Evaluation of the Home Safe Program

2022-2025

Homelessness Prevention for Older Adults & Adults with Disabilities

Benioff Homelessness and Housing Initiative

UCSF

University of California San Francisco

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Table of Contents

Executive Summary

The Home Safe program is administered by the California Department of Social Services (CDSS) and implemented by county Adult Protective Services (APS) agencies in partnership with other agencies and contracted providers. The program serves older and dependent adults who are either experiencing or at imminent risk of homelessness by offering a range of services, including eviction prevention, landlord mediation, short-term financial assistance, and intensive case management.

The California Legislature established the Home Safe program in 2018 with an initial $15 million General Fund allocation to support county APS agencies in starting their own Home Safe programs. Subsequent investments in 2021 and 2022—totaling $185 million—enabled CDSS to expand Home Safe to include all 58 counties, provide a Tribal Government set-aside, and remove the initial county 1:1 match requirement. The Budget Act of 2025 included another one-time appropriation of $83.8 million for counties and Tribes to continue or expand Home Safe programs throughout the state.[1]

In 2019, UCSF and CDSS conducted a mixed-methods evaluation of the Home Safe Pilot Program. That evaluation found evidence that Home Safe successfully stabilized many APS clients who were at risk of, or experiencing homelessness. Counties identified program flexibility as a key element of the model's success, noting that it allowed them to design programs tailored to local context. Counties chose either a direct model—hiring additional APS staff to serve as case managers and provide the homelessness prevention services—or a contract model that leverages outside expertise. A key secondary benefit identified in the evaluation was that Home Safe increased interaction between APS staff and homeless services staff, decreasing siloes between these systems. A limitation of the evaluation was the limited data collected by the counties.

Building on the findings of the pilot evaluation, CDSS engaged UCSF to evaluate the full-scale implementation of Home Safe. To do so, we used the RE-AIM framework, focusing on five key aspects:

- Reach—Did the program reach the targeted population?
- Effectiveness—What impact did the program have?
- Adoption—What support does APS draw on to deliver the program?
- Implementation—How is the program delivered?
- Maintenance—Is the program set up for long-term success?

Key Findings

Reach

- **Home Safe filled a critical unmet need in local homeless response systems** by allowing APS staff to meet the housing needs of older and dependent adults who were not served by other programs.
- **Home Safe reached populations that traditional homelessness prevention and diversion services do not adequately reach**, including older adults without prior episodes of homelessness, particularly those who are socially isolated and had not previously accessed social services.
- **Home Safe filled an important gap in the service delivery ecosystem** by serving participants with housing needs that left them vulnerable to homelessness, but whose income is above the cut-off for the Housing Choice Voucher Program or low-income senior housing.
- **Home Safe cases were evenly divided between preventing and ending homelessness** during the evaluation period. Half (51.9%) of Home Safe cases enrolled participants who were housed at program entry; half (48.1%) enrolled participants who were experiencing homelessness.
- **Compared to the general APS population, the population served by Home Safe included a higher proportion from groups overrepresented in the homeless population** (e.g., Black, Indigenous). However, the overall demographic profile of participants did not fully match that of older adults experiencing homelessness statewide, likely reflecting the demographics of the APS population.
- **For most populations, staff did not report specific barriers to accessing Home Safe. However, they identified barriers for:**
    - Rural areas, including limited transportation and spotty cellular service.
    - Latine and undocumented communities, including fear and stigma.

Effectiveness

- **Among participants for whom we have housing data at program exit, 93.9% of participants who were housed at program entry remained housed at exit**; among those homeless at program entry, 58.4% were housed at exit.[a]
    - For comparison, HDIS homelessness prevention data shows that 82.4% (of those housed and enrolled in homelessness prevention) retained their housing, and 18.8% of people who were homeless regained housing during their case.
- **Home Safe stabilized participants' housing situation, prevented homelessness, and increased exits into permanent housing** by providing direct housing support (housing deposits, temporary housing, and rental assistance).

[a] A county grantee "closed" a participant's case when they stopped providing interventions. A participant "exited" the program when their case was closed.

- **Home Safe prevented clients' homelessness and preserved naturally occurring affordable housing** by interrupting evictions from rent-controlled units.[b]
- **The high cost and low availability of housing impacted Home Safe staff's ability to find appropriate housing**. The lack of affordable housing limits the programs' effectiveness.

Adoption

- **Counties developed distinct program models**. Some brokered services and others used Home Safe resources to hire staff; some focused exclusively on prevention or diversion, others served those experiencing homelessness, and some provided a blend of prevention and assistance for those experiencing homelessness.
- **Home Safe had lasting positive impacts on California's social support infrastructure by breaking down silos between APS staff and homeless service sector staff**. APS staff have expertise with aging and people with disabilities, and homeless services staff have expertise in housing and homelessness; Home Safe provides an opportunity for cross-sector collaboration and shared learning that can increase the capacity of both systems.
- **Home Safe staff and leadership identified Home Safe's flexible funding as key to the program's success,** enabling the program to meet participants' needs.

Implementation

- **The most common intervention types** were enhanced case management, rent payment, and housing navigation.
- **The most common direct expenditures** were rent payments, temporary housing, security deposits, and emergency shelter.
- **The median cost per Home Safe case was $1,326**. In several counties, high case costs drove expenses, but these costs may have reflected the total cost of long-term interventions that spanned many months or years.

Maintenance

- **Some counties' Home Safe programs ran out of funding before the end of the project period;** other counties' programs limited their enrollment and intervention types to preserve funding to maintain their programming.
- **Home Safe leadership and staff expressed concern about program continuation, noting that their investment in staff training and program-building would be lost if program funding ended**. Additional one-time funding allocated for fiscal year 2025-2026 may not alleviate these concerns, as leaders continue to worry about program sustainability.

[b] Naturally occurring affordable housing (NOAH) refers to unsubsidized multifamily units, which due to age, location, condition, and other market factors, are able to offer rents affordable to low-income households.

Recommendations

- **Provide sustained funding and technical support to ensure continuity of services and preserve program capacity.** Home Safe fills a critical gap in the homeless response system by providing homeless prevention services and by increasing the capacity of APS and homelessness services systems through improved cross-sector alignment. If uninterrupted funding is not feasible, policymakers should consider providing technical assistance to help programs manage periods of funding uncertainty.
- **Ensure grantees can use funding flexibly.** Flexible funding is essential to Home Safe's success by allowing counties to tailor programs to their needs and by allowing staff to meet the clients' diverse needs.
- **Leverage CalAIM reimbursement to expand reach and better support Home Safe clients with complex needs.** Many clients' needs exceeded program resources. CalAIM (through California's Medicaid 1115 waiver) can be used to reimburse programs for some Home Safe interventions. This would allow grantees to use existing funding to meet clients' needs better or to expand participation.[2] Programs should further integrate service delivery with health systems. State agencies should work with grantees to find new ways to leverage the 1115 waiver.
- **Home Safe providers can use their experience to train and guide organizations** that provide homelessness prevention services to other populations using different funding sources, such as CalAIM.
- **Reduce fear and stigma around APS and Home Safe.** To increase reach, Home Safe programs should implement educational campaigns that reduce barriers to engagement, clarifying that it is voluntary and flexible, and that homelessness is a qualifying criterion.
- **Partner with trusted community groups.** To reach eligible populations that Home Safe is not serving, grantees should contract with agencies and nonprofit providers who have established expertise and trust within these communities.
- **Increase the supply and affordability of housing accessible to low-income older adults and people with disabilities.** The lack of deeply affordable housing limits Home Safe's effectiveness to prevent and end homelessness.

Recommendations to improve future evaluation and understanding of impact

- **Develop locally tailored evaluations to improve understanding of Home Safe implementation and effectiveness in Tribal contexts**. CDSS should collaborate with Tribal nations to co-develop these evaluations.
- **Establish standardized program accounting practices** for program costs to provide insights into resource utilization, program participant needs, and program impact.
- **Improve program entry data,** including the length of the current episode of homelessness. Doing so could provide meaningful insights into Home Safe's ability to divert and end episodes of homelessness.
- **Use HMIS data to identify what proportion of individuals returned to seek homelessness services**, if available.

Introduction

Nationwide, there is a need for effective strategies to prevent and end homelessness.[3] California is short nearly 1 million units of affordable rental units for extremely low-income (ELI) individuals—those earning 30% or less of the area median income.[4] This shortage leaves many ELI households at high risk of homelessness.[5] More than three-quarters (78%) of ELI residents in California experience severe housing cost burden, spending half or more of their income on housing.[4] Older adults are more likely than others to live on fixed incomes. California renters aged 62 years and older face a high rent cost burden, with 59% cost-burdened (paying >30% of their income in rent) and 37% severely cost-burdened (paying >50% of their income in rent). Severe housing cost burden is a risk factor for homelessness.[6–8] Individual vulnerabilities, such as physical disabilities or behavioral health issues, further compound this risk.[9] The 2024 national average cost for a one-bedroom rental unit was 142% of the average SSI payment, with California reaching as high as 168%.[10]

Older Californians face rising rates of homelessness. Adults aged 50 and older are the fastest-growing age group facing homelessness, accounting for approximately half of homeless adults, with rates expected to continue increasing.[11] Approximately half of single homeless adults are aged 50 or over. Our research found that 41-44% of adults aged 50 or older who were homeless experienced their first episode after turning 50.[12] [13] Once homeless, older adults face substantial barriers to regaining housing. Homelessness severely impacts health and well-being; homeless adults aged 50 or older exhibit worse cognitive and functional status (including the ability to complete activities of daily living, such as bathing or transferring from a chair) than their peers in the general population who are two decades older.[14] Adults experiencing homelessness have poor access to longitudinal care and high rates of use of acute care, including the emergency department.[15] Among older adults who are homeless, those who first became homeless after 50 had higher death rates than those who had been homeless since before they were 50.

Ending homelessness requires not only housing those who are currently homeless but also preventing homelessness among those at high risk. Identifying individuals during acute periods of risk and intervening with appropriate resources is essential. The National Alliance to End Homelessness outlines five principles for homelessness prevention: rapid assessment, triage and creation of an actionable plan to maintain housing; respect for the individual's preferences and choices; light-touch assistance essential to save housing; integration with services available in the community; and targeting those who are at the highest risk of becoming homeless, but who have a good chance of remaining housed with assistance.[16]

To achieve its goals, homelessness prevention must be both effective (in preventing homelessness) and efficient (targeting those at highest risk).[17] Older and dependent adults may face distinct risks compared to those experienced by youth, families, and young adults.[18]

Homelessness diversion addresses the needs of those who recently became homeless to end their homelessness rapidly. Employing many similar methods to prevention, diversion relies less on targeting, as participants have already become homeless. Diversion involves connecting individuals with natural supports (such as family, friends, and community connections other than shelter or government systems), identifying safe short-term and permanent housing options, and providing case management and financial assistance to restore sustainable housing, reduce trauma, and lessen the demand for more intensive and long-term local homeless services.[19]

The Home Safe pilot program was created in response to rising homelessness among older adults in California. Established by Assembly Bill (AB) 1811 (Chapter 35, Statutes of 2018),[20] it allocated $15 million from the General Fund for county APS agencies to start Home Safe programs with a 1:1 match requirement. APS agencies in 25 counties operated pilot Home Safe programs during this period. In 2021 and 2022, $185 million in additional Home Safe funding was appropriated (in two $92.5 million tranches) available over multiple years and the match requirement was removed. This allowed the program to expand to all 58 counties starting in FY 2021-22. [21,22] Furthermore, a Tribal Government set-aside allowed Tribes to establish Home Safe programs for the first time as well.[23] The All Tribal Leader Letter dated July 26, 2022, announced a non-competitive set-aside for Tribes, Tribal organizations, Tribal consortium, and Tribally led nonprofits in California.[24] Home Safe funding was awarded to 23 Tribal grantees. Neither quantitative nor qualitative Tribal data was collected for or included in our evaluation.

