

**Corporation for National and Community Service
2011 Social Innovation Fund
Corporation for Supportive Housing**

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**2011 Social Innovation Fund
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Executive Summary

CSH is seeking a \$1.15MM one-year Social Innovation Fund (SIF) award to advance enhanced supportive housing (SH) models, which combine health, housing and social services to improve health and housing outcomes for homeless individuals with complex health needs who frequently and often inappropriately use crisis and acute care at enormous expense to the public. CSH will use SIF funds to allow nonprofits to expand or replicate SH models that target frequent users of public crisis systems, including hospitals, shelters, and jails. The most cutting-edge SH models, which offer affordable housing coupled with integrated primary and behavioral health services, have been shown to improve housing and health outcomes for frequent users while reducing public costs. Yet these models exist only on a limited scale nationally. CSH is applying as an ISSUE-BASED INTERMEDIARY in the HEALTHY FUTURES area and will target four communities with high levels of need and capacity to expand/replicate SH models that target frequent users.

There is a window of opportunity to further scale these cutting-edge SH models and build stronger evidence of their effectiveness. The Affordable Care Act will expand Medicaid coverage for our target population, provide additional funding for community health centers, and focus on improved care delivery for people with complex health needs, making these enhanced SH models financially viable. As well, the current budgetary climate makes state and local government more receptive to initiatives that promise to cut costs. Yet, SH remains at the periphery of health systems and care. Through SIF, CSH would catalyze the adoption of SH by health systems, with these systems and providers embracing SH as a cost-effective strategy for serving frequent users and ending their institutional cycling.

PROGRAM DESIGN. CSH would provide grants through an open, competitive process to a diverse group of nonprofits seeking to expand or replicate innovative SH models that target frequent users. CSH has selected Los Angeles as our SIF anchor site, leveraging frequent user work underway, opportunity,

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and momentum. CSH also identified 10 other sites that represent the highest level of need and opportunity to scale enhanced SH models nationally. CSH will select nonprofits in three of these locations, and offer training and technical assistance (TA) to ensure subgrantees' effective implementation of SH models. CSH would also retain an independent evaluator to evaluate the initiative's efficacy. Our approach includes collaboration with other stakeholders in order to fund, plan, and implement the initiative. Public agencies will be engaged in each of the 4 locations as full project partners, providing access to frequent users of their services and data to effectively target these individuals, and advising on program design and implementation. Foundations will also be key partners, offering guidance and grant support to match SIF funding.

ORGANIZATIONAL CAPACITY. CSH is an established grantmaking entity, having provided \$17MM in grants to 333 nonprofits in the last 5 years. CSH has significant experience in successfully planning and implementing several, multi-site demonstration initiatives, including objectively assessing grantees and engaging multiple partners in a collaborative process for program design, implementation, management and evaluation. CSH combines financial support, training, TA, and coordination to guide grantees in achieving strong impact for their target populations. We target our grant resources to nonprofits with solid track records of developing and operating SH programs, with many grantees having performed well under third-party evaluations and under past CSH grants and loans.

COST-EFFECTIVENESS AND BUDGET ADEQUACY. Our proposed budget draws on a mix of unrestricted earned income and two in-hand foundation grants. We are committed to ensuring long-term sustainability; namely we will guide subgrantees in identifying sustainable funding for SH operations. CSH will offer significant financial support to our subgrantees for capacity-building and program implementation. Our program design and budget are based on past, successful CSH programs, with CSH benefiting from economies of scale by having national staff provide centralized oversight and

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guidance, and centrally liaising with the evaluator, while local staff provide hands-on support to subgrantees and develop deep ties to local stakeholders.

Program Design

1. GOALS AND OBJECTIVES

CSH will focus on Healthy Futures by promoting healthy lifestyles and reducing the risk factors that contribute to chronic illness, premature mortality, and homelessness among frequent and high-cost users of acute and crisis care systems. Nationally, 110,917 people are chronically homeless primarily due to untreated severe mental illness, addiction, and chronic health issues. A small but significant subset of this group are known as "frequent users," due to their long-term cycling between shelters, emergency rooms (ERs), jail, and other institutions. Frequent users are of growing national concern, as their reliance on crisis care results in exorbitant costs to public health and other systems. The most cutting-edge supportive housing (SH) models, those that offer affordable housing with supportive and health services, have been shown to improve housing and health outcomes for frequent users while reducing costs to the public. Yet, SH and these particular models remain at the periphery of major health systems. Via SIF, CSH would catalyze the adoption of SH by health systems as a strategy for cost-effectively serving frequent users. National healthcare reform offers significant opportunity for CSH to achieve this goal with expanded Medicaid coverage for our target population, additional funding for community health centers (CHCs), and focus on improved care delivery for people with complex health needs.

CSH will use SIF to expand and replicate SH models targeted to vulnerable and high-cost homeless clients, with the goal of improving their health and housing outcomes and lowering public costs. CSH will select grantees that will work with public agencies to identify frequent users and to provide SH tied to client-centered, integrated primary and behavioral health services. SIF grants will enable nonprofits to expand existing models, replicable/adapt proven models, demonstrate efficacy and cost-effectiveness, and increase local/national exposure and interest.

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NEED: HOMELESSNESS, RISKY BEHAVIORS AND CHRONIC HEALTH ISSUES. Poor health and risky behaviors contribute to homelessness and are exacerbated by prolonged periods of housing instability. Stable housing is a secure foundation for treating underlying health conditions and regular access to primary/preventive care. Instead, homelessness limits access to health coverage and appropriate care, exacerbates pre-existing conditions, and adds new health challenges. Absent stable housing tied to primary/preventive services, many high-need homeless individuals end up cycling between jail, shelters, ERs, hospitals, and other institutions, never receiving treatment to address the persistent health challenges that are the underlying causes of their homelessness and institutional cycling. Among the chronically homeless, per evaluations of CSH initiatives, at least 60% suffer from a serious mental illness, and over 80% have a long-term history of substance use. Street homelessness reinforces risky behaviors (substance use, unprotected sex, needle sharing) and exacerbates health problems. A 2007 study (Leaver) found that homeless individuals with HIV/AIDS are 16 times less likely to adhere to their drug regimen than those with stable housing. The Community Health Advisory & Information Network (CHAIN) project (2007) found that, after controlling for other factors, homeless individuals were 3 times more likely than stably housed individuals to use hard drugs and 4 times more likely to have recently shared needles or have had unprotected sex. Homelessness negatively impacts health through exposure to the elements, street violence, and communicable diseases, and lack of proper rest and nutrition. A 2005 NYC study found that homeless adults die at an earlier age due to preventable/treatable conditions.

Frequent users cycle between hospitalization, homelessness, and jail, with incarceration worsening their health. A 2006 Bureau of Justice Statistics report found that among mentally-ill inmates, 17% had been homeless in the year prior to jail entry and 25% had 3 or more prior incarcerations. Jails are typically over-crowded with a high concentration of people with contagious diseases (tuberculosis, HIV, and

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Hepatitis C). Substance abuse and mental health treatment capacity in jails does not meet the scale of need. A 2010 MI Dept. of Corrections study found 65% of mentally-ill prisoners do not receive treatment while incarcerated.

Despite their considerable health issues, frequent users typically are uninsured (67% of homeless single adults lack health insurance nationally (National Health Care for the Homeless Council, 2009)) and lack access to primary/preventive care. Many are ineligible due to their addiction; others are eligible but not receiving benefits due to challenges navigating the complex application process. As a result, this group often seeks emergency care. A 2007 national study found that homeless people with HIV/AIDS used ERs 92% more than stably-housed individuals with HIV/AIDS. A 2004 NY study found 20% of Medicaid beneficiaries incurred 73% of total program costs. Yet, crisis care does not address long-term health problems and leads to poor health outcomes. ERs are not equipped to meet frequent users' long-term health needs. Preventable/treatable conditions become serious health issues less effectively treated at a later stage.

SUPPORTIVE HOUSING: CHALLENGES AND OPPORTUNITIES FOR SCALING THIS INNOVATION.

SH, affordable housing coupled with supportive services, is proven to help vulnerable people stay housed and stabilize their lives. To address the specific challenges facing frequent users, CSH and nonprofits have improved upon this model, yielding the most cutting-edge approaches to client targeting and rich service models including: using data to identify/target frequent users; assertive services engagement and motivational enhancement; and partnering with CHCs to provide client-centered, integrated healthcare. Federally Qualified Health Centers (FQHCs) are particularly well-positioned to holistically meet the healthcare needs of this group. These special SH models address the underlying trauma and psychosocial factors that contribute to risky behaviors and involvement in crisis systems.

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Independent evaluations have consistently demonstrated the efficacy of these enhanced SH models, showing that housing connected to client-centered health care is a platform for behavioral change and reduction of risky behaviors, and that once in SH, even the most service-resistant and chronically addicted people begin living healthier lifestyles. Tenants utilize voluntary support services: medical (81%), mental health (80%), substance use (56%), benefit advocacy (51%), and employment services (41%) (CSH's Closer to Home (CTH) evaluation). Chicago Housing for Health Partnership (CHHP) included a randomized study of 405 homeless adults with chronic illness discharged from local hospitals, with half discharged into SH. The group in SH increased access to primary/preventive care and decreased use of crisis care, as compared to the control group. CHHP participants with HIV/AIDS enjoyed improved health, including an 87% lower viral load compared to the control group. A 2009 evaluation of Seattle's Eastlake project found SH tenants dramatically reduced alcohol use within 12 months (24% less drinks per day, 65% less days intoxicated). The CHAIN study found stably housed individuals were twice as likely to stop using drugs and having unprotected sex than those who remained homeless. In San Francisco (Martinez, Burt, 2006), tenants showed 56% less ER visits and 44% less inpatient stays after a year, while the control group had no reduction. As a result of reduced crisis care use, SH reduces public costs. Among the most costly 10% of homeless persons in Los Angeles, SH led to 71% lower costs (Economic Roundtable). A 2009 IL SH study found 39% cost reduction across public systems. In Denver, SH led to average savings of \$31,545 per person after 2 years (2006). Moreover, evaluations have shown that these enhanced models reduce jail recidivism. In the Eastlake project, over 50% of tenants had criminal justice histories, and the evaluation showed a 45% and 42% reductions in jail bookings and in jail days respectively over the baseline, yielding public cost-savings of over \$4MM in year 1. In ME, a study found that tenants' incarceration costs and days jailed dropped 95% after SH placement. Clients in CSH's NYC Frequent User Systems Engagement (FUSE)/Returning Home Initiative (RHI) pilot avoided returns to jail and shelter, 89% and 100% respectively.

