MOVING BEYOND STABILITY

Service Utilization and Client Trajectories in San Francisco's Permanent Supportive Housing

CITY AND COUNTY OF SAN FRANCISCO
OFFICE OF THE CONTROLLER
CITY SERVICES AUDITOR (CSA)

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CONTROLLER'S OFFICE
CITY SERVICES AUDITOR

The City Services Auditor was created within the Controller's Office through an amendment to the City Charter that was approved by voters in November 2003. Under Appendix F to the City Charter, the City Services Auditor has broad authority for:

- Reporting on the level and effectiveness of San Francisco's public services and benchmarking the city to other public agencies and jurisdictions.
- Conducting financial and performance audits of city departments, contractors, and functions to assess efficiency and effectiveness of processes and services.
- Operating a whistleblower hotline and website and investigating reports of waste, fraud, and abuse of city resources.
- Ensuring the financial integrity and improving the overall performance and efficiency of city government.

EXECUTIVE SUMMARY

Overview

The Human Services Agency (HSA) administers more than 3,800 units of permanent supportive housing for previously homeless individuals and families at a total General Fund cost exceeding $35 million in Fiscal Year 2012-2013 (FY12-13). HSA partnered with the Controller's Office City Services Auditor (Controller's Office) to identify the types of services clients in supportive housing sites utilize, the degree of utilization, how clients' needs may change over time while housed, and whether the services are supporting client transitions to other forms of stable housing.

For this report, the Controller's Office analyzed administrative data for all clients placed in supportive housing by HSA, surveyed more than 500 clients, interviewed 12 case managers, and examined case files for 85 clients who exited supportive housing during FY13-14. The review included buildings housing adults ("Adult") and those housing families or a mix of families and single adults ("Family/Mixed").

Findings

Supportive housing programs serve vulnerable populations requiring significant support. These programs are generally successful at stabilizing their clients and helping them to maintain their housing. However, HSA has not made self-sufficiency a priority in its program goals, and as such, certain gaps in linkage and services exist, leaving some clients unable or unwilling to transition to other forms of stable housing without support services attached. A lack of affordable options also plays a significant role in limiting these transitions.

Client Characteristics: Clients in HSA's Adult supportive housing sites are commonly male, African American or White, and between the ages of 45 and 64. Clients at Family/Mixed sites are more often female, African American and Latino, and ages 25 to 64.

Services Provided: Interviews and client surveys indicate that case managers engage with clients on a monthly basis, on average, though it is unclear whether interactions resulted in service delivery (e.g., a referral) or were more casual "check-ins." Client surveys indicate that "building events," such as food pantry and social hour, and "Medi-Cal" are the most common services clients receive or are referred to.

Case file reviews of exited clients showed a slightly different picture. Based on this source, the level of case manager engagement was most often light or minimal, with contacts commonly relating to income or rent stabilization needs, and many contacts occurring in writing only (e.g., a flyer or notice left on a client's door). Eviction proceedings may make it more difficult for a case manager to engage clients in services.

Service Gaps: Interviewed case managers highlighted the need for increased clinical support, with additional behavioral health and nursing services mentioned. Also, though all sites house older adults and seniors, their needs may not be adequately addressed. As one example, utilization of In-Home Supportive Services, at 9-12%, is lower than expected for this population.

Interviews and case file reviews indicate that case managers are less likely to offer services promoting self-sufficiency, such as education, employment and housing support, than crisis stabilization services. Some case managers noted that they spend much of their time managing client crises, with little to spare for more stable clients who may not actively reach out for support.

Public Benefit Utilization: Nearly a quarter of Adult clients receive income from County Adult Assistance Programs (CAAP), and over a quarter receive CalFresh benefits (food stamps). Of those Adults receiving CAAP, 45% (or nearly 300) receive Personally Assisted Employment Services benefits, meaning they have been identified as having employment potential by HSA. Family/Mixed clients have a significantly higher enrollment in Medi-Cal (47%) than Adult clients (15%), which is expected given that most Adult clients would not have been eligible prior to January 2014. Ten percent of Family/Mixed clients receive CalWORKs benefits, though this only accounts for adult recipients. When children under 18 are considered as well, 23% of all individuals at Family/Mixed sites are beneficiaries.

Health Care Utilization: Data from the Department of Public Health (DPH) indicates that supportive housing client utilization of urgent and emergency health services spiked immediately prior to being housed (e.g., during a period of homelessness) and declined during the years of housing. Client utilization and costs spiked again when a client exited housing.

Compared to homeless clients served by DPH in FY12-13, supportive housing clients are much less likely to use urgent and emergency services. Thirty six percent of housed HSA clients used urgent and emergency services while 67% of known homeless DPH clients used this type of health care.

Client Trajectories: Clients report positive experiences in supportive housing. Over two-thirds of surveyed clients report that support services are an important factor in their housing stability. The majority of respondents (72% of Adult respondents and 93% of Family/Mixed respondents) report that their life improved in at least one area during their stay in supportive housing.

While many clients may always need support services to stay housed, interviewed case managers suggest that at least 10% of clients have the potential to transition out of supportive housing. However, survey results indicate that the majority of clients do not plan to move in the next year: just 35% of Adult respondents and 20% of Family/Mixed respondents are "definitely" or "considering" moving to other housing.

Case managers noted a lack of affordable options as a major barrier for clients seeking alternate housing, as well as a difficult application process for subsidized units. Surveyed clients reported a median monthly income of $779 (Family/Mixed) to $882 (Adult). Over half of clients receive Supplemental Security Income (SSI) - an income support for aged, blind and disabled individuals - and are thus unlikely to reenter the labor force. Given these factors, most clients will not be able to afford market rate housing.

Reasons for Client Exits, FY12-13

Reason for Exit	Adult (n=489)	Family/Mixed (n=33)
Evicted or Received Notice of Eviction	23%	12%
Moved to Other Housing (type unknown)	20%	0%
Other	17%	0%
Died	15%	9%
Moved in with Family or Friends	10%	6%
Moved for Unknown Reasons	8%	9%
Moved to Non-Subsidized Housing	5%	6%
Moved to Other Subsidized Housing	3%	58%

Length of Stay and Client Exits: Nearly half of clients at Adult sites (47%) and 60% of those at Family/Mixed sites have lived at their current building for more than five years.

During FY12-13, 489 Adult clients (13%) and 33 Family/Mixed clients (6%) exited housing. Administrative data identifies the majority of exits as "stable,"[1] but the case file reviews provide additional context, showing that the actual outcomes for many clients was unknown, and case managers may have limited engagement with exiting clients. Of 71 case files reviewed from Adult sites, 27 (38%) had no documented referrals in the year prior to exit, and 40 (58%) had no documented referrals in the final quarter of housing. At Family/Mixed sites, 29% received no referrals in the final quarter of housing.

1 HSA defines a stable exit as one in which the client was not evicted and did not owe back rent.

Recommendations

The Controller's Office noted significant benefits of HSA's permanent supportive housing program. Housing retention is greater than 90% and is a testament to the work case managers do to support their clients. The recommendations offered in this report are intended to enhance this strong and established program through directional shifts, improved guidance and expectations, and further exploration of client needs. The Controller's Office also recommends HSA establish a working group of program staff and community providers to consider the implications of this report and create an implementation plan for the recommendations.

1.0 – Service Provision

1.1 Strategically Deploy Services. HSA should ensure that clients have the services they need at the time they need them by strategically deploying services throughout the supportive housing population. HSA should develop a system of roving services that can fill both clinical and self-sufficiency service gaps. For example, it may not be appropriate to conduct broad outreach about employment opportunities at every building, particularly as some buildings may house a majority of senior or disabled clients who are unable to work. Instead, roving teams can target services toward relevant populations, providing deeper levels of support than the on-site case manager may be capable of.

1.2 Address Self-Sufficiency Service Gaps. HSA should work with its providers to broadly assess the level of need among its clients in certain service areas (namely, education and employment, housing, seniors, and parenting) and explore ways to leverage existing resources to fill service gaps. Roving services, as recommended in 1.1 above, may be particularly effective. For example, a roving housing specialist could support clients capable of transitioning in learning about and applying for new housing opportunities.

1.3 Address Clinical Service Gaps. HSA should enhance the clinical support provided at its housing sites. Options may include expanding the use of the Behavioral Health Roving Team and instituting roving nursing services. The Behavioral Health Roving Team has been successful at providing short-term clinical support to clients in crisis, but is only available for certain buildings. Roving nurses may be able to offer more preventative care to clients who experience difficulty navigating the health care system.

2.0 – Service Quality and Effectiveness

2.1 Strengthen Service Expectations. HSA should clarify and strengthen its expectations about service delivery, and in particular, regarding outreach to clients and eviction-related services. For example, case managers are required to conduct outreach at signs of instability, but such outreach often takes the form of written notices. This is insufficient. HSA should provide additional guidance about these expectations to all service providers to ensure clients receive the necessary support.

2.2 Strengthen Documentation Expectations. HSA should clarify and strengthen its expectations about documentation of services. In particular, HSA should explore requiring a referral log in client case files to track referrals and outcomes. Also, HSA should clarify how to document resistance to services. For example, HSA should clarify and enforce a standard wherein case notes indicate actions the case manager takes to engage the client, any resistance encountered, and how the case manager attempted to counter that resistance.

2.3 Conduct Program Effectiveness Audits. HSA currently audits case files to assess compliance with service delivery standards. HSA should expand its site reviews to assess client outcomes as documented in referral logs.

3.0 – Program Administration

3.1 Create a Housing System Database. HSA should establish a housing system database to track clients and program outcomes. An existing database might be expanded to serve this function. At a minimum, HSA should create more uniform data tracking standards among its providers, such

as complete social security numbers, dates of birth, etc. HSA should also standardize and expand the "exit reasons" it uses to track client stability. Though most exits qualify as "stable," the actual destination of many of those clients is unknown to the provider, and this detail is important to understanding programmatic outcomes.

3.2 Minimize CAAP Discontinuances. Clients who receive CAAP benefits must verify their income annually, with benefits discontinued if an individual fails to complete the necessary paperwork, even if that person is still eligible. HSA should take a proactive approach to minimizing CAAP discontinuances given how destabilizing such occurrences are for clients.

4.0 – Program Goals

4.1 Reframe Goals to Include Self-Sufficiency. HSA should consider changing the overarching goal of the housing program from stability alone to stability and self-sufficiency. It is important to point out that the definition of self-sufficiency may vary by client. It would be unrealistic to assume that all, or even most, clients will be able to completely transition off of public benefits. Many may require various types of long-term support, such as Medi-Cal, nutritional assistance, or temporary or permanent subsidies. Despite this variation, HSA should make every effort to increase self-sufficiency to the degree possible for each client. Adding self-sufficiency to program goals potentially saves public funds by encouraging tenants who do not need support services to move to units without this extra cost. By encouraging these moves, supportive housing units can be made available for homeless residents needing housing and services. Additionally, building self-sufficiency improves client quality of life.

4.2 Explore Policies to Support a Full Spectrum of Housing Options. HSA, in partnership with other local agencies, such as the Mayor's Office of Housing and Community Development and the San Francisco Housing Authority, should explore policies and proposals to fill gaps in the current array of housing options. A functioning housing system is one with a diversity of options allowing each individual to be matched with the appropriate level of support s/he needs to achieve stability. Each individual's complex circumstances determine his or her placement on the spectrum of housing. San Francisco has several key gaps to be filled, including subsidized housing that would allow supportive housing clients with higher levels of self-sufficiency to live without on-site support services. Filling such gaps in the housing spectrum will require citywide and regional solutions.

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**Appendices posted separately. View online at:* http://openbook.sfgov.org/webreports/details3.aspx?id=1854

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INTRODUCTION AND BACKGROUND

As the cost of market rate housing continues to rise in San Francisco, city government services provide a safety net for our most vulnerable residents. As an integral part of this safety net, the San Francisco Human Services Agency (HSA) provides permanent supportive housing to homeless residents of San Francisco.

HSA administers more than 3,800 units of permanent supportive housing[1] for previously homeless individuals and families at a total General Fund cost exceeding $35 million in Fiscal Year 2012-2013 (FY12-13).

Permanent Supportive Housing

Links homeless individuals and families with:

- **A permanent home** – tenants have a lease and all associated protections
- **Rental subsidies** – rents may be a fixed amount or a percentage of income
- **On-site social services** tailored to the needs of clients

The number of units administered by HSA has increased dramatically in recent years, with 3,000 units of new housing brought online since the implementation of the city's *10-Year Plan to End Homelessness* began in 2004. While HSA has been diligent in its efforts to secure new housing, little local data exists to illustrate the effectiveness of the support services offered at HSA sites.

To address this gap, HSA partnered with the Controller's Office City Services Auditor (Controller's Office) to conduct research about permanent supportive housing funded by HSA in San Francisco. The research aims to identify the types of services clients in supportive housing sites utilize, the degree of utilization, how clients' needs may change over time while housed, and whether the services are supporting clients to transition to other forms of stable housing.

SUPPORTIVE HOUSING IN SAN FRANCISCO

HSA has a broad portfolio of 52 permanent supportive housing sites with on-site services provided by nonprofit organizations. HSA administers these programs using a variety of funding models.[2]

- **Master Lease Program:** HSA leases Single Room Occupancy (SRO) buildings and contracts with nonprofits to provide property management and supportive services. Some buildings are funded through Care Not Cash, the 2004 initiative that transfers some of the city's cash assistance to homeless single adults to investments in supportive housing for this population.
- **Shelter+Care Program:** Shelter+Care is a federal program that provides rental assistance to chronically homeless single adults and families with disabilities related to severe mental health, substance abuse, and disabling HIV/AIDS. The city's General Fund pays for support services.
- **Local Operating Subsidy Program:** The Mayor's Office of Housing finances new developments that are owned by nonprofit organizations. HSA controls tenant referrals to each site and provides both an operating subsidy and funding for support services. The portfolio includes units for homeless single adults, families, seniors and veterans.
- **Services Only:** HSA funds supportive services at certain long-standing sites, but does not control referrals or placement at those sites.

[1] Includes locally and federally funded programs

[2] See Appendix A for a detailed list of the current housing portfolio.

Housing First

HSA employs the "Housing First" model in its programming. This policy emphasizes immediate placement of an individual in permanent housing coupled with the on-site support needed to stabilize that individual. The model understands that a homeless individual or family's first and primary need is housing. After housing has been obtained, factors that often contribute to homelessness, such as substance abuse and mental illness, can be addressed. Housing First differs from housing programs that require residents to be "housing ready," meaning participants in HSA's programs have clients varying levels of need. Core principles of Housing First include:

- On-site services, with continuous engagement and outreach by case managers
- Voluntary services, with no service participation requirements as a condition of housing
- Focus on skill building through tenancy, e.g., being a good tenant promotes skill development in financial management, conflict resolution, etc.
- Eviction as a last resort

HSA's Tier System

Beginning in FY14-15, HSA has adopted a Tier system for contracting with supportive housing providers. Buildings are categorized into tiers based on eligibility requirements. HSA funds higher levels of case management support at buildings where HSA places clients and those with eligibility requirements mandating they serve individuals with high needs (e.g., chronically homeless with a certified disability).[3]

For example, HSA funds Tier I sites to provide one case manager for every 75 clients at Adult sites, while Tier V sites (the highest tier) must provide one case manager for every 25 clients. In addition to increased support levels, service expectations and reporting requirements also increase through the tiers, with Tier V programs required to create service plans, provide navigation assistance to clients, perform regular outreach, and report on all of these activities in detail.

HSA has established a multi-year implementation period to allow providers time to adjust their service levels at each building to the established guidelines, with full implementation of the Tier system expected by the end of FY17-18.

METHODOLOGY

HSA requested the Controller's Office explore a variety of topics through this project to determine:

- The types of services offered, sought and utilized by supportive housing clients
- How client needs change over time: before, during and transitioning out of supportive housing
- The level of public benefit utilization by clients
- Whether clients are transitioning to other stable housing, and what factors contribute to these transitions

The Controller's Office developed a mixed-method research design to encompass the range of topic areas. To begin, the Controller's Office created a randomly-selected sample pool of buildings where more targeted

[3] The Tier system was not in place at the time of this study, and so results could not be categorized by tier. However, the Tier system represents ongoing efforts by HSA to more clearly define service levels and expectations of providers.

research activities could occur. The sample included 13 sites: nine sites housing adults only ("Adult") and four housing either families only or a mix of families and adults ("Family/Mixed"). [4]

After developing the sample, the Controller's Office conducted its research in four parts (with the sample pool used in the first three):

1. **Case Manager Interviews:** interviews with 12 case managers, as well as a pre-interview survey to capture quantitative information (e.g., size of caseload, number of years in the field, etc.)
2. **Client Surveys:** paper surveys administered at 13 buildings, with over 500 respondents
3. **Case File Reviews:** examination of 85 case files of clients who exited the 13 sampled buildings between July 1, 2013 and April 30, 2014 (excluding deaths)
4. **Benefits Data Analysis**: analysis of administrative data related to supportive housing clients' utilization of public benefits (e.g. CalWORKs, Cal Fresh, etc.) and utilization of Department of Public Health services.

