Evaluation of California's Project Roomkey Program

Year 1 Report

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About This Report

Project Roomkey (PRK) was an innovative statewide effort in response to the COVID-19 pandemic to protect the health of people experiencing homelessness. Funded and overseen by the California Department of Social Services (CDSS), PRK provided people experiencing homelessness an alternative to staying on the street or in congregate shelters, instead placing them temporarily in rooms in hotels, motels, or trailers and providing limited supportive services. The California Health Care Foundation and the Conrad N. Hilton Foundation, in collaboration with CDSS, engaged Abt Associates to evaluate the PRK program. The purpose of this evaluation is to understand the successes and challenges of PRK and the experiences and outcomes of PRK participants. This report draws on the data collected and analyzed during the first year of the evaluation (August 2021 through July 2022) and summarizes early findings.

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Project Roomkey (PRK) was California's innovative statewide effort in response to the COVID-19 pandemic to protect the health of people experiencing homelessness and reduce their potential burden on the state's health care system. Funded and overseen by the California Department of Social Services (CDSS), PRK provided people experiencing homelessness an alternative to staying on the street or in congregate shelters, instead placing them temporarily in hotel or motel rooms or groups of trailers (PRK "sites") and providing limited supportive services.

The California Health Care Foundation (CHCF) and the Conrad N. Hilton Foundation, in collaboration with CDSS, engaged Abt Associates to evaluate the PRK program. Over the past year (August 2021 through July 2022), the Abt evaluation team interviewed staff from state departments involved in the design and oversight of PRK, administered a web survey to the 54 counties and Tribes that have accepted PRK funding, and interviewed organizations involved in the implementation of PRK programs in 15 communities across the state.

Almost every county and some Tribal jurisdictions in California received funding to operate one or more PRK sites at some point since the onset of the COVID-19 pandemic in early 2020. Some communities used PRK resources solely to set up isolation and quarantine beds for people who contracted or were exposed to COVID-19. Other communities used the PRK funds and framework to implement programs to function as non-congregate emergency shelters for people at risk for medical complications due to COVID-19. To prevent the spread of COVID-19, many emergency shelters decreased their number of beds to meet social distancing guidelines. PRK programs helped to offset some of the decreased shelter capacity. While PRK programs were initially designed to be short-term, as the pandemic continued some evolved into longer-term interim housing programs. As of mid-2022, many communities had closed their PRK sites, but some continued to operate.

In addition to offering non-congregate shelter, PRK provided short-term wraparound services that could include 24/7 staffing, three meals daily, sanitation and janitorial services, basic supplies, personal protective equipment, and laundry services. Some PRK sites also provided on-site medical services including nurses for daily medication, temperature monitoring, and symptom checks.

California counties and Tribal communities initially designed and implemented their PRK programs in a matter of weeks in March and April of 2020. The early goal of PRK was to save lives by quickly isolating medically vulnerable people experiencing homelessness when little was known about COVID-19. ***This urgency encouraged a new level of cooperation among stakeholders including county health and community development departments, Continuums of Care (CoCs), and homeless service providers.*** However, it also meant that communities were "*building the plane while flying it*."

To help as many people experiencing homelessness as possible, most PRK programs used a *low-barrier* approach to access, consistent with California's requirement that all state-funded homeless programs use Housing First practices. PRK participants were not required to receive any services to be eligible for assistance, and there were typically few program rules beyond those meant to prevent the spread of COVID-19 and protect the health and safety of participants. Many PRK programs also used a *harm reduction* approach, meaning that participants did not need to be sober to stay at a PRK site.

Key Findings from Year 1

- ***PRK provided non-congregate shelter features for people experiencing homelessness that were often not available in other emergency shelter or interim housing settings.*** PRK provided individual rooms where people could bring or store their possessions and did not have to be separated from their partners or pets. This model gave people autonomy, privacy, and safety. Communities reported that some PRK participants who previously had been unable or unwilling to use existing shelter programs engaged successfully in PRK. The safety and stability PRK provided enabled some participants to for the first time engage in important opportunities to receive health care and other services for untreated conditions. ***Many homeless system leaders and providers consider that PRK broke new ground for how emergency shelter and interim housing is offered to people experiencing homelessness.***

- ***Many PRK participants were extremely medically vulnerable and needed a high level of care.*** Counties reported that participants in PRK had a higher level of acuity than program designers anticipated. Many programs reported needing more physical, psychosocial, and mental health services at their PRK sites than expected; others reported that a significant number of participants needed help with completing activities of daily living. A few PRK programs partnered with organizations that provided personal care and care management; in other programs, those more intensive supports were not available. As a result, in some communities, people who were referred from hospitals or other health care providers could not be served by PRK because their needs were too great for the program; some were referred to skilled nursing facilities.

- ***California's governmental and robust homeless service system infrastructures supported a quick design and implementation of Project Roomkey.*** Various state departments came together in a matter of weeks to collaboratively design a program relying on hotels and motels to serve people experiencing homelessness who would be medically vulnerable if they contracted COVID-19 as recommended by the CDC. County agencies, Tribal communities, and homeless service systems then applied the state's PRK framework locally to devise their own programs, including creating targeting protocols, identifying and contracting with local hotels and motels, and staffing PRK sites quickly. ***The quick design and program implementation and infusion of federal, state, and local resources to this program were unprecedented in their speed and scale.***

- ***PRK transitioned from a short-term program for people experiencing homelessness who were medically vulnerable if they contracted COVID-19 to an interim housing program used to stabilize and house vulnerable people while more permanent housing options were secured.*** The initial purpose of PRK as described by CDSS was "*to provide non-congregate shelter options for people experiencing homelessness, protect human life, and minimize strain on health care system capacity.*"[1] Though creating an exit and re-housing strategy for PRK participants was part of communities' plans, the focus during the first few months was to recruit people into the program. In November 2020, CDSS began using PRK funding opportunities and guidance in notices to encourage communities to shift that focus to re-housing participants upon exit.

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[1] Hernandez, J. June 1, 2020. "All County Welfare Directors Letter (ACWDL): Project Roomkey Initiative." California Department of Social Services.

- ***Many counties are still waiting for federal reimbursement, and the reimbursement process is unclear.*** In March 2020, the Federal Emergency Management Agency (FEMA) announced that states or local governments could claim 75 percent reimbursement for costs associated with non-congregate sheltering based on public health orders, through its Public Assistance Program Category B, subject to certain requirements. This was later updated to allow for 100 percent reimbursement through July 1, 2022. California provided technical assistance to local governments on completing and submitting claims for FEMA reimbursement for some PRK program costs. Still, communities reported that the process was challenging. The FEMA reimbursement model of program funding is difficult because it requires local governments to identify and use local funding without a clear timeline for reimbursement.

This document is an interim report that describes PRK's design and statewide implementation efforts. Over the next year, the Abt evaluation team will complete several additional data collection and analysis activities to understand PRK participants' use of health care and shelter and housing programs. At the end of the second year, the Abt evaluation team will produce a final evaluation report detailing our analyses and findings.

1. Introduction

Project Roomkey (PRK) was California's innovative statewide effort in response to the COVID-19 pandemic to protect the health of people experiencing homelessness. Created, funded, and overseen by the California Department of Social Services (CDSS) since early March 2020, PRK has provided people experiencing homelessness an alternative to staying on the street or in congregate shelters. Instead, PRK placed people temporarily in hotel or motel rooms or groups of trailers (PRK "sites") accompanied by limited supportive services.

