

# Executive Summary

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## **San Francisco Five-Year HIV/AIDS Housing Plan** *Update*

Prepared for:  
**San Francisco Redevelopment Agency**

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## **To The One**

*You are the warrior,  
Your followers believe in you.  
They care for you,  
They protect you,  
They want you.  
Respect and Love,  
those are your weapons.  
You've won battles with them.  
The fight is lengthy and painful  
but they trust your courage and MORE!*

—Alberto Laos, Community Member

# San Francisco AIDS Housing Plan Update

## Executive Summary

The San Francisco Redevelopment Agency contracted with the Corporation for Supportive Housing and AIDS Housing of Washington to update the San Francisco Five-Year HIV/AIDS Housing Plan (1994). The update to the plan included a review of relevant planning documents and epidemiological data, site visits to AIDS housing programs, key informant interviews, planning sessions, and consumer focus groups and community meetings. This process resulted in the identification of critical issues and recommendations. The Executive Summary provides an overview of important data including recommendations.

### Background

During the spring and summer of 1993, the San Francisco Department of Public Health (DPH), AIDS, in collaboration with the San Francisco Redevelopment Agency (SFRA), initiated a community-based planning process addressing the housing needs of people living with HIV/AIDS. The process included an HIV/AIDS housing needs assessment conducted by the SFRA. The needs assessment and community-based planning effort culminated in the development of the San Francisco Five-Year HIV/AIDS Housing Plan (Five-Year Plan) issued in April 1994.

In 1997, the SFRA contracted with the Corporation for Supportive Housing (CSH) and AIDS Housing of Washington (AHW) to update the Five-Year Plan. CSH is a nonprofit national intermediary whose mission is to expand the quantity and quality of permanent supportive housing. CSH works in San Francisco and other Bay Area communities, and contracts with the SFRA to provide technical assistance to HIV/AIDS housing providers in San Francisco. AHW is a Seattle-based nonprofit organization which develops AIDS housing in the Seattle metropolitan area and, through a grant from the U.S. Department of Housing and Urban Development (HUD), provides technical assistance to agencies and communities nationwide.

### Planning Process

The update to the Five-Year Plan (Update) included an HIV/AIDS housing needs assessment and a community-based planning process that incorporated the input of interested community members, including people living with HIV/AIDS, AIDS service and housing providers, housing developers, representatives of local government agencies, members of the Mayor's HIV Health Services Planning Council (CARE Council), and members of the general public. Three general planning sessions, three RCF-CI program meetings, two rental assistance provider meetings, and a housing provider focus group were held to discuss critical issues and strategies to address those issues. Site visits were made to the following programs providing housing and/or substance abuse treatment to people living with HIV/AIDS:

A Woman's Place	Peter Claver Community
Cannon Kip Community House	Planetree Housing (Walden House)
Richard M. Cohen Residence	Precita House (Black Coalition on AIDS)
Derek Silva Community	Rafiki House (Black Coalition on AIDS)
Gift of Love Home	Redwood Center
Harbor Light Program	Restoration House
Hazel Betsey Program	Rita de Cascia
Larkin Street Assisted Care Program	Supported Living Program (Baker Places, Inc.)
Leland House	Western Addition Recovery House
Marty's Place	

In addition, AHW and CSH held five focus groups with people living with AIDS and two consumer forums to receive input on critical issues and feedback on proposed recommendations.

## **The Context of AIDS Housing in San Francisco**

This is a period of tremendous hopefulness and opportunity for people living with HIV/AIDS. At present, at least one-half of the people living with HIV/AIDS are able to access and respond well to protease inhibitors and/or other combination therapies. Life expectancy has increased due not only to these new therapies but also the availability of quality care through a cadre of experienced medical clinicians in communities such as San Francisco. However, it is a challenging time to be engaged in planning housing for people living with HIV/AIDS. Due to changes in the epidemic and federal funding, there is more uncertainty in the AIDS housing field today than ever before. The real estate and rental markets in San Francisco significantly impact the ability of many residents of the city, and certainly all low-income residents, to find safe and affordable housing. Available federal funding, the changing demographics of the population of people living with HIV/AIDS, advances in AIDS treatment protocols, and the unavailability of affordable housing all impact planning for and providing AIDS housing and supportive services.

### **Changing Needs of People Living with AIDS**

The ability to successfully utilize new therapies is directly linked to stability in housing. We know that successful treatment with these drugs requires strict adherence to daily medical protocols. Some medications require refrigeration. Others need to be taken before meals on an empty stomach, others after meals. Individuals are taking medications four or five times a day. Compliance is difficult; for those who are homeless, it is close to impossible.

