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WILLIAM T FUJIOKA
Chief Executive Officer

October 27, 2009

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

LOS ANGELES COUNTY HOMELESS PREVENTION INITIATIVE STATUS REPORT

According to the Los Angeles Homeless Services Authority (LAHSA), Los Angeles County has the highest concentration of homelessness in the nation (74,000 people). Various social and economic factors, as well as gaps in available housing and social services have contributed to the crisis. In response to this crisis, on April 4, 2006, the Los Angeles County Board of Supervisors made an investment toward addressing and preventing homelessness with the approval of the $100 million Homeless Prevention Initiative (HPI). The Chief Executive Office continues to implement specific key HPI programs in partnership with County Departments of Children and Family Services, Health Services, Mental Health, Probation, Public Defender, Public Health, Public Social Services and the Sheriff along with other agencies including the County's Community Development Commission, LAHSA, and various cities. Through June 2009, the HPI has been tremendously successful in implementing 28 programs and serving nearly 29,000 individuals and over 13,000 families (some programs may serve the same participants). The initiative focuses on reaching the following two goals through the six strategies shown below:

Goal 1 – Preventing Homelessness

- Housing assistance
- Transitional supportive services

Goal 2 – Reducing Homelessness

- Community capacity building
- Regional planning
- Supportive services integration linked to housing
- Innovative program design

Three attachments are included with this memo:

1. Executive Summary of Fiscal Year (FY) 2008-09, Fourth Quarter;

2. HPI Status Report (Attachment A): The FY 2008-09 Fourth Quarter HPI status report includes information on program participants, services provided, and associated outcomes; and

3. Index of Programs (Attachment B): The table presents key performance indicators and budget information on each program. Following the table, each program's performance measures are included with a description of successes, challenges, an action plan, and a client success story.

This HPI report provides information about the progress of your Board's investment to decrease homelessness and inform future planning efforts. If you have any questions, please contact me, or your staff may contact Vani Dandillaya at (213) 974-4190 or via e-mail at vdandillaya@ceo.lacounty.gov.

WTF:JW:KH
VKD:hn

Attachments (3)

c: Sheriff's Department
Department of Children and Family Services
Department of Community Development Commission
Department of Health Services
Department of Mental Health
Probation Department
Department of Public Defender
Department of Public Health
Department of Public Social Services
City of Santa Monica
Los Angeles Homeless Services Authority
Public Counsel
Skid Row Housing Trust

Los Angeles County
HOMELESS PREVENTION INITIATIVE (HPI)

FY 2008-09, APRIL – JUNE, FOURTH QUARTER EXECUTIVE SUMMARY

Left and Bottom Right: Families permanently housed by Beyond Shelter. – Courtesy Beyond Shelter

PARTNERING TO ALIGN HOUSING AND SUPPORTIVE SERVICES

To date, the HPI programs modeled after *Housing First* suggest significant cost savings and over 90 percent of individuals and families maintain permanent housing at six or more months. Programs that integrate services with housing show promising results. Through case management, such programs as the Skid Row Families Demonstration Project link participants to various community resources, including: schools, job training, money management, and counseling. By providing support to families placed into permanent rental housing, case managers assist families to stabilize in their new homes.

With the State budget shortfall impacting many programs, including domestic violence shelters, CalWORKs funding, and emergency hotline assistance, the County's Special Needs Housing Alliance is working to strengthen the regional network of housing developers and service providers so that resources are more effectively leveraged through partnerships. The County's Housing Alliance is made up of County departments, many cities, and non-profit organizations. For instance, the County and Cities of Los Angeles, West Hollywood, Pasadena, and Santa Monica participate in a dialogue to support projects that focus on collaboration between housing developers and service providers. The goal of the Alliance is to increase the number of housing units with supportive services for individuals and families.

Recently, the County has developed several projects that focus on strengthening alliances among partner agencies. Examples of strengthening partnerships include: 1) the County's Homelessness Prevention and Rapid Re-Housing Program, funded by the American Recovery and Reinvestment Act; 2) the Department of Mental Health's partnerships with housing developers funded by the Mental Health Services Act housing programs; and 3) with the forthcoming General Relief (GR) restructuring, the expansion of the HPI GR Housing Subsidy and Case Management project to connect clients to Supplemental Security Income (SSI) and move homeless GR participants into stable housing.

The HPI has served nearly 29,000 individuals and over 13,000 families. For each strategy, specific outcomes and a combined total of actual expenditures are listed. For both the Housing Assistance and Supportive Services Integration and Linkages to Housing strategies, cumulative results are shown.

GOAL 1: PREVENTING HOMELESSNESS

HOUSING ASSISTANCE

Eviction Prevention
Moving Assistance
Rental Subsidy

$9,763,711

Through housing assistance, individuals, youth, and families maintain permanent housing.

- **4,203 individuals and 9,934 families received housing assistance, which prevented homelessness.**

Note: A participant who received more than one type of housing assistance was counted once.

DISCHARGE PLANNING

Access to Housing for Health
Homeless Release Projects
Just In-Reach Program
Recuperative Care

$7,324,964

Clients discharged from public hospitals and jails receive case management, housing location, and supportive services.

- **3,288 clients received public benefits.**
- **97 clients placed into permanent housing.**
- **93% decrease in inpatient days and 83% decrease in ER visits a year post enrollment.**

GOAL 2: REDUCING HOMELESSNESS

COMMUNITY CAPACITY BUILDING

City and Community Program (CCP)
Revolving Loan Fund

$3,475,422

Provide 21 communities with housing development and supportive services via contracts with local housing developers and service providers.

- **2,469 individuals and 326 families received 6,124 linkages to supportive services and 413 housing placements.**

REGIONAL PLANNING

Council of Governments
Long Beach Homeless Veterans

$3,250,000

Helping communities address homelessness in their neighborhoods through development of housing resources and service networks.

- **Gateway and San Gabriel Valley Council of Governments (COGs) presented regional plans to include 1,253 units of permanent housing.**

SUPPORTIVE SERVICES INTEGRATION AND LINKAGES TO HOUSING

Case Management
Housing Locators
Multi-disciplinary Team/Access Center

$11,083,464

Provide clients with integrated supportive services and housing. Supportive services include case management, health care, mental health services, and substance abuse treatment.

- **11,164 individuals and 5,140 families placed into emergency, transitional, and permanent supportive housing.**
- **18,723 linkages to integrated supportive services enhanced participants' well-being.**
- **7,789 individuals and families achieved greater self-sufficiency through public benefits, income support, and connections to employment opportunities.**

INNOVATIVE PROGRAM DESIGN

Project 50
Skid Row Families Demonstration Project
Homeless Court
Housing Resource Center
Santa Monica Service Registry

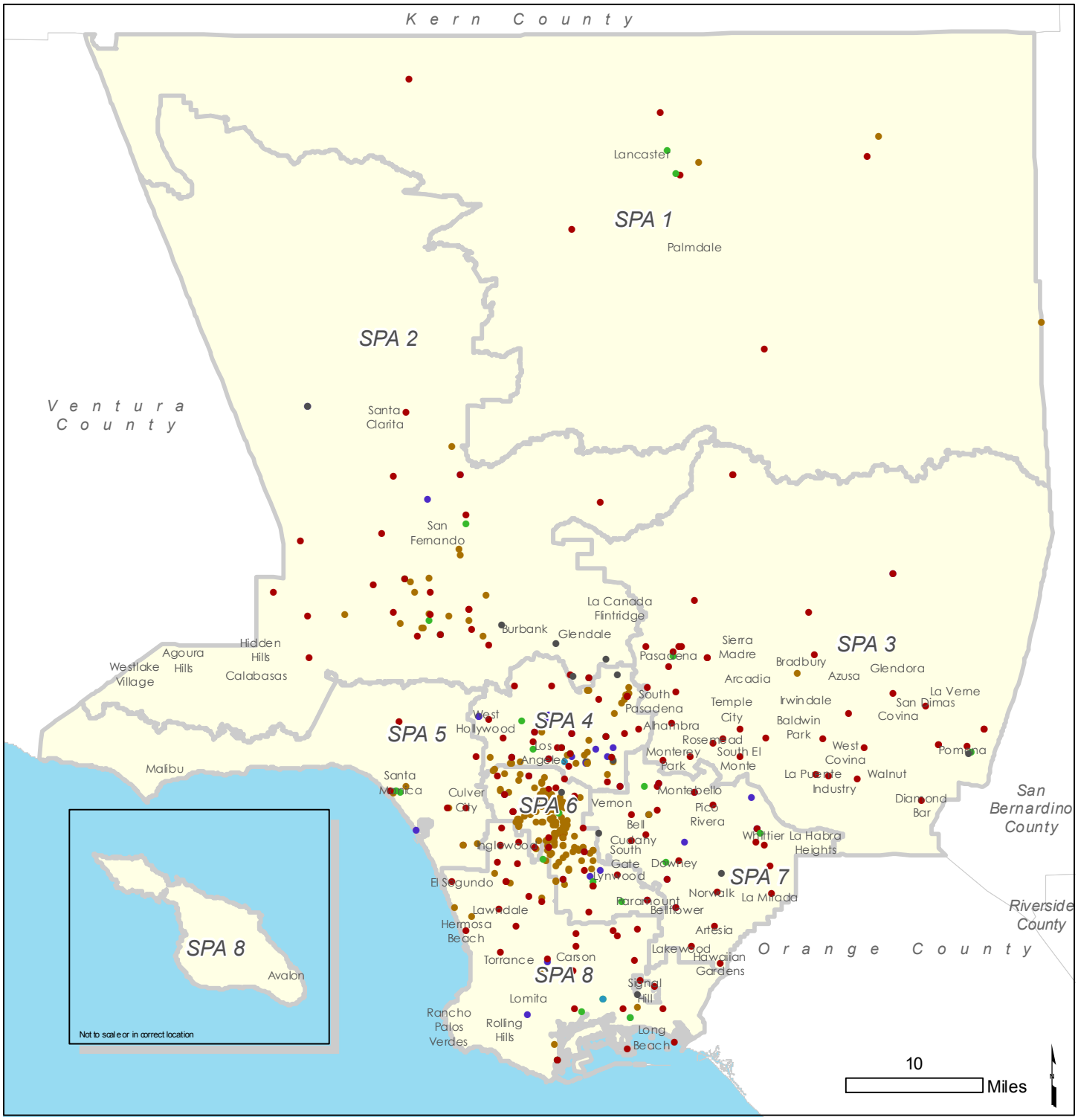
$17,044,622

Provide access to housing and services for the most vulnerable, including chronic homeless individuals and families on Skid Row, individuals with co-occurring disorders, and homeless individuals with outstanding warrants.

- **53 chronic homeless individuals placed into permanent supportive housing.**
- **241 Skid Row families placed into permanent rental housing.**
- **Citations and warrants dismissed for 1,240 individuals.**
- **Over 3.2 million housing searches conducted.**

County of Los Angeles Regional Homeless Prevention Initiative

Housing Placement and Service Locations by Service Planning Area (SPA)



Strategy

- 1 - Housing Assistance
- 2 - Transitional Supportive Services
- 3 - Community Capacity Building
- 4 - Regional Planning
- 5 - Supportive Services Integration and Linkages to Housing
- 6 - Innovative Program Design

Notes:

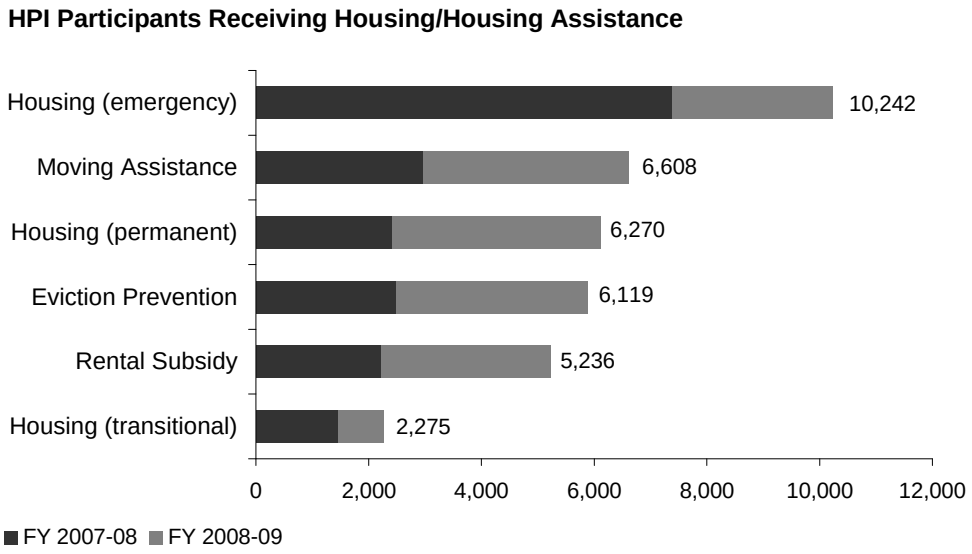
i) The following HPI programs are offered Countywide:
General Relief Housing Subsidy and Case Management Project
Los Angeles County Homeless Court
Los Angeles County Housing Resource Center
Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program
Project Homeless Connect

ii) Strategy 4 - Regional Planning includes San Gabriel Valley Council of Government Plan and Gateway Cities Homeless Strategy.

iii) Rental subsidies were provided to transition age youth who moved to cities in other counties, including: San Bernardino, Riverside, Kern, Orange, San Diego, Ventura, and Santa Barbara.

Map created by ISD/UR-GIS YM (562-940-2181) on 2009-05-14, HPI.mxd
Data from CEO/SIB, LACoeGIS Repository, and Thomas Bros Data.

It is the County's goal to work with community partners to further reduce and prevent homelessness. The chart below shows the number of HPI participants who received housing and financial assistance through June 2009.



Information about the County of Los Angeles Homeless Prevention Initiative

The Los Angeles County Board of Supervisors invested resources to address and prevent homelessness with the approval of the $100 million Homeless Prevention Initiative (HPI). The Chief Executive Office (CEO) continues to implement specific key HPI programs in partnership with County departments, the Los Angeles Homeless Services Authority (LAHSA), Community Development Commission (CDC), and various cities. To date, the HPI has been tremendously successful in implementing 28 programs and serving nearly 29,000 individuals and over 13,000 families. The initiative focuses on reaching the following two goals through six strategies shown below:

Goal	Strategy
Preventing Homelessness	• Housing assistance • Transitional supportive services
Reducing Homelessness	• Community capacity building • Regional planning • Supportive services integration and linkages to housing • Innovative program design

For additional information, please contact Vani Dandillaya at vdandilllaya@ceo.lacounty.gov.

COUNTY OF LOS ANGELES

Homeless Prevention Initiative (HPI)
FY 2008-09, Fourth Quarter Status Report

TABLE OF CONTENTS

Following the **Executive Summary** of this report are two attachments.

Attachment A: Overview of HPI Status

Attachment B: Index of HPI Programs by Population *(Table on page 1)*

HOMELESS PREVENTION INITIATIVE (HPI) STATUS REPORT
FY 2008-09, Fourth Quarter

I. INTRODUCTION

In accordance with your Board's direction on April 4, 2006, this report provides a status update on the implementation of 28 programs included in the Los Angeles County Homeless Prevention Initiative (HPI) during April-June of FY 2008-09. The Chief Executive Office (CEO) continues to implement specific key HPI programs in participation with the Community Development Commission (CDC), the Departments of Children and Family Services (DCFS), Health Services (DHS), Public Health (DPH), Mental Health (DMH), Public Social Services (DPSS), Probation, Public Defender, and the Sheriff. Representatives from these County agencies, departments, and several partner organizations meet frequently to ensure consistent communication and integration of services and facilitate successful implementation of HPI programs serving the County's homeless population.

HPI funding has allowed for greater access to housing and supportive services for the homeless and at-risk population. This HPI status update highlights results achieved through program strategies that have served nearly 29,000 individuals and over 13,000 families.[1] This report features components of the HPI, associated outcomes, and opportunities to further enhance and integrate the network of providers.

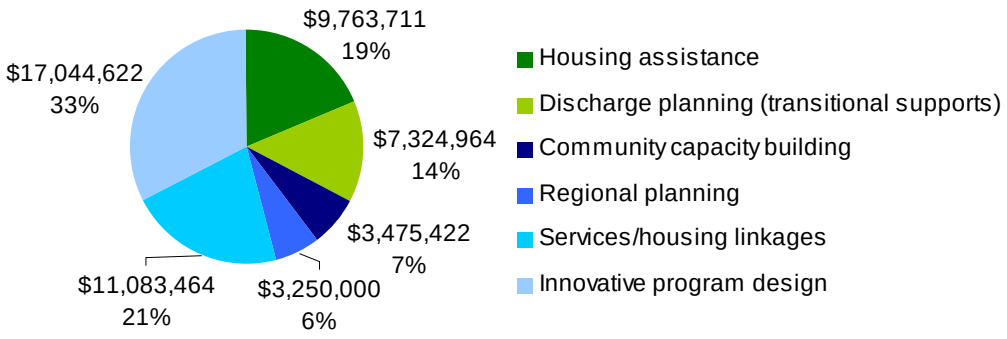
Goals and Strategies

As mentioned in the Executive Summary, the CEO continues to implement specific key HPI programs in partnership with County departments, the Los Angeles Homeless Services Authority (LAHSA), CDC, and various cities. The initiative focuses on meeting the following two goals through six strategies shown:

Goal	Strategy
Preventing Homelessness	• Housing assistance • Discharge planning (transitional supports)
Reducing Homelessness	• Community capacity building • Regional planning • Supportive services integration and linkages to housing • Innovative program design

[1] Currently, a standardized data system is not in place to determine if any client is shared across programs, therefore, the total number of participants may include a duplicate count.

Chart 1: Actual Expenditures
Total: $51,942,183*



*Actual expenditures are approximately $54.9 million. Additional expenditures include: 1) Board approved operational support at $1.9 million (FY 2006-07); and 2) operational support, administrative, and evaluation costs at approximately $1.2 million. *From upper right (clockwise) beginning with Housing Assistance.*

Actual Expenditures by Strategy

In this report, total expenditures include FYs 2006-07, 2007-08, and 2008-09 actual expenditures. The total expenditures for the HPI programs in this report are $54.9 million. Chart I shows that 33 percent of all expenditures have been spent on the initiative's first goal to prevent homelessness. Sixty-seven percent of all expenditures have been spent on the HPI's second goal to reduce homelessness. In addition, Chart I shows the amount expended by each strategy. For the community capacity building strategy, capital projects for housing development have been delayed due to the economic conditions, therefore, the actual expenditures are significantly less than previously estimated for FY 2008-09. Through FY 2008-09, the greatest percentage (one-third) of actual expenditures was spent on innovative programs, including *Housing First* models for chronically homeless participants.

Partnering to Align Housing and Supportive Services

With the State budget shortfall impacting many programs, including domestic violence shelters, CalWORKS funding, and emergency hotline assistance, the County's Special Needs Housing Alliance is working to strengthen the regional network of housing developers and service providers so that resources are more effectively leveraged through partnerships. The County's Housing Alliance is made up of various Cities, County departments, and non-profit organizations. For instance, the County and Cities of Los Angeles, West Hollywood, Pasadena, and Santa Monica participate in a dialogue to support projects that focus on collaboration between housing developers and service providers. The goal of the Alliance is to increase the number of housing units with supportive services for individuals and families.

Recently, the County has developed several projects that focus on strengthening alliances among partner agencies. Examples of strengthening partnerships include: 1) the County's Homelessness Prevention and Rapid Re-Housing Program, funded by the American Recovery and Reinvestment Act; 2) through the Mental Health Services Act housing programs, the Department of Mental Health's partnerships with housing developers; and 3) with the forthcoming General Relief restructuring, the expansion of the HPI GR Housing Subsidy and Case Management project to move homeless GR participants into stable housing.

II. PARTICIPANTS

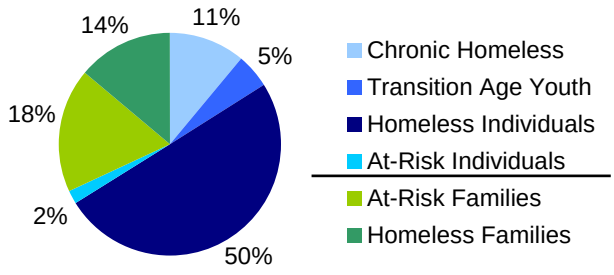
During the fourth quarter of FY 2008-09, 24 of 27 implemented HPI programs[2] directly served the County's homeless and nearly homeless. While several programs served more than one population, participants in 19 programs corresponded to one of five categories: homeless individuals (seven programs), chronic homeless individuals (four programs), transition age youth (two programs), homeless families (three programs), and at-risk families (two programs). Attachment B provides an overview of programs. To date, Table 1 shows HPI improved the lives of 28,848 individuals and 13,379 families.[3] From the third to fourth quarter, the number of families and individuals served increased by 11 and 15 percent, respectively.

Table 1: Number of Contacts by Participant Category
FY 2008-09

	FY 2008-09*	FY 2007-08	Cumulative	Fourth Qtr. Increase
Homeless Individuals	8,722	12,206	20,928	16%
Chronic Homeless Individuals	2,181	2,443	4,624	20%
Transition Age Youth	1,100	1,122	2,313	10%
At-Risk Individuals	983	-	983	-
Total for Individuals	12,986	15,771	28,848	15%
Homeless Families	1,860	3,950	5,810	1%
At-Risk Homeless Families	5,082	2,487	7,569	20%
Total for Families	6,942	6,437	13,379	11%
Total	**19,928**	**22,208**	**42,227**	**13%**

*FY 2008-09: Returning participants from FY 2007-08 have been subtracted for an unduplicated count.

Chart 2: Percent by Participant Category



From upper right (clockwise) beginning with Chronic Homeless.

Chart 2 illustrates that of HPI participants, 68 percent were individuals and 32 percent were families. According to LAHSA, 24 percent of the total homeless population lives in families,[4] and homeless families made up 14 percent of all HPI participants. Of all individuals, 50 percent were homeless adults, and five percent were transition age youth. Approximately one-third of the homeless in the County are chronically homeless,[5] while these individuals made up 11 percent of all participants.

[2] While Housing Locator and Housing Specialists programs are included, these programs are funded by CalWORKs Single Allocation and DMH Mental Health Services Act (MHSA), respectively. City and Community Program includes 21 separate programs.
[3] Note most programs provided an unduplicated participant number; however, four programs included a duplicated participant count during FY 2007-08. Housing Locators/Housing Specialists are included in total participant count.
[4] LAHSA 2007 Greater Los Angeles Homeless Count.
[5] Ibid.

Participant Characteristics

During the fourth quarter of FY 2008-09, all 24 programs provided demographic information for program participants. Demographic information included gender, age, and race/ethnicity of participants. To obtain data on HPI participants, demographic information from new participants served during this past quarter was included. Gender information from LAHSA contracted programs was added from FYs 2007-08 and 2008-09. Due to different categorization for race/ethnicity and age, these statistics for LAHSA contracted programs are shown separately in Attachment B.

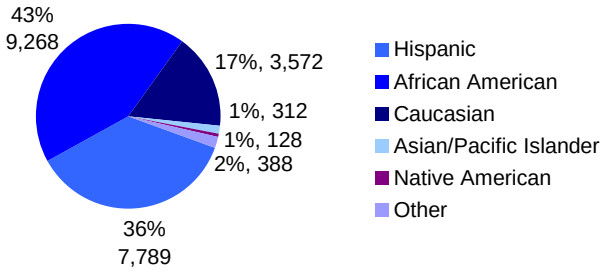
Gender

Approximately 59 percent of the homeless population in Los Angeles County consists of adult men.[6] Of the 28,618 participants whose gender was provided, 55 percent (15,675) were male and 45 percent (12,918) were female.

Race/Ethnicity

The total homeless population in Los Angeles County is about 55 percent African American and 19 percent Caucasian. Chart 3 shows 43 percent of HPI participants were African American and 17 percent Caucasian. Representing the total homeless population, 36 percent of participants were Hispanic. The remaining four percent of participants included Asian/Pacific Islander, Native American, and other racial/ethnic groups.

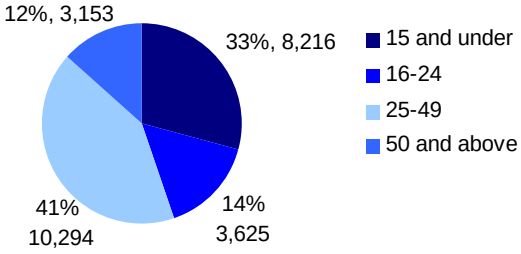
Chart 3: Race of HPI Participants (n=21,457)



Age

Compared to an average age of 45 years for homeless individuals in the County, 41 percent were between 25-49 years of age. Chart 4 shows that of HPI participants whose age was provided, 33 percent were children less than 15 years of age, 14 percent of participants were between the ages of 16-24, and 12 percent were 50 years of age and older.

Chart 4: Age of HPI Participants (n=25,288)



[6] LAHSA 2007 Greater Los Angeles Homeless Count.