Almost every county and some Tribal jurisdictions in California received funding from CDSS to operate at least one PRK site at some point since the onset of the COVID-19 pandemic. Some communities used PRK resources solely to support isolation and quarantine beds for people who contracted or were exposed to COVID-19.[2] Other communities used the PRK funds and framework to design and operate longer-term PRK programs to function as non-congregate shelters. As of mid-2022, many communities closed their PRK sites. Others have continued to operate PRK sites using federal, state, and local funding to provide isolation and quarantine beds or to temporarily house people experiencing homelessness.

The California Health Care Foundation (CHCF) and the Conrad N. Hilton Foundation, in collaboration with CDSS, engaged Abt Associates to evaluate the PRK program. ***The purpose of this evaluation is to understand the successes and challenges of PRK and the experiences and outcomes of PRK participants***. The findings from this evaluation could have many implications for public officials, leaders of homeless service systems, and other stakeholders, including the feasibility of non-congregate shelter in a post-pandemic environment; whether to replicate PRK to address future health or environmental emergencies in California and nationally; how to help people transition to permanent housing; potential changes to the congregate shelter model; and how to create strong partnerships among local and state entities in the public and private sectors to enhance health and related outcomes in emergency shelter and other types of interim housing.

During the evaluation's first year (August 2021 through July 2022), the Abt evaluation team, in close coordination with CHCF, the Hilton Foundation, and CDSS:

- Developed a research design and created an evaluation advisory board including people who had participated in PRK to guide all evaluation activities.
- Interviewed staff from state agencies and departments who designed and oversaw PRK.
- Administered a web survey to the 54 counties and Tribes that accepted PRK funding and received 45 responses (an 83 percent response rate).
- Interviewed representatives of organizations that implemented PRK programs in 15 communities across the state.

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[2] The Centers for Disease Control and Prevention defines *isolation* as something that "people with confirmed or suspected COVID-19" should do; *quarantine* is defined as "keeping people who have been in close contact with someone with COVID-19 apart from others" (https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html).

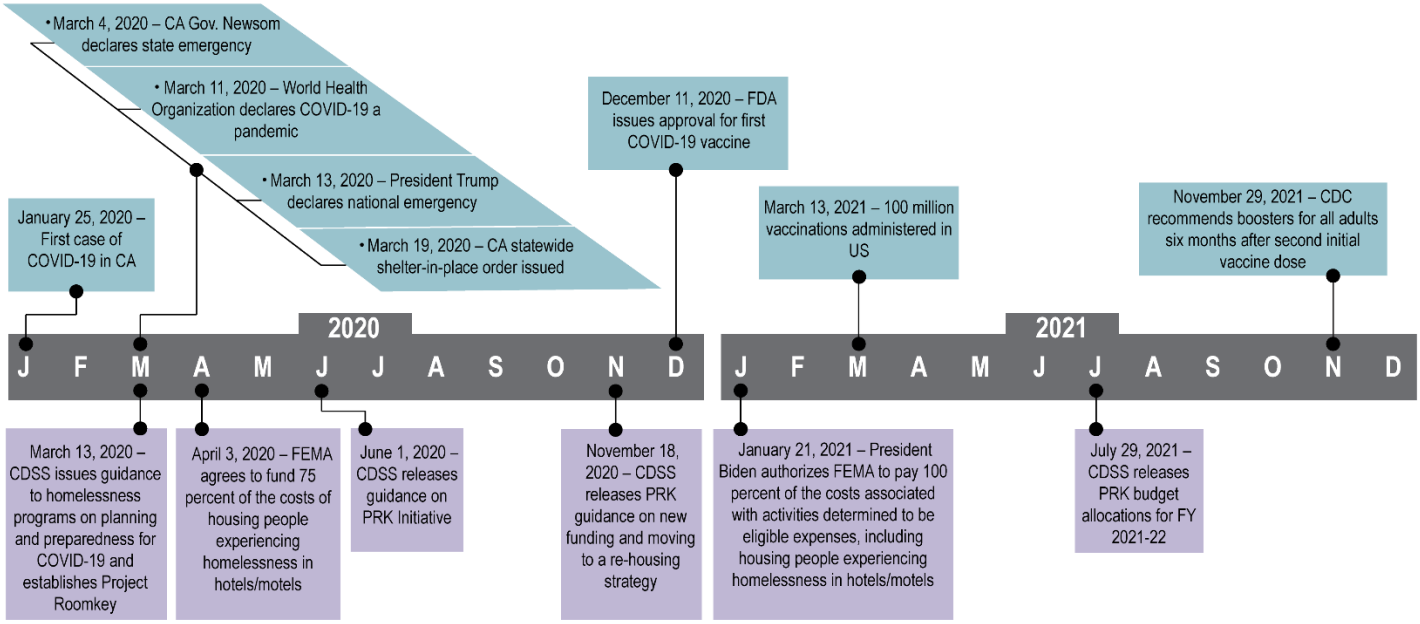
The map shows the counties that participated in the web survey and telephone interviews.

Exhibit 1. Map of Project Roomkey Study Activities

Source: Evaluation activities

Exhibit 2 shows the timeline of events related to the COVID-19 virus and the design and implementation of PRK.

Exhibit 2. Timeline of COVID-19 Responses



Sources:
https://calmatters.org/health/coronavirus/2021/03/timeline-california-pandemic-year-key-points/
https://www.cdss.ca.gov/inforesources/cdss-programs/housing-programs/project-roomkey
https://www.cdc.gov/museum/timeline/covid19.html

This report describes PRK's design and statewide implementation efforts. The report is organized as follows:

- Section 2 – the state's approach to designing and implementing PRK.
- Section 3 – the program's design and planning efforts by counties and Tribes across the state.
- Section 4 – the program's implementation efforts by government agencies and homeless service and health care providers locally.
- Section 5 – local approaches to closing PRK sites and re-housing people who were served there.
- Section 6 – key findings from the first year of the evaluation and the data collection and analysis activities planned for the second year.

2. State Response

California's Health and Human Services Agency leadership, public health experts, and health clinicians came together to develop Project Roomkey (PRK) at the onset of the COVID-19 pandemic in spring 2020. To quickly plan and implement PRK, multiple California agencies collaborated to recruit sites, develop program guidance, and work with communities across the state to stand up the program.

- The ***California Department of Social Services (CDSS)'s Disaster Services Branch*** (DSB) supports local emergency agencies that provide shelter, food, and other services during a disaster or emergency. In the initial weeks after state and federal governments declared the COVID-19 pandemic an emergency, DSB identified and provided lists of candidate hotels and motels to communities. As the pandemic continued, DSB helped with contracts and coordination between county welfare directors and CDSS's Housing and Homelessness Division, created pandemic preparedness guidance and food protocols, and worked with the Governor's Office of Emergency Services to coordinate the delivery of trailers for shelter. DSB transferred responsibilities to other entities in June 2020, about three months into the state's emergency response to the pandemic.

- The ***CDSS's Housing and Homelessness Division*** oversees statewide housing programs funded by CDSS and provides technical assistance to California's social service agencies. Throughout the pandemic, the Housing and Homelessness Division worked closely with the other state departments and offices to develop PRK sites and provide funding to communities. Specifically, the Division led outreach to bolster coordination among partners, including strengthening and implementing guidance from the Centers for Disease Control and Prevention (CDC) and the California Department of Public Health (CDPH). The Division also developed procedures for data collection and implemented technical assistance to communities seeking Federal Emergency Management Agency (FEMA) reimbursement.

