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Evaluation of the Conrad N. Hilton Foundation Chronic Homelessness Initiative

2013 Report

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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 Chronic Homelessness Initiative, the Foundation has distributed more than $27 million in multi-year grants to 17 nonprofit groups working in LA. 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)[1] 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** leveraged 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. The evaluation is designed to provide an assessment of each of the goals

[1] Appendix B lists terms and acronyms used in this report.

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 2012 Report, delivered in October 2012, provided the evaluation team's report on the first 18 months of the Initiative[2]. This second report in the series, the 2013 Report, covers actions undertaken and results accomplished from January 2011 through August 2013. Results in this 2013 Report are compared against baselines established in the 2012 Report where possible. The 2013 assessment is based on: information collected through a web-based survey; interviews with representatives of public and private organizations, including the Foundation's 2013 grantees; 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.

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.

[2] The 2012 Report – *Evaluation of the Conrad N. Hilton Foundation Chronic Homelessness Initiative 2012 Report* – can be accessed at http://www.hiltonfoundation.org/lessons-homelessness. A listing of all related and referenced reports can be found in Appendix C.

Exhibit 1: Summary of Progress on Hilton Foundation Initiative Goals, July 2013

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 future actions.	
	Status in 2013: Support among stakeholder groups for PSH continued to increase and elected and public officials demonstrated significant concrete actions to address chronic homelessness, although there are questions about whether support is sustainable.	
Progress on Goal to Leverage $90 million in Private and Public Funds toward PSH	***Baseline Established:*** Clear data are available for funds leveraged through the Funders Collaborative. While a lower priority for the Initiative evaluation, data on funding secured outside of the Funders Collaborative is inconsistent and difficult to deduplicate.	
	Status in 2013: The public goal has been exceeded and progress continues on the private funding commitments. Revisiting the goals for the Collaborative may be needed in light of the growing need for renewal funding year after year.	
Progress on Goal to Create 4,000 units of PSH	***Data Availability:*** Significant improvement in data quality over year one, through a process engaging an array of stakeholders; additional work is needed, but progress has been made.	
	Status in 2013: Forty five percent of the cumulative PSH creation goal has been achieved. System-wide, progress on creation of project-based PSH on target and creation of scattered site PSH is significantly higher than anticipated.	
Progress on the Goal to Establish a System of Prioritizing Chronically Homeless Persons for PSH	***Data Availability:*** Data on the pilot are available, but system-wide data are not yet available to test whether prioritized chronically homeless individuals are the ones routinely placed in available PSH.	
	Status in 2013: Significant progress was made on the Skid Row Pilot and other pilot efforts. System-wide adoption of prioritization practices will be contingent upon convincing housing providers throughout the county to participate.	
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:*** Data on chronic homelessness are only collected through the biennial point-in-time count and through occasional Vulnerability Index registry counts, but count data are not sufficient to understand growing need within the context of strong placement activity.	
	Status in 2013: Placements of chronically homeless individuals are on pace to exceed the Initiative goal, but impact is not affecting point-in-time count figures.	***Status in 2013:*** Prevention placements are lower than anticipated.
Progress on Goal to Increase Capacity of Developers and Providers to Effectively Provide PSH	***Data Availability:*** Stakeholder survey data measures changes in perceived capacity, but objective data on provider capacity relative to the Standards of Excellence is not yet systematically collected.	
	Status in 2013: There have been improvements in stakeholder perspectives of the capacity of providers, but external factors have limited PSH development opportunities. Service providers in some geographic areas need basic support, while other service providers are ready to take the "next step" to enhance their capacity to serve the most vulnerable populations.	

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

Broad community support for permanent supportive housing grew over the past year, and elected and public officials demonstrated increased support and action to address chronic homelessness in Los Angeles. More than nine out of ten stakeholders indicated that they were either avid champions of PSH (46 percent) or that it was a good idea and more should be built throughout LA County (44 percent) – very similar to last year's results, with a slightly higher share identifying as avid champions of PSH. Notable demonstrated action included a broad-based campaign against the proposed Community Care Ordinance, development of the LA County Interagency Council on Homelessness' *County Roadmap to Address Homelessness*, increased County Supervisor investment in PSH, housing authority commitments of Housing Choice Vouchers for PSH, and the launch of LA County Department of Health Services' Housing for Health Program.

However, wide-spread changes in political leadership and challenges associated with the federal sequestration and other funding shortfalls will make it challenging to translate many of these recent one-time efforts into sustained, ongoing funding and support.

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

As of August 2013, the community had received public funding commitments that exceed the goal of aligning $75 million in public funding and was nearly 60 percent of the way toward meeting the private goal of $15 million. Equally significant, the infrastructure for pooling funds and making joint and aligned funding decisions is developing well. In Summer 2013, the Home For Good Funders Collaborative successfully coordinated its second application cycle to award funding for PSH housing and services. The application included $4.9 million in private funding to fund new grants for supportive services for new PSH tenants and renewal grants for continued services for tenants first assisted with funding from last year. In addition, the Collaborative leveraged public vouchers and services valued at $60.5 million. While this is a very significant accomplishment, federal sequestration issues are putting the public funding commitments at risk, and the momentum in securing private funding may not be keeping pace with the need for renewal funding.

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. A total of 6,952 project-based and scattered site PSH units have been created or are in the pipeline. More than 3,500 of these are dedicated to chronically homeless individuals. Of these, 1,822 were supported by Hilton: through direct grants, through the work of the Funders Collaborative, or through Hilton-supported technical assistance. Thus 45 percent of the new PSH production goal has been achieved in the first two years of the Initiative – slightly ahead of the trajectory needed to reach 4,000 units in five years; although moving forward, progress will be somewhat dependent upon the availability of development resources and the end of federal sequestration and subsequent availability of Housing Choice Vouchers.[3] Progress has also been made in documenting the PSH inventory, which is critical if the community is going to improve the PSH placement process. Further, the City and County housing

[3] This goal was originally characterized in terms of the number of PSH units created system-wide, however, given the tremendous unmet need and the significant system-wide progress made to date, the Foundation decided to measure progress toward the PSH creation goal based on Hilton-supported units.

authorities are developing ways to speed up voucher issuance and PSH placement by streamlining administrative and applicant support processes.

Despite this progress, the countywide shortfall of PSH units needed to address chronic homelessness in Los Angeles is higher even than last year—now nearly 11,000 units – because of the inflow of individuals into chronic homelessness suggested by the 2013 Greater Los Angeles Homeless Count. Eligibility criteria associated with new units also constrain the system's ability to place individuals in PSH based on their relative need for housing.

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

Addressing chronic homelessness requires a systematic, widespread way to identify and prioritize chronically homeless individuals, especially those most vulnerable, for the much larger pool of general housing resources. Progress was made in developing strategies to identify those experiencing chronic homelessness, particularly through the establishment of Vulnerability Index (VI) Registries in 18 communities and increased efforts to coordinate the VI registry process with the biennial point-in-time counts.

Significant progress was also made in developing systematic methods to prioritize individuals for housing, albeit in focused pilot projects. The Skid Row CES pilot used a high-energy, short campaign approach to bring providers together, coordinate available resources, and establish protocols for triaging and matching clients to units. Providers created a list of vulnerable clients and then met weekly to case conference, assign a responsible agency, and track progress of clients; 37 individuals leased up within the first 100 day pilot. The other pilot, the FUSE project, is developing a system-wide prioritization effort to identify homeless people who are the most frequent users of hospitals and other costly public services and place them into supportive housing. The FUSE pilot now has 7 housing navigator/FQHC partnerships working with referrals from 14 hospitals. Through March of 2013, 182 of the 249 screened had been prioritized for FUSE assistance because they were among the ten percent of homeless patients with the highest public costs (the "10th decile"), and 52 had been permanently housed through the program.

The key challenge for the future is to define strategies to take these pilots and prioritization ideas like them to scale by ensuring that a broad-base of housing inventory is filled using these approaches.

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

Because of the significant PSH commitments secured through new funding strategies, such as the HUD-VASH Program and the Funders Collaborative, along with increased efforts to target PSH vacancies, almost 5,000 chronically homeless people were placed in PSH units system-wide from January 2011 through December 2012. Chronic Homelessness Initiative-supported grantees placed 856 chronically homeless people in PSH units during 2011 and 2012, or 86% of the current Initiative goal.[4] Efforts focused on preventing chronic homelessness have been small (55 individuals in 2012) and more challenging to document; nonetheless, important progress has been made on a number of pilots that target chronically medically ill, frequent service user, and transition-age youth. In addition, CSH received a grant in August

[4] This goal was originally characterized in terms of the number of individuals placed system-wide, however, given the tremendous unmet need and the significant system-wide placements made to date, the Foundation decided to measure progress toward the placement goal based on Hilton-supported placements.

2013 to expand the Just In Reach pilot program to focus on repeat offenders who have had three or more episodes of homelessness in the past five years.

Despite these efforts, the number of chronically homeless individuals identified in Los Angeles County (including Glendale, Pasadena, and Long Beach) increased by almost 2,500 people over the first two years of the Chronic Homeless Initiative -- from 12,498 individuals in January 2011 to 14,933 individuals in January 2013. These count numbers reinforce the importance of continued emphasis on all Initiative strategies.

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 PSH provider capacity on the development side as well as the operating and services side. Significant strides have been made defining a common set of Standards of Excellence for PSH providers, working on provider capacity and comfort-level in accepting and serving more vulnerable populations, and helping PSH developers understand and navigate the various stages of the development process. There are still major gaps in provider capacity in a number of high-need geographic areas of the county, and as providers gain knowledge and skills in PSH operations, there are opportunities to target more advanced skill-building to ensure that the needs of the higher-need, vulnerable populations being targeted through the Initiative are being met. Efforts to document and measure changes in capacity are still limited.

Primary Recommendations

A number of recommendations for improvement emerged from our evaluation. The recommendations fall into four broad categories:

- Strategies to sustain and continue to build community support for PSH;
- Data collection efforts that will result in better tracking to inform planning, decision-making, and accountability;
- Efforts to improve the performance of systems to achieve the goals of the Initiative; and
- Updates to Initiative goals.

Below we catalog primary recommendations in the first three categories to consider moving forward. In Chapter 10, the evaluation team recommends a formal revision to several Initiative goals to reflect progress to date and additional progress needed to end chronic homelessness in Los Angeles.

Recommendations Related to Sustaining and Growing Community Support for PSH
To ensure sustained political will and commitment of resources, we recommend that local stakeholders

1. Focus on emerging political leadership, particularly with new elected officials, to ensure sustained political will and to encourage continued and increased investment in PSH.

2. Mitigate the effects of sequestration, which have frozen Housing Choice Vouchers commitments and could adversely affect supportive service commitments, and advocate for new state funding for affordable housing through programs that create strong incentives for creating PSH prioritizing chronically homeless people.

3. Engage new and diverse funders to ensure sustainability of the Funders Collaborative.

Recommendations Related to Data Collection

To ensure consistent, readily available data for the Initiative, we recommend that local stakeholders:

1. Create an accurate, shared PSH inventory that can be easily maintained.

2. Identify strategies to improve and refine the chronic homelessness count in ways that can support efforts to prioritize chronically homeless individuals for permanent supportive housing.

3. Use HMIS to track PSH placements and match the placements with information about people who are chronically homeless to validate that those prioritized for PSH are being placed first.

4. Explore opportunities to deploy the Standards of Excellence to measure project and system performance in a way that streamlines provider tracking and reporting activities.

Recommendations Related to System Performance

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

1. Institutionalize streamlined practices for issuance and lease-up of Housing Choice Vouchers, including landlord outreach, move in support, and housing placement strategies.

2. Foster the development of transition support programs to help clients in PSH consider their next steps and transition smoothly into other permanent housing when ready.

3. Increase accessibility and prioritization of PSH to people who are chronically homeless, including strategies to get more housing providers to participate in coordinated entry.

4. Sustain or increase focus on preventing chronic homelessness, including greater investment in prevention strategies and in research to identify and target those at greatest risk of becoming chronically homeless.

5. Identify new and preserve existing resources to invest in the Initiative, most specifically in the creation of new PSH.

6. Increase the capacity of housing and service providers to develop and target PSH effectively throughout the County, but particularly in areas with high levels of chronic homelessness.

7. Increase the capacity of existing PSH providers to provide services to the more vulnerable individuals being targeted through increased prioritization and to expand tenant access to health resources.

Next Steps for the Evaluation

Over the next few months, the evaluation team and Hilton Foundation staff will disseminate and promote discussion of these results. Jointly and individually, grantees and community stakeholders will be asked to consider and discuss key findings and brainstorm suggested actions to advance the progress of the Chronic Homelessness Initiative. The evaluation team is also planning for the 2014 data collection cycle and ways

to enhance the next annual report of the evaluation of the Initiative. More rigorous evaluation methods will be incorporated as more reliable data sources become available. Grantees are also encouraged to recommend areas of evaluation that would be helpful to inform their work, and if feasible, the evaluation team will incorporate the grantee-identified data collection and research ideas into subsequent evaluation activity. Cumulatively, 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.

1. 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)[5] 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 Carol Wilkins, Julia Brown, Meghan Henry, 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.

The 2012 Report, delivered in October 2012, provided the evaluation team's report on the first 18 months of the Initiative[6]. This second report in the series, the 2013 Report, covers actions undertaken and results accomplished from January 2011 through August 2013. We include the results of interviews, administrative data collection, and a survey of 421 stakeholders about their level of support for PSH as a strategy to address chronic homelessness. The survey was conducted in the summer of 2012 and again in 2013. Results in this 2013 Report are compared against baselines established in the 2012 Report where possible.

1.1 Background on the Chronic Homelessness Initiative

The Chronic Homelessness Initiative launched in 2011[7] 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; and
- Developing and disseminating knowledge for the field.

[5] Appendix B lists terms and acronyms such as permanent supportive housing (PSH) used in this report.
[6] The 2012 Report – *Evaluation of the Conrad N. Hilton Foundation Chronic Homelessness Initiative 2012 Report* – can be accessed at http://www.hiltonfoundation.org/lessons-homelessness. A listing of all related and referenced reports can be found in Appendix C.
[7] More details about the history of the Initiative can be found in the 2012 Report.

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** leveraged 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 more than $27 million in multi-year grants to 17 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

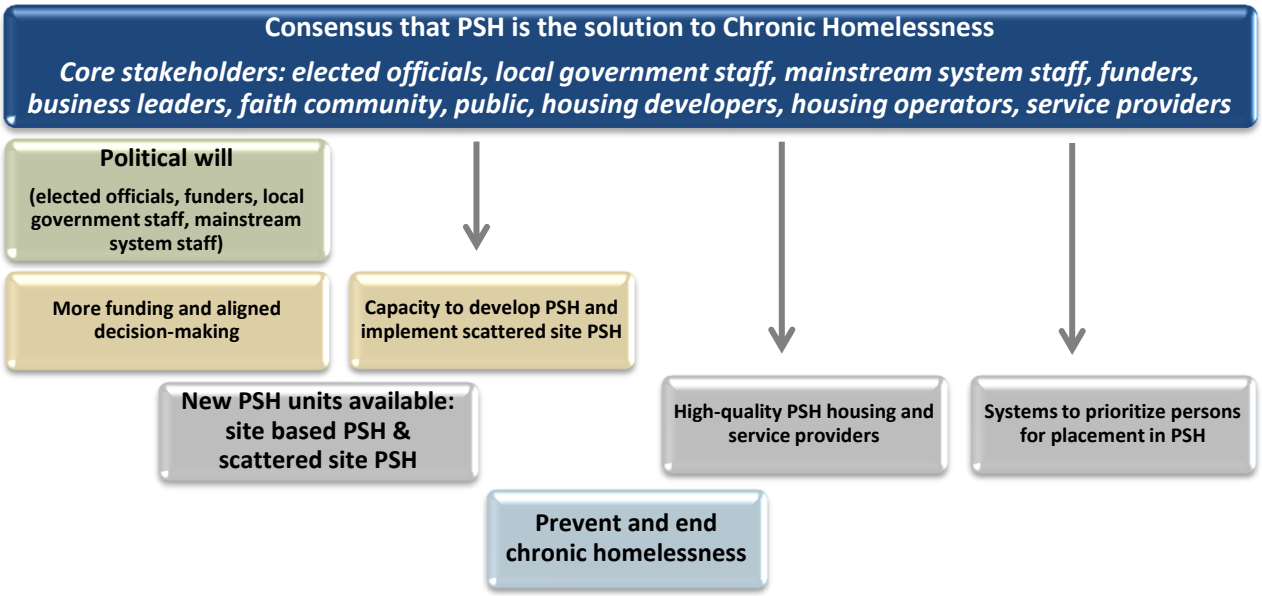
The evaluation of the Chronic Homelessness Initiative is intended to help the Foundation and local stakeholders advance efforts toward the Foundation's strategic goals. The evaluation is designed to:

- 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.

The evaluation is predicated on a Theory of Change[8]—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.

[8] 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.

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 Appendix D.

1.3 Organization and Focus of This Report

This second annual report of the evaluation of the Chronic Homelessness Initiative has ten main chapters, including this introduction. Chapter 2 summarizes the data collection approach, focuses on the sources of data used for this second annual report and explains the time period covered by each reported measure. Chapter 3 summarizes the Foundation's grant investments and the results for 2012-2013 grant cycles, as 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. At the beginning of each chapter, 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 measurable data or good progress toward meeting the goal. Yellow shows progress that may be slower than desired. Then, 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. 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 B.

2. Data Collection Approach for the 2013 Report

The data used to evaluate progress against the outcome and process measures identified by the evaluation team for the 2013 Chronic Homelessness Initiative evaluation report were collected from a range of sources, in most cases similar to those used in the 2012 Report. Section 2.1 provides detail on the data sources used. Section 2.2 discusses data limitations found during year one and progress made toward improving those data.

2.1 Data Collection and Sources

Data were collected to measure progress against the Chronic Homeless Initiative's five primary goals. The data used to measure progress in each area are listed in Exhibit 2.1, along with the timing of data collection for each measurement area and the time frame for which progress is reported. The rest of this section describes each data source in more depth, noting any changes from in the way the data were collected for the 2012 Report.

Exhibit 2.1: Data Sources for the 2013 Evaluation Report

Measurement Area	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–August 2013	Point in time June 2012; Point in time June 2013
Public and private funds leveraged with Hilton Foundation investments (funds committed)	• Home For Good Funders Collaborative • Grantee Reports	June 2012 – August 2013	January 2011 – August 2013
Housing inventory (units opened or vouchers added)	• LAHSA PSH Inventory Group	June 2012 – August 2013	Calendar Years 2011 and 2012
Housing pipeline (units added to the development pipeline or vouchers committed for future years)	• LAHSA PSH Inventory Group	June 2012 – August 2013	January 2011 – July 2013
System-wide housing placement activity	• Home For Good • 100,000 Homes campaign	June 2012 – July 2013	Calendar Years 2011 and 2012
Grantee activities, including housing placements and retention	• Grantee Reports • Grantee Interviews	October 2011 – July 2013	Grant Years 2011-2012 and 2012-2013

Stakeholder Survey

For the 2012 Report, 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 PSH or otherwise address chronic homelessness. For the 2013 Report, the survey was updated to refine questions by consolidating redundant questions and modifying skip patterns to gather more response information. The invitation list was updated and

expanded. The updated email list for the survey was developed by combining current mailing lists from Home For Good, Community Solutions, Corporation for Supportive Housing (CSH), People Assisting the Homeless, San Gabriel Valley Consortium on Homelessness, and United Homeless Healthcare Partners. From that combined list, key types of stakeholders were identified: 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 1,720 separate email addresses.

The survey was tailored to each stakeholder type, though a substantial number of questions relating to perceptions of PSH were constant from one group to the next. Respondents were given five weeks to complete the survey. Of the 1,720 individuals invited to participate, 421 recipients of the survey link started the survey (about a 24 percent response rate), and 345 completed the entire survey. Of the 421 respondents who started the survey for the 2012 Report, 167 (or 40 percent) also participated in the survey for the 2012 Report. The breakout of the 421 individuals by stakeholder group and repeat response rate is shown in Exhibit 2.2.

Exhibit 2.2: Stakeholder Survey Responses

Stakeholder Type	Respondents	Percentage of Total Respondents	Percentage of Repeat Respondents
Developers, operators, or service providers for homeless or chronically homeless people	226	54%	40%
Advocates, public policy analysts, or researchers	53	13%	53%
Government administrative staff (non-PHA)	50	12%	36%
Philanthropic or private sector funders	29	7%	41%
Faith community representatives	11	3%	18%
Elected officials or their staff	13	3%	23%
Public Housing Authority (PHA) staff members	12	3%	50%
Business community representatives	6	1%	33%
Other	18	4%	28%
Unidentified	3	1%	33%

Source: Abt Associates Inc. Stakeholder Survey, June 2013

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. Data from this survey are used to track progress on the evaluation's process measures throughout this report.

Site Visits and Interviews

The evaluation team collected information from key stakeholders through a series of phone and in-person interviews. Interviewees 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.

Following the release of the 2012 Report in the fall of 2012, the evaluation team engaged stakeholders through in-person and telephone interviews with 23 individuals from 14 grantee organizations, to discuss the results of the report and to gain a deeper understanding of subsequent activities undertaken by the

grantees. In November 2012 and February 2013, the evaluation team presented materials at two Foundation-organized convenings of grantees and key stakeholders and decision-makers within LA.

Over the winter—December 2012 through February 2013—the team conducted 30 phone and in-person interviews with funders, grantees, and other key stakeholders involved with the Funders Collaborative process. Members of the evaluation team also attended two Funders Collaborative meetings.

Another 18 interviews, conducted from April through July 2013, focused on gauging the extent of change from the prior year in community perception of PSH and on grantee data and annual reporting.

Consumer Focus Groups

Four focus groups were conducted in April 2013 with 22 residents of four different PSH projects to understand consumer perspectives on whether PSH is meeting the needs of residents. The projects were selected to reflect some of the variety in program models, length of time in operation, and target populations served. The sites were located on the Westside, in the San Fernando Valley, and in Downtown Los Angeles. The participants were:

- Eight clients living in a project-based facility, with tenancies ranging from six months to two years;
- Six clients living in a project-based facility targeted to people over the age of 55;
- Four clients living in scattered site housing, with tenancies of one year to more than two years;
- Four clients served by a project that supports both project-based and scattered site units.

Permanent Supportive Housing Inventory Group

Los Angeles Homeless Services Authority (LAHSA) has convened a PSH inventory group, which is working to align numerous tracking inventory lists maintained throughout LA County. The group comprises representatives from LAHSA, the Housing Authority of the City of Los Angeles, the Housing Authority of the County of Los Angeles, Los Angeles Housing Department, LA Community Development Commission of Los Angeles County, Veterans Affairs Greater Los Angeles Healthcare System, the LA County Department of Mental Health (DMH), CSH, United Way, and Shelter Partnership. The PSH inventory group's first round of updates are the source of the unit production counts found within this report.

Hilton Foundation Grantees' Administrative Data

Placement Tracking by Home For Good and the 100,000 Homes campaigns

The United Way of Greater Los Angles and Community Solutions have collaborated to establish a tracking system for participants to report quarterly placement data. The placement data are reported by communities that are participating the 100,000 Homes campaign or the Home For Good campaign. These data are included in this report to ensure consistent reporting of numbers across the community.

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 portions of the reports. In addition, data about additional funding leveraged by PSH projects receiving loans from CSH (supported by program related investments from the Hilton Foundation) was extracted from CSH's Portfol tracking system.

Other Documentation

Answers to some of the research questions are based on:

- Analysis of documentation of decisions or actions such as DMH Mental Health Services Act housing resource commitments;
- Grant decisions, and paperwork related to adopting and implementing new prioritization policies;
- Housing Inventory and Point-in-time count data from the Los Angeles area continuums of care;
- Related evaluation reports for local initiatives; and
- Homeless management information system (HMIS) participation statistics provided by LAHSA.

These administrative data sources are described further in the discussion of the 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*.[9] The challenges related to collecting and tracking data in Los Angeles are extensive and continue to have a significant impact on the ability of the evaluation team to collect data on key outcome measures with confidence.

Improvements in the Permanent Supportive Housing Inventory

In line with the recommendations in the Chronic Homelessness Initiative 2012 Report, LAHSA began working closely with Department of Housing and Urban Development (HUD)-funded technical assistance providers to encourage the growth of the nascent PSH inventory group. The group was reconvened with technical assistance providers in the last quarter of 2012, and met again in the second and third quarters of 2013. The group experienced some slowing of momentum during the biennial point-in-time count process and again during staff turnover at LAHSA during the early summer of 2013. Despite this, the group has made significant progress in merging the PSH inventory lists from the participants.

Though the resulting list is not perfect – there are still remaining discrepancies between sources regarding the number of PSH units in some buildings and the number of units set aside for chronically homeless individuals – the list has improved notably. In particular, a number of buildings and units that LAHSA had not been made aware of were added to the inventory, and several duplicates were cleaned up. The HUD-funded technical assistance providers will need to continue working with LAHSA staff in anticipation of the 2014 Housing Inventory Count (January 2014), and the group will likely continue to make improvements to the list. As a consequence, the evaluation team is more confident in the PSH inventory reported than the numbers included in the 2012 Report, but significant opportunities for refinement remain. As staff capacity at LAHSA rebuilds, continued momentum of this group will depend on LAHSA's willingness to dedicate staff time to leading the meetings and building the role of the group.

Improvements in HMIS Participation and Opportunities for Data Matching

In the 2012 Report, the evaluation team noted concerns about low levels of homeless management information system (HMIS) participation, particularly among PSH providers, and concluded that HMIS

[9] *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.

was not suitable as a valid source of comprehensive data for the evaluation of the Initiative. Over 2012, HMIS usage continued to rise from 16 percent in 2011 (see Exhibit 2.3) to 42 percent by January 2013. This was dramatically improved in early 2013, thanks to an arrangement between LAHSA and DMH to feed DMH homeless service provider client data (HMIS universal data elements) into LAHSA's HMIS. As a consequence, the participation rate among PSH beds has jumped to 92 percent.