Each figure in this report indicates the source of the data, referenced in the following ways:

- Case Manager Interviews = "interviews"
- Client Surveys = "surveys"
- Case File Reviews = "case files"
- Benefits Data Analysis = "client data"

CLIENT CHARACTERISTICS

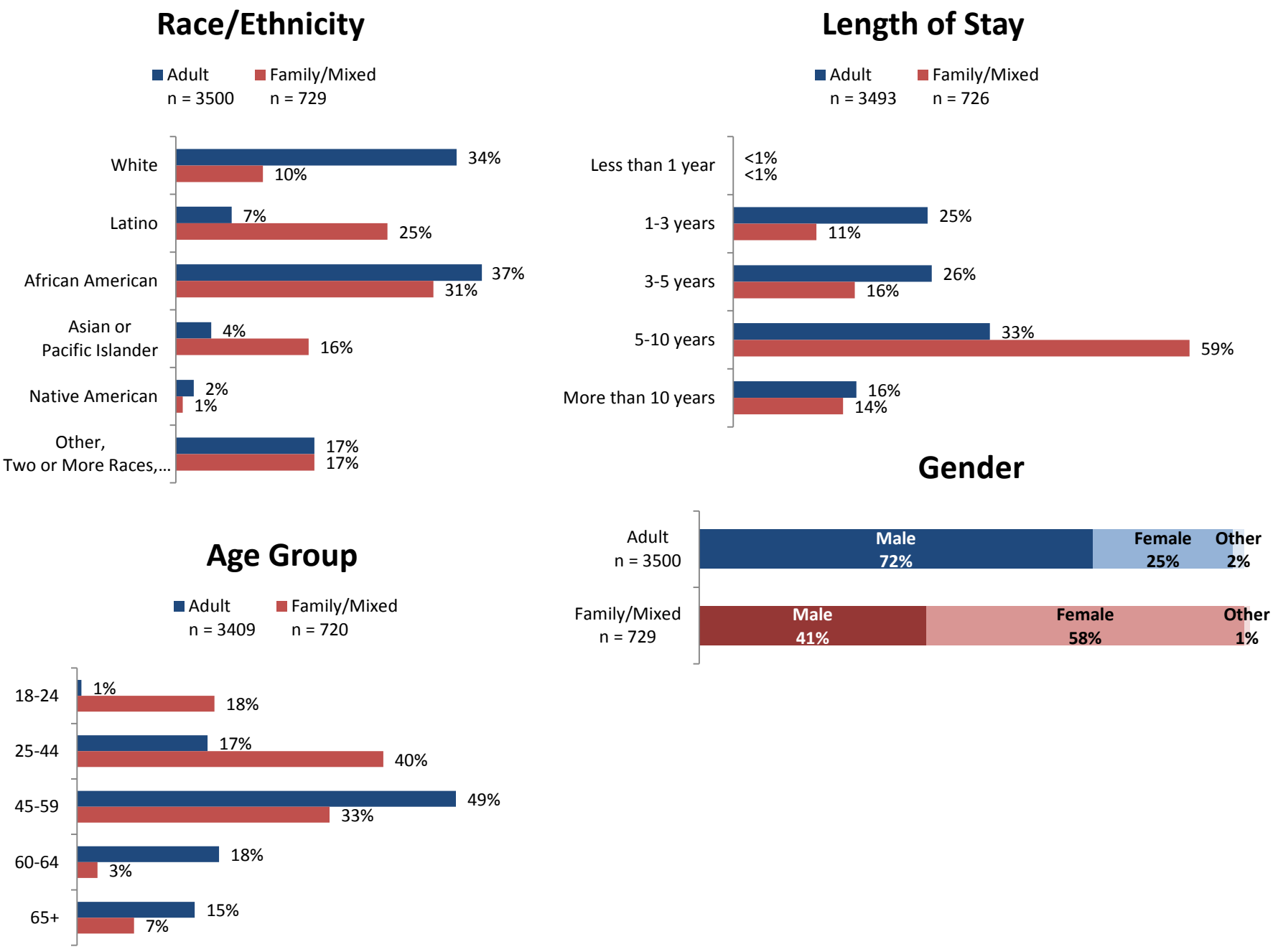
The Controller's Office received administrative data for 3,696 clients at Adult sites and 533 adult clients at Family/Mixed sites. Clients in HSA's Adult supportive housing sites are generally male, African American or White, and between the ages of 45 and 64. Clients at Family/Mixed sites are more often female, African American and Latino, and ages 25 to 64.

Nearly half of clients at Adult sites (47%) and 60% of those at Family/Mixed sites have lived at their current building for more than five years.[5] During the snapshot year (FY12-13), 13% of clients at Adult sites vacated their unit, while just 7% of Family/Mixed site clients exited housing. HSA considered the majority of exits (77% of Adult exits and 88% of Family/Mixed exits) stable (i.e., not evicted, not owing rent). Just 3% of all Adult clients and less than 1% of all Family/Mixed clients were evicted during the year. Figure 1 provides additional detail about these client demographics and exit types.

[4] Additional detail about the creation of a sample for this project, methodologies for each project phase, and detailed limitations for each phase has been included as Appendix B. Tools used in each phase, as well as full results from the phases are included in subsequent appendices.

[5] Length of stay data reflects duration at the current building of residence. Buildings may have housed tenants before HSA began conducting placement for its permanent supportive housing programs. Other buildings may have been "rented up" with new HSA-placed clients. The average length of stay presented here encompasses both scenarios.

FIGURE 1: SUPPORTIVE HOUSING CLIENT CHARACTERISTICS (SOURCE: CLIENT DATA)



Matched administrative data shows that 21% of clients at Adult sites receive income from County Adult Assistance Programs (CAAP),[6] while at Family/Mixed sites, 4% receive CAAP and 10% receive CalWORKs benefits.

HSA was unable to match administrative data to show federal benefits such as Supplemental Security Income (SSI) or private income from paid work. To address these limitations, the Controller's Office used the client survey to get a more detailed picture of income levels at housing sites. Survey respondents in Adult housing report a median monthly income of $882, and respondents in Family/Mixed housing report a 9% lower median monthly income of $779.[7] At this income level, most supportive housing residents could not afford market rate housing in San Francisco.[8]

Figure 2 illustrates the range of income sources among clients based on the client survey, with SSI as the most common source of income cited by respondents (58%). To put the data in context, survey respondents reported a higher utilization of CAAP income than the general population (33% compared to the 21% seen in the administrative data for Adult sites). Given this over-sampling of CAAP recipients, it is possible the survey represents an *under*-sampling of SSI recipients.

The higher median income reported from respondents at Adult sites could be linked to the type of income most commonly received in each site. SSI benefits average approximately $900 per month, while CAAP benefits can be as low as $42 per month, but generally average approximately $400 per month.

Respondents from Family/Mixed sites are much more likely to report having a paid job, with 23% indicating paid work as a source of income. Just 6% of Adult respondents listed a paid job as an income source. Some respondents may receive multiple types of income, such as paid work and CalWORKs. More respondents at Family/Mixed sites reported multiple sources of income, with 15% reporting two sources, and 2% reporting three sources. Nine percent of Adult respondents reported two income sources.

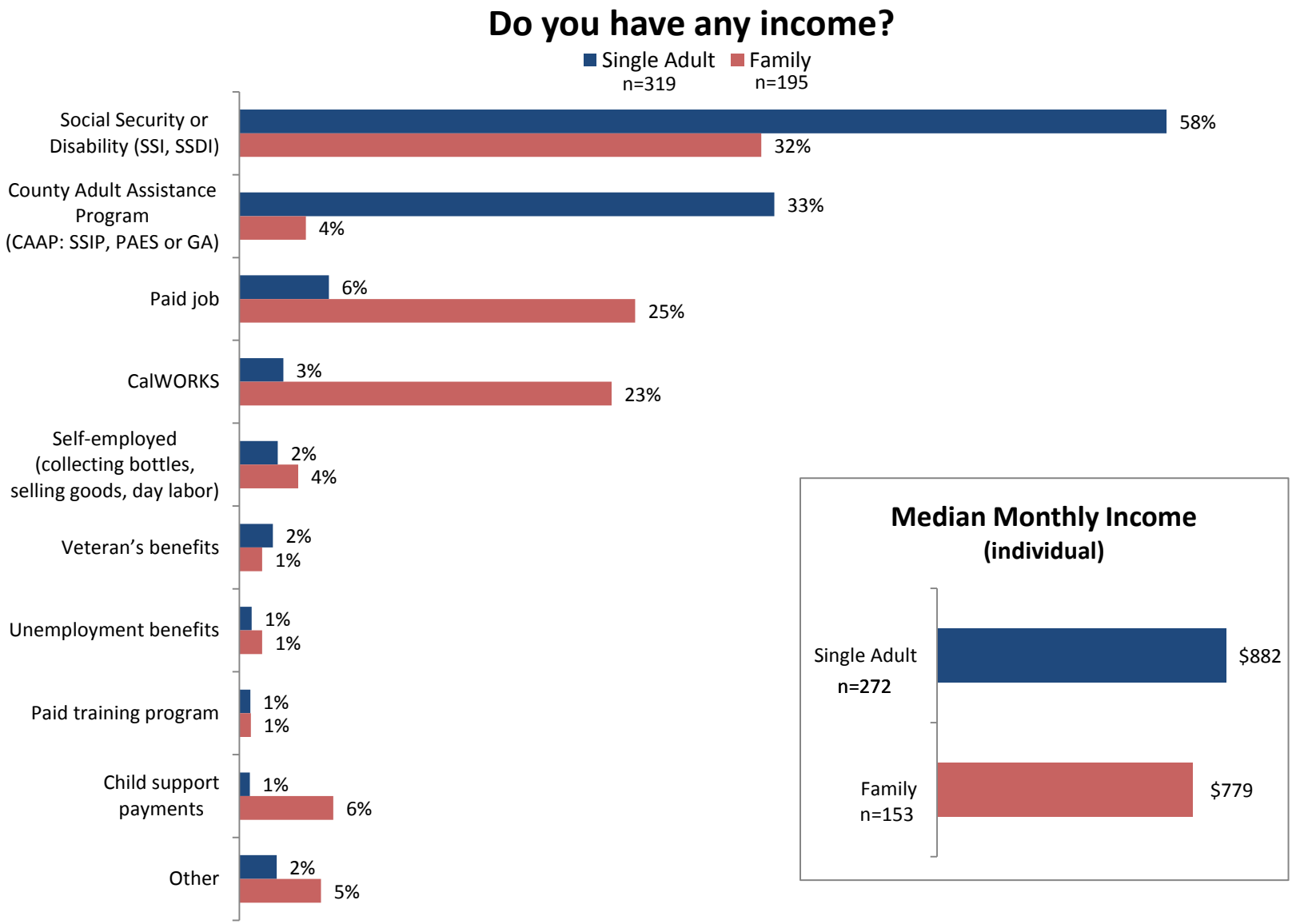
Though 13% of Adult site respondents indicated that they are a veteran, just 2% also indicated that they receive veteran's benefits as a source of income. At Family/Mixed sites, 5% of respondents reported veteran status, while 1% reported veteran's benefits. While there are reasons that a veteran may or may not receive financial benefits, this could be an area of increased outreach and linkage for service providers and HSA.

[6] There are four CAAP subprograms: General Assistance (GA), 30% of Adults on CAAP; Personally Assisted Employment Services (PAES), a "welfare to work" program, 45% of Adults on CAAP; Cash Assistance Linked to Medi-Cal (CALM), 2 clients; and Supplemental Security Income Pending (SSIP), a temporary program for individuals in process of applying to SSI, 25% of Adults on CAAP.

[7] It is important to note that respondents were asked to report their individual income, not household income. Household income may be higher for family/mixed respondents, though other sources indicate that most households have a single income source.

[8] The average asking rent in San Francisco was $3,057 in the first quarter of 2014, according to RealFacts data as reported in the Controller's Economic Barometer.

FIGURE 2: SELF-REPORTED CLIENT INCOME SOURCES AND AMOUNT (SOURCE: SURVEYS)[9]



[9] Both charts in Figure 2 are based on client self-reports, which may differ from the administrative data about client benefits discussed elsewhere.

CASE MANAGEMENT SUPPORT AND SERVICE UTILIZATION

SERVICES OFFERED

The core service offered at permanent supportive housing sites is case management. Additionally, service providers offer a variety of other services to clients both on- and off-site. Figure 3 lists the common on-site support services, per interviews and surveys of selected case managers. In general, the on-site services at Adult sites are consistent across the sample, including at Family/Mixed sites. However, some Family/Mixed sites also offer additional programing unique to this setting, listed separately below. Some agencies have broader programming, and offer extensive off-site services available to all clients. These services vary by agency and are not available to clients at all buildings.

FIGURE 3: SUPPORT SERVICES AVAILABLE TO CLIENTS (SOURCE: INTERVIEWS)

ON-SITE SUPPORT SERVICES: Adult and Family/Mixed Sites	
Services Most Commonly[10] Utilized by Tenants:	*Additional Services Offered:*
• Service Referrals • Basic Needs: clothing, household goods • Benefits Advocacy (e.g., income or subsidy) • Appointment Management • Food Pantry or Meals (on-site or off-site) • Eviction Prevention Advocacy and Counseling • Therapeutic Listening and Conflict Resolution • Transportation (tokens) • Money Management (payee services)	• Accompaniment to Appointments • Community Events: coffee hour, bingo • Application Support: jobs, housing, IHSS, rental assistance, other • Support Groups: psycho-social, educational • Life Skills Training (cooking shopping, budgeting) • Property Management (1 agency) • Psychotherapy (1 agency)
ON-SITE SUPPORT SERVICES: Family/Mixed Only *(mentioned by at least 1 provider)*	
• Student Nurse Visitation • Teen Programs: youth leadership, etc. • Youth Programs: field trips, mentoring, tutoring	• Tenant Council • Job Readiness Training • Parenting groups and courses
OFF-SITE SUPPORT SERVICES *(mentioned by at least 1 provider)*	
• Housing Counseling • Socialization and Support Groups • Harm Reduction Classes • Adult Education: culinary training, art workshops	• Targeted Services: Seniors, Disabled Adults, HIV Advocacy, Immigration • Community Events and Recreation Tickets • Child Care Referrals

[10] According to case managers interviewed, services least commonly utilized by clients include 1) substance abuse treatment services, 2) mental health services and therapy, and 3) "services that pry into personal details."

Services for Families

Four sites in the sample serve families, either solely or in combination with units for adults without children (i.e., "mixed"). Services for adults at Family/Mixed sites are consistent with those offered at Adult sites. However, three of the four Family/Mixed sites visited also have well-developed children's and youth programming coordinated by a separate staff member.[11] Social events at these sites are often geared toward building family connections, such as a monthly breakfast at one site and a monthly dinner at another.

According to case managers at these sites, serving families is a complex process and presents unique challenges. Case managers must tailor services to the needs of an individual, but also ensure that the needs of the whole family are addressed. For example, one parent may want individual and family counseling, but the other parent may be resistant.

Two case managers noted that, occasionally, parental behaviors may negatively influence children and be counterproductive to the work case managers and other providers do with those children. This makes parenting courses an important element of Family/Mixed site programming, as well as positive modeling by staff members.

Services for Seniors

Residents aged 65 and older represented 17% of the total Adult housing population and 5% of the Family/Mixed housing population in FY12-13. HSA funds two supportive housing sites specific to seniors, which house 123 residents age 65 and older (3% of the Adult housing population).[12] The sample used in this study does not include any sites specific to seniors. Despite this, all sites house older and aging clients. The majority of tenants at Adult sites are ages 45 to 64, and given the average length of stay of five or more years, many of these tenants will be aging in their current homes.

When asked if their sites had sufficient services to support clients aging in place, only three of the 12 case managers provided a clear affirmative, two of them at Family/Mixed sites. The majority (five) equivocated, noting that In Home Support Services (IHSS) may come to the site and support clients, but case managers themselves do not have the time or expertise to provide senior-specific services. Four case managers expressed significant concern for older tenants.

Case managers may have a mix of both service and environmental concerns for this population. Some mentioned that the buildings themselves were not set up to support older or disabled clients (e.g., an elevator frequently out of service), while others seemed concerned about issues such as isolation and inability to connect seniors to the right type of care. From the interviews alone, it is unclear why the case managers interviewed at Family/Mixed sites had more positive reactions about the ability of the site to address the needs of its older clients than the case managers from Adult sites. It is possible that seniors in Family/Mixed sites are more likely to live with family members or caregivers, while those in Adult sites generally live alone.

Senior housing is limited, and many clients prefer to stay in their existing homes. Given the responses of interviewed case managers, more attention should be paid to this aging population.

[11] The youth program at the fourth site had been canceled recently due to lack of funding.
[12] Buildings have varying ages to qualify for senior housing, and tenants at some sites may qualify at age 60 or 62.

SERVICES UTILIZED

All services are voluntary. Clients may or may not seek the support of a case manager, and service utilization varies widely.

The Controller's Office used data from the case manager interviews, the client surveys, and the case file reviews to determine the types of services that clients utilize. There are certain limitations to this analysis that should be recognized. The Controller's Office only reviewed case file for clients who exited their supportive housing site between July 2013 and April 2014. Given the broad range of experiences of the clients whose charts were reviewed, it is likely that this population is generally consistent with the population of supportive housing residents as a whole. However, it is possible that these clients had certain characteristic differences that would impact the type of work case managers do with those clients, and the resulting documentation in case files of that work (e.g., if only those most stable and most unstable clients exit, then "middle of the road" clients would not be included in this review). For these reasons, we may make some high level generalizations about clients and the role of case management based on the review of charts, but they should be tempered with the understanding that the generalizations may not apply to all clients.

Client-Reported Utilization

The client survey asked respondents to indicate which types of services they have received or been referred to while living in their current building. Figure 4 presents the number of services received by or referred to respondents. Most clients (93% at Adult sites, 96% at Family/Mixed sites) received or were referred to at least one service. On average, respondents received or were referred to 4.3 services while living in their current building. It is likely that supportive housing providers were not responsible for all of these services and referrals. Clients may have been connected to a service before they moved into the building, or may have been referred to the service by a different case manager.[13]

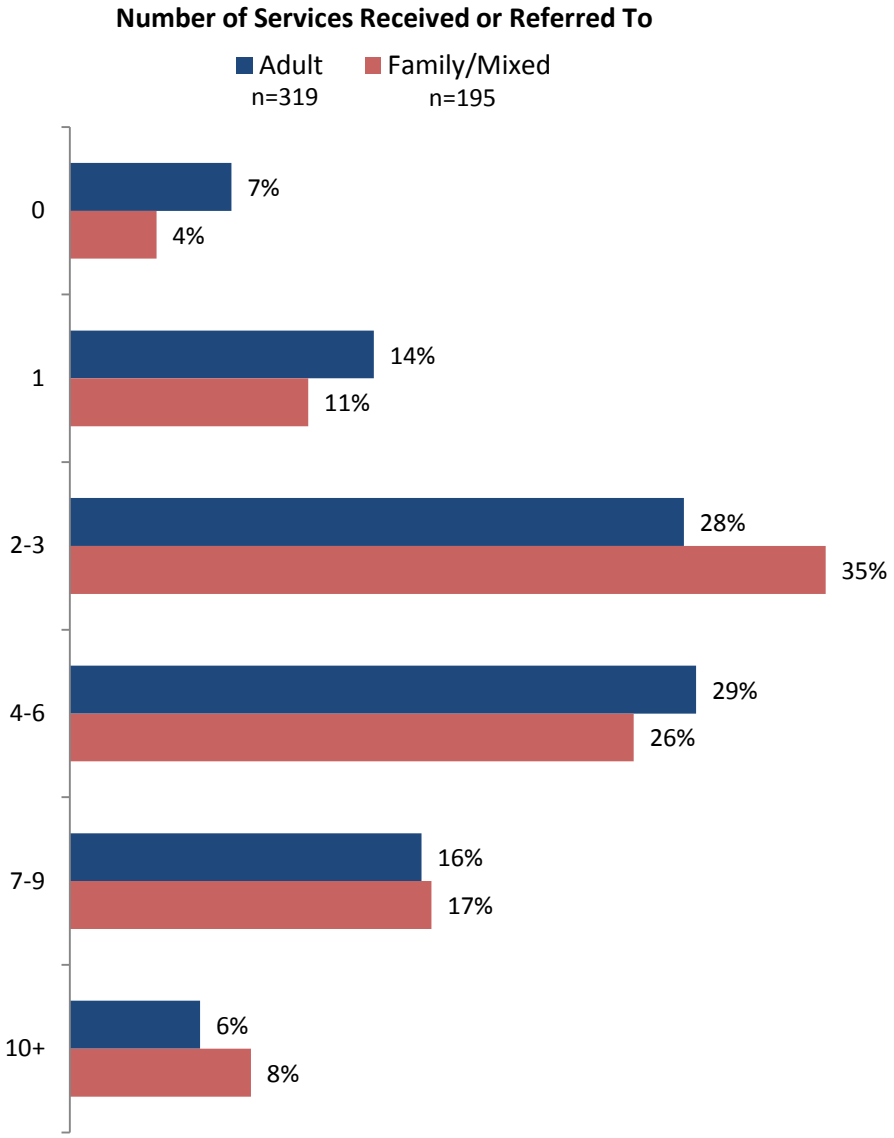
Figure 4 also shows the types of services respondents were referred to or received (darker shades of color represent more commonly received services). The top two service areas for both Adult and Family/Mixed respondents were "Medi-Cal"[14] and "building events," which are typically social gatherings such as coffee hour.

