HUMAN SERVICES GRANTS PROGRAM (HSGP)

FY 2020-21 PROGRAM STATUS REPORT

Agency: \_\_The People Concern\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program: \_\_Access Center\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### FY 2020-21 SUBMISSION CALENDAR



**Instructions:**

* This document should be used by HSGP grantees to report on mid-year and year-end outcomes and accomplishments.
* All reports submitted to the City are considered public record. Please note that staff will use the information provided in the mid-year and year-end reports to provide Council and the public with summary reports of agency performance highlighting key outcomes, successes, findings and concerns.
* Some programs or agencies may be subject to additional or different reporting requirements per the program’s Exhibit A, Special Funding Conditions, of your executed Grant Agreement with the City.
* It is important, when preparing this report, to be familiar with the program’s Exhibit B, Program Plan, of your executed Grant Agreement with the City.
* Please insert responses in the spaces provided for Sections I-VII for both the Mid-Year and Year-End Program Status Reports.
* A separate Program Status Report must be prepared for each Program Plan specified in your contract.
* To submit your completed report to the City, upload the file to your agency’s SharePoint folder. A link to your agency’s SharePoint folder as well as instructions on how to use the site will be emailed to your staff separately.

**SECTION I: PROGRAM ACCOMPLISHMENTS, CHALLENGES, AND CHANGES**

**Overview:**

The Access Center, located in downtown Santa Monica, is an entry point for homeless individuals to meet basic needs and receive integrated services. It is the main point of entry for many of our clients and provides basic services to an average of 250 people daily. In addition to the outreach and engagement that is crucial in helping the most vulnerable rebuild their lives, the Access Center provides a large variety of services including daily sack lunches and other meal programs, linkage to interim and permanent housing, mental health services, community referrals, and a mail and phone service. A shower, laundry, and locker program (SWASHLOCK) helps clients maintain their hygiene and store belongings while they work or access services. Venice Family Clinic’s onsite medical suite provides health care. The Wellness Coordinator works with the outreach team to engage hard-to-reach individuals with individualized services using evidence-based methodologies.

The COVID-19 pandemic dramatically affected the way services were provided over the past year. Since the beginning of the COVID-19 crisis in mid-March 2020, Access Center services have been modified substantially. Nearly all services have continued in a modified form and with reduced capacity, and some new or expanded services have helped address needs caused by the pandemic. For example, many clients had been able to use restrooms and charge their phones at public libraries and local businesses prior to the start of COVID-19; now that these options are unavailable due to the pandemic, the Access Center was able to use creative problem solving to fulfill this unmet need. By leveraging a grant for the Access Center, the agency was able to purchase high-end charging towers with the capacity to charge 10 phones and devices at a time. Participants could charge their phones and other devices while connecting to other Access Center services. As we know, the ability to maintain a charged phone at all times is critical, as this may be a participant’s only lifeline to stay connected to services, including accessing permanent housing. During this reporting period, most Access Center services are again available in person, based on an individual’s unique needs.

The Access Center was the only community-based daily resource center in Service Planning Area 5 (SPA 5) that was open since the start of the pandemic. While other organizations closed for some months, the Access Center quickly pivoted and implemented safety protocols while continuing to provide all of its needed services. Some services, like the meal services, saw a significant increase of consumers during this period. During the 12-month reporting period, the Access Center provided 65,375 sack lunches. The Access Center takes deep pride in this accomplishment, as this service represents a 10 percent increase over lunches provided in the same period the previous year, even while the pandemic limited capacity and access to resources. Through these actions and others, the Access Center fulfilled a great need in the Santa Monica community.

Masks, social distancing, and sanitizing are strictly observed throughout the Access Center and SWASHLOCK. Clients coming to the Access Center are required to wear masks and if they do not have one, masks are provided to them while they are waiting in line for services. Social distancing is ensured by tape marking the ground at 6-foot intervals both inside and outside the Access Center. Staff are required to wear personal protective equipment (PPE) at all times. Gloves are now required during any client interaction. Disinfection occurs after every client contact, and a deep cleaning conducted frequently.

While the state and local authorities have recently relaxed safety and health requirements, staff at the Access Center began expanding services in January 2021 while continuing to take precautionary measures to protect clients and staff. To this end, case managers are now seeing clients on site and in the field more regularly while still utilizing phone appointments when that is the preferred method of engaging in services by the client or the safest way for a client to access services given their current health status. Temperature and symptoms checks occur for staff at the beginning of each shift and every client who enters the premises for services must also have their temperature and symptoms checked. In addition, the Venice Family Clinic (VFC), which is co-located at the Access Center, still utilizes phone or video appointments, but has increased their walk-in capacity and can now see patients on site. Patients are referred to the Rose Avenue Clinic or the VFC main office the following day if walk-in slots are filled or if they require a service that cannot be administered on site.

Since clients are unable to spend as much time inside the Access Center due to the new protocols, some congregate in front of or next to the Access Center. Our Safety and Engagement team, with support from a private security service, works to disperse loiterers, de-escalate conflicts and maintain a clean and orderly environment using trauma-informed practices. Signage indicates all appropriate mask, physical distancing and cleaning protocols, and these are enforced by our Safety and Engagement staff.

**Accomplishments**

**Housing:**

Access Center Case Managers continue to focus on placing clients in interim and permanent housing. Of the approximately 250 individuals to receive daily basic services, 227 unduplicated individuals were enrolled in ongoing case management services, of which 85 were SMPPs. 38 of the 85 SMPP clients in case management were previously housed and are continuing to receive retention services through the Access Center case management team. 36 of the 38 individuals were able to successfully maintain their permanent housing status throughout this year. Of the remaining 47 participants who were unhoused at the start of the fiscal year, we placed 12 SMPP into permanent housing and eight SMPP into interim housing.

