared to the two-year time period prior to Strategy B3 implementation. Table 2 presents the demographic characteristics of the participants participating in RRH during the two time periods. Although the populations are somewhat comparable between the two cohorts, participants served after the strategy was implemented were, on average, more likely to be younger, Hispanic, and to identify as female or transgender or gender non-conforming. Cohorts also varied in racial composition. A higher proportion of those served post-implementation were multiracial or had an unknown or missing race, whereas a lower proportion served post-implementation were African American, Asian, and Hawaiian or Other Pacific Islander. Because race was missing for a larger proportion of the post-implementation cohort, it is not clear whether this reflects real shifts in the racial composition of the population served or differences in data quality over time. Although the absolute number of Veterans was comparable between the two cohorts, the expansion of the cohort following Strategy B3 implementation led to the proportion of Veterans being significantly smaller in that cohort than the earlier cohort. Proportionally more transition aged youth and fewer families and single adults were served post implementation of Strategy B3 than before it. Participants served after Strategy B3 are also considerably more likely to have known health insurance, and less likely to be missing insurance information than those served in RRH prior to Strategy B3.

[4] Problem-solving/diversion is a creative problem solving conversation that may include one-time financial assistance to help families access an alternative housing solution outside the homelessness system.

Table 2. Demographic characteristics of heads of household participating in rapid re-housing

	Pre-implementation cohort (N= 8,768)	Post-implementation cohort (N = 20,668)
Age***		
Mean	44 years	41 years
Median	43 years	38 years
Range	18-91 years	18-98 years
Age of HOH Unknown***	5%	6%
Household Type		
Single Adults***	61%	57%
TAY without children**	3%	7%
Families**	36%	33%
Gender		
Male***	55%	43%
Female***	44%	55%
Trans/Nonconforming***	<1%	<1%
Unknown*	1%	<1%
Race		
White	38%	39%
Black***	54%	51%
American Indian/Alaskan Native	1%	1%
Asian***	1%	<1%
Hawaiian/Pacific Islander	1%	<1%
Multiracial***	<1%	<1%
Unknown***	3%	6%
Ethnicity		
Hispanic***	25%	29%
Not Hispanic***	74%	69%
Unknown***	2%	3%
Veteran Status[1i]		
Yes***	43%	18%
No ***	54%	80%
Unknown***	2%	1%
Health Insurance		
Has health insurance***	65%	75%
Has no health insurance***	13%	17%
Medicare/Medicaid***	64%	72%
Employer-provided***	<1%	1%
Other insurance*	<1%	1%
Unknown***	22%	8%

***p<.001, *p < .01, *p < .05.

[1] While the number of veterans served has stayed roughly similar over the two study periods, they are a much smaller proportion of the population in the post-implementation cohort.

Participants in RRH after Strategy B3 are more likely to have income and a larger amount than those served prior to the strategy being implemented. As Table 3 shows, participants served after Strategy B3 implementation compared to those served before are more likely to have higher income and are more likely to have complete data on their income and benefits sources. They are also more likely to have earned income and to receive Supplemental Nutrition Assistance (SNAP). These findings should be interpreted with caution given the rates of incomplete data in the pre-implementation cohort.

Table 3. Income and benefits among household participating in rapid re-housing

	Pre-implementation cohort (N= 8,768)	Post-implementation cohort (N = 20,668)
Income		
Total Monthly income (from any source)		
Received***	64%	72%
Mean amount**	$991	$1,047
Earned income		
Yes***	18%	26%
No***	63%	74%
Unknown***	19%	<1%
General Assistance		
Yes	11%	11%
No***	71%	89%
Unknown***	19%	<1%
SSDI		
Yes	4%	4%
No***	74%	88%
Unknown***	22%	8%
SSI		
Yes***	13%	14%
No***	68%	86%
Unknown***	19%	<1%
TANF[1]		
Yes***	19%	21%
No***	60%	71%
Unknown***	22%	8%
Unemployment Insurance		
Yes	2%	2%
No***	79%	98%
Unknown***	19%	<1%
VA Income		
Yes***	9%	5%
No***	3%	9%
Unknown***	88%	85%
Other Income		
Yes***	3%	2%
No***	75%	83%
Unknown***	21%	14%

Table 3. Income and benefits among household participating in rapid re-housing (continued)

	Pre-implementation cohort (N= 8,768)	Post-implementation cohort (N = 20,668)
Non-cash benefits		
SNAP		
Yes***	35%	42%
No***	<1%	<1%
Unknown***	65%	58%
WIC		
Yes***	2%	3%
No***	73%	62%
Unknown***	25%	35%

***p<.001, **p < .01, *p < .05.

The health and related needs of RRH participants served after Strategy B3 differ from those of participants served in RRH prior to the strategy's implementation. As Table 4 shows, RRH participants in the post-implementation cohort have slightly higher rates of domestic violence and developmental disabilities and slightly lower rates of substance abuse, physical disabilities and chronic health, and mental health conditions than the pre-implementation cohort. These differences in services needs are small but statistically significant, and may be due, in part, to differences in the mix of populations served, as noted above.

The limited acuity information available does not suggest that acuity has increased overall since implementation of Strategy B3. As depicted in Tables 5A – 5D, average assessment scores of those served following Strategy B3 are comparable to or lower than those served prior to strategy implementation overall and among families, adults, and TAY. Likewise, the proportion of those served falling in the moderate category (4-7/8) has increased in the overall sample. However, these results should be interpreted with great caution, given that scores were only available for a subset of those served, and were missing for the majority of those served before Strategy B3 was implemented. Reanalysis would be needed following data quality control measures to verify that these patterns hold when scores are available for the full sample.

Table 4. Disability, chronic health conditions, and history of domestic violence among those with HMIS data

	Pre-implementation cohort (N= 8,402)	Post-implementation cohort (N = 19,050)
Physical Disability		
Yes***	26%	22%
No***	71%	77%
Unknown***	3%	1%
Developmental Disability		
Yes***	7%	10%
No***	90%	88%
Unknown***	3%	2%
Chronic Health Condition		
Yes***	27%	25%
No***	70%	74%
Unknown***	3%	1%
HIV/AIDS		
Yes***	1%	1%
No***	96%	97%
Unknown***	3%	2%
Mental Health Problem		
Yes***	32%	30%
No***	65%	68%
Unknown***	3%	2%
Substance Abuse		
Yes***	9%	7%
No***	88%	92%
Unknown***	3%	1%
Domestic Violence		
Yes***	17%	22%
No***	77%	74%
Unknown***	6%	4%

***p<.001, **p < .01, *p < .05.

Table 5A. Acuity of CES assessments

	Pre-implementation cohort (N=1,351)	Post-implementation cohort (N=11,036)
Average assessment score		
Mean**	7.003	6.78
Std. Dev.	3.56	3.26
Range	0-18	0-19
Score breakdown**		
0-3	17.0%	15.5%
4-7	41.1%	45.7%
8+	41.9%	38.8%

***p<.001, **p < .01, *p < .05.

Table 5B. Acuity of CES assessments among families

	Pre-implementation cohort (N=256)	Post-implementation cohort (N=3,281)
Average assessment score		
Mean	7.11	6.79
Std. Dev.	3.44	2.89
Range	0-18	0-19
Score breakdown*		
0-3	13.7%	10.3%
4-8	56.6%	63.8%
9+	29.7%	25.9%

***p<.001, **p < .01, *p < .05.

Table 5C. Acuity of CES assessments among adults

	Pre-implementation cohort (N=991)	Post-implementation cohort (N=6,454)
Average assessment score		
Mean	7.15	7.01
Std. Dev.	3.60	3.46
Range	0-16	0-18
Score breakdown		
0-3	17.3%	16.4%
4-7	38.8%	40.6%
8+	44.0%	43.1%

***p<.001, **p < .01, *p < .05.

Table 5D. Acuity of CES assessments among youth

	Pre-implementation cohort (N=74)	Post-implementation cohort (N=1,047)
Average assessment score		
Mean	5.53	5.54
Std. Dev.	3.19	2.77
Range	1-14	0-16
Score breakdown		
0-3	21.6%	24.3%
4-7	58.1%	52.8%
8+	20.3%	22.9%

***p<.001, **p < .01, *p < .05.

B. Length of Enrollment and Outcomes for RRH Participants

Participants served in RRH after Strategy B3 compared to those served prior to its implementation appear to have moved into housing at higher rates. Those who do so, move in more quickly and are more likely to exit to permanent housing without a subsidy. As shown in Table 6, a higher proportion of those served following Strategy B3 have a documented move into housing during their enrollment in a RRH program. Outcomes of those with records of moves into housing are also presented in Table 6. Among those who moved in, those in the post-implementation cohort moved in more quickly and were more likely to exit to permanent housing

without a subsidy. They were also less likely to exit to permanent housing with a subsidy and more likely to exit to another or unknown destination.

However, it is important to note that although these difference may reflect an actual change in rates and timing of move in and subsequent outcomes, they could also reflect a difference in data quality and completeness of move-in dates over time. For this reason it is important to also consider time from enrollment to exit and exit destinations among those who exited without a record of move-in to housing documented in the data, as discussed further in the sections below.

Table 6. Length of enrollment and outcomes among households with rapid re-housing

	Pre-implementation cohort (N= 8,768)		Post-implementation cohort (N = 20,668)	
Moved In to Housing				
% reported moved in***	41%		50%	
Days to move in***	109 days		98 days	
Enrollment and Exit Characteristics				
	Moved into housing (N = 3,583)	No record of move into housing (N = 5,185)	Moved into housing (N = 10,275)	No record of move into housing (N = 10,393)
Exited Rapid Re-Housing				
% Exited***	95%***	85%***	74%	62%
Days from Enrollment to Exit	245*	159***	254	182
Days from Move-in to Exit	144***	—	166	—
% enrolled 6 months or less	77%***	82%***	44%	57%
% enrolled 6-12 months	18%***	15%***	31%	30%
% enrolled over 12 months	4%***	3%***	25%	13%
Exit Destination among those Exited				
Sample Size	N = 3,402	N = 4,397	N = 7,591	N = 6,427
Permanent Housing No Subsidy	30%***	21%***	44%	6%
Permanent Housing with Subsidy	54%***	23%***	32%	5%
Doubled Up Permanent	2%***	3%**	7%	4%
Doubled Up Temporary	1%*	5%	<1%	4%
Institutional Setting	<1%	1%	<1%	2%
Transitional Housing	<1%	5%	<1%	6%
Shelter	<1%	3%	<1%	3%
Unsheltered	<1%	8%***	1%	18%
Other	<1%***	4%***	2%	10%
Unknown	10%**	28%***	12%	44%

***$p < .001$, **$p < .01$, *$p < .05$; Significance tests compare rates of exit destinations (1) across the pre and post-implementation cohorts among those who moved into housing, and (2) across the pre and post-implementation cohorts among those who did not move into housing.

Participants served in RRH after Strategy B3 compared to those served prior to its implementation stay longer in RRH programs before exiting. Participants served following Strategy B3 stay longer in RRH programs prior to exiting. This is true among all RRH participants, those with and without documented moves into housing. At the same time, the majority appear to remain in housing with assistance for less than the allotted 24 months. Less than one percent of those served following Strategy B3 were in housing with rapid rehousing assistance for more than 24 months.

Those served following Strategy B3 exit to both stable and unstable destinations at different rates than those served prior to Strategy B3, but findings vary depending on whether a record exists of a move into housing prior to exiting. It is not clear whether findings reflect real differences in client outcomes or changes in documentation practices and data quality over time. As shown in Table 6, those served after Strategy B3 who moved into housing were more likely to exit to permanent housing without a subsidy or a permanent doubled up situation. They were also, however, less likely to exit to permanent housing with a subsidy[5] and more likely to exit to another or unknown destination. These exit findings are similar for those with no recorded move-in date; a key exception is that, for those without a move-in date, those served following Strategy B3 are less likely than those served prior to Strategy B3 to exit to a permanent housing destination with or without a subsidy and are more likely to exit to unsheltered and unknown situations.

Additional analysis, beyond the scope of this evaluation, could shed further light on the outcomes of participants served through Strategy B3. Interpretation of the findings presented here can be bolstered by additional future analysis. A large proportion of participants served through Strategy B3 (32%) had not yet exited the program, and it is therefore not yet clear what their outcomes will be. While it is clear that those served following Strategy B3 are served for a longer period of time than those served prior, it is not clear whether this is positive or negative. Future analysis is needed to determine whether longer periods of enrollment ultimately correlate with better outcomes. It is promising that participants served following Strategy B3 appear to move into housing more rapidly and at higher rates and are more likely to exit to permanent housing without a subsidy after a documented move-in. However, these findings have to be considered with caution given the possibility that they could be artifacts of changes in methods of tracking move-ins and exits before and after the implementation of Strategy B3. Efforts to ensure that move-ins to housing and exits to permanent housing are recorded consistently over time and across providers can render future analysis of Strategy B3 outcomes more informative.

[5]Additional details regarding the types of subsidized permanent housing to which participants exit is provided in Appendix B.

Section IV. Conclusions and Recommendations

A. Conclusions

Expansion of Flexible RRH Resources to Broader Populations. Strategy B3 has resulted in an expansion of RRH services throughout Los Angeles County, with more providers administering the program on a wider scale than prior to the strategy. In addition, Strategy B3 has provided larger quantities of more flexible funding to cover additional staffing, longer term rental assistance, and more flexible coverage of other costs. In turn, following the Strategy, substantially more and a greater variety of participants have been served through RRH. The administrative data suggest that this population, compared to the population served in RRH prior to Strategy B3, has moved into housing at higher rates and more quickly, and has been more likely to exit into permanent housing without a subsidy following move-in. At the same time, people served following Strategy B3 appear to remain enrolled slightly longer before exiting compared with those served prior, and their patterns of exit destinations show key differences depending on whether a move-in date is documented in the administrative data. Due to inconsistencies in the administrative data, these quantitative findings may either reflect real changes in RRH operations and outcomes or alternatively may reflect differences in the quality and completeness of data over time and across providers. Additionally, outcomes are not yet known for a substantial portion of those served following Strategy B3, who have not yet exited the program.

Variability in Approach across Providers and Populations. With respect to implementation, a systematic, consistent approach to implementing RRH across providers is not yet in place. More recent guidance and training from LAHSA with the collaboration of providers is likely to help systematize the operation of RRH, but it continues to be highly variable. Decisions around length and amount of rental assistance, case management, housing location assistance, and client selection are largely left to the provider, within broad parameters. Consequently, providers differ in the duration and amount of financial assistance provided, the nature and amount of case management provided, and the nature of support provided to participants in the housing location and navigation process. Processes for identifying participants and enrolling them in housing are decentralized, and systematic prioritization and matching is not yet in place, resulting in a lack of transparency on client selection.

There are also differences in approach by population, in part due to differences in perceived need or in how other parts of the system, such as CES, vary by population. Families, for example, are over-enrolled in RRH due to the concern of having families without housing; this results in high caseloads as well as temporary, though often extended, placements in crisis housing, the conditions of which are challenging. CES for youth is more coordinated, with closer collaboration among providers than other systems, but youth may need more support around housing location and navigation as well as employment and vocational services.

Despite these differences, however, providers share the same challenges, including lack of standardized policies around RRH prioritization and implementation, difficulty securing sustainable housing and engaging landlords, and difficulties retaining staff. These challenges are described further below, along with some of the strategies that have been tried to address them. In some cases, these strategies have resulted in new challenges, which are also described.

Lack of Standardized Policies Around RRH Prioritization and Implementation. As described above, much of the implementation of RRH is left to the discretion of the providers, and the resulting variability is exacerbated by a lack of standardized policies around prioritization for RRH within CES. LAHSA has considered plans to standardize the CES process across all SPAs, prioritizing and matching to RRH the highest acuity participants (who are not matched to PSH or another deeper resource). These plans, however, were evolving as this evaluation was underway, amid provider concerns that such a policy would exclude participants of lower acuity who could benefit from RRH and do not now qualify for other resources, prioritize those who have a lower likelihood of retaining the housing, and make it difficult to serve participants they believe could benefit from RRH. Training and technical assistance offered by LAHSA that could ultimately lead to greater consistency in RRH practice requires a significant investment in time and resources by both providers and the system, exacerbated by staff turnover requiring additional trainings.

Difficulty Securing Sustainable Housing and Engaging Landlords. It is reportedly difficult to find affordable housing in the tight and costly Los Angeles County market and to engage landlords to rent to RRH participants. Having flexibility to house people experiencing homelessness in Los Angeles County in other more affordable geographic areas outside of the county, have been noted as a helpful strategy to address this challenge. Strategies for improving landlord engagement, such as one-time incentives, may help providers attract landlords, but have led to competition among housing programs for housing slots as well as reportedly attracting some landlords who engage in illegal or unethical practices, such as charging large fees. Similarly, several strategies for finding and keeping sustainable housing, such as shared housing, the Shallow Subsidy program, and housing location intermediaries, may help address the problem but bring in their own complexities. Shared housing does not lend itself to all housing arrangements, requires participants to navigate roommate relationships, often requires additional case management support, and is not a solution for all participants. The Shallow Subsidy program, recently implemented, has generated early concerns that the program has restrictive eligibility and may provide insufficient support, although there is not yet sufficient data to evaluate this concern. Finally, two organizations have been funded to conduct specialized housing location and retention efforts. These organizations have developed specialized strategies for engaging in outreach to landlords, providing landlord incentives, matching clients to available units, and providing ongoing tenancy support after clients move into housing. While the impact of these strategies have yet to be systematically evaluated, some program managers reported availing themselves of these resources, and it is likely that information gathered and challenges encountered through these efforts may inform future housing navigation efforts. For example, challenges to these efforts thus far include difficulties holding units for shared housing, identifying landlords willing to participate in RRH programs, and persuading providers to share information with one another on willing landlords when they find them.

Staff Turnover. There is reportedly a high rate of staff turnover, due to the challenging nature of the work itself and high availability of jobs in the field. Challenges of the work that may contribute to turnover include frustrations brought on by difficulties with the position and high caseloads, as well as staff concerns that they are unable to provide the assistance needed to successfully stabilize participants in housing, particularly those with higher needs.

B. Recommendations

The recommendations below can strengthen the existing RRH programs under Strategy B3 address key challenges.

✓ **Improve Program and Provider Consistency**

Enhanced provider consistency in RRH delivery would permit a stronger evaluation of program implementation and outcomes, and might lead to improved client outcomes and transparency around what is delivered. Moreover, having more consistency in approach will increase equity of access so that it will not matter where (through which provider or SPA) or when (at what time of year/time in the budget cycle) an individual seeks assistance. Finally, consistency can facilitate a more systematic evaluation of the outcomes of the program over time. Consistency can be enhanced through the following approaches.

1. Develop clear guidance and shared consensus around answers to the following questions.

    a) What is encompassed in RRH? What are the service expectations, and do they differ by population served?

    b) Who is RRH for? For participants of what need or acuity level?

    c) What is the structure for administering the financial assistance? What level of standardization versus what flexibility is expected in implementing progressive engagement?

    d) How is that flexibility and the expectations of the program and the client messaged to participants?

    e) What size and composition should caseloads have?

    f) What tools and/or guidance do providers have or need to fairly assess continued need?

2. Standardize CES processes, and, in particular, systematize the process whereby participants are prioritized and matched to programs. This should help enhance transparency around who is served and in in what order, reducing potential inequities in service receipt. In addition, ensuring completeness of CES vulnerability score data entered in HMIS and using those and other HMIS data to monitor the implementation of prioritization and matching would improve the ability to assess whether differences in outcomes relate to different CES vulnerability scores and other indicators of need. Findings can be used as they emerge to guide the process and to communicate with staff about outcomes.

3. Involve persons from all levels and perspectives (program managers, case managers, participants, landlords) in planning and decision making around RRH/Strategy B3. This can facilitate buy-in as well as avert possible additional challenges in the decisions that are made. Many of the challenges in implementing RRH require the cooperation of

others; having those with various perspectives on the ground floor in problem solving with RRH may help to develop workable strategies. In particular, challenges in navigating the private housing market may be addressed by engaging landlords in developing strategies to increase their involvement, as well as examining more closely the strategies that have worked to date and identifying the barriers that have been the most intractable.

4. Provide ongoing training and guidance to better equip staff to administer RRH in a consistent manner across programs. Continued training and guidance, tied closely to the program requirements and expectations, can improve consistency in RRH at all levels of a provider organization.

✓ **Enhance Landlord Cultivation**

1. Navigating the private housing market was described by many as a central component of the RRH program model. As efforts to engage landlords proceed, it will be worth gathering targeted information on what has worked to date and what barriers have been encountered by providers and specialized housing location and retention specialists. Some questions that may be informed by existing efforts include:

   a) How do landlords learn about RRH programs, and how can awareness of and understanding of these programs be increased among new landlords?

   b) What factors deter participation, and how can these be ameliorated?

   c) What are incentives to participation, and how can these be enhanced?

   d) How do strategies for engaging and working with landlords need to be tailored to particular populations of tenants (e.g., youth, families, or those of higher acuity) or housing arrangements (e.g., shared housing)?

   e) What are best practices for case managers and RRH providers in working with landlords and addressing tenant issues that may arise after clients have moved into housing and through the point when assistance expires? What practices foster housing stability and retain willing landlords as participants in these programs?

2. Landlords reported that they valued the case management and would like increased communication, especially when a participant is transitioning off of the RRH subsidy, as well as options for who to call or how to proceed if difficulties arise after a tenant completes the program.

3. Aligning the size and frequency of incentives, risk mitigation, and payment policies and practices across different program types may make landlords less likely to search for the most advantageous program. Because RRH programs have shorter term subsidies than other programs and may be perceived as riskier, it may be worthwhile to consider giving RRH programs the ability to offer greater incentives.

✓ **Address Staff Turnover**

Retaining staff is key to sustaining a successful program. At present, turnover is a significant challenge, and strategies to retain staff should be a priority. The following efforts may build morale and enhance retention:

1. Increasing salaries with the aim of encouraging retention within an agency;

2. Ensuring that staff have the right case mix and the capacity to adequately support those in their caseloads;

3. Providing training/guidance and supervision for staff around progressive engagement;

4. Holding forums where staff can share their concerns and barriers to serving clients and access resources; and

5. Providing staff with alternative resources to offer RRH participants who are lower priority, including problem-solving (diversion) resources.

✓ **Improve and Clarify the Relationship between Crisis Housing for Families and RRH**

1. Families in RRH that we interviewed reported that they believed that they were required to stay in crisis housing while working on finding housing through the RRH program. While some crisis housing was provided in motels, some of it was through shelters or other forms of temporary congregate housing. Families had significant concerns about the shelters and congregate housing; they found them uncomfortable, overcrowded, unsafe, and seemingly arbitrarily regulated by the agencies providing them. The relationship between the requirements of these programs and the RRH program was not clear and created confusion for families. Crisis housing is outside the scope of this evaluation; however, efforts appear warranted to clarify whether families must stay in crisis housing to receive RRH assistance.

✓ **Monitor and Improve Data Quality and Track and Report Outcomes including by Time in Program and Acuity**

1. Efforts are needed to improve data quality. The descriptive outcomes presented in this evaluation relied on administrative data, which were limited in their quality and completeness. Efforts are needed to improve data quality and to ensure that data are tracked systematically the same way across providers and over time. In particular, at present it is difficult to ascertain whether the absence of move-in and exit dates in the client record indicates that the client has not yet moved into housing or exited the program or alternatively reflects missing data. Likewise, it is not clear that moves into housing during program enrollment and subsequent exits to permanent housing or other destinations have been tracked consistently across providers or over time. Different provider practices around the timing of enrollment in the program relative to move-into housing may also render the data misleading. For example, we were told by some stakeholders (agency administrators as well as RRH participants) that some providers wait until clients are ready to sign a lease and move into housing before formally enrolling them in programs, a practice which could artificially reduce the estimates of time served prior to move-in and exit. Establishing and monitoring

adherence to guidelines to ensure that these measures are tracked consistently and comprehensively can form the basis for a stronger future evaluation of outcomes. Enhancing completeness of the data can also help to better understand the sociodemographic characteristics and needs of the populations served and capture changes in these characteristics over time. For example, the racial composition of the population served appears to have changed slightly over time, but there has been a comparable (3%) increase in rates of missing data over the same time period, making it difficult to determine whether there has been an actual shift in the population served or whether this just reflects changes in data quality.

2. Ongoing monitoring of the impact of programs over time is needed. A large proportion of those served through Strategy B3 had not yet exited the program at the time of this evaluation, and their outcomes remain unknown. Moreover, additional analyses that were not feasible within the scope and time constraints of this evaluation, can help to further understand observed outcomes and to differentiate more reliably between those who are missing move-in and exit information versus those who have not yet moved in or exited.

3. Future analysis should aim to better understand the factors associated with positive and negative outcomes. There were a number of concerns raised by staff and program managers that RRH is being used with people who may not be successful and many RRH programs believe they are serving higher acuity people. We did not see evidence to support this in the limited data available. However we did see increased lengths of programs stays and lower exit rates. Tracking the impact of the programs and being able to distinguish trends and differences in population outcomes from anecdotal experience is critical to monitoring program success and to achieving provider buy-in, especially if RRH will be offered to those with higher needs. Specific questions that could be informed by future evaluation include the following:

    a) To what extent does longer length of time served through RRH contribute to more positive outcomes (exits to permanent housing destinations and retention in housing without assistance)?

    b) To what extent does participant acuity influence RRH service receipt and participant outcomes? Do those of higher acuity experience comparable outcomes to those of lower acuity, and do they require more intensive services or longer program times to achieve comparable outcomes?

    c) What is the rate of movement between RRH and other types of housing assistance? For example, what proportion of participants served through Strategy B3 ultimately receive RRH assistance as a bridge to other higher levels of assistance, such as permanent supportive housing? Do longer stays reflect in some cases waiting for other resources to become available?

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Appendix A

Summary of Methods

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A. Document Review

Review of documents has been employed to better understand the history, evolution, and status of Strategy B3; to inform the development of interview and focus group protocols; and to contextualize the qualitative data gathered. Documents reviewed include: contextual information on homelessness in Los Angeles County, including Annual Homeless Assessment (AHAR) and Continuum of Care (CoC) reports; strategic documents from the Homeless Initiative (HI), HI performance evaluations, and HI quarterly reports; and publicly available and internal documents from the HI, Los Angeles Homeless Services Authority (LAHSA), including strategic planning and implementation documents, impact dashboards, community input session summaries, guides to contracting opportunities, lists of funded Strategy B3 contractors, presentations, and reports (Exhibit A-1).

Exhibit A-1. Relevant documents

- Contextual information on homelessness in Los Angeles County
- Annual Homeless Assessment Report (AHAR) data and Continuum of Care (CoC) reports
- Strategic documents from the Homeless Initiative (HI)
- HI performance evaluations and HI quarterly reports
- Budgets
- Internal documents from LAHSA
- Dashboards and publicly available documents from LAHSA

B. Interviews and Focus Groups

In-depth semi-structured interviews were conducted with key administrators of Strategy B3 and directors of organizations that administer rapid re-housing (RRH). Focus groups were conducted with direct line staff of RRH programs and with RRH program participants.

Sampling. We conducted telephone interviews with administrators from the agencies involved in administering RRH in LA County, as well as agencies that coordinate with RRH on housing and the coordinated entry system (CES). With the help of Los Angeles Homeless Services Authority (LAHSA), Department of Health Services (DHS), and the Chief Executive Office (CEO), we identified key administrators of Strategy B3 to interview at these agencies, as well as the Housing Authority of the City of Los Angeles (HACLA), the Los Angeles Community Development Authority (LACDA), the Department of Children and Family Services (DCFS), and the "LeaseUp" program at People Assisting the Homeless (PATH). We conducted 18 interviews across these agencies to understand the evolution and implementation of Strategy B3, the implementation of the strategy, funding, impending changes, and contextual information. A detailed list of administrators interviewed at these agencies is presented in Table A-3.

For the interviews and focus groups, we sampled a total of 13 organizations from the pool of 20 LAHSA-funded organizations administering RRH for all populations served across the SPAs in Los

Angeles County as of FY 2018-2019. We arrayed the organizations by the geographic regions and populations served. With input from LAHSA, we selected organizations that would permit us to represent organizations serving all populations across all geographic regions of Los Angeles.

We additionally sampled private landlords to gather information on landlords' perspectives. This aspect of data collection was added during the course of the evaluation based on initial findings that emerged from staff focus groups and provider interviews regarding the difficulty of finding housing and challenges engaging landlords. We recruited landlords known to have experience working with tenants with RRH assistance via PATH's LeaseUp program.

Overall, we conducted 18 interviews with agency administrators, 13 interviews with RRH program directors, and two interviews with private landlords. We conducted four staff focus groups, each with five to 12 direct line staff at these organizations, and five participant focus groups, each with two to eight RRH program participants. A list of providers sampled for interviews and focus groups is presented in Tables A-1 and A-2, respectively. A list of key informants interviewed is given in Table A-3.

Table A-4 presents demographic and housing characteristics for the participants in the focus groups, obtained through a brief survey administered at each of the five focus groups. A total of 25 participants completed the survey. Average age of participants was 36.8 years, with a range of 20 to 69 years of age. The median length of time homeless, for those who responded, was seven months, with a range from one month to four years.

Table A-1. Interviews with RRH program managers

Organization	SPA
Valley Oasis	1
LA Family Housing Corporation	2
The Village Family Services	2
Volunteers of America	3, 6
Union Station Homeless Services	3
Covenant House	4
LA LGBT Center	4
The People Concern	4
PATH	4, 5, 7, 8
St. Joseph's Center	5, 6
Coalition for Responsible Community Development	6
Special Service for Groups (SSG)/HOPICS	6
Harbor Interfaith	8

Table A-2. Focus groups with RRH direct line staff and participants

Organization	Population(s)
LA Family Housing Corporation	Families, staff
Volunteers of America	Single adults
LA LGBT Center & Covenant House	Youth, staff
PATH	Single adults, staff
Special Service for Groups (SSG)/HOPICS	Families, staff

Table A-3. List of administrators participating in key informant interviews

Point of contact	Organization
Paul Duncan, Alex Devin, and Jeffrey Proctor, Strategy B3 Leads	Los Angeles Homeless Services Authority (LAHSA)
Cheri Todoroff, Strategy B3 Lead	Department of Health Services (DHS)
Charisse Mercado	Los Angeles Homeless Services Authority (LAHSA)
Joshua Legere	Department of Health Services (DHS)
Julie Steiner	Los Angeles Homeless Services Authority (LAHSA) Consultant
Jonathan Sanabria	Los Angeles Homeless Services Authority (LAHSA)
Kevin Flaherty	Department of Health Services (DHS)
Steve Rocha and Christopher Chenet	Los Angeles Homeless Services Authority (LAHSA)
Linda Jenkins	LA Community Development Authority (LACDA)
Gail Winston	Department of Children and Family Services (DCFS)
Elizabeth Ben-Ishai	Chief Executive Office (CEO)
Meredith Berkson	Chief Executive Office (CEO)
Ashlee Oh	Chief Executive Office (CEO)
Halil Toros	Chief Executive Office (CEO)
Ryan Mulligan	Housing Authority of the City of Los Angeles – HACLA
Maureen Fabricante	LA Community Development Authority – LACDA (Previously called the Housing Authority of the County of Los Angeles – HACOLA)
Jennifer Lee	PATH LeaseUp program
Chris Contreras, Perlita Carrillo, Sophia Rice	Brilliant Corners Flexible Housing Subsidy Pool (FHSP) with DHS

Table A-4. Demographic and housing characteristics of focus group participants

Demographic characteristic	Number	Percent
Household Type	**N = 25**	
Adult	11	44%
Family	9	36%
Transition Age Youth	5	20%
Gender		
Female	15	60%
Male	8	32%
Other	2	8%
Race		
Asian/Pacific Islander	2	8%
Black/African American	7	28%
Latino/Hispanic	10	40%
Mixed Race/Ethnicity	2	8%
Native American	1	4%
White/Caucasian	2	8%
Other	1	4%
Primary Language		
English	23	92%
Spanish	2	8%
Housing status	**Number**	**Percent**
Current housing		
In an apartment	17	68%
In shelter, motel, or crisis housing	7	28%
In a vehicle	1	4%
Length of time housed		
less than 3 months	9	36%
3 to 12 months	6	24%
Missing	2	8%
Not yet housed	8	32%

Data Collection. All data collection followed informed consent and human subjects protection procedures approved by Westat's Internal Review Board (IRB). One-hour confidential telephone interviews were conducted with individual administrators and program directors, recorded to provide for confidential transcripts to provide a backup to note taking.

Interviews with county administrators and agency directors elicited information on the history of Strategy B3 and its impact on the organization, as well as the respondent's role and work relevant to the strategy. Interviews also gathered information on the following domains: the scope of the strategy, funding sources and their requirements and restrictions, the scope and size of the strategy (number of RRH programs and participants served through RRH), the services and supports received as part of RRH, including the structure of financial assistance, case management, and supports around housing location and navigation, and the process whereby participants are identified and enrolled in RRH; rates of client placement and retention in housing; information on the level and nature of collaboration around RRH implementation among and within agencies; key challenges around implementing RRH, including contextual factors impacting implementation. For all of these domains, we assessed the degree to which there were perceived changes following strategy implementation, as well as any variations by population served, provider, or SPA.

Focus groups gathered information on a number of these domains from the perspective of front line staff and RRH participants. Staff were asked to share information on how participants are received and enrolled in the program, types of RRH assistance provided, client outcomes, challenges around implementation, and the level of collaboration with other providers and staff. Participants were asked about their pathways to homelessness, the process of seeking housing and arriving at the RRH program, services and supports received while experiencing homelessness, type of RRH assistance offered and received, any assistance received around employment, and outstanding needs, and suggestions and recommendations for services and supports to help them remain in housing. All focus groups were conducted in a private space located at a participating RRH provider.

Landlord interviews gathered information on their background and experience with RRH programs, perceptions of Strategy B3, numbers of tenants receiving RRH assistance and the types of units in which they are housed and the housing providers with which they are affiliated, the nature of the financial assistance, the process whereby they are connected with RRH recipients as tenants, the nature of leasing agreements and eligibility criteria for tenancy, retention of tenants receiving RRH assistance in housing, challenges experienced around leasing to tenants with RRH assistance, and recommendations for program improvement/for ways to make the program more attractive to private landlords.

Full copies of our protocols were submitted with our Project and Data Collection Plan in September of 2019 and are available upon request.

C. HMIS AND CHAMP Administrative Data

Analyses of administrative data were conducted to provide information on the characteristics and needs, enrollment and length of time in RRH, and exits from RRH for participants served through RRH before and after Strategy B3 was funded.

Sample. The initial sample for our administrative data analysis was comprised of all participants served through RRH between the Strategy B3 implementation beginning on July 1, 2016 and June 30, 2019 (our post-implementation sample; N = 20,668) and the two years prior (our pre-implementation sample N = 8,768). Our pre-implementation cohort was limited to individuals whose enrollments were new on or after 7/1/2014, while our post-implementation cohort was limited to those with new enrollments on or after Strategy B3 implementation on 7/1/2016. The pre-implementation time frame selected was shorter than the post-implementation time frame because we had concerns about the quality of the administrative data prior to 2014. Rather than have equal time frames, we opted to include an additional year of observation in the post-implementation time frame to maximize the information provided.

