Bakersfield - Kern
BKRHC
REGIONAL HOMELESS COLLABORATIVE

Kern County Strategic Plan to Address Homelessness

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May 2024

Executive Summary

More people and families experience the crisis of homelessness in Kern County than the current system of care has the capacity to help. The crisis by the numbers:

4,876

The number of households that sought and received services from the Kern County Homeless System of Care last year.

180

The excess number of people who flow into the homeless system of care each year on average (3,621) compared to the average number who exit the system (3,444).

1 Year

The average time from when someone in an adult-only household first enters the homeless system of care until their first move-in date to permanent housing.

42%

The percent of individuals in adult-only homeless households who have previously experienced unsheltered homelessness.

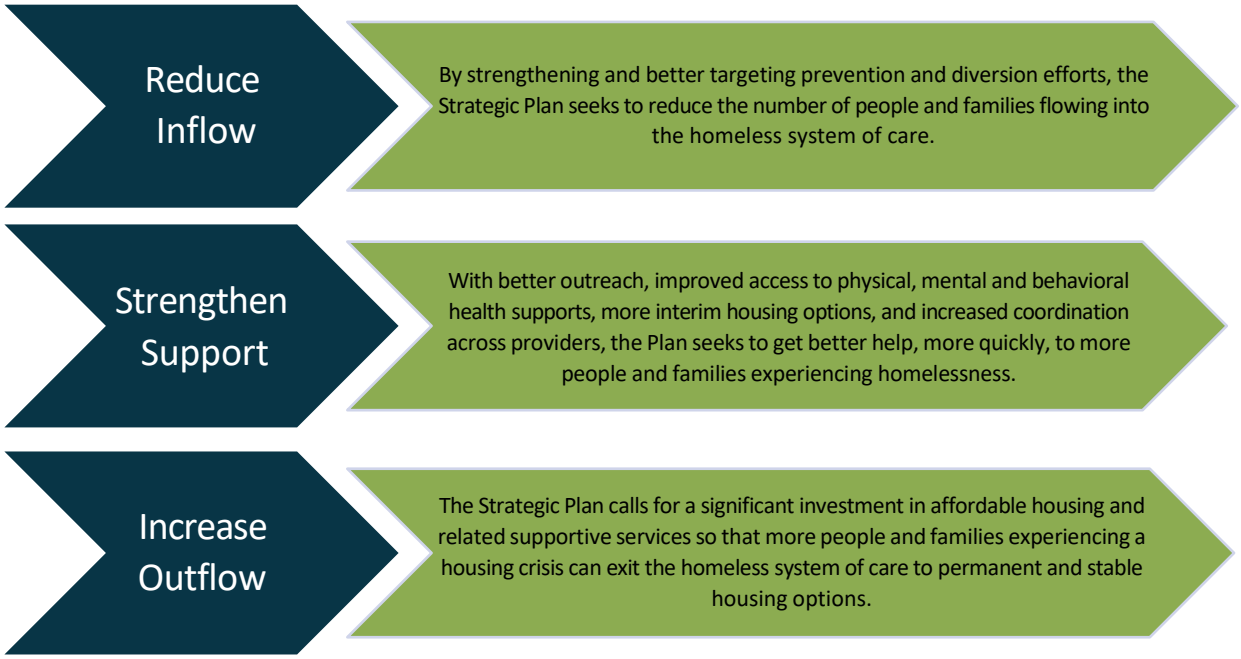
2,136

The number of permanent supportive housing beds the community needs to add in order to meet the unmet need in the homeless system of care.

1,945

The number of rapid rehousing beds the community needs to add in order to meet the unmet need in the homeless system of care.

This Strategic Plan to Address Homelessness in Kern County seeks to strengthen the current system of care so that it has the capacity to meet the full needs of the Kern County community. The Plan adopts three overarching goals supported by eight strategic objectives that, collectively, are designed to do three things: (1) reduce the number of people and families flowing into the homeless system of care, (2) deliver better help to the people and families who do experience homelessness, and (3) increase the number of people and families who exit the homeless system of care to permanent and stable housing arrangements.



Achieving these system improvements will require a coordinated and sustained effort from stakeholders across the homeless system of care. The Strategic Plan helps guide these efforts by providing detailed implementation strategies for each of its goals, as well as action steps through which the strategies can be achieved. The table below lists each of the Plan's goals, objectives, and related strategies. For details on the proposed action steps, please see the full Plan.

Goal 1	Reduce Inflow
Objective 1	Reduce the number of people experiencing homelessness through prevention and diversion.
Strategy 1A	Increase prevention and diversion resources and services.
Strategy 1B	Reduce homelessness for those exiting institutions.
Strategy 1C	Utilize data across systems to identify themes and trends for homeless and those at-risk of homelessness.
Strategy 1D	Ensure that homeless and formerly homeless people are represented throughout the system to support lived experience perspective in resource development, planning and advisement of service provision.
Strategy 1E	Educate the public on what services exist for those at risk of homelessness.

Strategy 1F	Improve economic security and workforce development programs that target those who are at-risk of homelessness.
Objective 2	Increase timely, equitable access to Coordinated Entry System (CES).
Strategy 2A	Expand outreach services throughout Kern County.
Strategy 2B	Improve system navigation of CES for clients.
Goal 2	Strengthen Support
Objective 3	Use data across the system to measure inflow, access to service, and outflow to measure program success and achievements.
Strategy 3A	Develop and implement a plan to expand HMIS license access and sustainability for HMIS programming.
Strategy 3B	Develop a data dashboard for HMIS to demonstrate key metrics for homeless goals.
Strategy 3C	Complete a full assessment of the utilization of the HMIS system and user activity.
Strategy 3D	Utilize data to make equity informed decisions and develop solutions to support equitable access for services and resources.
Objective 4	Increase access to supportive services
Strategy 4A	Ensure that wraparound and case management services are available for all housing and shelter options.
Strategy 4B	Increase the capacity and training for crisis response to behavioral and physical health care needs.
Strategy 4C	Enhance support for homeless specialty sub-populations.
Strategy 4D	Improve economic security, healthcare, and behavioral health care access for those who are homeless.
Objective 5	Improve emergency shelter options to increase access to quality emergency shelter beds.
Strategy 5A	Support resources for innovative plans that address the needs of specialty homeless sub-populations.

Strategy 5B	Strengthen referral and discharge between service providers to prevent unsheltered homelessness.
Strategy 5C	Better prepare emergency shelter clients to achieve housing stability.
Strategy 5D	Develop disaster contingency plan for sheltered and unsheltered individuals.
Objective 6	Increase the inventory and access to interim, transitional, and bridge housing.
Strategy 6A	Increase advocacy, funding, resources, and services for interim, transitional and bridge housing.
Strategy 6B	Utilize data to identify and prioritize the needs for specialty sub-populations to have equitable access to interim, bridge and transitional housing options.
Goal 3	Increase Outflow
Objective 7	Increase the inventory and access to affordable, permanent housing.
Strategy 7A	Encourage and support local efforts to increase affordable housing.
Strategy 7B	Increase the number of Rapid Re-Housing beds.
Strategy 7C	Coordinate and incentivize developers to increase affordable housing.
Strategy 7D	Increase landlord engagement to create more available units.
Objective 8	Reduce recidivism for those exiting into permanent housing.
Strategy 8A	Enhance availability and increase after-care case management programs.

Introduction

Like many communities across California, Kern County is experiencing a homelessness crisis. The number of people experiencing homelessness increased sharply in recent years, hitting an apparent peak in 2023, when 1,948 people experiencing homelessness were counted during the Point-in-Time (PIT) Count in January. Moreover, the portion of those experiencing homelessness who were living unsheltered skyrocketed. Kern County experienced a fluctuation in the number of people living unsheltered in the community ranging from 52 – 64% of the overall PIT Count population from 2019 through 2023. This meant that hundreds more people than in previous years were living in places not meant for human habitation – in their cars, under bridges, in parks, and on the streets. This made homelessness a particularly visible concern for the public. More importantly, this means that hundreds of Kern County residents experiencing a housing crisis are not receiving the help they need to resolve it.

What is particularly concerning about the increase in homelessness in Kern County is that it outpaces the system's capacity to provide needed assistance. Each year, more people come into the homeless system of care than exit it. This means there is a growing wait list for housing and services that the system cannot fill.

Specifically, 3,621 people and families flow into the homeless system of care, while just 3,444 move out of the system, leaving an excess demand of at least 180 people and families each year. What these figures do not reflect are the people and families who never get connected to the system of care – people living unsheltered, perhaps in cars or parks, or unnoticed places, whom our outreach teams fail to reach. Over time, that excess demand has built up, leading to a backlog in the demand for housing and services in the community. Figure 1 is a stylized graph that illustrates this growing demand.

Figure 1: Demonstrative line graph on impact of greater *inflow* than *outflow* in the homeless system of care.

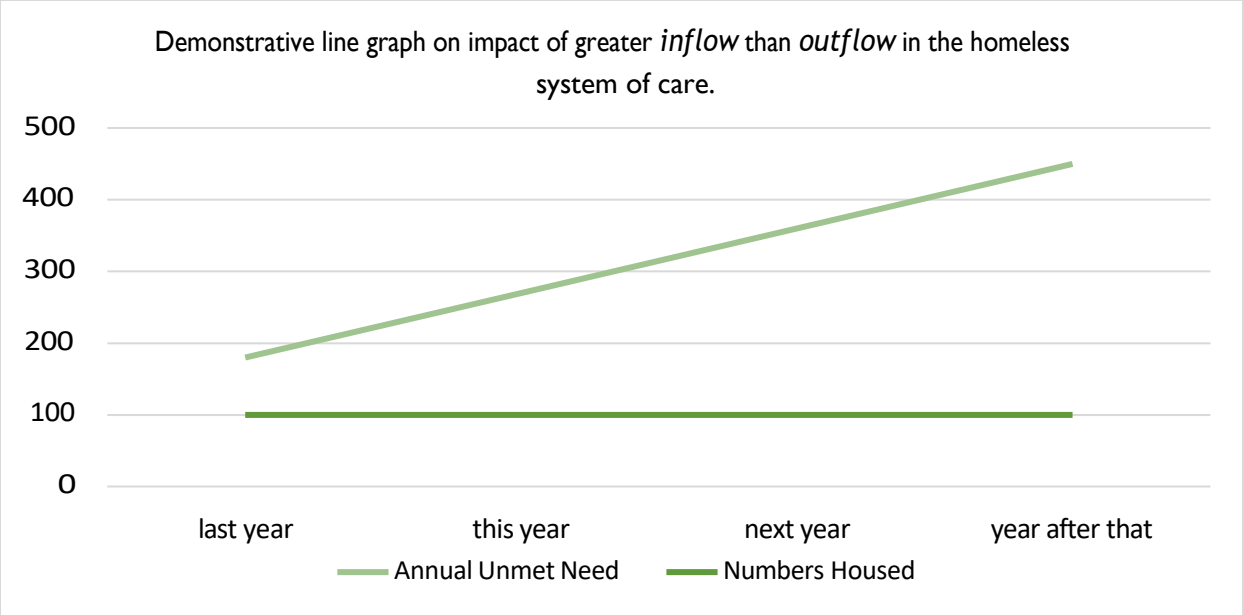


Figure 1 is offered for illustrative purposes only.

To address this imbalance and serve all the people and families who experience homelessness each year, the Plan adopts ten objectives that, collectively, are designed to do three things:

1. Reduce the number of people and families flowing into the homeless system of care.
    - By stepping up the community's commitment to homelessness prevention and diversion strategies, the plan aims to sharply reduce the number of people and families who experience the trauma of homelessness. "Prevention and diversion" refer to strategies such as providing financial assistance (to pay rent, utility bills, security deposits, moving costs, etc.) or supportive services (such as housing advice, landlord or family mediation, benefits advocacy, etc.), or both, to those at risk of or recently experiencing homelessness.
    - The plan also calls for increasing the availability of affordable housing throughout Kern County. Half of all renters in Kern County are "cost-burdened," meaning that they pay more than they can afford in rent. Indeed, a quarter of all renters spend more than half of their income on rent. Increasing affordable housing throughout the county will help these households move back from the precarious economic edge on which they live and find a more reasonable balance in their family budgets.
2. Deliver better help to the people and families who do experience homelessness.
    - Despite the community's best efforts, some people and families will fall into homelessness. The plan below calls for better supports for those experiencing homelessness, including:
    - Better-targeted outreach and case management efforts to reach underserved populations and people experiencing homelessness in underserved areas of the County.
    - More temporary and transitional housing options to provide increased safety and stability while people work on finding permanent housing options.
    - More access to wrap-around services beyond just housing, to meet people's needs for such things as mental health treatment, employment and job training, health care, and substance abuse treatment.
    - Improvements to the systems that support the homeless system of care to deliver help more effectively.
    - Better coordination among providers within the homeless system of care, and with the institutions (police, hospitals, jails, schools, etc.) that regularly interact with people experiencing homelessness or may discharge people to the homeless system of care.
3. Increase the number of people and families who exit the homeless system of care to permanent and stable housing arrangements.
    - To increase the outflow of people and families from the homeless system of care, the system needs homes where they can live. The plan calls for an additional 2,136 permanent supportive housing (PSH) and 1,945 rapid rehousing (RRH) units in Kern County.

- Successful exits to permanent housing may require ongoing support to ensure that people remain stably housed. The additional supports referenced above also include support for this transition to permanent housing.

Permanent Supportive Housing (PSH) provides long-term housing with intensive supportive services to persons with disabilities. These programs typically serve people with extensive experiences of homelessness and multiple vulnerabilities and needs who would not be able to retain housing without significant support.

Rapid Rehousing (RRH) provides rental housing subsidies and tailored supportive services for up to 24-months, with the goal of helping people achieve permanent housing stability. RRH is considered a permanent housing solution by HUD.

A summary of each objective and its rationale is provided in the chart below. More details, including specific strategies and action steps to achieve each goal can be found in the section below titled, "Goals and Strategies to Address Homelessness in Kern County."

	Prevention and Diversion (Objective 1)	Increase the amount of prevention and diversion resources and ensure targeted strategies for use of those resources to the groups most in need of prevention and diversion services. Advancing this goal should slow and diminish the flow of people into the homeless system of care.
	Timely, Equitable Access to CES (Objective 2)	Ensure the navigation of the Coordinated Entry System and the services provided through this system of care need to be efficient, accessible, and transparently available. Ensuring the CES system functions in this manner matches people served with the resources needed.
	Use of Data (Objective 3)	Data and transparent, accessible dashboards will support tracking of resources, identify areas of need, and guide informed decision making.
	Access to Supportive Services (Objective 4)	Ensure that wraparound services are available for all housing and shelter options so that clients can receive the support and care they need to reach self-sufficiency and/or remain stably housed. Programs such as mental health treatment, employment and job training, health care, and substance abuse treatment can meaningfully help people attain greater stability and exit the homeless system of care.
	Emergency Shelter (Objective 5)	Emergency shelter and services are essential to ensuring every community is prepared for crises. Offering a variety of emergency shelter options will ensure that every community member in need has access to a safe and accessible place to stay in the event a homelessness crisis.
	Interim/ Transitional/ Bridge Housing (Objective 6)	Interim, bridge and transitional housing provide someone with a longer place to reside while they access necessary treatment to build readiness to move into the right level of independent, permanent housing. These specialized resources allow emergency shelter to be a short-term solution and ensure people are ready when they move into permanent housing.

	Affordable and Permanent Housing (Objective 7)	Increase the inventory of affordable and permanent housing throughout the County with right-sized, targeted strategies for those in need. With more affordable and supportive housing options available, fewer people will enter the homeless system of care, more people will exit it, and fewer people will return to homelessness in the future.
	Reduce Recidivism (Objective 8)	Supporting the success of someone into housing, by building resources, services, training, and independence is the goal to building healthy, independent, successful communities. Reducing the cycle of recidivism by ensuring after-care services is a low-cost alternative to the ongoing resources used when someone enters homelessness.

As discussed below (see section: Goals and Strategies to Address Homelessness in Kern County), each of these goals is paired with a set of strategies and action steps intended to move the homeless system of care from plan to action.

In the pages that follow, we provide a summary of the strategic planning process, a description of homelessness in Kern County, and an overview of the system of care that works to prevent and end homelessness. We then present an analysis of gaps and needs in the current system. The plan concludes with a detailed summary of the goals, strategies and action steps proposed to strengthen the current system and help it meet the pressing needs of those at risk of or experiencing homelessness in Kern County.

Strategic Planning Process

The process to develop this plan was spearheaded by a Strategic Planning Committee, a group of community stakeholders.

