

Comprehensive HIV/AIDS Housing Plan

**Recommendations and Final Report of the
HIV/AIDS Housing Work Group**

May 2007

San Francisco Department of Public Health

Acknowledgements

The San Francisco Department of Public Health acknowledges and appreciates the committed efforts of the Work Group's membership:

- Sherilyn Adams
- Brian Basinger
- Pablo Bravo
- Chris Harris
- Boe Hayward
- Bill Hirsh
- Billie-Jean Kanios
- Greg Kats
- Jimmy Loyce
- Sara Malan
- Rachelle McManus
- Rodney Murphy
- George Simmons
- Mike Smith
- Don Soto
- Amy Tharpe
- Laura Thomas
- Steven Tierney
- Tony Ucciferri
- Martin Uhrin

Many thanks to the Reggie office and the countless non-profit service providers that provided qualitative and quantitative data to the HIV/AIDS Housing Work Group. Their efforts better equipped the Work Group to identify the many issues facing PLWHA in San Francisco as they strive to lead healthy, independent lives in stable housing.

Finally, the Department offers special thanks to Shelagh Little, Abbott Little Consulting, who provided consulting services to the HIV/AIDS Housing Work Group throughout the six month recommendation development process. Ms. Little also compiled the Work Group's final report.

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I. Executive Summary

San Francisco Board of Supervisors Resolution 380-06 established the HIV/AIDS Housing Work Group in June 2006, mandating that the group develop a Comprehensive HIV/AIDS Housing Plan for the City. A total of 24 stakeholders agreed to join the Work Group, which met six times over the six month period beginning September 2006 and ending February 2007.¹

San Francisco has published two previous HIV/AIDS Housing Plans: the *San Francisco Five-Year HIV/AIDS Housing Plan* (1994) and the *San Francisco Five-Year HIV/AIDS Housing Plan Update* (1998). Both the 1994 Plan and the 1998 Update resulted from strategic planning processes designed to identify and achieve shared priorities and system-wide goals. Many of the findings of the 1998 process remain salient in 2007. Therefore, the HIV/AIDS Housing Work Group did not attempt to revise or supplant these documents. The HIV/AIDS Housing Work Group opted instead to identify deficiencies in the current system and address them by developing specific, concrete goals that are actionable in the near term.

The Work Group approached its efforts aware that pending federal policy changes and funding cuts could result in the displacement of 500 persons living with HIV/AIDS (PLWHA) who currently receive housing subsidies funded by Ryan White CARE funding. While affirming that preserving these subsidies must be the first priority, the Work Group did not want to limit its vision to maintenance of effort. Rather, the Work Group stated its commitment to expanding housing opportunities for San Franciscans living with HIV/AIDS and seeking funding to implement this expansion.

To inform its recommendations, the Work Group reviewed existing data and conducted its own assessment of unmet housing need among PLWHA. The Work Group further supplemented its research by assessing the need for system change through conversations with HIV/AIDS service providers and via information provided through HIV/AIDS service consumers during Public Comment.

The Work Group's efforts culminated in a series of recommendations highlighted below and elaborated in the full report that follows.

¹ Please see Appendix B for a complete list of Work Group members.

Tier 1

Goals

- Protect PLWHA at risk of homelessness due to pending federal funding cuts and policy changes.
- Increase housing supply for PLWHA.
- Increase eviction prevention assistance for PLWHA.
- Implement system change measures to make the current HIV/AIDS housing system more user-friendly and responsive to changing health needs.

Recommendations

1. Prevent loss of housing for nearly 500 PLWHA living in CARE-subsidized units by moving the cost to the General Fund budget.
Cost: \$3.8 million
2. Provide 500 new tenant-based subsidies (200 “deep” subsidies and 300 “shallow” subsidies) to make private market housing more affordable to PLWHA who are currently homeless or at risk of homelessness. **Cost: \$3 million**
3. Increase the supply of supportive and affordable housing available to PLWHA by 55 new units through a master lease model or by subsidizing operating cost of units in new developments. **Cost: \$1 million²**
4. Expand emergency eviction prevention assistance programs to serve up to 800 additional clients per year (e.g., legal assistance, one-time back rent payment, short-term tenant-based shallow subsidies, and/or temporary rent payment during residential treatment). **Cost: \$1 million**
5. Revise Housing Wait List policies/procedures to allow for more frequent assessment of clients’ eligibility and periodic updating of list, resulting in a more accurate and efficient list.
Cost: \$120,000 per year
6. After drawing from all eligible clients on the Housing Wait List, allow RCF-CIs and other project-based programs to accept referrals from other sources. Also, facilitate transfers between programs based on medical need. Finally, modify Housing Wait List policies to support movement of RCF-CI clients to more independent housing. **Cost: Cost neutral. (A system of care that provides care at appropriate levels is a more cost-effective.)**

² The cost of creating 55 new units may vary depending on housing model. For more information, please consult the body of the report.

7. Re-open the Housing Wait List for enrollment after implementing the above streamlining measures (Tier 1, Recommendations 5 and 6).

Cost: Cost neutral

Tier 2

Goal

Improve affordable housing marketing and outreach to PLWHA to maximize access to existing mainstream housing resources.

Recommendations

1. Develop marketing requirements to ensure appropriate representation of PLWHA in mainstream affordable housing.

Cost: \$30,000 per year

2. To better track PLWHA's utilization of mainstream affordable housing, improve data collection by developing procedures that allow clients to disclose their HIV status. **Cost: Cost neutral**

Tier 3

Goals

- Promote opportunities for greater economic security, leading to housing stability.
- Pilot new housing models that offer a spectrum of housing opportunities, including home ownership, for PLWHA at all stages of disability.

Recommendations

1. Create 100 new employment opportunities for PLWHA receiving disability benefits. Such opportunities would improve housing stability and keep earnings within the limits imposed by SSI. **Cost: \$600,000 per year**

2. Create an innovative Community Land Trust model tied to supportive employment, short-term housing, and affordable homeownership opportunities. **Cost: Varies according to specific project.**

II. Introduction

Board of Supervisors (BOS) Resolution 380-06, adopted on June 20, 2006, mandated that the Department of Public Health:

[E]stablish a HIV/AIDS Housing Work Group to work with relevant City Agencies, community stakeholders and members of the Board of Supervisors to establish a Comprehensive HIV/AIDS Housing plan for San Francisco.³

The Resolution cited numerous reasons for the mandate including a long waiting list for existing HIV/AIDS housing opportunities and pending federal funding cuts and policy changes that threaten to reduce housing availability for PLWHA. The Resolution provided a timeframe of six months for the Work Group to complete its process and report its findings. This report is the outcome of the Work Group's efforts.

HIV/AIDS Housing Work Group Process

On August 8, 2006, the Department of Public Health-Housing and Urban Health section (DPH-HUH) notified representatives from various city agencies, offices of the Board of Supervisors, and community stakeholders serving PLWHA of the Work Group's purpose and invited them (or their delegates) to participate. DPH-HUH developed its list of potential members based on their affiliation with a specific agency or organization, while others were invited to represent other planning bodies such as the San Francisco HIV Health Services Planning Council ("CARE Council"), which sets priorities for CARE Act funding, and the HIV/AIDS Provider Network (HAPN). A total of 24 members agreed to join the Work Group.⁴

DPH-HUH convened and facilitated its first Work Group meeting in September 2006 with support (i.e., facilitation assistance, development of meeting agendas and minutes, analysis, presentation) provided by Shelagh Little of Abbott Little Consulting.⁵ All meetings were open to the public and provided opportunity for public comment. Per San Francisco Sunshine Act requirements, all meeting documents were made available at least 72 hours prior to each meeting on the DPH Website (<http://www.sfdph.org/Meetings/otherMeetings.htm>). Consumers were present during all meetings, frequently providing feedback as part of Public Comment.

The Work Group convened a separate subcommittee to assess the level and implications of unmet housing need among PLWHA in San Francisco. Subcommittee findings appear in the body of the report, beginning on p. 10, "Unmet Housing Need Among Persons Living with HIV/AIDS."⁶

³ Full text of Resolution 380-06 included in this report as Appendix A.

⁴ List of Work Group members and affiliations is included in this report as Appendix B.

⁵ Please see Appendix C for a complete list of meeting dates and topics.

⁶ The full report of the Subcommittee on Unmet Need is included in this report as Appendix D.

Prior to Meeting 5, DPH-HUH compiled and drafted recommendations based on Work Group discussions to date. The Work Group reviewed the draft recommendations during Meeting 5. Organized by issue, the Work Group assigned priorities to each recommendation based on potential impact, cost, and feasibility. DPH-HUH integrated comments received during the meeting or in writing between meetings for a second draft, which was reviewed during Meeting 6. A full list of recommendations and supporting information begins on p. 16 of this report.

Background: HIV/AIDS Housing Planning in San Francisco

San Francisco has produced two previous HIV/AIDS Housing Plans: the *San Francisco Five Year HIV/AIDS Housing Plan* (Department of Public Health 1994) and the *San Francisco Five-Year HIV/AIDS Housing Plan Update* (San Francisco Redevelopment Agency 1998). The 1994 plan marked the first attempt at coordinated city-wide system planning at a time when new federal funding – Housing Opportunities for People with AIDS (HOPWA) and Comprehensive AIDS Resources Emergency (CARE) Act funding - was being introduced and/or increased. The most critical issue at the time was to establish priorities to guide funding allocation decisions.

By the 1998 Update, many of the goals articulated in the 1994 Plan had been accomplished through the combined efforts of the City and non-profit HIV/AIDS service and housing providers. Subsidy programs had been expanded greatly; more than 100 Residential Care Facility for the Chronically Ill (RCF-CI) licensed beds had been developed, as well as many new transitional and treatment beds; additional technical assistance resources for housing developers had been established; and a new centralized intake and wait list system had been developed.