Data Sources. Data sources included DHS' Comprehensive Health and Management Platform (CHAMP) and the Homeless Management Information System (HMIS). The majority (93%) of our sample was tracked in HMIS or in both data systems, while the remainder (7%) was tracked only in CHAMP. Thus, some variables presented (the disability and domestic violence variables in Table 5 of the text) are presented only for those in HMIS. Our cohort was limited to individuals whose enrollments new on or after 7/1/2014, and those in the post-implementation cohort were not enrolled during the pre-implementation period.

Variables Extracted and Constructed. Sociodemographic variables extracted include age, gender, race, ethnicity, veteran status, health insurance, income, and benefits. Using HMIS data, we constructed household type using age and number of children under 18 in the household (determined by calculating whether children age 18 were linked to the head of household via a household ID). For CHAMP data, all participants were coded as heads of household; those under age 18, who were excluded from the sample. Family status for households tracked in CHAMP was coded based on the project with which the client was affiliated, with input from DHS.

For participants tracked in both data systems, we privileged whichever data source had more complete variables. In the event that both data systems had complete variables, we relied on HMIS for most of the constructed variables, with the exception of race, which appeared to be more complete in CHAMP.

The following descriptive variables were extracted from HMIS and CHAMP: Age, gender, race, ethnicity, veteran status, health insurance presence and type, income and sources, and non-cash benefits.

Outcome variables were constructed as described below:

1. **Enrollments.** Enrollments identified using project start and exit dates associated with enrollments in an RRH program (project type 13) in HMIS, and check-in and check-out dates associated with enrollments in an RRH program in CHAMP.

2. **Move In.** Participants who had a move-in date associated with an RRH enrollment in either data system were considered to have moved into housing, and time to move-in was calculated as days between the date of project start/check-in and move-in date.

3. **Exits.** All participants with either a check out date in CHAMP or an exit date documented in HMIS were considered to have exited the program. In cases where there were overlapping enrollments during the study period, the enrollment was considered to be a single time frame, with the earliest project entry or check-in date and the latest project exit or check-out date used across the two data systems. Likewise contiguous enrollments RRH (where check-in date was within 30 days of check out date in CHAMP or project start date was within 60 days of project exit date in HMIS) were treated as a single enrollment, a decision made based on our understanding of how data are tracked in the two data systems and in consultation with DHS and the CEO. Time to exit was calculated as days between project check-in or entry date and check out or exit date. Exit destination was coded based on HMIS data and was not available in a comparable format for DHS data, so is coded as unknown for recipients only tracked in that data system.

Rates and timing of move-in and exits and destination of exit were limited to those who exited within 3 years of entry. Importantly, for those without a record of move-in to housing during program enrollment (59% of those in the pre-implementation cohort and 50% of those in the post-implementation cohort), it is not clear whether the individual did not move into housing or moved into housing but is missing their move-in date. Likewise, for those without a record of exit, we are unable to distinguish between those who are still enrolled in a program and those who exited but have missing exit data. Exits to permanent housing are assessed only for the first exit over the follow-up period. Some of those who exited to a destination other than permanent housing may

have returned to the system and subsequently exited to permanent housing, but would not be captured in this analysis.

Analysis. We conducted descriptive analysis, examining percentages for categorical variables and means, medians, and standard deviations for continuous variables. Additionally, we examined bivariate associations between cohort and client characteristics and outcome variables.

Limitations. A number of limitations should be noted. Quantitative data were originally collected for administrative purposes and should be interpreted with caution when used for evaluation purposes. For the descriptive data, it was not always possible to clearly distinguish between data that were missing because they were not endorsed or because they were not collected. Because participants are tracked in two data systems, we were limited in the variables we could examine for the full sample. For example, we did not have access to information on disability and other health conditions or domestic violence for 7 percent of the sample, as this was available to us only through the HMIS data. Additionally, our analysis of the vulnerability results of the CES assessment was limited by the high rates of missingness. With regard to our outcome variables, when move-in and exit dates were missing, we could not differentiate between those who never exited or moved in, and those who did so but had missing information. We therefore likely underestimate the rate of move-in and exits in the sample. In addition, the length of available observation was longer for those in the pre-implementation cohort than the post-implementation cohort. We sought to address this by limiting our analysis of exits to those occurring within three years of entry, but our analysis has limited information on the outcomes of participants who more recently entered RRH.

With respect to the qualitative data collected, one limitation involves the size of our participant focus groups. RRH participants can be difficult to recruit for focus groups because they are by definition not residing in a single place, and we believe as a consequence of this, attendance at some of our participant focus groups was low. Additionally, we were limited in the number and range of providers we were able to sample within the scope of the evaluation, and may not have captured all perspectives.

Appendix B

Types of Exit Destinations to Permanent Housing with Subsidy

Appendix B
Types of Exit Destinations to Permanent Housing with Subsidy

Table B-1 below provides detailed information on exit destinations among those exiting to permanent housing with a subsidy among those with no record of a move-in date and among those with a documented move into housing while enrolled in an rapid re-housing (RRH) program. A rental with a Veterans Affairs Supportive Housing (VASH) or Other subsidy were the most common destinations across all samples. However, compared with those served prior to Strategy B3, those served following Strategy B3 were less likely to exit to these destinations and more likely to exit to permanent housing for formerly homeless persons or to a rental with an RRH or equivalent subsidy. These findings should be interpreted with caution, as it is possible that these differences reflect different practices around tracking exit destinations in the administrative data over time rather than real differences.

Table B-1. Exit destination among those exiting to permanent housing with subsidy

	Pre-implementation cohort (N= 8,768)		Post-implementation cohort (N = 20,682)	
	Exit destinations among those who move in	Exit destinations among those who move in	Exit destinations among those who move in	Exit destinations among those who move in
Exit Destination among those Exited				
Permanent housing (PH) for formerly homeless persons	8%	5%	17%	10%
Safe Haven	<1%	0%	5%	<1%
Rental, VASH Subsidy	55%	47%	26%	34%
Rental, Other subsidy	36%	45%	44%	44%
Owned by Client, Ongoing subsidy	<1%	1%	<1%	<1%
Rental, Grant and Per Diem Program Transition in Place (GPD TIP)	<1%	<1%	<1%	<1%
Rental, RRH or equivalent subsidy	<1%	1%	7%	11%

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Evaluation of Los Angeles County's Strategies to Expand and Enhance Rapid Re-Housing Services for Multiple Populations

Draft Report

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Executive Summary

A. Background

Rapid re-housing (RRH) provides time-limited rental assistance coupled with supportive services to help people experiencing homelessness access housing quickly. In Los Angeles County, RRH as funded through Strategy B3, is one of the original strategies developed by the Los Angeles County Homeless Initiative (HI). The Strategy was approved by the Board of Supervisors in February 2016 and expanded in July 2017 through Measure H, a ballot initiative in Los Angeles County to generate funding to prevent and combat homelessness. RRH consists of three core components: housing identification, rental and move-in assistance, and case management and services.

B. Evaluation Description and Methods

Westat, a national research organization, in collaboration with California-based consultant Katharine Gale, has contracted with Los Angeles County's Chief Executive Office (CEO) to evaluate the implementation and client-level outcomes of RRH under Strategy B3. The evaluation, conducted between June and November 2019, involves the analysis and collection of data from multiple methods and sources, including document review; individual interviews with administrators, RRH program managers and landlords, and housing location intermediaries; and focus groups with direct line staff and RRH participants. In addition, analyses were conducted using administrative data from the Homeless Management Information System (HMIS) maintained by the Los Angeles Homeless Services Authority (LAHSA) and the Department of Health Services' (DHS) Comprehensive Health and Management Platform (CHAMP). While these administrative data were not originally collected for research purposes and are limited in their reliability and completeness, they provide a basis for a descriptive understanding of the characteristics, length of time served, time from entry to move-in to housing, and exits to permanent housing for the 20,668 households served after Strategy B3 implementation. They also permit comparison of characteristics and outcomes of those served following Strategy B3 implementation with the 8,768 households served prior to B3 implementation. Prior RRH funding sources included Supportive Services for Veteran Families (SSVF) funding, Emergency Solutions Grants (ESG) and Continuum of Care (CoC) funding, First Five funding from the state of California, as well as funding from the LA County Department of Public Social Services (DPSS), and more limited city and county general funds.

C. Findings

Strategy B3 has led to more people being served through RRH in Los Angeles County and has provided a larger quantity of more flexible resources than were previously available to meet the needs of RRH participants. Expanded resources also led to a broader set of populations receiving RRH. Moreover, there appear to be improvements in the extent to which people move into housing, the time it takes to move in, and the rates at which people exit to permanent housing without a subsidy following move-in.

At the same time, those served following Strategy B3 implementation appear to remain enrolled slightly longer before exiting compared with those served prior. Moreover, among those with

documented move-in dates, their patterns of exit destinations show key differences. The most significant differences are that those served following Strategy B3 compared to those served prior are more likely to exit to permanent housing without a subsidy (44% v. 30%) but less likely to exit to permanent housing with a subsidy (32% v. 54%); they are also somewhat more likely to exit to an unknown (12% v. 10%) or other (2% v. less than 1%) destination. Due to inconsistencies in the administrative data, these quantitative findings may reflect real changes in RRH operations and outcomes or alternatively may be artifacts resulting from differences in the quality and completeness of data over time and across providers. Additionally, outcomes are not yet known for a substantial portion of those served following Strategy B3, who have not yet exited the program.

There is considerable variability in the way in which RRH has been implemented following Strategy B3. This variability introduces the potential for inequity in service receipt among RRH participants and poses challenges to systematic evaluation of RRH operations under Strategy B3. These findings are described in greater detail below.

Population Served. Expanded resources through Strategy B3 have provided RRH to a greater number of people and a broader set of populations. Over twice the number of participants were served in the three years following Strategy B3 implementation (July 1 2016 – June 30, 2019), compared to the 2-year time period prior (July 1, 2014 – June 30, 2016) to Strategy B3 implementation (20,668 compared to 8,768). In addition, administrative data suggest that the composition of the population served following Strategy B3 implementation is different in a number of ways from those served prior to Strategy B3 implementation. Those served following Strategy B3 compared to the earlier cohort reflect a greater proportion of transition aged youth (7% versus 3%) and females (55% versus 44%), and a smaller relative proportion of single adults (57% versus 61%) and veterans (18% versus 43%). Despite these changes, the total numbers of adults and males served is still larger than it was prior to Strategy B3, while the total number of veterans served is unchanged. The shift in populations likely also has created a shift in the service needs of the participants served, with the biggest difference being higher rates of domestic violence (22% versus 17%) and developmental disabilities (10% versus 7%) in the post-implementation cohort, and lower rates of participants with substance abuse (7% versus 9%), physical disabilities (22% versus 26%), chronic health conditions (25% versus 27%), and mental health conditions (30% versus 32%).

Outcomes. Administrative data suggest that compared to those served previously, the population served after Strategy B3 implementation show improvements in the documented rates at which households move into housing (50% compared to 41%) and the time it takes to move in (an average of 98 days compared to 109 days). At the same time, among those who move into housing, those served after Strategy B3 appear to remain enrolled longer before exiting compared with those served prior. Those served after Strategy B3, compared to those served prior, were more likely to be enrolled for more than 12 months (25% compared to 4%) and less likely to be enrolled for six months or less (44% compared to 77%). This pattern is the same for those who have no recorded move-in date.

Those served after Strategy B3 exit to stable and unstable housing destinations at different rates than those served prior to Strategy B3 implementation. Among those with a record of having moved into housing, those served after Strategy B3 are more likely than those served before Strategy B3 to exit to permanent housing without a subsidy (44% v. 30%). They are, however, less likely to exit to permanent housing with a subsidy (32% v. 54%) and more likely to exit to an unknown (12% v. 10%) or other (2% v. less than 1%) destination.

These findings need to be interpreted with caution given inconsistencies in the data; substantial proportions of those served exited the program without a documented move into housing during enrollment. Those records lacking move-in data encompass both households that never moved into housing and households that moved into housing but are missing a move-in date. It is therefore not clear whether findings represent real changes in outcomes after Strategy B3 implementation versus changes in quality and completeness of the data, or inconsistent approaches to tracking move-ins and exits across providers and over time. Further, outcomes are not yet known for 32% of those served after Strategy B3, who either remain in the program or have no recorded exit.

Resource Availability and Flexibility. Strategy B3 offers a larger quantity of more flexible resources than were previously available. It provides RRH assistance for up to 24 months in duration, with broadened income restrictions to 50 percent Area Median Income (AMI) from the 30 percent AMI required by Emergency Solutions Grant funding, and covers move-in costs not previously covered, as well as furniture assistance and landlord incentive fees. It also includes the ability to serve people experiencing homelessness in Los Angeles County by supporting them to obtain housing outside the county, where housing may be more affordable.

Guidance, Training, and Collaboration. Guidance and training from LAHSA, though initially delayed, has increased over time through a variety of mechanisms and has offered clearer expectations for RRH operations. Collaborative learning is reportedly strong within and across RRH agencies and providers through LAHSA's learning communities, although the type and degree of collaboration around service delivery appears to vary by provider and Service Planning Area (SPA).

Provider Discretion. Despite LAHSA's guidance and training, RRH implementation varies widely and appears to be largely based on provider discretion, as well as factors such as when in the budget cycle a participant enters the program. Providers have discretion in the nature, duration, and amount of both financial assistance and case management provided, as well as how they approach housing location. In addition, households are often referred to RRH through the coordinated entry system (CES), but the prioritization and matching of participants is left to the discretion of the providers, with some consideration of the vulnerability assessment score. As a result, there is a lack of transparency regarding how providers determine who to prioritize for RRH enrollment. Similarly, providers appear to vary in whether they expect households to satisfy requirements beyond LAHSA's eligibility criteria, such as requirements to have income or employment, before being enrolled.

D. Challenges in Implementing RRH

Providers face a variety of challenges in implementing RRH. These are listed below, along with some of the strategies that have been tried to address them. In some cases, these strategies have resulted in new challenges, which are also described.

Lack of Standardized Policies Around RRH Prioritization and Implementation. As described above, the implementation of RRH is left to the discretion of the providers and the resulting variability is exacerbated by a lack of standardized policies around prioritization for RRH within CES. LAHSA has considered plans to standardize the CES process across all SPAs, prioritizing and matching to RRH the highest acuity participants (who are not matched to permanent supportive housing [PSH] or another deeper resource). These plans, however, were evolving as this evaluation

was underway, amid provider concerns that prioritizing high acuity participants would exclude those of lower acuity who could benefit from RRH and do not now qualify for other resources, prioritize those who have a lower likelihood of retaining the housing, and make it difficult for providers to serve those they believe could benefit from RRH. Training and technical assistance offered by LAHSA that could ultimately lead to greater consistency in RRH practice requires a significant investment in time and resources by both providers and the system, exacerbated by staff turnover requiring additional trainings.

The current lack of prioritization standards has a particular impact on family providers, who believe they are expected to serve all families. This perceived expectation reportedly results in over-enrollment and/or high caseloads. In addition, the family system is expected to provide crisis housing for all families that are not immediately rehoused. Families who participated in our focus groups expressed strong concerns about the quality and safety of the available crisis housing, and confusion about whether staying in crisis housing was a prerequisite to receive RRH assistance.

Difficulty Securing Sustainable Housing and Engaging Landlords. It is reportedly difficult to find affordable housing in the tight and costly Los Angeles County market and engage landlords in renting to RRH participants. Strategy B3's flexibility in allowing providers to house people experiencing homelessness in Los Angeles County in other more affordable geographic areas outside of the county was noted as helpful, particularly by providers that border other counties. Other strategies perceived by providers as improving landlord engagement and helping to find and keep sustainable housing include one-time incentives for landlords, an increased focus on shared housing as a strategy, and specialized housing location services. While useful, these strategies also bring new challenges that require new solutions. Use of one-time incentives has helped secure units but has led to competition among housing programs for housing slots as well as reportedly attracting some landlords who engage in illegal or unethical practices, such as charging large fees. Shared housing requires participants to navigate roommate relationships, often requires additional case management support, and is not feasible for all participants. Challenges to specialized housing location and retention efforts thus far include difficulties holding units for shared housing and identifying landlords willing to participate in RRH programs. The Shallow Subsidy program, recently implemented, is perceived as potentially helpful in sustaining housing, but has generated early concerns that the program has restrictive eligibility and may provide insufficient support, although there is not yet sufficient data to evaluate this concern.

Staff Turnover. There is reportedly a high rate of staff turnover, due to the challenging nature of the work itself and high availability of jobs in the field. Challenges of the work that may contribute to turnover include frustrations brought on by difficulties inherent in the position and high caseloads, as well as staff concerns that they are unable to provide the assistance needed to successfully stabilize participants in housing, particularly those with higher needs.

E. Recommendations

The recommendations below are provided to address these challenges.

- ✓ **Improve Program and Provider Consistency.** Enhanced provider consistency in RRH delivery would permit a stronger evaluation of program implementation and outcomes and might lead to improved client outcomes, transparency, and equity of access. Although RRH is intended to be implemented on a case-by-case basis, the

quality of assistance should not depend on where and when participants access services. Continued training and guidance, tied closely to the program requirements and expectations, may help to improve consistency within and across provider organizations. In addition, system administrators' efforts to standardize the way in which CES operates across Service Planning Areas (SPAs) and to systematize the prioritization and matching process, should help provide greater consistency in who receives RRH. Using data to monitor implementation of these procedures and assess whether differences in outcomes relate to differences in vulnerability scores should help administrators of RRH programs to guide and communicate about the process. Moreover, by involving persons from all levels and perspectives in RRH (program managers, case managers, participants, landlords) in planning and decision-making around RRH/Strategy B3, administrators can facilitate buy-in as well as avert possible additional challenges in the decisions that are made.

- ✓ **Enhance Landlord Cultivation.** Navigating the private housing market was described by many as a central but difficult component of the RRH program model. As efforts to engage landlords proceed, it will be worth gathering targeted information on what has worked to date and what barriers have been encountered by providers and housing location and retention specialists. Efforts are needed to standardize landlord incentives so that all programs have similar tools and those receiving RRH through Strategy B3 are not at a disadvantage relative to those with other subsidies. Putting in place practices that mitigate perceived risks among landlords may also be helpful. These may include further increasing available incentives, offering risk mitigation funds, and developing and implementing best practices for RRH providers around communicating with landlords from the outset when RRH participants move into housing through the end of RRH assistance.

- ✓ **Address Staff Turnover.** Strategies to retain staff should be a priority given the reportedly high turnover. It may be helpful to increase salaries as well as ensure that caseload mixes afford staff the capacity to adequately support their participants. Where possible, it may also be helpful to give staff alternative resources to offer RRH candidates who are lower priority, including problem-solving (diversion) resources.

- ✓ **Improve and Clarify the Relationship between Crisis Housing for Families and RRH.** Families in RRH that we interviewed believed that they were required to stay in crisis housing while working on finding housing through the RRH program. While some crisis housing was provided in motels, some of it was through shelters or other forms of temporary congregate housing. Families had significant concerns about these places; they found them uncomfortable, overcrowded, unsafe, and seemingly arbitrarily regulated by the agencies providing them. The relationship between the requirements of these programs and the RRH program was not clear and created confusion for families. Crisis housing is outside the scope of this evaluation; however, efforts appear warranted to clarify whether families must stay in crisis housing to receive RRH assistance.

- ✓ **Monitor and Improve Data Quality and Track and Report Outcomes Including by Time in Program and Acuity.** Available administrative data have a number of inconsistencies and quality concerns that limit interpretability of findings for this report and the potential usefulness of data to providers and the system moving forward. Our

inability to reconcile inconsistent findings and to distinguish missing data from a move-in not occurring highlights the need to place greater attention on enhancing the completeness and quality of the data to guide program decisions. Relatedly, concerns were raised by providers that RRH is being used more for people of higher acuity, who may not be successful. We did not see evidence to support the perceived increases in acuity, although this was another area where data were limited. Tracking the impact of the programs for clients served and being able to distinguish trends and differences in population outcomes from anecdotal experience is critical, especially if RRH will be offered to those with higher needs.

List of Acronyms

AHAR	Annual Homeless Assessment Report
AJCCs	America's Job Centers of California
AMI	Area Median Income
CBEST	Countrywide Benefits Entitlement Services Team
CEO	Chief Executive Office
CES	Coordinated Entry System
CHAMP	Comprehensive Health and Management Platform
CoC	Continuum of Care
DCFS	Department of Children and Family Services
DHS	Department of Health Services
DPSS	Department of Public Social Services
DV/IPV	Domestic Violence/Intimate Partner Violence
ESG	Emergency Solutions Grant
FHSP	Flexible Housing Subsidy Pool
FSCs	Family Solutions Centers
GPD TIP	Grant and Per Diem Program Transition in Place
HACLA	Housing Authority of the City of Los Angeles
HI	Homeless Initiative
HJC	Housing and Jobs Collaborative
HMIS	Homeless Management Information System
HOH	Head of Household
HPI	Homeless Prevention Initiative
HPRP	Homeless Prevention and Rapid Re-Housing Program
LACDA	Los Angeles Community Development Authority
LAHSA	Los Angeles Homeless Services Authority
PATH	People Assisting the Homeless
PH	Permanent Housing
PSH	Permanent Supportive Housing
RFP	Request For Proposals
RRH	Rapid Re-Housing
SNAP	Supplemental Nutrition Assistance Program
SPA	Service Planning Area
SRS	Scope of Required Services
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSVF	Supportive Services for Veteran Families
TANF	Temporary Assistance for Needy Families
TAY	Transition Age Youth
VA	Veterans Administration
VASH	Veterans Affairs Supportive Housing
VI-SPDAT	Vulnerability Index – Service Prioritization Decision Assistance Tool
WIC	Supplemental Nutrition Program for Women, Infants, and Children

Section I. Introduction

A. Background

Rapid re-housing (RRH) provides time-limited rental subsidies to people experiencing homelessness, along with supportive services, with the goal of helping them to access housing quickly. In Los Angeles County, RRH as funded through Strategy B3, is one of the original strategies approved by the Los Angeles County Homeless Initiative (HI) in February 2016 (Los Angeles Chief Executive Office, Los Angeles County Homeless Initiative, 2016). The primary goal of Strategy B3 is to expand the availability of RRH for multiple populations. Initially funded through a one-time $26 million investment of state and county funds,[1] Strategy B3 received an infusion of additional ongoing funds through the passage in July 2017 of the county's ballot initiative to prevent and combat homelessness, Measure H, with increasing investment over the past 3 fiscal years that has led to continued expansion in the number of RRH programs operating during this time period (Los Angeles County Homeless Initiative, (2019a).

This report provides the findings from a mixed-methods evaluation of the implementation and client-level outcomes of RRH under the strategy. The evaluation, conducted by Westat, a national research organization, in partnership with California-based consultant Katharine Gale, was funded by Los Angeles County's Chief Executive Office (CEO) to shed light on the practices and procedures under the strategy and to inform policy decisions around the future use of Measure H revenue.

This report begins with an overview of the background and evaluation methodology in Section I, followed by the key findings in Section II related to the operation of the initiative, including funding and growth, training and guidance, and collaboration around implementation, and the nature of financial assistance and supports provided through RRH. In Section III, the report then describes what is known thus far about how participants are identified and enrolled and the characteristics and outcomes of participants served, followed by a set of conclusions and recommendations in Section IV.

B. Evaluation Purpose and Methods

This evaluation aims to answer the following overarching question:

> *How has Strategy B3 affected the operation and outcomes of rapid re-housing in Los Angeles County?*

Table 1 outlines specific questions encompassed within this question, mapped onto the methods of data collection and data sources.

[1] $10 million in funding for single adults had been approved by the Board of Supervisors on October 13, 2015 prior to the one-time allocation of an additional $26 million under the strategy approved by the HI in February of 2019. These included $8 million in one-time Homeless Preventive Initiative (HPI) funds was approved in February of 2019 ($5 million of which were allocated to serve families and $2 million of which were earmarked for transition age youth [TAY]). Additional funds came from $11 million in one-time SB 678 funding and $7 million in one-time AB 109 funding.

Table 1. Specific evaluation questions and methods to address them

Methods	Analysis of extant records		Interviews		Focus groups	
Sources	Documents /quarterly data	Admin data	Agency administrators	Program directors	Front line staff	RRH participants
How has Strategy B3 affected the operation of Rapid Re-Housing in Los Angeles County?						
Have there been changes in:						
Nature of funding sources (variations in requirements and restrictions by type)	✓		✓	✓		
Training and guidance provided around RRH implementation	✓		✓	✓	✓	
Nature of financial assistance (structure, timeline, amount)	✓		✓	✓	✓	✓
Services and supports received (Amount and nature of case management)	✓		✓	✓	✓	✓
Housing location and navigation	✓		✓	✓	✓	✓
How participants are identified and enrolled, and the characteristics of the populations served through rapid re-housing?	✓	✓	✓	✓	✓	✓
What are the key challenges that providers and administrators face in implementing RRH?			✓	✓	✓	
What are the client-level outcomes of RRH, including length of stay in rapid re-housing, and exits to non-subsidized and other permanent housing Do these differ from those of RRH prior to Strategy B3 implementation?	✓	✓				
How are outcomes influenced by provider approaches to RRH implementation, and individual differences within and across populations?			✓	✓	✓	✓
What are the sources of variation in these findings?						
How do the operations, implementation challenges, and outcomes of RRH vary by provider, service planning area (SPA), or population served?	✓	✓	✓	✓	✓	✓

Our evaluation methods are summarized in Exhibit 1 and described further in Appendix A. We reviewed documents to understand how Strategy B3 evolved over the implementation time period and to inform the development of the data collection protocols and analytic plan. We collected data

on the status, operation, and client service and housing experiences through multiple methods, including extracting extant administrative data, key informant interviews with government agency administrators and directors of service and housing agencies administering RRH, and focus groups with frontline staff and RRH participants in several of these agencies. A sample of 13 housing providers was selected to maximize representation of providers serving all populations (families, single adults, and youth) across all SPAs, with 13 director interviews, and four staff and five participant focus groups with a total of 53 participants conducted in the three largest SPAs (2, 4, and 6). Qualitative data from the documents, interviews, and focus groups were coded through iterative analysis, aided by an analysis software program, NVivo, to identify key themes. Quantitative administrative data, extracted from the Homeless Management Information System (HMIS) maintained by the Los Angeles Homeless Services Authority (LAHSA) and the Department of Health Service's (DHS) Comprehensive Health and Management Platform (CHAMP), were used to describe the population with respect to (1) sociodemographics and needs; (2) enrollment and length of time served; and (3) client-level outcomes, including time to obtaining housing and exits to permanent housing. Administrative data also permitted comparison of characteristics and outcomes of the 20,668 households served following Strategy B3 implementation with the 8,768 households served prior to Strategy B3 implementation. Prior RRH funding sources included Supportive Services for Veteran Families (SSVF) funding, Emergency Solutions Grants (ESG) and Continuum of Care (CoC) funding, First Five[2] funding from the state of California, as well as funding from the LA County Department of Public Social Services (DPSS), and more limited city and county general funds.

Exhibit 1. Summary of key evaluation methods

Document Review • Review of strategic planning documents, budgets, aggregate data, and other agency records
Interviews and Focus Groups • Individual interviews with key administrators (N = 18) and housing program managers from all SPAs (N = 13) • Four focus groups with 5-12 direct line staff (Total of 29 participants) in the three largest SPAs (2, 4, and 6) • Five focus groups with 2-8 RRH participants (Total of 24 participants) in SPAs 2, 4, and 6 • Four interviews with key informants around housing navigation/location (two landlords, People Assisting the Homeless [PATH] LeaseUp Program, and Brilliant Corners)
Administrative Data • Sample: All households served through RRH since Strategy B3 implementation (July 1, 2016) and 2 years prior (July 1, 2014 – June 30, 2016) • Data sources: HMIS and CHAMP

[2] First Five California is an initiative to bring services to young children (ages 0-5) and their families in the state of California. The initiative is funded through revenue generated by a state sales tax on cigarettes.

Section II. Understanding the Operation of Rapid Re-Housing Under Strategy B3

A. History and Funding

RRH is a short- to medium-term rental assistance and supportive services intervention designed to help people experiencing homelessness move quickly from homelessness into permanent housing (United States Interagency Council on Homelessness [USICH], 2016). The primary goal of RRH is to help individuals and families quickly exit homelessness and return to permanent housing with a reasonably high expectation of being able to maintain it after the program is over. RRH consists of three core components: (1) housing identification, (2) rental and move-in assistance, and (3) case management and services. This evaluation examines how the various components of RRH have been implemented under Strategy B3.

Figure 1 illustrates the timeline of Strategy B3, which has been implemented in stages. Los Angeles County's DHS's Housing and Jobs Collaborative (HJC) was the first Strategy B3-funded RRH program, which funded RRH for single adults in January of 2016. LAHSA subsequently began administering RRH for families and TAY later that year. In July of 2017, LAHSA's administration of RRH funds for single adults began (Los Angeles County Homeless Initiative, 2019b). Figure 1 depicts a timeline of the strategy. In the early stages, the agencies leading the strategy (DHS and LAHSA) focused on partnering with the cities to expand the availability of RRH, using both city and county funds. With increased availability of funding through Measure H, the focus has shifted to expanding RRH for multiple populations and to new efforts to standardizing the quality of implementation as well as introducing new RRH pilots and initiatives tailored to the needs of RRH participants that have emerged over the course of the strategy implementation (Los Angeles County Homeless Initiative, 2019b). The introduction of Strategy B3 brought $26 million in new one-time funding and additional annual revenue through Measure H, which has been awarded in increasing allotments thus far (Los Angeles County Homeless Initiative, 2019a): $57 million (FY 2017-2018), $73 million (FY 2018-2019), and $86 million (FY 2019-2020).

Figure 1. Timeline of implementation of strategy B3

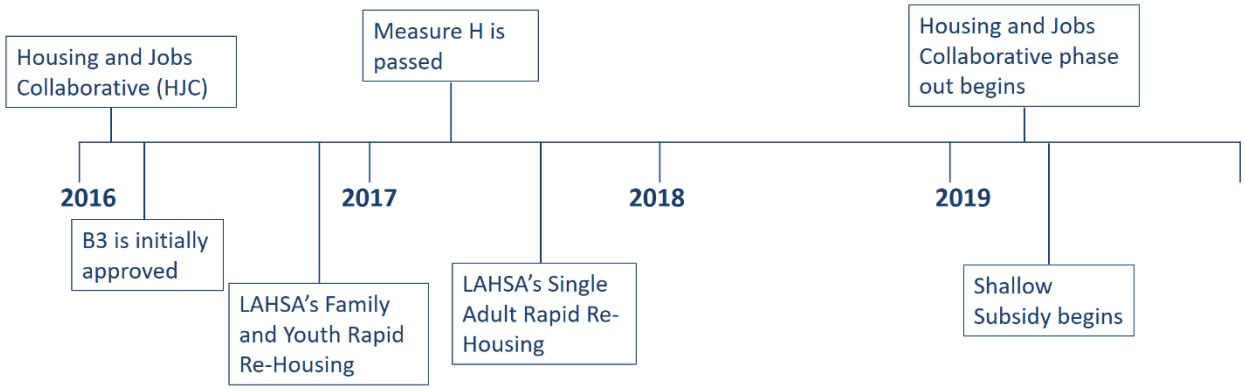
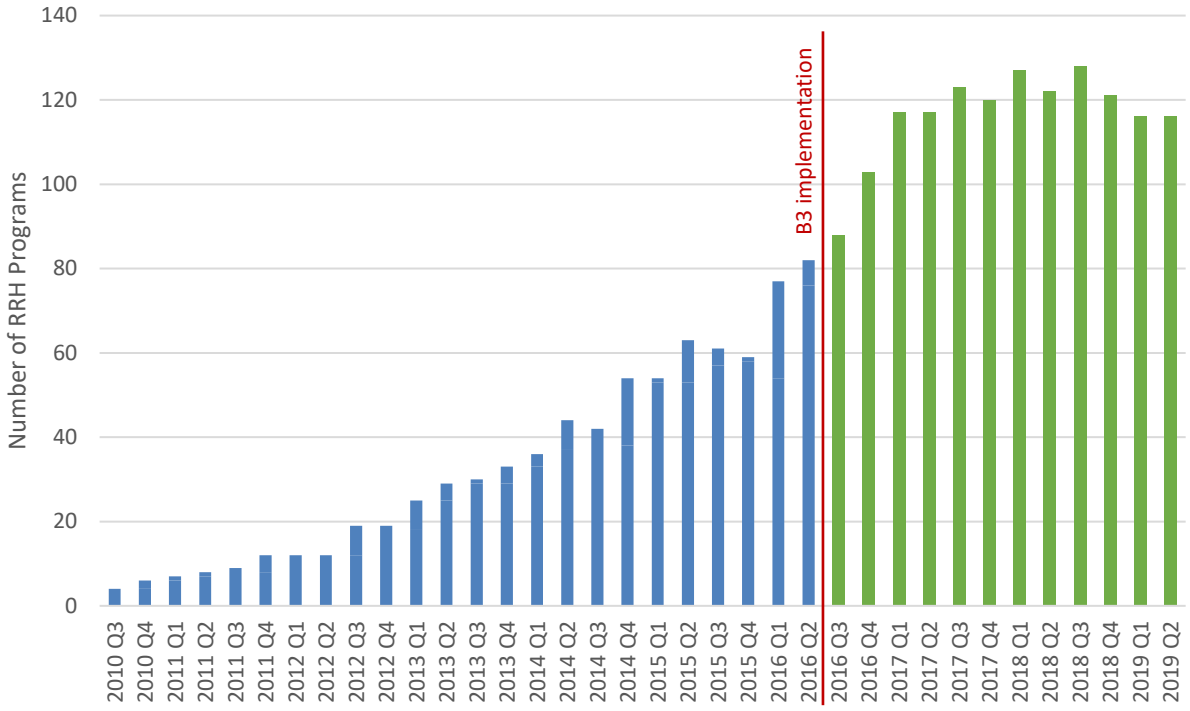


Figure 2 illustrates this growth, depicting the number of RRH programs[3] serving participants in the region between 2010 and 2018, as documented in HMIS.

Figure 2. Rapid rehousing programs in operation 2010-2019



Following implementation of Strategy B3 from July 1, 2016 until July 1, 2019, analysis of the HMIS/CHAMP data indicate that 20,668 households were served in RRH during the 3 years of implementation, as compared with 8,768 served in the 2 years prior to Strategy B3 implementation.

Below we describe our findings regarding the operation of RRH and client outcomes under Strategy B3, including

1. The availability and sufficiency of funding;
2. Training, guidance, and support provided around implementation;
3. Collaboration around the strategy occurring within and between housing providers and other agencies;
4. What constitutes RRH: financial assistance, case management, housing identification and navigation support;

[3] RRH programs depicted are all projects of type 13 documented in HMIS during this timeframe. It is possible for a single agency to operate multiple projects.