The strategic planning process included the following elements to engage the community, ensure feedback and input from a diverse and representative group, and secure support for implementation:

- ✓ A Strategic Planning Committee with a diverse representation of stakeholders from various jurisdictions, departments, agencies, and coalitions.
- ✓ Review of prior Strategic Planning and other systems-level documents.

- ✓ Review of results from the Coordinated Entry System SWOT (strengths, weaknesses, opportunities, threats) analysis.
- ✓ Homeless Management Information System (HMIS) data analysis.
- ✓ Research on practices, policies, and strategies to support the community's goals around homelessness.
- ✓ Interviews with key stakeholders.
- ✓ Iterative drafting with the BKRHC Executive Director.

Background on Homelessness in Kern County

This section of the plan is intended to answer some common questions about homelessness and the homeless system of care in Kern County. These include:

1. What does homelessness look like?
2. What causes homelessness?
3. Who is the Kern County homeless system of care serving?
4. How is homelessness changing in Kern County?
5. What help does the Kern County homeless system of care offer?
6. How is the Kern County homeless system of care performing?

1. What does homelessness look like?

When many people think about homelessness, they imagine someone who is sleeping and living on the street (e.g., "unsheltered" homelessness). However, homelessness isn't always obvious and takes on many forms that can be thought of in four categories: transitional, chronic, episodic, and hidden.

The most common type of homelessness is transitional homelessness. Transitionally homeless individuals typically have one short stay in a shelter before moving on to more stable housing.

Chronic homelessness refers to the experience of people who have been homeless for at least a year – or have repeatedly experienced homelessness in the last three years – while struggling with a disabling condition. In Kern County in 2022, 26% of those experiencing homelessness were chronically homeless.

Episodic homelessness refers to a frequent cycling in and out of homelessness.

The fourth type of homelessness is hidden homelessness, which refers to individuals who do not access homeless services but are temporarily living with friends or relatives ("couch surfing" or "doubled up") due to a lack of housing opportunities. Because they do not often qualify for homeless services, they are not counted in standard homelessness statistics.

Of those who are served by the homeless system of care, they may be unsheltered, sheltered, or in a housing program (note: the homeless system of care also serves individuals through supportive services only and homelessness prevention programs).

2. What causes homelessness?

Homelessness is the result of failed policies and holes in our social safety net. Underfunded support programs and inequitable access to quality education, health care (including treatment for mental health conditions and/or substance use disorders), and economic opportunity leave many people and families living a precarious existence that quickly falls into crisis when they hit hard times. This vulnerability has been exacerbated by local

development restrictions and an underinvestment in affordable housing development and preservation that has led to severe shortages of affordable, safe, and accessible housing. Moreover, wages have not kept up with soaring housing costs, leading to substantial rent burdens and persistent housing insecurity, particularly among those earning less than half of the area median income.

These vulnerabilities are not evenly distributed in our society. Rather, discriminatory practices against people of color and members of marginalized groups have left those populations particularly vulnerable to homelessness. The recently released "All In: The Federal Strategic Plan to Prevent and End Homelessness," makes the connection between homelessness and systemic racism and discrimination as follows (at page 15):

> For example, during the 20th century, federal and local governments implemented discriminatory housing, transportation, and community investment policies, such as redlining, that segregated neighborhoods, inhibited equal opportunity and wealth creation, and led to the persistent undervaluation of properties owned by people of color. These federal policies eroded intergenerational wealth creation for individuals and families across the United States, leaving many people of color more vulnerable to housing instability and homelessness. Similarly, policies like forced relocation have put American Indians and Alaska Natives at greater risk of housing insecurity and homelessness. At the same time, discriminatory policies, and practices against marginalized groups— such as LGBTQI+ Americans, people with disabilities, and people with HIV—have resulted in inequitable access to economic opportunity, housing security, and an inclusive social safety net.

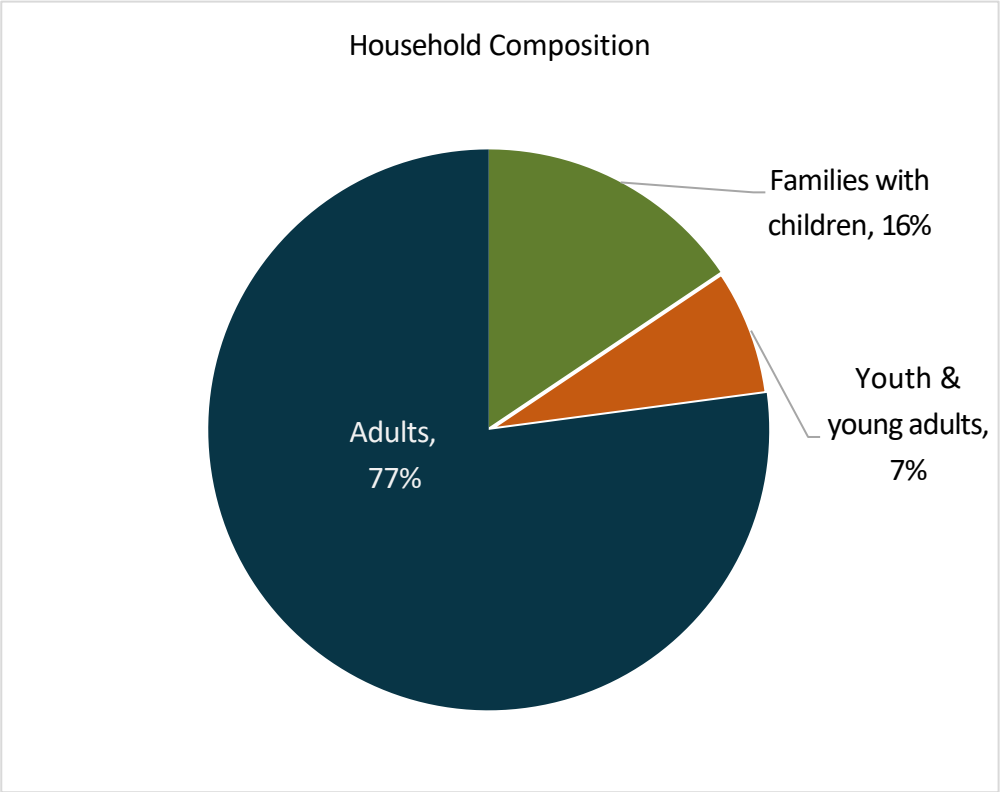
As discussed below, the disparate impacts of past and present discrimination can be seen in over-representation of Black residents in Kern County's homeless system of care. It may also account for an apparent reluctance among Hispanic or Latino/a/x residents, as well as LGBTQ+ youth, to seek assistance from the homeless system of care.

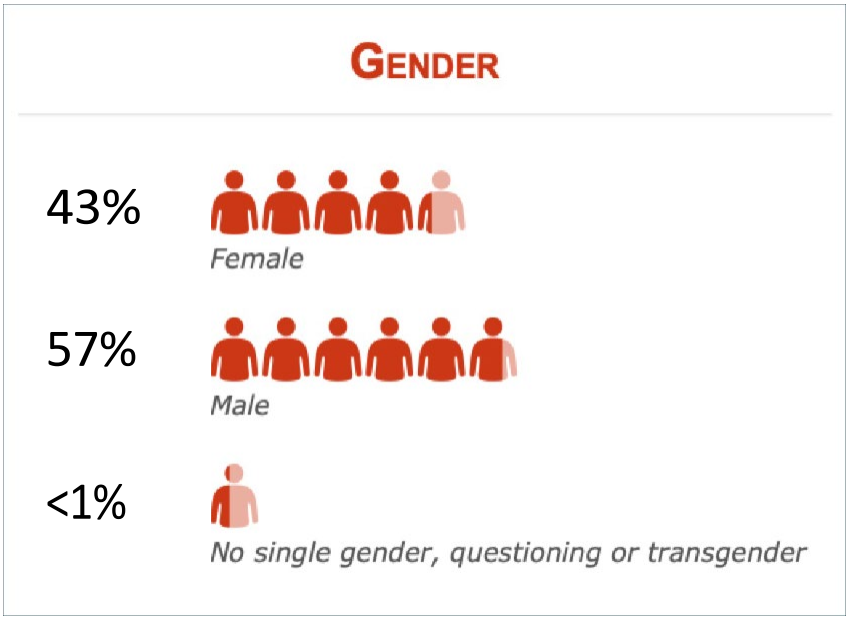
3. Who is the Kern County homeless system of care serving?

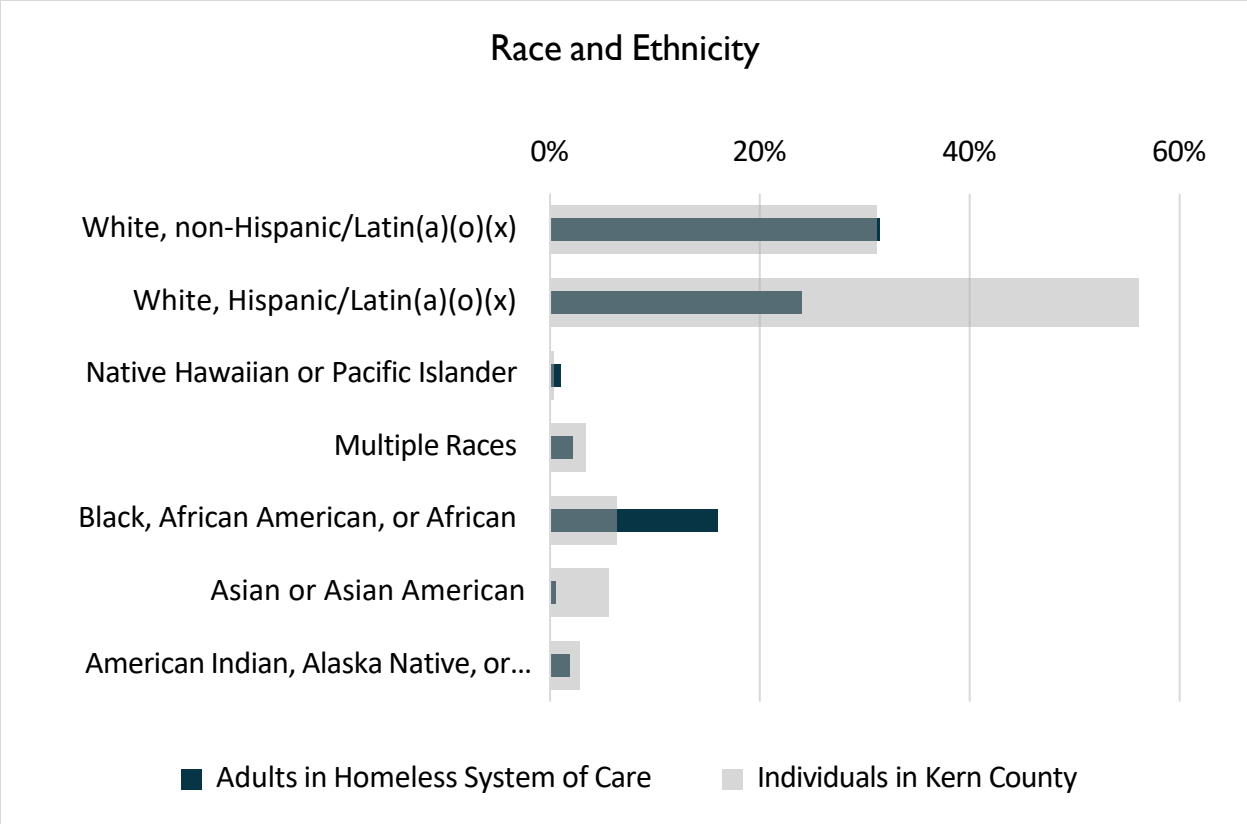
4,876 households (made up of 6,821 people) experienced homelessness and received services in Kern County during the 2021-22 reporting period for HUD's Longitudinal Systems Analysis of the local homeless system of care.

Adult-only households made up more than three-quarters of the households served in the homeless system of care. Families with children accounted for 16% of households served, and youth and unaccompanied young adults made up the remaining 7% of households.

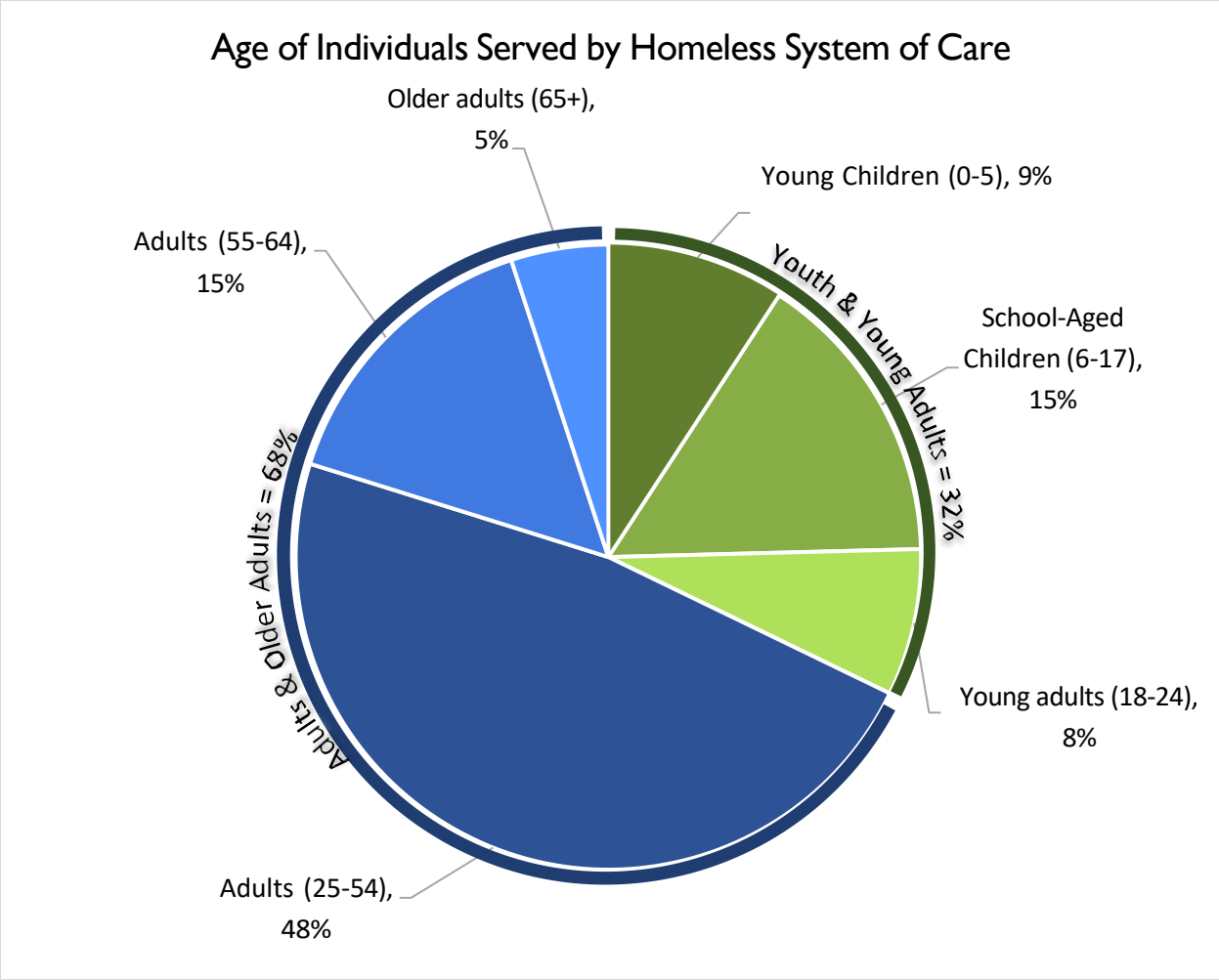
About 43% of adults served during the 2021-22 reporting period were female and 57% were male. Fewer than 1% of those served identified as no single gender, questioning, or transgender.







The chart above compares the percentage of people of various racial and ethnic backgrounds served by the Kern County homeless system of care during the 2021-22 reporting period to the percentage of people of those same backgrounds in Kern County as a whole. It shows that Black individuals are significantly over-represented in the homeless system of care. This disproportionality is a by-product of systemic inequity: the lingering effects of racism that continue to perpetuate disparities in critical areas that impact rates of homelessness, including poverty rates, housing segregation and discrimination, incarceration rates, and access to health care.



The chart above also shows that Asian and Hispanic or Latino/a/x individuals are significantly under-represented in the homeless system of care. This may be a sign that Asian and Hispanic or Latino/a/x individuals in Kern County experience homelessness at much lower rates than would be expected based on demographic data. Another possibility is that there are cultural or other barriers limiting Asian and Hispanic or Latino/a/x individual's access to the homeless system of care, which makes their numbers appear artificially low in available data. This may point to a need to improve cultural competency and outreach strategies among staff serving people experiencing homelessness.