Of the remaining 27 unhoused SMPP clients, four clients are holding vouchers and are currently searching for apartments, three clients submitted or are in process of submitting SMHA applications, 13 participants are currently working on gathering the necessary documentation, and seven were ineligible since three of those seven exited the program before we could apply for a SMHA voucher, three of the seven were undocumented, and one of the seven is now deceased. Especially notable, all SMPP clients are now eligible to apply for SMHA vouchers as a result trainings our staff received to conduct more accurate CES assessments. In addition, our staff conducting CES Revision Tools have led to increased CES matches.

To aid our clients in getting housed, Access Center implemented numerous trainings. The Access Center staff received trainings on DMH IHP referrals, which lead to increased interim housing placements throughout the year. Case managers received training to educate them on Covid-19 vaccinations as part of our contractual obligations to LAHSA so they can receive the vaccinations and bypass the quarantine stage of their sheltering process. In addition, The People Concern’s Directors of Interim Housing provided training to the Access Center on their referral process into each of their shelters, which provided greater clarity on our internal system and allowed our program to increase interim housing placements.

The Access Center has participated in the City of Santa Monica’s Project Homecoming since its inception and makes all the arrangements for housing placement, transportation, and background checks. A case manager is assigned daily as the designated person to manage Project Homecoming clients so that we can move quickly when a person is interested in this program. Twenty-five households utilized Project Homecoming to secure housing with friends or family during the reporting period.

All clients were encouraged to take advantage of the LA County Winter Shelter program once it opened and were provided with the necessary information to do so. We use the LAHSA interim housing referral process to help clients find temporary placements when they are available. Access Center case managers conduct assessments for Project Room Key and refer appropriate clients into the program. During this reporting period, 25 people were referred to Project Room Key, two of which were SMPP. When a client is accepted into Project Room Key, our staff provides transportation to the site, as well as ongoing case management for those clients.

The SPA 5 Coordinated Entry System (CES) has limited the eligibility for matches to housing resources to those clients with an acuity score of 17 on the VI-SPDAT universal assessment tool, which makes it difficult to find permanent supportive housing for those who have lower acuity but are otherwise considered a fit for permanent supportive housing. Our staff works to find alternative housing resources for these clients, such as shared housing, family reunification, board and care homes, or skilled nursing facilities. As needed, staff reevaluate clients’ VI-SPDAT scores using LAHSA’s CES Score Revision Tool to ensure client acuity scores accurately reflect client’s current vulnerability and eligibility for permanent supportive housing matches.

**Service Registry:**

Of the 85 clients who are SMPP, 61 individuals are also Service Registry participants. Forty-one of the sixty-one are unhoused participants. This reporting period, 10 service registry applications were submitted in order for Access Center staff to be able to submit SMHA applications on behalf of these participants.

**Case Management Services:**

Although the Access Center sees on average 250 individuals daily for basic services, due to COVID-related capacity restrictions, case management service enrollments were significantly reduced across the program for all participants. At year end, due to the pandemic, 227 of the annual target of 435 total participants (52 percent) were enrolled in ongoing case management services. Still, the agency continues to prioritize case management for Santa Monica Program Participants (SMPP), and at year-end has served 85 of the annual target of 154 SMPP’s (55 percent). Eligible SMPP are prioritized and able to access case management services immediately, including all people referred by the City. The Wellness Coordinator and triage coordinator assist in scheduling case management appointments. The Outreach Case Manager works to build rapport and conduct intakes on SMPP clients, motivating them to come to the Access Center for services such as meals, showers, or VFC medical care as a first step to enrollment in case management. Notably, case management services may be provided on the streets for individuals with physical barriers that keep them from entering the Access Center. While this service is rare and only offered to clients who cannot physically reach our site, staff will make exceptions to provide some services to the most vulnerable so that they can begin their transition into permanent housing.

This reporting period, 47 unhoused individuals and 38 permanently housed individuals received case management services through the City of Santa Monica contract. The unhoused individuals are working towards interim housing placement, Section 8 vouchers, or assistance through the City’s Project Homecoming program. They are also working to produce the required documentation (such as birth certificates, driver licenses, and proof of income), increase life skills, and to increase their income. Notably, 77 of 85 individuals (over 90 percent) increased or maintained their income this program year.

Case management orientation re-started in September under COVID safety protocols. In small, socially distanced and masked groups, clients are asked to complete enrollment information and provide any documentation they may have available. They learn how The People Concern will help them apply for housing and financial assistance, and what other services are available to support their transition into permanent housing as well as other personal goals. This may include obtaining identification, verifying their homeless status, screening for benefits eligibility, and other elements of housing readiness.

During this program period the Access Center added two new field-based case managers who work with the Mental Health Team, bringing the total case management staff to six. The Access Center has also integrated mental health services of The People Concern’s Field Based Mental Health program, which is funded by the Department of Mental Health (DMH) into daily programming. Two clinicians provide ongoing support, including individual and group treatment, as well as medication management, to clients who have been identified as having ongoing mental health concerns.

**Wellness Program:**

Beginning in July 2020 we were able to re-start housing readiness groups which had previously been discontinued due to COVID-related staffing reductions, including a weekly group each Monday afternoon (1 p.m. to 4:30 p.m.) when clients can obtain a voucher that covers the cost for a new identification card from the DMV so they can make progress on completing documentation requirements for housing placement. Tuesday afternoon groups (1 p.m. to 4:30 p.m.) offer a time when clients can receive assistance in increasing their income through General Relief, Unemployment, jobs, and Social Security (retirement and disability). The Wellness Coordinator helps clients by screening for eligibility for these income opportunities.