5. How participants are identified and enrolled in RRH programs, and the characteristics of those served; and

6. Client-level outcomes, including length of stay in RRH, and exits to permanent housing.

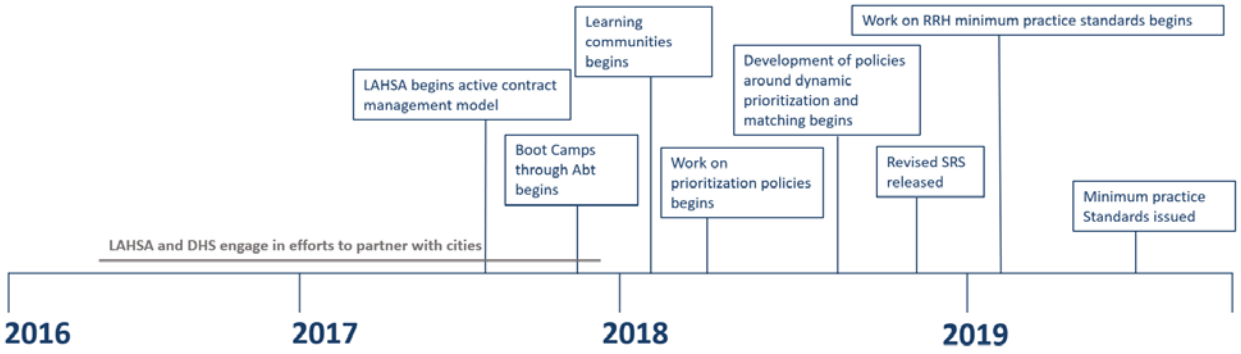
B. The Availability and Sufficiency of Funding

Strategy B3 offers more resources and more flexible resources than were previously available, and therefore, can serve greater numbers of people. The overwhelming perception of program managers interviewed was that there is more assistance on a larger scale than was available prior to the strategy. In general, Strategy B3 was perceived as relatively more flexible, providing assistance for a longer duration, and having broader eligibility compared with other current and prior funding sources, including Department of Public Social Services (DPSS), Continuum of Care (CoC), Emergency Solutions Grant (ESG), and Homeless Prevention and Rapid Re-Housing Program (HPRP) funding. Strategy B3 allows coverage of costs not previously covered , such as move-in costs, furniture assistance and landlord incentive fees. RRH under Strategy B3 also includes the ability to house people experiencing homelessness in LA County outside the county, where housing may be more affordable. In addition, its income restrictions are more generous than ESG funds; ESG funds restrict recertification to households with 30% of the area median income (AMI) whereas Strategy B3 has broadened income restrictions to 50% AMI, thus allowing more people to be served within the program, and for people to stay in the program longer despite income changes.

C. Training, Guidance, and Collaboration

Guidance and training around implementation have evolved over time. Providers noted that initially limited guidance was offered around implementing RRH under Strategy B3. For example, new guidelines were issued for assistance duration and the appropriate target population as the strategy was already being rolled out. As illustrated in Figure 3, over time, guidance and training has improved. LAHSA has added trainings and provided more formal guidance around standards and best practices to standardize implementation. LAHSA has updated the most recent Scope of Required Services (SRS) to be more specific than earlier iterations, including the definition of RRH, the nature of case management and progressive engagement, the role of problem solving/diversion, and the processes for assessing and identifying participants and determining their eligibility for the program. Minimum practice standards are currently under development, but have not yet been rolled out. LAHSA's current RRH coordinator also provides one-on-one technical assistance to providers on an as-needed basis. While this help was lauded by many providers, it came late in their implementation of the program.

Figure 3. Training and guidance around strategy B3 implementation



Formal trainings from LAHSA that are currently in place include a 2-day boot camp training for new frontline staff and program managers that provides introductory information on how to apply RRH best practices. LAHSA's "learning communities," begun in 2018, allow providers to exchange information and resources on a range of topics (e.g., information on available local resources to help participants, understanding leases and preventing evictions, and progressive engagement). Overall, many interviewed noted that expectations are clearer, more training support is provided, and more consistency in guidance is now available than when the expansion was launched, but there is still a very broad range of implementation and understanding of the expectations, which we discuss further below.

One challenge to the training and technical assistance is the resources and time that need to be devoted to it, by providers as well as the system at large. In particular, turnover in staff results in an ongoing, fairly significant investment of time and resources to continue to train new staff. Six months was the estimate to get new staff trained sufficiently and comfortable doing the job. In addition, staff must travel to attend the boot camp trainings and the learning communities, which can be a significant investment in travel time for some providers given the wide expanse of the county.

Collaborative learning around RRH implementation is occurring across RRH providers, while the type and degree of collaboration by providers around service delivery varies by provider and SPA. LAHSA's learning communities provide vehicles for collaborative learning, as providers across SPAs come together to share resources and receive shared guidance around implementation. The SPA-level organization of the Coordinated Entry System (CES) means that collaboration around client identification and enrollment is organized within SPAs and by population. Providers reported collaborating with a variety of other service providers within their SPA in order to link participants to needed services beyond rapid rehousing assistance (e.g., child care, employment assistance). Providers that rely more heavily on other service providers for resources such as employment services and mental health services report collaborating more than providers that can refer to in-house programs.

Within providers, there is staff-level collaboration between case managers and other staff, including housing navigators. In some cases, participants noted a need for better communication between case managers and other staff within and across organizations, including better communication with housing navigators who liaison with landlords and/or more involvement by case managers in

monitoring housing situations and advocating for them with the house managers in family crisis housing.

D. What Constitutes RRH: Financial Assistance, Case Management, Housing Identification, and Navigation Support

Strategy B3 provides more financial assistance for a longer period of time with greater flexibility. As noted earlier, financial assistance under Strategy B3 can be provided for a longer duration, with fewer eligibility restrictions, and with more flexible coverage of costs than other prior and current funding sources. For example, it covers financial assistance for up to 24 months, compared to earlier programs with 4 and 18 month caps.

Different Provider Approaches to RRH Rental Assistance

- One size fits all as a starting point
- Step-down approaches (e.g., decrease each month by 10% or each quarter by 25%; or 100% rental assistance for 4-6 months followed by monthly or quarterly reductions)
- Using a tool that considers income, rent, and assessment scores to determine monthly payments
- Case by case, based typically on case manager determination in consultation with participant

Program managers and frontline staff noted appreciation of the ability to tailor the financial assistance better to individual needs. In addition, having fewer restrictions in eligibility than funding sources such as ESG and DPSS, and having resources plus the subsidy to cover furniture assistance, transportation, application fees, utility bills, and other one-time needs related to move-in is perceived to be helpful by all (program managers, frontline staff, and participants).

Despite the increase in duration of the financial assistance, some providers and RRH participants are concerned that it can still be insufficient in some cases. Some providers and recipients perceive that the longer term assistance still may not meet the needs of all participants. For example, some households currently served in RRH have received more than 2 years of rental assistance and are not yet able to pay full rent. Others may stabilize and become independent and able to pay the rent, but have a sudden change in circumstances close to the end of their financial assistance which requires an increase in financial assistance and an extension of the assistance. Some participants expressed that even when they were working, their income was insufficient to cover their rent. Additionally, program managers and frontline staff worry that the financial assistance may not be enough to begin with given the housing market, will be insufficient to allow participants to stabilize in housing, or will leave participants with enough income to stay in housing but in a state of food insecurity. Some families echoed that the cost of rent left them with insufficient resources to cover their children's basic needs, like food or clothing. Other participants indicated that the funding at their particular program does not cover all costs, such as rental application fees and transportation subsidies, which can lead to missed opportunities to secure housing.

Some approaches to addressing these issues were described by program managers and administrators. An extension beyond 24 months is available upon request through LAHSA for those who need it. Providers also noted that some participants have qualified for and transitioned to a higher level of service, such as permanent supportive housing under Strategy D7. Finally, LAHSA

has introduced a new Shallow Subsidy program to provide a smaller amount of extended assistance, which is described further below.

There is not yet a systematic approach to determining the nature of financial assistance. The nature of the RRH financial assistance (duration, amount, and what is encompassed) provided to each client is determined by the provider organization, but is also influenced by the time of year the assistance is provided. Most providers report that the assistance is determined on a case-by-case basis, per LAHSA's SRS. However, assistance provided also appears to vary considerably by provider. The method for determining the rental subsidy amount is not always clear or consistent with participants' needs, according to both staff and participants. In addition, participants varied in how well they understood what to expect in duration and amount of assistance, some understanding the program to be very short, others believing it lasts a year or more with an ability to extend, and some understanding it as very flexible and undetermined.

In addition, the availability of funding in a provider's budget, especially at the end of the year, influences the amount and duration of financial assistance offered. As the fiscal year nears its end, some program managers reported that RRH provider organizations often have less funding available and only enroll people for short-term assistance because providers lack confidence they will have the funding to carry over or because they need to meet enrollment metrics. This reportedly results in less assistance than they may have provided the same client at an earlier time in the budget cycle. Similarly, some program managers and staff noted the difficulty in determining how much financial assistance is needed and to predict how much will be needed in the future by a particular client. This has reportedly been challenging from a budgetary and planning perspective, and several interviewees emphasized a need for stronger coordination between the housing providers' services and finance staff.

Similar to financial assistance, the nature of case management (amount, supports, caseloads) varies by provider as well as by population served. Program managers were consistent in their reports of what the minimum amount of case management should be and both participants and program managers and staff across our interviews and focus groups shared similar descriptions of the services to which case managers connect participants. However, beyond these two dimensions, case management varied considerably across provider and population served.

The size of caseloads varied by both provider and population, with the lowest caseloads (at approximately 20:1) for youth and highest for families, which were generally reported as being around 40:1 but could be as high as 60:1.

RRH provider organizations varied in the duration of case management they provided and whether and for how long it continued after rental assistance ended. Some reported it ended a set number of months after move-in and others reported it could continue for a longer period of time, even after the financial assistance ends.

Case Management

Minimum of one meeting per month (consistent with the SRS)

Connection with other services (Countywide Benefits Entitlement Services Team Program, child care, mental health services, and, in some cases, employment services).

Vary by provider and population:

- **Caseload size**
- **Amount and duration of case management provided**
- **Specific types of hands-on services**
- **Home visiting**

Finally, program managers, frontline staff, and participants were variable in their reporting of the extent to which case managers provided other services. Home visits were rare, although a few program managers did report providing monthly case management through home visits to some of their participants. In addition, some providers and their participants described case managers working on budgeting, credit and financial planning, and housing plans, as well as providing orientation to the participant's new neighborhood, including information about where potentially helpful local services could be found. Case management support appeared higher for youth than for other populations, with more of a focus on increasing income through employment and vocational assistance. Although differences varied by provider, providers' descriptions of services suggested more of a focus on connecting families to services, with for example linkage to Countywide Benefits Entitlement Services Team (CBEST) and child care services noted by a number of family providers.

Participants described varying experiences of the quality of case management received and outstanding unmet needs. Some participants in our focus groups reported having had a lot of case management support with the process, but others indicated their case manager was unavailable or doesn't help or listen, or "is new and doesn't know anything." In some cases, participants currently had a responsive case manager but reported less positive experiences with prior RRH case managers.

Areas with which participants noted they would like additional assistance include finding employment or vocational training assistance and child care, services not consistently accessed through housing providers. In particular, some youth participants in the focus groups stated that they were required to have a job to be enrolled in RRH, but that they had to find the job independently and would have found assistance helpful. There was some perception among providers that youth and families may need longer durations of assistance and more case management than single adults.

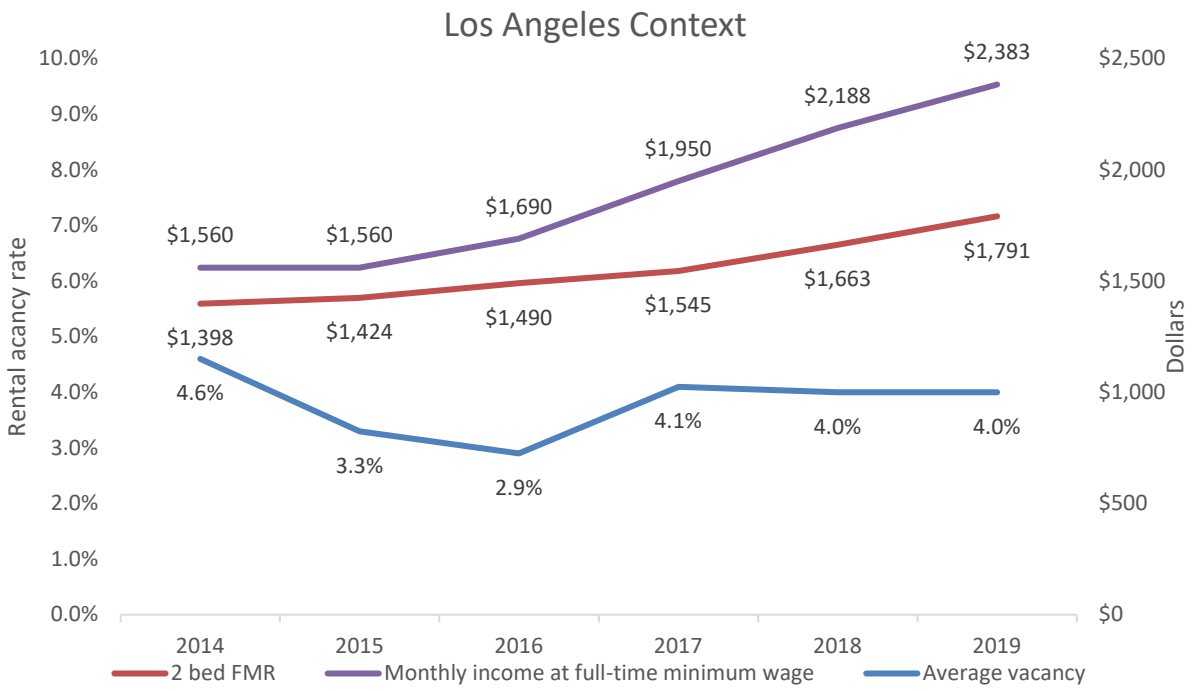
Turnover among case managers and direct service staff is high and affects the operation of RRH in a number of ways. A number of case managers and supervisors interviewed had been in their role for less than a year. Among frontline staff focus group participants, the majority (65%) had been in their positions for 2 years or less. Factors believed to contribute to high turnover among frontline staff are the high availability of jobs in the field coupled with some frustrations brought on by difficulties with the position and high caseloads. Difficulties included serving high acuity participants who staff perceive to need more support than they can offer, the inability to provide financial assistance to the numbers in need or when participants do not stabilize in housing, the inability to provide the needed level of case management support, changing implementation guidelines, and agencies not adhering to staff recommendations regarding participants' level of need for financial assistance.

Providers and participants report difficulty finding housing with the limited availability of affordable units. As a result of the tight housing market and high housing costs in Los Angeles County, staff report that it is getting harder for people to find housing and the time to find housing is growing. Program managers and staff reported that time to finding housing depends on a variety of factors, including the client's housing barriers (such as eviction and credit history), as well as whether the participant has income and is willing and able to share housing, which can expedite the housing location process. Program managers and staff also indicated that it is often necessary to work with participants to adjust their expectations around the type and location of housing they can afford after RRH assistance expires; in some cases, participants may find it necessary to move to a less central location or one further from their preferred area of residence to be able to find

affordable housing. Participants reported housing search times that varied from less than a month to a full year.

To provide context, Figure 4 below displays the vacancy rates, and the cost of housing relative to minimum wage earnings in Los Angeles County. The data show that over the past 5 years, overall vacancy rates (not just those within the affordable housing range) hit a low of 2.9 percent in 2016, but have increased to about 4 percent in the last 3 years. Both income and housing costs have increased, though the ratio of the minimum wage to the cost of housing has increased.

Figure 4. Vacancy rates, fair market rent, and minimum wage monthly income (2014-2019)



Analysis of administrative data on participants served through the RRH program after Strategy B3 implementation (July 1, 2016 - July 1, 2019) indicate that the average time from enrollment in RRH to move-in was 109 days (but this measure ranged widely, from less than a week to more than a year). This is longer than the average time to move-in following implementation of Strategy B3, which was 98 days (a small but statistically significant difference), although it is not clear what factors may be contributing to this difference. It is also important to acknowledge that variations in this time frame could be driven by variations in provider practices around the timing of enrollment relative to housing location as discussed further below.

Staff and client roles in housing location vary across provider and population served. There are two overarching approaches among providers supporting participants' housing location efforts: Having separate staff to do the housing location (some with specialized staff devoted specifically to identifying units and building landlord relationships) and having case managers assume the housing location role and assist participants with the housing search. It is unclear how these different models impact client outcomes.

According to both staff and participants interviewed, expectations vary both within and across providers around the role of the participant in the housing search process, as does the corresponding level of support case managers or housing navigators provide. Some participants find the housing themselves and bring it to the provider when they are ready to sign the lease. Others are given light support, such as a list of housing locations from the provider. In many cases, participants have help from a housing navigator or case manager, who may identify potential housing opportunities and accompany them to view units. Across populations, youth appear to need and receive more housing location support than other populations, including help screening possible housing and meeting with and talking to landlords. Youth providers sometimes have master lease housing and offer youth placements in that housing, or alternatively identify housing options in the community to which youth are referred. Overall, participants interviewed from all three populations perceived the housing search as difficult, and help with housing navigation to be useful.

RRH requires working with private landlords. Engaging landlords and securing and keeping housing in a tight rental market is one of the biggest challenges reported by program managers, frontline staff, and participants. Landlord reluctance to accept RRH participants as tenants is, in part, due to the limited duration of the rental assistance, reluctance to accept third-party checks, and the competitive housing market. Landlords also note a perceived risk around accepting tenants with housing barriers; similarly, participants indicate that the stigma of homelessness makes it difficult for them to find a landlord willing to rent to them.

Fostering good relationships with private landlords, therefore, has become an important activity for providers administering RRH. Through Strategy B3, in addition to the rental assistance, providers have resources to offer landlords incentives such as a one-time "signing" fee or providing 1 month's rent to hold a unit. However, the greater availability of funding for RRH assistance, as well as the new incentives, have brought new challenges. One provider indicated "we've created a bit of a monster," as some landlords expect one-time incentives on an ongoing basis. Different housing programs also offer competing incentives, and landlords are aware of the relative benefits that come with tenants with different sources of housing support. For example, one interviewee noted that rental subsidies through the Flexible Housing Subsidy Pool (FHSP) come with longer holding fees than other types of subsidies. Growth in available rental assistance and incentives create several unintended consequences such as competition for housing slots within and across providers and attraction of some landlords who engage in illegal or unethical practices, such as charging large fees, refusing to repair units, and finding ways to move a client out once the subsidy expires in order to get a new move-in.

Two landlords were interviewed about their perspectives on housing tenants with RRH assistance. Both work with PATH's LeaseUp program (described below) and primarily rent to single adults who are referred through housing agencies. The landlords stressed how they value the role that case managers play, and that knowing there is case manager support provided is a more important consideration in renting to a tenant than financial incentives, although these are also considered helpful. Both landlords communicate frequently with tenants' case managers and perceive this communication as essential to addressing tenant issues when they arise. At times, the landlords apprise the case managers when tenants need support. One of the landlords who primarily provides shared housing arrangements reported initiating frequent communication with case managers and taking on more of a case management role over time. This reportedly included assessing tenants' employment and financial plans at the time of application, matching them to compatible roommates, providing job referrals once they are housed, and instituting housing arrangements intended to

mitigate disputes between tenants. The landlord became engaged in these activities after experiencing tenant issues early in the program, including receiving threats from tenants and witnessing disputes between tenants that resulted in police involvement.

The landlords interviewed also reported a need for ongoing case manager involvement as needed during the tenants' transitions off of RRH assistance. One landlord noted that it is not uncommon for tenants to be unemployed when their assistance expires; in these situations, the landlord works with the case managers to arrange to relocate tenants unable to pay rent rather than formally evict them. The other landlord reported challenges around not being informed when a tenant transitions off of assistance, especially when the tenant subsequently experiences difficulties paying rent or other tenant issues. This landlord indicated that it would be helpful to have a roadmap for who to call or how to proceed if difficulties arise after a tenant graduates the program.

In addition to communication and responsiveness, the landlords recommended other strategies that may be useful in engaging other landlords, including providing more rental assistance or compensation for the added time needed to manage properties with high-need tenants, and providing resources (e.g., holding fees, risk mitigation, and compensation for gaps in unit occupancy) to offset the perceived risk around relaxing standard screening criteria for rental applications.

Strategies and solutions are under development to increase the pool of sustainable affordable housing. Shared housing and a shallow subsidy program are two strategies intended to provide more sustainable opportunities to house people, especially after the RRH financial assistance is completed. Additionally, specialized housing location and retention efforts through PATH's LeaseUp Program and Brilliant Corners Housing Location and navigation services are an additional strategy to expedite housing location and facilitate long-term housing stability.

Shared housing is cited often by providers as one solution to the problem of finding and keeping sustainable affordable housing, particularly for youth and single adults. Providers and landlords perceive that participants are more likely to be able to retain shared housing long term. However, this approach has its own challenges: It does not lend itself to certain housing location approaches such as the use of large-scale holding agreements, which have been used to hold a large number of units vacant while matching them to RRH participants, but have been found to remain open for too long when awaiting placement of multiple disparate people into a single housing location. It also requires participants to navigate roommate relationships; it may require additional case management support to help mediate roommate issues; and it is not a solution for everyone given that some participants are unwilling or unable to live in shared housing arrangements.

The Shallow Subsidy program was developed by LAHSA, and a request for proposals for the program was issued in July 2018 and awarded to the Salvation Army in January 2019. The goal of the program is to provide financial help to RRH tenants who are no longer in need of case management services and whose financial assistance is expiring, but who are unable to afford market rate housing. The Salvation Army received an annual investment of $12 million from February 2019 through June 2021, to begin implementation in April 2019. The program offers a security deposit (if needed) and a monthly amount of $300 for a one-person household or $500 for a multi-participant household for up to 5 years. RRH tenants eligible for the subsidy must meet all of the following criteria: Be waitlisted for subsidized or affordable housing, be currently housed and exiting RRH within 120 days, have income under 50 percent AMI, be paying 60 percent or more of their total income towards their current rent, and not be in need of intensive case management or other long-term service (LAHSA, 2018). The Shallow Subsidy program was in its early implementation during our evaluation and program managers interviewed had limited experience with actually using it. However, early concerns raised are that the program has restrictive eligibility that means many participants may not qualify, and that it may provide insufficient monthly amounts, particularly for families.

PATH and Brilliant Corners are two non-profit community organizations that operate specialized housing location and retention efforts. PATH, a housing and homeless services provider, operates the LeaseUp program, a resource that provides information about available units for eligible housing and homelessness programs involved with CES, including RRH and other housing programs. PATH's housing location program acts as a liaison between landlords and case managers throughout the housing location and retention process. Brilliant Corners is DHS's community-based fiscal intermediary, responsible for administering local rental subsidies for DHS and providing housing acquisition services to subsidy recipients. Several program managers mentioned currently accessing PATH's LeaseUp program for housing location and finding the resource helpful. Brilliant Corners housing acquisition services have been provided for RRH participants since Strategy B3 implementation, but the focus has since shifted to provision of services for other subsidy types.

The effectiveness of these programs has not been systematically examined, but future housing navigation efforts could benefit from a review of information on their work to date, information gathered through their landlord engagement efforts, as well as the challenges encountered. One challenge identified thus far has been holding units for shared housing and matching them to tenants in a timely manner, as it is reportedly difficult to identify and match disparate RRH participants to shared housing units. Another barrier is

Housing Location and Retention Efforts

PATH LeaseUp

- **Provider support in working with landlords, identifying vacancies and matching participants, understanding incentives**
- **Zillow-like platform for case managers to access pre-vetted units for tenants**
- **Landlord support, including Landlord Advisory Board, relationships with apartment associations, outreach and landlord education workshops, risk mitigation funds, a mediation coordinator to work with landlords and case managers to resolve issues that arise**

Brilliant Corners Housing Acquisition Services:

- **Landlord outreach, incentives, matching of tenants**
- **Unit holding agreements to retain large number of units and link clients to them**
- **Tenancy support services including assisting clients in housing selection and move in, and providing supports to prevent evictions**

identifying landlords willing to participate in the programs. Related to this, some providers are reportedly hesitant to share or publicize information on participating landlords, because such landlords are a limited resource.

Section III. Identification, Characteristics and Outcomes of RRH Participants

A. Identification and Enrollment in Rapid Re-Housing, and Characteristics of Populations Served

Participants identified and enrolled in RRH programs are reportedly generally assessed and tracked in CES at or prior to enrollment, although in same cases assessment comes afterwards. Potential participants may be identified and referred through a range of sources and are enrolled directly by the providers. The process whereby participants are identified and enrolled differs by population and by SPA. Populations differ in the number and type of referral sources, the pathways through CES, and the degree to which systems coordination and matching is already in place. Referrals into RRH come from a range of sources including CES, community partners, outreach workers, hospitals, and participants self-presenting. While single adults seem to be referred through the widest range of referral sources, CES for youth appears to be more coordinated and centralized, with matching to RRH providers occurring at the SPA-level in some cases.

For families, the process of identification and referral poses unique challenges. Unlike other populations, families are referred through the Family Solutions Centers (FSCs), a countywide network of homeless service providers that provided a centralized point of access for families in need of crisis services. In addition to connecting with other needed services, the FSCs connect families with temporary as well as permanent housing placements. The reported expectation is that, in the absence of an alternative housing resource, all families should be enrolled in an RRH slot if they are unable to be diverted. This results in a higher number of families enrolled than can be served.

All participants to be served through RRH are expected to complete a standardized vulnerability assessment (the VI-SPDAT, Family VI-SPDAT, or Next Step Tool for Youth) and to be connected to CES if they did not come through CES prior to their referral. This was confirmed by a number of focus group participants who reported calling 211 and completing assessments through CES, or doing an assessment after contacting the RRH provider. At present, however, CES across the populations functions as a source of referrals for RRH and a way to standardize initial screenings and systematically store data on intake information and vulnerability scores but not yet as a method of systematically prioritizing participants or matching them to RRH slots.

Prioritization and matching of participants to RRH are left to the discretion of the providers. Per the SRS, RRH provider organizations are required to assess whether a client is a "fit" for RRH and to consider the vulnerability assessment score. However, they are not required to rely solely on the score in making the determination; consequently, there is a lack of transparency regarding how the organizations determine who to prioritize for enrollment in the programs. Some program managers indicated that participants are served on a first come first served basis, whereas others indicated they try to serve everyone simultaneously or use a wait list and enroll participants when there is space available on caseloads.

Participants who are eligible for RRH under LAHSA's criteria (e.g., documented as homeless under HUD Categories 1 and 4 and under 50% AMI) may be required to meet additional requirements

from providers before being offered enrollment in the program. Client participants in focus groups noted requirements they believed they had to meet, including having income, being employed, having already identified housing and being ready to sign a lease, or being eligible for mental health services. It is unclear whether these perceived requirements are in fact enrollment requirements. What is clear is that there are differences across program managers and case managers in what they describe as the level of needs participants have in their programs as well as the extent to which they have income and employment. These client differences may be due to differences in how participants are recruited and enrolled. Due to time constraints in data availability and incomplete data about income and other characteristics, we were not able to examine differences in characteristics of participants served by provider; however, this may be something that can be pursued by LAHSA as it examines refinements it might make.

The administration of RRH is challenged by the lack of policies around prioritization for RRH and corresponding lack of standardization within CES. Challenges center around the lack of a system to determine how many participants can be served, the lack of consistency and transparency in who is prioritized for the limited resource, and a lack of consensus among stakeholders on how best to make such determinations. There are reportedly more people eligible for the programs than there are available resources, and no policy of establishing slots and openings to address this problem. Family providers, in particular, believe there are explicit or implicit expectations to serve all families, reportedly resulting in over-enrollment and/or high caseloads.

LAHSA has considered plans to standardize the CES process across all SPAs, prioritizing and matching the highest acuity participants to RRH (who are not matched to PSH or another deeper resource). Specifically, at the time of data collection, an operational manual was under development to standardize CES processes across the SPAs, and LAHSA had convened an advisory group to inform implementation of prioritization and matching to RRH. However, these plans have met with resistance and were evolving at the time of data collection. In our interviews, program managers repeatedly raised objections to the plan to prioritize and match to RRH resources based on high assessment scores. They worried that such a policy would make the resource less available for those of lower acuity who they feel are likely to benefit from it and do not qualify for other resources. They also were concerned that participants with high acuity would be less likely to be able to retain the housing, and concerned that system-wide matching will mean they are unable to serve existing participants of their agency for whom they believe their services may be most appropriate.

Providers and administrators also perceived that there already has been a shift in the acuity of the participants served under Strategy B3, which several providers reported was originally targeted to those of low to moderate acuity and later expanded under LAHSA's direction. While some providers and administrators indicate that those of higher acuity have also succeeded in RRH, others expressed concern that they may have a hard time maintaining housing once the assistance expires.

Analysis indicates that assessment scores are missing for 47 percent of those receiving RRH since the implementation of Strategy B3, and for 85 percent of those served in RRH in the 2 years prior. Due to large amounts of missing data on vulnerability scores in the HMIS, it is difficult to assess whether or not vulnerability has shifted over time or whether scores are related to retention.

Families' long stays in crisis housing while waiting for RRH are exacerbated by the uneven and, at times, poor quality of the temporary placements. As noted, families who go through

CES and whose needs cannot be addressed through problem solving or diversion[4] are to be offered crisis housing either in group settings or hotels. While this evaluation does not cover crisis housing, families' use of crisis housing is intertwined with the RRH program's efforts to rehouse them. Families may stay, and several reported that they believed they *must* stay, in these settings until rehoused, a process that can take many months. The families reporting these experiences sometimes had resided in hotels for a portion of their time awaiting RRH assistance and had spent the remaining time in group or shelter settings that they perceived to be uncomfortable, overcrowded, unsafe, and seemingly arbitrarily regulated by the agencies providing them. Lack of alignment between the requirements of the RRH program and of the crisis housing added to families' dissatisfaction. Providers and administrators interviewed did not indicate that staying in crisis housing was an eligibility requirement for RRH, although they did report that it is challenging to find shelter for all of the families in need while they are waiting for housing placements.

After Strategy B3 has been implemented, the size of the population served through RRH has increased considerably and there have been slight shifts in the demographics of the population. As noted earlier, over two times the number of households were served in the three years following Strategy B3 implementation, compared to the two-year time period prior to Strategy B3 implementation. Table 2 presents the demographic characteristics of the participants participating in RRH during the two time periods. Although the populations are somewhat comparable between the two cohorts, participants served after the strategy was implemented were, on average, more likely to be younger, Hispanic, and to identify as female or transgender or gender non-conforming. Cohorts also varied in racial composition. A higher proportion of those served post-implementation were multiracial or had an unknown or missing race, whereas a lower proportion served post-implementation were African American, Asian, and Hawaiian or Other Pacific Islander. Because race was missing for a larger proportion of the post-implementation cohort, it is not clear whether this reflects real shifts in the racial composition of the population served or differences in data quality over time. Although the absolute number of Veterans was comparable between the two cohorts, the expansion of the cohort following Strategy B3 implementation led to the proportion of Veterans being significantly smaller in that cohort than the earlier cohort. Proportionally more transition aged youth and fewer families and single adults were served post implementation of Strategy B3 than before it. Participants served after Strategy B3 are also considerably more likely to have known health insurance, and less likely to be missing insurance information than those served in RRH prior to Strategy B3.

[4] Problem-solving/diversion is a creative problem solving conversation that may include one-time financial assistance to help families access an alternative housing solution outside the homelessness system.

Table 2. Demographic characteristics of heads of household participating in rapid re-housing

	Pre-implementation cohort (N= 8,768)	Post-implementation cohort (N = 20,668)
Age***		
Mean	44 years	41 years
Median	43 years	38 years
Range	18-91 years	18-98 years
Age of HOH Unknown***	5%	6%
Household Type		
Single Adults***	61%	57%
TAY without children**	3%	7%
Families**	36%	33%
Gender		
Male***	55%	43%
Female***	44%	55%
Trans/Nonconforming***	<1%	<1%
Unknown*	1%	<1%
Race		
White	38%	39%
Black***	54%	51%
American Indian/Alaskan Native	1%	1%
Asian***	1%	<1%
Hawaiian/Pacific Islander	1%	<1%
Multiracial***	<1%	<1%
Unknown***	3%	6%
Ethnicity		
Hispanic***	25%	29%
Not Hispanic***	74%	69%
Unknown***	2%	3%
Veteran Status[1i]		
Yes***	43%	18%
No ***	54%	80%
Unknown***	2%	1%
Health Insurance		
Has health insurance***	65%	75%
Has no health insurance***	13%	17%
Medicare/Medicaid***	64%	72%
Employer-provided***	<1%	1%
Other insurance*	<1%	1%
Unknown***	22%	8%

***p<.001, *p < .01, *p < .05.

[1] While the number of veterans served has stayed roughly similar over the two study periods, they are a much smaller proportion of the population in the post-implementation cohort.

Participants in RRH after Strategy B3 are more likely to have income and a larger amount than those served prior to the strategy being implemented. As Table 3 shows, participants served after Strategy B3 implementation compared to those served before are more likely to have higher income and are more likely to have complete data on their income and benefits sources. They are also more likely to have earned income and to receive Supplemental Nutrition Assistance (SNAP). These findings should be interpreted with caution given the rates of incomplete data in the pre-implementation cohort.

Table 3. Income and benefits among household participating in rapid re-housing

	Pre-implementation cohort (N= 8,768)	Post-implementation cohort (N = 20,668)
Income		
Total Monthly income (from any source)		
Received***	64%	72%
Mean amount**	$991	$1,047
Earned income		
Yes***	18%	26%
No***	63%	74%
Unknown***	19%	<1%
General Assistance		
Yes	11%	11%
No***	71%	89%
Unknown***	19%	<1%
SSDI		
Yes	4%	4%
No***	74%	88%
Unknown***	22%	8%
SSI		
Yes***	13%	14%
No***	68%	86%
Unknown***	19%	<1%
TANF[1]		
Yes***	19%	21%
No***	60%	71%
Unknown***	22%	8%
Unemployment Insurance		
Yes	2%	2%
No***	79%	98%
Unknown***	19%	<1%
VA Income		
Yes***	9%	5%
No***	3%	9%
Unknown***	88%	85%
Other Income		
Yes***	3%	2%
No***	75%	83%
Unknown***	21%	14%

Table 3. Income and benefits among household participating in rapid re-housing (continued)

	Pre-implementation cohort (N= 8,768)	Post-implementation cohort (N = 20,668)
Non-cash benefits		
SNAP		
Yes***	35%	42%
No***	<1%	<1%
Unknown***	65%	58%
WIC		
Yes***	2%	3%
No***	73%	62%
Unknown***	25%	35%

***p<.001, **p < .01, *p < .05.

The health and related needs of RRH participants served after Strategy B3 differ from those of participants served in RRH prior to the strategy's implementation. As Table 4 shows, RRH participants in the post-implementation cohort have slightly higher rates of domestic violence and developmental disabilities and slightly lower rates of substance abuse, physical disabilities and chronic health, and mental health conditions than the pre-implementation cohort. These differences in services needs are small but statistically significant, and may be due, in part, to differences in the mix of populations served, as noted above.

The limited acuity information available does not suggest that acuity has increased overall since implementation of Strategy B3. As depicted in Tables 5A – 5D, average assessment scores of those served following Strategy B3 are comparable to or lower than those served prior to strategy implementation overall and among families, adults, and TAY. Likewise, the proportion of those served falling in the moderate category (4-7/8) has increased in the overall sample. However, these results should be interpreted with great caution, given that scores were only available for a subset of those served, and were missing for the majority of those served before Strategy B3 was implemented. Reanalysis would be needed following data quality control measures to verify that these patterns hold when scores are available for the full sample.

