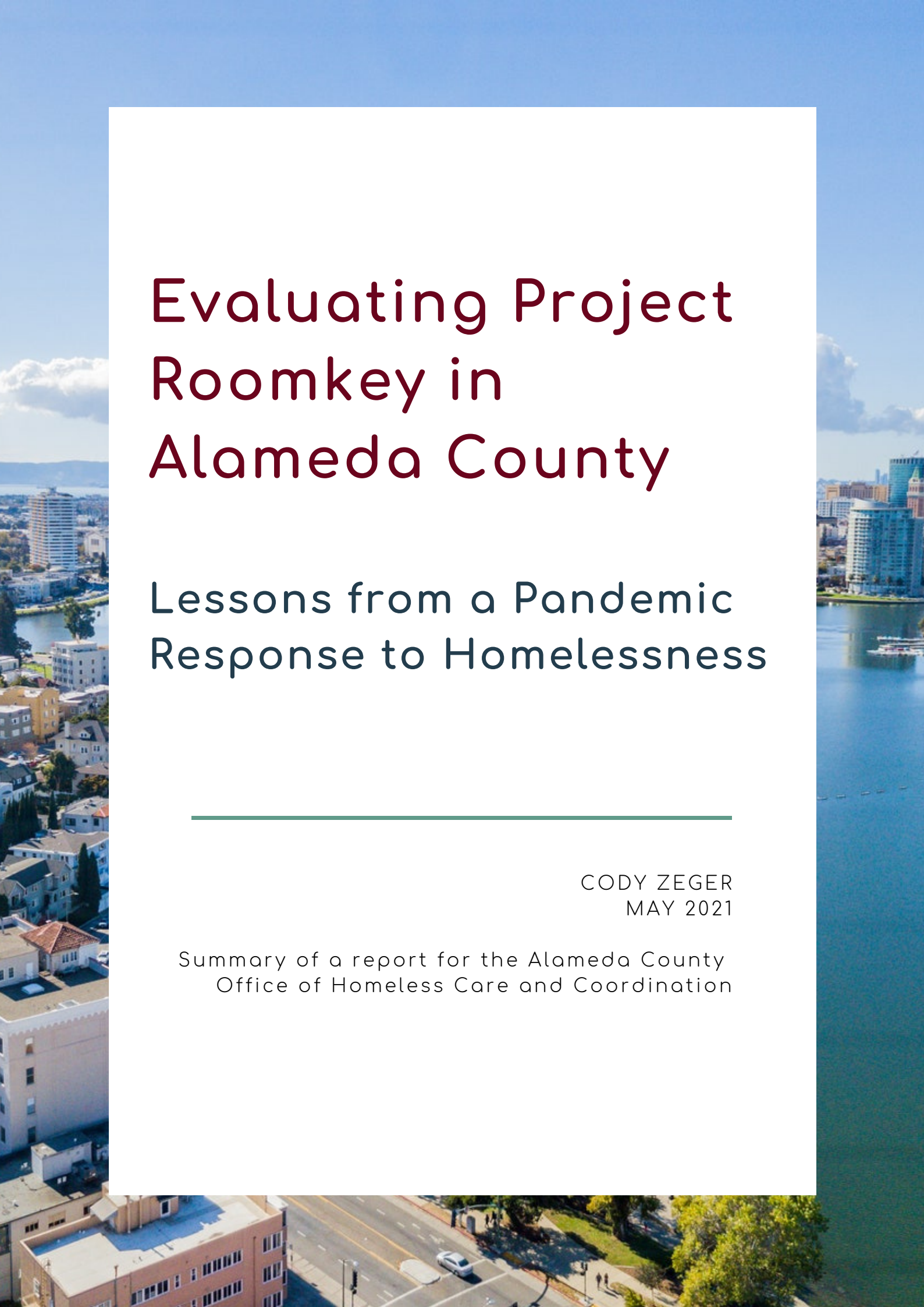

Evaluating Project Roomkey in Alameda County

Lessons from a Pandemic Response to Homelessness

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Summary of a report for the Alameda County Office of Homeless Care and Coordination

INTRODUCTION

In response to the COVID-19 pandemic, California was the first state to implement a program specifically designed to protect people experiencing homelessness. Dubbed Project Roomkey (PRK), the program utilized vacant hotel rooms as non-congregate shelter to prevent the spread of COVID-19 among this community. What followed was one of the fastest expansions of the state's shelter capacity in its history and an opportunity to reinvent emergency shelter provision.

