Los Angeles Homeless Data Assessment Report: Issues and Recommendations

April 2012

Prepared for:

The Los Angeles Homeless Funders Group

Prepared by:
Matt White and Julia Brown
Abt Associates Inc.
4550 Montgomery Avenue
Suite 800 North
Bethesda, MD 20814-3343

Acknowledgements

This project was supported by the Los Angeles Homeless Funders Group, a regional affiliate of Funders Together to End Homelessness. Members who contributed financially to support the data assessment include: Corporation for Supportive Housing, Weingart Foundation, United Way of Greater Los Angeles, UniHealth Foundation, Fannie Mae, Conrad N. Hilton Foundation, Carl & Roberta Deutsch Foundation, and Vladimir & Araxia Buckhantz Foundation.

Table of Contents

1. Executive Summary

In the summer of 2011, Abt Associates Inc. was engaged by the Los Angeles Homeless Funders Group to conduct an assessment of the current homeless data collection and management processes in Los Angeles County and to provide recommendations for improving them. The Homeless Funders Group is an association of philanthropic partners throughout the Los Angeles area committed to coordinated planning and investments to address homelessness.

This Data Assessment builds on the findings of the self-assessment conducted by the Los Angeles Homeless Services Authority (LAHSA) as part of a Continuum of Care (CoC) Checkup process in the summer of 2011. This Assessment is based on a deeper and more detailed investigation of the current state of homeless data collection and management in Los Angeles and reflects information from interviews with key stakeholders, including LAHSA staff, LAHSA's HMIS solution provider, County departments, and other funders and stakeholders in the Los Angeles region. The Data Assessment also included interviews and focus groups with HMIS end users and makes recommendations based on best practices across the nation, in particular for tools and processes associated with client assessment and coordinated client intake. The findings and recommendations in this document are intended to inform the planning and implementation of coordinated HUD and locally-funded technical assistance work.

Ending Homelessness in Los Angeles: A Data Management Strategy

In recent years Los Angeles has experienced increased national and local attention for the vexing problem of homelessness. The complexities involved in addressing the issue of homelessness anywhere are made more difficult in LA by the large geographic planning and coordination area and the multitude of independent, sometimes competing, political interests.

Los Angeles has experienced success recently with the development of thousands of new Permanent Supportive Housing units across the metro region, many of which use Mental Health Service Act (MHSA) funding to target the chronically homeless and persons with mental illness. Other small scale local initiatives such as Project 50 have provided permanent housing for fifty chronically homeless persons previously residing in tents along the sidewalks of skid row. Other groups are beginning to experience similar success on a neighborhood level by partnering with homeless assistance providers, elected officials, and public systems to create location-specific initiatives. And the United Way, in partnership with the Los Angeles Chamber of Commerce, has produced a strategic plan to end homelessness for particular subpopulations, people experiencing chronic homelessness and veterans, *Home for Good.* While a combination of specific subpopulation initiatives and geographically targeted strategies may ultimately provide the best region-wide approach for addressing homeless, successful implementation of these plans is hindered by the lack of a single, coordinated data collection and management strategy that can be used to measure progress and document success in ending homelessness.

While some stakeholders have expressed concerns about the adequacy of the LA HMIS as a platform for an improved data collection and management system in Los Angeles County, this Data Assessment finds that LAHSA's HMIS represents the foundation on which a homeless data management strategy for Los Angeles should be based. HMIS already provides a fully-functional infrastructure for client case coordination, program data management, and system-wide coordination and evaluation. Program performance outcomes, as well as system-wide measures, can be monitored using the standardized data

elements already defined as the building blocks of HMIS. System-wide outputs such as the supply of permanent supportive housing units, both in production and operational, can be tracked in HMIS.

Many homeless assistance providers in LA are already using HMIS or are familiar with administrative data management systems and can readily adopt HMIS as their primary data collection and management tool if provided the necessary resources and support. System improvements will be necessary to make HMIS viable as an ongoing tool. These improvements need to be targeted to end users of HMIS, so that their experience with entering and managing data and running data reports is positive and successful. Timely, complete and high quality data entered by end users then will be available to support the data and analysis needs of system planners and policy-makers as they analyze the performance of individual programs and the homeless services system. Homeless people themselves will benefit from more efficient and accurate service planning when service providers coordinate assessments, case plans, referrals, and outcome tracking using HMIS.

The detailed recommendations in this Data Assessment Report are organized around four main questions that center on HMIS as the foundation for a comprehensive data management strategy:

1. How can HMIS be improved to make it a more effective tool for planning and policy-making?

All funders throughout Los Angeles County should adopt HMIS as the standard data collection and management platform for all homeless assistance programs. Until HMIS is universally acknowledged and supported as the primary tool for collecting data on homeless people, managing data about service use, and tracking outcomes, it will not have the necessary reach and breadth to become an effective tool for planning and policy-making. The following action items are recommended:

- ✓ Funders should require HMIS participation as a contractual obligation for all programs.
- ✓ LAHSA should incorporate standardized client triage and intake tools, assessment processes, prioritization protocols, referral procedures, and enrollment methodologies into HMIS functionality.
- ✓ LAHSA and the Funders Group should develop consistent definitions and methodologies for calculating program performance measures and support adoption of common definitions and approaches among all homeless assistance programs.
- ✓ LAHSA should complete the mapping of program-level performance benchmarks to desired system-wide outcomes associated with the HEARTH Act.

Establish HMIS as the central management tool for HIC and PIT data collection and reconciliation processes. Managing homeless bed and unit inventory data, as well as point-in-time counts, is a natural fit with HMIS operations. HUD already requires that HMIS be the central repository of information about homelessness in the CoC, including information about both programs and clients. The Los Angeles community should support the central role of HMIS in collecting and managing updates about all CoC programs in the community by completing the following tasks:

- ✓ LAHSA should develop a standardized process, integrated within the organization, to survey shelter and housing operators during the PIT count to ensure that regular updates to HIC bed and unit inventory are accurate and complete.
- ✓ LAHSA should use HMIS to generate sheltered PIT counts and verify HMIS-generated counts with providers via survey responses.
- ✓ LAHSA should collaborate with members of the Funders Group to integrate the multiple and disconnected service and unit inventory count processes into a single community-wide effort to establish one consolidated, accurate and reliable HIC data set.

LAHSA should establish and monitor HMIS data quality standards. Ensuring high quality of data in HMIS is a labor intensive and continuing process. While some immediate management strategies can be employed to improve current quality and lay the foundation for future high quality, the following ongoing activities are recommended:

- ✓ Establish and monitor HMIS data quality standards for each program type.
- ✓ Provide regular (monthly) performance reports with accompanying detail (client-level drill down) to enable homeless assistance providers to review program performance and address inaccuracies and discrepancies.

2. How can HMIS be improved to make it a better tool for providing client services?

Enhance use of HMIS as a program and client management tool. While some users of HMIS adhere to only the baseline requirements for participation, many homeless assistance programs have started to use the powerful tools HMIS affords that enable providers to capture case management notes, establish and monitor clients' housing goals, and document program eligibility and certification requirements. These management functions can be further supported and expanded by adopting the following recommendations:

- ✓ LAHSA should integrate coordinated assessment tools and processes (such as Vulnerability Index and 10th Cost Decile Triage Tool) into HMIS data collection functionality.
- ✓ Policy-makers, funders, and stakeholders should develop systems that use HMIS to track program vacancy availability, document program eligibility, refer clients, and link clients throughout the program enrollment process.

Improve data sharing and analysis capacity. Sharing of client-level data among homeless assistance providers, when done with the necessary privacy, security, and consent protocols in place, can enhance providers' ability to understand a client's previous homeless and service enrollment history and coordinate future program services in a more thoughtful and intentional way. Providers and clients both benefit when HMIS data sharing protocols enable providers to build a more complete picture of each client's homeless history and service needs. The following recommendations will promote a more robust sharing environment while maintaining necessary privacy protections:

- ✓ LAHSA should permit and support enhanced HMIS data sharing among different provider agencies and programs.
- ✓ LAHSA and other entities with client-level data on homeless people such as the County Executive Office and other County departments should review existing HMIS client consent protocols to identify opportunities to streamline data sharing permissions while maintaining appropriate protections.
- ✓ LAHSA should update training materials and approaches to encourage and support data sharing.

LAHSA and its HMIS solution provider should improve HMIS participation rates by enhancing the end user experience. Homeless assistance providers, who are responsible for collecting client data and entering it into HMIS report that data collection and reporting are critically important to their jobs but that the current system and processes are cumbersome, and complicated. End users will improve their participation in HMIS and promote participation among other providers as the system becomes more user-friendly and provides more utility for day to day program management and operations. The following system and management improvements are recommended:

- ✓ Continue end user focus groups and provider discussion groups to document usability concerns and support system enhancements with Adsystech (the solution provider).
- ✓ Implement current plans to roll out *high-impact management reports* to agencies funded by LAHSA and other participants in the HMIS to encourage tracking of progress against HEARTH Act and community-defined performance measures.
- ✓ Develop targeted strategies to engage emergency shelter and permanent supportive housing providers in HMIS participation, with the goal of achieving 85 percent bed coverage rates across all program types by 2014.

3. How can HMIS be linked to other data to enable more comprehensive management and analysis?

LAHSA and the County Chief Executive Office/Service Integration Branch should integrate HMIS client data with Los Angeles County's Enterprise Linkage Project (ELP). The ELP, LA County's data warehouse project, presents a significant opportunity to integrate homeless client data from HMIS with County departmental data to create a more robust and complete dataset of public system service utilization and associated costs of the most vulnerable homeless people. The following recommendations will support integration of data for ongoing case planning and analytical purposes:

- ✓ Define a set of community-wide research and analysis objectives to inform the development and use of homeless client data in the ELP.
- ✓ Update HMIS client consent protocols to account for uses and disclosures associated with ELP integration.
- ✓ Develop integration protocols that provide guidance for the frequency, process and handling, and security of HMIS data.

LAHSA should enable integration of homeless data from proprietary systems into HMIS, based on narrowly defined limitations and specifications that promote direct HMIS participation as the preferred and supported option. HMIS should be the preferred vehicle for homeless data collection and management, but some homeless assistance providers do not receive public financing for their programs and are not managed to participate in HMIS. In these limited instances, data integration should be allowed and supported.

- ✓ Enable non HUD funded providers to integrate basic client data (Universal Data Elements) with HMIS on a periodic basis (at least annually), as long as program occupancy information is otherwise made available to the HMIS for purposes of real time client referral and enrollment coordination.

4. How can LA create a coordinated assessment and intake environment?

Los Angeles policy-makers, funders, and stakeholders should establish neighborhood-specific, locally-managed service coordination centers to use HMIS to support coordinated client assessment and program enrollment. New ESG and CoC program regulations issued by HUD will require use of coordinated assessment systems to document the needs of clients and make intentional service delivery decisions. While a single, centralized intake system for Los Angeles County is unrealistic, locally administered service coordination centers or 'access hubs' can be effective system management strategies if HMIS is an intentional component of the service delivery system. The system of coordinated assessment and intake would use HMIS in the following ways: Service coordination centers would evaluate homeless individuals' and families' eligibility for homeless assistance and document results in HMIS. Service coordination centers then would use HMIS to manage clients' prioritization for housing and homeless service resources.

- ✓ LAHSA should work with the solutions provider on future activation of the coordinated assessment functionality in the HMIS. This would include program wait list management, referral coordination, and coordinated assessment systems.
- ✓ The Broader group of stakeholders should define a set of system-wide expectations for coordinated assessment and intake but enable local service coordination centers to define and manage their own coordinated assessment and intake environments.

Current Efforts and Next Steps

In the past year, significant improvements have been realized within the HMIS project in Los Angeles. LAHSA has redoubled efforts to encourage additional providers to participate in HMIS. Rates of participation, especially among Transitional Housing providers, have improved dramatically. LAHSA's HMIS outreach, training, and support materials have been revamped based on a series of recent provider feedback forums and end user focus groups. End users are reporting that HMIS is evolving as an increasingly more effective tool for client case management, program management, and funder reporting. While there continue to be opportunities for improved project management, coordination, and end-user support, HMIS is growing into an effective client, program, and system management tool.

Funders and stakeholders in the homeless services system in Los Angeles County will need to continue to support the HMIS project as the foundation of a coordinated homeless data management strategy. Implementation of a coordinated data management strategy for Los Angeles will require the continued effort of LAHSA, City and County government departments, the Los Angeles Homeless Funders Group, and homeless assistance provider agencies and their staff. Abt Associates has been asked by the Funders Group, as well as HUD, to lead a team that will implement the technical assistance effort that supports this implementation. Technical assistance (TA) activities will need to be sequenced strategically. Based on this Data Assessment, we recommend the phasing of tasks presented in Exhibit 1.1 for review and consideration by the Funders Group and LAHSA. Resources have been committed for most of these tasks by either HUD or the LA Homeless Funders Group (HFG) and are shown on the exhibit.

The activities listed under Phase One are those needed immediately for the entire community working to end homelessness in LA, including providers, funders, and public officials, to adopt HMIS as the core technology for homeless data collection, management and reporting. The first step is to develop a comprehensive improvement plan that describes in more detail the resources needed for each task, time lines, and assignment of responsibility. Activities 7, 8, and 9 will improve basic HMIS data quality, data completeness, and system management functionality. Activity 10, integration of the HMIS with the ELP, is included in Phase One because of its important role in determining whether Permanent Supportive Housing Units are being targeted successfully to people with the greatest need. Activity 11 will expand the functionality of HMIS by designing screening and assessment tools and will lay the groundwork for this expanded use of the HMIS for managing a coordinated assessment and intake system in Phase Two. Phase Two is characterized by expanded and improved use of HMIS into more sophisticated management and analytical data uses as a result of the core HMIS functionality that will have been improved in Phase One. Phase Three then focuses on increasing system openness through HMIS data sharing across homeless assistance providers.