Table 4. Disability, chronic health conditions, and history of domestic violence among those with HMIS data

	Pre-implementation cohort (N= 8,402)	Post-implementation cohort (N = 19,050)
Physical Disability		
Yes***	26%	22%
No***	71%	77%
Unknown***	3%	1%
Developmental Disability		
Yes***	7%	10%
No***	90%	88%
Unknown***	3%	2%
Chronic Health Condition		
Yes***	27%	25%
No***	70%	74%
Unknown***	3%	1%
HIV/AIDS		
Yes***	1%	1%
No***	96%	97%
Unknown***	3%	2%
Mental Health Problem		
Yes***	32%	30%
No***	65%	68%
Unknown***	3%	2%
Substance Abuse		
Yes***	9%	7%
No***	88%	92%
Unknown***	3%	1%
Domestic Violence		
Yes***	17%	22%
No***	77%	74%
Unknown***	6%	4%

***p<.001, **p < .01, *p < .05.

Table 5A. Acuity of CES assessments

	Pre-implementation cohort (N=1,351)	Post-implementation cohort (N=11,036)
Average assessment score		
Mean**	7.003	6.78
Std. Dev.	3.56	3.26
Range	0-18	0-19
Score breakdown**		
0-3	17.0%	15.5%
4-7	41.1%	45.7%
8+	41.9%	38.8%

***p<.001, **p < .01, *p < .05.

Table 5B. Acuity of CES assessments among families

	Pre-implementation cohort (N=256)	Post-implementation cohort (N=3,281)
Average assessment score		
Mean	7.11	6.79
Std. Dev.	3.44	2.89
Range	0-18	0-19
Score breakdown*		
0-3	13.7%	10.3%
4-8	56.6%	63.8%
9+	29.7%	25.9%

***p<.001, **p < .01, *p < .05.

Table 5C. Acuity of CES assessments among adults

	Pre-implementation cohort (N=991)	Post-implementation cohort (N=6,454)
Average assessment score		
Mean	7.15	7.01
Std. Dev.	3.60	3.46
Range	0-16	0-18
Score breakdown		
0-3	17.3%	16.4%
4-7	38.8%	40.6%
8+	44.0%	43.1%

***p<.001, **p < .01, *p < .05.

Table 5D. Acuity of CES assessments among youth

	Pre-implementation cohort (N=74)	Post-implementation cohort (N=1,047)
Average assessment score		
Mean	5.53	5.54
Std. Dev.	3.19	2.77
Range	1-14	0-16
Score breakdown		
0-3	21.6%	24.3%
4-7	58.1%	52.8%
8+	20.3%	22.9%

***p<.001, **p < .01, *p < .05.

B. Length of Enrollment and Outcomes for RRH Participants

Participants served in RRH after Strategy B3 compared to those served prior to its implementation appear to have moved into housing at higher rates. Those who do so, move in more quickly and are more likely to exit to permanent housing without a subsidy. As shown in Table 6, a higher proportion of those served following Strategy B3 have a documented move into housing during their enrollment in a RRH program. Outcomes of those with records of moves into housing are also presented in Table 6. Among those who moved in, those in the post-implementation cohort moved in more quickly and were more likely to exit to permanent housing

without a subsidy. They were also less likely to exit to permanent housing with a subsidy and more likely to exit to another or unknown destination.

However, it is important to note that although these difference may reflect an actual change in rates and timing of move in and subsequent outcomes, they could also reflect a difference in data quality and completeness of move-in dates over time. For this reason it is important to also consider time from enrollment to exit and exit destinations among those who exited without a record of move-in to housing documented in the data, as discussed further in the sections below.

Table 6. Length of enrollment and outcomes among households with rapid re-housing

	Pre-implementation cohort (N= 8,768)		Post-implementation cohort (N = 20,668)	
Moved In to Housing				
% reported moved in***	41%		50%	
Days to move in***	109 days		98 days	
Enrollment and Exit Characteristics				
	Moved into housing (N = 3,583)	No record of move into housing (N = 5,185)	Moved into housing (N = 10,275)	No record of move into housing (N = 10,393)
Exited Rapid Re-Housing				
% Exited***	95%***	85%***	74%	62%
Days from Enrollment to Exit	245*	159***	254	182
Days from Move-in to Exit	144***	—	166	—
% enrolled 6 months or less	77%***	82%***	44%	57%
% enrolled 6-12 months	18%***	15%***	31%	30%
% enrolled over 12 months	4%***	3%***	25%	13%
Exit Destination among those Exited				
Sample Size	N = 3,402	N = 4,397	N = 7,591	N = 6,427
Permanent Housing No Subsidy	30%***	21%***	44%	6%
Permanent Housing with Subsidy	54%***	23%***	32%	5%
Doubled Up Permanent	2%***	3%**	7%	4%
Doubled Up Temporary	1%*	5%	<1%	4%
Institutional Setting	<1%	1%	<1%	2%
Transitional Housing	<1%	5%	<1%	6%
Shelter	<1%	3%	<1%	3%
Unsheltered	<1%	8%***	1%	18%
Other	<1%***	4%***	2%	10%
Unknown	10%**	28%***	12%	44%

***$p < .001$, **$p < .01$, *$p < .05$; Significance tests compare rates of exit destinations (1) across the pre and post-implementation cohorts among those who moved into housing, and (2) across the pre and post-implementation cohorts among those who did not move into housing.

Participants served in RRH after Strategy B3 compared to those served prior to its implementation stay longer in RRH programs before exiting. Participants served following Strategy B3 stay longer in RRH programs prior to exiting. This is true among all RRH participants, those with and without documented moves into housing. At the same time, the majority appear to remain in housing with assistance for less than the allotted 24 months. Less than one percent of those served following Strategy B3 were in housing with rapid rehousing assistance for more than 24 months.

Those served following Strategy B3 exit to both stable and unstable destinations at different rates than those served prior to Strategy B3, but findings vary depending on whether a record exists of a move into housing prior to exiting. It is not clear whether findings reflect real differences in client outcomes or changes in documentation practices and data quality over time. As shown in Table 6, those served after Strategy B3 who moved into housing were more likely to exit to permanent housing without a subsidy or a permanent doubled up situation. They were also, however, less likely to exit to permanent housing with a subsidy[5] and more likely to exit to another or unknown destination. These exit findings are similar for those with no recorded move-in date; a key exception is that, for those without a move-in date, those served following Strategy B3 are less likely than those served prior to Strategy B3 to exit to a permanent housing destination with or without a subsidy and are more likely to exit to unsheltered and unknown situations.

Additional analysis, beyond the scope of this evaluation, could shed further light on the outcomes of participants served through Strategy B3. Interpretation of the findings presented here can be bolstered by additional future analysis. A large proportion of participants served through Strategy B3 (32%) had not yet exited the program, and it is therefore not yet clear what their outcomes will be. While it is clear that those served following Strategy B3 are served for a longer period of time than those served prior, it is not clear whether this is positive or negative. Future analysis is needed to determine whether longer periods of enrollment ultimately correlate with better outcomes. It is promising that participants served following Strategy B3 appear to move into housing more rapidly and at higher rates and are more likely to exit to permanent housing without a subsidy after a documented move-in. However, these findings have to be considered with caution given the possibility that they could be artifacts of changes in methods of tracking move-ins and exits before and after the implementation of Strategy B3. Efforts to ensure that move-ins to housing and exits to permanent housing are recorded consistently over time and across providers can render future analysis of Strategy B3 outcomes more informative.

[5]Additional details regarding the types of subsidized permanent housing to which participants exit is provided in Appendix B.

Section IV. Conclusions and Recommendations

A. Conclusions

Expansion of Flexible RRH Resources to Broader Populations. Strategy B3 has resulted in an expansion of RRH services throughout Los Angeles County, with more providers administering the program on a wider scale than prior to the strategy. In addition, Strategy B3 has provided larger quantities of more flexible funding to cover additional staffing, longer term rental assistance, and more flexible coverage of other costs. In turn, following the Strategy, substantially more and a greater variety of participants have been served through RRH. The administrative data suggest that this population, compared to the population served in RRH prior to Strategy B3, has moved into housing at higher rates and more quickly, and has been more likely to exit into permanent housing without a subsidy following move-in. At the same time, people served following Strategy B3 appear to remain enrolled slightly longer before exiting compared with those served prior, and their patterns of exit destinations show key differences depending on whether a move-in date is documented in the administrative data. Due to inconsistencies in the administrative data, these quantitative findings may either reflect real changes in RRH operations and outcomes or alternatively may reflect differences in the quality and completeness of data over time and across providers. Additionally, outcomes are not yet known for a substantial portion of those served following Strategy B3, who have not yet exited the program.

Variability in Approach across Providers and Populations. With respect to implementation, a systematic, consistent approach to implementing RRH across providers is not yet in place. More recent guidance and training from LAHSA with the collaboration of providers is likely to help systematize the operation of RRH, but it continues to be highly variable. Decisions around length and amount of rental assistance, case management, housing location assistance, and client selection are largely left to the provider, within broad parameters. Consequently, providers differ in the duration and amount of financial assistance provided, the nature and amount of case management provided, and the nature of support provided to participants in the housing location and navigation process. Processes for identifying participants and enrolling them in housing are decentralized, and systematic prioritization and matching is not yet in place, resulting in a lack of transparency on client selection.

There are also differences in approach by population, in part due to differences in perceived need or in how other parts of the system, such as CES, vary by population. Families, for example, are over-enrolled in RRH due to the concern of having families without housing; this results in high caseloads as well as temporary, though often extended, placements in crisis housing, the conditions of which are challenging. CES for youth is more coordinated, with closer collaboration among providers than other systems, but youth may need more support around housing location and navigation as well as employment and vocational services.

Despite these differences, however, providers share the same challenges, including lack of standardized policies around RRH prioritization and implementation, difficulty securing sustainable housing and engaging landlords, and difficulties retaining staff. These challenges are described further below, along with some of the strategies that have been tried to address them. In some cases, these strategies have resulted in new challenges, which are also described.

Lack of Standardized Policies Around RRH Prioritization and Implementation. As described above, much of the implementation of RRH is left to the discretion of the providers, and the resulting variability is exacerbated by a lack of standardized policies around prioritization for RRH within CES. LAHSA has considered plans to standardize the CES process across all SPAs, prioritizing and matching to RRH the highest acuity participants (who are not matched to PSH or another deeper resource). These plans, however, were evolving as this evaluation was underway, amid provider concerns that such a policy would exclude participants of lower acuity who could benefit from RRH and do not now qualify for other resources, prioritize those who have a lower likelihood of retaining the housing, and make it difficult to serve participants they believe could benefit from RRH. Training and technical assistance offered by LAHSA that could ultimately lead to greater consistency in RRH practice requires a significant investment in time and resources by both providers and the system, exacerbated by staff turnover requiring additional trainings.

Difficulty Securing Sustainable Housing and Engaging Landlords. It is reportedly difficult to find affordable housing in the tight and costly Los Angeles County market and to engage landlords to rent to RRH participants. Having flexibility to house people experiencing homelessness in Los Angeles County in other more affordable geographic areas outside of the county, have been noted as a helpful strategy to address this challenge. Strategies for improving landlord engagement, such as one-time incentives, may help providers attract landlords, but have led to competition among housing programs for housing slots as well as reportedly attracting some landlords who engage in illegal or unethical practices, such as charging large fees. Similarly, several strategies for finding and keeping sustainable housing, such as shared housing, the Shallow Subsidy program, and housing location intermediaries, may help address the problem but bring in their own complexities. Shared housing does not lend itself to all housing arrangements, requires participants to navigate roommate relationships, often requires additional case management support, and is not a solution for all participants. The Shallow Subsidy program, recently implemented, has generated early concerns that the program has restrictive eligibility and may provide insufficient support, although there is not yet sufficient data to evaluate this concern. Finally, two organizations have been funded to conduct specialized housing location and retention efforts. These organizations have developed specialized strategies for engaging in outreach to landlords, providing landlord incentives, matching clients to available units, and providing ongoing tenancy support after clients move into housing. While the impact of these strategies have yet to be systematically evaluated, some program managers reported availing themselves of these resources, and it is likely that information gathered and challenges encountered through these efforts may inform future housing navigation efforts. For example, challenges to these efforts thus far include difficulties holding units for shared housing, identifying landlords willing to participate in RRH programs, and persuading providers to share information with one another on willing landlords when they find them.

Staff Turnover. There is reportedly a high rate of staff turnover, due to the challenging nature of the work itself and high availability of jobs in the field. Challenges of the work that may contribute to turnover include frustrations brought on by difficulties with the position and high caseloads, as well as staff concerns that they are unable to provide the assistance needed to successfully stabilize participants in housing, particularly those with higher needs.

B. Recommendations

The recommendations below can strengthen the existing RRH programs under Strategy B3 address key challenges.

✓ **Improve Program and Provider Consistency**

Enhanced provider consistency in RRH delivery would permit a stronger evaluation of program implementation and outcomes, and might lead to improved client outcomes and transparency around what is delivered. Moreover, having more consistency in approach will increase equity of access so that it will not matter where (through which provider or SPA) or when (at what time of year/time in the budget cycle) an individual seeks assistance. Finally, consistency can facilitate a more systematic evaluation of the outcomes of the program over time. Consistency can be enhanced through the following approaches.

1. Develop clear guidance and shared consensus around answers to the following questions.

    a) What is encompassed in RRH? What are the service expectations, and do they differ by population served?

    b) Who is RRH for? For participants of what need or acuity level?

    c) What is the structure for administering the financial assistance? What level of standardization versus what flexibility is expected in implementing progressive engagement?

    d) How is that flexibility and the expectations of the program and the client messaged to participants?

    e) What size and composition should caseloads have?

    f) What tools and/or guidance do providers have or need to fairly assess continued need?

2. Standardize CES processes, and, in particular, systematize the process whereby participants are prioritized and matched to programs. This should help enhance transparency around who is served and in in what order, reducing potential inequities in service receipt. In addition, ensuring completeness of CES vulnerability score data entered in HMIS and using those and other HMIS data to monitor the implementation of prioritization and matching would improve the ability to assess whether differences in outcomes relate to different CES vulnerability scores and other indicators of need. Findings can be used as they emerge to guide the process and to communicate with staff about outcomes.

3. Involve persons from all levels and perspectives (program managers, case managers, participants, landlords) in planning and decision making around RRH/Strategy B3. This can facilitate buy-in as well as avert possible additional challenges in the decisions that are made. Many of the challenges in implementing RRH require the cooperation of

others; having those with various perspectives on the ground floor in problem solving with RRH may help to develop workable strategies. In particular, challenges in navigating the private housing market may be addressed by engaging landlords in developing strategies to increase their involvement, as well as examining more closely the strategies that have worked to date and identifying the barriers that have been the most intractable.

4. Provide ongoing training and guidance to better equip staff to administer RRH in a consistent manner across programs. Continued training and guidance, tied closely to the program requirements and expectations, can improve consistency in RRH at all levels of a provider organization.

✓ **Enhance Landlord Cultivation**

1. Navigating the private housing market was described by many as a central component of the RRH program model. As efforts to engage landlords proceed, it will be worth gathering targeted information on what has worked to date and what barriers have been encountered by providers and specialized housing location and retention specialists. Some questions that may be informed by existing efforts include:

   a) How do landlords learn about RRH programs, and how can awareness of and understanding of these programs be increased among new landlords?

   b) What factors deter participation, and how can these be ameliorated?

   c) What are incentives to participation, and how can these be enhanced?

   d) How do strategies for engaging and working with landlords need to be tailored to particular populations of tenants (e.g., youth, families, or those of higher acuity) or housing arrangements (e.g., shared housing)?

   e) What are best practices for case managers and RRH providers in working with landlords and addressing tenant issues that may arise after clients have moved into housing and through the point when assistance expires? What practices foster housing stability and retain willing landlords as participants in these programs?

2. Landlords reported that they valued the case management and would like increased communication, especially when a participant is transitioning off of the RRH subsidy, as well as options for who to call or how to proceed if difficulties arise after a tenant completes the program.

3. Aligning the size and frequency of incentives, risk mitigation, and payment policies and practices across different program types may make landlords less likely to search for the most advantageous program. Because RRH programs have shorter term subsidies than other programs and may be perceived as riskier, it may be worthwhile to consider giving RRH programs the ability to offer greater incentives.

✓ **Address Staff Turnover**

Retaining staff is key to sustaining a successful program. At present, turnover is a significant challenge, and strategies to retain staff should be a priority. The following efforts may build morale and enhance retention:

1. Increasing salaries with the aim of encouraging retention within an agency;

2. Ensuring that staff have the right case mix and the capacity to adequately support those in their caseloads;

3. Providing training/guidance and supervision for staff around progressive engagement;

4. Holding forums where staff can share their concerns and barriers to serving clients and access resources; and

5. Providing staff with alternative resources to offer RRH participants who are lower priority, including problem-solving (diversion) resources.

✓ **Improve and Clarify the Relationship between Crisis Housing for Families and RRH**

1. Families in RRH that we interviewed reported that they believed that they were required to stay in crisis housing while working on finding housing through the RRH program. While some crisis housing was provided in motels, some of it was through shelters or other forms of temporary congregate housing. Families had significant concerns about the shelters and congregate housing; they found them uncomfortable, overcrowded, unsafe, and seemingly arbitrarily regulated by the agencies providing them. The relationship between the requirements of these programs and the RRH program was not clear and created confusion for families. Crisis housing is outside the scope of this evaluation; however, efforts appear warranted to clarify whether families must stay in crisis housing to receive RRH assistance.

✓ **Monitor and Improve Data Quality and Track and Report Outcomes including by Time in Program and Acuity**

1. Efforts are needed to improve data quality. The descriptive outcomes presented in this evaluation relied on administrative data, which were limited in their quality and completeness. Efforts are needed to improve data quality and to ensure that data are tracked systematically the same way across providers and over time. In particular, at present it is difficult to ascertain whether the absence of move-in and exit dates in the client record indicates that the client has not yet moved into housing or exited the program or alternatively reflects missing data. Likewise, it is not clear that moves into housing during program enrollment and subsequent exits to permanent housing or other destinations have been tracked consistently across providers or over time. Different provider practices around the timing of enrollment in the program relative to move-into housing may also render the data misleading. For example, we were told by some stakeholders (agency administrators as well as RRH participants) that some providers wait until clients are ready to sign a lease and move into housing before formally enrolling them in programs, a practice which could artificially reduce the estimates of time served prior to move-in and exit. Establishing and monitoring

adherence to guidelines to ensure that these measures are tracked consistently and comprehensively can form the basis for a stronger future evaluation of outcomes. Enhancing completeness of the data can also help to better understand the sociodemographic characteristics and needs of the populations served and capture changes in these characteristics over time. For example, the racial composition of the population served appears to have changed slightly over time, but there has been a comparable (3%) increase in rates of missing data over the same time period, making it difficult to determine whether there has been an actual shift in the population served or whether this just reflects changes in data quality.

2. Ongoing monitoring of the impact of programs over time is needed. A large proportion of those served through Strategy B3 had not yet exited the program at the time of this evaluation, and their outcomes remain unknown. Moreover, additional analyses that were not feasible within the scope and time constraints of this evaluation, can help to further understand observed outcomes and to differentiate more reliably between those who are missing move-in and exit information versus those who have not yet moved in or exited.

3. Future analysis should aim to better understand the factors associated with positive and negative outcomes. There were a number of concerns raised by staff and program managers that RRH is being used with people who may not be successful and many RRH programs believe they are serving higher acuity people. We did not see evidence to support this in the limited data available. However we did see increased lengths of programs stays and lower exit rates. Tracking the impact of the programs and being able to distinguish trends and differences in population outcomes from anecdotal experience is critical to monitoring program success and to achieving provider buy-in, especially if RRH will be offered to those with higher needs. Specific questions that could be informed by future evaluation include the following:

    a) To what extent does longer length of time served through RRH contribute to more positive outcomes (exits to permanent housing destinations and retention in housing without assistance)?

    b) To what extent does participant acuity influence RRH service receipt and participant outcomes? Do those of higher acuity experience comparable outcomes to those of lower acuity, and do they require more intensive services or longer program times to achieve comparable outcomes?

    c) What is the rate of movement between RRH and other types of housing assistance? For example, what proportion of participants served through Strategy B3 ultimately receive RRH assistance as a bridge to other higher levels of assistance, such as permanent supportive housing? Do longer stays reflect in some cases waiting for other resources to become available?

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Appendix A

Summary of Methods

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Summary of Methods

A. Document Review

Review of documents has been employed to better understand the history, evolution, and status of Strategy B3; to inform the development of interview and focus group protocols; and to contextualize the qualitative data gathered. Documents reviewed include: contextual information on homelessness in Los Angeles County, including Annual Homeless Assessment (AHAR) and Continuum of Care (CoC) reports; strategic documents from the Homeless Initiative (HI), HI performance evaluations, and HI quarterly reports; and publicly available and internal documents from the HI, Los Angeles Homeless Services Authority (LAHSA), including strategic planning and implementation documents, impact dashboards, community input session summaries, guides to contracting opportunities, lists of funded Strategy B3 contractors, presentations, and reports (Exhibit A-1).

Exhibit A-1. Relevant documents

- Contextual information on homelessness in Los Angeles County
- Annual Homeless Assessment Report (AHAR) data and Continuum of Care (CoC) reports
- Strategic documents from the Homeless Initiative (HI)
- HI performance evaluations and HI quarterly reports
- Budgets
- Internal documents from LAHSA
- Dashboards and publicly available documents from LAHSA

B. Interviews and Focus Groups

In-depth semi-structured interviews were conducted with key administrators of Strategy B3 and directors of organizations that administer rapid re-housing (RRH). Focus groups were conducted with direct line staff of RRH programs and with RRH program participants.

Sampling. We conducted telephone interviews with administrators from the agencies involved in administering RRH in LA County, as well as agencies that coordinate with RRH on housing and the coordinated entry system (CES). With the help of Los Angeles Homeless Services Authority (LAHSA), Department of Health Services (DHS), and the Chief Executive Office (CEO), we identified key administrators of Strategy B3 to interview at these agencies, as well as the Housing Authority of the City of Los Angeles (HACLA), the Los Angeles Community Development Authority (LACDA), the Department of Children and Family Services (DCFS), and the "LeaseUp" program at People Assisting the Homeless (PATH). We conducted 18 interviews across these agencies to understand the evolution and implementation of Strategy B3, the implementation of the strategy, funding, impending changes, and contextual information. A detailed list of administrators interviewed at these agencies is presented in Table A-3.

For the interviews and focus groups, we sampled a total of 13 organizations from the pool of 20 LAHSA-funded organizations administering RRH for all populations served across the SPAs in Los

Angeles County as of FY 2018-2019. We arrayed the organizations by the geographic regions and populations served. With input from LAHSA, we selected organizations that would permit us to represent organizations serving all populations across all geographic regions of Los Angeles.

We additionally sampled private landlords to gather information on landlords' perspectives. This aspect of data collection was added during the course of the evaluation based on initial findings that emerged from staff focus groups and provider interviews regarding the difficulty of finding housing and challenges engaging landlords. We recruited landlords known to have experience working with tenants with RRH assistance via PATH's LeaseUp program.

Overall, we conducted 18 interviews with agency administrators, 13 interviews with RRH program directors, and two interviews with private landlords. We conducted four staff focus groups, each with five to 12 direct line staff at these organizations, and five participant focus groups, each with two to eight RRH program participants. A list of providers sampled for interviews and focus groups is presented in Tables A-1 and A-2, respectively. A list of key informants interviewed is given in Table A-3.

Table A-4 presents demographic and housing characteristics for the participants in the focus groups, obtained through a brief survey administered at each of the five focus groups. A total of 25 participants completed the survey. Average age of participants was 36.8 years, with a range of 20 to 69 years of age. The median length of time homeless, for those who responded, was seven months, with a range from one month to four years.

Table A-1. Interviews with RRH program managers

Organization	SPA
Valley Oasis	1
LA Family Housing Corporation	2
The Village Family Services	2
Volunteers of America	3, 6
Union Station Homeless Services	3
Covenant House	4
LA LGBT Center	4
The People Concern	4
PATH	4, 5, 7, 8
St. Joseph's Center	5, 6
Coalition for Responsible Community Development	6
Special Service for Groups (SSG)/HOPICS	6
Harbor Interfaith	8

Table A-2. Focus groups with RRH direct line staff and participants

Organization	Population(s)
LA Family Housing Corporation	Families, staff
Volunteers of America	Single adults
LA LGBT Center & Covenant House	Youth, staff
PATH	Single adults, staff
Special Service for Groups (SSG)/HOPICS	Families, staff

Table A-3. List of administrators participating in key informant interviews

Point of contact	Organization
Paul Duncan, Alex Devin, and Jeffrey Proctor, Strategy B3 Leads	Los Angeles Homeless Services Authority (LAHSA)
Cheri Todoroff, Strategy B3 Lead	Department of Health Services (DHS)
Charisse Mercado	Los Angeles Homeless Services Authority (LAHSA)
Joshua Legere	Department of Health Services (DHS)
Julie Steiner	Los Angeles Homeless Services Authority (LAHSA) Consultant
Jonathan Sanabria	Los Angeles Homeless Services Authority (LAHSA)
Kevin Flaherty	Department of Health Services (DHS)
Steve Rocha and Christopher Chenet	Los Angeles Homeless Services Authority (LAHSA)
Linda Jenkins	LA Community Development Authority (LACDA)
Gail Winston	Department of Children and Family Services (DCFS)
Elizabeth Ben-Ishai	Chief Executive Office (CEO)
Meredith Berkson	Chief Executive Office (CEO)
Ashlee Oh	Chief Executive Office (CEO)
Halil Toros	Chief Executive Office (CEO)
Ryan Mulligan	Housing Authority of the City of Los Angeles – HACLA
Maureen Fabricante	LA Community Development Authority – LACDA (Previously called the Housing Authority of the County of Los Angeles – HACOLA)
Jennifer Lee	PATH LeaseUp program
Chris Contreras, Perlita Carrillo, Sophia Rice	Brilliant Corners Flexible Housing Subsidy Pool (FHSP) with DHS

Table A-4. Demographic and housing characteristics of focus group participants

Demographic characteristic	Number	Percent
Household Type	**N = 25**	
Adult	11	44%
Family	9	36%
Transition Age Youth	5	20%
Gender		
Female	15	60%
Male	8	32%
Other	2	8%
Race		
Asian/Pacific Islander	2	8%
Black/African American	7	28%
Latino/Hispanic	10	40%
Mixed Race/Ethnicity	2	8%
Native American	1	4%
White/Caucasian	2	8%
Other	1	4%
Primary Language		
English	23	92%
Spanish	2	8%
Housing status	**Number**	**Percent**
Current housing		
In an apartment	17	68%
In shelter, motel, or crisis housing	7	28%
In a vehicle	1	4%
Length of time housed		
less than 3 months	9	36%
3 to 12 months	6	24%
Missing	2	8%
Not yet housed	8	32%

Data Collection. All data collection followed informed consent and human subjects protection procedures approved by Westat's Internal Review Board (IRB). One-hour confidential telephone interviews were conducted with individual administrators and program directors, recorded to provide for confidential transcripts to provide a backup to note taking.

Interviews with county administrators and agency directors elicited information on the history of Strategy B3 and its impact on the organization, as well as the respondent's role and work relevant to the strategy. Interviews also gathered information on the following domains: the scope of the strategy, funding sources and their requirements and restrictions, the scope and size of the strategy (number of RRH programs and participants served through RRH), the services and supports received as part of RRH, including the structure of financial assistance, case management, and supports around housing location and navigation, and the process whereby participants are identified and enrolled in RRH; rates of client placement and retention in housing; information on the level and nature of collaboration around RRH implementation among and within agencies; key challenges around implementing RRH, including contextual factors impacting implementation. For all of these domains, we assessed the degree to which there were perceived changes following strategy implementation, as well as any variations by population served, provider, or SPA.

Focus groups gathered information on a number of these domains from the perspective of front line staff and RRH participants. Staff were asked to share information on how participants are received and enrolled in the program, types of RRH assistance provided, client outcomes, challenges around implementation, and the level of collaboration with other providers and staff. Participants were asked about their pathways to homelessness, the process of seeking housing and arriving at the RRH program, services and supports received while experiencing homelessness, type of RRH assistance offered and received, any assistance received around employment, and outstanding needs, and suggestions and recommendations for services and supports to help them remain in housing. All focus groups were conducted in a private space located at a participating RRH provider.

Landlord interviews gathered information on their background and experience with RRH programs, perceptions of Strategy B3, numbers of tenants receiving RRH assistance and the types of units in which they are housed and the housing providers with which they are affiliated, the nature of the financial assistance, the process whereby they are connected with RRH recipients as tenants, the nature of leasing agreements and eligibility criteria for tenancy, retention of tenants receiving RRH assistance in housing, challenges experienced around leasing to tenants with RRH assistance, and recommendations for program improvement/for ways to make the program more attractive to private landlords.

Full copies of our protocols were submitted with our Project and Data Collection Plan in September of 2019 and are available upon request.

C. HMIS AND CHAMP Administrative Data

Analyses of administrative data were conducted to provide information on the characteristics and needs, enrollment and length of time in RRH, and exits from RRH for participants served through RRH before and after Strategy B3 was funded.

Sample. The initial sample for our administrative data analysis was comprised of all participants served through RRH between the Strategy B3 implementation beginning on July 1, 2016 and June 30, 2019 (our post-implementation sample; N = 20,668) and the two years prior (our pre-implementation sample N = 8,768). Our pre-implementation cohort was limited to individuals whose enrollments were new on or after 7/1/2014, while our post-implementation cohort was limited to those with new enrollments on or after Strategy B3 implementation on 7/1/2016. The pre-implementation time frame selected was shorter than the post-implementation time frame because we had concerns about the quality of the administrative data prior to 2014. Rather than have equal time frames, we opted to include an additional year of observation in the post-implementation time frame to maximize the information provided.

Data Sources. Data sources included DHS' Comprehensive Health and Management Platform (CHAMP) and the Homeless Management Information System (HMIS). The majority (93%) of our sample was tracked in HMIS or in both data systems, while the remainder (7%) was tracked only in CHAMP. Thus, some variables presented (the disability and domestic violence variables in Table 5 of the text) are presented only for those in HMIS. Our cohort was limited to individuals whose enrollments new on or after 7/1/2014, and those in the post-implementation cohort were not enrolled during the pre-implementation period.

Variables Extracted and Constructed. Sociodemographic variables extracted include age, gender, race, ethnicity, veteran status, health insurance, income, and benefits. Using HMIS data, we constructed household type using age and number of children under 18 in the household (determined by calculating whether children age 18 were linked to the head of household via a household ID). For CHAMP data, all participants were coded as heads of household; those under age 18, who were excluded from the sample. Family status for households tracked in CHAMP was coded based on the project with which the client was affiliated, with input from DHS.

For participants tracked in both data systems, we privileged whichever data source had more complete variables. In the event that both data systems had complete variables, we relied on HMIS for most of the constructed variables, with the exception of race, which appeared to be more complete in CHAMP.

The following descriptive variables were extracted from HMIS and CHAMP: Age, gender, race, ethnicity, veteran status, health insurance presence and type, income and sources, and non-cash benefits.

Outcome variables were constructed as described below:

1. **Enrollments.** Enrollments identified using project start and exit dates associated with enrollments in an RRH program (project type 13) in HMIS, and check-in and check-out dates associated with enrollments in an RRH program in CHAMP.

2. **Move In.** Participants who had a move-in date associated with an RRH enrollment in either data system were considered to have moved into housing, and time to move-in was calculated as days between the date of project start/check-in and move-in date.

3. **Exits.** All participants with either a check out date in CHAMP or an exit date documented in HMIS were considered to have exited the program. In cases where there were overlapping enrollments during the study period, the enrollment was considered to be a single time frame, with the earliest project entry or check-in date and the latest project exit or check-out date used across the two data systems. Likewise contiguous enrollments RRH (where check-in date was within 30 days of check out date in CHAMP or project start date was within 60 days of project exit date in HMIS) were treated as a single enrollment, a decision made based on our understanding of how data are tracked in the two data systems and in consultation with DHS and the CEO. Time to exit was calculated as days between project check-in or entry date and check out or exit date. Exit destination was coded based on HMIS data and was not available in a comparable format for DHS data, so is coded as unknown for recipients only tracked in that data system.

Rates and timing of move-in and exits and destination of exit were limited to those who exited within 3 years of entry. Importantly, for those without a record of move-in to housing during program enrollment (59% of those in the pre-implementation cohort and 50% of those in the post-implementation cohort), it is not clear whether the individual did not move into housing or moved into housing but is missing their move-in date. Likewise, for those without a record of exit, we are unable to distinguish between those who are still enrolled in a program and those who exited but have missing exit data. Exits to permanent housing are assessed only for the first exit over the follow-up period. Some of those who exited to a destination other than permanent housing may

have returned to the system and subsequently exited to permanent housing, but would not be captured in this analysis.

Analysis. We conducted descriptive analysis, examining percentages for categorical variables and means, medians, and standard deviations for continuous variables. Additionally, we examined bivariate associations between cohort and client characteristics and outcome variables.

Limitations. A number of limitations should be noted. Quantitative data were originally collected for administrative purposes and should be interpreted with caution when used for evaluation purposes. For the descriptive data, it was not always possible to clearly distinguish between data that were missing because they were not endorsed or because they were not collected. Because participants are tracked in two data systems, we were limited in the variables we could examine for the full sample. For example, we did not have access to information on disability and other health conditions or domestic violence for 7 percent of the sample, as this was available to us only through the HMIS data. Additionally, our analysis of the vulnerability results of the CES assessment was limited by the high rates of missingness. With regard to our outcome variables, when move-in and exit dates were missing, we could not differentiate between those who never exited or moved in, and those who did so but had missing information. We therefore likely underestimate the rate of move-in and exits in the sample. In addition, the length of available observation was longer for those in the pre-implementation cohort than the post-implementation cohort. We sought to address this by limiting our analysis of exits to those occurring within three years of entry, but our analysis has limited information on the outcomes of participants who more recently entered RRH.

With respect to the qualitative data collected, one limitation involves the size of our participant focus groups. RRH participants can be difficult to recruit for focus groups because they are by definition not residing in a single place, and we believe as a consequence of this, attendance at some of our participant focus groups was low. Additionally, we were limited in the number and range of providers we were able to sample within the scope of the evaluation, and may not have captured all perspectives.

Appendix B

Types of Exit Destinations to Permanent Housing with Subsidy

Appendix B
Types of Exit Destinations to Permanent Housing with Subsidy

Table B-1 below provides detailed information on exit destinations among those exiting to permanent housing with a subsidy among those with no record of a move-in date and among those with a documented move into housing while enrolled in an rapid re-housing (RRH) program. A rental with a Veterans Affairs Supportive Housing (VASH) or Other subsidy were the most common destinations across all samples. However, compared with those served prior to Strategy B3, those served following Strategy B3 were less likely to exit to these destinations and more likely to exit to permanent housing for formerly homeless persons or to a rental with an RRH or equivalent subsidy. These findings should be interpreted with caution, as it is possible that these differences reflect different practices around tracking exit destinations in the administrative data over time rather than real differences.