Despite these successes, new medical therapies and extended life expectancies for PLWHA forced a re-examination of housing strategies locally. Consumers increasingly expressed preference for other affordable housing options offering lower levels of care and greater independence. Simultaneously, there were no new increased in federal funding for HIV/AIDS housing. Shrinking resources also necessitated a new statement of priorities.

Many of the issues and recommendations discussed in the 1998 update remain relevant today. On-going issues first noted in the 1998 report include:

- The demand for tenant-based subsidies far exceeds the supply. However, not all clients requesting subsidies are successful in securing placement due to rising housing costs, landlord discrimination, and behavioral health obstacles.
- PLWHA leaving or wishing to leave RCF-CIs, treatment programs, youth programs and other systems of care often have difficulty identifying permanent housing because of the shortage of appropriate affordable housing options.

- The role of RCF-CIs is to provide high-level care to those in greatest medical need and who may need such care periodically or on-going. As health conditions stabilize, providers must be able to identify alternatives for those able to succeed in more independent housing.
- Low-income, unsubsidized PLWHA may require access to short-term or shallow rental assistance to avoid eviction.
- Permanently housed PLWHA requiring a higher level of care often need temporary emergency housing assistance due to health deterioration and/or behavioral health needs.
- PLWHA with behavioral health issues need expanded access to supportive housing.
- PLWHA whose health has been stabilized often need help planning for gradual workforce re-entry and accessing new housing models that promote independence.

Critical issues that have emerged since the 1998 Update include:

- Pending federal funding and policy changes jeopardize housing security for nearly 500 PLWHA currently living in subsidized units.
- The supply of housing available to those on the Housing Wait List is inadequate to meet the need, resulting in long waits for housing. Because of this, the Housing Wait List has been closed since 2001. Wait List policies must be revised to promote greater flexibility and responsiveness to changing health status.
- It is unknown whether affordable housing providers' outreach and marketing to PLWHA is adequate to ensure PLWHA's proportionate utilization of "mainstream" affordable housing resources.

Both the 1994 Plan and the 1998 Update resulted from strategic planning processes designed to identify and achieve shared priorities and system-wide goals. Many of the findings of the 1998 process remain salient in 2007. Therefore, the HIV/AIDS Housing Work Group did not attempt to revise or supplant these documents. The HIV/AIDS Housing Work Group opted instead to identify deficiencies in the current system and address them by developing specific, concrete goals that are actionable in the near term.

III. Current HIV/AIDS Housing Supply and Unmet Need

Important Trends and Implications for Housing

A full summary of trends in HIV/AIDS in San Francisco is beyond the scope of this report. Researchers interested in comprehensive information of this nature are advised to consult the HIV/AIDS Epidemiology Annual and Quarterly Reports available through the San Francisco Department of Public Health AIDS Surveillance Unit.

However, several trends have implications for efforts to address the unmet housing need of PLWHA in San Francisco.

- The senior population with HIV/AIDS is growing. Persons 50 and older make up almost 40% of PLWHA, increased by approximately 50% from 3,270 in 2002 to 4,824 in 2005.⁷ Most senior-specific housing (e.g. project-based Section 8, federally funded senior projects) is limited to those aged 62 and older. Housing implications for the aging HIV/AIDS population include the need to integrate and/or provide access to the appropriate health, transportation, and other services needed to age in place.
- Approximately 10% of PLWHA are homeless.⁸ The number of homeless persons among all new cases of AIDS in San Francisco increased each year through 2000, when it reached a high of 14%. It has since declined to 10%. Homeless persons with HIV/AIDS are more likely, compared to the San Francisco HIV/AIDS population overall, to be women, African American, injection drug users (IDU), and younger.⁹ A high percentage of homeless PLWHA have co-occurring disorders such as mental illness and substance abuse issues. Due to co-occurring disorders, the homeless population may require services enriched supportive housing options even when HIV/AIDS-related health conditions have stabilized. For further discussion regarding the extent of homelessness in the PLWHA population, please see p. 10, “Unmet Housing Need.”
- Men Who Have Sex With Men (MSM) comprise the vast majority of HIV/AIDS diagnoses in San Francisco. The percentage of AIDS diagnoses in the MSM exposure categories (MSM and MSM/IDU) in San Francisco has remained relatively constant. Today, 84.8% of all persons living with AIDS in San Francisco are MSM.¹⁰ The predominance of the MSM population within the HIV/AIDS community in San Francisco suggests the need for cultural competence among housing providers, and housing options that allow gay men with HIV/AIDS to live in their communities of origin and other environments that are free of bias.
- Persons with HIV/AIDS are living longer and have more stable health status due to antiretroviral therapy. In 1996-2005, 78% of those diagnosed with AIDS survived at least five years, compared with 40% between 1990 and 1995.¹¹ This trend has implications for facilities that provide a higher level of care for those with medical needs. The role of such facilities may need to be re-framed in light of longer life spans (i.e., while these facilities once served as long-term final homes for very ill PLWHA, they may increasingly be sought out by PLWHA who temporarily require 24-hour nursing care but can eventually return to independent

⁷ SF HIV Health Services Planning Council (August 2006)

⁸ SF 2005 HIV/AIDS Epidemiology Annual Report

⁹ SF 2005 HIV/AIDS Epidemiology Annual Report

¹⁰ AIDS Quarterly Surveillance Report (3/31/07)

¹¹ SF 2005 HIV/AIDS Epidemiology Annual Report

housing). This also will require that PLWHA using Residential Care Facilities on a temporary basis be legally and financially able to keep their permanent housing while they receive care.

Current HIV/AIDS Housing Inventory

San Francisco currently provides targeted housing assistance to 1,566 households impacted by HIV/AIDS. In this instance, “targeted housing assistance” is defined as housing either built or operated with support from HIV/AIDS-specific funding sources or tenant based subsidy programs limited to PLWHA (i.e., the resident must be a PLWHA to qualify for the assistance). This number does not include other publicly financed affordable housing that may serve persons with HIV/AIDS who also meet other eligibility criteria.

Types of Housing

1. *Subsidy Programs*

Subsidy programs comprise a range of housing assistance types in which a tenant is assisted in meeting the full cost of his/her rent. Subsidies may be “tenant-based” (i.e., the tenant holds a subsidy s/he can apply toward the housing unit of his/her choice) or “project-based” (i.e., the unit itself is subsidized and available to qualifying tenants). Tenant-based subsidies are most often applied to privately-owned rental housing, whereas project-based subsidies are applied to non-profit owned housing with permanent affordability restrictions. Subsidies may be “deep,” meaning they pay the difference between a percentage of the tenant’s income - regardless of the type or amount of income - and the contract rent, or “shallow,” meaning they provide a fixed amount to make monthly housing expenses less burdensome.

Taken together, existing subsidy programs comprise the most common way of providing housing to persons with HIV/AIDS in San Francisco. There are a total of 995 subsidy “slots” in San Francisco. Below, these slots are broken out by type and funding source.

Deep Subsidies

Funding Souce	# of Slots	Funding Amount
CARE	259	\$2,587,569
HOPWA	280	\$3,009,415
GF	44	\$439,687
Total	583	\$6,036,671

Deep subsidies, on average, amount to \$855 per client per month.

Shallow Subsidies

Funding Source	# of Slots	Funding Amount
CARE	232	\$815,761
HOPWA	122	\$341,687
GF	58	\$203,628
Total	412	\$1,361,076

Shallow subsidies, on average, amount to \$272 per client per month.

The total number of available subsidy slots has declined over time due to cuts in federal funding. For example, HOPWA funded subsidies peaked at 571 slots in FY 02-03 and have since declined to 402 in FY 06-07. CARE funded subsidies peaked at 557 slots in FY 03-04 / 04-05 and have since declined to 491 in FY 06-07. The General Fund has supplemented federal funding to some extent to preserve slots that would otherwise be lost due to federal funding cuts. However, the overall number of subsidies available from all funding sources combined (i.e., HOPWA, CARE, General Fund) has declined by approximately 16% from 1190 slots in FY 02-03 to 995 slots in FY 06-07. The proportion of deep subsidy slots to shallow subsidy slots has also changed. For example, between FY 04-05 and FY 05-06, the City lost 69 CARE/General Fund deep subsidies and gained 70 CARE/General Fund shallow subsidies.¹²

2. Non-Profit Owned Housing Developed with HOPWA Funding

To date, HOPWA has financed a total of 425 units of non-profit housing reserved for PLWHA. HOPWA is a federal formula grant administered locally by the San Francisco Redevelopment Agency (SFRA).

3. Master-Leased/Set-Aside Housing

The Direct Access to Housing (DAH) Program offers permanent supportive housing to formerly homeless persons with special needs. Most DAH units are in properties leased from private owners and then rented to DAH-eligible tenants at below market, subsidized rents. Other DAH units are set-asides in non-profit owned affordable housing. DAH provides operating support to these units in exchange for reserving them for DAH-eligible clients. Of the total 876 units in the DAH program, 33 are specifically designated for persons with HIV/AIDS. (Note: An estimated 8% - 12% of the non-HIV/AIDS designated units are occupied by persons with HIV/AIDS, but disclosure of status is not required for occupancy.)

¹² Historical subsidy level data taken from the Office of the Legislative Analyst memo "HIV/AIDS Housing Subsidies," OLA No. 041-06, dated May 17, 2006. FY 06-07 provided by the San Francisco Redevelopment Agency and the San Francisco Department of Public Health.

