MEMORANDUM

To: Bay Area Regional Steering Committee on Homelessness

From: HomeBase

Date: 23 January 2009

Re: Best Practices in Homeless Housing & Services

Background
Reviewing best practices, pilot projects, and lessons learned in the field has long been a theme of discussion at the Regional Steering Committee on Homelessness and Housing (RSC). Every year since the early 1990s, the RSC has highlighted best practices to ending homelessness, focusing both on the programmatic level and the systems level. Most recently, the RSC reviewed homeless employment programs (January 2007), housing first models (October 2007), Continuum of Care structure and coordination (October 2007), and family rapid re-housing (July 2008).

The RSC has used the insight gained through its discussions and member's first-hand experience to then ask for new funding streams. For example, in March 2004 the RSC spent significant time outlining the ELHSI: Ending Long-term Homelessness Services Initiative, which would have created a dedicated funding stream from the U.S. Department of Health and Human Services Agency.

Today, we continue the tradition of reflecting on what we have learned to inform our future. Below are a number of pilot projects. They should help us to think about what kind of new initiatives we might like from the Obama Administration.

Frequent Users of the Healthcare System Initiative

Background
The Frequent Users of Health Services Initiative (FUHSI), jointly funded by the California Endowment and the California HealthCare Foundation, was a six-year project mandated to test new models designed to serve the "frequent users" population more effectively. The Initiative defines "frequent users" as group of individuals whose complex needs are inefficiently addressed in the high-cost acute care settings of emergency departments. This population faces barriers in accessing housing, medical, mental health, and substance abuse resources, all of which can contribute to frequent emergency department (ED) visits; this trend is extremely costly to communities. As such, the primary goal of the Initiative was to discover ways to avoid the overuse of these ED facilities, particularly by the homeless constituent. To reduce the "revolving door" phenomenon, the Initiative funded programs implementing coordinated, multi-disciplinary care. The Initiative provided one-year planning grants and three-year implementation grants to six counties—including Alameda, Sacramento, Santa Clara, and

Santa Cruz—in the state, beginning in 2003.

Goals

The Initiative was created to fund projects that employed innovative, integrated approaches to address the problem of frequent users of emergency health care services. In resolving this issue, the Initiative sought to catalyze two types of broad changes: program-level and, more importantly, system-level. Additionally, within each county the goals were more focused.

One objective of FUHSI was to reduce the use of emergency departments. The central goal was to invest in, and stimulate the development of, a comprehensive, coordinated system of care to address the needs of frequent users of emergency departments. Through inter-county partnerships and collaborations with agencies that work with the frequent user population, each county program identified and addressed barriers to coordinating care, improving access to needed services, and enhancing the quality of care delivered.

To generate system-level changes, counties concentrated their efforts in different areas, including: elevating the awareness and understanding of the needs of frequent users; increasing the capacity for housing homeless people; improving access to mental health and substance abuse treatment; improving communication and care coordination across hospital and primary care providers; streamlining processes for securing SSI benefits, food stamps, and Medi-Cal coverage; and, developing a sense of "collective accountability" within the community, which has addressed change in other areas, such as discharge planning, respite care, pain management, and overall improvements in case management.

Funding

The Initiative was a 5-year, $10 million endeavor, jointly funded by the California Endowment and the California HealthCare Foundation. The investment from these organizations financed the planning and implementation grants, the technical assistance for all grantees, outcome evaluations, and a program office at the Corporation for Supportive Housing. The Initiative funded six one-year planning grants and six three-year implementation grants. However, not every county participating in the project attained both grants. In 2003, the counties of Alameda, Sacramento, Santa Clara, and Santa Cruz were each awarded implementation grants. Additionally, Santa Cruz's grant was renewed in 2006, and the grants of Alameda and Santa Clara were renewed in 2007.

Approaches

The funded programs utilized a range of models that were tested through the Initiative—from various types of intensive case management to less intensive peer- and paraprofessional-driven interventions—to learn which strategies could help reduce the avoidable use of emergency departments, and to create a more effective system of care for the frequent user population.

