

County of Los Angeles Health and Mental Health Services

DATE: Wednesday, March 9, 2022

TIME: 10:30 a.m.

THIS MEETING WILL CONTINUE TO BE CONDUCTED VIRTUALLY TO ENSURE THE SAFETY OF MEMBERS OF THE PUBLIC AND EMPLOYEES AS PERMITTED UNDER STATE LAW.

TO PARTICIPATE IN THE MEETING, PLEASE CALL AS FOLLOWS:

DIAL-IN NUMBER: 1 (323) 776-6996 CONFERENCE ID: 322130288# MS Teams link (Ctrl+Click to Follow Link)

AGENDA

Members of the Public may address the Health and Mental Health Services Meeting on any agenda item. Two (2) minutes are allowed for each item.

THIS TELECONFERENCE WILL BE MUTED FOR ALL CALLERS. PLEASE DIAL *6
TO UNMUTE YOUR PHONE WHEN IT IS YOUR TIME TO SPEAK.

- I. Call to order
- II. Discussion Item(s):
 - a. DHS/DMH/CEO: Homeless Health Care
- III. Items Continued from a Previous Meeting of the Board of Supervisors or from the Previous Agenda Review Meeting
- IV. Items not on the posted agenda for matters requiring immediate action because of an emergency situation, or where the need to take immediate action came to the attention of the Department subsequent to the posting of the agenda
- V. Public Comment
- VI. Adjournment







Housing for Health Program Overview

Street-Based Engagement

Outreach and multidisciplinary services to individuals living on the street.

Outreach

Interim Housing

Short-term housing that offers a safe space to recuperate and stabilize, connect to services, and work on permanent housing.

Stabilization Beds

Recuperative Care

Permanent Housing

Housing assistance and individualized supportive services focused on housing retention and improving health outcomes.

Homelessness Prevention Unit Permanent Supportive Housing

Enriched Residential Care

Benefits Advocacy

Clinical Services





Street-Based Outreach and Engagement

- Multidisciplinary Teams (MDTs) deliver street-based outreach, engagement, and services. The most vulnerable clients will not come to us, we need to come to them.
- MDTs include health specialist, mental health specialist, substance use specialist, peer with lived experience, and a generalist.
- HFH and MDTs are one pilar of the E6 Coordinated Outreach System that also includes LAHSA, DMH, and other outreach partners across the county.

15,132 clients received services received MDT services in FY20/21

67 MDTS currently providing services across the country







Interim Housing

HFH operates about 2,600 interim housing beds that serve people with complex health and/or behavioral health conditions.

Stabilization Housing 1,750 beds

Interim housing for people who lack a place to live and need a higher level of support services than is available in most shelter settings.

Case management, assistance with life skills and community re-integration, and clinical oversight.

Recuperative Care 850 **beds**

Short-term care for individuals recovering from an acute illness or injury or who have conditions that would be exacerbated if they are not in stable housing with medical oversight.

Medical services including health monitoring, light assistance with activities of daily living, wound care, assistance with medication support and adherence.

Mental health and/or behavioral health services including ongoing evaluations, monitoring and groups.





Permanent Housing

Permanent Supportive Housing (PSH)

Rental assistance coupled with Intensive Case Management Services (ICMS) and other wraparound supports to support people with obtaining and sustaining housing

About **16,000** currently enrolled in HFH's PSH ICMS program

9,000 with a tenant-based subsidy

7,000 with a project-based subsidy

2,498 housed in FY 20/21

92% 1-year retention rate in FY 20/21

85% 2-year retention rate in FY 20/21

5,300 people currently housed with local rental subsidy







Permanent Housing

Enriched Residential Care (ERC) or "Board and Care"

- Housing option for clients who need daily, ongoing assistance with Activities of Daily Living (ADL) or other care and supervision
- ERC places people in licensed residential care settings:
 - Adult Residential Facilities (ARF)
 - Residential Care Facilities for the Elderly (RCFE)
- Residents receive case management and other enhanced services to support the transition and opportunity to move to other settings as needs change

770 currently housed







Permanent Housing

Homelessness Prevention Unit

- Data-driven demonstration program to identify County residents at high risk of becoming homeless and offer a time-limited intervention to stabilize their housing
- Partnership with California Policy Lab, DMH, CEO-HI, CIO, Hilton Foundation, and Brilliant Corners

73 participants served, July – Dec 2021

96% of participants retained permanent housing

Average of 2 successful linkages to supportive services made per client







Countywide Benefits Entitlement Services Team (CBEST)

- Assists individuals in applying for Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Cash Assistance Program for Immigrants (CAPI), and VA benefits
- Team consists of dedicated benefits advocates, clinicians, and legal partners

In FY20-21:

86% approval rate

1,564 of applications submitted

12,839 clients served

\$897 average monthly award amount; \$2,735,506 in retro-payments







Clinical Services – Star and Mobile Clinics

High-quality clinical care and consultations is fundamental to HFH service model

Star Clinic

- Hub of HFH clinical services
- Located in Skid Row, providing easy access to medical care for nearby IH or PSH clients
- Specializes in serving patients with complex physical and behavioral health issues with high rates of mortality

Mobile Clinic

- Four medical teams operating out of mobile clinics
- Deliver health care to patients unable to access brick & mortar clinics
- Team includes physicians, nurse practitioners, registered nurses, clinic licensed vocational nurses, certified medical assistants, clinical social workers, substance abuse counselors, and community health workers

Approximately **5,000** patients served through Star Clinic in FY20/21

Street medicine launched in FY20/21 as part of COVID response

Launching **4** new mobile clinics in FY21/22





COVID Response

Over **9,000** people provided with COVID medical sheltering

Over **290,000** COVID tests performed from April 2020 – March 2022

36,531 vaccines administered from February 2021 – March 2022

Accomplished through collaborative partnerships including DMH, DPH, LAHSA, CEO's, L.A. City, and more







Opportunities Ahead

- CalAIM Transition and Expansion
- Community Care Expansion (CCE)
- Expansion of current programming
- COVID Response
 - Moving to endemic phase of COVID
 - Reflecting on lessons learned with partners





Housing for Health

Mobile Clinic Program

Field-based care for those who need it most

Heidi Behforouz, MD Medical Director, HFH 03/09/2022



 66,000 individuals experiencing homelessness

- 50,000 unsheltered
- 16,000 temporarily sheltered

LA County
"Homeless
Count: 2020



Health Care Access Profile of HFH Clients

- HFH clients struggle with a myriad of health challenges: physical, mental, SUD, cognitive and chronic stress due to past and present trauma
- Based on available data, more than 85% of HFH clients are Medicaid eligible.
- Only 25% of HFH clients in interim housing and PSH environments are empaneled to DHS.
- Among those empaneled to DHS, it is estimated that 60% do not regularly attend their primary or specialty care appointments.
- Many of these individuals are "high-utilizers" of acute care facilities and require complex clinical and non-clinical care management to achieve wellness.



