TIPPING POINT
COMMUNITY

Reducing Chronic Homelessness in San Francisco

The 1970s and 1980s resulted created homelessness as we see it today

Declining Supply of Affordable Housing

Cuts to housing **construction** and Federal housing **assistance**

Demolition of substandard housing due to high maintenance, aging infrastructure

Conversion of **rental units to condos** for urban renewal

Lapses in assistance: three quarters of qualifying households do not receive income-based rental assistance

Rise in Income Inequality

Increased cost of living with local growth of high-skilled jobs

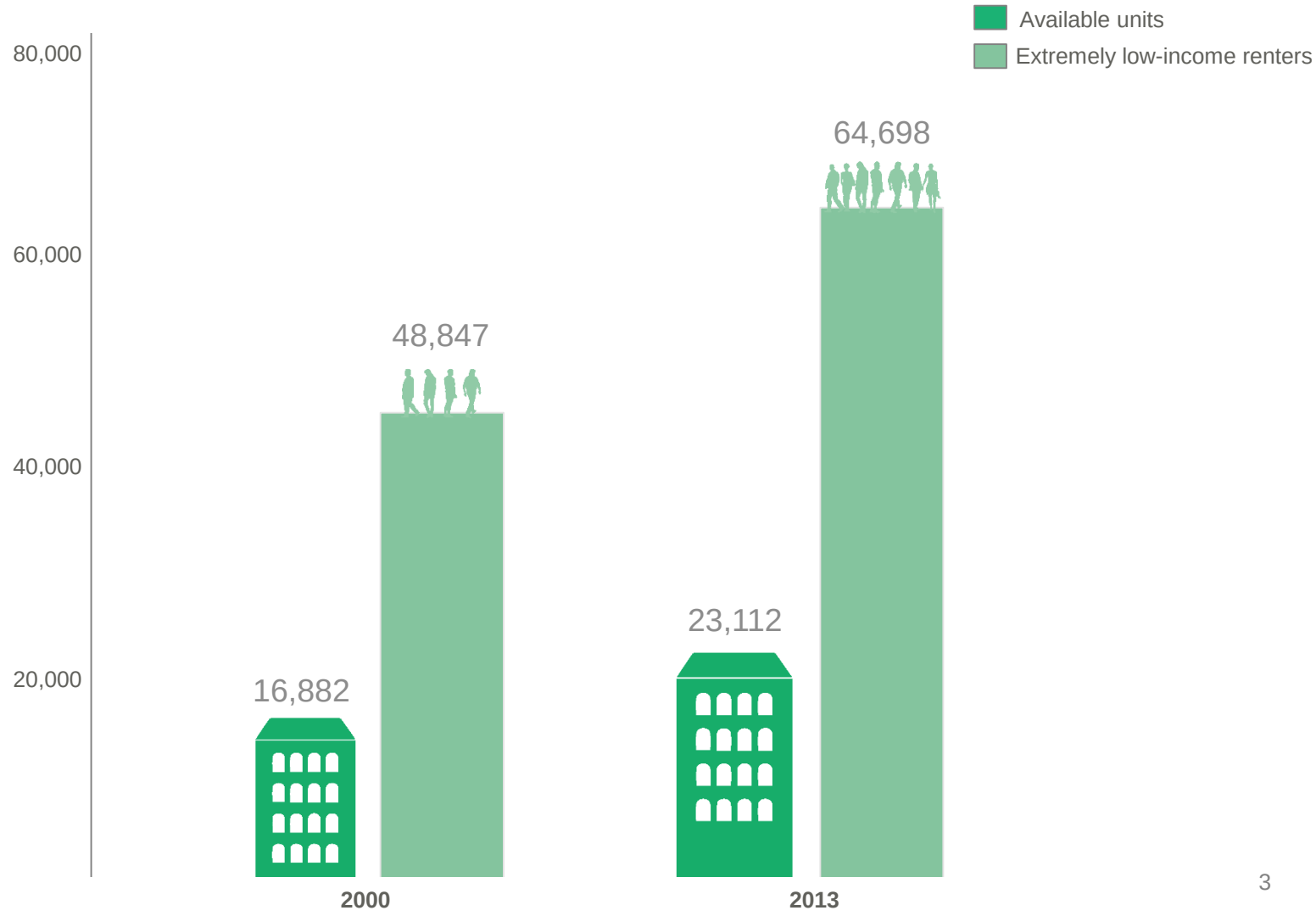
Loss of low-skilled and manufacturing jobs; rise of service and retail sector jobs

