Health Services
LOS ANGELES COUNTY

HOUSING FOR HEALTH

VOLUME III: JULY–DECEMBER 2022

Biannual Report

Sarah Mahin, *Director*
HOUSING FOR HEALTH

Inside

HOUSING FOR HEALTH

From the Director of Housing for Health:

A little more than a decade ago, Housing for Health began as a pilot program tasked with finding solutions for unhoused patients of the Department of Health Services who were in and out of our hospitals and emergency rooms. Those patients lacked housing where they could stabilize and improve their health and wellbeing. Our team began writing a "prescription for housing" as part of patients' care plans, which was an unconventional treatment for a health care system to deliver.

Since then, Housing for Health has become a national model for moving large numbers of unhoused people with complex physical and behavioral health needs into permanent homes. In partnership with CoCs, public housing authorities, and the Flexible Housing Subsidy Pool operated by Brilliant Corners, more than 18,000 people have moved into permanent supportive housing through Housing for Health over the past decade. These individuals all receive Intensive Case Management Services (ICMS) delivered by a community-based service provider and other wraparound supports to ensure that they remain housed. HFH's 91% housing retention rate after one year is yet more evidence that our approach works.

The secret to our success has always been built upon true partnerships that are deeply rooted in the diverse communities across LA County. Today, our greatest assets in the fight against homelessness are the people – our dedicated staff here at HFH, and those working at our community-based nonprofit partners, colleagues at other county departments, and our partners in cities across LA County.

We collaborate with these partners day in and day out. And we rely upon our partners to help identify the needs of the communities they serve, and it's our mission to do "whatever it takes" to help them deliver critical services to meet those needs. This community collaboration extends across existing programs, new initiatives, emergency response and beyond.

We're also partnering directly with more than a dozen communities – from the Antelope Valley to Long Beach – to bring critical primary, urgent and women's care to encampments where it's desperately needed. Our new mobile clinics are part of a larger strategy to create healthier communities and to connect individuals with housing and other supports that will bring them in off the streets.

In late 2022, we also coordinated a community driven process that brought stakeholders – including unhoused and formerly unhoused residents, nonprofit service providers, and other community members – together to help develop a Skid Row Action Plan, which will serve as a roadmap for meeting the needs of an area hit hardest by the homeless crisis. In the coming year, we hope to work with community members to make that plan a reality. That will include adding housing, expanding health care and reducing overdoses, the leading cause of death within the Skid Row community.

Through collaboration with municipalities and communities, we are strengthening the safety net and housing a historic number of people. However, solving one of the greatest social challenges of our time also requires significant continued investment and urgent solutions at the local, state, and federal levels to reverse decades of structural racism and inequities, to address policy and regulatory barriers, and to prevent more people from falling into homelessness in the first place.

On behalf of our compassionate and dedicated staff and partners, I present this brief overview of Housing for Health's activities for the second half of 2022. Much of this has been possible because of the public's support of Measure H, which provides unprecedented flexible resources to put tens of thousands of unhoused people on a healthier path home.

Sincerely,

Sarah Mahin
Director, Housing for Health

SUCCESS STORIES

"Trying to keep you alive"

Reilly Russia has called Skid Row home on and off for decades and has seen more than her fair share of tragedy over the years. But she'd never known so much death and devastation until opioids gripped the neighborhood. When one of her close friends died of an overdose on a patch of asphalt in Skid Row, she knew she had to do something to help keep her neighbors alive.

Reilly has since made it her mission to flood the neighborhood with naloxone, the medication that rapidly reverses an overdose. "Where my friend died," she said, "I put a pink bag with [naloxone] inside to show people in the community where they could access it in case of an emergency." Reilly didn't stop there. She began stapling naloxone to trees and telephone poles throughout Skid Row and called the effort "The Tree of Life."

Reilly's work is part of a community-wide effort to bring harm reduction strategies and supplies to the area, which has become the epicenter of the overdose crisis. Her mission is simple: remove barriers to accessing life-saving medication so it's readily available to anyone in the community. "I am just trying to keep you alive," she said.

On a recent walking tour with Ruby, her four-legged companion, Reilly pointed out tree after tree where she has pinned the naloxone since her friend's tragic death. A vast majority of overdoses reversed with the medication are administered by community members themselves. It's a testament to the success of the harm reduction community in raising awareness and building local capacity to address the crisis that's unfolding on the streets.

