FSG SOCIAL IMPACT ADVISORS

Phase I Findings:
Homelessness Landscape Research

Prepared for

Conrad N. Hilton Foundation

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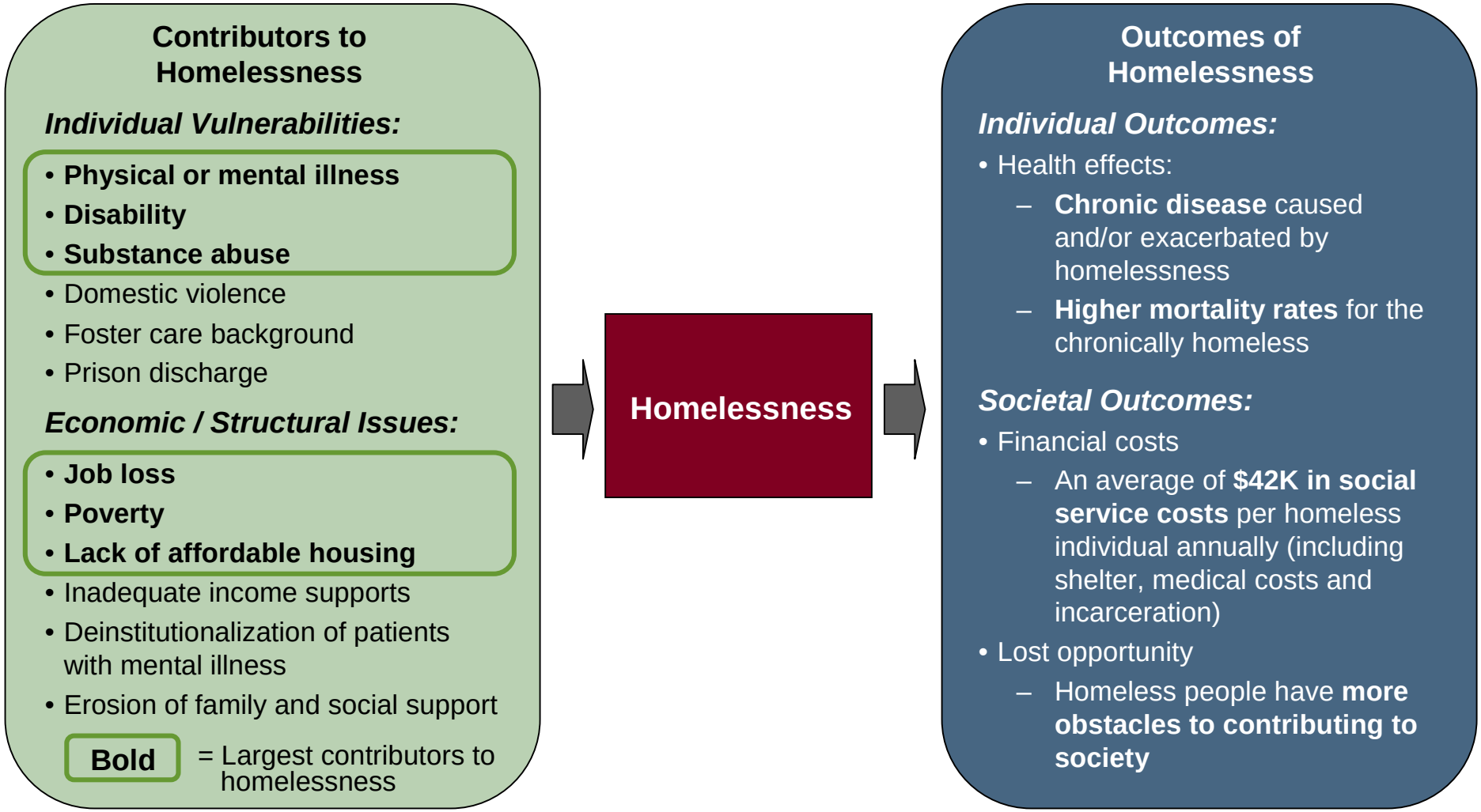
Boston • Geneva • San Francisco • Seattle

Structural and Individual Factors Contribute to Homelessness Yielding a Variety of Negative Outcomes



Sources: National Policy and Advocacy Council on Homelessness (NPACH) website; *An Environmental Scan of Homelessness,* Wertheimer, 2006. NAEH website. Perlman, Jennifer and John Parvensky. *Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report,* Colorado Coalition for the Homeless, 2006.

The Chronically Homeless Are the Most Vulnerable and Most Costly of All Homeless Populations

Definition of Chronic Homelessness:[1]

"An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years."

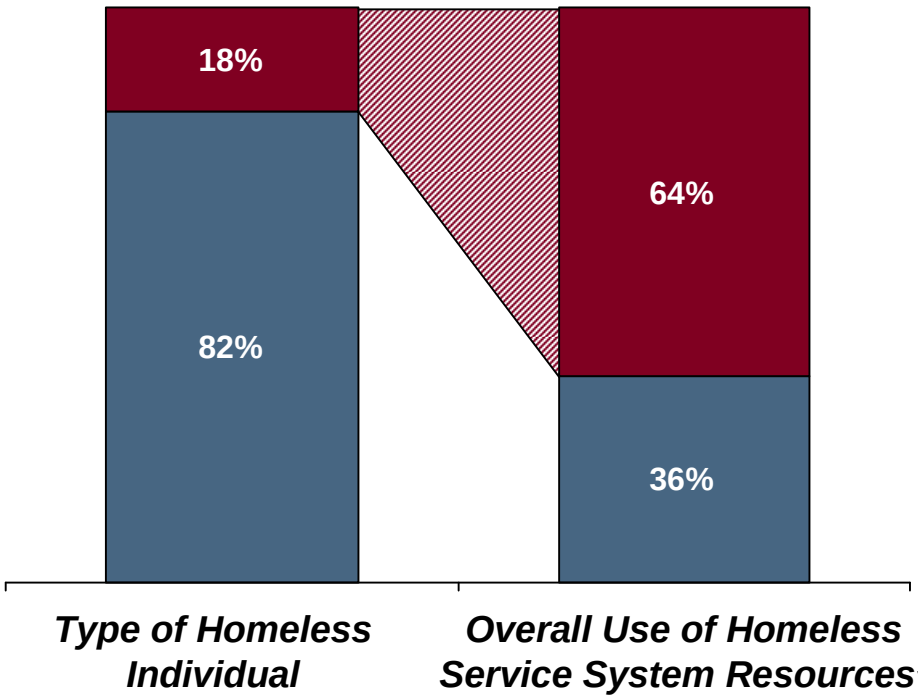
Chronically Homeless Population

Enter shelters a total of 2-5 times per year, spending between 60 and 280 days per stay. This group utilizes approximately 65% of system resources.

