MEMORANDUM

To: CES Participating Agencies
From: Policy & Systems Department Staff, Los Angeles Homeless Services Authority (LAHSA)
RE: Public Comment and Staff Responses on Housing Navigation Guidance
Date: June 15, 2018

Purpose

In February 2018, new Housing Navigation Interim Guidance was placed under administrative review to allow for community stakeholders to provide feedback and for LAHSA to review and subsequently revise the guidance. This memorandum summarizes public comment and LAHSA staff responses in order to highlight the key revisions made between the original January release and the re-issuance of the guidance in June.

Background: Housing Navigation Interim Guidance’s Development and First Release

Housing Navigation is street-based housing-focused case management provided in service of the goal of finding and securing permanent housing. LAHSA’s Housing Navigation program bridges a critical gap in the Coordinated Entry System (CES) by serving homeless participants who do not yet have a primary case manager assigned to them, in order to help move them along the path to permanent housing.

The Interim Guidance as issued on January 17, 2018 directed LAHSA’s Housing Navigation contractors to only enroll new participants who scored above a specific threshold on the CES Triage Tool (a 12 and above score for adults and a 8 and above score for youth) into their programs. In addition, the guidance included an exception process in order to allow flexibility where necessary and to enable system-wide tracking of these situations.

The guidance aimed to address three key issues within the homeless services system:

1. **To ensure the Housing Navigation resource is used strategically.** Housing Navigation contracts were intended to fill a critical gap in the system by ensuring that people have case management services to navigate to permanent housing, especially those who are least likely to self-resolve and most likely to die on the street.

2. **To respond to critical concerns expressed by housing providers.** Housing providers have reported challenges with filling their vacancies through CES, in part due to the difficulty in locating persons with sufficient documentation quickly. Some housing providers have experienced financial penalties as a result of these delays.
3. **To integrate Permanent Supportive Housing (PSH) resources into CES.** County Strategy D7 PSH resources are matched through CES. In order to utilize these resources efficiently and effectively, the system needs to have a pool of the highest acuity CES participants engaged and ready to quickly move into permanent housing in every Service Planning Area (SPA).

**Summary: Public Comments Submitted in Response to Initial Release**

The public comment period closed February 14, 2018. LAHSA received 21 written public comments, submitted by CES leads, community providers, and the general public. Additional comments were collected from the Los Angeles Continuum of Care Board.

LAHSA’s Policy and Systems Department staff reviewed and organized the public comment into topical categories. Following is a summary of these comments and LAHSA staff responses.

1. **Lowering Score Thresholds:** LAHSA received a number of comments suggesting lowering score cutoffs for both adults and youth in the Housing Navigation Guidance. In the initial guidance issued on January 17, 2018, adults scoring 12 and above and youth scoring 8 and above were prioritized for Housing Navigation services.

   **Revision to Guidance:** LAHSA used countywide data to inform the initial guidance. However, each Service Planning Area (SPA) may have different characteristics within the populations providers serve, and so LAHSA staff reviewed SPA-specific participant data and observed variation across LA County. To account for this variation, the score threshold has been adjusted to 8 and above for both youth and adult enrollments. The Housing Navigation Program Exception Request form remains a valid way to request program exceptions.

2. **Flexibility Needed:** LAHSA received comments from providers expressing a need for flexibility to work with a diverse range of individuals and acknowledging that focusing on 12 and above may require smaller caseloads. Comments also suggested that case conferencing should be the table for decision-making around prioritization of scarce resources. LAHSA received suggestions from providers to allow a defined percentage of the Housing Navigation services for use with for adults who score below 12 and youth who score below an 8. Other suggestions included revising performance measures to lower placement goals.

   **LAHSA Staff Response:** LAHSA provided the exception process to be able to provide flexibility to agencies to enroll people who are low-scoring but who case conferencing has identified as a good candidate for Housing Navigation. By shifting the current caseloads to include more vulnerable participants, LAHSA acknowledges that performance outcomes may need to be re-evaluated.

   **Revision to Guidance:** The revised Interim Guidance allows adults and youth with an acuity score of 8 or above to be prioritized for LAHSA funded Housing Navigation services. Exceptions for those with acuity scores below 8 may still be made via the Program Exception Request form.