Exhibit 2.3: HMIS Participation Rates for PSH Beds

Bed Type	Jan 2011	Jan 2012	Jan 2013	June 2013
Beds for households without children	26%	35%	44%	96%
Beds for households with children	7%	36%	40%	84%
All bed types	16%	36%	43%	92%

Source: Jan rates are from the Housing Inventory Chart provided by LAHSA to HUD; June 2013 rates are from LAHSA July 2013 Executive Director Report

In future reports, the evaluation team would like to be able to incorporate HMIS results alongside the other community data collection efforts. To date, opportunities to gather report data from LAHSA by the evaluation team and by other community-led initiatives have not been successful. In part, this has been impacted by LAHSA's complex report development pipeline. LAHSA is still in the process of defining and programming reports to measure their own system-wide and project-level performance measures. However, some community stakeholders have also shared that LAHSA has expressed reluctance to share data in the interest of protecting client privacy and ensuring that LAHSA is able to control the messaging around HMIS-related data

In the 2012 report, we reported that the County was working on efforts to integrate HMIS data with other client-level data from other County service departments, efforts that would support further tracking and analysis of Foundation Initiative goals. Since that report, progress has been slow, but is underway. LAHSA has executed an MOU with the County Chief Executive Office to move forward with sharing data and the Foundation has arranged for funding technical and analytical support to the effort in the future.

3. Summary of Hilton Foundation 2012 Grant Investments

The Hilton Foundation plays numerous roles in addressing chronic homelessness in Los Angeles. Key among them is its role as a direct funder of activities in three Initiative areas: 1) systems change; 2) targeted programs; and 3) knowledge dissemination. From the start of the Chronic Homelessness Initiative through June 2013, the Foundation supported 17 grantees in these Initiative areas. Annual results for grant years that started before June 2012 are summarized in Exhibit 3.1. The exact reporting periods vary by grant; reporting cycles are shown in Exhibit 3.1. Exhibit 3.2 provides basic information about eight new and two renewal Foundation grants with start dates after June 2012. Chapters 4 through 9 discuss the cumulative impact of these efforts and gauge the extent to which the milestones identified in the Theory of Change are being achieved.

Exhibit 3.1: Annual Results for Hilton Foundation Grants Funded Prior to June 2012

Grantee Org.	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; Knowledge Dissemination	$ 600,000	23 communities enrolled in 100,000 Homes campaign; 6,500 Vulnerability Index surveys completed	Participating communities will house 2.5% of their chronic and vulnerable populations per month and, collectively, LA County is housing 2.5% per month
Corporation for Supportive Housing (CSH)	Oct. 2010 - March. 2014	Systems Change; Targeted Programs; Knowledge Dissemination	$9,000,000	From October 2011 to September 2012, Corporation for Supportive Housing provided $1,311,660 in grants to 12 local organizations and $100,000 in project initiation loans to two projects in order to build local industry capacity and to seed initial project planning. The financial assistance was focused on building a robust pipeline of projects for CSH's four target populations: veterans, recently incarcerated individuals, transition-age youth, and frequent users of crisis health services. CSH also worked closely with United Way to assist in the development of Standards of Excellence for PSH and worked to publish a PHA Toolkit, with support from JPMorgan Chase. CSH also worked with a coalition of stakeholders to raise legal, practical, and NIMBY concerns regarding the Community Care Facilities ordinance. As a result, the City Council sent the ordinance back to committee in January 2013, with no further action taken to date. Finally, during the reporting period, CSH provided a range of group and agency-specific training to supportive housing providers, housing developers, and other project partners in Los Angeles County, conducting a total of 69 trainings, workshops, and presentations.	
Downtown Women's Center	Jan. 2011-Dec. 2012	Targeted Programs; Knowledge Dissemination	$ 830,000 (two grants)	80 women will be placed in permanent supportive housing	80% will remain housed for at least 12 months
Housing Works	Mar. 2012-Feb. 2015	Targeted Programs	$ 570,000	75 chronically homeless persons or families	90% will retain housing for the grant period
Mental Health America	Jan. 2011-Dec. 2013	Targeted Programs	$ 750,000	60 individuals will be placed in permanent supportive housing	85% will remain housed

Grantee Org.	Grant term	Initiative Areas	Grant Amount	Target One (through term of grant)	Target Two (through term of grant)
OPCC	Jan. 2012-Dec. 2014	Targeted Programs	$ 750,000	40 chronically homeless individuals housed over three years (20 on service registry; 20 referred from hospitals and FQHC)	85% will retain housing for at least 6 months
PATH Partners	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
Skid Row Housing Trust	Jan. 2011-Dec. 2013	Targeted Programs	$ 750,000	80 chronically homeless, high mortality-risk individuals per year 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
United Way/Home For Good	Sep. 2011-Aug. 2012	Systems Change; Targeted Programs; Knowledge Dissemination	$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 $1 million in grant funds
Western Center on Law and Poverty	Mar. 2011 - Feb. 2014	Systems Change	$ 300,000	The Western Center advocated for major legislative amendments through AB 1484, the redevelopment dissolution “clean-up” bill. The bill became effective June 27, 2012. It creates a new source of funds through a Low and Moderate Income Housing Asset Fund. The Western Center continued to work with CSH to implement a health home option for Low Income Health Program-eligible populations that are chronically homeless and use emergency departments as their usual source of care. Under the Affordable Care Act, states would receive an enhanced federal financial match to create this program. The Western Center, along with other advocates, provided education and background materials to the state to educate them about the possibility of creating a model for this program that would incorporate supportive housing providers. Though an agreement was not reached this year, the Western Center continues to work with the state and stakeholders to exercise this option that would significantly improve the health of chronically homeless persons while leveraging additional federal funds to save state dollars in the long run.	

Exhibit 3.2: Target Goals for Hilton Foundation Grants Funded June 2012 through August 2013

Grantee Organization	Grant term	Initiative Areas	Grant Amount	Target One (through term of grant)	Target Two (through term of grant)
Clifford Beers Housing, Inc.	Jan. 2014-Dec. 2016	Targeted Programs	$500,000	Develop 200 new PSH units (52% dedicated to chronically homeless people)	75% of chronically homeless clients will retain housing
Corporation for Supportive Housing	Oct. 2013-Dec. 2015	Targeted Programs	$1,500,000	Model for Just-in-Reach 2.0 is developed, drawing on lessons learned from pilot phase and evidence-based practice	135 people will be stably housed
Downtown Women's Center	Jan. 2013 - Dec. 2015 (Renewal)	Targeted Programs; Knowledge Dissemination	$450,000	99 participating women from Skid Row will secure housing	80% will retain housing during the project period
Enterprise Community Partners	Sept. 2012-Aug. 2014	Knowledge Dissemination	$ 190,000	Produce a white paper presenting analysis of PSH funding landscape and options for preserving and reforming current PSH financing	Examine innovative models of financing PSH, including Medicaid/pay for performance
Housing California	June 2012-May 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.
JWCH Institute	Jan. 2013 - Dec. 2013	Targeted Programs	$ 400,000	Enroll 4,160 homeless people in Healthy Way LA	95% will document engagement in a medical home
LA County Department of Health Services	Sept. 2013-Aug. 2015	Targeted Programs	$4,000,000	House 600 homeless Department of Health Services patients	90% will remain in housing 12 months after placement
LA Family Housing	July 2012-June 2014	Targeted Programs	$ 700,000	180 chronically homeless individuals and 30 frequent users will be placed in permanent housing	90% will remain in permanent housing after 12 months
SRO Housing	Jan. 2013 - Dec. 2015	Targeted Programs	$ 500,000	100 chronically homeless people will be placed in SRO units (40 existing, 40 new, 20 converted from TH)	80% will retain housing after 1 year
United Way/Home For Good	Sept. 2012-Aug. 2015 (Renewal)	Systems Change; Targeted Programs; Knowledge Dissemination	$7,775,000	Fund a minimum of 1,200 units of PSH each year of the grant	Secure $12.25 million from private funders to match Hilton Foundation investment of $3.65 million in the Funders Collaborative (3:1 match)

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

Broad community support for permanent supportive housing grew over the past year, and elected and public officials demonstrated increased support and action to address chronic homelessness in Los Angeles.

This is the good news – but sustaining and increasing the scale of public investments in PSH as a solution to chronic homelessness remains a huge challenge. Elected and public officials have made funding commitments and public agencies have made some changes to their programs and procedures to support pilot programs and special initiatives or campaigns. However, to have a lasting impact and to significantly reduce chronic homelessness in LA County, one-time funding commitments will need to translate into ongoing, reliable ways of financing PSH and other interventions at a larger scale. Similarly, public agencies will need to institutionalize changes in programs and procedures across their systems, policies, and routines, rather than adopting exceptions for special projects or initiatives.

Going forward, it is likely to be particularly challenging to engage and sustain the interest and commitment of elected officials (and those who influence them) in efforts to end chronic homelessness in LA County in order to fully achieve the goals of the Initiative and Home For Good. Action by elected and public officials at the local and state levels is even more necessary and important because of the impact of federal funding reductions on currently funded commitments and the likelihood of new investments.

Data Availability: Stakeholder survey establishes a baseline to compare changes in consensus and to document actions moving forward.
Status in 2013: Support among stakeholder groups for PSH continued to increase and elected and public officials demonstrated significant concrete actions to address chronic homelessness, although there are questions about whether the support and action are sustainable.

In section 4.1, 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. Responses from this year's stakeholder survey are compared with an equivalent survey conducted in 2012 to measure changes in public support and action for PSH. In section 4.2, we discuss the extent to which elected officials have taken concrete action in support of ending chronic homelessness in LA. In section 3, we summarize recommendations to continue progress in this area. In section 4.3, we provide recommendations for moving forward.

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

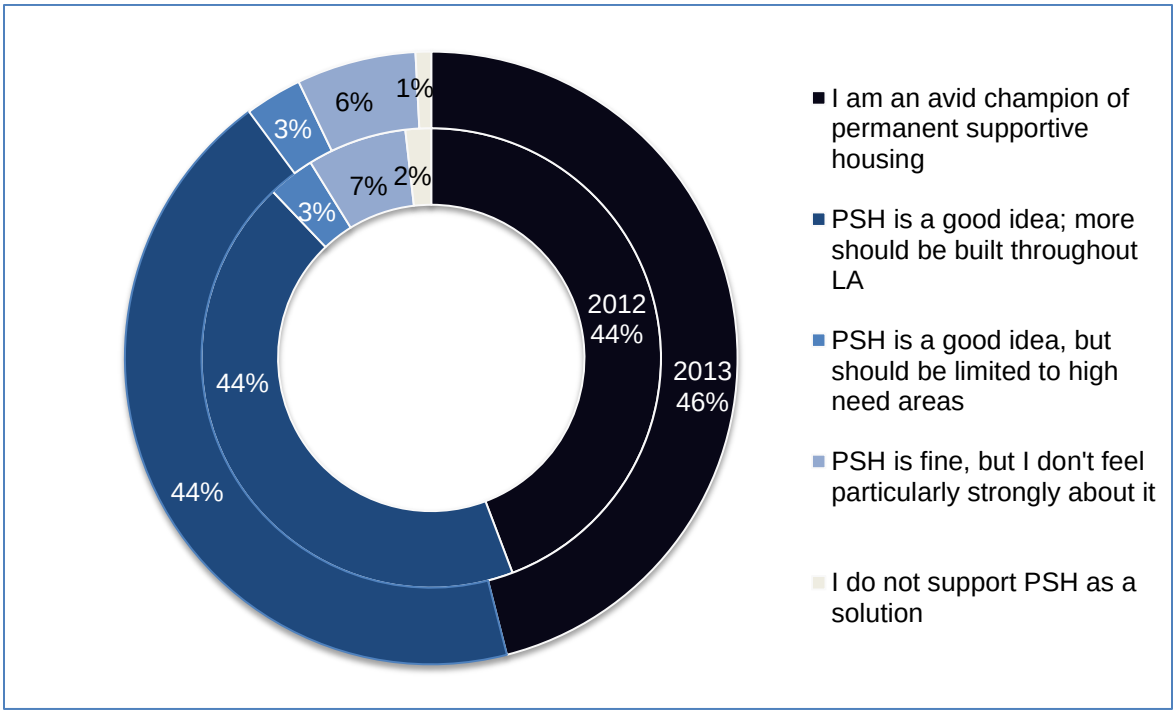
One of the goals of the Chronic Homeless Initiative is to build consensus among key stakeholders that PSH is an effective intervention for people who experience chronic homelessness and for other vulnerable homeless people and to cultivate an understanding among key stakeholders that: 1) people who are chronically homeless can be housed immediately from the streets using a housing first approach, and 2) people who are chronically homeless should be proactively prioritized for PSH over other populations who are not as vulnerable.

Key Stakeholder Support for Permanent Supportive Housing

The stakeholder survey asked respondents to select the statement that best reflects their level of support for PSH. Exhibit 4.1 shows the responses from 365 stakeholders in 2013 (and 330 stakeholders in 2012). Nine out of ten stakeholders indicated that they were either avid champions (46 percent) or that it was a good idea and more should be built throughout LA County (44 percent) – very similar to last year's results, with a slightly higher share identifying as avid champions of PSH. Fewer stakeholders indicated that they did not support PSH (1 percent compared to 2 percent last year) or that they did not feel strongly about it (6 percent in 2013 compared to 7 percent in 2012).

There was some variation in the responses by stakeholder type. Stakeholder groups with larger shares selecting the "avid champion" response than the overall average include: advocates (77 percent), TA providers (67 percent), elected officials (64 percent), and PSH developers or operators (57 percent). While it is encouraging that such a high share of elected officials selected "avid champion," it should be noted that there were only 11 responses from elected officials or their staff (from a list of 127). Groups with considerably lower numbers of avid champions include community residents (33 percent), faith community (30 percent), housing authority staff (27 percent), and health service providers (25 percent). Local government had a lower rate, only somewhat below average (38 percent).

Exhibit 4.1: Stakeholder Opinions about PSH, 2012 and 2013



Sources: Abt Associates Inc. Stakeholder Survey, June 2013, n = 365 stakeholders, all types; and Stakeholder Survey, July 2012, n = 330 stakeholders, all types

In a separate question, stakeholders were asked to rank different program models in terms of their likely effectiveness in ending chronic homelessness, and PSH was ranked as the most effective model with 51% selecting it as the "most important" program model for reducing chronic homelessness in Los Angeles. This perception held steady from 2012.

Key Stakeholder Adoption of the Housing First Philosophy

As part of the stakeholder survey, respondents were asked if they agreed or disagreed with statements describing PSH, in an attempt to gauge whether people understood PSH consistently and agreed with the premise that people who are chronically homeless can be placed directly in PSH without first addressing behavioral health needs or requiring compliance with strict rules as a condition of retaining the housing. Exhibit 4.2 lists the statements and the responses. Overall, there was only minimal change in perceptions on these topics. While responses show strong support for housing first, there is also a sizable share of respondents who continue to believe that people must be "housing ready" or must receive treatment prior to moving into PSH. Further, the housing readiness perspective was more evident with respect to some statements compared to those from last year's stakeholder survey. For instance, a higher percentage (14 percent in 2013 compared to 10 percent in 2012) strongly agreed that people who are seriously mentally ill need to accept treatment prior to entering housing. However, fewer people believed that people who were abusing alcohol or drugs need to complete treatment to enter housing than did last year and nearly half of stakeholders strongly disagreed that people with substance abuse issues needed treatment prior to housing.

Exhibit 4.2: Stakeholder Beliefs regarding PSH, 2012 and 2013

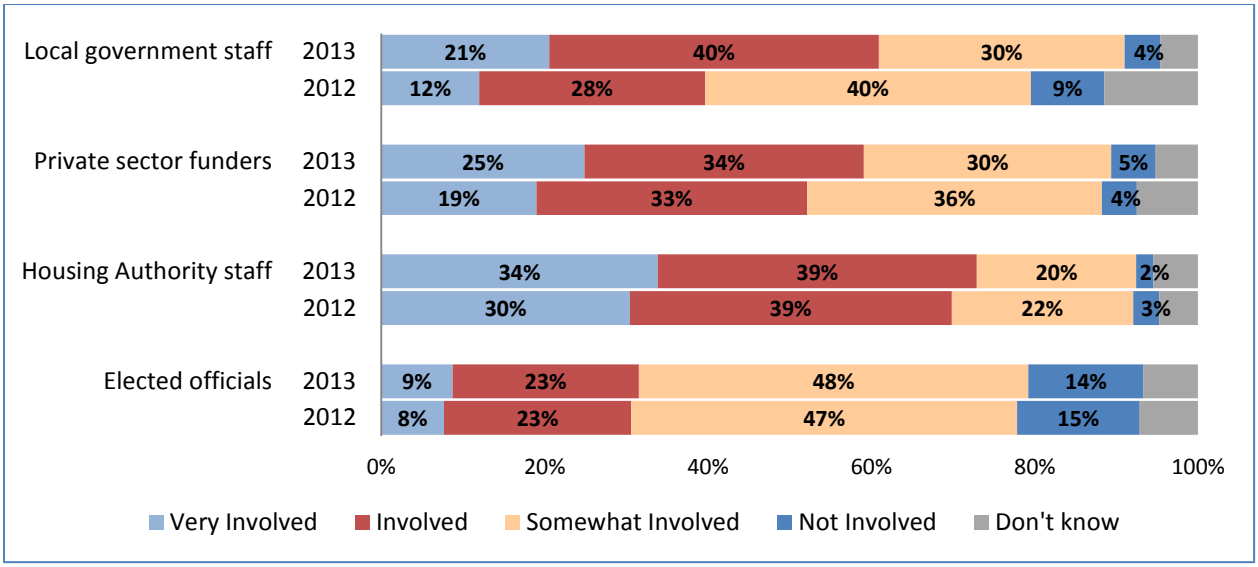
Beliefs about PSH	Extent of Stakeholder Agreement Percent of stakeholders' responses in 2013 (Percent of stakeholder responses in 2012)				
	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	No opinion
A lot of homeless people don't want housing - especially if they have been homeless for a long time	4.1% (3.1%)	13.5% (17.0%)	25.8% (23.2%)	54.1% (55.0%)	2.4% (1.7%)
People who are living on the streets need to enter shelters or transitional programs to get ready for housing	15.0% (14.9%)	24.3% (24.2%)	22.1% (24.0%)	36.9% (33.8%)	1.7% (3.1%)
People who are abusing alcohol or illegal drugs need to complete treatment before they're ready for housing	11.7% (14.6%)	15.8% (18.9%)	22.1% (20.6%)	48.3% (44.1%)	2.2% (1.7%)
People who are seriously mentally ill need to be willing to accept treatment and take medications before they're ready for housing	14.2% (9.8%)	18.1% (23.8%)	20.0% (25.0%)	45.3% (39.5%)	2.4% (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	63.7% (57.7%)	29.6% (31.4%)	4.7% (6.1%)	1.2% (3.9%)	0.7% (1.0%)
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	6.4% (4.2%)	18.1% (18.0%)	34.4% (32.3%)	39.9% (44.8%)	1.2% (2.2%)
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	79.5% (79.9%)	17.8% (17.0%)	0.5% (1.2%)	1.2% (1.0%)	1.0% (1.0%)

Sources: Abt Associates Inc. Stakeholder Survey, June 2013, n = 365 stakeholders, all types; and Stakeholder Survey, July 2012, n = 330 stakeholders, all types

Perceptions of Active Involvement for Different Types of Stakeholders

The annual stakeholder survey shows notable shifts in community perceptions about the engagement of key stakeholder groups in addressing chronic homelessness.[10] As illustrated in Exhibit 4.3, perceptions about the level of involvement of local government staff in efforts to address homelessness have shifted from 40 percent of respondents selecting "involved" or "very involved" in 2012 to 61 percent in 2013. The perceived level of engagement of elected officials remained relatively static, with 9 percent of respondents selecting "very involved" (compared to 8 percent in 2012) and 23 percent selecting "involved" (no change from the 2012 survey). The perceived involvement of private sector funders increased from 52 percent to 59 percent; housing authority staff from 69 percent to 73 percent.

Exhibit 4.3: Survey Respondents' Perception of Each Stakeholder Group's Level of Engagement in Addressing Chronic Homelessness, 2012 and 2013



Sources: Abt Associates Inc. Stakeholder Survey, June 2013, n = 369 stakeholders, all types; and Stakeholder Survey, July 2012, n = 379 stakeholders, all types

While survey respondents reported increases in perceived levels of engagement by key stakeholder groups, the evaluation team also heard in interviews that it has been challenging to maintain the level of commitment as the initial energy "settles" into more routine processes. This challenge was made even greater in the spring of 2013, when the federal sequestration resulted in freezing housing voucher commitments. At the same time, the point-in-time homeless count results showed a 15 percent increase in the number of homeless people and a 20 percent increase in the number of chronically homeless people in Los Angeles County since 2011.

[10] All stakeholder groups were asked to rate the level of engagement of various types of stakeholders, so the results reported are cumulative and do not solely reflect a self-assessment by individuals within each group.

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

In 2012 and early 2013, increasing support for PSH among elected and public officials was clearly demonstrated through a number of significant actions.

Concrete Action by Elected Officials

A successful campaign blocked enactment of a harmful LA City ordinance

"A victory – or at least not a defeat"

In one of the year's most notable victories, a sustained and well-organized campaign by hundreds of local advocates was successful in blocking passage by the LA City Council of the proposed Community Care Facilities Ordinance (CCFO). The CCFO, which was drafted in response to concerns about sober living facilities (shared housing for people in recovery), would have placed limits on some types of shared housing and residential projects that house more than three persons on probation or parole. Opponents recognized that the proposed ordinance would be a threat to many existing and future supportive housing projects in the City of Los Angeles. They mounted a successful grassroots campaign, Stop CCFO[11], with the support of more than 160 organizations, including the United Way, Corporation for Supportive Housing, LA Chamber of Commerce, Business Leaders Task Force, and many of the Initiative's grantees. In January 2013, the LA City Council withheld a vote on the ordinance, effectively blocking its passage, and the advocates declared victory, at least for now.

LA County Interagency Council on Homelessness

In January 2012, the LA County Board of Supervisors created the LA County Interagency Council on Homelessness (LACICH) to bring together County departments and agencies to coordinate the County's efforts to end homelessness. The LACICH is headed by the Chairperson of the LA County Board of Supervisors. Membership includes representatives of more than a dozen County agencies and departments.

During 2012, representatives of the LACICH member departments met eight times, and at the end of the year the LACICH issued a *County Roadmap for Addressing Homelessness*[12]. The *Roadmap* incorporates a set of recommendations that are intended to achieve five main outcomes:

- The development of more permanent supportive housing;
- Improved data sharing;
- The creation of integrated health and social service teams;
- Enhanced funding integration; and
- A legislative platform for homelessness.

Among the recommendations that are included in the *Roadmap*, several are focused on increasing the coordination between public social service agencies to ensure that all available resources are being accessed to provide supportive services in PSH, creating integrated health and social service teams, and pursuing opportunities under health care reform to support housing stability for homeless people with chronic medical and/or behavioral health conditions.

[11] For more information on the Stop CCFO campaign and a list of organizations that opposed the ordinance, see http://www.stopccfo.org.

[12] The *County Roadmap for Addressing Homelessness* is available at http://zev.lacounty.gov/wp-content/uploads/roadmap.pdf.

LA County Board of Supervisors

During the County's 2013 fiscal year, the LA County Board of Supervisors took action to increase investments in PSH as the County's primary strategy for ending chronic homelessness. Most visibly, the Supervisors demonstrated action through allocations of funding for the County Homelessness Prevention Initiative (HPI). In addition, the Supervisors supported the LA County Department of Health Services (DHS) Housing for Health program, described later in this chapter, and provided DHS with the authority to establish multi-year contracts with community-based providers for housing management and supportive services in supportive housing projects.

The HPI was launched by the Board of Supervisors in 2006. HPI provided $100 million in one-time funds and $15.6 million a year in ongoing funding for various initiatives to address homelessness in LA County. About half of the ongoing funding is allocated by Supervisors to projects within their districts, and the other half is allocated for county-wide or "non-district" programs. Some Supervisors members carry over unspent funds from their allocations from one year (or more) to be used in the next year(s), so the actual amount of funding awarded by each Supervisor's office each year varies.

According to information provided by the LA County Chief Executive Office (CEO), Supervisors increased the level of HPI funding directed toward PSH projects, from one-third of HPI funds available ($4.5 million) in County fiscal year 2012 to nearly 40 percent ($5.76 million) in County fiscal year 2013. Some of this increase reflects the reallocation or carryover of funds that had been allocated in the prior year but unspent because of implementation delays; nonetheless, the amount award for PSH represents approximately 80 percent of the HPI funding allocated by Board members at the district level. Fiscal year 2013 allocations are listed in Exhibit 4.4.

Exhibit 4.4: Fiscal Year 2012-2013 LA County Homeless Prevention Initiative Funding

PSH projects and programs that include PSH	
• Access to Housing for Health (DHS) • Project 50 / Project 60 replications in Venice (St. Joseph Center), Santa Monica (OPCC), Hollywood (Step Up on Second), and San Fernando Valley (San Fernando Valley Mental Health) • Gateway COG – permanent housing for single adults and families • Capital project with services in East LA • San Gabriel Valley Services Partnership and Capital Project • Del Rey Square • West LA CDC • Beyond Shelter • Transition Aged Youth Project 40 in Hollywood (Step Up on Second) • Transition Aged Youth Project (PATH Ventures)	
Total allocated by Board Members for projects including PSH	$ 6.89 million

Source: Chief Executive Office of Los Angeles County

One of the largest allocations went to the Gateway Council of Governments (COG), which received $2 million in fiscal year 2013. Of this amount, $1.16 million provides the second year of funding to support implementation of Gateway Connections, a three-year initiative launched in 2012 to implement the Gateway Cities Homeless Action Plan. Through a request for proposals (RFP) issued in 2012, PATH Partners was selected as the lead agency, working with four partner organizations to implement a regional response to homelessness in the Gateway Cities. Gateway Connections partners reach out to engage

unsheltered homeless people who are living on the streets or in encampments and other "hot spots," helps people move into permanent housing and access the services and supports needed to get housed, delivers ongoing case management services to people after they move into housing, and works to create new units of PSH in the region. During the program's first nine months (October 2012 – June 2013), 444 people were placed in emergency shelter or issued a motel voucher, 138 were provided move in assistance, and 225 people were permanently housed. The balance of funding allocated to Gateway COG is about $860,000 in carryover funding, which had been allocated but remained unspent in the prior year. As of Summer 2013, decisions had not been made about how to spend these one-time funds. A representative of PATH Partners indicated that plans are underway to focus on creating new units of PSH as part of the Gateway Connections Year Two.

