Evidence Matters

Transforming Knowledge Into Housing and Community Development Policy

SUMMER 2012

Estelle Richman, HUD Senior Advisor, and Veterans Affairs Deputy Secretary W. Scott Gould joined volunteers conducting the 2012 Point-In-Time count in Washington, DC.

U.S. Department of Veterans Affairs/ Photo by Robert Turtil

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Tackling Veteran Homelessness With HUDStat

HUD has adopted a new data-driven performance management tool designed to evaluate the effectiveness of its programs and investments. Launched in October 2010, HUDStat provides a framework for monitoring progress toward the agency's priority goals. At regular HUDStat meetings, led by Secretary Shaun Donovan, agency data are reviewed to identify and solve problems and share best practices. These meetings encourage the development of strategies to boost results and address impediments to meeting established goals.[1] One agency priority goal that is already seeing benefits from HUDStat is reducing homelessness among veterans.

Homelessness Among Veterans

More than 2.4 million American soldiers have served in Operation Iraqi Freedom/New Dawn and Operation

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Message from the Acting Assistant Secretary

As HUD's new Acting Assistant Secretary for Policy Development and Research (PD&R), it is my pleasure to present the fifth issue of *Evidence Matters.* With former Assistant Secretary of PD&R Raphael Bostic deciding to return home to Los Angeles and the academic world, it's a bittersweet debut.

Whether it's developing a comprehensive monthly Housing Scorecard, overseeing a historic lesbian, gay, bisexual, and transgender housing discrimination study, or bringing the way HUD affirmatively furthers fair housing into the 21st century, Raphael has made evidence-based policymaking integral to PD&R and HUD. But even more, he's shaped how this administration responds to challenges such as poverty and promotes opportunity for all Americans in new and important ways. His wit and intellect will be sorely missed.

In his time here, Raphael put HUD at the forefront of research into housing and social policy. As a consequence, one of his most profound legacies was ensuring that HUD has a seat at the table in the Obama administration's critical interagency work. Nowhere is that impact clearer than for the challenge that is the subject of this issue of *Evidence Matters*: the fight to end homelessness.

HUD has been able to prevent or end homelessness for 1.3 million people through the American Recovery and Reinvestment Act of 2009. And we've already housed more than 30,000 veterans through interagency partnerships such as HUD-VASH, which combines rental assistance through HUD's Housing Choice Voucher program with the U.S. Department of Veterans Affairs' (VA's) case management and clinical services.

With the U.S. Interagency Council on Homelessness' *Opening Doors*, we've forged a historic partnership across 19 different federal agencies to create the first-ever federal strategic plan to prevent and end homelessness. The most advanced research on homelessness shows us that homelessness cuts across traditional program silos. Whether they involve public health, public safety issues such as domestic violence, or the social and educational outcomes of children, the links between homelessness and other critical social problems are well understood by the research community and demand an interagency response.

The existing research on homelessness as a platform for social service intervention is a full decade ahead of other research on housing as a platform for better life outcomes. In the following pages, you'll read about research from the mental health community that links access to quality housing with positive health outcomes, as well as Dennis Culhane's hallmark effort demonstrating that combining housing and supportive services not only led to better outcomes for the homeless but also saved taxpayer money. The sophistication of these data has had real consequences for public policy in the Obama administration. Initiatives to combat homelessness are among the few to receive increased funding in this difficult budget environment; HUD's Homeless Assistance Grants, for example, grew by 14 percent in the administration's first budget and have maintained this funding level in subsequent years.

It's instructive that in recent years, most of the studies that have taught us about the connections between housing and health have come not from journals focused on housing or social policy but from premier medical journals. Research into housing as a platform is giving us not only important new data but also a new community to talk to, whether it's doctors, medical researchers, or public health professionals.

Clearly, the days of homelessness research being developed, conducted, and discussed solely by and among "housers" have long passed. That's why HUD's work to stay on the cutting edge of homelessness research is so important, and why a cross-agency, cross-disciplinary approach must stay at the heart of our research agenda. PD&R is moving forward with studying emerging trends in homelessness, from the rise in family homelessness to the uptick in homelessness among young people. We're also continuing to explore and deepen our partnerships with other agencies such as VA and the U.S. Department of Education.

As we work to build richer data resources across the federal government, one of the tasks ahead is to promote the same innovative research at the state and local level, looking at the outcomes of housing plus education, housing plus financial services, and other potential connections through which housing can be leveraged to improve the quality of people's lives.

As homelessness policy has shown us for years, public policy informed by quality research can lead to truly remarkable outcomes. As we continue to forge new paths in homelessness research, I'm excited to see where the evidence takes us.

— Erika C. Poethig, *Acting Assistant Secretary for Policy Development and Research*

Editor's Note

Our work at HUD touches the lives of millions of Americans in myriad ways, from home mortgages to community development funds for local infrastructure and services to public housing subsidies. But perhaps no population relies on our agency's efforts — and those of our partners within and beyond the federal government — more directly than homeless individuals. Homelessness in America takes many forms, encompassing those facing chronic illness or disabilities who have long-term difficulties remaining housed, working poor families unable to make rent or mortgage payments after losing a job, and so many others. Because of this, efforts to combat homelessness must target varied homeless populations and needs; there is no one-size-fits-all solution.

This issue of *Evidence Matters* examines several key topics in the fight to end homelessness. The lead story, "Tackling Veteran Homelessness With HUDStat," focuses on the critical problem of homelessness among U.S. veterans, especially those returning from Iraq and Afghanistan, and how HUD and other federal agencies have adopted a data-driven management approach to improve service and help these veterans become stably housed. "Using Data To Understand and End Homelessness" charts the evolution of federal data collection efforts such as Homeless Management Information Systems and point-in-time counts, exploring how measurement better enables policymakers to understand the scope of the homelessness problem and target resources to the most effective models of assistance. We are particularly pleased that Mark Johnston, Acting Assistant Secretary for Community Planning and Development, authored this research-focused article. Finally, "Linking Housing and Health Care Works for Chronically Homeless Persons," our In Practice article, presents the work of doctors, researchers, and practitioners who have shown the role that housing and supportive services play in improving health outcomes for chronically homeless individuals, emphasizing the significance housing can play as a platform for improving quality of life.

I am pleased to carry forward the editor's mantle begun by Erika Poethig. I hope you find this unique *Evidence Matters* issue on homelessness valuable and enlightening. Our next issue will focus on low-income homeownership. As always, we welcome your feedback at **www.huduser.org/forums**.