PEH Mortality Data

- Since 2017, drug overdose is leading cause of death among PEH
- PEH are 36X more likely to die from OD than non PEH
- Doubling of rate of OD deaths among black PEH
- Meth and fentanyl are leading perpetrators with fentanyl taking lead: particularly among PEH of color
- Heart disease is second leading cause of death among PEH (4x higher)
- Transportation-related injury is third leading cause of death among PEH (17x higher)
- Suicide/homicide is fourth leading cause of death
- COVID was fifth leading cause of death in 2020

HFH Street Medicine Initiative



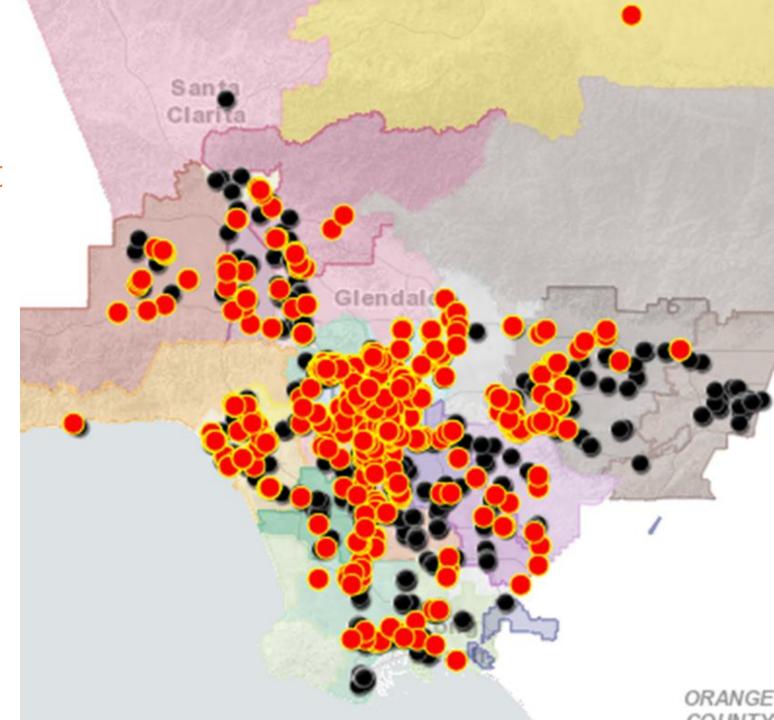
Need

- Life expectancy: 48-51 years among PEH
- Excess death tied to fentanyl/meth
- Premature death from chronic conditions
 (heart failure; cirrhosis; uncontrolled diabetes, chronic infections)
- Undiagnosed/untreated SPMI and SUD
- Violence/trauma



Encampment Assessment

- Via COVID outreach efforts over the past two years:
 - Surveyed over 1000 individuals across 8 SPAs
 - Asked about care connections and care preferences
- 80% have not received primary care for 2 years
- Most preferred to receive care in the encampments than go to clinics. Why?
 - Stigma/shame
 - Logistics
 - Poor treatment in health care settings
 - Low perceived benefit of traditional primary care



Mobile Clinics

- Demonstrated impact of "street medicine"
- Current players: VFC, Keck, LACHC, Northeast
 Valley FQHC, SCAN Health, UCLA
- DHS HFH has a 10-year history of coordinating SBE with MDTs and has had two years of CRT experience
- Used COVID dollars to purchase 4 medical vans
- Medical vans linked to Rancho Los Amigos (RLA)
 National Rehab Center



Operations

4 medical vans staffed with comprehensive team:
 MD, RN3, LVN, CMA, SrSW, CHW, SUDc, PRR

PT/OT and dental/vision services

Teams supported by a senior physician, consulting psychiatrist, and clinical pharmacist

Each unit:

