Evaluation of California's Project Roomkey Program

Final Report

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About This Report

Project Roomkey (PRK) was an innovative statewide effort established by the State of California in 2020 during the onset of the COVID-19 pandemic. Overseen by the California Department of Social Services (CDSS), PRK provided people experiencing homelessness the option to stay temporarily in non-congregate shelters (hotel and motel rooms and trailers) as an alternative to staying on the street or in congregate shelters. PRK also provided program participants limited on-site supportive services. The state initially funded the PRK program to reduce: the spread of COVID-19, the risk of death or serious illness for people who were particularly vulnerable to the virus because of age or underlying health conditions, and the anticipated strain on the state's health care system from the pandemic. Over time, the focus of the PRK program evolved to a longer approach of the program called the Rehousing Strategy. This phase of the program simultaneously focused on the ongoing emergency response of non-congregate shelter as well as supporting participants in their transition to long term, permanent housing and stabilization beyond PRK. The California Health Care Foundation (CHCF) and the Conrad N. Hilton Foundation, in collaboration with CDSS, engaged Abt Associates to conduct an evaluation of the PRK program. The purpose of this evaluation was to understand its successes and challenges and the experiences and outcomes of PRK participants. This final report summarizes the findings from the two-year evaluation (2021-2023).

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Executive Summary

Project Roomkey (PRK) was an innovative statewide effort established by the State of California in 2020 at the onset of the coronavirus (COVID-19) pandemic. Overseen by the California Department of Social Services (CDSS), PRK placed people experiencing homelessness who were medically vulnerable and unhoused staying on the street or in congregate shelters into hotel rooms, motel rooms, or trailers—that is, non-congregate shelters. The use of these non-congregate shelters, "PRK sites," was intended to (1) protect the health of program participants by limiting their exposure to COVID-19 and (2) minimize the anticipated strain on the health care system by limiting the spread of the virus.[1] PRK participants also received limited on-site supportive services. California was the first to establish this approach which served as a national model.

In May 2021, the California Health Care Foundation (CHCF) and the Conrad N. Hilton Foundation, in collaboration with CDSS, engaged Abt Associates to conduct a statewide evaluation of the PRK program. The purpose of this evaluation is to understand the successes and challenges of PRK and the experiences and outcomes of PRK participants.

PRK Design and Operation

In total fifty of the 58 California counties and four Tribal jurisdictions accepted funding from CDSS to operate at least one PRK site. These communities implemented PRK in varied ways. Most limited access to PRK sites to people who were experiencing homelessness; others also included people who were living in overcrowded housing and could not isolate. Some communities used PRK resources solely to support quarantine and isolation beds for people who contracted or were exposed to COVID-19. Most counties and Tribal jurisdictions operated longer-term PRK programs that functioned as non-congregate emergency shelters.

Designing and operating PRK required the collaboration of many entities—the county human services departments, communities' Continuums of Care, homeless service providers, health care organizations, and public housing agencies (PHAs).

Initially, both California state officials and local leaders believed PRK would be needed short term for only a few months. In November 2020, as the pandemic continued, making it apparent that PRK sites would need to stay open longer, California Governor Gavin Newsom's administration, with the Legislature, authorized additional one-time funding for PRK to increase. Many counties transformed and expanded the program focus to also include rehousing services to support long-term, permanent housing and stabilization for participants.[2]

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[1] Hernandez, J. (June 1, 2020). Letter to All County Welfare Directors and Federally Recognized Tribal Governments. Project Roomkey Initiative. California Department of Social Services. https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACWDL/2020/ACWDL_Project_Roomkey_Initiative.pdf

[2] Hernandez, J. (November 18, 2020). Letter to All County Welfare Directors and Federally Recognized Tribal Governments. Project Roomkey and Rehousing Strategy. California Department of Social Services. https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACWDL/2020/ACWDL-PRK-111820.pdf

CDSS guidance recommended using state and federal public health guidance to identify the most vulnerable populations and recommended FEMA guidance for eligible populations. However, local programs also had the autonomy to establish their own eligibility criteria. As vaccinations became available in late 2020 and early 2021, some communities operating PRK sites updated their eligibility requirements and began serving a broader population of people experiencing homelessness, including some participants who were less medically vulnerable or younger than age 65. Homeless Management Information System (HMIS) data from Los Angeles, Tulare, and Ventura counties were analyzed for this evaluation. However, there are limitations to the HMIS data available – including missing values.

Recruiting Hotels and Motels

Identifying and recruiting hotels and motels for the PRK program took a tremendous effort by state, county, local, and Tribal governments and homeless system providers. Some counties struggled to find hotel or motel owners willing to participate in the PRK program, while others had less difficulty. County officials with hesitant hotel and motel operators said that some owners refused to participate in PRK because they feared that housing people with COVID-19 or people experiencing homelessness would create negative public perceptions of their businesses or properties. Some owners expected the pandemic to end soon and wanted to be able to return quickly to normal business operations. Owners also were concerned about the level of wear and tear on their facilities from intensive, day-long use of the rooms. Even when hotel and motel owners were willing to participate in the program, local elected officials and neighbors sometimes objected to the PRK program because they feared increases in crime, COVID-19 cases, or people experiencing homelessness in their neighborhoods.

The hotel and motel buildings that participated in PRK varied in size and age. Both major hotel chains and smaller, family-operated motels participated in the program. The geographic location of PRK sites depended not only on which owners were willing to participate in PRK but also on what priorities communities set. Some communities considered proximity to grocery stores, laundromats, public transportation, and other services when recruiting PRK sites.

Overall, across the state, PRK served approximately 62,000 people. The PRK program was its most robust across the state from April 2020 through June 2021, peaking at more than 16,000 committed hotel/motel rooms in October 2020. After June 2021, the program began to slowly ramp down. As of December 2023, eight of the initial fifty counties and four Tribal jurisdictions still operated at least one PRK site that provided non-congregate shelter to people experiencing homelessness.

Participant Eligibility Criteria

Each county or Tribal jurisdiction developed its own eligibility criteria for PRK. Typically, this included people age 65 or older or with a preexisting condition that increased their vulnerability to the virus. Underlying conditions included chronic lung disease or moderate to severe asthma or chronic obstructive pulmonary disease (COPD), serious heart conditions, immunocompromise, severe obesity, diabetes, chronic kidney disease or undergoing dialysis, and liver disease.

Supportive Services

All communities tried to address participants' needs by providing various levels of supportive services at their PRK sites. On-site services included physical health care, behavioral health care, assistance with activities of daily living (ADLs), benefits assessments, case management, housing navigation, and

transportation. Some PRK participants required a higher level of care than community and homeless service system leadership anticipated. Because most communities designed their PRK program to serve older adults, some participants had age-related challenges such as needing help with ADLs and cognitive impairments. Some had severe physical disabilities that required accessibility modifications or other supports. Some had been experiencing unsheltered homelessness for prolonged periods and had to relearn how to live indoors.

Consistent with California's requirement that all state-funded homeless programs use Housing First practices, PRK participants were not required to engage in any services offered by staff before being eligible to stay at a PRK site. Most PRK sites established few program rules beyond those meant to prevent the spread of COVID-19 and protect the health and safety of participants.

PRK staffing models varied across communities. Staff composition at a PRK site often depended on the size of the site (i.e., how many rooms and participants), the needs of the participants, and the capacity of the site operator. ***Prior to the pandemic, staffing at homeless service providers across California was already stretched thin. The pandemic strained the homeless service system even more.***

Funding for PRK

The costs of operating the PRK program included lease payments to the property owner, food delivered to participants, COVID-19 testing and other medical supply costs (e.g., face masks, surgical gloves, hand sanitizer), security, cleaning and laundry services, and office supplies. Staffing the PRK program was a significant cost. Programs required staff to manage day-to-day operations, plus case managers, on-site nursing staff and sometimes designated staff to help participants find permanent housing. Larger counties deployed hundreds of staff members to support PRK operations. Some PRK sites reported many types of unforeseen operating costs, including replacing damaged furnishings such as television remotes and shower curtains.

California worked with the Federal Emergency Management Agency (FEMA) to establish a federal cost share for the PRK approach. At the start of PRK, FEMA agreed to reimburse the sites for 75 percent of eligible costs through its Public Assistance Program Category B, which reimburses state and local governments for costs related to disaster response. At the end of January 2021, FEMA announced that reimbursement levels would increase from 75 percent to 100 percent, backdated to January 2020. FEMA then announced that programs would be reimbursed at 100 percent for eligible costs until July 1, 2022, after which those still in operation would be reimbursed at 90 percent, with a 10 percent local cost share, until stated otherwise.[3] Communities needed to find alternative funding sources for operating costs not covered by FEMA, as well as funding to cover FEMA's share while awaiting reimbursement from the federal government. Local operators explored braiding together other federal, state, and local funding to cover the operating costs not covered by FEMA, including Emergency Solutions Grants (ESG), Coronavirus Relief Fund (CRF), Whole Person Care (WPC), and other CDSS programs.

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[3] FEMA. Coronavirus (COVID-19) Pandemic: Public Assistance Programmatic Deadlines (Interim) Version 2 FEMA Policy # 104-22-0002. https://www.fema.gov/sites/default/files/documents/fema_covid-19-pandemic-public-assistance-programmatic-deadlines-interim_03292023.pdf

Closing PRK Sites and Exiting Participants

CDSS required that grantees submit PRK Rehousing Plans to identify program goals and identify housing resources for exiting participants. The state did not require PRK grantees to close PRK sites by a specific date. Instead, local communities could make their own decisions about site closures and how and when to exit participants from PRK sites. Program sunset dates were identified by the local community based on their available funding, the needs of PRK participants, and local rehousing plans. As a result, each community and sometimes each site followed a different process and schedule for ending a PRK program and not all sites closed at the same time. Case managers and housing navigators staffing sites were charged with helping PRK participants develop rehousing plans. Several factors created challenges, including uncertainty of funding, the need for more housing subsidies, limited supply of affordable housing, and the reluctance of participants to leave a PRK site where their needs were being met.

According to data provided by CDSS, across California 22 percent of PRK participants exited to permanent housing, which could be subsidized or unsubsidized. Another 11 percent went to temporary housing – temporarily staying with friends or family, transitional housing, or motels that were not part of PRK. Twenty-five percent went to other emergency shelters, and 15 percent to an unsheltered setting. Despite their vulnerable health conditions, only four percent exited to institutional settings such as hospitals, board and care, nursing homes, or substance use treatment facilities. Approximately 23 percent of PRK exit destinations were recorded as unknown (18 percent) or other (5 percent). ***HMIS data from Los Angeles, Ventura, and Tulare counties suggest that, the longer someone stayed in PRK, the less likely they were to exit to homelessness and the more likely they were to exit to permanent housing.***

Findings and Key Themes from the Evaluation

Not only did PRK meet its original goal of saving the lives of people who were experiencing homelessness but the program enhanced how interim housing is designed and operated in some communities across California. The design, implementation, and demobilization of PRK programs across California offer some lessons for providing emergency and interim housing for populations with complex needs. The continued use of hotels and motels along with existing residential buildings was critical for COVID-19 response and could prove useful in response to the ongoing homelessness crisis, to natural disasters, or to future public health emergencies.

Prior to the COVID-19 pandemic, communities across California faced significant challenges responding to the growing number of people experiencing homelessness. For the past decade, leaders of homeless service systems and homeless service providers have struggled with organizational capacity, staff turnover, and burnout; the need for more permanent rental subsidies; and a low vacancy housing market with little affordable housing. The COVID-19 pandemic exacerbated these existing challenges while adding new hurdles during the initial period, including stay-at-home restrictions, social distancing, and uncertainty about how the virus spread and how long the pandemic would last. ***However, despite these challenges, various state agencies, health clinicians, homeless service system leaders, public health experts, local governments, Tribal jurisdictions, and homeless service providers quickly came together to launch a program that transformed how homeless service systems offer interim housing across the state.***

The findings from this evaluation may help local communities, the state of California, and the federal government as they continue to design solutions to end homelessness.

- ***California's government and robust homeless service system infrastructures supported a quick design and implementation of Project Roomkey. PRK enabled the ability of new partnerships to form between local government agencies and homeless service and health care providers.*** Several State agencies came together in a matter of weeks to design an emergency program to house vulnerable individuals experiencing homelessness in hotels and motels paired together with supportive services. County agencies, Tribal communities, and homeless service systems then applied the state's new PRK framework to design their own programs, creating targeting protocols, identifying and contracting with hotels and motels, and staffing PRK sites quickly. The quick design and program implementation and infusion of federal, state, and local resources to create and operate this program were unprecedented in their speed and scale. ***Policy Recommendation: Build on partnerships created with PRK for future responses. Under the state's new Housing and Services Partnership Accelerator there are opportunities to continue the collaboration between healthcare, housing, homelessness, disability, older adult providers.***[4]

- ***PRK sites had features that are often not available in other emergency shelters or interim housing settings. Most PRK participants reported having a positive experience at the hotels and motels***. PRK provided individual rooms where people could bring or store their possessions and did not have to be separated from their partners or pets. The rooms also had private bathrooms. This model for providing shelter gave people autonomy, privacy, and safety. Communities reported that some PRK participants had previously been unwilling to use shelter programs. PRK enabled some participants to receive health care and other services for untreated health conditions for the first time since they began experiencing homelessness. ***Policy Recommendation: Retain hotels and motels as a component of a homeless service system and ensure the program design meets the needs of participants.***

- ***Many PRK participants were extremely medically vulnerable and had complex needs.*** Some PRK participants required more intensive supports and services than county and homeless service system leadership anticipated. Because most communities focused PRK on older adults, some participants had age-related challenges such as needing help with activities of daily living and cognitive impairments. Some had severe or chronic health conditions and physical disabilities that required accessibility modifications or other supports. Some had been experiencing unsheltered homelessness for prolonged periods and had to relearn how to live indoors. We consistently heard from system leaders and homeless service providers that PRK participants needed more supportive services. We also heard from homeless service providers that having medical professionals like nurses on-site was critical. At some PRK sites, nurses provided continuous support and health monitoring. ***Policy Recommendation: Encourage the use of funding from Medi-Cal Managed Care Plans and Medi-Cal waivers for supports and services for people experiencing homelessness in residential settings.***

- ***HMIS data from Tulare, Los Angeles, and Ventura Counties suggest that, the longer someone stayed in PRK, the less likely they were to exit to homelessness and more likely they were to exit to permanent housing.*** Many PRK participants had experienced unsheltered homelessness for

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[4] Biden-Harris Administration Partners with States to Address Homelessness. February 9, 2024. https://www.hhs.gov/about/news/2024/02/09/biden-harris-administration-partners-states-address-homelessness.html

prolonged periods and some had to relearn how to live indoors. At PRK sites, participants stayed in private rooms and received meals, supportive services, on-site health care or referrals to medical facilities, and linkages to public benefits. During the period that PRK operated, the federal and state government provided new funding to be used to address homelessness. In many communities, system leaders used this funding to transition PRK participants into permanent housing. The package of services and supports that PRK sites provided helped many participants stabilize and the infusion of housing resources helped them secure a path to permanent housing. ***Policy Recommendation: Explore investing in interim housing and service models that promote stabilization.***

- ***Access to data is challenging across California state agencies and departments.*** The data needed to examine housing and healthcare service utilization and outcomes for PRK participants was unavailable for this evaluation. Many state agencies and departments who provide housing, healthcare, supportive services, and public benefits use different data systems and have different legalities protecting that data. Therefore, it was challenging for state agencies and departments to share data for the purposes of this evaluation. ***Policy Recommendation: Data sharing agreements need to be created across state agencies and departments to further understand the homelessness crisis in California.***

1. Introduction

Project Roomkey (PRK) was an innovative statewide effort established by the State of California in 2020 at the onset of the coronavirus (COVID-19) pandemic. Overseen by the California Department of Social Services (CDSS), PRK placed people experiencing homelessness who were staying on the street or in congregate shelters and who were medically vulnerable in non-congregate shelters (hotel rooms, motel rooms, or trailers). The use of non-congregate shelters, referred to as "PRK sites," was intended to (1) protect the health of program participants by limiting their exposure to COVID-19 and (2) minimize the anticipated strain on the health care system by limiting the spread of the virus.[5] PRK participants also received limited on-site supportive services.