3. **Score and Actual Vulnerability:** LAHSA received comments stating that score is not always an accurate reflection of a participant’s actual vulnerability and that there are other factors that must be taken into account.
LAHSA Staff Response: LAHSA acknowledges that the CES Triage Tools (CES Survey Packet, VI-FSPDAT, and Next Step Tool) may not always accurately reflect a person’s vulnerability. To address this concern, LAHSA issued Interim Guidance, “Updating and Correcting Population-Appropriate CES Triage Tool Scores,” on January 17, 2018 to provide guidance on when it is necessary to update a participant’s acuity score. Further, a participant’s score on a CES Triage Tool should not be the only factor in determining service interventions. Program exceptions were built into the Guidance to allow for flexibility.

4. **Vulnerabilities of the Aging Population**: LAHSA received comments that articulated concern that the CES Survey Packet does not adequately score the vulnerabilities of the aging population, and so aging adults would not meet the 12 and above threshold.

LAHSA Staff Response: In addition to lowering the threshold to 8 and above, program exceptions were built into the guidance to allow for flexibility in participants served.

5. **Detailed Exception Criteria**: LAHSA received comments requesting defined criteria of the circumstances that would result in an exception.

Revision to Guidance: The new guidance has defined three circumstances under which an exception may be granted, but remains open to considering other rationale. Part of the intention of Interim Guidance in general is to test new practices before developing formal policy. Learning the determinants that lead to exceptions will help to inform further policies, and so exception requests will be considered on a case-by-case basis even when they fall outside the three criteria listed in the guidance.

6. **Lack of Services for Lower Acuity Participants**: LAHSA received comments noting that in prioritizing participants with higher acuity scores for Housing Navigation, there will be limited resources for those whose scores do not qualify them for Housing Navigation.

LAHSA Staff Response: Resource constraints across the system necessitate prioritizing those people most in need for limited resources. The intent for Housing Navigation is to ensure that the most vulnerable individuals receive the assistance necessary to support quick placements into permanent housing.

7. **Lack of Eligible Participants**: LAHSA received a few comments from particular SPAs indicating that PSH is limited in their area, especially for people with a variety of service needs.

LAHSA Staff Response: County Strategy D7 creates greater PSH resource distribution across the county, including in SPAs that historically have had few PSH resources. Prioritizing people with high acuity scores for Housing Navigation will help prepare them for upcoming PSH and will help ensure SPAs with little PSH can take full advantage of these resources as they become available.
Community Feedback on Housing Navigation Interim Guidance

- What is the driver for this? It does not seem like a linear decision-making path. What other systems that we work in conjunction with need to change simultaneously? Federal Social Security benefits need to increase to cover rents? More buildings not vouchers? What do we tell people as agencies? How do we access funding to help everyone else?

- More Crisis and Bridge Housing in SA4

- Limiting whom to serve is counterproductive to the goal of stimulating continued growth in our provider community. The same agencies can’t continue shouldering this work – agencies have been discouraged to engage in CES based on restrictions limiting resources availability to the populations they generally serve.

- There are other less restrictive policy approaches that could facilitate appropriate prioritization and ensure a pool of eligible PSH applicants while considering Homeless Service Providers need for flexibility to prioritize based on resource availability and clinical judgment, not solely based on an assessment score.

- Individuals scoring an 8+ are suggested to require long-term supportive services, but this policy restricts agency’s ability to navigate those individuals to appropriate housing interventions. Large sectors of persons experiencing homelessness will be restricted from gaining necessary support and housing resources in an already limited resource environment.

- The recommendation that persons scoring 8+ should be prioritized for RRH draws limited RRH away from persons for which RRH may be an appropriate intervention, whereas RRH is less often an appropriate intervention for someone scoring 8+.

- Lack of PSH resources and focusing solely on persons scoring 12+ will likely create system bottlenecks and slow down/limit the number of people entering housing.

- This guidance is very helpful and I appreciate the recognition that youth prioritization needs to start at a lower cutoff score. I think it would also be worth clarifying in this guidance who is responsible for designing this prioritization. Presumably, Housing Navigation slots would be filled through CES with the lead agency for each population making referrals to HN accordingly. This guidance would be enhanced if it identified the referral and enrollment processes as that is indicative of how prioritization will actually occur.