Transitionally Homeless Population

Enter shelters only once or twice, stay just over a month, and do not return.

Homeless System Resource Use By Type of Homeless Population[2]



[1] Note that definition may be changing to include chronically homeless families. [2] Assumes that Culhane's 1998 definition of the "episodically homeless" population qualifies as chronically homeless based on HUD's current definition. [3]The Homeless Service System includes use of shelters, medical care, and other services. Sources: National Policy and Advocacy Council on Homelessness (NPACH) website; NAEH website; Culhane, Dennis and Randall Kuhn. *Patterns and Determinants of Public Shelter Utilization among Homeless Adults in New York City and Philadelphia,* Journal of Policy Analysis and Management, Vol. 17, No. 1 (Winter, 1998), pp. 23-43.

The Chronically Homelessness Also Have More Severe Health Outcomes than Those Experienced By the General Population

Chronic medical conditions are both caused and exacerbated by long-term homelessness:

- Lack of access to refrigeration for medications
- Prescribed diets compromised by limited menu choices at food banks or shelters
- Getting adequate rest is challenging when shelters close early in the mornings
- Greater exposure to extremes of heat and cold
- Greater exposure to contagious illnesses
- Rates of high risk behaviors are much higher when people are homeless[1]

Health Outcomes

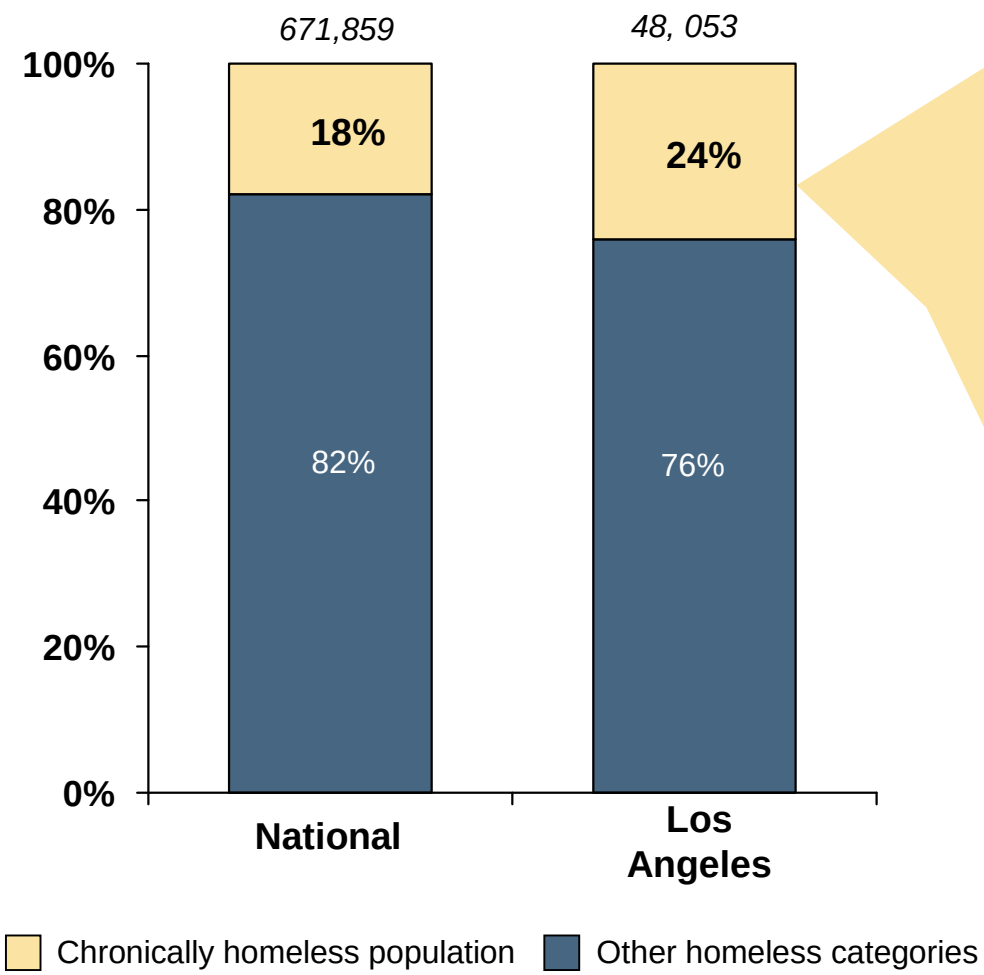
- Incidences of **HIV/AIDS, hepatitis, tuberculosis, asthma, diabetes, and hypertension** are higher among the chronically homeless
- People who have serious mental illness are especially at risk. **This population dies an average of 25 years sooner than other Americans** due to co-occurring chronic diseases which are more prominent and harder to treat on the streets[2]

Meanwhile, the homeless population is aging – threatening more dire outcomes

- As many as **one-third** of homeless single adults are **between the ages of 55 and 64**
- Among homeless adults, the **median age increased from 37 in 1990 to 46 in 2003**[3]
- Aging homeless people develop chronic diseases **10-15 years earlier than housed populations** with similar demographic characteristics.