Serves two SPAs and 20 sites every month

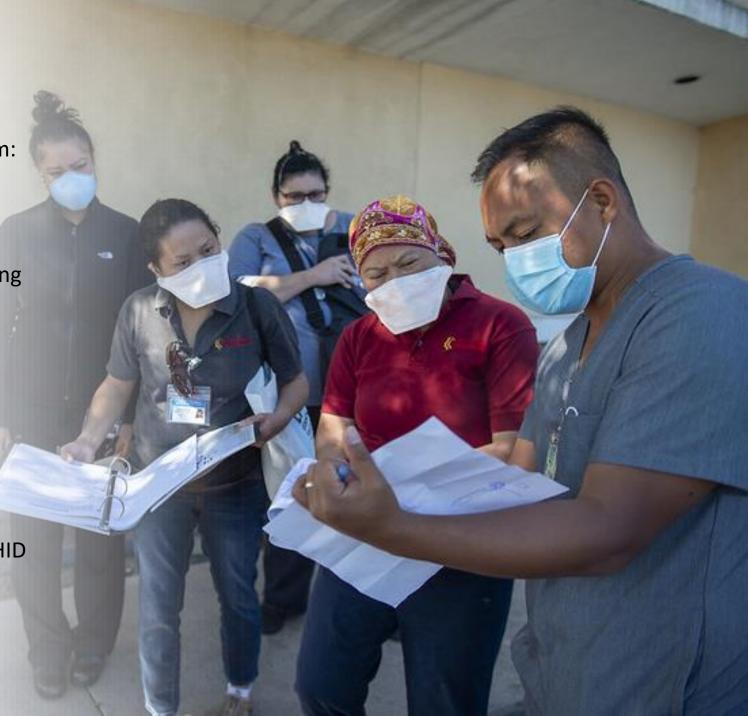
56 client encounters per day

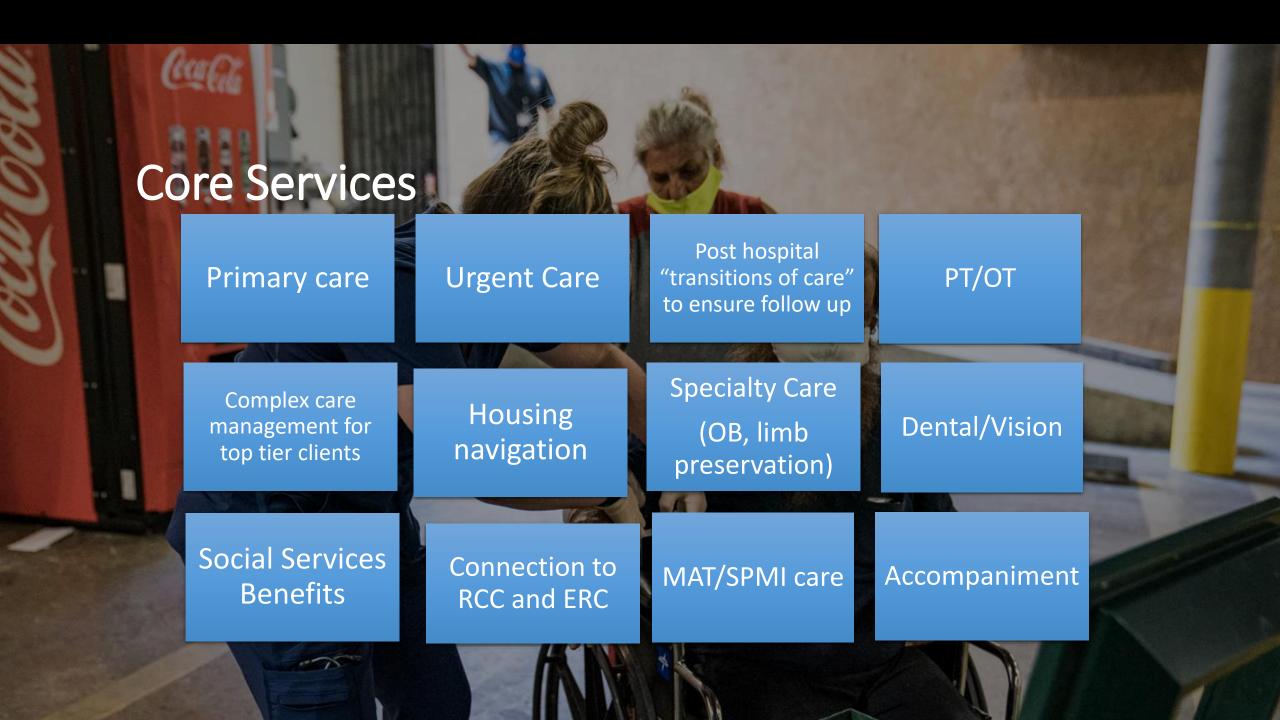
Primary care & urgent/specialty care

CalAIM services delivered and captured in ORCHID

Staff analyst for program operations

• Senior staff analyst for collaborations, communications, and impact measurement





Key Collaborations

Street-based engagement and street medicine teams

Federally Qualified Health Clinics/DHS clinics & DHS and private hospitals

County Partners: DMH, DPH/SAPC, DPSS Board of Supervisors
Homeless/Health
deputies

Cities/council districts, local police, Multi-Disciplinary Engagement Teams and Homeless Outreach Services Teams (HOST)

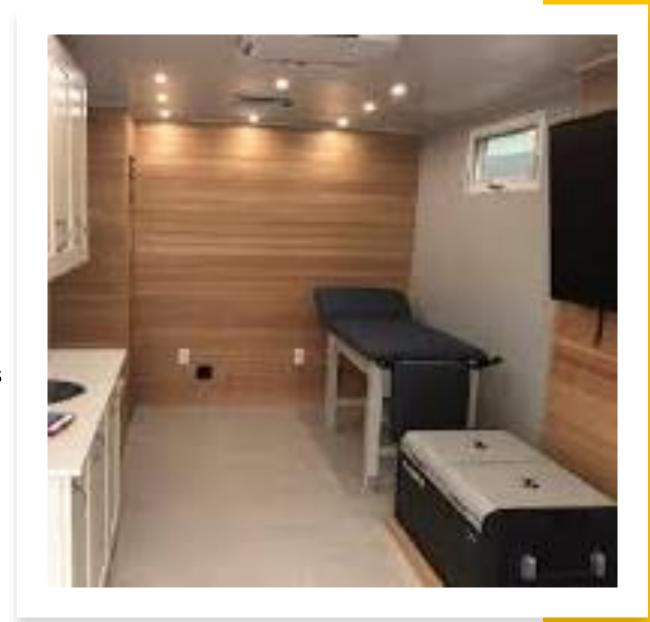
Managed Care
Organizations (MCO)
and Senior Care
Options (SCO)





Status of mobile clinics

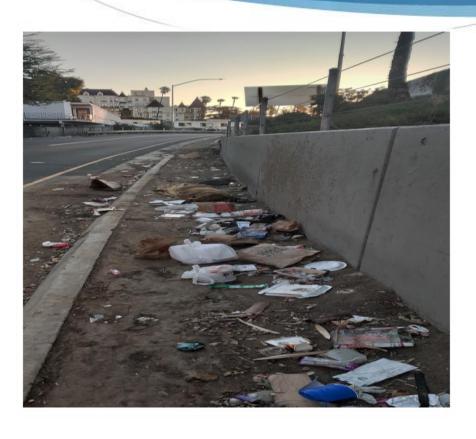
- Street medicine happening via unsheltered CRT
- CEO/DHS Finance have approved dedicated mobile clinic budget
- CEO Class/Comp has preliminarily approved organizational structure/staffing
- Currently hiring 41 items using RLA OPA items
- HFH/RLA have developed clinical P and Ps as well as routing for labs/pharmacy/radiology
- Submitting to CDPH for licensing
- Working with MCOs to be recognized as satellite clinic of RLA so we can assign patients to mobile clinic providers
- ORCHID build completed for mobile clinic documentation/billing
- Projected launch date 7/1/2023





Questions?