With support from state and federal funding, the state tasked communities across California with Project Roomkey's implementation. Alameda County jumped at the opportunity to participate in the program, and with the help of city, state, and nonprofit partners, opened 13 hotel and trailer sites—doubling its shelter capacity in less than six months. Between March 2020 and March 2021, these sites served over 1,700 participants. Given the federal requirement to prioritize people who had higher risks of complications from COVID-19, these participants were significantly older and sicker than the population of people experiencing homelessness overall.

To effectively serve these participants, a new form of shelter was needed: one that could not only bring many people inside quickly, but also meet their medical needs and put them on a path toward more permanent housing. The county responded by creating Shelter-in-Place (SiP) sites, adding health care and housing navigation services to a non-congregate setting. This combination formed the backbone of a new "PRK model" of shelter provision.

This report represents one of the first studies of Project Roomkey outcomes through an in-depth analysis of Alameda County's program design and implementation. Using both quantitative and qualitative research, it aims to break down the various components of Alameda County's Project Roomkey model in order to identify which components were key to improving health and housing outcomes for people experiencing homelessness.

The initial lessons from Alameda County's Project Roomkey program are clear:

1. The low-barrier, non-congregate shelter model was universally preferred by service providers and made shelter more appealing to many people living outside.
2. The health care services and other amenities provided at PRK sites helped participants stabilize and address long-standing medical issues.
3. The focus on housing navigation and the creation of new housing subsidies for people at PRK sites led to 65% of participants exiting to housing—nearly double that of traditional congregate shelters in the county.
4. The speed at which the program was implemented required government and nonprofits to collaborate in new, beneficial ways that could be maintained beyond this program.

This study demonstrates that with a substantial infusion of state and federal funding, as well as coordination between government and nonprofit partners, long-term progress can be achieved toward addressing the homelessness crisis.

While the success of Project Roomkey should be celebrated, it also came at a significant financial cost. Project Roomkey is estimated to have cost about $260 per participant per night. This is multiple times higher than congregate shelter and in line with other service-intensive environments such as medical respite centers. Therefore, while the PRK model may be more effective than congregate shelter at addressing homelessness, its cost could make it most viable as a short-term intervention, not a long-term solution for people experiencing homelessness.

In order to understand how to build on the success of the PRK model, this report delves into which components helped improve participant outcomes and suggests ways to bring those pieces forward into future county shelter operations.

THE PRK MODEL

Project Roomkey's Shelter-in-Place sites are low-barrier, non-congregate shelters that provide participants with access to health care and housing resources. Building off the county's prior work with the Whole Person Care program, which brought health care and housing services together for people experiencing homelessness, county staff knew how challenging it was to meet people's medical needs while they were living outside. Therefore, they used Project Roomkey as an opportunity to bring these services together again to improve people's health while they had a consistent place to live.

Participants at SiP sites could choose to live with partners, bring their pets and other belongings, and were not required to abstain from substance use while on site. This was intended to provide shelter that would appeal to as many people as possible and make participant stays more comfortable, which would help them shelter in place.

The large majority of participants had their own room or shared with family members. The exceptions to this were the trailer sites where some participants lived with a roommate. SiP sites were open 24-hours and participants were provided with three meals a day. Most participants had access to transportation for important appointments.

Since prioritization for SiP sites was given to people at the highest risk of complications from COVID-19, participants often came into the program with significant unmet medical needs. Therefore, the county added clinical services (such as nursing and caregiving) with the hope of helping participants access necessary care and creating stability before they moved on, ideally to permanent housing. Specifically, these clinical services were intended to help participants:

- Strengthen relationships with primary care providers in the community
- Facilitate access to the appropriate levels of care
- Foster independence
- Improve health literacy and management of chronic conditions

The clinical services available at each SiP site varied, with the highest level concentrated at the largest hotel sites. Nurses were available at most hotels to help participants meet the above goals. The two largest hotels also had staff assisting with caregiving for participants who could not take care of their daily needs alone. As the program progressed, the county saw a larger than expected need for these services.

While participants could apply for the state's in-home supportive services, service providers faced difficulty helping participants access this program. Therefore, the county increased their own caregiver services for these participants to support them as they applied for the state benefits. In February 2021, the county concentrated participants with the highest medical needs in one hotel and focused caregiver services there.