Stagnation in **low-income wages** jobs

Changes in minimum wage **lagging behind inflation rate**

A growing shortage of affordable housing continues

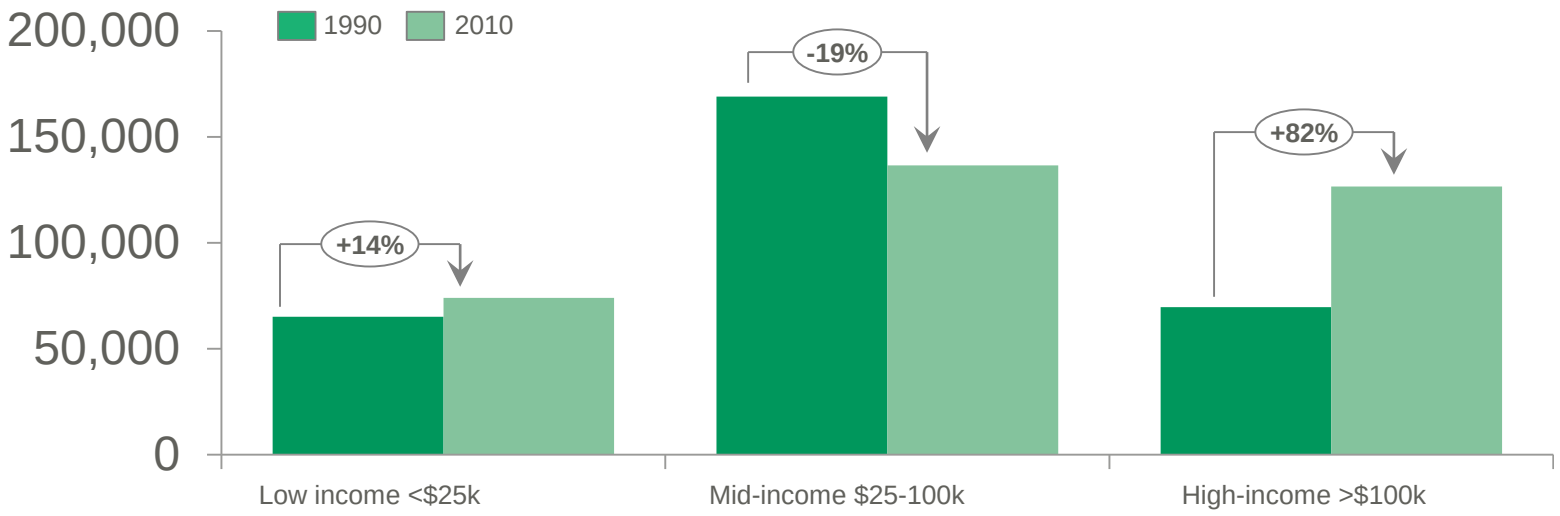
Affordable units vs. number of low-income renters in San Francisco



Along with unprecedented income inequality paired with the stabilization of poverty

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

Approximate number of households in San Francisco



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

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

Source: Brookings Institute "Some cities are still more unequal than others" 2015, San Francisco Human Services agency and US Census, Urban Displacement Project conducted by UC-Berkeley and UCLA (2013 data)

Public policy changes further exasperated growth of homeless and vulnerability of population