Exhibit 1.1: Homeless Data Management Tasks and Resource Considerations

Homeless Data Management Tasks	TA Resources Committed
Current Efforts	
1. Focus data quality improvement efforts on HIC and viable AHAR reporting categories	
2. Assess LAHSA HMIS project management and training effectiveness and implement improvements	
3. Define program and system-level performance outcome standards and draft corresponding specifications for HMIS *high-impact management reports*	
4. Conduct LA homeless data assessment	HFG[1] - $35,000
Phase One TA – Initiated in the next 6 months	
5. Adopt HMIS as standard homeless data management system, implement strategy	HFG - $34,630
6. Develop comprehensive HMIS improvement plan	HUD - $21,500
7. Establish and support HMIS as the central tool for HIC and PIT data	HUD - $10,000
8. Support HMIS participation through improved training and support materials	HUD - $27,500
9. Target TA to providers to increase HMIS participation	HFG - $47,530
10. Integrate HMIS client data with the Los Angeles ELP	HUD - $25,500
11. Use HMIS to support coordinated client assessment and intake	HFG - $29,000
Phase Two – Initiated in the next 12 months	
12. Establish and monitor HMIS data quality standards	HUD - $7,000
13. Use HMIS to document client eligibility, program targeting, and unit availability	HFG - $23,750
14. Support expanded program performance measurement and system evaluation	HUD - $5,500
Phase Three – Initiated in the next 18 months	
15. Support data sharing in HMIS	HUD - $6,000
16. Enable/support integration of provider-level data in HMIS	
Total Resources Committed	$272,910

TA resources have already been prioritized for many of these tasks and components within tasks. The LA Homeless Funders Group has provided the resources necessary to draft this report ($35,000) and has already committed $134,560 in additional resources for direct TA and ongoing assessment. HUD has approved $103,350 to address other critical TA needs.

Los Angeles is well on its way to creating a more comprehensive and effective data collection and management strategy for homeless programs and clients. With nearly $273,000 in technical assistance resources committed to these improvement efforts, Los Angeles will be able to develop and implement a more coordinated and intentional strategy for homeless data management, one that enumerates all persons who experience a housing crisis, tracks the inventory and provision of services and housing, manages client services in a way that successful links clients to the appropriate services and programs, and leverages the collective understanding of program and system performance to support ongoing improvement efforts.

[1] Los Angeles Homeless Funders Group

2. Data Assessment Approach and Focus

2.1 Background and Context

Los Angeles County is a vast and complex region, with 88 city jurisdictions, 22 public housing agencies, 17 Emergency Solutions Grant (ESG) entitlement areas, 4 Continuums of Care, and more than 4,000 square miles of area that encompass both highly urbanized central city regions and remote rural areas. This complexity poses many challenges for system planners and homeless assistance providers in their efforts to end homelessness, not least of which is the challenge of maintaining consistent, complete, and accurate data collection and data management.

Not surprisingly, the Los Angeles metropolitan region does not have a unified strategy for collecting and managing data on people who experience homelessness and the homeless service systems. This makes it difficult for the various entities and constituent groups involved in the effort to end homelessness in Los Angeles to undertake planning, coordinated service provision, monitoring, and evaluation in a cohesive manner. This Data Assessment Report attempts to document the major data collection efforts currently underway, identify challenges and gaps, and recommend strategies to improve and better coordinate data collection and management systems so that data are more accessible, inter-relatable, and useful for individual case planning, program evaluation, and system-wide monitoring.

LA County population	*9,830,420*
LA homeless population	*45,422*
Total ES beds	*5,071*
Total TH beds	*8,353*
Total PSH beds	*17,115*

Data Sources and Systems

In order to understand the landscape of homeless data collection efforts, Abt Associates staff began with an inventory of organizations and groups currently involved in some level of local or region-wide collection, management, or reporting of data on people who experience homelessness. This inventory included outreach to City and County departments, philanthropic partners, nonprofit organizations, and other commissions and quasi-governmental groups. Exhibit 2.1 is a list of groups included in this inventory. The list is not intended to represent all organizations that collect data on homeless people and the homeless services system; only the regional leaders in data collection, compilation, analysis, or reporting are included. Many small nonprofit service providers and some larger homeless assistance agencies collect and manage data as well.

Exhibit 2.1 Leading Entities for Homeless Data Collection and Management in LA

City of Los Angeles
Los Angeles Housing Department (LAHD)
Housing Authority of Los Angeles (HACLA)
Mayor's Office
County of Los Angeles
Chief Executive Office (CEO Office)
Community Development Commission
Community and Senior Services (CSS)
Department of Children and Family Services (DCFS)
Department of Health Services (DHS)

Department of Mental Health (DMH)
Department of Public Health (DPH)
Department of Public Social Services (DPSS)
Housing Authority of the County of Los Angeles (HACoLA)
Probation Department (PD)
Sheriff's Department
Comprehensive Care Health (CCH)
Independent Agencies (nonprofit)
Community Solutions
Corporation for Supportive Housing
Economic Roundtable
Los Angeles Homeless Services Authority (LAHSA)
United Way
Other Regional CoC Jurisdictions (exclusive of LAHSA)
City of Glendale – Community Service and Parks Department
City of Long Beach – Department of Health and Human Services
City of Pasadena – Housing and Community Development

Abt staff then assessed the role that each organization or group plays: what information it collects; how data are managed; and whether or not data are shared or able to be shared. The assessment included interviews with key stakeholders, including staff of the Los Angeles Homeless Services Authority (LAHSA), with the HMIS solution (software) provider for the LA Continuum of Care, with County departments, and with other funders and stakeholders, as well as interviews and focus groups with HMIS end users. As part of the assessment, each person interviewed was asked for recommendations on how to better coordinate and align strategies for collection and use of data collection. The recommendations presented in this Report also are based on Abt Associates research and expertise on best practices for homeless data collection, as well as for the design of coordinated assessment and intake systems.

HUD Technical Assistance

This data assessment, and the technical assistance that will follow, are not taking place independent of other, related assessment and technical assistance efforts, but is part of a larger effort to improve data collection efforts and increase participation in the Los Angeles HMIS. LAHSA, with the support of the U.S. Department of Housing and Urban Development (HUD) and its technical assistance providers, has been working toward improving HMIS results and participation for some time. The results of this effort, including both written reports and discussions with participants, have been integrated into the present assessment to ensure synergy and reduce duplication of effort. The other assessments and technical assistance work ongoing in Los Angeles include LAHSA's participation in the Continuum of Care (CoC) Checkup process; HUD technical assistance to improving management capacity, participation, and data quality of the LA HMIS systems; and broader HUD technical assistance work on homelessness to be carried out under OneCPD.[2] The CoC Checkup process was initiated by HUD in June of 2011. At that time, LAHSA, as the lead entity for the Los Angeles CoC, was provided with a CoC Check-up tool and distributed it to key CoC stakeholders. The tool solicits feedback on critical capacity needs relative to preventing and ending homelessness, including data collection capacities. Issues cited by respondents to

[2] OneCPD integrates technical assistance resources beyond homeless programs to include all of HUD's Community Planning and Development (CPD) initiatives funded by the HOME, CDBG, and HOPWA, and NSP programs.

the CoC Checkup tool that are particularly relevant to this report included a lack of sufficient provider coverage in HMIS, a lack of sufficient data quality of entered data, and inconsistent HMIS participation among providers who have agreed to participate and enter data.

As a result of the CoC Checkup self-assessment process, LAHSA has requested direct technical assistance from HUD to support improvements to its HMIS system and increase participation. This work will include improved trainings and data quality strategies and will also explore the feasibility of establishing a county-wide data warehouse in an effort to develop a more complete and accurate picture of homelessness in the region.

HUD's CoC and HMIS technical assistance efforts are being coordinated and integrated with other community-based planning and TA efforts, especially those supported by the Los Angeles Funders Group and the Hilton Foundation. (For more detail about Hilton's homeless infrastructure investments and capacity building efforts see Appendix B.)

Supported by the Funders Group and the Hilton Foundation, this Data Assessment builds on the findings of the CoC Checkup, is based on a deeper and more detailed investigation of the current state of homeless data collection and management in Los Angeles, and makes recommendations based on best practices across the nation. The findings from this assessment are intended to inform the planning and implementation of coordinated HUD and locally-funded technical assistance work.

2.2 Assessment Design

This Data Assessment is part of a larger, two-phased project over the 12-month period from December 2011 through November 2012. Phase One was the assessment and documentation of issues and recommendations for a more cohesive countywide data management strategy and was completed in April 2012. Phase Two will provide technical assistance and training associated with implementation of the recommendations. Phase Two technical assistance will occur from May 2012 through November 2012, supporting the implementation of strategies to improve local data collection, management, and reporting capacity.

The results of Phase One, presented in this document, consist of:

- *An overview of current HMIS data collection on homeless people and programs in Los Angeles County, including patterns of use of the HMIS and capacity for data sharing and coordination.*
- *An overview of other data collection and analysis related to homeless people or programs, including coverage of those data systems and capacity for integration with the HMIS.*
- *An assessment of key barriers to utilization of HMIS by providers and to its usefulness as a performance management tool.*
- *An examination of how best practices among high performing communities related to centralized client assessment and intake could be applied to Los Angeles.*

The Assessment results in this report are organized along four core issues:

1. *How can the HMIS be improved to make it a better tool for planning and policy-making?*
2. *How can the HMIS be improved to make it a better tool for providing client services?*
3. *How can the HMIS be linked to other data in the LA region to enable more comprehensive management and analysis?*
4. *How can LA create a coordinated assessment and intake environment?*

3. Inventory of Los Angeles Data Systems and Processes

This section first analyzes the Los Angeles HMIS database and data management system and the homeless data sources and reports that are integrated into or associated with the HMIS (Section 3.1). The section then turns briefly to the HMIS systems of other CoCs in the Los Angeles region (Section 3.2) and then to other, non-HMIS data systems related to homelessness and homeless people in the region (Section 3.3).

For any Continuum of Care, the components of the HMIS and the questions that should be asked about them are:

Homeless Management Information Systems (HMIS):

- What is the technical capacity of these systems and the management teams that administer them?
- Are data in HMIS complete, accurate, and representative?
- What functionality do these systems offer in terms of data integration, analysis, and management functions related to CoC system operations?

Housing Inventory Count (HIC):

- How accurate and complete are HIC data?
- Are programs listed on the HIC also participating in HMIS by contributing client-level data?

Point-in-Time Count (PIT):

- How accurate and complete are PIT data?
- What changes in methodological counting approaches impact ability to conduct trend analysis?

Annual Homeless Assessment Report (AHAR):

- As a tool for measuring data accuracy, completeness, and coverage rates, how does the AHAR inform the need for HMIS and data system improvements?

HMIS databases include client-level data from persons participating in residential or other homeless assistance services. The rate of provider participation or "bed coverage" in HMIS is a strong indicator of an HMIS database's reach and representativeness of all persons who experience homelessness throughout a region. A 50 percent bed coverage rate in HMIS is generally considered the minimum threshold for data usability when HMIS data are used to describe a community's overall homeless population and service use patterns. Participation rates above 85 percent are needed for credible and reliable planning, analysis, and performance measurement of local homeless services systems.

HMIS databases usually include the Housing Inventory Count (HIC) that captures data on the inventory of beds and housing units designated for people who are homeless. While the HIC can be compiled and updated outside the HMIS environment, managing HIC data in HMIS provides a good opportunity to integrate data on the inventory of beds and services with the utilization data derived from homeless clients' service use.

Point-in-Time (PIT) data measure the extent of homelessness from a single point in time. PIT data include both persons residing in shelter programs and persons living on the "streets"--that is, not in shelter

programs. Counts of sheltered homeless people for the PIT estimates can be derived from HMIS only if all homeless programs are entering client data into HMIS--or if overall bed coverage is high enough to permit accurate estimates of participation in missing programs. Unsheltered PIT counts must be compiled separately through street census and other outreach efforts.

The Annual Homeless Assessment Report (AHAR) is a national report compiled from aggregate HMIS and related data submitted by CoCs for geographic reporting units or "sample sites" based on political jurisdictions as defined for the Community Development Block Grant (CDBG) program. The AHAR includes estimates of numbers of individuals and families and their demographic characteristics, as well as special population groups such as veterans and chronically homeless people. The AHAR also covers the types of locations where people use emergency shelter and transitional housing; where people were just before they entered a residential program; how much time they spend in shelters over the course of a year; and the size and use of the inventory of residential programs for homeless people.

3.2 Los Angeles HMIS

The Los Angeles HMIS covers the entire county, with the exception of three jurisdictions within the county that function as independent CoCs and operate their own HMIS systems. These independent CoCs are Pasadena, Glendale, and Long Beach. Santa Monica is part of the Los Angeles CoC, but maintains a separate data management system. Data from Santa Monica are integrated into the Los Angeles HMIS.

LAHSA is a Joint Powers Authority established in 1993 as an independent agency by Los Angeles County and the City of Los Angeles. LAHSA is the lead agency for the Los Angeles Continuum of Care, and coordinates and manages over $70 million dollars annually in Federal, State, County and City funds for programs providing shelter, housing, and services to homeless people in Los Angeles City and County. LAHSA administers between $44.2 and $56.1 million dollars annually in HUD renewal funding for the Los Angeles CoC.

A 10-member Commission governs LAHSA. Five members are selected by the County Board of Supervisors, and five are chosen by the Mayor and City Council. The Commission is empowered with making budgetary, funding, planning, and program policies and decisions. LAHSA has a staff of over 100 people and is organized into the following departments: Administration, Communications, Finance, Information Technology, Policy and Planning, Programs, and Homeless Services /Emergency Response Team.

LAHSA is also the entity designated by the CoC to lead the HMIS project for the CoC. Within LAHSA, 9 HMIS staff are located within the Information Technology (IT) Department. LAHSA contracts with Adsystech, a national HMIS software provider, to provide operating software and support for the HMIS. LAHSA provides HMIS project management support, end user support, training, and data analysis capacity, while Adsystech maintains the actual HMIS software. LAHSA and Adsystech work together to ensure the HMIS implementation complies with HUD standards and expectations while locally defined requirements and needs are also addressed.

Adsystech, like many other HMIS software solutions, offers a broad and flexible enterprise system for managing client data. The product enables homeless assistance staff to collect and manage client data, make referrals and appointments on behalf of their clients for services and housing, review and update client assessment data, record clients' progress in achieving goals, and track outcomes. Other features

can help program management staff with activities such as scheduling, accounting, resource tracking, and program reporting.

