CITY AND COUNTY OF SAN FRANCISCO
BOARD OF SUPERVISORS
BUDGET AND LEGISLATIVE ANALYST
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POLICY ANALYSIS REPORT

To: Supervisor Mark Farrell
From: Budget and Legislative Analyst's Office
Date: May 31, 2016
Re: Impact of Supportive Housing on the Costs of Homelessness

SUMMARY OF REQUESTED ACTION

Pursuant to your request, this report analyzes the impact of supportive housing on total costs for homeless adults. To analyze these costs, we identified 1,818 adults who entered City supportive housing programs in FY 2010-11 or FY 2011-12 and analyzed their use of City and other provider services over eight years from approximately three years prior to entering housing (beginning in FY 2007-08) and three years after entering housing (ending in FY 2014-15). In order to maintain confidentiality and comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Department of Public Health and Human Services Agency provided us with de-identified information on these 1,818 adults, as described further in the Methodology Appendix to this report.

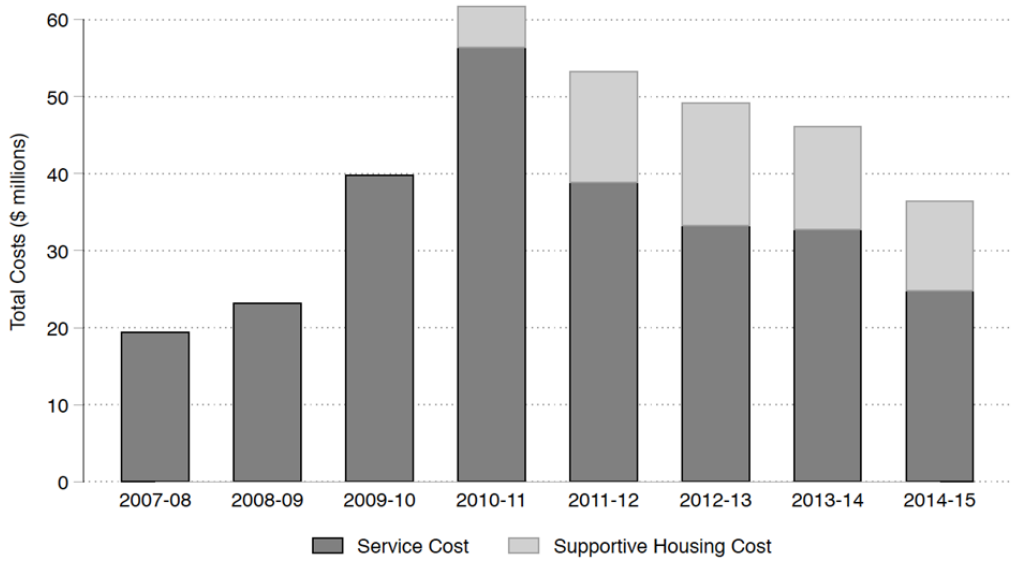
For further information about this report, contact Severin Campbell at the Budget and Legislative Analyst's Office.

Executive Summary

- The 2004 San Francisco *Plan to Abolish Chronic Homelessness* developed the City's "Housing First" policy, finding that "permanent supportive housing has been proven to be the most effective and efficient way to take chronically homeless off the streets". Supportive housing in the City is managed by the Department of Public Health (DPH) and the Human Services Agency (HSA).
- Service costs for the 1,818 homeless adults in this study increased significantly between FY 2007-08 (the first year of the study) and FY 2010-11 (when these adults began to enter supportive housing) indicating rapidly deteriorating conditions for many individuals. The transition between homelessness and housing has been identified by DPH as the most concentrated period of cost "spikes" for homeless individuals. The increase in costs was due primarily to the costs of inpatient hospitalization.
- Combined service and supportive housing costs decreased between FY 2010-11 and FY 2014-15, as these adults stabilized in supportive housing, as shown in the Exhibit below. The decrease in costs was due primarily to a 58 percent decrease in emergency/urgent care costs, especially inpatient hospitalization. However, emergency/urgent care costs continued to make up more than one-half of total costs during the eight-year study period between FY 2007-

08 and FY 2014-15. Between FY 2007-08 and FY 2014-15, costs also shifted from homeless services and jail time to benefits and primary medical care, and shifted within the behavioral health and emergency/urgency care categories to less intensive care, showing that overall the 1,818 adults in this study were better able to access routine or ongoing care in FY 2014-15 than in FY 2007-08.

Estimated Costs for Supportive Housing and Services from FY 2007-08 to FY 2014-15



Policy Considerations

- Most of the 1,818 adults who entered supportive housing in FY 2010-11 and FY 2011-12 benefitted from being housed. The City also benefitted from reductions in costs between the time when adults began to enter supportive housing in FY 2010-11 and FY 2014-15.
- However, not everyone benefitted the same. Much of the spike in costs that occurred when adults entered supportive housing was due to a few individuals having very high costs for inpatient hospital stays. HSA and DPH should evaluate whether the City's existing supportive housing sites, programs, and services are sufficient to care for this high-needs population, or whether alternative residential settings, such as residential treatment or more medically-intensive placements, are available or appropriate.
- These 1,818 adults were older on average than the general homeless population. As the homeless population ages and stays unhoused, the more likely they are to develop acute medical and behavioral health needs that require crisis stabilization and intensive support. Earlier intervention and access to medical care and housing could lessen potential steep increases in emergency/urgent care costs, especially inpatient hospitalization costs.
- Many individuals who are placed in HSA's Master Lease housing have higher usage of both medical and behavioral health services after placement in

housing than before, whether or not they remained housed. These adults likely had under-treated medical, mental health, or substance abuse problems prior to entering the Master Lease program, and HSA should evaluate how to better match shelter users, for example, with medical and behavioral health services. HSA should also evaluate whether these adults with high medical needs should be placed in DPH's Direct Access to Housing program or other medically-intensive placements.

- While supportive housing is considered permanent housing, many adults leave their supportive housing placement, and some number who leave do not go into other stable housing. DPH and HSA should continue evaluating contributing factors to why individuals leave supportive housing without going into other stable housing; and whether certain supportive housing sites, providers, or programs have relatively higher housing stability rates. HSA specifically should identify programs and services to reduce turnover and improve outcomes among adults likely to leave Master Lease placements because they are unable to achieve stability while housed, and reevaluate the effectiveness of current housing stability measures. HSA should evaluate how the tiered housing program, implemented in FY 2014-15, has impacted outcomes for adults in the Master Lease program and report to the Board of Supervisors prior to December 2016.
- New programs and initiatives implemented by the City since FY 2010-11 and FY 2011-12 could further alter the general cost and service trends presented in this report by identifying higher-needs populations, improving connections to housing, facilitating greater access to services, increasing housing stability, and enabling better outcomes. The proposed Department on Homelessness in FY 2016-17 provides an opportunity to assess the effectiveness of these various initiatives, ensure that past recommendations for improvement are being implemented, better coordinate information and resources, and clarify and standardize policy goals.

Project Staff: *Jennifer Millman, Mina Yu, Chirag Rabari and Severin Campbell*

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Supportive Housing Programs to Address Homelessness

The City counts the number of people living on the City's streets or in homeless shelters every two years. The 2015 Homeless Survey found 6,686 homeless adults, an increase of 250 or four percent from the 2013 count of 6,436. In the ten year period from 2005 to 2015, the homeless count increased by 438 adults or seven percent, from 6,248 adults in 2005 to 6,686 adults in 2015. According to U.S. Census data, the City's population increased by 79,185 or 10 percent, over approximately the same period, from 773,284 in 2004 to 852,469 in 2014.

The City's Supportive Housing Programs

In 2004, the San Francisco Plan to Abolish Chronic Homelessness (Ten Year Plan) developed the City's "Housing First" policy, finding that "permanent supportive housing has been proven to be the most effective and efficient way to take chronically homeless off the streets". Previously the City's model to provide services was the "continuum of care", in which services, such as substance abuse treatment, were provided to individuals prior to housing. Supportive housing combines housing with on-site support services, such as case management, clinical services, and mental health interventions.

The Human Services Agency (HSA) and the Department of Public Health (DPH) administer the City's major supportive housing programs.

- Direct Access to Housing: DPH administers Direct Access to Housing, in which DPH provides permanent supportive housing through master leases and non-profit providers, targeting homeless adults with medical or behavioral health needs.
- Master Lease Program: HSA contracts with non-profit organizations to enter into master leases with private owners of Single Room Occupancy (SRO) hotels, and to provide property management and supportive services. The Master Lease program includes sites funded through the Care Not Cash program, where homeless adults who qualify for the County Adult Assistance Program (CAAP) are offered housing and support services as part of their benefit package.
- Non-profit Providers in HSA's Local Operating Subsidy Program (LOSP): The Mayor's Office of Housing (MOH), on behalf of DPH and HSA, enters into 15-year agreements with nonprofit affordable housing providers to subsidize operating costs at supportive housing sites for homeless adults and families.[1] Direct funding is provided by HSA and DPH for supportive services.

[1] For the purposes of this report and to comply with confidentiality requirements, the Budget and Legislative Analyst evaluated the service usage and service costs associated with homeless adults placed in housing on a per-adult basis. Children and other family members placed in HSA family supportive housing units were not evaluated, although certain per-unit or per-adult costs may therefore be modestly overstated for a small number of individuals.

- HUD/Continuum of Care: HSA manages permanent supportive housing funded by the federal government, targeting primarily homeless adults with disabilities.

These DPH and HSA programs had 5,874 supportive housing units as of the end of FY 2014-15:

Direct Access to Housing	1,680
Master Lease	2,526
Non-profit Providers (HSA LOSP units)	610
HUD/Continuum of Care	1,058
Total Supportive Housing Units	**5,874**

Budget and Legislative Analyst's Methodology to Compare the Costs of Services for the Homeless Before and After Placement in Supportive Housing

The Budget and Legislative Analyst worked with the Department of Public Health and Human Services Agency to (a) identify homeless adults who entered supportive housing in FY 2010-11 or FY 2011-12, (b) create an eight-year (FY 2007-08 through FY 2014-15) service and housing profile for each of the 1,818 adults identified, and (c) estimate the cost of services and housing over the eight-year period.

Cost estimates in this report are presented in constant dollars. In addition, cost figures should not be interpreted as exclusively costs to the City and County of San Francisco. Funding for medical and mental health services, for example, can come from a variety of sources including Medi-Cal, Medicare, other federal and state grants, and private sources.

Additional details on data systems, source files, matching records, service types, cost estimating, and limitations are included in the Methodology Appendix to this report.

Description of Homeless Adults Entering Supportive Housing in FY 2010-11 or FY 2011-12

1,818 adults entered the City's supportive housing programs in FY 2010-11 and FY 2011-12. Approximately two-thirds of these adults entered programs operated by the Human Services Agency and one-third entered programs operated by the Department of Public Health. As shown in Table 1 below, the majority of those who reported their gender, or 72 percent, were male.

Table 1: Description of Homeless Adults Entering Supportive Housing in FY 2010-11 or FY 2011-12

	Department of Public Health	Human Services Agency	Total	Percent
Women	163	307	470	28%
Men	441	769	1,210	72%
Not Identified or Reported	15	135	150	--
Total	619	1,211	1,830 [a]	100%
Percent	34%	66%	100%	

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 or FY 2011-12

[a] Of the 1,830 placements shown in Table 1, 12 individuals received a second placement in supportive housing soon after exiting their first placement, resulting in 1,818 non-duplicated adults.

The average age of these 1,818 adults entering supportive housing was 48 years at placement, ranging from 19 years (the youngest) to 90 years (the oldest). The average age of adults entering supportive housing programs operated by DPH was 52 years, while the average age of adults entering supportive housing programs operated by HSA was 47 years. As shown in Table 2 below, adults placed in supportive housing during FY 2010-11 and FY 2011-12 were older at their time of placement compared to the general homeless population surveyed in the City's 2011 Homeless Count.

Table 2: Age of Homeless Population, San Francisco Homeless Count Vs. Placements in Supportive Housing

Age	San Francisco Homeless Count, 2011	Supportive Housing Placements, FY 2010-11 & 2011-12
18-30	16%	9%
31-40	29%	16%
41-50	26%	30%
51-60	22%	29%
61 or older	7%	16%

Source: 2011 San Francisco Homeless Count; DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12

Adults aged 51 or older comprised 45 percent of placements in supportive housing versus 29 percent of the homeless count population. By contrast, adults aged 18 to 40 comprised 25 percent of placements in supportive housing versus 45 percent of the homeless county population. The relatively advanced age of supportive housing placements is noteworthy due to the higher prevalence of medical and behavioral health needs among this population.

Approximately half of the homeless adults entering supportive housing programs in FY 2010-11 and FY 2011-12 were placed in Master Lease programs operated by HSA (48 percent). About one-third, or 34 percent, were placed in the Direct Access to Housing program operated by DPH. The rest were placed in two other smaller programs operated by HSA, as shown in Table 3 below.

Table 3: Number of Homeless Adults Entering Supportive Housing by Type of Housing

	Number of Placements	Percent
Human Services Agency		
HUD/Continuum of Care	230	13%
Nonprofit Providers	98	5%
Master Lease	883	48%
Subtotal Human Services Agency	1,211	66%
Department of Public Health		
Direct Access to Housing	619	34%
Total	**1,830** [a]	**100%**

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12

[a] Of the 1,830 placements shown in Table 3, 12 individuals received a second placement in supportive housing soon after exiting their first placement, resulting in 1,818 non-duplicated adults

Turnover in Supportive Housing Programs

While supportive housing is considered permanent housing, 46 percent of the adults who entered supportive housing in FY 2010-11 or FY 2011-12 left their supportive housing placement as of June 2015. Approximately 47 percent of the adults remained in their original housing placement and 7 percent had died, as shown in Table 4 below.[2]

Table 4: Adults Who Remained or Left Housing Placements as of June 2015

	Total Original Placements	Deaths	Left Original Housing Placement	Remained in Original Housing Placement
Human Services Agency				
HUD/Continuum of Care	230	20	86	124
Nonprofit Providers	98	3	19	76
Master Lease	883	24	565	294
Subtotal HSA	1,211	47	670	494
Public Health				
Direct Access to Housing	619	87	171	361
Total	**1,830** [a]	**134**	**841**	**855**
Percent of Total	100%	7%	46%	47%

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 or FY 2011-12

[a] Of the 1,830 placements shown in Table 3, 12 individuals received a second placement in supportive housing soon after exiting their first placement, resulting in 1,818 non-duplicated adults

[2] This study was limited to adults who received a supportive housing placement in FY 2010-11 and FY 2011-12. We know how many of the 1,818 adults in this study left their housing placement by the end of FY 2014-15, but not how many of the adults who left received another placement after June 2012. For reference, less than one percent of the adults in this study received multiple housing placements within the two-year housing period evaluated. While we consider it unlikely that a large number of these adults received other City supportive housing replacements after FY 2012-13, this would require further study and evaluation.

On average, adults who received Direct Access to Housing placements remain for a longer duration than adults who received Master Lease placements. The average length of stay for a placement in Direct Access to Housing over the study period was 3.0 years and the average length of stay in a Master Lease placement was 2.2 years. For the adults in this study who exited supportive housing, the average length of stay in a Direct Access to Housing placement was 1.8 years and the average length of stay in a Master Lease placement was 1.3 years.[3]

Use of Services for Homeless Adults Entering Supportive Housing in FY 2010-11 or FY 2011-12

The 1,818 homeless adults who entered supportive housing in FY 2010-11 or FY 2011-12 had access to City and other provider services shown in Table 5 below over the eight-year study period.[4] A detailed description of service types is included in the Service Type Glossary Appendix to this report.

[3] According to HSA, the Department "calculates an annual 'stability rate' for its permanent supportive housing sites each fiscal year… Each of the non-profit housing providers contracted with HSA reports the number of tenants at the beginning of each fiscal year and how many in this group are still in the housing or moved to other stable housing at the end of the year. HSA then takes this raw data and calculates an overall percentage across all sites. For FY 2014-15, the HSA supportive housing stability rate was 96 percent." The Budget and Legislative Analyst believes this stability measure has limitations which should be further evaluated and refined by the Department; additional comment is provided in the section below, "Impact of Housing Exits on Service Utilization".