While health outcomes, including preventing the spread of COVID-19, were the primary focus of the program, connecting people with permanent housing was also a key part of the PRK model. Housing navigation services to help participants find more permanent housing options were built into each service provider contract. Additionally, the county used funding from the federal Emergency Solutions Grant program within the CARES Act (ESG-CV) to create hundreds of new bridge housing subsidies for PRK participants. The effects of these investments in health care and housing are explored further in the Lessons section of this report summary.

SHELTER MODEL COMPARISONS

Alameda County created the SiP sites to provide medically frail people experiencing homelessness with a way to reduce their risk of contracting COVID-19. The PRK model differs from other shelter models available in Alameda County in a variety of ways. Table 2 below collects data from published reports as well as interviews with county staff to highlight differences between various shelter models in Alameda County and the broader Bay Area.

Table 2: Shelter Model Comparisons

	PRK Model	Traditional Congregate Shelter	Navigation Center[1,2,3]	Medical Respite[4,5,6]
Homeless Populations Served	High-risk of complications from COVID-19 (e.g. 65+ or underlying health conditions)	Varies; some are broad while others have populations of focus (e.g. Transitional-Age Youth, survivors of domestic violence, veterans, etc.)	In Alameda County, prioritized for people with an identified path to housing, either through rapid rehousing and employment, or permanent supportive housing	Individuals exiting the hospital, or at risk of entering the hospital, with acute medical conditions that make other shelter impractical
Room Occupancy	Non-Congregate: One household per room + may	Congregate:	Congregate: Multiple households per room + may	Congregate: Multiple

	elect to stay with partners or family	Multiple households per room	elect to stay with partners	households per room
Food Provided	Three meals per day	One meal per day	One meal per day	Three meals per day
Time Limit	None	Varies	Varies, generally 90 days	90 days
Nursing + Caregiver Services	Nursing: 1 nurse + 1 medical assistant for every 100 residents Caregiver: 1 caregiver for every 35 participants at participating hotels	Nursing: Shelter Health providers support staff in accessing nursing care for residents with acute health needs	Nursing: Shelter Health providers support staff in accessing nursing care for residents with acute health needs	Nursing + Caregiver: Varies, some have light touch case management with few services, others have more intensive services with 1 nurse for every 20-30 residents
Case Management + Housing Navigation	1 housing navigator (or similar staff) for every 25 guests Behavioral health services assigned as assessed	Varies, some on-site housing services with undefined ratios Alameda County Behavioral Health Care services provided directly in several sites	1 housing navigator for every 20 participants	Varies, as above
% of Exiting Participants Who Enter Housing	65%	35%	40% - 90%, varies by model	20% - 30%
Approximate Per-Night Cost	$260	$50	$100	$200 - $250, varies based on services

PARTICIPANT DEMOGRAPHICS AND PROGRAM COST

Between March 2020 and March 2021 a total of 1,708 participants stayed in at least one SiP site. This represents over 20% of Alameda County's homeless population and around 50% of those the county originally identified as the population eligible for Project Roomkey. Referrals to the sites initially stopped in November 2020 due to the program reaching capacity. However, they were reopened in February 2021 and will continue through the end of the program, so these numbers will change going forward. For a full analysis of participant demographics, see Appendix A of this report summary.

Based on an analysis of county financial records for the seven largest Project Roomkey SiP hotel sites, the per-night cost for the PRK model is around $260 per person per

night. This cost is significantly higher than that of congregate shelters or navigation centers, but is similar to programs designed for populations with high medical needs, like medical respite centers (see Table 2 above).

Overall, this analysis confirms the assumption of nearly all county staff and service providers that PRK was much more expensive to operate than traditional congregate shelter. Simply looking at cost, however, ignores improvements in participant outcomes from this investment in shelter services. If the PRK model is better at helping participants stabilize and exit homelessness, it may result in long-term outcomes that make it worth the investment. Therefore, the next section will explore what aspects of Project Roomkey made the biggest difference in participant health and housing status.

LESSONS

This section brings together the most common themes from key informant interviews[i] as well as quantitative data, where available, to elucidate the benefits and challenges of using the PRK model.

Lesson 1: The PRK model increased shelter acceptability and engaged those who may not have otherwise used shelter.