Table B-1. Exit destination among those exiting to permanent housing with subsidy

	Pre-implementation cohort (N= 8,768)		Post-implementation cohort (N = 20,682)	
	Exit destinations among those who move in	Exit destinations among those who move in	Exit destinations among those who move in	Exit destinations among those who move in
Exit Destination among those Exited				
Permanent housing (PH) for formerly homeless persons	8%	5%	17%	10%
Safe Haven	<1%	0%	5%	<1%
Rental, VASH Subsidy	55%	47%	26%	34%
Rental, Other subsidy	36%	45%	44%	44%
Owned by Client, Ongoing subsidy	<1%	1%	<1%	<1%
Rental, Grant and Per Diem Program Transition in Place (GPD TIP)	<1%	<1%	<1%	<1%
Rental, RRH or equivalent subsidy	<1%	1%	7%	11%

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Evaluation of Los Angeles County's Strategies to Expand and Enhance Services Provided Through Permanent Supportive Housing

Report

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Executive Summary

A. Background

Strategy D7 (Provide Services and Rental Subsidies for Permanent Supportive Housing) is one of 21 strategies funded through Measure H, a 2017 ballot initiative in Los Angeles County to prevent and combat homelessness. Permanent supportive housing (PSH) is an evidence-based approach to ending homelessness for individuals who have experienced chronic homelessness and have multiple service needs, typically including mental health and/or substance use disorders (United States Interagency Council on Homelessness, 2010). Following "housing first" principles, PSH provides clients with expedited access to an independent, permanent residence and needed services and supports.

Strategy D7 aims to improve access to and enhance the provision of services for additional PSH by creating a model of integrated services, including intensive case management services (ICMS), specialty mental health services (Housing Full Service Partnership), and substance use disorder services (Client Engagement and Navigation Services), as well as filling in the service gaps in existing permanent supportive housing and creating new local rent subsidies.

B. Evaluation Description and Methods

Westat, a national research organization, in collaboration with the University of Southern California, has contracted with Los Angeles County's Chief Executive Office (CEO) to evaluate the operation and outcomes of PSH under Strategy D7. The evaluation, conducted between June and November 2019, involves the analysis and collection of data from multiple methods and sources, including document review; individual interviews with administrators and housing and services program managers; and focus groups with case managers, housing and services program managers, and PSH residents in project-based housing (i.e., congregate settings). In addition, administrative data from the Homeless Management Information System (HMIS) administered by the Los Angeles Homeless Services Authority (LAHSA) and the Department of Health Services' (DHS's) Comprehensive Health and Management Platform (CHAMP) were analyzed. These data were not originally collected for research purposes and are limited in their reliability and completeness. However, they provide a basis for a descriptive understanding of the characteristics, length of time served, time to move-in to housing, and rates and timing of exits of households served through Strategy D7-funded PSH . Between July 1, 2017 and July 1, 2019, 5,472 households were served through Strategy D7-funded ICMS. Among those served, 1,057 households were in housing when they enrolled in services, and an additional 1,700 households moved into housing while enrolled in services. Additionally, 4,434 of households served through Strategy D7-funded programs were still enrolled in services and had not yet exited at the end of the two-year post-implementation period.

C. Findings

Overall, D7 has provided more resources for services provision to those in PSH and is perceived positively by providers who appreciate the high quality guidance, training, and support they have received from DHS to guide implementation of PSH under Strategy D7. The majority of program

managers interviewed report that it has enhanced their ability to provide holistic, comprehensive services for clients. Key findings are described further below.

Greater availability of funding for services and rental subsidies for new and existing PSH. The operation of PSH under Strategy D7 has accelerated the availability and sufficiency of funding for PSH and sustained the growth in the PSH inventory. Strategy D7 has provided more funding and more flexible funding for services for PSH, including dedicated services funding for preexisting units. Strategy D7 has also funded services for inventory under development, thus facilitating the development of new units, and has expanded the availability of local subsidies for those who do not qualify for Federal rental subsidies.

Improved training and guidance and increased collaboration. Greater collaboration across agencies, PSH program managers, and staff has reportedly occurred to support the integration of services. Moreover, to guide the overall implementation of PSH, DHS provides what program managers describe as high-quality guidance, using a coaching model and comprehensive training.

More intensive individualized services and improved service coordination. Strategy D7 has provided for more intensive and more flexible services funding than previously available and has increased the availability of intensive case management services in permanent supportive housing, enhanced the case management services and supports provided, and strengthened coordination with mental health and substance abuse services. Since Strategy D7, case manager caseloads are reportedly smaller and based on acuity, and case managers are able to provide more hands-on, individualized, and frequent services to residents in both project-based housing and scattered-site housing.

In all project-based housing under Strategy D7, DMH is operating the Housing Full Service Partnership program that provides on-site mental health care including group and individual therapy and medication management by a psychiatrist. These services existed prior to Measure H, but were additionally expanded to new sites under Strategy D7, although it should be noted that not all clients funded through Strategy D7 are located at DMH FSP sites. In addition, referral for substance abuse screening and treatment is co-located with the mental health services at some sites or "connected" at some sites where co-location is not logistically feasible. These services are provided through the Client Engagement and Navigation Services (CENS) funded by the Substance Abuse Prevention and Control (SAPC), and to date, SAPC's services have primarily been linked to project-based sites.

The population served through PSH under Strategy D7 is comprised predominately of single male adults and is racially diverse. Clients are referred to PSH through the Coordinated Entry System (CES). While PSH program managers reportedly have minimal exclusionary criteria for enrolling clients, housing authorities, landlords, and property managers may apply additional criteria. Clients served after Strategy D7 was implemented are predominantly single male adults. The racial composition of the population served is predominately white (40%) and Black or African American (42%), with the remaining clients identifying as multiracial (6%), Asian (2%), Hawaiian/Pacific Islander (< 1%), or having missing or unknown race (9%). Just under a third of clients served (30%) identify as Hispanic or Latino, and 4% are veterans. Other characteristics of the population served after Strategy D7 are unknown, as reliable information was not available on income and benefits or client need characteristics (e.g., acuity, health and mental health conditions, or history of domestic violence).

Strong case management support for moving clients into housing, despite challenges. Case managers' roles under Strategy D7 include working with clients early in the process when they are identified and matched through CES, allowing case managers to help clients find and move into housing, including supporting the completion of the housing authority rental subsidy application. Those served after Strategy D7 who have moved into housing following enrollment in ICMS have done so in a median of 103 days. The process of moving clients into housing reportedly remains challenging, despite case manager support, and outcomes are not yet known for many of those served after Strategy D7, more than a third of whom were recently enrolled (for a median of 80 days) and still waiting to move into housing as of July 1, 2019.

Retention facilitated through long-term and on-site services. Program managers viewed Strategy D7 as aligned with retention goals because it provides long-term and ongoing case management support for clients in housing, including assistance with recertification and the availability of on-site service providers to catch problems early and work with property managers to prevent eviction. While it is too soon to assess long-term retention outcomes for most of those served after Strategy D7, findings indicate that 19% of those served after Strategy D7 exited services during the two year post-implementation period; 5% of those served exited services after moving into housing, while 14% exited services without a record of moving into housing. It should be noted that it is possible to exit PSH programs tracked in CHAMP and to stop receiving services, but to remain housed through a rental subsidy; therefore, exits among those who moved in do not necessarily reflect exits to homelessness. At the same time, exit destination is not tracked in CHAMP for those who exit without moving into housing, so it is possible that those in this category (14% of those served after Strategy D7) are exiting to homelessness or an unstable living situation. The plurality (46%) of those served after Strategy D7 were in housing and receiving services at the end of the post-implementation period. This group had been enrolled in services for close to a year (a median of 318 days). The outcomes of many of those served after Strategy D7 are not yet known due to the recency of the program.

D. Challenges

Despite the improvements in operation of PSH under Strategy D7, there are a number of challenges that need to be addressed.

Staff turnover and burnout. These two challenges are chief among those described and are attributed both to the demands of the job and a positive job market. The turnover impacts rapport with clients, requires additional training, and increases other staff's caseloads when a position is vacant.

With increased funding through Strategy D7, some case managers support clients from the time they are matched through CES until exit. Though this early assignment allows for continuity of case management and greater time to build rapport, case managers are faced with challenges that come with navigating an increasingly competitive housing market and processing housing authority applications.

Gaps in service coordination. Service coordination efforts are new. At the start of implementation, these efforts reportedly resulted in initial role confusion across staff from different agencies. Communication and philosophical alignments among staff across administering agencies

and/or service providers are not yet in place. Geographic dispersion of services, which are sometimes located far from clients' places of residence, also poses barriers to service coordination.

Barriers to accessing and engaging in services. Ensuring access both to case management and to other disparate services across the vast geographic distances in Los Angeles was a frequently cited challenge. Gaps reported in access to mental health and/or substance abuse services may be driven by challenges in engaging clients in needed services, as well as barriers to timely uptake for clients who do seek treatment. Clients in focus groups reported difficulties accessing needed mental health services and substance use support groups.

Difficulties obtaining housing. Providers noted challenges around obtaining housing for clients, including delayed and denied applications for housing through the housing authorities and reluctance of landlords to accept vouchers in the competitive housing market. For clients, the quality and safety of the physical housing was an additional concern.

Lack of integration across data systems and incomplete data. Due to a lack of integration across data systems and differences in methods of tracking information across HMIS and CHAMP, the types and intensity of services received during program enrollment, and the destinations of those exiting the program without obtaining housing are not known. Additionally, we were unable to complete an in-depth assessment of the needs and characteristics of the population served (e.g., health and mental health conditions, CES vulnerability scores) or to examine whether these have shifted over time, as these data were not collected in CHAMP and the majority of the sample was not tracked in HMIS. We were additionally unable to assess changes in outcomes before and after implementation because findings potentially reflected inconsistent methods of tracking enrollments over time.

E. Recommendations

Although Strategy D7 is largely operating the way it was intended to operate, the challenges faced suggest that a few improvements are needed for it to function optimally. These are outlined below.

Reduce turnover and burnout among staff. Strategies to improve staffing stability should address heightened work demands, such as providing case managers with support and supervision, implementing safety protocols, and reducing the need for case managers to travel across such wide distances. In addition, increases in salary may be warranted to match the attraction of other job opportunities.

Address gaps in service coordination. It may be helpful to develop and implement measures to clarify roles and improve communication among staff across agencies and to notify case managers of turnover among staff at DMH or SAPC. Frequent retraining of staff across agencies may also help to address any misalignments in philosophies (e.g., housing first, harm reduction, and trauma-informed care). It may also help to address the geographic dispersion of services through additional reimbursements to case managers to cover vehicle repair and maintenance and other transportation costs, transportation resources for clients, and incentivizing mental health and substance use service providers to deliver field-based services to clients who are not already connected to on-site services through FSP and CENS at project-based sites.

Address underutilization of mental health and substance abuse services. The challenges with client access and engagement in mental health and substance abuse services may require greater examination of why some clients report difficulty accessing these services yet providers report underutilization of some services. This finding suggests that there may be clients in need of services who are not located at FSP and CENS co-located sites. This discrepancy requires greater attention, with more examination through interviews with staff and examination of client records where the mismatch in services exists as well as where utilization appears to be lowest and highest. Understanding service patterns and the match with clients' backgrounds may help to calibrate services more to where the needs appear to be. In addition, talking with an array of clients about the barriers they see in accessing services and how to make them more low-barrier may help with the client-driven challenges to access. For services that appear to be oversubscribed, more resources may be needed to reduce intake and appointment wait times and increase frequency of appointments and for substance abuse counselors to be present to provide on-site screening and intervention.

Address barriers to obtaining housing through landlord cultivation and coordination with the housing authorities. Given the competitive housing market, it may be helpful to increase landlord outreach strategies. In addition, coordinated efforts among housing and services providers and the housing authorities are reportedly needed to improve the process of applying for rental subsidies through the housing authorities. Efforts need to focus on reducing errors in submitted applications, streamlining the approach to updating incorrect or incomplete applications, and expediting the housing inspection process.

Improve data quality and integration across systems, and track service receipt and outcomes over time. The HMIS and CHAMP data systems offer the potential to understand who is served, monitor their own implementation of services, and examine exit rates and patterns. While all clients funded through Strategy D7 are tracked in CHAMP, improved integration across these two data systems can permit more complete characterization of the clients being served, primarily by being able to maximize the data collected through the HMIS which tracks client characteristics and exit destinations more extensively. In addition, it may be helpful to track services delivery, including the frequency of case management delivered and linkage to other mental health, substance use, and medical services, and benefits. Such information could help to inform our understanding of the nature and intensity of the services provided before and after move-in and how these services impact outcomes. Likewise, it would be useful to track exit destinations among those who exit ICMS without moving into housing. Finally, ensuring that check in and check out dates and move in dates in CHAMP are used consistently across providers and over time will permit more targeted assessment of change in outcomes over time. Such efforts could potentially yield richer, more complete data on client characteristics and outcomes, and permit examination of how acuity of population and intensity and type of service receipt has changed over time and impacts outcomes.

List of Acronyms

CEO	Chief Executive Office
CENS	Client Engagement and Navigation Services
CES	Coordinated Entry System
CHAMP	Comprehensive Health and Management Platform
DHS	Department of Health Services
DMH	Department of Mental Health
DPH-SAPC	Department of Public Health, Substance Abuse Prevention and Control
ERC	Enhanced Residential Care
FHSP	Flexible Housing Subsidy Pool
FSP	Housing Full Service Partnership
HACLA	Housing Authority of the City of Los Angeles
HI	Homeless Initiative
HMIS	Homeless Management Information System
HOH	Head of Household
ICMS	Intensive Case Management Services
LACDA	Los Angeles Community Development Authority
LAHSA	Los Angeles Homeless Services Authority
PATH	People Assisting the Homeless
PSH	Permanent Supportive Housing
SAPC	Substance Abuse Prevention and Control
SNAP	Supplemental Nutrition Assistance Program
SPA	Service Planning Area

Section I. Introduction

A. Background

Permanent supportive housing (PSH) is an evidence-based approach to ending homelessness for individuals who have experienced chronic homelessness and have multiple service needs, typically including mental health and/or substance use disorders (United States Interagency Council on Homelessness, 2010). Following "housing first" principles, PSH provides expedited access to an independent residence and needed services and supports. Strategy D7 (Provide Services and Rental Subsidies for Permanent Supportive Housing) aims to improve access to and enhance the provision of services in PSH.

Strategy D7 is one of 21 strategies funded through Measure H in July 2017 (County of Los Angeles Chief Executive Office, 2017), a ballot initiative in Los Angeles County to prevent and combat homelessness[1]. The intent of the strategy is to:

- Create an integrated services model for all clients matched to PSH through the Coordinated Entry System (CES), comprised of intensive case management services as well as site-based and mobile specialty mental health and substance use disorder services for those who need it;
- Fill the gaps in services for existing PSH; and
- Create additional local rent subsidies, when Federal subsidies are insufficient to meet the need.

Westat, a national research organization, in collaboration with the University of Southern California, was contracted by Los Angeles County's Chief Executive Office (CEO) to evaluate the operation and outcomes of PSH under Strategy D7. Following this introduction, the report provides an overview of the evaluation methodology. Section II describes the key findings with regard to funding and inventory; the nature and coordination of services provided; training, guidance, and collaboration around implementation; and how clients are identified, prioritized, and matched to housing. Section III outlines the characteristics, enrollment, and retention of clients in PSH. The final section, Section IV, offers conclusions and recommendations.

B. Evaluation Purpose and Methods

This evaluation aims to answer the following over-arching question:

> *"How has Strategy D7 affected the operation, outcomes, and inventory of Permanent Supportive Housing (PSH) in Los Angeles County?"*

[1] Measure H is a quarter cent sales tax to generate funding for homeless services that was approved by Los Angeles County voters in March of 2017.

Table 1 outlines specific questions encompassed within this question, mapped onto our methods and data sources.

Table 1. Specific evaluation questions and methods to address them

Methods	Analysis of extant records		Interviews and focus groups		
Sources	Documents/quarterly data	Admin data	Agency administrators	Program directors	PSH/services staff
Operation of D7					
In what ways has Strategy D7 impacted the funding or expanded the inventory of housing?	✓		✓	✓	
In what ways has Strategy D7 affected the intensity and role of case management to support clients' access to services and their ability to maintain their housing?	✓		✓	✓	✓
How do services or does the coordination of services provided through Strategy D7 compare to what was previously available?	✓		✓	✓	✓
Has Strategy D7 expedited how individuals are identified and matched with PSH? In what ways and for what populations?	✓		✓	✓	✓
Subpopulation and Client Differences					
How does the provision of PSH services through Strategy D7 differ by the population served?			✓	✓	✓
What are the characteristics of the population served through PSH under Strategy D7?		✓	✓	✓	✓
Client Retention and Outcomes					
What are PSH retention rates and other client outcomes under Strategy D7? What factors are perceived to contribute to these?	✓	✓	✓	✓	✓
Integration and Coordination Among Agencies					
How has Strategy D7 affected collaboration among the key agencies involved in providing PSH, including DMH, DPH/SAPC, LAHSA, and the Housing Authorities?			✓		
What levels of collaboration and coordination are occurring (e.g., at agency level, at provider level, at staff level)? What are the challenges and barriers to working together at these different levels? What are the opportunities at each level and how can they be maximized? What are the benefits of collaboration? What are the downsides?			✓	✓	✓

Our evaluation methods are summarized in Exhibit 1 and described in detail in the Appendix. We reviewed a number of documents, including strategic planning documents and agency records to understand the evolution of Strategy D7 and to inform the development of the data collection protocols and analytic plan. We collected data to assess the operations and outcomes of Strategy D7 through multiple methods, including key informant interviews with administrators, directors of agencies administering permanent supportive housing, and property managers; and focus groups with program directors, case managers, and residents in project-based PSH. Qualitative data

collected through these sources were coded in NVivo and analyzed through iterative analysis to identify key themes.

Exhibit 1. Summary of key evaluation methods

Document Review
- Review of strategic planning documents, budgets, aggregate data, and other agency records

Interviews and Focus Groups
- Individual interviews with key administrators (N = 17) and housing program managers (N = 10) from Service Planning Areas (SPAs) 1, 3, 5, 7, and 8 (N = 17)
- Three focus groups, each with 2-5 case managers and 2-7 housing program managers from housing programs in the three largest SPAs (2, 4, and 6)
- Three focus groups, each with 4-10 PSH residents in SPA 4 (a total of 24 clients; limited to congregate facilities; one with women only and two with more mixed populations)

Administrative Data
- Sample: All households served through PSH programs and tracked in CHAMP since Strategy D7 implementation (July 1, 2017-June 30, 2019)
- Data sources: CHAMP and HMIS

Administrative data extracted from the Department of Health Services' (DHS's) Comprehensive Health and Management Platform (CHAMP) and the Homeless Management Information System (HMIS) administered by LAHSA were analyzed to (1) characterize the population's sociodemographics and needs; (2) describe the length of time served; and (3) describe client-level outcomes, including time to moves into to housing and rates of exits from the program. Our administrative data analysis initially sought to compare those served after Strategy D7 with those served in the two years prior to Strategy D7. However, after preliminary analysis of the data, we determined that such a comparison would not be meaningful or informative, and would yield findings that were potentially misleading. We therefore limited our analysis to a description of characteristics and outcomes of those served after Strategy D7 through Strategy D7-funded programs. This decision was informed by several considerations. First, Strategy D7 is new, limiting our ability to assess outcomes for the majority of those served through the program. Second, the majority of those served through Strategy D7-funded programs are tracked only in CHAMP, whereas the majority of those served prior to Strategy D7 implementation were tracked in HMIS. There are systematic differences between the two data systems in the way in which enrollments in PSH are tracked; these result in apparent differences in outcomes that are attributable to methods of data tracking rather than to true differences in client outcomes. Finally, those served through PSH and tracked in CHAMP prior to Strategy D7 did not constitute a meaningful pre-implementation cohort for the purposes of comparison because of the potential for unmeasured differences in the populations served by DHS-administered programs before and after Strategy D7 was implemented. Prior to Strategy D7, these programs were targeted to frequent users of the DHS system, and reliable information was not available on the acuity and need characteristics of this group. For these reasons, quantitative findings throughout this report do not employ a pre-implementation comparison group, but instead characterize those served under Strategy D7 and describe their outcomes to date.

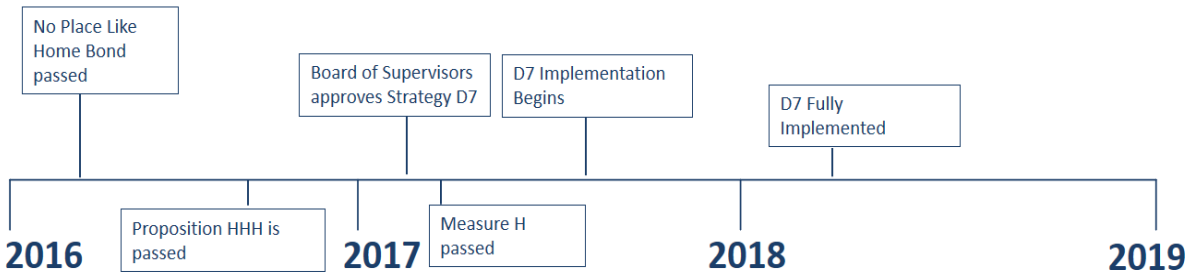
Between July 1, 2017 and July 1, 2019, 5,472 households were served through Strategy D7-funded ICMS. Among those served, 1,057 households were in housing when they enrolled in services, and an additional 1,700 households moved into housing while enrolled in services. Likewise, 4,434 of households served through Strategy D7-funded programs were still enrolled in services and had not yet exited at the end of the two-year post-implementation period. Findings are described further in the sections that follow.

Section II. Understanding the Operation of Permanent Supportive Housing Under Strategy D7

A. History, Funding, and Structure

Strategy D7 (Provide Services and Rental Subsidies for Permanent Supportive Housing) aims to improve the services and supports provided in PSH, as well as create local rental subsidies when Federal subsidies for housing are insufficient. As the timeline illustrates in Figure 1 below, Strategy D7 builds on and complements two previous measures that financed the construction of PSH units in the region: the State of California's No Place Like Home program and Proposition HHH[2].

Figure 1. Timeline of implementation of Strategy D7



The strategy was approved by the Los Angeles County Homeless Initiative (HI) in June 2016 and implemented following the passage of Measure H in July 2017. Funding has been provided through Measure H in three increasing allotments thus far (Los Angeles County Homeless Initiative, 2019): $25.1 million (FY 2017-2018), $49.3 million (FY 2018-2019), and $69.6 million (FY 2019-2020). The bulk of these funds were allocated to DHS, with a smaller portion allocated to the Department of Mental Health (DMH) and the Department of Public Health (DPH). In the first two fiscal years, a total of 5,472 clients were served through Strategy D7-funded PSH ICMS (in both project-based and scattered-site housing) across 61 unique agencies.

The strategy's implementation is led by three county departments: DHS, DMH, and the Department of Public Health, Substance Abuse Prevention and Control (DPH-SAPC).

DHS funds community-based organizations to provide ICMS for all Strategy D7 clients. The services are intended to be comprehensive and tailored to client needs. The case managers coordinate with the housing authorities in accessing project-based and tenant-based subsidies and with the Los Angeles Homeless Services Authority (LAHSA) on the CES.

[2] Proposition HHH allowed the City of Los Angeles to finance up to 10,000 units of PSH over 10 years, and the State of California's No Place Like Home Program financed PSH units over multiple funding cycles across the county of Los Angeles.

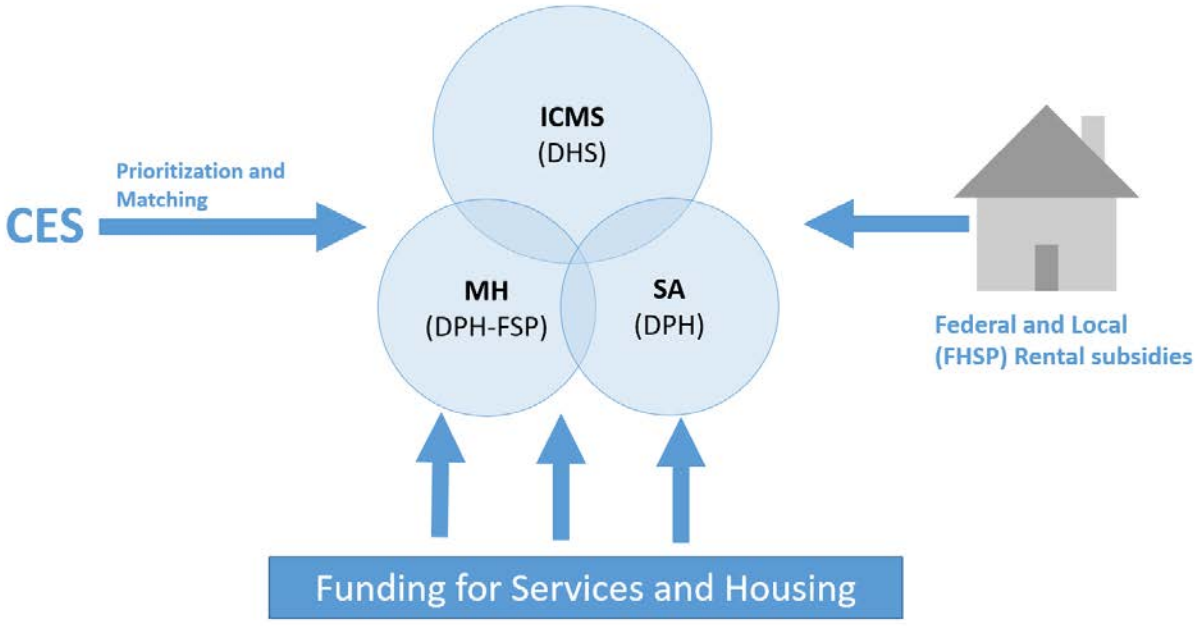
DMH funds community-based organizations to provide on-site mental health services at some Strategy D7-funded sites for PSH clients who need them. The services are provided through DMH's Housing Full Service Partnership model, which includes individual and group therapy and counseling, crisis intervention, medication management services, and linkage to other needed services. It should be noted that not all clients funded through Strategy D7 are located at DMH FSP sites.

DPH-SAPC funds community-based organizations to link PSH clients to substance use services through its Client Engagement and Navigation Services (CENS), which funds counselors to conduct outreach, screening, and referral for substance use treatment.

Local rental subsidies are additionally made available through the Flexible Housing Subsidy Pool (FHSP), a rental subsidy program administered by Brilliant Corners, a nonprofit community partner that acts as the DHS fiscal intermediary. The FHSP allows the use of local funds for rental subsidies for those in need of the subsidy who do not qualify for Federal subsidies. Strategy D7 also expands funding for ICMS in PSH that began operation prior to July 1, 2017 through a flexible annual allocation of $7.5 million (D7 Flex).

Figure 2 illustrates the different components of the integrated services model under Strategy D7.

Figure 2. Strategy D7 integrated services model



Below we describe findings on the operation of PSH and how it has changed under Strategy D7, including:

- The availability and sufficiency of funding and growth in the PSH inventory;
- The intensity and role of the case management provided;

- The type and degree of service provision and coordination;
- The training, guidance, and collaboration that is occurring within and between housing providers and other agencies;
- The processes whereby clients are identified, prioritized, and matched to PSH programs; and
- The characteristics, enrollment, and retention of clients in PSH.

B. Funding and Inventory

Strategy D7 has resulted in greater, more flexible funding for services and subsidies than was previously available. Prior to Strategy D7, funding was perceived as very thin, with few resources; providers mostly relied on private funding sources and building revenue to fund services for PSH residents. Through Strategy D7, providers have received increased and more flexible funding for both case management services and individualized supports, such as bus passes. In addition, rental subsidies through increased funding for the FHSP have allowed providers to serve a broader pool of people than they had been able to serve (e.g., now being able to serve a larger number of people who are not eligible for Federal housing subsidies). Providers also noted that dedicated services funding allowed them to serve and retain clients in pre-existing units. In particular, as CES began successfully identifying and matching high-acuity clients to PSH, housing program managers noted that the building revenue for services was no longer sufficient to fund services for those clients, particularly in buildings with a high concentration of clients of high acuity. Funding under Strategy D7 allowed for more services in these buildings, a finding echoed by some long-term PSH recipients in focus groups who indicated that until recently they had little access to services in their building, which now has improved. Consistent with this report, our analysis of the administrative data indicated that 19 percent of those served after Strategy D7 were already in housing at the time of their connection to DHS ICMS.

In addition to ICMS, Strategy, D7 has funded other resources, including local rental subsidies through FHSP vouchers, placements in Enhanced Residential Care (ERC), and move-in assistance, all components respondents described as useful. At the time of data collection, the bulk of the available funding was for ICMS only; Strategy D7 funding for rental subsidies through FHSP vouchers had been fully committed, ERC placements were temporarily on pause while supplemental funding was being secured, and move-in assistance was available through Strategy D7 funding only for clients who do not qualify for move-in assistance through other sources. Although other resources could be used to support move-in assistance and ERC placements, the perception among staff and administrators was that the funding was now less available for these subsidies and services. Several front-line staff referenced a perceived current lack of available funding for ERC placements or a reduction in availability of move-in assistance. Staff from one focus group also commented on the current lack of FHSP vouchers, reporting that there are clients who do not qualify for Federal housing subsidies who are waiting for housing and unable to access it.

There is growth in the inventory of PSH under development. Providers noted that although other funding sources (Proposition HHH and No Place Like Home) have driven capital development, the availability of a committed stream of services funding for tenants under Strategy

D7 has facilitated this growth. One housing developer explained that lenders are willing to invest in PSH on more favorable terms because Los Angeles County's guarantee of services funding for building units reduces the building operating costs and the perceived risk of the loan. Knowing that there is a committed stream of services funding for tenants has been helpful in alleviating lenders' and investors' concerns, making them willing to invest on more favorable terms. To illustrate the current level of growth in inventory, one housing and services provider reported that the number of units it currently has in the development pipeline is roughly equivalent to the number of units it had constructed over the course of the past 30 years.

Strategy D7 also has allowed program implementers to be involved in planning services for new units before they are constructed. DHS, DMH, and DPH-SAPC track project-based housing that is under development for PSH, so that Strategy D7-funded services can be matched to these units.

C. Nature of Case Management

Strategy D7 has resulted in smaller caseloads, based on acuity. Program managers fairly consistently described case manager caseloads as 1 to 20 or 25 for high-acuity clients and 1 to 40 for low-acuity clients based on DHS guidelines, and this was echoed by some case managers. A few program managers framed the caseloads as a significant change from the landscape before Strategy D7 when providers might have caseloads of up to 70 people. The shift has been necessitated by DHS funding requirements and facilitated by the increase in funding for case management services.

Case management is individualized and intensive. Consistent with the ICMS design under Strategy D7, case managers noted that services are tailored to the client's acuity and needs, and several mentioned the importance of client choice and preference. One program manager described ICMS as encompassing "anything and everything," such as help with life skills, apartment and money management, or accessing transportation, taking clients to appointments or the grocery store, and fostering social connections. This sentiment seemed to be validated by most PSH residents in our focus groups, who remarked that most of their needs were met by their case managers. In addition, ICMS appears to include individualized service planning, biopsychosocial assessments at move-in, and quarterly re-evaluations.

Case managers described frequency of case management as varying depending on client need. Program manager and case managers consistently cited a contact or visit at least once per month as a minimum standard, per reported DHS guidelines, with the highest-acuity clients necessitating multiple home visits per week. A number of case managers also stated that case management needs to be more intensive during the transition period when the client is first placed in housing. PSH clients in our focus groups reported that they received case management visits anywhere from once a month to weekly in person, or on an as-needed basis. Most described their case management as helpful and indicated they were able to access the services when they needed them. However, a few noted confusion about the case manager's role or stated that case managers' roles involve too much paperwork. Because the frequency of case management, services provided, and size of caseloads were not available through the administrative data, we were unable conduct a quantitative examination of the case management delivered through Strategy D7-funded programs or to examine how aspects of case management might influence outcomes.

Based on the program managers and case managers with whom we spoke, the nature of case management services did not appear to vary substantially by population served, although some program managers noted that families may be more resource intensive to serve, in that they need to support multiple people with disparate needs.

Case managers support clients in navigating housing, but some challenges persist. Program managers indicated that clients are assigned to an ICMS provider early in the process when clients are identified and matched through CES. This early connection of case managers to clients is largely viewed as beneficial in helping facilitate clients finding and moving into housing. Both case managers and program managers describe case managers as helping clients navigate housing, with a particular role in supporting the completion of the housing authority application.

Case managers also access housing acquisition and retention assistance for clients served through the FHSP through Brilliant Corners. The organization's housing acquisition team cultivates relationships with landlords, offers landlord incentives, and matches tenants and landlords. The organization has unit holding agreements to retain a large number of units and links them to referrals. Its tenancy support team supports tenants through the process of viewing units and moving into housing, and places a focus on eviction prevention (e.g., facilitating voluntary relinquishments and interim housing placements when needed).

Despite case manager support for housing navigation, challenges were noted, including the competitive housing market and delays and denials in processing applications through the housing authorities. Contributing factors to this last issue reportedly include delays in processing background checks, issuing certificates of eligibility, and notifying clients that their applications are incomplete or contain errors; failure of housing to pass inspections; and errors in the paperwork submitted by clients, despite case manager support. One provider suggested that an electronic system for sharing applications could help address the issue.

D. Service Provision and Coordination

Case managers play a key role in linking clients to needed services. Program managers and case managers described connecting clients to needed services, either to in-house services or off-site resources, through scheduling and accompanying them to off-site appointments. They talked about connecting clients to primary care and other health care, mental health and substance use resources, employment, education, benefits, legal assistance, help getting documentation, and food pantries and other resources. PSH clients also commented on the extent to which case managers help link them to needed care. At the same time, though, PSH clients identified some gaps in access to services and unmet need, particularly around transportation and employment or vocational assistance.

Strategy D7 has reportedly resulted in increases in health, mental health, and substance abuse service access and coordination (CENS, FSP). A high degree of service access was reported by both case managers and tenants at project-based sites and, to a lesser extent, by case managers at some scattered-site locations. As noted earlier, the DMH Full Service Partnership programs provide PSH clients access in project-based sites to on-site mental health care including group and individual therapy, crisis intervention, and medication management by a psychiatrist. These services were already being expanded prior to Measure H, but were additionally expanded to new sites under Strategy D7. PSH clients also have access to referrals for substance abuse screening

and treatment through CENS funded by SAPC, which may either be co-located at project-based housing, or "connected" in cases where co-location is not logistically feasible. To date, SAPC's services have primarily been linked to project-based sites.

While access to medical care was available on-site in some cases, case managers reported putting considerable effort into helping clients, especially those living in scattered-site apartments, track and attend off-site medical appointments. In one PSH focus group at a project-based site, clients reported that it is easy for them to access health clinics when needed.

Home nursing visits are reportedly also available through DHS and are perceived to be helpful as on-site services are seen to be much easier to access. A number of staff reported that the nurses were communicative, which facilitated coordination of care. A team-based approach to service delivery and service coordination was typically described. Depending on whether a client lives in a scattered-site apartment or project-based housing, teams can involve service coordinators, ICMS providers, psychiatrists, psychologists, the property manager, and the CENS counselor. Based on the data collected through multiple sources, the nature of the service coordination varies across providers, and depends on a number of factors, including the client's needs, and whether the site is project-based or scattered-site, the services and housing providers are separate entities, the program is a DMH-Full Service Partnership, and CENS counselors are co-located or connected to that site. We were unable to integrate these qualitative findings with quantitative analysis within the current evaluation, as administrative data were not available that would permit us to examine rates of access to mental health, substance abuse, or medical services or frequency of service use

Staff burnout and turnover is reportedly common, has multiple causes and impacts, and varies by provider. Contributors to burnout include the following.