Engagement in employment services is relatively low for respondents, but Family/Mixed respondents are more likely to receive or be referred to these services. Twenty-two percent of Family/Mixed respondents engaged in or were referred to a job training program, compared to only 10% of Adult respondents. In addition, 13% of Family/Mixed respondents received or were referred to job placement services, compared to only 3% of Adult respondents. It is unclear whether the lower service rates occur because clients have too many barriers to engage in employment, or if case managers simply do not focus on these referrals.

[13] According to the survey, 33% of Adult respondents and 19% of Family/Mixed respondents report having other case managers in addition to the case manager at their supportive housing building.

[14] Surveys were administered during March through May 2014. Referrals to Medi-Cal may have increased significantly in the months prior due to the Affordable Care Act's Medicaid expansion and related outreach efforts.

FIGURE 4: CLIENT-REPORTED SERVICE UTILIZATION (SOURCE: SURVEYS)



Percent Receiving or Referred To Each Service

	Adult	Family /Mixed
Public Benefits		
CAAP: GA, PAES, SSIP	32%	5%
Social Security (SSI)	32%	17%
Food Stamps (CalFresh)	25%	30%
Disability Benefits (SSDI)	15%	7%
CalWORKS	4%	15%
Employment and Education		
Job training program	10%	22%
Employment resources (EDD)	8%	10%
GED or diploma program	7%	13%
Job placement	3%	13%
Other education or training program	10%	15%
Children and Family		
Child support services	2%	9%
Child welfare	1%	5%
Child care resources	1%	9%
Housing		
Rental assistance	23%	23%
Eviction prevention/Legal services	11%	8%
Property management	8%	13%
Section 8 application assistance	8%	28%
Other housing applications	18%	11%
Health		
Medi-Cal	48%	37%
Healthy San Francisco	28%	20%
Medical care	15%	10%
Mental health care	13%	15%
In-Home Supportive Services	11%	14%
Dental care	9%	17%
Substance abuse	8%	6%
Other Insurance	4%	4%
Other Services		
Building events	36%	42%
Referral to community resources	19%	20%
Other on-site services	15%	22%

Frequency of Service Delivery

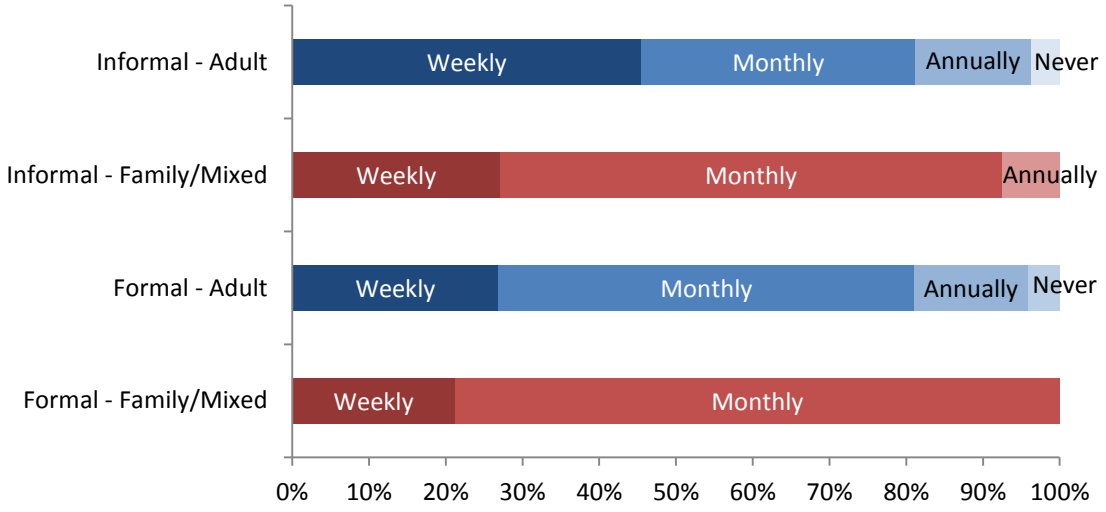
Case managers and clients report regular interactions, but the case file reviews indicate these interactions may be primarily informal in nature, with little formal linkage or referral occurring to support client self-sufficiency (particularly in the cases of clients exiting housing).

HSA requires sites to provide initial outreach to new clients within one month of move-in, but agencies differ in further standards for client interaction. All but three of the case managers interviewed (75%) indicated that their agencies have standards for client interaction. These standards range from requiring one outreach upon move-in and again within 90 days to three outreach attempts per client per month. The most common standard is one contact or outreach attempt per client per month.[15]

In the pre-interview survey, case managers estimated how frequently they interact with clients, both formally and informally. Formal interactions include planned case management sessions or support group sessions. Informal interactions include on-site social events (e.g., a weekly coffee hour) or other gatherings of tenants (e.g., monthly food pantry).

As Figure 5 shows, the case managers interviewed reported seeing over 85% of their clients formally at least once a month, with 25% of their caseloads receiving formal interactions on a weekly basis. The Family/Mixed case managers interviewed report formal interactions with clients more regularly than the case managers at Adult sites.[16] Figure 5 represents an average of the responses, and it is possible that the range of interactions across all sites differs from what is presented here.

FIGURE 5: PERCENT OF CASELOAD SEEN FORMALLY AND INFORMALLY (SOURCE: INTERVIEWS)



[15] The new Tier system will create new standards for outreach: three in the first 60 days and again at any sign of instability or when property management issues a written warning.

[16] It is important to highlight the range of responses. While one case manager may see 100% of clients formally each month, another may see only 25% on a monthly basis. Given the difference between these figures and the level of service documented in client charts (discussed below), it may be relevant to consider whether program/agency requirements influenced case managers' responses to these inquiries (e.g., inflating their monthly engagement levels to match programmatic expectations).

Of the case managers interviewed, those at Adult sites were more likely to have clients that they never see, whether formally or informally. Though HSA requires case managers to outreach to new residents at least once, the client can refuse service. Also, some tenants have lived in their current building for years, perhaps longer than the building has had supportive services attached to it. One case manager noted that these long-standing clients often refuse services.

In general, client surveys support the frequencies reported by case managers. A majority of survey respondents (88% of Adult respondents and 82% of Family/Mixed respondents) indicate they see their on-site case manager at least monthly, though it is unknown what proportion of these interactions are formal meetings inclusive of referral and delivery of supportive services and what proportion are informal social gatherings or hallway discussions. Conversely, at least one in ten survey respondents indicate they see their case manager only yearly or never. This statistic may even be an underestimate, since disengaged clients are less likely to complete a survey than clients engaged in services.

Case Manager Engagement

Case file reviews present a more varied picture of the level of engagement by both case managers and clients. The following assessment is subjective, and the population represented differs from those surveyed. The Controller's Office reviewed the case files of clients who exited in the prior year to determine the level of involvement the case managers had in the outcomes of these clients, creating the following categories to classify case manager engagement with those exiting clients.[17]

- **Active:** Case file indicates that the case manager made referrals and had both casual and formal contact with the client, including navigation support and advocacy activities relating to topics beyond housing retention.
- **Light:** Case file indicates that the case manager checked in with the client occasionally, and may have made one or more basic referrals without significant follow-up, such as for household goods at the request of the client. Light contact may also indicate all contacts related to non-payment of rent, such as reminders to pay and written offers of support, without significant in-person contact providing other types of services or referrals.
- **Minimal/None:** Case files indicate that all contacts with the client were in written form, such as putting a monthly activity calendar in the client's mailbox or leaving written notices about rent issues for the client. May indicate the client was resistant to services and refused to engage with case managers. May also indicate no contacts with a client.

FIGURE 6: ASSESSMENT OF CASE MANAGER ACTIVITY (SOURCE: CASE FILES)

Level of Engagement	Adult Clients	Family/Mixed Clients
Active	21	6
Light	32	4
Minimal/None	18	4
Total	71	14

As noted above, case management services are voluntary. Clients may refuse to meet with a case manager and may also refuse to address emergent needs.

[17] Exiting clients may differ from those who remain in housing, and as such, the level of engagement of the case manager may also differ.

Case managers provided active levels of service in 30% of Adult cases and 43% of Family/Mixed cases. Several charts from Family/Mixed sites refer to "required monthly meetings." All services are voluntary, and it is unclear how such meetings were framed with clients, but it is possible that the expectation of regular meetings contributed to the higher levels of active engagement than seen in Adult case files. Both Adult and Family/Mixed files reveal a similar percentage of cases with minimal or no engagement.

A primary role for case managers is navigation support. Several clients had complex health needs requiring regular medical appointments with a variety of providers. Case notes showed that case managers kept lists of upcoming appointments to remind the client of when they would occur, assisted the client with faxing or mailing paperwork to providers, and attended appointments with the client when needed.

At times, a client's behavioral health challenges interfered with his or her participation in services. There were several instances when a case manager interceded on behalf of the client, as in one case when the case manager called a clinic the client had been banned from for his behavior and requested he be allowed back for treatment with accompaniment by that case manager. In another case, the client had many altercations with other tenants. The case manager referred the client to the Behavioral Health Roving Team[18] for support with mental health and substance abuse, and later indicated that the client's behavior improved from receiving this support.

Despite these examples of active engagement, the majority of case management services were light or minimal. Over a quarter of the clients that exited Adult sites received minimal to no case management services, including those eventually evicted, based on the documentation in the files. Contacts most commonly related to property management and rent payment issues, such as reminders about back-rent, lease violation follow-up letters, or CAAP discontinuances that put the lease in jeopardy. There were numerous files in which all client contacts dealt with these topics and no other client issues. There were also numerous files in which all of these contacts took the form of written notices. For clients facing many challenges, the scope of the case management, according to the case files, seemed quite limited.

One limitation to this analysis is the Controller's Office's inability to discern the reason for minimal documentation. It may be the result of a) client resistance to case manager engagement, b) a lack of case manager engagement, or c) poor documentation of the engagement that occurred or was attempted. There does not appear to be a correlation between active case management and type of exit (e.g., evictions versus other stable exits). Better documentation would help illuminate whether this is true, and if so, why.

Barriers to Service Utilization

When the Controller's Office questioned case managers about the barriers clients face that may keep them from utilizing the supportive services offered at the site, a few key themes arose.

Clients with extremely high needs, such as those with co-occurring conditions (e.g., mental health and substance abuse or physical disabilities), are less able and/or willing to take advantage of services offered to them. Clients with this level of need experience frequent crises related to their health, their mental health, their housing status, or other life events. Several case managers noted that clients will seek services during such a crisis, but once marginally stabilized, they experience difficulty following through with the service plan to reach a full solution.

[18] Discussed in more detail below.

Stringent program guidelines often overwhelm clients. For example, one case manager highlighted CAAP's Personal Assisted Employment Services (PAES), which requires that clients meet with an employment counselor weekly. She noted that it can be difficult for clients who experience frequent crises to adhere to these types of expectations.

Some clients find it difficult to leave their rooms or the site itself, whether because of fear (e.g., agoraphobia or neighborhood safety concerns) or depression. Attending a doctor's appointment requires they navigate a complex health system, which can be particularly daunting for individuals with high needs such as cognitive impairments, mental health diagnoses, physical disabilities, or other limiting factors. When clients are overwhelmed, they are less likely to actively engage in support services.

Additionally, certain clients are not used to seeking help or accepting services. A few case managers mentioned that they must make special effort to outreach to clients just entering housing to inform them of the types of services that are available and how to use the services.

The following barriers to service uptake were mentioned by at least one case manager, but were not widely discussed in the interviews:

- Lack of motivation
- No models for good outcomes and/or negative influence of other tenants
- Lack of life skills
- Desire for privacy
- Need for accompaniment
- Cultural resistance to accepting services

Tools for Addressing Barriers

Regular outreach and consistent follow-up are the primary tools case managers use to engage clients in support services. Some case managers noted that they serve as an "appointment keeper" for their clients. Many clients have low literacy levels, so the case manager is often a resource when that client receives a reminder notice for a medical or other appointment. After reviewing the document with the client, the case manager often makes note of the appointment date to remind the client prior to the meeting. The case manager may also review transportation options, necessary paperwork, and other details to prepare the client for the visit.

Several case managers noted that "if a client really needs something, they'll follow through." Clients with basic needs, such as furniture for their unit, will generally follow through on a referral to St. Vincent de Paul for home goods. Clients in crisis who seek out the case manager for assistance usually follow through on the referrals the case manager provides, though it is unclear whether this applies when the need is also a barrier (e.g., if a client with severe mental health needs will follow through on referrals for treatment).

For non-urgent needs, factors like having a strong support network can help a client follow through on service goals. This could include friends, family or other case managers and service providers. Many case managers noted that they do not have time to regularly accompany clients on their appointments, but when they do accompany them, it generally has positive results. Navigating benefits systems or health systems is challenging

for this population, as noted above, and accompaniment or other types of navigation support can improve the likelihood that the client will succeed.

Service Gaps and Unmet Needs

When queried about what services should be added for clients, case manager responses varied widely based on the unique needs of clients at each of the sites. One common theme, however, was the need for additional clinical support, both medical and behavioral. In particular, several case managers mentioned wanting an on-site or roving nurse. Clients have many small medical problems or questions about medication, but cannot or will not go to community clinics to get their needs met. An on-site nurse or roving nurse could address basic needs, provide preventative care, ensure clients are taking medications correctly, and refer to a primary care doctor when the situation merits it.

A few case managers also noted that they do not have the training to manage the psychiatric challenges posed by many clients. They would like more clinical supervision and training to learn how to relate to clients with specific mental health diagnoses more effectively, and to be able to offer more targeted interventions, when necessary.

Several case managers interviewed commented that they do not have sufficient time to address deeper needs of clients because much of their time goes toward managing crises. These case managers identified more case managers, possibly targeted to specific needs or populations, as an expanded service that would benefit clients.

Other services mentioned by at least one case manager include:

- CAAP "house calls" to prevent discontinuance: One supervisor noted that CAAP discontinuance is a large predictor of eviction because it destabilizes clients. If CAAP worked more closely with tenants at housing sites to collect necessary paperwork to prevent discontinuances, it would likely also prevent evictions.
- On-site or roving job developer: One case manager mentioned that there are many freelance job opportunities that could be appropriate for clients, such as computer-based work that could be done from home. Most clients do not know how to seek or apply for this type of work, and a job developer would be needed to support them in finding these opportunities.[19]
- Additional services for former foster youth: One case manager noticed a recent rise in the number of former foster youth entering supportive housing from homelessness, and suggested more life skills training specific to this population (i.e., before exiting foster care, to prevent homelessness).
- Training: Life skills, such as learning to cook using the limited facilities available in a unit; money management; literacy
- Grief counseling
- Community events
- Building amenities, such as washer/dryers, additional cooking facilities, in-room bathrooms, etc.
- Additional muni tokens
- Grocery store in the Tenderloin, or alternately, a regular van service to the grocery store

[19] The Controller's Office compared the percent of clients with paid jobs by site and found that the percentage varied little across sites, even for the one site surveyed with a job developer on staff. It can't be determined from this research why that would be true, but it is possible that job development may be most effective targeted at specific populations rather than broadly throughout a single building.

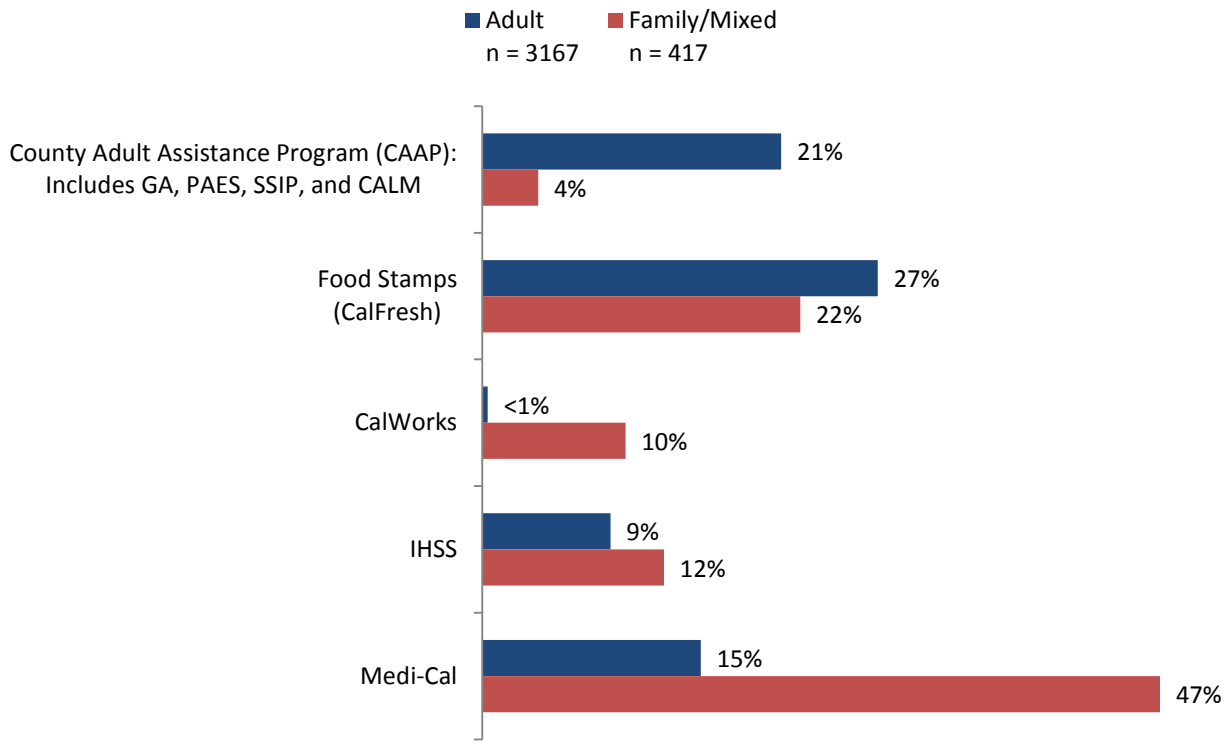
PUBLIC BENEFIT UTILIZATION

As part of this study, the Controller's Office attempted to assess the degree to which supportive housing clients are connected with public benefits. The Controller's Office did not have access to utilization data for SSI, but as noted above, utilization rates for this benefit may be inferred from other sources, such as the client survey. The data shows that clients could be linked to certain benefits more effectively, such as In Home Support Services. However, there are indications that being connected with housing increases appropriate utilization of health care.