While the scope of this assessment did not include a comprehensive technical review of Adsystech software, Abt staff received several demonstrations of the product, conducted interviews with Adsystech management staff, and spoke with many end users of the system who interact daily with the HMIS. Based on this level of review, Abt staff have concluded that Adsystech provides a fully functional and HUD-compliant software product that is completely capable of meeting current data management functionality needs. The system has the capacity to meet additional functionality needs as homeless assistance staff use the HMIS increasingly for coordinating client intake and assessment, managing bed and unit vacancy data, managing electronic client referrals, and managing enrollment prioritization processes and tools.

A more complete profile of the Los Angeles HMIS and a description of LAHSA's HMIS management approach are in Appendix C at the conclusion of this Report.

HIC

The Housing Inventory Count (HIC) is a snapshot of a CoC's housing inventory on a single night during the last ten days in January. It should reflect the number of beds and units available on the night designated for the count that are dedicated to serve persons who are homeless. Beds and units included on the HIC are considered part of the CoC's homeless services system.

The Los Angeles CoC's HIC is maintained and updated by the Programs Division of LAHSA. Each January the Programs Division staff surveys homeless service organizations located in the CoC to obtain data about each program. These surveys go to all organizations that serve and house homeless families and individuals, regardless of whether or not they are funded through LAHSA-administered funds and regardless of whether the organization actively participates in the HMIS. Data from this survey is used to update the HIC, as well as to determine the sheltered Point-in-Time (PIT) count from programs that do not participate in the HMIS.

LAHSA staff have made an effort to conform the HIC surveys to the Program Descriptors in HUD's 2010 HMIS Data Standards, as well as to current HUD guidance on HIC and PIT data collection, though some improvements were necessary following review by HUD HMIS TA staff for the 2012 HIC and PIT counts. For example, the review found that the HIC was an accurate account of CoC-funded beds and units, but that data on privately-funded programs and those funded with public sources but not managed by LAHSA are much less reliable.

HIC survey results are then shared with local coalitions to ensure accuracy and verify the results. Any differences are reconciled before the data is reported to HUD.

In the past, results from HIC surveys were not reviewed by LAHSA's HMIS project staff, and this led to discrepancies between bed coverage rates calculated by HMIS staff and rates based on data maintained by the LAHSA Programs Division.

Beginning in November 2011, HMIS staff began analyzing the HIC in an effort to determine HMIS bed coverage rates more accurately for the AHAR sample sites that are part of the Los Angeles CoC. National AHAR TA staff gave LAHSA HMIS staff an Excel-based tool to help calculate HMIS bed coverage rates for the AHAR sample sites. Focusing on Emergency Shelter (ES) and Transitional Housing (TH) programs, HMIS staff used this tool, together with their information on programs and beds,

to estimate HMIS bed coverage rates. Permanent Supportive Housing (PSH) programs were not reviewed, as it was clear that they would not be able to meet the 50 percent bed coverage rate required for participation in the AHAR. The resulting analysis was shared with LAHSA Program Division staff in January 2012, and program staff began working with HMIS staff to ensure that the updates that had been made were accurate according to the data from the HIC survey. This process took place quickly because of the rapidly approaching AHAR reporting deadline, but needs to become a regular occurrence at LAHSA. As HMIS staff complete outreach to agencies and help them participate in HMIS, they will receive updates on bed counts, program names, target populations and other items recorded on the HIC, just as Program Division staff will as they perform their duties. This information should be recorded in the HMIS Program Descriptors and communicated between the HMIS and Program staffs to ensure that each is working with the most up-to-date information on programs in the LA CoC.

HMIS staff use the HIC to determine which organizations to target for HMIS participation and have made significant strides toward improving HMIS bed coverage and data quality for ES and TH programs through improved outreach, additional resources devoted to HMIS implementation at homeless assistance programs, and a regular training schedule. Exhibits 2 and 3 show the improving rate, especially for TH.

In addition to continuing efforts with ES and TH to reach the 85 percent rate needed for local planning and analysis, LAHSA staff need to turn their attention to PSH programs, where HMIS participation is very low (Exhibit 3.3). Many people interviewed for this Data Assessment say that the HIC is double or triple counting PSH beds that have multiple funding sources. LAHSA staff should determine a method for identifying PSH programs on the HIC to avoid duplication so that the CoC has a more accurate view of the PSH universe. Once the HIC PSH data have been cleaned and updated, HMIS staff should implement an aggressive plan to recruit PSH programs to participate in HMIS.

Exhibit 3.1 Emergency Shelter HIC and HMIS Participation Rates

Emergency Shelter	2008 Count	2009 Count	2009 % Change from previous year	2010 Count	2010 $ Change from previous year	2011 Count	2011 % Change from previous year
Units, Households with Children	278	394	42%	356	-10%	418	17%
Beds, Households with Children	1,081	1.360	26%	1,307	-4%	1,488	11%
Beds, Households without Children	3,436	3,573	4%	3,183	-11%	3,623	14%
Total Beds	4,517	4,933	7%	4,490	-7%	5,071	13%
HMIS Bed Coverage Rate	10%	47%		50%		49%	

- HMIS bed coverage rates for Emergency Shelter programs have improved over the past four years but are still just at the 50 percent threshold level for inclusion in AHAR.

Exhibit 3.2 Transitional Housing HIC and HMIS Participation Rates

Transitional Housing	2008 Count	2009 Count	2009 % Change from previous year	2010 Count	2010 $ Change from previous year	2011 Count	2011 % Change from previous year
Units, Households with Children	1,024	1,097	7%	966	-12%	886	-8%
Beds, Households with Children	3,418	3,267	-4%	2,924	-10%	2.709	-7%
Beds, Households without Children	5,580	6,827	22%	6,101	-11%	5,644	-7%
Total Beds	8,998	10,094	12%	9,025	-11%	8,353	-7%
HMIS Bed Coverage Rate	22%	30%		35%		57%	

- HMIS bed coverage rates for Transitional Housing improved in 2011, achieving a 57 percent rate in 2011.

Exhibit 3.3 Permanent Supportive Housing HIC and HMIS Participation Rates

Permanent Supportive Housing	2008	2009		2010		2011	
	Count	Count	% Change from previous year	Count	$ Change from previous year	Count	% Change from previous year
Units, Households with Children	932	3,014	223%	2,946	-2%	3,125	6%
Beds, Households with Children	2,921	8,567	193%	8,364	-2%	8,883	6%
Beds, Households without Children	5,156	7,878	53%	8,644	10%	8,232	-5%
Total Beds	8,077	16,445	104$	17,008	3%	17,115	1%
HMIS Bed Coverage Rate	13%	8%		8%		16%	

- The 2011 HMIS bed coverage rate of 16 percent for Permanent Supportive Housing is well below the target 50 percent threshold rate for AHAR participation and even further below the rate of 85 percent that is the usability benchmark for local planning and analysis.

Los Angeles should establish HMIS bed coverage goals of 85 percent for all program types to create the capacity for more effective planning and analysis

PIT

Each program recorded on a CoC's HIC must also provide a Point-in-Time (PIT) count. The PIT is an important tool for understanding the extent and scope of homeless in a community. PIT counts analyzed over the course of several years make it possible to measure trends in the extent of homelessness and to assess the CoC's effectiveness in reducing homelessness.

The PIT number is the unduplicated number of persons served on the night of the count in beds reported for each program. The PIT count also includes people who are homeless but unsheltered. These unsheltered persons are residing in places not meant for human habitation such as abandoned buildings, cars, and on the streets.

While the HIC is conducted annually, HUD requires that CoCs report PIT numbers only every two years. When the HIC and the PIT data are collected concurrently, they should apply to the same night or series of nights during the last ten days in January.

A particularly challenging part of the PIT count is the estimate of homeless persons who are unsheltered and often difficult to locate. Many communities use extrapolation techniques to project the number of unsheltered from a representative sample. While HUD provides guidance about methodological approaches to extrapolation, communities have some discretion to apply an extrapolation methodology that fits within their community context and resource constraints. Los Angeles has been criticized in the past for making significant changes in methodological approaches from one PIT count to another, making trend analysis impossible. LAHSA, the agency that oversees the PIT count and releases the final count numbers, has maintained a consistent PIT methodology only since 2009. Future trend analysis is dependent on LAHSA maintaining a consistent and methodologically sound approach to enumeration. CoC system planners are not able to determine if large reductions in unsheltered PIT counts are a result of

fewer homeless persons or inconsistent counting methodologies. Exhibit 3.4 shows PIT data for each the last three available years, broken out by single-person households and families.

Exhibit 3.4 PIT Trend Data

Shelter Status	Population Type	2009			2010			2011			2009-11
		Count	%	% Chng from prev yr	Count	%	% Chng from prev yr	Count	%	% Chng from prev yr	% Change Overall
Sheltered	Households without Children	10,176	88%	23%	10,176	88%		9,541	79%	-6%	-6%
	Households with Children	1,365	12%	50%	1,365	12%		2,570	21%	88%	88%
	Total Households	11,541	100%	26%	11,541	100%		12,111	100%	5%	5%
Unsheltered	Households without Children	27,633	98%	-34%	27,633	98%		26,297	97%	-5%	-5%
	Households with Children	475	2%	-91%	475	2%		831	3%	75%	75%
	Total Households	28,108	100%	-41%	28,108	100%		27,128	100%	-3%	-3%

Note that no PIT count was conducted in 2010. 2009 numbers are carried forward for the 2010 count.

AHAR

The Annual Homeless Assessment Report (AHAR) is a national report derived from local HMIS, HIC, and PIT data describing the extent of homelessness, service use patterns, and the inventory of programs available to persons who are homeless. The national AHAR represents a compilation of aggregate community-level data geocoded into distinct geographical reporting units or "sample sites." Several AHAR sample sites are in the Los Angeles region. The City and County of Los Angeles are the largest AHAR reporting units, but a few other sites in the region have been defined as "certainty sites"--sites with high priority because they are part of a sample used by AHAR analysts to create national estimates. Successful participation in AHAR among CoC jurisdictions by providing data generated from HMIS is a strong indicator of a community's HMIS maturity, capacity, and data quality. Until 2011, the City and County of Los Angeles were not able to generate sufficient bed coverage or high enough data quality to contribute data to the AHAR. 2011 marks the first year that Los Angeles data will be included in the AHAR. Data was determined usable in the following categories:

- *Los Angeles City Transitional Housing for Families*
- *Los Angeles County Emergency Shelter for Families*
- *Los Angeles County Transitional Housing for Families*

Most usable data was contributed by Transitional Housing programs for families, largely funded by HUD's SHP program and, therefore, strongly encouraged to participate in HMIS. HMIS bed participation is improving year-to-year in every category except PSH. This may be partly attributable to the increase in PSH beds during that time, but also speaks to the need to ensure coordination between this Data Assessment and other efforts so that PSH data systems can be used for planning, client prioritization, and analysis.

3.3 Other (Non LA) HMIS Systems

The other CoCs within Los Angeles County--Glendale, Pasadena, and Long Beach, have adopted the HMIS standards and policies established by the Los Angeles/Orange County Collaborative. The Collaborative comprises all the CoCs within Los Angeles and Orange Counties and was established to create and support consistent HMIS design and operations decisions for the larger metropolitan region. While each Collaborative member operates its own HMIS implementation, consistent approaches are used for client consent, participation requirements, data sharing, data use and disclosure agreements, and reporting. A more detailed description of the Glendale, Pasadena, and Long Beach HMIS operations and results can be found in Appendix D.

The recommendations for HMIS enhancements and improvements in Section 4 of this report are focused on LAHSA and the LA HMIS, but many of the recommended improvements are also applicable to all LA/OC Collaborative CoCs.

3.4 Other (Non HMIS) Data Systems and Processes

Several entities throughout Los Angeles County collect and manage data on homeless people but, as of now, do not participate in the HMIS. These other, non-HMIS, systems collect primary data or analyze secondary data for purposes such as client assessment, cost analysis, PSH unit inventory tracking, and individual case planning. These other systems are included in this Assessment Report

because of the significant role they play either locally or regionally in collecting or using homeless data, as well as their potential for data sharing or integration into the HMIS.

Vulnerability Index: Community Solutions 100,000 Homes Campaign

Community Solutions is a nonprofit organization that mobilizes local efforts in communities across the country to identify homeless people living on the streets who are at greatest risk of death. This mobilizing effort, called the 100,000 Homes Campaign, uses a screening tool called the vulnerability index. Community Solutions staff train and support community volunteers during a week-long registry period in which homeless individuals are surveyed and scored according to the vulnerability index criteria. Information collected through the surveys carried out during these campaigns is used to develop health registries of individuals who are most likely to die on the street and who should have priority for accessing housing. Specific communities in the Los Angeles region are part of the 100,000 Homes Campaign and have created registries.

The vulnerability index identifies the following characteristics that place a person experiencing homelessness on the street homeless at a heightened risk of mortality:

- More than 3 inpatient hospitalizations in a year
- More than 3 emergency room visits in the previous three months
- Age 60 or older
- Cirrhosis of the liver
- End-stage renal disease
- History of frostbite, immersion foot, or hypothermia
- HIV/AIDS
- Tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical conditions

In order to be scored as "vulnerable," a survey respondent must have been homeless for at least six months. A value of one (+1) is assigned to each risk characteristic. The highest possible score is 8, although Community Solutions staff report that scores higher than 6 are rare.

Data from individuals surveyed during the vulnerability registry are entered into a health registry database maintained by Community Solutions. The database, QuickBase, generates individual vulnerability index (VI) scores for each client and has basic analysis and report generation functionality. Community Solutions can generate health registries and various other reports on behalf of participating communities. Authorized community representatives are also able to access QuickBase themselves.

The QuickBase registry includes data on client characteristics such as age, gender, race, ethnicity, education attainment, incarceration history and homeless history. Behavioral health characteristics are also tracked, including mental health status and substance use. Communities are also able to add locally specific registry questions such as names of healthcare facilities clients use most frequently.

In addition to the QuickBase registry, Community Solutions also maintains a separate database that tracks housing placement rates for communities that have completed a VI registry. Placement rates

are updated based on quarterly survey data collected from communities. However, housing placement data are not tied to individual records within the VI registry. Thus, although Community Solutions reports on the number of persons who have been placed in PSH, the database cannot be used to determine that VI registry individuals are the source of individual housing placements.