As the length of the COVID-19 pandemic exceeded initial predictions, PRK continued to provide emergency response and supported rehousing strategies for people who participated in the program.[6] The growth of the program focused on supporting participants in their transition to long-term, permanent housing and stabilization beyond PRK, in line with CDSS Rehousing Guidance.

Fifty of the 58 California counties and four Tribal jurisdictions accepted funding from CDSS to operate at least one PRK site. These communities implemented PRK in varied ways. Most limited access to PRK sites to people who were experiencing homelessness; others included people who were living in overcrowded housing and could not isolate. Some communities used PRK resources solely to support quarantine and isolation beds for people who contracted or were exposed to COVID-19. Most counties and Tribal jurisdictions operated longer-term PRK programs that functioned as non-congregate emergency shelters.[7]

The California Health Care Foundation (CHCF) and the Conrad N. Hilton Foundation, in collaboration with CDSS, engaged Abt Associates to conduct an evaluation of the PRK program. ***The purpose of this evaluation is to understand the successes and challenges of PRK and the experiences and outcomes of PRK participants.*** The findings from this evaluation have many implications, including (1) the feasibility of using non-congregate shelter in a post-pandemic environment; (2) whether to replicate PRK to address future health or environmental emergencies in California and nationally; (3) how to help people transition from emergency shelter to permanent housing; (4) potential changes to the traditional congregate shelter model; and (5) how to create strong partnerships among local and state agencies that oversee and operate health and housing programs.

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5 Hernandez, J. (June 1, 2020). Letter to All County Welfare Directors and Federally Recognized Tribal Governments. Project Roomkey Initiative. California Department of Social Services. https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACWDL/2020/ACWDL_Project_Roomkey_Initiative.pdf

6 Hernandez, J. (November 18, 2020). Letter to All County Welfare Directors and Federally Recognized Tribal Governments. Project Roomkey and Rehousing Strategy. California Department of Social Services. https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACWDL/2020/ACWDL-PRK-111820.pdf

7 FEMA defines *non-congregate shelters* as locations where each individual or household has living space that offers some level of privacy, such as hotels, motels, or dormitories. FEMA Emergency Non-Congregate Sheltering during the COVID-19 Public Health Emergency (Interim), accessed December 18, 2023.

In the first year of the evaluation, we interviewed state officials involved in designing PRK, conducted a statewide web survey of the state's PRK grantees, and interviewed people involved in operating PRK programs in 15 communities. We produced the *Evaluation of California's Project Roomkey Program: Year 1 Report*, which summarized early evaluation findings, including how state agencies quickly planned and implemented PRK across California, funding sources used to implement the program, and early findings on program design and implementation.

In the second year of the evaluation, we conducted weeklong site visits to five communities: Los Angeles County, San Francisco City and County, Santa Cruz County, Tulare County, and Ventura County. During these visits, teams of two researchers interviewed homeless service system leadership, homeless service providers, local government partners, health care agencies, and current and former PRK program participants. The teams also toured and observed hotels and motels that served as PRK sites.

To augment the data collected through the site visits, we analyzed Homeless Management Information System (HMIS) data from three communities (Los Angeles County, Ventura County, and Tulare County) to better understand the demographics of PRK participants and their exit destinations from PRK.

This final report summarizes the comprehensive findings of the two-year PRK evaluation. The report is organized as follows:

- Chapter 2 – the rapid design of the PRK program by California state officials and the goals of the program.
- Chapter 3 – how the state and local communities recruited hotels and motels and how they designed the program's eligibility criteria.
- Chapter 4 – the services provided on-site, site staffing and operations, participant needs, and program rules.
- Chapter 5 – the ramping down and closure of PRK sites across California.
- Chapter 6 – lessons learned from the PRK program for designing and implementing future disaster response programs and non-congregate housing programs.

We also provide an appendix detailing the evaluation's methodology.

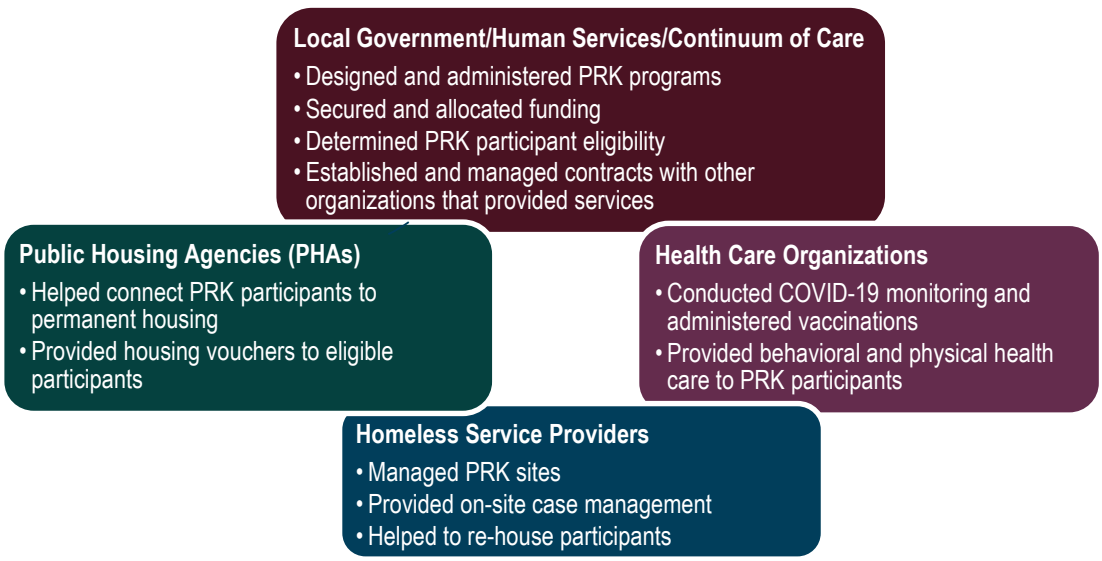
2. Designing PRK

As the initial threat of the COVID-19 pandemic emerged in early March 2020, California's Health and Human Services (HHS) Agency, the Governor's Office, California Department of Social Services (CDSS), the state's Interagency Council on Homelessness (Cal ICH, then known as the Homeless Coordinating and Financing Council), health clinicians, homeless service system leaders, and public health experts came together to plan and implement the Project Roomkey (PRK) program.[8] Within HHS, the state's Department of Social Services (CDSS) awarded California counties and Tribal jurisdictions grant funding to design and implement PRK programs in their communities. This chapter explains how local governments partnered with homeless service and health care organizations to design and operate PRK. This chapter also discusses the goals of the program.

2.1 Developing Partnerships to Design PRK

The grant funding from CDSS went to county human service departments and Tribal entities. Given the speed of COVID-19's spread and the concern that the virus would have a devastating effect on people experiencing homelessness who were vulnerable to serious illness or death, county and Tribal jurisdictions rapidly engaged other organizations in their communities. They typically engaged organizations that had expertise in serving people experiencing homelessness and providing health care. Common partners that helped design and operate PRK programs included Continuums of Care (CoCs), local health organizations, homeless service providers, and public housing agencies (PHAs). In response to the evaluation's statewide web survey, almost all state PRK grantees surveyed said that at least two partner organizations were involved in their planning. Exhibit 2.1 shows the key partners of PRK programs across the state.

Exhibit 2.1. Organizations that Served as PRK Key Partners



[8] The response of state agencies and their roles in designing PRK is discussed in the *Evaluation of California's Project Roomkey Program: Year 1 Report*.

- **Local government / CoCs.** County agencies, often Departments of Human or Health Services, assumed responsibility for the overall administration of the PRK program. In some communities, the local CoC led the design and implementation of PRK. County agencies or the CoC determined program eligibility; secured, distributed, and monitored funding; and established and managed contracts with the organizations that operated the hotels/motels and provided services to PRK participants. Some local governments and CoCs also prioritized shelter and housing resources for people leaving their PRK site. Approximately four-fifths (82 percent) of surveyed state PRK grantees named county government staff as key PRK partners, and about two-thirds (64 percent) named CoC staff as key PRK partners.
- **Local health departments and other health care organizations.** The role of local public health departments and other health organizations was to provide medical care to PRK program participants. These organizations were key partners in operating PRK programs. Health care staff assessed participants at program entry for COVID-19 symptoms and exposure and determined whether they needed to be in isolation/quarantine. Health care staff also provided on-site medical services such as symptom monitoring, COVID-19 vaccines, and support related to other physical and behavioral health conditions.
- **Homeless service providers.** In some communities, local homeless service providers supported day-to-day operations of PRK sites. In other communities, daily operations at the site continued to be managed by hotel or motel employees, whereas homeless service providers came to the site to deliver supportive services such as housing navigation and case management. Eighty percent of communities that responded to the web survey named homeless service providers as key PRK partners.
- **Public Housing Agencies.** Some PHAs across the state supported rehousing strategies for PRK program participants by prioritizing them to receive federal rental subsidies such as Emergency Housing Vouchers or HUD-Veteran Affairs Supportive Housing vouchers.

When interviewed for the case studies, partners in the implementation of PRK said that creating and maintaining relationships across government agencies and community organizations was challenging, especially because the need occurred during the COVID-19 pandemic. Some entities had never worked together but needed quickly to design their collaboration and start implementing PRK programs. In particular, partnerships were created during a time when most organizations were just learning how to operate remotely. For many local government agencies and community organizations, conducting meetings entirely remotely for several hours a day was a new experience.

2.2 PRK Program Goals

When the program started, PRK's primary goal was to save lives by quickly isolating medically vulnerable people experiencing homelessness. Another goal was to minimize anticipated strain on the health care system by preventing this population from contracting COVID-19. In early 2020, little was known about the transmission of the virus. The lack of knowledge of how it spread created a sense of urgency for isolating populations with health vulnerabilities.

Alameda County's PRK Program Offered Sites for Isolation/Quarantine and for Longer-Term Interim Housing

From the outset, Alameda County's PRK program provided both an emergency response to the pandemic and non-congregate interim housing. The County's "Operation Comfort" sites isolated or quarantined people who had contracted or been exposed to COVID-19. People could stay at Operation Comfort sites for two weeks or less. The County's "Safer Ground" sites allowed people experiencing homelessness who were vulnerable to COVID-19 to stay in private rooms for an extended period. Said a County official:

> ***"We saw PRK as an opportunity to keep the most vulnerable people safe…but at Safer Ground sites, we had a commitment that no one has to leave without an offer of housing. We saw it as creating a pipeline into housing."***

Isolation/Quarantine Sites

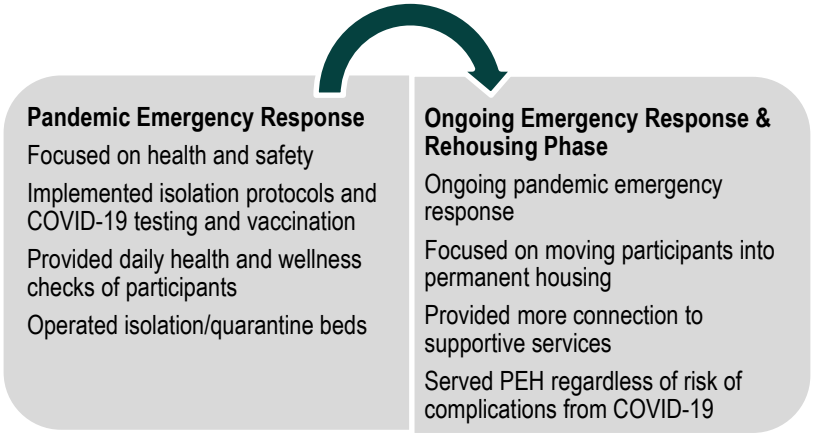
Some communities dedicated separate isolation/quarantine (I/Q) sites for people experiencing homelessness who contracted or who were exposed to COVID-19. Other communities did not distinguish that population from people who just were more vulnerable to severe illness or death if they contracted the virus.

PRK staff reported that people who used I/Q beds typically stayed up to 14 days. In some communities with I/Q beds, people could transfer from I/Q to the broader PRK program; in other such communities, people had to leave after their I/Q period concluded.

Most respondents to the evaluation's web survey (39 out of 45 communities) conducted in 2022 indicated that the goal of their PRK sites was to protect vulnerable people most at risk of death or health complications from COVID-19. They focused on people older than age 65 and people with certain medical conditions. By quickly moving people experiencing homelessness from congregate shelters and unsheltered locations into hotel and motel rooms and trailers where they could be isolated from others, state and local officials hoped to curb the spread of COVID-19.

Initially, both California state officials and local community leaders believed PRK would be needed for only a few months. As the pandemic persisted, it became apparent that PRK sites would need to stay open longer. Many communities continued to operate PRK sites and integrated a focus on supporting PRK participants in obtaining permanent housing. As vaccinations became available in late 2020 and early 2021, some communities relaxed their eligibility requirements and began serving a broader population of people experiencing homelessness, including participants who were not medically vulnerable or older than age 65.

Exhibit 2.2. Shift in PRK Program Goals



3. Recruiting PRK Sites and Identifying Participants

Identifying and recruiting hotels and motels for the Project Roomkey (PRK) program took a tremendous effort by state, county, local, and Tribal governments and homeless system providers. Additionally, counties and homeless system leaders had to create eligibility criteria and a pathway in which to receive and assess referrals. This chapter discusses how hotels and motels were recruited and the ways communities identified participants.

3.1 Identifying and Recruiting Hotels and Motels

During the first few weeks of the pandemic, California's state-level agencies worked together to identify hotel/motel rooms. The CDSS Disaster Services Bureau (DSB) created lists of candidate properties by conducting internet searches of hotels and motels across the state. Then the Department of General Services (DGS) expanded these lists by contacting the California Hotel & Lodging Association (CHLA) to add major hotel chains. Eventually, word of mouth spread in the hotel/motel community, and CHLA started referring interested owners to DGS.

In many communities, local government or homeless service provider staff also identified hotels and motels that might be appropriate and willing to participate in PRK. Local homeless service provider staff often had existing relationships or recent experiences working with motels to implement pre-existing motel-based shelter programs. Based on interpretation of the guidance from the federal Centers for Disease Control and Prevention (CDC), property searches initially focused on hotels and motels with doors opening onto outside walkways, independent air conditioning units, private bathrooms, and on-site laundry.

Some counties struggled to find hotel or motel owners willing to participate in the PRK program, while others had less difficulties. County officials in communities with more resistant hotel and motel owners said that some owners refused to participate in PRK because they feared that housing people with COVID-19 or people experiencing homelessness would create negative public perceptions of their businesses or properties. Some owners expected the pandemic to end quickly and wanted to be able to return rapidly to normal business operations. Owners that were resistant were also concerned about the level of wear and tear on their facilities from intensive, all day use of the rooms. Even when hotel and motel owners were willing to participate in the program, local elected officials and neighbors sometimes objected to the PRK program because they feared increases in crime, COVID-19 cases, or people experiencing homelessness in their neighborhoods.