HUMAN SERVICES BENEFITS UTILIZATION

Figure 7 shows the overall utilization of a variety of public benefits. Medi-Cal enrollment at Adult sites is quite low, particularly compared to Family/Mixed sites. This is expected, as most single adults without children only became eligible for Medi-Cal in January 2014 at the roll-out of the Affordable Care Act.[20] Similarly, though only a quarter of clients receive CalFresh, this low figure may be explained by the fact that SSI recipients are barred from receiving that benefit.

FIGURE 7: PUBLIC BENEFITS UTILIZATION RATES (SOURCE: CLIENT DATA)



Considering that 17% of residents at Adult sites are seniors, and also the large proportion of presumably disabled clients (58% on SSI, by self-report), utilization of In Home Support Services (IHSS) appears low at Adult sites, with just 9% receiving this service. More clients at Family/Mixed sites are connected to IHSS, at 12%. Though the average age of clients in Family/Mixed settings is lower than at Adult sites, the number of clients with a disability that might qualify them for IHSS is unknown from this data.

[20] Matched data related to Healthy San Francisco, San Francisco's health care access program available to low-income clients ineligible for Medi-Cal, was not included in this analysis.

The Controller's Office analyzed IHSS and SSI data provided by HSA and found that 40% of all SSI recipients in San Francisco receive IHSS benefits. If IHSS uptake rates among SSI recipients in Adult supportive housing were similar, *at least* 16% of all Adult supportive housing clients would receive IHSS benefits.[21] Yet, only 9% of Adult supportive housing clients currently receive this service. This 7% gap represents approximately 250 individuals who could potentially qualify for additional in-home support.

CAAP utilization varies little by race/ethnicity, but does vary slightly by age and length of stay. Older clients and those housed longer than five years are less likely to receive CAAP, likely due to transitions to SSI as a source of income. Less than 1% of CAAP recipients are age 65 or older, and only 12% have lived in their building for more than five years.

Just 10% of Family/Mixed site clients receive CalWORKs benefits.[22] Latino clients have the highest utilization rate, at 17%. Latino clients also have a higher-than-average utilization rate for Medi-Cal, inclusive of both Adult and Family/Mixed sites.[23]

Given the low rate of CalWORKs utilization, the Controller's Office investigated the drivers of this finding. The utilization rate for CalWORKs mentioned above is calculated for adult clients only. However, CalWORKs benefits can be in the name of the parent or the child.[24] The Controller's Office calculated a CalWORKs utilization rate inclusive of adults and children in supportive housing and found that 23% of Family/Mixed clients receive CalWORKs, more than double the rate when considering adults only. It should be noted that the Controller's Office excluded two Family/Mixed buildings from this calculation because data on children and youth in those buildings was not available. Child-only CalWORKs benefits are lower than the benefits for adults engaged in work activities, leaving these families with very limited incomes that could impact quality of life (e.g., less money available for food, medical expenses, or savings for alternate housing).

The Controller's Office analyzed whether clients are receiving more than one benefit (see Figure 8[25]). Given that the matched data did not include SSI utilization, the number of clients listed as receiving zero benefits is likely vastly overstated.

Excluding consideration of SSI, 24% of all clients receive a single benefit, and 21% receive two benefits. Clients receiving CAAP are more likely to be connected with other benefits, and with CalFresh in particular. HSA requires clients to apply to CalFresh when enrolling in CAAP. Clients are most likely to receive IHSS alone, without other benefits (though some of these may be receiving SSI).

[21] Of Adult site survey respondents, 58% report that they receive SSI benefits. An IHSS utilization rate of 40% for this subpopulation would result in at least 16% of all Adult supportive housing clients receiving IHSS (.58*.40=.16), The 16% estimate represents a floor of likely IHSS eligibility because it assumes the IHSS utilization rate among non-SSI recipients is zero.

[22] Less than 1% of clients at Adult sites receive CalWORKs benefits, as expected, given the family-oriented nature of the benefit.

[23] Other than the trends mentioned here, there is little other variation in benefits utilization based on race/ethnicity, age, or length of stay in supportive housing. See Appendix F for figures illustrating this utilization data.

[24] CalWORKs provides a federal benefit to adults with children that is limited to four years. Once an adult has reached the four-year limit, s/he can no longer receive the full benefit, but California provides a partial benefit awarded in the child's name.

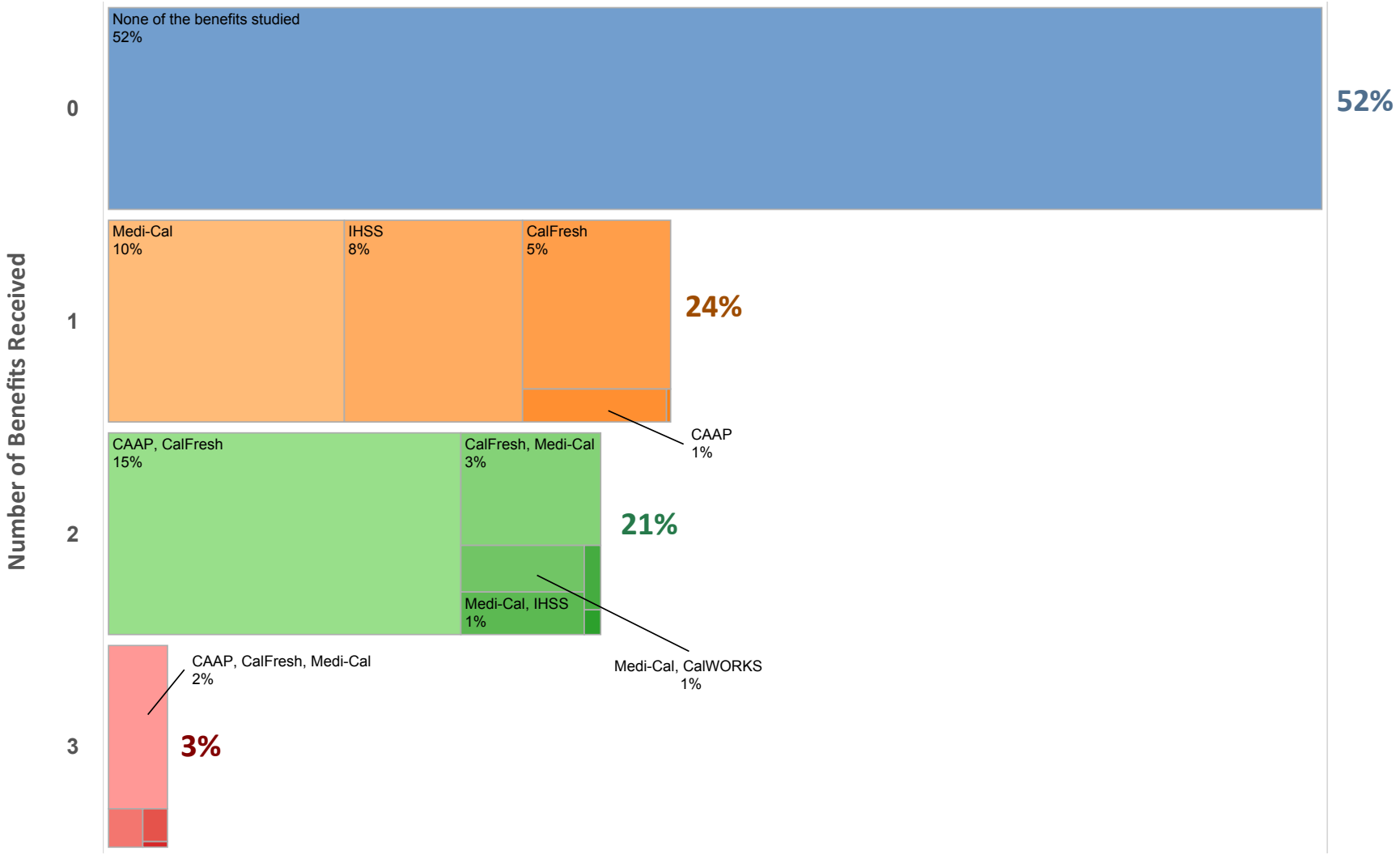
[25] CalWORKs data in Figure 8 only represents adult recipients of the benefit, as data about children and youth was not universally available for this report.

Figure 8

Public Benefits Received by Supportive Housing Clients

The chart belows combines data on utilization for five public benefits: County Adult Assistance Program (CAAP), CalFresh, CalWORKs, In-Home Support Services (IHSS), and Medi-Cal. The bars in the chart represent the number of benefits received by supportive housing clients. For example, the green bar shows all clients receiving exactly two of the five benefits. The rectangles within each bar present the percentage of clients who receive specific combinations of benefits. For example, 15% of supportive housing clients receive CAAP and CalFresh, but no other benefits.

Data on utilization of Supplemental Security Income (SSI) was not available to the Controller's Office. Individuals in the zero benefits bar (blue) may receive SSI.



Note: Labels were excluded for all combinations of benefits received by less than one percent of all supportive housing clients. These combinations include: CalWORKS (.03%); CAAP and Medi-Cal (.22%); CalFresh and IHSS (.08%); CalFresh and Medi-Cal and IHSS (.28%); CalFresh and Medi-Cal and CalWORKs (.17%); Med-Cal and CalWORKs and IHSS (.03%). In addition, two supportive housing clients received four benefits: one client received CAAP and CalFresh and Medi-Cal and CalWORKS; the other received CAAP and CalFresh and Medi-Cal and IHSS.

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HEALTH CARE BENEFITS AND UTILIZATION

According to the client survey, 48% of Adult clients and 37% of Family/Mixed clients received or were referred to Medi-Cal since becoming housed. Healthy San Francisco ranked as the second most common health-related referral at both Adult and Family/Mixed sites.

FIGURE 9: CLIENT-REPORTED HEALTH REFERRALS (SOURCE: SURVEYS)

	Adult	Family/Mixed
Medi-Cal	48%	37%
Healthy San Francisco	28%	20%
Medical care	15%	10%
Mental health care	13%	15%
In-Home Supportive Services	11%	14%
Dental care	9%	17%
Substance abuse	8%	6%
Other Insurance	4%	4%

Research suggests that one benefit of supportive housing is more appropriate usage of other public systems, particularly health systems. For example, a 2006 San Francisco-based study compared acute health service utilization during homelessness to usage after being housed, and showed a 16% decline in clients with any visits to the emergency department (from 54% to 37%).[26] To a small degree, analysis in this report seems to substantiate previous research.[27]

The Department of Public Health (DPH) provided the Controller's Office with aggregate data on utilization of urgent and emergent (U/E) services at all DPH facilities for all clients in supportive housing during FY12-13, grouping the utilization data by cohort based on year of entry into housing. U/E services encompass emergency room visits, psychiatric emergency services, the sobering center and other crisis-related care. U/E services are typically more expensive than primary and preventative care and indicate a client has an unstable medical or behavioral health condition or has not been connected to appropriate care. DPH monitors U/E services to better manage costs and to target outreach toward clients with inappropriate usage of the health care system.

Of the 3,520 supportive housing clients[28] for whom data was available, 36% utilized U/E services in FY12-13, with a total cost of $6.7 million. The average annual cost for utilizers of U/E services was $5,257, and the average cost for all supportive housing clients was $1,904. The vast majority (70%) of FY12-13 U/E costs were for medical services, with 16% going toward mental health services, and 5% attributed to U/E substance abuse treatment.

The data also shows that 6% of supportive housing clients utilized Jail Health services during FY12-13, and these utilizers were in jail for an average of 20 days.[29]

[26] Tia Martinez and Martha Burt, "Impact of Permanent Supportive Housing on the Use of Acute Care Health Services by Homeless Adults," *Psychiatric Services 57*(July 2006): 992 – 999 and Proscio, 2000

[27] This study only examined use of health systems, and did not include utilization of police, fire, jail or other emergency systems.

[28] Ten percent of HSA clients could not be matched in DPH's system.

[29] Jail Health utilization is included in the U/E services data provided by DPH. A more detailed assessment of Jail Health utilization, which can be used to infer information about criminal justice involvement, has been included as Appendix F.

Supportive housing clients use U/E services more than the general DPH client population. If supportive housing clients who utilized U/E services were similar to all U/E users, one would expect 50% of client users to be in the top 50% of all U/E users. However, 67% of matched HSA U/E utilizers were in the top 50% of all U/E users, 8% were in the top 5% of users, and 2% were in the top 1% of users. This could indicate that supportive housing clients have disproportionately high needs, or it could mean that only the most acute supportive housing clients are engaged with the U/E system.

As a comparison to the snapshot of housed clients, DPH also provided FY12-13 data for all homeless patients accessing U/E services. Figure 10 shows that the homeless clients served by DPH in FY12-13 had higher rates of utilization in nearly all areas of urgent and emergent services at a much higher cost to the system than the housed clients at HSA sites. [30]

In particular, the average cost of U/E services for HSA's supportive housing clients is 63% less than the average cost of DPH's homeless clients using urgent and emergency services. Though HSA's clients are high utilizers of U/E services, DPH's homeless clients are much more likely to use U/E care than housed clients: 67% of homeless clients accessed U/E services in FY12-13, as compared to just 36% of HSA's supportive housing population.

Building the Cohorts:

To protect the confidentiality of patients, DPH only provided data in aggregate form. The Controller's Office used the client data to create nine cohorts for a more nuanced analysis of service utilization.

Step 1: Housed vs. Exited

Using data on all clients in HSA supportive housing during FY 12-13, the Controller's Office first divided the population into two groups, those housed at the end of FY12-13, and those who exited housing during FY12-13.

Step 2: Length of Stay

Next, the Controller's Office further divided the two groups based on the clients' length of stay in housing. New clients who entered in FY12-13 had their own cohort, as did long-term clients in housing for more than 10 years. Other cohorts represented two-year spans of time when a client may have entered housing.

Step 3: Change over Time

The Controller's Office requested DPH provide data for each cohort for successive fiscal years. DPH provided data for FY07-08, FY09-10, FY11-12 and FY12-13. If a client entered housing during FY11-12, the data captures his U/E utilization for two fiscal years prior to entering housing, and one fiscal year after entering housing, showing the trajectory of that client (in aggregate), and how her service utilization changed before and after housing.

See Appendix F for further detail on the cohort development.

[30] While these results are promising, they do not point to housing as the sole driver for the difference in cost between formerly and currently homeless patients. It is important to note that homeless clients may be engaged with preventative or primary care at DPH in addition to the U/E services accessed during the year.

FIGURE 10: COMPARISON OF URGENT/EMERGENT SERVICE UTILIZATION AMONG HSA CLIENT POPULATION AND DPH HOMELESS CLIENTS (SOURCE: CLIENT DATA)

FY12-13 U/E Utilization	HSA Clients	DPH Homeless Clients
Total Clients	3,520	11,045
Use of U/E Services Overall[31]		
Total U/E Utilizers	1,275	7,345
% Utilizers	36%	67%
Total Cost	$6,702,344	$56,527,886
Average Cost (all clients)	$1,904	$5,118
Average Cost (U/E utilizers)	$5,257	$7,696

Similarly, longitudinal data indicates that supportive housing is associated with declines in utilization of U/E services. Figure 11 shows the trend of urgent/emergent service utilization prior to and after entering housing.[32] In general, the data shows utilization (and resulting cost) spiking just prior to and during the year of being housed, but declining thereafter. The charts paint a picture of increasing instability and illness when a client becomes homeless, alleviated only after the client receives housing and support services.

The change in average cost per client is not large. Average U/E costs in FY12-13 ranged from $1,266 to $5,495 per client based on cohort. Examining the lowest and highest average costs for all cohorts over the sampled years, the average change in cost is $2,468 per client.

Thus, the "savings" in U/E healthcare costs will not offset the cost of housing clients, but this analysis does not factor in other system savings, such as in the criminal justice system or other emergency services.

Clients who exit housing after a substantial length of stay show increasing utilization of U/E health services following their exit, with usage and costs spiking. The aggregate data does not allow for a nuanced examination of why each client left housing (e.g., if clients with negative exits are the primary driver of the increase in utilization). Spikes in cost may also relate to the age of clients who have been housed for longer and who may be more likely to have complex or chronic health conditions that result in U/E utilization, even with appropriate connection to primary and preventative care. A single adverse event may also spike costs for a cohort during a year.