A vital service for clients during the pandemic is having a place to charge their phones and other devices that provide a vital link to services, family, and other resources. Clients had been able to plug in at a library or a coffee shop, but with the Stay at Home Orders in place, many of these locations closed their doors. Starting in September we opened a charging station at the Access Center. Clients can drop off their devices to be charged while they are accessing other services at the Access Center. The charging station is open for several hours on Mondays and Thursdays and longer hours on Fridays. Clients must have identification and are required to sign a charging station protocol form before being able to utilize the station. Clients who do not have an ID may attend the Identification group on Mondays where they can obtain a voucher for support in obtaining an ID card at the DMV.

The Triage Coordinator staffs a drop-in resource table at the Access Center every Tuesday to provide Access Center resources while clients are not able to come into the lobby due to the pandemic. The Triage Coordinator offers simple referrals to resources including shelters, employment assistance, shared housing opportunities, and other resources that may be needed. This serves as a low-barrier entry into services for those who are not ready to commit to case management.

Another new service started in response to COVID restrictions is a weekly Homeless Verification support activity on Thursdays from 1 p.m. to 4 p.m. Starting in November, the Wellness Coordinator makes an appointment to observe the individual’s living situation in order to complete the Observation of Homeless Status form and to assist them in completing the Self-Certification of Homeless Status form. These certifications are used to document the individual’s homeless status to establish eligibility for a variety of services, including interim and permanent housing.

In response to the rapid spread of COVID, the Access Center collaborated with the Department of Health Services (DHS) to provide on-site COVID testing and flu vaccines weekly. Every Monday morning, the DHS teams are stationed at the Access Center, providing walk-in COVID testing to those who are living on the streets as well as any The People Concern staff working with people experiencing homelessness. When positive results occur, the DHS team will go out to encampments and known locations to locate the positive individual and assist them with transportation to Quarantine and Isolation (QI) sites. For those who decline the QI site, clients living on the streets are provided with instructions and PPE for quarantining away from others. Outreach teams encourage their clients to come for testing as well as those who show up for meals, showers and other services. Hundreds of individuals have been tested through this clinic. Because flu symptoms can often mirror those of COVID, clients are also offered free flu shots at the same time.

**Medical Care:**

This reporting period, Venice Family Clinic at the Access Center served 738 unduplicated patients. Notably, the Venice Family Clinic began accepting walk-ins again in March 2021, although appointments can still be completed on the phone. Clients with COVID symptoms can receive medical care on-site, with proper safety measures in place. The goal is to get rapid treatment for people who may have COVID. If a patient needs to see a provider for another reason, we help them to obtain appointments at the Rose Avenue clinic. Importantly, this reporting period the Access Center established a Venice Family Clinic referral process for case management, wherein the Venice Family Clinic can directly refer patients into the program if a participant is not able to attend the case management orientation due to medical reasons.

**Homeless Community Court:**

We have one Homeless Court client who obtained housing and has graduated from the program. We update the Homeless Court on client progress as required. During this reporting period, The Access Center has not identified any new participants for Homeless Community Court due to the pandemic when Homeless Court is operating remotely.

**Outreach and Engagement:**

The three-person Outreach Team at the Access Center consists of the Outreach Program Manager, the Outreach Case Manager, and the Senior Outreach Specialist. Each team member has a caseload and is responsible for engaging specific SMPP individuals. The Senior Outreach Specialist is primarily responsible for providing linkages and referrals to individuals, including re-connecting clients with their case managers from other programs. Additionally, this staff is primarily responsible for answering city referrals and coordinating services for the people on his caseload. The Outreach Case Manager position was created to increase the ability to collaborate with outreach teams, such as C3, E6, and Homeless Multi-Disciplinary Street Team (HMST), to engage SMPP clients to receive services at the Access Center. Since then, C3 and Access Center have established monthly team meetings to coordinate services and plan strategy. The location, engagement, and case management of SMPP clients is the outreach team’s priority. Indeed, in this reporting period, staff have established a direct referral process for SMPP clients from the C3 team to the Access Center, allowing for more efficient services to better serve our clients. Once engaged, outreach team members assist Service Registry clients as they complete the Santa Monica Housing Authority application, search for an apartment, and complete a lease.

The Outreach Case Manager spends three mornings and two afternoons each week working with an outreach team to engage clients on the streets. Clients are invited to come to the Access Center, but services can be delivered wherever the client is willing to engage in order to overcome barriers preventing them from coming into the Access Center. This is particularly important during the pandemic, when safety concerns can be a barrier to receiving services. The Outreach Case Manager uses evidence-based practices including Motivational Interviewing and Harm Reduction to help clients focus on housing readiness. Outreach staff perform their duties while practicing social distancing, and wearing all appropriate PPE. They also educate clients on the streets on the risks of contracting COVID-19 and distribute masks, gloves, and hand sanitizer in the hope of reducing the spread of the disease.

This reporting period the outreach team engaged a total of 184 unduplicated clients and had 944 contacts. The team also provided 34 transports for case-managed and outreach clients. These transports were for various reasons, including transportation to medical, mental health, and housing appointments.

