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SACHI A. HAMAI
Chief Executive Officer

June 23, 2020

To: Supervisor Kathryn Barger, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Shelia Kuehl
Supervisor Janice Hahn

From: Sachi A. Hamai
Chief Executive Officer

PILOTING A COMPREHENSIVE CRISIS RESPONSE TO ENSURE POST-COVID-19 HOUSING FOR HOMELESS OLDER ADULTS IN LOS ANGELES COUNTY (ITEM NO. 8, AGENDA OF APRIL 14, 2020)

On April 14, 2020, the Board of Supervisors (Board) directed the Chief Executive Office-Homeless Initiative, along with all appropriate County departments, and in coordination with the City of Los Angeles and State officials, to:

1. Report back in writing within 30 days with a strategy to provide long-term housing options to individuals experiencing homelessness who are aged 65 years or older and were provided emergency housing based on the COVID-19 emergency public health declaration; and

2. Report back in writing within 45 days with an interim report, followed by a multi-year implementation framework as part of Fiscal Year 2020-2021 Supplemental Budget deliberations, with cost estimates for the pilot program targeting all individuals experiencing homelessness who are aged 65 or older (65+).

The first report was submitted to the Board on May 15, 2020 to address Directive No. 1. This memorandum provides both an update to the May 15 report and an interim report, which responds to Directive No. 2. The third report in response to this motion will be submitted on September 1, 2020, in advance of Fiscal Year 2020-2021 Supplemental Budget deliberations.

Housing for Homeless Older Adults Pilot

Attachment I is a description of the overall population of people experiencing homelessness aged 65+ in Los Angeles County, including estimates for the first year of the potential pilot. The report estimates that the pilot's target population in Year One will be 4,800 homeless older adults and that the estimated gross cost to house this population would be

$100.5 million. One major source of funding to offset these costs would be Medi-Cal; however, additional on-going funding would need to be identified for this pilot. Additionally, the agreement between the City and County of Los Angeles submitted to Judge David Carter on June 18, 2020 identifies people experiencing homelessness aged 65+ as one of the priority populations for the 6700 beds which the City of Los Angeles will provide over the next 18 months.

Status of Project Roomkey and Exit Planning

As described in the May 15, 2020 report, Project Roomkey (PRK) was created to combat the spread of COVID-19 and address the needs of the most vulnerable individuals in the community by temporarily providing hotel and motel rooms for people experiencing homelessness who are at high-risk for hospitalization if they contract Coronavirus (COVID-19). The target population for PRK is individuals ages 65+ and/or who have certain underlying health conditions, (e.g., respiratory, compromised immunities, and/or a chronic disease). The County, in partnership with the City of Los Angeles and the Los Angeles Homeless Services Authority (LAHSA), is using state and federal funding for this effort. As of June 3, 2020, there were 3,559 participants enrolled in PRK, including 658 persons (or 18 percent) aged 65+.

Attachment II provides additional information on the status of exit planning for participants age 65+ enrolled in PRK. This status report includes information on Governor Gavin Newsom's 100-Day Challenge on homelessness, which was announced on December 5, 2019, with an initial cohort of Los Angeles, Alameda, Stanislaus, and Riverside Counties. The focus for each of these counties is to create permanent housing exit pathways for PRK clients. In Los Angeles County, the Challenge is focusing on the exit strategy for persons ages 55+; more than one-third of whom are ages 65+.

Conclusion

A final report will be submitted on September 1, 2020, which will contain cost estimates for a multi-year pilot program targeting all individuals ages 65+ experiencing homelessness. If you have any questions, please contact Phil Ansell, Director of the Homeless Initiative, at (213) 974-1752 or by email at pansell@ceo.lacounty.gov.

SAH:FAD:TJM
PA:JR:RM:tv

Attachments

c: Executive Office, Board of Supervisors
County Counsel
Health Services
Mental Health
Workforce Development, Aging and Community Services
Los Angeles Homeless Services Authority

Attachment I

WHAT IT WILL COST TO ENSURE HOUSING FOR VULNERABLE OLDER ADULTS:

Year One Estimates for Los Angeles County's Older Adult Housing Pilot

A 45-Day Report Back on a Motion Approved by the Los Angeles County Board of Supervisors on April 14, 2020 (Agenda Item No. 8)

Dennis Culhane &
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Max Stevens,
Los Angeles County
Chief Executive Office
Office of the Chief Information Officer

June 2020

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Executive Summary

This report responds to a motion from the Board of Supervisors to develop a plan that will house all homeless adults age 65 years and older (65+). Projections of homelessness in Los Angeles and across the country show that the number of older homeless adults is likely to grow—in many places more than doubling—over the next several years as a result of a cohort effect described elsewhere in this report. This plan is thus very well timed, as it allows Los Angeles County to get ahead of this problem as it threatens to worsen throughout the next decade.

The pilot presented here represents an innovation in homelessness services, targeting paired housing allowances and service plans on a scale previously unseen for this uniquely vulnerable population and doing so primarily through funds recouped from resultant reductions in other services. We expect that most of the service costs (excluding rental subsidies) will be fundable through Medi-Cal, and the transition of people through interim housing, if planned carefully, could be accomplished with existing housing stock. We propose that the need for Permanent Supportive Housing (PSH) and housing vouchers be met through a combination of turnover in existing units and new allocations. The success of this plan hinges on a well-coordinated effort that includes an expansion of housing stabilization case managers, who will be required to enroll and manage the transition into housing.

- The high-level plan presented in this report is not simply a plan to end older adult homelessness; it is a plan to end it beginning in fiscal year 2020-21: much of the plan, including the assumed rate of enrollment in permanent housing, the reduced role of interim housing and the urgent intensity of service provision, is specific to current circumstances, including the COVID-19 public health crisis and the County and State's responses to that crisis.
    - Move-ins to permanent housing will be accelerated in part by the existence of Project Roomkey as a springboard into long-term housing.
    - Interim housing other than Project Roomkey is excluded from estimates due to safety concerns associated with congregate shelter for older adults in the post-COVID environment.
- We estimate the total gross cost of housing 4,800 adults age 65 and older in Year One of the pilot to be **$100.5 million**.
    - This cost is attributable about 48% to housing subsidies, 36% to supportive and case management services, and 16% to one-time move-in costs.
    - The total cost of services, $36.3 million, is higher than the costs normally associated with a group of individuals experiencing homeless of this size; this recommended allocation of resources recognizes the accelerated timeline contemplated for housing so many people and the increases in labor and coordination that will be necessary for the program to succeed.
- Of the gross amount, $58.8 million could be funded with existing resources, while funding to cover $41.7 million needs to be identified before the pilot can be launched.
    - Of the $58.8 million in identified offsets, $52.6 million would come from Medi-Cal.
    - The projected use of Medi-Cal dollars to pay for supportive services and move-in costs is very much in keeping with the State's plans (reimbursement for these types of expenses is included in the planned California Advancing and Innovating Medi-Cal [CalAIM] program),

but such expenses are not yet fully reimbursable, and we anticipate that advocacy to the State will be required for these offsets to be achieved.
    - We therefore contemplate a coordinated ask to the State for a Demonstration Project that would both help fund the pilot and gather evidence of its effectiveness.

- This plan assumes a significant diversity of clients and needs and emphasizes that a similarly diverse range of interventions will be required to serve clients effectively; four main housing interventions are included:

    - Enriched Residential Care (10%), for clients requiring a higher level of care than is available in supportive housing.
    - Permanent Supportive Housing (45%), for clients experiencing chronic homelessness, high vulnerability, and/or disabling conditions of indefinite duration.
    - Shared housing allowance (29%), a shallow subsidy with no end date, payable directly to a landlord or homeowner; this novel intervention is designed to support and stabilize family reconciliation and other shared housing situations in which a client can move in with a loved one or someone else willing to take them in.
    - Housing voucher (16%), including Housing Choice Vouchers and other sources of subsidy for fair market housing with limited or no services attached.
    - This diversity and the requirement that providers work closely with clients to tailor interventions to individual needs is also a factor in our increased cost estimate for housing navigation and supportive services.

- The plan seeks to support the subset of older adults experiencing homelessness who will become known to the homeless services system and who will require support to end their homelessness.

    - We project that roughly one-quarter of the 6,400 older adults who experience homelessness in Pilot Year One will resolve their homelessness independently of the system.
    - This projection helps explain the high acuity levels of the net target population: those who "self-resolve" will be disproportionately low in acuity.

- Roughly 37% of the total net target population over five years is projected to experience homelessness and be served in Year One.

    - The balance of the target population in Years Two through Five will be either newly homeless or newly over 65 years of age and may therefore have different acuity levels, and/or a different range of needs relative to the Year One target population.
    - The increased case management costs per person discussed below are not necessarily anticipated to continue for the life of the program beyond Year One.
    - The multi-year implementation plan to be filed with the Board in September will detail the projected features of the target population in future years and their associated costs.

WHAT IT WILL COST TO ENSURE HOUSING FOR VULNERABLE OLDER ADULTS:
Year One Estimates for Los Angeles County's Older Adult Housing Pilot

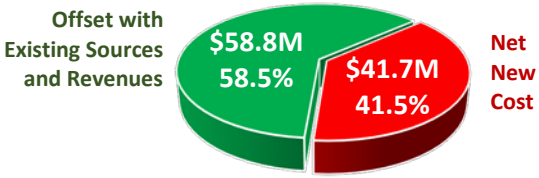
I. Background: Responding to an April 14, 2020 Board Motion

Older Adults and the Statewide Homelessness Crisis Response Strategy. On March 24, 2020, the Chief Executive Office's (CEO's) Homeless Initiative (HI) submitted a report to the Board detailing progress made in the development of a plan to implement the *Comprehensive Crisis Response Strategy to Address Homelessness Statewide* released by Governor Gavin Newsom's Council of Regional Homeless Advisors in January 2020. The March 24, 2020 report included '*a prioritized strategy for implementing or scaling up, where feasible*' 16 of the 40 strategies included in the *Comprehensive Crisis Response Strategy*. The March 24, 2020 report also recommended conducting a pilot program, to be undertaken in partnership with the State, to test approaches to ensuring housing or shelter for all persons at least 65 years of age who are ready and willing to receive such services (i.e., an Older Adult Housing Pilot). On April 14, 2020, the Board of Supervisors approved a motion directing County departments to adopt the CEO's recommended approach, including moving forward with initial planning of the proposed pilot.

The Intervening COVID-19 Emergency. In the time between the release of the Governor's *Crisis Response Strategy* and the CEO/HI March 24, 2020 report to the Board, the urgency of the focus on older adults intensified with the onset of the COVID-19 public health emergency. The April 14, 2020 Board motion referenced above therefore instructs the CEO, in coordination with County departments and relevant City and State Officials, to both (a) report back in 30 days *'with a strategy to provide long-term housing options to individuals experiencing homelessness who are aged 65+ and were provided emergency housing based on the COVID-19 emergency public health declaration';* and (b) report back in 45 days '*with an interim report, followed by a multi-year implementation framework as part of Fiscal Year 2020-2021 Supplemental Budget deliberations, with cost estimates for the pilot program targeting all individuals experiencing homelessness who are aged 65 or older.'*

An Interim Report on Year One Pilot Costs. On May 15, 2020, the HI submitted its 30-day report back on long-term housing options for older adults provided with emergency housing as part of Project Roomkey, the County's effort to protect high-vulnerability homeless persons from the COVID-19 pandemic. The present report is responsive to the instructions to produce a 45-day interim report back and includes cost estimates for the first year of an Older Adult Housing Pilot, which focuses more broadly on ensuring permanent housing for all adults experiencing homelessness who are at least 65 years of age.