Home Safe aids vulnerable aging and dependent adults engaged with APS who are either currently experiencing or at risk of homelessness by providing funding for APS programs to provide homelessness prevention and diversion, either within their agencies or through contracted partners. APS investigates unsafe situations affecting dependent adults and those 60 years or older who cannot meet their own needs or who are victims of physical abuse, sexual abuse, mental/emotional abuse, neglect, abandonment, self-neglect or financial abuse—which may contribute to homelessness. APS workers interact with vulnerable elders at moments of crisis and are well-positioned to identify those at imminent risk for homelessness and then intervene to prevent its onset.

For the purposes of Home Safe, Welfare and Institutions Code (WIC) section 15770 defines an individual as experiencing homelessness or at risk of homelessness if their living situation poses an imminent health or safety risk; if they lack a regular or fixed nighttime residence; have received a judgment for eviction, a pay-rent-or-quit eviction notice, credible evidence that an eviction is imminent; or if APS staff has a substantiated report of abuse, neglect, or financial exploitation. The statute requires that individuals do not have any identified or available replacement housing and lack the resources or support network to obtain other permanent housing.[25] Although not stated in the statute, actual or threatened foreclosure or non-leaseholder de facto “evictions” from shared housing fit the definition of imminent risk; participants experiencing these risks could be assisted with Home Safe funds.[26]

Home Safe offers immediate monetary assistance and housing stabilization services, including case management, landlord mediation, and eviction protection. The CDSS provided grantees with best practices guidelines, including systematized referrals to the Coordinated Entry System (CES) for participants experiencing homelessness, and adherence to Housing First[c] principles.[27]

Early identification of housing instability enables interventions that reduce pressure on homeless services. Home Safe is designed to support participants until housing stability or connection to permanent housing is achieved. This may require short-term, medium-term, or long-term support, depending on the individual’s needs, and is independent from APS services.[27]

Not all APS clients are eligible for a Home Safe intervention; those who are not currently experiencing homelessness or whose circumstances do not put them at imminent risk of losing their housing do not qualify.[25,27]

[c] “Housing First means that individuals should be connected to housing or housing supports immediately without preconditions, services shall be voluntary, client choice shall be respected, and applicants shall not be rejected on the basis of income, past evictions, substance use or any other behavior that may indicate a lack of ‘housing readiness.” (CDSS Home Safe Program General Program Overview and Best Practices)

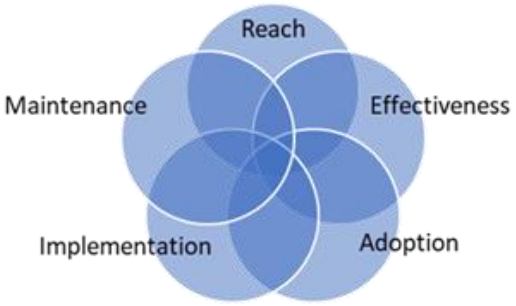
Home Safe fills a critical need in California. By focusing homelessness assistance and prevention resources into a mainstream program that engaged older adults in moments of heightened vulnerability to homelessness, Home Safe enabled staff with deep expertise in the needs of older adults to intervene to end, prevent (or divert) homelessness. There is general acceptance of the interventions that can prevent homelessness—flexible funding to pay for housing costs during discrete crises, case management, housing navigation to ensure that participants have access to resources or could locate new housing, and legal assistance to help individuals exercise their rights when faced with evictions and other threats to housing. However, the challenge with homelessness prevention lies in identifying people at high risk and being able to act quickly. Home Safe was designed to fill the need created by the growth in homelessness among older adults.

Evaluation Design

Research Framework

BHHI used the RE-AIM[d] research framework to guide the evaluation. RE-AIM makes use of five dimensions to examine key aspects of program operation:

- **R**each—Did the program reach the targeted population?
- **E**ffectiveness—What impact did the program have?
- **A**doption—What support does APS draw on to deliver the program?
- **I**mplementation—How was the program delivered?
- **M**aintenance—Is the program set up for long-term success?



Quantitative Methods

Filtering cases to the current evaluation period

BHHI received Home Safe programmatic data for all 58 counties available as of February 4, 2025. Tribal grantees did not submit data as part of the Home Safe evaluation. To focus the evaluation on the expansion of Home Safe after the initial pilot phase, we filtered the data to exclude cases that concluded prior to September 30, 2022. Therefore, we included cases that had at least one intervention on or after October 1, 2022, regardless of start date. To eliminate errors, we excluded those cases whose start date was after the closure date or after February 4, 2025, the date counties submitted their data. Using these criteria, there were 7,308 observations from 56 counties.[e]

Eight percent of Home Safe participants had more than one case (i.e., Home Safe closed one case and opened another); 1.5% had two or more cases within six months of one another or had overlapping case dates (which suggests that these could have been considered the same case or a data error). We treated those with two or more cases within six months as a "single case". We retained the earliest case start date, used the latest closure date, and aggregated

[d] RE-AIM stands for Reach, Effectiveness, Adoption, Implementation, Maintenance

[e] The two counties excluded from analysis due to lack of any data in the evaluation period are Alpine and Sierra counties.

information about interventions and amounts received. We dropped the second case in participants with more than two cases or those whose cases were more than 6 months apart from analysis, since we couldn't consolidate their cases (N=599), leaving 6709 cases. In a sensitivity analysis examining whether there were differences in the second versus the first case, there were no significant differences, supporting this analytical choice.

Data Cleaning

Before analysis, we cleaned and recoded the data following the variable definitions outlined in Home Safe Adult Protective Service (HSAPS) 19 All County Information Notice No. I-02-23[i].[28] We shared the recategorization decisions with the CDSS HHD data team for review and feedback to ensure accuracy.

Housing Status and Housing Trajectory

We defined a participant as:

- Homeless if their living situation was "homeless" or "temporary housing."
- Housed if their living situation was "rent leaseholder," "owner," "other permanent housing," or "permanent residential program."

We categorized the housing for those who met neither criterion as "unknown." We excluded those who died or those whose housing was described as "other/temporary residential program" living situations from analyses of housing outcomes. We defined housing trajectory as the combination of housing status at program entry (case start) and program exit (case closure).

Analysis

We analyzed the data by housing status, housing trajectory, and region, where CDSS guidelines determined seven regions: Los Angeles, Bay Area, Southern California, San Joaquin Valley, Sacramento area, Central Coast, and Balance of the State.[29] We used programmatic data to describe the population (including housing) and the interventions. We analyzed differences for selected analyses. We analyzed interventions and their costs. We grouped similar explanations for interventions classified as "other" and explained what that meant. We assessed the amount spent on interventions by county, region, housing status, and housing trajectory. We assessed whether counties that began programming during the Home Safe pilot phase differ from counties in the expansion phase in case characteristics, costs, duration, and outcomes.

To assess cases that received direct payments for housing, we combined rent back pay, mortgage payment, rent payment, and security deposit, since receiving direct housing support iindicates that someone had housing at some point during their case.[f] We analyzed cases by housing trajectory and the receipt of any of the direct housing payment interventions. Some proportions in tables may not add up to 100% due to rounding.

Case Closure

We assessed Home Safe participants' housing trajectories from program entry (case start) to exit (case closure). We determined a case to be closed if it had a closure date. For cases that

[f] We evaluated whether specific interventions were associated with housing status at exit by performing Chi-square tests between living situation at exit and whether a specific intervention was received. We assessed if total amount received varied by intervention type using Mann U Whitney tests between total amount received and each intervention type. Chi-square tests and Mann U Whitney tests were performed within individuals housed and homeless at entry, separately.

noted a living situation at exit but did not have a case closure date, we included them in analyses of living situation at exit but excluded them from analyses of case duration. We excluded individuals who died or were in institutional settings at entry or exit from any housing trajectory analyses. To assess housing outcomes, we had a sample of 3,887.
Using the housing status variable, we assessed:

- the proportion of individuals who were housed at entry and remained housed at exit,
- the proportion of individuals who were homeless at entry and housed at exit,
- the proportion of individuals who were housed at entry and homeless at exit, and
- the proportion of individuals who were homeless at entry and still homeless at exit.

Qualitative Methods

BHHI conducted interviews with 14 grantee counties from eight geographic regions. We chose one county grantee in each of the eight regions that participated in the Home Safe pilot before September 30, 2022. One pilot region, Los Angeles, had only one county; in another (the inner Bay Area)—San Francisco, Alameda, and Santa Clara—had full participation in the pilot. In the other six regions, we chose a second county that was new to the program after the pilot. In those, we created pairs of grantees with similar weighted average demographic and homelessness indicators. We had a total of 14 counties, with six dyadic pairs.[g]

Table 1. County Grantees for Qualitative Data

Region	Existing (Pilot) County	New County
Los Angeles	Los Angeles	--
San Francisco/Alameda/Santa Clara	Alameda	--
Rest of Bay Area	Sonoma	San Mateo
Northern	Butte	Colusa
Northern Central Valley	Sacramento	San Joaquin
Southern Central Valley	Kern	Tulare
Central Coast and Southern	San Diego	Santa Barbara
Inland	Nevada	Inyo

To understand the program, its impacts, and its challenges, we conducted in-depth interviews. Between August 2023 and July 2025, staff conducted panel interviews, key informant interviews, and separate dyadic interviews (with Home Safe Social Workers, and separately and individually, one or more of their clients). The panel interviews, conducted via Zoom, included Home Safe staff and contractors.[h] The key informant interviews, conducted by Zoom or phone, included people who worked in collaboration with and had knowledge of a grantee's Home Safe program but did not work for Home Safe (e.g., resource specialists, housing/facility and repair coordinators, program managers, case managers, behavioral health outreach staff, advocacy groups, and legal aid staff). The dyadic interviews, conducted by phone, included interviews with selected Home Safe social workers and Home Safe program participants they served.

[g] The overall population demographics we considered were: gender, age, race/ethnicity, education, homeownership, employment industry, poverty rate, unemployment rate, income, rent, home value, income inequality, population density, and total population (data source: Census Bureau). The homeless population demographics we considered were: overall count, gender, race, sheltered/unsheltered, family status, and chronicity (data source: PIT).

[h] Panel interviews included one to six Home Safe staff members or contractors participating in implementation

All interviewees provided informed consent. We audiotaped, transcribed, summarized, and thematically analyzed interviews to add context to the programmatic data collected by grantees. For individuals who declined to have us audiotape their interview, we took careful notes.

We interviewed 91 Home Safe staff and contractors, 12 key informants, 14 social workers, and 34 program participants.

Findings

Home Safe Program Participants

Home Safe serves older and dependent adults engaged with APS who are either experiencing or at risk of homelessness. The program aims to provide housing-related assistance, such as case management and financial assistance, to help stabilize their living situations and prevent homelessness or regain housing.

Most Home Safe program participants were older adults (60+) (82.5%). Home Safe staff and program participants described some of the needs faced by the older adult population.

> *"...if Home Safe goes away. Where are we going to have the funds to put her? She needs durable medical equipment to ambulate, so she walks with the walker, and she's also [supplemental] oxygen reliant. At Home Safe I was able to get her into a hotel for a couple of weeks until we could figure it out... I tried calling shelters just to just get an idea of what the trajectory is like. I must have called at least 5 shelters, and they all told me she would have to go and sit outside..."*
>
> *-County Grantee*

County grantees and social workers shared that many participants in the Home Safe program exhibited a combination of significant medical needs and financial constraints, which together create challenges to remaining housed. Older adults faced myriad health issues, including chronic pain, mobility challenges, and other debilitating medical conditions.[30] Inadequate housing conditions worsened these health problems, highlighting the need for accessible and stable housing.[31] Home Safe used a variety of interventions to help stabilize participants with complex health needs, including coordinating medical and mental health visits, providing essential medications, setting up In-Home Supportive Services (IHSS) services, providing in-home medical beds, repairing hazardous flooring, and building accessible shower and entrance facilities (e.g., ramps or railings) for participants with mobility impairments.