- The ***California Department of General Services (DGS)*** "*serves as a business manager for the state of California, including providing procurement and acquisition solutions, real estate management and design, transportation, and legal services.*"[3] At the beginning of the pandemic, DGS built the initial list of candidate hotels and motels and negotiated leases for communities. Eventually, communities (usually county or Tribal governments) took over contract negotiations, with DGS continuing to help at the community's request.

[3] https://www.dgs.ca.gov/

- The ***California Interagency Council on Homelessness*** (Cal ICH)[4] "*oversees the implementation of Housing First guidelines and regulations, and identifies resources, benefits, and services to prevent and end homelessness.*"[5] Cal ICH manages the Homeless Housing, Assistance, and Prevention (HHAP) Grant Program and the Homeless Emergency Aid Program (HEAP) funding. Cal ICH encouraged PRK sites to use these funding sources to support wraparound services (e.g., case management, sanitation, laundry).

State Agencies Exhibited Strong Communication in Designing PRK

"Communication [among state agencies] was really good. There was a daily meeting at the start [of the pandemic] and OES was involved. There was a lot of communication that CDSS spearheaded of multiple departments."

– DGS staff member

- The ***Governor's Office of Emergency Services (Cal OES)*** "*serves as the state's leadership hub during all major emergencies and disasters.*"[6] Cal OES responds, directs, and coordinates state and federal resources across all state regions. Cal OES serves as the pass-through recipient of federal funding to local governments once they apply for FEMA assistance, submitting community requests for reimbursement. Early in the pandemic, Cal OES worked with CDSS to answer questions and provided guidance to communities on how to prepare a project worksheet and best comply with the requirements of the FEMA Public Assistance program. If a community's application is approved, FEMA sends reimbursement to Cal OES, then Cal OES distributes funds to local governments through the State Controller's Office. Early in the pandemic, Cal OES also provided PRK sites with personal protective equipment (PPE; e.g., masks, gloves, hand sanitizer) upon request.

Designing Project Roomkey

PRK could provide non-congregate shelter for people experiencing homelessness who were COVID-19 positive, COVID-19 exposed, or at high risk of contracting COVID-19. However, not all communities served all three populations. In planning their PRK programs, some communities were concerned about COVID-positive PRK participants staying at a hotel or motel without hotel staff being equipped to follow the Centers for Disease Control and Prevention's isolation and quarantine guidelines and to provide care with PPE.

In addition to offering non-congregate shelter, PRK provided short-term wraparound services that could include 24/7 staffing, three daily meals, sanitation and janitorial services, basic supplies, personal protective equipment (PPE), and laundry services. CDSS recommended that all PRK sites would have on-site medical services, including nurses for daily medication, temperature monitoring, and symptom checks. However, not all programs were able to implement these services. During the design phase, CDSS's Housing and Homelessness Division worked with Cal ICH to develop health screening tools, identify screening criteria for participants, and write guidance for monitoring temperature and other symptoms daily. Cal ICH and CDSS then led dissemination of this information to communities.

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4 Until late 2021, Cal ICH was known as the Homeless Coordinating and Financing Council.

5 https://bcsh.ca.gov/calich/

6 https://www.caloes.ca.gov/cal-oes/about-cal-oes/

Recruiting Hotels and Motels

DSB and DGS worked together to identify and lease hotel/motel rooms and secure trailers for PRK sites. Initially, CDSS recommended leasing entire hotels/motels to separate PRK participants from guests. Property searches initially prioritized hotels/motels with outward-facing doors, independent air conditioning units, private bathrooms, and on-site laundry, in accordance with CDC guidance. During the first few weeks of the pandemic, DSB created lists of candidate properties by conducting internet searches of hotels and motels across the state. DGS expanded these lists by contacting the California Hotel & Lodging Association (CHLA) to add major hotel chains. DSB then produced a list that included corporate and independent hotels, motels, and five-star resorts. The Housing and Homelessness Branch worked with DSB and DGS to distribute information about state regulations and the list of hotels/motels to each community receiving PRK funds. Eventually, word of mouth spread in the hotel/motel community, and CHLA started referring interested owners to DGS. After identifying a property, DGS would contact the hotel/motel and begin conversations about participating in the program and ask to tour the property.

In many communities, local government or homeless service provider staff worked independently to identify hotels and motels that might be appropriate and willing to participate in PRK. Local homeless service provider staff often had existing relationships or recent experiences working with motels to implement motel-based shelter programs. Initially, DGS drafted lease agreements for local entities to use with hotels/motels, but eventually local entities took this on.

DGS initially used its Real Estate Services Division to negotiate leases with hotels/motels. When the state made communities responsible for negotiating leases, DGS helped them by finding places and sending sample lease documents that met FEMA reimbursement criteria, tailoring the sample if asked. Overall, lease negotiations were complex and highly individualized, as both the hotel/motel owners and the surrounding communities often had concerns.

Hotel/Motel Owners' Concerns

Public perception. DGS staff reported that hotel/motel owners worried about the public perception of housing people experiencing homelessness who might have been exposed to or tested positive for COVID-19. Some hotel/motel owners agreed to rent out their entire property to reduce the concern of having both PRK participants and hotel guests staying there. This presented financial challenges, however, as FEMA initially agreed to reimburse PRK programs only for occupied rooms. Communities and hotels/motels were unsure how to fund rooms that were waiting for occupants as the program started up. DGS staff said that FEMA's refusal to reimburse for vacant rooms was one of the biggest hurdles to recruiting hotels/motels. Many of the larger hotel chains worried about what would happen to their brand if they participated in PRK. One notable exception was Motel 6, which agreed to a mass leasing agreement across the state.

Wear and tear. Some hotel/motel owners were anxious about what physical condition their rooms would be in after the PRK program ended. Sometimes DGS would send a team to review the initial condition of the property to guarantee it would be restored to that condition.

Not being prepared for "return to normal." Some hotel owners believed the COVID-19 stay-at-home orders would last only a few weeks. Their hotels had bookings for conferences in late spring and summer 2020 that they did not want to cancel.

Staffing. Staffing played a significant part in hotel/motel leasing discussions. Some hotels/motels did not want their staff to work at the PRK site. In these instances, the site had to secure third-party service providers to perform traditional hotel/motel tasks such as front desk staffing and room cleaning. Other sites made providing hotel/motel staff at PRK sites a condition of the lease.

Communities'/Local Governments' Concerns

Hotels/motels sometimes faced strong public opposition to participation in PRK. In one community, the local government threatened to turn off a hotel's utilities if the hotel served as a PRK site. Another community blocked participation in PRK because the mayor did not want the number of rooms leased for PRK to be greater than the number of homeless households in the community, citing concerns about raising the local homelessness count. In some communities, it was difficult to find hotels in the geographic regions where the need was greatest.

Insurance Companies' Concerns

Sometimes hotel/motel owners were willing to participate in PRK, but their insurance carriers would not continue coverage because of the change in housing designation to shelter and concerns about damages. DGS, local communities, and hotel/motel owners contacted insurance carriers to explain PRK. In many instances, insurance carriers still declined coverage, but some hotels/motels successfully obtained third-party insurance to become PRK sites.

Funding Project Roomkey

CDSS awarded PRK funds to interested county welfare departments and federally recognized Tribal administrations to pay the cost of leasing hotel and motel rooms and operating them as PRK sites. CDSS provided initial funding to California communities to implement PRK, but some PRK costs were eligible to be reimbursed by FEMA through its Public Assistance Program Category B, which reimburses state and local governments for eligible costs related to disaster response. CDSS funding could be used to fund program expenses that could not be reimbursable by FEMA's list of eligible expenses. Exhibit 3 details the three rounds of PRK funding offered by CDSS to California communities.

