

Committee on Best Practices for Standardization of Care

JUNE 12, 2025

ITEM FOUR

PROGRESS ON DEVELOPING REGIONAL “STANDARDS OF CARE”

Eight elements of an effective standard of care:

1. Shared, measurable performance targets

Quantitative targets should contribute to meaningful progress toward approved regional goals; targets should reflect best practices and the quality of care we believe should be delivered in all programs; targets should also acknowledge the need for flexible approaches to support client's needs and success

2. Regional approach to qualitative measures of the quality of care and quality of participant's lives

3. Regionally consistent approach to service delivery, appropriate for the population being served

4. Regionally consistent approach to gathering data to track progress

5. Regionally consistent approach to performance management

Consistent contractual requirements to create consistent expectations for providers

6. Regular public reporting to support accountability

Public reporting should be paired with cross-jurisdictional collaboration and operational problem solving to improve performance

7. Support for providers and our workforce

Regional collaboration to support achieving the standard of care

8. Regional commitment to learning and refining

Regional collaboration to review what is working and align resources to impact

OUTREACH- REGIONAL INVESTMENTS AND GOALS

	Funded strategies and programs	Standards of care	Regional goals
Definitions	LA County, LA City, and other jurisdictions' homelessness spending, including but not limited to Measure A-funded programs	Specific, measurable performance targets for each strategy and program informed by evidence-based best practices	ECRHA-endorsed and Board of Supervisors-approved five-year numeric metrics for regional progress
Outreach	Goal for this committee: Shared understanding of investments, revenue sources, and outreach capacity across the County, LA City, and all cities within the County	Proposed outreach standards of care on fully leveraged investments, quality of assistance, and housing outcomes	Goal 1: Increase the number of people moving from encampments into permanent housing to reduce unsheltered homelessness with a focus on addressing gender, ethnic and racial disproportionality, disparities and inequities. Metric 1.a.: Decrease by 30% the number of people experiencing unsheltered homelessness from a baseline of 52,365 in 2024 to a target of 36,656 in 2030 Metric 1.b.: Increase by 80% the number of people moving into permanent housing from unsheltered settings from a baseline of 5,937 in FY 23-24 to a target of 10,687 in 2030 Metric 1.c: Increase by 32% the rate of people moving into interim housing from unsheltered settings from a baseline of 34% in FY 23-24 to a target of 45% in 2030

ENGAGEMENT TO INFORM OUTREACH STANDARDS

ENGAGED

40 MDT Representatives

- PATH
- HOPICS
- The Center in Hollywood
- St. Joseph Center
- The People Concern
- DHS Mobile Clinic
- Helpline Youth Counseling (HYC)
- Hope the Mission
- LA Family Housing
- Union Station Homeless Services
- Christ-Centered Ministries
- Homeless Health Care Los Angeles (HHCLA)
- DHS
- Exodus Recovery
- Mental Health America of Los Angeles

Four HET Representatives

- Ryan Worrall, *Manager, Access & Engagement*, LAHSA
- Jayde Collins, *Manager, Unsheltered Strategies*, LAHSA
- Carmecia Carson-Glover, *Director, Access & Engagement Department*, LAHSA
- Ghaailb Green, *Housing Navigator*, LAHSA

Four Outreach Coordination Leads

- Kyran Green, *SPA 2 Outreach Coordinator*, LA Family Housing
- Jayde Collins, *Manager, Unsheltered Strategies*, LAHSA
- Colleen Murphy, *Principal, Homeless Solutions*, Lesar Development Consultants
- Libby Boyce, *LA County CEO-HI*

Four Operational Leads

- La Tina Jackson, *LCSW, Deputy Director Countywide Engagement Division*, DMH
- Maria Funk, *Ph.D., Deputy Director Housing and Job Development Division*, DMH
- Victor Hinderliter, *Director of Street Based Engagement and Mobile Clinics*, DHS
- Brittnee Hill, *Program Implementation Manager*, DHS

Two People with Lived Expertise

- LaToya Cooper, *LA Emissary, Homeless Youth Forum of Los Angeles*
- Alexis Obinna, *Homeless Youth Forum*

DOCUMENT REVIEW TO INFORM OUTREACH STANDARDS

REVIEWED

18 scopes of required services, protocols, reports, and guides on outreach

- LAHSA (7)
- LA County CEO-HI (6)
- DHS (2)
- DMH (2)
- City of Los Angeles (1)

