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**An Outcome Analysis of the Achievement of the Five Objectives by the
Housing 1000 Care Coordination Project:**

Ending Homelessness in Santa Clara County Through Affordable Housing

By

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A Thesis Quality Paper
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INTRODUCTION

Homelessness is a pervasive and epidemic problem throughout the United States. It is estimated that there are over 2 million homeless individuals in the United States each year (Santa Clara County, 2013). This number is considered an underestimate of the actual number of homeless individuals because it does not count those who choose not to enter through formal homeless support networks that register individuals through central tracking databases. These databases hold key information that allows agencies and counties nationwide to study the pervasiveness of the homeless problem within their cities and counties. It also allows agencies and counties to generate information that is useful to track individuals as they navigate through systems and determine if their programs are meeting agency goals.

Local governments also track homelessness. In California, the Santa Clara County Homeless Census and Survey Report performed a point-in-time survey in January 2011 and found that there were 7,045 homeless people in the county, of whom 2,520 were chronically homeless. The three main causes of homelessness reported in the report were job loss (27%), alcohol/drug abuse (20%) or an argument with a family or friend (10%). Additionally, 70% of individuals reported having a disabling condition. A person is considered to have a disabling condition if he has any of the following criteria: has a physical or developmental disability, mental illness, severe depression, PTSD, chronic health problems, HIV/AIDS, Hepatitis C, Tuberculosis, or substance abuse. The most common disabling conditions in Santa Clara County are mental health (46%) and substance abuse (39%). (Santa Clara County Homeless Census and Survey – Fact Sheet, 2011).

A total of 18, 272 people experience homelessness each year. However, not every individual accesses government assistance programs. According to the Santa Clara County Homeless Census and Survey Report (2011), 36% received no government assistance, 43% received food stamps, 33% received general assistance, 8% received SSI/SSDI, 2% received Cash Aid/CalWORKS. Over 75% of

individuals had resided in Santa Clara County prior to being homeless. Over 73% of homeless individuals did not have adequate shelter. First time homelessness was reported in 48% of individuals. Additionally, the length of time that each individual experienced his or her last period of permanent housing prior to becoming homeless in Santa Clara County varied. The report shows that 11% had been homeless for less than 1 month, 24% for 2-6 months, 13% for 7-11 months, 28% for 1-2 years, 10% for 2-3 years, and 14% for more than 3 years.

Mortality rates for homeless individuals are two to four times higher than that of the general population. Thus policies that focus on reducing homelessness through innovative programs are vitally important to local communities. Homeless shelters are one such program that communities use to temporarily house individuals and families. However, shelters only provide temporary respite for individuals and there are always a limited number of available beds. While short term stays in shelters that lead to housing have been associated with positive outcomes for individuals and families, studies have shown that long-term use of the shelters actually leads to higher mortality rates. Metraux, Eng, Bainbridge, & Culhane, (2011) conducted a study of 160,000 individuals and families who were admitted through the New York Municipal Shelter system from 1992-2002. They found that mortality rates for males and females was reduced when they exited to housing that was either subsidized or non-subsidized. However, extended shelter use patterns showed increased mortality rates for both groups. The key implications for their study shows that linking individuals to housing quickly is positively associated with reduced mortality but prolonged pattern of shelter usage is actually negatively associated with mortality rates.

The complex issues of those who are chronically homeless pose challenges for case managers who struggle to find appropriate resources on limited budgets, all the while trying to gain the cooperation from supporting agencies. Case managers face challenges with timelines, individual's

motivation, lack of available resources, and legal issues. Chronic homelessness, therefore, is both a social and health problem that is only addressed through multiple angles and strategies. No one solution will solve the homeless issue for any one agency or county. Key strategies used by case workers include locating affordable housing, assisting with vocational and employment training, tying in mental health and substance abuse treatment programs, addressing unresolved medical issues by ensuring that individuals sign up for low cost health insurance (Medi-Cal and Medicare), and applying for financial assistance for individuals through programs like Social Security Disability (SSDI), Supplemental Social Security (SSI), General Assistance (GA) and Food Stamps. Most of these solutions require the client to be actively engaged with their case managers.

The United States is not the only country with a homeless problem. In an article by de Vet, van Luijelaar, Brilleslijper-Kater, and Vanderplasschen et al. (2013) it is estimated that the lifetime prevalence for homelessness in the United States is around 5.6% and 13.9% for Europe. This shows that homelessness occurs globally. With this in mind, perhaps other country's strategies can be employed in the United States to address what can be considered a global issue.

In the United States, rising home prices and apartment rents coupled with economic instability have caused even the American middle class to experience homelessness. Families have been displaced and have had to live in shelters (Grant, Gracy, Goldsmith, Shapiro, and Redlener, 2013). Other causes of homelessness include individuals with severe mental illness (SMI) (Hodgson, Shelton, van den Bree, and Los, 2013), frequent encounters with law enforcement (Fedock, Fries, and Kubiak, 2013), being female (Tsai, Rosenheck, and Mcguire, 2012), loss of job or insufficient income (O'Connor, Kline, Sawh, et al., 2013), lack of social support (Clark and Lee, 2013), drug abuse (Linton and Shafer, 2014), lack of affordable housing (Loftus-Farren, 2011), and a history of physical and emotional abuse while in foster care systems (Dworsky, Napolitano, and Courtney, 2013). Many individuals may suffer one or a

few of the aforementioned causes of homelessness throughout their lifetimes and never become homeless. However, taken cumulatively these factors place higher than average stressors on individuals with these life experiences.

National efforts to end homelessness involved the Housing 100,000 campaign that had the intended goal of housing 100,000 individuals by the year 2014. The campaign was run by Community Solutions and involved partnering with over 230 communities throughout the United States (Johnson & Maquire, 2014). Santa Clara County's local campaign to end homelessness involved a partnership with the City of San Jose, private corporations, and non-profits. This campaign was called the Housing 1000 Care Coordination Project. The Housing 1000 Care Coordination Project's initial goal was to identify 1000 of the most vulnerable homeless individuals in Santa Clara County and provide services that would result in long term housing by 2014. It worked by providing intensive case management to homeless individuals in order to help them transition from unsheltered to sheltered housing that is permanent and stable. The program initially began when the Santa Clara County Board of Supervisors approved funding for 100 housing vouchers for homeless individuals meeting certain criteria. The program's proposed end date was 2013 and was to be evaluated on a yearly basis (Seipel, 2012). The Housing 1000 Care Coordination Project actually ran from July 1, 2011 through December 31, 2014.

The Housing 1000 Care Coordination Project was a collaborative that partnered with project Destination: Home, Santa Clara County Collaborative on Affordable Housing and Homelessness (The Collaborative), City of San Jose, Santa Clara County, and Community Technology Alliance (CTA) (Mitchell & Meng, 2012). Additional support came from other non-profit and for-profit agencies such as Catholic Charities, New Directions, and St. Joseph's Family Center.

The County of Santa Clara planned to spend \$1.2 million for chronically homeless individuals over the course of the year. Another 25 vouchers would provide a monthly housing subsidy in the

amount of \$1,000 each and be paid for through AB109 funding (Mitchell and Meng, 2012). A portion of AB 109 funding was allocated from housing costs for jail parolees because it reduces recidivism (California Mental Health Planning Council, 2013). Actual costs for the city's homeless population were unknown due to the difficulty in tracking homeless individuals' information due to privacy related data collection limitations, but one of the Care Coordination Project's intended goals is to gather baseline data on this factor. However, initial estimates based on other regional programs estimated that it costs Santa Clara County \$60,000 per homeless individual annually. The cost could be reduced in half if proper housing were obtained (Siepel, 2012).

Destination: Home was responsible for locating case management agencies through the Requests for Proposal (RFP) process. Case management is an essential part of placing homeless individuals because studies have shown that providing case management helps homeless individuals transition to housing and decreases hospital room stays and emergency room visits (Sadowski, Kee, VanderWeele, & Buchanan, 2009). A study by Sadowski, Kee, VanderWeele, and Buchanan (2009) showed that homeless HIV patients' health improved when offered case management and housing. Agencies adopted this same approach when working with the chronically homeless individuals in this study.

There were four Santa Clara County agencies selected from the RFP process that provided case management for the Housing 1000 Care Coordination Project. Case managers were responsible for contacting the homeless and locating housing and other resources for them. The lead case management agency was EHC Lifebuilders. EHC Lifebuilders is a nonprofit which operates eight housing and shelter sites across Santa Clara County. However, EHC Lifebuilders only has approximately 1,200 beds available at its shelters, thus emphasizing the need for permanent supportive housing for the over 7,000 homeless individuals in Santa Clara County (Byrd, 2013). The other agencies involved in the program were the Downtown Streets

Team, InnVision the Way Home, and New Directions. The Community Technology Alliance (CTA) was responsible for tracking all data on clients and their demographics as they entered the program through the Homeless (Help) Information Management System (HMIS).

The Housing 1000 Care Coordination Project was completed at the end of December 2014. It showed the following results:

- *715 chronically homeless individuals and families received housing*
- *Out of the total number, 190 veterans received housing*
- *230 men and women were housed that used to live in encampments*
- *4,000 men and women were surveyed in Santa Clara County and entered into the Housing 1000 registry*
- *In Santa Clara County, 81% of individuals who were successfully housed remained housed in a 12 month period.*
- *Nationally the estimated savings to taxpayers for housing homeless individuals is \$1.3 billion (Johnson, Loving, & Maquire, 2014).*

LITERATURE REVIEW

PATHS TOWARDS HOMELESSNESS

Adverse early life events place individuals on the path towards homelessness if they are not mitigated early enough. The causes and effects include individuals who grow up in social deprivation, suffer from severe mental illness (SMI), lack needed social support, and suffer physical and mental abuse by one or both parents. These individuals are at an added risk for becoming homeless (Padgett, Smith, Henwood, & Tiderington, 2012). The youth are a special population that are exceptionally at risk for homelessness if they leave their home prior to age 18 or 19, primarily because most young individuals are not prepared financially or emotionally, and do not have the needed social supports to sustain themselves prior to graduation from high school (Fielding & Forchuk, 2013)

Young individuals who become homeless are often placed on that trajectory through multiple negative life events. These events are termed *transitions* and primarily deal with young individuals who are placed in the foster care system. Individuals who end up homeless who were previously involved in and out of the foster care system reported multiple foster placements and experienced higher degrees of abuse and neglect (Tyler & Schmitz, 2013).

Other common transitions or themes that place individuals on paths towards homelessness include leaving home prior to age 18; dropping out of school resulting in insufficient education and affecting future employment opportunities; drug use; witnessing violence or being the victim of violence; neglect by one or both parents; sexual abuse or trauma; and other conflicts. Indeed, abuse and conflict were cited as the number one reason that young individuals ran away from their households (Tyler & Schmitz, 2013). Perpetuating the cycle of homelessness, young individuals who are victims of violence learn only that violence is the way to cope with the physical and emotional stressors in their lives. This leads to many run-ins with law enforcement, which further complicates their issues of

homelessness, because legal issues place barriers on employment opportunities (Fielding & Forchuk, 2013). Taken together these factors make it extremely difficult to access needed services later on in life.

HOMELESSNESS AND HEALTHCARE

Research shows that homeless individuals have a significantly higher rate of unmet medical needs and emergency room visits (Argintaru, Chambers, Gogosis, et al., 2013). De Vet, et al. (2013) shows that this number is as high as 73%. One contributing factor of higher than average emergency room visits was reported in a study by Lebrun-Harris, Baggett, Jenkins, et al. (2009). They showed that homeless factors such as mental health needs and drug and alcohol addiction were leading factors contributing to increased rates of emergency room visits.

Unmet medical needs are also associated with statistically higher rates of mortality among chronically homeless individuals (Linton & Shafer, 2014; and Hwang, Lebow, Bierer, et al., 1998). Homeless individuals are at a higher than average risk for infectious disease (Gerber, 2013). Other conditions that lead to earlier mortality among homeless individuals include HIV, obesity, pneumonia, tuberculosis, hepatitis C, cardiovascular disease, and diabetes (Lydia, et al., 2012). A review of premature indicators of mortality amongst homeless populations also shows that illness and disease are likely contributing factors but mental health and substance abuse are not (O'Connell, 2005).

Lydia, Tsai, and Rosenheck (2012) found that chronically homeless individuals were more likely to use hospital emergency rooms as their primary preventative care doctor if they did not have healthcare insurance. Hospital resources become strained when individuals seek care through the emergency room without a true emergency. On the other hand, individuals may only use the emergency room because they know that hospitals cannot refuse services to anyone, and may only go to request things such as medication refills, medical equipment, housing resources, substance abuse treatment, or just respite from the elements during inclement weather conditions. Emergency rooms are also used by

individuals who are at imminent risk for becoming homeless or are seeking shelter from domestic violence situations. In fact, homeless individuals' patterns and utilization of hospital emergency room services were 3.8 times higher than the average Medicaid user in one Boston hospital study (Bharel, Wen-Chieh, Jianying, et al., 2013).

Shelter and food appear to be a large part of the reason why homeless individuals seek out emergency room care, aside from true medical needs. This places unnecessary strain on hospital resources, as homeless individuals need to receive a full medical evaluation, taking time and resources away from those suffering from true medical emergencies. Engaging individuals prior to entering the hospital emergency room is a more proactive strategy. Multiple services, linkages, and accessibility are identified as key elements to preventing and eliminating the homeless epidemic. However, individuals may not actively seek out these resources because they are unable or unwilling to locate these resources because of a fragmented system or lack of available transportation, wait lists, income, and feelings of hopelessness. Indeed an individual's motivation may be a large factor in whether or not he/she seeks help and wants to get out of homelessness. Given that many chronically homeless people are frequent users of hospital emergency rooms, hospitals that set up task forces targeting these individuals and developing strategies to address this issue may show promising results in reducing the homeless epidemic.

MENTAL HEALTH, SUBSTANCE ABUSE, AND LEGAL BARRIERS

Aside from unresolved medical issues, individuals with drug and alcohol dependence also have co-occurring mental health disorders (Lebrun-Harris, Baggett, Jenkins, et al., 2009). Cities have in the past enacted ordinances against vagrancy, sleeping in public, camping in public, and begging. This "criminalizing" of homelessness has not helped solve the city's problem but only served as a means to disperse homeless to other locations (Liese, 2006).

It is difficult to address a single issue without touching on another. Mental health, substance abuse, and problems with the law may overlap and be so intertwined that an individual cannot be placed in permanent housing unless all three are addressed at the cost of considerable time and resources. Research shows that 40% of homeless individuals suffer from alcohol related disorders, 25% from drugs, 13% from psychosis, 11% from depression, 23% from personality disorder, and 73% from an unmet medical need (de Vet, et. al., 2013). Drug and alcohol dependence is associated with the barriers to housing placement, right behind employment (Aguilar, 2013).

Subsets of individuals who are particularly vulnerable include single mothers and formerly incarcerated individuals. Single mothers were an especially vulnerable population who faced overwhelming barriers in locating housing if they had a substance abuse issue (Clark and Lee, 2013). Individuals released from prison also represent a subset of individuals who face an extremely difficult time in finding housing. That is because of the stigmatization associated with incarceration and the fact that many shelters will not admit individuals with a criminal record if the nature of the offense was violent in nature or included a sexual offense. Furthermore, sexual offenders have few options of where to live based on the nature of their crime, and very few resources are available for them. (Zgoba, Levenson, and McKee, 2009). Individuals being released from prison face an almost insurmountable task of finding housing when they realize that there are very few resources for them. Inmates are released without incomes or may have a physical or mental health illness that make placement extremely difficult. They are unable to establish a foothold in the community without financial assistance such as AB 109 housing subsidies (Mitchell and Meng, 2012).