The hotel and motel buildings that were used as PRK sites varied in size and age. Both major hotel chains and smaller, family-operated motels were used in the program. The geographic location of PRK sites depended not only on which owners were willing to participate in PRK but also on what priorities communities set. Some communities considered proximity to grocery stores, laundromats, public transportation, and other services when recruiting PRK sites. Said a program director:

> ***We were also taking costs, location into consideration. Proximity to services, near where folks experiencing homeless already tend to be. Those were our guiding criteria.***

Exhibit 3.1. Photographs of PRK sites across California

Photo Credit: Abt Global

Almost all communities offered on-site meals for participants. PRK sites contracted with external vendors (e.g., local nonprofit organizations, commercial food vendors, restaurants) to deliver individually packaged meals two or three times per day. Some participants had special dietary and physical needs, including limited chewing ability from poor dental health, so some PRK programs offered diabetic, low-sodium, or soft food meals. During interviews, PRK staff explained they typically delivered meals to participants in their rooms, often combining this service with a wellness check. Wellness checks often included taking the participant's temperature and asking about other potential COVID-19 symptoms. The wellness checks also allowed staff to confirm that the participant was adhering to the program rules (such as the number of pets allowed in the room). Many former participants interviewed reported liking having meals delivered and appreciating the consistency of access to three meals per day; however, one participant said that he would have liked to have been able to cook for himself and another that the meals lacked variety.

Some PRK sites either provided typical hotel/motel housekeeping and laundry services while others expected the participants to clean their own rooms and bathrooms. Where those housekeeping and laundry services were provided, some PRK sites contracted with the owner to have their staff perform these tasks and some sites had PRK staff perform them.

Most PRK sites offered program participants a single room, with either one or two queen-size beds and a private bathroom. Almost all communities reported that the hotels and motels had amenities such as cable television, internet, and telephones. Some sites also provided a microwave and mini refrigerator in each room. Many sites had parking for cars, and some provided parking for RVs. All PRK programs supplied participants with personal protective equipment, including face masks and hand sanitizer, as well as personal hygiene products such as shampoo and soap.

PRK participants' opinions about their rooms varied greatly, even within the same site. Some participants described rooms as small and run-down, others as spacious, new, and very clean. Some participants complained of vermin such as cockroaches and rodents. Overwhelmingly, participants expressed

appreciation for having their own private bathroom, including a toilet and shower, describing how PRK provided stability and allowed them to feel at ease:

> ***I felt rejuvenated. It was a place to recover, a space to recalibrate. It made you feel like you weren't homeless.***

As the pandemic progressed, some sites experienced significant wear and tear. PRK staff explained that the properties were not designed for long-term, full-time living:

> ***One challenge was that the state was basically targeting the most decrepit motels, but it became long-term and there were no cooking facilities. Mini fridges can only keep enough food for one to two days and [are] poor quality.... [Rooms] could not have hotplates; some residents wanted BBQ pits. It was hard to get the population to understand why we couldn't do that.***

Another mismatch between the design of the facilities versus the needs of PRK participants was that more participants needed ADA accessible rooms than were available.

3.2 Scale of PRK Program across California

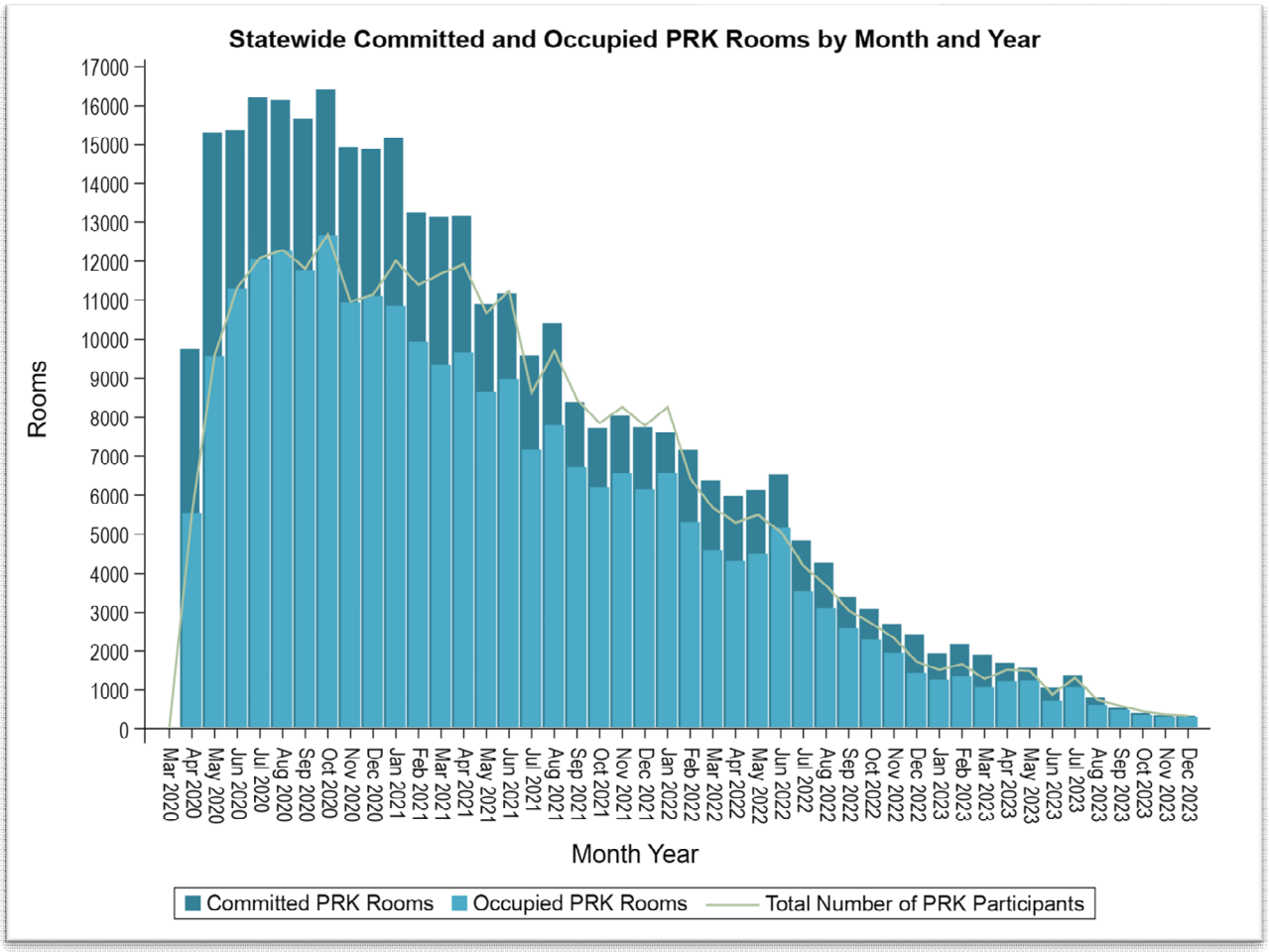
Overall, across the state, PRK served approximately 62,000 people. The PRK program was its most robust from April 2020 through June 2021, peaking at more than 16,000 committed hotel/motel rooms in October 2020. After June 2021, the program began to slowly ramp down (Exhibit 3.2). As of December 2023, eight communities still operated at least one PRK site in their community.

Throughout PRK implementation, communities had more committed rooms from motels/hotels than number of occupied rooms. This situation was due to a variety of factors including:

- Daily turnover of rooms and having to clean and air out rooms before a new participant could occupy a room.
- The challenge of real-time data entry lags for participants' entry and exits from PRK sites.
- Rooms reserved for isolating people experiencing homelessness who tested positive with COVID-19.

Some communities served more participants than rooms they had occupied because of partners or families being placed in one room.

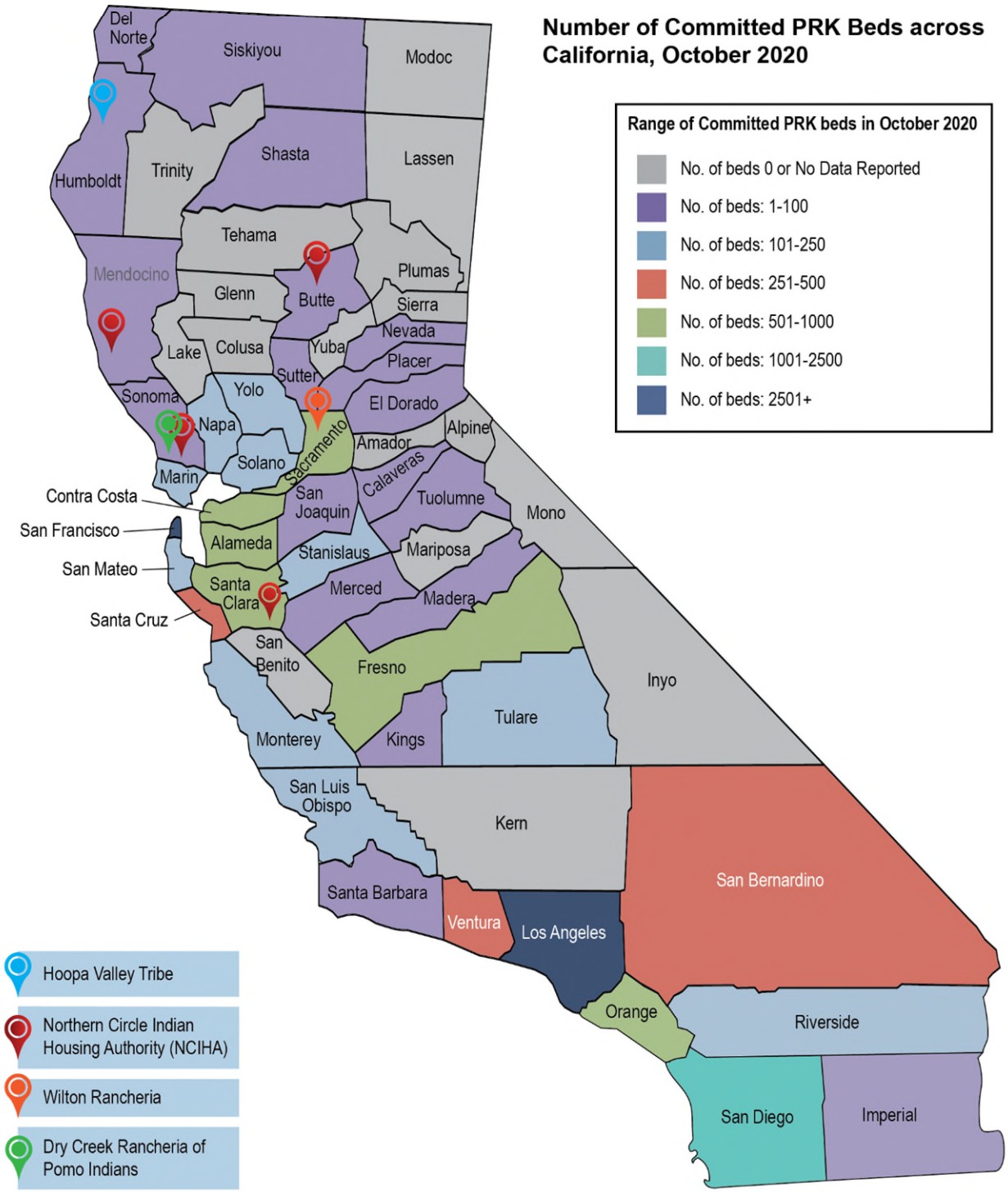
Exhibit 3.2. Statewide Implementation of PRK by Month and Year



Source: California Department of Social Services, data received in January 2023

The number of committed PRK rooms was its highest across the state in October 2020. The majority of counties and Tribal jurisdictions in California had at least one PRK site by this time (Exhibit 3.3). More than 50 percent of communities that had PRK programs operated sites with more than 100 rooms. Communities with large numbers of people experiencing homelessness including San Francisco and Los Angeles each secured more than 2,500 rooms. San Diego secured more than 1,000.

Exhibit 3.3. PRK Beds Statewide, October 2020



Source: California Department of Social Services, data received in January 2024

3.3 Identifying PRK Participants

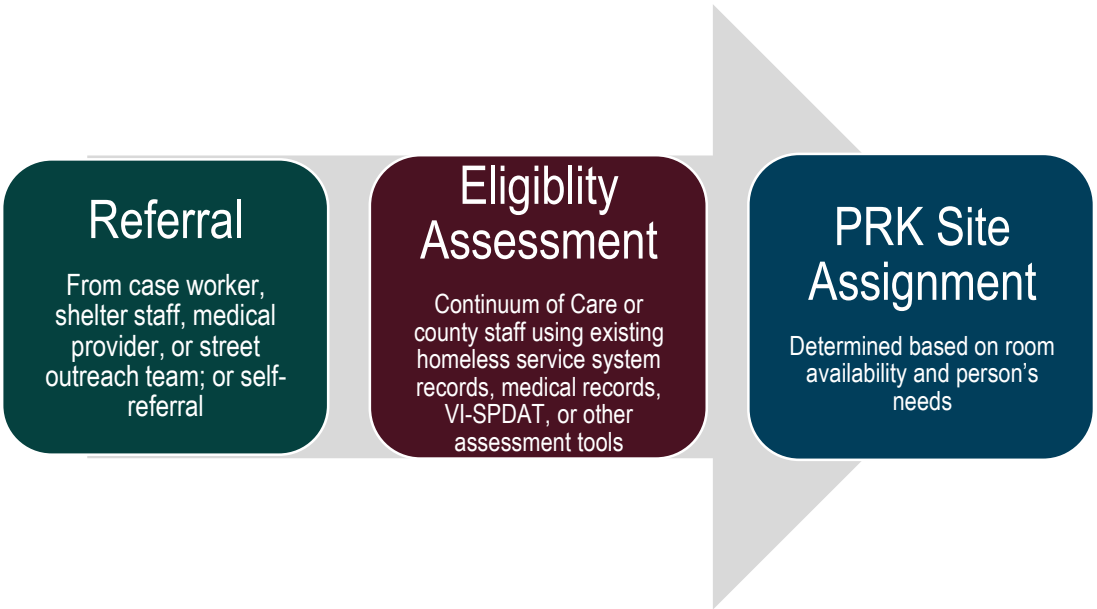
Decentralized Referral System

In San Francisco County, 53 different outreach teams (including street outreach and encampment resolution teams) referred people to PRK sites. The teams met daily to discuss bed allocation in the sites and outreach strategies.

State guidance recommended that PRK rooms be offered to people experiencing homelessness and in need of space to isolate or to practice safe social distancing. Guidance from the state also recommended that communities implement PRK eligibility criteria consistent with state and federal public health guidance and prioritize FEMA eligible populations.[9] However, each community had the flexibility to develop its own PRK eligibility criteria. Almost all grantees that responded to the evaluation's web survey said they focused on serving people who would be at a high risk of death or serious illness if they contracted COVID-19. Typically, this included people age 65 or older or with a preexisting condition that increased their vulnerability. Underlying conditions included chronic lung disease or moderate to severe asthma or chronic obstructive pulmonary disease (COPD), serious heart conditions, immunocompromise, severe obesity, diabetes, chronic kidney disease or undergoing dialysis, and liver disease. A much smaller percentage (36 percent) of communities also indicated that they focused explicitly on decompressing emergency shelters (15 out of 42 communities) or housing people experiencing unsheltered homelessness (14 out of 42 communities). One community reported that they focused on serving pregnant women.

Exhibit 3.4 displays the three-step process that the PRK communities followed to place someone in a PRK site: (1) referral, (2) eligibility assessment, and (3) PRK site assignment.

