

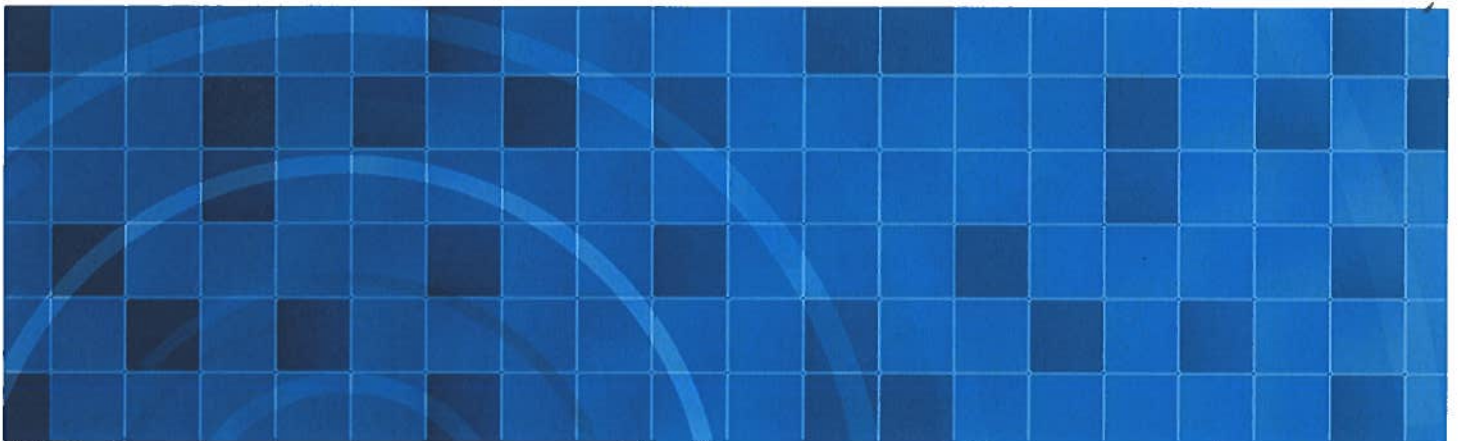
Evaluation of Los Angeles County's Strategies to Expand and Enhance Services Provided Through Permanent Supportive Housing

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 homelessness¹. 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 | | |
|---|----------------------------|------------|-----------------------------|-------------------|--------------------|
| | Documents/quarterly data | Admin data | Agency administrators | Program directors | PSH/services staff |
| Sources | | | | | |
| 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.

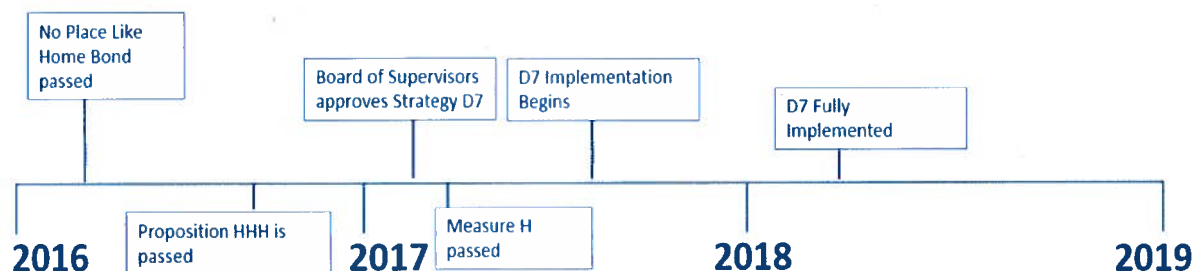
Between July 1, 2017 and July 1, 2019, 5,472 households were served through Strategy D7-funded ICMS. Among those served, 1,057 households were in housing when they enrolled in services, and an additional 1,700 households moved into housing while enrolled in services. Likewise, 4,434 of households served 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 HHH².

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.

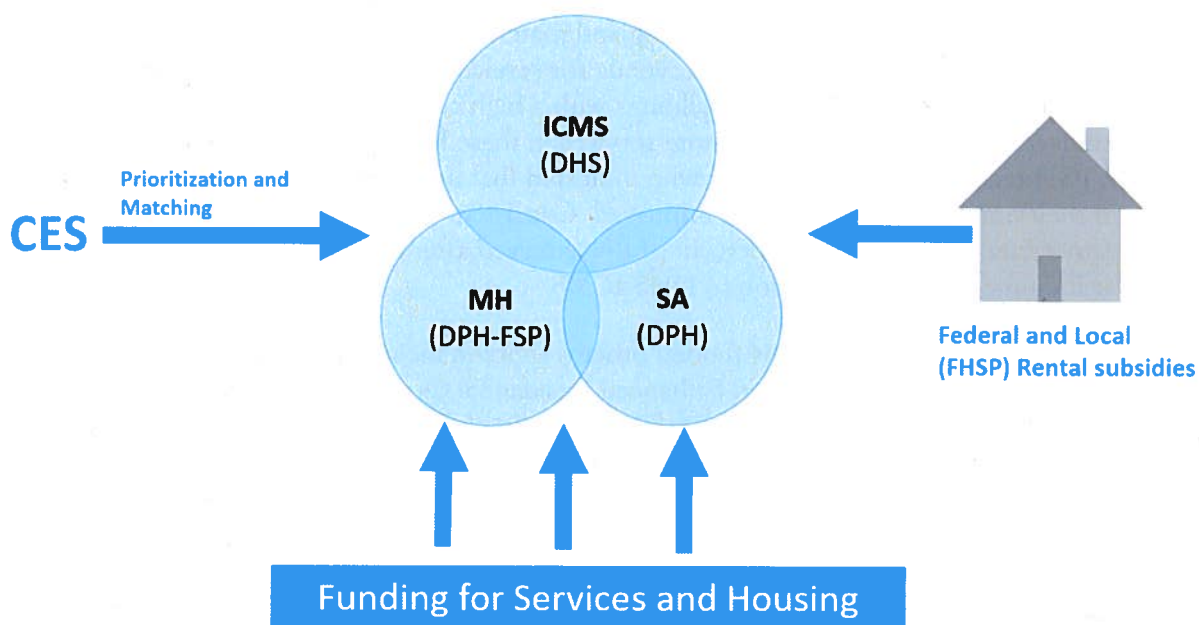
DMH funds community-based organizations to provide on-site mental health services at some Strategy D7-funded sites for PSH clients who need them. The services are provided through DMH's Housing Full Service Partnership model, which includes individual and group therapy and counseling, crisis intervention, 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 to 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.

References

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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 (<i>interviewed</i>) | 2 |
| Penny Lane Centers (<i>staff only</i>) | |
| LA Family Housing Corporation (<i>staff and directors</i>) | |
| Ascencia (<i>staff and directors</i>) | |
| Bridge to Home (<i>interviewed</i>) | |
| Downtown Women's Center (<i>directors</i>) | 4 |
| Skid Row Housing Trust (<i>interviewed</i>) | |
| The People Concern (<i>staff and directors</i>) | |
| Volunteers of America (<i>staff</i>) | |
| PATH Ventures (<i>staff and directors</i>) | |
| Gettlove (<i>directors</i>) | 6 |
| Special Service for Groups (<i>directors</i>) | |
| Watts Labor Community Action Committee (<i>staff and directors</i>) | |
| Tarzana Treatment Centers (<i>staff</i>) | |
| Upward Bound House (<i>directors</i>) | |
| Lutheran Social Services of Southern California (<i>staff and directors</i>) | |

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.