Figure 1
Estimated Year One Los Angeles County Older Adult Pilot Gross Costs
4,800 Clients, $100.5 Million*



EXPECTED PILOT COSTS PER PERSON

Gross:	Net New Cost:
$20,939	$8,687 (41.5%)

*This estimate does not include interim housing costs

II. Estimating Year One Older Adult Housing Pilot Costs

Based on an overview of the envisioned Older Adult Housing Pilot provided in the HI's March 24, 2020 report to the Board, this interim report projects a pilot target population in Year One of approximately 6,400 homeless older adults, one-quarter of whom we assume will self-resolve their homelessness, leaving a net target population of 4,800 in need of housing and supportive services. We estimate the gross cost of meeting this need in Year One of the Older Adult Housing Pilot to be roughly $100 million, a projection that does not include interim housing costs for reasons that will be described in this report (Figure 1).

Existing Funding Sources, New Costs, and Estimated Costs Per Person. As shown in Figure 1, the expected composition of the pilot's target population and an analysis of the available funding options suggest that roughly three-fifths of the total Year One permanent housing costs can be offset, or potentially offset, with existing funding and revenues from Medi-Cal and already-existing homeless services resources.

Table 1. Estimated Year One Pilot Costs, Overall and Per Person

OLDER ADULT HOUSING PILOT	GROSS COSTS	FUNDING COMPONENTS	
		Offset Sources	Net New Costs
Overall	**$100.5M**	**$58.8M**	**$41.7**
Mean Per Person	$20,939	$12,252	$8,687
Highest Cost Client	$43,180	$25,260	$17,920
Lowest	$11,590	$6,780	$4,810

Providing the Year One target population with permanent housing therefore necessitate identifying or creating net new funding in the amount of $41.7 million. Beyond Year One, we anticipate that sources such as Supplemental Security Income (SSI), for which all persons who are at least 65 are automatically eligible absent other income, as well as Medi-Cal and Measure H, can fund portions of the services provided to pilot participants. Given a population of 4,800 Older Adults, these aggregated costs translate into expected gross expenditures of $20,939 per person, of which $8,687 would represent new cost (Table 1).

Costs Parsed by Client Vulnerability. Following the guidance provided in the HI's March 24, 2020 Board report, the estimates presented here are parsed by four groupings defined by degrees of client vulnerability, where Group One and Group Four consist of the most and least vulnerable older adults in the target population respectively. The four groupings are additionally subdivided into tiers based on specific types of client medical and behavioral health issues. Unit costs for the three components of the Year One estimate—permanent housing, Intensive Case Management Services (ICMS) and one-time move-in costs - are pegged to the vulnerability groupings and tiers, and the overall estimate for each subset of clients is a function of both their associated unit costs and the number of clients within a given subset.

The most vulnerable clients are the costliest in terms of anticipated per person expenditures due to the intensity of supportive and case management services expected to address their needs. Table 1 shows that the cost of serving the most expensive client in the Year One target population ($43,180) is expected to be almost four times that of serving the least expensive client. While this partly reflects variance in the amount of time different clients will be served through the pilot in Year One, the gap also reveals the range of housing arrangements and services that must be made available given evidence suggesting a target population with a diverse array of vulnerabilities, levels of acuity, and associated degrees of medical and supportive service needs.[1]

The State as a Potential Funding Source for New Costs Associated with the Pilot. Per the Board's instructions in the April 14 motion, the overall Year One pilot estimate and its various components are presented in this report as a first step in the subsequent development of a *'multi-year implementation plan.'* In providing this first step, it is impossible to ignore that the COVID-19 emergency constitutes an economic crisis as well as a public health crisis. The economic impact of the pandemic on the County's

[1] The clients are not evenly distributed across the four vulnerability groups established for our analysis and cost estimates. The two higher-vulnerability groups consist of 3,120 clients versus 1,680 in the two lower-vulnerability groups, a difference of 46.2%. This difference, combined with the gap separating the cost bases for the high- and low-vulnerability groups, can be inferred from the mean projected Year One pilot costs per person of the combined set of clients in the top two vulnerability groupings shown in Table 2 below ($24,114), which is more than 15% higher than the mean cost shown for the full target population in Table 1 ($20,939). The overall target population represents a diverse cross-section of older adult vulnerabilities and needs but from an overall perspective the population skews towards higher vulnerability.

budget will undoubtedly restrict the availability of discretionary funds for bold and inventive initiatives such as the Older Adult housing pilot. Relatedly, the effects of the crisis on Measure H receipts, which are driven by a quarter-cent sales tax, are not known as of this writing but are expected to be significant and lengthen the shadow the COVID-19 crisis casts over the funding contemplated in this report.

Given this fiscal environment, the County is not likely to conduct the pilot in the absence of an infusion of funding from the State in connection with both COVID-19 relief and the *Crisis Response Strategy*. Moreover, while this report assumes a highly significant pilot cost offset via Medi-Cal payment of ICMS and move-in costs, this is an assumption that will require negotiation with the State. Our estimates are therefore accompanied by a recommendation that the multi-year implementation plan be informed by a deeper assessment of potential State investment in the Older Adult Housing Pilot.

The Four Components of the Year One Pilot Cost Estimate

The cost estimates presented here are based on four components: (i) The scope of the envisioned pilot's services; (ii) The projected size of the Older Adult target population; (iii) the population's expected vulnerabilities and needs, informed by a historical analysis of the acuity and vulnerability levels of homeless older adults in Los Angeles County; and (iv) the funding sources available to the pilot (Figure 2).

III. Essential Features of the Envisioned Older Adult Pilot

As laid out in the descriptive document included in the CEO's March 24, 2020 report to the Board, the envisioned pilot would be designed to *'eliminate unsheltered homelessness for all adults age 65+ who desire shelter and eliminate homelessness for all adults age 65+ who desire housing*.' The COVID-19 crisis and the creation of Project Roomkey (PRK), however, have caused us to focus on the latter goal. PRK provides shelter (i.e., interim housing) to persons over 65 and accelerates their connection to permanent housing. Details of the project are included in the HI's May 15, 2020 and LAHSA's May 27, 2020 reports to the Board regarding plans and progress made toward housing PRK clients over age 65.

Since PRK is already funded, and because congregate shelter is not currently considered safe for older adults due to the risk of exposure to the novel coronavirus, we assume that the County will continue to prioritize placement of homeless older adults directly into permanent housing whenever possible and that any interim housing resources that must be used to help transition older adults into permanent housing will be existing resources only. Therefore, this interim report projects no net new costs associated with the directive to '*eliminate unsheltered homelessness for all adults age 65+ who desire shelter*.' Unlike most of the housing services older adults use, which are not age-specific, the pilot will provide housing through mechanisms designed by the HI's Older Adult Workgroup specifically to provide housing and supportive services targeted to homeless services clients who are at least 65 years of age.[2]

A Coordinated Intervention. Initiating the pilot will necessitate the *coordinated assessment of homeless adults ages 65 and older to identify appropriate candidates for the combinations of housing and services included in this proposal.* This assessment and the other features of the coordinated intervention

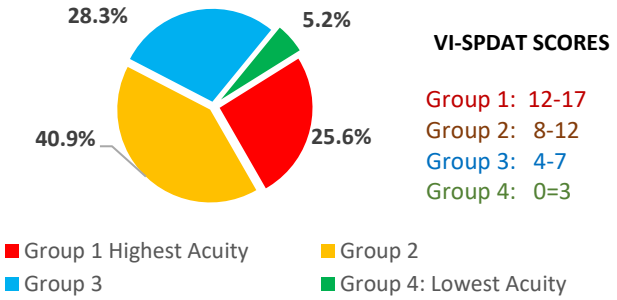
[2]The key factors informing the selection of older adults as the target population for the pilot include the higher risk among older adults for negative health outcomes and the comparatively high likelihood that homeless adults who are at least 65 years of age will be chronically homeless, face behavioral health challenges, and incur comparatively high health care costs. At the same time, older adults who are not homeless but live on fixed incomes and face health problems are at a relatively high risk of becoming homeless in the face of mounting medical costs and rents. Insofar as homelessness compounds the health and service costs associated with aging, moreover, a pilot targeting older homeless and at-risk adults represents an opportunity to re-invest savings yielded through housing the older adult subset into the services provided via the pilot in subsequent years.

referenced in the March 24, 2020 Board report are not itemized among the costs presented in this report, but they are inputs influencing the high cost per person of supportive services.

Flexibility in Meeting a Varied Range of Needs. Although the pilot is to be focused on what amounts to a comparatively small subset of persons experiencing homelessness, the target population nevertheless presents varied sets of needs and vulnerabilities that demand a flexible approach to service provision. As the CEO's March 24, 2020 report to the Board notes, *'*(h)*ousing options that allow for variable intensity of services and length of stays will be required,'* and the range of permanent housing interventions contemplated takes the need for flexibility and innovation into account.

Vulnerability, Services and Costs. As noted in the previous section, we follow the framework of the March 24, 2020 report to the Board and parse the prospective older adult client population into four groupings based on vulnerability. Figure 2 shows the distribution of vulnerability—determined by VI-SPDAT scores—among older adults served by LAHSA during Fiscal Year (FY) 2018-19.[3] In preparing the pilot cost estimates presented in this report, we remain consistent with the four-tiered vulnerability framework and rely significantly, though not exclusively, on VI-SPDAT assessment scores over a lookback period spanning three years.

Figure 2. Older Adults Served by LAHSA During FY 2018-19, by Acuity Score Grouping, n= 2,666



*HMIS enrollment records indicate that LAHSA served 4,957 older single adults in FY 2018-19. The count here (*n=2,666)* represents those within this older adult client population for whom any VI-SPDAT scores are recorded in HMIS dating back to July 1, 2016.

An attachment included with the March 24, 2020 CEO report to the Board presents estimated *per person* permanent and interim housing costs per month for pilot participants, inclusive of Intensive Case Management Services (ICMS). The estimates encompass three permanent housing types: *Standard Rental Subsidies*, inclusive of Permanent Supportive Housing, *Shallow Subsidies* and *Enriched Residential Care.* The per person costs per month attached to both case management and housing types for Year One of the Older Adult Housing Pilot are discussed further below. One-time move-in expenditures are also included in our estimates.

IV. The Expected Target Population: Projecting Older Adult Homeless Inflow

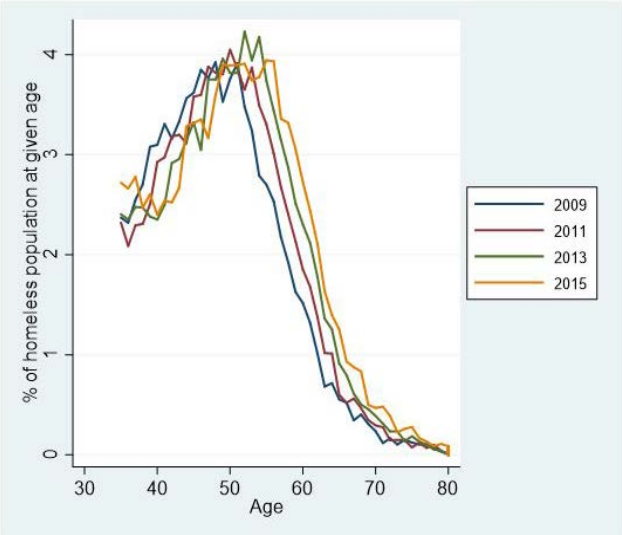
A Cohort Effect Drives the Increase in Older Adult Homelessness. The rise in homelessness among adults over 65 results from a highly persistent yet avoidable pattern of disadvantage within the late Baby Boom cohort, roughly persons born between 1954 and 1962. There is evidence dating as far back as 1990, when these individuals were in their 20s or 30s, that members of this cohort have dominated the shelter population. The pattern has been found over time, nationally, and across all major localities, as shown in Figure A1 in Appendix A, which tracks this pattern through 20 years of US Census data.