Exhibit 3.4. Pathway to PRK Site Assignment



[9] Hernandez, J. (June 1, 2020). Letter to All County Welfare Directors and Federally Recognized Tribal Governments. Project Roomkey Initiative. California Department of Social Services. https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACWDL/2020/ACWDL_Project_Roomkey_Initiative.pdf

3.3.1 Referrals

Most communities had two or three pathways of referring people for PRK sites, while some communities had up to six pathways. The most common referral methods described in the survey were from the outreach staff of homeless service providers (78 percent) and from local hospitals or other health care providers (73 percent). About half of communities identified people through the local Coordinated Entry System (CES) and through referrals from emergency shelter staff. These referral pathways are similar to how local communities identify people for housing resources that become available. However, communities opened PRK sites and referred people to sites at a faster pace than is usually seen due to the public health emergency. A small number of communities permitted self-referrals. Santa Cruz County operated a phone hotline and email where people could self-refer or refer someone else to PRK. Referrals for isolation and quarantine (I/Q) beds for people who contracted or were exposed to COVID-19 were more likely to come from medical professionals such as local hospitals or other health care providers or public health departments.

In the evaluation's web survey, 11 communities reported they explicitly considered racial and ethnic equity when identifying people to participate in PRK. For example, one community described making sure that staff of homeless service providers and other partners who worked with marginalized populations—in particular, farmworkers—were aware of its referral processes.

3.3.2 Eligibility Assessment

Some PRK communities determined participant eligibility and vulnerability using existing systems. For example, some communities used their existing CES to identify people and determine their eligibility for PRK using the Vulnerability Index–Service Prioritization Decision Assistance Tool (VI-SPDAT) to identify medical vulnerability to COVID-19.[10] Other communities quickly created their own health related assessment protocols, often with help from public health or other trained medical staff.

Los Angeles County determined eligibility based on the medical conditions that contributed to a person being most at risk for severe illness or death if they contracted COVID-19. In Santa Cruz County, a team of nurses reviewed referrals and medical records weekly to determine eligibility and rank priority based on five priority types.[11]

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[10] VI-SPDAT assesses a person's level of vulnerability based on a range of factors including age, self-reported medical issues and health needs, and duration of homelessness.

[11] Priority 1: Person experiencing homelessness confirmed COVID-19 positive. Priority 2: Person experiencing homelessness presumed COVID-19 positive, has COVID-19 symptoms, and has a known contact with a COVID-positive person. Priority 3: Person experiencing homelessness whom County Public Health advised to quarantine because they have COVID symptoms or have had significant contact with a COVID-positive person. Priority 4: Person experiencing homelessness who is elderly (65 years of age or older) OR considered medically vulnerable as determined by County Public Health nurse. Priority 5: Low-income person who did not meet the criteria required for Priorities 1-4. Alternative Housing: Low-income individual or family confirmed or presumed COVID-19 positive and NOT experiencing homelessness but needed shelter to isolate or quarantine.

In interviews, PRK participants reported positive reactions to being accepted into PRK:

> ***I was excited. I was going to be inside. I knew the hotel was beautiful.***
>
> ***Having a safe place to sleep every night makes a world of difference in being able to search for jobs.***

3.3.3 PRK Site Assignment

After confirming eligibility and assessing the person's needs, PRK staff matched participants to a PRK site with an available room. Each of San Francisco County's 53 outreach teams offered PRK beds to people they were engaging on the streets or in encampments based on which sites had available beds. Overall, this referral system worked well, though there were instances of people assigned to incorrect rooms or to rooms at sites that were full. Most communities provided transportation from the participant's current location to the PRK site, often by taxi or van.

In Los Angeles County, the PRK program assigned participants to a PRK site based on where they were currently located (either sheltered or unsheltered) and whether they needed an ADA accessible room to accommodate a disability. If the person tested positive for COVID-19, they often went to an I/Q bed.

3.4 PRK Participant Characteristics

Because communities received referrals from various sources, PRK participants entered the program with a wide range of medical needs from long-term untreated conditions, mental illness, and general difficulty performing activities of daily living. Participants entered PRK from outdoor encampments, emergency shelters, hospitals, their vehicles, and other living situations.

The San Francisco Department of Health nursing team reported that almost all people referred to its PRK program had previous experiences of trauma. San Francisco's PRK Shelter-in-Place (SIP) hotel nursing staff reported that initially most people who came to the hotels from congregate shelters were older adults with multiple chronic health conditions. As the pandemic progressed, SIP hotels served more younger adults with serious substance use disorder referred from encampments and other unsheltered locations.

Many communities reported PRK participants have many serious health conditions. Ventura County PRK site staff reported their PRK participants were more likely to have physical health conditions than mental health diagnoses. Physical health conditions they reported included kidney failure requiring dialysis, lung disease like emphysema, diabetes, heart failure, cancer, seizures, autoimmune disease, gastrointestinal disease including stomach and liver problems, limited mobility and physical disability including hip replacement and back problems. Mental health conditions reported by Ventura participants included depression, anxiety, suicidal ideations, PTSD, and memory issues.

3.4.1 Participant Characteristics in Los Angeles, Tulare, and Ventura Counties

The study was able to obtain Homeless Management Information System (HMIS) data for PRK in three California counties.[12] HMIS is primarily used by homeless service providers to record person-level

[12] We received HMIS data extracts from Los Angeles County, Tulare County, and Ventura County. The data extracts and variables included varied slightly across communities. Therefore, some exhibits include more information than others and are not uniform across all three communities.

information (e.g., demographics, health status, employment, income, benefits) on people who interact with a community's homeless service system. While usage of HMIS is expanding across health and safety net programs in the state of California, it has historically been used by homeless service systems. Information recorded in HMIS is self-reported by people interacting with the homeless service system and therefore the complexity or acuity of a person's housing status and health conditions depend on what a person feels comfortable disclosing.

PRK programs in Los Angeles, Ventura, and Tulare counties each served a different population of people experiencing homelessness (Exhibit 3.5). Across the state, communities reported designing PRK programs that focused on serving people 65 years or older. However, in Los Angeles, according to HMIS data available over the program's duration almost half of PRK participants were between 25 and 50 years old. Tulare's PRK program served families with young children. More than three-quarters of PRK participants were younger than 50 years old. Ventura County did serve an older population, where close to 70 percent were 51 or older.

The HMIS data from these communities suggests that participants were somewhat less vulnerable overall than reported in the interviews with site staff and healthcare providers. However, as noted, HMIS data is self-reported and therefore could be an underestimate of health conditions. It could also suggest that people experiencing homelessness who were younger than 65 also had pre-exiting medical conditions that made them vulnerable to the virus, and, therefore, PRK programs served them. In addition, as the program was extended at some sites, and rooms turned over, participants with less vulnerability moved up in the queue and were assigned to a room.

Exhibit 3.5. Demographics of PRK Participants in Los Angeles, Ventura, and Tulare Counties

	Los Angeles		Ventura		Tulare	
	N	Percent (%)	N	Percent (%)	N	Percent (%)
Full Population	12,422	100.0	459	100.0	573	100.0
Gender						
Female	4,859	39.3	182	37.7	269	52.5
Male	7,507	60.5	268	61.5	303	47.4
Trans or Gender Non-Conforming	24	0.2	4	0.8	1	0.1
Race/Ethnicity						
Hispanic/Latino	4,209	31.7	127	33.8	255	50.0
White (non-Hispanic)	3,582	27.4	280	59.5	214	33.9
Black (non-Hispanic)	3,874	35.0	23	3.6	65	11.0
Other (including multiracial)	558	5.7	23	3.2	38	5.1
Age, in Years						
Under 18	10	0.1	1	0.4	57	29.4
18 to 24	506	4.8	6	1.7	41	7.6
25 to 50	5,951	49.7	119	29.5	243	44.0
51 to 64	4,432	33.2	198	40.1	124	15.0
65 and over	1,507	12.1	132	28.4	41	4.1
Veteran Status						
Yes	576	5.3	32	7.1	20	3.5
No	11,510	94.7	421	92.9	534	96.5
Disabling Condition at Program Entry						
Yes	6,496	40.2	306	55.7	203	25.3
No	3,853	59.8	107	44.3	247	74.7

Source: Homeless Management Information System (HMIS)
Note: PRK population includes all PRK participants who exited the program.

3.4.2 Comparing Participants Characteristics across PRK and Non-PRK Emergency Shelters

We compared PRK participant characteristics to those of other people in the HMIS dataset who stayed in non-PRK emergency shelters in each community.[13] The patterns were broadly consistent across the three counties.

In Los Angeles County, PRK and non-PRK participants had some similar characteristics. They were somewhat older and somewhat more likely to be male but not more likely to be veterans (Exhibit 3.6). Roughly 30 percent of participants in Los Angeles from both types of programs had experienced four or more episodes of homelessness in the past three years.

Across all three communities, approximately three-quarters of participants from both types of programs were already connected to health insurance (mostly Medicaid) when they entered PRK or other emergency shelters. That does not mean they were making use of their health insurance to see doctors regularly. Some participants described in interviews the difficulty of treating chronic health conditions while experiencing homelessness on the street or in a congregate shelter. A PRK participant in Ventura County explained,

> ***Once I got here to PRK, I got a cardiologist appointment, I'm seeing a cancer doctor, I'm seeing a psychiatrist. Being here they make it a focus, I'm not on the streets.***

Another participant in Ventura said that staying at a PRK site allowed him to refrigerate his insulin, consistently take his medication, and attend all his medical appointments. The participant explained that when he was living on the streets he was embarrassed to go to his medical appointments because he did not have a chance to clean himself and therefore, he did not go. Since staying at a PRK site he had not missed any medical appointments.

In Los Angeles and Ventura Counties, PRK participants were only slightly more likely to have disabling conditions reported to the HMIS than non-PRK participants. The HMIS data standard used during this period may not have counted all people with chronic medical conditions as having a disability.

In Ventura County, PRK participants were somewhat older and considerably more likely to be White (non-Hispanic) than people who stayed in non-PRK emergency shelters.

In Tulare County, PRK participants were somewhat more likely to be White (non-Hispanic) and somewhat less likely to be Hispanic/Latino.

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[13] Each community provided us a different timeframe for the comparative non-PRK sample. In Tulare, the earliest and latest program information we received on non-PRK participants were 2/2016 and 12/2022. In Ventura, the earliest and latest among non-PRK participants were 1/2017 and 8/2023. In Los Angeles the earliest and latest among non-PRK participants were 4/2002 and 12/2022. Four percent of non-PRK participants had entry dates prior to 2017. However, nearly all of these were in 2016; just 0.1 percent were prior to 2016.

Exhibit 3.6. Demographics of PRK Participants and PRK Non-Participants in Emergency Shelters in Los Angeles County

	PRK Participants		Non-PRK ES Participants	
	N	Percent (%)	N	Percent (%)
Full Population	12,422	100.0	91,145	100.0
Gender				
Female	4,859	39.3	37,435	41.6
Male	7,507	60.5	51,591	58.1
Trans or Gender Non-Conforming	24	0.2	216	0.3
Race/Ethnicity				
Hispanic/Latino	4,209	31.9	30,387	35.3
White (non-Hispanic)	3,582	27.4	14,693	17.1
Black (non-Hispanic)	3,874	35.0	38,573	43.5
Other (including multiracial)	558	5.7	3,647	4.1
Age, in Years				
Under 18	10	0.1	17,490	18.6
18 to 24	506	4.8	10,294	11.2
25 to 50	5,951	49.7	42,043	46.6
51 to 64	4,432	33.2	17,300	19.5
65 and over	1,507	12.1	3,697	4.2
Veteran Status				
Yes	576	5.3	4,311	5.9
No	11,510	94.7	67,763	94.1
Disabling Condition at Program Entry				
Yes	6,496	40.2	29,242	37.9
No	3,853	59.8	54,843	62.1
Covered by Health Insurance at Program Entry				
Yes	8,155	77.3	58,641	71.0
No	1,990	22.7	24,365	29.0
Type of Health Insurance at Program Entry				
Medicaid Only	6,516	81.2	49,935	85.1
Multiple Insurance Types	759	9.0	2,141	3.8
Medicare Only	468	5.8	2,222	3.9
State Funded Only	16	0.2	723	1.2
Other	293	3.9	3,530	6.0
Times Homeless past three years at Program Entry				
1 time	4,277	43.4	31,652	47.6
2 times	1,354	13.8	10,683	16.1
3 times	849	8.8	5,929	9.0
4 or more times	3,534	34.1	17,789	27.3

Source: Homeless Management Information System (HMIS),
Note: PRK population includes all PRK participants who exited the program. Non-PRK population includes all non-PRK participants in Emergency Shelters who exited the program. The earliest and latest program information for PRK participants were 6/2019 and 12/2022. Among non-PRK participants program information was 4/2002 and 12/2022. Four percent of non-PRK participants had entry dates prior to 2017. However, nearly all of these were in 2016; just 0.1 percent were prior to 2016.

Exhibit 3.7. Demographics of PRK Participants and PRK Non-Participants in Emergency Shelters in Ventura County

	PRK Participants Who Exited Project		Non-PRK ES Participants	
	N	Percent (%)	N	Percent (%)
Full Population	459	100.0	3,148	100.0
Gender				
Female	182	37.7	1,258	40.1
Male	268	61.5	1,853	59.4
Trans or Gender Non-Conforming	4	0.8	16	0.5
Race/Ethnicity				
Hispanic/Latino	127	33.8	1,446	45.0
White (non-Hispanic)	280	59.5	1,312	42.7
Black (non-Hispanic)	23	3.6	209	6.9
Other (including multiracial)	23	3.2	155	5.3
Age, in Years				
Under 18	1	0.4	302	9.2
18 to 24	6	1.7	204	6.4
25 to 50	119	29.5	1,425	45.2
51 to 64	198	40.1	964	31.3
65 and over	132	28.4	241	7.9
Veteran Status				
Yes	32	7.1	189	6.2
No	421	92.9	2,908	93.8
Covered by Health Insurance at Project Entry				
Yes	355	88.1	2,523	87.2
No	33	11.9	380	12.8
Disabling Condition at Project Entry				
Yes	306	55.7	1,519	53.0
No	107	44.3	1,507	47.0

Source: Homeless Management Information System (HMIS),
Note: PRK population includes all PRK participants who exited the program. Non-PRK population includes all non-PRK participants in Emergency Shelters who exited the program. In Ventura, the earliest and latest program information among PRK participants were 2/2020 and 6/2023. Among non-PRK participants, it was 1/2017 and 8/2023.

Exhibit 3.8. Demographics of PRK Participants and PRK Non-Participants in Emergency Shelters in Tulare County

	PRK Participants		Non-PRK ES Participants	
	N	Percent (%)	N	Percent (%)
Full Population	573	100.0	7,084	100.0
Gender				
Female	269	52.5	3,813	53.3
Male	303	47.4	3,266	46.6
Trans or Gender Non-Conforming	1	0.1	3	0.0
Race/Ethnicity				
Hispanic/Latino	255	50.0	3,979	55.6
White (non-Hispanic)	214	33.9	2,028	29.6
Black (non-Hispanic)	65	11.0	767	10.9
Other (including multiracial)	38	5.1	263	3.9
Age, in Years				
Under 18	57	29.4	2,734	36.8
18 to 24	41	7.6	634	9.0
25 to 50	243	44.0	2,749	39.5
51 to 64	124	15.0	795	12.1
65 and over	41	4.1	172	2.6
Veteran Status				
Yes	20	3.5	234	4.1
No	534	96.5	5,475	95.9
Type of Health Insurance at Program Entry				
Multiple	25	3.3	41	1.9
Medicaid Only	293	82.4	1,951	89.0
Medicare Only	48	8.4	88	4.1
State Funded Only	9	1.9	34	1.5
Other	24	4.0	75	3.4
Disabling Condition at Program Entry				
Yes	203	25.3	1,205	21.2
No	247	74.7	5,037	78.8

Source: Homeless Management Information System (HMIS),
Note: PRK population includes all PRK participants who exited the program. Non-PRK population includes all non-PRK participants in Emergency Shelters who exited the program. In Tulare, the earliest and latest program information we received on PRK participants was 4/2020 and 12/2022. Among non-PRK participants in Tulare, it was 2/2016 and 12/2022.