Key Takeaways

- Having private space created autonomy and reduced tension compared to congregate shelter.
- Allowing participants to stay with their communities made the prospect of moving inside more appealing.
- Removing time limits may have given participants time to stabilize.

One of the most common advantages that service providers identified about the PRK model was its success in engaging communities that may not have previously wanted to use congregate shelter. Providers described that some people experiencing homelessness are reasonably hesitant to move into congregate shelter for many reasons, including not wanting to stay in a crowded environment, having to leave their communities behind, and not being sure if it would help resolve their homelessness.

While it is safe to assume that the presence of the pandemic was a factor in people's decision to seek shelter, providers also thought the PRK model had other advantages that helped bring people inside for the first time. All of the providers interviewed said offering participants a private room, three meals a day, and the ability to stay with their partners and pets, was key to moving a large number of people off the streets in such a

[i] Lessons were compiled from interviews with 25 individuals across 14 organizations representing both service providers operating PRK hotels and government staff overseeing program implementation. The service providers interviewed had decades of experience and could therefore speak to the differences between the PRK model and congregate shelter, in particular.

short time. “If this was congregate shelter,” one provider noted, “we’d have to spend 50 million years convincing people to come inside.” Additionally, providers pointed to the fact that there were no set time limits on participant stays as something that encouraged participants to enter shelter and gave them time to stabilize, which will be discussed in the next section.

While all of the providers interviewed preferred the non-congregate shelter setting, most acknowledged that it would be unrealistic to get rid of congregate shelters altogether due to the county’s overall shortage of shelter beds.[7] However, most felt that the PRK model created a much better living environment for participants and that components of it should be continued in some form.

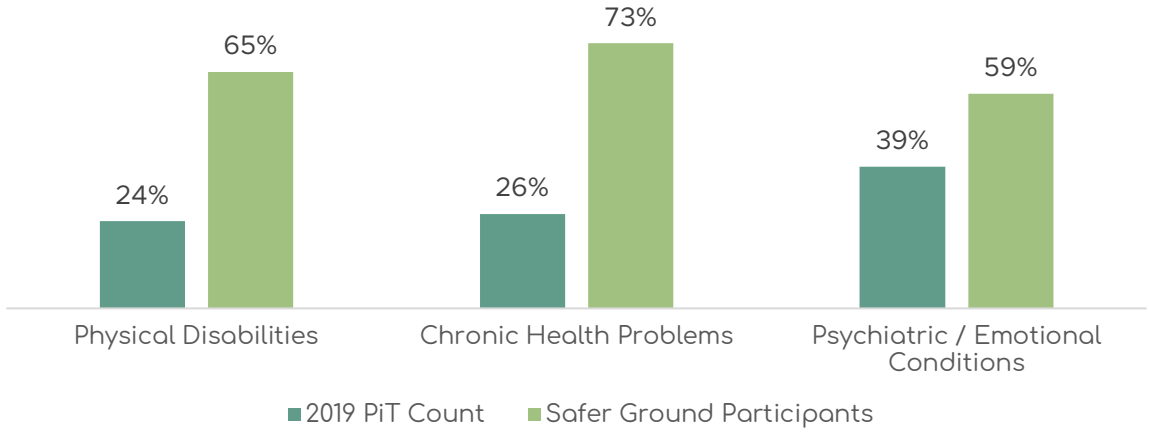
Lesson 2: The PRK model facilitated better access to services, but could be better tailored to serve certain populations.

Key Takeaways

- Participants were able to more easily access necessary health care and stabilize, especially those who traditionally have less success in a congregate setting.
- The PRK model could be better tailored to work for some populations, such as survivors of domestic violence and people with higher health care needs.

The data available on participants’ self-reported health conditions confirms that PRK served a population of people with significant medical needs. Figure 4 below demonstrates that PRK participants reported higher rates of physical disabilities, chronic conditions, and mental or psychiatric illness than those in the population of people experiencing homelessness overall.

Figure 4: Comparing Participant Self-Reported Health Conditions



While offering health care and other services to participants was not new for providers, the PRK model committed more resources toward stabilizing participants than other shelter models. As a baseline, the county was able to fund nursing, caregiving, housekeeping, transportation, and three meals a day, which are rarely available in a

congregate shelter setting. Building these services into the PRK program allowed participants to access resources they may have needed but could not get before.