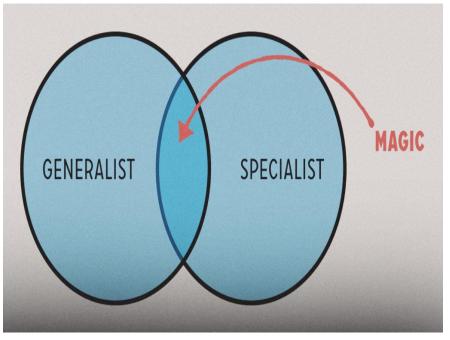
Homeless Outreach & Mobile Engagement (HOME)



- Countywide Program
- 9 Multidisciplinary Teams
 Across 8 Service Areas
- **▲** 100% Street Based Services
- Provides Full Spectrum of Specialty Mental Health Care:
 - Assessment
 - **Targeted Case Management**
 - Medication Support
 - Rehabilitation/ Therapy
 - Crisis Intervention



LA County Coordinated Outreach System



Generalist Teams

- Provide support for immediate needs e.g. food, clothing, medical treatment etc.
- Enrolls individual in Coordinated Entry System
- **Ad Hoc Case Management Assistance**
- When appropriate refer for specialized outreach teams (e.g. mental health, domestic violence, multi-disciplinary)

Specialty Mental Health Teams

- Provide specialized care for individuals with severe mental illness
- Street based psychiatric assessment
- Street psychiatry
- Psychiatric hospitalization
- Housing placement/support
- Broad Knowledge & Awareness + Depth of Expertise



HOME Target Population A Clinical Definition



- **Chronically Homeless**
- Seriously Mentally III
- Unable To Sustain/Provide Basic Needs In Independent Contexts Due To Psychiatric Disability
- "Gravely Disabled"
- Refuse Any Kind Of Treatment And/Or Care



Outpatient Conservatorship Pilot

Conservator

In law, a guardian or protector appointed by a court to manage the affairs, finances, of someone who is too ill or incanah doing so themselves or incapab.



Practice Innovation

Inpatient Pathway

- Lacks Care Continuity
- Assumes That All Clients Require Locked Placement
- Recovery Is Not At The Forefront
- Extended Hospital Stays (Well Past Acute Need)
- Administrative Days Result In Lost Hospital Revenue
- Average Wait For Locked Facility Is 3-4
 Months
- Reduces Acute Bed Access Unnecessarily
- Experience Can Be Traumatic On Multiple Levels

Outpatient Pathway

- Laser Focus On Our Mandated Focal Population
- Provides Avenue To Intensive Care
 Meeting the Client Where They Are i.e
 street based
- **♦** Assumes Recovery Is Possible
- Seeks Least Restrictive Housing Options To Support Recovery
- Maintains Continuity Of Care Throughout The Process
- Testimony For Hearing Is Informed By Home's Relationship Vs. Acute Visit



HOME Orchestrated Interventions

- Start With Least Restrictive Measures
- Offer Everything & Alternatives
- Collective Brainstorming
- Involve Public/Private Partners
- Advance Navigation Of All Systems Effecting Outcomes
- Plan For Contingencies





The Pilot relied on 40+ partnerships to render services for its vulnerable and complex cases





Pilot Engaged Highly Vulnerable Individuals

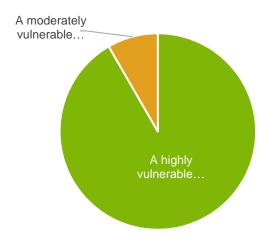
Most Common Diagnoses

- Schizophrenia
- Schizoaffective Disorder
- Delusional Disorder
- Co-occurring substance use
- Severe physical health problems: HIV, Extremity Infections, Atrial Fibrillation, Wheelchair-Dependence, Traumatic Brain Injury, Pulmonary Embolism

Data through 6/29/21. VAT scores are for assessments completed at time of committee discussion.

VAT Vulnerability Categories

N=36





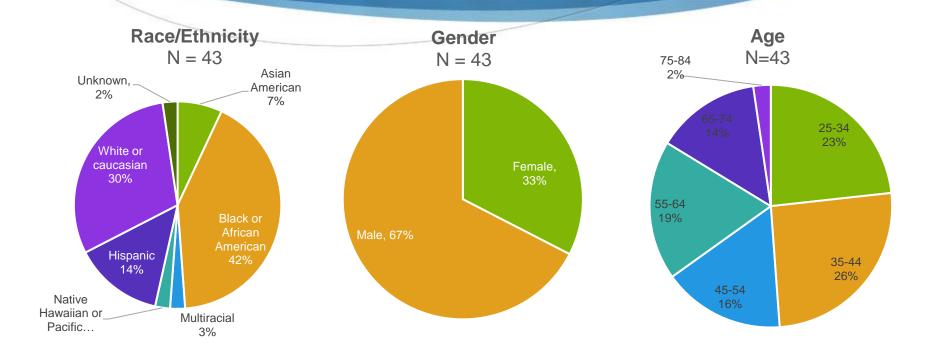
The Clinical Dilemma Autonomy Versus Beneficence Outpatient Conservatorship Pilot Results







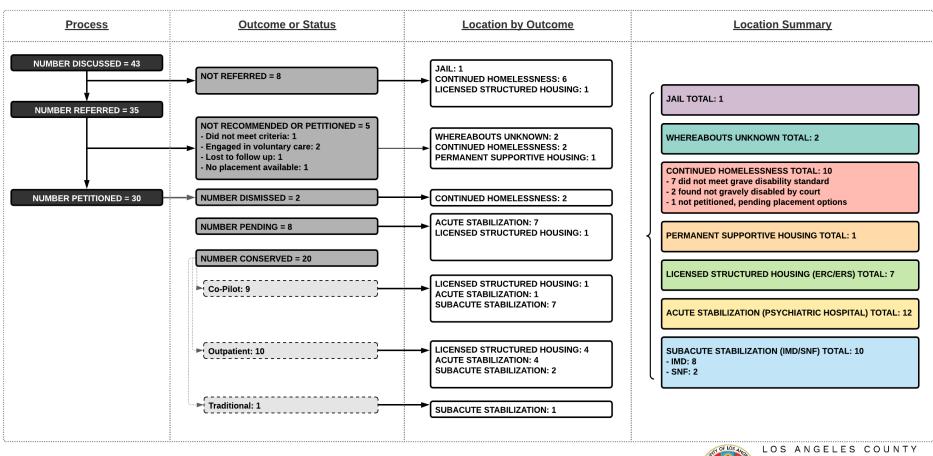
Committee "Discussed" 43 Individuals



Data through 6/29/21 10



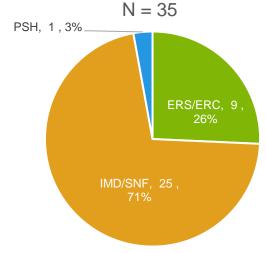
Outpatient Conservatorship Pilot Data: 8/5/2020 - 6/29/2021