In June 2013, the Board of County Supervisors adopted a motion by Supervisors Mark Ridley-Thomas and Zev Yaroslavsky that directs the County's CEO to develop recommendations for reprogramming the remaining unspent one-time HPI funds, as well as the ongoing non-district funds starting in 2013-2014 "in a manner that both promotes permanent supportive housing and best practices and considers geographic burden and need as determined by the latest Homeless Count results" in the LA County Continuums of Care (Los Angeles, Glendale, Long Beach, and Pasadena). The motion also directs the CEO to ensure that at least 90 percent of the recommended reprogrammed funds will "go to permanent supportive housing efforts, especially those efforts that could leverage significant federal, state, local, and philanthropic funds and resources." The CEO's recommendations may provide significant opportunities to build understanding and support among Supervisors for investments in PSH projects and program initiatives that are aligned with the goals of the Chronic Homelessness Initiative.

In the second half of 2013, the LA County CEO's office will engage with the LACICH to review and provide input into recommendations that are being developed for the reallocation of HPI funds, pursuant to the resolution adopted by the LA County Board of Supervisors.

Transitions in leadership among elected officials may challenge progress

This is a critical moment to continue engaging elected and public officials. The City of LA has a new Mayor, and the County Board of Supervisors has a new President. At the end of 2014, term limits will result in losing two Supervisors who are supporters for PSH. These changes present challenges, but also opportunities to educate new policymakers and engage them in making commitments that move beyond one-time funding and pilot programs.

State-level Challenges and Opportunities

In the 2012 Report, the evaluation team noted that the loss of the Redevelopment Agency funding was having a significant impact on the availability of PSH development funding. Since the dissolution of the Redevelopment Agencies, the increased property tax increment has been returned to local jurisdictions as general revenues. There is a tremendous opportunity for stakeholders to advocate that the City and County make and adhere to commitments to expend an appropriate portion of this revenue on PSH.

Meanwhile, state funding for the production of affordable and supportive housing is running dry as the funds provided by bonds approved by voters in prior years and other one-time sources have been almost fully allocated. The State Legislature is considering SB 391, the CA Homes and Jobs Act, which would establish permanent, ongoing sources of funding dedicated to affordable housing development. Housing California, CSH, and other Hilton Foundation grantee agencies are actively involved in working with the Legislature on this bill. Though the bill was not passed during 2013 (the first year of a two-year legislative session), legislative leaders and advocates believe that the bill may be passed early in the

coming year. A SAMHSA-funded California State Policy Academy on Chronic Homelessness has provided a forum for several Hilton grantees and other stakeholders to provide input to state policymakers about opportunities to target some of the new resources that would be provided by SB 391 to creating more PSH for people experiencing chronic homelessness. The evaluation team will monitor the bill's progress over the coming year.

Concrete Action by Public Agency Leadership

Representatives from LA County's Department of Mental Health (DMH), DHS, Housing Authority of the City of Los Angeles (HACLA), and the Housing Authority of the County of LA (HACoLA) all reported working together in increasingly effective partnerships within the past year to deliver housing and services to the most vulnerable and chronically homeless people. Stakeholders also saw the Los Angeles Homeless Services Authority (LAHSA) taking steps to engage more fully with community initiatives.

Shared commitments for PSH made, but sequestration creates roadblocks to fulfilling commitments
Before 2012, redevelopment agencies had been major partners in financing affordable and supportive housing projects in LA County and other parts of the state. When the redevelopment agencies were dissolved in 2012 because of state budget cuts, many public officials who were interviewed by the evaluation team expressed enthusiasm and hopefulness about using Housing Choice Vouchers administered by public housing authorities (PHAs) to support the expansion of PSH instead. In fact, many public officials noted that scattered site PSH created from Housing Choice Voucher subsidies linked with services funded (at least in part) by DMH and DHS, could significantly increase the availability of PSH in LA County because it does not require large investments of capital funding and it avoids many of the NIMBY siting battles that can block or delay the development of new affordable and supportive housing projects. Tenant-based rent subsidies also seemed to offer the promise of allowing PSH program participants more choice about where to live and greater opportunities for public officials to address unmet housing needs in parts of LA County where there are few developers with the capacity or will to develop and operate site-based PSH for chronically homeless people. For some public officials who had little experience with PSH, it was much easier to get started by working with private landlords and service partners, an approach that has the potential to deliver greater impact, by housing more people more quickly, with less initial investment than a capital project.

As described in the 2012 Report, HACLA committed 300 new tenant-based housing vouchers (later increased to 310) and HACoLA committed 50 vouchers in early 2012 as part of the Home For Good Funders Collaborative. At the same time HACLA and HACoLA also committed to making an additional 250 new vouchers available in 2013 to provide PSH to chronically homeless people. In early 2013, HACLA increased their 2013 commitment by another 90 vouchers. DMH and DHS committed to fund supportive services for an initial two-year period – with the expectation that services would continue to be funded beyond that – linked to 250 of the vouchers committed by the PHAs in 2012 and an additional 250 allocated through the 2013 Funders Collaborative request for proposals (RFP). The two-year funding commitments for supportive service were valued at $3.25 million each year. Other commitments from philanthropy provided funding for services that would be delivered by community-based service providers and linked to HACLA vouchers for chronically homeless people. Also as part of the Home For Good Funders Collaborative 2013 RFP, the Housing Authority of the City of Santa Monica committed to making housing vouchers available to serve chronically homeless people who are from and/or residing in the City of Santa Monica. In addition, the City of Los Angeles committed capital resources, paired with project-based vouchers from HACLA, to develop 150 units of PSH dedicated to chronically homeless

people. More details about these funding commitments and the current status of the projects are included in Chapter 5.

These promising commitments and efforts by PHAs and their companion services funding are now almost completely stalled because of the impact of sequestration, the across-the-board cuts in federal funding imposed in March 2013. In LA County and across the country, most PHAs were required to stop issuing new housing vouchers and to rescind vouchers that had been issued if units were not under lease by April.[13] PHAs may continue to issue vouchers for homeless veterans through the Housing and Urban Development's Veterans Affairs Supportive Housing program, and some homeless people may receive housing assistance through the Shelter Plus Care program or in housing that had received prior commitments of project-based vouchers, but with few exceptions, PHAs are now unable to issue tenant-based rental assistance through the voucher program. Depending upon the actions Congress will take on appropriations for federal housing programs in the fiscal year that begins October 1, 2013, PHAs may be able to resume issuing vouchers as they become available through turnover at some time during 2014. However, by then federal funding cuts are likely to have significantly reduced the size of the voucher program nationwide.

Thus, the prior impact of the elimination of redevelopment agencies on the production of new facility-based PSH units is now compounded by the impact of sequestration on the commitment of Housing Choice Vouchers for new scattered site PSH units.

Voucher commitments through Home For Good leverage change in other public agencies and systems
Despite the challenges posed by sequestration, HACLA has played a critically important role in expanding the supply of PSH available to people who are chronically homeless. In 2012, following several years of moving in this direction gradually, HACLA requested of its partners that all existing Shelter + Care be used primarily to serve people experiencing chronic homelessness, when these housing subsidies become available through turnover. By focusing on this population in its Shelter Plus Care and other voucher programs, HACLA is helping to leverage changes among the many partner organizations, including other public agencies that use vouchers to provide housing to the people they serve.

In interviews with members of the evaluation team, LA County DMH staff said that in the past year the focus of DMH housing programs has shifted to a stronger focus on serving chronically homeless people. In part this is because the housing resources committed by housing authorities participating in the Home For Good Funders Collaborative (HACLA and HACoLA) are increasingly prioritized to chronically homeless people. In the past DMH did not distinguish between homelessness and chronic homelessness in determining eligibility or priority for housing or services. Between July 2012 and June 2013, 87 percent of voucher applications submitted by DMH to HACLA and HACoLA were for chronically homeless people. This reflects a significant culture change for DMH and its contract providers. While homeless people still must have some connection to DMH services in order to obtain housing assistance, DMH leadership is increasingly working to move the system in the direction of a housing first approach, recognizing that the offer of housing can be a powerful tool for engaging a chronically homeless person and a first step in the process of connecting people to the services they need to support recovery.

[13] According to estimates prepared by the Center on Budget and Policy Priorities, nationwide approximately 140,000 low-income households will be unable to receive rental assistance from PHAs through the Housing Choice Voucher program because of the impact of sequestration. See http://www.cbpp.org/files/4-2-13hous.pdf.

County Department of Health Services launches Housing for Health

The LA County DHS director, Dr. Mitch Katz, brought a strong commitment to creating PSH to reduce avoidable hospitalizations and improve health for vulnerable homeless people when he came to Los Angeles, after serving as the Director of the San Francisco Department of Public Health.[14] Efforts are now underway to create thousands of housing and residential options, including but not limited to PSH, for homeless people who receive care through DHS and its partners. The DHS Housing for Health Team believes that the system needs a range of options that include permanent and temporary housing with varying levels of support, including medical respite and recuperative care, PSH, interim housing where people can stay while waiting for a permanent housing placement, temporary housing for people experiencing a short term crisis, and licensed residential care for those who need more intensive care and supervision.

The team has been exploring options for creating or obtaining access to housing "slots" for homeless people identified and prioritized by DHS. The team is presently talking with non-profit housing developers, as well as "anyone and everyone" who has a facility or an idea that might offer an appropriate housing or residential option for homeless people served by the County's health care system. In exchange for access to housing opportunities, DHS offers the promise that appropriate service supports will be attached to each unit. This offer is extremely attractive to PSH developers and operators who often find it very difficult to get the flexible, ongoing funding needed to deliver supportive services to their tenants. The offer of DHS funding is particularly attractive for PSH programs that serve chronically homeless tenants who are not eligible for services funded by the County mental health system.

Funding for Housing for Health has been provided from a one-time allocation of HPI funds, and additional funds reallocated from within the DHS budget to establish contracts for both property management and supportive services. The Department used a request for qualifications process to select vendors with the capacity to deliver either (or both) types of services, and entered into master contracts with 8 companies for property management services, and about 20 service provider organizations with experience working with homeless people in supportive housing. The LA County Board of Supervisors gave DHS authority to use these master contracts, or indefinite quantity contracts, to streamline the process of entering into specific agreements or task orders with these pre-qualified vendors when housing becomes available. This allows DHS to move quickly when negotiating agreements with pre-qualified providers, and to take a "just in time" approach to putting property management and supportive services in place, as opposed to the typical timeframe for real estate transactions which can be slow and unpredictable.

DHS is doing very exciting work and has ambitious plans to expand Housing for Health, but will need more than a strong champion to make this a sustainable effort at the scale needed. DHS and its partners will need to pursue opportunities to use Medi-Cal financing through partnerships with managed care plans and collaborations with providers who can use other Medi-Cal benefits to pay for services in PSH for the most vulnerable chronically homeless people. LA County will need to advocate for the state to include provisions in the state's next Medicaid waiver proposal in order to allow Medi-Cal managed care plans to

[14] In San Francisco, Dr. Katz had provided leadership in creating the Housing and Urban Health Section and the Direct Access to Housing permanent supportive housing program, which was first launched with support from the Hilton Foundation. That program now serves more than 1,000 formerly homeless people using a "low threshold" housing first approach.

partner with DHS (and others) to pay for the services that are most effective for chronically homeless people, including services in PSH.

Los Angeles Homeless Services Authority

Similar to the other public agencies, LAHSA has demonstrated increased engagement with community initiatives since the 2012 Report with concrete results. As mentioned in Chapter 2, LAHSA has worked with HUD technical assistance providers to dramatically improve Homeless Information Management System (HMIS) participation among PSH providers. It is now at 92 percent. The bulk of this improvement was the result of a negotiation with DMH to share data from the DMH system with HMIS. The prior lack of data exchange between these two systems was cited in the 2012 Report as a significant obstacle to HMIS participation. Similarly, LAHSA has worked to engage and expand the PSH inventory group.

LAHSA has also been engaged with the Skid Row Coordinated Entry System (CES) pilot effort, led by Home For Good and Community Solutions. Stakeholders report that, although HMIS is not currently being used for the CES, LAHSA has expressed willingness to build out a test HMIS database that may be able to be used for matching clients and units in the future. The second 100 day phase of the pilot project includes a goal to develop clear business rules that would allow HMIS to be a functional system for this purpose. Similarly, LAHSA has been engaged with the Standards of Excellence development process and may incorporate the measures into future HMIS reports.

Challenges remain, however, as some of the staff members identified as most fully engaged with these community efforts are no longer with the agency. In addition, no new PSH projects were included in the highest priority "tier" in response to HUD's 2012 Continuum of Care application process, and so none of these projects were funded.

4.3 Recommendations to Move Forward

Continue to build a broad constituency to support public investment in PSH designed and targeted to people who are chronically homeless. Refine messaging to build more consensus for housing first approaches and prioritization of resources to people who are chronically homeless or highly vulnerable and likely to become chronically homeless without assistance.

Focus on emerging political leadership. Work with new elected officials to ensure sustained political will and to encourage continued and increased investment in PSH through the HPI, allocation of existing mainstream services, and creation of new initiatives.

Mitigate the effects of sequestration. Community groups should consider action such as advocating for a swift end to the Housing Choice Voucher freeze that adversely affects efforts to expand PSH opportunities and align necessary supportive services. Measures also need to be taken to ensure that County service commitments are maintained until the vouchers become available again, so the service commitments are not lost altogether. Stakeholders should also explore whether funding sources – in addition to the recent commitment by the Foundation to DHS – could be used to create bridge subsidies until Housing Choice Vouchers are available again.

Encourage public officials to institutionalize their commitment to ending chronic homelessness. While some commitments are resource-constrained, other actions can be taken by public officials, such as changes to program eligibility, application procedures, and program design to help improve access to PSH

and services for people who are chronically homeless or at risk of becoming chronically homeless. This may also include advocating for new state funding for affordable housing through programs that create strong incentives for creating PSH prioritizing chronically homeless people and advocating for City and County officials to honor the commitments to PSH previously made by the Redevelopment Agencies. This recommendation also requires that grantee agencies and other PSH providers become more active in communicating with elected officials and public agency representatives, including regular attendance at LAHSA Commission meetings.

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

The Foundation established two strategic goals for the five-year period related to leveraging resources for PSH – one that aims to raise $15 million in private funds toward PSH and another that aims to realign $75 million in public sector funds to PSH. The Theory of Change for the Chronic Homelessness Initiative assumes that building greater political will is a precursor to demonstrated action by elected and public officials, which is integral to securing increased resources for PSH. Certainly the findings reported in Chapter 4 on the high levels of consensus and strong action by elected and public officials in support of PSH set the stage for making real progress on this goal.

In the 2012 Report, we documented that the community was on course to exceed the public funding goal and to meet the private funding goal by the end of the five-year Initiative period. In the 2013 report, as of August 2013, we are reporting that the community had received public funding commitments that exceed the public goal and was nearly 60 percent of the way toward meeting the private goal. While this is a very significant accomplishment, the sequestration issues discussed in Chapter 4 are putting the public funding commitments at risk, and the momentum in securing private funding may not be keeping pace with the need for renewal funding.

Data Availability: Clear data are available for funds leveraged through the Funders Collaborative. While a lower priority for the Chronic Homelessness Initiative evaluation, data on funding secured outside of the Funders Collaborative is inconsistent and difficult to deduplicate.
Status in 2013: The public goal has been exceeded, and progress continues on the private funding commitments. Revisiting the goals for the Collaborative may be needed in light of the growing need for renewal funding year after year.

Section 5.1 reports the cumulative funding committed through July 2013 – the second year of the Home For Good Funders Collaborative. The also section includes documentation of additional commitments leveraged through Hilton Foundation investments, beyond the direct grants made through the Funders Collaborative. Section 5.2 reports on the status of aligning and coordinating housing and services funding for PSH, based on feedback provided through interviews with public and private funders, applicants, and grantees about the activity that occurred over the past year and their impressions of the impact of that work. Section 5.3 provides recommendations related to continuing that work.

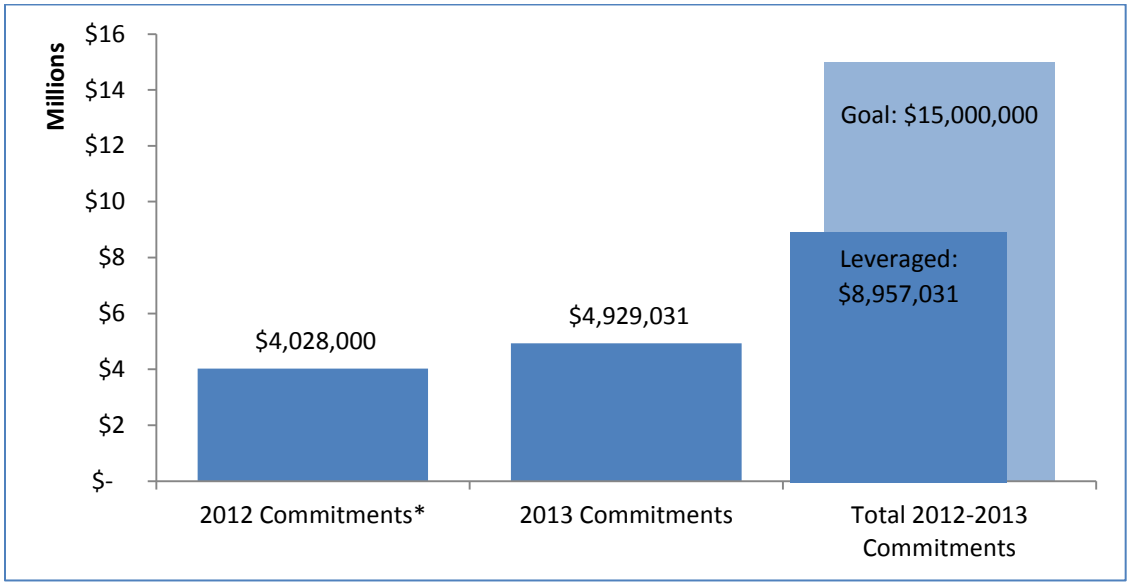
5.1 Process Measure: Is there a commitment of $15 million in additional private funding and $75 million in realigned public funding?

Home For Good Funders Collaborative

Nearly $9 million in private funding commitments and more than $117 million in public funding commitments were made from the beginning of the Chronic Homelessness Initiative in January 2011 through the second round of the Funders Collaborative request for proposals (commitments made through August 2013). Exhibit 5.1 illustrates the private commitments and Exhibit 5.2 illustrates the public funding committed to date. The private funding was leveraged in part through a $1.5 million seed grant that the Hilton Foundation awarded to United Way to support the Funders Collaborative process, similar to the $1 million seed grant awarded for Year 1 of the Funders Collaborative. Just over $4.9 million was raised for the 2013 Funders Collaborative request for proposals (RFP) – a 22 percent increase over the $4

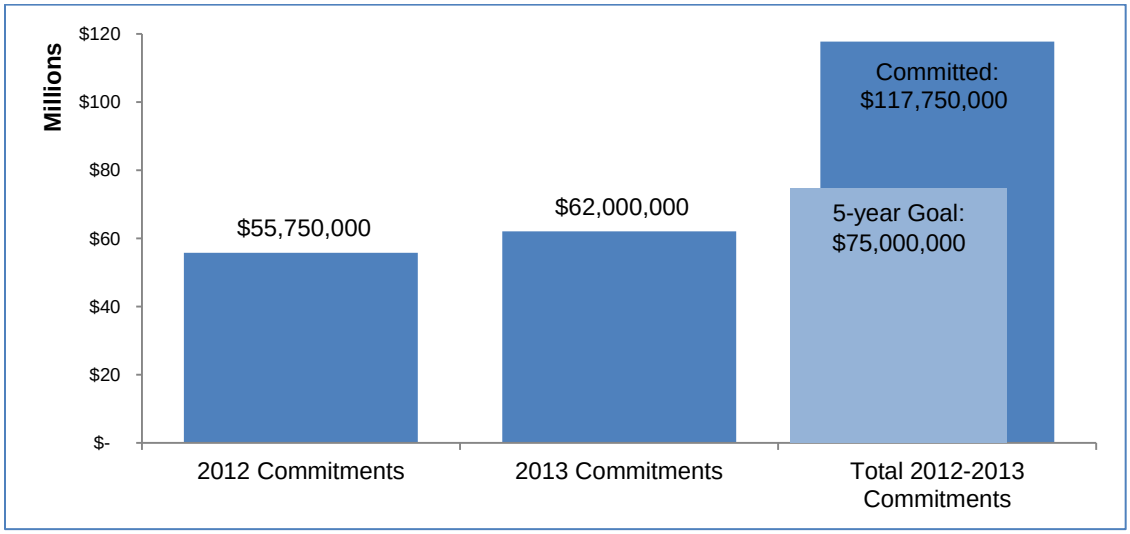
million raised for the 2012 Funders Collaborative RFP (excluding the Hilton Foundation seed grants). Home For Good has a goal of funding more than 1,000 additional PSH units each year of the Funders Collaborative (through 2016). The ability of the collaborative to fund both renewal and new projects will depend on its ability to increase this amount significantly year over year and gain a better understanding of decreasing service needs as clients stabilize in housing. As detailed in Exhibit 5.3, four new funders (3 private and 1 public) joined the Funders Collaborative RFP in 2013, while four prior participating funders have, to date, not pooled or aligned funds this year.

Exhibit 5.1: Progress Toward Goal of Leveraging $15 million in Private Funding for PSH



**Correction to 2012 Commitment, per Home For Good*

Exhibit 5.2: Progress Toward Goal of Leveraging $75 million in Public Funding for PSH



Source: Home For Good Funders Collaborative (Commitments made January 2011 – August 2013)

The private funding allocated through the annual Funders Collaborative RFP was intentionally designed to fill the historical gap in funding for supportive services, particularly for basic case management and tenant services that help to ensure residents' ongoing housing stability. In its second round of funding, the

Funders Collaborative RFP was able both to provide prior applicants with the opportunity to request renewal grants for continued service funding and to fund additional grants for supportive services to assist new PSH tenants. As the number of units supported by the Collaborative grows, this accomplishment may prove difficult to maintain without significantly increasing the level of funding allocated through the Funders Collaborative. Stakeholders will need to redouble efforts to meet the private funding goal and to fill the ongoing supportive services gap.

The public funding commitments of $117,750,000 are detailed in Exhibit 5.3. The calculation of the value of the 360 tenant-based vouchers dedicated in 2013 is based on the present value of a voucher of $10,000 per voucher per year for a 15-year period. The participating public housing authorities have agreed to retain the tenant-based vouchers for chronically homeless individuals for the full 15-year period, meaning that the vouchers can be used to house more than the initial 360 chronically homeless individuals through turnover. In turn, the County pledged services, valued for a one-year period (ongoing services for the 2012 commitments plus an additional commitment in 2013), for persons placed in 250 of these units. (The County agencies and PSH providers have developed intake assessment and placement processes to identify and place chronically homeless persons who are eligible for the specific County services).

However, due to the impacts of sequestration, only 300 of the 360 vouchers committed in 2012 have been leased to date and paired with committed services. The remaining vouchers from 2012, plus the 360 vouchers committed in 2013 (valued at $63 million altogether), are anticipated to become available in 2014 and will be paired with services at that time.

Aligned funding commitments

In addition to the vouchers leveraged as part of the Funders Collaborative, the Los Angeles Housing Department and the Housing Authority of the City of LA (HACLA) issued a coordinated RFP in 2013 for capital and operating support for 150 project-based units, all of which are expected to be dedicated to chronically homeless persons. This commitment was a requirement of the Jones Settlement. The Jones Settlement, agreed to in October 2007, required the City to create 1,250 new units of PSH for chronically homeless people – half of which are required to be in Downtown/Skid Row – before the City is permitted to re-start enforcing its anti-public sleeping ordinance. According to the LA Housing Department, the City created 750 units prior to 2011 as part of the settlement effort, so this commitment will bring the City to approximately 75 percent of the overall settlement commitment. While it is anticipated that these units will have service commitments at the time they are occupied, no specific service commitment has been included as part of the development commitment to date. These resources, therefore, were not counted as progress toward the Initiative goal.

In addition, the City of Pasadena included funding for a rapid re-housing project for homeless families and the City of West Hollywood timed their regular homeless services funding cycle to align with the Home For Good RFP cycle in 2013. HUD technical assistance resources have also been set aside to support trainings for PSH providers aligned with the Home For Good Standards of Excellence. These resources were not counted as progress toward the Initiative goal.

Exhibit 5.3: Funding Commitments to PSH through the 2012 and 2013 Home For Good Funders Collaborative RFPs

Source	Value	Year of pledge/ award[15]	Use period	Type	Method of Allocation	Details about Commitment
Conrad N. Hilton Foundation	$1,000,000	2012	2012-2013	Grant	Pooled	
Conrad N. Hilton Foundation	$1,500,000	2013	2013-2014	Grant	Pooled	
Leveraged Private Funders: 2012 and 2013 Commitments						
Aileen Getty Foundation	$1,000,000	2012	2012-2013	Grant	Pooled	
Annenberg Foundation	$250,000	2012	2012-2013	Grant	Pooled	
Business Leaders Task Force	$25,000	2012	2012-2013	Grant	Aligned	
Cedars Sinai	$100,000	2012	2012-2013	Grant	Pooled	
Corporation for Supportive Housing	$200,000	2012	2012-2013	Grant	Aligned	
Goldman Sachs	$15,000	2012	2012-2013	Grant	Pooled	
Kaiser Permanente	$710,000	2012	2012-2013	Grant	Aligned	
The California Endowment	$250,000	2012	2012-2013	Grant	Pooled	
The Carl and Roberta Deutsch Fdn.	$50,000	2012	2012-2013	Grant	Pooled	
The Carl and Roberta Deutsch Fdn.	$328,000	2012	2012-2013	Grant	Aligned	
United Way of Greater Los Angeles	$500,000	2012	2012-2013	Grant	Pooled	
United Way of Greater Los Angeles	$100,000	2012	2012-2013	Tech. Assist.	Aligned	
Weingart Foundation	$500,000	2012	2012-2013	Grant	Pooled	
Annenberg Foundation	$250,000	2013	2013-2014	Grant	Pooled	Second-time contributor
California Community Foundation	$245,700	2013	2013-2014	Grant	Aligned	New FC contributor
Cedars Sinai	$100,000	2013	2013-2014	Grant	Pooled	Second-time contributor
Corporation for Supportive Housing	$122,500	2013	2013-2014	Grant	Aligned	Second-time contributor
Downtown Business Association	$2,500	2013	2013-2014	Grant	Pooled	Second-time contributor (part of BLTF)
JP Morgan Chase	$300,000	2013	2013-2014	Grant	Pooled	New FC contributor
Kaiser Permanente	$500,000	2013	2013-2014	Grant	Aligned	Second-time contributor
The Carl and Roberta Deutsch Fdn.	$328,000	2013	2012-2013	Grant	Aligned	Second-time contributor
The Carl and Roberta Deutsch Fdn.	$75,000	2013	2013-2014	Grant	Pooled	
UniHealth	$1,005,331	2013	2013-2014	Grant	Aligned	New FC contributor
United Way of Greater Los Angeles	$1,500,000	2013	2013-2014	Grant	Pooled	Second-time contributor
Weingart Foundation	$500,000	2013	2013-2014	Grant	Pooled	Second-time contributor
Private Pooled Funding Subtotal	**$5,392,500**					
Private Aligned Funding Subtotal	**$3,564,531**					
Private Funders Subtotal	**$8,957,031**					

[15] The 2013 commitments reflect commitments made through August 31, 2013. Home For Good continues to work with private funders to bring in funding for allocation during the 2013 grant cycle, and amounts may fluctuate past this date as they are finalized.

