County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

February 11, 2010

To: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
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 (50,000 people). Various social and economic factors, as well as gaps in available housing and social services, have contributed to the crisis.

On April 4, 2006, your Board approved the County Homeless Prevention Initiative (HPI) in response to this crisis. The HPI consisted of two categories of funding: 1) $15.4 million in funding for ongoing programs; and 2) $80 million in one-time funding to develop innovative programs. Both funding categories are to focus on reducing or preventing homelessness. In approving the HPI, your Board directed the Chief Executive Office (CEO) to coordinate the preparation of quarterly status reports beginning in September 2006, providing your Board with implementation updates and analysis of results of the various HPI programs in reducing and preventing homelessness.

The CEO 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 September 2009, the HPI has been tremendously successful in implementing 30 programs and serving nearly 34,500 individuals and 15,500 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
- Discharge planning (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) 2009-10, First Quarter;

2. HPI Status Report (Attachment A): The FY 2009-10 First 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 Jacqueline White, Deputy Chief Executive Officer at (213) 974-4530, or via e-mail at jwhite@ceo.lacounty.gov.

WTF:JW:KH
VKD:hn

Attachments (3)

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

Los Angeles County
HOMELESS PREVENTION INITIATIVE (HPI)

FY 2009-10, JULY – SEPTEMBER, FIRST QUARTER EXECUTIVE SUMMARY

Above: At the Center for Community Health Downtown Los Angeles Grand Opening *from left*: Fred Ali (Weingart Foundation), Gregory Scott (Weingart Center Association), and Al Ballesteros (JWCH Institute, Inc.).
Top left: The Center's Registration. *Bottom from left*: Care Team members: Karina Manayan, Bianca Gurrola, Dr. Sarah Carpenter, and Beatriz Torres.

SPOTLIGHT ON HEALTH CARE FOR THE HOMELESS

Approximately 5,000 homeless people live in the Skid Row area in downtown Los Angeles. Knowing that about 70% of the County's homeless population suffers from mental illness, substance abuse problems, or AIDS/HIV-related illness, the majority of these individuals have multiple medical needs. However, without regular health care, high utilization of ERs and lengthy inpatient stays have dramatically increased cost. By providing access to a medical home, health outcomes for individuals would improve.

In July 2009, JWCH Institute, Inc., in partnership with the County of Los Angeles, and the Weingart Center Association, opened the Center for Community Health Downtown Los Angeles (CCH), a state-of-the-art, 21,000 square foot medical facility, made possible by the Weingart Foundation and other funders. Serving the homeless and low-income communities in and around Skid Row, CCH offers medical, mental health, substance abuse services, dentistry, ophthalmology, and pharmacy. The CCH is a result of collaboration among public and private partners committed to enhance access to health care through an innovative and integrated model.

On October 29, 2009, representatives from the Offices of Congresswoman Roybal-Allard, the County Board of Supervisors, the Mayor, Weingart, and JWCH attended the Center's ribbon cutting ceremony for an official grand opening. Expected to provide health care to 9,000 patients annually, the Center's dedicated team provided care to 2,377 new patients during July-September 2009. Moreover, linkages with community-based organizations connect patients with job training and housing. Fred Ali, president and CEO of the Weingart Foundation remarked, "[The Center] is an exciting culmination of community efforts to address the important health care needs of individuals in downtown Los Angeles."

The HPI has served nearly 34,500 individuals and 15,500 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
$9,763,711

Eviction Prevention
Moving Assistance
Rental Subsidy

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

- **4,856 individuals and 10,641 families received housing assistance, which prevented homelessness.**

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

DISCHARGE PLANNING
$7,324,964

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

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

- **3,738 clients received public benefits.**
- **171 clients placed into permanent housing.**
- **90% decrease in inpatient days and 83% decrease in ER visits a year post enrollment.**

GOAL 2: REDUCING HOMELESSNESS

COMMUNITY CAPACITY BUILDING
$3,475,422

City and Community Program (CCP)
Revolving Loan Fund

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

- **3,260 individuals and 531 families received 8,759 linkages to supportive services and 893 housing placements.**

REGIONAL PLANNING
$3,250,000

Homeless Services
Long Beach Homeless Veterans

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

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

SUPPORTIVE SERVICES INTEGRATION AND LINKAGES TO HOUSING
$11,083,464

Case Management
Housing Locators
Multi-disciplinary Team/Access Center

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

- **12,377 individuals and 6,101 families placed into emergency, transitional, and permanent supportive housing.**
- **26,027 linkages to integrated supportive services enhanced participants' well-being.**
- **9,408 individuals and families achieved greater self-sufficiency through public benefits, income support, and connections to employment opportunities.**

INNOVATIVE PROGRAM DESIGN
$17,044,622

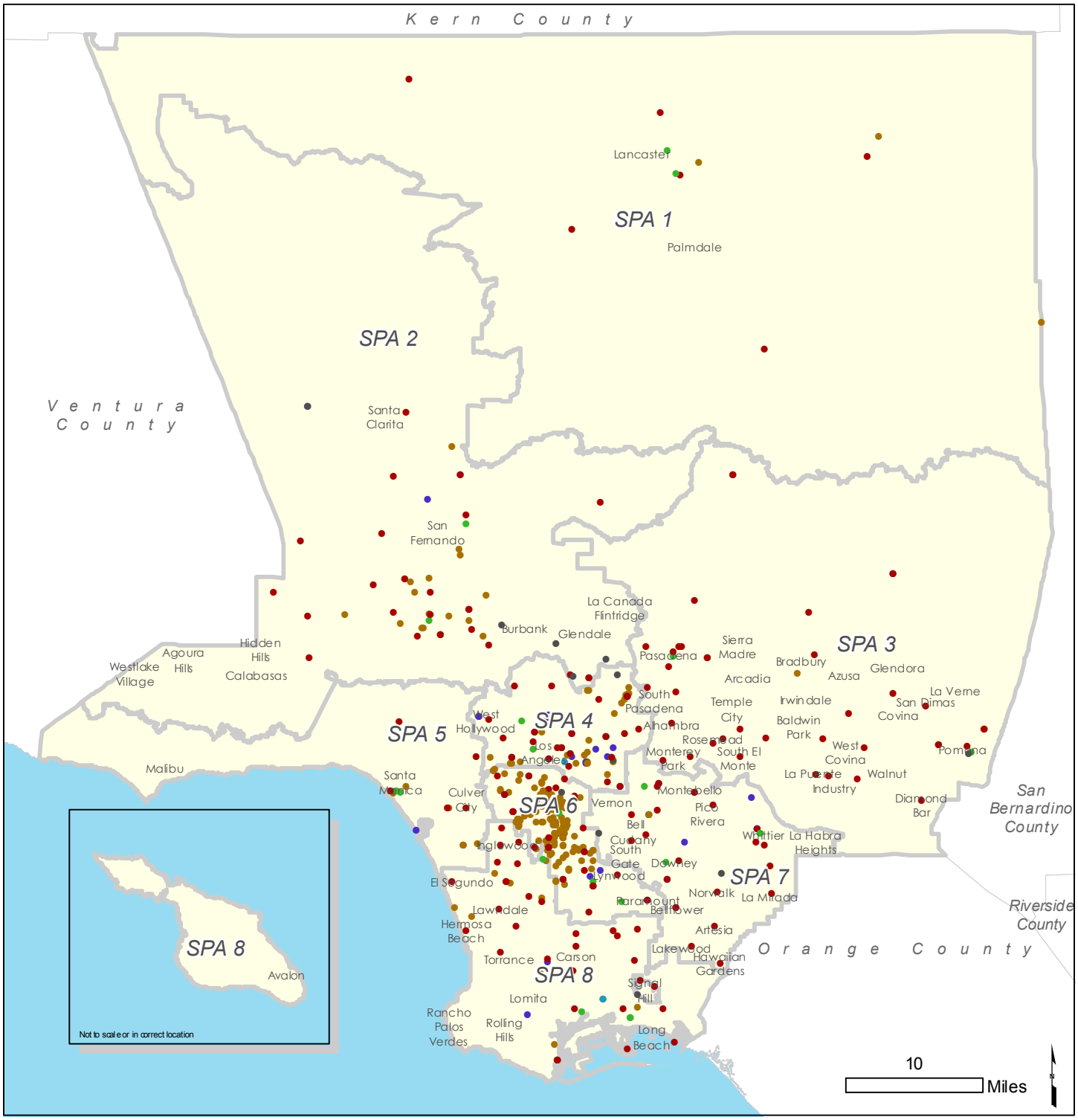
Project 50
Skid Row Families Demonstration Project
Homeless Court
Housing Resource Center
Santa Monica Service Registry

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.

- **75 chronic homeless individuals placed into permanent supportive housing.**
- **241 Skid Row families placed into permanent rental housing.**
- **Citations and warrants dismissed for 1,409 individuals.**
- **Over 3.6 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

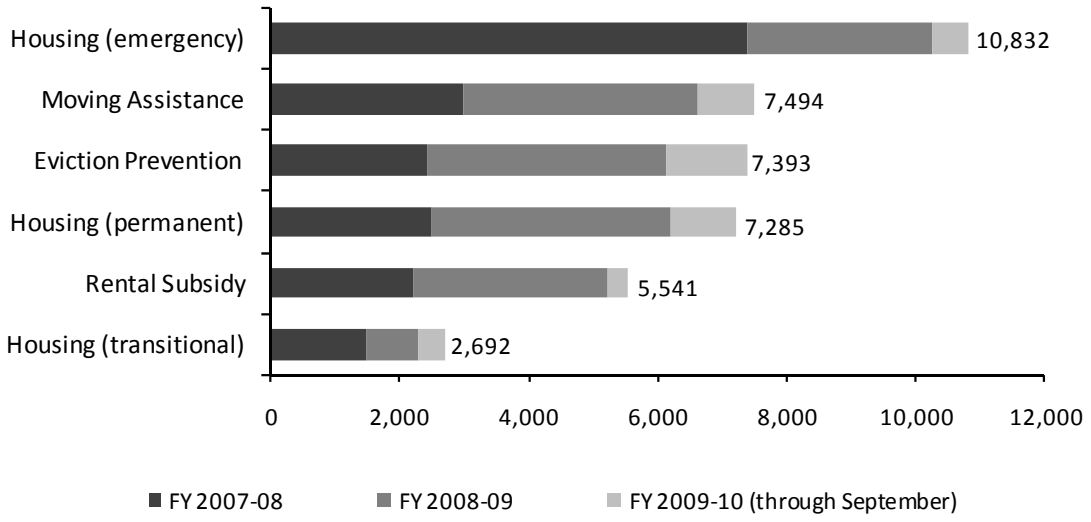
ii) Strategy 4 - Regional Planning includes San Gabriel Valley Council of Government Plan and Gateway Cities Homeless Strategy.

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 September 2009.

HPI Participants Receiving Housing/Housing Assistance



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 30 programs and serving nearly 34,500 individuals and 15,500 families. The initiative focuses on reaching the following two goals through six strategies shown below:

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

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

COUNTY OF LOS ANGELES

Homeless Prevention Initiative (HPI)
FY 2009-10, First 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 2009-10, First Quarter

I. INTRODUCTION

In accordance with your Board's direction on April 4, 2006, this report provides a status update on the implementation of 30 programs included in the Los Angeles County Homeless Prevention Initiative (HPI) during July-September of FY 2009-10. 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 34,500 individuals and 15,500 families.[1] This report features components of the HPI, associated outcomes, and opportunities to strengthen County homeless coordination.

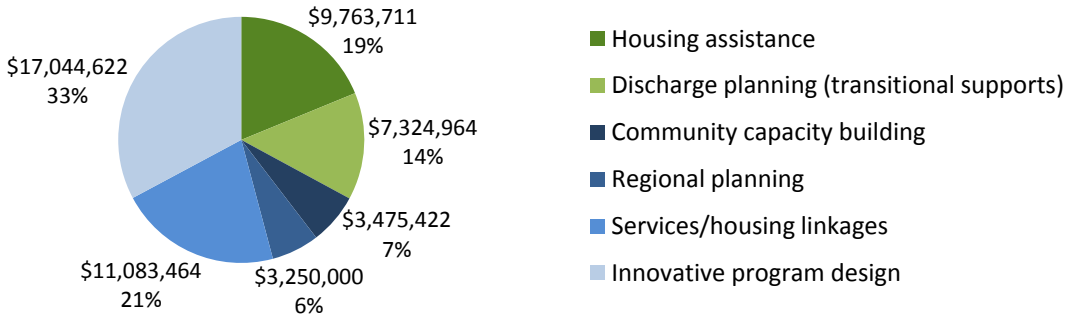
Goals and Strategies

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.

The following sections of the HPI status report provide an overview of participants and the initiative's progress in preventing and reducing homelessness.

II. PARTICIPANTS

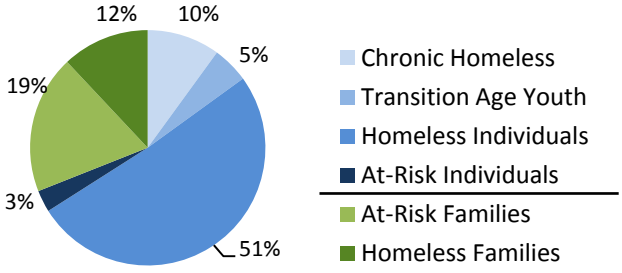
During the first quarter of FY 2009-10, 26 of 30 implemented HPI programs[2] directly served the County's homeless and nearly homeless. While several programs served more than one population, participants in 19 programs corresponded to one of five categories: homeless individuals (seven programs), chronic homeless individuals (four programs), transition age youth (two programs), homeless and at-risk families (six programs). Attachment B provides an overview of programs. To date, Table 1 shows HPI improved the lives of 34,503 individuals and 15,491 families.[3] During the first quarter, the number of families and individuals served increased by 16 and 20 percent, respectively.

Table 1: Number of Contacts by Participant Category
FY 2009-10 through September 30, 2009

	FY 2009-10*	FY 2008-09*	FY 2007-08	Cumulative	First Qtr. Increase
Homeless Individuals	4,829	8,722	12,206	25,757	23%
Chronic Homeless Individuals	288	2,181	2,443	4,912	6%
Transition Age Youth	77	1,100	1,122	2,299	3%
At-Risk Individuals	461	983	-	1,444	47%
Total for Individuals	5,655	12,986	15,771	34,412	20%
Homeless Families	241	1,860	3,950	6,051	4%
At-Risk Homeless Families	1,871	5,082	2,487	9,440	25%
Total for Families	2,112	6,942	6,437	15,491	16%
TOTAL	**7,767**	**19,928**	**22,208**	**49,903**	**18%**

*FYs 2008-09 and 2009-10: Returning participants were not included in order to calculate an unduplicated count.
Correction: In previous quarterly report, the cumulative number of transition age youth through June 30, 2009 was 2,222.

Chart 2: Percent by Participant Category



From upper right (clockwise) beginning with Chronic Homeless.

Chart 2 illustrates that of HPI participants, 69 percent were individuals and 31 percent were families. According to LAHSA, 12 percent of the total homeless population lives in families,[4] and homeless families made up 12 percent of all HPI participants. Of all HPI participants who were individuals, 51 percent were homeless adults, and five percent were transition age youth. Approximately one-fourth of the homeless in the County are chronically homeless,[5] while these individuals made up 10 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 2009 Greater Los Angeles Homeless Count.
[5] Ibid.

Participant Characteristics

During the first quarter, all 26 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. Due to different categorization for race/ethnicity and age, these statistics for LAHSA contracted programs are shown separately in Attachment B.

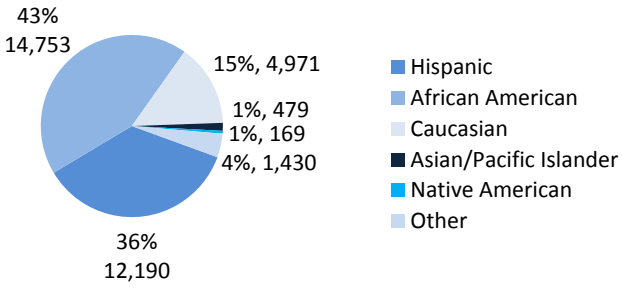
Gender

Approximately 67 percent of the homeless population in Los Angeles County consists of adult men.[6] Of the 34,038 participants whose gender was provided, 55 percent (22,168) were male and 45 percent (18,647) were female.

Race/Ethnicity

The total homeless population in Los Angeles County is 47 percent African American and 29 percent Hispanic/Latino. Chart 3 shows 43 percent of HPI participants were African American, 36 percent were Hispanic/Latino, and 15 percent Caucasian. The remaining six percent of participants included Asian/Pacific Islander, Native American, and other racial/ethnic groups.

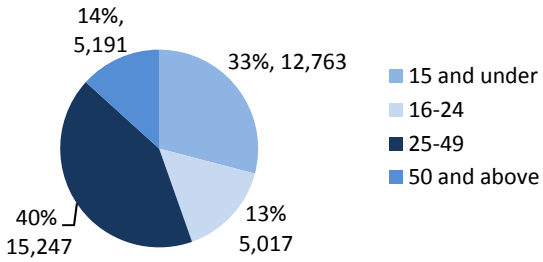
Chart 3: Race of HPI Participants (n=33,992)



Age

Of all HPI participants, a total of 40 percent was between 25-49 years of age. Chart 4 shows that of HPI participants whose age was provided, 33 percent were children 15 years of age or younger, 13 percent of participants were between the ages of 16-24, and 14 percent were 50 years of age and older.

Chart 4: Age of HPI Participants (n=38,218)



[6] LAHSA 2009 Greater Los Angeles Homeless Count.

III. GOALS, STRATEGIES, AND OUTCOMES

Goal I: Preventing Homelessness

Strategy 1 Housing Assistance $9,763,711

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

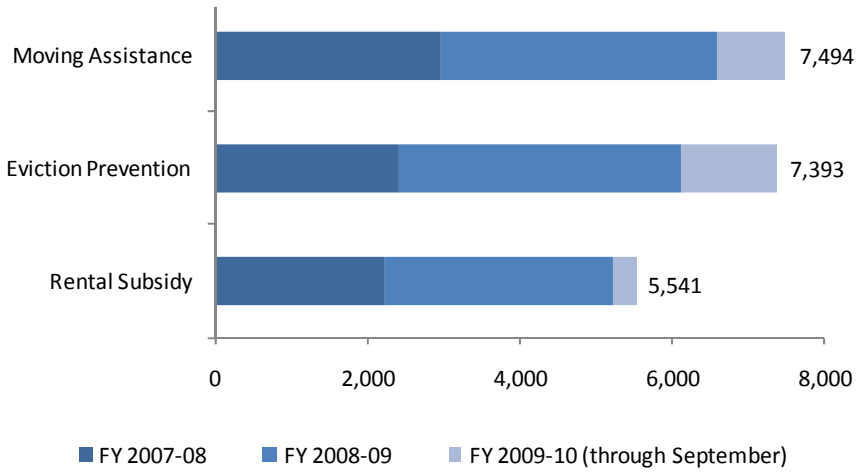
Eviction Prevention • Moving Assistance • Rental Subsidy

HPI programs provided housing assistance through moving assistance, eviction prevention, and rental subsidies; five programs focused on these services. ***Through September 2009, a total of 15,497 participants received housing assistance to secure permanent housing and prevent homelessness.*** A participant who received more than one type of housing assistance was counted once. Table 2 shows 69 percent of participants who obtained housing assistance were families, 25 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 obtained eviction prevention. Chart 5 shows the number of participants who received each type of housing assistance through September 2009.

Table 2: Through September 2009		Housing Assistance	Moving Assistance	Rental Subsidy	Eviction Prevention
Individuals	3,830	25%	2,745	4,497	94
Transition Age Youth	1,026	7%	580	930	2
Families	10,641	69%	4,155	376	7,271
Total participants	15,497	100%	7,480	5,803	7,367
Expenditures		**$9,763,711**	**$5,467,886**	**$688,274**	**$3,607,551**

The following participants were not included in Table 2: 143 participants who received moving assistance, 202 who received eviction prevention, and 150 who received rental subsidies.

Chart 5: Housing Assistance Provided to HPI Participants



During July –September 2009, the number of HPI participants who received eviction prevention and moving assistance increased by 40% and 31% respectively - the greatest quarterly rate increases for these HPI programs since FY 2007-08.

Strategy 2 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)

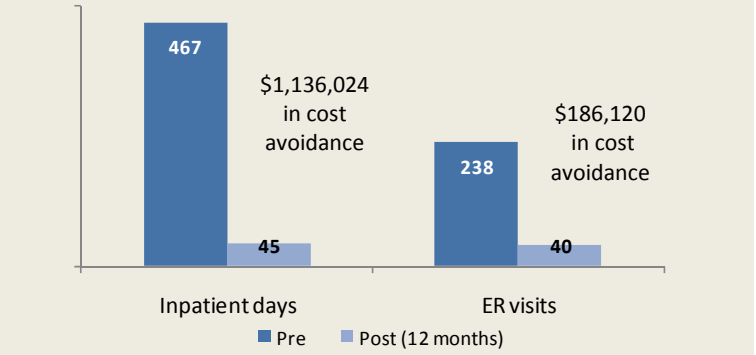
Discharge Planning for Hospital Patients

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 patients to 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.

Outcomes

- ***Improved Health***: Since March 2007, 40 AHH clients completed 12 months with an 83% decrease in ER visits and a 90% reduction in inpatient days.
- ***Cost Avoidance:*** After 12 months, a reduction in the number AHH patients' ER visits and inpatient days resulted in the cost avoidance of $1.3 million (Chart 6).
- ***Linkages to Public Benefits***: These programs made 614 connections to public benefits for individuals, including: Supplemental Security/Disability Income (SSI/SSDI), Medi-Cal, and General Relief (GR).
- ***Housing Stability***: AHH placed 73 individuals into permanent housing, and 96 percent (52 individuals to date) have maintained permanent housing for six months or more.