Exhibit 3. Project Roomkey Funding Details

Date Funding Awarded	Amount	Distribution Methodology	Purpose
April 2020	$50 million	By community request & designated trailer	To support the use of hotel/motel occupancy agreements, trailers, and core operating support services associated with emergency non-congregate shelter placements.
December 2020	$62 million	By # of PRK rooms currently occupied	To ensure the safety of participants during the ongoing public health emergency and increase the rate and speed of re-housing placements out of PRK sites.
July 2021	$150 million	By # of PRK rooms currently occupied	To ensure the safety of participants during the ongoing public health emergency and increase the rate and speed of re-housing placements out of PRK sites.

Source: CDSS notices to county and Tribal welfare directors.
Note: CDSS used the "Number of PRK rooms currently occupied" as an estimate of the people in the program for the second and third round of funding.

In late March 2020, the state of California submitted a request for FEMA to reimburse communities for non-congregate shelter and wraparound services that were necessary for people experiencing homelessness during the public health emergency who were "*COVID-19 positive, exposed to COVID-19 as verified by a health provider, or asymptomatic but 'high risk' such as over 65 years old or with an underlying health condition."*[7] On March 27, 2020, FEMA approved this request, making communities eligible for FEMA reimbursement at up to 75 percent.[8]

Eligible expenses for FEMA reimbursement for PRK were:

- Hotels, trailers, or other non-congregate temporary housing; and
- Items that are essential for maintaining emergency non-congregate shelter operations including on-site supervision and security, meals, and health care services related to COVID-19 and medical conditions associated with COVID-19.[9]

Expenses not eligible for FEMA reimbursement for PRK were:

- Non-congregate shelter for individuals who are asymptomatic and not from the defined populations;
- Supportive services such as case management, connections to ongoing health care, and behavioral health counseling; and
- Conversion of facilities for the provision of emergency medical care.[10]

CDSS grants, as well as other local, state, and federal funding, could be used for PRK costs that were not allowable for FEMA reimbursement such as case management and behavioral health counseling.

Between April and December 2020, FEMA required states to submit monthly extension requests for program reimbursement. In January 2021, FEMA eliminated this requirement and authorized states to continue their programs until the end of the pandemic. At the end of January 2021, FEMA also announced that reimbursement levels would increase from 75 percent to 100 percent. Local governments would receive 100 percent reimbursement for expenses backdated to January 2020. FEMA then announced that programs would be reimbursed at 100 percent for eligible costs until July 1, 2022, after

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7 CDSS. "Project Roomkey Federal Emergency Management Agency (FEMA) Reimbursement Frequently Asked Questions." Updated June 8, 2020. https://www.cdss.ca.gov/Portals/9/FEMA/202006-Project-Roomkey-FEMA-Reimbursement-FAQ.pdf

8 FEMA. Approval letter. March 27, 2020. https://www.cdss.ca.gov/Portals/9/FEMA/202005-DR-4482-CA-Non-Congregate-Sheltering-Request-Response-Letter-03272020.pdf

9 CDSS. "Project Roomkey Federal Emergency Management Agency (FEMA) Reimbursement Frequently Asked Questions." Updated June 8, 2020. https://www.cdss.ca.gov/Portals/9/FEMA/202006-Project-Roomkey-FEMA-Reimbursement-FAQ.pdf

10 Cal OES. "Emergency Non-Congregate Sheltering: Approval and Reimbursement of Costs Frequently Asked Questions (FAQ)." https://www.cdss.ca.gov/Portals/9/FEMA/202005-Approval-of-Non-Congregate-Sheltering-FAQ-30-March2020-v2-003.pdf

which programs still in operation would be reimbursed at 90 percent, with a 10 percent local cost share, until stated otherwise.[11]

Cal OES serves as the pass-through recipient of federal funding to local governments for FEMA reimbursement. For local communities to be reimbursed by FEMA, they must work with Cal OES to submit project expenses and documentation. Initially, Cal OES worked with CDSS to develop guidance for communities on how to prepare a project expense worksheet. Once a community's application is approved, FEMA sends reimbursement to Cal OES, then it distributes funds through the State Controller's Office to local communities. DGS staff reported FEMA's refusal to reimburse for vacant rooms as one of the biggest hurdles to recruiting hotels/motels during program design.

Cal OES reported that working with FEMA during the pandemic was challenging. Both Cal OES and FEMA had a backlog because of the large number of submitted requests. Typically, both Cal OES and FEMA handle disasters and emergencies in only a few local areas at one time. However, the national pandemic combined with statewide PRK implementation resulted in FEMA receiving a very large number of reimbursement claims. In addition, many communities worry about receiving reimbursement from FEMA because of negative experiences with FEMA during previous California disasters and emergencies.

[11] FEMA. "Coronavirus (COVID-19) Pandemic: Public Assistance Programmatic Deadlines FEMA Policy # 104-22-0002." June 13, 2022. https://www.fema.gov/sites/default/files/documents/fema_COVID-19-public-assistance-programmatic-deadlines-policy.pdf

3. PRK Design and Planning

California counties and Tribal communities initially designed and implemented their Project Roomkey (PRK) programs in a matter of weeks in March and April of 2020. The early goal of PRK was to save lives by quickly isolating medically vulnerable people experiencing homelessness when little was known about COVID-19. ***This urgency encouraged a new level of cooperation among stakeholders including county health and community development departments, Continuums of Care (CoCs), and homeless service providers.*** However, it also meant that communities were "*building the plane while flying it*." This section summarizes the local PRK design and planning efforts across California.

Partnerships

Designing local PRK approaches brought together diverse groups of community agencies and organizations to partner in planning and executing PRK programs. The number of partners that came together to design and operate PRK programs ranged greatly. The number of partners often depended on the size of the community, the number of people experiencing homelessness there, the capacity of local social service and health care organizations (e.g., hospitals, clinics), and the roles that the partners already performed in their community. Survey respondents reported that the most frequent partners in PRK planning were county government staff (80 percent), followed by local homeless service providers (67 percent) and CoC staff (62 percent).

As the state grantees of PRK funds, county social service departments often led the local design and implementation of PRK. County social service departments frequently partnered with the local CoC or local homeless service providers, making use of their expertise in serving people experiencing homelessness. County staff also built relationships with local health care organizations, including hospitals, public health departments, and other community health providers (e.g., Tribal medical centers, community health networks). Health care partners were important for several reasons. They provided expertise about the rapidly changing pandemic conditions, nurses and medical assistants to help oversee the PRK referral process, and on-site COVID-19 monitoring, as well as physical and behavioral health care. Partners sometimes provided health care directly and sometimes made referrals to other local providers.

Some counties also mobilized local emergency services designed to respond to natural disasters such as earthquakes, fires, and floods. For example, local fire departments sometimes helped organize PRK sites and staffed them temporarily.

Other frequent partners were local vendors that provided meals, laundry services, and security at PRK sites. Some communities also partnered with local nonprofit organizations to help manage and staff PRK sites.

Program Goals

Given the urgency of the pandemic, strategically planning all aspects of PRK programs was not possible at the outset. Instead, county and Tribal officials and their partners focused on how to reduce the risk of COVID-19 outbreaks among people living in congregate shelters and unsheltered locations.