— Rachelle Levitt, *Director of Research Utilization Division*

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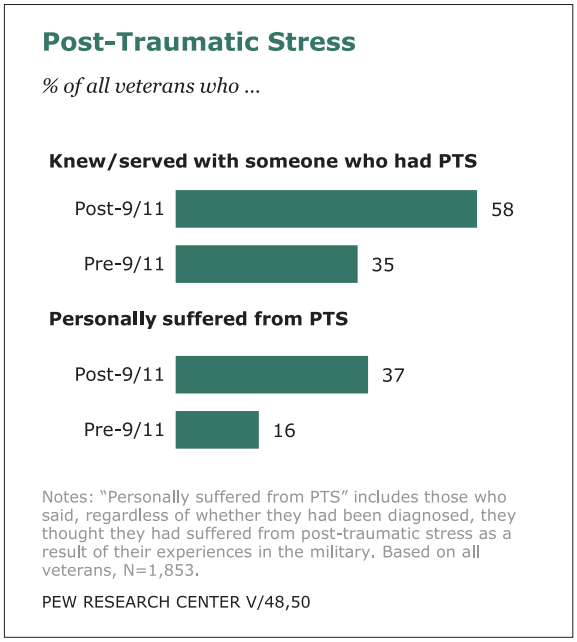
Enduring Freedom since September 11, 2001.[2] Hundreds of thousands of these men and women have returned from Iraq, and many more will be returning from Afghanistan in the next few years. "Soldiers are returning with higher rates of injury after multiple deployments with severe economic hardships," says John Driscoll, president and chief executive officer of the National Coalition for Homeless Veterans.[3] Studies show that nearly 20 percent of returning Iraq and Afghanistan veterans have experienced a traumatic brain injury, and 10 to 18 percent suffer from posttraumatic stress disorder (PTSD).[4] A recent Pew Research Center survey showed that post-9/11 veterans found the transition to civilian life harder and had higher rates of post-traumatic stress than veterans who served in previous wars.[5] Rates of military sexual trauma, which is associated with an increased risk of developing PTSD, are high among female veterans, who make up more than 11 percent of veterans of these two wars.[6] For both male and female veterans, PTSD is linked to an increased risk of depression and substance abuse, which exacerbate social isolation and make employment difficult.[7]

The economic downturn and high unemployment rates add to the challenges these soldiers face on returning from active duty. The U.S. Bureau of Labor Statistics reports that veterans between the ages of 25 and 34, who make up more than half of post-9/11 veterans, had a 2011 unemployment rate of 12 percent, compared with 9.3 percent for nonveterans. Among veterans aged 18 to 24, the unemployment rate is much higher — 30.2 percent.[8]

All of these factors contribute to an increased risk of homelessness for returning veterans, even though they have higher education levels (62 percent of veterans over the age of 25 have at least some college compared with 56.4 percent of nonveterans) and higher median incomes compared with the general population.[9] Female veterans and



© Pew Research Center, Social & Demographic Trends Project
October 5, 2001.
The Military-Civilian Gap: War and Sacrifice in the Post-9/11 Era
www.pewsocialtrends.org/2011/10/05/war-and-sacrifice-in-the-post-911-era/.

Highlights

- Veterans are far more likely to experience homelessness than other Americans, in part because of their high rates of posttraumatic stress disorder, physical injuries and disabilities, and other factors that make reintegrating into civilian life and employment difficult.
- HUD, in partnership with the U.S. Department of Veterans Affairs, has made veteran homelessness a focus area of its HUDStat performance management tool, using data to improve program effectiveness.
- Through HUDStat, HUD has identified local challenges that have led to streamlined processes, resulting in outcomes such as increased voucher utilization in Los Angeles and Jacksonville.

younger veterans are more than twice as likely to be homeless as their nonveteran counterparts. According to HUD's 2011 Point-in-Time (PIT) Estimates of Homelessness, veterans constitute 14 percent of the homeless population, although they represent only 10 percent of the U.S. adult population. This PIT count documented 67,495 homeless veterans on a single night in January, a number that is 12 percent lower than a year earlier.[10] Throughout the entire year that ended in September 2010, nearly 145,000 veterans were homeless for at least one night.[11]

Post-9/11 veterans find the transition to civilian life harder and experience higher rates of post-traumatic stress than veterans who served in previous wars.

The Goal To End Homelessness

Ending homelessness among veterans is a top priority for the White House, HUD, and the U.S. Department of Veterans Affairs (VA). This commitment is reflected in the nation's first comprehensive plan to prevent and end homelessness, *Opening Doors*. Released by the United States Interagency Council on Homelessness (USICH) in 2010, the federal plan sets the goal of ending veteran homelessness by 2015.[12] To achieve this goal, *Opening Doors* calls for breaking down institutional silos, increasing collaboration among and within all levels of government, and improving data collection and analysis. Accordingly, HUD collaborates with other federal agencies to collect data and target assistance programs to move veterans from the street into permanent supportive housing — a critical component of the USICH plan.[13]

In its Strategic Plan, HUD confirms its commitment to providing affordable housing units to homeless veterans, calling for stable housing as a platform for improving health, educational, and economic outcomes for vulnerable populations.[14] "Housing somebody first makes it much more likely that they can stabilize their condition," said Secretary Donovan.[15] The effectiveness of this approach in combating veteran homelessness, especially among the chronically ill, is well documented. A 2010 study of 622 veterans entering substance abuse treatment found that veterans who were homeless at any point during the 12-month study period were more likely to have inpatient admissions and incur higher treatment costs compared with veterans who were consistently housed. A study of formerly homeless veterans and their risk factors for returning to homelessness found that participants receiving case management and rent subsidy vouchers had "significantly longer periods of continuous housing" than those who received only case management or standard care.[16]

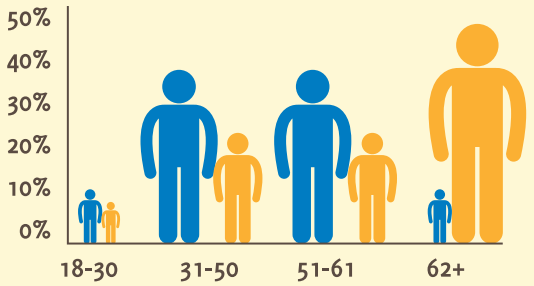
Stable Housing for Veterans

HUD's commitment to reducing veteran homelessness is longstanding. The agency provides homeless veterans with housing resources through three primary programs: HUD-Veterans Affairs Supportive Housing (HUD-VASH), the Homelessness Prevention and Rapid Re-Housing Program (HPRP), and Continuum of Care (CoC) program.