The VI registry follow-up housing placement survey tracks the following information:

- Number of chronically homeless persons placed in PSH
- Number of chronically homeless persons placed in scattered site PSH
- Number of chronically homeless persons placed in new development/rehab PSH
- Number of chronically homeless persons placed in turnover PSH
- Number of homeless veterans placed in PSH
- Number of chronically homeless veterans placed in PSH
- Housing retention rates for all housed individuals since program start date
- Housing retention rates for all individuals housed for at least 6 months
- Housing retention rates for all individuals housed for at least 1 year

The VI registry is reported to be a particularly effective community mobilizing effort that focuses attention on prioritizing housing placement for homeless individuals at greatest risk of death. Because the tool is administered by trained volunteers conducting street outreach, clients who are difficult to engage such as those suffering from severe psychotic disorders and those with paranoia may be less likely to participate in the VI registry or provide detailed and accurate responses.

As the County investigates options and tools for coordinating client assessment and prioritizing clients for PSH, the VI score and registry can play an important role. System designers and planners have an opportunity to leverage the effective community mobilizing capacity of the VI registry process to strengthen homeless system intake and assessment procedures. While not a precise tool, the VI score provides an easily applied mechanism for prioritizing scarce PSH resources. Used in combination with other system-based tools and processes, the street-based VI score can help identify multiple tiers of need within the overall universe of at-risk homeless persons.

Crisis Indicator: Triage Tool for Identifying Homeless Adults in Crisis

The Economic Roundtable, a nonprofit research organization based in Los Angeles, developed a triage tool for use by homeless assistance providers and other health care providers to identify homeless individuals in hospitals, jails, and in homeless service programs who have continuing crises in their lives that create very high costs to public systems of care such as jails and hospitals.

The tool is designed to identify the one-tenth of homeless persons with the highest public costs, often referred to as the 10th decile. The tool provides a predictive model for assessing the probability that a homeless individual currently has attributes that will create high public cost in the future. The high cost profile was developed by analyzing County cost data from General Relief recipients. The Economic Roundtable accessed the LA County's ELP database records (discussed below) to analyze over 13,000 client records, including County service utilization and associated costs. A typology of

the 10th decile of high cost homeless individuals was created from health status data and incarceration records.

The triage tool serves two main purposes: (1) identifying homeless individuals who will continue to incur tremendous public costs without appropriate service and housing intervention, and (2) prioritizing access to scarce PSH supply using an information-rich and data-based methodology. For public system managers and planners focused on cost avoidance, the triage tool must be able to provide a highly accurate predictive tool to identify homeless individuals who can be prioritized for PSH, thereby reducing high public costs resulting from these individuals' ongoing crises.

A pilot project is currently underway to refine and validate procedures for using the triage tool. The pilot project is planned and supported jointly by the Corporation for Supportive Housing (CSH), the Economic Roundtable, and Conrad N. Hilton Foundation. The sites for the pilot are California Hospital Medical Center in downtown Los Angeles and Ocean Park Community Center (OPCC) and Venice Family Clinic in Santa Monica. Medical staff are being trained to administer the triage tool to identify patients who meet the 10th decile criteria. Once identified these individuals are prioritized for PSH as part of the Frequent Users Systems Engagement (FUSE) initiative.

The triage tool has great promise for expansion more broadly throughout the County as a tool to identify high cost system users and prioritize these individuals for PSH.

Enterprise Linkage Project: County Data Warehouse Project

The Enterprise Linkage Project (ELP) is a real-time data warehouse being developed by the County's Chief Executive Office to link client records across multiple County departments. The ELP initiative grew out of a similar analytical database, the Adult Linkage Project or ALP, which the County created on a pilot bases to track the costs of different public agencies for a representative sample of adults experiencing homelessness.

The Adult Linkage Project (ALP) system was developed in 2009 by the Los Angeles County Chief Executive Office and the Department of Public Social Services (DPSS) in collaboration with several County departments (Community and Senior Services, Children and Family Services, Health Services, Mental Health, Probation, Public Health, and Sheriff's departments). The ALP system implemented a data warehouse, linking information from a group of participants in the General Relief (GR) program with information on services provided to this cohort by County departments. The ALP data warehouse also contained information on the costs incurred by the County in providing these services. ALP was utilized to produce an analysis of the complex patterns of services accessed by GR participants and the cost of those services.

Application of the ALP technology was limited to analytical purposes, providing the Board of Supervisors, the CEO, as well as other County departments involved in the ongoing provision of services to GR recipients, with information on the GR population's complex service use patterns and the costs departments face in making those services available to recipients. Because the ALP was so successful, the CEO and DPSS in collaboration with other County departments are now in the process of expanding the ALP system as part of a broader Enterprise Linkage Project (ELP) effort to integrate departmental data on an ongoing basis and enable authorized users to access dynamic data for ongoing case planning and analytical purposes.

The County has identified three main objectives of the ELP initiative: (1) enable real-time identification of GR recipients who are heavy users of County services; (2) enable County case management staff to provide heavy service users with targeted services that eliminate redundancies; and (3) enable data analysis and case planning through an interactive web-based interface.

The County has executed a contract with SAS Institute, Inc. (SAS) to create the web-based interface, enabling ELP search and analytical functionality for multiple authorized users throughout the County. The interface will eliminate redundancies, link recipients with services in a more efficient manner, and reduce the need for certain types of services, all leading to significant cost avoidance for the County departments providing services to GR recipients. SAS is in the process of developing the data warehouse and preparing it for quality testing. Most County departments have now uploaded historical data on client service utilization to the ELP. The target data for implementation of the ELP is June 2012. The following County departments will be supplying data:

- Community and Senior Services (CSS)
- Department of Children and Family Services (DCFS)
- Department of Health Services (DHS)
- Department of Mental Health (DMH)
- Department of Public Health (DPH)
- Probation Department (PD)
- Sheriff's Department

Plans are also underway to integrate HMIS client data into the ELP. HMIS client consent protocols are being updated by LAHSA to allow for the disclosure of client data to the ELP and use of data by the County for administrative and analysis purposes. Likewise, County staff are completing training in HIPAA certification so that County staff can appropriately secure consent from residents whose protected personal information can be included in the ELP and released to designated County personnel for purposes of case coordination and analysis.

Other Entities Involved in Homeless Data Collection or Management

While HMIS data systems represents the most comprehensive effort to collect client-level data on persons who experience homelessness in Los Angeles, other entities also collect and manage data on homeless persons or resources for homeless persons. These entities often play a significant role in collecting, analyzing, or presenting data. Brief descriptions of each are included here.

Los Angeles Housing Department (LAHD)

LAHD is charged with development of citywide housing policy and supporting safe livable neighborhoods through the promotion and preservation of decent affordable housing. LAHD is one of the primary coordinators of PSH funding in the City of Los Angeles, managing PSH development capital and operating resources from HOME, CDBG, tax credits, bonds, private loans, and other local sources. While LAHD does not collect or manage client-level data, the department does track the funding and development status of PSH projects using a PSH production database. The LAHD PSH production database collects information on project development status, funding sources, location,

and target population for project-based developments. Scattered site PSH are not part of the LAHD tracking system.

The LAHD PSH inventory and development tracking database provide a significant source of valuable PSH data that should be used to build and verify the HIC information managed by LAHSA.

Housing Authority of the City Los Angeles (HACLA)
HACLA administers the Housing Choice Voucher program for the City of Los Angeles. HACLA actively partners with PSH housing developers by designating a portion of HACLA's housing choice voucher allocation to housing projects that target formerly homeless and chronically homeless individuals. HACLA is also a member of the Funders Collaborative group.

County Department of Mental Health (DMH)
The County Department of Mental Health coordinates the California Mental Health Services Act (MHSA) funding for services and treatment for persons with mental illness. MHSA funding is coordinated with other housing development and operations funding to provide PSH for this population. DMH's role in funding PSH services means that the Department can establish and enforce data collection and management requirements associated with MHSA funding. While DMH does not require that programs receiving MHSA funding participate in HMIS, programs are required to document the provision of services and report treatment outcomes using reliable and tested instruments and protocols. Some MHSA funded projects have elected to collect and manage their client data in HMIS. However, DMH does not track the specific data collection systems or HMIS participation rates of DMH funded providers.

United Way
The United Way's Home for Good partnership provides strategic leadership for the Los Angeles community by initiating a county-wide action plan to prevent and end chronic and veteran homelessness. Home for Good, a partnership among the United Way, the LA Chamber of Commerce and the Business Leaders Task Force, establishes goals and action steps so that all stakeholders and community members have a clear road map for ending homelessness. These activities include creating a Funders Collaborative group to coordinate and focus investment to priority need areas, creating a system for prioritizing chronically homeless persons for PSH, mobilizing community members to count and engage homeless persons living on the streets, and enhancing data collection and management efforts.

The United Way manages a joint PSH Notice of Funding Availability (NOFA) application process with multiple funders throughout LA, including the Los Angeles Housing Department (LAHD), the Housing Authority of the City Los Angeles (HACLA), the County Department of Mental Health, the County Department of Health Services, LAHSA, and private funders. This Funders Collaborative group releases the consolidated NOFA in an effort to streamline and coordinate the PSH funding process. PSH project developers can simultaneously apply for capital funding from LAHD, housing vouchers from HACLA, and services funding from the County through this joint NOFA. All participating NOFA funders have adopted the same PSH and chronic homeless definition in an effort to standardize the PSH development process and inventory.

In an effort to track and communicate the systemic change that Home for Good supports, the United Way will issue regular progress reports that describe trends in creating more housing and service capacity and decreasing the number of persons who experience chronic homelessness. These reports

are compiled from data that were initially collected from other sources but United Way's efforts at organizing, reconciling, and reporting data represent a significant community resource for gauging progress.

Highlights from an annual *Home for Good* report released in February identified baseline numbers of chronically homeless individuals and veterans, the PSH inventory pipeline and operational housing stock, and number of persons housed. In order to document progress toward these goals, United Way does extensive surveying and fact checking of responses from funders and homeless assistance providers. The compilation of *Home for Good* annual report data represents a hugely labor intensive process, since that source information is managed by multiple independent entities, requiring de-duplication and reconciliation on the part of United Way analysts.

United Way grantees and recipients of *Funders Collaborative* funding are required to collect and report on homeless clients served in PSH projects. However, HMIS is not specifically identified as the required data collection and management system associated this funding.

CSH

The Corporation for Supportive Housing (CSH) has a regional office in LA and actively partners with area developers and homeless service providers to develop PSH. Since many housing and service providers in LA have limited experience developing, operating, or delivering services in supportive housing, CSH is widely seen as a critical partner in local efforts to end homelessness. CSH provides technical support, predevelopment and development loans, and capacity building to organizations implementing PSH. With a portfolio of nearly $55,000,000 in loan and capacity building funding, CSH is supporting more than 1,500 units of both project-based and scattered-site PSH.

CSH maintains a database of information on PSH projects in the development pipeline and operational stock. This database, Portfol, tracks, monitors, and services all CSH lending and technical assistance efforts nationally. Portfol tracks CSH's PSH project funding sources, unit information, targeted populations, and timing of development versus operational status. While Portfol has the potential to provide information on the CSH-funded PSH inventory in LA, project configuration and funding situations tend to evolve throughout the development stages of a project and detailed and accurate reports from Portfol can sometimes be difficult to generate.

4. Recommendations for an Improved Data Management Strategy

The findings and recommendations in this Homeless Data Assessment Report are derived from multiple sources: a review of the HMIS, HIC, PIT, and AHAR data systems and processes in Los Angeles; a review of the management structure of the LA CoC's HMIS project; targeted interviews and focus groups with end users of HMIS and with key stakeholders who collect, analyze, and report data on homeless persons and services in LA; and a review of the data collection and reporting needs required for a community to be able to track the progress of strategic planning efforts such as the United Way's *Home for Good* initiative.

On the basis of that review, Abt Associates recommends that the Los Angeles Homeless Funders Group adopt HMIS as the primary data collection, management, and reporting platform for homeless clients and services in LA.

HMIS provides an existing infrastructure that can be expanded to form the basis for improved client case coordination, program data management, and system-wide coordination and evaluation. Many homeless assistance providers in LA are already using HMIS or are familiar with administrative data management systems and can readily adopt HMIS as their primary data collection and management tool if provided the necessary resources and support. While baseline HMIS functionality theoretically meets the needs of both homeless assistance providers and policy planners, system improvements will be necessary to make HMIS viable as an ongoing tool. These improvements need to be targeted to end users of HMIS, so that their experience with entering and managing data and running data reports is positive and successful. Timely, complete and high quality data entered by end users then will be available to support the data and analysis needs of system planners and policy-makers as they analyze the performance of individual programs and the homeless services system.

Homeless people themselves will benefit from more efficient and accurate service planning when service providers coordinate assessments, case plans, referrals, and outcome tracking using HMIS. However, HMIS alone cannot address all of the needs of homeless assistance providers, CoC planners, and persons experiencing homelessness. A comprehensive data management strategy will improve the current HMIS platform by focusing on ongoing data quality and improved bed coverage, but will also integrate data from other systems, and increase data sharing capabilities, making possible more robust analysis and evaluation.

The remainder of this section of the Report presents findings and recommendations in response to four questions:

- ***How can HMIS be improved to make it a better tool for planning and policy-making in the LA region (Section 4.2)?***
- ***How can HMIS be improved to make it a more effective tool for managing client services in the LA region (Section 4.3)?***
- ***How can HMIS data be linked to other data sources to enable more comprehensive management and analysis (Section 4.4)?***
- ***How can LA create a coordinated assessment and intake environment (Section 4.5)?***

4.2 HMIS as an Effective Tool for Planning and Policy-making

The key to making the HMIS a better tool for planning and policy-making is to improve the experience of the homeless provider staff who interact with HMIS on a regular basis, entering client data into HMIS. An enhanced end user experience, along with other system management improvements and improved coordination, will lead to better quality data to support planning and policy-making.

Findings:

HMIS staffing and the LAHSA organizational structure do not support efficient management of the HMIS project. HMIS maintenance and administrative functions are not sufficiently integrated into CoC system and program policy discussions at LAHSA.