Some people living with HIV/AIDS who are successfully taking the new therapies, particularly those with an established work history prior to disability, are considering a return to work. To do so, a range of complicated issues must be considered including the possible loss of disability income, medical benefits, and housing, and fear about what happens when or if their health declines again. The potential of having to work one's way through the disability system for a second time is daunting. For people living with HIV/AIDS and histories of mental illness, homelessness or substance abuse who were marginally employed or unemployed prior to AIDS, returning to work without substantial training and work preparedness is not a viable option.

Housing success for these individuals is linked to case management and access to an array of support services.

In 1994, the Five-Year Plan very clearly identified a shortage of beds to provide 24-hour attendant, skilled and hospice care for individuals in need. Since that time more than 100 Residential Care Facility for the Chronically Ill (RCF-CI) licensed beds have been developed or existing beds licensed. Today, the demand for these types of services has shifted. Although many people need the level of supervision and services RCF-CI programs can offer, few individuals on the HIV/AIDS housing waitlist are choosing that level of care as their housing goal. Some individuals require supervision and support due to behavioral health issues rather than a need for nursing services. Others are utilizing these licensed beds for “tune ups” and could be discharged to permanent housing or their own homes at a lower cost, if those housing resources were available. Even with these shifting consumer needs, in San Francisco, at least 320 individuals died from AIDS in 1997<sup>1</sup> and required a range of end-of-life services.

In 1998, San Francisco has the highest housing costs in the country, a vacancy rate below 1%, unemployment of 3.9%, and very little developable or vacant properties. Most people living with HIV/AIDS in San Francisco have access to good medical and social services, but many lack access to affordable and safe housing or do not have adequate income to pay their rent. In such an extremely tight rental market, it is difficult even for individuals who do receive a rental subsidy to find safe affordable housing. As of December 31, 1997 there were 7,963 people living with AIDS in San Francisco and more than 3,000 individuals on the HIV/AIDS Housing Waitlist in need of housing assistance.

## **Funding**

Congress has reduced the amount of overall funding for HUD in FY 1998, including flat funding for all homeless programs for the third straight year, and called for the elimination of all new Section 8 subsidies and project-based subsidies by 2002. With the balanced budget amendment, there may not be enough money in the HUD budget to handle all of the Section 8 renewals and the expenses of operating housing authority properties. Although the current HUD budget proposes some increases, funding for homeless programs, the Housing Opportunities for Persons with AIDS (HOPWA) Program, and other housing programs for the disabled and elderly remain under extreme budgetary pressure.

Although there have been modest yearly increases in the total amount of HOPWA funds, the number of metropolitan areas and states that are eligible to receive formula allocations of those funds is increasing each year. In 1992 there were 27 EMSAs and 11 states eligible to receive formula allocations of \$42,935,000 in HOPWA funds. By 1995 funding had increased to \$153.9 million, but grantees increased to 66 (43 EMSAs and 23 states). In 1997, although grantees increased by 21% to 80, funding only increased by 15% to \$176.4 million. There has been a fluctuation in HOPWA funding received by San Francisco since 1992, which reached a plateau with the 1994 allocation of \$10 million. Per capita funding also peaked in 1994 at \$1,469 per person living with AIDS. Based on the number of people known to be living with AIDS on January 1, 1998, the FY 1998 HOPWA allocation has decreased to \$904 per capita. The HIV/AIDS specific housing resources available in San Francisco do not and cannot meet the

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<sup>1</sup> AIDS Surveillance Report, San Francisco Department of Public Health, December 1997.

housing needs of all people living with HIV/AIDS.

Since the epidemic first began twenty years ago, San Francisco has been known throughout the world for the wide array of social and medical services available to consumers and for its tremendous compassion and caring for people living with HIV/AIDS. Both the community and nonprofit agencies have responded to the AIDS crisis and emergent issues. The 1997 HIV Resource Guide lists more than 500 organizations, many of which are HIV/AIDS specific. More than 20 organizations provide housing or housing assistance to people living with HIV/AIDS. It can be difficult for consumers to navigate among so many different agencies, and change necessarily comes more slowly within such a large system.

## **Real Estate and Housing Factors**

The rental housing market in San Francisco is extremely tight for people seeking housing at all rent levels. Occupancy rates are very high, and there is significant competition for available rental housing. In such a market, some individuals are willing and able to pay a year's rent in advance. For individuals who are low-income and/or utilizing a subsidy to cover a portion of their rent, options are very limited.

The Fair Market Rent (FMR) is a rent level set by HUD for a state, county, or urban area that defines the maximum allowable rents in subsidy programs. Given high housing costs and the competitive rental market in San Francisco, it has been difficult for consumers to locate units that meet FMR requirements. In early 1998, the City of San Francisco requested that HUD raise the FMR to 140% of current levels. While considering the request, HUD approved across-the-board exception rents at the following levels: \$724 per month for an efficiency apartment, \$937 per month for a one-bedroom apartment, \$1,184 for a two-bedroom apartment, and \$1,625 per month for a three-bedroom apartment.

