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Evaluation of California's Housing for a Healthy California Program

Prepared for:

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UCLA Center for Health Policy Research

Evaluation of California's Housing for a Healthy California Program

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Statutory Basis of This Report

This report is produced in response to the statutory requirement in Health and Safety Code Section 53591:

(a) On or before January 1, 2019, establish the Housing for a Healthy California Program to create supportive housing opportunities through either or both of the following:

(1) Grants to counties for capital, rental assistance, and operating subsidies. The department shall award grants to counties on a competitive basis pursuant to rating and ranking criteria that include, but are not limited to, points based upon all of the following:

(A) Need, which includes consideration of the number of individuals experiencing homelessness and the impact of housing costs in the county.

(B) Ability of the county to administer or partner to administer a program offering capital loans, rental assistance, or operating subsidies in supportive housing, based on the county's proposed use of program funds. Operating subsidies may include operating reserves.

(C) The county's documented partnerships with affordable and supportive housing providers in the county.

(D) Demonstrated commitment to address the needs of people experiencing homelessness through existing programs or programs planned to be implemented within 12 months.

(E) Preferences or set asides for housing populations established by the department pursuant to Section 53595.

(F) Coordination with all of the following:

(i) Community-based housing and homeless service providers.

(ii) Behavioral health providers.

(iii) Safety net providers, including community health centers.

(2) Operating reserve grants and capital loans to developers. The department may use existing guidelines in awarding grants and loans to developers.

(3) In administering the operating reserve grants and capital loans to developers

pursuant to paragraph (2), the department shall do all of the following:

(A) Make program funds available at the same time funds, if any, are made available under the Multifamily Housing Program (Chapter 6.7 (commencing with Section 50675) of Part 2).

(B) Rate and rank applications in a manner consistent with the Multifamily Housing Program (Chapter 6.7 (commencing with Section 50675) of Part 2), except that the department may establish additional point categories for the purposes of rating and ranking applications that seek funding pursuant to this part in addition to those used in the Multifamily Housing Program.

(C) Administer funds subject to this part in a manner consistent with the Multifamily Housing Program (Chapter 6.7 (commencing with Section 50675) of Part 2) to the extent permitted by federal requirements.

(D) Only applications serving persons that meet all of the requirements of Section 53595 and any other threshold requirements established by the department, shall be eligible to receive funds pursuant to paragraph (2).

(b) Until August 31, 2022, if the department elects to fund operating grants and loans to developers in any year, or before August 31, submit federal Housing Trust Fund allocation plans to the Department of Housing and Urban Development that includes state objectives consistent with the goals of this part.

(c) Draft any necessary regulations, guidelines, and notices of funding availability for stakeholder comment.

(d) Midyear and annually, collect data from counties and developers awarded grant or loan funds.

(e) No later than October 1, 2020, contract with an independent evaluator to analyze data collected pursuant to Section 53593 to determine changes in health care costs and utilization associated with services and housing provided under the program. The department shall provide, on a regular basis as needed, collected data to the evaluator.

(f)(1) On or before January 1, 2024, report data collected to the Assembly Committee on Budget, the Senate Committee on Budget and Fiscal Review, the Assembly and Senate Committees on Health, the Assembly Committee on Housing and Community Development, and the Senate Committee on Transportation and Housing.

(2) A report to be submitted pursuant to paragraph (1) shall be submitted in compliance with Section 9795 of the Government Code.

(g) The department is encouraged to consult with the State Department of Health Care Services where appropriate to carry out the intent of this section.

(h) This section shall become operative on January 1, 2022.

Glossary

Exhibit 1 defines acronyms referenced throughout the report.

Exhibit 1: UCLA HHC Evaluation Acronyms and Definitions

Acronym	Definition
AB	Assembly Bill
ADA	Americans with Disabilities Act
BHS	Behavioral Health Services
BHRS	Behavioral Health and Recovery Services
BKRHC	Bakersfield-Kern Regional Homeless Collaborative
CalAIM	California Advancing and Innovating Medi-Cal
CB-CME	Community-Based Care Management Entity
CBO	Community-Based Organization
CES	Coordinated Entry System
CFLC	Consumer Family Learning Center
CoC	Continuum of Care
COD	Co-morbid disabilities or disorders
COSR	Capital operating subsidy reserve
DD	Difference-in-Difference
DHCS	California Department of Health Care Services
ED	Emergency Department
FQHC	Federally Qualified Health Center
HCD	California Department of Housing and Community Development
HFH	Housing for Health
HHC	Housing for a Healthy California
HHP	Health Homes Program
HIMS	Homeless Information Management System
ICMS	Intensive Case Management Services
ILC	The Independent Living Center
JIR PFS	Just in Reach Pay for Success
KernBHRS	Kern County Behavioral Health and Recovery Services
LA	Los Angeles
MFT	Marriage and Family Therapist
NHTF	National Housing Trust Fund
PBV	Project-Based Voucher
PCP	Primary Care Provider
SSP	Supportive Service Plan
SUD	Substance Use Disorder
UCLA	University of California, Los Angeles Center for Health Policy Research
VA	Veteran's Assistance
VI-SPDAT	Vulnerability Index – Service Prioritization Decision Assistance Tool
WPC	Whole Person Care

Exhibit 2 defines terms referenced throughout the report.

Exhibit 2: UCLA HHC Evaluation Terminology and Definitions

Term	Definition
Grantee	County, developer, sponsor, or agency awarded with Housing for a Healthy California (HHC) grant funding for one or more projects.
Lead Entity	Organization, developer, sponsor, or agency who is providing required HHC program services (i.e., housing, core supportive services). A grantee is sometimes also a lead entity, and sometimes only the grant manager. A lead entity is a contracted partner but is differentiated by also having responsibility of managing the provision of services on an administrative level.
Contracted Partner	An organization or department that is contracted by the grantee to provide HHC program services. Contracted partners are usually community-based organizations, or healthcare organizations.
Capital Operating Subsidy Reserves (COSR)	COSR is a reserve established to address project operating deficits attributable to assisted units (e.g., insurance, utilities, maintenance, supportive services costs) for a minimum of 15 years.
Long Term Rental Assistance (RA)	Rental assistance or rental subsidies to support long term or permanent housing. Rental assistance is offered for scattered-site and project-based housing.
Program	Refers to the general HHC program, as well as the HHC program being implemented by a grantee at the local level. The HHC program is implemented by grantees funded to provide supportive housing projects and are required to meet program guidelines established by the California Department of Housing and Community and National Housing Trust Fund.
Project	HHC funding for the development or redevelopment construction of housing, administrative costs, capitalized operating subsidy reserves (COSR), and long-term rental assistance or rental subsidies for existing supportive housing (including but not limited to HHC). Grantees can have one or more projects based on financial awards provided through Article I or II funding allocation type and purpose.
Project-Based Voucher (PBV)	The project-based voucher allows rental assistance to be attached to a specific unit and/or dedicated project, instead of to an eligible participant.
Provider	A healthcare organization, clinic, or individual professional providing primary or behavioral healthcare.
Participant	A person who is actively enrolled in the HHC program after eligibility criteria has been assessed and met. Not all participants are housed but are enrolled and may be provided with services or interim housing until permanent housing is available.
Move-in	The starting point for HHC programs and participants to be included in UCLA evaluation analysis. First move-in refers to a grantee's HHC program start date based on first housed participant. A participant is included in analysis if they have a move in date for permanent housing.
On-site/off-site	Indicating location of services, providers, staff, or program activities at the place of participant housing (on-site), or located in the community, local clinics, or buildings outside of participant housing. Most project-based programming and services happen on-site compared to scattered-site

Term	Definition
	housing placement, programming and services are sometimes on-site, but primarily off-site.

Executive Summary

HHC Program Overview

The California Department of Housing and Community Development (HCD) implemented Housing for a Healthy California (HHC) established through the enactment of California Assembly Bill (AB) 74 (Chapter 777, Statutes of 2017). HHC was established for the purposes of providing supportive housing for Medi-Cal eligible individuals in California who were experiencing homelessness using the Federal National Housing Trust Fund (NHTF) also referred to as Article I and the Building Homes and Jobs Trust Fund Allocation also referred to as Article II. Article I allocations were competitively awarded to Counties for acquisition and/or development of new construction projects in addition to grants for project-based operating assistance. Article II funds were competitively awarded to Counties for long-term rental assistance, capitalized operating subsidy reserves, and acquisition, new construction and/or rehabilitation of a project to achieve permanent supportive housing for individuals who are chronically homeless, or homeless and a high-cost health user.

The goal of HHC was to improve access to supportive housing, complemented with improved access to primary and behavioral health care services, to reduce inappropriate utilization of emergency departments, hospitals, nursing homes, and correctional resources for eligible Medi-Cal beneficiaries who were experiencing homelessness or chronic homelessness. HCD required a Housing First approach when identifying potential participants, providing housing and stabilizing enrollees followed by offering supportive services and working towards other care management goals. HCD required HHC awardees to offer housing navigation, case management, peer support services, linkages to primary care and behavioral health, housing retention promotion, services for individuals with co-occurring disabilities/disorders, and benefit enrollment as supportive services. In addition, HCD required that caseloads of case managers not exceed 20 participants, allowing for intensity of touch and accommodating for the high acuity of participants.

UCLA Evaluation Methods

The UCLA Center for Health Policy Research (UCLA) was selected to evaluate HHC. UCLA used all available data for the evaluation, including grantee supportive services plans, bi-annual and annual reports to HCD, Medi-Cal enrollment and claims data, and brief interviews with Article II grantees in March 2023. Interviews and reports highlighted the implementation processes and

services delivered by grantees. Medi-Cal data analysis informed whether HHC led to better health and lower costs. Analyses of Medi-Cal data included utilization and cost measures before and after HHC implementation for HHC participants and a comparison group of Medi-Cal enrollees with similar characteristics that align with HHC-eligibility (i.e., Medi-Cal beneficiary living in an HHC county that has evidence of experiencing homelessness, and has similar patterns of emergency department hospital utilization in the period prior to housing). The evaluation mainly covered information from January 2021 when the first beneficiary was housed to end of December 2022. HHC continued after this date, but the evaluation findings do not reflect beneficiaries that were housed later on or the potential changes in their outcomes following being housed. Qualitative data was collected from January 2021 to June 2023, including grantee interviews that were conducted in March 2023 and the most recent round of Bi-annual Article II Reports that are reflective of the implementation status as of June 2023.

Results

HHC Article I: Program Implementation

As of October 2023, there are a total of 26 Article I HHC awards to 22 awardees. Awardees were typically housing corporations or developers, but also included county housing authorities. Awardees came from 10 primally urban or rural counties across California and had projects in Alameda, Fresno, Humboldt, Los Angeles, Orange, Santa Clara, Santa Barbara, San Mateo, Sonoma, and Ventura counties. Awards were distributed in 2019, 2020, and 2021 and ranged from $3,379,011 to $26,666,667, with total funding of $221,434,411.

As of the date of this report, two of the awardees have achieved “permanently closed” status, which is defined by HHC as the completion of construction or rehabilitation of the property and subsequent occupancy by HHC participants. The typical timeline for a permanently closed project ranges from two to four years after all funding sources are secured, including any tax credits or bonds which are generally applied for after securing funds through HHC. As a result, this report focuses on Article I project descriptions and intentions as well as awardee-reported delays and challenges related to supply chain restrictions, unmet labor demands, and material cost increases.

HHC Article II: Program Implementation

All Article II grantees were county agencies from Kern, Los Angeles, Marin, Sacramento, San Mateo, and San Francisco counties and they received a total of $60,118,937 in funding beginning in March 2020. By December 2022, San Francisco and San Mateo had not yet housed any HHC participants and therefore were not included in the analyses presented in this report. These grantees planned to use HHC funds for new construction projects or rehabilitation of existing units. Similar to Article I, the timeline to complete a new construction or rehabilitation of a project typically ranges from two to four years.

Assessment of Article II's remaining four grantees indicated successful implementation of projects. All four grantees provided rental assistance and Marin County also used HHC funds for capitalized operating subsidy reserves. Of these, three counties were offering scattered-site rental assistance (Kern, Los Angeles, and Sacramento) and one was offering project-based rental assistance (Marin). Additional implementation detail and achievements of these County agencies included:

- Grantees projected that they would fund between 22 (Kern) and 253 (Los Angeles) units over the course of the program (through December 2024). At the time of this report, three of the four grantees had not yet reached these projected number of units.
- Grantees reported challenges to program implementation including tough housing markets with limited unit supply and high rental rates; high acuity and social needs of participants; and inability to access or collect necessary data, particularly around an individual's social history.
- Grantee perspectives highlighted pros and cons associated with both scattered-site and project-based housing models, and how the preferred model may be influenced by available funding, timelines, staffing and resource capacity, and geographic region. For example, Los Angeles emphasized that scattered-site rental assistance allowed participant choice and preference on location, while also embedding participants in the broader community. Further, Marin highlighted how project-based housing provided quicker access to and intensity of supportive services and developed a sense of community amongst those housed at the project. Ultimately, grantees felt it is most important that the housing model meets the participant's needs.
- County agencies relied on their Coordinated Entry System (CES) for identification and referrals of potential participants and used standardized housing assessments such as the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) in order to prioritize housing and supportive services for participants.
- Three of the four grantees used contractors to deliver supportive services and one (Kern) hired staff directly. Grantees often relied on their existing provider networks established

through Whole Person Care (WPC) and other similar programs to offer housing navigation services. Counties further utilized their connections with other government agencies and County departments to enroll participants in benefits such as disability benefits and CalFresh.

- Case manager caseloads ranged from eight to 20 participants. Case managers identified needs and services for participants; referred participants to primary care and helped them to establish and maintain their relationship with a primary care provider; assessed and referred participants to outpatient or residential substance use treatment providers; and were often involved in crisis management and behavioral health support.
- The most common services provided to individual participants included tenant support services, care coordination of medical and behavioral health care, and life skills training. Tenant support services included activities such as move-in coordination, tenant-landlord relationship education, and housing issue mitigation. Care coordination included use of case managers to reconnect participants to primary care and help them to establish and maintain their relationship with a primary care provider and/or referrals to appropriate behavioral health supports. Life skills services included training on basic domestic skills (e.g., maintaining a home, cooking) and exploring opportunities to earn income for rent and food.
- All grantees identified the provision of HHC comprehensive supportive services as critical to their housing retention strategy. Successful strategies included ensuring the most appropriate housing placement based on participant need and acuity profile, and connecting the participant with appropriate supportive services that complemented their housing placement.

HHC Article II: Participant Characteristic and Housing Patterns

Analysis of grantee reports and interviews showed varying degrees of progress across grantees in housing participants and success in housing retention. Key findings include:

- Los Angeles County was the first to house participants in January 2021. Marin County was the last to house their first participants in December 2022.
- As of December 2022, grantees reported a total of 230 participants had been housed successfully. The number of participants housed per county was highest in Los Angeles County (161) and lowest in Marin County (5), Marin County having only 15% the size of LA's award. An additional 60 participants had been identified and entered into the program but had yet to be housed.

- A total of 41 housed participants had moved out of their HHC housing as of December 2022. The most common reasons for moving out of HHC housing were permanent housing found elsewhere (37%) or the participant was deceased (29%). On average, participants that moved out stayed in HHC housing for 214 days. For the 189 participants that remained in housing as of December 2022, the average length of time they had been housed was 343 days.
- Prior to being housed by HHC, 10% of participants were in temporary stable housing in programs such as Project Roomkey.
- Housed HHC participant were most often age 50 to 64 years old (49%), non-Hispanic black or African American (43%), and had not been stably housed in over one year (60%). Housed HHC participants had high rates of both physical health and behavioral health conditions. For example, 57% had hypertension, 33% had chronic kidney disease, 47% had depression or depressive disorders, and 40% had drug use disorders. Over half (59%) of house participants had three or more physical health conditions.

HHC Article II: Impact of HHC on Use of Acute Care Services

Assessment of Medi-Cal enrollment and claims data indicated a greater decline in use of acute services from six months before being housed to the first six months of being housed by HHC compared to a group of similar Medi-Cal beneficiaries not housed by HHC. Key findings include:

- In the year prior to being housed, 42% of HHC participants had both emergency department (ED) visits and hospitalizations. An additional 28% only had ED visits and 8% were only hospitalized. The remaining 22% did not have either. Use of ED visits or hospitalizations was a program requirement, but Los Angeles County applied for and received an exception for participants that were at high-risk of use or had high use of these services prior to the COVID-19 pandemic, since the pandemic naturally caused typical over utilizers to use the ED less due to the risk of COVID-19.
- HHC housed participants had 3.7 ED visits on average in the year prior to being housed. The most common primary diagnosis for these visits included pain in the throat, chest, abdomen, or pelvis, soft tissue disorders, and symptoms and signs involving emotional state.
- HHC participants had 1.5 hospitalizations on average in the year prior to HHC. The most common primary diagnosis for these stays included hypertensive heart and chronic kidney disease, schizoaffective disorders, sepsis, and schizophrenia.

- From 7-12 months to 1-6 months prior to being housed, HHC participants' utilization of all specific healthcare service types measured was increasing, with the highest increases in utilization rates seen in nursing home stays (60%), hospitalizations (34%), substance use disorder treatment services (30%), and primary care services (30%). In the year after housing, utilization of each service type was decreasing from 1-6 months to 7-12 months after being housed except for nursing home stays (20% increase). The average length of hospitalizations declined in the year after hosing from 17.4 days to 12.6 days.
- Exhibit 3 shows a significant decline of 0.58 ED visits and 0.38 hospitalization per beneficiary from six months before to six months after being housed by HHC. This decline was greater among HHC participants than comparison beneficiaries by 0.41 ED visits and 0.28 hospitalizations.

Exhibit 3: Changes in Trends of Emergency Department Visits and Hospitalizations of Housed HHC Participants and a Comparison Group of Medi-Cal Beneficiaries

		Change in Trend from Prior to After Housing		Change in Six-Month Utilization from Prior to After Housing	
Acute Care Service	**Population**	**Difference**	**Difference-in-Difference**	**Difference**	**Difference-in-Difference**
Emergency Department Visits	HHC Participants	-0.31	-0.17	**-0.58***	**-0.41***
	Comparison Group	-0.14		-0.17	
Hospitalizations	HHC Participants	-0.17	-0.01	**-0.38***	**-0.28***
	Comparison Group	-0.16		-0.11	

Source: UCLA analysis of Medi-Cal claims data from January 2020 through December 2022.
Notes: Utilization was reported per beneficiary per six-month period. Emergency department visits were restricted to visits followed by discharge. * Denotes p≤0.05, a statistically significant difference. Trend prior to housing is calculated as: (1-6 months prior minus 7-12 months prior). Trend after housing is calculated as: (7-12 months after minus 1-6 months after). Difference between trends is calculated as: (trend after housing minus trend prior to housing). Difference between six-month utilization is calculated as: (utilization 1-6 after housing minus utilization 1-6 month prior to housing). Difference-in-difference is calculated as: (difference in HHC participants – difference in comparison group). Includes 224 HHC participants with Medi-Cal data prior to housing and 448 matched controls.

HHC Article II: Impact of HHC on Cost

Assessment of payments associated with Medi-Cal claims indicated a decline in total Medi-Cal payments and payments associated with use of acute health services. Key findings include:

- Total estimated Medi-Cal payments were $32,315 per beneficiary in the year prior to being housed by HHC. This includes $2,585 in ED payments and $17,450 for hospitalizations per beneficiary.
- Total estimated Medi-Cal payments were $17,585 per beneficiary in the year after housed by HHC. This includes $1,055 in ED payments and $7,386 for hospitalizations per beneficiary.
- Exhibit 4 shows a significant decline of $6,771 in total payments per beneficiary from six months before to six months after HHC and this decline was greater by $5,590 then the comparison Medi-Cal beneficiaries. Similarly, payments for ED visits ($5,251) and hospitalizations ($647) significantly declined from before to after HHC. The decline in hospitalization payments was significantly greater among HHC participants than comparison beneficiaries by $3,496 per beneficiary. However, there was no different in payments for emergency department visits between the two groups.

Exhibit 4: Changes in Trends of Emergency Department Visit and Hospitalization Payments for Housed HHC Participants and a Comparison Group of Medi-Cal Beneficiaries

		Change in Trend from Prior to After Housing		Change in Six-Month Utilization from Prior to After Housing	
Estimated Medi-Cal Payment	**Population**	**Difference**	**Difference-in-Difference**	**Difference**	**Difference-in-Difference**
Total Payments	HHC Participants	-$3,609	$2,357	**-$6,771***	**-$5,590***
	Comparison Group	**-$5,966***		-$1,181	
Hospitalization Payments	HHC Participants	-$2,085	$2,009	**-$5,251***	**-$3,496***
	Comparison Group	**-$4,094***		**-$1,755***	
Emergency Department Payments	HHC Participants	-$185	$141	**-$647***	-$229
	Comparison Group	**-$326***		**-$419***	

Source: UCLA analysis of Medi-Cal claims data from January 2020 through December 2022.

Notes: Estimated Medi-Cal payments were reported per beneficiary per six-month period. * Denotes p≤0.05, a statistically significant difference. Trend prior to housing is calculated as: (1-6 months prior minus 7-12 months prior). Trend after housing is calculated as: (7-12 months after minus 1-6 months after). Difference between trends is calculated as: (trend after housing minus trend prior to housing). Difference between six-month utilization is calculated as: (utilization 1-6 after housing minus utilization 1-6 month prior to housing). Difference-in-difference is calculated as: (difference in HHC participants – difference in comparison group). Includes 224 HHC participants with Medi-Cal data prior to housing and 448 matched controls.

- UCLA lacked data on costs to law enforcement and corrections because no reliable measures of arrests or incarcerations before, during, or after being housed by HHC were available. However, existing literature indicates that homelessness increases the likelihood of incarceration and incarcerated individuals also have an increased likelihood of homelessness. Studies further show that providing affordable housing to individuals experiencing homelessness reduces incarceration, number of days incarcerated, and associated costs of incarceration.

Conclusions

As of December 2022, the evaluation findings of HHC indicated notable progress in identifying scattered-site and project-based rental units by four Article II grantees that led to housing of Medi-Cal beneficiaries experiencing homelessness. In addition to a Housing First approach, evidence further showed that HHC participants were referred to and often received an array of supportive services designed to address their medical and social needs, promote retention, prevent incarcerations or involvement with law enforcement, and improve health and well-being. Findings further indicated declines in short-term use of acute services and associated payments that were attributable to housing individuals under HHC.

Evaluation findings suggest the following for continued implementation of HHC and future efforts to house individuals experiencing chronic homelessness:

- Careful planning of future projects to anticipate implementation challenges and adequate follow-up time for evaluations,
- Increased collaboration and partnership between government and community-based organizations to use Housing First approaches,
- Continued efforts to adapt tenancy and other support services to the needs of those housed, and
- Further evaluation to understand medium to long-term impacts of housing on health and well-being.

Introduction

This evaluation report describes the implementation and outcomes associated with the Housing for a Healthy California Program (HHC), from January 2021 (when the first participant was housed) to December 2022. The evaluation period is shorter than the entire HHC program timeline and therefore, the findings do not reflect the complete scope of HHC.

HHC Program Overview

HHC was established under the statutory authority of California Assembly Bill (AB) 74 to provide supportive housing for Medi-Cal eligible individuals in California that are experiencing homelessness. AB 74 directed the California Department of Housing and Community Development (HCD) to utilize 2018-2021 Federal National Housing Trust Fund (NHTF) allocation for HHC. HCD submitted a three-year federal NHTF allocation plan starting in August 2018 that aligns with federal NHTF and AB 74 requirements.

HHC program funding allocations originated from the NHFT (Article I) and the Building Homes and Jobs Trust Fund Allocation (Article II). Article I allocations were awarded to developers for operating reserve grants and capital loans for acquisition and/or new construction through a competitive process for years 2019-2021. Article II allowed HCD to grant funds competitively to counties for acquisition, new construction or reconstruction and rehabilitation, administrative costs, capitalized operating subsidy reserves (COSR), and long-term rental assistance or rental subsidies for existing supportive housing to assist the HHC program's target population.

Rental assistance is defined by HCD Program Guidelines (June 2020) as "a rental subsidy provided to a housing provider, including a developer leasing affordable housing or supportive housing, private-market landlord, or sponsor master leasing private-market apartments, to assist a tenant to pay the difference between 30 percent of the tenant's income and fair/reasonable market rate rent as determined by the grant recipient and approved by HCD." COSR is defined as "a reserve established to address project operating deficits attributable to assisted units."

HHC Goals and Target Population

The goal of HHC was to improve access to supportive housing, complemented with improved access to primary and behavioral health care services, in order to reduce inappropriate utilization of emergency departments, hospitals, nursing homes, and correctional resources for

individuals experiencing homelessness or chronic homelessness. The target population for HHC includes high-cost healthcare utilizers who are experiencing homelessness or chronic homelessness and are eligible for the California Department of Health Care Services (DHCS) Medi-Cal program. Eligibility criteria and associated definitions are shown in Exhibit 5 below.

Exhibit 5: HHC Program Eligibility Criteria and Definitions

Participant Eligibility Criteria	Definition
Individuals experiencing homelessness or chronic homelessness	Experiencing chronic homelessness means a person who is chronically homeless, as defined by (a) living in a place not meant for human habitation, a safe haven, or in an emergency shelter; who has been homeless and living as described in (a) continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in (a). A person who was experiencing chronic homelessness before entering an institution would continue to be defined as experiencing chronic homelessness upon discharge, regardless of length of stay. Experiencing homelessness means an individual or family who lacks a fixed, regular, and adequate nighttime residence or will imminently lose their nighttime residence.
High-cost health care users	High-cost health users means people who have had either at least three emergency department visits or one hospital inpatient stay over the last year (upon initial eligibility screening).
Medi-Cal eligible individuals	Individuals who are currently enrolled or are eligible for the California Department of Health Care Services (DHCS) Medi-Cal program.

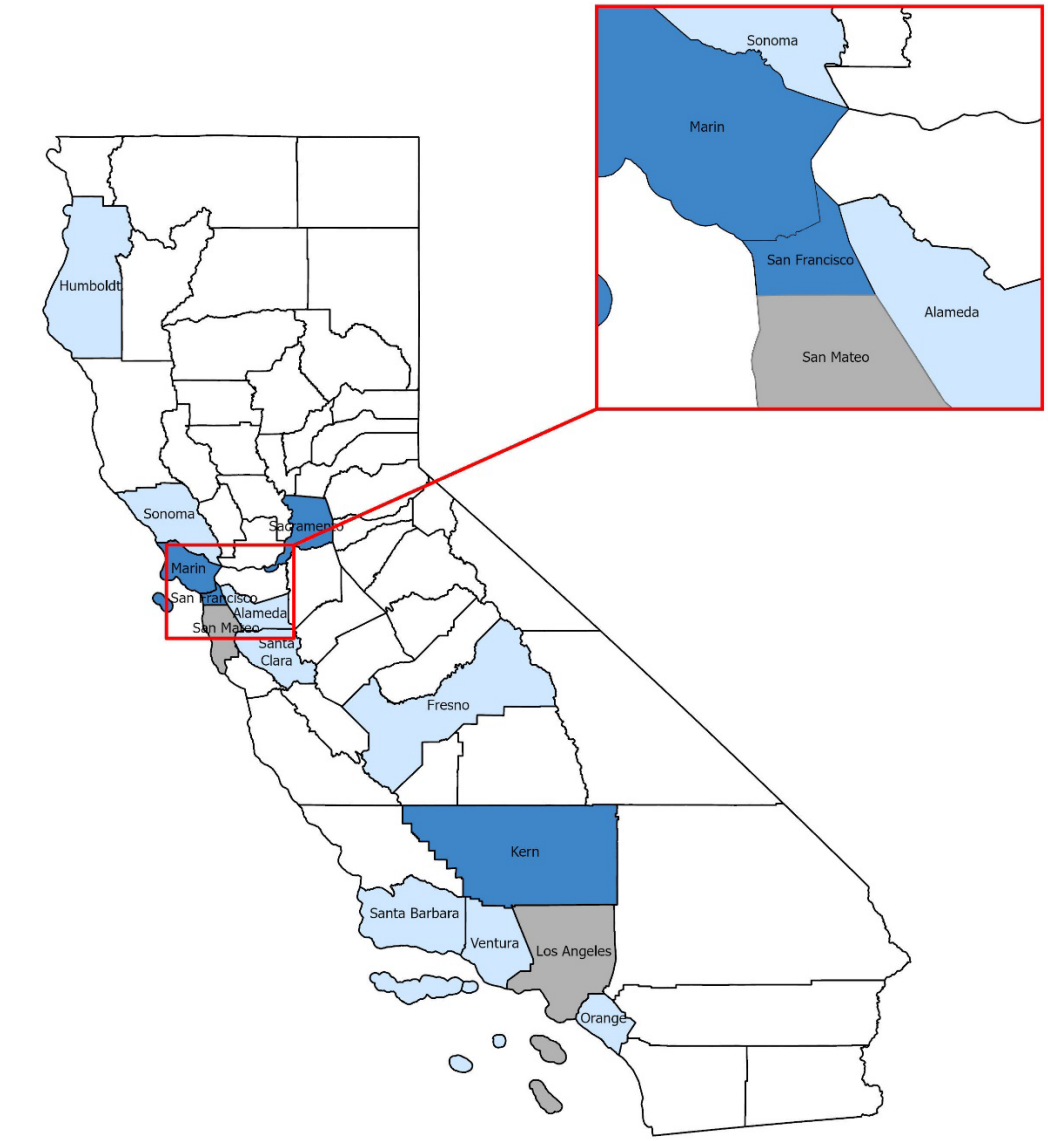
Source: HHC Program Guidelines, June 2020.
Notes: "Chronic homelessness" and "homeless" as defined by 578.3 of Title 24 of the Code of Federal Regulations as that section read on January 1, 2018.