- HMIS Project management leaders appear to be proficient IT professionals but lack the detailed knowledge of CoC programs and typical client flow that might inform the design, maintenance, support, and data analysis functions required of the HMIS project. Many HMIS management functions, including prioritizing training and outreach, reviewing data quality, and preparing data reports are conducted by LAHSA HMIS staff who do not have enough programmatic and CoC design experience to do the job well without increased participation of staff with other expertise. Although staff from the Programs Department assume primary responsibility for drafting and validating customized program performance measurement reports in HMIS, these staff are not involved in project management discussions with Adsystech staff that prioritization of these reports among other database management tasks.
- The process for compiling and reconciling HIC data is inefficient and cumbersome, consisting of multiple ad hoc meetings and review from separate staff in LAHSA's IT/HMIS, Program, and Contracts departments.

HMIS end users report frustration and confusion. Some potential end users are concerned that HMIS data may be used for identifying undocumented immigrants or for reporting clients with outstanding warrants to legal authorities. They also are concerned about identify theft.

- Many HMIS users expressed frustration that HMIS is used only to satisfy an administrative requirement for HUD-funded programs. These end users expressed interest in using the more sophisticated program management and case planning functionality of the HMIS system. These other uses and functions include assessment tools and scoring protocols such as the Vulnerability Index, 10th Cost Decile Triage Tool, Milestones of Recovery Scale (MORS), and Multnomah Community Ability Scale. Expanded use of the HMIS platform would improve end user satisfaction and data quality.
- Homeless assistance staff who are users of the HMIS report challenges with their user experience. These challenges relate to user interface (for example, Adsystech windows in HMIS are not adjustable to account for different screen sizes or viewer preferences), lack of understanding of how to accurately and completely enter data and run reports, and lack of knowledge about the process and timelines for addressing system use questions and problems.
- HMIS users report that the data entry process can be time consuming, cumbersome, and not intuitive. Running reports is especially time consuming, typically at the end of the month when many provider programs are running other reports, which taxes staff capacity.

- Many HMIS users are new homeless assistance staff and lack the experience or knowledge base that provides a necessary context for HMIS participation. This is especially true of end users who are short-term contract staff at cold weather shelter programs.

HMIS training and support processes are not always well received.

- End users report that standard HMIS training and support materials have improved over the past year but the content and delivery is still inflexible, dry, and too general.
- End users must attend trainings at LAHSA downtown offices, which are inconvenient for many staff and require a moderate parking fee for each of the three days of training.
- While written training materials and manuals are available, end users are more likely to seek support and answers to software use questions from coworkers rather than contacting LAHSA HMIS support staff.

Privacy practices and client consent protocols do not support flexible data sharing practices.

- The default client consent protocol for the LA HMIS is written consent. While providers report that obtaining written consent is not overly burdensome, a single, more comprehensive consent protocol would be easier to administer than multiple protocols for different systems to which providers report. The current HMIS consent protocol and privacy practices should be reviewed to identify opportunities to consolidate multiple consents. This also might increase the feasibility of data sharing among staff from different agencies.

HIC, PIT, and AHAR functions are cumbersome and not coordinated with other community planning efforts.

- HIC Program Descriptor data are recorded in the HMIS but not routinely and frequently verified among the HMIS and Program staff in LAHSA to ensure that each department is working with the most current and accurate HIC information for programs in the LA CoC.
- Program inventory data from non-providers that do not participate in the HMIS is often inaccurate, out dated and may reflect duplicate reporting.
- Accurate and comprehensive PSH data is missing from the HIC.
- Changes in methodological approaches to the unsheltered PIT enumeration have made year to year comparisons problematic.
- The process for managing the PIT enumeration needs to be more intentionally integrated with the process to update the HIC inventory of programs.

Recommendations:

Adopt HMIS as the standard data collection and management tool for the homeless services system in Los Angeles.

- All public and private funders of homeless assistance services and housing should adopt HMIS as the primary data collection and management tool for providers, incorporating HMIS participation in all grant agreements and contracts.
- LAHSA should incorporate standardized client intake, assessment, prioritization, referral, and enrollment methodologies into HMIS functionality. Coordinated assessment and centralized intake plans should use the HMIS infrastructure as the common platform for implementation.
- LAHSA should work with the County's Chief Executive Office to integrate the HMIS and ELP databases to create a single, comprehensive homeless information dataset for region-wide analysis and reporting on the most vulnerable homeless people.

Establish HMIS as the central HIC and PIT data compilation and reconciliation tool.

- Current PIT counting methodologies have remained consistent for the past three years. LAHSA should maintain existing methodologies and protocols to ensure future PIT counts are comparable, enabling long term trend analysis.
- LAHSA should develop a standardized process to survey shelter and housing operators during the PIT count process to insure that regular updates to HIC bed and unit inventory are accurate and complete.
- LAHSA should integrate outreach efforts to engage PSH providers in HMIS participation with the HIC reconciliation process by comparing HIC data with United Way, CSH, HACLA, HACoLA, and DMH information sources.

Enhance HMIS data quality by establishing clear standards and monitoring progress in achieving them.

- LAHSA should establish HMIS data quality standards and monitor data quality for each program type.
- LAHSA should provide regular (monthly) performance reports to providers, with sufficient client-level detail to enable providers to review program performance and to fix inaccuracies and discrepancies in client-level records.
- LAHSA and Adsystech should add to the HMIS software real-time error checking and mouse-over windows for definition of terms and clarification of instructions.

Use AHAR participation as a vehicle for improving HMIS program participation and data accuracy

- LAHSA should develop a formalized and detailed process for sharing and updating Program Descriptors among LAHSA Program staff, HMIS/IT staff, and Contracts staff. This process should reconcile HIC information several times throughout the year.
- LAHSA and the Funders Group should develop method for tracking the development of PSH units that permits de-duplication of beds that are funded by multiple entities within a single PSH

project. All of the entities involved in funding and developing PSH should devote time and resources to reviewing the PSH portion of the HIC, paying special attention to deleting duplicative programs and beds.

- LAHSA should document AHAR data quality processes and review data to be reported to AHAR several times a year to identify major data quality issues in time to address them before the AHAR reporting deadline.
- LAHSA should align HMIS participation goals with AHAR sample sites and reporting categories to work towards providing more categories of usable data for future AHAR submissions.

Improve homeless assistance providers' experience with HMIS.

- LAHSA and Adsystech should improve front-line user experience by making improvements to the look, feel, functionality, and usability of the HMIS software.
- LAHSA and Adsystech should add enhanced functionality and mobility tools – scan card technology, smart forms for scanning, use of smart phones and tablet applications for outreach teams – for those sophisticated users and agencies that could benefit from them.
- LAHSA should provide HMIS training and support targeted by geography, program type, and service population type.
- LAHSA is creating monthly progress reports (MPR) to help providers independently review their own performance against HEARTH performance targets. These reporting improvements should be pushed out to all providers as soon as possible.
- LAHSA should target Emergency Shelter and Permanent Supportive Housing programs for participation in HMIS, especially those providers not funded directly with CoC resources.
- LAHSA should expand scan card technology to non-HUD funded providers as a way to increase HMIS participation among program and agencies that do not receive LAHSA funding.
- LAHSA and Adsystech should create data entry wizards specific to certain provider groups so that only required or relevant questions are viewable to end users.

4.3 HMIS as an Effective Tool for Providing and Managing Client Services

Findings:

End user experience with the client management functionality of HMIS is poor.

- HMIS users report that the Dashboard feature that is intended for real-time assigning of clients to specific beds and housing units is too cumbersome to use and often includes inaccurate data.

Privacy practices and client consent protocols do not promote data sharing and client service coordination across provider agencies.

- Sharing of client data across providers and agencies is an essential strategy for getting provider buy-in and support. LA HMIS consent protocols do not enable flexible data sharing among providers without the administrative burden of collecting written consents from clients.

Existence of other data management systems creates duplication and redundancy.

- Providers do not maintain waiting lists for Transitional Housing and Permanent Supportive Housing programs in HMIS. Typically wait list information is managed in separate, agency-specific systems, even though LAHSA's HMIS technology enables this feature.

Recommendations:

Enhance use of HMIS as a program and client management tool.

- LAHSA should encourage providers to use HMIS to track program vacancy availability, document program eligibility, refer clients, and link clients throughout the program enrollment process. This will require some improvements to the Adsystech software, as well as specialized training for providers on how to use these HMIS functions.
- LAHSA should integrate coordinated assessment tools and processes such as the Vulnerability Index and 10th Cost Decile Triage Tool into HMIS data collection functionality.

Improve data sharing and analysis capacity

- LAHSA should enable and support enhanced HMIS data sharing among different provider agencies and programs. While sharing of basic identifiers and demographics is currently enabled, data quality and case planning efficacy will improve when providers can access client records that also include historical service use and dates. Training materials and approaches should be updated to support enhanced data sharing.
- LAHSA should review existing HMIS client consent protocols to identify opportunities to streamline data sharing permissions while maintaining appropriate protections.
- Community strategic planning efforts such as Home for Good require consistent and uniform definitions to clearly identify and track indicators such as number of chronically homeless, housing retention, recidivism, and behavioral health status among others. The Funders Group should develop consistent, community-wide definitions, which in turn will support improved data use locally and inform analysis regionally.

Improve HMIS participation rates by enhancing the end user experience.

- LAHSA should continue end-user focus groups and provider discussion groups to document usability concerns and support system enhancements in collaboration with Adsystech management.
- LAHSA should produce high-impact management reports to encourage tracking of progress against HEARTH Act and community-defined performance measures.
- LAHSA should develop targeted strategies to engage Emergency Shelter and Permanent Supportive Housing providers in HMIS participation, with the goal of achieving 85 percent participation rates across all program types by 2014.

4.4 Linking HMIS to Other Data to Enable More Comprehensive Management and Analysis

Findings:

Flexible data integration practices are not enabled.

- LAHSA has established a policy of not supporting integration of valid and complete data from non-HMIS systems. Agencies with proprietary or locally-supported systems must engage in double data entry into both their own system and the LA HMIS.
- While technological systems and standards are in place to enable the integration of data from other HMIS implementations in LA County (Pasadena, Glendale, Long Beach, and Santa Monica), resources and protocols within LAHSA inhibit integration of data as a standard practice.

Existence of multiple data management systems throughout LA creates duplication and inefficiencies.

- Many provider agencies and programs use non-HMIS or other privately developed and supported software solutions to manage client data and reporting as an alternative or in addition to participation in the LA HMIS. This creates duplication and potentially inconsistent records for the same clients.

Recommendations:

Enable integration of homeless data from proprietary systems into HMIS, based on narrowly defined limitations and specifications that promote direct HMIS participation as the preferred and supported option.

- LAHSA should enable non-HUD funded providers to integrate basic client data (Universal Data Elements) into HMIS on a periodic basis (at least annually), as long as the program occupancy information needed for client referral and coordinated intake is made available to the HMIS on a real-time basis.

Integrate HMIS client data with the Los Angeles County's Enterprise Linkage Project (ELP).

- The County's Chief Executive Office Service Integration Branch, LAHSA, and other stakeholders should define a set of community-wide research and analysis objectives to inform the development and use of homeless client data in the ELP.
- LAHSA should update HMIS client consent protocols to account for uses and disclosures associated with ELP integration.
- LAHSA and the County's Chief Executive Office Service Integration Branch should develop integration protocols that provide guidance for the frequency, process and handling, and security of HMIS data.

4.5 Establishing Coordinated Assessment and Intake Environment

The assessment and intake and priority-setting strategies currently in place or in the planning stages in Los Angeles, including use of the Vulnerability Index or the 10th Decile Tool, reflect the beginnings of efforts to use data collection to make the overall system of services more effective and efficient. Without coordination and coverage, however, these efforts are likely to remain limited in scope and usefulness. After studying a number of communities working strategically to end homelessness, HUD has determined that systematizing the mechanisms through which people gain access to the homeless services system has been critical to successful strategies. These communities use data and the data management structure to make intentional matches between homeless individuals and families and the most appropriate services that will help them transition quickly out of homelessness. This ensures that resources are used most efficiently and that high-intensity services are provided only to those most in need of such services, while homeless individuals and families requiring less support receive only the minimal amount of resources required to become stable. Using coordinated assessments, structured referrals, and consistent data capture, communities are able to monitor performance of their systems and evaluate the effectiveness of their strategies, while service delivery personnel are able to conduct thorough case planning and communicate effectively with peers in case conferencing.

Therefore, in the regulations that implement the HEARTH Act, HUD requires that communities establish a coordinated assessment and system entry process for all programs that use ESG funds or are part of the award of HUD McKinney-Vento funds to the CoC. Los Angeles will be required to implement such a process in the near future. Best practices from other communities should be considered as LA develops this process for streamlining access to appropriate services. See Appendix E for case studies of coordinated assessment in other communities.

Coordinated assessment and intake requires homeless services providers to triage, refer and intake homeless individuals and families in a consistent manner across a specified area. Those homeless people who are triaged into the homeless services system (rather than diverted to more appropriate or more cost-effective resources), a single, streamlined intake assessment is used to ensure that clients are assessed once and that the appropriate data are collected during that assessment. Based on this assessment of housing barriers and goals, clients may be referred (either through direct placements into available beds or through non-binding referrals) to an appropriate short-term shelter where they can begin working with housing service providers to quickly transition into permanent housing.

The benefits of this system are clear from the client perspective. There is no longer a need for clients to travel from program to program, completing multiple intakes, in order to gain access to an appropriate housing or service provider. The first point of entry gathers all needed information, and the first referral is the most appropriate one based on client circumstances and availability. From the provider perspective, intake burden is cut down and staff members can focus more fully on moving clients out of shelter and into permanent housing.

Critical issues and best practices in coordinated assessment and intake

Establishing coordinated system entry in Los Angeles would supplant a process that is currently fragmented and primarily based on personal relationships between case workers or small-scale formal or informal relationships between agencies. The geographic challenges in the Los Angeles Continuum of Care are huge, and the current system of service delivery is unusually fragmented. Furthermore, as shown by this Report's other findings and recommendations, the data systems required to ensure the

needed data sharing, real time information on the availability of beds and units, and mechanisms for reserving units for triaged clients will require significant investment of time and resources by LAHSA.