[4] We included services in our analysis for which we had comprehensive, reliable service information. Other services and costs that could apply to this population are provided by the Mayor's Office of Housing and Community Development, Adult Probation, Police Department, and Recreation and Park Department. Additional details are available in the Methodology Appendix to this report.

Table 5: Services Provided by the City and Other Providers and Accessed by Homeless Adults

Service	Types
Primary Medical	• Outpatient services
Emergency/Urgent Care	• Ambulance transports • Emergency Department visits • Psychiatric Emergency Department visits • Inpatient services • Medical Respite • Urgent Care • Sobering Center visits • Psychiatric Inpatient, Residential, and Day Crisis care • Residential Medical and Social Detoxification
Behavioral Health	• Mental Health Outpatient, Day, and Residential Treatment services • Behavioral Health Primary Care • Substance Use Outpatient, Day, and Residential Treatment services • Methadone Counseling and Dosing services
Homeless Services	• Emergency Shelter stays • Transitional Housing • Stabilization Rooms stays • Psycho-social support services • Homeless Prevention & Rapid Re-Housing Programs • Homeless Outreach
Public Benefits[5]	• County Adult Assistance Program (CAAP) • CalWORKS[6] • CalFresh (formerly known as Food Stamps)
Jail	• County Jail records

Most of the 1,818 homeless adults accessed primary medical and other services during the eight-year period from FY 2007-08 to FY 2014-15, as shown in Table 6 below. Significant majorities of the 1,818 homeless adults accessed primary medical care, emergency/urgent care, and homeless services. Approximately two-thirds of the 1,818 homeless adults received behavioral health services or public benefits not including federal Supplemental Security Income (SSI). Over one-third of the 1,818 homeless adults spent time in jail, primarily before being placed in supportive housing.

[5] Many permanent supportive housing residents receive federal Supplemental Security Income (SSI) benefits, which are not captured in this analysis but preclude utilization of CAAP, CalWORKs, and CalFresh.

[6] For adults in the study who received CalWORKs and CalFresh benefits on behalf of their household, the costs of providing these benefits are modestly overstated in this report because the benefit amount served more than the individual adult family member.

Table 6: Use of Services from FY 2007-08 to FY 2014-15 for Homeless Adults Placed in Supportive Housing

	Number of Homeless Adults [a]	Number who Used Services	Percent
Primary Medical	1,818	1,520	84%
Emergency/Urgent Care	1,818	1,483	82%
Homeless Services	1,818	1,361	75%
Behavioral Health	1,818	1,223	67%
Public Benefits	1,818	1,190	65%
Jail	1,818	653	36%

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12. Use of Services by fiscal year is provided in the Numeric Tables Appendix.

[a] Based on 1,818 homeless adults who entered supportive housing in FY 2010-11 and FY 2011-12

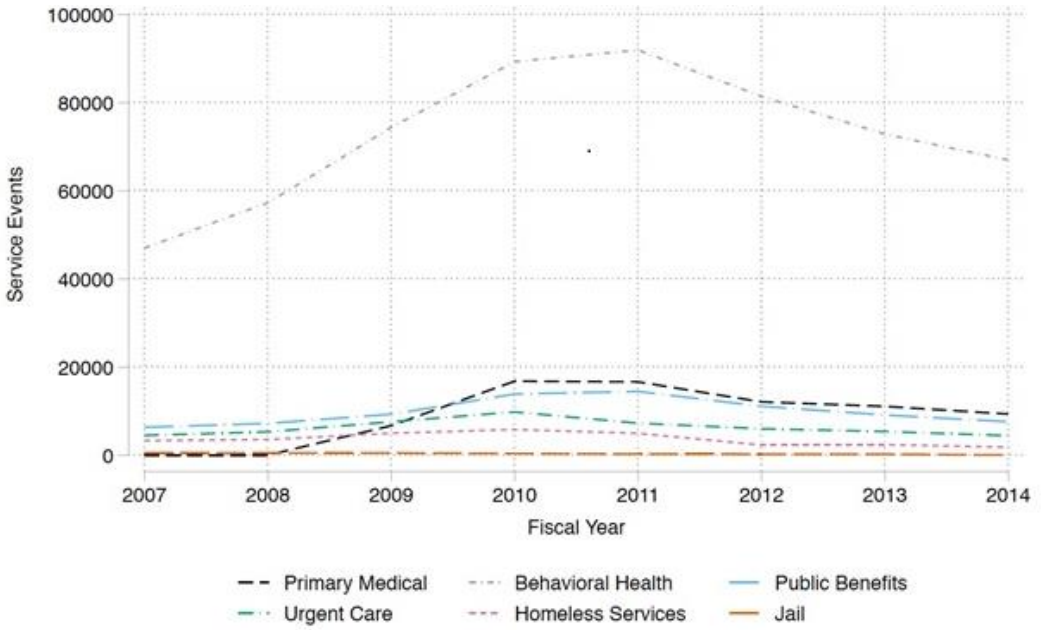
As shown in the table above, more homeless adults accessed primary medical care, emergency/urgent care, and homeless services than behavioral health services. In terms of the total number of service records, however, utilization of behavioral health services including mental health and substance abuse service records was higher than for all other service categories combined.[7] As can be seen in the chart below, overall service utilization for all service categories except jail increased substantially between FY 2008-09 and FY 2010-11, the first year when these adults began to enter supportive housing, prior to stabilizing and then declining between FY 2012-13 and FY 2014-15.[8]

Numeric tables for this and all subsequent charts are provided in the Numeric Tables Appendix to this report.

[7] The reason for the significantly higher number of behavioral health service events is attributable to the large number of unique service records for methadone treatment including dosing and counseling. Approximately 63 percent of all behavioral health records are for methadone treatment. Service costs in this category are relatively modest, however, accounting for 15 percent of all behavioral health costs and 2 percent of all service costs. More information is available in the Numeric Tables Appendix to this report.

[8] Total days spent in jail peaked in FY 2007-08, total jail records peaked in FY 2008-09, and the total number of individuals entering jail peaked in FY 2009-10. These numbers subsequently declined every year between FY 2010-11 and FY 2013-14, the last year for which jail data was available. More details on jail use are available in the Numeric Tables Appendix to this report.

Chart 1: Use of Services from FY 2007-08 to FY 2014-15 by Homeless Adults Placed in Supportive Housing



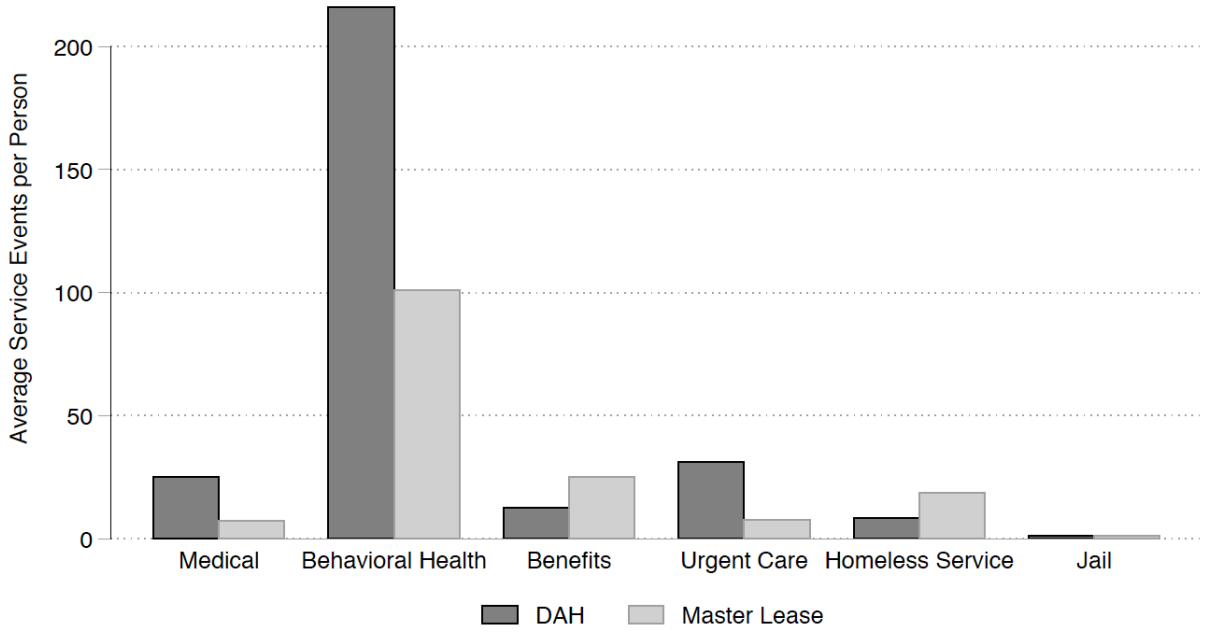
Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12
Number of adults using services each year provided in Numeric Tables Appendix, Chart 1a.

This trend is consistent with assertions by DPH officials that placement in housing is often precipitated by crisis events such as deteriorating medical or behavioral health or worsening personal circumstances involving jail or frequent shelter use, after which there is a service spike involving care and stabilization, or attempts at stabilization, in housing. The types of services used tend to shift over time, while overall service usage declines. This shift in service usage, and its impacts on costs, is discussed in further detail in the below section, "Comparison of Services Used by Adults Before and After Entering Supportive Housing".

Homeless adults generally need to access homeless, behavioral, medical or other services in order to be identified as homeless and receive a supportive housing placement, particularly for supportive housing programs with eligibility requirements based on health needs. Use of these various services typically serves as an entry point to different supportive housing programs. As shown in the below chart, prior to receiving housing an adult placed in the Direct Access to Housing program had on average approximately twice as many behavioral health service events and nearly four times as many primary medical or emergency/urgent care service events compared to an adult placed in the Master Lease program. By contrast, on average, an adult placed in Master Lease housing had approximately twice as many homeless services events and twice as many public benefit records compared to an adult placed in Direct Access to Housing. These differences are consistent with the eligibility requirements of the Direct

Access to Housing program, which aims to serve a population with high medical and/or behavioral health needs.

Chart 2: Average Number of Service Events per Person prior to Housing Placement among Adults in Direct Access to Housing or Master Lease



* 607 adults were placed in DAH, 881 adults were placed in Master Lease

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12
Note: The average number of service events per person represented in this chart is based on adults who used any type of service during the study period. Adults who received a housing placement and never used services are not included in the average. Average number of service events per person after exiting placement provided in Numeric Tables Appendix, Chart 2a.

Estimated Costs of Services for Homeless Adults Entering Supportive Housing in FY 2010-11 or FY 2011-12

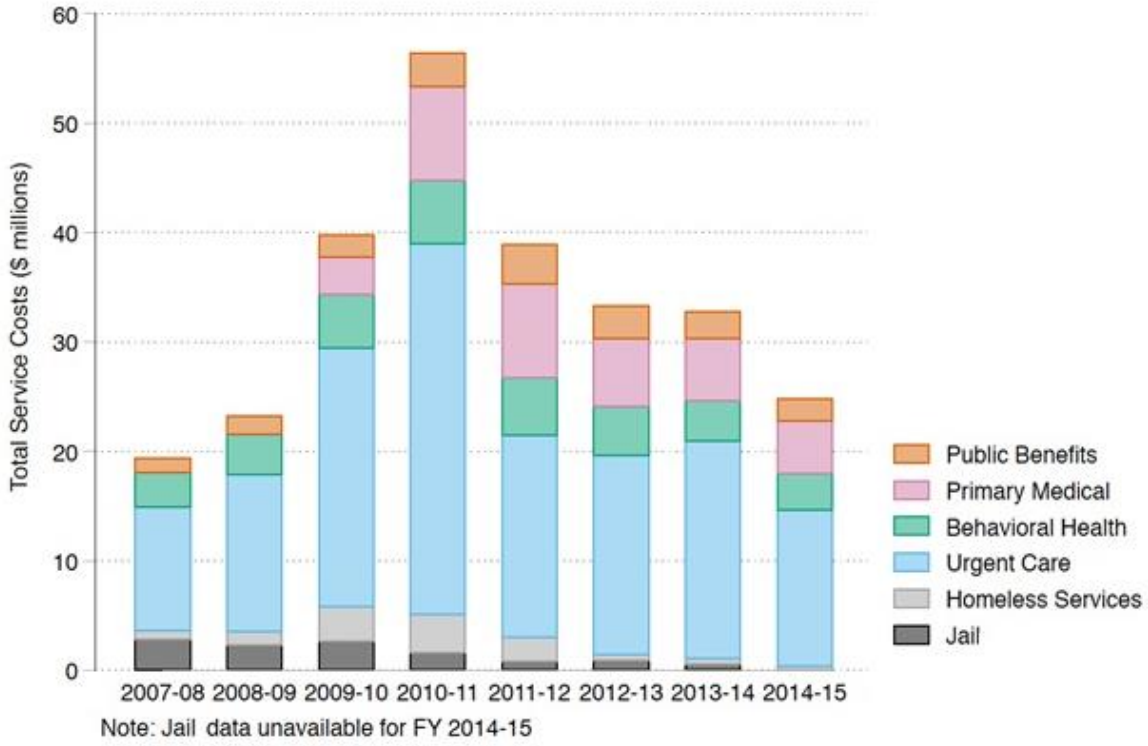
The 1,818 homeless adults included in this study entered supportive housing programs at different times during the two-year period from July 2010 to June 2012 but all were housed for some portion of the two-year period. Both service utilization and service costs increased once these adults entered housing.

As shown in the chart below, total estimated service costs (excluding supportive housing) rose from $19.4 million in FY 2007-08 to $56.3 million in FY 2010-11, an increase of approximately $37 million, or 191 percent. The change from FY 2007-08 to FY 2010-11 indicates rapidly deteriorating conditions for many individuals over the period preceding and including their transition to supportive housing as they accessed greater amounts of emergency/urgent care, behavioral health services, homeless services and primary medical care. Total service costs then

declined over the next four years following placement in housing, decreasing from $56.3 million in FY 2010-11 to $24.8 million in FY 2014-15, a reduction of $31.5 million, or 56 percent.

While the adults in this study used a greater number of behavioral health services (as shown in Chart 1 above), costs for each emergency/urgent care service were substantially higher and were the main driver of cost increases between FY 2007-08 and FY 2010-11. Inpatient stays and emergency department visits to City hospitals, for example, are expensive, but the cost of each inpatient stay or emergency department visit varies substantially depending on the length of hospitalization. In FY 2010-11, the median per person cost for adults using emergency/urgent care was $2,919, whereas the average per person cost was $35,195, or 12 times greater than the median. The difference between the median cost per person of $2,919 and the average cost per person of $35,195 is due to a few individuals having very high costs for inpatient stays. Over the eight-year period evaluated in this report, estimated costs for emergency/urgent care totaled $154.1 million, or 57 percent of all estimated service costs of $268.6 million from FY 2007-08 to FY 2014-15.

Chart 3: Estimated Service Costs for Homeless Adults Placed in Supportive Housing in FY 2010-11 or FY 2011-12



Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Cost Estimates Calculated by Budget and Legislative Analyst

Average and median services costs per year by service category provided in Numeric Tables Appendix, Charts 3a and 3b, respectively. Average and median costs per year by service category are based on the adults that used the service category in a particular year and not based on all adults in the study.

The steep rise in total service costs through FY 2010-11 was due to increases in (a) the number of adults accessing services, (b) the number of service events per adult, and (c) shifts in the types of services accessed.

Table 7 below shows the total number of adults accessing services, the total number of service events and events per adult, as well as total, average, and median costs. The number of adults accessing services increased from 924, or 51 percent of the 1,818 adults, in FY 2007-08 to 1,602, or 88 percent of the 1,818 adults, in FY 2011-12. After FY 2011-12, the number of adults accessing services decreased each year.