Providers attributed at least part of this success to people having their own space that they could return to for a longer period of time. One provider described a transformation they saw in the stability of participants at their site overall: "Something about having your own space is really impactful. It gives [participants] time to think what their next steps are and go back to their old selves. When we opened in May many people didn't have anything. They were just off the street, hadn't taken a shower, didn't have any extra clothes. Between May and now there has been a real change: people are definitely more stable than when they started."

Some providers also noted that while the services at SiP sites were an improvement over the traditional congregate shelter model, they could have been more tailored to effectively serve the needs of certain populations, such as survivors of domestic violence or people who cannot take care of their own basic needs. A large, low-barrier, non-congregate hotel site may not always be effective for these groups, so providers recommended future shelter programs plan further in order to serve their distinct needs.

Lesson 3: The PRK model nearly doubled the number of participants exiting to housing, while also posing challenges to facilitating those exits.

Key Takeaways

- 65% of participants who exited PRK entered housing, as compared with 35% in congregate shelter the year before.
- Some participants were initially hesitant to move out of PRK sites, but most elected to move into housing once the temporary nature of the program became clear.

Possibly the most striking outcome from Alameda County's Project Roomkey is the proportion of participants who moved from the SiP shelters into housing. Even though connection to housing was a secondary goal of the program—given its focus on participant health outcomes—the PRK model nearly doubled the percent of participants transitioning into more permanent housing. While some providers reported challenges in motivating participants to move out initially, nearly all of them stated that this program housed more participants than they had seen in past programs.

During the period of study, 65% of the 815 participants who left the program during the study period went to a housing destination (see Table 4 below). As a comparison, according to HMIS data on exits from emergency shelters in Alameda County from the prior year (April 2019 - March 2020), around 35% of participants exited to housing.

Table 4: PRK Participant Exits by Category

Exit Category	Participants	Percentage
Housing	532	65%
Place Not Meant for Habitation	104	13%
Shelter	71	9%
Other/Data Not Collected	50	6%
Deceased	25	3%
Medical or Treatment Facility	24	3%
Jail	9	1%
Total	*815*	*100%*

Further, PRK residents who were leaving for housing accessed public subsidies at much higher rates than those in shelters in prior years. Nearly three-quarters of PRK residents who transitioned to housing used a public subsidy and only 11% went to stay with friends or family. In comparison, only around 29% of participants from congregate shelters in Alameda County accessed public subsidies in the year prior to PRK, while 43% left to live with friends or family. Exits to housing using public subsidies may be more stable, as they often are paired with continued support services. Exits to live with friends or family are typically not monitored in any way and therefore it is harder to know if a participant is successful in finding permanent housing.

Multiple Factors to Housing Success

One reason providers gave for the high percentage of exits to housing was the addition of funding from the federal Emergency Solutions Grant program within the CARES Act (ESG-CV). Through this bridge funding, the county was able to subsidize twelve-month housing placements for participants moving out of a PRK site, with a commitment to continue funding the subsidies beyond the first year.

The data shows that 217 Project Roomkey participants found housing using a bridge subsidy between when they became available in November 2020 and March 2021. This represents over 40% of the total exits to housing overall and was therefore clearly a significant factor in the program's high housing exit rate. Many other participants exiting to housing with public subsidies utilized the county's standard process to access available permanent supportive housing.

Additionally, the county participated in California's 100-Day Challenge, which provided a structure to collaborate with the cities of Oakland, Berkeley, and Alameda to align funding around housing exits. The county contracted with Abode Services to provide a centralized housing navigation team that assisted participants across sites in working with landlords and finding available housing in apartments across the county. To help ensure participant success after exiting to housing, the county also funded 11 housing providers to offer ongoing tenancy support.

Some providers affirmed that the resources for these new subsidies as well as the work of their housing navigators was crucial in helping participants find housing. As one provider said, referring to the new subsidies, "We would never have been able to house so many people if not for Abode and the resources they had access to." Another provider described the addition of these resources as unprecedented and said, "I've never seen so many people with housing options. In shelter you're lucky if 25% of people have real housing options—not just living with relatives." One provider described what it was like to see so many of her participants given the opportunity to access housing once it was announced that the site was going to close. "It was magical and intense," she said.