4. Residential Care Facilities for the Chronically Ill (RCF-CIs)

Residential Care Facilities for the Chronically Ill (RCF-CIs) are state-licensed facilities for persons requiring 24-hour care to assist them with activities of daily living (e.g., bathing, dressing). Residents must initially demonstrate medical necessity to occupy RCF-CIs. Most of RCF-CI programs—those not regarded as short-term respite care—are regarded as permanent housing. Once in the unit, tenants have a right to remain there even if their health condition improves to the point of no longer requiring such a high level of care. There are a total of 113 RCF-CI slots in San Francisco. Below, the names of the existing RCF-CI programs are provided, along with the number of beds, the number of persons served, and the total annual funding level.

San Francisco RCF-CIs (FY 05-06 Data)

Program	# of Beds	# Clients	Annual Funding Level
Leland House	45	53	\$1,450,020
Peter Claver Comm.	32	39	\$710,252
Maitri	14	47	\$492,167
Cohen Residence	10	12	\$479,350
Larkin-Assisted Care	12	27	\$348,144
Total	113	177	\$3,479,933

Unmet Housing Need Among Persons Living with HIV/AIDS

The current supply of housing designated for PLWHA falls short of the demand despite innovative efforts to develop housing options for this population. To assess the degree of this gap, the Work Group formed a subcommittee to review and analyze data related to the unmet need for housing for PLWHA in San Francisco. The subcommittee's findings are summarized below.¹³

Homelessness and HIV/AIDS

The subcommittee's findings indicated that there are between 1,400 and 2,600 persons who are currently homeless and living with HIV/AIDS in San Francisco. Of this total, an estimated 917 have co-occurring disorders such as substance abuse and/or mental health issues. The following chart shows the likely prevalence of this and other subpopulations of homeless PLWHA.

¹³ The subcommittee's full report appears in Appendix C.

SUMMARY CHART Currently Homeless with HIV/AIDS Estimated Range: 1,411 – 2,562		
Subpopulations Within Total Homeless with HIV/AIDS (NOTE: Categories are not mutually exclusive.)	Lower Bound Estimates	Upper Bound Estimates
Adults in Families		91
With Disabling HIV	121	418
With Disabling AIDS	103	352
With Co-occurring Disorders	917	1,665
Chronically Homeless	345	512
Youth (18 or Younger)	80	160
Seniors (50 and Older)	466	845
Formerly Incarcerated	151	274

Housing Challenges for Homeless PLWHA with Co-Occurring Disorders

The high incidence of co-occurring disorders among homeless PLWHA has implications for HIV/AIDS housing planning. The co-occurring disorder—not symptoms related to HIV/AIDS—frequently becomes the primary qualifying special need for housing placement. A client who presents for a subsidy, for example, may not be successful in achieving placement in private housing due to problems with presentation and/or a history of eviction related to substance abuse or untreated mental illness. Meeting the needs of this population must include planning for supportive housing and other types of supervised units that offer on-site services and property management working in collaboration with the service provider. Even when housed, formerly homeless PLWHA may require services to help prevent eviction such as legal services, residential drug treatment, and emergency financial assistance to pay rent/back rent while in treatment.

PLWHA At-Risk of Homelessness

The subcommittee estimated that there are between 6,108 and 11,911 PLWHA in San Francisco who are at risk of homelessness due to the disparity between their ability to pay and the high cost of housing in San Francisco. While the lack of specific data precludes a more refined estimate, this range indicates the difficulty low-income PLWHA with disabilities have maintaining their housing. The subcommittee further concluded that approximately 8,418 PLWHA in San Francisco face extreme rent burden, defined as paying more than 50% of income toward rent. For others, the difficulty of finding and maintaining housing on limited income is compounded by other challenges such as “aging out” of youth programs, living with HIV/AIDS-related disabling conditions, aging, and histories of incarceration. Without any other options, low income PLWHA frequently turn to Single Room Occupancy (SRO) hotels, which, in some cases, are poorly managed, in substandard condition, and/or inaccessible for persons

with disabilities. The chart below provides a breakdown of PLWHA subpopulations considered to be at risk of homelessness.

At-Risk of Homelessness and HIV/AIDS+ Estimated Range: 6,108 - 11,911		
<u>Subpopulations Within Total At-Risk Category</u> (NOTE: Not all categories are mutually exclusive.)	Estimate	
Extreme Rent Burden (Paying More than 50% of Income Toward Rent)	8,418 (5,135 are estimated to have disabling HIV/AIDS)	
Youth (18 or Younger) Exiting from Youth Programs	76	
Seniors (50 and Older)	2,016	3,930
Formerly Incarcerated	654	1,274
Living in Single Room Occupancy (SRO) Hotels	1,199	2,013

Budget Issues

Current Allocation of Federal and Local Funding

Currently, there are three main funding sources for housing for PLWHA in San Francisco:

- HOPWA (Federal),
- CARE (Federal), and
- General Fund dollars appropriated annually through the Board of Supervisors.

The chart below summarizes current San Francisco annual public expenditures on housing for PLWHA.

	CARE	HOPWA	GF¹⁴	Totals
Emergency	\$162,855	--	--	\$162,855
Transitional	\$278,885	--	--	\$278,885
Subsidies	\$3,403,330	\$3,436,613	\$643,315	\$7,483,258
Other Residential Programs	\$2,454,930 ¹⁵	\$3,252,383 ¹⁶	--	\$5,707,313
Capital Projects	--	\$338,337	--	\$338,337
Totals	\$6,300,000	\$7,027,333	\$643,315	\$13,970,648

Trends in Federal Funding and Policy

Federal funding support for housing for PLWHA is declining. San Francisco's annual allocation of HOPWA funding, which peaked in 1994 at nearly \$10 million, is now just over \$7 million. San Francisco's CARE allocation has also decreased over time, though pending policy changes will impact the funding available for housing in a much more dramatic way. Currently, nearly 500 PLWHA receive CARE funded housing assistance.

The recently approved CARE Act Reauthorization established a new formula mandating that 75% of direct services funding be allocated to "core" services, while only 25% may be spent on other services, including housing. Because San Francisco allocates significant local funding to core services, its current allocation of CARE funding is closer to 50% "core" and 50% "other." The San Francisco Eligible Metropolitan Area (EMA) will also experience a 5% funding cut in FY 2007-2008, further reducing the total amount available for core and other services. Replacement funds must be identified to cover all housing costs that can no longer be funded through CARE.

Furthermore, a pending policy amendment (amendment to HAB Policy Notice 99-02) jeopardizes housing for those in CARE-funded subsidy programs. The amendment will limit stays in CARE-funded housing placement, which heretofore did not have a time limit, to a lifetime total of 24 months. To avoid displacement, alternative funds must be substituted for CARE subsidy funding. Implementation of the policy amendment, originally scheduled to take place on March 1, 2007, has been postponed indefinitely due to national opposition to the change.

While avoiding displacement of the 500 PLWHA potentially affected by Federal changes must be the first priority, the HIV/AIDS Housing Work Group expressly did not want to limit its vision to preserving the current inventory. The Work Group confirmed its support for finding creating solutions to the threat posed by pending federal policy decisions, but committed to forging a vision for expansion of housing opportunities for San Franciscans living with HIV/AIDS and seeking funding to implement this vision.

¹⁴ Does not include general fund add-backs.

¹⁵ Includes housing related services such as residential case management, residential substance abuse treatment, and home health care.

¹⁶ Includes partial funding for RCF-CIs.

IV. System Change Issues

While many of the Work Group's discussions focused on creating new housing opportunities, the Work Group also focused on system improvements to make the current array of programs and services more responsive and user-friendly for consumers. System change discussions focused on two main areas:

- Minimizing barriers in accessing available housing opportunities.
- Creating policies that allow the system to respond flexibly to consumers' changing health needs.

Housing Wait List

The City's centralized Housing Wait List provides access to most of the current inventory of affordable housing opportunities for PLWHA in San Francisco. Those enrolled on the Housing Wait List have access, contingent upon eligibility, to a range of specific tenant-based subsidy programs, non-profit owned supportive housing, special programs, and RCF-CIs. The Housing Wait List is not a housing program; it is a referral mechanism. In all, 23 housing programs accept referrals from the Housing Wait List.

The Housing Wait List was first established in 1995 in an attempt to provide equitable access to a variety of housing options. It is not "weighted" according to need; enrollees are served on a first-come, first-served basis according to their application date. The Housing Wait List was administered by the San Francisco AIDS Foundation until July 2001, when the list's administration was transferred to DPH-HUH.

As of August 2006, there were 7,452 clients on the Housing Wait List. Of those, 2,431 held "active" status (i.e., available for placement); 1,971 were "inactive." A total of 998 clients have been permanently placed. A total of 1,341 are confirmed deceased. The Housing Wait List has been closed to new applicants since November of 2001, and the clients now being interviewed for subsidy placement enrolled on the Housing Wait List as early as 1998.

According to Housing Wait List staff, 98% of the clients on the Housing Wait List want a tenant-based housing subsidy, which means some may have been offered other types of placement and deferred in favor of waiting for a subsidy. The Housing Wait List successfully places approximately 40 clients annually.

The single biggest issue limiting the Housing Wait List's ability to place clients in housing is the overall lack of housing available. This is especially true as it relates to tenant-based subsidies, for which the demand is highest.

Work Group members discussed other difficulties related to the Housing Wait List:

- Clients referred from the Housing Wait List are not always appropriate for the type of housing available. This is true for RCF-CIs, where admission is based on medical necessity. Only one out of every four to five clients referred to high level care facilities is placed. Some clients do not meet the medical criteria for RCF-CI placement, while others refuse RCF-CI placement because they do not want to live in a highly structured environment. (NOTE: Many clients who choose to wait for a housing subsidy may not always be able, due to health or special needs issues, to navigate the search and screening processes necessary to secure independent housing.)
- Clients placed in most RCF-CIs (the ones not designated as respite care) are considered to be permanently housed. The current policy does not allow for transfers to other types of housing once placed—even if a client’s health condition improves.
- Because the Housing Wait List has been closed since 2001, it is not serving those with more recent diagnoses, including those aging out of youth programs. Some of those most in need of housing would not be eligible for placement through the Housing Wait List.
- The Housing Wait List is a misleading barometer of the true nature and extent of unmet housing need among PLWHA because:
 - The Housing Wait List has been closed for more than five years and does not capture those with more recent diagnoses.
 - The Housing Wait List does not reflect the need among youth and those aging out of youth programs.
 - The Housing Wait List cannot not reliably track the changing housing and medical needs of those who are enrolled, and this leads to less efficient and appropriate referrals.