For Reilly, she's gained as much as she's given through her outreach work, which she expanded in partnership with a local nonprofit, the Sidewalk Project. Her life has a purpose that was missing before, and that's helped with her long-standing depression. It's also helped her to cut back on her own drug use. Being housed in an apartment she was connected to through Housing for Health and finding a confidant in Ruby, whom she describes as the most important relationship in her life, has also given her the stability to turn adversity in her life into giving back.

Whatever It Takes...

Our Origin Story

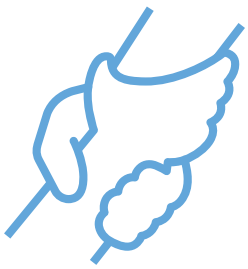
Housing for Health, a division of the Department of Health Services, was founded in 2012 to provide housing and services to unhoused patients who frequented the County's public hospitals and health services. By connecting patients with housing subsidies and intensive case management, the program helped to stabilize individuals' health, while reducing avoidable inpatient, outpatient, and emergency department visits.

The County leveraged Housing for Health's infrastructure to expand housing and services to thousands of unhoused adults and families after Measure H, a Countywide sales tax to fund homeless services, was approved by voters in 2017. Other County departments have invested in HFH housing and services for their prioritized populations.

For the past 10 years, Housing for Health has maintained its core ethos and founding principles of improving the health and quality of life for some of L.A. County's most vulnerable residents. Housing for Health now operates a full continuum of services, from street outreach to permanent housing, with case management, benefits advocacy and clinical services integrated into all programming.

Our Approach

Housing for Health provides housing and services to people experiencing homelessness with physical and/or behavioral health conditions, high utilizers of public services and other vulnerable populations.



PRINCIPLES:

Housing First — Connect individuals to permanent housing without preconditions or barriers to entry

Harm Reduction — Help reduce unhealthy behaviors with respect, dignity, and compassion

"Whatever It Takes" — Flexible services delivered to meet individual needs

COLLABORATION WITH NONPROFIT PROVIDERS, CITIES, AND COMMUNITY PARTNERS IS CRITICAL

Our innovative approach to funding services and contracting with community-based partners enables Housing for Health to build a strong network of experts who deliver housing and social supports. Features of our partnerships include:

- Centralized funding creates simplicity so financial resources are disbursed quickly and efficiently
- Master Services Agreements with partners remove "red tape" to enable quick scaling and flexibility
- Collaboration and frequent hands-on technical support for partners

Flexible Housing Subsidy Pool

The Flexible Housing Subsidy Pool (FHSP) is a fiscal and contractual tool that enables Housing for Health and its partners to quickly create housing options; the flexibility to combine various revenue sources for local rent subsidies; and offers participants mobility if their housing needs change. The FHSP also helps facilitate engagement with landlords and housing development that responds to the needs of vulnerable County residents. The program is administered by Housing for Health's nonprofit partner, Brilliant Corners.

During this reporting period, the FHSP directed new funding from various sources – including the American Rescue Plan Act (ARPA) and the Care First and Community Investment (CFCI) initiative – towards transitioning unhoused people into permanent housing. During the reporting period, FHSP housed 108 households in project-based buildings and deployed tenant-based vouchers to support people as they sought housing in the private rental market.

From July - December 2022

5,308 households housed through FHSP

510 were newly housed

Street-Based Engagement

Housing for Health contracts with community-based partners to operate Multi-Disciplinary Teams (MDTs) that conduct outreach to engage unsheltered people and connect them with housing and supportive services. Each team is composed of a licensed health care provider, a behavioral health professional, a substance use specialist, a caseworker, and a peer with lived experience. By combining this range of expertise, MDTs are uniquely equipped to provide comprehensive assessments and services on the streets. These specialized street teams provide sustained engagement to build trust among some of the County's most vulnerable so they will accept housing and supportive services.

From July - December 2022

7,263 clients received a service or referral by MDTs

521 clients connected to Interim Housing

Interim Housing

The Interim Housing (IH) program provides an avenue for people experiencing homelessness to move safely inside and connect with services and permanent housing. Housing for Health specializes in providing this temporary housing for individuals with complex medical and behavioral health conditions who need a higher level of support services than typically available in shelter settings.