III. GOALS, STRATEGIES, AND OUTCOMES

Goal I: Preventing Homelessness

Strategy ❶ Housing Assistance $9,763,711

Through housing assistance, individuals, youth, and families maintain permanent housing.

Eviction Prevention • Moving Assistance • Rental Subsidy

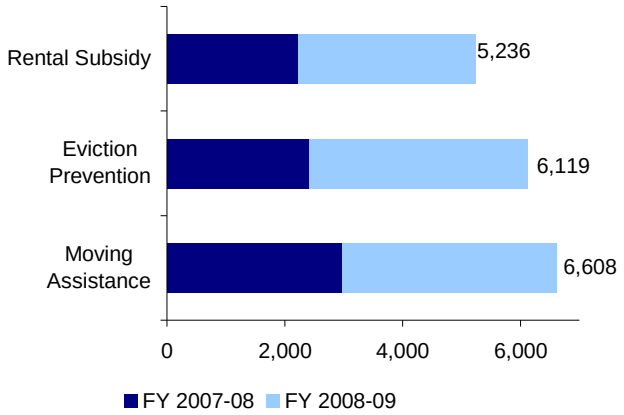
HPI programs provided housing assistance through moving assistance, eviction prevention, and rental subsidies; five programs focused on these services. ***Through June 2009, a total of 14,137 participants received housing assistance to secure permanent housing and prevent homelessness.*** Table 2 shows 70 percent of participants who obtained housing assistance were families, 23 percent were individuals, and seven percent were transition age youth. Table 2 illustrates that a greater proportion of individuals and transition age youth received rental subsidies, whereas significantly more families received eviction prevention. A participant who received more than one type of housing assistance was counted once. Chart 5 shows the number of participants who received housing assistance through June 2009.

Implemented on October 1, 2009, the County's HPRP invests into housing assistance to prevent homelessness for families and individuals, including seniors and veterans. The Departments of Public Social Services, Children and Family Services, and Community and Senior Services provide financial assistance for eviction prevention, moving assistance, and rental subsidies.

Table 2: Through June 2009		Housing Assistance	Moving Assistance	Rental Subsidy	Eviction Prevention
Individuals	3,190	23%	2,456	4,032	33
Transition Age Youth	1,013	7%	568	925	1
Families	9,934	70%	3,577	257	6,066
Total participants	**14,137**	**100%**	**6,601**	**5,214**	**6,100**
Expenditures		**$9,763,711**	**$5,467,886**	**$688,274**	**$3,607,551**

The following participants were not included in Table 2: seven participants who received moving assistance, 19 who received eviction prevention, and 22 who received rental subsidies.

Chart 5: HPI Participants Receiving Housing Assistance



Strategy ❷ Discharge Planning (Transitional Supports) $7,324,964

Clients discharged from public hospitals and jails receive case management, housing location, and supportive services.

Access to Housing for Health (AHH) • Recuperative Care • Homeless Release Projects (DPSS-DHS and DPSS-Sheriff) • Just In-Reach Program (JIR)

Discharge Planning for Hospital Patients

The Access to Housing for Health (AHH), Recuperative Care, and DPSS-DHS Homeless Release programs provided discharge planning for hospital patients at-risk of becoming homeless. A discharge plan connected these patients to needed services that helped them attain stable housing and a better quality of life. Both the AHH and Recuperative Care programs have shown improvements in health outcomes, such as reductions in Emergency Room (ER) visits and inpatient hospitalizations. In addition, these reductions lead to cost savings for the County.

Outcomes

- ***Improved Health***: Since March 2007, 45 AHH clients reached their one-year mark. They had a combined total of 197 ER visits during the 12 months prior to enrollment. Post enrollment, the clients only had a combined total of 34 ER visits for an 83% reduction. The 41 AHH clients were hospitalized for a combined total of 394 days prior to AHH enrollment. These same clients only had 28 inpatient days post AHH enrollment. The number of inpatient days was reduced by 93%.
- ***Cost Avoidance:*** A six month pre/post analysis for Recuperative Care patients reported a 33% reduction in ER visits and a 67% reduction in inpatient hospitalizations.
- ***Linkages to Public Benefits***: The AHH, Recuperative Care, and DHS-DPSS Homeless Release projects made 525 connections to public benefits for individuals, including: SSI/SSDI, Medi-Cal, and General Relief.
- ***Housing Stability***: AHH placed 62 individuals into permanent housing. All 47 individuals who have been placed into permanent housing for six or more months have remained in housing.

Discharge Planning for Individuals Released from Jails

The Just In-Reach (JIR) and DPSS-Sheriff Homeless Release projects connected individuals to services and benefits prior to release from jail to help support steps towards building a better future, including stable housing and employment.

Outcomes

- ***Linkages to Public Benefits***: The JIR and DPSS-Sheriff Homeless Release projects have served 5,086 individuals and made 2,763 connections to public benefits, including: General Relief, Food Stamps, SSI/SSDI, and Veteran's benefits.
- ***Housing Placement***: Housing locators have assisted 292 individuals with housing placement. The majority of housing has been emergency and transitional housing. Through the JIR program, 170 clients identified as homeless or chronically homeless have been released to housing, transitional living or a residential program. These are clients that if not for this program, would have otherwise ended up homeless on the streets.
- ***Transition to Communities:*** By offering case management to all JIR clients and focusing on education/job opportunities, 276 individuals received job related/education services. The recidivism rate of JIR participants has been 34% this past year, which is half that of the general County Jail system population (70%).

Goal 2: Reducing Homelessness

Strategy ❸ Community Capacity Building $3,475,422

Provide 21 communities with housing development and supportive services via contracts with local housing developers and service providers.

City and Community Program (CCP) • Revolving Loan Fund

City and Community Program (CCP)

- To date, 14 programs served 2,469 individuals and 326 families. They made ***6,124 linkages to supportive services and 413 housing placements***. Fourteen of 15 service contracts were executed.
- The State's current inability to fund previously committed loans has brought a number of developments that include HPI, City of Industry or other CDC funding to a virtual standstill. Challenges continue from the previous quarter. Coordination with other local, state and/or federal funding and construction industry changes has caused delays. Projects that were expecting State Multifamily Housing Program (MHP) funding are on hold because of the "freeze" caused by the State budget. The state has started to release some funding, but it is unknown at this time which Homeless and Housing Program Fund (HHPF) projects will be affected.

Revolving Loan Fund (RLF)

- The collapse of the capital markets in 2008 negatively affected RLF operations. The Investor suspended its participation, and the search for a new investor began. Further, market conditions have made it very difficult to attract a new investor using the existing risk structure. Many potential investors are now requiring additional insulation from losses. Despite this, Los Angeles County Housing Innovation Fund, LLC (LACHIF) members have successfully identified new investors. CDC met with each Board office to discuss necessary changes to the RLF. CDC filed a Board letter requesting authorization to amend the existing loan agreement between CDC and LACHIF, LLC, which was adopted on July 28, 2009.

Strategy ❹ Regional Planning $3,250,000

Helping communities address homelessness in their neighborhoods through development of housing resources and service networks.

Gateway Cities Council of Government (COG) • San Gabriel Valley COG • Long Beach Homeless Veterans

- The San Gabriel Valley Council's of Government (COG) and the Gateway Cities COG are in the process of beginning phase II of their respective initiatives. Phase II will consist of overseeing the implementation of each plan. The efforts will serve to create affordable permanent housing, interim housing, homeless services, and capacity building. The County's Chief Executive Office is creating funding agreements with the COGs, and/or their contracted partner, to support these efforts.
- San Gabriel Valley COG's Regional Homeless Service Strategy includes an objective to create 588 units of permanent supportive housing over the next five years, and PATH Partners' Gateway Cities Homeless Strategy plans to create 665 units of permanent supportive housing over five years (Attachment B, p. 59).
- Long Beach Homeless Veterans served 369 veterans this quarter, including two families. Services

included: case management, child support reduction, mental health care, and housing. During the fourth quarter, Single Parents United N Kids (SPUNK) assisted 25 clients with a total of 28 child support cases. Of those, SPUNK closed 14 client cases for a total arrears savings of $211,912.

Strategy ❺ Supportive Services Integration and Linkages to Housing $11,083,464

Clients receive integrated supportive services and housing.

Case Management • Housing Locators • Multi-disciplinary Team/Access Center • Project Homeless Connect

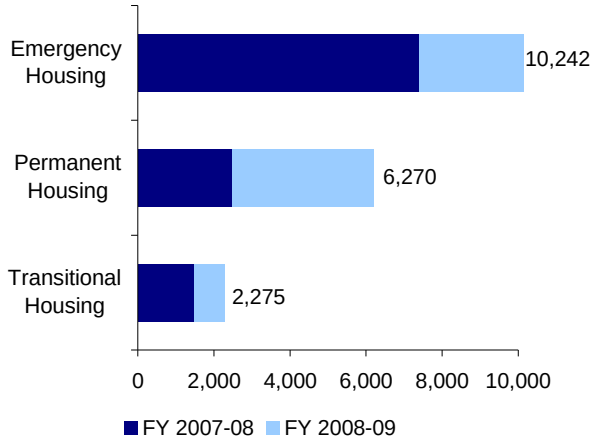
Linkages to Housing – A total of 5,597 participants received permanent housing with 66 percent being families, 13 percent transition age youth, and 21 percent individuals. In contrast, 84 percent of individuals received emergency/transitional housing placement. Chart 6 shows the number of participants who received housing; several LAHSA contracts for emergency/transitional housing ended during FY 2007-08. This quarter, 15 programs placed participants into temporary housing. Participants in these programs spent an average of 104 days in temporary housing prior to permanent or transitional housing. Participant stay in temporary housing ranged from 12 to 180 days (six months).

Five programs focus on supportive services integration and linkages to housing. Two programs will serve as service integration models. In June 2009, the Weingart Center Association in partnership with JWCH Institute and the County of Los Angeles opened a state-of-the-art, 20,000 square foot Center for Community Health (CCH) Downtown Los Angeles. In addition, the SSI Advocacy program will increase the number of early SSI approvals by coordinating efforts between DPSS and DHS to utilize existing County medical records and improve the overall SSI application process.

Table 3: Housing Placement through June 2009	Emergency/ Transitional		Permanent Housing	
Individuals	8,986	84%	1,196	21%
Transition Age Youth	273	2%	709	13%
Families	1,448	14%	3,692	66%
Total	**10,717**	**100%**	**5,597**	**100%**

Services not categorized by population above: 673 who were moved into permanent housing; 1,255 who were moved into transitional housing; and 524 who were placed into emergency housing.

Chart 6: HPI Participants Receiving Housing



Supportive Services Integration – Participants received supportive services in three categories: 1) employment/education, 2) benefits advocacy and enrollment assistance, and 3) health and human services.

Employment/Education Services and Support

Through June 2009, nine HPI programs reported a total of 1,798 participants received job and/or education related supports (Table 4). Fifty-eight percent of these participants received job training, referrals, or related resources. Participants in these programs included transition age youth, chronic homeless individuals and families on Skid Row, and participants with co-occurring disorders. As programs continue to make linkages to job and education related services and build infrastructure for data collection, these numbers have increased. Knowing that 93 percent of the homeless in Los Angeles are unemployed,[7] providing them with the support to overcome barriers in obtaining and maintaining employment will assist them in attaining greater self-sufficiency.

Table 4: Jobs/Education	FY 2008-09	Cumulative	Percent
Job training/referrals/resources	1,005	1,049	58%
Education (course, class, books)	383	404	23%
Job placement (employment)	335	345	19%
Total number of services provided:	**1,723**	**1,798**	**100%**

Benefits Advocacy and Enrollment Assistance

For participants who entered programs in need of specific public benefits, 11 HPI programs reported enrolling homeless individuals and families. Table 5 shows that through June 2009, 4,116 homeless individuals were enrolled into General Relief, which consisted of 69 percent of all benefit enrollments. Nine percent of participants were enrolled into Supplemental Security/Disability Income (SSI/SSDI), and 10 percent received Shelter Plus Care or Section 8 to secure permanent housing. This quarter, the number of participants who enrolled into Medi-Cal/Medicare increased by 42 percent - the greatest percent increase from the previous quarter. Followed by public health insurance enrollment, the number of participants receiving Food Stamps increased by 27 percent during this quarter.

Table 5: Benefits	FY 2008-09	Cumulative	Percent
General Relief (and Food Stamps)	1,987	3,517	59%
General Relief only	345	599	10%
SSI/SSDI	489	537	9%
Shelter Plus Care	329	362	6%
Medi-Cal or Medicare	219	293	5%
Section 8	168	264	4%
CalWORKs	161	160	3%
Food Stamps only	149	189	3%
Veterans	40	41	1%
Total number of benefits provided:	**3,887**	**5,991**	**100%**

[7] LAHSA 2007 Homeless Count.

Supportive Health and Human Services

For FY 2008-09, 16 programs (including the City and Community Program) made 18,723 linkages between participants and supportive health and human services. These programs served homeless and chronic homeless individuals, homeless families, and transition age youth. Table 6 shows 32 percent (6,014) of these HPI participants received case management, which was the most frequently reported supportive service. Followed by case management, 13 percent of linkages were for health care (2,481), and 10 percent (1,921) were for mental health care. Another 10 percent of these linkages connected participants to transportation services, including bus tokens and public transportation.

Knowing that 74 percent of the homeless population have a physical or mental disability, depression, alcohol or drug use, or chronic health problems,[8] linking these individuals and families with health care, mental health care, and substance abuse treatment is critical. Additionally, with the HPRP funds, the County has expanded services to assist families and individuals with credit repair, legal assistance, and money management. In a recent HPI survey, providers also indicated interest in improving access to child care, law enforcement, and employment support.

Twenty-four programs reported providing case management services, and 10 programs selected the most intense level of case management. The HPI Report Form asked about the level of case management provided, with level one assessing the client and level three assisting with supported referrals and counseling.[9] Hours provided to each participant per month ranged from 1-80 hours (average of 19 hours) with an average caseload of 23 cases per case manager.

Table 6: Supportive Services	FY 2008-09	Percent	FY 2007-08*
Case management	6,014	32%	2,257
Health care	2,481	13%	183
Transportation	1,967	10%	615
Mental health care	1,921	10%	182
Life skills	1,808	10%	676
Alternative court	1,220	6%	286
Resident rights/responsibilities	902	5%	-
Substance abuse treatment	691	4%	130
Social/community activity	599	3%	51
Food vouchers/food	350	2%	414
Recuperative care	345	2%	45
Other**	216	1%	5
Clothing/hygiene	117	1%	80
Legal services	92	1%	15
Total number of services provided to participants:	**18,723**	**100%**	**4,939**

* For FY 2007-08, this report includes LAHSA contracted programs that provided referrals to mental health care (including domestic violence counseling) and substance abuse treatment.

**Other services include: auto insurance, driver's license release, identification card, and credit repair.

[8] LAHSA 2007 Greater Los Angeles Homeless Count.

[9] Post PA. Developing Outcome Measures to Evaluate Health Care for the Homeless Services. National Health Care for the Homeless Council. May 2005.

Strategy ❻ Innovative Program Design $17,044,622

Provides access to housing and services for the most vulnerable, including chronic homeless individuals and families on Skid Row, individuals with co-occurring disorders, and homeless individuals with outstanding warrants.

Project 50 • Santa Monica Service Registry • Skid Row Families Demonstration Project • Homeless Courts • Housing Resource Center

INNOVATIVE PROGRAM OUTCOMES

Housing First Models

- **Housing stability**: Housing First models showed a successful 93 percent housing retention rate for individuals and families in permanent housing for six or more months. Housing First programs include: Project 50, Skid Row Families Demonstration Project, and the Santa Monica Service Registry.
- **Increased income**: After one year, Project 50 participants showed a 56 percent increase in benefits since enrollment.
- **Improvement in overall health and well-being**: At the end of one year, Project 50 participants spent significantly fewer days in ERs, hospitals, and jails with considerable cost savings for the County.

Homeless Courts

- **Pathways to self-sufficiency**: Ninety-two percent of Homeless Court participants had their warrants or citations dismissed, and they have been able to move forward by securing employment, reconnecting with their families, and planning for their future.

Los Angeles County Housing Resource Center (LACHRC)

- **Information sharing**: Over 3.2 million searches for housing listings have been conducted online.

The HPI Report Form requested for programs to report on three outcome areas for participants receiving services for 6, 12 and 18 months. The three outcome areas were: 1) housing stability, 2) education and employment status, and 3) health and well-being. Ten programs that served chronic homeless individuals, transition age youth, and homeless individuals and families reported on these longer-term outcome areas.

Point in time outcomes for this past quarter at 6, 12, or 18 months post enrollment:

- **Housing stability**: A total of 1,748 participants continued to live in permanent housing and 1,281 continued to receive rental subsidies.
- **Employment/education**: A total of 99 participants obtained employment, 206 maintained employment, and 101 enrolled in an educational program.
- **Health and well-being**: The following number of participants continued to receive these services for six months or more: 1,566-case management; 1,143-health care; 618-mental health services; and 136-substance abuse treatment.

A brief description of each innovative program:

- **Project 50** – The project is a successful collaboration that includes over 24 government and non-profit agencies. Based on Common Ground's *Street to Home* strategy, Project 50 integrates housing and supportive services for vulnerable, chronic homeless individuals living near downtown Los Angeles on Skid Row. A year after its launch, the pilot successfully moved 50 vulnerable, chronic homeless individuals off of Skid Row with an impressive housing retention rate of 88 percent. Moreover, significant decreases in hospitalizations and emergency room visits indicate improved health and behavioral health outcomes. In addition to improving the quality of life for these 50 individuals, estimates show considerable cost savings as a result of fewer days spent in ERs, hospitals, and jails.

- **Skid Row Families Demonstration Project** – A total of 241 families have been placed into permanent housing. Of these families, 96 percent have successfully maintained permanent housing for six or more months (188 have maintained their permanent housing for 12 months or more, 44 families have maintained permanent housing for seven to 12 months, and five families are in their first six months of permanent housing). For the first six months in permanent housing, families are offered home-based case management. Consistent contact has enabled the Housing First Case Managers to develop positive relationships based on trust. Case management has included linking families to various supportive services, including: community resources, mental health referrals, school referrals, job training referrals, money management, and financial planning. After six months of home-based case management to help families stabilize, the majority of families received follow-up phone calls to ensure they are doing well and are not in crisis.

- **Homeless Courts** – A total of 1,240 individuals have had their warrants or citations dismissed as a result of successful completion of mental health and/or substance abuse treatment requirements of the Los Angeles County Homeless Court and Santa Monica Homeless Community Court. In addition, 11 individuals have graduated from the Co-Occurring Disorders Court to have charges dismissed. As a result of having outstanding warrants, citations, or charges resolved, these individuals have been able to move forward by securing employment, reconnecting with their families, and planning for their future. For example, one participant obtained his GED, became a certified cook and hopes of owning his own restaurant. Another participant said that the program has changed his life by helping him achieve sobriety for over 17 months and reunite with his family.

- **Los Angeles County Housing Resource Center (LACHRC)** – The online database provides information on housing listings for public users, housing locators, and caseworkers. Over 3.2 million searches have been conducted by users to receive listings. The LACHRC is an excellent example of using technology to make information more accessible, and clients are very grateful for this service. In October 2009, the LACHRC added a pre-screening feature to determine HPRP program eligibility and further improve system navigation for clients.

V. PROGRAM NARRATIVE (included in Attachment B)

Program Successes, Challenges, and Action Plans

Each quarter, programs provide information on successes, challenges, and action plans. A review has identified four common themes in implementing strategies to reduce homelessness: collaborative partnerships, innovative processes, outreach strategies, and leveraged funds.

1. Develop and strengthen *collaborative partnerships* between public, private, and non-profit agencies to ensure a seamless and integrated service system.
2. Support *innovative processes* that promote information sharing between service providers to better meet clients' housing and service needs.
3. Expand *outreach strategies* and education efforts to provide specialized supportive services and housing to more homeless and at-risk individuals and families.
4. *Leverage funds* to expand access to housing and services for more homeless and at-risk individuals and families.

Client Success Stories

A former foster youth in the Transition Age Youth Moving Assistance program -

A 23-year-old former foster youth residing in an apartment received rental assistance that enabled the youth to stabilize his living situation as he worked to create his own Oatmeal Cupcake Business that shows lucrative potential. This youth serves as a mentor to other foster youth and has plans to create employment opportunities for both current and former foster youth.

A dually diagnosed Co-Occurring Disorders Court (CODC) program participant -

Mr. R is a 55-year-old Hispanic male with an extensive history of substance abuse and mental illness. Upon entering the program, Mr. R presented extreme hopelessness and debilitating depression. His chronic abuse of drugs and neglected mental illness contributed to his inability to hold a job or secure housing. His own family ostracized him due to his inability to control his behaviors, mood swings, and continued substance abuse. Mr. R initially struggled with adjusting to the parameters of the CODC program and treatment regimen. He ended up leaving the program on multiple occasions and was even re-incarcerated for several weeks. But Mr. R's case manager did not give up on him. Eventually, due in large part to the intensive coordination of services orchestrated by Mr. R's case manager along with his family members, jail and court staff, and the mental health and substance abuse treatment providers, Mr. R finally realized that treatment was a better alternative to incarceration and living on the streets. He allowed himself to accept help and develop trust. Today, Mr. R. has been sober for almost a year and is learning to effectively manage his mental illness. Mr. R took steps to reunify with his family, and he now shares a residence with his sister. Mr. R is grateful for the assistance he received from a program that did not "give up" on him and continues to support him on his journey to recovery.

A Los Angeles County Homeless Court participant -

Client D was referred to Homeless Court by his counselor at a substance abuse treatment program. He had numerous unresolved traffic citations and his driver's license had been suspended. Through Homeless Court, the client's outstanding citations were resolved, and he was able to get his driver's license reinstated. His experience in treatment inspired him to help others struggling with substance abuse. He is now living independently and working full-time as a counselor at a substance abuse treatment program similar to the program he participated. With his driver's license reinstated, he commutes nearly 100 miles to work from his home. Client D frequently submits applications to Homeless Court on behalf of his clients.

VI. RECOMMENDATIONS

County of Los Angeles Homeless Service Integration Plan
Through June 2009, the HPI offered hope to many homeless and at-risk individuals and families living in Los Angeles County. As we apply lessons learned to inform future planning efforts, we will continue to make a greater impact on the lives of many residents who need the support to achieve and sustain a safe, stable place to live.

The FY 2009-10 County of Los Angeles Homeless Service Integration Plan includes four goals:

- Support residents towards self-sufficiency to prevent homelessness;
- Increase linkages to transitional supportive services;
- Create a regional approach to housing development; and
- Enhance integration of supportive services and housing.

The Plan aligns efforts to more effectively use resources and achieve better outcomes. Focusing on a regional approach, the Plan includes expansion of successful *Housing First* models, greater access to integrated health and social services, and support for pathways to stable housing for the homeless General Relief (GR) population.

Homelessness Prevention and Rapid Re-Housing Program (HPRP)
The County received $12.1 million in American Recovery and Reinvestment Act (ARRA) funds for HPRP. Implemented in October 2009, the County's HPRP provides residents of unincorporated areas and 47 smaller cities with financial assistance and housing stabilization services. In addition, the Cities of Huntington Park and Alhambra are partnering with the County to offer its residents similar services. Families and individuals who are eligible for HPRP may receive rental, security, utility, and moving assistance from the Departments of Public Social Services and Community and Senior Services, respectively. The Department of Consumer Affairs also provides such supportive services as household budgeting and tenant-landlord counseling to help residents maintain housing. Moreover, Neighborhood Legal Services and the Department of Children and Families Services will launch services in November. Through a range of financial assistance and housing stabilization services, HPRP offers a seamless, integrated system to prevent homelessness.

The County CEO and departments worked with the CDC and LAHSA to enhance coordination of HPRP services by using two web-based tools. First, the HPRP proposal added an online pre-screening feature to the LACHRC website so that the public and County staff can determine program eligibility, assist with making referrals, and improve overall system navigation. Second, LAHSA trained over 80 County staff to enter client and service information into the U.S. Housing and Urban Development's Homeless Management Information System (HMIS). The HMIS not only collects data for program evaluation, but the system also allows internal agencies to communicate and share information in order to better serve clients. Beginning in November, the County departments will make direct referrals using HMIS. Through both web-based tools, the HPRP team will make more connections to community resources for clients.

In summary, the CEO will continue to develop partnerships with cities and communities throughout the County to create regional solutions to prevent and reduce homelessness. To ensure the greatest return on the County's investment, the CEO holds monthly Board briefings and homeless coordination meetings that include staff from Board offices, County departments, LAHSA, CDC, and several cities to provide updates on the HPI budget and programs. The forum is an opportunity to discuss various homeless issues. Each of these efforts and the Board's continued investment will ensure that the initiative to reduce homelessness throughout Los Angeles is successful.

We would like to acknowledge the time and effort of the following who have contributed to the HPI program data included in this report.