Over a much shorter period, we can see a similar pattern of persistence in the age distribution of sheltered home-lessness observed in LAHSA's HMIS records from 2009 to 2015. As seen in Figure 3, this same cohort remained the largest in the shelter system throughout this period, with the peak age groups simply

[3] Clients are placed in the SPDAT score ranges based on the mean of all scores recorded for them in HMIS since July 1, 2016.

shifting to the right over time as the cohort grew older. The persistence of homelessness within this cohort does not mean that it is the same individuals who experience homelessness at each time point, however. Instead, new members of the cohort have become homeless at different times in their lives based on the consistent pattern of disadvantage identified above.

Figure 3: Age distribution of the sheltered population In Los Angeles County: 2009-2015.



Population Projections for Los Angeles. Based on the late-Baby-Boom cohort effect, we generated a forecast of the growth of the over-65 homeless population from the most recent complete fiscal year, through to the present, and then beyond to FY 2024-25. This forecast reflects the natural growth of homelessness among Los Angeles's over-65 population if no added intervention took place. The 2019 report and accompanying research paper (Culhane, Metraux, Kuhn, 2019) provided detailed analysis of age, period and cohort patterns of homeless persistence and produced a wide range of forecasts, all of which pointed to roughly 8%-9% annual growth in the over-65 homeless population due almost entirely to the fact that larger homeless cohorts are reaching age 65.

Figure 4 shows a simplified version of this forecast. In FY 2020-21, Year One of the Older Adult Housing Pilot, we estimate that 6,394 persons over age 65 will experience homelessness, including 2,644 over age 70. The model expects 9% annual growth in the following year, with slightly decreasing growth in subsequent years. The result is a projection of 8,633 adults over 65 experiencing homelessness during FY 2024-25, a 35% increase over four years.

The forecast depicted in Figure 4 includes many people who would be homeless across multiple years. To estimate the deduplicated total population of people over age 65 who will experience homelessness at any time in the next five years, we used HMIS case histories to distinguish each year's new entries from people persisting from prior years. We estimate that, in any given year, about 34% of over-65 clients would be newly homeless. As depicted in Figure 3 of Appendix B, this results in the addition of two- to three thousand new clients each year, for a total of 17,097 unique persons over the pilot's first five years. This total, however, must be adjusted to account for client self-resolution (see Appendix B for more information).

Figure 4: Projected growth in 65+ PEH through FY 2023-24, PIT adjusted, forecast begins 2018-19

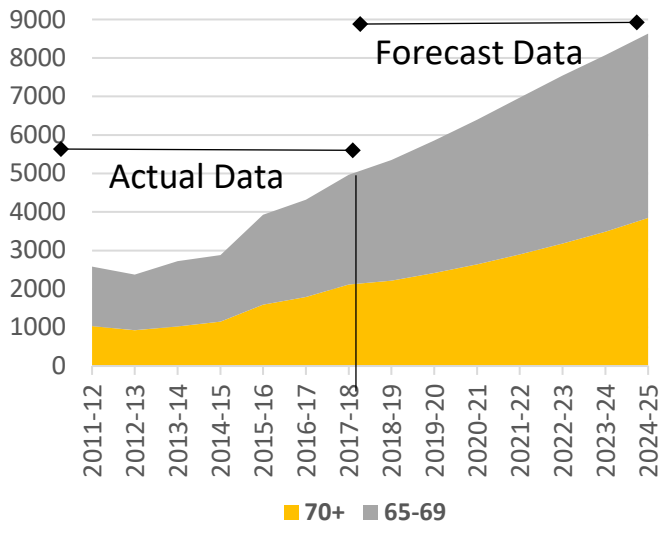
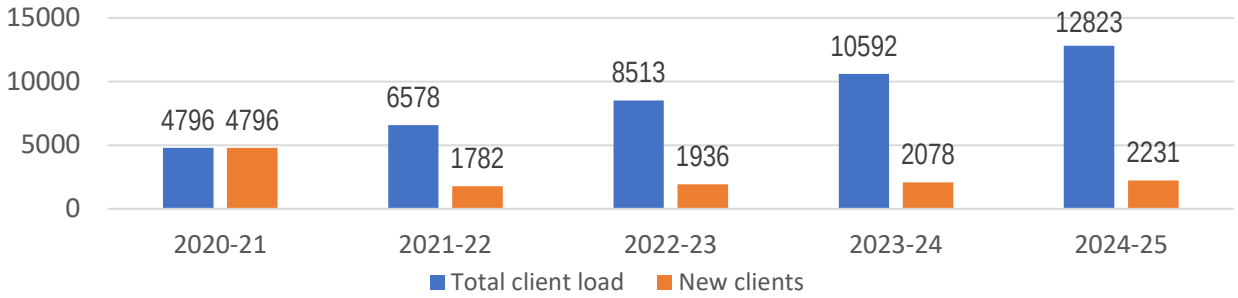


Figure 5. Projecting Older Adult Housing Pilot Clients Over Five Years



V. The Expected Composition of the Target Population.

A Study Population and a Target Population. As indicated above, we project roughly 6,400 single adults aged 65+ will experience homelessness at some point in FY 2020-21. This older adult subset of the larger homeless population represents the *target population* for whom the housing pilot will attempt to eliminate unsheltered homelessness. Producing a pilot cost estimate requires a projection not only of the number of persons to be served, however, but also of the types of housing and services they will require.

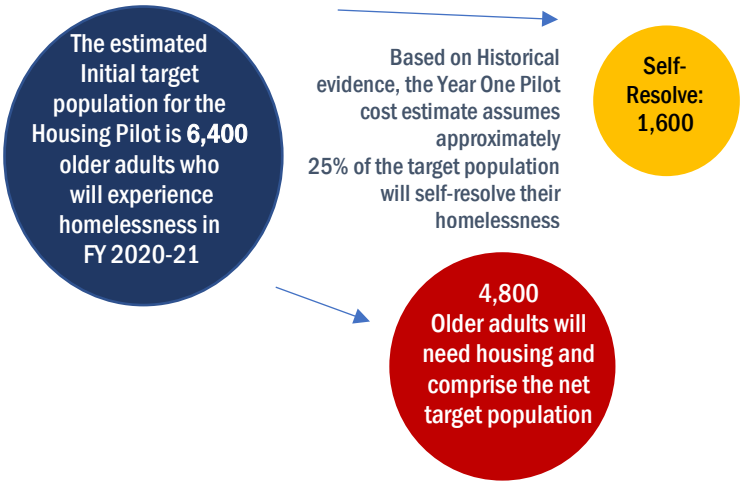
In order to project these needs for the target population, we analyze a *study population*, the set of older adults with an open HMIS enrollment during FY 2018-19. We assess the demographics and vulnerability levels of the study population and project a similar distribution of relevant characteristics across the expected target population. Using these characteristics, we then distribute the target population's members among four vulnerability groups, corresponding roughly to the four CES Acuity Groups. Section V explains this distribution, its derivation and some of its consequences. Section VI will address the estimated costs associated with these projections.

Demographics. Table B1 in Appendix B presents historical data from the study population and applies their demographic composition to the FY 2020-21 target population. Table B2 in Appendix B shows the expected breakdown of the full homeless older adult population, aged 55 and over, projected for Los Angeles County in the same year. In part as a result of the cohort effect documented in Appendix A, the projected homeless population aged 55-64 is significantly greater than the group aged 65 and above.

We project that 14,668 persons between the ages of 55 and 64 will experience homelessness in FY 2020-21. Of those experiencing homelessness over age 65, approximately 3,750 will be 65 to 69 years old and 2,644 will be 70 or older.

Self-Resolution. We assume that not all older adults experiencing homelessness will require homeless services—or even become known to the homeless system. Indeed, of the 6,400 projected members of the Year One target population, roughly 25% may be expected to "self-resolve," or to end their homeless spell without system intervention.

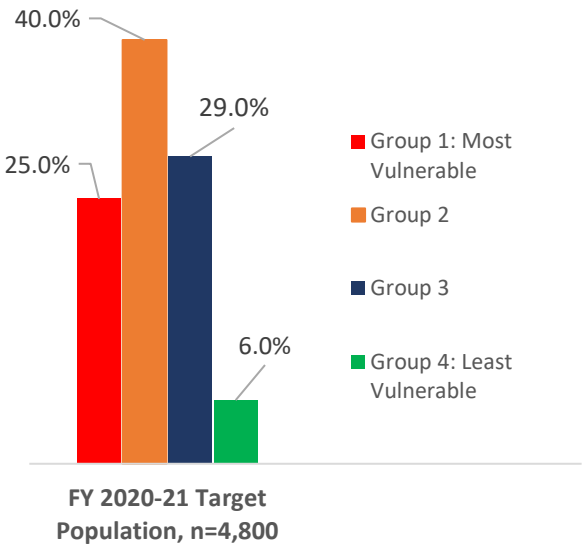
Figure 6. Self-Resolvers in the Initial Target Population



Thus, we expect 4,800 older adults to require housing placement services as part of the FY 2020-21 Older Adult Housing Pilot. This *net target population* is more likely to resemble historical HMIS and CES clients in its acuity distribution than is the full universe of homeless adults 65 and older, which includes people experiencing homelessness who have not availed themselves of homeless services and for whom, therefore, no data are available. More detail is provided in Appendix B.

Measures of Vulnerability. We use three measurements of vulnerability to project the needs of the net target population: CES assessment scores, reports of "indefinite and impairing" disabilities in HMIS, and Gagne Index comorbidity scores based on clients' diagnostic records received through the Departments of Health Services (DHS) and Mental Health (DMH). These measures are applied to the members of the FY 2018-19 study population to assign them to vulnerability categories and to tiers within those categories. The resulting proportions are then applied to the projected FY 2020-21 net target population. See Appendix B for more information.

Figure 7. Distribution of Homeless Older Adults by Vulnerability Grouping: Pilot Target Population



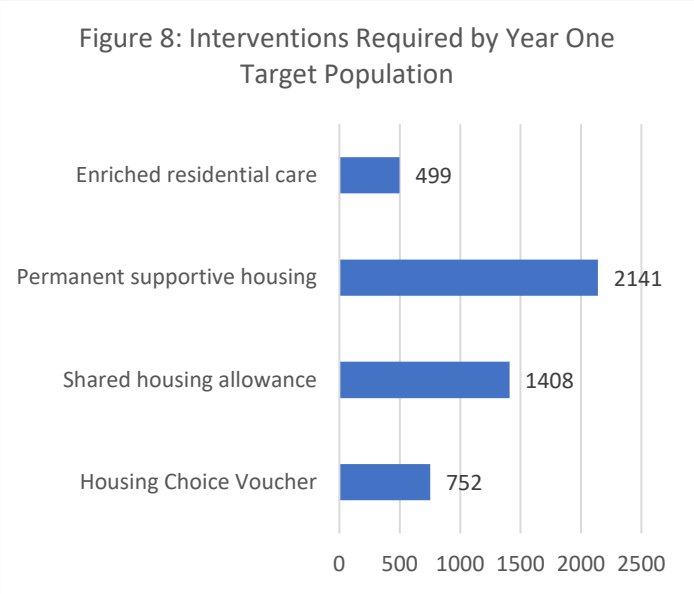
Distribution of the Net Target Population into Vulnerability Groupings and Tiers. Based on the study population's CES scores and reported disabilities, we project that 25% of the net target population will fall in the highest-vulnerability grouping, followed by 40% in the second-highest, 29% in the third, and 6% in the least vulnerable grouping (see Figure 7).

The March 24, 2020 report to the Board recommends flexibility of intervention within each vulnerability grouping, assuming, for example, that some clients in Groups 1 and 2 will access Permanent Supportive Housing (PSH) while others will access Enriched Residential Care (ERC).

Thus, we subdivide the four vulnerability groupings into tiers to estimate the full range of housing solutions. Table 2 details the population distribution by both group and tier, and Appendix B delves in detail into our use of Gagne comorbidity scores to apportion the high-acuity segment of the net target population between PSH and ERC.