Recuperative Care

Short-term housing 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 care.

Stabilization Housing

Immediate housing solution for individuals who are medically vulnerable if not placed into a stable living environment.

During the last reporting period, the IH program brought on two analysts who played a critical role in updating the program's bed management system, which tracks participant information and vacancies. The team also supported the development of stakeholder data reports for various IH partners and County departments. And, after more than two years, more than 330 beds came back online that were closed due to COVID-19 safety protocols. The program also continued its Project Home Key demobilization efforts, which focused on exiting all clients to safe and stable housing, to enable the sites to convert to permanent supportive housing.

- **255** days: average length of stay among all Interim Housing clients*
- **2,089** clients served*
- **318** clients exited to permanent housing, which was **37%** of exits during the reporting period

* Data is from July–December 2022.

Permanent Supportive Housing

Permanent supportive housing (PSH) is an evidence-based intervention that ends homelessness for vulnerable people with complex health conditions by pairing housing subsidies and supportive services. Housing for Health matches people to housing subsidies and Intensive Case Management Services (ICMS), which are delivered by community-based providers. ICMS services are supplemented with the wraparound support of in-home caregivers that bridge to IHSS, field-based nursing support by DHS, specialty mental health care from the Department of Mental Health (DMH), and substance use services by Department of Public Health. Integrating these services promotes housing retention and improves individuals' health and overall well-being.

In 2021, about 7,000 Emergency Housing Vouchers (EHV) were allocated to public housing authorities across LA County through the American Rescue Plan Act, and Housing for Health jumped into action to support the quick and effective utilization of these precious resources. Under federal guidelines, 100% of all vouchers must be issued by September 2023. Housing for Health was tasked with connecting ICMS to 2,100 EHVs distributed among community-based service providers. DHS will continue to coordinate and strategize with partners, including Los Angeles Homeless Services Authority (LAHSA), public housing authorities and DMH, to ensure maximum utilization of EHVs.

CalAIM Community Supports (CS) implementation remained a major focus during this reporting period. The PSH team continued to work with Medi-Cal Managed Care Plans (MCPs) on reauthorizing over 10,000 members who were grandfathered into CS when CalAIM launched. The PSH team has also referred 3,300 new program participants for CS between July and December of 2022, bringing the total number of active participants to approximately 15,000.

- **19,461** individuals received Intensive Case Management Services*
- **91%** of PSH participants retained housing for 1 year*
- **86%** of PSH participants retained housing for 2 years*

Enriched Residential Care or "Board and Care"

Enriched Residential Care (ERC) facilities are an important housing option for people who require ongoing assistance with basic daily activities because of complex physical or behavioral health conditions. Participants are often discharged from an inpatient hospital or living in an unsheltered setting or in housing that lacks the higher level of care they require to be safe. Residents are placed in licensed residential care facilities and receive time-limited case management to connect with ongoing benefits and services.

1,021
individuals served*

122
new placements into ERC*

* Data is from July–December 2022.

Homelessness Prevention Unit

The Homelessness Prevention Unit (HPU) is a proactive, data-driven program launched in January 2021 to identify DHS and DMH clients at high risk of becoming homeless. Clients are identified through predictive modeling by UCLA's California Policy Lab (CPL). HPU staff work with clients over four and six months to help stabilize their housing and improve their overall health. HPU provides flexible financial assistance, including rent, utility payments, vehicle repair and debt resolution. Participants are also linked to County health and mental health services, substance use treatment, benefits advocacy, legal aid, employment and education.

Through the County's investment in federal ARPA dollars, the HPU expanded in May of 2022 to also serve families at risk of losing their housing. The unit's caseload capacity increased to include more than 200 households at any given time. In 2023, the HPU will complete its efforts to scale and then move into a formal evaluation period with CPL, which will perform a rigorous examination of the program's success.

285
households served*

88%
of HPU clients retained housing or transitioned to other permanent housing at program exit

Countywide Benefits Entitlement Services Team

The Countywide Benefits Entitlements Services Team (CBEST) helps unhoused people, individuals at-risk of homelessness, veterans, and formerly incarcerated people to apply for public benefits, including Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Cash Assistance Program for Immigrants (CAPI) and VA benefits veterans. CBEST consists of dedicated intensive case managers, benefit advocates, clinicians, and legal partners who provide wraparound services to support successful disability benefit connections.