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Union Rescue Mission	Jessica Brown-Mason Carrie Gatlin Bert Paras
Volunteers of America of Los Angeles	Jim Howat Veronica Lara Alma Martinez
Women's and Children's Crisis Center	Judith Gordon Dolores Salomone

Pg. Strategy

Table of Homeless Prevention Initiative (HPI) Programs

	Program	Indicator (to date)	Target	Funding	Budget
	Families (I)				
3 ❶	1. Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	6,016 families received eviction prevention to prevent homelessness	2,079	One-Time	$500,000
❶	2. Moving Assistance for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families	3,354 families received moving assistance and permanent housing	1,305 450	One-Time	$1,300,000
❶	3. Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	211 families received rental subsidies to prevent homelessness	1,475	One-Time	$4,500,000
5 ❺	4. Housing Locators	573 families placed into permanent housing	n/a	*DPSS*	$1,930,000
6 ❻	5. Skid Row Families Demonstration Project	241 families placed into permanent housing	300	Board Approved	$9,212,000
	Transition Age Youth (II)				
9 ❶	6. Moving Assistance/Rental Subsidies for TAY – DCFS	431 TAY received rental subsidies	335 3yr	One-Time	$1,750,000
9 ❶	7. Moving Assistance/Rental Subsidies for TAY – Probation	358 TAY received rental subsidies	335 3yr	One-Time	$1,750,000
	Individuals (III)				
11 ❷	8. Access to Housing for Health (AHH)	62 clients placed into permanent housing 93% decrease in inpatient days; 83% in ER visits	115 cap	Board Approved	$3,000,000
13 ❻	9. Co-Occurring Disorders Court	47 individuals placed into transitional housing	n/a	Ongoing	$200,000
15 ❺	10. DPSS General Relief Housing Subsidy & Case Management Project	2,512 homeless GR participants received housing subsidies for housing placement	900 time	Ongoing	$4,052,000
16 ❷	11. DPSS-DHS Homeless Release Project	373 potentially homeless individuals received benefits	n/a	Ongoing	$588,000
16 ❷	12. DPSS-Sheriff's Homeless Release Project	2,635 potentially homeless individuals received benefits	n/a	Ongoing	$1,171,000
18 ❷	13. Homeless Recuperative Care Beds (DHS)	280 individuals were served through this program 73% decrease in hospitalizations; 32% in ER visits	490/2yr	One-Time	$2,489,000
20 ❺	14. Housing Specialists (most clients are individuals)	555 placed into permanent housing	n/a	*DMH MHSA*	$923,000
21 ❷	15. Just In-Reach Program	128 individuals received public benefits	Individuals 400/2 yr	One-Time	$1,500,000
23 ❹	16. Long Beach Services for Homeless Veterans (mostly individuals)	83 veterans received case management services	n/a	Ongoing	$500,000
26 ❻	17. Los Angeles County Homeless Court Program	1,122 individuals with citations or warrants dismissed	n/a	Ongoing	$379,000
28 ❶	18. Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program	190 single adults received moving assistance to prevent homelessness	until 2,000	One-Time	$1,100,000
29 ❻	19. Project 50	53 chronic homeless individuals placed into permanent housing	50	One-Time	$3,600,000
31 ❻	20. Santa Monica Homeless Community Court	118 individuals with citations or warrants dismissed	90	Board Approved	$540,000
33 ❻	21. Santa Monica Service Registry	68 chronic homeless individuals have participated	n/a	3rd District	$1,178,100
	Multiple Populations (IV)				
36 ❻	22. Los Angeles County Housing Resource Center	Over 3.2 million housing searches conducted	n/a	Ongoing	$202,000

Attachment B

Table of Homeless Prevention Initiative (HPI) Programs

	Program	Indicator (to date)	Target	Funding	Budget
37 ❸	23. Pre-Development Revolving Loan	$9.1 million requested to provide 266 housing units	n/a	One-Time	$20,000,000
38 ❺	24. Project Homeless Connect	8,848 participants were connected to services/benefits	n/a	One-Time	$45,000
39 ❸	25. **City and Community Program -CCP(V)**	$11.6 m capital, $20.6 m City Community Programs	Multiple	One-Time	$32,000,000
58 ❸	26a. **Gateway Cities Homeless Strategy -COGs (VI)**	Final report completed in March 2009	n/a	Ongoing	$135,000
58 ❹	26b. San Gabriel Valley Council of Governments	Final report completed in March 2009	n/a	Ongoing	$200,000
60 ❺	27. LAHSA contracted programs	7,396 placements into transitional housing	n/a	One-Time	$1,735,000
❺	28. PATH Achieve Glendale (families and individuals)	272 placements into housing	n/a	One-time	$150,000
60 ❺	29. Center for Community Health Downtown Los Angeles	Program launched on June 30, 2009	n/a	Ongoing	*$186,000
❺	30. SSI and Other Benefits Advocacy Program	Program to be launched during FY 2009-10	Individuals	One-Time	$2,000,000
	HPI Funding Total (excludes Board approved operational support (FY 2006-07), administrative and evaluation costs) *Ongoing costs expected to be $76,000				**$98,815,100**

39 ❸	City and Community Program (CCP) Funds	Service ($)	Capital ($)
	A Community of Friends – Permanent Supportive Housing Program	$1,800,000	
	Beyond Shelter Housing Dev. Corp. – Mason Court Apartments		$680,872
	Catalyst Foundation for AIDS Awareness and Care – Expansional Supportive Services Antelope Valley	1,800,000	
	Century Villages at Cabrillo, Inc. – Family Shelter EHAP I & II		1,900,000
	City of Pasadena – Nehemiah Court Apartments	102,685	858,587
	City of Pomona – Community Engagement & Regional Capacity Building	1,239,276	
	City of Pomona – Integrated Housing & Outreach Program	913,975	
	CLARE Foundation, Inc. – 844 Pico Blvd., Women's Recovery Center		2,050,000
	Cloudbreak Compton LLC – Compton Vets Services Center	322,493	1,381,086
	Homes for Life Foundation – HFL Vanowen	369,155	369,155
	Nat'l Mental Health Assoc. of Greater L.A. – Self Sufficiency Project for Homeless Adults and TAY Antelope Valley	900,000	
	Nat'l Mental Health Assoc. of Greater L.A. – Self Sufficiency Project for Homeless Adults and TAY Long Beach	1,340,047	
	Ocean Park Community Center (OPCC) – HEARTH	1,200,000	
	Skid Row Housing Trust – Skid Row Collaborative 2 (SRC2)	1,800,000	
	So. California Housing Development Corp. of L.A. – 105th and Normandie	200,000	600,000
	So. California Alcohol & Drug Programs, Inc. (SCADP) – Homeless Co-Occurring Disorders Program	1,679,472	
	Special Services for Groups (SSG) – SPA 6 Community Coordinated Homeless Services Program	1,800,000	
	The Salvation Army – Bell Shelter Step Up Program		500,000
	Union Rescue Mission – Hope Gardens Family Center	756,580 1,096,930	646,489
	Volunteers of America of Los Angeles – Strengthening Families	1,000,000	
	Women's and Children's Crisis Shelter	300,000	
	Total for Service and Capital	$18,620,613	$8,986,189
	Grand Total for CCP	**$27,606,802**	

For this report, unless specified: Fiscal Year (FY) refers to the four quarters in FY 2008-09 (July 1, 2009 - June 30, 2009). Cumulative refers to the number of clients served to date.

I. PROGRAMS FOR FAMILIES

1, 2, 3) DPSS Programs: Moving Assistance, Eviction Prevention, and Rental Subsidy

Goal: Assist families to move into and/or secure permanent housing.

Budget: (One-Time Funding)

1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	$500,000
2) Moving Assistance for CalWORKs Non- Welfare–to-Work and Non-CalWORKs Homeless Families	$1,300,000
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	$4,500,000

Table A.1: DPSS Services for Families by Program
FY 2008-09

Program (unduplicated count)	**FY**	**Cumulative**
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	3,608 received eviction prevention	6,016 received eviction prevention
2) Moving Assistance for CalWORKs Non- Welfare-to-Work and Non-CalWORKs Homeless Families	1,868 received moving assistance and permanent housing	3,354 received moving assistance and permanent housing
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	131 received rental subsidies for permanent housing	211 received rental subsidies for permanent housing

Table A.2: DPSS Measures by Program
FY 2008-09

Program (unduplicated count)	**Number of applications received**		**Percent of applications approved**		**Average amount of grant**	
	FY	**To date**	**FY**	**To date**	**FY**	**FY 07-08**
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	5,343	9,003	68%	67%	$649	$589
2) Moving Assistance for CalWORKs Non- Welfare–to-Work and Non-CalWORKs Homeless Families	2,631	4,922	71%	68%	$821	$629
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	137	215	96%	99%	$427	$150

Each program reported an average of three business days to approve an application.

FY 2008-09 January - June 2009 only	Moving Assistance	Rental Subsidy	Emergency Assistance
Homeless/At-Risk Families	765	58	1,707
Female	1,466	105	2,949
Male	911	91	2,323
Hispanic	862	85	3,166
African American	1,358	81	1,809
White	54	23	174
Asian/Pacific Islander	56	2	54
Native American	-	2	6
Other	47	3	63
15 and below	1,502	121	1,769
16-24	231	11	237
25-49	641	64	560
50+	3	-	4

1) Moving Assistance (MA) for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families

Successes: During this past quarter through the MA program, a total of 419 families received assistance to secure permanent housing. and/or received assistance for one or more of the following: a) utility turn-on fees; b) truck rental; c) purchase appliances (stove and/or refrigerator).

Challenges: Finding affordable housing is a significant challenge for Los Angeles County residents.

Action Plan: DPSS is in the process of finalizing an MOU with the Los Angeles County Housing Authority to set aside a total of 100 Section 8 vouchers for homeless families with a Domestic Violence issue. Additionally, through the same MOU, a percentage of Public Housing slots will become available to DPSS to make referrals.

Client Success Story: A homeless participant with two children applied for CalWORKs benefits. The participant was a victim of Domestic Violence (DV)and was seeking protection from an abusive husband. The family was placed in a DV Shelter by the Homeless Case Manager. The participant was able to receive DV and mental health services while at the shelter. Additionally, with tireless efforts of the participant and the case manager from DPSS, they were able to locate affordable housing. The participant received Moving Assistance funds to secure housing. The participant is very optimistic about the future of her family.

2) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families

Successes: This program has provided rental subsidy assistance to 58 families for this quarter.

Challenges: Due to budget constraints, this program was terminated for new program applicants effective February 28, 2009.

Action Plan: The action plan is to continue assisting families that were approved prior to the termination of this program (2/28/09).

Client Success Story: A CalWORKs family who became homeless due to a domestic violence situation accessed GAIN supportive services after resolving a CalWORKs program sanction with the assistance of the participant's HCM. The participant found permanent housing from a listing the HCM provided to her from the Socialserve.com/restricted area search. The participant qualified for Permanent Homeless Assistance, Moving Assistance and the 12 Month Rental Subsidy Program. Through the collaborative

efforts of the DPSS HCM, the Housing Resources Eligibility Unit, GAIN and LAHSA (shelter), this family was able to move from a DV shelter into permanent housing.

3) Emergency Assistance to Prevent Eviction (EAPE) for CalWORKs Non-Welfare-to-Work Homeless Families

Successes: Through the EAPE program, a total of 853 families at-risk of homelessness received assistance to maintain their current housing and/or maintain their utility services this quarter.

Challenges: Due to the high volume of applications for EAPE, funding is always a challenge.

Action Plan: Management is always trying to identify new funding opportunities to maintain the program or shift unused dollars from other programs to continue EAPE.

4) Housing Locators - DPSS

Goal: Assist families to locate and secure permanent housing.
Budget: $1.93 million (DPSS CalWORKs funding)

Table A.3: Housing Locators Measures
FY 2008-09, through December 31, 2008

(unduplicated count)	FY	Cumulative
Homeless Families	471	1,685
Housing (permanent)	210	573
Number of referrals to Program	471	1,685
Average time to place family (days)	60-180	60-180

Successes: Through the assistance of the Housing Locators, 210 families were placed into permanent housing during October-November 2008. No placements were made in December 2008.

Challenges: Due to budget constraints, the Housing Locators contract has been officially terminated effective December 15, 2008. Referrals to the Housing Locators program ended effective October 15, 2008.

Action Plan: The Housing Locator's program contract was terminated effective December 15, 2008.

5) Skid Row Families Demonstration Project

Goal: Locate 300 families outside of Skid Row and into permanent housing.
Budget: $9.212 million (Board Approved Funding)

Table A.4: Skid Row Families Demonstration Project Participants and Services
FY 2008-09

(unduplicated clients)	Cumulative (3/31/09)		FY 2008-09	FY 2007-08
Homeless Families (individuals)	300 / 1,084	Moving assistance	52	123
		Eviction prevention	40	-
Female	273	Housing (emergency/transitional)	31	278
Male	27	Housing (permanent)	*241	123
		Rental subsidy	19	14
Hispanic	68			
African American	187	Education	8	2
White	12	Job training/referrals	35	25
Asian/Pacific Islander	3	Job placement	8	6
Native American	-	Section 8	12	65
Other	30			
		Case management	263	254
15 and below	619	Life skills	440	254
16-24	80	Mental health/counseling	33	17
25-49	295	Transportation	224	410
50+	15	Food vouchers	190	390

Program Specific Measures	FY 2008-09	FY 2007-08
Number of families enrolled in project	300	300
Number of families relocated from Skid Row area within 24 hours	-	-
Number of families placed into short-term emergency housing	-	300
Number of adults who received referrals to community-based resources and services	386	420
Number of children who received intervention and services	679	850
Number of families who received monitoring/follow up after 6 months case management	353	64
Number of families no longer enrolled (termination or dropped out of program)	59	50
Number of families who received an eviction notice during the last 3 months	30	-
Number of families who lost their permanent housing during the last 3 months	6	-

Emergency Housing/Case Management	Fourth Quarter
Average length of stay in emergency housing:	46 days
Most frequent destination (permanent housing):	3 families
Case management (level 2)	
Average number of case management hours for each participant per month:	50 hours
Total case management hours for all participants during current reporting period:	1,170 hours
Number of cases per manager:	13 cases

Longer-term Outcomes	6 mo	12 mo
Continuing to live in housing	44	188

*A total of 241 families have received permanent housing since the beginning of the program.

Additional measures to be provided after close of program:

- Gainful employment - (Number of individuals who obtained employment)
- Access to appropriate and necessary mental health or substance abuse treatment - (Number of individuals who received mental health services, Number of individuals who received substance abuse treatment)
- Educational stability for children - (Number of children)
- Socialization/recreational stability for children - (Number of children)
- Services to assist domestic violence victims - (Number who received domestic violence services/counseling)

Successes: The Skid Row Families Demonstration Project (SRFDP) has had positive outcomes for participant families who moved to permanent housing. With the exception of 58 families who were terminated from the program due to loss of contact or non-compliance, Beyond Shelter has placed 241 of 300 participant families into permanent housing. Of the 241 families who moved to permanent housing, only four have been evicted and have returned to homelessness. As of June 30, 2009, 188 families have successfully completed 12 months in permanent housing (62 families during the fourth quarter), 44 have completed 7 to 12 months, and 5 are in their first six months of permanent housing.

With all participating families moved to permanent housing, the entire focus of the case managers shifted to assisting families with stabilizing in their new homes. The primary goal was linking them to community services, teaching life skills, budgeting, managing stress, and navigating through the public social service systems. Beyond Shelter case managers provided six months of home-based case management to 229 families who moved to permanent housing; the remaining families are continuing to receive six months of home-based case management. Only 12 families' cases were closed prior to their completion of six months in permanent housing. In 11 of these cases, the family requested termination of case management for various reasons, and in one case the family was evicted and moved out of the County. Most families welcomed the support of their Beyond Shelter case manager and were open to being assisted by them. During this quarter, there was a lower incidence of crisis intervention required for families in permanent housing. This can be directly attributed to the decreased number of high intensity needs families and the lower number of families on each caseload, allowing case managers to provide more intensive and individualized support to help families move to improved housing stabilization.

Challenges: Limited resources and the struggling economy had a negative impact on clients this year. Most of the families enrolled in the SRFDP receive CalWORKs public assistance. Beginning in June, the overall CalWORKs program was revised and the benefits were decreased by 6% for all recipients. Additionally, community resources, such as food banks, which previously provided a safety net for families in need, are now being accessed by a greater number of people in local communities. Generally, resources available in the community have decreased, while the demand for resources has increased dramatically. Employment opportunities have also decreased, with current statewide unemployment rates very high. With limited incomes, and sparse employment opportunities, participants in the SRFDP are experiencing a new level of stress based on these uncontrollable external factors. Approximately 5% of the 241 families in permanent housing were faced with property owners going into foreclosure, requiring proactive intervention to ensure their rights, including remaining in the foreclosed properties but making rent payments to banks. Often it was unclear where to send rent payments and who to contact for property repairs. Not only did these factors create additional stress and anxiety for families, but they also posed new challenges for the case managers.

Action plan: Beyond Shelter case managers are working closely with families to develop Family Action Plans that help them maintain their monthly goals and to identify their priorities. The plans include money management, budgeting, shopping wisely, and utilizing all available resources. Clients who have not been successful finding employment are encouraged to continue participation in GAIN through DPSS, and to obtain any and all education and training available to them. Case managers focus on stress management techniques to help alleviate the anxiety which may result in negatively impacting their stability in permanent housing. In the foreclosure cases, case manager's have assisted clients by advocating for them, ensuring they send their rent payments to the appropriate recipient, and helping clarify their rights and responsibilities as they relate to Section 8 guidelines.

Client Success Story: Client S is a 23-year-old African American single mother with three children, four-year-old twin boys and a three-year-old daughter. Prior to becoming homeless, she and her twin boys, and their father were living with an aunt. A month before her daughter was born, the children's father became incarcerated. Shortly after, the client's aunt raised her portion of rent and she was not able to afford it, forcing the family to move out. Client S was unable to afford to live on her own. She stayed with relatives and friends for two months until she went to the Midnight Mission on Skid Row.

The Skid Row Assessment Team referred the client to the Skid Row Families Demonstration Project and the family was enrolled in May 2007. Once referred to the SRFDP, she and her children were immediately

removed from the Skid Row area and placed in a motel. She was assisted through the Section 8 application process and received tenant education. Throughout this episode of homelessness, the client managed to continue her education at Everest College to earn a certificate in Medical Billing while her children attended daycare. At intake, the client's service needs intensity was assessed as high due to a variety of components including her age and the age of her children, her history of evictions, and her limited education. Prior to moving to permanent housing, her service needs intensity was re-assessed to low because she was attending school and had been quite responsible and diligent in the care of her children and her efforts to obtain permanent housing. She was assigned a Housing Relocation Specialist who assisted her with moving to a large three-bedroom unit in Los Angeles in February 2008.

The family was happy with their permanent housing but a water leak caused irreparable plumbing damage, which required them to move again. With the support of her Beyond Shelter case manager, the client successfully moved to another permanent housing location where she had saved enough money to pay the move-in fees. Beyond Shelter provided her with home furnishings including beds, a sofa, and a dining table. Her new home is on a quiet residential street in Los Angeles, a single family residence with sufficient space for her children. She finally felt comfortable at home. She stated that she had learned the techniques to be successful through discussions with her case manager about topics presented in the *Successful Household Money Management* booklet and *Family Survival Guide*.

Once stabilized in permanent housing, Client S became aware that her two twin boys' verbal skills were developmentally delayed. The case manager referred her to a speech therapist near the home where she took her children for evaluations. The children's school was not providing the necessary resources to address their needs. She took the initiative to enroll them in a LAUSD school where they were assessed and provided with necessary resources as well as an Individualized Education Plan (IEP).

Client S has been working diligently to rebuild her life for herself and her three children. She graduated from Everest College and is currently working in the healthcare field in medical billing. The client is interested in going back to school and obtaining her bachelor's degree in criminal justice. She has utilized the assistance provided by Beyond Shelter to its full potential and has exceeded program expectations. She has now completed more than 12 months in permanent housing. Prior to closure of her case, she had demonstrated remarkable changes in her mood, self esteem and personal goals throughout the stabilization process.

II. PROGRAMS FOR TRANSITION AGE YOUTH

6 and 7) Moving Assistance for Transition Age Youth

Goal: Assist Transition Age Youth (TAY) to move into and secure permanent housing.
Budget: $3.5 million (One-Time Funding)

Table B.1: Moving Assistance for Transition Age Youth Participants
FY 2008-09

	Total	Probation		DCFS	
	FY	FY	Cumulative	FY	Cumulative
Transition Age Youth	515 (100%)	*155 (new)	358	360 (all)	**434
Female	271 (64%)	61	150	252	-
Male	151 (36%)	94	208	108	-
Hispanic	112 (27%)	47	94	87	-
African American	284 (67%)	101	248	245	-
White	17 (4%)	2	10	22	-
Asian/Pacific Islander	8 (2%)	5	6	5	-
Native American/Other	-	-	-	-	-
16-24	422 (100%)	155	358	360	-

*During the First Quarter of FY 2008-09, 68 new TAY were enrolled;
**FY 2007-08 DCFS demographic participant data was duplicative.

Table B.2: Moving Assistance for Transition Age Youth Services
FY 2008-09

(unduplicated count)	Total	Probation		DCFS	
	FY	FY	Cumulative	FY	Cumulative
Moving assistance	238	132	253	149	204
Rental subsidy	451	189	358	352	431
Housing (permanent)	210	152	311	101	234
Eviction prevention				1	1
Any supportive service+	67	48	101	19	64
Education	57	9	-	48	58
Job training, referrals	39	-	-	31	35
Job placement	39	39	81	-	-
Case management	516	249	358	360	434
Life skills	8	-	-	8	8
Mental health	1	-	-	1	1
Transportation	77	-	-	90	107
Food vouchers	29	-	-	43	43
Clothing	58			72	72
Auto insurance	10	-	-	11	11

+Probation does not break down supportive service by type, except for job placement.

Table B.3: Longer-term Outcomes for Transition Age Youth
(6 or more months), FY 2008-09, Fourth Quarter

	Probation	DCFS
Continuing to live in housing	84	88
Continuing to receive rental subsidy	-	5
Obtained employment	79	30
Maintained employment	-	60
Enrolled in educational program/school	-	49
Received high school diploma/GED	-	-

DCFS data is from the Second Quarter.

Table B.4: Program Specific Measures for Transition Age Youth
FY 2008-09, Number of approvals through June 30, 2009; other measures through December 2008

	Probation		DCFS	
	YTD	Cumulative	YTD	Cumulative
Number of new approvals	155	437	230	310
Average cost per youth	$4,082	*$3,815	$1,913	*$2,663
Number of program participants satisfied with program services	129 (of 131)	216 (of 218)	66	135
Number of pregnant/parenting youth placed in permanent housing	37	90	10	71
Number exited housing	21	48	148	324
Number remaining in permanent housing and receiving assistance at 6 months	n/a	n/a	41	78

*FY 2007-08 average cost per youth.

Probation– Moving Assistance for TAY

Successes: Of the 215 youth served by one of our two caseworkers, 144 remain in housing. Fifty-four youth left with a plan for continued permanent housing, and only 17 left with no plan (eight percent). ***Therefore, 92 percent of these youth maintained permanent housing.*** Only 8 of the these 215 youth (four percent) re-offended while housed.

Challenges: Probation's HPI money will be exhausted by the end of July 2009. The program first started spending money in May 2007, and will run for three years. For the remaining months, current clients will be monitored. No new client will be served unless additional funding is allocated.

Action Plan: Continue to monitor current clients and request additional funding to provide services to additional youth.

Client Success Story: Father Gregory J. Boyle, S.J., Executive Director of Homeboy Industries writes, "... As some young people are released from incarceration and have no family to live with; or others are ready to move out on their own and get their first apartment, the kind of support they have received from the Transition to Permanency Project has been invaluable. The Program has provided the first and last month's rent and has acquired basic furnishings, such as stove, refrigerator, bed, etc. The young clients are checked on regularly throughout the first year and are offered support as they need it."

DCFS – Moving Assistance for TAY

Successes: The program continues to have success. During this quarter, 268 youth were contacted and 46 were new approvals. The program provided move-in assistance to 43 youth. The average spending was $61,000 per month. An average of an hour of level 1 case management was provided to participants (a total of 26 hours was provided during the fourth quarter).

Challenges: Maintaining contact with the youth continues to be a monumental challenge. During the course of this quarter, it also became obvious that youth are very challenged with budgeting and understanding the debt ratio v/s earned income. Their wants and desires far exceed their ability to afford, based on their salaries.

Action Plan: Continue to stress to the youth the importance of maintaining contact with the program. Discuss in the initial interviews debts versus income and the necessity of budgeting to enable youth to pay their bills.

Client Success Story: A 23-year-old former foster youth residing in an apartment received rental assistance that enabled the youth to stabilize his living situation as he worked to create his own Oatmeal Cupcake Business that shows lucrative potential. This youth serves as a mentor to other foster youth and has plans to create employment opportunities for both current and former foster youth.