Article I and II Grantees

In total, HCD funded 32 Article I and II grants across 14 counties. Article I funded 22 grantees that were housing corporations and developers and received funding for 26 construction projects over three funding rounds in 2019, 2020, and 2021. Article I grantees had projects in Alameda, Fresno, Humboldt, Los Angeles (LA), Orange, Santa Clara, Santa Barbara, San Mateo, Sonoma, and Ventura counties. Article II grantees were all county agencies from Kern, Los Angeles, Marin, Sacramento, San Mateo, and San Francisco counties award letters were issued in March 2020.

Exhibit 6 shows the location of HHC Article I and II grantees. Grantees were located primarily in populated California counties and cover a significant geographic area of California.

Exhibit 6: Map of HHC Participating Counties



HHC Housing and Supportive Service Requirements

As required by Section 214 and 215 in the Housing for a Healthy California Final Program Guidelines, grantees were required to provide eight evidence-based supportive services themselves or through contracted partners to all HHC participants. Services included housing navigation, case management, peer support services, linkages to primary care and behavioral health, housing retention promotion, services for individuals with co-occurring disabilities/disorders, and benefit enrollment. In addition, HHC program guidelines for grantees encourages the provision of optional supportive services including recreational and social activities, educational services, employment assistance services, and access to other needed services such as civil legal services, transportation, food, and clothing.

Grantees were required to make supportive services available for all HHC participants that are flexible, individualized, based on need, and voluntary. A Housing First approach was required of grantees when identifying potential participants, providing housing, and offering supportive services to enrolled participants. This meant participant selection and support was provided independent of an individual's sobriety, agreement to participate in services, credit score, financial and housing history, or behaviors.

UCLA HHC Evaluation

AB 74 required an independent evaluation of HHC and submission of a report to the legislature by January 1, 2024. The UCLA Center for Health Policy Research (UCLA) was selected as the evaluator of the HHC program.

HHC Program and Evaluation Timeline

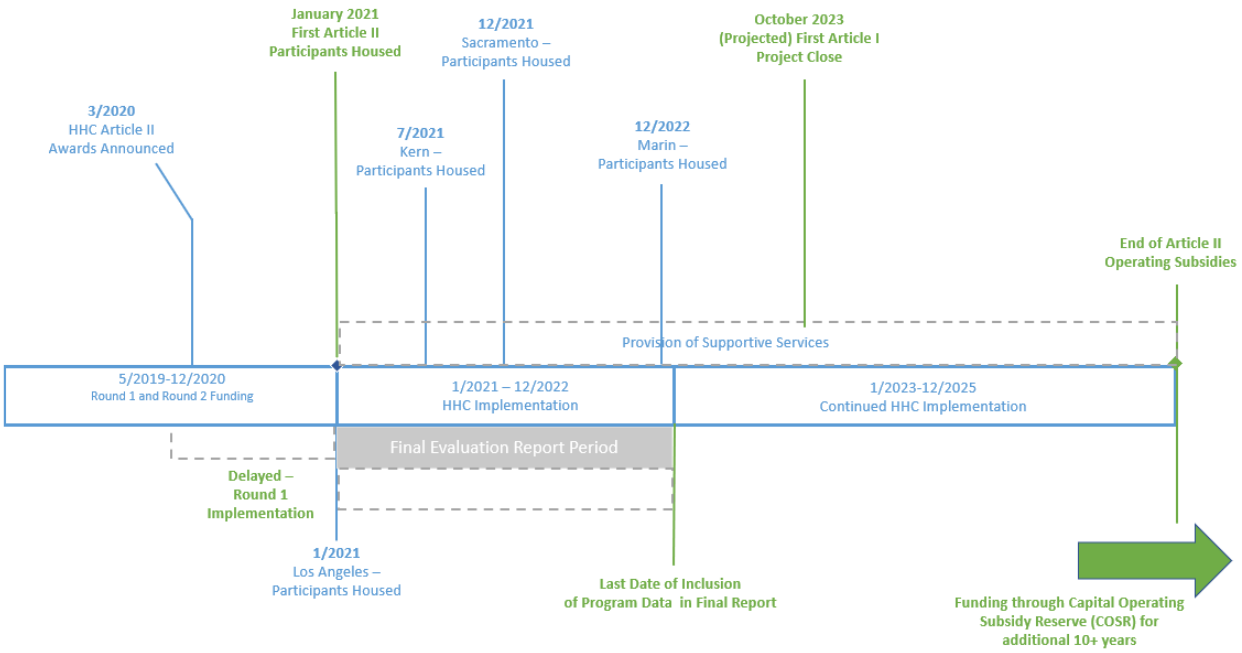
Nearly all Article I and II grantees' HHC projects have experienced delays and changes in planned program implementation and timeline. Grantees provided with federal funding allocation for new construction, development, redevelopment, and rehabilitation projects faced delays and challenges related to supply chain restrictions, unmet labor demands, and material cost increases. Whereas grantees provided with funding for rental subsidies and assistance have faced tough housing markets, with limited unit supply and high rental rates.

Two Article I projects have completed acquisition or construction of HHC housing by October 2023. However, since fiscal year end has not yet occurred, reports are not yet due. Therefore, only one grantee and project characteristics and reporting obligations were described in this report.

As of January 2023, four of six Article II grantees had successfully housed program participants. The date when the first participant was housed, which was in January 2021, marked the initiation of an HHC program for this evaluation. All Article II projects are described in this report. Program implementation and participant level outcomes are described for those that housed any participants by December 2022. Plans and intentions were included for Article II grantees that did not have housed HHC participants during the evaluation period.

Exhibit 7 provides a timeline of key milestones related to HHC implementation of Article I and Article II projects and UCLA evaluation period covered in this report.

Exhibit 7: Timeline for HHC Article I and Article II Projects



Conceptual Framework

UCLA developed a conceptual framework for the evaluation of HHC (Exhibit 8). The framework indicates that receipt of stable housing and supportive services through HHC will improve the health of participants and will lead to lower health care costs. It is expected that individuals being housed and receiving supportive services will have improved health due to reduced environmental exposure, reduced number of adverse events such as being victims of crimes or arrests and incarcerations, and improved capacity for self-care and use of necessary outpatient services. Better health is expected to lower an individual's utilization of costly acute care such as emergency department (ED) visits and hospitalizations. Reduced arrests and incarcerations contribute to reduced costs accrued to Department of Corrections and Rehabilitation and law enforcement, including costs of delivery of health care. Cost reductions associated with lower arrest and incarceration rates are not included in the scope of this evaluation.

Exhibit 8: HHC Evaluation Conceptual Framework

Evaluation Questions

The evaluation questions were aligned with the components of the conceptual framework.

Implementation of HHC was examined by the following evaluation questions:

- What approaches did grantees and sponsors use to identify and enroll beneficiaries?
- How many beneficiaries were housed and what were their characteristics?
- What types of supportive housing services did grantees provide?
- Did grantees meet projected milestones?
- What key factors aided or hindered the success of specific strategies related to (a) general program implementation and (b) frontline service delivery and housing provision? What measures are grantees taking to address these barriers?

Impact of HHC on better health was examined by the following evaluation question:

- Did housed beneficiaries have improved health status after being housed?

Impact of HHC on lower costs was examined by the following evaluation questions:

- Did HHC housed participants incur lower costs associated with use of health services under Medi-Cal?
- Did HHC housed participants incur lower costs associated with arrests or incarcerations?

HHC Article I

In this chapter, UCLA describes the current HHC Article I grantees and their progress towards housing HHC participants. The data used to inform this chapter included a list of awardees with some award details and the planned reporting template for Article I awardees.

As of October 2023, there are a total of 26 Article I HHC awards to 22 awardees (Exhibit 9). Awardees were typically housing corporations or developers, but also included county housing authorities. Awardees came from 10 primally urban or rural counties across California. Awards were distributed in 2019, 2020, and 2021 and ranged from $$3,379,011 to $26,666,667. As of the date of this report, two of the awardees' projected had achieved "permanently closed" status, which is defined by HHC to refer to completion of initial construction or rehabilitation of the property and subsequent occupancy by HHC participants. The timeline for a permanently closed project typically ranges from two to four years. HCD had routine closing meetings with their Division of Federal Assistance counterpart to ensure timely completion of projects. Of the three projects (BFHP Hope Center, Casa Paloma, and Phoenix) that received their awards starting in 2019 only BFHP Hope Center and Casa Paloma permanently closed in 2023.

UCLA did not have access to planned implementation details for these projects because reporting for Article I awardees was not required until Fiscal Year end after permanent closing. Once permanently closed, Article I projects will be required to submit a report to HCD each fiscal year on: (1) occupancy information, including reporting on housing of special needs populations and homeless youth; (2) individual-level details on participant characteristics, length in housing, and income; (3) supportive services providers; and (4) measurable self-reported outcomes. Awardees must report at least one self-reported outcome from each of the following three categories: residential stability, increased skills and/or income, and greater self-determination. The full list of contractors providing supportive services will also be included in the annual reporting, Exhibit 9 shows that 18 of 26 projects had identified a lead supportive service provider prior to being permanently closed at the time of this report.

Exhibit 9: HHC Article I Awardees and Housing Projects

Project Name	Awardee	City	Award Year	Award Amount	Lead Supportive Service Provider
Alameda County					
BFHP HOPE Center	Berkeley Foods Housing Project	Berkeley	2019	$3,443,026	Berkeley Foods Housing Project
Ruby Street	Eden Development, Inc.	Castro Valley	2021	$8,270,000	Adobe Services

Project Name	Awardee	City	Award Year	Award Amount	Lead Supportive Service Provider
Phoenix	East Bay Asian Local Development Corporation*	Oakland	2019, 2021	$26,666,667	Not reported
Pimentel Place	EAH Inc.*	Hayward	2019, 2021	$3,379,011, $5,133,330	Not reported
Fresno County					
Crossroad Village	Housing on Merit & UP Holdings California, LLC	Fresno	2021	$10,998,246	Not reported
Humboldt County					
Providence Mother Bernard House AKA Providence Eureka House	Providence Health & Services - Washington	Eureka	2020	$4,066,583	Not reported
Los Angeles County					
1634 20th Street	Venice Community Housing Corporation	Santa Monica	2021	$20,400,000	Venice Community Housing Corporation
2111 Firestone	Kingdom Development	Los Angeles	2021	$9,250,000	Kingdom Development
Danny's Home for Heroes	Kingdom Development	Quartz Hill	2021	$5,875,000	Kingdom Development and VA
My Angel	The Angel 2018 LP	Los Angeles	2020	$5,061,918	LA Family Housing
Crocker Umeya	LTSC Community Development Corporation	Los Angeles	2021	$10,000,000	Housing Works
Historic Lincoln Theatre	Coalition for Responsible Community Development	Los Angeles	2021	$4,900,000	Coalition for Responsible Community Development
Walnut Park Apartments	Hollywood Community Housing Corporation	Los Angeles	2021	$11,250,000	Housing Works
Western Landing	Abode Communities	Los Angeles	2021	$14,000,000	LA Family Housing

Project Name	Awardee	City	Award Year	Award Amount	Lead Supportive Service Provider
The Garvey	Coalition for Responsible Community Development*	Compton	2021	$6,700,000	Not reported
Voltaire Villas	Flexible PSH Solutions, Inc.*	Los Angeles	2020	$10,770,765	Not reported
Orange County					
Casa Paloma	American Family Housing*	Midway City	2019	$4,464,144	American Family Housing
Santa Clara County					
Kifer Senior Housing	Allied Housing, Inc*	Santa Clara	2020	$13,094,479	Not reported
San Mateo County					
Middlefield Junction	Mercy Housing	Redwood City	2020, 2021	$5,400,000	Mercy Housing
Santa Barbara County					
Escalante Meadows	Housing Authority of the County of Santa Barbara	Guadalupe	2020, 2021	$5,600,000	United Way Home For Good Santa Barbara County
Heritage Ridge Family	Housing Authority of the County of Santa Barbara	Goleta	2021	$6,955,954	Santa Barbara County Department of Behavioral Wellness
Heritage Ridge Senior	Housing Authority of the County of Santa Barbara	Goleta	2021	$5,450,000	Santa Barbara County Department of Behavioral Wellness
Patterson Point	Patterson Point LP	Lompoc	2021	$4,400,000	County of SB Behavioral Wellness
Village Senior	Cabrillo Economic Development	Ventura	2021	$3,960,000	ND Vets
Sonoma County					
South Park Commons also known as Bennett Valley	Allied Housing, Inc	Santa Rosa	2021	$4,265,288	Abode Services, Inc

Project Name	Awardee	City	Award Year	Award Amount	Lead Supportive Service Provider
Ventura County					
Camino de Salud	Cabrillo Economic Development Corporation	Ojai	2021	$7,680,000	Not reported

Source: Article I pipeline and project list; Ca.gov HCD Notice of Funding Awardee List 2019, 2020, 2021.
Notes: Article I funds could be granted to developers, housing corporations, or county agencies. HHC is the Housing for Healthy California program. * Indicates awardee information not listed in Article I pipeline and project list, and obtained through UCLA's independent internet search.

HHC Article II: Program Implementation

This chapter includes a summary of the structure and implementation approach taken by four grantees that had initiated the intervention and plans for two grantees that had not initiated HHC at the time of this report. The findings address the following evaluation questions:

1. What approaches did grantees and sponsors use to identify and enroll participants?
2. What types of supportive housing services did grantees provide?
3. Did grantees meet projected milestones?
4. What key factors aided or hindered the success of specific strategies related to (a) general program implementation and (b) frontline service delivery and housing provision? What measures are grantees taking to address these barriers?

Data Sources and Analysis

UCLA used the supportive service plans (SSPs) submitted by grantees during the application process and key informant interviews with grantee administrative staff conducted in March 2023 to describe program structure and implementation and obtain updates on their progress. UCLA further asked grantees about their challenges and successes. UCLA used Article II bi-annual reports submitted by each grantee to HCD to understand program challenges, resolutions and successes, grantee-identified project milestones, and participant-level data for HHC services delivered from July 2021-December 2022. The summary of the findings from grantee applications and key informant interviews are reported in this chapter and a more detailed description for each grantee is included in Appendix B: Article II Case Studies.

Article II Program Implementation

The following section describes HHC implementation of the four grantees that had successfully placed participants into permanent housing as of December 2022.

Project Type

Exhibit 10 provides an overview of grantees, project type, and the date they first housed HHC participants. Each grantee's project(s) also differed by the use of existing partnerships, programs, systems serving people experiencing homelessness, and other available funding within the county.

Exhibit 10: HHC Article II Grantees and Project Details

County and Abbreviated Grantee Name	Grantee	Project Type	Month First Participants were Housed – Program Initiation*	Number of Units
Kern	Kern County Behavioral Health and Recovery Services (BHRS)	Rental Assistance-Scattered-Site	July 2021	22
Los Angeles (LA)	Department of Health Services, Housing for Health (HFH)	Rental Assistance-Scattered-Site	January 2021	253
Marin	Marin County Behavioral Health and Recovery Services (BHRS)	COSR and Rental Assistance-Project Based Voucher (PBV)	December 2022	32 (PBV), 15 (COSR)
Sacramento	Sacramento County Division of Behavioral Health Services	Rental Assistance-Scattered-Site	December 2021	125

Source: Article II Supportive Service Plans and Bi-annual Reports; Ca.gov HCD Notice of Funding Awardee List 2019
Notes: *All grantees were awarded funding March 6, 2020. Rental Assistance-Scattered-Site refers to a voucher assigned to an eligible participant, which places them in private market apartments scattered throughout the county. The project-based voucher (PBV) allows rental assistance to be attached to a specific unit and/or dedicated project, instead of to an eligible participant. Capitalized Operating Subsidy Reserve (COSR) is a reserve established to address project operating deficits attributable to assisted units (e.g., insurance, utilities, maintenance, supportive services costs) for a minimum of 15 years.

Supportive Services Staffing Models

As highlighted in Article II grantee supportive services plans, three grantees worked with contracted partners for staffing and provision of supportive services. Only one grantee hired supportive service staff directly (Kern). Some counties hired several direct service providers to develop a dedicated team of part-time social workers, clinicians, peer support staff, and therapists; while other grantees hired a smaller number of case managers or housing coordinators that focused on tenant services, referrals and connections to health care, behavioral health, and other supportive services. For grantees that received funding for rental assistance to place participants in scattered-site housing, housing navigators were hired through contracted partners to identify potential participants and landlords with available housing. In key informant interviews, grantees reported that their HHC supportive services staffing model was in part due to the capacity of contracted partners and local providers.

Lower caseloads allowed staff to spend adequate time with participants and reflected the high acuity and needs of those served by HHC. Marin's "Jonathan's Place," a dedicated HHC project site, was able to offer 24/7 participant access to staff. All grantees emphasized the importance

of having a dedicated case manager per participant and ensuring frequent and regular touch when possible.

> *"We try to assign them [case managers] based on whose [staff person's] strengths might be best to support that individual." - Sacramento*

Grantees utilized a variety of mechanisms to provide necessary support to staff, which included daily huddles to discuss priority items, weekly case conference meetings, and trainings in topics relevant to the program's target population.

> *"[A priority is] ensuring that all of our case managers are trained and have continual training in [trauma informed care]… we have vicarious trauma groups… because we're working with a very intense population that can cause a lot of burnout." - Los Angeles*

Identification of Potential Participants

In key informant interviews, all grantees noted relying on their Coordinated Entry System (CES) for identification and referrals of potential participants. Additionally, all grantees utilized a standardized housing assessment (e.g., Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)), that provides a prioritization score based on need and specific risk factors such as chronicity of homelessness, health related needs, and disability.

Grantees emphasized the importance of utilizing community access points to the CES through existing networks that serve people experiencing homelessness (e.g., street outreach programs, housing agencies, homeless shelters). Grantees discussed the necessity of data sharing infrastructure to better understand potential participants' service utilization, needs, and prior involvement with systems of care. For example, Sacramento referred to accessing "MyAvatar," an electronic health record with a focus on behavioral health, as well as the County's Homeless Management Information System (HMIS), to appropriately assess the complexity of HHC participants and to be able to connect them to the most appropriate housing and supportive services. Not all grantees felt they had adequate access to necessary data to determine eligibility.

Grantees faced challenges to identify participants who met the required utilization of acute care services criteria and were not housed by competing programs.

Housing and Supportive Services

Using information provided in grantee SSPs, bi-annual reports, and key informant interviews, UCLA summarized the provision of housing and required supportive services for all four grantees.

Housing Navigation Services

Housing navigation focused on helping participants secure housing with the support of a specialized staff member. All grantees contracted partners to provide housing navigation services. Partners providing these services included community-based organizations and county agencies (e.g., county housing authorities) and these providers were commonly found through existing networks established by Whole Person Care, California Advancing and Innovating Medi-Cal (CalAIM), and housing programs. Exhibit 11 provides specific examples of services provided by housing navigation staff, including identification of potential participants, participant assessments, and identifying and securing housing and landlord relationships (e.g., for rental assistance – scattered-site).

Exhibit 11: Illustrative Examples of Housing Navigation Services Provided by HHC Grantees

Illustrative Examples of Housing Navigation Activities
Contracted Partner hired housing navigation staff to: • Identify potential participants through local Coordinated Entry System (CES) based on HHC eligibility criteria or through direct referrals. • Conduct participant housing needs assessments and connect participants to needed services. • Assist participants wishing to move into scattered-site unit from project-based housing. • Identify and coordinate with private landlords for scattered-site housing.

Source: Article II Supportive Services Plans (SSPs), Bi-annual Reports (July 2021-December 2022), and Key Informant Interviews (March 2023).
Notes: SSPs were submitted prior to program implementation. Bi-annual reports and key information surveys provided updates to program implementation activities. See Appendix B: Article II Case Studies for additional detail by grantee on specific supportive services.

Case Management Services

Case management focused on connecting participants to supportive services based on participants' needs and goals. Case management services required more staffing compared to housing navigation, as they served as the central point of contact and support for participants after they had been housed. HHC program guidelines specified a maximum caseload of 20 participants per case manager, which all grantees met. Three grantees had staff with a caseload of 20 participants per case manager and Sacramento had staff with a caseload of eight to 12 participants per case manager.

Exhibit 12 provides specific examples of services provided by case management staff, including participant needs assessments, linkages to primary and behavioral health care, and other services for social and emotional well-being. In some cases, staff helped participants connect to benefit assistance, employment assistance, peer support services, tenant support services, and social activities. The role of case management staff varied by grantee, depending on the staff composition and specialties of contracted partners. For example, Kern case management services were performed by dedicated clinical staff who were responsible for coordinating and integrating behavioral health services (BHS) for participants. In Sacramento, staff within a large, contracted partner network, provided comprehensive case management. Similarly, contracted partners in Los Angeles hired intensive case management service providers, who offered support to participants in need of crisis management and substance abuse recovery.

Exhibit 12: Illustrative Examples of Case Management Services Provided by HHC Grantees

Illustrative Examples of Case Management Activities
Hired case management staff to: • Identify needs and services for participants. • Provide comprehensive care coordination, including linkages or referrals to clinical and non-clinical care, medical benefits enrollment, and coordinating transportation to appointments as needed. • Provide direct behavioral health services (when staff were licensed behavioral health providers). • Provide connections to all supportive service offerings using a participant-centered, goal-oriented, and trauma informed approach. • Assist with tenant support services once a participant is placed in housing, such as move-in coordination, tenant- landlord relationship education and issue mitigation, and life-skills support and training.

Source: Article II Supportive Services Plans (SSPs), Bi-annual Reports (July 2021-December 2022), and Key Informant Interviews (March 2023).
Notes: SSPs were submitted prior to program implementation. Bi-annual reports and key information surveys provided updates to program implementation activities. See Appendix B: Article II Case Studies for additional detail by grantee on specific supportive services.

Linkages to Primary Care

Case management staff referred participants to primary care and supported participants as they established and maintained primary care. Exhibit 13 provides illustrative examples of the primary care linkages provided by case managers. Case managers of three grantees referred participants to primary care clinics or other community healthcare providers. One grantee (Marin) had providers that could see participants on-site for primary care needs. Two grantees required their contracted case managers to link participants with a primary care provider within 60 days of intake into the program.

Exhibit 13: Illustrative Examples of Linkages to Primary Care Services by HHC Grantees

Illustrative Examples of Linkages to Primary Care
Hired case management staff to: • Provide referrals to local primary care provider. • Assist participants with applying for and maintaining Medi-Cal enrollment. • Provide referrals for ongoing medical, dental, and preventative health care needs.

Source: Article II Supportive Services Plans (SSPs), Bi-annual Reports (July 2021-December 2022), and Key Informant Interviews (March 2023).
Notes: SSPs were submitted prior to program implementation. Bi-annual reports and key information surveys provided updates to program implementation activities. See Appendix B: Article II Case Studies for additional detail by grantee on specific supportive services.

Linkages to Behavioral Health

Exhibit 14 provides illustrative examples of behavioral health linkage activities performed by case managers. Some provided an initial behavioral/mental health assessment to participants and, if needed, participants would be referred for full mental health services. Other grantees hired case management staff that were primarily non-clinical social workers and who focused on connecting participants to mental health assessments and behavioral health care. For example, Marin BHRS Full-Service Partnership, a comprehensive and intensive mental health program, provided on-site staff for participants which complemented services provided by their contracted partner, Homeward Bound, including a mobile crisis team and case management referrals.

Exhibit 14: Illustrative Examples of Linkages to Behavioral Health Services by HHC Grantees

Illustrative Examples of Linkages to Behavioral Health
Grantee BHS/case management staff: • Provide participants with, or referrals for, mental health assessments. • Provide behavioral health referrals, system navigation, and care coordination services. • Provide participants with serious mental health support services/crisis response services, including education on how to access these services, and development of an individualized crisis plan. • Provides participants with individual and group therapy and counseling using motivational interviewing, trauma-informed, and harm reduction practices.

Source: Article II Supportive Services Plans (SSPs), Bi-annual Reports (July 2021-December 2022), and Key Informant Interviews (March 2023).
Notes: SSPs were submitted prior to program implementation. Bi-annual reports and key information surveys provided updates to program implementation activities. See Appendix B: Article II Case Studies for additional detail by grantee on specific supportive services.

Linkages to Substance Use Disorder Services

Exhibit 15 provides a descriptive summary of substance use disorder treatment linkages by HHC grantees. All Article II grantee or contracted partner staff completed some form of intake assessment that included screening for substance abuse disorders so that services could be offered, referred, or provided to participants interested in recovery treatment. Linkages to treatment were integrated into case management services by referring participants to providers that offered and specialized in substance abuse disorder. For example, Kern BHRS staff were trained in harm reduction treatment models and offered individualized treatment options to participants who could be at different stages in their recovery. Marin utilized their on-site health center as a safety net to provide participants with outpatient substance use disorder support, and referred participants who needed additional supports to county substance use services for residential and outpatient treatment or prevention services.

Exhibit 15: Illustrative Examples of Linkages to Substance Use Disorder Services by HHC Grantees

Illustrative Examples of Linkages to Substance Abuse Disorder Treatment Activities
Case Management staff: • Provide participants with, or referrals for, outpatient substance use disorder treatment, such as medication assisted treatment, residential treatment, or detox services. • Provide on-site individual and group treatment, education, recovery skills, and self-help peer support recovery groups.

Source: Article II Supportive Services Plans (SSPs), Bi-annual Reports (July 2021-December 2022), and Key Informant Interviews (March 2023).
Notes: SSPs were submitted prior to program implementation. Bi-annual reports and key information surveys provided updates to program implementation activities. See Appendix B: Article II Case Studies for additional detail by grantee on specific supportive services.

> *"What we see across the board is that when people are able to get their physiological needs met and be indoors… we see that they can start to process some of those other things that may have kept them or had contributed to their homelessness. So in providing those intensive services along the way, but especially as soon as they get indoors and into a safe space, we see a lot of breakthroughs in their primary care, behavioral health, and their substance use." – Los Angeles*

Peer Support Services

Grantees provided peer support services on-site or off-site. Case managers or peer support staff referred participants to peer support services based on individual needs and interests.

Exhibit 16 describes peer support services provided by HHC grantees. All projects had a mental health focus for peer support activities and included services like support groups, group therapy, and social activities in the community or housing development. For example, Kern BHRS peer staff provided one-to-one peer support and mentoring services typically based on referrals from clinical staff, both on- and off-site.

Exhibit 16: Illustrative Examples of Peer Support Services Provided by HHC Grantees

Illustrative Examples of Peer Support Activities
Peer support staff who: • Provide on- and off-site peer support services based on referral from clinical or case management staff. • Provide participants with on-site peer counseling, system navigation and advocacy, direct support services, and linkage to community support and services throughout the county. • Encourage participation in organized and healthy social and recreational activities to foster community, social support, and participant well-being.

Source: Article II Supportive Services Plans (SSPs), Bi-annual Reports (July 2021-December 2022), and Key Informant Interviews (March 2023).
Notes: SSPs were submitted prior to program implementation. Bi-annual reports and key information surveys provided updates to program implementation activities. See Appendix B: Article II Case Studies for additional detail by grantee on specific supportive services.