- This is worthless without an accompanying explanation of how acuity is scored; the document says NOTHING about youth. Disappointing.

- I believe this policy should be indefinitely withdrawn and a new viable policy developed. Prioritizing such high scores to all housing navigation team members would create a bottleneck. High Acuity individuals require long term supportive services and this policy would restrict the ability to navigate the appropriate candidates to the resources available. This would also leave resources unmatched because no persons would be fitting as decided by the resource. Filly caseloads with high acuity individuals will leave those scoring below the proposed prioritization still on the streets for even longer periods of time. Many current issues stand with PSH rejecting high scoring individuals when there should be no set back in this resource for these persons. This is an area to address that is not and cannot be addressed in a policy such as this. Addressing this could result in an immediate increase in higher scoring individuals being placed in housing. Perhaps a feasible resolution would be to regulate eligible persons, that eligible persons must be Priority 3. Lastly, the VISPDAT, though it is a helpful tool, it is not an efficient tool at quantifying barriers. The creator stated the tool is merely a starting point, but should not be a definitely guiding tool. Many providers and navigators have stated the inconsistencies with the tool when assessing the needs of an individual. Someone may score a 9 but really should be considered for housing resources for those scoring a 12+. With this policy, these clients would not be housed although their need could very well be at that level. Agencies are already prioritizing these high scoring individuals and the reason you see less served is not that they aren’t, it’s that getting them to that point is a much longer process. There is no reason others shouldn’t be assisted while engaging those who require more attention. I realize there is an “Exception” form that must be submitted for approval to match a lower scoring person to a Housing Navigator, but this only elongates the process of matching. It also exhibits a distrust of those working directly with the clients. If there are any better people to assess an individual’s need/eligibility to matching to a navigator, it’s those on the ground.
working directly with them. Re-evaluating the policy to look at prioritization by ratios would allow more flexibility to avoid bottlenecks, does not ‘promote’ score inflation, exhibits trust and allows the ability to serve the multitude of individuals encountered while matching them to the appropriate available resources. This group of persons is probably being served at about an average of 15% right now. Increase it to 20%.

- We recognize the need to focus limited resources on those individuals with the greatest needs and to navigate them to PSH, and if provided continued flexibility we will continue to focus on those most likely to die on the streets.

- Providers need flexibility to be able to work with a diverse range of individuals to navigate them to an equally diverse set of housing resources, including: nontraditional PSH, family reunification, and other housing for which there are narrow eligibility criteria and 12+ individuals may not be easily located - HOPWA, OTH Vets, etc.

- Though some 11- individuals may benefit from RRH, this potentially shifts RRH resources away from lower acuity individuals for which RRH is a more appropriate intervention.

- Focusing entirely on 12+ would likely require smaller caseloads and result in longer periods from engagement to lease-up, thereby creating system bottlenecks and resulting in less people being housed.

- Decisions about prioritization of scarce resources are best made at the regional level at case conferencing or in Housing Navigation team meetings, not through a request for exception to be reviewed by LAHSA (without criteria for exception established). Local decision making encourages engagement by providers in case conferencing and allows decisions to be made based on individualized local resource availability.

- There are other alternatives to ensure PSH units are leased up in a more expedited fashion, which should be undertaken in relation to CES matching policy and protocols. We can ensure a pool of “match ready” high vulnerably individuals while maximizing the utility of Housing Navigation to serve a greater number of people.

- Flexibility could be provided to providers, while ensuring a focus on the most vulnerable by allowing a certain percentage (20%) of housing navigation enrollments to be for people scoring 11-. Alternatively, outcomes could dictate a focus on 12+ while still providing some flexibility at the provider level.

- Shelter funded by LAHSA through CES is reserved for people scoring 8+. This policy would not be aligned with Housing Navigation Policy, thereby potentially limiting some shelter residents access to housing navigation.

- Limiting access to Housing Navigation also potentially limits non CES funded partner’s participation in CES as access to resources would be less available to the populations they frequently serve. We should be striving for a more inclusive system where we leverage participation from a full range of partners to house persons in need.