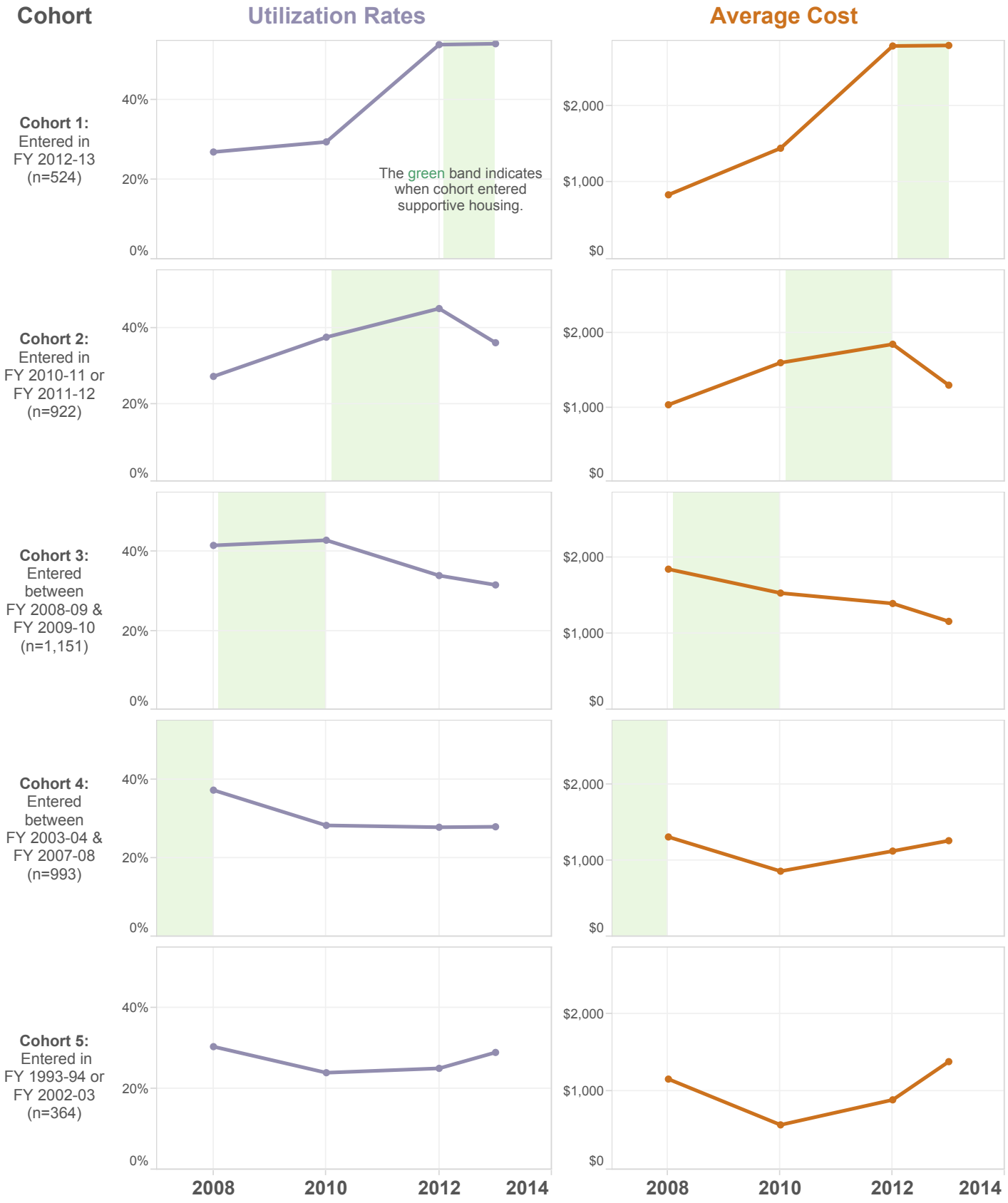
This report does not attempt to quantify the cost savings of supportive housing. The U/E utilization data provide here can inform the discussion about the benefits of supportive housing, but does not represent the total system costs associated with either homelessness or supportive housing. Other City services, such as ambulance services, fire, police, and preventative and primary healthcare, have not been analyzed as part of this report, but these systems may experience disproportionate usage by homeless individuals, as well as cost-savings associated with entering supportive housing.

[31] See Appendix F for a breakdown of this comparison by medical, mental health and substance abuse services.
[32] See Appendix F for a breakdown of U/E data based on type of service utilized (health, mental health, and substance abuse).

Figure 11

Urgent and Emergent Service Utilization and Cost: Housed Clients

Urgent and emergent services include medical, mental health, and substance abuse services. Charts include all clients in supportive housing on June 30, 2013. Each row of charts represents one cohort of clients. Cohorts were selected based on date of entry into supportive housing. The green bands indicate when each cohort entered housing. The horizontal axis displays fiscal year.



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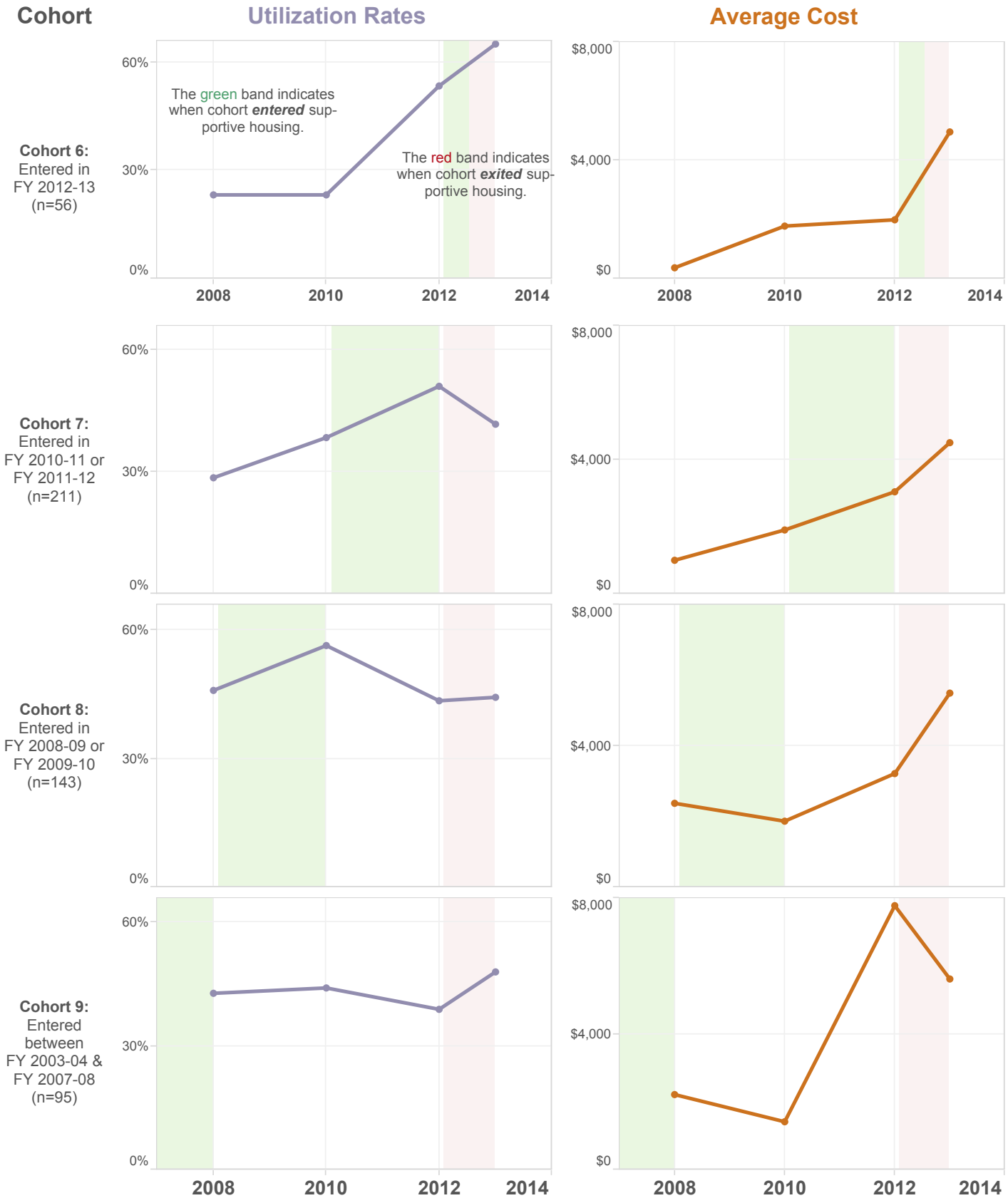
Urgent and Emergent Service Utilization and Cost: Exiting Clients

Urgent and emergent services include medical, mental health, and substance abuse services. Charts include all clients who exited supportive housing during FY 2012-13. Each row of charts represents one cohort of clients. Cohorts were selected based on date of entry into supportive housing. The green bands indicate when each cohort entered housing, and the red bands indicate when each cohort exited housing. The horizontal axis displays Fiscal Year.



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CLIENT TRAJECTORIES AND TRANSITIONS

The Controller's Office examined how clients' lives changed after being housed ("trajectories"), and whether those changes resulted in the clients moving to other stable housing ("transitions"). HSA's supportive housing providers support client stability, but for the system to function effectively, those clients who are able must transition to other stable housing to make units available for other homeless clients needing housing. Transitioning to other housing can improve the quality of life for many clients as well. Supportive housing has certain restrictions and limitation, such as shared bathrooms, communal cooking facilities, and restrictive visitor policies. If a client has the capacity to live without on-site support services, it can benefit both the client and the housing system overall. The data shows there is a population within supportive housing that have stabilized and become self-sufficient enough to succeed in housing without attached support services, but there are barriers that limit the flow of client transitions.

IMPACT OF SERVICE PROVISION

Clients report that support services offered at HSA sites have a positive impact their lives: 66% of Adult survey respondents and 75% of Family/Mixed respondents stated that that support services are an important factor in their housing stability.

The survey asked respondents to indicate what areas of their lives had improved since entering supportive housing, such as physical health, income, and relationships with family and friends. The majority of respondents (72% of Adult respondents and 93% of Family/Mixed respondents) report that their life improved in at least one area. On average, Adult respondents reported life improvements in 2.0 of the eight areas listed on the survey, while Family/Mixed respondents experienced improvements in 2.8 areas. The difference between Adult and Family/Mixed respondents is statistically significant ($p<.01$), but is driven mostly by the high percentage of Family/Mixed respondents who indicate they have experienced improvements in their children's well-being and/or in their relationships with friends and family. Family/Mixed respondents are also much more likely than Adult respondents to have experienced improvements in the areas of "job skills" and "education."

FIGURE 12: PERCENT OF RESPONDENTS REPORTING IMPROVEMENTS IN EACH AREA

Areas of Improvement	Adult	Family /Mixed
Children's well-being	6%	43%
Education	19%	40%
Income	26%	33%
Job skills	12%	21%
Mental health	39%	41%
Physical health	40%	39%
Relationships w family/friends	28%	51%
Substance abuse	26%	14%

Figure 12 presents the percentage of clients who report their life has improved in each of eight specific areas. "Mental health" is in the top three for Adult (39%) and Family/Mixed (41%) respondents, yet only 13% of Adult respondents and 15% of Family/Mixed respondents indicate they were referred to or received mental health care while in supportive housing (see Figure 9 above). There are at least two possible reasons for this dissonance. First, for many clients, the reported mental health improvement may have been a result of gaining

stable and affordable housing rather than the receipt of mental health services. Second, case file reviews conducted by the Controller's Office indicate that some clients were connected to mental health services before entering supportive housing. It is possible that some respondents failed to report this service utilization in the survey.

CHANGING NEEDS

The Controller's Office examined whether clients' needs and/or outcomes changed over the course of residing in supportive housing. If housing provides the stability needed for previously homeless individuals to better address the issues and barriers that led to their homelessness, one might expect that clients who have been in supportive housing for an extended period of time would have better outcomes than clients who have been in supportive housing for only a short period of time. In an initial examination of the survey data, the Controller's Office found that survey respondents with a long-term stay (three or more years) in supportive housing had a 28% higher income than respondents in supportive housing for less than three years. However, further study revealed that the driver of the income difference was income type. Respondents with a long-term stay in supportive housing are much more likely to receive "Social Security or Disability (SSI, SSDI)" benefits, while short-term respondents are much more likely to receive CAAP benefits. SSI benefit amounts are typically higher than CAAP benefit amounts (Figure 13).

FIGURE 13: OUTCOMES FOR SHORT-TERM AND LONG-TERM CLIENTS

	Length of Stay	
	< 3 years (short-term)	3+ years (long-term)
Average Income*	$665	$851
Types of Income Received		
Social Security or Disability (SSI, SSDI)*	35%	63%
County Adult Assistance Program (CAAP)*	50%	14%
Avg # of Improvement Areas Reported[ns]	2.14	2.12
Avg # of Services Received/Referred To[ns]	4.13	4.44

[ns] Not statistically significant

* Statistically significant (p<.001)

The Controller's Office compared outcomes between short-term and long-term clients in other areas such as self-reported client progress and service utilization, but found no statistically significant differences. It is possible that the survey sample size was too small to detect statistically significant differences in these areas. However, case managers interviewed confirmed that there is little change in the basic type of work they carry out with clients over time, particularly high-need clients who tend to have cyclical patterns of crisis and stability. Indeed, as noted below, some clients will always need supportive services to remain stably housed.

THE NEED FOR PERMANENT SUPPORT

Transitions are not possible for all clients. For many, housing stability is the primary goal. All of the surveyed case managers indicated that the support services provided at the building will always be necessary for certain clients to remain stably housed, though the range of responses was quite broad, stretching from a low of 15% to a high of 90%. Alternatively, this data suggests that at least 10% of clients have the potential to transition out of supportive housing, if affordable housing is available.

FIGURE 14: PERCENT OF CASELOAD NEEDING PERMANENT SUPPORTIVE SERVICES (SOURCE: INTERVIEWS)

Housing Type	Range of Responses
Adult	25% - 90%
Family/Mixed	15% - 90%

The wide range of responses regarding clients needing ongoing support could be indicative of either case manager attitudes about clients or actual differences in the acuity of client need between sites. Despite this variation in the estimated number of clients needing permanent support, case managers were more definitive about the primary reasons why clients may need such support. Case managers were asked to consider their highest need clients who would always require support, and to rank the reasons why this support is necessary, choosing from 1) mental health, 2) disability or cognitive impairment, 3) substance abuse, 4) physical health, or 5) other. Mental health tops the list, with 67% of surveyed case managers ranking it first.

FIGURE 15: REASONS SOME CLIENTS MAY REQUIRE PERMANENT SUPPORT (SOURCE: INTERVIEWS)

Reason	Adult	Family/ Mixed
Mental Health	50%	38%
Disability / Cognitive Impairment	19%	38%
Substance Abuse	25%	13%
Physical Health	6%	13%
Other	0%	0%

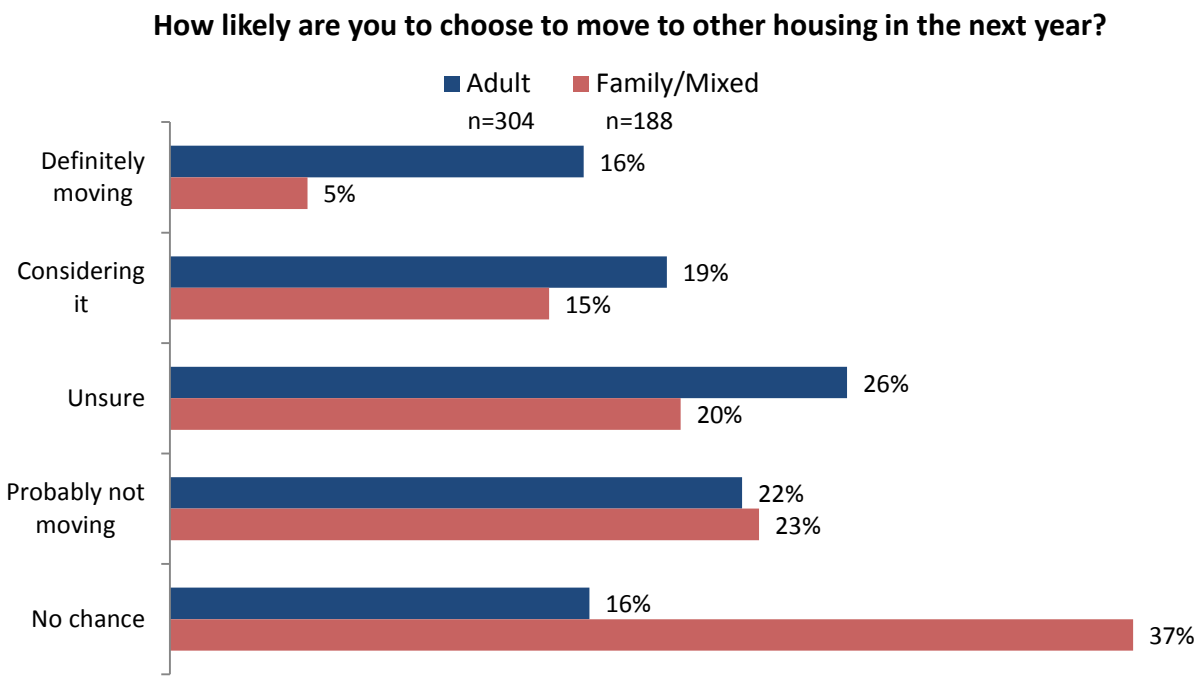
Figure 15 shows case managers' first and second choices. Case managers at Adult sites overwhelmingly named mental health as the number one reason why certain clients will require support services to maintain their housing, while case managers at Family/Mixed sites had mixed interpretations, ranking Mental Health and Disability or Cognitive Impairment equally. The small sample of case managers at Family/Mixed sites makes generalizations challenging, but it is possible that mental health is not as widespread and/or severe in this population, creating more variability in responses.

CLIENT INTEREST IN TRANSITIONING

Given the lengthy duration most clients reside in supportive housing (averaging 5.7 years at Adult sites and 6.3 years at Family/Mixed sites), it is reasonable to question whether clients *want* to move. Indeed, according to case managers, the biggest "barrier" preventing clients from transitioning out of supportive housing and into other stable housing is not a barrier at all; rather, it is a desire to stay. Many clients have lived in their building for years, they have developed support networks, they know where the services are, and they have built a home for themselves. According to case managers, these clients signed a lease and consider their unit their permanent home. They have no inclination to move.

The client survey asked respondents how likely they are to plan to move in the next year (see Figure 16). While the majority of Adult and Family/Mixed respondents reported they are either unsure or not planning to move, respondents in Family/Mixed housing are far more likely to say there is "no chance" they will move in the next year than respondents in Adult housing.

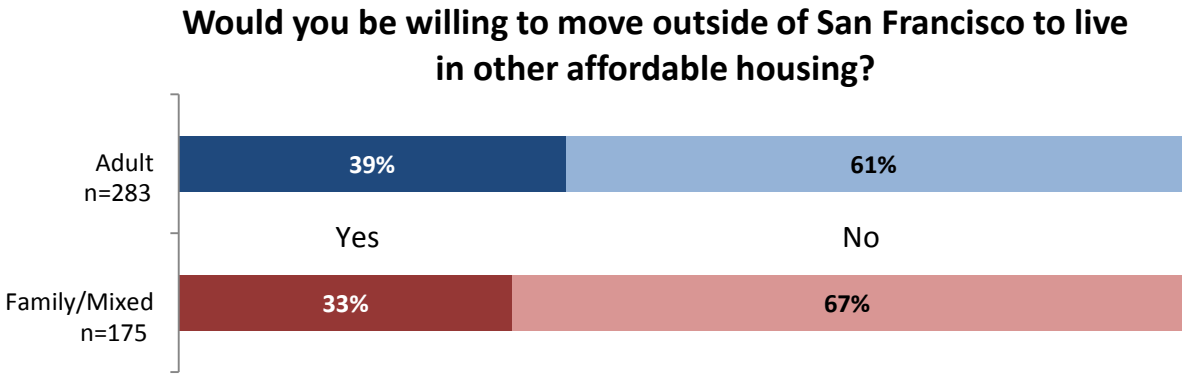
FIGURE 16: CLIENT-REPORTED INTENTIONS TO MOVE (SOURCE: SURVEYS)



Moving Out of San Francisco

With limited affordable housing options in San Francisco, it may be necessary for many clients to migrate from San Francisco if they wish to exit supportive housing. At least a third of respondents in Adult and Family/Mixed supportive housing indicate they are willing to move outside of San Francisco to live in other affordable housing (see Figure 17).