Ultimately, county programs sought to redirect care from the emergency department to lower-cost community-based settings by assisting frequent users in accessing the

appropriate services, decreasing psychosocial problems (e.g. homelessness or substance abuse) that may contribute to excess hospital utilization, and improving the coordination of acute, primary, and preventive care among service providers.

Each of the models implemented involved connecting frequent users with a range of clinical (e.g., primary care, mental health, drug and alcohol treatment services) and non-clinical (e.g., housing, transportation, legal advocacy) care. The Initiative's interventions were designed to be client-centered and responsive to the immediate and long-term needs of the clients, while also addressing their medical and social problems comprehensively and holistically.

Best Practices:
The six FUHSI programs provided a range of direct and supportive services that addressed problems in outreach, enrollment, engagement, service delivery, partnership development, and systems change. The Initiative established extensive case-management, as well as partnerships between County service providers, which facilitated access to services for clients, while also enhancing coordination and communication between agencies and departments. Linkages to primary care, mental health, and substance abuse treatment services were developed. Additionally, most programs provided, or had connections to, housing assistance and benefits advocacy. Ultimately, the approaches of each County reflect a collective shift toward meeting the individual needs of homeless clients, instead of simply managing the problem.

Outreach

Some County Programs used electronic "flagging" systems for automated enrollment and patient identification. Program staff were usually located throughout their respective County in various partner hospitals and community providers, making themselves available to all clients. Additionally, staff were trained to be culturally competent and were typically multi-lingual. Recruitment and participation in the County programs were enhanced through the implementation of "small incentives" (e.g., phone cards, grocery vouchers, bus tokens) and transportation assistance. Moreover, some programs involved clients—referred to as "peers"—in outreach efforts.

Team Composition and Service Delivery

Multidiscplinary staff were created in each County to better serve the clients. For example, one team was comprised of nurse practictioners, case managers, a benefits advocate, and a psychologist. County programs also had routine case conferences with a multidisciplinary provider group from primary care, psychiatry, mental health, alcohol/drug services, homeless services, and the Initiative program to address the clinical and social service needs, housing, substance abuse treatment, and psychiatric issues of the frequent user population. Moreover, teams that were culturally and linguistically competent and provided written materials in
multiple languages, as well as interpretation assistance at medical appointments as needed. Most importantly, staff educated and coached clients in navigating

the service system. Lastly, to help balance the caseload and provide effective care to clients, most County programs integrated a "stepped care" approach. This system triaged referrals and moved clients through a tiered service process that increased efficiencies in overall program management.

Partnership Development and Collaboration

Through a shared vision between the programs and other agencies, partnerships were developed that facilitated access to services and served to create collective solutions to the frequent user population. Culture shifts within public sectors resulted in buy-in and support from several groups, such as hospital staff. Concurrently, partnerships and collaboration with the criminal justice, mental health, and primary care allowed for better program evaluation. The County initiatives more effectively assessed cost and utilization impacts across their communities.

Data Collection and Evaluation

To increase effectiveness, collaborative steering committees moved beyond reporting on program operations to also address policy and systems issues across the counties. Programs implemented a consistent, systematic data collection strategy with hospitals and other partner organizations to track data over time, which was used to leverage additional funding and establish the business case for intensive case management. Some initiatives went even further by developing a countywide database linking the utilization of hospital, primary care, and mental health services, as well as drug and alcohol treatment, which enhanced data sharing capabilities and care coordination across medical and social service systems. Importantly, data sharing revealed inefficiencies in the community's service system, such as the duplicated case management. Finally, the funding foundations also contributed to the evaluation process by convening County stakeholders in "Stakeholder Summits," which created a forum for service providers and other various program partners to establish priorities and develop action plans to address systems change goals.

Systems Change

While the County programs experienced successes in making changes on the program-level, they also achieved systems change. The initiative defined "systems-change" as the following: a change in the policies and procedures of individual organizations, or between organizations, that improve the service system for the frequent user population by increasing access to new or existing services.