In 1996 it was estimated that many individuals were unable to afford the FMR for apartments in San Francisco without incurring a cost burden. A person incurs a housing cost burden when they spend 30% or more of their income on housing and utility costs.

- 32% of all residents were unable to afford the FMR for an efficiency apartment,<sup>2</sup>
- 40% of the population were unable to afford the FMR for a one-bedroom apartment, and
- 51% were unable to afford the FMR for a two-bedroom apartment<sup>3</sup> without incurring a cost burden.

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<sup>2</sup> Mean Sweeps: A Report on Anti-Homeless Laws, Litigation and Alternatives in 50 United States Cities, National Law Center on Homelessness and Poverty, December 1996, p. 6.

<sup>3</sup> Out of Reach: Can American Pay the Rent?, National Low-Income Housing Coalition, May 1996, p. 12.

Actual rent levels typically exceed the FMR levels, and are significantly higher in San Francisco; therefore, it is likely that a higher percentage of residents are impacted by cost burdens. It is estimated that almost three-quarters of extremely low-income renters (earning less than 30% of area median income) have a cost burden, while more than half have a severe cost burden and are considered at risk of homelessness.<sup>4</sup> In addition there are an estimated 8,000–10,000 homeless individuals in San Francisco.

## AIDS in San Francisco

San Francisco is often described as the epicenter of the AIDS epidemic. At the end of 1996, the city ranked third among metropolitan areas in cumulative reported AIDS cases and fourth in annual rates per 100,000 population. At the end of 1997, 24,962 cumulative cases of AIDS had been reported in San Francisco, and 7,963 people were known to be living with AIDS. **Table 1** presents the demographics of cumulative reported AIDS cases and people known to be living as of December 31, 1997, by race/ethnicity, gender, age, and transmission category.

The proportion of living cases in women, African Americans, and Hispanics have increased yearly between 1990 and 1997, and living cases among gay and bisexual men have decreased yearly. There has been a dramatic increase in the proportion and number of people living with AIDS between the ages of 20 and 29. As of December 31, 1996, 379 people in that age group were living with AIDS, representing approximately 5% of the total population of people living with AIDS. One year later those figures had risen to 1,043 and 13%, respectively. The proportion of living cases in those age 30 and over has decreased each year between 1990 and 1997.

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<sup>4</sup> Continuum of Care: A Five Year Strategic Homeless Plan 1996–2001, the City and County of San Francisco, August 1996, p. 20.

*Table 1*  
**Profile of Cumulative AIDS Cases and People Living with AIDS in San Francisco  
as of December 31, 1997\***

Demographic Category	Cumulative AIDS Cases <i>n=24,962</i>		People Living with AIDS <i>n=7,963</i>	
	Number	Percent	Number	Percent
<b>Race/Ethnicity</b>				
Caucasian	18,813	75%	5,556	70%
African American	2,819	11%	1,143	14%
Latino	2,559	10%	972	12%
Asian/Pacific Islander	661	3%	253	3%
American Indian/Alaska Native	110	<1%	39	<1%
<b>Gender</b>				
Male	24,120	97%	7,524	95%
Female	842	3%	439	6%
<b>Age</b>				
19 and under	69	<1%	20	<1%
20–29	2,941	12%	1,043	13%
30–39	11,471	46%	3,736	47%
40–49	7,665	31%	2,392	30%
50 and over	2,816	11%	772	10%
<b>Transmission Category</b>				
Gay or bisexual male (MSM)	20,059	80%	6,059	76%
Injection drug users (IDU)	1,637	7%	783	10%
Gay/bisexual male IDU	2,483	10%	801	10%
Lesbian/bisexual IDU	31	<1%	19	<1%
Hemophilia	39	<1%	14	<1%
Heterosexual contact	301	1%	164	2%
Transfusion/tissue	194	1%	32	<1%
Risk not reported or identified	177	1%	85	1%
Pediatric	41	<1%	6	<1%

\*Note: Percentages may add up to more than 100% due to rounding.

The San Francisco Department of Public Health analyzed data related to living cases to determine the proportion of low-income and homeless individuals as of the end of 1996.<sup>5</sup> Income and homelessness data was stratified by male and female, white and non-white, and MSM (including MSM IDUs) and other risk groups for comparison. Women and non-whites are more likely to be low-income and homeless, and those with a risk factor other than MSM were more likely to be low-income. **Table 2** presents the results of this analysis.