HUD-VASH is a program administered jointly by HUD and VA. Through HUD-VASH, HUD issues housing choice vouchers to homeless veterans and VA provides them with supportive services, including case management and clinical services. HUD-VASH vouchers are awarded to public housing agencies (PHAs) that partner with eligible VA medical centers and are allocated based on geographic need and housing agency performance. Case managers at VA centers screen and refer veterans eligible for HUD-VASH vouchers to PHAs. First established in 1992, the HUD-VASH program was revived in 2008 with a $75 million appropriation from Congress. The program initially targeted homeless veterans with chronic mental illness or substance abuse disorders; this requirement was waived in 2008 to provide housing vouchers to all homeless veterans who receive VA case management services. Approximately 10,000 HUD-VASH vouchers have been funded each year with annual appropriations of $75 million in 2008, 2009, 2010, and 2012. In 2011, $50 million was appropriated to serve approximately 7,000 homeless veterans and their families. HUDStat has played a key role in increasing the distribution of HUD-VASH vouchers and has fundamentally altered the agencies' success metrics for the program.[17]

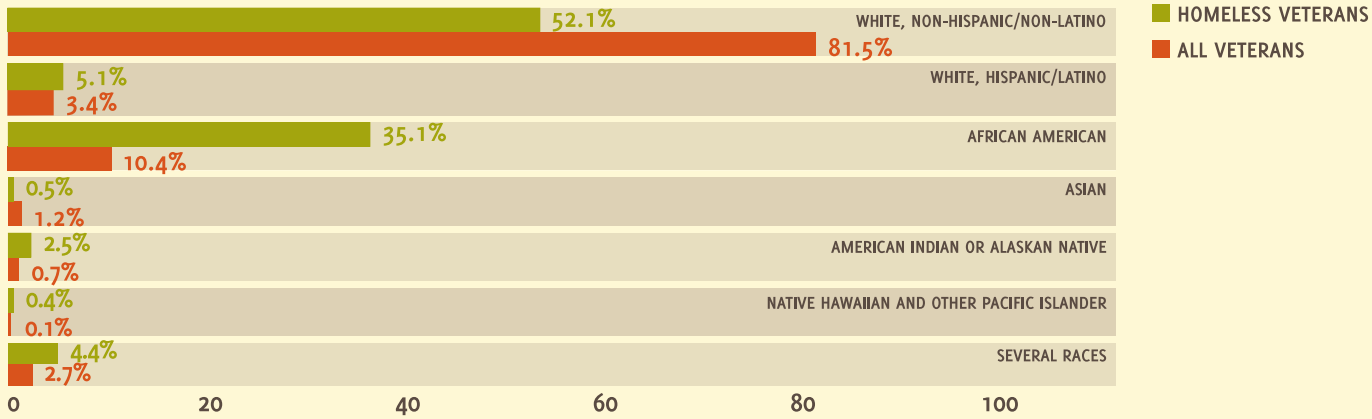
FACTS ABOUT HOMELESS VETERANS

VETERANS BY AGE



- **13%** of homeless adults are veterans.
- **92%** of homeless veterans are men.
- **One in nine** veterans living in poverty is homeless.
- **Over half** of homeless veterans are disabled.

VETERANS BY RACE



Note: Data shown are for sheltered homeless veterans — veterans who spent at least one night homeless in an emergency shelter or transitional housing facility between October 1, 2009 and September 30, 2010.
Source: U.S. Department of Housing and Urban Development, "Veteran Homelessness: Supplement to the 2010 Annual Homeless Assessment Report to Congress," 4–7.

A more recent effort, HPRP is a three-year program authorized under the American Recovery and Reinvestment Act of 2009. Through HPRP, communities nationwide received $1.5 billion to provide financial assistance and services to either prevent individuals and families from becoming homeless or help re-house and stabilize those who are experiencing homelessness. In particular, many communities used the resources available through HPRP for homeless veterans entering HUD-VASH. The funds were used to provide a security deposit and first month's rent — activities that are not eligible for HUD-VASH assistance. More than 1.3 million people have been served by HPRP.[18] After the program expires in 2012, many of its activities will be funded through the Emergency Solutions Grants (ESG) program, which identifies homeless and at-risk persons and provides the services needed to help them quickly regain stability in permanent housing.

Through the CoC and ESG programs, HUD funds an array of homeless interventions: outreach, emergency shelter, rapid re-housing, transitional housing, and permanent supportive housing. HUD estimates that 19,162 veterans obtained permanent housing assistance through the HPRP and CoC programs in 2010.[19]

HUD is also a partner in a joint effort with VA and the Department of Labor (DOL) to prevent homelessness among veterans. In 2011, the three agencies launched the $15 million, 3-year Veterans Homelessness Prevention Demonstration Program, with a special focus on veterans returning from Iraq and Afghanistan. The funds were awarded to five communities located near military installations — MacDill Air Force Base in Tampa, Florida; Camp Pendleton in San Diego, California; Fort Hood in Killeen, Texas; Fort Drum in Watertown, New York; and Joint Base Lewis-McChord near Tacoma, Washington — to provide housing and supportive services for veterans at increased risk of becoming homeless. DOL provides the veterans with employment counseling and related services. In addition to this initiative, VA and DOL operate several key programs that address the needs of homeless veterans (see "Other Federal Programs Targeted to Homeless Veterans," p. 7).

Joint Focus on Data

HUD and VA have jointly committed to the USICH goal of eliminating veteran homelessness by 2015, a goal that Harvard University Professor Robert Behn calls a true performance or "stretch" target. Stretch targets cannot be achieved "simply by working a little harder or a little smarter," Behn says.[20] "To achieve a stretch target, people have to invent new strategies, new incentives, and entirely new ways of achieving their purposes."[21] Secretary Donovan agrees: "Setting big, ambitious goals and establishing clear targets inspires and moves people to look for innovative solutions."[22]

Secretary Shaun Donovan leads a HUDStat meeting in Washington, DC.