Of the models established as best practices, Los Angeles would most likely find a multiple-location system using a uniform intake tool to be most appropriate. In this model, clients may call or go to any one of multiple participating prevention and homeless programs at different geographic locations. Intake workers at each location use standardized intake, assessment, and referral procedures and tools, often in the context of shared HMIS data collection and reporting. Given the fragmented nature of the funding landscape in Los Angeles, the system will likely have mixed authority, in which "the centralized intake program provides centralized information and referral, and has admissions authority over some housing/service types…, but not others."

Recommendations for a Successful Coordinated Assessment and Intake Environment

Document the level of participation that can be expected from each provider and program and establish protocols to accommodate it

In moving toward coordinated assessment and intake, Los Angeles policy-makers, funders, and stakeholders should undertake collaborative system mapping within and between Service Planning Areas (SPAs) to identify:

- *Which of the current intake approaches and protocols can be readily integrated into a single client intake and coordinated assessment system?*
- *Which additional systems would be willing to participate in exchange for reduced intake burden and clear, streamlined intake process?*
- *Which systems are unwilling to participate? How might their exclusion affect the establishment of a geographically or population-targeted system?*
- *Which systems can and should be segregated into separate systems--for example, family programs, DV programs, and transition-age youth programs? Are existing outreach teams specifically targeting one of these populations? Should they (and the emergency beds and permanent housing units to which they have access remain segregated from the system of coordinated intake or should attempts be made to include them?*
- *Which geographies can be wholly segregated and encapsulated in their own program clusters?*
- *Which geographies are missing critical resources such as emergency shelter beds that can be used while families or individuals are waiting for housing locators to identify permanent housing resources? Can these geographies be broadened or interwoven with adjacent geographies to provide adequate coverage to the targeted population?*

Los Angeles will need to develop system plans, identifying all participating agencies and programs, as well as non-participating agencies to which intake centers may make non-binding referrals, for each geographic area and target population within it. Target populations could be families, chronically homeless people, other people homeless as individuals, unaccompanied youth, victims of domestic violence, veterans, or any other subpopulation for which there is a separate service and housing systems. In Los Angeles, SPAs could be used, depending on the providers and programs willing to participate in centralized intake. Within these geographic clusters, groups of programs

would be identified into which triaged clients can be "tracked" based on their need for prevention, rapid rehousing, supportive housing, or more in-depth wrap around services such as those targeted to chronically homeless individuals with complex needs. Based on the system mapping, incomplete systems for specified subpopulations may require inter-SPA collaboration. For example, resources targeted to specific subpopulations that may only be found in certain geographic regions (Downtown Los Angeles, Hollywood, or West Hollywood or the Westside of Los Angeles) may need to be opened to a broader geographic reach than systems that simply target families or single adults. In addition, the role in the referral process of substance abuse programs, detox shelter beds, and housing programs targeted to individuals with mental health issues will need to be established. Coordination with these resources may not be as formal as with programs participating in coordinated intake, but nonetheless will be critical.

"Centralize" the point-of-entry into the system for people experiencing homelessness or a housing crisis by Service Planning Area (SPA).

Los Angeles will need to establish the mechanisms through which coordinated intake will take place. A combination of centralized telephone systems and physical locations will likely be necessary, given the geographic spread of the Los Angeles service areas. One or more physical points of contact within each SPA can be supplemented by a central telephone line and outreach workers equipped with consistent triage tools. Intake workers might be out-stationed at DPSS offices. Using existing Access Center locations will reduce some of the good-neighbor challenges that have been faced in other communities when small-scale programs were converted to single points of entry into the homeless service system. As long as consistent protocols are used for triaging clients, expanding the number of intake points will still result in improved coordination. However, a system based on multiple intake elements will require effective communication between the various groups conducting the intake. Regular coordination meetings among outreach and intake workers within each established geographic region are recommended, both to discuss contacts made with individuals and families and to ensure ongoing consistency in the methods used to triage and prioritize applicants.

Effectively and efficiently triage clients – moving clients into the appropriate system of care for their situation – and then only intake clients for whom homeless assistance is truly most appropriate

Los Angeles will need to establish the roles of the coordinated intake points, based on the participation levels of programs within those areas. Following best practices, establishing a simple, consistent triage tool will help homeless individuals and families access the most appropriate, least resource-intensive, service for them. Efforts should be made to use the triage process to divert clients from emergency shelter – either through helping the client find a safe place to stay outside of the homeless system or through referral or placement in another system of care. These other referrals could include referrals to providers of mental health services, including those with additional housing resources; referrals to substance abuse treatment programs or detox centers; and referrals to veterans systems, youth services systems, or others, depending on which such programs exist within each geographic region and have agreed to accept referrals.

Clients who are determined to be appropriate for intake into the coordinated homeless assistance system should be further assessed using the common tool. Given the number of programs in Los Angeles, each with its own specific intake process, it may be beneficial to develop a simple prioritization assessment rather than a single intake tool covering all programs' intake questions.

Using the simple assessment, clients would be triaged into groupings such as chronically homeless, high-barrier, and low-barrier, for whom separate "tracks" of participating programs are available. Each of these groupings may have its own further prioritization assessment. The Vulnerability Index, discussed earlier in this report, is an excellent tool already in use in some communities within Los Angeles to prioritize chronically homeless individuals for permanent supportive housing programs. Adding this assessment to the HMIS could allow for its use as the central tool for intake into the coordinated "track" for this group. In other CoCs, the Vulnerability Index has been incorporated into the HMIS and shared among providers so they can see the client's responses. Similar tools are available or can be developed for other target populations.

Use the intake information to place the client in the most appropriate program or set of programs as quickly as possible

The coordinated assessment and intake systems should have clear and consistent protocols for programs to notify the intake center of openings and for intake staff to match clients with those available program spaces based on the results of their assessments. In the Columbus (OH) family system, this process is handled through case conferencing at weekly meetings. In Seattle, programs pre-identify the client assessment score they are most suited to assist and the additional intake information required to enter the program. This information is stored in the HMIS so that an intake staff member can easily review this information when considering a client for an opening and gather the needed information before completing the referral. Communities are clear with clients and program staff about the number of referrals they may decline and the consequences of declining a referral. (Appendix E has more information about best practices for coordinated assessment and intake in other communities.)

Leverage coordinated assessment and intake protocols to "close side doors"

A coordinated assessment and intake system in Los Angeles will need to establish up front that agencies that participate in the coordinated intake process must not take referrals from any other source. This is a critical component to ensuring the success of the system. Without this restriction in place, programs have very little incentive to participate, and the fragmented system will not change. When this restriction is in place, programs have more incentive to participate in order to gain access to housing resources for their clients. In Los Angeles, these restrictions will depend on the program types that participate. Ideally, emergency shelters will participate along with programs that provide housing. Given the limited availability of emergency shelter beds, especially in some of LA's geographic regions, these beds would be prioritized for individuals awaiting placement in a housing program via the coordinated intake process. This targeted access to emergency beds would provide incentives for both providers and clients to participate fully in the process.

Track, monitor, and publicize coordinated assessment process results

Communities with mature coordinated assessment and intake systems operate from the knowledge that the systematized data collection is not useful unless it is used to improve programs and client experiences. Using the data from the centralized intake system to monitor the timing of each transaction allows communities to identify bottlenecks and set targets for shortening clients' stays in emergency or transitional shelter. Additionally, these data can be used to assess and refine the coordinated intake process. Increasing the capacity of the CoC for oversight and monitoring of data is a central theme for this Report's recommendations.

5. Next Steps and Resource Considerations

While a coordinated homeless data management strategy has been lacking in Los Angeles up to this point, key stakeholders have nonetheless been engaged in targeted and sometimes coordinated efforts to create more cohesive, accurate and usable datasets on homelessness and on shelter and housing resources for persons experiencing homelessness. During 2011, HUD, LAHSA, and members of the Los Angeles Funders Group documented problems and inconsistencies with local data sets and began to implement solutions to address deficiencies and redundancies. These improvement efforts are becoming more focused and coordinated, but more will be needed. Given limited resources, TA efforts will need to be sequenced strategically.

Implementation of a coordinated data management strategy for Los Angeles will require the continued effort of LAHSA, City and County government departments, the Los Angeles Homeless Funders Group, and homeless assistance provider agencies and their staff. Some of the implementation steps are currently in progress. LAHSA has already completed an internal review of HMIS project management within LAHSA and of training and support to HMIS end users. As a result, HMIS project management roles have been more clearly defined, and outreach and training materials have been refined to be more responsive to the needs of the HMIS end users. Additionally, LAHSA has begun to translate HEARTH Act performance measures and locally specific performance indicators into a set of query specifications that can be used by the HMIS to generate program and system performance data. These "*high impact management reports*" will be rolled out to LAHSA agencies later this summer. HMIS-generated performance reports will enable end users of HMIS to assess their program's performance against HEARTH standards, and as a result, implement and monitor program improvement strategies.

Funders and stakeholders in the homeless services system in Los Angeles County will need to continue to support the HMIS project as the foundation of a coordinated homeless data management strategy. Implementation of a coordinated data management strategy for Los Angeles will require the continued effort of LAHSA, City and County government departments, the Los Angeles Homeless Funders Group, and homeless assistance provider agencies and their staff. Abt Associates has been asked by Funders Group, as well as HUD, to lead a team that will implement the technical assistance effort that supports this implementation. TA activities will need to be sequenced strategically. Based on this Data Assessment, we recommend the phasing of tasks presented in Exhibit 5.1 for review and consideration by the Funders Group and LAHSA. Resources have been committed for most of these tasks by either HUD or the LA Homeless Funders Group (HFG) and are shown on the exhibit.

The activities listed under Phase One are those needed immediately for the entire community working to end homelessness in LA, including providers, funders, and public officials, to adopt HMIS as the core technology for homeless data collection, management and reporting. The first step is to develop a comprehensive improvement plan that in more detail the resources needed for each task, time lines, and assignment of responsibility. Activities 7, 8, and 9 will improve basic HMIS data quality, data completeness, and system management functionality. Activity 10, integration of the HMIS with the ELP, is included in Phase One because of its important role in determining whether Permanent Supportive Housing Units are being targeted successfully to people with the greatest need. Activity 11 will expand the functionality of HMIS by designing screening and assessment tools and will lay

the groundwork for this expanded use of the HMIS for managing a coordinated assessment and intake system in Phase Two. Phase Two is characterized by expanded and improved use of HMIS into more sophisticated management and analytical data uses as a result of the core HMIS functionality that will have been improved in Phase One. Phase Three then focuses on increasing system openness through HMIS data sharing across homeless assistance providers.

Exhibit 5.1: Homeless Data Management Tasks and Resource Considerations

Homeless Data Management Tasks	TA Resources Committed
Current Efforts	
1. Focus data quality improvement efforts on HIC and viable AHAR reporting categories	
2. Assess LAHSA HMIS project management and training effectiveness and implement improvements	
3. Define program and system-level performance outcome standards and draft corresponding specifications for HMIS *high-impact management reports*	
4. Conduct LA homeless data assessment	HFG - $35,000
Phase One TA Activities – Initiated in the next 6 months	
5. Adopt HMIS as standard homeless data management system, implement strategy	HFG - $34,630
6. Develop comprehensive HMIS improvement plan	HUD - $21,500
7. Establish and support HMIS as the central tool for HIC and PIT data	HUD - $10,000
8. Support HMIS participation through improved training and support materials	HUD - $27,500
9. Target TA to PSH providers to increase HMIS participation	HFG - $23,750
10. Integrate HMIS client data with the Los Angeles ELP	HUD - $25,500
11. Use HMIS to support coordinated client assessment and intake	HFG - $29,000
Phase Two – Initiated in the next 12 months	
12. Establish and monitor HMIS data quality standards	HUD - $7,000
13. Use HMIS to document client eligibility, program targeting, and unit availability	HFG - $23,750
14. Support expanded program performance measurement and system evaluation	HUD - $5,500
Phase Three – Initiated in the next 18 months	
15. Support data sharing in HMIS	HUD - $6,000
16. Enable/support integration of provider-level data in HMIS	
Total Resources Committed	$272,910

TA resources have already been prioritized for many of these tasks and components within tasks. The LA Homeless Funders Group has provided the resources necessary to draft this report ($35,000) and has already committed $134,560 in additional resources for direct TA and ongoing assessment. HUD has approved $103,350 to address other critical TA needs.

Los Angeles is well on its way to creating a more comprehensive and effective data collection and management strategy for homeless programs and clients. With nearly $273,000 in technical assistance resources committed to these improvement efforts, Los Angeles will be able to develop and implement a more coordinated and intentional strategy for homeless data management, one that enumerates all persons who experience a housing crisis, tracks the inventory and provision of services and housing, manages client services in a way that successful links clients to the appropriate services

and programs, and leverages the collective understanding of program and system performance to support ongoing improvement efforts.

Appendix A: Terms and Acronyms

Administration for Children and Families (ACF) – A division of the U.S. Department of Health and Human Services (HHS). ACF has a budget for 65 programs that target children, youth and families, including for assistance with welfare, child support enforcement, adoption assistance, foster care, child care, and child abuse.

Annual Homeless Assessment Report (AHAR) – The AHAR is a national report derived from local HMIS, HIC, and PIT data describing the extent of homelessness, service use patterns, and the inventory of programs available to persons who are homeless.

Chronic homelessness – HUD defines a chronically homeless person as an unaccompanied homeless individual or member of a family household with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years. To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter during that time.

Client Intake – The process of collecting client information after entrance into a program.

Continuum of Care (CoC) – A community with a unified plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximize self-sufficiency. HUD funds many homeless programs and HMIS implementations through Continuums of Care grants.

Disabling Condition – A disabling condition in reference to chronic homelessness is defined by HUD as a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. A disabling condition limits an individual`s ability to work or perform one or more activities of daily living.

Domestic Violence (DV) – Occurs when a family member, partner or ex-partner attempts to physically or psychologically dominate another. Including; physical violence, sexual abuse, emotional abuse, intimidation, economic deprivation, and threats of violence. Violence can be criminal and includes physical assault (hitting, pushing, shoving, etc.), sexual abuse (unwanted or forced sexual activity), and stalking. Although emotional, psychological and financial abuse are not criminal behavior, they are forms of abuse and can lead to criminal violence.