7,441
individuals enrolled in CBEST*

951
benefit applications submitted*

91%
approval rate for benefit claims*

Capital Improvement Intermediary Program

The Capital Improvement Intermediary Program (CIIP) manages the construction of facilities that expand housing and services for people experiencing homelessness. Housing for Health works closely with its nonprofit partner, Brilliant Corners, and project sponsors to design, build, convert, and renovate spaces that offer a supportive and dignified experience for clients. See Appendix A for a full list of past and pending projects.

1,146
units/beds created*

706
units/beds currently in the CIIP pipeline

* Data is from July–December 2022.

Clinical Services

Two Approaches

Direct: Teams of Housing for Health nurses, social workers, substance-use counselors and other providers offer wrap-around care for individuals challenged by physical and behavioral health comorbidities. These teams also conduct assessments, make clinical referrals, and deliver complex care management in non-traditional settings – such as riverbeds, shelters and apartments – to improve client health outcomes, enhance meaningful connections to health care, and optimize quality of life.

Contracted Partners: Housing for Health clinical and non-clinical staff provide robust training and technical assistance to subcontracted outreach workers and case managers so that they can accompany individuals to medical appointments, improve follow through on medications and/or treatment recommendations, develop disease self-management skills and health literacy.

Star Clinic

Located in the heart of Skid Row in downtown L.A., the Star clinic is a patient centered medical home that specializes in the care of unhoused and previously unhoused patients, all of whom require a special touch from compassionate, trauma-informed providers.

Acts as the hub of our clinical services and specializes in serving patients with complex physical and/or behavioral health issues who suffer high rates of morbidity.

Provides easy access to medical care for Housing for Health clients residing in nearby interim and permanent housing.

Over the past six months, Star clinic has continued to hire and train staff to provide enhanced case management (ECM) services as part of the CalAIM initiative. Through the ECM program, Star clinic nurses and social workers provide wrap-around services to the most complex patients, many of whom are frequently hospitalized or have poor quality of life due to substance use disorders or mental health crises. Through intensive phone-based and field-based support, the Star clinic ECM staff provide health coaching to these patients, ensure that their basic needs are met, ease their access and utilization of available health and social service resources, and provide encouragement and support so patients can pursue health and wellbeing.

- Star clinic staff provided primary care and urgent care services during **1,300** unique patient encounters*
- **166** patients enrolled in the ECM program*
- Over **1,400** interventions delivered to ECM program participants*

* Data is from July–December 2022.

PSH Clinical Support Program

The Permanent Supportive Housing Clinical Support program (PSH-CSP) provides complex care management services to PSH clients. These formerly homeless clients are at risk of losing their homes and/or suffering from premature illness, disease, or mortality because of unmanaged physical and behavioral health conditions and maladaptive life skills.

Referred by intensive case management services (ICMS) providers and DMH social workers, clients may have a combination of unmanaged chronic diseases, substance use disorder, profuse mental health symptoms, and an inability to navigate the health and social service system due to past and ongoing trauma. PSH-CSP staff provide frequent home visits to monitor and accompany clients to improve their health and wellbeing through field-based complex care management services. Nurses also assess clients who struggle with basic daily activities for In-Home Care Giving (IHCG) services or place them in Enriched Residential Care. PSH-CSP staff also perform transitions of care (TOC) visits for PSH clients who have been admitted to a DHS hospital within the past two weeks and are at risk of readmission or worsening illness without a home visit.

- PSH-CSP staff provided home-based services to over **244** unique clients*
- **98** clients were assessed for In-Home Care Giving services*
- Transitions of Care visits were conducted with **57** high risk patients discharged from DHS hospitals*
- **93** clients received complex care management services*

In-Home Care Giving

The In-Home Care Giving (IHGC) program was established to provide caregiving and home health services to help participants maintain independent living. The program works with home health agencies to match caregivers with eligible clients who live in various settings, such as Project Roomkey and permanent supportive housing.

85
new participants enrolled*

221
individuals overall received IHCG services*

* Data is from July–December 2022.