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Despite these powerful health and system outcomes, these innovative models only exist on a limited scale nationally. There are several challenges to scaling SH models that target frequent users. Many communities lack the tools and systems (integrated data or predictive modeling tools) needed to identify frequent users. Providers may also lack experience with the housing-based service models that best serve this population. Also, while SH projects often offer some onsite medical/mental health treatment, providers struggle to cover the cost of comprehensively addressing tenants' complex health needs. SH providers expend significant time navigating health systems to maintain tenants' coverage/care, detracting time and resources from helping tenants achieve progress toward service goals. While SH/CHC models that target frequent users offer great promise, there are challenges to brokering effective partnerships between these groups, requiring an intermediary to structure their work and effectively target frequent users.

Through SIF, CSH will help communities develop the tools, practices, and partnerships needed to expand/adopt these SH models. SIF would provide needed catalytic funding to jump-start the creation of these models, build credible evidence for their efficacy in improving health and reducing costs, and increase national awareness of these approaches. Aiding us are the opportunities created via national health reform (increased: health care coverage via Medicaid and CHC funding, and focus on cost-cutting and client-centered, integrated primary and behavioral care).

TARGET GEOGRAPHIES. CSH has selected Los Angeles as the 'anchor site' for this initiative due to it: having the largest chronically homeless population (10,245 in 2009) and a large number of frequent users; being home to skilled SH providers that have adopted innovative models; having developed tools to identify frequent users. CSH would hold an open RFP process to select grantees in LA and in 3 other sites (details in 2.1) from a pool of 10 sites that represent the highest level of need and opportunity to

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develop and scale innovative SH models that target frequent users: NYC; Camden, NJ; Salt Lake City; Bay Area, CA; Denver; Detroit; Franklin Co, OH; Seattle; MN; and CT. SIF would leverage small-scale successes and momentum to catapult these communities forward. This pool is characterized by varying degrees of need, opportunity, and prior experience, supporting knowledge sharing between sites.

The 10 sites were selected based on these criteria: 1) largest chronically homeless populations (Detroit: most homeless persons per capita); 2) existing, small-scale frequent user or SH/health pilots, allowing CSH to expand/scale this work (e.g. frequent user of hospitals/jails initiative in Detroit, small-scale pilot to link frequent ER users to SH/FQHC teams in LA), with these programs in need of TA, coordination and grants to improve program design, targeting, and evaluation capacity; 3) agency data shared across agencies or routinely matched across systems, providing the basis for targeting frequent users; 4) relatively mature/sophisticated practitioner capacity, given that frequent user models represent a cutting-edge solution even within these fields; 5) opportunities for health system integration; 6) potential for public partnership, given that these systems will be critical partners for the frequent user models, evidenced by local governments' active involvement in SH and/or demonstration pilots, and collaboration between public agencies to address homelessness; 7) potential local funding; and 8) CSH presence/capacity, with CSH having deep local knowledge and experience in all sites, and field offices in 8 sites. Physical proximity to subgrantees will allow CSH to cost-effectively provide onsite training, TA, and subgrantee management, and tapping existing knowledge to assess applicants, inform program design and engage public agencies as partners.

TARGETED MEASURABLE OUTCOMES AND METHODOLOGY. Our primary goal will be to realize healthy futures for some of the most vulnerable members of low-income communities, guided by our Theory of Change (TOC): SH and coordinated health services>Mitigate trauma, exposure; increase access to primary/preventive health services>Reduce stressors that trigger risky behaviors; increase

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self-care>Decrease risky behaviors; increase use of appropriate health services, management of chronic conditions>Improved health; reduced use of crisis services & costs. CSH will issue a RFP to identify an evaluator, seeking a firm with a strong track record, sound methodological approach, well-regarded researchers, and knowledge/experience in issues of homelessness, health, and SH. CSH and the evaluator will develop an evaluation plan and methodology (details in 2.1), grounded in our TOC, with CSH, the evaluator, and subgrantees collectively identifying shared goals, expected outcomes, planned activities, and needed/available resources. We expect the evaluation to consist of a pre/post assessment of client-level outcomes, comparing key outcomes before and 1 year after SH placement. Key measurable outcomes for will include:

- New partnerships among public systems, CHCs and SH providers in 4 communities (signed agreements);
- Improved housing stability (length of tenure in SH, fewer returns to shelter/street);
- Increased healthcare coverage (clients enrolled for Medicaid);
- Increased use of preventive and primary care (wellness and sick visits);
- Rise in following of regular drug regimens for chronic and/or mental illness;
- Less mental illness symptoms (practitioner assessment);
- Improved physical health (client self-assessment);
- Increased mental health and substance use treatment utilization (overall service uptake and days in treatment);
- Reduced use and public costs of shelters, ERs, hospitalization, jail, and other crisis care.

2.DESCRPTION OF ACTIVITIES

CSH would use SIF funds to expand/replicate proven SH models that help frequent users overcome service resistance, promote self-care and empowerment, access primary/preventive care, and reduce risky behaviors and inappropriate/overuse of public health/crisis systems. CSH will facilitate

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partnership development, lead interagency data sharing/analysis to identify frequent users in each site, provide cross-sector training to solidify SH/health/public system partnerships, facilitate peer-to-peer learning, and provide technical expertise in financial modeling to achieve scale and financial sustainability (via Medicaid billing). As a result, the subgrantees will offer proven models for effectively, cost-efficiently serving frequent users.

1) SUBGRANTING: SELECTION PROCESS AND CRITERIA. CSH will design and implement an open, objective grantmaking process to select qualified subgrantees. In collaboration with CNCS, CSH will develop an RFP for nonprofit SH providers located in the 10 target locations. CSH will market the RFP to a broad list of local social service providers, CHCs, housing developers, and other nonprofits via direct mail and email, and utilizing the websites and newsletters of CSH, our partners and other local membership/trade organizations. CSH will hold online bidders' conferences to educate potential applicants on the Initiative, review the RFP, and answer questions. The RFP will detail the following selection criteria and application format:

*INITIAL SH/CHC PARTNERSHIP. The RFP will require a joint application from a SH/CHC team to help ensure that the SH providers and CHCs have established working relationships to be built on, reflecting our goal for subgrantees to quickly begin serving frequent users once awarded. Some groups may be partnering on a small-scale or informal basis (e.g. cross-referral of tenants between SH and CHCs), with a handful of applicants having strong, structured partnership models. The RFP will spur other groups to develop new partnerships, hammering out shared goals and roles/responsibilities as part of the application process.

*TOC AND EVALUATION PLAN. Applicants will articulate expected outcomes, planned activities, role of grant funds and other resources in narrative form and graphical representation (TOC) that depicts the relationship between planned activities and expected short and long term outcomes. CSH will assess the TOCs based on their alignment with the targeted outcomes/TOC for the initiative and overall

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soundness/logical flow of the proposed approach. CSH will seek out applicants with strong potential to create impact; those who articulate outcomes for the proposed program, identify numeric targets tied to these outcomes, detail a plan for data collection and analysis, and document a track record of achieving outcomes (preliminary or moderate evidence levels). CSH will work with subgrantees to refine these plans and to align/integrate them with the overall evaluation plan.

*VARIABLE PLAN FOR REPLICATING/EXPANDING INNOVATIVE MODELS. CSH seeks subgrantees that demonstrate firm commitment to expand/replicate models that target frequent users and offer integrated, comprehensive health, housing and social services, considering applicants' proposed: methods for targeting frequent users, program elements that address high-risk behaviors and chronic health needs, housing site or units, necessary funding or financing plan to support housing operations and ongoing services, and partnership structure.

*TRACK RECORD ACHIEVING OUTCOMES. Applicants will detail systems for tracking housing/service outputs/client outcomes, frequency of data collection, systems/databases, and how they use data to drive program management and refinement. We will consider their past participation (if any) in third-party evaluations and the results. Subgrantees should have preliminary to moderate evidence of current program efficacy.

*STRONG LEADERSHIP AND FINANCIAL AND MANAGEMENT SYSTEMS. Applicants must describe leadership team qualifications and involvement in program design, implementation, management, and evaluation, and their financial and management infrastructure, including accounting practices, budgeting processes, associated staff/qualifications, and Information Technology systems. Applicants will describe their performance and reporting with federal contracts and funders.

*GOOD FINANCIAL HEALTH AND SUSTAINABILITY PLAN. Applicants will provide financial statements for the past 3 years. CSH will gauge organizations' financial stability based on the type, amount, and duration of funding sources. Applicants should present a viable plan for using grant funds/program sustainability, encouraging one-time investments to seed programs (planning costs,

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infrastructure improvements, and engaging consultants for additional expertise) rather than operational costs. Applicants will identify sources for a portion of the match, but CSH would help subgrantees fundraise. Subgrants would start at \$100,000 but be prorated, with larger grants for nonprofits that BOTH propose a large scale/impact AND that CSH assesses as well-positioned to realize this scale/impact, based on their evidence of impact for current/past programs.

*STRONG POTENTIAL FOR SYSTEM ENGAGEMENT AND COORDINATION. The public systems that affect the target population will play a critical role by providing access to data. Strong applicants will have signed letters of support from appropriate government agencies, indicating agency interest in the proposed work and commitment to actively participate in the subgrant.

2) TECHNICAL ASSISTANCE AND SUPPORT. CSH will provide a comprehensive suite of TA to subgrantees to ensure their achievement of our shared goals and targeted outcomes.