Emergency Shelter (ES) – Any facility that's primary purpose is to provide temporary shelter for the homeless in general or for specific populations of the homeless.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – U.S. law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals, and other health care providers. Developed by the Department of Health and Human Services, these standards provide patients access to their medical records and give them more control over how their personal health information is used and disclosed.

Homeless Emergency And Rapid Transition to Housing (HEARTH) Act – This law amends and reauthorizes federal funding for all homeless assistance programs identified in the McKinney-Vento

Act and substantially changes homeless programs by amending the definition of homeless, updating eligible project activities, and instituting system-wide measures for performance related to reduction in homelessness rates, reduction in length of time homeless, and reduction of recidivism.

Homeless Management Information System (HMIS) – Computerized data collection tool designed to capture client-level information over time on the characteristics and service needs of men, women, and children experiencing homelessness.

Housing Inventory Chart (HIC) – Consists of three housing inventory charts for: emergency shelter, transitional housing, and permanent supportive housing.

HUD – See U.S. Department of Housing and Urban Development

McKinney-Vento Act – The McKinney-Vento Homeless Assistance Act was signed into law by President Ronald Reagan on July 22, 1987. The McKinney-Vento Act funds numerous programs providing a range of services to homeless people, including the Continuum of Care programs: the Supportive Housing Program, the Shelter Plus Care Program, and the Single Room Occupancy Program, as well as the Emergency Shelter Grant Program.

Mental Health Services Act (MHSA) – California law enacted by ballot proposition in 2004 which increased funding to California Department of Mental Health (DMH) to provide funding for personnel and other resources to support county mental health programs. Los Angeles County DHM us using MHSA funding to support the development of Permanent Supportive Housing (PSH).

Permanent Supportive Housing (PSH) – Long-term, community-based housing that has supportive services for homeless persons with disabilities. This type of supportive housing enables the special needs populations to live independently as possible in a permanent setting. Permanent housing can be provided in one structure or in several structures at one site or in multiple structures at scattered sites.

Point in Time (PIT) Inventory – A calculation of number of beds in a region on one particular night.

Point in Time (PIT) – A snapshot of the homeless population taken on a given day. Since 2005, HUD requires all CoC applicants to complete this count every other year in the last week of January. This count includes a street count in addition to a count of all clients in emergency and transitional beds.

Shelter Plus Care (McKinney-Vento Program) (S+C) – A program that provides grants for rental assistance for homeless persons with disabilities through four component programs: Tenant, Sponsor, Project, and Single Room Occupancy (SRO) Rental Assistance.

Supplemental Security Income (SSI) – A monthly stipend provided to aged (legally deemed to be 65 or older), blind, or disabled persons based on need, paid by the U.S. Government.

Supportive Housing Program (SHP) – A program that provides housing, including housing units and group quarters that has a supportive environment and includes a planned service component.

Supportive Services Only (SSO) – Projects that address the service needs of homeless persons. Projects are classified as this component only if the project sponsor is not also providing housing to the same persons receiving the services. SSO projects may be in a structure or operated independently of a structure, such as street outreach or mobile vans for health care.

Technical Assistance (TA) – The providing of advice, assistance, and training pertaining to the installation, operation, and maintenance of HMIS, homeless programs, or CoC systems.

Transitional Housing (TH) – A project that's purpose is facilitating the movement of homeless individuals and families to permanent housing within a reasonable amount of time (usually 24 months).

U.S. Department of Health and Human Services (HHS) – A Cabinet department of the United States government with the goal of protecting the health of all Americans and providing essential human services.

U.S. Department of Housing and Urban Development (HUD) – The Federal agency responsible for national policy and programs that address America's housing needs that improve and develop the Nation's communities, and enforce fair housing laws. HUD's business is helping create a decent home and suitable living environment for all Americans, and it has given America's cities a strong national voice at the Cabinet level.

Appendix B: Conrad N. Hilton Foundation Chronic Homeless Initiative

For the last twenty years, the Hilton Foundation has put homelessness at the forefront of its mission to address the needs of the world's most vulnerable populations. The Foundation has supported efforts through approximately $30 million in grants to reduce and eliminate long-term homelessness, specifically for people with mental illnesses, and the Foundation plays a leading role in the development and dissemination of strategies for this group. In May 2008, the Foundation board of directors decided to target future efforts on the chronically homeless population in Los Angeles County, the area with the largest homeless population in the country. As a first step, the Foundation conducted a situation analysis of the issue of homelessness in Los Angeles. This analysis examined the size and nature of homelessness in LA, funding sources and levels already committed to homelessness, and research on chronic homelessness and strategies to address it. The culmination of their planning was the adoption of the Conrad N. Hilton Foundation five-year strategy (2011 to 2015) to address chronic homelessness in Los Angeles County.

The crux of the Foundation's strategy – the Chronic Homeless Initiative – is the idea that chronic homelessness is eliminated through the successful creation and operation of permanent supportive housing (PSH) and ensuring that those most vulnerable access and remain housed in these units. As part of the Chronic Homelessness Initiative, the Hilton Foundation has disseminated 11 multi-year grants totaling more than $20 million to high functioning intermediaries and non-profit housing and service providers working in LA. Through these grants, the Foundation aims to leverage the development of 3,000 units of PSH and at least 1,000 units of scattered-site PSH, and to increase the capacity of stakeholders in such a way that stakeholders are more inclined and equipped to address chronic homelessness in the future.

Implementation and evaluation of the Chronic Homeless Initiative is taking place across a number of dimensions. In September 2011, Abt Associates Inc. was contracted by the Conrad N. Hilton Foundation to conduct an evaluation of the Initiative looking at the cumulative results of the Foundation's grantees efforts, both interim milestones related to improving the systems designed to house and serve people experiencing chronic homelessness and the ultimate impact on chronic homelessness itself.

In concert with the evaluation of the impact of its strategy, the Foundation has contracted with Abt Associates, through a grant to Corporation for Supportive Housing, to conduct an assessment of the quality and reach of existing data about homelessness in LA. This assessment is being conducted in recognition of the fact that a full and complete understanding of data about homeless persons and housing units is critical to planning and evaluation of chronic homelessness efforts. The established Homelessness Management Information System (HMIS) is underutilized and disjointed, which not only results in incomplete information about the population in need, but places federal resources at risk. Additionally, and most relevant to the Foundation's goal of ensuring that the most vulnerable persons access and remain housed in PSH, there is no central or coordinated data system that helps prioritize homeless persons and match them with housing units.

Appendix C: Los Angeles HMIS Project Description

Project Staffing

The LAHSA HMIS project is housed within the LAHSA Information Technology department which oversees all database management and technology functions for LAHSA such as the grants management database, fiscal and accounting systems, LAHSA staff computers, and communication systems. A total of 16 staff work within the IT department, although not all of these positions are dedicated to the HMIS project. HMIS management activities including system administration, training and support, data analysis and report generation are distributed across 9 staff persons. These HMIS staff functions include 1 project manager, 4 training and support specialists, 3 data analysts, and 1 program assistant.

Training and Support

LAHSA provides a comprehensive series of HMIS trainings for new users that cover topics such as HUD Data and Technical Standards, locally specific policies and procedures, and system navigation and uses. Although trainings are offered at no cost and are required for all new system users prior to gaining access to the system, ongoing training is also offered as a refresher for returning users. LAHSA specifically targets and prioritizes CoC-funded programs for training and outreach, but any homeless assistance agency in LA is welcome to sign up for training and gain access to the HMIS system.

LAHSA's initial HMIS training series consists of the following:

- HMIS 10: *Policies and Procedures* (3 hours) – HMIS 10 defines HMIS and covers applicable policies and procedures for appropriate HMIS participation, data collection, uses, and disclosures.
- HMIS 100/101/102: *System Navigation and Client Data Input* (6 hours total) – HMIS 100 focuses on navigating the LA CoC HMIS, including intake procedures, agency services, group services and upgrade features. HMIS 101 focuses on using swipe-card technology and other system functionality. HMIS 102 focuses on using HMIS for outreach programs.
- HMIS 150: Agency-Specific Focus Training (3 hours) – HMIS 150 uses existing client files from partner agencies to practice entering actual client files in a structured support setting. Data quality validation report generation processes are also covered.

Agency staff receive their logins following completion of the HMIS 150 course. Additional training courses are offered to agencies at least once a month at a training facility downtown. These additional courses focus on HPRP and running Quarterly Performance Reports for a variety of different program types. Those interested in training can sign up and preregister at a special training website that LAHSA maintains. There are approximately four trainers at LAHSA who rotate responsibility for conducting each of the trainings. Each training also has at least one backup trainer.

Data Quality Assurance

After a program begins participating in HMIS, LAHSA HMIS staff begins regular analysis of the program's data to identify missing data and data accuracy issues. HMIS staff have implemented weekly data cleaning protocols so that data are monitored and updated as soon as possible to the time

when data were entered into HMIS. This weekly data cleaning involves running eight different reports looking for missing data and gathering information to determine if accuracy issues are system-wide or program specific. HMIS staff work with each program to address past and present data quality issues before the program can be considered viable for contributing data to national reports like the AHAR. Homeless provider staff also report that they are required to run data quality reports themselves and address any issues identified with incomplete, inaccurate, and inconsistent data. Programs that do not conduct these data quality self-assessments are contacted by LAHSA HMIS staff for more intensive follow up.

Throughout 2011 LAHSA HMIS staff made a concerted effort to monitor and cleanse data in preparation for the 2011 AHAR. Working closely with national AHAR TA staff, HMIS staff at LAHSA first analyzed the 2011 HIC data by AHAR sample site (measured by geocode) and determined which AHAR reporting categories had the baseline bed coverage rates of 50% required for participation. This HIC/HMIS discrepancy reconciliation process and helped staff focus on which programs would need extensive data cleaning to maintain HMIS participation rates and submit data for the AHAR. In the months leading up to the start of AHAR data collection in October 2011, LAHSA submitted draft AHAR reports to TA staff for analysis. Data quality issues were identified, consisting mostly of incorrect entry/exit dates and incorrect household configurations. LAHSA HMIS staff was able to correct data quality issues and data discrepancies in time to meet the first deadlines for AHAR report generation in November 2011.

Data Sharing Management

The LA HMIS privacy policy requires written client consent in order for provider staff to enter client data into HMIS. The LA HMIS operates a data sharing environment in which only basic client identifiers, demographics, employment data, and education history are universally open or viewable to all authorized HMIS users. This policy enables provider staff to first search the database to determine if a client record exists in which case additional data are appended to the original record rather than creating a new, duplicative, record. Data about a client's homeless history, name and date of previous shelter stays, are not shared.

Data sharing functionality is completely enabled for provider staff associated with a predefined "provider group" as defined by LAHSA. The provider group includes only staff among providers within the same homeless assistance program. HMIS users have the flexibility to disable sharing or enable additional data sharing following written consent from the client and only within predetermined sharing groups. LAHSA HMIS administration staff must change the default settings that define sharing groups to enable data sharing more broadly.

Provider Participation Requirements

All LAHSA funded homeless assistance agencies are contractually required to participate in HMIS. There is no charge or fee to participating agencies and users for software, licensing, training, or support. Other homeless assistance agencies and programs that do not receive LAHSA funding are welcome to participate in HMIS, although LAHSA prioritize training slots to funded partner agencies.

Participating providers must collect all HUD-required Universal and Program-Specific (if applicable) data elements. If addition, LAHSA requires HMIS participating agencies to participate in the Dashboard, a bed maintenance, tracking and assignment module so that program occupancy and bed

availability can be tracked in real time. Dashboard enables providers to make referrals and enroll clients in programs with the knowledge that bed or unit availability is accurate and up to date. Participating agencies must execute an HMIS Agency Agreement with LAHSA which outlines the expectations and responsibilities of HMIS participation. Agency Agreement topics cover compliance with confidentiality and client consent protocols, data uses and disclosures, agency legal responsibilities, appropriate system usage guidelines, agency rights, and escalation protocols in the event of violations.

Participating providers must enter client data directly into HMIS. Upload or integration of data managed in separate, non HMIS, systems is not allowed. Participating agencies must enter client data in real time. Batch data entry, at the end of the month for example, is not allowed.

Appendix D: Other (Non LA) HMIS Systems

As noted earlier in this Report, Los Angeles County is comprised of four separate CoCs: Los Angeles, Glendale, Pasadena, and Long Beach. While Los Angeles is by far the largest in terms of geographic land area, numbers of homeless assistance programs, and numbers of persons who experience homelessness, the other CoCs also serve an important safety net and homeless services coordination role in their respective jurisdictions.

The other CoCs with Los Angeles County have adopted the HMIS standards and policies established by the LA/OC Collaborative. The Collaborative comprises all the CoCs within Los Angeles and Orange Counties and was established to create and support consistent HMIS design and operations decisions for the larger metropolitan region. While each Collaborative member independently operates their own HMIS implementation, consistent approaches are defined for client consent, participation requirements, data sharing, data uses and disclosure agreements, and reporting.

Glendale

The Glendale CoC is comprised of the City of Glendale. With an estimated total PIT population of 339 homeless households in 2011, Glendale represents a relatively small CoC compared to Los Angeles PIT estimates of over 39,000 households. Exhibit D.1 indicates that the homeless household PIT count has been increasing in Glendale over the past five years.

Exhibit D.1 Glendale Point-in-Time (PIT) Trends

Population Type	2007	2008		2009		2010		2011		2007-11
	Count	Count	% Change from previous year	Count	$ Change from previous year	Count	% Change from previous year	Count	% Change from previous year	% Change from over all
Total Persons	296	306		306	3%	428		412	-4%	39%
Total Households	211	211		220	4%	290		339	17%	61%

Exhibit D.2 provides the most recent Housing Inventory Count data for the Glendale CoC, indicating a total of 307 beds designated for persons who experience homelessness. Overall Glendale has a 54% HMIS participation rate, although the PSH beds make up the vast majority of beds that are not covered in HMIS.