Chart 6: AHH Participant Outcomes and Cost Avoidance (n=40)



Discharge Planning for Individuals Released from Jails

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 served 5,086 individuals and made 3,124 connections to such public benefits as: GR, Food Stamps, SSI/SSDI, and Veteran's benefits.
- ***Housing Placement***: Housing locators have assisted 404 individuals with housing placement. Through the JIR program, 186 clients identified as homeless or chronically homeless have been released to housing, transitional living or a residential program.
- ***Transition to Communities:*** By offering case management to all JIR clients, 332 linkages have been made to job training/placement or education. 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 3,260 individuals and 531 families. They made ***8,759 linkages to supportive services and 893 housing placements***. Fourteen of 15 service contracts were executed.
- Nine capital projects were funded under the CCP. The CDC is in constant contact with all developers and set up internal tracking systems to monitor project progress. As of June 2009, the Bell Shelter project was completed to provide an additional 30 beds of transitional housing with supportive services for individuals. Loan agreements are being finalized for three capital projects. The progress of many projects has been delayed by the State budget freeze, and one project (Century Villages at Cabrillo) is awaiting State funding. Another project (Mason Court) is in need of additional gap financing. 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.

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. On July 28, 2009, $9.8 million was wired to the LACHIF. The Board of Commissioners approved a restructuring plan, and the LACHIF is negotiating investments by three financial institutions.

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.
- Over the next five years, San Gabriel Valley COG's Regional Homeless Service Strategy includes an objective to create 588 units of permanent supportive housing, and PATH Partners' Gateway Cities Homeless Strategy plans to create 665 permanent supportive housing units (Attachment B, p. 67).
- Long Beach Homeless Veterans served 275 veterans this quarter. Services included: case

management, child support reduction, mental health care, and housing. Single Parents United N Kids (SPUNK) closed 16 child support cases for a total arrears savings of $278,827. Due to the program's continued success, SPUNK is expanding services to the Veterans Affairs Medical Center and Beacon House, a residential substance abuse center that serves a large number of veterans. The Veterans Affairs Long Beach Healthcare System is scheduled to receive 105 HUD-VASH vouchers; through ongoing coordination between program and VA staff, these vouchers will provide veterans with housing stability.

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

Clients receive integrated supportive services and housing.

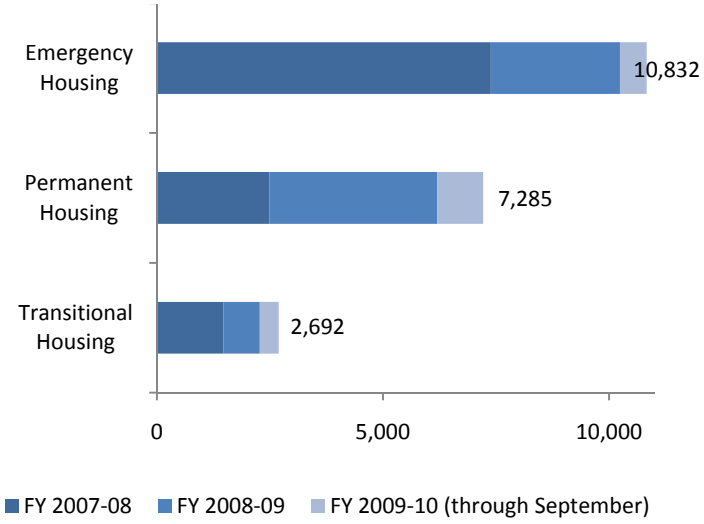
Case Management • Housing Locators • Multi-disciplinary Team/Access Center • Project Homeless Connect

Linkages to Housing – Chart 7 shows that a total of 7,285 participants received permanent housing. Of the total categorized by population, 64 percent were families, 11 percent transition age youth, and 25 percent individuals, as shown in Table 3. In contrast, 83 percent of individuals received emergency/transitional housing placement. This quarter, 19 programs placed participants into temporary housing. Participants in these programs spent an average of 79 days in temporary housing prior to permanent or transitional housing. Participant stay in temporary housing ranged from three to 180 days. Five programs focus on supportive services integration and linkages to housing. An example is the state-of-the-art Center for Community Health (CCH) Downtown Los Angeles, which is a collaborative effort of the Weingart Center Association, JWCH Institute, and the County of Los Angeles.

Table 3: Housing Placement through September 2009	**Emergency/ Transitional**		**Permanent Housing**	
Individuals	9,621	83%	1,693	25%
Transition Age Youth	287	2%	776	11%
Families	1,713	15%	4,388	64%
Total	**11,621**	**100%**	**6,857**	**100%**

Services not categorized by population above: 428 who were moved into permanent housing; 1,308 who were moved into transitional housing; and 595 who were placed into emergency housing.

Chart 7: HPI Participants Moved into 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 September 2009, 15 HPI programs reported a total of 2,138 participants received job and/or education related supports (Table 4). Fifty-nine 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. By supporting the employable homeless to overcome barriers in obtaining and maintaining employment, more individuals have attained greater self-sufficiency.

Table 4: Jobs/Education	FY 2009-10	Cumulative*	Percent
Job training/referrals/resources	218	1,267	59%
Education (course, class, books)	77	481	23%
Job placement (employment)	45	390	18%
Total number of services provided:	**340**	**2,138**	**100%**

*Cumulative includes: FYs 2008-09 and 2009-10 through September 30, 2009.

Benefits Advocacy and Enrollment Assistance

For participants who entered programs in need of specific public benefits, 23 HPI programs reported enrolling homeless individuals and families. Table 5 shows that through September 2009, 4,603 homeless individuals were enrolled into General Relief, which consisted of 63 percent of all benefit enrollments. Ten percent of participants were enrolled into Supplemental Security/Disability Income (SSI/SSDI), and 12 percent received Shelter Plus Care or Section 8 to secure permanent housing. This quarter, the rate increase for enrollments increased significantly for several benefits. The number of HPI participants who enrolled into Food Stamps increased by 78 percent - the greatest percent increase from the previous quarter. The number of HPI participants receiving CalWORKs increased by 76 percent, and the number receiving Medi-Cal/Medicare increased by 56 percent during this quarter.

Table 5: Benefits	FY 2009-10	Cumulative*	Percent
General Relief (and Food Stamps)	415	3,932	54%
SSI/SSDI	175	712	10%
General Relief only	72	671	9%
Shelter Plus Care	127	489	7%
Medi-Cal or Medicare	165	458	6%
Food Stamps only	147	336	5%
Section 8	66	330	5%
CalWORKs	121	281	4%
Veterans	20	61	<1%
Total number of benefits provided:	**1,308**	**7,270**	**100%**

*Cumulative includes: FYs 2008-09 and 2009-10 through September 30, 2009.

Supportive Health and Human Services

Through the first quarter of FY 2009-10, 18 programs (including the City and Community Program) made 26,027 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 28 percent (7,301) of these HPI participants received case management, which was the most frequently reported supportive service. Followed by case management, 21 percent of linkages were for health care (5,501), and 10 percent (2,752) were for mental health care. Another 10 percent of these linkages connected participants to transportation services, including bus tokens and public transportation.

With 69 percent of the homeless population having a mental illness, substance abuse problem, or AIDS/HIV-related illness,[7] linking these individuals and families with health care, mental health care, and substance abuse services is critical. Additionally, with the Recovery Act's Homelessness Prevention and Rapid Re-Housing Program (HPRP) funds, the County has expanded services to assist families and individuals with credit repair, legal assistance, and money management. In a 2009 HPI survey, providers also indicated interest in improving access to child care, law enforcement, and employment support.

Twenty-five programs reported providing case management services, and 15 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.[8] Hours provided to each participant per month ranged from 1 to 337 hours (average of 33 hours) with an average caseload of 28 cases per case manager.

Table 6: Supportive Services	FYs 2008-09 and 2009-10 (through September)	Percent	FY 2007-08*
Case management	7,301	28%	2,257
Health care	5,501	21%	183
Mental health care	2,752	10%	615
Transportation	2,568	10%	182
Life skills	2,385	9%	676
Alternative court	1,526	6%	286
Resident rights/responsibilities	904	3%	-
Substance abuse treatment	801	3%	130
Social/community activity	788	3%	51
Food vouchers/food	521	2%	414
Recuperative care	436	2%	45
Other**	275	1%	5
Clothing/hygiene	147	1%	80
Legal services	122	1%	15
Total number of services provided to participants:	**26,027**	**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.

[7] LAHSA 2009 Greater Los Angeles Homeless Count.

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

Strategy 6 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**: On average, *Housing First* models showed a successful 90 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-one 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 3.6 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. Seventeen 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 1,422 participants continued to live in permanent housing and 1,363 continued to receive rental subsidies.
- **Employment/education**: A total of 58 participants obtained employment, 105 maintained employment, and 90 enrolled in an educational program.
- **Health and well-being**: The following number of participants continued to receive these services for six months or more: 1,900-case management; 2,855-health care; 820-mental health services; and 204-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 86 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, 94 percent have successfully maintained permanent housing for six or more months (213 have maintained their permanent housing for 12 months or more, 10 families have maintained permanent housing for seven to 12 months, and three 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 1,409 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, 12 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 3.6 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.

IV. PROGRAM NARRATIVE (included in Attachment B)

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.

Client Success Stories

A Co-Occurring Disorders Court (CODC) program participant in his own words-
"I work at SSG Central Mental Health. I am also a member of the Peers Program. Peers help people with mental and addiction histories become employable. A year ago, I was on drugs and never thought I had a mental problem. Yet, I had spent 20 years in and out of drug programs. I went to jail, and then ended up at SSG. And for the first time in my life, I got help with my addiction and mental problems. I love my job and never thought I could have the life I have today."

A Los Angeles County Homeless Court participant -
Client M was referred to Homeless Court by his Department of Public Social Services General Relief Opportunities for Work (GROW) caseworker. He had been looking for work but found that his outstanding citations hindered his job search. Once his citations were resolved through Homeless Court, he was able to be hired as a fire safety inspector.

After years of struggling with substance abuse, Client R sought help from a drug and alcohol rehabilitation program. Once he had completed 90 days of treatment, his case manager applied to Homeless Court on his behalf. His outstanding citations were resolved through Homeless Court, making it possible for him to work as a driver for the drug and alcohol rehabilitation program in which he had participated. He was recently accepted into a violence prevention program at a top university in Southern California and he plans to focus his career on reducing gang violence.

A Women's and Children's Crisis Shelter participant –
Client E from the emergency shelter exited the program and entered WCCS transitional shelter in August. The client is grateful for this opportunity to get ahead and raise her two children in a safe, non-violent home. Her four-year-old son was thrilled to have his own room, and he jumped and laughed with joy. In less than two months, she obtained a permanent restraining order for three years, free childcare through the Child Development Consortium of Los Angeles, and enrolled herself in ESL classes. She enrolled her oldest son in Head Start, and they are now able to understand some English and practice speaking English together. She is very excited about her future and plans to put forth the effort into learning English as quickly as possible, so that she can enroll into a medical administration program.

V. RECOMMENDATIONS TO STRENGTHEN COUNTY HOMELESS COORDINATION

On November 17, 2009, the County Board of Supervisors passed a motion instructing the CEO, with assistance from DCFS, DHS, DMH, DPSS, the CDC, and LAHSA, to develop recommendations on how to strengthen the CEO's ability to oversee, coordinate and integrate Countywide homeless service delivery so that homeless individuals and families can more successfully find safe and permanent housing. In response, a CEO report to the Board on January 4, 2010 made three main recommendations to strengthen the County's homeless strategy: 1) leverage funds to maximize resources; 2) coordinate a regional approach among partners; and 3) address cost avoidance.

Leverage funds to maximize resources
The Special Needs Housing Alliance (SNHA) includes representatives from departments and agencies who have the expertise in services for the homeless and/or local, State, and Federal funding sources that serve homeless persons. The purpose of this workgroup is to collectively make decisions regarding the identification of integrated projects in order to make recommendations to the Board to fund, plan,

and implement these ideas into results. Some of these projects include *Housing First* models that align housing with services. For example, a subgroup is working on leveraging resources with the Skid Row Housing Trust's (SRHT) Charles Cobb Apartment in order to expand and sustain the Project 50 program. By moving the Project 50 clients to the Cobb Apartments, SRHT will let the integrated services team move rent free. Moreover, SRHT has agreed to leverage a recent Substance Abuse and Mental Health Services Administration (SAMSHA) grant to fund supportive services in housing for an additional 100 chronically homeless individuals without increasing costs to the County.

Coordinate a regional approach among partners

As partner agencies continue to join the SNHA and work together on specific projects, relationships among agencies will become stronger. The facilitating body is necessary to bring together agencies to put together a plan of action to link efforts, identify roles, and coordinate decision making. Moreover, if the body helps foster relationships and joins key partners, a single plan of action can represent the vision of an entire region. The plan would build on existing regional infrastructure and lessons learned. For instance, an important lesson learned from the County's HPI is the need to better share information to make connections and link various efforts, ranging from prevention to rapid re-housing. As stronger connections are made by braiding funds, integrating data systems, and having coordinated program entry and referral, a more comprehensive system of care and better service delivery could result. Simply, a shared vision and knowing what partners are doing would build a more integrated system that meets the multiple needs of clients. Therefore, the SNHA would play a critical role in bringing agencies together in order to plan and implement a regional approach to preventing and reducing homelessness. Furthermore, various HPI programs and the Recovery Act's HPRP focus on preventing homelessness to avoid significant costs. It is the County's intent to build upon these programs that support eviction prevention and pathways towards greater self-sufficiency.

Address cost avoidance

The findings in the LAHSA's commissioned report, *Where We Sleep: Costs When Homeless and Housed in Los Angeles* conducted by the Economic Roundtable provides detailed costs savings yielded through the provision of supportive housing through SRHT. Based on the analyses of over 10,000 General Relief recipients using County services, the findings show that while the typical public cost for residents in supportive housing is $605 per month, a similar chronic homeless person without housing is $2,897, which is five times higher. The report provides a wealth of information about the public costs incurred by homeless populations served by the County. The report not only showed that there are significant cost savings when homeless individuals enter and stay in permanent supportive housing but it also found that the greatest cost savings were achieved by the Skid Row Collaborative and Project 50. This means that future funding for permanent supportive housing should focus on projects that target the most vulnerable and use a *Housing First* approach.

Significant progress has been made to develop collaborative working partnerships with multiple public and private agencies and philanthropic organizations. It is the County's intent to work with the SNHA to put together an action plan with a timeline that would continue to align resources, while at the same time not increase Net County Cost (NCC) and maximize resources to serve homeless individuals and families. The CEO will continue to develop partnerships with cities and communities throughout the County to create regional solutions to address homelessness. Monthly Board briefings and homeless coordination meetings 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 in Los Angeles in successful.

VI. Acknowledgements

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

A Community of Friends	Dora Leong Gallo Nancy Neilson Dorene Toutant
Beyond Shelter	Zoe Ellas Tanya Tull
Catalyst Foundation for AIDS Awareness and Care	Elizabeth Gomez Susan Lawrence
Century Villages at Cabrillo	Brian D'Andrea Aaron Wooler
Chief Executive Office, County of Los Angeles	Betty Betts-Turner Lynn Cao Michael Castillo Rosemary Gutierrez Maggie Ly
City of Long Beach	Rene Miyasato Susan Price
City of Pasadena	Anne Lansing
City of Pomona	Jan Cicco
City of Santa Monica	Stacy Rowe Setareh Yavari
CLARE Foundation, Inc.	David Rolston
Cloudbreak Compton, LLC	Scott Fichter
Community Development Commission (Los Angeles County)	Virginia Adame Terry Gonzalez Linda Jenkins Larry Newnam LaCheryl Porter Elena Quon Carolina Romo Lois Starr Scott Stevenson
Department of Children and Family Services, County of Los Angeles	Bedrae Davis Theresa Rupel Rhelda Shabazz
Department of Health Services, County of Los Angeles	Elizabeth (Libby) Boyce Rowena Magana Vicki Nagata
Department of Mental Health, County of Los Angeles	Maria Funk Adrienne Gee Juataun Mark Mary Marx Jaime Nahman John Snibbe Reina Turner
Department of Public Social Services, County of Los Angeles	Consuelo Ayala LaShonda Diggs Ken Krantz Charlotte Lee Judith Lillard

Department of Public Social Services (continued)	Dorothea Manns Charles Medlin Antonio Roldan Jose Salgado
Gateway Cities Council of Governments	Joel John Roberts (PATH Partners) Margaret Willis
Homes for Life Foundation	Deborah Gibson
JWCH Institute, Inc.	Al Ballesteros Paul Gregerson Itohan Oyamendan
Los Angeles Homeless Services Authority (LAHSA)	Steve Andryszewski Michael Nailat
National Mental Health Association of Greater Los Angeles	Lesley Braden Jamie Gonzalez Dave Pilon
Ocean Park Community Center (OPCC)	Cherry Castillo
PATH Achieve Glendale	LaViva Primm Natalie Profant Komuro
Probation Department, County of Los Angeles	Suzy Moraes Michael Verner Maria Vicente
Public Counsel Law Center	Jennifer Amis David Daniels Sarah Evans Paul Freese
San Gabriel Valley Council of Governments	Nicholas Conway Bekah Cooke
Sheriff's Department, County of Los Angeles	Lt. Edward Ramirez
Skid Row Housing Trust	Katherine Hill Shannon Parker
Southern California Alcohol and Drug Programs, Inc. (SCADP)	Heidi Hobart-Ferraro
Southern California Housing Development Corp. of Los Angeles	Sandra Peterson
Special Service for Groups (SSG)	Cheryl Branch Chris Minnick Carlos Moran
Step Up on Second	Aaron Criswell Tod Lipka
Superior Court of California (County of Los Angeles)	Jessica Delgadillo Ken Kallman Saida Lopez
The Salvation Army	Alen Davtian
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	Dolores Salomone

Table of Homeless Prevention Initiative (HPI) Programs

Pg.	Strategy	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	7,210 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	3,903 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
8	❺	6. Multi-disciplinary Team Serving Families	120 families received case management services	n/a	Ongoing	$494,000
		Transition Age Youth (II)				
10	❶	7. Moving Assistance/Rental Subsidies for TAY – DCFS	436 TAY received rental subsidies	335 3yr	One-Time	$1,750,000
10	❶	8. Moving Assistance/Rental Subsidies for TAY – Probation	358 TAY received rental subsidies	335 3yr	One-Time	$1,750,000
		Individuals (III)				
12	❷	9. Access to Housing for Health (AHH)	73 clients placed into permanent housing 90% decrease in inpatient days; 83% in ER visits	115 cap	Board Approved	$3,000,000
14	❻	10. Center for Community Health Downtown Los Angeles	2,377 individuals received health/mental health care	n/a	Ongoing	*$186,000
16	❺	11. Co-Occurring Disorders Court	50 individuals placed into transitional housing	n/a	Ongoing	$200,000
18	❷	12. DPSS General Relief Housing Subsidy & Case Management Project	2,723 homeless GR participants received housing subsidies for housing placement	900 time	Ongoing	$4,052,000
19	❷	13. DPSS-DHS Homeless Release Project	409 potentially homeless participants received benefits	n/a	Ongoing	$588,000
19	❷	14. DPSS-Sheriff's Homeless Release Project	2,958 potentially homeless individuals received benefits	n/a	Ongoing	$1,171,000
21	❺	15. Homeless Recuperative Care Beds (DHS)	344 individuals were served through this program 73% decrease in hospitalizations; 32% in ER visits	490/2yr	One-Time	$2,489,000
23	❷	16. Housing Specialists (most clients are individuals)	625 placed into permanent housing	n/a	*DMH MHSA*	$923,000
24	❹	17. Just In-Reach Program	166 individuals received public benefits	Individuals 400/2 yr	One-Time	$1,500,000
26	❻	18. Long Beach Services for Homeless Veterans (mostly individuals)	129 veterans received case management services	n/a	Ongoing	$500,000
29	❶	19. Los Angeles County Homeless Court Program	1,291 individuals with citations or warrants dismissed	n/a	Ongoing	$379,000
31	❻	20. Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program	240 single adults received moving assistance to prevent homelessness	until 2,000	One-Time	$1,100,000
32	❻	21. Project 50	58 chronically homeless placed into permanent housing	50	One-Time	$3,600,000
34	❻	22. Santa Monica Homeless Community Court	118 individuals with citations or warrants dismissed	90	Board Approved	$540,000
36	❻	23. Santa Monica Service Registry (programs a and b)	70 chronic homeless individuals have participated	n/a	3rd District	$1,178,000
		Multiple Populations (IV)				
40	❻	24. Los Angeles County Housing Resource Center	Nearly 3.7 million housing searches conducted	n/a	Ongoing	$202,000

Table of Homeless Prevention Initiative (HPI) Programs

Attachment B

	Program	Indicator (to date)	Target	Funding	Budget
41 ❸	25. Pre-Development Revolving Loan	Restructuring plan approved by Board in July 2009	n/a	One-Time	$20,000,000
42 ❺	26. Project Homeless Connect	8,848 participants connected to services/benefits	n/a	One-Time	$45,000
43 ❸	27. **City and Community Program -CCP (V)**	$11.6 m capital, $20.6 m City Community Programs	Multiple	One-Time	$32,000,000
66 ❸	28a. **San Gabriel Valley Council of Governments -COGs (VI)**	Final report completed in March 2009	n/a	Ongoing	$135,000
66 ❹	28b. Gateway Cities Homeless Strategy	Final report completed in March 2009	n/a	Ongoing	$200,000
68 ❺	29. LAHSA contracted programs	7,718 placements into temporary housing	n/a	One-Time	$1,735,000
68 ❺	30. PATH Achieve Glendale (families and individuals)	379 placements into housing	n/a	One-time	$150,000
❺	31. SSI and Other Benefits Advocacy Program	Program to be launched during FY 2009-10	Individuals	One-Time	$2,000,000
❺	**HPI Funding Total** (excludes Board approved operational support (FY 2006-07), administrative and evaluation costs) *Ongoing costs expected to be $76,000				**$99,309,000**

	City and Community Program (CCP) Funds	Service ($)	Capital ($)
43 ❸	*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 Service 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**	

**Actual total of $32 million includes administrative costs.*

For this report, unless specified: Fiscal Year (FY) refers to the first quarter of FY 2009-10 (July 1, 2009 - September 30, 2009). Cumulative refers to the number of clients served to date. Note: complete demographic information may not have been provided.