Source	Value	Year of pledge/ award[16]	Use period	Type	Method of Allocation	Details about Commitment
Leveraged Public Funders: 2012 and 2013 Commitments						
HACLA	$46,500,000	2012	2012-2027	Vouchers	Aligned	310 new TB vouchers for CH
HACOLA	$7,500,000	2012	2012-2027	Vouchers	Aligned	50 new TB vouchers
L.A. County - DMH, DHS, DPH	$3,250,000	2012	2012-2013	Services	Aligned	Services for 250 new units
HACLA	$43,500,000	2013	2013-2028	Vouchers	Aligned	290 new TB vouchers for CH
HACOLA	$7,500,000	2013	2013-2028	Vouchers	Aligned	50 new TB vouchers
L.A. County - DMH, DHS, DPH	$6,500,000	2013	2013-2014	Services	Aligned	Services 250 ongoing/250 new units
City of Santa Monica	$3,000,000	2013	2013-2027	Vouchers	Aligned	New FC contributor; 20 TB vouchers
Public Funds Aligned with Service Funding	**$117,750,000**					
Aligned Public Funders: 2012 and 2013 Commitments						
City of Pasadena	$2,850,000	2012	2012-2027	Vouchers	No svs.	19 new PB vouchers
City of LA Housing Department	$8,594,111	2012	2012-2016	Construction	No svs.	218 new units
HACLA	$32,700,000	2012	2012-2027	Vouchers	No svs.	218 new PB vouchers (39 CH)
City of Pasadena	$38,500	2013	2013	Rapid Re-housing	Aligned	20 homeless and CH families
City of West Hollywood	$381,519	2013	2013-2016	Services	Aligned	General-fund services grants
City of LA Housing Department	$16,600,000	2013	2013-2017	Construction	No svs.	150 new units
HACLA	$22,500,000	2013	2013-2028	Vouchers	No svs.	150 new PB vouchers (all CH)
HUD	$47,000	2013	2013	Tech. Assist.	Aligned	
Public Funds Realigned to PSH	**$83,711,130**					
Total Leveraged Directly and Indirectly through Funders Collaborative						**$ 210,649,142**

** "Pooled" funds are those that are paired with services and allocated by United Way through the coordinated Funders Collaborative RFP. "Aligned" refers to funds that are not directly allocated through United Way, but the funder has committed to allocating the funding to projects rated highly through the Funders Collaborative RFP process.*

Source: Home For Good Funders Collaborative (Commitments made January 2011 – August 2013)

[16] The 2013 commitments reflect commitments made through August 31, 2013. Home For Good continues to work with public funders to bring in funding for allocation during the 2013 grant cycle, and amounts may fluctuate past this date as they are finalized.

Additional Funding Raised Directly by Hilton Foundation Grantees

In addition to the new resources leveraged through the Funders Collaborative, individual Hilton Foundation grantees raised resources directly to support their PSH projects. (Resources leveraged by grantees funded only for "systems change" or "knowledge dissemination" activities are not included in these calculations). Though it is not possible to demonstrate that these resources were directly leveraged by Hilton Foundation resources, the additional public and private resources dedicated to serving this population should not be overlooked. Exhibit 5.4 shows the funding raised by Foundation grantees.

In addition, the table shows the funds leveraged by projects supported by Corporation for Supportive Housing (CSH) program related investment (PRI) loanmaking and technical assistance. The magnitude of these additional resources is notable – almost $400 million have been leveraged to support the construction of new PSH units from January 2011 through July 2013. The sources include public and private grants, tax credits, and private loans.

Exhibit 5.4: Additional Funding Raised by Hilton Foundation Grantees (in millions)

	2011		2012		Total 2011-2012 Commitments	
	Public	Private	Public	Private	Public	Private
Funds raised by Hilton Foundation direct grantees*	$1.17	$0.81	$2.20	$1.45	$3.37	$2.26
Funds raised by CSH PRI or TA recipients**	$51.42	$37.56	$67.79	$175.66	$119.21	$213.22
Total Funding	**$52.59**	**$38.37**	**$125.74**	**$181.12**	**$178.33**	**$219.49**

** Includes only grantees providing direct PSH services*
*** All funds leveraged for the project are counted in the year of the CSH PRI loan approval date*
Sources: Grantee reports; CSH

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

As described in the 2012 Report, a coordinated decision-making strategy has been adopted and implemented through the Home For Good Funders Collaborative, which was established to respond to the complexities associated with developing and operating PSH for chronically homeless people. Prior to the Collaborative, providers interested in developing or operating PSH usually had to apply for funds from a multitude of sources with different funding cycles, priorities, and availability, any of which could obstruct the project. The group was formed to bring public and private partners together to create a single funding application process, align funding priorities around PSH, and make funding decisions collaboratively. This section will focus on what facilitated the adoption of a coordinated strategy and how to improve the implementation of the strategy.

The stakeholder survey asked respondents to identify whether they were participants, supporters, not in support of, or not aware of various local initiatives, including the Funders Collaborative. Understanding the scale of recognition of this effort sheds light on the level to which it has been adopted by all stakeholders.

Exhibit 5.5 shows that most stakeholders were supportive of the Funders Collaborative, 65 percent were either supporters or participants. However, many were not yet aware of the effort, even among funders, local government, and housing authority stakeholder groups. Few in any stakeholder group were not supporters. The only stakeholders that selected "not a supporter" were a few direct service providers and local government respondents.

Exhibit 5.5: Level of Engagement in Home For Good Funders Collaborative, 2013

Involvement Level	Total (n=374)	Private Funders (n=24)	Local Government (n=44)	Housing Authority (n=10)	Service Providers (n=206)	Elected Official (n=11)
Participant	21.5%	33.3%	18.2%	50.0%	20.4%	45.5%
Supporter	43.7%	45.8%	36.4%	10.0%	45.6%	18.2%
Not a Supporter	2.8%	0.0%	4.5%	0.0%	3.4%	0.0%
Not yet aware	32.1%	20.8%	40.9%	40.0%	30.6%	36.4%

Sources: Abt Associates Inc. Stakeholder Survey, June 2013, n = 374 stakeholders, all types

Path to Coordinated Decision-Making

The evaluation team interviewed participants (funders, applicants, and non-funding members) in the 2012 Funders Collaborative funding process, as well as invitees that did not participate in the 2012 process. The team used data collected through these interviews to develop a "lessons learned" document for communities interested in developing a similar approach[17]. Much of the information learned through the interviews also helped to inform the status of this particular process measure.

The Funders Collaborative benefited from existing efforts by City and County staff to align public RFPs, by the nonprofit sector to support the work of the public agencies, and by private sector funders already working to share knowledge and align resources around homelessness. Many of the participants in the Funders Collaborative had also signed on to the Home For Good action plan, building on existing efforts and likely hastening the process.

Highly visible champions – United Way and the Hilton Foundation – helped to provide resources and encourage participation by other stakeholders. Leadership willing to push forward quickly and assertively was critical to maintaining momentum. While a structure and process was not necessary in the first year, a clear goal was. In the initial planning meetings, the Funders Collaborative set a goal of releasing a single RFP within five months and set a deadline for doing so.

Large, collaborative efforts need strong and visible champions, but they also need the right champions at the right time. High-level community leaders were brought into in the Funders Collaborative and provided financial resources, public support, and political will. Philanthropic and public agency staff were key to putting plans into action.

The first Funders Collaborative process was meant to be flexible, and the array of participation methods grew as the process grew. For example, the aligned approach was at first intended to be made available only to public funders, but the approach was expanded to private funders as it became clear that they, too, needed a more flexible participation option.

[17] That report – *Home For Good Funders Collaborative: Lessons Learned from Implementation and Year One Funding* – can be accessed at http://www.hiltonfoundation.org/lessons-homelessness.

Lessons Learned from Implementation and Adoption

The Funders Collaborative brought together multiple funders with different terms of funding and different funding periods. To the extent possible, these were standardized (e.g. a funder that typically makes multi-year grants was asked to make a single-year grant through the aligned process or a single grant to United Way to administer to subgrantees). In interviews, grantees noted that, when these standardizations were not possible, there was confusion about the timing of the grants, the resources each grantee would be required to bring to match the grant, and the timing of that match.

The first two cycles of grant-making have used an annual, structured RFP. Some interviewees shared that this was not be universally workable for certain funders or applicants, and that it may help to create other opportunities to match funders and projects on an ongoing or project-by-project basis. In this way, the coordinated approach could rely further on established relationships with funders focused exclusively on types of housing targeted to certain subpopulations or geographies. When the collaborative receives applications meeting those criteria, they could make an intentional connection (i.e. match-maker) between the funder and grantee. An issue that came up during interviews relatively frequently was the misalignment of funding cycles. To increase participation from private and local government funders, it will continue to be necessary to account for the existing funding cycles and board or council voting schedules for participating funders when establishing the RFP timeline.

Many funders decided to align their funds instead of pool them. The Funders Collaborative remained flexible around this decision. In interviews, participants suggested that it was critical to be transparent about how funding decisions would be made for each of these approaches. In the case of pairing vouchers with private services funds, participants indicated that they desired more clarity about the order of decision-making, in other words, that more restricted, public funding required a separate review process because the funders had regulatory standards to meet.

Stakeholder interviews also revealed some confusion in the delivery of grant award letters. An implementation improvement would be to determine in advance who will be sending award and decline letters, in particular when portions of the same project will be funded through separate contracts (in the case of aligned funding). The letters should be clear about what has been awarded, with which funders grant agreements will be signed, and implications for not fully funding an applicant's request on the term of the contract, proposed budget, and proposed outcomes. It is also important to set a "cutoff" date for adding funders to each award cycle, to avoid confusion arising from multiple rounds of award letters for a single RFP cycle. Funders wishing to join after the final award decisions are made could be encouraged to join in the following grant cycle – or be matched with potential grantees after the formal grants are awarded.

5.3 Recommendations to Move Forward

Interviews with Collaborative participants and non-participants led the evaluation team to several recommendations to support the ongoing work of the Collaborative. Collaborative leadership should:

Consider the need for extensive renewal resources in future years. Make sure the annual fundraising goals reflect the increasing renewal funding needs, and the fact that funding new PSH units each year will amplify the need for future renewal funding. Increase outreach to private and public funders to join the Collaborative to meet increased fundraising targets while simultaneously working to better understanding the changing costs of services as clients stabilize in housing.

Establish a standard approach to monitoring the funded projects. The Funders Collaborative is working toward this by using consistent reporting forms and implementing common performance measures – the Standards of Excellence – for PSH providers.

Engage new and diverse funders to ensure sustainability. Responsibility for outreach and engagement of new funders could be shared among the collaborative members. Many funders have strengths and relationships that could be leveraged.

Recognize that new funders will need to build their knowledge of PSH before engaging in complex funding decisions. Identify funders that have not traditionally been engaged with housing and homelessness issues and provide education to them (e.g. terminology, how the public system funding process works, and how to most effectively pool with public sources). Consider having the experienced funders provide this education to the newer funders. Building the skills of the beginners in a structured way can allow everyone to delve into complex issues more quickly. Also recognize that some funders may be willing to support PSH activities, but may not have the interest or time to delve into every conversation; allow funders to decide the extent to which they want to get involved in discussion and decision-making.

Formalize additional ways in which funders can participate. Participants requested more diverse opportunities to participate. The Funders Collaborative could consider adding an ongoing 'resource matchmaker' approach (for example, pairing up one-off development deals with private funders that may be interested) in addition to a once-per-year RFP. Establishing the parameters for participation – while still maintaining flexibility – will ensure that roles and responsibilities are clear.

Determine the community goals for the ongoing role of a collaborative. If the Funders Collaborative is intended to continue long-term, additional infrastructure may need to be developed to staff the project and a unique identity may need to be created for a collaborative.

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

The Foundation has two strategic goals related to PSH unit creation – one to create or begin development of 3,000 project-based PSH units and another to support 1,000 scattered site PSH units. 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.

A total of 6,952 project-based and scattered site PSH units have been created or are in the pipeline. More than 3,500 of these are dedicated to chronically homeless individuals. The Foundation clarified that it would measure progress toward the goal in terms of the number of Hilton Foundation-supported units created during the five-year Chronic Homelessness Initiative, while continuing to track and report on system-wide unit creation. Of the PSH units brought online or in the pipeline, 1,822 were supported by the Foundation through direct grants, the work of the Funders Collaborative, or Hilton Foundation-supported technical assistance. This represents 45 percent of the new PSH production goal achieved in the first two years of the Initiative.

Data Availability: Significant improvement in data quality over year one, through a process engaging an array of stakeholders; additional work is needed, but progress has been made.
Status in 2013: Forty five percent of the cumulative PSH creation goal has been achieved. System-wide, progress on creation of project-based PSH is on target and creation of scattered site PSH is significantly higher than anticipated.

Section 6.1 reviews the inventories of units of PSH that were brought on line in 2011 and 2012 and also the units of PSH that are in the pipeline. Section 6.2 examines the extent to which the inventories of units are geographically distributed throughout the LA area relative to need. Section 6.3 describes the current shortfall in PSH for chronically homeless individuals and makes recommendations to inform future work.

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

PSH Inventory Data Collection Process

For the 2012 Report, the evaluation team experienced significant challenges with gathering and confirming housing inventory data. Over the course of the last year, the Los Angeles Homeless Services Authority (LAHSA), working with HUD technical assistance providers, has convened a PSH inventory group to work through disparate community inventories and try to refine LAHSA's annual housing inventory count. (See chapter 2 for more information about the participants in the process). The process is improving, and the evaluation team believes the numbers generated through this process are more accurate than those generated last year. Some projects misclassified as PSH have been removed, family PSH units have been identified and removed, and other projects that were not previously included have been added. There is still significant work to be done to formalize the annual review and verification process in order to generate increasingly accurate counts, to simplify the burden involved for all parties to

maintain the inventory count, and to improve year-round access to the information. Work is also needed to ensure that the homeless management information system (HMIS) is consistent with actual inventory, perhaps by asking providers to verify data in HMIS on a regular basis. (This might be timed with the annual project application process). The evaluation team still recommends exploring the use of the HMIS as the ultimate repository of the PSH inventory data, but that may be a longer-term action once the reconciliation process and baseline data are solidified.

Project-based PSH Units

As shown in Exhibit 6.1, 1,104 PSH project-based units for individuals were brought on line between 2011 and 2012, of which 455 units were dedicated to chronically homeless individuals. This represents a correction that added roughly 50 PSH units to the 2011 count plus nearly 400 new PSH units that came online during 2012. Approximately 40 percent of the new PSH units were dedicated to people who are chronically homeless. There are 1,781 PSH units in the pipeline (1,227 added since the Chronic Homelessness Initiative began), somewhat fewer than reported last year, because of the refinements made to the PSH inventory. These were primarily adjustments to unit counts, though a handful of projects were purged from the inventory because the project is no longer in development or the project is not PSH. The pipeline count includes units that are in some phase of development, even if only the feasibility stage. Of the pipeline PSH units, 451 units are expected to be designated for individuals experiencing chronic homelessness.

Cumulatively, 2,885 project-based PSH units have been brought online or are in development system-wide. However, the completion of pipeline units never is guaranteed. For the additional pipeline units come to fruition, continued funding commitments and public support through the project siting and development process will be needed.

Furthermore, it is important to acknowledge that since only 455 of the PSH units brought online and 451 of the PSH units under development are designated for people who are chronically homeless, the community will need to work aggressively to ensure that the new units are targeted and prioritized to people who are chronically homeless or at risk of chronic homelessness. Without that, the additional units will not make an impact on the Initiative's overall goal of addressing chronic homelessness.

Exhibit 6.1: New Project-based PSH Units for Individuals

	All PSH Units for Individuals (incl. those dedicated to CH)				Subset of PSH Units dedicated for Chronically Homeless Individuals			
	New Units Online	New Pipeline Units*		Total created	New Units Online	New Pipeline Units*		Total created
	Opened 2011-2012	Added prior to 2011	Added since 2011		Opened 2011-2012	Added prior to 2011	Added since 2011	
All new project-based PSH units	1,104	554	1,227	**2,885**	455	62	389	**906**
Subset supported by Chronic Homelessness Initiative grants	297	240	565	**1,102**	90	32	102	**224**

** Pipeline reflects units in some stage of the development process, which will not come online until 2013 or later. At minimum, these units have at least once source of construction funding or are receiving development technical assistance from CSH.*

Sources: PSH Inventory Group; Long Beach, Glendale, and Pasadena Housing Inventory Charts; Hilton Foundation-supported unit data from CSH

In this year's report, the evaluation team has also taken a closer look at the PSH units receiving direct support from the Hilton Foundation. This includes projects receiving support from program related investment loans made through Corporation for Supportive Housing (CSH) or through direct grants. The Foundation directly supported the creation of 1,102 PSH units in the first two years of the Initiative (37 percent of the 3,000 unit goal): 297 units already available and 805 units in the pipeline. In this year's report and going forward, the evaluation team will measure progress toward the goal using this universe of units, while still reporting on system-wide unit creation.

Scattered Site PSH Units

Exhibit 6.2 shows the break out of new scattered site PSH for individuals system-wide. A total of 1,882 new vouchers were made available in 2011 and 2012, of which 849 were dedicated to chronically homeless individuals. Another 2,185 PSH vouchers, 1,813 designated for chronically homeless individuals, have been committed and are expected to be available in 2013 or 2014. In all, 4,067 vouchers have been pledged or made available since January 2011, of which 2,662 – or 65 percent – are designated for individuals experiencing chronic homelessness.

Exhibit 6.2: New Tenant-based PSH Vouchers

	All Vouchers for PSH for Individuals (incl. those dedicated to CH)			Subset of Vouchers for PSH Dedicated to Chronically Homeless		
	Newly Funded and Made Available 2011-2012	Newly Funded and Anticipated to become available in 2013 or later	Total Created	Newly Funded and Made Available 2011-2012	Newly Funded and Anticipated to become available in 2013 or later	Total Created
All new scattered site PSH units	**1,882**	**2,185**	**4,067**	**849**	**1,813**	**2,662**
Subset not targeted beyond general homelessness (Shelter Plus Care vouchers, Housing Choice Vouchers)*	202	397*	599	108	343*	451
Subset for DMH or DHS clients (Housing Choice vouchers)	250	250	500	250	250	500
Subset for Homeless Veterans (HUD-VASH vouchers)	1,225	1,538	2,763	401	1,220	1,621
Subset for Persons with HIV/AIDS (HOPWA vouchers)	205	0	205	90	0	90
Subset supported by the Chronic Homeless Initiative	300	420	720	300	420	720

**Up to 100 of these may be dedicated to DMH and DHS clients, depending on final funding decisions made through the Home For Good Funders Collaborative process.*

Source: PSH Inventory Group; Long Beach, Glendale, and Pasadena Housing Inventory Charts; Hilton Foundation-supported unit data from Home For Good

Note: Scattered site "availability" is a somewhat imprecise concept, because vouchers are allocated at one point in time, but lease ups may happen gradually after that. In this case, vouchers are considered available in the year they were allocated by a Housing Authority to an agency for use. The exception is the Housing Choice Vouchers administered through the Home For Good campaign: in this case, 300 vouchers were considered allocated in 2012, since the agencies were notified of their availability in 2012, and the majority of the commitment was able to be honored prior to sequestration. The remaining 300 vouchers allocated in 2012 - which were frozen as of April 1st 2013 - are anticipated to become available again in 2014, and so have been included in the "anticipated to become available in 2013 or later" pipeline columns.

As part of the work Community Solutions is leading through the Acceleration Boot Camps kicked off in summer 2013, the Housing Authority of the City of LA (HACLA) and the Housing Authority of the County of LA (HACoLA) are on the verge of making a commitment of 100 percent of all turnover Shelter Plus Care vouchers to chronically homeless people. These commitments are not reflected in Exhibit 6.2, since the commitments have not been fully formalized. The purpose of the Boot Camp has been to establish a 100 day campaign with key stakeholders to develop ways to speed up the placement of chronically homeless people in housing through streamlining processes and identifying and securing new and realigned housing resources. The evaluation team expects to report more fully in the 2014 Report on the progress made by this campaign.

As we noted in the 2012 Report, a significant portion of the new PSH vouchers (available and pipeline) are limited to subpopulations within the chronically homeless population. Some are set aside for people already engaged in Department of Health Services (DHS) or Department of Mental Health (DMH) services and some for people with HIV or AIDS. As was the case for PSH vouchers discussed in the 2012 Report, the largest share is set aside for veterans, using vouchers funded through the Department of

Housing and Urban Development's Veterans Affairs Supportive Housing (HUD-VASH) Program. Sixty eight percent of the PSH vouchers overall and 61 percent of the chronically homeless vouchers are restricted to homeless veterans. Originally, the commitment Veterans Affairs Greater Los Angeles Healthcare System (VA) made was that 65 percent of all the VASH vouchers would be committed to chronically homeless people. In practice, only 36 percent of the HACLA, HACoLA, and Pomona VASH allocations have been used to house chronically homeless veterans. The VA is committing that 60 percent of the 2013 allocation will be used for chronically homeless veterans and that 100 percent of the vouchers available in the future will be so dedicated. This commitment has been made as part of the work of Solving Veteran's Homelessness as One Los Angeles (discussed further in Chapter 8).

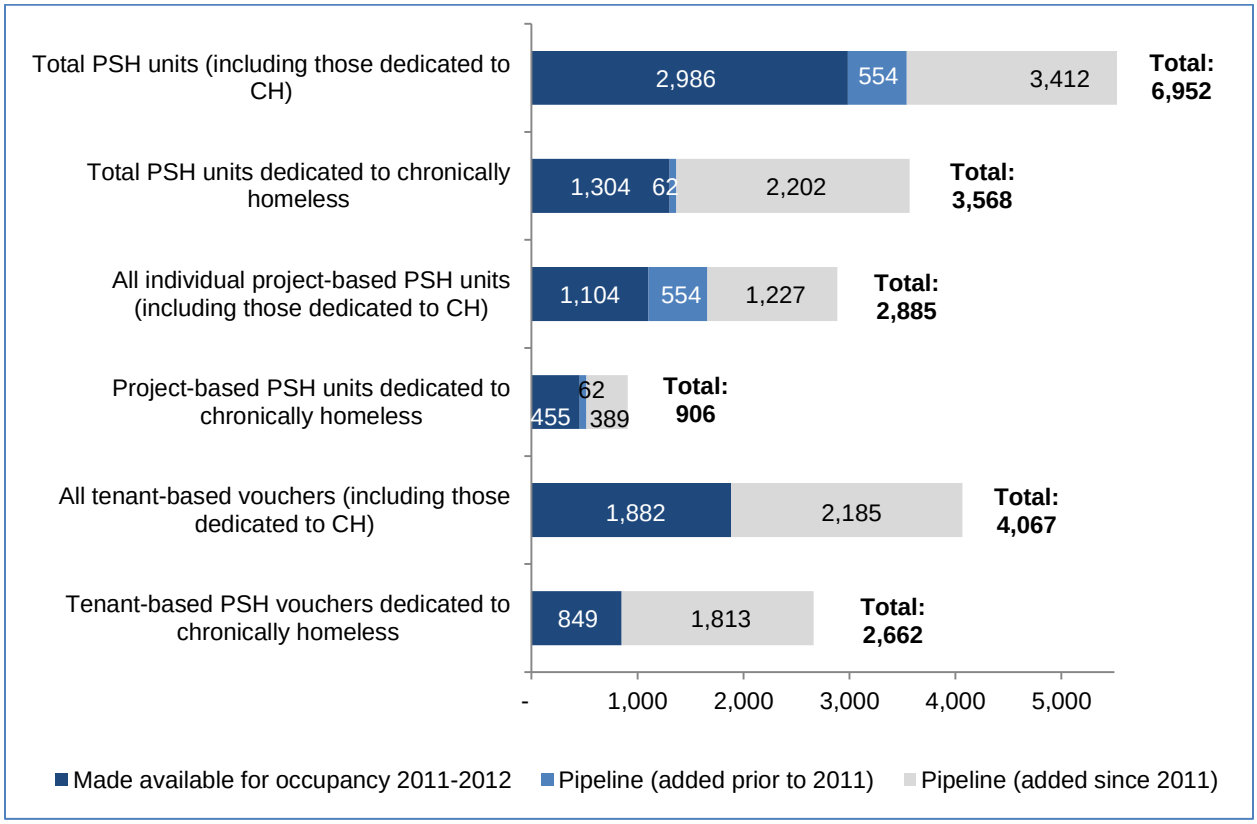
While the special commitments of vouchers are extremely important, the community must develop specific assessment and triage processes to ensure that those among the chronically homeless who qualify for the specialized units are placed in them, saving the general PSH units for other individuals who are not able to access the specialized units.

Exhibit 6.2 also highlights the PSH vouchers for chronically homeless persons supported by the Chronic Homelessness Initiative – in this case, those specifically committed through the Home For Good Funders Collaborative process. To date, 720 vouchers have been committed (72 percent of the 1,000 unit goal), 300 have been leased up, and 420 are anticipated to come online when the voucher freeze due to sequestration is lifted. These vouchers do not include any additional vouchers from other sources that may have been used by Initiative grantees to serve the priority population.