Approximately one-third of the individuals served by the homeless system of care are youth and young-adults.

Most of the adults served fall between the ages of 25 and 54. Adults aged 55-64 make up 15% of the total population served. Just 5% of those receiving services are older adults (aged 65+).

4. How is homelessness changing in Kern County?

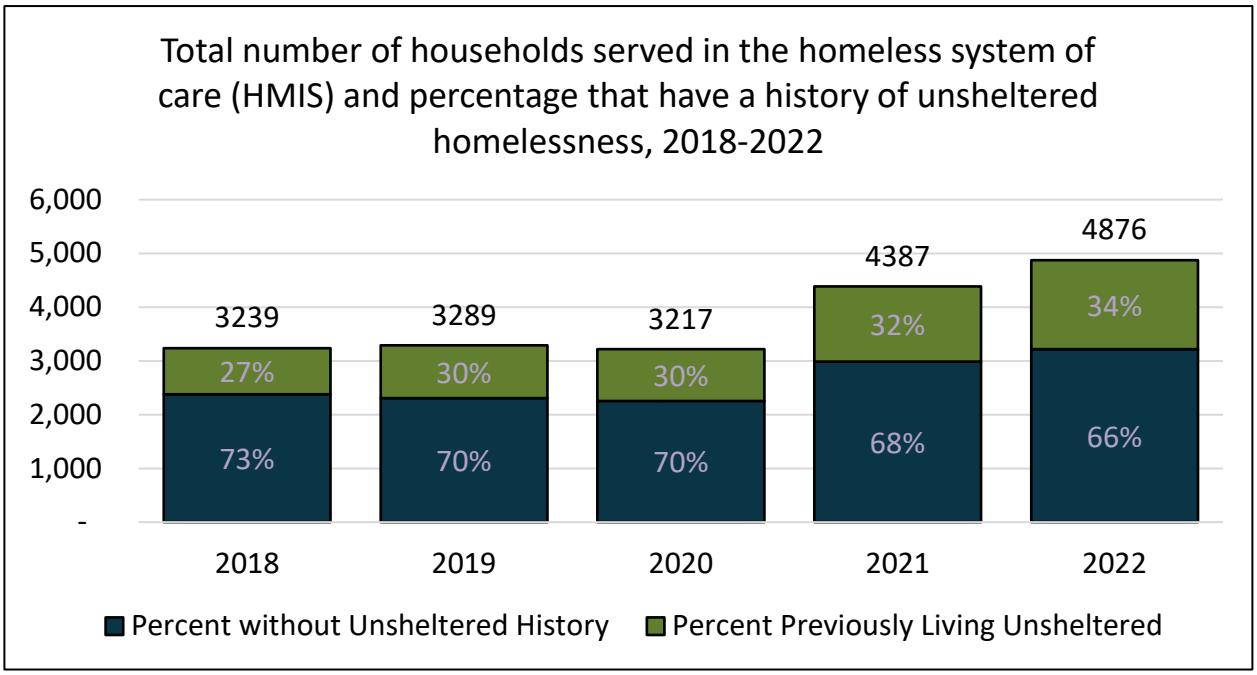
↑51%

The number of households who experienced homelessness and received services in Kern County increased by 51% between 2018 and 2022.

Measuring how many people experience homelessness is challenging, particularly in a large county such as Kern. No methodology can provide a 100% accurate count of individuals experiencing homelessness; any approach will inevitably result in an undercount. As laid out below, we use multiple data sources to better understand the homelessness crisis facing the community.

Households Accessing Services (HMIS Data)

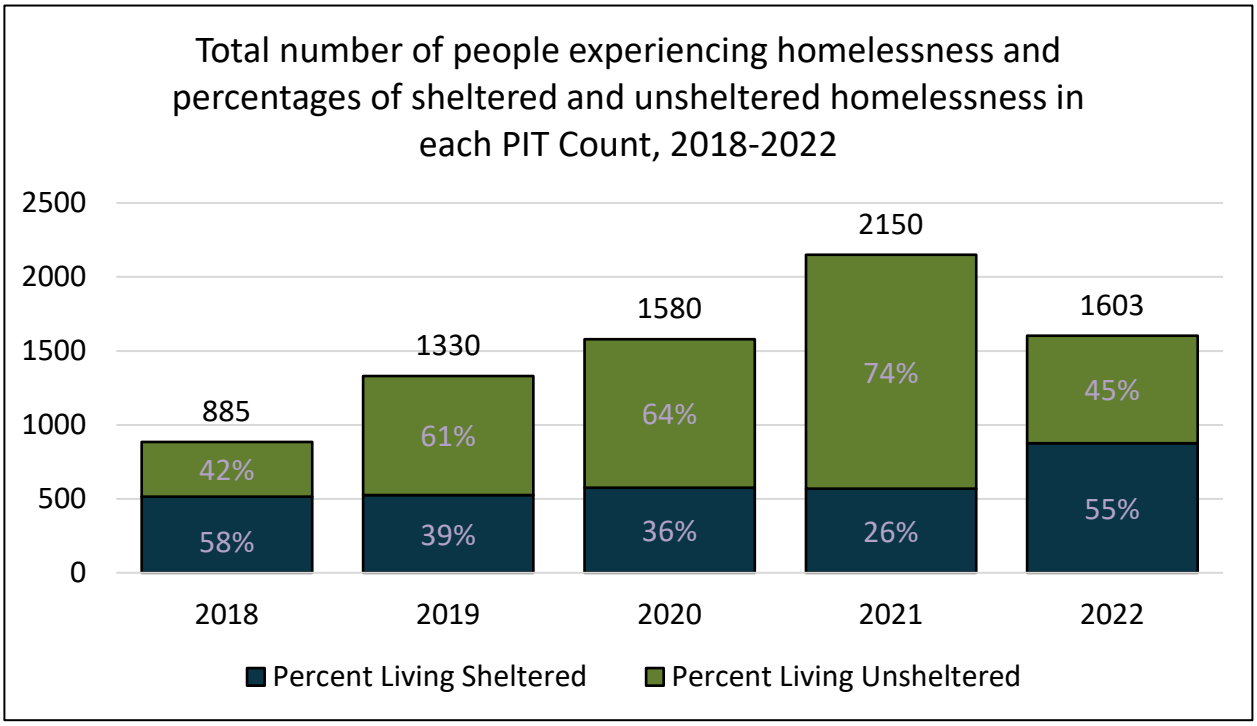
One way to measure homelessness is to track how many households access the services offered through the homeless system of care. Kern County uses a Homeless Management Information System (HMIS) to track client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. This data usefully tracks how many households the system is reaching every year but lacks information about people who may experience homelessness but do not get connected to the system. The chart below reports this data for the five years from 2018 and 2022. It also shows the percent of households that indicated they were living unsheltered prior to entering the homeless system of care. Please note that COVID-19 restrictions significantly limited the number of people who could be housed in emergency shelters between 2020 and 2022.



Individuals Experiencing Homelessness on a Given Night (PIT Data)

Another way that the Kern County community measures homelessness is to count how many individuals are experiencing homelessness on a given night. This "Point-in-Time" or "PIT" count is conducted every January in compliance with the U.S. Department of Housing and Urban Development's requirements for all Continuums of Care. A significant limitation of this data is that it only includes information about people experiencing homelessness who could be located by staff and volunteers on the night of the count. Moreover, the number of people experiencing homelessness each night no doubt fluctuates significantly over the course of the year. Accordingly, care must be taken in interpreting the data; broad generalizations typically should be avoided.

The results of the PIT count for each year from 2018 to 2022 are shown below. Please note that COVID-19 restrictions significantly impacted the system's ability to conduct PIT counts in 2020 and 2021.



Trends of Homelessness based on HMIS and PIT Count Data

Both the HMIS data and the PIT Count data show similar patterns. The number of people in Kern County experiencing homelessness has increased significantly in recent years, as has the number of households served by the homeless system of care. Moreover, the PIT Count data shows a sharp increase in the number of people experiencing unsheltered homelessness, particularly in 2021. The HMIS data also shows an uptick in unsheltered homelessness, but the increase is not as substantial.

5. What help does the Kern County homeless system of care offer?

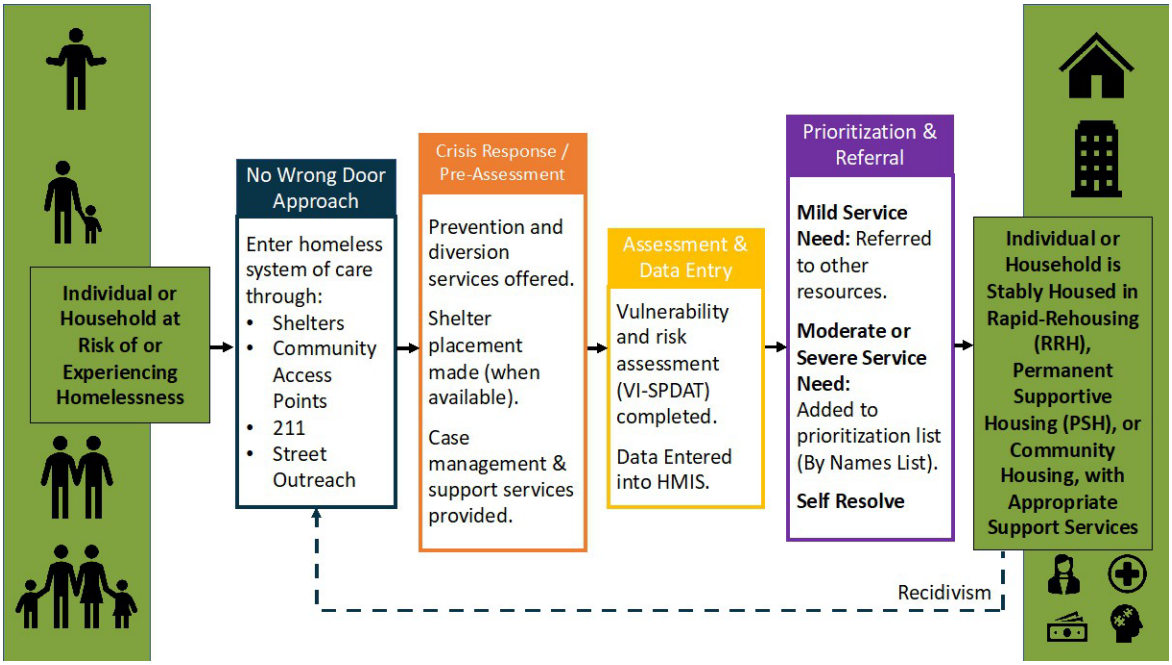
A wide range of organizations and entities in Kern County serve individuals and families who are at risk of or experiencing homelessness. These include nonprofit organizations, shelter providers, local and federal government agencies, faith-based organizations, school systems, health care providers, and more. These entities and their diverse efforts to serve people at risk of or experiencing homelessness make up the "homeless system of care" in Kern County.

The task of coordinating this system and aligning the efforts of its many stakeholders falls to the Bakersfield/Kern Regional Homeless Collaborative ("BKRHC") and the Bakersfield/Kern County Continuum of Care ("CoC").

Overview of the Homeless System of Care

The diagram below provides a stylized illustration of how a person or household might move through the homeless system of care in Kern County. It starts at the point where a person or household is at risk of homelessness or has become homeless. They may reach out to shelters, the 211 system, or other community access points for assistance, or they may encounter a street outreach team that will triage people from living unsheltered to the homeless system of care.

Regardless of how they reach the homeless system of care, they should receive an immediate crisis response. Where appropriate, that response may start with prevention and diversion services to help avoid homelessness (prevention) or to immediately resolve it if it has already occurred (diversion). Prevention and diversion typically include financial assistance (to pay rent, utility bills, security deposits, moving costs, etc.) or supportive services (such as housing advice, landlord or family mediation, benefits advocacy, etc.), or both.



If a person or household experiences homelessness despite these supports, the homeless system of care offers a variety of other services and resources to help them achieve stability in permanent housing. These include:

I. **Emergency Response**

a. **Outreach and engagement** to triage people from living unsheltered to the homeless system of care.

b. **Emergency Shelters** that provide overnight sleeping accommodations for people experiencing homelessness.

c. **Navigation Centers** that provide temporary living facilities while case managers connect individuals experiencing homelessness to income, public benefits, health services, shelter, and housing.

d. **Transitional Housing** which is temporary housing that is intended to serve as a bridge to permanent housing, offering housing with structure, supervision, support (for addictions and mental health, for example), and life skill building.

II. **Permanent Housing Solutions**

a. **Rapid Rehousing** that provides medium term (up to 24 months) rental assistance and case management support to help homeless individuals or households (with or without a disability) to quickly become housed.

b. **Permanent Supportive Housing** that provides access to a housing unit and rental assistance and supportive services on an ongoing basis to assist households with at least one member (adult or child) with a disability to achieve housing stability.

Emergency responses are intended to be temporary measures that provide the stability people need to move on to permanent housing in the community – either market-rate housing or subsidized housing offered through various programs. In some cases, households with at least one member with a disability may be unable to maintain housing stability without long-term support. In these cases, permanent supportive housing may be offered.

Housing First

In all housing options, Kern County follows a Housing First approach. This approach emphasizes placing people directly into housing without preconditions (e.g., completing a program or demonstrating "housing readiness"). Under the Housing First approach, supportive services are offered to help achieve housing stability, but they are not required.

The Housing First approach is based on evidence that stable housing is a prerequisite for stabilizing other aspects of people's lives, including employment and mental, physical, and behavioral health. This approach has proven successful in decreasing homelessness and improving housing stability. A 2020 study in Kern County also found it to be a cost-effective approach, saving the community approximately $28,000 per year per person served[2].

[2] https://bkrhc.org/wp-content/uploads/2020/09/CBA-Report.pdf

Prioritizing Limited Services

At any given time, the number of people experiencing homelessness in Kern County exceeds the number of beds and units available to serve them within the homeless system of care. Moreover, some housing is specifically funded to serve certain subpopulations of people experiencing homelessness, such as youth, seniors, veterans, or people fleeing domestic violence.

To ensure that these limited housing resources are distributed fairly and effectively, the homeless system of care uses a Coordinated Entry System. That system relies on a standardized assessment and prioritization process ("VI-SPDAT") that considers length of time homeless, severity of service needs, and other factors to prioritize housing for the most vulnerable community members. Those with a moderate or severe need for housing and services get placed on a "By Names List" that is used to allocate available resources based on priority. Those with a mild service need might be referred to other programs for assistance (e.g., legal aid, public benefits), while others are able to resolve their housing situation on their own. Information about people seeking and/or receiving assistance is tracked in a Homeless Management Information System (HMIS).

The above description provides a high-level overview of how the homeless system of care works in Kern County. Please see Appendix 5 for additional details on how the systems' efforts related to prevention, outreach, access, assessment, prioritization, supportive services, shelter and housing, and community engagement. The section that follows details some of the challenges that the current system of care faces in meeting community needs for housing and services.

6. How is the Kern County homeless system of care performing?

The homeless system of care in Kern County helps thousands of people every year. Nonetheless, the demand for assistance still exceeds the system's capacity to provide it. The following section outlines findings from a data analysis conducted by Homebase for the Strategic Planning process, it identifies key gaps in the system and where there is potential for action to help address homelessness in the community.

Data Sources

The primary sources of data that provide insight into homelessness in Kern County include (please see Appendix 2 for definitions off each of these terms):

- The Homelessness Management Information System (HMIS).
- The Point-in-Time Count (PIT count).
- The Housing Inventory Count (HIC).
- Data from connected systems (e.g., Department of Human Services), when available.

- Survey, focus group, and interview data with various individuals who are familiar with the homeless system of care and its current gaps or needs.
- Census and economic data (e.g., about the cost of housing and vacancy rates).

Several of the above data sources were used in a recent BKRHC Gaps Analysis (completed in January 2021) and Coordinated Entry System SWOT (strengths, weaknesses, opportunities, threats) analysis (completed in May 2022), both of which help to inform the current Strategic Plan.

Summary of Key Takeaways from Data

Below is a summary of key takeaways from the data analysis conducted for the Strategic Planning process. Please see Appendix 6 for additional details related to the HMIS data analysis.

Unmet Need

Each year, the system's average *inflow* is greater than the average *outflow* (of about 180 people extra more coming into the system each year than leaving the system). This surplus *inflow* means that the system does not have room or capacity to house these extra 180 people each year. Over time, these 180 compounds to be thousands of individuals that the system does not have room to serve.