The goal has spurred HUD and VA to strategically align their resources and coordinate on data collection and reporting. "Good data helps to deploy resources where we need them. It helps us know the population much better and because of that, we can show the need," says Dennis Culhane, director of research for VA's National Center on Homelessness Among Veterans.[23] The departments jointly developed and released the first-ever supplements to the *Annual Homeless Assessment Report to Congress*, which quantitatively profiles the nation's veteran population. "Understanding the nature and scope of veteran homelessness is critical to meeting President Obama's goal of ending veterans homelessness within five years," said Secretary Donovan upon releasing the first report in February 2011.[24] Such interagency improvements to federal data collection are essential to HUDStat's efforts.

In addition, local providers of VA-funded services have begun to participate in Homeless Management Information Systems (see Research Spotlight, p. 11), ensuring that data on HUD-VASH clients and their services are incorporated into community service planning and coordination for homeless veterans. Vincent Kane, director of VA's National Center on Homelessness Among Veterans, says that collaborating on collection and analysis of data makes it possible to "look at the aggregate data, see how entities are or are not using vouchers, sharpen how we define the need, and evaluate performance."[25]

Data-Driven Problem Solving Is Key

Data-driven performance management processes have been propelled by the success of COMPSTAT, which was pioneered by the New York City Police Department in the mid-1990s, and CitiStat, instituted by the city of Baltimore in 1999.[26] These efforts sought to hold these organizations accountable for results by analyzing data presented at regular meetings. In monthly HUDStat meetings, Secretary Donovan leads discussions steeped in data to evaluate performance measures for the agency's annual priority goals. Progress toward each priority goal is reviewed quarterly.

Seven weeks before a HUDStat meeting, staff from the Office of Strategic Planning and Management begin reviewing data with program staff and field offices. The staff single out strong and weak performances and follow up with a site visit to discuss findings and possible solutions. At the meetings, the 20–50 attendees, including HUD senior officials, key program staff, and other stakeholders, continue to discuss and analyze the findings.[27] With the discussion grounded in data, HUD staff can identify management challenges that impede progress and recommend

program improvements that will enhance outcomes. As *New York Times* columnist David Brooks wrote after observing a HUDStat meeting about veteran homelessness, "Amid the hot-rhetoric government wars, it was important to see the talent and commitment of real-life government workers running a successful program."[28]

Although enormous effort goes into preparing for and conducting HUDStat meetings, perhaps more important to note is how HUDStat helps drive the daily work that happens between meetings. Through collaboration and data sharing across departments and agencies, program administrators and staff have the information they need to tackle project goals. The result is that "staff is taking leadership on this issue," says HUD Senior Advisor Estelle Richman about veteran homelessness.[29] The advantages of the HUDStat process stem from both the focus on evidence and the increased initiative among the agency's problem solvers.

HUD and VA program staff members regularly participate in HUDStat meetings, where they jointly analyze performance data to understand trends, identify best practices, and prioritize the actions needed to achieve the goal of ending veteran homelessness. Working together and with partners at the local level, HUD and VA succeeded in reducing the population of homeless veterans from 76,329 in January 2010 to 67,495 by January 2011, a 12-percent decline. Secretary Donovan attributes much of this reduction to increased HUD-VASH participation; since 2008, more than 33,500 veterans have been housed through the HUD-VASH program, a result of focusing on problem-solving through HUDStat.

HUDStat changed the evaluation standards for the HUD-VASH program. Previously, HUD-VASH's success was based on the number of housing vouchers made available. But staff and leadership realized that a better measure of effectiveness was the number of veterans placed in housing. This change meant that HUD increased the focus on whether the vouchers are actually used, not simply whether they are available. By changing the standard of success, agency staff and leaders are able to learn where and how the program serves veterans and which areas need greater attention.

HUDStat on the Ground

The improvement of HUD-VASH voucher distribution in Los Angeles is a particularly good example of how analysis of ground-level data has helped improve services to homeless veterans. One in four of the nation's homeless

Other Federal Programs Targeted to Homeless Veterans

In 2009, U.S. Department of Veterans Affairs (VA) Secretary Eric Shinseki launched his department's five-year plan to end veteran homelessness. "Those who have served this nation as veterans should never find themselves on the streets, living without care and without hope," said Secretary Shinseki when announcing the plan.[1] The department funds several programs to support its mission, such as the Homeless Providers Grant and Per Diem Program, through which funds are awarded to community agencies that provide supportive housing or supportive services to homeless veterans. The program is intended to help homeless veterans not only achieve residential stability but also improve their skill levels. To be eligible for funding, local agencies must offer up to 24 months of supportive housing or establish service centers that offer case management, education, crisis intervention, counseling, and services targeted to specialized populations including homeless women veterans. In 2009, VA funded more than 400 community agencies that provided services to 17,008 veterans.[2]

The department aids low-income veteran families that are homeless or at risk of becoming homeless through the Supportive Services for Veteran Families (SSVF) program. Authorized in 2008, SSVF provides supportive services and short-term rental assistance to veteran families who earn less than 50 percent of the area median income and either reside in permanent housing or will do so within 90 days. The goal of the services is to improve these families' housing stability and prevent a return to homelessness.[3]

The U.S. Department of Labor operates programs to tackle one of the root causes of veteran homelessness — lack of employment. The agency's Homeless Veterans' Reintegration Program (HVRP) offers funds to organizations that provide services — including outreach, job search assistance, and résumé and interview preparation — for homeless veterans. In 2010, the agency established another HVRP specifically for female veterans and veterans with children that includes childcare among its covered services. The program's main goals are to help veterans obtain meaningful employment and develop a service delivery system to address the problems homeless veterans face. Between July 1, 2009 and June 30, 2010, nearly 60 percent of the 14,424 HVRP participants were placed into jobs.[4]

[1] U.S. Department of Veterans Affairs, Public and Intergovernmental Affairs. 2009. "Secretary Shinseki Details Plan to End Homelessness for Veterans," 3 November press release.

[2] U.S. Department of Veterans Affairs. "Grant and Per Diem Program." (**www.va.gov/homeless/gpd.asp**). Accessed 26 March 2012; Libby Perl. 2012. "Veterans and Homelessness," Congressional Research Service, 25; Wesley J. Kasprow, Timothy Cuerdon, Diane DiLello, Leslie Cavallaro, and Nicole Harelik. 2010. "Healthcare for Homeless Veterans Programs: Twenty-Third Annual Report," U.S. Department of Veterans Affairs Northeast Program Evaluation Center, Table 5-1, 193.