Overall System-wide Unit Creation

Exhibit 6.3 sums the total units brought on line and those in the pipeline (project-based and scattered site). A total of 6,952 project-based and scattered site PSH units have been created or are in the pipeline system-wide. More than 3,500 of these vouchers are dedicated to chronically homeless individuals.

Exhibit 6.3: New PSH Units for Individuals, System-wide



Sources: PSH Inventory Group; Long Beach, Glendale, and Pasadena Housing Inventory Charts

Challenges in Making New PSH Available

As discussed in Chapter 4, the commitment of Housing Choice Vouchers to the Home For Good Funders Collaborative has been challenging to fulfill because of the impact of the automatic federal spending cuts imposed through sequestration. In the summer of 2012, HACoLA committed 50 vouchers a year for two years (2012 and 2013) through the Home For Good Funders Collaborative. In the fall of 2012, HACoLA was unable to issue vouchers to new program participants because its voucher program was temporarily "over-leased." In March, when Congress failed to reach a budget deal, and the sequester was imposed, HACoLA immediately suspended lease-up of HCV vouchers, including those that had been committed through the Home For Good Funders Collaborative.

HACoLA continues to partner with DMH and DHS to link chronically homeless persons already housed with County-funded services, but HACoLA officials are worried that additional federal funding cutbacks being considered by Congress could result in terminating housing assistance to some households currently participating in the voucher program. Further cutbacks could mean that HACoLA will be unable to pledge any vouchers through Home For Good in the coming year(s) and will be unable to fulfill the commitment of 100 vouchers made through the 2012 Funders Collaborative process.

HACLA had also made a two-year commitment for 2012 and 2013, 600 vouchers in total. At the time HACLA officials learned of the threat to the voucher program, they had already begun working with DMH, DHS, and the providers of case management services to implement a variety of strategies to issue the vouchers and to streamline and speed up the issuance and lease-up process. When faced with the freeze, these efforts took on added urgency. HACLA and the service partners held one-day "marathon"

events with groups of 25 to 30 applicants and case managers. The application review and interview process was completed and a voucher was issued the same day, instead of after several weeks. HACLA conducted a landlord fair to match empty apartments with homeless people who had vouchers. Case managers worked with homeless people to identify and select housing units, and some applicants were able to bring lease documents with them to the meeting with HACLA so that the lease approval process could be completed at the same time. For people who were moving into the new DHS supportive housing sites in South LA, the DHS housing partner participated and executed lease agreements at the same time.

Because of these efforts by HACLA and its partners, most of the 2012 commitment, 300 PSH vouchers, was in use by the time of the freeze; only 22 vouchers were rescinded because participants were unable to get units leased before the deadline.

The loss of housing vouchers is a significant obstacle to sustaining the momentum of the collaborations that have leveraged substantial County commitments for supportive services. The housing authorities and their partner agencies hope that vouchers can be issued again sometime in 2014, but uncertainty about the federal budget outlook makes it hard to predict how soon vouchers can be made available. This may have a damaging effect on the collaborations with County agencies and service partners, and it also undermines the trust that was being established with chronically homeless people, as some promises of housing opportunities had to be withdrawn, at least for now. The partnering public agencies have continued working to sustain their relationships despite the uncertainty and to use the "pause" as an opportunity to consider fine tuning procedures. Just recently, the Hilton Foundation supported a proposal to implement a Flexible Housing Subsidy Pool to house at least 600 of the Los Angeles County Department of Health Services' most challenging homeless clients, reflecting the first local action taken as an effort to mitigate the effects of sequestration. As indicated in Chapter 4, the evaluation team recommends protecting existing commitments and supporting additional, similar bridge subsidies to maintain housing placement momentum.

Loss of the vouchers was compounded by the fact that HUD limited bonus funding opportunities for PSH in its 2012 funding application and the only other way for the Los Angeles Continuum of Care to seek funding for new PSH was to reallocate grant funds away from other funded projects, which it did not pursue. Consequently, no new funding was secured for PSH projects through that avenue. In light of the loss of significant Redevelopment Agency funding, waning state bond funding, and declining federal funding for PSH, the community must continue to advocate for development funds to be targeted to PSH for this vulnerable population.

Profile of New Housing Resources: Housing for Health

The first Housing for Health PSH units were created by attaching DHS-funded service teams to tenant-based Housing Choice Vouchers provided by HACLA and HACoLA. In addition to these tenant-based PSH units, DHS partnered with the City of LA Housing Department, which used funding from the Neighborhood Stabilization Program to acquire and renovate about a dozen small apartment buildings or houses that were in foreclosure, with a total of 56 units. Chronically homeless people prioritized by DHS began to move into these units in 2013.

Other short-term and permanent housing options, including several PSH projects, are in development or on the drawing boards, and DHS hopes to have about 1,000 units of housing available by the end of 2013. One of these projects is the Star Apartments, under development by Skid Row Housing Trust, with completion expected in late summer 2013. In 2013, the Hilton Foundation provided grant funding to support this project. DHS will rent space for a ground floor clinic and provide funding for supportive services in exchange for access to housing units for homeless people prioritized by the Housing for Health program.

In 2013, when faced with the inability to rely on Housing Choice Vouchers, because of federal funding reductions, DHS began looking for new sources of funding to pay for tenant-based rent subsidies that can be used to continue expanding the Housing for Health program. DHS has proposed the creation of a fund that would leverage commitments from local governments and philanthropy to provide funding for local housing subsidies, which the Foundation recently agreed to support.

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

The population of chronically homeless people – and therefore the need for PSH housing units – is not evenly distributed across the geographic area of Los Angeles. Exhibit 6.4 reports the geographic distribution of the project-based PSH units that were brought online in 2011 and 2012 and those that are in the pipeline (when site information is available), using both County Supervisorial Districts and the service planning areas (SPAs) widely used by the County and by local stakeholders for planning purposes.

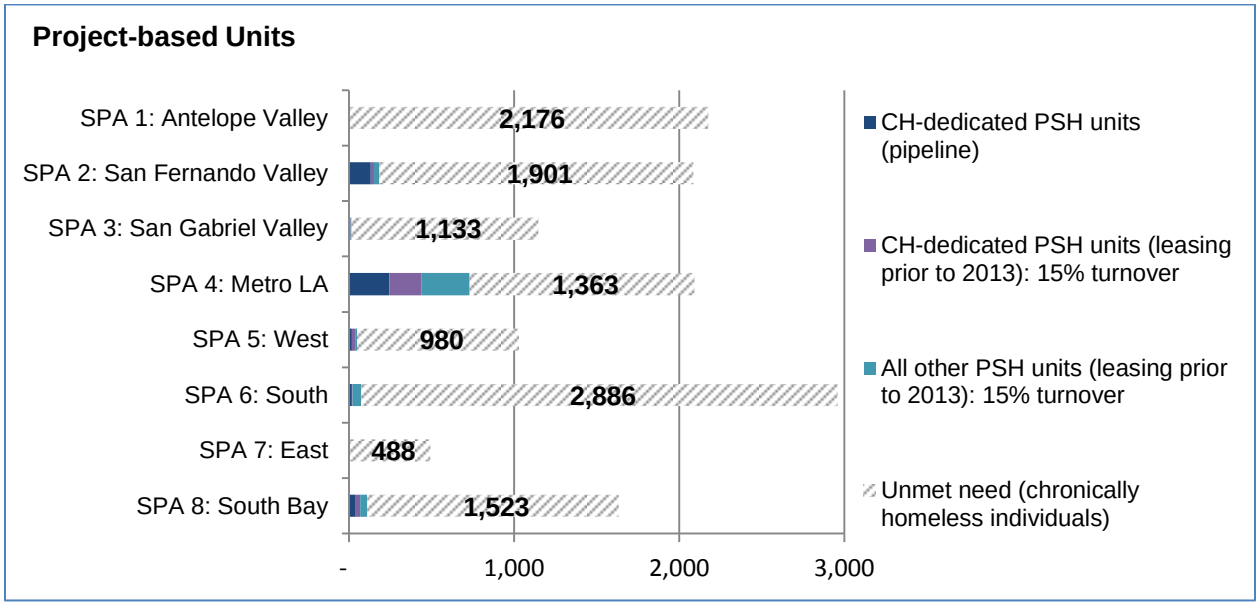
Exhibit 6.4: New Project-based PSH Units by Geographic Subarea

	All Project-based Units (incl. those dedicated to CH)			All Project-based Units dedicated to Chronically Homeless		
	Made Available for Occupancy 2011-2012	In Pipeline prior to 2011	Added to Pipeline since 2011 (sited projects)	Made Available for Occupancy 2011-2012	In Pipeline prior to 2011	Added to Pipeline since 2011
Supervisorial District 1	360	172	229	198	0	65
Supervisorial District 2	502	59	658	114	18	199
Supervisorial District 3	206	303	264	120	44	125
Supervisorial District 4	36	0	0	23	0	0
Supervisorial District 5	0	20	56	0	0	0
SPA 1: Antelope Valley	0	0	0	0	0	0
SPA 2: San Fernando Valley	135	183	140	70	12	119
SPA 3: San Gabriel Valley	0	20	127	0	0	0
SPA 4: Metro LA	609	252	441	337	32	212
SPA 5: West	19	40	112	19	0	18
SPA 6: South	109	59	87	6	18	0
SPA 7: East	0	0	16	0	0	0
SPA 8: South Bay	232	0	284	23	0	40

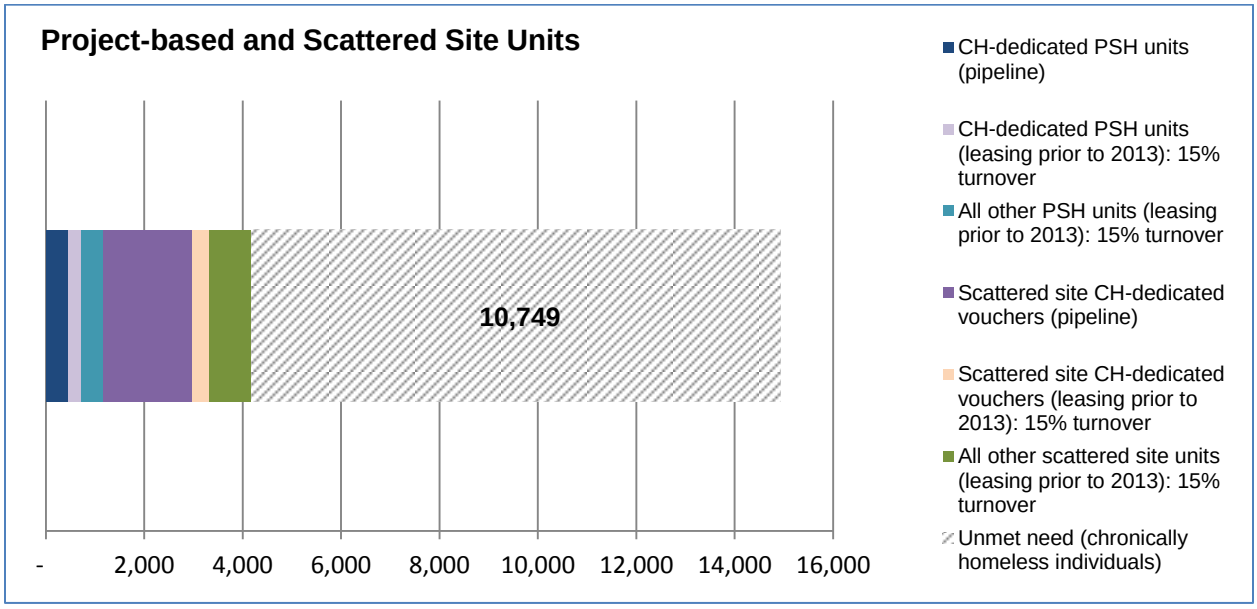
Sources: PSH inventory group

Using data from the 2013 Greater LA Homeless Count coordinated by LAHSA in 2013 and the 2013 point-in-time (PIT) count data reported to HUD from the other three Continuums of Care in LA County (discussed further in Chapter 8), 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 in the future to house the chronically homeless population and the estimated shortfall by SPA. The distribution by SPA is based on housing unit address data provided by the PSH Inventory Group. The estimate of potentially available units is constructed by summing the total number of dedicated chronically homeless PSH units currently in the pipeline and 15 percent of all existing PSH units (assuming that chronically homeless people will be able to access some proportion of "general PSH" turnover units and that a portion of dedicated units will also turnover each year). The 15 percent turnover and usage rates are consistent with assumptions on turnover used by Home For Good in its projections, based on working with local housing authorities. In addition, almost 3,000 existing or committed scattered site vouchers are projected to be available to help address the unmet needs of people who are chronically homeless in the County. Since scattered site units are not restricted to a specific SPA, they are shown only in the "unit totals" bar.

Exhibit 6.5: Distribution of PSH Units Projected to be Available Relative to Number of Chronically Homeless Individuals within each SPA



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.



Sources: PSH Inventory Group and PIT counts

Including scattered site, the gap between the need and the available units has grown from the roughly 8,000 units estimated in the 2012 Report to nearly 11,000 units. Though unit development has continued over the last year, production has simply not kept pace with the large growth in the chronic homeless population in the PIT counts over the past two years. In the 2012 Report, we identified two geographic areas in need of increased housing development: SPA 6 and SPA 8. The comparison of the projected PSH unit availability with the recent counts of chronically homeless individuals reveals that SPA 6's unmet need is still at the top of the list, with a gap of almost 3,000 PSH units. However, the needs of SPAs 1 and 2 have also become apparent, each with a gap of around 2,000 PSH units. The tremendous increase in the

chronic homeless count in those SPAs put the spotlight squarely on the lack of development there. SPAs 4 and 8 both have an unmet need around 1,500 units each.

We will discuss the increased chronic homeless counts in greater depth in Chapter 8 and opportunities for targeted capacity development in Chapter 9.

6.3 Recommendations to Move Forward

Create an accurate, shared PSH inventory that can be easily maintained. Stakeholders should continue to support the work of the PSH inventory group in formalizing and streamlining the process of merging, reconciling, and cleaning inventory data from all sources. This group should consider ways to obtain regular updates from providers, such as by requiring updates to the inventory as part of annual funding applications, and explore use of the HMIS as a central repository for the housing inventory, so the inventory can be maintained and accessed year-round by all parties.

Institutionalize streamlined procedures to issue and lease-up Housing Choice Vouchers. Housing authorities and service providers should capitalize upon the lessons learned from the rapid voucher issuance process that occurred in Spring 2013. In addition to removing administrative barriers and institutionalizing efficiencies, practices related to landlord outreach, move-in assistance, apartment matching, and resident coaching could improve lease up of turnover units by people who are chronically homeless.

Engage Housing Authorities in underserved areas. The Funders Collaborative should reach out to smaller housing authorities, especially those in underserved regions of the County, to educate them about the benefits of dedicating voucher resources to chronically homeless people.

Work with local leaders to prioritize creation of new PSH relative to other opportunities, to ensure this funding source is supporting the goal of ending chronic homelessness. Given sequestration, Continuum of Care (CoC) Program funds may be one of the few federal sources available for new projects. With the current preference to continue funding existing projects, poorly performing CoC Program recipients may be funded in lieu of creating important new housing resources. Funding priorities should be reviewed to ensure that funding opportunities for new PSH are maximized to the extent possible. In addition, local stakeholders should continue to advocate for new state funding for affordable housing through programs that create strong incentives for creating PSH prioritizing chronically homeless people and advocate for City and County officials to honor the commitments to PSH previously made by the Redevelopment Agencies.

Designate additional resources to geographic areas with high need. Given the extreme unmet needs in some geographic areas of the County, funders and stakeholders may want to focus capacity-building and development funding in specific areas with high need and few resources. Perhaps scattered site PSH providers could be incentivized or even required to serve geographies with higher needs. Regardless of geographic targeting, the higher number of individuals counted experiencing chronically homeless in the 2013 PIT count demonstrates a need for more PSH than originally anticipated.

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

During the January 2011 point-in-time (PIT) count, 12,498 individuals were counted as chronically homeless in Los Angeles County (including Glendale, Pasadena, and Long Beach). In the January 2013 PIT count, that number increased appreciably, to 14,933. Given the voucher freezes in place because of federal budget sequestration, along with the continued impact of the dissolution of California's redevelopment agencies, the new project-based and scattered site PSH units designated for chronically homeless individuals are unable to meet the now growing need. Thus, addressing chronic homelessness requires a systematic, widespread way to prioritize chronically homeless individuals, especially those most vulnerable, for the much larger pool of general housing resources.

Unfortunately, that strategy is not without debate. As the need for PSH for chronically homeless people grows, so too does the need for housing for homeless people who are not chronically homeless. According to figures recently released by the Los Angeles Homeless Services Authority (LAHSA) and PIT data from the other continuums of care, the overall homeless count in Los Angeles County jumped by 15 percent between the 2011 and 2013 PIT counts.

Nonetheless, the community has made important progress over the last year in creating a pilot system for coordinated entry and placement in available PSH.

Data Availability: Data on the pilot are available, but system-wide data are not yet available to test whether prioritized chronically homeless individuals are the ones routinely placed in available PSH.
Status in 2013: Significant progress was made on the Skid Row Pilot and other pilot efforts. System-wide adoption of prioritization practices will be contingent upon convincing housing providers throughout the county to participate.

Section 7.1 describes progress in specific efforts to develop a system for prioritization, each of which could ultimately expand as the basis for systematic prioritization and placement. Section 7.2 describes the extent to which PSH providers and their housing placement partners systematically prioritize people who are chronically homeless for placement in turnover or newly available PSH units. Section 7.3 lists recommendations for moving forward on this goal.

7.1 Process Measure: How do PSH providers define priority populations?

Identifying the Priority Populations

Community Solutions provided direct support for 18 new community Vulnerability Index (VI) Registry projects in 2012. Of those, twelve communities signed up to be "count plus" communities in the 2013 PIT count. "Count plus" communities are those that simultaneously conducted a full enumeration as part of the PIT count and a VI registry. In all cases, the communities started their process of establishing a registry in January, but have continued to target those on the registries for outreach and housing. The newer communities have joined communities such as Santa Monica, Venice, and Hollywood that are enumerating their homeless population and completing vulnerability assessments on each person encountered. The new and longer-term registry communities may be well suited for adoption of some next-level approaches to coordinated entry.

Particularly in areas where the chronic homeless count increased between the 2011 and 2013 PIT counts, expanding the scope and reach of a registry could prove beneficial to the community of providers in the

region. Some communities currently have the capacity to conduct a single point-in-time count accompanied by a survey, but lack the resources or buy-in to take the next steps in terms of prioritizing and targeting. In SPA 1, for example, a small group of community leaders completed the registry as part of the PIT count in January, but the capacity to take the next step of focusing on placing these individuals is still to be determined.

Prioritization Effort: Skid Row Coordinated Entry System

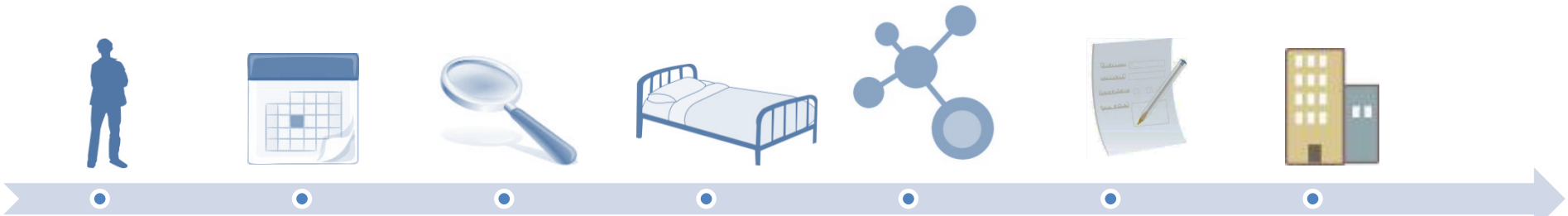
In the spring of 2013, the Home For Good and 100,000 Homes campaigns collaborated with the Rapid Results Institute to facilitate a 100-day effort to develop a Coordinated Entry System (CES) for highly vulnerable chronically homeless people living in the Skid Row area of downtown LA. The Skid Row CES pilot used a high-energy, short campaign approach to bring providers together, coordinate available resources, and establish protocols for triaging and matching clients to units. Providers created a list of vulnerable clients and then met weekly to case conference, assign a responsible agency, and track progress of clients. A general illustration of the process steps established and the results from the initial 100-day campaign are shown in Exhibit 7.1.

Several aspects of the process used in the Skid Row CES pilot were critical to the success of the first 100 days and offer the potential for broader community adoption:

- The process established a prioritization approach based on a numerical score. This is different than the typical process in which a "vulnerable" score equates to a threshold for inclusion on a community registry. If everyone on a registry is targeted for housing placement case management, then the vulnerability score does not establish a person's relative need.
- The process enumerated all of the unsheltered homeless individuals assumed to need PSH who were encountered, thereby ensuring that a substantial universe of individuals was assessed and their relative need and priority for PSH was established. Additional individuals can be assessed and added to the registry as they are encountered.
- PSH units were dedicated to the pilot from several Skid Row providers – a portion of each provider's PSH stock. This strategy allowed providers to test the process. Ideally, all of a provider's inventory would be channeled through the CES' "matching" process – with a project's eligibility criteria being accounted for by searching the registry for the highest need, eligible individual when a unit becomes available – but this was an opportunity to get a "foot in the door."
- Dedicated bridge resources were made available to ensure that, as soon as an individual was identified for an open PSH unit, the person could quickly be moved off the street and could be more easily located when his application materials were ready for the next phase. Though other resources were always sought out first, the availability of the Skid Row Housing Navigation Fund meant that deposits or utility payments were never a barrier to moving a client quickly into housing.
- The group established a standardized housing application for participating housing providers – the Rapid Universal Supportive Housing (RUSH) application. At this point, the RUSH application is only being used for those units/vouchers set aside for this project, but broader adoption of the universal application would signal expanded influence of the CES process.

Exhibit 7.1: Skid Row Coordinated Entry System

First 100 days: process and results



Assess Clients	Track clients in CES Tool	Housing Navigator Case Conferencing	Access Bridge Resources	Match to housing	Rapid Universal Supportive Housing (RUSH) Application	Place in housing
Result Developed an assessment tool to prioritize client need based on: 1)mental illness, 2)high service utilization, 3)Vulnerability Index, and 4)10 or more years homeless	Results • Developed shared tracking tool • 122 clients assessed and entered in tracking tool • 75% of clients are “3s” or “4s” on the prioritization scale • 40% are women • 15% are veterans	Results • 134 people received housing navigation services • 91 clients are ready to apply for housing • 14 agencies participated in navigation activities • Ongoing weekly case conferencing	Results • 32 temporary beds committed to the project • $35,000 committed to the Skid Row Housing Navigation Fund	Results • 76 individuals have been matched to a housing resource	Results • Same day voucher issuance (from 2-4 weeks) • Clients moved in as quickly as 9 days	Results • 75 units have been dedicated to the project • 37 have been leased up

Source: United Way and Community Solutions

As the project moves into the expansion and replication phase, there are two critical aspects to scaling the projects up. First, the geographic focus. The CES expansion team is working to expand the pilot approach to each SPA. Over the coming year, it will be important to measure other regions' adoption of some or all aspects of the process. Many local areas already have established community registries and have processes in place for case conferencing and placing people from their registry lists. As the CES approach is rolled out to these areas, it will be important to work from each region's existing strengths. In all likelihood, this will require helping communities enhance their registries to accommodate better tracking of individual client needs and incorporate new clients onto the registry. These approaches can be layered on top of existing coordinated outreach and case conferencing meetings that are likely already ongoing.

Second, and perhaps most critically, the approach to allocating inventory will need to become systematized. This will require helping a broad group of stakeholders to establish a significant pool of housing resources that will draw from the CES client tracker when vacancies arise, inventorying and monitoring availability of these resources, and encouraging adoption of the standardized housing application. These resources will then need to be fully committed to the target population on an ongoing basis, through turnover. The CES expansion team is working with a broad base of stakeholders to move in this direction and the evaluation team looks forward to observing this evolution over the coming year – an evolution in approach from limited commitments of a finite set of units to a more systematic approach.

Prioritization Effort: Corporation for Supportive Housing FUSE Pilot Project

In addition to the geographic targeting being piloted in Skid Row, Corporation for Supportive Housing's (CSH) Frequent Users Systems Engagement (FUSE) project in LA is developing into a system-wide prioritization effort to identify homeless people who are the most frequent users of hospitals and other costly public services and place them into supportive housing. The project has received technical assistance and grant funding from the Hilton Foundation and the Social Innovation Fund (Los Angeles is one of four sites supported by CSH's grant from SIF). In 2011, the FUSE project was piloted by OPCC, Housing Works, and Homeless Health Care Los Angeles and their partner federally qualified health centers (FQHC) and hospitals. The project was expanded in 2012 through the SIF and now includes a total of 7 housing navigator/FQHC partnerships working with referrals from 14 hospitals. Further detail about the results of the FUSE project can be found in Chapter 9.

Continued growth of geographic approaches, as well as approaches targeting specific systems such as the FUSE project's approach with hospitals, could effectively serve Los Angeles, as long as they are coordinated and integrated with each other.

7.2 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?

To gain a better understanding of whether people who are chronically homeless are being systematically prioritized for PSH, the annual stakeholder survey asked PSH providers (operators, managers, and developers), public funders, and private funders to indicate whether they prioritize particular populations for units they manage or through funding they provide. Of the 35 PSH providers that manage units, all but two indicated they prioritized specific populations. Of the 38 government representatives responding to the question, 16 indicated that funding is targeted toward specific populations. Of the 15 private sector funders responding, 13 indicated that funding is targeted toward specific populations. For those that

prioritize, the survey also asked about the practices they use to operationalize their prioritization preferences.

Priority Populations

The percentages of providers and funders (public and private) who indicated in the web-based stakeholder survey that they prioritize specific subpopulations are shown in Exhibit 7.2.