The collective experience of the grantees in advancing systems changes to meet the needs of frequent users followed a "developmental progression," with certain steps (pre-conditions) that facilitated success. Over the course of the Initiative, programs in Alameda, Santa Cruz, and Santa Clara counties advanced their systems change activities by focusing primarily on expanding and strengthening partnerships and collaborations within their counties, while Sacramento County's program concentrated on program marketing efforts, expanding awareness, and obtaining buy-in from partners and other

community stakeholders.

Through the development of partnerships, County programs had connections to stabilizing services such as housing, health insurance, and income benefits. Empirical data reveals the effectiveness of these relationships in reducing the homeless and uninsured populations. For example, homelessness was prevalent in the frequent user population. Evidence illustrated that housing is a critical factor in addressing the health concerns for this population; connecting clients to housing became a major focus of the county programs. Results from the FUHSI project further support the concept that connection to permanent housing is a contributing factor in reducing rates of ED use. Clients provided with permanent housing showed greater reductions in both ED use and charges compared to those who remained homeless or in less-stable housing arrangements.

Lessons Learned

The collective experiences of the FUHSI grantees—both successes and challenges—generated significant lessons in the areas of program planning, staff composition, client engagement, service delivery, partnership development, and data collection and evaluation. Achieving success with frequent users requires significant financial investment, intensive health and behavioral health interventions, small caseloads, resources and capacity in the community, partnership across systems of care, and an understanding that the issues faced by the frequent user population are complex. Treatment solutions require long-term vision and commitment.

Program Planning and Implementation

Because system-level changes take time, the county programs illustrate the patience and commitment that is necessary to produce them. The FUHSI project reveals the difficult challenge in not only developing and stabilizing a program, but also in creating partnerships and attaining support from community stakeholders in a short period of time (3 years).

There is a widespread need to determine the difference between appropriate and avoidable ED use, so case-management is properly utilized. Concurrently, payment agreements between programs and insurance agencies, such as Medi-Cal, should be established to financially support the County initiatives. Also, the programs reveal the need to provide efficient and culturally-competent care to compete with the "convenience" of seeking care at the ED—often perceived as a "one-stop shop" for health care.

Staffing

The programs exposed the importance of a multidisciplined staff who have experience working with individuals experiencing multiple medical and psychosocial needs. Including nurses on program teams allows for greater connection with hospital staff through shared medical backgrounds and language. Many breakthroughs in relationship-building occur between frontline staff working together toward collective compassion.

Client Engagement
County programs revealed the effectiveness of using incentives (e.g. food boxes, transportation assistance, benefits advocacy, and housing vouchers) in enhancing recruitment and program participation. Additionally, some programs integrated peer counselors in the team, which helped to build rapport and trust with clients in the community.

Service Delivery
Addressing problems of a complex and high-needs population requires the incorporation of a multi-systemic, multi-modal approach. Therefore, programs concentrated on providing access to services their clients needed. One resource County initiatives tried to provide was housing, since a high percentage of frequent users are homeless or unstably housed. The Initiative established the valuable connection between housing and health care, realizing that the lack of housing options for homeless individuals sabotages progress made through mental health services, substance abuse treatment, and medication stabilization. Also, despite paying to hold shelter beds in the community, grantees found that some clients choose to remain "homeless by choice," because of poor or unsafe conditions within the shelter system. Connections really must be made to safe, permanent housing.

Connecting clients to SSI and Medi-Cal entitlements benefits the client and the hospital. While program efforts in all Counties managed to connect some clients to needed insurance or income benefits, a large percentage of applicants were left without either resource. With that, reducing costs associated with uncompensated care (uninsured clients) is one issue that remains to be addressed.
Also, a persistent drug-seeking population emerged as the most resistant sub-group served by the Initiative programs. The programs learned that availability of mental health or substance abuse treatment is not enough to engage this population in program services. Effective interventions for this population requires enormous cooperation across the medical community (e.g., hospitals, clinics, pharmacy) regarding prescription policies, pain management, data sharing and patient monitoring.