Many program participants reported that chronic pain and mobility issues limited their ability to perform daily activities, especially when they lived in housing that was not suited to their needs. County grantees note that many shelters are not equipped to provide adequate services to participants with complex health conditions, leaving them with no choice but to provide emergency hotel stays while they worked to identify stable housing.[32] These challenges included identifying shelters that could accommodate participants who were unable to climb into bunk beds or who required electric outlets in order to plug in supplemental oxygen.

Financial constraints exacerbated the difficulties faced by Home Safe program participants. Many participants' sole income was Social Security, which fell short of covering their basic monthly expenses, including rent, utilities, and food.[33] One participant noted receiving $915 per month from Social Security and Supplemental Nutrition Assistance Program (SNAP), leaving little to pay for housing, transportation, and other costs. Another participant, with a monthly

income of $1282, faced high utility and rent expenses, underscoring the financial hurdles to stable housing.

During panel interviews, several Home Safe staff highlighted the difficult choices participants made. One staff member stated, “We have a very aging community. People are really struggling with PG&E bills. They [have to] make decisions on paying bills versus [buying] food. You know, rent versus medicine. So, it’s just constantly a struggle, and as things go up and the income stays the same, it’s very challenging for folks to maintain their housing longer.” Another Home Safe staff member from a different county echoed the same sentiment, “…they have to make a choice about whether to buy food or pay rent. And when you’re on a fixed income, you don’t have a lot of flexibility to decide and keep, you know, one or the other together.”

The Home Safe program aims to mitigate these challenges by providing financial and other support, including initial deposits, temporary housing, and rent adjustments, to help prevent homelessness or reestablish housing. Program participants consistently highlighted how the program significantly improved their housing stability and overall well-being.

Total Cases in Reporting Period

Table 2. Total Cases in Reporting Period

Region	Reporting Agency	N (# of cases)
Bay Area	Alameda	311
	Contra Costa	153
	Marin	80
	Napa	66
	San Francisco	302
	San Mateo	65
	Santa Clara	165
	Solano	84
	Sonoma	172
Central Coast	Monterey	49
	San Benito	<20
	San Luis Obispo	73
	Santa Barbara	44
	Santa Cruz	52
Los Angeles	Los Angeles	756
Sacramento Area	El Dorado	<20
	Placer	60
	Sacramento	302
	Sutter	<20
	Yolo	63
	Yuba	32
San Joaquin Valley	Fresno	65
	Kern	566
	Kings	56
	Madera	23
	Merced	106

Region	Reporting Agency	N (# of cases)
	San Joaquin	43
	Stanislaus	192
	Tulare	143
Southern California	Imperial	29
	Orange	298
	Riverside	1014
	San Bernardino	<20
	San Diego	404
	Ventura	146
Balance of the State	Amador	29
	Butte	148
	Calaveras	<20
	Colusa	36
	Del Norte	<20
	Glenn	44
	Humboldt	95
	Inyo	<20
	Lake	<20
	Lassen	<20
	Mariposa	<20
	Mendocino	35
	Modoc	21
	Mono	<20
	Nevada	83
	Plumas	47
	Shasta	31
	Siskiyou	<20
	Tehama	<20
	Trinity	46
	Tuolumne	46
Total:		**6709**

The distribution of Home Safe cases varied by county. Counties with more people tended to have more Home Safe cases. While Home Safe caseloads varied in proportion to county population, they did not vary in proportion to either APS case load or the population of people experiencing homelessness in each county. Riverside and Kern had a disproportionately high number of cases relative to their respective county populations and populations of people experiencing homelessness. Los Angeles served only twice as many participants as Alameda or San Francisco counties, despite having seven times the number of people experiencing homelessness. [34] Differences in the ways grantees chose to design and implement programs (whom they serve, how many participants they serve, how they implement interventions) accounted for many of the observed differences between counties. Because counties implemented the program differently, including targeting different populations (e.g., only those at

risk of homelessness or those at risk of and those experiencing homelessness), the number of participants, the intensity of services, and the demographics of the population may differ.

Demographics

Table 3. Sociodemographic Characteristics of Home Safe Participants

Age (N = 6646)	Home Safe	PEH in California	APS cases
Mean +/- SD	66.5 +/- 11.5	-----	-----
Minimum, Maximum	18, 99	-----	-----
Median (Interquartile range)	67 (61, 74)		
% 65+	61.8%	6.5%	76.7%
Gender (N = 6571)			
Man	2963 (45.1%)	56.4%	42.7%
Woman	3592 (54.7%)	42.7%	57.0%
Non-Binary/Transgender	16 (0.2%)	0.9%	0.3%
Race (N= 5402)[i]			
American Indian/Alaskan Native/Indigenous	88 (1.6%)	4.2%	0.7%
Asian/Asian American	205 (3.8%)	2.6%	7.5%
Black/African American/African	942 (17.4%)	28.5%	10.6%
Native Hawaiian/Pacific Islander	34 (0.6%)	1.9%	0.5%
White	4133 (76.5%)	45.1%	64.4%
Other	----	-----	16.2%
Ethnicity (N = 5276)			
Hispanic/Latine	1162 (22%)	37.1%	21%
Non-Hispanic/Latine	4114 (78%)	62.9%	79%
Marital Status (N = 4622)			
Single/Never Married	1298 (28.1%)	-----	-----
Separated/Divorced	1406 (30.4%)	-----	-----
Widowed	846 (18.3%)	-----	-----
Married/Living Together	1072 (23.2%)	-----	-----
Sexual Orientation (N = 4609)			
Straight/Heterosexual	4449 (96.5%)	-----	96.7%
Not straight/Heterosexual	160 (3.5%)	-----	3.3%
Veteran (N = 5348)			
Yes	404 (7.6%)	6%	2.3%

Home Safe intended to focus on serving a different population (older adults and adults with disabilities) than the general population of those experiencing homelessness in California. The median age of Home Safe participants was 67 (interquartile range 61-74; range 18-99). Over 80% (82.5%) of Home Safe participants were aged 60 or older. By serving those at high risk of

[i] HDIS race data for PEH numbers reported as % alone or in combination with other races and thus add up to more than 100%

or experiencing homelessness, Home Safe focuses on a different population than that of APS participants overall.

Participants under age 60 were more likely to be enrolled while experiencing homelessness (rather than at risk of homelessness) than those 60 and older. (see Table 4).

Table 4. Demographic and Case Characteristics by Participants Under 60 and 60 and Older.

	Under 60	60 +
Gender		
Man	571 (49.1%)	2369 (44.4%)
Woman	593 (51%)	2971 (55.6%)
Race		
American Indian/Alaskan Native/Indigenous	22 (2.3%)	65 (1.5%)
Asian/Asian American	36 (3.8%)	167 (3.8%)
Black/African American/African	192 (20.2%)	743 (16.8%)
Native Hawaiian/Pacific Islander	----	27 (0.6%)
White	693 (73.0%)	3411 (77.1%)
Ethnicity		
Hispanic/Latine	271 (29.5%)	883 (20.4%)
Non-Hispanic/Latine	647 (70.5%)	3438 (79.6%)
Housing at Entry		
Homeless	674 (63.4%)	2411 (49.4%)
Housed	390 (36.7%)	2467 (50.6%)
Housed, with homelessness history in prior 3 years[j]		
Yes	73 (24.8%)	255 (12.2%)
Housing at Exit		
Homeless	219 (31.9%)	775 (22.5%)
Housed	459 (66.8%)	2593 (75.4%)
Deceased	----	70 (2.0%)
Total Amount Per Case		
Median (IQR)	$1235 [$420, $3826]	$1325 [$450, $3439]
Mean (sd)	$4609 ($9344)	$4097 ($8936)

Home Safe served a higher proportion of women (56% over the age of 60 and 51% younger than 60) than the population experiencing homelessness. Most people experiencing

[j] These data were optional. These analyses exclude those who are missing this homelessness history data. Home Safe grantees reported whether someone had been homeless, the duration of their homelessness, and the number of times they were homeless in the three years prior to their Home Safe case. For some, these data elements lacked internal consistency, with discrepant data. We used any instance of prior homelessness as evidence of prior homelessness, overriding other responses that conflicted. This may overestimate the proportion of Home Safe participants with past experiences of homelessness.

homelessness in California are men.[35] This difference could be a result of who is referred to APS or point to different patterns of service utilization.

The Home Safe population served was majority white (76.4%); 17.4% of the population identified as Black, and 0.6% of the population identified as American Indian, Alaskan Native, or Indigenous, and nearly a quarter (22%) identified as Hispanic/Latine. Black and indigenous Californians, and to a lesser extent, Latine Californians, are dramatically overrepresented in the population of people experiencing homelessness;[31] Black and indigenous Californians are overrepresented among older homeless adults.[35] Because the Latine population (and Latine population experiencing homelessness) is younger, Home Safe serves a similar proportion of Latine individuals compared to those who are older adults experiencing homelessness in California.[35]

Home Safe participants are more likely to be Black, indigenous, and Latine than APS clients overall, but less likely to identify as Black, indigenous, or Latine than the homeless population overall.

Table 5. Proportion of Black, indigenous, and Latine individuals in the overall population:

	California[36]	Home Safe	APS[37]	People Experiencing Homelessness in California (PIT)[34]
Proportion of Black Individuals	5.7%	17.4%	9.4%	22.2%
Proportion of Native Individuals	1.6%	0.6%	0.5%	3.0%
Proportion of Latine individuals	39.4%	22%	12.7%	36.9%

In considering these demographic differences, one could consider Home Safe as an APS program or a prevention/diversion program for people experiencing homelessness (PEH). If viewed as a homelessness prevention/diversion program, Home Safe should strive to serve populations in proportion to their presence in the population of people experiencing homelessness. If viewed as an intervention for adults experiencing abuse and neglect who face homelessness (or the threat thereof), Home Safe's reach should match the racial and ethnic makeup of those served by APS who face housing instability or homelessness. Home Safe encompasses both perspectives.

We heard several grantees describe a "paradigm shift" within APS since the start of their Home Safe programs. Many staff began to recognize housing instability as a protective issue. One county grantee described this shift, "...the shift with APS and doing this work, and the community, the mandated reporters, knowing that we now have services around housing…it was really important to just help reframe that, that eviction is a protective issue, and that they can make a report."

Although the population that APS serves may never match the demographics of people experiencing homelessness, Home Safe could reduce this discrepancy. The Home Safe model could be expanded to include similar models within agencies/non-profit organizations that have expertise and trust in communities with older adult homeless disparities. Home Safe could have a contractor outside of APS engage participants who meet other Home Safe criteria without requiring that participants meet APS criteria or be evaluated through APS.

Home Safe serves a higher proportion of Black and Indigenous adults compared to their representation in all APS cases. This higher level of engagement among Black and Indigenous adults may be due to these communities' increased risk of homelessness due to structural and

historical discrimination. Home Safe reached older adults within APS who were at high risk of homelessness. APS programs should strive to conduct outreach to communities at the highest risk of homelessness. California should ensure that Home Safe programs have the resources and support to be rolled out equitably in counties with disproportionate representation of those who face inequities (such as those from racial and ethnic minoritized groups or those from rural areas).