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 (EAPE)	$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 2009-10, through September 30, 2009

Program (unduplicated count)	FY	Cumulative
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	1,194 received eviction prevention	7,210 received eviction prevention
2) Moving Assistance for CalWORKs Non- Welfare-to-Work and Non-CalWORKs Homeless Families	549 received moving assistance and permanent housing	3,903 received moving assistance and permanent housing
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	Program ended in FY 2008-09.	211 received rental subsidies for permanent housing

Table A.2: DPSS Measures by Program
FY 2009-10, through September 30, 2009

Program (unduplicated count)	Number of applications received		Percent of applications approved		Average amount of grant	
	FY	To date	FY	To date	FY	FY 08-09
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	1,639	10,642	71%	68%	$669	$649
2) Moving Assistance for CalWORKs Non- Welfare–to-Work and Non-CalWORKs Homeless Families	761	5,683	72%	69%	$773	$821
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	137	215	96%	99%	-	$427

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

January - September 2009	Moving Assistance	Rental Subsidy	Emergency Assistance
Homeless/At-Risk Families	1,314	58	2,901
Female	2,408	105	5,076
Male	1,577	91	3,930
Hispanic	1,482	85	5,236
African American	2,243	81	3,298
White	104	23	251
Asian/Pacific Islander	71	2	98
Native American	5	2	6
Other	80	3	117
15 and below	2,490	121	2,402
16-24	405	11	428
25-49	1,085	64	900
50+	5	-	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 549 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; and c) appliance purchases (stove and/or refrigerator).

Challenges: Due to the current economy, many CalWORKs families are losing their housing due to foreclosures and job losses. This has increased the cost of the program; therefore, additional funding is always needed.

Action Plan: DPSS continues to administer funds wisely. In addition, DPSS is maximizing the use of the Emergency Contingency Funds which became available on October 1, 2009.

Client Success Story: A single mother with six children was referred to DPSS by the DCFS Linkages Greater Avenues for Independence (GAIN) Social Worker (GSW). DCFS had been paying for the participant's housing for approximately one year; however, there was now a need for DPSS to step in and assist the family in locating more affordable permanent housing. Since one of the children was not being aided due to the Maximum Family Grant (MFG) rule, the Homeless Case Manager (HCM) was able to determine that the participant qualified for a MFG Waiver due to domestic violence. This increased the participant's monthly CalWORKs grant. Through the collaboration between DCFS and DPSS staff, more affordable permanent housing was found for the participant and her six children. DPSS approved the family for the Permanent Housing Assistance program to pay for the security deposit and for moving assistance to purchase a refrigerator and stove.

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 1,194 families at-risk of homelessness received assistance to maintain their current housing and/or maintain their utility services this quarter. The number served increased 40% from the previous 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 2009-10, through September 30, 2009

(unduplicated clients)	Cumulative (3/31/09)		Cumulative
Homeless Families	300	Moving assistance	175
(individuals)	1,084	Eviction prevention	40
Female	273	Housing (emergency/transitional)	300
Male	27	Housing (permanent)	241
		Rental subsidy	33
Hispanic	68		
African American	187	Education	15
White	12	Job training/referrals	65
Asian/Pacific Islander	3	Job placement	14
Native American	-	Section 8	77
Other	30		
		Case management	270
15 and below	619	Life skills	453
16-24	80	Mental health/counseling	53
25-49	295	Transportation	224
50+	15	Food vouchers	390
		Clothing	13

Program Specific Measures		Cumulative
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	Quarter
Average length of stay in emergency housing:	-
Most frequent destination (permanent housing):	-
Case management (level 2)	
Average number of case management hours for each participant per month:	60 hours
Total case management hours for all participants during current reporting period:	780 hours
Number of cases per manager:	7 cases

Longer-term Outcomes	6 mo	12 mo
Continuing to live in housing	10	213

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: Three-hundred families were referred by the Skid Row Assessment Team to Beyond Shelter into the Skid Row Families Demonstration Project (SRFDP). Beyond Shelter placed 241 of 300 participant families in permanent housing. The majority of these families have remained in permanent housing for at least 12 months. As of September 30, 2009, 213 families have successfully completed 12 months in permanent housing. During the current reporting quarter, 49 families completed 12 months, 10 families completed 7-12 months, and three families are in their first 6 months of permanent housing. Only five families have reported to Beyond Shelter that they were evicted from their apartments, and they have returned to homelessness. Each incidence of eviction was a result of a crisis including mental health issues, substance abuse, or domestic violence. A total of 59 of 300 families were terminated from the program for non-compliance, or loss of contact.

The current focus of the Skid Row Families Demonstration Project remains on assisting families with stabilizing in permanent housing. At the end of the first quarter of the fiscal year, there were 13 active cases, and case managers have continued to provide specialized, individualized, and intensive support for each family. Case managers link families to community resources and provide guidance through Housing Authority issues and various other obstacles related to income via public social services. The assistance provided by case managers to navigate through the public social service systems has been extremely helpful for families with limited knowledge about available resources. With the support of their case managers, at least five families were assisted with the Housing Authority of the City of Los Angeles (HACLA) annual recertification process. These families needed assistance to the extent that they may have lost their Section 8 vouchers without direct and specific guidance through the process.

Challenges: The main challenge for the SRFDP continues to revolve around income and employment issues. Clients continue to struggle with 6% less income from CalWORKs as of June 2009, decreased hours from their employers in some cases, and utility bill increases from the City's Department of Water and Power (DWP). The 6% shift in income has had a huge impact on these families. Food Banks have lower reserves, and utility assistance funds from other resources are limited and difficult to access. With decreasing resources and lowered incomes, families are forced to cut back and budget more strictly. Although there have been no new incidences of foreclosure during this quarter, 5% of 241 families that were enduring this issue last quarter, continue to deal with the ongoing issue this quarter. This challenge involves case managers ensuring clients know their tenant rights, and that clients send their payments to the correct recipient.

Clients also have been challenged with the HACLA annual recertification process. Complications with this system include: difficulties for clients reaching their advisors at HACLA, property owner's timely compliance with repairs identified at re-inspection, and language barriers. Difficulty with receiving mail and telephone correspondence from HACLA continues as a problem for clients as well. Often clients' phones are disconnected and the only form of communication is through the postal service. Clients who are unable to read or write in English have been challenged with this method of communication.

Action plan: Beyond Shelter case managers continue to closely work with families to develop Family Action Plans and identify their priorities to help them meet their goals. Case managers have also assisted families by providing support and information as needed throughout the process. They especially have focused on money management and budgeting to assist clients with the adjustment to the change in their income. Clients are urged to evaluate other income resources and to seek employment, but with a difficult economy and job market, this has not been readily possible in many cases. In the foreclosure cases, case managers continue to assist clients by advocating for them, ensuring they send their rent payments to the appropriate recipient, and help to clarify their rights and responsibilities as Section 8 tenants.

Client Success Story: Client F is a 30-year-old African American, single mother of one seven-year-old daughter. The client has endured several incidences of homelessness. Two of the incidences occurred because she was living with relatives or friends and could no longer stay with them. One incidence was due to domestic violence between herself and the father of her child. He has since been incarcerated and she has no contact with him. Her last episode of homelessness was caused by an injury she suffered on the job. She was no longer able to work, fell behind on her rent and was evicted. She also has a record for petty theft for which she was on probation. The Department of Mental Health referred her to the Union Rescue Mission. From there she was referred to the SRFDP.

Client F and her daughter were enrolled in the SRFDP in June 2007. Upon intake, her service intensity level was assessed as high, due to multiple episodes of homelessness, recent mental health issues, and a lack of a high school diploma. The family was immediately placed in a motel away from the Skid Row area. During the crisis phase, she was provided with food vouchers, bus tokens, and emotional support. She received tenant education classes and a Housing Relocation Specialist was assigned to assist her with applying for a Section 8 voucher through HACLA. She was interested in returning to work as soon as possible. In order to facilitate her return to work, an Employment Specialist at Beyond Shelter assisted her with employment related services such as updating her resume, identifying job leads, and practicing interviewing techniques. The client also received counseling services provided by a therapist at the Department of Mental Health. Once she received her Section 8 voucher, she was assisted with a housing search. With the assistance of her Housing Relocation Specialist, she moved to a two-bedroom house located near USC in April 2008. Client F made great progress in meeting her goals. By the time she moved into permanent housing, her service intensity level had been reduced to moderate. She continued to meet with her therapist, fulfill her probation obligations, and actively searched for work. Over the next six months, her case manager provided home-based case management services to assist the family with stabilizing in permanent housing. She also received an additional six months of follow-up phone calls to assist with any other issue or support that the family needed.

Client F has lived in her house for more than one year. Initially, she had a hard time finding a job because of her prior arrest and active probation status, but she refused to give up and continued to seek employment. About two months after moving into permanent housing, she was able to find a job where she currently remains employed full-time as a Courtesy Clerk at a well known grocery store. She has also completed her probation. The judge waived the balance of her court fees, because she had been compliant with all the court's requirements. Her child is doing very well in school and is well adjusted to her new home.

6) Multi-Disciplinary Team Serving Families
Budget: $494,000 (Ongoing Funding)

Table E.5: Multi-Disciplinary Team
FY 2009-10

(unduplicated clients)	Quarter		Quarter
Homeless Families (individuals)	89 274	Housing (transitional) Housing (permanent)	23 3
Female	165		
Male	109	CalWORKs	1
Hispanic	83	Case management	120
African American	178	Health care	106
White	13	Mental health care	31
15 and below	163		
16-24	24		
25-49	77		
50+	10		

The Skid Row Assessment Team (SRAT) originated as a result of a Board Motion in December 2004. It is a collaborative between the Los Angeles County Departments of Children and Family Services (DCFS), Public Social Services (DPSS), Mental Health (DMH), and Public Health (DPH).

On July 1, 2009 the SRAT moved into the Family Assessment Center located at the Center for Community Health, Downtown Los Angeles. The SRAT is committed to attaining the goals of assuring child safety, providing ongoing case management and enforcing the zero tolerance goal for families on Skid Row. The SRAT is excited about the new opportunities that have been identified during the collaboration between County Departments and the community agencies that will assist Skid Row families in the care and protection of children.

Successes: During this quarter, the SRAT screened a total of 70 new families (an additional 19 families were previously served and 111 families continued to receive services). A total of 66 families are currently receiving financial public assistance (CalWORKs) and seven families have been approved and issued Homeless Assistance through DPSS. DPH conducted 106 health assessments; set five appointments with primary care providers, and referred 101 to a primary care provider. DMH referred 129 clients for clinical assessments to the downtown mental health office. DCFS conducted 110 child safety assessments and referred 23 families to Family Preservation or Family Support Services.

The current focus of the SRAT remains on assisting families with relocating into shelter, transitional housing, and/or permanent housing outside of Skid Row. Presently, there are four DPSS Homeless Case Managers who are available to provide individualized support with referrals to services and resources to overcome the various obstacles related to the barriers that prevent the family from obtaining permanent housing.

The collaboration with other local community service providers such as Los Angeles Homeless Services Authority (LAHSA), AmeriCorps, Union Rescue Mission (URM), Midnight Mission (MM) and Beyond Shelter provides the opportunity for better communication, information sharing, development of partnerships and better working relationships, which all promote positive housing outcomes for the homeless families served.

Challenges: The Homeless Case Manager (HCM) working with the homeless family faces numerous challenges. The biggest challenge, the vast majority of families are dependent on CalWORKs for income and the availability of low-income and/or subsidized housing is meager It is also difficult to access emergency shelter services in other parts of the City. Repetitive calls are made to the community agencies in the Homeless Continuum of Care to be unsuccessful in locating vacancies. When an opening is located, the family is often denied access because the family does not meet the criteria specific to the program. With many shelters allowing families to remain for longer periods of time, long waiting lists for entry, and increasingly stringent entry requirements, most homeless families in Skid Row cannot get into shelter.

Action Plan: In collaboration with LAHSA and community partners, the team is working together to establish a more effective system to identify and access the vacancies in the Los Angeles Homeless Continuum of Care. Additionally, we are working to partner with the agencies that have received American Recovery and Reinvestment Act stimulus funds to establish an effective means to refer and prioritize services and funds for the eligible homeless families on Skid Row.

Client Success Story: Family S is an intact family comprised of a 26-year-old mother and 31-year-old father with four children ranging in one to nine years in age. The family came to Los Angeles from St. Louis, Missouri in August 2009 with a promise to stay with their maternal cousin. When these plans did not work out the way they had expected, they sought assistance from DPSS - where they were issued Temporary Homeless Assistance.

In early September 2009, the family sought shelter at the URM. While the family reports that this is their first incidence of homelessness, they have limited but steady income from CalWORKs and SSI. An assessment of the family's strengths shows that this is an intact family that is motivated to participate in services. The mother is potentially eligible for DPSS Greater Avenues for Independence (GAIN) services and would be able to receive such services as child care, assistance with transportation, counseling, housing locator services and other DPSS benefits. While at the URM, they have saved $2,800 of their income in the URM voluntary savings program. This is approximately 99% of the family income and illustrates the motivation of the family to take full advantage of the URM program.

As a result of the family's strengths and ability to save their income, the team expects to assist this family in locating permanent housing in the near future.

II. PROGRAMS FOR TRANSITION AGE YOUTH

7 and 8) 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 2009-10, through September 30, 2009

	Total	Probation		DCFS	
		FY	Cumulative	FY	Cumulative
Transition Age Youth	780 (100%)	32 *(new)	390	30 *(new)	**464
Female	439 (56%)	14	164	23	275
Male	341 (44%)	18	226	7	115
Hispanic	190 (24%)	4	98	5	92
African American	544 (70%)	28	276	23	268
White	34 (5%)	-	10	2	24
Asian/Pacific Islander	6 (1%)	-	6	-	-
Native American/Other	-	-	-	-	-
16-24	780 (100%)	32	390	30	390

* During the First Quarter of FY 2009-10, 62 new TAY were enrolled; 179 TAY continued to participate.
**FY 2008-09 total was 360. FY 2007-08 DCFS demographic participant data was duplicative (duplicated total 464); cumulative demographic information includes FYs 2008-09 and 2009-10.

Table B.2: Moving Assistance for Transition Age Youth Services
FY 2009-10, through September 30, 2009

(unduplicated count)	Total	Probation		DCFS	
	FY	FY	Cumulative	FY	Cumulative
Moving assistance	12	-	253	12	216
Rental subsidy	5	-	358	5	436
Housing (permanent)	67	32	343	35	269
Eviction prevention	-			1	1
Any supportive service+	-	-	101	-	64
Education	27	-	9	27	85
Job training, referrals	-	-	-	-	35
Job placement	-	-	81	-	-
Case management	62	32	390	30	464
Life skills	-	-	-	-	8
Mental health	-	-	-	-	1
Transportation	2	-	-	2	109
Food vouchers	1	-	-	1	44
Clothing	2			2	74
Auto insurance	-	-	-	-	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 2009-10, First Quarter

	Probation	DCFS
Continuing to live in housing	93	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	-	-

Table B.4: Program Specific Measures for Transition Age Youth
FY 2009-10, through September 30, 2009

	Probation		DCFS	
	FY	Cumulative	FY	Cumulative
Number of new approvals	32	469	30	340
Average cost per youth	$2,181	*$3,806	$3,500	*$2,663
Number of program participants satisfied with program services	32 (of 32)	248 (of 250)	20	155
Number of pregnant/parenting youth placed in permanent housing	-	90	1	72
Number exited housing	11	32	-	324
Number remaining in permanent housing and receiving assistance at 6 months	n/a	n/a	16	94

*Average cost per youth for FY 2008-09; in FY 2007-08, the average cost was $3,816 for Probation.

Probation– Moving Assistance for TAY

Successes: HPI funds helped many youth find permanent housing that enabled them to maintain employment, get additional job training, and attend college.

Challenges: One of the biggest challenges is to motivate clients to continue their education by enrolling in a trade program or a two/four-year college. Many of the youth lack the confidence and or drive to do so. The program's coordinator constantly addresses the importance of education and the positive outcomes from furthering one's education or becoming certified in a trade, and they often walk the youth through the process of enrolling in trade school or college.

Action Plan: In addition to continuing to offer support to youth placed in permanent housing, the current action plan includes continued assistance with both educational and job placement activities.

Client Success Story: Client M was placed in her grandmother's home by DCFS and eventually came in contact with Probation. She was supervised by Probation for approximately four years. She has two sons, ages six and three, and she attends California State Northridge University. Her major is Sociology and her projected graduation date is the Spring of 2010. Client M obtained employment with the County of Los Angeles as a Career Development Clerk, and she completed a two-year internship to gain permanent status. The program was able to assist with her rent during her maternity stage as she was unable to pay rent and her bills. She resided in her first apartment for approximately 18 months and recently relocated to a larger house. Client M was asked if she was satisfied with the program and she replied, "The TPP program is awesome. I don't know what I would have done without the assistance."

DCFS – Moving Assistance for TAY

Successes: During the quarter, 54 youth were served, and 30 were new approvals. The program provided move-in assistance to 12 youth. Average expenditure for an individual was $38,926 per month.

Challenges: Follow-up continues to be a major challenge. Youth have a major problem with maintaining a stable telephone number. That instability presents a barrier to communication. Additional challenges include - following through with the intake process and completing required documents in a timely manner.

Action Plan: Youth will continue to be encouraged to ensure that a current phone number stays on file, for follow-up purposes. During case management, staff will emphasize the necessity of following through in a timely manner.

Client Success Story: A 22-year-old female was laid off from work at an oil refinery. DCFS provided rental assistance, which enabled the youth to attend welding school and pursue a license in Real Estate.

III. PROGRAMS FOR INDIVIDUALS

9) 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 2009-10, through September 30, 2009

(unduplicated count)	FY	Cumulative
Homeless Individuals	6	20
Chronic Homeless	5	94
Homeless Families	1	5
Female	7	51
Male	7	77
Transgender	1	1
Hispanic	1	28
African American	7	56
White	6	43
Asian/Pacific Islander	-	1
Native American	-	-
Other	-	1
15 and below	2	9
25-49	6	47
50+	7	73
Moving assistance	9	62
Housing (emergency/transitional)	12	119
Housing (permanent)	11	73
Rental subsidy	11	73
Eviction prevention	2	2

	FY	Cumulative
Education	1	3
Job training	1	2
Job placement	-	2
General Relief and Food Stamps	1	1
General Relief	1	62
Food Stamps only	-	1
Medi-Cal/Medicare	5	34
Section 8	9	37
Public Housing Certificate	6	16
SSI/SSDI	6	29
	FY	**Cumulative**
Case management	12	119
Health care	12	119
Life skills	12	119
Mental health/counseling	3	31
Substance abuse (outpatient)	1	17
Transportation	4	101

Program Specific Measures	FY	Cumulative
Number of referrals	57	660
Number admitted to program (enrolled)	12	119
Pending applications	4	n/a
Number that did not meet eligibility criteria	41	535
Number of exited clients	2	31
Reduction in Emergency Department visits (12 months post enrollment, n=52)	-	83%
Reduction in number of inpatient days (12 months post enrollment, n=52)	-	90%
Number of new AHH enrollees that have a primary healthcare provider	12	119

Transitional Housing/Case Management	
Average stay at emergency/transitional housing:	160 days, 73 into permanent housing
Case management (level 3)	
Average case management hours for each participant per month:	14 hours
Total case management hours for all participants during current reporting period:	648 hours
Number of cases per case manager:	13 cases

Successes: To date, there are 52 AHH clients that have reached their one year mark in the program. They had a combined total of 238 Emergency Department visits during the 12 months prior to AHH enrollment. Post enrollment, the clients had a combined total of 40 Emergency Department visits. **The number of Emergency Department visits was reduced by 83%.**

Table C.2: Longer-term Outcomes FY 2009-10, First Quarter	**6 mo.**	**12 mo.**
Continuing to live in housing	52/54	40/42
Receiving rental subsidy	100%	95%
Case management	10	6
Health care	10	6
Mental health care	5	2
Substance abuse treatment (outpatient)	1	-
Reunited with family	1	2

The 52 AHH clients also had a combined total of 467 inpatient days prior to AHH enrollment. These clients had a combined total of 45 inpatient days post AHH enrollment. **The number of inpatient days was reduced by 90%.**

Challenges: There continues to be challenges in obtaining all of the necessary and current documentation from clients in order to submit complete housing authority applications in a timely manner.

Action Plan: The AHH staff is currently fully staffed with the addition of one new case manager. The Housing Locator continues to assist in ensuring the housing application, location, and move-in process meet the client's needs and occur in a timely manner. The case managers and housing locator continue to work closely to ensure that the client's needs are met and that they obtain and maintain permanent housing.

Client Success Stories: Mr. R is a 44-year-old Latino male and was homeless for almost one year. Mr. R is divorced and has two adult step children living in Los Angeles and San Francisco. In 1993, he was diagnosed with oral cancer; he has a history of hypertension, and in 2008 he was diagnosed with diabetic type II neuropathy which resulted in a below the knee amputation of his right lower leg. Following this procedure, the client ambulated via wheelchair. Mr. R worked as a carpet manufacturer for 15 years and later as a vegetable packer. Due to his medical issues and amputation, the client lost his job and subsequently his rented accommodation was shutdown for public health reasons; Mr. R became homeless. The client began receiving unemployment in June 2008. Mr. R was referred to AHH by Recuperative Care in Bell. He began the AHH program in March 2009 and was permanently housed in April 2009. Mr. R receives on-going medical care from Harbor-UCLA and Rancho Los Amigos and recently received a prosthetic limb allowing him to ambulate with a walker. The AHH program assisted Mr. R in applying for GR and SSI/SSDI and ensures that he accesses on-going medical treatment. The client has reconnected with his son who is now an active support in his life. Upon starting the AHH Program, Mr. R's affect was dysphoric, and he now presents with an elevated mood and is highly motivated. The client started his own support group for amputees. The client has been successful in his housing for six months. Mr. R now has a stable living environment that has improved his medical condition as well as his familial relationships and social networks.