Policy reforms targeting social systems failed to provide corresponding community investments

Mental Health

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

Social Welfare

Loss of subsidies for low-income groups:

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

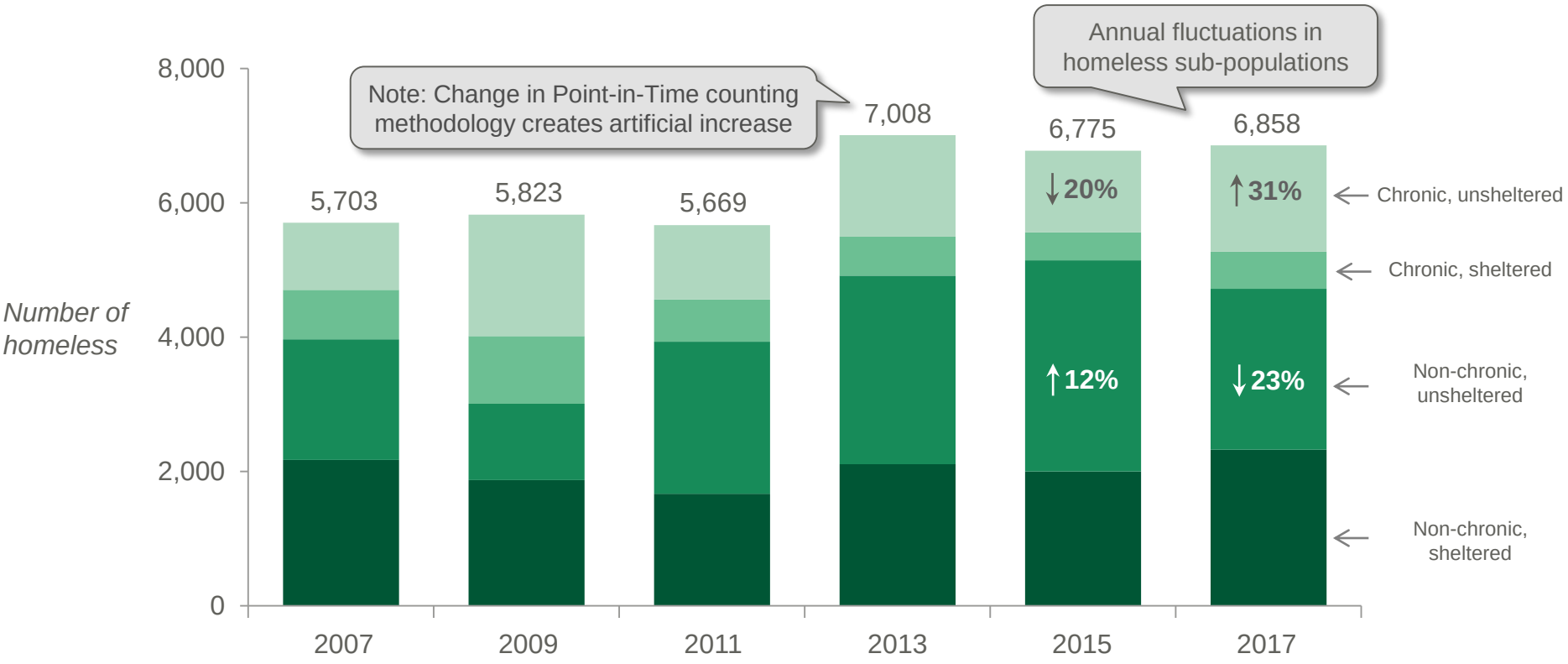
Criminal Justice

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

Result	**Systems failure resulting in clear failure of our safety net: homelessness**