*COMMITMENT TO LONG-TERM RELATIONSHIPS, SETTING SHARED GOALS, ONGOING COMMUNICATION AND ADJUSTMENTS. CSH will draw on subgrantees' TOCs to facilitate 1-2 groups sessions in each jurisdiction in order to develop an overall TOC for the initiative, collectively identifying short and long term outcomes, needed resources and activities to realize the outcomes and anticipated potential challenges. CSH and the evaluator will facilitate group sessions to develop a global evaluation plan for the initiative, and guide subgrantees/partners in identifying numeric targets tied to identified outcomes, data indicators, and a plan for data collection and analysis. As the initiative becomes operational, we will use monthly meetings to identify challenges and make course corrections. CSH will provide individualized TA to grantees to overcome any challenges and/or adjust the grantees' targets in case of insurmountable challenges. CSH will provide a mix of training group and 1:1 support from the planning stage to the end of the grant term.

*ASSIST SUBGRANTEES INVEST IN PERFORMANCE IMPROVEMENT. Building on their successful proposals, CSH will work with the subgrantees to refine program models, offering trainings on

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enhanced SH models, drawing on CSH frequent user/health initiatives and knowledge of Medicaid billing mechanisms/financial models, and guiding project planning and implementation. CSH and the evaluator will guide each subgrantee in developing and implementing an evaluation plan that aligns with the overall initiative's plan but is customized to the nonprofit's specific program/local conditions. CSH will help subgrantees develop an implementation workplan and create protocols for service delivery, tenant engagement, and housing provision. CSH will use regular site visits, phone calls, and quarterly reports with subgrantees to monitor their progress in meeting set targets. CSH will provide intensive TA to subgrantees that experience challenges and draw on our government partners to assist in troubleshooting, detailed under EVIDENCE.

*RESOURCES AND SUPPORT TO BUILD CAPACITY. CSH will provide responsive training and TA to address capacity-building needs including financial management practices, aligning the projects with the nonprofit's mission, and improving management. At the initiative's inception, CSH will work with each nonprofit to develop an individual workplan that details the agency's needs, capacity-building goals, tasks to be completed, and a timeline for implementation, with this workplan guiding our TA work.

*LEARNING/IMPROVEMENT ACROSS SUBGRANTEES. Building on past experience, CSH will utilize a multi-pronged approach to peer learning. We will create a Learning Collaborative, with CSH providing subgrantees with monthly opportunities (in-person and web-based) to share experiences and challenges. CSH will tap experienced/proven SH providers and CHCs (with strong evidence) to mentor subgrantees and participate in information exchange around program successes, challenges, and lessons learned from peers. Collectively, these groups possess tremendous first-hand knowledge of successful approaches and challenges in selecting program models, structuring partnerships, financing health services in SH via Medicaid, and implementing projects. Public agencies will provide insight on using public funding streams to underwrite ongoing services for the SH projects.

*SUPPORT RE: MATCH AND ONGOING SUSTAINABILITY. CSH will require applicants to identify

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funding sources for a portion of the match, but will work closely with subgrantees to raise match dollars. We will leverage our role as an implementing partner of Funders Together to End Homelessness, a national network of foundations and corporations that support grantmaking to end homelessness, to help subgrantees meet their SIF match.

SUBGRANTEE AND CSH ACCOUNTABILITY. CSH will be accountable for achieving the overall, macro-level targets for the outputs and outcomes, holding subgrantees accountable for meeting individual targets. We will work with CNCS semi-annually to assess overall progress and solicit CNCS's feedback in troubleshooting any challenges. We will work intensively to detect any operational or programmatic issues early on and quickly address these issues in conjunction with our subgrantees, collaborators, and CNCS.

3.USE OF EVIDENCE

CSH uses grants to allow proven nonprofits to plan new, innovative programs and expand programs with preliminary or moderate evidence of effectiveness, bringing this work to scale and positioned for greater impact and more rigorous evaluation. CSH routinely contracts with evaluators and researchers to conduct robust evaluations of CSH grantees and initiatives. We leverage this learning to further invest in proven grantees and to replicate their program models.

ROLE OF EVIDENCE IN SELECTING GRANTEES. Evidence of program/organizational effectiveness plays a paramount role in CSH's grantee selection. Applicants must provide detailed information on their organization, current programs, evidence of impact (third-party evaluation results, self-reported data), and proposed project in a standardized format. CSH evaluates the soundness of the program concept/model and the extent to which it draws on industry best practice and evidence-based approaches, and the plan for service delivery and evaluation. For FUHSI (2003-2008), a \$10MM pilot, CSH developed/tested models to serve frequent users of ERs and acute care in California. Tarzana

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Treatment Center and LA Family Housing were both successful grantees, per their strong evaluation results, leading CSH to make additional grants to both post-FUHSI. For CSH's Taking Health Care Home (THCH) (2002-2008), public agencies and SH providers applied via an RFP process, and CSH awarded 6 locations with innovative health/housing models that yielded preliminary evidence of effectiveness but lacked scale and formal evaluation. Evidence plays a key role in loan decisions, with CSH reviewing our past loans and grants to the nonprofit and its track record meeting grant deliverables, targeted outcomes for loans, and/or effectiveness under evaluated initiatives, and reinvesting in groups with a solid track record. We also use grants and loans to incent nonprofits to enter the SH industry, building their capacity and growing the field, in order to scale this innovation nationally. After successful performance on a \$1.7MM loan for a SH project, CSH awarded another loan to Jericho Project in NYC for \$1.9MM for another project.

ROLE OF EVIDENCE IN REPLICATION AND EXPANSION. Evaluation results inform CSH decisions to expand our grantees' programs and replicate successful models with other nonprofits/locations. Based on the initial, strong results of RHI grantees in NYC, CSH expanded the program to 100 more participants, with 4 of the 9 RHI grantees receiving additional funds to support expansion. The strong NYC RHI results also provided the impetus for bringing this model to other jurisdictions, with reentry SH/frequent user pilots now underway in 10 locations and CSH leveraging evaluation results to provide TA to grantees on program design. In CA, CSH is leveraging FUHSI lessons learned to provide training/TA to more health centers and SH providers to replicate successful models in Los Angeles and the Bay Area.

HOW EVIDENCE DRIVES IMPROVEMENT AND TRACK RECORD USING RESULTS. Our grantmaking is directly tied to clear, measurable outcomes for our grantees. CSH regularly monitors grantee progress against set targets for service/housing provision and client-level outcomes. For RHI, a

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national reentry and frequent user (of jail) initiative, CSH monitors each grantee's performance against set targets on a quarterly basis and provides intensive TA to address any performance issues. We use monthly meetings with grantees/project partners to review self-reported or evaluation data, collectively troubleshoot issues, and develop course corrections. This approach enabled grantees to learn from the data in real-time and from their peers, and to adjust their approaches accordingly. For instance, CSH presented data analysis at a quarterly RHI meeting in OH, revealing an issue with client enrollment, and led subgrantees and partners brainstorming potential causes and solutions. CSH then provided training to address the issue, resulting in improved prison in-reach procedures and the program meeting its targets. For NYC RHI, data monitoring uncovered grantee performance issues and led CSH to reduce grant amounts/targets for several grantees and reallocate these funds to other successful grantees.

STUDIES THAT GENERATED EVIDENCE. CSH has sponsored numerous independent evaluations to test program efficacy on client and systems level outcomes, including varying methodologies (random assignment, treatment and control group, pre- and post- treatment data analysis), depending on available funding and whether the project lends itself to a random assignment/control group design. Our work has yielded impressive client and systems level outcomes, consistent with CNCS's definition of strong impact. Columbia University tracked NYC RHI participants and a group of similar non-participants, and documented positive outcomes after a year: 91% of tenants remained stably housed; 92% experienced a reduction in shelter stays; and 53% recorded a decline in jail recidivism. For CTH, Columbia collected data at project baseline and during the 2-year program period on clients' housing history and service engagement, demographic characteristics, and mental health and substance use status. Pre and post data comparison showed that 82% of participants were still in housing after 2 years, a major feat considering they previously had been homeless for years and difficult to engage in other housing and service programs. The Lewin Group's evaluation of FUHSI showed that homeless clients experienced a 61% decline in ER visits and a 62% drop in inpatient hospital stays over 2 years, and that

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the subset placed in SH experienced even stronger outcomes than those only offered health services, a 27% drop in inpatient hospitalization versus a 26% increase, respectively.

PLAN FOR/ROLE OF EVIDENCE IN SELECTING SIF SUBGRANTEES. Evidence will play a key role in SIF subgrantee selection, monitoring, and capacity-building. As detailed in Description of Activities, CSH will select nonprofits with preliminary or moderate evidence of effectiveness for existing innovative SH or frequent user programs but that require TA/grant support to refine these models, reach scale, and demonstrate larger impacts via more rigorous evaluation methods. Once selected, CSH and our evaluator will work with each subgrantee to design a data collection and evaluation plan, and CSH will require quarterly reports from the subgrantees on self-reported client-level data. CSH will use this data to assess their progress toward set targets and provide intensive TA to improve performance, working with subgrantees to refine client recruitment, assessment, service delivery, case management, and other program components as needed.

Organizational Capacity

A. ABILITY TO PROVIDE PROGRAM OVERSIGHT

ORGANIZATION HISTORY AND ACCOMPLISHMENTS. Established in 1991, CSH was the first and remains the only national nonprofit intermediary dedicated to building the SH industry and ending homelessness. Integral to achieving this mission is the provision of financial support to housing developers, homeless service providers, and SH project sponsors, building their capacity and supporting the implementation of innovative, effective program models. CSH has committed over \$272MM in loans and grants to SH projects to support the creation of nearly 50,000 new SH units nationally. The units in operation have ended homelessness for over 29,000 people, and improved their health along the way.

CSH provides the following core activities:

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*CAPACITY BUILDING. CSH offers grants and training to encourage homeless service providers and affordable housing developers to enter the SH industry and increase develop and operate high-quality SH and document the effectiveness of these programs.

*PROJECT-SPECIFIC ASSISTANCE. SH project sponsors must cobble together funding from disparate sources, engage in a lengthy planning process, and build community support. We provide recoverable grants, low-cost loans, and TA to overcome these challenges.