OVERVIEW OF OUTREACH & ENCAMPMENT RESOLUTION PROGRAMS

PROACTIVE OUTREACH

HET & MDTs – teams are assigned to geographic areas, familiar with those who are unhoused to engage, build trust, etc. They visit regularly and work on bringing folks inside and connected to needed services

REACTIVE OUTREACH

Responsive to Reports & Inquiries

LA-HOP referrals are for the public and **ECRC** referrals for elected officials, cities/municipalities, governmental agencies



Most appropriate team dispatched (**HET or MDT**)



Other teams called in as needed such as **HOME**, **vets**, **street medicine**, etc.

ADDITIONAL OUTREACH SUPPORT & RESOURCES

Clean-ups arranged as needed:

- **County HOST** (entered into **HEARs**)
- **City of LA Care/Care+** (CDs/CAO)

Encampment resolutions i.e. **Inside Safe** and **Pathway Home** arranged as resources allow and in consultation with elected officials

ECRC assists outreach teams with access to IH when immediately needed and as available and with access to other County or available resources

FIVE CATEGORIES OF OUTREACH & ENCAMPMENT RESOLUTION PROGRAMS

Category	Goal	Specific team type examples
1. Outreach not connected to a specific housing resource*	To connect people to all appropriate resources, including but not limited to life sustaining supports, connections to interim housing to document readiness support, case management, enrollments in health services and transportation to housing related appointments	LAHSA Homeless Engagement Teams (HET) DHS-HFH Multi-Disciplinary Teams (MDTs)
2. Specialized outreach that includes medical or specialized psychiatric treatment or care and is not connected to a specific housing resource	Accessed via referrals To deliver clinical care and services to a subpopulation of people experiencing unsheltered homelessness with serious mental illness who are gravely disabled (HOME teams) OR To deliver clinical care and services to people experiencing unsheltered homelessness	DMH Homeless Outreach and Mobile Engagement (HOME) Various Street Medicine Teams
3. Outreach connected to a specific housing resource	To help a specific group of people move into a specific housing resource (often encampment resolution)	City of LA Inside Safe Outreach Teams County Pathway Home
4. Encampment sanitation support	To provide sanitation services in encampments, and To engage individuals experiencing homelessness in encampments, and connect them with resources, referrals, and interim housing placements before a sanitation focused operation	City of LA CARE/CARE+ County HOST teams (Homeless Outreach Service Teams)
5. Unarmed crisis response**	Alternative, unarmed crisis response to 911 calls regarding people experiencing homelessness	City of LA CIRCLE

*The June 12, 2025 presentation will focus on: Standards for the first category and for overall system coordination. The June 26, 2025 presentation will focus on standards for categories two, three, and four.

**We recommend focusing on the first four categories and setting performance targets for unarmed crisis response at a different time, given its distinct goals.

1. OUTREACH TEAMS NOT CONNECTED TO A SPECIFIC HOUSING RESOURCE – ARE TEAMS EFFECTIVELY ENGAGING PEOPLE IN NEED?

Proposed regional performance targets	Regional alignment?				
	LA County	City of LA	LAHSA	Local Jurisdictions	Engaged Providers
<p>Number of unduplicated individuals with whom teams initiate contact <i>Existing measure; Data source HMIS</i></p> <p>70% of all unduplicated, contacted individuals are engaged or re-engaged (meaning enrolled in an outreach program and accepting services) <i>Existing measure; Data source HMIS</i></p> <p><i>Equity measures: Percentage of all unduplicated engaged individuals who are successfully enrolled engaged or re-engaged by an outreach team, by race, ethnicity, and gender</i> <i>New measure; Data source HMIS</i></p>	Yes	Yes	Yes	TBD	Yes

1. OUTREACH TEAMS NOT CONNECTED TO A SPECIFIC HOUSING RESOURCE – ARE TEAMS PROVIDING PEOPLE WITH NEEDED CASE MANAGEMENT, HEALTH, BEHAVIORAL HEALTH, AND SOCIAL SERVICES?