Table 6. Proportion of Black, indigenous, and Latine individuals of those 60+:

	California[35]	Home Safe	APS[37]	People Experiencing Homelessness in California (CASPEH)[35k]
Proportion of Black Individuals	6%	16.8%	9.4%	31%
Proportion of Native Individuals	0.3%	0.6%	0.5%	3%
Proportion of Latine individuals	28%	20.4%	12.7%	18%

Grantees had a wide latitude in how they implemented their Home Safe program. Some served a larger proportion of people who were already experiencing homelessness, using Home Safe services to either divert those newly homeless or end homelessness among those with longstanding homelessness. Others used it primarily to prevent homelessness among those who were housed. Different strategies may reflect different conditions: housing costs and availability, administrative costs, and the makeup of their communities. Some counties served a higher number of people with less intensive resources, and others served proportionally fewer with more intensive resources. Sociodemographic differences between counties that served proportionally more (or fewer) people may be responsible for the differences in sociodemographic makeup between Home Safe participants and the older adult homelessness population.

For instance, Riverside County has a population of 2.4 million and reports fewer than 3,900 people experiencing homelessness in their PIT.[38]They reported 1,014 Home Safe cases. Los Angeles County has 10 million people and reports 75,000 experiencing homelessness in their PIT.[39] Los Angeles County reported serving 756 people in Home Safe. This difference can be explained by different approaches to Home Safe resources, including varied intensity and length of service. These differences complicate state-wide analyses of equity. Across the state, approximately 22% of the homeless population identifies as Black.[34] In Riverside County, 18% of those experiencing homelessness identify as Black, and in Los Angeles 31% do.[40] The comparatively larger caseload of Home Safe participants served in Riverside County versus in LA County could account for a relative "underrepresentation" of Black Home Safe cases compared to the population of people experiencing homelessness.

We recommend a continued effort to track the racial and ethnic breakdown within counties and compare them to the population at risk (seniors and people with disabilities), the population served by APS, and the population experiencing homelessness.

[k] PIT numbers do not include race breakdown by different age cutoffs.

Housing Outcomes: Participants' Living Situation at Program Entry and Exit, Among Those with Housing Data at Program Exit

Table 7. Living Situation at Program Entry to Exit, of those With Closed Cases (N = 3887)

Living Situation at Entry	Living Situation at Exit		
	Homeless	Housed	Total
Homeless	845 (41.6%)	1184 (58.4%)	2029
Housed	114 (6.1%)	1744 (93.9%)	1858
Total	959	2928	3887

The flexibility of Home Safe allows staff to determine when cases should be closed. The time to case closure varied within and between grantees. When staff opened and closed cases, they reported participants' housing status. We had housing data at entry for most Home Safe participants (N = 5998). For those 5998 cases, we had housing data at case closure for 3,887 of those. (Of the 2111 who were missing data, 1408 were because the case remained open, and 703 because the individual was deceased or the case was closed, but there was no housing data recorded.) Among those with data at program entrance, Home Safe clients were evenly divided between being homeless (51.9%) and housed (48.1%).

For the 3,887 with closed cases for whom we had housing data at entrance and case closure, we calculated the proportion who were housed at case closure, analyzing separately for those who entered housed versus those who entered homeless. We would expect higher housing rates among those who entered housed, where Home Safe was engaged in homelessness prevention, than among those who entered homeless. Of participants with closed cases, 93.9% of participants who were housed at program entry remained housed when their case closed; 58.4% of those who were homeless at the start of their case were housed when their case closed (Table 7).

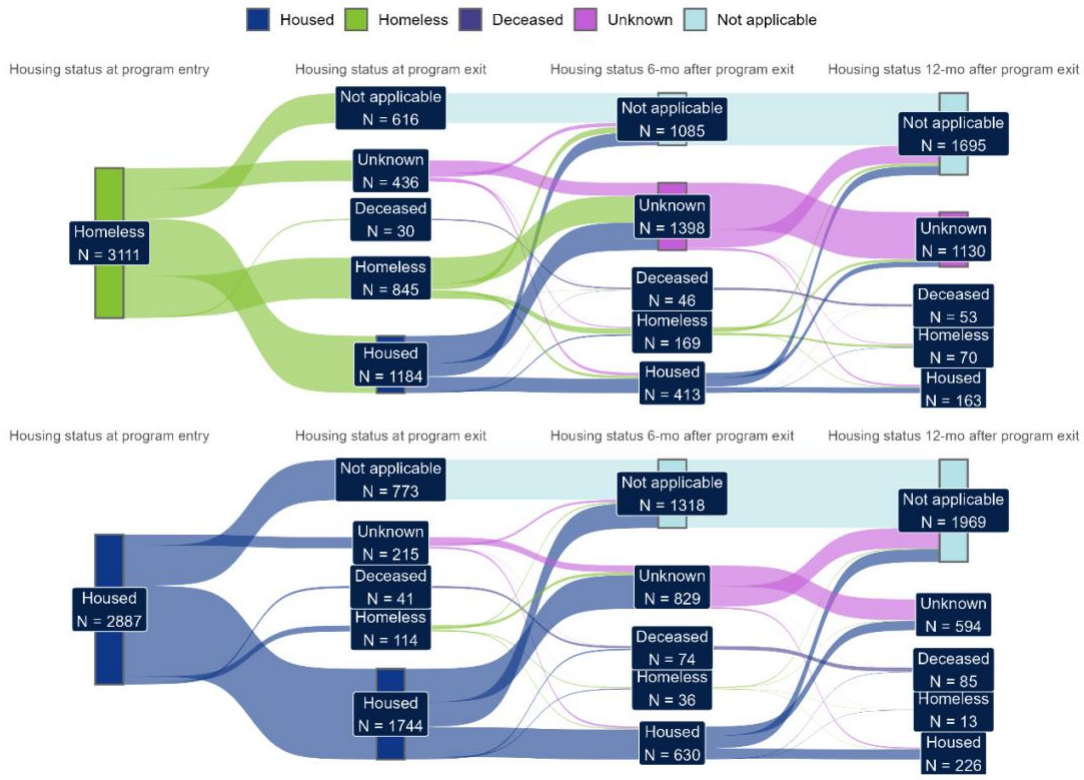
Next, to understand the range of findings assuming we had complete data, we conducted sensitivity analyses. In these, we assumed an outcome for cases that remained open for a full year. (The median case closure time was three months). First, we created the most *pessimistic* estimates of outcomes by assuming that all cases that were *missing a living situation at case closure* or that were *open for more than a year* (and therefore not included in the analyses) signaled that the participant was *homeless*. This gives us the lower bound of housing outcomes at case closure. With these assumptions, among those who entered housed, 71.0% were housed at exit, and among those who entered homeless, 42.7% were housed at exit. Next, we reanalyzed the results at case closure with the most *optimistic* outcomes: assuming that all who either were *missing data at case closure,* and those whose *cases were still open at one year* were *housed*. With these assumptions, we would estimate that among those who were housed at entrance, 95.4% were housed at exit and among those who were homeless at entrance, 69.5% were housed. Thus, the range of possible outcomes for those who entered housed (at case closure) is between 71.0% and 95.4% and for those who entered homeless is between 42.7% and 69.5%.

For comparison, we examined data from the Homeless Data Integration System (HDIS), which collates all data from Homeless Management Information Systems throughout California (all people who receive homeless services). Among people who entered the HDIS system during an episode of homelessness, 18.8% were reported as housed at exit. Among those who entered HDIS for homelessness prevention (were housed when they entered), 82.4% remained housed at exit. These data should be interpreted with caution based on the different ways HDIS and Home Safe define cases, and different levels of risk of those entering HDIS and Home Safe. For

example, HDIS views a program exit as leaving a single program. So, a person who moves from unsheltered homelessness into a shelter and then from shelter into housing would have one "case" where they remained homeless and another "case" where they gained housing. HDIS homelessness prevention programs may see a higher or lower degree of risk.

Housing Outcomes at 6- and 12-months following Case Closure

Figure A. Living situation at entry,[l] exit, 6- and 12-month follow-up[m]



Home Safe staff were asked to contact participants at 6- and 12-months after case closure to determine their housing outcomes. Gathering these data is difficult. In the majority of cases, staff were unable to report 6- and 12-month follow-up data. However, even with limited data, the results are illustrative. In Figure A, we use colors to present the outcomes of participants at program exit, 6, and 12 months after program exit. We divided the figure into those who were homeless at entry (n=3111), represented in green, and those who were housed at entry (n=2987), represented in blue. At each time point (program entry, exit, 6- and 12-months after program exit), we represent the outcomes, along with the number of participants.

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[l] A county grantee "closed" a participant's case when they stopped providing interventions. A participant "exited" the program when their case was closed.

[m] "Not applicable" indicates cases that had not yet closed or had not yet reached the applicable follow-up period.

Of those housed at program entry, the vast majority remained housed at program exit, and few of these participants (for whom the program collected data) became homeless later on.

Among those homeless at entry, slightly more than half were housed at program exit. Most who had regained housing at exit and had 6- and or 12-month follow-up data remained housed, but most did not have these data. Of those homeless at program exit, most did not have 6- or 12-month follow-up data. Of those who did, most remained homeless.

When Home Safe participants required further assistance at the program's 6- or 12-month post-case closure follow-up, staff could open a new case if participants qualified under APS guidelines. This reflected a cultural shift within APS from the previous practice of closing cases without further follow-up contact. Among all Home Safe participants, 7.8% had one, or more additional cases opened after their initial case closure.

Missing data could have biased our results. There are many possible reasons for missing data at 6- and 12-months post-case closure. If the programs did not attempt to obtain these data, because it took time away from caring for participants, the missingness would be random. This would mean that those with missing data were no more or less likely to be homeless at 6- and 12-months. If the missing data were because programs could not reach participants because they didn't have working phone numbers or addresses, or because participants who were homeless were ashamed to talk to staff, those with missing data would be more likely to be homeless. If this were true, the findings would overstate the positive outcomes. It is possible that those who were homeless were more likely to have 6- and 12-month data, if participants who needed more help reached back and reported on their homelessness. If this were true, the findings would overstate the proportion who were homeless.

Other Case Characteristics

Table 8. N (%) of reporting source by housing status at Home Safe entry, collapsed

Reporting source	Homeless	Housed
Community Member*	456 (23.1%)	504 (24.4%)
Family or Anonymous	93 (4.7%)	124 (6.0%)
Health Care Worker	189 (9.6%)	210 (10.2%)
Self	517 (26.2%)	307 (14.9%)
Social Services, Law Enforcement**	716 (36.3%)	917 (44.5%)

*Not involved with homeless services necessarily

**Law enforcement that work with homeless services

We analyzed the reporting source for participants' cases, stratified by their housing status at entry (homeless versus housed). People who were homeless at program entry were more likely to self-report to APS rather than being referred to APS by a social services provider.

We analyzed key sociodemographic characteristics of those who were housed and homeless at entry and compared sociodemographic characteristics by participants' living situation at case closure. Whether entering housed or homeless, we found no significant differences in age, gender, race, ethnicity, sexual orientation, or veteran status for those who exited either housed or homeless. For those who entered housed, those who were married were more likely to exit housed (Appendix Tables 1 and 2). There was an association between the total amount spent and outcomes for participants who entered homeless. Those who exited housed had a higher amount spent. Spending more money helped staff find housing and securing stable housing cost money.

Table 9. Total amount spent per case by housing trajectory, of those with direct intervention expenditures (N = 2777)*

Housing from Entry to Exit	N (%)	Median [IQR]
Homeless to Homeless	399 (14.4%)	$1580 [$408, $5402]
Homeless to Housed	952 (34.3%)	$3520 [$1422, $8536]
Housed to Homeless	71 (2.6%)	$3075 [$1106, $8060]
Housed to Housed	1355 (48.8%)	$2709 [$1065, $6338]

* Table columns may not sum to 100% due to rounding.