Residential Care Facilities for the Chronically Ill (RCF-CIs)

RCF-CIs are licensed by the State to provide 24-hour care and supervision to adults with HIV/AIDS who require assistance with activities of daily living. With the advent of effective antiretroviral therapies, the role of RCF-CIs is evolving. Some PLWHA may require high levels of care from time to time but may be able to return to independent living once their health is stabilized.

Many RCF-CI residents have, in addition to HIV/AIDS, behavioral health issues that require medication management and other types of support. Even when AIDS-related issues stabilize, many of these residents remain in RCF-CIs because few alternatives provide the level of care and supervision they need for their co-occurring disorders.

The best use of RCF-CIs is to be responsive to the needs of those who require high levels of medical care when their need is most acute. However, the Housing Wait List

currently prioritizes referrals to most RCF-CI beds¹⁷ based on when the client was first enrolled on the Housing Wait List. While the referred HWL client has to meet the medical necessity and other eligibility requirements of the RCF-CI, this assessment and verification does not occur until the actual intake with the program. Clients in RCF-CIs who might otherwise like and be able to leave RCF-CIs for more independent settings are constrained from doing so because of the lack of suitable alternatives. The cost per slot in RCF-CIs far exceeds that of other, more independent settings.

Specific system change recommendations related to the Housing Wait List and RCF-CIs are included in the following section, “Housing Work Group Recommendations,” p. 16.

V. HIV/AIDS Housing Work Group Recommendations

Having thoroughly discussed inventory, unmet need and system change issues, the Work Group synthesized its recommendations, evaluating the cost and priority of each recommendation. The Work Group framed its recommendations along “Guiding Principles” that helped contextualize, refine and prioritize recommendations.

Guiding Principles

1. The Comprehensive HIV/AIDS Housing Work Group was formed for the purpose of making recommendations that would expand and improve housing options for PLWHA. However, pending federal funding cuts and policy changes could result in loss of housing assistance for nearly 500 PLWHA in San Francisco. As a first priority, any loss of housing that could follow from these changes at the federal level should be prevented. This may require that certain housing costs currently supported by the federal government be shifted to local funding sources.
2. The Comprehensive HIV/AIDS Housing Work Group acknowledges that the demand for appropriate, affordable housing in San Francisco exceeds the supply—not only among those living with HIV/AIDS. The recommendations below do not obviate the need to provide decent, safe, affordable housing for all San Franciscans.
3. The City of San Francisco views housing as healthcare and a key component to the stabilization of health and behavioral health conditions.
4. Eviction prevention is necessary for all San Franciscans at risk of homelessness, especially those who are vulnerable due to health conditions. Preventing eviction is less costly and less destabilizing than re-housing for those who become homeless.

¹⁷ Not all RCF-CIs are required to accept referrals exclusively from the Housing Wait List.

5. Increased capacity is needed across the board in every type of HIV/AIDS-related housing program and service. There are no services or programs that are underutilized. The lack of capacity across the continuum results in clients being “stuck” in settings not suited to their care needs.
6. The Comprehensive HIV/AIDS Housing Work Group supports efforts to increase in-home and community-based support for all persons in need of long-term care so that they can remain in their homes and out of institutions as much as possible.
7. The Comprehensive HIV/AIDS Housing Work Group supports development of a centralized, interactive Web-based affordable housing search and application system to benefit all low-income San Franciscans in need of housing.
8. Guiding long-term efforts is the belief that the City should continue to explore new models/ideas for meeting the unmet housing need of people with HIV/AIDS.

Goals, Recommendations and Cost

The Work Group arrived at each of the below recommendations by consensus, and the Work Group deems each recommendation to be of merit. The assignment of relative priority (Tier 1, Tier 2 and Tier 3) is based on cost-effectiveness, likely impact (i.e., numbers served), and the speed with which the recommendation could be implemented.

Priority Tier 1 Goals

- Protect those at-risk of homelessness due to pending federal funding cuts and policy changes.
- Increase housing supply for PLWHA.
- Increase eviction prevention assistance for PLWHA.
- Implement system change measures to make the current system more user-friendly and responsive to changing health needs.

Tier 1 Recommendations

1. Prevent loss of housing for nearly 500 PLWHA currently living in CARE subsidized units by moving the cost to the General Fund.

Pending federal funding cuts and policy changes could result in a loss of up to \$3.8 million in CARE funded housing subsidies for PLWHA. The federal government has recently proposed a 24-month lifetime total limit on CARE-funded housing assistance. It has also implemented a new funding formula that mandates 75% of CARE funding be spent on “core” medical services, leaving only 25% for all other costs currently funded through CARE, including housing. The City has already expressed its opposition to the 24 month cap (see Board Resolution 10-06). Putting the cost of these subsidy slots into

the general fund budget would protect them from pending and future federal funding and policy changes.

Cost: \$3.8 million¹⁸

2. Provide 500 new tenant-based subsidies (200 “deep” subsidies and 300 “shallow” subsidies)-¹⁹ to make private market housing more affordable to PLWHA who are currently homeless or at risk of homelessness.

The Work Group estimates that there are a minimum of 1,400 homeless persons with HIV/AIDS and more than 6,000 who are at risk of homelessness. Ninety-eight percent (98%) of the PLWHA awaiting placement on the Housing Wait List express wanting a subsidy. Clients now being referred for subsidies were originally put on the Housing Wait List nearly ten years ago. An infusion of new subsidies will create dynamic movement in the Housing Wait List, which has been closed since 2001.

Cost: \$3 million (200 “deep” subsidies, 300 “shallow” subsidies)

3. Increase the supply of supportive and affordable housing available for PLWHA by 55 new units through a master lease model or by subsidizing units in new developments. Provide priority access to high-need clients on the Housing Wait List, clients exiting RCF-CIs, and clients aging out of youth programs. Avoid subsidy layering that limits access.

Some clients on the Housing Wait List and in RCF-CIs have not and will not be successful in tenant-based subsidy programs (e.g., those that need a higher level of support due to behavioral health or other issues). There are an estimated minimum of 900 homeless PLWHA with co-occurring disorders. Supportive housing (independent housing with on-site support services) has proven an effective intervention for homeless clients who have behavioral health needs but do not want or require the structure or level of care provided in RCF-CIs.

Cost: \$1 million (55 units of supportive housing in a master lease model or operating subsidy)²⁰

4. Expand emergency assistance / eviction prevention programs to serve up to 800 additional clients per year (e.g., legal assistance, one-time back rent payment, short-term tenant-based shallow subsidies, and/or temporary rent payment during treatment).

¹⁸ Work Group members indicated a strong preference for moving all housing-related CARE costs to the General Fund.

¹⁹ Deep subsidies support the difference between the rent and a tenant portion calculated based on income; they average \$855 per month per client. Shallow subsidies pay a flat rate to help alleviate rent burden; they average \$272 per month per client.

²⁰ Assumes \$1,500 per unit per month (based on Direct Access to Housing Program costs). Actual costs may deviate from this proposed figure depending on the housing model supplying the 55 units.

The Work Group estimates that there are a minimum of 6,000 PLWHA who are at-risk of homelessness, more than 50% of whom are assumed to have disabling HIV/AIDS. For some, eviction is avoided through legal assistance or a one-time back payment of rent, while for others it requires short-term assistance with rent payments until benefits are approved or while completing residential treatment. Others require help with move-in costs when transitioning from one housing situation to another. Preventing homelessness through the interventions above is more cost effective and less deleterious to health than allowing PLWHA to become homeless.

Cost: \$1 million²¹

5. Revise Housing Wait List policies/procedures to allow for more frequent assessment of clients' eligibility and periodic updating of the Housing Wait List, resulting in a more accurate and efficient list.

Current Housing Wait List clients enrolled prior to 2001 and little is known regarding their current health status and need for housing. Current policy does not allow for "purging" of the Housing Wait List; therefore, some clients may have left the area. Having an outdated list slows the referral process and results in inappropriate referrals.

Cost: \$120,000 per year (staffing and operations) PLWHA can participate as a supported work activity.

6. After drawing from all eligible clients on the Housing Wait List, allow RCF-CIs and other project-based programs to accept referrals from other sources. Also, facilitate transfers between programs based on medical need. Finally, modify Housing Wait List policies to support movement of RCF-CI clients to more independent housing.

RCF-CIs should be reserved for those in greatest medically need, regardless of their Housing Wait List enrollment date. The current transfer system does not allow for easy transfer in and out of RCF-CIs based on changes in health status and should be more responsive to the changing needs of PLWHA. Implementation of this recommendation will ensure Fair Housing compliance.

Cost: Cost neutral. (A system of care that provides care at appropriate levels is a more cost-effective system of care.)

7. Re-open the Housing Wait List for enrollment after implementing the above streamlining measures (Tier 1, Recommendations 5 and 6).

PLWHA with more recent diagnoses, including youth, have not been able to join the Housing Wait List. Those whose medical conditions call for transfer to a different level of

²¹ Assumes legal costs of \$100,000 for one full-time attorney to serve 200 clients per year (includes salary and overhead); 300 clients needing emergency funds for back rent or move in costs (\$1,000 per client + associated staffing and overhead = \$350,000); approximately 310 people receiving a shallow rent subsidy of approximately \$400 per month for 4 months = \$550,000. Total: \$1 million.

care are not able to do so. A Housing Wait List that opens at regular intervals would be more responsive to the needs of the PLWHA generally.