[1] High risk behavior defined as needle sharing, unsafe sex, trading sex for money or a place to stay. [2] Chronic diseases include asthma, diabetes, cancer, heart disease, and cardiopulmonary conditions. [3] **Representative data from a San Francisco study – similar trends have been documented in L.A.** Source: "Health Care Reform: Solutions That Make Sense," CSH, March 2009, Accessed through NAEH website: 6/29/09.

L.A. is the Homeless Capital of the Nation and Has a Greater Proportion of Chronically Homeless Individuals

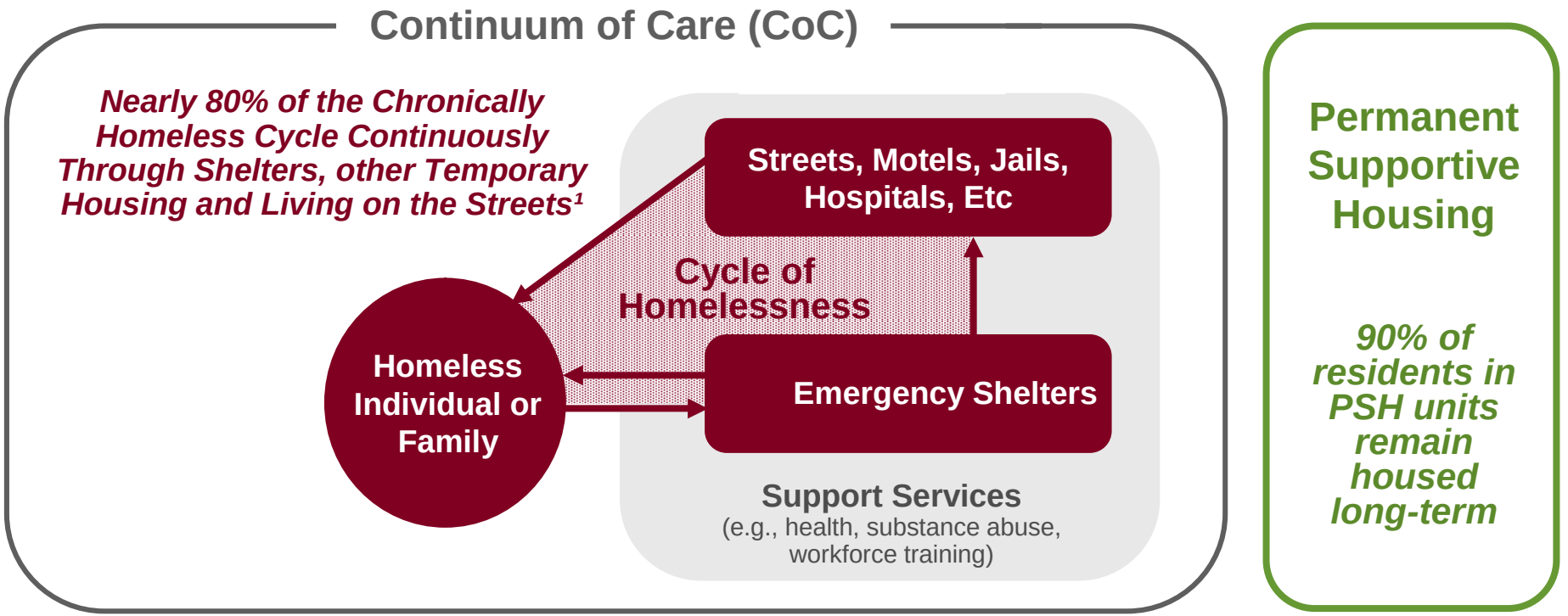


Characteristics of Chronic Homelessness in L.A.

- **Total chronically homeless** population in Los Angeles **~12,000**
- 93% of chronic homeless are **unsheltered** (sleep on streets or in parks, cars, abandoned buildings)
- 24% of all L.A.'s homeless population have a **mental illness**

Source: 2009 LAHSA Count

80% of L.A.'s Chronically Homeless Population Are Stuck in a Cycle of Homelessness, However, PSH Can Provide an Effective Alternative



PSH is proven to be more effective than shelters or service-only programs at helping the most difficult to house individuals escape the homeless cycle

[1] Calculated by dividing the total point in time chronically homeless population (28K) by the sum of this population and the number of current PSH units available (assumed to equal the number of housed chronically homeless individuals). Sources: Cunningham, Mary. *Preventing and Ending Homelessness – Next Steps.* Urban Institute, Feb 2009.

PSH – While a Relatively New Approach – Is Widely Acknowledged As the Most Effective Solution for Addressing Chronic Homelessness