Figure 8 shows the overall projected need for each category of housing placement based on the analysis in Table 2. Importantly, however, the same flexibility in initial placement recommended in the March 24, 2020 Board report will be necessary in re-evaluating and adjusting those placements over time. Some clients will prove not to be good candidates for the interventions initially recommended and will require program transfers. Some clients whose initial placements are successful will decompensate over time and eventually require transfers to a higher level of care. The multi-year implementation plan that follows this interim report will need to account for those factors in its final estimation of costs, and this estimation should also be updated after Year 1 of the pilot to reflect lessons learned during that year.

Table 2: Projected Vulnerability Groupings of FY 2020-21 Pilot Population			
Initial Target Population	**6,400**		
Self-Resolvers	1,600	%	
NET TARGET POPULATION, *N*=	**4,800**	Targeted	
Group 1	**1,200**	25%	**Intervention**
Tier 1	192	4%	Enriched Residential Care
Tier 2	1,008	21%	Permanent Supportive Housing
Group 2	**1,920**	40%	
Tier 1	307	6%	Enriched Residential Care
Tier 2	1,133	24%	Permanent Supportive Housing
Tier 3	480	10%	Housing allowance/shallow subsidy
Group 3	**1,392**	29%	
Tier 1	928	19%	Housing allowance/shallow subsidy
Tier 2	464	10%	Housing Choice Voucher or equivalent
Group 4	**288**	**6%**	Housing Choice Voucher or allowance



Other Demographic Considerations. Two other features of the target population's members are likely to influence providers' ability to house them effectively. Older adults experiencing homelessness in Los Angeles County are more likely to be unsheltered and more likely to be experiencing long-term homelessness than is the homeless population as a whole (Henwood et. al, 2019).

At the same time, a significant proportion of the long-term older adult homeless population has been homeless long enough to qualify as chronic but lacks the disabling condition or the frequency of homeless spells that would make them eligible for housing resources available only to those categorized by HUD as chronically homeless (See Appendix B).

These factors combined make it likely that members of the high-acuity groups listed in Table 2 will require significant ICMS and housing navigation services to build trust, prepare them for housing, and match them to placements that meet their needs. Some may also require more creative solutions; we anticipate that as many as 25% of the clients in Group 2 may benefit from a shallow subsidy if they are unable to access, or are not well suited for Permanent Supportive Housing, but have family or friends who could take them in if provided with a modest contribution toward rent. We refer to this subsidy as a *shared housing allowance*.

Common Costs. Regardless of housing destination, all members of the target population who do not self-resolve will require some level of case management and/or housing navigation services. Some clients will need only a light touch, while others will require intensive outreach and case management to build relationships over many months before they are ready to trust a provider to connect them to housing.

The March 24, 2020 Board report included in its estimates of costs per person monthly ICMS costs for clients in interim housing, and it assumed clients would average nine months in interim housing before accessing permanent housing. For the reasons explained above, we do not include the costs of interim housing in our estimates, but we do retain monthly ICMS costs per person for every pilot client, regardless of housing status. (That is, we include 12 months of ICMS services for all pilot clients, to cover both housing navigation for unhoused clients and supportive services for housed clients.)

VI. Estimating Pilot Costs

This section provides the Year One housing pilot cost estimate requested in the April 14, 2020 Board motion. The costs build on the programmatic vision provided in the HI's March 24, 2020 Board report with a model that includes a mix of permanent housing placements: Enriched Residential Care for people who need on-site supports with daily living, Permanent Supportive Housing for those who need behavioral and physical health supports that are routine but not necessarily on site, traditional subsidies, e.g. housing choice vouchers, supplemental rental allowances, and shallow subsidies/shared housing allowances.

Year One Gross Costs. We estimate the pilot's Year One gross cost will be $100.5 million. This will be the cost of providing the Year One net target population of homeless Older Adults – i.e., the target population minus those who self-resolve their homelessness – with permanent housing, inclusive not only of housing itself but also of case management services and move-in costs.

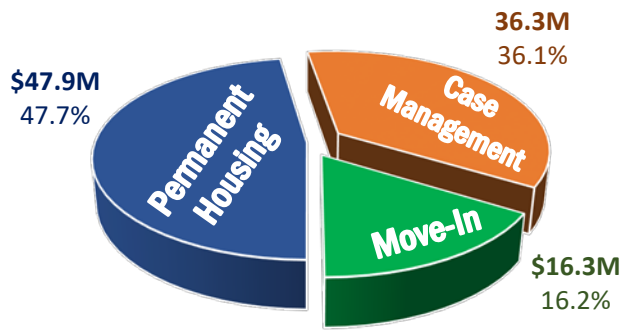
Table 3. Estimated Gross & Net New Pilot Costs

Target Population minus Self Resolvers = 4,800 Older Adults

Service Category	Gross Cost	Net New Cost		
		$	% Row	% Column
Permanent Housing	$47.9M	$41.7M	87.0	100
Case Management	$36.3M	$0	0	0
Move-In	$16.3M	$0	0	0
TOTAL	$100.5M	**$41.7M**	**41.5**	**100**

Year One Net New Costs. Within estimated Year One gross costs of $100.5 million, our assessment of both the array of needs and vulnerabilities within the net target population and the programs and resources available to older adults suggests that roughly 42% of the gross estimate - $41.7 million - would require new expenditures. It is critical to emphasize, however, that *net new spending* does not exclusively refer to County expenditure *per se* or to Net County Cost (NCC). The $42 million in net new cost that the pilot would require simply refers to the portion of the gross cost for which funding sources have yet to be identified from existing County, State, or federal programs. The sources of the $58.8 million in projected cost offsets are discussed further below in this section.

FIgure 9. Basic Components of the Estimated Gross Year One Housing Pilot Cost
$100.5 Million



Distribution of Cost Components. We estimate that permanent housing will comprise roughly 48% of Year One pilot expenditures ($47.9 million) and are the only source of net new cost in the overall Year One estimate. Costs associated with specific housing and subsidy types are detailed below. Case management at varied levels of intensity for clients with different types and degrees of vulnerability is estimated to account for approximately 36% of the gross Year One estimate, while move-in costs account for 16.2% (Figure 9).

As shown in Table 5, the housing costs factored into the Year One pilot estimate are divided into groups differentiated by degrees of service and resource intensity. These costs are based on guidance provided in the HI's March 24, 2020 report to the Board.

An Atypical Year. Year One of the pilot will not be a typical year for several reasons. In addition to the need to ramp up staffing, training, and services, the pilot seeks to permanently house all 4,800 persons expected to require services over the course of the year, despite the varied times at which they will become homeless and their varied paths into homelessness. Moreover, roughly 1,000 older adults within the net target population, slightly more than one of every five, are expected to begin Year One already connected to accelerated and prioritized housing navigation services through PRK.

Ambitious Placement Projections and their Rationale. To produce annualized estimates for the net target population as a whole, we project that the average time spent in permanent housing during Year One will be between 10 and 12 months, which is likely to strike at least some working within the County's homeless services system as overly optimistic and ambitious, particularly insofar as the ten months do not include any time in interim housing for reasons discussed in section 3.[4] The HI, LAHSA and all other key stakeholders involved in the development of the multi-year implementation plan for the pilot, to be developed at the direction of the Board in time for the County's FY 2020-21 supplemental budget process, will ultimately determine whether an average of ten months in housing within the space of a year and, by extension, the associated costs require adjustment. Our rationale for this projection is based on the following considerations:

- Approximately 20% of the target population, as noted above, will be on an expedited path to placement in permanent housing through PRK either contemporaneously with the start of the pilot or shortly thereafter.

- Despite added capacity provided through PRK thanks to the single room occupancy units that the participating hotels and motels make available to the County, the COVID-19 emergency has significantly reduced the system's interim housing more generally. The vast majority of interim housing facilities within the County's service system consists of congregate shelters.

    - Unless and until social distancing requirements are eased, the providers operating these facilities will necessarily serve smaller numbers of people to comply with social distancing requirements. Interim housing is further restricted for older adults since congregate shelter is now simply deemed unsafe for them given the intensified health risks should they become infected with the coronavirus.

- Within this context, and particularly given the priority and urgency with which the Board is approaching the need to house homeless older adults, we anticipate that the process will occur at an appreciably accelerated rate. Our case management estimate for Year One of the pilot ($36.3 million) seeks at once to reflect and facilitate this expectation.

[4]Those skeptical of this projection might note, for example, that despite the implementation and ramp-up processes referenced here, an average of more than ten months housed during Year One implies a placement process within which pilot participants housed within the first quarter of the year would be the most commonly observed tendency and/or that the number of clients housed during the first three months of the pilot would appreciably outweigh the number of clients housed between the fourth and twelfth months of the year. While this is true, the disproportionate representation of chronically homeless individuals among older adults, combined with the existence of Project Roomkey as a springboard for housing, lead us to err on the side of caution in predicting the average number of months housed and therefore the cost of permanent housing over the pilot's first year.

- The case management estimate averages to $7,552 per person, which is roughly 40% higher on a *per capita* basis than the typical costs for a client receiving the most intensive variant of these services for all 12 months in given a year.

- These dollars are added to the projected case management costs to account for the premium the County is placing on ensuring homeless older adults are housed, including those sheltered through PRK as their stays in the participating hotel and motel facilities end and as the County and LAHSA prepare to sunset the program.

Table 5. Estimated Gross & Net New Pilot Cost Detail

Service Category	Clients	Costs*		Offset		Net New Cost (NNC)		
		Monthly, Per Person	Gross Total	Source	Total	$	% Row	% Gross Total
PERMANENT HOUSING	**4,800**	**$908**	**$47.9M**	**HI, LAHSA**	**$6.2M**	**41.7M**	**87.0**	**41.5**
Shallow Subsidies	1,408	$400	$6.2M	LAHSA	$805k	5.4M	87.0	5.4
Vouchers*	752	$900	$7.4M	HACOLA	$968K	$6.5M	87.0	6.5
Permanent Supportive Housing	2,141	$900	$21.2M	LAHSA, HI	$2.8M	$18.4M	87.0	18.3
ENRICHED RESIDENTIAL CARE	499	$2,385	$13.1M	DHS	$1.7M	11.4M	87.0	11.3
ERC I	192	$3,000	$6.3M	DHS	824K	$5.5M	87.0	5.4
ERC II	307	$2,000	$6.8M	DHS	$878K	$5.9M	87.0	5.9
CASE MANAGEMENT	**4,800**	**$629**	**$36.3M**	Medi-Cal	**$36.3M**	$0	0	0
ICMS I	3,120	$765	$28.6M	Medi-Cal	$28.6M	$0	0	0
ICMS II	1,680	$383	$7.7M	Medi-Cal	$7.7M	$0	0	0

Service Category	Clients	Per Person	Gross Total	Source	Total	NNC		
One-Time MOVE-IN	**4,800**	**$3,402**	**$16.3M**	Medi-Cal	**$16.3M**	**$0**	**0**	**0**
Shallow Subsidies	1,408	$3,700	$5.2M	Medi-Cal	$5.2M	$0	0	0
Vouchers	752	$3,700	$2.8M	Medi-Cal	$2.8K	$0	0	0
Permanent Supportive Housing	2,141	$3,700	$7.9M	Medi-Cal	$7.9M	$0	0	0
Enriched Residential Care	499	$1,000	$499K	Medi-Cal	$499K	$0	0	0

TOTAL	Clients	Monthly Per Person	Gross Total	Estimated Offset Total	NNC $	NNC % Gross Total
ESTIMATED YEAR ONE COST	**4,800**	**$1,745**	**100.5M**	**$58.8M**	**41.7M**	**41.5**

Red typeface in the *Monthly Cost Per Person* column denotes a categorical average for the given subset of the target population since the row comingles multiple rates. All other rates within the column are those that were included in the March 24, 2020 report to the Board of Supervisors.