Most Individuals Need Locked Placements and/or Skilled Services

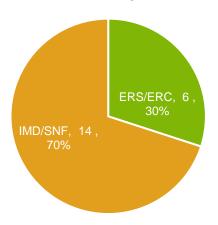
Referred Individuals: Placements Required



Data through 6/29/21

Conserved Individuals: Placements Required

N = 20



3 of 20 conserved individuals are pending IMD or SNF level placement



Challenges

- ▲ Lack of adequate housing capacity in multiple settings (i.e., subacute, skilled nursing, residential care, co-occurring treatment beds)
- Requirement for in-person court proceedings
- Staffing limitations (HOME, Public Guardian, Full-Service Partnership)
- Need for novel methods to support street based involuntary hospitalizations



Outcomes To Date

- ♦ 68 Individuals Presented To The Committee
- ♦ 40 Permanent Conservatorships Appointed
- 6 Petitions Filed Pending Court Hearings
- ♦ 2 Pending Investigation
- 5 Dismissed
- ♦ 5 Non-handle



Moving Forward

- ♦ HOME continues to coordinate outreach and interventions in coordination with the larger Countywide outreach strategy
- Outpatient conservatorship has become a standard part of the HOME program's service array
- Biweekly committee meetings for active and new cases
- Monthly check-in meetings for conserved clients
- Formalize knowledge articulated and processes created
- Continue to strategize and problem solve barriers



The Clinical Dilemma Autonomy Versus Beneficence







Questions....







DMH Investments in Combatting Homelessness FY 21-22

Housing Investments \$78,339,647

Service Investments \$442,551,600

Total \$520,891,247

Housing Investments FY 21-22

Capital* \$31,200,000

Subsidy \$47,139,647

Total \$78,339,647

^{*}Total one-time since 2008 = \$984.5M

Service Investments FY 21-22

Engagement/Re-entry Initiatives \$40,765,792

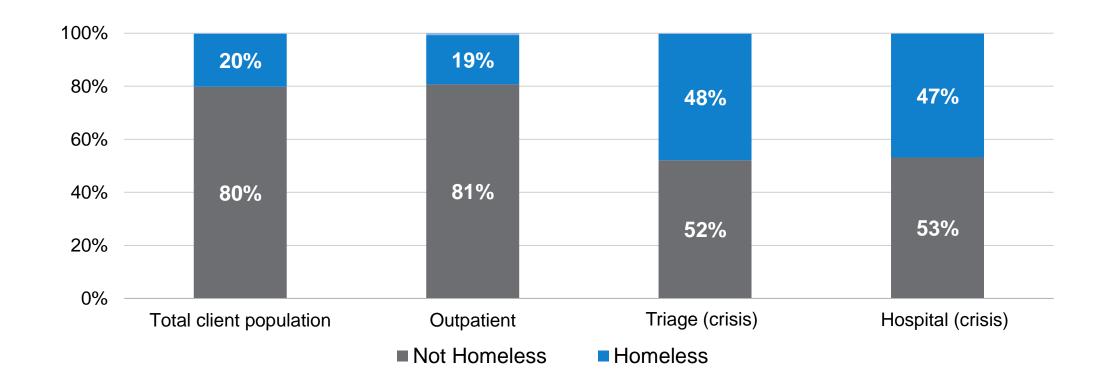
Crisis Care \$219,185,225

Community Services \$182,600,583

Total \$442,551,600

Service Costs by Level of Care FY 19-20

• DMH clients who were homeless comprised 20% of the overall client population in FY 19-20 but accounted for almost half of triage and hospital costs.



DMH Housing & Job Development Division Housing and Service Programs

- Capital Investments Program
- Federal Housing Subsidies Program
- Housing for Mental Health Program
- Housing Assistance Program
- Permanent Supportive Housing (PSH) Supportive Services
- Enriched Residential Care Program
- Interim Housing Program

Capital Investments Program FY 20-21 Outcomes

- Provides capital and operating subsidy funding for the development of PSH countywide targeting DMH clients with Serious Mental Illness who are homeless
- Over \$958M in Mental Health Services Act (MHSA) dollars invested since 2008 including \$700M in No Place Like Home funding
- \$664M committed to date funding 148 developments and 3,719 units

MHSA Capital Investment Commitments since 2008				
TARGET POPULATION	PSH DEVELOPMENTS	MHSA UNITS		
Adults	80	2,154		
Families	14	408		
Older Adults	26	621		
TAY	20	360		
Veterans	8	176		
TOTAL	148	3,719		

Capital Investments Program FY 20-21 Outcomes (Continued)

- As of June 30, 2021:
 - 56 of 148 PSH developments had finished construction
 - 1,100 of 3,719 MHSA units were occupied
 - MHSA units provided housing for 1,912 clients and family members in FY 20-21 including 222 children.
- New lease-ups = 268
- Housing retention rate = 95%

Federal Housing Subsidies Program FY 20-21 Outcomes

- Provides DMH clients who are homeless with access to federal tenant-based PSH subsidies including:
 - Continuum of Care (CoC) Certificates
 - Tenant Based Supportive Housing (TBSH) Vouchers
 - Mainstream Vouchers
 - Housing Choice (Section 8) Vouchers
- Subsidized housing for 3,068 clients and family members in FY 20-21 including 766 children
- New lease-ups = 314
- Housing retention rate = 94%

Housing for Mental Health Program FY 20-21 Outcomes

- Funds housing subsidies and move-in assistance for DMH clients countywide who are homeless and enrolled in a Full Service Partnership (FSP) program
- 20% of housing subsidies reserved for FSP clients referred by the Office of Diversion
 & Re-entry (ODR)
- Housing retention rate = 90%

FY 20-21 OUTCOMES				
HOUSING TYPE	NEW REFERRALS	NEW MOVE-INS*	TOTAL IN HOUSING**	TOTAL SERVED
Tenant-Based	95	150	236	281
Project-Based	70	90	140	147
ARF/RCFE	6	8	15	17
TOTAL	171	248	391	445

^{*} New Move-Ins includes clients referred the previous fiscal year.