III. PROGRAMS FOR INDIVIDUALS

8) Access to Housing for Health (AHH)

Goal: To provide clients discharged from hospitals with case management, housing location and supportive services while permanent housing applications are processed.
Budget: $3 million (Board Approved Funding)

Table C.1 : Access to Housing for Health Participants and Services
FY 2008-09

(unduplicated count)	FY	Cumulative
Homeless Individuals	10	14
Chronic Homeless	31	89
Homeless Families	-	4
Female	18	44
Male	22	70
Transgender	1	1
Hispanic	7	27
African American	16	49
White	18	37
Asian/Pacific Islander	-	1
Native American	-	-
Other	-	1
15 and below	-	7
25-49	15	42
50+	26	66
Moving assistance	15	53
Housing (emergency/transitional)	41	107
Housing (permanent)	23	62
Rental subsidy	23	62

	FY	Cumulative
Education	-	2
Job training	-	1
Job placement	-	2
General Relief	14	61
Food Stamps only	-	1
Medi-Cal/Medicare	5	34
Section 8	17	48
Public Housing Certificate	6	14
SSI/SSDI	6	29
	FY	**Cumulative**
Case management	41	107
Health care	41	107
Life skills	41	107
Mental health/counseling	13	28
Substance abuse (outpatient)	5	16
Transportation	31	97

Program Specific Measures	FY	Cumulative
Number of referrals	250	603
Number admitted to program (enrolled)	41	107
Pending applications	2	n/a
Number that did not meet eligibility criteria	200	494
Number of exited clients	9	29
Reduction in Emergency Department visits (12 months post enrollment, n=41)	-	83%
Reduction in number of inpatient days (12 months post enrollment, n=41)	-	93%
Number of new AHH enrollees that have a primary healthcare provider	41	107

Transitional Housing/Case Management	
Average stay at emergency/transitional housing:	142 days, 62 into permanent housing
Level 3 Assisted/Supported Referral and Counseling case management services	
Average case management hours for each participant per month:	14 hours
Total case management hours for all participants during current reporting period:	645 hours
Number of cases per case manager:	10 cases

Successes: To date, 45 AHH clients have reached their one-year mark in the program. They had a combined total of 197 Emergency Department visits during the 12 months prior to AHH enrollment. Post enrollment, the clients only had a combined total of 34 Emergency Department (Emergency Room) visits. **The number of Emergency Department visits were reduced by 83%.**

Table C.2: Longer-term Outcomes FY 2008-09, Fourth Quarter	**6 mo.**	**12 mo.**
Continuing to live in housing	11/11	36/38
Receiving rental subsidy	100%	95%
Case management	7	4
Health care	7	4
Mental health care	4	2
Substance abuse treatment (outpatient)	1	1
Reunited with family	4	1

The 45 AHH clients also had a combined total of 394 inpatient days prior to AHH enrollment. These same clients only had 28 inpatient days post AHH enrollment. **The number of inpatient days was reduced by 93%.**

Challenges: There continues to be challenges in obtaining appropriate referrals for clients that would be suitable for the AHH program. Many of the referred clients do not possess the skills for independent living or require a higher level of care. Many clients present with severe physical and psychiatric conditions and are unwilling to access treatment or comply with medications.

Action Plan: The AHH Project Coordinator continues to receive many referrals and these are being processed in a timely manner. The AHH staff are actively processing referrals in a timely manner to ensure this process is efficient. The AHH staff are currently fully staffed with the addition of two case managers and a Housing Locator. The Housing Locator has assisted in ensuring the housing application, location and move in process are meeting the client's needs and occurring in a timely manner. The AHH staff continues to promote the program with current referral sources and the development of new sources. The staff plans to continue to reconnect with referral sources on a regular basis.

Client Success Stories: Mr. M is a 45-year-old Caucasian male and was homeless for over a year. Mr. M is divorced and has four children: two adult children and two daughters (ages 11 and 12 who live with his mother in Palmdale). Mr. M was injured in a motor vehicle accident in 2005 and has since been unable to resume work as a truck driver manager and instructor. Mr. M was living in a motor home on his mother's property; however, following family breakdown the client became homeless. Mr. M lived in a shed with no electricity or running water for many months. Mr. M obtained medical care from High Desert Multi-Ambulatory Care Center (MACC) to treat his multiple medical conditions, i.e., Type II Diabetes, Obesity, Hypertension, Depression, Asthma, Metal Pins in his Right Leg, and a Large Ventral Hernia. Mr. M attended a weekly Health Education Group through the Healthy Way LA program at the High Desert MACC and was referred by a social worker to AHH. Mr. M enrolled in the AHH program on March 4th, 2009. Mr. M was determined to live in the Antelope Valley, so that he could be reunited with his daughters. He was approved for a Section 8 voucher through the County of Los Angeles and moved into a large four bedroom, three bathroom home with a yard last May. By enrolling in the AHH program, Mr. M has been able to address both his physical conditions and his depression by receiving on-going treatment at the High Desert MACC, the Department of Mental Health, and case management through Homeless Healthcare Los Angeles. The client has been successful in his housing for nearly two months. Mr. M now has a stable living environment to improve his medical and mental health conditions as well as improve his relationship with his daughters. Mr. M has demonstrated an improvement in his self esteem and his ability to advocate for himself to ensure his health and housing remain stable.

9) Co-Occurring Disorders Court

Goal: Assist dually diagnosed adult defendants in receiving comprehensive community-based mental health and substance abuse treatment.
Budget: $200,000 (HPI On-going Funding; pass through for DMH)

Table C.3: Co-Occurring Disorders Court Participants and Services
FY 2008-09

(unduplicated count)	FY	Cumulative		FY	Cumulative
Chronic Homeless	31	66	Education	5	15
Homeless Individuals	5	5	Job training/referrals	18	27
Transition Age Youth	1	1	Job placement	-	1
Female	25	42	CalWORKs	-	1
Male	12	30	General Relief (GR,FS)	11	14
			Food Stamps only	2	3
Hispanic	4	8	Medi-Cal/Medicare	9	32
African American	27	57	SSI/SSDI	5	30
White	4	5	Shelter Plus Care	5	5
Other	2	2			
			Alternative court	36	45
16-24		3	Case management	36	45
25-49		42	Health care/medical	19	23
50+		28	Life skills	33	41
			Mental health/counseling	36	45
Eviction prevention	2	2	Social/community activity	15	20
Housing (emergency)	4	8	Substance abuse (outpatient)	54	63
Housing (transitional)	27	47	Substance abuse (residential)	15	18
Housing (permanent)	2	2	Transportation	36	45
Rental subsidy	26	33	Clothing/hygiene	33	42
Moving assistance	2	2			

Longer-term Outcomes (six or more months)	
Receiving rental subsidy	5
Enrolled in educational program, school	5
Case management	13
Health care	13
Good or improved physical health	13
Mental health/counseling	11
Good or improved mental health	11
Substance abuse treatment (outpatient)	7
Substance abuse treatment (residential)	4
No drug use	8

Emergency Housing/Case Management	
Average level III case management hours for each participant per month:	8 hours
Total case management hours for all participants during current reporting period:	1,090 hours
Number of cases per case manager:	5 cases

Successes: The third cohort of clients has now graduated from the 18-month court-supervised CODC treatment program, bringing the overall total of graduates to eleven. Three clients are expected to graduate in August 2009. Clients graduating have successfully met their treatment goals and are subsequently transitioned into lower levels of care. Many of the graduates have chosen to continue their affiliation with Special Services for Groups (SSG) Central Mental Health for ongoing social support and resources. CODC graduates even return to court to celebrate the accomplishments and graduation of their peers. Two of the clients have become full time volunteers at SSG and provide valuable mentorship for new program participants. A new Employment Specialist will be starting with SSG in August 2009. The Employment Specialist will participate in designing and implementing a Peer Leadership & Consumer Employment Program for the graduates. The addition of this Employment Specialist will enable SSG to increase its provision of support services, linkages, and employment resources for clients re-integrating into the community and re-entering the workforce. The SAMHSA-funded CODC residential treatment program at Antelope Valley Rehabilitation Center (AVRC) began accepting CODC clients in April 2009. This component of the program offers integrated mental health treatment and drug rehabilitation at the

AVRC residential treatment facility in Acton. It also expands the continuum of integrated treatment for CODC clients who suffer from severe and persistent mental illness, serious substance abuse disorders, and chronic homelessness. Clients participate daily in both psychotherapy and chemical dependency counseling. They also receive psychopharmacological interventions, intensive case management, and continued supervision by the COD Court. AVRC recently graduated their first three CODC clients. Currently, ten CODC clients receiving residential COD services at AVRC are responding well to the treatment milieu and rehabilitation services, and the increased structure and supervision offered by this program. In addition, SSG continues to expand its evidenced-based programming. SSG recently introduced a Women's Trauma Group and a Men's Trauma Group to the clients who attend group therapy at the SSG Central clinic. The response to these new therapeutic interventions has been positive.

Table C.4: Program Specific Measures	FY	Cumulative
Number of clients screened for enrollment	129	409
Number of clients accepted for observation	27	78
Total number of clients enrolled	28	66
Number of clients pending enrollment	2	15
Number of clients not meeting Program criteria	55	190
Number of clients rejecting/dropping out prior to enrollment	26	98
Number of clients lost during follow-up process	3	6
Number of participants in ER/crisis stabilization while enrolled in program	17	21
Average length of hospital stay (days)	10	14
Number of participants who have a primary healthcare provider while enrolled	22	53
Number of participants with new arrest(s)	18	21
Misdemeanor:	1	3
Felony:	17	14
Number of participants in jail	21	22
Average number of days in jail	25	(FY 07-08) 36

Challenges: Without its own housing, SSG relies on sober living home providers. The housing managers at these homes have been moderately receptive to the trainings offered by SSG. However, continuing education needs to be provided to the housing providers to optimize care and supervision for the residents. Additionally, the sober living housing programs available in Los Angeles are typically located in areas where drugs are readily available, thereby presenting a formidable challenge to the clients and their efforts to maintain sobriety. Due to the impending curtailment of funding for the Proposition 36 courts, identification of prospective CODC candidates has been impacted. Department of Mental Health is working closely with the Public Defender to overcome this obstacle, promote visibility for the program, and generate new referral sources.

Action Plan: Energy continues to be focused on grant writing to access new funds for enhancing and expanding the program. The SSG development team is working closely with the Countywide Criminal Justice Coordination Committee (CCJCC) to explore various grant opportunities to increase its capacity to serve additional clients and enhance services. Efforts will be made by all partners to create an effective system for outreaching to the courts in order to ensure positive enrollment numbers for the program.

Client Success Story: Mr. R is a 55-year-old Hispanic male with an extensive history of substance abuse and mental illness. Upon entering the program, Mr. R presented with extreme hopelessness and debilitating depression. His chronic abuse of drugs and neglected mental illness contributed to his inability to hold a job or secure housing. His own family ostracized him due to his inability to control his behaviors, mood swings, and continued substance abuse. Mr. R initially struggled with adjusting to the parameters of the CODC program and treatment regimen. He ended up leaving the program on multiple occasions and was even re-incarcerated for several weeks. But Mr. R's case manager did not give up on him. Eventually, due in large part to the intensive coordination of services orchestrated by Mr. R's case manager along with his family members, jail and court staff, and the mental health and substance abuse treatment providers, Mr. R finally realized that treatment was a better alternative to incarceration and living on the streets. He allowed himself to accept help and develop trust. Today, Mr. R. has been sober for almost a year and is learning to effectively manage his mental illness. Mr. R took steps to reunify with his family, and he now shares a residence with his sister. Mr. R is grateful for the assistance he received from a program that did not "give up" on him and continues to support him on his journey to recovery.

10) DPSS General Relief (GR) Housing (Rental) Subsidy and Case Management Project

Goal: To assist the homeless GR population with a rental subsidy. In addition, coordinate access to supportive services and increase employment and benefits to reduce homelessness.

Budget: $4.052 million (HPI On-going Funding)

Table C.5: DPSS GR Housing Subsidy and Case Management Project Measures
FY 2008-09

	FY
Chronic Homeless	425
Homeless Individuals	1,088
Female	586
Male	927
Hispanic	212
African American	983
White	257
Asian/Pacific Islander	36
Native American	15
Other	10
16-24	158
25-49	1,043
50+	312

	Cumulative
Rental (housing) subsidy*	2,512
Moving assistance	1,652

	Cumulative
Education	21
Job training/referrals	577
Job placement	183
SSI/SSDI	106
Section 8	3
Veteran's	1
Case management	2,512
Health care	585
Life skills	266
Mental health/counseling	502
Substance abuse (resident)	20
Substance abuse (outpatient)	106
Transportation	558
Recuperative care	3
Social/community event	1

Longer-term Outcomes	6 mo.	12 mo.	18 mo.
Receiving rental subsidy	545	188	164
Obtained employment	38	1	-
Maintained employment	5	-	-
Enrolled in educational program, school	3	-	-
Case management	545	188	164
Health care	41	14	26
Good or improved physical health	-	-	-
Mental health/counseling	30	13	14
Recuperative care	-	1	-
Substance abuse treatment (outpatient)	3	-	-

**Total number served from July 2006- June 2009*

Table C.5: DPSS GR Housing Subsidy and Case Management Project Measures
FY 2008-09, Fourth Quarter

	Fourth Quarter	To date
Number of applications received	217	1,451
Average number of business days to approve	19	19
Average amount of rental subsidy	$292	$291
Number of individuals re-entering program	20	93
Number of SSI approvals	15	94
Percent of SSI approvals	(15/315) 4.76%	7.94%
Number of individuals disengaged from program	77	490

Level 3 Case Management (assessment)	
Average case management hours for each participant per month:	5 hours
Total case management hours for all participants during current reporting period:	3,910 hours
Number of cases per case manager:	86 cases

Successes: During this quarter, there were 38 job placements, 15 SSI approvals, and project district offices reported 893 active subsidies for the quarter. An evaluation study of the pilot's outcomes showed that the average length of stay for participants in the pilot program was about seven months. Compared

to a control group, employable participants enrolled in the pilot project were two times more likely to find jobs.[1]

Challenges: It has been difficult to contact homeless participants on the waiting list.

Action Plan: We make every effort to ensure participants provide current and accurate contact information and update the waiting list on a monthly basis.

Client Success Stories:
Success Story #1 - Mr. P had conflicts with this landlord; however, with the early intervention of the Housing Case Manager, the issues were resolved. The HCM encouraged Mr. P to follow-up with medical and SSA appointments. His placement in the housing subsidy afforded him the opportunity to receive and respond to correspondences promptly. Mr. P was approved for SSI this quarter and is very grateful for all the assistance he received from DPSS.

Success Story #2 - Ms. C, a homeless 54-year-old GR participant, was accepted to the GR Housing Subsidy Program last December. Ms. C was very active and enthusiastic in her GROW activities, including her job search. Ms. C was hired full-time by Design for Living Company during this quarter.

[1] Moreno MH, Toros H, and Stevens M. *The General Relief Housing Subsidy and Case Management Pilot Project: An Evaluation of Participant Outcomes and Cost Savings*. County of Los Angeles, Chief Executive Office, Service Integration Branch. September 2009.

11 and 12) Homeless Release Projects (DPSS-DHS and DPSS-Sheriff)

Goal: Identify individuals scheduled for release who are eligible for DPSS administered benefits.
Budget: DPSS-DHS: $588,000; DPSS-Sheriff: $1.171 million (On-going Funding)

Table C.6 Homeless Release	**FY Total**	**DPSS-DHS**		**DPSS-Sheriff**	
(unduplicated count) FY 2008-09		**FY**	**Cumulative**	**FY**	**Cumulative**
Homeless Individuals	1,999	414	828	1,585	4,631
Female	806	89	*n/a	717	*n/a
Male	979	325		654	
Transgender	5	-		5	
Hispanic	666	123		543	
African American	876	164		712	
White	423	107		316	
Asian/PI	13	8		5	
Native American	5	2		3	
Other	32	10		22	
16-24	296	18		278	
25-49	1,132	220		912	
50+	356	176		180	
Housing (emergency)	262 (cumulative)	75	75	86	187
Average stay (days)	13	12	-	13	-
CalWORKs (approvals)	51	-	1	25	50
General Relief (w/FS)	2,492	114	290	909	2,202
General Relief only	380	23	77	142	303
Food Stamps only	54	2	5	27	49
SSI/SSDI	25	-	-	25	25
Veterans' benefits	6	-	-	6	6

*Information not available for FY 2007-08.

Table C.7 Program Measures	Cumulative Total	DPSS-DHS		DPSS-Sheriff	
		FY	Cumulative	FY	Cumulative
Total referrals received	8,688	398	812	2,473	7,876
Total referrals accepted	5,625 (65%)	138	424	1,738	5,201
Of the total referrals accepted:					
Total approved	1,079 (FY)	133	*133	1,254	2,646
Total denied	226 (FY)	186	*186	47	133
Total pending release:	1,365 (QTR)	-	*-	1,365	-
Releases/discharges	372	94	239	133	133
Number of applications					
Food Stamps	38	-	1	15	49
General Relief	2,214	137	375	961	2,356
CalWORKs	45	-	1	25	44

Demographic information not provided for all participants

DPSS-DHS Homeless Release Project

Successes: During the last quarter of FY 2008-09 (April - June 2009), the DPSS/DHS Homeless Release Project received and approved the highest number of referrals for the fiscal year.

Challenges: Patients are discharged on weekends, which makes it difficult to connect homeless individuals to this program.

Action Plan: DPSS staff met with private hospital staff to discuss ways to increase the number of referrals. The Department has agreed to retrain private hospital staff on the program referral procedures and other DPSS administered programs.

DPSS-Sheriff Homeless Release Project

Successes: At LASD's request, DPSS agreed that the Eligibility Worker interview area be moved from the attorney's interview area to the Inmate Reception Center (IRC). This has resulted in an increased number of released inmates receiving benefits from the DPSS cashier at the County Men's Central Jail (MCJ).

Challenges: The number of referrals pending at the end of the month, as shown in the monthly reports, continues to increase. When released, many inmates are no-shows at the DPSS district offices to receive same day benefits. Some are applying for benefits at other district offices upon their release, but not as part of the homeless release project.

Action Plan: Civic Center/MCJ and South Central/Century Regional Detention Facility (CRDF) will receive a reminder to inform inmates at the interview that same day benefits are available for a period of 60 days after release. MCJ inmates may obtain same day benefits at all other district offices, when they provide the Homeless Release Referral form and/or inform the District that they are part of the DPSS/Sheriff Homeless Release Project. Inmates released from CRDF must show at South Central District office to obtain same day benefits.

13) Homeless Recuperative Care Beds

Goal: Provide recuperative care services to homeless individuals being discharged from area hospitals and assist participants with accessing transitional or permanent housing, ongoing health care, and other resources and supportive services.

Budget: $2.489 million (One-Time Funding)

Table C.8 : Homeless Recuperative Care Beds Participants and Services
FY 2008-09

(unduplicated count)	Qtr	Cumulative		Qtr	Cumulative
Homeless Individuals	72	280	Housing (permanent)	6	*32
			Housing (transitional)	13	*32
Female	14	43	Housing (emergency)	10	*31
Male	57	235			
Transgender	-	2	General Relief only*		11
			Medi-Cal/Medicare*		7
Hispanic	25	46	SSI/SSDI*		7
African American	27	68			
White	19	50	Case management	72	280
Asian/Pacific Islander	-	2	Health care	72	280
Other	1	17	Life skills*		12
(race doesn't include two quarters; updating)			Mental health/counseling		1
16-24	3	4	Recuperative care	72	280
25-49	30	173	Transportation*		70
50+	35	175	Substance abuse (outpatient)*		2

	Quarter	Cumulative
Number of patients referred for recuperative care beds	85	356
Number of patients admitted to recuperative care services	72	280
Number of patients who were discharged from recuperative care services	83	249
Number of patients who were assigned to a primary health care provider during recuperative care stay	72	280
Average length of stay for patients in recuperative care program (days)	18	31
Percent decrease in ER visits 6 months after receiving recuperative care	-	32%
Percent decrease in inpatient admissions 6 months after receiving recuperative care	-	73%

Emergency Housing/Case Management	
Average stay at emergency/transitional housing:	31 days
Level 3 Assisted/Supported Referral and Counseling case management services	
Average case management hours for each participant per month:	6 hours
Total case management hours for all participants during current reporting period:	480 hours
Number of cases per case manager:	25 cases

* Specific discharge and service data through December 2008 only; program staff is updating.

Successes: The Recuperative Care program **served 280 unduplicated individuals** to date, from April 2008 to June 2009. At the end of this quarter, a six-month pre- and post- analysis was conducted on the participants served who received recuperative care services at least six months prior to the analysis. For these recuperative care participants, a pre-/post- comparison showed a **32% reduction in ER visits and a 73% reduction in inpatient hospitalizations.** In addition, there was a **43% decrease in the number of participants who utilized the ER and a 73% decrease in the number of participants who required hospitalization**.

Challenges: The most significant challenge continues to be the lack of available and appropriate housing after discharge from recuperative care. In addition, a few recuperative care participants leave the facility and do not return.

Action Plan: Increased efforts to link recuperative care services with permanent housing opportunities are continuing. Eligible participants who are frequent users of DHS inpatient and/or ER services can be referred into to the Access to Housing for Healthcare program. The newly hired recuperative care director at JWCH is now overseeing program activities and is working on addressing the identified challenges. DHS staff provided technical assistance to the program director and the recuperative care clinical team members and will continue to provide assistance as needed. DHS will continue to meet with JWCH management staff to discuss program status and progress. DHS also will continue to work with the program director to improve data collection and reporting activities.

Client Success Story: Mr. G is a 49-year-old Hispanic male who was hospitalized at a County facility for acute respiratory failure due to a neurological disorder. He was referred to the JWCH Recuperative Care program by a hospital social worker and admitted into the program in May 2009.

Mr. G was homeless for one year prior to his hospitalization. Prior to becoming homeless, he was renting a room from a friend. When his friend was no longer able to pay the mortgage, Mr. G was suddenly faced with being homeless. Mr. G. began to live in his truck at that time and eventually lost his job, although he continued to seek small jobs whenever possible.

When admitted into the Recuperative Care program, Mr. G had no source of income and no medical insurance. A recuperative care case manager assisted Mr. G with successfully accessing General Relief (GR) benefits and completing applications for transitional/permanent housing and other benefits and resources. Mr. G learned to effectively manage living on very limited funds and participated in the program's budget management services. He was able to save enough money to purchase personal necessities and a cell phone to assist him in following up with appointments and searching for employment.

When first discharged from the hospital, Mr. G had much difficulty walking and required time to adjust to his medical condition and to work on increasing his physical strength and mobility. The recuperative care clinical team continued to provide medical oversight and monitoring of the client's progress. In June 2009, one month after his admission to the recuperative care program, Mr. G was accepted into the Salvation Army's two-year transitional housing program in Bell.

Mr. G continues to deal with physical disabilities and generalized body weakness, but he is now able to walk without assistance. He informed the program staff that he continues to work out daily at the gym, located on-site at the Salvation Army facility, to build up his strength and reported that he is feeling much better. The client has recently requested follow-up assistance from the recuperative care case manager to access mental health services. He has been referred to outpatient services through the Department of Mental Health (DMH). Mr. G is currently seeking employment as a personal or small truck driver. He is planning to eventually travel to Washington D.C. and reunite with his sister.

14) Housing Specialists - DMH

Goal: Assist homeless individuals, families, and TAY to obtain and maintain permanent housing.
Budget: $923,000 (annually in MHSA funding)

Table C.9: Housing Specialists Program Specific Measures
FY 2008-09

(duplicated count)	FY 2008-09	FY 2007-08
Number of referrals to program	842	n/a
Number of property owners contacted	360 (QTR)	898

Successes: The Department of Mental Health (DMH) sustained additional funding to supplement the Move-in Assistance component of the Countywide Housing Assistance Program for FY 2008-09 through the Mental Health Services Act. The Move-in Assistance component provides financial assistance to homeless individuals with a mental illness moving into permanent affordable housing. This program, funded through the Projects for Assistance in Transition from Homelessness (PATH) grant, received a significant reduction in funding for FY 2008-09. By identifying other funding streams, DMH was not forced to reduce the number of individuals and/or families served through these programs.

Table C.10: Participants and Services
FY 2008-09 and FY 2007-08

	FY 2008-09	FY 2007-08
Chronic homeless individuals	79	-
Homeless individuals	804	2,343
Homeless families	58	255
Transition age youth	12	142
Demographics not provided for all participants in families		
Female	520	*n/a
Male	429	
Transgender	8	
Hispanic	321	
African American	316	
White	223	
Asian/Pacific Islander	25	
Native American	3	
Other	45	
16-24	6	
25-49	896	
50+	18	
	FY 2008-09	**Cumulative**
Moving assistance	94	142
Eviction prevention	5	10
Housing (emergency)	498	1,305
Housing (transitional)	264	567
Housing (permanent)	238	555
Rental subsidy	111	215
Section 8	191	*191
Mental health	458	*458

*Information not available for FY 2007-08.