Approximately 7,000 homeless in San Francisco on any given night

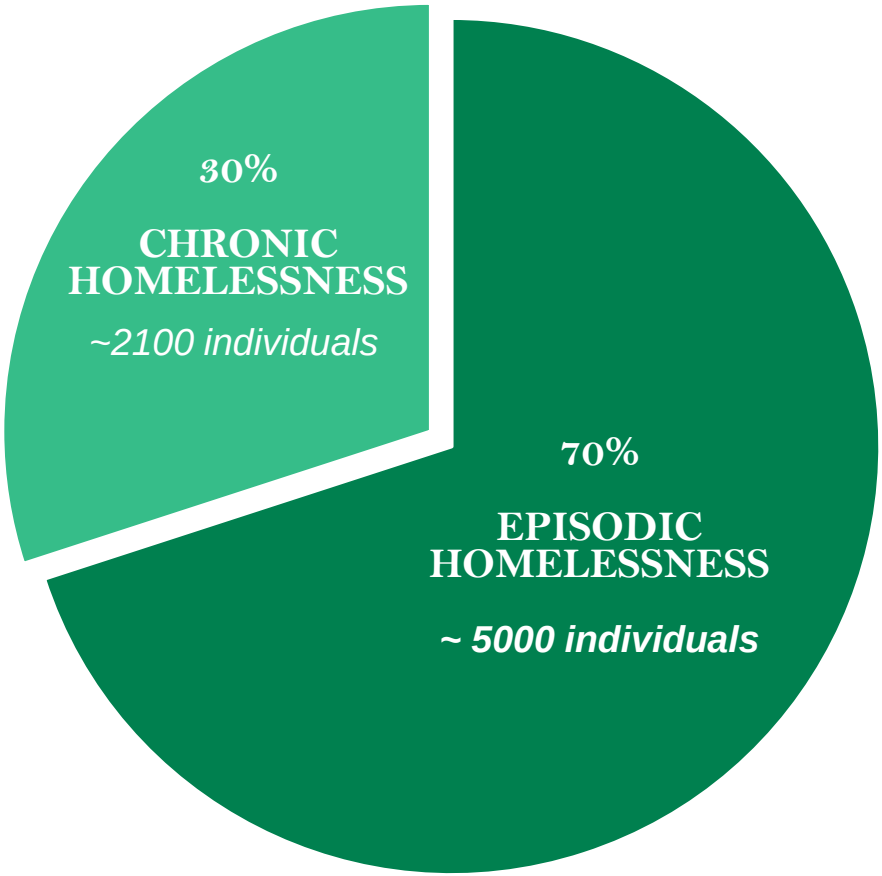
Total homeless population has stayed steady while sub-populations have fluctuated



1. HUD PIT SF 2015
Source: HUD PIT Data 2007-2015, 2017 San Francisco ASR Homeless Count & Survey

Our $100 million investment will focus on chronic homelessness

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



Source: 2017 San Francisco Point-In-Time Count + Survey

Emergency medical, mental health, and substance abuse services spend greatest amount on chronically homeless

	All homeless			High users, long time homeless			
	Total cost	# people	Cost / person	Total cost	# people	Cost / person	
Medical *Includes ED, Urgent Care, Medical Inpatient, Medical Respite, EMS*	$109.4 million	6,401	$17.1k per person	$38 million	536	**$70.9k per person**	**Top 8%** of users: **35% of cost**
Mental health *Includes PES, Dore Urgent Care, ADU, Psych Inpatient, Mobile/Westside Crisis*	$34.7 million	2,445	$14.2k per person	$10.4 million	312	**$33.2k per person**	**Top 13%** of users: **30% of cost**
Substance abuse *Includes Social Detox, Sobering Center, Medical Detox*	$4.5 million	1,847	$2.5k per person	$1.5 million	319	**$4.8k per person**	**Top 17%** of users: **33% of cost**

For total emergency health costs, the top 13% of homeless users make up 72% of total costs

Note: PES (Psychiatric Emergency Services); ADU (Acute Diversion Unit)
Source: CCMS data base FY14-15.