County programs also revealed the positive effect of having case managers attend medical appointments with clients, which allowed staff to model appropriate rapport-building with the provider, to serve as the client's "care historian," and to model for providers how to treat the clients with respect.

Collaboration/Partnership Development
The Initiative programs demonstrate the importance, in creating a network of services, of partnerships. However, their experiences cite the issues with collaboration that must be addressed for the relationship to be effective. Firstly, clearly defining roles and responsibilities of each partner agency in writing at the time the proposal is submitted. Establishing broad stakeholder buy-in is difficult because of perceptions about the

frequent user profile (e.g., unemployed, homeless, primarily males with substance addiction). Therefore, reframing the mission and implementing a preventive approach in addition to serving frequent users will enhance buy-in with some stakeholder groups. I

In addition, sustaining relationships with hospitals, especially ED provider commitment and buy-in, is challenging. High turnover and rotation of medical students and contract staff through the ED affect the continuity of program understanding and the referral process. A regular and consistent presence of FUHSI program staff in the ED is necessary to bridge organization cultures and reinforce relationships.

Programs should integrate into the staff "Program Champions" within the hospital. These individuals are instrumental in building partnerships and creating buy-in. Champions with management responsibilities in the ED are especially valuable in building strong relationships between the ED staff and the frequent user program and creating long-term sustainability of the program.

It should be realized that the "top-down" approach to collaboration is not sufficient to move the program forward during implementation. In addition to hospital administrators, frequent user programs need to partner with ED providers, discharge planners, outpatient clinic providers, and nurses to secure buy-in at the patient level. Moreover, cross-county hospital collaboration and greater program penetration increases visibility and allows the program to track frequent ED use across hospital systems. Lastly, creating better systems of communication between ED and primary care providers enhances care coordination for frequent users with complex medical needs.

New Freedom Initiative

Background

In February 2001 the President Bush announced the New Freedom Initiative, which was intended to support augmented access to employment and educational opportunities to individuals with disabilities. This announcement was followed by the creation of the New Freedom Commission on Mental Health. Upon concluding a year-long study, the Commission released the findings in its Final Report, *Achieving the Promise: Transforming Mental Health Care in America*, in July 2003. As the Final Report notes, the study identified three main obstacles preventing Americans with mental illness from getting the quality care necessary to achieve the New Freedom Initiative's goal of full participation in community life:

(1) Public stigma surrounding mental illness;
(2) Unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance; and
(3) A fragmented mental health service delivery system that frequently allows people with mental illness and children with serious emotional disturbances to fall through the cracks.

The commission recognized a connection between mental health and homelessness, and

explained that affordable housing alone is insufficient for people with serious mental illnesses as they frequently require flexible, mobile, individualized support services to stabilize them in their housing. As a matter of fact, the Commission's Final Report identified the shortage of decent, safe, affordable, and integrated housing that meets the needs of people with mental illness as one of the more significant hurdles to their full participation in community life. The shortage of affordable housing with accompanying stabilization services causes many people with mental illness to rotate among institutions, shelters, jails, and the streets. A Subcommittee on Housing and Homelessness was formed to further examine key issues regarding the connection between disability and homelessness.

Funding

Under this initiative, many funding opportunities were presented specifically targeted towards the homeless population. The Department of Labor collaborated with the Housing and Urban Development in October 2003 to provide funding for local communities to address housing and service needs of homeless persons. A total of $75 million was made available as component of the New Freedom Initiative and the stated goal of the Bush Administration to end homelessness.

The Program: CHETA/Hope House and Work Fast

In 2003 the Department of Labor Office of Disability Employment Policy in cooperation with the Employment and Training Administration, working with HUD, announced the Chronic Homelessness Employment Technical Assistance Initiative (CHETA), which has since awarded five local workforce investment boards and their respective housing partner. The overall purpose was to create a technical assistance capability designed to assist the DOL funded "Ending Chronic Homelessness through Employment and Housing" awardees, and was cooperatively sponsored by ODEP and the Veterans Employment and Training Service (VETS). The intention of CHETA was, and still is, to "meet customized employment-related program goals and to collect and disseminate information on how best to meet the customized employment needs of persons who are chronically homeless".