*SYSTEMS CHANGE. CSH partners with government to reform SH policy, increase funding, and coordinate systems to make SH easier to develop and operate. We also increasingly partner with government agencies to effectively target frequent users.

*INNOVATION. CSH leads the industry by developing innovative SH models with our partners and testing them through national demonstration pilots. We partner with independent evaluators to document lessons learned and assess impact. This work provides cutting-edge best practices and techniques for the industry.

For 20 years, CSH has refined the SH model, built credible evidence for its outcomes and cost-effectiveness, and helped establish SH as the central solution to long-term homelessness. We have helped move thousands of people with disabilities into SH, ending long, costly and difficult years of life on the streets and in crisis systems and institutional settings. Given its broad impact, our goal is to bring SH to the forefront of mainstream systems. Specifically, CSH is focused on engaging the health system to target frequent users. While operating on a limited scale nationally, models that target frequent users, and those that partner SH providers and health providers have proven to improve client outcomes while reducing public costs.

EXPERIENCE IN THE PROPOSED PRIORITY AREA. CSH has a long and successful track record of designing and implementing complex, multi-site demonstration initiatives that include subgranting,

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grantee oversight, and rigorous evaluation. CSH also has significant experience in SH programs that reduce high-risk behaviors and improve health status. FUHSI, for instance, demonstrated the critical role that housing and voluntary, client-driven services play in reducing risky behaviors and enhancing health outcomes. We have leveraged lessons learned to provide capacity-building training, TA, and grants to additional SH providers and community health clinics. As well, CSH has developed FUSE initiatives in NY, Washington, D.C., OH, MN, CT, WA, and CO, which established partnerships across systems to identify frequent users and provide SH and coordinated care. CSH has a strong track record of partnering with public agencies to access data and clients to conduct in-reach. Through FUHSI, CSH facilitated the development of a systematic, long-term data collection strategy with hospitals and other partners. The program tracked crisis service use/entry, support service utilization, and costs. The community-wide database linking various systems enhanced data-sharing capabilities and care coordination across medical and social service systems.

Our proposed SIF work builds on our recent track record and current focus on developing new "health home" models through SH/health provider partnerships. CSH has launched and is currently piloting these efforts in communities in CT, CA, NYC, Detroit and Seattle.

RANGE OF REPLICATIONS AND EXPANSIONS OVERSEEN. CSH has successfully overseen a range of SH expansion/replication efforts. Our SH Institute is our signature capacity-building and grant-making effort through which we share lessons learned and proven SH program models with nonprofits new to the SH field. We also offer stand-alone trainings nationally to disseminate findings from CSH-sponsored initiatives and evaluations, highlighting promising approaches to housing/service delivery and collaborative efforts among nonprofits and government.

Our track record directly attests to our organizational ability to simultaneously support and oversee

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multiple national, grantmaking and demonstration initiatives in jurisdictions nationally. CSH's successful, large-scale national grantmaking initiatives include RHI, THCH, and FUHSI. Within a given initiative, CSH typically oversees subgrantees and evaluators in multiple jurisdictions at once (e.g. RHI demonstration initiatives are currently underway in 6 states). To successfully manage these multi-site initiatives, 1 national staff person serves as the overall lead. Local staff offers training and TA, coordinates project partners, and manages grantee selection and monitoring. Local staff and the national lead work together to identify additional staffing needs to support subgrantee planning, implementation, and evaluation efforts. The national lead centrally monitors the initiative's overall progress and ensures that lessons learned are shared across sites. Local staff shepherds the implementation process in his or her respective site and ensures that resources are in place for the site to meet its share of the initiative's targets and goals.

RANGE OF EVALUATIONS, METHODOLOGIES, AND RESULTS DISSEMINATION. CSH has partnered with numerous evaluators to test the efficacy of SH models on client and systems level outcomes. Evaluations have included a variety of methodologies, based on initiative goals, research questions, and available funding. CSH-sponsored evaluations typically include comparison and treatment groups, with some evaluations using random assignment to create and track such groups and others using comparable control groups. Other CSH-funded evaluations have collected data on key client service and engagement milestones and housing, health, and social outcomes, drawing on data from client and provider surveys and government databases. CSH contracts evaluators to analyze project data at multiple points in initiatives' operations and develop several interim reports as well as final reports. Complementing the work of evaluators, CSH also collects self-reported data from subgrantees to monitor progress, identify trouble spots, and remediate any issues in real time.

CSH partners with renowned research institutes and evaluators that abide by the highest standards for

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independence and technical rigor in order to ensure both internal and external validity for the evaluations. CSH contracts researchers who specialize in homelessness and/or specific homeless sub-populations, bringing expertise in understanding the target population, knowledge of other field research and appropriate methodologies. All CSH-selected evaluators employ rigorous evaluation methodologies and adhere to the highest guidelines for impartiality and independence. For instance, CSH is working with Urban Institute's Justice Policy Center to evaluate RHI pilots in Washington, D.C., Ohio, and Cook County, IL. For the FUHSI evaluation, CSH partnered with The Lewin Group, a premier research firm specialized in health care and human services research. CSH publishes and disseminates evaluation reports and findings to the industry and stakeholders via our website and those of our partners and peers, industry conferences, incorporating findings into our training curricula and TA, and holding meetings with policymakers.

CAPACITY TO MANAGE A FEDERAL GRANT AND OVERSEE SUBGRANTEES. CSH has a strong track record as a federal grantee, a TA provider and a grant maker as well as in meeting match requirements for our federal grants.

*HUD TA: CSH has received and successfully managed 14 U.S. Department of Housing and Urban Development (HUD) TA awards totaling over \$12MM, 3 of which are still active (2008, 2009 & 2010). CSH staff works extensively with HUD grantees/potential applicants, other TA providers, and government and nonprofits in over 30 states, offering training and TA on HUD housing programs. Given that performance on past CDTA awards is a major factor in the awards process, our numerous awards from HUD attest to the quality and timeliness of our TA provision, compliance with federal reporting requirements, accounting procedures, and federal spending guidelines, and our track record in raising match funds.

*CDFI AWARDS: CSH has received 8 awards (\$11MM total) from the U.S. Department of Treasury CDFI Fund which has all been re-awarded out to project sponsors. 3 awards are currently active (2008,

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2009, and 2010); the remaining 5 have been successfully implemented and closed out. We have deployed these awards per assistance agreements with the CDFI Fund, as evidenced by our repeated awards, given the Fund's policy to fund fully-compliant prior awardees with successful track records. As well, the Fund requires a 1:1 match for awards, which CSH has fulfilled for each award, with CSH raising over \$11MM in match funds.

*RCDI: CSH recently closed out a grant award from the U.S. Department of Agriculture's Rural Community Development Initiative (RCDI) Program, under which we provided financial support, capacity-building training and TA to American Indian tribes to develop SH on tribal land. CSH successfully raised the 1:1 match for that grant, having secured \$300,000 in private foundation resources as match funds. In 2010, CSH received an additional RCDI award for work with additional tribes in MN, reflecting our strong performance on the first grant. We have already raised the \$200,000 match for the second award. Both RCDI awards included subgranting federal funds to tribes for capacity-building and SH project planning, with CSH meeting all federal requirements and using subgrant funds strategically to catalyze the replication of a successful American Indian SH model.

*SECTION 4: In the last 2 years, CSH has received 4 HUD Section 4 subgrants for a total of \$310,000 from Enterprise Community Partners to provide TA to nonprofits and tribes to develop American Indian SH. This program requires a 3:1 match of Section 4 funds, with CSH having successfully met this match requirement.

CSH has considerable experience managing federal subgrantees. For our first RCDI award, CSH provided \$140,100 in a federal subgrant to our technical and financial assistance recipient to build its capacity and cover the costs of predevelopment work for SH projects. CSH required the nonprofit to submit quarterly reports, formally documenting its RCDI-eligible expenditures, related activities and outcomes as compared to a pre-set budget and targeted milestones for the subgrant. CSH reported this information along with our own expenses and activities to USDA on a quarterly basis.

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For our 7 CDFI awards, CSH has provided \$11MM in Project Initiation Loans (PILs) to providers nationally. For each PIL, applicants must complete a detailed application that documents their plans for a specific project, needed and projected funding sources, organizational capacity and relevant experience. CSH reviews these applications against set, objective criteria. Selected CDFI sub-awardees must then report to CSH quarterly on the use of funds and their progress in developing their SH project. CSH provides intensive TA and support to ensure that the project planning process moves smoothly and funds are spent according to CDFI Fund rules. CSH also uses quarterly reports from the sub-awardees to develop and submit quarterly reports to the CDFI Fund.

RESOURCES TO SUPPORT SUBGRANTEE REPLICATION AND EXPANSION. CSH currently has 88 full-time staff, 1 part-time staff, and 3 volunteers, with extensive experience in housing and community development, nonprofits, government, supportive services, grants management, leadership, and administration. CSH has staff in 20 U.S. locations, each overseen by 1 of 3 regional managing directors (MDs). CSH would leverage local staff's strong community relationships and knowledge of local conditions to design each local initiative, select subgrantees, and provide support to the providers.

In each region, the MD is empowered to nimbly deploy his/her staff to high-need communities, enabling us to leverage our staff's extensive range of expertise with broad geographic reach. CSH regularly deploys national staff with expertise in innovative program models, evaluation, specific homeless sub-populations, and funding streams to support local grantmaking, lending, training, evaluation, and TA efforts in jurisdictions nationally. For the SIF initiative, national CSH staff would be instrumental in leveraging lessons learned nationally to promote the replication of best practices and proven models in the 3 target sites.

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CSH regularly develops toolkits and web-based resources for the SH industry that offer step-by-step guidance in identifying funding sources, creating program design, developing budgets, partnership structures, and evaluation. These tools are available free on csh.org. CSH recently upgraded our internal MIS; and our database that tracks SH projects that receive training, TA and/or financial assistance from CSH, and the number of SH units added to the pipeline as a result of our work. We supplement this data by collecting client-level service and outcome data for individual demonstration projects. CSH would provide SIF subgrantees with real-time data on their grant performance and program outcomes, helping to identify trouble spots and implement course correction.