When staff could not identify housing solutions, they spent less money (Table 9). Among participants for whom there were any direct intervention expenditures, grantees spent the least on those who remained homeless and the most on those who went from homeless to housed.

Table 10. Median [IQR] of case duration by housing trajectory

Status	Case Duration Median [IQR] in days
Homeless to Homeless	62 days [29, 142]
Homeless to Housed	117 days [56, 263]
Housed to Homeless	81 days [49, 151]
Housed to Housed	81 days [38, 156]

Participants with a closed case had a median case duration of 84 days. A small fraction (3.1%) of cases were less than one week. About a fifth (18.5%) of cases were about a month long. Those who both entered and exited homelessness had the shortest median case duration; those who were homeless at entry but housed at exit had the longest median duration.

Over half of participants' (57.9%) cases were closed during the evaluation period. Open cases had a longer median length (372 [258, 574] days) than closed cases, which could indicate simpler cases that could be closed faster, cases closed due to participants' choice, lack of participant engagement, or challenges staying in contact. Shorter cases may indicate rapid resolution, and cases in which higher barriers prevented sustained contact or assistance.

Table 11. Case characteristics by pilot and expansion counties

Total Amount Per Case *	Pilot county	Expansion county
Median (IQR)	$1148 [$0, $5283]	$1875 [$200, $5761]
Mean (SD)	$5742 ($11958)	$4803 ($8003)
Case Duration		
Median (IQR)	76 days [35, 161]	119 days [61, 226]
Housing at Entry		
Homeless	2576 (57.2%)	535 (35.8%)
Housed	1928 (42.8%)	959 (64.2%)
Housing at Exit		
Homeless	856 (26.5%)	150 (16.2%)
Housed	2324 (72%)	746 (80.5%)

Total Amount Per Case *	Pilot county	Expansion county
Deceased	48 (1.5%)	31 (3.3%)

*Total amount spent per case is for direct expenditure on interventions.

Twenty-five grantee counties operated Home Safe programs during the pilot period. During the evaluation period covered in this analysis, these counties served a higher proportion of people enrolled while homeless and had a shorter average case duration. The higher proportion of participants who entered homeless could reflect that pilot counties tended to be larger counties with larger homeless populations and may have developed stronger relationships with their local homelessness service planning bodies, known as Continuums of Care (CoC), allowing for more referrals of people experiencing homelessness.

Program Implementation

Assessments

While the program required county grantees to assess participants' housing needs and develop a plan to meet those needs, there was no standardized assessment tool. County grantees used a mix of tools to understand client needs, most commonly the Standard APS Risk Assessment, the VI-SPDAT Vulnerability Index - Service Prioritization Decision Assistance Tool, and PR-VI-SPDAT (Prevention and Rapid Rehousing Vulnerability Index - Service Prioritization Decision Assistance Tool), and various bio-psycho-social assessments. Most used a combination of tools to assess eligibility and needs at different stages of a client's case.

Most grantees reported that the assessment tools helped determine and triage the needs of a participant and in guiding potential interventions and referrals, but most did not use these to prioritize who received services.

While many grantees find these tools helpful, some staff reported that the instruments were redundant or contained invasive questions that damaged relationships. Some APS social workers reported completing multiple similar assessments for the same client.

Operational Model

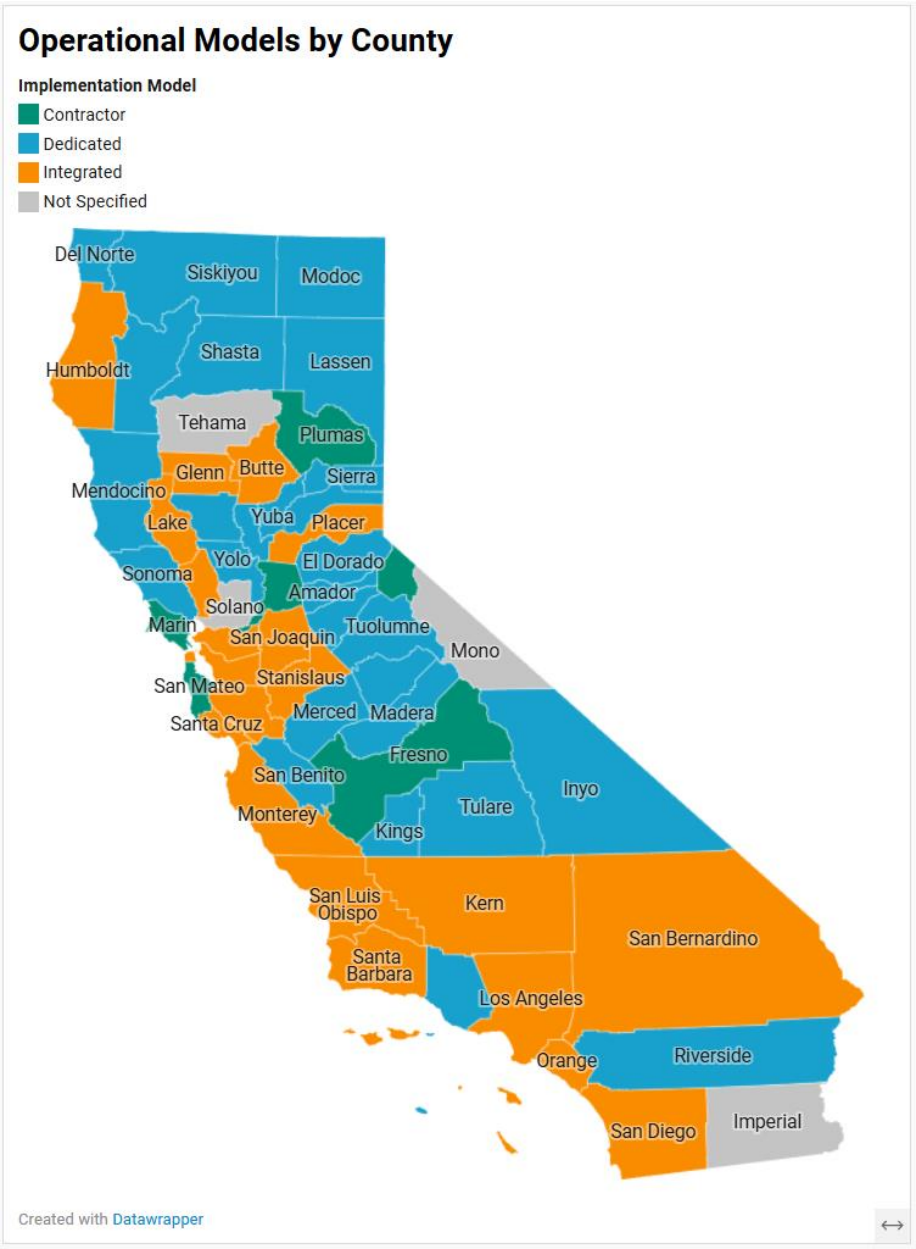
Home Safe allowed grantees to choose the implementation model that would work best for their program, based on their unique needs and capabilities (e.g., the size of their service area, population density, staffing constraints, and funding). Nearly all considered this flexibility to be a program strength.

County grantees developed different models to best meet their needs. There were three main operational models. The first model incorporated Home Safe into APS' usual case work ("Integrated"). The second model established a dedicated Home Safe social worker or unit of social workers within APS ("Dedicated Home Safe"). The third used contractors for all or part of Home Safe's implementation, including contractors for case management, housing navigation, or legal services ("Contractor"). This model could include elements of either the Integrated or Dedicated models. Staff from counties that used the Contractor model noted that they chose contractors who had established relationships with service providers, which facilitated referrals.

For fiscal year 2023-2024, CDSS asked grantees to complete the annual Program Update Survey, which provides a comprehensive update from grantees operating a Home Safe program. Figure B shows operational models by county as reported to CDSS by grantees in December of 2024. We asked qualitative interview participants to describe their operational models. Table 12 shows operational models as described by grantees during qualitative interviews. In these interviews, some grantees we spoke with made changes to their operational

models after completing the Program Update Survey, thus they may not match the operational models pictured in Figure B.

Figure B. Operational Models by County as of December 2024*



*Operational models are pictured here as reported to CDSS in December 2024. County-specific operational models could change over time and may not match the models described elsewhere in this report.

Table 12. County Operational Models and Housing Navigation of Counties included in Qualitative Interviews

Major City CoC	Operational Model PILOT	Operational Model CURRENT	Housing Navigation
Los Angeles	Dedicated Model with Contractor	Dedicated Model with Contractor	Dedicated contractor assists with housing navigation
San Diego	Contractor	Contractor	Dedicated contractor assists with housing navigation
Alameda	Integrated Model with Contractor	Integrated with Contractor	Dedicated contractor assists with housing navigation
Santa Barbara	Not in Pilot	Integrated	General—caseworkers help with housing navigation
Sacramento	Dedicated Model with Contractor	Dedicated Model with Contractor	Integrated—APS/HS workers assist with housing navigation Contractors do follow-up instead.
Other Largely Urban CoC			
Kern	Integrated Model with Contractor	Integrated **without** Contractor	APS/social worker helps with housing navigation
San Joaquin	Not in Pilot	Integrated	Dedicated housing navigator within APS
Largely Suburban CoC			
Sonoma	Dedicated Model with Contractor	Dedicated Model with Contractor	In house social worker dedicated to housing navigation
San Mateo	Not in Pilot	Integrated with Contractor	Dedicated contractor assists with housing navigation alongside APS and HSA
Largely Rural CoC			
Inyo	Not in Pilot	Integrated	General—participants do their own searching
Nevada	Integrated	Integrated with contractor	Nobody is dedicated to looking for participant housing--sometimes social workers can help but mostly on participant
Tulare	Not in Pilot	Integrated	Assigned APS social worker for housing navigation
Colusa	Not in Pilot	Integrated	Built-in housing case management unit—case workers have contacts and offer substantial assistance
Butte	Integrated Model with Contractor	Dedicated	Contracts out to shelter case managers to help participants navigate housing

Dedicated Model: Establishes a dedicated social worker or unit of social workers within APS for Home Safe casework.
Integrated Model: Incorporates Home Safe requirements into normal APS casework.
Contractor: Allocates all or part of Home Safe casework, such as legal services, housing navigation, or case management, to a third-party contractor. Can be combined with the dedicated and integrated models mentioned above.

Table 13. N (%) of counties and cases by operational model

	Contractor	In-house	Hybrid	Not specified
Number of Counties (N=56)	5 (8.9%)	26 (46.4%)	20 (35.7%)	5 (8.9%)
Number of cases (N=6,709)	559 (8.3%)	2173 (32.4%)	3800 (56.6%)	177 (2.6%)

Grantees with contracted partners found that as these partners could use their own funds to deliver interventions (with the county reimbursing them later), they could provide more timely interventions to participants. These grantees shared that this ability to access funding quickly was crucial to their program's success. For this to be successful, counties would have to reimburse contractors promptly. One contractor operating on this model suggested that contracting organizations would benefit from receiving an initial advance of Home Safe funds so they would not have to wait for reimbursement for all funds. Alleviating budget pressure on contractors' ability to "push money out" more quickly overcame administrative barriers the county faces in disbursing funds when it administers the programs directly. The nature of homelessness prevention requires a fast response to prevent housing loss. Grantees viewed Home Safe's flexibility in allowing counties to make these arrangements as a strength.

Several grantees designated a Home Safe housing navigator responsible for all aspects of assisting clients regain housing, including locating available units, assisting with rental applications, obtaining necessary documentation, and overseeing lease agreements. This role helps consolidate work, allows for expertise, and streamlines services. Grantees without a designated housing navigator expressed that having one would be beneficial.