Challenges: The DMH is continuously challenged with identifying affordable permanent housing. The Department has grants from the Housing Authority of the City of Los Angeles (HACLA) and the Housing Authority of the County of Los Angeles (HACoLA) for Homeless Section 8 applications, which have returned over 100 applications submitted to DMH due to reaching capacity in the Section 8 program. A limited number of federal housing subsidies is available for DMH clients through Shelter Plus Care.

Action Plan: During the 2008 Continuum of Care process, DMH applied for and was granted additional Shelter Plus Care and Homeless Section 8 certificates/vouchers through HACLA and HACoLA. The Department is waiting for the certificates/vouchers through the new grants to become available.

Client Success Story: The Housing Specialist in Service Area 3 has been working with a client who receives services through Arcadia Mental Health Center's Full Services Partnership Program. The client has a long history chronic homelessness, living in his car. He suffers from mental illness and multiple health issues. His health required him to go to a County hospital where he learned that he needed major surgery. Knowing that living in his car was not an appropriate environment for him to recover after major surgery, the Housing Specialist assisted the client with applying for and obtaining a Section 8 housing voucher and an adequate apartment. The client was able to move in his apartment before his surgery, and after his operation he returned to a nice, warm place where he could recover properly in a timely manner. He is now living in his apartment with the goal of maintaining his housing as he recovers from surgery.

15) Just In-Reach Program

Goal: Engage homeless nonviolent inmates upon entry into jail. Develop a release plan that coordinates an assessment and links clients to supportive services, benefits, and housing options upon their release. Case management team works with clients to obtain employment and explore rental subsidy eligibility.
Budget: $1,500,000 (One-Time Funding)

Table C.11 : Just In-Reach Program
FY 2008-09

(duplicated count)	FY		FY
Homeless Individuals	198	Housing (emergency)	12
Chronic Homeless	257	Housing (transitional)	105
		Housing (permanent)	53
		Moving assistance	5
Female	127	Job training	232
Male	257	Job placement	24
		Education	20
Hispanic	110	Life skills	4
African American	175	General Relief (Food Stamps)	42
White	135	General Relief only	47
Asian/Pacific Islander	9	Food stamps only	32
Native American	3	Veterans' benefits	7
Other	49	Case management	330
(not for all participants)		Health care	8
		Mental health care	10
16-24	75	Substance abuse, outpatient	38
25-49	443	Substance abuse, residential	65
50+	87	Transportation	66
		Legal advocacy	86

Program Specific Measures	FY
Number of participants who received intake/enrollment	452
Number of participants who received intake/enrollment within 72 hrs of initial interview	298
Number of participants who did not complete program (exited prior to completing)	118
Number by violent crime	132
Number by non-violent crime	322
Number by area of residence prior to incarceration (most frequent residence)	-
Number by area of residence prior to incarceration (second most frequent residence)	-
Number of times in County jail	492
Number of times in State prison	65
Number of participants with a service plan	1,902
Number of participants with a service plan within a week from intake/enrollment	1,902
Number of referrals provided to participants by type:	
- Service(s): Case management, health/medical care, mental health, substance abuse treatment, transportation, and mentoring	330
- Benefit(s): CalWORKs, General Relief, Food Stamps only, Section 8 and/or Shelter Plus Care, SSI/SSDI, Medi-Cal, Veterans	453
- Job/education related service(s): Job training, employment referrals, education	453
Number of participants who do not return to jail	335

Emergency Housing/Case Management	
Average stay at emergency/transitional housing: (103 participants)	88 days
Level 1 Assisted/Supported Referral and Counseling case management services	
Average case management hours for each participant per month:	2 hours
Total case management hours for all participants during current reporting period:	1,448 hours
Number of cases per case manager:	59 cases

Longer-term Outcomes (6 or more months) at end of FY 2008-09	
Maintained permanent housing	28
Obtained employment	19
Maintained employment	4
Enrolled in educational program, school	5
Case management	166
Health care	15
Mental health/counseling	23

Successes: The Just In-Reach program (JIR) has assisted in placing 156 homeless or chronically homeless inmates into transitional or permanent housing during the program year. With partnerships with other agencies, JIR has contributed directly toward move in costs for placements in permanent housing. Staff continue to work with clients after housing placements to provide them the necessary supportive services to continue their success. The JIR program continues to establish its name and reliability within the court systems and other Probation, Parole and Public Defender's offices resulting in participants being released to our program as an alternative to jail/ prison. Staff accompany clients to court dates and appointments to advocate for their alternative placement into a program. The recidivism rate of clients enrolled in the program is averaging 34% for the first year which is less than half of the recidivism rate for the general population of the County Jail system (70%). JIR continues to hold weekly housing and employment readiness groups at the jails with the groups ranging from 5 to 65 participants in size. JIR staff participate in structured staff trainings that are approved by the Sheriff's Department in order to stay current on and consistent with best practices for the clients.

Challenges: The program continues to see a very high enrollment rate. Although the Sheriff's Department and JIR administration worked on an attempt to be more selective when assessing and enrolling clients, a large number still met the minimum criteria and were not subsequently turned away. Due to the high amount of participants, JIR staff struggles to find time to maintain contact with those who are not making an effort to follow up with their case managers. The high enrollment causes large drops offs from continued case management, employment, and housing services. For example, when a client receives the initial case management session and enrollment, they are left to follow up on their own with connecting services. Staff carry extremely high caseloads and are not always able to effectively transition a client from intake to our employment and housing specialists, before we lose contact. Through the first program year, the Sheriff's Community Transition Unit (CTU) referred 927 inmates to the JIR program which indicates the mass amounts of clients the front line case managers are trying to serve.

The maintenance of the data continues to be challenging. During the entire program year, JIR have met with their database contractor, in an effort to alleviate these issues. After this first year it will be suggested that up to 75% of the data be reentered under a new program written for JIR specifically.

Relationships and functionality continue to improve between JIR staff and Jail personnel. There are some areas that remain fragmented such as the Pitchess Detention Center. Staff continue to have space issues and do not have adequate work space at this location. It is also the location that utilizes the JIR program the least. Part of this is attributed to its size and difficulty from getting from one section of inmates to another. JIR staff will continue to work with LASD to alleviate the problem.

Action Plan: JIR has begun incentive plans for participants during their initial contact and have stated that we require a strong commitment from the client before they are entered into the program. Incentives have included transportation and store credits for simply returning for a case management session post release. Although enrollment level remains high, it did trend lower for the last quarter. JIR does not have adequate staff to maintain these high levels, but they have remained fully staffed for the past six months. JIR also added a Coordinator position that will assist in the management and data collection for this program. JIR staff has participated in employment training, housing training, anger management and crisis intervention, which has been incorporated directly to the clients. In addition, staff participated in an extensive training from a collaborative that runs the similar program with six years of practical experience. JIR, LASD and County staff continue to work with this outside collaborative in an effort to reach the efficiency and outcomes that the older program is able to achieve.

Client Success Story: A female client from the Central Regional Detention Center Facility in Lynwood entered the JIR program as a frequent user of the County Jail and emergency shelter systems. She was very hesitant and non-cooperative in the beginning and would not return correspondence from staff. No less than five JIR staff members worked with her until she finally felt comfortable with one of them. She was initially given shelter at the Union Rescue Mission in downtown. She was actively involved in the Volunteer Services Program, working in the URM warehouse. She continued working with the Housing Specialists and was eventually placed on a waitlist for Skid Row Housing Trust. JIR staff had begun building relationships with agencies such as SRHT in an effort to show support for clients that come through the JIR program. During her time on the waitlist, she worked with our Employment Specialist and she was linked with the L.I.T.E. program where she perfected her resume. The L.I.T.E. Program is a collaborative between the Skid Row Development Corporation and Volunteers of American (VOA) to provide a portal in Skid Row to Worksource Centers. The program provides assistance with resume writing, creating email accounts, and offers Saturday computer classes.

The client then applied for a job and was just recently offered a full-time position. After a few months, she secured an apartment in the Simone Hotel (part of Skid Row Housing Trust). JIR covered her basic move-in costs and provided housing necessities. JIR staff continues to meet with her on a regular basis to ensure her continued success.

16) Long Beach Services for Homeless Veterans

Goal: Assist veterans with housing, employment, SSI/SSDI, and legal issues such as child support. The program provides case management, outreach, and mental health services.
Budget: $500,000 (Ongoing Funding)

Table C.12 : Long Beach Services for Homeless Veterans
FY 2008-09

	FY		FY
Homeless Individuals	532		
Chronic Homeless	74	Education	10
Homeless Families	4	Job training	3
Female	81	General Relief (and Food Stamps)	9
Male	529	General Relief	6
		SSI/SSDI	6
Hispanic	124	Veterans' benefits	19
African American	206	Case management	83
White	220	Health care	7
Asian/Pacific Islander	30	Mental health	28
Native American	4	Substance abuse (residential)	6
Other	26	Transportation	95
		Life skills	13
16-24	42	Other	
25-49	340	Credit repaired	18
50+	230	Legal services	4
		Drivers license reinstated	13
Moving assistance	4		
Housing (emergency)	64		
Housing (transitional)	21		
Housing (permanent)	6		
Rental subsidy	12		

Program Specific Measures	**FY**
Number of mental health coordination activities conducted	39
Number of mental health assessments provided to homeless veterans by MHALA	21
Number of meals provided to homeless veterans. (includes food/meal vouchers)	64
Number of homeless veterans whose child support payment was eliminated or reduced by SPUNK	28
Number of outreach sessions conducted by U.S. Vets and DHHS	14
Number of homeless veterans contacted through outreach sessions by U.S. Vets and DHHS	360
Number of outreach sessions conducted with veterans recently returning from tour of duty	5
Number of mental health educational pamphlets developed	2

Successes: The partners of the Long Beach Homeless Veterans Initiative ("HVI") – City of Long Beach ("City"), Mental Health America ("MHA"), Single Parent United N Kids ("SPUNK"), and United States Veterans Initiative ("US VETS") – continue to meet regularly and implement comprehensive outreach and service delivery for homeless veterans. To support the goals of HVI, the partners continue their collaborations with other agencies such as Veterans Affairs ("VA") Long Beach Healthcare System, Legal Aid Foundation of Los Angeles and the University of Southern California ("USC") Military Social Work and Veteran Services Program in the School of Social Work. The Mental Health Coordinator, based in the City of Long Beach, Department of Health and Human Services ("Long Beach Health Department"), continues to collaborate with the Los Angeles County Department of Mental Health to evaluate future funding sources associated with Mental Health Services Act dollars.

This quarter, the four partner agencies of the HVI served 369 veterans, including two veterans with families, with a variety of services that include outreach, case management, child support reduction, mental health interventions and housing. (NOTE: For the two families, demographic information was only provided on the head of the household.) MHA Homeless Assistance Program staff continued their outreach efforts with the implementation of a new group (The White Bison) that provides another door for veterans to enter into recovery and wellness services, specifically for veterans who have previously been unwilling to engage in services. During the 4th quarter, SPUNK engaged 25 clients with a total of 28 cases (two clients had more than one case). Of those cases, SPUNK w closed 14 cases with a total arrears savings of $211,912. The Long Beach Multi-Service Center ("MSC"), operated by the Long Beach Health Department, continues to outreach to veterans through a variety of activities, including traditional street outreach, as well as participation in community events such as a Veterans Appreciation Day, held on June 24th at Veterans Park in Long Beach. Information regarding Veterans' Homeless Services was provided at the Veterans Appreciation Day event. US VETS, working in conjunction with the VA Long Beach Healthcare System, Homeless Program, continues to place veterans into their own apartments through the HUD-Veterans Affairs Supported Housing ("HUD-VASH") voucher program. Following is a breakdown of agency referrals to the HUD-VASH voucher program for Long Beach:

- 40% from the Villages at Cabrillo
- 40% from the VA Long Beach Medical Center; and
- 20% from Homeless Services community agencies, such as: Multi-Service Center, Mental Health America and the Long Beach Housing Authority

The Mental Health Coordinator held a citywide mental health fair, "Healthy Minds, Healthy Body" on May 9, 2009. The event was co-sponsored by California State Assemblymember Bonnie Lowenthal, Long Beach Health Department and Second District Councilmember, Suja Lowenthal. This event, held at Bixby Park in Long Beach, was attended by an estimated 300 people. Planning partners included Community Hospital of Long Beach, St. Mary's Medical Center, VA Long Beach Medical Center in Long Beach, The Children's Clinic, MHA Village Integrated Service Agency, National Alliance on Mental Illness, City's Center for Families and Youth, Los Angeles County Department of Mental Health, Choices Recovery Services and the Wellness Center. Over 50 agencies participated in this event, which featured health information booths, educational sessions, entertainment, health screenings, mental health advocacy, and anti-stigma information.

In addition, the Mental Health Coordinator continues to lead a variety of projects designed to provide better access to mental health services in Long Beach. During this quarter, the Mental Health Coordinator developed a Long Beach mental health resource directory and two mental health brochures. The formation of a Discharge Collaborative group is being initiated; this collaborative will include representatives from area hospitals and clinics, as well as the City Fire and Police departments. The primary goal of this collaborative is to reduce recidivism of homeless clients in emergency public health systems.

Challenges: The HVI project has faced challenges in program staffing that have been corrected. MHA experienced the transition of a full-time Nurse Practitioner to a .75 Nurse Practitioner. HVI outreach staff members report that many of the veterans encountered are already connected to veteran benefits. Additionally, affordable housing options for HVI veteran clients have been challenging to identify.

Action Plan·
The HVI partners will:

- Utilize Homeless Management Information System (HMIS) to allow for better tracking and coordination of homeless veterans.
- Further coordinate efforts to outreach to homeless veterans and identify affordable housing options.
- Develop the Discharge Planning Collaborative and continue participation in MHSA related activities.
- Continue to seek additional funding for mental health and/or veteran services/housing.
- Enhance housing stability for veterans in Long Beach by leveraging resources available under the 2009 American Reinvestment and Recovery Act ("Recovery Act"). One potential Recovery Act resource is the Homelessness Prevention and Rapid Re-Housing Program ("HPRP"); the City was allocated $3,566,451 for HPRP.

Client Success Stories:
An Operation Iraqi Freedom/Operation Enduring Freedom veteran (OIF/OEF) was living on the streets prior to entering the US VETS Veterans Reentry Program (VRP, formerly Recently Separated Veterans program). While in the program, the client received mental health support to deal with combat-related Post Traumatic Stress Disorder (PTSD). With the help and guidance of his case manager, he received a HUD-VASH voucher and was able to get his own apartment. The client is now a student at National Polytechnic College of Science, where he is enrolled in an advanced diving paramedic course. The client continues to receive case management services and demonstrates good academic commitment to his education.

In March, the Veterans Case Manager and Outreach Coordinator received a call from the East Division of the Long Beach Police Department regarding a homeless male living near the City's water treatment plant. The 68-year-old Hispanic male was reported to have been living by the plant for over nine years. Over the next 30 days, the case manager was able to locate a vacancy in a senior housing program, and assist with his security deposit through the HOME Program. The case manager also coordinated a furniture donation for the apartment, which was fully furnished before the individual moved in. The individual reported that he was extremely happy to move into his new apartment and was very grateful for all the help he had received. He stated that he was happy that he was now able to make his own coffee rather than walking a mile for a fresh cup. The individual has retained his permanent housing for 60 days.

The MHA outreach staff has been working with a homeless veteran for the past several months. The client suffers from multiple medical problems, co-occurring disorder, and has been very difficult to engage. Recently, he confided to outreach workers that he was ready to check himself into a substance abuse rehabilitation program. The client requested assistance from the outreach staff with the admission process. Medical clearance was obtained through collaboration of the outreach worker, nurse practitioner and registered nurse, allowing him to enter substance abuse rehabilitation program in early July.

17) Los Angeles County Homeless Court Program

Goal: Assist homeless individuals with clearing outstanding tickets, fines, and warrants upon successful completion of rehabilitation recovery programs for mental health, substance abuse and/or other issues.
Budget: $379,000 (On-going Funding)

Table C.13 : Los Angeles County Homeless Court Program Participants
FY 2008-09

	FY	Cumulative		FY	Cumulative
Homeless Individuals	1,034	1,188	Hispanic	245	281
			African American	540	618
Female	351	402	White	197	231
Male	681	783	Asian/Pacific Islander	15	15
Transgender	2	3	Native American	5	6
			Other	32	37
			15 and below	-	-
			16-24	80	96
			25-49	677	768
			50+	277	324

Program Specific Measures	FY	Cumulative
Number of Los Angeles County Homeless Court motions received	3,055	3,389
Number of program participants whose qualifying motions are submitted to and filed by Superior Court, and resolved within 30 days of submission	3,054 100%	3,389 100%
Number of audited records in the Superior Court's automated case management systems (TCIS/ETRS) that are accurate	87 93%	147
Number of motions that are granted by Superior Court	3,002 99%	3,325
Number of motions that are denied by Superior Court	8	8
Number of individual cases filed under the Los Angeles County Homeless Court	3,493	3,893
Number of participants whose applications are submitted to the Los Angeles County Homeless Court within 30-days of initial contact with participant	961	1,115
Number of participants that have Los Angeles County citations or warrants dismissed upon program completion	996	1,122
Number of participants who complete at least 90 days of necessary case management, rehabilitative, employment or mental health services before their first appearance in Court	1,006	1,160
Number of case managers who receive training on Los Angeles County Homeless Court benefits, application and eligibility requirements, and legal resources	789	965

Successes: During this quarter, the program successfully implemented a new procedure for handling Homeless Court motions for the City of Long Beach and City of Burbank. In the past, there were long delays in resolving citations from these cities because they did not have court clerks dedicated to processing Homeless Court motions. Rather than continue to place the burden of processing these motions on the local city prosecutors and court clerks, a procedure was developed whereby Homeless Court staff prepares all motions for the City of Long Beach and City of Burbank prosecutors to sign and then sends them to the Superior Court's Homeless Court clerks to be processed. Since implementing this new procedure, a significant improvement in the processing time for Long Beach and Burbank motions has been achieved, and Public Counsel plans to develop similar procedures for other jurisdictions.

Superior Court acted as a liaison between Public Counsel and the Inglewood and Burbank City Attorneys to expand program benefits for the clients among those prosecutors.

Challenges: One challenge is the recent increase in the number of applications submitted for clients who are ineligible for Homeless Court as a result of having received a recent citation (within six months prior to applying to Homeless Court). Clients also may be determined ineligible due to having previously participated in Homeless Court, having an outstanding felony warrant, or having no outstanding citations

that can be resolved through Homeless Court, although these reasons are less frequent. For every application received, Homeless Court staff must complete a comprehensive criminal record review to determine whether or not the client is eligible for Homeless Court. Therefore, case managers are required to pre-screen their clients for eligibility prior to submitting an application. When a case manager submits an application for a client who clearly is not eligible, based on the criteria outlined on the application form itself as well as in the case manager instructions, it creates delays in the processing of eligible applications. Another ongoing challenge involves case managers submitting old versions of the Homeless Court application and not collecting all of the information necessary for reporting requirements. Although the missing information is usually gathered through reviewing clients' criminal records and following up with referring case managers, this creates an additional administrative burden and slows processing of applications. The program continued accepting some old versions of the application while providing case managers with the updated version so as not to delay clients' access to Homeless Court. However, old versions continue to be received despite efforts to widely distribute the updated application.

Superior Court: In keeping with one of the main purposes of the HPI grant money allocated to the Court, Public Counsel is now working with prosecutors to redirect motions filed on behalf of the clients to the Central Arraignment Courts. One point of contact in the Court for Public Counsel is resulting in more efficiency in judicial and clerical processing, and another point of contact allows for resolving of issues.

Action Plan: The program plans to address the challenges described above through continued outreach and training of case managers. Trainings emphasize the importance of case managers thoroughly screening clients to ensure that they meet all eligibility requirements before submitting an application on the clients' behalf. Case managers are provided with information about how to use the Superior Court's traffic website to verify whether their clients have received recent citations. Case managers are encouraged to contact the Homeless Court office to consult prior to submitting an application if they are unsure as to whether the client is eligible for Homeless Court. Finally, the program stresses the importance of using the most recent application and inform case managers that if they use an old form the application may be returned to them unprocessed.

Superior Court: With existing resources, Public Counsel and Superior Court worked closely together and changed practices to accommodate a larger number of clients during graduation ceremonies. The Central Arraignment Courts retrieve case information for every motion received from Public Counsel prior to presenting it to the judicial officer for review and determination. Some case information is readily available while other information must be retrieved from other work units. At times not all the work for individual clients is processed at the same time--the choice of waiting to get all the case information and submit it to the judicial officer for review, or to submit work as it becomes ready for review. Superior Court continues to work with Public Counsel to resolve discrepancies over motions submitted from the various prosecutors. These discrepancies include: maintaining a log of motions received; ensuring the motion is complete; receiving signed copies of the motions by the judicial officers; and, resolving questions on recordkeeping or notification to other agencies. Superior Court and Public Counsel continue to work together to resolve inconsistent handling of motions by participating prosecutors. This includes resolving outstanding warrants, fines/fees and pending charges that were not previously identified until after the client participated in the program.

Client Success Story: Client D was referred to Homeless Court by his counselor at a substance abuse treatment program. He had numerous unresolved traffic citations and his driver's license had been suspended. Through Homeless Court, the client's outstanding citations were resolved, and he was able to get his driver's license reinstated. His experience in treatment inspired him to help others struggling with substance abuse. He is now living independently and working full-time as a counselor at a substance abuse treatment program similar to the program he participated. With his driver's license reinstated, he commutes nearly 100 miles to work from his home. Client D frequently submits applications to Homeless Court on behalf of his clients.

18) Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program

Goal: Assist individuals to move into permanent housing.
Budget: $1.1 million (One-Time Funding)

Table C.14: Moving Assistance for Single Adults Program Measures
FY 2008-09

(unduplicated count)	FY	Cumulative		FY
Homeless Individuals	421	599	Female	192
			Male	229
Number applications received	421	599		
Moving assistance approved	127	190	16-24	19
Percent applications approved	30%	32%	25-49	216
Average days to approve	12	*20	50+	186
Average amount of grant	$722	*$575	Hispanic	54
			African American	253
			White	93
General Relief (w/FS)	166	n/a	Asian/Pacific Islander	1
General Relief only	9	n/a	Native American	15
Food Stamps only	9	n/a	Other	5
Medi-Cal/Medicare	1	n/a		
SSI/SSDI	20	n/a	Number remaining in housing	41
Section 8	1	n/a	(after six months)	
Shelter Plus Care	10	n/a		
Veterans' benefits	2	n/a		

* FY 2007-08 average
**FY 2007-08 data not available

Successes: The program maintained a steady increase in the number of referrals for this reporting quarter.

Challenges: To date, the program is still experiencing a low number of approvals despite the increase in referrals.

Action Plan: The program plans to continue the outreach efforts at transitional shelters and other agencies that provide services to the homeless population.

Client Success Story: Mr. D is a mentally challenged participant who was successfully placed in permanent housing after availing of the HPI Move-In Assistance funds to pay for a security deposit.

19) Project 50

Goal: To move 50 of the most vulnerable, chronically homeless individuals off of Skid Row and into permanent housing.
Budget: $3.6 million (Board Approved Funding)

Table C.15: Project 50 Participants and Services
FY 2008-09

(unduplicated count)	YTD	Cumulative
Chronic Homeless Individuals (ever housed)		53
Female	3	5
Male	5	47
Transgender	-	1
Hispanic	-	11
African American	3	43
White	3	6
Asian/Pacific Islander	-	-
Native American	-	-
Other	1	1
25-49	-	16
50+	11	37
Eviction prevention	8	8
Housing (emergency)	-	41
Housing (permanent)	6	53
Rental Subsidy	-	41
Moving assistance	1	1

	YTD	Cumulative
Education	2	2
Job training/referrals	-	2
Job placement	2	2
General Relief (GR,FS)	-	10
General Relief only	4	7
Food Stamps	-	1
Medi-Cal/Medicare	10	16
Section 8	-	1
Shelter Plus Care	5	41
SSI/SSDI	10	31
Veterans	-	8
Case management	38	41
Health care/medical	37	41
Mental health/counseling	35	38
Social/community activity	-	30
Substance abuse (outpatient)	-	20
Substance abuse (residential)	5	14
Transportation	-	35
Legal Services	-	11

Longer-term outcomes (12 months)	**Quarter**
Continuing to live in housing	41
Receiving rental subsidy	41
Obtained employment	2
Maintained employment	1
Enrolled in educational program	2
Case management	41
Health care	41
Mental health/counseling	34
Substance abuse treatment (outpatient)	30
Substance abuse treatment (residential)	5
No drug use	14
Reunited with family	3

Case Management	**Quarter**
Level 3 case management services	
Average for each participant per month:	5 hours
Total hours for all participants:	95 hours
Number of cases per case manager:	19 cases

Program Specific Measures	Quarter	Cumulative
Number of participants who exited housing	-	11
Number of participants developing individualized treatment plans	5	41
Number of participants participating in a housing retention group	-	30
Number of Project 50 participants having arrests	3	15
Number of Project 50 participants having hospitalizations	3	15
Number of Project 50 participants having an emergency room (ER) visit	2	6
Number of Project 50 participants with increased income (i.e., due to SSI/SSDI, GR)	3	16

Successes: As of March 31, 2009, Project 50 maintained 41 people in housing. A total of 53 individuals have ever been housed. This month, the program was able to obtain non-Skid Row housing for one Project 50 participant. This was a major undertaking that involved cooperation from many agencies including DMH, HACLA, SRHT and JWCH social services. The program was able to maintain housing for two participants who were about to be on the streets again. Five people were housed this quarter and two more are in line for housing. A new social worker was hired, and a new Team Leader was successfully recruited. The counselors have proven to be very helpful in working with the drug addicted population.