Serowik and Yanos's (2013) study shows that 13% of prison inmates have a severe mental illness, with recidivism rates as high as 78%. A study by Greenberg and Rosenheck (2008) shows that jail inmates were 7.5 to 11.3 times more likely to have experienced homelessness the year prior to being

incarcerated. This population is more vulnerable to homelessness as a result of being recently incarcerated, along with their mental illness. Padgett, Smith, Henwood, & Tiderington (2012) found that this population experiences a higher degree of stressful life events that are associated with social losses, such as the loss of someone close to them and an overall lifetime of adversity.

While incarceration for some is an unavoidable outcome, the plan identifies mental health treatment in lieu of incarceration. Treatment is seen as a better alternative to breaking the cycle rather than incarceration. Since post-incarceration individuals have a more difficult time accessing services, programs are designed to link individuals being released from jail with needed services (Santa Clara County Task Force, 2005). In fact, for some nations, jails have become the last institution for housing individuals with mental illness (Huxter, 2013). Tsai and Rosenheck (2012) found that individuals who were incarcerated for more than one year had a significantly harder time accessing resources and had a higher degree of homelessness than those with no criminal histories.

THE ROLE AND IMPORTANCE OF CASE MANAGEMENT

The goal of any homeless services program is to find affordable housing for chronically homeless individuals. This task is daunting considering the already discussed complexity of homeless individuals' issues and lack of available resources. Nevertheless, case management is an essential part in forming recovery chains and assisting individuals with housing resources. Chronically homeless individuals reported that case management services significantly decreased feelings of isolation, increased their feelings that someone cared, valued help with navigating the "system" of services, and reported subjective feelings of overall improvements in their personal health (Davis, Tamayo, Fernandez, & Cresswell, 2012). The process begins through a comprehensive assessment to identify a client's needs. Usually these assessments identify an individual's needs based on the severity of the risk associated with being homeless. Risks can be directly linked to the degree at which an individual is at

risk for death if services are not put in place. Once an individual's risk is identified, he is prioritized and assigned case managers that will handle the individual cases (K. Lee, personal communication, 2015).

Since each case is unique, case managers face many barriers when working with chronically homeless individuals. Barriers prevent individuals from being able to locate and reside in permanent housing and usually fall into several categories. These categories can include the following areas: financial support, substance abuse and treatment programs, medical and mental health complications, elderly and frail, and problems in the legal system. What makes these barriers difficult to address is the interrelatedness of them to each other (Mago, Morgan, Fritz, et al., 2013).

Financial assistance programs are one of the biggest barriers to assisting individuals in finding housing and keeping individuals housed. Some individuals may have not worked enough eligible quarters and therefore may not be eligible for Social Security Disability Insurance (SSDI). Alternatively, individuals may be on SSDI and may not be eligible for further financial assistance or may be unable to go back to work. Others may not be able to maintain employment due to substance abuse, disability, age, or mental health. Indeed, substance abuse was associated with rates of first time homelessness (Thompson, Wall, Greenstein, et al., 2013).

For those individuals with substance abuse issues, case managers may attempt to get them into treatment, but this is also dependent on a few factors. Some of these factors are: 1. Whether or not the individual is motivated to change, 2. Whether there are any appropriate programs for the individual to participate in, and 3. Whether the individual been barred from any program due to past behaviors. Oftentimes, lack of motivation or unwillingness to change the behavior is a leading factor in failing to find housing. The following is a list of additional factors that have been associated with homelessness and consequently if left unaddressed continue to contribute to the problem. Case managers must work to find solutions to these issues that many of their clients may face.

Factors Associated with Homelessness

- **Automobile related** – Broken down car, no insurance, tickets, etc.
- **Decline in Public Assistance** – Current TANF benefits and food stamps combined are below the poverty level in every state; in fact, the median TANF benefit for a family of three is approximately one-third of the poverty level. Thus, contrary to popular opinion, welfare does not provide relief from poverty.
- **Divorce** - Divorce often leaves one of the spouses homeless. Most often it's the father, but sometimes it's the mother and children or everyone involved.
- **Domestic Violence** – Battered women who live in poverty are often forced to choose between abusive relationships and homelessness.
- **Drug and Alcohol related problems** – Rates of alcohol and drug abuse are disproportionately high among the population without homes.
- **Illness** - For families and individuals struggling to pay the rent, a serious illness or disability can start a downward spiral into homelessness, beginning with a lost job, depletion of savings to pay for care, and eventual eviction.
- **Job loss** – No income to pay rent.
- **Lack of affordable housing** - The lack of affordable housing has led to high rent burdens (rents which absorb a high proportion of income), overcrowding, and substandard housing.
- **Lack of child support** – In families where child support is ordered but not paid, the decrease in income can lead to an inability to pay rent, utilities, or both.

- **Low wages** – *Declining wages have put housing out of reach for many workers: in every state, more than the minimum wage is required to afford a one- or two-bedroom apartment at Fair Market Rent*
- **Mental Illness** – *Approximately 20-25% of single adult people experiencing homelessness suffer from some form of severe and persistent mental illness.*
- **Natural Disaster/Fire** – *Situations where due to chance a fire, tornado, flood or hurricane renders housing inhabitable.*
- **Physical Disabilities** – *Disabled individuals may be unable to work or find appropriate employment. For those receiving SSI, they often struggle to obtain and maintain stable housing.*
- **Post Traumatic Stress Disorder** – *This disorder is common with veterans and those that have been in violent situations. It can make it difficult to have a stable life.*
- **Poverty** – *Being poor means being an illness, an accident, or a paycheck away from living on the streets.*
- **Roommates** - *When one or more roommates fall through with their end of the bargain that can be a reason for others to lose their housing.*
- **Severe Depression** – *Can make it impossible for an individual to maintain a stable life.*
- **Tragedy** - *It is surprising how many people just quit functioning because their families died or were killed. Sometimes recently, but other times years ago (Homeless Resource Network, 2010).*

Case management is an effective means of providing external support to individuals who need permanent housing but lack the social support and the means to identify what their needs are and locate available resources. The intensity and frequency of case management

encounters with individuals depends upon the complexity of the needs that each individual has. There are different models of case management with various levels of effectiveness.

In a study by de Vet, van Luitelaar, Brilleslijper-Kater, et al., (2013) four case management models were evaluated on their effectiveness with working with homeless individuals. The four models were Standard Case Management (SCM), Intensive Case Management (ICM), Assertive Case Management (ACM), and Critical Time Intervention (CTI). Each model is designed for a specific instance of need. SCM usually is associated with continuous care while working to link available resources throughout time for that individual. ICM is associated with individuals with higher needs who require closer and more intensive resources in order for them to be successful. ACM is similar to ICM, however the service is delivered through a team of individuals and not just one case manager. Lastly, the CTI model of case management is used to bridge gaps between shelter and permanent housing and is only delivered for a limited time.

The study found that the ICM model was not as effective as the other three. SCM, ACM, and CTI all showed positive results for maintaining housing stability, locating employment assistance, and providing mental health supportive networks. The study demonstrates the need for effective case management that is ongoing, supportive, and multi-disciplinary. In regards to the multi-disciplinary approach found in the ACM model, oftentimes case managers must rely on partnerships with other support agencies to get the most difficult and challenging individuals housed de Vet, van Luitelaar, Brilleslijper-Kater, et al., (2013).

Case management services are usually delivered individually on a one-on-one basis as client's needs are identified. However, other research has shown that group intensive treatments during the supportive housing phase of transition are just as important and effective (Tsai & Rosenheck, 2012). There are a few advantages that group case management and treatment offers over individual modes.

First, group treatment allows case managers the ability to provide services to multiple individuals simultaneously, while preserving individual case management only for those who really need it.

Second, groups facilitate peer support amongst individuals. Social support networks are an important factor in an individual's resiliency during homelessness (Tsai & Rosenheck, 2013).

HOUSING ENTRY POINTS

Shelters employ case managers who work with individuals and families to "link" them to available resources and get individuals housed in either a transitional or permanent living environment. Since shelter beds are on a space available basis the goal of case managers is to assist individuals in finding housing as quickly and efficiently as possible. Usually, individuals are not able to locate permanent and independent housing directly from a shelter, but some do.

Various low cost housing options exist for those few individuals who qualify. Programs are based on individual needs, income, sustainability, substance abuse history, criminal background, and passing credit history checks. This can be coordinated by working with a case manager at the shelters, or individuals can be self-motivated and apply to any of the available programs as long as there is no waiting list and there are available openings. Various low income and low cost housing resources are:

- *Section 8 Housing Choice Voucher Program*
- *Family Self-Sufficiency Program*
- *Mainstream Vouchers*
- *Veterans Affairs Supportive Housing (VASH) Program*
- *Shelter Plus Care Program*
- *Project-Based Assistance and Moderate Rehabilitation Program*
- *Below Market Rate (BMR) and Below Market Price (BMP) Purchase Program*
- *Affordable Multi-Family Rental Apartments*

- *Resident Programs/Services* (Housing Authority of Santa Clara County, 2013)

However, for chronically homeless individuals, not all of these options are obtainable without outside support. Additionally, the myriad of support networks is oftentimes confusing and the homeless do not know the particular eligibility requirements of each program. The typical route that these individuals navigate through to obtain housing is to first enter an emergency shelter. Shelter entry is usually on a first-come, first-served basis or referral from either a case manager or voucher from a non-profit agency that manages beds at a homeless shelter. Shelter stays are usually only temporary placements lasting anywhere from 1-4 weeks, depending on the needs of the individual and whether or not they are complying with shelter rules. Additionally, those that can get into a shelter may only be able to do so if they do not meet certain exclusionary criteria, such as violent criminal histories, untreated mental health issues, current substance abuse issues, victims of domestic violence, frail individuals, and sex offenders.

Non-profit agencies help clients to find the right shelters. An example of some of these agencies in Santa Clara County are EHC Lifebuilders, The Housing Authority of the County of Santa Clara, Mackey House for Sober Living, and St. Vincent de Paul. They offer housing or housing assistance to individuals and families in need. Housing assistance can be in the form of subsidies, emergency shelter, transitional housing, or supportive housing. Certain shelters focus on women and children (Commercial Street Inn) located in San Jose while others focus on one and two parent households offering up to four months of transitional housing (Home First Boccardo Family Living Center) (HSD Helping the Needy, 2015).

Supportive housing resources in Santa Clara County are one step above shelters. These programs include San Jose Family Shelter, Bridges AfterCare, and Transitional Housing. They differ from shelter care in that they are designed for families and offer longer periods of case management

services ranging from 90 days to 9 months, depending on the program and available openings (Family Supportive Housing, 2013).

Alternative studies have shown that utilizing the Housing First (HF) approach instead of shelters for chronically homeless individuals can be more successful for those suffering from substance abuse dependence (Collins, Malone, and Clifasefi, 2013); mental health disorders (Palepu, Patterson, Moniruzzam, et al., 2013); and that these strategies are successful in reducing hospital emergency room visits (Srebnik, Connor, and Sylla, 2013). The Housing First approach is a model of permanent supportive housing that bypasses shelter stays by reducing the need to transition clients from shelters to permanent supportive housing more directly. Housing First approaches are driven by “harm reduction” strategies, and the belief is that individuals are driven by self-choice and motivation rather than rewards given for abstaining from adverse behaviors. Housing First also emphasizes safety. That is that when clients feel that they are in a safe environment they will be more motivated to recover. Behaviors driven by these factors are more intrinsic and longer lasting (Collins, Malone, and Larimer, 2012). Combining case management (National Alliance to End Homelessness, 2006) or group treatment (Tsai and Rosenheck, 2012) among Housing First sites increases the likelihood that individuals will remain housed.

PERMANENT SUPPORTIVE HOUSING: THE HOUSING FIRST APPROACH

Permanent supportive housing provides service support and housing to chronically homeless individuals who have disabilities or who are unable to maintain themselves independently (Rynearson, Barnett, & Clark, 2010). There are two models of permanent supportive housing: Housing First and Transitional Housing. The Housing First model of permanent supportive housing is a superior model of housing for the most chronically homeless individuals because the emphasis is first on finding housing regardless of physical, mental, or emotional disability. Further it does not require individuals to

participate in support services such as drug and alcohol programs as a prerequisite to being housed as Transitional Housing models often do. It is instead based on the premise that individuals will be motivated to participate in support programs if they are first in a safe environment and off the street. It is only when individuals feel a sense of safety and are not focused on survival that they can fully participate in treatment programs. Housing First approaches deemphasize drug and alcohol treatment programs. Although treatment programs are offered and encouraged through case managers, participation in service and supports are not required to remain housed. Once again the premise is that safety is paramount amongst the chronically homeless, and once safety is established only then can individuals become self motivated to treatments (Rynearson, Barnett, & Clark, 2010).

Research by (Rynearson, Barnett, & Clark, 2010) has shown that housing first options for the chronically homeless can ensure that up to 80% of individuals remain housed. Previous approaches such as Transitional Housing models that require treating substance abuse, medical, mental, and employment issues prior to providing housing proves counterproductive to chronically homeless individuals. Chronically homeless individuals must first feel that they are safe and stable prior to engaging in treatment options (Housing First Report, 2010). The Housing First model focuses on the most difficult to house clients as the priority.

Housing First models can be broken up into four domains: housing choice and structure; separation of housing and services; service array; and program structures (Rynearson, Barnett, & Clark, 2010). Housing First models use a scattered site housing approach. This means that housing is provided throughout geographic areas that are not centralized into one building. Centralizing individuals in one location is less successful in maintaining housing provided that the housing is safe, stable, secure, and permanent in nature. Usually, the population is no more than 10% of the total population of individuals within one location. The drawback to this approach is that individuals may not

always be placed in close proximity to case managers, which is an essential tool for maintaining housing (Rynearson, Barnett, & Clark, 2010).

Next, housing choice is another key factor in helping individuals rehabilitate. By allowing individuals an opportunity to participate in their choice and location of their home, the ideology is that individuals will be better off because they will be in familiar surroundings that will support their recovery. Further, affordability is another factor affecting survivability and longevity for individuals to remain housed. Affordability is defined by HUD as 30% of a person's income (Rynearson, Barnett, & Clark, 2010). The remainder of their income is used for other ancillary living expenses such as food, transportation, and clothes (Rynearson, Barnett, & Clark, 2010).

The separation of housing and services in the Housing First approach means that service supports are not required to remain housed. In fact, services are primarily offered off-site in locations that keep individuals participating in treatment programs separate from their residences. Additionally, service supports are entirely independent from the housing agency in order to reduce potential conflicts of interests that may come up along the road to recovery (Rynearson, Barnett, & Clark, 2010).

Housing First program philosophies emphasize empowerment. That is, individuals are empowered to take control of their housing situation and learn to make good decisions. This requires training and goal setting that takes time, and individuals often suffer setbacks. But, these setbacks do not interfere with an individual's ability to remain housed. Every effort is made to keep individuals in their housing. Services provided by Housing First models include crisis support, psychosocial support, employment/vocational support, money management, and independent living skills (Rynearson, Barnett, & Clark, 2010).

Housing First models have been shown to reduce the costs of unneeded hospital admissions, which equates to fewer costs to community resources, since many of the homeless populations end up

being treated in county facilities. Clients in supportive housing communities reported more autonomy and required less crisis intervention. Housing First is limited to funding and limitations on where scattered site housing is located (Rynearson, Barnett, and Clark, 2010).