Linkages to Benefit Enrollment Services

Since all grantees were county agencies, each project relied on a network of partner government agencies or departments to support linking participants to a variety of programs and resources. The most common linkages were to disability benefits, Medi-Cal, and food assistance programs such as CalFresh. Other linkages included Veteran's Assistance (VA), income assistance, unemployment benefits, and money management services.

Housing Retention Promotion Services and Strategies

Housing retention promotion services are those that support participants in maintaining long-term housing, such as life skills training. Exhibit 17 describes examples of housing retention activities performed by Article II project staff. All grantees identified their comprehensive supportive service offerings as essential to promoting housing retention, since any service that supports an individual's health and well-being also supports their ability to adjust to everyday life in a stable housing environment. Additionally, all grantees emphasized continued contact or relationship building with participants and case managers as the primary housing retention strategy. All projects offered some level of education and training in life skills, housing skills, and money management. Life skills training was an optional service that was encouraged by HCD for grantees to have integrated within their supportive services plan and included how to maintain a home, fulfill rental agreements, earn income for rent and food, and sustain landlord relationships.

Exhibit 17: Illustrative Examples of Housing Retention Promotion Services Provided by HHC Grantees

Illustrative Examples of Housing Retention Activities
Staff: • Provide life skills training, tenant education, and advocacy for housing retention (such as unit maintenance and upkeep, cooking, laundry, working with a landlord, getting along with neighbors, and money management). • Encourage service use and address housing needs/issues through continued outreach and engagement with participants.

Source: Article II Supportive Services Plans (SSPs), Bi-annual Reports (July 2021-December 2022), and Key Informant Interviews (March 2023).
Notes: SSPs were submitted prior to program implementation. Bi-annual reports and key information surveys provided updates to program implementation activities. See Appendix B: Article II Case Studies for additional detail by grantee on specific supportive services.

> *"What happens to somebody who has been failed over and over by our systems and then finally gets to live in a place that brings them … some hope and dignity … that is a really difficult transition in itself." – Sacramento*

In key informant interviews, all grantees mentioned utilizing a "whatever it takes" model to meet participants "where they are at." Housing retention strategies often involved structured, community-driven activities and a focus on creating a comfortable and safe environment for participants. Consistency in staffing (e.g., a dedicated case manager for each participant) was also cited as a primary tactic to build trust and rapport to promote retention.

> *"Another thing that we see with permanent supportive housing is that people will get housed and then not have a lot of regular engagement with service providers or, just have like meaningful things to do with their day. And so, when we're bringing in groups, we're trying to just have as much activity on site at the congregate living settings that we can."* – *Marin*

Services for Individuals with Co-occurring Disabilities or Disorders

HHC specifically required services for participants with co-morbid disabilities or disorders (COD) that are common conditions among people experiencing homelessness. Exhibit 18 provides

illustrative examples of provision of these services. All grantees mentioned providing accessible housing for those with disability and connecting participants to disability benefits and services. Some grantees provided participants with individual and group therapy treatment and linkages to rehabilitation and support services, while others provided referrals if participants are identified with having a co-occurring mental health and substance use disorder (SUD). For example, Los Angeles integrated information regarding co-occurring disorders on participants Health Action Plans for delivery of services.

Exhibit 18: Illustrative Examples of Provision of Services for Participants with Co-occurring Disabilities or Disorders by HHC Grantees

Illustrative Examples of Co-occurring Disabilities/Disorders Service Activities
Staff: • Assist with identifying and applying for disability services and benefits, as well as accommodating disabilities with appropriate housing based on individual need. • Provide co-occurring disorder assessment. • Provide or refer participants with COD to outpatient substance abuse disorder support specifically for co-occurring disorders.

Source: Article II Supportive Services Plans (SSPs), Bi-annual Reports (July 2021-December 2022), and Key Informant Interviews (March 2023).
Notes: SSPs were submitted prior to program implementation. Bi-annual reports and key information surveys provided updates to program implementation activities. See Appendix B: Article II Case Studies for additional detail by grantee on specific supportive services.

Transportation Services

Grantees planned to provide optional transportation services for participants to access off-site services or resources. HCD defined reasonable access as access that does not require walking more than half a mile. All grantees offered transportation options including public transit education and assistance, providing public transit passes or tokens, access to specialized transport, or staff members providing rides or accompaniment to services. Kern, for example, provided public transportation education, bus passes to allow for travel throughout Bakersfield, paratransit resources for participants with disabilities, and when appropriate, staff accompaniment to services.

Employment Services

Employment services were optional, and all grantees included employment services as a part of their supportive services plan. These services focused on helping participants with entering or

re-entering the workforce by linking them with supported employment, jobs skills training, or job placement resources and organizations. For example, Sacramento offered an assigned employment advisor to help eligible participants with employment and provided counseling services to help break down barriers to employment. For participants who were unable to work in Marin, assistance was provided to find volunteer work, based on a participant's needs and abilities.

Referrals to and Receipt of Supportive Services by HHC Participants

Grantees reported the proportion of successfully housed HHC participants that received specific supportive services in Article II bi-annual reports. UCLA excluded services provided to HHC participants that had yet to be housed in this analysis (Sacramento).

Grantees reported both referrals to and receipt of eight supportive services (Exhibit 19). All participants were referred to tenant support services (100%) and 82% were referred to medical and behavioral health care. Fewer were referred to life skills training (47%), crisis management interventions (17%), and other services (17%). Only LA used the "other" services category and reported referring to benefit and document assistance. Receipt of services following referral was high among HHC participants, with between 91% and 100% of participants referred receiving each service.

Exhibit 19: Grantee Referrals to and HHC Participant Receipt of Supportive Services by Category of Service

Category of Service	Proportion of Housed Participants who were Referred to Services	Proportion of Participants Referred that Received Services
Tenant Support Services	100%	99%
Coordination of Medical and Behavioral Health Care	82%	100%*
Crisis Management Interventions	17%	100%*
Peer Support Services	2%	100%
Employment Services	7%	94%
Substance Use Disorder Treatment	9%	100%
Life Skills Training	47%	91%
Benefit and Document Assistance	17%	95%

Source: Article II Bi-annual Reports (July 2021- December 2022).
Notes: *HHC grantees reported additional participants that received this service without a referral. "Benefit and Document Assistance" was reported by one grantee (Los Angeles). 230 housed HHC participants included.

Project Milestones

In the Article II bi-annual reports grantees reported on project milestones they hoped to achieve in the next six months. HCD monitored and supported the milestone goals developed and reported by Article II grantees to help grantees reach milestones that aligned with their project goals and HHC program objectives. Prior to housing participants and/or early in program implementation, grantees reported milestones that included: contracting partners to provide services, establishing housing units and relationships with potential landlords, creating documents (e.g., legal inspections, rental agreements, grievance procedures), identifying project completion or housing timelines, and increasing the number of housed participants. After grantees had successfully started housing participants, milestones included: increasing outreach and participant enrollment or referrals to HHC, increasing utilization of supportive services by participants, increasing the number of participants housed or receiving housing vouchers, opening more housing sites (for scattered-site housing), and hiring more service providers.

In addition to project milestones, grantees reported vacancy rates, which measured the percent of HHC designated units that did not have occupancy by an enrolled participant. This measure has more meaning for project-based housing and scattered-site housing that had reserved units to be filled by HHC participants, compared to scattered-site housing that were privately owned units in the market and not reserved until filled by HHC participants. If a grantee reported a vacancy rate greater than 10%, HHC required that they provide an explanation of barriers to reaching higher occupancy.

Exhibit 20 describes Article II projects, the date grantees first housed participants, their lowest reported vacancy rates, and barriers to low vacancy. LA and Kern defined vacancy rate as unused housing vouchers while waiting for a participant to match through CES referral to HHC. LA was the first to house participants and reached vacancy rates below 10% in their first year (data not shown). The lowest vacancy rate LA reached was 8% in July 2022. Kern housed their first participant in July 2021, and reached a 25% vacancy rate by July 2022. Sacramento did not document vacancy rates. Marin faced program delays as their housing-project, “Jonathan’s Place,” underwent rehabilitation, but accomplished 50% vacancy rate upon program initiation.

Exhibit 20: Lowest Vacancy Rates and Barriers Reported by HHC Grantees

Project	Date of first participant housed	Lowest vacancy rate, date achieved	Barriers to reach below 10% vacancy
Kern	July 2021	25%, July 2022	Did not begin housing participants until second half of 2021
Los Angeles	January 2021	8%, July 2022	Expected time to enroll and house participants
Marin	December 2022	50%, January 2023	Project still under construction until mid-2022 Delays due to construction, COVID, and HHC funding
Sacramento	December 2021	Not reported	The program had a slow start to implementation in 2021 partially due to length of time on amendment agreements and board authority to start the program

Source: Article II Bi-annual Reports from July 2021 to January 2023.
Notes: Kern and Los Angeles reported vacancy rate based on housing vouchers ready to be dispersed. Sacramento did not report on vacancy rate. Marin reported a true vacancy rate based on their project-based site "Jonathan's Place."

Challenges, Solutions, and Lessons Learned

In Article II bi-annual reports and key informant interviews, all HHC grantees reported challenges and delays in proposed implementation timelines due to circumstances involving construction and rehabilitation costs, supply chain issues, housing and labor force shortages, and funding. Many of these challenges were directly related to or exacerbated by the COVID-19 pandemic. Counties worked strategically with HCD to modify and adjust project plans accordingly.

Successful strategies utilized by grantees were often in direct response to the challenges faced. More specifically, Kern and Los Angeles both cited challenges with the mismatch between market-based rates and voucher coverage. To address this issue, Kern established partnerships with owners who were willing to reduce rent for HHC units and Los Angeles expanded their contracted service providers and leveraged other available supplemental funding opportunities. As a strategy to keep participants engaged while they waited for housing placement, Sacramento and Los Angeles provided initial supportive services to appropriately prepare participants for housing. All counties prioritized ensuring the most appropriate housing

placement, based on participant need and acuity profile. For example, Marin conducted comprehensive unit viewings with participants prior to placement to ensure transparency and understanding of expectations.

> *"I would say the most helpful thing is getting to be intentional about the placements and not working out of urgency. That has been something that has felt like the most success."* – *Sacramento*

Additionally, all counties mentioned the synergistic effect of HHC with WPC and Cal-AIM. Strong partnership development with community-based organizations, healthcare providers, and housing providers through WPC allowed continued collaboration on shared priorities and the ability to leverage resources and funding for HHC. The implementation of CalAIM helped HHC participants to access supportive services and increased early Medi-Cal enrollment with improved awareness of enhanced care management services and stronger provider integration.

As emphasized by grantees, there are pros and cons associated with both scattered-site and project-based housing models, and the preferred model may be influenced by available funding, timelines, staffing and resource capacity, and geographic region. For example, Los Angeles emphasized how scattered-site projects may prove advantageous by allowing participant choice and preference on location, while also embedding participants in the broader community. Los Angeles noted how they were able to house participants near family and work opportunities with the scattered-site model. However, scattered-site may pose challenges to connecting participants with supportive services due to associated transportation and other logistics. To address these challenges, Kern, Los Angeles, and Sacramento all outlined transportation support for participants. In comparison, as highlighted by Marin, project-based housing can provide quicker access to and intensity of supportive services; with all participants located in one place, case managers may be able to spend more time with each participant. Furthermore, project-based sites can develop a sense of community amongst those housed at the project through events and activities held on-site. For example, Marin emphasized community social outings and group-meals. Project-based housing may pose challenges if some participant behaviors negatively impact others (e.g., sobriety, noise); and therefore, may require additional monitoring and resources. Ultimately, grantees felt that it is most important that the housing model meets the participant's unique needs. Marin expressed that project-based housing may be best for higher acuity participants.

Specific challenges and successes by grantee are outlined in Appendix B: Article II Case Studies.

Implementation Plans of San Francisco and San Mateo

San Francisco and San Mateo did not initiate their HHC programs during the evaluation period.

In San Mateo, the Housing Authority of the County of San Mateo was granted COSR and new construction funding for 59 units (i.e., single-site housing project where staff and services would be offered on-site). San Mateo planned to contract community partners for supportive service delivery and intended to use their local CES to identify potential HHC participants. San Mateo planned to provide supportive services through a network of contracted partners in coordination with San Mateo County agencies. Planned services include housing navigation, case management, peer support activities, linkages to primary and behavioral health care, and substance use disorder services. For case management, each participant would have an assigned case manager (caseload of 15 participants per case manager) to support the participant with referrals and linkages to resources, counseling, psychoeducation, care coordination, and advocacy. Optional services would include recreational activities, education, employment services, and public transit assistance.

In San Francisco, the Department of Homelessness and Supportive Housing was provided funding for a housing rehabilitation project for 30 units (i.e., single-site housing project where staff and services would be offered on-site). San Francisco planned to contract community partners for supportive service delivery and intended to use their local CES to identify potential HHC participants. Housing navigation and tenant supportive services would be provided on-site to support housing stability. A case management team comprised of social workers and peer-support specialists would be on-site to coordinate supportive services related to linkages to primary and behavioral health care, benefits advocacy, crisis management, substance abuse treatment, peer support activities, and other supportive services to HHC participants. On-site peer support staff is planned as a primary focus of the San Francisco project. Peer support staff would be available to participants for relationship building, sharing lived experience, accompaniment to appointments or referrals, and providing information about peer support programs and referrals to these programs. San Francisco's housing project would have on-site clinical staff (20 weeks a year) to provide health education, screenings, and nurse-provided physical healthcare. For other primary care services, San Francisco planned to refer participants to providers and services located half a mile walk from the on-site housing, but would also provide free or reduced public transit or paratransit options for eligible participants.

HHC Article II: Participant Characteristic and Housing Patterns

The goal of the HHC program was to provide supportive housing to people who were experiencing homelessness and had high healthcare costs. This chapter addresses the following evaluation question: "How many beneficiaries were housed and what were their characteristics?" The findings include a description of HHC participant housing patterns and their demographics and health status.

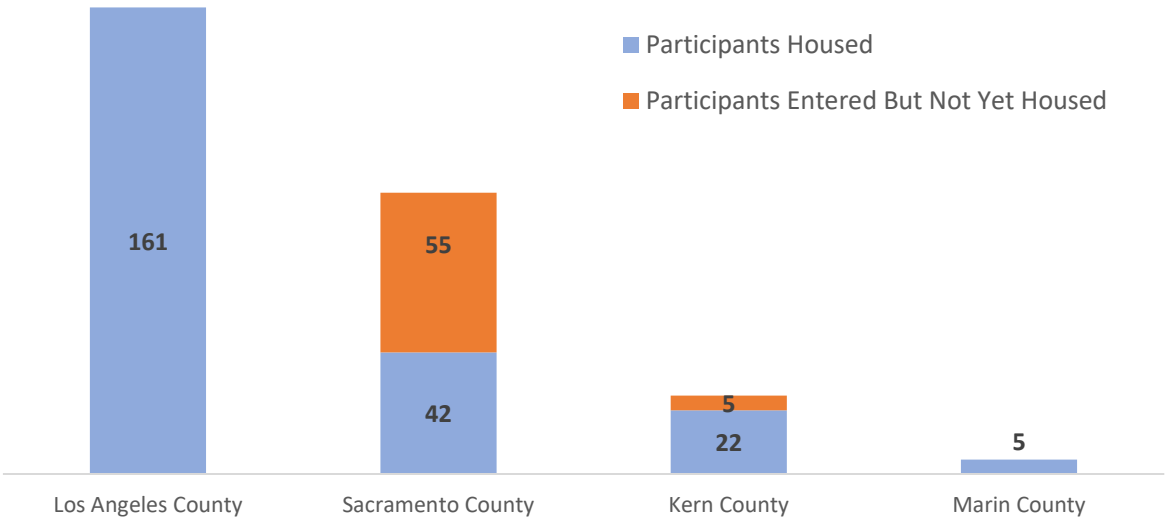
Data Sources

UCLA used Article II bi-annual reports submitted by each grantee to HCD. The bi-annual reports included participant-level data from June 2021 to December 2022. UCLA analyzed participant move-in and move-out dates as applicable, demographics, and length of time experiencing homelessness from these reports. UCLA also used Medi-Cal enrollment and claims data from January 2020 to December 2022; UCLA identified HHC participants in this data and examined diagnoses reported per encounter to assess health status the year prior to being housed. The data in this chapter were limited to participants of the four grantees that had housed individuals by December 2022.

Housing Patterns

Grantees reported both the date that participants entered the HHC program and the date that they successfully moved into housing, if they had been housed at the time of reporting. As of December 2022, a total of 290 participants had entered the program and 230 had successfully been housed (Exhibit 21). All Los Angeles County participants (161) and Marin County participants (5) had both program entry and move-in dates. Sacramento and Kern counties reported participants that had entered the program, but had not yet been housed (55 and 5 participants, respectively) and participants that had successfully moved-in (42 and 22 participants, respectively).

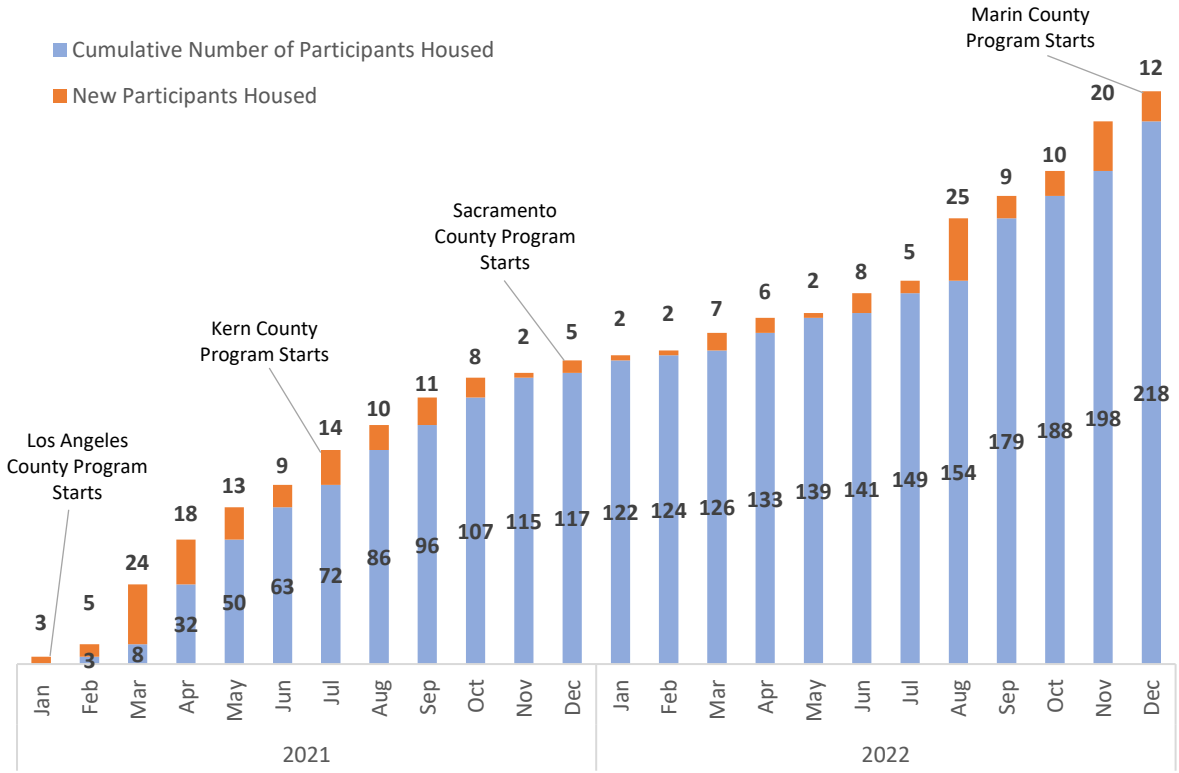
Exhibit 21: Number of HHC Participants That Entered the Program or Were Housed by Grantee, From January 2021 to December 2022



Source: HHC Article II Bi-annual Reports from July 2021 to December 2022. HHC is the Housing for a Healthy California Program.

By the end of December 2022, 230 participants had been housed by HHC. Exhibit 22 shows that the first HHC participants were housed in January 2021, with new participants housed every month through December 2022. More new participants were housed in March 2021 (24) and August 2022 (25) than any other month.

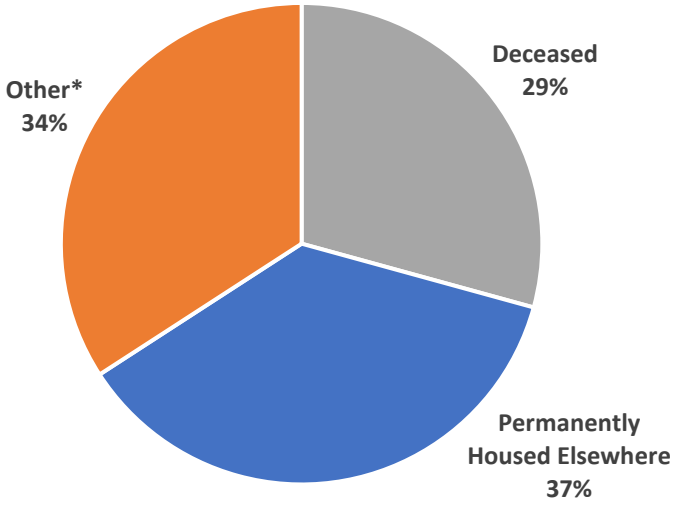
Exhibit 22: Cumulative and New Number of Housed HHC Participants Housed and New Participants Housed by Month, From January 2021 to December 2022



Source: HHC Article II Bi-annual Reports from July 2021 to December 2022. HHC is Housing for a Healthy California Program.

Grantees reported that 41 housed participants had moved out of HHC housing by December 2022 (Exhibit 23). Of these, 37% had moved out due to the procurement of housing elsewhere and 29% were reported as having moved out due to being deceased. The remaining 34% had moved out due to other reasons that included eviction and incarceration.

Exhibit 23: Reasons for Housed HHC Participants Moving Out, as of December 2022



Source: HHC Article II Bi-annual Reports from July 2021 to December 2022. HHC is Housing for a Healthy California Program.
Notes: *Other included No Longer Medi-Cal Eligible, Evicted, Not Specified, Incarceration, Relinquished unit voluntarily, Declined Program, or Unable to maintain engagement or contact (N = 41).

UCLA calculated length of time housed for participants that remained housed and those that moved out of their HHC housing as of December 2022. The average length of time that HHC participants were housed and remained housed was 343 days (Exhibit 24). Among participants that had moved out of their HHC housing, the average length of time in housing was 214 days.

Exhibit 24: Average Length of Time in HHC Housing Among HHC Participants That Remained Housed or Moved Out as of December 2022

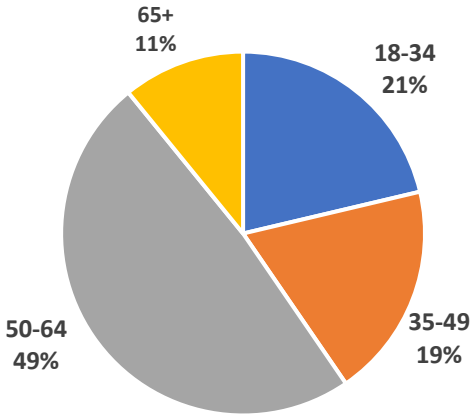
	Housed as of December 2022 (n= 189)	**Moved-Out as of December 2022 (n=41)**
Average length in housing	343 days	214 days

Source: HHC Article II Bi-annual Reports from July 2021 to December 2022. HHC is Housing for a Healthy California Program.

Housed HHC Participant Characteristics

At the time of move-in, most (49%) housed participants were 50-64 years of age (Exhibit 25). The mean age of participants was 49 years old, and ages ranged from 18 to 79 years (data not shown).

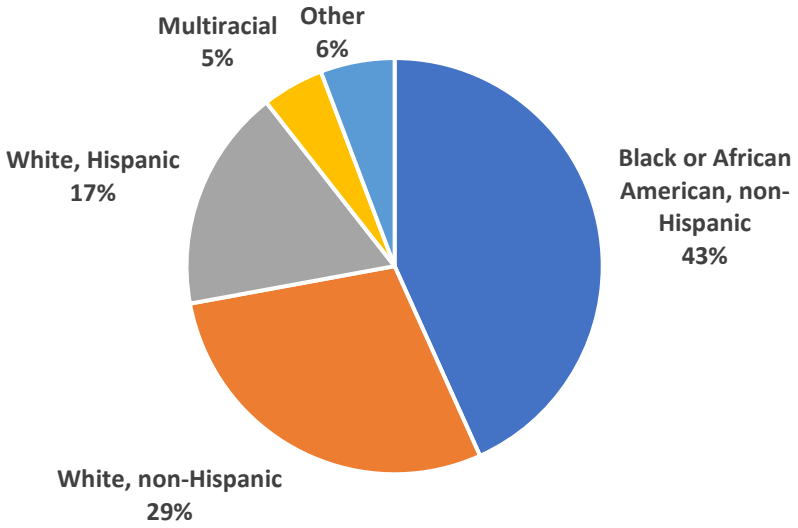
Exhibit 25: Age Categories of Housed HHC Participants at Move-In Date, From January 2021 to December 2022



Source: HHC Article II Bi-annual Reports from July 2021 to December 2022. HHC is Housing for a Healthy California Program.
Notes: Includes 230 HHC participants.

Housed HHC participants most commonly identified as non-Hispanic Black or African American (43%), followed by non-Hispanic White (29%) and Hispanic White (17%; Exhibit 26). Individuals identifying as multiracial made up the smallest proportion of participants at 5%. A tenth of participants declined to provide this information.

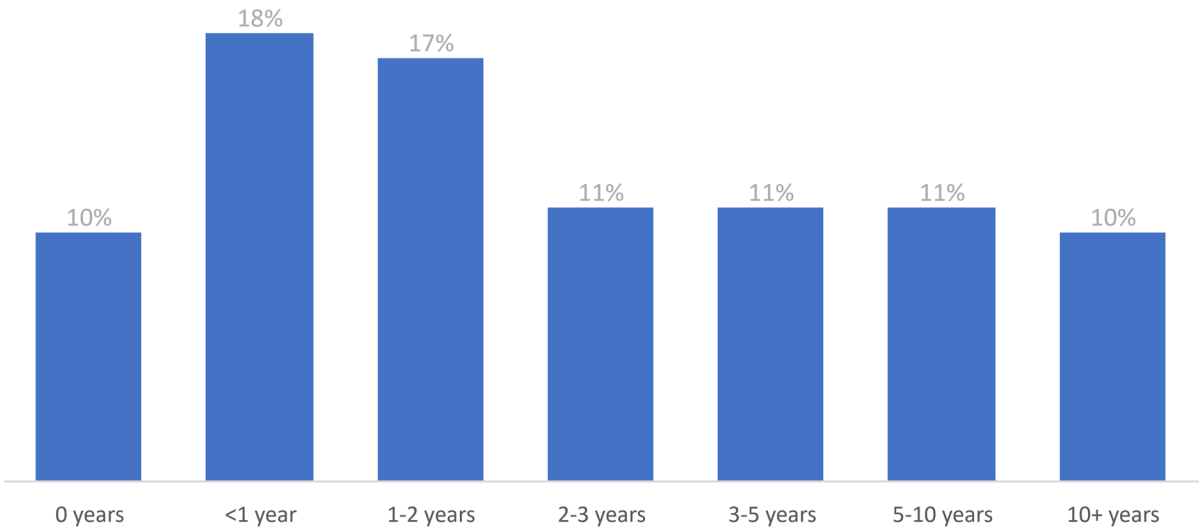
Exhibit 26: Race/Ethnicity of Housed HHC Participants by Race and Ethnicity, From January 2021 to December 2022



Source: HHC Article II Bi-annual Reports from July 2021 to December 2022. HHC is Housing for a Healthy California Program.
Notes: 230 participants were housed by HHC between January 2021 and December 2022. Race and ethnicity was reported by grantees. Other included American Indian or Alaska Native, Asian, and Native Hawaiian or other Pacific Islander.

Exhibit 27 shows the length of time since housed HHC participants had been stably housed when they entered the program. Most participants, 60%, had not been stably housed for more than 1 year prior to being housed, with 10% of these having not been stably housed for 10 or more years prior (Exhibit 27). Those with "0 years" since being stably housed were temporarily housed prior to HHC through programs like Project Roomkey.