Providers, however, were more mixed on whether the PRK model specifically was better at preparing participants to move into housing as compared with congregate shelter, or if it was the investment in new subsidies alone. According to one, the ability to give participants time to stabilize and get to know shelter staff was crucial in creating a successful housing search. "Having people in one place and having time helps," she said. "The time-limited shelters can be hard to get people stabilized and focusing on housing." Another provider, however, was less sure that the PRK model had an effect on housing outcomes since most of the participants at her site who found housing were utilizing these new subsidies.

One way of understanding the impact of these subsidies on housing exits overall is to examine what the rate of exits to housing would have been without them. Even when the participants that used this subsidy are removed from the sample, the rate of at which those who exited PRK sites entered housing was 53%. As stated above, this is still significantly higher than exits to housing from congregate shelters (35%). Therefore it appears the PRK model, with its increased housing navigation and case management, may have had an effect independent from this new subsidy.

Two main factors stand out as barriers to comprehensively analyzing the housing outcomes from Project Roomkey. First, since this study was conducted during the first year of the program, more time is needed to understand the retention rates of participants moving to housing from PRK sites, which will help demonstrate if the PRK model helped prepare participants for housing. Second, permanent supportive housing units procured through the Project Homekey program (a follow-up to Project Roomkey that helped communities purchase hotels to convert into permanent housing) were not ready to be used during the study period. However, they are likely to be a growing source of housing exits for PRK participants going forward. Therefore, following up on this study will be crucial in understanding the housing outcomes of PRK participants.

While more research is needed to extricate the effect the PRK model had on participant housing outcomes from the new subsidies, one provider made sure to emphasize the overall success of the program. "People are going to pick apart the data for years to come," she said. "But the bottom line is I don't think there's ever been a situation where over 400 people have been housed in this fast of a period."

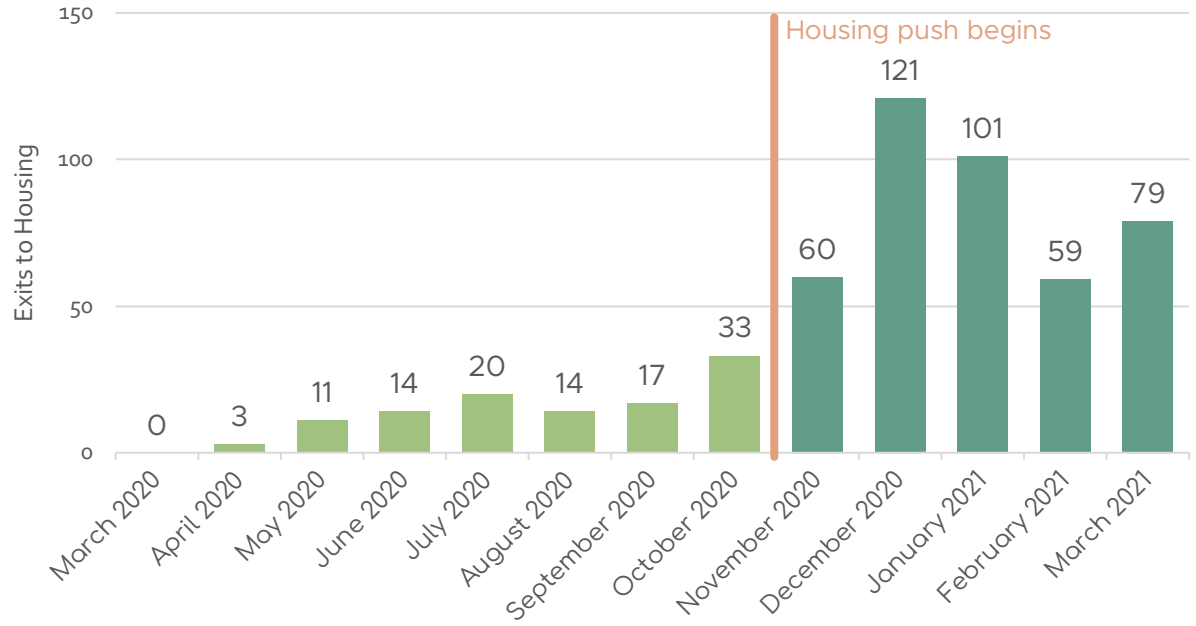
Challenges Facilitating Exits

Despite the significant increase in the number of participants getting access to housing through Project Roomkey, providers noted that the PRK model created some difficulties in facilitating participant exits. Since people had their own rooms, access to numerous services, and three meals a day, without paying any portion of their income, many providers reported that some participants were understandably hesitant to leave, even when they were offered housing.