**Mental Health:**

The Access Center’s Field-Based Mental Health (FBMH) program is back at multiple sites providing mental health services to our clients. The FBMH case management team integrated into the Access Center during this reporting period in order to increase the Center’s capacity to provide ongoing case management services. They have provided ongoing mental health care to 116 individuals, referring another 73 individuals to outside mental health services. The FBMH team assisted the Access Center team by adding caseload capacity, thereby supporting the Access Center’s efforts to minimize the wait list for case management services. The Access Center looks to build on this partnership in future periods to enhance service to clients in need of mental health support.

**Food Services:**

Food is both an incentive for people to enroll in services and a necessity of life that we provide for those in need. During this reporting period, 65,375 sack lunches and 2,257 bags of groceries were provided to clients. The food distribution at the Access Center has been in operation continuously every day since the start of the pandemic. These meals and groceries were especially critical for our homeless neighbors during this time when grocery chains and other community programs experienced disruption in services.

**Hygiene Services:**

The SHWASHLOCK program provides a place where clients can feel safe while meeting their hygiene needs. Using trauma-informed procedures, the aspect of safety is a core part of this service. Clients are provided with the required necessities to shower, do laundry, and store their items. This serves as a major outreach tool to connect people to other agency services, including case management. Several lockers are reserved for clients who are not enrolled in case management but are employed and/or enrolled in school. This is an opportunity to assist clients to increase their income, which would ultimately allow them to afford housing without the need for enrolling in formal case management. During this reporting period, SHWASHLOCK provided 15,665 showers and 1,040 laundry services. While SWASHLOCK continued to operate every day during this reporting period in order to provide people with access to showers and laundry facilities, reduced numbers are due to social distancing requirements. An increased number of clients have requested to-go hygiene bags since they were not able to be accommodated because of the COVID restrictions.

**Housing for Individuals with Low VI-SPDAT Scores:**

Those with low VI-SPDAT scores have relatively few options for services, as most services are prioritized for those with the highest acuity needs. Case managers have been encouraging such clients to apply for any affordable housing that they may qualify for, such as senior housing and tax credit buildings. Some low acuity clients have been able to reunify with friends and family for support as well, and staff make sure all are aware of Project Homecoming. Case Managers are exploring all options for housing with clients and are working with all of our clients so that they are receiving maximum government benefits. We connect those who are able to work to Chrysalis for employment opportunities. Leveraged LAHSA funding for staffing and flex funds under the Problem-Solving program has assisted this population. Staff continues to encourage clients to utilize SHARE! Collaborative Housing, or SRO type housing which they may be able to afford without a rental subsidy once benefits have been established. If the person’s circumstances change, we work to update their VI-SPDAT scores to reflect their actual vulnerability. The information we submit is essential in maintaining client records and allows them the potential to be matched to subsidized housing opportunities. The information we submit allows clients to be matched to subsidized housing opportunities through CES.

**Security and Safety:**

Our security contractor continues to patrol the area around the Access Center together with our safety and engagement team. We all work together to build relationships with people and encourage them to access services. We hold monthly meetings with the Santa Monica Police Department and City staff to address loitering, camping and other problematic behavior. We also hold monthly meetings with our security contractor to work collaboratively to solve problems through changes to service delivery, procedures, scheduling, training, or other solutions, as well as a daily morning huddle with Access Center management and the guards to address any current issues. Training has been provided to both Access Center staff and security personnel so that there is a common understanding of incident reporting procedures and evidence-based practices including Trauma Informed Care and Harm Reduction techniques that facilitate successful intervention in incidents. Staff were also trained on basic resources that they can offer to potential clients including cold weather shelters, Project Homecoming, case management, medical care, and mental health services. All three Safety/ Engagement Attendant positions were filled during this reporting period ensuring that the safety protocols were able to be maintained. Maintenance staff members clean the perimeter of the Access Center twice daily.

**Trainings and Staff Development:**

This reporting period agency staff continued to receive training in a variety of areas. The following trainings are offered to all staff on an ongoing basis, including HIPAA, Trauma Informed Care, Harm Reduction, mandated reporting, boundaries, mental health first aid, client charts and files, cultural diversity, HMIS, responding to an opioid overdose, crisis intervention, methamphetamine use, occupational resiliency, and Sojourn’s domestic violence training. Most of the above are offered multiple times throughout the year.

Additional trainings provided specifically over the course of this year include “Handle with Care,” focusing on de-escalation and trauma-informed crisis intervention, a training on self-care and vicarious trauma, training on substance use disorders and Narcan, Motivational Interviewing, and CES.

In addition, Access Center has also implemented new trainings such as Civil Rights Training and Effective Communication. A variety of trainings were accessed by staff through the online Relias system or through Fred Pryor.

The People Concern provides a 26-hour management training program for all supervisory staff. New case managers attend a two-day “Case Management University” to equip them to serve clients from a holistic, culturally competent perspective.

Managers continued to cross-train staff in an effort to prevent issues which can arise due to staff vacancies. Additionally, frequent team meetings serve as informal case conferencing sessions and help staff make trauma-informed decisions when behavioral issues arise.

**CHALLENGES:**

In addition to the COVID-related capacity reductions that are affecting case management and interim housing availability, finding permanent housing for clients remains a key challenge. This obstacle includes issues that are ongoing and are outside of the case managers’ control, such as clients failing credit checks and background checks, finding units within the voucher payment standard, finding available units in safe environments, and clients’ preferences. COVID-19 has also slowed down apartment viewings as fewer landlords were showing apartments and fewer clients were willing to view apartments out of fears related to the pandemic. Rental subsidies from all sources are in increasingly short supply and are allocated by the Countywide Coordinated Entry System based on acuity (score of 17). This means that even highly acute clients (e.g. scores 8-16) may wait very long periods of time before receiving a voucher. This slow pipeline affects bed availability in interim housing sites as those residents wait longer for permanent housing.