Special Initiatives

Mobile Clinic Program

In October 2022, Housing for Health launched L.A. County's first-ever fleet of mobile clinics on wheels to bring comprehensive care to unsheltered people experiencing homelessness throughout the county. The clinical program was licensed to provide field-based care by the California Department of Public Health in September 2022, a first of its kind certification in California. Each mobile clinic is equipped with a full-service exam room, a physician, nurses, a counselor and a social worker and services include primary, urgent and reproductive health care, case management, behavioral health services, substance use treatment, psychiatry and pharmacy.

Mobile clinics operate in partnership with various entities, including fellow County agencies, cities, Measure H-funded outreach teams, faith-based organizations, homeless service providers and other community-based agencies. In 2023, the Mobile Clinic Program will begin implementing Enhanced Care Management (ECM) and Transition of Care (TOC) services as well. This will provide comprehensive care management that helps address both the clinical and social needs of the high-risk, frail and underserved population served by the mobile units.

The Mobile Clinic Program provided 640 interventions to 458 unique patients during July through December 2022

Target populations for ECM and TOC include but are not limited to:

Frequent and high utilizers of County services

1. Individuals transitioning from incarceration
2. Individuals suffering from chronic homelessness
3. Individuals at risk for institutionalization (long term care)
4. Individuals with frequent emergency room visits and/or admissions

Skid Row Action Plan

On June 28, 2022, the Los Angeles County Board of Supervisors passed a motion introduced by Supervisor Hilda Solis to create the Skid Row Action Plan, a roadmap for creating a healthy and safer community in downtown Los Angeles.

Housing for Health, in collaboration with the CEO's Homeless Initiative, led a community-driven process that brought together various stakeholders, including unhoused or formerly unhoused people who rely on services in the community, service providers, County departments, the City of L.A. and the Los Angeles Homeless Services Authority (LAHSA).

The Skid Row Action Plan aims to create a more flexible service delivery system, improve housing options and deliver additional low-barrier healthcare. The plan's components and governing principles strive to reflect the culturally vibrant and diverse Skid Row community.

To watch a video on the Skid Row Action Plan, click here.

Components of the Skid Row Action Plan include:

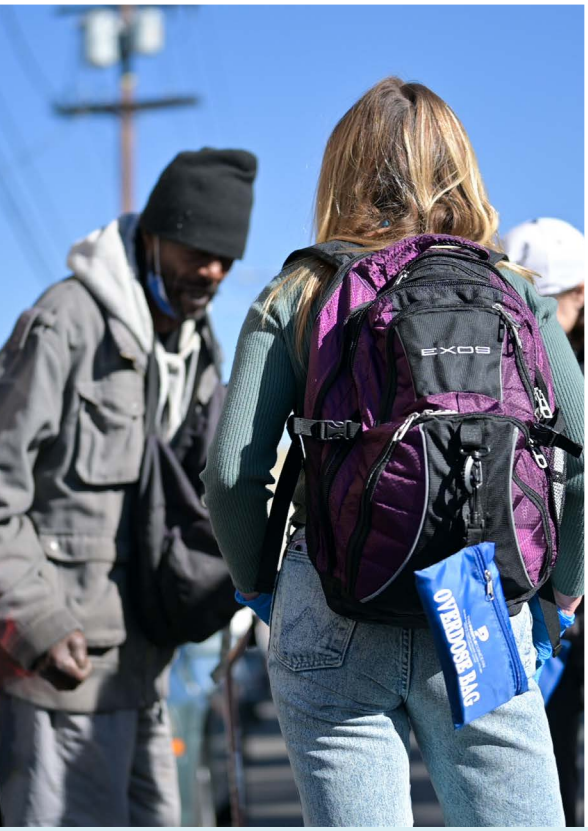
i. Creating and improving permanent housing in Skid Row

ii. Increasing and improving interim housing in Skid Row

iii. Developing a Safe Services space to provide comprehensive services in one location

iv. Establishing a 24/7 low barrier healthcare center

v. Launching a Drug User Health Hub



Throughout its development and implementation, the Skid Row Action Plan will be governed by the following principles:

- Provide all housing and services through trauma-informed practices, in a culturally aware manner that recognizes the community culture of Skid Row.
- Develop services and infrastructure with particular attention to the most vulnerable residents, including those with severe mentally illness, substance users, sex workers, families, undocumented individuals, women, and members of the LGBTQ+ community.
- Develop housing and service spaces that are welcoming and designed with an eye towards positivity, tranquility, warmth, and trust.
- Develop and employ well trained, compassionate, non-judgmental staff whao are invested in the wellbeing and compassionate care of Skid Row residents.