- During the webinar, LAHSA representatives repeatedly stressed that this guidance was drafted in response to an identified problem; i.e., a high percentage of mid-acuity folks being enrolled in Housing Navigation. However, there were many problems with this data at the time it was pulled. For example, the transition from Adsystech to Clarity resulted in all of SPA 3’s assessment only records being dumped in to our Housing Navigation program. This means that everyone who had completed a VI-SPDAT in SPA 3 was erroneously “enrolled” in Housing Navigation. Additionally, the funding in the first year of this program (E8) dictated that SPAs 1, 3 and 7 could only enroll folks in HN if they were residing in a LAHSA funded shelter, which mean that all of the individuals we were serving who were living on the streets stayed open in outreach, and were never enrolled in HN, regardless of if we were providing HN services. Many of the individuals we serve who are most vulnerable are those living on the streets.

- Services are still needed for individuals with a lower acuity. What will supplement those services?

- Given limited resources we fully understand the need for prioritization and are 100% on board with placing a focus on those individuals with the greatest needs and who are least likely to navigate their own way to housing, and if provided continued flexibility we will continue to focus on those who need our services most, while exercising appropriate judgement and engaging in case conferencing discussions to maximize the full utility of housing navigation to assist a greater number of people.

- As additional PSH resources become available, and as Housing Navigation is scaled up, we will continue to have more Housing Navigation “slots” available than there are PSH units available. Therefore, while focusing on those
with the highest needs, there is some room to assist a targeted group of TAY and Single Adults who do not score in the highest range.

- There is some dissonance between policy, the expectations/deliverables of the contract, and how serving the highest in need plays out in the field considering the limited amount of appropriate housing interventions.

- I am addressing the issue of only prioritizing adults with an acuity score of 12 or over, with those scoring 16 given priority. Under this scoring system, the vulnerability of homeless older adults is being overlooked under the current prioritization system: the CES Survey, Basic Intake, VI-SPDAT. This occurs primarily in the categories of age, physical condition, length of homelessness, and what can be termed the “invisibility” of older adult homeless, 60 and over, who tend not to access public facilities and providers, such as the police dept. and hospitals. They are most likely to hide in their cars, and therefore tend to score at a lower level than is necessary to access high priority housing. For example, according to the VI-SPDAT, a homeless person 60 years or older only scores 1 point for vulnerability due to age. This seems to indicate that an 80-year-old has the same vulnerability as a 25-year-old.

- Regarding length of homelessness, an older adult of 60+ must be on the streets at least one year to be given 1 point for vulnerability. This suggests than an 80-year-old woman on the streets for 6 months is not considered vulnerable enough to earn one point!

- Regarding risks, a 60+ person must have accessed the police dept, been in jail, or prison, or used a crisis service to be considered vulnerable. Many elder adults fear for their lives and hide in their cars and do not access these services. Does this mean they are not at risk?

- Regarding legal issues, most homeless older adults do not have legal issues that result in being jailed or engage in risky behaviors such as sex in exchange for money. Again, does this mean they are not vulnerable?

- Regarding physical health, homeless older adults have many chronic conditions such as arthritis, cancer, etc. but can only score 1 on this section. This means that a homeless 80-year-old woman with a history of emphysema, arthritis, and breast cancer only scores “1” for vulnerability!

- According to this measure, a former client of mine, an 80-year-old female with Bipolar Disorder, homeless 6 months in her car due to eviction with multiple health problems would only score 7 out of 16 possible points. Does this seem humane? There are many more like her out there, believe me, I work with them every day and I am amazed at how they are underserved and ignored by this present system. Please contact me if you would like to learn more about this distressing situation.

- I think with an acuity score of 12 there will be many individuals experiencing homelessness that will not qualify for housing navigation but will need the services. I think the acuity score should be 8 to qualify for Housing Navigation. People with an acuity score of 8 and above are still in the high acuity range. At the same time, there are individuals that are on GR that need to be placed in Housing Navigation because if they are enrolled in Rapid Rehousing they cannot afford their rent once the program is over. I think this new policy is going to affect our clients in a negative way and they will be more challenges in trying to get them housed.