From October 2021 through September 2022, 72% of households that entered the system also exited. However, only 23% of those exits were to permanent destinations. The rest of the exits were to unknown or temporary destinations, which have high rates of return to the system.

This means that most households are either staying in the system (28%) or are returning to the system (6% - 35% of households return, depending on the length of time examined and the destination type).

In order to have an "unmet need of zero," the system would need to find a way to increase the number of households *exiting* to permanent destinations each year so that *outflow* rates are greater than *inflow* rates, and the system would need to do this until the "surplus" (7,535) is down to zero and the system is then able to balance its annual inflow and outflow.

In total, there is a gap of 2,136 Permanent Supportive Housing (PSH) and 1,945 Rapid Re-Housing (RRH) units needed to end homelessness in the community (see Level of Acuity section for details on this).

TABLE: UNMET NEED ESTIMATE				
	Individual	Family	Transition Age Youth (TAY)	Total
AVERAGE INFLOW	1,834	1,586	201	3,621
AVERAGE OUTFLOW	1,621	1,647	175	3,444
AVERAGE YEARLY UNMET NEED	213	-61	26	180*
TOTAL UNMET NEED ESTIMATE	4,974	1,990	549	7,535*

Length of Time in the System

Length of time in the system is calculated from the time someone first enters the homeless system of care until their first move-in date to permanent housing. This helps us understand how long it takes someone to gain housing, which is an important metric for improvement in 26-how the system of care is operating.

Veterans generally find interim housing more quickly than other populations in the system but take longer to find permanent housing. This means that the system is doing well at getting veterans into housing, but that they are taking longer to exit the system into permanent housing of their own, outside of the system's resources.

Elderly adult-only households take less time to exit to a *permanent destination* and to move into housing than younger adult-only households.

Those who are **chronically homeless** take longer to move into housing and exit to permanent destinations.

Those who have a **history of *unsheltered* homelessness** take longer to exit the system of care to a permanent destination (as compared to those without a history of unsheltered homelessness). While this is a complex issue, two factors are important to understand:

(1) **Those with unsheltered histories are also *higher acuity***, meaning they have more needs for support and/or need a higher level of support than others.

(2) **Higher acuity clients are likely to be the ones who return to homelessness** and may be a portion of those returning to unsheltered homelessness. This means that the proportion of those who are unsheltered (or have an unsheltered history) with high levels of acuity may be increasing over time and could be a population of focus for prevention resources.

TABLE: LENGTH OF TIME HOMELESS BY HOUSEHOLD TYPE

HEAD OF HOUSEHOLD TYPE	Mean Days	Maximum Days	Minimum Days	Number of Households
ADULT ONLY	367.11	2,004	1	973
ADULT AND CHILD	165.85	1,919	1	3,145
TRANSITION AGE YOUTH	307.49	1,236	9	69
TOTAL	214.95	2,004	1	4,187

Level of Acuity

Level of Acuity is assessed by a household's VI-SPDAT score, which is based on an assessment they are given during intake into the CES as well as case conferencing. Level of Acuity helps us understand what level of housing supports a household may need to solve their homelessness.

- Adult only households have the highest overall acuity (compared to family and youth households), with nearly 58% qualifying for permanent supportive housing (PSH).

Acuity helps to determine whether a household qualifies for Rapid Re-Housing (RRH) or Permanent Supportive Housing (PSH):

- There is a 1:1.5 need for RRH vs. PSH for adult only households (the majority of Chronically Homeless, Veterans, and Intense Service Needs groups are adult only households). This means that for every RRH unit needed for adult only households, there are 1.5 PSH units needed for adult only households.
- There is a 2:1 need for RRH vs. PSH for family households. This means that for every 2 RRH units needed for families, there is 1 PSH unit needed for families.
- There is about equal need (1:1) for RRH and PSH for youth households.

Table 1: Level of acuity by VI-SPDAT score and household type.

VI-SPDAT Score	Adult Only / Individual Percent (Frequency)	Family Percent (Frequency)	TAY Percent (Frequency)
0 to 3	6.67% (129)	6.23% (70)	16.77% (27)
4 to 7 (4-8 for families)	35.52% (687)	61.21% (688)	40.37% (65)
8+ (9+ for families)	57.81% (1,118)	32.56% (366)	42.86% (69)
Total	100% (1,934)	100% (1,124)	100% (161)

In total, there is a gap of 2,136 PSH and 1,945 RRH units needed to end homelessness in the community (see Level of Acuity section for details on this).

Unsheltered Homelessness:

Unsheltered homelessness refers to individuals sleeping in a place not meant for human habitation, such as outside or in a vehicle.

- Based on HMIS, **at least 42% of individuals in adult-only households have previously experienced unsheltered homelessness.**
    - Based on the PIT count, 53% of individuals in adult-only, actively homeless households are unsheltered (47% are in ES or TH).
- **People with disabling conditions** are much more likely to experience unsheltered homelessness (49% for those with a disability vs. 17% for those without a disability).
- **People experiencing chronic homelessness** experience unsheltered homelessness at the highest rates (69% vs. 23% of those who are non-chronic). When excluding Family households, who have very low rates of both chronic and unsheltered homelessness, this percentage rises to 80% (80% of those who are chronically homeless have experienced unsheltered homelessness).

Table 2: Unsheltered homelessness in the system by data element (2016-2021).

	Number of People	Percentage of Total
Total clients in any project type	25,896	100%
Ever entered the system from a place not meant for human habitation	6,908	26.22%
Ever exited the system to a place not meant for human habitation	1,458*	5.68%*
Ever enrolled in a Street Outreach project	3,210	12.40%
People with Unsheltered Histories at any point	7,478	28.88%
* = more than 10% of missing data.		

Data Takeaways

The above information helps us understand that certain groups are more likely to experience unsheltered homelessness, including those with a disability, those who are chronically homelessness, and those in adult only households (as compared to families or youth). Further, adult only households have the highest levels of acuity and experience homelessness for longer periods of time than other household types. This extended time homeless is likely due, in part, to these households needing a higher level of care and housing services than others, which means waiting longer for those limited resources.

Moreover, disability status, unsheltered homelessness, and chronic homelessness can all reinforce each other: an individual with a disability is more likely to experience unsheltered homelessness, which can worsen (or cause additional) disabilities and contributes to chronic homelessness (which includes a longer period of time homeless) -- all of which increases an individual's acuity level.

The current data likely reflect the community prioritizing family and youth households for services (above adult only households). Additional resources (e.g., PSH) for adult only households with high levels of acuity (e.g., a disability, unsheltered histories, and/or chronic homelessness) could help to reduce the length of time that these households are experiencing homelessness while also helping them access the services they need to successfully exit homelessness.

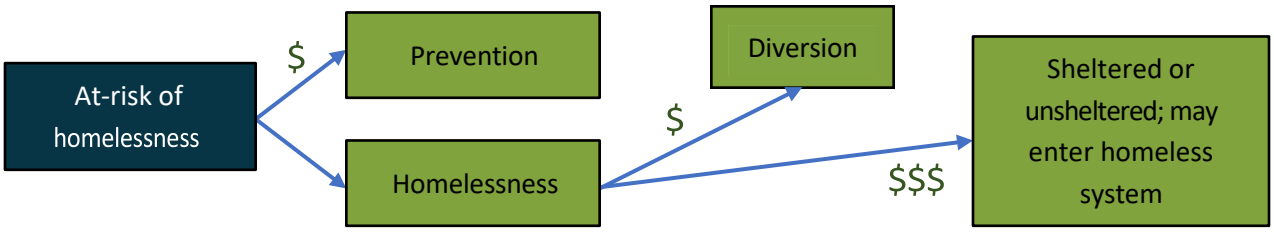
Goals and Strategies to Address Homelessness in Kern County

Based on the above data on homelessness in Kern County, as well as extensive work with the Strategic Plan Steering Committee and conversations with stakeholders, providers, and persons with lived experience, the following areas of focus were developed for this Strategic Plan.

Goal 1: Reduce Inflow

Objective 1: Reduce the number of people experiencing homelessness through prevention and diversion.

Preventing homelessness by supporting individuals and families before they become homeless is not only more humane, but also more cost-effective. Homelessness prevention can be a low-cost strategy that can be implemented immediately at any agency serving homeless clients. Diversion protocols identify people and divert them from homelessness back to stable housing options that they may not have been able to reach themselves.



Homelessness Prevention activities are designed to prevent an individual or family from moving into an emergency shelter or living in a public or private place not meant for human habitation (HUD, 2022), and is typically categorized as up to six months of assistance.

Diversion strategies and practices assist people to resolve their immediate housing crisis by accessing alternatives to entering emergency shelter or the experience of unsheltered living (USICH, 2019), and is typically categorized as one-time assistance. Part of prevention is cross-system coordination to ensure individuals do not exit a system (e.g., jail, hospital) into homelessness (see Strategies 2B and 7A).

Strategy 1A: Increase prevention and diversion resources and services.

Action Steps:

- Identify sub-populations associated with diversion and prevention funding.
- Identify additional funding sources for diversion with a focus on sub-populations.
- Identify additional funding sources for homeless prevention with a focus on sub-populations.
- Implement mediation strategies with landlords to keep renters housed.
- Identify a cohort of staff (from healthcare, schools, human services, and other partner agencies) who focus on problem-solving with people before they enter the homeless system of care.

- Provide one-time financial assistance to keep individuals or families housed.
- Identify and utilize strategies for reunification with family members or support systems.
- Provide regular training for all homelessness partners in problem-solving techniques and motivational interviewing to promote prevention and diversion.
- Support legal assistance to prevent eviction.
- Develop early interventions for those experiencing severe mental illness, behavioral health and substance use that put them at risk of homelessness.

Strategy 1B: Reduce homelessness for those exiting institutions.

Action Steps

- Create discharge planning for post incarceration individuals.
- Create discharge planning for foster youth exiting the care system and a tangible, resource-based action plan to support youth transitioning into adulthood.
- Create discharge planning for those exiting acute inpatient hospitals and healthcare facilities.

Strategy 1C: Utilize data across systems to identify themes and trends for homelessness and those at-risk of homelessness

Action Steps

- Perform a study on causes of homelessness in Kern County.
- Develop and utilize data across all collaborative sub-committees to inform decision making, identify barriers and measure outcome.
- Use data systems (e.g., GIS, HMIS) to assess geographic areas of the county to ensure outreach coverage and to identify areas with a high number of encampments.

Strategy 1D: Ensure that homeless and formerly homeless people are represented throughout the system to support lived experience perspective in resource development, planning and advisement of service provision.

Action Steps

- Stakeholders to hire peer support and/or individuals with lived experience.
- Create and implement a plan to embed people with lived experience across levels of the Continuum of Care.
- Utilize and implement guidance provided by the Lived Experience Advisory and Youth Action boards.

STRATEGY 1E: Educate the public on what services exist for those at risk of homelessness.

Action Steps

- Develop and implement community-wide engagement and education campaign. Support the effort by establishing a position with BKRHC to facilitate this task.
- Participate in the planning process to support new housing resources and development.
- Ensure businesses, neighborhoods, faith-based organizations, and other community groups are aware of resources in the community that prevent and address homelessness.
- Add regularly updated information on resources, educational information, progress towards Strategic Plan goals, and other relevant information to the BKRHC website that can be accessed by the public.

STRATEGY 1F: Improve economic security and workforce development programs that target those who are at-risk of homelessness.
Action Steps • Create partnerships with prevention providers and employment assistance programs. • Create more jobs for people who are at risk of homelessness. • Link more people at risk of homelessness through income vulnerability to social service programs. • Increase resources for reliable transportation across Kern. • Implement community resources to support financial literacy.

Desired Outcomes and Progress Measures

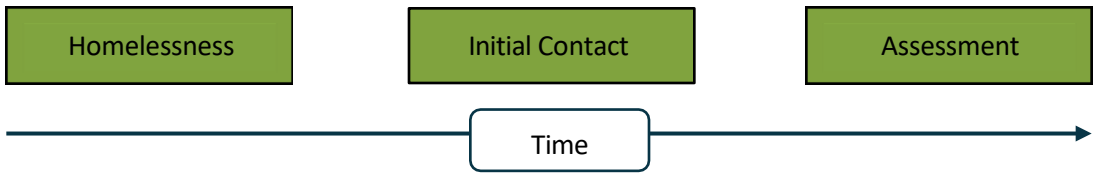
- Decrease first-time homelessness by 15% by 2029.
- Increase the number of households served by prevention activities by 10% by 2029.
- Increase the number of households served by diversion (one time only) activities by 25% by 2029.

Objective 2: Increase timely, equitable access to Coordinated Entry System (CES).

The Coordinated Entry System *SWOT* (strengths, weaknesses, opportunities, threats) analysis found that timely and equitable access to the system were weaknesses and threats to the system operating as it should.

Timely and equitable access to the coordinated entry system and other available services in the community can help to prevent unsheltered homelessness and promotes resolving a household's homelessness as quickly as possible. These improvements can be supported by timely and equitable access to Coordinated Entry and the system of care through targeted outreach and improved system navigation for clients.

Timely access includes reducing the time between (1) homelessness and initial contact with the system (via outreach, 2-1-1, or a provider), and (2) initial contact with the system and intake into the system (e.g., assessment).



Equitable access includes ensuring that individuals experiencing homelessness throughout the county, particularly in rural geographic areas, receive the same timely outreach and access that those within the major metropolitan areas do; and that individuals who have high acuity and are of varying age, family type, disability status, and gender, racial, or ethnic backgrounds also receive the same timely outreach and access to the system as other groups.

Strategy 2A: Expand outreach services throughout Kern County.
Action Steps • Increase outreach staff throughout the county. • Address skill set for outreach staff with enhanced training. Ensure training includes cultural sensitivity modules. • Engage in targeted outreach for underserved groups to ensure equitable outreach. Utilize feedback from Lived Experience Advisory and Youth Action boards to improve access. • Identify and implement strategies to increase penetration for underserved groups, utilizing strategies that may include campaigns, resources, and targeted outreach to those groups.
Strategy 2B: Improve system navigation of CES for clients.
Action Steps • Reduce wait and response times within the CES system. • Utilize the Homelessness Prevention/Diversion sub-committee to routinely examine and refine these processes to eliminate barriers. • Increase training for front line/data entry staff on quality data entry. • Create additional fully staffed access points. • Increase numbers of highly qualified case managers (including case coordinators, care coordinators, housing navigators, and others in similar case management roles) throughout the COC and CES to support client navigation and reduce case management-to-client ratio. • Ensure all staff across all agencies that engage the CES receive bi-annual training on "screening in" clients, triaging to appropriate resources, trauma informed care, and motivational interviewing. • Educate the public on 211 and homeless service providers.

Desired Outcomes and Progress Measures

- Increase the number of connections to services in underserved geographic areas by people who are experiencing homelessness by 10% by 2029.
- Increase the percentage of people exited from street outreach directly into temporary destinations by 7% by 2029.
- Increase the percentage of people exited from street outreach directly into permanent destinations by 10% by 2029.

Goal 2: Strengthen Support

Objective 3: Use data across the system to measure inflow, access to service and, outflow to measure program success and achievements.

A systemic, coordinated response for all clients, including those who are high acuity, will ensure effective overall response to homelessness in the community. No one strategy or agency alone will achieve the goal of ending homelessness in Kern County. To be successful, the community needs a systematic and multi-faceted approach that engages the entire community – it requires investments from both the public and private sectors, dedicated resources with a focus on proven strategies, and cooperation from the community at-large.

Ensuring this progress is mapped and tracked with data, further strengthens the resources available to understand progress made and the value of interventions and strategies implemented. The Homeless Management Information System, HMIS, is a resource that not only feeds meaningful data on the people being served but is also a necessary component to ensure fiscal resources can be made available to the county and cities.

Strategy 3A: Develop and implement a plan to expand HMIS license access and sustainability for HMIS programming.

Action Steps

- Create a budget and funding plan for HMIS.
- Acquire sustainable and renewable funding for expanded HMIS and HMIS licenses.
- Secure funding for ongoing HMIS training and support to providers and system overall.

Strategy 3B: Develop a data dashboard for HMIS to demonstrate key metrics for homeless goals.

Action Steps

- HMIS operator shares data with BKRHC to publish on website.
- HMIS operator develops internal dashboards for HMIS users.
- Planning and Performance committee to review HMIS data on a regular basis ensure regulatory requirements are being met.

Strategy 3C: Complete a full assessment of utilization of the HMIS system and user activity.

Action Steps

- Create data standards for internal HMIS service providers.
- Provide regular reporting of data standards and reporting to organizations utilizing HMIS.
- HMIS operator will offer quarterly training to HMIS users.