Case Management as the Key to Innovative Service Provision. Prior to the onset of the pandemic, initial planning for the Older Adult Housing Pilot included provisions for older adults whose preferences are for interim housing arrangements. Since accommodating such preferences under the current circumstances is no longer a viable option, making the case for the appropriate type of permanent housing to this subset of the target population will be one of the key responsibilities for those working as housing stabilization case managers.

The cost estimates provided in this report also serve as a programmatic proposal for a pilot based on scaled housing stabilization case management services, independent living supports and payment of move-in costs, lynchpins of this program model. Housing stabilization case management on the scale we anticipate the pilot will require, when tied with these types of housing assistance programs, represent a significant innovation

in how services are targeted and implemented. Estimated service costs per person have been increased accordingly. Case managers will be crucial in managing every step of the process—identifying housing resources, completing applications, searching for housing and more—and providers will have to scale up and train their housing assistance teams and ensure that they are incentivized for timely and stable placements.

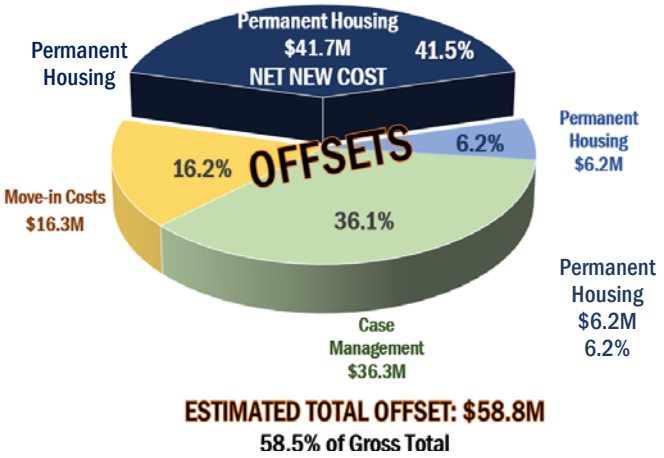
Housing stabilization case management will also ensure clients are enrolled in benefits (e.g., SSI, CalFresh and Medi-Cal), counseled on housing options, assisted with negotiations with landlords or other housing providers, provided with move-in assistance, and connected to ongoing case management and other community-based services once housed.

Offsets and Net New Costs. The County will seek to maximize the extent to which the Older Adult Housing Pilot is funded through (a) existing resources and (b) savings yielded through reductions in the use of other services. Although this is standard procedure in the way local government jurisdictions normally proceed in efforts to fund large-scale initiatives, the budgetary and fiscal constraints resulting from the ongoing economic fallout of the COVID-19 crisis lend added urgency to minimizing the assumption of new costs and funding obligations. Our estimate projects offsets in the amount of $58.8 million, which is close to 60% of the estimated Year One Gross total for the pilot. This would necessitate identifying funding sources for the remaining Net New Cost in the projected amount of $41.7 million

As noted above, the $41.7 million categorized as Net New Cost neither automatically excludes nor is restricted to the use of Net County Cost (NCC) or County resources more generally. In presenting a portion of the estimate as *new cost,* the intention is to underscore that the source for these funds has not yet been identified and to emphasize that a thorough examination of all potential sources - including any potential offsetting savings not included among those discussed in this report - as well as of the processes through which funds from each would be made available to the County, will be a critical component of implementation planning for the pilot.

New Costs and Cost Offsets Related to Permanent Housing. As shown in Table 5, housing subsidies are the only source of net new cost in our Year One $100.5 million estimate. As discussed in Section 3, historical data in HMIS provides evidence to expect that roughly 13% of the net target population represent those who would be housed in the absence of a pilot (i.e., 624 clients). These costs are therefore recorded as offsets. To account for these clients and offsets, we compute the target population's gross permanent housing costs in the four subsidy/housing categories our estimate considers ($47.9 million) and register 87% of these gross costs as Net New Costs ($41.7 million) and the remaining 13% as being offset by existing capacity ($6.2 million).

Figure 10.
New Costs and Offsets in Year One of the Older Adult Housing Pilot
Gross Total Cost: $100.5 Million



ESTIMATED TOTAL OFFSET: $58.8M
58.5% of Gross Total

Medi-Cal, the State, and Using the Pilot as a Potential Demonstration Project. Offsets from existing permanent housing resources comprise 10.5% of the total offset estimate ($58.8 million). The remaining 89.5% of the projected offsets, totaling to $52.6 million, comprise 52.3% of the Year One pilot estimate and constitute the more difficult aspect of the approach to funding the pilot reflected in our cost projection. Specifically, the cost calculations assume that all case management and move-in costs will be paid by Medi-Cal. This is not an 'expectation' *per se*, but rather a recommended road map for the County in pursuing the pilot.

This path will require the development of a proposal to the State, one that could potentially be joined by other County jurisdictions to authorize the deployment of Medi-Cal for the purposes of the pilot. The County might consider proposing that the Medi-Cal piece of the pilot be framed as a Demonstration project aimed at showing Medi-Cal cost savings yielded by the pilot. Doing so would have the advantage of alignment with the emphasis that Governor Newsom's Council of Regional Homeless Advisors placed on innovative solutions in the *Comprehensive Crisis Response Strategy*. As part of the preparations for the development of the multi-year pilot implementation plan, we recommend that the HI and LAHSA work with the County's Office of the Chief Information Officer (OCIO) to produce baseline medical costs for the target population and clients in historical data who resemble those in the target population.

Costs by Vulnerability Group. Unsurprisingly, clients in the higher-vulnerability groupings account for disproportionate shares of both total program costs and net new costs. As shown in Figure 7 above, Group 1 accounted for 25% of the target population and Group 2 accounted for 40%. Table 6A shows that Group 1 accounts for 31.1% of the projected gross cost of the program and 34.0% of the net new cost, while Group 2 accounts for 43.8% and 41.9%, respectively.

Table 6A: Program Costs of Pilot Year One by Group and Tier, Groups 1 and 2

	GROUP 1: 1,200 Clients					GROUP 2: 1,920 Clients				
			Net New Cost					Net New Cost		
				%					%	
Tiers	GROSS COST	Offset	$	Row	Pilot NNC	GROSS COST	OFFSET	$	Row	Pilot NNC
1			192 Clients					307 Clients		
PH	$6.3M	$824K	$5.5M	87	13.2	$6.8M	$878K	$5.9M	87.0	14.1
ICMS	$1.8M	$1.8M	$0	0	0	$2.8M	$2.8M	$0	0	0
Move-In	$192K	$192K	$0	0	0	$307K	$307K	$0	0	0
TOTAL	$8.3M	$2.8M	$5.5M	66.3	13.2	$9.9M	$4.0M	$5.9M	59.6	14.1
% Gross Total	8.2	4.7				9.8	6.8			
2			1,008 Clients					1,133 Clients		
PH	$10.0M	$1.3M	$8.7M	87	20.8	$11.2M	$1.5M	$9.8M	87.0	23.4
ICMS	$9.3M	$9.3M	$0	0	0	$10.4M	$10.4M	$0	0	0
MOVE-IN	$3.7M	$3.7M	$0	0	0	$4.2M	$4.2M	$0	0	0
TOTAL	$23.0M	$14.3M	$8.7M	37.8	20.8	$25.8M	$16.1M	$9.8M	59.4	23.4
% Gross Total	22.8	24.3				25.7	27.4			
3.								480 Clients		
PH			N/A			$2.1M	$275K	$1.8M	87	4.4
ICMS						$4.4M	$4.4M	$0	0	0
MOVE-IN						$1.8M	$1.8M	$0	0	0
TOTAL						$8.3M	$6.5M	$1.8M	21.7	4.4
% Gross Total						8.3	11.1			
GROUP TOTAL	$31.3M	$17.1M	$14.2M	45.4	34.0	$44.0M	$26.6M	$17.5M	39.8	41.9
% Gross Total	31.1	29.1				43.8	45.2			

By contrast, Group 3, which accounts for 29% of the target population, represents 20.1% of gross costs and 18.1% of net new costs, while Group 4 accounts for 6% of the target population, 5.0% of gross costs, and 5.9% of net new costs (Table 6B).

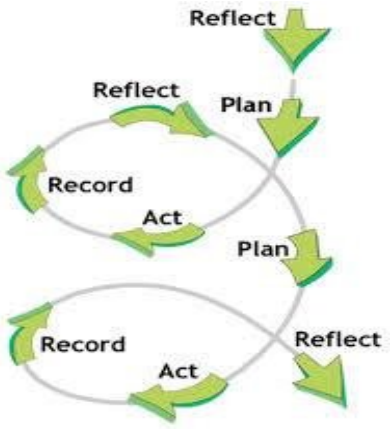
Table 6B: Program Costs of Pilot Year One by Group and Tier, Groups 3 and 4

	GROUP 3: 1,392 Clients					GROUP 4: 288 Clients				
			Net New Cost					Net New Cost		
Tiers	GROSS COST	Offset	$	% Row	Pilot NNC	GROSS COST	Offset	$	% Row	Pilot NNC
1	928 Clients					288 Clients				
PH	$4.1M	$531K	3.6M	87	8.5	$2.9M	$371K	$2.5M	87	5.9
ICMS	$4.3M	$4.3M	$0	0	0	$1.2M	$1.2M	$0	0	0
Move-In	$3.4M	$3.4M	$0	0	0	$984K	$984K	0	0	0
TOTAL	$11.8M	$8.2M	3.6M	30.5	8.5	$5.1M	$2.8M	$2.5M	49.0	5.9
% Gross Total	11.7	13.9				5.0	0.6			
2	464 Clients									
PH	$4.6M	$597K	$4.0M	87	9.6			N/A		
ICMS	$2.1M	$2.1M	$0	0	0					
Move-In	$1.7M	$1.7M	$0	0	0					
TOTAL	$8.4M	$4.4M	$4.0M	47.6	9.6					
% Gross Total	8.4	7.5								
GROUP TOTAL	$20.2M	$12.6M	$7.5M	37.1	18.1	$5.1M	$2.8M	$2.5M	49.0	5.9
% Gross Total	20.1	21.3				5.0	4.7			

Net New Costs. All net new cost estimates assume that Medi-Cal will cover the entirety of new costs for case management, housing navigation, and move-in expenses. For permanent housing interventions, a small subset can use existing resources, such as turnover units or vouchers, but roughly 87% will require new funding from the State or other sources.

VII. The Path to a Multi-Year Implementation Plan

Figure 10: Data-Driven, Iterative Program Implementation



An Iterative Approach. Year One of the Older Adult Housing Pilot will be an important learning year, and it will be crucial for the team charged with implementing the program to monitor it closely, with an eye toward identifying assumptions that prove not to match the reality on the ground. The need to track metrics, iterate new approaches, and evaluate the results will not be limited to Year One. A fundamental assumption informing the projections in this report is that the future will resemble the past.

However, the COVID-19 pandemic and responses such as Project Roomkey add unprecedented factors to the homeless services system, and our projections may not account accurately for the resulting changes. For this reason, a full multi-year implementation plan should include a data collection and self-evaluation plan from the beginning. If, for example, the pilot's observed client vulnerability levels diverge significantly from those projected here, program managers will need the tools and the infrastructure in place both to recognize this divergence early enough and to reallocate resources quickly enough to compensate.

The pilot, as well, will not be implemented in a vacuum. Many new units of PSH funded by Proposition HHH will be coming online during the pilot years, and those units will create a significant demand for new staff and training resources. We envision the Older Adult Housing Pilot creating similar but not entirely coextensive demands, and it will be important to explore potential synergies in recruiting and training intentionally, rather than allow different parts of the homeless services system to compete for scarce resources. This too is likely to require multiple iterations to get right.