Almost all web survey respondents reported their goals for PRK and most communities reported more than one goal. The most frequently reported goal across communities was to ***protect vulnerable people***

most at risk of mortality or health complications if they contracted COVID-19 (87 percent), followed by ***isolation/quarantine for those who were exposed to or contracted COVID-19*** (78 percent) ***and reducing exposure of people experiencing unsheltered homelessness*** (73 percent). Only about half of communities (51 percent) indicated a goal of PRK to decompress or reduce bed capacity in emergency shelters (Exhibit 4).

Exhibit 4. Local Communities' Goals for Project Roomkey

PRK Goals	Number of counties	Percentage of counties that reported goal
Protect vulnerable people who were most at risk of mortality or health complications if they contracted COVID-19	39	87
Provide location for people experiencing homelessness to isolate or quarantine if they contracted or were exposed to COVID-19	35	78
Reduce potential exposure of people experiencing unsheltered homelessness to COVID-19	33	73
Reduce the number of people staying in emergency shelters (decompress or reduce bed capacity) to reduce the spread of COVID-19	23	51
Other (please specify)	0	0

Source: Evaluation's statewide web-survey n=45.

Note: Communities were asked to select as many goals as applied from the options provided on the survey.

Program Design

When the pandemic initially began and the state launched PRK, many officials thought the program would only be needed for a few months. In the beginning of the pandemic, CDSS, counties, and Tribes all considered PRK a public health program to prevent the spread of COVID-19 and protect vulnerable populations from contracting COVID-19. ***State and local government officials and homeless service system leaders worked quickly to build the infrastructure of PRK and recruit people into the hotels/motels to remain safe from COVID-19.***

By providing individual hotel/motel rooms where people can bring their possessions and do not have to be separated from their partners or pets, PRK offered people autonomy, privacy and safety not found in traditional congregate shelters. PRK also offered an opportunity to bring medically vulnerable people experiencing homelessness in from the streets and connect them with healthcare and other types of supportive services. Communities reported that some PRK participants who had been unable or unwilling to use existing shelter programs engaged successfully in PRK. The safety and stability this non-congregate shelter program provided offered some participants important opportunities to engage with health care and other services related to their mental and physical health conditions. However, stakeholders said given the rapid pace of program design and planning and the changing guidance and infection rates related to the pandemic, in some cases they did not think about how to ramp-down and demobilize the hotels/motels.

As the pandemic continued to worsen, PRK evolved from a response to a public health crisis to a longer-term non-congregate shelter program for medically vulnerable people. After several months, some counties interviewed said they thought state officials changed their perspective to think of PRK as an interim housing intervention. County officials described their programs turning into "*de-facto rapid re-housing programs*". In late 2020, CDSS released guidance encouraging PRK programs to move to a re-

housing strategy now that the program had been implemented and people who may have been at high risk during the public health emergency had moved to the sites.

The unprecedented federal and state funding dedicated towards homelessness during the pandemic caused state and local communities to view PRK as an opportunity to continue to offer non-congregate shelter and supportive services to some of the most vulnerable people experiencing homelessness for an extended period. Instead of exiting participants after the immediate threat of their exposure to COVID-19, PRK programs worked on re-housing people upon exit from PRK. Many of the other federal pandemic-related funding streams (CARES, ARP, ESG-CV) could be used to pay costs associated with PRK sites and services—for example, those not eligible for reimbursement by FEMA. Those funding streams could provide upfront funding for PRK operations while communities waited for FEMA reimbursement. However, stakeholders in several California counties reported it was "*hard to absorb [the different funding] all at once*." Stakeholders cited limited staffing capacity and staff turnover as two reasons that made acquiring the available funding challenging.

As a result of the two phases of PRK implementation, in more than half of counties across California, two distinct PRK models emerged and were implemented.

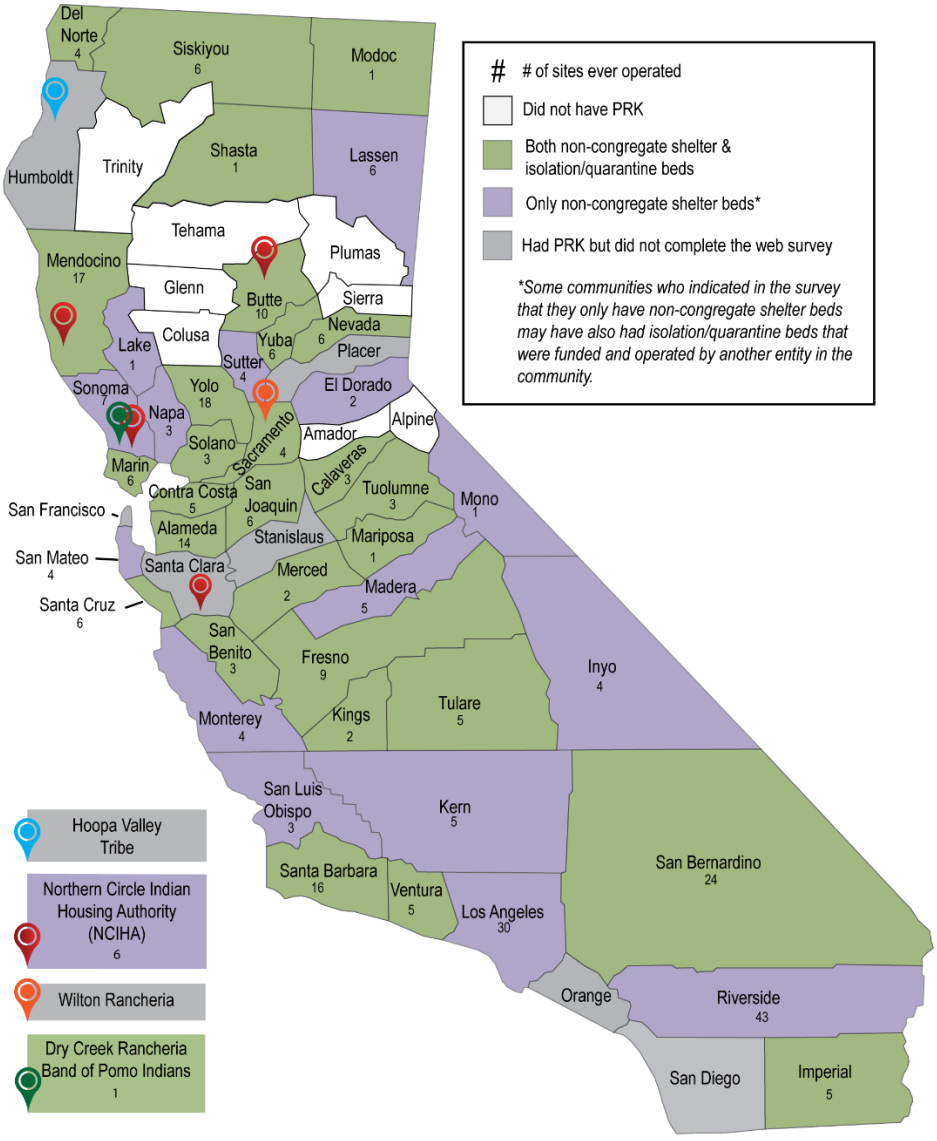
(1) Isolation and quarantine for people experiencing homelessness who were diagnosed or exposed to COVID-19 and needed to quarantine to prevent the spread of the virus, and
(2) Interim housing for people experiencing homelessness who were at high-risk of medical complications if they contracted COVID-19.

All counties and Tribes that responded to the web-survey (n=45) reported implementing the interim housing PRK model, while 64 percent of respondents reported also implementing the isolation and quarantine PRK model at some point during the pandemic. The total number of isolation and quarantine beds per community ranged from 2 to 477, with a median of 27 beds. Depending on the scale of the PRK program locally, some counties decided to have distinct sites for the two PRK models. Other counties used one hotel or motel but had separate floors or blocks of rooms dedicated to the different populations. In counties with separate sites, program staff often relied upon trailers provided by the state for isolation and quarantine.