10) Center for Community Health Downtown Los Angeles
Budget: $186,000; ($76,000 expected for Ongoing Funding)

Table E.4: Center for Community Health Downtown Los Angeles (CCH)
FY 2009-10 through September 30, 2009

(unduplicated clients)	Quarter		Quarter
Homeless Individuals	2,377	Moving assistance	1
		Housing (emergency)	9
Female	630	Housing (transitional), average stay 90 days	25
Male	1,747	Housing (permanent)	8
		Rental subsidy	1
Hispanic	487		
African American	1,227		
White	295	General Relief and Food Stamps	7
Asian/Pacific Islander	41	Medi-Cal/Medicare	2
Native American	7	Section 8	5
Other	807	SSI/SSDI	2
More than one race/ethnicity may be selected		Case management	168
		Health care	2,162
16-24	69	Mental health care	205
25-49	1,122	Recuperative care	1
50+	1,186	Substance abuse treatment (outpatient)	2
		Transportation	7
Job training/referrals	8	Other	8

Successes: The opening of CCH has provided services to 2,377 unduplicated patients during the first three months of operations. The services are provided in an integrated fashion with one chart containing pertinent information from the partnering agencies about the patients. This centralized case file is a first for Los Angeles County. It enables the team to better coordinate client care. Registration for all patients is conducted centrally.

The Center has provided the opportunity to provide Case Management Services as part of an integrated service delivery system to homeless patients. Case managers (MSW, BSW level) provided services to 167 unduplicated patients and have begun the process of developing Individualized Service Plans for them. Many of these patients have co-morbid chronic disease, mental health, and substance abuse disorders in addition to their social service needs. For the first time, all of the patient's problems are being addressed in conjunction with their physical health.

Patients from Recuperative Care are also meeting with case managers at CCH prior to their discharge in order to facilitate the transfer of care into the new clinic. Previously many of these patients would be lost to follow-up and the gains achieved in Recuperative Care lost.

Additionally, the case managers have placed an emphasis on locating and working with our sickest chronic disease patients. Most of these patients have social service needs that need to be addressed in order to improve their compliance.

Challenges: The opening of CCH has provided us with an opportunity to provide patients a comprehensive treatment plan. However, as expected, with opportunity comes challenges.

The biggest challenge has been the implementation of the multidisciplinary team meetings and determining a time frame for action plans. This is a multi-factorial problem. Finding time for meetings is a problem due to the high volume of patients. With only one psychiatrist and two medical case managers for three PODS, it is difficult for all teams to meet at the same time. Therefore, each team has a designated time to meet each day. This means that often times the psychiatrist and case managers have three meetings a day, which disrupts their patient schedule.

There has also been an inconsistency in the staffing of the PODS. One primary care provider has been out on sick leave, with per diem providers filling in. Another provider has also been out for family reasons.

There has also been an adjustment period for the staff. There are multiple agencies working together in a new environment. It takes time to adapt to the new surroundings and get into a routine. There are also specific criteria for obtaining integrated services from the various departments co-located in the facility. For example, many patients do not qualify for mental health services from DMH (patients have a case opened elsewhere in the County, are not schizophrenic, bipolar or have major depressive disorder, do not have a chronic physical illness necessitating ongoing care by a primary care provider etc.).

Action Plan:

1) Each POD is required to maintain a log of meetings and patients discussed.
2) Provider schedules are blocked during the designated meeting times (8:00 am, 8:20 am and 4:40 pm).
3) It is the responsibility of the case manager to ensure the patient chart is available and that patients have an ISP completed before they are discussed.
4) Ongoing discussions about barriers to success in meeting and formulating an action plan (the desired multidisciplinary team approach) are a part of the monthly Clinical Services meetings.
5) There is a commitment by leadership to find funding for an additional case manager and a LCSW.

Client Success Story: Patient M is a patient with breast cancer who initially presented to CCH in August. She had completed a five-year prison sentence for possession of heroin a few weeks earlier, and was homeless at the time she presented for medical care. While incarcerated she was placed on methadone for pain management due to gunshot wound and severe body trauma she sustained prior to starting her prison sentence. At the patient's initial visit to the CCH, her newly designated primary care provider referred her to the MSW. During the evaluation by the MSW, the patient reported the following: 1) she was staying at a local shelter, but was there on a limited stay only basis; 2) she had no income and was not receiving public assistance; 3) she had recently lost her California ID; 4) she was about to be terminated from a local methadone program unless she was able to obtain Medi-Cal; 5) she had not been able to contact her new parole agent due to a case transfer; and 6) she had not communicated with her only family contact (sister) for several months.

The MSW was able to work with the shelter to extend her stay at the facility while he assisted the patient with her application to the JWCH Institute Recuperative Care program, where she currently resides. He also referred the patient to DPSS for General Relief and Food Stamps as well as to the local SSI office. The patient now receives GR and food stamps while her Medi-Cal and SSI are pending. The Program at CCH was able to provide the patient with a DMV voucher to lower the cost of obtaining her new ID at the local DMV office. The MSW also contacted her new parole agent and hosted a visit between the patient and her agent in his office at CCH. Additionally, with the patient's permission, her sister was contacted by telephone, and the sister has agreed to take her in once she successfully completes parole in a few months. The MSW continues to monitor this patient for symptoms of depression secondary to her medical problems and economic situation, and is providing social support for the patient as she completes her parole.

11) 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 2009-10, through September 30, 2009

(unduplicated count)	FY	Cumulative		FY	Cumulative
Chronic Homeless	10	76	Education	-	15
Homeless Individuals	2	7	Job training/referrals	-	27
Transition Age Youth	3	4	Job placement	-	1
Female	8	50	CalWORKs	-	1
Male	7	37	General Relief (GR,FS)	1	15
			Food Stamps only	-	3
Hispanic	2	10	Medi-Cal/Medicare	-	32
African American	10	67	SSI/SSDI	-	30
White	3	8	Shelter Plus Care	-	5
Other	2	2			
			Alternative court	15	60
16-24		7	Case management	15	60
25-49		50	Health care/medical	15	38
50+		30	Life skills	15	56
			Mental health/counseling	15	60
Eviction prevention	-	2	Social/community activity	15	35
Housing (emergency)	-	8	Substance abuse (outpatient)	4	67
Housing (transitional); avg. 210 days	3	50	Substance abuse (residential)	15	33
Housing (permanent)	-	2	Transportation	15	60
Rental subsidy	4	37	Clothing/hygiene	15	57
Moving assistance	-	2			
Longer-term Outcomes (six or more months)					
Continuing to live in housing					17
Receiving rental subsidy					10
Enrolled in educational program, school					5
Obtained/maintained employment					5
Case management					39
Health care					23
Good or improved physical health					24
Mental health/counseling					41
Good or improved mental health					38
Substance abuse treatment (outpatient)					25
Substance abuse treatment (residential)					19
No drug use					26
Reunited with family					3
Emergency Housing/Case Management					
Case management (level 3)					5 hours
Total case management hours for all participants during current reporting period:					800 hours
Number of cases per case manager:					7 cases

Successes: The Co-Occurring Disorders Court (CODC) program continues to provide co-occurring disorders treatment that is responsive to clients' needs and facilitates positive change. Classes and therapy groups are offered at various settings, including SSG Central Mental Heath, Antelope Valley Rehabilitation Center (AVRC), and Mt. Carmel (a residential treatment center). Groups address topics such as: anger management, trauma, moral recognition therapy, drug and alcohol education, relapse prevention, money management, and the power to change (facilitated by Recovery International). During the first quarter, 21 clients participated in a 90-day residential co-occurring disorders treatment program at AVRC. Seven clients graduated from the AVRC program during the quarter, transitioned into outpatient treatment at SSG Central Mental Health, and now reside in sober living housing. SSG continues to increase housing options for clients. Special Service for Groups (SSG) has contracted for additional beds at the Mt. Carmel residential drug treatment facility in South Los Angeles. Clients who reside at Mt. Carmel participate in both drug and alcohol groups and mental health therapy. CODC

clients continue to work closely with SSG's Employment Specialist and have demonstrated significant strides towards pursuing adult education and employment (both volunteer and paid). During the quarter, three clients attended Los Angeles City College and Los Angeles Trade Tech College, while eight other clients engaged in job training and/or job seeking. Two additional CODC clients obtained paid employment as Consumer Employees for the SSG Central Mental Health agency. Both Consumer Employees continue to participate in co-occurring disorders treatment programming, as they carry out their new duties, which include facilitating client court visits and writing a monthly newsletter. Both Consumer Employees are highly regarded by their peers and serve as outstanding role models. Both are expected to graduate from the program in the Spring of 2010. Two additional Consumer Employees, a full-time Peer Advocate, and a full-time file clerk will be hired.

Table C.4: Program Specific Measures	FY	Cumulative
Number of clients screened for enrollment	45	454
Number of clients accepted for observation	20	98
Total number of clients enrolled	15	81
Number of clients pending enrollment	5	20
Number of clients not meeting Program criteria	26	216
Number of clients rejecting/dropping out prior to enrollment	6	104
Number of clients lost during follow-up process	-	6
Number of participants in ER/crisis stabilization while enrolled in program	6	27
Average length of hospital stay (days)	2	16
Number of participants who have a primary healthcare provider while enrolled	18	71
Number of participants with new arrest(s)	4	25
Misdemeanor:	-	3
Felony:	4	18
Number of participants in jail	4	26
Average number of days in jail.	26	(FY 08-09) 25

FY 2007-08 average number of days in jail: 36

Challenges: While treatment at AVRC has been well-received by a majority of clients, the treatment schedule has been limited, resulting in extended periods of "down time." Management at AVRC plans to adopt the Matrix System of Care which will improve daily structure and increase the amount of treatment and service delivery for each client. With the curtailment of the Proposition 36 Courts at the Foltz Criminal Justice Center in Downtown Los Angeles, the program has been faced with finding new sources for client referrals. In July 2009, the Public Defender (PD) and DMH staff launched a concerted effort to increase program visibility and referrals for the program. The Public Defender has conducted a number of trainings and presentations for attorneys and bench officers at the Foltz Criminal Justice Center. The PD also reviews Early Disposition Program cases for potential candidates. Likewise, DMH has conducted in-service trainings for DMH staff working at Twin Towers and Century Regional Detention Facility (the women's jail) with the goal of increasing disposition planning options for eligible inmates and generating continuous referrals to the program. In addition, DMH has increased the number of days dedicated to court outreach and the evaluation of potential candidates to four days per week. In September 2009, the CODC relocated from Division 113 to Department 42 at the Foltz Criminal Justice Center. The Court also increased the frequency of hearings from biweekly to weekly. The program now meets every Monday to conduct team meetings, hear progress reports, and enroll new clients.

Action Plan: Energy continues to be focused on grant writing to access new funds for the CODC program. The SSG development team is working closely with the Countywide Criminal Justice Coordination Committee (CCJCC) on numerous grants to expand services to additional clients and to enhance the services that are currently offered. SSG Central Mental Health was recently awarded a new Department of Justice grant which will fund an additional Employment Specialist and facilitate the provision of increased supportive employment services. Finally, the PD and DMH will continue to work collaboratively to increase awareness and generate appropriate client referrals.

Client Success Story (by client): "I work at SSG Central Mental Health. I am also a member of the Peers Program. Peers help people with mental and addiction histories become employable. A year ago, I was on drugs and never thought I had a mental problem. Yet, I had spent 20 years in and out of drug programs. I went to jail, and then ended up at SSG. And for the first time in my life, I got help with my addiction and mental problems. I love my job and never thought I could have the life I have today."

12) 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
FYs 2008-09 and 2009-10, through September 30, 2009

			Cumulative
Chronic Homeless	515	Education	22
Homeless Individuals	1,338	Job training/referrals	622
		Job placement	196
Female	723		
Male	1,130		
		SSI/SSDI	152
Hispanic	247	Section 8	4
African American	1,215	Veteran's	1
White	328		
Asian/Pacific Islander	36		
Native American	16	Case management	2,723
Other	11	Health care	719
		Life skills	357
		Mental health/counseling	629
16-24	197	Substance abuse (resident)	21
25-49	1,266	Substance abuse (outpatient)	115
50+	390	Transportation	716
	Cumulative	Recuperative care	3
Rental (housing) subsidy*	2,723	Social/community event	1
Moving assistance	1,793		

Longer-term Outcomes (point in time)	6 mo.	12 mo.	18 mo.
Receiving rental subsidy	486	196	179
Obtained employment	13	-	-
Maintained employment	7	1	-
Enrolled in educational program, school	5	-	-
Case management	486	196	179
Health care	28	13	17
Mental health/counseling	18	34	21
Substance abuse treatment (outpatient)	4	2	1

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

Table C.5: DPSS GR Housing Subsidy and Case Management Project Measures
FY 2009-10, First Quarter

	First Quarter	To date
Number of applications received	339	1,790
Average number of business days to approve	18	19
Average amount of rental subsidy	$292	$292
Number of individuals re-entering program	10	103
Number of SSI approvals	46	140
Percent of SSI approvals	(46/1,057) 4.35%	(FY 2008-09) 7.94%
Number of individuals disengaged from program	166	656
Case Management (level 3)		
Average case management hours for each participant per month:		5 hours
Total case management hours for all participants during current reporting period:		4,793 hours
Number of cases per case manager:		96 cases

Successes: During this quarter, there were 13 job placements and 46 SSI approvals. 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.

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

Action Plan: Staff encourage participants to provide valid contact numbers and update the waiting list every month.

Client Success Stories:
Mr. S, a homeless GR employable participant, was admitted to the GR Housing Subsidy program in June 2009. The Housing Case Manager (HCM) recommended to his case carrying General Relief Opportunities for Work (GROW) Service Worker that Mr. S be placed in the Intensive Case Management (ICM) component. After four months in ICM, Mr. S was hired by an assembly plant earning $10 per hour. As a result, Mr. S pursued his employment goals and has become self-sufficient.

Ms. M, a potential SSI participant, has been in the GR Housing Subsidy since June 2008. She was referred to the SSI Advocate to immediately start her SSI application process. It was a challenging task for the SSI Advocate to locate medical records. After 15 months of SSI advocacy, Ms. M's SSI benefits were approved beginning in September 2009. Ms. M has exited the GR Housing Subsidy project and is very thankful to all DPSS staff that helped her transition to SSI.

13 and 14) 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 (unduplicated count) FY 2009-10, through September 30, 2009	**Total FY**	**DPSS-DHS**		**DPSS-Sheriff**	
		FY	**Cumulative**	**FY**	**Cumulative**
Homeless Individuals	739	106	934	623	5,254
Female	250	26	*115	224	*941
Male	479	80	405	399	1,053
Transgender	-	-	-	-	5
Hispanic	241	33	156	208	751
African American	270	25	189	245	957
White	171	36	143	135	451
Asian/PI	28	8	16	20	25
Native American	4	1	3	3	6
Other	15	3	13	12	34
16-24	151	1	19	150	428
25-49	449	56	276	393	1,305
50+	129	49	225	80	260
Housing (emergency)	309 cumulative	16	91	31	218
Average stay (days)	13	13	-	13	-
CalWORKs (approvals)	4	-	1	4	54
General Relief (w/FS)	2,750	25	315	233	2,435
General Relief only	431	11	88	40	343
Food Stamps only	62	-	5	8	57
SSI/SSDI	56	-	-	31	56
Veterans' benefits	13	-	-	7	13

*Demographic information not available for FY 2007-08. Cumulative demographic information includes FYs 2008-09 and 2009-10.

Table C.7 Program Measures	Cumulative Total	DPSS-DHS		DPSS-Sheriff	
		FY	Cumulative	FY	Cumulative
Total referrals received	9,584	106	918	790	8,666
Total referrals accepted	6,286 (66%)	38	462	623	5,824
Of the total referrals accepted:					
Total approved	321 (FY)	36	*169	285	2,931
Total denied	18 (FY)	-	*186	18	151
Total pending release:	1,465 (QTR)	2	-	1,464	-
Releases/discharges	860	38	277	450	583
Number of applications					
Food Stamps	69	11	12	8	57
General Relief	3,029	25	400	273	2,629
CalWORKs	49	-	1	4	48

**Information not available for FY 2007-08.*

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: Although the number of referrals has increased, the current accepted level of referrals is very low. The number of accepted referrals should be higher.

Action Plan: The program manager will work with the staff to ensure they are fully aware of the eligibility criteria and are using the referral tool correctly.

DPSS-Sheriff Homeless Release Project

Successes: Priority list interviews at the Inmate Reception Center (IRC) have increased significantly. The priority list allows the Eligibility Worker (EW) to interview more inmates in less time. These interviews are also insuring more processing at the Community Transition Unit (CTU).

Challenges: Referrals received by fax are not being seen by the EW due to a priority list, and it is difficult for the Sheriff Custody Assistants to request inmates from the Men's Central Jail (MCJ) throughout the day. Many referrals sent via fax are released prior to the EW interview.

Action Plan: The program will identify an alternative method to receive fax information to assure interviews.

15) Homeless Recuperative Care Beds

Goal: Provide recuperative care services to homeless individuals being discharged from County 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 2009-10, through September 30, 2009

(unduplicated count)	Quarter	Cumulative		Quarter	Cumulative
Homeless Individuals	64	344	Housing (permanent)	5	37
			Housing (transitional)	10	42
Female	13	56	Housing (emergency)	1	32
Male	51	286			
Transgender	-	2	General Relief only	-	11
			Medi-Cal/Medicare	-	7
Hispanic	27	73	SSI/SSDI	-	7
African American	20	88			
White	14	64	Case management	64	344
Asian/Pacific Islander	1	3	Health care	64	344
Other	2	19	Life skills	-	12
(race doesn't include two quarters; updating)			Mental health/counseling	-	1
16-24	-	4	Recuperative care	64	344
25-49	30	169	Transportation*	-	70
50+	34	171	Substance abuse (outpatient)*	-	2

Program Measures	Quarter	Cumulative
Number of patients referred for recuperative care beds	81	437
Number of patients admitted to recuperative care services	64	344
Number of patients who were discharged from recuperative care services	65	314
Number of patients who were assigned to a primary health care provider during recuperative care stay	64	344
Average length of stay for patients in recuperative care program (days)	25	30
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:	30 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

Successes: The Recuperative Care program **served 344 unduplicated individuals** to date, from April 2008 to September 2009. At the end of the last 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. There are various challenges noted in data collection and reporting activities, particularly given the use of manual data collection and reporting methods.

Action Plan: 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 Health (AHH) program. The recuperative care director at

JWCH has oversight responsibilities for program activities and is continuing to work on addressing the identified challenges, including development of a database/data collection system for these services. DHS staff will continue to meet with JWCH management staff to discuss program status and progress and provide assistance as needed. Although some improvements have been noted for data collection and reporting activities, further improvement is needed and DHS will continue to work with the program director.

Client Success Story: Mr. D was admitted to Rancho Los Amigos Rehabilitation Center due to severe burn wounds to his lower legs. He had a previous hospitalization for these wounds, however his lack of stable housing and support with limited self-care abilities led to an exacerbation of his condition. After his inpatient stay, Mr. D. was admitted to the Recuperative Care Program for his after-care needs.

Although Mr. D. received daily wound care from program staff and follow-up care on an outpatient basis with the referring County facility, it was noted that there was no significant change to his condition. Program staff continued to provide daily monitoring and care as his wounds slowly healed. Mr. D.'s condition improved enough for staff to teach him to perform self-care and dressing changes.

During his recuperative care stay, case management staff assisted Mr. D. with applying for and accessing needed services, such as mental health treatment, support groups, and transportation. His case manager also helped him with housing resources and placement options. An application for permanent housing with the AHH project was submitted and approved. Recuperative care staff worked closely with Mr. D. and AHH staff to plan and coordinate Mr. D.'s discharge from recuperative care into an independent living environment.

Mr. D. was discharged from recuperative care in August 2009 into permanent housing through the AHH program. He is being followed at the JWCH Center for Community Health for his medical needs. Mr. D. was very appreciative of the services and support he received and said he now has a new outlook on his life.

16) Housing Specialists - DMH

Goal: Assist homeless individuals, families, and transition age youth (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

	FY 2009-10	FY 2008-09	FY 2007-08
Number of referrals to program	n/a	842	n/a
Number of property owners contacted	381	360 (QTR)	898

Successes: The Countywide Housing Specialists, funded through the Mental Health Service Act (MHSA), initiated contact with 308 unduplicated homeless individuals and 23 homeless families with a mental illness during the first quarter of FY 2009-10. During the various contacts, the Countywide Housing Specialists provided a variety of housing related services: 70 received assistance to find permanent housing; 312 were referred to an emergency shelter funded through the Department of Mental Health (DMH), 74 were assisted with moving into a transitional housing program and 46 received financial assistance with their moving-in expenses (security deposits). DMH secured additional funding through the American Recovery and Reinvestment Act (ARRA) Emergency Food and Shelter Program (EFSP) to supplement the existing Countywide Housing Assistance Program funded through MHSA and the Projects for Assistance in Transition from Homelessness (PATH) grant. DMH was awarded $51,051 to provide rental assistance, eviction prevention, hotel/motel vouchers, and grocery store food vouchers.

Table C.10: Participants and Services
FY 2009-10, through September 30, 2009

	FYs 2008-09 and 2009-10	FY 2007-08
Chronic homeless individuals	79	-
Homeless individuals	1,112	2,343
Homeless families	81	255
Transition age youth	12	142
Demographics not provided for all participants in families		
Female	667	*n/a
Male	611	
Transgender	10	
Hispanic	473	
African American	389	
White	300	
Asian/Pacific Islander	33	
Native American	7	
Other	62	
16-24	6	
25-49	1,222	
50+	23	
	FY 2009-10	**Cumulative**
Moving assistance	140	282
Eviction prevention	5	10
Housing (emergency)	810	1,617
Housing (transitional)	338	641
Housing (permanent)	308	625
Rental subsidy	119	223
Section 8	199	*199
Mental health	681	*681
Life skills	223	223

*Information not available for FY 2007-08.