Prerequisites for a Full Plan. We have included in this interim report projections of the number of clients who must be served if older adult homelessness is to be eliminated, as well as the costs of placing them in the permanent housing solution best suited to their needs. We have not included in our projections the cost of creating most of the housing resources required. Project-based Permanent Supportive Housing slots are limited by the number of physical units in existence. Housing Choice Vouchers and Continuum of Care Vouchers are finite resources that can be created only by the federal government. Los Angeles' Flexible Housing Subsidy Pool is an important resource that is under local control, but it is also finite. The shared housing allowance described here would be a new resource that the State must create. Similarly, we believe that with the right advocacy and policy innovations

Medi-Cal could be leveraged to pay for most if not all of the new case management and supportive services contemplated by the pilot, but that can happen only if policy advocates and legislators work together to effect the necessary changes. Thus, a full multi-year implementation plan will require an advocacy plan and timetable as well as a program deployment and management plan and timetable.

Increased Granularity in Planning. In moving from a one-year planning window to a five-year planning window, we will need to produce a granular analysis of the outcomes and exits expected from year to year. The total client load initially represented in Figure 5 above, for example, assumes no exits from the program. Once the full Year One target population has been served, however, the housing resources used by that population need to be accounted for from year to year. Some clients will require program transfers. Some clients will die in housing. Some clients will exit to unsubsidized housing. Some will exit to street homelessness or shelter and need renewed outreach. All of these events will affect the costs to the system and the resources available to new clients, and initial projections of such annual transfers and exits should be incorporated into the multi-year implementation plan.

In addition to projected housing outcomes, the multi-year implementation plan should incorporate outcomes in health and other County services, such as increases in outpatient mental health utilization and decreases in jail days. These projections will not only help identify offsets and costs avoided through the pilots, but they will also help identify the timescale on which such offsets may be expected to materialize. It is common for newly housed PSH clients to experience a short-term increase in costs and services as they stabilized in housing and meet needs that went unmet while they were unhoused. Once those needs are met, then costs decrease over time. This pattern may look different for an older adult population than it does for the homeless population overall, so granular outcome projections specific to adults over 65 will be incorporated into the multi-year implementation plan.

Specifying the Coordinated Intervention. The March 24, 2020 report to the Board states that '*In order to move forward with the pilot, a coordinated intervention for older adults would be needed in the key domains of prevention, rapid re-housing, permanent housing with services and housing placement retention.'* This intervention would be the mechanism that would enable, for example, the level of enrollment in housing programs contemplated by this report, which is much greater than has been accomplished heretofore. We have described some features of the coordinated intervention (greater and

more systematic application of assessments, housing stabilization case management services), but the multi-year implementation plan will provide a more exhaustive (if provisional) description.

Annual Costs. Finally, the multi-year implementation plan will identify annual costs over the first five years of the pilot. As indicated above, Year One will not be typical in terms of costs. It will be a building year, during which capacity will ramp up, direct permanent housing will be unusually feasible, and PRK will be available as a "feeder" program, at least at the year's beginning.

Year Two will also be atypical, because the inflow during that year will likely include some Year One clients not yet permanently housed, in addition to newly homeless older adults. Years Three through Five will be the first in which a stable, successful, ongoing intervention could take shape, so the transition from Years One and Two to the later pilot years will be important to model in detail to delineate the true expected costs of the ongoing program.

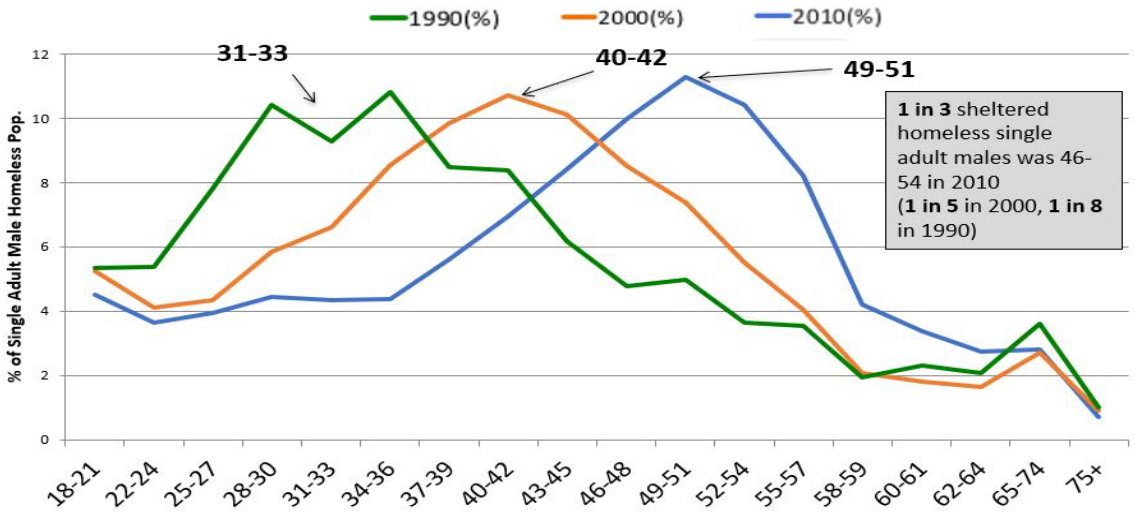
Securing Long-Term Funding. This interim report has identified potential offsets and non-County funding sources for the Older Adult Housing Pilot. It is crucial to recognize that, among these sources, one is a federal entitlement program. As such (and as long as the pilot identifies sufficient cost savings resulting from its expenditures), Medi-Cal has the potential to become a stable, permanent source of funding for homeless services for older adults. By contrast, Measure H's sales tax will sunset unless extended, housing vouchers will always be in limited supply, and State programs can be cut in difficult times.

For this reason, the multi-year implementation plan should explicitly seek to maximize the Medi-Cal dollars drawn down by the program, should create a framework for innovating in this regard, and should prioritize collecting data that would allow evaluators to measure the cost savings realized by the state Department of Health Care Services and by LA County's Managed Care Organizations as a result of Medi-Cal expenditures to provide housing and supportive services to the pilot's clients. By planning these activities at the outset, the County can increase its ability to sustain an Older Adult Housing Program well beyond its pilot phase.

Appendix A: Estimates of Older Adult Homeless Inflows and Exits in FY 2020-21

For purposes of planning the Older Adult Housing Pilot, it is important to understand the nature of the late-Baby-Boom cohort that has been observable in the homeless services system for the past thirty years. As shown in figure A1, members of this cohort have been experiencing homelessness disproportionately relative to their older and younger peers throughout their adult lives. The specific cohort members experiencing homelessness change over time, however, so simply housing all currently homeless members of the cohort would not prevent the cohort effect from continuing.

Figure A1 – Age Distributions of Male Shelter Users



Source: Culhane et al. (2013)/ U.S. Census Bureau Decennial Census Special Tabulation

Our projections of client load take into account the fact that not all persons who experience homelessness remain homeless in the absence of services. Indeed, part of the reason each Continuum of Care conducts an annual or biannual point-in-time count is precisely that a portion of the population experiencing homelessness would otherwise remain invisible to the homeless system, and a subset of this invisible homeless population regains housing stability without accessing homeless services. This group is referred to as "self-resolving." Based on historical trends, we estimate that, of the adults over 65 projected to experience homelessness during the years of the Older Adult Housing Pilot, roughly 25% will self-resolve. Thus, in Pilot Year One, we project that about 6,400 persons over age 65 will experience homelessness and about 1,600 will find a stable housing solution without intervention by the homeless system.

Figure A2 charts the number of new entries, self-resolvers, decedents, and total persons projected to experience homelessness in each year of the Housing Pilot. The effects of self-resolution and mortality on the overall size of the population targeted for services over the course of the pilot is shown in figure A3.

Figure A2: Projected Growth in Annual Homelessness Among Adults 65+, Pilot Year 1 Through Year 5

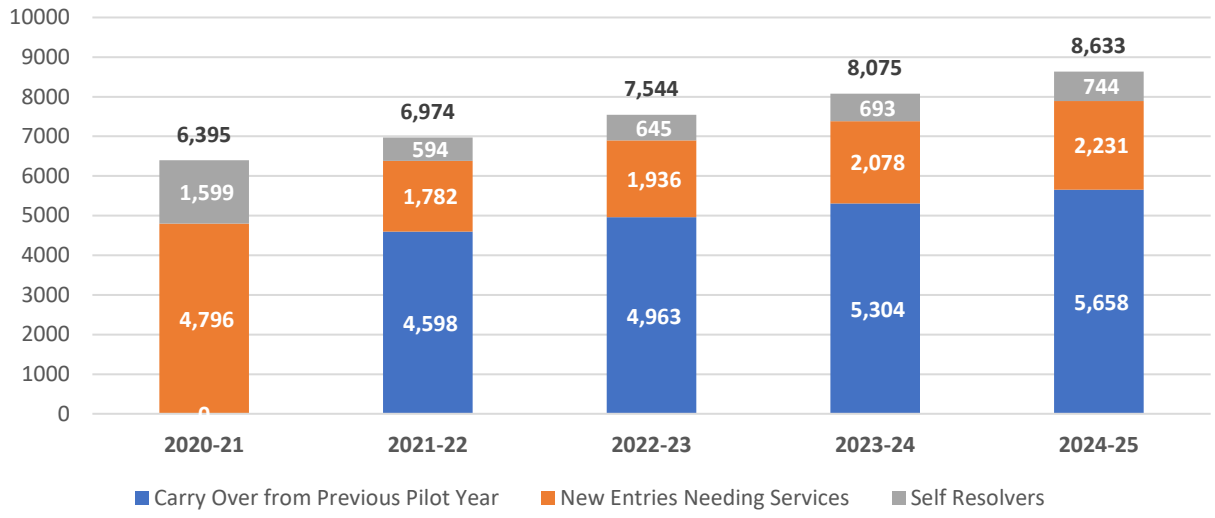
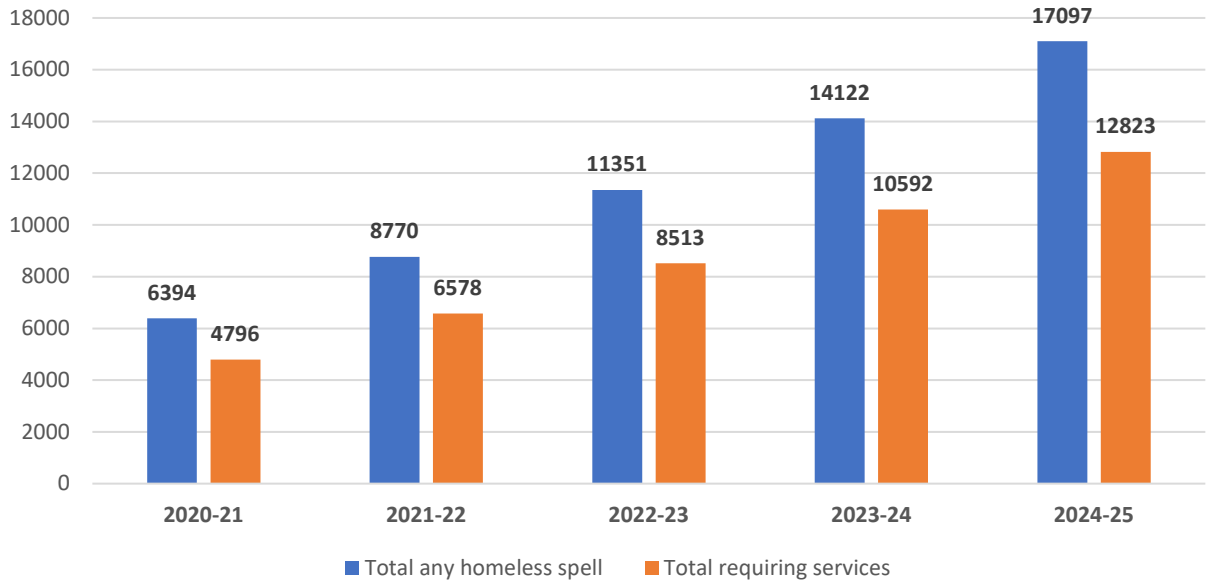


Figure A3: Total Cumulative Persons Over 65 Experiencing Homelessness and Requiring Services, Pilot Year 1 Through Year 5



Appendix B: The Likely Demographic Composition of the Pilot Target Population

A Study Population and a Target Population. The older adults who experience homelessness and who are served by the homeless services system in Los Angeles County in FY 2020-21 are expected to resemble their counterparts in the FY 2018-19 study group in terms of their race, ethnicity, and gender. The distribution of ages will differ, as the group of people experiencing homelessness in Los Angeles continues to "grey" with each passing year. As noted in Section IV, and elaborated below, of the 6,394 older adults projected to experience homelessness during the pilot year, roughly 1,600 are expected to self-resolve and, more importantly in the present context, may resemble the greater homeless population more closely than the subset of the population known to HMIS. That is, they may resemble the group of older adults experiencing homelessness described in LAHSA's annual point-in-time (PIT) count more closely than the group enrolled in a LAHSA program. (As an example, in FY 2018-19, the population of adults 55 and older with an open HMIS enrollment in homeless services was 69% male and 30% female. According to a statistical analysis of older adults surveyed as part of the 2018 point-in-time count, the full population of adults 55 and older experiencing homelessness in late January 2018 was 76% male and 22% female.)