The Tipping Point strategy will build towards a five-year vision to **drive systems change**, with a clear impact target

Create more housing: Target chronically homeless and streamline housing access and creation

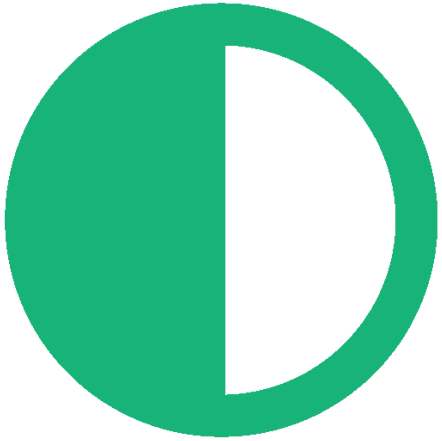
- Movement between housing levels of care
- Prioritization of most vulnerable for housing with buy-in for effective implementation

Prevent homelessness: Intervene at key moments of opportunity, times when the public sector interfaces with those most at risk of becoming chronically homeless

- Improved care transitions
- Know the at-risk population by need and provide services based on individual need

Optimize public sector: Maximize funding and coordinate, individualize approach to homelessness

- Leverage and maximize dollars
- Understand, through data, the impact of funding, interventions, and policy on homeless population



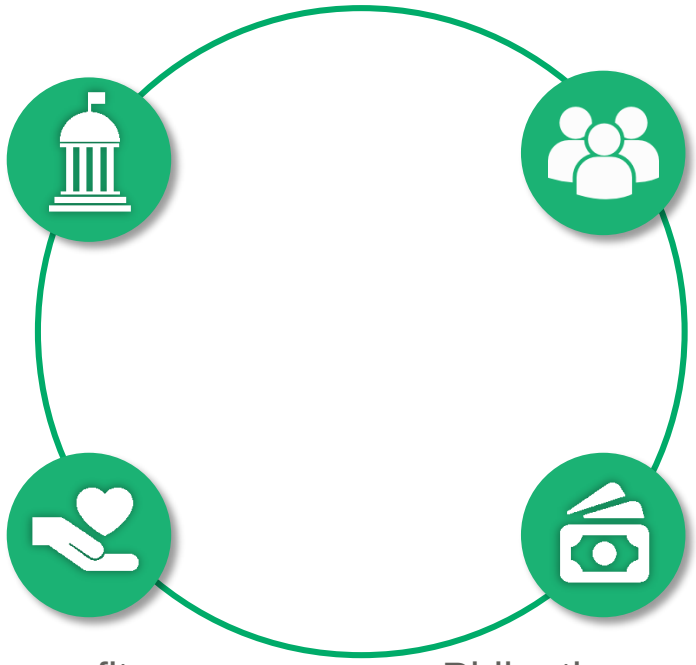
50%

REDUCTION OF 2017 CHRONIC HOMELESSNESS

With a focus on redefining funding relationships to create aligned investments and greater impacts

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

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



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

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

Maximize State / Federal funding to expand homelessness services

Medicaid through Affordable Care Act, Whole Person Care

Housing Vouchers through Section 8 HUD program

TAY Housing and Services through Title IV-E

Challenges

Goal	Creating mutual accountability across multiple systems
Objective	Increase affordable housing and provide support services as needed
Barriers	Housing IS health but not viewed as a health outcome Medicaid: Eligibility ≠ Enrollment ≠ Access ≠ Good Outcomes Housing providers and health providers don't speak the same language

Housing is Health: Funding Opportunities

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

Increase Medi-Cal Enrollment

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

Support policy and practice changes

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

Housing is Health: Funding Opportunities

Increase number of affordable housing units

- Fund housing subsidies
- Provide capital for affordable housing

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

- Child welfare
- Criminal justice
- Mental health

Alignment, coordination and information sharing

Information sharing

- Help support sharing between multiple systems serving people experiencing homelessness

Participate in aligned and coordinated funding

- San Francisco Funders Table to End Chronic Homelessness