Table 7: Services and Estimated Costs per Adult from FY 2007-08 to FY 2014-15

Fiscal Year	Adults Accessing Services	Number of Service Events	Service Events per Adult	Service Costs	Average Cost Per Adult [a]	Median Cost Per Adult [a]
FY 2007-08	924	61,530	67	$ 19,383,856	$ 20,978	$ 6,328
FY 2008-09	1053	73,730	70	$ 23,202,810	$ 22,035	$ 6,601
FY 2009-10	1318	103,272	78	$ 39,814,216	$ 30,208	$ 11,312
FY 2010-11	1577	135,823	86	$ 56,362,988	$ 35,741	$ 13,606
FY 2011-12	1602	135,372	85	$ 38,883,796	$ 24,272	$ 11,812
FY 2012-13	1433	113,023	79	$ 33,288,566	$ 23,230	$ 9,548
FY 2013-14	1310	100,876	77	$ 32,781,960	$ 25,024	$ 8,941
FY 2014-15	1182	90,034	76	$ 24,835,776	$ 21,012	$ 8,553
All Years	1720	813,660	473	$ 268,553,968	$ 156,154	$ 74,867
Annual Average	1300	101,708	77	$ 33,569,246	$ 25,312	$ 9,588

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Cost Estimates Calculated by Budget and Legislative Analyst

[a] The significantly higher average cost per adult compared to the median cost per adult is due to a small number of adults accessing high cost services, such as inpatient care.

Note: The "per adult" figures reported in this table are based on adults who accessed services in a particular year, and not for all adults in the study. For example, the service events per adult are calculated as the number of service events divided by the number of adults accessing services each year.

The average number of service events increased from 67 events per adult accessing services in FY 2007-08 to 86 events in FY 2010-11 and 85 events in FY 2011-12, the years when the adults in this study entered supportive housing. The average number of service events per adult decreased to 76 events in FY 2014-15, as shown in the chart above.[9] The composition of services used changes over time, as discussed further in the below section, "Comparison of Services Used by Adults Before and After Entering Supportive Housing".

[9] The FY 2014-15 average number of events per adult does not include jail time, for which we do not have data. If the number of jail events in FY 2014-15 is assumed to be the same as FY 2013-14, the average number of events does not change significantly due to the low number of jail events.

The average cost of services for each adult accessing services (not including supportive housing costs) increased from $20,978 in FY 2007-08 to $35,741 in FY 2010-11. The average cost of services per adult accessing services decreased by 41 percent between FY 2010-11 and FY 2014-15, from $35,741 to $21,012.

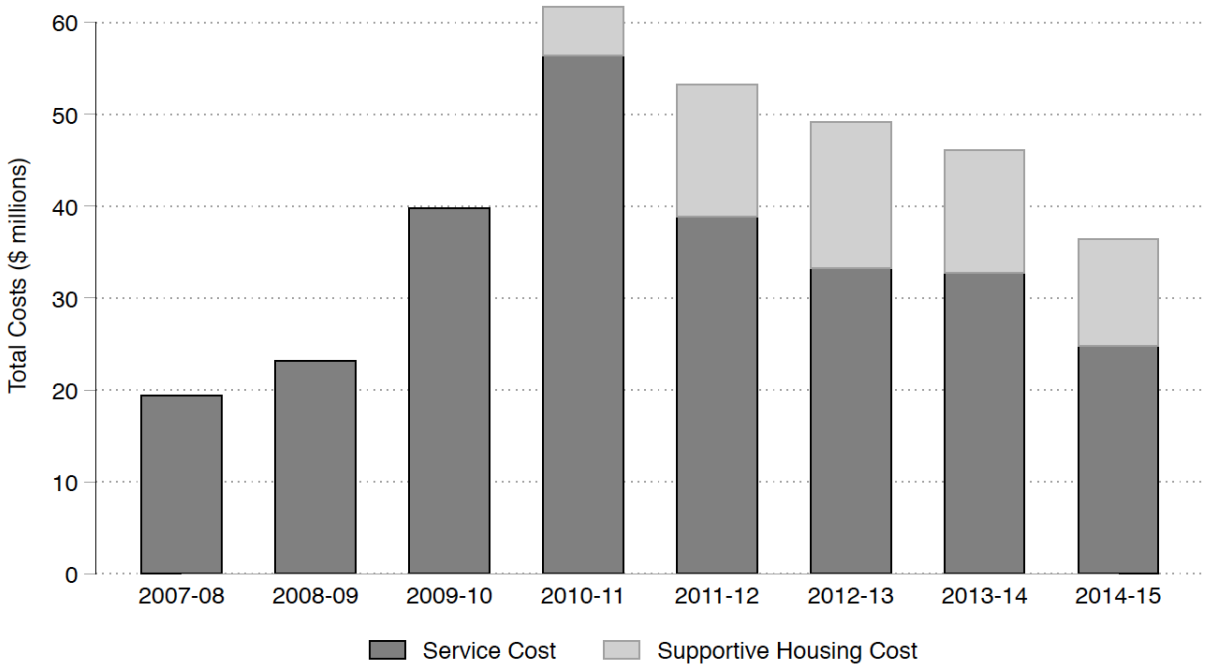
The median cost of services among adults accessing services (not including supportive housing costs) increased from $6,328 in FY 2007-08 to $13,606 in FY 2010-11, as shown in Table 7 above. The median cost of services decreased by 37 percent between FY 2010-11 and FY 2014-15, from $13,606 to $8,553.

As shown in Table 7 above, average service costs per adult range between twice to three times the median service costs, which indicates that significantly higher service costs among a portion of the population are responsible for pushing up the overall average. The impacts of the individuals who comprise the top 10 percent of service costs estimated for this report are discussed further in the below section, "Trends in Use of Services by the Top 10 Percent Service Users by Cost".

Shifts in Costs and Services after Adults Enter Supportive Housing

The total estimated service *and* housing costs for the 1,818 adults who entered supportive housing in FY 2010-11 and FY 2011-12 increased from $19.4 million in FY 2007-08 to $61.7 million in FY 2010-11, and then decreased to $36.4 million in FY 2014-15, as shown in the chart below. While the City's costs to provide supportive housing increased the total costs for these 1,818 adults beginning in FY 2010-11, the decrease in service costs beginning in FY 2011-12 partially offset the increased costs associated with supportive housing. Total estimated service and supportive housing costs of $36.4 million in FY 2014-15 were approximately $3.4 million, or nine percent, lower than service costs alone of $39.8 million in FY 2009-10, the last year when there were no supportive housing expenditures.

Chart 4: Estimated Costs for Supportive Housing and Services from FY 2007-08 to FY 2014-15



Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Cost Estimates Calculated by Budget and Legislative Analyst. Estimated housing and services costs by fiscal year provided in Numeric Tables Appendix, Chart 4.

Total estimated supportive housing expenditures between FY 2010-11 and FY 2014-15 for this population equaled $60.5 million, or 18 percent of the total $329 million in estimated expenditures for services and housing between FY 2007-08 and FY 2014-15. Supportive housing expenditures average approximately $13,400 per unit per year.

Overall estimated service costs were highest in FY 2010-11, which marks the period immediately prior to or just after individuals in this study were placed in supportive housing. As previously noted, this transition between homelessness and housing has been identified by DPH as the most concentrated period of cost and service "spikes".

As shown in Table 8 below, overall service costs increased by 191 percent between FY 2007-08 to FY 2010-11. The total estimated service costs for each category of services, except costs associated with time spent in jail, increased over this time period, including a 199 percent increase in emergency/urgent care costs, a 365 percent increase in homeless services costs, and an 85 percent increase in behavioral health costs. There were no expenditures for primary medical care (such as routine visits to outpatient clinics) captured or recorded for this population in FY 2007-08.

Table 8: Total Estimated Service Costs by Category in FY 2007-08, FY 2010-11, and FY 2014-15

Service Category	FY 2007-08	FY 2010-11	Change	FY 2014-15	Change
Emergency/Urgent Care	$ 11,335,586	$ 33,892,388	199%	$ 14,280,867	-58%
Primary Medical	-	$ 8,621,322	-	$ 4,787,910	-44%
Behavioral Health	$ 3,111,799	$ 5,751,446	85%	$ 3,295,998	-43%
Homeless Services	$ 751,435	$ 3,491,150	365%	$ 400,151	-89%
Public Benefits	$ 1,372,429	$ 2,987,825	118%	$ 2,070,850	-31%
Jail	$ 2,812,608	$ 1,618,857	-42%	$ 580,716	-64%
Total	$ 19,383,856	$ 56,362,988	191%	$ 24,835,776	-56%

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Costs estimated by Budget and Legislative Analyst; Jail data unavailable for FY 2014-15 (FY 2013-14 used instead).

Overall estimated service costs subsequently decreased by 56 percent from FY 2010-11 and FY 2014-15, as shown in Table 8 above. This included a 64 percent reduction in jail costs, a 58 percent reduction in emergency/urgent care costs, and a 43 percent reduction in behavioral health costs. The largest percentage decrease was for homeless services, which decreased by 89 percent.

As shown in Chart 5 below, between FY 2007-08 and FY 2014-15 estimated service costs shift from homeless services and jail time to benefits and primary medical care costs. Primary medical care costs, for example, were 0 percent of all estimated service costs in 2007-08 versus 19 percent of all estimated service costs in 2014-15. Behavioral health (including substance abuse and mental health), jail, and homeless services, by contrast, all comprised a smaller share of service costs in FY 2014-15 than in FY 2007-08. Jail costs equaled approximately 15 percent of all estimated service costs in FY 2007-08 versus closer to 2 percent later in the study period.[10]

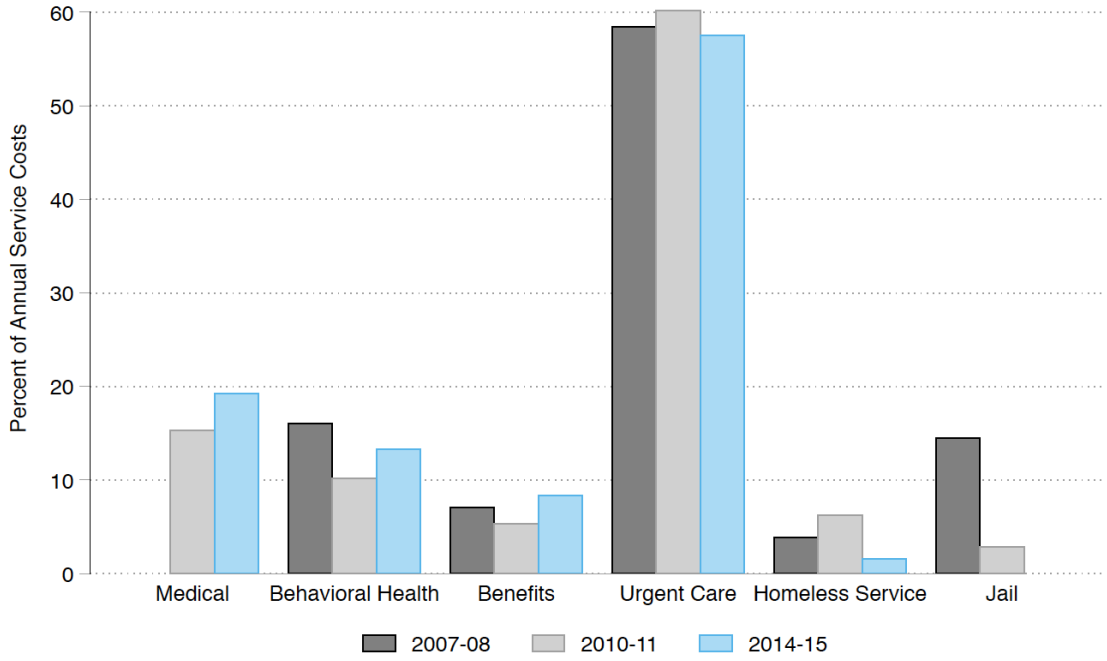
Over time, costs also shift within service subcategories from more acute care to more routine care. For example, residential and day treatment costs comprise a smaller share of total behavioral health costs in FY 2014-15 compared to FY 2007-08. By contrast, outpatient treatment, primary behavioral health care, and counseling for mental health and substance abuse comprise a larger share of total behavioral health costs in FY 2014-15 compared to FY 2007-08 (see Numeric Tables Appendix, Chart 5a).

Emergency/urgent care comprised approximately 58 percent of all service costs in both FY 2007-08 and in FY 2014-15. Due to the high costs of inpatient medical care, emergency department visits, and ambulance transports, costs for emergency/urgent care remain a high percentage of overall spending even as overall costs and the number of adults receiving services decline.[11] Costs due to

[10] As previously stated, jail data was unavailable for FY 2014-15. However, time in jail declined substantially every year from FY 2010-11 to FY 2013-14, and by 2013-14 accounted for two percent of total estimated service costs.
[11] Inpatient medical care, emergency department visits, and ambulance transports account for 84 percent of all emergency/urgent care expenses.

psychiatric emergencies, psychiatric crisis, and psychiatric inpatient care, however, did comprise a smaller share of total emergency/urgent care costs in FY 2014-15 than in FY 2007-08 (see Numeric Tables Appendix, Chart 5b)

Chart 5: Percent of Annual Service Costs by Service Type in FY 2007-08, FY 2010-11 and FY 2014-15



Note: Figures for each year add up to 100 percent. There were no expenditures for primary medical care in FY 2007-08 and Jail data was unavailable for FY 2014-15. For reference, jail accounted for two percent of service expenditures in FY 2013-14.
Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Costs estimated by Budget and Legislative Analyst. Percent of annual service costs available in Numeric Tables Appendix, Chart 5.

The shift in costs from homeless services and jail time to benefits and primary medical care, and the shifts within the behavioral health and emergency/urgency care categories, shows that overall the 1,818 adults in this study were better able to access routine or ongoing care in FY 2014-15 than in FY 2007-08. Although the City's total services costs were higher in FY 2014-15 than in FY 2007-08 ($14.3 million in FY 2014-15 compared to $12.9 million in FY 2007-08, or 11 percent greater), more adults were served (1,182 in FY 2014-15 compared to 924 in FY 2007-08) and more were housed. In addition, total estimated service and housing costs were lower in FY 2014-15 than service costs alone in either FY 2009-10, FY 2010-11, or FY 2011-12 as shown in Chart 4 above.

The shift in costs from homeless services and jail time to benefits and medical care also partially shifts costs from the City's General Fund to federal and state programs, including CalFresh (food stamps), Medi-Cal and other programs. Finally, costs for emergency/urgent care and behavioral health services are

covered by a variety of sources including the City's General Fund, federal and state sources, private insurance, and grants.

Impact of Adults Leaving Supportive Housing on their Service Utilization

With the exception of those who died in supportive housing, the HSA and DPH services and housing data utilized by the Budget and Legislative Analyst for this report does not include reasons for housing exits. Individuals who died after receiving a housing placement comprised seven percent of the 1,818 adults in the study and, as shown in Table 9 below, 14 percent of the overall number of individuals who were no longer in supportive housing. This percentage varied by housing program.

Table 9: The Number of Deaths as a Percentage of All Adults Leaving Supportive Housing by Program

	Total Deaths	Total Adults Leaving Supportive Housing	Death as a Percentage of Total Adults Leaving Supportive Housing
Direct Access to Housing	87	258	34%
HSA Master Lease	24	589	4%
HUD/ Continuum of Care	20	106	19%
Non-profit Operated	3	22	14%
Total	134	975	14%

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12

Over the eight-year study period, adults who died comprised 15 percent of total estimated service costs, or $41.1 million out of $268.6 million. Adults who die after receiving a supportive housing placement are often among the adults with the highest medical needs and therefore have higher associated medical costs.

Excluding those who died, of the adults who entered supportive housing in FY 2010-11 and FY 2011-12, 855 adults, or 47 percent, were still in their supportive housing placement in FY 2014-15 and 841 adults, or 46 percent, had left their original placement, as shown in Table 10 below.

Table 10: Number of Adults Who Died, Left, or Remained in Supportive Housing Placement[12]

	No. of Placements	Percent
Deaths	134	7%
Left Housing Placement	841	46%
Remained in Housing Placement	855	47%
Total	1,830	100%

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12.

Of the individuals placed in supportive housing who did not die, approximately half remained in their housing placement while half left their housing placement. As shown in Table 11 below, there is significant variation between City supportive housing programs. On average about 67 percent of adults remained in non-Master Lease housing placements while 33 percent left non-Master Lease housing placements.

Within the Master Lease program, by contrast, the figures were reversed: 34 percent remained in their Master Lease housing placements while 66 percent left their Master Lease housing placements. [13]

Table 11: Percent of Adults Remaining in Housing versus Leaving Housing By Supportive Housing Program, Excluding Those who Died

	Percent Remaining in Housing	Percent Leaving Housing
Direct Access to Housing	68%	32%
HSA Master Lease	34%	66%
HUD/Continuum of Care	59%	41%
Non-profit Operated (HSA LOSP)	80%	20%
Total	50%	50%

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12.