*Table 2*  
**People Living with AIDS in San Francisco (1996), by Low-income and Homeless Status**

Category	Total Living (n=7,365)		Low-income (n=2,794)		Homeless (n=314)	
	Number	Percent	Number	Percent	Number	Percent
Men	6,970	95%	2,582	93%	267	85%
Women	395	5%	202	7%	47	15%
White	5,162	70%	1,721	62%	133	42%
Non-white	2,203	30%	1,063	38%	181	58%
MSM	6,342	86%	2,215	80%	158	50%
Other risk groups	1,023	14%	569	20%	156	50%

## HIV/AIDS Housing Inventory

There has been a significant increase in the number of HIV/AIDS dedicated housing resources since the Five-Year Plan was issued in 1994. **Table 3** presents the number of beds/units by type. **Table 3** includes a wide range of housing and treatment resources, including a one-week emergency hotel voucher, permanent housing, a stay in a detoxification bed, and long-term transitional housing for those in recovery. In addition to these resources, more than 1,500 unduplicated individuals receive financial assistance annually, averaging \$300–400 in assistance for housing and/or utility costs. A detailed inventory is included in the San Francisco HIV/AIDS Housing Plan Update, beginning on page 20.

<sup>5</sup> Trend Analysis of Persons Living with AIDS in San Francisco; San Francisco Department of Public Health, AIDS Office, June 1997. For the purposes of the DPH's analysis, "low-income" was defined as the HUD low-income limit of \$29,100 for one person in San Francisco. The actual income of infected individuals is not tracked. In this analysis, the DPH utilized the median income for the census tract where the individual resided at diagnosis. In addition, this analysis was based on information that was current as of the individual's diagnosis, and therefore cannot account for changes in income or housing status over time.

*Table 3*  
**HIV/AIDS-dedicated Housing Beds/Units in San Francisco,  
by Type**

Type of Housing	Number of Beds/Units
Detoxification Beds	29
Emergency	800
Transitional/Residential Treatment*	215
Transitional Subsidies	80
Permanent Congregate	64
Permanent Independent	103
Permanent Rental Subsidies	766
Long-term Shallow/Partial Rent Subsidies	256
RCF-CI Licensed**	114
Skilled Nursing Facility	52
<b>Total</b>	<b>2,479</b>

\*This category includes residential treatment, recovery, and other transitional beds. Lengths of stay range from 45 days to more than 18 months.

\*\*The total includes 10 late-stage beds located at Leland House.

## Critical Issues Summary

Critical issues identified in the needs assessment process include rental subsidies, capital project development, licensed housing, the HIV/AIDS Housing Waitlist, special populations, and systems integration. These recommendations reflect changes in the housing market in San Francisco since the Five-Year Plan was completed in 1994, and the emergent needs of people living with HIV/AIDS whose need for housing and services may 1) be related more to mental health, substance abuse, and periods of homelessness than health care issues, and 2) change over time as their health conditions fluctuate. People living with HIV/AIDS and HIV/AIDS housing and service providers were involved in the identification of critical issues and the development of strategies to address those issues. In addition, data related to the HIV/AIDS Housing Waitlist, the San Francisco Housing Authority's AIDS housing program, and the epidemiology of HIV/AIDS in San Francisco was reviewed in depth.

**Rental Subsidies** Repeatedly, the challenging rental market was noted as a barrier to meeting the housing needs of people living with HIV/AIDS. Consumers and providers noted that it was extremely difficult to utilize a subsidy in a market where individuals are willing and able to pay a year's rent in advance. Landlords do not have incentives to become and stay involved with the subsidy program. Paperwork and potential damage to apartments are impediments to landlord involvement. The FMR levels set by HUD are substantially lower than the costs of available units. The impact of recently approved exception rents on consumer access to housing must be evaluated. Restrictions on pooling subsidies to allow for communal living limit the options of subsidy recipients willing to live in shared housing. Some individuals would move out of San Francisco to access affordable housing if the regulations governing their rental subsidies would allow such a

move. In addition to the barriers noted, the housing search process is extremely difficult for those who may be dealing with weakened immune systems, opportunistic infections, and in some cases, mental illness, substance abuse, or both. The challenges of using rent subsidies are borne out by the facts: 10% to 30% of subsidies are returned because no eligible apartment is found within the timeframe permitted for the housing search.

***Licensed and other Capital Projects*** Many of the “capital” projects owned by nonprofit developers that were developed based upon the recommendations in the Five-Year Plan are licensed buildings intended to serve people with a need for a high level of medical services. A higher than expected percentage of those now living in these licensed buildings, and those that are applying for available beds, have significant mental health and/or substance abuse issues, in addition to medical needs associated with HIV/AIDS. For individuals who do not need a high level of medical care, there are few openings in nonprofit-owned permanent housing buildings. In addition, the costs of development have increased since the Five-Year Plan was developed—in some cases to more than \$200,000 per unit for family housing.