Table B1. Expected Older Adult Target Populaton

Demographics	*N*=4,800 Persons	
	Clients	% *N*
Male	3,240	67.5
Female	1,531	31.9
Other/Data incomplete	29	0.6
White, Non-Hispanic	1,431	29.8
Black, Non-Hispanic	1,968	41.0
Hispanic (any race)	1,171	24.4
Other/Data incomplete	230	4.7
Age 65-69	2,813	58.6
Age 70+	1,987	41.4

Demographics. Thus, in Table B1, we take the proportion of the FY 2018-19 study population within each demographic category and apply those proportions to the 4,800 members of the FY 2020-21 target population expected to interact with the homeless system and to require services under the Older Adult Housing Pilot. As would be expected based on recent analyses of both HMIS and PIT Count data, the projected target population is even more likely to be African American than Is the general LA County homeless population, and it is projected to be roughly two-thirds male and one-third female. About one-quarter of the target population is projected to be Hispanic/Latino.

As a point of comparison, Table B2 presents the projected population during the pilot year of single adults aged 55 and over. Because street homelessness causes premature aging and physical frailty (see Henwood, 2017), 55 is the cut-off age often used for studies of older persons experiencing homelessness.

Table B2. Expected Homeless Older Adult Population, FY 2020-21

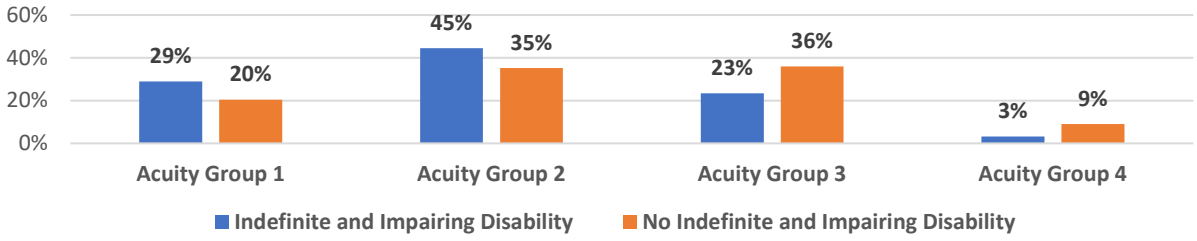
	Count	%
Overall, age 55+, *N*=	21,062	100
55-59	7,837	37.2
60-64	6,831	32.4
65-69	3,750	17.8
70+	2,644	12.6
65+	6,394	30.4

Moreover, unless they too are housed, adults aged 60-64 experiencing homelessness today will become adults over 65 experiencing homelessness tomorrow, so understanding the size of that group is crucial for planning future years of the pilot.

Measures of Vulnerability and Distribution of the Target Population into Vulnerability Groupings and Tiers. CES assessments are designed to measure the level of vulnerability of a client seeking housing through the Coordinated Entry System. In Los Angeles, these scores, ranging from 0 to 17, are placed into four categories, or Acuity Groups, that determine the housing intervention most likely to be appropriate for each client and that are also used to prioritize clients for placement in that housing. Because they are recognized by the system and combine estimates of need and priority in one measurement, these scores represent the simplest mechanism for assigning older adults in our study population to broad vulnerability categories, and we use them to the extent possible. Only 56% of the study population received a CES assessment during FY 2018-19 or the two preceding fiscal years, however.

Clients being assessed for housing are also asked whether they have any physical, mental, or emotional condition that (a) is expected to be of long or indefinite duration; (b) substantially impedes the individual's ability to live independently; and (c) could be improved by the provision of more suitable housing. Almost 45% of the members of the study population who lack CES assessments recorded a positive response to this question during the same time period (fiscal years 16-19). As shown in Figure B1, when both data elements are populated, the relative distribution of clients among CES Acuity Groups is different for clients who did and did not respond positively to this question. As a result, the indefinite disability response can be used to estimate the acuity distribution of clients who did not receive a CES assessment.

Figure B1: CES Acuity Group Distribution by Permanent Disabilty Status Among Homeless 65+ Adults, FY 2018-19



Our final estimate of vulnerability distribution therefore combines these two data points to produce a more nuanced projection (Table B3). To the study population's CES assessments, we assign a weight of 56%, equal to the proportion of clients in the study population who have CES assessments. To the other 44% of our projections, we assign weights corresponding to the proportions in the study population lacking assessments who do and do not report indefinite and impairing disabilities (19% and 25%, respectively). We assume that members of each category (those with and without disability reports) will tend to resemble their peers with CES assessments and distribute them among acuity groups accordingly.

Table B3: Weighted Components of the Target Population's Vulnerability Projection		Prevalence			
Study Population Subgroup	**Weight**	**Acuity Group 1**	**Acuity Group 2**	**Acuity Group 3**	**Acuity Group 4**
With CES Assessment	56%	26%	41%	28%	5%
Without CES but with reported indefinite & impairing disability	19%	29%	45%	23%	3%
With neither CES nor reported indefinite & impairing disability	25%	20%	35%	36%	9%
Final Projection	**100%**	**25%**	**40%**	**29%**	**6%**

Finally, we use the algorithm developed by Gagne et. al., (2011) to help project the target population's need for the highest levels of care. The Gagne Index assigns *comorbidity scores* to older adults based on this algorithm, which uses subjects' medical diagnoses to identify those more likely than average to die within a given time frame. For example, Gagne's initial study found that when the time frame was one year, a comorbidity score of 3 corresponded with a mortality rate of around 10% and a score of 5 corresponded with a rate of around 20%. We apply this algorithm to the FY 2018-19 study population to gauge the prevalence of medical frailty in order to help estimate the proportion of clients in the highest-acuity categories who may require a higher level of care than is available in Permanent Supportive Housing and for whom placement in ERC may therefore be appropriate.

Figure B2: FY 2016-19 Gagne Scores of All 65+ Health Agency Patients vs Those with an HMIS Enrollment in FY 2018-19

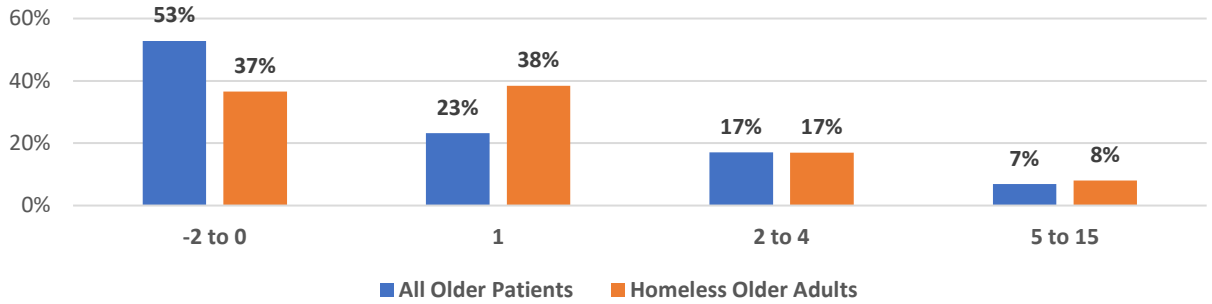
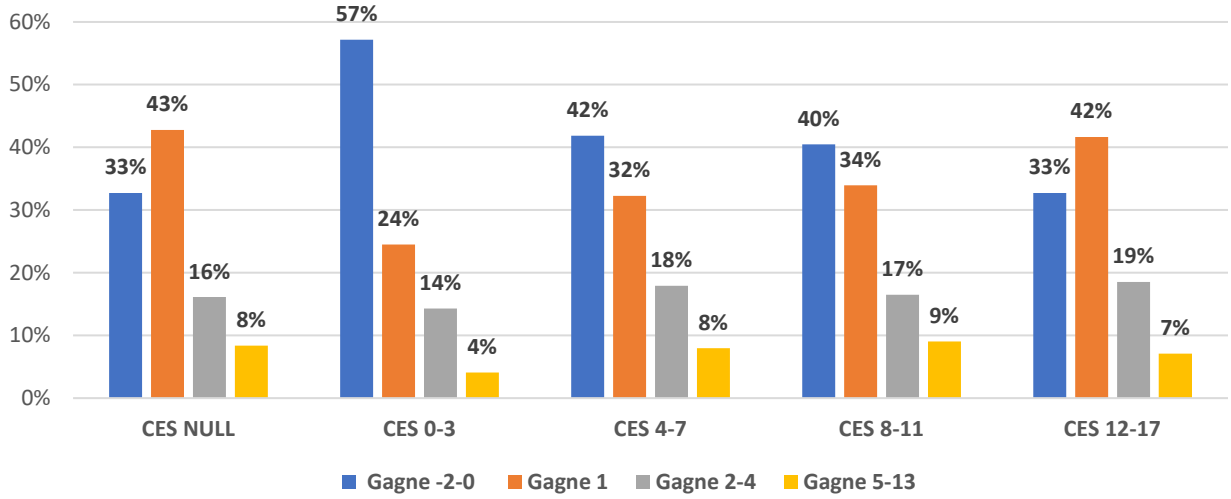


Figure B2 shows the distribution of Gagne comorbidity scores across two groups: all clients of either DHS or DMH who were over 65 in FY 2018-19 and accessed Health Agency services in FYs 2016-19, and the subset of those clients who had an open HMIS enrollment during the study year. The homeless subset is much more likely than the full group to have a score of 1, and much less likely to have a score of less than 1. It is noteworthy, however, that the proportion of patients with scores of 2 or more is extremely similar among the two groups, suggesting that medical risk of mortality among homeless older adults[5] is much more related to their age than to their homeless status. Unsurprisingly, then, as shown in Figure B3, the proportion of homeless clients with high Gagne scores does not vary appreciably among the top three CES Acuity Groups.[6]

[5] More precisely, medical risk of mortality *as identified by specific medical diagnoses* is more attributable to clients' age than to their homeless status. The Gagne Index does not assign a greater likelihood of mortality based on social determinants of health or other non-diagnostic factors, such as the increased frailty associated with lived experience of street homelessness or the racial disparities in medical outcomes.

[6] The VI-SPDAT tool used by Los Angeles's Coordinated Entry System to measure client acuity assigns higher scores to clients with more kinds of vulnerability, rather than to clients with more intensive needs in one dimension of vulnerability. Higher acuity scores therefore do not indicate greater medical needs, but rather a greater range of types of needs.