Placements into interim housing were hindered this period in part by COVID-related capacity reductions at interim housing sites in Santa Monica and across the County. Additionally, for non-Santa Monica Program Participants, referrals for LAHSA funded interim housing are centralized. After the agency refers a client to LAHSA’s interim housing list, the agency has no influence on placement.

During this period, in order to address the increasing number of people on the waitlist for case management services, the Access Center staff proactively changed the process for assisting participants. Due to improved triage services, clients needing help with income verification, homeless verification or identification were assisted by wellness staff in one-on-one sessions, rather than being sent for case management services. Where appropriate, individuals were referred for Problem Solving assistance to maintain employment and remain in their housing. Because of these changes and because the Field Based Mental Health case managers now assist with carrying a small caseload, the case management waitlist was no longer necessary.

During this period, the Access Center housed 12 SMPP clients, which exceeds the Access Center annual target of permanently housing 11 clients. While 47 unhoused clients were enrolled for services, this is lower than the annual projected goal (107). There are an additional 60 SMPP individuals who were referred by the City. While they have not yet accepted case management services, Access Center staff are in varying states of engagement with these individuals.

During the COVID-19 pandemic it has been more difficult to fill vacant positions for direct services staff, including case managers, as these positions are seen as high-risk. The pandemic has also decreased the number of beds in interim housing, and the eviction moratorium has reduced the availability of apartments in the rental market. Finally, because employees were occasionally out quarantining after reporting COVID symptoms, the pandemic also created staff shortages.

###### SECTION II: ASSESSMENT, EVALUATION AND PARTICIPANT INVOLVEMENT

The People Concern follows established practices related to client feedback in order to ensure the highest quality services. Evaluation and planning are specific to each project, and are also implemented on an agency-wide basis. Service models are based on evidence-based practices and are documented through policies and procedures.

The People Concern maintains a robust data collection and evaluation infrastructure overseen by the Chief Compliance Officer and the Director of Evaluation and Compliance. A four-person team collects and validates data and trains line staff to submit data accurately and in a timely manner. Compliance and Evaluation staff conduct chart reviews on a bi-weekly basis to ensure clean data collection.

Data in each program is collected and analyzed for use in program compliance, reporting, and quality improvement. Outcomes tracked include housing acquisition and retention, increase in benefits or other income, use of mental health and medical services, and engagement with outreach teams. Agency staff review outcomes and trends to inform potential changes to program design/implementation.

Working in collaboration with other departments, ACC staff members participate in monthly Westside leadership meetings where different programs discuss collaboration, best practices, and uniform implementation of policies. These meetings frequently include case conferencing.

Prior to the pandemic, The Access Center solicited client feedback in a variety of proactive and responsive ways: a suggestion box inside the lobby, monthly community advisory board (CAB) meetings for in-person feedback, Grievance forms, and the Access Center Feedback Survey. However, during the reporting period, because of COVID restrictions, no CAB meetings were held and the suggestion box was not utilized as clients were not allowed to enter the Access Center. In October, the Wellness Coordinator provided the Access Center Client Feedback Survey at the resource tables. She distributed surveys to all clients as they entered for services. 8 surveys were returned. In the second half of the fiscal year, staff have collected an additional 53 surveys. Based on the comments and suggestions from the survey and other feedback received by staff, the Access Center changed its programming to include:

* A resource table - to make referrals for shelter, and community resources (food, medical, etc.). During the second half of the reporting period, the Access Center increased access to the resource table from twice a month to weekly.
* An income/benefits – to assist in benefits enrollment and income verification, the Access Center provides weekly appointments for staff to assist clients in increasing their income and/or benefits. This service is provided by our Wellness Coordinator and is also provided to clients who are not enrolled in case management services.
* An Identification table – to provide clients with a DMV voucher so they could apply for ID cards
* Charging station – because there was huge need to charge phones and other devices, the Access Center leveraged a financial donation to purchase a large capacity charging station and was able to offer charging services to clients.
* Cell phones – based on clients’ need to stay connected to people and services, The People Concern obtained donations and distributed 30 free cell phones to clients. Access Center has also contacted Assurance Wireless to join staff at the weekly resource table to provide free cell phones to eligible clients
* Access to a telephone – to provide clients with a cordless phone they can sign up to use for emergencies, the Access Center created a space in the lobby and purchased a cordless phone. Due to COVID we had not been able to provide this service because it did not allow for the 6 foot social distance.
* Vaccine information – for the health and safety of our clients and staff, The People Concern provided fliers and information on Covid-19 vaccination events.

The People Concern continues to review and update all data policies, procedures, and trainings across all programs for consistency and improvements according to the latest best practices.