The final barrier to Housing First approaches is in identification of appropriate clients and establishing criteria on who to provide services to first. Prioritization is accomplished through a number of means, including identifying the degree of “vulnerability” of each client. Since there are limited amounts of resources available for clients, prioritizing them in accordance with their degree of vulnerability is important.

GOVERNMENT AND FINANCIAL ASSISTANCE PROGRAMS

Government and financial assistance programs are available for those that qualify. The Federal Poverty Level (FPL) issued by the US Department of Health and Human Services lists \$11,490 per year or the monthly amount of \$938 as the income cutoff for assistance (Santa Clara County, 2013). Federal assistance can come from General Assistance (GA); Supplemental Social Security Income/Social Security Disability Income (SSI/SDI); and CalFresh, Woman, Infants, and Children (WIC) Food and Nutrition Program, and Supplemental Nutrition Assistance Program (SNAP) or Food Stamps (Aguilar, 2013). Eligibility for these programs is based on need and not merit. For instance, an alcoholic may qualify for SSI based on the fact that he does not make enough under the FPL, but not be required to participate in an alcohol and drug rehabilitation program as a prerequisite to continue to draw this monetary benefit. Information found at Social Security website states that "individuals experiencing homelessness who have a disability have the same rights and privileges in applying for disability benefits as someone who is not homeless" (Social Security, 2015).

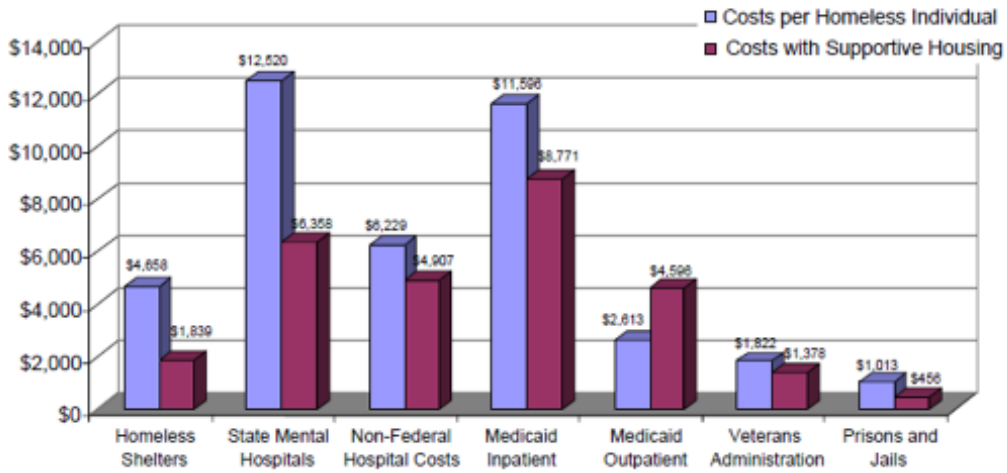
Another special population of homeless individuals are those suffering from mental health illnesses. The 2004 Mental Health Services Act allocated \$3 billion for the development of special programs to assist this population (Jangho, Bruckner, & Brown, 2013). These monies created programs called Full Service Partnerships (FSP). These “partnerships” provide case management, housing, employment, substance abuse treatment, outreach, and peer support to this especially vulnerable and underrepresented population. In Jangho, Bruckner, and Brown’s (2013) study they showed that repeat program usage and substance abuse was significantly reduced, which contributed to long-term independent housing and recovery. Oftentimes this population requires intensive engagement by dedicated case managers who work relentlessly to link individuals to appropriate services and housing (Jangho, Bruckner, and Brown, 2013)

COSTS SAVINGS

The costs to local communities dealing with chronically homeless individuals are often difficult to determine. These costs can be related to medical or mental treatment. It can even be costs related to issues with addiction and law enforcement. The costs grow because communities tend to treat the symptoms rather than getting at the root cause of the problem. A report by the National Alliance to End Homelessness (2007) shows that the net cost of providing permanent supportive housing to homeless individuals is about the same as or less than allowing them to remain homeless. Chronic homelessness exacerbates the symptoms of medical and mental illness. Studies in some major metropolitan cities in the United States lends support to the model that providing permanent supportive housing is cost effective for communities rather than allowing individuals to remain homeless. A summary of those studies is shown below.

In New York, permanent housing saved the city \$16,282 in shelter, medical, mental and legal costs. While the costs to provide supportive housing was \$17,277.

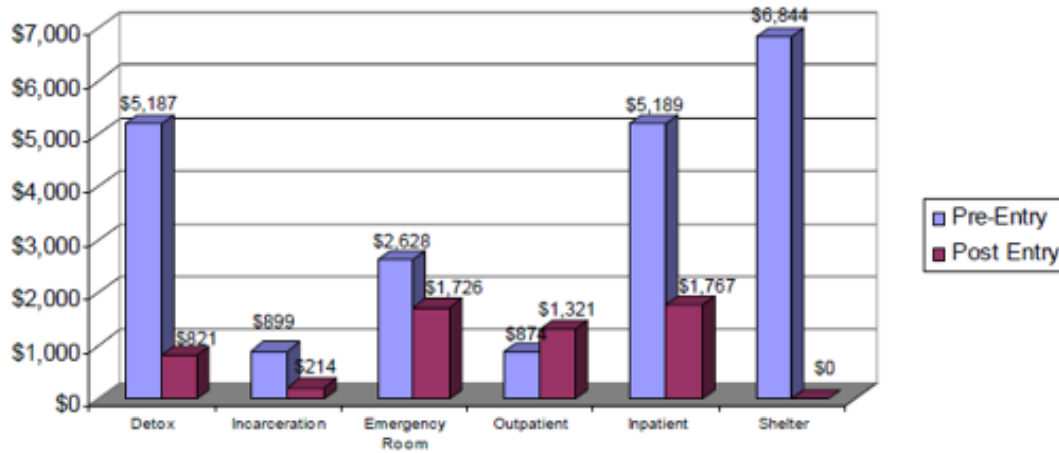
Exhibit 1: Annual Cost of Supportive Housing vs. Homelessness



Source: *The Impact of Supportive Housing on Services Use for Homeless Persons with Mental Illness in New York City*. Dennis Culhane, Ph.D., Stephen Metraux, M.A., Trevor Hadley, Ph.D., Center For Mental Health Policy & Services Research, University of Pennsylvania. Data from 4,679 NY/NY placement records between 1989-97.

In Denver, CO the chart shows that the city saved \$15,773 per person per year. While the cost to provide support housing was only \$13,400 annually.

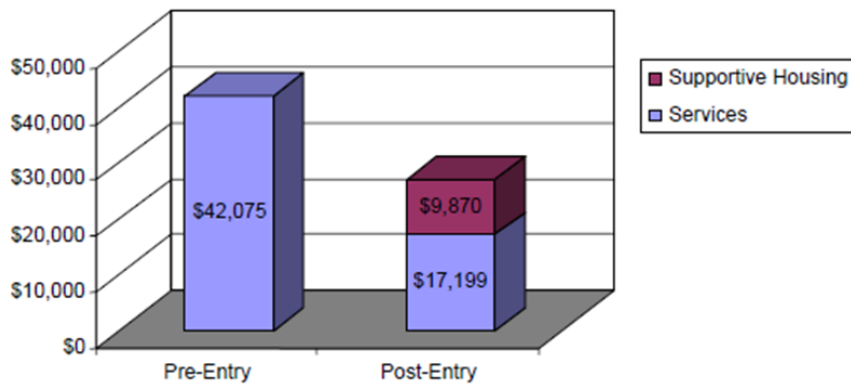
Exhibit 2: Annual Costs Before and After Entering Supportive Housing



Source: *Denver Housing First Collaborative: Cost Benefit Analysis And Program Outcomes Report*. Jennifer Perlman, PsyD, and John Parvensky. Colorado Coalition for the Homeless. December 2006.

In Portland, OR their program showed a savings from an initial cost \$42,075 to \$17,199 in healthcare and criminal justice.

Exhibit 3: Annual Cost Before and After Entering Supportive Housing



Source: *Estimated Cost Savings Following Enrollment In The Community Engagement Program: Findings From A Pilot Study Of Homeless Dually Diagnosed Adults.* Thomas L. Moore, PhD. Portland, OR: Central City Concern. June 2006.

(Charts reproduced from the National Alliance to End Homelessness, 2007).

FEDERAL LEGISLATION TO END HOMELESSNESS

McKinney Vento-Act

The McKinney Vento-Act is federal legislation addressing homelessness in the nation. President Ronald Reagan signed the original act into law on July 22, 1987 (NCH, 2006). It has been amended several times since its original creation. It outlined 15 programs to address homelessness. Some of these programs included funding for emergency shelters, transitional housing, job training, healthcare, education, and some permanent housing. The McKinney Vento-Act contained nine titles. A summary of those titles is below:

1. Defined homelessness
2. Describes the function of the Interagency Council of Homelessness
3. Authorized the Emergency Food and Shelter Program administered by the Federal Emergency Management Agency (FEMA)
4. Authorized emergency shelter and transitional housing programs that are administered by the Department of Housing and Urban Development (HUD). These programs include: Emergency Shelter Grant Program, Supportive Housing Demonstration Program, Supplemental Assistance

to Assist the Homeless Program, and Section 8 Single Room Occupancy Moderate Rehabilitation (SRO)

5. Requires federal agencies to make available surplus federal property (building and land) so that states and local governments can use this to assist the homeless
6. Authorizes the Department of Health and Human Services to provide healthcare, mental health, and drug rehabilitation programs to the homeless
7. Authorized four programs associated with adult and youth education programs for the homeless
8. Allowed homeless to participate in the Food Stamp Program
9. Extended the Veterans Job Training Act (NCH, 2006).

The McKinney Vento-Act also defined what is considered “sufficient resources” for an individual to be able to live successfully. Without sufficient resources, individuals are at an increased "risk" for becoming homeless. Title 24, Chapter V, Subpart §578.3 states that individuals are at greater risk for homelessness if they lack *“Support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another plan described in paragraph (1) of the “Homeless” definition in this section: and meets of the following conditions:”* (Code of Federal Regulations, §578.3).

A listing of the conditions is below:

1. *“Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;*
2. *Is living in the home of another because of economic hardship;*
3. *Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days of the date of the application for assistance;*

4. *Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;*
5. *Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons, or lives in a larger housing unit in which there reside more than 1.5 per room, as defined by the U.S. Census Bureau;*
6. *Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or*
7. *Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan (Government Publishing Office, 2015).*

Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act

The HEARTH Act of 2009 reauthorized the McKinney Vento-Act. It also made amendments to the original McKinney Vento-Act. The following is a summary of those changes:

1. Homeless prevention was expanded
2. Focus is on rapid-rehousing
3. Emphasis on supplying permanent supportive housing for chronically homeless individuals and some families who are considered chronically homeless
4. Added to the definition of homelessness to include those individuals who are at “risk” of being homeless
5. Consolidated the Shelter Plus Care Program, Supportive Housing Program, Moderate Rehabilitation/SRO Programs into one “Continuum of Care Program”. Eligibility requirements were kept and consolidated under this one new program (National Alliance

to End Homelessness, 2009). The key to HEARTH was the reauthorization of the McKinney Vento Act, consolidation of several programs under one Continuum of Care Program (COC), adding to HUD's definition of homelessness, and a focus on prevention and rapid rehousing strategies especially for families.

DEDICATED NATIONWIDE PLANS TO END HOMELESSNESS

Opening Doors

On June 22, 2010 the Obama Administration created Opening Doors, which was a federal strategic plan to end homelessness throughout the nation. The plan authorized the United States Interagency Council on Homelessness (USICH) to create a plan to end homelessness through the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH). The key behind the plan was the belief that no one should experience homelessness. There are four core goals to the plan:

1. *“End chronic homelessness in five years;*
2. *Prevent and end homelessness in Veterans in five years;*
3. *Prevent and end homelessness in family, youth, and children; and*
4. *Set a path the end all types of homelessness”* (Opening Doors, 2010)

In order to accomplish these goals Opening Doors realized that creating housing that is “*safe, decent, and affordable*” is necessary for individuals to gain independence and stability in their lives. Opening Doors pushed to create stable housing that would reduce cycling through institutions such as jails, hospitals, drug rehabilitation, and mental health care facilities. At the same time it allowed individuals to gain access to primary medical care and needed case management services. Opening Doors focused on intergovernmental collaboration at all levels - federal, state, and local. It encouraged federal housing agencies to work closely with Public Housing Authorities (PHA) at the local levels (Donovan, 2011).

In keeping with the plan to end homelessness, national and local efforts were started. Opening Doors utilized two separate housing strategies. The first strategy focused on utilizing permanent supportive housing. This is housing that links healthcare and social services to individuals living in affordable housing. The second method involved the Homeless Prevention and Rapid Rehousing Program (HPRP). This program focused on stabilizing current housing for those individuals and families who were at risk of becoming homeless. Providing stabilization could involve something as simple as providing a security deposit for housing (Donovan, 2011).

Results have shown that Opening Doors is a success. In Utah permanent supportive housing contributed to a 70 percent reduction in homelessness since 2005 and rapid rehousing contributed to a 26 percent drop in homelessness since 2005 (Donovan, 2011). In Seattle, WA jail visits were cut in half and Medicaid costs dropped by 40 percent (Donovan, 2011).

Housing 100,000

The Housing 100,000 Campaign was started by Community Solutions and had the intended goal of housing 100,000 of the most vulnerable individuals by 2014. It was a nationwide effort that involved the partnership with over 230 communities. The campaign partnered with private and non-profit agencies in a collaborative effort to accomplish their goals. The collaborative efforts help smooth transitions from homelessness to housing by providing funding and also eliminating common barriers such as access to healthcare and other vitally important services necessary to keep individuals housed. Community Solutions was the lead agency that was responsible for coordinating this effort. In order to prioritize individuals, the Housing 100,000 program utilized the Vulnerability Index Questionnaire. This questionnaire is based on research from Boston University (1998) that identifies the specific health conditions that make homeless individuals more susceptible to mortality (Hwang, Lebow, Bierer, et al., 1998). There were eight risks that were identified by researchers:

- *More than three hospitalizations or emergency room visits in a year*
- *More than three emergency room visits in the past three months*
- *Age 60 or older*
- *Cirrhosis of the liver*
- *End-stage Renal Disease*
- *History of frostbite, immersion foot, or hypothermia*
- *HIV+/AIDS*
- *Tri-morbidity: Co-occurring psychiatric, substance abuse, and chronic medical condition.* (United States Council Interagency Council on Homelessness, 2013).

Housing 1000 Care Coordination Project

Local campaigns included the Housing 1000 Care Coordination Project. This was a collaborative effort with 27 private and non-profit agencies and Santa Clara County. It was the local arm of the nationwide Housing 100,000 campaign. The project received funding from outside agencies as well as the City of San Jose to fund case managers and housing subsidies. The project's goal was to provide housing for 1,000 of the most vulnerable individuals in the county by 2014. It utilized the same strategies as the nationwide campaign to identify and assess chronically homeless individuals. It also followed the same philosophy of collaborating with multiple agencies in order to link clients to housing and resources.

CITY AND COUNTY SPECIFIC HOMELESS ISSUES

Santa Clara County

In 2005, the County of Santa Clara developed a 10-year plan for ending chronic homelessness. A joint 45-member task force was created with multiple partner agencies that had a vested interest in ending homelessness, and involved cooperation between the community, government, and private

business partnerships (Office of the County Executive, 2005). In 2012 this led to the development of a pilot program to identify and house 100 chronically homeless people. Over 150 cities and counties nationwide also developed 10-year plans following the Housing 100,000 efforts (Office of the County Executive, 2005).

