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Evaluation of the Conrad N. Hilton Foundation Chronic Homelessness Initiative

2012 Report

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Table of Contents

Executive Summary

Abt Associates Inc. was contracted by the Conrad N. Hilton Foundation in September 2011 to conduct an evaluation of the Hilton Foundation's Chronic Homelessness Initiative, a strategy designed to reduce and eliminate chronic homelessness within the Los Angeles County region. Since the beginning of the Initiative in January 2011, the Foundation has distributed nearly $18 million in multi-year grants to 14 nonprofit groups working in Los Angeles. The grants are focused on regional systems change and capacity-building, targeted programs to house and serve chronically homeless individuals, and dissemination of knowledge on emerging and evidence-based practices to prevent and end chronic homelessness.

The evaluation is intended to answer the overarching question: ***Is the Chronic Homelessness Initiative an effective strategy to end and prevent chronic homelessness in Los Angeles County?*** The evaluation will provide both interim milestones related to improving the systems designed to house and serve people experiencing chronic homelessness and estimates of the effect of the development and operation of permanent supportive housing (PSH) on its residents and on chronic homelessness itself.

The Foundation articulated the following five-year strategic goals for the Initiative, significant milestones toward the goal of ending and preventing chronic homelessness in Los Angeles:

- **Demonstrated action by elected and public officials** to support a systemic approach to addressing chronic homelessness;
- **$15 million in private funds** allocated directly toward PSH;
- **$75 million in public sector funds** realigned toward PSH;
- **3,000 new PSH units** constructed or in the development pipeline;
- **1,000 scattered site PSH units** made available with necessary operating and service funding;
- **1,000 of the most vulnerable** chronically homeless persons housed in PSH;
- **A system of prioritizing** chronically homeless persons for PSH in place; and
- **Increased capacity** of developers and providers to provide PSH effectively.

The goals and the Foundation's associated grant investments reflect an underlying theory of what the Hilton Foundation thought was needed in order to address chronic homelessness in Los Angeles. The evaluation team documented the unspoken rationale behind the investments in a Theory of Change, developed through discussions with Foundation staff and other key stakeholders. Briefly, the theory is that to end chronic homelessness, Los Angeles needs significantly more PSH resources and a formal system of linking chronically homeless individuals with available PSH based on well-established priorities for identifying who is chronically homeless and who among those should be placed in housing first. Further, the theory recognizes that to develop more PSH resources, the community will need consensus that PSH should be a priority, political will to overcome funding and siting battles that have hampered wide-spread development of PSH in the past, commitments from funders to develop the units needed, and increased capacity among housing and service providers to effectively target PSH to chronically homeless people.

This document provides the evaluation team's report on the first 18 months of the Initiative, covering actions undertaken and results accomplished from January 2011 through July 2012. The report provides

an assessment of each of the goals within the context of the Theory of Change. Each goal is examined in relation to whether there is sufficient data to adequately measure progress on the goal and then, if possible, the extent to which each goal has been attained.

The assessment is based on: information collected from 460 local stakeholders through a web-based survey; interviews with 50 people representing 43 public and private non-grantee organizations; interviews with 30 people from the Foundation's 2011 grantees; 4 focus groups with formerly homeless PSH residents; analysis of data from Hilton Foundation grantees – especially Home For Good, the Corporation for Supportive Housing, and Community Solutions; analysis of Los Angeles Homeless Services Authority (LAHSA) point-in-time count estimates; and independent documentation of other local actions and events. Data were reviewed and cleaned by the evaluation team, and validated against other sources when available.

Progress on Hilton Foundation Initiative Goals

Exhibit 1 summarizes the evaluation team's findings, using color-coding to depict areas that are moving ahead well (green) and areas that are moving slower than anticipated (yellow). The exhibit is followed by a brief discussion of the team's observations related to each goal.

Exhibit 1. Summary of Progress on Hilton Foundation Initiative Goals, July 2012

Progress on Goal to Build Demonstrated Action by Elected and Public Officials to Support Addressing Chronic Homelessness	***Data Availability:*** Stakeholder survey establishes a baseline to compare changes in consensus and to document actions moving forward	
	Status in 2012: Progress in building support, but limited demonstrated action	
Progress on Goal to Leverage $90 million in Private and Public Funds toward PSH	***Data Availability:*** Financial data are available for grants allocated in conjunction with the Funders Collaborative; more information is needed to calculate other commitments	
	Status in 2012: On track to meet or exceed five-year financial commitment goals	
Progress on Goal to Create 4,000 units of PSH	***Data Availability:*** Figures for PSH inventory are available; tracking is not centralized and various sources provide differing information, leading to concerns that data is inaccurate	
	Status in 2012: Surpassed one-fifth of goal in 2011/12; on track to meet or exceed goal, but the goal may need to be revised	
Progress on Goal to Establish a System of Prioritizing Chronically Homeless Persons for PSH	***Data Availability:*** Estimates are available, but more work is needed to develop verifiable data systems	
	Status in 2012: Getting started; current system relies on separate PSH provider-managed placements	
Progress on Goal to House 1,000 Most Vulnerable Chronically Homeless Persons in PSH and Prevent 1,000 Persons from Becoming Chronically Homeless	***Data Availability:*** Figures for chronically homeless placements are available, but more detailed accounting is needed; more information is needed for other vulnerable populations	
	Status in 2012: Surpassed five-year chronic homeless placement goal in 2011	***Status in 2012:*** Made progress on prevention goal, but results are not clearly documented
Progress on Goal to Increase Capacity of Developers and Providers to Effectively Provide PSH	***Data Availability:*** Stakeholder survey establishes a baseline to compare changes in perceived capacity, but there is no clear consensus among partners on how to define, much less measure, capacity of developers and providers	
	Status in 2012: Limited documentable progress	

Progress on Goal to Build Demonstrated Action by Elected and Public Officials to Support Addressing Chronic Homelessness

While this goal is challenging to measure definitively, the evaluation team found much evidence of consensus among key stakeholders that PSH is an important part of the solution to chronic homelessness in Los Angeles. Of the 331 respondents who completed the web-based stakeholder survey, 88 percent either indicated that PSH is a good idea and that there should more of it throughout Los Angeles or identified themselves as avid champions of PSH. Stakeholders demonstrated an understanding of PSH by consistently identifying key elements of PSH in their responses to the survey. While the majority of respondents noted their agreement with housing first and harm reduction sentiments, there was less consensus on these concepts than on PSH more generally.

Progress on the goal to build demonstrated action by elected and government officials to support addressing chronic homelessness was evidenced by endorsement of the Home For Good plan to end

chronic homelessness by the City and County of Los Angeles as well as several other cities in the county and by discretionary spending through LA County's Homelessness Prevention Initiative and funding commitments from the County Board of Supervisors. There was a significant level of public sector participation in the Home For Good Funders Collaborative, resulting in greater alignment of public funds for PSH with private funding. Public sector partners were the LA City Housing Department; the LA County Departments of Mental Health, Health Services, and Public Health; the Housing Authorities of the City and County of LA (HACLA and HACoLA); and the City of Pasadena.

Progress on Goal to Leverage $90 million in Private and Public Funds toward PSH

Local stakeholders are on track to meet this goal before the end of the five-year period. In the past 18 months, partners have successfully established a Home For Good Funders Collaborative to pool and leverage public and private funding. In 2012, private funders committed $4 million to match the $1 million in seed funding that had been provided by the Hilton Foundation and directly leveraged almost $56 million in public funding, primarily funding for tenant-based vouchers and two-year service commitments, all of which were allocated through a common Funders Collaborative RFP. Another $44 million in public funds has been committed to support development of PSH and is aligned with the Home For Good efforts but is not directly allocated through the Collaborative.

Progress on Goal to Create 4,000 units of PSH

Funders and providers have made significant progress on PSH unit production and voucher and service commitments and have surpassed the 4,000 unit goal in terms of funding for the housing component of PSH. The community has had very strong success in securing tenant-based voucher commitments, with services provided through public mainstream agencies and service gaps filled in part by the newly established Funders Collaborative. However, all acknowledge that much more is needed to meet the 8,000 unit shortfall to address chronic homelessness in Los Angeles. Furthermore, current commitments may not allow stakeholders to house some of the most vulnerable on the streets, including those who do not meet the specialized eligibility criteria associated with more than half of the new vouchers dedicated to chronically homeless individuals (e.g., vouchers set-aside for chronically homeless veterans and persons with HIV/AIDS) and those who are located in certain geographic areas of the region.

Progress on Goal to Establish a System of Prioritizing Chronically Homeless Persons for PSH

Substantial work is underway to establish systems to identify and prioritize chronically homeless people for PSH. Two primary approaches are being employed to identify chronically homeless people, the most vulnerable among them, and to some extent people with high needs who are at risk of becoming chronically homeless. 1) Community Solutions is working with communities throughout the county to conduct Vulnerability Index Registries to count and assess the relative vulnerability of people on the streets as a basis for estimating need and creating a list of individuals to prioritize from. 2) Several initiatives such as Project 50, Project 60, and the Frequent Users Systems Enhancement pilot use administrative data to identify the top homeless users of mainstream systems in order to prioritize housing to those using mainstream systems in ineffective and expensive ways (and who would presumably have better health outcomes and lower costs if housed in PSH). The county is working to develop data sharing systems that could potentially be used to establish a more regular system of identifying frequent users of these systems for purposes of analysis and prioritization.

While identification efforts are increasingly in place, the next step of using the data to proactively place chronically homeless individuals in housing is not as far along, even when units are explicitly set-aside for chronically homeless persons. Twenty-two percent of the 85 PSH providers surveyed indicated that

they select tenants from a shared registry or priority list for their community, whereas 63 percent of providers make admission decisions based on provider-specific application processes. The other nine percent have developed processes of referrals that reflect shared priorities for placement in PSH with other providers.

Progress on Goal to House 1,000 Most Vulnerable Chronically Homeless Persons in PSH and Prevent 1,000 Persons from Becoming Chronically Homeless

PSH providers reported that 2,162 chronically homeless individuals were placed in PSH in 2011, more than double the five-year goal. Almost one-quarter of these individuals were housed by Hilton Foundation grantees (though not necessarily with Hilton grant funds), and nearly half of the placements were reported by Veterans Affairs of Greater Los Angeles and undoubtedly reflect the use of Department of Housing and Urban Development Veterans Affairs Supportive Housing (HUD-VASH) program vouchers to house chronically homeless veterans. The number of chronically homeless individuals placed this year represents 20 percent of the total number of chronically homeless persons estimated by the 2011 point-in-time count.

While promising pilots are in place that focus on developing strategies to prevent chronic homelessness by special populations, actual progress on the prevention goal will not be evident until the strategies have been implemented more fully. Concurrent with implementation of these pilots, stakeholders need to work on a process to document efforts to prevent chronic homelessness, such that progress can be reasonably measured.

Progress on Goal to Increase Capacity of Developers and Providers to Effectively Provide PSH

Meeting the other goals of the Initiative that focus on increasing the supply of PSH and increasing targeting of PSH units to those with higher needs is dependent upon having a cadre of PSH providers with the capacity to develop PSH and to provide it effectively to chronically homeless individuals. Efforts are underway to increase capacity on the development side as well as the operating and services side, but there is no clear consensus about how to define capacity much less how to document and measure it. Two thirds of the PSH developers responding to the stakeholder survey indicated that it has become more difficult to develop PSH, but they cited funding loss as the reason for the increased barrier rather than a lack of skills. However, there is broad agreement among stakeholders in Los Angeles that more developers need to cultivate the capacity to produce PSH in underserved areas of the County such as the San Gabriel Valley, the Gateway Cities, and South LA.

On the operating and services side, challenges in securing funding also were cited as the major barriers to effectively providing PSH to a chronically homeless population. However, the evaluation team also identified capacity gaps related to provider skills in the areas of prioritization strategies, techniques to shorten housing placement processes, provision of PSH with a housing first philosophy, and delivery of services to address social connectedness and landlord relations.

Another important area in which PSH provider capacity needs to be strengthened relates to measuring tenant health outcomes over time. PSH providers are actively working on their capacity to serve more vulnerable residents, and they are presuming that their services and housing will result in health improvements, reduced vulnerability, and lower medical costs, but the processes to measure such changes are not in place.

Recommendations

Several recommendations for improvement emerged from our assessment. These recommendations fall into three broad categories:

- Data collection efforts that will result in better tracking to inform planning, decision-making, accountability;
- Opportunities to improve the performance of systems to achieve the goals of the initiative; and
- Considerations for long-term leadership of efforts to end chronic homelessness.

Activities in all of these areas are already underway at some level within LA, but we repeat the recommendations here to reinforce their importance to the Initiative.

Recommendations Related to Data Collection

Data are at the heart of the Chronic Homelessness Initiative to support local planning, to benchmark progress on local efforts, and to support real-time service delivery. To ensure consistent, readily available data for the Initiative, we recommend that local stakeholders:

1. Specify definitions across organizations to guide counting and classification of permanent supportive housing, individuals who are chronically homeless, and individuals at risk of chronic homelessness because they are highly vulnerable.
2. Create a central database of information on project-based and scattered site permanent supportive housing that clearly tracks project-based projects and scattered site programs from pipeline to available status.
3. Define methodologies, ideally using the Homeless Management Information System (HMIS) or integrated into the HMIS infrastructure to track and report client outcomes for housing placement and retention.
4. Similarly, define methodologies to track and report client and improvements in health.
5. Create a transparent central accounting of resources leveraged by the Initiative to ensure consistent reporting of funds, including financial contributions and in-kind service commitments.
6. Consider revising the housing placement goal to align with unmet need.

Recommendations Related to System Performance

To expand and strengthen the impact of efforts to end chronic homelessness, we recommend that local stakeholders:

1. Create more intentional bridges between the parts of the homeless system designed to identify people who are chronically homeless and the PSH operators or service providers who are tasked with leasing PSH properties. Efforts also need to be made to expedite the placement process, and this could also be supported through a systematic, more coordinated placement system.
2. Cultivate PSH partnership or mentoring models to expand PSH provider capacity and reach, by marrying experienced PSH providers with less knowledgeable ones, perhaps targeting underserved communities.
3. Continue efforts to engage smaller public housing authorities and maximize opportunities with HACLA and HACoLA to designate more vouchers for chronically homeless and prioritize chronically homeless individuals for non-designated Housing Choice Vouchers.

4. Continue to address funding gaps for services through the Funders Collaborative or other systematic processes to align housing and service resources at the project-level, including strategies to fully utilize Medicaid as a funding source. The Funders Collaborative could be pushed further to augment services in areas that cannot be funded by other public sources or for specific client groups.

5. Consider whether other PSH and service models, like the Critical Time Intervention approach being explored at Downtown Women's Center, would be viable ways to address chronic homelessness at lower costs or would enable providers to more easily tap Medicaid and other funding sources.

6. Foster the development of more peer support programs to pair clients who have successfully made the transition into permanent housing from the streets, such as models currently employed by Skid Row Housing Trust.

Considerations for Long-term Leadership of Efforts to End Chronic Homelessness

The leadership provided through Home For Good has been cited universally as a very important and successful effort to mobilize non-traditional partners, to align stakeholders through a shared vision, and to hold the community accountable for results. The energy of the Home For Good campaign is probably derived in part by its short-term emphasis. The question is how Los Angeles will use this timeframe to consider how homeless resources should be managed, the type of leadership and planning needed to support local decision-making and service delivery, and how the leadership roles should be centralized or delegated among key stakeholders. Determining a long-term governance structure that meets the needs of the community seems essential to sustaining and continuing the results achieved through this Initiative.

Next Steps for the Evaluation

Over the next few months, the evaluation team will meet with the Foundation and individual grantees to review the results reported, focusing discussion with grantees on measures most directly related to their efforts. Grantees will be encouraged to consider ways to collect other information year-round that may inform their efforts and will be asked to identify other data that the evaluation team could collect that might be helpful to them in understanding and improving their results. The team will also work with grantees to develop reasonable data collection strategies to measure client-level change in housing stability and health outcomes. In addition, the team will talk with relevant parties to discuss the data challenges described in this report, as a means of helping to improve the local data collection infrastructure.

Introduction

Abt Associates Inc. was contracted by the Conrad N. Hilton Foundation in September 2011 to conduct an evaluation of the Hilton Foundation's Chronic Homelessness Initiative, a strategy designed to reduce and eliminate chronic homelessness within the Los Angeles County region. The evaluation is intended to answer the overarching question: ***Is the Chronic Homelessness Initiative an effective strategy to end and prevent chronic homelessness in Los Angeles County?*** The evaluation will provide both interim milestones related to improving the systems designed to house and serve people experiencing chronic homelessness and estimates of the effect of the development and operation of permanent supportive housing (PSH)[1] on its residents and on chronic homelessness itself.

Abt has been at the forefront of research and technical assistance aimed at reducing and preventing homelessness, applying its research and analytic expertise to help policymakers understand the magnitude and causes of homelessness and the impact and cost-effectiveness of homeless assistance programs. The Evaluation of the Chronic Homelessness Initiative is led by Brooke Spellman, Principal Investigator, and Dr. Jill Khadduri, Project Quality Advisor. The Abt team includes Jill Spangler, Carol Wilkins, Sophia Heller, and Matt White, each of whom has in-depth experience working on issues related to homelessness and permanent supportive nationally and in Los Angeles or other cities. More information on the full Abt evaluation team is contained in Appendix A.

This document provides the evaluation team's report on the first 18 months of the Initiative, covering actions undertaken and results accomplished from January 2011 through July 2012. We include the results of a survey of 460 stakeholders about their level of support for PSH as a strategy to address chronic homelessness conducted in the summer of 2012. Those results will be used as a baseline to compare changes in stakeholder perception over time.

[1] Appendix C lists terms and acronyms such as permanent supportive housing (PSH) used in this report.

1.1 Background on the Chronic Homelessness Initiative

In February 2010, the Hilton Foundation board of directors approved a Chronic Homelessness strategy. This strategy was informed by lessons learned over the past decade through the Foundation's focused investments in an Initiative to End Homelessness for People with Mental Illness in Los Angeles County, launched in 2004 in partnership with the Corporation for Supportive Housing, and earlier grant funding for innovative programs to serve homeless people in LA's Skid Row, as part of the Closer to Home Initiative. These earlier investments by the Foundation supported the development of promising new program models and helped to engage public agencies and stakeholders in developing and operating PSH. The results of those and related efforts included significant increases in the availability of PSH, declines in the number of unsheltered chronically homeless people with disabilities, and a growing recognition of the need to increase and coordinate investments in housing and services and to strengthen the capacity of communities throughout LA County to create, effectively target, and sustain PSH in ways that would achieve the goal of ending chronic homelessness.

The Chronic Homelessness Initiative launched in 2011 and is focused on grant investments and Foundation-led actions in three broad areas:

- Facilitating systems change by creating an enabling environment for PSH.
- Strengthening targeted programs and pilots through leveraged grants.
- Developing and disseminating knowledge for the field.

The Foundation articulated the following five-year strategic goals for the Initiative, significant milestones toward the goal of ending and preventing chronic homelessness in Los Angeles:

- **Demonstrated action by elected and public officials** to support a systemic approach to addressing chronic homelessness;
- **$15 million in private funds** allocated directly toward PSH;
- **$75 million in public sector funds** realigned toward PSH;
- **3,000 new PSH units** constructed or in the development pipeline;
- **1,000 scattered site PSH units** made available with necessary operating and service funding;
- **1,000 of the most vulnerable** chronically homeless persons housed in PSH;
- **A system of prioritizing** chronically homeless persons for PSH in place; and
- **Increased capacity** of developers and providers to provide PSH effectively.

Since the beginning of the Chronic Homelessness Initiative, the Foundation has distributed nearly $18 million in multi-year grants to 14 nonprofit groups working in LA. The LA grantees include nonprofit groups working on regional systems change and capacity-building, as well as local groups providing direct services to chronically homeless individuals, PSH developers, and public policy advocates. The work of these grantees is highlighted throughout this report.

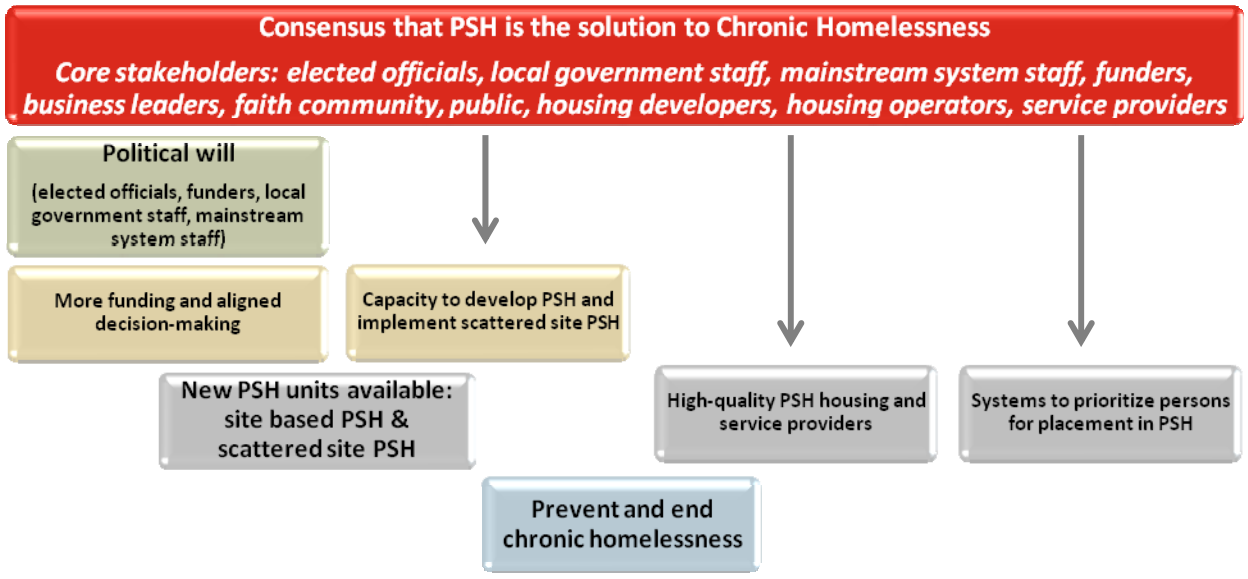
1.2 Evaluation Overview

The evaluation of the Chronic Homelessness Initiative is intended to help the Foundation and local stakeholders advance efforts toward the Foundation's strategic goals. The evaluation is designed to:

- Measure progress on the strategic goals through outcome and process-focused measures that can be tracked over time.
- Advise grantees on which data to collect and outcomes to measure that will help them benchmark their progress.
- Use annual reports, related discussions, and evaluation findings to improve results at the Initiative and individual program levels.