- We’d encourage LAHSA to keep in mind that the CES survey does not always reflect the acuity needs of women, older adults, and other unique populations. Someone scoring lower than 12 can still have urgent high acuity needs and benefit from Housing Navigation resources. Conversely, sometimes Housing Navigation enrollment is the first time that clients learn about the Rapid Rehousing program. Potentially not enrolling people who score between 1-11 into Housing Navigation may prevent them from being referred to a Rapid Rehousing intervention. Instead of a blanket requirement of only enrolling those who score 12 and above, we would like to recommend that the requirement be separated out into a % of people enrolled in Housing Navigation scoring 12 and higher and a % scoring 1-11. We would recommend that changes to the contract happen at the beginning of the next contract year and not mid-year. These changes might impact a programs ability to reach our goals in the current contracted period.

- This policy would not be aligned with Housing Navigation Policy, thereby potentially limiting some shelter residents access to housing navigation.
• Our program both has Bridge Housing, Outreach, and Housing Navigation. While our contract to Bridge Housing is light touch case management, many individuals in our program rely on the housing navigation services for more in-depth case management to permanent housing. Changes in guidance can affect all our programs and leave many without the needed case management they deserve.

• Many of our clients in housing navigation are an average 7-10. My concern is leaving a lot of individuals without housing navigation services. Our organization thrives on being innovative in finding housing for all our clients with diverse needs. This includes family reunification, OTC Veteran housing, and other housing for higher acuity (>12) clients. What I would recommend is more flexibility for our SPA.

• Rapid Rehousing (RRH) would be strained with these new guidelines as clients below a 12 would probably be recommended to move toward RRH. I am not confident that many clients are able to thrive and maintain permanent housing with their circumstances and may find themselves homeless once again.

• Furthermore, shifting clients who are below a 12 may create unnecessary competition for clients who may need RRH and may benefit from RRH.

• I feel that guidelines should be done on a regional level as opposed to a county level as communities have different circumstances and resources for the clients they serve. For example: SPA 7 has little to no PSH for clients let alone high acuity ones. Our high acuity numbers are low because of the difficulty of working with the environment the client is in (let alone the co-morbidities associated with the client's circumstances). It is not that we refuse to work with them, it is because we have little resources for the end game with them and they remain on our caseloads.

• I feel that the CES system’s intent is to create local collaborations stronger and provides service to a diverse range of homelessness throughout the county. I feel that implementing these guidelines would be counter-intuitive and will exclude a set of our homeless neighbors.

• Limiting housing navigation services to adults acuity 12+ and youth 8+ restrict providers ability to serve the homeless population of the region and coordinate in response to the distinct needs of our region. Service providers must have the flexibility to provide services as needed to the individuals who enter a CES door and restricting housing navigation service to those who score 8+ or 12+ respectively only accounts for one measure of their need and vulnerability. Furthermore, with these scores linked to resources like housing navigation and bridge beds, this does not take into account personal preference and choice, something which has driven the youth system since it’s onset. Youth scores range from 1-14 and we’ve seen this does not determine the level of need they have over the course of a year. Their need changes, but their score does not and we need to be able to work with them when they are ready for help without this restriction barring us from doing so. TAY best practices show that working with youth where they are with limited restrictions and a relational approach versus exclusionary approaches help their success long term. Decisions about prioritization of scarce resources are best made at the regional level at case conferencing or in Housing Navigation team meetings. Providers need flexibility to be able to work with a diverse range of individuals to navigate them to an equally diverse set of housing resources.