TRACK RECORD OF FUNDRAISING AND FUNDER DIVERSITY. CSH enjoys diverse support from government funding agencies, corporations, national and local foundations, earned income, and individual donations. CSH has consistently diversified and broadened our funding base. Revenue from government contracts, investments, and financial products having increased greatly since 2004. In 2010, CSH raised over \$7MM in new signed contracts and \$14.4MM in grants, more than doubling our targets for fundraising and with 25% of the awards representing new funders. CSH enjoys long-standing relationships with several private, national foundations including the Conrad N. Hilton Foundation, the Open Society Institute (OSI), the Robert Wood Johnson Foundation (RWJF), Fannie Mae, and the Oak Foundation. While these funders provide substantial support for national staff, our field staff are supported mainly through grants from local community foundations and corporations, and through training and TA contracts with local and state funding agencies. Altogether we manage approximately 200 grants and contracts annually. As we deepen our work in locations where we have field offices and in new sites, we develop stronger relationships with local foundations and government agency staff, and demonstrate our value to the local community, leading to additional local contract and grant opportunities.

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As an implementing partner of Funders Together, CSH has helped educate funders of homeless issues on SH and SH innovation, and has established good relationships with diverse foundations and corporations nationally.

Board of Directors, Administrators and Staff

LEADERSHIP AND ACCOUNTABILITY. Our senior management guides the creation of our strategic plans, providing a roadmap for working towards our mission. The team has long tenures in the field and with CSH, with all but 1 member having been with CSH for at least 7 years. The team is dispersed nationally, allowing our leadership to take a direct role in local operations and relationship-building, and on-the-ground program monitoring.

BOARD. The 16 members of CSH's Board of Directors collectively have deep and wide-ranging experience in affordable housing, housing finance, serving vulnerable populations, state and local government, real estate development, and the criminal justice system.

KEY STAFF POSITIONS AND QUALIFICATIONS. This national initiative will be led by the Innovations team at CSH. Local CSH field staff would serve as the primary trainer, TA provider, and convener in each local area. MDs who oversee our overall work in each of 3 regions will supervise the work of the local staff and help to troubleshoot any operational issues with Innovations as well as offer strategic guidance on the program's overall direction.

CONNIE TEMPEL, CHIEF OPERATING OFFICER, provides overall direction of CSH's local offices, MDs, as well as our Innovations team and the Consulting and Training unit, which provides technical assistance beyond the CSH footprint. Ms. Tempel has been with CSH for 17 years; prior CSH positions

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included MD, Eastern Region and New York Program Director. She also oversaw a UPenn study proving SH's cost-effectiveness and the NY State Psychiatric Institute's evaluations of interim housing. Ms. Tempel will provide high-level guidance in shaping the program, advising on the role of partners, assisting in raising match funds, and monitoring the initiative's progress and challenges on a monthly basis.

RICHARD CHO, DIRECTOR, INNOVATIONS AND RESEARCH (I&R), oversees CSH's efforts to design, advance, test, and replicate new housing and services innovations adapted for a variety of vulnerable populations. Mr. Cho has been with CSH for 10 years and led CSH's efforts to create SH for people leaving criminal justice involvement. Mr. Cho, based in New Haven, CT, will have overall responsibility for coordinating the work to be completed. He will set the direction of subgrantee outreach and selection, guide the training and TA delivery, advise on program design and evaluation, and monitor the initiative's overall progress in meeting key outcomes.

JACQUELYN ANDERSON, I&R SENIOR PROGRAM MANAGER, manages all CSH's research and evaluation efforts. Prior to CSH, she was a Research Associate for MDRC, where she evaluated a number of large-scale national initiatives targeted to low-income families and disabled individuals focused primarily on employment, job retention, and career advancement. She also worked for two years at Mathematica Policy Research in Washington, DC where she studied anti-poverty programs and policies. Jacquelyn has a master's degree in public policy from the University of Michigan.

PLAN FOR SELF-ASSESSMENT AND IMPROVEMENT. CSH is an outcome-driven organization and invests in tracking the impact of our work on the SH industry. The short-term outcome of our grantmaking, lending, training, and TA is increased capacity for government and practitioners. As well, CSH's work is guided by our own TOC. The main long-term outcomes for our work are the number of

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SH units created and the impact on SH tenants (i.e. increased housing stability, decreased jail, shelter and inpatient hospital stays, and increased uptake of primary/preventive care and ongoing services). CSH will track/evaluate our TA/training/financial assistance activities and client-level outcomes (as described above). For our systems change efforts, through our semi-annual Systems Change Survey, we track a number of indicators to assess positive changes in the funding and policy environment for SH, including increased/re-allocated funding and incentives to create more SH. Data from these sources is tabulated in a quarterly MSP report, which tracks our quarterly and annual progress against set numeric targets for CSH's overall organizational goals. CSH uses these quarterly reports to trouble-shoot issues and drive management decisions regarding staff allocations and the need for professional development and additional infrastructure investments. As well, our senior management team meets weekly to discuss macro-level organizational progress and challenges, assess new programmatic and fundraising opportunities, and re-deploy staff and other resources as needed to deliver on contract and grant deliverables.

B. ABILITY TO PROVIDE FISCAL OVERSIGHT

CSH possesses a unique mix of staff skills, expertise, and infrastructure that we will leverage in order to provide effective fiscal oversight of our own use of grant funds as well as that of our subgrantees. As detailed in Part II, Section A, CSH staff have considerable expertise in performing on federal grants, complying with federal rules and regulations for grant expenditures, and in monitoring the expenditures, documentation, and billing of our subgrantees. Our qualifications as they relate specifically to the Review Criteria are:

*QUALIFICATIONS AS AN ELIGIBLE GRANTMAKING INSTITUTION. CSH has provided \$17MM in grants to 333 nonprofits in the last 5 years, in addition to our provision of \$128.6MM in low-interest

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loans to 210 nonprofits for affordable housing creation. Offering financial support is a primary function for CSH in achieving our mission. We fund a diverse array of nonprofits nationally and openly market grant and loan opportunities. We also set numeric targets for our subgrantees and guidelines and timeframes for reporting progress against these targets and financial expenditures. We play a hands-on role in monitoring the progress of our subgrants and couple this monitoring with training and intensive 1:1 TA.

*KNOWLEDGE, SKILLS AND ABILITY TO PROVIDE FISCAL OVERSIGHT AND EXPERIENCE WITH FEDERAL SUBGRANTEES. CSH has considerable experience managing federal grants and in providing fiscal oversight for federal subgrantees. Our Finance Manager, Matthew Hughes, directly oversees the processing of all grant and loan dispersals and tracks grantees'/borrowers' progress in meeting grant/loan agreement terms. For our CDFI awards, Mr. Hughes has reported quarterly to the Fund on time and in compliance with federal rules for expenditures. This includes collecting information from our borrowers on their use of funds and the status of their housing development projects. CSH has 5 additional, experienced accounting professionals who make up our Finance Team.

*EXPERIENCE AND INFRASTRUCTURE FOR GRANTS MANAGEMENT. CSH has a successful track record in grantmaking, monitoring subgrantees, reporting to funders, and achieving strong outcomes. Our Finance Team supports program directors in monitoring subgrantee performance, developing financial reports for funders that include subgrantees' expenditures, and ensuring that these expenses align with the approved line items for our overall grant budget and that of the subgrantee. Finance has a powerful accounting and financial reporting tool to record expenses against multiple grants and contracts, and quickly generate detailed reports for grants and subgrants. CSH would tap this rich expertise and infrastructure to guide and support our program staff in monitoring subgrantees for the SIF award.

*ORGANIZATIONAL BUDGET AND PERCENT REPRESENTED BY SIF AWARD. CSH's 2011 budget is \$21,249,470, which includes a diverse mix of grant support, federal and local contracts, earned income

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from our loan fund, and individual donations, as detailed in Part II, A, above. A SIF award would represent 5% of our annual budget.

*PLAN TO ENSURE COMPLIANCE WITH FEDERAL REQUIREMENTS. CSH would leverage our existing infrastructure, protocols, and approaches for fiscal oversight, which have proven successful with past federal grants and contracts, and private grants. CSH's Finance and Fund Development Teams would hold a kick-off meeting with key program staff to review the approved budget, grant terms, milestones, and deliverables, reporting requirements, eligible uses, and federal regulations. Finance would then generate monthly financial reports to review expenditures against eligible uses and set budget lines. CSH would also generate semiannual financial reports. CSH would maintain organized, detailed files for the SIF award, including all expenditures, documentation, and reporting materials.

Budget/Cost Effectiveness

A. BUDGET AND PROGRAM DESIGN

*COST-EFFECTIVENESS OF BUDGET AND STAFFING PLAN AND DIVERSITY OF FUNDING SOURCES. Our proposed budget draws on a mix of unrestricted earned income from our lending operations and in-hand national and local private foundation grant funds to support the initiative's implementation. As well, several aspects of our budget and proposed approach reflect a commitment to ensuring the long-term sustainability of the funded program models and subgrantees. We will direct subgrantees to use SIF funds for one-time investments in organizational infrastructure and due diligence activities, and/or to provide initial support for new staff who will be charged with centralized in-reach (jail, shelter, ERs, etc.), intake/assessment, and/or case management/service coordination to ensure coordination between public systems and health/housing/social service providers. For new staffing requests, SIF funds would pay for this position in the first year, with the goal of developing a financial model for billing Medicaid for such services to cover this position in the second year and beyond. Our training and TA will guide subgrantees in identifying sustainable funding streams for SH

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operations, with emphasis on newly-available federal resources for CHCs, Medicaid reimbursement, and SH funding streams. The proposed budget also includes other one-time costs. Due to the austere budgetary and fundraising environment, CSH is conservative in our projections for match funds, with the attached budget only assuming that CSH will meet the minimum 1:1 match requirement. However, if funded, CSH would work intensively to exceed this benchmark in order to maximize the available resources for the initiative and to ensure its success. Additionally, depending on the locations selected, CSH has more match funds on hand to pledge to this initiative. As well, CSH is proposing to offer significant financial support to our subgrantees, through SIF and match funds, to underwrite capacity-building and support program implementation, see details below.