Strategy 3D: Utilize data to make equity informed decisions and develop solutions to support equitable access for services and resources.

Action Steps

- Establish data reporting on equity measures to be used across sub-committees, in planning and performance, and in the allocation of resources.

Desired Outcomes and Progress Measures

- Achieve a minimum of 90% participation in HMIS by all homeless service providers in the CoC by 12/31/2024.
- Public-facing data dashboard is established by 7/31/2024.
- Internal-facing data dashboard is established by 12/31/2024.
- Achieve and maintain a 90% threshold for data quality of HMIS users by 12/31/2025.

Objective 4: Increase access to supportive services.

Nonprofits, community groups, and County agencies provide a variety of services that can help people exit homelessness and stay housed permanently. Programs such as mental health treatment, employment and job training, health care, and substance use recovery can meaningfully help people attain greater stability.

While some of these programs are dedicated to people experiencing homelessness, others are resources available to everyone in the community. Ensuring that these programs are available and accessible for people experiencing homelessness allows the community to get the most out of its existing resources.

Strategy 4A: Ensure that wraparound and case management services are available for all housing and shelter options.

Action Steps

- Complete an assessment of case management standards and staff to client ratios throughout the system, including outreach and after-care services.
- Increase outreach, housing, and after-care case management to mirror the level of need of the client.
- Expand partnerships with healthcare systems to capitalize on funding streams (e.g., Cal-AIM, HHIP).

Strategy 4B: Increase the capacity and training for crisis response to behavioral and physical health care needs.

Action Steps

- Coordinate with medical teams to ensure outreach includes medical and crisis-response staff.
- Increase the number of mobile crisis teams and expand their hours, to support individuals experiencing severe mental health and substance use crises.
- Increase the number and type of beds available for substance use treatment.
- Ensure follow-up supportive services are provided to prevent relapses.
- Implement strategies for motivating clients to receive services (e.g., recovery and housing-based peer ambassadors / specialists to support outreach; motivational interviewing; collaboration with Behavioral Health services to support clients to accessing services).
- Increase training to inform available resources, referral systems, and interventions including crisis response to the public and homeless providers.

Strategy 4C: Enhance support for homeless specialty sub-populations.
Action Steps • Identify sub-populations that don't have access to needed services (e.g., youth, seniors, individuals with severe mental health and substance use needs, families, individuals with assistance with daily living needs) to develop resources. • Strategize and collaborate on services that are provided to those with a Care Court Plan. • Establish and improve data points to track and measure the number of people with mild-moderate and severe mental health issues experiencing homelessness.
Strategy 4D: Improve economic security, healthcare, and behavioral health care access for those who are homeless.
Action Steps • Increase the amount of income received from public benefits for which they are eligible. • Increase the amount of employment income earned. • Ensure that all homeless clients have medical insurance coverage and have access to primary health and dental care. • Ensure that behavioral health services (mental health and substance abuse treatment services) are readily available to eligible homeless people.

Desired Outcomes and Progress Measures

- Interdisciplinary teams available at housing, shelter and CES access locations by 12/31/2026.
- 10% increase in homeless individuals enrolled in Medi-Cal by 12/31/2026.
- Establish baseline data to show the % of homeless people with severe mental illness by 12/31/2024.
- Increase by 10% the number of substance use disorder beds, including sober living beds to inpatient detox beds by 12/31/2026.
- Achieve an average case management ratio of 1:25 clients per case manager by 2029.

Objective 5: Improve emergency shelter options to increase access to quality emergency shelter beds.

Emergency shelter and services are essential to ensuring every community is prepared for crises. Offering a variety of emergency shelter options will ensure that every community member in need has access to a safe and accessible place to stay in the event of a homelessness crisis.

Strategy 5A: Support resources for innovative plans that address the needs of specialty homeless sub-populations.
Action Steps • Develop plans for interim, non-congregate, medical respite, detox, skilled nursing, and alternative models for the following subpopulations: youth, seniors, families with children, and those with intensive needs. • Secure funding for additional emergency shelter models to be implemented and advocate for greater funding flexibility to support emergency shelters.

- Advocate for stable state and federal funding for emergency shelters.
- Use data to ensure bed capacity meets the need for people coming into emergency shelter.
- Analyze data to evaluate the utilization of emergency shelter to ensure equitable access.

Strategy 5B: Strengthen referral and discharge between service providers to prevent unsheltered homelessness.

Action Steps

- Create a task force to review and monitor referral and discharge policies by service providers.

Strategy 5C: Better prepare emergency shelter clients to achieve housing stability.

Action Steps

- Perform a service gap analysis.
- Establish a standard of best practices that service providers can follow.

Strategy 5D: Develop disaster contingency plan for sheltered and unsheltered individuals.

Action Steps

- Create and utilize emergency plans for extreme weather, public health emergencies, and other disaster related events.

Desired Outcomes and Progress Measures

- Decrease unsheltered homelessness by 15% by 2029.
- Increase the percentage of people exited from emergency shelter into permanent destinations by 15% by 2029.

Objective 6: Increase the inventory and access to interim, transitional, and bridge housing.

Much like maintaining a robust service continuum, a robust housing resource continuum is a necessary to ensure people have access to the supports needed in their journey. Interim, bridge, and transitional housing refers to the various types of housing that may be specialized and embedded with specific resources and supports, but ultimately provide someone with a longer place to reside while they access necessary treatment to build readiness to move into the right level of independent, permanent housing. These specialized resources allow emergency shelter to be a short-term solution and ensure people are ready when they move into permanent housing.

Strategy 6A: Increase funding, resources, and services for interim, transitional and bridge housing.
Action Steps • Secure funding for additional interim, transitional, and bridge housing. • Advocate for flexible and sustainable local, state and federal funding for interim, transitional, and bridge housing. • Develop recommendations for the appropriate level of supportive services, including case management, for interim, transitional, and bridge housing.
Strategy 6B: Utilize data to identify and prioritize the needs for specialty sub-populations to have equitable access to interim, bridge and transitional housing options.
Action Steps • Perform a service gap analysis for interim, transitional, and bridge housing options available throughout the county. • Use data to ensure bed capacity meets the need for people needing and utilizing interim, transitional and bridge housing. • Analyze data to evaluate the utilization of interim, transitional and bridge housing to ensure equitable access to these housing resources. • Support development and implementation of countywide shared housing matching system.

Desired Outcomes and Progress Measures

- Increase number of RRH units by 10% by 2028.
- Increase the number of interim, transitional, and bridge housing by 10% by 2029.

Goal 3: Increase Outflow

Objective 7: Increase the inventory and access to affordable, permanent housing.

Affordable and permanent housing is essential to addressing homelessness in the community. The vacancy rate for Kern County has been under 2% for several years, whereas 5% vacancy is indicative of a healthy housing market (this is a conservative estimate; some economists would argue for closer to 8%). With low vacancy rates in Kern County, the costs of housing have risen; for 2021-22, there was a roughly 10% increase in the cost of housing in Bakersfield.

Increasing access to affordable and permanent housing helps to address the primary cause of homelessness and is an investment in a future with decreased numbers of homeless in the community. Increasing the inventory of affordable and permanent housing in the community also enables the System of Care to have more access to housing units to place clients, addressing the current backlog of clients waiting for housing.

Strategy 7A: Encourage and support local efforts to increase affordable housing.
Action Steps • Complete an evaluation of how much permanent housing is needed based on the current year Point In Time count or other relevant, available data. • Repurpose existing housing for the expansion of affordable housing. • Develop additional low-income housing. • Implement shared housing models. • Coordinate with jobs programs and educational programs to increase family incomes so they don't have to rely on voucher assistance to move on.
Strategy 7B: Increase the number of Rapid Re-Housing beds.
Action Steps • Obtain new funding for Rapid Rehousing. • Increase the number of landlords participating in Rapid Re-Housing.
Strategy 7C: Coordinate and incentivize developers to increase affordable housing.
Action Steps • BKRHC to develop a summary of affordable housing needs that we can supply to developers who want to develop regional approaches to affordable housing for their projects. • Encourage and support local government's efforts to expand affordable housing. • Evaluate the feasibility and next steps for immediate development of rent-controlled apartment buildings, multi-family housing units, and in-law units, as well as non-traditional options such as repurposed motels/hotels and/or Accessory Dwelling Units (ADUs). • Eliminate barriers that impede construction, repurposing, or rehabilitation of additional, affordable permanent housing.
Strategy 7D: Increase landlord engagement to create more available units.
Action Steps • Develop partnerships with landlords and enhance landlord incentive program. • Increase landlord enrollment into Padmission through a targeted marketing program. • Develop funding and create a program for a landlord risk-mitigation incentive.

Desired Outcomes and Progress Measures

- Increase number of PSH units by 400 units annually by 2028.
- Establish at least 240 new shared housing units by 2029.
- Increase number of units affordable to extremely low-income (ELI) households across the County by 1800 annually by 2029.
- Reduce evictions by 15% by 2029.

Objective 8: Reduce recidivism for those exiting into permanent housing.

Supporting people placed into permanent housing to ensure their success staying in housing is a priority to break the cycle of recidivism. Exiting housing and returning into a cycle of homelessness is a trauma for the individual served and requires extensive resources. Supporting the success of someone into housing, by building resources, services, training, and independence is the goal to building healthy, independent, successful communities. Reducing the cycle of recidivism by ensuring after-care services is a low-cost alternative to the ongoing resources used when someone enters homelessness.

Strategy 8A: Enhance availability of after-care case management programs.

Action Steps

- Improve case management ratios for after-care case management.
- Increase availability and ensure the aftercare services mirror the level of need of the client.
- Increase the connections to necessary supportive services and resources that will assist in maintaining housing.
- Identify sub-populations currently receiving and in need of after-care case management.
- Evaluate trends to understand the factors influencing recidivism.

Desired Outcomes and Progress Measures

- Decrease returns to homelessness to 13% by 2029.

Strategic Plan Governance

The Bakersfield-Kern Regional Homeless Collaborative, in coordination with its Executive and Governing Boards, subcommittees, and stakeholders, will oversee the strategic action plans governance. As a dynamic document, the strategic plan will include a quarterly report based on specific reporting time frames to ensure the plan's efficacy and an annual plan review to ensure any necessary changes identified are incorporated.

Under the direction of Governing Board chair and co-chairs, will be responsible for preparation, review, and presentation of quarterly reporting to Executive and Governing Boards as well as completion of the annual plan review in coordination with stakeholders.

Role of the Executive Board in Strategic Governance

The Executive Board will review quarterly progress on all goals, strategies, and action steps to guide any changes needed because of objective completion or determinations on continued improvements. The Executive Board will provide any necessary input on funding allocations to help support the strategic plan.

Role of the Governing Board in Strategic Governance

The Governing Board will receive quarterly progress reports from subcommittees tasked with overseeing any strategies or action steps. The Governing Board will provide recommendations on improvements should progress not align with the intended timeframe for outcome completion. The Governing Board will also provide recommendations on priorities, changes to goals, objectives, or action items, and provide support to the strategic plan's continuance.

Governing Board Subcommittees

Governing Board subcommittees will be tasked with leading action steps as outlined within the plan. Subcommittees, Governing Board members or their designees will work in collaboration with the Bakersfield-Kern Regional Homeless Collaborative and any necessary stakeholders to complete progress on the work based on the data measurements or objectives outlined within the plan. Subcommittee work frequency will be largely dependent on the timeline for the assigned actions, objectives, strategies, and data measurements with consideration of HUD annual or CoC quarterly reporting requirements.

Any designated subcommittees will provide a quarterly progress report to the Bakersfield-Kern Regional Homeless Collaborative, which will be presented at Executive and Governing Board meetings quarterly.

Appendices

Appendix 1: Acknowledgements

The Kern Strategic Plan was drafted by Homebase and was guided and developed by all organizations that participate in the Kern Strategic Plan Steering Committee as well as many other service providers and partners that engaged in meetings, focus groups, and surveys. Homebase would like to thank the members of the Kern Strategic Planning Committee for their partnership and guidance throughout the process of developing this Strategic Plan. Special thanks to the many nonprofit service providers; faith-based, healthcare, and other stakeholders; city and county government staff; individual community members and the individuals experiencing homelessness or with recent experience for sharing their invaluable stories, expertise, and insight. This plan would not exist without the effort and commitment of all of you.

Steering Committee Members

- Anna Laven, Former Executive Director, Bakersfield Kern Regional Homeless Collaborative
- Amisha Pannu, Senior Director of Provider Network, Kern Health System
- Anthony Valdez, Assistant to the City Manager, City of Bakersfield
- Diane Contreras, Former Director of Operations, FLOOD Bakersfield Ministries
- Karen Monsma, FLOOD Bakersfield Ministries
- Lauren Skidmore, Chief Executive Officer, The Open Door Network
- Melinda Santiago, LMFT, Provider Relations Manager, BH & CHW Special Programs, Kern Health System
- Rick Ramos, Executive Director, Bakersfield Kern Regional Homeless Collaborative
- Stacy Kuwahara, County of Kern, Chief Operations Officer
- Steve Peterson, Director of Programs, The Mission at Kern County
- Vanessa Webster, Programs Officer, California Veterans Assistance Foundation
- Nina Carter, Homeless Services Principal Planner, City of Bakersfield

Additional Stakeholders Who Provided Information, Input, and Feedback

- Deborah Johnson, President, California Veterans Assistance Foundation
- Eliana Argueta, MHI, Program Manager III, Medi-Cal Operations, Health Net
- Heather Kimmel, Assistant Executive Director, Housing Authority of the County of Kern
- Janet Paine, Director of Program Management CA Medicaid Health Plan
- Jim Wheeler, Executive Director of FLOOD Bakersfield Ministries
- Joseph Aguilar, CES Program Specialist, Community Action Partnership of Kern
- Kris Kuntz, Anthem Housing Manager
- Rebecca Moreno, Director of Community Development, Community Action Partnership of Kern
- Selina Escobar, Director of Community Support, Anthem

- Stephen Pelz, Executive Director, Housing Authority of the County of Kern

Bakersfield-Kern Regional Homeless Collaborative (BKRHC)

- BKRHC is an independent, nonprofit organization founded in 2019 specifically to coordinate regional efforts to address and end homelessness. It is a membership-based organization comprising most of the entities active in the homeless system of care. It is led by a nine-member Executive Board and run by a four-person professional staff that includes an executive director, data analyst, compliance coordinator, and programs administrator.
- The CoC is the regional planning body that the U.S. Department of Housing and Urban Development (HUD) relies on to coordinate regional housing and services funding for homeless families and individuals. The work of the Bakersfield/Kern County CoC is carried out by a sixteen-member Governing Board and its various subcommittees and work groups. By charter, membership on the Governing Board must be representative of the organizations and projects serving people experiencing homelessness in Kern County and must include at least one person with lived experience of homelessness.
- BKRHC and the CoC are closely related. BKRHC voting members elect the members of the CoC Governing Board. Moreover, BKRHC serves as the Collaborative Applicant and Fiscal Agent for the CoC, giving it significant responsibility for grant funding and fiscal monitoring for the CoC. In practice, BKRHC provides much of the staffing and support for CoC activities.

Appendix 2: Glossary of Terms

ACS – American Community Survey	A demographics survey program conducted by the U.S. Census Bureau. It regularly gathers information previously contained only in the long form of the decennial census, such as ancestry, citizenship, educational attainment, income, language proficiency, migration, disability, employment, and housing characteristics.
ADU – Accessory Dwelling Unit	A secondary house or apartment that shares the building lot of a larger, primary home.
Bridge Housing	Short- and mid-term residential options leading towards permanent housing.
CalAIM – California Advancing and Innovating Medi-Cal	California Advancing and Innovating Medi-Cal. The Department of Health Care Services developed framework that encompasses a broader delivery system, program, and payment reform across the Medi-Cal program.
CES – Coordinated Entry System	A system that prioritizes the most vulnerable people experiencing homelessness in the community for certain types of housing
CoC – Continuum of Care	A group organized to carry out the responsibilities prescribed by the Department of Housing and Urban Development in the CoC Program Interim Rule for a defined geographic area. Typically, CoCs act as decision-making bodies for a community's homeless assistance activities and funding.
Chronic Homelessness	(1) An individual who: (i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) (ii) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and (iii) (iii) Can be diagnosed with substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, and/or chronic physical illness or disability;

	(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.
Diversion	A strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternative housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing.
DV – Domestic Violence	Domestic Violence, which includes dating violence, sexual assault, stalking, and other dangerous or life-threatening conditions that relate to violence against the individual/family member that make them afraid to return to their primary nighttime residence.
ES – Emergency Shelter	Any facility with overnight sleeping accommodations the primary purpose of which is to provide temporary shelter for the homeless in general or for specific populations of the homeless
HHAP – Homeless Housing, Assistance, and Prevention	A one-time block grant that provides local jurisdictions with funds to support regional coordination and expand or develop local capacity to address their immediate homelessness challenges.
HCV – Housing Choice Voucher Rental Assistance	A federal program that assists very low-income families, the elderly, and the disabled, to afford decent safe and sanitary housing in the private market participants are able to choose any housing that meets the program requirements. The housing subsidy is paid directly to the landlord by the local Public Housing Authority that administers the voucher program. Formerly referred to as Section 8.