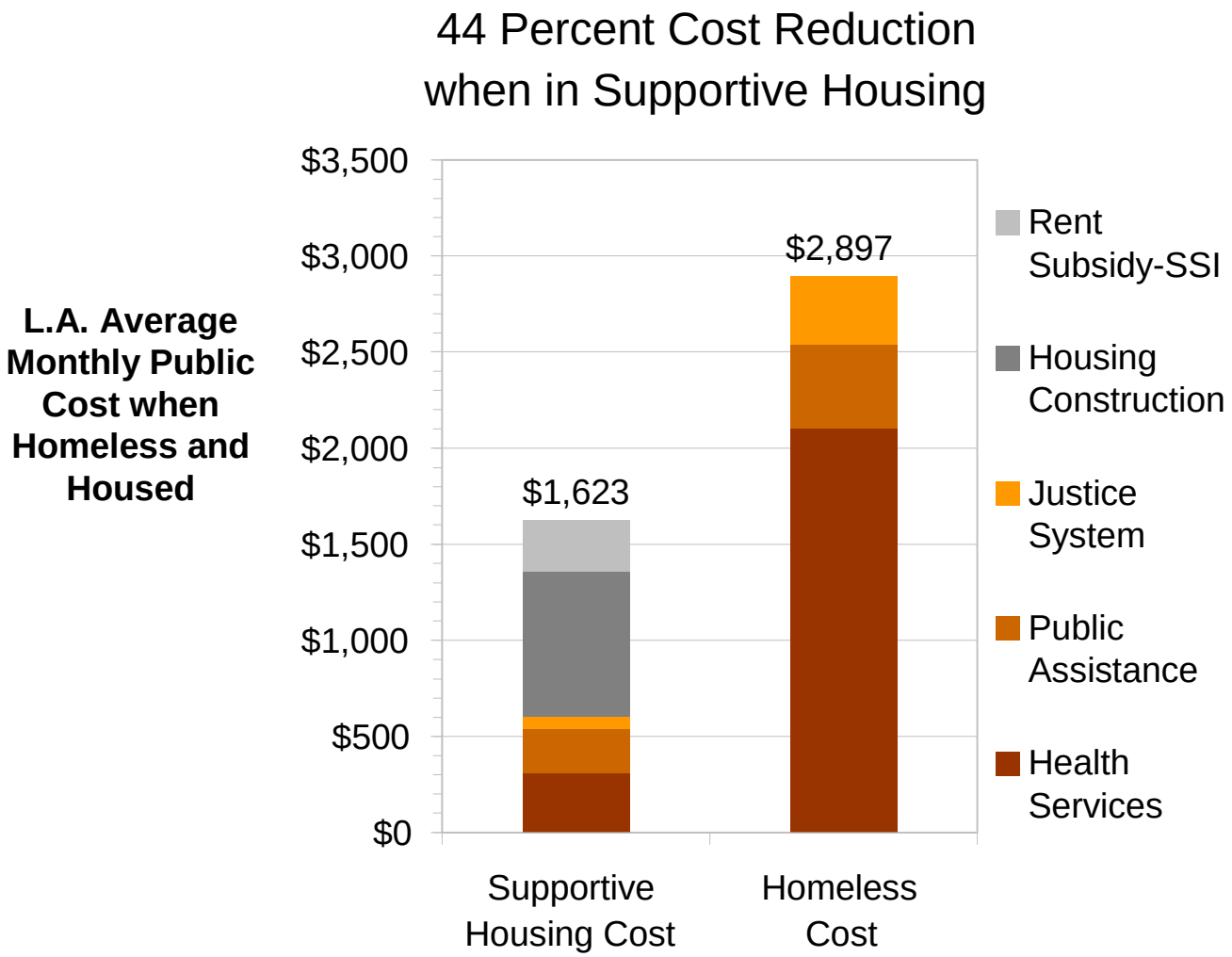
Research Findings Demonstrating the Effectiveness of PSH

	Minnesota *2009*	Illinois *2009*	Massachusetts *2008*
Approach	Evaluation of the **effect of supportive housing on people who had the most complex needs** and the longest histories of homelessness, and who had not been helped by other programs.	Two-year study of 177 individuals in Illinois, **comparing use of publicly-funded services** two years before entering supportive housing to two years after entry.	Pilot Housing First program placed **130 chronically homeless individuals in permanent supportive housing**. An evaluation of this study is ongoing. Preliminary results are documented below.
Result	Supportive housing **significantly improved residential stability and decreased mental health symptoms and alcohol and drug use**.	**39% cost reduction in the use of public services,** such as inpatient mental health care, nursing homes, and criminal justice. Total 2-year cost savings of more than $850K.	**Costs per person, including the cost of housing and services**, **decreased by 29%.** Most of these savings are a result of a **drastic decrease in inpatient medical care.**

Overall, PSH results in better mental and physical health, greater income, fewer arrests, better progress toward recovery and self-sufficiency, and less homelessness

Sources: *The Minnesota Supportive Housing and Managed Care Pilot: Evaluation Summary,* Hearth Connection, March 19, 2009. *Supportive Housing in Illinois: A Wise Investment,* Heartland Alliance Mid-America Institute on Poverty, April 1, 2009. *Massachusetts Premier Housing First Initiative,* Massachusetts Housing and Shelter Alliance, Februrary 15, 2008. All accessed through Funders Together website.

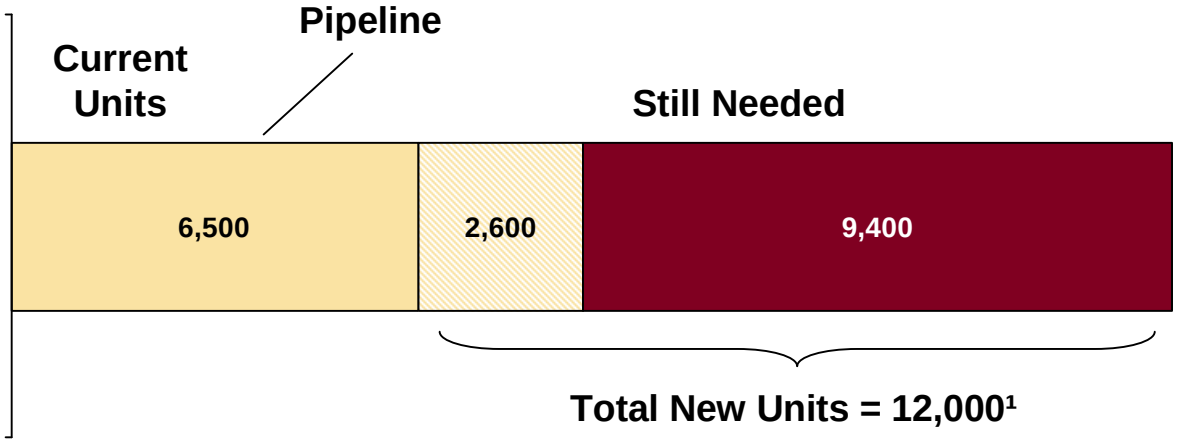
A New Study Finds That After Rent Subsidies and Capital Costs, Public Costs in L.A. Decrease By 44% with Supportive Housing



Source: Economic Roundtable, *Where We Sleep*

In Total, L.A. Needs 12,000 PSH Units at a Ballpark Cost of $280M Annually and, Assuming 50% New Construction, $2B for Development