***Service Needs and Special Populations*** While the new treatment protocols have improved the health status of many individuals, the long-term impact is not yet known. Although mortality rates have dropped substantially, health conditions of many of those taking the new medications still fluctuate significantly. New infections are rising among young people and women. It is more difficult for homeless people and people with disabilities like mental illness and chemical dependency to access treatment and to follow treatment protocols. As some people are living longer and feeling better, they are reassessing whether or not they can return to work, or in the case of those who have been out of the workforce for some time, obtain employment. Others are facing eviction as they deplete savings and utilize an ever-increasing portion of their monthly income to maintain their housing.

The combination of these issues—new treatments, the health status of people living with HIV/AIDS, and the rental and real estate markets in San Francisco—drive many of the recommendations included below and to a large extent dictate the possible solutions to critical housing-related issues. As the real estate market, utilization of existing housing programs, and individual care needs evolve, the recommendations included herein should be updated and re-evaluated regularly.

## **Recommendations**

It is suggested that recommendations in bold be prioritized for implementation.

### **Rental Assistance**

Rental subsidies are by far the type of housing assistance that has the highest demand among people living with AIDS. Currently there is a wide range of rental assistance programs. For individuals who do receive a subsidy, it is difficult to find an appropriate place to live because of rental prices that exceed the FMRs and the complexity of the housing search process. Ten to thirty percent of recent rental subsidy recipients returned the subsidy unused because they were unable to find an affordable apartment within the time period allowed. Through the end of 1997, 86% of individuals enrolled on the HIV/AIDS Housing Waitlist had indicated that a subsidy was their first

housing goal. In addition, many individuals have indicated the need for some rent subsidy in order to remain in their home. Thus, they must utilize an increasing portion of their monthly income and/or savings to meet their rent expenses. While the new treatments extend life, each individual's ability to work, and therefore their income, may fluctuate significantly over time. Given the extremely tight rental market, where appropriate, it is more cost effective to assist individuals to maintain their housing, rather than to try to help them once they are homeless.

1. **The SFRA should seek out linkages with all programs that can assist people living with HIV/AIDS to more effectively find appropriate affordable housing, especially privately-owned apartments that will accept rent subsidies. This would include appropriate search and referral programs, resource listings, as well as information to assist prospective tenants with poor credit or rental histories.**
2. The SFRA should work with HUD to change subsidy regulations so that rental assistance recipients may be allowed to pool subsidies in order to live in multi-bedroom shared housing and apartments.
3. The City should change its rent control ordinance so that it applies to units which house persons with HOPWA and other HUD-funded rent subsidies.
4. The SFRA should establish a small grant fund for minor repair of apartments used by rental subsidy tenants on a one-year pilot basis and assess effectiveness in keeping landlords renting to subsidy recipients. Such a grant should be made only to landlords who agree to leases at fixed rents for the amortized life of the improvements and agree not to pass through the costs of these capital improvements to new tenants.
5. The DPH, CARE Council, SFRA, and CHAS should jointly request that the mayor establish a one-year initiative to inspire and recognize private landlords' participation in the rental subsidy program. This might include a reception, certificates and flowers for landlords who have provided a minimum number of units to the rent subsidy program, or lunch with the mayor and/or a local or visiting celebrity or dignitary. The San Francisco Housing Authority should identify and address paperwork simplification and other issues which would encourage landlord participation.
6. **The HIV/AIDS Housing Network should consider the programmatic benefits and downfalls of 1) the increase in the FMR, including an evaluation of its impact on consumer access to housing and the cost of rental housing for those without subsidies; 2) possible conversion of HOPWA subsidies from certificates to vouchers and the potential change to permit rent subsidies to be used outside of San Francisco; 3) development of the HOPWA Shallow Rent program; 4) methods of increasing participation of landlords in the rent subsidy program, including the possibility of requiring participation from developers that receive City redevelopment or housing funds; and should 5) seek clarification from HUD and the Health Resources and Services Administration (HRSA) regarding the utilization of HOPWA and Ryan White funding for a variety of short- and long-term rental subsidy programs. The working group should track progress on these endeavors and work with the DPH and SFRA to report its findings to the CARE Council by March 1, 1999.**

### *Shallow Rent Subsidy Programs*

7. **The SFRA should immediately develop guidelines and implementation strategies for a pilot shallow rent subsidy program intended to prevent evictions for those who are not currently receiving a housing subsidy. Guidelines should include caps on income and rent levels and should permit rent levels above the FMR set by HUD. This program must be coordinated with the existing similar programs and should reflect the best aspects of those programs.**
8. The AIDS Office should develop guidelines and implementation strategies for an emergency assistance program specifically targeting individuals who have permanent housing and are at risk of losing that housing, because they need to temporarily access (for up to 30 days) a higher level of care due to health deterioration.
9. The SFRA should establish a new “interim assistance” shallow rent subsidy tied to the planned DPH Direct Access to Housing Program, targeting those who are leaving RCF-CI, treatment programs, and transitional housing (including individuals “aging out” of programs targeted to young adults) and who have incomes below \$750 per month.