4. Project Roomkey Implementation

Communities across California implemented their Project Roomkey (PRK) programs differently depending on their needs. This section discusses communities' target populations for PRK sites. It also summarizes the referral sources for PRK programs, including community approaches for considering racial and ethnic equity in the referral process. Lastly, it describes the PRK sites and the services they offered to participants. Exhibit 5 shows the counties and Tribes that received PRK funding, as well as the communities that implemented isolation and quarantine sites versus non-congregate shelter beds.

Exhibit 5. Map of Project Roomkey Implementation across California



Source: Evaluation's statewide web-survey

Target Populations

Across the state, PRK served a variety of target populations from both sheltered and unsheltered settings. More than 80 percent of communities that responded to the study's web-survey reported relying on the Centers for Disease Control and Prevention (CDC) guidance, targeting their PRK programs to people at high risk of mortality or suffering medical complications if they contracted COVID-19 (e.g., 65 years of age or older, with underlying health conditions). A majority of communities reported targeting people experiencing homelessness who needed to isolate after testing positive for COVID-19 (76 percent) and people exposed to COVID-19 (62 percent). A smaller number of communities reported targeting the decompression[12] of emergency shelters (33 percent) and people experiencing unsheltered homelessness (31 percent). While PRK partners knew that PRK participants would have a high level of medical needs given their target populations, stakeholders in several communities stated that PRK participants were more medically vulnerable than they anticipated. In some instances, participants needed a higher level of care than could be offered through PRK and were referred to skilled nursing or licensed residential care facilities.

Program Referrals

Communities reported that homeless service providers' outreach staff was the most common referral source (78 percent), followed by referrals from local hospitals or other health care providers (73 percent). Some communities reported working closely with their local Continuum of Care (CoC) to use its coordinated entry system (53 percent) or Homeless Management Information System (HMIS) (36 percent) to identify people for PRK or getting referrals from emergency shelter staff (49 percent).

Exhibit 6. Project Roomkey Program Interim Housing Model Referral Sources

Referral Source	Number of Communities with Referral Source	Percentage of Communities with Referral Source
Homeless service provider outreach staff	35	78
Local hospitals or other health care providers	33	73
Local coordinated entry system	24	53
Emergency shelter staff	22	49
Review of CoC's HMIS records to identify most vulnerable people within the community	16	36
Other prioritization tool	10	22
Other (please specify)	6	13

Source: Evaluation's statewide web survey of PRK administrators (*n*=45).
Note: Communities were asked to select as many referral sources as applied from the options provided on the survey.

Referrals for isolation and quarantine beds were more likely to come from medical professionals (e.g., local hospitals or other health care providers, local public health department). One county opened a

[12] In this instance, *decompress* means reducing the number of people staying in shelters to allow social distancing consistent with CDC guidelines.

hotline staffed by nurses to triage people's conditions and COVID-19 symptoms and refer them to PRK and other housing programs in their community.

Among the subset of communities with isolation/quarantine beds, the most common referral sources were local hospitals or other health care providers (86 percent), followed by local public health departments (79 percent) and homeless service providers' outreach staff (66 percent).

After receiving a referral, PRK programs typically conducted an assessment to determine the person's eligibility and needs. Most communities used multiple approaches to assess PRK participants for housing and health needs during their stay, with 82 percent of communities reporting that they used between three and five assessment methods. The most frequently used method was HMIS records (87 percent), followed by information gathered from a case manager or street outreach provider (84 percent).

Prioritizing Racial and Ethnic Equity in PRK Implementation

In the study's web survey, 11 communities reported that they explicitly considered racial and ethnic equity when identifying people to participate in PRK. They responded to open-ended questions with some examples of equity efforts:

- Ensuring homeless service provider and partner staff working with people from racial and ethnic minority groups (particularly staff working with farmworker populations) were aware of referral processes.
- Conducting concentrated outreach in communities comprising people of racial and ethnic backgrounds typically overrepresented or underserved.
- Reviewing the race and ethnicity impact of prioritization scoring to ensure equitable placement of people experiencing homelessness into PRK sites.
- Identifying racial and ethnic disparities in access to PRK early in the pandemic and subsequently taking steps to remedy disparities, including ensuring outreach and other staff were using an equity lens.
- Continuously evaluating racial/ethnic data to identify and address disparities in PRK.
- Ensuring the presence of bilingual staff at all PRK sites.
- Collaborating with Tribes to identify unsheltered persons who are Tribal members.

PRK Program Approach

Most PRK programs implemented a *low-barrier* approach to serving people experiencing homelessness, consistent with California's requirement that all state-funded homeless programs use Housing First practices. PRK participants were not required to receive any services to be eligible for assistance. Few programs had rules beyond those meant to prevent the spread of COVID-19 and protect the health and safety of participants. Many PRK programs also used a *harm reduction* approach, meaning that participants did not need to be sober to stay at a PRK site. Many sites had naloxone available in case of an accidental overdose.

Low-barrier and other program features of PRK sites reported in the web survey include:

- **Household composition.** Almost all sites allowed partners to stay together: 82 percent of communities reported all sites allowed multi-person households; seven percent reported most of their sites allowed this. Couples usually shared one hotel/motel room.
- **Pets.** Almost all sites allowed participants to bring their pets: 33 percent of communities reported all sites allowed pets; 44 percent reported most sites allowed this. Seven percent reported most sites did not allow pets and seven percent reported no sites allowed pets. One community said that sites did not allow pets but made other arrangements for pets and one community said that no clients served had pets.
- **Personal possessions.** About half of communities reported that all (40 percent) or most of their sites (11 percent) set limits on the quantity of personal possessions. The other half of communities reported all (24 percent) or most (20 percent) of their sites did not set limits.
- **Parking.** Almost all communities reported that all their PRK sites had parking available (82 percent) or most sites had parking available (9 percent).
- **Security.** PRK sites often had on-site security to help resolve any conflicts that arose between PRK participants or between them and other hotel/motel guests or visitors. Almost half of communities (47 percent) reported that all their sites had 24-hour security, while a third of communities (33 percent) reported that none of their sites had 24-hour security.

PRK Program Services

In addition to housing and COVID-related health services (e.g., temperature checks, COVID-19 screenings), PRK sites also offered a variety of voluntary services to program participants. Communities reported offering a total of 16 different services.