• I’m operating under the assumption that the primary reason for having "matching" to Housing Navigators is that we want to ensure we’re triaging/prioritizing appropriately and connecting people with the highest need to Housing Navigators first - similar to matching PSH resources to the most vulnerable. While I agree that we should generally be focusing limited housing navigation resources toward the most vulnerable individuals, I see some issues with trying to have a formal matching protocol/process for matching people/clients to housing navigators. I also wonder how prevalent the perceived issue of navigators not working with highest scoring people is, and if there has been thoughtful analysis of that data and the real impact. Lastly, there may be other options to meet the goal/intention described above. I'll start with recommending an alternative solution - I've advocated for a while now that CES (and other) outcomes should be focused on the end goal and that the goals should be communal. This promotes sticking with people/clients through tough times, minimizes "creaming," promotes inclusiveness and cooperation, and allows different programs/agencies/staff the flexibility necessary to utilize expertise/creative solutions and niche to meet the goals. So, if the goal is to ensure navigators are working with the most vulnerable people, you could make the performance measures be about the number of people housed at various acuity levels. This is not dissimilar from our past year's UW-HFG goals that asked us to house a certain
number of "3's." I believe our current goals just ask us to serve a minimum number of people and link them to housing search and placement. This could, for some people, encourage working with lower vulnerability people that could get linked to the significantly higher resourced RRH programs or are easier to house. As far as the data - Do we have data to demonstrate that highly vulnerable people aren’t entering into permanent housing, or that there are trends that show the number of highly vulnerable people entering PH is significantly lower in the past? If so, have we taken into consideration things like: the number of PSH units available, some of the people unhoused are the hardest to serve, we've been encouraged to not just focus on chronic but all pops, etc. If evaluating the characteristics of people/clients enrolled in the HN HMIS program, in addition to what I’ve noted above, I can tell you that the program enrollees are not an accurate representation of the HN’s caseloads. This is in large part due to the HMIS software transition. Something like 1,500 records from our “assessment” program were transferred into our HN program, and we’re working to clean that up. As for matching itself- Some of the same issues that we’ve seen, and made necessary that we rely on things like matching outside the system, relying on clinical judgment, scores not being reflective of need or goodness of fit, and making exceptions to the prioritization guidelines would no doubt also be issues. The community in general agrees that the CES assessment score is not always reflective of the need, therefore to limit access to housing navigation on score alone is negligent to those with equally high needs. The VI-SPDAT was never intended to be used as an eligibility criteria, but rather as a pre-screening tool to make a suggestion as to what housing intervention might be more appropriate. The CES Policy Workgroup has been discussing these very issues and in on the cusp of making a recommendation. It would be appropriate to wait for the work group’s recommendation. There are a few other things to consider as well. Even lower vulnerability people/client very often require some housing navigation assistance to get linked to appropriate supports/resources/housing, and I think we do want to continue to route people to RRH when appropriate. We’ve been trying to promote/ensure "CES for All," to demonstrate that CES isn’t just for chronically homeless high acuity anymore and to bring in partners (paid and unpaid) that focus on a variety of populations. The vast majority of “housing navigation” is not funded by LAHSA, and therefore will likely continue to focus on their preferred population, regardless of LAHSA policy. As much as it would be nice to have them all get with the program, we still need them to be at the table and contributing. I know we’re getting a few more dollars, but I think we currently have only 3 LAHSA funded HN’s, two of which are actually outreach. This last comment might not be very PC, but I think it’s a reality we should recognize... Sometimes we need to focus on low hanging fruit. While we should absolutely be prioritizing limited resources for high need individuals, which we do, this can and does create bottlenecks in the system. Since CES, and prioritizing chronic high need folks, our average length of stay at our shelter has actually gone up and not down. I'm mostly ok with this though because these high need people are generally ending up in housing. However, this, of course, means less beds are available to other people. I believe our HN’s should also be free to have balanced caseloads, not only to avoid burnout, but also to have the opportunity to identify and work with people that they can perhaps more quickly navigate to housing - even if they sometimes aren’t always the most vulnerable. In a way it’s similar to how we’re triaging for the shelter. Just because someone is high vulnerability, it doesn’t mean they get the first bed. We’re trying to use this limited resource to do the greatest good by prioritizing people who are en-route for a housing plan - this is the whole idea of bridge housing.

- A priority score of three is needed for minimum 80% of all Housing Navigation enrollments.

- I understand the purpose of needing a policy however, I think that given the nature of this work, a restrictive policy is not helpful. Housing Navigation should have built in flexibility and guidance not criteria for eligibility. Instead of restricting those served to high acuity (12 or above) there should be a percentage allocated to the various acuity groups so that this resource is inclusive and addresses the need but makes an added effort to work with high acuity folks. All this to say, a better strategy might be to say that 50% of those enrolled must but 12 or above, 25% in the 8-12 group, and 25% in the 8 or below group.

- This piece (exceptions) needs more explanation. Is this exception intended to be completed to enroll someone or to re-enroll after exiting? Also does this entail additional paperwork? If this second question is yes, this just feels like another bottlenecking step.