Housing First	A national evidence-based best practice that eliminates barriers to housing ensuring individuals and families can exit homelessness as quickly as possible
HIC – Housing Inventory County	A count of housing available to homeless persons carried out on one night in the last 10 calendar days of January (same time as the PIT Count) as required by HUD.
HMIS – Homeless Management Information System	A data system used by many homeless service and housing providers to track participants and outcomes and meet federal and state reporting requirements.
Homeless System of Care	The homeless system of care refers to the network of resources, supports, services and governance structures in the community that support addressing homelessness.
HUD – U.S. Department of Housing and Urban Development	U.S. Department of Housing and Urban Development, a federal agency that administers many housing and homeless assistance programs
Interim Housing	See Bridge Housing definition, used interchangeably with Bridge Housing.
PH – Permanent Housing	Community-based housing without a designated length of state including both permanent supportive housing and rapid rehousing
PSH – Permanent Supportive Housing	Permanent Supportive Housing, permanent housing with intensive supports for residents.
PIT – Point-in-Time Count	A yearly count of all people experiencing homelessness on a single night in January. The unsheltered count is conducted biennially, every odd numbered year and the sheltered count is carried out on one night in the last 10 days of January as required by HUD (same time as the HIC).
Prevention	A strategy intended to target people who are at imminent risk of homelessness (whereas diversion usually targets people as they are initially trying to enter shelter)

RRH – Rapid Rehousing	Supportive services and or short term (up to three months) or medium term (3 to 24 months) tenant based rental assistance and accompanying appropriate services as necessary to help a homeless individual or family with or without disability move as quickly as possible into permanent housing and achieve stability in that housing.
SUD – Substance Use Disorder	Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.
TAY – Transition Age Youth	Youth (usually ages 18-24) who are experiencing homelessness. This can sometimes include youth as young as age 12. This is a unique population in homelessness due to being too old for child services, but also typically unable to effectively served by adult services due to their development stage and context.
TH – Transitional Housing	A project that is designed to provide housing and appropriate supportive services to homeless persons to facilitate movement to independent living. The housing is short-term, typically less than 24 months. In addition to providing safe housing for those in need, other services are available to help participants become self-sufficient.
Unsheltered homelessness	An individual/family whose primary nighttime residence is public/private place not designed for or ordinarily used as a regular sleeping accommodation for human beings. These are typically households living on the street or in makeshift shelters (tents, boxes), encampments, as well as cars
VI-SPDAT – Vulnerability Index & Service Prioritization Decision Assistance Tool	The standardized assessment tool chosen by the continuum of care to place chronically homeless people inappropriate housing and services

Appendix 3: What does homelessness look like?

When many people think about homelessness, they imagine someone who is sleeping and living on the street (e.g., "unsheltered" homelessness). However, homelessness isn't always obvious and takes on many forms that can be thought of in four categories: transitional, chronic, episodic, and hidden.

The most common type of homelessness is **transitional** homelessness. Transitionally homeless individuals typically have one short stay in a shelter before moving on to more stable housing. Typically, this type of homelessness is caused by a catastrophic event such as a sudden loss of income, a sudden loss of one's home, illness, or the need to flee violence. Over time, transitionally homeless individuals will account for most persons experiencing homelessness given their higher rate of turnover (3).

Chronic homelessness (1) refers to the experience of people who have been homeless for at least a year – or have repeatedly experienced homelessness in the last three years – while struggling with a disabling condition such as serious mental illness, substance use disorder, or physical disability. Across the US, roughly 27% of those experiencing homelessness are chronically homeless (2). In Kern County in 2022, 26% of those experiencing homelessness were chronically homeless.

Episodic homelessness refers to a frequent cycling in and out of homelessness, and the recurrent episodes of homelessness are typically caused by unemployment and/or medical issues, mental health concerns, and/or substance use (3).

The fourth type of homelessness is **hidden** homelessness, which refers to individuals who do not access homeless services but are temporarily living with friends or relatives ("couch surfing" or "doubled up") due to a lack of housing opportunities. Because they do not often qualify for homeless services, they are not counted in standard homelessness statistics.

Of those who are served by the homeless system of care, they may be unsheltered, sheltered, or in a housing program (note: the homeless system of care also serves individuals through supportive services only and homelessness prevention programs). Those who are **unsheltered** are residing in a place not meant for human habitation, such as cars, parks, sidewalks, and abandoned buildings (e.g., "on the street"). Those who are **sheltered** are those in an Emergency Shelter, Transitional Housing, or supportive housing for homeless persons who originally came from the streets or emergency shelters (4). **Housing programs** include Rapid Rehousing and Permanent Supportive Housing; once in these programs, a person is no longer considered to be homeless, though they are still being served by the homeless system of care until they *exit* the system of care, typically to affordable rental housing available through private or nonprofit landlords in the community.

(1) https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/definition-of-chronic-homelessness/

(2) https://endhomelessness.org/homelessness-in-america/who-experiences-homelessness/chronically-homeless/
(3) https://nationalhomeless.org/about-homelessness/
(4) https://www.hudexchange.info/sites/onecpd/assets/File/Guide-for-Counting-Unsheltered-Homeless-Persons.pdf

Appendix 4: Examples of common pathways into homelessness in Kern County

No one arrives at homelessness in the same way. Each person or household has their own story to tell, encompassing a wide range of factors specific to their own lives. Nonetheless, those who work closely with people experiencing homelessness recognize some common themes. Below are narratives describing common pathways into homelessness for specific subpopulations, and the challenges they face achieving housing stability in Kern County, as related by local staff working in the homeless system of care.

Older Adults

The challenges of aging put many older adults at risk of homeless. Many of those challenges are financial. Living on a fixed-income, seniors are especially vulnerable to the increasing cost of both housing and health care in Kern County. As rents rise and medical bills pile up, they may find themselves priced-out of a community where they have lived for decades.

The dependency that often comes with aging also makes older adults vulnerable to losing their homes. Seniors often depend on family members or others with whom they live for their physical care. Sometimes those relationships break down, and they are forced from their homes. At other times, the households on which they depend are themselves financially stressed and rent-burdened. When a health emergency, job loss or other economic crisis hits the household, older adults will lose their homes along with everyone else.

Navigating transitions when a change in circumstances occurs can also be challenging for seniors. When a lease ends or an older adult gets evicted, they may be overwhelmed by the task of finding new housing. They may lack access to computers or other technology that are necessary to find housing today. Even when they have such access, lack of experience and the cognitive decline that comes with aging may put the task of a housing search out of their reach. Transportation issues also significantly limit the housing options available to seniors. For many older adults, living on a bus line is a practical necessity. For those in multigenerational households, they may need 3-4 bedrooms to house all family members. Finding those at an affordable price in Kern County is a real challenge.

Even when older adults find housing they can afford, they still face barriers. Landlords, for example, typically want two to three times the monthly rent as a security deposit. Many older adults lack the resources to pay these sums.

When older adults experience homelessness, it can be difficult for the homeless system of care to meet their needs. Older adults often require a level of medical assistance and support that staff at emergency shelters are not equipped to provide. Housing navigators that help them look for permanent housing report that the housing that is available and affordable may not be accessible to those in wheelchairs or with other mobility

challenges. One provider noted that many older adults who present at shelters should be in assisted living or other skilled medical facilities, but cost and a lack of beds prevents them from accessing those facilities.

Transition-Aged Youth

When youth in Kern County become homeless, it is often due to a crisis in their family relationships. Conflicts related to teen pregnancy, a teen's sexual orientation or gender identity, or emotional or physical abuse in the home can leave a youth or young adult with nowhere to live and no support system to turn to for help. Youth in the foster care system can similarly find themselves without support when they age-out of that system.

Youth can find it particularly challenging to find rental housing. They often have limited incomes and little or no job or credit history. Landlords typically demand significant security deposits as a condition of rental, and it can be hard for youth to come up with those funds. Landlords may also be wary of renting to youth, whose maturity and reliability may be in doubt.

When youth become homeless in Kern County, their emergency shelter options are limited. The Dream Center provides scattered-site housing, but it is available only to those aging out of the foster care system. Even this scattered-site housing can pose a challenge, as it leaves youth housed there dependent on the public transit system to get to jobs, school, grocery stores, etc. It can take 2-3 hours to get to a destination by public transit. Homeless youth not associated with the foster care system may find housing through the emergency shelter system, but many are wary to participate, as it may expose them to mistreatment or abuse by other adults housed there.

Service providers emphasized that youth very commonly enter homeless amid traumas. While processing this, they are simultaneously trying to do adult tasks (find housing, find, and hold down a job, support a family, navigate public benefits or the health care system, etc.) without the knowledge, experience or maturity needed to reliably succeed. Case managers must provide them with significant support when system resources allow. Helping them find a safe and stable space that will allow them to get some distance from their traumas and allow them to chart the next steps in their lives is a key to success.

Chronic Homelessness

For people experiencing chronic homelessness, mental illness and substance use are often contributing factors. For some people, their pathway into homelessness has direct roots in mental illness or substance use, while for others, the trauma of homelessness triggers mental illness or substance use or aggravates pre-existing conditions.

For those with pre-existing mental illness or substance dependency, their conditions can be deeply destabilizing. They impact people's ability to maintain employment or sustain relationships. Whether from a

slow downward spiral or a sudden mental, physical, or economic crisis, people with mental illness or substance dependency may find themselves with nowhere to live. Long experience with bureaucracies and other institutional systems, and a fear of being forced to change their behavior, often make them reluctant to seek or accept help that is offered. Sometimes, when they enter shelter, conflicts with staff or other residents lead them to leave again. Consequently, many resign themselves to life on the street as their only option.

It's important to remember, however, that for many people who experience chronic homelessness, their pathway into homelessness had nothing to do with mental illness or substance use. Many simply experienced a housing crisis, perhaps precipitated by job loss, or a natural disaster, or a health condition that rendered them unable to work. Others may have experienced abuse in a domestic relationship and turned to living on the street as their best option for escaping their situation.

For some of these individuals, mental illness and substance abuse are conditions that developed after becoming homeless. As one provider told us,

> "If you have someone entering homelessness who didn't have one or the other [mental illness or drug dependency], they'd have one or the other 12 months down the line. People experiencing homelessness are constantly in trauma. They're in fight or flight mode. They self-medicate to deal with it, and deal with a lot of depression. Substance abuse can also make you hyper vigilant and paranoid."

To address these challenges, outreach workers invest significantly in building trusting relationships with people experiencing chronic homelessness. This is a slow, incremental process that may pay off months down the line when a client agrees to enter a shelter or permanent housing — a key step in stabilizing their lives and addressing their mental illness or substance use issues.

Appendix 5: Community System of Care Background

Homelessness Prevention

BKRHC recognizes that preventing homelessness is both a more humane and a more cost-effective strategy than providing help after a person or household have become homeless. Under the current system, people thought to be at risk of experiencing homelessness are screened through a Quick Referral Tool (QRT) that evaluates, prioritizes, and recommends services for at-risk persons based on several factors that may make it hard to remain in housing, including:

- Household size and composition
- Safety in current location
- Legal problems
- Prior homelessness
- Frequent moves
- Threat of eviction
- Debt
- Financial resources
- Overcrowding
- Medical issues
- Substance abuse
- Mental or other disabilities.

Based on this assessment, people are placed on a service priority list. That list is used to provide referrals to housing stability case management, housing search and placement assistance, landlord-tenant mediation, tenant legal services, and credit repair support. Financial assistance may include up to six months of rental assistance, rental arrears, utility payments, security, and utility deposits, and moving costs. Supportive services linkages may include employment services, income benefits, health care, mental health and/or substance abuse treatment, and transportation.

BKRHC and CoC members also work to prevent returns to homelessness after a person or household is placed in permanent housing. Strategies include providing aftercare, monitoring, and case management for three years after placement (or longer if needed); education on how to access the homeless system of care when support is needed; and a focus on increasing self-sufficiency.

While prevention has long been part of the region's strategy to address homelessness, minimal funding has historically been available for these efforts.

Outreach and Engagement

The CoC strives to conduct outreach to people experiencing homelessness throughout the entire county. To achieve this, it divides the county into two target areas: metro Bakersfield and rural Kern County. Two agencies work together to provide daily rural outreach, dividing their efforts between West and East Kern County. A third agency focuses on the metro Bakersfield area, where 90% of those living unsheltered have

been identified. All agencies work to help people living unsheltered get the support they need to move to permanent housing.

For persons who are uncomfortable with or have barriers to use of the available shelters, outreach teams maintain regular contact. They discuss the individuals' needs, and provide items such as food, water, hygiene produces, clothing and blankets. These ongoing contacts help build trust and strengthen relationships with outreach workers. Outreach staff may also help connect people to street medicine and behavioral health support.

Access, Assessment, and Prioritization

The Coordinated Entry System (CES) is a part of the CoC and is currently run by CAPK (Community Action Partnership of Kern). The CES provides a single point of access for shelter, job resources, mental health, substance abuse, and other services for individuals experiencing homelessness in Kern County.

The CES offers homeless providers a single point of intake for clients and tracks services provided for those individuals to ensure individuals are accessing services that will best address their needs while stream-lining delivery of resources and preventing duplication of care.

Access

Typically, clients access the CES by calling 211, through a referral from an Outreach team, or by visiting one of the agencies connected to the CES (who then either conducts intake or refers the individual to 211).

The recent CES SWOT (strengths, weaknesses, opportunities, threats) analysis found that there are several areas for improvement to the *Access* portion of CES, including:

1. The model of outreach, phone-based connection, and referral-only access.
2. Service to rural areas (part of Outreach)
3. Improving service to clients with behavioral health needs, intensive service needs, and/or who are perceived to have barriers.
4. Equity issues in CES access, enrollment, assessment across race, ethnicity, age, disability status, and family type.

Assessment

The Quick Referral Tool (QRT) is used by all agencies to quickly assess an individual or household and triage them to a CES assessment point. Once connected with an assessment point, an individual or household has a VI-SPDAT (Vulnerability Index - Service Prioritization Decision Assistance Tool) completed. The purpose of

this tool is to identify a household's severity of need, which informs prioritization of households to limited services.

Overall, the assessment is intended to be a standardized, timely, and equitable process that *screens in* clients (as opposed to screening out clients due to perceived barriers to receiving support), helping to determine the level of support needed by a household and assessing who is most vulnerable in the community.

Prioritization

While a household's score on the VI-SPDAT is currently the primary way that a household is prioritized for services, there are two other layers to service prioritization in Kern County. First, there are five by-name lists: an individual or household is put on the appropriate by-name list (by population type e.g., chronically homeless, youth, etc.), which helps to further triage them to appropriate services. Second, case conferencing is conducted to provide additional information on clients to ensure they receive an appropriate level of services.

Supportive Services

Supportive services are those offered parallel to housing programs in the community. Within the CoC, supportive services include:

- case management
- employment assistance and job training
- food
- housing search and counseling services
- legal services
- life skills training
- mental health services
- outpatient health services
- outreach services
- substance abuse treatment services
- transportation assistance

Further, supportive services include other non-CoC services in the community that the CoC and CES connects clients to, such as food benefits, healthcare, job training and income, and other health and human services connections. For a listing of supportive services providers in Kern County and the services they offer, please see https://bkrhc.org/find-help/.