Exhibit 7.2: PSH Unit Set-asides and Funding Priorities for Homeless Populations, 2012 and 2013

Specific Subpopulations Prioritized for PSH	Percent of Respondents indicating they prioritize* 2013 survey response (2012 survey response)		
	PSH Providers: Units Prioritized (n=33)	Government Reps: Funding Prioritized (n=16)	Private Sector Funder: Funding Prioritized (n=13)
Chronic/Long-term homeless individuals	69.7% (54.3%)	93.8% (71.4%)	84.6% (100%)
Homeless people with serious mental illness	60.6% (71.4%)	68.8% (57.1%)	23.1% (44.4%)
Homeless youth (ages 18-24)	39.4% (22.9%)	43.8% (42.9%)	46.2% (44.4%)
Homeless veterans (written in as "other" in 2012 survey)	33.3% (14.3%)	75.0% (7.1%)	61.5% (22.2%)
Homeless people with chronic substance use issues	24.2% (28.6%)	43.8% (35.7%)	7.7% (33.3%)
Homeless individuals with high medical vulnerability or a high likelihood of mortality	21.2% (22.9%)	62.5% (50%)	15.4% (33.3%)
Chronic/Long-term homeless families	18.2% (17.1%)	87.5% (50%)	53.8% (55.6%)
Homeless people who are frequent users of emergency health services	15.2% (8.6%)	62.5% (42.9%)	30.8% (33.3%)
People at high risk of homelessness when they re-enter the community from jail, prison, hospitals, or mental health facilities	9.1% (2.9%)	31.3% (28.6%)	23.1% (33.3%)
People experiencing homelessness for extreme lengths of time (10 years or more)	3.0% (n/a)	50.0% (n/a)	23.1% (n/a)
People at high risk of homelessness, not from institutions	3.0% (n/a)	31.3% (n/a)	7.7% (n/a)
Other (examples given: seniors, families, unaccompanied minors, persons with HIV/AIDS)	21.2%	6.3%	7.7%

** The responses are not mutually exclusive, so the percentage sum to more than 100 percent. Those who do not prioritize or who did not respond to this question are excluded. Responses are sorted based on the percentage of PSH providers that prioritize the subpopulation, since providers were the largest group and are assumed to reflect the closest approximation to actual practice.*

Source: Abt Associates Inc., Stakeholder Survey, June 2012 and July 2013

Chronically homeless individuals and homeless people with serious mental illness were cited by the highest percentages of respondents—more than two-thirds of the PSH providers—as a subpopulation that is prioritized for placement in available PSH units or prioritized through funding for PSH. More PSH providers and public funders cited prioritizing chronically homeless individuals this year than last,

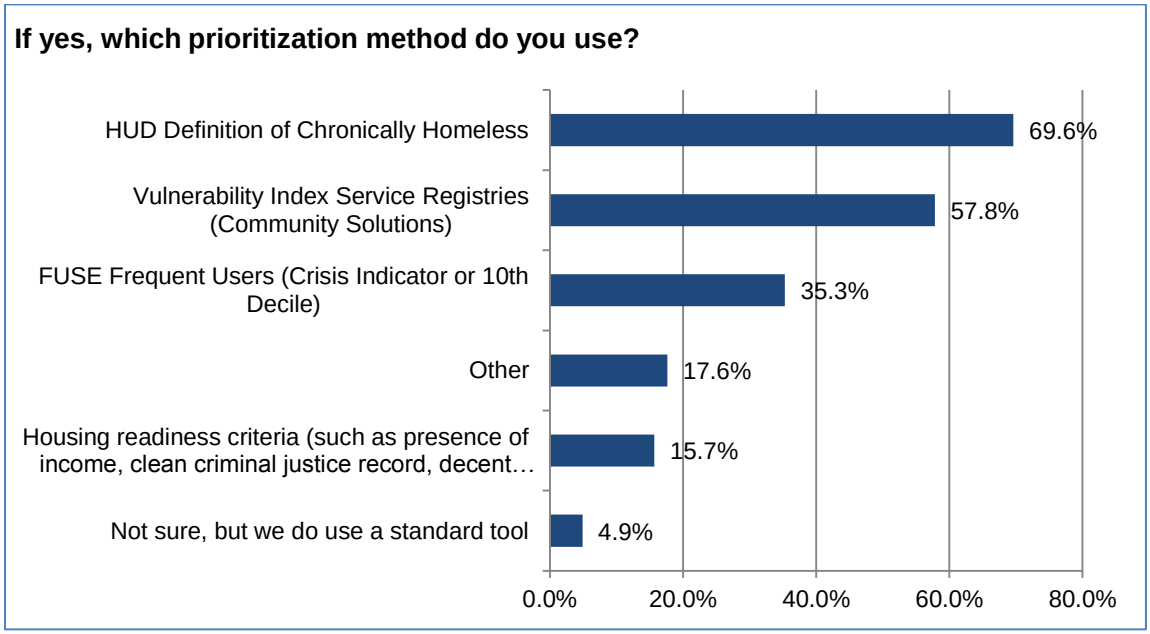
although a slightly smaller percentage of private funders did. Just over a third of providers indicated they prioritize homeless youth, and a third indicated they prioritize homeless veterans, also considerably higher rates of prioritization than in prior years. Compared with last year, public funders indicated much higher rates of prioritization for chronically homeless families (88 percent as compared with 50 percent) and for homeless people who are frequent users of emergency health services (63 percent as compared with 43 percent), probably reflecting special funding initiatives for these groups.

The private funder group was the only group for which the rate of prioritization decreased for many of the subpopulations, including chronically homeless individuals, people with serious mental illness, chronic substance abusers, people with high likelihood of mortality, and re-entry groups. This may suggest that the private funders are able to broaden or retract their priorities more easily than providers and public funders.

Prioritization Approaches

The web survey also asked about the use of specific tools for identifying people for whom priority is given in placement into PSH. Among the 42 PSH operators and 128 service providers responding to the stakeholder survey, 60 percent (102 individual respondents) indicated that they currently use a prioritization tool or definition to identify individuals for placement in available PSH units, as compared with only 43 percent last year. The largest proportion of those (70 percent) uses the Department of Housing and Urban Development's (HUD) definition of chronic homelessness at intake as a means of identifying priority populations (Exhibit 7.3). However, prioritization criteria are not mutually exclusive, and a noteworthy 58 percent indicated they use the VI as part of their prioritization process.

Exhibit 7.3: Prioritization Tools or Methods Used, 2013



Abt Associates Inc. Stakeholder Survey, June 2013, n = 102

Just over one-third of respondents reported using a FUSE tool such as the crisis indicator or 10th Decile tool. About 18 percent reported using an internal prioritization tool based on their programmatic targets. Sixteen percent of respondents reported using criteria that suggested a housing readiness, rather than a housing first orientation, reflecting either that the program has not philosophically embraced a housing

first approach or that the program has not revised its program eligibility criteria to reflect a housing first approach. The latter would be worth exploring, as programs may not even realize that their historical program eligibility criteria are creating barriers to serving chronically homeless individuals.

In an effort to better understand the responses given, the evaluation team reformulated the way these questions were asked on the 2013 survey. Direct comparisons with the 2012 survey, therefore, are not possible. However, based on the structure of the questions in 2012, we estimate that 43 percent of the providers who used a prioritization tool in 2012 indicated use of the HUD definition of chronic homelessness, 43 percent indicated use of the VI, and 10 percent used the FUSE criteria. Thus, these results suggest the VI and FUSE prioritization tools are becoming more widely used. We anticipate being able to show a more direct year-over-year comparison in the adoption of these prioritization approaches in the 2014 report.

7.3 Recommendations to Move Forward

Catalog eligibility criteria of PSH providers. As part of the expansion of the Skid Row CES, the expansion team should identify opportunities to remove criteria that limit access to targeted populations or reinforce a housing readiness philosophy.

Build on the mobilization and current efforts of the VI Registry Communities. As part of plans to expand the geographic reach of the CES, the expansion team should include the VI communities. Coupled with PIT count and housing inventory data, the CES expansion team could identify the VI communities that have high needs and a critical mass of providers willing to engage in a "next step" prioritization effort. Adoption of some of the approaches employed in the Skid Row CES pilot would assist these communities in moving more rapidly toward consistent prioritization approaches that would ensure that the most vulnerable community members are receiving the most service-enriched housing resources.

Incorporate the scope of PSH inventory dedicated to chronically homeless people into the CES. The expansion of the Skid Row CES may be undermined by the lack of housing resources discussed in Chapter 6. As a way to engage more PSH providers in a systematic prioritization approach, the CES expansion team should develop a systematic "ask" to get PSH providers to agree to fill a portion of their turnover and new units through a CES process. In addition, the CES expansion team should continue to work strategically with key stakeholders to incorporate Continuum of Care, Public Housing Authority, DMH, DHS, and other housing resources into this approach.

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

The Chronic Homelessness Initiative Theory of Change follows a fairly common sense logic: if the community creates new PSH and establishes systems to prioritize placement of the most vulnerable chronically homeless persons and those likely to become chronically homeless in these units and others that turnover, then chronic homelessness will decline over time. Assuming that the correct population is targeted, placing 1,000 of the most vulnerable chronically homeless persons in PSH should result in a corresponding decline in chronic homelessness. Similarly, placing 1,000 homeless individuals who are at high risk of becoming chronically homeless should slow the number of people becoming chronically homeless during this period, perhaps eventually stopping it altogether.

Because of the significant commitments secured through new funding strategies, such as the Housing and Urban Development's Veterans Affairs Supportive Housing (HUD-VASH) Program and the Funders Collaborative, along with increased efforts to target PSH vacancies, almost 5,000 chronically homeless people were placed in PSH units system-wide from January 2011 through December 2012. The Foundation also clarified that it would measure progress toward the goal in terms of the number of Hilton Foundation-supported placements during the five-year Chronic Homelessness Initiative, while continuing to track and report on system-wide placements. Initiative-supported grantees placed 856 chronically homeless people in PSH units during 2011 and 2012, or 86 percent of the current Initiative goal. Efforts focused on preventing chronic homelessness have been smaller and more challenging to document; nonetheless, important progress has been made with the chronically medically ill, frequent service user, transition-age youth, and criminal justice re-entry populations.

Despite these efforts, the number of chronically homeless individuals identified in Los Angeles County (including Glendale, Pasadena, and Long Beach) increased by almost 2,500 people over the first two years of the Chronic Homeless Initiative – from 12,498 individuals in January 2011 to 14,933 individuals in January 2013. This increase raises important questions about whether the scope of chronic homelessness is really accurately understood, whether the targeted populations are really making it into the vacant PSH units, and whether the number of people at risk of chronic homelessness is actually greater than previously understood.

Data Availability: Data on chronic homelessness are only collected through the biennial point-in-time count and through occasional Vulnerability Index registry counts, but count data are not sufficient to understand growing need within the context of strong placement activity.
Status in 2013: Placements of chronically homeless individuals are on pace to exceed the Initiative goal of 1,000 individuals, but is not affecting point-in-time count figures. Prevention placements are lower than anticipated.

Section 8.1 reports the total number of chronically homeless and at risk individuals who have been placed to date and how they have been placed. Section 8.2 discusses whether there have been measurable declines in chronic homelessness within LA County. Section 8.3 lists recommendations for moving forward on this goal.

8.1 Outcome Measure: How many new project-based and scattered site PSH units and existing PSH units are filled by persons who are chronically homeless or at risk of chronic homelessness?

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 in the Home For Good and 100,000 Homes campaign partners reporting data. The cumulative total number of chronically homeless individuals placed in 2011 and 2012 was 4,878. Of those, 1,613 individuals were placed in or by *organizations* receiving support by the Initiative, for example through a project funded through the Funders Collaborative.

The specific *projects* supported by the Hilton Foundation Chronic Homeless Initiative, for example through a direct grant or a project funded through the Funders Collaborative, housed 856 individuals in the two-year period. In the 2012 report, the evaluation team considered system-wide placements as the measure of progress toward the Initiative goal. In this year's report and going forward, the Foundation determined that it would measure progress toward the goal in terms of Hilton Foundation-supported placements, while continuing to report on system-wide placements. Since the Initiative has already reached 86 percent of the five-year goal of 1,000 placements, we recommend increasing the Initiative goal to 2,000 Hilton-supported placements.

In the 2012 Report, the evaluation team noted that nearly 50 percent of the chronically homeless individual placements in 2011 were made by the Veterans Affairs Greater Los Angeles Healthcare System (VA), because of the availability of a large number of HUD-VASH vouchers. The VA again reported an impressive number of placements, 882, representing 32 percent of all 2,779 placements for the year.

Though the Home For Good team makes an effort to unduplicate the placement data submitted by providers, the data are reported to them by PSH providers in aggregate and do not include identifiers to allow for data validation and unduplication, nor is there a way to validate whether the individuals placed in PSH truly meet a strict definition of chronically homelessness, nor whether the most vulnerable among that population are being placed when possible.

Exhibit 8.1: Placements in PSH

	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 PSH types	
	2011	2012	2011	2012	2011	2012	2011	2012
Total placements of individuals experiencing chronically homeless	211	394	266	358	1,622*	2,027	2,099	2,779
Placements by the VA (subset of above)	0	74	0	6	1,004	802	1,004	882
Placements by *organizations* receiving Hilton Foundation support (direct grants, CSH subgrants, or Home For Good grants)	78	149	163	286	247	690	488	1,125

	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 PSH types	
	2011	2012	2011	2012	2011	2012	2011	2012
Placements by *projects* receiving Hilton Foundation support (subset of above)	Not tracked						203	653
Total placements of individuals at risk of chronic homelessness (non-chronically homeless veterans and TAY placements)	Not tracked						864	1,347

**2011 number corrected by Home For Good from 1,685 to 1,622*

Source: Home For Good and Community Solutions quarterly data collection

The data related to the placements of chronically homeless individuals in PSH were collected by Home For Good and Community Solutions through a joint quarterly provider reporting process. Providers are asked to report the type of PSH unit into which each client has been placed.

Efforts to Prevent Chronic Homelessness

In the first year report, we described partners developing approaches to systematically prevent chronic homelessness, for example Corporation for Supportive Housing's (CSH) frequent user and transition age youth (TAY) programs. These programs now have begun and have made significant progress over 2012. However, they are small-scale programs and are reaching a mix of chronically homeless and at risk populations. Overall, the prevention placements by direct Hilton Foundation grantees have been minimal (55 people in 2012). However, the system-wide placements of non-chronically homeless veterans have been successfully tracked through the Home For Good campaign and the results are included in the at-risk placements shown in the last row of Exhibit 8.1.

In addition to the frequent user and TAY activities, CSH received a grant from the Hilton Foundation in August 2013 to expand the work of the Just In Reach pilot program, The two-year pilot program was started in 2008 by the Los Angeles County Sheriff's Department. The project was designed to focus on repeat offenders with three episodes of homelessness in the past five years and provided needs assessment, employment assistance, benefits enrollment, drug and alcohol treatment, mental health services, and placement in temporary and permanent housing. According to a report prepared for the Los Angeles County Board of Supervisors, only 24 percent of the program participants were re-convicted within one year of being released compared to 65 percent of the general inmate population[18]. In building on the work of the pilot, CSH plans to refine the model with improved coordination with the Department of Mental Health (DMH) and Department of Health Services and to conduct a formal evaluation of the project using existing County data systems, potentially including the integrated county-wide database currently being created. The CSH goals for the two-year project include fully developing the model for the expanded project, drawing on lessons learned and evidence-based practice, and stably housing 135 people. During this time, CSH will continue working with the Board of Supervisors to establish a "pay for

[18] This report – *Expanding Just In Reach Through Pay-for-Success* – is available at http://file.lacounty.gov/bc/q3_2013/cms1_198921.pdf

success" contract to support the Just In Reach project. This model typically means that a government agency reimburses private funders if client outcomes are achieved. Moving toward this model will require establishing clear definitions of success, data tracking protocols to measure success, and conducting a cost-benefit analysis, all of which is built into CSH's recently funded project proposal.

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

Because the Los Angeles Homeless Services Authority (LAHSA) conducts a point-in-time (PIT) count of unsheltered persons only once every two years, we were not able to track changes in the count of chronically homeless persons between 2011 and 2012 in the 2012 Report. Chronic homelessness among individuals in Los Angeles County increased by nearly 20 percent between 2011 and 2013. The smaller continuums of Long Beach, Glendale, and Pasadena each showed decreases in their chronic homeless counts. The first several data columns of Exhibit 8.2 provide baseline and updated information on chronic homelessness on the night of the biennial PIT counts in January 2011 and 2013, as reported in LAHSA's 2013 Greater LA Homeless Count[19] and the PIT counts the Glendale, Pasadena, and Long Beach Continuums of Care submitted to HUD's Homelessness Data Exchange.

Exhibit 8.2: Countywide Measures of Chronic Homelessness

	Number of homeless individuals counted on night of PIT (sheltered, unsheltered, and hidden)		Number of CH individuals counted on night of PIT (sheltered and unsheltered)		Increase (or decrease) in Chronic Homelessness Count (2011 to 2013)		Chronically Homeless People Placed in PSH	
	Jan-11	Jan-13	Jan-11	Jan-13	Number	Percent	2011	2012
Countywide	50,193	57,735	12,498	14,933	2,435	19.5%	2,099	2,779
Los Angeles Continuum	45,422	53,798	10,901	13,613	2,712	24.9%		
Glendale Continuum	412	318	102	89	-13	-12.7%		
Long Beach Continuum	3,143	2,847	1,074	1,026	-48	-4.5%		
Pasadena Continuum	1,216	772	421	205	-216	-51.3%		

Sources: 2011 and 2013 PIT Counts and Home For Good placement data

The last 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 and the placement data, the chronic homeless count should have dropped substantially over the two-year period since almost 5,000 chronically homeless people were placed in PSH. Instead, it did the opposite. Thus to get a count of 14,933 people, either close to 7,500 people became chronically homeless during this period or many were already chronically homeless but were missed in the 2011 count.

[19] Data from LAHSA's 2013 Greater LA Homeless Count can be accessed at http://lahsa.org/homelesscount.asp

One question is whether a methodological change can account for the difference in counts. Local officials feel confident that the methodology did not artificially inflate the 2013 count, since it did not change from the 2011 methodology. Countywide (all four continuums in the County), the overall homeless count increased from 50,193 to 57,735 (a 15 percent increase). The largest portion of this increase was in the "hidden homeless" count – a special supplemental measure gathered by LAHSA via a telephone survey of sampled households continuum-wide. Between 2011 and 2013, the overall sheltered and unsheltered homeless count increased by only two percent (from 34,622 to 35,524), whereas the hidden homeless count increased by 70 percent (from 10,800 to 18,274). This additional, special count has been conducted in past years, but the disproportionate increase in the hidden homeless portion of the count has brought considerably more attention to the approach this year. The street population characteristics (based on a survey) are applied to the hidden homeless population estimates, so the increases shown in the chronic homeless count are directly affected by the hidden homeless approach.

However, we must also recognize that the increase may be a real measure of need and that perhaps the count in 2011 was an undercount.

The change in the count of chronically homeless individuals was not evenly distributed across the County. As shown in Exhibit 8.3, there were some service planning areas (SPAs) where the number decreased, some where the number was relatively static, and others where the increase was substantial (note that the SPAs with large increases in chronic homeless counts are the same as the SPAs with large increases in hidden homeless counts). In particular, Antelope Valley had a dramatic increase; San Fernando Valley and South LA also had notable increases. East LA County saw a substantial decrease in its count, while the other SPAs had relatively stable counts.

Exhibit 8.3: SPA-Level Measures of Chronic Homelessness

	Number of CH individuals counted on night of PIT (sheltered and unsheltered)		Increase (or decrease) in Chronic Homelessness Count (2011 to 2013)	
	Jan-11	Jan-13	Number	Percent
Countywide (2011)	12,498	14,933	2,435	19.5%
SPA 1: Antelope Valley	209	2,176	1,967	941.1%
SPA 2: San Fernando Valley*	1,591	2,174	583	36.6%
SPA 3: San Gabriel Valley**	1,570	1,352	-218	-13.9%
SPA 4: Metro LA	2,175	2,092	-83	-3.8%
SPA 5: West LA	1,076	1,029	-47	-4.4%
SPA 6: South LA	2,073	2,960	887	42.8%
SPA 7: East LA County	1,078	491	-587	-54.5%
SPA 8: South Bay***	2,726	2,659	-67	-2.5%

**Includes Glendale count data*
***Includes Pasadena count data*
****Includes Long Beach count data*

Sources: 2011 and 2013 PIT Counts; LAHSA's 2013 Greater LA Homeless Count

Exploring Changes in the Homeless Count in 2013

In the 2013 Count, there was a significant uptick in the participation of "opt in" communities – cities or communities that elect to fully enumerate the street homeless population in all of the census tracts within the area. In areas without opt-in communities, census tracts are sampled to ensure they are representative of a SPA, Supervisory District, or City Council District. In 2011, 24 cities and 9 communities "opted in," while in 2013 this jumped in to 68 cities and 22 communities. In particular, SPA 1 had no opt in communities in 2011, but added Palmdale and Lancaster (the two largest communities in the SPA) as opt in communities in 2013. Though the sampling approach was likely well considered in prior years, it may be that the opt in approach – fully enumerating the large regions of Palmdale and Lancaster – provided additional information not previously available to the Greater LA Homeless Count research team. LAHSA and the community may wish to explore further comparisons between the raw street count and the extrapolated street count to examine changes over time and the potential benefits to the accuracy of the count from increased participation through the participation of other cities and communities. In addition, analysis of the biennial change to the chronic homeless count excluding the hidden homeless factor may provide additional information about the population targeted by the Initiative.

Even if increased participation improved the accuracy of the count, there may also have been real increases to the chronic homeless count in some SPAs. For example, LAHSA staff have suggested that preliminary discussions with community representatives from SPA 1 do point to a noticeable increase in access center drop-ins and contacts by outreach workers. It is worth considering that the SPAs where chronic homelessness remained flat or decreased – SPAs 3, 4, 5, 7, and 8 – are those where the community has heavily invested resources and coordination efforts. Given the placement rates, we would expect to see a more substantial decrease, but the investments may have allowed these communities to hold steady.

In interviews, some community stakeholders have posited that the Chronic Homelessness Initiative and associated campaigns–Home For Good and 100,000 Homes campaigns–are simply too early in their runs to see the true impact. New resources such as voucher commitments and additional services dollars made available through the Funders Collaborative process only came online in July of 2012, perhaps too soon to see their full impact. Other placements made prior to that may simply have reflected shifts in resources from less vulnerable chronically homeless or near-chronically homeless people to the more vulnerable population. If this is the case, then deeper impacts should be seen in 2014 and, in particular, in 2015, assuming the additional vouchers committed become available again following the sequestration voucher freeze. In addition, this suggests the Foundation should continue to focus resources on preventing chronic homelessness, to ensure this near-vulnerable population does not simply backfill the progress being made with the large placement numbers.

The evaluation team suggests that the community continue to explore the rich data available in the 2013 Greater LA Homeless Count to parse more clearly the chronic homeless population. In particular, reviewing the characteristics data in the street count survey may be able to produce a distinction between those chronically homeless people who are "long-term" homeless, meaning those who are homeless continuously for one year or more, as opposed to "episodically homeless," meaning those who qualify as chronically homeless by virtue of having been homeless four or more times over the past three years. Though both of these characteristics (in addition to a disability) are currently sufficient to qualify an individual as "chronically homeless," HUD has recently proposed changing the definition of chronically homeless. In the proposed Rural Housing Stability Assistance Program Rule, HUD included a revised definition of chronic homelessness that is informed by research from U.S. Interagency Council on

homelessness to "better target… persons with the longest histories of homelessness and therefore the highest level of need" (24 CFR Part 579, Preamble). This definition eliminates the simple episodic test and instead requires that the four occasions of homelessness over the past three years must cumulatively total one year.

Given that these long-term homeless people with higher needs appear to have been prioritized in many facets of the Initiative, it may be valuable for LAHSA and the community to conduct an analysis of the 2013 data to get a "long-term" chronically homeless count as compared to the "episodic" homelessness count (using responses to the survey questions) to get a better sense of the size of the highest need category among those who currently qualify as chronically homeless and to track progress in targeting the higher need group over time.

Placement Rates by SPA

The placement data reported by Home For Good is not explicitly reported by SPAs. In particular, the county-wide nature of the VA placements makes it difficult to look at placement rates by SPAs. The 100,000 Homes campaign does gather placement data for a few specific campaign communities (see Exhibit 8.4) to track progress toward their goal of placing 2.5 percent of the number of individuals enumerated on their campaign-supported Vulnerability Index (VI) registries per month. These campaign communities do not reflect the entire SPA in which they are located. If they were expanded to a broader array of communities within each SPA, they might eventually be able to provide more information about the impact of the placements made through the Initiative.

Exhibit 8.4: SPA-Level Placement Rates in Participating 100,000 Homes Campaign Communities

SPA	Size of Registry in Campaign Communities (individuals)	Placement Rate through 2012
1	n/a	n/a
2	417	46%
3	156	22%
4	893	38%
5	927	38%
6	127	35%
7	200	35%
8	1,193	13%

Source: Community Solutions

Recent increases in homeless management information system (HMIS) participation among PSH providers, particularly from LAHSA's efforts to integrate data with DMH, would allow for a comprehensive look at placements among chronically homeless individuals and could serve as a way to track PSH placements over time. Ultimately, the HMIS data could replace the Home For Good placement tracking system, assuming LAHSA's HMIS had the appropriate reporting capabilities, and enough access was granted to support Home For Good's tracking needs. Home For Good staff has reported exploring this possibility with LAHSA staff.

In addition, a number of community stakeholders have called for conducting a "by-name" registry and street count in 2014. If such a registry existed, then it could be matched with permanent housing placement data from HMIS to allow for a fuller understanding of whether the most vulnerable, high need

persons are being placed in PSH and the extent to which new people are becoming chronically homeless over time.

Signs of Progress in Reducing Homelessness Among Veterans

The goal of Home For Good is to end chronic and veteran homelessness in LA County by 2016, and many of the homeless people who have been housed since Home For Good was launched are veterans (4,593 altogether, including 2,437 chronically homeless veterans and 2,156 non-chronically homeless veterans). While the number of chronically homeless people increased between 2011 and 2013, the count of homeless veterans in the LA Continuum of Care declined 23 percent from 8,131 individuals in 2011 to 6,248 individuals in 2013. This seems to validate the success that can be created with the infusion of resources at the scale needed.