- Score shouldn’t be a determining factor for Navigation. Anyone who is matched to needing supportive services should be eligible. That was the intended purpose of that program. If we start differentiating scores we are excluding a significant group of people from accessing help.
• PATH thinks we should target services to more vulnerable folks, but not limit who's enrolled because scores often don't reflect actual vulnerability and we see people decompensate on the street without being reassessed (especially if they're not assigned a housing navigator). This is why I think having placement goals for high acuity folks would achieve the aim of targeting more vulnerable without limiting who we are able to serve. United Way used to do that, and it worked!

• Rather than excluding people from being enrolled, I think LAHSA should set placement goals for high acuity folks (ex. 40% of people placed need to have a score of 12 or higher.) would achieve the aim of targeting more vulnerable without limiting who we are able to serve.

• In the youth system, we have found that the acuity score does not always reflect our youth’s vulnerabilities as many of them do not feel comfortable answering certain questions on the Next Step Tool honestly if they do not know or trust the person conducting the tool. Up until this point, we have been able to decide as a community through our care coordination meetings what the most appropriate housing resource is for our youth who we feel may not be accurately represented by the acuity score they were given. The Housing Navigation Guidance will put too much emphasis on an acuity score, something that LAHSA has encouraged us not to do, and will prevent us from being able to serve many of the youth we are currently able to serve now. It was my understanding that CES is supposed to make the housing process fair and low-barrier, however, this interim guidance is taking the control away from the SPAs to determine what is best for the individuals they work with, and makes it harder for individuals to access services they need.

• If the acuity moves to 11 and above, time for additional outreach and engagement of these individuals should be accounted in the contract outcomes

• I have a question about the navigation and housing resources changes and case scenario to consider when thinking about the impact these changes will have on the work done on the ground level around the County. We were presented with a woman a few months ago who for several reasons did not find housing through the HOPWA resources at Alliance for Housing and Healing and Foothill Aids Project. She was in and out of hospitals all her life for surgeries on different conditions, got her disease from a surgery, became blind from a surgery, and was taking care of her mother for several years until last spring when her mother became too sick and was put in a nursing home, and then her brother kicked her out. Many people look at her case and say she needs higher level of care BUT this person does not want to do that and wants autonomy. And, in fact has been able to live in a motel with an IHHS worker and mobility supports in place. They had put her in a motel last year when she became literally homeless but it ran out after 6 months so the FAP staff brought her to our case conferencing meeting. They referred her to CES and an assessment was done. She scored a 4 at that time on the assessment. The only option we were able to consider was putting her in a motel with our CES funds and do a Housing for Health application which she passed eligibility for. Richy Myers looked at her case and questioned how she was only a 4 so I, as matcher who does the Housing for Health apps, reviewed the assessment then spoke with her and looked at her records that were on file. She does not meet some of the risk factors as she was never on the street and reports and exhibits only symptoms related to the distress from her situation so does not have a mental health dx. She has high acuity medically but not necessarily using the CES Tool. So, my question I propose to LAHSA is what do you expect us to message to providers and people out in our communities. She doesn't require limited assistance to be rehoused and I can’t see where you would change the answers on that assessment to reflect her vulnerability as the VISPDAT does not capture her areas of vulnerability. The reality is that we are seeing people in outreach and in our shelters who are older and have physical health issues but want independence so I want to know how LAHSA wants to guide us on working with this when all the affordable senior buildings are filled and the assisted living waiver fund is capped and on hold for the next year and the other modes of living remove a large amount of autonomy from people. I am in dialogue with Alliance for Housing and Healing to see if anything can be done and she does have allies in the community but finding a place for her outside of CES has been fruitless and finding one in CES is fruitless too. I am almost feel like the only options is newspaper articles and Go Fund Me campaigns...Thank you for reviewing - Barbra Bowman

• Presently youth in Probation camps historically score very low on the NST - until the Justice SPADT is implemented should programs submit Housing Navigation exception requests?
• How would a LAHSA-funded CES Housing Navigation be able to refer clients to permanent supportive housing if they score below a 12 with these guideline changes?

• How long do we try to initiate contact or find these individuals before we move on? What’s the protocol if a client denies HN services, and once all the interested individuals have been connected to a housing Navigator what’s the protocol for prioritizing new slots below 12+, or do we leave slots open until 12+ clients become available? How far back should we run reports for individuals to find candidates for HN program?