### Capital Projects

There is a need for additional HIV/AIDS dedicated housing resources. However, site availability and the extremely tight and expensive housing market in San Francisco limit development options. Capital projects can provide the kind of long-term affordability difficult to achieve under rental subsidy programs. The dearth of affordable permanent housing in San Francisco creates a void in the continuum of housing available to people living with HIV/AIDS. Even in the best of circumstances it can be difficult to secure rental housing in San Francisco, and it is much more difficult for individuals who are utilizing a subsidy and/or do not have strong rental or credit histories. Capital projects, owned by nonprofits, with site-based services may be more willing to admit those who would be excluded by apartments on the private rental market. Over time, the availability of these affordable units can be more cost-effectively guaranteed than the availability of units on the private market.

The capital development recommendations reflect the following: women and young adults are the fastest growing populations of people living with AIDS; consumers prefer to live in housing that mixes different populations; and nonprofit-owned supportive housing can effectively serve multiply diagnosed individuals. For individuals exiting emergency shelters or transitional programs, long-term housing options are limited. Given the lack of affordable housing, this logjam precludes prioritizing the development of additional transitional housing beds at this time. In addition, given the new treatments available, this plan does not recommend the development of additional licensed or high-end care beds at this time. However, as the care needs of people living with AIDS change with the epidemic and advances in medical treatment protocols, this should be re-evaluated regularly.

10. **The SFRA, DPH, CARE Council, and advocates should seek additional opportunities to establish set-asides for persons living with HIV/AIDS in mainstream affordable housing projects, such as development under the new affordable housing bond measure; other**

**citywide housing programs including Treasure Island, if feasible based on the City’s plans for housing there; or other nonprofit-sponsored projects for single adults/couples (with a priority on funding projects that include at minimum a studio with kitchen and bath) and families with a goal of adding 30 units per year (including a minimum of 5 multi-bedroom family units). Programs that target extremely low-income and homeless people, young adults and women, with or without children, should be given a high priority. HOPWA funds should be used to leverage these set-asides to the extent necessary.**

11. The SFRA should fund at least one site-based housing program based on a harm reduction model for single adults living with HIV/AIDS who have substance abuse problems and/or mental illness. Explore incorporating this program into a larger housing development for low income and/or homeless people in San Francisco. This project should be fewer than 40 units, or make up 50% or less of a larger project.
12. The SFRA should set as its goal ensuring the affordability of HOPWA-funded capital developments to people with very low and extremely low incomes for as long as possible, when necessary utilizing HOPWA funds if other rent subsidies are not available.

### Licensed Projects

As a result of need identified through the Five-Year Plan, approximately 120 Residential Care Facility for the Chronically Ill (RCF-CI) licensed beds were developed or existing beds became licensed. As care and service needs of people living with AIDS change, the RCF-CI programs continue to evolve to best meet the needs of residents. Licensed providers have found that a higher than anticipated number of tenants and prospective tenants have significant mental health and substance abuse issues.

13. The RCF-CI providers, with the support of the DPH and SFRA, should develop a centralized outreach program and intake process to work with mental health providers, hospital discharge planners, etc. to facilitate enrollment of individuals needing RCF-CI level of care on the HIV/AIDS Housing Waitlist.
14. **Utilize the existing RCF-CI working group to incorporate the results of the ongoing evaluation of RCF-CI licensed programs in a reorganization of program structure.**
  - **Differentiate those programs that have permanent housing funding and those that do not, in order to facilitate utilizing the resources for emergent needs, including short stays or “tune-ups” for those living in other housing settings.**
  - **Evaluate core competencies and/or opportunities for specialization.**
  - **Identify effective approaches to strengthen services to residents with substance addiction, mental illness, and/or dementia., such as partnerships with other agencies that specialize in these services, staff training, changes in staff qualifications, etc.**

**Recommendations and analysis from this working group should be forwarded to the SFRA and the CARE Council by December 31, 1998.**

15. The SFRA, DPH, and CARE Council should jointly plan for and implement funding decisions related to the RCF-CI licensed programs. Prior to prioritization of CARE funds for the RCF-CI

programs, the SFRA and CARE Council Housing Committee should make a joint presentation to the CARE Council on relevant HOPWA/CARE budget issues. Once prioritization is complete, a CARE Council representative should present the outcomes related to RCF-CI programs to the SFRA and its commission.