Exhibit 27: Length of Time Experiencing Homelessness or Unstable Housing for HHC Participants Prior to Being Housed, as of December 2022

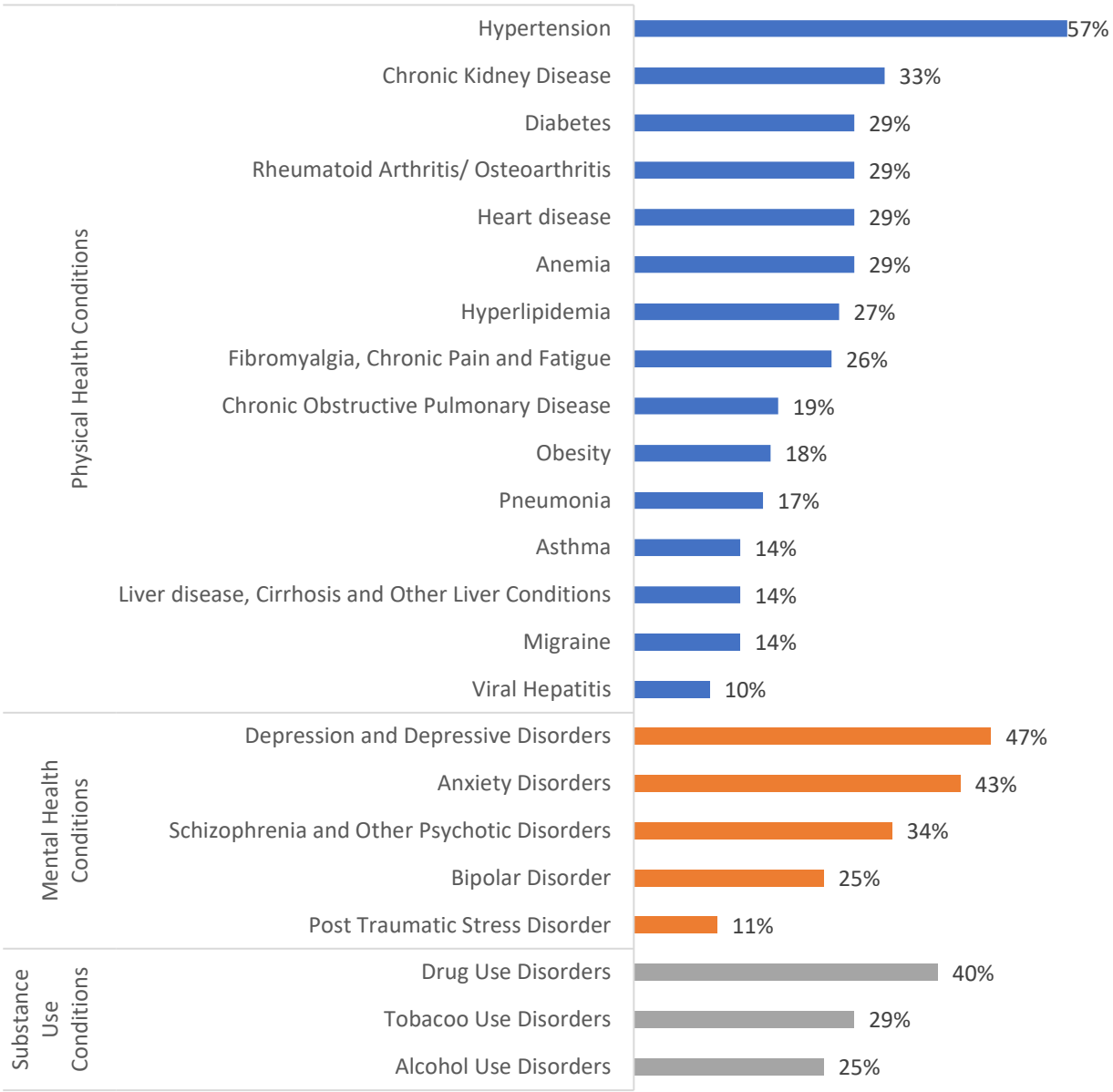


Source: HHC Article II Bi-annual Reports from July 2021 to December 2022. HHC is Housing for a Healthy California Program.
Notes: Includes 206 HHC participants; of the 230 participants housed by HHC from January 2021 to December 2022, 24 participants gave no response to this question.

Health Status of HHC Participants

UCLA reported the prevalence of chronic physical and behavioral health conditions identified in the two years prior to housing using Medi-Cal enrollment and claims data among the 224 HHC participants with this data (Exhibit 28). Hypertension was the most common (57%) health condition, followed by chronic kidney disease (33%), diabetes (29%), rheumatoid arthritis or osteoarthritis (29%), heart disease (29%), and anemia (29%). Common mental health conditions included depression and depressive disorders (47%), anxiety disorders (43%), and schizophrenia and other psychotic disorder (34%). Drug use disorder was the most common substance use disorder among participants (40%).

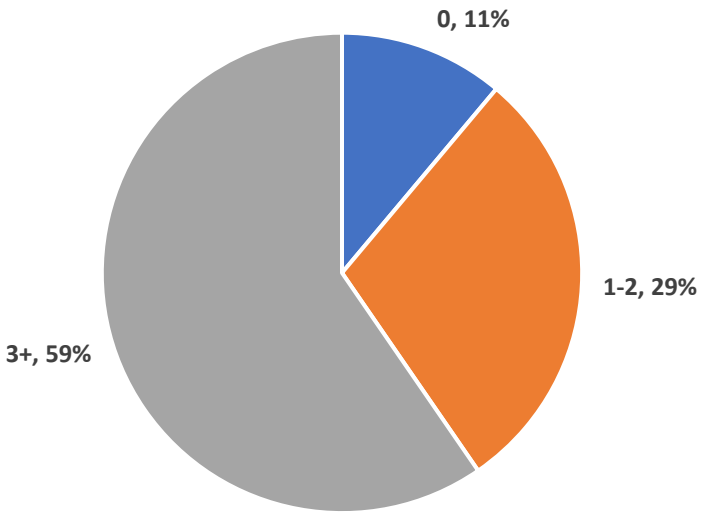
Exhibit 28: Selected Physical and Behavioral Chronic Conditions of Housed HHC Participants, as of December 2022



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2019 to December 2022.
Notes: Physical and behavioral health conditions were identified using the algorithms described in the Chronic Conditions Data Warehouse. Of the 230 housed participants, this includes 224 participants that had Medi-Cal enrollment and claims data in the year prior to housing.

A small portion (11%) of the housed HHC participants had no diagnosed physical health conditions prior to entering the program, but 29% had one or two conditions and 59% had three or more conditions (Exhibit 29).

Exhibit 29: Proportion of Housed HHC Participants by Number of Comorbid Chronic Physical Health Conditions, as of December 2022



Source: UCLA analysis of Medi-Cal enrollment and claims data from January 2019 to December 2022.
Notes: Physical health conditions were identified using the algorithms described in the Chronic Conditions Data Warehouse. Includes 224 participants that had Medi-Cal enrollment and claims data in the year prior to housing.

HHC Article II: Impact of HHC on Use of Acute Care Services

HHC aimed to "to reduce the financial burden on local and state resources due to the over utilization of emergency rooms…as the first point of healthcare provision." This chapter addresses the following evaluation question: "Did housed beneficiaries have improved health status after being housed?" UCLA answered this question by examining the impact of HHC on utilization of acute care services such as emergency ED visits and hospitalizations as proxies for health status and in the absence of more direct measures. The analyses were limited to Article II enrollees due to delayed implementation of Article I projects.

Data sources for this chapter included Bi-annual Article II Reports submitted by HHC Article II grantees from June 2021 to December 2022 and Medi-Cal enrollment and claims data from January 2019 to December 2022. The Bi-annual Article II Reports were used to identify participants and their move-in dates. UCLA then obtained Medi-Cal enrollment and claims data, which included both managed care and fee-for-service encounters, to construct ED visit and hospitalization rates per beneficiary per six-months. There were 230 participants that moved into housing through HHC by the end of 2022; however, UCLA only included in this analysis the 224 who were enrolled in Medi-Cal in the year prior to being housed and identifiable based on the data provided by the grantees.

UCLA identified a comparison group of Medi-Cal beneficiaries likely to experience homelessness using a previously developed and reliable methodology.[1] The comparison group was selected based on similar demographic, health status, and past use of acute care services. UCLA measured the impact of HHC on acute care use by developing difference-in-difference (DD) models in six-month intervals. This included first measuring differences in utilization trends before housing (from 7-12 months vs. 1-6 months) and after housing (from 1-6 months vs. 7-12 months) for both HHC participants and the control group. Next, the difference between the differences in trends between the two groups were measured. UCLA conducted a second DD analysis to show the immediate impact of HHC on acute care utilization by focusing on the change in utilization from 1-6 months before move-in to 1-6 months after move-in for both groups and then difference in these differences. These models were adjusted for beneficiary

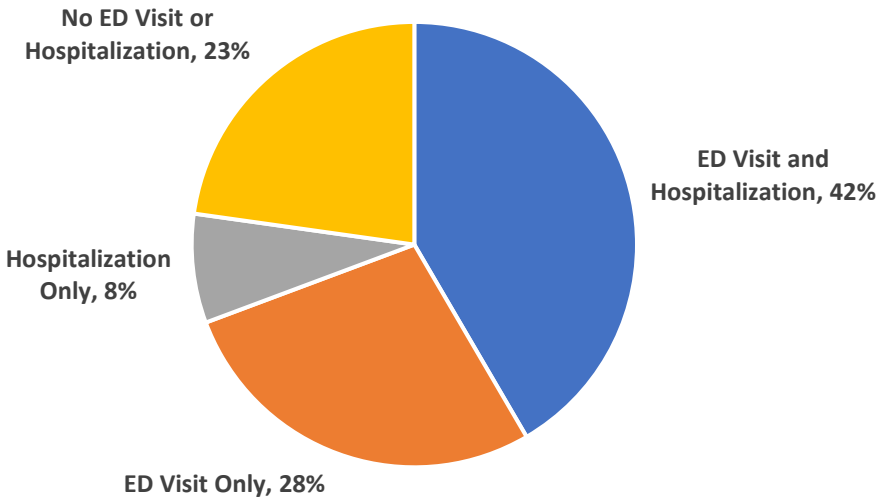
[1] Pourat, Nadereh, Dahai Yue, Xiao Chen, Weihao Zhou, and Brenna O'Masta. "Easy to Use and Validated Predictive Models to Identify Beneficiaries Experiencing Homelessness in Medicaid Administrative Data." Health Services Research n/a, no. n/a. Accessed April 24, 2023. https://doi.org/10.1111/1475-6773.14143.

demographics as well as health status, health complexity, and use of services prior to move-in. Further details can be found in Appendix A: Data Sources and Analytic Methods.

Utilization of Acute Services in the Year Prior to Housing

In the year prior to housing under HHC, 42% of participants utilized both the ED and the hospital (Exhibit 30). Over one-quarter (28%) utilized the ED only, 8% utilized the hospital only, and 23% had no ED or hospital utilization. HHC defined eligible participants as those who had at least one hospitalization or three or more ED visits in the past year. The reason for presence of participants without prior acute care utilization was because Los Angeles County applied for exceptions for participants that were at high-risk of acute care use (e.g., a several co-morbidities) or those that had the required high level of utilization prior to the COVID-19 pandemic, since utilization of these services declined during the pandemic restrictions.

Exhibit 30: Acute Care Utilization Among Housed HHC Participants in the Year Prior to Housing

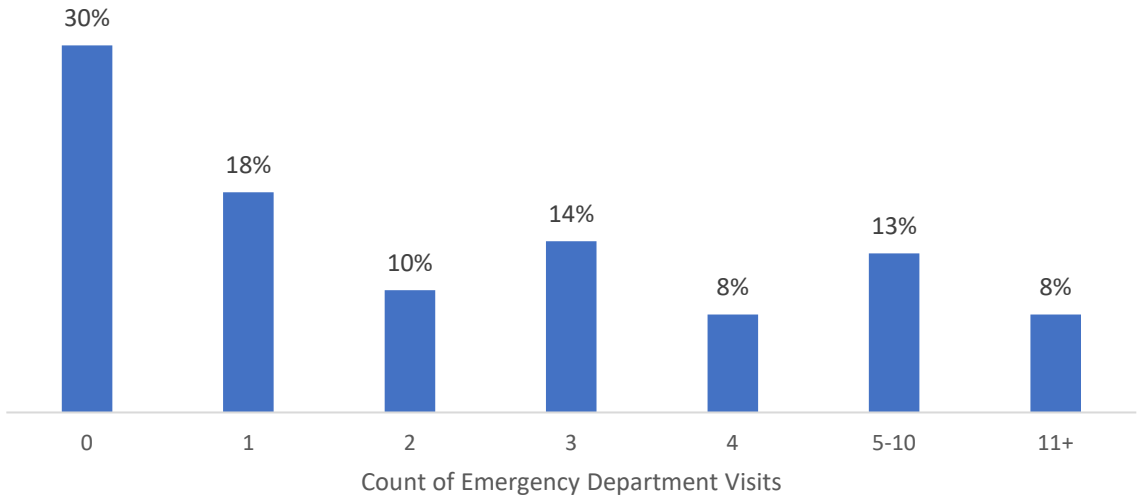


Source: UCLA analysis of Medi-Cal claims data from January 2020 to December 2022.
Notes: HHC is the Housing for a Healthy California Program. Acute care utilization included visits to the emergency department (ED) or hospitalizations. ED visits only included those visits that were followed by discharge. Includes 224 HHC participants with Medi-Cal data in the year prior to housing.

Among housed HHC participants, 30% had no ED visits, 18% had only one visit, and 29% had four or more ED visits in the year prior to housing (Exhibit 31). The average number of visits during that year among housed HHC participants was 3.7 visits (data not shown). Based on the

primary diagnosis reported for each ED visit, the most common reason for visits to the ED was for pain in the throat or chest, soft tissue disorders, abdominal and pelvic pain, symptoms and signs involving emotional state, and joint disorders (data not shown).

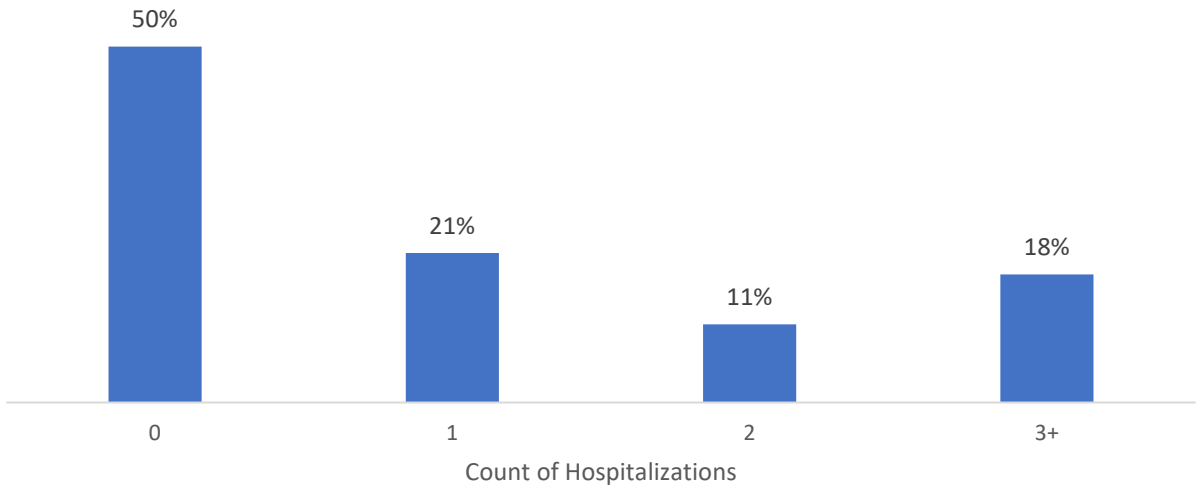
Exhibit 31: Proportion of Housed HHC Participants by Number of Emergency Department Visits Followed by Discharge in the Year Prior to Being Housed



Source: UCLA analysis of Medi-Cal claims data from January 2020 to December 2022.
Notes: HHC is the Housing for a Healthy California Program. Emergency Department visits included those visits that were followed by discharge. Includes 224 HHC participants with Medi-Cal data in the year prior to housing.

Among housed HHC participants, 50% were not hospitalized in the year prior to being housed and 21% had one hospitalization (Exhibit 32). The average number of hospitalizations during that year was 1.5 stays (data not shown). Based on primary diagnosis, the most common reasons for hospitalizations were hypertensive heart and chronic kidney disease, schizoaffective disorders, sepsis, schizophrenia, and hypertensive heart disease (data not shown).

Exhibit 32: Proportion of Housed HHC Participants by Number of Hospitalizations in the Year Prior to Being Housed



Source: UCLA analysis of Medi-Cal claims data from January 2020 to December 2022.
Note: HHC is the Housing for a Healthy California Program. Includes 224 HHC participants with Medi-Cal data in the year prior to housing.

Changes in Health Care Utilization Prior to and After Housing Among HHC Participants

Exhibit 33 shows changes in utilization of health services among housed HHC participants before and after being housed. Data show an increase in use for all service categories examined in the months prior to housing, with the increase ranging from 14% for ED visits to 60% for long-term care stays. During the year after housing, utilization of most services declined, ranging from 3% for specialty care to 61% for mental health services. Long-term care stays increased by 20%. Furthermore, utilization of all services declined in first six months after housing compared to the six months prior to housing.

Exhibit 33: Changes in Average Service Use per Housed HHC Participant in the Year Prior to and Year After Housing

	Months Prior to Housing			Months After Housing		
Healthcare Service	**7-12**	**1-6**	**Percent Change**	**1-6**	**7-12**	**Percent Change**
Primary Care Services	3.53	4.58	30%	3.08	2.87	-7%
Specialty Care Services	1.62	1.95	20%	1.59	1.54	-3%
Mental Health Services	1.37	1.70	24%	1.26	0.49	-61%
Substance Use Services	0.60	0.78	30%	0.39	0.29	-26%

ED Visits	1.70	1.95	14%	1.24	1.14	-8%
Hospitalizations	0.65	0.88	34%	0.47	0.38	-19%
Long-Term Care Stays	0.08	0.13	60%	0.06	0.07	20%

Source: UCLA analysis of Medi-Cal claims data from January 2020 to December 2022.
Notes: HHC is the Housing for a Healthy California Program. Includes 224 HHC participants with Medi-Cal data in the year prior to housing. Healthcare utilization was measured as the average number of services, stays or visits per HHC participant every 6 Medi-Cal member-months.

Exhibit 34 shows the changes in distribution of average length of hospital stay among HHC participants before and after being housed. Data showed that overall average length of stay (mean) was shorter following being housed (17.4 vs 12.6 days). The decline was greater for the longest stays (75^{th} percentile or the highest quartile).

Exhibit 34: Descriptive Statistics of Length of Stay (in days) by Housed HHC Participants in the Year Prior to and Year After Housing

		Year Prior to Housing	Year After Housing
	Mean	17.4	12.6
Quartiles	25th percentile	5	4
	50th percentile	10	8
	75th percentile	19	13

Source: UCLA analysis of Medi-Cal claims data from January 2020 to December 2022.
Notes: HHC is the Housing for a Healthy California Program. Includes 224 HHC participants with Medi-Cal data in the year prior to housing.

Differences in Trends in Acute Care Utilization Before and After Housing Among HHC Participants and the Comparison Group

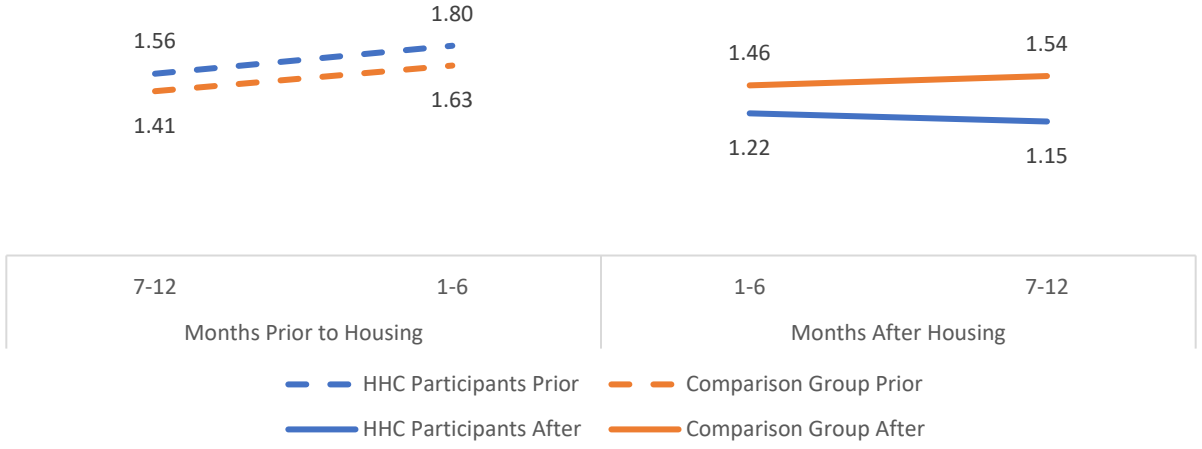
The DD analyses were conducted for ED visits and hospitalizations following the methods described earlier in this chapter. The findings of these analyses are described below and illustrate whether HHC resulted in better outcomes for housed participants than the control group who were not housed by HHC.

Emergency Department Visits

UCLA measured the utilization of ED visits followed by discharge rather than hospitalization because ED visits followed by hospitalization were included in analysis of trends in hospitalization. Exhibit 35 shows that the number of ED visits in the year prior to housing (from 7-12 month before to 6-1 months before) was significantly increasing by 0.24 visits but after housing declined by 0.07 visits, an overall decline of -0.31 visits per HHC housed participant per six months. The trends for the control group in the same timeframe were similar with an overall decline of -0.14 per control beneficiary per six months. The overall decline for each group was not statistically significant and the pattern of change (DD: -0.17) was also not statistically significant.

However, comparing changes from six months before to six months after being housed indicated a significant decline of 0.58 visits per beneficiary for HHC housed participants and a nonsignificant decline of 0.17 visits for the comparison group. The difference in the decline was significantly greater among housed HHC participants compared to the comparison group by 0.41 fewer visits per beneficiary. This analysis indicated that HHC reduced ED visits followed by discharge for HHC housed participants more so than declines observed among similar Medi-Cal beneficiaries not housed by HHC.

Exhibit 35: Trends in Emergency Department Visits Followed by Discharge per Beneficiary per Six-Months Prior to and After Housing for Housed HHC Participants and the Comparison Group



			Change in Trend from Prior to After Housing		Change in Six-Month Utilization from Prior to After Housing	
	Trend Prior to Housing	**Trend After Housing**	**Difference**	**Difference-in-Difference**	**Difference**	**Difference-in-Difference**
HHC Participants	**0.24***	-0.07	-0.31	-0.17	**-0.58***	**-0.41***
Comparison Group	**0.22***	0.08	-0.14		-0.17	

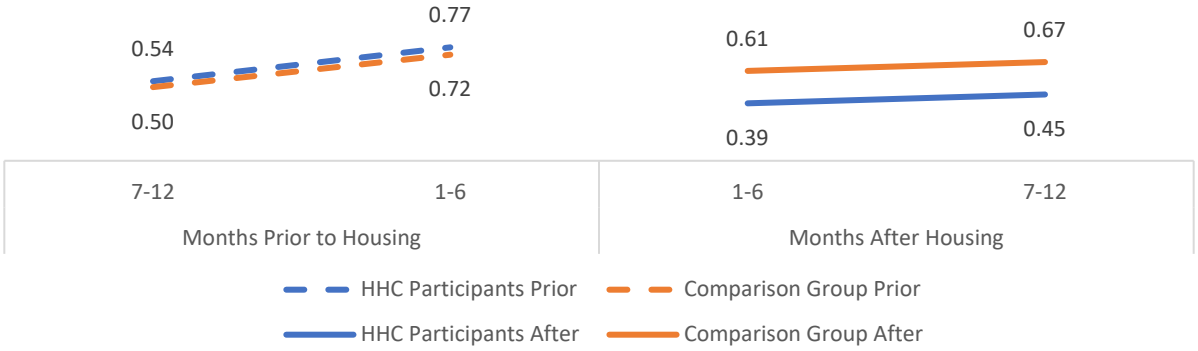
Source: UCLA analysis of Medi-Cal claims data from January 2020 through December 2022.
Notes: Includes ED visits that do not result in hospitalization. * Denotes p≤0.05, a statistically significant difference. Trend prior to housing is calculated as: (1-6 months prior minus 7-12 months prior). Trend after housing is calculated as: (7-12 months after minus 1-6 months after). Difference between trends is calculated as: (trend after housing minus trend prior to housing). Difference between six-month utilization is calculated as: (utilization 1-6 after housing minus utilization 1-6 month prior to housing). Difference-in-difference is calculated as: (difference in HHC participants – difference in comparison group). HHC is the Housing for a Healthy California Program. Includes 224 HHC participants with Medi-Cal data prior to housing and 448 matched controls.

Hospitalizations

Exhibit 36 shows, for HHC participants, a significant increase in the rate of hospitalizations prior to housing by 0.23 and a smaller nonsignificant increase of 0.06 per six months after being housed, an overall and not statistically significant change of -0.17. In contrast, the rate of hospitalization for the comparison group declined by -0.16 in the same time period. The changes in trends between HHC participants and the comparison group were not statistically significant (DD: -0.01).

Comparing changes in rates of hospitalization from six months before to six months after being housed indicated a significant decline of -0.38 visits per beneficiary for HHC housed participants and a nonsignificant decline of -0.11 for the comparison group. The DD of -0.28 hospitalization per beneficiary from before to after HHC was statistically significant. This analysis indicated that HHC reduced hospitalizations for HHC housed participants in the six months following being housed.

Exhibit 36: Trends in Inpatient Utilization per Beneficiary per Six-Months Prior to and After Housing



			Change in Trend from Prior to After Housing		Change in Six-Month Utilization from Prior to After Housing	
	Trend Prior to Housing	**Trend After Housing**	**Difference**	**Difference-in-Difference**	**Difference**	**Difference-in-Difference**
HHC Participants	**0.23***	0.06	-0.17	-0.01	**-0.38***	**-0.28***
Comparison Group	**0.22***	0.05	-0.16		-0.11	

Source: UCLA analysis of Medi-Cal claims data from January 2020 through December 2022.
Notes: * Denotes p≤0.05, a statistically significant difference. Trend prior to housing is calculated as: (1-6 months prior minus 7-12 months prior). Trend after housing is calculated as: (7-12 months after minus 1-6 months after). Difference between trends is calculated as: (trend after housing minus trend prior to housing). Difference between six-month utilization is calculated as: (utilization 1-6 after housing minus utilization 1-6 month prior to housing). Difference-in-difference is calculated as: (difference in HHC participants – difference in comparison group). HHC is the Housing for a Healthy California Program. Includes 224 HHC participants with Medi-Cal data prior to housing and 448 matched controls.

HHC Article II: Impact of HHC on Cost

HHC Article II projects aimed to "to reduce the financial burden on local and state resources due to the over utilization of emergency rooms, corrections systems, and law enforcement resources as the first point of healthcare provision." This chapter addresses the following evaluation questions: "Did HHC housed participants incur lower costs associated with use health services under Medi-Cal?" and "Did HHC housed participants incur lower costs associated with arrests and incarcerations?"

Data sources for this chapter included Bi-annual Article II Reports submitted by HHC Article II grantees from June 2021 to December 2022 and Medi-Cal enrollment and claims data from January 2019 to December 2022. The Bi-annual Article II Reports were used to identify participants and their move-in dates. UCLA then obtained Medi-Cal enrollment and claims data, which included both managed care and fee-for-service encounters, to calculate estimated Medi-Cal payments per beneficiary per six-months. There were 230 participants that moved into housing through HHC by the end of 2022; however, UCLA only included in this analysis the 224 who were enrolled in Medi-Cal in the year prior to being housed.

UCLA identified a comparison group of Medi-Cal beneficiaries likely to experience homelessness using a previously developed and reliable methodology.[2] The comparison group was selected based on similar demographic, health status, and past use of acute care services. Medi-Cal payments were estimated by creating unique categories of service and attributing a fee to each Medi-Cal claim in that category (Appendix A: Data Sources and Analytic Methods). UCLA calculated the average payment per HHC participants and for the comparison group prior to and after HHC housing.