Under this program, the Private Industry Council in San Francisco created the Hope House project under an agreement to deliver to persons with disabilities who are chronically homeless customized employment services and permanent housing services through the local One-Stop Career Center System, in collaboration with each city's homeless serving community. Hope House was funded to provide Housing First/Work First services using scattered site HUD supportive housing to implement "vocationalized" housing to a representative group of individuals that were formerly chronically homeless. The program was designed (a) to coordinate service delivery, including among employment staff, housing case managers, vocational rehabilitation staff, a general assistance worker and One-Stop Career Center staff, and (b) to improve the workforce development system, including the One-Stop Career Centers, and employment options for this population.

People who are chronically homeless face a number of different hurdles to employment. Work Fast or Work First, one employment policy strategy, like Housing First, is designed to meet people where they are. Work First, paired with Housing First at the Hope House project, requires strong, integrated services and supports for consumers from outreach until long into the housing experience. These services include mental health services, substance use services, and other types of support.

Work Fast programs are client-driven and emphasize choice for the consumers. Each consumer has different needs and preferences, so the program requires significant flexibility. Many homeless people are already working in some capacity to create some income stream, so Work Fast also proposes redefining what is "job ready," what is "work," and further, what is "success." Work Fast recognizes the skills and strengths that consumers bring and allows for a lot of flexibility and customization.

Customized employment means individualizing the employment relationship between employer and employee to meet the needs of both. This strategy involves determining the strengths, requirements and interests of a person with a complex life. Customized employment builds on strategies like supported employment and self-employment, and pairs them with services and support. It begins with an in-depth job seeker- led assessment process, and may be followed by a negotiating process with an employer, that could involve job carving (that is, individualized job design), negotiating a job description, job creation and job sharing, job supports or flexibility in hours and location of job.

Outreach for Work Fast begins with talking with the consumer about his or her likes or dislikes and listening to his or her stories to start the consumer thinking about possibilities. From the beginning, the program should provide a standing offer of work, or in-house jobs, as not every moment is a competitive job placement moment (e.g., because the consumer may not be able to pass a drug test). To make this work, the whole organization must support and assume employability. The program must find internal and external partners and the employment process should not require lengthy prerequisites or training. The program should have a variety of jobs for people with different needs or interests. The project is now under the leadership of the San Francisco Human Services Agency.

In addition to linking chronically homeless men and women to meaningful employment opportunities, one of the other goals of the DOL/HUD Demonstration Projects like Hope House was to enhance the ability of mainstream employment programs to serve individuals with more complex needs. By placing employment specialists within the existing network of One-Stop Career Centers, the Hope House initiative sought to ensure that chronically homeless people could benefit from the array of employment services already being offered at the One-Stops.

Crowell Danielle 1/22/09 2:32 PM
Deleted: CAN STACEY ADD SOMETHING MORE?

Chronic Homeless Initiative

Background
The Collaborative Initiative to End Chronic Homelessness (CICH) is a grant program that was launched in 2003 intended to provide assistance to states and communities seeking to substantially reduce chronic homelessness. Funding partners include the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), the U.S. Department of Housing and Urban Development (HUD), and the U.S. Department of Veterans Affairs (VA).

Goals
The stated goals of this program were to:

- Provide comprehensive services and treatment and link chronically homeless clients to housing.
- Create permanent housing for persons experiencing chronic homelessness.
- Increase the use of mainstream resources that pay for services and treatment for the target population.
- Foster the replication of effective service, treatment, and housing models.
- Support the development of infrastructures that sustain services, treatment, housing, and inter-organizational partnerships beyond this Federal initiative.

The target population of this grant program was persons experiencing chronic homelessness, including veterans. A chronically homeless person is defined as "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more or has had at least four (4) episodes of homelessness in the past three (3) years." A disabling condition is defined as a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.