While the structure of the implementation models used by pilot grantees remained largely the same from the pilot to the expanded program, certain elements changed. These changes include switching contractors, adjusting the roles of existing contractors, and establishing agreements with other community organizations. One pilot grantee built a dedicated Home Safe unit using expansion funds, whereas during the pilot period they had staff split time between standard APS cases and Home Safe cases.

County grantees noted that the models they implemented met their needs and required little modification since the program launch. Some grantees had used a hybrid contractor model but had to end community contracts due to funding constraints. They then consolidated operations into an in-house model.

The lack of comparability between counties made evaluating the comparative effectiveness of different models difficult. There were no clear patterns to which models had the best outcomes. Counties, however, expressed that the choice and the diversity of models that allowed counties to meet their needs was crucial to Home Safe's success.

Continuum of Care and Community Partnerships

Several county grantees identified the need to enhance the collaboration between Home Safe programs and their local Continuum of Care (CoC). Some grantees have taken steps to improve collaboration—such as having Home Safe team members attend CoC meetings or inviting CoC liaisons to APS meetings. For instance, one county grantee highlighted their CoC's responsiveness and accessibility, noting that a representative regularly attends meetings to discuss core programs and wrap-around services. Another grantee engaged their CoC to train APS staff on the Coordinated Entry System.

> *"...We've created and are part of multidisciplinary team meetings where we're staying engaged with the other agencies, and we're talking about mutual [participants] and to help keep everyone informed and help keep that participant on track."*
>
> *-County Grantee*

Some grantees participate in multi-county CoCs, facilitating resource sharing and coordinated service delivery across county lines to better support Home Safe program participants.

Many county grantees emphasized the crucial role of community organizations and partnerships in enhancing program effectiveness. The ways programs collaborated varied: some grantees worked with dedicated contractors to implement aspects of Home Safe interventions, while others referred participants to local community organizations for supplemental assistance. This assistance included transportation, supplemental food, behavioral and physical health services, enrichment activities at senior centers, and emergency shelters.

Several grantees conducted multidisciplinary meetings with community organizations to devise strategies for better serving mutual participants or to reach individuals who were unaware of Home Safe but engaged with other services. These meetings involved a wide range of partners, including homeless and senior services, religious organizations, CoCs, contractors, behavioral health providers, law enforcement, and emergency services. One county grantee shared, "…I think it comes back to our relationship with our community partners because maybe they didn't [initially] come into our door, but then they're working with [other community organizations] so they [are made] aware of our program and would contact us."

Gaps Filled by Home Safe

Flexibility of Home Safe funds allowed grantees to tailor interventions to participants

The Home Safe program addresses a service gap in homelessness prevention and assistance for older and dependent adults. Grantees highlighted the critical role Home Safe funding played in enabling them to assist participants who would otherwise become homeless. County grantees praised both the availability and flexibility of funds; they reported that Home Safe transformed their ability to prevent homelessness in older adults. Home Safe allowed grantee staff to offer tailored approaches to program participants. They explained that one participant may need help paying back rent to keep their housing, while another may need temporary shelter before they find a long-term solution.

> *"...it's kind of like a breath of fresh air. The fact is that, you know, the funding...can be allocated...to meet the needs [of people] with less restraint..."*
>
> *-County Grantee*

Grantees shared that their Home Safe Program reached populations that many traditional homeless prevention and diversion services didn't reach, including older adults new to homelessness, including those who were socially isolated, had mobility issues, or struggled with accessing services independently. Some grantees shared how Home Safe filled an important gap in homelessness prevention services by serving those whose income is just above the cut-off for certain public benefits and assistance programs (e.g., General Assistance, CalFresh, Housing Choice Voucher Program). By providing them with assistance, Home Safe could prevent or end homelessness for these individuals.

Table 14. Count and proportion of cases that logged each intervention type (N = 6709)

Intervention Type	N (%)
Enhanced Case Management	3410 (50.8%)
Other	2028 (30.2%)
Rent Payment	1628 (24.3%)
Housing Navigation	1569 (23.4%)
Temporary Housing	1030 (15.4%)
Emergency Shelter	1023 (15.2%)
Security Deposit	848 (12.6%)
Home Habitability	701 (10.4%)
Relocation Assistance/Storage	576 (8.6%)
Deep Cleaning or Hoarding Assistance	497 (7.4%)
Utilities	446 (6.6%)
Rent Back Pay	393 (5.9%)
Legal Services	385 (5.7%)
Caregiver Services/Respite Care	247 (3.7%)
Mortgage Payment	42 (0.6%)

Home Safe staff implemented interventions for their participants flexibly, depending on participant needs. The interventions represented only a part of Home Safe funding. The expenditure data included here do not include the personnel and administrative costs that programs used. Grantees logged up to six interventions per case, organized into fourteen intervention types. For the 6709 cases we analyzed, there were 15,687 interventions. Enhanced case management, rent payment, and housing navigation were the most prevalent intervention types. Examples of interventions that fell into the category of other included food or groceries, transportation, and medical costs.

Following reporting guidance, county grantees included only non-staff direct expenditures. Thus, these direct expenditures did not include the personnel costs of newly hired staff who provided enhanced case management or costs such as the costs of constructing a new emergency shelter for Home Safe participants that one county grantee did. Grantees that used APS staff funded by Home Safe to provide enhanced case management did not provide an expenditure for these services, while those who contracted for enhanced case management did. This makes comparisons between counties or accounting for the costs of all services provided difficult.

Approximately half (52.5%) of the 15,687 interventions had an associated direct expenditure; 41.6% of interventions had no recorded cost.[n] Home Safe grantees provide many services that

[n] The remaining 5.9% of interventions were missing direct expenditure data.

the reported expenditures do not capture, including services provided by staff who were hired using Home Safe funds, services that Home Safe staff enabled participants to access by navigating participants to outside resources, or by using funding from other programs to pay for part or all of the intervention. These interventions with no recorded cost may be driven in part by data input errors. Several interventions represented a large proportion of all interventions provided, despite the direct expenditures reflecting only a small proportion of these interventions. For example, over half of the total cases reported enhanced case management, but because the program data on enhanced case management only captures direct expenses related to case management and not the cost of the staff time used, only 15% of all enhanced case management cases were described with direct expenditures. Nearly a quarter (23.4%) of cases used housing navigation, despite only 12.5% of cases of housing navigation being reflected as a direct expenditure. Over five percent (5.7%) of cases included legal services, despite 93% of all cases of legal services not involving direct expenditures.

Commonly, in cases where participants exited the program homeless, Home Safe grantees recorded no expenditures. In panel and in-depth interviews, staff discussed the difficulty of engaging participants who were homeless, suggesting that in some of these cases, staff closed these cases without having conducted any interventions. In other cases, the lack of expenditures could reflect the use of staff time to assist participants in ways that didn't involve direct expenditures, such as helping participants become document-ready, fill out applications, or driving participants to appointments. In other cases, the case management staff leveraged other resources (e.g., getting participants into permanent supportive housing by assisting with document readiness and liaising with landlords), without direct expenditures. Among those who started and ended homeless, Home Safe grantees recorded no expenditures in over half (52.1%) of cases. Among those who started and exited the program housed, grantees recorded no expenditures in a third (32.5%) of cases. Among those who were either homeless or housed at entry and exited the program housed, grantees recorded no direct expenditures in one-fifth (19.2% and 20.5% respectively) of cases. In future evaluations, to assess the full extent of Home Safe interventions, we recommend assessing grantees' staffing cost data and evaluating the ways they used funds to serve their programs in ways beyond those captured by direct expenditures.

Table 15. Median, IQR, and range of amount per case by intervention type for cases with direct expenditures (N = 8227)

Intervention Type	N (%)	Median	IQR	Range
Rent Payment	1455 (17.69%)	$2,400	[$1098, $6834]	$25, $146855[o]
Other	1099 (13.36%)	$494	[$102, $5086]	$1, $87647
Temporary Housing	897 (10.9%)	$3,750	[$1400, $10468]	$62, $86406
Security Deposit	827 (10.05%)	$1,350	[$700, $2398]	$35, $8972
Emergency Shelter	713 (8.67%)	$1,990	[$850, $4928]	$23, $63583
Home Habitability	648 (7.88%)	$763	[$280, $1727]	$11, $34593
Relocation Assistance/Storage	491 (5.97%)	$1,002	[$448, $2042]	$12, $21398
Enhanced Case Management	488 (5.93%)	$218	[$95, $800]	$1, $29360
Deep Cleaning/Hoarding Assistance	426 (5.18%)	$2,074	[$926, $4873]	$85, $21370

[o] Maximum intervention amounts may represent multiple interventions of the same type accumulated over the course of a case and is not always a large one-time payment.

Intervention Type	N (%)	Median	IQR	Range
Utilities	422 (5.13%)	$689	[$312, $1516]	$12, $14045
Rent Back-Pay	367 (4.46%)	$2,459	[$1341, $4612]	$34, $21214
Housing Navigation	197 (2.39%)	$90	[$40, $450]	$10, $9920
Caregiver Services/Respite Care	132 (1.6%)	$2,280	[$824, $4810]	$20, $74160
Mortgage Payment	38 (0.46%)	$4,362	[$2394, $5904]	$40, $20035
Legal Services	27 (0.33%)	$800	[$380, $1614]	$38, $4999

The most frequently reported direct expenditures included rent payment, temporary housing, security deposits, and emergency shelter (Table 15). The range of intervention costs might imply inconsistency in reporting or differing needs when implementing interventions in different places for different participants. There is a need for more context. For example, a county grantee may have provided a high-cost rent payment intervention as multiple payments over the course of many months, rather than a large, one-time payment.

Distinct Challenges Among Homeless and Housed Participants

Program participants who were homeless at entry faced different challenges than those who entered housed, which impacted the interventions they required (or were able to make use of). For instance, if staff were unable to identify housing options, they did not make use of Home Safe funds for housing payments. Among Home Safe participants who entered homeless, some had access to housing and others didn't. These opportunities were a factor in determining housing outcomes at case closure. To investigate this, we looked within groups of cases clustered by their housing status at the start and end of their Home Safe enrollment to better understand how frequently staff deployed direct housing payments (interventions categorized as rent payment, rent back-pay, security deposit, or mortgage payment).

Only 6.9% of participants who entered and exited Home Safe homeless received services that included a direct housing payment, compared with nearly half (46.1%) of those who entered homeless but exited housed. Many factors influence staff's ability to locate housing for participants, including community factors (mainly the affordability and availability of housing) and individual factors including participants' physical and behavioral health conditions and their engagement with the program.

Among Home Safe cases where the participant was homeless at entry and housed at exit that recorded housing payments, 28.9% received rent payments, 29.8% received security deposits, and 36.5% received a combination of rent payments and security deposits.[p]

Among cases where participants entered and exited housed, 39.8% received a direct housing payment. Approximately a third of these received housing dollars related to staying in their current housing situation, i.e., rent back-pay (19.9%), mortgage payments (2.5%), or a combination of rent back-pay and rent payments (10.6%). Over a third (37.5%) received rent payments, which could have supported either their having stayed in their current situation or having moved to a new one. Fewer than a third (26.9%) received payments related to moving to a new home: 9.7% received a security deposit only, and 17.2% received both rent payments and a security deposit.

[p] A small proportion of participants (N = 11) received rent back-pay while entering the program homeless and exiting housed. This may be data error or may be individuals who were recently evicted, where case managers were able to regain their lost housing.