Proposed regional performance targets	Regional alignment?				
	LA County	City of LA	LAHSA	Local Jurisdictions	Engaged Providers
<p>75% of all engaged individuals who are willing to accept a non-housing service in HMIS and who are successfully enrolled in that service <i>Existing measure; Data source HMIS</i></p> <p><i>Equity measures: Percentage of all engaged individuals who are willing to accept a non-housing service in HMIS and who are successfully enrolled in that service, by race, ethnicity, and gender</i> <i>New measure; Data source HMIS</i></p> <p>Percentage of all engaged, unduplicated individuals who receive life sustaining support (i.e., food, water, hygiene, clothing, etc.) <i>New measure; Data source HMIS</i></p> <p>Percentage of all engaged, unduplicated individuals who receive and upload state ID in HMIS <i>New measure; Data source HMIS</i></p> <p>Percentage of all engaged, unduplicated individuals who receive and upload a social security card in HMIS <i>New measure; Data source HMIS</i></p>	Yes	Yes	Yes	TBD	Yes

1. OUTREACH TEAMS NOT CONNECTED TO A SPECIFIC HOUSING RESOURCE – ARE TEAMS PROVIDING PEOPLE WITH NEEDED CASE MANAGEMENT, HEALTH, BEHAVIORAL HEALTH, AND SOCIAL SERVICES?

Proposed regional performance targets	Regional alignment?				
	LA County	City of LA	LAHSA	Local Jurisdictions	Engaged Providers
Percentage of all referred unduplicated individuals who are enrolled in a specialized mental health or substance use treatment outreach team <i>New measure; Multiple data sources</i>	Yes	Yes	Yes	TBD	Yes
Percentage of all referred, unduplicated individuals who receive substance use treatment <i>New measure; Multiple data sources</i>					
Percentage of all referred, unduplicated individuals who receive mental health care <i>New measure; Multiple data sources</i>					
Percentage of unduplicated individuals engaged who are enrolled in Countywide Benefits Entitlement Services Team (CBEST) (e.g., SSI, SSDI, CAPI) <i>New measure</i>					

1. OUTREACH TEAMS NOT CONNECTED TO A SPECIFIC HOUSING RESOURCE – ARE TEAMS HELPING PEOPLE ACCESS HOUSING?

Proposed regional performance targets	Regional alignment?				
	LA County	City of LA	LAHSA	Local Jurisdictions	Engaged Providers
<p>Percentage of all engaged unduplicated individuals who have their CES assessment completed and score indicated in HMIS <i>New measure; Data source HMIS</i></p> <p>15% of unduplicated individuals engaged successfully attain an interim housing resource (inclusive of crisis and/or bridge housing) (MDTs) <i>This measure is dependent upon the availability of housing resources</i> Existing measure, higher target; Data source: HMIS</p> <p>10% of unduplicated individuals engaged successfully attain an interim housing resource (inclusive of crisis and/or bridge housing) (Public Spaces and Generalized Outreach teams) Existing measure; Data source: HMIS</p> <p>5% of unduplicated individuals engaged are permanently housed Existing measure; Data source: HMIS</p> <p><i>Equity measures: Percentage of all unduplicated engaged individuals who attain an interim housing placement and percentage who are permanently housed, by race, ethnicity, and gender</i> <i>New measure; Data source HMIS</i></p>	Yes	Yes	Yes	TBD	Yes

ALL OUTREACH TEAMS – MEASURES OF COORDINATION AND PRIORITIZATION

Proposed regional performance targets	Regional alignment?				
	LA County	City of LA	LAHSA	Local Jurisdictions	Engaged Providers
Geographic prioritization based on need Regularly updated heat map showing: <ul style="list-style-type: none"> • Most recent point-in-time count of geographic distribution of unsheltered homelessness (Data source: PIT count) • Encampment Data: Locations with five or more people experiencing unsheltered homelessness (Data source: HMIS) • Frequency of contact from an outreach team: <ul style="list-style-type: none"> ○ In response to a request for service (LA-HOP and Emergency Centralized Response Center (ECRC)) ○ In response to a major event (e.g., disease outbreak, natural disaster) ○ Proactive engagement, to serve people known and enrolled in outreach services in the SPA <i>New measure; data source HMIS</i>	Yes	Yes	Yes	TBD	Yes
Urgent, appropriate response to high acuity needs After an assessment team is dispatched in response to an LA-HOP or ECRC request for service, specialized care / MDTs are assigned with 48 hours of a referral <i>New measure; data source HMIS</i>					