San Jose

According to the Santa Clara County Homeless Census (2013), the City of San Jose experiences the largest population of homeless individuals in the county and Silicon Valley has the fifth largest homeless population in the country (Byrd, 2013). The problem has become so profound that it has become a priority for the city. A large percentage of homeless individuals set up encampments around the Coyote Creek. This encampment is known as the Jungle. It is estimated that the 65 acres along Coyote Creek house roughly around 175 residents at a time. The Jungle is the largest homeless encampment in the United States (Johnson, 2013). Annually the city spends money to clean up the homeless camps and the waterways they litter and pollute. The city cleaned up the encampment in April 2013 and collected 685 pounds of trash per person (Newman, 2013). The Jungle is home to a varied population and conditions are deplorable. Deaths have occurred in the Jungle as the result of gang violence, drowning, and exposure (Newman, 2013).

In 2011 the City of San Jose used a \$680,000 grant from the EPA to remove the encampments and clean the creek. They received other donations from eBay (\$20,000) and the Santa Clara County Water District (\$200,000). The total budget to clean the creek was \$942,867. The grant funded a four-year pilot program called the Clean Creeks, Healthy Communities Program. The intended goal of the program was to improve the creek's condition by 1. Engaging neighbors as creek stewards, 2. Employing the homeless to clean up the creek and assisting them in finding housing, and 3. Deter future dumping in the creek. The Downtown Streets Team led the way with this project (Samonsky, 2011).

More recently, the City of San Jose shut down the Jungle in December 2014 as a result of a complaint from the Department of Fish and Wildlife. Its complaint cited that the city had failed to adequately clean up the encampments. The city spent between \$300,000 and \$400,000 to shut the Jungle down. Additionally, costs to the water district were estimated to be around \$200,000 (Emmons, 2014).

In 2013, San Jose's Homeless Rapid Response Team found that there were 4,770 homeless individuals living on the streets in San Jose, which represented a 17% increase from 2011. Of those who were living on the street, the team found that 77% were living along creek beds, in cars, or simply on the street. Key facts included in the team's report included the following:

- San Jose had one of the largest homeless populations in the nation
- 26% of the homeless population were living in encampments
- 91% of individuals in encampments were San Jose residents at the time they became homeless
- 96% of individuals living in encampments were willing to accept housing (Emmons, 2014).

Through a Rapid Re-Housing strategy, San Jose's Rapid Response Team hoped to target individuals in these encampments using intensive case management and the infrastructure to house clients that was already in place through the Housing 1000 Care Coordination Project. The programs identified that some clients would never be able to become self-sufficient and would need permanent subsidies in order to remain housed in the community. Other individuals were classified as transitionally homeless. Transitionally homeless individuals differed from chronically homeless in that they were homeless as the result of behavioral or legal issues. These individuals were typically younger. The goal was to link these individuals to employment so that they could gain economic stability (Corsiglia, 2013).

Homeless individuals also required case managers in order to assist them in locating housing. Case managers served as a single point of contact that help coordinate services for homeless individuals, such as linkage to mental health and medical treatment. They are also essential for assisting clients with obtaining housing vouchers. However, San Jose's Rapid Response Team found that in 2013 there were 110 individuals with housing vouchers that were still unable to obtain housing. This shows that although individuals have housing vouchers it was not a guarantee of immediate housing. This is due largely to the competitive nature of the housing market and lack of available affordable housing. Those with vouchers who did obtain housing were expected to achieve housing self-sufficiency by the end of the 2-year period when their subsidy ran out (Corsiglia, 2013).

San Francisco

An article by Aguilar (2013) focused on the homeless problem in San Francisco for females over the age of 50. The problem primarily is that San Francisco has the most expensive rental units in the nation, making finding affordable housing almost impossible. This is further compounded by government budget cuts to programs ordinarily aimed at helping older and frail adults stay housed through the use of care giver support, adult day programs, and case management. Nationally, in 2010 there were 40,750 homeless individuals over the age of 62. Aguilar (2013) states that by 2050 this number is expected to double.

SUMMARY

The County of Santa Clara developed a 10-year plan to end chronic homelessness but they are far from reaching their goals. Yet milestones have been accomplished through the Housing 1000 campaign, which utilizes a Housing First strategy. Some early solutions include the following strategies:

- Linking housing services and preventing duplication of services, streamlining access for homeless individuals
- Eliminating the need to “transition” from several levels of housing (shelter, transitional, supportive, etc.) prior to placing individuals in permanent housing
- Directly engaging the chronically homeless with special treatment and outreach teams to gain needed trust, which will enable those individuals to seek out permanent housing
- Facilitating employment strategies specially tailored to the needs of the individuals with participating employers
- Gaining assistance from the community to end homelessness (Santa Clara County Task Force, 2005).

Ending homelessness needs to be a collaborative effort. It requires the cooperation of key public and private agencies, policy changes, funding sources, availability of affordable housing, adequate social services, employment opportunities and many more similar resources. Recent point-in-time survey data shows that Santa Clara County is facing a growing epidemic of homelessness (Applied Survey Research, 2013). The City of San Jose leads the county in homeless individuals. Local efforts that focus on ending homeless will be successful only if they address the multi-faceted nature of the issue.

Many of these individuals are chronically homeless and require special attention. The co-occurrence of mental health disorders, lifetime of chronic adversity, untreated medical issues, and legal problems make finding housing a very complex problem for individual case managers. Chronically homeless individuals lack the ability to seek employment and also cannot retain employment. In fact, employment was identified as the single most important factor in preventing homelessness (Applied Survey Research, 2013). If a solution to homelessness is to be found, a multi-faceted approach will have to be developed in order to address all psychosocial barriers.

METHODOLOGY

This research was based on an outcome analysis of the Housing 1000 Care Coordination Project for Santa Clara County. Data was obtained from Community Technology Alliance (CTA) for the periods from 2011 to 2014. CTA tracked all homeless data for this period through the Homeless (Help) Information Management System (HMIS). This research hopes to contribute to a further understanding of possible solutions to the homeless crisis throughout Santa Clara County, and the nationwide effort to end homelessness.

The Housing 1000 Care Coordination Project was composed of partnerships with the City of San Jose and the County of Santa Clara. The project's principal strategy was to partner with both public and private agencies, in order to address the shortage of housing resources within the county. Destination Home initiated a Request for Proposal (RFP) process from case management and housing agencies that could participate in identifying and placing the chronically homeless individuals in Santa Clara County. Four housing and case management agencies were chosen from the RFP process: EHC Lifebuilders, Downtown Streets Team, InnVision the Way Home, and New Directions. EHC Lifebuilders was the lead case management agency of the Housing 1000 Care Coordination Project.

HOUSING AND CASE MANAGEMENT PROGRAMS

The agencies selected did have certain specialties that separated each from one another. EHC Lifebuilders had had previous experience with placing homeless clients; New Directions worked closely with medical providers and focused more on a clinical approach; Downtown Streets Team focused on peer based supports, supportive employment, and education; and InnVision Shelter Network was a long-time provider of homeless services and operated shelters in the County of Santa Clara. However, there were only slight differences in program

philosophies and access to resources between the case management agencies. For the purpose of the study, CTA considered agencies as equal in regards to delivery of services.

INDICES

Personnel responsible for finding supportive housing and linking clients with subsidies were case managers. Case managers' educations and experiences varied among agencies from high school education to graduate level. Some agencies did not require case manager to have a bachelor's degree. Regardless of education and experience, all case managers were trained on two standardized assessment tools: Vulnerability Index Tool and the Self Sufficiency Matrix (SSM). The Vulnerability Index Tool was the same one used by the nationwide Housing 100,000 program, but Housing 1000 Care Coordination Project raters used a shortened version of the SSM.

Vulnerability Index Tool

The Vulnerability Index was used to ascertain the degree that a client is vulnerable to dying on the street. It is a tool that provides information on the following domains: health, institutional history (jail, prison, hospital, and military), length of homelessness, patterns of shelter use, and previous living situations. This tool is a relevant measure because chronically homeless individuals are four to nine times more likely to die from living on the streets from preventable illnesses compared with the general population (O'Connell, 2005). Individuals were interviewed using this tool and then were assigned a severity score based on their answers to the Vulnerability Index. They were then ranked by risk for death and given higher priority for services. The eight key vulnerabilities previously described were used to identify the most vulnerable.

The Vulnerability Index is shown below:

Vulnerability Index

Calculating Vulnerability Index

o At-risk Qualifiers:

More than six months on the streets and at least one of the following-

- Tri-morbidity (a combination of at least one from each category below) +1
- 3 or more Emergency Room visits in the past three months (+1)
- 3 or more hospitalizations and/or ER visits over a year (+1)
- 60 years or more of age (+1)
- HIV+/AIDS (+1)
- Kidney Disease/ESRD or Dialysis (+1)
- Liver Disease/HEP C/Cirrhosis/End stage liver disease (+1)
- Cold weather injuries (frostbite, immersion foot, hypothermia) (+1)

o Tri-morbidity

- Mental Health + Serious Medical Condition + Substance Abuse

- o Client must have at least one condition in each of the following areas to qualify for tri-morbidity:

- Mental Health Qualifiers
- Being treated/receiving counseling for mental health issues
- Taken to the hospital against your will for mental health reasons
- Observed signs or symptoms of mental illness

- o Serious Medical Condition Qualifiers

- Kidney Disease/ESRD or Dialysis
- Liver Disease/HEP C/Cirrhosis/End stage liver disease
- Heart Disease/arrhythmia/irregular heartbeat
- HIV+/AIDS
- Emphysema
- Diabetes
- Asthma
- Cancer
- Hepatitis C
- Tested positive for TB
- Observed signs or symptoms of serious physical health condition

- o Substance Abuse Qualifiers

- Ever abused alcohol or drugs, or told you do
- History of injection drugs
- Has been treated for alcohol or drug abuse
- Consumed alcohol everyday for the last 30 days

- o Observed signs or symptoms of alcohol or substance abuse

- Time Considerations
- Length of time homeless
- Vulnerability is triggered at 6 or more months homeless
- Database should be able to conduct real-time assessments of vulnerability as someone's length of time homeless increases

- o Age

- Age over 60 is a determinant for vulnerability
- Database should be able to conduct real-time assessments of vulnerability

- How to Avoid Double Counting
 - as someone's age increases
 - Individual reporting ONLY Emergency Room visits receive 1 point for "3 or more Emergency Room visits in the past three months," but NOT also for "3 or more Hospitalizations and/or ER visits over a year." (Community Technology Alliance, n.d.)

SELF SUFFICIENCY MATRIX (SSM)

Once clients were selected based on priority they were interviewed and assessed using the Self Sufficiency Matrix (SSM). This tool assesses clients on 18 domains and measures a client's ability to live independently without government financial support. A score between 1-5 is given to clients based on their answers to the questions on the domains. A low score of 1 indicated total dependence on government assistance while a 5 indicated complete independence on that domain (Self Sufficiency Matrix). A complete list of the 18 domains is below:

- Income
- Employment
- Housing
- Food
- Childcare
- Children's Education
- Adult Education
- Legal
- Health Care
- Life Skills
- Mental Health
- Substance Abuse
- Family Relations
- Mobility
- Community Involvement
- Safety
- Parenting Skills
- Credit History

Even though the minimum number of domains to assess a client is six (income, employment, housing, legal, mental health, and substance abuse) raters in this study used a shortened version of the SSM to assess 8 domains. This version is below.

DOMAIN	1	2	3	4	5
Income	No income.	Inadequate income and/or spontaneous or inappropriate spending.	Can meet basic needs with subsidy; appropriate spending.	Can meet basic needs and manage debt without assistance.	Income is sufficient, well managed; has discretionary income and is able to save.
Employment	No job.	Temporary, part-time or seasonal; inadequate pay, no benefits.	Employed full time; inadequate pay; few or no benefits.	Employed full time with adequate pay and benefits.	Maintains permanent employment with adequate income and benefits.
Housing	Homeless or threatened with eviction.	In transitional, temporary or substandard housing; and/or current rent/mortgage payment is Unaffordable (> 30% of income).	In stable housing that is safe but only marginally adequate.	Household is in safe, adequate subsidized housing.	Household is safe, adequate, unsubsidized housing.
Food	No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Household is on food stamps.	Can meet basic food needs, but requires occasional assistance.	Can meet basic food needs without assistance.	Can choose to purchase any food household desires.
Childcare Skip if no age appropriate children	Needs childcare, but none is available/accessible and/or child is not eligible.	Childcare is unreliable or unaffordable, inadequate supervision is a problem for childcare that is available.	Affordable subsidized childcare is available, but limited.	Reliable, affordable childcare is available, no need for subsidies.	Able to select quality childcare of choice.
Children's Education Skip if no school age children	One or more eligible children is/are not enrolled in school.	One or more eligible children enrolled in school, but not attending classes.	Enrolled in school, but one or more children only occasionally attending classes.	Enrolled in school and attending classes most of the time.	All eligible children enrolled and attending on a regular basis.
Health Care	No medical coverage with immediate need.	No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health.	Some members (e.g. Children) on ABW or MiChild.	All members can get medical care when needed, but may strain budget.	All members are covered by affordable, adequate health insurance.
Life Skills	Unable to meet basic needs such as hygiene, food, activities of daily living.	Can meet a few but not all needs of daily living without assistance.	Can meet most but not all daily living needs without assistance.	Able to meet all basic needs of daily living without assistance.	Able to provide beyond basic needs of daily living for self and family.

PARTICIPANTS

Participants were those individuals who were assessed as the most vulnerable due to serious medical problems, mental health and substance abuse issues. First, researchers obtained written consent prior to conducting a survey using the Vulnerability Index Assessment Tool. After completing the survey, all participants had their photograph taken for future identification purposes. Participants were thanked for their time then all consent forms and pictures were emailed to the Community Technology Alliance (CTA) or directly uploaded to the Santa Clara County Homeless (Help) Management Information System. Community Technology Alliance managed the HMIS database for all clients. The purpose of the survey was merely to identify the most vulnerable homeless. Participating in the survey did not add clients to a housing waiting list. No promises of housing were given to clients.

Participants who were first identified as vulnerable (Score of 1-5) on the Vulnerability Index Tool were then included in the Vulnerability Registry for Santa Clara County. Initially, surveying was done for any homeless residents of the county. As the program has matured, surveying targeted those living in the county's homeless encampments.

CRITERIA FOR INCLUSION INTO THE PROGRAM

There were three basic criteria that homeless individuals had to meet in order to be able to participate in the program. Participants were first identified using the Vulnerability Index Assessment Tool, which measured the participant's degree of vulnerability and/or mortality to living on the streets. Individuals with a score between 1 – 5 on the Vulnerability Index Tool met the first criteria. Trained raters determined this through face-to-face interviews conducted with homeless individuals.

Next, individuals had to meet the HUD definition of chronic homelessness as defined below:

- An unaccompanied homeless adult with a disabling condition or;
- A family with at least one member (18 and older) who has a disabling condition who:
 - Is currently residing on the streets or in a place not meant for human habitation, an emergency shelter or safe haven, and
 - Has been continually homeless for one year or more (during this current episode of homelessness) or,
 - Has experienced 4 or more episodes of homelessness in the past 3 years.

(National Alliance to End Homelessness, 2012).

The final criteria in ranking priority for inclusion into the program were based on the length of time that an individual had been living on the street. For example, an individual who answered that he had been homeless for twenty years was given a higher priority than someone who answered only ten years. If clients met all three criteria they were ranked and included in the study group.