Table 16. Interventions received for those who did not receive housing dollars, by housing trajectory

Intervention Type	No housing dollars, Homeless to Housed N (%)	No housing dollars, Housed to Housed N (%)
Enhanced Case Management	705 (26.1%)	797 (27.2%)
Other	503 (18.6%)	366 (12.5%)
Housing Navigation	366 (13.6%)	341 (11.7%)
Home Habitability	138 (5.1%)	301 (10.3%)
Deep Cleaning or Hoarding Assistance	16 (0.6%)	279 (9.5%)
Utilities	29 (1.1%)	214 (7.3%)
Relocation Assistance/Storage	78 (2.9%)	191 (6.5%)
Legal Services	44 (1.6%)	123 (4.2%)
Temporary Housing	386 (14.3%)	121 (4.1%)
Caregiver Services/Respite Care	28 (1%)	98 (3.4%)
Emergency Shelter	406 (15%)	94 (3.2%)

Table 16 highlights the interventions which Home Safe grantees used for participants who did not receive any direct Home Safe housing payments for those who exited housed, divided by their housing status at entrance (homeless or housed). These data illustrate the importance of case management and housing navigation for reestablishing housing among people who enter homeless. Aside from case management and housing navigation, grantees paid for temporary accommodations to stabilize these participants, including emergency shelter ($990 median cost) and temporary housing ($2,989 median cost). For participants who entered the program housed, grantees used interventions aimed at maintaining their housing (home habitability, deep cleaning or hoarding assistance, and utilities).

Homelessness Prevention, Mitigation, and Rehousing

Home Safe prevented housing loss, mitigated homelessness, and identified new housing for clients. Staff sought to preserve housing for any participants who were at risk of losing their housing; frequently, they were successful. Whenever possible, Home Safe staff aimed to maintain a person's existing housing. One grantee described how important Home Safe interventions were in keeping participants housed, "[their current housing] is the only place that they can stay because they couldn't leave here and go afford $1400 a month in rent…. Home Safe has been able to step in and say 'Hey, now we can take care of that for you this time'…That [is] a lifesaver for some people, I guess I can't even express enough that [Home Safe has] been a lifesaver."

> *"They are just so grateful that someone is there to help them."*
>
> *-County Grantee*

Home Safe's flexible funding enabled them to protect the housing participants already occupied through interventions including paying rental arrears, hiring legal services, providing services to make homes habitable, and working with landlords to improve building conditions. Staff noted how helping participants stay in their housing effectively increased the supply of naturally occurring affordable housing, as it prevented landlords from placing the housing older adults had lived in for years at lower rents on the market at higher rents. Home Safe staff noted that protecting and preserving the units in which their participants were living in was an important strategy to maintain housing, as it was less expensive than producing new housing. When

participants lose their housing, it is difficult to identify new housing that participants can afford. As one Home Safe staff member put it, “Once a client loses housing, trying to rehouse them is like climbing Mount Everest.”

For participants for whom staff were unable to preserve their existing housing, as for those who entered the program homeless, staff sought to move participants to other housing options. They used a variety of strategies to do so, including identifying existing affordable housing, enrolling clients in programs that offered long-term subsidies, moving clients to lower-cost regions, and identifying shared housing opportunities. Staff and participants highlighted that many participants declined offers of shared housing or housing far from where they came from. In interviews, participants expressed that they were placed in housing that was not ideal for them and didn’t meet their expectations. However, they understood that Home Safe staff have limited housing options; they appreciated the help that APS and Home Safe provided.

Several staff noted that they offer short-term shallow rental subsidies to “buy time” until they can identify permanent housing. But, with limited funds, they could do this indefinitely. One county grantee shared that, like Rapid Rehousing programs, their program had used Home Safe funds to provide 6-9 months of rental assistance to participants, starting at 100% of their rent and gradually decreasing the subsidy. When these strategies were unsuccessful, they sought emergency shelter. In one county, Home Safe used funds to develop an emergency shelter for clients. Because many clients preferred non-congregate shelter, many grantees used Home Safe funds to shelter participants in motels while they worked toward identifying appropriate permanent housing. To prepare participants for post-program housing retention, some grantees helped them apply for Housing Choice Vouchers or benefits that would provide ongoing income, sometimes leaving cases open for longer to help participants complete these applications.

> *“We fear that [without Home Safe] a lot of very vulnerable clients are going to end up homeless. Some of these people have physical problems and can't maybe clean up and don't really have the money to fund a caregiver, or maybe they've been abused financially. I mean, there are just a couple agencies in [this county] that you know help with a one-time rent [payment], but that's not enough.”*
>
> *-County Grantee*

Most grantees told us that Home Safe’s ability to flexibly implement program and funding decisions set it apart from other programs. They pointed out that, unlike other programs, Home Safe targeted seniors and people with disabilities, but left other criteria flexible—noting this as an important strength. Others shared that it enabled more enhanced case management per participant compared to other programs, including APS, which had shorter case durations.

Many program participants praised case management for its personalized support and guidance, helping participants navigate complex situations. Staff noted that case managers’ role in providing consistent check-ins and facilitating access to additional social services was invaluable.

Barriers

Lack Of Affordable Housing

While program staff, key informants, and participants were enthusiastic about Home Safe’s impact, they noted several key barriers. Nearly all grantees pointed out high cost and low availability of housing as the main barrier to re-housing program participants. Rural grantees noted particular challenges in accessing appropriate housing. Several grantees pointed out that,

in addition to rising costs of rent and living, construction of new affordable housing units is lagging far behind need, especially those targeted to low-income older adults. Home Safe staff struggled to find appropriate housing for participants who required a higher level of care, such as residential care facilities or nursing home care, due to high costs and lack of facilities.

Home Safe staff noted how natural disasters (wildfires), extreme weather events, tourism, and rurality complicated their search for temporary or permanent shelter. Wildfires and other extreme weather-related events decreased the number of housing units available and increased demand in impacted communities. Areas with a seasonal tourism industry had limited access to hotel rooms for emergency shelter during the high tourist season.

Home Safe staff, key informants, and participants emphasized that Home Safe played a critical role in assisting participants who might otherwise become homeless by providing interventions such as rental backpay, security deposits, and move-in fees. However, these one-time interventions may not result in participants' long-term housing stability due to their inability to overcome barriers, including the rising cost of living, lack of available affordable housing, and program participants' very low income. Grantees shared that most Home Safe participants had extremely low incomes, relying on Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or Social Security Retirement Benefits alone. Among the participants we interviewed, nearly all had a monthly income of $1500 or less. One county grantee shared, "Costs have gone up, but their income has remained the same. So, if there were a stipend that you can give them on a continuous basis to help them cover their rent, we get a lot of seniors that are having to choose between paying their rent, eating food, or paying for their medication. And that's, you know, that's tough." Due to program participants' low incomes, coupled with the high cost of living in California, Home Safe clients remained at risk of losing their housing after Home Safe stabilized their housing or returned them to housing.

Interviewees noted that participants who qualified faced long wait times for long-term housing assistance programs. Others would not qualify, because their income was just above the eligibility threshold. Multiple county grantees and key informants recommended that state funding be used for additional supplemental income and rental subsidy programs for those who have been stabilized or re-housed by Home Safe to help ensure long-term housing stability.

Long-Term Support Needs Among Some Home Safe Participants

County grantees noted that they determined whether participants needed extensive ongoing supportive services on a case-by-case basis but reported that their ability to provide for or refer to these services varied. Most grantees acknowledged that Home Safe was able to offer short-term interventions, including case management and financial assistance, but faced limitations when participants needed longer-term financial subsidies or ongoing intensive case management. In interviews, many Home Safe staff highlighted the lack of existing services serving low-income older adults in their communities to provide needed long-term support. Existing services lacked the resources necessary to serve all in need.

In interviews with participants, some mentioned that they would have liked more follow-up support, even after they achieved initial housing stability. Multiple participants stated the last time they had interacted with Home Safe staff was when they received their housing placement; others reported receiving check-in phone calls once or twice in the months after they had received housing. One participant mentioned feeling "dropped" once they were moved into housing. Another, who had to move far away, stated they would have benefited from help with "familiarizing themselves" with their new county. A few participants mentioned struggling with managing their finances. They reported that they would have liked more advice about how to manage this or needed ongoing rental assistance. Many grantees mentioned that continued

engagement and possible ongoing support could help stabilize housing maintenance for participants.

Many Home Safe staff mentioned that they aimed to transition participants into either permanent supportive housing or other programs that offered housing subsidies. However, these programs were limited and difficult to access. Smaller, rural counties reported particular difficulties in providing post-intervention wrap-around services, relying instead on referring clients to food banks, free and low-cost meal programs, and mobile showers to ameliorate the participants' housing crises.

Difficulty Achieving Success with Several Populations

Grantees discussed challenges serving people who experienced chronic homelessness. Home Safe staff noted that, in many cases, they were unable to secure housing, instead offering congregate or non-congregate shelter. Many participants who were experiencing chronic homelessness viewed these as overly strict and restrictive and declined these offers. Staff then struggled to continue to engage these participants while they were unsheltered. Staff noted that participants living outdoors were hard to track, due to their frequent moves. They noted that it was difficult for participants to keep access to cell phones (which would get lost, stolen, or lose charge), making it difficult for Home Safe staff to remain in touch with them.

Grantees mentioned challenges with other populations. Some mentioned that they faced challenges reaching undocumented individuals and Latine communities. Some noted that members of these communities expressed fear of APS and government entities, which held stigma. A grantee mentioned that many community members equate APS with child protective services (CPS) and fear punitive interventions from government entities. Grantees mentioned the need to reframe Home Safe to some participants. One grantee shared that in instances where cultural interpretations of government support view Home Safe as a form of welfare, and therefore shameful, the grantee explains that the program is an extension of their own tax dollars, "you have already paid into this and should consider it your own tax money coming back to you".

Some grantees stated that, despite frequent community reports to APS, their Home Safe programs were not serving many dependent adults. These county grantees hypothesized that other systems or resources, such as regional centers or the Housing Choice Voucher Program, support these individuals' needs by the time they were connected to APS, making them less likely to need Home Safe intervention.

Lack of Guaranteed Ongoing Funding

Home Safe staff emphasized the importance of funding stability to realize the program's objectives. County grantees expressed uncertainty about how much effort they could or should devote to developing infrastructure to support Home Safe without assured ongoing funding. They noted that it takes time and staff to develop systems to maintain and improve Home Safe, and program managers worried that the return on investment would not be worth it if the program was discontinued. Despite these challenges and uncertainties, Home Safe staff remained enthusiastic and hopeful about the possibility of future funding, the opportunities the program offered their participants, and the program's general impact.

County grantees viewed Home Safe as essential for maintaining housing stability and providing comprehensive support to those in need. Due to this, they were concerned about the consequences should the program end—including an increase in eviction and a rise in homelessness.

> *"The hospital would be severely burdened with seniors and people with disabilities that have nowhere else to go. Other programs would have to try to absorb people they are not able to support."*
>
> *-County Grantee*

County grantees shared that the absence of the Home Safe Program would place considerable strain on existing resources and services. Grantees said they were already managing limited resources and would find it increasingly challenging to provide necessary support, which could result in substantial burdens on local services. Some grantees expressed concern that in the absence of Home Safe funding, individuals whom Home Safe might have served would end up in emergency departments and hospitals, putting additional strain on these services.

Homeless adults use the emergency department at higher rates than the general population, especially homeless adults aged 50 years or older.[41] Home Safe connected program participants to medical services, helped participants apply for Medicaid, and helped older adults age in place by providing participants with home habitability upgrades, repairs and connecting participants with in-home care such as through Programs of All-Inclusive Care for the Elderly (PACE) and In-Home Supportive Services (IHSS).

Grantees expressed concerns about the lack of viable alternatives if the program were to end. Without the Home Safe Program, APS staff would face significant challenges in directing individuals to appropriate resources.