Cost: Cost neutral

Priority Tier 2 Goals

Improve affordable housing marketing and outreach to PLWHA to maximize access to mainstream housing resources.

Tier 2 Recommendations

1. Develop marketing requirements to ensure appropriate representation of PLWHA in mainstream affordable housing.

PLWHA do not always participate in systems of care that offer information on and referrals to available mainstream affordable housing opportunities; there is no one centralized source of information on available affordable housing opportunities in San Francisco. Referral sources for various housing programs vary—some include PLWHA-serving organizations as access points for completing housing applications, others do not. PLWHA requesting housing assistance may be directed to HOPWA-funded units and other specialized programs instead of being given access to the broad array of affordable housing programs. It is unknown whether PLWHA have accessed mainstream affordable housing to an extent that is proportionate to PLWHA per capita representation. More deliberate marketing to PLWHA is likely to result in more appropriate participation by PLWHA in mainstream affordable housing programs.

Cost: \$30,000 per year (staffing/operations for monitoring and compliance)

2. To better track PLWHA's utilization of mainstream affordable housing, improve data collection by developing procedures that allow clients to disclose their HIV status.

Most housing applications do not provide space for PLWHA to voluntarily disclose their HIV status. Allowing housing applicants to *voluntarily* disclose HIV status would ensure that PLWHA are informed of all appropriate housing options. Voluntary disclosure allows providers and funders to monitor the effectiveness of outreach and marketing to PLWHA by tracking the numbers of applications received by persons who self-disclose HIV status. Disclosure of HIV status on housing applications does not raise issues of confidentiality or discrimination provided that 1) it is voluntary and access to housing is not contingent on disclosure; 2) all applicants are offered the opportunity to disclose their HIV status—not just targeted applicants; and 3) the information is kept in a way that would protect confidentiality to the extent possible.

Cost: Cost neutral

Priority Tier 3 Goals

- Promote opportunities for greater economic security leading to housing stability.
- Pilot new housing models that offer a spectrum of housing opportunities, including home ownership, for PLWHA at all stages of disability.

Tier 3 Recommendations

1. Create 100 new employment opportunities for PLWHA receiving disability benefits. Such opportunities would improve housing stability and keep earnings within the limits imposed by SSI.

Today, PLWHA are planning for futures they feared would never come thanks to the success of new antiretroviral medications leading to longer life expectancies. However, surviving a life-threatening illness and living with a disability for a long period of time have psychological impacts that may include fears about re-entering the workforce. Some may fear losing disability benefits and need a gradual and flexible re-introduction to employment that allows for changing health conditions. Others may never be able to resume full-time work but still would like to work and earn money to the extent that their health allows. Projects such as the HOPWA/SPNS Second Start Program combine a "shallow" rent subsidy with a back-to-work employment program for PLWHA. Models of this type should be expanded with a special emphasis on increasing staff representation by PLWHA in HIV/AIDS service provider organizations.

The Work Group estimates that there are a minimum of 6,000 PLWHA who are at-risk of homelessness, more than 50% of whom are assumed to have disabling HIV/AIDS. Many can and want to work but need flexible hours and the ability to earn income within the limits imposed by SSI. Work opportunities provide PLWHA with a sense of purpose and an incentive to move toward self-sufficiency as health status allows. A new stipend program could provide employment and leadership opportunities for disabled PLWHA within the agencies that provide services to the HIV/AIDS community.

Cost: \$600,000 per year (stipends)²²

²² Assumes 100 participants earning \$500 per month.

2. Create an innovative Community Land Trust model tied to supportive employment, short-term housing, and affordable homeownership opportunities.

As PLWHA plan for the future, they will want and need different housing options, including homeownership. New models can offer:

- A range of housing options for PLWHA at all points in the disability spectrum, and
- Individualized assistance moving to stable, permanent housing in the form of homeownership.

Housing programs that provide paths to affordable homeownership improve housing stability while helping PLWHA envision a future beyond disability. The Community Land Trust (CLT) concept offers one possibility.

In this model, a democratically controlled, non-profit CLT organization acquires land. The CLT can then build housing on the land and rent or sell it to individuals. The CLT's ownership of the land makes housing more affordable because increasing land values are not reflected in home prices. The CLT can also ensure permanent affordability of the housing by restricting re-sale prices. Urban CLTs have been developed all over the country as a response to gentrification and speculation, helping create and maintain homeownership opportunities for those that might otherwise be priced out of the market. Some CLTs also include special needs housing for specific populations.

Cost: Varies according to specific project.

Appendix A: San Francisco Board of Supervisors Resolution 380-06

Resolution calling on the Department of Public Health to establish a HIV/AIDS Housing Working Group to work with relevant City Agencies, community stakeholders and members of the Board of Supervisors to establish a comprehensive HIV/AIDS Housing plan for San Francisco.

WHEREAS; Stable and affordable housing is essential for persons living with HIV/AIDS; and

WHEREAS; Lack of access to housing for people with HIV/AIDS often results in serious decline of health and significantly higher rates of death; and

WHEREAS, While San Francisco is the leader in the movement to provide housing for people living with HIV/AIDS, San Francisco does not have a comprehensive HIV/AIDS Housing plan even though a plan is required for all municipalities that receive Federal funding; and

WHEREAS, San Francisco continues to face a shortage of appropriate housing options for people with HIV/AIDS, as evidenced by the HIV/AIDS Housing Waitlist which has more than 2,400 people on it today; and

WHEREAS, In addition to current challenges faced by San Francisco, there are proposed Federal changes to the Ryan White CARE Act that will reduce the funds available for HIV/AIDS specific housing; and

WHEREAS, These actions by the Federal Government would further erode San Francisco's ability to adequately house a vulnerable population whose life often depends on access to housing; and

WHEREAS, Supervisor Dufty and Ammiano sponsored a hearing on June 12, 2006 to examine the impacts of the existing HIV/AIDS housing shortage as well as the

impacts of future reductions with the goal of developing innovative strategies to ensure that the existing housing stock is preserved and expanded; now therefore, be it

RESOLVED, That a working group will be established by the Department of Public Health that includes other relevant City agencies, community stakeholders and representatives from the Board of Supervisors to ensure that the existing housing stock for people with HIV/AIDS is preserved and expanded; and, be it

FURTHER RESOLVED, That this working group will convene no later than August 1, 2006 and meet monthly for six months; and, be it

FURTHER RESOLVED, That the HIV/AIDS Housing working group will present its findings to the Board of Supervisors for further consideration and action.

Appendix B: HIV/AIDS Housing Work Group Membership

Name	Title	Agency	Representing
Sherilyn Adams	Executive Director	Larkin Street Youth Services	Larkin Street Youth Services
Margot Antonetty	Director of Programs	DPH-HUH	DPH-HUH
Brian Basinger	Executive Director	AIDS Housing Alliance	AIDS Housing Alliance
Pablo Bravo	Director, Community Grants and Investments	Catholic Healthcare West	Philanthropic Sector
Lori Cook	Health Program Planner	DPH-HUH	DPH-HUH
Chris Harris	Senior Development Specialist	SFRA	SFRA
Boe Hayward	Aide	Supervisor Dufty's Office	Supervisor Dufty's Office
Bill Hirsh	Director	ALRP	ALRP
Billie-Jean Kanios	Program Manager, Preventive Health Services	Walden House	HAPN
Greg Kats	Deputy Director of Housing Programs	Human Services Agency	Human Services Agency
Shelagh Little	Consultant	Abbott Little	DPH-HUH
Jimmy Loyce ²³	Deputy Director	San Francisco AIDS Office	San Francisco AIDS Office
Sara Malan	Staff Attorney	ALRP	ALRP
Rachelle McManus	Aide	Supervisor Dufty's Office	Supervisor Dufty's Office
Rodney Murphy	Program Director, Peter Claver Community	CCCYO	CCCYO
George Simmons	Senior Program Director, Assisted Housing and Health Programs	CCCYO	CCCYO
Mike Smith	Executive Director	AIDS Emergency Fund	HAPN
Don Soto	Program Manager-AIDS Financial Services	Lutheran Social Services	HAPN
Amy Tharpe	Planning and Monitoring Director	MOH	MOH

²³ Since the Work Group's inception, Jimmy Loyce has left the San Francisco AIDS Office.

Name	Title	Agency	Representing
Laura Thomas	TCWG Program Manager	Tenderloin Health ²⁴	CARE Council
Steven Tierney	Deputy Director	San Francisco AIDS Foundation	San Francisco AIDS Foundation
Marc Trotz	Director	DPH-HUH	DPH-HUH
Tony Ucciferri	Administrator, Section 8 Housing Department	SFHA	SFHA
Martin Uhrin	Special Programs Manager	SFHA	SFHA

²⁴ Since the Work Group's inception, Laura Thomas has left Tenderloin Health to work as an independent consultant.

Appendix C: HIV/AIDS Housing Work Group Meeting Dates and Topics

1. Tuesday, September 5, 2-4pm: Work Group Purpose; Federal Funding and Policy Issues
2. Tuesday, October 3, 2-4pm: Current Allocation of Available Resources and Effectiveness of Current Allocation; Data; Unmet Need
3. Tuesday, November 7, 2-4pm: New Housing Models and System Change
4. Tuesday, December 5, 2-4pm: AIDS Housing Wait List
5. Tuesday, January 9, 2-4pm: Discussion: Summary, Conclusions and Recommendations
6. Tuesday, February 6, 2-4pm: Distribution of Draft Recommendations, Discussion, and Wrap-Up

Appendix D: Report of the Unmet Need Subcommittee

A subcommittee comprised of five Work Group members, a DPH-HUH representative and DPH's consultant was formed to analyze existing data related to the need for housing among PLWHA in San Francisco. The subcommittee reviewed existing needs assessments and analyzed data from the Reggie system and relevant service providers. The subcommittee met a total of four times between November 2006 and January 2007 to discuss the available information and arrive at estimates of unmet need. The subcommittee's report, including source document citations, follows below. Please note that, to preserve the formatting integrity of the original report, the text below appears in a smaller font than the rest of this more comprehensive document.