###### SECTION III: BOARD INVOLVEMENT

* Eleven board meetings were conducted during this 12-month period.
* Average attendance was 82%.
* **Board development:** We recruited two new Board members during the reporting period and the newly elected Board Co-Chairs began their three-year term on January 1, 2021. The Board Governance Committee began working with individual Board members and the agency’s fundraising staff to create custom fundraising plans for each member in 2021, and also continued to focus on leadership transition from long-tenured members to newer members. We are finalizing a Diversity, Equity and Inclusion (DEI) plan for the entire organization, including our Board of Directors, as a roadmap for expanding and strengthening current DEI efforts. The Board Governance Committee has also established a mentorship program for new Board members to assist them in learning about the agency and the field in which we work. In this process, longer tenured Board members commit to ongoing, one-on-one support and engagement as part of this new mentorship initiative. The four newest Board members bring expertise in healthcare, real estate, Human Resources and communications and all add to the diversity of professional skill sets among Board members.
* **Significant policy actions:** The Board’s primary focus during the beginning of this reporting was to ensure the agency is able to continue functioning during the pandemic, and to build leadership capacity within the agency at the Board and Executive Leadership levels. Over the next two to three years we anticipate several Board members will move from the Governing Board to our Emeritus Council, which will make room for both new Board members and leadership opportunities as Officers, Committee Chairs and members of the Executive Committee. The new Board Co-Chairs will be working with the CEO to build out the Executive Leadership Team, to strengthen the depth and experience of the management team, in preparation for a shift in the CEO’s role and focus going forward. A significant policy focus is meeting the agency’s strategic plan goal of housing 20,000 people by 2028. We continue to expand our collaborations with housing development partners to construct more units and be a trusted service provider in those new projects, and innovate the way permanent supportive housing is financed, constructed and scaled across LA County. The Board has also approved adding a Chief DEI Officer to our Executive Leadership Team to oversee implementation of the agency’s DEI plan, as well as the ongoing DEI work across programs and departments. Increasing private fundraising so the agency has the resources it needs to fulfill its mission, as well as continuing to innovate, remains a top Board priority.

The Board’s focus during the second half of the reporting period has been to support the Executive Leadership staff in responding to and navigating the current political climate as it relates to homelessness and the order by Judge Carter; as well as the increased public pressure from the housed community to see a visible change in street homelessness across Los Angeles County. The Board reaffirmed the agency’s commitment to creating more, long-term housing solutions in partnership with entities such as FlyawayHomes and other housing developers. An ad-hoc Housing Committee was formed to focus on this issue specifically. The Board also approved the hiring of a Chief Housing Development Officer to expand housing development relationships and opportunities with the intention of creating more permanent supportive housing. The Board also dedicated a renewed emphasis on private fundraising, partnering with the agency’s newly hired Chief Development Officer to forge new potential funding relationships. The Board Co-Chairs began their work with the CEO to build out the Executive Leadership Team, to strengthen the depth and experience of the management team, in preparation for a shift in the CEO’s role and focus going forward.

* Seven board members reside and/or work in Santa Monica.
* The Board currently has no vacancies.

###### SECTION IV: STAFFING PATTERN

There were seven vacancies at the Access Center at the end of the reporting period. Where necessary and appropriate, additional security staff were contracted to provide coverage to assist with safety and promoting compliance with public health guidelines. Assistant Directors and Human Resources are currently recruiting for all vacant positions.

Additionally, COVID 19 resulted in several staff remaining at home due to vulnerability to the virus or due to childcare issues and we continue to make adjustments as individuals test positive or are exposed to the virus and must quarantine. As such, Access Center has a reduced number of employees working on site on a daily basis. To address this staff shortage, management provided staff support to avoid disruption in services for our lunches. Notably, the two FBMH case managers that were integrated into the program also assisted with the case management load.

Notably, this reporting period’s staff shortages impacted showers, case management, and outreach services. For example, Access Center staff shortages led to the halting of case manager orientation for clients and the program only had the capacity to take on SMPP clients. For those SMPP clients referred to outreach, the Access Center had reduced capacity to travel to the field, engage them, transport and link them to case management due to the limitations facilitated by the pandemic.

Volunteer opportunities are severely limited by COVID restrictions and limited to administrative/non-client facing activities. Despite the restrictions, the Access Center benefited from the services of 37 volunteers who provided 1,787.5 hours of service.

**SECTION V: SPECIAL FUNDING CONDITIONS**

• *Participate in the City’s efforts to develop an outcomes measurement system to better track human services program demographics and outcomes.*

The Access Center tracks all services in Service Point to provide accurate demographic and outcomes data to the City. The agency will continue to make staff available to participate in efforts to develop outcomes measurement systems.

• *Detail steps taken to provide services in adherence to the safety protocols related to the COVID-19 pandemic, including modifications to service delivery, physical infrastructure and safety equipment and protocols to protect participants and staff.*

The Access Center adheres to comprehensive safety protocols related to COVID-19. Highlights of steps take to modify service delivery, physical infrastructure, safety equipment, and new protocols include:

* A Director of Safety was hired to assist with protocols related to COVID-19 across the agency
* All services were modified to accommodate social distancing practices, and PPE guidelines.
* PPE is ordered weekly and we have stock onsite for two weeks.
* Temp and symptoms check stations were created. Fliers encouraging compliance with mask, social distance, and hand-washing requirements are posted all through the building.
* All staff are trained in and must follow social distancing and PPE practices.

*• Describe how your organization operationalizes racial equity, diversity, and cultural*

*Competency.*

The People Concern has completed the first year of a newly developed and adopted three-year Diversity, Equity, and Inclusion (DEI) Strategic Plan. The DEI Plan was developed collaboratively with agency leadership staff, the staff co-chairs of the DEI Committee and the Human Resources Department. The results from an agency-wide DEI survey were incorporated in the components of the plan as well as industry-best practices. The effort was led by a DEI consultant who completed their consultation term on June 30, 2021.