Challenges: The Department is challenged with assisting its target population (who primarily fall in the low and very low-income levels) to identify affordable permanent housing. In the past, the Department has relied on rental subsidies provided through contracts with the Housing Authority of the City of Los Angeles (HACLA) and the Housing Authority of the County of Los Angeles (HACoLA) to access private rental housing. Currently, the Department has a limited number of federal housing subsidies available for DMH clients through the Shelter Plus Care and the local Homeless Section 8 Programs offered by both HACLA and HACoLA. Although DMH has been successful in competing for additional rental subsidies with the local housing authorities, the execution of those contracts continues to be delayed.

Action Plan: To confront the challenge of identifying affordable permanent housing to meet the housing needs of low and very low income residents, the Department will continue to apply for rental subsidies offered by the local housing authorities; seek other funding sources for rental subsidies; and disseminate information regarding the availability of affordable housing projects that target individuals with low income.

In addition, DMH will work to move local housing projects with a commitment of MHSA Housing Program funds toward completion, thereby creating approximately 800 new affordable housing units in the County.

Client Success Story: The Service Area 3 Housing Specialist reported that he recently housed one of his clients who had been homeless for over 20 years. The client lived on the streets and in his car with a long history of alcoholism. Prior to seeking assistance with housing, the client participated in mental health services from Arcadia Mental Health for one year. The Housing Specialist worked with the client for nine months to complete the Shelter Plus Care application and identify an apartment. After he was housed, the client had his items secured in his apartment, but he continued to sleep in his car and take showers at the YMCA. The Case Manager and the Housing Specialist offered support and encouragement during this transition from living in his car to having his own place. After thirty days, he was able to sleep in the apartment and take advantage of the apartment's amenities. The client is doing well and has remained housed. He is able to address his alcoholism problem by attending Alcoholics Anonymous (AA) meetings. The Housing Specialist reported that if he did not have a place of his own, it would have been difficult for him to focus and work on his sobriety.

17) 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 2009-10, through September 30, 2009

(duplicated count)	Cumulative		Cumulative
Homeless Individuals	202	Housing (emergency)	12
Chronic Homeless	287	Housing (transitional)	113
		Housing (permanent)	61
		Moving assistance	13
Female	142	Job training	258
Male	276	Job placement	30
		Education	44
Hispanic	120	Life skills	10
African American	188	General Relief (and Food Stamps)	56
White	146	General Relief only	56
Asian/Pacific Islander	11	Food stamps only	32
Native American	3	SSI/SSDI	10
Other	49	Veterans' benefits	12
(not for all participants)		Case management	364
		Health care	14
16-24	82	Mental health care	14
25-49	469	Substance abuse, outpatient	40
50+	88	Substance abuse, residential	67
		Transportation	88
		Legal advocacy	107

Program Specific Measures	Cumulative
Number of participants who received intake/enrollment	486
Number of participants who received intake/enrollment within 72 hrs of initial interview	332
Number of participants who did not complete program (exited prior to completing)	120
Number by violent crime	135
Number by non-violent crime	353
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	636
Number of times in State prison	69
Number of participants with a service plan	1,936
Number of participants with a service plan within a week from intake/enrollment	1,936

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	**Quarter**
Average stay at emergency/transitional housing: (11 participants)	70 days
Case management (level 1)	
Average case management hours for each participant per month:	2 hours
Total case management hours for all participants during current reporting period:	1,214 hours
Number of cases per case manager:	36 cases
Longer-term Outcomes (6 or more months) FY 2009-10, First Quarter	
Maintained permanent housing	28
Maintained employment	7
Enrolled in educational program, school	10
	166
Case management	15
Health care	23
Mental health/counseling	

Successes: The Just In-Reach program (JIR) has assisted in placing 186 homeless or chronically homeless inmates into transitional or permanent housing during the program year. With partnerships with other agencies, the JIR program has contributed directly toward move in costs for placements in permanent housing. Staff continues to work with clients after housing placements to provide them the necessary supportive services to continue their success. JIR staff participate in structured staff trainings that are approved by the Sheriff's Department in order to stay current and consistent with best practices for the clients. Staff has applied training materials into workshops pre and post release. These workshops are often accompanied with written materials that are provided to clients.

Challenges: Staff continues to manage high caseloads due to a high demand for the services. Specifically, JIR employment specialists have had difficulty placing clients into jobs. Most of JIR clients report not having any history of employment. Coupled with the current state of the job market, JIR staff relies heavily on existing and new employer relationships to place the clients. Clients are also given incentives such as clothing and transportation passes for their job search. Once the client is placed, intensive follow up continues with the client to aid them in adapting to new circumstances. Although the enrollment level remains high, it did trend lower for the last two quarters. There is still not enough staff to maintain these high levels, and there is a big emphasis to utilize linkages and existing partnerships.

Action Plan: JIR began incentive plans for participants during their initial contact and have stated that they 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. This has expanded to job search and housing placements. There has been a positive reaction to job seekers, knowing that there is additional incentive in conducting legitimate job searches. JIR staff has increased its participation in employment training, housing training, anger management, and crisis intervention which has been incorporated directly to the clients. During the quarter, staff attended a two day re-entry symposium. In addition, staff participated in an extensive training from an East Coast collaborative that runs a 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 initial program is able to achieve.

Client Success Story: A male client from the Twin Towers facility had re-entered the system after recently completing 15 years in prison. He entered the JIR program as a frequent user of the County Jail and

emergency shelter systems. He was able to secure employment less than one month after release. JIR staff members worked tirelessly with him to secure housing. Although he was able to secure decent income, he had little or no credit history. JIR assisted him in securing credit checks with multiple renters, but he was not able to clear any of them. JIR contacted each landlord after the failed credit checks to try to negotiate for the client and give the landlord assurances that this person would have support. One landlord finally agreed, if JIR would provide a company check to pay for the security deposit and first month's rent. The client has since moved into his own apartment and has begun to reestablish his relationship with his teenage son.

18) 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 2009-10, through September 30, 2009

	Cumulative		Cumulative
Homeless Individuals	807	Education	10
Chronic Homeless	114	Job placement	2
Homeless Families	10	Job training	3
Female	112	General Relief (and Food Stamps)	13
Male	818	General Relief	6
Transgender	1	SSI/SSDI	6
Hispanic	199	Veterans' benefits	21
African American	319	Case management	129
White	332	Health care	19
Asian/Pacific Islander	32	Mental health	28
Native American	5	Substance abuse (residential)	8
Other	44	Transportation	144
		Life skills	28
16-24	62	Social/community event	5
25-49	523	Other	
50+	348	Credit repaired	34
		Legal services	4
Moving assistance	16	Drivers license reinstated	20
Housing (emergency)	92		
Housing (transitional)	29		
Housing (permanent)	18		
Rental subsidy	13		

Program Specific Measures	Cumulative
Number of mental health coordination activities conducted	42
Number of mental health assessments provided to homeless veterans by MHALA	22
Number of meals provided to homeless veterans. (includes food/meal vouchers)	96
Number of homeless veterans whose child support payment was eliminated or reduced by SPUNK	44
Number of outreach sessions conducted by U.S. Vets and DHHS	26
Number of homeless veterans contacted through outreach sessions by U.S. Vets and DHHS	513
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, Department of Health and Human Services (City), Mental Health America of Los Angeles (MHALA), Single Parent United N Kids (SPUNK) and United States Veterans Initiative (U.S. VETS) continue to meet regularly and implement comprehensive outreach and service delivery for homeless veterans. To support the goals of the HVI, the partners continue their collaborations with other agencies such as Veterans Affairs Long Beach Healthcare System, Legal Aid Foundation of Los Angeles and the University of Southern California (USC) School of Social Work. The Mental Health Coordinator (MHC) has also established a relationship with the Los Angeles County Department of Mental Health (DMH) Veteran's

liaison to promote future collaborations and funding opportunities with Mental Health Services Act (MHSA) Prevention and Early Intervention programs.

This quarter, the four partner agencies of the HVI served 275 veterans with services that include street outreach, case management, child support reduction, mental health and substance abuse interventions and housing placement. MHALA outreach team has been particularly effective with engagement, building trust with service resistant veterans, and linking them directly to Veterans Affairs (VA) services. MHALA "White Bison" program has been instrumental with the increased engagement of veterans on the street. U.S. VETS recently expanded the Veterans Reentry Project (VRP). The project, which previously had a 12-bed capacity, now serves 23 recently separated veterans. This increase, due to the growing demand for services within Long Beach, provides additional housing resources for the HVI. During the first quarter of the fiscal year, SPUNK reported a total of 35 cases. Of the 35 cases, SPUNK was able to close 16 cases for a total arrears savings of $278,827. Due to the program's continued success, SPUNK has received requests to expand services to the Veterans Affairs Medical Center and Beacon House, a residential substance abuse center that serves a large number of veterans.

The City's Multi-Service Center (MSC) HVI staff has done extensive outreach to the Veterans Affairs Healthcare System, Clinical Social Work Division. Together, these two agencies are working to streamline referrals for the Department of Housing and Urban Development and Department of Veterans Affairs Supported Housing (HUD-VASH) Program, which provides long-term case management, supportive services and permanent housing support to eligible homeless Veterans. The Veterans Affairs Long Beach Healthcare System is scheduled to receive 105 HUD-VASH vouchers; through ongoing coordination between HVI and VA staff, these vouchers will provide HVI veterans with housing stability.

In addition, the City's MSC, MHALA and U.S. VETS outreach staff participated in the Long Beach Connections Homeless Survey project in July 2009. The Homeless Connections Initiative (HCI) is a group of stakeholders led by PATH and MHALA working together to design specific actions that will help homeless people transition off the streets into housing. A total of 347 people were surveyed, of which 76 self identified as U.S. Veterans. Outreach staff continues to engage the veterans identified during this survey to assist with HUD VASH housing opportunities. During this quarter, three of the 76 veterans surveyed have been housed permanently.

The Mental Health Coordinator (MHC) continues to engage in projects that lead to better access of mental health care for veterans. As a participating member of the Veteran's Mental Health Council in Long Beach, the MHC collaborates with the DMH veteran's liaison to promote the collaborative process between City, County and federal agencies. MHC initiated a Long Beach Discharge Collaborative group comprised of City, County, non-profit and private agencies that are impacted by recidivism and high utilization of emergency medical and mental health services by the most vulnerable populations. This group meets monthly to discuss system barriers, solutions and promote a more comprehensive approach to addressing discharge planning and aftercare. In addition, the Discharge Collaborative will work with other community projects such as HCI in the outreach, engagement and housing of vulnerable homeless veterans.

Challenges: The HVI collaborative had previously reported a challenge in the duplication of client information amongst the different agencies in the collaborative. Each of the partners had been tracking and reporting the data for their clients, while the collaborative worked on a method to eliminate duplicated clients in the demographic information for the report. U.S. VETS staff members are now formally trained to track clients through the Homeless Management Information System (HMIS), which reduces the duplication of information and services for clients served under this collaborative. The HMIS facilitates access to client information by members of the HVI collaborative in order to be able to efficiently coordinate services. In addition to compiling client information, the HMIS also assists with developing accurate reports regarding outcomes for the HVI client population. Using the HMIS has also streamlined intake processes among the collaborative partners working with the same veterans accessing different components of the HVI collaborative. U.S. VETS continues to report barriers in setting up presentations about their programs on the local military bases. SPUNK has encountered various systematic issues due to the backlog in Los Angeles County and the Compromise of Arrears Program (COAP). Due to this

backlog, a case can take up to 4 months. The unemployment rate is 13.8% in Long Beach; therefore affordable housing options have been difficult to access with limited resources available.

Action Plan·
The HVI partners will:

- Continue to provide essential outreach and engagement services to homeless veterans.
- Utilize HMIS to reduce the duplication of information and services for clients served under this collaborative.
- Continue to collaborate with other service providers with the HVI so as to ensure continuity and streamlining of services to veterans experiencing homelessness.
- Collaborate with the Acting Deputy Commander at Los Alamitos Joint Forces Training Base to discuss a partnership that will enable U.S. VETS to participate in the Department of Defense's Yellow Ribbon Reintegration Program (YPRP), which provides resources and counseling to Guard and Reserve members and their families throughout combat deployments.
- Continue to investigate and utilize funding opportunities through the Homelessness Prevention and Rapid Re-Housing Program under the 2009 American Reinvestment and Recovery Act and future Mental Health Services Act Prevention and Early Intervention funding sources.

Client Success Stories:
An 81-year-old chronically homeless veteran had been living out of his van for six years. The client has both mental and physical health issues. He has been unable to obtain housing because of his child support debt and was reported delinquent to various credit agencies. SPUNK was able to get his back child support of $5,200 reduced to zero, and it was discovered that he had actually overpaid in the amount of $264. The SPUNK staff member was able to get this veteran a refund of the overpayment. This client was also referred to Legal Aid to investigate whether he was entitled to additional credit towards his child support. The client is moving into permanent housing with the assistance of his HVI case manager.

Through HVI outreach efforts, an honorably discharged homeless veteran of the U.S. Navy was recently admitted to the Veterans Re-entry Project (VRP) program. The veteran experienced co-morbid substance abuse and mental health issues, including suicidal tendencies and depression. U.S. VETS has provided and assisted the veteran in obtaining veterans benefits; counseling services, work re-entry assistance, and case management, among others. As a result of the intensive efforts, he has been stabilized and recently obtained employment as an office clerk. The U.S. VETS team continues to provide ongoing support to this veteran to ensure his successful road to recovery is maintained.

Client is a 45-year-old homeless man partially blind, diagnosed with cataracts in both eyes. HVI outreach staff placed the client at Project Achieve Shelter, and subsequently was referred for medical services to address his vision impairment. He initially received a cane and protective eyewear through the Disabled Resources Center. He was then referred to St. Mary Medical Center's Low Vision Center/ Angels for Sight Program (ASP), and has now started the process for eyesight restoration. The client shared that he had grant writing experience with his ASP counselor and was looking for a job. The client was offered a position with ASP, and he is thrilled to have the opportunity to give back to a program that helped restore his vision.

19) 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 2009-10, through September 30, 2009

	FY	Cumulative		FY	Cumulative
Homeless Individuals	322	1,510	Hispanic	81	362
			African American	149	767
Female	117	519	White	71	302
Male	204	987	Asian/Pacific Islander	11	26
Transgender	1	4	Native American	7	13
			Other	3	40
Alternative court	287	1,453			
Transportation	35	52	15 and below	-	-
Food card	24	24	16-24	33	129
Housing (emergency)	2	2	25-49	203	971
Substance abuse treatment (residential)	2	2	50+	86	410

Program Specific Measures	FY	Cumulative
Number of Los Angeles County Homeless Court motions received	950	4,339
Number of program participants whose qualifying motions are submitted to and filed by Superior Court, and resolved within 30 days of submission	932 100%	4,321 100%
Number of audited records in the Superior Court's automated case management systems (TCIS/ETRS) that are accurate	48 100%	195
Number of motions that are granted by Superior Court	932 100%	4,257
Number of motions that are denied by Superior Court	-	8
Number of individual cases filed under the Los Angeles County Homeless Court	987	4,880
Number of participants whose applications are submitted to the Los Angeles County Homeless Court within 30-days of initial contact with participant	272	1,387
Number of participants that have Los Angeles County citations or warrants dismissed upon program completion	169	1,291
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	287	1,447
Number of case managers who receive training on Los Angeles County Homeless Court benefits, application and eligibility requirements, and legal resources	291	1,256

Successes: During this quarter, Public Counsel and Volunteers of America (VOA), with whom Public Counsel subcontracts to administer the Homeless Court Program's transportation services and emergency hotel and food vouchers, succeeded in identifying two hotels to accept emergency hotel vouchers, one in East Los Angeles and one in South Los Angeles. With the implementation of this component, VOA is now administering all three services—transportation, housing and food—as provided for in the subcontract. Public Counsel and VOA also worked together to create a uniform procedure for administering all three services so that they can be accessed more effectively and their usage can be tracked more accurately.

Public Counsel and VOA have also been successful in increasing utilization of transportation services. Transportation services are especially valuable for getting clients to and from Homeless Court sessions. In addition, transportation services help clients get to other courts and the mental health, substance abuse, housing, vocational, and case management service providers that play a crucial role in helping Homeless Court participants overcome the problems that led to or prolonged their homelessness.

Superior Court: With the increase in the number of clients and the associated requests for court relief, a second judicial officer (Honorable Gregory A. Dohi) has agreed to participate in the graduation ceremonies. Now, for each graduation ceremony there are two sessions. One continues to be presided

over by the Honorable Michael A. Tynan. The advantages of two equally weighted and smaller sessions include that each ceremony takes less time to complete and the judicial officers have more time to recognize individual participating clients.
Superior Court refined workflow procedures to better group client motions for judicial review and determination. The results have included faster turnaround times for both judicial review and clerical processing.

Challenges: The greatest challenge this quarter for the Homeless Court Program was a significant turnover in staff at the Los Angeles City Attorney's Office. The departure of City Attorney staff that played an integral role in the development and operation of the Homeless Court Program has resulted in the loss of expertise and valuable leadership. However, new City Attorney staff has been assigned to the program and all indications are that the City Attorney's Office will continue to fully support and facilitate the implementation of this vital program. Public Counsel also experienced staff turnover during this quarter. Although this required a temporary diversion of resources towards the training of the new personnel, Public Counsel does not anticipate any loss of productivity or capacity to serve those accessing the program.

One Superior Court performance measure is to ensure all matters are resolved within 30 days of submission. Resolved means that a judicial officer has ruled on the request, all clerical processing has been completed, and Public Council has received notice of ruling. A continuing challenge for Superior Court remains in obtaining all case files wherein the prosecutor has filed a formal complaint against a client in a timely manner. Superior Court staff at the Central Arraignment Courts sometimes encounters delays in obtaining case files from other courthouses. This can result in delays in processing all of a client's pending requests for court relief at the same time.

Action Plan: During this transition period, Public Counsel's Homeless Court team is focusing its efforts on training new staff and volunteers on all aspects of the Homeless Court process, including the administrative procedure for resolving citations as well as management of the ceremonial Homeless Court sessions. Public Counsel's staff is also working to ensure that Homeless Court cases continue to be processed efficiently while new staff is trained. Regular meetings continue to occur with the new City Attorney staff to ensure continuity in the services provided to the community.

Superior Court: Public Council recently assigned different staff to participate in this program. Superior Court began working with Public Council to set up training on reviewing the information contained in the Court's case management systems.

Client Success Story: Client M was referred to Homeless Court by his Department of Public Social Services General Relief Opportunities for Work (GROW) caseworker. He had been looking for work but found that his outstanding citations hindered his job search. Once his citations were resolved through Homeless Court, he was able to be hired as a fire safety inspector.

After years of struggling with substance abuse, Client R sought help from a drug and alcohol rehabilitation program. Once he had completed 90 days of treatment, his case manager applied to Homeless Court on his behalf. His outstanding citations were resolved through Homeless Court, making it possible for him to work as a driver for the drug and alcohol rehabilitation program in which he had participated. He was recently accepted into a violence prevention program at a top university in Southern California and he plans to focus his career on reducing gang violence.

20) 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 2009-10, through September 30, 2009

(unduplicated count)	FY	Cumulative
Homeless Individuals	168	767
Number applications received	168	767
Moving assistance approved	50	240
Percent applications approved	30%	31%
Average days to approve	10	*
Average amount of grant	$595	**
***		
General Relief (w/FS)	82	244
General Relief only	3	12
Food Stamps only	18	27
Medi-Cal/Medicare	-	1
SSI/SSDI	5	25
Section 8	-	1
Shelter Plus Care	-	10
Veterans' benefits	-	2

	Cumulative
Female	252
Male	337
16-24	23
25-49	285
50+	281
Hispanic	75
African American	360
White	128
Asian/Pacific Islander	1
Native American	20
Other	5

Demographic information was not available for all clients during FY 2007-08.

* FY 2007-08 average was 20 days; FY 2008-09 average was 12 days.
**FY 2007-08 average was $575; FY 2008-09 average was $722.
***Cumulative data for benefit information only includes FYs 2008-09 and 2009-10.

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 outreach efforts at transitional shelters and other agencies that provide services to the homeless population.

Client Success Story: Mr. G, a homeless participant, had difficulty in getting a job because of his situation. Fortunately, Mr. G was referred to the Single Adults Move-In Program and was provided the security deposit to move into permanent housing. The move enabled Mr. G to search and apply for employment. He called his HPI Eligibility Worker to inform him that he has gone for several interviews and may be offered a permanent job soon.

21) 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 2009-10, through September 30, 2009

(unduplicated count)	FY	Cumulative
Chronic Homeless Individuals (ever housed)		58
Female	2	7
Male	3	50
Transgender	-	1
Hispanic	1	12
African American	3	46
White	1	7
Asian/Pacific Islander	-	-
Native American	-	-
Other	1	1
25-49	1	17
50+	4	41
Eviction prevention	2	10
Housing (emergency/transitional)	5	46
Housing (permanent)	5	58
Rental Subsidy	-	41
Moving assistance	1	2

	FY	Cumulative
Education	-	2
Job training/referrals	-	2
Job placement	-	2
General Relief (GR,FS)	-	10
General Relief only	3	10
Food Stamps	-	1
Medi-Cal/Medicare	5	21
Section 8	-	1
Shelter Plus Care	5	46
SSI/SSDI	5	36
Veterans	3	11
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 (6 of more 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:	15 hours
Total hours for all participants:	157 hours
Number of cases per case manager:	15 cases

Program Specific Measures	Quarter	Cumulative
Number of participants who exited housing	-	11
Number of participants developing individualized treatment plans	5	46
Number of participants participating in a housing retention group	-	30
Number of Project 50 participants having arrests	4	19
Number of Project 50 participants having hospitalizations	3	18
Number of Project 50 participants having an emergency room (ER) visit	2	8
Number of Project 50 participants with increased income (i.e., due to SSI/SSDI, GR)	3	19

Successes: Project 50 was one of the top ten recipients of the Quality and Productivity Award for 2009. Project 50 has an 89% housing retention rate along with a 70% rate of participants with SSI. Specifically, 32 people have received SSI, and 11 applications have been submitted for the remaining participants. Two have been denied for various reasons.