As part of the preparation for this evaluation, the team reviewed critical background documents and interviewed Hilton Foundation staff, all of the Chronic Homelessness Initiative grantees, and other key local stakeholders working on the shared goal of addressing chronic homelessness. The information the team learned about the purposes and content of the Initiative was used to develop a Theory of Change[2]—a model that illustrates the individual actions of the partners and how the actions sequentially and cumulatively are expected to lead to the desired goal of ending and preventing chronic homelessness. A simplified diagram that explains the Theory of Change is shown in Exhibit 1.1. A full discussion of the Theory of Change and a detailed version of the model can be found in the *Evaluation Plan* that the Abt evaluation team submitted to the Foundation on April 20, 2012.

Exhibit 1.1: Theory of Change for the Chronic Homelessness Initiative



The Theory of Change provides the framework for each of the research questions explored in the evaluation of the Initiative. A full list of the research questions and sub-questions can be found in

[2] A Theory of Change is an analytic approach that helps multiple stakeholders to identify a clear long-term goal and then relate measurable indicators of success and planned actions to that goal. For an evaluation, a Theory of Change helps to create a framework for the research questions and the measures of change on which the evaluation will focus.

Appendix B. The conclusion to this report (Chapter 10: Recommendations and Future Work) returns to the Theory of Change to provide an assessment of whether the cumulative efforts of the Foundation and local stakeholders appear to be "on track" to achieve the broader goal of ending chronic homelessness.

1.3 Organization and Focus of This Report

This first annual report of the evaluation of the Chronic Homelessness Initiative has ten main chapters, including this introduction. Chapter 2 summarizes the data collection approach, focusing on the sources of data used for this first annual report and explains the time period covered by each reported measure. Chapter 3 summarizes the Foundation's grant investments and the results for 2011 reported by grantees in the Foundation's three initiative areas: 1) systems change; 2) targeted initiatives; 3) and knowledge dissemination related to strategies to end chronic homelessness in Los Angeles. Chapters 4 through 9 are organized according to the five-year strategic goals of the Initiative. Each of these chapters starts with a description of the relationship of the goal to the Theory of Change, explaining why the goal is important to achieving the long-term goal of ending chronic homelessness. Then, a multi-colored summary box 1) indicates whether baseline data have been established to benchmark change over time on the strategic goal, and 2) reports on progress on the goal to date. Green is used to signify success in establishing the baseline or good progress towards meeting the goal. Yellow shows greater difficulty in establishing a baseline or progress that may be slower than desired. Red signals areas that have been still more challenging to achieve. Next, specific data on outcome and process metrics related to each goal are reported, followed by a discussion of the accomplishments thus far and considerations for future efforts.

As we anticipated in the evaluation plan, some of the data needed to track progress on the Foundation's goals is not yet available, and some grantee efforts are still in early stages of implementation. We have focused this initial reporting of our findings on those research questions and sub-questions that have data available as of the summer of 2012 and that the team found to be most salient to present efforts.

Chapter 10 provides a summary of recommendations for the Foundation and local stakeholders to consider and a discussion of future work associated with the evaluation.

A list of terms and acronyms used frequently in this report is provided in Appendix C.

2. Data Collection Approach for the 2012 Report

For this first year report of the evaluation of the Chronic Homelessness Initiative, data to measure outcomes and process changes were collected from a range of sources. Section 1 of this chapter provides detail on each data source and describes the timing of data collection and the timeframes measured and reported for each outcome. Section 2 of this chapter discusses data limitations and plans for improved data to be used for future reports. Some of the process measures used to report progress towards meeting the Foundation's strategic goals relate to these plans for data improvement.

2.1 Data Collection and Sources

Data were collected to measure progress in five major topic areas, as shown in Exhibit 2.1. The sources of data for each measure are provided in the exhibit, along with the timing of data collection and the time frame for which the measure is reported in this document. The remainder of this chapter describes each data source.

Exhibit 2.1: Year One Evaluation Data Sources

Measure	Source(s)	Timing of Collection	Time Period Reported
Community perception of chronic homelessness, the role of permanent supportive housing, and the engagement of civic leaders and housing providers in the issues.	• Stakeholder Survey • Stakeholder Interview • Consumer Focus Groups	June 2012	Point in time June 2012
Public and private funds leveraged with Hilton Foundation investments (funds committed)	• Home For Good Funders Collaborative	June – July 2012	January 2011 – July 2012
Housing inventory (units opened or vouchers added)	• Home For Good • Corporation for Supportive Housing	June – August 2012	Calendar Year 2011
Housing pipeline (units added to the development pipeline or vouchers committed for future years)	• Home For Good • Corporation for Supportive Housing	June – August 2012	January 2011 – July 2012
System-wide housing placement activity	• Home For Good • Community Solutions 100,000 Homes Campaign	June – July 2012	Calendar Year 2011
Grantee activities, including housing placements and retention	• Grantee Reports • Grantee Interviews	October 2011 – July 2012	Calendar Year 2011

Stakeholder Survey

In June 2012, the evaluation team developed and fielded a comprehensive, web-based stakeholder survey to gauge community sentiment around chronic homelessness and to document broadly the actions taken since the inception of the Initiative to develop permanent supportive housing (PSH) or otherwise address chronic homelessness. The email list for the survey was developed by combining the Home For Good, Community Solutions, and United Homeless Healthcare Partners mailing lists. The targeted stakeholders were: elected officials; government staff; private funders; business leaders; homeless providers; and PSH

developers, operators, and service providers. A personalized link to the survey was sent directly to 1,056 separate email addresses. In addition, the San Gabriel Valley Consortium on Homelessness sent a general survey link to its email list, and People Assisting the Homeless (PATH) sent the survey link to its Our Faith Matters email list. The lists likely have considerable overlap, and it is not possible to determine the number of unduplicated individuals or the number of potential respondents of each stakeholder type who received the survey.

The survey was tailored to each stakeholder type, though a substantial number of questions relating to perceptions of PSH as an effective intervention were constant from one group to the next. Respondents were given four weeks to complete the survey. Of the individuals directly contacted by the evaluation team, 350 recipients of the survey link started the survey (about a 33 percent response rate), and 271 individuals completed the survey. The two additional mailing lists generated an additional 110 respondents who started the survey, of whom 60 completed the survey.

Thus, results reported from the stakeholder survey in this report represent input from 460 individuals, of whom 331 completed the survey. The 460 individuals represent the following stakeholder groups:

- 144 Non-PSH direct service program staff (county, healthcare, other non-PSH): 31%
- 105 PSH Developers, operators or providers: 23%
- 43 Government administrative staff (non-PHA): 9%
- 41 Advocates, public policy analysts, or researchers: 9%
- 32 Philanthropic or private sector funders: 7%
- 20 Faith community representatives: 4%
- 14 Elected officials or their staff: 3%
- 14 public housing authority (PHA) staff members: 3%
- 10 Business community representatives: 2%
- 14 Other (e.g. community residents, homeless or formerly homeless persons): 3%
- 23 Unidentified: 5%

Though the respondents cannot be said to be a representative sample of stakeholders in the Los Angeles area, the mix of respondents provides an illustrative snapshot of the perspectives of those individuals most interested in or relevant to the issue of homelessness in the Los Angeles region. For surveys conducted for future years of the evaluation, we anticipate using the same email target lists, with limited additions, and we will analyze changes in the response rates in addition to the responses. Data from this survey are used to track progress on the evaluation's process measures throughout this report. The data analyzed for this report cover only a subset of the survey questions. Information from the survey that was too detailed to warrant inclusion in this evaluation report will be discussed with stakeholders as relevant to help inform their work over the next year.

Site Visits and Stakeholder Interviews

From the start of this evaluation project, the evaluation team engaged stakeholders in one-on-one conversations to inform the evaluation plans, identify appropriate indicators of progress, and find out about the availability of data. In fall 2011, the team conducted in-person and telephone interviews with

18 stakeholders from 16 non-grantee organizations identified by the Hilton Foundation as key to the Initiative. The team also attended a Home For Good quarterly meeting and the Home For Good Year One annual meeting. In April 2012, we held in-person discussions with 11 more stakeholders from 9 non-grantee organizations and observed a Funders Collaborative meeting. In July 2012, we conducted formal telephone interviews, using a discussion guide, with 21 representatives from 18 additional non-grantee organizations. The primary intent of these latter interviews was to provide context for responses to the web-based stakeholder survey.

Altogether, 50 individuals from 43 separate non-grantee organizations were interviewed in the first year of the evaluation. They included PSH providers and developers; government staff members, including public housing authority (PHA) representatives; staff of private, philanthropic funders; elected officials and their staff; and representatives from the business community, healthcare organizations, and housing-related researchers.

Grantee Interviews

The evaluation team talked extensively with the Foundation's Initiative grantees. Preliminary interviews with grantees were conducted in October 2011. The team also participated in the Foundation's grantee meeting in December 2011 and facilitated discussions with participants to solicit their ideas about the strategic goals and how to measure them, maximizing the use of existing data in ways that would ultimately strengthen data systems needed for other grantee or community purposes. In December 2011, the team also worked with grantees one-on-one to develop logic models in an effort to understand the role of each grantee in relation to the Theory of Change model. Additional discussions were held with grantees during the team's April 2012 site visit to Los Angeles and then throughout June and July by telephone. These later discussions centered heavily on data collection for the outcome measures and assessments of data capacity related to health and mortality. In total, 30 individuals from 13 grantee organizations were interviewed.

Consumer Focus Groups

Four focus groups were conducted in June 2012 with residents of different PSH projects to understand consumer perspectives on whether PSH is meeting the needs of residents. The programs were selected to reflect some of the variety in program models, length of time in operation, and target populations served in PSH. The sites were located in South Los Angeles, the Westside/Santa Monica, the San Fernando Valley, and Downtown Los Angeles. The participants included:

- 13 clients living in a project-based facility, with tenancies ranging from 6 months to 10 years;
- 6 clients living in a recently-opened, project-based facility supported with Mental Health Services Act (MHSA) funding;
- 3 clients living in a recently-opened project-based facility for transition-age youth; and
- 9 clients living in scattered site housing, with tenancies ranging from 4 months to 7 years.

Hilton Foundation Grantees' Internal Administrative Data

Community Solutions – 100K Homes

Community Solutions' database, Quickbase, which contains data collected through the Vulnerability Index (VI) Registry process, is a proprietary health registry that houses client-level information on individuals identified through locally organized "Registry" campaigns. For the purposes of this evaluation, the VI Registry has provided information about numbers and geographic locations of

chronically homeless individuals, as well as their relative vulnerability. While Community Solutions collects monthly data from local campaigns about housing placement achievements, the housing placement data are collected in aggregate, and there is no explicit confirmation that the placements were for persons identified on the communities' Registries.

United Way of Greater L.A. – Home For Good

The United Way, in its capacity of leading the Home For Good plan, has developed a system to track Home For Good strategies and outcomes, using data collected and consolidated by Home For Good from a number of sources, including the Corporation for Supportive Housing, housing and service providers, PHAs, and the Los Angeles Homeless Management Information System (HMIS).

Home For Good (HFG) provided the evaluation team with PSH inventory data, including the status of units in the development pipeline. Home For Good's primary purpose in collecting this information was to account for units dedicated to chronically homeless people. Therefore, we supplemented the HFG unit information with data from the Corporation for Supportive Housing data to provide more detailed unit counts and other information about projects with no dedicated units. Home For Good also provided information about the public and private funds aligned through the Funders Collaborative.

Corporation for Supportive Housing

The Corporation for Supportive Housing (CSH) manages a national project- management tracking system, referred to as Portfol. Portfol tracks both facility-based and scattered site PSH units through the various stages of development, from pre-development research to client move-in, and includes facility characteristics and funding information about each project. The system is primarily used to track projects supported through CSH loans, grants, or technical assistance, but other projects are recorded in the system as well. For this evaluation, the data have been used in conjunction with data provided by United Way to enhance the count of PSH units not expressly dedicated to the chronically homeless population.

Other Grantees

Grantee data were gathered primarily from annual grant progress reports submitted to the Hilton Foundation. The evaluation team also held discussions with each grantee to review and verify housing placement and retention data and to understand successes and challenges articulated in narrative chapters of the reports.

Other Documentation

Answers to some of the research questions are based on: analysis of documentation of decisions or actions such as MHSA housing resource commitments, grant decisions, and paperwork related to adopting and implementing new prioritization policies; Housing Inventory and Point-in-time (PIT) count data from the Los Angeles area continuums of care (CoCs); and HMIS participation statistics. These administrative data sources are identified in the discussion of the process measures to which they are applicable.

2.2 Data Limitations

The baseline status of data collection on homelessness has been described in a related report, *Los Angeles Homeless Data Assessment Report: Issues and Recommendations*.[3] The challenges related to collecting and tracking data in Los Angeles are extensive, and have had a significant impact on the ability of the evaluation team to move forward with collecting key outcome measures with confidence.

Information on the Permanent Supportive Housing Inventory

While seemingly the most straight-forward to track and collect, the housing inventory data has proved notably challenging. Home For Good and CSH staff are making great strides in collecting, cleaning, and vetting PSH stock data in collaboration with Los Angeles Homeless Services Authority (LAHSA) staff and other community stakeholders' records, but the effort this requires is large and still incomplete. HFG and CSH have taken on this task because a complete and accurate Housing Inventory Count (HIC), especially of scattered site units, does not yet exist. A comprehensive, shared database on housing resources is needed for tracking and reporting, but more importantly to support local placement and prioritization efforts. Without a clear understanding of the universe of available units, coordinating placement into those units will not be possible.

As described in the *Data Assessment Report*, the Los Angeles CoC's HIC is maintained and updated by the Programs Division of LAHSA. Each January the Programs Division staff surveys homeless service organizations located in the CoC to obtain data about each program. These surveys go to all known organizations that serve and house homeless families and individuals, regardless of whether they receive LAHSA-administered funds and regardless of whether the organization actively participates in the HMIS. Data from this survey is used to update the HIC, as well as to determine the sheltered PIT count from programs that do not participate in the HMIS.

LAHSA staff has made an effort to conform the HIC surveys to the Program Descriptors in the Department of Housing and Urban Development's (HUD) 2010 HMIS Data Standards, as well as to current HUD guidance on HIC and PIT data collection, though some improvements were necessary following review by HUD HMIS TA staff for the 2012 HIC and PIT counts. For example, the review found that the HIC was an accurate account of CoC-funded beds and units, but that data on privately-funded programs and those funded with public sources but not managed by LAHSA are much less reliable. Even information about Housing Choice Vouchers set aside for the homeless population through the Housing Authorities of the City and County of Los Angeles (HACLA and HACoLA) is not wholly accurate, as a number of these vouchers appear to have been included as PSH even though supportive services are not consistently provided in connection with the housing assistance. Current systems for identifying project-based PSH also are not always able to verify the extent to which units have and sustain supportive services. Thus, many of the units counted as PSH in the Los Angeles region may be operating more as subsidized permanent housing rather than permanent *supportive* housing.

In the *Data Assessment Report*, Abt recommended that LAHSA develop a standardized process to survey shelter and housing operators during the PIT count to ensure that regular updates to HIC bed and unit inventory are accurate and complete. In addition, Abt recommended that LAHSA 1) integrate outreach

[3] *Los Angeles Homeless Data Assessment Report: Issues and Recommendations*, also prepared by Abt Associates Inc., can be accessed from http://www.hiltonfoundation.org/lessons-homelessness.

efforts to engage PSH providers to participate in HMIS with the HIC reconciliation process and 2) compare HIC data with United Way, CSH, HACLA, HACoLA, and the County Department of Mental Health (DMH) information sources.

Based on recent interviews with key staff from CSH and LAHSA, efforts to track the PSH inventory are increasing. A group formed to work on developing a coordinated housing inventory includes CSH, LAHSA, United Way, HACLA, DMH, Community Development Commission of Los Angeles County, Los Angeles Housing Department (LAHD), and Shelter Partnership. HUD-funded technical assistance is also being provided to help assist with the housing inventory clean-up and efforts to improve an ongoing tracking system. Though they recognize that their work is in progress, participants believed that tracking had improved.

Information on Chronically Homeless Persons Housed

The HIC represents only one facet of data collection. As noted in the *Data Assessment Report*, the HMIS is not widely used by providers, particularly by PSH providers. Among the eight direct service Hilton Foundation grantees, all have at least one program participating in HMIS, but only two agencies consistently input client-level data from the program funded by the Hilton Foundation grant into the HMIS.

In part, the low level of participation in the HMIS is due to frustration with the HMIS itself. As documented in the *Data Assessment Report*, HMIS end users report frustration that HMIS is used only to satisfy an administrative requirement for HUD-funded programs, that the system is not sufficiently flexible to accommodate their use preferences, and that the data entry process can be time consuming, cumbersome, and not intuitive.

In other cases, lack of HMIS use by Hilton Foundation grantee programs is related to data entry requirements from other funding sources and grantees' unwillingness to enter similar data into two different systems. The data requirements of DMH are commonly cited. Abt staff working on a parallel data improvement effort are exploring with DMH and other county entities the possibility of expanding HMIS participation through strategies to minimize duplicative data entry between the HMIS and county systems.

LA County is exploring opportunities to integrate client data across county departments. If successful this is expected to create an integrated dataset that includes public system service utilization across multiple systems, and this data is expected to be available for analysis, research, and individual case planning. If integrated or matched with homeless client data from HMIS, this could provide an opportunity to examine service utilization by the most vulnerable homeless people and the associated costs. As data in the HMIS and integrated county data become available, the information on PSH units provided by an improved HIC could be supplemented with client-level information on actual usage of PSH and related services, including the extent to which chronically homeless persons are being prioritized for new PSH placement.

3. Summary of Hilton Foundation 2011 Grant Investments and Results

The Hilton Foundation plays numerous roles in addressing chronic homelessness in Los Angeles. Key among them is its role as a direct funder of 14 grantees, as of July 2012, to support activities in three initiative areas related to strategies to end chronic homelessness in Los Angeles: 1) systems change; 2) targeted initiatives; and 3) knowledge dissemination. Exhibit 3.1 provides a brief overview of key activities that were supported in calendar year 2011 in each of these areas, as described in grantee reports and confirmed in interviews. Exhibit 3.2 lists grants made in early 2012, along with the goals associated with each grant. Chapters 4 to 9 discuss the cumulative impact of these efforts with other community actions and gauge the extent to which the milestones identified in the Theory of Change are being achieved.

Exhibit 3.1: Summary of Hilton Foundation Homelessness Grants – 2011 Grants

Grantee Organization	Grant term	Initiative Areas	Grant Amount	Target One (through term of grant)	Target Two (through term of grant)
Community Solutions	Jan. 2011-Dec. 2013	Targeted Programs	$600,000	23 communities; 6,500 VI surveys completed	4,500 individuals placed in housing by registry communities
Downtown Women's Center	Jan. 2011-Dec. 2012	Targeted Programs Knowledge Dissemination	$830,000	80 women will be placed in permanent supportive housing	80% will remain housed for at least 12 months
Mental Health America	Jan. 2011-Dec. 2013	Targeted Programs	$750,000	60 individuals will be placed in permanent supportive housing	85% will remain housed
OPCC	Jan. 2009-Dec. 2011	Targeted Programs	$300,000	30 chronically homeless persons will be placed in permanent supportive housing	85% will remain housed for at least 6 months
Skid Row Housing Trust	Jan. 2011-Dec. 2013	Targeted Programs	$750,000	80 chronically homeless, high mortality-risk individuals will be will be placed in permanent supportive housing	80% will remain housed for 12 months
St. Joseph Center	Jan. 2011-Dec. 2013	Targeted Programs	$750,000	53 clients (35 new and 18 first stage) will be placed in permanent supportive housing	90% will remain housed for at least 12 months
Step Up on Second	Jan. 2011-Dec. 2013	Targeted Programs	$750,000	50 individuals (including 10 Vets) will be placed in permanent supportive housing	85% will remain in the program for 2 years

Grantee Organization	Grant term	Initiative Areas	Grant Amount	Target One (through term of grant)	Target Two (through term of grant)
Corporation for Supportive Housing	Jan. 2010-Dec. 2013	Systems Change Targeted Programs Knowledge Dissemination	$9,000,000	In 2011, CSH provided training to 804 persons representing 186 organizations (duplicated) in property management, Dimensions of Quality, development, financial structures, and tenant selection. CSH LA also partnered with United Homeless Healthcare Partners to facilitate a learning collaborative around the involvement of Federally Qualified Health Centers in supportive housing, CSH continues to use grants and program-related investment loan funds to catalyze development and reactivate projects stalled due to resource losses. CSH is focusing on transition-aged youth, re-entry, and medically fragile homeless people through grantees such as OPCC, Southern California Association of Non-Profit Housing, LA Family Housing, A New Way of Life Foundation, Volunteers of America, New Directions, Skid Row Housing Trust, Venice Family Clinic, LA Dependency Lawyers, and Venice Community Housing Corporation. CSH also hosted a Quality Awards event in December 2011 for 300 stakeholders representing housing and service providers from around the state, local government, and funding partners.	
PATH	Jan. 2011-Dec. 2012	Systems Change	$200,000	50 new faith groups will join Our Faith Matters	Develop 160 new units of permanent supportive housing
United Way/Home For Good	Sept. 2011-Aug. 2012	Systems Change	$1,600,000	Dedicate 60% of turnover units to chronically homeless individuals in 2011 and 75% in 2012	Secure 4:1 match of Hilton Foundation investment of $1M in grant funds
Western Center on Law and Poverty	Mar. 2011-Feb. 2014	Systems Change	$300,000	The Western Center advocated for successful passage of AB 1296, which set parameters for CA's eligibility, enrollment, and retention system for health coverage through Medi-Cal and other programs. AB 1296 was enacted and signed into law. The Center also provided advocacy for SB 1220, The Housing Opportunity and Market Stabilization (HOMeS) Act, which proposed a new source of funding for affordable housing to replace the funding lost when the California Supreme Court ruled in late 2011 to uphold a law to abolish redevelopment agencies (effective in February 2012). The Legislature failed to pass the HOMeS Act, despite advocacy by Western Center, Housing California, and many others. Western Center also worked with other advocates to provide information to the state Department of Health Care Services about enrollment challenges and other issues related to implementation of the Low Income Health Plan, which provides health coverage for people based on income - potentially covering most homeless people and PSH tenants who are not otherwise eligible for Medi-Cal.	

Exhibit 3.2: Summary of Hilton Foundation Homelessness Grants – 2012 Grants

Grantee Organization	Grant term	Initiative Areas	Grant Amount	Target One (through term of grant)	Target Two (through term of grant)
Housing California	Mar. 2012-Apr. 2014	Systems Change Knowledge Dissemination	$300,000	Develop shared understanding of system that funds development/ homelessness strategies	Develop platform to reach policymakers/ public about need for governmental involvement in housing and homelessness.