> *"Not sure what it would really look like, but it will be disastrous."*
>
> *-County Grantee*

In June of 2025, California Assembly Bill AB 102 allocated an additional 83.8 million dollars for the Home Safe program for fiscal year 2025-2026.[42,43] These funds will allow county grantees to continue operating their Home Safe programs. However, grantees expressed fear that without permanent funding, local leadership may be hesitant to commit to the long-term investments that strengthen Home Safe interventions, including hiring staff. Some county grantees that had exhausted funding from the previous cycle closed their programs and reduced their Home Safe staffing. Reopening the programs will require difficult decisions about resources. Several expressed concern about spending internal resources on reopening the programs, due to fears of a lack of long-term funding to keep them open.

Grantee Reliance on APS as the Sole Lead Agency

While CDSS did not require that county welfare departments APS be the lead agency for each county's Home Safe program, all counties chose APS. Some county grantees expressed their opinion that Home Safe would be more effective if it leveraged other community resources. Their reasons varied: some believed that APS and Home Safe had different operational standards—APS focuses on rapid stabilization and interventions that last no more than 30 days, while Home Safe's strategy required a more in-depth and longstanding approach to stabilize clients' housing. Some staff shared having questions when they first learned that APS would provide Home Safe services, noting APS's limited experience with intensive case management and homeless services. They argued that distinguishing Home Safe from APS would have allowed Home Safe to design its own eligibility and intake process differently, to better meet the need to provide homeless prevention services. Others pointed out that prior to Home Safe, APS

hadn't focused on supporting homeless individuals; thus, APS staff would require specific training to ensure that they could maximize their existing resources. Still others recommended Home Safe be integrated with local non-profit organizations to reduce administrative burdens. In practice, many Home Safe programs did this by employing contractors. Some staff emphasized the potential benefits of having Home Safe closely aligned with organizations and or agencies that are well-versed in providing homeless services, while working in collaboration with APS to draw from their expertise on protective issues. When asked if APS effectively housed Home Safe, the response from these grantees was contemplative. Some noted the program is best held under APS, particularly as APS can leverage its existing infrastructure to run the program, including training staff and building community relationships. Others believed APS might benefit from deeper collaboration and integration with other local agencies. Regardless, Home Safe, operated by APS, has opened up access to homelessness prevention to a group of at-risk people who had not been well-served by existing systems. The grantees expressed a strong desire for the program to continue and thrive.

Evaluation Limitations

We acknowledge several methodological limitations in the evaluation.

We cannot say with confidence whether Home Safe averted homelessness—and for whom. Without counterfactual data, i.e., people similar in every way to Home Safe participants who did not receive the Home Safe interventions, we cannot say that without Home Safe, participants would have become (or remained) homeless. We were unable to use some common strategies to assess this, such as comparing those who just met criteria for enrollment to those who just missed it. To do so would have required programs use a standardized (and reliable) instrument to assess risk, which they did not do. However, through case reports and in-depth interviews, it is evident that Home Safe did reach clients at extremely high risk of homelessness (or who already experienced homelessness), and with Home Safe efforts, appeared to have staved off homelessness. Second, we lacked 6- and 12-month follow-up data in the majority of cases limiting our ability to describe long-term housing outcomes. Of those whose cases were closed more than 6 months ago, we had complete living situation at follow-up data for only 39.3% of cases. Of those whose cases closed at least 12 months ago, we had complete living situation at follow-up for only 25.9% of cases. This could bias results in either direction. If the missing data were at random (because programs did not want to devote resources to find clients' housing outcomes), the results would not be biased (although differences would be harder to detect). If programs attempted to contact participants but were unable to reach those who were homeless, the results would be biased toward positive housing outcomes. Conversely, if programs recorded housing data for those who called asking for ongoing help—thus more commonly recorded data that clients were homeless—the results would be biased toward negative outcomes.

The program's goals include preventing and ending homelessness for seniors and adults with disabilities. However, we did not have reliable data on the length of the current episode of homelessness for those who were homeless at program entry. This limited our ability to separately analyze those with very recent onset of homelessness (for whom the intervention would be described as diversion) compared to those with prolonged homelessness experiences (including chronic homelessness). It is possible that Home Safe would more successfully serve those with a shorter length of homelessness, for those who were homeless at program entry.

Finally, we had limited information on some program expenditures. Consistent with guidance, programs reported expenditures differently. Those who brokered case management services

reported these as a per-client expenditure; however, those who hired new APS staff to serve as case managers with Home Safe dollars did not account for staff time. Thus, it is difficult to compare per-client cost estimates between grantees. Expenditure data may not capture the extent of case management or other staff-intensive services. Based on program reporting guidance, staff reported costs for just over half (52.5%) of all interventions; 41.6% had "no-cost." If grantees used Home Safe funds to hire staff (such as case managers) and those case managers provided interventions that had no associated direct expenditures, these interventions were reported as "no-cost" as they did not bill directly to Home Safe. As every county grantee had different personnel needs and operational structures, this complicated comparing costs across the program.

Conclusion

Home Safe plays a vital role in addressing the housing needs of high-risk individuals who are not adequately served by other programs, filling a critical gap in the local homeless response system. The program served approximately equal proportions of those who were housed (and faced homelessness) and those who were experiencing homelessness (and needed support to regain housing). Flexibility—both in how grantees designed their program to match their county's needs, and how staff could use funding to meet participants' needs—was key to its success. Some county grantees used funding to increase APS staff to manage the additional Home Safe cases; others used funding to broker services from outside organizations, and some used both. The most reported interventions: enhanced case management, housing deposits, and rent payments, point to the needs of clients. Uniformly, staff, key informants, and program participants supported Home Safe as an essential program, but most noted that funding limitations limited its reach. Programs should consider leveraging Medicaid 1115 waiver payments to extend Home Safe's reach and impact. Despite these strengths, the lack of affordable housing prevented many clients from achieving long-term stability, highlighting the need for broader systemic efforts to expand housing availability and affordability.

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Appendix

Appendix Table 1. Of those housed at entry, demographic characteristics by housing status at exit

Variable	Overall	Homeless at exit	Housed at exit
Age (N = 1843)			
Mean +/- SD	68.7 +/- 11.0	67.6 +/- 10.8	68.8 +/- 11.1
Minimum, Maximum	19, 98	33, 96	19, 98
Median (Interquartile range)	69 (63, 76)	68 (62, 74)	69 (63, 76)
Gender (N = 1839)			
Man	731 (39.7%)	47 (41.2%)	684 (39.7%)
Woman	1103 (60%)	67 (58.8%)	1036 (60.1%)
Race (N = 1545)			
American Indian/Alaskan Native/Indigenous	28 (1.8%)	--	28 (1.9%)
Asian/Asian American	70 (4.5%)	--	65 (4.5%)
Black/African American/African	252 (16.3%)	21 (21%)	231 (16%)
Native Hawaiian/Pacific Islander	--	--	--
White	1183 (76.6%)	72 (72%)	1111 (76.9%)
Other	--	--	--
Ethnicity (N = 1526)			
Hispanic/Latine	297 (19.5%)	17 (17.3%)	280 (19.6%)
Non-Hispanic/Latine	1229 (80.5%)	81 (82.7%)	1148 (80.4%)
Marital Status (N = 1333)			
Single/Never Married	331 (24.8%)	27 (30.3%)	304 (24.4%)
Separated/Divorced	392 (29.4%)	35 (39.3%)	357 (28.7%)
Widowed	301 (22.6%)	16 (18%)	285 (22.9%)
Married/Living Together	301 (22.6%)	16 (18.0%)	285 (22.9%)
Sexual orientation (N = 1407)			
Straight/Heterosexual	1355 (96.3%)	82 (95.3%)	1273 (96.4%)
Not straight	52 (3.7%)	--	48 (3.6%)
Veteran (N = 1491)			
Yes	129 (8.7%)	--	121 (8.7%)

Appendix Table 2. Of those homeless at entry, demographic characteristics by housing status at exit

Variable	Overall	Homeless at exit	Housed at exit
Age (N = 2014)			
Mean +/- SD	64.5 +/- 10.9	63.3 +/- 10.9	65.3 +/- 10.9
Minimum, Maximum	18, 96	18, 94	18, 96
Median (Interquartile range)	65 (60, 71)	64 (60, 69)	66 (61, 72)
Gender (N = 2324)			
Man	1093 (47%)	472 (49.3%)	621 (45.5%)
Woman	1226 (52.8%)	485 (50.6%)	741 (54.2%)
Race (N = 1997)			
American Indian/Alaskan Native/Indigenous	37 (1.9%)	15 (1.9%)	22 (1.8%)
Asian/Asian American	60 (3%)	25 (3.1%)	35 (2.9%)
Black/African American/African	371 (18.6%)	130 (16.2%)	241 (20.2%)
Native Hawaiian/Pacific Islander	--	--	--
White	1513 (75.8%)	627 (78.1%)	886 (74.2%)
Other	--	--	--
Ethnicity (N = 1922)			
Hispanic/Latine	451 (23.5%)	201 (25.7%)	250 (21.9%)
Non-Hispanic/Latine	1471 (76.5%)	582 (74.3%)	889 (78.1%)
Marital Status (N = 1800)			
Single/Never Married	376 (22.6%)	159 (23.9%)	217 (21.8%)
Separated/Divorced	610 (36.7%)	241 (36.2%)	369 (37%)
Widowed	276 (16.6%)	106 (15.9%)	170 (17.1%)
Married/Living Together	400 (24.1%)	159 (23.9%)	241 (24.2%)
Sexual orientation (N = 1748)			
Straight/Heterosexual	1602 (97.3%)	626 (97.1%)	976 (97.4%)
Not straight	45 (2.7%)	19 (2.9%)	26 (2.6%)
Veteran (N = 2001)			
Yes	120 (6.6%)	48 (6.3%)	72 (6.8%)

About the Authors

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Margot Kushel, MD, is Professor of Medicine at UCSF, Division Chief of the Division of Health Equity and Society, and Director of the Benioff Homelessness and Housing Initiative and the Action Research Center for Health Equity (formerly Center for Vulnerable Populations) at Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG). Her research focuses on reducing the burden of homelessness on health through examining efforts to prevent and end homelessness and mitigating its effects on health care outcomes. Margot is a primary care physician at ZSFG's Richard H. Fine People's Clinic. A leading homelessness researcher, her research has been funded by the NIH, government, and foundations. Margot is quoted frequently in the press. She provides advice and testimony to governmental bodies.

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Angelica is a researcher with an interdisciplinary background in anthropology, sociology, international relations, and law. After working in direct service for many years, she worked in multiple research settings before joining BHHI—including years conducting public opinion research to advance policy on a range of issues. Angelica holds an LL.M from the University of Essex and an M.Phil from the University of Oxford.

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Gina has worked on numerous studies with UCSF, including a statewide study of homelessness and a randomized clinical trial evaluating treatment initiation for people who inject drugs and have HCV. Gina received a BS in Bioengineering with a minor in Global Poverty and Practice from UC Berkeley and has spent many years in direct service provision for people experiencing homelessness in the East Bay. Gina hopes to further her exploration of increasing accessibility to medicine, biotechnology, and systems of care for homeless and otherwise marginalized populations through public policy research.

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Kenny is the Director of Research Operations at BHHI. He began working at UCSF in 2013 as an intern while attending UC Berkeley for his bachelor's degree in Psychology and Peace and Conflict Studies. He has since served as an Assistant CRC, CRC, Project Manager, and Senior Project Manager. Kenny holds an MPH from UC Berkeley. His primary professional and academic interests focus on using research methods to work with and for homeless and underserved populations within the San Francisco Bay Area.