After clients were ranked based on the above criteria raters then went back out to individuals and asked them if they would like to be included in the study. If individuals opted into the program, EHC Lifebuilders would assign that individual to one of the four case management agencies. Assignment to an agency was based on a combination of staffing and agency specialty (mental health, medical issues, for example) although as stated before specialty did not play a large part in determining where the client was assigned.

If at all possible a case manager's client load was limited to twenty at most. Any difference in philosophies between agencies was minimized since Housing 1000 Care Coordination Project's case management agencies were encouraged to share resources among one another. Resource sharing alleviated any advantage that an agency had over another for placing clients in permanent supportive housing. Once enrolled with one of the four case management agencies, participants were given an intensive case management assessment and evaluation. Agencies utilized the Self-Sufficiency Matrix (SSM) tool within a week of entry and exit from the program. Case management was responsible for addressing several housing barriers which included mental health, substance abuse, personal income, and unaddressed medical issues.

Case managers would then try to find subsidies for individuals. These subsidies were used to pay for the cost of housing and were based on a client's income. Housing was granted on first come, first served basis and there was no higher priority given for the clients who were participating in the Housing 1000 Care Coordination Project than for those who were not participating and were in the general population. All clients regardless of inclusion or exclusion in the Housing 1000 Care Coordination Project competed for limited scattered site housing. The subsidies were meant to pay anywhere from 30% to 100% of an individual's rent depending on whether an individual was receiving other forms of income, such as SSI or SSDI. Funding for the subsidies came primarily from McKinney-Vento Act funds and Santa Clara County general funds. Subsidies were meant to be permanent lifetime subsidies for individuals in the program, especially if those individuals were not deemed eligible for other forms of federal assistance.

All survey data and demographics were entered into the HMIS database. This was required by the Department of Housing and Urban Development (HUD) for all homeless

assistance programs receiving federal funding. The data was de-identified by CTA prior to use in this project in order to protect individuals' identities, and agency data were only available as anonymous numbers to protect the individual agency's reputations in the community.

GOAL OF THE HOUSING 1000 CARE COORDINATION PROJECT

The overall measure of success of the Housing 1000 Care Coordination Project was whether or not participants were placed in affordable housing from homelessness. In Santa Clara County, the low-income housing is available due to two forces:

- The Housing Authority of the County of Santa Clara set aside Section 8 Vouchers for Chronically Homeless residents
- The County of Santa Clara has made a significant investment in subsidizing housing for Chronically Homeless residents

There were five measurable objectives that Housing 1000 Care Coordination Project looked at.

They are listed below

1. 80% of clients would receive housing within 60 days of referral to case management
2. 80% of clients who received housing would remain housed for at least 12 months
3. 75% of clients would improve their self-sufficiency matrix scores
4. 75% of clients would have access to sufficient resources to meet their basic needs
5. Housed clients' latest income must be greater than or equal to \$850 per month

The goal of this project was to determine the following:

1. Determine if any case management agency outperformed another for any of Housing 1000 Care Coordination Project's five measurable objectives
2. Identify individual variables that presented barriers to housing based on available research

Since all agencies operated in the same county and all used the same case management approach, using data from all four as a 100% survey would eliminate differences in performance based on variables like funding sources and location. Based on a review of the current literature on homelessness it was hypothesized that factors such as substance abuse, mental health, chronic unresolved medical issues, and income would be the greatest barriers to placement.

Table 1: Outcome Evaluation Matrix

Program	Theoretical Goal	Program Goals	Program Functions	Proximate Indicators	Program Measures
Housing 1000	T1: Move 1000 chronically homeless into permanent housing	<p>G1: Conduct outreach to potential clients and assess "vulnerability" (VI) (T1)</p> <p>G2: Refer to appropriate homeless agency (T1)</p>	<p>F1: Outreach conducted (G1)</p> <p>F2: Assess their SSOM and link clients to case management (G2)</p> <p>F3: Identify appropriate housing types (G2)</p> <p>F4: Link clients to needed services so that they can functionally remain in permanent housing (G2)</p>	<p>I1: Number of clients reached (F1)</p> <p>I2: Time clients spent with case management (F2)</p> <p>I2: Time spent in shelters prior to placement (F4)</p> <p>I3: Number and level of placements prior to placement in permanent housing (F3)</p> <p>I4: Amount of services required by client prior to placement (F4)</p>	<p>M1: Number of clients requiring alcohol and drug support services (I1 & I4)</p> <p>M2: Number of clients needing mental health services (I1 & I4)</p> <p>M3: Number of clients needing medical support/insurance (I1 & I4)</p> <p>M4: Number of clients needing rental subsidies (I1 - I4)</p> <p>M5: number of interviewees ineligible for services due to legal problems (I1 & I4)</p>

FINDINGS

The tables and data that follow were gathered directly from CTA for the period between 7/1/2011 – 1/1/2014. The data was de-identified by CTA prior to use in this project in order to protect individuals’ identities. Agency data were only available as anonymous numbers to protect the individual agency’s reputations in the community. The names of the agencies have been fictionalized to keep the four tracks separate while maintaining anonymity. Individual client information is not available due to client privacy rights. Therefore, cross matching exact client characteristics with the agencies that served them and the agency’s outcomes is not possible. Differences in service levels were observed, but only analysis of comparative data at the agency level can be conducted. Causes of possible differences can only be theorized here. However, since the individual agencies can identify their data from this report, this comparative data can be used by the agencies to further study their own outcomes and clients to better understand the causes of their outcomes, with the goal of leading to improvement.

The first table below summarizes total client enrollment in Housing 1000 Care Coordination Project for the time period specified.

Care Coordination Project Client Enrollment and Housing Summary

CCP Entry Exit Provider Id	Clients Currently Enrolled	Housed*	Currently Housed & Enrolled	Currently Unhoused & Enrolled
Active Assistance	21	27	17	4
Community Cares	82	74	60	22
Helping Hands	30	27	14	16
Saving Service	25	36	21	4
Count:	158	156	112	46

*Housed number includes clients housed in Care Coordination Project or exited to permanent destination after case managed by Care Coordination Project.

The data shows that there were 158 clients enrolled during this period. There were a total 156 clients that were classified as housed by either the CCP directly or exited the program to permanent housing. Out of the total enrollment of 158 clients, 112 clients (71%) were currently enrolled and still housed and 46 clients (30%) were enrolled but not housed. CTA categorized “housed” destinations as the following:

- Homeownership
- Owned by client, no housing subsidy (HUD)
- Owned by client, with housing subsidy (HUD)
- Own house/apartment
- Permanent: Home subsidized house/apartment
- Permanent: Other subsidized house/apartment
- Permanent: Section 8
- Permanent: Shelter Plus Care
- Permanent: Public Housing
- Permanent supportive housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab) (HUD)
- Rental by client, no housing subsidy (HUD)
- Rental by client, other (non-VASH) housing subsidy (HUD)
- Rental by client, VASH Subsidy (HUD)
- Rental room/house/apartment
- Staying or living with family, permanent tenure (HUD)
- Staying or living with friends, permanent tenure (HUD)
- Staying in a family members room/apartment

(Community Technology Alliance Data Tables)

The table below shows the total number of clients that exited the Housing 1000 Care Coordination Project.

CCP Entry Exit Provider Id	Clients Exited	Unhoused/ Temporary Destinations	Institutions	Deceased	Other PH Destinations	Transferred to other CCP Providers
Active Assistance	15	7	2	0	4	2
Community Cares	41	18	4	4	4	11
Helping Hands	14	9	2	0	1	2
Saving Service	22	6	3	2	9	0
Count:	92	40	11	6	18	14

A total of 92 clients exited CCP for this time period. Only Community Cares and Saving Service reported clients that were deceased. Community Cares accounted for the largest percentage (45%) of client exits from the CCP. Of those exits, 18 (44%) remained unhoused, 4 (10%) exited to an institution, 4 (10%) were reported deceased, 4 (10%) were transferred to other permanent housing destinations, and 11 (27%) were transferred to other CCP providers. CTA categorized “un-housed” destinations as the following:

- Emergency shelter
- Emergency shelter, including hotel or motel paid for with emergency shelter voucher (HUD)
- Foster care home or foster care group home (HUD)
- Hospital (non-psychiatric) (HUD)
- Hotel or motel paid for without emergency shelter voucher (HUD)
- Jail, prison or juvenile detention facility (HUD)
- Place not meant for habitation (e.g., a vehicle or anywhere outside) (HUD)
- Psychiatric hospital or other psychiatric facility (HUD)
- Safe haven
- Staying in a family members room/apartment
- Staying in a friend’s room/apartment/house
- Staying in a friend’s room/apartment/house
- Staying or living with family, temporary tenure (e.g., room, apartment or house)(HUD)
- Staying or living with friends, temporary tenure (e.g., room apartment or house)(HUD)
- Substance abuse treatment facility or detox center (HUD)
- Transitional housing for homeless persons (including homeless youth) (HUD)

The following five tables summarize the results of the Housing 1000 Care Coordination Project objectives. The tables were obtained directly from CTA. The first table below shows the number of clients that were housed in less than 60 days after being referred to one of the four case management agencies. CCP’s first objective was that 80% of clients would be housed within 60 days of referral.

Objective 1: 80% of clients that are housed within 60 days of referral to case management.

CCP Entry Exit Provider Id	Clients Housed	Avg Days to House	Housed <60 Days	<60Days / All Housed
Active Assistance	27	96.34	9	33.33%
Community Cares	74	113.48	20	27.03%
Helping Hands	31	176.20	2	6.45%
Saving Service	36	120.80	12	33.33%
Count:	156	125.32	43	27.56%

The data reveals that 156 clients received housing. However, no agency was able to meet Objective 1 to house 80% of their clients within 60 days of referral. Community Cares housed the most clients, 74 or 47% of the total. However, only 20 (27.03%) were housed within 60 days of referral. Active Assistance and Saving Service housed a smaller number of the total clients enrolled; 27 clients (17.30%) and 36 (23.07%) respectively. Active Assistance and Saving Service housed 9 clients (33.33%) and 12 clients (33.33%) in less than 60 days. Helping Hands housed 31 clients (19.87%) of the total enrollees but only 2 (6.45%) in fewer than 60 days.

Large differences between the average numbers of days to house clients existed between agencies. However, when confidence intervals were applied to all four agencies' average days to house measure, none of the agencies statistically significantly outperformed the group: Active Assistance 96.34 (85.6, 107.1); Community Cares 113.48 (90.6, 102.1); Helping Hands 176.2 (79.1, 113.6); and Saving Service 120.8 (82.4, 110.3).

The confidence interval results per case management agency show that although Helping Hands took the longest time to find permanent for 31 clients there was no significant difference in the number of average days to find housing from Community Cares who housed a total of 74 clients. The results may possibly suggest that on average there were no differences in client demographics between agencies and that clients were housed based on a case manager's individual abilities to find resources. Further client assignment, although based primarily on staffing and not individual agency specialty, was random and allowed each agency to receive an

equal distribution of clients who required either much support or very little, and client load was balanced. This may have been inadvertent and not actually part of the original design of CCP’s study.

The table below shows results for Objective 2, which was that 80% of clients would remain housed for at least 12 months or 365 days.

Objective 2: 80% of clients are that housed will remain housed for at least 12 months.

CCP Entry Exit Provider Id	Housed Before 365 Days	Housed >=365 Days	>=365 Days / Housed Before 365 Days
Active Assistance	20	12	60.00%
Community Cares	23	18	78.26%
Helping Hands	14	11	78.57%
Saving Service	22	16	72.73%
Count:	79	57	72.15%

There were a total of 79 clients who received housing in less than 365 days. Fifty-seven clients (72.15%) kept their housing for more than 12 months or 365 days. While none of the four agencies was able to meet Objective 2’s goal, both Community Cares and Helping Hands kept their clients housed for 12 months at a rate of 78.26% and 78.57% respectively.

One explanation for this data is that since Community Cares was able to house more clients than the other three agencies they may also have used resources more efficiently to keep their clients housed for more than 365 days. The same can be said of Helping Hands in that although they took the longest on average number of days to house clients, they may have been more particular or had clients with more specific needs. This may have further required Helping Hands to focus on specific types of resources used for their clients.

The table below summarizes the results of Objective 3. CCP’s goal for this objective was that 75% of clients would improve their SSM Scores. Scores were obtained a week prior to entry and exit from the program. CCP defined improvement as an increase in a client’s SSM score of 1 point on any domain.

Objective 3: 75% of clients will improve their self-sufficiency score.

Matrix Record Provider	Total Clients Housing 1000 Care Coordination Project/Matrix Measures	Clients Housing 1000 Care Coordination Project/Improved Self-Sufficiency	Percentage
Active Assistance	31	24	77.42%
Community Cares	111	91	81.98%
Helping Hands	42	33	78.57%
Saving Service	49	38	77.55%
Count:	232	182	78.45%

The data reveals that all four agencies met Objective 3. Since SSM scores are point-in-time assessments and show a client’s dependence on public assistance, any improvement on one of the 18 domains would reach this goal.

Confidence intervals were applied to average SSM score increases. Average score increases per organization were: Active Assistance 9.93 (6.79, 13.08); Community Cares 9.37 (7.78, 10.03); Helping Hands 7 (4.73, 9.27); and Saving Service 17.125 (12.275, 21.975). The data reveals that Saving Service had the highest average score increase of the four organizations at 17.125. Also, the confidence intervals reveal that Saving Service had a statistically significant score increase over Community Cares and Helping Hands but not Active Assistance.

The table below summarizes the results of Objective 4 per agency. Objective 4’s goal was to ensure that 75% of the clients would have sufficient resources to meet their basic needs. Sufficient resources were defined under the McKinney-Vento Act.

The following table was used to determine if a client had access to sufficient resources:

Use of Matrix Measures

- Shelter/Housing x2
- Income x1
- Food and Nutrition x1
- Health Care Coverage x1

Average score (+5) of ≥ 2.8 is a success

Objective 4: 75% of clients will have access to sufficient resources to meet their basic needs.

Matrix Record Provider	Total Clients Housing 1000 Care Coordination Project/Matrix Measures	Clients Housing 1000 Care Coordination Project/Sufficient Resources	Percentage
Active Assistance	33	24	72.73%
Community Cares	115	68	59.13%
Helping Hands	42	18	42.86%
Saving Service	50	39	78.00%
Count:	226	149	65.93%

The data indicates that Saving Service met Objective 4. No other agency was able to meet this objective. Helping Hands had the lowest percentage of clients who met this objective. One possible explanation for this result could be that Helping Hands had a demographically more challenging population to work with who may have suffered from more complex psychosocial issues requiring longer case management and additional resources.

The table below shows data summarizing Objective 5 of the Housing 1000 Care Coordination Project. The goal was to ensure that client's income was equal to or greater than \$850. This amount was based on the July 1, 2009 – December 31, 2009 SSI/SSP payment standards. These payment standards entitled a client moving into independent living to a total of \$674 of monthly SSI and \$176 of monthly SSP (SSI charts, 2014).