Grantee Organization	Grant term	Initiative Areas	Grant Amount	Target One (through term of grant)	Target Two (through term of grant)
Housing Works	Mar. 2012-Apr. 2015	Targeted Programs	$570,000	75 chronically homeless persons or families	90% will retain housing for the grant period
LA Family Housing	July 2012-June 2014	Targeted Programs	$700,000	120 chronically homeless individuals and 20 frequent users will be placed in permanent housing	90% will remain in permanent housing after 12 months
OPCC	Jan. 2012-Dec. 2014	Targeted Programs	$750,000	Engage and house 40 chronically homeless persons	85% will retain housing for at least 6 months

4. Progress on Goal to Build Demonstrated Action by Elected and Public Officials to Support Addressing Chronic Homelessness

Political will is a key element of the Theory of Change for ending chronic homelessness in the Los Angeles region. During the study team's discussions and interviews, as well as in responses to the web-based surveys, local stakeholders regularly noted that LA is a highly political environment and cited the need to cultivate strong political support in order to make progress on chronic homelessness. Furthermore, the public sector controls the bulk of the resources that are most likely to be used to support permanent supportive housing (PSH) housing operations and supportive services. Therefore, the Foundation established an explicit separate goal to build demonstrated action by elected and public officials, recognizing that this action was an important precursor to other goals within the Initiative.

The United Way of Greater Los Angeles, in conjunction with the LA County Chamber of Commerce, has taken on this goal most directly through leadership and facilitation of the Home For Good Initiative. Home For Good partners meet regularly to discuss strategies and progress in achieving the goals of the Home For Good action plan. United Way and the Business Leaders Task Force, that is helping to mobilize the business sector in support of the plan, have been working to strengthen buy-in among stakeholders by sharing credit for accomplishments. Chronic homelessness and efforts to address it clearly have more visibility than ever both through the Home For Good Initiative and though United Way's annual Home Walk, which targets awareness among the general community. United Way has been able to generate positive press coverage of Home For Good accomplishments, helping to get the word out to the public about the plan's goals and the importance of PSH in achieving progress toward ending chronic homelessness.

The Hilton Foundation itself was a key player. Foundation staff worked through Home For Good and independently communicated with elected and public officials and proactively disseminated knowledge about best practices related to PSH and strategies to end chronic homelessness. Despite progress in building consensus among key stakeholders that PSH has a critical role in ending chronic homelessness, there has been more limited demonstrated action.

Baseline Established: Stakeholder survey establishes a baseline to compare changes in consensus and to document actions moving forward
Status in 2012: Progress in building support, but limited demonstrated action

In section 1 of this chapter, we provide analyses of stakeholder survey and interview responses related to opinions about chronic homelessness and perception of engagement in the issue by community leaders. Then, in section 2, we discuss the extent to which elected officials have taken concrete action in support of ending chronic homelessness in LA.

4.1 Process Measure: Is there growing consensus among key stakeholders around the critical role of PSH in ending chronic homelessness?

During site visits and interviews with a range of stakeholders, the evaluation team repeatedly heard evidence that key stakeholders are in general agreement that PSH is an effective intervention for people who experience chronic homelessness and for other vulnerable homeless people. Members of the team

heard that this agreement has been growing in LA. Many of the activities, innovative programs, and research results that contributed to the level of agreement in place at the start of this Initiative received support from the Hilton Foundation in previous years, beginning with a grant for innovative programs to serve homeless people in LA's Skid Row, as part of the Closer to Home Initiative, and continuing with multi-year grant and loan funding which was provided primarily through a partnership with the Corporation for Supportive Housing.

An evaluation of the Hilton Foundation's prior multi-year strategy, the Initiative to End Homelessness for People with Mental Illness in Los Angeles County[4], launched in 2004, found that between 2004 and 2009 there was a major increase in the number of public agencies, housing and service provider organizations, and other stakeholders engaged in financing, developing, and operating PSH, and a growing agreement about the need for and impact of PSH as a solution to chronic homelessness. That evaluation also described a growing recognition of both the need to increase and coordinate investments in housing and services, and the need to be able to offer PSH in communities throughout LA County. While the results of those earlier efforts included significant increases in the availability of PSH, the development of promising program models and partnerships, and declines in the number of unsheltered chronically homeless people with disabilities in LA County, there was also a growing recognition of the need to continue to expand the supply of PSH, target available units appropriately, and strengthen the capacity of providers to successfully housing people with long histories of homelessness and complex needs in order to achieve the goal of ending chronic homelessness.

The overall consensus that PSH is an effective intervention was reflected in the results of the evaluation's stakeholder survey as well. However, there were differences in opinion around appropriate target populations and application strategies for PSH. Some respondents were not in favor of housing first approaches for all chronically homeless people, particularly those with chronic substance use or serious mental health issues.

Support for the Concepts of Permanent Supportive Housing

Stakeholders who participated in interviews for this evaluation expressed a common understanding of what PSH is, identifying the following as fundamental components:

- Housing locator assistance;
- Provision of stable housing coupled with comprehensive support services;
- Customized and individualized approach to comprehensive services;
- Case management;
- Mental health and substance use treatment, including assertive clinical treatment teams;
- Outreach to engage unsheltered chronic homelessness;
- Supportive services to enable people to keep housing;

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[4] The final evaluation report, *Initiative to End Homelessness for People with Mental Illness in Los Angeles County*, was prepared by The Urban Institute and can be accessed from http://documents.csh.org/documents/pubs/LA%20County_systems%20change_2010.pdf.

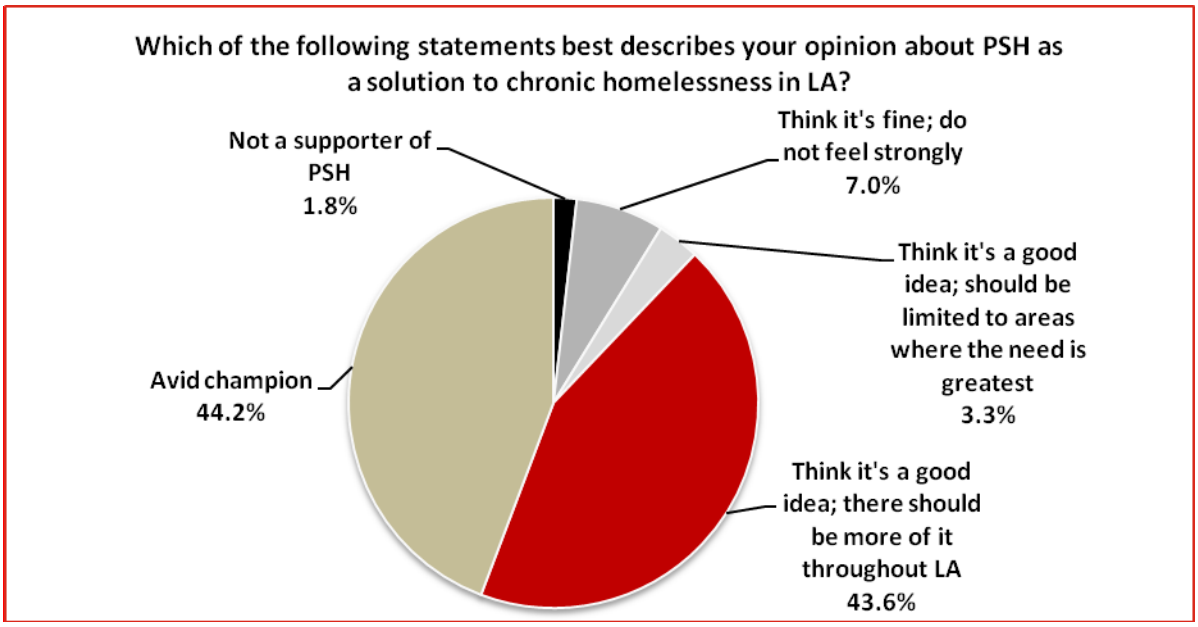
- Financial planning and job training;
- Assistance linking to benefits; and
- Better integration of health and mental health—more psychiatric care on-site in PSH and at clinics that serve PSH tenants.

In the interviews, stakeholders also revealed their overall agreement that PSH is an effective solution to chronic homelessness. One elected official responded that he or she was a "strong supporter," while another responded that PSH was the "only solution to chronic homelessness" and that the permanent nature of PSH makes it a solution, not a Band-Aid. Private, philanthropic funders, too, reported strong support for PSH, identifying strong outcomes and the cost-effectiveness of the model as reasons for support. Public housing authorities agreed with the other groups, citing tenant outcomes and long-run cost savings.

Housing providers interviewed for the evaluation also acknowledged a role for PSH in the solution to chronic homelessness, but were more likely to indicate that they did not believe it was the whole solution. Advocates, too, recognized PSH as a necessary component, but some advocates stated that it is only part of the solution. The implication was that PSH addresses a specific need for certain populations, but that homelessness, including chronic homelessness, is too complicated an issue for a single approach to a solution. Overall, stakeholders agree that PSH is essential, but have differing perspectives on the size of its role – the entire solution or just part of the solution.

In the stakeholder survey, all respondents were asked to review five statements about their overall perspective on PSH in the Los Angeles area and to select the statement that most aligned with their own view. Exhibit 4.1 shows that there was broad baseline support for PSH as a solution to chronic homelessness among the 330 respondents who answered this question. Only five percent of respondents indicated that they were not supporters of PSH (1.8 percent) or that it should be limited to areas such as Skid Row where the need is greatest (3.3 percent). This limited support was distributed among all groups, so no single stakeholder type seemed to voice opposition to PSH.

Exhibit 4.1: Stakeholder Opinions about PSH



Source: Abt Associates Inc. Stakeholder Survey, June and July 2012, n = 330 stakeholders, all types

Respondents were also provided with a series of statements that described different philosophies or beliefs about PSH and its role and were asked to agree or disagree with each statement. In some cases, the statements used "housing first" language, and in other cases the statements used "housing readiness" language. The results are summarized in Exhibit 4.2. Conceptually, people believe that homeless people can and should be housed. Nearly 80 percent of respondents disagreed with the statement that a lot of homeless people do not want housing, revealing a general belief that it is possible to house homeless people. Almost 90 percent agreed with the statement that, even if people are seriously mentally ill or abusing alcohol or drugs, they can still be housed successfully with help from a counselor or case manager.

Exhibit 4.2: Stakeholder Beliefs regarding PSH

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	No Opinion
A lot of homeless people don't want housing - especially if they have been homeless for a long time	3.1%	17.0%	23.2%	55.0%	1.7%
People who are living on the streets need to enter shelters or transitional programs to get ready for housing	14.9%	24.2%	24.0%	33.8%	3.1%
People who are abusing alcohol or illegal drugs need to complete treatment before they're ready for housing	14.6%	18.9%	20.6%	44.1%	1.7%
People who are seriously mentally ill need to be willing to accept treatment and take medications before they're ready for housing	9.8%	23.8%	25.0%	39.5%	2.0%
Even if people are seriously mentally ill or abusing alcohol or drugs, they can learn how to be responsible tenants and good neighbors if they have help from a counselor or case manager who visits them regularly	57.7%	31.4%	6.1%	3.9%	1.0%
If people abuse alcohol or drugs after they move into supportive housing, they should be evicted or required to enter treatment	8.1%	18.0%	26.8%	44.8%	2.2%
If people abuse alcohol or drugs after they move into supportive housing, it's up to them to seek help to solve their problems before they get evicted, or accept the consequences	4.2%	20.2%	32.3%	42.4%	1.0%
If people abuse alcohol or drugs after they move into supportive housing, service providers need to make an extra effort to connect with them, so they can offer help before it's too late to solve problems that could lead to eviction	79.9%	17.0%	1.2%	1.0%	1.0%

Source: Abt Associates Inc. Stakeholder Survey, June and July 2012, n = 418 stakeholders, all types
Notes: Shading indicates whether the majority of stakeholders surveyed agreed or disagreed with the statement.

Consistent with statements made by some stakeholders during the interviews, consensus is not as clear around issues related to the *path* to housing for chronically homeless people. While still a majority, only 58 percent of respondents *disagreed* (somewhat or strongly) with the statement that people who are living on the streets need to enter shelters or transitional programs to get ready for housing, while 39 percent *agreed* (somewhat or strongly) that long-term, unsheltered homeless persons should live in emergency shelter or transitional housing prior to permanent housing. Thus, many respondents continue to reflect "housing readiness" sentiments.

Ninety-six percent of respondents agree, 80 percent strongly, that PSH providers should make an extra effort to connect with tenants in order to prevent eviction for tenants who struggle with issues related to substance use or serious mental illness. Nonetheless, approximately 25 percent of respondents agreed that tenants should be evicted if caught abusing drugs or alcohol, and 25 percent agreed that it was up to the client to seek help to solve their problems before getting evicted.

PSH Relative to Other Strategies to Reduce Chronic Homelessness

Another way to gauge the level of support for PSH is to examine how stakeholders rank the importance of different programs or services for reducing chronic homelessness in Los Angeles. Survey respondents were asked to rank programs from 1 to 8 on their level of importance. Looking across all types of stakeholders, PSH was ranked higher in importance for reducing chronic homelessness than any other program type, with a mean rank of 2.30. Exhibit 4.3 displays the program types survey respondents were asked to rank and gives the mean rank order across all survey respondents.

Exhibit 4.3: The relative importance of programs and services to reducing chronic or long-term homelessness in Los Angeles County

Program Types	Overall Mean Rank
Permanent supportive housing	2.30
Outreach and case management	3.22
Mental health programs	4.03
Substance abuse programs	4.65
Transitional housing	4.89
Homelessness prevention services	5.01
Emergency homeless shelters	5.05
Job training programs	6.05

Source: Abt Associates Inc. Stakeholder Survey, June and July 2012, n = 365 stakeholders, all types

However, some stakeholder groups felt more strongly about the relative importance of PSH than others. Public housing authority (PHA) staff, private funders, advocates, and PSH developers, operators and managers all ranked PSH programs first. In contrast, county direct service program staff such as staff in the Department of Mental Health and the Department of Public Social Services ranked PSH as less important than any of the other seven program types. Survey respondents identifying as community residents or homeless/formerly homeless people also ranked other programs ahead of PSH in importance to ending chronic homelessness.

In addition, while stakeholders demonstrate overall consensus that PSH is important, they do not necessarily demonstrate a clear consensus about the idea that PSH should be primarily targeted to chronically homeless individuals. Survey respondents were asked to identify three populations they believed to be the most critical target groups for PSH. Exhibit 4.4 provides the results for all stakeholder types.

Exhibit 4.4: Priority Target Groups for PSH

Which three populations do you believe are the most critical target groups for PSH in LA?	Percent
Long-term homeless families	51.3%
Homeless persons with serious mental illness	45.1%
Homeless individuals who are frequent users of emergency and other health services	40.7%
Long-term homeless individuals	39.5%
Homeless individuals with a high likelihood of mortality	32.3%
Elderly homeless persons	31.5%
Homeless youth (ages 18-25)	26.4%
Persons at risk of homelessness when discharged from hospitals, mental health facilities, jails, or prisons	21.4%
Homeless persons in recovery from substance abuse	8.3%
Homeless persons with active substance abuse problems	7.1%
Source: Abt Associates Inc. Stakeholder Survey, June and July 2012, n = 337 stakeholders, all types	

The most common response, given by 51 percent of respondents, was long-term homeless families. Frequent users of health services and homeless persons with serious mental illness were also frequently identified as priority populations by survey respondents, both overall (as shown in the exhibit) and in most stakeholder groups. Long-term homeless individuals, while selected by nearly 40 percent of all respondents as one of three priority populations, were not selected as a priority by a majority within several of the stakeholder groups including health service providers, elected officials, and PHA staff. This population was selected as a priority by PSH developers and operators, advocates, and business community representatives. Given the strong focus of Home For Good on the business community, the sentiments of business leaders surveyed may be a reflection of the success of the Home For Good communication strategies with this group.

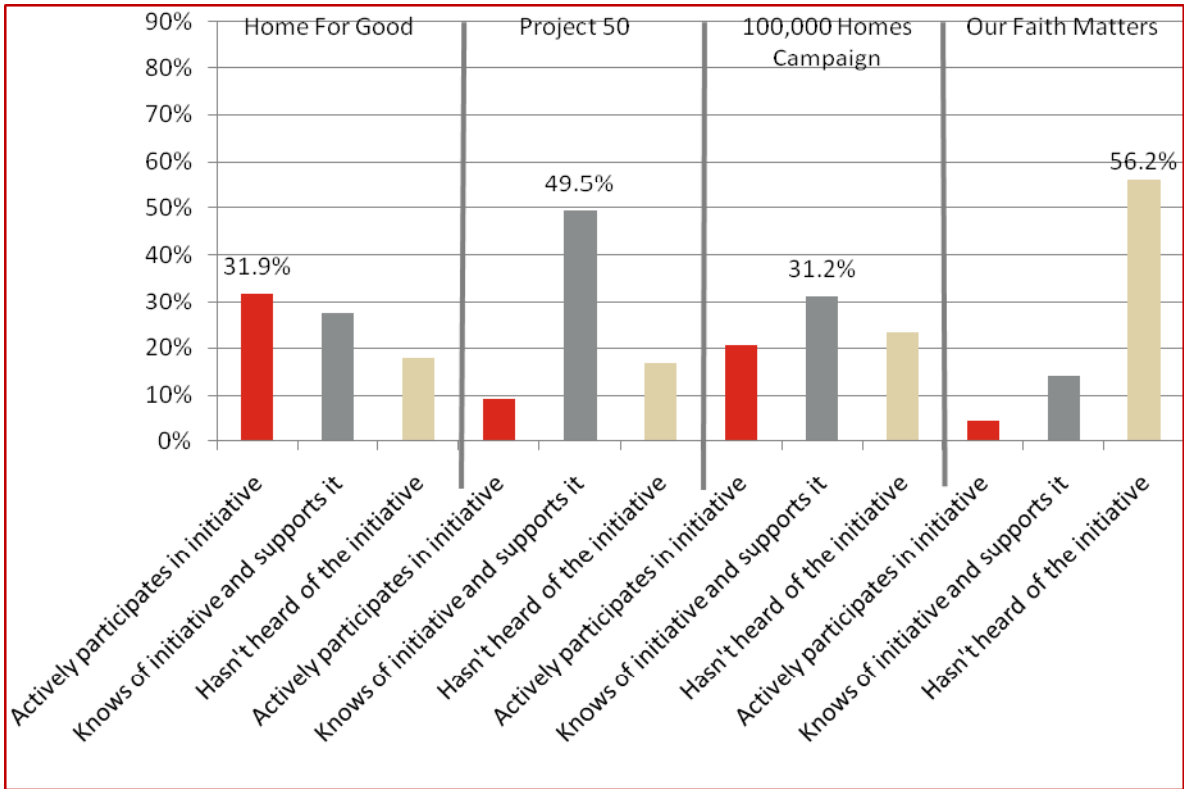
There is significant overlap among the needs of chronically homeless individuals, frequent users of health services, those with a high level of mortality, and homeless persons with serious mental illness, and respondents in some stakeholder groups may have focused on these characteristics of homeless people rather than on their chronic patterns of homelessness. Nearly all of the fourteen stakeholder groups surveyed selected at least one of those groups among their three highest-priority groups. The exception was elected officials, who focused on long-term homeless families, elderly homeless persons, and homeless youth.

In addition, when the results are analyzed based on self-perceived familiarity with the PSH model, those who stated they are “very” familiar with the model are much more likely than those who are “somewhat” familiar to choose long-term homeless individuals (7% more likely), homeless persons with severe mental illness (4% more likely), homeless individuals with a high likelihood of mortality (8% more likely), and homeless individuals who are frequent users of emergency and other health services (5% more likely). These are populations for which research has demonstrated PSH is an effective intervention. Those who were very familiar with the model were also less likely to choose elderly homeless persons (9% less likely), long-term homeless families (7%), or homeless youth (4% less likely) – populations for which there is considerably less literature on the effectiveness of PSH.

Awareness of Special Efforts to Address Chronic Homelessness

The survey also asked about stakeholder knowledge and engagement in specific efforts supported by the Foundation to address chronic homelessness, in an attempt to determine whether information about current projects was being broadly disseminated and to establish a baseline on the extent of broad community involvement in them. Their responses are shown in Exhibit 4.5. Most of the key activities funded through the Initiative had somewhat limited exposure among survey respondents. Home For Good had the broadest participation and awareness by respondents, especially by private funders (64 percent of the 25 private funder representatives responding to this question) and PHA staff (8 of the 11 – 72 percent – of the PHA respondents). Presumably the higher levels of participation reflect the campaign nature of the project and the active outreach by Home For Good to formally solicit funders to sign on. PHA staff also indicated a high level of participation in the 100,000 Homes Campaign, the national effort led by Community Solutions to identify and house 100,000 highly vulnerable homeless individuals. Overall, Project 50 was the most widely known initiative, and in response to a separate open-ended question the media coverage related to Project 50 was cited frequently as the reason that respondents were knowledgeable and supportive of it. There was very little awareness of Our Faith Matters, the effort led by People Assistance the Homeless (PATH) to build support for PSH among faith leaders and congregations, which may reflect its targeted nature on the faith community.

Exhibit 4.5: Level of Stakeholder Engagement in Specific Chronic Homeless Initiatives



Source: Abt Associates Inc. Stakeholder Survey, June and July 2012, n = 341 stakeholders, all types

Challenges Looking Forward

One challenge associated with the Initiative relates to acknowledging the long road to achieving accomplishments. A number of organizations and individuals reported to the evaluation team in

interviews that they had been working on addressing chronic homelessness, coordinating funding for PSH, and implementing innovative PSH programs long before Home For Good was created. These stakeholders reminded the team that Home For Good is reporting on recent accomplishments, but that the seeds for the current momentum were planted before Home For Good started. These stakeholders acknowledge the impact that Home For Good has had in broadening public and political support for the cause and in creating the tipping point that has led to some recent substantial accomplishments, but still indicated a sense of obligation to be "on board" with the Home For Good message about ending chronic homelessness with PSH and to participate in Home For Good meetings, rather than full buy-in. A few stakeholders also expressed the view that some Home For Good promoters do not have sufficiently detailed knowledge and are advising providers to take actions that may conflict with their federal and state funding requirements.

United Way staff are sensitive to these concerns and are attempting to demonstrate greater respect for the contributions and concerns of other stakeholders and partners--for example, by making an increased effort to give credit where it is due when announcing and celebrating accomplishments and progress and by tempering some of the language used by Home For Good leaders when describing frustrations or limitations of "status quo" responses to homelessness in LA.

This dynamic should be considered when thinking about long-term leadership for ending chronic homelessness. While LAHSA is the entity formally charged by the City and County of Los Angeles with coordinating resources and planning to improve the community's capacity to end homelessness, it has not historically been viewed as being a leader in that area. (Note that it is viewed as a very competent administrator of grant resources, and since January 2012, LAHSA has incorporated more Home For Good priorities into their processes – such as prioritizing recruitment of PSH providers into HMIS and integrating Home For Good Standards of Excellence into their performance measurement reports.) For the remainder of Home For Good, its leaders will need to take extra care to engage their public sector partners, without whose support and engagement it will be impossible to create an effective prioritization mechanism or an aligned system of funding PSH and supportive services for chronically homeless people. Similarly, the public sector should fully recognize the success of Home For Good in engaging non-traditional partners in ending chronic homelessness. Together, they need to find an effective long-term home for leadership and coordination of ongoing efforts.