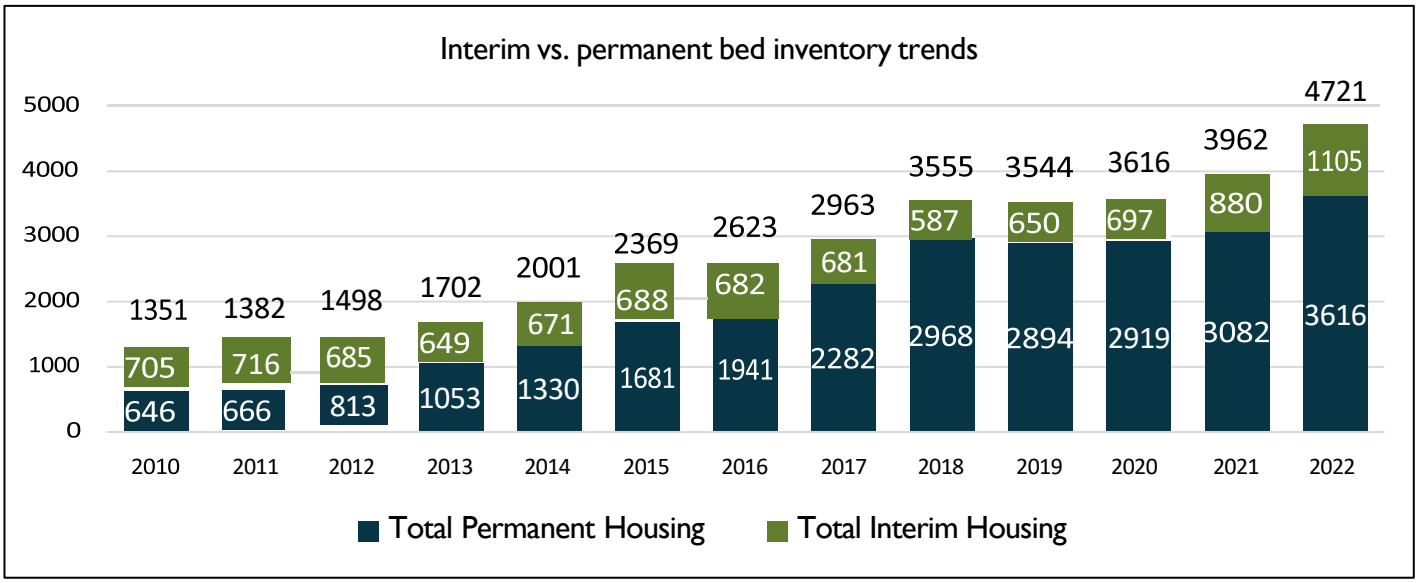
The current plan has identified a need for additional supportive services in the community, including:

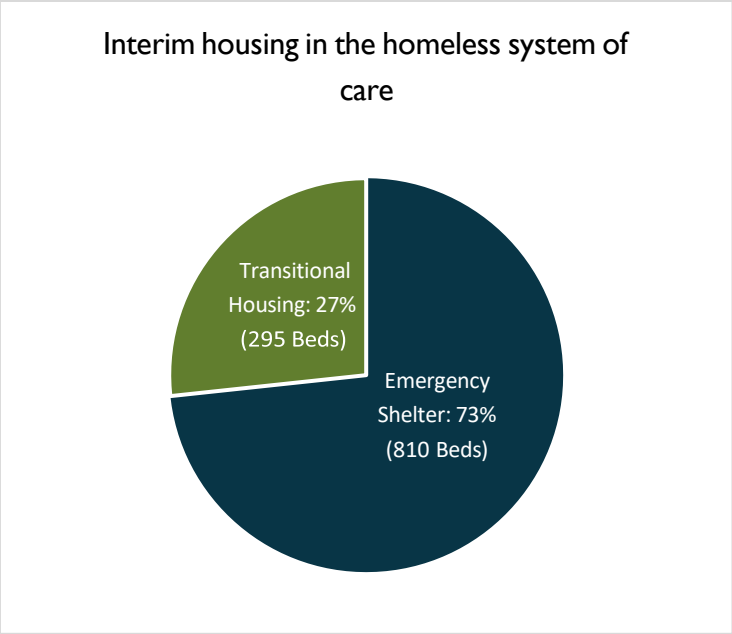
(1) Increased capacity for mental, behavioral, and physical healthcare services;
(2) Increased capacity for crisis response in the community; and
(3) Increased availability of supportive services that lead to self-sufficiency through coordination of social agencies across the CoC.

An important aspect of supportive services is case management. Case managers help to identify what services a client needs and supports clients in accessing those services. A prior Gaps Analysis and conversations with stakeholders identified a need for additional case management staff throughout the system, which is addressed in the current plan.

Shelter and Housing

As discussed above, a range of housing options (from interim to permanent) are available for people experiencing homelessness in Kern County. As shown in the chart, *Interim vs. permanent bed inventory trends*, the homeless system of care has significantly increased its bed inventory since 2010. A 2022 inventory reported a total of 4,721 beds available in the homeless system of care.





Almost a quarter of the beds (23%) are dedicated to Emergency Shelter or Transitional Housing. Another 65% are dedicated to Permanent Supportive Housing. The remaining 12% of beds serve households needing Rapid Rehousing.

Interim Housing.

The most common interim housing offered in the county is Emergency Shelter. Seventy- three percent of interim housing beds in the county are offered through emergency shelters. Emergency Shelter is intended to provide temporary refuge for the homeless in general or for specific populations of the homeless (e.g., youth or those fleeing domestic violence). Emergency Shelters are often the places where people first turn when experiencing an economic or domestic crisis that leaves them homeless. Emergency Shelters typically provide support services and short-term stabilization for individuals and families while they work to find housing that meets their long-term needs. Emergency Shelters may offer shared ("congregate") space or more private ("non-congregate") space.

Transitional Housing is another type of temporary accommodation. It serves as an intermediate step between Emergency Shelter and Permanent Housing for those who may need more sustained support, such as those addressing the challenges that come with addiction or mental illness, or those recovering from the trauma of domestic violence. Twenty-seven percent of the interim housing beds offered in the Bakersfield/Kern homeless system of care are Transitional Housing.

The current shelter models available in the community may not be accessible or appropriate for all persons experiencing unsheltered homelessness. This plan thus proposes evaluating the need for additional shelters to serve the general population or to serve specific subpopulations, as well as the need for additional shelter models (e.g., safe parking, safe camping, tiny homes, etc.).

Rapid Rehousing.

There are 548 Rapid Rehousing (RRH) beds in the Bakersfield/Kern homeless system of care. Rapid Rehousing provides short-term rental assistance (up to 24 months) with some case management and supportive services to people experiencing homelessness.

Permanent Supportive Housing.

There are 3,058 Permanent Supportive Housing (PSH) beds in the homeless system of care. Permanent Supportive Housing provides affordable housing and voluntary supportive services to households with at least one member with a disability. It often serves those who have experienced chronic homelessness.

Our analysis indicates a community need for significantly more rapid rehousing and permanent supportive housing beds. See the Data and Gaps Analysis section below for more information.

Community Engagement

BKRHC and its CoC partners engage a wide range of stakeholders to build community support for efforts to address and end homelessness. Nonetheless, throughout this strategic planning process, stakeholders have noted the importance of broadening these efforts. They have called for an engagement effort that ensures that the Kern County community (1) understands homelessness, its causes, and its challenges, (2) understands solutions to homelessness, and (3) is able to actively involve themselves in supporting solutions to homelessness. All the above are critical to successful implementation of the goals and strategies developed with this Strategic Plan.

Appendix 6: Additional Data

HMIS Data Analysis

The following section details results of an analysis of HMIS data. The data used for the current report include all persons who touched some aspect of the CoC (from street outreach to permanent supportive housing) between January 1, 2016, and November 30, 2021.

Programs that participate in their Continuum of Care (CoC) and receive certain types of funding are required to enter data into the HMIS. Typically, other service providers in the community connected to homelessness also participate in HMIS.

That makes this database the most robust that the community has to understand important datapoints, including:

- The **level of unmet need** (how many more people enter than exit).
- **Rates of exiting and returning** to the system of care.
- The **length of time** households are homeless once they enter the system.
- The **level of acuity** that households have (e.g., what level of support they need to resolve their homelessness).
- How many individuals experience **unsheltered** homelessness.

Unmet Need

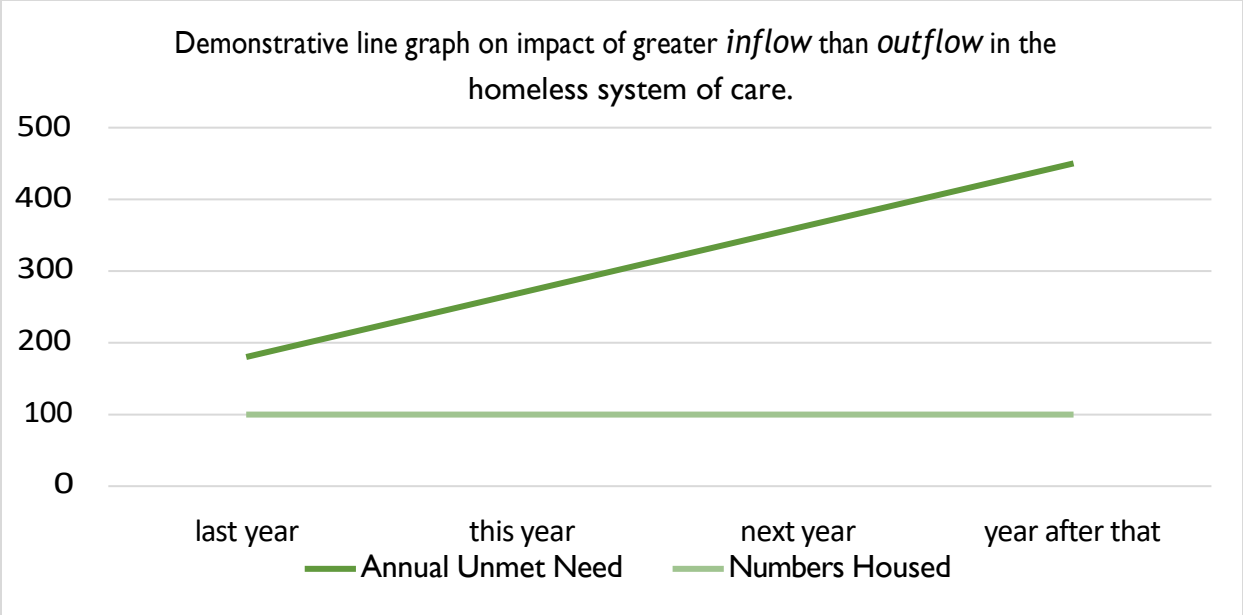
The below table shows the average *inflow*, average *outflow*, and average yearly *unmet need* for the Bakersfield-Kern CoC. It also shows an estimate of the *total unmet need*, based on the excess inflow to the CoC that has occurred over time.

The *average yearly unmet need* is estimated by subtracting the *outflow* from the *inflow*. When there is a negative *average yearly unmet need*, that means the system is successfully addressing the backlog of households through successfully having more households exit (outflow) than enter (inflow) the system.

Table 3: Unmet need estimate.				
	Individual	Family	Transition Age Youth (TAY)	Total
Average Inflow	1,834	1,586	201	3,621
Average Outflow	1,621	1,647	175	3,444
Average Yearly Unmet Need	213	-61	26	180*
Total Unmet Need Estimate	4,974	1,990	549	7,535*

Each year, the system has about 180 people enter the system that it does not have space to house. This is primarily driven by individual (typically, adult only) households. On the other hand, the system is successfully addressing the backlog of family households in the system through exiting more families from the system than are entering it each year.

These number will change from year to year based on both factors outside of the system's control (e.g., housing vacancy rate, economic climate) as well as factors the system can influence (e.g., the number of RRH



vouchers or of new PSH units).

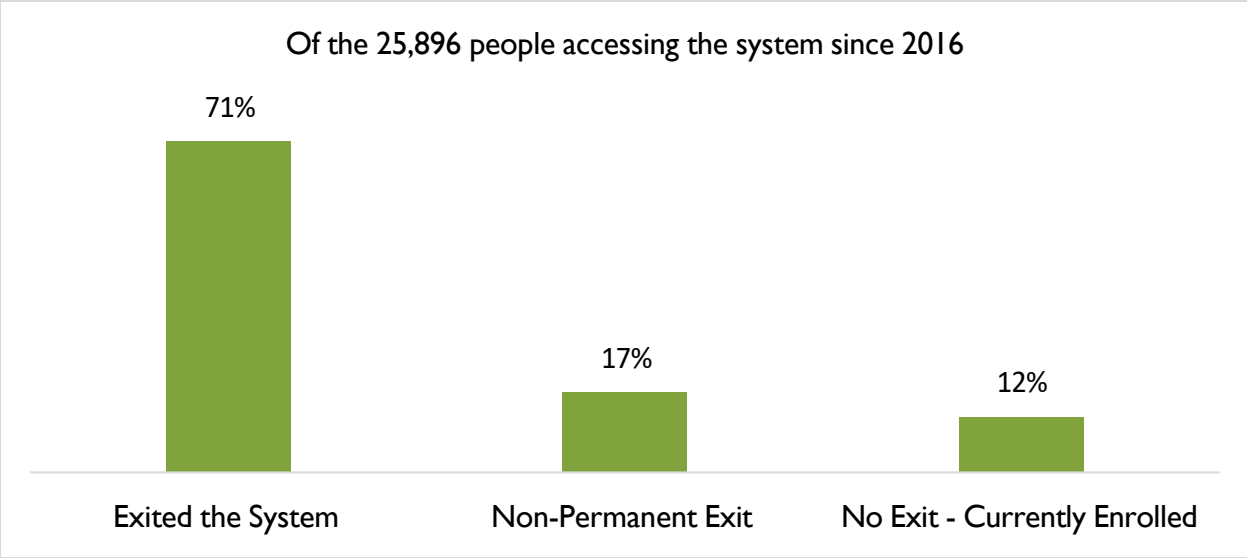
The *total unmet need estimate* is based on the backlog of households that the system has been unable to serve over the last five years (the time frame these data are based on is 2016-2021). Each year, the number of

people not housed adds to the number unhoused the year before, even if the system is using its housing availability to full capacity.

Currently, the homeless system of care has an unmet need of about 7,535 households, meaning there are 7,535 households in need that the system does not have capacity to serve. To have an "unmet need of zero," the system would need to find a way to increase the number of households *exiting* the system each year so that *outflow* rates are greater than *inflow* rates, and the system would need to do this until the "surplus" (7,535) is down to zero and the system is then able to balance its annual inflow and outflow.

Exits and Returns

"Exited from the system" is defined as including (a) people who leave to *permanent* destinations (as opposed to *temporary* or *unknown* destinations), (b) people with current enrollments in the system who have a move-in date for housing, and (c) those who have left and have not returned to the system for over a year.



The above graph shows that, of all the households to enter the system since 2016: 71% of households have permanently exited the system, 12% are currently enrolled in the system, and 17% have had a non-permanent exit (meaning it hasn't been a full year since their exit and there is a chance they will return to the system).

An average of 3,444 people per year exit the homeless system of care through one of the following project types:

- Homelessness Prevention (HP)
- Coordinated Entry (CE)
- Services Only (SO)
- Emergency Shelter (ES)
- Transitional Housing (TH)

- Rapid Rehousing (RRH)
- Permanent Supportive Housing (PSH).

Exits and Returns by Project Type

Certain project types have higher rates of *permanent exits* than other project types. This means that individuals who exit the system after that project type are more likely to exit to a permanent destination. For example: households that access Permanent Supportive Housing have higher rates to *permanent exit destinations* than those who exit from Emergency Shelter (who are more likely to exit to a non-permanent destination, such as an unsheltered location).

Similarly, certain project types have lower *rates of return* than others, meaning that once a household exits the system after using that project type, they are less likely to return to homelessness.

The project types with high rates of exits to permanent destinations and low rates of returns to homelessness include Rapid Rehousing (RRH) and Permanent Supportive Housing (PSH).

- 88% of RRH clients exit to permanent destinations and only 9% return to homelessness.
- 92% of PSH clients either retain their housing or move on to permanent destinations.

This means that RRH and PSH are highly effective project types, helping households to successfully exit homelessness and not return to homelessness.

On the other hand, certain project types have low rates of permanent exits and high rates of returns, meaning that while they may provide a household with temporary services or shelter, they are not successfully helping households permanently exit homelessness.

- For those who exit the system from Emergency Shelter, 27% return to homelessness.
    - This is highest for those who exit Emergency Shelter to a non-permanent destination, with 46% of those with non-permanent destination exits returning to the system. An example of this would be someone who exits the system from an Emergency Shelter and goes to either an unsheltered or a temporary living situation, and then returns to the system again within a year.
    - However, of those who exit from Emergency Shelter to a permanent destination (e.g., an apartment they are renting), only 15% return to homelessness within the year.
- Similarly, about 28% of those who exit the system from Transitional Housing return to homelessness and the system of care within a year.
    - Again, this is highest for those who exit Transitional Housing to a non-permanent destination, with 54% of those exit types returning.

- However, of those who exit to a permanent destination, only 11% return to homelessness within the year.

The above data show us that, to successfully (e.g., without return) exit individuals from the homeless system of care, households need to be able to access higher level housing programs than Emergency Shelter or Transitional Housing.