The goal for the project is for homeless participants to be sustained in permanent supportive housing. The project has also demonstrated that various County, City and non-profit agencies can work together as a team to make this project a success. Project 50 staff has initiated a Community Integration program that encourages participants to visit various cultural and recreational attractions throughout the city. The most recent trip to the J. Paul Getty Museum in Brentwood was a rousing success. The participants had a personal tour and several expressed a desire to return again to this wonderful cultural icon. Project 50 continues to innovate and support participants as they integrate into and maintain stable housing.

Challenges: Working as a team, the Project 50 staff has had significant success in maintaining housing for the chronic homeless. The team continues to work with clients to resolve substance abuse and 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, explore development of a process group for participants to deal with loss;
- Continue to add participants to continually have 50 clients currently housed; and
- Hire a money manager and continue intensive substance abuse interventions.

Client Success Story: Client M has been going to school to regain his Merchant Marine License. He has passed all his coursework and is awaiting physical and security clearance before he returns to work.

22) 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 (Board Approved Funding)

Table C.16: Santa Monica Homeless Community Court Participants and Services
FY 2008-09, Cumulative (February 2007 – June 2009)

(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 (FSP) 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 FSP'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 the 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 the 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 participants 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.

23) 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 2009-10, through September 30, 2009

(unduplicated clients)	Cumulative		Cumulative
Chronic Homeless Individuals	27	Moving assistance	11
		Housing (transitional), 38 day stay	13
Female	9	Housing (permanent)	9
Male	18	Housing (emergency)	2
		Eviction prevention	2
Hispanic	5	Rental subsidy	7
African American	5		
White	15	General Relief with Food Stamps	1
Other	2	Medi-Cal/Medicare	1
		Case management	46
25-49	13	Health care	6
50+	14	Life skills	23
		Mental health care	31
		Social/community activity	33
Job training	1	Transportation	33
Section 8	1	Substance abuse treatment (outpatient)	3
Shelter Plus Care	3	Substance abuse treatment (residential)	4
		SSI/SSDI	1
		Alternative court	2

Case management level 3	**Quarter**
Average hours per case:	20
Total number of hours:	498
Caseload per case manager:	6
Longer-term outcomes (six months)	
Continuing to live in housing	2
Continuing to receive rental subsidy	2
Case management	7
Health care	2
Good or improved physical health	2
Mental health care	5
Good or improved mental health	4
Number of organizations/agencies that your program has a formal collaboration for this project	6
Number of times collaborative partners met each month	1
Total amount ($) of HPI funding leveraged for project	$2,645,657
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	68%
Total number currently enrolled in program	84
Number of participants who left the program during this period	32
Number of clients who received an assessment (if applicable)	1
Cost per participant	$1,639
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning/end*** of the quarter	20 0

Successes: The HOME Team has provided ongoing case management to 20 active clients in need. They have been successful in supporting permanent, transitional and emergency housing for 13 of these participants. In this reporting period the program assisted two participants in diverting legal consequences by writing letters of support and attending court dates. They prevented an eviction of a participant through mediation with tenant and landlord. The HOME Team provided support and transportation assistance to promote physical health and medical intervention. In addition, they provided support and case management to assist participants in increasing their mainstream benefits.

Challenges: There are several challenges in assisting chronically homeless individuals into permanent housing. It is difficult to prepare a client for the interview process with a landlord due to their emotional state and appearance. Clients can become resistant, uncomfortable and even experience a triggering of

their symptoms from the pressure of having to meet with a person of authority and fill out paperwork to apply for housing. Landlords may not be familiar with the Section 8 process and may have had some previous experiences with Section 8 that cause them to pause when considering the chronic homeless population. In Santa Monica, the team has an additional challenge of finding apartments that are compatible with the monetary cap of Section 8 requirements. Finally, participants are subject to the fears and bias people have about mental health issues. Also, there is self-stigma which leaves individuals living with a mental illness to feel powerless, causing them to settle for less than they deserve or not even attempting to utilize these housing opportunities.

Action Plan: The Step Up HOME Team will continue to acquire Section 8 vouchers and increase benefits for participants. The team will educate and encourage participants to engage in a money management program to assist them in improving their financial situation so they will be prepared to pay rent and a deposit when housing options are available. They will assist participants in navigating the legal system to reduce or remove legal barriers to housing and growth. The program will educate participants in presentation skills and better prepare them for interviews. In addition, the program will outreach to landlords and property management companies in the community to educate them about the Section 8 program and encourage their participation. Through such resources as Craigslist, the program advertises to landlords willing to accept Section 8 voucher holders. During home visits with participants who are housed, staff will assist in improving their life skills so that they can maintain their home and retain their housing. Moreover, the program will continue to assist participants in maintaining their physical health through connections to medical and dental care.

Client Success Story: Client J was diagnosed with major depression and alcohol abuse. He struggled with his mental illness, self-medicated by taking more than prescribed medications, and was not able to keep scheduled appointments. In January 2008, he was placed on the City of Santa Monica's Service Registry and listed as vulnerable. He became familiar with the Santa Monica Police Department, and eventually, after several arrests for intoxication was referred to Drug Court. From there he was sent to the CLARE Foundation for detox services and the Step Up on Second HOME Team advocated for him to be placed into their six month recovery program. In May 2009, the client and the Step Up team completed and submitted a Shelter Plus Care application to the City of Santa Monica Housing Authority and received his voucher in July. At that time, the client was accepted into Turning Point Transitional Program. During this period, the HOME Team searched for housing and supported him with his sobriety. In August 2009, the client and the HOME Team met with a landlord who agreed to rent an apartment to him. Together, the HOME Team and the client visited a furniture store and selected furniture for his apartment. Client J moved into permanent housing in September, and he continues to maintain sobriety, keeps scheduled psychiatric appointments, meets with the HOME Team weekly, and meets with his Shelter Plus Care case manager bi-weekly.

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

Table C.18: OPCC Safety Net (Access Center)
FY 2009-10, through September 30, 2009

(unduplicated clients)	Cumulative		Cumulative
Chronic Homeless	43	Section 8	9
		SSI/SSDI	7
Female	11	Shelter Plus Care	7
Male	32	Job placement	1
		Job training	4
Hispanic	2		
African American	8	General Relief with Food Stamps	2
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	24
50+	24	Substance abuse treatment (residential)	5
		Substance abuse treatment (outpatient)	8
Housing (emergency)	30	Food	12
Housing (transitional), avg. stay 24 days	7	Clothing	4
Housing (permanent)	8	Transportation	16
Rental subsidy	6	Life skills	8
Moving assistance	7	Recuperative care	1
		Case management level 3	
		Average hours per case:	337
		Total number of hours:	1,012
		Caseload per case manager:	10
Longer-term outcomes (six or more months)			
Continuing to live in housing			1
Receiving rental subsidy			1
Case management			10
Health care			3
Good or improved physical health			3
Mental health care			4
Good or improved mental health			4

Number of organizations/agencies 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	$2,238,567
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	54%
Number of participants who have enrolled (entered) into program during the reporting period	213
Number of participants who left the program during this period	128
Total number currently enrolled in program	334
Number of clients who received an assessment (if applicable)	919
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: OPCC Project Safety Net has outreached and engaged 40 of the most vulnerable, chronically homeless individuals in Santa Monica. OPCC Project Safety Net has secured permanent housing for eight chronically homeless clients since its inception. This quarter, two clients were placed in permanent housing. It is expected that an additional four individuals will sign leases and move into their own apartments in the coming days to be reflected next quarter. Four clients currently live in transitional housing (including a sober living facility, an inpatient treatment program, a VA residential program and OPCC Safe Haven shelter). This quarter, 11 clients stabilized in emergency housing in either shelter or

master leased units. One client is conserved in a VA facility, and an individual is in long-term hospitalization in the process of conservatorship due to grave disability.

To date, a total of 22 individuals accessed temporary or permanent housing this quarter. Additionally, eight individuals who currently hold housing vouchers are either seeking an apartment or have already secured an apartment (a ninth voucher was held by a client who passed away while in a master lease program this quarter). An additional four individuals have submitted completed applications to the Santa Monica Housing Authority and await approval for voucher issuance.

Challenges: Substance addiction, physical health conditions and serious untreated mental health issues, including resistance to mental health treatment are ongoing challenges. Staff is required to utilize much creativity, persistence and flexibility to face the hostility, suspicion and alienation often encountered by those with the longest histories of homelessness. The lack of low income housing and the time it takes to navigate government systems such as the Housing Authority, Social Security Administration, and obtaining ID, are significant challenges. However, interaction with the Santa Monica Housing Authority has become more efficient, and the program has made inroads in reaching willing landlords. Supporting housed clients with special needs who require intensive life skills training is time consuming and challenging. Project Safety Net lost its psychiatrist this quarter, and this has made it challenging to connect clients on the street with mental health.

Action Plan:

- OPCC Safety Net continues to creatively recruit landlords and provide them with the intensive support required for them to be willing to participate in the housing program.
- Project staff continues advocating with the Santa Monica Housing Authority to increase timeliness and efficiency in the housing voucher application process.
- Staff team will continue fostering a good working relationship with the Santa Monica Police Department's Homeless Liaison Program to move clients forward into services.
- Team is currently recruiting a new psychiatrist.
- Peer support groups are being developed in the next quarter to strengthen support to the increasing number of permanently housed clients.

Client Success Story: Client M, a senior who is partially deaf and blind, became homeless in 1981 after losing his job with the US Postal Service due to cutbacks. For 23 years he lived on the streets with no source of income; it was only in the last five years that he received General Relief benefits. Always very private and proud, he lived "under the radar" and refused any form of assistance. His plan was to "lay low" and sleep on the street until he became old enough to qualify for Social Security. In the past he came to OPCC's Access Center, but whenever anyone mentioned shelter he would quickly disappear. It took an intensive effort of developing enough trust to begin to accept help in small ways, but on his terms. As he became willing to accept services, however, things came together. He went into emergency housing in a motel room, and worked with his case manager to secure a housing subsidy with the Santa Monica Housing Authority. The client moved into his own apartment this month, and he has shown himself to be an ideal tenant - respectful and responsible.

IV. PROGRAMS FOR MULTIPLE POPULATIONS

24) Los Angeles County Housing Resource Center, (LACHRC; formerly known as the Socialserve 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 – September 30, 2009**	**Cumulative**	**Year 1 6.1.07 - 6.30.08**
Number of landlords registered on the site	6,595 *1,316 new*	3,505
Average monthly number of units available for rental	2,902	1,324
Total housing unit/ apartment complex listings registered on site (includes units that have been leased) *(as of December 2008)*	11,174 *1,402 new*	5,171
Total number of housing searches conducted by users that returned listing results	3,692,074 *402,996 new*	1,590,825
Average number of calls made/received to the Socialserve.com toll-free call center per month	3,034	2,897
Number of collaborative efforts forged between County Departments, Cities, and other stakeholder agencies.	78 *8 new*	33

Successes: The focus of activities during this past quarter was the development of an on-line pre-screening tool for the Homelessness Prevention and Rapid Re-Housing Program (HPRP) funded under the federal ARRA stimulus fund initiative. The website developer successfully developed a simple on-line form that allows the general public and County departments to quickly determine HPRP eligibility and make appropriate referrals for intake. The website also provides a rent comparability tool that assists County staff in placing HPRP clients in housing.

Challenges: The website is being used effectively to assist both the public and County staff in the implementation of both federal stimulus fund programs – Neighborhood Stabilization Program (NSP) and HPRP. However, the high priority rollout of these new federal programs continues to push back implementation of other housing information services and website functions planned for the website.

Action Plan: The following are key action items: 1) the contractor will continue to refine the HPRP pre-screening and referral tools and provide training for County departments; 2) the NSP State program will be added to the website; 3) additional mapping features are being launched to display NSP target areas in an interactive Google Map format; 4) the City of Pasadena will launch a partner site; and 5) LACHRC will outreach and partner with the Apartment Association of Greater Los Angeles.

Client Success Story: The Department of Public Social Services was able to use a “rent comparability” tool on this website that helped them meet federal program requirements to approve HPRP housing payments. Because the LACHRC has a database of local rental properties, it allows for rent reasonableness studies of comparable units. The contractor, Socialserve.com, provided the tool and training to County staff, which assisted with the timely launch of the HPRP program in the Los Angeles Urban County.

25) 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 (One-Time Funding)

Table D.2: Pre-development Revolving Loan Fund FY 2009-10, through September 30, 2009	**Quarter**
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	4
Number of loans by Supervisorial District	
Supervisorial District 1	2
Supervisorial District 2	-
Supervisorial District 3	-
Supervisorial District 4	-
Supervisorial District 5	2
Number of special needs households to be served by each loan	42
Number of low-income households to be served by each loan	209
Number of proposed total and affordable housing units	251
Number of housing units to be developed at 60% or below AMI	251
Number of housing units to be developed at 35% or below AMI	42
Number of reports collected on time from LLC	-
Number/percent of lost loans (live to date)	-

Successes: On July 28, 2009 $9,800,000 was wired to the Los Angeles County Housing Innovation Fund LLC (LACHIF).

Challenges: The current financial markets are making investment in the fund difficult.

Action Plan: On July 28, 2009, the Board of Commissioners approved a restructuring plan for the LACHIF. The LACHIF is currently negotiating investments by three financial institutions.

26) 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 (One-Time Funding)

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 (CEO) 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 has resulted in events on an ongoing, year-round basis.

Successes: Between December 2006, which is the first year the 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. Table D.3 shows the total number of PHC participants who were linked to emergency, transitional, and permanent housing by fiscal year.

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: A total of nine capital projects are funded under the CCP, and the Bell Shelter project has been completed. The Community Development Commission (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. Loan agreements are being finalized for three capital projects.

Challenges: The progress of many projects has been delayed by the State budget freeze, and one project (Century Villages at Cabrillo) is still awaiting State funding. One project (Mason Court) is in need of additional gap financing.

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 will provide technical assistance and conduct site visits to projects that are not under the oversight of any other public agency.

Cumulative Expenditures to Date: $3,817,638

Service Projects

Successes: To date, the CDC has executed 15 service contracts that are in full implementation. Four additional service contracts will be executed upon completion of the capital component of these projects. Programmatic and financial monitoring of projects began in September, with the initial four engagements completed and another six scheduled in the next six weeks. The results so far reveal that the programs are being implemented as proposed and costs are properly supported. Only minor deficiencies in internal control and administrative procedures have been noted.

Most agencies have recruited program staff, and have developed subcontract agreements with their identified collaborators. Most have been expending funds, with the remaining 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, four service projects will not start until their capital project component is completed.

CDC worked extensively with their 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. The Risk Manager and County Counsel have revised the language in contracts so that the responsibility to verify subcontractor compliance with insurance requirements will be with the contracted agencies instead of the CDC. The CDC also strengthened the indemnification provisions in the contracts. To implement these changes, the CDC processed contract amendments, which are currently in the final stages of approval.

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. CDC provided extensive individual technical assistance and training in these areas and has successfully resolved all of these concerns. They continue to provide technical assistance to agencies in the contract amendment process and bring new agencies up to speed as they start the online billing process. Cloudbreak Compton, one of the developers, notified CDC that they have worked out a new partnership with United States Vets (US Vets) who will again be the service provider for their project. US Vets has responded to CDC's letter with a formal reconciliation of the two parties as well as provided a response to unresolved financial issues. The CDC will continue to work with both Cloudbreak Compton and US Vets to facilitate resolution of all pending issues.

Action Plan: The CDC will continue to implement the programmatic and financial monitoring of these projects, which began in September 2009. CDC completed four monitoring visits as of this writing, and

has scheduled six more in the coming month and a half. The CDC plans to visit all agencies on a quarterly basis and will adjust the priority of these visits based on the results of previous monitoring reviews.

Cumulative Expenditures to Date: $4,086,552

27. 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. Special Service for Groups (SSG)
k. Volunteers of America Los Angeles – Strengthening Families
l. Women's and Children's Crisis Shelter
m. City of Pomona: Community Engagement and Regional Capacity Building
n. City of Pomona: Integrated Housing and Outreach Program

27a) A Community of Friends (ACOF) - Permanent Supportive Housing Program
Budget: $1,800,000 (City and Community Program)

Table D.1: ACOF
July 1, 2008 – September 30, 2009

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	191	Education	26
Chronic Homeless	36	Job training, referrals	19
Homeless Families	118	Job placement	21
Female	318	CalWORKs	78
Male	275	General Relief w/Food Stamps	46
Transgender	1	General Relief only	3
		Food Stamps	3
Hispanic	146	Medi-Cal/Medicare	10
African American	331	Shelter Plus Care	34
White	102	SSI/SSDI	234
Asian/Pacific Islander	7		
Native American	-	Alternative court	3
Other	6	Case management	342
More than one race/ethnicity may be selected		Life skills	340
		Mental health	299
15 and below	178	Health care	164
16-24	69	Social/community activity	277
25-49	225	Substance abuse treatment (outpatient)	87
50+	122	Substance abuse (residential)	5
		Transportation	178
Moving assistance	11	Residential management support	331
Eviction prevention	18		
Rental subsidy	335	Case management (level 2)	
Housing (permanent)	335	Average hours per case:	7 hours
		Total number of hours:	6,318 hours
		Caseload:	18 cases

Longer-term Outcomes (at six or more months)	
Continuing to live in permanent housing	310
Receiving rental subsidy	310
Obtained employment	7
Maintained employment	24
Enrolled in educational program, school	34
Received high school diploma/equivalent	2
Case management	
Health care	310
Good or improved physical health	132
Mental health care	128
Good or improved mental health	229
Recuperative care	200
Substance abuse treatment (outpatient)	2
Substance abuse treatment (residential)	2
No drug use	3
Reunited with family	4

Successes: 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 ACOF case management staff, with the assistance of the MIST team, has helped 271 (83% of total enrolled) formerly homeless individuals and families maintain housing stability for 12 months or more. 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, and case management staff has been able 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 data 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 reporting challenge. Challenges the tenants face include: struggling 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. With the beginning of the new contract year, ACOF will be reporting based on supporting documentation. New systems have been put in place to ensure that all reporting is accurate. 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 is unavailable on nights and weekends.

Client Success Story: Tenant C was referred to the MIST team one year ago. She is a woman in her mid-50s struggling with both physical and mental health challenges. She was at risk of losing the apartment she had lived in for the past two years due to failure to pass housing inspections on numerous occasions.

Throughout her adult life, Tenant C has been unable to sustain her housing because of two complex sets of behaviors – hoarding and rescuing stray animals. Despite the potential serious consequences (eviction), she was unable to modify her behavior. Her apartment was filled with clothing, papers, animal carriers and food dishes. At its worst, the apartment would smell of animal waste and rotting food. Tenant C would become completely overwhelmed trying to sort and organize “too much stuff” only to find she had

the entire apartment piled high with layers of disorganization and no space for her or her rescue animals to move, sit, or lie down. MIST worked with property management and on-site support staff to develop a plan that could meet Tenant C's needs and responsibilities to the lease. The work so far has involved building a foundation of trust with Tenant C so that she would have confidence that: 1) the MIST and ACOF staff were invested in her success; 2) the team understood the depth and complexity of her behavior; and 3) the establishment of structures and limitations to help change her behavior. MIST and ACOF support staff worked with her to clean and organize her apartment, learning new skills, and experience a new appreciation for having space and being able to find things. Tenant C participates in weekly "clutter anonymous" groups, individual therapy, yoga classes, and mental health treatment.

The greatest challenge was getting Tenant C to be completely honest about sheltering additional dogs or cats. Until two months ago, she continued doing this, counteracting efforts to keep the unit clean and in compliance with the lease. With this last rescue, a detailed agreement was prepared and signed by Tenant C, Property Manager, and service staff. It required Tenant C to continue the efforts she was making, cease taking in animals, and allow property management to inspect her apartment at least twice/month. Up to this time, property management had not been consistently inspecting the unit, giving Tenant C a lot of room to 'fail.'

Collective successes so far: Tenant C has retained her housing. She has one authorized dog and for two months (a long stretch) has not taken in strays. She has passed most inspections without a warning or return inspection. She has new insights into her behavior and is taking much greater responsibility for it, including reducing the amount of things she stores, hiring help to assist her in cleaning her apartment, complying with mental health treatment, and publicly speaking about her hoarding so that others will learn from her experience.