4.2 Process Measure: Have elected officials and other key stakeholders demonstrated commitment to PSH through concrete actions?

Perception and Concrete Action by Elected Officials and Government Staff

There is a general sentiment among key stakeholders in the effort to end chronic homelessness in LA that elected officials are supportive of PSH and that some are taking concrete actions. However, other stakeholders interviewed by the evaluation team do not feel that most elected officials have demonstrated bold leadership or taken actions that have resulted in dramatic increases in PSH or reductions in chronic homelessness.

During the evaluation team's site visits and telephone interviews, the most commonly mentioned concrete action taken was the LA County Board of Supervisor's endorsement of the Home For Good plan. In 2011, United Way worked with the Business Leaders Task Force to persuade elected officials in LA City and LA County, as well as in several other cities in the county, to sign on as supporters of the Home For

Good Action Plan. The LA County Board of Supervisors passed a motion endorsing the Home For Good plan and unanimously voted to align the county's efforts with the Home For Good goals. The Home For Good plan was also endorsed by a large number of other elected officials and key stakeholders -- 111 cross-sector leaders as of April 2012, including 26 elected officials (one state assemblyman, three county supervisors, mayors of ten cities, and eleven additional councilmembers from two cities).

Some 27 percent of elected officials or their staff who responded to the stakeholder survey said that they attended community meetings in support of PSH. However, one-quarter of elected official respondents indicated that they did not take any concrete action steps to advance PSH.

In addition, the stakeholder survey asked staff of government agencies about the action steps they have taken to promote the development of PSH in the past year. More than half of the 33 respondents, 51.5 percent, reported that they had advocated in favor of additional PSH, and one-third said that they encouraged PHAs to commit more vouchers to PSH. These responses are consistent with the timing of PHA commitments of vouchers to the 2012 Home For Good Funders Collaborative Request for Proposals (RFP) in late winter 2011/early spring 2012.

In interviews with stakeholders about their perceptions of the concrete actions taken by government staff, the team repeatedly heard about the importance of the LA County Department of Mental Health's (DMH) leadership deciding to make investments in PSH and to require that contractors target Mental Health Services Act services to chronically homeless people. New leadership in the LA County Department of Health Services (DHS) has also been critical, as that Department now is launching an ambitious effort to create new PSH.

Public Sector Participation in the Home For Good Funders Collaborative

Many public sector organizations have participated in the Home For Good Funders Collaborative. The City of Pasadena; the Housing Authorities of the City and County of LA (HACLA and HACoLA); The City of Los Angeles Housing Department; and the Los Angeles County Departments of Mental Health, Health Services, and Public Health all aligned funding resources under the first Request for Proposals of the Funders Collaborative.

Initially, HACLA was the only PHA that joined the Home For Good campaign. However, United Way and the Task Force viewed participation of additional PHAs as critical to achieving the plan's goals and worked to obtain support from mayors and housing authority board members. HACoLA contributed resources to the Home For Good Funders Collaborative and has adopted several policy shifts that reduce barriers to access to PSH (and other housing) for people experiencing or at risk of chronic homelessness. Several of the smaller PHAs in other cities also signed on to support the plan.

Support from County Board of Supervisors

Discretionary spending through LA County's Homelessness Prevention Initiative (HPI), which started in 2006, provided $120 million in one-time funding and $15 million per year in ongoing funding commitments from the county Board of Supervisors. An illustrative list of projects funded with the $15 million awarded in the 2011-2012 fiscal year was provided to the evaluation team by staff in the Chief Executive Office and is shown in Exhibit 4.6.[5] About half the funds are used for programs funded at the

[5] No single, comprehensive list is available publicly.

county level, and $7.1 million is allocated to the county Supervisors to use for projects within their districts. As a benchmark for comparison with future years, roughly one-third of the HPI funds are dedicated to PSH or to projects that include a substantial PSH component.

Exhibit 4.6: FY 2011-2012 Homeless Prevention Initiative Funding 2011-2012

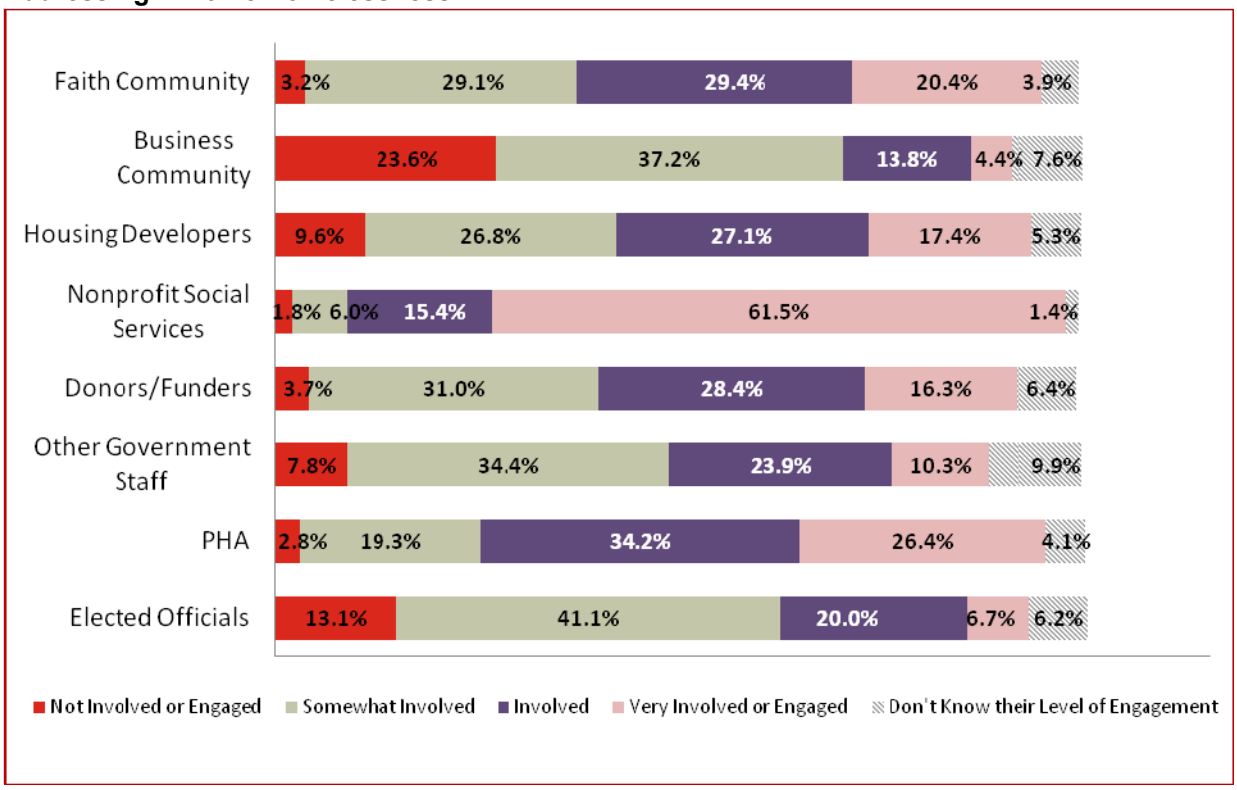
PSH projects and programs that include PSH (some examples)		Other projects and programs (some examples)
• Project 50 replications (2nd round of funding) grants to OPCC, Step Up on Second, St. Joseph Center, San Fernando Valley Mental Health • San Gabriel Council of Governments – outreach and intensive services linked to housing • Gateway Cities Council of Governments – to implement Homeless Action Plan including PSH and outreach • Exodus – case management program for homeless people at LAC/USC hospital including linkages to PSH • Grants to LA Family Housing, Ascencia (PATH Achieve), Union Station, West LA Community Development Corp		• Skid Row Homeless Family Access Center • Homeless Court and Co-Occurring Disorders Court – resolve warrants, citations, etc. that can be barriers to housing access • Shallow rent subsidies (no support services) for GR recipients applying for SSI • Homeless encampment protocol – outreach to connect people to services and housing • Grants to several organizations (including Salvation Army, LA Family Housing Chavez House, Catholic Charities, and others) for shelters
Total (approximate)	$ 4.5 million	$ 9.1 million
Source: information provided by the Chief Executive Office of Los Angeles County		

Perceptions of Active Involvement for Different Types of Stakeholders

The stakeholder survey asked respondents to identify the level of engagement that other stakeholder groups had in addressing chronic homelessness, ranging from not involved to very involved. The responses across all groups of stakeholders are shown in Exhibit 4.7.

- Not surprisingly, nonprofit social service groups were identified as "very involved or engaged" by more than 62 percent of respondents, and as "involved" by another 15 percent.
- PHAs were perceived as having the next highest level of involvement, with 61 percent of respondents indicating that PHAs were either very involved or involved in addressing chronic homelessness.
- Business and faith groups were perceived as very involved or involved by roughly half of respondents.
- Funders and housing developers were identified as being very involved or involved by only 45 percent of respondents, which was still a higher level of involvement than that perceived for government staff (34 percent) or elected officials (27 percent).

Exhibit 4.7: Survey Respondents' Perception of Each Stakeholder Group's Level of Engagement in Addressing Chronic Homelessness



Source: Abt Associates Inc. Stakeholder Survey, June and July 2012, n = 379 stakeholders, all types

5. Progress on Goal to Leverage $90 million in Private and Public Funds toward Permanent Supportive Housing and Align Resources

According to the Theory of Change for the Chronic Homelessness Initiative, greater political will can be expected to lead to more and better-aligned funding for permanent supportive housing (PSH), which in turn will create more PSH that is used to end chronic homelessness. The Foundation established two strategic goals related to leveraging resources for PSH, one that aims to raise an additional $15 million in private funds toward PSH and another that aims to realign $75 million in public sector funds to PSH. Prior to the Initiative, PSH developers and homeless providers noted that a lack of funding, especially for sustainable operations and supportive services associated with the housing, was a significant barrier to creating PSH. They also noted that the fragmented and siloed nature of funding systems for PSH development made it difficult to secure complete funding for a single project. Thus, the Initiative aimed to increase funding available to support development, operations, and services for PSH, as well as strategies to better align funding resources to streamline and improve grant making. To measure progress on these goals, the evaluation team documented the array of funds committed to PSH from January 2011 to July 2012 and examined whether the process for coordinating decisions around funding had changed.

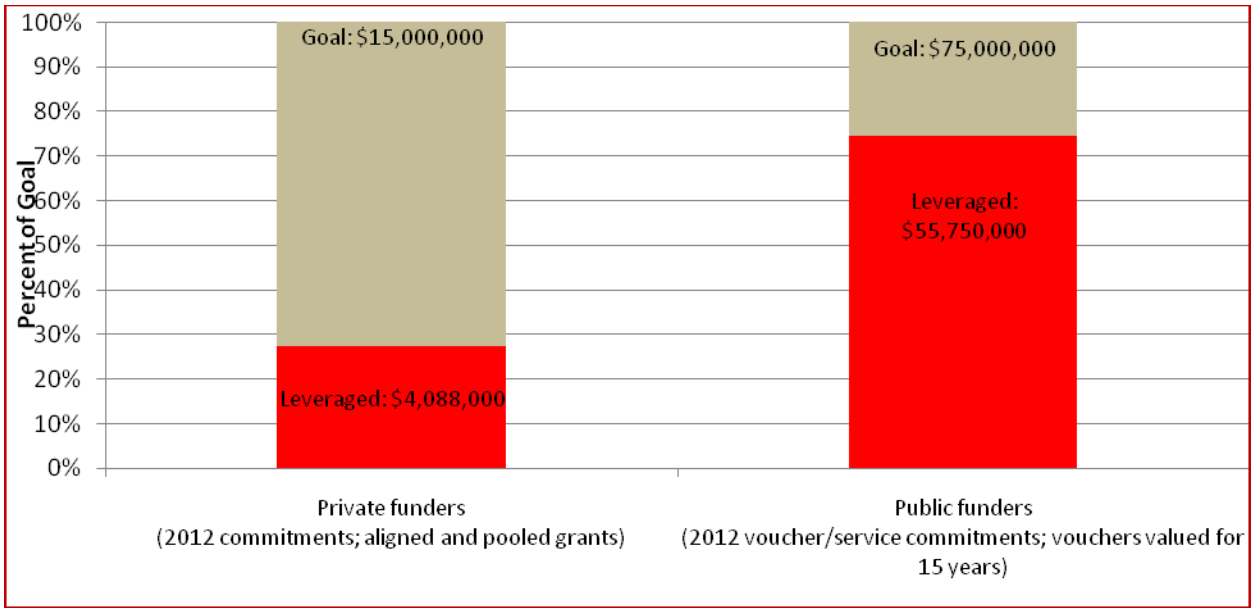
Data Availability: Financial data are available for grants allocated in conjunction with the Funders Collaborative; more information is needed to calculate other commitments
Status in 2012: On track to meet or exceed five-year financial commitment goals

Section 1 of this chapter reports on whether the Foundation's strategic goal related to funding for PSH has been met, and section 2 of this chapter reports on whether housing and services funding for PSH has been aligned or better coordinated.

5.1 Process Measure: Is there a commitment of $15 million in additional private funding and $75 million in realigned public funding?

Exhibit 5.1 shows that $4 million from private funding sources and $55 million in public funding commitments were made through the Home For Good Funders Collaborative 2012 Request for Proposals. This followed a $1 million seed grant that the Hilton Foundation awarded to United Way to allocate through the Funders Collaborative that was intended to create an incentive to other funders to pool resources through the Collaborative.

Exhibit 5.1: Progress Toward Goal of Leveraging $90 million for PSH



Source: Funds leveraged through Home For Good Funders Collaborative (January 2011 – July 2012)

By some measures, the goal of $75 million in realigned public funding already has been surpassed. The funding is further detailed in Exhibit 5.2, with the total calculation for tenant-based vouchers (350 newly dedicated tenant-based Housing Choice Vouchers in 2012) and project-based Housing Choice Vouchers (237 newly dedicated in 2012) based on the present value of the voucher of $10,000 per voucher per year for a 15-year period. Both the Housing Authority of the City of Los Angeles (HACLA) and the Housing Authority of the County of Los Angeles (HACoLA) have agreed to retain the tenant-based vouchers for chronically homeless individuals for the full 15-year period, meaning that turnover vouchers can be used to house additional chronically homeless individuals. HACLA has set aside 218 project-based vouchers in total for PSH, but only 39 of these are dedicated to chronically homeless individuals.

Exhibit 5.2: Funding Commitments to PSH January 2011 through July 2012

Source	Value ($ or # of units for service commitments)	Year of pledge/award	Use period	Type (Grant, forgivable loan, service commitment)	Method of Allocation (independent, aligned, pooled)	Funding for new PSH units/New funding for existing PSH units
Conrad N. Hilton Foundation	$1,000,000	2012	2012-2013	Grant	Pooled	
Leveraged Private Funders: 2012 Commitments						
Aileen Getty Foundation	$1,000,000	2012	2012-2013	Grant	Pooled	
United Way of Greater Los Angeles	$500,000	2012	2012-2013	Grant	Pooled	
United Way of Greater Los Angeles	$100,000	2012	2012-2013	Technical Assistance	Aligned	
Weingart Foundation	$500,000	2012	2012-2013	Grant	Pooled	
The California Endowment	$250,000	2012	2012-2013	Grant	Pooled	
Annenberg Foundation	$250,000	2012	2012-2013	Grant	Pooled	
Cedars Sinai	$100,000	2012	2012-2013	Grant	Pooled	
Task Force	$100,000	2012	2012-2013	Grant	Aligned	
The Carl and Roberta Deutsch Foundation	$50,000	2012	2012-2013	Grant	Pooled	
The Carl and Roberta Deutsch Foundation	$328,000	2012	2012-2013	Grant	Aligned	
Kaiser Permanente	$710,000	2012	2012-2013	Grant	Aligned	
Corporation for Supportive Housing	$200,000	2012	2012-2013	Grant	Aligned	
Subtotal	$4,088,000					
Leveraged Public Funders: 2012 Commitments						
HACLA	$45,000,000	2012	2012-2027	Voucher commitment	Aligned	300 new tenant-based vouchers for CH
HACOLA	$7,500,000	2012	2012-2027	Voucher commitment	Aligned	50 new tenant-based vouchers
L.A. County - DMH, DHS, DPH	$3,250,000	2012	2012-2013	Service commitment	Aligned	Service commitment to 250 new units
Subtotal	$55,750,000					
Previously Aligned Public Funders: 2012 Commitments						
City of Pasadena	$2,850,000	2012	2012-2027	Voucher commitment	Previously Aligned	19 new project-based vouchers
City of LA Housing Department	$8,594,111	2012	2012-2016	Construction funds	Previously Aligned	218 new units
HACLA	$32,700,000	2012	2012-2027	Voucher commitment	Previously Aligned	218 new project-based vouchers (39 for CH)
Subtotal	$44,144,111					
Total Leveraged Directly and Indirectly through Funders Collaborative						**$ 104,982,111**

Source: Home For Good

These vouchers are for use in new construction supported by The LA Housing Department. Finally, the county has dedicated $3.25 million annually for two years to link services to 250 of the tenant-based vouchers each year – 200 from HACLA and 50 from HACoLA. Only the first two years of this service funding is included in the amounts shown in Exhibit 5.1, as ongoing funding for these services will be contingent upon future allocation decisions.

The public resources intentionally aligned with service funding – public or private – are counted as part of the goal of $75 million. This includes $55.75 million in funding issued through the 2012 Request for Proposals (RFP).

The $5 million in private funding, including the Hilton Foundation's seed grant, has been coordinated and aligned with the voucher allocations through the Funders Collaborative process. These private grants reflect one-year commitments of resources. Funding for ongoing service costs will be contingent upon future funding commitments.

Additional public and private funds have been leveraged by Hilton Foundation grantees and through the Foundation's program-related investment loans administered through Corporation for Supportive Housing (CSH). CSH has also secured federal funding through the Social Innovation Fund (SIF) to expand the Hilton Foundation-supported Frequent User Service Enhancement (FUSE) pilot projects that link housing and services for the most frequent users of hospitals and other costly public services. More information on the SIF expansion project is provided in the text box.

Social Innovation Fund

CSH was awarded a Social Innovation Fund (SIF) grant from the Corporation for National and Community Service (CNCS) to expand the FUSE pilot projects that link housing and services for the most frequent users of hospitals and other costly public services. Some of the projects and partnerships that were initially launched with support from CSH (including technical assistance, facilitation, and grants funded in part with Hilton Foundation grants) will be expanded. CSH will match CNCS SIF grant award 1:1 with help of the Hilton Foundation, Melville Charitable Trust, Fannie Mae, UniHealth Foundation, and the Jacob and Valeria Langeloth Foundation. CSH subgrantees (in LA the Economic Roundtable) are also required to match the subgrant amount, resulting in the tripling of the initial investment. CSH is working to secure additional funding for the FUSE projects, including funds dedicated by members of the LA County Board of Supervisors.

CSH is conducting a SIF Evaluation, and selected a team of researchers at NYU to conduct a rigorous evaluation of CSH's SIF program, which will measure the impact of the intervention in all four sites. The SIF evaluation team will measure success of housing and services through metrics such as housing stability, improved health outcomes, reduced use of emergency health services, reduction in public costs, and overall improved access to preventive care. The evaluation in LA, however, will likely be limited to the 107 targeted SIF clients, not the individuals enrolled through the FUSE pilot phase.

Implementation is expected to begin in August 2012, with program participants identified and enrolling as early as August or September 2012.

5.2 Process Measure: Has a coordinated decision-making strategy been adopted and implemented to align funding for PSH (housing and services)?

Significant work occurred throughout 2011 to create a more coordinated approach to funding different aspects of PSH through the creation of a new PSH Funders Collaborative. Interested funders were invited to pool resources that would then be allocated through a single, streamlined Request for Proposal process. Even if funders did not want to pool resources, the Funders Collaborative was intended to align the allocation and decision-making processes so that, for example, one project did not end up with housing vouchers and no services, while another project had services but no ongoing source of operating funds.

Home For Good Funders Collaborative

In Chapter 4, we reported on the Home For Good Funders Collaborative as a result of political will and as a vehicle for concrete actions by government and other stakeholders to commit funds to permanent supportive housing. Here we assess the extent to which the Funders Collaborative succeeded in creating a coordinated decision-making strategy that aligns housing and services funding.

In March 2012, the Home For Good Funders Collaborative released an RFP for over $75 million in private and public funding, including some resources that were pooled in a collaborative funding application. Non-profit organizations were able to apply for multiple funding streams through a single application process. Applications were reviewed jointly by representatives from public agencies, private funders, and public housing authorities (PHAs). The Funders Collaborative RFP is an important milestone marking significant progress toward the goal of aligning funding. However, the evaluation team also learned that there is still room to improve upon the process for future years.

In interviews with representatives of funders, participants generally had very positive reactions to the process and said they were impressed at the ability of Home For Good to get the public sector stakeholders to the table. United Way was cited as an excellent facilitator and very effective in increasing the focus of elected officials on the issue.

Private sector funders noted that they appreciated the opportunity to combine funds with public funding to make a greater impact. Some of the already-realized benefits of coordinating funding through the Funders Collaborative are:

- The collaborative process helps funders gain a better understanding of what else is happening in the field and provides a framework for addressing the issue strategically (with other funders), rather than just responding in a fragmented way.
- The collaborative process helps funders make better strategic decisions about how to allocate funding by having access to the thinking of other funders and the opportunity to align decisions with those of the City of LA and Los Angeles County.
- Several private foundation respondents described being able to use the broad support for PSH demonstrated through the Funders Collaborative to "sell" the approach internally at their organizations.

We also discussed the Funders Collaborative with current public and private participants in the Collaborative and representatives from three applicants for funding through the Home For Good Spring 2012 RFP. The applicants reported that the services application was quite straightforward. One respondent indicated that it was "easier than most."

Some of the participants we interviewed noted that the Collaborative helped bring a regional view to the funding process, which they believed would ultimately help to create an understanding of the appropriate geographic distribution of services and housing. Without this understanding, smaller jurisdictions with a lot of services may believe that they are "taking on more than [their] fair share of the burden by building too much housing and possibly attracting homeless from other regions."

However, some funder and applicant participants expressed some concerns about the Funders Collaborative in the interviews with the evaluation team.

- Funder participants were unclear on whether different or better projects received funding through this process than would have through a more typical funding approach.
- Concern was raised about the effort's sustainability: "it can be challenging to sustain collaboratives because people get burned out and priorities change for some funders."
- Applicants indicated that the funding did not seem to reflect substantial increases in the overall pool of available resources and that the funding for services did not appear to be sustainable, which was what they were hoping to see.

United Way provided its own perspective on the process, including challenges encountered. In interviews with the evaluation team, United Way staff noted that understanding and accounting for the political nature of funding process was critical to implementing a coordinated approach to funding. They said that the inclusion of the Chamber of Commerce and the business community in the process helped to motivate politicians to continue prioritizing PSH. United Way is currently thinking through how to keep the business leaders engaged and how to bring the faith community into the process. They are focusing on "widening the approach without losing focus."