16. The SFRA should provide training and written materials to RCF-CI providers which clarify the points at which state licensing and HUD requirements differ, as well as other legal issues and how to address them.
17. The SFRA and DPH should identify gaps in available transportation services for people living in licensed facilities and develop a mechanism to increase access for those residents.
18. The SFRA and DPH should develop mechanisms to increase access to attendant care for individuals in RCF-CI programs who require more care during acute illnesses or when they are at end-stage.
- 19. The RCF-CI working group should incorporate appropriate recommendations from the *Evaluation of Five San Francisco Residential Care Facilities for the Chronically Ill* into system changes and determine a timeline for changes by December 31, 1998.**
20. The SFRA and DPH should continue to evaluate the need for existing and/or additional RCF-CI licensed beds.

### HIV/AIDS Housing Waitlist

The HIV/AIDS Housing Waitlist (formerly known as CHIPS) was developed as a result of the Five-Year Plan and as of February 1998, comprises nearly 3,000 people living with AIDS who are in need of housing assistance. There has been confusion on the part of consumers and providers about what function the Waitlist has, how the Waitlist facilitates movement into housing programs, and the relationship between the Waitlist and AIDS housing programs.

- 21. The HIV/AIDS Housing Waitlist administrator should develop, with client review and input, user-friendly educational materials and trainings on the HIV/AIDS Housing Waitlist for consumers and providers. Areas of focus should include: enrollment, waiting list, housing programs which utilize the HIV/AIDS Housing Waitlist, the estimated waiting time to obtain various kinds of housing, how consumers can get involved in housing advocacy, and program-specific eligibility criteria. The SFRA, DPH, and Department of Human Services (DHS) should distribute this information to mental health, substance abuse, health care, homeless, and HIV/AIDS providers.**
22. The Housing Waitlist administrator should develop and deliver an annual training to providers of services to homeless people, including shelter staff, case managers at San Francisco General Hospital and the jail. The training should provide specific information which will ensure that as many homeless people as possible remain engaged with the system through comprehensive intake and placement. The SFRA, DPH, and DHS should perform outreach and invite providers they fund to the annual training.

## Special Populations

### *Homeless*

There are an estimated 8,000–10,000 homeless persons in San Francisco. Local data suggests that 9% of homeless individuals are HIV-infected. However, national estimates indicate that up to 20% of homeless people may be HIV-infected, or as many as 1,600 to 2,000 people in San Francisco. Individuals who are homeless often get “lost” between brief enrollment and comprehensive intake to the HIV/AIDS Housing Waitlist, and are less likely to be placed into housing than non-homeless individuals. Homeless people living with HIV are more likely to be people of color and to have issues related to mental illness and substance abuse than non-homeless people living with AIDS. As of the end of 1997, 22% of the individuals on the Waitlist were homeless at the time of enrollment, yet only 10% of those placed in permanent housing from the Waitlist were homeless at enrollment.

### *Young Adults*

Between 1990 and 1997, the number of people under the age of 40 living with AIDS grew from 25% to more than 60% of the total number of people living with AIDS in San Francisco. Since 1990, the number of people between the ages of 20 and 29 living with AIDS grew from 1% to 13% of the total number living with AIDS in San Francisco. Even more dramatically, this population more than doubled between December 1996 and December 1997. Approximately 200 of those young adults are between the ages of 20 and 24. It is also reported that 10.5% of youth entering homeless shelters test positive for HIV. Youth who are housed in programs targeting youth and young adults face the prospect of “aging out” of these programs and needing to transfer within the HIV/AIDS Housing system to other housing options.

### *Women*

The proportion of women living with AIDS has tripled since 1990. As of the end of 1997, there were 439 women living with AIDS in San Francisco. Based on a DPH analysis of the characteristics of those living with AIDS, women were more likely to be low-income and homeless than their proportion of the total population living with AIDS would indicate. Most women living with AIDS are responsible for taking care of either children or aging family members and report great difficulty in securing housing that can accommodate extended family. Temporary housing displacement due to illness can create especially complex problems for women with dependent children

*Additional recommendations included in the Rental Assistance, Capital Projects, and Services sections address issues related to the Special Populations.*

- 23. Require rental subsidy programs for people living with HIV/AIDS to identify in writing to their funding agencies by December 31, 1998 changes they will make in admissions policies or service programs that would improve their level of service to homeless people. Elements of such plans may include changes in tenant screening criteria, establishment of services that address the needs of homeless people, and improved outreach to homeless applicants for available slots. Provide technical assistance and/or training to improve the ability of these programs to serve homeless people.**

## Services

While new treatments are improving the health status of many individuals, it is not yet clear how many will be able to return to work, or return full-time, despite the fact that they are living longer. Employment counseling and services are needed to sort out these issues and assist those who can go to work. Many housing providers are struggling with tenant substance abuse issues, balancing their effort to maintain a “clean” environment for those who are trying to stay sober with the reality of trying to keep those who are still using from becoming homeless. While these providers may have strong skills in providing health and other services to people living with HIV/AIDS, new approaches are needed to address the substance abuse and mental health issues they now confront. New approaches to providing and financing housing-linked services are required to ensure that as many people as possible obtain housing and remain housed.

