Deborah De Santis
President and CEO
Corporation for Supportive Housing
50 Broadway, 17th Floor
New York, NY 10004

Deborah De Santis became President and CEO of the Corporation for Supportive Housing (CSH) in January 2007; she had joined the nonprofit organization in 2003 as Director of CSH's New Jersey program. A national organization, CSH helps communities throughout the country create permanent affordable housing with services that prevent and end homelessness.

As President and CEO, Ms. De Santis has guided the development of initiatives that bring the benefits of supportive housing to many more people at risk of chronic homelessness including veterans, those reentering society from hospitals and correctional facilities, youth and the elderly. Her efforts have lead to the creation of an internal CSH Innovations Team, placing a continuing effort on better programs, and CSH Consulting Group, a flexible and mobile group of experts who travel the country assisting communities with supportive housing development. She has also stressed more accountability in the supportive housing industry and the creation of Dimensions of Quality; independent benchmarks to measure successful supportive housing projects.

As CSH-New Jersey Director, Ms. De Santis tripled the state program's lending portfolio, successfully advocated for the creation of New Jersey's $200 million Special Needs Housing Trust Fund, and helped launch a statewide grassroots organization to advance the development of 100,000 units of affordable housing over 10 years, including 10,000 units of supportive housing.

Immediately prior to joining CSH, Ms. De Santis oversaw the business operations of a real estate development company, International Senior Development, LLC. From 1998 to 2002, she was with the New Jersey Housing and Mortgage Finance Agency, first as COO and then as Executive Director. While at the Agency, and in the spirit of CSH's work, she initiated joint investment opportunities with other state offices including the NJ Health Care Facilities Finance Agency and the NJ Department of Human Services. Ms. De Santis also served as Deputy Chief of Staff to New Jersey Governor Christine Todd Whitman from 1996 to 1998, and as Deputy Commissioner of the NJ Department of Community Affairs, which oversees the development of affordable housing in the state. As Deputy Commissioner, she was actively involved in efforts to move disabled, nonviolent mentally ill residents from unsafe and substandard boarding homes to more appropriate living conditions within their communities.

Ms. De Santis received a BS in Business Administration from Babson College. She resides in New Jersey with her partner and two children.

Brief Response to US Interagency Council Report on Chronic Homelessness
Deborah De Santis, President/CEO of Corporation for Supportive Housing
March 20, 2012

The Corporation for Supportive Housing (CSH) is pleased to submit this written response to the analysis conducted by the US Interagency Council on Homelessness (USICH) entitled *Trends in Chronic Homelessness*. CSH shares USICH's concerns regarding the plateauing of progress on chronic homelessness, and the weak association between the national inventory of permanent supportive housing (PSH) and the number of people experiencing chronic homelessness. While this finding is admittedly discouraging, we remain committed both to the goal of ending chronic homelessness and to our belief that PSH is the most effective vehicle for achieving this goal. In this paper, we provide our own thoughts regarding why increases in communities' inventory of PSH may not be producing the expected reductions in chronic homelessness and also provide lessons—drawn from our direct experience over the past few years—for how to put us back on the course of progress.

CSH believes that the report rightly identifies two of the primary reasons why reductions in chronic homelessness have not come alongside increases in the PSH inventory: a) that the geographic distribution of PSH does not always match the geographic distribution of chronic homelessness; and b) that PSH units are still only inconsistently targeted at people experiencing chronic homelessness. We believe that both reasons are important and worthy of attention. Indeed, our own recognition of the geographic mismatch between need and PSH availability is one of the reasons why CSH has made concerted efforts in the past few years to expand our reach to new locations such as Texas and Florida, while redoubling our efforts in chronic homelessness "hot spots" like California and New York. However, we believe that the lack of consistent and effective targeting of PSH is likely the more important of the two reasons why the impact of PSH creation has resulted in lower-than-expected impacts on chronic homelessness.

From our direct experience working in more than a dozen states across the country, we have found that the degree to which communities are able to target and prioritize individuals experiencing chronic homelessness for PSH placement varies greatly. This is for four reasons. First, while some communities have effective and sophisticated systems for targeting supportive housing including the use of Homeless Management Information Systems (HMIS) to identify and prioritize individuals based on their length of homelessness and their high service needs, many communities still lack the data systems and capacity to track and prioritize PSH access based on duration or persistence of homelessness. Second, shelter and PSH providers in many communities still have not adopted a 'housing first' philosophy and simply do not cooperate with efforts to prioritize and immediately place individuals with the longest histories of homelessness. Third, in places where funding for supportive services is limited or difficult to secure, PSH providers often feel that they do not have the adequate support needed to successfully house chronically homeless individuals who tend to (at least initially) have higher service needs. Fourth and perhaps most importantly, as noted in the report, targeting efforts in most communities have focused on shelters perhaps at the expense of other potential locations where chronically homeless individuals may be found and engaged. Indeed, the report rightly points out that many chronically homeless individuals are in fact only episodic users of shelters, frequenting many other public systems and institutions like hospitals, jails, substance abuse treatment programs, detox, psychiatric hospitals, as well as the streets. Given this, focusing on homeless shelters as the primary or sole point of referrals or outreach essentially limits a community's opportunities to identify and engage chronically homeless individuals.