[3] U.S. Department of Veterans Affairs, Office of Patient Care Services and Office of Mental Health Services. 2010. "Supportive Services for Veteran Families (SSVF) Program Fact Sheet"; John Kuhn. "Supportive Services for Veteran Families." Undated presentation for the U.S. Department of Veterans Affairs, Veterans Health Administration.

[4] U.S. Department of Labor, Veterans Employment and Training Service. 2010. "Annual Report to Congress: Fiscal Year 2010," 12.

veterans are located in the state of California. Consequently, HUD staff began examining data from the state, and the Los Angeles region in particular, more closely. Their research revealed that, despite the need, vouchers were not being used in Los Angeles County at nearly the same rate (49.3%) as in the city of Los Angeles (93.9%). Voucher utilization at the national level was 85.6 percent.[30]

Personnel from HUD and VA went to Los Angeles to meet with the county and city public housing agencies and VA centers to assess the situation. The investigation revealed that the PHAs used different application processes and methods for distributing vouchers. Repetitive administrative procedures among the various agencies delayed the voucher delivery process.[31] The county PHA faced an additional obstacle; the main VA centers that veterans prefer to live near are located in the city, out of its jurisdiction.

This information led HUD and VA staff to reexamine how HUD-VASH vouchers were distributed. Local housing authorities and VA providers agreed to streamline the application process, which led to a single HUD-VASH application that can be used for both the Housing Authority of the City of Los Angeles and the Housing Authority of the County of Los Angeles. The collaboration also resulted in a policy that allows the two PHAs to distribute HUD-VASH vouchers in both jurisdictions. In addition, VA providers outsourced case management to community groups with even closer ties to homeless veterans, which led to more referrals for HUD-VASH vouchers.[32] More veterans are now accessing housing and services in Los Angeles County while still being able to access city services.

The housing authorities and VA providers in the Los Angeles region continue to work together to solve problems. "HUDStat compels us to focus more on the utilization of VASH vouchers in Southern California and how it compares to that of other areas," notes K. J. Brockington, director of the Office of Public Housing at HUD's Los Angeles Field Office. She attributes the successful resolution of barriers to housing homeless veterans to the collaboration that was developed among staff from the different agencies involved.[33]

An increased focus on data also led to improved voucher utilization in the Jacksonville, Florida region. The PHAs and VA centers in the area initially faced numerous challenges to implementing

The Housing Authority of the City of Los Angeles

Twelve homeless veterans received HUD-VASH vouchers at this day long housing fair in the Greater Los Angeles area.

The Housing Authority of the City of Los Angeles

A homeless veteran is interviewed for a HUD-VASH voucher.

the HUD-VASH program, including communication barriers, lack of steady referrals, and low lease-up rates. HUD's Public and Indian Housing (PIH) staff in the Jacksonville Field Office has been actively helping the area's housing authorities and VA centers identify and resolve some of these challenges. Since the inception of HUDStat and the resulting improvements in data availability, PIH staff has been monitoring monthly data updates on voucher utilization to evaluate program performance among the different PHAs. Working together, they are able to map out annual performance targets and steps needed to achieve preferred outcomes.

One of the major barriers to effective HUD-VASH operation in Jacksonville was a lack of understanding of each agency's work and agency-specific differences in terminology and procedures. The PIH office was able to facilitate and participate in regular meetings with personnel from PHAs and VA centers to address these issues and enhance collaboration. As a result, "Everyone's on the same page now. The housing authorities feel like they are part of a team to reduce chronic veteran homelessness," notes Victoria Main, director of Jacksonville's PIH office. To address procedural differences, staff from VA centers and housing authorities are collaborating on a uniform application process for the area's multiple PHAs. Discussions with VA teams also led to an examination of the lack of steady referrals from VA facilities to PHAs, which contributes to the low rates of housing voucher use. The area's VA centers are hiring additional staff to rectify the delay, which stems from a shortage of caseworkers.

Veterans who receive HUD-VASH vouchers have 120 days to sign a lease for a housing unit and are required to pay out of pocket for security and utility deposits and other upfront costs. For chronically homeless veterans, these expenses are often insurmountable barriers to gaining stable housing. The PIH Field Office staff helped identify and explore alternative funding sources to cover these costs. They conducted joint presentations with PHA and VA staff on the HUD-VASH program as part of reaching out to nonprofit and military service organizations, such as the American Legion and the Fleet Reserve Association. In some cases, these organizations have responded with funds to pay for security deposits, while in others they helped supply furnishings, basic kitchen items, and other move-in essentials.

As a result of the efforts and commitment of local HUD and VA staff and the various service organizations, the utilization of HUD-VASH vouchers in the Jacksonville region has improved significantly. "Our numbers are going up every single month," says Main.[34]

Forging Ahead

With the help of HUDStat, VA and HUD are coordinating efforts to jointly house another 35,735 homeless veterans by the end of September 2013. Accordingly, HUD's FY2012 and 2013 budget proposals include $75 million to fund an additional 10,000 HUD-VASH vouchers for homeless veterans, with VA providing $245 million in case management funding (a 21-percent increase from the previous year). HUD's budget also includes funding for the Emergency Solutions Grants program, which allows activities currently funded under the HPRP to be continued.[35]

For veterans, reentry into civilian life after military service is fraught with

The Housing Authority of the City of Los Angeles

Victoria Harris, an Air Force veteran, and her family were homeless prior to receiving a HUD-VASH voucher from the Housing Authority of the City of Los Angeles.

adjustments and, for a significant number, the stress of managing combat-related mental and physical trauma. The risk of becoming homeless is higher for veterans, and the Obama administration is committed to eliminating that risk. In partnership with USICH, HUD and VA are setting ambitious goals to ensure that every veteran in the United States is housed — by cutting across silos to jointly set goals, align resources, and work systematically with the best tools available. This collaboration intends to build on the 12-percent reduction in homeless veterans realized from 2010 to 2011, a significant step towards eliminating veteran homelessness. Part of this success is attributable to improvements in data gathering and analysis as well as the adoption of innovative tools such as HUDStat. This data-driven performance management process identifies bottlenecks, directs resources toward housing homeless veterans, and empowers stakeholders at all levels of the public and private sectors to achieve the goal of ending homelessness among veterans. EM

[1] "Breaking Down Silos and Boosting Results Through HUDStat: An Interview With Lisa Danzig of HUD." Gov Innovator Blog (**www.govinnovator.com**). Accessed 5 May 2012.

[2] Communication with Press Operations, Department of Defense, March 2012.

[3] Interview with John Driscoll, February 2012.