^{**} Total in Housing includes clients housed in previous fiscal years.

Housing Assistance Program FY 20-21 Outcomes

- Funds move-in and eviction prevention assistance, as well as rental subsidies, for DMH clients who are homeless or at risk of homelessness
- \$2.3M spent, 894 clients served

FY 20-21 OUTCOMES				
ASSISTANCE TYPE	NUMBER SERVED	EXPENDITURES		
Security/Utility Deposits	221	\$306,669		
Household Goods	485	\$478,558		
Time-Limited Rental Assistance	124	\$425,235		
Eviction Prevention	11	\$8,699		
Permanent Rental Subsidies	53	\$1,162,292		
TOTAL	894	\$2,381,453		

PSH Supportive Services FY 20-21 Outcomes

- Housing FSP Program (renamed Housing Supportive Services Program)
 - Provides field-based/on-site specialty mental health services including therapy, crisis intervention and medication management
 - 1,490 clients served in FY 20-21
- Intensive Case Management Services (ICMS) Program
 - Provides field-based/on-site housing case management services including completing housing-related paperwork and supporting clients with move-in and retention
 - 1,183 clients served in FY 20-21 (in partnership with DHS)
- Many DMH clients received both Housing FSP and ICMS services.

Enriched Residential Care Program FY 20-21 Outcomes

- Assists DMH clients to obtain and maintain housing at licensed residential facilities by providing funding for rent, Personal & Incidentals (P&I) and/or enhanced services
- Serves those who are homeless as well as those exiting higher levels of care
- June 30 program census = 595 clients
- New referrals = 236, New move-ins = 184
- Housing retention rate = 85%

FY 20-21 OUTCOMES					
FUNDING TYPE	NEW ERC REFERRALS	NEW ERC MOVE-INS			
Rent + P&I + Enhanced Rate	151	119			
Enhanced Rate Only	85	65			
Total	236	184			

Interim Housing Program FY 20-21 Outcomes

- Provides DMH clients who are homeless, as well as their minor children, with short-term housing
- 413* individual beds available in FY 20-21, 1,129 individuals served
- 69 family units available in FY 20-21, 153 families served

FY 20-21 EXITS OVERVIEW					
EXIT DESTINATION/REASON	#	%	EXIT DESTINATION/REASON	#	%
Permanent Housing	153	23.5%	Homelessness	35	5.4%
Interim Housing incl. Hotels/Motels	98	15.0%	Deceased	1	0.2%
Institutions (Jails, Hospitals, Skilled Nursing)	28	4.3%	Unknown/Left Site	325	49.9%
Substance Use Treatment	11	1.7%	TOTAL EXITED	651	100.0%

^{*} DMH was previously contracted for 506 individual beds but site capacity was reduced due to the pandemic.



Measure H After Five Years

March 9, 2022

HMHS Cluster Meeting
Cheri Todoroff, Executive Director
LA County Homeless Initiative and Affordable Housing

HOMELESS INITIATIVE and MEASURE H



HI STRATEGIES & IMPACT



CHALLENGES



THE WAY FORWARD

HOMELESS INITIATIVE and MEASURE H



LOS ANGELES COUNTY HOMELESS INITIATIVE



The **Homeless Initiative** oversees Los Angeles County's ongoing effort – unprecedented in scale – to expand and enhance services for people at risk of or experiencing homelessness, primarily financed through **Measure H**. It directs **strategies** and allocates **funding** to scale up:

- Homeless Prevention for people at risk of eviction or exiting foster care, hospitals, jails, other institutions
- Outreach to connect people in encampments and vehicles to housing and supportive services
- Interim Housing such as shelters, recuperative care facilities, and sober living facilities
- Permanent Housing with subsidized rent and, if necessary, supportive services for those with acute needs
- Supportive Services such as health and mental health care, substance use disorder treatment, criminal record clearing, benefits enrollment, job training and employment, and other services to help people achieve stability and self-sufficiency

TIMELINE



2015 AUG

Homeless
Initiative
created by
Board of
Supervisors

2016 FEB

Board approves Homeless Initiative Strategies + \$100M

2016 DEC

Board
declares
State of
Emergency,
places
Measure H
on ballot

2017 MAR

Measure H

passes
with 69% of
votes,
generating
\$355M
annually for
10 years

2017 JUL

Measure H

revenue
triggers
expansion
of homeless
services
system

2027 SEP

Measure H
expires
unless
voters
approve
extension



69.34%Voter Approval

1/4 CENTSales Tax

10 Years 2017 - 2027

\$355M Annual Revenue

MEASURE H

Measure H is the first revenue stream dedicated to preventing and addressing homelessness across Los Angeles County.

The Homeless Initiative allocates funds to County departments/agencies, cities, service providers to implement its strategies.

Distribution is either countywide or by Service Planning Area (SPAs), based on the size of their homeless population.



HI STRATEGIES AND IMPACT









Initial Strategy Development Process

The Board of Supervisors launched the Homeless Initiative on August 17, 2015, to develop a comprehensive set of recommended strategies to reduce homelessness.

- An inclusive, collaborative planning process
- 25 County departments, 30 cities, and over 100 community organizations
- 18 policy summits
- 500-person community meeting
- Written comments from over 200 organizations and individuals

OVERVIEW OF CURRENT STRATEGIES

In 2016 – pre-Measure H – the Board approved 47 strategies and \$99.7M to implement them.

This later expanded to the current 51 strategies, with the below strategies funded through Measure H.

A. PREVENT HOMELESSNESS

Homeless prevention for families and individuals

B. SUBSIDIZE HOUSING

- Rapid rehousing
- Subsidized housing to disabled homeless individuals pursuing SSI
- Landlord incentives for federal housing subsidies
- Family reunification housing subsidies
- Interim/bridge housing for those exiting institutions

C. INCREASE INCOME

- Increase employment for homeless adults
- Countywide SSI/SSDI, and veterans benefits advocacy.