Because a larger number of adults left Master Lease housing placements compared to the other supportive housing programs, the Budget and Legislative Analyst investigated service usage among adults who left their original Master Lease housing placements.

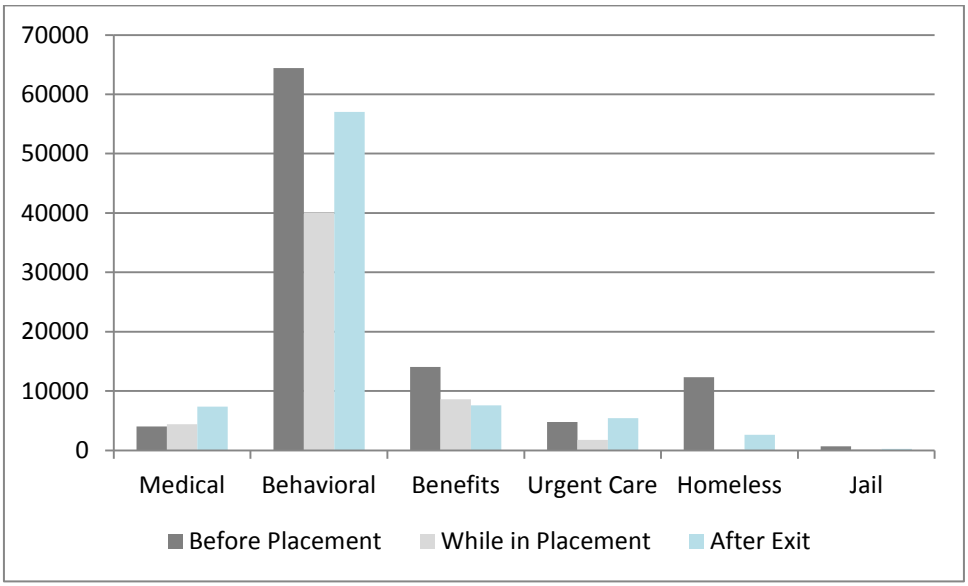
[12] As previously stated, out of 1,830 total placements, 12 individuals received a second placement in supportive housing soon after exiting their first placement, resulting in 1,818 non-duplicated adults in the study. Housing stability could only be evaluated based upon placement data, however. The total figures and percentages presented in this section therefore contain a small amount of duplication, equaling less than 0.6 percent.

[13] Because our study was limited to adults receiving supportive housing placements in FY 2010-11 and FY 2011-12, it does not account for individuals who may have been re-placed in supportive housing after June 2012. We do not expect that this is a large number; further study and evaluation would be required to confirm.

Service Usage Among Adults Who Left the Master Lease Program

Among the 589 total adults who left their original HSA Master Lease placement prior to the end of FY 2014-15, use of all services increased after leaving housing, except for benefits, as shown in Chart 6 below.

Chart 6: Use of Services by Adults who Left Master Lease Placements



Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12. Use of services by adults leaving Master Lease placement provided in Numeric Tables Appendix, Chart 6.

The use of primary medical and behavioral health services was higher after leaving housing compared to while in housing, which indicates ongoing outpatient medical care as well as mental and substance abuse treatment. However, use of emergency/urgent care services was higher after leaving the supportive housing placement compared with both the housing and pre-housing period. This fact, coupled with the increase in homeless services utilization and the increase in jail events, indicates that the status of some individuals who left the Master Lease program worsened.[14]

Use of services did not increase for every individual who left their Master Lease housing placement. As shown in Table 12 below, of the 589 adults who left HSA Master Lease placements, 24 adults died. Of the remaining 565 adults, 113 adults, or 20 percent, did not use any services after exiting. Approximately 18 percent, or 104 adults, continued to use benefits, primary medical care, or

[14] The number of jail events increased from 184 events while in Master Lease housing to 225 jail events after exiting Master Lease housing. While adults no longer in the Direct Access to Housing program in FY 2014-15 had lower use of services overall after leaving housing than while in housing, this was likely due in part to the high number of deaths (34 percent in Direct Access to Housing compared to 4 percent in HSA's Master Lease program, as shown in Table 9 above). The 105 adults who left the HUD/Continuum of Care and Non-profit Operated housing programs also increased their use of urgent care and homeless services after leaving housing. For more information please see the Numeric Tables Appendix to this report.

behavioral health care only. By contrast, 348 adults, or 62 percent, had at least some continued use of homeless services, jail, or urgent/emergency care following their exit from Master Lease housing.

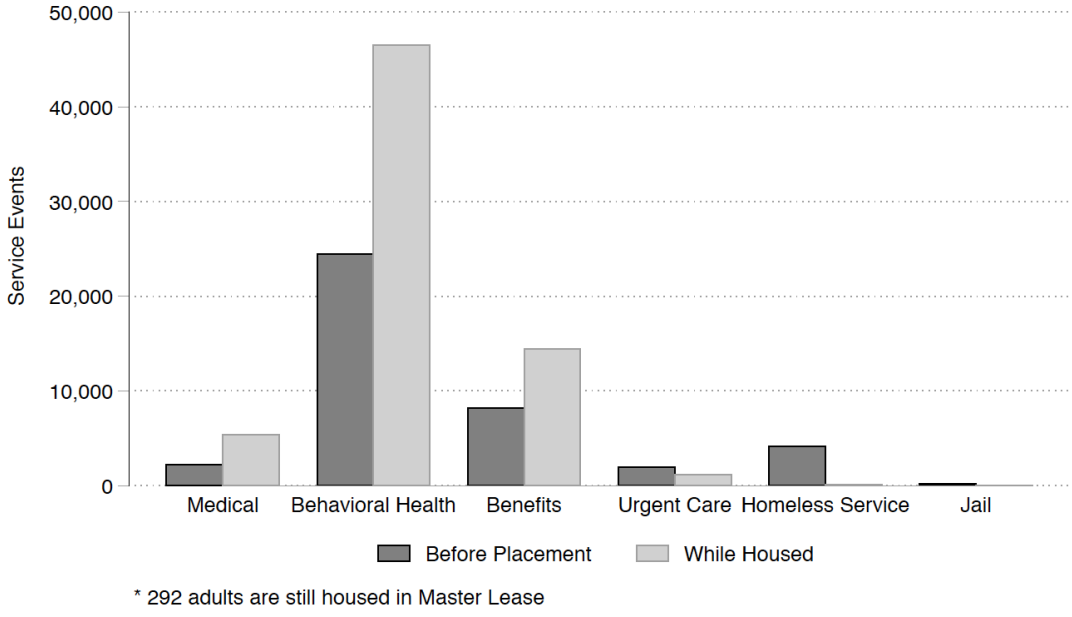
Table 12: Service Usage after Leaving Master Lease Housing

	Number of Adults Leaving Supportive Housing	Percent of Adults Leaving Supportive Housing
Continued use of benefits, medical care, or behavioral health care ONLY	104	18%
No service usage following housing exit	113	20%
Continued use of homeless services, jail, or urgent/emergency care	348	62%
Total	565	100%

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12

The 292 individuals who remained housed in their original Master Lease placement as of the end of FY 2014-15, by contrast, remained stable. These individuals increased their use of primary medical, behavioral health services, and public benefits, but decreased their use of emergency/urgent care, homeless services, and jail time, as shown in Chart 7 below.

Chart 7: Use of City Services by Adults Who Remained in HSA Master Lease Placement by Housing Status



Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12. Use of services by adults who remained in their Master Lease placement provided in Numeric Tables Appendix, Chart 7.

We cannot state whether the increase in service utilization by some individuals leaving their Master Lease housing placement was *caused* by leaving supportive housing as opposed to other factors, only that there is a relationship. For example, the adults leaving Master Lease housing may be more likely to have had undiagnosed or untreated medical, mental, or behavioral health conditions prior to placement in housing. The presence of these conditions could in turn have impacted the individual's ability to stabilize while housed.[15]

Certain providers or housing sites may have more success than others at stabilizing individuals, either because of the quality or availability of support services, the quality or safety of the housing site, or the compatibility of the housing environment with the needs of the target population.

HSA's current contract performance and outcome measures limit the ability to track outcomes for supportive housing clients at the individual level. For example, HSA's current housing stability measures evaluate stability on a year-over-year basis, includes the entire housed population, and includes exits to "other stable housing" along with those in HSA housing. More effective stability measures would evaluate stability over time periods longer than one year, distinguish between long-term supportive housing residents and recent placements, and distinguish those remaining housed in City supportive housing programs versus those exiting to other housing.

Although HSA's new tiered contract structure currently being implemented will enable more detailed tracking of the rates of and contributing factors to "positive" housing exits, the Budget and Legislative Analyst recommends that HSA re-evaluate the utility of its current stability measures and develop alternatives as described above.

Finally, the Departments should continue evaluating contributing factors to positive and negative exits from supportive housing, including medical and behavioral health histories, jail histories, past use of emergency and crisis services, the availability and accessibility of supportive services, and whether certain supportive housing sites and providers have relatively higher or lower housing stability rates.

[15] For example, there is a significant relationship between jail events and length of stay in supportive housing placements. On average, length of stay decreased by 25 days for each jail event that an adult had. While jail events for the adults in this study decreased substantially after housing placements, from 1,783 events before placement to 737 events after placement, we do not know what caused the relationship between jail events and length of stay. In other words: we cannot state that a jail history indicates definitively that an individual will be more likely to exit housing, only that there is a correlation.

Trends in Use of Services by the Top 10 Percent Service Users by Cost

We identified two groups of high cost service users among the 1,818 adults who entered supportive housing in FY 2010-11 and FY 2011-12. These individuals comprise those who made up the top 10 percent of service users by cost, based on service costs estimated in this report.[16] Those identified included:

- 162 adults who incurred high costs prior to entering housing; and
- 157 adults who incurred high costs after entering housing

These two groups of adults separately comprised the top 10 percent of service users by cost prior to entering housing and after entering housing, respectively. Among these two groups were 58 adults who fell within both groups of top 10 percent service users by cost.

85 percent of the high cost service users prior to placement were placed in DPH's Direct Access to Housing which is designed for individuals with high medical and behavioral health needs, as shown in Table 13 below. Of the high cost service users prior to placement, 7 percent were placed in Master Lease housing, which is less equipped to provide services to individuals with high medical and behavioral health needs than Direct Access to Housing. A larger number of high cost users *after* placement in supportive housing – 29 percent – were in Master Lease housing, as shown in the table below.

Table 13: Number of High Cost Service Users by Type of Housing

	Number of Placements	Percent	High Costs Before Placement	Percent	High Costs After Placement	Percent	High Costs Before and After Placement	Percent
Human Services Agency								
HUD/Continuum of Care	230	13%	12	7%	14	9%	4	7%
Nonprofit Providers	98	5%	1	1%	0	0%	0	0%
Master Lease	883	48%	12	7%	46	29%	4	7%
Subtotal Human Services Agency	1,211	66%	25	15%	60	38%	8	14%
Department of Public Health								
Direct Access to Housing	619	34%	137	85%	97	62%	50	86%
Total	**1,830** [a]	**100%**	**162**	**100%**	**157**	**100%**	**58**	**100%**

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12.

[a] Of the 1,830 placements shown in Table 13, 12 individuals received a second placement in supportive housing soon after exiting their first placement, resulting in 1,818 non-duplicated adults.

Master Lease housing is likely not the appropriate housing placement for these high cost adults, who have higher levels of medical and behavioral health needs and thus require greater levels of intensive care and supportive services. Both Departments should evaluate how they may improve assessments so that

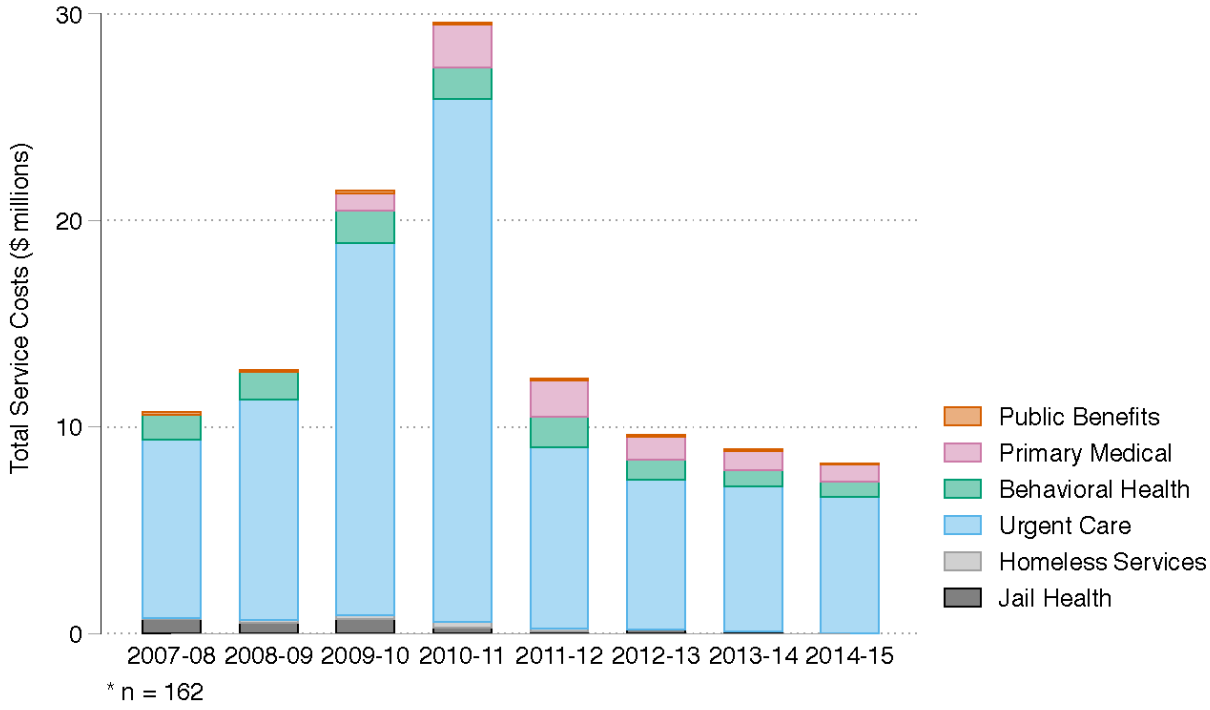
[16] This group is specific to the adults and estimated costs evaluated for this report only, and are not the same as "High Users" identified by the Department of Public Health.

individuals receive the correct placement prior to entering housing, and how to share information and resources so that individuals whose high needs emerge after entering housing may be transferred to the appropriate program.

High Service Users before Entering Housing

The 162 adults who incurred high service costs prior to entering housing had significant reductions in service costs after entering housing, as shown in the chart below. Estimated service costs for this group peaked at $29.6 million in FY 2010-11 and declined to $8.2 million in FY 2014-15, a decrease of $21.4 million, or a reduction of 72 percent.