Participants indicated that some of the next steps under consideration to ensure that the Funders Collaborative remains an effective avenue for aligning funding for PSH are:

- Attempt to increase the resources being allocated and bring more sustainable funding to the table, particularly for services, to match the 15-year voucher commitments being promised by the PHAs.
- Bring to the table smaller PHAs and local governments, as well as community-based funders, to ensure that the Funders Collaborative can reach and leverage resources in all areas of the county.
- Find ways to foster a regional conversation while engaging more public and private funders within local communities.
- Identify strategies to retain political support for PSH and for aligned funding over time.
- Include Los Angeles Homeless Services Authority (LAHSA)-administered funding such as Federal McKinney-Vento grants in the collaborative.

- Increase funding from business community

Identifying Other Resources

Other efforts are also in progress to align other resources, particularly for supportive services. CSH has been actively encouraging and aiming to build capacity of providers to access Medicaid to fund supportive services for persons placed in PSH, as well as other Department of Mental Health and other mainstream funding. CSH hopes to use the FUSE and SIF projects to document best practices in this area, particularly as additional opportunities arise through the implementation of the Affordable Care Act.

6. Progress on Goal to Create 4,000 units of PSH

Two of the Foundation's strategic goals relate to unit creation, with a goal of constructing or beginning development of 3,000 project-based permanent supportive housing (PSH) units and making available 1,000 scattered site PSH units with the necessary operating and service funding. The goals include both PSH units dedicated to individuals who are chronically homeless and units that are not designated for a specific subpopulation. The underlying assumption of the Theory of Change is that housing must be available in order to move chronically homeless individuals, or highly vulnerable homeless individuals at risk of becoming so, into housing. Thus, unit creation is a precursor to ending chronic homelessness. While dedicated units are most likely to make an impact on the long-term goal of ending chronic homelessness, availability of a broader supply of PSH is also helpful, because units not *dedicated* to individuals experiencing or at risk of chronic homelessness may nonetheless be *targeted* to chronically homeless people through outreach and admission preferences.

Data Availability: Figures for PSH inventory are available; tracking is not centralized and various sources provide differing information, leading to concerns that data is inaccurate
Status in 2012: Surpassed one-fifth of goal in 2011/early 2012; on track to meet or exceed goal, but the goal may need to be revised

Section1 of this chapter reviews the inventories of units of PSH that were brought on line during calendar year 2011 and also the units of PSH that are in the pipeline. Section 2 examines whether the inventories of units are geographically distributed throughout the LA area relative to need. Section 3 of this chapter describes the current shortfall in PSH for chronically homeless individuals.

6.1 Outcome Measure: Has there been an increase in the supply of permanent supportive housing inventory, both project-based and scattered site?

Project-based PSH Units

Exhibit 6.1 shows that 669 PSH project-based units were brought on line within calendar year 2011 and that 270 of those units were dedicated to chronically homeless individuals. Another 605 PSH units were added to the pipeline in 2011, meaning that they initiated some phase of development in 2011, even if only the feasibility stage. This addition brought the total number of PSH units in the development pipeline from 1,601, in development prior to 2011, to 2,136. Of the pipeline units, 412 are expected to be designated for individuals experiencing chronic homelessness.

The units made available in 2011 are a reflection of prior years' efforts and, therefore, not entirely attributable to the Chronic Homelessness Initiative. However, the completion of pipeline units never is guaranteed, and the pipeline units brought on line during the first year of the Hilton Initiative constitute more than one-fifth of the Initiative's goal of 3,000 units. The strong pipeline figures suggest that enough units are in progress to achieve the full five-year goal, if funding commitments can be confirmed and sustained and if project siting and development can proceed unimpeded. However, achieving the 4,000 unit goal is less secure than the table suggests in light of the dissolution in 2012 of California's redevelopment agencies, organizations that were an

anticipated source of resources for much of the development of PSH planned as of 2011 in Los Angeles and throughout the state.

Exhibit 6.1: New Project-based PSH Units

	All Units (incl. those dedicated to CH)			Dedicated to Chronically Homeless		
	Made Available for Occupancy in 2011	In Pipeline prior to 2011	Added to Pipeline in 2011	Made Available for Occupancy in 2011	In Pipeline prior to 2011	Added to Pipeline in 2011
Project-based PSH units	669	1,601	535	270	370	42

Sources: Home For Good and Corporation for Supportive Housing (CSH)

The exhibit reflects information provided by Home For Good on the production of project-based PSH units dedicated to individuals who are chronically homeless. The Home For Good data are the most comprehensive currently available and reflect information collected by United Way from PSH developers and reconciled with information collected by CSH on projects in the development pipeline and the Los Angeles Homeless Services Authority housing inventory data. The evaluation team worked with CSH to confirm occupancy start dates and collect additional information on PSH projects that are not dedicated to house individuals who are chronically homeless.

Scattered Site PSH Units

Exhibit 6.2 shows that 550 new vouchers were made available in 2011 to support homeless individuals in scattered site PSH, of which 317 were dedicated to chronically homeless individuals. Another 1,625 vouchers to support PSH were committed between January 2011 and July 2012, but they will not be available for issuance to individuals who need them until after July 2012. Of those becoming available in 2012, 1,219 vouchers are expected to be designated for individuals experiencing chronic homelessness.

In total, 1,536 out of the 2,175 new vouchers that were either made available or committed to PSH in 2011 or the first half of 2012 are designated for individuals experiencing chronic homelessness (70 percent).

However, 58 percent of the vouchers that are or will be available for scattered site PSH dedicated to chronically homeless individuals are funded by the Department of Housing and Urban Development's Veterans Affairs Supportive Housing (HUD-VASH) or HUD's Housing Opportunities for Persons with AIDS (HOPWA) programs. The HUD-VASH program may be used only by veterans, and HOPWA only by people with HIV/AIDS. This means that relatively few PSH units will be available to the majority of chronically homeless people, who probably do not meet these eligibility criteria. In addition, some communities have found that the case management services offered by the VA for veterans placed in housing with HUD-VASH vouchers do not fully meet the needs of chronically homeless individuals, particularly if the veteran was not previously engaged in services through VA Medical Centers.

Thus, the five-year goal of 1,000 scattered site PSH will be easily exceeded, but additional vouchers will be needed from the Housing Authorities of the City and County of LA and other public housing authorities (PHAs) in the LA region in order to meet the need for scattered site housing for people experiencing chronic homelessness.

Exhibit 6.2: Tenant-based PSH by Voucher Funding Source

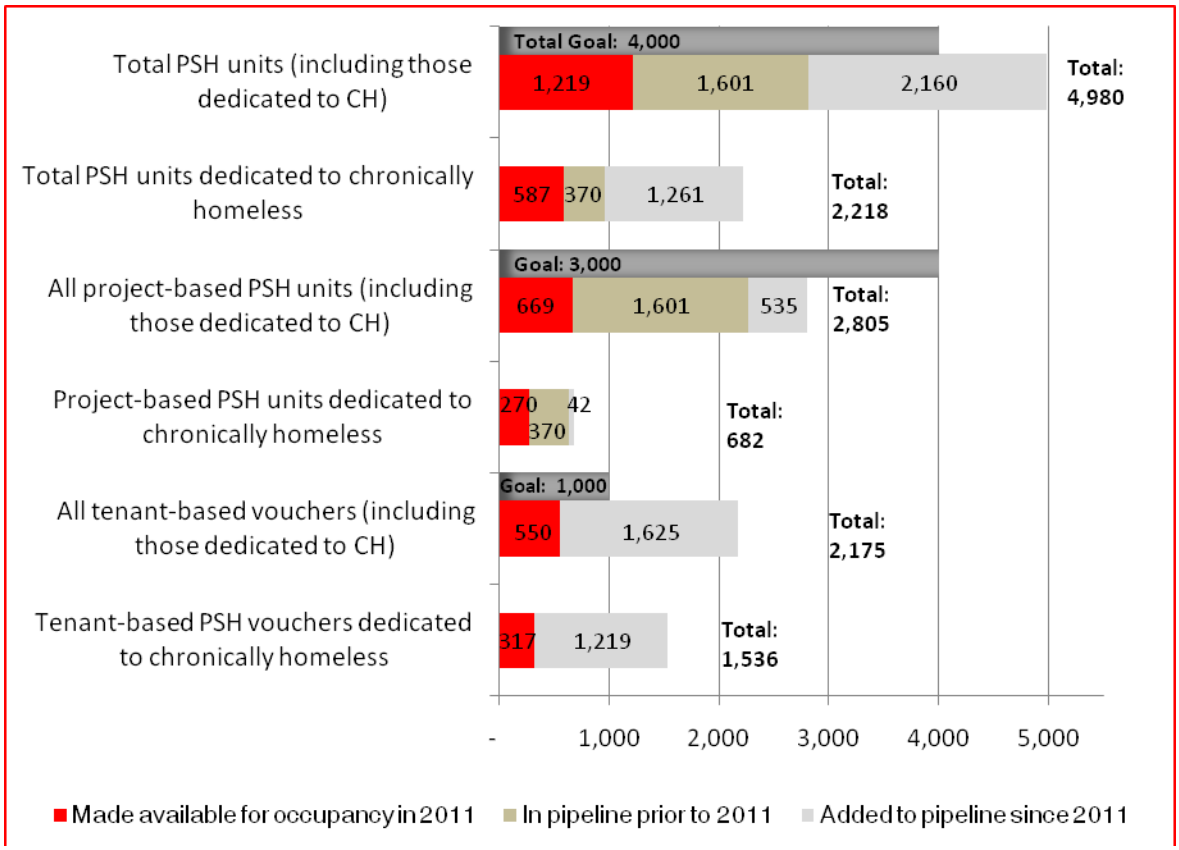
	All PSH Vouchers (incl. those dedicated to CH)		Vouchers Dedicated to Chronically Homeless	
	Newly Funded and Made Available in 2011	Newly Funded and Anticipated to Come On Line in 2012 or 2013	Newly Funded and Made Available in 2011	Newly Funded and Anticipated to Come On Line in 2012 or 2013
Total	**550**	**1,625**	**317**	**1,219**
Shelter Plus Care and Serial Inebriate Vouchers	35	110	0	51
City Homeless Housing Choice Vouchers	0	500	0	500
County Homeless Housing Choice Vouchers	0	100	0	100
HUD-VASH	350	875	227	568
HOPWA	165	40	90	0
Other PHA Housing Choice Vouchers	0	0	0	0

Source: Home For Good
Data was confirmed with individual Housing Authorities (except City of Long Beach).

Progress towards Meeting the 4000-unit Goal

Exhibit 6.3 sums the total units brought on line in 2011 and added to the pipeline in 2011 (project-based and scattered site) and 2012 (scattered site only). As the summary figures show, local stakeholders exceeded the goal of creating or adding to the pipeline 4,000 units of PSH by almost 1,000 units, of which 2,218 of the units are dedicated to chronically homeless. That said, we report this total with some reservations.

Exhibit 6.3: New PSH Units



Sources: Home For Good and Corporation for Supportive Housing; see Exhibit 6.1 for more detail on how the estimates of units were derived.

First, counts of PSH units are not captured consistently by a single entity in Los Angeles; therefore the numbers of units presented in this section represent only an approximation of the available and pipeline inventory. Information about project-based and scattered site PSH was challenging to acquire and interpret for reasons that have to do with unduplicated counting of units, definitions of PSH, and PSH dedicated to individuals with chronic patterns of homelessness.

- United Way has made efforts to gather information over the past year, but because there is no single source of reliable information about the housing inventory in Los Angeles, they report significant struggles to gather consistent information over time and among sources. For example, the multiple lists examined provide inconsistent reports of unit designation (PSH or affordable housing; families or individuals) and unit counts, even for the same project address.
- It has been challenging to make the distinction between supportive housing for homeless people that *includes* chronically homeless people and housing units that are *dedicated exclusively* for chronically homeless people. In part, this reflects inconsistent terminology among PHAs and providers.
- Finally, a percentage of tenant-based vouchers are actually used to support individuals in project-based housing developments, which creates some double-counting between the project-

based and scattered site inventories. Significant additional data collection from the PHAs would be required in order to assess the overlap. Identifying the overlap would require disclosing addresses of voucher users and, therefore, a data use agreement, if done by the evaluation team rather than by the PHAs themselves.

Given these limitations, it is difficult to confirm the totals presented here as accurate. We look forward to working with the relevant organizations over the coming year to continue to collect, reconcile, and refine the counts of PSH units.

Second, the goal included units constructed, added to the development pipeline, and scattered site units made available with necessary operating and services funding. Almost 2,000 of these units are in the development pipeline, which means there is no guarantee they will come to fruition. While the tenant-based vouchers are paired with services, many would argue that the services are not sufficient to meet the needs of people who are chronically homeless and that funding for services is only committed for the next year or two and therefore is not enough to claim as a victory. And finally as discussed above, the narrow focus of some of the tenant-based funding streams in particular may limit the ability of stakeholders to house the most vulnerable among the chronically homeless.

We have indicated progress on this goal in green to reflect that progress is on track, in particular given the extent of progress in the first year of the five-year period. However, we want to clearly note that we do not believe that this goal should be considered "achieved" at this stage. Substantial work will be needed ahead to secure sustainable service funding, to bring the pipeline project-based units to fruition, and to add additional PSH resources beyond those dedicated to very specific populations such as veterans or persons with HIV/AIDS.

Further, stakeholders may want to consider whether the goal should be formally revised to increase the target beyond 4,000 or to focus the 4,000 on units dedicated to persons who are chronically homeless, to shift more emphasis toward scattered site models moving forward, or to clarify expectations regarding sustainability of funding.

6.2 Process Measure: Is the PSH inventory geographically distributed throughout the Los Angeles area, relative to need?

In the interviews conducted by the evaluation team, stakeholders indicated that, to truly address chronic homelessness in Los Angeles, efforts needed to extend beyond Skid Row and other geographies previously associated with high concentrations of street homelessness. There appears to be broad agreement that increasing the geographic distribution of PSH throughout the county would be an important indicator of success. Exhibit 6.4 reports the geographic distribution of the project-based PSH units that were brought on line in 2011, using both county Supervisorial Districts and the service planning areas (SPAs) widely used by the county and by local stakeholders for planning purposes.

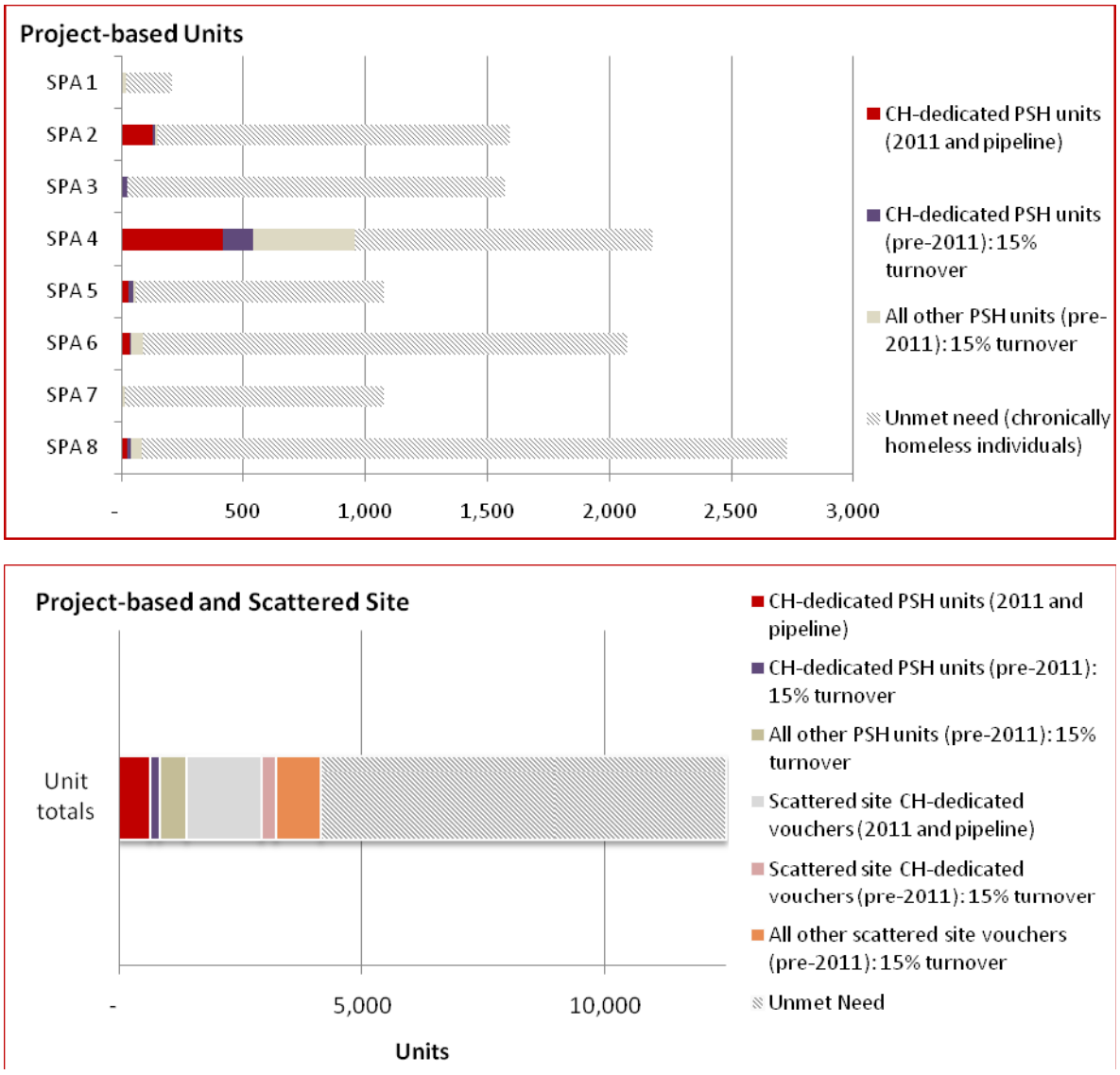
Exhibit 6.4: New Project-based PSH Units by Geographic Subarea

	All Units (incl. those dedicated to CH)			Dedicated to Chronically Homeless		
	Made Available for Occupancy in 2011	In Pipeline prior to 2011	Added to Pipeline in 2011	Made Available for Occupancy in 2011	In Pipeline prior to 2011	Added to Pipeline in 2011
Supervisorial District 1	137	*Not available by subarea, as many pipeline projects have not been sited.*	*Not available by subarea, as many pipeline projects have not been sited.*	75	138	42
Supervisorial District 2	364			90	117	0
Supervisorial District 3	132			82	97	0
Supervisorial District 4	36			23	3	0
Supervisorial District 5	0			0	15	0
SPA 1: Antelope Valley	0			0	0	0
SPA 2: San Fernando Valley	106			36	92	0
SPA 3: San Gabriel Valley	0			0	0	40
SPA 4: Metro LA	313			193	225	2
SPA 5: West	18			18	14	0
SPA 6: South	196			0	36	0
SPA 7: East	0			0	0	0
SPA 8: South Bay	36			23	3	0

Sources: Home For Good and Corporation for Supportive Housing
See Exhibit 6.1 for more detail on how the estimates of units were derived. The distribution by SPA is based on housing unit address data provided by Home For Good and CSH.

Using data from the LA Homeless Count coordinated by LAHSA in 2011 and the point-in-time (PIT) data reported to HUD from the other three Continuums of Care in LA County, the evaluation team compared the relative need for PSH with the distribution of project-based PSH units. Exhibit 6.5 displays an estimate of the units potentially available during 2011 to house the chronically homeless population and the estimated shortfall by SPA. The estimate of potentially available units is constructed from the total number of new chronically homeless dedicated units brought on line during 2011 (shown in Exhibit 6.4) coupled with a turnover rate of 15 percent of approximated "pre-2011" PSH units dedicated to chronically homeless individuals and an assumed use of 15 percent of general PSH units by individuals who are chronically homeless. The distribution by SPA is based on housing unit address data provided by Home For Good. The 15 percent turnover and usage rates are consistent with assumptions on turnover used by Home For Good in its projections. Scattered site units, which are not dedicated to a specific location, are shown only in the "unit totals" bar.

Exhibit 6.5: Distribution of estimated PSH units and need by SPA



Sources: Home For Good, Corporation for Supportive Housing, and PIT counts

The distribution of chronically homeless individuals is based on aggregated information from the Los Angeles, Pasadena, Glendale, and Long Beach PIT counts submitted to HUD. These counts may use differing methodologies.

The turnover portions of each SPA bar shown in the top chart in Exhibit 6.5 illustrate the relative proportions of existing PSH throughout the county. The largest supply of PSH is in SPA 4, which includes Downtown Los Angeles. Although most of the increase of project-based PSH units also occurred in SPA 4, the exhibit shows some growth in the distribution of PSH, particularly in SPA 2, which includes the San Fernando Valley. Minor increases occurred in several other SPAs as well. Relative to the estimated shortfall of PSH needs, additional units are needed throughout the county, but are especially needed in SPA 6 and SPA 8, which encompass the South Los Angeles, South Bay, and Long Beach geographies, to make headway on the unmet needs.

6.3 Current Shortfalls in PSH for Chronically Homeless Individuals

The total shortfall for housing all chronically homeless persons countywide is more than 8,000 PSH units. Projects that were made available in 2011 show some improvements in diversifying the PSH stock relative to the need, as shown in Exhibit 6.6. The exhibit shows the estimated percentage of the overall project-based PSH units located within each SPA, based on data provided by Home For Good. Prior to 2011, SPA 4 (downtown Los Angeles) was home to 71 percent of the PSH stock, but only 45 percent of the 2011 and pipeline units will be located there. SPA 2, the San Fernando Valley, has picked up a significant portion of newer PSH developments, but still has a large gap to close.

During the interviews conducted for this evaluation stakeholders pointed to the system's reliance on scattered site housing, which can be anticipated to grow with the loss of critical development resources. The location of scattered site housing can be expected to be more geographically diverse than project-based housing. Reliable data on the location of scattered site units is difficult to collect. The evaluation team will work with available resources over the coming year to determine if it is feasible to gather information about the geographic diversity of scattered site housing to gain a better understanding of the unmet needs of each SPA's chronically homeless population.

Exhibit 6.6: Distribution of Project-based PSH Units by SPA Relative to Need

	Pre-2011 PSH Units	2011 and Pipeline PSH units	CH Individuals (January 2011)
SPA 1: Antelope Valley	3%	0%	2%
SPA 2: San Fernando Valley	3%	22%	13%
SPA 3: San Gabriel Valley	4%	4%	13%
SPA 4: Metro LA	71%	45%	17%
SPA 5: West	4%	3%	9%
SPA 6: South	7%	24%	17%
SPA 7: East	2%	0%	9%
SPA 8: South Bay	8%	2%	22%

Sources: Home For Good, Corporation for Supportive Housing, and PIT counts

Housing address data provided by Home For Good and Corporation for Supportive Housing. This information is only available for pipeline projects that have been sited. The distribution of chronically homeless individuals is based on aggregated information from the Los Angeles, Pasadena, Glendale, and Long Beach PIT counts submitted to HUD. These counts may use differing methodologies.