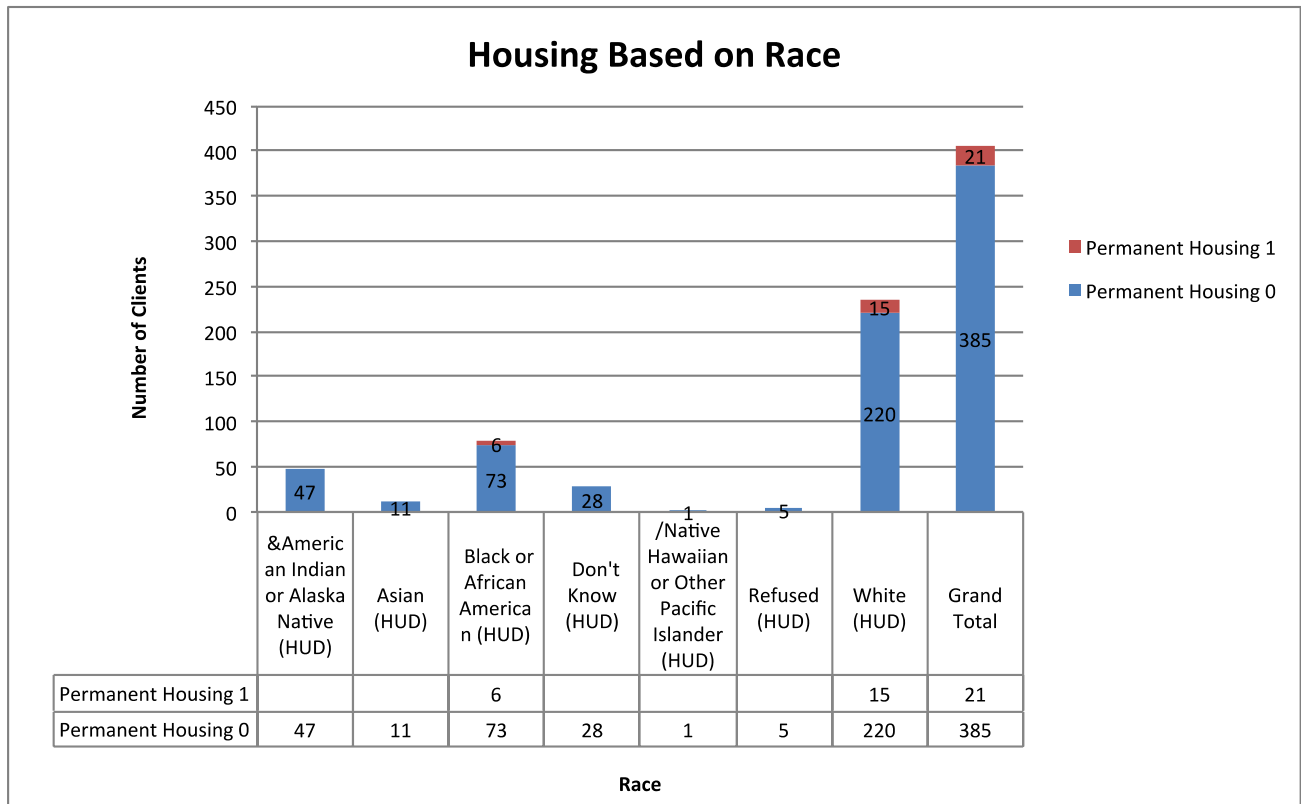
Objective 5: Housed clients' latest income must be greater than or equal to \$850

Entry Exit Provider Id	Total Housed Clients with Income	Housed clients Housing 1000 Care Coordination Project/ Income >= \$850	Unhoused clients Housing 1000 Care Coordination Project/ Income >= \$850	Housed Percent age
Active Service	23	10	4	43.48%
Community Cares	72	28	15	38.89%
Helping Hands	19	2	8	10.53%
Saving Service	33	18	2	54.55%
Count:	141	57	29	40.43%

The data shows only clients who were housed with incomes greater than or equal to \$850. Not all clients who were enrolled and housed actually received income and therefore had to rely on

lifetime subsidies. Only 141 total clients were housed with income and only 57 (40%) had incomes greater than \$850. Helping Hands was able to help 10% of their clients get incomes greater than \$850 while Saving Service achieved a 54.55%. There were large differences in the percentage of clients per agency that achieved incomes greater than \$850. One possible explanation may have been that demographically not all agencies had clients who met the eligibility criteria for federal assistance.

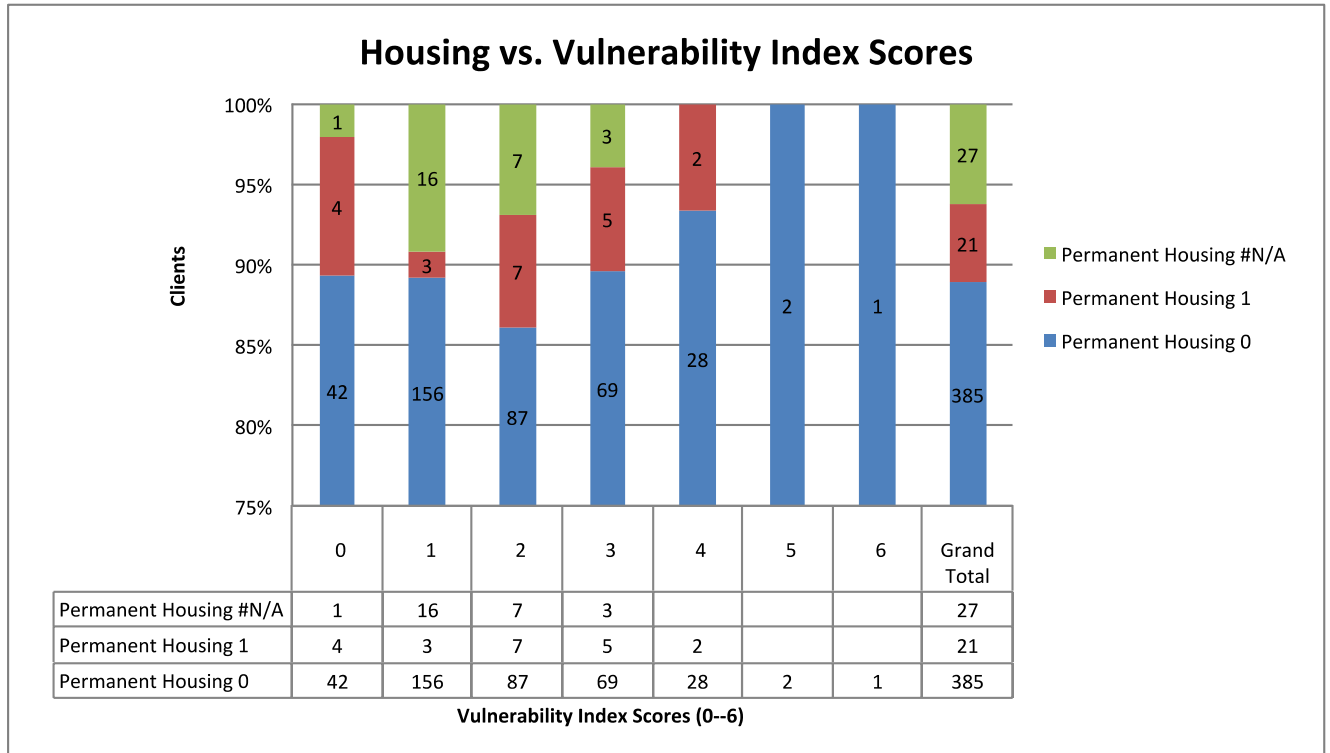
This study then focused on the second objective which was to look at the degree to which individual variables, such as overall physical health, mental health, legal issues, and substance abuse history, impact a client’s ability to obtain permanent supportive housing from homeless status. A summary of tables and explanations follow. The table below shows the number of clients placed to permanent supportive housing based on their race.



An examination of the data reveals that only clients identified as black or white were housed.

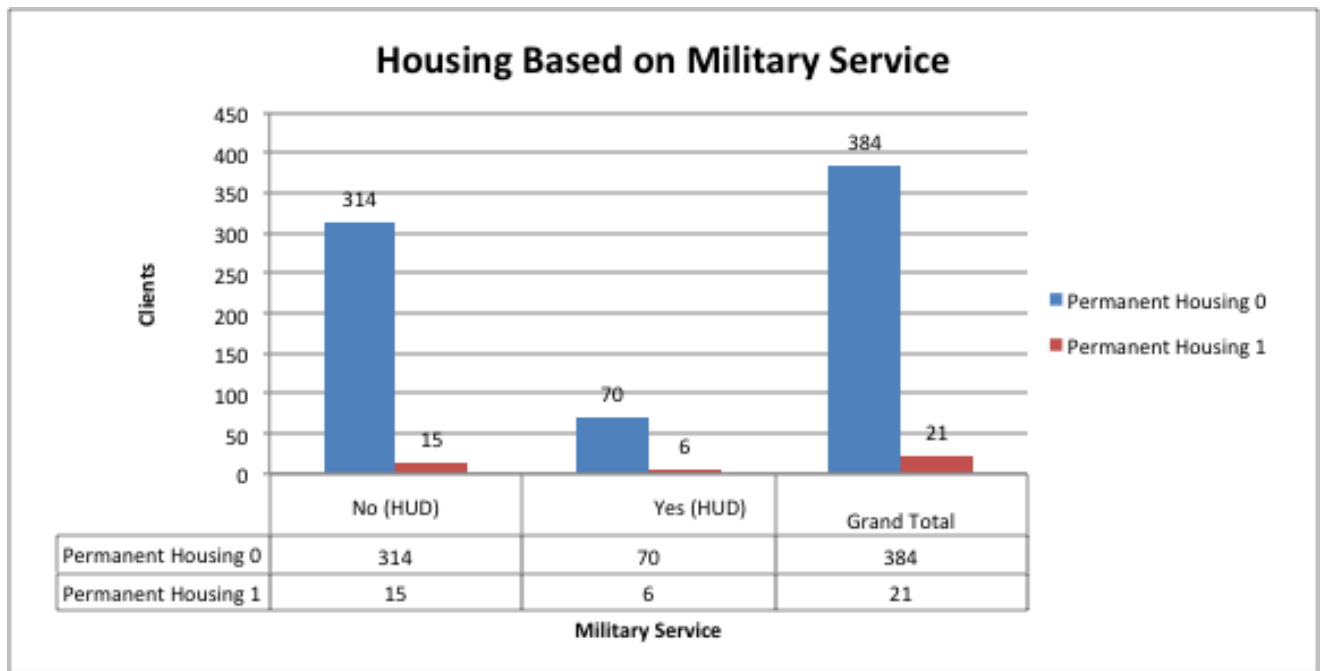
Additionally, over twice as many white clients were housed as black clients. No other clients from other races were housed. One explanation for this data could be that the data was preliminary in nature and may not have clients that were housed later on as the project matured.

The next table below shows the number of clients placed into permanent supportive housing based on their vulnerability scores.



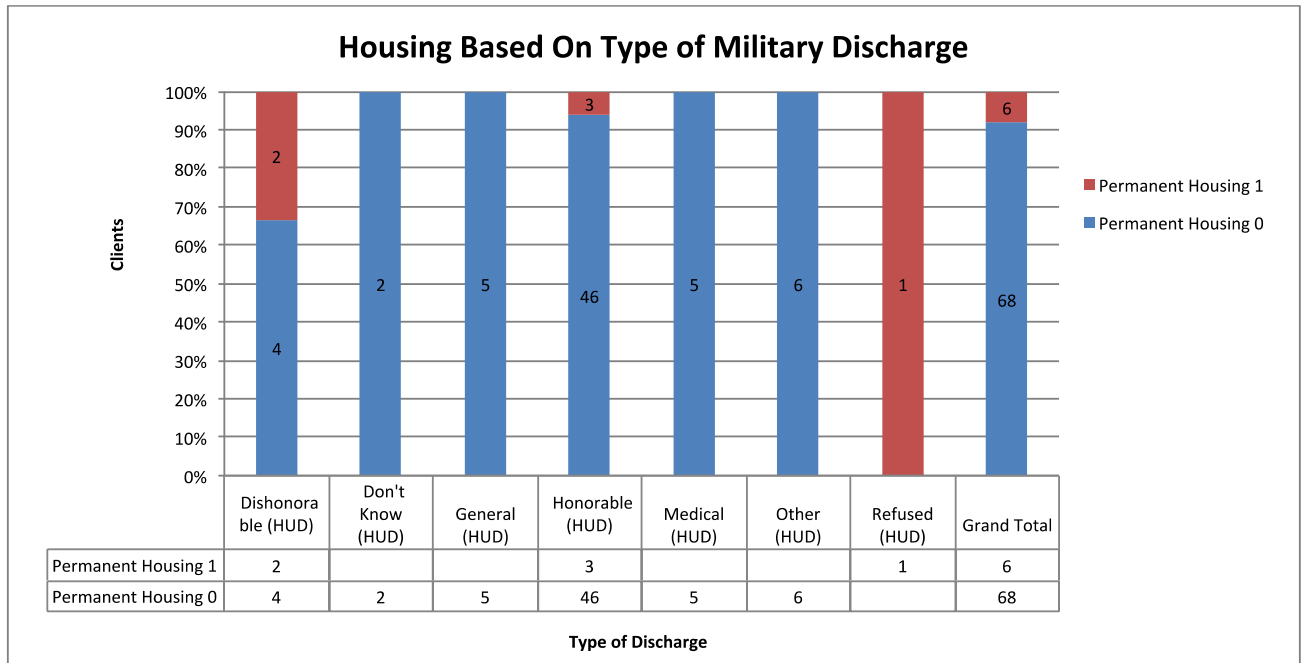
In examining the data, clients who had vulnerability scores of 0, 2, or 3 received housing over clients who with vulnerability scores of 5 & 6. One explanation could be that clients with vulnerability scores of 0, 2, or 3 were more receptive to receiving support from case managers and Housing 1000 Care Coordination Project agencies. Also, clients with vulnerability scores of 5 and 6, although they may have represented a more vulnerable population, may not have been able to function or follow up with case managers on the level that was necessary to maintain housing.

The table below shows the total number of clients who were placed in housing based on whether they identified themselves as having served in the military.



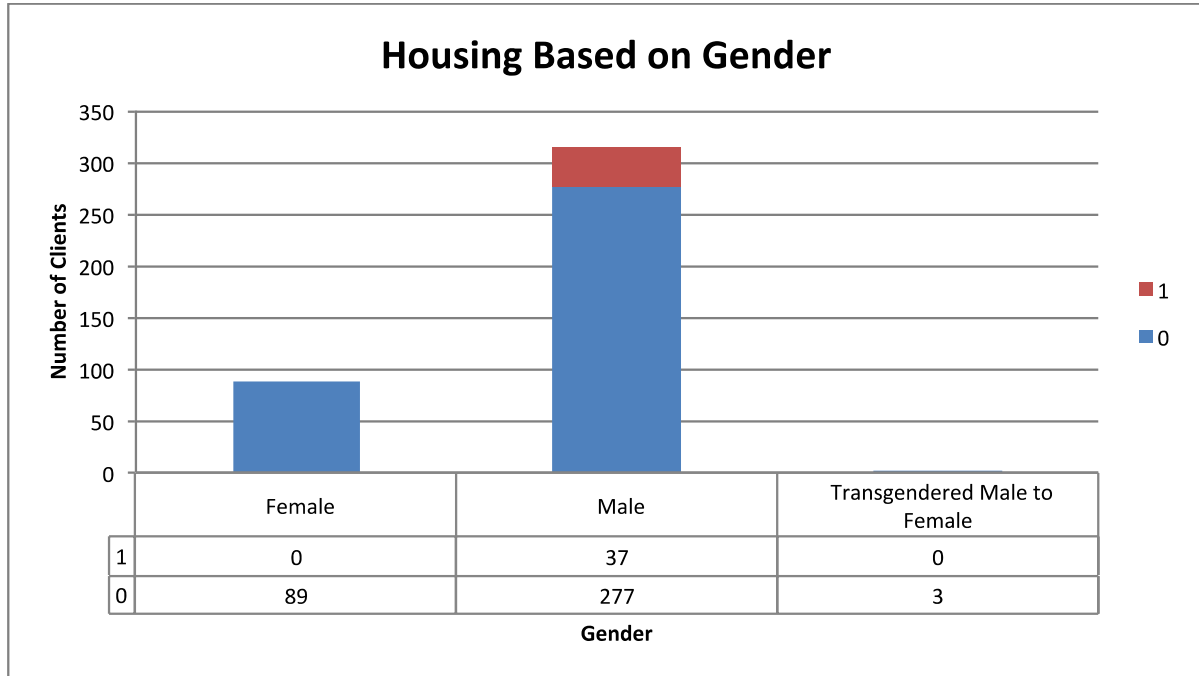
An examination of the data shows that more non-veterans received housing than those that served in the military. It is possible that more military veterans suffered from other chronic mental or physical disabilities and were not willing to participate in housing programs than those who were not veterans. Another explanation is that veterans may have already engaged with case managers within the Veteran’s Hospital system and were already on waiting lists through those programs.