Chart 8: Service Costs for Adults with High Service Use Prior to Entering Supportive Housing



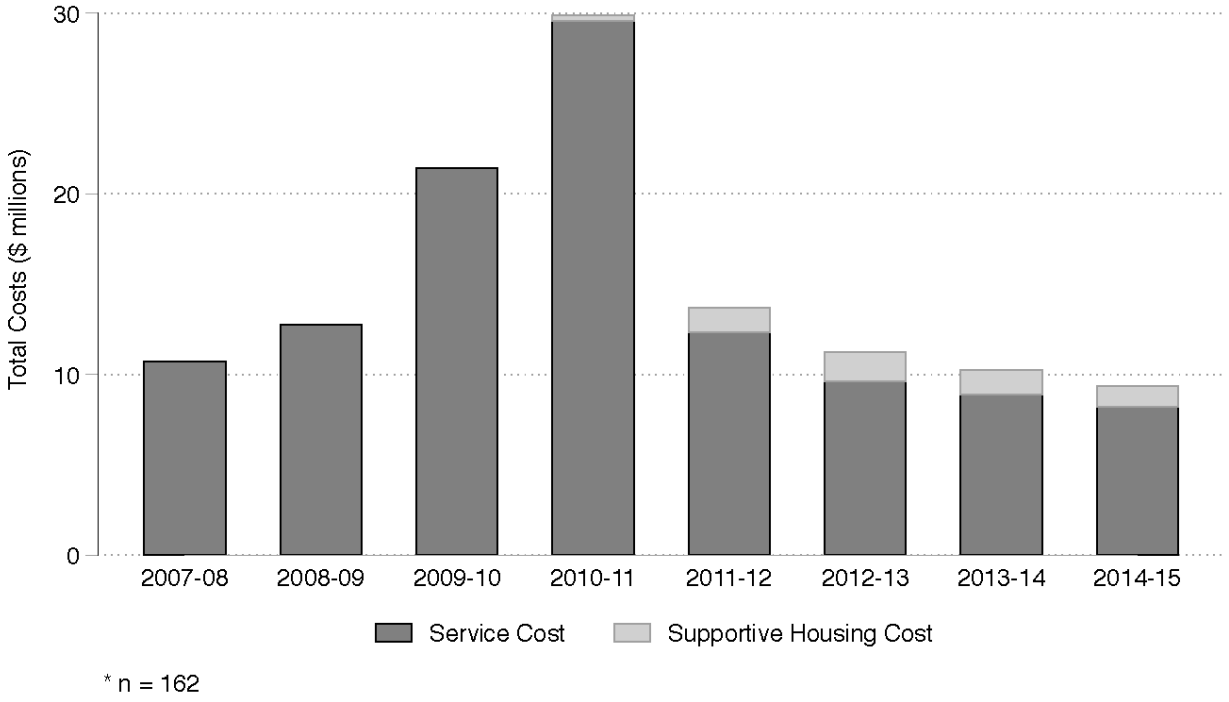
Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Cost Estimates Calculated by Budget and Legislative Analyst. Data provided in Numeric Tables Appendix, Chart 8.

The 162 adults in this pre-housing high cost group comprise nine percent of the overall housed population of 1,818 individuals. Across the entire eight-year period, however, expenditures for this group equaled $113.6 million, or 42 percent of total service expenditures of $268.6 million from FY 2007-08 to FY 2014-15. Of the $113.6 million in total estimated service costs for this group, 81 percent of costs, or $92.3 million, were for emergency/urgent care costs.

The reductions in service costs for these adults after housing placement more than offset the costs of supportive housing, as seen in the chart below. Total estimated supportive housing costs for this group equaled $5.8 million between

FY 2010-11 and FY 2014-15. This figure is considerably less than the $21.3 million reduction in estimated service costs over the same period.

Chart 9: Total Service and Housing Costs for Adults with High Service Use Prior to Entering Supportive Housing

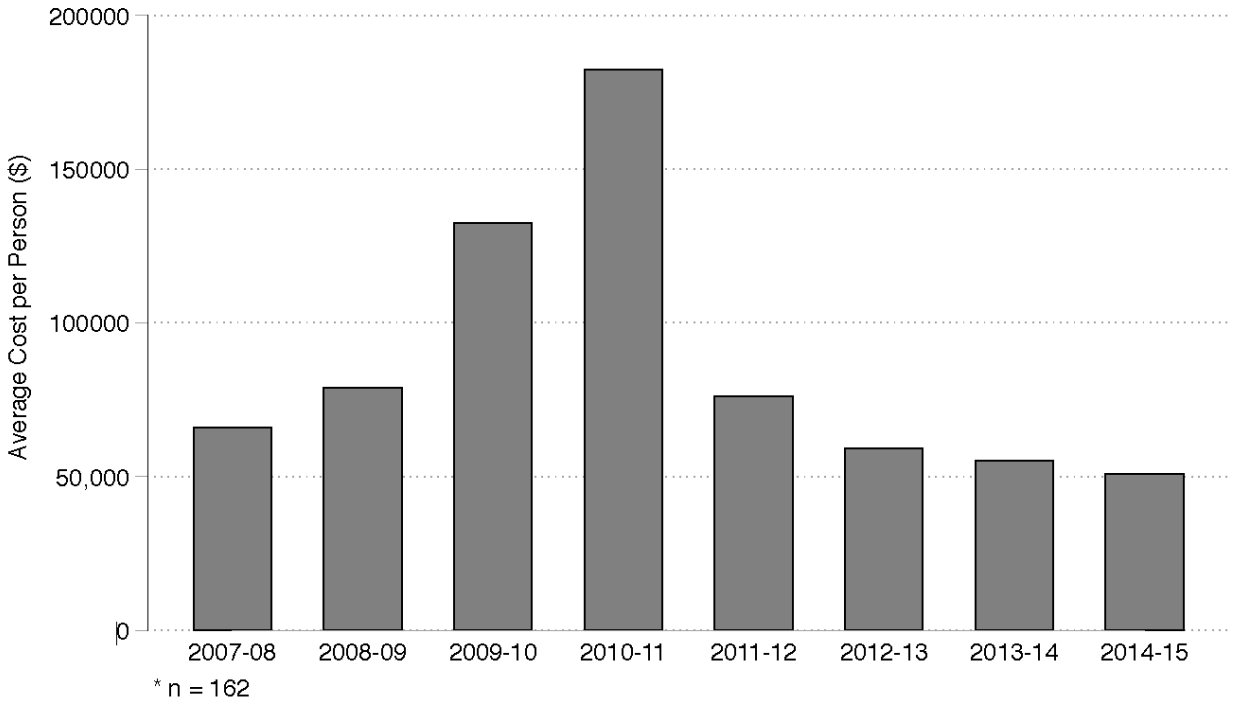


* n = 162

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Cost Estimates Calculated by Budget and Legislative Analyst. Data provided in Numeric Tables Appendix, Chart 9.

As shown in the chart below, the average annual service cost per adult in this group (excluding supportive housing) increased from $66,067 per adult in FY 2007-08 to $182,428 per adult in FY 2010-11, an increase of $116,361, or 176 percent. Costs then declined to $50,745 per adult in FY 2014-15, a reduction of $131,683, or 72 percent. As previously stated, the major driver of changes in costs was emergency/urgent care services.

Chart 10: Average Annual Service Costs for Adults with High Service Use Prior to Entering Supportive Housing



Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Cost Estimates Calculated by Budget and Legislative Analyst. Data provided in Numeric Tables Appendix, Chart 10.

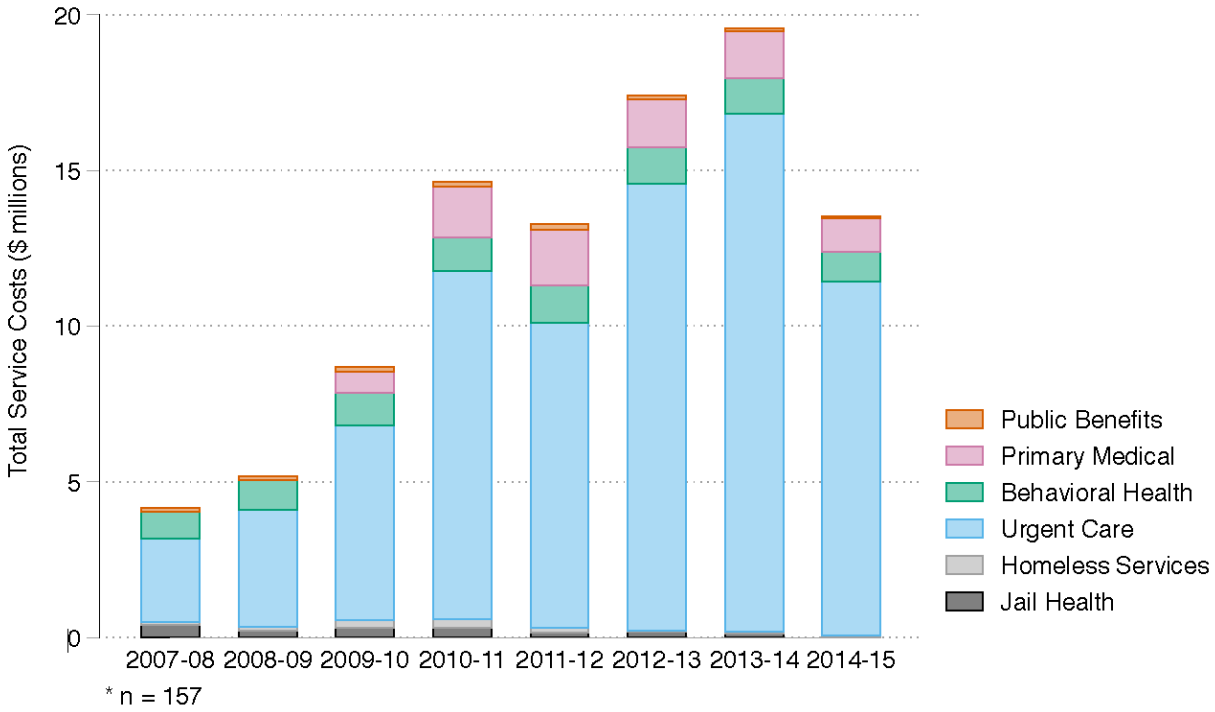
Note: The average cost per person is based on the total annual service costs divided by the 162 adults in the pre-housing high service user group.

Of the 162 adults in the top 10 percent of service users by cost prior to entering housing, 36 adults, or approximately 22 percent, died after placement in supportive housing. These 36 adults also comprised 22 percent of overall estimated spending on services for the group of 162 adults ($25.5 million out of $113.6 million).

High Service Users after Entering Housing

The 157 adults in the top 10 percent of service users by cost after entering housing generally had lower service costs prior to entering housing, which increased and stayed high after placement in supportive housing, as shown in the chart below. Expenditures on emergency/urgent care services comprised 79 percent of all estimated spending on this group over the eight-year period from FY 2007-08 to FY 2014-15, or $76.1 million out of $96.4 million.

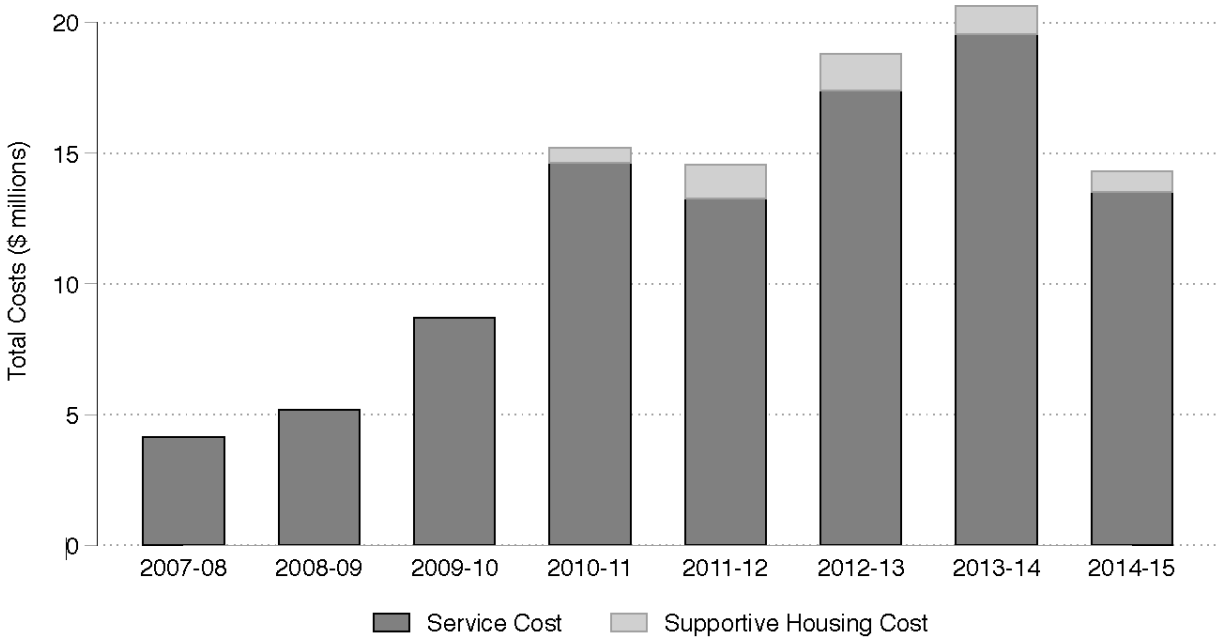
Chart 11: Total Service Costs for Adults with High Service Use after Entering Supportive Housing



Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Cost Estimates Calculated by Budget and Legislative Analyst. Data provided in Numeric Tables Appendix, Chart 11.

Estimated spending on services for this group rose by 352 percent from a low of $4.3 million in FY 2007-08 to a high of $19.6 million in FY 2013-14. Supportive housing increased overall expenditures for this group because there was no trend toward reductions in service costs relative to the years before housing placement, as seen in the chart below.

Chart 12: Service and Housing Costs for Adults with High Service Use after Entering Supportive Housing

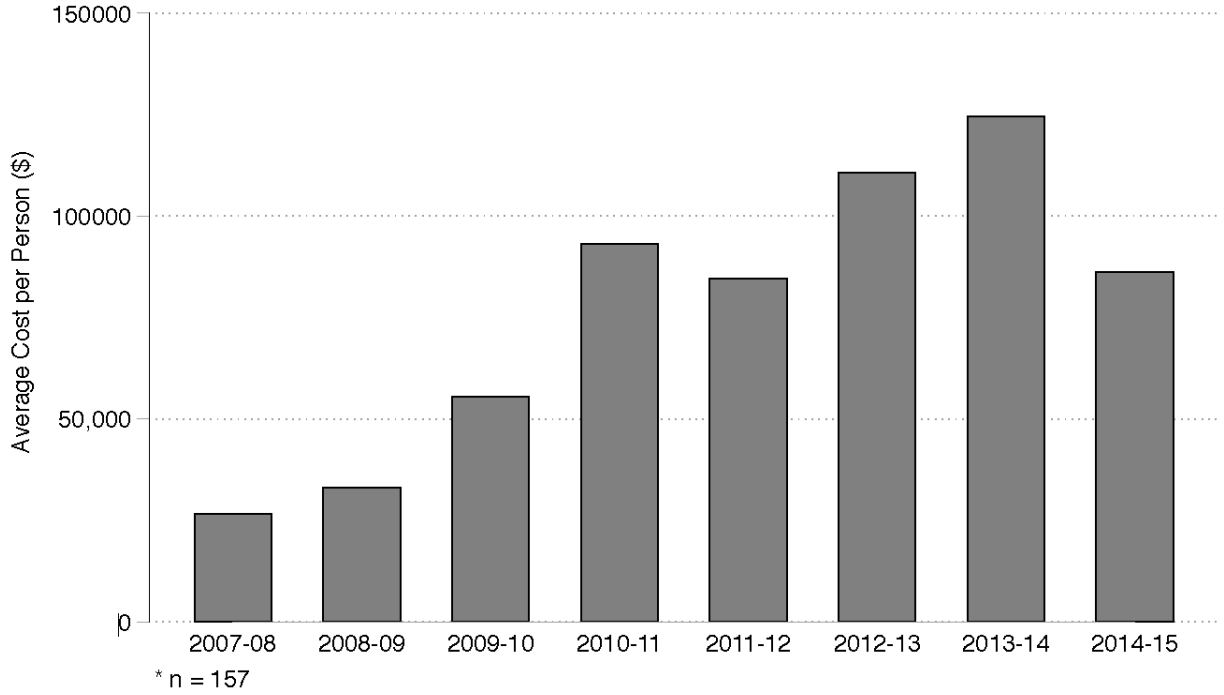


* n = 157

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Cost Estimates Calculated by Budget and Legislative Analyst. Data provided in Numeric Tables Appendix, Chart 12.

The average annual service cost (excluding housing) per adult increased from $26,493 in FY 2007-08 to $93,191 in FY 2010-11, and decreased to $86,109 in FY 2014-15, as shown in the chart below. Average annual service costs per adult increased by $59,616, or 225 percent, from FY 2007-08 to FY 2014-15.

Chart 13: Average Annual Service Costs for Adults with High Service Use after Entering Supportive Housing



Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Cost Estimates Calculated by Budget and Legislative Analyst. Data provided in Numeric Tables Appendix, Chart 13.
Note: The average cost per person is based on the total annual service costs divided by the 157 adults in the after-placement high service user group.