7. Progress on Goal to Establish a System of Prioritizing Chronically Homeless Persons for PSH

During the January 2011 point-in-time count, 12,498 individuals were counted as chronically homeless in Los Angeles County (including Glendale, Pasadena, and Long Beach). Even if permanent supportive housing (PSH) unit creation continues at an unprecedented pace, which seems unlikely given the substantial setback related to the recent dissolution of California's redevelopment agencies and the limited numbers of vouchers under the control of public housing authorities (PHAs) compared to the overall need for rental assistance, new project-based units and new vouchers designated for PSH for chronically homeless people are unlikely to meet the need. Instead, ending chronic homelessness will require that PSH units that are not explicitly designated for people with chronic homelessness serve increased numbers of chronic individuals. Thus, another strategic goal of the Chronic Homelessness Initiative is to "establish a system to prioritize persons for placement in PSH."

There are three major efforts involving prioritization in LA. First, Community Solutions has been actively working with local community leaders to conduct Vulnerability Index (VI) Registry Weeks and to use the resulting lists of highly vulnerable, largely chronically homeless individuals as the basis for prioritizing access to available PSH as new units come on line or existing units turn over. Second, the Corporation for Supportive Housing, area hospitals, and other partners have been piloting a Frequent User Service Enhancement (FUSE) project to identify frequent users of mainstream health systems in order to prioritize them for PSH. Finally, LA County is working to integrate client-level data from numerous county departments to create an integrated database that can be used to identify top users of services and prioritize them for PSH resources. None of these prioritization efforts are mutually exclusive. In fact, there is probably significant overlap among the individuals who would be prioritized by the three systems, but each works on and would likely operationalize prioritization within a different part of the system. The evaluation team examined the extent to which the philosophy of prioritization has taken root, as well as specific progress in implementing the three prioritization efforts.

Data Availability: Estimates are available, but more work is needed to develop verifiable data systems
Status in 2012: Getting started; current system relies on separate PSH provider-managed placements

Section 1 of this chapter examines the extent to which PSH is prioritized to particular homeless populations in the LA region, based on responses to the survey of stakeholders. Section 2 of this chapter describes the activities under way by Chronic Homelessness Initiative grantees to establish more systematic approaches to prioritization and concludes with a discussion of challenges.

7.1 Process Measure: Do PSH providers and their housing placement partners systematically prioritize the placement of "target" groups as PSH units come on line or turn over?

Priority Populations

Housing authority representatives, PSH providers (operators, managers, and developers), government representatives, and funders were asked in the web-based stakeholder survey to indicate whether they prioritize populations in the allocation of units they control or through funding of programs for particular populations. A majority of respondents in all groups indicated that they do so.

- Six out of 8 respondents from the 8 separate PHAs that answered questions related to prioritization indicated that they have set-asides of vouchers for specific homeless populations.
- Thirty-four out of 40 respondents identifying themselves as PSH operators (those responsible for the day-to-day operation of PSH) indicated that they gave certain target populations priority in the selection of tenants to occupy PSH units.
- Fourteen out of 18 government representatives indicated that they fund PSH for particular homeless populations.
- Nine out of 17 funders indicated that they fund programs that serve particular homeless populations.

Exhibit 7.1 shows which populations these groups reported that they prioritize (or set aside, in the case of vouchers), either for funding projects or for placing people in housing. PSH units are set aside for chronically homeless individuals and for persons with serious mental illness by two-thirds of PHA representatives responding to the question. More than half of the providers of PSH responding to the survey (54.3 percent) reported that they prioritize units for chronically homeless individuals, and 71 percent said that they do so for persons with serious mental illness. More than two-thirds of respondents from government agencies in the LA region (71 percent) said that they target funding to PSH for chronically homeless individuals, and 57 percent said that they do so for PSH for persons with serious mental illness. This may reflect in part the significant investments of Mental Health Services Act (MHSA) funds allocated by the LA County Department of Mental Health to create PSH for homeless people with serious mental illnesses. LA County has established eligibility criteria for MHSA "Full Service Partnerships" that prioritize people with serious mental illness who have long histories of homelessness as well as repeated crises such as hospitalization and incarceration. All of the staff of private sector funders of PSH (100 percent) indicated that they target programs that serve chronically homeless individuals.

Exhibit 7.1: PSH Unit Set-asides and Funding Priorities for Homeless Populations

Respondents indicating they prioritize populations for PSH	PHA Set aside (n=6)	PSH Providers: Units Prioritized (n=34)	Gov't Reps: Funding Prioritized (n=14)	Private Sector: Funding Prioritized (n=9)
Chronically homeless individuals	66.7%	54.3%	71.4%	100%
Chronically homeless families	66.7%	17.1%	50.0%	55.6%
Persons with serious mental illness	66.7%	71.4%	57.1%	44.4%
Transition-aged youth (18-24)	66.7%	22.9%	42.9%	44.4%
Frequent users of emergency health services	50.0%	8.6%	42.9%	33.3%
Persons at high risk of homelessness when they re-enter the community from jail, prison, hospitals, or mental health facilities	33.3%	2.9%	28.6%	33.3%
Homeless individuals with chronic substance use issues	16.7%	28.6%	35.7%	33.3%
Homeless individuals identified as having a high likelihood of mortality or are medically fragile according to a VI Registry	16.7%	22.9%	50.0%	33.3%
Selected as "other" and written in:				
Veterans	16.7%	14.3%	7.1%	22.2%
Persons at risk of homelessness	16.7%			
HIV/AIDS		5.7%		
Shelter Plus Care		5.7%		
Seniors		5.7%		
Families				11.1%

Source: Abt Associates Inc. Stakeholder Survey, June and July 2012

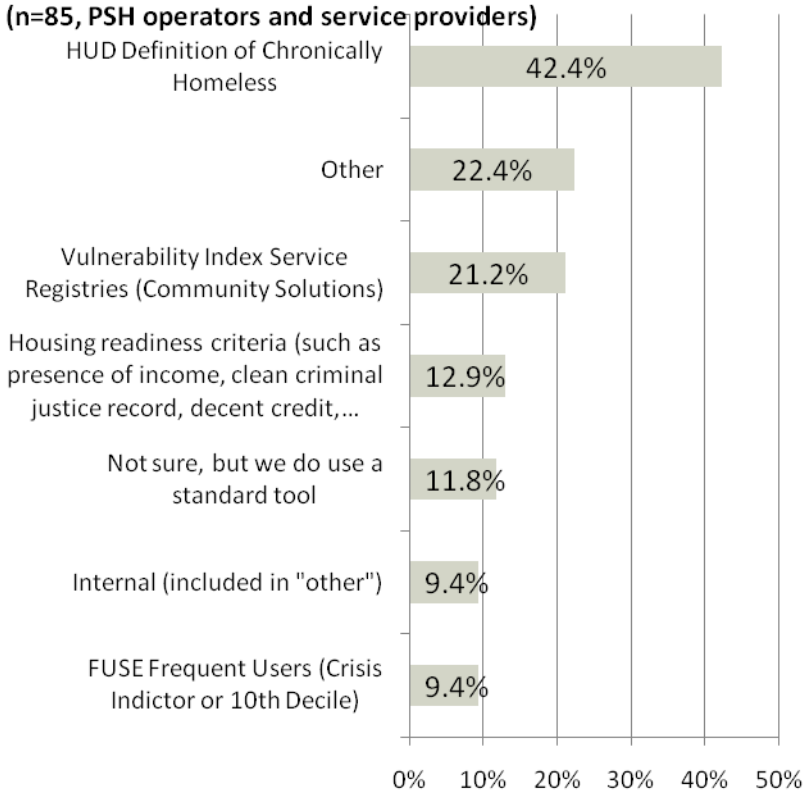
Within each stakeholder group, only those respondents indicating a priority or set aside were asked to identify the target population for that priority or set aside. The number of respondents for each stakeholder group is provided in the column header.

Prioritization Approaches

A separate question on the web survey asked about the use of specific tools for identifying people for whom priority is given in placement into PSH. Among the 40 PSH operators and 154 service providers responding to the stakeholder survey, 54 percent indicated that they do not currently use a prioritization tool to identify individuals for placement in available PSH units. Of the 85 providers (44 percent) who indicated that they do use such a tool, the largest proportion uses the Department of Housing and Urban Development's (HUD) definition of chronic homelessness at intake as a means of identifying priority populations (Exhibit 7.2). More than one-fifth of the 85 providers who use a prioritization tool (about 10 percent of all provider respondents) indicate that they use the Vulnerability Index as a basis for prioritization. Smaller numbers of providers use a FUSE tool or an internal prioritization tool based on their programmatic targets.

While providers are reflecting the language of prioritization and many feel they are currently prioritizing chronically homeless people, less than 10 percent of the 194 providers responding to the survey indicated that they use a community registry or shared priority list to drive placement. This means that prioritization is very individualized and based on who presents to a given provider requesting housing, rather than based on a community effort to house the most vulnerable persons living on the streets.

Exhibit 7.2: Prioritization Tools Used to Place Individuals in PSH
(n=85, PSH operators and service providers)



Source: Abt Associates Inc. Stakeholder Survey, June and July 2012, n=85, all PSH operators and service providers using a prioritization tool

Overall, the 85 providers indicated that their primary prioritization approach is:

- **34.1 percent** (29 providers) -- We do not have a community registry/priority list, but we assess potential clients and prioritize them for housing based on the results of their assessment.
- **29.4 percent** (25 providers) -- We have a community registry/priority list, but we conduct our own assessment to determine priority for placement in our program.
- **22.4 percent** (19 providers) -- We select clients for placement in our program from the registry/priority list in our community.
- **9.4 percent** (8 providers) -- We do not have a community registry/priority list, but clients referred to our program have been prioritized using a standardized method by another program or outreach team.

7.2 Grantee Actions to Establish Systematic Prioritization of Vulnerable and Chronically Homeless People for PSH

Several of the Hilton Initiative grantees are working to implement more proactive prioritization practices. Some of these efforts are described below.

Community Solutions – Vulnerability Index Registry

Community Solutions provided direct support for 10 new community VI Registry projects in 2011. In addition, Long Beach updated the list of vulnerable and chronic homeless people by completing a second formal VI Registry Week (the original Registry Week took place in the summer of 2009). Two thousand homeless people were identified in 2011 by LA communities using the VI surveys. Community Solutions has also worked with several demonstration sites to integrate the VI survey into data systems used by homeless providers, including the Homeless Management Information System (HMIS) system.

In meetings with the leadership of the Los Angeles Homeless Services Authority (LAHSA) in 2011, Community Solutions made some progress toward developing a work plan to integrate the VI data points and vulnerability scoring formula into HMIS. As a result of these meetings, LAHSA determined it was interested in proceeding with the integration of the VI data points, but was not interested in building in the Vulnerability Index logic (scoring) into the HMIS system. Without integration of this logic, however, communities would not be able to run HMIS reports rank-ordered by vulnerability to use to set priorities among homeless people for housing and services resources. With conversations between Community Solutions and LAHSA stalled at this point, it is Community Solutions' intent to continue to pursuing VI integration with HMIS.

Despite this lack of progress on integrating VI data into the HMIS, Community Solutions worked with LAHSA in 2011 to commit new HUD Shelter Plus Care funding to applicants that planned to prioritize housing for the most vulnerable and chronically homeless households as identified through community registry projects. Specifically, extra points were awarded to applicants for Shelter Plus Care funding with a housing outreach plan that included "coordination with a local community's priority lists, such as the Vulnerability Index." In interviews with the evaluation team, Community Solutions staff stated that, in their view, this prioritization of LAHSA-controlled funding demonstrates a movement toward coordinating housing resources with community-based efforts to identify the most chronic and vulnerable among the homeless population and moves the LA Continuum of Care into better alignment with the national priority to end chronic homelessness.

Corporation for Supportive Housing –FUSE Pilot Project

Corporation for Supportive Housing's (CSH) FUSE pilot project in LA, which has received technical assistance and grant funding from the Hilton Foundation and the Social Innovation Fund, identifies homeless people who are the most frequent users of hospitals and other costly public services. In the pilot phase (2011), 38 individuals were enrolled in the program and received immediate, temporary housing. Of those, 10 have dropped out due to death, incarceration, or disappearance, and 12 have been approved for permanent supportive housing and are in their housing or seeking apartments. CSH hopes that property managers and support services staff will become more familiar with PSH models that are effective for chronically homeless people and less reluctant about renting to them.

Challenges to Increasing Prioritization

While prioritization efforts are occurring at the program-level, as just described for several Chronic Homelessness Initiative grantees, PSH providers and other stakeholders have concerns about how a wide-spread prioritization system would work. Some of these concerns reflect the size and geographic scale of Los Angeles County and the fact that people who are homeless want to live in different communities or regions of the county. In many cases, the supportive services that are part of PSH projects are not funded by resources dedicated to the PSH project but instead are reallocated from existing contracts for services programs. As a result, providers find it more feasible to offer PSH to people who are already engaged in their service programs, and they want to meet the housing needs of homeless people they already serve when they obtain new PSH resources. These service providers are extremely wary of the idea that someone else (e.g. "the county") would be making decisions about who gets the next available housing opportunity, and they are concerned that the people they already serve would not be prioritized.

8. Progress on Goal to House 1,000 Most Vulnerable Chronically Homeless Persons in PSH and Prevent 1,000 Persons from Becoming Chronically Homeless

If prioritization strategies like those discussed in Chapter 7 are successfully and broadly implemented, the number of chronically homeless individuals placed in housing should equal the number of newly available units and vouchers designated as permanent supportive housing (PSH) for chronically homeless individuals plus a portion of the newly available PSH units that are not so designated. While it is not realistic to assume that every PSH vacancy will be filled by someone who is chronically homeless, an extremely high proportion of chronically homeless placements relative to the total available vacancies is desired and necessary in order to end chronic homelessness. Prioritization efforts should also enable people who are chronically homeless to access turnover vouchers and units in existing PSH projects. Thus, placement data should be considered relative to the 587 project-based and scattered site PSH units designated for people who are chronically homeless that were brought on line in 2011, the 632 PSH units that were not designated for chronically homeless individuals that became available, and the total number of vacancies due to turnover in existing PSH. Unfortunately, the latter number is not readily available.

Based on the numbers reported by PSH providers, the goal of 1,000 chronically homeless persons in PSH has already been exceeded. However, gaps in data maintained by PSH providers at the level of individual residents make it challenging to understand whether the most vulnerable among those who meet the definition of chronic homelessness were placed and the extent to which their placement reflects systematic prioritization efforts. In addition, while efforts are underway related the goal to prevent 1,000 persons from becoming chronically homeless, data systems are not yet sufficient to accurately quantify their impact.

Data Availability: Figures for chronically homeless placements are available, but more detailed accounting is needed; more information is needed for other vulnerable populations	
Status in 2012: Surpassed five-year chronic homeless placement goal in 2011	**Status in 2012: Made progress on prevention goal, but results are not clearly documented**

Section 1 of this chapter assesses whether priority populations, including individuals who are chronically homeless and especially the most vulnerable among them, are being placed in PSH. The section also assesses whether other high-risk homeless and vulnerable individuals who need to be prevented from becoming chronically homeless are being placed in PSH. Section 2 of this chapter lays the groundwork for assessing in future years whether progress has been made towards the ultimate goal of the Chronic Homelessness Initiative—preventing and ending chronic homelessness in the LA region.

8.1 Outcome Measure: Are priority populations being placed in PSH units?

Exhibit 8.1 shows the total placements of people who are chronically homeless in different types of PSH, as well as the total number of placements of individuals at risk of chronic homelessness, as documented by the Community Solutions Vulnerability Index (VI) Registry partners. The total

number of chronically homeless individuals placed in 2011 was 2,162, well above the full five-year goal for the Initiative. Of those, 488 were placed by agencies supported directly or indirectly by the Hilton Foundation, of which 203 individuals were placed by Hilton Foundation targeted grant programs—that is, programs that work directly with chronically homeless individuals. (The targeted programs are described in Chapter 3 of this report.)

Nearly 50 percent of the 2,162 placements of chronically homeless individuals in 2011 were made by the VA of Greater Los Angeles. As discussed in Chapter 6, a substantial majority of the vouchers made newly available for scattered site PSH in 2011 came from the Department of Housing and Urban Development's Veterans Affairs Supportive Housing (HUD-VASH) program.

Although 270 project-based PSH units dedicated to chronically homeless individuals were reportedly brought on line in 2011 (see Chapter 6), the placement data shows only 211 chronically homeless individuals placed in new units. Based on information provided in interviews and focus groups, this may reflect the long processing times clients experience when attempting to move into an available unit. In contrast, the placement data for chronically homeless individuals in scattered site PSH is significantly higher than the number of dedicated and general PSH vouchers made available in 2011. This suggests that providers of PSH were able to successfully access additional housing vouchers for chronically homeless individuals through annual turnover of the homeless set-asides established by the city and county housing authorities, as well through Shelter Plus Care.

The exhibit shows that 118 homeless individuals who did not meet HUD's definition of chronic homelessness were also placed in PSH through Community Solutions' community partners. While these individuals were not chronically homeless at the time of the Registry, this is the number of placements estimated by Community Solutions to be homeless and highly vulnerable as measured by the Community Solutions Vulnerability Index. Placement in PSH is assumed to have prevented long-term or chronic homelessness for these individuals.

Although Corporation for Supportive Housing and other partners are involved in other activities to begin to more systematically prevent chronic homelessness, these efforts are still in their infancy and do not have concrete placement results. The figures reported here on prevention are likely an undercount, since there is not a data system in place that can comprehensively record PSH placement data, and the Home For Good quarterly placement data collection process for 2011 did not include data on prevention of chronic homelessness.

Exhibit 8.1: Placements in PSH in 2011

	Placements in new Project-based PSH	Placements in existing Project-based PSH (turnover)	Placements in Scattered site PSH (new and turnover)	Total Placements across all Housing
Total placements of individuals experiencing chronically homeless	211	266	1,685	2,162
Placements by Hilton Foundation-supported organizations of individuals experiencing chronically homeless (subset of above)	*Not tracked consistently in 2011*			488
Placements by Hilton Foundation Grantee Programs of individuals experiencing chronically homeless (subset of above)	*Not tracked consistently in 2011*			203
Total placements of individuals at risk of chronic homelessness	*Not tracked in 2011*			118

Source: Chronically Homeless Placements – Home For Good Year 1 Annual Report; At risk placements – Community Solutions

The data related to the placements of chronically homeless individuals in PSH was collected by Home For Good through a quarterly provider reporting process. In general, this can be assumed to be an underestimate, because if there is any potential duplication in reporting (e.g. a housing operator reports placements and the service partner for its facility also reports the placements), the questioned placements are removed from the count. Providers are asked to report the type of PSH unit into which each client has been placed. Determination of chronic homelessness is based on the HUD definition.

At risk placements are reported by Community Solutions, based on an approximation of the number of persons determined homeless and highly vulnerable but who did not meet the HUD definition of chronic homelessness as part of the VI Registry.

Starting in early 2012, Community Solutions and Home For Good aligned their regular data collection processes into a single form that requests several types of information on housing placements, including chronic homeless status and type of placement. Thus, in future years the evaluation team should be able to report more definitively about the number of placements made by chronic homelessness status and the type of placement: project-based, scattered site, and both new units and turnover.

For the long-term, the evaluation team is working with the Los Angeles Homeless Services Authority (LAHSA) to retrieve information from the Homeless Management Information System (HMIS) about individuals placed in PSH. To date the team has worked with the LAHSA staff to develop queries specifically related to housing placements and retention for those PSH programs that submit data to HMIS, even while recognizing that many PSH providers do not yet do so. Though most Hilton Foundation grantees participate in HMIS for some of their programs, the majority do not submit data to HMIS for their Foundation-funded programs. The evaluation team

is also working with LAHSA on strategies to increase PSH and other homeless provider participation in HMIS.[6]

8.2 Outcome Measure: Are there measurable declines in number of individuals experiencing chronic homelessness in Los Angeles?

Ultimately, the success of the Initiative has to be measured by whether the overall count of chronically homeless people within LA County declines. The first two data columns of Exhibit 8.2 provide baseline information on chronic homelessness on the night of the biennial point-in-time (PIT) count in January 2011, as reported in LAHSA's Greater Los Angeles Homeless Count Report and the PIT counts the Glendale, Pasadena, and Long Beach Continuums of Care as submitted to HUD's Homelessness Data Exchange. The third column, drawn from Exhibit 8.1, shows the number of chronically homeless people placed in PSH during 2011. While there are limitations to the PIT data, it appears that nearly 20 percent of the chronically homeless people counted in the January PIT count were placed in PSH over the course of 2011. Thus, there may have been a notable decline in chronic homelessness in the Los Angeles region within the first year of the Initiative. Whether future estimates of chronically homeless people confirm such a decline depends on whether efforts to prevent vulnerable people from becoming chronically homeless are successful as well.

Exhibit 8.2: Countywide Measures of Chronic Homelessness

	Number of CH persons counted on night of PIT (sheltered and unsheltered)	Number of CH persons counted on night of PIT (unsheltered)	Number of CH persons placed in PSH in 2011 (from Exhibit 8.1)
Countywide (2011)	12,498	9,839	2,162
LAHSA Continuum	10,901	8,544	
Glendale Continuum	102	13	
Long Beach Continuum	1,074	962	
Pasadena Continuum	421	320	
Sources: 2011 PIT Counts and Home For Good			

[6] More information about challenges with the HMIS can be found in Chapter 2 of this report.

9. Progress on Goal to Increase Capacity of Developers and Providers to Effectively Provide PSH

The final goal of the Initiative relates to the capacity of developers and providers to effectively provide permanent supportive housing (PSH). The evaluation team has assessed capacity in two areas – capacity to develop more PSH throughout the county, and capacity to successfully fund and operate PSH with appropriate services, particularly within the context of prioritization of PSH to more vulnerable persons with potentially greater service needs. A high degree of capacity along both dimensions is integral to the Theory of Change underlying the Initiative. For the Initiative to succeed, there need to be more units located in more geographies throughout the county, more secure funding for operations and services, prioritization to ensure the units get allocated to the individuals who need them most in order to end their chronic homelessness, and sufficient expertise in providing a housing and services environment that can help tenants achieve successful housing outcomes.

Three Hilton Foundation grantees are funded for activities that build developer and provider capacity: Corporation for Supportive Housing (CSH), United Way, and Community Solutions. Through its Hilton grant, CSH focuses on building capacity among housing developers to assemble complex development funding streams, navigate local processes for approval of sites, and secure sufficient operating and services resources to serve vulnerable people with chronic patterns of homelessness. In addition, CSH is facilitating provider collaboratives designed to pilot strategies to serve subpopulations such as frequent users of acute health care, transition aged youth, and people returning from incarceration in prison or jail.