The table below shows the number of homeless military veteran clients who were housed based on their type of military discharge.



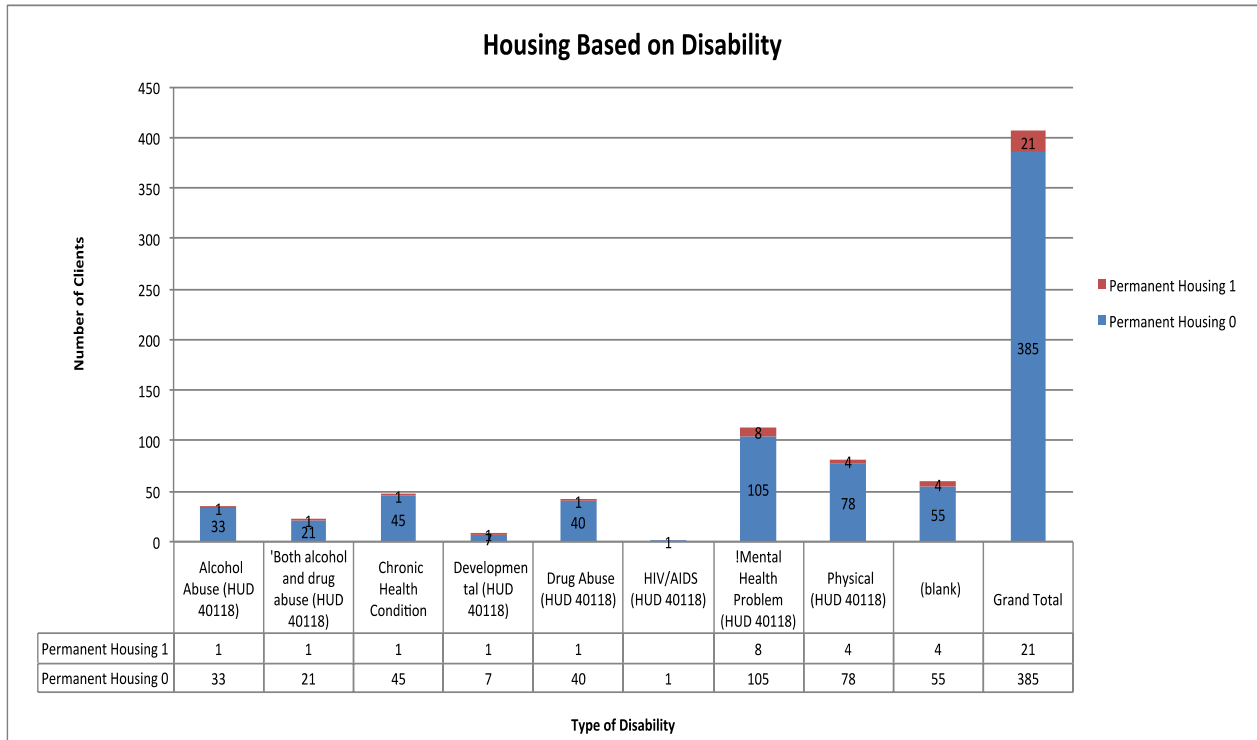
The only clients to receive housing were those who were discharged either dishonorably, honorably, or refused to answer. All other veterans with discharge types other than the ones mentioned above did not receive any housing supports.

The table below shows housing based on gender. This table takes into account both males, females, and those individuals that identified themselves as transgender.



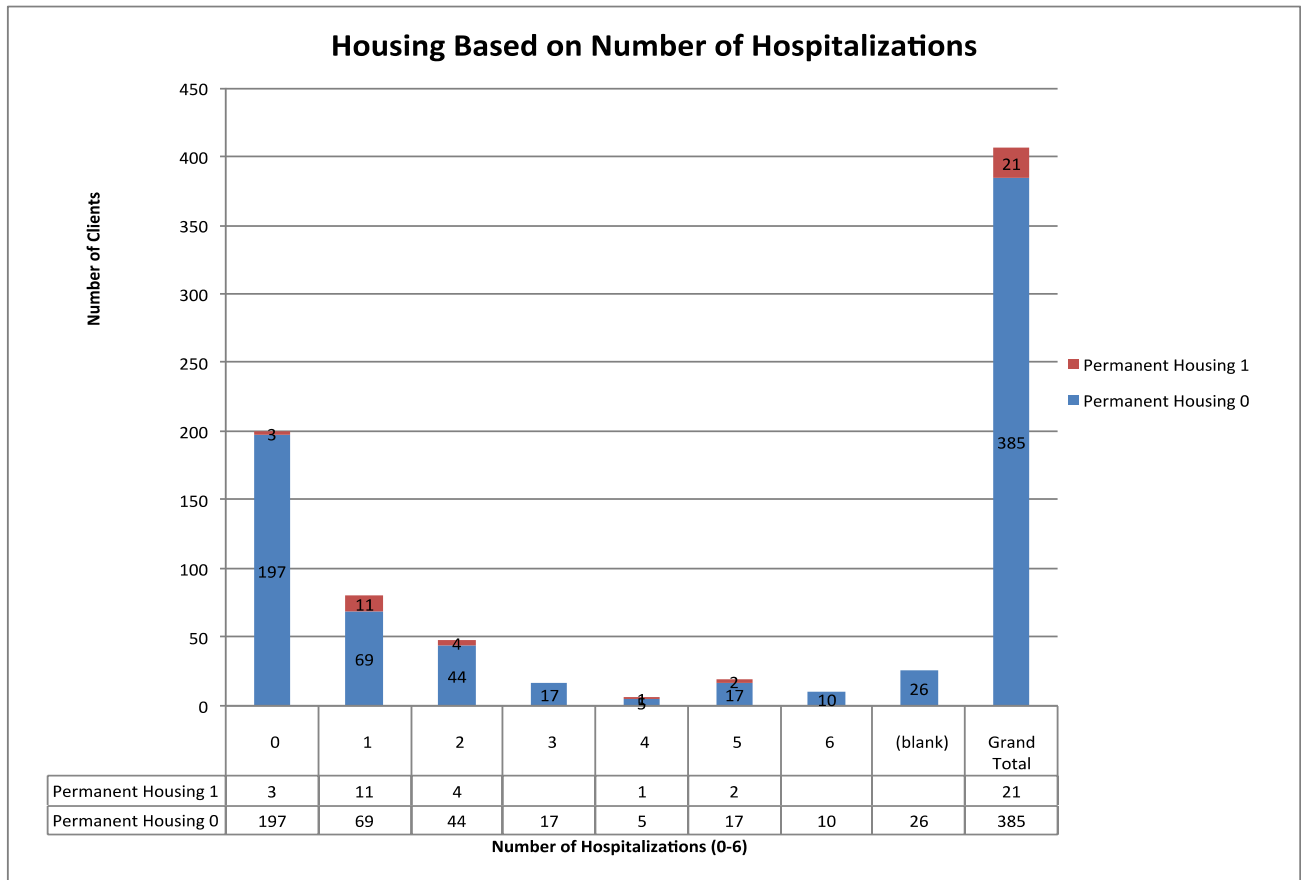
An examination of the data shows that more males received housing than females. These numbers may be reflective of preliminary data gathered during this study period. No females or transgendered (males to female) clients were housed during this study period. This data is consistent with previous research described in this report that females had more difficulty obtaining housing than males. Females may face additional challenges and barriers associated with gender that males do not face.

The table below shows the number of clients who were housed based on their type of disability (physical, mental, or substance abuse history). As stated before, physical disability is a contributing factor to homelessness.



An examination of the data reveals that mental health clients were twice as likely to receive housing as those with physical disabilities. Mental health clients were also more likely to receive housing over clients with other disabling conditions, such as alcohol abuse, alcohol and drug abuse, developmental disabilities, and other chronic health conditions. Clients with HIV/AIDS were the only group of clients who did not receive housing during this study period.

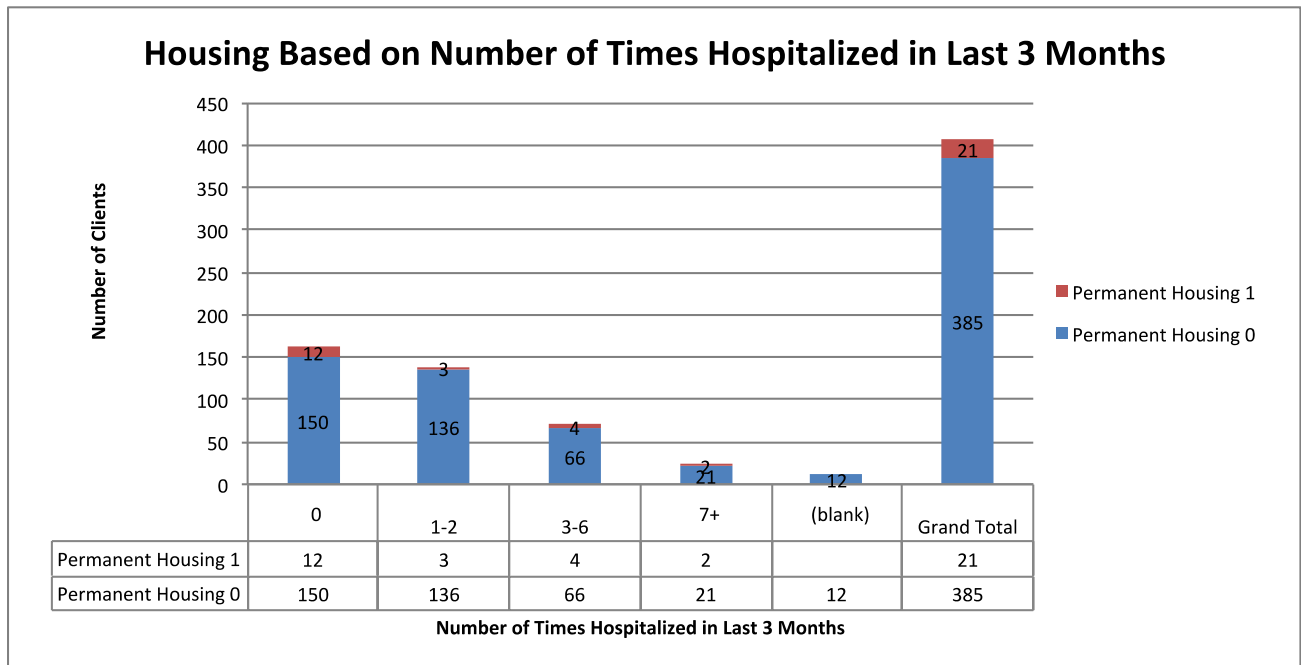
The table below shows clients who were housed based on their number of hospitalizations over the past 365 days.



The data reveals that a large majority of the clients who were housed had only been hospitalized one time in the past 365 days. Clients who were hospitalized 2, 4, or 5 times also received housing to a lesser extent. Clients who were hospitalized 3 times or greater than 6 times did not receive housing. One possible explanation is that the clients who were not housed at 3 hospitalizations were not seen as a drain to resources and those that exceeded 6 or more hospitalizations were seen as too draining on resources. Thus 6 hospitalizations may be the tipping point at which time case managers were no longer able to help clients. Another explanation is that clients who were hospitalized more than 6 times may reveal unwillingness by clients to make changes or accept help in their lives in order for them to live stably in permanent

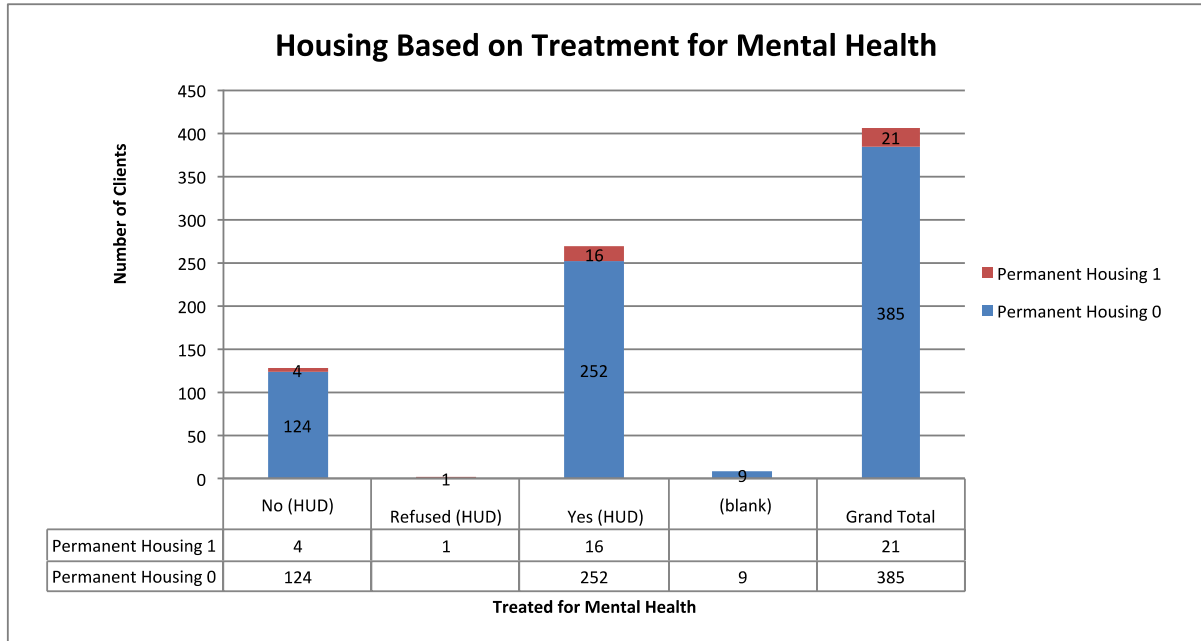
supportive housing. These clients could also be suffering from chronic substance abuse issues that go untreated.

The table below shows how many clients received housing based on the number of times that they reported hospitalizations over the past 3 months.