The federal strategic plan to prevent and end homelessness calls for ending homelessness among veterans by 2015. The US Department of Veterans Affairs Secretary and senior staff at Veterans Affairs headquarters are committed to achieving this goal and are working in partnership with HUD and the US Interagency Council on Homelessness. Congress has provided substantial funding increases for the VASH Program, which combines vouchers administered by public housing authorities with case management and other services provided by the VA. Since 2008, more than 4,000 VASH vouchers have been allocated for homeless veterans in LA County. The VA Medical Center of Greater Los Angeles has been partnering with the Housing Authority of the City of LA (HACLA), the Housing Authority of the County of LA, and the Housing Authority of the City of Pasadena to implement HUD-VASH. The majority of the VASH vouchers available in LA County (2,375) are administered by HACLA. The City of Long Beach has its own local public housing authority, which is working with the local VA Long Beach Healthcare System to implement the program that uses its allocation of VASH vouchers.

At the start of the HUD-VASH program, community stakeholders had serious concerns about the VA Medical Center's capacity to effectively reach, engage, and house chronically homeless veterans. Instead of using housing first strategies, existing program models based at the VA Medical Center used a "treatment first" approach, providing housing to veterans who participate in treatment programs and commit to achieving sobriety. In addition, the VA had little or no staff capacity to make home visits or see homeless veterans outside of the VA's Medical Center and clinics, creating obstacles to using VASH to serve chronically homeless veterans living on the streets and homeless veterans with the most severe mental health or substance use disorders, who may be unable or unwilling to visit the VA Medical Center to meet with case managers.

County resources have been used since 2011 to develop and implement Project 60, a partnership involving some of the Hilton Foundation grantees as providers of flexible services for homeless veterans using a housing first approach. The expectation of LA County officials and their community partners has been that, by serving homeless veterans with a housing first approach, Project 60 would be recognized as a model, and the VA would eventually be willing to use models that demonstrate results.

In 2012, the VA agreed to contract with at least one community provider to deliver case management services for some HUD-VASH participants. The VA awarded PATH funding for case management services and all of the 400 VASH vouchers that were to be connected to the contracted case management services.

With substantial leadership from the US Interagency Council on Homelessness, HUD, and the VA, officials from the Greater LA VA Medical Center have agreed to participate with the County and

community stakeholders in Solving Veterans Homelessness as One Los Angeles (SVHO-LA). SVHO-LA is seeking to dedicate the resources needed to achieve the federal goal of ending homelessness among veterans by 2015. SVHO-LA has resulted in commitments by the VA to expand its partnerships with community-based providers of case management services through a new solicitation. The VA has also agreed to adopt changes in practice to increase housing placements and prioritize HUD-VASH resources to chronically homeless veterans. As the VA and its partners fulfill these commitments and implement changes during the Chronic Homelessness Initiative's third year, the result is expected to be a further significant reduction in the number of chronically homeless veterans.

8.3 Recommendations to Move Forward

Use PIT count results to advocate for additional resources to meet growing needs, especially in the underserved parts of the County. Use the PIT data to support efforts to build political will and mobilize community partners. Particularly engage leaders representing underserved areas of the County, other housing authorities, and mainstream affordable housing funders and developers. Analyze subpopulation data in the PIT to show the extent to which specialized voucher programs like HUD-VASH can be used to address the needs of the highest priority individuals. Identify other resources and specific strategies to target resources to the highest need groups that are not eligible for specialized resources.

Broaden the reach of VA resources. As the VA expands resources available to community-based providers of case management services, work to encourage the VA to expand the base of providers able to access these resources. Distributing the resources among multiple providers will ensure that the needs of veterans can be met quickly, without creating delays associated with projects staffing up.

Sustain or increase focus on preventing chronic homelessness. Given the dramatic increase in chronic homelessness over the past two years, prevention efforts are increasingly important. In addition to working to expand the Just In Reach project, identify ways to institutionalize some of the strategies currently being piloted through the Initiative. Encourage increased investment from the criminal justice and health systems to focus on this population. Marry the prevention and Coordinated Entry System (CES) efforts to ensure that high-need homeless individuals at risk of chronic homelessness who are identified through the CES can be readily referred to appropriate prevention efforts. Collaborate, to the extent possible, with the Continuum of Care as community-wide funding priorities are established for Emergency Solutions Grant, Family Solutions Center, and other system resources to align with this goal. The Foundation should also consider supporting work to more clearly define the universe of individuals that are "at risk" of chronic homelessness. Identifying those subpopulations most likely to fall into chronic homelessness may reveal opportunities to prevent the chronic homeless population from growing even larger.

Identify strategies to improve and refine chronic homelessness count. Examine raw versus extrapolated count data to understand the effect of Count Plus community participation on the accuracy of the count. If higher rates of "opt in" participation are associated with more accurate counts, work to improve participation of communities in subsequent counts. Explore whether the chronic homelessness goal should use a narrower definition of chronic homelessness that is more aligned with the prioritization efforts.

Use HMIS to track PSH placements and match the placements with the biennial unsheltered count to validate prioritization efforts. Expand HMIS capacity to report on PSH placements and explore giving

Home For Good staff direct access to these reporting data in order to eliminate duplicative Home For Good reporting. Explore creating a by-name registry count, perhaps built over time through the VI registries and biennial counts, to support better targeting and relative prioritization. Develop capacity to match registry data with newly available placement data in HMIS to validate that the highest need individuals are typically the ones getting prioritized and placed in available PSH units.

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

The Chronic Homelessness Initiative's goal to end chronic homelessness is bold and requires elected officials, funders, providers, and even people who are homeless to change the way they have previously provided or accessed housing assistance. However, the changes are probably most profound for the PSH providers who are being asked to build units in different neighborhoods, accept tenants through different paths, serve people with more intensive needs, and provide outreach, housing and services differently to ensure resident success. To equip providers for these changes, Corporation for Supportive Housing (CSH), United Way, and Community Solutions are all actively working to build developer and provider capacity.

- CSH has focused 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. CSH also laid the groundwork for the development of the Standards of Excellence in its Dimensions of Quality and has continued to be engaged in the development of the Standards. In addition, CSH has facilitated provider collaboratives designed to promote peer learning around property management, 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 worked collaboratively with CSH to develop the Standards of Excellence, which include performance indicators and operating standards for PSH. Plans are underway to implement the Standards by encouraging funders to adopt the performance metrics.

- 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 and Veterans Affairs, with the objective of increasing housing placement rates for chronically homeless people.

Whether directly from these efforts or other influences, providers appear to be increasing their capacity to serve the higher-need, vulnerable populations being targeted through the Initiative. Progress in expanding the capacity of developers is somewhat harder to measure, given the constraints in funding and more limited opportunities to demonstrate increased capacity to develop PSH over the past year.

Data Availability: Stakeholder survey data measures changes in perceived capacity, but objective data on provider capacity relative to the Standards of Excellence is not yet systematically collected.
Status in 2013: There have been improvements in stakeholder perspectives of the capacity of providers, but external factors have limited PSH development opportunities. Service providers in some geographic areas need basic support, while other service providers are ready to take the "next step" to enhance their capacity to serve the most vulnerable populations.

Section 9.1 describes the capacity of developers to develop (or build) PSH throughout the LA region in light of the recent changes in the funding landscape. Section 9.2 examines the capacity of PSH operators and service providers to operate and serve clients in PSH. Section 9.3 describes efforts made to address

and measure changes in the complex health needs of the vulnerable population served in PSH. Section 9.4 provides recommendations.

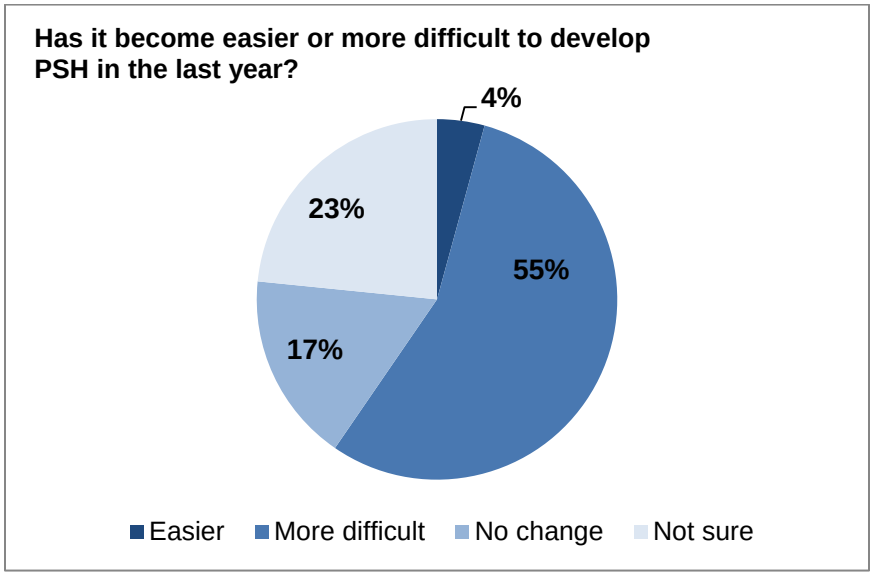
9.1 Process Measure: Is there a discernible increase in the capacity of housing developers to produce PSH in Los Angeles County?

The annual stakeholder survey asked respondents about their roles in the development, operation, and management of PSH. Fifty-seven participants in the survey identified themselves as being responsible for one of those three roles, and often for more than one role. Forty seven of the 57 reported being a PSH developer. Of PSH developers:

- 64 percent also operate PSH;
- 47 percent also conduct outreach; and
- 81 percent also provide services.

The stakeholder survey asked PSH developers whether they believed it has become easier to develop PSH in LA County over the past year. More than half of stakeholders (55 percent) responded that it had become more difficult, and only 4 percent reported that it has become easier. The remaining 40 percent reported that they either were not sure or that there was no change in the ease of the development process. While these percentages do not seem very positive, they are actually encouraging. Compared to last year, there was a considerable (13 percent) decline in the percentage of people who believed it became more difficult to develop PSH in LA. However, there was also a decline (by 9 percent) in the share of people who believed it became easier. The increases were observed in the share of people who were unsure of whether it has gotten easier or not and those who felt the ease of the process had not changed.

Exhibit 9.1: PSH Developer Perception of the Development Process, 2013



Sources: Abt Associates Inc. Stakeholder Survey, June 2013, n = 47 developers

The stakeholder survey also asked respondents that developed PSH to select reasons why it became more difficult to develop PSH over the past year. The results are shown in Exhibit 9.2. The reason selected by most (64 percent) of participants was the elimination of redevelopment agencies. Other resource-related

issues were also frequently cited, but they were cited less often than in last year's survey. Nearly 60 percent of respondents identified less funding (public or private), 47 percent cited that it was harder to obtain public commitment of resources, more than one-third cited misalignment between funding sources (a large jump from last year), and one-quarter cited fewer private commitments of resources as a reason for increased difficulty in development. One-quarter of PSH developers (26 percent) reported that staff capacity in the area of PSH has decreased. Nearly one quarter reported that administrative burdens associated with development have increased the difficulty.

Comparing the results from last year shows interesting shifts. Of the reasons that could be selected in both years, only fragmentation or misalignment of funding sources was selected with considerably more frequency in 2013. Notably, program-related capacity issues were identified in 2013 at rates nearly half those of 2012. This may point to other issues, such as the elimination of the redevelopment agencies having such a great effect that stakeholders do not see program-level capacity issues as having a role in the development process. However, it may also point to advances made based on local efforts made toward improving program capacity.

Exhibit 9.2: Reasons Respondents Cited for Increased Difficulty in Developing PSH, 2012 and 2013

When you compare now to this time last year, are there any ways you think it has become more difficult to develop permanent supportive housing?		
	2012	2013
Redevelopment agencies have been eliminated		63.8%
Less public or private funding is available for development costs	59.6%	57.4%
Public commitments of resources (subsidies, operating, services, etc.) are harder to obtain	44.2%	46.8%
Fragmentation and misalignment between funders makes it difficult to assemble funding for a project	23.1%	36.2%
Private commitments of resources (subsidies, operating, services, etc.) are harder to obtain	36.5%	25.5%
Staff capacity has decreased	40.4%	25.5%
Administrative burdens associated with developments have increased	42.3%	23.4%

Sources: Abt Associates Inc. Stakeholder Survey, June 2013, n = 47 developers; and Stakeholder Survey, July 2012, n = 52 developers

In 2013, stakeholders were also asked to select reasons that it had become easier to develop PSH. Nearly 7 in 10 PSH developers indicated that there were no ways in which it had become easier or that they did not know. Of those that did identify ways that it has become easier (n=18), one-third selected the response that administrative or financing processes associated with PSH development were easier to navigate because of training or support received from CSH, United Way, or other capacity-building organizations. Forty-four percent reported that they thought that public and private funding sources had become better aligned, and easier to access – presumably a reflection of the efforts to coordinate funding through the Funders Collaborative.

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

Measuring Capacity: The Standards of Excellence

The Standards of Excellence are goals and operating standards for high quality performance by PSH, emergency shelters, and outreach programs. The goals are set based on the most critical outcome measures – those that are necessary to reduce and end homelessness – and include a list of best practices to which service providers should adhere. The Standards were developed as part of the Home For Good campaign, with the close participation of CSH and other community partners. The Los Angeles Homeless Services Authority (LAHSA) has also been engaged in the development of goals, and the Standards workgroup has been careful to align goals, where possible, with project performance goals being established by LAHSA.

The goals and operating standards created for PSH programs are:

- Housing retention;
- Dedication of units for chronically homeless people;
- Application for mainstream benefits by clients;
- Tenant satisfaction;
- Easy access to supportive services, but participation is not a condition of tenancy;
- Tenants have a lease or occupancy agreement with no limit on length of tenancy;
- No requirement to have completed a program, have had a shelter stay, or be sober or med compliant;
- Tenants receive list of CA Tenant's Rights and Responsibilities;
- Tenant pays no more than 30% of his or her income toward rent; and
- Program participates in LAHSA's homeless management information system (HMIS) and is not on a Continuum of Care probation list

The Standards, in effect, articulate a community definition of PSH. Assuming the Standards are adopted universally, this definition may support efforts to enumerate housing units, as well as to establish minimum standards for performance. Home For Good is rolling out a series of trainings, supported by HUD technical assistance resources, to support the adoption of the Standards. The results of these trainings – which are planned to roll out over the fall of 2013, will be included in the 2014 Report. To ensure that the Standards do not simply amount to additional tracking and reporting burden on providers, they will need to be adopted broadly.

An approach to measuring tenant satisfaction is still in development. In focus groups that CSH has conducted, tenants have been adamant that tenant satisfaction data should be collected by a neutral third party, rather than by each program directly. Contracting with a third party will result in a significant additional cost burden, yet all recognize the need for clients to feel comfortable that their responses will not jeopardize their tenancy. This measure will be rolled out as part of a later phase of implementation.

There is not yet a baseline assessment of PSH providers relative to the metrics established in the Standards of Excellence, nor a complete plan for system-wide adoption of the Standards. In the interim, the evaluation team has used several measures from the annual stakeholder survey to develop a system-wide "scorecard" for PSH. These survey responses relate closely to the performance goals, operating

standards, suggested practices, and system recommendations established in the Standards of Excellence. Results from 2013 (and 2012, when comparable data are available) are shown in Exhibit 9.3.

Exhibit 9.3: PSH Service Provider Capacity Scorecard, 2012 and 2013

PSH Provider Capacity Metric	2012 Survey Results	2013 Survey Results	Change
Percent of operators reporting that units are set aside for chronically homeless individuals	54.3% (n=34)	69.7% (n=33)	Increase: 15.4%
Percent of operators reporting formal or informal agreements with case managers or outreach teams to prepare for service needs of clients in housing	73.7% (n=38)	73.5% (n=34)	No change
Percent of engagement workers reporting a placement time of less than 2 months	n/a	20.8% (n=173)	Baseline
Percent of engagement workers reporting use of "housing readiness" criteria to select people for enrollment in PSH	n/a	15.7% (n=102)	Baseline
Percent of PSH providing case management services	85.2% (n=68)	95.7% (n=140)	Increase: 10.5%
Percent of PSH providing assistance linking to benefits	n/a	72.1% (n=140)	Baseline
Percent of PSH providers reporting having challenges helping chronically homeless clients retain their PSH	n/a	48.3% (n=205)	Baseline

Sources: Abt Associates Inc. Stakeholder Survey, June 2013; and Stakeholder Survey, July 2012

The Standards strongly reinforce the goals of the Initiative and, if universally adopted, could serve to support dramatic system change among PSH providers. If funders broadly use these Standards as the basis for reporting, there would be a dual benefit of streamlining provider reporting. That said, at this point there are no specific commitments from funders to adopt the Standards as universal performance measures for PSH. LAHSA's adoption of these metrics – and their inclusion in standard HMIS reports – would go far in ensuring that providers consistently report performance with reduced burden, and it would enable calculation of system-wide performance results.

Tenant Perspective on Provider Capacity

The evaluation team conducted focus groups with 22 residents of four different PSH projects to understand consumer perspectives on whether PSH is meeting the needs of residents. The evaluation team conducted focus groups at three of the same programs as last year to encourage continuity and to measure any changes in program practices and perspectives of residents. One site was changed. The participants were:

- Eight clients living in a project-based facility, with tenancies ranging from six months to two years;
- Six clients living in a project-based facility targeted to people over the age of 55;
- Four clients living in scattered site housing, with tenancies of one year to more than two years;
- Four clients served by a project that supports both project-based and scattered site units.

Tenant participants were asked about three overall topics: the referral, application and entry process; the services provided; and suggestions for improvements.

Referral, Application, and Entry

The application process presented a challenge to nearly all participants. Many respondents, however, reported relying on case managers and housing specialists to complete the necessary paperwork. This helped to dissolve some of the anxiety of the application process. Clients who did not report assistance with the application expressed frustration with the process much more than those who had assistance. Many either did not understand the process by which decisions were made or felt the selection process was disingenuous. For example, participants in one focus group were living in a program that changed the status of their vouchers from tenant-based to project-based after they moved into the building (meaning they would likely be unable to take their voucher with them if they eventually moved). Most of the participants in that focus group had to switch to what they considered to be the far less valuable voucher.

The waiting period reported by participants ranged from one week to approximately one year. Most participants, however, reported waiting between 3 and 6 months for a unit after filling out the initial paperwork. Many participants reported staying in emergency shelter and receiving services while they waited for housing. However, all participants from the "Over 55" PSH program reported staying elsewhere. Four reported staying in their cars, one lived under a bridge, and one in a motel.

Services

Clients reported accessing a wide range of programs. By far, the clients of the scattered site program placed a higher value on the services provided to them by various service providers than those in the project-based programs. The services identified as important to this group were mental health services, benefit referrals, substance use support groups, and other life skills support. For clients living in project-based programs, the services provided were mostly social or recreational. A few respondents indicated that participation in services helped them to avoid relapsing. Social and recreational services also helped to alleviate the isolation and loneliness often identified by PSH clients. A participant described his involvement in his building improvement committee, where he felt he had some control over decisions made for his building. Nearly all clients agreed with sentiments that clients need to seek out services. "Dead time," reported one client, "is dangerous."

In every focus group, clients reported a lack of services aimed at helping clients transition from PSH when they are ready. One client stated that she wished someone at the program would help her plan for and find new housing. Another client in the same program reported feeling "stuck" in his unit after a year. He hoped that the program would provide him access to a different, higher quality unit with its own kitchen and bathroom. Other clients simply felt uncertain about how to take the next step, even if they were not ready yet. Additional case management to help plan for the transition was desired. Other services clients believed would be helpful include: workforce training, additional referral services, legal assistance, and benefits navigation.

Suggestions for Improvements

Clients were asked to discuss things that could be improved or that PSH programs should consider when developing new programs. By far, the most common suggestion by clients was to provide additional planning and support for the transition to more independent living. Other service-related suggestions include improved advocacy for benefits access (particularly SSI and SSDI) and increased home visits for people living in scattered site housing.

Participants made some suggestions around application and entry processes. Some suggested additional assistance with paperwork during the application process. Others thought that they should have received comprehensive information about who to contact for various needs or services. They often felt that the

people working at the program were reluctant to redirect them or say that they did not have an answer, so they would make one up. Clients were then told different information later. In one particular program, residents mentioned that the role of the property manager was unclear. Clients suggested that the roles of the various employees should be outlined more clearly – both to the residents and the staff. The property manager of that particular program, they reported, was taking on issues that should have been addressed by a case manager. A related suggestion was for the staff of programs to take the time to explain decisions to residents. When changes were made, they were not explained, and clients felt deceived. Finally, participants observed that people living in PSH often have mental health issues and that in project-based programs, residents often acted out or otherwise made the building feel uncomfortable or unsafe. PSH program staff were encouraged to take a more active role in creating an environment that is comfortable and safe for everyone.

Housing Retention

One measure of provider capacity is a project's rate of housing retention, with high housing retention reflecting stronger provider capacity in working with the high-need populations being targeted by the Initiative. In 2012, Hilton Foundation grantee projects, in aggregate, achieved a retention rate of 82 percent, as shown in Exhibit 9.4. These projects cumulatively placed 546 chronically homeless individuals in PSH. As of the end of 2012, 192 of these individuals had completed a full year of living in PSH, and an additional 78 exited during the current reporting period (2012). The housing retention rates of individual projects ranged from 56 percent to 96 percent.

Exhibit 9.4: Grantee Retention Rates, 2012

Retention Measure	Foundation Grantees directly delivering PSH
Universe: Total chronically homeless people who exited during the reporting period + chronically homeless people still living in PSH who entered more than 12 months ago	270
Persons who exited to a permanent housing destination and had at least 6 months of residence in reporting unit	28
Persons who entered at least 12 months prior to the reporting period who are still living in the unit	192
Persons who retained housing 12+ months or moved to other permanent housing after 6 months	176
Retention Rate	81.5%

Source: Grantee reporting

These rates will be tracked in subsequent years to determine whether provider retention is increasing, and whether provider capacity should be further targeted to improve retention rates.

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 205 PSH provider respondents, 48 percent reported having had "challenges" housing people who had chronic patterns of homelessness 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:

- Adding money management services

- Supporting the client to build new relationships and connections to the placement community
- Developing ongoing coordination with public service providers and interdisciplinary service teams to create a wrap-around support system
- Bringing in additional crisis support when warranted. Housing Works, Shelter Partnership, and Project Housed were all cited as providing supplementary intervention support when the program's onsite case management was unable to handle a client or situation.
- Conducting frequent home visits – daily at first
- Building staff knowledge of specific interventions and techniques: conflict resolution, crisis intervention, harm reduction, motivational interviewing, and critical time intervention

In addition, respondents cited two specific systematic challenges in their responses. First, they noted that clients often need to be hospitalized or become incarcerated for a period of time longer than current housing authority rules allow for vacancies. This forces the clients to give up their housing in order to receive appropriate treatment or to clear their legal record. Second, they noted that many client issues stem from client isolation, in particular for scattered site tenants. Tenants invite friends from their former street lives to move in with them and relapse into old behaviors, or else they spend their time at access centers or even shelter programs to stay connected with their new support group. Creating specialized support centers (similar to a senior center) for housed clients was suggested as an approach to resolving this challenge.

Profile of PSH Model: Critical Time Intervention[20]

Starting in 2011, the Hilton Foundation provided a grant to the Downtown Women's Center (DWC) to implement a Critical Time Intervention (CTI) approach with their client population. The CTI model is highly structured; there are three-month "phases," each with its own treatment plans. The treatment plans are focused on a limited number of goals (1 to 3) in each phase and on issues that affect long-term housing stability. The model includes intensive client contact in the first phase, which tapers over the course of the intervention. At the end of the nine-month intervention, care is transferred to a more typical community-based service provider. Downtown Women's Center was initially planning to implement this service approach with clients in their residential program, but construction delays meant housing some clients in the Ford Hotel and implementing the intervention as offsite service providers.

DWC worked with Housing Innovations to provide training on the intervention model and to monitor ongoing fidelity to the model. An evaluation of the project is ongoing, conducted by Harder + Company. DWC has demonstrated fidelity to the model and data collection processes are improving. Clients are showing improved independent living skills over each of the three intervention phases and housing retention remained at 100 percent through the end of 2012.

Given the time-limited nature of the intervention, understanding its use and applicability may prove useful to a broad array of providers working to manage ever-increasing caseloads of PSH clients. Downtown Women's Center has already begun providing trainings and sharing results of the work with peers. The project has experienced some challenges, in particular working as off-site providers serving clients in the Ford Hotel. Linking these clients to community-based resources to access after the intervention period is more difficult, similar to the challenges faced by scattered site PSH providers.

Movement Toward a Housing First Approach in the Department of Mental Health

In interviews, some stakeholders have shared past challenges in using Department of Mental Health (DMH) resources to make PSH placements such as being limited to homeless individuals who had already been engaged with DMH mental health services when making placements. From the perspective of stakeholders outside of DMH, this limitation seems inconsistent with a housing first approach, because homeless people must agree to become clients of the County mental health system and receive services for several months before they can use housing resources administered by DMH. This challenge is particularly important as DMH contracts are the source for mental health services in many PSH units and DMH-funded mental health services are often used to fulfill the required service match for homeless individuals housed through Shelter Plus Care.

However, DMH and its partner agencies have taken significant steps in the direction of housing first over the past two years. While access to housing comes through a connection to DMH services, an offer of housing can be used to engage people in making a connection to services that are very flexible. For the most vulnerable and chronically homeless people, access to housing can happen very soon after a person

[20] The full 2012 report is not yet available publicly, but the Year One report – *Annual Evaluation Report Downtown Women's Center Critical Time Intervention Project* – can be accessed here: http://www.dwcweb.org/communityresources/DWCAnnualReportYearOne.pdf

engages in services, instead of requiring months of participation in mental health treatment programs or other services before housing is offered.

During the 2012-2013 fiscal year, DMH added $2 million to the Mental Health Services Act (MHSA) Housing Fund, which is administered through a partnership with the California Housing Finance Agency. This funding will be used to support one or more additional PSH projects. In early 2013, DMH worked with CSH to conduct listening sessions about MHSA housing programs. Some DMH staff and mental health providers under contract to DMH continue to argue that DMH-allocated housing resources should be used for homeless people who are engaged in DMH services. While DMH considers making additional changes in policies and procedures to move toward even more of a housing first approach, the Department faces competing views that may hamper movement in that direction.

Integrated Mobile Health Teams

An example of the innovative housing first work DMH has funded includes the five Integrated Mobile Health Teams (IMHT) that use resources set aside for innovation by California's MHSA. The IMHTs use a vulnerability scale to identify and serve the most vulnerable individuals among those engaged by the team through outreach. The teams are responsible for delivering mental health, physical health, and substance abuse services, coupled with a Housing First approach that offers access to housing without requirements for treatment, sobriety, or "housing readiness." All IMHT services are delivered in the community, either engaging homeless people on the streets or making home visits to people in PSH – with the exception of medical procedures that must be conducted in a clinic setting.