3.4.3 Prior Living Situation

Across all three counties, most participants (between 85 and 96 percent) identified in the HMIS analysis were experiencing homelessness before entering PRK (Exhibit 3.9). In Tulare County, half of PRK participants entered PRK from an emergency shelter and half entered from an unsheltered situation. In contrast, in Ventura and Los Angeles Counties three-quarters of PRK participants entered from unsheltered homelessness.

Exhibit 3.9. Prior Living Situations among PRK Participants in Ventura, Tulare, and Los Angeles Counties

	Ventura County (N=436)	Tulare County (N=484)	Los Angeles County (N=11,124)
Prior Living Situations among PRK Participants: Ventura, Tulare, and Los Angeles Counties			
Homeless (%)	**85.3**	**96.3**	**91.6**
Emergency shelter or Safe Haven	11.2	42.1	14.3
Transitional housing	0.5	0.2	0.6
Unsheltered	73.6	53.9	76.7
Own Housing (%)	**2.5**	**0.2**	**0.6**
Rented or owned with subsidy	0.5	0.2	0.3
Rented or owned without subsidy	2.1	0.0	0.3
Other Housing (%)	**8.9**	**1.2**	**3.9**
Staying or living with family	1.8	0.4	1.0
Staying or living with friends	1.6	0.6	1.5
Other temporary housing	5.5	0.2	1.4
Institutional Setting (%)	**2.5**	**2.3**	**3.8**
Other (%)	**0.7**	**0.0**	**0.0**

Source: Homeless Management Information System (HMIS) from Ventura County, Tulare County, and Los Angeles County.
Notes: For all characteristics, population is restricted to PRK participants who exited the program. Other temporary housing includes hotels or motels not in the PRK program, halfway homes, and host homes.

4. Providing Services at PRK Sites

The operation of Project Roomkey (PRK) sites varied across communities. Creating PRK sites from existing hotels and motels and providing on-site services depended on the organizational capacity and funding of each community's health and homeless service systems. While communities relied on the promise of FEMA reimbursing eligible expenses like the hotel and motel costs, supportive services had to be paid for by local communities. This chapter describes the services offered to PRK participants, how sites were staffed, enforcement of program rules, participant needs, and funding.

Housing as Health Care

For many PRK participants, especially those who were reluctant to come indoors prior to PRK, a sustained period of housing offered the opportunity to engage with health care services in a sustained way. One participant said:

"I can't be on the streets with my conditions. My kidneys are ok – living here has allowed me to take my medicine. I have a place to put my insulin [I take 2 different kinds]. Sleeping on the cement is bad on my hips [I'm getting a hip replacement]. I am taking my medicine and seeing the doctor since living here – previously I would skip appointments, and I haven't missed any since moving in."

4.1 Services Offered to PRK Participants

Most communities tried to address participants' needs by providing various supportive services at the PRK sites. This required collaboration with health care providers, which was new in some communities. On-site services could include physical health care, behavioral health care, assistance with activities of daily living, benefits assessments, case management and housing navigation, and transportation. For the most part, the participants we interviewed agreed that they ***"got everything they needed"*** from the services offered on-site. Some participants had their own primary care providers and did not use on-site medical services when PRK sites offered them. However, those who did use the PRK-provided medical services reported finding them helpful and liking that they could see a health care provider and receive medications immediately.

Consistent with California's requirement that all state-funded homeless programs use Housing First practices, PRK participants were not required to engage in any services offered by staff before being eligible to stay at a PRK site. Most PRK sites also established few program rules beyond those meant to prevent the spread of COVID-19 and protect the health and safety of participants.

4.1.1 Physical Health Care Services

PRK programs focused mainly on providing health care services specifically related to preventing and treating COVID-19, including testing, monitoring, and vaccinating.

In some communities, county health department staff provided additional on-site health care. For the many participants with more complex physical health care needs, PRK programs relied on local community-based health providers to provide on-site medical care at PRK sites. This service was not available in all communities or even at all PRK sites within a community.

In Tulare County, Kaweah Health offered a range of primary care services on-site for PRK participants, including wound care, acute asthma treatment, and diabetes management. Kaweah Health also had a mobile pharmacy that enabled staff to write prescriptions and dispense common medications on-site. Kaweah Health rotated among the County's PRK sites each month. In Los Angeles County, the Los Angeles Homeless Services Authority (LAHSA) contracted with GO RN, a health care workforce solution agency, to provide Los Angeles PRK sites with a regular on-site nurse to monitor COVID-19

symptoms and outbreaks and provide other health care services. A homeless service provider in Los Angeles explained how prior to PRK his organization did not have nurses at interim housing sites. When he managed PRK sites, he saw how nurses being on-site made a difference in how clients disclosed their medical conditions and built trusting relationships with them. ***He said nurses being at PRK sites were incredibly beneficial for participants and his staff.***

As local governments lifted stay-at-home orders and community health care became more available in 2021, on-site health services at PRK sites decreased and PRK staff made more referrals to external health care providers.

4.1.2 Behavioral Health Care Services

PRK programs offered varying levels of behavioral health care services, with more-resourced communities offering more robust services. For example, in San Francisco County, staff from medical outreach teams and on-site teams supported by the San Francisco Department of Public Health provided continuity of care to participants from PRK entry to exit. Staff provided behavioral health support, peer counseling, referrals, therapy services, psychiatry, and case management both on-site and at other facilities. PRK staff in another community reported it was challenging to provide behavioral health services because of staffing shortages at behavioral health partner organizations.

Other California communities struggled with providing behavioral health care services during the PRK stay because of staffing and funding challenges. On-site staff at some PRK sites said that more behavioral health and substance use treatment was needed by PRK participants than could be provided. Many participants' behavioral health conditions were exacerbated by being in an unfamiliar environment, coupled with the social isolation resulting from the COVID-19 safety protocols implemented at the sites. PRK staff also said that some PRK participants refused medical care, which staff believed was related to untreated behavioral health conditions.

In alignment with Housing First principles, some PRK programs implemented a harm reduction approach for substance use. This approach included training on-site staff to administer naloxone, providing clean syringes and fentanyl test strips, and having places to dispose of used syringes. The San Francisco Shelter Health team offered medication-assisted treatment and prescribed buprenorphine at PRK sites, arranging same-day delivery for participants who were interested in starting substance use treatment.

4.1.3 Caregiving Services

Some of the most vulnerable PRK participants, including older adults and people with disabilities, needed assistance with activities of daily living, personal hygiene, and medication reminders. Some of these participants also were unable to clean their rooms and bathrooms or take care of other basic needs without help. PRK programs did not want to turn anyone away, so staff needed to determine how to care for participants who needed more care.

San Francisco County, for example, used its contract with local service provider Homebridge to create teams of caregivers who could provide personal caregiving at PRK sites. Homebridge's care workers coordinated with other PRK staff to identify residents who needed assistance, by participating in the intake process or by accepting referrals from PRK staff. Doing so ensured that participants could receive caregiving services both during their stay in PRK and as they transitioned to permanent housing.

Not all communities or sites within communities were able to offer dedicated caregiver services, however they did find ways to assist program participants with higher needs. In Los Angeles County, for example, its Department of Health Services designated the Orlando Hotel to be a PRK site where a higher level of care was provided to participants. In Santa Cruz County, public health nurses provided PRK participants with assistance to complete activities of daily living and manage their medications as the nurses were able after completing their other duties. Ventura County used Whole Person Care teams to support PRK participants, including In-Home Support Services for seniors who needed additional assistance.

4.1.4 Case Management, Benefit Assessments, and Housing Navigation

Most PRK programs provided some level of case management. Case managers typically provided housing navigation, including helping participants obtain the necessary documents, identifying available housing units, and applying for various housing subsidy programs. Case managers also helped participants access benefits such as Social Security, the Supplemental Nutrition Assistance Program, Medi-Cal, and CalFresh. During interviews, PRK staff explained that participants were more disconnected from federal and state benefit programs than staff anticipated. Though experiences vary across communities, applying for public benefits and staying connected to them can be challenging for people experiencing homelessness. Birth certificates, identification, and other legal documents; income documentation; and verification of homelessness are often needed to secure public benefits. Those documents can be challenging to acquire and keep during a shelter stay or time spent on the street. ***Helping PRK clients apply for public benefits became a critical component of PRK.***

Description of supportive services from PRK participant in San Francisco

"They provided laundry services and sheets. There were nurses, doctors and housing services. They helped me with my forms and got me vouchers so I could get an ID. They'd help you with anything. They gave you clean clothes, toiletries. Anything I asked I got it. They give you an avenue to get what you need, and they send you where you need to go. They helped you get on your feet. They help with housing services."

4.1.5 Transportation

Most PRK programs offered transportation to medical appointments and government offices. Some sites used vehicles that belonged to the organization operating the site. Others used transportation vendors such as Uber Health. Having transportation available allowed participants to access health care regularly and to visit offices that can provide the documentation needed to qualify for housing and other benefit programs. One participant explained that while in PRK,

> ***[I] could easily see the doctor and got rides to appointments.... [I] got to order [my] birth certificate, ID, all of those sorts of things they helped with. [I] had lost [my] wallet with all those documents, but they helped get copies again.***

4.2 PRK Site Staffing

PRK programs required large teams of staff to operate sites and deliver the services just described above. In most communities, a county's human services department or Continuum of Care (CoC) leadership made decisions about PRK site staffing. In some cases, employees from local government agencies were diverted from their usual positions to PRK sites. In other cases, county agencies or CoC leadership contracted with homeless service organizations to open the PRK program at the hotel or motel and staff the operations and the services to them.

PRK staffing models varied across communities and sites within communities. Staff composition at a PRK site often depended on the size of the site (i.e., how many rooms and participants), the needs of the participants, and the capacity of the site operator. Prior to the pandemic, staffing at homeless service providers across California was already stretched thin. The pandemic strained the homeless service system even more. Sometimes homeless service providers operated PRK sites with staff performing jobs both at a PRK site and in other parts of the provider organization. For example, one provider staff member in Los Angeles described overseeing several PRK sites as well as performing other roles in the organization.

Typically, a PRK site had a site manager or supervisor; front desk staff who checked participants in and screened them for COVID-19 symptoms upon entering the property; and staff who oversaw day-to-day operations such as delivering meals, conducting wellness checks, and supporting participants during their stay. In some sites, the same staff also provided case management; other sites had dedicated case managers.

Public health employees or contracted nurses also staffed some sites. A few programs had 24-hour coverage by nurses to provide continuous support and health monitoring to participants.

Sometimes sites hired security personnel to screen and search participants before they entered the property and to help resolve conflicts that arose between PRK participants or between participants and PRK site staff or other people staying in the hotel or motel. Homeless service providers at some sites explained that they did not use contracted security because it was not consistent with their trauma-informed approach to care. Others said that security personnel were needed to augment provider staff. Approximately half of communities that responded to the evaluation's web survey used 24-hour security at their PRK sites.

4.3 Program Rules

Many communities designed their PRK sites with minimal participant requirements, allowing participants to enter the program with their personal belongings, pets, and family members or partners. However, because PRK programs sought to keep participants safe from COVID-19, sites implemented rules and safety measures to limit virus transmission.

To keep participants safe from contracting COVID-19, most programs limited visitors and asked participants not to congregate in common areas. Early in the pandemic, some PRK sites also required participants to stay in their rooms except for a few specific reasons such as medical appointments. To enter or leave the site, participants were required to check in and out at a security desk. Another common rule was nightly curfews to limit exposure to other participants or outsiders.

These rules were intended to help keep participants safe, but they sometimes affected participants' mental health and led to their feeling lonely. A PRK participant commented on the challenges that isolation posed to their well-being:

> ***Physically I was getting better when I was at the SIP hotel, but mentally…I was too isolated. I needed more interaction. It eventually came to a point where I was talking to the TV and arguing with myself in my room.***

For participants with substance use disorders, the isolation requirement could have increased the risks of overdose by making it more likely that their drug use was not observed. PRK staff in several communities reported that a small number of PRK participants left the program because of the rules and isolation policies. However, one participant interviewed said that the PRK site allowed more personal freedom than their previous living situation:

> ***I was very happy; I have so many aches, but if I could do somersaults, I would have!***

To combat the adverse effects of isolation, Santa Cruz County worked with Miracle Messages, a phone-based buddy service for people experiencing homelessness, to have its program volunteers call PRK participants weekly. Santa Cruz's Parks and Recreation Department also contracted with a local artist to visit PRK sites and facilitate outdoor art projects.

4.4 PRK Participants' Need for a Higher Level of Care

Some PRK participants had complex needs and required a higher level of care than county and homeless service system leadership anticipated. In some instances, prior to participating in PRK, some participants had not accessed emergency shelters or other homeless service system resources consistently and therefore the complexity of their conditions were unknown. Because most communities designed their PRK program to serve older adults, some participants had age-related challenges such as needing help with activities of daily living and cognitive impairments. Some had severe physical disabilities that required accessibility modifications or other supports. Some had been experiencing unsheltered homelessness for prolonged periods and had to relearn how to live indoors.

When PRK program and on-site health care staff recognized that a participant had a higher need for behavioral and physical health care than staff could provide, they tried to serve the participant until they could be moved to a hospital or nursing facility. Many participants with less acute needs successfully remained at PRK sites. One participant in Santa Cruz described using an emergency room to treat his medical conditions when he was living on the street but when he was at a PRK site he did not go to the emergency room at all. Another participant in Tulare County said that being able to keep her phone charged meant that she made it to her medical appointments on time. She also said that it was easier to manage medications and medical appointments during her stay at a PRK site.

Sometimes available resources created ongoing challenges of meeting all service needs through duration of the PRK program. For example, some sites reported that rooms opening onto outside walkways and stairways, which were the favored design for PRK to prevent the spread of COVID-19, were not always ADA accessible, making it hard to meet the physical needs of some participants. In other cases, the service gaps were just in the early months of the pandemic, when stay-at-home orders limited access to specialized staff and services.

4.5 Funding for PRK Programs

The costs of operating the PRK program included lease payments to the property owner, food delivered to participants, COVID-19 testing and other medical costs (e.g., face masks, surgical gloves, hand sanitizer), security, cleaning and laundry services, and office supplies. Staffing the PRK program was another significant cost. Programs required staff to manage day-to-day operations, plus case managers, on-site nursing staff and sometimes designated staff to help participants find permanent housing. Larger counties deployed hundreds of staff members to support PRK operations. Some PRK sites reported many types of

unforeseen operating costs, including replacing damaged furnishings such as television remotes and shower curtains.

At the start of PRK, the Federal Emergency Management Agency (FEMA) agreed to reimburse the sites for 75 percent of eligible costs through its Public Assistance Program Category B, which reimburses state and local governments for costs related to disaster response. At the end of January 2021, FEMA announced that reimbursement levels would increase from 75 percent to 100 percent, backdated to January 2020. FEMA then announced that programs would be reimbursed at 100 percent for eligible costs until July 1, 2022, after which those still in operation would be reimbursed at 90 percent, with a 10 percent local cost share, until stated otherwise.[14] Communities needed to find alternative funding sources to cover the operating costs not covered by FEMA, as well as funding to cover FEMA's share while awaiting reimbursement from the federal government. The sites used a network of other federal, state, and local funding to pay for the operating costs not covered by FEMA including Emergency Solutions Grants (ESG), Coronavirus Relief Fund (CRF), Whole Person Care (WPC), and other CDSS funded programs.