[4] Bret T. Litz and William E. Schlenger. 2009. "PTSD in Service Members and New Veterans of the Iraq and Afghanistan Wars: A Bibliography and Critique," *PTSD Research Quarterly* 20(1), 1–3; RAND Corporation. 2008. "Invisible Wounds: Mental Health and Cognitive Care Wounds of America's Returning War Veterans," 2.

[5] Research attributes the higher incidence of PTSD to more recent veterans serving in combat (60 percent of post-9/11 veterans compared with 42 percent of pre-9/11 veterans) as well as increased awareness of the disorder in recent times. When comparing the experiences of veterans of the current wars with those who served before them, the researchers caution that the time lapse and experiences between those surveyed from earlier wars and when they served is much longer than those of the recent war, which could change their views over time; Rich Morin. 2011. "The Difficult Transition from Military to Civilian Life," 1; Paul Taylor, Rich Morin, Ana Gonzalez, Seth Motel, and Eileen Patten. 2011. "For Many Injured Veterans, A Lifetime of Consequences," 11; Pew Social & Demographic Trends. 2011. "The Military-Civilian Gap: War and Sacrifice in the Post-9/11 Era," 49.

[6] U.S. Department of Veterans Affairs. "The Changing Face of Women Veterans." (**www.womenshealth.va.gov/WOMENSHEALTH/facts.asp**). Accessed 27 March 2012.

[7] Howard Balshem, Vivian Christensen, and Anais Tuepker. 2011. "A Critical Review of the Literature Regarding Homelessness among Veterans," Department of Veterans Affairs Health Services Research & Development Service, 32.

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Using Data to Understand and End Homelessness

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Highlights

- Measuring the extent of homelessness is essential to combating it, and efforts to count the homeless population have evolved significantly since the early 1980s.
- A combination of Homeless Management Information Systems, Point-in-Time counts, and Housing Inventory Counts inform policymakers and advocates on demographics, trends, and the availability and usage of services among America's homeless population.
- Improved accuracy and detail of homeless data have influenced all aspects of HUD's policies as well as those of its partner agencies.

Since homelessness emerged as an issue in the United States, a broad group of dedicated individuals and organizations — from advocacy groups and shelters to local, state, and federal government agencies — have fought to help homeless persons find housing and remain stably housed. Data have become a critical component of these efforts. Documenting the number, characteristics, and needs of homeless persons in American communities, as well as the number of people receiving services and the capacity of these services, is essential to identifying the proper strategies to tackle the problem; it's very difficult to manage what you can't measure.

Because counting the homeless population is difficult and resource intensive, local governments have had to develop systems that are flexible enough to accommodate differing local circumstances yet also consistent enough to aggregate local data and get a holistic picture at the national level. This article summarizes the evolution in understanding homelessness in this country through data, detailing early attempts at measurement and the current systems used by HUD and its federal and local partners, principally Point-in-Time (PIT) counts, the Housing Inventory Count (HIC), and Homeless Management Information Systems (HMIS). The article also explores the ways that this information has helped policymakers confront homelessness more effectively. When used together, these complementary data collection efforts offer a more in-depth picture of homelessness that enables policymakers to target resources toward effective assistance models and more quickly adapt less effective programs.

Early Efforts To Understand America's Homeless Problem

As homelessness increased in the 1980s, interest grew in understanding the nature and scope of the problem. Advocates, particularly at the Community for Creative Non-Violence, asserted that the national homeless population totaled two to three million homeless persons. In the absence of other data, these numbers became conventional wisdom.[1] To gather more accurate data on homelessness in the United States, federal agencies began to conduct national point-in-time (PIT) studies. These PIT studies were based on the number of homeless persons counted during a specific time period and in specific places and were conducted to enumerate the homeless population.

HUD conducted the first national PIT study from 1983 to 1984.[2] The study was limited to a sample of shelters in 60 areas and used statistical methods to derive counts of persons with shelter and those without shelter. Building on HUD's 1983 sample study, the U.S. Department of Agriculture (USDA) funded a large study in 1987 to derive a national count and learn more about the characteristics of the homeless population. This study involved hundreds of providers in 20 cities and yielded the first nationally representative dataset including demographic information, such as household composition, race, age, and income sources. In 1988, HUD conducted its first shelter inventory to assess the capacity of the shelter system.[3]

Following the lead of these national efforts, a number of local communities began systematically collecting data on homeless persons as early as 1986. New York City and Philadelphia were pioneers in collecting citywide data. They were among the first cities to have local government-funded homeless shelters that required grant applicants to collect client-level data. Other early municipal or statewide systems included Columbus, Ohio; Phoenix, Arizona; St. Louis, Missouri; and the state of Rhode Island.[4]

Private researchers drew significant insights from the data that had implications for decisionmakers at all levels. For instance, Dr. Dennis Culhane analyzed New York's data and found that it cost an average of $40,500 for a single person to live on the streets of New

> Data have become critical to the efforts of dedicated individuals and groups who help homeless persons find stable housing.

York City during the course of a year.[5] This finding helped elected officials, policymakers, program administrators, advocates, and researchers recognize that homelessness was an economic issue as well as a moral one.

The next significant effort to enumerate homelessness at the national level was initiated by the U.S. Census Bureau as part of the 1990 census. The effort, referred to as "S-Night" (the "S" stood for both street and shelter[6]), did not result in an estimate of the homeless population but introduced the notion of enumerating in every community rather than relying on sampling.[7] In that same year, the first longitudinal analysis, tracking changes in homelessness over time, was performed based on a telephone survey which asked respondents if they had ever experienced homelessness and, if so, whether it had been in the past five years.[8]

The U.S. Interagency Council on Homelessness and its agency members (HUD, the U.S. Department of Health and Human Services, and the U.S. Department of Veterans Affairs) conducted another sample-based PIT count in 1996, similar to the 1987 USDA study, which was used to inform policymakers, especially with regard to the geographic distribution of homelessness.

