New Prioritization Strategy for Project Roomkey

Summary

The following is an outline of a uniform prioritization strategy for the placement of referred individuals into Project Roomkey (PRK). As our partner, we want to inform you about this shift in PRK operations. This prioritization is one piece of larger, ongoing efforts by LAHSA that is necessary to address structural racism which drives disproportionate representation of Black people experiencing homelessness across LA County. This specific strategy moves the administration of PRK in a more equitable direction by ensuring that those who are the most vulnerable are prioritized for PRK enrollment. The key factors in this prioritization strategy are: 1) whether a referred person comes from one of the most disadvantaged communities (MDC) as defined from an analysis using CalEnviroScreen, 2) the person’s length of time homeless, and 3) the number of underlying medical conditions the person has that puts them at higher risk for hospitalization and death if they contract COVID-19. The following sections provide 1) a background on initial PRK work, 2) the development of this MDC prioritization strategy, 3) implementation for the MDC prioritization strategy, and 4) ongoing evaluation of the MDC prioritization strategy.

Background

As PRK and other COVID-19 crisis response efforts came online, in monitoring preliminary data, LAHSA had concerns about proportionality of access to these resources by all racial and ethnic groups. In April, internal workgroups were formed to investigate, recommend changes, and operationalize adjustments to improve our processes around referral and access to PRK.

On May 13, LAHSA issued a suite of updated guidance to homeless services providers to ensure that all eligible and interested individuals were referred to the program and to gain as comprehensive assessment as possible of the full scope of need for PRK. Within the suite of May 13 materials, in recognition of COVID-19’s disproportionate impact on communities of color, LAHSA released a racial equity resource guide which underscores the importance of providers’ efforts to counter structural inequities and remove implicit bias as they work to provide equitable access to vital resources in this crisis.

Developing a prioritization schema

Due to limitations of sites available for the City and County to lease up for PRK, it became clear that there were SPAs that would not have resources proportional to that area’s need. Motivated by a desire to achieve equitable racial and ethnic representation of the homeless population in PRK and concerned by the disproportionate impact of COVID-19 on Black, Latinx, and Indigenous communities, LAHSA recognized the need to create a process for prioritizing placements into PRK so that it is a more racially equitable program.

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1 Equity refers to proportional representation (by race, class, gender, etc.) of opportunities in housing, healthcare, employment, and all indicators of living a healthy life. When talking about equity, it is helpful to distinguish it from equality. Equality is typically defined as treating everyone the same and giving everyone access to the same opportunities. The assumption is that everyone will benefit from the same support and services. This is not true. Some populations are situated differently because of historical and current discrimination against them. Equity addresses those differences. Equality is about sameness; it focuses on making sure everyone gets the same thing. Equity is about fairness; it ensures that each person gets what the person/population needs. To achieve equity, policies and procedures may result in an unequal distribution of resources but will lead to equitable outcomes for everyone.

Updated 6/25/2020
Public health experts note that aspects of structural racism such as residential segregation, inequitable access to healthcare, employment discrimination—as well as inadequate testing, unconscious bias in healthcare, distrust between vulnerable communities and healthcare providers, and limited health literacy—have contributed to the increased vulnerability to COVID-19 for communities of color. In order to support the process of identifying those at highest vulnerability to COVID-19, LAHSA was mindful that using solely race and ethnicity as a factor for PRK placement would be both inadequate and impermissible under the Fair Housing Act. However, research has shown that high-poverty neighborhoods and neighborhoods of color are disproportionately located near sources of diesel and air pollution such as major freeways, ports, and other industrial sites, which may trigger asthma attacks and other respiratory problems, particularly among children and other vulnerable populations. Thus, it made sense to make use of geographic/neighborhood proxy for prioritization.

LAHSA has decided to utilize CalEnviroScreen, which has precedent being used across California in order to advance environmental justice and racial equity in various programs. CalEnviroScreen uses vetted environmental data at the census tract level, which is useful in more precisely defining vulnerability and assisting with the PRK prioritization process. In order to most precisely target individuals coming from the most disadvantaged communities, census tracts at the top range (95 to 100 percentile) of the CalEnviroScreen scale became the focus and the following 14 SPA subregions have been identified as MDCs:

- SPA 2- Central and East
- SPA 3- Central and East
- SPA 4- Downtown and North East LA
- SPA 6- North, South, South East, and West
- SPA 7- Central
- SPA 8- Beach Cities, Harbor Area, and North

Implementing this Prioritization Strategy

Moving forward, the PRK Matchers and the Call Center will be the only sources of referrals for all sites. Starting the week of June 15, the PRK matcher team at LAHSA began to use a new prioritization strategy involving specific allocations for referred individuals from MDCs and non-MDCs.

This new prioritization strategy is in place in order to 1) prioritize individuals coming from MDCs, which are subregions that have faced the highest levels of environmental injustices, which in turn exacerbate COVID-19 vulnerability, 2) to correct for previous limited range of access to PRK sites for individuals from MDCs, and 3) protect against implicit bias by having matchers prioritize based on length of time an individual has experienced homelessness. If a referred individual does not have length of time homelessness previously documented in HMIS, the referring provider may now provide an estimated length of time homeless on the PRK referral form.

The strategy distinguishes between new PRK sites that come online versus spots at existing PRK sites that become available due to turnover. It is important to note that in both instances, individuals from the MDCs closest to the PRK site are prioritized. For example, there may be a PRK site in one SPA subregion

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2 Through a mapping process, SPA subregions with total populations of up to 500,000, with 10%+ populations residing within 95 to 100 percentile CalEnviroScreen census tracts, are labeled as the Most Disadvantaged Communities (MDCs). For SPA subregions with total populations greater than 500,000, the threshold of 5%+ of the population residing within 95 to 100 percentile CalEnviroScreen census tracts is used for identifying Most Disadvantaged Communities.
that is non-MDC but is adjacent to a SPA subregion that is an MDC. Individuals from the adjacent MDC would be prioritized for a portion of the slots in the PRK site of the neighboring non-MDC subregion.

**Evaluation Framework for Prioritization Strategy**

The following are data on the under/over representation across race and ethnicity groups for PRK as compared to 2019 PIT count, as of June 11, prior to the implementation of the new prioritization strategy. An asterisk indicates small PIT count percentages for those groups. These groups account for 0.5% to 2% of 2019 PIT and an increase or decrease of just a few people from these groups in PRK can drastically change the proportions.

- Underrepresented: Indian/Alaskan Native* clients by 45%; Native Hawaiian/Other Pacific Islander* clients by 26%; Latinx clients by 16%, Black clients by 3%
- Overrepresented: Asian* clients by 45%, White clients by 20%

As the aforementioned prioritization strategy is implemented, we will monitor the data on the under/over representation across race and ethnicity groups for PRK as compared to the recently released 2020 PIT count. While this prioritization strategy is currently being applied only to PRK, LAHSA is eager to learn from this application to consider how similar prioritization strategies with a refined racial equity lens could be incorporated into other programs. Please direct any questions about these guidelines to tier1referrals@lahsa.org.

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3 Race and ethnicity percentages from the PIT count is currently the best metric LAHSA can use to measure baseline PRK proportionality. An even better indicator would be if LAHSA have precise data on COVID-19 high risk of entire homeless population, by race and ethnicity, but LAHSA does not yet have that level of data. As previously noted, guidance has been issued to homeless service providers for them to comprehensively review their caseload for individuals who may be COVID-19 high risk.