However, most of the Alameda County providers that reported these challenges shared a similar view about participants' eventual participation in their housing search process. One reported that when the county told them the site would have to close, the temporary nature of PRK became clear to participants, and they were more willing to move to housing. "When we thought we were going to close the site in February, suddenly everybody wanted a case management appointment," she said. "It's hard when you don't have an end date to get people motivated to have a plan."

The timing of PRK exits backs up the idea that participants were eventually willing to move to housing. In November 2020, the county prepared to close all PRK sites by the end of the year due to the lack of long-term program funding. Additionally, this is when the bridge housing subsidies became available and there was a push to find housing for participants. The data shows that after this point exits to housing doubled for the next two months (see Figure 6 below). While many of the hotels ended up being able to remain open, this demonstrates that when the temporary nature of the program became clear and more resources were added to help find housing, participants were willing to move out of PRK sites.

Figure 6: Exits to Housing by Month



Lesson 4: The PRK model created new partnerships and coordination between homeless service providers, despite challenges with quick program implementation.

Key Takeaways

- PRK created a chance for new collaboration among service providers and county staff.
- PRK started quickly and was high intensity for staff, but overall was a successful mobilization of resources.

According to providers, a major benefit of Project Roomkey's design was that it created new channels of communication between their organizations and the other nonprofits or government agencies they work with. Because there was such a fast mobilization to get PRK sites up and running, Alameda County staff were highly involved in meeting with all the service providers individually as well as regularly bringing them together. Specifically, providers found the connection between the health care and housing sectors to be particularly important to participant success.

"We've had a lot of support from key players in Alameda County," one provider stated. "The medical directors have been very hands on, which has been integral to getting access to a lot of services and answering important questions." They went on, giving an example of one of their participants who isn't technically qualified for a housing subsidy yet, but needs one. "The coordination between these groups helps us fill in all the cracks that this person would otherwise fall through."

Overall, Project Roomkey provided a chance for service providers and government agencies to work together in new, collaborative ways that improved service provision at the sites. While providers faced some challenges with hiring, training, and retaining staff in a program that included so much uncertainty, they hope to keep up these new levels of collaboration in future programs.

Conclusion

This study demonstrates that with a substantial infusion of state and federal funding as well as coordination between government and nonprofit partners, true progress can be achieved toward addressing the homelessness crisis. In a matter of months, the county doubled its available shelter beds and created a new model of non-congregate shelter provision.

Based on the data available, the PRK model appears to have been more appealing to those who may not have wanted to use shelter before, helped participants stabilize through connection to appropriate health care services, put many more on a path toward permanent housing, and facilitated new collaborations between homeless service providers. These improved outcomes show that investing in shelter can make a long-term difference in homelessness for participants.

However, given the program's cost, it is unlikely the county will be able to maintain this program at its current scale. Therefore, this report summary recommends three strategies for bringing the success of the PRK model into future shelter provision (see the full report for more detailed descriptions of these recommendations):

1. Maintain the PRK model at a smaller scale, focused on people with high medical needs who would not be able to stabilize in congregate shelter but do not feel comfortable in other institutional settings.
2. Address drawbacks of congregate shelter by adjusting service design, including creating or expanding centralized teams to provide clinical care and housing navigation.
3. Continue utilizing state and federal grant funding while it remains available to purchase hotels and create long-term housing subsidies for people experiencing homelessness.

Alameda County's Project Roomkey program provides an opportunity to understand the benefits that can come from a renewed investment in the county's shelter system. While shelter alone is not the answer to homelessness, it is an important part of meeting people's immediate needs. Even resource-intensive shelter models, such as PRK, should be a temporary measure for people experiencing homelessness. However, this report summary shows that shelter can and should be improved in ways that put people on a path toward stability and long-term housing.

Appendix A: Participant Demographics

(Text from full report)

Between March 2020 and March 2021 a total of 1,708 participants stayed in at least one Project Roomkey SiP site. This represents over 20% of Alameda County's homeless population (see Table 3 below) and around 50% of those the county originally identified as the population eligible for Project Roomkey. Referrals to the PRK sites initially stopped in November 2020 due to the program reaching capacity, however they were reopened in February 2021 and will continue through the end of the program, so these numbers will change going forward.