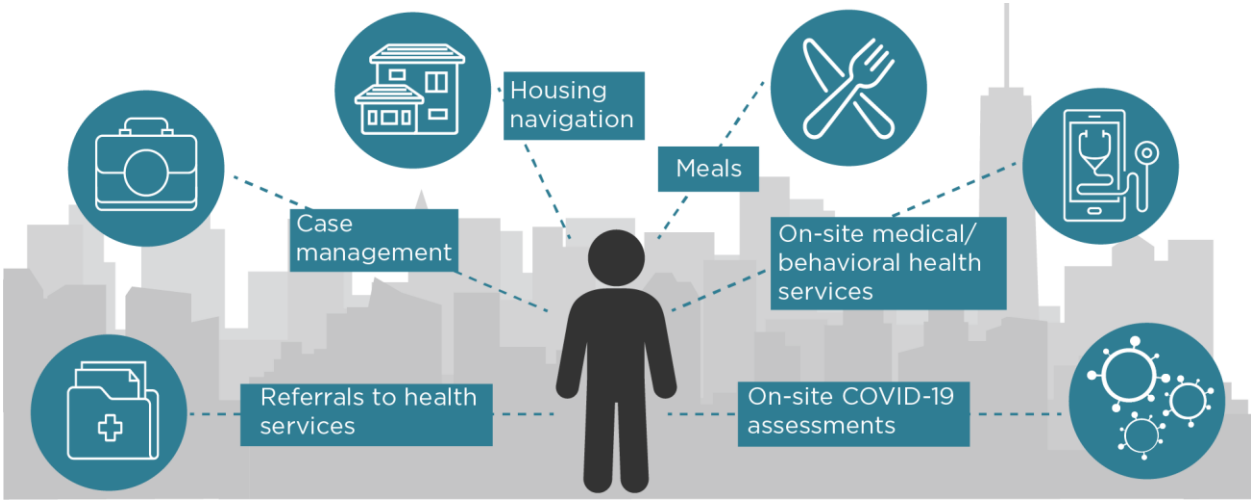
- **Housing navigation.** PRK staff helped participants gather necessary documentation (e.g., Social Security cards, state identifications, birth certificates), apply for housing assistance, and locate housing units. Most communities (89 percent) reported that they provided housing navigation services to PRK participants.
- **Referrals to health services.** PRK participants typically had health conditions that made them vulnerable to COVID-19. PRK programs provided referrals to receive health care services, including mental health, physical health, and substance use services. More than three-quarters of communities (78 percent) reported that their PRK programs provided referrals to health care providers.
- **Meals.** Most PRK sites provided daily meals to participants to ensure they did not need to leave the site to get food. PRK sites typically delivered two or three meals daily to participants' rooms. Most communities (76 percent) reported that their PRK programs provided meals to participants.
- **Case management.** More than half of survey respondents (64 percent) reported that their PRK programs offered case management to participants. However, implementation of case management varied greatly across sites and communities. Some PRK sites had on-site case managers who could meet regularly with participants. In one community, participants could receive case management from the agency that referred them to the program. That PRK program did not offer further services and made it clear that the focus of its program was health, not housing.

- **Transportation to medical appointments.** Many respondents (62 percent) reported that their PRK programs provided transportation for participants to travel to and from medical appointments.
- **On-site medical, behavioral health, and substance use services.** Because of their initial health care focus, some PRK programs provided medical, behavioral health, and substance use services on-site. Almost half (42 percent) reported offering on-site physical health services; fewer reported offering on-site mental health and substance use treatment services (33 percent). County staff reported various approaches to connecting willing PRK participants with health care. Some PRK sites had nurses on-site who met either in person or virtually with participants to identify their medical needs and refer them to medical services. Some counties had mobile health care providers visit their PRK sites one or two times weekly.

Communities reported that PRK participants had greater medical and behavioral needs than the program originally anticipated. PRK sites responded to this need in a variety of ways including referring participants to skilled nursing facilities and creating specific PRK sites for clients with higher needs. Some communities described participants needing help with activities of daily living (ADLs) and some sites struggled finding funding or providers in their community to support those needs. About one-third of communities (29 percent) reported having PRK sites that provided caregiving services for ADLs.

About half of communities with isolation and quarantine sites (52 percent) reported that the services offered at those sites differed from the services offered at non-congregate shelter sites.

Exhibit 7. Services Offered by Project Roomkey Programs



COVID-19 Safety Protocols

Most PRK sites had safety measures in place to mitigate the spread of the COVID-19 virus. These measures were more robust during the early months of the pandemic, prior to the availability of vaccinations. Communities reported the most common safety measure implemented at PRK sites was not allowing visitors (87 percent), followed by mask requirements (82 percent), and prohibitions on gathering

in the hotel/motel's common areas (64 percent). Many PRK sites also conducted daily welfare checks (often while delivering meals). Early in the pandemic, these welfare checks often included temperature checks and monitoring for any other potential COVID-19 symptoms.

PRK Use of Trailers

About a third of communities that responded to the study's web survey used trailers as PRK sites (36 percent). In some communities where stakeholders were never able to engage a hotel or motel into participating in PRK, trailers offered the only source of housing assistance during the early phase of the pandemic.

- Of the communities that used trailers, there was a fairly even distribution of using them to house households where a member was at high risk of dying or suffering medical complications if they contracted COVID-19 (63 percent); households where a member tested positive for COVID-19 (57 percent); or households where a member was exposed to COVID-19 and needed to quarantine (50 percent). One-third of these communities (31 percent) used trailers to serve households in all three categories.
- Most communities reported using trailers to house single people (88 percent), followed by households with two adults (56 percent), families with children (50 percent), and two or more unrelated adults (38 percent).
- Trailers were primarily located on land owned by the county, city, or Tribal government, but sometimes on land owned by homeless service providers or on state property. Other placements for trailers included local fairgrounds and trailer parks. PRK participants in trailers received meals, referrals to case management, referrals to health care providers, housing navigation services, and transportation to medical appointments.

Many communities decided to use trailers as isolation units for people experiencing homelessness who contracted COVID-19. However, counties quickly found that trailers presented many challenges.

- Trailers were difficult to site, as they needed a place to be parked with water, sewer, and electrical access. Providing this infrastructure is quite costly and takes time to construct and maintain (e.g., dispose of sewage, make repairs). When trailers were placed on sites that lacked this infrastructure, operating costs (including pumping sewage and providing water deliveries) were high.
- Trailers were also difficult to staff, as they often were located far from the hotels and motels and offered no office or place for staff to operate.
- The trailers also presented safety concerns for occupants in hot weather (e.g., heat-related illness, fire from spontaneous combustion).

5. Program Exits and Closures

Between mid-2020 and mid-2022, communities across California closed some or all their Project Roomkey (PRK) sites, exiting participants into other short-term and permanent housing placements. This section explains the local efforts and challenges communities experienced identifying housing opportunities for PRK participants, transitioning clients into other housing, and responding to an ever-evolving pandemic.

Closing Project Roomkey Sites

Communities across the state have taken different approaches to closing PRK programs. Reasons for closures include local funding constraints, declining rates of COVID-19, reduced ongoing access to hotels/motels, and uncertainty about funding from the federal government.

The Federal Emergency Management Agency (FEMA) reimbursement model is difficult because it requires local governments to identify and use local funding without a clear timeline for reimbursement. California communities have paid for PRK's hotel/motel rooms with local and state funding, and many still are waiting for their first FEMA reimbursements as of the summer of 2022.

During PRK's first year, the federal government frequently extended the end date for its authorizing of FEMA reimbursement for costs of non-congregate shelters such as PRK. This was a source of continual stress and uncertainly for both program staff and participants about when the program would end. One community reported preparing to close its PRK sites and then – on the last day of the month – receiving notice that the federal government extended FEMA reimbursement. Continued uncertainty about FEMA reimbursement has made it difficult for communities to ramp down programs, find other housing placements for participants, and ultimately close sites.

Exiting Clients from Project Roomkey

In many communities, staff and program leaders reported that their goal was to help participants exit from PRK to permanent housing. However, some communities did not have the funding, housing resources, or staff capacity to achieve this for all PRK participants.

Voluntary Early Departures

Some participants left their PRK program voluntarily; some did not like the program's rules. Particularly, early in PRK implementation, when less was known about how COVID-19 spread and before vaccinations, some PRK programs limited participants from leaving their rooms or having visitors. That isolation and lack of autonomy drove some participants to leave PRK without formally exiting the program. The uncertainty of the PRK program's duration also caused some participants to exit voluntarily. An interviewee in Los Angeles reported that some participants abruptly left one of that community's PRK sites as soon as they had alternative living arrangements because they did not know how long the PRK site would stay open.