Managing multiple sources of funding created challenges for communities, as they had to ensure that each source was used only for its allowable activities. For example, Tulare County received Cares Act funding (ESG-CV), but it could not be used to cover the cost of services provided to PRK participants by the County's Alcohol and Other Drug Treatment, Mental Health, or Human Services divisions. The County had to pay for those services through local funding.

Although communities were able to combine funding sources to operate their PRK programs, sites still noted significant funding gaps. For example, Tulare County did not have dedicated state or federal funding for medical services and had to arrange for the Street Medicine team to volunteer their time to serve PRK participants. Ventura County reported that the evolving timeline for FEMA reimbursement resulted in significant administrative work for County staff. As a result, beginning in February 2023, the County decided to fund PRK exclusively through its CDSS grant until that funding source was exhausted.

California provided technical assistance to local governments on completing and submitting claims for FEMA reimbursement, but sites reported confusion about what types of services or materials FEMA funding would cover.

[14] FEMA. Coronavirus (COVID-19) Pandemic: Public Assistance Programmatic Deadlines (Interim) Version 2 FEMA Policy # 104-22-0002. https://www.fema.gov/sites/default/files/documents/fema_covid-19-pandemic-public-assistance-programmatic-deadlines-interim_03292023.pdf

5. Ending Project Roomkey

Project Roomkey (PRK) was designed quickly, as a crisis response to growing COVID-19 transmission and death rates. Consequently, during the design period many communities did not have time to develop strategies for moving participants to permanent housing. As the COVID-19 public health emergency endured and the PRK program continued, CDSS required and communities began to create strategies for securing pathways to permanent housing for PRK participants. However, many factors made creating these strategies challenging, including the uncertainty of PRK funding, limited permanent housing subsidies, and shortages of affordable rental units.

5.1 Challenges to Rehousing Strategies

The California Department of Social Services (CDSS) required that communities submit PRK Rehousing Plans to identify program goals and identify housing resources for exiting participants. Local communities made decisions about site closures and how and when to exit participants from PRK sites. Site closure dates were determined based on the available funding, the needs of PRK participants, and local rehousing plans. As a result, each community and sometimes each site followed a different process and schedule for ending its PRK program.

In response to the evaluation's statewide web survey of the 54 communities that accepted PRK funding, 58 percent reported having sites where participants could stay only during their isolation/quarantine (I/Q) period; 60 percent of communities reported having sites that allowed participants to stay until they found an alternative; and 55 percent reported having sites where participants could stay as long as the site was open.

Case managers and housing navigators staffing sites were charged with helping PRK participants develop rehousing plans. Despite this assistance, several factors created challenges.

- ***Uncertainty of funding.*** Communities received funding from FEMA retroactively to reimburse eligible costs of operating PRK programs. The federal government extended FEMA funding incrementally, leading to uncertainty in communities about how long funding would be available to operate their PRK sites.

  > ***It was hard to turn and pivot and say, "Oh, we will now be open for another six months."***
  >
  > ***It was hard when the date [for funding] kept changing. We lost credibility with our clients, they stopped believing the motels would actually close.***

  Some communities closed sites before the FEMA funding expired; other communities relied on other federal, state, and local funding sources to continue to operate.

- ***Need for housing subsidies.*** Many older PRK participants and those with serious health challenges were not able to work and would need an ongoing housing subsidy to secure and maintain permanent housing. However, communities noted that they have limited permanent housing subsidies compared with the need. Some communities prioritized PRK participants for receiving HUD Emergency Housing Vouchers, a pandemic-era housing program specifically for people experiencing homelessness. Other communities prioritized PRK participants for the community's general pool of Housing Choice Vouchers or for the time-limited rental assistance known as rapid re-housing.

- ***Limited supply of affordable housing units.*** In California, especially in large metro areas, housing units that are available for rent and affordable are scarce without a rent subsidy or even with one. Even when PRK participants secured a rent subsidy, they struggled to find an available housing unit with a willing landlord. PRK staff reported that participants needed housing navigation services, including assistance searching for housing, completing applications, and visiting units. Finding units that could accommodate accessibility needs was difficult. Providing all PRK participants with housing navigation services was also challenging because when sites announced their intention to close, all (or most) participants sought help at once. Some sites tried to mitigate the rush of needing housing navigation assistance by proactively providing participants who had a rental subsidy with housing navigation services prior to site closure.
- ***Reluctance to leave PRK.*** Some communities had limited permanent and interim housing options for participants after a PRK site closed. In some instances, PRK participants were referred to a congregate shelter or shared housing. Since, most PRK sites offered accommodations that participants considered desirable (e.g., private bedrooms and bathrooms, secure places for belongings, and the opportunity to be with partners and pets), understandably, some participants just did not want to leave their PRK site.

5.2 Closing and Demobilizing PRK Sites

The timing and approach to PRK site closures varied by community. Some communities decided to close all their sites (or all their remaining sites) on a single day, and that was the day the community's PRK program ended. Other communities decided to close sites on a rolling basis, allowing participants who did not have a rehousing plan or were waiting for a housing subsidy to move to another PRK site that was still open. The latter approach allowed PRK staff to continue to help participants who were trying but finding it difficult to secure permanent housing.

Closure timelines evolved over time. Most communities had closed their sites by Summer 2022. Some communities began closing when the number of COVID-19 cases dropped, then re-opened sites in response to new COVID-19 outbreaks (including the spikes in the Delta and Omicron variants of the virus). Other communities decided to end their PRK program based on the availability of the state's PRK funding and the extensions of FEMA funding. Some communities decided to keep a limited number of PRK sites open to expand their interim housing capacity within their existing homeless service system, cobbling together various funding sources.

The uncertain timing of the end of FEMA funding caused challenges with both planning and credibility with participants. PRK staff explained that they would notify participants of an impending closure date, but then be notified by county leadership that FEMA funding was extended and the site would remain open. As a result, participants became skeptical and delayed planning their exits.

Once all participants exited the sites, PRK staff were responsible for demobilization of the hotels and motels. One PRK staff person explained:

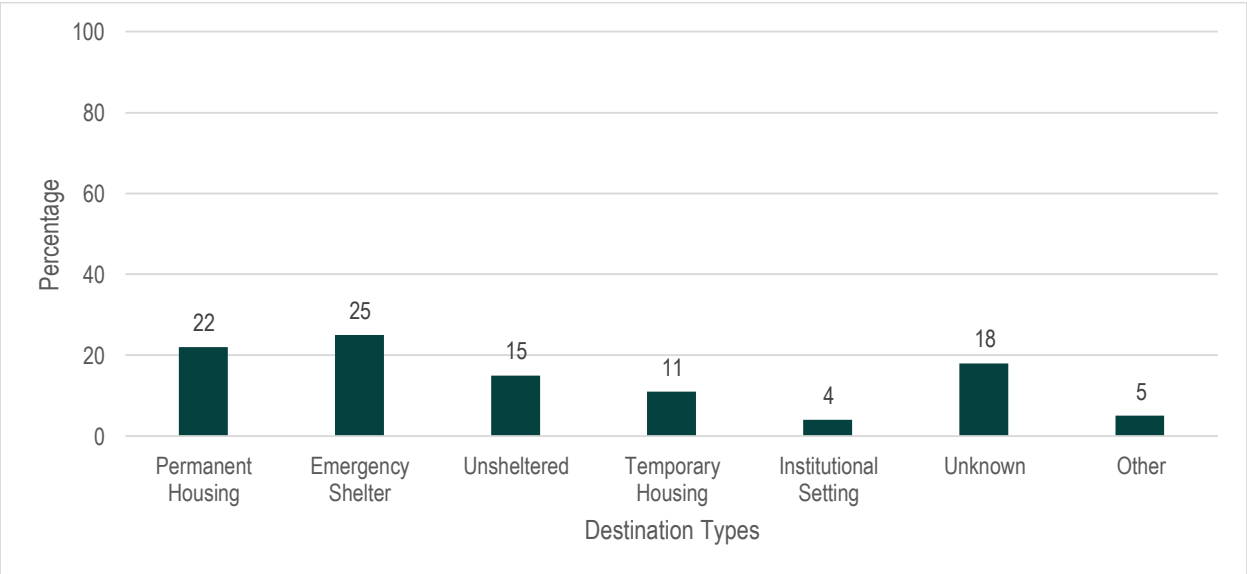
> ***Demobilization was a tremendous lift. I think it's three times more difficult to [demobilize] a shelter than to set it up. Getting people out, cleaning it up, finding out what's destroyed, helping people's emotions, keeping staff upbeat, finding a place for the items and clean them, a LOT of cleaning!***

5.3 PRK Participant Exit Destinations

Exit destinations varied significantly by community. During PRK operation, counties and Tribal communities submitted biweekly rehousing reports to CDSS on exit destinations of participants.[15,16]

Across California, 22 percent of PRK participants exited to permanent housing, 25 percent to an emergency shelter, 15 percent to an unsheltered setting, and 11 percent to temporary housing such as transitional housing or a temporary stay with family and friends. Despite their vulnerable health conditions, only four percent exited to institutional settings such as hospitals or skilled nursing facilities. Approximately 18 percent of PRK exit destinations are marked as unknown, and many of those may be exits to a homeless situation.

Exhibit 5.1. Exit Destination of PRK Participants across CA



Source: California Department of Social Services (CDSS) PRK Rehousing Data, January 2024. Data was self-reported by local communities to CDSS.
Note: CDSS masked some communities exit destination data because of the small numbers of people exiting to those destinations. Values that were masked were interpreted as zero in the data analysis.

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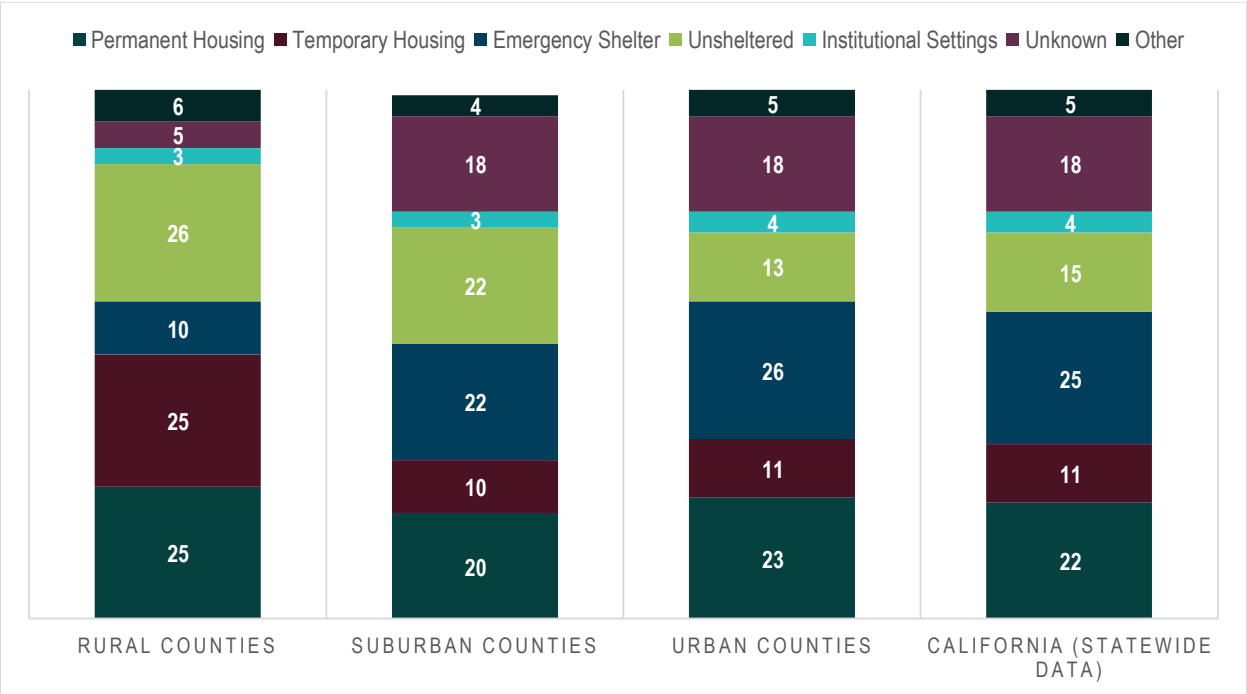
15 CDSS defined seven exit categories: (1) Permanent Housing. Can be subsidized (e.g., vouchers, rapid rehousing) or unsubsidized and includes shared housing, housing rented or owned by participant, and permanently staying with friends or family. (2) Temporary Housing. Includes transitional housing, temporarily staying with friends or family, or hotel/motel rooms that are outside of Project Roomkey (e.g., not in response to COVID-19, or not for FEMA-eligible populations). This category does not include emergency congregate shelter. (3) Emergency Shelter. Shelter in a group shelter setting, including traditional emergency shelters that have been decompressed or reconfigured due to COVID-19. (4) Institutional Settings. Includes both short-term institutions (e.g., hospitalization, foster care in a group home, substance use treatment facility, incarceration) and long-term settings (e.g., board and care, long-term facilities, nursing homes). (5) Unsheltered/Vehicle/ Street. Places not meant for habitation including staying in a car, tent, or street. (6) Other. Unlisted destinations or deceased. (7) Unknown. Data not collected, no exit interview completed, participant did not want to share information, or PRK participant did not know his or her destination at time of exit.

16 CDSS began requesting communities to submit rehousing reports on PRK participants in 2021. Therefore, if a PRK site closed prior to 2021, data was not submitted to CDSS.

There are a few evident patterns of exit destinations by community or type of community (Exhibit 5.2). ***In all types of communities, between 20 to 25 percent of PRK participants exited to permanent housing and approximately 40 percent of PRK participants exited back to homelessness either to sheltered or unsheltered settings.*** A smaller percentage of PRK residents exited to emergency shelters in predominately rural counties, which was unsurprising given that there are likely fewer emergency shelters available in rural areas compared to other areas across the state. More surprising is the relatively small percentage of PRK participants who left for an unsheltered situation in predominately urban counties. Based on interviews with local PRK program leadership and site staff, participant exit destinations depended on several factors, including access to rent subsidies for permanent housing, availability of staff to assist with housing navigation, and whether site rules led participants to leave the site rather than remain in the program.

Exhibit 5.2. Percentage of PRK Participants by Exit Destination and Geographic Type



Source: Data communities reported to the California Department of Social Services (CDSS)

5.4 Exit Destinations for Los Angeles, Ventura, and Tulare Counties

The study obtained HMIS data for three of the California counties: Los Angeles, Tulare, and Ventura. Within all three communities, PRK participants exited to permanent housing, temporary housing, and back to homelessness at rates similar to those of people who exited other non-PRK emergency shelters. (For both Tulare and Ventura counties, a higher share of exit destinations is missing for PRK than for other emergency shelters.) However, there are limitations to the HMIS data available – including substantial missing values.

- In Ventura County, fewer PRK participants than people staying in other emergency shelters exited to unsheltered homelessness, (36.8 percent vs 45.4 percent). The shares exiting to other emergency shelters were smaller for both groups but also smaller for PRK than for other emergency shelters.

Approximately, 27 percent of PRK participants exited to permanent housing, while 20 percent of non-PRK participants exited to permanent housing.