Funding
Within this $55 million dollar project, agencies distributed the efforts accordingly. SAMHSA focused on substance abuse treatment and mental health care with $7 million originally, HRSA on funding primary health care services contributing $3 million, HUD on funding permanent housing with $20 million, with the VA offering medical services to homeless veterans contributing $5 million and the U.S. Interagency Council on Homelessness helping to coordinate all of the components. $20 million more dollars became available in subsequent years after this program was introduced.

There were 11 grantees for this program:

- Broward County Human Services Division, Fort Lauderdale, FL
- Central City Concern, Portland, OR
- Colorado Coalition for the Homeless, Denver, CO
- Contra Costa County Health Services, Martinez, CA
- Fortwood Center, Chattanooga, TN
- Horizon House, Inc., Philadelphia, PA

- Illinois Department of Human Services, Chicago, IL
- Lamp, Inc., Los Angeles, CA
- Project Renewal, Inc., New York, NY
- San Francisco Department of Public Health, San Francisco, CA
- Southeast, Inc., Columbus, OH.

Lessons Learned

An evaluation of the CICH released in 2008 prepared for HHS, VA and HUD revealed that comparisons of overall group differences and rates of change between CICH clients and a similar comparison group of homeless clients who received some lesser combination of housing and services (i.e., usually available) than the CICH clients provided evidence that the CICH increased access to housing, physical health and mental health care, and community-based case management resulting in a more integrated package of services. This conclusion was based on information from 734 of 1,242 individuals enrolled into the program (59 percent) who gave their written informed consent to be part of the research sample. Also involved were the local VA research staff, which administered quarterly follow-up assessments during the first years of the evaluation.

- At the time of program entry, CICH clients had been homeless an average of 8 years in their lifetimes, 72 percent had substance abuse problems, 76 percent had mental health problems, and 66 percent reported medical problems. Thirty percent (220) of the sample of 734 evaluation participants were veterans.
- The average number of days that CICH clients were housed in the previous 90 days increased over time. At baseline, the average was 18 days of the previous 90 days; at the 3 month follow-up, the average was 68 days of the previous 90 days; and at the 12 month follow-up, the average was 83 days of the previous 90 days. Although the CICH clients did not stay the full 90 days (of the previous 90 days) at any of these measurement intervals, this data suggests increasing stability over time.
- The mean monthly public assistance income of the CICH clients increased steadily from $316 at baseline to $478 at 1 year, a 50% increase.
- Although statistically significant, improvements of a modest magnitude of the CICH clients were observed in overall quality of life, mental health functioning, and reduced psychological stress.
- Total quarterly health costs per CICH client declined by 50%, from $6,832 at baseline to $3,376 at 12 months.
- The alcohol and drug problems of CICH clients remained largely unchanged over time.
- Improved coordination of services and positive relationships between CICH clients and their primary mental health/substance abuse practitioners were the strongest predictors of positive client outcomes.

Rapid Rehousing for Families

Background
Rapid Rehousing is one broad solution to connect the homeless community to long-term housing, and it is a combination of rental and housing search assistance, relationships with landlords, and comprehensive case management. The philosophy behind Rapid Rehousing, which affirms that the primary need of homeless families is a home, is that families will be better able to take advantage of social services and supports—and thus become self-sufficient—after they are in secure, permanent housing. Efforts have focused on addressing California's family homelessness, with rapid rehousing as one solution. In 2004, the Charles and Helen Schwab Foundation launched the Shifting Gears Initiative: Fast Track to Housing for Bay Area Families. This was a multi-year project, funding nine different agencies operating in five different counties, that worked toward a better future in which periods of family homelessness in the Bay Area are shortened, formerly homeless families are more successful at retaining housing, and fewer at-risk families become homeless.

Funding
The Initiative convened a learning community of nine outstanding Bay Area homeless family service providers. Agencies first received a six-month, $5,000 planning grant. Subsequently, they were awarded two one-year, $75,000 grants.

Funding sources for homeless service agencies are often fairly restrictive, with highly specific grant requirements. This type of funding tends to discourage innovation in service delivery. The Initiative grants were meant to be a partial antidote, and essentially became an "incubator" for new solutions to family homelessness. Participation in the Initiative was by invitation only, rather than selection through an RFP process. In this way, grants were non-competitive and guaranteed.