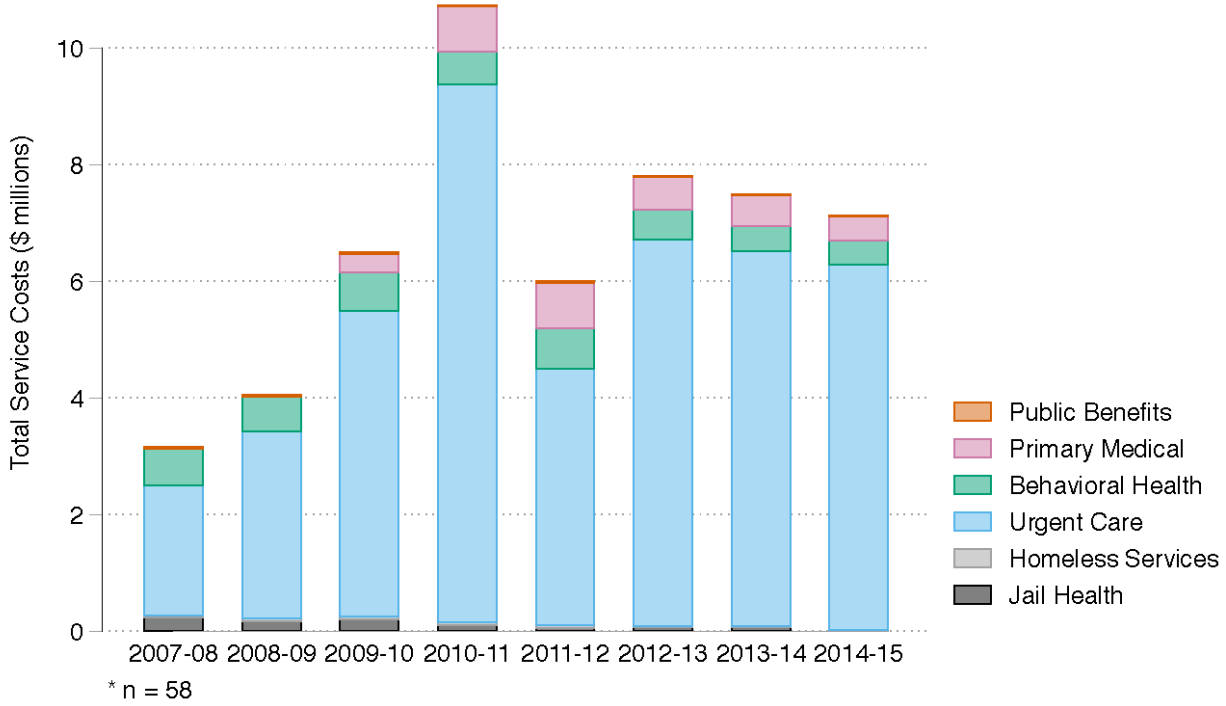
The high service users (both high service users before entering housing and high service users after entering housing) use more emergency/urgent care services than the total population of 1,818 adults. Between FY 2007-08 and FY 2009-10, prior to the 1,818 adults entering supportive housing, costs for emergency/urgent care comprised 79 percent of services costs for the high users versus 60 percent of service costs for the total population of 1,818 adults. Over the eight year period from FY 2007-08 through FY 2014-15, emergency/urgent care costs comprised 80 percent of total service costs for the highest users versus 57 percent of total service costs for the total population of 1,818 adults.

Individuals with High Service Use Both Before and After Entering Housing

Among the two groups of adults identified above, there were 58 adults who fell within the highest 10 percent of service users by cost both before and after entering supportive housing. These 58 adults had higher average annual costs in FY 2010-11 and FY 2014-15 than the adults in the two high-cost service user groups discussed above.

As shown in the chart below, total service costs for this group of 58 adults increased from $3.2 million in FY 2007-08 to $10.7 million in FY 2010-11, prior to declining to $7.1 million in FY 2014-15.

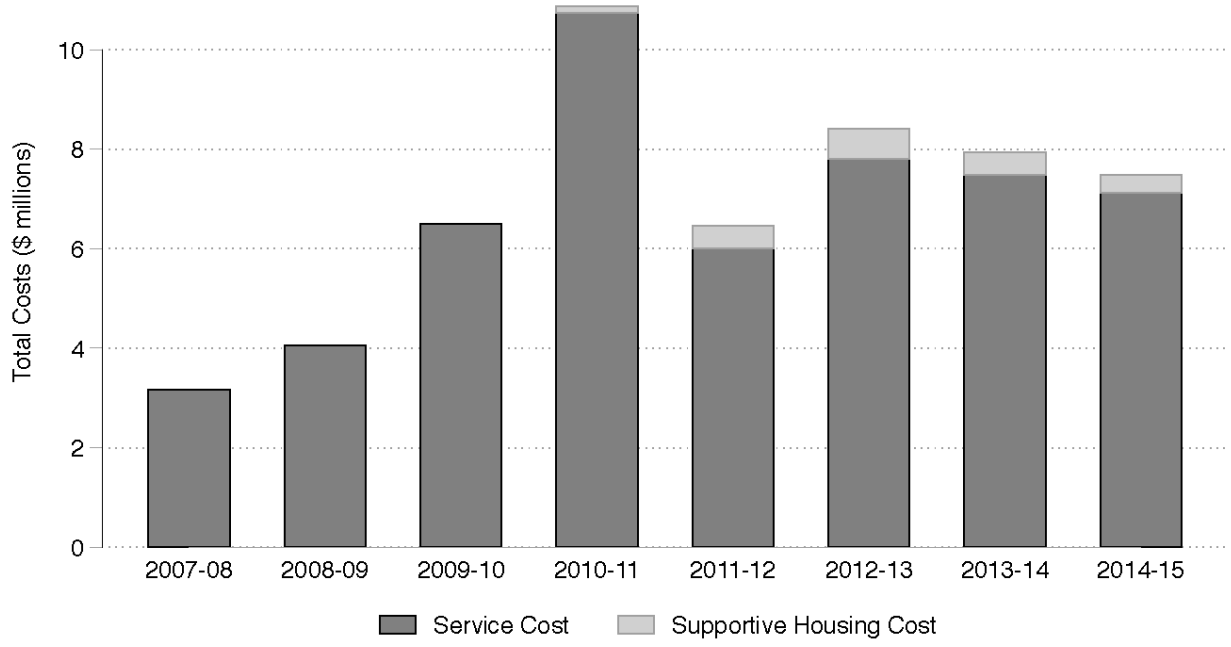
Chart 14: Total Service Costs of 58 Adults with High Service Use Prior to and After Entering Supportive Housing



Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Cost Estimates Calculated by Budget and Legislative Analyst. Data provided in Numeric Tables Appendix, Chart 14.

From FY 2010-11 to FY 2014-15, decreases in service costs offset the additional costs of providing supportive housing for this group, as seen in the chart below.

Chart 15: Service and Housing Costs of 58 Adults with High Service Use Prior to and After Entering Supportive Housing



* n = 58

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Cost Estimates Calculated by Budget and Legislative Analyst. Data provided in Numeric Tables Appendix, Chart 15.

The average annual estimated service cost per adult for this group (excluding supportive housing) increased from $54,591 in FY 2007-08 to $185,035 in FY 2010-11, and decreased to $122,881 in FY 2014-15. As shown in the chart below, average costs rose sharply between FY 2007-08 and FY 2010-11, followed by a steep decline between FY 2010-11 and FY 2011-12, after which average costs rose again before slowly declining. The major driver of the change in costs is due to utilization of emergency/urgent care services. The FY 2010-11 average annual estimated service cost of $185,035 for these 58 individuals was approximately five times the estimated average cost per adult out of the 1,818 individuals in the sample in the same year, and nearly 14 times the estimated median cost per adult, as shown above in Table 7. This illustrates how a significant amount of overall service costs are concentrated among a relatively small number of adults.

Of the 58 adults in the top 10 percent of service users by cost prior to and after entering housing, 16 adults, or approximately 28 percent, died after placement in supportive housing. These 16 adults also comprised 28 percent of overall estimated spending on services for the group of 58 adults ($15.1 million out of $54.4 million).

Chart 16: Average Annual Costs of 58 Adults with High Service Use Prior to and After Entering Supportive Housing

Source: DPH and HSA Data on Adults Entering Supporting Housing in FY 2010-11 and FY 2011-12; Cost Estimates Calculated by Budget and Legislative Analyst. Data provided in Numeric Tables Appendix, Chart 16. Note: The average cost per person is based on the total annual service costs divided by the 58 adults who fall within both the pre-housing and the after-placement high service user groups.

Policy Considerations

Benefits of Supportive Housing for Homeless Adults

Most of the 1,818 adults who entered supportive housing in FY 2010-11 and FY 2011-12 benefitted from being in supportive housing. While their use of services increased initially, much of the increase was due to additional access to medical services, including emergency and urgent care (especially inpatient hospitalization), as well as behavioral health services and public benefits. Between FY 2010-11, when the use of services peaked, and FY 2014-15, the number of adults accessing services and the number of services accessed by these adults decreased. During the same period, the estimated median cost of services per adult decreased.

The types of services used by the adults in this study changed after they entered supportive housing. Primary medical care and public benefits comprised a larger share of estimated service costs in FY 2014-15 than in FY 2007-08. By contrast, behavioral health, including mental health and substance abuse services, homeless services and jail time comprised a smaller share of estimated service costs in FY 2014-15 than in FY 2007-08. The shift in services from homeless

services and jail time to primary medical care and benefits shows that most adults who entered supportive housing were better able to access routine or ongoing services in FY 2014-15 than in FY 2007-08.[17]

Benefits of Supportive Housing for the City

The most frequently stated goal in funding permanent supportive housing is eventual cost savings through decreased use of emergency and other costly services. According to the City's 2004 Ten Year Plan to Abolish Chronic Homelessness, the chronically homeless "consume the lion's share of dedicated resources and, if their needs are met, the city will save money…Logic and compassion dictate that moving our 3,000 chronically homeless into permanent supportive housing would be cost effective, saving the taxpayers millions of dollars each year". While there were cost savings for the 1,818 adults who entered supportive housing in FY 2010-11 and FY 2011-12, service and housing costs remain high for these adults, totaling $36.4 million in FY 2014-15.

According to the Ten Year Plan, San Franciscans consistently identify homelessness as the number one problem. Therefore, reducing the number of chronically homeless adults on City streets, independent of any direct cost savings, may be a benefit to City residents.

High Service Users and the Need for Earlier Intervention

Some adults remained high service users after entering supportive housing. 58 adults were in the top 10 percent of service users by cost both before and after housing placement, comprising three percent of the 1,818 adults who entered supportive housing between FY 2010-11 and FY 2011-12 and 20 percent of estimated service costs excluding housing over the eight-year period from FY 2007-08 to FY 2014-15. The high costs were generally due to the costs of inpatient hospitalization.

HSA and DPH should evaluate whether the City's existing supportive housing sites, programs, and services are sufficient to care for this high-needs population, or whether alternative residential settings, such as residential treatment for behavioral health needs or more medically-intensive placements, are available or appropriate.

These 1,818 adults were older on average than the general homeless population based on the 2011 homeless count. As the homeless population ages and stays unhoused, the more likely they are to develop acute medical and behavioral health needs that require crisis stabilization and intensive support. Earlier intervention, access to medical care, and access to housing could therefore lessen the steep increases in emergency/urgent care costs, especially inpatient

[17] Emergency and urgent care services comprised approximately 58 percent of all services in FY 2007-08 and in FY 2014-15, as shown in Chart 5. Within emergency and urgent care services, inpatient hospitalization comprised approximately 70 percent of costs in FY 2007-08 and FY 2014-15, showing the continued high medical needs of this group. However, while estimated costs for inpatient hospitalization increased from $8.0 million in FY 2007-08 to $25.6 million in FY 2010-11, these costs decreased to $10.0 million in FY 2014-15.

hospitalization costs, typical for homeless adults prior to placement in supportive housing.

Increase in Service Use for Adults in Master Lease Housing

Many individuals who are placed in HSA's Master Lease housing have higher usage of both medical and behavioral health services after placement in housing than before, whether or not they remained housed. These adults likely have under-treated medical, mental health, or substance abuse problems prior to entering the Master Lease program, and HSA should evaluate how to better match shelter users, for example, with medical and behavioral health services.

Of the 883 adults placed in Master Lease housing, 46 adults were among the top 10 percent of service users after placement. Much of these costs were due to inpatient hospitalizations. HSA should evaluate whether these adults with high medical needs should be placed in DPH's Direct Access to Housing program or other medically-intensive placements.

Turnover, Stability, and Use of Services After Leaving Supportive Housing

While supportive housing is considered permanent housing, many adults do not remain in their supportive housing placement. Both DPH and HSA should continue evaluating contributing factors to why individuals leave supportive housing without going into other stable housing, including medical and mental health histories, jail histories, past use of emergency and crisis services, and the availability and accessibility of supportive services. DPH and HSA should also evaluate whether certain supportive housing sites, providers, or programs have relatively higher or lower housing stability rates, and whether individuals at those sites leave supportive housing because they are more stable and able to live independently or conversely because they are unable to achieve stability while housed.

HSA specifically should identify programs and services to reduce turnover and improve outcomes among adults likely to leave Master Lease placements because they are unable to achieve stability while housed, and reevaluate the effectiveness of current housing stability measures. In 2014, HSA revised their supportive housing program to create five tiers of supportive housing with increasing levels of service provision, including three tiers within the Master Lease program. HSA's new tier system standardized service and outcome objectives depending on the type of housing and client need. HSA planned to collect baseline data on the new tier system in FY 2014-15 and establish performance targets. HSA should evaluate how the tiered program has impacted outcomes for adults in the Master Lease program and report to the Board of Supervisors prior to December 2016.

Ongoing Developments and Initiatives in the City's Homeless Programs

Since these 1,818 adults entered supportive housing in FY 2010-11 and FY 2011-12, the City has made changes to programs for the homeless and formerly homeless.

DPH standardized objectives for supportive housing providers in the fall of 2013, and, as noted above, HSA recently implemented a new tiered program for structuring services among their supportive housing providers. In 2014, the City's Homeless Outreach Team received a supplemental appropriation of funding to expand its efforts. The City also opened a temporary "Navigation Center" in 2015 as a place for homeless adults to stay and receive services while they wait for a placement in long-term housing. The City is evaluating the creation of additional centers.

DPH and HSA are also jointly in the process of developing a coordinated entry system, as required by HUD, for all federally supported homeless programs by 2017, with the purpose of targeting individuals with the longest histories of homelessness. Both agencies have also been evaluating the feasibility of moving to a coordinated entry system for all homeless programs. Coordinated entry systems are standard operating procedure in other jurisdictions including Salt Lake City and New York City, and should be a priority for the City.

All of these developments could further alter the general cost and service trends presented in this report by identifying higher-needs populations, improving connections to housing, facilitating greater access to services, increasing housing stability, and enabling better outcomes. The proposed Department on Homelessness in FY 2016-17 provides an opportunity to assess the effectiveness of the various initiatives identified above, ensure that past recommendations for improvement are being implemented, better coordinate information and resources, and clarify and standardize policy goals.

Conclusion

Most of the 1,818 adults who entered supportive housing in FY 2010-11 and FY 2011-12 benefitted from being housed. The City also benefitted from reductions in costs between the time when adults began to enter supportive housing in FY 2010-11 and FY 2014-15, although the City continues to incur significant costs for these adults.

The City has not yet adopted a new long term plan after the expiration of the Ten Year Plan to Abolish Homelessness in 2014. City policy makers need to address the policy issues raised in this report through an updated plan that recognizes recent programs and improvements made by DPH and HSA in providing homeless services and identifies the role of the proposed Department of Homelessness.

Appendix A: Methodology

Supportive Housing Cohort and Matching Service Data

The Budget and Legislative Analyst worked closely with the Department of Public Health (DPH) and Human Services Agency (HSA), with additional support from the Fire Department and Sherriff's Department, to gather service and housing information about a cohort of homeless adults before and after they were placed in supportive housing.

The cohort consists of every adult placed into the City's four largest supportive housing programs (Direct Access to Housing, Master Lease, HUD/Continuum of Care, and Local Operating Subsidy Program) between FY 2010-11 and FY 2011-12, or a period from July 1, 2010 to June 30, 2012. DPH funds and tracks the Direct Access to Housing program, and HSA funds and tracks the remaining three programs.