As compared with the 2019 Alameda County point-in-time Count, women and people identifying as White were slightly overrepresented as participants in PRK sites, while those identifying as Multi-Racial were slightly underrepresented. Participants of other races and ethnicities were generally represented proportionately. Additionally, PRK participants were significantly older and reported longer histories of homelessness. PRK also served a higher proportion of people experiencing chronic homelessness as well as people who had ever reported having physical disabilities, chronic health problems, or psychiatric and emotional conditions.

Table 3: Participant Demographic Comparisons with Overall Homeless Population

Demographic Information	2019 Point-in-Time Count	Safer Ground Participants
Individuals	8,022	1,708
Gender		
Male	61%	56%
Female	35%	43%
Transgender or Gender Non-Binary	4%	1%
Race		
Black or African American	47%	46%
White	31%	40%
Multi-Racial	14%	7%
Asian	2%	3%
American Indian or Alaska Native	4%	3%
Native Hawaiian or Other Pacific Islander	2%	1%
Ethnicity		

Hispanic/Latinx	17%	17%
Age		
Under 18	4%	7%
18 - 24	9%	2%
25 - 59	73%	56%
60+	14%	35%
Sexual Orientation		
LGBTQ+	14%	5%
Length of Homelessness		
More than 1 year	63%	90%
Other Conditions		
Chronically Homeless	28%	67%
Physical Disabilities	24%	65%
Chronic Health Problems	26%	73%
Psychiatric/Emotional Conditions	39%	59%

The presence of a higher proportion of women in Project Roomkey could be due to the fact that one hotel (as well as the scattered-site voucher program) prioritized women and families in order to better serve survivors of domestic violence and people who were pregnant. Additionally, some of this difference could be due to the fact that the PRK model focused on keeping couples and families together in shelter. According to a few of the providers interviewed, women often do not feel comfortable in congregate shelters, so given the higher proportion of women in the sample, it would be useful for future research to investigate whether the PRK model was able to provide a better environment for those individuals.

Participants in Project Roomkey were also generally older with more medical conditions than the homeless population overall. They also had longer histories of homelessness, with 90% of participants having experienced homelessness for more than 1 year and a median length of homelessness just over 4 years. This data is confirmed by the experience of the service providers running the sites who discussed serving an older and sicker population than before. One reason for this difference is that the FEMA eligibility criteria required participants to be "at risk" of complications for COVID-19 as defined by their age and underlying health conditions. It follows, then, that these eligibility requirements selected for participants that were older and had more co-occurring illnesses or disabilities.

The overrepresentation of people identifying as White and underrepresentation of people identifying of Multi-Racial could be due to multiple factors. First, county staff reported that they initially had an over-representation of referrals for participants from

areas of the county outside Oakland, which are much whiter overall. This may have had to do with the referral response times of providers in the various parts of the county and points to the need to do more targeted outreach to communities that are overrepresented in the homeless population when new programs begin.

However, given the low representation of people identifying as Multi-Racial, and the relatively proportionate representation of other racial and ethnic groups, it is also possible the difference has more to do with data entry than participant demographics. As discussed in the Methods section of this report, the quick startup of Project Roomkey could have affected data collection. If staff collecting participant data did not ask participants to self-identify their race, it is possible they identified multi-racial people as the one race they perceived them to be and created an unintentional bias in the available data.

When the county re-opened referrals for PRK sites in February 2021, they received a higher portion from Oakland. Looking at participants entering between February and March 2021, it appears the proportion of participants identifying as Black or African American has gone up slightly, White has stayed the same, and Multi-Racial has gone down slightly. It will be important for future research to look into the final demographic breakdown of PRK participants and check the data quality to understand if the program served all racial and ethnic groups proportionately.

The data also shows people identifying as transgender or gender non-binary and LGBTQ+ as being underrepresented in SiP sites. While it is important to understand if these groups are being appropriately served by PRK, their underrepresentation may also be a result of the HMIS data collection challenges. Given the speed of program startup and the fact that many participants choose not to answer questions about gender and sexuality, providers may fill out the answers based on what they perceive about a participant. Additionally, if people are asked to select between mutually exclusive gender categories, some individuals may select the option that applies to their gender instead of the one related to their transgender identity. Due to these factors, more work needs to be done to determine whether SiP sites served a proportional number of transgender, gender non-binary, and LGBTQ+ people.

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