These early studies helped the homeless assistance community make critical strides toward understanding and addressing homelessness. With each new study a national picture began to form. The first study established a baseline number of homeless persons, and subsequent studies have helped bring homeless issues into greater focus, from the demographics of the homeless population to its geographic distribution. However, a few national studies with varying methodologies and purposes spanning a 25-year period were grossly inadequate to understand homelessness and the tools that could best solve it. To more effectively confront homelessness, stakeholders at both the local and national levels needed to have much more reliable data based on regular and consistent local data collection efforts.[9]

Developing a Vehicle for Regular National Reporting

The new millennium brought a monumental change in HUD's role in data collection. In 1999, Congress directed HUD to develop a representative sample of jurisdictions to collect unduplicated counts of clients served, demographic information, types of housing received, and outcomes of homelessness projects, such as housing stability.[10] In 2001, Congress charged HUD to work with communities to develop unduplicated counts of homeless persons assisted, analyze the patterns

From left to right: Carrie Schmidt, Field Office Director in Richmond, Ronnie Legette, CPD Director for Richmond, and Mark Johnston participated in the 2012 PIT count in Richmond, Virginia.

of service use by homeless clients, and evaluate the effectiveness of programs locally. To accomplish this expansive mandate, communities needed to collect consistent, longitudinal data through what had become known as Homeless Management Information Systems (HMIS).

HMIS is a locally administered electronic system that collects and stores client-level data for those receiving homeless assistance. HUD deployed professionals with HMIS experience to communities to provide extensive technical assistance, including one-on-one assistance and an HMIS implementation guide. HUD also sought input from the early implementing communities, other HMIS professionals, homeless researchers, advocates, providers, and privacy experts to get helpful advice to communities that were slow to implement HMIS. In the course of this undertaking, HUD decided not to develop a software application that all providers would be required to use, instead relying on the marketplace to develop software that would adhere to HMIS standards.

With the congressional mandate to collect and report on the homeless population, HUD created tools and incentives for communities to collect data. Through a coordinated effort between HUD and homeless assistance stakeholders with HMIS expertise, HUD developed HMIS technical, privacy, and security standards as well as a format for an Annual Homeless Assessment Report (AHAR) to be submitted to Congress. HUD also established national standards for the count of homeless persons (through a regular PIT count) and for an annual inventory of homeless beds and units. HUD continues to provide extensive technical assistance on implementing and operating HMIS at national, regional, statewide, and local conferences. Once the standards were issued and the mechanism for technical assistance was in place, HUD began to expect that all recipients of HUD homeless funds participate in HMIS.[11]

HUD also changed its homeless assistance grants competition to reflect an emphasis on quality data. The Homeless Assistance Grant competition represents the largest single federal resource to combat homelessness. As a part of their annual application for Homeless Assistance Grant funding, communities must conduct a PIT count in their area and report that data in their applications. In addition, communities must report the date they conducted the count, the nature of the count (i.e., sheltered and/or unsheltered), and the methodology for the count. Communities are also required to report annually on their HUD-funded and non-HUD-funded housing inventory targeted for the homeless, referred to as the Housing Inventory Count (HIC).

In addition to reporting data on homeless populations and the housing inventory, HUD added questions to its funding applications regarding the quality of HMIS that communities were using. To help cover the costs associated with implementing and operating HMIS, HUD successfully sought from Congress the ability to allow grantees to use Homeless Assistance Grant funds for this purpose, which has been another key factor in implementing HMIS nationally. As a result of these various efforts, PIT and HMIS participation have increased dramatically.

HUD has established national standards for regularly counting homeless persons and inventorying available homeless beds and units.

HUD's Current Data Collection Efforts

HUD continues to rely on data to learn about and address the homeless crisis in America. The core data sets that HUD uses for its current evaluation are PIT, HIC, and HMIS. Each data set has its own strengths and limitations, and HUD leverages each of these data sets to form a more complete picture of homelessness in the United States.

PIT. HUD requires communities to submit a count of the homeless population in their area as well as information on specific subpopulations, including chronically homeless persons, veterans, and unaccompanied youth. Communities report this information by household type (i.e., households with at least one adult and one child, households without children, and households with only children) and program type (i.e., Emergency Shelter, Transitional Housing, and Permanent Housing). A PIT count is composed of two parts: a sheltered PIT count, which is required every year, and an unsheltered PIT count, which is required at least every other year. Communities submit these data annually through their Continuum of Care (CoC) applications for Homeless Assistance Grants.

Many communities develop their sheltered count from their HMIS data. However, when the HMIS data are insufficient, due to lack of coverage across the community of providers or other reasons, communities generally supplement the data based on surveys. The surveys vary in complexity from mere observations of the surveyor to in-depth, interview-based surveys. HUD does not prescribe the survey method to use but does provide guidance on survey techniques in its publication, *A Guide to Counting Sheltered Homeless People.*

The unsheltered count is more complicated and costly to conduct than the sheltered count, and HUD is more strict about the acceptable methodologies for performing these counts. Because

Barbara Poppe, Director of USICH, and HUD Secretary Shaun Donovan participated in a 2011 PIT count in Washington, DC.

unsheltered persons are not generally recorded in HMIS, communities have much more planning to do. HUD's *A Guide to Counting Unsheltered Homeless People* outlines the three basic approaches that HUD accepts for conducting an unsheltered count. First, many communities conduct street counts, in which community volunteers visit the streets and locations where they expect to find homeless individuals and count them based on observation over a very specific period (usually between dusk and dawn on a single night). This method is relatively easy to organize, train volunteers to conduct, and aggregate. Although simple, this method of counting invariably misses some people, and little information is gained beyond the total number of unsheltered persons.

The second approach combines the street count with an interview. With this approach, count participants are trained to either interview every single person they encounter who appears to be unsheltered, or interview every *n*th person to create a simple random sample. The sample-with-interview approach yields a much richer level of data to the community but tends to be more complicated to staff, conduct, and unduplicate.

The third method for counting the homeless population is a service-based count in which the community counts people as they receive homeless services during the specific count period. Communities using the service-based approach will often plan a specific event that is likely to attract homeless persons such as a special breakfast or health-care option. Although this method requires the community to carefully determine who has already been counted, it tends to reach a particular homeless population that chooses to use the supportive services available, including soup kitchens, drop-in centers, and street outreach teams, but would be difficult to count through other methods because of where they choose to sleep.

To determine the most appropriate methodology to use, communities need to evaluate, among other things, their climate, size, and availability of resources. The number of participants in the count and the size of the area often drive the method that is chosen. However, several communities use a combination of these methodologies.

In addition to homeless population data, HUD requires communities to submit subpopulation data on chronically homeless individuals and families, veterans, severely mentally ill individuals, chronic substance abusers, persons with HIV/AIDS, victims of domestic violence, and unaccompanied children (under 18). When the subpopulation data are incomplete, communities use sampling and extrapolation methods to derive their counts.