Each department identified the adults placed in their respective supportive housing programs between July 1, 2010 and June 30, 2012 and assigned each person a unique anonymized numeric identifier. HSA and DPH collaborated to use a custom identifier that would match across HSA's Homeless Management Information System (HMIS) and DPH's Coordinated Care Management System (CCMS). Using the custom anonymized identifier, the departments produced compiled administrative records of service and housing events linked to each of the 1,818 adults in the cohort over an eight-year period from FY 2007-08 to FY 2014-15, or July 1, 2007 to June 30, 2015.

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), DPH excluded all personal identifying information including names, social security numbers, dates of birth, telephone numbers, and demographic characteristics prior to sending the records to the Budget and Legislative Analyst. Children, youth, and family members of adults placed in supportive housing family units were not evaluated.

DPH and HSA provided the Budget and Legislative Analyst with a set of files with service and housing records tied to the anonymized cohort IDs. These files included:

- A cohort file including unique numeric IDs, gender, and year born for the members of the supportive housing cohort
- An HSA supportive housing placement file including program name, move-in date, move-out date, and housing site name
- A DPH housing placement file including supportive housing and stabilization room stays, move-in date, move-out date, and housing site name
- A DPH non-mental health services file including behavioral health, homeless outreach, jail health, death registry, substance abuse, and various types of medical care

- Two DPH mental health services files including various types of mental health treatment services and urgent/emergent psychiatric services
- Three DPH substance abuse service files including data on medical and social detoxification, and various types of substance use treatment
- An HSA file from the CHANGES shelter reservation system providing emergency shelter data
- An HSA file from HMIS including non-CHANGES emergency shelter data, transitional housing, homeless prevention and rapid re-housing, and services-only programs
- An HSA file from the CalWIN database including public benefits data such as CalFresh (formerly known as Food Stamps), CAAP (cash aid for single adults), and CalWORKs (cash aid for families).

The Budget and Legislative Analyst used Stata to merge each adult's service event records with their housing placement record so that each event could be coded as having occurred before housing placement, while in supportive housing, or after housing exit. The Budget and Legislative Analyst consolidated all of the service records files in Stata and categorized each service event record as belonging to one of six main service categories. These included:

Service	**Types**
Primary Medical	• Outpatient services
Emergency/Urgent Care	• Ambulance transports • Emergency Department visits • Psychiatric Emergency Department visits • Inpatient services • Medical Respite • Urgent Care • Sobering Center visits • Psychiatric Inpatient, Residential, and Day Crisis care • Residential Medical and Social Detoxification
Behavioral Health	• Mental Health Outpatient, Day, and Residential Treatment services • Behavioral Health Primary Care • Substance Use Outpatient, Day, and Residential Treatment services • Methadone Counseling and Dosing services
Homeless Services	• Emergency Shelter stays • Transitional Housing • Stabilization Rooms stays • Psycho-social support services • Homeless Prevention & Rapid Re-Housing Programs • Homeless Outreach
Public Benefits	• County Adult Assistance Program (CAAP) • CalWORKS • CalFresh (formerly known as Food Stamps)
Jail	• County Jail records

Cost Estimates

With the exception of public benefit data, actual service event-level cost records were not available. Therefore, the Budget and Legislative Analyst, with assistance from DPH and HSA, developed per-unit cost estimates for each service type in the consolidated data file. Costs were estimated on the basis of either duration or unique service events. Supportive housing, emergency shelter, transitional housing, inpatient care, jail costs, and medical respite, for example, were all calculated on a per-day basis. Ambulance transports, emergency department visits, outpatient care, and sobering center visits, by contrast, were calculated on a per-record or per-visit basis.

In some cases, cost estimates were provided by HSA or DPH, and in others, the Budget and Legislative Analyst estimated costs using program-level budget data from the relevant service years, as available. The cost figures for each service type were inflation-adjusted into constant dollars and then averaged across the sample period.

It is important to note that while many programs that serve the homeless or formerly homeless are General Fund supported, the largest share of service costs are in Emergency/Urgent Care, Primary Medical, and Behavioral Health. These services typically receive a portion of their funding from federal and state sources such as Medi-Cal or Medicare in addition to local general funds, and some grant funding. Therefore, costs presented in this report should not be interpreted as exclusively costs to the City and County of San Francisco. City General Fund support likely constitutes a significant portion of costs presented, and the majority of costs are publicly funded. However, estimating the breakdown of funding sources for each service category and service type would have been difficult, time-consuming, and beyond the scope of this report.

Limitations

1. The service and housing costs assigned to each event (with the exception of public benefits) are estimates and do not represent actual budgetary costs to the City or the public. Instead, the figures are intended to provide a sense of the scale of costs associated with the actual service-level data presented.

2. It was not possible to capture every interaction that the City may have had with each person in this supportive housing cohort. The findings presented in this report are based on the best available information for the most significant service sectors for which the City collects administrative records. There are likely other instances in which City departments interacted with the homeless individuals in the cohort, including the Police Department, Adult Probation, the Recreation and Parks Department, the Department of Public Works, and so on. The Budget and Legislative Analyst believes that the costs associated with these departments that would be traceable to the individuals in the

cohort would be minor, particularly when compared with medical, mental health, jail, or supportive housing costs, for which administrative data was available.

3. Although the Budget and Legislative Analyst collapsed service events into six main service categories to facilitate interpretation of results, it is important to note that there are subcategories that may have trends that are distinct from the category as a whole. For example, ambulance trips may not follow the same trends as other subcategories within emergency/urgent care, such as psychiatric events. Additionally, ambulance trips collapsed within emergency/urgent care cannot be compared with behavioral health treatment and medical care to see how utilization changes over time. Although we can get a general sense of what the main service trajectories look like for the cohort, or particular groups within it, some nuances are lost when evaluating data under broader categories.

4. Although this report presents comprehensive data on the population of homeless individuals placed in supportive housing in FY 2010-11 and FY 2011-12, it is not necessarily representative of the overall homeless population. It is reasonable to believe that the cohort presented in this study is different from the general homeless population because some housing programs, such as Direct Access to Housing, prioritize homeless individuals with the highest needs for housing placement. HSA has also moved to a new tiered contract structure for its supportive housing sites since some of the adults studied in this report received housing placements. The purpose is to organize supportive housing sites based on the characteristics of the units and service needs of the residents (the higher the tier, the greater the service needs). These tiers have specific funding, service and outcome targets, and eligibility and referral processes. Although the Budget and Legislative Analyst believes the cost and service trends presented in this report are generally applicable to the homeless population, they may be somewhat overstated because the supportive housing population is older than the general homeless population and includes more long-term, chronically homeless individuals.

Appendix B: Service Type Glossary

Service	Type	Description
Primary Medical	*Outpatient*	Prevention, stabilization, treatment, and recovery services provided at Department of Public Health clinics and affiliated nonprofit and other health clinics
Emergency/ Urgent Care	*Ambulance*	Emergency Medical Services (EMS) transports provided mainly by SF Fire Department
	Emergency Department	Emergency medical services at San Francisco General Hospital (and recently from other hospital EDs if patient is known member of DPH health plan) for patients who have serious conditions or injuries that require complex procedures and/or hospitalization; patients may arrive without prior appointment either by ambulance or their own means
	Psychiatric Emergency Services	Program at San Francisco General Hospital providing brief emergency mental health care primarily for involuntary patient admissions
	Inpatient	24-hour medical care received while admitted to San Francisco General Hospital (and recently at other hospitals if patient is known member of DPH health plan) by a doctor's order
	Medical Respite	Hospital Inpatient step-down facility, primarily for homeless adults who no longer need hospital-based care but lack adequate community support for medical needs
	Urgent Care	Same-day walk-in medical care for illnesses or injuries requiring immediate care but not requiring complex procedures or admission to a hospital bed
	Sobering Center	Emergency Department diversion facility for individuals needing safe sobering from alcohol intoxication
	Psychiatric Inpatient	Psychiatric Inpatient services at San Francisco General Hospital, or occasionally at St. Francis Memorial Hospital and California Pacific Medical Center, for individuals with severe mental illness who may require urgent care; can be voluntary or involuntary
	Psychiatric Residential Crisis Care	Crisis psychiatric acute diversion facilities for adults with severe mental illness who may be treated voluntarily in the community; utilized to prevent hospitalization or as a step-down from hospitalization
	Psychiatric Day Crisis Care	Psychiatric ED diversion facility at Dore Urgent Care Clinic serving individuals experiencing a brief

		psychiatric crisis who can be stabilized in a voluntary community-based setting
	Residential Medical Detoxification	Community-based hospital Inpatient diversion facility providing medically-managed residential detoxification for individuals needing medication for drug withdrawal
	Residential Social Detoxification	Community-based hospital Inpatient diversion facility providing supervised residential detoxification for individuals not requiring medication support
Behavioral Health	*Mental Health Outpatient Treatment*	Community-based mental health services of less than a half-day provided in voluntary community settings that stabilize, reduce, and teach recovery from psychiatric symptoms
	Mental Health Day Treatment	Mental health services of several hours provided in voluntary community settings that stabilize, reduce, and teach recovery from psychiatric symptoms
	Mental Health Residential Treatment	24-hour mental health care primarily lasting weeks or months in voluntary community settings that stabilize, reduce, and teach recovery from psychiatric symptoms; may include protective long-term care in involuntary facilities
	Behavioral Health Primary Care	Behavioral health care services provided in a primary care setting
	Substance Use Outpatient Treatment	Substance use treatment of less than a half-day provided in voluntary community settings that stabilize, reduce, and teach recovery from substance use problems
	Substance Use Day Treatment	Substance use treatment of several hours provided in voluntary community settings that stabilize, reduce, and teach recovery from substance use problems
	Substance Use Residential Treatment	24-hour substance use treatment lasting weeks or months in voluntary community settings that stabilize health, reduce cravings, and teach recovery from substance use problems
	Methadone Counseling	Counseling sessions for adults receiving methadone replacement therapy for opiate addiction
	Methadone Dosing	Methadone replacement therapy for adults addicted to opiates
Homeless Services	*Emergency Shelter*	HSA-funded shelters where homeless adults can reserve a bed for stays between one and 90 days, as available; some beds set aside for CAAP recipients as part of Care Not Cash for a reduced

		cash benefit
	Transitional Housing	Medium-term housing (six months to two years) for homeless individuals transitioning from the street to permanent housing
	Stabilization Rooms	DPH-funded housing in SRO hotels for homeless individuals transitioning from the street to permanent housing
	Psycho-social support services	Voluntary services including but not limited to: outreach, intake and assessment, case management, benefits advocacy and assistance, and health and behavioral health promotion and interventions
	Homelessness Prevention & Rapid Re-Housing Programs	Federal- and General Fund-supported programs that provide a variety of forms of assistance to individuals and families such as short- or medium-term rental assistance, mediation, credit counseling, security or utility deposits, utility payments, moving cost assistance, and case management
	Homeless Outreach	Street outreach team operated by DPH that provides outreach, engagement, stabilization, and handoffs from the street and engagement into housing, benefits, primary care and behavioral healthcare providers, and other services
Public Benefits	*County Adult Assistance Program (CAAP)*	Cash assistance for low-income single adults in San Francisco; for homeless adults, may include housing, shelter, food, or utilities for a reduced cash benefit
	CalWORKS	Cash assistance for low-income families
	CalFresh	Benefit that helps low-income single adults and families to buy food
Jail	*County Jail*	Days in county jail

Appendix C: Numeric Tables

Chart 1: Use of Services from FY 2007-08 to FY 2014-15 by Homeless Adults Placed in Supportive Housing

Fiscal Year	Primay Medical	Behavioral Health	Public Benefits	Emergency/ Urgent Care	Homeless Services	Jail	Total
2007-08	-	46,967	6,317	4,473	3,281	492	61,530
2008-09	-	57,235	7,186	5,274	3,538	497	73,730
2009-10	6,667	74,347	9,267	7,549	4,962	480	103,272
2010-11	16,773	89,249	13,856	9,789	5,787	369	135,823
2011-12	16,613	91,901	14,437	7,233	4,942	246	135,372
2012-13	12,072	81,376	11,082	5,978	2,284	231	113,023
2013-14	11,054	72,813	9,085	5,352	2,367	205	100,876
2014-15	9,315	66,940	7,576	4,412	1,791	-	90,034

Chart 1a: Number of Homeless Adults Placed in Supportive Housing Using Services Each Year

Fiscal Year	Primay Medical	Behavioral Health	Public Benefits	Emergency/ Urgent Care	Homeless Services	Jail
2007-08	0	415	505	427	340	271
2008-09	0	475	573	531	396	287
2009-10	780	571	717	768	632	296
2010-11	1185	760	897	963	853	231
2011-12	1160	823	877	873	557	170
2012-13	945	728	684	708	231	144
2013-14	848	651	565	610	184	122
2014-15	780	583	464	583	158	0
All Years	1520	1223	1190	1483	1361	653

Chart 2: Average Number of Service Events per Person prior to Housing Placement among Adults in Direct Access to Housing or Master Lease

Service Category	DAH	Master Lease
Medical	25	7
Behavioral Health	216	101
Benefits	13	25
Urgent Care	31	8
Homeless Service	9	19
Jail	1	1

Chart 2a: Average Number of Service Events per Person after Exiting Housing Placement among Adults in Direct Access to Housing or Master Lease

Service Category	DAH	Master Lease
Medical	10	13
Behavioral Health	56	97
Benefits	3	13
Urgent Care	8	9
Homeless Service	1	4
Jail	0	0

Chart 3: Estimated Costs for Services for Homeless Adults Placed in Supportive Housing

Fiscal Year	Public Benefits	Primary Medical	Behavioral Health	Emergency / Urgent Care	Homeless Services	Jail	Total
2007-08	$ 1,372,429		$ 3,111,799	$ 11,335,586	$ 751,435	$ 2,812,608	$ 19,383,856
2008-09	$ 1,661,086		$ 3,633,591	$ 14,395,971	$ 1,212,896	$ 2,299,266	$ 23,202,810
2009-10	$ 2,078,922	$ 3,426,838	$ 4,862,099	$ 23,640,196	$ 3,133,088	$ 2,673,072	$ 39,814,216
2010-11	$ 2,987,825	$ 8,621,322	$ 5,751,446	$ 33,892,388	$ 3,491,150	$ 1,618,857	$ 56,362,988
2011-12	$ 3,585,393	$ 8,539,082	$ 5,252,270	$ 18,542,292	$ 2,152,170	$ 812,592	$ 38,883,796
2012-13	$ 2,986,573	$ 6,205,008	$ 4,445,873	$ 18,230,004	$ 542,854	$ 878,256	$ 33,288,566
2013-14	$ 2,447,065	$ 5,681,756	$ 3,729,846	$ 19,815,482	$ 527,096	$ 580,716	$ 32,781,960
2014-15	$ 2,070,850	$ 4,787,910	$ 3,295,998	$ 14,280,867	$ 400,151		$ 24,835,776
Total by Service Category	$ 19,190,141	$ 37,261,916	$ 34,082,922	$ 154,132,786	$ 12,210,840	$ 11,675,367	$ 268,553,968

Chart 3a: Average Annual Service Costs for Homeless Adults Placed in Supportive Housing

Fiscal Year	Public Benefits	Primary Medical	Behavioral Health	Emergency / Urgent Care	Homeless Services	Jail
2007-08	$ 2,718		$ 7,498	$ 26,547	$ 2,210	$ 10,379
2008-09	$ 2,899		$ 7,650	$ 27,111	$ 3,063	$ 8,011
2009-10	$ 2,899	$ 4,393	$ 8,515	$ 30,782	$ 4,957	$ 9,031
2010-11	$ 3,331	$ 7,275	$ 7,568	$ 35,195	$ 4,093	$ 7,008
2011-12	$ 4,088	$ 7,361	$ 6,382	$ 21,240	$ 3,864	$ 4,780
2012-13	$ 4,366	$ 6,566	$ 6,107	$ 25,749	$ 2,350	$ 6,099
2013-14	$ 4,331	$ 6,700	$ 5,729	$ 32,484	$ 2,865	$ 4,760
2014-15	$ 4,463	$ 6,138	$ 5,654	$ 24,495	$ 2,533	

Note: The average annual service costs are based on adults who used the service category each year. Adults who did not use a type of service in a particular year are not included in the average.