UCLA measured the impact of HHC on estimated payments by developing DD models in six-month intervals. This included first measuring trend differences in payment before housing (from 7-12 months vs. 1-6 months) and after housing (from 1-6 months vs. 7-12 months) for both HHC participants and the control group. Next, the difference between the differences in trends between the two groups were measured. UCLA conducted a second DD analysis to show the immediate impact of HHC on payments by focusing on the change in payment from 1-6

[2] Pourat, Nadereh, Dahai Yue, Xiao Chen, Weihao Zhou, and Brenna O'Masta. "Easy to Use and Validated Predictive Models to Identify Beneficiaries Experiencing Homelessness in Medicaid Administrative Data." Health Services Research n/a, no. n/a. Accessed April 24, 2023. https://doi.org/10.1111/1475-6773.14143.

months before move-in to 1-6 months after move-in for both groups and then difference in these differences. These models were adjusted for beneficiary demographics as well as health status, health complexity, and use of services prior to move-in. Further details can be found in Appendix A: Data Sources and Analytic Methods.

The estimated payments reported in this section are not equivalent to actual Medi-Cal expenditures for multiple reasons, including significant differences between this attribution methodology and per member per month payments to managed care plans for enrolled beneficiaries. These estimated payments are primarily intended to compare change in trends between HHC participants and the comparison group. See Appendix A: Data Sources and Analytic Methods for further detail and limitations.

Change in Estimated Medi-Cal Payments Prior to and After Housing Among HHC Participants

The average total estimated Medi-Cal payments per HHC participant per year was $32,315 in the year prior to housing, which ranged from a low of $0 to a high of $249,277 (Exhibit 37). In the year after housing, this average amount declined to $17,585, with a high of $215,109. Examining the distribution of these payments shows that the estimated payments for participants at the 25th, 50th and 75th quartile all declined in the year after housing.

Exhibit 37: Estimated Annual Total Medi-Cal Payments Among Housed HHC Participants in the Year Prior to and Year After Housing

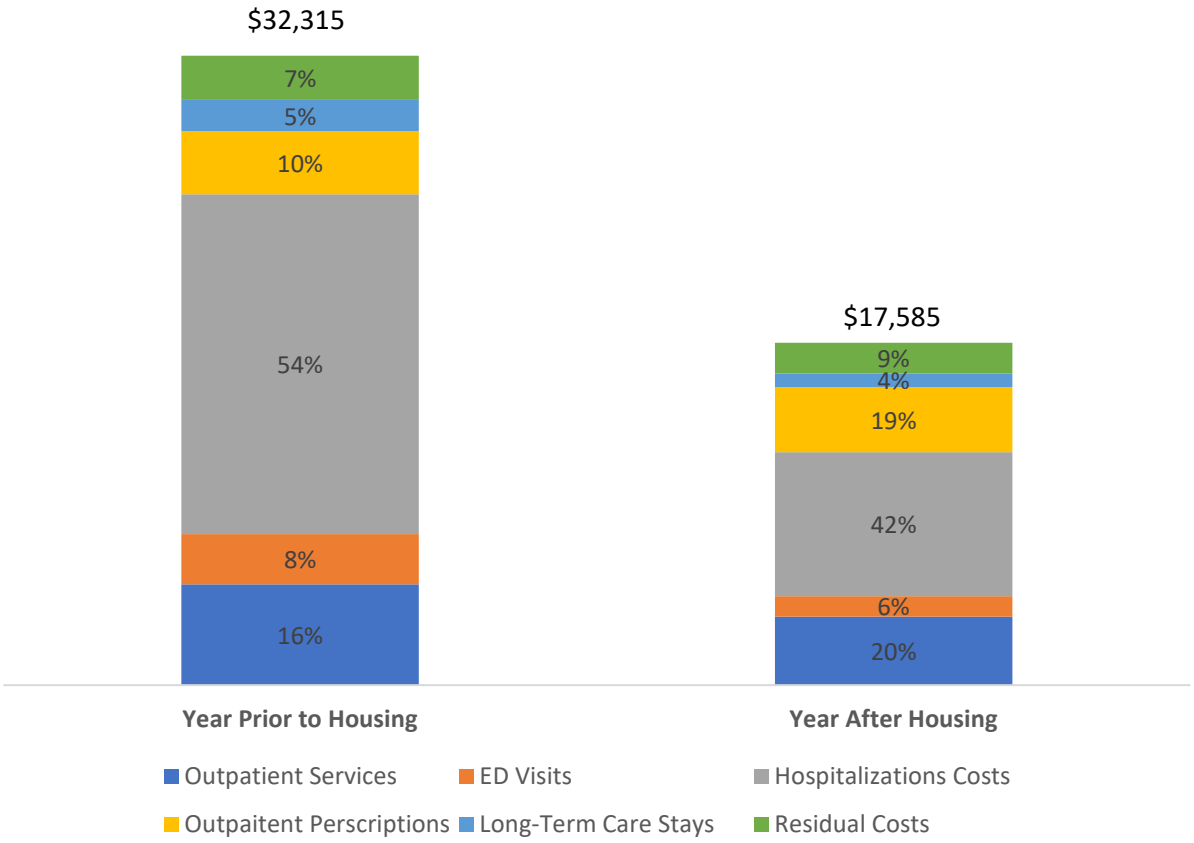
	Year Prior to Housing	Year After Housing
Mean	$32,315	$17,585
Range		
Minimum	$0	$0
Maximum	$240,277	$215,109
Quartiles		
25th percentile	$3,515	$573
50th percentile	$14,286	$4,194
75% percentile	$43,047	$20,016

Source: UCLA analysis of Medi-Cal claims data from January 2020 to December 2022.
Notes: HHC is the Housing for a Healthy California program.

UCLA estimated the proportion of the total average estimated Medi-Cal payment in six categories of service including outpatient services, outpatient prescriptions, hospitalizations,

emergency room visits, long-term care stays, and other residual services (Exhibit 38). The latter category included services such as imaging and laboratory, home health, physical therapy, emergency transportation, and all other types of services covered by Medi-Cal. Of the estimated $32,315 per HHC housed beneficiary in the year before being housed, the largest proportions were spent on hospitalizations (54%), outpatient services (16%), outpatient prescriptions (10%), and ED visits (8%). During the year following being housed, patterns of payments changed, with declines in all these categories except for outpatient services, which increased from 16% to 20%, and outpatient prescription, which increased from 10% to 19%. A small increase in payments for residual services (from 7% to 9%) was also observed.

Exhibit 38: Proportion of Estimated Medi-Cal Payments by Categories of Service for HHC Participants in the Year Prior to and Year After Being Housed



Source: UCLA analysis of Medi-Cal claims data from January 2020 to December 2022.
Note: ED is Emergency Department. HHC is the Housing for a Healthy California program. Includes 224 HHC participants that were housed and had Medi-Cal data prior to housing.

Differences in Trends in Medi-Cal Payments Before and After Housing Among HHC Participants and the Comparison Group

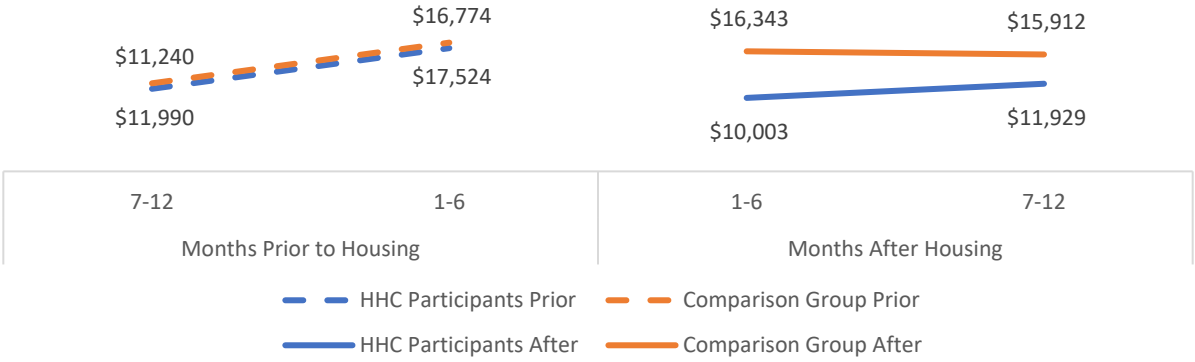
The DD analysis was conducted for total payments, ED visit payments, and hospitalization payments following the methods described earlier in this chapter. The findings of these analyses are described below and illustrate whether HHC resulted in lower costs for housed participants than the control group who were not housed by HHC.

Total Estimated Medi-Cal Payments

Exhibit 39 shows a statistically significant increase in the total estimated Medi-Cal payments prior to housing by $5,535 per HHC participants and the comparison group per six-months. After housing, this rate increased by $1,925 for HHC participants, but this increase was not statistically significant. This rate declined for the comparison group by -$435, but this was also not significant. The difference in these trends between the two groups (DD: $2,357) was not significant.

Comparing changes from six months before to six months after being housed indicated a significant decline in total costs for HHC housed participants by -$6,771. Compared to the control group this decline was statistically greater among HHC housed participants by $5,590. This analysis indicated that HHC reduced total payments for HHC housed participants and this reduction was significantly greater than declines observed due to other contextual factors seen in the comparison group.

Exhibit 39: Trends in Total Estimated Medi-Cal Payments per Beneficiary per Six-Months Prior to and After Housing for Housed HHC Participants and the Comparison Group



	Trend Prior to Housing	Trend After Housing	Change in Trend from Prior to After Housing		Change in Six-Month Utilization from Prior to After Housing	
			Difference	Difference-in-Difference	Difference	Difference-in-Difference
HHC Participants	**$5,535***	$1,925	-$3,609	$2,357	**-$6,771***	**-$5,590***
Comparison Group	**$5,535***	-$431	**-$5,966***		-$1,181	

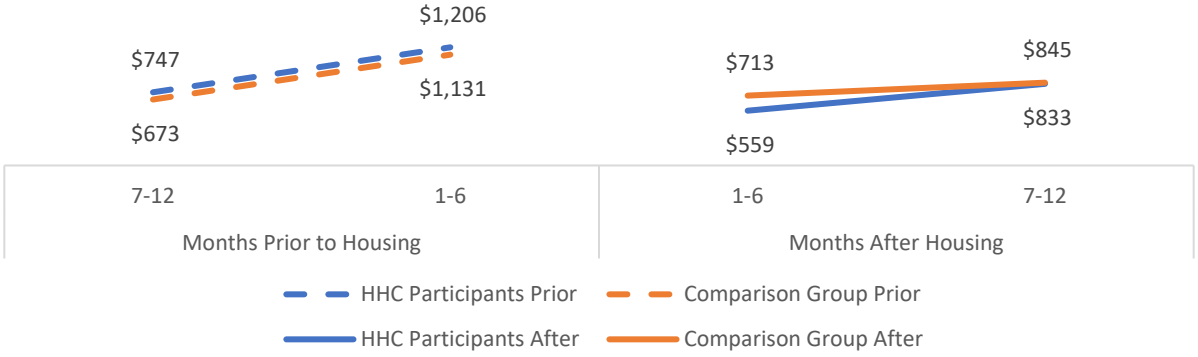
Source: UCLA analysis of Medi-Cal claims data from January 2020 through December 2022.
Notes: * Denotes p≤0.05, a statistically significant difference. Trend prior to housing is calculated as: (1-6 months prior minus 7-12 months prior). Trend after housing is calculated as: (7-12 months after minus 1-6 months after). Difference between trends is calculated as: (trend after housing minus trend prior to housing). Difference between six-month utilization is calculated as: (utilization 1-6 after housing minus utilization 1-6 month prior to housing). Difference-in-difference is calculated as: (difference in HHC participants – difference in comparison group). HHC is the Housing for a Healthy California Program. Includes 224 HHC participants with Medi-Cal data prior to housing and 448 matched controls.

Estimated Payments for Emergency Department Visit Followed by Discharge

Exhibit 40 shows very similar trends in estimated payments for ED visits to total estimated payments. In the year prior to housing, there was a statistically significant increase in the estimated ED payments by $459 per six-months for both HHC participants and the comparison group. After housing, this rate increased by $274 for HHC participants, but this increase was not statistically significant. This rate increased for the comparison group by $133 and was also not statistically significant. The difference in these trends (DD: $141) was not significant.

Comparing changes from six months before to six months after being housed indicated a significant decline in ED payments for both HHC housed participants and the control group but the difference was not statistically significant (DD: -$229). This analysis indicated that HHC reduced ED payments for HHC housed participants but not significantly more than contextual changes leading to similar beneficiaries not housed by HHC.

Exhibit 40: Trends in Estimated Payments for Emergency Department Visit Followed by Discharge per Beneficiary per Six-Months Prior to and After Housing for Housed HHC Participants and a Comparison Group



	Trend Prior to Housing	Trend After Housing	Change in Trend from Prior to After Housing		Change in Six-Month Utilization from Prior to After Housing	
			Difference	Difference-in-Difference	Difference	Difference-in-Difference
HHC Participants	**$459***	$274	-$185	$141	**-$647***	-$229
Comparison Group	**$459***	$133	**-$326***		**-$419***	

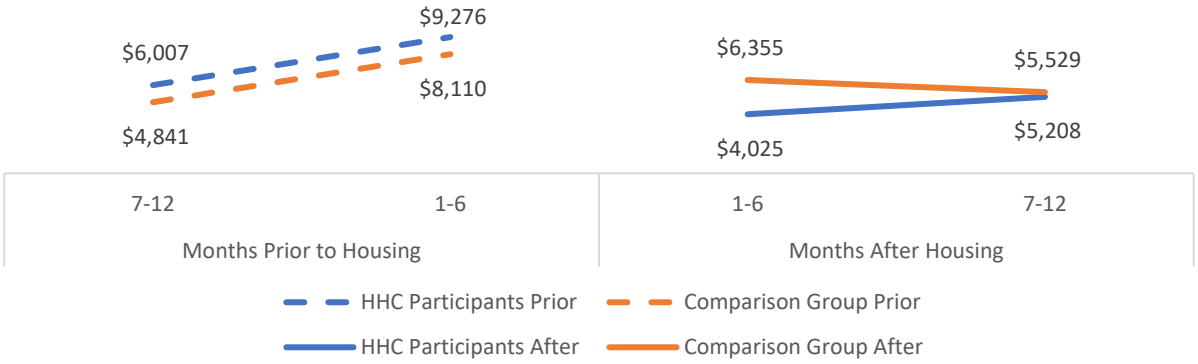
Source: UCLA analysis of Medi-Cal claims data from January 2020 through December 2022.
Notes: Includes ED visits that do not result in hospitalization. * Denotes p≤0.05, a statistically significant difference. Trend prior to housing is calculated as: (1-6 months prior minus 7-12 months prior). Trend after housing is calculated as: (7-12 months after minus 1-6 months after). Difference between trends is calculated as: (trend after housing minus trend prior to housing). Difference between six-month utilization is calculated as: (utilization 1-6 after housing minus utilization 1-6 month prior to housing). Difference-in-difference is calculated as: (difference in HHC participants – difference in comparison group). HHC is the Housing for a Healthy California Program. Includes 224 HHC participants with Medi-Cal data prior to housing and 448 matched controls.

Estimated Hospitalization Payments

Exhibit 41 shows a statistically significant increase in the estimated Medi-Cal payments for hospitalizations prior to housing by $3,269 per six-months for both HHC participants and the comparison group. After housing, this rate increased by $1,183 for HHC participants, but this increase was not statistically significant. In contrast, this rate declined for the comparison group by -$826. The difference in these trends (DD: $2,009) was not significant.

Comparing changes from six months before to six months after being housed indicated a significant decline in estimated payments for hospitalizations for both HHC housed participants and the control group. However, HHC house participants had a significantly greater change during this period by -$3,496. This analysis indicated that HHC reduced payments for hospitalizations for HHC housed participants and this reduction was significantly greater than declines observed due to other contextual factors seen in the comparison group.

Exhibit 41: Trends in Estimated Hospitalization Payments per Beneficiary per Six-Months Prior to and After Housing



	Trend Prior to Housing	Trend After Housing	Change in Trend from Prior to After Housing		Change in Six-Month Utilization from Prior to After Housing	
			Difference	Difference-in-Difference	Difference	Difference-in-Difference
HHC Participants	**$3,269***	$1,183	-$2,085	$2,009	**-$5,251***	**-$3,496***
Comparison Group	**$3,269***	-$826	**-$4,094***		**-$1,755***	

Source: UCLA analysis of Medi-Cal claims data from January 2020 through December 2022.
Notes: * Denotes p≤0.05, a statistically significant difference. Trend prior to housing is calculated as: (1-6 months prior minus 7-12 months prior). Trend after housing is calculated as: (7-12 months after minus 1-6 months after). Difference between trends is calculated as: (trend after housing minus trend prior to housing). Difference between six-month utilization is calculated as: (utilization 1-6 after housing minus utilization 1-6 month prior to housing). Difference-in-difference is calculated as: (difference in HHC participants – difference in comparison group). HHC is the Housing for a Healthy California Program. Includes 224 HHC participants with Medi-Cal data prior to housing and 448 matched controls.

Impact of HHC on Cost to Law Enforcement and Corrections

UCLA was unable to calculate costs to law enforcement and corrections because no reliable measures of arrests or incarcerations before, during, or after being housed by HHC were available. Instead, UCLA searched the existing literature for evidence of such costs or savings from programs that housed individuals experiencing homelessness and measured the impact of housing on incarceration and associated cost to corrections or law enforcement systems.

The evidence indicated that homelessness increases the likelihood of incarceration and incarcerated individuals also have an increased likelihood of homelessness.[3] The 2019 Adult Demographic Survey by the Los Angeles Homeless Services Authority (LAHSA) reported that almost two-thirds (64%) of unsheltered adults experiencing homelessness had been involved with the justice system; including jail, prison, adult and juvenile probation, parole, and juvenile detention.[4]

One study documented Los Angeles County's total expenditures across six departments for single individuals experiencing homelessness during fiscal year 2014-2015 and found that more than 10% of the study population had arrests that led to jail stays. Over 10% of these arrests resulted in jails stays that were longer than three months and these long stays accounted for more than half of jail costs in this population ($38.4 million of $74.1 million). The average cost spent per individual experiencing homelessness that interacted with the Sheriff's Department or Probation was $5,397 or $4,328, respectively.[5]

Housing solutions in Los Angeles County, such as Project 50 or Just in Reach Pay for Success (JIR PFS), have demonstrated that programs that provide affordable housing to individuals experiencing homelessness have the potential for cost-savings to corrections and law enforcement. Project 50, a program that housed 50 individuals from Skid Row in Los Angeles County from 2008 to 2009, aimed to provide housing and integrative supportive services. The yearly average days of incarceration per participant dropped from 31 days to 19 days and resulted in a 28% ($12,444 to $8,900) reduction in incarceration costs (includes booking, daily

[3] Cusack, Meagan, and Ann Elizabeth Montgomery, "Examining the Bidirectional Association Between Veteran Homelessness and Incarceration Within the Context of Permanent Supportive Housing," Psychological Services, Vol. 14, No. 2, 2017, pp. 250–256.
[4] Homeless Policy Research Institute, Homelessness and the Criminal Justice System, Los Angeles, Calif.: Homeless Policy Research Institute, Sol Price Center for Social Innovation, University of Southern California, July 9, 2020.
[5] Wu, F., & Stevens, M. (2016). The services homeless single adults use and their associated costs: An examination of utilization patterns and expenditures in Los Angeles County over one fiscal year. Los Angeles Chief Executive Office. https://www.aisp.upenn.edu/wp-content/uploads/2015/03/LACountyHomelessness2016.pdf

maintenance, and medical services, which includes both physical and mental health treatment)[6] versus 40 days of incarceration and a 42% increase ($17,733 to $25,229) in associated costs for demographically similar individuals who did not participate in the program.

The JIR PFS program, a program providing a long-term housing subsidy with intensive case management services for over 300 formerly incarcerated individuals with a history of homelessness or chronic illness from 2017 to 2019,[7] was associated with a decrease of 24 days in jail over a 12-month post housing period and a decrease in jail service costs of $16,891 per participant versus $37,201 in associated costs for individuals who did not participate in the program.[8]

[6] Toros, H., Stevens, M., & Moreno, M. (2012, August 12). Project 50: The cost effectiveness of the permanent supportive housing model in the skid row section of Los Angeles County. County of Los Angeles Chief Executive Office Service Integration Branch. https://socialinnovation.usc.edu/homeless_research/project-50-cost-effectiveness-permanent-supportive-housing-model-skid-row-section-los-angeles-county/

[7] L.A. Program to Divert Homeless from Jail into Supportive Housing Decreases Use of County Services | RAND

[8] Hunter, Sarah B., Adam Scherling, Matthew Cefalu, and Ryan K. McBain, Just in Reach Pay for Success: Impact Evaluation and Cost Analysis of a Permanent Supportive Housing Program, RAND Corporation, RR-A1758-1, 2022. As of April 13, 2023: https://www.rand.org/pubs/research_reports/RRA1758-1.html

Conclusions

As of December 2022, the evaluation findings of HHC indicated notable progress in identifying scattered-site and project-based rental units by four Article II grantees that led to housing of Medi-Cal beneficiaries experiencing homelessness. In addition to a Housing First approach, evidence further showed that HHC participants were referred to and often received an array of supportive services designed to address their medical and social needs, promote retention, prevent incarcerations or involvement with law enforcement, and improve health and well-being. Findings further indicated declines in short-term use of acute services and associated payments that were attributable to housing individuals under HHC.

A closer look at grantee efforts indicated varying degrees of progress in availability of rental units and housing of participants. The majority of Article II grantees did not reach their projected number of housing units by December 2022 even though some had participants that had entered the program and were awaiting placement into housing. While some delays were attributable to less predictable challenges related to the COVID-19 pandemic that disrupted usual fluctuations in housing and rental supply, others were the result of predictable challenges such as time required to identify appropriate units or landlords and competing programs that can shrink the pool of eligible participants. Other potentially predictable challenges were related to pros and cons of scattered vs. project-based housing.

The examination of the grantee approach and activities to housing participants suggested a streamlined process to identify and house individuals and pointed out the importance of existing relationships between grantees and community-based organizations or landlords established under other programs, such as Whole Person Care. Grantees faced challenges to identify participants who met the required utilization of acute care services criteria and were not housed by competing programs. Challenges identifying participants were compounded by a lack of access to a combined data system on housing and medical utilization.

Evaluation data confirmed that HHC participants were primarily those not stably housed in over a year and with high level of need due to physical health and behavioral health conditions. Similarly, evidence showed efforts to provide a wide array of supportive services as well as adjusting case manager caseloads when participants needed high-intensity of care and delivery of crisis management and behavioral health support. Data indicate the importance of a strong relationship and trust between participants and dedicated case managers. Successful retention

in the program was associated with active engagement of participants and referrals to needed resources.

Assessment of the short-term impact of housing HHC participants on their utilization of health care services and associated costs indicated that participants had a reduction in ED visits but this reduction was not accompanied with a decline in associated payment indicating that reduced visits were for avoidable reasons and limited level of care provided by the ED during the visit. These findings suggested that sustainable housing likely provided shelter from exposure to weather or violence. In addition, tenancy support and referrals to needed support services likely reduced the reasons for participants to turn to ED as a source of shelter or for non-urgent medical and behavioral needs.

Evidence further indicated that housing under HHC was associated with a decline in hospitalizations and their associated payments. These findings suggested that sustainable housing and shelter from adverse circumstances prevented hospitalizations due to exacerbation of chronic conditions by providing opportunities for rest or promoted health and well-being in alternative ways such as a place to keep and use medications. Sustainable housing may have further prevented admissions to hospitals following discharge from ED or prevented readmissions following a hospitalization because participants had a place to recuperate.

Evidence also indicated a reduction in overall payments for all services provided to participants following being housed. This reduction was greater than the reduction associated with hospitalizations. This finding suggested lower overall use and more appropriate use of outpatient services, prescription medications, or long-term care stays following being housed and in lieu of ED visits and hospitalizations. Such changes were likely due to ability of case managers to either directly address the needs of participants or refer them to outpatient and social service providers resulting in diversion of participants away from higher intensity and high-cost acute services. Collectively, the findings suggest that health and well-being of participants following housing may have improved.

A significant limitation of the evaluation of HHC was that the evaluation period was restricted to the first two years of HHC implementation due to HHC reporting requirements, but the program continued and was operational as of the date of this report. Due to delays in implementation for most grantees, many individuals were housed in the later part of the observation period and only had a short follow-up period to observe service use and associated

payments. The evaluation of HHC was further limited by lack of progress of two Article II grantees and all Article I grantee projects to complete initial construction or rehabilitation of the property in order to house HHC participants. Due to delayed implementation, the number of housed individuals included in this report was smaller than anticipated and may have resulted in a lack of adequate power to identify some program impacts. Additionally, data on costs to law enforcement and corrections were not available which prevented analysis of the impact of HHC interactions with law enforcement and corrections and their associated costs.

Evaluation findings highlighted the potential short-term benefits of a stable housing environment coupled with tenancy and other support services to promote health and well-being of individuals experiencing chronic homelessness and potential cost-savings due to shifts in service utilization. Evaluation findings suggest the following for continued implementation of HHC and future efforts to house individuals experiencing chronic homelessness:

- Weigh pros and cons of scattered-site vs. project-based housing when designing housing programs. For example, anticipate delays in construction of new projects but long-term benefits of on-site, dedicated supportive services that promote easy access to such services. Similarly, anticipate wait times for housing eligible participants in scattered-sites that fit their needs but greater flexibility and speed in housing participants in scattered-site rental assistance. Flexibility to allow longer timelines for implementation of some housing projects and oversight would increase the likelihood of success of housing programs.
- Promote availability of data systems that jointly include housing and health care utilization information in order to facilitate identification and prioritization of participants in need of housing and inform their decision making.
- Include dedicated case managers and adjust their caseloads depending on the level of need of participants they support to promote their ability to provide the range and depth of needed services. Individuals experiencing chronic homelessness who have multiple physical and chronic conditions require intensive support and multiple referrals to health and social services providers. Smaller caseloads allow for trust and rapport building, leading to meaningful engagement with case managers and stronger uptake of needed services.
- Develop and build on existing networks and partnerships and increase collaboration between government and community-based programs to promote housing availability

and reduce barriers to identification and housing eligible individuals using a "no-wrong door" and Housing First approach.

- Assess longer term impacts of housing on health and well-being of individuals experiencing chronic homelessness by ensuring the evaluation follow-up period covers multiple years. Early reductions in use of acute services and associated payments may not continue in the future without adaptation of tenancy and housing support services to the changing needs of individuals once housed. Once stably housed, the role of housing as a contributor to poor health and reliance on acute settings for shelter or support services is likely to be diminished. However, newly housed individuals are likely to continue to need other services such as intensive health and behavioral health care management to further promote their health.
- Assess the impact of HHC participants housed by Article I grantees and remaining Article II grantees that experienced delays. The increased number of HHC housed participants will increase the strength of the findings, assuming that housing individuals would have a similar impact on health and health service use.
- Facilitate access to data that allows for the impact of HHC or similar programs on the frequency of interactions with law enforcement, the number and length of stays in correctional facilities and the associated costs with these encounters.

Appendix A: Data Sources and Analytic Methods

UCLA Center for Health Policy Research

Overview of Data Sources

UCLA used all available data sources for this evaluation, including Article II Supportive Services Plans (SSPs), bi-annual reports, interviews with grantees, and Medi-Cal enrollment and claims data (Exhibit 42).

Exhibit 42: Overview of HHC Evaluation Data Sources

Data Source	Description	Time Period
Article I*		
Article I Project Lists	Included information on funding awards, project location, lead service provider, projected permanent closing date, projected occupancy.	Provided March 2023
Annual Article I Reporting Template	Reporting template to be used for required annual reporting by Article I sponsors after permanent close of their project.	N/A
Article II		
Supportive Services Plans (SSPs)	Described planned supportive services, contracted partners, staffing composition, and intended implementation strategies.	Submitted by each county as part of their HHC funding application in FY 19-20
Article II Bi-annual Reports	Included data on HHC program participant demographics, number of participants housed, supportive services offered and received, and other information such as homelessness history, arrests, or incarcerations. Included narrative text for descriptions of challenges and solutions to program implementation and delivery of supportive housing services. Included program budget and expenses. Each report covered activities from the previous six months.	Submitted bi-annually in January and July by each grantee. Bi-annual reports were submitted on July 2021, January 2022, July 2022, January 2023, and July 2023.
Key Informant Interviews with Article II Grantees	Grantees discussed their program structure including staffing; contracted partners; strategies for outreach, identification, and engagement of participants; case management model; supportive services provided; and challenges, successes, and lessons learned.	Interviews by UCLA in March 2023

	UCLA developed an Interview Protocol to guide Key Informant Interviews (see Exhibit 43).	
Medi-Cal enrollment and claims data	Data provided extensive detail on Medi-Cal enrollment, health status, and service use of participants that were Medi-Cal beneficiaries; used to estimate the number of healthcare services and Medi-Cal costs.	January 2019 through December 2022

Notes: HHC is the Housing for a Healthy California Program. *As of the date of this report, none of the grantees' projections had achieved "permanently closed" status, which is defined by HHC as the completion of initial construction or rehabilitation of the property and subsequent occupancy by HHC participants. Therefore, only Article I intentions are included in this report.