D. CASE MANAGEMENT AND SERVICES:

- Jail in-reach
- Criminal Record Clearing Project
- Permanent supportive housing services and subsidies

E. CREATE A COORDINATED SYSTEM:

- Countywide outreach system
- Coordinated Entry System
- Emergency shelter system
- Services for transition age youth

F. AFFORDABLE HOUSING FOR THE HOMELESS:

HOMELESS INITIATIVE IMPACT DASHBOARD

July 2017 - December 2021

(FIRST 4 YEARS + 1 QTR OF MEASURE H)



78,101
People placed in permanent housing



104,681
People placed in interim housing



20,067
People prevented from becoming homeless

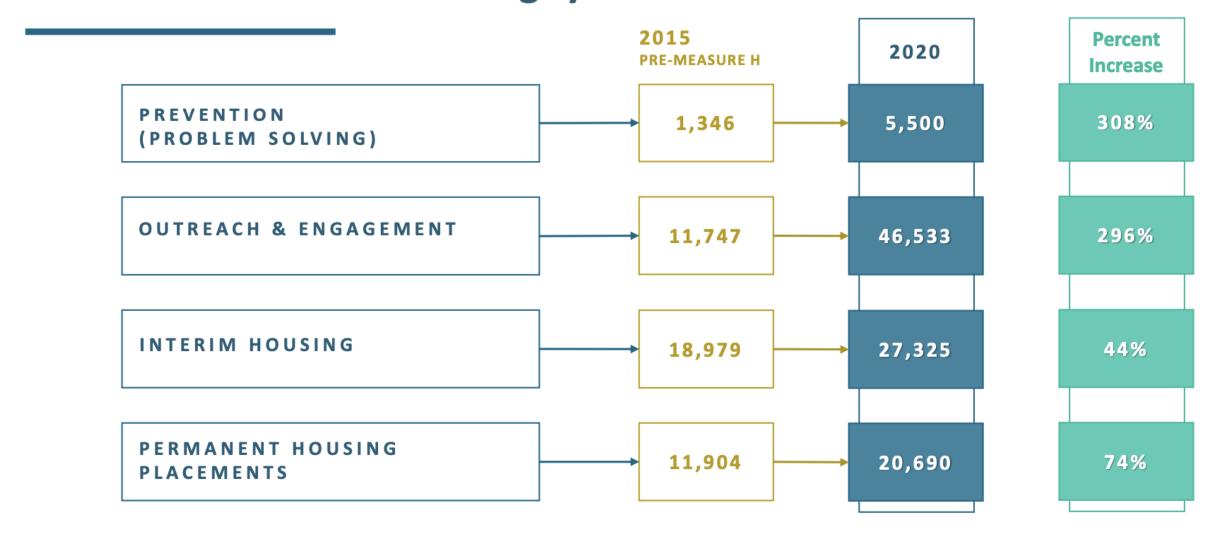


34,738
People increased income from employment/benefits

Measure H completely or partially funded: 41% of permanent housing placements (31,898 people)

54% of interim housing placements (56,453 people)

LA County's investment in Measure H has created a robust and effective homeless rehousing system.

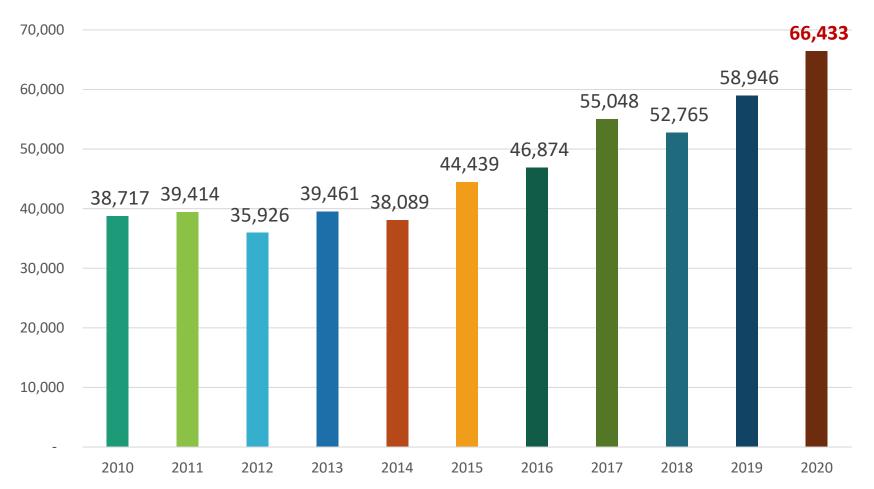




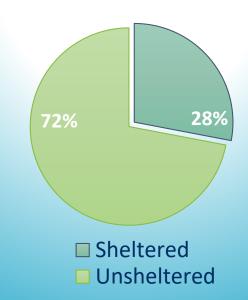
CHALLENGES



GREATER LOS ANGELES HOMELESS COUNT



Despite growing investments and significantly increased housing placements, the homeless census continues to increase in Los Angeles County.



PERSISTENTLY UNDERSERVED

- Most newly homeless people are assisted effectively, but some fall into persistent homelessness, struggling to have their needs met.
- Persistently underserved homeless individuals are those who received homeless services for 6 or more months in the previous 12 months.
- The number of persistently underserved homeless people **more than doubled** between 2017 and 2019, going from 16,000 to **35,500**.
- It is this growth in the number of persistently underserved homeless people that drives the increase in the Homeless Count.
- The challenges this group faces are exacerbated by lack of affordable housing and a gap between availability of interim housing and that of permanent housing. In addition, our homeless services system needs to be scaffolded by fully engaged mainstream social services systems, so that it can adequately serve the most vulnerable PEH.

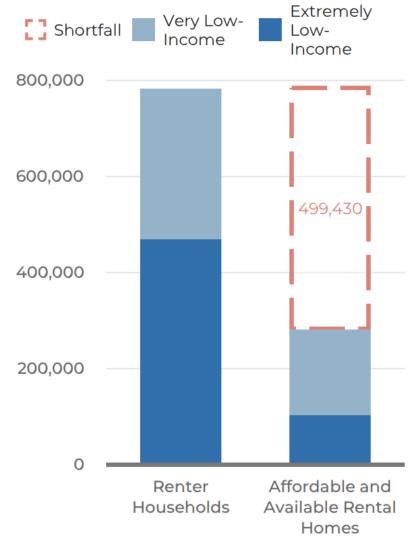




AFFORDABLE HOMES SHORTFALL

499,430 low-income renter households in Los

Angeles County do not have access to an affordable home.