	QTR
Number of organizations 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	50%

	QTR
Number of participants who have enrolled into program during the reporting period	28
Number of participants who left the program during this period	19
Total number currently enrolled in program	96
Number of clients who received an assessment (if applicable)	28
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	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	-
Program Specific Question:	
Number of participants who received benefits (as a result of the program)	327

27b) Ocean Park Community Center (OPCC) HEARTH
Budget: $1,200,000 (City and Community Program)

Table D.2: OPCC HEARTH
FY 2009-10, through September 30, 2009

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	402	Education	-
Chronic Homeless	240	Job training, referrals	2
Transition Age Youth	33	Job placement	-
Female	218	Food Stamps	1
Male	457	Shelter Plus Care	4
		Section 8	6
		SSI/SSDI	1
Hispanic	66	Medi-Cal/Medicare	1
African American	189		
White	375	Case management	119
Asian/Pacific Islander	12	Life skills	20
Native American	5	Mental health	7
Other	29	Health care	675
		Social/community activity	34
		Recuperative care	87
15 and below	11	Substance abuse (outpatient)	9
16-24	46	Transportation	54
25-49	350	California identification	3
50+	268	Veterans	1
		Legal	2
Moving assistance	10	Locker	7
Housing (emergency)	30		
Housing (permanent)	23	Case management (level III)	
Housing (transitional)	17	Average hours per case:	135
(Average 25 days in temporary housing)		Total number of hours:	406
		Caseload:	26
Longer-term Outcomes (at six or more months)			
Continuing to live in permanent housing			5
Receiving rental subsidy			2
Obtained employment			2
Maintained employment			1
Case management			12
Health care			5
Good or improved physical health			5

Successes:

- OPCC Project HEARTH provided 213 homeless individuals with primary health care from a Venice Family Clinic physician co-located at OPCC Access Center.
- Nineteen clients receiving health care became engaged in case management services with 15 (79%) achieving temporary or permanent housing as follows:
  - Seven individuals (47%) obtained emergency housing;
  - Four individuals (27%) obtained transitional housing; and
  - Four individuals (27%) obtained permanent housing.
  - Twenty-six individuals received respite care at OPCC Samoshel who were referred from Venice Family Clinic and two local hospitals (St. Johns and SM/UCLA Medical Center), and 27% 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-income housing options for medically vulnerable individuals who do not always qualify for federal housing.
- Lack of the necessary income to expand affordable housing options.
- Few housing and income resources exist for undocumented clients.

	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	2
Number of participants who left the program during this period	-
Total number currently enrolled in program	25
Number of clients who received an assessment (if applicable)	1
Cost per participant	$1,772
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 improve the process of discharging homeless patients from the local hospitals into the respite program (through scheduled Project HEARTH orientations to hospital personnel).
- Continue to refer permanently housed clients to In-Home Support Services.
- Utilize interns to assist in home visitation support.
- Prepare for HACLA vouchers by enlisting new landlords in the Los Angeles area.

Client Success Story: Client T is a 50-year-old former professional dancer, who was diagnosed in 1999 with HIV/AIDS. The client came to OPCC Access Center in 2001 seeking services after his loss of support of family and friends. He gave up his housing in 2007 to become his sister's full-time caregiver after she developed cancer. In 2008, he returned to the streets of Santa Monica where his health took a significant turn for the worst. He had been hospitalized and entered the OPCC/VFC respite bed program. He continued case management services with OPCC Access Center where he met consistently with the OPCC Project HEARTH team. Advocating on his behalf, the housing coordinator was successful in obtaining a Shelter Plus Care housing voucher for him. The client received his housing voucher in June, and with intensive assistance from the OPCC Project HEARTH housing coordinator, he obtained permanent housing in July. Client T has not had any hospitalizations; he receives primary care from his Venice Family Clinic physician co-located at OPCC Access Center, and he participates in a medication management program to address his illness. Client T is living in his own apartment, and he is grateful for his stability and daily delivery of special meals arranged through his case manager.

27c) 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 2009-10, through September 30, 2009

	Cumulative		Cumulative
At-risk Individuals	1,111	Education	383
At-risk Families	149	Job training	1
		Job placement	1
Female	662		
Male	783	General Relief	51
Transgender	4	General Relief and Food Stamps	4
		Food Stamps	1
Hispanic	456	Medi-Cal/Medicare	4
African American	455	Section 8	2
White	414	Case management	94
Asian/Pacific Islander	14	Health care	854
Native American	10	Life skills	394
Other	82	Mental health care	88
		Transportation	125
15 and under	19	Food	232
16-24	594	Pet food/vet care	117
25-49	400	Social/community activity	32
50+	171	Substance abuse treatment (residential)	1
Moving assistance	3		
Eviction prevention	10		
Rental subsidy	24		
Housing (emergency); avg. stay 120 days	1		
Housing (permanent)	2		

Longer-term outcomes (Six or more months)	
Continuing to live in housing	394
Continuing to receive rental subsidy	6
Obtained employment	1
Case management	66
Health care	232
Mental health care	33
Substance abuse treatment (residential)	1
No drug use	8
Level 1 case management services	Quarter
Average for each participant per month	2 hours
Total hours for all participants	132 hours
Number of cases per case manager	66 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	394
Number of participants who left the program during this period	-
Total number currently enrolled in program	394
Number of clients who received an assessment (if applicable)	66
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

FY 2008-09 may include duplicated counts. For FY 2009-10 to date, a total of 295 individuals and 99 families were served; complete demographic information was provided for head-of-household.

Successes: The Catalyst Foundation continues to provide a continuum of services under one roof. Services are designed to meet each participant's unique, basic, and practical needs; while addressing the root cause of childhood abuse and trauma. When providing services to participants, staff helps them

identify high-risk behaviors and choices they are making that are putting them in difficult situations. At point of entry, participants complete an ACE (Adverse Childhood Experience) questionnaire that provides information about the impact of childhood abuse and trauma on their lives. Outreach efforts have been extremely successful in targeting those who are homeless, at risk of homelessness, and the medically un-insured. In addition, the Outreach Department has been instrumental in promoting services and bringing in potential participants to obtain services. Such services include: primary medical care, mental health services, and case management to secure permanent housing, rental assistance, move-in, and utility assistance. In addition, supportive social services ensure that participants maintain the stability of permanent housing. The Supportive Services Department continues to provide food, transportation, legal assistance, support groups, veterinary care and pet food. In addition, personal inner-growth classes such as: Yoga, Meditation, Martial Arts, Art, and *Creating a Healing Society* classes allow participants to help address unresolved trauma issues and incorporate healing modalities. The program has experienced a tremendous growth in the number of people wanting to access food, case management, and housing. Rental assistance and eviction prevention programs are very well solicited. During this quarter, the program assisted 36 participants to obtain housing assistance and eviction prevention. Food services were provided to over 150 participants year to date.

Challenges: Due to the tremendous number of people wanting to access the programs, particularly in the Supportive Services Department and primary medical care, it has been challenging to meet the needs of everyone applying for services. For example, the program currently serves over 150 clients that are eligible and registered for the food program. Due to limited space and staffing, clients have been placed on a waiting list to receive food and case management services. The client to staff ratio has tremendously increased due to high levels of unemployment in Service Planning Area (SPA) 1. The Catalyst Foundation is experiencing an influx of applicants that have been impacted by the foreclosure rates in the Antelope Valley. Presently, there is no other program that serves people devastated by the current housing crisis. These clients mention being victims of owners that are collecting rent even though they know they are in the foreclosure process. Clients are struggling to find safe, affordable housing. Moreover, residents who do find housing do not have the money for the security deposit and the first month's rent. While providing referrals and resources, the program continues to accept applications and explains to clients that the need for services has increased tremendously.

Action Plan: The Director of Supportive Services will continue to train and support staff to continue providing the assistance clients are requesting. The waiting list for the food program will be reviewed weekly, and clients that are on that waiting list will be contacted as slots become available. Two volunteers have joined the team to assist with the distribution of the groceries. The Director of Supportive Services will continue to meet with the Data Management team to come up with effective ways of collecting and reporting. In addition, The Director of Supportive Services will continue to work with County HPI staff to obtain technical assistance on data management issues. The program will consider adding an additional Case Manager to assist with opening cases and providing more clients with Case Management programs. In addition, housing assistance and eviction prevention services will be provided to those who meet the eligibility criteria. Moreover, clients who meet the criteria for the HPRP program will be referred to the Access Solution Center to obtain assistance.

Client Success Story: During the this quarter, the program worked with a 62-year-old African American male who had been homeless since January 2009. He requested case management and housing assistance. The case manager was able to refer and assist him with obtaining senior housing. He stated that if he had been homeless with no hope, he would have reverted to using drugs and his old way of coping with life. The participant was very appreciative and felt the program saved his life. He mentioned no other organization helped him when he was "down and out."

27d) Homes for Life Foundation – Vanowen Apartments
Budget: $738,310 (City and Community Program)

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

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	36	Housing (permanent)	48
Chronic Homeless Individuals	6	Rental subsidy	24
At-risk Individuals	30		
		Case management	48
Female	30	Life skills	48
Male	42	Mental health care	48
		Transportation	48
Hispanic	5	Food Stamps	46
African American	17	Medi-Cal/Medicare	46
White	39	SSI/SSDI	46
Asian/Pacific Islander	6	Social/community event	48
Other	4	Substance abuse treatment (outpatient)	8
		Substance abuse treatment (residential)	5
16-24	1		
25-49	39		
50+	32		
Longer-term Outcomes (at six months)			
Continuing to live in housing			24
Receiving rental subsidy			24
Case management			24
Health care			24
Good or improved physical health			24
Mental health			24
Good or improved mental health			24
Case management (level 2)			
Average for each participant per month			3 hours
Total hours for all participants			72 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			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			24
Number of participants who left the program during this period			-
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			-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter			-

Successes: All clients have successfully maintained their housing since move-in.

Challenges: Staff has continued to manage clients' transition to independent living. Overall, the transition has been very smooth and when clients have had some difficulty, staff have worked closely with the clients and their support networks to manage their mental health and well-being.

Action Plan: Staff will continue to work closely with clients to manage their mental health.

Client Success Story: Several years ago, one client was a regional manager at Supercuts, saving money and doing extremely well. She has always experienced symptoms of her illness, but was unaware of her illness, until her illness (and drugs) resulted in her spending her savings, losing her job, and becoming homeless for several years. During this time, she was in and out of hospitals. During her last hospital stay she was able to find a therapist and psychiatrist in which she was able to confide in and trust, which resulted in her being able to control her illness for good. With the help of that agency and the therapist,

she was able to find a home at Homes for Life. Since her stay, she is able to build her savings again, peruse her hobby of playing the guitar, and maintain her health and overall sense of self. She is grateful to Homes for Life for giving her the opportunity and support she needs to maintain her independence.

27e) Hope Gardens Family Center – Union Rescue Mission (URM)
Budget: $1,853,510 for services and $646,489 for capital (City and Community Program)

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

(unduplicated count)	Cumulative		Cumulative
Homeless Families	51	CalWORKs	144
(individuals)	157	Food Stamps	144
		Medi-Cal/Medicare	144
Female	103	Section 8	5
Male	54	SSI/SSDI	6
		Veterans	3
Hispanic	37		
African American	77	Case management	84
White	25	Life skills	59
Asian/Pacific Islander	4	Mental health	75
Other	14	Health care	45
		Social/community activity	82
15 and below	90	Substance abuse treatment (outpatient)	33
16-24	16	Transportation	84
25-49	41		
50+	6	Case management (level II)	
		Average hours per case:	10
Moving assistance	17	Total number of hours:	390
Housing (emergency)	8	Caseload:	11
Housing (transitional), *average 358 days*	138		
Housing (permanent)	16	Education	90
		Job training, referrals	22
		Job placement	8
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

Successes: During the first quarter of FY 2009-10, the program transitioned six families (17 individuals) of which five families (12 individuals) moved into permanent housing. During the course of this contract term, Hope Gardens has transitioned six of 39 families receiving services at the transitional living facility.

The families transitioned into the following areas:
- Twelve individuals (five families) were housed in Fair Market Housing
- Five individuals (one family) were transitioned to a more appropriate transitional housing setting.

Challenges: Hope Gardens Family Center continues to learn, evaluate and modify program services to meet the demanding needs of its diverse population. Many families face additional challenges in the area of housing affordability. Many families continue to depend on housing vouchers from numerous programs, however, these resources have been unable to provide these resources leaving the families frustrated. Families 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. Hope Gardens has increased capacity through the Employment/Vocational Development Department Team, to assist families in securing employment or increasing their skill/educational levels in this demanding employment market. Hope Gardens and staff are meeting those challenges with each family as they continue to work with participants to identify barriers and get

beyond the history and challenges that have kept them from achieving (and exceeding) their goals. During the course of the program, outcomes will be tracked during the contract term FY 2009-10.

Number of organizations/agencies that your program has a formal collaboration for this project	2
Number of times collaborative partners met each month	4
Total amount ($) of HPI funding leveraged for project	$249,600
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	41%
Number of participants who have enrolled (entered) into program during the reporting period	10
Number of participants who left the program during this period	7
Total number currently enrolled in program	97
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	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	-

Action Plan: Hope Gardens will continue to work through challenges that are presented either in program design and/or with families. The program vows to consistently evaluate services, staff and program to ensure excellent care is provided to families served at Hope Gardens. This includes establishing 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 served. It is a goal to increase the number of families being served until maximum capacity is reached. Increased capacity is expected once renovations are completed on additional buildings.

Client Success Story: "I am a single mom of eight children, of which five are minor children still in my care. I have four daughters ranging from ages 14 to one year and one son [of 10 years of age]. I have lived in Los Angeles all my life. We were living in a two-bedroom apartment on my own, but chose to help a friend financially which led to our homelessness. I was assisted with temporary shelter through the Los Angeles Homeless Services Authority with a 120-day voucher in a motel. I was then referred to Hope Gardens where I was accepted into the program in July 2009.

Many families are faced with a systemic challenge of limited housing of male children over the age of 10. My only son is a twin, and he is 10-years-old. The trauma of homelessness has had a tremendous effect on my children. My oldest daughter began to display tremendous anger management problems, which resulted in temporary placement for additional care. My 10-year-old twins are faced with additional educational challenges, which place them at a first grade reading level, but they are currently in special education at the fifth grade level.

In my search for assistance, Union Rescue Mission has offered my family more than transitional housing, they have embraced every aspect of our lives. They made accurate assessments of our family dynamic that others in our lives have skimmed over. The Youth Staff took a personal interest in my children's education and made referrals and sought alternative assistance for the twins to bring them up to grade level.

Through these difficult times, I was diagnosed with a potentially terminal illness and the staff has walked with me every step of the way. They have taken me to my doctors' appointments to ensure that I truly understood my diagnosis and the medical terminology that is being utilized. I have also been challenged educationally which has lead to difficulties as well. I have a loving case manager who continues to support me in everyway. We are still walking through this difficulty journey but with the intensive supportive services and the staff, we believe that we will be able to complete this journey.

27f) National Mental Health Association of Greater Los Angeles – Self Sufficiency Project for Homeless Adults and TAY Antelope Valley
Budget: $900,000 (City and Community Program)

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

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	32	Shelter Plus Care	5
Chronic Homeless Individuals	58	Veteran's benefits	1
		General Relief and Food Stamps	5
Female	42	Medi-Cal/Medicare	3
Male	48	SSI/SSDI	6
		CalWORKs	1
Hispanic	18	Case management	58
African American	49	Mental health	58
White	49	Health care	17
Asian/Pacific Islander	1	Social/community activity	29
Native American	2	Substance abuse treatment (residential)	2
More than one race/ethnicity may be selected		Substance abuse treatment (outpatient)	2
16-24	14	Transportation	52
25-49	54	Like skills	2
50+	22		
		Case management (level 2)	
Moving assistance	9	Average hours per case:	80
Eviction prevention	3	Total number of hours:	80
Housing (emergency)	1	Caseload:	30
Housing (transitional)	14	Average stay in emergency housing:	6 months
Housing (permanent)	16	Number to permanent housing:	11 participants
Education	3		
Job training	27		

Program Specific Measures	**QTR**
Number of TAY who have obtained a technical school or college degree while in program	-
Number of participants who have a primary care physician	-
Number of participants who have a dentist	-
Number of participants with good or improved recovery status (substance abuse)	1
Longer-term Outcomes (at six months)	
Continuing to live in housing	14
Case management	44
Good or improved physical health	3
Good or improved mental health	24
Substance abuse treatment (outpatient	1
No drug use	1
Reunited with family	2
	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	$78,658
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	80%
Number of participants who have enrolled (entered) into program during the reporting period	-
Number of participants who left the program during this period	-
Total number currently enrolled in program	90
Number of clients who received an assessment (if applicable)	-
Cost per participant	$698

Successes: This quarter, the program assisted 11 members into permanent housing and five received Shelter Plus Care certificates.

Challenges: It has been challenging to have members follow through with continuous care and case management.

Action Plan: The program continues to research and locate more affordable housing as well as build more community relationships. Staff will connect with members in the community.

Client Success Story: A member obtained competitive employment this quarter.

27g) National Mental Health Association of Greater Los Angeles – Self Sufficiency Project for Homeless Adults and TAY Long Beach
Budget: $1,340,047 (City and Community Program)

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

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	42	Case management	45
Chronic Homeless Individuals	23	Job placement	17
Transition Age Youth	3	Benefits assistance/advocacy	3
		Bus tickets	*241
Female	10		*number of tickets*
Male	58	Transportation	31
		Housing (emergency)	7
Hispanic	11	Average stay in emergency housing (day)	3
African American	20	Housing (permanent)	8
White	31	Rental subsidy	2
Native American	1		
Other	4	Job training	8
Demographics do not match total population.		Mental health	13
16-24	4	Health care	2
25-49	32	General Relief and Food Stamps	1
50+	32	Medi-Cal/Medicare	2
		SSI/SSDI	2
Case management (level 3)			
Average hours per case:	14		
Total number of hours:	428		
Caseload:	10		

Program Specific Measures	**Quarter**
Number of TAY who have obtained a technical school or college degree while in program	-
Number of participants who have a primary care physician	9
Number of participants who have a dentist	11
Number of participants with good or improved recovery status (substance abuse)	1
Longer-term Outcomes (at six months)	
Continuing to live in housing	6
Obtained employment	19
Maintained employment	14
Enrolled in education program, school	1
Case management	60
Health care	3
Good or improved physical health	1
Mental health	21
Good or improved mental health	17
Substance abuse treatment (outpatient)	1
Reunited with family	7
	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	1
Number of times collaborative partners met each month	-
Total amount ($) of HPI funding leveraged for project	$90,540
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	69%
Number of participants who have enrolled (entered) into program during the reporting period	31
Number of participants who left the program during this period	2
Total number currently enrolled in program	56
Number of clients who received an assessment (if applicable)	13
Cost per participant	$1,128

Successes: Staff working on the Self-Sufficiency Project have been able to adeptly familiarize themselves with grant obligations. The Benefits Coordinator has been attending trainings to become better informed and to increase the ability to navigate the Social Security, Department of Public Social Services, and other benefit systems. The Housing Coordinator has been successful at building relationships with

apartment owner/managers in the local area in order to facilitate project members with moving into their own apartments. The SSP Day Labor Specialist has been successful at building relationships with local businesses in order to increase employment opportunities for project participants.

Challenges: The continued decrease in SSI benefit enrollment and the lack of affordable, low income apartments in the local community make finding housing a particular challenge for the participants and staff of the SSP Program.

Action Plan: This program will continue to explore low income housing resources in the community. The Benefits Coordinator will continue to attend trainings targeted to increase knowledge of the benefit systems. Staff of this program will work on increasing the numbers of members served as they become more familiar with their individual roles and coordinate more effectively with Homeless Assistance Program (HAP) case management staff.

Client Success Story: V is a 51-year-old chronically homeless woman, who prior to coming to the drop in center, was living in parks and on the streets in the local downtown area. Her initial income was only General Relief with Food Stamps. She was also struggling with mental health symptoms of Posttraumatic Stress Disorder (PTSD), anxiety disorder, and isolative tendencies. After engaging and building a relationship with V, she was enrolled into the Self-Sufficiency Project. Initially, she began working with the Benefits Coordinator of the Project, who assisted her with her SSI benefits application. Next, she was connected with the Housing Coordinator, who assisted project members by providing supportive contact and resources to locate an apartment. V was also linked to the Psychiatric Nurse Practitioner for treatment and therapy. V began working part-time at the Village Homeless Assistance Program as a Support Assistant. She was approved and received her Supplemental Security Income (SSI), and may be receiving additional survivor benefit income in December 2009. She moved into her own apartment in July 2009. At present, V has been able to successfully maintain her housing and manage her income, and with continued supportive case management is living independently in the community.

27h) Skid Row Housing Trust – Skid Row Collaborative (SRC2)
Budget: $1,800,000 (City and Community Program)

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

(unduplicated count)	Cumulative		Cumulative
Chronic Homeless Individuals	110	Case management	104
Female	32	Mental health	65
Male	78	Health care	64
		Life skills	35
Hispanic	7	Social/community activity	139
African American	90	Substance abuse treatment (outpatient)	76
Asian/Pacific Islander	18	Substance abuse treatment (residential)	2
White	1	Transportation	18
Other	1	Benefits advocacy	31
More than one race/ethnicity may be selected		General Relief and Food Stamps	5
		Medi-Cal/Medicare	10
16-24	2	SSI/SSDI	10
25-49	55	Legal	3
50+	53		
		Case management (level 3)	
Rental subsidy	110	Average hours per case:	9
Housing (permanent)	110	Total number of hours:	844
Shelter Plus Care	110	Caseload:	25
Education	2		
Job training	31		
Job placement	4		
Longer-term Outcomes			
Continuing to live in housing			85
Receiving rental subsidy			85
Obtained employment			4
Maintained employment			9
Case management			84
Health care			52
Good or improved physical health			44
Mental health			52
Good or improved mental health			37
Substance abuse treatment (outpatient)			55
Substance abuse treatment (residential)			2
No drug use			36
Reunited with family			49
			QTR
Number of organizations/agencies that your program has a formal collaboration for this project			3
Number of times collaborative partners met each month			1
Total amount ($) of HPI funding leveraged for project			$498,747
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)			66%
Number of participants who have enrolled (entered) into program during the reporting period			-
Number of participants who left the program during this period			2
Total number currently enrolled in program			38
Number of clients who received an assessment (if applicable)			-
Cost per participant			$2,137
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 is fully staffed. Residents are stabilizing in housing and actively participating in the program. The integrated services staff continue to develop and refine the program.

Challenges: No significant challenge was reported this quarter.

Action Plan: N/A

Client Success Stories: Client R suffered from several serious medical conditions. When he entered housing, he was able to live independently with support--his health care was in place and he had an In-Home Supportive Services (IHSS) worker. The client with the staff, developed a plan to coordinate his existing services and provide additional support to maximize his independence and enhance his quality of life. Shortly after entering housing, however, his condition worsened. He was hospitalized but was able to return home within a few days. Although he would have benefited from being in a skilled nursing facility, no beds were available and he did not want to leave his new home. Staff arranged for additional IHSS hours and engaged hospice services. His neighbors quickly mobilized. They began to check on him routinely, often preparing meals, doing his laundry, or listening to music with him. Forty-two days after moving into his new home, the client died. While a neighbor for a very short time, the residents' memorial service for the client made it clear that he had truly become a member of their community.