The initiatives identified in the plan are organized based on constituencies and emphasis: culture, workforce, clients and community. Launch activities were held in May and June of this year to introduce all staff to the components of the plan and for agency leadership to share their personal commitment in this work. Ongoing communication and engagement activities are planned over the coming year to continue to build investment in this change-work by staff from across the agency. These activities are intentionally scheduled

Additional achievements during the reporting period include:

* The agency began recruiting for a Chief Diversity, Equity and Inclusion Officer, to join the Executive Leadership Team of the agency.
* Social Justice Principles were developed to guide the agency in establishing collaborative relationships with like-mind external partners as well as to guide the agency’s response and support of staff in times of local and nationwide community violence and traumatic events.
* A peer-led support group for Asian-American and Pacific Islander staff was formed as a new addition to the Standing in Solidarity groups.
* Additional professional growth paths have been developed within functions, such as leadership and case management, to provide for increased internal promotion opportunities and a Professional Development Program curriculum has been developed that will be offered to all staff. It is in the pilot phase currently.
* Recruiting practices have been enhanced to include outreach to a broader network of potential feeder systems such as workforce development community centers and hyper-local job boards.
* Mandatory all-agency cultural competency training continues to be part of the annual training calendar.

Below please find our aggregate data for the agency’s Board of Directors, Executive Leadership Team, and supervisory staff of the Access Center:

|  |  |
| --- | --- |
| **RACE/ETHNICITY**  **(Board of Directors)** |  |
| 1. African American | 2 |
| 2. Asian or Pacific Islander | 0 |
| 3. Latinx | 0 |
| 4. White | 15 |
| 5. Multiple Race/Ethnicity | 0 |
| 6. Other : Middle Eastern; Ethiopian | 0 |
| 7. Refuse to State | 0 |
| **TOTAL:** | 17 |
|  |  |

|  |  |
| --- | --- |
| **GENDER**  **(Board of Directors)** |  |
| Male | 11 |
| Female | 6 |
| Transgender | 0 |
| Other | 0 |
| **TOTAL:** (SUM OF MALE, FEMALE, TRANSGENDER, OTHER) | 17 |

|  |  |
| --- | --- |
| **RACE/ETHNICITY**  **(Executive Leadership Team)** |  |
| 1. African American | 1 |
| 2. Asian or Pacific Islander | 1 |
| 3. Latinx | 2 |
| 4. White | 7 |
| 5. Multiple Race/Ethnicity | 0 |
| 6. Other : Middle Eastern; Ethiopian | 0 |
| 7. Refuse to State | 0 |
| **TOTAL:** | 11 |

|  |  |
| --- | --- |
| **GENDER**  **(Executive Leadership Team)** |  |
| Male | 2 |
| Female | 9 |
| Transgender | 0 |
| Other | 0 |
| **TOTAL:** (SUM OF MALE, FEMALE, TRANSGENDER, OTHER) | 11 |

|  |  |
| --- | --- |
| **RACE/ETHNICITY**  **(Access Center Leadership)** |  |
| 1. African American | 2 |
| 2. Asian or Pacific Islander | 0 |
| 3. Latinx | 2 |
| 4. White | 1 |
| 5. Multiple Race/Ethnicity | 0 |
| 6. Other : Middle Eastern; Ethiopian | 0 |
| 7. Refuse to State | 0 |
| **TOTAL:** | 5 |
|  |  |

|  |  |
| --- | --- |
| **GENDER**  **(Access Center Leadership)** |  |
| Male | 1 |
| Female | 4 |
| Transgender | 0 |
| Other | 0 |
| **TOTAL:** (SUM OF MALE, FEMALE, TRANSGENDER, OTHER) | 5 |

*• Agency will assist eligible participants in submitting applications to applicable Santa Monica Housing programs, including but not limited to: Section 8 and Below Market Housing (BMH) Waitlists, Preserving Our Diversity (POD), and Continuum of Care (CoC) programs.*

The Access Center screens all clients for eligibility for these programs and those eligible in submitting applications for the Santa Monica Housing Programs listed. During the reporting period, 12 individuals were housed in and outside of Santa Monica, ten of whom were housed through the Santa Monica Housing Authority, one through RRH and one in below-market housing. Staff assisted 14 clients in submitting applications to the Housing Authority; four are holding vouchers and are searching for apartments and another 16 are in the process of gathering documentation.

The Access Center is in full compliance with all conditions relating to homeless programs.

* We continue to align resources with the goal of permanently housing priority populations consistent with the City’s Santa Monica Program Participant criteria (SMPP). We leverage extensive non-City funding to serve our client population.
* We begin our client service planning process by linking clients with services and resources in their community of origin or other appropriate regional services, and by offering appropriate transportation services, such as Project Homecoming.
* We provide ongoing, individualized supportive services based on individual need to Santa Monica Program Participants placed in permanent housing to promote housing retention, regardless of the type of subsidy or housing utilized.
* We use the City’s HMIS to comply with reporting requirements for participants in the City’s homeless initiatives.
* We document service match in the City’s Homeless Management Information System (HMIS) for all clients utilizing SMHA Continuum of Care vouchers.
* All SMPP individuals who receive case management services are assessed through the VI-SPDAT and are co-enrolled in the Coordinated Entry System (CES).
* SMPP clients who score high acuity (8 or higher) on the VI-SPDAT are submitted to the Santa Monica Service Registry.
* We notify Human Services Division staff when SMPP program participants are at risk of eviction.
* We adhere to the City’s Intake Policy for documenting homelessness.
* We prioritize services and outcomes for the individuals designated by the City. See Attachment A for information on specific individuals.