To learn more about the Skid Row Action Plan, click here.

Training Team

In 2022, the DHS Community Programs training team led and organized numerous training sessions for Housing for Health program staff and community-based organizations. Topics included Housing for Health 101, motivational interviewing, project management, crisis response, suicide awareness, hoarding and working with challenging client behaviors. Community providers also received training on harm reduction and overdose prevention, with a special emphasis on the use of naloxone. The team also provided regular training on the Comprehensive Health Accompaniment Management Platform (CHAMP), a care coordination system. Housing for Health and its contracted community providers use CHAMP to help improve referral processes, reduce placement wait times and promote collaboration. Much more training is planned to continue improving services and standardize knowledge across the system.

HFH Celebrates Ten Year Anniversary

This year, Housing for Health celebrated a decade of creating housing and developing services for some of the County's sickest unhoused people.

18,000 people moved into permanent supportive housing.

77,757 unsheltered people were served through outreach.

27,000 people were provided with interim housing.

9,100 CBEST applications were submitted; on average, 88% were approved.

"Thank you for supporting Housing for Health for the past 10 years"

10 Years of Friendship and Support

Oscar Flores and Casimiro Ajin, two of Housing for Health's first clients, found one another nearly a decade ago at Rancho Los Amigos, a rehabilitation hospital run by DHS in Downey, California. Both were recovering from accidents that left them paralyzed and they faced the similar challenges. After more than a year in the hospital, they wanted to be discharged, but neither had a home.

Oscar was starting to lose hope, until a new pilot program, Housing for Health, stepped up and found the two friends a place to call their own. "It was amazing," Oscar said of first seeing the little yellow house in South Los Angeles where they've lived ever since. "Everything was set up for us, for our needs. There is a ramp in the back we can enter and a shower, the bedroom, so everything was adjusted for us."

Getting Oscar and Casimiro into a house equipped to meet their needs was the first challenge. Keeping them housed would require additional support. Housing Works, a nonprofit that has partnered with Housing for Health from the beginning, assigned the pair a caseworker named Judy who has been working with the roommates and best friends since they left the hospital. "Anything we need, Judy is always there to help," Oscar said.

Their recovery hasn't always been easy, but with a place to call his own Oscar says he can finally let his imagination fly.

SUCCESS STORIES

A Long Road Home

For 10 years, Levy J. lived on the streets, most recently finding comfort on a pile of dirty clothes and trash in a vacant private lot on Main Street in Los Angeles. At 66 years old, he didn't have identification and other documents that would give him access to support and services. Thanks to the team at HOPICS, he learned about the support available to him, but at first, he wasn't receptive. The team didn't give up.

Every week, HOPICS would visit Levy, bringing him lunch and water. Eventually, they were able to help him get an ID and social security card, which led to him connecting to income and benefits.

When Levy was matched to Wakeland Housing's Chesterfield Apartments, a permanent housing community for seniors, the HOPICS staff quickly moved him to a motel while he waited for the building to be finished. He took a shower and got a good night's rest for the first time in a long while.

"When we checked on him a few days later, it was like seeing a different person," his HOPICS case manager said. "He was showered, shaved and wearing brand new clothes." In addition to feeling like a new man, he was also reunited with his daughter, who he hadn't talked to in more than a year. And he says he never wants to go back to life on the streets again.

Levy is now permanently housed at the Chesterfield Apartments, where he was welcomed with open arms by St. Joseph Center, the services provider. He calls the HOPICS team his "guardian angels." He said, "Because of you guys, I no longer feel like an animal – I feel human."