Modeling Unmet Need for HIV/AIDS Housing in San Francisco: Executive Summary

San Francisco Board of Supervisors' Resolution 380-06 resulted in the formation of the Comprehensive HIV/AIDS Housing Work Group, a body convened by the San Francisco Department of Public Health and composed of representatives from other relevant City agencies, community stakeholders, and representatives from the Board of Supervisors. Issued on June 13, 2006, the resolution charged the group with establishing a comprehensive HIV/AIDS housing plan for San Francisco "to ensure that the existing housing stock [for people with HIV/AIDS] is preserved and expanded." The Comprehensive HIV/AIDS Housing Work Group commenced its efforts in September 2006, bound, within a six month timeframe, to produce a series of specific, actionable recommendations for consideration by the Board of Supervisors. To better inform its recommendations, the Work Group formed a subcommittee to investigate the nature and extent of unmet housing need among persons living with HIV/AIDS in San Francisco based on research and analysis of existing data.

Subcommittee members conducted an extensive review of existing data related to housing status and need among persons living with HIV/AIDS in San Francisco. Through the course of its research, the subcommittee attempted to determine:

- Among San Francisco's HIV/AIDS population, how many people are currently homeless?
- Among currently homeless persons living with HIV/AIDS, which subpopulations are disproportionately affected? For example, among the currently homeless living with HIV/AIDS:
 - How many are adults living with dependent children?
 - How many have co-occurring diagnoses (e.g., mental health issues, substance abuse, chronic medical issues, etc.) or other special needs?
 - How many are chronically homeless?²⁵
 - How many are seniors (aged 50+) or youth (aged 18 or younger)?
 - How many were formerly incarcerated?
- How many low-income San Franciscans with HIV/AIDS are at-risk of homelessness due to excessive rent burden, inappropriate living conditions, and/or pending funding cuts and policy changes at the Federal level?

This document captures the work of the subcommittee as reflected in the summary tables below. (NOTE: Detailed justification of these figures appears in subsequent sections of this report.)

²⁵ According to the U.S. Department of Housing and Urban Development, a "chronically homeless" person is defined as "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years."

SUMMARY CHART		
Currently Homeless with HIV/AIDS		
Estimated Range: 1,411 – 2,562		
Subpopulations Within Total Homeless with HIV/AIDS (NOTE: Categories are not mutually exclusive.)	Lower Bound Estimates	Upper Bound Estimates
Adults in Families		91
With Disabling HIV	121	418
With Disabling AIDS	103	352
With Co-occurring Disorders	917	1,665
Chronically Homeless	345	512
Youth (18 or Younger)	80	160
Seniors (50 and Older)	466	845
Formerly Incarcerated	151	274

At-Risk of Homelessness and HIV/AIDS+		
Estimated Range: 6,108 - 11,911		
(See calculations below.)		
Subcategory	Lower Bound Calculations	Upper Bound Calculations
Persons Living with HIV/AIDS (PLWHA) At-Risk of Homelessness by Virtue of Being Low-Income	10,248	17,202
Less Those Known to be Homeless	(1,411)	(2,562)
Less Those Estimated in HIV/AIDS-designated Housing or Subsidized by CARE/HOPWA	(1,533)	(1,533)
Less Estimated in Public Housing, Section 8, Other Affordable Housing	(1,196)	(1,196)
Total Estimated At-Risk of Homelessness	6,108 (3,726 are estimated to have disabling HIV/AIDS)	11,911 (7,266 are estimated to have disabling HIV/AIDS)
Revised At-Risk Estimates Pending Cuts in Federal Funding		
Revised Estimated Range: 6,599 – 12,402		
Persons At-Risk Due to Potential Cuts in Federal Funding		491
Total Estimated At-Risk of Homelessness, Including At-Risk Due to Pending Cuts	6,599	12,402

At-Risk of Homelessness and HIV/AIDS+		
Estimated Range: 6,108 - 11,911		
Subpopulations Within Total At-Risk Category (NOTE: Not all categories are mutually exclusive.)	Estimate	
<u>Extreme Rent Burden</u> (Paying More than 50% of Income Toward Rent)	8,418 (5,135 are estimated to have disabling HIV/AIDS)	
<u>Youth (18 or Younger)-</u>	76	
<u>Seniors (50 and Older)-</u>	2,016	3,930
<u>Formerly Incarcerated</u>	654	1,274
<u>Living in Single Room Occupancy (SRO) Hotels</u>	1,199	2,013

Limitations

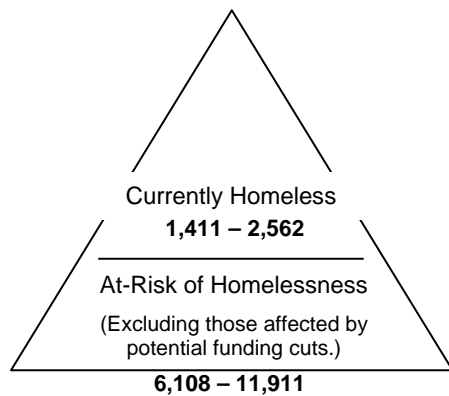
The subcommittee quickly discovered that no single data source fully describes the unmet housing need among persons with HIV/AIDS in San Francisco. For example, while some databases capture housing status, they only speak to the experiences of those persons served under specific programs and/or funding sources. In response to this lack of consolidated data, the subcommittee based its findings primarily on “proxy” measures, such as data from academic research and San Francisco’s Reggie system. While best estimates of unmet housing need, the subcommittee believes that its findings

represent a responsible starting point from which the Comprehensive HIV/AIDS Housing Work Group may develop recommendations for the San Francisco Board of Supervisors.

Modeling Unmet Need for Housing

Since the beginning of the AIDS epidemic, San Francisco has systematically collected health status and demographic information on impacted persons. Less is known, however, about housing status among persons with HIV/AIDS. Specifically, it is unknown exactly how many people with HIV/AIDS are currently homeless or at-risk of homelessness based on factors such as housing status, income, and degree of rent burden.

Certain databases, such as the Reggie system and the Housing Wait List (HWL), provide a limited amount of information about the persons captured in those systems. Other programs can produce aggregate data on their clients. However, there is no single database or program that tracks housing information for all persons living with HIV/AIDS in San Francisco. At best, existing data can inform estimates, with more conservative methods of estimating informing “lower bound” numbers, and more inclusive methods of estimating informing “upper bound” figures.



This report provides estimates of the number of persons living with HIV/AIDS who are homeless and at-risk of homelessness according to the following definitions:

- Currently Homeless: Those living in shelters / emergency housing, cars, abandoned buildings, parks, on the street, those who are “couch surfing.”
- At-Risk of Homelessness: Those who are rent burdened, living in inappropriate living situations (e.g., doubled-up / overcrowded situations) and people already in housing who require financial assistance to stabilize their living situation.

Those in the “at-risk of homelessness” category constitute the majority of San Franciscans living with HIV/AIDS; however, those who are currently homeless have the greatest need for housing if they are to stabilize and improve their health outcomes. Further detail on each of these categories (characteristics and subpopulations), and data used to support the estimates, appear in subsequent sections of this report.

Measuring Need Among the Currently Homeless

Through the course of its research, the subcommittee attempted to determine:

- Among San Francisco’s HIV/AIDS population, how many people are currently homeless?
- Among currently homeless persons living with HIV/AIDS, which subpopulations are disproportionately affected? For example, among the currently homeless living with HIV/AIDS:
 - How many are adults living with dependent children?
 - How many have co-occurring diagnoses (e.g., mental health issues, substance abuse, chronic medical issues, etc.) or other special needs?
 - How many are chronically homeless?
 - How many are seniors (aged 50+) or youth (aged 18 or younger)?
 - How many were formerly incarcerated?

Subcommittee Findings

SUMMARY CHART Currently Homeless with HIV/AIDS Estimated Range: 1,411 – 2,562		
Subpopulations Within Total Homeless with HIV/AIDS (NOTE: Categories are not mutually exclusive.)	Lower Bound Estimates	Upper Bound Estimates
Adults in Families		91
With Disabling HIV	121	418
With Disabling AIDS	103	352
With Co-occurring Disorders	917	1,665
Chronically Homeless	345	512
Youth (18 or Younger)	80	160
Seniors (50 and Older)	466	845
Formerly Incarcerated	151	274

The subcommittee arrived at these estimates by posing the “homelessness question” in two different ways:

- What percentage of San Francisco’s homeless population is impacted by HIV/AIDS?
- What percentage of persons with HIV/AIDS in San Francisco are homeless?

Research estimates that 17,000 persons experience homelessness in San Francisco each year.²⁶ According to another research study, 8.3% of homeless adults in San Francisco are HIV positive.²⁷ This information yields the “lower bound” estimate of HIV/AIDS among the homeless population in San Francisco: **8.3% of 17,000 = 1,411**.

Approaching the calculation slightly differently yields a higher estimate. According to the HIV Services Planning Council, approximately 18,300 persons in San Francisco are HIV positive.²⁸ Also according to the HIV Services Planning Council, 14% of San Franciscans with AIDS are homeless.²⁹ Assuming that persons who are HIV+ are at least as like as those with AIDS to be homeless,³⁰ the subcommittee calculated the following “upper bound” estimate: **14% of 18,300 = 2,562**.