- In Tulare, the percentage of exits to a homeless situation was smaller than in Ventura, and the percentage going to permanent housing was greater. About the same shares of PRK and non-PRK participants exited to an unsheltered situation (19 percent and 18 percent), but more people leaving non-PRK shelters went to other shelters, 15 percent of non-PRK shelter participants vs. 6 percent of PRK participants. However, only 30 percent of PRK participants exited to permanent housing, while 37 percent of non-PRK participants did so.
- In Los Angeles County, more exit destinations are missing for non-PRK shelters (43 percent) than for PRK participants (36 percent). The high percentages of missing data for both types of shelter make comparisons of exit destinations for the two types of shelter difficult to interpret. However, a higher percentage of PRK participants than non-PRK participants moved to other shelters, suggesting that staff of PRK sites were attempting to prevent people from returning to unsheltered homelessness.

Exhibit 5.3. Exit Destination at PRK and Non-PRK Program Exit for Ventura, Tulare, and Los Angeles Counties

Exit Destination	Ventura		Tulare		Los Angeles	
	PRK	Non-PRK	PRK	Non-PRK	PRK	Non-PRK
Permanent Housing (%)	**27.4**	**20.5**	**29.2**	**37.5**	**18.9**	**24.6**
Rented or owned with subsidy	12.4	6.2	18.2	3.9	17.3	17.5
Rented or owned without subsidy	8.5	6.1	3.0	25.0	0.7	4.1
Staying or living with family/friends permanently	5.0	7.1	5.6	8.3	0.9	3.0
Other permanent housing	1.5	1.1	2.4	0.3	0	0
Temporary Housing (%)	**4.8**	**7.6**	**12.6**	**12.6**	**3.8**	**6.1**
Staying or living with family/friends temporarily	2.6	5.6	10.3	10.1	2.1	4.9
Other temporary housing	2.2	2.0	2.3	2.5	1.7	1.2
Homeless (%)	**44.2**	**56.7**	**26**	**33.9**	**28**	**17**
Emergency shelter or Safe Haven	6.3	7.3	6.3	15.3	16.4	6.7
Transitional housing	1.1	4.0	0.7	0.6	1.5	2.5
Unsheltered	36.8	45.4	19.0	18.0	10.1	7.8
Institutional Setting (%)	**6.6**	**5.7**	**4.8**	**2.4**	**4**	**3**
Foster care home, group home	0	0.1	0.3	0.1	0	0.3
Institutional setting for medical, substance use, or behavior health	5.9	4.7	2.4	1.9	3.1	2.1
Jail, prison, juvenile detention	0.7	0.9	2.1	0.4	0.9	0.6
Deceased (%)	**4.8**	**0.8**	**2.8**	**0.1**	**1.1**	**0.4**
Other (%)	**0.9**	**1.0**	**4.7**	**1.7**	**8.0**	**5.5**
Missing (%)	**11.3**	**7.6**	**19.9**	**11.8**	**36.0**	**43.4**

Source: Homeless Management Information System data provided by Ventura, Tulare, and Los Angeles Counties

Across California, PRK programs operated sites anywhere from a couple months to several years. We learned from interviews and the evaluation's web-survey that PRK participants were often allowed to stay at the site until they found an alternative or until the site closed.

HMIS data from Tulare, Los Angeles, and Ventura Counties suggest that the longer someone stayed in PRK the less likely they were to exit to homelessness and more likely to exit to permanent housing (see Exhibits 5.4 and 5.5). During the first 12 months of PRK program stays, percentages of participants exiting to homelessness continuously declined. Percentages continued to decline for Ventura County but

began to increase for Tulare and Los Angeles Counties between 12 to 18 months. While after 18 months, Ventura's percentage of participants exiting to homelessness rose, the percentages in Tulare and Los Angeles dropped again.

In Los Angeles, after the first three months, participants who exited to homeless mostly exited to an emergency shelter rather than to an unsheltered location. In Ventura and Tulare Counties, most participants who exited to homelessness did so to an unsheltered location across the entire period.

Exits to a PRK participant's own housing either with or without a rental subsidy continuously increased over time in Tulare, Ventura, and Los Angeles Counties. Most participants who exited to their own housing did so with a rental subsidy. In Tulare County, beginning during the first few months of the program there was an increase in participants securing their own housing. This continued for the first year and then another increase happened after that. In Los Angeles and Ventura Counties, there was an increase in months 3-6 of the program and then a steady increase throughout the program's duration. ***This data is consistent in what we heard across the state – that the first few months of the program was seen as an emergency response to COVID-19 and then many counties transformed and expanded the program's focus to also include rehousing services to support long-term, permanent housing and stabilization for participants.***

Exhibit 5.4. Exit Destination to Homelessness among PRK Participants by Program Length of Stay

Exit Destination: Homelessness	0-1 Months	1-3 Months	3-6 Months	6-12 Months	12-18 Months	18+ Months
Tulare County						
Homelessness (%)	**46.4**	**31.2**	**17.1**	**26.3**	**30.4**	**22.6**
Emergency shelter or Safe Haven	9.2	10.4	3.9	9.2	2.2	9.7
Transitional housing	0.7	1.3	0.0	2.6	0.0	0.0
Unsheltered	36.6	19.5	13.2	14.5	28.3	12.9
Ventura County						
Homelessness (%)	**72.9**	**66.4**	**44.1**	**37.5**	**22.4**	**37.0**
Emergency shelter or Safe Haven	10.2	7.1	7.4	3.1	8.2	7.4
Transitional housing	0.0	4.4	0.0	0.0	0.0	0.0
Unsheltered	62.7	54.9	36.8	34.4	14.3	29.6
Los Angeles County						
Homelessness (%)	**57.3**	**49.4**	**47.6**	**38.0**	**45.6**	**31.6**
Emergency shelter or Safe Haven	12.5	22.1	32.3	29.5	35.5	23.2
Transitional housing	1.8	3.2	3.0	2.1	3.1	0.4
Unsheltered	43.1	24.1	12.2	6.4	6.9	8.1

Source: Homeless Management Information System (HMIS).
Note: For all characteristics, population is restricted to PRK participants who exited the program. Ns at program exit vary due to missing responses. Program length of stay was measured in days. "0-1 months" corresponds to 0-30 days; "1-3 months" corresponds to 31-90 days; "3-6 months" corresponds to 91-180 days; "6-12 months" corresponds to 181-360 days; "12-18 months" corresponds to 361-540 days; and "18+ months" corresponds to 541+ days.

Exhibit 5.5. Exit Destination to Own Housing among PRK Participants by Program Length of Stay

Exit Destination: Own Housing	0-1 Months	1-3 Months	3-6 Months	6-12 Months	12-18 Months	18+ Months
Tulare County						
Own Housing (%)	**9.8**	**31.2**	**32.9**	**32.9**	**54.3**	**67.7**
Rented or owned with subsidy	7.8	24.7	28.9	30.3	50.0	61.3
Rented or owned without subsidy	2.0	6.5	3.9	2.6	4.3	6.5
Ventura County						
Own Housing (%)	**5.1**	**10.6**	**30.9**	**37.5**	**38.8**	**44.4**
Rented or owned with subsidy	0.0	0.9	19.1	28.1	26.5	35.2
Rented or owned without subsidy	5.1	9.7	11.8	9.4	12.2	9.3
Los Angeles County						
Own Housing (%)	**5.7**	**19.0**	**25.0**	**39.5**	**36.2**	**50.7**
Rented or owned with subsidy	4.9	17.0	23.1	38.0	34.9	50.1
Rented or owned without subsidy	0.8	1.6	1.6	1.2	0.6	0.4

Source: Homeless Management Information System (HMIS) data for Ventura County, Los Angeles County, and Tulare County.
Note: For all characteristics, population is restricted to PRK participants who exited the program. Ns at program exit vary due to missing responses. Program length of stay was measured in days. "0-1 months" corresponds to 0-30 days; "1-3 months" corresponds to 31-90 days; "3-6 months" corresponds to 91-180 days; "6-12 months" corresponds to 181-360 days; "12-18 months" corresponds to 361-540 days; and "18+ months" corresponds to 541+ days.

5.5 Data Limitations for the Evaluation

During the evaluation's research design phase, the Abt team, the California Health Care Foundation, the Conrad N. Hilton Foundation, and CDSS discussed the importance of understanding both housing and healthcare utilization and outcomes of PRK participants. To operationalize collecting healthcare and housing data to answer the evaluation's research questions, Abt hoped to match identifiable Homeless Data Integration System (HDIS) data from the California Interagency Council on Homelessness (Cal ICH) with health data, including Medicaid (Medi-Cal) data from the Department of Health Care Services (DHCS) and death record data from the California Department of Public Health (CDPH) or the Department of Health Care Access and Information (HCAI). Due to data sharing restrictions, Abt created a back-up plan to collect person-level homeless services data. Abt's backup plan was to obtain identifiable Homeless Management Information System (HMIS) data from local communities on PRK participants and match that data to state-level or local health data. To be able to request and analyze health system data we first needed to obtain identifiable HMIS/HDIS data to identify who used PRK across the state. Unfortunately, there were roadblocks to both plans and the Abt team was not able to collect identifiable homeless service system data from the state or local communities and therefore could not request health systems data.[17]

[17] The Abt team was able to collect de-identified HMIS data from three communities for this evaluation.

6. Findings and Policy Recommendations

Not only did Project Roomkey (PRK) meet its original goal of saving the lives of people who were experiencing homelessness but the program enhanced how interim housing is designed and operated in some communities across California. The design, implementation, and demobilization of PRK programs across California offer some lessons for providing emergency and interim housing for populations with complex needs. The continued use of hotels and motels along with existing residential buildings was critical for COVID-19 response and could prove useful in response to the ongoing homelessness crisis, to natural disasters, or to future public health emergencies.

Prior to the COVID-19 pandemic, communities across California faced significant challenges responding to the growing number of people experiencing homelessness. For the past decade, leaders of homeless service systems and homeless service providers have struggled with organizational capacity, staff turnover, and burnout; the need for more permanent rental subsidies; and a low vacancy housing market with little affordable housing. The COVID-19 pandemic exacerbated these existing challenges while adding new hurdles during the initial period, including stay-at-home restrictions, social distancing, and uncertainty about how the virus spread and how long the pandemic would last. ***However, despite these challenges, various state agencies, health clinicians, homeless service system leaders, public health experts, local governments, Tribal jurisdictions, and homeless service providers quickly came together to launch a program that transformed how homeless service systems offer interim housing across the state.***

This chapter highlights the evaluation's key findings, along with policy recommendations as California continues to respond to the homelessness crisis and refine its emergency response plans.

Key Finding #1: California's government and robust homeless service system infrastructures supported a quick design and implementation of PRK. This program enabled the ability of new partnerships to form between local government agencies and homeless service and health care providers.

Several State agencies came together in a matter of weeks to design an emergency program to house vulnerable individuals experiencing homelessness in hotels and motels paired together with supportive services. County agencies, Tribal communities, and homeless service systems then applied the state's new PRK framework to design their own programs, creating targeting protocols, identifying and contracting with hotels and motels, and staffing PRK sites quickly. The quick design and program implementation and infusion of federal, state, and local resources to create and operate this program were unprecedented in their speed and scale.

- ***Policy Recommendation #1: Build on partnerships created with PRK for future responses.*** There was little time during the design of PRK to create partnerships strategically. Over time, however, strong relationships formed across local government agencies, homeless service providers, and health care providers. These relationships should not end with the demobilization of PRK sites. Under the state's new Housing and Services Partnership Accelerator there are opportunities to continue the

collaboration between healthcare, housing, homelessness, disability, older adult providers.[18] Employees of state and local agencies also made significant efforts to recruit hotel and motel owners for the program and to garner community support for opening PRK sites. This information, both the procedures used and contact data for the sites, should be retained for local communities to use as they consider local responses to homelessness or in preparation for the next weather-related or public health emergency or natural disaster.

Key Finding #2: PRK sites had features that are often not available in other emergency shelters or interim housing settings. Most PRK participants reported having a positive experience at the hotels and motels.

PRK provided individual rooms where people could bring or store their possessions and did not have to be separated from their partners or pets. The rooms also had private bathrooms. This model for providing shelter gave people autonomy, privacy, and safety. Communities reported that some PRK participants had previously been unwilling to use shelter programs. PRK enabled some participants to receive health care and other services for untreated health conditions for the first time since they began experiencing homelessness.

- ***Policy Recommendation #2: Retain hotels and motels as a component of a homeless service system and ensure the program design meets the needs of participants.*** Some communities across California continue to use hotels and motels to expand their inventory of emergency and interim housing. For this model to be successful, however, communities need to consider site staffing, supportive services, linkages to public benefits, meals, and other amenities offered to participants. Though using hotels and motels worked for many PRK participants, homeless service providers said that hotels and motels do not work for everyone and should not be the only interim housing option for people experiencing homelessness. Communities also need to bring people with lived experience to the decision-making table to provide insight into needed services and supports. Communities should seek input on what services and supports should be offered at congregate and non-congregate shelters and interim housing programs to support participants on their pathway to permanent housing. The engagement of people with lived experience should be tailored to specific populations and circumstances such as people displaced by a natural disaster, families with children, older adults, people with disabilities, migrants, and youth.

Key Finding #3: Many PRK participants were extremely medically vulnerable and had complex needs.

Some PRK participants required more intensive supports and services than county and homeless service system leadership anticipated. Because most communities focused their PRK programs on older adults, some participants had age-related challenges such as needing help with activities of daily living and cognitive impairments. Some had severe or chronic health conditions and physical disabilities that required accessibility modifications or other supports. Some participants had been experiencing unsheltered homelessness for prolonged periods and had to relearn how to live indoors. We consistently

[18] Biden-Harris Administration Partners with States to Address Homelessness. February 9, 2024. https://www.hhs.gov/about/news/2024/02/09/biden-harris-administration-partners-states-address-homelessness.html

heard from system leaders and homeless service providers that PRK participants needed more supportive services. We also heard from homeless service providers that having medical professionals like nurses on-site was critical. At some PRK sites, nurses provided continuous support and health monitoring.

- ***Policy Recommendation #3: Encourage the use of funding from Medi-Cal Managed Care Plans and Medi-Cal waivers for supports and services for people experiencing homelessness in residential settings.*** Since CalAIM was enacted in January 2022, managed care plans (MCPs)—organizations that provide Medi-Cal coverage, supports, and services—have worked with state and county health departments and their provider networks to coordinate a suite of supportive services for people experiencing homelessness. These services include Enhanced Care Management (intensive care coordination), housing tenancy supports, recuperative care, post-hospitalization housing and housing navigation. We heard that many PRK participants needed these supports as they transitioned to permanent housing.

  Some homeless service providers are uncertain about which services are likely to be funded through contracts with MCPs and which services are not. MCPs should provide more guidance and training to homeless service providers and system leaders for them to access these resources for their clients. MCPs should also invest in their local homeless response systems through incentive programs, community benefits, or flexible contracting. Additionally, the state needs to expand the mechanisms that are already in place (e.g., Assisted Living Waiver and the Home & Community Based Alternative Waiver) to provide more supports and services for seniors and people with disabilities experiencing homelessness as they move into permanent housing.

Key Finding #4: HMIS data from Los Angeles, Tulare, and Ventura Counties suggest that, the longer someone stayed in PRK, the less likely they were to exit to homelessness and more likely they were to exit to permanent housing.

Many PRK participants had experienced unsheltered homelessness for prolonged periods and some had to relearn how to live indoors. At PRK sites, participants stayed in private rooms and received meals, supportive services, on-site health care or referrals to medical facilities, and linkages to public benefits. During the period that PRK operated, the federal and state government provided new funding to be used to respond to homelessness. In many communities, system leaders used this funding to transition PRK participants into permanent housing. The package of services and supports that PRK sites provided helped many participants stabilize and the infusion of housing resources helped them secure a path to permanent housing.