CSH has long known that just creating PSH units is itself not enough to end chronic homelessness, but that these units must work as part of a coordinated targeting initiative. For this reason, as much as we focused on unit creation over the past ten years—contributing to the creation of more than 150,000 new PSH units—CSH has also focused on designing and implementing approaches for targeting and reaching individuals experiencing chronic homelessness. CSH was a key partner in New York City's Long-Term Shelter Stayers Initiative, where assertive and persistent outreach was conducted into shelters and barriers were eliminated to place the longest-term shelter residents into supportive housing, and in Housing First pilots in Rhode Island, San Diego, Phoenix, and elsewhere. In our Frequent Users Systems Engagement (FUSE) Initiatives, CSH works with communities like New York City, Connecticut, Chicago, Washington DC, and Denver to match jail and HMIS data to identify and prioritize individuals for PSH who were both chronically homeless as well as frequent users of jails. Recently, CSH launched a new initiative through our Social Innovation Fund grant, to pilot models of supportive housing connected to health services targeted at the highest utilizers of crisis health services like emergency rooms, inpatient hospitalizations, detox, etc. Working with partners in four communities, CSH will use data to identify the highest cost users of publicly funded

crisis health services, reach into hospitals, emergency rooms, and other crisis settings to recruit individuals, prioritize and place them into supportive housing, and provide them with care management and primary and behavioral health care.

From these pilot programs, we have learned valuable lessons about what it takes to successfully prioritize and target individuals experiencing chronic homelessness. We learned about the importance of **data-driven and utilization-based targeting**, where administrative data is matched across public systems to identify and locate individuals who were not only chronically homeless, but also high utilizers of costly public services. We learned that **referrals and intake for supportive housing needed be coordinated or centralized**, and created tools in some communities like Chicago to achieve this coordination. We also learned that PSH providers must not be passive in tenant selection but rather should conduct **assertive outreach and recruitment into various crisis settings**—including but beyond homeless shelters—to find and recruit chronically homeless individuals. We learned that such **offers of housing needed to be persistent and come with few strings attached**. We learned to not mistake initial "No's" for a lack of interest in housing, as individuals seldom were refusing housing, but rather the treatment mandates and required behavioral modifications that had come with previous offers. We learned that PSH providers needed **funding and resources for supportive services** like engagement and rapport building, motivational enhancement, prevention of lease violations, crisis intervention, and connection to primary and behavioral health, so that they prove that chronically homeless individuals were indeed "not unhouseable." CSH can share and disseminate these lessons with more communities in order to maximize the use PSH as a tool for ending chronic homelessness

Most importantly of all, we learned that chronic homelessness should be understood not simply in terms of the length of homeless shelter use, or even the time spent on the streets, but as *an institutional circuit* where individuals are caught in a semi-permanent revolving door of multiple crisis service settings. Likewise, chronic homelessness is not a separate and distinct policy problem belonging to the specialized 'homelessness' policy field, but rather must be recognized as a problem shared by multiple mainstream public systems. Mainstream public systems like corrections and hospitals are not simply important in *preventing new* homelessness, but rather in *ending chronic* homelessness. **Efforts to end chronic homelessness must engage, mobilize, and partner with mainstream public systems like corrections, the health sector, substance abuse service systems, the affordable and public housing sector, and others to become active partners in identifying the shared clients who are chronically homeless and who also are the highest cost utilizers of their systems.** Moreover, these mainstream systems can and must be enlisted to contribute their resources and funding to help finance and create PSH, particularly funding for the essential supportive services that will enable PSH providers to successfully support the long-term housing stability of chronically homeless individuals.

This brings us to our final lesson and challenge for USICH and its partner communities for how PSH can be maximally leveraged as a tool to end chronic homelessness: that new PSH must be created and in a concentrated surge. A common feature of CSH's targeting pilots is that they all involved bringing about a concentrated surge of targeted PSH units within a short timeframe. For instance, New York City's FUSE Initiative created a surge of 100 new supportive housing units into which individuals were placed within roughly 18 months, followed by a second surge of 100 units three years later. Connecticut's FUSE Initiative involved three successive surges of 30, 50 and 160 units in four years. These surges not only resulted in the rapid housing of a large number of chronically homeless individuals, but also had the effect of focusing the attention and rallying the efforts of key partners and agencies (including those representing mainstream public systems like corrections, mental health agencies, and public housing authorities.)

We recognize that increasing investment in PSH, let alone to achieve a surge of new PSH units, is a difficult consideration in the current economic and political climate. However, rather than looking to homeless assistance funding, we believe that the path to achieving scale and a surge of new units lies in engaging the mainstream housing and services systems who have far greater resources than specialized homeless assistance funding streams. On the housing side, we must enlist the partnership of public housing authorities, state housing finance agencies, and local governments to contribute mainstream affordable housing resources. Public housing authorities (PHAs) have been a key partner in our FUSE pilots and are already figuring prominently as partners and contributors of Housing Choice Vouchers in three of our four Social Innovation Fund sites. We have found many PHAs to be compelled by the idea that they can contribute to helping reach individuals while also improving public safety and improving health outcomes. On the services side, a tremendous opportunity presents itself with Medicaid and the State and county Medicaid and managed care organizations that administer it. These agencies—struggling to control costs among high-cost beneficiaries—can be enlisted to create Medicaid benefits that would enable the provision of services essential to ensuring housing and health stability among the many vulnerable individuals who stand at the intersection between chronic homelessness and high-cost use of Medicaid services. The opportunity here—to make housing and services available virtually as an entitlement to chronically homeless people based on their need—can not be overstated.