- *Time-intensive caseloads:* Despite caseloads being reduced and improved under Strategy D7, some case managers noted that they sometimes exceed the recommended size due to staff departures and that even the recommended caseload size is still sometimes too high when the caseload comprises clients with extensive needs and high acuity. High-acuity clients have fluctuating needs and may require minimal intervention for a period of time and then may unpredictably require intensive crisis intervention and daily contact.

- *Travel demands:* In addition, case managers spend much of their time traveling long distances, which can further reduce the time required for clients. Because case managers are assigned to clients at the point of entry through CES, they are often assigned to clients before it is known where the client will be housed. As a result, they reportedly must often travel across multiple SPAs to provide services.

- *Safety concerns:* Due to safety concerns at times when working with particular clients, staff would prefer to travel in pairs to visit these clients as a precaution; this takes considerable staff time, however, and staffing is typically insufficient to permit staff to accompany one another in these cases.

- *Job availability:* Turnover also appears to be driven by the high availability of direct service positions in the field; staff reportedly move across agencies frequently, sometimes for only small pay raises.

Some program directors reported using pay raises as well as developing a supportive culture to retain staff and offset the work demands. Supervision, time for staff interaction and group support, and support for self-care are among the strategies they use to build a culture of staff support.

Case manager turnover reportedly impacts a number of aspects of implementation.

- ***Rapport:*** PSH clients and case managers both noted that when a case manager leaves, it takes time to establish a new relationship and rapport with the new case manager.

- ***Need for training:*** Several program directors and agency administrators spoke about a need for training and retraining of case managers around such principles as harm reduction and housing first, as well as documentation requirements, to help them handle the stress and workload in their positions.

- ***Caseloads:*** Staff turnover also can exacerbate the caseload problem by shifting clients onto other case managers' caseloads and exceeding guidelines. For example, one case manager reported her caseload was twice the recommended amount as a result of staff turnover.

- ***Continuity of care:*** These impacts in turn interfere with continuity of care and disrupt client-provider rapport-building and relationships.

Service coordination efforts have encountered challenges. Agency administrators, program managers, and case managers described challenges in integrating ICMS, DMH, and CENS services into a single on-site model, an endeavor that is happening for the first time under Strategy D7. Challenges impeding service coordination between case managers and staff from other agencies include the following:

- ***Geographic dispersion:*** Services and clients (especially those in scattered-site housing) are geographically dispersed. The vast geographic distances in Los Angeles make it difficult for case managers to visit clients as frequently as is needed, arrange transportation for clients to disparate services, persuade clients to leave home to access services, or find affordable field-based service providers for those in scattered-site housing. Clients living in scattered-site apartments are particularly vulnerable to these challenges. Some of the clients in our focus groups living in project-based units also spoke of the gaps in access to transportation that at times can make it difficult to access specific types of services.

- ***Lack of communication:*** There are problems in connecting and getting responses from staff in other agencies as well as differing philosophies among staff from different agencies administering services and/or housing and services providers. Case managers described difficulties communicating with staff at other agencies, including DMH and SAPC. Some described difficulty reaching the staff, getting timely responses, and not being notified when staff left the agencies. One program manager stated that Strategy D7 scaled up rapidly, and that initial service coordination efforts were accompanied by role confusion among staff from different agencies. A second challenge in working with staff across different administering agencies and/or services providers relates to the

different philosophies they may hold (e.g., harm reduction vs. abstinence) and how these different views make it difficult to work together along the same goals for a client. At a minimum, some staff may be less well versed than others in the principles of housing first, harm reduction, and trauma-informed care

- ***Barriers to engaging in mental health and substance abuse services:*** A very common challenge described by agency administrators, program managers, and case managers involved engaging clients in mental health and/or substance abuse treatment. Agency administrators report that the anticipated level of need for these services has not been reflected in treatment uptake. When Strategy D7 was initiated, it was estimated that approximately 30 percent of PSH clients would require access to mental health and/or substance use services in addition to the ICMS provided to all Strategy D7 clients. Although administrative data were not available on services to examine service receipt or mental health and substance abuse need, the program managers and case managers we interviewed indicated that they believe fewer clients than projected are accessing these services, due to multiple factors. First, it is not clear how many clients being served have mental health conditions unless they are in dedicated units or buildings for individuals with mental health conditions. Both mental health and substance abuse counselors are reportedly being underutilized for treatment, but are devoting time to outreach efforts that may not be reimbursable or captured under performance metrics. Interviewees believe that underutilization of behavioral health services is likely less due to need and more due to clients' reluctance to engage in the services. Client reluctance to engage in services can stem from stigma and a fear of losing housing if they admit to substance abuse, a lack of desire for treatment, and a reluctance to leave home to go to treatment coupled with the lack of substance abuse providers willing to visit clients in their units. These challenges do not appear to vary substantially by population served, although one provider noted that families may be relatively easier to engage and youth relatively more difficult to engage than other populations.

- ***Delays in access:*** Some case managers indicated clients can wait up to three months for a mental health intake through off-site DMH clinics and then experience long wait times for mental health appointments. Substance abuse treatment was highlighted as a particular area of unmet need, possibly because the CENS services do not involve full-time on-site staff. Several providers emphasized the importance of having linkages to substance abuse services immediately available when a client seeks treatment to ensure that they can access the services when they are motivated to engage with them. One provider described problems linking clients to CENS counselors in a timely fashion and described an experience in which a counselor did not show up to an appointment with a client seeking to initiate treatment. PSH clients also gave varying accounts of the accessibility of mental health services. A number reported currently having a therapist or described how their case managers had helped them access one, while a few said they had not received services or had to seek them out on their own. In addition, case managers reported that it is challenging to manage clients living in PSH where there is active substance use, and one program manager suggested a need for more substance abuse resources for clients in the active use phase. PSH clients in one focus group also

voiced the need for having Alcoholics Anonymous and other substance abuse recovery groups on-site.

E. Training, Guidance, and Collaboration

More guidance and training are available to guide the implementation of PSH under Strategy D7, although some potential areas for improvement were noted. Program managers described the level of support from DHS as "unprecedented in a funder" and described the guidance as following a "coaching" model, involving bi-weekly calls with a program manager, ongoing case note reviews, frequent site visits with technical assistance and support, and annual site monitoring with case note review. The approach reportedly keeps staff looped in so that they can meet expectations and avoid surprises. Several program managers spoke positively about the Case Management Institute, which provides a 10-month cohort training for new case managers**.** Some case managers perceived the training as therapeutic and supportive with resources, while others did not find the training suited to their roles within their agencies. Others wanted more of a focus on best practices and foundational knowledge (i.e., Housing First, Substance Use 101) or to have the trainings clustered on fewer days.

Strategy D7 has necessitated increased collaboration across agencies, PSH providers, and staff to coordinate services for clients within and across agencies. The integrated services model and the case manager's role in housing navigation has required the cooperation of DHS, DMH, DPH-SAPC, the housing authorities, and LAHSA. Several providers noted that collaboration has helped systems work together to identify and address problems and barriers, such as addressing delays in filling units through CES and challenges in navigating applications through the housing authorities. No issues were noted around collaboration among senior staff, but case managers described difficulties coordinating with staff from DMH and DPH-SAPC on client service coordination, as described previously.

F. Client Identification, Prioritization, Matching, and Housing Placement

Client identification, prioritization, and matching to housing resources occurs through CES, with few exceptions. The majority of program managers and case managers identified CES as the primary (and exclusive) referral source for PSH. Program managers noted that CES began identifying and prioritizing high-acuity individuals to PSH prior to Strategy D7 implementation and that this generated problems around inadequate services funding. Strategy D7 has helped to address the needs of this population through a richer services package than was previously available.

Housing providers report using few exclusionary criteria after a person is referred to them by CES. However, housing authorities, landlords, and property managers may subsequently apply criteria. Program managers consistently reported employing a housing first model and minimal exclusionary criteria for PSH programs. However, they noted that additional exclusionary criteria may be applied that can affect access to housing during screenings by the housing authorities, landlords, or housing managers due to the requirements of specific buildings' funding sources. Exclusionary criteria cited included a history of manufacturing substances, arson, sex offender status, and undocumented status. The FHSP is reportedly a useful resource to house households when applications are denied through the housing authorities based on these types of exclusionary criteria.

The expansion of resources provided through Strategy D7 has funded case managers to work with PSH participants to find and move into housing. Case managers' roles under Strategy D7 include working with clients early in the process when they are identified and matched through CES, allowing case managers to help clients find and move into housing, including supporting the completion of the housing authority rental subsidy application. Table 2 below provides information on the 1,700 households (that who moved into housing while receiving ICMS services following Strategy D7. This subset of households constitutes 31% of the total sample of 5,472 households served through Strategy D7-funded programs, while an additional 1,057 households not represented here (19% of the total sample) moved into housing prior to accessing Strategy D7-funded services. As shown in Table 2, those who moved into housing after enrolling in services did so in a median of 103 days from initiating services. Only 8% of those who moved into housing after enrollment exited services within the two-year post-implementation period. The process of moving clients into housing reportedly remains challenging, despite case manager support, and outcomes are not yet known for many of those served after Strategy D7, more than a third of whom are currently and recently enrolled (for a median of 80 days) and still waiting to move into housing, as outlined further in the sections below.

Table 2. Time to move into housing and exits from services among households moving into housing during enrollment

Sample size	N=1,700
Days to Move In	Mean = 134 Median = 103
% Exiting Services within 2 Years of Entry	8%
Days to Exit	Mean = 291 Median = 274

Section III. Characteristics and Outcomes of Clients Served through Permanent Supportive Housing Under Strategy D7

A. Characteristics of Clients Served Through Permanent Supportive Housing

Clients served through PSH after Strategy D7 are predominately single male adults, and are racially diverse. Table 3 provides information on the demographic composition of the population served after Strategy D7 (Provide Services and Rental Subsidies for Permanent Supportive Housing). The majority (99%) of those served are single adults, and 58% are male. The racial composition of the population served is predominately white (40%) and Black or African American (42%), with the remaining clients identifying as multiracial (6%), Asian (2%), Hawaiian/Pacific Islander (< 1%),or having missing or unknown race (9%). Just under a third of clients served (30%) identify as Hispanic or Latino, and 4% are veterans. Reliable information was not available on income and benefits or need characteristics (e.g., acuity, health and mental health conditions, or history of domestic violence) among those served after implementation of Strategy D7.

Table 3. Demographic characteristics of clients served by PSH

Sample size	N = 5,472
Household Composition	
Single Adults	99%
Families	<1%
Gender	
Male	58%
Female	40%
Trans/Nonconforming	1%
Unknown/Missing	<1%
Race	
White	40%
Black or African American	42%
American Indian/Alaskan Native	0%
Asian	2%
Hawaiian/Pacific Islander	<1%
Multiracial	6%
Unknown/Missing	9%
Ethnicity	
Hispanic or Latino	30%
Not Hispanic or Latino	67%
Ethnicity Unknown/Missing	3%
Veteran Status	
Veteran	4%
Not a Veteran	92%
Unknown/Missing	3%

B. Client Enrollment and Retention

Retention is perceived to be high and potentially facilitated by ICMS provided under Strategy D7. Program managers typically reported retention rates of 90 percent or higher in

housing. This was consistent with the composition of our focus groups (though a convenience sample), which illustrated a high retention rate in general in projects funded through Strategy D7 dollars, with many of the PSH clients having been in PSH for more than a decade. It is also consistent with our finding that 5% of households served after Strategy D7 exited services after moving into housing. Some program managers believed retention had improved due to Strategy D7, while others felt retention had already been high, or that it was too soon to tell. Program managers viewed Strategy D7 as aligned with retention goals because it provides long-term and on-going case management support for clients in housing. One specific facilitator is that Strategy D7 allows case managers to help clients with annual recertification through the housing authorities, which some clients find overwhelming. Additionally, service providers are now more available on-site to coordinate with property managers to catch problems early and avert potential eviction. One benefit a program manager described is that property managers can easily connect to on-site ICMS and, in some cases, mental health providers flag issues like hoarding as they arise, which can avert eviction.

While it is still too early to assess long-term retention outcomes using administrative data for most of those served under Strategy D7, findings presented in Tables 4 and 5 indicate the following.

- *Exits:*
  - 19% of those served after Strategy D7 exited services within the two-year implementation period; 5% of those served exited services after moving into housing, while 14% exited services without a record of moving into housing. Those exiting had been enrolled in services for median of 167 days, close to six months.
  - It should be noted that it is possible to exit PSH programs tracked in CHAMP and to stop receiving services, but to remain housed through a rental subsidy, so exits among those who moved in do not necessarily reflect exits to homelessness. At the same time, exit destination is not tracked in CHAMP for those who exit without moving into housing, so it is possible that those in this category (14% of those served after Strategy D7) are exiting to homelessness or an unstable living situation.
- *Housing and Service Receipt:*
  - The plurality (46%) of those served after Strategy D7 were in housing and receiving services at the end of the two-year post-implementation period, as of July 1, 2019. This group had been enrolled in services for close to a year, a median of 318 days
  - As noted previously, more than a third of those served after Strategy D7 (35%) were enrolled in services but had not yet moved into housing at the end of the post-implementation period. This group had been enrolled in services for an average of 160 days, with half enrolled for less than three months.

Table 4. Housing and services status among households in PSH

Sample size	N = 5,472
% In Housing with Services	46%
% Enrolled in Services, Not yet in Housing	35%
% Exited Services within 2 Years	19%
% Exited with Housing	5%
% Exited without Housing	14%

Table 5. Length of enrollments among households in PSH

Sample size	N = 5,472
Days Enrolled among those In Housing with Services	N = 2,495
Mean	340
Median	318
Days Enrolled among those Enrolled in Services, Not yet in Housing	N = 1,939
Mean	160
Median	80
Days Enrolled among those Exiting Services within 2 Years	N = 1,038
Mean	200
Median	167

Reasons clients leave housing include substance use, need for a higher level of care, drawbacks to some housing, and, in rare cases, eviction. Program managers reported that eviction is rare, citing rates from one to four percent, and indicated that it is primarily due to lease agreement violation. They described efforts to avert eviction, and, in the worst case scenario, working with the client to voluntarily relinquish housing and move elsewhere rather than be formally evicted. Program managers believed that substance abuse often plays a role in clients leaving housing. Clients sometimes need to transition to a higher level of care, such as Enhanced Residential Care, a process that staff indicated is not always straightforward. Some clients in the PSH focus groups reported that they would like to move because of aspects of the housing, such as a lack of a real kitchen or bathroom in the apartment or due to safety concerns, but that affordability is a barrier. In one focus group, clients noted that in order to retain their housing, they could not violate the guest restriction (no more than 14 nights per year, including family), a rule that several expressed their dissatisfaction with.

Section IV. Conclusions and Recommendations

A. Conclusions

Overall, Strategy D7 (Provide Services and Rental Subsidies for Permanent Supportive Housing) has provided richer resources for services provision to those in PSH and is perceived positively by providers who appreciate the high quality guidance, training, and support they have received from DHS around implementation of PSH under Strategy D7, and report that it has enhanced their ability to provide holistic, comprehensive services for clients. However, some challenges persist. Key findings are described further below.

Greater availability of funding for services and rental subsidies for new and existing PSH. Strategy D7 has provided greater and more flexible funding for services for PSH. Dedicated services funding is appreciated by providers, especially for preexisting units. Increased services funding for existing units is evident in the administrative data, which indicate that 19% of those served after Strategy D7 were already in housing when they initiated ICMS through Strategy D7-funded PSH programs. Strategy D7 has also funded services to match housing inventory under development, thus facilitating the development of new PSH units, and has expanded the availability of local subsidies that can be used for those who do not qualify for Federal rental subsidies.

Improved training and guidance and increased collaboration. Greater collaboration across agencies, PSH program managers, and staff has occurred to support the integration of services. Moreover, to guide the overall implementation of PSH, DHS provides what program managers describe as high-quality guidance, using a coaching model and comprehensive training. Increases in efforts to coordinate services within and across agencies and increased collaboration across agencies have reportedly resulted in more service coordination, team-based care, and availability of on-site services. In addition, providers spoke highly of the guidance and training from DHS around Strategy D7 implementation, which they perceived as responsive and relevant.

More intensive individualized services and improved service coordination. Strategy D7 has reportedly strengthened case management and service coordination for high-acuity individuals with complex needs. In doing so, it has met a growing need for services for the most vulnerable, chronically homeless individuals, who increasingly are being identified and prioritized through CES. Case management services have improved under the strategy, with lower caseloads, more holistic and individualized case management, and a focus on linkage to needed services. Case managers are also matched to clients when clients are matched to PSH through the CES, and therefore are able to support clients in navigating the process of securing housing. Program managers believe the extended case management support provided through the increased funding helps to foster retention.

Strong case management support for moving clients into housing, despite challenges. Case managers' roles under Strategy D7 include working with clients early in the process when they are identified and matched through CES, allowing case managers to help clients find and move into housing. Those who moved into housing after enrolling in ICMS services did so in a median of 103 days from initiating services. The majority of those who moved into housing (92%) remained enrolled and did not exit within the two-year post-implementation period. The process of moving clients into housing reportedly remains challenging, despite case manager support, and outcomes are

not yet known for many of those served after Strategy D7, more than a third of whom are currently and recently enrolled (for a median of 80 days) and still waiting to move into housing

Retention facilitated through long-term and on-site services. Program managers typically reported high retention rates in housing. This was consistent with the composition of our focus groups (though a convenience sample), which illustrated a high retention rate in general in projects funded through Strategy D7 dollars, with many of the PSH clients having been in PSH for more than a decade. It is also consistent with our finding that 5% of households served exited services after moving into housing. Program managers viewed D7 as aligned with retention goals because it provides long-term and ongoing case management support for clients in housing, including assistance with recertification and the availability of on-site service providers to catch problems early and work with property managers to prevent eviction. Administrative data analysis indicated that 5% of those served exited services after moving into housing, while an additional 14% of those served exited services without moving into housing. Because exit destinations are not tracked for those who do not move into housing, it is possible that those in this category are exiting to homeless or unstable housing situations. The plurality of those served after Strategy D7 (46%) were in housing and receiving services at the end of the post-implementation follow-up period; this group had been enrolled in services for close to a year (a median of 318 days). It should be noted that outcomes of many of those served through Strategy D7 are not yet known due to the recency of the program.

Ongoing Challenges. While the program is operating in general as it was intended to, there are several challenges around service delivery, described below:

- **Staff turnover and burnout.** Case manager burnout and turnover as well as turnover among staff at other agencies reportedly is high and impacting service delivery. Serving high-acuity clients with complex needs is reportedly challenging, placing unpredictable demands on case managers' time. Clients we spoke with noted the frequent turnover among case managers, and staff reported this can pose challenges to building rapport with clients.

- **Gaps in service coordination.** Service coordination efforts are new. At the start of implementation, these efforts reportedly resulted in initial role confusion across staff from different agencies, and communication and philosophical alignments among staff across administering agencies and/or service providers are not yet in place. Geographic dispersion of services which are sometimes located far from clients' places of residence, also poses barriers to service coordination.

- **Barriers to accessing and engaging in services.** Ensuring access both to case management and to other disparate services across the vast geographic distances in Los Angeles was a frequently cited challenge. Gaps reported in access to mental health and substance abuse services may be driven by challenges in engaging clients in needed services, as well as barriers to timely uptake for clients who do seek treatment. Clients in focus groups reported difficulties accessing needed mental health services and substance use support groups

- **Difficulties obtaining housing.** Providers noted challenges around obtaining housing for clients, including delayed and denied applications for housing through the housing authorities and reluctance of landlords to accept vouchers in the competitive housing market. For clients, the quality and safety of the physical housing was an additional concern.

- **Lack of integration across data systems and incomplete data.** Due to a lack of integration across data systems and differences in methods of tracking information across HMIS and CHAMP, the types and intensity of services received during program enrollment, and the destinations of those exiting the program without obtaining housing are not known. Additionally, we were unable to complete an in-depth assessment of the needs and characteristics of the population served (e.g., health and mental health conditions, CES vulnerability scores) or to examine whether these have shifted over time, as these data were not collected in CHAMP and the majority of the sample was not tracked in HMIS. We were additionally unable to assess changes in outcomes before and after implementation because findings potentially reflected inconsistent methods of tracking enrollments over time.

B. Recommendations

Although Strategy D7 is largely operating the way it was intended to operate, the challenges faced suggest that a few improvements are needed for it to function optimally. These are outlined below.

- ✓ **Reduce turnover among staff.** Having more stability in staffing is critical, given the negative impacts of staff transitions on rapport with clients and coordination of services, as well as increasing the need for additional trainings. Among the measures that could help with turnover involve:
  - Reducing the need for case managers to travel across such wide distances by greater attention to clients' potential housing placements and geographic matching of case managers;
  - Increasing salaries; and
  - Developing and implementing protocols to ensure that case managers and other external staff (e.g., mental health providers, substance use counselors) feel safe while delivering services, and creating a culture of support and self-care through access to support groups and behavioral health resources
- ✓ **Fill gaps in service coordination.** Service coordination might be enhanced with strategies for improving communication and cross-training for staff from different agencies. Addressing the geographic dispersion of services may also be helpful. Strategies could include ensuring case managers are fully compensated for vehicle repairs and maintenance and other transportation costs, providing more transportation resources for clients (ride sharing accounts, shuttles), and incentivizing mental health and substance abuse service providers to deliver field-based services to clients who are not already connected to on-site services through FSP and CENS at project-based sites.
- ✓ **Address underutilization of mental health and substance abuse services.** Providers report underutilization of mental health and substance abuse services, while clients report delays in accessing needed care. This discrepancy requires greater attention, with more examination through interviews with staff and examination of client records where the mismatch in services exists as well as where utilization appears to be lowest and highest. Understanding service patterns and the match with clients' backgrounds may help to calibrate services more to where the needs appear to be. In addition, talking with an array of

clients about the barriers they see in accessing services and how to make them more low-barrier may help with the client-driven challenges to access. For services that appear to be oversubscribed, more resources may be needed to reduce intake and appointment wait times and increase frequency of appointments and for substance abuse counselors to be present to provide on-site screening and intervention.

- ✓ **Reduce barriers to obtaining housing through landlord cultivation and coordination with the housing authorities.** Given the competitive housing market, it may be helpful to increase landlord outreach strategies. In addition, coordinated efforts between housing and service providers and the housing authorities are reportedly needed to improve the process of applying for rental subsidies through the housing authorities. These efforts could potentially focus on reducing errors in submitted applications, streamlining the approach to updating incorrect or incomplete applications, and expediting the housing inspection process.

- ✓ **Improve data quality and integration across systems, and track service receipt and outcomes over time.** The HMIS and CHAMP data systems offer the potential to understand who is served, monitor its own implementation of services, and examine exit rates and patterns. While all clients funded through Strategy D7 are tracked in CHAMP, improved integration across these two data systems can permit more complete characterization of the clients being served, primarily by being able to maximize the data collected through the HMIS which tracks client characteristics and exit destinations more extensively. In addition, it may be helpful to track services delivery, including the frequency of case management delivered and linkage to other mental health, substance use, and medical services, and benefits. Such information could help to inform our understanding of the nature and intensity of the services provided before and after move-in and how these services impact outcomes. Likewise, it would be useful to track exit destinations among those who exit ICMS without moving into housing. Finally, ensuring that check in and check out dates and move in dates in CHAMP are used consistently across providers and over time will permit more targeted assessment of change in outcomes over time. Such efforts could potentially yield richer, more complete data on client characteristics and outcomes, and permit examination of how acuity of population and intensity and type of service receipt has changed over time and impacts outcomes.

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Appendix

Summary of Methods

Appendix
Summary of Methods

A. Document Review

Review of documents has been employed to better understand the history, evolution, and status of Strategy D7 (Provide Services and Rental Subsidies for Permanent Supportive Housing); to inform the development of interview and focus group protocols; and to contextualize the qualitative data gathered. Documents reviewed include: contextual information on homelessness in Los Angeles County, including Annual Homeless Assessment (AHAR) and Continuum of Care (CoC) reports; strategic documents from the Homeless Initiative (HI), HI performance evaluations, and HI quarterly reports; and publicly available and internal documents from the HI, Los Angeles Homeless Services Authority (LAHSA), including strategic planning and implementation documents, impact dashboards, community input session summaries, guides to contracting opportunities, lists of funded Strategy D7 contractors, presentations, and reports (Exhibit A-1).

Exhibit A-1. Relevant documents

- Contextual information on homelessness in Los Angeles County
- Annual Homeless Assessment Report (AHAR) data and Continuum of Care (CoC) reports
- Strategic documents from the Homeless Initiative (HI)
- HI performance evaluations and HI quarterly reports
- Budgets
- Internal documents from DHS
- Dashboards and publicly available documents from LAHSA

B. Interviews and Focus Groups

Individual semi-structured interviews and focus groups with program administrators, and permanent supportive housing (PSH) program directors, case managers, and residents were the main source of information on the operation of PSH following the funding of Strategy D7. In this section, we describe how we selected agencies and individuals to interview, and the processes for data collection.

Sampling. We conducted telephone interviews with administrators from all key agencies that are involved in administering PSH in LA County, as well as agencies that coordinate with PSH on housing and the coordinated entry system (CES). Agencies include the Chief Executive Office (CEO), Department of Health Services (DHS), Department of Mental Health (DMH), Los Angeles Homeless Services Authority (LAHSA), Housing Authority of the City of Los Angeles (HACLA), and Los Angeles Community Development Authority (LACDA). Additional information on the agencies and the interviewees are available in Table A-3.

We sampled a total of 16 organizations to be included in the interviews and focus groups that administer permanent supportive housing in LA County from the pool of 65 ICMS providers and an overlapping pool of 105 PSH programs receiving Strategy D7 funding through DHS. We first limited the selection to PSH organizations that receive Strategy D7 funding. We arrayed the organizations by the geographic regions and populations served, inclusive of both newer and older

programs. With input from DHS we identified those Strategy D7-funded organizations that were both housing and Intensive Case Management (ICMS) providers as well as those that DHS believed would have a sufficient number of clients served under Strategy D7 to be able to provide perspective on PSH under that strategy. We initially selected 10 organizations for interviews and 11 organizations for focus groups that were both housing and ICMS providers and were arranged across the SPAs.

After speaking with DMH and DPH, we expanded our sample to ensure we had organizations that had FSP and CENS collocated/connected services. To ensure the full range of perspectives on case management, we additionally expanded our sample to include some ICMS providers who were not also housing providers and to include additional providers that served families and youth. This expansion resulted in recruitment of 5 additional organizations for focus groups.

We selected 10 of the organizations in SPAs 1, 3, 5, 7, and 8, with which to conduct telephone interviews with program directors. Before the telephone interview, program directors were sent a brief web survey to gather information on the program and the services that the agency offers. We conducted 17 interviews with agency administrators and 10 interviews with program directors in SPAs 1, 3, 5, 7, and 8. We conducted three additional interviews with program directors in SPAs 2, 4, and 6 who were unable to attend our focus groups.

We conducted three focus groups with two to five case managers in each and three focus groups with two to seven program directors each, representing the three largest SPAs (2, 4, and 6). Three focus groups were conducted with PSH recipients in SPA 4. Recipients' focus groups included one focus group with five women from one project-based housing program, one focus group with 10 residents of a project-based housing program with mental health dedicated units, and one focus group with 10 residents from four different PSH project-based sites. Lists of providers sampled for interviews and focus groups are presented in Tables A-1 and A-2, respectively. A list of key informants interviewed is provided in Table A-3. A list of providers sampled for PSH client focus groups is shown in Table A-4.

Table A-1. Interviews with program directors

Organization	SPA
Mental Health America	1
Union Station Homeless Services	3
Koreatown Youth and Community Center	4
Venice Community Housing	5
Jovenes	7
The Whole Child	7
Coalition for Responsible Development	8
Harbor Interfaith Services	8
Homeless Healthcare LA	Across SPAs
Imagine LA	Across SPAs

Table A-2. Focus groups with program directors and staff

Organization	SPA
A Community of Friends *(interviewed)* Penny Lane Centers *(staff only)* LA Family Housing Corporation *(staff and directors)* Ascencia *(staff and directors)* Bridge to Home *(interviewed)*	2
Downtown Women's Center *(directors)* Skid Row Housing Trust *(interviewed)* The People Concern *(staff and directors)* Volunteers of America *(staff)* PATH Ventures *(staff and directors)* Gettlove *(directors)*	4
Special Service for Groups *(directors)* Watts Labor Community Action Committee *(staff and directors)* Tarzana Treatment Centers *(staff)* Upward Bound House *(directors)* Lutheran Social Services of Southern California *(staff and directors)*	6

Table A-3. List of administrators participating in key informant interviews

Point of contact	Organization
Leepi Shimkhada, Strategy D7 Lead	Department of Health Services (DHS)
Ryan Izell	DHS Office of Diversion and Reentry (ODR)
Maria Funk, Priscilla Moore	Department of Mental Health (DMH)
Yanira Lima, Kristine Glaze	Department of Public Health (DPH)/ Substance Abuse Prevention and Control (SAPC) – Client Engagement and Navigation Services (CENS)
Sarah Mahin	Department of Health Services (DHS)
Kevin Flaherty	Department of Health Services (DHS)
Marina Genchev, Josh Hall	Los Angeles Homeless Services Authority (LAHSA)
Steve Rocha and Christopher Chenet	Los Angeles Homeless Services Authority (LAHSA)
Jonathan Sanabria	Los Angeles Homeless Services Authority (LAHSA), Coordinated Entry System
Elizabeth Ben-Ishai	Chief Executive Office (CEO)
Meredith Berkson	Chief Executive Office (CEO)
Ashlee Oh	Chief Executive Office (CEO)
Halil Toros	Chief Executive Office (CEO)
Ryan Mulligan	Housing Authority of the City of Los Angeles - HACLA
Maureen Fabricante	LA Community Development Authority - LACDA (Previously called the Housing Authority of the County of Los Angeles - HACoLA)
Jennifer Lee	PATH LeaseUp program
Chris Contreras, Perlita Carrillo, Sophia Rice	Brilliant Corners Flexible Housing Subsidy Pool (FHSP) with DHS

Table A-4. Focus groups with clients

Organization	Population	SPA
Skid Row Housing Trust	Mixed	
Downtown Women's Center	Women	4
PATH Ventures	Mixed	

Data Collection. All data collection followed informed consent and human subjects protection procedures approved by Westat's Institutional Review Board (IRB). One-hour confidential telephone interviews were conducted with individual administrators and program directors, recorded to provide for confidential transcripts to provide a backup to note taking.

All focus groups were conducted in a private space located at a participating PSH provider organization. Interviews and focus groups with agency administrators and providers gathered information on the funding sources for Permanent Supportive Housing (PSH) under Strategy D7, the current inventory (number and type) of PSH, the nature and amount of case management (size of caseloads, frequency of contact, supports provided, continuity of case management over time), the types of other services provided and degree of service coordination, the degree of guidance and training around implementation within and across organizations, and the ways in which clients are identified and matched to PSH, as well as the populations served, program eligibility requirements and causes of eviction, as well as rates of and contributors to retention or departure from programs. Case manager focus group protocols elicited information about their roles in PSH, covering how clients enter PSH, types and coordination of services, level of collaboration within and across providers, and client retention. PSH recipient focus groups gathered information on the problems that led them to need housing interventions, experiences with finding and moving into housing and

retention in housing, the services and supports received, and outstanding needs and recommended changes to the programs. All interviews and focus groups elicited information on perceived changes under Strategy D7 and sought to gather information on any variations in populations served. Full copies of our interview protocols were submitted with our Project and Data Collection Plan in September 2019 and are available upon request.

C. HMIS and CHAMP Administrative Data

Analyses of administrative data were conducted to provide information on the characteristics and needs, enrollment and length of time in PSH, and exits from PSH for clients served in PSH after Strategy D7 was funded.

Sample. The sample for our administrative data analysis comprised all clients served through PSH in programs funded through Strategy D7 between Strategy D7 implementation on July 1, 2017, and July 1, 2019 (N = 5,472).

Data sources. Data sources included DHS' Comprehensive Health and Management Platform (CHAMP) and the Homeless Management Information System (HMIS). Of note, given that a substantial proportion of our sample was tracked in only one of the two data systems, we limited our analysis to data elements that were available across both data systems to have the most complete sample possible.

Construction of Variables. Sociodemographic variables extracted include age, gender, race, ethnicity, and veteran status. Using HMIS data, we constructed household type using age and number of children under 18 in the household (determined by calculating whether children age 18 were linked to the head of household via a household ID). For CHAMP data, which does not provide household ID, all clients were coded as heads of household, with the exception of the project with which the client was affiliated, with input from DHS.

For clients tracked in both data systems, we privileged whichever data source had more complete variables. In the event that both data systems had complete variables, we relied on HMIS for most of the constructed variables, with the exception of race, which appeared to be more complete in CHAMP.

The following descriptive variables were extracted from HMIS and CHAMP: age, gender, race, ethnicity, and veteran status.

Outcome variables were constructed as described below:

1. **Enrollments.** Enrollments identified using check-in and check-out dates in CHAMP (that is the dates clients initiated and exited from ICMS). For those tracked in HMIS, enrollments were also identified using project start and exit dates for those entering PSH programs (project type 13 in HMIS).

2. **Move-in Dates.** Clients were considered to have moved into housing if there was a record of a move-in date associated with their enrollment in PSH. For those who moved into housing on or after they enrolled in PSH, time to move into housing was

calculated based on the check-in date and move-in date in CHAMP (as well as project start date and move-in date among those additionally tracked in HMIS).

3. **Exits.** Clients who were no longer checked into a PSH program and had a check-out date documented were considered to have exited the program (as were those who had a project exit date from a PSH program documented in HMIS). Days to exit for these individuals was calculated as days from check-in date to check-out date (or days from project start date to project exit date for those additionally tracked in HMIS).

4. **Length of Enrollment.** For clients who had not yet exited the program, length of enrollment was calculated between check-in date and the end of the implementation period (6/30/2019)

In some cases, clients who appeared to have multiple enrollments very close together in time (with one enrollment period starting within 30 days of the last program exit date in CHAMP or within 60 days of the last program exit date in HMIS) were determined to have administratively unenrolled and re-enrolled. For these individuals, we consulted with DHS and the CEO and determined that we should not count these individuals as having had multiple periods of enrollment. Instead, we counted these cases as a single period of enrollment, beginning with the earliest check-in date and ending with the latest exit date information. Periods of enrollment in PSH that overlapped in time were considered to be a single period of enrollment, retaining the earliest enrollment date and the latest exit date. We also identified cases where clients had enrolled and exited the program within a single day and who had no record of having moved into housing. These individuals were excluded from the sample, as it was not clear that they had actually initiated any service receipt.

Analysis. We conducted descriptive analysis, examining percentages for categorical and means, medians, and standard deviations for continuous variables.

Limitations. A number of limitations should be noted. Quantitative data were collected for administrative purposes and should be interpreted with caution. Because CHAMP and HMIS data systems are not fully integrated, we were limited in the variables we could examine. For example, we did not have access to information on vulnerability scores, disability and other health conditions, or domestic violence for the majority of the sample, as this was available to us only through the HMIS data. Strategy D7 is new, and the length of available observation was therefore a maximum of two years. Finally, as described previously, our analysis was limited by the absence of a meaningful pre-implementation cohort that could be used as a point of comparison to understand quantitatively how population characteristics and outcomes have changed following Strategy D7.

With respect to the qualitative data collected, we were limited in the number and range of providers and PSH clients we were able to sample within the scope of the evaluation, and may not have captured all perspectives. For example, we did not have the resources to systematically sample sites with and without FSP and CENS services in place, to systematically look at the experiences of ICMS only providers versus those providing both housing and services, or to speak with PSH clients in scattered site housing.