Goals
The broad objective of the program was a systems change. The program aimed to catalyze a cultural shift not only toward rapid re-housing, but also from merely "managing" homelessness toward ending it.

Strategy
There were several aspects to the overall design of the Initiative. The primary task was rapidly placing families in permanent housing. Following this, programs provided financial assistance for housing transitions until families became more self-sufficient, as well as home-based case management to connect them to other services in the community. Concurrently, the Initiative sought to prevent at-risk families from losing their homes, while also increasing the supply of supportive and affordable housing through advocacy and housing development.

The Initiative included a six-month planning period in which the participating agencies learned about new service delivery models and listened to others in the field before designing their respective projects. Recognizing that "failures" often offer the best

learning opportunities, the Initiative organizers encouraged the grantees (the participating agencies) to take risks in their project design. If an aspect of their projects was not successful, the grantees could change course without penalty, since their grants had few conditions. This allowed the agencies to take their programs in directions they previously had not been able to do.

Another unique aspect to the Initiative was the Learning Community that the agencies convened every few months. These conferences served as forums for the exchange of ideas, tools, and resources, as well as an arena for networking. Moreover, the Initiative funded and provided training of new service delivery models for the front-line staff of the agencies; this was a cost-effective approach toward stabilizing the initial efforts of each program.

Results

In comparing results from the final year of the Shifting Gears initiative with the initial year, there are significant results for participating agencies and the families they serve. Firstly, families successfully transitioned into permanent housing more quickly. Families experienced shorter stays in shelter, as well as in transitional housing. All families, whether going to transitional or permanent housing, moved out of shelter more swiftly. On average, they spent 25 fewer days in shelter (from an average of 106 days to 81 days). Specifically, families moving from shelter to permanent housing moved 27 days sooner (from an average of 89 days to 62 days). Families moving from transitional to permanent housing moved 33 days sooner (from an average of 357 days to 324 days). Consequently, the greater turnover expanded the capacity of providers to shelter families.

Empirical evidence affirms subsidies as the single most important factor in housing stability. And due to the expansion of subsidy programs in the agencies, more families received rental subsidies, and may continue to do so in the future. The number of families receiving rental assistance doubled: during the year prior to the initiative 231 families received rental subsidies; during the last year of the initiative 466 families received them. While this translates into the need for deeper funding sources, families transitioned into permanent housing more quickly than they would have without financial assistance.

Additionally, more families avoided homelessness. Added and expanded homelessness prevention programs meant that there were families that avoided entering the homeless service system altogether. Agencies provided emergency rental assistance to families that could not make their next rental payment, provided other financial support (such as grants to pay for utilities), or negotiated with landlords to help prevent eviction. The number of families that avoided homelessness doubled: in the year prior to the initiative, agencies prevented homelessness for 572 families; in the last year of the initiative, 964 families were prevented from being homeless.

Organizations also incorporated harm reduction approaches into their programs. Harm reduction is defined as a set of practical strategies that reduce the negative consequences associated with drug and alcohol use, and non-punitive abstinence. Staff actively engaged with residents, met drug and alcohol users where they were at, and addressed the

conditions and motivations of drug use along with the use itself. This approach fostered an environment where individuals could openly discuss substance use without fear of judgment or reprisal, and did not condone or condemn drug use.

Importantly, investments in permanent supportive housing also expanded. Homeless families are not, by definition, chronically homeless, but there is a small group that cycles in and out of the homeless services system. They often struggle with a variety of stressors, such as extreme poverty, substance use, poor health, or mental illness. This group would benefit from permanent supportive housing (PSH). Research affirms that building PSH ends chronic homelessness for the families living there, and frees up the homeless system to more effectively support families that are experiencing a housing crisis for economic reasons (e.g. temporary unemployment, high medical bills, the loss of a paycheck that comes with divorce, etc). Over the course of the initiative, agencies developed more PSH units, and additional providers began to invest in PSH. Though only 61 PSH units existed at the beginning of the Initiative, by its conclusion, there were 142 new PSH units.