United Way, through Home For Good, has focused more on developing capacity to operate effective housing models, though both CSH and United Way have encouraged fidelity to minimum quality standards in PSH.

Community Solutions has focused on improving community capacity in a particular aspect of operating PSH: identifying highly vulnerable and chronically homeless persons most in need of PSH and prioritizing them for placement in PSH. Community Solutions has also run Housing Placement Boot Camps for public housing authorities (PHAs) and Veterans Affairs with the objective of shortening and improving the process of placing chronically homeless people in scattered site PSH.

Baseline Established: Stakeholder survey establishes a baseline to compare changes in perceived capacity, but there is no clear consensus among partners on how to define, much less measure, capacity of developers and providers
Status in 2012: Limited documentable progress

Section 1 of Chapter 9 describes the capacity of developers to build PSH throughout the LA region in light of the recent changes in the funding landscape. Section 2 of this chapter examines the capacity of PSH operators and service providers to meet the needs of clients, based on survey responses and focus groups conducted with residents of PSH programs. Section 3 addresses the capacity of service providers to measure and understand the complex health needs of the vulnerable population served in PSH.

9.1 Process Measure: Is there a discernable increase in the capacity of housing developers to produce PSH in Los Angeles County?

Over the course of the interviews conducted between October 2011 and July 2012, the evaluation team noted a distinct change in the discussions related to capacity. Discussions about provider capacity in our initial interviews tended to focus more on providers' capacity to house and serve the types of homeless people who need PSH and to provide the right services to support housing stability, particularly for people with long histories of homelessness who are "hard to house." Following the recent losses of California redevelopment agency resources and HOME (Home Investment Partnerships) funds, the conversation has shifted from "can do we do this well" to "can we continue to develop more PSH at all?" The evaluation team heard more about funding constraints than any other aspect of capacity related to development of housing units.

Facing Funding Constraints

PSH housing developers responding to the stakeholder survey were asked a series of questions related to their perceived capacity to produce PSH. Respondents were asked to assess ways in which development had become easier, ways in which it had become harder, and then provide an overall opinion about whether development was, on the whole, easier or harder than it had been two or three years ago. The evaluation team selected the time frame "two or three years ago" to ensure that developers focused on recent events related to development, and not simply on the inevitable changes in the development landscape arising from the Great Recession of the 2000s.

Two-thirds of respondents – 36 of the 54 PSH developers who responded to this question – reported that development had become more difficult. The top seven reasons for difficulty are provided in Exhibit 9.1. In addition to choosing one or more of the response options provided, three respondents specifically noted the loss of funding resulting from the state's decision (upheld by the California Supreme Court) to eliminate redevelopment agencies in 2012 as a major challenge.

Exhibit 9.1: Compared to 2 or 3 years ago, in what way has it become more difficult to develop PSH?

	Percent
Economy has stagnated	63.5%
Less able to obtain development funding	59.6%
Less able to obtain operating or services funding - public	44.2%
Administrative burdens increased	42.3%
Staff capacity	40.4%
Less able to obtain operating or services funding - private	36.5%
Increased opposition/NIMBY	30.8%
Funding is fragmented	23.1%
Other	11.5%
Source: Abt Associates Inc. Stakeholder Survey, June and July 2012, n=52, PSH developers	

In our most recent stakeholder interviews, conducted in June 2012, housing developers reported seeing support around the LA region for housing more vulnerable or chronically homeless people in

PSH, but no net increases in funding. CSH provides technical assistance to help developers become more skilled at securing complex funding sources for development. Up until relatively recently, these efforts had resulted in many projects in the pipeline, including some led by first-time PSH developers, based on Mental Health Services Act (MHSA) development resources, state bonds for affordable housing, and federal stimulus funding.

However, the loss of the redevelopment funds was described as a major setback to developing new projects and, in some cases, to completing the projects in the pipeline. Developers do not believe that goals for new development are feasible given the loss of bond funding and other redevelopment agency resources, reductions in CDBG and HOME resources, and a dwindling MHSA set-aside for housing. Developers told us that the landscape is going to get much worse before it gets better. However, in interviews with the evaluation team, CSH noted that, in past years when other sources of funding were limited, PSH development did not completely stop as they have been able to use Hilton grants and PRI loans to at least incrementally advance development projects.

Developers also mentioned in interviews that they continue to struggle with NIMBY (not in my backyard) issues and would like to see more low income and homeless people on the leadership of the neighborhood councils to advocate for these projects and educate their neighbors.

In the interviews with the evaluation team, funders, public housing authority (PHA) staff, and elected officials were asked for their perspective on the changing capacity of developers. These groups also tended to focus on funding issues and said that the funding environment has made PSH development much more challenging and requires an even more skilled housing developer.

We heard from many stakeholders that the difficulty of developing project-based PSH puts more pressure on resources available for scattered site housing approaches and for service providers who help homeless people get and use housing vouchers in scattered site PSH. While PHA staff told us about improved alignment between service providers and developers and said that they are seeing increased interest in mixed-income developments that include a component of special needs housing supported by vouchers, many stakeholders said that the funding sources for these deals is gone.

Elected official interviewees gave more varied responses about difficulties in funding and siting project-based PSH. Though some noted the loss of funding and ongoing NIMBY concerns, one reported, “I don't think it's harder. Producing PSH depends on two elements - money and local politics... In my experience, there’s more sophistication now among nonprofit housing developers and PSH project sponsors [and] there's now less resistance from neighbors… Even negative press attention – for example LA skid row sweeps – help to build more recognition that something must be done… For example, [an LA City Council Member] recently stood up to NIMBYs who were opposing a proposed PSH project. That represents a lot of progress - compared to a few years ago.”

Creating Development Capacity throughout the LA Region

Many of the stakeholders we interviewed talked about the need to increase the number of developers with capacity to develop or operate PSH, particularly in areas of LA County that have large numbers of chronically homeless people and few (or no) local nonprofit housing developers who have experience with PSH. In particular, stakeholders in the San Gabriel Valley, Gateway Cities, and South LA talked about a variety of strategies to strengthen local capacity to create PSH

to address local needs. Stakeholders described the need for multiple approaches, recognizing that local non-profit community development organizations have relationships and credibility with residents, neighborhood organizations, and local public officials, but they lack experience with PSH and the property management practices and service partnerships that make PSH successful for people with long histories of homelessness.

Several larger non-profit developers who have years of experience with successful PSH programs operate regionally or in other parts of LA County, and several stakeholders, including elected officials, advocates, and local government agency representatives, reported increasing interest in bringing these experienced providers into communities with significant unmet needs for PSH to create successful local programs that can be models for others, and to partner with or mentor local organizations that lack experience with PSH. In South LA, for example, one interviewee reported that, "we would welcome strong providers [from other parts of LA County] who would be willing to partner with and mentor groups working in South LA."

9.2 Process Measure: Do PSH housing and service providers demonstrate capacity to operate PSH?

During site visits and interviews, the evaluation team heard about challenges or concerns about the capacity of PSH housing and service providers to operate PSH models appropriate for chronically homeless people. As with development capacity, described in the Section 1 of this chapter, the capacity challenges cited by providers were primarily related to the lack of availability of funding. Funding shortfalls surfaced as a more significant obstacle with stakeholders than the lack of provider skills or readiness to implement effective services or changes in policies and procedures. However, the evaluation team also observed the need for still more education about the basic fundamentals of the housing first approach to PSH.

Service Approaches

Our interviews and the stakeholder survey revealed that some PSH providers have not yet adopted the housing first PSH approach that is being encouraged by the Initiative. Their philosophy is evident in the housing readiness language they use, the fact that outreach providers say that they have challenges getting these providers to accept individuals coming directly from the streets, and in the eligibility criteria they use to screen clients. About 45 percent of the providers who responded to the stakeholder survey indicated that they use their own prioritization tools (i.e. not a larger community tool or process to prioritize admissions for PSH vacancies) and nearly 20 percent of those reported using "housing readiness criteria" to select persons for enrollment in their PSH program. These responses suggest that while the capacity of PSH providers may be improving relative to their willingness and ability to serve chronically homeless individuals, there is still work to be done.

Nonetheless, CSH reports success in providing technical assistance through PSH institutes and learning collaborative meetings, and a number of new organizations have become engaged in operating or providing services in PSH for the first time in projects that opened in 2011 and early 2012 or will be opening soon. CSH will need to continue to work with these providers to help them move from basic agreement with the housing first philosophy to actually making the programmatic and process changes needed to transform their programs.

Dealing with Gaps in Service Availability

Exhibit 9.2 shows the most common funding gaps identified by PSH developers and operators in a closed-ended question in the stakeholder survey. The most commonly identified gap was in funding for services in general. The next most common were a lack of funding for case management and for operating costs. In interviews and the survey, stakeholders told us about the need for specific "housing case management" services that focus on addressing the challenges that can lead to the loss of housing after a chronically homeless person moves into PSH.

Exhibit 9.2: Funding Gaps

	Percent
Service costs (overall)	59.5%
Case management costs	54.1%
Operating costs	54.1%
Capital costs	45.9%
Rent subsidies	45.9%
Clinical service costs	43.2%
Other (including security deposits, admin, permanent long-term development financing, and educational/employment support costs)	13.5%
None	8.1%
Source: Abt Associates Inc. Stakeholder Survey, June and July 2012, n=37, PSH developers and operators *Respondents were permitted to select as many funding gaps as they wanted.*	

For many PSH projects, including both site-based PSH buildings and scattered site programs, the supportive services available to tenants come from existing county-contracted providers of mental health services, and homeless people "bring their service connections with them" when they move into PSH. The LA County Department of Mental Health and its provider network have created innovative and flexible services models, including Full Service Partnerships and Field Capable Clinical Services that use multi-disciplinary teams. The teams can deliver services through home visits using client-centered service approaches such as Motivational Interviewing, and these services teams often include housing specialists who assist clients in getting and keeping housing. However, PSH providers and other stakeholders talk about gaps in the availability of services that focus on building social connectedness and a sense of community with support for recovery and positive social norms among tenants in a PSH building. There are also gaps in resources for collaborating with property managers or landlords to identify and solve problems that might otherwise lead to evictions, particularly when a tenant has become disengaged with mental health services.

PSH operators also talk about a disconnect between prioritizing PSH for vulnerable, chronically homeless individuals on the streets and the need to place individuals who already have access to Department of Mental Health (DMH) services. For tenants with serious problems related to substance use or other health conditions who are not eligible for mental health services funded

through DMH, most PSH providers have much less capacity to finance and deliver services using models appropriate for chronically homeless people.

Overcoming Operating Challenges of Serving Chronically Homeless People

In the stakeholder survey, PSH providers were given a series of possible responses related to their experience operating and providing services to chronically homeless individuals. Of 38 PSH provider respondents, 55 percent (21) reported having had "challenges" housing people who were chronically homeless prior to entry in their programs. When asked in an open-ended question about what steps they had taken to mitigate these challenges, the following themes emerged among the 18 respondents:

- Modified program rules
- Increased coordination with other types of providers
- Strengthened case management - more frequent, smaller goals
- Increased levels of care, especially related to health and mortality prevention; and
- Added eviction prevention services

To understand the tenant perspective on whether PSH programs were operated effectively, the evaluation team conducted four focus groups with PSH residents, including residents of new and older project-based PSH and participants in a scattered site PSH program[7]. Residents were interviewed about the application process and entry into the program; rules and terms of tenancy; appropriateness and accessibility of services; and ability of program terms and services to support the client in his or her "next step" (whether ongoing permanent residency or transition to a less supportive permanent housing situation).

Each client group expressed gratitude to be living in supportive housing and for the services offered. However, this resident feedback suggests that PSH providers, and their partners in public housing authorities and service provider organizations could target numerous areas for improvement, including reducing the time period between application and placement in housing, better supporting the transition from the streets to permanent housing, addressing resident isolation and stress, improving the quality of the PSH facilities, and supporting movement to other permanent housing if residents no longer needed a supportive housing environment.

Length of Wait and Lack of Coordinated Entry

Nearly all focus group participants reported that the application process for new tenants was challenging and required a significant waiting period. For two new project-based facilities, the time between signing up for the facility and moving in averaged around six months. Most residents stayed in shelters during that waiting period. Residents also reported long placement periods for PSH projects that had been in operation longer. One project-based program encouraged those on the waiting list to travel to the main office once a week to check in on their status. Most residents of this project reported travelling to the office for roughly eight months before their names came up on

[7] Chapter 2 provides more detail on the focus group participants.

the wait list. In the scattered site PSH program, clients' experiences with the waiting list for the vouchers administered by the PHAs seemed to vary more – some clients reported waiting years while others were prioritized and moved into housing within a period of one or two months because they were on local chronic homeless Vulnerability Index registries. In the interim, they stayed in transitional housing and shelter programs.

Transition and Anxiety about Permanence

Upon entry into housing, focus group participants reported difficulty with the transition to living in their own spaces. A client in one of the newer facilities described having operated in survival mode for so long that it was difficult to relax and feel safe. She sleeps on the small couch in her unit because it feels more enclosed and protective than the bed. Another client reported that she is trying to make a plan for where to go next on the assumption that she could be told to leave at any time. Several clients also reported feeling anxious and suspicious about changes to the terms of tenancy or moves that occurred after they had moved in. Direct communication about such changes and transparency by program staff was cited as a need by tenants in each of the project-based programs.

Isolation and Stress

In the scattered site program, focus group participants reported feeling isolated after placement. One client reported that she "felt so lonely inside the box" of her apartment. Peer support from clients who have successfully made the transition was cited as potentially helpful both for the new tenants and for the peer supporters, who would feel empowered from the experience. A similar issue of isolation was cited for a project-based program targeting transition-aged youth. One client said all of her relationships have been with service providers ever since she was in foster care, and it would be helpful to her to get assistance in building permanent relationships through mentorship or a similar service.

Facility Issues

A number of practical health and comfort concerns were raised by participants in the focus groups about the quality of the PSH in which they resided. Some cited cleanliness issues and insect infestations (bedbugs and cockroaches). Some noted that the use of mini-appliances prevented them from being able to buy in bulk and stretch their food budgets. Tenants of one program also noted that the program's newer buildings have more features – for example, a bathroom in the unit and a kitchenette. The tenants suggested that the older buildings should be considered transitional housing and that residents living in them be offered the opportunity to transition into the newer units with more amenities.

Support for the Next Step

Focus group participants expressed a desire for assistance in transitioning out of supportive housing and into more independent living situations, particularly case manager support in completing paperwork associated with transitioning to scattered site units. A transition-aged youth participating in the focus group suggested specific checklists of documents she would need in order to move out and a desire for program staff to accompany her to the appropriate offices to gather documentation and complete paperwork.

9.3 Process Measure: What Steps are PSH Providers Taking to Improve Health Outcomes for PSH Tenants?

A number of Hilton Foundation grantees receive grant funding to improve access to health care for PSH residents. Other PSH providers receive financial or technical assistance from CSH and participate in identified pilot projects that prioritize people for PSH based on vulnerability and/or health service utilization (e.g. Frequent User Service Enhancement). Because of this focus, the evaluation team is beginning to work with these grantees to gain an understanding of the approaches to meeting their clients' health needs and tracking health outcomes. The following section reflects preliminary discussions with grantees.

Providing for Health Needs of PSH Residents

As PSH providers are prioritizing and housing extremely vulnerable and chronically homeless individuals, there is an expectation that these providers will target services to address resident health needs and that PSH residents will experience corresponding improvements in health outcomes, more appropriate utilization of health care systems, and lower associated health care costs. For instance, Skid Row Housing Trust (SRHT) has focused on trying to create a stronger link to treatment providers to address mental health and substance use needs that are more prevalent in the prioritized population.

Providers reported in interviews that they have observed considerable frailty among their prioritized clients. SRHT indicated that the clients taken from the VI Registry for its Prioritization Program are notably more vulnerable than a seemingly similar group of clients identified through Project 50 (see Chapter 3, Section 2).

SRHT and other "targeted program" Hilton Foundation grantees have indicated an awareness of high mortality in their PSH programs, particularly those programs that target the most vulnerable homeless people. Housing Works, for example, reported that, in the one-year Frequent User Service Enhancement (FUSE) pilot project, three of the 20 clients died – a much higher mortality rate than for its more typical projects. The FUSE participants come directly into the program from hospital beds. They receive medical care immediately, but they are placed in housing on Skid Row in close proximity to the street culture that contributed to their vulnerable health. Interviewees observed that FUSE participants have generally been overusing hospitals for a long time, but not actually getting the drug treatment they needed. So they get "worse and worse until they become part of FUSE right at their end." Housing Works would like to further develop their partnership with the hospitals to start this process before "it's too late."

Tracking Health Outcomes for PSH Residents

Aside from the goal of moving chronically homeless individuals off of the streets into permanent housing, one of the key motivations for PSH as a solution to chronic homelessness is that the permanent housing and supportive services are expected to improve the health and disability conditions affecting individuals, particularly those targeted for units because of their extreme vulnerability or unnecessarily high use of medical systems. To answer the question of whether health outcomes improve after placement in PSH, providers must be able to uniformly and convincingly measure improvements in health and disability conditions without creating unreasonable diagnostic or documentation requirements.

At this stage, most PSH projects funded through the Hilton Chronic Homelessness Initiative have not had sufficient periods of enrollment to document measurable improvements in tenant health. However, the evaluation team has started to explore how grantees are tracking resident health outcomes over time to determine if methods are easily replicable and whether a common measurement approach could be adopted by all grantees in the future.

Several of the Hilton Foundation grantees that provide PSH also contract with LA County DMH to provide mental health services, and these grantees indicated that they are required to track information about client engagement in the healthcare system, but they do not track health status. During the engagement process, some grantees gather self-reported client health status through outreach assessments or through vulnerability index assessments. Others collect health status and information on the extent of clients' engagement with a primary care physician from referral sources, such as hospitals participating in FUSE pilots. Over time, most grantees track ongoing client engagement with a primary care physician. In cases where grantees work directly with a clinic or hospital (e.g., Mental Health America, Downtown Women's Center, St. Joseph Center, OPCC, and LA Family Clinic), the providers receive regular updates about a client's overall health status through case conferencing.

Mental Health America of Los Angeles (MHA) has taken steps to increase attention to health status in its programs and services recognizing that people with serious mental illnesses often die prematurely from untreated or poorly managed chronic health conditions. For example, clinical staff is proactive about helping clients enroll in coverage for health care, select a health plan and medical home, and manage chronic illnesses. If the client engages with a partner health clinic, MHA can track the status of blood work, which is important for monitoring health conditions that may be side effects of psychiatric medications. Visits to emergency rooms tend to be tracked in cases where the client seeks care at the hospital with which the provider maintains a close working relationship. And mental health care practitioners talk with clients about other hospital utilization to try to integrate care and promote improved treatment.

Several grantees reported that they were working on developing FUSE health outcome tracking tools. MHA, OPCC, and St. Joseph are also recipients of MHSA Innovations grants allocated by LA County DMH to create Mobile Integrated Health Teams in partnership with Federally Qualified Health Centers. These projects will enhance and expand partnerships to track and improve health outcomes for chronically homeless people and PSH tenants and may provide additional input on methods to track health outcomes.

All Hilton Foundation targeted program grantees expressed an interest in peer learning or facilitated discussions to help them implement better systems for tracking changes in health outcomes, in addition to peer-to-peer learning about strategies to actually improve them. Given the high rates of mortality among PSH residents, some providers are also interested in developing metrics to track mortality, perhaps even measuring how the mortality rates of those placed in PSH compare with rates for persons who remain on the streets.

MHA tried to analyze patterns of mortality in its projects as part of an accreditation process in the past, but they were not able to see a pattern. Participants tended to die from physical issues while in hospital and MHA was not able to access and track detailed medical information. At Skid Row Housing Trust, staff have not been able to gather cause of death information from the LA Coroner's Office consistently or systematically, so they are not able to track with any certainty. St. Joseph

Center staff reported that they have developed procedures related to advance directives, wills, and handling death. Until they have a tool that takes into account a medical baseline and tracking information, they agree it would be challenging to track mortality over time or start to predict or understand mortality. Twelve of St. Joseph Center's clients have died since the organization started the housing first approaches with vulnerable, chronically homeless individuals; 11 of these clients were in housing at the time of their death. The interviewee speculated that placement in housing causes the clients' survival mechanisms to relax so they feel like they can die with dignity.

10. Conclusion: Recommendations and Future Work

This report describes Hilton Foundation funded grant efforts and their cumulative impact in relation to the major goals established for the Chronic Homelessness Initiative. The dashboard-style summary provided at the beginning of the discussion of each goal is compiled in Exhibit 10.1. Significant progress is being made on goals related to creating new project-based and scattered site permanent supportive housing (PSH) units, placing chronically homeless individuals in PSH, and obtaining the funding needed to support the development and operation of PSH. In fact, stakeholders have already met the five-year goal for placement of chronically homeless people in housing and are on track to exceed the targets for unit production and obtaining commitments of funds.

Exhibit 10.1: Summary of Progress on Hilton Foundation Initiative Goals, July 2012

Progress on Goal to Build Demonstrated Action by Elected and Public Officials to Support Addressing Chronic Homelessness	***Data Availability:*** Stakeholder survey establishes a baseline to compare changes in consensus and to document actions moving forward	
	Status in 2012: Progress in building support, but limited demonstrated action	
Progress on Goal to Leverage $90 million in Private and Public Funds toward PSH	***Data Availability:*** Financial data are available for grants allocated in conjunction with the Funders Collaborative; more information is needed to calculate other commitments	
	Status in 2012: On track to meet or exceed five-year financial commitment goals	
Progress on Goal to Create 4,000 units of PSH	***Data Availability:*** Figures for PSH inventory are available; tracking is not centralized and various sources provide differing information, leading to concerns that data is inaccurate	
	Status in 2012: Surpassed one-fifth of goal in 2011/12; on track to meet or exceed goal, but the goal may need to be revised	
Progress on the Goal to Establish a System of Prioritizing Chronically Homeless Persons for PSH	***Data Availability:*** Estimates are available, but more work is needed to develop verifiable data systems	
	Status in 2012: Getting started; current system relies on separate PSH provider-managed placements	
Progress on Goal to House 1,000 Most Vulnerable Chronically Homeless Persons in PSH and Prevent 1,000 Persons from Becoming Chronically Homeless	***Data Availability:*** Figures for chronically homeless placements are available, but more detailed accounting is needed; more information is needed for other vulnerable populations	
	Status in 2012: Surpassed five-year chronic homeless placement goal in 2011	***Status in 2012:*** Made progress on prevention goal, but results are not clearly documented
Progress on Goal to Increase Capacity of Developers and Providers to Effectively Provide PSH	***Data Availability:*** Stakeholder survey establishes a baseline to compare changes in perceived capacity, but there is no clear consensus among partners on how to define, much less measure, capacity of developers and providers	
	Status in 2012: Limited documentable progress	

Progress has been slower on the system change milestones related to establishing a system of prioritization for PSH placement, achieving demonstrated action by elected and public officials, and building capacity of developers and providers to provide PSH effectively, although substantial efforts have been made. And across all goals, there are few systematic processes in place to collect

and compile data to document progress on the goal and, more importantly, to support process improvements that ultimately will improve system outcomes. The most obvious gap for local planning and for supporting prioritization processes is the absence of a transparent, widely available housing inventory database.