Client J was able to obtain Section 8 housing out of Skid Row. A long term "crack" abuser who almost lost his housing was sent to rehab. Six people who were in danger of losing housing were manage and stayed.

Challenges: Keeping difficult people in housing is the major challenge of the project. Program participants continue to be a challenge with their significant needs and the high degree of support they require. Working as a team, the Project 50 staff has had significant success in maintaining housing for the chronic homeless.

Continued substance abuse, poor money management.

Action Plan:

- Utilize other agencies to assist in locating appropriate potential participants for housing. The Project 50 staff have refreshed the Registry to concentrate outreach and engagement activities on an ongoing basis;
- Encourage staff stability, maybe have a process group for participants to deal with loss;
- Continue to add participants to our list until we have 50 currently housed.
- Obtain money management for P50 participants and continue substance abuse groups.

Client Success Story: Project 50 staff has housed five chronically homeless in the last quarter. Several have had over twenty five years of homelessness. One client had not slept in a bed in twenty years.

Client E had a plan to motivate himself to stop using drugs. He was not going to re-certify with HACLA, be evicted and then muster the courage to go into rehab. After much work by the staff, he agreed to re-certify and go into rehab where he has been a great success.

20) Santa Monica Homeless Community Court

Goal: Assist homeless individuals with clearing outstanding citations, warrants, and misdemeanor offenses upon successful completion of mental health, substance abuse and case management.

Budget: $540,000

Table C.16: Santa Monica Homeless Community Court Participants and Services
FY 2008-09, Cumulative (February 2007 – June 2008)

(unduplicated count)	Cumulative		*Cumulative
Chronic Homeless Individuals	155	15 and below	-
		25-54**	121
Female	49	55+	34
Male	106	Housing (emer/trans)	66
		Housing (permanent)	26
Hispanic*	17	Rental subsidy	11
African American	34		
White	102	Alternative court	155
Asian/Pacific Islander	3	Case management (level 3)	148
Native American	1	Mental health	65
Other	15	Substance abuse (outpatient)	5
		Substance abuse (residential)	32

Program Specific Measures	Cumulative
Total number of clients who have enrolled in Program	155
Number who participate that have citations or warrants dismissed upon completion	118 (72%)
Number who receive an emergency shelter bed and remain for two weeks or longer	35 (53%)
Number who accessed psychiatric and/or mental health services, received their mental health services at a DMH facility within the six-month program period (February-June 2009)	24 (37%)
Number who enter residential treatment complete a substance abuse program of 90 days or longer	24 (71%)
Number of arrests for all Court participants that have been placed in an emergency, therapeutic, transitional or permanent bed (or some combination of bed-types) for 90-days or longer as compared to the 90 days prior to entering residential program	70% reduction
Number of permanently housed who continue to be housed after four months, or will still be housed at the end of the program periods (which may be less then four months after housing placement)	24 (92%)
Average length of stay in emergency housing:	14-160 days

*Latino is not categorized as a distinct race by Santa Monica Homeless Community Court
** Age range is categorized differently by Santa Monica Homeless Community Court.

Successes: The most successful ongoing collaboration which the Homeless Community Court program is engaged in is its relationship with Edelman Mental Health Center. Every Thursday morning, the Edelman psychiatrist and social worker, provide in-office services at the St. Joseph Center Homeless Services Center and occasional outreach to Homeless Community Court clients. The primary benefit of this Edelman collaboration is giving clients easy access to psychiatric care, with medications administered at two area pharmacies. Given the limited mobility, organization and/or motivation of many Court clients, this is often a superior service option to conventional mental health clinics. Integrating these psychiatric services into the pre-existing relationship which clients have with their program Case Manager and Mental Health Specialist also provides context which can help overcome service barriers stemming directly from mental health symptoms. A secondary but lasting benefit of the Edelman collaboration is

streamlining the eventual transfer of client services from in-office services at the Homeless Services Center to long-term mental health care at Edelman or other Department on Mental Health facilities.

Exodus Full Service Partnership has been another valuable collaborator with the Homeless Community Court Program. A dually diagnosed client referred to this program was rapidly entered into intensive services with an outreach case manager. Working in tandem with Homeless Community Court and Exodus staff, this client was able to access a full range of services including psychiatric care, substance abuse treatment, emergency shelter, and permanent housing at a sober living. The Full Service Partnership's collaboration with Exodus Mental Health Urgent Care Center accelerated the client's access to mental health services and dealt with acute mental health situations. This collaboration has also contributed to St. Joseph Center's familiarity with the services offered by Exodus Urgent Care, benefiting the agency more generally.

Building on the success of our Chronic Homeless Program (CHP), the program has managed to link many CHP participants to the Court which has resulted in the removal of barriers and has allowed for the successful transition by clients to the next phase of their lives.

Continued collaboration between service providers, police and fire has allowed the program to continue engaging clients in the field and seizing opportunities to refer them to the program, when it appears they will be receptive to services.

The program's talented Public Defender is greatly appreciated not only by the Resource Coordinator but also by our service providers. She creatively strikes a balance between advocating for her clients and using her motivational interviewing techniques to help clients see the benefits of connecting to services.

Challenges: The voluntary nature of the program allows many of the most chronic, high users of police, fire and social services the opportunity to opt out of the program. These are the very people the program had wished to engage in services using the authority of the Court. Experience has shown that many of the most chronic homeless do not want to access services. Moreover, the voluntary nature of the program does not allow the program to use the authority of the Court to connect individuals to much needed resources, including: mental health, psychiatric, medical, substance abuse and monetary assistance programs – all of which can be barriers to stabilizing clients, housing them and helping them maintain their housing.

Action Plan: The Court will only accept participants cited with quality of life crimes – misdemeanors and infractions. The Court will not accept felons or sex offenders. The very nature of the crimes, misdemeanors and infractions, prevent the court from following participant for extended periods of time and result in citations being dismissed with limited client progress. Greater oversight by the Court could have a very positive influence on participants and result in better outcomes. Currently, participants average 2-3 court visits before their citations and warrants are dismissed. This impacts both substance abuse treatment and housing placements. Indeed, because of Case Management initiated by the Court, some individuals may achieve outcomes months after their exit from the program.

Court participants would benefit from a more directive tone and more exact prescriptions from the Court. While this has improved, the program continues to need progress in this area. The court appointed psychiatrist linked with the program supports this change in tone of court orders, and feels that it would result in greater client success. Furthermore, it would lend more objective finality to the process, taking out a great deal of ambiguity for the client.

21) Santa Monica Service Registry

A) Step Up on Second
Budget: $ 518,000 (Board Approved – Third District)

Table C.17: Step Up on Second, Santa Monica Service Registry
FY 2008-09

(unduplicated clients)	FY		FY
Chronic Homeless Individuals	25	Moving assistance	4
		Housing (transitional), 30-60 day stay	7
Female	8	Housing (permanent)	7
Male	17	Rental subsidy	1
Hispanic	5	General Relief with Food Stamps	1
African American	5	Medi-Cal/Medicare	1
White	13	Case management	22
Other	2	Health care	3
		Life skills	12
25-49	12	Mental health care	14
50+	13	Social/community activity	15
		Transportation	13
		Substance abuse treatment (outpatient)	3
		Substance abuse treatment (residential)	2

Case management level 3	**QTR**
Average hours per case:	3
Total number of hours:	225
Caseload per case manager:	6

Number of participants who have enrolled (entered) into program during the reporting period	14
Number of participants who left the program during this period	2
Total number currently enrolled in program	23
Number of clients who received an assessment (if applicable)	1
Cost per participant	$6,853
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning/end*** of the quarter	n/a

Successes: The program referred clients to appropriate services, provided transportation and/or bus tokens to allow clients to maintain appointments, and provided appropriate resources for medical care. Five clients were placed into permanent housing and received support and life skills training to allow them to live independently. One participant maintained employment at six months, three continued to receive case management, and four continued to receive mental health treatment (with improvement).

Challenges: Challenges included: finding available housing units; following through with clients' plans; maintaining relationships with people who we house; finding available services; and dealing with clients' involvement with law enforcement.

Action Plan: The program plans to continue: conduct outreach; seek and utilize local resources; communicate with law enforcement; build bonds with clients; collaborate with the City of Santa Monica staff to participate in a process of adding eligible people to the registry and enrolling them in our program.

Client Success Story: We were able to assist an older male who had been homeless for 10 years, undocumented with no income, and ineligible for mainstream benefits into permanent housing. With the funds available through our program, we were able to assist him with all the necessary steps, including the purchase of furniture and other household goods, as well as getting his utilities established. Due to his ineligibility for benefits, this program has afforded him the opportunity to participate in the Housing First model, so that he has the secure base of a home from which to improve his level of functioning and engage new income opportunities. We believe that through the ongoing support of the HOME Team, this individual will be able to become self-sustaining and will be able to maintain his private apartment for as long as he chooses to remain there. We have already seen him improving in his psychiatric functioning and socializing in our community.

B) OPCC Safety Net (Access Center)
Budget: $ 660,000 (Board Approved, Third District)

Table C.18: OPCC Safety Net (Access Center)
FY 2008-09

(unduplicated clients)	YTD		YTD
Chronic Homeless	43	Section 8	9
		SSI/SSDI	4
Female	11	Shelter Plus Care	2
Male	32	Job placement	1
		Job training	4
Hispanic	2		
African American	8	General Relief with Food Stamps	1
White	30	General Relief	2
Asian/Pacific Islander	1	Food Stamps	2
Native American	-	Alternative court	2
Other	2	Case management	39
		Health care	16
25-49	19	Mental health care	23
50+	24	Substance abuse treatment (residential)	5
		Substance abuse treatment (outpatient)	8
Housing (emergency)	30	Food	11
Housing (transitional)	7	Clothing	3
Housing (permanent)	6	Transportation	13
Rental subsidy	4	Life skills	2
Moving assistance	5	Recuperative care	1
Average stay in temporary housing is 24 days		Case management level 3	
		Average hours per case:	61
		Total number of hours:	1,350
		Caseload per case manager:	11
Longer-term outcomes (six months)			
Continuing to live in housing			2
Case management			18
Health care			3
Mental health care			3

Number of organizations/agencies that your program has a formal collaboration for this project	3
Number of times collaborative partners met each month	2
Total amount ($) of HPI funding leveraged for project	n/a
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	n/a
Number of participants who have enrolled (entered) into program during the reporting period	9
Number of participants who left the program during this period	1
Total number currently enrolled in program	43
Number of clients who received an assessment (if applicable)	9
Cost per participant	$2,517
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	n/a

Successes:

- As a result of OPCC Project Safety Net, 23 of the most vulnerable chronically homeless individuals in Santa Monica are off the street, including: six maintaining permanent housing, five in transitional housing and substance abuse treatment facilities; seven stabilizing their health and mental health status in master leased units; and three in emergency shelter.
- OPCC Project Safety Net has engaged a total of 43 individuals with intensive outreach and case management. Thirty-nine individuals have completed Intake Assessments.

- Twelve individuals are in the process of accessing housing vouchers through the City of Santa Monica Housing Authority (including six clients with vouchers conducting apartment search and six awaiting voucher issuance).
- All staff positions have been filled including the most recently hired MSW/MPH Clinical Consultant.

Challenges:
- The manifestation of untreated mental illness and substance abuse in the form of suspicion, hostility and alienation pose challenges in establishing trusting relationships, a necessary prerequisite in forward movement for participants to seek/accept housing.
- Market competition for available permanent housing rental units continues to be a challenge in addition to a long process (2-3 months) for housing voucher application and issuance.

Action Plan:
- Increased collaboration with Santa Monica Housing Authority toward expediting voucher issuance.
- Clinical Consultant and Psychiatrist coordinating effectively to educate clients of the benefits in accepting medication and other mental health treatment.
- OPCC has acquired an open-air, electric cart soon to be utilized in the coming months for ease in transporting clients, especially those unwilling to enter a closed vehicle.

Client Success Story: Client H, a 65-year-old Army Veteran homeless in Palisades Park for over four years, lost his job as a pantry cook in Beverly Hills. Then, he lost everything while attempting to get by as a day laborer. Feeling intense alienation, anger and disconnection the client was finally willing to allow OPCC Safety Net staff to advocate and send for his birth certificate, obtained within a few weeks. A trusting rapport developed and he accepted emergency housing in a Santa Monica motel. He then moved quickly into OPCC Turning Point. In May his housing voucher was approved, and he moved into his own apartment. Today, he volunteers for Mt. Olive Lutheran Church where he has become an engaged member of the community. Client H is completing his education and aspires to receive his BA degree.

IV. PROGRAMS FOR MULTIPLE POPULATIONS

22) Los Angeles County Housing Resource Center, (formerly known as the Housing Database)

Goal: Provide information on housing listings to public users, housing locators, and caseworkers.
Budget: $382,000 ($202,000 allocation from HPI funding and $180,000 from CDC).

Table D1: LACHRC Program Measures June 1, 2007 – June 30, 2009	Cumulative	Year 1 6.1.07 - 6.30.08
Number of landlords registered on the site	5,279 *650 new*	3,505
Average monthly number of units available for rental	1,814	1,324
Total housing unit/ apartment complex listings registered on site (includes units that have been leased) *(as of December 2008)*	7,448 *1,373 new*	5,171
Total number of housing searches conducted by users that returned listing results	3,289,078 **414,490 new*	1,590,825
Average number of calls made/received to the Socialserve.com toll-free call center per month	3,093	2,897
Number of collaborative efforts forged between County Departments, Cities, and other stakeholder agencies.	38	33

**Correction: In the last quarterly report (third quarter of FY 2008-09), the total was 2,874,588 searches since initial launch (instead of 2,485,663).*

Successes: In this past quarter, the Housing Resource Center website launched several new features related to the Neighborhood Stabilization Program (NSP). These included single family for-sale listings, lists of Fannie Mae foreclosed properties, and a search tool to determine if a foreclosed property was in an eligible NSP-HERO (Home Energy Rebate Option) neighborhood.

Challenges: The high-priority rollout of federal stimulus fund projects related to the NSP and Homelessness Prevention and Rapid Re-Housing Program (HPRP) are causing several other planned website improvements to be delayed.

Action Plan: For the next quarter, the priority work items will relate to implementing the HPRP web-based pre-screening tool.

Client Success Story:
The for-sale listings of the CDC's Affordable Home Ownership Program (AHOP) was launched on April 13th. Within two hours, the developer received a call from an interested first-time homebuyer, and has subsequently received seven additional calls. The AHOP program markets new-construction houses that have HOME or City of Industry financing assistance for first-time homebuyers.

23) Pre-Development Revolving Loan Fund (RLF)
Goal: Affordable housing developers will receive loans directly from the Los Angeles County Housing Innovation Fund, LLC (LACHIF) to build much needed affordable housing in Los Angeles County.
Budget: $20 million

Table D.2: Pre-development Revolving Loan Fund	Quarter/FY
Number of applications received that are eligible for the RLF.	4
Number of projects with a complete environmental review within 90 days	-
Number of projects with environmental clearance	-
Average amount of time from receipt of application to loan approval	-
Dollar ($) amount of loans distributed by LLC	-
Average length of time from loan close to loan maturity date	-
Average length of time from anticipated construction start to end date	-
Number of loans approved	-
Number categorized as predevelopment	-
Number categorized as land acquisition	-
Number of loans by Supervisorial District	
Supervisorial District 1	1
Supervisorial District 2	1
Supervisorial District 3	1
Supervisorial District 4	-
Supervisorial District 5	1
Number of special needs households to be served by each loan	82
Number of low-income households to be served by each loan	184
Number of proposed total and affordable housing units	266
Number of housing units to be developed at 60% or below AMI	184
Number of housing units to be developed at 35% or below AMI	82
Number of reports collected on time from LLC	1
Number/percent of lost loans (live to date)	0

Successes: CDC staff and LACHIF LLC have developed a strategy to restructure the revolving loan fund that would attract new investors.

Challenges: Potential investors have requested that the County increase its risk exposure to cover 33% of County funds used in each loan AND to cover the investors 53.5% contribution in each loan up to the total $19.8 million.

Action Plan: CDC met with each Board office to discuss necessary changes to the Revolving Loan Fund. CDC filed a Board letter requesting authorization to amend the existing loan agreement between CDC and LACHIF LLC, which was adopted on July 28th.

Client Success Story: Four projects are requesting $9,114,000. The four projects would provide 266 units of affordable housing.

24) Project Homeless Connect

Goal: Provide individuals and families with connections to health and human services and public benefits to prevent and reduce homelessness.

Budget: $45,000

Project Homeless Connect (PHC) is designed to bring government, community-based, and faith-based service providers together, as well as other sectors of the local community, to provide hospitality, information, and connections to health and human services and public benefits to homeless individuals and families. PHC provides a unique opportunity for homeless individuals and families to access services in a supportive, community-based, “one-stop shop” setting. The Los Angeles County, Chief Executive Office participates as the lead organizer for local PHC Day events, which normally take place during the first week of December; however, recent need and popularity of PHC Day events have created a situation where the CEO's Office is being requested to plan events on an ongoing, year-round basis.

Successes: Between December 2006, which is the first year the County CEO served as the event coordinator, and February 2009, PHC Day events have served to connect/engage 8,848 homeless participants with: public benefits, health and mental health screenings, dental services, voice mail services, substance and alcohol treatment, food distribution programs, alternative courts and legal assistance. Health services included immunizations such as flu shots. Social services included domestic violence services and shelter and parenting classes. By fiscal year, Table D.3 shows the total number of PHC participants who were linked to emergency, transitional, and permanent housing.

On April 16, 2009, an estimated 115 clients attended the first annual Whittier Connect Day event; approximately 20% of the guests at the Whittier event were classified as "at-risk" of homelessness. One family was housed in emergency housing at the Whittier Salvation Army. Clients were offered Influenza and other vaccinations, birth certificate applications, California identification card applications, alcohol and drug treatment, and referrals to various health and human services. Additional services included: checking and savings account information, legal assistance, health education and screenings, mental health assessments, as well as public benefits. Specifically, resources for SSI eligibility, parenting/child welfare guidance, foreclosure information/counseling, Healthy Families enrollment, food bank resources, and free community voice mail services were offered.

Challenges: With the current economic condition and the fact that families and individuals are losing their homes due to property foreclosures, future Project Homeless Connect events will need to continue to target the at-risk population.

Table D.3: Project Homeless Connect

Fiscal Year	Emergency Housing	Transitional Housing	Permanent Housing
FY 2006-07	59	-	70
FY 2007-08	117	19	-
FY 2008-09	235	78	25
Total	411	97	95

V. CITY AND COMMUNITY PROGRAM (CCP)

Capital Projects

Successes: The CDC is in constant contact with all of the Capital Developers regarding the projects. The CDC has set up internal tracking systems to monitor project progress. The timeline for execution is being determined based on the need of each grantee. It is customary for grants to be executed near the start of construction. Bell Shelter has executed the loan agreement and purchased the property for the project. All funds granted to the project have been expended.

Challenges: Challenges continue from the previous quarter. Coordination with other local, state and/or federal funding and construction industry changes has caused delays. Projects that were expecting state MHP funding are on hold because of the "freeze" caused by the State budget. The state has started to release some funding, but it is unknown at this time which HHPF projects will be affected.

Action Plan: Continuing from the previous quarter: the CDC is determining with each developer, whether or not to enter into the grant agreements soon or if it is best to wait until near the beginning of construction to avoid the necessity of several amendments. The CDC staff is providing technical assistance and will be conducting site visits to projects that are seeking funding for rehab of existing buildings.

Cumulative Expenditures to Date: $922,227

Service Projects

Successes: To date, the CDC has executed 15 service contracts that are ready to be implemented. We recently conducted a second annual comprehensive training for all service agencies to address all areas of technical assistance concerning contract compliance. Areas covered included an online system review, key contract provisions, financial program requirements, cost allocation plans, procurement, site monitoring visits, and performance counts reporting. Additionally, we provided guidance on the new micro-procurement policy and revised insurance requirements for both HHPF/CCP agencies and their subcontractors. The new micro-procurement policy will streamline the documentation requirements for small purchases under $1,500. Thirty service agency staff from 15 different agencies attended the comprehensive training, and post-training evaluation scores and comments from the attendees were very positive.

Most agencies have begun the implementation of their programs and have recruited program staff and developed subcontract agreements with the identified collaborators. Most have been expending funds and the remaining are planning to do so in the next month. To that end, the CDC has assisted a number of agencies in the submittal of payment requests and required documentation to support expenditures. Projects that had a slow start needed time to hire for key positions and to coordinate with subcontractors to ensure they meet all CDC requirements. Additionally, three service projects will not start until their capital project component is completed.

We have worked extensively with our Risk Manager to facilitate the review and approval of insurance documentation for both the HHPF/CCP agencies and their subcontractors, while still meeting the County mandated requirements. Our Risk Manager and County Counsel have revised the language in our contracts so that the responsibility to verify subcontractor compliance with insurance requirements will be with our contracted agencies instead of the CDC. We also strengthened the indemnification provisions in our contracts. These changes will streamline the approval of subcontracts in the future.

Challenges: A number of agencies had not used automated systems before and were challenged by the CDC's automated systems for digital contract execution and submittal of payment requests. We have provided extensive technical assistance in these areas and have successfully resolved all concerns.

One developer, Cloudbreak Compton, notified us that they have worked out a new partnership with United States Vets who will again be the service provider for their project. The US Vets will respond to our letter with a formal reconciliation of the two parties as well as provide us with a new timeline. Cloudbreak Compton said they are on a tight timeline with the construction permits and want to start

construction by the end of August 2009. We will continue to work with both Cloudbreak Compton and US Vets to facilitate resolution of all pending issues.

Action Plan: Our next challenge will be the implementation of the programmatic and financial monitoring of these projects, set to begin in September 2009. We are currently preparing for monitoring and will be scheduling the visits in the next month.
Cumulative Expenditures to Date: $1,903,669

25. City and Community Program (CCP)

a. A Community of Friends (ACOF) – Permanent Supportive Housing Program
b. Ocean Park Community Center (OPCC) HEARTH
c. Catalyst Foundation for AIDS Awareness and Care –Supportive Services Antelope Valley
d. Homes for Life Foundation – Vanowen Apartments
e. Hope Gardens Family Center (Union Rescue Mission)
f. National Mental Health Association of Greater Los Angeles – Self-Sufficiency Project for Homeless Adults and TAY in the Antelope Valley
g. National Mental Health Association of Greater Los Angeles – Self-Sufficiency Project for Homeless Adults and TAY in Long Beach
h. Skid Row Housing Trust – Skid Row Collaborative (SRC2)
i. Southern California Alcohol and Drug Programs – Homeless Co-Occurring Disorders Program
j. Volunteers of America Los Angeles – Strengthening Families
k. Women's and Children's Crisis Shelter
l. City of Pomona: Community Engagement and Regional Capacity Building
m. City of Pomona: Integrated Housing and Outreach Program

25a) A Community of Friends (ACOF) - Permanent Supportive Housing Program
Budget: $1,800,000 (City and Community Program)

Table D.1: ACOF
FY 2008-09, July 1, 2008 – March 31, 2009

(unduplicated count)	FY		FY
Homeless Individuals	182	Education	26
Chronic Homeless	36	Job training, referrals	19
Homeless Families	117	Job placement	21
Female	311	CalWORKs	78
Male	268	General Relief w/Food Stamps	41
Transgender	1	General Relief only	3
		Food Stamps	3
Hispanic	145	Medi-Cal/Medicare	8
African American	321	Shelter Plus Care	29
White	102	SSI/SSDI	229
Asian/Pacific Islander	7		
Native American	-	Alternative court	3
Other	5	Case management	332
		Life skills	332
15 and below	175	Mental health	293
16-24	67	Health care	163
25-49	219	Social/community activity	274
50+	119	Substance abuse treatment (outpatient)	86
		Substance abuse (residential)	5
Moving assistance	11	Transportation	172
Eviction prevention	16	Residential management support	329
Rental subsidy	325		
Housing (permanent)	325	Case management (level II)	
		Average hours per case:	10 hours
		Total number of hours:	6,700 hours
		Caseload:	16 cases

Longer-term Outcomes (at 12 months)	
Maintaining permanent housing	319
Receiving rental subsidy	319
Obtained employment	23
Maintained employment	41
Enrolled in educational program, school	30
	305
Case management	
Health care	253
Good or improved physical health	40
Mental health care	295
Good or improved mental health	253
Recuperative care	1
Substance abuse treatment (outpatient)	67
Substance abuse treatment (residential)	4
No drug use	40
Reunited with family	3

Successes: During this fourth quarter reporting period, A Community of Friends (ACOF) is pleased to report that the HPI funding has led to the continued successful collaboration with the Housing Works Mobile Integrated Service Team (MIST team). Collaboration with the MIST Team continues to provide for case management services, allow for additional supportive services through Resident Management support systems, and provide for needed property maintenance. The MIST team, in conjunction with ACOF case management staff, provided intensive services to 26 formerly homeless individuals and 13 families with over 30 children. The MIST team and case management staff have met regularly to ensure a continued overlay of needed services for “at risk” tenants, played an integral role in preventing evictions for those residents in jeopardy of losing housing to ensure that the majority of residents remain permanently housed in a safe and healthy environment.