FIGURE 17: CLIENT-REPORTED WILLINGNESS TO MOVE OUT OF SAN FRANCISCO (SOURCE: SURVEYS)



In addition to asking if clients would be willing to leave San Francisco for other affordable housing, the survey provided space for respondents to identify why or why not. The most common reason tenants gave for wanting to stay in San Francisco was that they like it here, with medical and age concerns coming in second (see Figure 18).

FIGURE 18: REASONS CLIENTS CHOOSE TO REMAIN IN SAN FRANCISCO (SOURCE: SURVEYS)

Reason for Staying	#	%	Example
Like it Here	37	35%	*"I think here is my best available option to achieve my cleanliness, safety, and comfort goals."*
Medical/Age	16	15%	*"Because my husband is permanently disabled and all of his doctors are here."*
Other	11	10%	
Employment/Education	10	9%	*"My job and my son's school are both located in the city."*
Convenience	10	9%	*"Convenient part of the city with good public transit."*
Home town	8	7%	*"I was born here, I intend to die here. No economic hardship, life situation, or natural disaster will alter that."*
Resources/Services	8	7%	*"I would not move out of SF because most of the community resources are located here in the city."*
Family/Support	7	7%	*"Feel safer in SF. Family and friends live here."*
Total Reasons Provided	**107**		

Responses for why clients would be willing to move out of San Francisco could not be categorized as distinctly as those for why clients desire to stay, with just 49 total responses. However, issues of cost and the availability of affordable or subsidized housing did rise to the top. Several respondents mentioned wanting better, healthier or safer conditions for themselves and/or their children. Some simply do not have an attachment to San Francisco and see change as a potentially positive thing. Ambivalence about moving was apparent in a number of responses, with at least seven noting that moving would "depend" on certain factors, such as medical care being covered, affordable housing or jobs being available, or only as a "last resort."

County benefits, such as CAAP, do not transfer with a client if s/he moves outside San Francisco; yet, only one client noted that s/he did not want to leave San Francisco because s/he "would lose too many benefits." Some may have implied concern over loss of benefits with comments about their "services" being in San Francisco, but it is unknown from these responses how much this factor influenced the more than 60% of respondents who indicated they were willing to move outside of San Francisco.

BARRIERS TO CLIENT TRANSITIONS

As seen above, motivation is a primary barrier to transitioning out of supportive housing. Sometimes, this lack of inclination goes further. Leaving would be challenging, and presents a risk of failure. If the client is successful in remaining stably housed with the supports provided at the current unit, it makes sense to many (including their case managers) to stay put.

However, most of the case managers interviewed stated that they have clients who do want to move out of supportive housing. Those clients may see their current setting as a stepping stone, or they may not like the neighborhood or lack of private facilities in the building (e.g., few units have private bathrooms or kitchens). Even clients with the motivation to leave the building face many barriers.

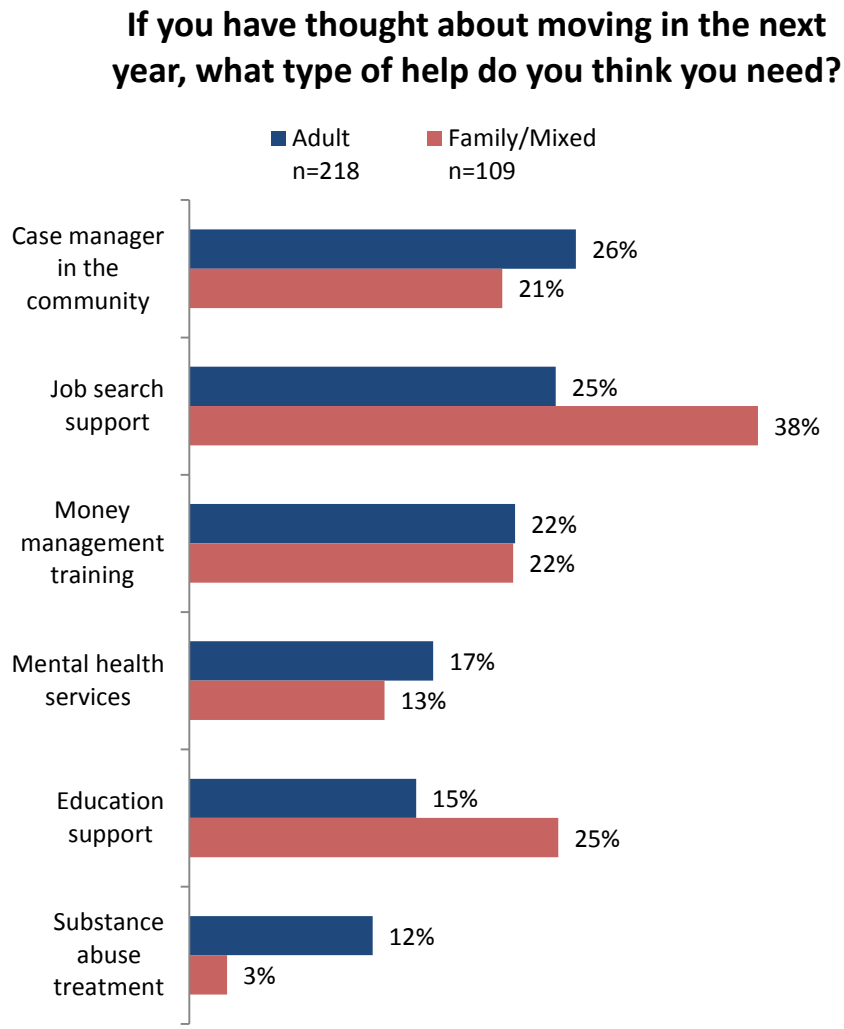
Top among these is the application process for affordable housing. According to several case managers, low literacy levels and difficulty navigating complex systems can make getting on waitlists and staying on these lists extremely challenging for clients. One case manager noted that she worked with one client for two years and supported that client with filling out 25 forms before he was able to transition to other stable housing. This takes time that most case managers do not have, and it takes persistence from the client that can feel hopeless at times. Another case manager commented that only the highest functioning clients are able to see this process through. Luck may also be a factor, as at least two case managers noted.

Of course, a lack of affordable housing options, particularly for clients on fixed incomes, is a primary barrier to successful transitions. On top of this, many clients do not have the financial planning skills to save enough for move-in costs or to manage monthly rental payments. In fact, according to case managers, having a stable income and money management skills is one of the greatest commonalities among clients able to successfully transition to other housing (second only to clients moving to be closer to family).

Services Needed to Support Transitions

Survey respondents who considered moving in the next year were asked what type of help they think they would need to facilitate the move. Of the six areas listed, the most common selection for respondents in Family/Mixed housing was "job search support" at 38%. The top selection for Adult respondents was "case manager in the community" at 26%, but "job search" was a close second at 25% (see Figure 19). "Substance abuse treatment" was the least common selection for both Family/Mixed (3%) and Adult respondents (12%).

Figure 19: Support Clients Would Need to Transition to Other Housing (source: surveys)



In a survey delivered to case managers prior to the interview, they were asked to rank factors most influential in helping clients transition to other stable, non-supportive housing. According to the survey, availability of housing that is affordable for tenants on fixed incomes is critical to their success in such transitions with 75% of case managers ranking it either first or second in importance. Employment or education gained while in supportive housing also plays a key role, which aligns with comments made by case managers in interviews, stating that a stable income and money management skills are necessary for client success in finding other housing.

Some variation exists in responses by case managers in Adult housing sites compared to those in Family/Mixed sites. While availability of affordable options remains the top factor, case managers at Family/Mixed ranked attainment of employment or education equally, and two of the four case managers ranked family support as one of their top two choices. Case managers at Adult sites saw family support as much less influential, with just one of the eight case managers ranking it first or second. Instead, case managers at Adult sites ranked employment or education attained while in housing on par with linkage to services while in housing.

Case managers that listed "other" factors in their array of choices provided the following examples:

- Having wrap-around medical/mental health services
- Specific needs clients might bring to case managers
- Having outside mental health and/or substance abuse services
- Having a history of stable employment and housing

These examples indicate that linkage to community-based support services may be more influential than noted quantitatively.

CLIENT EXITS

Despite the barriers noted above, some clients do exit supportive housing. Data on all HSA supportive housing clients shows that 489 Adult clients (13%) and 33 Family/Mixed clients (6%) exited housing during FY12-13.[33] The Controller's Office examined the characteristics of these exits to identify trends and ascertain the impact of support services on client outcomes. Administrative data identifies the majority of exits as "stable," but the case file reviews provide additional context, showing that the actual outcomes for many clients is unknown. Additionally, the case files indicate that case managers may have limited engagement with exiting clients, whether the exits are positive or negative.

DEMOGRAPHICS

The average length of stay for clients who exited both Adult and Family sites is over five years. The gender, age and ethnicity demographics of the exiting population generally correspond to those in the supportive housing population as a whole, with a few small exceptions. While 18% of Family/Mixed clients are Latino and 12% are Asian American, only one Latino client and one Asian American client exited Family/Mixed sites in FY12-13 (each representing 3% of exiting clients). Alternately, younger Family/Mixed clients are underrepresented in the exiting client data, with just 10% of clients 19-24 exiting compared to 19% in the total Family/Mixed population.

[33] This does not include children residing with their parents in Family units. The total number of individuals exiting Family/Mixed housing inclusive of children is much higher, but unknown, as the data requested did not include information about children.

EXIT TYPES

Exits from Adult sites vary greatly from Family/Mixed exits. Five of the fourteen Family/Mixed exits (36%) were for moves to other subsidized housing, which may include transfers to other HSA supportive housing units. In contrast, just 3% of Adult clients exited to other subsidized housing. Clients at Adult sites are more likely to have a "negative" exit than those at Family/Mixed sites. Nearly a quarter of all Adult exits are a result of eviction, as compared to 12% of Family/Mixed exits. Additionally, many of the 17% of Adult exits labeled "Other" could be construed as negative, as the reasons provided by programs include abandonment, "left voluntarily, no housing," and "emergency shelter."

FIGURE 20: REASONS FOR CLIENT EXITS, FY12-13 (CLIENT DATA)

Reason for Exit	Adult	Family/Mixed
Evicted or Received Notice of Eviction	23%	12%
Moved to Other Housing (type unknown)[34]	20%	0%
Other[35]	17%	0%
Died	15%	9%
Moved in with Family or Friends	10%	6%
Moved for Unknown Reasons	8%	9%
Moved to Non-Subsidized Housing	5%	6%
Moved to Other Subsidized Housing	3%	58%

HSA uses a "stability measure" to assess outcomes for its clients. The stability measure asks providers to report the percentage of clients who either remained housed in their unit, or moved but left in good standing.(e.g., not evicted, or left without owing back-rent). The stability measure would generally count all reasons for exit above, except for Evicted and Other, as "stable" exits.

The Controller's Office expected case file reviews to provide additional context to these generic reasons for exit, but found that the outcome of many "stable" exits remained unknown. Clients are not required to leave a forwarding address, and many exit without sharing their destination, leaving programs unable to document whether or not the exit is truly "stable."

The Controller's Office reviewed 85 case files of clients who exited supportive housing between July 1, 2013 and April 30, 2014,[36] and identified three basic categories for exits:

- **Positive:** other supportive housing, subsidized or affordable housing, market rate housing, moved in with family/friends, other housing of unknown type
- **Negative:** eviction, abandonment, jail
- **Higher Level of Care:** inpatient medical care, inpatient mental health care, residential substance abuse treatment

[34] This category was added after data submission by providers to account for non-coded responses such as "moved to other housing."
[35] Per notes in the data provided by programs, "Other" includes: Abandonment; Hospital; Inpatient Treatment; Jail; Left Voluntarily Unknown/Refused; Left Voluntarily No Housing; Non-Tenant, move-out under 32 days; Substance Use Treatment; Hospice; Residential Treatment; Relinquishment; Emergency Shelter; Over Income Limit; Higher Level of Care
[36] Demographics for the clients represented in the case file review are located in Appendix E.

At both Adult and Family/Mixed sites, there were more positive exits than negative, though a closer look at the factors involved in each exit may call this high-level assessment into question, as discussed in more detail below.

FIGURE 21: EXIT TYPE DESCRIPTIONS (SOURCE: CASE FILES)

Exit Detail	Adult	Family/Mixed
Positive		
Moved in with Family/Friends	21%	7%
Moved to Other Housing - Type Unknown	14%	7%
Moved to Subsidized or Affordable Housing	8%	7%
Transferred to Other Supportive Housing	6%	29%
Moved to Market Rate Housing	0%	7%
Sub-Total	**49%**	**57%**
Negative		
Evicted	34%	29%
Abandonment	6%	7%
Jail	1%	0%
Sub-Total	**41%**	**36%**
Higher Level of Care		
Hospital or Inpatient Medical Treatment	6%	7%
Residential Substance Abuse Treatment	3%	0%
Inpatient Mental Health Treatment	1%	0%
Sub-Total	**10%**	**7%**

EXITS FROM ADULT SITES

Positive Exits

The Controller's Office reviewed 35 case files for clients at Adult sites making positive exits to other housing:

- 15 (43%) moved in with family/friends
- 10 (29%) moved to other housing, type unknown
- 6 (17%) moved to subsidized or affordable housing
- 4 (11%) moved to other supportive housing sites

There was one potential case of a client moving to market rate housing, but the type of housing could not be verified through the case notes, and has been listed as "moved in with family/friends." There may be other residents that moved to market rate housing within the "other housing, type unknown" category, but based on the case file notes for each of those tenants, this is unlikely.

Of the 35 positive exits, the case files indicated the following major factors for leaving:

- 11 (31%) upgraded, including moving to Section 8 housing, other affordable housing, a more preferred or larger supportive housing unit, or a senior housing unit.
- 11 (31%) were unknown. The case files do not provide sufficient detail to show where the tenant went, whether they were stable, and/or what spurred the tenant's desire to move.
- 7 (20%) left for health, family or other reasons, such as to be closer to a daughter or return to a home-country.
- 6 (17%) left due to rent issues, such as moving home with family due to difficulty paying rent.

Though these are "positive" exits and not evictions, many tenants faced the threat of eviction at some point during their tenancy. Within these 35 charts reviewed by the Controller's Office, 13 (37%) included notations of case manager contact related to non-payment of rent or eviction prevention services. This ranged from occasional letters to clients requesting that they pay their rent on time to referrals to nonprofits providing rental assistance services for outstanding debt that could lead to eviction. As stated above, inability to pay rent was a major factor in the move-out for at least six of the positive exits.

Negative Exits

Of the 29 negative exits from Adult housing sites (i.e., eviction, abandonment or jail), most (76%) occurred within three years of entering housing, with 17% (or five exits) occurring in under one year of entering housing. The average length of stay for tenants with a negative exit was 2.6 years.[37]

Behavioral health was a major contributor to evictions from supportive housing. Of the 29 negative exits, mental health and/or substance abuse contributed to nonpayment evictions, nuisance evictions or jail time in 14 (48%) cases.

These behavioral health challenges faced by clients also contributed to income instability. CAAP discontinuances appear regularly in client case files (including those with positive exits and those without behavioral health concerns). Seventeen (59%) of the 29 tenants with negative exits received CAAP at the time of entrance into the building, and five of these individuals experienced CAAP discontinuances that contributed to their eventual eviction for non-payment.

Once a case entered formal eviction proceedings, most case files showed a lessening in case management support. While case managers generally cannot discuss legal disputes with tenants, there is no legal barrier to continuing to offer other support services. However, given that eviction proceedings would likely be a primary challenge for the client at that time, it may cause clients to become resistant to outreach attempts, though case notes rarely documented any outreach attempts during these times.

Moved to a Higher Level of Care

Seven (10%) clients in Adult sites left their units for a "higher level of care," including inpatient medical treatment (four), residential substance abuse treatment (two) or inpatient psychiatric treatment (one). Three clients eventually went to Laguna Honda Hospital for skilled nursing care due to complex medical conditions. In one case, the chart shows that the client was eventually evicted from her unit due to non-payment during her hospitalization.

Case manager involvement varied in these cases where tenants required higher levels of care. For example, one client's file shows significant navigation by the case manager as s/he supported the client to address his substance abuse and seek treatment. In another, the client had minimal involvement with case managers, and substance abuse was not noted anywhere in the chart except in the exit paperwork listing residential treatment as the exit location.

[37] Analysis of data from the larger population of supportive housing clients does not show a similar correlation between short length of stay and negative exit.

EXITS FROM FAMILY/MIXED SITES

The Controller's Office reviewed 14 case files from Family/Mixed sites. In four cases, the files related to individuals living alone in their units. In another two cases, the files were for an adult child moving out of the unit while others in the household stayed. The remaining eight case files related to family units of varying sizes, though in two, the children had left or been removed by the time of the exit.

The small number of exits from Family/Mixed sites limits trend identification, but the characteristics of these cases can illustrate the variety of experiences of clients in these units. Exits from Family/Mixed sites can be divided into four categories, as shown in the table below.

FIGURE 22: SUMMARY OF FAMILY/MIXED SITE EXITS (SOURCE: CASE FILES)

Exit Category	Number of Households	Length of Stay (range)	Exit Descriptions
Stable Exits	4 Households	2.8 - 11.4 years	• Moved to skilled nursing facility - dementia • Moved out of the country • Moved to market rate housing • Transferred to other supportive housing site
Adult Child Exits	2 Households	11.2 – 11.3 years	• Adult child moved out, while parent retained unit (2)
Unit Downsizing	3 Households	6.0 - 14.2 years	• Moved to smaller supportive housing unit, child living elsewhere • Moved to smaller supportive housing unit, child removal - substance abuse (2)
Negative Exits	5 Households	2.2 – 13.1 years	• Non-payment eviction - behavioral health related • Non-payment eviction - job or subsidy loss related (2) • Nuisance eviction - behavioral health related • Abandonment - criminal activity related

Though an initial review shows that nine of the 14 (64%) exits were "stable" in that the tenant retained housing of some sort, a deeper reading of the files illustrates the complexity of these families' lives. In three cases, the adult tenants were required to move to smaller units due to reduced household size. In two cases, Child Protective Services removed the children from their homes because of the parents' substance abuse. In the third, the child lived with a grandparent while the mother dealt with health-related hospitalizations.