Appendix A

Capital Improvement Intermediary Program Project List (July 1, 2022–December 31, 2022)

No	Project/Operator Owner/Partner	Project Type/ Est. Capacity	Population Served	Current Status	Estimated Cost/ Est. Completion
1	**Safe Landing** Exodus	Clinically Enhanced Interim Housing 172 Beds	Single Adults and Couples	Construction	$36,271,448 January 2023
2	**WLA Armory** DHS	Interim Housing 171 Beds	Single Adults and Couples	Pre-development including architectural and professional services	$437,000 TBD
3	**Santa Clarita BTH** Bridge to Home	Interim Housing 80 Beds	Families and Single Adults	Construction	$500,000 January 2024
4	**Santa Fe Springs** The Whole Child	Interim Housing 40 Units / 120 beds	Families	Pre-development including architectural and professional services	$500,000 October 2024
5	**Willow Tree Inn** The People Concern	Permanent Housing 100 Units / 100 beds	Single Adults	Pre-development including architectural and professional services	$500,000 March 2025

Completed Projects

No	Project/Operator Owner/Partner	Project Type/ Est. Capacity	Population Served	Current Status	Estimated Cost/ Est. Completion
6	**Jovenes Housing** HOPICS	Permanent Housing 8 Units / 8 beds	Transition Age Youth	Completed	$300,000 June 2022
7	**Tropicana Motel** HOPICS	Interim Housing 120 Beds	Families	Completed	$45,000 June 2022
8	**628 San Julian (Oasis)** JWCH	Recuperative Care 40 Beds	Women	Completed	$7,838,241 December 2021
9	**Covenant House** Covenant House	Interim Housing 18 Beds	Transition Age Youth	Completed	$500,000 August 2021
10	**Figueroa** HOPICS	Interim Housing 15 Units / 45 beds	Families	Completed	$43,160 April 2021
11	**Long Beach** HOPICS	Interim Housing 18 Units / 54 beds	Families	Completed	$44,780 March 2021
12	**Canoga/The Willows** LA Family Housing	Interim Housing 70 Beds	Single Adults and Couples	Completed	$8,032,346 February 2021
13	**Paloma/The Lotus** Home at Last	Interim Housing 119 Beds	Single Adults	Completed	$6,750,826 December 2020
14	**North Long Beach** City of Long Beach	Interim Housing 125 Beds	Single Adults and Families	Completed	$3,400,000 September 2020
15	**VOALA** VOALA	Interim Housing 45 Beds	Single Adults	Completed	$500,000 August 2020

Appendix A

Capital Improvement Intermediary Program Project List (July 1, 2022–December 31, 2022)

Completed Projects (Continued)

No	Project/Operator Owner/Partner	Project Type/ Est. Capacity	Population Served	Current Status	Estimated Cost/ Est. Completion
16	**51st Street Motel** HOPICS	Interim Housing 18 Units / 54 beds	Families	Completed	$53,668 August 2020
17	**Santa Fe Springs** Salvation Army	Interim Housing 24 Beds	Single Adults	Completed	$850,000 July 2020
18	**Kensington Lancaster** The People Concern	Interim Housing 156 Beds	Single Adults	Completed	$6,661,000 July 2020
19	**Sylmar Armory/ The Arroyo** LA Family Housing	Interim Housing 85 Beds	Women	Completed	$7,781,341 June 2020
20	**Bellflower Homeless Shelter** City of Bellflower	Interim Housing 60 Beds	Single Adults and Couples	Completed	$1,500,000 May 2020
21	**627 San Julian (FRAC)** The People Concern	C3 Day Center 300 Visits Per Day	Single Adults	Completed	$4,309,128 May 2020
22	**Pomona** City of Pomona	Interim Housing 200 Beds	Single Adults	Completed	$3,800,000 April 2020

Discontinued Projects

No	Project/Operator Owner/Partner	Project Type/ Est. Capacity	Population Served	Current Status	Estimated Cost/ Est. Completion
23	**Bell Shelter** JWCH	Recuperative Care 100 Beds	Single Adults	Discontinued	$50,000 N/A
24	**Virginia Road** HOPICS	Interim Housing 15 Beds	Families	Discontinued	$50,015 N/A
25	**Mount Moriah Housing Development** Mount Moriah Baptist Church	Permanent Housing 6 Units	Single Adults	Discontinued	$263,430 TBD

HOUSING FOR HEALTH

Health Services
LOS ANGELES COUNTY

dhs.lacounty.gov/housing-for-health