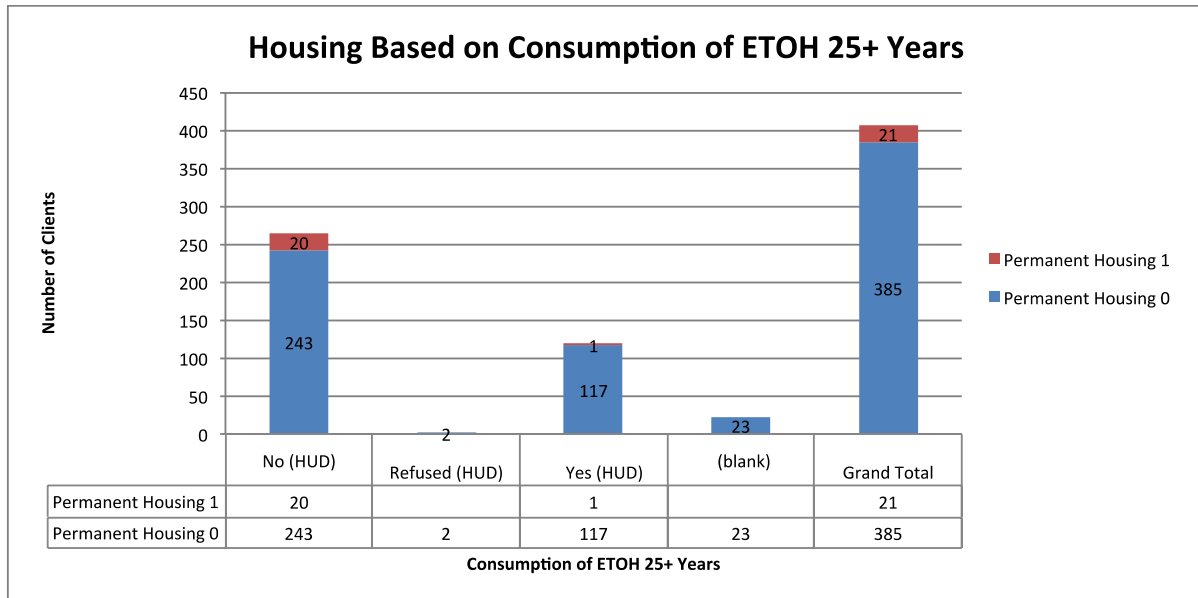
The data reveals that clients who were not hospitalized or were hospitalized more than 7 times in the past 3 months were more likely to receive housing than other clients who reported between 1 – 6 hospitalizations. Unlike the table above this data suggests that not being hospitalized is advantageous to receiving housing over those clients who habitually go to the hospital. Several possibilities exist for why clients go to the hospital so many times over the past 3 months. These reasons include such things as respite from the elements, shelter, pain medications, security, hygiene, and food. Clients who go to the hospital more than 7 times in 3 months indicate a habitual pattern of behavior for those particular individuals.

The table below shows the number of clients who received housing based on whether or not they were receiving treatment for a mental health condition.



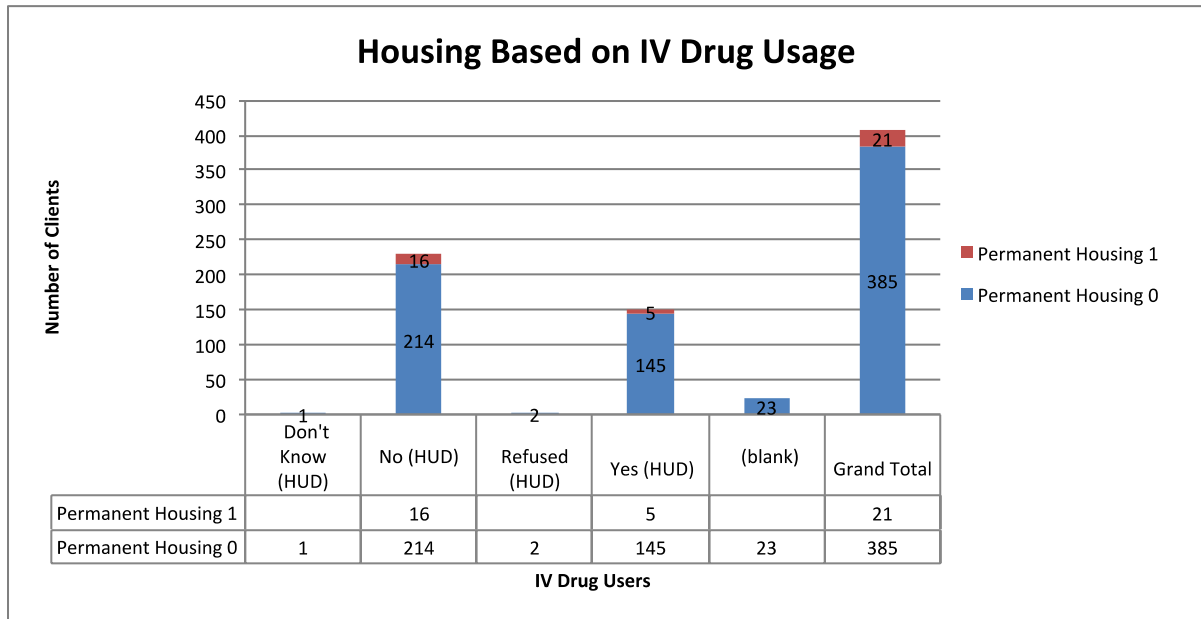
Based on the data, clients who received treatment (6%) were more likely to get permanent housing than those who did not receive treatment (3%). One explanation for this may be that those who received treatment were more likely to be able to function stably enough to remain in housing. Also, those that received treatment may have been more likely to stabilize due to support systems such as medication management or psychotherapy.

The table below shows the number of clients who received housing based on whether they reported that they had abused alcohol daily for the past 25 years or longer.



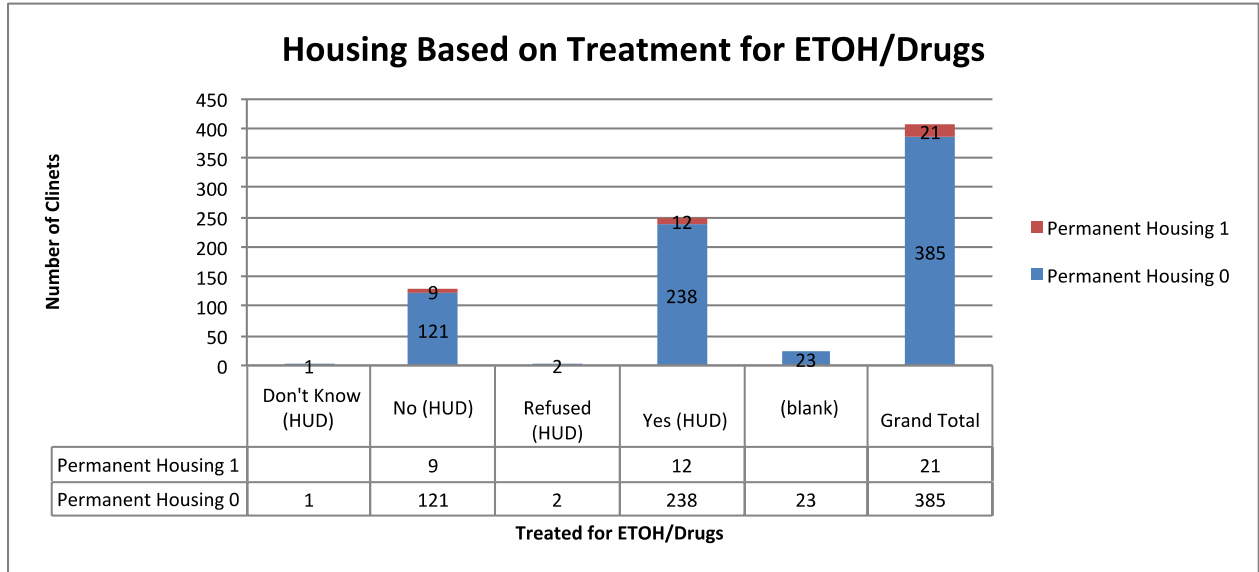
The data reveals that clients who abused alcohol daily for the past 25 years or more (.8%) were not likely to get housing as opposed to those who did not abuse alcohol daily (8%). One explanation for this result could be that those clients who reported daily abuse were not willing to engage with case managers or willing to make necessary changes. Another explanation is that those clients with daily alcohol abuse suffered from other medical conditions, which may have made it impossible to succeed independently, and this daily abuse signifies a lifelong prevalence of addiction.

The table below shows the number of clients that were housed based on whether or not they abused IV drugs.



The data reveals that IV drug users were housed at a rate of 3.4% versus non-IV drug users at 7.4%. From this data, it appears that IV drug usage is a disadvantage to receiving housing. One explanation for this data could be that IV drug usage is more addicting and make it more difficult for clients to accept rehabilitation.

The table below shows the number of clients that received housing who were treated for drug and ETOH abuse.



The data shows that clients without treatment received housing at a rate of 7.4% whereas clients who received treatment for ETOH/drugs received housing at 5.4%. More clients received treatment (62%) for drugs than those that did not (31%).

ANALYSIS

EVALUATION OF HOUSING 1000 CARE COORDINATION PROJECT'S 5 GOALS

This research performed an outcome analysis of the four core agencies involved in the Housing 1000 Care Coordination Project. In an analysis of each of the project's five objectives the following results were found. For Objective 1, none of the four agencies met the first goal. Initially Community Cares housed the most number of clients but only 27.03% were within the first 60 days. This was far below the projected goal that 80% of clients would be housed within 60 days of referral. Active Assistance and Saving Service each housed fewer clients but were able to house a larger percentage of their clients within 60 days.

Although confidence intervals showed that none of the agencies significantly outperformed one another it is clear that Community Cares was able to house the most number of clients, which may indicate that caseloads were less strenuous than other agencies, or that more clients had access to Community Cares. Active Assistance and Saving Service housed the fewest clients but more of their clients were housed closer to the 60-day mark. Both agencies may have had better access to supportive housing or supportive housing had more openings in their geographic areas. Still the shortage of housing seems to be an overall barrier with all four agencies, since none of the four could house 80% of their clients within 60 days of referral.

Objective 2's goals were not met either by any of the four community agencies. Community Cares and Helping Hands achieved a success rate of 78% but still fell short of the 80% goal. Saving Service was also able to house clients at 72%. Only Active Assistance scored 60% which is below the other 3 agencies. This may indicate that Active Assistance clients did not engage as readily in case management follow on services as clients from other agencies. Also, case management services were not a prerequisite to maintain housing, and therefore

Active Assistance's clients may have had more challenging behaviors. Overall, all four agencies achieved an overall success rate of 72%, indicating that they shared similar strategies in case management approaches that lead to success of their clients maintaining their housing. Resource management may have played a key role in the success or failure of whether or not agencies were able to keep their clients housed for the year after initial placement.

Objective 3's goal was met by all four agencies. In order to reach these goal clients had to increase their SSM score by 1 point. Community Cares showed that 82% of their clients improved their SSM scores upon exit. The overall success rate for all four agencies was above 78%. Further research should focus on which SSM domain or combination of domains from the SSM would be the key factors in keeping clients housed for over a year. This would help focus case managers to ensure that these key domains were established first before others. The Santa Clara County Homeless Census and Survey Report (2011) shows job loss, alcohol/drug abuse, and an argument with a family or friend as the cause of homelessness. This indicates that focusing on the SSM domains of employment, healthcare, and life skills are keys to success in not only obtaining housing but maintaining housing.

The drawbacks to obtaining these three are that they are interrelated. Oftentimes clients lacking life skills cannot obtain employment or keep employment. This may have caused them to lose their employment in the first place. Also, lack of available healthcare may require clients to actively participate in the application process but they may not be willing to do this. Employment is the means to keep housing through stable income. However, for chronically homeless clients employment may not be feasible or they may be too old to rejoin the workforce. Not only do life skills need to be taught, but case managers also need to determine what level of

education their clients have obtained, and how well they are functioning. All these factors pose various degrees of challenges for case managers.

Only Saving Service was able to meet Objective 4's goal. This indicates the long-term need to provide services to chronically homeless clients for the rest of their lives. Once clients entered the Care Coordination Project they had access to subsidies and housing, although no guarantee of housing was made. The subsidies were meant to be long term and were funded through a combination of local and federal programs. The subsidy was meant to provide for a percentage of the clients' rent based on a sliding scale of the client's net income. The subsidy was long term, and there was no plan to terminate the subsidy as long as the client remained in the program. Case managers kept in contact with clients to help them get the maximum amount of financial support, education, and if possible employment. Gaining income would have been seen as a positive contribution and monies could be redirected to other clients within the program.

However, many long term chronic homeless clients may have been too old or too disabled, based on the definition under the Social Security Disability Act, to work, and therefore eligible for lifetime subsidy assistance. Clients without sufficient resources were still housed, if possible. Additionally, Housing First programs do not impede clients from continually seeking out their drug of choice but all four agencies within the Care Coordination Project did provide resources to drug and alcohol rehabilitation programs.

Case management did have a direct impact on how long it took for clients to get housed. Typically, those clients with more case management hours took a shorter time to find housing and get placed. This may indicate a willingness by clients to engage with their case managers or

active case managers who sought out the most vulnerable of clients and focused on placing them successfully throughout scattered site housing in the county.

On Objective 5, Saving Service was able to get over 54% of their clients to have incomes greater than \$850. This reflects the amount of Supplemental Social Security (SSI) for eligible single individuals living independently. Eligibility for SSI is based on federal guidelines. The goal of each agency was to try to qualify their clients for any financial assistance programs available. Subsidies could therefore be more efficiently directed towards clients who were ineligible for SSI or other government financial assistance programs. It appears that the other agencies did not have as many clients eligible for SSI or other governmental financial assistance programs.

Although not all the Care Coordination Project's goals were met, overall performance shows that Saving Service appeared to do well on Objectives 1, 4 and 5 and Community Cares did well on Objective 2 and 3. However, no conclusion can be drawn that Saving Service was superior in their approach or placed their clients in permanent supportive housing better than the other 3 agencies. Research has shown which Vulnerability Index scores lead to increased mortality amongst the homeless, but further research needs to focus on client individual demographics and SSM scores that lead to success. Also it appears that access to adequate housing plays a key role in whether or not agencies are successful in placing clients in housing.

FOLLOW ON ANALYSIS OF INDIVIDUAL VARIABLES

Follow on analysis of individual variables shows that housed clients were generally white males; had a vulnerability index score of either a 0, 2, or 3; suffered from a mental health disorder; and had been hospitalized at least once in the past year. Clients who reported that they

had been drinking daily for the past 25 years, abused IV drugs, or had been treated for a mental health condition were less likely to receive permanent supportive housing.

Barriers to housing included clients who had vulnerability scores of 5 and 6 did not receive housing. This may indicate that these clients either needed more extensive case management or were unable to live independently even with supportive services. This may also be the reason that clients who were drinking excessively for the past 25 years were also not housed. Also, clients who admitted to abusing IV drugs were less likely to receive housing than clients who did not report using IV drugs.

There were some limitations to this study. First, alcohol and drug abuse were evaluated together and not separated. This may be due to the possibility that both alcohol and drug abuse are co-occurring disorders in many individuals. Future studies should evaluate these two variables separately and determine the individual detrimental impacts on housing. Another limitation to the study is the lack of available affordable housing. Scattered site housing is the model that Housing First programs utilize, but the availability of this housing impedes case managers' efforts to successfully place clients within 60 days of referral. Also, clients with vulnerability scores of 5 and 6 did not receive housing. This indicates that available resources did not extend to these clients or that these clients were unable to actively engage with case managers.

CONCLUSIONS

Overall, Saving Service appeared to do better than the other 3 agencies. Case management is directly related to the success of clients being housed, and increased hours of case management per client is positively correlated with decreased time to find housing and place clients. Clients who are severely vulnerable may not be willing or may be unable to engage with case managers. Services for severely vulnerable clients may not be available or these clients may be unreachable with resources currently available. Barriers to housing include alcohol and drug related disorders, but IV drug usage is seen as a potentially harmful barrier where no clients receive housing. Finally, improving a client's employment, gaining access to healthcare, and teaching life skills appear to be the key client domains for case managers to focus on.

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