24. The SFRA and DPH should establish protocols for services linking substance abuse and mental health counseling to the proposed “interim assistance” rent subsidy program which will help move people, to the extent possible, out of RCF-CI and transitional programs and into more appropriate housing settings when their care needs change.
- 25. The DPH should restructure its use of the California State Medi-Cal AIDS waiver and, as other counties do now, utilize it to reimburse for services provided through licensed projects and for a range of other services to people in rent subsidy programs.**
26. The SFRA and DPH should provide annual training on harm reduction service strategies in supportive housing, both for providers of housing to people living with HIV/AIDS and for residents of the housing.
27. The SFRA and DPH should ask providers of housing for people living with HIV/AIDS, as part of their contract renewal process, to 1) identify how they will assist interested residents in linking with agencies that provide employment services and benefits advocacy to obtain information and assistance related to job preparation, job placement, and the potential impact of employment on SSI, Medi-Cal, and other public benefits; and 2) obtain and report to the two agencies information from tenants or residents on their need for employment services and their goals for becoming employed.
28. The Private Industry Council and DHS should offer at least two opportunities annually for people living with HIV/AIDS and HIV/AIDS service providers to inform employment training program grantees about special issues related to delivering these services to people living with HIV/AIDS.
29. The SFRA and DPH should consider utilizing the proposed storefront outreach centers meant to provide information and assistance to very low-income and homeless people living with HIV/AIDS as centers for mobile services linked to the rent subsidy and shallow rent subsidy programs proposed in this Update.
30. Every DPH-administered consumer survey for people living with HIV/AIDS should include questions about housing status jointly developed with the SFRA and CARE Council Housing Committee. Suggested information to gather includes: current housing status (specifically addressing homelessness, those who are doubled up, etc.), rent paid and current income (to determine proportion of income paid to rent), appropriateness of current housing (accessible

given current health, etc.), and what assistance individuals need to maintain housing (modifications to apartment, an additional dollar amount per month, etc.).

31. DPH should seek opportunities to redirect contractual services to ensure that people living with HIV/AIDS obtain and keep their housing placements and to ensure that effective coordinated services are provided to those living in HIV/AIDS housing.
32. The SFRA should request all property managers of HIV/AIDS-dedicated housing to submit a copy of their policies regarding the screening of persons with histories of incarceration by December, 31 1998. If these policies automatically exclude persons with specific criminal records from accessing any housing, the SFRA should request that at least some providers submit a modification of their policies that provides for some additional assessment, so that these persons are not automatically screened-out. This should also apply to those who may have failed to pay rent in the past, due to incarceration.
33. Providers of housing for families living with HIV/AIDS should be required to submit a specific service plan that details how they will address housing and housing management issues related to reunification with children, responsibilities that women may have as caretakers for extended family, and issues related to preparing for placement of children in the case of the death or illness of the primary caretaker.

### Systems Integration

It is clear that the housing needs of people living with HIV/AIDS cannot be met by the resources of the AIDS system alone. Federal funds for housing and community development require coordinated planning and service delivery within participating jurisdictions. Homeless programs operate within HUD's Continuum of Care, and HOPWA-funded activities fall under the guidance of San Francisco's Consolidated Plan. For these reasons it is essential that consumers, AIDS advocates, and service providers become invested in community-wide planning systems and activities.

34. Develop cross-representation among advocates and persons living with HIV/AIDS and the City's CHAS, Continuum of Care Committee, Shelter Plus Care Program, and Long-term Care Task Force. The CARE Council and SFRA should explore the possibility of providing stipends to advocates, particularly if the advocate can be shown to represent the views of a group of persons living with HIV/AIDS and regularly attends one or more of these meetings.
35. **The SFRA and DPH AIDS Office should jointly develop an ongoing mechanism of continuing education for CARE Council members, City departments, and other policy makers regarding AIDS housing issues, homeless programs, and integrated services programs.**

### **Conclusion**

Although a significant amount of AIDS-dedicated funding in San Francisco is targeted to housing and housing-related needs of people living with HIV/AIDS, available resources are not sufficient to meet current and emergent needs. The rental and real estate markets in San Francisco

significantly impact maintenance of the current level of rental subsidies and the development of new capital projects. People living with HIV/AIDS, their advocates, and AIDS service organizations must aggressively seek partnerships with their colleagues in the housing and homelessness fields to ensure that the needs of all low-income residents of San Francisco are addressed. Given the dynamic nature of HIV disease and the uncertainty of government funding in the future, the needs of people living with HIV/AIDS and the most appropriate strategies to meet those needs must be reassessed regularly. This plan is intended to be built upon, revised, and expanded as the current objectives are met and new gaps and needs emerge.