Reducing Chronic Homelessness in San Francisco
The 1970s and 1980s resulted in homelessness as we see it today.

**Declining Supply of Affordable Housing**
- Cuts to housing construction and Federal housing assistance
- **Demolition of substandard housing** due to high maintenance, aging infrastructure
- Conversion of rental units to condos for urban renewal
- **Lapses in assistance**: three quarters of qualifying households do not receive income-based rental assistance

**Rise in Income Inequality**
- **Increased cost of living** with local growth of high-skilled jobs
- **Loss of low-skilled** and manufacturing jobs; rise of service and retail sector jobs
- Stagnation in **low-income wages** jobs
- Changes in minimum wage **lagging behind inflation rate**
A growing shortage of affordable housing continues

**Affordable units vs. number of low-income renters in San Francisco**

- **2000**: Available units: 16,882, Extremely low-income renters: 48,847
- **2013**: Available units: 23,112, Extremely low-income renters: 64,698

Available units
Extremely low-income renters
Along with unprecedented income inequality paired with the stabilization of poverty.

Since 1990, the number of low-income and high income households have increased dramatically while the number of mid-income households has declined.

Approximate number of households in San Francisco:

- Low income <$25k: +14%
- Mid-income $25-100k: -19%
- High-income >$100k: +82%

Today, the top 5% households in San Francisco make 17x more annual income than the bottom 20% households...

...and >53% of low-income households in Bay Area at-risk of or experiencing displacement.

Source: Brookings Institute "Some cities are still more unequal than others" 2015, San Francisco Human Services agency and US Census, Urban Displacement Project 4 conducted by UC-Berkeley and UCLA (2013 data)
Public policy changes further exasperated growth of homeless and vulnerability of population

**Policy reforms targeting social systems failed to provide corresponding community investments**

**Mental Health**

Deinstitutionalization of mentally ill without an increase in funding for community supports;
Began in the 1960s with major funding cuts in the 1980s

**Social Welfare**

Loss of subsidies for low-income groups:

- HUD authority shrank from $83B to $18B\(^1\) from 1978 to 1983; loss of rental subsidy, rise of homeowner subsidy
- Dramatic cuts to cash assistance (e.g. Aid to Families with Dependent Children and General Assistance)

**Criminal Justice**

Mass incarceration that increased jail and prison population from <200,000 in 1972 to 2.2M today;
Reforms without investment in community reentry supports, leaving individuals with a record, debt, social disconnection

**Result**

Systems failure resulting in clear failure of our safety net: homelessness
Approximately 7,000 homeless in San Francisco on any given night.

Total homeless population has stayed steady while sub-populations have fluctuated.

Annual fluctuations in homeless sub-populations:
- Chronic, unsheltered: 20% decrease in 2015, 31% increase in 2017
- Chronic, sheltered: 12% increase in 2015
- Non-chronic, unsheltered: 23% decrease in 2017
- Non-chronic, sheltered: 12% increase in 2015

Note: Change in Point-in-Time counting methodology creates artificial increase.

Our $100 million investment will focus on chronic homelessness

Ch3ronically homeless are those who have a disabling condition; and have been homeless for over a year or 4 times in 3 years.

- 30% CHRONIC HOMELESSNESS
  ~2100 individuals

- 70% EPISODIC HOMELESSNESS
  ~5000 individuals

Source: 2017 San Francisco Point-In-Time Count + Survey
Emergency medical, mental health, and substance abuse services spend greatest amount on chronically homeless

<table>
<thead>
<tr>
<th></th>
<th>All homeless</th>
<th>High users, long time homeless</th>
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<tbody>
<tr>
<td><strong>Medical</strong></td>
<td><strong>Total cost</strong></td>
<td># people</td>
</tr>
<tr>
<td></td>
<td>$109.4 million</td>
<td>6,401</td>
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<tr>
<td><strong>Mental health</strong></td>
<td>$34.7 million</td>
<td>2,445</td>
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<tr>
<td></td>
<td>$4.5 million</td>
<td>1,847</td>
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For total emergency health costs, the top 13% of homeless users make up 72% of total costs

Note: PES (Psychiatric Emergency Services); ADU (Acute Diversion Unit)
The Tipping Point strategy will build towards a five-year vision to **drive systems change**, with a clear impact target

**Create more housing:** Target chronically homeless and streamline housing access and creation
- Movement between housing levels of care
- Prioritization of most vulnerable for housing with buy-in for effective implementation

**Prevent homelessness:** Intervene at key moments of opportunity, times when the public sector interfaces with those most at risk of becoming chronically homeless
- Improved care transitions
- Know the at-risk population by need and provide services based on individual need

**Optimize public sector:** Maximize funding and coordinate, individualize approach to homelessness
- Leverage and maximize dollars
- Understand, through data, the impact of funding, interventions, and policy on homeless population

**50%** REDUCTION OF 2017 CHRONIC HOMELESSNESS
With a focus on redefining funding relationships to create aligned investments and greater impacts

**Government**
Maintain a safety net of services for the most underserved by promoting integration and coordination, and sustaining proven interventions

**People in need**
Share expertise based on first-hand knowledge of conditions, experience, and what works.

**Non-profits**
Provide culturally competent services rooted in community needs in a coordinated partnership with the public sector

**Philanthropy + Private Sector**
Raise flexible private dollars to drive innovation, risk-taking, and public-sector systems change

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**Maximize State / Federal funding to expand homelessness services**

- **Medicaid** through Affordable Care Act, Whole Person Care
- **Housing Vouchers** through Section 8 HUD program
- **TAY Housing and Services** through Title IV-E

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People in need
Share expertise based on first-hand knowledge of conditions, experience, and what works.
Challenges

<table>
<thead>
<tr>
<th><strong>Goal</strong></th>
<th>Creating mutual accountability across multiple systems</th>
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<tbody>
<tr>
<td><strong>Objective</strong></td>
<td>Increase affordable housing and provide support services as needed</td>
</tr>
<tr>
<td><strong>Barriers</strong></td>
<td>Housing IS health but not viewed as a health outcome</td>
</tr>
<tr>
<td></td>
<td>Medicaid: Eligibility ≠ Enrollment ≠ Access ≠ Good Outcomes</td>
</tr>
<tr>
<td></td>
<td>Housing providers and health providers don’t speak the same language</td>
</tr>
</tbody>
</table>
Housing is Health: Funding Opportunities

With Affordable Care Act the Majority of the Homeless are eligible for Medi-Cal

Increase Medi-Cal Enrollment

- Solutions that look at community-based enrollment at shelters, jail, and outreach at encampments

Support policy and practice changes

- Hold Managed Care Organizations accountable for housing as an outcome
- Help bring health plans to the table to fund support services
  - Example: VASH- vouchers provided by HUD, support services provided by VA, for non-vets, health providers could partner or sub-contract with housing providers
Increase number of affordable housing units

- Fund housing subsidies
- Provide capital for affordable housing

Support public systems interacting with clients who are homeless, or at risk of homelessness focusing on improving transitions and discharge from systems, including:

- Child welfare
- Criminal justice
- Mental health
Information sharing

• Help support sharing between multiple systems serving people experiencing homelessness

Participate in aligned and coordinated funding

• San Francisco Funders Table to End Chronic Homelessness