**SECTION VI: DEMOGRAPHICS**

|  |  |  |
| --- | --- | --- |
| **ASSESSMENT OF ADDITIONAL SERVICE NEEDS**  **(Santa Monica Participants)** | **FY 20-21**  **Number Responding “Yes”**  **at Mid-year** | **FY 20-21**  **Number Responding “Yes”**  **at Year-end** |
| 1. “Do you or anyone in your household have unmet employment needs?” | 3 | 4 |
| 1. ”Have you missed or been late on a home rental or mortgage payment within the last 12 months?” | 0 | 0 |
| 1. “Do you or anyone in your household have an unmet childcare/afterschool need?” | 0 | 0 |

|  |  |  |
| --- | --- | --- |
| **INCOMING PARTICIPANT REFERRALS**  **(Santa Monica Participants)** | **FY 20-21**  **Number**  **at Mid-year** | **FY 20-21**  **Number**  **at Year-end** |
| Participants referred by another agency | 10 | 20 |
| **Please list the top 3 referring agencies** |  |  |
| * 1. **City of Santa Monica** | 9\* | 19 |
| * 1. **St. Joseph Center** | 1 | 1 |
|  |  |  |

**SECTION VII: PROGRAM SERVICES AND OUTCOMES**

| **OUTPUTS AS SHOWN IN PROGRAM PLAN** | **OUTPUT STATUS REPORT**  (Actual number of unduplicated persons who received/participated in the output during the reporting period) | **OUTCOMES AS SHOWN IN PROGRAM PLAN** | **OUTCOME STATUS REPORT**  (Actual number and percentage of unduplicated participants who achieved the outcome during the reporting period) |
| --- | --- | --- | --- |
| 154 individuals will receive case management (107 un-housed and 47 in permanent housing) | Service 1: 85 of 154 (55%) individuals received case management (47 un-housed and 38 in permanent housing at the start of the reporting period)  \*See variance report | 27 of 107 participants (25%) will be placed in interim housing during the program year. | Outcome 1: 8 of 47 unhoused individuals (17%) were placed in interim housing during the program year. \*See variance report |
|  |  | 11 of 107 participants (10%) will be placed in permanent housing during the program year. | Outcome 2: 12 of 47 unhoused individuals (26%) were placed in permanent housing during the program year. |
|  |  | 42 of 47 participants (90%) in permanent housing will maintain their permanent housing through the end of the program year. | Outcome 3: 36 of 38 (95%) individuals in permanent housing maintained their permanent housing at year end.  \*There were 12 participants that entered PH this FY and all 12 remain housed. |
| 154 individuals will be screened for income development. | Service 2: 154 of 154 (100%) individuals were screened for income development. | 116 of 154 participants (75%) will increase or maintain their income during the program year. | Outcome 1: 77 of 85 individuals (91%) increased or maintained their income within the program year. |
| 88 individuals will access Project Homecoming. | Service 3: 25 of 88 (28%) individuals accessed Project Homecoming. | 70 of 88 participants (80%) will be permanently housed through Project Homecoming. | Outcomes 1: \*16 out of 25 individuals (64%) were permanently housed through Project Homecoming. \*See variance for further explanation |

###### VARIANCE REPORT:

###### Service 1, Output 1: *Unhoused Santa Monica Program Participants served*

Due to COVID-related capacity restrictions, case management service enrollments were significantly reduced across the program for all participants; at year-end, 227 of the annual target of 435 total participants (52 percent) were served. Still, the agency continues to prioritize case management for Santa Monica Program Participants (SMPP), and at year end has served 47 of the annual target of 107 unhoused SMPP’s (44 percent). Twenty SMPP participants were referred from the City of Santa Monica during this reporting period, of which five were enrolled into case management and 40 SMPP individuals were referred by the City in prior years. The remaining 55 individuals are in varying states of engagement and have not yet been enrolled in case management services. The agency will continue to partner with the C3 multidisciplinary teams and Field-Based Mental Health program to increase case management enrollments of unhoused SMPP’s in subsequent periods.

CCM report reflects 49 participants served in housing retention. This figure represents the 38 participants previously housed and 11 housed during this period that continue to receive supportive case management services through The People Concern.

**Service 1, Outcome 1: *Interim Housing Placement***

LA County Public Health direction to reduce bed capacity during COVID posed barriers to reaching interim housing placement goals during this period. All interim housing sites county-wide halted new intakes when in outbreak status. Referrals for LAHSA-funded interim housing are now centralized, and this has led to somewhat longer waits before placement. Some participants continue to prefer working on permanent housing while living on the streets; however, we continue to encourage participants to be open to the possibility of interim housing while working on other options. We currently have participants on interim housing waitlists while we continue to work with participants on permanent housing. SMPP clients continue to receive priority on the waitlist. Additionally, the program referred 25 participants to LAHSA’s Project Roomkey waitlist.

**Service 3: *Project Homecoming:***

Staff continue to encourage participants to utilize Project Homecoming, but fewer clients were interested or able to identify a suitable host/destination during this period. We were successful in using this program to secure permanent housing for sixteen individuals during this reporting period.

Twenty-five individuals accessed Project Homecoming and were placed in permanent housing with loved ones. Sixteen participants have confirmed their arrival, however, nine participants have not responded to the agency’s attempts to reach them. The agency will continue reaching out to these nine in order to confirm that they reached their final destination.

**SECTION VII: PROPERTY MANAGEMENT**

The People Concern’s facilities team shampooed the carpets, waxed and buffed flooring, and power-washed the facility. Minor repairs and painting were conducted routinely during this reporting period.

**By submitting this report to the Housing and Human Services Division, I certify that this report is true, complete and accurate to the best of my knowledge and that all disbursements have been made in compliance with the conditions of the Grantee Agreement and for the purposes indicated.**