Chart 3b: Median Annual Service Costs for Homeless Adults Placed in Supportive Housing

Fiscal Year	Public Benefits	Primary Medical	Behavioral Health	Emergency / Urgent Care	Homeless Services	Jail
2007-08	$ 1,923		$ 3,631	$ 3,232	$ 1,050	$ 2,223
2008-09	$ 2,114		$ 4,002	$ 3,982	$ 1,550	$ 1,539
2009-10	$ 2,372	$ 2,570	$ 4,271	$ 3,003	$ 3,400	$ 2,394
2010-11	$ 3,081	$ 4,112	$ 4,074	$ 2,919	$ 2,900	$ 1,026
2011-12	$ 4,095	$ 4,626	$ 4,415	$ 2,836	$ 2,650	$ 855
2012-13	$ 4,775	$ 4,112	$ 4,278	$ 2,670	$ 350	$ 1,368
2013-14	$ 4,332	$ 4,112	$ 4,098	$ 3,157	$ 838	$ 855
2014-15	$ 4,378	$ 3,598	$ 3,726	$ 2,670	$ 1,175	

Note: The median annual service costs are based on adults who used the service category each year. Adults who did not use a type of service in a particular year are not included in the median.

Chart 4: Estimated Costs for Supportive Housing and Services from FY 2007-08 to FY 2014-15

Fiscal Year	Service Cost	Supportive Housing Cost	Total
2007-08	$ 19,383,857		$ 19,383,857
2008-09	$ 23,202,810		$ 23,202,810
2009-10	$ 39,814,215		$ 39,814,215
2010-11	$ 56,362,988	$ 5,320,503	$ 61,683,491
2011-12	$ 38,883,799	$ 14,413,592	$ 53,297,391
2012-13	$ 33,288,568	$ 15,843,526	$ 49,132,094
2013-14	$ 32,781,961	$ 13,349,365	$ 46,131,326
2014-15	$ 24,835,766	$ 11,576,257	$ 36,412,023
Total	$ 268,553,962	$ 60,503,243	$ 329,057,205

Chart 5: Share of Annual Service Costs by Service Type in FY 2007-08, FY 2010-11 and FY 2014-15

Service Category	FY 2007-08	FY 2010-11	FY 2014-15
Medical	0%	15%	19%
Behavioral Health	16%	10%	13%
Benefits	7%	5%	8%
Urgent Care	58%	60%	58%
Homeless Service	4%	6%	2%
Jail	15%	3%	0%
Total	100%	100%	100%

Chart 5a: Estimated Costs for Behavioral Health Services for Homeless Adults Placed in Supportive Housing

Fiscal Year	1171 Mission	Methadone Counseling	Methadone Dosing	Primary Care Beh Health	Sub Abuse Day Treatment	Sub Abuse Outpatient Treatment	Sub Abuse Res Treatment	Treatment Mental Health Day	Treatment Mental Health Outpatient	Treatment Mental Health Res	Total
2007-08		$ 45,452	$ 313,742		$ 6,375	$ 193,410	$ 582,010	$ 141,120	$ 1,369,650	$ 460,040	$ 3,111,799
2008-09		$ 57,156	$ 398,762		$ 85	$ 214,650	$ 691,273	$ 151,368	$ 1,615,152	$ 505,145	$ 3,633,591
2009-10		$ 66,506	$ 511,381		$ 2,890	$ 179,280	$ 1,133,649	$ 282,912	$ 1,990,926	$ 694,555	$ 4,862,099
2010-11		$ 84,238	$ 629,616	$ 1,176	$ 5,950	$ 215,100	$ 903,023	$ 525,840	$ 2,616,618	$ 769,885	$ 5,751,446
2011-12		$ 96,008	$ 715,936	$ 51,408	$ 25,585	$ 166,050	$ 300,322	$ 309,120	$ 3,200,496	$ 387,345	$ 5,252,270
2012-13		$ 90,618	$ 650,221	$ 37,296	$ 5,440	$ 114,570	$ 328,515	$ 163,800	$ 2,867,088	$ 188,325	$ 4,445,873
2013-14		$ 88,572	$ 604,565	$ 26,040	$ 4,675	$ 82,440	$ 288,585	$ 132,216	$ 2,311,638	$ 191,115	$ 3,729,846
2014-15	$ 542	$ 87,384	$ 563,186	$ 21,336	$ 595	$ 80,100	$ 334,686	$ 58,464	$ 2,059,650	$ 90,055	$ 3,295,998
Total	$ 542	$ 615,934	$ 4,387,409	$ 137,256	$ 51,595	$ 1,245,600	$ 4,562,063	$ 1,764,840	$ 18,031,218	$ 3,286,465	$ 34,082,922

Chart 5b: Estimated Costs for Emergency/Urgent Care Services for Homeless Adults Placed in Supportive Housing

Fiscal Year	Ambulance	ED	Inpatient	Medical Respite	Out-of-Medical-Group ED	OOMG Inpatient	Sobering Center
2007-08	$ 334,400	$ 950,950	$ 8,066,586	$ 138,768			$ 22,764
2008-09	$ 678,832	$ 1,383,382	$ 9,548,143	$ 380,352			$ 55,826
2009-10	$ 819,280	$ 1,816,815	$ 17,617,710	$ 667,968			$ 80,216
2010-11	$ 610,280	$ 2,117,115	$ 25,654,486	$ 1,419,264			$ 69,105
2011-12	$ 327,712	$ 1,813,812	$ 11,405,306	$ 587,328	$ 128,128	$ 1,085,580	$ 53,929
2012-13	$ 647,064	$ 1,328,327	$ 11,697,444	$ 122,304	$ 155,155	$ 1,647,930	$ 42,547
2013-14	$ 499,928	$ 1,206,205	$ 14,416,116	$ 131,712	$ 276,276	$ 704,160	$ 31,707
2014-15	$ 356,136	$ 1,103,102	$ 10,051,932	$ 54,432	$ 411,411	$ 831,300	$ 34,688
Total	$ 4,273,632	$ 11,719,708	$ 108,457,723	$ 3,502,128	$ 970,970	$ 4,268,970	$ 390,782

Fiscal Year	Urgent/Emergent (UE) Psy Day Crisis	UE Psy ED	UE Psy Inpatient	UE Psy Res Crisis	UE Res Med Detox	UE Res Social Detox	Urgent Care	Total
2007-08		$ 514,052	$ 748,098	$ 375,648	$ 119,520	$ 64,800		$ 9,513,468
2008-09	$ 17,273	$ 762,733	$ 1,060,254	$ 212,205	$ 234,475	$ 62,496		$ 12,046,535
2009-10	$ 105,140	$ 702,649	$ 688,896	$ 441,266	$ 361,465	$ 49,392	$ 289,398	$ 21,001,989
2010-11	$ 159,963	$ 463,982	$ 1,587,690	$ 570,094	$ 480,985	$ 45,936	$ 713,487	$ 29,870,250
2011-12	$ 117,156	$ 393,884	$ 1,369,719	$ 306,719	$ 345,695	$ 18,936	$ 588,387	$ 15,401,795
2012-13	$ 87,116	$ 330,462	$ 1,200,186	$ 233,576	$ 241,530	$ 21,816	$ 474,546	$ 15,640,771
2013-14	$ 85,614	$ 382,201	$ 1,361,646	$ 204,680	$ 147,740	$ 23,472	$ 344,025	$ 17,266,104
2014-15	$ 73,598	$ 307,096	$ 543,582	$ 139,062	$ 142,760	$ 31,608	$ 200,160	$ 12,843,001
Total	$ 645,860	$ 3,857,059	$ 8,560,071	$ 2,483,250	$ 2,074,170	$ 318,456	$ 2,610,003	$ 133,583,913

Chart 6: Use of City Services by Adults who Left Master Lease Placements

Housing State	Medical	Behavioral	Benefits	Urgent Care	Homeless	Jail
Before Placement	4038	64430	14051	4767	12329	703
While in Placement	4382	40095	8625	1760	135	184
After Exit	7377	57041	7602	5404	2600	225

Chart 7: Use of City Services by Adults Who Remained in HSA's Master Lease Program by Housing Status

Service Category	Before Placement	While in Placement
Medical	2,220	5,386
Behavioral Health	24,445	46,479
Benefits	8,202	14,409
Urgent Care	1,920	1,183
Homeless Service	4,107	74
Jail	221	36

Chart 8: Service Costs for Adults with High Service Use Prior to Entering Supportive Housing

Fiscal Year	Public Benefits	Primary Medical	Behavioral Health	Emergency / Urgent Care	Homeless Services	Jail	Total
2007-08	$ 110,513		$ 1,213,074	$ 8,621,582	$ 59,209	$ 698,535	$ 10,702,913
2008-09	$ 121,715		$ 1,327,023	$ 10,683,424	$ 137,967	$ 507,870	$ 12,777,999
2009-10	$ 125,380	$ 823,428	$ 1,591,507	$ 18,033,876	$ 158,828	$ 704,862	$ 21,437,881
2010-11	$ 94,408	$ 2,076,560	$ 1,515,005	$ 25,328,054	$ 253,757	$ 285,570	$ 29,553,354
2011-12	$ 106,917	$ 1,771,758	$ 1,476,866	$ 8,736,432	$ 145,112	$ 111,150	$ 12,348,235
2012-13	$ 93,919	$ 1,074,774	$ 980,676	$ 7,264,664	$ 20,850	$ 166,725	$ 9,601,608
2013-14	$ 67,080	$ 952,442	$ 781,761	$ 6,997,097	$ 31,049	$ 87,039	$ 8,916,468
2014-15	$ 52,672	$ 828,054	$ 717,187	$ 6,600,587	$ 22,136		$ 8,220,636
Total	$ 772,604	$ 7,527,016	$ 9,603,099	$ 92,265,716	$ 828,908	$ 2,561,751	$ 113,559,094

Chart 9: Total Service and Housing Costs for Adults with High Service Use Prior to Entering Supportive Housing

Fiscal Year	Service Cost	Supportive Housing Cost	Total
2007-08	$ 10,702,913		$ 10,702,913
2008-09	$ 12,777,999		$ 12,777,999
2009-10	$ 21,437,880		$ 21,437,880
2010-11	$ 29,553,354	$ 343,254	$ 29,896,608
2011-12	$ 12,348,235	$ 1,349,564	$ 13,697,799
2012-13	$ 9,601,608	$ 1,653,891	$ 11,255,499
2013-14	$ 8,916,468	$ 1,327,525	$ 10,243,993
2014-15	$ 8,220,636	$ 1,118,167	$ 9,338,803
Total	$ 113,559,093	$ 5,792,401	$ 119,351,494

Chart 10: Average Annual Service Costs for Adults with High Service Use Prior to Entering Supportive Housing

Fiscal Year	Average Cost per Person
2007-08	$ 66,067
2008-09	$ 78,877
2009-10	$ 132,333
2010-11	$ 182,428
2011-12	$ 76,224
2012-13	$ 59,269
2013-14	$ 55,040
2014-15	$ 50,745

Chart 11: Total Service Costs for Adults with High Service Use after Entering Supportive Housing

Fiscal Year	Public Benefits	Primary Medical	Behavioral Health	Emergency / Urgent Care	Homeless Services	Jail	Total
2007-08	$ 119,050		$ 859,304	$ 2,696,013	$ 87,631	$ 397,404	$ 4,159,402
2008-09	$ 144,815		$ 943,376	$ 3,763,844	$ 107,605	$ 226,233	$ 5,185,873
2009-10	$ 158,907	$ 665,630	$ 1,057,782	$ 6,263,574	$ 241,589	$ 304,209	$ 8,691,691
2010-11	$ 165,496	$ 1,612,932	$ 1,070,861	$ 11,185,546	$ 289,223	$ 306,945	$ 14,631,003
2011-12	$ 167,278	$ 1,792,832	$ 1,202,204	$ 9,805,774	$ 126,679	$ 171,684	$ 13,266,451
2012-13	$ 118,025	$ 1,538,402	$ 1,151,268	$ 14,358,032	$ 37,665	$ 188,100	$ 17,391,492
2013-14	$ 84,349	$ 1,520,412	$ 1,141,093	$ 16,616,223	$ 70,780	$ 125,685	$ 19,558,542
2014-15	$ 61,479	$ 1,058,326	$ 956,497	$ 11,377,731	$ 65,040		$ 13,519,073
Total	$ 1,019,400	$ 8,188,534	$ 8,382,385	$ 76,066,737	$ 1,026,212	$ 1,720,260	$ 96,403,528

Chart 12: Service and Housing Costs for Adults with High Service Use after Entering Supportive Housing

Fiscal Year	Service Cost	Supportive Housing Cost	Total
2007-08	$ 4,159,402		$ 4,159,402
2008-09	$ 5,185,873		$ 5,185,873
2009-10	$ 8,691,691		$ 8,691,691
2010-11	$ 14,631,003	$ 575,542	$ 15,206,545
2011-12	$ 13,266,451	$ 1,283,013	$ 14,549,464
2012-13	$ 17,391,492	$ 1,420,862	$ 18,812,354
2013-14	$ 19,558,542	$ 1,083,045	$ 20,641,587
2014-15	$ 13,519,073	$ 807,443	$ 14,326,516
Total	$ 96,403,528	$ 5,169,905	$ 101,573,433

Chart 13: Average Annual Service Costs for Adults with High Service Use after Entering Supportive Housing

Fiscal Year	Average Cost per Person
2007-08	$ 26,493
2008-09	$ 33,031
2009-10	$ 55,361
2010-11	$ 93,191
2011-12	$ 84,500
2012-13	$ 110,774
2013-14	$ 124,577
2014-15	$ 86,109

Chart 14: Total Service Costs of 58 Adults with High Service Use Prior to and After Entering Supportive Housing

Fiscal Year	Public Benefits	Primary Medical	Behavioral Health	Emergency / Urgent Care	Homeless Services	Jail	Total
2007-08	$ 40,818		$ 635,397	$ 2,221,139	$ 29,838	$ 239,058	$ 3,166,250
2008-09	$ 34,726		$ 589,395	$ 3,202,317	$ 49,852	$ 172,197	$ 4,048,487
2009-10	$ 31,631	$ 315,082	$ 659,012	$ 5,246,729	$ 42,358	$ 200,925	$ 6,495,737
2010-11	$ 21,014	$ 781,794	$ 562,786	$ 9,221,268	$ 51,998	$ 93,195	$ 10,732,055
2011-12	$ 34,099	$ 787,962	$ 691,961	$ 4,394,404	$ 47,131	$ 52,497	$ 6,008,054
2012-13	$ 26,769	$ 553,578	$ 518,926	$ 6,627,987	$ 6,178	$ 74,556	$ 7,807,994
2013-14	$ 20,312	$ 529,934	$ 419,631	$ 6,428,773	$ 20,224	$ 68,571	$ 7,487,445
2014-15	$ 17,335	$ 407,088	$ 426,512	$ 6,265,096	$ 11,061		$ 7,127,092
Total	$ 226,703	$ 3,375,438	$ 4,503,620	$ 43,607,713	$ 258,640	$ 900,999	$ 52,873,113

Chart 15: Service and Housing Costs of 58 Adults with High Service Use Prior to and After Entering Supportive Housing

Fiscal Year	Service Cost	Supportive Housing Cost	Total
2007-08	$ 3,166,250		$ 3,166,250
2008-09	$ 4,048,487		$ 4,048,487
2009-10	$ 6,495,737		$ 6,495,737
2010-11	$ 10,732,055	$ 143,385	$ 10,875,440
2011-12	$ 6,008,054	$ 461,928	$ 6,469,982
2012-13	$ 7,807,994	$ 597,230	$ 8,405,224
2013-14	$ 7,487,445	$ 451,367	$ 7,938,812
2014-15	$ 7,127,092	$ 363,984	$ 7,491,076
Total	$ 52,873,113	$ 2,017,894	$ 54,891,007

Chart 16: Average Annual Costs of 58 Adults with High Service Use Prior to and After Entering Supportive Housing

Fiscal Year	Average Cost per Person
2007-08	$ 54,591
2008-09	$ 69,802
2009-10	$ 111,996
2010-11	$ 185,035
2011-12	$ 103,587
2012-13	$ 134,621
2013-14	$ 129,094
2014-15	$ 122,881