Homeless Subpopulations

Adults in Families

According to First Five, there are approximately 2,700 people in homeless families in San Francisco.³¹ Of those, approximately 582 reside at the city’s emergency shelters for homeless families.³² Assuming that approximately 40% of family shelter clients are adults,³³ 233 adults reside in shelters with their children.

²⁶ Fagan, Kevin and Todd Wallack. “Money well spent? The city can’t tell.” *San Francisco Chronicle*. October 31, 2006. <http://sfgate.com/cgi-bin/article.cgi?file=/c/a/2006/10/31/MNGD9M1QV41.DTL>.

²⁷ Robertson, Marjorie, PhD, et al. “HIV Seroprevalence Among Homeless and Marginally Housed Adults in San Francisco.” *American Journal of Public Health* (July 2004).

²⁸ San Francisco HIV Health Services Planning Council. *Trends and Data Review* presentation. Priority Setting / Resource Allocation Summit. August 24, 2006.

²⁹ 2006-2009 Comprehensive HIV Health Services Plan, San Francisco HIV Services Planning Council (December 2005).

³⁰ Based on the subcommittee’s analysis of Reggie data for the period March 1 – August 31, 2006.

³¹ Coalition on Homelessness, San Francisco. “How many people are homeless and who are they?” *Fact Sheet on Homelessness*. www.cohsf.org/eng/resources/factsheets/hfs.php.

³² Human Services Agency. “Other Informational Links: Fact Sheet.” http://www.sfhsa.org/files/Housing_Homeless/HousingFirstFactsheet.doc.

³³ Ward, Cindy. Homeless Family Programs Manager, Human Services Agency. January 2, 2007.

Another 65 mothers and their children reside at domestic violence shelters.³⁴ An estimated 1,560 family members (760 children, 800 adults) reside in single room occupancy (SRO) hotels.³⁵

233 Adults in Families in Emergency Shelters
65 Adults in Families in Domestic Violence Shelters
+ 800 Adults in Families in SROs
1,098 Adults in Homeless Families

Knowing, based on previously referenced research, that 8.3% of homeless persons in San Francisco have HIV/AIDS, **8.3% of 1,098 = 91 Homeless Adults with HIV/AIDS in Families**

Disabling HIV and Disabling AIDS

For disabling HIV/AIDS information, the subcommittee relied heavily on data provided by the Reggie system, a standardized client registration system for HIV-related services in San Francisco. The system provides a centralized registration and information referral system for non-profit and government organizations providing health care and social services to low-income persons living with HIV/AIDS. It is important to note, however, that Reggie does not capture the HIV/AIDS services “universe” in San Francisco. For example, only those agencies contracted by the HIV Health Services Branch of the Department of Public Health are required to input data into the Reggie system. This means that Reggie does not fully capture / reflect all services / clients covered by Housing Opportunities for Persons with AIDS (HOPWA) or other funding streams. This limitation notwithstanding, Reggie is one of the most comprehensive “snapshots” available of persons living with HIV/AIDS in San Francisco. Among other indicators, Reggie tracks clients’ housing and health status, informing the subcommittee’s lower and upper bound calculations based on data from the period March 1 – August 31, 2006:

Lower Bound

The actual numbers of clients tracked by Reggie were used as the basis for lower bound figures. The data shows that 24.3% of clients tracked had disabling HIV and 36.3% had disabling AIDS.

- Among those with disabling HIV, 9.4% (**121/1285**) were homeless.
- Among those with disabling AIDS, 5.3% (**103/1935**) were homeless.

Upper Bound

Applying these numbers to the total number of persons living with HIV/AIDS in San Francisco provided the basis for upper bound calculations:

- Disabling HIV:
 - 18,300 PLWHA in SF x 24.3% = 4,446.9 persons with disabling HIV
 - **4,446.9 with disabling HIV x 9.4% = 418 homeless persons with disabling HIV**
- Disabling AIDS:
 - 18,300 PLWHA in SF x 36.3% = 6,642.9 persons with disabling AIDS
 - **6,642.9 with disabling AIDS x 5.3% = 352 homeless persons with disabling AIDS**

NOTE: The following chart summarizes health status among those clients tracked by Reggie from March 1 – August 31, 2006, cross-referencing housing status. Of all the clients for whom housing status was tracked, 63% (3323/5274) rented or owned the house, apartment, or flat in which they lived; Reggie cannot discern how many of these persons receive subsidies. For the purposes of this report, all categories other than “rented or owned” were classified as falling under “homeless” (emergency housing, shelter, streets) or “marginally housed.”

³⁴ Human Services Agency. Ibid.

³⁵ Human Services Agency. Ibid.

Homeless and Marginally Housed by Health Status SFDPH/AIDS Office: Reggie Database 3/1/06-8/31/06						
Current Living Situation Expressed as % of all persons in each health status category	AIDS Diagnosis UDC=788	Disabling AIDS UDC=1,935	Disabling HIV UDC=1,285	HIV Symptomatic (Not AIDS) UDC=342	HIV Asymptomatic UDC=461	HIV Disease Stage Unknown UDC=341
Homeless Categories						
Emergency Housing	1.8	2.2	4.3	1.8	1.3	1.8
Shelter	0.8	0.9	1.6	0.6	1.1	1.2
Street	1.1	2.2	3.5	2.3	0.7	1.2
SUBTOTAL	3.7	5.3	9.4	4.7	3.1	4.2
Marginally Housed/At-Risk						
Drug/Alcohol Treatment	4.1	4.1	7.5	9.1	4.3	5.3
Hospital	3.2	2.4	1.2	0.6	0.4	0.3
Jail/Incarcerated	2.9	2.4	2.8	2.6	5	11.1
Family/Friend-No Rent	7.1	4.4	4.3	10.2	13.9	9.1
SRO	4.3	14.4	19.4	5.6	3.9	5.6
SUBTOTAL	21.6	27.7	35.2	28.1	27.5	31.4

Co-Occurring Disorders

Reggie does not reliably track the number of persons with HIV/AIDS who also have co-occurring disorders such as substance abuse or mental illness. However, it is known that 65% of persons living in Catholic Charities CYO (CCCYO)-assisted housing have co-occurring disorders—a potential proxy for prevalence among homeless living with HIV/AIDS. Applying this number to our upper and lower bound estimates of homeless persons with HIV/AIDS, we arrive at a range estimate for homeless PLWHA with co-occurring disorders:

- Lower Bound: 65% of 1,411 = 917
- Upper Bound: 65% of 2,562 = 1,665

Chronically Homeless

According to the *San Francisco Plan to Abolish Chronic Homelessness*, there are approximately 3,000 homeless persons in San Francisco who meet the federal definition of chronically homeless.³⁶ This is in keeping with the national estimate that 10-20% of homeless persons meet the definition of chronically homeless.³⁷ Among San Francisco's homeless population, the rate of seroprevalence among the chronically homeless (11.5%) is higher than for the homeless population overall (8.3%). **11.5% of 3,000 = 345** (lower bound estimate).

An alternate means of calculating this number is to start with the number of PLWHA in San Francisco (18,300), of which 14% are assumed to be homeless (14% of 18,300 = 2,562). Twenty percent (20%) of this number—based on the above referenced National Alliance to End Homelessness upper figure—would be **512** chronically homeless PLWHA.

³⁶ Ten Year Planning Council. *San Francisco Plan to Abolish Chronic Homelessness*. www.ich.gov/slocal/plans/sanfrancisco.pdf.

³⁷ National Alliance to End Homelessness

Youth

Based on estimates provided by Larkin Street Youth Services (LSYS), approximately 4,000 youth experience homelessness in San Francisco annually. Based on HIV testing conducted by LSYS, 2% - 4% of homeless youth served by LSYS test positive (approximately 250 tested annually). Therefore:

- Lower Bound: 2% of 4,000 = 80 currently homeless with HIV/AIDS
- Upper Bound: 4% of 4,000 = 160 currently homeless with HIV/AIDS

NOTE: LSYS cautions that this might not fully capture the unmet future housing need due to the pervasiveness of high-risk behaviors among youth.

Seniors

According to the *2005 HIV/AIDS Epidemiology Annual Report*, 33% of persons with HIV/AIDS were 50+ years old at the end of 2005.³⁸ Applied to the upper and lower bound estimates of homeless persons with HIV/AIDS cited above:

- Lower Bound: 33% of 1,411 = 466
- Upper Bound: 33% of 2,562 = 845

Formerly Incarcerated

Reggie tracks clients with histories of incarceration. Based on persons captured in the Reggie system between March 1 – August 31, 2006, 10.7% were formerly incarcerated. Applying this percentage to the upper and lower bound estimates of homeless persons with HIV/AIDS:

- Lower bound: 10.7% of 1,411 = 150
- Upper bound: 10.7% of 2,562 = 273

Measuring Need Among Those At-Risk of Homelessness

Through the course of its research, the subcommittee attempted to determine, among housed San Franciscans living with HIV/AIDS:

- How many are at risk for homelessness based on being low-income?
- How many are currently living in publicly subsidized housing—both in HIV/AIDS-specific housing and in other affordable housing programs—versus private market housing?
- How many could better stabilize their health and housing with outside financial support? (E.g., how many could avoid eviction with the help of an emergency, time-limited subsidy?)
- How many live in SROs?
- Among those at-risk of homelessness, which subpopulations are disproportionately affected (e.g., seniors, youth, formerly incarcerated, etc.)?
- How many are at-risk of homelessness due to excessive rent burden (i.e., pay more than 50% of income toward rent)?