Furthermore, agencies that participated in the Initiative are well-positioned to apply for funding that will support rapid re-housing for families. One sign of success is the sustainability of programs for which the Schwab Foundation supplied initial funding. At the end of the initiative, six providers reported that they had been successful in accessing additional dollars for rapid re-housing programs. For example, the cities of San Francisco and San Jose added funding for rapidly re-housing homeless families, and two initiative participants with operations in those cities succeeded in securing this funding. In addition, the department of Housing and Urban Development (HUD) released its first RFP for programs using the rapid re-housing model of service delivery for families. Only providers who have experience with this model are eligible for this grant; so by virtue of having participated in the Initiative, agencies are qualified for this major source of funding.

Most importantly, as agencies continued with their efforts, they gradually experienced a major philosophical shift. The programs increasingly based their service delivery on rapid re-housing principles, and moved away from practices based on housing readiness principles. By the end of the Initiative, five of the agencies developed new mission statements, with four relfecting an additional commitment to housing-based solutions. These new mission statements paralleled the vision of the Initiative, emphasizing homelessness prevention, supportive housing, rapid re-housing, and voluntary services.

From their internal cultural shifts, agencies also changed their structures. Seven organizations added new staff positions that focused solely on getting families housed. And five organizations revised their case manager job descriptions so that the onus of the work with client families is to help find housing as soon as possible. Four organizations established the use of shallow rental subsidies to rapidly re-house families, and four organizations expanded the use of these subsidies. Lastly, two organizations established homelessness prevention projects, while three expanded their exisiting programs.

Lessons Learned
Participants found the initial planning period, wherein they received input from others in the field before designing their own project, very useful. However, agencies learned that an additional ramp-up period after grantees received their project funding would have provided the time necessary to do the "foundational work" that is necessary before making operational changes. Foundational work is time-consuming, and including a wide range of stakeholders (e.g. staff, board members, clients, and funders) is critical. Changes in operational mechanisms may require new job descriptions, new protocols, and new staff to ensure the right personnel are in place. In addition, cultural shifts often lead to turnover as those who do not agree with the new model may choose to leave the organization.

Funding
The participating agencies were extremely appreciative of the leniant grant requirements. The lack of conditions provided the agencies with an opportunity to consider changes in their organization that they had never considered before. They had the freedom to try out ideas they had not previously had the funding to pursue. For several agencies, this resulted in developing new directions. For instance, one agency initially believed that long shelter stays fostered family success. Its traditional service delivery model linked services to shelter and transitional housing, encouraging families to stay in order to take advantage of these services. As the organization's project evolved over the course of the Initiative, it changed its focus to providing an array of home-based services. It linked services to permanent housing, changing the incentive structure. Families no longer had to stay in shelter to access needed services. Instead, they could stay connected with the program after moving out by accessing services that helped them maintain permanent housing.

Strategy
Harm reduction became a major focus of the philosophical shift among the agencies. Agencies quickly integrated harm reduction models into their permanent supportitive housing, transitional housing, and family shelter units. The Initiative hosted harm reduction trainings for executive management as well as front-line staff – trainings which all agencies attended. Providers began to move away from drug testing and zero tolerance. Instead they actively worked with those families with drug or alcohol issues, rather than evicting them or screening them out of program participation.

- How do these stories comport with your own experience? Did you participate in any of these projects? If so, what insight can you add?
- What are the most important lessons learned from these Initiatives and from your work? What programmatic designs are integral? What lessons are most pertinent for systems-level change?
- How might we take what we have learned from these projects to develop a set of parameters for a new source of funding? What requirements seem to make sense for a new grant or stream of funding?
- How should these projects inform the way we move into the future?

If you have additional questions, please feel free to contact Danielle Wildkress at 415.788.7961 ext. 301 or at Danielle@HomeBaseccc.org.

Dan Smith and Laura Horton, HomeBase interns, contributed significantly to the research and the writing of this memorandum.