27i) 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 2009-10

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	83	Housing (transitional)	3
Homeless Families (individuals)	5 / 12		
Transition Age Youth	10	Mental health care	100
At-risk Individuals	29	Substance abuse treatment (residential)	75
Chronic Homeless Individuals	4	General Relief	4
Female	20	At six months:	
Male	89	Continuing to receive mental health care	10
		Good or improved mental health	9
Hispanic	46		
African American	23	Average length of stay for residents (days)	88
White	36	Residents discharged due to graduation	1
Native American	1	Discharge status for residents of transfer	2
Asian/Pacific Islander	1	Discharge status for residents of walk-out	1
15 and under	9	Discharge status for residents, violated rules	6
16-24	12		
25-49	76		
50+	16		

Number of participants who have enrolled (entered) into program during the reporting period	7
Number of participants who left the program during this period	10
Total number currently enrolled in program	23
Number of clients who received an assessment (if applicable)	7
Cost per participant	$1,050

Successes: Of the clients who have received program services for at least six months, nine of 10 are doing well. Three are in school, and all passed their coursework. One client works full-time at McDonald's and has now taken their management training course. She helped two new service recipients obtain work at the same franchise. One moved into permanent supported housing with her two children. Three are approaching graduation and will transfer to outpatient programs. Staff will be able to continue to follow them.

Challenges: Instructing the therapists who are coming on board next quarter about the grant's requirements has been a challenge. The other challenge affected the project director. She needed to work full-time on a federal grant that was sun-setting, so she is looking forward to being able to build the number of people being served over the upcoming year. The number of people served was below expectations this year.

Action Plan: Three residential sites will begin receiving CDC funded psychiatric / mental health services over the upcoming quarter. This will bring numbers served into line with this funding.

Client Success Story: One mother who has a major depressive disorder, asserted herself and applied for the agency's Shelter Plus Care program. She did all the footwork required while raising her two children and living on an exceedingly tight budget. When she entered one of their domestic violence shelters, she encountered program staff. She was shut down, unable to nurture her children, and had no energy to maintain a daily regime and hygiene. She was transferred to the agency's transitional shelter, where psychiatric/mental health services were provided. Over the course of the next ten months, the structure of the onsite program, therapy, psychiatry (plus parenting, substance abuse education, relapse prevention, anger management, stress management, and remedial education services), she improved at a slow but steady rate. Once settled in her housing, her goal was to volunteer at the children's school and look for part-time work.

27j) Special Service for Groups (SSG) – SPA 6 Community Coordinated Homeless Services Program

Budget: $1,800,000 (City and Community Program)

Table D.10: SSG
FY 2009-10

(unduplicated clients)	Quarter		Quarter
Homeless Individuals	27	Eviction prevention	11
Homeless Families	46	Housing (emergency)	37
(individuals)	150		
Transition Age Youth	1	Housing (transitional), *average stay 34 days*	25
At-risk Families	10	Housing (permanent)	25
(individuals)	23	Rental subsidy	10
Female	119	Education	1
Male	82	Job training/resources	6
		Job placement	2
Hispanic	7		
African American	179	Case management	84
White	13	Life skills	58
Other	2	Mental health care	2
		Transportation	15
15 and under	93	Other	41
16-24	21		
25-49	68	Case management (level 3)	
50+	19	Average hours per participant per month	2
		Total hours for reporting period	416
		Number of cases per case manager	21

Number of organizations/agencies that your program has a formal collaboration for this project	6
Number of times collaborative partners met each month	1
Total amount ($) of HPI funding leveraged for project	$2,635,657
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	68%
Number of participants who have enrolled (entered) into program during the reporting period	84
Number of participants who left the program during this period	32
Total number currently enrolled in program	52
Number of clients who received an assessment (if applicable)	84
Cost per participant	$1,639
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	20
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	-

Successes: The quarter of July-September 2009 marked the successful implementation of the Housing and Homeless Prevention Fund (HHPF) contract. Service delivery began July 1st when staff was hired. By July 16th all four case management positions were filled. All of SSG's subcontract agreements have been signed and monthly collaborative meetings have taken place. SSG is pleased to announce that 25 HPI participants have been stabilized in permanent housing within the first three months of the program's start-up.

Challenges: The most notable challenge that has presented itself this quarter was having more clients in need of temporary housing (emergency/transitional) than available slots with partner agencies. In addition, there is a lack of emergency and transitional housing that accepts intact families. Most available temporary housing slots will only service single women with children or single males, but not both parents with children. Furthermore, most transitional houses will not house teenage boys if women are present in the home. This is a major barrier given that two-thirds of program participants are families. Although case managers do everything possible to keep families together, there have been circumstances where fathers had to be temporarily housed away from their partner and children.

Action Plan: Monthly collaborative meetings will continue to take place to coordinate client's services, strengthen community/partner relationships, build service capacity amongst members, and address program barriers. SSG will develop strategies to address the overall lack of paid emergency and housing slots, in addition to the lack of available, intact family slots. Case management staff will also work to establish relationships with other housing service providers in Service Planning Area (SPA) 6 to temporarily house individuals and families.

Client Success Story: Two homeless men were referred to SSG from its collaborative partner People Helping People Emergency Shelter. Through their experience at the emergency shelter and with SSG the two clients befriended each other. Having limited income, the two agreed to combine their earnings and become roommates. Very early, SSG staff recognized their bond and individual strengths. With input from the clients, a plan toward permanency was developed and coordinated with SSG's collaborative partners. The clients were initially vouchered at a hotel through People Helping People then stabilized at Community Minded Business' transitional home. After attending financial literacy classes, maintaining a savings account, and receiving move-in assistance from SSG, the clients were able to move into an apartment within 45 days of program enrollment. The two men have built a strong camaraderie that helped them successfully transition out of homelessness. While in the program, they both have secured a permanent source of income through employment and benefits assistance and are able to properly manage their finances. In addition, one of the gentlemen has enrolled in a trade school for the Spring 2010 semester and is working on restoring relationship with his three sons. They both express a great deal of gratitude for SSG and its partners.

27k) Volunteers of America - Los Angeles, Strengthening Families
Budget: $1,000,000 (City and Community Program)

Table D.11: VOALA
FY 2009-10

(unduplicated clients)	Cumulative		Cumulative
Homeless Families	60	Alternative court	5
(individuals)	271	Case management	168
At-risk Families	69	Life skills	103
(individuals)	301	Mental health	43
		Health care	35
Female	300	Social/community activity	62
Male	273	Substance abuse treatment (outpt.)	2
		Transportation	92
Hispanic	571	Food	32
Other	2	Medi-Cal/Medicare	90
		CalWORKs	30
15 and below	294	General Relief w/Food Stamps	17
16-24	85	General Relief only	2
25-49	180	Shelter Plus Care	1
50+	13	SSI/SSDI	9
		Food Stamps only	49
Eviction prevention	47	Section 8	44
Moving assistance	42	Legal	9
Housing (emergency)	14	Clothing	27
Housing (transitional)	6		
Housing (permanent)	9	Education	46
Rental subsidy	6	Job training, referrals	93
		Job placement	23

Average stay at emergency housing:	21 days
Number placed into transitional housing:	14 families
Case management (level 2)	
Average case management hours for each participant per month:	6 hours
Total case management hours for all participants during current reporting period:	270 hours
Number of cases per case manager:	20 cases
Longer-term Outcomes (at six months)	
Maintained permanent housing (through eviction prevention, linkages to jobs)	75
Receiving rental subsidy	5
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

Successes: During this reporting period, case managers assisted families in finding and obtaining affordable, temporary, transitional, and emergency housing. They prevented many families from becoming homeless by assisting with finding employment. The case managers took program participants to various job fairs, employment agencies and community resource fairs, and provided them with job leads and referrals. Clients received rental deposit assistance. Strengthening Families collaborates with the Center for Law and Justice in order to provide families a series of workshops on foreclosure prevention and tenant rights. The case mangers received training on the Transportation Rider Relief Program and now are providing families with transportation discount coupons. Case managers also received training on how to assist their clients with filling out an online application for social security benefits. Through the Strengthening Families program, two computers and a printer were purchased for the clients, so that they could come and work on their resumes or find employment. Strengthening

Families has set up a grief support group and parent support groups to assist the families that are dealing with the death of a loved one or are having problems with their children.

	Quarter
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	14
Number of participants who left the program during this period	8
Total number currently enrolled in program	96
Number of clients who received an assessment (if applicable)	14
Cost per participant	-

Challenges: Some of the challenges that the case managers have encountered during this reporting period have been maintaining communication with their families, especially during the summer when their children are off from school. The lack of affordable housing for low income families with multiple family members and families with a household member with disabilities continues to be a major challenge. The inability for many families to qualify for conventional housing programs, because of their lack of stable employment history, bad credit due to foreclosure, and many rental requirements continues to be a challenge. In addition, as many of the families do not have legal residency, finding employment and housing is very challenging. Immigration status continues to be a problem for the case managers and parents. Although the families have a strong desire to work and improve their family's situation, their immigration status stands in the way.

Action Plan: The program will continue to provide effective case management for families, and connect them with additional supportive services. Strengthening Families will continue to organize and sponsor community collaborative meetings and resource fairs. At these fairs, various agencies provide information about their services/resources. Additionally, Strengthening Families has begun and will continue to collect and distribute clothes and other essentials items to the families in the program. Strengthening Families intends to continue to seek additional agencies that can provide additional assistance to the families and establish MOUs with these agencies. Strengthening Families will be working with a local domestic violence shelter to provide domestic violence workshops and support groups at the East Los Angeles office. The Strengthening Families program will also begin to offer support groups for the families who are enrolled in program.

Client Success Story: Through effective and compassionate case management, the case managers have assisted their families with finding housing and furniture. A number of the families received donations of refrigerators, beds, and other items that allowed them to save their money and open savings accounts. By collaborating with other community agencies and service providers, the case managers have obtained employment, job leads, job referral and job training for their families. A client's partner had been deported, but through Strengthening Families, he found employment and received legal immigration assistance and now is working and supporting his family. Also, the case managers' active community networking has led to preventing a number of the families from receiving foreclosure notices and finding housing for families with children with disabilities.

27l) Women's and Children's Crisis Shelter
Budget: $300,000 (City and Community Program)

Table D.12: Women's and Children's Crisis Center (WCCS)
FY 2009-10

(unduplicated clients)	Cumulative		Cumulative
Homeless Families	51	15 and below	108
At-Risk Individuals	288	16-24	41
		25-49	136
Female	252	50+	9
Male	64		
		Housing (emergency)	90
Hispanic	217	Housing (transitional)	4
African American	42	Average stay in days *(for quarter)*	52
White	26	Number to shared living w/friends or family	15
Asian/Pacific Islander	8		
Native American	-	Life skills	19
Other	23	Mental health care	40
Families are made up of individuals.		Transportation	51

Program Specific Measures	**Quarter**
Number of hotline calls that are related to domestic violence issues.	199
Number of hotline calls that are related to homeless issues.	156
Of the calls related to domestic violence, the number of families/individuals at-risk of becoming homeless.	90
Number of individuals reunited with their families.	-
Number of families who have enrolled (entered) into program during the reporting period	10
Number of families who left the program during this period	8
Total number of families currently enrolled in program	327
Number of clients who received an assessment (if applicable)	-
Cost per participant	$2,654
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	16
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	12

Successes: Two Housing and Homeless Prevention Funding (HHPF) clients entered transitional housing after fully completing the program at the emergency shelter. The program assisted three clients with obtaining temporary restraining orders (TRO); two clients are currently pending TROs. Client T from the transitional shelter is actively seeking employment; attending job fairs and submitting resumes. Client T had a job interview with a popular nationwide department store mid-September and is currently waiting for a response on their decision.

Challenges: The emergency shelter household families were stricken with the chicken pox virus this quarter. The facility was shut down and unable to accept any new families into the program until the virus was contained. Many of the workshops and program activities were suspended as well.

Action Plan: The emergency shelter is hoping to reopen the program for potential new clients/families beginning in October as well as resume all program activities.

Client Success Story: Client E from the emergency shelter exited the program and entered WCCS transitional shelter in August. The client is grateful for this opportunity to get ahead and raise her two children in a safe, non-violent home. Her four-year-old son was thrilled to have his own room, and he jumped and laughed with joy. In less than two months, she obtained a permanent restraining order for three years, free childcare through the Child Development Consortium of Los Angeles, and enrolled herself in ESL classes. She enrolled her oldest son in Head Start, and they are now able to understand some English and practice speaking English together. She is very excited about her future and plans to put forth the effort into learning English as quickly as possible, so that she can enroll into a medical administration program.

27m) City of Pomona: Community Engagement and Regional Capacity Building (CERC)
Budget: $1,239,276 (City and Community Program)

Table D.13: City of Pomona: Community Engagement and Regional Capacity Building
FY 2008-09, April – September 2009

	Quarter
Number of groups included in Consortium	53
Number of community meetings that the CEM and Consortium members attended	-
Number of speaking engagements (by CEM and Consortium)	4
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	4
Number of cities that designate a point person on staff to work on implementing recommendations	13
Number of organizations/agencies that your program has a formal collaboration for this project	52
Number of times collaborative partners met each month	3
Total amount($) of HPI funding leveraged for project	$175,460
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	16%

Successes: The CONSORTIUM Ad-hod Start Up Committee has met and set key elements including refining Mission statement, written Articles or Incorporation and By-laws. A slate of candidates for the Interim Board of Directors is in place. Public Council has agreed to assist with the CONSORTIUM's 501(c)3 application.

Challenges: The program anticipates that the budget and scope of work modification will be completed soon and then will move forward with the CERC Resources and Y!MBY campaign.

Action Plan: Elect interim board of directors. Hire staff to begin resource component and Y!MBY Campaign. Implement multi-agency performance system for reporting.

27n) City of Pomona: Integrated Housing and Outreach Program (IHOP)
Budget: $913,975 (City and Community Program)

Successes: IHOP has had success within our community collaborating with other agencies, both non profit and government. IHOP is a key part of the community and works together with the city, police, hospitals, non profits, property managers, and citizens of the community to serve homeless clients. This is due to: 1) the Outreach Team's proactive outreach to agencies as well as clients; 2) program linkage to the City of Pomona; and 3) the strong Continuum of Care Coalition (COC). The COC has recruited the core of its Faith-based Committee. Members are actively planning and will participate in the upcoming Project Homeless Connect. The resource directory has been updated, and an initial copy has been given to members of the COC for review and revision.

Challenges: The greatest challenge is finding housing for General Relief (GR) clients and families on CalWORKs alone. Neither program provides enough income to support housing for the clients. Additional

income is needed. The program has found one provider that will accept clients on GR, with the expectation that within a month or two they will find employment to pay full price for their transitional housing. This is very hard for clients, especially in the current job market. So the program will continue to search for housing opportunities for this group of clients.

Action Plan: The plan is to continue to search for new avenues to help clients gain housing. The Foothill Aids Project received Emergency Food and Shelter Program (EFSP) funds which are used to place families into an emergency hotel until the program can find housing. In addition, the City of Pomona has awarded Emergency Shelter Grants (ESG) funds with which will assist more clients. This money will work together with the HPI funds to help assist clients with utilities and security deposits.

The Homeless Services Liaison is developing a data gathering method for receiving information on client service from all active members of the Pomona Continuum of Care. Faith-based Committee meetings will begin in 2010 after the big Project Connect Event in December. The website is in process.

Client Success Story: The IHOP grant has been very successful in placing families into permanent housing. Client R had been homeless for months since being laid off of her job. She has two young children and is a single parent. She had been to many agencies seeking assistance, but all avenues fell through. She was beginning not to trust workers and programs. However, IHOP Case Managers were able to build trust with R and help her get back on her feet. IHOP paid for her first month in housing, and she has been stable since.

Table D.14: City of Pomona: Integrated Housing and Outreach Program
FY 2008-09, April – September 2009

(unduplicated clients)	**Cumulative**		**Cumulative**
Homeless Individuals	4	Eviction prevention	9
Chronic Homeless	3	Housing (emergency)	6
Homeless Families	11	Housing (transitional)	6
(individuals)	36	Housing (permanent)	10
Transition age youth	1		
		Job training	3
Female	28	Job placement	2
Male	16	CalWORKs	1
		General Relief (and Food Stamps)	1
Hispanic	19	General Relief	1
African American	41	Case management	25
Other	1	Health care	4
		Life skills	7
715 and below	17	Mental health care	6
16-24	13	Social/community event	3
25-49	11	Substance abuse treatment (outpatient)	3
50+	4	Transportation	6
		Food	8

	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	34
Number of times collaborative partners met each month	2
Total amount($) of HPI funding leveraged for project	$32,992
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	83%
Number of participants who have enrolled (entered) into program during the reporting period	17
Number of participants who left the program during this period	2
Total number currently enrolled in program	15
Number of clients who received an assessment (if applicable)	17
Cost per participant	$653

VI. COUNCIL OF GOVERNMENTS (COGs)

28a) San Gabriel Valley Council of Governments
Budget: $200,000 (On-going Funding)

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

28b) PATH Partners/Gateway Cities Homeless Strategy
Budget: $135,000 (On-going Funding)

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 bring 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.

29) 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)

Six programs are currently in progress, two emergency shelters and four transitional housing programs.

Table E.2: LAHSA Participants and Services

(unduplicated clients)	FY 2007-08	FY 2008-09	FY 2009-10 Sept. 2009	Total
Homeless Families	483	275	95	853
Homeless Individuals	3,162	890	218	4,270
Chronic Homeless	2,206	336	19	2,561
Female	1,938	493	80	2,511
Male	3,931	1,003	38	4,972
Hispanic*	1,385	647	89	2,121
African American	2,838	636	98	3,572
White	2,004	1,097	91	3,192
Asian/Pacific Islander	151	83	18	252
Native American	168	110	-	278
Other	1,598	99	24	1,721
Adult**	6,064	1,550	105	7,719
Child	1,029	444	113	1,586
Transition Age Youth *(not included as individuals)*		91	13	104
Emergency housing	5,869	1,462	130	7,461
Transitional housing	-	156	101	257

*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.

30) PATH Achieve Glendale
Budget: $150,000 (One-Time Funding)

Successes: As evidenced by 183 new clients admitted, the quality of services provided, and 20% of clients moving into permanent housing, the Access Center is continuing to provide essential services to homeless individuals and families from Glendale and throughout the County. Clients have benefited from reciprocal referral relationships from the following agencies: All for Health Clinic, Healthy Start, School on Wheels, Verdugo Jobs Center, Glendale Adventist Medical Center, Verdugo Mental Health, and Glendale Police Department. Additionally, interns from USC School of Social Work, California State University Northridge Sociology Department, and Glendale Community College have expanded services offered on-site to include a greater number of mental health counseling and case management hours and assistance with intake and front office functions.

Challenges: Community Outreach and Access Center case managers work tenaciously with chronically homeless individuals assisting them in transitioning from the street into housing. As the team builds rapport and trust with clients, a host of various assets and liabilities are identified. Many are present with physical and mental health disabilities, none has enough income to fund their first choice in housing, and a few are overcoming recent physical assaults. All are survivors – mostly women who have survived

abusive childhoods and adult relationships and have not entirely given up on their goals for the future. They are willing to do the footwork to access services and make better decisions. Staff has reported that work with these individuals can be frustrating, difficult, intensive, time-consuming, rewarding and inspiring.

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

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	407	15 and below	268
Chronic Homeless	96	16-24	131
Homeless Families	*224	25-49	549
(Individuals)	673	50+	214
Female	605	Housing (emergency)	156
Male	561	Housing (transitional), *average stay 53 days*	**60
		Housing (permanent)	155
Hispanic	362	Moving assistance	8
African American	442		
White	325	Job training	60
Asian/Pacific Islander	19	Job placement	6
Native American	13	CalWORKs	2
Other	5	General Relief and Food Stamps	27
		Medi-Cal/Medicare	2
Case management (level 3)	183	SSI/SSDI	23
Number of cases per case manager	76	Health care	32
		Life skills	13
		Mental health	30
		Social/community event	20
		Substance abuse treatment (outpatient)	47
		Substance abuse treatment (residential)	1
		Transportation	61

**A total of 673 individual family members was served; the number of families was calculated by dividing by three (estimated average family size).*
***FY 2008-09 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.*

Action Plan: The Access Center plan for next quarter includes continuing case management training, placing chronically homeless clients in the new PATH Ventures permanent supportive housing program in Glendale, providing case management for local Winter Shelter Program guests as a subcontractor for EIMAGO, expanding into Burbank with family case management on a part-time basis at Burbank Temporary Aid Center, and leading in local Connect Day activities.

Client Success Story: Client C is a 25-year-old who was seven months pregnant with her third child, when she came to PATH Achieve Glendale in June 2009 with her two beautiful and very well-behaved girls, both under age six. She had become homeless in April, because she could no longer afford to pay rent for her apartment. The father of her three children, an auto mechanic, was of no monetary or emotional help. He kept promising that he would help, but things just kept going wrong for him. She asked him to get a job, but he did not want to give up his business and chose instead to let her become homeless. She does not have relatives nearby, but a friend offered to let her stay in a room for a few days. The client spoke to her priest, and he referred her to PATH Achieve Glendale. She was working and made a decent wage, but with her three children she was at a very low income level. Her newborn baby developed several ailments, requiring a longer hospital stay. The client returned to the shelter from the hospital and was able to move into the private room in the Emergency Housing Program. She was very sad and missed her baby, but never complained. Soon after the birth of her son, PATH Achieve's Transitional Housing Program had an opening, and she was able to move with her children into an apartment where PATH Achieve helps pay for her rent and she receives services.