PSH Units Needed to House the Chronically Homeless Population in L.A.[1]



Key Assumptions:

- *$375K construction cost per new unit*
- *$50K renovation per scatter site unit*
- *$7K annual operating cost per unit*
- *$7.5K annual services cost per unit for chronic and TAY populations*
- *$12.5K annual services cost per family unit*
- *50% scattered site units*

Funding Required to Bring 28K New Units Online[2]

	New Construction	Scatter Site
Capital Total[2]	**$1.8B**	**$200M**
Total	**$2B**	

	Today[3]	With New Units
Operating	$45M	$130M
Services	$55M	$150M
Annual Totals	**$100M**	**$280M**

[1] The 2009 LAHSA Homeless Count Summary cites there are 10,245 chronically homeless individuals in the L.A. Continuum of Care. This figure has been expanded to 12,000 to account for individuals in other L.A. County CoCs. For both new and existing units, assumptions are a break-down of 87% general chronic, 6% TAY, 7% families. [2] Assumes that 2,600 units in pipeline have already raised necessary capital. [3] Operating and Services costs "Today" apply to 6,500 current units while "With New Units" applies to 18,500 total units, including current, pipeline, and needed units. As of 2007, only $28.6M in operating funding and $9.4M in services was reported, suggesting that the required amounts here may be inflated. Sources: Burt, Martha. "Taking Health Care Home: Evolution of PSH in the THCH Communities 2004-2007", *CSH Evidence Series,* Feb 2008; FSG Interviews.

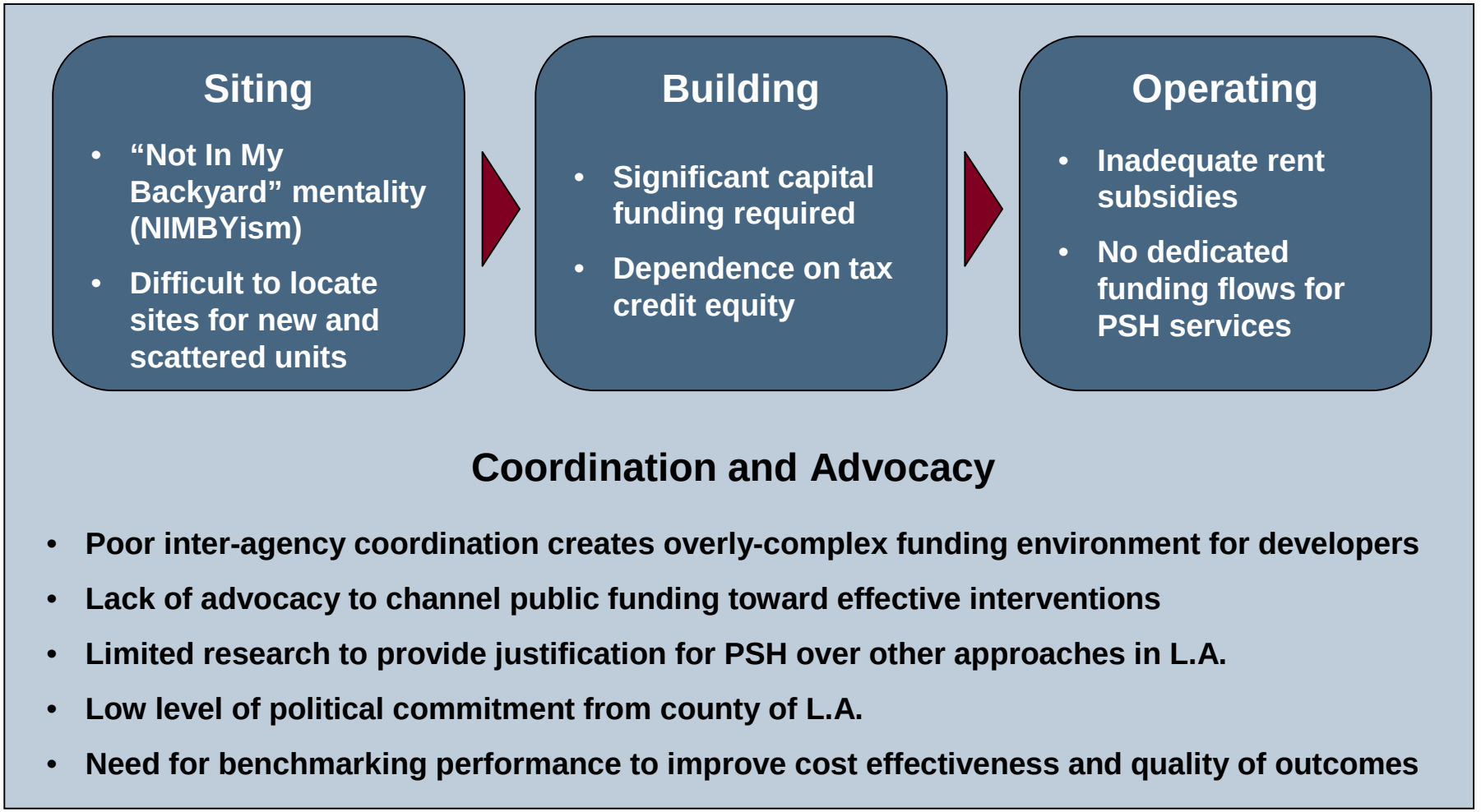
The Capital, Operating, and Services Categories Cover a Broad Range of PSH Costs