*BUDGET ADEQUACY FOR PROGRAM DESIGN. The staffing pattern leverages the collective and complementary resources and expertise of our national teams and local field staff, which has been successfully utilized for our RHI, THCH, and FUHSI initiatives. CSH will benefit from economies of scale with national staff providing centralized oversight and expert guidance to local staff and subgrantees, and centrally liaising with the evaluator. For instance, our Innovations and Research (I&R) Director, Richard Cho, will oversee the Initiative's design and implementation, providing centralized monitoring and guidance to the four implementation sites, local CSH staff, subgrantees, and the evaluator. He will devote 40% of his time to the Initiative. As well, Jacquelyn Anderson, I&R Senior Program Manager, budgeted at 37% full-time equivalent (FTE), will tap her research expertise to guide the evaluation's design in collaboration with the independent evaluator. She will also serve as the intermediary between the evaluator and local CSH staff and subgrantees. In each selected location, the project will be staffed by a CSH Program Director (30% FTE) and Program Manager (60% FTE) who will provide intensive training, TA, and implementation support to the nonprofit subgrantees and liaise with the public system partners. The local staff will be guided and supported in these efforts by their respective Managing Director, with one MD overseeing each of CSH's three regions. While we are only proposing for SIF funds to cover \$35,499 in personnel costs, the budget includes another \$359,415 in

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such costs, reflecting the intensive level of TA and coordination needed to expand and replicate successful, sustainable SH/health models that target frequent users. The budget also includes fringe benefits, calculated at 29% of personnel costs and supplies (rent, utilities, telephone/internet, office supplies, postage, copying/printing), all calculated at set percentages applied to the total personnel costs. The budget includes costs for meeting space for training for the subgrantees, local travel to conduct site visits and training, and overnight travel for national staff to provide onsite training and support to local CSH staff and the subgrantees and their public system collaborators. Based on past evaluation costs, we budgeted \$190,000 for an independent evaluator (with \$140,000 coming from SIF funds and \$50,000 from match funds), and \$39,000 for training fees for seasoned SH/health providers to train and mentor the subgrantees. We budgeted \$1.275MM for subgrants, with \$924,736 from SIF funds and \$350,264 from match funds, as well as \$100,000 for forgivable loans from CSH match funds. The budget includes considerable resources for subgrantees in order to ensure that they have adequate resources for designing, planning, and implementing their proposed programs. The budget includes 15.2% in indirect costs, using CSH's federally-approved indirect rate.

B.MATCH SOURCES

Between cash-in hand and committed grant funds, CSH currently has \$575,000 in match funds for our SIF initiative, or 50% of the required match as part of our formal application documents.

*CASH IN-HAND. CSH earns income from loan repayments and fees and interest charged on our affordable loans products for the affordable housing industry. This earned income represents unrestricted revenue for CSH, of which we will commit \$225,000 for the SIF initiative.

*COMMITTED FOUNDATION RESOURCES. In 2010, CSH secured a three-year grant of \$9,000,000 from the Conrad N. Hilton Foundation to support our work in Los Angeles, with a significant portion of the grant earmarked for work with frequent users. \$310,000 of our funds on-hand come from this grant,

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and CSH has received the Foundation's written support to use these funds for SIF match. As well, our committed funds also include \$50,000 from another Hilton Foundation grant (\$700,000) to support CSH's work to expand supportive housing's reach into more high-need communities and to proliferate/replicate innovative SH models, including those targeting frequent users. CSH has also received the Foundation's written support to use these funds for SIF match. Depending on the sites selected, CSH has additional local grant resources that may be used as match for our SIF initiative. For instance, CSH has a \$50,000 grant from Kaiser Permanente and a \$50,000 grant from the William Hearst Foundation, both to foster SH/health models that target frequent users in the Bay area.

*PLAN FOR RAISING ADDITIONAL MATCH FUNDS. As well, In Los Angeles, the SIF anchor site, CSH has additional grants resources to support the initiative's implementation, including a \$400,000 grant from the UniHealth Foundation to support our work with frequent users in five Los Angeles neighborhoods that could be pledged if CSH receives the SIF award. In many of the other potential SIF sites, CSH has current or pending grants to support this work (Detroit, New York, Franklin County (OH), and Minnesota). As well, CSH has longstanding ties with several foundations that have indicated a strong interest in the initiative and a willingness to commit match funds if our application is successful. CSH has also discussed this proposal with the head of the Funders Together to End Homelessness, which is a 200 member trade association of the country's largest funders of homeless issues. CSH will seek to tap Funders Together members who are interested in supporting innovation in the health and housing fields. CSH has grants pending that may be pledged to this initiative, depending on the sites selected. For instance, CSH has a \$450,000 request pending with the Kresge Foundation for implementation of a FUSE initiative in Detroit. As well, CSH has submitted a \$40,000 request to Hartford Foundation for Public Giving to advance our SH/health innovations efforts in Connecticut.

Clarification Summary

PROCESS TO SELECT SUBGRANTEES. As described in our SIF proposal, CSH would hold an open RFP process to select grantees in Los Angeles and 3 other sites from a pool of 10 sites that represent the

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highest level of need and opportunity to develop and scale innovative supportive housing (SH) models that target frequent users: NYC; Camden, NJ; Salt Lake City; Bay Area, CA; Denver; Detroit; Franklin Co, OH; Seattle; MN; and CT. CSH's Innovations and Research (I&R) Team will lead the RFP development and subgrantee selection process, drawing on its deep experience in selecting, guiding, monitoring, and evaluating subgrantees in partnership with independent evaluators. CSH will seek advice from CNCS staff and draw on examples, best practice, and lessons learned from our experience in designing and successfully implementing national initiatives.

RFP MARKETING & OUTREACH: CSH will develop and widely disseminate a RFP in all 10 target communities to solicit applications from local nonprofits (SH providers) and their service and system partners (health centers and government agencies). CSH would solicit CNCS' input on the RFP and throughout the subgrantee selection process. Announcements would be made of the RFP process in our e-newsletter that reaches over 9,000 subscribers and via targeted outreach in the 10 communities via email blast, regular mail, and dissemination via our local networks of SH providers and government. CSH will also hold online bidders' conferences to educate potential applicants on the Initiative, review the RFP, and answer questions.

REVIEW OF RESPONSES/SELECTION PROCESS: CSH will develop a team of 10-12 internal and external experts to review and score the applications received in response to the RFP, based on criteria set by CSH and with input from CNCS. The criteria will be driven by the guidelines detailed in our SIF proposal and will broadly include: commitment/adherence to our Theory of Change for SIF, the applicant's organizational capacity, proposed program model, number of clients to be served, level of program evidence, and capacity to participate in a robust evaluation. The team will consist of CSH staff with expertise and experience in implementing FUSE models; knowledge of each of the 10 local communities, including local provider capacity, philanthropic support potential, public administrative

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data availability and quality, and public, sustainable SH and health service funding streams and payment systems (Medicaid); and evaluation. CSH will also engage external experts as part of the team, including individuals with community health, criminal justice, homelessness, housing, Medicaid, and/or evaluation experience/knowledge to round out CSH staff experience and expertise. Building off of CSH's conflict of interest policy for staff, CSH would create a conflict of interest policy for all reviewers to sign and abide by in order to identify any conflicts that a reviewer may have in assessing a given applicant's proposal (e.g. affiliation with applicant organization as staff or Board member, paid consultant, etc.). Should a conflict arise, CSH would instruct the reviewer to recuse him or herself from reviewing that particular nonprofit's application. Depending on the volume of responses, CSH may sub-divide up the applications among the expert panel for review.

CSH will aggregate the scores and calculate the average score for each application. We will then rank the applications from highest to lowest based on their average score. The applicants' scores will be the primary driver for our selection of subgrantees; however, a secondary consideration is our goal to geographically cluster subgrantees in four target sites. That is, our assumption is that subgrantees will benefit more from peer-to-peer to the extent that they are located near one another, allowing CSH to convene these groups in person for training and learning collaborative (peer-to-peer sharing) meetings. As well, there would be cost-savings and economies of scale in CSH coordinating and convening local government agency and philanthropic partners, and to push for the subgrantees' access to administrative data to identify and target frequent users and coordinate with public agency staff to best serve clients. Thus, our goal is to limit the number of sites in which we select subgrantees to four in an effort to maximize our impact in each of the selected sites and to control our own staff costs. Ideally, we would like to select 2 to 3 subgrantees in each of the four sites.

NUMBER & AMOUNT OF SUBGRANTS. Our goal is to select 4-10 subgrantees in total, with the

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number of awards dependent on the quality of the applicant pool overall and the number of individuals proposed to be served by the applicants with the highest scores. The number of awards and the relative amounts of each subgrant will depend on the strength of the proposals, the project's financial need, and the scale/scope of the proposed project's impact relative to the amount of funding requested/needed. All subgrants would be at least for \$100,000 per year per subgrantee, with a handful of subgrantees receiving larger amounts based on the aforementioned factors, for a total of \$1.275M in subgrants in year 1. In summary, we will: a) let an RFP to 10 localities; b) solicit applications from SH providers (partnering with health centers and government systems); and c) select 4 sites, each of which will have 1-3 subgrantees. Therefore, we will select between 4-12 subgrantees across 4 selected sites, with grants ranging from \$100k-\$300k.

Subgrantees will use monies to cover start-up costs for SIF, primarily building infrastructure and capacity to implement the project and for the initial provision of additional health services to frequent user clients and/or coordinating outreach and service provision between SH and health service providers. We will allow for flexibility, inviting applicants to propose the use of funds based on their experience, proposed program model, and target population's needs. We anticipate that subgrantees will hire additional staff and/or re-purpose existing staff to provide case management/coordination, shelter/ER/jail in-reach, and comprehensive health and wrap-around services to frequent users. (We further assume that part of these staff's salary and associated direct costs will be covered by Medicaid reimbursement and other SH funding sources in Year 2 and the portion covered by these ongoing funding sources will grow in year 3.) We also anticipate that the subgrantees will use subgrant funds to cover the costs for their staff to participate in pre-operational planning meetings, coordination with public systems and service staff, ongoing workgroup meetings, and one-on-one visits and check-ins with CSH, public partners, and evaluator. These are one-time costs that would decrease significantly after the first six months of the grant and drop in the second year.