Analytic Methods

SSPs and Article II Bi-annual Reports

Qualitatively, UCLA used SSPs and Article II bi-annual reports to better understand intended Article II program implementation. Content was reviewed for emergent themes and descriptive examples.

A limitation of SSPs is that they were written prior to the HHC award, and did not reflect changes in program funding, implementation, and structure. UCLA validated the information synthesized from SSPs directly with grantees as presented in case studies (Appendix B: Article II Case Studies).

UCLA further used bi-annual report data quantitatively to describe program participant characteristics and housing patterns. A limitation of the bi-annual reports is that they may contain errors in data recording and entry, and certain fields may have been dependent on participant self-report (e.g., income).

Key Informant Interviews

To gain in-depth understanding of HHC, outside of narrative provided in Bi-annual Article II Reports, UCLA conducted semi-structured interviews with key informants from all six Article II counties. Interviews were conducted in March 2023 and lasted roughly 60 minutes.

HHC contacts were asked to include individuals with expertise on the county's implementation strategy and plan; often these individuals were from leadership and management roles (e.g., Director, project/program manager). Interviews were conducted with WPC Pilots via Zoom

video conferencing. Interviews were recorded and transcribed. Interviews were led by a member of the UCLA evaluation team, with input from additional members, as appropriate.

Interviews focused on greater understanding of overall experiences with HHC and associated infrastructure and processes, program implementation, and challenges, successes, and lessons learned. See Exhibit 43 for the interview protocol utilized for key informant interviews.

Exhibit 43: Article II Grantee Interview Protocol

- **Introduction of team members**. "Hi, my name is ___ and these are my colleague(s) _____. He/she/they are with me today to help ensure I cover all the bases and to take notes. Thank you for taking the time to speak with us today."
- **Broad evaluation goals**. "Before we begin, let me review some general information. This interview is being conducted as part of our evaluation of the Housing for a Healthy California, and is designed to supplement information already being provided in your supportive services plans and bi-annual reports. We will ask questions about your overall experiences with HHC and associated infrastructure and processes, program implementation, and challenges, successes, and lessons learned. We may also follow up on your responses to questions we posed in your case study review, to ensure we accurately represent your activities in our deliverables."
- **Interview format**: "We expect the interview to last between 1-1.5 hours. This interview is voluntary, and you are free to skip questions or stop or postpone the interview at any time."
- **Permissions.** "Because we value everything you have to say and want to make certain we don't miss anything, we would like to audio-record this interview. Is this okay with you? Only project staff will hear the recording and it will stay password protected on secure computers. Recordings will be transcribed, analyzed, and summarized. Your name will not be used in interview paperwork or in any final reports or publications. The recording is purely for our internal purposes. If you are not comfortable being recorded, we can take written notes instead."

[If Yes] Thank you. I will now turn on the recorder and re-ask this question of you to record your oral permission to record. [Turn on Recorder] This interview is being recorded. I am asking your oral permission to be recorded. Do you grant me your permission to record this interview session? [pause for "Yes" answer] As stated before in our earlier conversation, you can ask me to pause or turn off the recorder at any time.

[If No] OK, I will not be recording this session but only taking notes of our conversation.

[If recording] This is code number XXXXXX, and the date is XXXXXXX.

First, we'd like to gather a little background information.

1. Can you tell me a little bit about your role in [County name's] HHC program?
2. How long have you been in this role?
    - Were you hired specifically for HHC?
3. Can you provide a broad overview of how HHC functions in your County?
    - Walk us through what the experience might look like "on the ground" for an eligible participant.
4. Can you tell us about synergy or potential overlap with any other housing programs or initiatives in your county?
    - Can you explain the transition from WPC to HHC?
    - Is CalAIM part of this transition or integrated into your HHC program?
    - Does your HHC program have blended funding for any portion of the program (e.g., rental assistance, staffing, services)?
5. What are the "core elements" of your HHC program (e.g., in terms of infrastructure, partnerships, or services delivered)?
    - Which of these do you view as new or particularly innovative in terms of how housing services are delivered within your County?

[To understand critical partnerships, data sharing infrastructure (if any), and case management infrastructure and processes]

6. Overall, what has your experience been in identifying and engaging potential HHC participants?
    - How do you utilize the Coordinated Entry System (CES) or other methods?
7. Can you describe the typical process and timeline from identification of potential HHC participants to housing participants?
    - How do you ensure participants meet program eligibility criteria (specifically what data sources are used)?
8. Can you describe your case management model? (e.g., staff involved, location on v. off site, etc.)
9. What strategies do you utilize to keep participants housed?
    - What do you see as the main reasons that participants are unable to maintain housing and how could those issues be addressed?

10. Recognizing that acceptance of supportive services is "entirely voluntary, and not a requirement to obtain or continue in housing" - how do you encourage utilization and engagement of these services?
    - Can you speak to the variety of supportive services available and their utilization by participants in your program?
        - *Required Supportive Services = Housing Navigation, Case Management, Peer Support Services, Linkages to Primary Care, Behavioral Health and SUD, Connection to Benefits, Housing Retention Promotion, Services for Individuals with Co-occurring Disabilities/Disorders*
        - *Optional Supportive Services*
11. Do you provide supportive services prior to move-in date?
    - If so, how did services differ between "program entry" and "once being housed"?
12. What resources do you provide in regards to transportation?

Other elements we may want to assess here:

- *Whether generally housing individuals or families/multi-person households*
- *Access to primary care/use of telehealth*

13. What do you view as the critical success factors affecting whether HHC outcomes/program benefits are realized?
    - Specifically, program's ability to reduce inappropriate utilization of emergency department and hospitals? To reduce interactions with law enforcement? To increase appropriate use of outpatient services (primary care, behavioral health, etc.)?
14. If you could change one thing about HHC, what would it be?
15. What is your perceived impact on outcomes (e.g., ED utilization, patterns of care/utilization)?
16. Could you speak to overall impact and value of HHC to your organization/county?
17. Our evaluation is time-restricted; can you tell us about your future plans/intentions?

Medi-Cal Data

UCLA used Medi-Cal enrollment and claims data from January 1, 2019 to December 31, 2022 to create demographic indicators, health status indicators, health care utilization indicators, and estimated Medi-Cal payments both prior to and after HHC housing. UCLA selected a comparison group of Medi-Cal beneficiaries to examine changes in health care utilization and associated payment using a quasi-experimental design and a difference-in-difference (DD) methodology. Claims data included both managed care and fee-for-service encounters.

Demographic Indicators

Exhibit 44 displays demographic indicators created by UCLA using Medi-Cal monthly enrollment data. UCLA calculated age based on participant's date housed by HHC. While not common, if the Medi-Cal enrollment data contained conflicting data for gender, race, or language, UCLA used the most frequently reported category.

Exhibit 44: Demographic Indicators

Indicators	Definitions
Age	Participant's final age in years at the time of housing.
Gender	Indicates whether a participant is male or female.
Race	The race label for a participant: White, Hispanic, African American, Asian American and Pacific Islander, American Indian and Alaska Native, other, or unknown.
English as Primary Language	Indicating whether a participant's primary language is English or not.
Number of Months with Full Scope Coverage	Full scope coverage is defined as at enrollment in at least one dental MCP and another non-dental MCP during the eligible date period. The number of months that an enrollee is full scope is reported for the year prior to the participant's housing.

Health Status Indicators

UCLA used Medi-Cal claims data from January 1, 2019 to December 31, 2022 to assess health status of HHC participants prior to being house by HHC. UCLA followed CMS's Chronic Condition Warehouse (CCW) to obtain a complete list of chronic condition and potentially chronic or disabling condition categories impacting HHC participants prior to being housed. Additionally, UCLA calculated CDPS (Chronic Illness and Disability Payment System Risk Score) for all HHC participants. Exhibit 45 displays these indicators.

Exhibit 45: Health Status Indicators

Indicators	Definition
Chronic Condition Warehouse (CCW) Conditions	The percentage of participants meeting each of the CCW condition category criteria in the period prior to housing.
CDPS (Chronic Illness and Disability Payment System Risk Score)	The mean, median, and standard deviation of CDPS among all participants. The CDPS is calculated based on the International Classification of Diseases (ICD) diagnosis codes in Medi-Cal claims data.

Healthcare Utilization Indicators

UCLA also created healthcare biannual utilization indicators using Healthcare Effectiveness Data and Information Set (HEDIS) 2019 Volume 2 definitions, National Uniform Claim Committee taxonomy designations, the Chronic Conditions Warehouse, and the American Medical Association's Current Procedure Terminology (CPT) Codebook. Exhibit 46 displays these indicators.

Exhibit 46: Healthcare Utilization Indicators

Indicators	Definitions
Hospitalizations per six member months	(The number of hospitalizations during a six months period divided by the number of months enrolled in Medi-Cal during those six months) multiple by six
Average length of hospitalization (days)	The average length of hospitalizations during the period of interest
ED Visits resulting in discharge per six member months	(The number of ED visits followed by discharge during a six months period divided by the number of months enrolled in Medi-Cal during those six months) multiple by six

Attributing Estimated Medi-Cal Payments to Claims

Background

The great majority of services under Medi-Cal are provided by managed care plans that receive a specific capitation amount per member per month and do not bill for individual services received by Medi-Cal beneficiaries. While managed care plans are required to submit claims to Medi-Cal, these claims frequently include payment amounts of unclear origin that are different from the Medi-Cal fee schedule. A small and unique subset of Medi-Cal beneficiaries are not enrolled in managed care and receive care under the fee-for-service (FFS) reimbursement methodology and have claims with actual charges and paid values. FFS claims are reimbursed primarily using fee schedules developed by Medi-Cal. The capitation amounts for managed care plans are developed using the same fee schedules by Mercer annually, using complex algorithms and other data not included in claims.

To address the gaps in reliable and consistent payment data for all claims, UCLA estimated the amount of payment per Medi-Cal claim under HHC using various Medi-Cal fee schedules for services covered under the program. The methodology included (1) specifying categories of service observed in the claims data, (2) classifying all adjudicated claims into these service categories, (3) attributing a dollar payment value to each claim using available fee schedules and drug costs, and (4) examining differences between these and available external estimates. UCLA estimated payments for both managed care and FFS claims to promote consistency in payments across groups and to avoid discrepancies due to different methodologies.

The payment estimates generated using this methodology are not actual Medi-Cal expenditures for health care services delivered. Rather, they represent the estimated amount of payment for services and are intended for measuring whether HHC led to efficiencies by reducing the total payments for HHC participants before and after housing, and in comparison, to a group of comparison patients in the same timeframe.

Service Category Specifications

Data Sources

UCLA used definitions from multiple sources to categorize and define different types of services. These sources included Medi-Cal provider manuals, HEDIS value set, DHCS 35C File,

American Medical Association's CPT Codebook, National Uniform Code Committee's taxonomy code set, and other available sources.

- DHCS's Medi-Cal provider manuals included billing and coding guidelines for provider categories and some services.
- The HEDIS Value Set by the National Committee for Quality Assurance used procedure codes (CPT and HCPCS), revenue codes (UBREV), place of service codes (POS), and Systematized Nomenclature of Medicine-Clinical Terms (SNOMED CT) to define value sets that measure performance in health care. For example, the HEDIS value set "ED" is a combination of procedure codes that describe emergency department services and revenue codes specifying that services were provided in the emergency room.
- DHCS Paid Claims and Encounters Standard 35C File (DHCS 35C File) provided specifications to managed care plans on how claims must be submitted and contained detailed information about claims variables and their meaning and utility, such as vendor codes describing the location of services and taxonomy codes describing the type of provider and their specializations.
- The American Medical Association's Current Procedure Terminology (CPT) Codebook contained a list of all current procedural terminology (CPT) codes and descriptions that are used by providers to bill for services.
- The National Uniform Claim Committee's (NUCC's) Health Care Provider Taxonomy code set identified provider types such as Allopathic and Osteopathic Physician and medical specialties such as Addiction Medicine defined by taxonomy codes.

Methods

UCLA constructed eighteen mutually exclusive categories of service (Exhibit 47).

Available claims data included managed care, fee-for-service, and Short-Doyle. Some categories were defined using complementary definitions from more than one source.

UCLA assigned claims to only one of the eighteen service categories to avoid duplication when calculating total estimated payments. The outpatient services category may include claims included in other categories and therefore is not included in calculation of the total estimated

payment in this report. UCLA assigned claims to the first service category a claim meets the criteria for as ordered in Exhibit 47.

All services, apart from primary care visits, provided on the day of an ED visit were grouped as part of the ED visit to represent the total cost of the visit. For example, patients may have received transportation to an emergency department and laboratory tests during the emergency department visit, and these services were included in the ED category rather than the transportation or laboratory services categories. This approach may have included lab or transportation services in the ED category that were not part of the ED visit, and may have undercounted lab and transportation in their respective categories. However, this was necessary because claims data lacked information on the specific time of day when services were rendered. Similarly, all claims for services received during a hospitalization were counted as part of the same stay and were excluded from other categories of service, except for primary care visits on the day of admission. Other categories were identified solely by the procedure code or place of service and were not bundled with other services occurring on the same day, such as long-term care, home health/home and community-based services, community-based adult services, FQHC services, labs, imaging, outpatient medication, transportation, and urgent care.

Some claims lacked the information necessary to be categorized and were classified under an "Other Services" category. These frequently included physician claims without a defined provider taxonomy and durable medical equipment codes that were billed separately and could not be associated with an existing category.

Exhibit 47: Description of Mutually Exclusive Categories of Service*

Order	Service category	Definition source	Description
1	Emergency Department Visits (ED)	HEDIS	Place of service is hospital emergency room and procedure code is emergency service
2	Hospitalizations	DHCS 35C File	Place of service is inpatient and admission and discharge dates are present and are on different days
3	Hospice Care	DHCS 35C File, HEDIS, and DHCS Medi-Cal Provider Manuals	Provider is hospice or procedure code is hospice service
4	Long-Term Care (LTC) Stays	DHCS 35C File	Claim is identified as LTC or provider is LTC organization; stays one day apart are counted as one visit, stays two or more days apart are separate stays
5	Home Health and Home and Community-Based Services (HH/HCBS)	DHCS 35C File and DHCS Medi-Cal Provider Manuals	Provider is a home health agency or home and community-based service waiver provider, procedure is home health or home and community-based service
6	Community-Based Adult Services (CBAS)	DHCS 35C File and DHCS Medi-Cal Provider Manuals	Provider is adult day health care center or procedure code is community-based adult service, which are health, therapeutic and social services in a community-based day health care program
7	Federally Qualified (FQHC) and Rural Health Center (RHC) Services	DHCS 35C File	Provider is an FQHC or RHC
8	Laboratory Services	DHCS 35C File	Claim is identified as clinical laboratory, laboratory & pathology services, or laboratory tests
9	Imaging Services	DHCS 35C File	Claim is identified as portable x-ray services or imaging/nuclear medicine services

Order	Service category	Definition source	Description
10	Outpatient Medication	DHCS 35C File	Claim is identified as pharmacy
11	Transportation Services	DHCS 35C File	Claim is identified as medically required transportation
12	Primary Care Services	National Uniform Claim Committee	Provider is allopathic and osteopathic physician (with specialization in adult medicine, adolescent medicine, or geriatric medicine, family medicine, internal medicine, pediatrics, or general practice), or physician assistant or nurse practitioner (with specialization in medical, adult health, family, pediatrics, or primary care)
13	Specialty Care Services	National Uniform Claim Committee	Provider is allopathic and osteopathic physician or physician assistant or nurse practitioner (with all specializations not captured in the Primary Care Services category)
14	Outpatient Facility Services	DHCS 35C File	Claim is identified as outpatient facility
15	Dialysis Services	DHCS 35C File and CPT Codebook	Provider is a dialysis center and procedure is dialysis
16	Therapy Services	DHCS Medi-Cal Provider Manual	Procedure code is occupational, physical, speech, or respiratory therapy
17	Urgent Care Services	National Uniform Claim Committee	Provider is ambulatory urgent care facility
18	Other Services	N/A	Provider, procedure, or place of service is not captured above
N/A	Outpatient Services	HEDIS	Claim type is outpatient and procedure code, revenue code, or place of service code is outpatient

Source: UCLA Methodology.
Notes: * indicates categories are mutually exclusive except for outpatient services category.

Attributing Payments to Specific Services

To attribute payments to each category of service, UCLA developed methods to calculate an estimated payment for each category based on available data.

Exhibit 48 displays the categories of service and what is included in the calculation of estimated payments for each category.

Exhibit 48: Category of Service and Payment Descriptions

Category of Service	Calculation of Estimated Payment
Emergency Department Visits (ED)	Payments for all services taking place in the emergency department of a hospital, including services on the same day of the ED visit, excluding services by PCPs and FQHCs and RHCs. Two sub-categories are reported: ED visits followed by hospitalizations and all other ED visits that are followed by discharge
Hospitalizations	Payments for all services that take place during a hospitalization, excluding visits with primary care providers on the first or last day of the stay, FQHC visits on the first or last day of the stay, or ED visits that preceded hospitalization
Hospice Care	Payments for hospice services in an LTC facility or Home Health setting, excluding hospice services rendered during a hospitalization
Long-Term Care (LTC) Stays	Institutional fees billed by LTC facilities; the per diem rate includes supplies, drugs, equipment, and services such as therapy
Home Health and Home and Community-Based Services (HH/HCBS)	Payments for services provided by a home health agency (HHA) and services provided through the home and community-based services (HCBS) waiver
Community-Based Adult Services /(CBAS)	Payments for community-based adult services and for services rendered at an adult day health care center
Federally Qualified (FQHC) and Rural Health Center (RHC) Services	Payments for all services provided in an FQHC or RHC

Category of Service	Calculation of Estimated Payment
Laboratory Services	Payments for laboratory services, except those provided during a hospitalization or ED visit
Imaging Services	Payment for imaging services, except those provided during a hospitalization, ED visit, or LTC stay
Outpatient Medication	Payments for outpatient drug claims, excluding prescriptions filled on the same day as an ED visit or on the day of discharge from a hospitalization
Transportation Services	Payments for medically required transportation, excluding transportation on the same day as an inpatient admission or an emergency department visit
Primary Care Services	Payments for services provided by a primary care physician
Specialty Care Services	Payments for services provided by a specialist, excluding services provided during an inpatient stay or an emergency department visit, and excluding facility fees
Outpatient Facility Services	Facility fees paid to hospital outpatient departments and ambulatory surgical centers
Dialysis Services	Payments for dialysis services rendered in a dialysis center
Therapy Services	Payments for occupational, speech, physical, and respiratory therapy services
Urgent Care Services	Payments for services provided in an urgent care setting
Other Services	Payments for services not captured above
Outpatient Services	Payments for all services delivered in an outpatient setting

Source: UCLA Methodology.

UCLA used all available Medi-Cal fee schedules and supplemented this data with other data sources as needed. Payment data sources, brief descriptions, and the related categories of services they were attributed to are provided in Exhibit 49.

Exhibit 49: Payment Data Sources

Source	Description	Applicable Service Categories
Medi-Cal Physician Fee Schedule	Contains rates set by DHCS for all Level I procedure codes that are reimbursable	ED, Hospitalizations, Hospice, LTC, HH/HCBS,

Source	Description	Applicable Service Categories
Annual files 2013 to 2020 inflated/deflated to 2019	by Medi-Cal for services and procedures rendered by physicians and other providers	CBAS, Imaging, Transportation, Primary Care, Specialty Care, Dialysis, Urgent Care, Other, and Outpatient Services
Durable Medical Equipment (DME) Fee Schedule Annual files 2017 to 2020 inflated/deflated to 2019	Contains rates set by CMS for Level II procedure codes for durable medical equipment such as hospital beds and accessories, oxygen and related respiratory equipment, and wheelchairs	ED, Hospitalizations, Hospice, LTC, HH/HCBS, CBAS, Transportation, Primary Care, Specialty Care, Dialysis, Urgent Care, and Other
Medical Supplies Fee Schedules October 2019	Contains rates set by DHCS for supplies such as needles, bandages, and diabetic test strips	ED, Hospitalizations, Hospice, LTC, HH/HCBS, CBAS, Transportation, Primary Care, Specialty Care, Dialysis, Urgent Care, and Other
Average Sales Price Data (ASP) for Medicare Part B Drugs Annual files 2014 to 2020 inflated/ deflated to 2019	Contains rates set by CMS for procedure codes for physician-administered drugs covered by Medicare Part B	ED, Hospitalizations, Hospice, LTC, Primary Care, Specialty Care, and Other
CMS MS-DRG grouping software, DHCS's APR-DRG Pricing Calculator 12/1/2019	Contains Diagnostic Related Grouping (DRG) codes used for hospitalizations (CMS), base rate per DRG (DHCS) and DRG weights (CMS)	Hospitalizations, LTC
FQHC and RHC Rates 12/19/2018 inflated to 2019	Contains rates set by DHCS for services provided by FQHCs and RHCs	FQHC and RHC

Source	Description	Applicable Service Categories
Hospice per diem rates 9/28/2020 deflated to 2019	Contains rates set by DHCS for hospice stays and services	Hospice
Nursing Facility Level A per diem rates 8/1/2019	Contains per diem rates set by DHCS per county for Freestanding Level A Nursing Facilities	LTC, Hospice
Distinct Part Nursing Facilities, Level B 8/1/2019	Contains per diem rates set by DHCS for nursing facilities that are distinct parts of acute care hospitals	LTC, Hospice
Home Health Services Rates 8/1/2020 deflated to 2019	Contains billing codes and reimbursement rates set by DHCS for procedure codes reimbursable by home health agencies	Home health
Home and Community-Based Services Rates 8/1/2020 deflated to 2019	Contains billing codes and reimbursement rates set by DHCS for the home and community-based services program	Home and community-based services
Community-Based Adult Services Rates 8/1/2020 deflated to 2019	Contains billing codes and reimbursement rates set by DHCS for community-based adult services	Community-based adult services
National Average Drug Acquisition Cost (NADAC) File 12/30/2019	Contains per unit prices for drugs dispensed through an outpatient pharmacy setting based on the approximate price paid by pharmacies, calculated by CMS	Outpatient medication
Clinical Laboratory Fee Schedule 12/30/2019	Contains rates set by CMS for clinical lab services	Laboratory
Therapy Rates 8/1/2020 deflated to 2019	Contains billing codes and reimbursement rates set by DHCS for	Therapy

Source	Description	Applicable Service Categories
	physical, occupational, speech, and respiratory therapy	
Ambulatory Surgical Center (ASC) Fee Schedule January 2019	Contains billing codes and reimbursement rates set by CMS for facility fees for ASCs	ED, Hospitalizations, Outpatient Facility
Outpatient Prospective Payment System (OPPS) File October 2019	Contains billing codes and reimbursement rates set by CMS for facility fees for hospital outpatient departments	ED, Hospitalizations, Outpatient Facility

Payments were attributed based on available service and procedures codes included in each claim. A specific visit may have included a physician claim from the providers for their medical services and a facility claim for use of the facility and resources (e.g., medical/surgical supplies and devices) where service was provided.

The Medi-Cal Physician Fee Schedule contained monthly updated rates for all procedures that were reimbursable by Medi-Cal to providers and hospital outpatient departments. Each procedure code had multiple rates that varied based on provider type (e.g., physician, podiatrist, hospital outpatient department, ED, community clinic) and patient age. UCLA distinguished between these rates, but the paid amount for FFS still varied within the same procedure code, likely due to the directly negotiated rates between the providers and DHCS. For the purpose of the cost evaluation, UCLA used the procedure code with the most expensive rate when adequate information was lacking.

UCLA also included a payment augmentation of 43.44% for claims for physician services provided in county and community hospital outpatient departments following DHCS guidelines. UCLA did not include any other reductions or augmentations that may have been applied by Medi-Cal due to limited information in claims data. Some procedures such as those performed by a qualified physical therapist in the home health or hospice setting did not have a fee in the Medi-Cal physician fee schedule but had fees in the Medi-Cal Provider Manual and UCLA used these fees when applicable.

A number of claims lacked procedure codes but had a revenue code such as "Emergency Room-General" or "Freestanding Clinic- Clinic visit by member to RHC/FQHC". UCLA obtained documentation from DHCS that enabled identification of a price using outpatient revenue codes alone.

CMS's Durable Medical Equipment (DME) Fee Schedule included billing codes that are reimbursable by Medi-Cal for DMEs such as hospital beds and accessories, oxygen and related respiratory equipment, and wheelchairs. Rates for other medical supplies such as needles, bandages, and diabetic test strips were found in DHCS's Medical Supplies Fee Schedules.

FQHCs and RHCs consist of a parent organization with one or more clinic sites and are paid a bundled rate for all services during a visit. DHCS publishes FQHC and RHC Rates for each clinic within the parent organization.

Payments for outpatient medication claims were calculated using the national average drug acquisition cost (NADAC), which contains unit prices for drugs. UCLA calculated the drug cost by multiplying the unit price by the number of units seen on the claim. Drugs administered by physicians were priced using CMS's Average Sales Price Data (ASP) for Medicare Part B drugs.

Facility fees were priced based on the ambulatory surgical center (ASC) fee schedule or the outpatient prospective payment system (OPPS) depending on whether the billing facility was an ASC or an outpatient department.

Medi-Cal paid most LTC institutions such as nursing and intermediate care facilities for the developmentally disabled on a per-diem rate, while long-term care hospital stays were reimbursed via diagnosis related group (DRG) payments. Per diem rates for LTC facilities were obtained directly from DHCS's long-term care reimbursement webpage, and these rates varied by type of facility. Rates for hospice services were based on DHCS's hospice care site and hospice room and board rates were based on the Nursing Facility/Intermediate Care facility fee schedule. UCLA lacked some variables in claims data that were needed to calculate some LTC and hospice payments, such as accommodation code which specifies different rates for each nursing facility depending on the type of program including the "nursing facility level B special treatment program for the mentally disordered" or "nursing facility level B rural swing bed program." In these cases, UCLA used the rates associated with accommodation code 1: "nursing facility level B regular," which were higher than other accommodation code rates.

Hospitalizations are paid based on diagnosis related groups (DRGs), a bundled prospective payment methodology that is inclusive of all services provided during a hospitalization, except for physician services. Identification and pricing of DRGs varies by payers such as Medi-Cal and Medicare. In California, DHCS uses 3M's proprietary APR-DRG Core Grouping Software to assign DRGs and 3M's APR-DRG Pricing Calculator to calculate prices for Medi-Cal DRG hospitals. APR-DRGs have more specific DRGs for Medicaid populations such as pediatric patients and services such as labor and delivery, and incorporate four levels of illness severity.

However, UCLA did not have access to this software and used 3M's publicly available CMS MS-DRG grouping software for the Medicare population, which includes Medicare-Severity DRGs (MS-DRGs) and their corresponding weights. MS-DRGs only include two levels of severity of illness, with complications or without complications. UCLA used this software to assign a DRG to each hospitalization based on procedure code, diagnosis, length of stay, payer type, patient discharge status, and patient age and gender. Although CMS uses the Inpatient Prospective Payment System to assign hospital prices based on the MS-DRGs, UCLA used available data and publicly available prices for DHCS's APR-DRG Pricing Calculator to calculate payments for each DRG. DHCS's APR-DRG Pricing Calculator used multiple hospital and patient-level variables to calculate the final payment for hospitals, and UCLA incorporated some of these variables into the estimated payment (such as patient age and hospital status of rural vs. urban) but could not incorporate other modifiers due to data limitations (such as other health coverage and whether or not the hospital was an NICU facility).

UCLA calculated the estimated payment by starting with the base rate from DHCS's APR-DRG Calculator, which was $12,832 for rural hospitals and $6,507 for urban hospitals. This base rate was multiplied by the weight assigned to each MS-DRG, which modified the base rate to account for resources needs for a given DRG. For example, more severe hospitalizations such as "Heart Transplant or Implant of Heart Assist System with major complications" had a high weight of 25.4241 but "Poisoning and Toxic Effects of Drugs without major complication" had a lower weight of 0.7502. This rate was further modified by one available policy adjuster, which increased the payment amount by patient age and was higher for those under 21 (1.25) than those 21 and older (1). Overall payment for a hospitalization was calculated by adding the estimated payments for physician specialist services that occurred during the hospitalization.