³⁸ San Francisco Department of Public Health, HIV Seroepidemiology Unit. *2005 HIV/AIDS Epidemiology Annual Report*. www.sfdph.org/PHP/HIVSeroUnit.htm

Subcommittee Findings

At-Risk of Homelessness and HIV/AIDS+ Estimated Range: 6,108 - 11,911 (See calculations below.)		
Subcategory	Lower Bound Calculations	Upper Bound Calculations
Persons Living with HIV/AIDS (PLWHA) At-Risk of Homelessness by Virtue of Being Low-Income	10,248	17,202
Less Those Known to be Homeless	(1,411)	(2,562)
Less Those Estimated in HIV/AIDS-designated Housing or Subsidized by CARE/HOPWA	(1,533)	(1,533)
Less Estimated in Public Housing, Section 8, Other Affordable Housing	(1,196)	(1,196)
Total Estimated At-Risk of Homelessness	6,108 (3,726 are estimated to have disabling HIV/AIDS)	11,911 (7,266 are estimated to have disabling HIV/AIDS)
Revised At-Risk Estimates Pending Cuts in Federal Funding Revised Estimated Range: 6,599 – 12,402		
Persons At-Risk Due to Potential Cuts in Federal Funding	491	
Total Estimated At-Risk of Homelessness, Including At-Risk Due to Pending Cuts	6,599	12,402

The subcommittee looked at the number of PLWHA who are at-risk of homelessness due to being low-income in two ways:

- Using Reggie income data, and
- Using the number of persons on public insurance as a proxy for being-low income and, therefore, unable to afford market rate housing.

During the period March 1 – August 31, 2006, a total of 94% of clients in Reggie earned less than \$25,000 per year. It is assumed that this is an accurate estimate of whether an individual may be at risk of homelessness by virtue of not being able to afford:

- Market rate housing – including shared and rent controlled housing, and/or
- Most publicly supported affordable housing, based on income and eligibility requirements.

The resulting calculation: **94% of 18,300 = 17,202** provided an estimate of the “upper bound.”

However, due to the limited universe of clients represented in Reggie, the subcommittee also looked at insurance type as a proxy for being low-income. Between 1997 and 2005, 56% of persons with an AIDS diagnosis had public or no insurance. Applied to 18,300 estimated PLWHA: **18,300 PLWHA x 56% = 10,248** with public insurance or no insurance (proxy for low-income). This was considered the “lower bound.”

Once the subcommittee established upper at lower bounds for the at-risk population, the subcommittee reduced these estimates by the number of PLWHA estimated to be:

- Homeless (accounted for in the homeless category above) or
- Served by existing HIV/AIDS housing and non-HIV/AIDS-specific housing.

The number served in HIV/AIDS housing was obtained from funded programs (**1,533**), while the number served by non-HIV/AIDS specific affordable housing programs was estimated based on reports by affordable/specialized housing providers. For example, The Progress Foundation estimates that, in its residential treatment settings, 8% of clients report HIV/AIDS. Progress estimates that prevalence is actually higher (11-12% total), given that some clients may choose not to disclose their status, or they are

undiagnosed / do not know their status. Approximately 3% of persons in public housing and in Section 8 units are assumed to be occupied by persons with HIV/AIDS, based on the percentage of current public housing/Section 8 wait list applicants who voluntarily self-disclosed HIV status on their applications. The San Francisco Housing Authority indicated that 1,044 out of 30,334 Section 8 applicants “self-declared” HIV/AIDS status. The San Francisco Housing Authority oversees 33,000 units of affordable housing.

8% of 2,575 = 206
 3% of 33,000 = 990

Total number of persons with HIV/AIDS served in non-HIV/AIDS specific affordable housing:
206 + 990 = 1,196

Having arrived at an estimate of the number of persons who are currently housed but at risk of homelessness, the subcommittee wanted also to represent (i.e., “add back”) those who are currently living in assisted housing who are at-risk of homelessness due to pending federal budget cuts and policy changes (491). The number of “at-risk” are those receiving CARE-funded rent subsidies. Due to pending changes in the federal funding allocation formula that will reduce San Francisco’s funding allocation—and pending policy changes regarding allowable uses of funds—it is unlikely that CARE will continue to fund these rental subsidies.

At-Risk Subpopulations

At-Risk of Homelessness and HIV/AIDS+ Estimated Range: 6,108 - 11,909	
Subpopulations Within Total At-Risk Category (NOTE: Not all categories are mutually exclusive.)	Estimate
<u>Extreme Rent Burden</u> (Paying More than 50% of Income Toward Rent)	8,418 (5,135 are estimated to have disabling HIV/AIDS)
<u>Youth (18 or Younger)-</u>	76
<u>Seniors (50 and Older)-</u>	2,016
<u>Formerly Incarcerated</u>	654
<u>Living in SROs</u>	1,199

Extreme Rent Burden

According to a 2005 needs assessment of persons receiving CARE Act funded services in San Francisco, 46% of respondents earned incomes at approximately poverty level (\$9,570) and paid an average monthly rent of \$416 (more than 50% of income).³⁹ Applied to all PLWHA, this would equate to **8,418** PLWHA (46% of 18,300) with an extreme rent burden. Extreme rent burden is an additional means of determining the number of PLWHA who at risk of homelessness by virtue of their income. It is approximately midway between the upper and lower bounds established above.

Youth

Youth who are currently served in transitional housing beds for youth with HIV/AIDS are assumed to be at-risk for homelessness upon aging out of those programs due to the lack of available placements. Currently, a total of **76** youth are served in such transitional programs.⁴⁰

³⁹ Harder + Company. 2005 Comprehensive HIV/AIDS Health Services Needs Assessment Final Report. www.sfcarecouncil.org.

⁴⁰ Data from Larkin Street Youth Services.

Seniors

According to the *2005 HIV/AIDS Epidemiology Annual Report*, 33% of persons with HIV/AIDS were 50+ years old at the end of 2005.⁴¹ Applied to the upper and lower bound estimates of at-risk persons with HIV/AIDS cited above:

- Lower Bound: 33% of 6,108 = 2,016
- Upper Bound: 33% of 11,911 = 3,930

Formerly Incarcerated

Based on persons captured in the REGGIE system between March 1 – August 31, 2006, 10.7% were formerly incarcerated.

- Lower bound= 10.7% of 6,108 = 654
- Upper bound = 10.7% of 11,911 = 1,274

Living in SROs

Private SROs that do not offer tenants rights, and in some cases, access to reliable basic services such as heat, hot water, elevator services and basic security, are not seen as appropriate environments in which to stabilize the health of persons with living with HIV/AIDS. Persons with HIV/AIDS living in such environments are viewed as “marginally housed” and thereby at risk of homelessness; however, other SROs are operated by non-profit owners that ensure tenant rights and a range of on-site supportive services. Unfortunately, existing data does not distinguish between SRO housing environments.

Based on persons captured in the Reggie system between March 1 – August 31, 2006, 11.7% reported living in an SRO. This percentage was applied to all persons estimated to be at-risk of homelessness based on being low income.

- Lower Bound: 11.7% of 6,108 = 1,199
- Upper Bound: 11.7% of 11,911 = 2,013

It is unknown how many of these persons subsidized versus unsubsidized.

Other Issues

Research revealed other issues that the Comprehensive HIV/AIDS Housing Work Group should consider when shaping final recommendations for the San Francisco Board of Supervisors. These issues include:

- Preserving current resources vs. developing a broader, more visionary approach to HIV/AIDS housing in San Francisco
- Opportunities for transfer within the HIV/AIDS continuum of care / housing
- Incentives to motivate transfers / exits to more appropriate levels of care

⁴¹ San Francisco Department of Public Health, HIV Seroepidemiology Unit. *2005 HIV/AIDS Epidemiology Annual Report*. www.sfdph.org/PHP/HIVSeroUnit.htm.

- Help with placement
 - Problems with client presentation
 - Unwillingness of some landlords to house subsidized persons
 - Substance use may make some clients incapable of undertaking the housing search / lease signing without case management support
- Deep vs. shallow subsidies
- Developing appropriate housing for those with co-occurring disorders (e.g., harm reduction vs. “clean and sober” models—or a combination of both)
- Dynamic nature of HIV/AIDS population (e.g., growing senior component, youth aging out of certain programs / funding sources, etc.)

Summary of Additional Findings and Data Gaps

Based on subcommittee research:

- There are no exact measures of HIV/AIDS housing need in San Francisco. Most data serve as proxies only.
- Housing works. Based on data obtained in CCCYO satisfaction surveys, subsidies—shallow and deep—help improve health outcomes and client stability. Data captured here, however, do not give a clear picture of whether one type of subsidy is “better” or more effective than another.
 - CCCYO’s ’05-’06 Client Satisfaction Survey results indicate that:
 - 86% of deep subsidy clients indicated that their health remained stable or improved because of financial assistance. 92% reported better access to food, healthcare, and other services because they had stable housing.
 - 94% of shallow subsidy recipients reported that their health remained stable or improved because of financial assistance. 96% reported better access to food, healthcare, and other services because they had stable housing.
- Many gaps exist between existing data and data needed to accurately indicate unmet need for housing among San Francisco’s HIV/AIDS population. Several subcommittee questions, for example, remain unanswered:
 - How many persons living with HIV/AIDS are actually homeless? How many are inappropriately housed (including the rent burdened)?
 - What is the unmet need for housing among subcategories of the HIV/AIDS population?
 - Within the city’s HIV/AIDS population, how many people have co-occurring disorders? How many of those are homeless?
 - Among San Franciscans considered chronic, high users of emergency services, how many have HIV/AIDS?
 - Among those HIV/AIDS positive persons who are housed (e.g., renting apartments, living in SRO hotels), how many are subsidized? How many require placement in a more appropriate level of care?
 - How many lack but require in-home support?
 - How many are living in overcrowded situations?