The below table shows where households exit to, and their rates of return after exit, based on their last project type. For example: while 37% of households will exit Emergency Shelter to a permanent destination, 15% will then return to homelessness. Further, the overall rate of return after exiting the system from Emergency Shelter is about 27% (regardless of destination type).

Table 4. Exit type and returns to the system by project type.

	SO*	ES*	TH*	RRH	PSH Enrollment	PSH Enrollment + move-in	PSH Enrollment + move in with retention	HP*
Number of exits before 11/30/21	2,141	7,882	1,336	4,471	2,011	1,889	3,348	763
Permanent exits	35%	37%	53%	88%	79%	80%	92%	78%
Family or friends	16%	17%	16%	3%	9%	9%	5%	8%
Self-resolved	2%	8%	17%	46%	30%	30%	17%	47%
PH project (CoC or other)	17%	11%	19%	39%	40%	40%	20%	22%
Permanent exit return	16%	15%	11%	9%	9%	9%	4%	15% (39%)
Non-permanent exit	45%	27%	21%	7%	16%	15%	5%	6%

Non-permanent exit return	40%	46%	54%	37%	26%	25%	36%	65%
Unknown exit	20%	36%	26%	6%	6%	5%	3%	16%
Unknown exit return	54%	24%	41%	31%	26%	25%	20%	50%
Total return regardless of exit destination type	35%	27%	28%	12%	13%	13%	6%	24%

* = missing data >10%.

SO, ES, TH, and HP have destination data quality issues (missing data is high). However, rates of permanent exit and the returns from those exits look promising.

Length of Time Homeless

Length of time homeless is calculated from the time someone first enters the homeless system of care until their first move-in date to permanent housing. This helps us understand how long it takes someone to gain housing, which is an important metric for improvement in how the system of care is operating.

Summary for Length of Time Homeless:

- The average **veteran** takes longer to exit to permanent destinations but takes less time to get to move into housing than other populations. This means that they system is doing well at getting veterans into housing, but that they are taking longer to exit the system into permanent housing of their own, outside of the system's resources.
- **Elderly adult-only households** take less time than to exit to a *permanent destination* and to move into housing than younger adult-only households.
- Those who are **chronically homeless** take longer to move into housing and exit to permanent destinations.
- Those who have a **history of *unsheltered* homelessness** take longer to exit the system of care to a permanent destination (as compared to those without a history of unsheltered homelessness). While this is a complex issue, two factors stand out as important to understand.
    - (1) Those with unsheltered histories are also *higher acuity*, meaning they have more needs for support and/or need a higher level of support than others.

- (2) Higher acuity clients are likely to be the ones who return to homelessness and may be a portion of those returning to unsheltered homelessness. This means that the proportion of those who are unsheltered (or have an unsheltered history) with high levels of acuity may be increasing over time.

The below table shows the length of time from first entry (after 1/1/2016) until first move-in date by family type. These data show that adult only households are spending longer homeless (and in the system of care) than family (adult and child) and youth (transition age youth) households.

Table 5: Length of time homeless by household type.

Head of Household Type	Mean Days	Maximum Days	Minimum Days	Number of Households
Adult Only	367.11	2,004	1	973
Adult and Child	165.85	1,919	1	3,145
Transition Age Youth	307.49	1,236	9	69
Total	214.95	2,004	1	4,187

As demonstrated below (in the section on Level of Acuity), adult-only households have an overall higher level of acuity than family or TAY households. Those with higher levels of acuity typically need higher levels of support with their housing and would thus need PSH (as opposed to TH or RRH). Given the limited numbers of PSH beds, these adult-only households are likely in the system of care longer because they are waiting for a PSH unit to become available.

In addition to the above information, certain subpopulations have a longer than average length of time homeless (averages below):

- Veteran: 257.59 days
- Elderly (65+): 280.53 days
- Chronically homeless: 401.67 days
- Unsheltered history: 308.49 days.

The driver of adult only households experiencing homelessness for a longer period of time than other households could be because they are more likely to be chronically homeless and/or to have a history of

unsheltered homelessness, both of which can contribute to higher levels of acuity, and thus a need for higher level care and supports – which are limited resources in the system, and which a household may thus have to wait a while to receive.

Level of Acuity

Level of Acuity is assessed by a household's VI-SPDAT score, which is based on an assessment they are given during intake into the CES as well as case conferencing. Level of Acuity helps us understand what level of housing a supports a household may need in order to solve their homelessness.

The below table shows what percentage (and actual number of individuals or households) of those in the system who have had a VI-SPDAT completed score in three different ranges. Typically, 8+ qualifies a household for PSH (9+ for families), 4-7 (or 4-8 for families) qualifies a household for RRH, and 3 or below does not qualify for housing (though they may qualify for prevention or other services).

Of those accessing CE and receiving a VI-SPDAT assessment score between 1/1/2020 and 11/30/2021, 60% received a VI-SPDAT assessment. The remaining 40% received a prevention assessment.

Table 6: VI-SPDAT average score by household type.

VI-SPDAT Score	Adult Only / Individual Percent (Frequency)	Family Percent (Frequency)	TAY Percent (Frequency)
0 to 3	6.67% (129)	6.23% (70)	16.77% (27)
4 to 7 (4-8 for families)	35.52% (687)	61.21% (688)	40.37% (65)
8+ (9+ for families)	57.81% (1,118)	32.56% (366)	42.86% (69)
Total	100% (1,934)	100% (1,124)	100% (161)

This acuity analysis helps us understand how much of each housing program type is needed in the community.

Table 7: Housing need by household type, based on VI-SPDAT score (acuity).

Housing need	Individual	Family	TAY
PSH	57%	33%	43%
RRH	35%	61%	40%
Diversion	6%	6%	17%

When combined with the annual unmet need, we can estimate how many units of each housing type are needed to address homelessness in the community:

Table 8: Amount of housing needed, by housing type and household type.

Housing need	Individual	Family	TAY	Total
PSH	1,550	488	97	2,136
RRH	952	903	90	1,945
Prevention / Diversion	163	89	38	290

Based on the above, we can determine that:

- **Adult only** households have the highest overall acuity (compared to family and youth households), with nearly 58% qualifying for PSH.
- Acuity helps to determine whether a household qualifies for RRH or PSH:
    - There is a 1:1.5 need for RRH vs. PSH for adult only households (the majority of Chronically Homeless, Veterans, and Intense Service Needs groups are adult only households).
    - There is a 2:1 need for RRH vs. PSH for family households.
    - There is about equal need (1:1) for RRH and PSH for youth households.

In total, there is a gap of 2,136 PSH and 1,945 RRH units needed to end homelessness in the

community. There was also a recent backlog of vouchers not being used by clients because there are very few units in the community available to clients with vouchers.

Unsheltered Homelessness

Unsheltered homelessness refers to individuals sleeping in a place not meant for human habitation, such as outside or in a vehicle.

There are several ways to analyze unsheltered homelessness in the community. First, several datapoints in HMIS tell us about unsheltered homelessness:

Table 9: Unsheltered homelessness in the system by data element.

	Number of People	Percentage of Total
Total clients in any project type	25,896	100%
Ever entered the system from a place not meant for human habitation	6,908	26.22%
Ever exited the system to a place not meant for human habitation	1,458*	5.68%*
Ever enrolled in a Street Outreach project	3,210	12.40%
People with Unsheltered Histories at any point	7,478	28.88%
* = more than 10% of missing data.		

As expected, people in adult only households experience unsheltered homelessness a much higher rates compared to youth and family (adult and child) households:

- Adult only unsheltered history: 42.24%
- Family unsheltered history: 12.04%
- Youth unsheltered history: 32.48%

Overall, families are the least likely to have a history of unsheltered homelessness.

Further, certain subpopulations are more likely to experience unsheltered homelessness:

- **People with disabling conditions** are much more likely to experience unsheltered homelessness (49% for those with a disability vs. 17% for those without a disability).

- **People experiencing chronic homelessness** experience unsheltered homeless at the highest rates (69% vs. 23% of those who are non-chronic). When excluding Family households, who have very low rates of both chronic and unsheltered homelessness, this percentage rises to 80% (80% of those who are chronically homeless have experienced unsheltered homelessness).

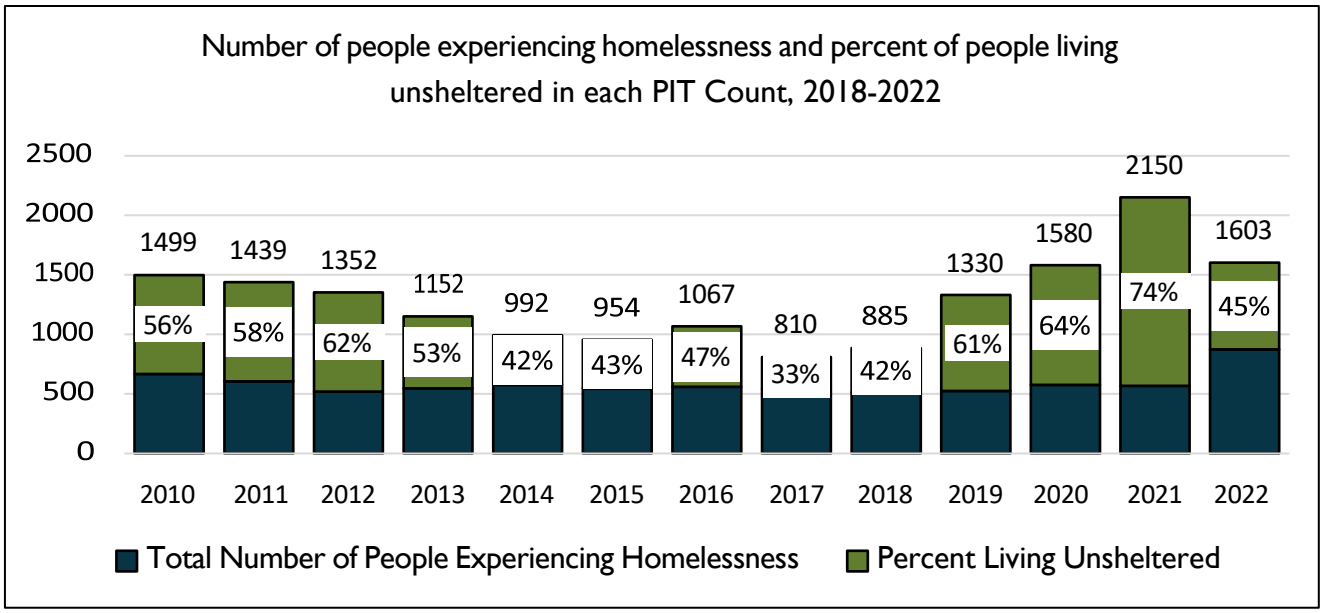
The PIT Count also helps us understand unsheltered homelessness. During the most recent 2022 PIT Count, there were 728 (45%) persons unsheltered, primarily adults. There were another 875 (55%) persons in Emergency Shelter and Transitional Housing.

Summary: **At least 42% of individuals in adult-only households have unsheltered histories**. Based on the PIT Count: **53% of individuals in adult-only, actively homeless households are unsheltered** (47% are in ES or TH).

PIT Count Data

Below, data insights from the annual Point-in-Time ("PIT") count are presented, with comparison data from HMIS. The PIT Count is a count of all sheltered and unsheltered people experiencing homelessness on a single night in January. PIT data from 2010-2022 shows how homelessness has changed over the years. Four points stand out from this data:

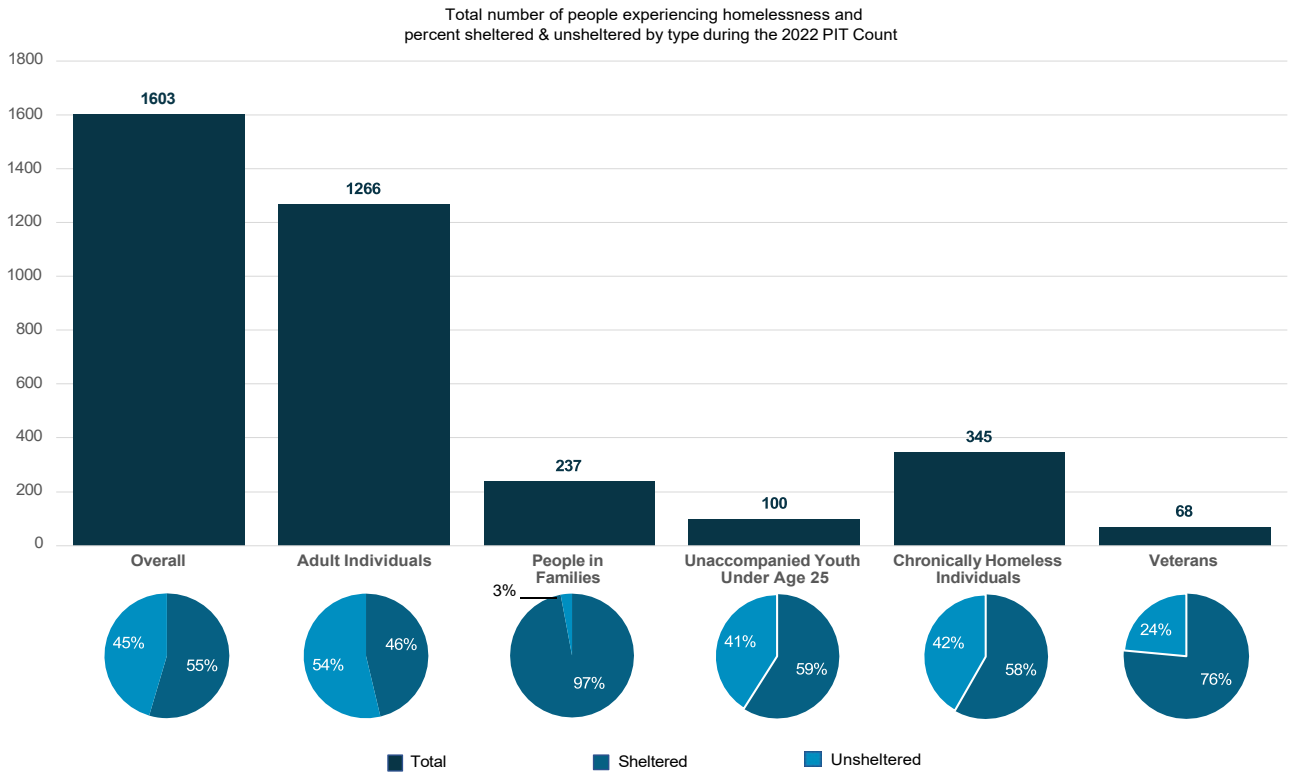
- Most of the variation in total homelessness has come in the number of people experiencing **unsheltered homelessness**. That number generally decreased between 2010 and 2017, and then increased sharply through 2021. After that peak, the number of people experiencing unsheltered homelessness decreased by more than half between 2021 and 2022.
- The number of people experiencing **sheltered homelessness** remained relatively stable from 2010 to 2021, before seeing a large increase in 2022.
- 2022 is the first year since 2018 when **more people experiencing homelessness were sheltered than were unsheltered.**
- Despite the improvements in 2022, **the total number of people experiencing homelessness remains troublingly high**. At 1,603 people during the PIT Count (with only the 2021 PIT Count being higher), it is approximately double the number of people who experienced homelessness in the 2017 PIT Count.



The high total number of people who were experiencing homeless in the 2022 PIT count points to the need to **expand interim and permanent housing options** in Kern County. Moreover, the high number of people who were living unsheltered indicates a need to **target strategies to address the unique needs of households living in places not meant for human habitation** to ensure they can access supportive services as appropriate and move into housing as quickly and stably as possible.

The figure below breaks down the 2022 PIT count figures according to who experienced homelessness and whether they were sheltered or unsheltered. It shows that the majority of people experiencing homelessness were individuals (79%), with about 15% of the people in the count being people in families, and about 6% being unaccompanied youth under age 25. By comparison, 93% of those served by the system of care were individuals, and 7% were families.

About 22% of people in the 2022 PIT Count experienced chronic homelessness. For the remaining 78%, their experience of homelessness was largely transitional. People in families and veterans were most likely to be sheltered. By contrast, a large percentage of individuals, unaccompanied youth, and chronically homeless were living unsheltered.


Total number of people experiencing homelessness and
percent sheltered & unsheltered by type during the 2022 PIT Count
1800
1600
1400
1200
1000
800
600
400
200
0
1603
1266
237
100
345
68
Overall
Adult Individuals
People in Families
Unaccompanied Youth Under Age 25
Chronically Homeless Individuals
Veterans
45%
55%
54%
46%
3%
97%
41%
59%
42%
58%
24%
76%
Total
Sheltered
Unsheltered