Figure B3: FY16-19 Gagne Scores Plotted Against CES Scores for All 65+ Health Agency Patients with FY 2018-19 HMIS Enrollments

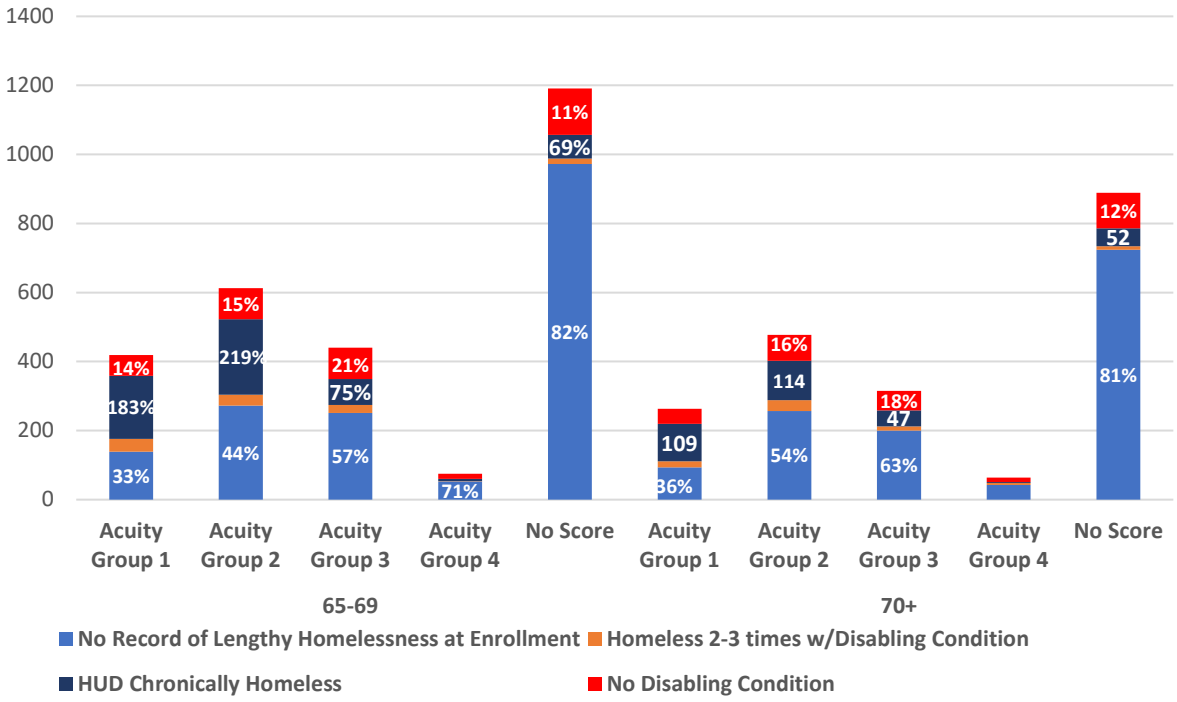


Figures B2 and B3 tend to confirm that Gagne comorbidity scores represent a range of conditions associated with heightened mortality, not all of which taken by themselves necessarily correspond to greater frailty or indicate a need for higher levels of care. Very high scores, however, tend to correlate with multiple conditions, and therefore with medical complexity. Therefore, we assume that high-acuity clients who have Gagne scores above 5 will benefit from placement in ERC, while about half of those with Gagne scores between 2 and 4 will also benefit from such care. Thus, we estimate that 16% of clients in Acuity Groups 1 and 2 will be appropriate candidates for ERC rather than PSH.

Other Demographic Considerations. For the Older Adult Housing Pilot to be successful, Los Angeles' homeless services and allied mainstream services (including but not limited to senior services) will need to be ramped up until the system is capable of understanding and responding to each client's individual needs on their own terms. This is true in large part because of the diversity of clients and needs to be addressed. Part of this diversity is represented in Figure B4, which visualizes the varied set of intersections between chronicity and acuity among older adults experiencing homelessness. The figure shows that, in FY 2018-19, even among clients in the highest acuity group, only a plurality rather than a majority (44% of 65-69-year-olds and 41% of 70-year-olds) was experiencing chronic homelessness as defined by HUD[7] at the time of their most recent service enrollment. A sizeable percentage of the high-acuity groups (in some cases a majority) had not experienced lengthy homelessness at all, defined as at least twelve months of homelessness in the previous three years. Smaller minorities were not chronic by reason of the number of times homeless (2 or 3, rather than 4) or because they lacked a disabling condition. Clients not experiencing chronic homelessness have a narrower range of interventions available to them. Thus, for many clients, providers will need either to exercise creativity in matching them to available housing interventions for which they qualify or to maintain and build relationships over time as those clients who remain homeless for many months age into chronicity.

[7] HUD defines chronic homelessness as (1) either (a) twelve or more months of continuous homelessness or (b) four or more episodes of homelessness totaling twelve or more months in the last three years, *plus* (2) an indefinite and impairing disabling condition.

Figure B4: Reported Chronicity and Acuity of Older Adults with Open HMIS Enrollments, FY 2018-19



Project Roomkey Exit Plans for Age 65 and Older Population

As of June 3, 2020, there are 658 active clients in Project Roomkey (PRK) who are age 65 and older (65+) (approximately 18 percent of all PRK active clients). The average acuity score of these clients, as determined by the Coordinated Entry System (CES) assessment, is 11, a mid-acuity score for which Rapid Re-housing is generally the most appropriate housing intervention. PRK providers, with support from the Los Angeles Homeless Services Authority (LAHSA) and County departments, are working to rapidly assess all participants and develop exit plans. Outlined below, is progress toward developing and executing exit plans for the 65+ populations.

CES Assessments, Housing Navigation, and Connections to Public Benefits

To date, 76 percent of active PRK clients ages 65+ (502 out 658) have completed the CES assessment. Of these 502 clients who have been assessed, 39 were assessed after entering the PRK program, with the remainder having been assessed prior to entry. Assessment is critical to determining the appropriate housing pathway for each client. LAHSA and the PRK providers are aiming to have assessed 100 percent of PRK clients ages 65+ by July 1, 2020.

The staffing model for PRK relies on housing navigation services to be supported by case managers and outreach workers who have existing relationships with the clients they referred to the program. LAHSA is overseeing ongoing conversations with outreach teams and directing providers to assess their capacity to provide onsite PRK case management support. Capacity is being leveraged from housing navigation programs with existing client capacity and LAHSA Housing Central Command staff, who are expediting the housing process for each client in PRK who holds a Permanent Supportive Housing (PSH) voucher.

In addition to the CES assessment, the Department of Public Social Services (DPSS) has partnered with the PRK program to assist with connecting PRK clients to public benefits. DPSS has assessed all PRK clients by running their information through the DPSS database that tracks enrollment in DPSS programs. Overall, 75 percent of PRK clients enrolled as of May 29, 2020 were “known to DPSS,” meaning that they have an active case with DPSS. Of those known to DPSS, 37 percent are receiving General Relief (GR), 73 percent are receiving Medi-Cal, and 85 percent are receiving CalFresh.

100-Day Challenge

County system and service partners are currently engaged in a 100-Day Challenge to connect homeless individuals currently enrolled in Project Roomkey (PRK) to permanent housing. 100-Day Challenges are designed to inspire and empower frontline teams to set ambitious goals, and harness the intense levels of innovation, collaboration, and execution required to achieve them. Governor Gavin Newsom announced a 100-Day Challenge Initiative to address homelessness across California on December 5, 2019 with an initial cohort of Los Angeles, Alameda, Stanislaus, and Riverside Counties. The focus of each of these counties is on creating permanent housing exit pathways for PRK clients. The Rapids Results Institute (RRI) is providing technical assistance. The United Way of Greater Los Angeles (UWGLA) and LAHSA are facilitating the challenge on behalf of the County.

The Los Angeles County team, led by frontline CES matchers, navigators, case managers, and other service providers, officially launched this 100-Day Challenge on May 26, 2019, with a specific goal of connecting and stably housing 700 individuals aged 55 and older who are presently participating in PRK. Although this initiative does not specifically target the 65+ age group, more than one-third of clients who are 55 and older are ages 65+, so they are a significant part of the target population.

The team aims to not only utilize existing permanent supportive housing, but to explore the use of Rapid Re-Housing, shared housing, shallow subsidies, and other innovative strategies that can be taken to scale and replicated in the broader County COVID-19 Recovery Plan for Homelessness.

Exit Planning

PRK providers are working closely with PRK participants aged 65+ to establish exit plans. Through this engagement process, providers have determined that 56 percent of the 65+ population is already connected to case management. Among those who are enrolled in housing programs, 2 percent (17 people) are enrolled in Rapid Re-Housing, and 11 percent (84 people) are matched to Permanent Supportive Housing.

LAHSA's May 27, 2019 response to the Board Motion, "COVID-19 RECOVERY PLAN FOR HOMELESSNESS (ITEM NO. 4, AGENDA OF MAY 12, 2020)", outlines a global rehousing plan to comprehensively and strategically rehouse up to 15,000 people in LA County, prioritizing the expedited re-housing of PRK participants. Such a plan will greatly benefit PRK participants who are 65+, as they are part of the prioritized, COVID-vulnerable group. The overarching goal of this plan is to expeditiously house people through a few defined exit pathways, leveraging a Rapid Re-housing model to place people in a large number of newly-identified scattered site apartments. This approach will enable LAHSA and the County to very quickly move a high number of people from PRK into housing, making sure to prevent returns to unsheltered homelessness.

Exit Pathways

Based on the assessment information that providers have collected from clients ages 65+ in PRK, the following table provides information on the ideal exit pathways identified for these clients.

Exit Pathways	**Percentage of PRK Clients Ages 65 and Older Suited to the Pathway**
Rapid Re-Housing	34%
Permanent Supportive Housing	41%
Problem Solving	25%

Assessments for appropriate referrals to Higher Levels of Care (Recuperative Care, Board and Care/Residential Care) will continue for people currently identified as needing PSH, in partnership with the Department of Health Services during clients' stay in PRK. Clients with acuity scores below 12 (and even some with higher acuity scores) could be successfully exited from PRK utilizing a shallow subsidy, shared housing, or sober living placements, as

determined by ongoing onsite assessments of both client choice and client strengths. Such placements would decrease the number of clients exiting into the broader housing categories listed above. Interim housing beds will be leveraged for clients without immediate pathways to housing. In interim housing, clients will continue to receive housing case management to move them toward permanent housing.

Prioritization and Innovations

In order to provide clients with the support needed to pursue the pathways determined above, LAHSA and County Departments have established a prioritization process that will increase access to permanent housing for PRK participants, including those aged 65+. The prioritization process was included in the May 15, 2020 Report Back to the Board on the Board Motion "PILOTING A COMPREHENSIVE CRISIS RESPONSE TO ENSURE POST-COVID-19 HOUSING FOR HOMELESS OLDER ADULTS IN LOS ANGELES COUNTY (ITEM NO. 8, AGENDA OF APRIL 14, 2020)", and can be found in Attachment II of that report.

In addition to this prioritization process, LAHSA is considering the following innovations and program design modifications to more effectively move clients from PRK to permanent housing:

- Utilizing creative, alternative housing assessment tools to most effectively determine appropriate exit pathways and housing plans.

- Intentionally leveraging shared housing models for older adults in PRK, including by encouraging connection to potential roommates while people are sheltered together in Project Roomkey hotels.

Next Steps

Over the coming months, PRK providers, with support from LAHSA and County departments, will continue to work with great urgency to move clients aged 65+ out of PRK and into permanent housing, whenever possible, and in some cases, into temporary housing options prior to their exit to permanent housing. As the 100-Day Challenge proceeds and as LAHSA and partners pursue the innovations and existing pathways described above, all partners expect to achieve success in moving this vulnerable population into stable housing prior to the termination of PRK.