When no fees were found for procedure codes in any payment data sources, UCLA used the most frequent paid amount seen in fee-for-service claims for the procedure code. These included procedures such as tattooing/intradermal introduction of pigment to correct color

defects of skin and excision of excessive skin. When outlying units of service were found on the claim, UCLA used the 90th percentile value of units for the procedure code rather than the observed units. All claims were included in a category of service and were assigned a price.

For dual beneficiaries, Medi-Cal is the secondary payer (payer of last resort) and covers a portion of the costs of the service. However, UCLA lacked information on percentage of services paid for by Medi-Cal for dual managed care beneficiaries. Therefore, UCLA used Medi-Cal claims data to calculate payments for these dual beneficiaries using the same methodology as non-dual managed care beneficiaries.

For the purpose of evaluation, all payments were calculated using the 2019 fee schedules when available. In the absence of 2019 data, UCLA inflated or deflated payment amounts using the paid amounts for similar FFS claims in available data. Using the 2019 fees removed the impact of inflation and pricing changes in subsequent analyses.

Control Group Construction

The comparison group was constructed using Medi-Cal beneficiaries who were high utilizers of health care and were potentially experiencing homelessness. Homelessness was predicted using a previously developed algorithm to identify beneficiaries who were experiencing homelessness as homelessness is not indicated in Medi-Cal enrollment data.[9]

UCLA requested administrative Medi-Cal monthly enrollment and claims data from January 2019 to December 2022 for 310 individuals reported by HHC in their bi-annual reports and for 178,019 individuals that were potentially eligible for HHC based on their use of acute care services and likelihood of experiencing homelessness. Not all individuals reported in the bi-annual reports were housed by HHC. Potential controls had to be at least 18 years at the start of the program, live in one of the counties where the program was implemented, have as least one emergency department visit or hospitalization between January 2019 and December 2022, and have evidence of experiencing homelessness between January 2019 and December 2022. Evidence of experiencing homelessness included having an address that included keywords such as “homeless,” “shelter,” or “living on streets” or they had a Medi-Cal claim that included a diagnosis or place of service indicating homelessness.

[9] Pourat, Nadereh, Dahai Yue, Xiao Chen, Weihao Zhou, and Brenna O’Masta. “Easy to Use and Validated Predictive Models to Identify Beneficiaries Experiencing Homelessness in Medicaid Administrative Data.” Health Services Research n/a, no. n/a. Accessed April 24, 2023. https://doi.org/10.1111/1475-6773.14143.

UCLA used 27 indicators and variables describing beneficiaries' demographic, health status, service utilization, and cost characteristics to select the control group (Exhibit 50). Demographic variables were constructed from Medi-Cal enrollment data. Health status variables were constructed from claims data. UCLA created and included a measures of acute care utilization by grouping participants based on their number of ED visits and hospitalizations and also including there change in utilization from the 7-12 months prior to being housed to the 1-6 months prior to being housed. Additionally, UCLA created and included measures of the change in estimated Medi-Cal payments for overall service use, hospitalizations, and ED visits.

Exhibit 50: Variables Used to Select the Control Group

Indicator	Description
Demographics and Baseline Description (7 indicators and variables)	
Age Group	Age at the time of housing
Gender	Reported Gender in Medi-Cal Enrollment (Male or Female)
Race/Ethnicity	Reported Race/Ethnicity in Medi-Cal (White, Hispanic, Black, Asian or Pacific Islander, or Native American/Other/Unknown)
Language	English as the preferred language
County	County of residence
Bi-Annual Full Scope Months in Medi-Cal	Number of months during each six-month period having full-scope Medi-Cal coverage
Health Status (10 indicators or variables)	
Chronic Condition Count	Categorial variable of having 0, 1-2 or 3+ chronic conditions
Chronic Conditions	Indicators for specific chronic conditions: asthma, diabetes, hypertension, heart failure, chronic obstructive pulmonary disorder, serious mental illness, substance use disorder, and COVID infection
CDPS Risk Score	Risk score that measures illness burden
Service Utilization (5 variables)	
Starting Utilization	Emergency department visits and hospitalizations rates 7-12 months prior to being housed
Utilization Change	Change in service utilization of emergency department visits and hospitalizations from 7-12 months to 1-6 months prior to being housed
Acute Care Services Use Categories	Categorial variable indicating use of acute care services prior to being housed. At risk for high utilization is defined as no ED utilization or hospitalizations 24 months prior to housing, low utilization is less than 2 ED visits and less than 1 hospitalizations per year, moderate utilization is 2 or more ED visits or 1 or more hospitalizations per year, high utilization is 5 or

Indicator	Description
	more ED visits or 2 or more hospitalizations per year, and super utilization is 10 or more ED visits or 4 or more hospitalizations per year.
Estimated Medi-Cal Payments (5 variables)	
Starting Medi-Cal Cost	Estimated Medi-Cal payments overall and for emergency department visits and hospitalizations 7-12 months prior to being housed
Medi-Cal Cost Change	Change in overall estimated Medi-Cal payments and payments specifically for emergency department visits and hospitalizations from 7-12 months to 1-6 months prior to being housed

Due to the delayed implementation of HHC across the grantees, UCLA grouped HHC participants into eight cohorts based on the quarter in which they were housed and selected control beneficiaries for each cohort. This method ensured that the control group beneficiaries had a similar baseline period to their matched participant.

The control group selection generalized additive models were set to require an exact match for county and the closest possible match for all other variables described above. UCLA aimed to create a matched sample with a 1:2 ratio (1 HHC participant to 2 control beneficiaries).

Exhibit 51 shows the characteristics of the final control group for the largest HHC cohort (cohort 2; n=40), which consisted of those housed from April to June 2021. Data show that the control group was similar to the HHC participants for all indicators and measures.

Exhibit 51: Comparison of Select Characteristics of HHC and Matched Control Beneficiaries

		HHC Participants in Cohort 2	Before Match Control Group	After Match Control Group
Age (at time of housing)	Average	51	46	47
Gender	% Male	65%	60%	60%
Race/Ethnicity	% White	18%	23%	24%
	% Latinx	38%	34%	35%
	% African American	43%	31%	33%
	% Asian	3%	3%	3%
	% Other or Unknown	0%	9%	6%
Language	% English proficient	88%	91%	93%
Medi-Cal full-scope months	Average number of months in the year prior to enrollment	12	12	12
Select Chronic Conditions	Hypertension	65%	37%	58%
	Diabetes	38%	19%	26%
	Serious Mental Illness	65%	45%	51%
	Substance Use Disorders	43%	39%	53%
Emergency Department Utilization	ED Starting	1.61	1.11	1.41
	ED Change	-0.06	-0.07	-0.04
Inpatient Utilization	Hospitalization Starting	0.61	0.36	0.65
	Hospitalization Change	0.13	-0.01	0.18
Acute Care Utilization Categories	At-Risk	18%	14%	10%
	Low Utilization	35%	40%	36%
	Moderate Utilization	18%	27%	23%
	High Utilization	18%	11%	21%
	Super Utilization	13%	7%	10%

Difference-in-Difference Models

UCLA assessed changes in the outcomes of interest before and after housing with HHC, and in contrast to the control group in difference-in-difference (DD) models. All models were controlled for demographics (gender, age, race/ethnicity, primary language, months of Medi-Cal enrollment), utilization indicators (acute care utilization group), and health status indicators (chronic condition indicators). The models additionally included an indicator for having at least one primary or secondary diagnosis of COVID-19 in the claims data. The baseline and enrollment periods for each HHC participant and their matched controls were based on the

date the participant was housed, and the participants sample included only HHC participants with Medi-Cal enrollment in the baseline data and at least one month of housing under HHC.

UCLA used count models with Poisson distribution for count metrics (ED visits and hospitalizations rates) and zero-inflated Poisson models for estimated Medi-Cal payments. The exposure option within a Generalized Linear Model (GLM) was used to adjust for different number of months of Medi-Cal enrollment and the subsequent different lengths of exposure to housing. All analyses of individual-level metrics were analyzed based on Medi-Cal member months.

UCLA measured the impact of HHC on acute care use by developing difference-in-difference (DD) models in six-month intervals. This included first measuring differences in utilization trends before housing (from 7-12 months vs. 1-6 months) and after housing (from 1-6 months vs. 7-12 months) for both HHC participants and the control group. Next, the difference between the differences in trends between the two groups were measured. UCLA conducted a second DD analysis to show the immediate impact of HHC on acute care utilization by focusing on the change in utilization from 1-6 months before move-in to 1-6 months after move-in for both groups and then difference in these differences.

Limitations

One of the criteria for HHC was chronic homelessness. However, Medi-Cal Enrollment and Claims data do not include an indicator of chronic homelessness. As a result, UCLA created an indicator of homelessness based on Medi-Cal eligibility and claims data, which is likely subject to estimation error. The identification of chronic conditions relied on the primary and secondary diagnoses associated with each service. Any error in original reporting of these diagnoses by providers may have resulted in under- or over-reporting of chronic conditions.

There were three types of limitations associated with UCLA's cost analysis including the availability of needed variables in the claims data and access to fee schedules and other pricing resources. The goal of the cost analysis was not to calculate exactly what DHCS paid for claims, but rather to calculate estimated payments and measure the impact of HHC by comparing changes in estimated payments over time. The limitations below describe why UCLA results may be different from DHCS reimbursements for certain services and categories.

The first limitation was related to estimating payments for hospitalizations. First, the MS-DRG relative weights reflected Medicare payments, which were higher than Medi-Cal. This likely led

to higher estimated payments for hospitalization. Second, MS-DRG only identified those levels of severity, with and without complication, but APR-DRG includes four severity levels. Third, DHCS uses multiple criteria to adjust hospital payments but UCLA was only able to adjust for urban and rural rates.

A second limitation was related to availability of fee schedules for accurate pricing. The HHC evaluation required analysis of multiple years of claims data and UCLA used all available fee schedules to price procedures, supplies, and facilities from multiple years and inflated prices to 2019 dollars whenever necessary. UCLA always used the most recent rate for a procedure. The inflation rates used were based on medical care Consumer Price Index provided by US Bureau of Labor Statistics without adjusting for regional-specific inflation rates. Not all procedures that appeared in the claims data had corresponding rates in all the available fee schedules. Procedures that required Treatment Authorization Requests (TARs) lacked a fee-schedule and are frequently more expensive than covered services. Some specific procedures had no fees in the Medi-Cal fee schedule. When fee schedules were missing, UCLA attributed the most frequently observed price from the paid amount for a similar FFS claim. If the procedure did not appear in any FFS claims, UCLA assigned the median allowed amount from all managed care claims for the given procedure code.

A third limitation was related to outlier values for service units, some of which were extremely high. UCLA attributed the 95th percentile value instead of the original value in the claim, potentially underestimating payments for some claims.

A major limitation is that the overall number of individuals housed was relatively small and may have reduced the power in DD models to measure changes in outcomes. There is a lag of six or more months before Medi-Cal claims data were complete and ready for analysis, which may have led to incomplete assessment of encounters and associated payments. The identification of the control group experiencing chronic homelessness was not possible due to lack of specific data needed for such assessment in Medi-Cal enrollment and claims data. Similarly, UCLA estimated Medi-Cal payments but these estimates were subject to incomplete data or fee schedules. UCLA lacked data on the details for arrests and incarcerations to estimate such costs or savings.

This evaluation represents program findings through December 2022 and not the program end date of March 2024. Therefore, the findings underestimate the number of individuals that were

enrolled and housed and may have underestimated reductions in use of acute services and associated Medi-Cal payments.

Appendix B: Article II Case Studies

UCLA Center for Health Policy Research

Housing for a Healthy California:

Kern

OVERVIEW

Kern Behavioral Health and Recovery Services (KernBHRS) and the Housing Authority lead the Housing for a Healthy California program (HHC) in Kern County to offer scattered-site rental assistance and supportive services to participants. Potential participants are identified, assessed, prioritized, and referred to the program through the Coordinated Entry System (CES) managed by the Bakersfield-Kern Regional Homeless Collaborative (BKRHC; HUD-recognized Continuum of Care for Bakersfield/Kern County). The Housing Authority is responsible for providing housing navigation services through the CalAIM program, established to replace and transition from the Whole Person Care (WPC) program. KernBHRS behavioral health services and case management is available to participants in HHC-assisted housing units. Housing retention and participant engagement are supported through coordination between the property manager, service providers, and individual participant. The program provides "tenant-driven" supportive services that use a Housing First approach, harm reduction strategies, and other evidence-based practices.

- **Project type**: Rental assistance – scattered-site
- **Number of units funded**: 22 vouchers
- **Total Budget:** $634,946

PROGRAM STRUCTURE

Participating Entities

Agency	Role	Details
KernBHRS	• Grantee • Lead entity • Case management	• Referrals and service-linkage for individuals engaged in the KernBHRS system of care
Housing Authority	• Lead entity • Housing navigation • Outreach/referrals/ participant eligibility	• Housing navigators through CalAIM • Potential, eligible participants are accessed through the CES
Bakersfield-Kern Regional Homeless Collaborative (BKRHC)	• Outreach/referrals/ participant eligibility	• BKRHC manages the CES

Staffing

- **# FTE hired specifically for project**: Approximately 5
- **Staff-to-participant ratio (case load):** 1:20
- **Key HHC roles**: Behavioral health recovery specialist/psychiatric specialist, behavioral health administration, and housing navigator

Client Outreach, Engagement, and Retention

BKRHC identifies potential participants through the CES. Individuals experiencing homelessness or seeking services can access the CES through existing homeless programs, agencies, and street outreach workers throughout the county. The CES Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) has been adapted by the BKRHC to incorporate additional questions that help identify potential HHC-eligible persons, including persons who meet the criteria for being at-risk of chronic homelessness. Engagement and retention strategies include relationship building, individualized case management, housing navigation, monitoring of and regular contact with participants, early intervention to prevent problems from escalating, and crisis intervention.

SUPPORTIVE SERVICES

Housing Navigation

Housing navigation services are performed by CalAIM housing navigators provided by the Housing Authority of the County of Kern, who previously worked as part of the WPC Program. Each housing navigator is under the supervision of a housing coordinator, and provides housing transition and retention services to HHC eligible participants.

- **Responsible staff:** Housing navigators within CalAIM
- **Activities included:** Assessment and enrollment of participants in CES; assisting participants with establishing relationships with private landlords; housing assessment; creating individualized housing supportive plans with housing inspections; identifying and securing resources to cover allowable move-in expenses; completing necessary records and verification forms; providing advocacy related to supportive and social services; and training clients on available services, client's rights, lease obligations, and occupancy policies

Case Management Approach

KernBHRS employs a "client-centered" and "goal-oriented" case management approach. Case management services are performed by clinical staff (licensed or pre-licensed Masters in Social Work and Marriage and Family Counselors, medical doctors, certified substance use specialists, and case management staff) working as a member of a recovery team, under the supervision of a unit supervisor. The unit supervisor staff member is responsible for coordinating and integrating behavioral health services for participants who are engaged in the KernBHRS service system.

- **Case management team composition:** KernBHRS teams typically include the following: psychiatrist, psychiatric nurse, mental health therapist, substance abuse specialist, and other recovery personnel including peer staff

Other Supportive Services

Service Type	Service Provider	Service Location	Service Details
Peer support activities	KernBHRS peer staff, Consumer	On-site and off-site	• Within the KernBHRS system, peer staff provide peer support services, typically based on referral from clinical staff

Service Type	Service Provider	Service Location	Service Details
	Family Learning Center (CFLC) The Independent Living Center (ILC) of Kern County Dream Center		• KernBHRS CFLC offers free social, recreational, hobby, art and fitness groups, recovery classes, self-help groups, and education on mental illness • ILC provides services for adults with disabilities • The Dream Center is a resource center for current and former foster youth who are transitioning to independence and self-sufficiency • Self-help groups (e.g., AA, NA and Dual Recovery Anonymous groups in the Bakersfield area) • Property manager is willing to host self-help groups on site
Linkages – behavioral health	KernBHRS case management team	On site, off-site at treatment and recovery team offices, some phone services	• Mental health, comprehensive case management, and initial/annual substance use assessments • Psychiatric services • Individual & group counseling • 24/7 crisis response services
Linkages – substance abuse treatment disorder	KernBHRS CA-Drug/Alcohol Abuse Counseling (DAAC) certified staff KernBHRS contractors: Aegis, Medical Systems, and American Health Services	On site during business hours and off-site/local	• Individual therapy and group treatment • Harm reduction treatment • Matrix model, and the Seeking Safety model for participants with co-occurring trauma and substance use disorders • Outpatient substance use disorder (SUD) treatment • Self-help groups • Detox services • Residential treatment - housing is held for 30 days while undergoing residential treatment • Medication assisted treatment
Linkages – primary care services	KernBHRS case management staff Local healthcare providers	Staff on-site. Off-site/local primary care, hospitals, EDs, urgent care, dentists, and screening sites	• KernBHRS staff help participants apply for and maintain insurance coverage • HHC participants who were enrolled in WPC received care coordination and services available through WPC, now CalAIM • KernBHRS staff encourage participants to have a physical exam and provide referrals to primary care physician or clinic for ongoing medical, dental, and preventive health care needs, including vaccinations • Staff accompany participants to appointments as needed
Benefits counseling and advocacy	KernBHRS case management staff	Staff on-site	• KernBHRS staff assist participants with obtaining and maintaining benefits • Benefits include health insurance, disability benefits, sources of financial assistance (e.g.,

Service Type	Service Provider	Service Location	Service Details
			unemployment, County General Assistance, food stamps, veteran's benefits, representative payee money management services)
Housing retention skills	KernBHRS case management staff	Staff and trainings on-site	• Staff provide housing retention skills education through life-skills training groups to improve activities of daily living and maintain lease requirement adherence • Staff provide one-to-one mentoring on basic life and domestic skills
Other (some optional services they may provide)	KernBHRS case management staff	Staff on-site	• KernBHRS staff connect participants to social, recreational, education, employment, charity, and legal resources and services • Participants with child(ren), transitional age youth, foster children, and minors are provided additional child services (e.g., child care support, medical, social, and psychological resources)

Transportation Plan

Many of the KernBHRS services are provided on-site at various locations in Kern County, not requiring transportation for participation. For off-site activities and appointments, KernBHRS staff provide participants with public transportation assistance; including identifying bus routes and schedules or scheduling and planning trips for participants. When deemed appropriate, participants are provided with bus passes, connected to paratransit resources (e.g., GET-A-Lift, Kern Transit Medical Dial-A-Ride), or may be accompanied by staff during travel, or provided vehicle rides by staff. This occurs most frequently with the initial engagement and when linkages to services are being established.

CHALLENGES, SUCCESSES, AND LESSONS LEARNED

Challenges, Resolutions, and Successes

General Program Implementation	
Challenges	Resolutions
Difficulty finding affordable housing for participants with low-income and no income	Found housing owners that are willing to reduce rent for HHC participants; partnership was established with an owner that is willing to house participants and they developed a positive relationship with the Housing Authority staff
Participants with criminal backgrounds may not qualify for housing	The HHC program staff were still able to provide comprehensive clinical and psychological assessments, develop individualized plans, maintain recovery-oriented treatment that addresses their particular housing barriers, mental health, and physical health

	Housing was found through the Continuum of Care (CoC) network of available units and through their cohesive approach to landlord engagement with participants who have criminal backgrounds
Participants with physical disabilities had additional barriers to finding housing	Found housing owners that have Americans with Disabilities Act (ADA) compliant units
Successes	
Leveraging the transition from WPC to the new CalAIM program has provided access to more potential participants through the CES and increased housing navigation services	
Frontline Service Delivery and Housing Provision	
Challenges	Resolutions
Participants face barriers to read, write, and interpret documentation of program	Housing navigators interviewed participants, acted as advocates and supported participants through all documentation needed for HHC program and outside agency services
Participants faced barriers to obtaining vital documentation during homelessness	Housing navigators provided support to HHC participants in obtaining documentation
Participants have faced barriers in finding housing and supportive services	Goal of HHC is to provide housing navigators and case managers that assist participants in overcoming barriers to housing and health
Successes	
Established partnership with Flood, Independent Living Center, and City Serve for supportive service provision	

UCLA Center for Health Policy Research

Housing for a Healthy California:

Los Angeles

OVERVIEW

Los Angeles Department of Health Services (DHS) Housing for Health (HFH) and L.A. Care lead the Housing for a Healthy California (HHC) program in Los Angeles County. DHS – in coordination with a local partner, Brilliant Corners, and other Community-Based Care Management Entities (CB-CMEs) – provide permanent and affordable housing with supportive services to people experiencing chronic homelessness. Potential HHC participants are referred through the Los Angeles County Coordinated Entry System (CES) and matched to permanent housing based on need and availability throughout Los Angeles County. Scattered-site housing is provided through a project-based model or the private rental market where participants are provided rental assistance through rental subsidies or vouchers. Voluntary supportive services are provided to participants, including access to medical and behavioral health care using a Housing First approach. Since the program goals align with those of a previously existing program, Health Homes Program (HHP), HHP resources are being used for HHC and have also been integrated in the implementation of the new CalAIM program.

- **Project type**: Rental Assistance-Scattered-site
- **Number of units funded**: 253
- **Allowed activity cost (budget)**: $19,958,664

PROGRAM STRUCTURE

Participating Entities

Agency	Role	Details
Los Angeles Department of Health Services (DHS) Housing for Health (HFH) and L.A. Care	• Grantee • Lead entity • Outreach/referrals/ participant eligibility • Supportive services	• Outreach through CES • Supportive services through DHS contracted non-profit service providers established in HHP and CalAIM
Community-Based Care Management Entities (CB-CMEs)	• Case management • Housing navigation	• Network of partner organizations • Intensive case management services (ICMS) • Referrals to mental and physical healthcare services • Facilitates participant identification and enrollment • Housing navigation services to secure housing, prior to lease-signing
Brilliant Corners	• Outreach/referrals/ participant eligibility • Housing navigation	• Provides property related tenant services (PRTS) after participant move-in

Staffing

- **# FTE hired specifically for project**: No staff hired by DHS HFH
- **Staff-to-participant ratio (case load):** DHS contractors maintain 1:20 for case management and 1:75 for housing navigation
- **Key HHC roles**: Participants who are connected to a HHC subsidy are also connected to DHS contracted non-profits for supportive services. ICMS, which includes housing navigation services prior to lease signing, are subcontracted to CB-CMEs and PRTS are subcontracted to Brilliant Corners

Client Outreach, Engagement, and Retention

Households are referred to HFH through the LOS ANGELES County CES, which includes dedicated street outreach, as well as access points across the county in other systems of care and traditional homeless services organizations. Participants referred through CES are connected with ICMS to help facilitate the coordination and management of housing resources and match participants with the services that best fit their needs. An early biopsychosocial assessment of each participant informs their "client profile" and goals. ICMS providers use profiles to proactively engage participants in activities they have expressed interest in or that align with their individual goals. Retention strategies are focused on relationship building, ICMS, tenancy sustainment education, and issue prevention and mitigation.

SUPPORTIVE SERVICES

Housing Navigation

Subcontracted CB-CMEs providing ICMS also provided housing navigation to participants. Housing navigation prior to lease signing help facilitate the enrollment of HHC participants, and secure permanent supportive housing. Brilliant Corners is contracted by DHS to provide PRTS through hired housing coordinators. All participants have a dedicated housing coordinator (case ratio of 1:75) who acts as a liaison between the participant, ICMS, and property provider. Housing coordinators focus exclusively on housing related supportive services and housing retention for participants once they have moved in.

- **Responsible staff:** ICMS providers and Brilliant Corners housing coordinators
- **Activities included:** Conduct housing assessments; provide support with housing applications and search process; provide move in assistance; coordinate with ICMS, property providers, and participants; provide tenancy supports like maintenance requests, recertification paperwork, and habitability inspections; connect to resources; and support long-term housing

Case Management Approach

ICMS providers develop an action plan to coordinate and integrate a participant's clinical and non-clinical care related needs and services. Supportive services include providing access to medical and behavioral health care aimed at achieving housing stability, improving health status, and fostering

greater levels of independence and economic security. ICMS meet participants in their home, public spaces, or at medical offices.

- **Case management team composition:** ICMS are contracted through CB-CMEs. ICMS providers are assigned to participants at a 1:20 ratio, work with housing coordinators at Brilliant Corners, and provide referrals to all supportive services within the HHP network of partners

Other Supportive Services

Service Type	Service Provider	Service Location	Service Details
Peer support activities	CB-CMEs	ICMS providers see participants on- and off-site, other services off-site at location of service provider	• Connect to social support resources based on individual needs and interests
Linkages – behavioral health	CB-CMEs	ICMS providers see participants on- and off-site, other services off-site	• Provide referrals, system navigation support, and care coordination with behavioral health providers
Linkages – substance abuse treatment disorder	CB-CMEs	ICMS providers see participants on- and off-site, other services off-site	• Provide referrals to substance abuse disorder treatment • Use motivational interviewing, trauma-informed care, and harm-reduction practices
Linkages – primary care services	CB-CMEs	ICMS providers see participants on- and off-site, other services off-site	• Establish care with Primary Care Provider (PCP) within 60 days of enrollment • Coordinate care between the PCP and other service providers
Benefits counseling and advocacy	CB-CMEs	ICMS providers see participants on- and off-site, other services off-site	• Collect all needed documents for housing • Apply for benefits such as Supplemental Security Income (SSI) • Enroll in available programs (i.e., CalFresh and In-Home Support Services)
Housing retention skills	CB-CMEs	ICMS providers see participants on- and off-site, other services off-site	• Individual housing and tenancy sustaining services (e.g., tenant and landlord education)
Other (some optional services they may provide)	CB-CMEs	ICMS providers see participants on- and off-site, other services off-site	• Link to resources for education, employment counseling, and other needed services for food assistance, faith-based networks, child care, etc.

Transportation Plan

ICMS providers regularly meet with participants in their home or convenient public places to provide service delivery. Bus tokens are provided for transportation access to off-site resources. ICMS also arrange transportation for health services (e.g., medical or behavioral health appointments), including

access to non-medical transportation and/or non-emergency medical transportation through participants health plan.

CHALLENGES, SUCCESSES, AND LESSONS LEARNED

Challenges, Resolutions, and Successes

General Program Implementation	
Challenges	Resolutions
Long wait from initial HHC enrollment to move-in	Clear communication with participants as they wait and option to start ICMS process for participants to stay engaged while they wait for housing placement
COVID-19 changed emergency department (ED) use (i.e., lower utilization) and affected eligible participant enrollment criteria	Adjusted the high utilization definition to accommodate lower ED use rates and still locate eligible participants
Difficulties in both matching participants to HHC and then subsequently locating a unit due to market competition with influx of federal Tenant Based Vouchers (TBVs) compounded by the LA housing market continuing to be more expensive than vouchers can afford which reduces the amount of available affordable housing for participants	Expanded project based/scattered-site contracted service providers and increased payment standards by leveraging other funding
Successes	
Implementation of CalAIM has helped HHC participants access supportive services and increased early Medi-Cal enrollment because there has been an increase in awareness of enhanced care management services and better integration of participants medical providers	
Frontline Service Delivery and Housing Provision	
Challenges	Resolutions
Eligible HHC participants have higher incidence of mortality, as “medical vulnerability” is a criterion for enrollment	Trauma training and support provided to frontline staff and other residents. All ICMS agencies are trained in trauma informed care, harm reduction and Housing First principles and are required to employ those principles with all clients
COVID-19 affected enrollment and case management staff capacity to meet face-to-face with participants	When not able to meet in person due to quarantine guidelines, virtual support was proved to participants
Some participants experienced lapses in their Medi-Cal coverage, affecting successful referral to care	Medi-Cal enrollment and convenient PCP established care early in HHC enrollment and staff engage with participants to help maintain continuous enrollment
Successes	
Increased flexibility in services, expanded HHC eligibility, and improved communication with L.A. Care helped participants transition from recuperative care facilities/interim housing, secure SSI, and receive ICMS	
Participants benefitted from ICMS wrap around services (e.g., health, mental health, and behavioral health referrals, benefits assistance, legal assistance, and familial/family support) while waiting for housing	

UCLA Center for Health Policy Research

Housing for a Healthy California:

Marin

OVERVIEW

Marin County Department of Health and Human Services' Divisions of Whole Person Care (WPC) and Behavioral Health and Recovery Services (BHRS), community partner Homeward Bound, and the Marin Housing Authority lead the Housing for a Healthy California (HHC) program to house and support people experiencing homelessness in Marin County. Participants are identified through the Coordinated Entry System (CES) and if eligible for HHC, are provided with rental assistance through placement in an HHC-funded unit with permanent supportive housing (PSH). As part of HHC, Jonathan's Place PSH provides 32 single room occupancy units over a 40-bed emergency shelter, providing on-site case management and supportive services to participants. HHC provides rental subsidies for PSH units and partially funds case management and operations costs through Capitalized Operating Subsidy Reserve (COSR) grant funding. Case management is staffed by Homeward Bound and Marin County BHRS and follows previously established goals of the WPC program. Housing navigation is provided by Homeward Bound and Marin Housing Authority when participants are ready to transition to off-site independent living with rental assistance.