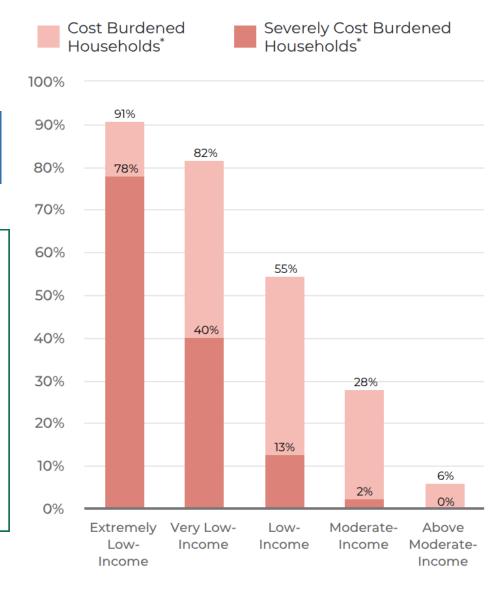


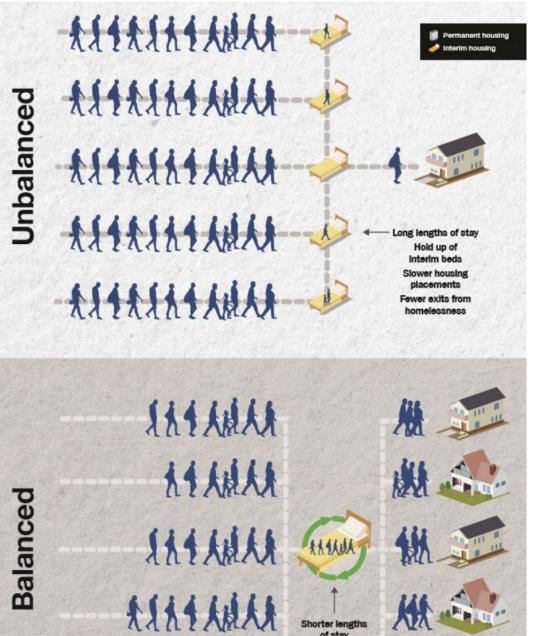
LOS ANGELES COUNTY 2021 Affordable Housing Needs Report



COST BURDENED RENTER HOUSEHOLDS

78% of ELI households in Los Angeles County are paying more than half of their income on housing costs compared to just 2% of moderate-income households.





THE EXIT GAP

- Our homeless services system has an exit gap a gap between the number of people who need permanent housing and those who receive it.
- The supply of interim housing rose 57% over the last three years to 25,000 beds. But we need more exits to permanent housing.
- A balanced system would have:
 - 5 housing exits for every 1 shelter bed.
- Los Angeles now has only 1 exit for every 1 shelter
 bed.

THE WAY FORWARD

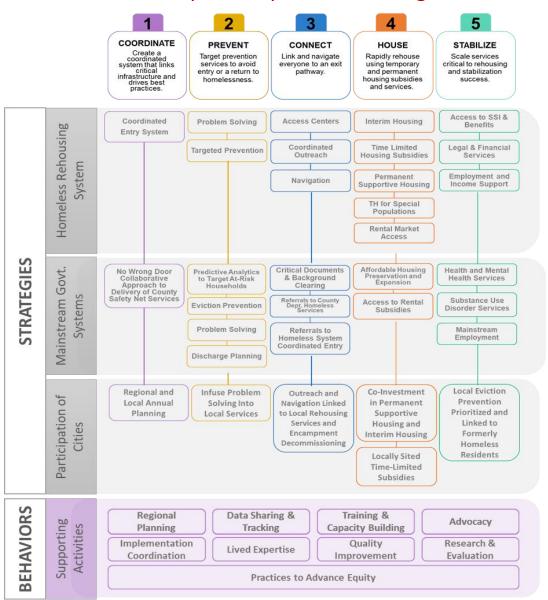


HOMELESS INITIATIVE STRATEGY REASSESSMENT

Strategy Reassessment Recommendations

- Enable the homeless re-housing system to effectively use its resources to serve the persistently underserved.
- Fully leverage mainstream systems to utilize safety net programs to prevent homelessness before people need the homeless re-housing system or quickly rehouse them.
- Co-invest with cities to increase the supply of housing to close the exit gap.
- Strategic effort to advance racial equity.

Proposed Update to Strategies



OLD FRAMEWORK VS. NEW FRAMEWORK

- 6 categories intended to activate a regional plan
- 51 strategies a mix of homeless system infrastructure, mainstream system programs, and supporting activities
- Insufficient clarity on the role of mainstream systems and opportunities for cities to accelerate impact in their jurisdictions

- 5 linked categories reflecting the regional rehousing system plan
- Strategy sets for each system partner: Homeless System, Mainstream System, Cities
 - 14 strategies to sustain the homeless rehousing system
 - 13 strategies to activate mainstream systems and fully utilize their programing to prevent and address homelessness
 - 6 strategies to support shared investment in housing and regional coordination and accelerate impact in local jurisdictions with housing
 - Strategic effort to advance racial equity

NEXT STEPS

With Board direction -

Rehousing system

• In the next budget cycle, allocate funding to clarified set of strategies to support system partners in meeting the needs of persistently underserved PEH.

Mainstream systems

- County departments are directed to prioritize the identified activities to scale their impact in preventing and addressing homelessness.
- HI leads a process to identify how best to ensure the identified activities permeate all of our mainstream systems.
- HI and Departments agree on accountability mechanisms, with HI empowered to implement.

Cities

 HI to lead a process with cities and Councils of Governments to fully flesh out implementation of co-investment strategies and funding mechanisms

Beyond the Strategies

Systemic Change

- Address the drivers of homelessness – criminal justice system, child welfare system, education system, healthcare system, racial injustice, etc.
- Fully implement racial equity plan within the homeless services system and beyond.

Resources and Advocacy

- Advocate at the state and federal level for increased resources – at least \$500M/yr (ongoing) in additional funding (above and beyond) Measure H.
- Reauthorize Measure H to maintain a critical, flexible local funding source.
- Increase availability of affordable housing and rental subsidies