The IMHT program model is designed to serve people with serious mental illness who also have other vulnerabilities, including age, years of homelessness, co-occurring substance abuse or other physical health conditions that require ongoing primary care (such as diabetes, hypertension, cardiovascular disease, asthma or other respiratory illnesses, obesity, cancer, arthritis, and chronic pain). Providers report that the people they serve through the IMHTs are sicker, more vulnerable, and have more severe and untreated mental illness or substance abuse problems compared to the people their agencies usually serve. Nearly all have co-occurring substance use disorders and most are uninsured at the time of enrollment.

Each IMHT has a multidisciplinary team of staff from one or two mental health service providers (community-based organizations under contract with DMH) and a federally qualified health center, and each partners with PSH developer(s) that dedicates housing units to clients served by the IMHT. Each of the five IMHTs includes at least one Hilton Foundation grantee organization as a service provider or supportive housing partner.

MHSA funding is expected to be combined with reimbursement through Medi-Cal and other resources available to the project partners, including housing assistance. Providers are expected to use MHSA funds for costs that cannot be reimbursed through other funding sources. DMH expects that Medi-Cal reimbursement will cover an increasing portion of project costs and contribute to the financial sustainability of these program models.

DMH program managers describe a vision of fully integrated teams that can effectively engage, serve, and house some of the most vulnerable and chronically homeless people in LA County, and this vision is reflected in the terms of DMH contracts with service providers. At this point, providers involved with IMHT implementation say that this vision has not been fully reconciled with the separate – and unchanged – state and County agency requirements for documenting and billing for Medi-Cal reimbursement for primary care and mental health services. These administrative burdens are likely to

make it challenging for the partner service providers to be able to sustain the IMHT service model with Medi-Cal reimbursements after the MHSA Innovations funding ends.

9.3 Process Measure: What steps are PSH providers taking to improve health Outcomes for PSH Tenants?

Though it was not an explicitly identified as an outcome goal of the Initiative, linking PSH residents with health benefits is critical to the work of the Initiative. Connecting clients with mainstream benefits relieves financial pressure on service providers and creates opportunities for high users of emergency services to engage with a medical home and begin receiving more appropriate primary care.

Health Care Linkages Through Healthy Way LA Enrollment

In 2013, the Hilton Foundation began funding – in partnership with Weingart and UniHealth Foundations – a collaborative of community clinics to support a Healthy Way LA enrollment campaign. Healthy Way LA is the Department of Health Services' (DHS) implementation of California's Medicaid Demonstration Waiver program called the "Bridge to Reform." The project's goal for 2013 is to enroll 4,160 homeless people in Healthy Way LA, connect 100 percent of them to a medical home, and conduct at least one physical and mental health assessment for 95 percent of enrollees. JWCH Institute is the lead working with five partner agencies (Central Neighborhood Health Foundation, Los Angeles Christian Health Centers, Northeast Valley Health Corporation, The Saban Free Clinic, and Venice Family Clinic) and with DHS to deploy eight Healthy Way enrollment teams across the County. Though the first year of the grant has not yet been completed, in the first six months: 2,233 people had been enrolled, 54 percent of the enrollment goal. All of those enrolled were assigned a medical home, 84 percent received a physical assessment, and 73 percent received a mental health assessment. The partnership will continue to work on linking clients to supportive services and housing resources, in particular the Housing For Health projects operated by DHS.

FUSE Results

In 2012, CSH was awarded a Social Innovation Fund (SIF) grant from the Corporation for National and Community Service to expand the Frequent Users Systems Engagement (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 have been significantly expanded over the course of 2012 and early 2013.

As part of this work, the Economic Roundtable (ERt) developed and implemented two screening tools (one of which was self-funded by ERt) specifically for the project, known as the "10th Decile" tools. ERt and CSH together have prepared a report of outcomes of the project for the first 163 referrals made through three phases of the project (April 2011 through January 2013). The 10th Decile Tool is a screening tool used to determine the probability that a patient in a hospital is part of the ten percent of patients with the highest public costs. Hospital staff were trained to identify potential candidates to be screened with the tool and then hand off eligible and interested patients to a navigator to link them with housing resources and appropriate services. Eighty percent of the 163 patients screened were in the 10th decile (meaning that the screening tool revealed a greater than 35 percent probability that they were in the 10th decile).

Of those patients in the 10th decile, 89 (68 percent) were engaged by navigators. As of May 2013, 36 had been placed in PSH and 22 were actively engaged in seeking housing. Consistent with other reporting

from FUSE and SIF grantees, a high proportion of clients (7 of the 89 people engaged) passed away following their engagement with the navigators. A few of the 10th decile patients who were not engaged had left the hospital before the navigator was able to arrive and a few declined to participate in the program. However, most of those screened but not handed off to navigators were reported to have had such severe health issues that they were better suited to skilled nursing facilities than independent living situations or had criminal histories that would have prevented them from accessing housing vouchers.

As part of its evaluation of the results of the FUSE project, ERt developed estimates of public costs avoided by the clients because of their participation in the FUSE project. ERt used two approaches: 1) comparing FUSE participants to a group created from LA County public service department records of non-participant individuals similar to the evaluated group; and 2) comparing actual billing records for the participants from two participating hospitals during the year prior to enrollment and the year after referral into the program. Costs analyzed included sheriff and probation, LAHSA records, General Relief, Food Stamps, paramedic costs, and private and County hospitals. The groups analyzed were 106 matched pairs of 10th decile patients and homeless persons.

The reduction in annual average cost for each 10th decile patient was $46,977. (This estimate does not take into account the cost of the housing subsidy or the cost of the navigator.) Health care costs were reduced by 70 percent, and non-medical justice system costs by 90 percent.[21]

Increasing Availability of Substance Abuse Disorder Treatment

A number of stakeholders interviewed spoke about the dearth of substance abuse treatment resources available for homeless and formerly homeless clients. The state is significantly expanding Medi-Cal coverage for substance use treatment for adults. Starting in 2014, the PSH and other service providers should find it easier to enroll people into certified residential or outpatient substance abuse treatment programs if they are willing to participate (and enrolled in Medi-Cal). Some PSH service providers (particularly those already using Medi-Cal as mental health service providers) may be able to establish programs that meet Drug Medi-Cal certification requirements, or potentially some PSH programs may be able to partner with Drug Medi-Cal providers to establish satellite clinics in or close to PSH. Assuming that many of the challenges CH people face after they move into PSH are related to substance use disorders, the expansion of these Medi-Cal benefits should create opportunities for better access to treatment. As this expansion unfolds, there is an opportunity to engage with the Department of Public Health's Substance Abuse Prevention and Control about how to make the expanded Drug Medi-Cal benefits work for the chronically homeless people and PSH clients.

9.4 Recommendations to Move Forward

The stakeholder survey responses, stakeholder interview feedback, and specific project results suggest that there is a shifting need for capacity development work in Los Angeles. Over the past several years, CSH in particular has focused on helping developers navigate financing strategies and encouraging providers to adopt a housing first approach. While elected and public officials, funders, and the public at

[21] A report detailing this project and outcomes, *Getting Home: Outcomes from Housing High Cost Homeless Patients* prepared by the Economic Roundtable, can be accessed at http://www.economicrt.org/summaries/Getting_Home.html

large continue to need messaging about the benefits of the housing first approach, the needs of many PSH developers and service providers have evolved.

Explore opportunities to deploy the Standards of Excellence to measure project and system performance in a way that streamlines (rather than adding to) provider tracking and reporting activities. Develop HMIS-based reports to support measuring performance relative to the Standards**.**

Foster the development of more transition support programs (such as the "Moving On" grants supported through the Funders Collaborative in 2013) to help clients in PSH to consider their next steps and transition smoothly into other permanent housing when ready. In addition to expanding "Moving On" projects, this may include developing specialized support programs for housed clients.

Shift capacity-building to target messaging and focus on more advanced topics. On the development side, there is less need to expand the universe of developers. In a landscape of shrinking resources, maximizing the available resources and siting them where the need is highest should be the goal. On the services side, most housing providers have absorbed the basic message of adopting a housing first philosophy. Targeted messaging to those who have not would be valuable, while other providers are now ready to move to the "next level" of learning – understanding more fully how to provide effective services to the most vulnerable clients.

The evaluation team has identified three specific focus areas for capacity development over the coming years of the Initiative:

1) South LA: SPA 6 has seen a rapid increase in chronically homeless individuals since 2011. Stakeholders have indicated that a significant number of smaller provider programs in the SPA appear to need support on very basic levels to ensure they are maintaining nonprofit status and are running programs that meet community standards. A geographic focus in this area may be a better use of basic-level training resources than a broad-based community learning effort.

2) Existing PSH providers are beginning to take more vulnerable and fragile people, and could use "next level" training to support the level of services those clients need. CSH has noted that PSH projects vary widely in their retention levels and apparent levels of staff expertise, even among projects operated by the same agencies. Some of these issues may be addressed in the trainings Home For Good is establishing around the Standards of Excellence, but these will be broadly-focused trainings covering issues applicable to many different types of providers. Working closely with providers to seek out high performing building management and developing a training strategy around supporting highly vulnerable clients retain their housing would appear to be a natural evolution from the more basic provider trainings of the past.

3) Providers need to develop capacity to help their clients access health resources – particularly new resources available under the Affordable Care Act. For example, supportive housing providers and their service partners need to be able to help tenants who are newly eligible for Medi-Cal navigate the process of enrollment in Medi-Cal managed care plans. Changes in Medi-Cal covered mental health and substance use disorder services may create or expand financing opportunities for services delivered to supportive housing tenants. However, providers will need to have the capacity to meet requirements associated with Medi-Cal reimbursement.

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 summaries provided at the beginning of the discussion of each goal are compiled in Exhibit 10.1. Significant progress is being made on goals related to building support and demonstrated action by elected and public officials, leveraging private and public resources, creating new project-based and scattered site PSH units, and placing chronically homeless individuals in PSH. In fact, stakeholders have already exceeded the five-year goal for leveraging public funds and are on track to exceed the targets for unit production, chronic homeless placements, and obtaining commitments of funds.

Exhibit 10.1: Summary of Progress on Hilton Foundation Initiative Goals, August 2013

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 future actions.	
	Status in 2013: Support among stakeholder groups for PSH continued to increase and elected and public officials demonstrated significant concrete actions to address chronic homelessness, although there are questions about whether support is sustainable.	
Progress on Goal to Leverage $90 million in Private and Public Funds toward PSH	***Baseline Established:*** Clear data are available for funds leveraged through the Funders Collaborative. While a lower priority for the Initiative evaluation, data on funding secured outside of the Funders Collaborative is inconsistent and difficult to deduplicate.	
	Status in 2013: The public goal has been exceeded and progress continues on the private funding commitments. Revisiting the goals for the Collaborative may be needed in light of the growing need for renewal funding year after year.	
Progress on Goal to Create 4,000 units of PSH	***Data Availability:*** Significant improvement in data quality over year one, through a process engaging an array of stakeholders; additional work is needed, but progress has been made.	
	Status in 2013: Forty five percent of the cumulative PSH creation goal has been achieved. System-wide, progress on creation of project-based PSH on target and creation of scattered site PSH is significantly higher than anticipated.	
Progress on the Goal to Establish a System of Prioritizing Chronically Homeless Persons for PSH	***Data Availability:*** Data on the pilot are available, but system-wide data are not yet available to test whether prioritized chronically homeless individuals are the ones routinely placed in available PSH.	
	Status in 2013: Significant progress was made on the Skid Row Pilot and other pilot efforts. System-wide adoption of prioritization practices will be contingent upon convincing housing providers throughout the county to participate.	
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:*** Data on chronic homelessness are only collected through the biennial point-in-time count and through occasional Vulnerability Index registry counts, but count data are not sufficient to understand growing need within the context of strong placement activity.	
	Status in 2013: Placements of chronically homeless individuals are on pace to exceed the Initiative goal, but impact is not affecting point-in-time count figures.	***Status in 2013:*** Prevention placements are lower than anticipated.

Progress on Goal to Increase Capacity of Developers and Providers to Effectively Provide PSH	***Data Availability:*** Stakeholder survey data measures changes in perceived capacity, but objective data on provider capacity relative to the Standards of Excellence is not yet systematically collected.
	Status in 2013: There have been improvements in stakeholder perspectives of the capacity of providers, but external factors have limited PSH development opportunities. Service providers in some geographic areas need basic support, while other service providers are ready to take the "next step" to enhance their capacity to serve the most vulnerable populations.

While headway has been made, progress has been slower on the system change milestones related to establishing a system of prioritization for PSH placement; preventing people from becoming chronically homeless by placing in PSH those who are high-need and at high-risk of chronic homelessness; and building the capacity of developers and providers to provide PSH effectively. However, the evaluation team recognizes the vast scale and complexity of the Los Angeles homeless system of care and applauds the progress made to date. The number of jurisdictions, public agencies, and providers presents challenges not often found in other efforts to improve system coordination.

Furthermore, across all goals, few systematic processes are in place to collect and compile data to document progress on the goal and, to support process improvements that ultimately will improve system outcomes. The most obvious gap is the absence of a transparent, widely available housing inventory database and comprehensive data on the specific individuals who are chronically homeless in order to establish their relative need for PSH.

In section 10.1, the evaluation team presents a consolidated list of the primary recommendations provided within each of the discrete chapters for the Foundation and other key stakeholders to advance progress in achieving the ultimate goals of the Initiative. In section 10.2, we describe the next steps of the evaluation and how these results will be disseminated among stakeholders to inform next steps.

10.1 Recommendations

A number of recommendations for improvement emerged from our evaluation and have been discussed within each of the chapters. The recommendations fall into four broad categories:

- Strategies to sustain and continue to build community support for PSH;
- Data collection efforts that will result in better tracking to inform planning, decision-making, and accountability;
- Efforts to improve the performance of systems to achieve the goals of the Initiative; and
- Updates to Initiative goals.

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 Sustaining and Growing Community Support for PSH

1. Focus on emerging political leadership. Work with new elected officials to ensure sustained political will and to encourage continued and increased investment in PSH through the County Homelessness Prevention Initiative, allocation of existing mainstream services, and creation of new initiatives.

2. Mitigate the effects of sequestration. Community groups should consider action such as advocating for a swift end to the Housing Choice Voucher freeze that adversely affects efforts to expand PSH opportunities and align necessary supportive services.

3. Engage new and diverse funders to ensure sustainability of the Funders Collaborative. Formalize different ways of participating with the Funders Collaborative and the roles and expectations associated with each type of membership.

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. Create an accurate, shared PSH inventory that can be easily maintained. Continue the work of the PSH inventory group in formalizing and streamlining the process of merging, reconciling, and cleaning inventory data from all sources. This group should consider ways to obtain regular updates from providers, such as by requiring updates to the inventory as part of annual funding applications, and explore use of the homeless management information system (HMIS) as a central repository for the housing inventory, so the inventory can be maintained and accessed year-round by all parties.

2. Identify strategies to improve and refine chronic homelessness count. Examine raw versus extrapolated count data to understand the effect of Count Plus community participation on the accuracy of the count. If higher rates of "opt in" participation are associated with more accurate counts, work to improve participation of communities in subsequent counts. Explore whether the chronic homelessness goal should use a narrower definition of chronic homelessness that is more aligned with the prioritization efforts.

3. Use HMIS to track PSH placements and match the placements with the Vulnerability Index (VI) registries to validate prioritization efforts. Expand HMIS capacity to report on PSH placements, and explore giving Home For Good staff direct access to these reporting data in order to eliminate duplicative Home For Good reporting. Explore creating a by-name registry count, perhaps built over time through the VI registries and biennial counts, to support county-wide targeting and relative prioritization. Develop capacity to match registry data with newly available placement data in HMIS to validate that the highest need individuals are typically the ones getting prioritized and placed in available PSH units.

4. Explore opportunities to deploy the Standards of Excellence to measure project and system performance in a way that streamlines (rather than adding to) provider tracking and reporting activities. Develop HMIS-based reports to support measuring performance relative to the Standards.

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 on 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. Streamline and institutionalize measures to improve overall system performance.

    a. Institutionalize streamlined procedures to issue and lease-up Housing Choice Vouchers. Housing authorities and service providers should capitalize upon the lessons learned from the rapid voucher issuance process that occurred in Spring 2013. In addition to removing administrative barriers and institutionalizing efficiencies, practices related to landlord outreach, apartment matching, and resident coaching could improve lease up of turnover units by people who are chronically homeless.

    b. Foster the development of more transition support programs (such as the "Moving On" grants supported through the Funders Collaborative in 2013) to help clients in PSH to consider their next steps and transition smoothly into other permanent housing when ready. In addition to expanding "Moving On" projects, this may include developing specialized support programs for housed clients.

2. Increase accessibility and prioritization of PSH to people who are chronically homeless.

    a. As part of the expansion of the Skid Row Coordinated Entry System (CES), the expansion team should identify opportunities to remove criteria that limit access to targeted populations or reinforce a housing readiness philosophy.

    b. The CES expansion team should include the VI Registry communities as they expand the CES pilot. Adoption of some of the approaches employed in the Skid Row CES pilot would assist these communities in moving more rapidly toward consistent prioritization approaches that would ensure that the most vulnerable community members are receiving the most service-enriched housing resources.

    c. As a way to engage more PSH providers in a systematic prioritization approach, the CES expansion team should develop a systematic "ask" to get PSH providers to agree to fill a portion of their turnover and new units through a CES process. In addition, the CES expansion team should continue working strategically with key stakeholders to incorporate Continuum of Care, Public Housing Authority, DMH, DHS, and other housing resources into this approach.

3. Sustain or increase focus on preventing chronic homelessness. Given the increase in chronic homeless numbers in the PIT count over the past two years, prevention efforts are increasingly important. In addition to working to expand the Just In Reach project, identify ways to institutionalize some of the strategies currently being piloted through the Initiative. Encourage increased investment from the criminal justice and health systems to focus on this population. Marry the prevention and CES efforts to ensure that high-need homeless individuals at risk of chronic homelessness who are identified through the CES can be readily referred to appropriate prevention efforts. Collaborate, to the extent possible, with the Continuum of Care as community-wide funding priorities are established for Emergency Solutions Grant, Family Solutions Center,

and other system resources to align with this goal. The Foundation should also consider supporting work to more clearly define the universe of individuals that are "at risk" of chronic homelessness. Identifying those subpopulations most likely to fall into chronic homelessness may reveal opportunities to prevent the chronic homeless population from growing even larger.

4. Identify new and preserve existing resources to invest in the Chronic Homelessness Initiative, most specifically in the creation of new PSH.

    a. Work with LA County to preserve County service commitments until the vouchers become available again, so the service commitments are not lost altogether.

    b. Explore whether other funding sources could be used to create bridge subsidies until Housing Choice Vouchers are available again. Advocate to preserve and increase state and local funding for affordable housing.

    c. Use point-in-time (PIT) count data to advocate for additional resources to meet growing needs, especially in the underserved parts of the County. Use the PIT data to support efforts to build political will and mobilize community partners. Particularly engage leaders representing underserved areas of the County, other housing authorities, and mainstream affordable housing funders and developers. Analyze subpopulation data in the PIT to show the extent to which specialized voucher programs like Housing and Urban Development's Veterans Affairs Supportive Housing can be used to address the needs of the highest priority individuals. Identify other resources and specific strategies to target resources to the highest need groups that are not eligible for specialized resources.

5. Develop the capacity of providers to implement PSH effectively throughout the County while targeting the highest need chronically homeless individuals.

    a. South LA (SPA 6) has seen a rapid increase in chronically homeless individuals since 2011. Stakeholders have indicated that a significant number of smaller provider programs in the SPA appear to need support on very basic levels to ensure they are maintaining nonprofit status and are running programs that meet community standards. A geographic focus in this area may be a better use of basic-level training resources than a broad-based community learning effort.

    b. Existing PSH providers are beginning to take more vulnerable and fragile people, and could use "next level" training to support the level of services those clients need. Corporation for Supportive Housing staff have noted that PSH projects vary widely in their retention levels and apparent levels of staff expertise, even among projects operated by the same agencies. Some of these issues may be addressed in the trainings Home For Good is establishing around the Standards of Excellence, but these will be broadly-focused trainings covering issues applicable to many different types of providers. Working closely with providers to seek out high performing building management and developing a training strategy around supporting highly vulnerable clients retain their housing would appear to be a natural evolution from the more basic provider trainings of the past.

c. Providers need to develop capacity to help their clients access health resources – particularly new resources available under the Affordable Care Act.

Recommendations Related to the Chronic Homeless Initiative Goals

Finally, the evaluation team recommends a formal revision to Initiative goals to reflect progress to date and additional progress needed.

1. Revise the PSH creation goal to increase the target beyond 4,000, specifically increasing the scattered site portion of the goal. Also redefine a new PSH unit as a unit that is brought online, tracking pipeline units to assess likelihood of achieving the goal rather than achievement of it. Only list units in the pipeline if funding has been secured for development (when relevant), housing operations or subsidy, and services.

2. Revise the financial leverage goal to reflect the funding needed to reach the PSH creation goal, assuming some level of provider match and a slightly higher proportion of public funding than in the current funding goals. Also consider the need for extensive renewal resources in future years. Make sure the goals are sustainable in light of the need for increasing renewal grant resources and targets to increase the PSH supply on top of that each year.

3. Revise the chronically homeless placement goal to increase the number of PSH placements to 2,000 chronically homeless individuals, focusing on the most vulnerable.

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 October 2013, the evaluation team will present results at a Hilton Foundation convening. Grantees and stakeholders will be asked to consider and discuss key findings and brainstorm suggested actions to advance the progress of the Initiative. Following the grantee convening, the evaluation team will meet individually with the Foundation-funded 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 the data collected for this evaluation that may help to identify barriers that will need to be mitigated to progress.

The evaluation team is also planning for the 2014 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. Grantees will be encouraged to recommend areas of evaluation that would be helpful to inform their work, and if feasible, the evaluation team will incorporate the grantee-identified data collection and research ideas into subsequent evaluation activity.

More rigorous evaluation methods will also be incorporated as more reliable data sources become available. For instance, the team will seek to measure PSH placement for chronically homeless

individuals from client-level HMIS data. The evaluation team will also continue to explore matching PSH placement data in HMIS with vulnerability registry or PIT count data to assess the extent to which priority populations are being placed in PSH. In addition, the team will work on linking HMIS data with County mainstream agency data to support subsequent analysis of service utilization, costs, and prioritization strategies.

Cumulatively, 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 2012 from Feeding America, where she was the Manager of Research. She brings experience housing and food security research and program evaluation experience. Previously, 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 from 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 and community-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. Terms and Acronyms

Acronym	Term
CCFO	Community Care Facilities Ordinance
CEO	Chief Executive Officer
CH	Chronic Homelessness
CES	Coordinated Entry System
CSH	Corporation for Supportive Housing
CTI	Critical Time Intervention
DHS	Department of Health Services
DMH	Department of Mental Health
DPH	Department of Public Health
DWC	Downtown Women's Center
ELP	Enterprise Linkage Project
FQHC	Federally Qualified Health Center
FUSE	Frequent Users Systems Engagement
HACLA	Housing Authority of the City of Los Angeles
HACoLA	Housing Authority of Los Angeles County
HMIS	Homeless Management Information System
HOPWA	Housing Opportunities for Persons with AIDS (HUD)
HPI	Homelessness Prevention Initiative (LA County)
HUD	US Department of Housing and Urban Development
IMHT	Integrated Mobile Health Teams
LA	Los Angeles
LACICH	Los Angeles County Interagency Council on Homelessness
LAHSA	Los Angeles Homeless Services Authority
MHSA	Mental Health Services Act
NIMBY	Not In My Backyard
PATH	People Assisting the Homeless
PHA	Public Housing Authority
PIT	Point-in-Time
PSH	Permanent Supportive Housing
RFP	Request for Proposals
RUSH	Rapid Universal Supportive Housing
SIF	Social Innovation Fund
SPA	Service Planning Area
SVHO-LA	Solving Veteran's Homelessness as One LA
SRO	Single-Room Occupancy
VA	Veterans Affairs - Greater Los Angeles Healthcare System
VASH	Veterans Affairs Supportive Housing
VI	Vulnerability Index

Appendix C. Related Reports

Abt Associates Inc. "Home For Good Funders Collaborative: Lessons Learned from Implementation and Year One Funding," Conrad N. Hilton Foundation, 2013. http://www.hiltonfoundation.org/images/stories/PriorityAreas/Homelessness/Downloads/Home%20For%20Good%20Funders%20Collaborative_Public_Final2013%2005%2010.pdf

Abt Associates Inc. "Evaluation of the Conrad N. Hilton Foundation Chronic Homelessness Initiative 2012 Report," Conrad N. Hilton Foundation, 2012. http://www.hiltonfoundation.org/images/stories/PriorityAreas/Homelessness/Downloads/homelessnessinitiative_abt_yearonerpt_finalpublic.pdf

Abt Associates Inc. "Los Angeles Homeless Data Assessment Report: Issues and Recommendations," The Los Angeles Homeless Funders Group, 2012. http://www.hiltonfoundation.org/images/stories/PriorityAreas/Homelessness/Downloads/LA_Homeless_Data_Needs_Assessment_Final_Report_5-1-12.pdf

Center on Budget and Policy Priorities. "Sequestration Could Deny Rental Assistance to 140,000 Low-Income Families," April 2, 2013. http://www.cbpp.org/files/4-2-13hous.pdf

Economic Roundtable. "Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients," 2013. http://www.economicrt.org/summaries/Getting_Home.html

Harder + Company. "Annual Evaluation Report: Downtown Women's Center Critical Time Intervention Project," Downtown Women's Center, 2012. http://www.dwcweb.org/communityresources/DWCAnnualReportYearOne.pdf

Los Angeles County Chief Executive Office. "Expanding Just In Reach Through Pay-for-Success," August 20, 2013. http://file.lacounty.gov/bc/q3_2013/cms1_198921.pdf

Los Angeles County Interdepartmental Council on Homelessness. "County Roadmap for Addressing Homelessness," 2012. http://zev.lacounty.gov/wp-content/uploads/roadmap.pdf

Appendix D. 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 Foundation 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 Foundation 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?