In section 1 of this chapter, the evaluation team outlines recommendations for the Foundation and other key stakeholders to advance progress in achieving the ultimate goals of the Initiative. In section 2, we describe the next steps of the evaluation and how these results will be disseminated among stakeholders to inform next steps.

10.1 Recommendations

Recommendations

Several recommendations for improvement emerged from our assessment. These recommendations fall into three broad categories:

- Data collection efforts that will result in better tracking to inform planning, decision-making, and accountability;
- Opportunities to improve the performance of systems to achieve the goals of the initiative; and
- Considerations for long-term leadership of efforts to end chronic homelessness.

Activities in all of these areas are already underway at some level within LA, but we repeat the recommendations here to reinforce their importance to the Initiative.

Recommendations Related to Data Collection

Data are at the heart of the Chronic Homelessness Initiative to support local planning, to benchmark progress on local efforts, and to support real-time service delivery. To ensure consistent, readily available data for the Initiative, we recommend that local stakeholders:

1. Specify definitions across organizations to guide counting and classification of permanent supportive housing, individuals who are chronically homeless, and individuals at risk of chronic homelessness because they are highly vulnerable.

2. Create a shared, internet-based central database of information on project-based and scattered site permanent supportive housing that clearly tracks the development of housing projects and the availability of tenant-based rental assistance from pipeline or promise to available status, any designations for special populations, location of projects or service areas, and the point-of-access for housing placement. The database should include explanatory notes that aid tracking inventory changes over time and reconciling multiple funding commitments by project.

3. Define methodologies, ideally using the Homeless Management Information System (HMIS) or integrated into the HMIS infrastructure, to track housing placement and retention at the client-level, and common metrics to synthesize housing retention outcomes. Current reporting on housing placement occurs in aggregate by community or provider and does not allow matching prioritization lists to placement results. Further, current

approaches do not enable stakeholders to understand the types of PSH in which people were placed, whether the people placed were chronically homeless or highly vulnerable and at risk of chronic homelessness, the length of time from identification on the streets to placement in housing, and client outcomes related to housing retention.

a. Hilton Foundation annual report forms could be modified to provide more consistent, specific direction on how to report subpopulation placement and housing retention data, or these data could be compiled centrally if all grantees were reporting client data in HMIS.
b. The Corporation for Supportive Housing (CSH) is currently working with new sub grantees to establish contracts with more consistent, aligned outcome reporting requirements. Contracts for PSH operators or service providers could incorporate the same outcomes for placement and housing retention developed for Hilton Foundation grantees.

4. Define methodologies, ideally using the HMIS or integrated into the HMIS infrastructure, to track changes in resident health status at the client-level and use common metrics to synthesize health outcomes. Convene facilitated discussions among Hilton Foundation grantees, Community Solutions, CSH, and CSH Frequent User Service Enhancement (FUSE) sub grantees to help them define and implement better systems for tracking health outcomes and changes in health care costs.

5. Work with Home For Good, CSH, private funders, and major public agencies to agree upon conventions for counting financial and in-kind service resources committed to PSH projects and associated services and their likely sustainability, so there is consistent reporting of public and private investments newly committed, renewed, and remaining gaps. Create a transparent central accounting of resources committed to the Initiative to ensure consistent reporting of funds.

6. Consider whether the PSH creation goal should be formally revised to increase the target beyond 4,000 or to focus the 4,000 on units dedicated to persons who are chronically homeless, to shift more emphasis toward scattered site models moving forward, or to clarify expectations regarding sustainability of funding.

Recommendations Related to System Performance

Ending chronic homelessness in Los Angeles is a mammoth undertaking, and significant strides have already occurred and have been documented in this report. Throughout the process of assessing progress, the evaluation team noted ways to build off and improve current efforts by adjusting, aligning, and expanding efforts in some areas, in particular focusing on establishing prioritization systems and building provider understanding to deliver PSH.

We recommend that local stakeholders:

1. Create more intentional bridges between the outreach teams and parts of the homeless system designed to identify people who are chronically homeless and the PSH operators or service providers who are tasked with leasing PSH properties. While the Vulnerability Index registries and frequent user databases provide promising tools for assessing people

who might be considered for PSH placement, the evaluation team noted a disconnect between these efforts and PSH admissions. Stakeholders could consider creating prioritization protocols or even waiting lists at the neighborhood, city or service planning area-level to support community-based, rather than project-based placement decisions. This type of centralized process could also address application bottlenecks and reduce application processing times. In addition, a coordinated process could address constraints imposed by service funding and could be used to align appropriate housing and service resources with client needs. Efforts also need to be made to expedite the placement process, and this could also be supported through a systematic, more coordinated placement system.

2. Cultivate PSH partnership or mentoring models to expand PSH provider capacity and reach, by marrying experienced PSH providers with less knowledgeable ones. This may be a particularly effective way to build capacity in underserved communities if experienced PSH providers can partner with housing developers who have little PSH experience but strong roots in communities with significant unmet needs for PSH.

3. Continue efforts to engage smaller public housing authorities and maximize opportunities with the Housing Authorities of the City and County of LA to designate more vouchers for chronically homeless and prioritize chronically homeless individuals for non-designated Housing Choice Vouchers.

4. Continue to address funding gaps for services through systematic processes, such as the Funders Collaborative, to align housing and service resources at the project-level. Alignment strategies could include explicit approaches for marrying mainstream services with vouchers, structuring project partnerships to fully utilize Medicaid as a funding source, creating prioritization systems to help match tenants with units and services appropriate to their needs, and reallocating Continuum of Care funding and other sources to better meet needs. As well, the Funders Collaborative could consciously identify and augment funding for services in areas that cannot be funded by other public sources or for specific client groups.

   For example, stakeholder enthusiasm about the bounty of Department of Housing and Urban Development Veterans Affairs Supportive Housing (HUD-VASH) vouchers has been somewhat tempered by their pessimism about the VA's willingness to use a housing first approach for chronically homeless veterans with HUD-VASH vouchers, and about their capacity and willingness to deliver services with enough intensity and flexibility to be successful for veterans who don't have strong connection to services at VA Medical Centers. Given the unmet need for PSH in LA, it would be unfortunate if these vouchers were under-utilized or not made available to the most vulnerable homeless veterans due to lack of coordination and alignment among local funders. Perhaps, the Funders Collaborative could examine the unmet service needs and directly or indirectly help to address identified gaps.

   Similarly, providers have voiced concerns that service funding is needed to enable PSH providers to house individuals that are not already served by the LA County Department of Mental Health system or other mainstream systems that are primary sources of PSH service

support. Strategies to build provider capacity to access Medicaid to fund services and at the client-level to enroll chronically homeless persons in mainstream programs to broaden providers' abilities to pair clients with PSH partners could help to address PSH funding shortfalls.

5. Consider the viability of innovative PSH and service models, like the Critical Time Intervention approach being explored at Downtown Women's Center, to address chronic homelessness at lower costs or enable providers to more easily tap Medicaid and other funding sources.

6. Foster the development of more peer support programs to pair clients who have successfully made the transition into permanent housing from the streets, such as models currently employed by Skid Row Housing Trust. This type of effort would address some of the issues raised by PSH residents about challenges transitioning to and sustaining PSH.

Considerations for Long-term Leadership of Efforts to End Chronic Homelessness

The leadership provided through Home For Good has been cited universally as a very important and successful effort to mobilize non-traditional partners, to align stakeholders through a shared vision, and to hold the community accountable for results. Yet, the strong leadership and involvement of new partners has also created tension. All in all, this tension is probably healthy and may foster a more inclusive, long-term approach to ending chronic homelessness and managing system resources. The energy of the Home For Good campaign is probably derived in part by its short-term emphasis. The question is how Los Angeles will use this timeframe to consider how homeless resources should be managed, the type of leadership and planning needed to support local decision-making and service delivery, and how the leadership roles should be centralized or delegated among key stakeholders, in particular the Los Angeles Homeless Services Authority and other Continuums of Care. This will not be an easy discussion, but determining a long-term governance structure that meets the needs of the community seems essential to sustaining and continuing the results achieved through this Initiative.

10.2 Next Steps for the Evaluation

This report documents progress on the strategic goals, broken into discreet outcome and process-focused measures. Since the evaluation of the Chronic Homelessness Initiative is intended to be formative—to help the Foundation and local stakeholders advance efforts toward the Foundation's strategic goals—several activities are planned over the next three months to disseminate and promote discussion of these results.

In the fall of 2012 the evaluation team will meet with the Foundation and individual grantees to review the results reported, focusing discussion with grantees on measures most directly related to their efforts. If relevant, the team will share more detailed information from data that may help to identify barriers that will need to be mitigated to progress. Grantees will be encouraged to consider ways to collect other information year-round that may inform their efforts and will be asked to identify other data that the evaluation team could collect that might be helpful to them in understanding and improving their results. The team will also work with CSH and their SIF

evaluation team to help grantees develop reasonable data collection strategies to measure client-level change in housing stability and health outcomes.

In addition, the team will talk with relevant parties to discuss the data challenges described in this report, as a means of helping to improve the local data collection infrastructure. These discussions will piggyback on the ongoing technical assistance work that is being conducted in follow-up to the HMIS Data Needs Assessment.

The evaluation team is also planning for the 2013 data collection cycle and ways to enhance the next annual report of the evaluation of the Chronic Homelessness Initiative. Data collection implemented next spring will measure the extent of progress on the outcome and process measures one year later. More rigorous evaluation methods will be incorporated as more reliable data sources become available. For instance, as participation in HMIS increases and HMIS data are more reliable, PSH placement for chronically homeless individuals will be measured from client-level HMIS data, and success in prioritizing placements to persons listed in Vulnerability Index (VI) Registries or other prioritization lists will be calculated by comparing VI lists with placement data. New data will be collected if discussions with the Foundation staff and grantees reveal areas that would benefit from more examination.

These evaluation efforts will enable the team to measure continued progress toward the Hilton Foundation strategic goals, as well as progress in developing improved local data systems to measure chronic homelessness. The annual benchmarking process will ensure that Hilton Foundation grantees are continually assessing results and questioning which strategies work and which need improvement.

Appendix A. Evaluation Team

Principal Investigator

Brooke Spellman is a national leader in conducting research and developing strategies to improve policy and programmatic responses to homelessness and poverty. She has expertise in using homeless management information system (HMIS) and mainstream system administrative data to understand homelessness, patterns of homeless service utilization, client outcomes, and homeless and mainstream system costs. She led a HUD study on the costs of homelessness and is now leading a study of HUD's Rapid Re-Housing Demonstration Program.

Project Quality Advisor

Dr. Jill Khadduri has worked extensively on homelessness, particularly on the intersection of rental housing assistance and efforts to reduce homelessness, and is the author of several publications on that topic. Since 2002, she and Dr. Dennis Culhane have been Co-Principal Investigators of HUD's Annual Homeless Assessment Report. She was Co-Director of the 2007 National Symposium on Homelessness Research and currently is Principal Investigator for a study of public housing agency efforts to serve homeless households through mainstream housing assistance programs.

Evaluation Team

Julia Brown joined Abt Associates in January 2012 from Feeding America, where she was the Manager of Research, working on food security issues and practical program evaluation for food banks. Prior to this work, she held several positions within the City of Santa Monica Human Services Division, including managing the city's SHP and HMIS projects and implementing locally-driven homeless service programming.

Sophia Heller brings an intimate knowledge of homelessness, housing and economic development issues in Los Angeles, and the people and organizations that work on them, stemming from her work as the former Los Angeles mayor's Director of Policy for Housing and Economic Development.

Meghan Henry joined Abt Associates in 2010, having worked for four years as a Research Associate at the National Alliance to End Homelessness. She brings experience researching and evaluating federal programs and policies related to homelessness; coordinating data collection activities for a communities reporting homelessness data to HUD; and authoring policy briefs, data briefs and major research papers.

Jill Spangler brings 20 years of experience coordinating and evaluating community-wide approaches to homelessness planning, funding, program/housing development, and both program-level and CoC-level evaluation. She has also worked extensively with private nonprofit clients, local foundations and local/state governments on organizational development and strategic planning.

Matt White has been in the housing field for nearly 15 years, specializing in strategic planning and homeless system policy development, research and evaluation, and HMIS development. Mr. White's current work at Abt focuses on HMIS technical assistance and homeless system evaluation, facilitation, and planning.

Carol Wilkins is a national expert on permanent supportive housing who brings 25 years of experience leading the design and implementation of several major evaluations of new program models and systems change initiatives supported with philanthropic investments, and leading national public policy and systems change efforts.

Appendix B. Research Questions

The table below represents the complete listing of research questions identified in the Evaluation Plan.

Outcome Measures	
1. Has there been an increase in the supply of project-based/scattered site PSH inventory?	
	Number of new permanent supportive housing units since January 2011, reported in total and separately by housing type and geography. For project-based PSH, this measure will track both the number of units added to the pipeline (when funding commitments are made for development of new projects) and the number of units newly available for occupancy.
2. Are PSH units being targeted to priority populations, including (a) individuals who are chronically homeless, especially the most vulnerable among them, and (b) other high-risk homeless and vulnerable individuals, including those who are frequent users of high-cost care in hospitals or other settings who need to be prevented from becoming chronically homeless?	
	Number and percent of new project-based and scattered site PSH units and existing PSH units that turn over each year that are filled by persons who are chronically homeless or at risk of chronic homelessness.
	Number of both new PSH units (those reported in measure #1) and existing PSH units that turn over each year that are filled by persons who are not chronically homeless, but are prioritized for PSH because they are in one or more of the priority populations for this initiative, meaning that they are 1) meet the criteria for service in FUSE projects (using the "10th decile" Crisis Indicator Tool developed by the Economic Roundtable or other criteria established by the Department of Health Services; 2) on a Registry established in conjunction with the Community Solutions 100,000 Homes campaign but do not meet the chronic homeless definition; 3) the county ELP Priority list; or 4) meet other criteria related to the goal of preventing chronic homelessness.
3. Once housed in PSH, are persons who were chronically homeless able to (a) retain their housing, and (b) improve health outcomes?	
	Of chronically homeless individuals who were placed in PSH programs that have received a Hilton grant, the percent who remain housed in PSH for 12 months or longer or exit to a permanent housing destination after at least 6 months of residence in the reporting program.
	The extent to which persons who are placed in PSH based on their health utilization or health conditions and vulnerability improve their improve health outcomes.
4. Are there measurable declines in number of individuals experiencing chronic homelessness in Los Angeles?	
	Number of chronically homeless people in LA County over time relative to January 2011.
5. For the individuals identified as a priority for placement in PSH and placed in PSH, to what extent has placement in PSH been associated with a reduction in their mainstream and homeless costs?	
	Cost of mainstream services (e.g., mental health, substance abuse, jail, emergency rooms, hospitals and other health services) and homeless services used by individuals who are chronically homeless and/or members of priority populations and placed in PSH, compared with the costs of services used by the same people while homeless.

Process 1	**Is there growing consensus among key stakeholders around the critical role of PSH in ending chronic homelessness?**
1.1	Do key stakeholders demonstrate consensus on the fundamental components of PSH, the population most in need of PSH, and why PSH is an effective intervention?
1.2	Is there reduced resistance to PSH among key stakeholders?
1.3	Grantees: What actions have been attempted over the past year to change stakeholder consensus about PSH and its role in ending chronic homelessness? What were the outcomes and how were they measured? What barriers were encountered and what attempts were made to mitigate them?
Process 2	**Have elected officials and other key stakeholders demonstrated commitment to PSH through concrete actions?**
2.1	Do key stakeholders report having directly taken concrete action to advance PSH?
2.2	What is the perception of concrete actions taken by elected officials and government staff? Other key stakeholders?
2.3	Does independent documentation, such as use of officials' discretionary funding funds and zoning voting records, demonstrate concrete action taken?
2.4	Grantees: What actions have been attempted over the past year to persuade or mobilize elected officials and other key stakeholders to action to advance PSH? What were the outcomes and how were they measured? What barriers were encountered and what attempts were made to mitigate them?
Process 3	**Has a coordinated decision-making strategy been adopted and implemented to align funding for PSH (housing and services)?**
3.1	Are funders, public and private, committed to an aligned/pooled funding process that make funding for PSH easier to access and better focused on the strategy of using PSH to address chronic homelessness?
3.2	Did PSH developers, operators, and service providers perceive benefits and/or challenges associated with the coordination and alignment of funding?
3.3	Grantees: What actions have been attempted over the past year with key funders in LA County to align funding and achieve coordinated decision-making? What were the outcomes and how were they measured? What barriers were encountered and what attempts were made to mitigate them?
Process 4	**Is there a demonstrated commitment of $15 million in additional private funding and $75 million in realigned public funding?**
4.1	Amount of private and public funding for new PSH development and operations or service provision for those units (United Way, CSH, Funders Collaborative, Direct Hilton funding, county and city commitments)
4.2	Are current operators receiving new (or newly targeted) funds to enhance services/operations in order to support targeting units to more vulnerable population, efforts to prevent recidivism, to achieve Home For Good certification or some other enhancement?

Process 5	Is there a discernable increase in the capacity of housing developers to produce PSH in Los Angeles County?
5.1	Do developers/stakeholders report increased capacity to produce PSH since January 2011 through increased number of developers, increase in developers willing to develop additional PSH, increase in the number of mainstream affordable housing developers willing to develop PSH, increase in PSH developers scoring well in financing application process, increasing number of organizations receiving pre-development financing that complete the development process, and/or shorter elapsed time from funding commitment to occupancy.
5.2	Increased number of new or current developers who are viewed by stakeholders as having the capacity to develop or operate high-quality PSH.
Process 6	**Do PSH housing and service providers demonstrate capacity to operate PSH appropriate to the needs of those targeted by this Initiative, including the ability to security sustainable funding for housing and services and to implement housing and service models appropriate for this population?**
6a.1	Number of PSH housing and service providers demonstrating capacity to operate PSH models appropriate for chronically homeless individuals and other priority populations: understanding of models, experience delivering similar services, adaptation of policies and procedures, fidelity to models appropriate for chronically homeless, turnover rates and strategies to reduce turnover.
6a.2	What is the perspective of residents of different PSH projects about whether the PSH projects are meeting their needs?
6a.3	What specific improvements to capacity have been made as a result of CSH or United Way funding or technical assistance? What was the role of the assistance in making this change?
6a.4	Documentation on the percentage of PSH projects brought on line since January 2011 that meet Home For Good PSH Certification standards or have demonstrated most or all of the indicators of quality described in the CSH Dimensions of Quality and on year to year changes in the results of these assessments.
6b.1	To what extent have those PSH operators/service providers with units coming on line in the next year secured sustainable funding for operations and services through the homeless system, mainstream systems, or other sources?
6b.2	What is the current state of overall funding sources/trends, typical areas in which providers face gaps in funding, and perceived effectiveness of technical assistance provided by CSH or other intermediaries, if applicable?
6b.3	Grantees: What capacity support or technical assistance were provided over the past year in order to improve provider capacity to develop and deliver PSH?
Process 7	**Is PSH geographically distributed throughout the LA area, relative to need?**
	Percentage of new PSH project-based units or geographically clustered scattered site projects that are located in areas with concentrations of chronically homeless people outside of Skid Row.

Process 8	**How do PSH providers and other stakeholders define priority or "target" populations for PSH? What criteria do they use to determine who has priority access to PSH? Do PSH providers and their housing placement partners systematically prioritize the placement of "target" groups as PSH units come on line or turn over?**
8.1	What is the extent to which PSH providers and other stakeholders have established and agreed upon criteria used to set priorities for PSH, and which group(s) of homeless people are included in priority population(s)?
8.2	Do providers use consistent prioritization tools? Do those most vulnerable/highly prioritized receive prioritization for housing placement with local PSH providers?
8.3	Do subsidy administrators and funders target subsidies to chronically homeless or other priority populations or require recipients to prioritize these populations?
8.4	Grantees: What actions were attempted over the last year to improve systematic prioritization of specific subpopulations for PSH units? What were the outcomes and how were they measured? What barriers were encountered and what attempts were made to mitigate them?
Process 9	**How do PSH providers and their partners measure or track health outcomes including mortality? What steps are PSH providers taking to better understand causes of mortality among PSH tenants and reduce risks related to mortality? What steps are PSH providers taking to improve health outcomes for PSH tenants?**
	Grantees: Description of measurement and practices employed among PSH providers and their partners (including service providers, funders, and evaluators) to measure and intentionally working to improve health outcomes and mortality rates
Process 10	**Is Los Angeles better able to measure chronic homelessness, efforts to address it and performance of the system? Is there more confidence in the data?**
	To what extent are key community data systems, including Housing Inventory repository, HMIS, ELP, Vulnerability Index Registries and annual point-in-time counts, used for local evaluation and planning purposes and meet standard indicators of reliability?
Process 11	**How have data and information about best practices and successes of the Initiative been disseminated across grantees and stakeholders and what have been the results?**
11.1	To what extent do key stakeholders indicate awareness of local PSH best practices and successes locally to prevent and end chronic homelessness in Los Angeles?
11.2	Grantees: How have data and information about best practices and successes of the Initiative been disseminated across grantees and stakeholders and what have been the results? What were the outcomes and how were they measured? What barriers were encountered and what attempts were made to mitigate them?

Appendix C. Terms and Acronyms

Acronym	Full Name
CDBG	Community Development Block Grant
CH	Chronic Homelessness
CNCS	Corporation for National and Community Service
CoC	Continuum of Care
CSH	Corporation for Supportive Housing
CTI	Critical Time Intervention
DMH	County Department of Mental Health
DHS	County Department of Health Services
DPH	County Department of Public Health
FUSE	Frequent User Service Enhancement
HACLA	Housing Authority of the City of Los Angeles
HACoLA	Housing Authority of Los Angeles County
HFG	Home For Good
HIC	Housing Inventory Count
HMIS	Homeless Management Information System
HOME	Home Investment Partnerships
HOMeS	Housing Opportunity and Market Stabilization
HOPWA	Housing Opportunities for Persons with AIDS (HUD)
HPI	Homelessness Prevention Initiative (LA County)
HUD	US Department of Housing and Urban Development
LAHSA	Los Angeles Homeless Services Authority
MHA	Mental Health America
MHSA	Mental Health Services Act
NIMBY	Not In My Backyard
OPCC	Ocean Park Community Center
PATH	People Assisting the Homeless

Acronym	Full Name
PHA	Public Housing Authority
PIT	Point-in-Time
PSH	Permanent Supportive Housing
RFP	Request for Proposals
SIF	Social Innovation Fund
SPA	Service Planning Area
SRHT	Skid Row Housing Trust
SRO	Single-Room Occupancy
RFP	Request for Proposals
VA	Department of Veterans Affairs
VASH	Veterans Affairs Supportive Housing
VI	Vulnerability Index