One-time Capital Costs ····· *Annual Costs* ····▶

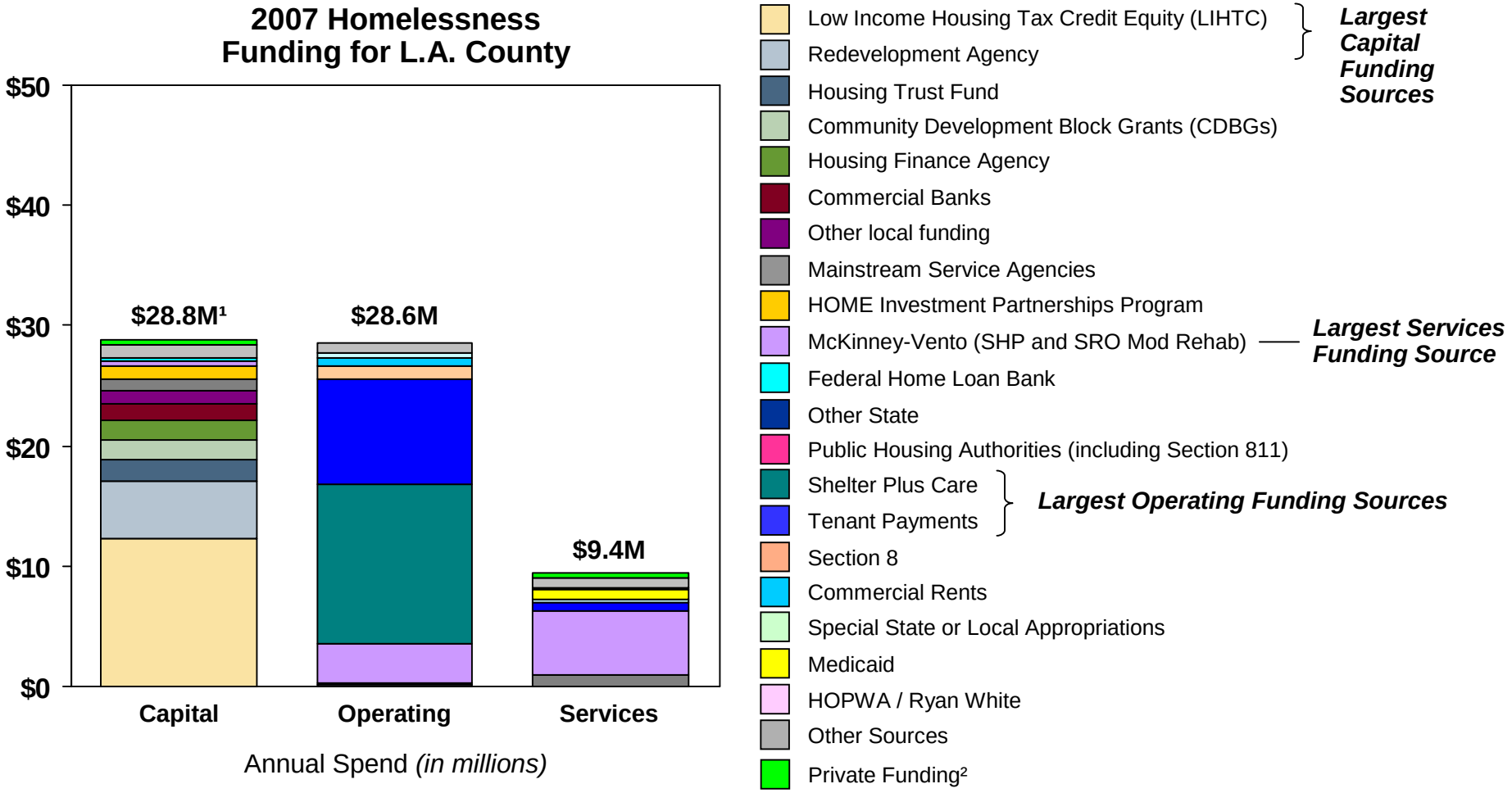
	Acquisition and Soft Costs	Hard Costs	Operating	Services
Example Line Items	• Land • Architect • Financial consultants • Lawyers • Interest payments • Holding costs • Insurance	• All costs related to construction	• Utilities • Security • Janitor • Landscaping • Insurance • Manager to coordinate service providers	• Mental health • Employment • Primary healthcare • Substance abuse counseling • Case management
Cost per Unit	$150K	$225K	$7K	$7.5K - $12K
Main Funding Sources	• CDFIs • State programs	• Banks	• Shelter Care Plus • Tenant payments • SHP • Section 8 Vouchers	• SHP • Medicaid • Mainstream agencies • Philanthropy

Source: FSG Interview with CSH

The PSH Field Also Faces Significant Long-Term Challenges That Will Need to Be Addressed



A Complex Assortment of Public Funds, Loans, and Tax Credits Dwarf Private Funding Contributions to Homelessness