Westat

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Evaluation of Los Angeles County's Strategies to Expand and Enhance Services Provided Through Permanent Supportive Housing

Report

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Executive Summary

A. Background

Strategy D7 (Provide Services and Rental Subsidies for Permanent Supportive Housing) is one of 21 strategies funded through Measure H, a 2017 ballot initiative in Los Angeles County to prevent and combat homelessness. Permanent supportive housing (PSH) is an evidence-based approach to ending homelessness for individuals who have experienced chronic homelessness and have multiple service needs, typically including mental health and/or substance use disorders (United States Interagency Council on Homelessness, 2010). Following "housing first" principles, PSH provides clients with expedited access to an independent, permanent residence and needed services and supports.

Strategy D7 aims to improve access to and enhance the provision of services for additional PSH by creating a model of integrated services, including intensive case management services (ICMS), specialty mental health services (Housing Full Service Partnership), and substance use disorder services (Client Engagement and Navigation Services), as well as filling in the service gaps in existing permanent supportive housing and creating new local rent subsidies.

B. Evaluation Description and Methods

Westat, a national research organization, in collaboration with the University of Southern California, has contracted with Los Angeles County's Chief Executive Office (CEO) to evaluate the operation and outcomes of PSH under Strategy D7. The evaluation, conducted between June and November 2019, involves the analysis and collection of data from multiple methods and sources, including document review; individual interviews with administrators and housing and services program managers; and focus groups with case managers, housing and services program managers, and PSH residents in project-based housing (i.e., congregate settings). In addition, administrative data from the Homeless Management Information System (HMIS) administered by the Los Angeles Homeless Services Authority (LAHSA) and the Department of Health Services' (DHS's) Comprehensive Health and Management Platform (CHAMP) were analyzed. These data were not originally collected for research purposes and are limited in their reliability and completeness. However, they provide a basis for a descriptive understanding of the characteristics, length of time served, time to move-in to housing, and rates and timing of exits of households served through Strategy D7-funded PSH . Between July 1, 2017 and July 1, 2019, 5,472 households were served through Strategy D7-funded ICMS. Among those served, 1,057 households were in housing when they enrolled in services, and an additional 1,700 households moved into housing while enrolled in services. Additionally, 4,434 of households served through Strategy D7-funded programs were still enrolled in services and had not yet exited at the end of the two-year post-implementation period.

C. Findings

Overall, D7 has provided more resources for services provision to those in PSH and is perceived positively by providers who appreciate the high quality guidance, training, and support they have received from DHS to guide implementation of PSH under Strategy D7. The majority of program

managers interviewed report that it has enhanced their ability to provide holistic, comprehensive services for clients. Key findings are described further below.

Greater availability of funding for services and rental subsidies for new and existing PSH. The operation of PSH under Strategy D7 has accelerated the availability and sufficiency of funding for PSH and sustained the growth in the PSH inventory. Strategy D7 has provided more funding and more flexible funding for services for PSH, including dedicated services funding for preexisting units. Strategy D7 has also funded services for inventory under development, thus facilitating the development of new units, and has expanded the availability of local subsidies for those who do not qualify for Federal rental subsidies.

Improved training and guidance and increased collaboration. Greater collaboration across agencies, PSH program managers, and staff has reportedly occurred to support the integration of services. Moreover, to guide the overall implementation of PSH, DHS provides what program managers describe as high-quality guidance, using a coaching model and comprehensive training.

More intensive individualized services and improved service coordination. Strategy D7 has provided for more intensive and more flexible services funding than previously available and has increased the availability of intensive case management services in permanent supportive housing, enhanced the case management services and supports provided, and strengthened coordination with mental health and substance abuse services. Since Strategy D7, case manager caseloads are reportedly smaller and based on acuity, and case managers are able to provide more hands-on, individualized, and frequent services to residents in both project-based housing and scattered-site housing.

In all project-based housing under Strategy D7, DMH is operating the Housing Full Service Partnership program that provides on-site mental health care including group and individual therapy and medication management by a psychiatrist. These services existed prior to Measure H, but were additionally expanded to new sites under Strategy D7, although it should be noted that not all clients funded through Strategy D7 are located at DMH FSP sites. In addition, referral for substance abuse screening and treatment is co-located with the mental health services at some sites or "connected" at some sites where co-location is not logistically feasible. These services are provided through the Client Engagement and Navigation Services (CENS) funded by the Substance Abuse Prevention and Control (SAPC), and to date, SAPC's services have primarily been linked to project-based sites.

The population served through PSH under Strategy D7 is comprised predominately of single male adults and is racially diverse. Clients are referred to PSH through the Coordinated Entry System (CES). While PSH program managers reportedly have minimal exclusionary criteria for enrolling clients, housing authorities, landlords, and property managers may apply additional criteria. Clients served after Strategy D7 was implemented are predominantly single male adults. The racial composition of the population served is predominately white (40%) and Black or African American (42%), with the remaining clients identifying as multiracial (6%), Asian (2%), Hawaiian/Pacific Islander (< 1%), or having missing or unknown race (9%). Just under a third of clients served (30%) identify as Hispanic or Latino, and 4% are veterans. Other characteristics of the population served after Strategy D7 are unknown, as reliable information was not available on income and benefits or client need characteristics (e.g., acuity, health and mental health conditions, or history of domestic violence).

Strong case management support for moving clients into housing, despite challenges. Case managers' roles under Strategy D7 include working with clients early in the process when they are identified and matched through CES, allowing case managers to help clients find and move into housing, including supporting the completion of the housing authority rental subsidy application. Those served after Strategy D7 who have moved into housing following enrollment in ICMS have done so in a median of 103 days. The process of moving clients into housing reportedly remains challenging, despite case manager support, and outcomes are not yet known for many of those served after Strategy D7, more than a third of whom were recently enrolled (for a median of 80 days) and still waiting to move into housing as of July 1, 2019.

Retention facilitated through long-term and on-site services. Program managers viewed Strategy D7 as aligned with retention goals because it provides long-term and ongoing case management support for clients in housing, including assistance with recertification and the availability of on-site service providers to catch problems early and work with property managers to prevent eviction. While it is too soon to assess long-term retention outcomes for most of those served after Strategy D7, findings indicate that 19% of those served after Strategy D7 exited services during the two year post-implementation period; 5% of those served exited services after moving into housing, while 14% exited services without a record of moving into housing. It should be noted that it is possible to exit PSH programs tracked in CHAMP and to stop receiving services, but to remain housed through a rental subsidy; therefore, exits among those who moved in do not necessarily reflect exits to homelessness. At the same time, exit destination is not tracked in CHAMP for those who exit without moving into housing, so it is possible that those in this category (14% of those served after Strategy D7) are exiting to homelessness or an unstable living situation. The plurality (46%) of those served after Strategy D7 were in housing and receiving services at the end of the post-implementation period. This group had been enrolled in services for close to a year (a median of 318 days). The outcomes of many of those served after Strategy D7 are not yet known due to the recency of the program.

D. Challenges

Despite the improvements in operation of PSH under Strategy D7, there are a number of challenges that need to be addressed.

Staff turnover and burnout. These two challenges are chief among those described and are attributed both to the demands of the job and a positive job market. The turnover impacts rapport with clients, requires additional training, and increases other staff's caseloads when a position is vacant.

With increased funding through Strategy D7, some case managers support clients from the time they are matched through CES until exit. Though this early assignment allows for continuity of case management and greater time to build rapport, case managers are faced with challenges that come with navigating an increasingly competitive housing market and processing housing authority applications.

Gaps in service coordination. Service coordination efforts are new. At the start of implementation, these efforts reportedly resulted in initial role confusion across staff from different agencies. Communication and philosophical alignments among staff across administering agencies

and/or service providers are not yet in place. Geographic dispersion of services, which are sometimes located far from clients' places of residence, also poses barriers to service coordination.

Barriers to accessing and engaging in services. Ensuring access both to case management and to other disparate services across the vast geographic distances in Los Angeles was a frequently cited challenge. Gaps reported in access to mental health and/or substance abuse services may be driven by challenges in engaging clients in needed services, as well as barriers to timely uptake for clients who do seek treatment. Clients in focus groups reported difficulties accessing needed mental health services and substance use support groups.

Difficulties obtaining housing. Providers noted challenges around obtaining housing for clients, including delayed and denied applications for housing through the housing authorities and reluctance of landlords to accept vouchers in the competitive housing market. For clients, the quality and safety of the physical housing was an additional concern.

Lack of integration across data systems and incomplete data. Due to a lack of integration across data systems and differences in methods of tracking information across HMIS and CHAMP, the types and intensity of services received during program enrollment, and the destinations of those exiting the program without obtaining housing are not known. Additionally, we were unable to complete an in-depth assessment of the needs and characteristics of the population served (e.g., health and mental health conditions, CES vulnerability scores) or to examine whether these have shifted over time, as these data were not collected in CHAMP and the majority of the sample was not tracked in HMIS. We were additionally unable to assess changes in outcomes before and after implementation because findings potentially reflected inconsistent methods of tracking enrollments over time.

E. Recommendations

Although Strategy D7 is largely operating the way it was intended to operate, the challenges faced suggest that a few improvements are needed for it to function optimally. These are outlined below.

Reduce turnover and burnout among staff. Strategies to improve staffing stability should address heightened work demands, such as providing case managers with support and supervision, implementing safety protocols, and reducing the need for case managers to travel across such wide distances. In addition, increases in salary may be warranted to match the attraction of other job opportunities.

Address gaps in service coordination. It may be helpful to develop and implement measures to clarify roles and improve communication among staff across agencies and to notify case managers of turnover among staff at DMH or SAPC. Frequent retraining of staff across agencies may also help to address any misalignments in philosophies (e.g., housing first, harm reduction, and trauma-informed care). It may also help to address the geographic dispersion of services through additional reimbursements to case managers to cover vehicle repair and maintenance and other transportation costs, transportation resources for clients, and incentivizing mental health and substance use service providers to deliver field-based services to clients who are not already connected to on-site services through FSP and CENS at project-based sites.

Address underutilization of mental health and substance abuse services. The challenges with client access and engagement in mental health and substance abuse services may require greater examination of why some clients report difficulty accessing these services yet providers report underutilization of some services. This finding suggests that there may be clients in need of services who are not located at FSP and CENS co-located sites. This discrepancy requires greater attention, with more examination through interviews with staff and examination of client records where the mismatch in services exists as well as where utilization appears to be lowest and highest. Understanding service patterns and the match with clients' backgrounds may help to calibrate services more to where the needs appear to be. In addition, talking with an array of clients about the barriers they see in accessing services and how to make them more low-barrier may help with the client-driven challenges to access. For services that appear to be oversubscribed, more resources may be needed to reduce intake and appointment wait times and increase frequency of appointments and for substance abuse counselors to be present to provide on-site screening and intervention.

Address barriers to obtaining housing through landlord cultivation and coordination with the housing authorities. Given the competitive housing market, it may be helpful to increase landlord outreach strategies. In addition, coordinated efforts among housing and services providers and the housing authorities are reportedly needed to improve the process of applying for rental subsidies through the housing authorities. Efforts need to focus on reducing errors in submitted applications, streamlining the approach to updating incorrect or incomplete applications, and expediting the housing inspection process.

Improve data quality and integration across systems, and track service receipt and outcomes over time. The HMIS and CHAMP data systems offer the potential to understand who is served, monitor their own implementation of services, and examine exit rates and patterns. While all clients funded through Strategy D7 are tracked in CHAMP, improved integration across these two data systems can permit more complete characterization of the clients being served, primarily by being able to maximize the data collected through the HMIS which tracks client characteristics and exit destinations more extensively. In addition, it may be helpful to track services delivery, including the frequency of case management delivered and linkage to other mental health, substance use, and medical services, and benefits. Such information could help to inform our understanding of the nature and intensity of the services provided before and after move-in and how these services impact outcomes. Likewise, it would be useful to track exit destinations among those who exit ICMS without moving into housing. Finally, ensuring that check in and check out dates and move in dates in CHAMP are used consistently across providers and over time will permit more targeted assessment of change in outcomes over time. Such efforts could potentially yield richer, more complete data on client characteristics and outcomes, and permit examination of how acuity of population and intensity and type of service receipt has changed over time and impacts outcomes.

List of Acronyms

CEO	Chief Executive Office
CENS	Client Engagement and Navigation Services
CES	Coordinated Entry System
CHAMP	Comprehensive Health and Management Platform
DHS	Department of Health Services
DMH	Department of Mental Health
DPH-SAPC	Department of Public Health, Substance Abuse Prevention and Control
ERC	Enhanced Residential Care
FHSP	Flexible Housing Subsidy Pool
FSP	Housing Full Service Partnership
HACLA	Housing Authority of the City of Los Angeles
HI	Homeless Initiative
HMIS	Homeless Management Information System
HOH	Head of Household
ICMS	Intensive Case Management Services
LACDA	Los Angeles Community Development Authority
LAHSA	Los Angeles Homeless Services Authority
PATH	People Assisting the Homeless
PSH	Permanent Supportive Housing
SAPC	Substance Abuse Prevention and Control
SNAP	Supplemental Nutrition Assistance Program
SPA	Service Planning Area

Section I. Introduction

A. Background

Permanent supportive housing (PSH) is an evidence-based approach to ending homelessness for individuals who have experienced chronic homelessness and have multiple service needs, typically including mental health and/or substance use disorders (United States Interagency Council on Homelessness, 2010). Following "housing first" principles, PSH provides expedited access to an independent residence and needed services and supports. Strategy D7 (Provide Services and Rental Subsidies for Permanent Supportive Housing) aims to improve access to and enhance the provision of services in PSH.

Strategy D7 is one of 21 strategies funded through Measure H in July 2017 (County of Los Angeles Chief Executive Office, 2017), a ballot initiative in Los Angeles County to prevent and combat homelessness[1]. The intent of the strategy is to:

- Create an integrated services model for all clients matched to PSH through the Coordinated Entry System (CES), comprised of intensive case management services as well as site-based and mobile specialty mental health and substance use disorder services for those who need it;
- Fill the gaps in services for existing PSH; and
- Create additional local rent subsidies, when Federal subsidies are insufficient to meet the need.

Westat, a national research organization, in collaboration with the University of Southern California, was contracted by Los Angeles County's Chief Executive Office (CEO) to evaluate the operation and outcomes of PSH under Strategy D7. Following this introduction, the report provides an overview of the evaluation methodology. Section II describes the key findings with regard to funding and inventory; the nature and coordination of services provided; training, guidance, and collaboration around implementation; and how clients are identified, prioritized, and matched to housing. Section III outlines the characteristics, enrollment, and retention of clients in PSH. The final section, Section IV, offers conclusions and recommendations.

B. Evaluation Purpose and Methods

This evaluation aims to answer the following over-arching question:

> *"How has Strategy D7 affected the operation, outcomes, and inventory of Permanent Supportive Housing (PSH) in Los Angeles County?"*

[1] Measure H is a quarter cent sales tax to generate funding for homeless services that was approved by Los Angeles County voters in March of 2017.

Table 1 outlines specific questions encompassed within this question, mapped onto our methods and data sources.

Table 1. Specific evaluation questions and methods to address them

Methods	Analysis of extant records		Interviews and focus groups		
Sources	Documents/quarterly data	Admin data	Agency administrators	Program directors	PSH/services staff
Operation of D7					
In what ways has Strategy D7 impacted the funding or expanded the inventory of housing?	✓		✓	✓	
In what ways has Strategy D7 affected the intensity and role of case management to support clients' access to services and their ability to maintain their housing?	✓		✓	✓	✓
How do services or does the coordination of services provided through Strategy D7 compare to what was previously available?	✓		✓	✓	✓
Has Strategy D7 expedited how individuals are identified and matched with PSH? In what ways and for what populations?	✓		✓	✓	✓
Subpopulation and Client Differences					
How does the provision of PSH services through Strategy D7 differ by the population served?			✓	✓	✓
What are the characteristics of the population served through PSH under Strategy D7?		✓	✓	✓	✓
Client Retention and Outcomes					
What are PSH retention rates and other client outcomes under Strategy D7? What factors are perceived to contribute to these?	✓	✓	✓	✓	✓
Integration and Coordination Among Agencies					
How has Strategy D7 affected collaboration among the key agencies involved in providing PSH, including DMH, DPH/SAPC, LAHSA, and the Housing Authorities?			✓		
What levels of collaboration and coordination are occurring (e.g., at agency level, at provider level, at staff level)? What are the challenges and barriers to working together at these different levels? What are the opportunities at each level and how can they be maximized? What are the benefits of collaboration? What are the downsides?			✓	✓	✓

Our evaluation methods are summarized in Exhibit 1 and described in detail in the Appendix. We reviewed a number of documents, including strategic planning documents and agency records to understand the evolution of Strategy D7 and to inform the development of the data collection protocols and analytic plan. We collected data to assess the operations and outcomes of Strategy D7 through multiple methods, including key informant interviews with administrators, directors of agencies administering permanent supportive housing, and property managers; and focus groups with program directors, case managers, and residents in project-based PSH. Qualitative data

collected through these sources were coded in NVivo and analyzed through iterative analysis to identify key themes.

Exhibit 1. Summary of key evaluation methods

Document Review
- Review of strategic planning documents, budgets, aggregate data, and other agency records

Interviews and Focus Groups
- Individual interviews with key administrators (N = 17) and housing program managers (N = 10) from Service Planning Areas (SPAs) 1, 3, 5, 7, and 8 (N = 17)
- Three focus groups, each with 2-5 case managers and 2-7 housing program managers from housing programs in the three largest SPAs (2, 4, and 6)
- Three focus groups, each with 4-10 PSH residents in SPA 4 (a total of 24 clients; limited to congregate facilities; one with women only and two with more mixed populations)

Administrative Data
- Sample: All households served through PSH programs and tracked in CHAMP since Strategy D7 implementation (July 1, 2017-June 30, 2019)
- Data sources: CHAMP and HMIS

Administrative data extracted from the Department of Health Services' (DHS's) Comprehensive Health and Management Platform (CHAMP) and the Homeless Management Information System (HMIS) administered by LAHSA were analyzed to (1) characterize the population's sociodemographics and needs; (2) describe the length of time served; and (3) describe client-level outcomes, including time to moves into to housing and rates of exits from the program. Our administrative data analysis initially sought to compare those served after Strategy D7 with those served in the two years prior to Strategy D7. However, after preliminary analysis of the data, we determined that such a comparison would not be meaningful or informative, and would yield findings that were potentially misleading. We therefore limited our analysis to a description of characteristics and outcomes of those served after Strategy D7 through Strategy D7-funded programs. This decision was informed by several considerations. First, Strategy D7 is new, limiting our ability to assess outcomes for the majority of those served through the program. Second, the majority of those served through Strategy D7-funded programs are tracked only in CHAMP, whereas the majority of those served prior to Strategy D7 implementation were tracked in HMIS. There are systematic differences between the two data systems in the way in which enrollments in PSH are tracked; these result in apparent differences in outcomes that are attributable to methods of data tracking rather than to true differences in client outcomes. Finally, those served through PSH and tracked in CHAMP prior to Strategy D7 did not constitute a meaningful pre-implementation cohort for the purposes of comparison because of the potential for unmeasured differences in the populations served by DHS-administered programs before and after Strategy D7 was implemented. Prior to Strategy D7, these programs were targeted to frequent users of the DHS system, and reliable information was not available on the acuity and need characteristics of this group. For these reasons, quantitative findings throughout this report do not employ a pre-implementation comparison group, but instead characterize those served under Strategy D7 and describe their outcomes to date.

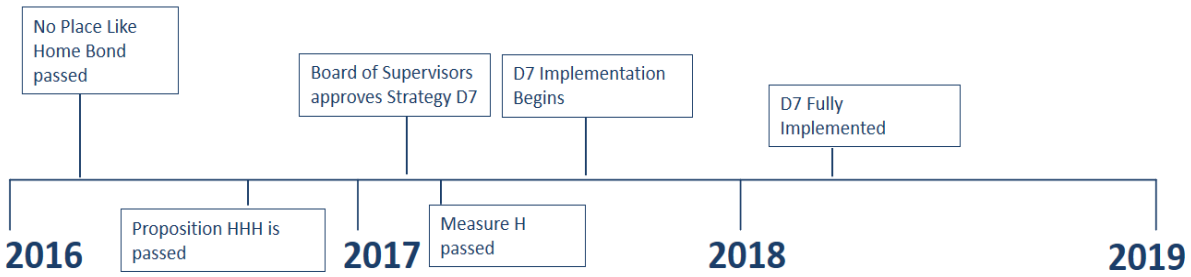
Between July 1, 2017 and July 1, 2019, 5,472 households were served through Strategy D7-funded ICMS. Among those served, 1,057 households were in housing when they enrolled in services, and an additional 1,700 households moved into housing while enrolled in services. Likewise, 4,434 of households served through Strategy D7-funded programs were still enrolled in services and had not yet exited at the end of the two-year post-implementation period. Findings are described further in the sections that follow.

Section II. Understanding the Operation of Permanent Supportive Housing Under Strategy D7

A. History, Funding, and Structure

Strategy D7 (Provide Services and Rental Subsidies for Permanent Supportive Housing) aims to improve the services and supports provided in PSH, as well as create local rental subsidies when Federal subsidies for housing are insufficient. As the timeline illustrates in Figure 1 below, Strategy D7 builds on and complements two previous measures that financed the construction of PSH units in the region: the State of California's No Place Like Home program and Proposition HHH[2].

Figure 1. Timeline of implementation of Strategy D7



The strategy was approved by the Los Angeles County Homeless Initiative (HI) in June 2016 and implemented following the passage of Measure H in July 2017. Funding has been provided through Measure H in three increasing allotments thus far (Los Angeles County Homeless Initiative, 2019): $25.1 million (FY 2017-2018), $49.3 million (FY 2018-2019), and $69.6 million (FY 2019-2020). The bulk of these funds were allocated to DHS, with a smaller portion allocated to the Department of Mental Health (DMH) and the Department of Public Health (DPH). In the first two fiscal years, a total of 5,472 clients were served through Strategy D7-funded PSH ICMS (in both project-based and scattered-site housing) across 61 unique agencies.

The strategy's implementation is led by three county departments: DHS, DMH, and the Department of Public Health, Substance Abuse Prevention and Control (DPH-SAPC).

DHS funds community-based organizations to provide ICMS for all Strategy D7 clients. The services are intended to be comprehensive and tailored to client needs. The case managers coordinate with the housing authorities in accessing project-based and tenant-based subsidies and with the Los Angeles Homeless Services Authority (LAHSA) on the CES.

[2] Proposition HHH allowed the City of Los Angeles to finance up to 10,000 units of PSH over 10 years, and the State of California's No Place Like Home Program financed PSH units over multiple funding cycles across the county of Los Angeles.

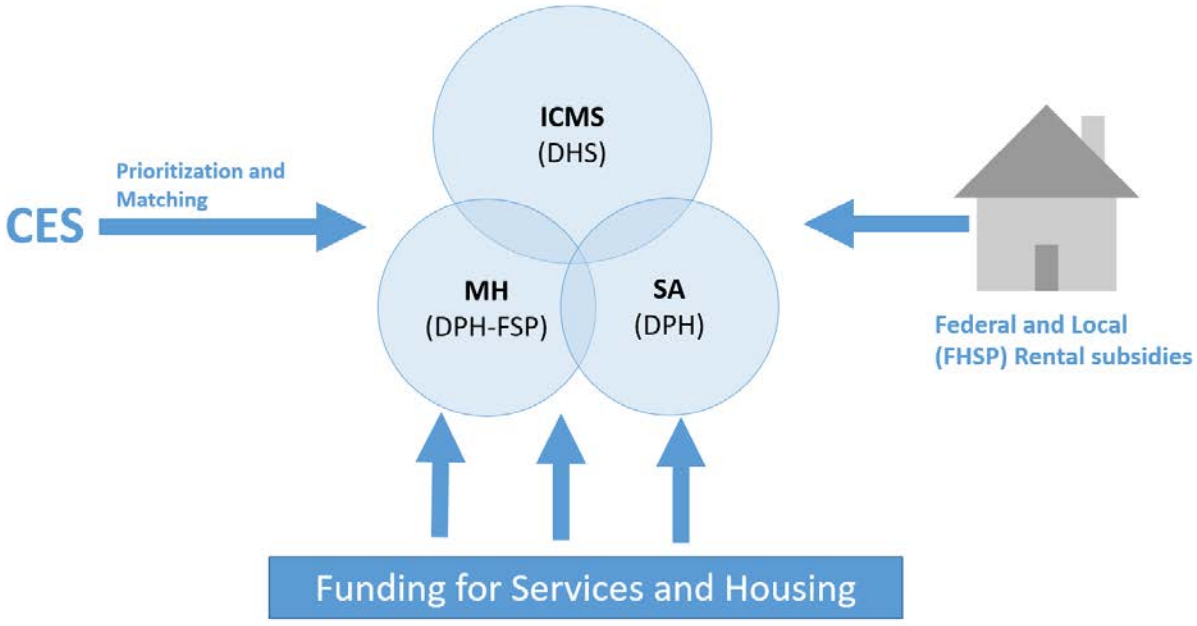
DMH funds community-based organizations to provide on-site mental health services at some Strategy D7-funded sites for PSH clients who need them. The services are provided through DMH's Housing Full Service Partnership model, which includes individual and group therapy and counseling, crisis intervention, medication management services, and linkage to other needed services. It should be noted that not all clients funded through Strategy D7 are located at DMH FSP sites.

DPH-SAPC funds community-based organizations to link PSH clients to substance use services through its Client Engagement and Navigation Services (CENS), which funds counselors to conduct outreach, screening, and referral for substance use treatment.

Local rental subsidies are additionally made available through the Flexible Housing Subsidy Pool (FHSP), a rental subsidy program administered by Brilliant Corners, a nonprofit community partner that acts as the DHS fiscal intermediary. The FHSP allows the use of local funds for rental subsidies for those in need of the subsidy who do not qualify for Federal subsidies. Strategy D7 also expands funding for ICMS in PSH that began operation prior to July 1, 2017 through a flexible annual allocation of $7.5 million (D7 Flex).

Figure 2 illustrates the different components of the integrated services model under Strategy D7.

Figure 2. Strategy D7 integrated services model



Below we describe findings on the operation of PSH and how it has changed under Strategy D7, including:

- The availability and sufficiency of funding and growth in the PSH inventory;
- The intensity and role of the case management provided;

- The type and degree of service provision and coordination;
- The training, guidance, and collaboration that is occurring within and between housing providers and other agencies;
- The processes whereby clients are identified, prioritized, and matched to PSH programs; and
- The characteristics, enrollment, and retention of clients in PSH.

B. Funding and Inventory

Strategy D7 has resulted in greater, more flexible funding for services and subsidies than was previously available. Prior to Strategy D7, funding was perceived as very thin, with few resources; providers mostly relied on private funding sources and building revenue to fund services for PSH residents. Through Strategy D7, providers have received increased and more flexible funding for both case management services and individualized supports, such as bus passes. In addition, rental subsidies through increased funding for the FHSP have allowed providers to serve a broader pool of people than they had been able to serve (e.g., now being able to serve a larger number of people who are not eligible for Federal housing subsidies). Providers also noted that dedicated services funding allowed them to serve and retain clients in pre-existing units. In particular, as CES began successfully identifying and matching high-acuity clients to PSH, housing program managers noted that the building revenue for services was no longer sufficient to fund services for those clients, particularly in buildings with a high concentration of clients of high acuity. Funding under Strategy D7 allowed for more services in these buildings, a finding echoed by some long-term PSH recipients in focus groups who indicated that until recently they had little access to services in their building, which now has improved. Consistent with this report, our analysis of the administrative data indicated that 19 percent of those served after Strategy D7 were already in housing at the time of their connection to DHS ICMS.

In addition to ICMS, Strategy, D7 has funded other resources, including local rental subsidies through FHSP vouchers, placements in Enhanced Residential Care (ERC), and move-in assistance, all components respondents described as useful. At the time of data collection, the bulk of the available funding was for ICMS only; Strategy D7 funding for rental subsidies through FHSP vouchers had been fully committed, ERC placements were temporarily on pause while supplemental funding was being secured, and move-in assistance was available through Strategy D7 funding only for clients who do not qualify for move-in assistance through other sources. Although other resources could be used to support move-in assistance and ERC placements, the perception among staff and administrators was that the funding was now less available for these subsidies and services. Several front-line staff referenced a perceived current lack of available funding for ERC placements or a reduction in availability of move-in assistance. Staff from one focus group also commented on the current lack of FHSP vouchers, reporting that there are clients who do not qualify for Federal housing subsidies who are waiting for housing and unable to access it.

There is growth in the inventory of PSH under development. Providers noted that although other funding sources (Proposition HHH and No Place Like Home) have driven capital development, the availability of a committed stream of services funding for tenants under Strategy

D7 has facilitated this growth. One housing developer explained that lenders are willing to invest in PSH on more favorable terms because Los Angeles County's guarantee of services funding for building units reduces the building operating costs and the perceived risk of the loan. Knowing that there is a committed stream of services funding for tenants has been helpful in alleviating lenders' and investors' concerns, making them willing to invest on more favorable terms. To illustrate the current level of growth in inventory, one housing and services provider reported that the number of units it currently has in the development pipeline is roughly equivalent to the number of units it had constructed over the course of the past 30 years.

Strategy D7 also has allowed program implementers to be involved in planning services for new units before they are constructed. DHS, DMH, and DPH-SAPC track project-based housing that is under development for PSH, so that Strategy D7-funded services can be matched to these units.

C. Nature of Case Management

Strategy D7 has resulted in smaller caseloads, based on acuity. Program managers fairly consistently described case manager caseloads as 1 to 20 or 25 for high-acuity clients and 1 to 40 for low-acuity clients based on DHS guidelines, and this was echoed by some case managers. A few program managers framed the caseloads as a significant change from the landscape before Strategy D7 when providers might have caseloads of up to 70 people. The shift has been necessitated by DHS funding requirements and facilitated by the increase in funding for case management services.

Case management is individualized and intensive. Consistent with the ICMS design under Strategy D7, case managers noted that services are tailored to the client's acuity and needs, and several mentioned the importance of client choice and preference. One program manager described ICMS as encompassing "anything and everything," such as help with life skills, apartment and money management, or accessing transportation, taking clients to appointments or the grocery store, and fostering social connections. This sentiment seemed to be validated by most PSH residents in our focus groups, who remarked that most of their needs were met by their case managers. In addition, ICMS appears to include individualized service planning, biopsychosocial assessments at move-in, and quarterly re-evaluations.

Case managers described frequency of case management as varying depending on client need. Program manager and case managers consistently cited a contact or visit at least once per month as a minimum standard, per reported DHS guidelines, with the highest-acuity clients necessitating multiple home visits per week. A number of case managers also stated that case management needs to be more intensive during the transition period when the client is first placed in housing. PSH clients in our focus groups reported that they received case management visits anywhere from once a month to weekly in person, or on an as-needed basis. Most described their case management as helpful and indicated they were able to access the services when they needed them. However, a few noted confusion about the case manager's role or stated that case managers' roles involve too much paperwork. Because the frequency of case management, services provided, and size of caseloads were not available through the administrative data, we were unable conduct a quantitative examination of the case management delivered through Strategy D7-funded programs or to examine how aspects of case management might influence outcomes.

Based on the program managers and case managers with whom we spoke, the nature of case management services did not appear to vary substantially by population served, although some program managers noted that families may be more resource intensive to serve, in that they need to support multiple people with disparate needs.

Case managers support clients in navigating housing, but some challenges persist. Program managers indicated that clients are assigned to an ICMS provider early in the process when clients are identified and matched through CES. This early connection of case managers to clients is largely viewed as beneficial in helping facilitate clients finding and moving into housing. Both case managers and program managers describe case managers as helping clients navigate housing, with a particular role in supporting the completion of the housing authority application.

Case managers also access housing acquisition and retention assistance for clients served through the FHSP through Brilliant Corners. The organization's housing acquisition team cultivates relationships with landlords, offers landlord incentives, and matches tenants and landlords. The organization has unit holding agreements to retain a large number of units and links them to referrals. Its tenancy support team supports tenants through the process of viewing units and moving into housing, and places a focus on eviction prevention (e.g., facilitating voluntary relinquishments and interim housing placements when needed).

Despite case manager support for housing navigation, challenges were noted, including the competitive housing market and delays and denials in processing applications through the housing authorities. Contributing factors to this last issue reportedly include delays in processing background checks, issuing certificates of eligibility, and notifying clients that their applications are incomplete or contain errors; failure of housing to pass inspections; and errors in the paperwork submitted by clients, despite case manager support. One provider suggested that an electronic system for sharing applications could help address the issue.

D. Service Provision and Coordination

Case managers play a key role in linking clients to needed services. Program managers and case managers described connecting clients to needed services, either to in-house services or off-site resources, through scheduling and accompanying them to off-site appointments. They talked about connecting clients to primary care and other health care, mental health and substance use resources, employment, education, benefits, legal assistance, help getting documentation, and food pantries and other resources. PSH clients also commented on the extent to which case managers help link them to needed care. At the same time, though, PSH clients identified some gaps in access to services and unmet need, particularly around transportation and employment or vocational assistance.

Strategy D7 has reportedly resulted in increases in health, mental health, and substance abuse service access and coordination (CENS, FSP). A high degree of service access was reported by both case managers and tenants at project-based sites and, to a lesser extent, by case managers at some scattered-site locations. As noted earlier, the DMH Full Service Partnership programs provide PSH clients access in project-based sites to on-site mental health care including group and individual therapy, crisis intervention, and medication management by a psychiatrist. These services were already being expanded prior to Measure H, but were additionally expanded to new sites under Strategy D7. PSH clients also have access to referrals for substance abuse screening

and treatment through CENS funded by SAPC, which may either be co-located at project-based housing, or "connected" in cases where co-location is not logistically feasible. To date, SAPC's services have primarily been linked to project-based sites.

While access to medical care was available on-site in some cases, case managers reported putting considerable effort into helping clients, especially those living in scattered-site apartments, track and attend off-site medical appointments. In one PSH focus group at a project-based site, clients reported that it is easy for them to access health clinics when needed.

Home nursing visits are reportedly also available through DHS and are perceived to be helpful as on-site services are seen to be much easier to access. A number of staff reported that the nurses were communicative, which facilitated coordination of care. A team-based approach to service delivery and service coordination was typically described. Depending on whether a client lives in a scattered-site apartment or project-based housing, teams can involve service coordinators, ICMS providers, psychiatrists, psychologists, the property manager, and the CENS counselor. Based on the data collected through multiple sources, the nature of the service coordination varies across providers, and depends on a number of factors, including the client's needs, and whether the site is project-based or scattered-site, the services and housing providers are separate entities, the program is a DMH-Full Service Partnership, and CENS counselors are co-located or connected to that site. We were unable to integrate these qualitative findings with quantitative analysis within the current evaluation, as administrative data were not available that would permit us to examine rates of access to mental health, substance abuse, or medical services or frequency of service use

Staff burnout and turnover is reportedly common, has multiple causes and impacts, and varies by provider. Contributors to burnout include the following.

- *Time-intensive caseloads:* Despite caseloads being reduced and improved under Strategy D7, some case managers noted that they sometimes exceed the recommended size due to staff departures and that even the recommended caseload size is still sometimes too high when the caseload comprises clients with extensive needs and high acuity. High-acuity clients have fluctuating needs and may require minimal intervention for a period of time and then may unpredictably require intensive crisis intervention and daily contact.