While the adult children that exited from their parents' units seemed to have identified exit locations, the reasons for the exits were not definitively positive (e.g., one may have been "kicked out"), and their housing stability is unknown.

Tenant engagement with case management services varied from active acceptance of services to outright resistance to services, but this level of engagement has minimal correlation with the type of exit the tenant had from the site.

For example, one family generally participated in the site's monthly check-in meetings during their six years as tenants, sharing various challenges and requesting services such as counseling, though it is unknown if the family took advantage of the counseling referrals offered. However, in the final year of tenancy, case notes indicate that the parents' substance abuse escalated, contributing to their eventual eviction. Alternatively, an adult tenant regularly reported "no needs" at the monthly check-ins, and eventually moved to the Philippines to follow up on a business opportunity with no involvement by a case manager.

Case Manager Involvement with Client Exits

As noted to in the sections above, levels of case manager engagement varies widely, and case files did not demonstrate that case managers had any significant involvement with positive exits.

Indeed, case managers themselves indicated that they do not focus on client exits in their work. Nearly all of the case managers interviewed post or provide information about other housing options for clients, but only a few go beyond these basic steps. This holds true for Section 8 vouchers and public housing. While some clients have received Section 8 housing through involvement in Child Welfare Services or because of a disability, several case managers noted that most clients do not have the patience to sit on a waitlist and others do not have the ability to retain the paper-based documents needed for the extensive application process. For this reason, notifying and supporting clients with Section 8 applications is generally not a priority for most case managers interviewed.

While all case managers interviewed provide basic housing information, several case managers expressed that encouraging client transitions was not a priority in their work with clients. These case managers stated that, while clients may indicate an interest in moving to other housing, most fail to follow-through with the work that is needed to find a new home. As one case manager noted, often an event at the site, such as a conflict with another tenant or with property management, inspires the initial interest, but this brand of instigation cannot sustain a prolonged housing search.

Only two case managers indicated that they increase or significantly change their work with clients who express interest in moving to other housing, while eight case managers stated that they provide necessary referrals and information, but leave the bulk of the work of securing new housing to the client. As a caveat, one case manager noted that this type of work begins when the client first moves into supportive housing. The case management process focuses on helping the client develop successful patterns of behavior, such as paying rent on time. As part of this, some case managers try to help clients see the connection between their behaviors and potential for eviction. For example, if a client fails to pay rent, but expresses an interest in moving to other housing, the case manager may work with him to explain that failure to pay rent is cause for eviction in market rate and other housing.

Referrals Prior to Exits

None of the case managers at the 13 buildings where the Controller's Office conducted case file reviews used a referral log or other structured instrument to track new and ongoing referrals made to clients or the outcome of those referrals. Instead, the Controller's Office read case notes in each chart to identify instances when the case manager documented assessing a need and providing resources to the client. It is possible that case managers delivered referrals without noting it explicitly in the chart, so the figures below may not be complete. Additionally, though case managers may indicate that they provided information on a particular service to a client, case managers seldom noted follow-up on the referral or the outcome. These limitations in the charts should be weighed against the findings offered below.

It should be noted that some tenants have case managers outside of their building, and may be receiving referrals and support from another source. Some charts indicated that the building case manager checked in with a client on referrals made by another provider.

Using the case notes, the Controller's Office documented whether a client who exited in FY12-13 received a referral in a variety of common categories within the last year. Of the 71 reviewed exits from Adult housing sites, 27 (38%) had no documented referral in their charts in the year prior to departure, including 37% of those with positive exits and 45% of those with negative exits.

The most common type of referrals made relate to housing retention issues, with 14 individuals (20%) receiving eviction prevention or rental assistance referrals and 14 individuals (20%) receiving advocacy with property management (such as mediating a nuisance complaint). Ten individuals (14%) received benefits advocacy, which could include helping a tenant apply for SSI or could relate to outreach and support in light of a CAAP discontinuance.

In contrast, just two (12%) of the tenants that moved out of Family/Mixed buildings received no referrals in the final year of housing. The majority of referrals made were for property management advocacy, with ten of the 14 exiting clients or families (71%) receiving some type of advocacy. Six clients (43%) received resources for food (generally connection to a food pantry), and five (36%) received referrals for subsidized housing. None of the tenants exiting Family/Mixed sites received a referral for benefits advocacy, representative payee services, In-Home Supportive Services, or household goods or clothing in the final year of housing.

The Controller's Office hypothesized that referrals might increase closer to a client's exit, whether positive or negative, as that client received assistance with moving out, and compared referrals in the final quarter to those in the final year to determine if this correlation exists.[38]

FIGURE 23: CLIENTS WITH NO REFERRALS IN FINAL QUARTER PRIOR TO EXIT (SOURCE: CASE FILES)

Exit Type	Adult	Family/Mixed
Positive	60%	38%
Negative	45%	20%
Higher Level of Care	86%	0%
All Clients	**58%**	**29%**

Instead, the Controller's Office found that 40 of the 71 Adult clients that exited (58%) received no referrals in the final quarter of their stay. Six of the seven clients requiring a higher level of care received no new referrals in the final quarter. The case manager for one of these clients made frequent contacts during the hospitalization, but the client was not responsive to the case manager's outreach and did not accept services. In the other cases, case managers documented few contacts and no referrals prior to the clients' moves to inpatient or residential treatment.

Four exiting Family/Mixed tenants (29%) received no referrals during their final quarter at the site. However, in contrast to Adult sites, most of the tenants with negative exits received both eviction prevention and property management referrals within three months of their exit from the building.

It may be that clients with positive exits are *less* likely to require services and referrals immediately prior to exit because these clients are generally more stable and able to address their needs without significant intervention or support. This would suggest that clients with negative exits would have a greater need for

[38] See Appendix E for a full description of referrals made in the final year and final quarter.

referral immediately prior to exit, though nearly half of these received zero referrals during this unstable time period.

FIGURE 24: REFERRALS IN FINAL QUARTER PRIOR TO EXIT (SOURCE: CASE FILES)[39]

Referral Type	Adult (71)	Family/Mixed (14)
None	40	4
Eviction Prevention/Rental Asst.	10	5
Property Management Advocacy	7	7
Subsidized Housing Resources	6	4
Mental Health	7	2
Utility Assistance	6	0
Household Goods or Clothing	4	0
Other[40]	3	0
Substance Abuse	2	1
Benefits Advocacy	2	0
Food Insecurity	1	1
Job Placement / Employment Svcs.	1	1
Socialization	0	2
Health Care	1	0
Representative Payee Svcs.	1	0
Unsubsidized Housing Resources	1	0
Job Search	0	0
IHSS	0	0

Mental Health

There was a small uptick in the number of individuals receiving referrals for behavioral health (mental health and substance abuse) in the final quarter in relation to the final year of housing. In three of the nine cases of behavioral health referrals, case managers referred individuals at risk of eviction to the Behavioral Health Roving Team, an HSA-funded program that conducts assessments and intensive case management for individuals with severe mental health and substance abuse problems.[41] In all three of these cases, the result was an eviction that same quarter.

Given the number of clients with mental health and substance abuse conditions impacting their tenancy, the low number of referrals in these areas is eye-catching, but in interviews, some case managers indicated these are the areas of highest resistance for clients, meaning potentially undocumented outreach on these topics might have been rebuffed. However, case notes for certain clients showed escalating mental illness, including violent outbursts, with no behavioral health intervention sought by the case manager.

Though the charts for the exiting clients at Family/Mixed sites did not reveal the same degree of mental health and substance abuse issues as those at Adult sites, there were at least five tenants with behavioral health

[39] Number indicates at least one referral made to a client in a category. Except for "None," which is an unduplicated count of clients with no documented referrals, clients may be duplicated among referral types if they received multiple referrals.

[40] "Other" referrals were commonly related to legal matters, such as restraining order or child custody issues.

[41] Only select buildings (5 within the sample used in this study) have access to the Behavioral Health Roving Team services.

needs noted on an initial intake or elsewhere in the chart. In three cases, the most severe, case managers provided referrals for substance abuse or mental health treatment in the last quarter.

Eviction Prevention

Given HSA's mandate to conduct outreach when a tenant displays any signs of housing instability, the Controller's Office expected that clients with negative exits would have a higher rate of referrals to agencies that support clients with eviction prevention, such as the Eviction Defense Collaborative or Catholic Charities, which provide rental assistance to help with back-rent as well as legal assistance during eviction proceedings.

Charts often documented that case managers attempted outreach about these matters, usually by putting a letter in the client's mailbox encouraging the client to come to the office to discuss it. It is unclear what other types of outreach may have been made but not documented. The Controller's Office found just nine instances of clients with negative exits receiving an in-person referral for eviction prevention or rental assistance, or 31% of evicted tenants.

It is important to point out that many buildings have separate property management offices with their own records for tenants. Property management staff members often make their own referrals to eviction prevention services. This would not eliminate the requirement that case managers document outreach to clients showing signs of housing instability.

In some charts, casual and formal contacts diminished during the months leading up to an eviction. In 11 of the 29 negative exits from Adult sites (38%), there were no formal or casual in-person contacts noted in the case files in the final three months of housing (though a couple of these charts noted unsuccessful outreach attempts, most had no notes at all). The legal proceedings can take several months, and it is reasonable to assume that clients would be less willing to engage with building staff to request or receive other services during that difficult time. There was very little documentation of effort by case managers to overcome this possible resistance and deliver other necessary services unrelated or auxiliary to the eviction.

Housing Resources

Nine individuals (13%) received a referral about subsidized or unsubsidized housing in their final year. In many cases, the chart notes show that the client addressed their housing needs without the building case manager's support.[42] No case managers noted referrals to temporary housing or shelter for clients with impending evictions. Clients may have received such referrals from external sources, such as an eviction prevention services, though case file have no record of case manager inquiry about these client needs.

Parenting Services

Though most tenants at Family/Mixed sites have one or more children, few referrals related to parenting needs. No charts documented referrals for parenting courses or childcare. Several charts indicated Child Protective Services involvement with a family (including two cases of child removal), but building case managers did not document active work with families on parenting needs.

As a caveat to this finding, parenting work with clients often takes the form of modeling behaviors during family gatherings such as community meals. Case managers at family sites highlighted these occasions during interviews. Also, the scale of this review should be reiterated. Given that the Controller's Office only examined 14 Family/Mixed charts, it is possible that targeted parenting linkage and referral activities occur but did not make it into this sample.

[42] Case managers might have noted that they passed out flyers or announcements about housing opportunities to all tenants, but this was not counted as a referral unless the case manager individualized the outreach.

SHOULD SERVICES BE MANDATORY?

Participation in the support services offered at each building is voluntary for all clients, as noted above. In discussions with case managers about how and why clients seek out and use services, another question arose in several of the interviews: should services be mandatory?

This question was not on the official interview protocol, and not all case managers discussed this issue during their interview. However, three of the case managers suggested that perhaps some services should indeed be required for tenants placed in housing by HSA. It may be notable that all three of these case managers work at Family/Mixed sites.

One case manager discussed the need for consistency to help stabilize clients' lives. This might include attending regular meetings with a service provider, creating and complying with goals, and taking the steps necessary to achieving independence.

Some clients may need a push to take difficult steps, like addressing a mental health condition, signing up for a job training program, or attending substance abuse counseling. Making all services voluntary means clients may choose complacency over challenge, or may only use services for crises rather than long-term change.

During at least one interview at an Adult site, the question of mandating services also arose. Though the case manager at the site thought some clients were stable enough to work on deeper issues, she noted that few of them approached her to do so, despite her outreach. However, when the issue of requiring services arose, she stated that this would not be appropriate.

Clients come to supportive housing from homelessness. Another case manager compared the behaviors of formerly homeless clients as "PTSD symptoms" created by living on the street for long periods. These clients have had significant trauma. On top of that, many struggle with mental illness, substance abuse, physical or cognitive disabilities, and/or other issues that make maintaining a stable lifestyle challenging.

The Adult site case manager that did not approve of mandating services indicated that requiring compliance with a service plan could potentially lead to more evictions. With requirements come consequences for failure to comply. Many clients, given the challenges listed above, would be unwilling or unable to follow through, which could lead to an eviction or their choosing to leave housing. This case manager prioritized housing above mandated services.

Mandating support services is counter to the Housing First model HSA has adopted, which does not condition housing on participation in other activities. However, given the mixed opinions on this issue, it merits further discussion. Is there a time frame, e.g., after a client has been stable in housing for a year or more, when they must commit to addressing other issues that would allow them to live without on-site crisis management services? Or alternately, is there a way to "incentivize" services geared toward self-sufficiency (e.g. through small rent reductions or special building privileges) rather than mandating them? Participation in support services can improve the quality of life of supportive housing clients, and HSA, in partnership with service providers, should consider how to increase client engagement in these services.

STABILITY VS. SELF-SUFFICIENCY

HSA prioritizes its goal of client stability with its providers by creating a "stability measure" to track outcomes. The measure focuses on housing retention, but not necessarily client self-sufficiency. In general, providers have been successful in meeting these stability goals, with just 3% of clients at Adult sites were evicted in FY12-13 and 1% from Family/Mixed sites. Keeping the eviction rate low is a challenging task given the extensive needs of this vulnerable population, and it speaks to the successful stabilization work provided by case managers. Perhaps because of the emphasis HSA has placed on stability, programs prioritize crisis stabilization over long-term work with clients on housing, employment, or other self-sufficiency goals.

In addition to the funding realities that guide this prioritization – HSA funds staffing ratios that do not allow for significant self-sufficiency activities on the part of case managers – in interviews, many case managers noted that client motivation also plays a role. They indicated that a client will follow through with service referrals while in crisis or to fulfill basic needs, but often do not have the skills or inclination to follow through on a long-term service plan after the initial crisis has been addressed. Thus, case managers are often left supporting clients to address immediate needs (e.g., housing retention) but are unable to work on deeper issues (e.g., mental health stabilization).

In particular, one case manager described client needs as cyclical, with one client experiencing a crisis and then stabilizing just as another client fell into his or her own crisis. This type of cycle means that a case manager performs more *crisis management* than case management, and it leaves some clients, those without urgent or visible needs, with less attention from the case manager. At least two case managers stated that they have a small number of clients that are stable and high-functioning and, with some dedicated support, could potentially move to non-supportive housing. However, both these case managers also stated that they were too busy managing crises to focus on those stable individuals enough to prepare them for non-supportive living.

Building tenants have mixed levels of need. Some case managers indicated that this can be helpful in modeling self-sufficiency to less stable clients. However, because client crises can take up significant case manager time, most case managers spend time on triage rather than supporting more stable clients in building additional self-sufficiency.

RECOMMENDATIONS

The Controller's Office noted significant benefits of HSA's permanent supportive housing program. Housing retention is quite high, as is stability. For such a high-need population, an eviction rate of just 1-3% is surprisingly low and testament to the work case managers do to support clients in their buildings. Additionally, the DPH trend data showing decreasing utilization of urgent and emergent services upon being housed is quite promising.

The recommendations offered below are not intended to indicate the program is not fulfilling its mission. Rather, they are intended to enhance this strong and established program through directional shifts, improved guidance and expectations, and further exploration of client needs.

RECOMMENDATION 1.0 – SERVICE PROVISION

1.1 Strategically Deploy Services. HSA should ensure that clients have the services they need at the time they need them by strategically deploying services throughout the supportive housing population. Using economies of scale, HSA should develop a system of roving services that can fill both clinical and self-sufficiency service gaps. For example, it may not be appropriate to conduct broad outreach about employment opportunities at every building, particularly as some buildings may house a majority of clients on disability and unable to work. Instead, roving teams can target services toward relevant populations, providing deeper levels of support than the on-site case manager may be capable of.

1.2 Address Self-Sufficiency Service Gaps. HSA should work with its providers to broadly assess the level of need among its clients in service areas related to building self-sufficiency and explore ways to leverage existing resources to fill the gaps identified earlier in this report. Discussion of services gaps can be found in the "Case Management Support and Service Utilization" section above. Roving services mentioned in Recommendation 1.1 may be particularly effective in filling these gaps.

1.2.1 Education and Employment Services: The proportion of clients able to take advantage of these types of services is currently unclear, as is the specific level of need. For example, most clients receiving SSI are disabled and unable to work and would not benefit from employment services. Such services would need to be targeted toward those with employment potential, and more research is needed to identify the scope and scale of need. HSA offers employment services for its CAAP, CalWORKs and Jobs Now clients. One solution may involve enhancing the coordination and linkage between HSA employment counselors and building case managers.

1.2.2 Housing Specialist: HSA should consider creating a roving housing specialist to support clients in learning about and applying for new housing opportunities and managing application materials and documentation. A model exists: the central intake agency for family shelters in San Francisco employs a housing specialist to do intensive re-housing work with homeless families. This model could be expanded to serve supportive housing clients as well.

1.2.3 Senior Services: Given the number of senior and disabled clients, utilization of IHSS is lower than expected. HSA should explore what the barriers to IHSS enrollment might be, and enhance outreach about the service to building case managers. Additionally, HSA should assess what senior services are most needed and what services are available in the community already. Where services exist, HSA should coordinate appropriate linkages between programs. Where gaps exist, HSA should explore means for addressing client needs.

1.2.4 Parenting Services: HSA should assess needs in this area, identify and leverage existing resources, and explore ways to address any gaps.

1.2.5 Other Self-Sufficiency Services: In addition to the services described above, other self-sufficiency services include money management, life skills, etc. HSA should assess needs in this area, identify and leverage existing resources, and explore ways to address any gaps.

1.3 Address Clinical Service Gaps. HSA should enhance the clinical support provided at its housing sites. While the new tier system (see Introduction) attempts to address issues of skill mix and level of need at sites through case manager ratios for sites with higher-need clients, even the more diverse buildings have clients with highly complex behavioral health and medical issues, often beyond the skill level of case managers assigned to those sites. HSA should address this by exploring the two recommendations offered below. Expanded Medi-Cal enrollment through the Affordable Care Act may provide some funding opportunities for both recommendations.

1.3.1 Behavioral Health Roving Team Expansion: This service is currently only budgeted for certain buildings with lower levels of service on-site. Given expanded access to healthcare coverage, including behavioral health services, it should be expanded to additional sites to further support case managers with addressing client crises and ongoing behavioral health care.