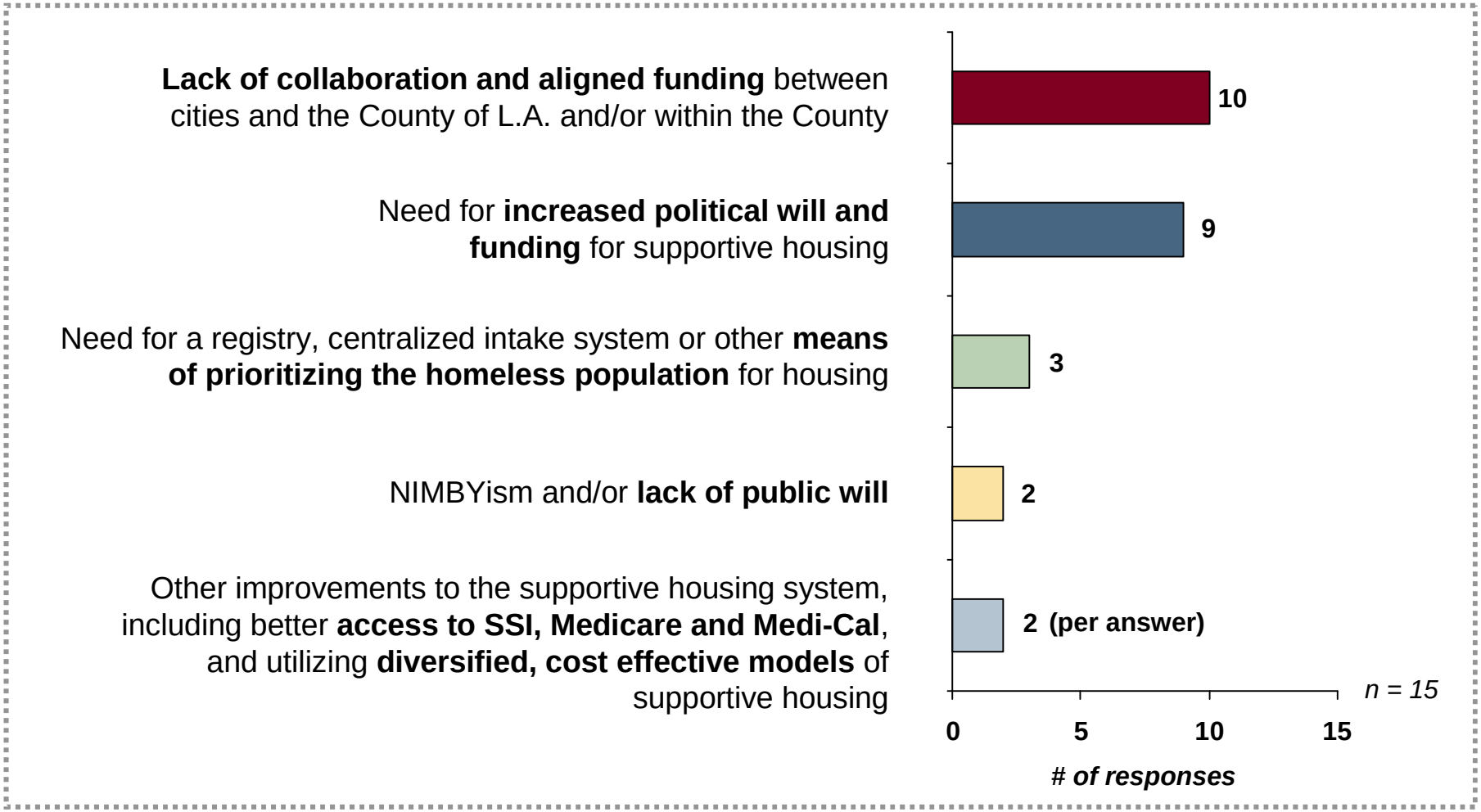


Due to the current economic crisis, tax credits – one of the largest source of funding – are diminishing, which may create a significant funding gap in coming years

¹ Capital funding amount was made into an annualized figure by taking the total amount reported in the 2007 survey by all projects ($550M) and dividing by a 20 year amortization period. While this is an artificially simple calculation, it gives a sense for the proportion of funding from different sources. Operating and Services amounts were reported based on annual figures. ² Private funding accounts for $400K in capital and $500K in services dollars. Sources: Burt, Mart;y. *Evolution of PSH in THCH Communities: 2004-2007*, CSH, Feb 2008. Overviews of Formula and Competitive Grants for L.A. County accessed on HUD website, FSG Interviews and Homeless Funders Group Survey.

Interviewees Pointed to Several Issues That Hinder the Creation and Operation of Successful Supportive Housing in L.A.

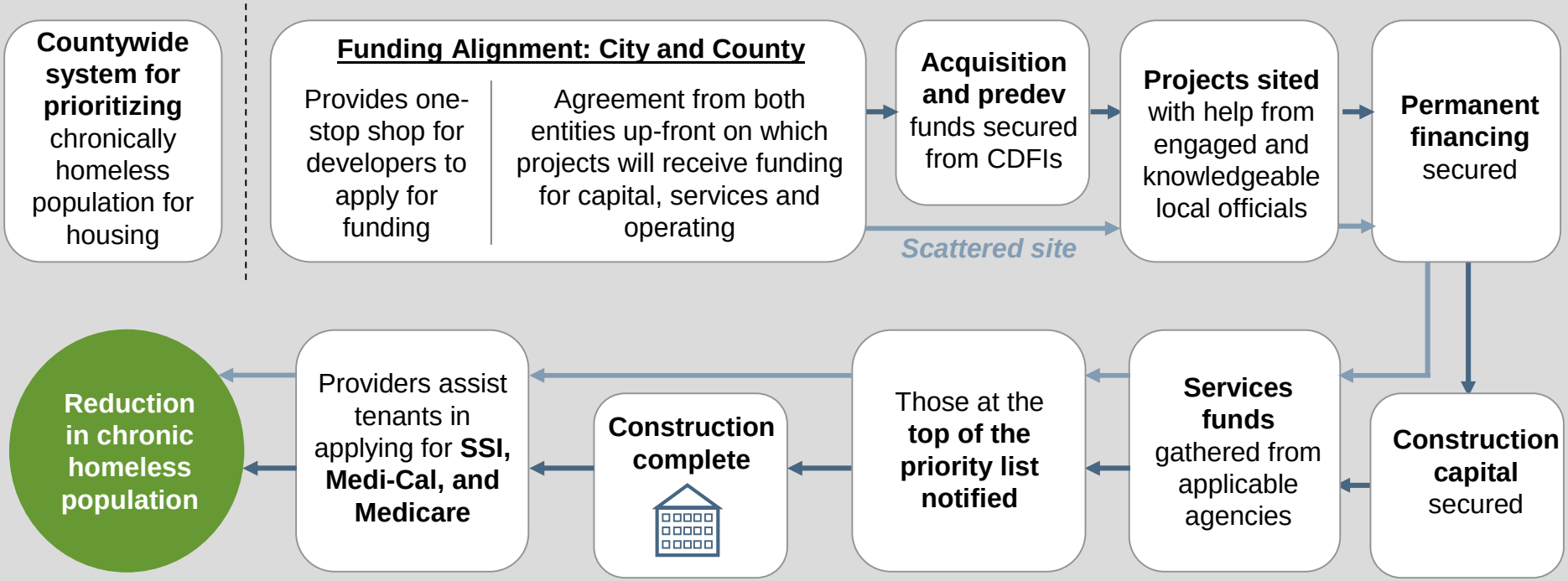
Interviewee responses to the question "What do you feel are the biggest challenges in L.A. to the success of supportive housing?[1]