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NUMBER OF PEOPLE TO BE SERVED. CSH anticipates that a minimum of 100 frequent users will be served in each of the four sites in Year 1, for a total of at least 400 clients for our SIF initiative in Year 1. This minimum number is needed in order to ensure statistical validity for our evaluation design. As well, our goal from a programmatic standpoint is to develop models among the subgrantees that bring frequent user/SH programs to scale by tapping Medicaid and other sustainable sources. We anticipate that a minimum of 100 individuals will be served through SIF in Year 1 and enrolled in the evaluation treatment group for tracking, but that, once billing systems and service/coordination protocols are set up and tested, subgrantees will be positioned to serve many more frequent users in future years, with subgrants increasing substantially in years 2-5 to allow subgrantees to serve more clients with a mix of subgrant monies, Medicaid reimbursement, and SH funding.

ASSUMPTIONS & RATIONALE FOR CSH STAFFING. Frequent user models are extremely promising and innovative, yet, they are complex and involve coordinating funding, client targeting, and service provision among a number of nonprofit and public service providers, funding streams, and sectors that traditionally have not worked in coordination. Thus, a significant level of training, technical support, and coordination is needed to ensure that projects are successfully planned and launched in each community. Assistance is needed to develop cross-systems understanding and to design an intervention that coordinates and integrates housing and services. That said, these planning and early operational costs would largely be one-time costs for Year 1, shifting in Year 2 to CSH triaging operational issues, liaising between the evaluator, subgrantees, and government partners to ensure timely and accurate data collection, and ensuring that subgrantees achieve sustainability and scale via reimbursement from Medicaid and other sources. CSH's costs and associated work would decrease dramatically in the third year as the SH/health partnerships are institutionalized, the evaluation nears completion, and the billing systems are firmly in place.

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The rationale is that the initiative and subgrantees will benefit from a third party to centrally liaise with the evaluator and public agencies in each site, and convene project partners within and across sites to learn from one another. Our assumption is that these functions are staff-intensive initially and would not be appropriate to subgrant out to another nonprofit. Moreover, CSH is uniquely positioned to act in these roles; this a core strength for CSH, given our experience in successfully playing these project-launching and boundary-spanning roles for other initiatives. As well, our goal is to position subgrantees to staff their projects using mainstream programs and sustainable funding streams, primarily Medicaid, rather than being dependent on specialized, time-limited grant funding. The level of staff that a subgrantee could hire with the first year of SIF subgrant funding is sufficient to serve the number of frequent users anticipated to be served (roughly 100 participants to be served in Year 1 per each of 4 target locations). Subgrantees would further staff up in Years 2 and 3, as they serve many more clients. While they would secure some Medicaid reimbursement in Year 2 (and much more in Y3-5), as they serve more clients, they will need larger subgrants. (Subgrantees will also use the larger subgrants to invest in their infrastructure.) In Year 3, they will begin to enroll enough clients and patient visits to cover a significant proportion of costs for new staff, with this proportion rising and reaching a breakeven point in later years.

Our national I&R team will centrally design the training, TA, and other support provided to subgrantees and their partners in each community. In terms of staffing in each implementation site, with guidance from I&R staff, a local program manager will serve as the lead staff in each site, leading training sessions, hosting subgrantee convenings and project planning workgroups, conducting subgrantee site visits, and developing an individual TA plan for each subgrantee. With guidance and support from I&R staff, the local Program Director will be critical to the systems change efforts and high level structural exchanges that will be necessary for these projects to be successful. In coordination with I&R, the local

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Project Director will also supervise the local program manager and will guide their work. As well, the local Program Director will supplement the work of the local Program Manager, assisting in training and TA provision, based on the local Director's experiences and areas of expertise. The local Program Director will also lead efforts to raise match funds locally in each site for CSH and to assist the subgrantees in raising funds from local funders.

TIMING OF SUBGRANTEE AND EVALUATOR SELECTION, AND FOR DEVELOPING EVALUATION METHODOLOGY AND OVERALL PLAN. CSH expects that, given the need to expeditiously begin operations under the SIF grant, we would need to conduct the RFP processes for selecting the evaluator and the subgrantees on parallel tracks (i.e. at the same time). These processes should not affect each other, and therefore will not be sequenced. As detailed below, our expectation is that the evaluator would be selected shortly before the subgrantees in order to ensure that the evaluator would be able to participate in all initial meetings with subgrantees once they are selected.

Grant start date: 9/30/2011

Six month mark 3/28/2012

10/21/11 Let RFP for evaluator selection

10/28/11 Let RFP for sub-grantee selection in LA & 9 potential sites

11/23/11 Due date for sub-grantee applications

11/11/11 Due date for evaluator applications

11/24/11 - 12/9/11 Select sub-grantees

11/12/11 - 11/25/11 Select evaluator

11/26/11 - 12/13/11 Process grant documents (from PARs to grant agreement and disbursement of awards)

12/13/11 - 1/13/12 Develop TA workplan with each subgrantee

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1/2/12 - 1/25/12	Hold TOC/shared outcome setting meetings in the 4 selected sites
1/1/12 - 2/28/12	Provide training on SH best practice/SIF Initiative in 4 sites
1/1/12 - 2/28/12	Work with each subgrantee & evaluator to create individual evaluation plan
3/28/12	Subgrantees begin program operations under SIF subgrant
1/16/12, ongoing	Provide training on additional topics based on TA needs of subgrantees
1/16/12, ongoing	Provide 1:1 TA to each subgrantee per workplan
2/1/12, ongoing	Hold monthly planning/workgroup meetings with each subgrantee & their project partners
4/2/12, ongoing	Convene Learning Collaborative (with all sub-grantees, their partners, peer mentors & guest trainers)
April 2012	First participants placed into SH
October 2012	Last participants placed into SH
April 2013	First participants reach one-year mark in SH
October 2013	Last participants reach one-year mark in SH

PROCESS TO COLLABORATIVELY IDENTIFY OUTCOMES AND TARGETED ACTIVITIES, AND PLAN TO HANDLE ANY CONFLICTS THAT ARISE. CSH will carefully craft the RFP for subgrantees in order to convey our expectations for the SIF initiative and our working TOC while also allowing for some tailoring SH models, based on local needs/circumstances and innovation. Our expectation is that we would develop the RFP in such a way as to allow the reviewers to get a solid sense of the applicants' service philosophy, proposed service/program model for SIF, and working TOC and evaluation plan/metrics. We would select subgrantees whose proposed projects align well with our working TOC and the core principles of the model, while allowing and encouraging appropriate local adaptation and variation in target population and service mix/delivery approaches. To the extent that CSH selects a subgrantee who later wishes to substantively diverge from their proposed project, CSH would work with

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the subgrantee 1:1 to better understand the reasons for this shift and to reiterate our core goals for SIF. To the extent that we cannot reach agreement with the subgrantee to adhere to our core model components and program logic, CSH would present the case to CNCS to defund the subgrantee and shift the de-committed funds in order to increase a sub-grant amount and deliverables for another subgrantee or to award a non-selected finalist from the RFP review process.

HOW SUBGRANTEE TA PLANS WILL BE FUNDED AND PLAN FOR ACCOUNTABILITY. As detailed in our SIF proposal, intensive and comprehensive technical assistance (TA) is a hallmark of CSH's approach to our work and achieving our mission. It has ensured the success of similar re-granting demonstration initiatives and is a key feature of our proposed SIF work. CSH estimates \$394,914 in costs for staff salaries. This figure includes staff costs for developing and implementing individualized TA plans with the subgrantees and a range of other CSH technical support and coordination functions for the initiative, (e.g. holding trainings for sub-grantees, hosting Learning Collaborative forums, and working with subgrantees individually to plan and implement their projects, trouble-shoot operational issues, and address underlying organizational capacity issues). The majority of these costs will be covered through our match funds for the initiative, with only \$35,499 coming from SIF monies. The individual workplans that we develop with each subgrantee will have very clear goals and measurable outcomes/outputs for our TA work with each subgrantee. CSH will track our progress toward completing all tasks in the workplans and in realizing improved capacity among subgrantees that is measurable and time-limited. This improved capacity will be directly tied to ensuring that there is a solid foundation for the successful implementation of each subgrantee's SIF project (e.g. nonprofit has system in place to track and report out on SIF project outputs and outcomes). As well, the ultimate measure of accountability for our TA work will be the extent to which the subgrantees successfully implement their SIF projects, reach all targeted client-level outputs and outcomes, and show strong evidence of effectiveness through rigorous evaluation.

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ROLE OF THE PEER BEST PRACTICES TRAINERS. In addition to one-on-one consultation via phone and site visits, CSH's technical assistance to grantees will also entail holding teleconference and webinar-based Learning Collaborative meetings for grantees, as well as "peer-to-peer" site visits for grantees to existing innovative models of supportive housing focused on people with chronic health challenges. CSH intends to retain six to eight 'peer expert' presenters and speakers to provide trainings for select Learning Collaborative sessions, and anticipates that the fee for presenters will be approximately \$1,200 per session. In addition, CSH will organize two peer-to-peer site visits for grantees at a cost of \$15,000 per site visit, including travel and lodging for participants, ground transport during the site visit, and honoraria/stipends for the site hosts.