Exhibit D.2 Glendale Housing Inventory Count (HIC) for 2011

Housing Inventory Count by Program Type	2011	
	Bed Count	Percent of Beds in HMIS
Emergency Shelter Beds	50	100%
Transitional Housing Beds	98	100%
HPRP Beds	18	80%
PSH Beds	141	2%
Total Beds	307	
Overall HMIS Bed Coverage Rate		54%

In 2011 Glendale successfully contributed 4 (of a possible 6) reporting categories to the AHAR. Glendale had the following usable data:

- *Transitional Housing – Families*
- *Transitional Housing – Individuals*
- *Permanent Supportive Housing – Individuals*
- *Permanent Supportive Housing – Families*

The Glendale CoC and HMIS are managed by the City of Glendale Community Services and Parks Department. Glendale CoC and HMIS management staff and homeless assistance providers from the Glendale and Burbank areas expressed preference for their relatively small system in which data collection and management issues can easily be addressed within a close knit community in which all key stakeholders are on a first name basis with one another. Since the Glendale HMIS uses the same software system and provider, Adsystech, as Los Angeles, Glendale finds it difficult to compete against the larger resources and needs of LA. Glendale providers expressed frustration that even minor HMIS customization and analysis needs that are specific to their community often get subsumed by the much larger budget and political clout of LA.

Pasadena

The Pasadena CoC is comprised by the City of Pasadena. With an estimated total PIT population of 1,097 homeless households in 2011, Pasadena is also a small CoC compared to the much larger Los Angeles PIT estimates of over 39,000 households. Exhibit D.3 indicates that the homeless household PIT count has been increasing in Pasadena over the past five years.

Exhibit D.3 Pasadena Point in Time (PIT) Trends

Population Type	2007	2008		2009		2010		2011		2007-11
	Count	Count	% Change from previous year	Count	$ Change from previous year	Count	% Change from previous year	Count	% Change from previous year	% Change from over all
Total Persons	969	983		1,144	16%	1,137		1,216	7%	25%
Total Households	745	759		987	30%	966		1,097	14%	47%

Exhibit D.4 provides the most recent Housing Inventory Count data for the Pasadena CoC, indicating a total of 485 beds designated for persons who experience homelessness. Overall Pasadena has a 74% HMIS participation rate, better than LA and Glendale but still below the target of 85% set by the CoC competitive application for McKinney-Vento funding. Pasadena reports a 100% bed coverage rate in HMIS.

Exhibit D.4 Pasadena Housing Inventory Count (HIC) for 2011

Housing Inventory Count by Program Type	2011	
	Bed Count	Percent of Beds in HMIS
Emergency Shelter Beds	126	100%
Transitional Housing Beds	144	100%
HPRP Beds	40	100%
PSH Beds	175	100%
Total Beds	485	
Overall HMIS Bed Coverage Rate		100%

The Pasadena HMIS is managed by the Housing and Homeless Network within the City Housing Department. The HMIS project has enjoyed relatively stable staffing and resource support from the City over the past five years with consistent leadership and grant allocations.

Complete (100%) HMIS participation has held steady among all homeless assistance providers since 2009. Data quality, however, continues to be an issue. In 2011 Pasadena contributed only 1 (of a possible 6) reporting categories to the AHAR. Pasadena had the following usable data:

Transitional Housing – Families

Long Beach

The Long Beach CoC is comprised by the City of Long Beach. With an estimated total PIT population of 2,720 homeless households in 2011, Long Beach has twice the number homeless households than Pasadena but still much less than Los Angeles PIT estimates of over 39,000 households. Exhibit D.5 indicates that the homeless household PIT count is trending downward with 13% fewer homeless households in 2011 compared to 2007.

Exhibit D.5 Long Beach Point in Time (PIT) Trends

Population Type	2007	2008		2009		2010		2011		2007-11
	Count	Count	% Change from previous year	Count	$ Change from previous year	Count	% Change from previous year	Count	% Change from previous year	% Change Overall
Total Persons	3,829	3,829		3,909	2%	3,909		3,164	-19%	-17%
Total Households	3,121	3,121		3,424	10%	3,424		2,720	-21%	-13%

Exhibit D.6 provides the most recent Housing Inventory Count data for the Long Beach CoC, indicating a total of 1,783 beds designated for persons who experience homelessness. Overall Long Beach has a 54% HMIS participation rate, better than LA but still below the target of 85% set by the CoC competitive application for McKinney-Vento funding. Like Los Angeles and Glendale, PSH beds make up the vast majority of beds that are not covered in the Long Beach HMIS.

Exhibit D.6 Long Beach Housing Inventory Count (HIC) for 2011

Housing Inventory Count by Program Type	2011	
	Bed Count	Percent of Beds in HMIS
Emergency Shelter Beds	347	36%
Transitional Housing Beds	659	80%
HPRP Beds	30	100%
PSH Beds	747	38%
Total Beds	1,783	
Overall HMIS Bed Coverage Rate		54%

The Long Beach HMIS is managed by the Long Beach Department of Health and Human Services, Community Health Bureau.

In 2011 Glendale successfully contributed 3 (of a possible 6) reporting categories to the AHAR. Long Beach had the following usable data:

- ✓ Transitional Housing – Families
- ✓ Transitional Housing – Individuals
- ✓ Permanent Supportive Housing – Families

Appendix E: Case Studies in Coordinated Assessment

In what follows, we will describe several examples of coordinated system entry from other communities. In each, system structures and approaches that may be relevant to the Los Angeles region will be highlighted. Following the examples, we will discuss the various best practices that are most relevant to shaping a potential program model for the Los Angeles Continuum of Care. Given the unique challenges inherent in serving a physical area as large as Los Angeles, some aspects of the best practices in existing programs could be incorporated into a model providing this streamlined approach, while other aspects would need to be modified significantly to be effective.

Columbus/Franklin County, Ohio

Columbus, OH has separated their coordinated intake system into two systems: one for families and one for single adults. Each system has a single point of entry. Households are triaged at these sites 24 hours per day, seven days per week. Through the triage process, persons still in housing are referred to a prevention program, while those who are literally homeless are supported in finding a safe place to stay. If possible, homeless individuals are placed with family or friends. Clients with self-care issues are referred to the mental health system or a substance abuse detox shelter, as appropriate. Emergency shelter is considered a last resort.

In the family system, the single point of entry is the emergency shelter for families (the only one in the system). If a family is appropriate for emergency shelter, an intake assessment is completed and the household is admitted directly to the shelter (in either standard or overflow beds). The intake assessment becomes the basis for referral to a permanent housing provider, including a rapid rehousing program. Decisions about which family will be assigned to which housing provider are made in weekly coordination meetings between housing provider and emergency shelter staff. These decisions are made through discussion about the household's barriers to housing, appropriateness of the program's sites, if applicable (e.g. proximity to child's school of origin, etc.), and the availability of resources. Once accepted into a housing provider, no further intake assessment is completed. The housing providers all use the original intake completed by the single point of entry. Aspects of this program model may be appropriate in Los Angeles, or certain geographical areas within Los Angeles, for specific, smaller populations with limited, segregated resources, such as families or youth.

The single adult system, at this time, is primarily focused on coordinating entry into the several emergency shelters (and some motel vouchers). The triage and intake is completed at a central location, similar to the family system, but referrals are made to available beds in a multitude of shelters, based on matching the client's needs and characteristics with shelter requirements. Individuals must appear at the central location or call the publicized 800-number to be triaged. Individuals who are placed in an available bed (the bed is electronically reserved in HMIS) are provided with bus fare or transportation to the shelter. It is important to note that by the time the client arrives at the shelter, all the relevant intake work has been completed. When no beds are available, clients are placed on a waitlist and asked to check back in daily to see if a bed has become available. Once placed in an emergency shelter program, the shelter program is expected to refer the client quickly to an appropriate housing provider, using information about housing barriers and needs from the single intake assessment. Aspects of this approach, if modified for a larger geographical area, may be relevant to Los Angeles. This is especially true if referrals are focused on placements into housing provider programs, rather than only into emergency shelter programs.

It is important to note that both the family and single adult intake assessments were created with consultation from all participating programs (emergency shelter and housing providers) to ensure that every question required by each program is included in the master intake. This assessment can then be shared with all participating providers, preventing the client from completing multiple intake forms. Data collected about program participants is used for program planning and to track performance of participating program. Goals are established at the system and program level to shorten stays in emergency shelter, increase bed utilization rates, reduce recidivism, and increase successful housing placements.

Alameda County, California

In Alameda County, enrollment in homelessness prevention and rapid rehousing programs is conducted through a decentralized coordinated assessment model. Other resources for people having more or less severe housing issues are not incorporated into the coordinated system, except through non-binding referrals. In this system, people having a housing crisis call 2-1-1 and receive a brief eligibility screening, the results of which are entered into the CoC's HMIS. If the household appears to be eligible for prevention or rapid rehousing (i.e. their score on the screening tool falls within the specified range), 2-1-1 refers the household to one of eight, geographically diverse housing resource centers. People may also present at the housing resource center without a referral from 2-1-1. Once there, housing resource staff conducts an in-depth assessment, develops a housing assistance plan and begins providing the household with housing placement assistance, rental assistance, and case management services. Each housing resource center has its own pool of rapid rehousing funds which it administers directly. Though there are many other options for households to pursue in order to get assistance if they access help through more 'traditional' approaches, the housing resource centers are the only means by which to access the rapid rehousing resources available in Alameda County. In addition, by coordinating with 2-1-1, households with little other knowledge of the housing and homelessness system are very likely to end up at the housing resource center (provided they qualify), rather than attempting to access this program through other means.

A similar approach could certainly be appropriate for a large geographic area such as Los Angeles, though the triage and intake process could be broadened to cover program models beyond rapid rehousing. By limiting the system to just one program type, many homeless individuals will still find themselves making multiple attempts to access appropriate programs if their needs are not met by the rapid rehousing program. More to the point, limiting intake to just this program type does not address the goals of the Hilton Foundation to coordinate prioritization for as many permanent supportive housing program types as possible. Although not all program types operate under the same jurisdictional authority, homeless persons and case managers can be encouraged to use the coordinate point of access if that is the only way to gain access to certain program resources.

Cincinnati/Hamilton County, Ohio

In Cincinnati, all persons who are homeless or at-risk of homelessness call the Central Access Point (CAP) to access prevention assistance, emergency shelter, or other help. On the phone, the CAP specialist conducts an initial phone screening using a standardized assessment tool within HMIS. The screening results in a numerically-based mild, moderate, or hard to house "level" determination and refers callers to appropriate programs based on that level. Households with mild housing issues receive low-intensity rapid rehousing support, while those with moderate receive more intensive, long-term rapid rehousing support. Households with more intensive service needs are placed into

appropriate shelters. This approach, consistent with Alameda County, but slightly broader in scope, can provide some ideas for functionality that can be integrated into existing structures, such as Access Centers, in Los Angeles.

Denver, Colorado

In Denver, CO, coordinated intake is centralized for rapid rehousing programs, but referrals are provided from a wide array of sources, including County Human Services agency, day shelters, overnight emergency shelters, street outreach workers and the Denver metro 211 system. In this case, intake into the broader homeless service system is diffuse, but each provider wishing to refer a client into a housing program must work through the appropriate housing agency in its county. Three of the RRHD agencies offer a broad continuum of housing and homeless-related programs and services allowing for families to be placed in the most appropriate housing program administered directly by the agency. In Denver, the coordinated intake agency added an intake point in the local welfare office. Aspects of this program model may prove useful in Los Angeles when considering the uneven array of emergency shelter programs available throughout the region and over the course of the year.

Seattle/King County, Washington

Seattle, WA is currently in the developmental phase of a coordinated entry approach for homeless families. Though their model and approaches have not yet been tested, their approaches may prove relevant for the Los Angeles Continuum due to some specific similarities between the two communities. Most notably, the two communities share an HMIS service provider. Seattle has worked with Adsystech to develop centralized tools and resources to enable their intake strategy, and these tools may be useful in LA. In addition, like Los Angeles, they have very low turnover rates in emergency shelter, leading to long wait periods during which families and individuals may receive case management or other services before placement in a lodging program. Their centralized intake system specifically addresses this unique challenge in ways that may be adopted by Los Angeles.

Currently, their plan for coordinated entry is limited to homeless services targeted to families with children. Prevention programs, housing without supportive services attached (such as Section 8), and programs targeted to other populations are not included in their centralized system. In addition, families seeking victim services are referred to providers outside the coordinated intake system. The system will manage referrals to emergency shelter, transitional housing, rental assistance (rapid re-housing and transition-in-place), and permanent supportive housing for families. All publicly-funded programs within these categories have agreed to participate in the process and all participating programs have agreed to restrict access to their program to the coordinated intake process.

The coordinated intake will be handled by a single agency with intake assessment staff located at several service locations throughout the Continuum. These assessors will see families by appointment only. Families can schedule an appointment by calling 2-1-1, which will screen callers in its typical fashion. Callers that are both families and homeless will be provided with only one referral – an appointment with the centralized intake staff. The 2-1-1 operator will schedule their appointment directly in HMIS. Appointment availability can be searched either by time or geographic proximity, depending on the client's needs and desires. Clients can call 2-1-1 to reschedule appointments, as well. Appointment history will be visible to 2-1-1 operators, as well, so they can see if clients are repeat no-shows to scheduled appointments. Clients will receive an automated reminder text or email prior to their appointment.

At their appointments, clients are given a 20 to 30 minute housing-focused, strengths-based assessment recorded in HMIS. The assessor uses this information to place clients into one of four levels of housing-barrier status. This status is determined by the assessor in consultation with the program supervisor. They are then added to a placement roster. No placements are made at the initial assessment appointment, primarily due to the very low turnover at emergency shelter programs where families would be able to wait for housing resources to come available.

Independent of this process, participating agencies will use HMIS to post notices of openings in their programs. Each participating agency has specific enrollment criteria recorded in HMIS, including additional intake questions required of families prior to entry. Families from the placement roster are then matched with the available program slot, based on the housing barrier level most suited to the program and the length of time on the roster. When a matching family is identified, the family will be called and, if they are interested in the program, will be referred to the program. Additional intake information is recorded in HMIS so the family's intake is complete by the time they arrive at the receiving program. This program model does not rely on case conferencing between programs. Both clients and agencies are free to decline any and all program enrollments. Clients placed in emergency shelters will remain active on the placement roster for longer-term housing strategies and clients declining a placement will retain their position on the placement roster without penalty.