- *Travel demands:* In addition, case managers spend much of their time traveling long distances, which can further reduce the time required for clients. Because case managers are assigned to clients at the point of entry through CES, they are often assigned to clients before it is known where the client will be housed. As a result, they reportedly must often travel across multiple SPAs to provide services.

- *Safety concerns:* Due to safety concerns at times when working with particular clients, staff would prefer to travel in pairs to visit these clients as a precaution; this takes considerable staff time, however, and staffing is typically insufficient to permit staff to accompany one another in these cases.

- *Job availability:* Turnover also appears to be driven by the high availability of direct service positions in the field; staff reportedly move across agencies frequently, sometimes for only small pay raises.

Some program directors reported using pay raises as well as developing a supportive culture to retain staff and offset the work demands. Supervision, time for staff interaction and group support, and support for self-care are among the strategies they use to build a culture of staff support.

Case manager turnover reportedly impacts a number of aspects of implementation.

- ***Rapport:*** PSH clients and case managers both noted that when a case manager leaves, it takes time to establish a new relationship and rapport with the new case manager.

- ***Need for training:*** Several program directors and agency administrators spoke about a need for training and retraining of case managers around such principles as harm reduction and housing first, as well as documentation requirements, to help them handle the stress and workload in their positions.

- ***Caseloads:*** Staff turnover also can exacerbate the caseload problem by shifting clients onto other case managers' caseloads and exceeding guidelines. For example, one case manager reported her caseload was twice the recommended amount as a result of staff turnover.

- ***Continuity of care:*** These impacts in turn interfere with continuity of care and disrupt client-provider rapport-building and relationships.

Service coordination efforts have encountered challenges. Agency administrators, program managers, and case managers described challenges in integrating ICMS, DMH, and CENS services into a single on-site model, an endeavor that is happening for the first time under Strategy D7. Challenges impeding service coordination between case managers and staff from other agencies include the following:

- ***Geographic dispersion:*** Services and clients (especially those in scattered-site housing) are geographically dispersed. The vast geographic distances in Los Angeles make it difficult for case managers to visit clients as frequently as is needed, arrange transportation for clients to disparate services, persuade clients to leave home to access services, or find affordable field-based service providers for those in scattered-site housing. Clients living in scattered-site apartments are particularly vulnerable to these challenges. Some of the clients in our focus groups living in project-based units also spoke of the gaps in access to transportation that at times can make it difficult to access specific types of services.

- ***Lack of communication:*** There are problems in connecting and getting responses from staff in other agencies as well as differing philosophies among staff from different agencies administering services and/or housing and services providers. Case managers described difficulties communicating with staff at other agencies, including DMH and SAPC. Some described difficulty reaching the staff, getting timely responses, and not being notified when staff left the agencies. One program manager stated that Strategy D7 scaled up rapidly, and that initial service coordination efforts were accompanied by role confusion among staff from different agencies. A second challenge in working with staff across different administering agencies and/or services providers relates to the

different philosophies they may hold (e.g., harm reduction vs. abstinence) and how these different views make it difficult to work together along the same goals for a client. At a minimum, some staff may be less well versed than others in the principles of housing first, harm reduction, and trauma-informed care

- ***Barriers to engaging in mental health and substance abuse services:*** A very common challenge described by agency administrators, program managers, and case managers involved engaging clients in mental health and/or substance abuse treatment. Agency administrators report that the anticipated level of need for these services has not been reflected in treatment uptake. When Strategy D7 was initiated, it was estimated that approximately 30 percent of PSH clients would require access to mental health and/or substance use services in addition to the ICMS provided to all Strategy D7 clients. Although administrative data were not available on services to examine service receipt or mental health and substance abuse need, the program managers and case managers we interviewed indicated that they believe fewer clients than projected are accessing these services, due to multiple factors. First, it is not clear how many clients being served have mental health conditions unless they are in dedicated units or buildings for individuals with mental health conditions. Both mental health and substance abuse counselors are reportedly being underutilized for treatment, but are devoting time to outreach efforts that may not be reimbursable or captured under performance metrics. Interviewees believe that underutilization of behavioral health services is likely less due to need and more due to clients' reluctance to engage in the services. Client reluctance to engage in services can stem from stigma and a fear of losing housing if they admit to substance abuse, a lack of desire for treatment, and a reluctance to leave home to go to treatment coupled with the lack of substance abuse providers willing to visit clients in their units. These challenges do not appear to vary substantially by population served, although one provider noted that families may be relatively easier to engage and youth relatively more difficult to engage than other populations.

- ***Delays in access:*** Some case managers indicated clients can wait up to three months for a mental health intake through off-site DMH clinics and then experience long wait times for mental health appointments. Substance abuse treatment was highlighted as a particular area of unmet need, possibly because the CENS services do not involve full-time on-site staff. Several providers emphasized the importance of having linkages to substance abuse services immediately available when a client seeks treatment to ensure that they can access the services when they are motivated to engage with them. One provider described problems linking clients to CENS counselors in a timely fashion and described an experience in which a counselor did not show up to an appointment with a client seeking to initiate treatment. PSH clients also gave varying accounts of the accessibility of mental health services. A number reported currently having a therapist or described how their case managers had helped them access one, while a few said they had not received services or had to seek them out on their own. In addition, case managers reported that it is challenging to manage clients living in PSH where there is active substance use, and one program manager suggested a need for more substance abuse resources for clients in the active use phase. PSH clients in one focus group also

voiced the need for having Alcoholics Anonymous and other substance abuse recovery groups on-site.

E. Training, Guidance, and Collaboration

More guidance and training are available to guide the implementation of PSH under Strategy D7, although some potential areas for improvement were noted. Program managers described the level of support from DHS as "unprecedented in a funder" and described the guidance as following a "coaching" model, involving bi-weekly calls with a program manager, ongoing case note reviews, frequent site visits with technical assistance and support, and annual site monitoring with case note review. The approach reportedly keeps staff looped in so that they can meet expectations and avoid surprises. Several program managers spoke positively about the Case Management Institute, which provides a 10-month cohort training for new case managers**.** Some case managers perceived the training as therapeutic and supportive with resources, while others did not find the training suited to their roles within their agencies. Others wanted more of a focus on best practices and foundational knowledge (i.e., Housing First, Substance Use 101) or to have the trainings clustered on fewer days.

Strategy D7 has necessitated increased collaboration across agencies, PSH providers, and staff to coordinate services for clients within and across agencies. The integrated services model and the case manager's role in housing navigation has required the cooperation of DHS, DMH, DPH-SAPC, the housing authorities, and LAHSA. Several providers noted that collaboration has helped systems work together to identify and address problems and barriers, such as addressing delays in filling units through CES and challenges in navigating applications through the housing authorities. No issues were noted around collaboration among senior staff, but case managers described difficulties coordinating with staff from DMH and DPH-SAPC on client service coordination, as described previously.

F. Client Identification, Prioritization, Matching, and Housing Placement

Client identification, prioritization, and matching to housing resources occurs through CES, with few exceptions. The majority of program managers and case managers identified CES as the primary (and exclusive) referral source for PSH. Program managers noted that CES began identifying and prioritizing high-acuity individuals to PSH prior to Strategy D7 implementation and that this generated problems around inadequate services funding. Strategy D7 has helped to address the needs of this population through a richer services package than was previously available.

Housing providers report using few exclusionary criteria after a person is referred to them by CES. However, housing authorities, landlords, and property managers may subsequently apply criteria. Program managers consistently reported employing a housing first model and minimal exclusionary criteria for PSH programs. However, they noted that additional exclusionary criteria may be applied that can affect access to housing during screenings by the housing authorities, landlords, or housing managers due to the requirements of specific buildings' funding sources. Exclusionary criteria cited included a history of manufacturing substances, arson, sex offender status, and undocumented status. The FHSP is reportedly a useful resource to house households when applications are denied through the housing authorities based on these types of exclusionary criteria.

The expansion of resources provided through Strategy D7 has funded case managers to work with PSH participants to find and move into housing. Case managers' roles under Strategy D7 include working with clients early in the process when they are identified and matched through CES, allowing case managers to help clients find and move into housing, including supporting the completion of the housing authority rental subsidy application. Table 2 below provides information on the 1,700 households (that who moved into housing while receiving ICMS services following Strategy D7. This subset of households constitutes 31% of the total sample of 5,472 households served through Strategy D7-funded programs, while an additional 1,057 households not represented here (19% of the total sample) moved into housing prior to accessing Strategy D7-funded services. As shown in Table 2, those who moved into housing after enrolling in services did so in a median of 103 days from initiating services. Only 8% of those who moved into housing after enrollment exited services within the two-year post-implementation period. The process of moving clients into housing reportedly remains challenging, despite case manager support, and outcomes are not yet known for many of those served after Strategy D7, more than a third of whom are currently and recently enrolled (for a median of 80 days) and still waiting to move into housing, as outlined further in the sections below.

Table 2. Time to move into housing and exits from services among households moving into housing during enrollment

Sample size	N=1,700
Days to Move In	Mean = 134 Median = 103
% Exiting Services within 2 Years of Entry	8%
Days to Exit	Mean = 291 Median = 274

Section III. Characteristics and Outcomes of Clients Served through Permanent Supportive Housing Under Strategy D7

A. Characteristics of Clients Served Through Permanent Supportive Housing

Clients served through PSH after Strategy D7 are predominately single male adults, and are racially diverse. Table 3 provides information on the demographic composition of the population served after Strategy D7 (Provide Services and Rental Subsidies for Permanent Supportive Housing). The majority (99%) of those served are single adults, and 58% are male. The racial composition of the population served is predominately white (40%) and Black or African American (42%), with the remaining clients identifying as multiracial (6%), Asian (2%), Hawaiian/Pacific Islander (< 1%),or having missing or unknown race (9%). Just under a third of clients served (30%) identify as Hispanic or Latino, and 4% are veterans. Reliable information was not available on income and benefits or need characteristics (e.g., acuity, health and mental health conditions, or history of domestic violence) among those served after implementation of Strategy D7.

Table 3. Demographic characteristics of clients served by PSH

Sample size	N = 5,472
Household Composition	
Single Adults	99%
Families	<1%
Gender	
Male	58%
Female	40%
Trans/Nonconforming	1%
Unknown/Missing	<1%
Race	
White	40%
Black or African American	42%
American Indian/Alaskan Native	0%
Asian	2%
Hawaiian/Pacific Islander	<1%
Multiracial	6%
Unknown/Missing	9%
Ethnicity	
Hispanic or Latino	30%
Not Hispanic or Latino	67%
Ethnicity Unknown/Missing	3%
Veteran Status	
Veteran	4%
Not a Veteran	92%
Unknown/Missing	3%

B. Client Enrollment and Retention

Retention is perceived to be high and potentially facilitated by ICMS provided under Strategy D7. Program managers typically reported retention rates of 90 percent or higher in

housing. This was consistent with the composition of our focus groups (though a convenience sample), which illustrated a high retention rate in general in projects funded through Strategy D7 dollars, with many of the PSH clients having been in PSH for more than a decade. It is also consistent with our finding that 5% of households served after Strategy D7 exited services after moving into housing. Some program managers believed retention had improved due to Strategy D7, while others felt retention had already been high, or that it was too soon to tell. Program managers viewed Strategy D7 as aligned with retention goals because it provides long-term and on-going case management support for clients in housing. One specific facilitator is that Strategy D7 allows case managers to help clients with annual recertification through the housing authorities, which some clients find overwhelming. Additionally, service providers are now more available on-site to coordinate with property managers to catch problems early and avert potential eviction. One benefit a program manager described is that property managers can easily connect to on-site ICMS and, in some cases, mental health providers flag issues like hoarding as they arise, which can avert eviction.

While it is still too early to assess long-term retention outcomes using administrative data for most of those served under Strategy D7, findings presented in Tables 4 and 5 indicate the following.

- *Exits:*
  - 19% of those served after Strategy D7 exited services within the two-year implementation period; 5% of those served exited services after moving into housing, while 14% exited services without a record of moving into housing. Those exiting had been enrolled in services for median of 167 days, close to six months.
  - It should be noted that it is possible to exit PSH programs tracked in CHAMP and to stop receiving services, but to remain housed through a rental subsidy, so exits among those who moved in do not necessarily reflect exits to homelessness. At the same time, exit destination is not tracked in CHAMP for those who exit without moving into housing, so it is possible that those in this category (14% of those served after Strategy D7) are exiting to homelessness or an unstable living situation.
- *Housing and Service Receipt:*
  - The plurality (46%) of those served after Strategy D7 were in housing and receiving services at the end of the two-year post-implementation period, as of July 1, 2019. This group had been enrolled in services for close to a year, a median of 318 days
  - As noted previously, more than a third of those served after Strategy D7 (35%) were enrolled in services but had not yet moved into housing at the end of the post-implementation period. This group had been enrolled in services for an average of 160 days, with half enrolled for less than three months.

Table 4. Housing and services status among households in PSH

Sample size	N = 5,472
% In Housing with Services	46%
% Enrolled in Services, Not yet in Housing	35%
% Exited Services within 2 Years	19%
% Exited with Housing	5%
% Exited without Housing	14%

Table 5. Length of enrollments among households in PSH

Sample size	N = 5,472
Days Enrolled among those In Housing with Services	N = 2,495
Mean	340
Median	318
Days Enrolled among those Enrolled in Services, Not yet in Housing	N = 1,939
Mean	160
Median	80
Days Enrolled among those Exiting Services within 2 Years	N = 1,038
Mean	200
Median	167

Reasons clients leave housing include substance use, need for a higher level of care, drawbacks to some housing, and, in rare cases, eviction. Program managers reported that eviction is rare, citing rates from one to four percent, and indicated that it is primarily due to lease agreement violation. They described efforts to avert eviction, and, in the worst case scenario, working with the client to voluntarily relinquish housing and move elsewhere rather than be formally evicted. Program managers believed that substance abuse often plays a role in clients leaving housing. Clients sometimes need to transition to a higher level of care, such as Enhanced Residential Care, a process that staff indicated is not always straightforward. Some clients in the PSH focus groups reported that they would like to move because of aspects of the housing, such as a lack of a real kitchen or bathroom in the apartment or due to safety concerns, but that affordability is a barrier. In one focus group, clients noted that in order to retain their housing, they could not violate the guest restriction (no more than 14 nights per year, including family), a rule that several expressed their dissatisfaction with.

Section IV. Conclusions and Recommendations

A. Conclusions

Overall, Strategy D7 (Provide Services and Rental Subsidies for Permanent Supportive Housing) has provided richer resources for services provision to those in PSH and is perceived positively by providers who appreciate the high quality guidance, training, and support they have received from DHS around implementation of PSH under Strategy D7, and report that it has enhanced their ability to provide holistic, comprehensive services for clients. However, some challenges persist. Key findings are described further below.

Greater availability of funding for services and rental subsidies for new and existing PSH. Strategy D7 has provided greater and more flexible funding for services for PSH. Dedicated services funding is appreciated by providers, especially for preexisting units. Increased services funding for existing units is evident in the administrative data, which indicate that 19% of those served after Strategy D7 were already in housing when they initiated ICMS through Strategy D7-funded PSH programs. Strategy D7 has also funded services to match housing inventory under development, thus facilitating the development of new PSH units, and has expanded the availability of local subsidies that can be used for those who do not qualify for Federal rental subsidies.

Improved training and guidance and increased collaboration. Greater collaboration across agencies, PSH program managers, and staff has occurred to support the integration of services. Moreover, to guide the overall implementation of PSH, DHS provides what program managers describe as high-quality guidance, using a coaching model and comprehensive training. Increases in efforts to coordinate services within and across agencies and increased collaboration across agencies have reportedly resulted in more service coordination, team-based care, and availability of on-site services. In addition, providers spoke highly of the guidance and training from DHS around Strategy D7 implementation, which they perceived as responsive and relevant.

More intensive individualized services and improved service coordination. Strategy D7 has reportedly strengthened case management and service coordination for high-acuity individuals with complex needs. In doing so, it has met a growing need for services for the most vulnerable, chronically homeless individuals, who increasingly are being identified and prioritized through CES. Case management services have improved under the strategy, with lower caseloads, more holistic and individualized case management, and a focus on linkage to needed services. Case managers are also matched to clients when clients are matched to PSH through the CES, and therefore are able to support clients in navigating the process of securing housing. Program managers believe the extended case management support provided through the increased funding helps to foster retention.

Strong case management support for moving clients into housing, despite challenges. Case managers' roles under Strategy D7 include working with clients early in the process when they are identified and matched through CES, allowing case managers to help clients find and move into housing. Those who moved into housing after enrolling in ICMS services did so in a median of 103 days from initiating services. The majority of those who moved into housing (92%) remained enrolled and did not exit within the two-year post-implementation period. The process of moving clients into housing reportedly remains challenging, despite case manager support, and outcomes are

not yet known for many of those served after Strategy D7, more than a third of whom are currently and recently enrolled (for a median of 80 days) and still waiting to move into housing

Retention facilitated through long-term and on-site services. Program managers typically reported high retention rates in housing. This was consistent with the composition of our focus groups (though a convenience sample), which illustrated a high retention rate in general in projects funded through Strategy D7 dollars, with many of the PSH clients having been in PSH for more than a decade. It is also consistent with our finding that 5% of households served exited services after moving into housing. Program managers viewed D7 as aligned with retention goals because it provides long-term and ongoing case management support for clients in housing, including assistance with recertification and the availability of on-site service providers to catch problems early and work with property managers to prevent eviction. Administrative data analysis indicated that 5% of those served exited services after moving into housing, while an additional 14% of those served exited services without moving into housing. Because exit destinations are not tracked for those who do not move into housing, it is possible that those in this category are exiting to homeless or unstable housing situations. The plurality of those served after Strategy D7 (46%) were in housing and receiving services at the end of the post-implementation follow-up period; this group had been enrolled in services for close to a year (a median of 318 days). It should be noted that outcomes of many of those served through Strategy D7 are not yet known due to the recency of the program.

Ongoing Challenges. While the program is operating in general as it was intended to, there are several challenges around service delivery, described below:

- **Staff turnover and burnout.** Case manager burnout and turnover as well as turnover among staff at other agencies reportedly is high and impacting service delivery. Serving high-acuity clients with complex needs is reportedly challenging, placing unpredictable demands on case managers' time. Clients we spoke with noted the frequent turnover among case managers, and staff reported this can pose challenges to building rapport with clients.

- **Gaps in service coordination.** Service coordination efforts are new. At the start of implementation, these efforts reportedly resulted in initial role confusion across staff from different agencies, and communication and philosophical alignments among staff across administering agencies and/or service providers are not yet in place. Geographic dispersion of services which are sometimes located far from clients' places of residence, also poses barriers to service coordination.

- **Barriers to accessing and engaging in services.** Ensuring access both to case management and to other disparate services across the vast geographic distances in Los Angeles was a frequently cited challenge. Gaps reported in access to mental health and substance abuse services may be driven by challenges in engaging clients in needed services, as well as barriers to timely uptake for clients who do seek treatment. Clients in focus groups reported difficulties accessing needed mental health services and substance use support groups

- **Difficulties obtaining housing.** Providers noted challenges around obtaining housing for clients, including delayed and denied applications for housing through the housing authorities and reluctance of landlords to accept vouchers in the competitive housing market. For clients, the quality and safety of the physical housing was an additional concern.

- **Lack of integration across data systems and incomplete data.** Due to a lack of integration across data systems and differences in methods of tracking information across HMIS and CHAMP, the types and intensity of services received during program enrollment, and the destinations of those exiting the program without obtaining housing are not known. Additionally, we were unable to complete an in-depth assessment of the needs and characteristics of the population served (e.g., health and mental health conditions, CES vulnerability scores) or to examine whether these have shifted over time, as these data were not collected in CHAMP and the majority of the sample was not tracked in HMIS. We were additionally unable to assess changes in outcomes before and after implementation because findings potentially reflected inconsistent methods of tracking enrollments over time.

B. Recommendations

Although Strategy D7 is largely operating the way it was intended to operate, the challenges faced suggest that a few improvements are needed for it to function optimally. These are outlined below.

- ✓ **Reduce turnover among staff.** Having more stability in staffing is critical, given the negative impacts of staff transitions on rapport with clients and coordination of services, as well as increasing the need for additional trainings. Among the measures that could help with turnover involve:
  - Reducing the need for case managers to travel across such wide distances by greater attention to clients' potential housing placements and geographic matching of case managers;
  - Increasing salaries; and
  - Developing and implementing protocols to ensure that case managers and other external staff (e.g., mental health providers, substance use counselors) feel safe while delivering services, and creating a culture of support and self-care through access to support groups and behavioral health resources
- ✓ **Fill gaps in service coordination.** Service coordination might be enhanced with strategies for improving communication and cross-training for staff from different agencies. Addressing the geographic dispersion of services may also be helpful. Strategies could include ensuring case managers are fully compensated for vehicle repairs and maintenance and other transportation costs, providing more transportation resources for clients (ride sharing accounts, shuttles), and incentivizing mental health and substance abuse service providers to deliver field-based services to clients who are not already connected to on-site services through FSP and CENS at project-based sites.
- ✓ **Address underutilization of mental health and substance abuse services.** Providers report underutilization of mental health and substance abuse services, while clients report delays in accessing needed care. This discrepancy requires greater attention, with more examination through interviews with staff and examination of client records where the mismatch in services exists as well as where utilization appears to be lowest and highest. Understanding service patterns and the match with clients' backgrounds may help to calibrate services more to where the needs appear to be. In addition, talking with an array of

clients about the barriers they see in accessing services and how to make them more low-barrier may help with the client-driven challenges to access. For services that appear to be oversubscribed, more resources may be needed to reduce intake and appointment wait times and increase frequency of appointments and for substance abuse counselors to be present to provide on-site screening and intervention.

- ✓ **Reduce barriers to obtaining housing through landlord cultivation and coordination with the housing authorities.** Given the competitive housing market, it may be helpful to increase landlord outreach strategies. In addition, coordinated efforts between housing and service providers and the housing authorities are reportedly needed to improve the process of applying for rental subsidies through the housing authorities. These efforts could potentially focus on reducing errors in submitted applications, streamlining the approach to updating incorrect or incomplete applications, and expediting the housing inspection process.

- ✓ **Improve data quality and integration across systems, and track service receipt and outcomes over time.** The HMIS and CHAMP data systems offer the potential to understand who is served, monitor its own implementation of services, and examine exit rates and patterns. While all clients funded through Strategy D7 are tracked in CHAMP, improved integration across these two data systems can permit more complete characterization of the clients being served, primarily by being able to maximize the data collected through the HMIS which tracks client characteristics and exit destinations more extensively. In addition, it may be helpful to track services delivery, including the frequency of case management delivered and linkage to other mental health, substance use, and medical services, and benefits. Such information could help to inform our understanding of the nature and intensity of the services provided before and after move-in and how these services impact outcomes. Likewise, it would be useful to track exit destinations among those who exit ICMS without moving into housing. Finally, ensuring that check in and check out dates and move in dates in CHAMP are used consistently across providers and over time will permit more targeted assessment of change in outcomes over time. Such efforts could potentially yield richer, more complete data on client characteristics and outcomes, and permit examination of how acuity of population and intensity and type of service receipt has changed over time and impacts outcomes.

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Appendix

Summary of Methods

Appendix
Summary of Methods

A. Document Review

Review of documents has been employed to better understand the history, evolution, and status of Strategy D7 (Provide Services and Rental Subsidies for Permanent Supportive Housing); to inform the development of interview and focus group protocols; and to contextualize the qualitative data gathered. Documents reviewed include: contextual information on homelessness in Los Angeles County, including Annual Homeless Assessment (AHAR) and Continuum of Care (CoC) reports; strategic documents from the Homeless Initiative (HI), HI performance evaluations, and HI quarterly reports; and publicly available and internal documents from the HI, Los Angeles Homeless Services Authority (LAHSA), including strategic planning and implementation documents, impact dashboards, community input session summaries, guides to contracting opportunities, lists of funded Strategy D7 contractors, presentations, and reports (Exhibit A-1).

Exhibit A-1. Relevant documents

- **Contextual information on homelessness in Los Angeles County**
- **Annual Homeless Assessment Report (AHAR) data and Continuum of Care (CoC) reports**
- **Strategic documents from the Homeless Initiative (HI)**
- **HI performance evaluations and HI quarterly reports**
- **Budgets**
- **Internal documents from DHS**
- **Dashboards and publicly available documents from LAHSA**

B. Interviews and Focus Groups

Individual semi-structured interviews and focus groups with program administrators, and permanent supportive housing (PSH) program directors, case managers, and residents were the main source of information on the operation of PSH following the funding of Strategy D7. In this section, we describe how we selected agencies and individuals to interview, and the processes for data collection.

Sampling. We conducted telephone interviews with administrators from all key agencies that are involved in administering PSH in LA County, as well as agencies that coordinate with PSH on housing and the coordinated entry system (CES). Agencies include the Chief Executive Office (CEO), Department of Health Services (DHS), Department of Mental Health (DMH), Los Angeles Homeless Services Authority (LAHSA), Housing Authority of the City of Los Angeles (HACLA), and Los Angeles Community Development Authority (LACDA). Additional information on the agencies and the interviewees are available in Table A-3.

We sampled a total of 16 organizations to be included in the interviews and focus groups that administer permanent supportive housing in LA County from the pool of 65 ICMS providers and an overlapping pool of 105 PSH programs receiving Strategy D7 funding through DHS. We first limited the selection to PSH organizations that receive Strategy D7 funding. We arrayed the organizations by the geographic regions and populations served, inclusive of both newer and older

programs. With input from DHS we identified those Strategy D7-funded organizations that were both housing and Intensive Case Management (ICMS) providers as well as those that DHS believed would have a sufficient number of clients served under Strategy D7 to be able to provide perspective on PSH under that strategy. We initially selected 10 organizations for interviews and 11 organizations for focus groups that were both housing and ICMS providers and were arranged across the SPAs.

After speaking with DMH and DPH, we expanded our sample to ensure we had organizations that had FSP and CENS collocated/connected services. To ensure the full range of perspectives on case management, we additionally expanded our sample to include some ICMS providers who were not also housing providers and to include additional providers that served families and youth. This expansion resulted in recruitment of 5 additional organizations for focus groups.

We selected 10 of the organizations in SPAs 1, 3, 5, 7, and 8, with which to conduct telephone interviews with program directors. Before the telephone interview, program directors were sent a brief web survey to gather information on the program and the services that the agency offers. We conducted 17 interviews with agency administrators and 10 interviews with program directors in SPAs 1, 3, 5, 7, and 8. We conducted three additional interviews with program directors in SPAs 2, 4, and 6 who were unable to attend our focus groups.

We conducted three focus groups with two to five case managers in each and three focus groups with two to seven program directors each, representing the three largest SPAs (2, 4, and 6). Three focus groups were conducted with PSH recipients in SPA 4. Recipients' focus groups included one focus group with five women from one project-based housing program, one focus group with 10 residents of a project-based housing program with mental health dedicated units, and one focus group with 10 residents from four different PSH project-based sites. Lists of providers sampled for interviews and focus groups are presented in Tables A-1 and A-2, respectively. A list of key informants interviewed is provided in Table A-3. A list of providers sampled for PSH client focus groups is shown in Table A-4.

Table A-1. Interviews with program directors

Organization	SPA
Mental Health America	1
Union Station Homeless Services	3
Koreatown Youth and Community Center	4
Venice Community Housing	5
Jovenes	7
The Whole Child	7
Coalition for Responsible Development	8
Harbor Interfaith Services	8
Homeless Healthcare LA	Across SPAs
Imagine LA	Across SPAs

Table A-2. Focus groups with program directors and staff

Organization	SPA
A Community of Friends *(interviewed)* Penny Lane Centers *(staff only)* LA Family Housing Corporation *(staff and directors)* Ascencia *(staff and directors)* Bridge to Home *(interviewed)*	2
Downtown Women's Center *(directors)* Skid Row Housing Trust *(interviewed)* The People Concern *(staff and directors)* Volunteers of America *(staff)* PATH Ventures *(staff and directors)* Gettlove *(directors)*	4
Special Service for Groups *(directors)* Watts Labor Community Action Committee *(staff and directors)* Tarzana Treatment Centers *(staff)* Upward Bound House *(directors)* Lutheran Social Services of Southern California *(staff and directors)*	6

Table A-3. List of administrators participating in key informant interviews

Point of contact	Organization
Leepi Shimkhada, Strategy D7 Lead	Department of Health Services (DHS)
Ryan Izell	DHS Office of Diversion and Reentry (ODR)
Maria Funk, Priscilla Moore	Department of Mental Health (DMH)
Yanira Lima, Kristine Glaze	Department of Public Health (DPH)/ Substance Abuse Prevention and Control (SAPC) – Client Engagement and Navigation Services (CENS)
Sarah Mahin	Department of Health Services (DHS)
Kevin Flaherty	Department of Health Services (DHS)
Marina Genchev, Josh Hall	Los Angeles Homeless Services Authority (LAHSA)
Steve Rocha and Christopher Chenet	Los Angeles Homeless Services Authority (LAHSA)
Jonathan Sanabria	Los Angeles Homeless Services Authority (LAHSA), Coordinated Entry System
Elizabeth Ben-Ishai	Chief Executive Office (CEO)
Meredith Berkson	Chief Executive Office (CEO)
Ashlee Oh	Chief Executive Office (CEO)
Halil Toros	Chief Executive Office (CEO)
Ryan Mulligan	Housing Authority of the City of Los Angeles - HACLA
Maureen Fabricante	LA Community Development Authority - LACDA (Previously called the Housing Authority of the County of Los Angeles - HACoLA)
Jennifer Lee	PATH LeaseUp program
Chris Contreras, Perlita Carrillo, Sophia Rice	Brilliant Corners Flexible Housing Subsidy Pool (FHSP) with DHS

Table A-4. Focus groups with clients

Organization	Population	SPA
Skid Row Housing Trust	Mixed	
Downtown Women's Center	Women	4
PATH Ventures	Mixed	

Data Collection. All data collection followed informed consent and human subjects protection procedures approved by Westat's Institutional Review Board (IRB). One-hour confidential telephone interviews were conducted with individual administrators and program directors, recorded to provide for confidential transcripts to provide a backup to note taking.

All focus groups were conducted in a private space located at a participating PSH provider organization. Interviews and focus groups with agency administrators and providers gathered information on the funding sources for Permanent Supportive Housing (PSH) under Strategy D7, the current inventory (number and type) of PSH, the nature and amount of case management (size of caseloads, frequency of contact, supports provided, continuity of case management over time), the types of other services provided and degree of service coordination, the degree of guidance and training around implementation within and across organizations, and the ways in which clients are identified and matched to PSH, as well as the populations served, program eligibility requirements and causes of eviction, as well as rates of and contributors to retention or departure from programs. Case manager focus group protocols elicited information about their roles in PSH, covering how clients enter PSH, types and coordination of services, level of collaboration within and across providers, and client retention. PSH recipient focus groups gathered information on the problems that led them to need housing interventions, experiences with finding and moving into housing and

retention in housing, the services and supports received, and outstanding needs and recommended changes to the programs. All interviews and focus groups elicited information on perceived changes under Strategy D7 and sought to gather information on any variations in populations served. Full copies of our interview protocols were submitted with our Project and Data Collection Plan in September 2019 and are available upon request.

C. HMIS and CHAMP Administrative Data

Analyses of administrative data were conducted to provide information on the characteristics and needs, enrollment and length of time in PSH, and exits from PSH for clients served in PSH after Strategy D7 was funded.

Sample. The sample for our administrative data analysis comprised all clients served through PSH in programs funded through Strategy D7 between Strategy D7 implementation on July 1, 2017, and July 1, 2019 (N = 5,472).

Data sources. Data sources included DHS' Comprehensive Health and Management Platform (CHAMP) and the Homeless Management Information System (HMIS). Of note, given that a substantial proportion of our sample was tracked in only one of the two data systems, we limited our analysis to data elements that were available across both data systems to have the most complete sample possible.

Construction of Variables. Sociodemographic variables extracted include age, gender, race, ethnicity, and veteran status. Using HMIS data, we constructed household type using age and number of children under 18 in the household (determined by calculating whether children age 18 were linked to the head of household via a household ID). For CHAMP data, which does not provide household ID, all clients were coded as heads of household, with the exception of the project with which the client was affiliated, with input from DHS.

For clients tracked in both data systems, we privileged whichever data source had more complete variables. In the event that both data systems had complete variables, we relied on HMIS for most of the constructed variables, with the exception of race, which appeared to be more complete in CHAMP.

The following descriptive variables were extracted from HMIS and CHAMP: age, gender, race, ethnicity, and veteran status.

Outcome variables were constructed as described below:

1. **Enrollments.** Enrollments identified using check-in and check-out dates in CHAMP (that is the dates clients initiated and exited from ICMS). For those tracked in HMIS, enrollments were also identified using project start and exit dates for those entering PSH programs (project type 13 in HMIS).

2. **Move-in Dates.** Clients were considered to have moved into housing if there was a record of a move-in date associated with their enrollment in PSH. For those who moved into housing on or after they enrolled in PSH, time to move into housing was

calculated based on the check-in date and move-in date in CHAMP (as well as project start date and move-in date among those additionally tracked in HMIS).

3. **Exits.** Clients who were no longer checked into a PSH program and had a check-out date documented were considered to have exited the program (as were those who had a project exit date from a PSH program documented in HMIS). Days to exit for these individuals was calculated as days from check-in date to check-out date (or days from project start date to project exit date for those additionally tracked in HMIS).

4. **Length of Enrollment.** For clients who had not yet exited the program, length of enrollment was calculated between check-in date and the end of the implementation period (6/30/2019)

In some cases, clients who appeared to have multiple enrollments very close together in time (with one enrollment period starting within 30 days of the last program exit date in CHAMP or within 60 days of the last program exit date in HMIS) were determined to have administratively unenrolled and re-enrolled. For these individuals, we consulted with DHS and the CEO and determined that we should not count these individuals as having had multiple periods of enrollment. Instead, we counted these cases as a single period of enrollment, beginning with the earliest check-in date and ending with the latest exit date information. Periods of enrollment in PSH that overlapped in time were considered to be a single period of enrollment, retaining the earliest enrollment date and the latest exit date. We also identified cases where clients had enrolled and exited the program within a single day and who had no record of having moved into housing. These individuals were excluded from the sample, as it was not clear that they had actually initiated any service receipt.

Analysis. We conducted descriptive analysis, examining percentages for categorical and means, medians, and standard deviations for continuous variables.

Limitations. A number of limitations should be noted. Quantitative data were collected for administrative purposes and should be interpreted with caution. Because CHAMP and HMIS data systems are not fully integrated, we were limited in the variables we could examine. For example, we did not have access to information on vulnerability scores, disability and other health conditions, or domestic violence for the majority of the sample, as this was available to us only through the HMIS data. Strategy D7 is new, and the length of available observation was therefore a maximum of two years. Finally, as described previously, our analysis was limited by the absence of a meaningful pre-implementation cohort that could be used as a point of comparison to understand quantitatively how population characteristics and outcomes have changed following Strategy D7.

With respect to the qualitative data collected, we were limited in the number and range of providers and PSH clients we were able to sample within the scope of the evaluation, and may not have captured all perspectives. For example, we did not have the resources to systematically sample sites with and without FSP and CENS services in place, to systematically look at the experiences of ICMS only providers versus those providing both housing and services, or to speak with PSH clients in scattered site housing.