GOAL TO DEVELOP FINANCIAL MODEL FOR BILLING MEDICAID AND OTHER SOURCES TO COVER SUBGRANTEE STAFFING IN YEAR 2 AND BEYOND. A secondary goal of the project (besides reducing risky behaviors and improving the health of the targeted tenants) is to increase the utilization of Medicaid to cover the housing-based supportive services that makes supportive housing an effective health intervention. Medicaid represents a more stable and sustainable source of funding for these services, and analysis has shown that many of the services currently provided in supportive housing are eligible for Medicaid coverage. Currently, many services offered in SH can be covered via Medicaid, provided that the SH provider is also a Federally Qualified Health Center (FQHC) or other community-based health provider, or linked to such a health provider, who is already eligible and equipped to bill to Medicaid for a range of health services and the stabilizing supports (e.g. case management) provided in supportive housing. By partnering SH providers and these health centers, frequent user-serving projects will be able to bill Medicaid for many housing-based services. However, these groups require assistance in structuring their partnerships and in some instances, working with State or county Medicaid Departments or managed care organizations to allow the inclusion of housing-based supports as part of

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the package of eligible services. Moreover, they will require assistance in determining which housing-based supportive services are Medicaid eligible and which are not, and how to sustainably finance the non-eligible services. CSH will work intensively with the subgrantees and their partners in the first year to structure their working relationships and to craft and refine services financing plans and mechanisms. Based on our experience in structuring such partnerships in a handful of sites nationally, our expectation is that billing to Medicaid for housing-based services is highly attainable, although it requires partnership and significant upfront design, planning, and the development of services delivery tracking, monitoring, and billing systems. Absent a partnership with a health center, direct billing to Medicaid for services provided in SH (if the SH provider is not also a CHC) is more challenging and would require systems change at the state level to allow for this, along with capacity-building among providers. We will work with public agency partners to push for this option in order to widen opportunities for covering comprehensive care delivery for frequent users; yet, the success of the initiative does not depend on these policy changes.

RESEARCH DESIGN PARAMETERS AND METRICS. In our evaluations, we strongly prefer to conduct random-assignment control and treatment (RCT) group studies, and will work diligently to use this evaluation method for the SIF initiative, to the extent feasible from a logistical and cost perspective. Factors that will affect our ability to undertake RCT include: the evaluation budget for the project, the size of the pilot (the number of people to be served), and whether the size of the eligible population allows for it. Given these considerations, many of the pilot evaluations that we currently have underway involve a quasi-experimental design with a comparison group chosen from eligible individuals who do not receive program services because of limited slots or for other reasons, or from a matched group selected from administrative data. We also work to strengthen our evaluation design in our quasi-experimental studies by selecting individuals for the match group under the same process, timeframe, and geographic proximity as for the treatment group in order to better match the two groups. At a

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minimum for SIF, we plan to use quasi-experimental research design for the evaluation, but we will exhaust all options to allow for RCT.

In two of RHI evaluations -- New York City FUSE and Ohio RHI - propensity scores are used to match individuals in the comparison group with those in the program group. Moreover, in NYC, the comparison group is drawn from the same client selection and recruitment process as the treatment group, increasing the comparability of the two groups. We also have experience with experimental methods. Working with the Urban Institute, our FUSE pilot in Cook County, Illinois used random assignment to create a control group to measure the counterfactual.

Our ability to evaluate the programs implemented by the subgrantees using RCT or a quasi-experimental design will be influenced by the following factors:

- oThe number of people served by the pilot. The sample size has to be large enough to detect impacts, which the contracted evaluator will determine by conducting a power analysis. In our case, that generally means serving 100 people or more. If pilot programs across subgrantees are similar enough, we may be able to pool the sample to create a larger sample size.
- oSize of the eligible population. To get a comparison group, the number of people eligible for the program must exceed the number of people served by at least 2:1. Given the need in most communities, this should not be as much of an issue. However, if the target population is difficult to locate and engage, getting enough people for a comparison group could be an issue. Alternatively, a comparison group could be created using matched administrative data which is not likely to require consent for some types of data (incarceration and homeless data) but not health data.
- oAbility to get informed consent from a comparison group. A workable process would need to be in place in order to get consent from the comparison group, especially if we want to track health outcomes. Consent may not be required to track certain types of outcomes for a comparison group (i.e. shelter use

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and incarceration).

oFor experimental design: flow of eligible individuals into program. The control group must be selected as part of the program enrollment process. As such the flow of clients into the program has to be large enough for us to complete enrollment within the specified timeframe. In our experience, the more complex the client identification process, the slower and smaller the program enrollment flow, and the longer it takes to utilize housing subsidies. If there are substantial delays in using housing subsidies, subgrantees could lose access to them. Also, RCT evaluations often get held up in the Internal Review Board (IRB) process, given the increased scrutiny on ethical and human subjects considerations.

We anticipate that we will have the number of people and size of the eligible population to conduct a QED. We plan to have a contracted evaluator assisting each subgrantee with their evaluation plan, and intend to have multiple impact evaluations. However, we may decide to pool the sample across multiple sites -- if the interventions are similar enough -- in order to achieve greater statistical power for subgroup analysis. We plan to have a QED for each of the sites.

As outlined in the proposal, we propose to use the following metrics to measure program outcomes:

- New partnerships among public systems, Community Health Centers (CHCs) and SH providers in 4 communities (signed agreements);
- Improved housing stability (length of tenure in SH, fewer returns to shelter/street);
- Increased healthcare coverage (clients enrolled for Medicaid);
- Increased use of preventive and primary care (wellness and sick visits);
- Rise in following of regular drug regimens for chronic and/or mental illness (provider data);
- Less mental illness symptoms (practitioner assessment);
- Improved physical health (client self-assessment/self-report);
- Increased mental health and substance use treatment utilization (overall service uptake and days in

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treatment);

-Reduced use and public costs of shelters, ERs, hospitalization, jail, and other crisis care;

We have added a metric for clients' risky drug and sex behaviors, which would be gathered using client self-reported data. These metrics would be measured using administrative data from public systems (shelters, hospitals, jails, Medicaid data, etc) for both a program and comparison group to measure service utilization, housing stability, and healthcare coverage; provider data for the program group to measure medication adherence and mental health symptoms (pre/post supportive housing); and client surveys/assessments for the program and control groups on health and mental health outcomes and use of preventative and primary care (pre/post supportive housing).

HOW METRICS INDICATED IN EVALUATION PLAN WOULD INFORM DESIRED HEALTH

OUTCOMES. As outlined above, our metrics include measures of improved health insurance coverage, access to preventative and primary care, and ongoing treatment for chronic conditions. We also plan to track improvements in health and mental health before and after entering supportive housing. By tracking these metrics, we will have a much better understanding of the impact of supportive housing on tenants' health and well being.

PLAN TO ASSIST SUBGRANTEES WITH IDENTIFYING AND SECURING MATCH FUNDS. As

detailed in our SIF proposal, CSH will ask nonprofits via the RFP to identify committed or proposed sources for a portion of match funds for their SIF project. That said, we expect to work closely with subgrantees to raise additional match funds, primarily from foundation sources, with CSH assisting the subgrantees in identifying grant prospects and developing strong applications for funding. We will leverage our relationships with national and local funders in order to facilitate our direct fundraising and/or to connect subgrantees to our contacts at these funding institutions. We will enlist Funder

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Together to End Homelessness to help with our local outreach, a network of over 100 philanthropic funders nationally that is excited to help us in this effort.

ASSUMPTIONS FOR YEAR 2 & BEYOND. CSH's work will shift in Year 2 to systems change, monitoring subgrantees, trouble-shooting operational issues, implementing sustainability plans, and ensuring the evaluation is completed successfully. With this shift, our required staffing will decrease by 20% overall (CNCS and match funds in equal proportions) in Year 2 but will still be significant. In Years 3-5, CSH staffing costs will decrease more significantly (-25% from Year 2 level and 40% less than Year 1 staffing cost). There will be a sharp drop (-75%) in costs for peer trainers in Year 2, given that this training will be most intensive in Year 1 and will be less frequent and less travel-intensive in Year 3-5. There also will be less travel costs for CSH staff in Year 2 (-25%) and even less in Years 3-5 (-37% over Y2), as locally-based CSH staff serve as the primary onsite trainers and TA providers for subgrantees and rely less on national staff for onsite training and TA, with national guidance and advisement shifting to more remote approach. Given these reductions in staffing and other costs, subgrants will increase 21% in Year 2 and another 9% in Year 3-5. Total subgrants (CNCS and match) will equal 67% of the total Y2 budget, rising to 73% in Year 3-5. Subgrants will represent 53% of CSH's total match budget in Year 2 and 64% in Year 3-5. This coincides with making larger subgrants years 2-5 to: 1) reach scale: greatly grow the number of people subgrantees serve substantially in these years; and 2) invest in one-time costs to build their infrastructure (e.g. better technology to track outcomes, specialized training for staff, etc.)

Continuation Changes

N/A

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Required Documents

<u>Document Name</u>	<u>Status</u>
Match Verification	Sent
Federally-approved indirect cost rate	Sent

**2011 Social Innovation Fund
Corporation for Supportive Housing
Section 2 – Budget**

on August 15, 2011 10:14 AM

Reducing risky behaviors through supportive housing

Corporation for Supportive Housing

Application ID: 11SI128306

Budget Dates: 09/01/2011 - 08/31/2016

	Total Amt	CNCS Share	Grantee Share
Section I. Program Costs			
A. Project Personnel Expenses	706,608	58,847	647,761
B. Personnel Fringe Benefits	97,627	9,288	88,339
FICA	29,084	2,406	26,678
Health Insurance	52,664	4,356	48,308
Retirement	21,616	1,788	19,828
Life Insurance	3,931	326	3,605
Total	\$204,922	\$18,164	\$186,758
C. Travel	37,930	9,458	28,472
D. Equipment			
E. Supplies	80,727	7,764	72,963
F. Contractual and Consultant Services	429,000	284,960	144,040
H. Other Costs	1,644,018	938,435	705,583
Subgrants	1,275,000	924,736	350,264
Total	\$2,919,018	\$1,863,171	\$1,055,847
Section I. Subtotal	\$4,378,205	\$2,242,364	\$2,135,841
Section II. Indirect Costs			
J. Federally Approved Indirect Cost Rate			
Indirect Costs	221,795	57,636	164,159
Total	\$221,795	\$57,636	\$164,159
Section II. Subtotal	\$221,795	\$57,636	\$164,159
Budget Totals	\$4,600,000	\$2,300,000	\$2,300,000
Funding Percentages		50%	50%
Required Match		n/a	
# of years Receiving CNCS Funds		n/a	