Resistance to Exiting PRK

PRK's isolation and quarantine sites generally limited participants' stays (usually to 14 days), but many other PRK sites across the state provided non-congregate emergency shelter in which participants could stay as long as they wanted, as long as the site was open. Sometimes this presented a challenge for

communities when they needed to close a PRK site and participants did not want to leave. PRK offered privacy and amenities that many participants did not have when living in a congregate emergency shelter or in an unsheltered location. Program staff reported that participants appreciated private rooms, bathrooms, television, and internet access. Many of the options available to participants when a PRK site closed, including shared housing and congregate shelter, did not offer these features. Some PRK participants declined options that were temporary or less desirable, wanting to remain in PRK until they received a housing voucher or other permanent housing option became available. Additionally, some PRK participants did not believe that their PRK site was going to ever close because the end date had been extended so many times with FEMA reimbursement extensions.

Exit Destinations

Communities reported that the most common destinations to which PRK participants exited were emergency shelters and other hotels/motels in the community. In communities where there was more than one PRK site, it was common for participants to exit one and enter another, either because their site had closed or because the other PRK site was in a more desirable location. The next most common destinations were evenly spread across (1) staying with family or friends, (2) renting with an ongoing subsidy, (3) staying in a place not meant for human habitation, and (4) other (which often meant the destination was unknown). Very few PRK participants moved into rental housing without an ongoing subsidy.

Across California, helping PRK residents move into permanent housing was challenging because of the lack of affordable, available housing units. Many communities cited the high cost of housing and low vacancy rates as barriers to helping people move to stable housing from PRK, even when rent subsidies were available. Studio and one-bedroom rental units in some locations are hard to find and, when available, are extremely competitive. Because of these housing market conditions, PRK participants usually needed housing navigation services to help them find a rental unit and prepare to move into permanent housing.

Many communities used rapid re-housing funding and federal vouchers (Housing Choice Vouchers, Emergency Housing Vouchers) to help PRK participants exit into permanent housing. In communities where those permanent housing resources were not available, they referred participants to other interim or emergency housing placements. For participants who needed ongoing supportive services after PRK exit, communities used funding from a variety of local, state, and federal sources. Some PRK participants had severe medical and behavioral health conditions or disabilities and were unable to perform activities of daily living independently, so communities sought housing that had services included, such as permanent supportive housing or licensed residential care facilities (e.g., Board and Care facilities).

Many communities (41 percent) reported that exit destinations were different for participants exiting from isolation and quarantine beds compared to interim housing sites. More than half of communities that indicated this difference said that often participants in isolation and quarantine beds went back to their previous program or location.

6. Summary of Year 1

The first year of the Project Roomkey (PRK) evaluation examined program design and implementation, partnerships created, housing and supportive services offered, and re-housing efforts when sites closed. Based on the evaluation team's data collection and analysis, this section offers several findings that might help state and local policy makers, homeless service systems and providers, and funders as they continue to develop ways to provide shelter, services, and permanent housing to medically vulnerable people experiencing homelessness in California.

Key Findings

- ***PRK provided non-congregate shelter features for people experiencing homelessness that were often not available in other emergency shelter or interim housing settings.*** PRK provided individual rooms where people could bring or store their possessions and did not have to be separated from their partners or pets. This model gave people autonomy, privacy, and safety. Communities reported that some PRK participants who previously had been unable or unwilling to use existing shelter programs engaged successfully in PRK. The safety and stability PRK provided enabled some participants to for the first time engage in important opportunities to receive health care and other services for untreated conditions. ***Many homeless system leaders and providers consider that PRK broke new ground for how emergency shelter and interim housing is offered to people experiencing homelessness.***

- ***Many PRK participants were extremely medically vulnerable and needed a high level of care.*** Counties reported that participants in PRK had a higher level of acuity than program designers anticipated. Many programs reported needing more physical, psychosocial, and mental health services at their PRK sites than expected; others reported that a significant number of participants needed help with completing activities of daily living. A few PRK programs partnered with organizations that provided personal care and care management; in other programs, those more intensive supports were not available. As a result, in some communities, people who were referred from hospitals or other health care providers could not be served by PRK because their needs were too great for the program; some were referred to skilled nursing facilities.

- ***California's governmental and robust homeless service system infrastructures supported a quick design and implementation of Project Roomkey.*** Various state departments came together in a matter of weeks to collaboratively design a program relying on hotels and motels to serve people experiencing homelessness who would be medically vulnerable if they contracted COVID-19 as recommended by the CDC. County agencies, Tribal communities, and homeless service systems then applied the state's PRK framework locally to devise their own programs, including creating targeting protocols, identifying and contracting with local hotels and motels, and staffing PRK sites quickly. ***The quick design and program implementation and infusion of federal, state, and local resources to this program were unprecedented in their speed and scale.***

- ***PRK transitioned from a short-term program for people experiencing homelessness who were medically vulnerable if they contracted COVID-19 to an interim housing program used to stabilize and house vulnerable people while more permanent housing options were secured.*** The initial purpose of PRK as described by CDSS was "*to provide non-congregate shelter options for people experiencing homelessness, protect human life, and minimize strain on health care system*

capacity."[13] Though creating an exit and re-housing strategy for PRK participants was part of communities' plans, the focus during the first few months was to recruit people into the program. In November 2020, CDSS began using PRK funding opportunities and guidance in notices to encourage communities to shift that focus to re-housing participants upon exit.

- ***Many counties are still waiting for federal reimbursement, and the reimbursement process is unclear.*** In March 2020, the Federal Emergency Management Agency (FEMA) announced that states or local governments could claim 75 percent reimbursement for costs associated with non-congregate sheltering based on public health orders, through its Public Assistance Program Category B, subject to certain requirements. This was later updated to allow for 100 percent reimbursement through July 1, 2022. California provided technical assistance to local governments on completing and submitting claims for FEMA reimbursement for some PRK program costs. Still, communities reported that the process was challenging. The FEMA reimbursement model of program funding is difficult because it requires local governments to identify and use local funding without a clear timeline for reimbursement.

Data Collection and Analysis Planned for Year 2

Over the next year, the Abt evaluation team will complete several additional data collection and analysis activities to understand the use of health care and shelter and housing programs by PRK participants. Additional evaluation activities are:

- Collecting and analyzing Homeless Management Information System data, California state Medicaid data, California Department of Social Services data, and California Department of Public Health data to understand the demographics of PRK participants and their housing and health needs when they entered PRK. This administrative data will also help us to understand whether PRK connected participants to health care services, whether they engaged in these services, and if participants achieved housing stability after exiting PRK programs.

- Conducting site visits at six communities across the state to gain a deeper understanding of PRK implementation. The site visits will collect cost data specifically around FEMA reimbursement and will provide information on how communities funded housing, services, and other resources needed for PRK participants, as well as unanticipated costs that arose during implementation. The evaluation team also will interview people who stayed at a PRK site (15 in each community) and observe and visit PRK sites. If programs are no longer in operation, the site visit team members will go to a few of the hotels/motels that were once PRK sites for photos and neighborhood observations.

At the end of the second year, the Abt evaluation team will produce a final evaluation report detailing our analysis and findings.

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[13] Hernandez, J. June 1, 2020. "All County Welfare Directors Letter (ACWDL): Project Roomkey Initiative." California Department of Social Services.