- **Project type**: COSR and Rental Assistance-Project Based Voucher (PBV)
- **Number of units funded**: 32 PBV, 15 COSR
- **Total Budget:** $2,830,392

PROGRAM STRUCTURE

Participating Entities

Agency	Role	Details
Marin County WPC (within Marin Department of Health and Human Services)	• Grantee • Lead entity • Coordinated entry	• Grant management • Facilitates identification and enrollment through CES
Marin County BHRS (within Marin Department of Health and Human Services)	• Lead entity • Supportive services • Case management	• Case management and supportive services previously established through WPC and BHRS partnerships
Homeward Bound	• Lead entity • Outreach/ referrals/participant eligibility • Supportive services	• Provide additional supportive services • Manages project
Marin Housing Authority	• Housing navigation	• Provides vouchers to HHC participants

Agency	Role	Details
		• Provides housing navigation for participants moving on to independent living
Ritter Center	• Medical services	• Federally Qualified Health Center (FQHC)

Staffing

- **# FTE hired specifically for project**: Approximately 5
- **Staff-to-participant ratio (case load):** 1:20
- **Key HHC roles**: Housing-based case manager, case management program manager, Homeward Bound housing program director, Homeward Bound on-site staff

Client Outreach, Engagement, and Retention

Housing First principles are applied to outreach, assessment, and retention strategies. Potentially eligible participants are referred through the CES. Marin County has a network of system partners to provide a variety of access points to coordinated entry for potential participants. Participant engagement and retention strategies include using a client-centered approach and providing individualized services.

SUPPORTIVE SERVICES

Housing Navigation

Housing navigation services are performed by Homeward Bound and Marin Housing Authority and are only necessary for participants moving on to independent living, as HHC rental assistance is site-based at Jonathan's Place. Housing locators help find landlords willing to accept vouchers and help participants complete paperwork and landlord interviews. Marin Housing Authority additionally utilizes an existing 2-person housing locator team, funded through county general funds and US Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Program coordinated entry grant. Housing locators partner with Homeward Bound case managers to guide clients through the rental process.

- **Responsible staff:** Homeward Bound, Marin Housing Authority housing locators
- **Activities included:** Assistance finding voucher-eligible housing outside of Jonathan's Place PSH occupancy

Case Management Approach

BHRS case management works with Homeward Bound to provide participants with housing-based case management and supportive health services. Homeward Bound provides 24/7 staffing for daily supportive services. Homeward Bound staff regularly interact with participants and provide a range of supportive services. Case managers refer participants for behavioral health; primary care; and substance abuse disorder treatment; offered on-site through the Ritter Center, a FQHC, and off-site at Marin Community Clinic. Property managers have access to the county's WPC client portal WIZARD to communicate with case managers regarding housing and tenant concerns.

- **Case management team composition:** BHRS provides on-site staff at Jonathan's Place through Marin's Odyssey Full-Service Partnership for participants receiving HHC rental assistance.

Other Supportive Services

Service Type	Service Provider	Service Location	Service Details
Peer support activities	BHRS	On-site	• BHRS offers peer counseling for participants, such as smoking cessation groups, women's support groups, and a dual recovery anonymous group
Linkages – behavioral health	BHRS Homeward Bound	On-site	• Housing-based case management through BHRS full-service partnerships • Homeless mentally ill outreach and treatment team provide on-site assessment for serious mental illness • Homeward Bound provide case management referrals and links participants with the mobile crisis team
Linkages – substance abuse treatment disorder	Ritter Center County providers	On-site and off-site	• Ritter Center outpatient substance use disorder support • County substance use services, including residential and outpatient treatment and primary and secondary prevention services
Linkages – primary care services	Ritter Center Community clinics	On-site and off-site	• BHRS case managers and Homeward Bound staff provide referrals to local FQHCs, Marin community clinics, and Ritter Center to link participants with primary care services • Services include: routine and preventive health care, dental care, medication management, and wellness services
Benefits counseling and advocacy	BHRS Ritter Center	On-site	• BHRS case management and Ritter Center provide referrals to General Relief and RISE for benefits applications and assist participants in filling out applications • Monitoring to ensure Medi-Cal does not lapse • Dedicated assistance with connection to Medi-Cal, General Relief, and CalFresh
Housing retention skills	BHRS Ritter Center Homeward Bound	Staff on-site	• Homeward Bound, BHRS, and Ritter Center staff provide housing retention and soft skills, motivational coaching, communal living skills, cleaning services, in-home supportive services, money management coaching and representative payee services
Other (some optional services they may provide)	BHRS Ritter Center, Homeward Bound, Marin Center for Independent Living (MCIL),	On-site and off-site	• BHRS/Ritter Center connect participants to County services and the Community Institute for Psychotherapy to treat co-occurring disorders or tri-morbidities • Recreational activities provided by Homeward Bound include: games and movie events, fitness, tickets for local events

Service Type	Service Provider	Service Location	Service Details
	Career Point, Spark Point, Legal Aid of Marin		• Homeward Bound provides additional services for computer skills coaching, General Education Development Test (GED) referrals, culinary job training, employment placement programs, legal aid, Veterans Affairs (VA) benefits, and food assistance

Notes: Service location referred to participants living in HHC-funded unit with Permanent Supportive Housing at Jonathon's Place.

Transportation Plan

All participants are provided with bus vouchers, linkages to specialized transportation through Marin Access Catch-a-Ride and Marin Access ADA Paratransit via Whistlestop. Case managers have access to cars that can transport participants to appointments directly. Community Action Marin's CARE outreach teams, funded through BHRS and Marin County Probation, can also provide transportation to participants.

CHALLENGES, SUCCESSES, AND LESSONS LEARNED

Challenges, Resolutions, and Successes

General Program Implementation	
Challenges	Resolutions
Potential participants often did not meet high emergency department utilization criteria	Worked with partner organization to find alternative rental assistance funds to help house these participants
Construction delays meant HHC grant would end before rental assistance funding was used	Transferred a significant portion of HHC funding to COSR and prioritized clients for Emergency Housing Vouchers (EHVs) to ensure rental assistance would be available
Successes	
Positive community support for the program	
Strong partnership development with Ritter Center and St. Vincent de Paul to help support participants ineligible for HHC rental assistance funding	
Frontline Service Delivery and Housing Provision	
Challenges and Resolutions	
Specific barriers of participants were not accounted for when assessing eligibility. For example, several participants were not eligible for social services	Staff found alternative food sources (because they did not qualify for CalFresh) such as local food pantries, and used communal kitchen to provide evening meals to residents

because of their income status of previous partners (spouses they are separated from)	
The nature of the target population for HHC participation meant that many people did not have information or access to information to provide full medical histories, incarcerations, or hospitalizations which makes it difficult to identify participant service needs	Staff spent time accessing participant data from local jails and the collective Medi-Cal CalAIM database for hospitalization data
Successes	
After years of planning and creating partnerships, grantee initiated the program and housed 16 participants	

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Housing for a Healthy California:

Sacramento

OVERVIEW

Sacramento County Housing for a Healthy California (HHC) program is a multi-agency collaboration. HHC is led by the Sacramento County Division of Behavioral Health Services (BHS) and Department of Health Services (DHS), and together they contract with partners to provide housing and supportive services. Sacramento County provides long term rental assistance to eligible participants in HHC through scattered-site housing. Sacramento Housing and Redevelopment Agency (SHRA), as the Sacramento County Public Housing Authority, provides housing choice vouchers (HCVs), and additional move-in funds to cover security deposits, furniture, and utilities. All participants receive supportive services through two contracted partner networks administered by the BHS; Mental Health Program (MHP), a network of contracted behavioral health service providers; and Property Related and Tenant Services (PRTS), a network of contracted housing service providers.

- **Project type**: Scattered-site rental assistance through HCVs
- **Number of units funded**: 125
- **Total Budget:** $9,900,900

PROGRAM STRUCTURE

Participating Entities

Agency	Role	Details
Sacramento County - Department of Health Services (DHS) and Division of Behavioral Health Services (BHS)	• Grantee • Lead entity • Supportive services	• HHC program is a partnership between County agencies and contracted providers • Contracted providers for Mental Health Program (MHP) and Property Related Tenant Services (PRTS)
Sacramento Housing and Redevelopment Agency (SHRA)	• Housing navigation • Sacramento County Public Housing Authority	• Coordinates with housing navigators • Provide HCVs • Move in funds (deposits, furniture, utilities)
PRTS - Sacramento Self Help Housing, Bay Area Community Services, and Volunteers of America	• Housing navigation	• Sub-Contractors/Partners for housing • Housing location placement, retention services • Tenant property management satisfaction survey
MHP - River Oak, Asian Pacific Community Counseling, Central Star, El Hogar, Telecare, Transitional Living &	• Case management	• Sub-Contractors/Partners for support services • Case management, peer support, behavioral health/substance use/primary care linkage, benefits

Agency	Role	Details
Community Support (TLCS)/Hope Collaborative, Sacramento Steps Forward, and Turning Point		counseling, housing retention, co-occurring disabilities treatment
Sacramento Steps Forward	• Operates the local Continuum of Care (CoC)	• Operates the Coordinated Entry System (CES) • Facilitates case conferencing

Staffing

- **# FTE hired specifically for project**: No staff hired by BHS
- **Staff-to-participant ratio (case load):** MHP caseloads range from 1:8-1:12 based on intensity
- **Key HHC roles**: MHP providers for case management and healthcare/treatment linkages, PRTS providers for housing related services and housing retention

Outreach, Engagement, and Retention

Participants are referred to HHC through the county's Homeless Management Information System (HMIS) Coordinated Entry System (CES). Outreach is a collaborative effort between the service provider and housing partner. Engagement with participants is through assigned case management staff and other service providers. Practices for retention include regular contact with tenants, early intervention to prevent problems from escalating, and crisis intervention. PRTS and MHP providers elicit participant feedback and participation in resident meetings to address concerns.

SUPPORTIVE SERVICES

Housing Navigation

PRTS providers engage participants in all housing related activities, including housing location services, housing placement, and ongoing retention. Participants engage in an initial appointment with PRTS staff to understand the type of housing needed by the individual.

- **Responsible staff:** Contracted PRTS providers
- **Activities included:** Participant housing needs assessment, housing profile, location services, placement, and retention activities

Case Management Approach

Participants are engaged with their MHP provider for comprehensive case management, including linkages to primary care, behavioral health care, rehabilitation, as well as connecting to educational, recreational, and other meaningful life activities. MHP providers are available for participant advocacy and crisis intervention.

- **Case management team composition:** Contracted MHP providers and the PRTS providers (wider team to include access to: licensed professional of the healing arts staff, mental health rehabilitation specialist, mental health assistant, peer staff/wellness coach, psychiatric nurse/nurse practitioner or physician's assistant, licensed vocational nurse, psychiatrist)

Other Supportive Services

Service Type	Service Provider	Service Location	Service Details
Peer support activities	Sacramento County DHS/BHS & Partner Organizations Sacramento Self Help Housing, Volunteers of America	Off-site, throughout county, near public transit routes	• MHP service providers are encouraged to hire staff with lived experience • System navigation and advocacy, direct support services, linkage to community supports and services (e.g., training services, self-help, and support groups for children, youth, transition age youth, adults, and their families)
Linkages – behavioral health	Outpatient MHP service providers	Off-site, throughout county, near public transit routes	• Participants referred to MHP receive a mental health assessment and if eligible, receive full mental health services
Linkages – substance abuse treatment disorder	Outpatient MHP service providers	Off-site, throughout county, near public transit routes	• Participants receive a co-occurring disorder assessment during their MHP intake and assessment process • Sacramento County requires that all participants identified as having a co-occurring disorder be offered referrals to appropriate substance use disorder treatment
Linkages – primary care services	Outpatient MHP service providers	Off-site, throughout county, near public transit routes	• Participant information from health questionnaire help identify potential issues the contractor can help with • Regardless of health issues, all contractors are required to help a participant link to a primary care provider within 60 days of intake
Benefits counseling and advocacy	El Hogar for Multiple Advocate Resource Team (SMART) Outpatient service providers for other benefits	Off-site, throughout county, near public transit routes	• Support participants in gaining income and other benefits • Comprehensive disability assessment • Appointments with Social Security Administration (SSA) and or Department of Disability Services (DDS)
Housing retention skills	Sacramento Self Help Housing, Volunteers of America Outpatient service providers	Off-site, throughout county, near public transit routes	• Benefit enrollment assistance • Job development • Childcare assistance • Independent living skills including budgeting, grocery shopping, nutrition, parenting skills, housekeeping • PRTS provided landlord-tenant rights and responsibilities education
Other (some optional services they may provide)	City of Sacramento	Off-site, throughout county,	• Community parks and centers with dog parks, playgrounds, recreational fields and facilities

Service Type	Service Provider	Service Location	Service Details
	San Juan Unified School District Sacramento County Kaiser Permanente	near public transit routes	• Local public primary and secondary schools with Free and Reduced-Price Lunch (FRL) meal programs; SAT waivers; discounted student transit, internet, and computers • Sacramento County CalWORKs employment advising, counseling, and mental health assessment and treatment • Kaiser Medical Center primary care, psychiatry, emergency department, and hospital

Transportation Plan

All MHP service providers provide pick up transportation support or public transportation navigation education. Participants are also assisted with requesting transportation services through their Geographic Managed Care provider, Medi-Cal healthcare provider, and paratransit.

CHALLENGES, SUCCESSES, AND LESSONS LEARNED

Challenges, Resolutions, and Successes

General Program Implementation	
Challenges	Resolutions
Initial employee turn-over, lack of program guidelines, and time-consuming contract amendments with HCD. This created a lag in contracting providers for services	Potential resolution is to streamline the application amendment process within Sacramento County DHA and HCD
New staff faced capacity challenges to establish provider partnerships while also managing administrative duties of funding timelines, and program onboarding	The county and providers have increased program capacity and efficiency when the provider became a direct behavioral health service provider
Participant enrollment was difficult because of competing programs (Whole Person Care (WPC), CalAIM, Mental Health Services Act), and data sharing barriers to identify eligible participants. Many eligible participants found were already receiving other services	Attempting to update tenant selection plan to allow flexibility in the use of long-term rental assistance for people already receiving other services, like a Capitalized Operating Subsidy Reserve (COSR).
Successes	
Leveraging the transition from WPC to the new CalAIM program has provided access to more potential participants through the CES and increased housing navigation services	
Consistent meetings with partners across County agencies and contracted providers helped with planning, referral outreach, program messaging, operations, and challenge mitigation in a collaborative effort	
Participation from partners with the CoC has been robust. For example, the county has partners who co-chair CoC committees	
Frontline Service Delivery and Housing Provision	
Challenges and Resolutions	

Challenges with enrollment and assessment coordination between County and service providers	Adding new assessment for best supportive services to CoC HMIS database to help with coordination of community provider referrals to HHC
Care coordination and case management is determined by behavioral health service providers and has been increasing capacity, enrollment, active participation, and rental assistance	The county is changing contracted services with provider that will allow for more staffing support, which will increase enrollees and housing outcomes
Successes	
Have increased tenancy every month since start of program, allowing for more client level successes as the program gathers data from participants over time	

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Housing for a Healthy California:

San Francisco

OVERVIEW

Housing for a Healthy California (HHC) is supported by the San Francisco Department of Homelessness and Supportive Housing (HSH) and the San Francisco Mayor's Office of Housing & Community Development (MOHCD). Potential participants for HHC will be referred through the Coordinated Entry System (CES) to obtain a unit in the single room occupancy (SRO) apartments at the Knox, a low-income housing apartment complex. A blended stream of funding that includes Article II acquisition, new construction, or reconstruction and rehabilitation funds, will be used to rehabilitate and reserve 30 units at the Knox for HHC participant placements. Once HHC units are occupied, operations will be funded through a MOHCD Local Operating Subsidy Program (LOSP) contract and support services will be funded through a services contract with HSH. HSH contracts with community partners for on-site services, case management, and peer support services. Recognizing that there are no active program participants, program intentions are detailed below.

- **Project type**: Acquisition, new construction, or reconstruction and rehabilitation
- **Number of units funded**: 30
- **Total Budget:** $6,798,810

PROGRAM STRUCTURE

Participating Entities

Agency	Role	Role and Existing Program Infrastructure
San Francisco Department of Homelessness and Supportive Housing (HSH)	• Grantee • Lead entity • Supportive services	• Contracts community partners for supportive services, case-management, and housing navigation
San Francisco Mayor's Office of Housing & Community Development (MOHCD)	• Lead entity • Operations	• Provides capital financing for affordable housing developments • Local Operating Subsidy Program (LOSP) contract
Knox SRO (the Knox)	• Housing • Supportive services	• Affordable housing provider working with HSH for HHC placement • Peer support through community living in the complex
Felton Institute (Felton)	• Case management • Housing navigation	• Contracted community partner to provide housing navigation, case management and other supportive services

Staffing

- **# FTE hired specifically for project**: Approximately 2 at Felton Institute
- **Staff-to-participant ratio:** 1:20
- **Key HHC roles**: Case manager, peer support specialist, program manager, social worker, Felton division director, evaluator

Client Outreach, Engagement, and Retention

Individuals experiencing homelessness will be referred to the Knox through the CES. Engagement with participants will be on-site with designated office space at the Knox for Felton staff. Participant engagement activities will be held mainly in the ground floor community room and in the activity outdoor space. Participation in services will be voluntary and not required as a condition of tenancy. Retention strategies will be based on individualized services and adapted to the level and intensity of needs. The goal of supportive services will be to support participants with housing retention, improve health status, and maximize ability to live and work in the community.

SUPPORTIVE SERVICES

Housing Navigation

The Felton Institute will provide on-site support for housing stability including assistance in dealing with landlord and utilities, and offering services related to maintaining current housing or seeking other housing.

- **Responsible staff:** Case manager and peer support specialist at Felton
- **Activities included:** Housing workshops will be provided to help participants learn to seek Section 8 housing and assist them to identify housing out of the area if desired. Should housing choice vouchers (HCVs) become available for the formal moving on program, participants get assistance in accessing those vouchers if desired, as part of the supportive services offered at the Knox

Case Management Approach

The Felton Institute plans to provide on-site case management for HHC participants in residence at the Knox who request assistance. Services will include stabilization of emergencies and crises, development and coordination of a housing stabilization plan, benefits advocacy, referrals to service providers, counseling, and service planning and coordination. Supportive services staff will provide pertinent information about the availability of services, programs and other types of assistance in written form and in one-to-one or group meetings.

- **Case management team composition:** On-site case manager, peer support specialist, social worker and providers for mental health and substance abuse service

Other Supportive Services

Service Type	Service Provider	Service Location	Service Details
Peer support activities	Felton Institute DPH and Mental Health Association of San Francisco	On-site Felton staff Off-site referral locations	• On-site part-time peer support staff for relationship building, sharing lived experiences, accompanying to appointments, and off-site referrals • Off-site support service referrals and peer support programs through DPH and Mental Health Association of San Francisco
Linkages – behavioral health	Felton Institute SOMA Mental Health Clinic, Tom Waddell Clinic, Central City Older Adults program Mobile Crisis Unit	On-site Felton staff Off-site mental health provider locations	• Felton Institute staff on-site for non-urgent support needs • On-site services consist of brief individual counseling, and non-urgent support, assessment, triage, referrals, and accompaniment to off-site services • Off-site mental health providers for more intensive services
Linkages – substance abuse treatment disorder	Felton Institute Treatment Access Program (TAP)	On-site Felton staff for referrals Off-site service connection at TAP Off-site recovery service provider locations	• Felton staff refer to substance abuse services for relapse prevention, recovery activities, and weekly peer recovery groups • Service staff refer participants desiring recovery services to the city's TAP for initial intake, and those trying to get into a detox program
Linkages – primary care services	Felton Institute SOMA Health Clinic, Tom Waddell Clinic Urban Health, and Curry Senior Center	On-site and neighboring TODCO building Off-site at community organizations for other primary health care services	• On-site nurse for physical health care services for Knox SRO residents 20 weeks each year • Nurse provides health education, screening, lifestyles education (e.g., cooking classes held at a neighboring TODCO building) • The Knox hosts concentrated clinics such as: eye care clinic, mini health fair, vital signs clinic, and health & fitness promotional education and activities • Felton Institute supportive services staff connect participants with public health

Service Type	Service Provider	Service Location	Service Details
			clinics (i.e., SOMA Health Clinic, Tom Waddell Clinic Urban Health, and Curry Senior Center) for primary care
Benefits counseling and advocacy	Felton Institute	On-site	• Felton Institute staff work with Social Security/SSI, other benefits agencies, and enlist legal aid or other community-based resources as appropriate if benefits are stopped
Housing retention skills	Felton Institute	On-site	• Felton staff work with participants on a variety of services aimed at housing retention through a Housing First model and addressing individually based needs
Other (some optional services they may provide)	Felton Institute South of Market office of Mission Hiring Hall, St. Anthony's Tenderloin Technology Lab, Hospitality House's Employment Program	Felton staff on-site for referrals Off-site community resources	• Felton and TODCO offer a variety of activities such as yoga, mindfulness, medication, education services, and resource connection • Employment service referrals to local organizations that help with job placement, skills training, and employment programs

Transportation Plan

Services will be available either on-site or in close proximity to the Knox SRO residence. Most participants will be referred to providers and services located within 1/2 mile walk or a short bus or paratransit ride. San Francisco has a dense network of public transit routes and passes are free or discounted for qualifying low-income seniors, youth, and persons with disabilities. Staff will assist participants in obtaining discounted or free passes as needed. For group activities, TODCO provides privately owned bus transportation.

CHALLENGES, SUCCESSES, AND LESSONS LEARNED

Challenges, Resolutions, and Successes

General Program Implementation	
Challenges	Resolution
Obtaining sufficient capital financing to start the rehabilitation project	The State of CA just awarded Portfolio Reinvestment Program (PRP) funds, so the rehabilitation can now move forward with initiation
Successes	

Interagency collaboration between HSH, MOHCD, and the community housing provider
Obtaining financial support from the State of California through HHC and PRP programs

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Housing for a Healthy California:

San Mateo

OVERVIEW

The San Mateo County Department of Housing leads the Housing for a Healthy California (HHC) program in coordination with the San Mateo County Health System, and a network of community partners to provide housing and supportive services. The HHC program follows the structure established in the previous Whole Person Care (WPC) program by using partnerships both with community-based organizations (CBOs) and county-operated supportive services. San Mateo County has been challenged to deliver HHC units in a timely manner due to interest rate increases, construction cost increases, and the increasingly competitive tax credit market. The program plans to include three new-construction affordable housing developments that will collectively serve 59 HHC households and which will house participants beginning in 2025. Ultimately, through the use of supportive services and a Housing First approach, the goal is to support housing retention and improve health outcomes for HHC participants. Recognizing that there are no active program participants, program intentions are detailed below.

- **Project type**: New construction and Capitalized Operating Subsidy Reserve (COSR)
- **Number of units funded**: 60
- **Total Budget:** $19,995,225

PROGRAM STRUCTURE

Participating Entities

Agency	Role	Details
San Mateo County Department of Housing	• Grantee • Lead entity	• Housing is in development
San Mateo County Health System	• Supportive services	• County plans to use prior providers from WPC to develop a service provider network to serve HHC participants
Network of community partners and contracted organizations	• Supportive services	• All supportive services and health providers are CBOs and community partnerships contracted by Department of Housing

Staffing

- **#FTE hired specifically for project**: Approximately 5
- **Staff-to-participant ratio (case load):** 1:15
- **Key HHC roles**: Case manager/peer support, registered nurse, physician administration, supervising social worker

Client Outreach, Engagement, and Retention

Outreach is planned to be through the existing Coordinated Entry System (CES) to recruit and enroll participants. Programming, partnerships, and supportive services will be established through those used in the WPC program. Several providers from WPC have transitioned to become Enhanced Care Management (ECM) providers under CalAIM. San Mateo plans to design a process to identify the most vulnerable population referred through the CES to HHC. To promote participant engagement and housing retention, staff will work with participants to identify the services and supports that maintain health. Retention strategies will be based on Housing First principles and include skill building in independent living. Participants will receive an annual living skills assessment with an individualized skill development plan if needed.

SUPPORTIVE SERVICES

Housing Navigation

San Mateo intends to provide housing navigation services through various CBOs that are partnering with San Mateo County.

Case Management Approach

Each participant will be assigned a case manager who will work with them on a voluntary basis. Services will include assessment, referral and linkage to resources, supportive counseling, psychoeducation, and advocacy. Case managers will coordinate with other team members and service providers to ensure integrated care is received.

- **Case management team composition:** Case manager/peer support, registered nurse, physician, administration, and supervising social worker

Other Supportive Services

Service Type	Service Provider	Service Location	Service Details
Peer support activities	San Mateo County Various CBOs	On- and off-site	• Existing supportive housing providers will employ peer support specialists with similar lived experience • San Mateo County case managers and peer support specialists will link participants with peer support services and peer-run organizations that provide social and vocational activities, support groups, and wellness recovery action planning
Linkages – behavioral health	San Mateo County and community providers	On- and off-site	• All participants with a mental health need will be linked to a mental health clinician either through San Mateo County Behavioral Health and Recovery Services (BHRS) or a community service provider • Services will include: assessments, treatment planning and goal setting, crisis intervention, medication management and monitoring, psychoeducation, psychosocial rehabilitation, and individual and group therapy

Service Type	Service Provider	Service Location	Service Details
Linkages – substance abuse treatment disorder	Contracted community providers	On- and off-site	• BHRS contracts with several substance use providers that offer residential and outpatient treatment
Linkages – primary care services	San Mateo County and community providers	On- and off-site	• County operated services and private community providers will offer primary care, specialty medical services, and dental services • Provider relationships previously established through WPC program
Benefits counseling and advocacy	San Mateo County and community providers	On-site	• Participants will be offered an assessment of their current income and benefits • Case managers will assist those who need to obtain benefits or who need advocacy in clarifying their benefits by linking them to the San Mateo County Human Services Agency
Housing retention skills	San Mateo County	On-site	• Participants will be offered services that focus on daily living skills to promote good tenancy and housing retention • Services will include initial and continued assessment of housing skills and knowledge, development of an individualized instruction plan, money management, and representative payee services
Other (some optional services they may provide)	Property staff and CBOs	On-site Off-site CBOs	• Recreational activities provided by property's resident service staff • Education program through CBOs and community colleges • CBO supported employment services

Transportation Plan

Most supportive services will be provided on-site. For supportive services that take place off-site from housing, transportation services will be provided to and from each event not in walking distance (>0.5 miles). Service staff will actively promote the use of public transportation through education and training.

CHALLENGES, SUCCESSES, AND LESSONS LEARNED

Challenges, Resolutions, and Successes

General Program Implementation	
Challenges	Resolutions
Program cost challenges from increases in interest rates, construction cost, competition in tax credit market has delayed COSR construction and program has not started	Department of Housing worked closely with development partners to identify remaining funding gaps, how to use them, and finding additional support from county, Housing Authority, and state
Developers were not originally interested in participating in HHC because construction costs are so high in San Mateo County; grantee was unsure if COSR funding would be sufficient to help supplement cost	Grantee continued to develop relationships with developers to overcome the resistance to a new program, and to help them understand the disparities of income in the county and the importance of serving the HHC population
Successes	
Middlefield Junction received an accelerator fund, allowing the project to close on construction around March 2023	
Because development was delayed, San Mateo County has been able to influence building design to integrate anticipated participant needs in design standards (i.e., Americans with Disability Act standards) to accommodate a large aging population with high co-morbidity rates	

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