Challenges: The greatest challenge continues to be the reporting tool itself. While it may be effective to use one tool to collect data across programs, this sometimes makes it difficult to capture date not specifically stated in the reporting tool. For example, spouses and adults often enter or leave mid quarter, affecting the demographic counts for gender, race, and age. Also, adults in families are often not counted as having received a service, as they are not the "head of household." Yet, spouses and adult members of the household are often indirect beneficiaries of the services provided. Additionally, combining data from different collaborators and properties presents a tracking challenge.

Challenges the tenants face include on-going struggles with substance abuse, correctly budgeting funds each month, managing medication, and improving life skills to a level which increases self sufficiency.

Action Plan: ACOF has worked with HPI staff to clarify the reporting process and make minor adjustments that will ensure the correct capture of data. Now that a baseline has been established, only data for those entering will be collected and HPI staff will merge that data. This will ensure that there are not duplicate counts or counts including newly added adults in families.

Case management staff will continue to work with the MIST team to focus on those individuals most at risk of losing their housing. In addition, case management staff will work with Resident Managers on "best practices" to increase support when case management staff are unavailable on nights and weekends.

Client Success Story: Tenant B is a 42-year-old Vietnamese man that was chronically homeless and living on the streets of Pasadena for over 10 years. Due to the nature and severity of his chronic mental condition and disabilities, he completely isolated himself from everyone including his family. Tenant B didn’t receive any type of services or treatment during the time he was living on the streets, until a Pasadena area outreach team found him and began the challenging process of building enough trust so that Tenant B could accept the assistance he so desperately needed.

After Tenant B was successfully treated for a serious mouth infection, the outreach team was able to

assist him into emergency housing at Union Station in Pasadena. During his emergency housing stay, Tenant B began receiving treatment for both his physical and psychological issues as well as regular case management . Tenant B's case manager focused on finding permanent housing.

Tenant B moved into Las Palomas Apartments during August of 2008, and he began receiving intensive case management services from both the A Community of Friends onsite case management team and the newly formed MIST Team. Tenant B's primary language is Vietnamese and his English is limited so the language barrier was initially a challenge. Case management staff worked with the MIST Team and located and referred Tenant B to services with staff who spoke Vietnamese, including a Vietnamese psychiatrist. Tenant B's chronic mental health condition gradually stabilized enabling him to more fully participate in both on-site and community services.

Tenant B is now regularly meeting with his doctor and taking his medications as prescribed. Due to Tenant B's stabilization and ongoing treatment, case management and the MIST team have been able to assist him with applying for and receiving SSI benefits, accessing and using public transportation, managing medication, improving and increasing life skills, and forming social relationships with others.

Transitioning from a life on the streets to one in an apartment can be difficult, and despite experiencing many challenges Tenant B has settled into his new, stable lifestyle. Tenant B has become a regular participant of on-site groups such as Community Meetings and Healthy Cooking Groups. Moreover, he has developed friends for the first time in many years.

Tenant B has made a great deal of personal progress over the past year, but his most important accomplishment was reuniting with his brother for the first time in over 10 years. Tenant B's quality of life has improved dramatically with permanent housing and much needed supportive services.

	fY
Number of organizations that your program has a formal collaboration for this project	1
Number of times collaborative partners met each month	25
Total amount ($) of HPI funding leveraged for project	$1,775,550
Percent of HPI funding leveraged for project	33%

	QTR
Number of participants who have enrolled into program during the reporting period	10
Number of participants who left the program during this period	7
Total number currently enrolled in program	328
Number of clients who received an assessment (if applicable)	n/a
Cost per participant	$2,645
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	2
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	0
Program Specific Question:	
Number of participants who received benefits (as a result of the program)	328

25b) Ocean Park Community Center (OPCC) HEARTH
Budget: $1,200,000 (City and Community Program)

Table D.2: OPCC HEARTH
FY 2008-09

(unduplicated count)	FY		FY
Homeless Individuals	246	Education	-
Chronic Homeless	193	Job training, referrals	2
Transition Age Youth	23	Job placement	-
Female	151	Food Stamps	1
Male	311	Shelter Plus Care	4
		Section 8	6
		SSI/SSDI	1
Hispanic	64	Medi-Cal/Medicare	1
African American	131		
White	230	Case management	100
Asian/Pacific Islander	9	Life skills	15
Native American	3	Mental health	6
Other	25	Health care	462
		Social/community activity	32
		Recuperative care	61
15 and below	11	Substance abuse (outpatient)	7
16-24	23	Transportation	50
25-49	247	California identification	3
50+	181	Veterans	1
		Legal	2
Moving assistance	8	Locker	5
Housing (emergency)	23		
Housing (permanent)	19	Case management (level III)	
Housing (transitional)	13	Average hours per case:	64
		Total number of hours:	1,397
		Caseload:	31
Longer-term Outcomes (at six months)			
Maintaining permanent housing			4
Obtained employment			2
Maintained employment			2
Health care			9
Good or improved physical health			6
Reunited with family			1

Successes:

- OPCC Project HEARTH provided 119 homeless individuals with primary health care from a Venice Family Clinic physician co-located at OPCC Access Center.
- Thirty-two clients receiving health care became engaged in case management services with 20 (63%) achieving temporary or permanent housing as follows:
  - Twelve individuals (38%) obtained emergency housing
  - Three individuals (9%) obtained transitional housing
  - Five individuals (16%) obtained permanent housing
  - Twenty-eight individuals received respite care at OPCC Samoshel referred from Venice Family Clinic and two local hospitals (St. Johns and SM/UCLA Medical Center), and 36% obtained temporary or permanent housing following a three-week respite stay.
- Increased coordination of discharge of homeless patients from local hospitals to OPCC.

Challenges:

- Lack of low-cost housing options for medically vulnerable clients with health/mental health conditions who are not able to earn a living wage and don't meet the criteria for SSI.
- Coordination/communication with local hospitals regarding a consistent process for discharge planning of homeless patients.

	FY
Number of organizations that your program has a formal collaboration for this project	4
Number of times collaborative partners met each month	2
Total amount ($) of HPI funding leveraged for project	$186,547
Percent of HPI funding leveraged for project	106%
Number of participants who have enrolled into program during the reporting period	119
Number of participants who left the program during this period	0
Total number currently enrolled in program	462
Number of clients who received an assessment (if applicable)	32
Cost per participant	$381
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	n/a
Program Specific Question:	
Number of participants who received benefits (as a result of the program)	3

Action Plan:

- Continue to develop strategies to improve the discharge process of homeless patients from local hospital emergency rooms and inpatient services.
- Conduct more outreach and training with local hospital discharge and emergency room staff.
- Increase attendance of local hospital staff to monthly HEARTH meetings.
- Improve data collection of costs and utilization to assess and compare pre and post utilization rates of respite care clients.

Client Success Story: Client M, an 81-year-old homeless women with congestive heart failure, has been living off and on in local area motels since 2005. OPCC staff discovered that at the end of each month when she runs out of SSI income she comes to the local hospitals for medical care and a place to stay. OPCC Access Center worked intensively with her and successfully secured permanent housing and transportation through the City of Santa Monica, Project Homecoming. The day before Mother's Day, she was reunified with her adult son and family living in another state. Client M had over 55 hospital visits during the past three years.

Efforts are underway through collaboration with OPCC, Venice Family Clinic, St. Johns Hospital and SM/UCLA Hospital to track related costs of hospital visits and emergency services provided by first responders.

25c) Catalyst Foundation for AIDS Awareness and Care - Supportive Services Antelope Valley
Budget: $1,800,000 (City and Community Program)

Table D.3: Catalyst Foundation
FY 2008-09 *Participant count was not updated; program is developing new system to track unduplicated numbers..*

	YTD		YTD
At-risk Individuals	816	Moving assistance	3
At-risk Families	50	Eviction prevention	2
		Rental subsidy	1
Female	492		
Male	561	Education	383
Transgender	2	General Relief	51
		Medi-Cal/Medicare	3
Hispanic	302	Section 8	2
African American	349	Case management	28
White	334	Health care	622
Asian/Pacific Islander	13	Life skills	383
Native American	9	Mental health care	55
Other	30	Transportation	65
		Food	88
15 and under	1	Pet food/vet care	99
16-24	436		
25-49	241		
50+	112		

Longer-term outcomes (6 months)	
Continuing to live in housing	720
Case management	28
Health care	555
Good or improved health	66
Mental health care	66
Good or improved mental health	66
Level 2 case management services	Quarter
Average for each participant per month	5 hours
Total hours for all participants	420 hours
Number of cases per case manager	28 cases
Number of organizations/agencies that your program has a formal collaboration for this project	33
Number of times collaborative partners met each month	1
Total amount ($) of HPI funding leveraged for project	$696,919
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	46%
Number of participants who have enrolled (entered) into program during the reporting period	720
Number of participants who left the program during this period	-
Total number currently enrolled in program	720
Number of clients who received an assessment (if applicable)	720
Cost per participant	$863
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	n/a

Successes: During this quarter we had two families that were at the verge of losing their home. As a result of getting assistance through the Catalyst Foundation, they managed to maintain their safe, affordable housing. The Catalyst Foundation continues to provide services to disenfranchised communities that are at high risk for homelessness. Services provided allow our clients to continue to maintain independent living arrangements and continue to be self-sufficient. Clients mention that a major burden is relieved by the supportive services assistance provided, which allows them to focus on other aspects of their lives that require more attention.

Challenges: During this quarter, the case manager position became vacant. The Case Manager resigned and our Supportive Services Coordinator as well as the Director of Supportive Services stepped in to

provide clients with case management services. Another challenge we experienced during this quarter has been accurately tracking client demographics and the different services we are currently providing.

Action Plan: The Director of Supportive Services is in the process of recruiting qualified candidates. We are in the process of developing a new tracking system to support our needs. The data management team will be meeting to come up with solutions to simplify the reporting process.

Client Success Story: We had a patient that came into our clinic diagnosed with AIDS. When he initially enrolled in our services, he could not walk and had lost a tremendous amount of weight. His T-Cell count was extremely low. However, after a few months of obtaining medical treatment and case management services, he was able to apply for the AIDS Drug Assistance Program and other supportive services such as food and transportation. He was able to obtain medications and nutritious food that helped him get well. As a result, he is currently in a healthy weight and able to walk on his own without assistance. The client mentioned that if it was not for the clinic and supportive services, he would have passed away. The client is very grateful and thankful.

25d) Homes for Life Foundation – Vanowen Apartments
Budget: $738,310

Table D.4: Homes for Life Foundation – Vanowen Apartments
FY 2008-09, January - June 2009

(unduplicated clients)	FY		FY
Homeless Individuals	24	Housing (permanent)	24
Chronic Homeless Individuals	4	Rental subsidy	24
At-risk Individuals	20		
		Case management	24
Female	20	Life skills	24
Male	28	Mental health care	24
		Transportation	24
Hispanic	3		1
African American	11	Food Stamps	22
White	27	Medi-Cal/Medicare	22
Asian/Pacific Islander	3	SSI/SSDI	22
Other	3	Social/community event	24
		Substance abuse treatment (outpatient)	8
16-24	1	Substance abuse treatment (residential)	5
25-49	26		
50+	21		

Level 2 case management services	
Average for each participant per month	10 hours
Total hours for all participants	300 hours
Number of cases per case manager	12 cases
Number of organizations/agencies that your program has a formal collaboration for this project	1
Number of times collaborative partners met each month	2
Total amount ($) of HPI funding leveraged for project	-
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	-
Number of participants who have enrolled (entered) into program during the reporting period	24
Number of participants who left the program during this period	0
Total number currently enrolled in program	24
Number of clients who received an assessment (if applicable)	24
Cost per participant	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	24
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	24

Successes: All clients have successfully maintained their housing for over three months. No six month outcomes have been completed as the project has only been open for three and a half months.

Action Plan: Staff will continue to work with clients on meeting their goals.

Client Success Story: Prior to one client's first psychological break, he went to live in Europe. He made a great success as a street artist. He was interviewed on television and in the newspapers. After his return to the States, he experienced his first break. After two years of being in hospitals and trying to deal with his illness, he found himself living in the streets. With the help of several not-for-profits and the County, his illness stabilized and he found temporary housing. Until he came to Homes for Life several months ago he did not have a permanent home. He is now doing well and is grateful to know he has a home no matter what the future brings. He did stop painting years ago and now he reports feeling free enough to paint again. This will be a process that will take time, but he is well on his way to taking back his talent as he has taken back his life. He would tell you that if it was not for Homes for Life giving him a real home of his own, he would not be painting at all. The security he now enjoys has given him the ability to express himself in his art work. A freedom that had been lost to him several years ago is now back.

25e) Hope Gardens Family Center (Union Rescue Mission (URM))
Budget: $1,853,510

Table D.5: Hope Gardens
FY 2008-09, January - June 2009

(unduplicated count)	FY		FY
Homeless Families	45	CalWORKs	45
(individuals)	133	Food Stamps	45
		Medi-Cal/Medicare	45
Female	86	Section 8	5
Male	47	SSI/SSDI	3
		Veterans	2
Hispanic	24		
African American	66	Case management	45
White	25	Life skills	45
Asian/Pacific Islander	4	Mental health	22
Other	14	Health care	45
		Social/community activity	45
15 and below	72	Substance abuse treatment (outpatient)	16
16-24	16	Transportation	45
25-49	35		
50+	6	Case management (level II)	
		Average hours per case:	13
Moving assistance	6	Total number of hours:	360
Housing (emergency)	3	Caseload:	13
Housing (transitional)	45		
Housing (permanent)	4	Education	90
		Job training, referrals	22
		Job placement	5
Longer-term outcomes (6 months)			
Continuing to live in housing			9
Receiving rental subsidy			4
Case management			32
Health care			32
Good or improved health			25
Substance abuse treatment (outpatient)			5
No drug use			27
Reunited with family			6

Clients stayed an avg. of 650 days in temporary housing; four participants were placed into permanent housing.

Successes: During the course of this contract term, Hope Gardens transitioned 38 of 70 families receiving services at our transitional living facility. Sixty-five percent of our families transitioned into permanent housing in FY 2008-09. The transitioning families were part of the total 70 families served (146 individuals/family members) this year, of which 37 families (87 individuals/family members) are still housed at Hope Gardens. The 37 families transitioned into the following areas:

- Four families (15 individuals) were housed in Fair Market Housing

- Nine families (24 individuals) were housed with Section 8 housing.
- Five families (20 individuals) were permanently relocated into low income housing.
- Three families (five individuals) were permanently housed with family and friends.

Challenges: During the course of this fiscal year, we continue to learn, evaluate, and modify program services to meet the demanding needs of our diverse population. Many of our families face additional challenges in the area of housing affordability; to name a few - many families were promised housing vouchers from numerous programs, however, these resources have all been unable to provide these resources leaving the families frustrated. They are burdened with the enormous task of securing living wage employment with minimal job skills; and many have been unsuccessful in finding affordable/subsidized housing to meet their individual family needs. As a result of these challenges, Hope Gardens has strengthened its Employment/Vocational Development Department, by adding a new Director, to assist families in securing employment or increasing their skill/educational levels in this demanding employment market. Hope Gardens is a comprehensive program with a wide variety of opportunities available for those wanting to break the cycle of homelessness. Families are faced with ever changing challenge both internally and from the external environment. Hope Gardens and staff is meeting those challenge with each family as we continue to work with our participants to identify barriers and get beyond the history and challenges that have kept them from achieving (and exceeding) their goals. It is our hope that our outcomes during the next fiscal year will exceed those of FY 2008-09.

Action Plan: Hope Gardens will continue to work through challenges that are presented either in our program design and/or with our families. We vow to consistently evaluate our services, staff and program to ensure that we are providing excellent care to the families served at Hope Gardens. This includes establishing very realistic and specific timelines and individualized service plans with each family without trying to fit them into a “one size fits all” mold that is unachievable for many families that we serve. It is our desire to increase the number of families being served until we reach our maximum capacity once renovations are completed on additional buildings.

Client Success Story:
“I am a single mom from New Jersey. I have three minor children (two teen age boys and one teenage daughter), a young adult daughter and one grandson. We moved to Los Angeles, in August 2007 to help my sister with her son. We were living in a two bedroom apartment. I was able to secure employment, but it did not pay enough to be able to pay the entire rent. My sister was unable to find a job to cover her half of the rent and bills. We eventually got evicted from our home. My children and I stayed in a few different hotels until all my money was gone, and I was unable to keep my job.

In my search for assistance, I was able to obtain safe temporary refuge with a classmate and her family for my 12-year-old daughter. During the process, I also found that the majority of emergency shelters and transitional housing programs in Los Angeles did not accept young males 10 years and older. My family was in crisis; eventually we made a decision to have my sons join Job Corp which provides immediate stability through housing and educational opportunities. My oldest daughter was living in a semi-stable environment of her own, but unable to assist us. In my search, I found information about Union Rescue Mission (URM) at the local library and we received immediate assistance. However; in an effort to get to the mission, I informed my sister of the housing options. Living in the Skid Row area of Los Angeles at the Mission, she showed no compassion and charged us $10 to drop us off there.

During our stay at the downtown URM facility, I was made aware of URM’s long-term transitional housing facility – Hope Gardens and given an opportunity to apply for residency. I was interviewed and accepted. The day I found out that we were moving to Hope Gardens brought great joy to my heart as well as lifted the tremendous burden I faced daily. Since we moved to California, there was nothing positive happening for us. I was losing hope and ready to give up. I had decided to send my children to Georgia to live with my younger sister while I stayed at the URM. Finally, during my stay at Hope Gardens, I was able to secure employment after obtaining my Class B certified license. The staff at Hope Gardens also assisted me in applying for low income housing as well as wrote a grant to help me secure transportation. Everything came together at once which ensured my family a smooth transition from homelessness to permanent housing. The only thing I can say is this, that Hope Gardens has been a blessing to us.”

25f) National Mental Health Association of Greater Los Angeles – Self Sufficiency Project for Homeless Adults and TAY Antelope Valley
Budget: $900,000

Table D.6: Self Sufficiency Project for Homeless Adults and TAY Antelope Valley
FY 2008-09, January - June 2009

(unduplicated count)	FY		FY
Homeless Individuals	24	Education	1
Chronic Homeless Individuals	52	Job training	19
		General Relief and Food Stamps	1
Female	38	Medi-Cal/Medicare	2
Male	38	SSI/SSDI	3
		CalWORKs	1
Hispanic	15	Case management	44
African American	42	Mental health	44
White	46	Health care	16
Native American	2	Social/community activity	16
		Substance abuse treatment (residential)	1
16-24	11	Transportation	38
25-49	43	Like skills	1
50+	22		
		Case management (level 2)	
Moving assistance	7	Average hours per case:	80
Eviction prevention	3	Total number of hours:	80
Housing (emergency)	1	Caseload:	30
Housing (transitional)	6	Average stay in emergency housing:	6 months
Housing (permanent)	5	Number to permanent housing:	15 participants

Longer-term Outcomes (at six months)	
Case management	16
Mental health care	8
Substance abuse treatment (outpatient)	1
Substance abuse treatment (residential)	1

	Qtr
Number of organizations/agencies that your program has a formal collaboration for this project	-
Number of times collaborative partners met each month	-
Total amount ($) of HPI funding leveraged for project	$115,382
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	55%
Number of participants who have enrolled (entered) into program during the reporting period	44
Number of participants who left the program during this period	0
Total number currently enrolled in program	60
Number of clients who received an assessment (if applicable)	44
Cost per participant	$1,069
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	n/a

Successes: The program has been able to meet members' basic needs, such as providing a safe place for the homeless to shower, do laundry, receive counseling, psychiatric treatment, case management, referrals, housing placement, etc.

Challenges: Locating affordable housing for members with a limited source of income continues to be challenging.

Action Plan: The program continues to research and locate more affordable housing as well as build more community relationships.

Client Success Story: We have been able to house seven members and assist a member with eviction prevention this quarter.

25g) National Mental Health Association of Greater Los Angeles – Self Sufficiency Project for Homeless Adults and TAY Long Beach
Budget: $1,340,047

Table D.7: Self Sufficiency Project for Homeless Adults and TAY Long Beach
FY 2008-09, April - June 2009

(unduplicated count)	Qtr		Qtr
Homeless Individuals	13	Case management	37
Chronic Homeless Individuals	21	Job placement	15
Transition Age Youth	3	Benefits assistance/advocacy	3
		Bus tickets	*94
Female	5	*number of tickets, not clients*	
Male	32	Emergency housing	3
		Average stay in emergency housing (day)	1
Hispanic	6		
African American	13		
White	16	Case management (level 3)	
Other	2	Average hours per case:	12
		Total number of hours:	45
16-24	3	Caseload:	12
25-49	19		
50+	15	Rental subsidy	2

	Qtr
Number of organizations/agencies that your program has a formal collaboration for this project	1
Number of times collaborative partners met each month	1
Total amount ($) of HPI funding leveraged for project	-
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	-
Number of participants who have enrolled (entered) into program during the reporting period	36
Number of participants who left the program during this period	-
Total number currently enrolled in program	37
Number of clients who received an assessment (if applicable)	37
Cost per participant	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	n/a

Successes: This grant has provided us the opportunity to serve members of our Homeless Assistance Program in ways that we were not able to previously. We are now fully staffed with a benefits coordinator, a housing coordinator, and day labor specialist. These staff collaborate with our Drop In Center Staff to provide much-needed support and case management services. The team has done well to familiarize themselves with the obligations of the grant.

Challenges: The recent decrease to Social Security benefits and the continued high cost of apartments in our community make finding affordable housing a particular challenge.

Action Plan: We will continue to build relationships with community landlords and employers and streamline linkages to the public benefits systems, if possible.

Client Success Story: There is a woman whom we have been working with in our drop in center for over two years. She has had continued difficulty maintaining permanent housing, and has been chronically homeless as a result. She was enrolled in the Self Sufficiency Project in early May, and with program staff assistance, she has been able to locate and obtain an apartment of her own. She will continue to receive follow up case management support in an effort to help her keep her housing, and possibly to explore employment opportunities.

25h) Skid Row Housing Trust – Skid Row Collaborative (SRC2)
Budget: $1,800,000

Table D.8: Skid Row Housing Trust
FY 2008-09, January – June 2009

(unduplicated count)	FY		FY
		Education	1
Chronic Homeless Individuals	100	Job training	20
		Shelter Plus Care	100
Female	30		
Male	70	Case management	98
		Mental health	65
Hispanic	7	Health care	64
African American	82	Life skills	35
Asian/Pacific Islander	18	Social/community activity	139
More than one race/ethnicity may be selected		Substance abuse treatment (outpatient)	76
		Substance abuse treatment (residential)	1
16-24	1	Transportation	18
25-49	49	Benefits advocacy	31
50+	50	Case management (level 3)	
		Average hours per case:	9
Rental subsidy	100	Total number of hours:	1,144
Housing (permanent)	100	Caseload:	22

	Qtr
Number of organizations/agencies that your program has a formal collaboration for this project	2
Number of times collaborative partners met each month	2
Total amount ($) of HPI funding leveraged for project	$193,747
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	77%
Number of participants who have enrolled (entered) into program during the reporting period	15
Number of participants who left the program during this period	4
Total number currently enrolled in program	96
Number of clients who received an assessment (if applicable)	19
Cost per participant	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	15
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	4

Successes: Our program began in February 2009. At the end of this program period, 96 participants were enrolled. Our on-site integrated service team, which is comprised of staff from three agencies, continues to refine its operating procedures and modify the program to better meet the needs of our residents. We were fully staffed in mid-June with the arrival of our Benefits Specialist.