1.3.2 Roving Nursing Services: One building had a successful partnership with Samuel Merritt University's nursing program, with nurses stationed at the building for a six-week "community health" rotation. The case file review showed evidence of these nurses providing therapeutic support to one elderly client, resulting in her decision to move in with her daughter to alleviate her isolation. A roving nursing program could also help with medication management issues, preventative care, and referrals when a patient's medical concerns merit further treatment. The medical system is particularly complex, and roving nurses could help build trust and comfort and support the more appropriate utilization of medical care. The Behavioral Health Roving Team includes medical support, but as noted above, this service is limited to crisis intervention at specific buildings. A nursing program could support preventative care, medication management, and other non-crisis nursing needs.

RECOMMENDATION 2.0 – SERVICE QUALITY AND EFFECTIVENESS

2.1 Strengthen Service Expectations. HSA should clarify and strengthen its expectations about service delivery. Some new service delivery requirements have been implemented through the Tier system, and HSA should use that framework to help providers understand how it expects services to be delivered, primarily in the two areas below.

2.1.1 Outreach: Outreach is required upon move-in and at signs of housing instability. In many cases, case files showed that this outreach consisted solely of written notices left at a client's door. Such minimal attempts at outreach should not be considered sufficient, and case notes should also indicate other actions the case manager takes to engage the client about any housing instability, any resistance encountered, and how the case manager attempted to counter that resistance. HSA should provide additional guidance about these expectations to all service providers to ensure clients receive the necessary support, and enforce these standards through its case file reviews.

2.1.2 Eviction-Related Services: Case file reviews showed very little evidence of supportive services offered during eviction proceedings, though clients remain eligible for support services unrelated to the eviction. For example, referrals related to shelter or alternate housing, as well as linkage to other community-based support services would all be appropriate.

2.2 Strengthen Documentation Expectations. HSA should clarify and strengthen its expectations about documentation of services. Some new service delivery requirements have been implemented through the Tier system, and HSA should use that framework to help providers understand how it expects services to be documented. The two recommendations below provide examples of guidance HSA should consider

implementing to enrich the documentation by providers. HSA should engage providers in discussions about these recommendations and other options for ensuring and documenting client outcomes.

2.2.1 Referral Log: Each case file should include a referral log that tracks specific referrals provided, reason for the referral, and outcome of the referral. HSA should determine standards to assess success, and enforce standards through case file reviews.

2.2.2 Documenting Resistance: If clients are resistant to accepting services, case notes should document the resistance, and how the case manager attempted to counter that resistance. HSA should provide additional guidance to providers to ensure clients receive the necessary support.

2.2.3 Assessments and Service Plans: HSA has mandated that Tier IV and V buildings must conduct an assessment and create a service plan for clients. HSA should continue to assess the effectiveness of service plans, and consider providing guidance on required assessment areas (e.g., household needs, health care, education and employment, financial stability, etc.). Guidance should also relate to the level of detail required in case files necessary to show the activities and progress of case managers and clients in addressing any goals identified in the service plans. HSA and community providers should also consider what standards are appropriate for case management at supportive housing sites. HSA should consider the purpose of case management in these settings. A lack of engagement by clients has created a de facto "emergencies only" role for case managers, who focus their energies on triage with little ongoing "maintenance" work. Targeted roving teams may help address some service gaps, but HSA and its partners should continue to discuss the appropriate focus for on-site services.

2.3 Conduct Program Effectiveness Audits. HSA should conduct regular Program Effectiveness Audits. HSA currently conducts regular case file reviews to establish whether contracted providers are in compliance with regulations, e.g., outreach within first 60 days of move-in, etc. These audits do not address program effectiveness or assess outcomes for clients beyond stability. If a referral log is included in the case files, HSA can begin to understand the tangible impact of case managers on the lives of building tenants. With clarified guidance on documentation requirements and contact, HSA can assess whether case managers are engaging with clients appropriately to address housing instability, and whether they are helping clients move from stability to self-sufficiency. It is important to note that implementation of this recommendation would require additional definition within contracts, and would also require HSA staff time to conduct the monitoring, which would incur a cost.

RECOMMENDATION 3.0 – PROGRAM ADMINISTRATION

3.1 Create a Housing System Database. HSA should establish a database to track housing program clients and outcomes.

HSA is piloting a "Coordinated Assessment" tool. This is a single database tool that will be used to identify and prioritize clients for available housing placements (longest homeless, chronic homeless, most vulnerable, etc.). It is being piloted with the Shelter+Care Program but has no connection with supportive services in housing once someone becomes a tenant. HSA also uses the Homeless Management Information System (HMIS) to gather limited information about clients accessing homeless and housing programs.

While HSA tracks unit availability, there is no structured tracking and maintenance of client-level data in the permanent housing system. In order to conduct this study, the Controller's Office needed to request client

data from each housing provider separately. In addition to the level of effort required to request the data, this method resulted in several duplications as clients moved between housing sites within the year.

Particularly as the City's investment in supportive housing grows, tracking the effectiveness of services and client outcomes gains greater importance. Other City departments require nonprofit contractors to provide client-level data on a regular basis (e.g., DPH, Department of Children, Youth and Their Families).

If feasible, HSA should expand the functionality of an existing system (e.g., HMIS) to track clients throughout the housing program, including transitional housing, supportive housing, and housing subsidy programs. Some providers still use paper charts, while others have established internal databases for tracking clients, and stakeholders should be included in the development or expansion of a database to ensure smooth roll-out and to mitigate duplication of effort, as possible (e.g., field matching to streamline file uploads).

As a minimum standard, if creation of a central database is not feasible, HSA should create more uniform data tracking requirements for its providers, to ensure accuracy in analysis when combining data from multiple sources.

3.1.1 Standardize Exit Reasons: The stability measure used by HSA asks whether clients have retained their housing or left for other stable housing. In many cases, the case files did not indicate the type of housing clients exited to. Clients are not obligated to leave a forwarding address upon move-out, and as long as they do not owe back-rent, even exits to unknown locations are recorded as "stable." To the degree possible, HSA should consider standardizing exit reasons for outcome tracking purposes. Exit reasons should include, at minimum:

- Exit to unknown location – stable (no rent owed)
- Higher level of care (e.g., residential treatment program)
- Transfer to other supportive housing
- Exit to stable housing (e.g., subsidized or market rate housing)
- Living with family/friends
- Evicted
- Exit to unknown location – unstable (back rent owed, abandonment, threat of eviction)
- Death

3.2 Minimize CAAP Discontinuances. HSA should take a proactive approach to minimizing CAAP discontinuances. Case file reviews and case manager interviews highlighted the destabilizing effect CAAP discontinuances have on clients, in many cases jeopardizing their housing. HSA has already developed notification systems to support clients with re-enrollments in other benefits programs. For example, CalFresh uses a text messaging application to send automatic reminders to clients when program paperwork is due. HSA should explore adopting similar "hands on" techniques with CAAP administration to promote income stability and thus housing stability for its clients.

3.2.1 Restructure Benefit Incentives. HSA should continue to explore ways to restructure its various benefits program to support and incentivize work. Currently, a participant may lose CAAP eligibility when his or her income reaches a certain threshold, but this can potentially destabilize members with seasonal or intermittent employment.

RECOMMENDATION 4.0 – PROGRAM GOALS

4.1 Reframe Goals to Include Self-Sufficiency. HSA should consider changing the overarching goal of the housing program from stability alone to stability *and self-sufficiency*.

Traditionally, HSA uses a "stability measure" to assess the success of the program overall and the work of the providers. The equation considers whether the client maintains stable housing from year to year. While this is an appropriate goal, and may be the best goal for many clients, particularly those needing significant supportive services, an emphasis on stability alone may limit options and opportunities for other clients.

Case managers prioritizing crisis management have little time left for helping a stable client with a job or housing search. Other recommendations above attempt to address the needs of these more stable clients to promote transitions out of supportive housing when appropriate, and these recommendations should be placed in the context of a reframing of the program overall.

It is important to point out that the definition of self-sufficiency may vary by client. It would be unrealistic to assume that all, or even most, clients will be able to completely transition off of public benefits. Many may require various types of long-term support, such as Medi-Cal, nutritional assistance, or temporary or permanent subsidies. Despite this, HSA should make every effort to increase self-sufficiency to the degree possible for each client.

Challenges: This may require a restructuring of the measures of success and program effectiveness, as well as a potential shift in where program funds are directed. For example, if HSA funds roving case managers to support long-term self-sufficiency of clients, it will change the current ratios of case management within the buildings, and would require new or re-purposed funding. There is a possibility that directing services away from focused stability work could leave unstable clients without the support they need to remain housed. However, other recommendations within this report attempt to address that concern.

Benefits: Adding self-sufficiency to program goals potentially saves public funds by encouraging tenants who do not need support services to move to units without this extra cost. By encouraging these moves, supportive housing units can be made available for homeless residents needing housing and services. Additionally, building self-sufficiency improves client quality of life.

4.2 Explore Policies to Support a Full Spectrum of Housing Options.

HSA, in partnership with the citywide housing system (e.g., DPH, Mayor's Office of Housing and Community Development, etc.) should explore policies and proposals to fill gaps in the current array of housing options.

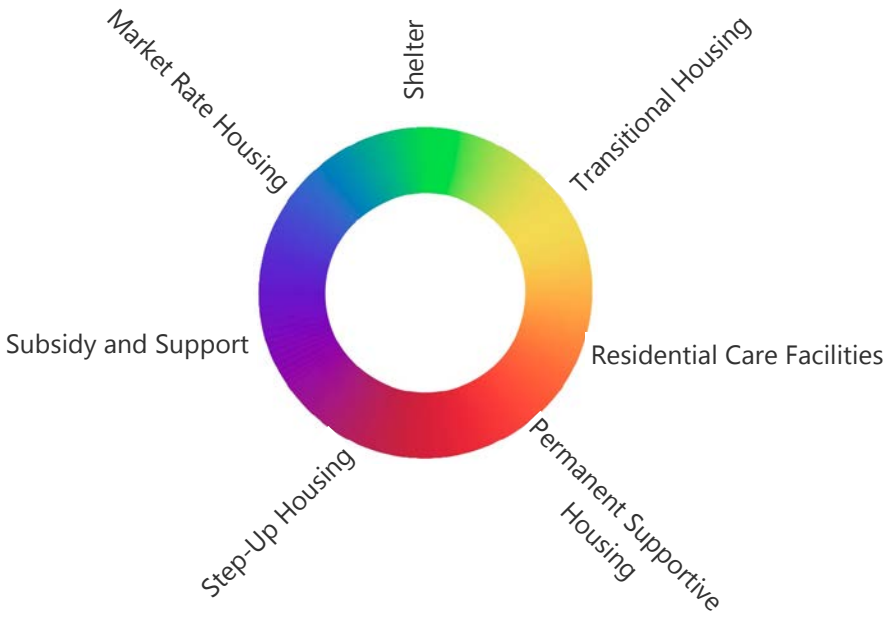
In recent months, newspapers and elected leaders have begun discussing San Francisco's housing programs using the term "Housing Ladder." The imagery evoked by the term "ladder" is one of rungs in a line, with an individual stepping from rung to rung, from homelessness to self-sufficiency in market rate housing. While this is an admirable goal, the framework ignores the basic realities of both homelessness and housing in San Francisco. Clients enter housing with unique and varied needs. Some will be able to stabilize and will require less support to remain housed, but these individuals may be on a fixed income barring them from most housing options in the region. Others will always need support services to remain stable. The image of an individual climbing, rung by rung, toward self-sufficiency does not accurately represent the experiences of individuals as seen in the interviews, surveys and other data gathered through this research.

Instead of a straight and progressive path up a ladder, the City's vision should be that of a spectrum of housing, with a diversity of options to allow each individual to be matched with the appropriate level of support s/he needs to achieve stability. Each individual's complex circumstances determine their placement on the spectrum.

Unfortunately, though the vision is sound, the spectrum is incomplete. The lack of affordable housing in San Francisco leaves low-income clients that could potentially live stably without support services remaining in

units with HSA-funded services attached. Alternately, a dearth of residential care facility beds could mean seniors with escalating illness or disability may not get the level of care they need in their current setting.

FIGURE 25: HOUSING SPECTRUM



A complete spectrum of options might include the following:

- **Shelter:** Short-term emergency services for homeless individuals and families
- **Residential Care Facilities:** Assisted living for individuals with complex health care needs requiring on-site support. (***High-need area)***
- **Transitional Housing:** Long-term housing services, generally lasting less than two years, which can be used as a bridge between homelessness and market-rate housing
- **Permanent Supportive Housing:** Permanent housing units with on-site case management and support services
- **Step-Up Housing:** Permanent housing, with limited support services on-site. Units are often in nicer buildings, have more amenities, and have few restrictions (e.g., overnight guests). Current Step-Up buildings are Master Lease sites, meaning they have fixed rent. These sites are less desirable for clients housed in LOSP buildings where rent is a percentage of income.
- **Subsidy and Support:** HSA currently operates a General Fund-supported rental subsidy program. It is targeted at homeless families or those at risk of homelessness. Clients generally remain on the subsidy for up to two years while increasing their income to be able to transition off of the subsidy. Other subsidized housing options, such as Section 8, are severely limited in availability. Individuals receiving CAAP, as well as low-wage workers, would not be able to afford market rate housing without a subsidy. Connection to support services (possibly time-limited) may also be necessary to ensure housing stability. (A program of decreasing subsidy would not be viable for clients on SSI or other types of fixed income, as they will likely always need a subsidy to remain housed.) This is one of the biggest gaps in the spectrum. ***(High-need area)***
- **Affordable and Market Rate Housing:** Clients on fixed incomes, such as SSI, will not be able to afford market rate housing anywhere in the Bay Area, and even Affordable Housing may be out of reach.

Employed clients may be able to afford market rate or affordable housing with the right support services to increase self-sufficiency.

See the table below for possible barriers to creating a full spectrum of housing options, with strategies that may have the potential to help overcome those barriers. These strategies are not meant as firm proposals, but rather as starting points for further discussion on the topic.

FIGURE 26: SUMMARY OF BARRIERS AND POTENTIAL STRATEGIES FOR CREATING A FULL SPECTRUM OF HOUSING OPTIONS

Barriers	Potential Mitigation Strategies
<u>Not all options exist.</u> The limited pool of subsidized housing available and the gap between the cost of supportive housing and market rate housing makes it difficult for clients to find their most appropriate place in the spectrum.	<u>Pilot programs.</u> Instead of rolling out large-scale programs to create new housing options, pilot programs can be used to conduct smaller tests of change that can be scaled up if successful. The data here suggests that tenants in Family/Mixed sites may have more potential for mobility (e.g., more likely to attain employment). Using specific criteria, such as a minimum length of time stably housed in supportive housing, HSA can consider expanding its current rental subsidy program, linked with support services, and targeted toward supportive housing residents with the potential to increase their income. It will be important to gather progress and outcome data to measure the success of the pilot. **New funding would be necessary.* <u>Prioritize affordable housing units for supportive housing clients.</u> Examples exist of targeted populations receiving priority status for affordable housing units (e.g., HIV positive clients). Though prioritizing units for the supportive housing population would require negotiation with a broad array of stakeholders, it would not require additional funding to implement.
<u>Steep subsidies needed.</u> Given the price of market rate housing, the amount of subsidies needed to transition out of permanent supportive housing may be insurmountable for many clients, particularly those on fixed incomes, like SSI. Providing such subsidies is an expensive proposition for the City.	<u>Pilot programs.</u> Again, starting small programs to test program effectiveness will support the eventual growth. <u>Engage private sector and foundations.</u> The City may need to invest its own resources in a pilot, but with proven interventions, HSA can engage others in the solution more effectively. <u>Develop regional solutions</u>. Though the cost of housing is growing throughout the Bay Area, clients willing to move out of San Francisco may have more options for affordable,

	subsidized, or market rate housing. HSA should explore partnerships with regional housing providers to create more direct linkage to housing stock outside the City limits. This may involve convening a regional summit on housing and homelessness designed to develop partnerships among counties, providers and businesses.
<u>Moving is challenging.</u> The application process for affordable and subsidized housing is cumbersome and time consuming. Additionally, planning the move itself has costs that are often unanticipated. The stress of moving can destabilize someone, particularly if the move takes them away from their support network.	<u>Provide moving assistance services.</u> As part of the pilot, HSA could provide certain moving assistance services to address both the emotional needs of managing the stress of a move and the financial needs that might arise. <u>Streamline application process.</u> HSA should consider creating a tool to manage applications to various housing programs. Often clients stay on waitlists for years, and then can be removed from the list because renewal paperwork went missing. An application management tool would help clients know what lists they are eligible for, how to apply to each and send reminders about missing paperwork or renewal notices, giving clients the most current information about their status for all types of housing. This may require integration with various federal and local systems, but could streamline the work and create new efficiencies for staff and clients. **Note: the Mayor's Office of Housing and Community Development is in the process of developing a website to help clients navigate the housing options in the area.*
<u>Fixed incomes.</u> According to the client survey, 58% of respondents at Adult sites receive SSI or SSDI. These individuals' incomes are unlikely to increase, meaning they will never be able to afford market rate housing.	<u>Increase case manager focus on job training and employment.</u> Nearly half of all Family/Mixed survey respondents stated they have a paid job or receive CalWORKs. Though many clients in supportive housing are likely no longer within the labor market, the generally younger clients within Family/Mixed sites could still engage in education and employment services and increase their income. This would require focused effort and attention by case managers, which is currently targeted to clients in crisis.
<u>Lack of incentives to move</u>. Supportive housing is permanent, and there is no requirement that tenants move out. Some stable clients prefer to stay in their current	<u>Incentivize other options</u>. Explore ways to make other options in the housing spectrum both attainable and desirable. Consider incentives to encourage moves. Subsidies may be

home, though they may not need the supportive services attached to the building.	one incentive, but there may be others that would encourage tenants to take the risk.
Other Barriers to Consider: • There is a low supply of affordable housing in San Francisco and the Bay Area. • Existing tenants in supportive housing must move for the system to be fully functional, but the average length of stay is currently quite long. • Many current clients in supportive housing are resistant to moving outside of San Francisco.	

RECOMMENDATION 5.0 - WORKGROUP

5.1 Convene Workgroup. HSA should convene a workgroup of City program staff and community-based service providers to consider the implications of this report and draft an implementation plan for its recommendations.

Many of the recommendations offered below require input from a variety of stakeholders to fully and effectively enact. HSA has convened such groups in the past, and might consider the example of the Single Adult Supportive Housing (SASH) Workgroup as a model.