- ***Policy Recommendation #4: Explore investing in interim housing and service models that promote stabilization.*** In some cases, people who have experienced homelessness for prolonged periods may need a transition period to relearn life skills and stabilize their health conditions before moving into an independent housing unit without on-site supports. In most homeless service systems, programs that provide such intensive services are limited to project-based permanent supportive housing intended for long-term occupancy. Additionally, most shelter programs are time-limited and supportive services can vary significantly. HMIS data from three communities shows us that longer lengths of stay in PRK accompanied by consistent, supportive services and available rental subsidies is key to creating a pathway to permanent housing. It is worth exploring how the PRK model can be

used to support a pathway to permanent housing for people whose need for intensive support is temporary.

Key Finding #5: Access to data is challenging across California state agencies and departments.

The data needed to examine housing and healthcare service utilization and outcomes for PRK participants was unavailable for this evaluation. Many state agencies and departments who provide housing, healthcare, supportive services, and public benefits use different data systems and have different legalities protecting that data. Therefore, it was challenging for state agencies and departments to share data for the purposes of this evaluation.

- ***Policy Recommendation #5: Data sharing agreements need to be created across state agencies and departments to further understand the homelessness crisis in California.*** People experiencing homelessness use social and health care safety net programs that span many of the state's agencies and departments. There needs to be a way for data sharing, analysis, and evaluation to occur while looking across programs and public benefits, which often exist in different data systems and are protected by different legalities. To further understand the homelessness crisis across the state and evaluate what is working well, we need to understand how people are interacting with the many public systems, programs, and benefits; which combination of programs and benefits are best at preventing and resolving homelessness; and who is most at risk for homelessness.

Appendix: Evaluation Methodology

This appendix presents the evaluation's research questions and the methodology for its data collection and analysis.

Research Questions

Exhibit A.1. Research Questions

Research Question by Domain	Data Source							
	CDSS	Web Survey	PRK Community Telephone Interviews	PRK Community Visit Interviews	People with Lived Experience in PRK Interviews	HMIS[a]	Medi-Cal[b]	Criminal Legal System[c]
PRK Implementation								
How did PRK implementation vary across the state and by community type?	✓	✓	✓	✓				
Who were the key implementation partners at the state and local level?		✓	✓	✓				
How did local design affect implementation?		✓	✓	✓				
How did local stakeholder support and neighborhood acceptance vary among PRK sites?			✓	✓				
How did communities ensure that participant recruitment and service delivery considered racial and ethnic equity?		✓	✓	✓				
What challenges or obstacles did PRKs face during the start-up, operation, and ramp-down processes? How did they overcome them?			✓	✓				
How did implementation change over the award cycles?	✓	✓	✓					
What were the exit strategies created by communities? How did the exit strategies evolve over time?		✓	✓	✓	✓			
Shelter and Services Provided								
What was the physical configuration of PRK sites?		✓	✓	✓	✓			
What control over access and independence of movement did the participants have?		✓	✓	✓	✓			
What basic services did PRK offer and how were they provided (e.g., meals, laundry, security, health checks)?		✓	✓	✓	✓			
Were case management services available to all participants?		✓	✓	✓	✓			
How did PRK sites provide primary health care services to participants?			✓	✓	✓	✓		
How did PRK connect participants to behavioral health providers and other health care services?			✓	✓	✓	✓		

Research Question by Domain	Data Source							
	CDSS	Web Survey	PRK Community Telephone Interviews	PRK Community Visit Interviews	People with Lived Experience in PRK Interviews	HMIS[a]	Medi-Cal[b]	Criminal Legal System[c]
Participant Characteristics and Vulnerabilities								
How were participants selected and their housing and health needs assessed?		✓	✓	✓	✓			
Who was not selected? Who was offered PRK but declined to participate?			✓	✓				
What were participants' demographic and health characteristics?						✓		
What were participants' housing and health needs (i.e., how vulnerable were participants)?						✓		
Housing and Health Outcomes								
Did PRK facilitate connections to health services (e.g., primary care, substance use recovery, harm reduction and overdose prevention services)?			✓	✓	✓	✓		
Did PRK serve people not previously served by the homeless system?					✓	✓		
Did participants achieve housing stability after leaving PRK? Did PRK result in better rehousing outcomes than congregate shelters?			✓	✓	✓	✓		
How long did participants continue to receive health care services after exit?			✓	✓	✓	✓		
Beyond protecting participants against COVID-19, did PRK affect their physical and behavioral health? Did participants' health status change over time?			✓	✓	✓			
What did participants' service utilization look like?					✓	✓		
Did receipt of other social safety services/receipt of benefits improve for PRK participants?					✓	✓		
System Collaboration								
What local systems partnered and collaborated to implement PRK?		✓	✓	✓				
How did homeless service providers and systems collaborate with health care systems or other housing providers (e.g., PHAs)?		✓	✓	✓				
What challenges did partners face and how did they overcome them?			✓	✓				
What data systems did partners use? How was data and information exchanged across partners?			✓	✓				

Research Question by Domain	Data Source							
	CDSS	Web Survey	PRK Community Telephone Interviews	PRK Community Visit Interviews	People with Lived Experience in PRK Interviews	HMIS[a]	Medi-Cal[b]	Criminal Legal System[c]
Participant Experiences								
Did participants think PRK enrollment and service provision were equitable?			✓	✓	✓			
How did their experiences differ compared with other interventions (emergency shelter, interim housing, other congregate settings) they may have participated in during their time experiencing homelessness? Did they feel safer? More in control of their environment? Were they less exposed to violence?			✓	✓	✓			
Did they have greater access to services they wanted? Did their access to permanent housing improve?			✓	✓	✓			
Were they less likely to be arrested? Less likely to overdose?					✓			✓
PRK Costs								
What expenditures did local communities and providers need for successful PRK implementation?		✓						
How did local communities fund housing, services, and other expenditures needed for PRK clients?		✓	✓	✓				
What were the unanticipated costs incurred by communities or providers?			✓	✓				
What have been communities' experiences with FEMA reimbursement?		✓	✓	✓				

Key: CDSS=California Department of Social Services. FEMA=Federal Emergency Management Agency. HMIS=Homeless Management Information System. PHA=Public Housing Agency. PRK=Project Roomkey.

[a] HMIS data was collected from three communities: Ventura County, Tulare County, and Los Angeles County.

[b] Medi-Cal data was not able to be collected during this evaluation. Therefore, this column has been shaded grey.

[c] Criminal justice data was obtained from San Francisco County and Ventura County; however, we were not able to use data from Ventura County because of data quality issues.

Web Survey

The Abt evaluation team administered a web survey to the 54 counties and Tribes that accepted PRK funding. We received 45 responses (an 83 percent response rate). The survey covered topics such as: number and types of PRK sites, planning and implementation of sites, identifying PRK participants, operating PRK sites, PRK services and supports, and program exits.

Telephone Interviews

At the beginning of the evaluation, Abt researchers interviewed staff from state agencies and departments who designed and oversaw PRK. Then, in consultation with the Hilton Foundation, California Health Care Foundation, and state's Department of Social Services (CDSS) staff, the research team selected 15 communities who received PRK grants from the state to participate in telephone discussions about their programs. Abt researchers interviewed three to four PRK partners in each community. The 15 communities were:

- Alameda County
- Fresno County
- Hoopa Valley Tribe
- Los Angeles County
- Mendocino County
- Placer County
- Riverside County
- Sacramento County
- San Bernardino County
- San Diego County
- San Francisco County
- Santa Clara County
- Santa Cruz County
- Tulare County
- Ventura County

Site Visits

In fall 2022, we conducted site visits to five communities: Los Angeles County, San Francisco County, Santa Cruz County, Tulare County, and Ventura County. During the site visits, project staff interviewed county staff, PRK site staff, and people with lived experience in the counties' PRK programs. Staff also visited hotels and motels that served as PRK sites in each of the five counties. At that time, some were still in operation and some had already closed.

California Department of Social Services (CDSS) Administrative Data

CDSS provided the Abt research team with data on PRK sites across the state. Data was aggregated by PRK grantee (mostly counties) and included number of PRK sites, rooms committed, rooms occupied, and participants served. This data was self-reported and submitted regularly (sometimes daily) to CDSS from PRK grantees. CDSS also sent us destination at exit data for participants that exited PRK for programs that were still active in 2021 onwards. PRK grantees submitted data regularly to CDSS and grouped the destinations into seven categories: (1) Permanent Housing, (2) Temporary Housing, (3) Emergency Shelter, (4) Institutional Settings, (5) Unsheltered/Vehicle/Street, (6) Other, and (7) Unknown. It should be noted that PRK grantees stopped reporting data as their programs ended. Ending a local PRK program was determined by the PRK grantee depending on the need, available resources, and other local factors.

Homeless Management Information System (HMIS) Data

Samples. The data we received for Los Angeles included 192,358 enrollments for 112,709 clients, 12,843 of whom had enrollments in PRK. In Tulare, we received 8,561 enrollments for 7,933 clients, 628 of

whom had PRK enrollments. In Ventura, there were 21,587 enrollments for 3,776 clients, 567 of these clients enrolled in PRK. In all three communities, clients not enrolled in PRK had enrollments in other emergency shelter programs. We reduced this dataset to include only enrollments with an exit date. We also excluded non-PRK enrollments from participants who were also enrolled in PRK.

In Los Angeles and Ventura, the data included multiple enrollments for many of the participants, sometimes including multiple PRK enrollments with different enrollment dates. The analysis dataset that we created included data collected upon program entry and data reported at program exit. After excluding non-PRK enrollment from participants who were also enrolled in PRK, we created a person level analysis dataset by taking the enrollment data for the first entry date for each participant and the exit data for the last exit date for each participant.

The Los Angeles data that we received included data collected at different timepoints. The data tables for the health and domestic violence data, income benefits data, and employment and education data included an Information Date field, corresponding to the date of collection, and a Data Collection Stage. Data collection stages of 1 indicates project entry, 3 indicates project exit, 2 indicates project update, and 5 indicates annual assessment. For such data, we took the record collected at the date closest to, but not after, the enrollment date. When there were duplicates (records having the same recorded data collection date), we prioritized records by data collection stage. After a careful review of the data with duplicates, we prioritized including data collected at the annual assessment (DCS5) followed by the data collected at a project update (DCS2) followed by data collected at project entry (DCS1).

At the time of the data was extracted for the evaluation's analysis in LA, 103,567 clients had exited their respective programs. Of these clients, 12,422 exited PRK and 91,145 were in Non-PRK Emergency Shelters. In Tulare, 7,670 clients had exited their respective programs at the time of data collection. Of these clients, 573 exited PRK, and 7,659 exited a Non-PRK Emergency Shelter program. In Ventura, 3,607 of these clients exited their respective programs. Of these 3,607, 459 exited PRK and 3,148 exited a Non-PRK Emergency Shelter program.

All descriptive statistics from the HMIS were derived from the population recorded as having exited one of these emergency shelter programs.

Variables. We created a combined race-ethnicity variable. In the three communities, there are variables for race including: American Indian/Alaska Native, Asian, Black/African American, Middle Eastern or North African, Native Hawaiian or Pacific Islander and White. We considered someone to be "Hispanic/Latino" if the field indicated they were such. Otherwise, we considered someone to be "White, non-Hispanic" if "White" was their only race listed and their Ethnicity was not Hispanic/Latino. Similarly, we considered someone to be "Black, non-Hispanic" if "Black" was their only race selection and their Ethnicity was not Hispanic/Latino. We considered all other participants, including those who indicated multiple races, to be "Other" race-ethnicity. The "Other" category includes non-Hispanic clients whose race are American Indian/Alaska Native, Asian, Black/African American, Middle Eastern or North African, Native Hawaiian or Pacific Islander, or multiple of these.

We created a gender variable with three categories: female, male, and transgender/gender non-conforming. For the latter category, we combined participant responses indicating non-binary gender and transgender due to low frequencies.

In Los Angeles and Tulare, our analysis included type of health insurance upon program entry (e.g., Medicaid, Medicare, State Funded, Other). In Ventura, we received data on whether clients had health insurance but not insurance type. In all three communities, we limited analysis to insurance information reported at assessments within 180 days prior to program entry, and we used the assessment closest to (but before) program entry.

Participants reported two types of living situations in the HMIS: their living situation immediately prior to program entry and their destination at program exit.

We observed 32 distinct living situations in our data and, for reporting purposes, aggregated them into a smaller number of categories. These were based on categories found in the 2020 HMIS Data Standards but deviated from it in key ways. Whereas the Data Standards classify transitional housing as a "temporary or permanent housing" situation, we classified it as a "homeless" situation since it is included in HUD definitions of "literal homelessness" and "sheltered homelessness." In addition, we subdivided the "temporary or permanent housing" category into "rented/owned housing" (i.e., housing that participants themselves rented or owned) versus other forms of housing (e.g., staying or living with family or friends). Thus, our major categories were "rented/owned," "other housing," "homeless," "institutional setting," and "other."

Within these major categories, we also created subcategories. For "homeless" situations, we grouped emergency shelter and safe haven into one subcategory and kept transitional housing and unsheltered situations separate.

For the tables, we distinguished between those who rented or owned with a subsidy versus without a subsidy. Within "other housing," we distinguished between staying or living with family versus staying or living with friends versus some other housed situation. Because of the limitations of the table format, we wanted consistent categories for prior living situation and exit destination in the tables. For "institutional setting" situations, all categories had small percentages. Therefore, we combined all of these situations and reported a single institutional setting category. Finally, the general "Other" category of living situations included cases where participants were deceased (applicable to exit destinations only) or had some unspecified living situation.

We collapsed prior living situation at program entry into the categories "Rented/Owned Housing," "Family or Friends," "Homeless," "Institutional," "Other (Temporary)", and "Other" to look at common pathways clients followed from program entry to exit. We collapsed destination at program exit the same way as prior living situation except for "Family or Friends." For destination at exit we distinguished between temporary and permanent stays by creating the categories "Family or Friends (Temporary)" and "Family or Friends (Permanent)." After creating the categories described above, we combined prior living situation at entry and destination at exit into one variable to describe the pathway each client followed from entry to exit.

Missing Data. For purposes of this report, we considered "don't know," "refused," "data not collected" and blank responses to be missing. We calculated all percentages out of the total number of participants with a non-missing response for a given characteristic. Thus, the denominator varied slightly, depending on the characteristic being reported.

There were some variables we could not include in our analysis due to high missing rates. In Los Angeles, these included disability type, chronic health condition, mental health problems, and substance use problems. These variables were not available to analyze in Tulare or Ventura. In Tulare, variables with prohibitively high missing rates were the number of times and number of months homeless in the past three years at program entry. Other variables in Tulare with missing rates too high to be analyzed were those related to income and employment. The missing rate for whether the client was a domestic violence survivor at program entry was low enough to be analyzed in Los Angeles but not in Tulare or Ventura.

Analysis. There were statistically significant differences between PRK and non-PRK participants on most demographic measures in all three communities. These differences generate bias when comparing outcomes between these two groups. To reduce this bias, balance correcting weights were estimated and applied to analyses comparing PRK and non-PRK participants.

To support the descriptive analysis, we tested for statistical significance in housing outcomes between the PRK and Non-PRK participants and between subgroups among PRK participants (e.g., gender, race-ethnicity, and program duration). Transgender/gender non-conforming participants needed to be excluded from the significance tests due to their low frequencies.

Exhibit A.2. PRK Evaluation Data Collection Activities across California