Challenges: We have not experienced any significant challenges this quarter.
Action Plan: N/A

Client Success Stories: Client E is 37 years old. Prior to moving into the Abbey Apartments, he had been homeless for about eight years. The process of entering subsidized housing can be a frustrating one – it involves a lot of waiting and a lot of paperwork. “E” spent much of his waiting time carrying on a quiet conversation with himself. “E” has schizophrenia of the paranoid type. During his brief face-to-face interview with our staff, he struggled to coherently answer the questions he was asked. His efforts during the interview (if not his answers) clearly communicated his desire to be housed. When “E” moved into the Abbey, he had a long beard, poor hygiene, and very dirty clothes. He was not receiving any mental health services. Today, “E” is close shaven and his clothes are not only clean, but pressed! He drops by his case manager’s office almost every day just to say good morning. He works with the mental health staff and has started taking medication for his schizophrenia. He has been able to forge a friendly relationship with the mother of his son who he visits weekly. “E” recently spent the day with many of his Abbey neighbors on a day trip to Knott’s Berry Farm. He went on almost all the rides, played carnival games, and won a stuffed bear for his son. “E” has worked hard and accomplished an amazing number of personal goals in a very short time. He looks to the future with great optimism.

25i) Southern California Alcohol and Drug Programs (SCADP), Inc. - Homeless Co-Occurring Disorders Program
Budget: $1,679,472 (City and Community Program)

Table D.9: SCADP
FY 2008-09

(unduplicated clients)	FY
Homeless Individuals	81
Homeless Families (individuals)	5 / 12
Transition Age Youth	9
At-risk Individuals	29
Female	16
Male	86
Hispanic	44
African American	23
White	32
Native American	1
15 and under	8
16-24	11
25-49	71
50+	15

	FY
Housing (transitional)	3
Mental health care	93
Substance abuse treatment (residential)	75
At six months:	
Continuing to receive mental health care	5
Good or improved mental health	4
Average length of stay for residents	55
Residents discharged due to graduation	18
Discharge status for residents of transfer	1
Discharge status for residents of walk-out	10
Discharge status for residents, violated rules	14

Number of participants who have enrolled (entered) into program during the reporting period	30
Number of participants who left the program during this period	43
Total number currently enrolled in program	27
Number of clients who received an assessment (if applicable)	23
Cost per participant	$1,000
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning/end*** of the quarter	n/a

Note: The last quarterly report showed a duplicated number of participants for this program. This report shows unduplicated numbers, and the cumulative total in Attachment A of this report has been adjusted.

Successes: We are now able to screen more of the clients entering our substance abuse treatment facilities. Every client screened for mental health services is already receiving substance abuse treatment and has a primary counselor. It is the substance abuse treatment staff who refers a client for a mental health screening. Any client who acknowledges a current or past history of diagnosis is automatically referred for supplemental services. All clients remaining in treatment for a month are screened regardless of prior history. A significant number of the people who are receiving services have no previous treatment. Such services include: substance abuse relapse prevention, parenting, GED or vocational prep, and life skills coursework. From our original grant, we have learned that people receiving these services have higher graduation rates and remain in treatment longer than those who do not. Grant staff work with the primary counselor to facilitate continued mental health care after leaving the program and have input into the client's treatment plan. This is the first quarter we have clients who have enrolled in the program for over six months. Four of the five clients who have been enrolled for over six months are reporting improved mental health, increased social involvement, and greater participation in 12-step programs. Those four are in stable housing and are sober. Recently, the fifth relapsed; we are still working with her.

Challenges: Our therapist took ill in May; his condition caused him to resign. Due to the California budget cuts, we expect significant funding cuts and have not replaced him. We are also working on incorporating the federally funded programs into this grant. We may request that our grant time frame be altered to be able to continue to provide these very important services. It may be four years until we can apply for another Center for Substance Abuse Treatment (CSAT) grant, when our Center for Mental Health Services (CMHS) grant expires.

Action Plan: We are waiting for the California budget to be signed, so we know where our agency stands with regard to our collateral funding sources. Additionally, we were not eligible to apply for a new federal grant this year despite that fact that our current grant (which the county grant is modeled after) will end on September 30th.

Client Success Story: The two clients who enrolled in community college passed their courses. One saved enough money to purchase a car; she no longer dreads going out with her toddler. Several more clients who are nearing six months have begun searching for employment and/or enrolled in school.

25j) Volunteers of America - Los Angeles, Strengthening Families
Budget: $1,000,000

Table D.10: VOALA
FY 2008-09

(unduplicated clients)	FY		FY
Homeless Families	52	Alternative court	3
(individuals)	240	Case management	106
At-risk Families	50	Life skills	47
(individuals)	217	Mental health	19
		Health care	21
Female	246	Social/community activity	28
Male	212	Substance abuse treatment (outpt.)	2
		Transportation	54
Hispanic	456	Food pantry	2
Other	2	Medi-Cal/Medicare	73
		CalWORKs	15
15 and below	228	General Relief w/Food Stamps	16
16-24	74	General Relief only	2
25-49	142	Shelter Plus Care	1
50+	13	SSI/SSDI	7
		Food Stamps only	33
Eviction prevention	10	Section 8	2
Moving assistance	17		
Housing (emergency)	12	Education	31
Housing (transitional)	4	Job training, referrals	52
Housing (permanent)	6	Job placement	18
Rental subsidy	4		

Average stay at emergency housing:	45 days
Number placed into transitional housing:	1 family
Level 2 Case management	
Average case management hours for each participant per month:	5 hours
Total case management hours for all participants during current reporting period:	335 hours
Number of cases per case manager:	22 cases

Longer-term Outcomes (at six months)	
Maintained permanent housing (through eviction prevention, linkages to jobs)	75
Receiving rental subsidy	4
Obtained employment	5
Maintained employment	13
Enrolled in educational program, school	9
Received High School Diploma/GED	1
Case management	81
Health care	59
Good or improved physical health	31
Mental health care	32
Good or improved mental health	32
Substance abuse treatment (outpatient)	1
No drug use	1
Reunited with family	2

Number of organizations/agencies that your program has a formal collaboration for this project	5
Number of times collaborative partners met each month	4
Total amount($) of HPI funding leveraged for project	$1,000,000
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	50%
Number of participants who have enrolled (entered) into program during the reporting period	105
Number of participants who left the program during this period	22
Total number currently enrolled in program	83
Number of clients who received an assessment (if applicable)	-
Cost per participant	-

Successes: During this reporting period, the strengthening family case managers assisted families in finding and obtaining affordable housing, transitional housing and emergency housing. Additionally, they also prevented many families from becoming homeless by assisting families with finding employment. The case managers took participants to various job fairs, employment agencies and community resource fairs, in addition to providing them with job leads and referrals. They also conducted a number of employment readiness workshops (including but not limited to a resume writing workshop) and continued to assist families with resume writing and other employment skills. The case managers actively worked on establishing community partnerships to better assist our families and established a number of MOU agreements with local agencies.

Challenges: Case managers encountered a lack of affordable housing for low income families with multiple family members and families that have a household member with disabilities. Additionally, many families did not qualify for conventional housing programs, because they lacked stable employment history, had bad credit due to foreclosure, and were unable to meet other rental requirements. In addition the lack of and limited number of suitable emergency shelters that house the whole family unit together has been another recurring challenge.

Action Plan: The program will continue effective case management for families, in addition to other supportive services. We will continue organizing and sponsoring community resource fairs where different agencies are invited to participate and provide information about their services/resources. For families that we have assisted through our housing and employment assistance services, we will be conducting three, six, nine, and 12 month follow-up. The follow-up will focus on issues of sustainability (i.e. increased income because of services/assistance, continued employment, and continued permanent housing). We will compare the monthly family income at the initial intake to the follow-up income and determine if there were any income increases as a result of the services and assistance provided by the case managers. The follow-ups will hopefully assist us in determining if our services/assistance has equipped our families with resources and tools that prevented them from again becoming vulnerable to homelessness.

Client Success Story: Through effective and compassionate case management, our case workers have assisted families with housing issues, such as finding affordable housing, emergency shelters, transitional housing, permanent housing, rental subsidies, and preventing evictions. By collaborating with other community agencies and service providers, the case managers have obtained employment, job leads, job referrals and job training for families. In addition, the case managers have taken program participants to various job fairs and continued to assist them with job readiness skills, such as resume writing. Also, the case managers have actively networked in the community, which has led to preventing a number of families from becoming evicted from foreclosed properties and finding housing for families with children with disabilities.

25k) Women's and Children's Crisis Shelter
Budget: $300,000

Table D.11: Women's and Children's Crisis Center
FY 2008-09

(unduplicated clients)	FY		FY
Homeless Families	42	15 and below	89
At-Risk Individuals	132	16-24	11
		25-49	32
Female	81	50+	-
Male	51		
		Housing (emergency)	81
Hispanic	111	Housing (transitional)	4
African American	11	Average stay in days *(for quarter)*	27
White	2	Number to shared living w/friends or family	7
Asian/Pacific Islander	6		
Native American	-	Life skills	14
Other	2	Mental health care	33
		Transportation	46

Program Specific Measures	**Quarter**
Number of hotline calls that are related to domestic violence issues.	194
Number of hotline calls that are related to homeless issues.	181
Of the calls related to domestic violence, the number of families/individuals at-risk of becoming homeless.	115
Number of individuals reunited with their families.	-
Number of families who have enrolled (entered) into program during the reporting period	13
Number of families who left the program during this period	13
Total number of families currently enrolled in program	6
Number of clients who received an assessment (if applicable)	-
Cost per participant	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	13
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	19

Successes: One of our clients at our transitional shelter is ready to enter the workforce and has been actively applying for job openings. In an effort to help build her resume, the client has been interning at our Administration office. As an intern, she has learned and performed basic office duties as well as practiced her customer service skills.

Challenges: We continued to have a difficult time finding transitional housing for our clients. Unfortunately, the lack of available transitional housing can create a burden for many families whom do not have a strong support system from friends or family.

Action Plan: Our shelter and transitional shelter clients will continue to receive individual counseling, support groups, parenting classes, and transportation.

Client Success Story: One of our families was accepted and entered into a transitional shelter. The head of household will continue to receive domestic violence support services. She entered with a permanent restraining order which our agency helped her obtain.

Note: The last quarterly report showed a duplicated number of participants for this program. This report shows unduplicated numbers, and the cumulative total in Attachment A of this report has been adjusted.

25l) City of Pomona: Community Engagement and Regional Capacity Building
Budget: $1,239,276

Table D.12: City of Pomona: Community Engagement and Regional Capacity Building
FY 2008-09, April – June 2009

	Quarter
Number of groups included in Consortium	52
Number of community meetings that the CEM and Consortium members attended	-
Number of speaking engagements (by CEM and Consortium)	-
Number of key leaders engaged with Consortium meetings	11
Number of cities actively involved in Consortium meeting	-
Number of strategies developed to eliminate barriers to service and housing delivery	-
Number of legislative, zoning changes, etc.	-
Number of cities actively engaged in strategic planning and/or community activity	7
Number of cities that designate a point person on staff to work on implementing recommendations	7

Successes: The Community Engagement and Regional Capacity Building program contract was executed on June 26, 2009.

Challenges: Our partner, Citrus Valley Health Foundation, has returned the West Covina Access Center back to LAHSA. LAHSA has in turn awarded this program to the Volunteers of America, who will be moving the Access Center. We are considering moving with the VOA, or looking at other locations that may better meet the needs of the CONSORTIUM and the CERC program. We will communicate closely with the CDC as this siting situation is resolved.

Action Plan: The San Gabriel Valley Consortium is meeting weekly to quickly implement the CERC program. Each agency has adopted an area of responsibility. We are doing as much of the initial infrastructure work as we can ourselves in order to save HPI money for the actual resource linkages delivery.

25m) City of Pomona: Integrated Housing and Outreach Program
Budget: $913,975

Successes: IHOP's greatest success is its collaboration and partnership with local agencies, as well as, its reputation in the community. We have gained the trust of our population. We have successfully been placing individuals and families on fixed incomes into transitional, supportive and permanent housing. We have increased our pool of resources to best serve our growing client base.

Challenges: The biggest challenge we face is the gap in services provided for GR recipients. Many of our chronically homeless clients receive GR as their sole benefit and source of income and there is a lack of affordable housing opportunities for these clients. Also, providing funding for services up front for reimbursement grants is always a challenge.

Action Plan: We are continuing to seek safe and suitable housing opportunities for clients on General Relief. We are constantly expanding our network efforts within the community to increase resources. We are also actively seeking placement options for clients with mental health issues as beds for these clients in this area are insufficient.

Client Success Story: Due to alcoholism, Client F, a 58-year-old Hispanic male, has been living in his truck for several years. The client came to the IHOP program truly ready for a change. We placed him in a motel while awaiting admittance to American Recovery Center's detoxification treatment program. After completing a 10-day detox, he entered our Pomona Transitional Living Program last May. The client continues to reside there successfully, clean and sober. Client F is now working part-time as a dental technician. He attends at least one Alcoholic Anonymous meeting a day.

Table D.13: City of Pomona: Integrated Housing and Outreach Program
FY 2008-09, April – June 2009

(unduplicated clients)	FY		FY
Homeless Individuals	2	Eviction prevention	4
Chronic Homeless	3	Housing (emergency)	5
Homeless Families	4	Housing (transitional)	6
(individuals)	12	Housing (permanent)	1
Transition age youth	1	*Four families have spent 35 days in transitional housing to date.*	
Female	9	Job training	1
Male	9	Job placement	2
		CalWORKs	1
Hispanic	5	General Relief (and Food Stamps)	1
African American	13	Case management	11
15 and below	6	Health care	3
16-24	4	Life skills	6
25-49	5	Mental health care	1
50+	3	Social/community event	3
		Substance abuse treatment (outpatient)	3
		Transportation	4
		Food	7

Other	Quarter
Number placed in the Transitional Living Center (TLC)	n/a
Number of participants who remain in the TLC for at least six months	n/a
Number compliant with housing plan (keeping appointments, etc)	1
Average change in income for TLC participants (annually)	n/a
Number of agencies that use a uniform client consent form	-
Number of meetings held by Faith-based Committee	-
Number of organizations regularly participating on the Committee	-
Number of website hits for online directory (if available)	-
Number of agencies that are active on the POCC (based on meeting record attendance)	28
Number of service delivery recommendations implemented by the Committee and PCOC	-
Number of new collaborative relationships with landlords/owners/providers	2

VI. COUNCIL OF GOVERNMENTS (COGs)

26a) San Gabriel Valley Council of Governments
Budget: $200,000 (On-going)

In April 2009, a study team consisting of the Corporation for Supportive Housing, Shelter Partnership, Inc., Urban Initiatives, and McDermott Consulting, presented the San Gabriel Valley Regional Homeless Services Strategy Final Report to the San Gabriel Valley Council of Governments (SGVCOG). The final report included a summary of priorities presented by sub-regional cluster group and the following key issues were identified.

- First Priority: Permanent Supportive Housing
- Second Priority: Short-Term Housing (Emergency Shelter & Transitional Housing)
- Third Priority: Access Center

Implementation Strategy and Recommendations
A summary of five-year housing and service targets was presented by cluster group. Overall for the region, three strategic objectives, related recommendations, and a timeline were presented.

Strategic Objective I: Develop Leadership, Political Will, and Community Support

- Recommendation 1: Create a Valley-wide Membership Based Organization for the Primary Purpose of Education, Advocacy, and Coordination
- Recommendation 2: Meet and Confer with Municipal Leaders, Community Groups, Business Leaders, Faith-based and Community Service Providers within the San Gabriel Valley

Strategic Objective II: Build Provider Capacity and Expand the Service Delivery System

- Recommendation 1: Engage Community and Faith-based Service Providers in Planning, Training and Overall Capacity Building
- Recommendation 2: Create More Housing Opportunities for Homeless Persons in the San Gabriel Valley
  - √ 588 units of permanent supportive housing over the next five years
  - √ 150 emergency shelter beds and 300 transitional housing beds for single individuals over the next five years
  - √ Scattered-site housing programs to serve 100 families annually
- Recommendation 3: Create an Access Center in Cluster Five (Claremont, Diamond Bar, Glendora, La Verne, Pomona, and San Dimas)
- Recommendation 4: Develop Valley-wide Referral and Information Sharing System

Strategic Objective III: Leverage and Maximize Utilization of Available Financial Resources

- Recommendation 1: Form a San Gabriel Valley Supportive Housing Pipeline Review Committee
- Recommendation 2: Commit Local Investments from Municipalities Across Multiple Jurisdictions within the San Gabriel Valley to Stimulate Housing Production
- Recommendation 3: Utilize New Funding Opportunities to Expand Short-term Housing and Rapid Re-housing Programs

26b) PATH Partners/Gateway Cities Homeless Strategy
Budget: $135,000 (On-going)

PATH Partners presented the Gateway Cities Homeless Strategy to the Gateway Cities Council of Governments (GCCOG). The first three categories (LEAD, ENGAGE and COLLABORATE) provide recommended actions that will build the leadership and infrastructure required to plan, develop and successfully start up the proposed programs and services presented in the IMPLEMENTATION category of the strategy.

The LEAD phase includes identification of a current or new regional leadership entity as well as designating a “Homeless Liaison” for each city. The ENGAGE phase involves formation of a stakeholder

regional homeless alliance, implementation of “connections” strategies to engage the community, and development of a public education campaign. Third, the COLLABORATE category focuses on enhanced government-wide collaboration. Specific strategies include: leveraging $1.2 million of County HPI funds to secure matching dollars within the region, exploring opportunities to secure funding from the American Recovery and Reinvestment Act of 2009, and organizing and coordinating the GCCOG cities to apply for additional funding; and coordinating a region-wide, multi-sector homeless collaborative event that integrates services and resources across agencies and departments, including government departments, service providers, faith groups and the business community. One example of an effective event that has produced demonstrated results in several communities are “homeless connect days.” The County of Los Angeles currently sponsors events that brings together hundreds of volunteers to engage homeless people and connect them to needed services all on one day.

The IMPLEMENT phase consists of four categories of implementation actions that are proposed as part of the Gateway Cities Homeless Strategy, which are all very closely intertwined and form a mini-“homeless strategy” in a region that effectively assists homeless individuals and families to move from the streets into housing and long-term independence –

√ **Homeless Prevention Services**: The region will create a minimum of two new homeless prevention programs over the next 12 months to provide prevention services to the homeless. A target goal is to have a total of four programs formed (one in each of the four group areas of the GCCOG region), over the next 3-5 years to provide accessible prevention services to those in need. Each homeless prevention program will serve 500 unduplicated individuals annually, providing screening and assessments, prevention programs and housing assistance.

√ **First Responders Program**: Geographic-based street outreach team(s) would serve as “first responders” and coordinate with local law enforcement, service providers, hospitals, businesses and others. Teams would be comprised of staff and/or volunteers, and would be multiPATH Partners 2009 disciplinary, utilizing staff from existing mental health providers, substance abuse treatment providers, county agencies, and faith groups. The GCCOG region will create a minimum of two new outreach teams over the next 12 months to provide outreach services to the Gateway Cities. A target goal is to have a total of four teams operating (one in each of the four group areas of the GCCOG) over the next 3-5 years to provide more accessible outreach services. Each outreach team will engage 80 new unduplicated homeless individuals and assist them in connecting to services annually.

√ **Interim Housing**: Develop a strategy to “rapidly re-house” individuals into interim housing, with the end goal of long-term housing. This approach will be linked to street outreach teams and will focus on intensive housing and placement assistance upon entry into interim housing, and will include linkages to housing subsidies, rental assistance programs and other supportive services. Cities/communities would place special emphasis on connecting existing interim beds and programs to street outreach, homeless prevention services, permanent supportive housing and other supportive services. The region will create a minimum of two new interim housing programs (30-40 beds per program) over the next 12 months. A target goal is to have four new interim housing programs (one in each of the four group areas in the region) over the next 3-5 years to provide housing. Each new program will serve 100 unduplicated homeless individuals annually, providing them with housing, case management and assistance in connecting to long-term housing opportunities and supportive services.

√ **Permanent Supportive Housing (PSH)**: Create a multi-year plan to increase the stock of PSH units in the GCCOG region. A proposed goal for the region is to invest in the creation of 665 units of PSH over the next five years (2010 to 2014). The production goal of 665 new units will double the number of available supportive housing units. The goal is based on an assessment of the available funding resources the GCCOG will be able to realistically access to support the creation of new PSH units. The breakdown of the 665 unit production goal over five-years includes: one 40 unit development, 175 units of smaller PSH projects and set aside units, and 450 scattered-site leasing units. A plan will be developed for acquiring further rental vouchers and/or creating more subsidized housing in the region for homeless families and single adults who do not require supportive housing but do require affordable housing in order to end their homelessness as they transition out of interim housing.

27) Los Angeles Homeless Services Authority (LAHSA) Contracted Programs

Goal: Emergency shelter and transitional housing are provided to families and individuals.
Budget: $1,735,000 (One-Time Funding)

Of these nine programs, seven program ended as of March 15, 2009; and two programs will end on June 30, 2011.

Table E.2: LAHSA Participants and Services

(unduplicated clients)	FY 2007-08	FY 2008-09	Total		FY 2007-08	FY 2008-09	Total
Homeless Families	483	275	758	Adult**	6,064	1,550	7,614
Homeless Individuals	3,162	890	4,052	Child	1,029	444	1,473
Chronic Homeless	2,206	336	2,542	Transition Age Youth		91	91
Female	1,938	493	2,431	Emergency housing	5,869	1,462	7,331
Male	3,931	1,003	4,934	Transitional housing	-	156	156
Hispanic*	1,385	647	2,032				
African American	2,838	636	3,474				
White	2,004	1,097	3,101				
Asian/Pacific Islander	151	83	234				
Native American	168	110	278				
Other	1,598	99	1,697				

*LAHSA uses the federal definition of Hispanic origin (which for the Feds includes all Spanish speaking nations in the Americas and Spain). There are two options: Hispanic or Non-Hispanic.

**The U. S. Department of Housing and Urban Development (HUD)defines an adult as a person 18 years of age or older. LAHSA uses the HUD definition of adult in its data collection process.

28) PATH Achieve Glendale

Budget: $150,000 (One-Time Funding)

Table E.3: PATH Achieve Glendale
FY 2008-09, January – June 2009

(unduplicated clients)	YTD		YTD
Homeless Individuals	337	15 and below	209
Chronic Homeless	92	16-24	114
Homeless Families	*183	25-49	472
(Individuals)	550	50+	183
Female	515	Housing (emergency)	124
Male	464	Housing (transitional)	**29
		Housing (permanent)	119
Hispanic	302		
African American	402	Case management	520
White	249		
Asian/Pacific Islander	16		
Native American	10		

*A total of 550 individual family members was served; the number of families was calculated by dividing by three (estimated average family size).

***Transitional and permanent housing placement was estimated based on the ratio of transitional to permanent housing placements indicated in HMIS reports. The total number of placements (61 residents) was verified by an Emergency Housing Program report.*

Successes: Access Center case managers served 232 individuals and 183 families (estimated number based on total number of family members served) experiencing homelessness during the reporting period. Some were living on the streets of Los Angeles County, others in a variety of shelter or housing programs. As of March 2009, 86 women, men, girls and boys were admitted into the 60-90 day Emergency Housing Program at PATH Achieve Glendale (PAG). Fifty-four percent of the households in Emergency Housing saved at least $500. Fifty-three percent increased their life skills by accessing at least two supportive services. Of those who exited the shelter program, 73% were placed in permanent or transitional housing.

Challenges: PATH Achieve Glendale staff and managers have been working with City of Glendale administrators of the Homeless Management Information System (HMIS) to perfect the data and work bugs out of the system; however, there are still barriers to getting reliable reports based on the entered data.

Also, there is the ongoing challenge of placing local chronically homeless from the street into housing.

Action Plan: More regular meetings between PAG and City staff have been scheduled to address lingering issues and structure is being developed for documenting issues as they are identified.

A team is being assembled across disciplines and agencies to address the special needs of the most vulnerable on the street in Glendale in time to take advantage of five new Shelter + Care units.

Client Success Story: (Letter from a client) “When I came to PATH Achieve Glendale in March 2009, I was frightened and didn’t know what to expect, being this was the first time I’ve been without a home. Tears were flowing and I couldn’t stop them. Then I heard that PATH Achieve Glendale has a stress management class on Wednesday mornings. I went the next Wednesday and really enjoyed how the social worker taught her class so I made an appointment the same day for an individual eye movement desensitization and reprocessing (EMDR) appointment. Within two weeks the tears stopped flowing. I cannot tell you how much the social worker has helped me, she brought me through some painful things I shared. Her training skills really work and I use them today when I’m going through difficult situations. She has been a blessing to me. She’s very kind and easy to talk to. I thank God that PATH Achieve has such a wonderful program.”

A 74-year-old client has been working diligently with her case manager to meet her goals, including establishment of savings from her Social Security income, obtainment of necessary medical care for a chronic respiratory condition, and application for affordable housing. The client’s application for subsidized housing has been accepted at a lovely building for seniors in the San Fernando Valley. She plans to move into her new apartment by July 1, 2009.