Source: FSG Interviews with 15 representatives from the county, city, philanthropic and research communities

These Responses Suggest That A Comprehensive System Where All Players Are Aligned Would Be More Effective and Efficient

Comprehensive Supportive Housing System



Underlying agreement among public and private stakeholders:

- that the **most vulnerable will be prioritized** for supportive housing (and on how "most vulnerable" is defined),
- on quantified **goals for reduction in the chronically homeless population**, and on the **timeline** for goals to be met
- on quantified **goals for the number of supportive housing units** with wrap-around services that will be produced or provided and
- on **funding commitment by agency**

Source: FSG Interviews and Analysis

To Create Such a System, Several Key Components Are Necessary

- **Political will** – i.e. educated public officials who understand the costs of the chronically homeless population and the importance and effectiveness of supportive housing to address this population
- **Agreement from all players** on supportive housing unit production and placement goals, the approach that will be taken to meet those goals, and the role that each stakeholder will play to get there
- **Aligned funding flows** to minimize complexity for developers (align capital, operating, and service dollars) and more efficiently utilize public resources (utilization of SSI and other benefits, increase in the number of housing vouchers)
- **Coordinated prioritization** that ensures the appropriate population is identified and given precedence for housing (e.g., through a centralized intake system)
- **Increased capacity of developers and providers** to target the most vulnerable and provide appropriate level of services to ensure housing stability and cost-effectiveness
- **Data management, research and evaluation** to measure progress and share knowledge with the field

A Model Like the NY/NY Agreement or the Washington Families Fund Could Potentially Align Stakeholders and Increase Collaboration

Model	NY / NY Agreement	Washington Families Fund
Key Players	• State of NY • New York City	• State of WA • Three counties • Three cities • Philanthropic and corporate funders
Basic Details	• Commitment from State and City to create 9,000 units of supportive housing by 2016 for a variety of disabled homeless people in New York City • Outlines specific production targets for new construction and scattered site units by population to be served	• MOU through which the involved players commit to reduce the number of homeless families in WA by 50% by 2019 • All parties agreed to redouble efforts to minimize shelter stays, better coordinate services to meet needs of families, align existing funding streams and, where possible, tap new resources

More detail on these agreements can be found in the Appendix

The NY/NY Agreement

Timeline	Initiative Description
NY/NY Agreement *(1990)*	• **Historic joint effort** by the State and City that created 3,615 units of supportive housing and licensed permanent and transitional housing for homeless mentally ill people in New York City • It was **largest housing initiative for homeless mentally ill individuals in history** and provided Dennis Culhane and his colleagues an extremely large group on which to base their first cost study
NY/NY Agreement II *(1999)*	• Committed the City and State to creating an **additional 1,500 units** of supportive housing • In 2001, Culhane's cost study was published, documenting that supportive housing for the mentally ill in NY translates to a **service reduction savings of $16K per person** which covers 95% of the costs of building, operating and providing services in these units
NY/NY Agreement III *(2005)*	• In November 2005, Mayor Bloomberg and Governor Pataki signed the third NY/NY Agreement, committing to **create 9,000 units of supportive housing by 2016** for a variety of disabled homeless people in New York City • Through the agreement, the City and State agree to commit and/or identify the capital, operating, and services expenses associated with these units; in the first iteration of the NY/NY Agreement, this translated to the state and city allocating a total of $195M in capital funds • The document also outlines **specific production targets for new construction and scattered site units** by population to be served • An oversight committee was established and meets quarterly to ensure that the objectives are met • Through the agreement, a task force was also created to identify **mechanisms to give priority** to clients who use a disproportionate amount of Medicaid-funded or other publicly funded services

Sources: FSG Interviews; Houghton, Ted. "A Description and History of the New York / New York Agreement to House Homeless Mentally Ill Individuals," accessed on the Supportive Housing Network of NY website: www.shnny.org; "New York / New York Agreement," www.PolicyOptions.org

The Washington Families Fund

Timeline	Initiative Description
Sound Families Initiative ***(2000)***	• Launched in 2000 with a $40M commitment from Gates to build 1500 units of service-enriched transitional housing for homeless families in 3 Washington counties[1] • Required local public funder support before Gates would make donation. In all, Gates' $40M leveraged an additional $220M
Washington Families Fund ***(2004)***	• MOU established in 2004 to expand Sound Families across the state and to secure long-term funding from the state. Building Changes was selected as nonprofit administrator • $5M in initial funding ($2M from State with $1M Gates match and $1M from private foundation with $1M Gates match). To date, the Fund has received a total of $20.3M[2]
Washington Families Fund ***(2009)***	• In March 2009, the State of WA, three counties, three cities and several philanthropic and corporate partners signed a new Washington Families Fund MOU. It had taken Gates **18 months of 1-on-1 meetings to educate and achieve buy-in from public officials** • The goal of the MOU is to **reduce the number of homeless families in WA by 50% by 2019** • All parties agreed to redouble efforts to minimize shelter stays, **better coordinate services** to meet needs of families, **align existing funding** streams and, where possible, **tap new resources** • Investments are funding **three pilot programs** in King, Snohomish, and Pierce Counties that utilize 1) early intervention/prevention, 2) coordinated access to support services, 3) Rapid re-housing, 4) tailored programs, and 5) increased economic opportunity • Gates has pledged $60M to the initiative; unclear how much additional funding will be leveraged, however, Gates has stated it will **only contribute through incentive grants**

[1] A 2007 evaluation of the Sound Families Initiative shows that 1,445 units were funded, the majority of which implemented a transitional housing model. [2] $12M from the State and $8.3M from 18 private funders. Sources: FSG Interviews, Building Changes website: www.buildingchanges.org