HIC. HUD requires communities to collect HIC data, which is an annual inventory of the beds, units, and programs designated to serve the area's homeless population. These data are also submitted annually, in conjunction with the PIT population and subpopulation data. HUD requests that the data be reported based on household types served in the inventory (i.e., households with at least one adult and one child, households without children, and households with only children). The HIC data are often pulled directly from the community's HMIS. When the HMIS data are incomplete, communities contact the missing providers to determine the nature of their homeless assistance inventory.

HMIS. An HMIS is an electronic data collection system that stores longitudinal client-level information about those who access the homeless services system through a CoC program.[12] Because HUD does not create or own HMIS software, HUD does not directly receive client-level information. To ensure consistency and data quality, HUD publishes its *HMIS Data Standards* as well as other notices and guidance. Communities use HMIS to track homeless individuals as they access services in the community, and they are able to develop a rich data set on homeless persons, from their demographic data to the services they receive to where they go after exiting a program.

Communities aggregate their HMIS data and submit it to HUD through various mechanisms, including their Homeless Assistance Grant applications and their Annual Performance Reports for their HUD-funded projects.

HUD also receives HMIS data through its AHAR process, in which it collects unduplicated annual HMIS data at the community level to evaluate its coverage and completeness. HUD uses aggregated HMIS data from communities that have sufficient coverage and completeness to determine national estimates on the nation's sheltered homeless population.

Each of these three major data sources plays a unique role in informing HUD and the public about the nation's homelessness. PIT data provide a snapshot in time of the homeless population. Although PIT data are limited to household population, program types, and subpopulation data, they are the only means HUD has of determining the unsheltered population, and they allow communities to report data on providers that are not participating in HMIS. HIC data are HUD's primary means of gauging the nature and extent of resources that are dedicated to homeless persons across the country, whether funded by HUD or not. HMIS data allow a more holistic understanding of the homeless clients served by participating providers and offer an understanding of data on an annual rather than a point-in-time basis.

HUD's Data Produces an In-Depth Picture of Homelessness

Data collection efforts have advanced considerably in the past few decades and have opened up new opportunities and insight into homelessness in America. Having regular, accurate data locally and nationally is key to solving homelessness. Initial studies largely provided basic information about the homeless population and demographic composition. For instance, the 1987 USDA survey found that only 10 percent of homeless adults were in households with children, and 84 percent of these households were female headed. The 90 percent of households that had no children were overwhelmingly headed by single men.[13] Data collection methods have evolved beyond mere enumeration to allow a more robust understanding of the nature of homelessness and effective interventions.

At a local level, elected officials, government agencies, nonprofit service providers, advocates, and the public can use the data reported in PIT counts, HIC, and HMIS to more effectively engage in solving homelessness if they understand the scope of the problem. Communities are using the PIT count to determine the extent of homelessness in their area and then comparing that with HIC data to determine the resources available. These communities then use HMIS data to determine whether the resources they have are effectively meeting the needs of their homeless populations. Communities are reviewing HMIS data measurements, such as length of stay, to determine the best-performing projects. This review is leading communities to provide assistance to low-performing projects or even consider defunding them in favor of projects that are more efficient.

The depth and frequency of reporting has also been a critical factor in national decisionmaking. Knowing how many persons are chronically homeless, how many are veterans, and how many are families with children enables HUD to more strategically work with communities. For instance, when HUD saw an increase in family homelessness in 2009 and 2010, especially in less urban areas, the agency was able to target more CoC resources to this needy population. In part because of increased funding for family projects and communities' use of the Homelessness Prevention and Rapid Re-Housing Program (HPRP) to serve families, family homelessness had declined by two percent by 2011.[14]

HUD recognizes the importance of letting all stakeholders review and comment on the homeless picture as it is depicted by HUD-collected data. Each year, HUD makes its HIC and PIT data publicly available and reports these data, as well as HMIS data, to Congress in its Annual Homelessness Assessment Report (AHAR). In the 2010 AHAR, HUD reported that in the last 10 days of January nearly 650,000 homeless persons were on the streets and in emergency shelters and transitional housing, and that over the course of the year approximately 1.59 million people spent at least one night in an emergency shelter or transitional housing program. These two figures demonstrate the tremendous churning in the homeless population. A closer examination reveals that homeless individuals in emergency shelters tended to stay for short periods of time, a finding

HMIS data have been a critical component of HUD's understanding of the benefits of using a rapid re-housing intervention model for homelessness.[1] Communities have been using HMIS to track many factors, including length of stay and recidivism, to determine the effectiveness of the rapid re-housing interventions. For instance, the city of Cincinnati and the state of Michigan used HMIS to assess the relative effectiveness of HPRP's rapid re-housing intervention during the second of the program's three years of operation. Cincinnati found that only 12 percent of all homeless people assisted with rapid re-housing had fallen back into homelessness; Michigan found that of all rapid re-housing recipients in the state, only 6 percent had fallen back into homelessness. These jurisdictions will be able to continue to track recidivism of their clients over time. Without HMIS, Michigan, Cincinnati, and communities nationwide would not have known the effectiveness of this intervention. Based in part on these findings, HUD is explicitly encouraging communities nationwide to use available funds in existing programs, such as the Emergency Solutions Grants Program, for rapid re-housing.

[1] Rapid re-housing is an intervention model where households maintain a lease of their own and providers assist the household with rental payments and services until the household is able to maintain the housing on their own.

A short-term intervention such as rapid re-housing is an effective and more efficient form of assistance for most homeless persons.

that has been consistent year after year. The most recent report on 12-month sheltered data found that about one-third (34%) stayed a week or less in emergency shelter during a 12-month period, and 61 percent stayed less than a month.[15]

Knowing the data about homeless persons' length of stay in emergency shelters has allowed policymakers to recognize that many — in fact most — homeless individuals do not need a permanent housing subsidy and supports to exit homelessness. Rather, a short-term intervention such as rapid re-housing is an effective and more efficient form of assistance for most homeless persons. Whereas nearly two-thirds of homeless persons who enter emergency shelters are homeless only for a month or less during the year, only 6 percent are homeless for more than 6 months during the 12-month period; these long-term homeless persons will typically need a more robust intervention, such as permanent housing with supportive services, to successfully exit homelessness and remain stably housed.

Other federal partners are using the data to make decisions and are encouraging their partners to use HMIS and similar databases. In 2010, the Obama administration, through the U.S. Interagency Council on Homelessness, published *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*, the first comprehensive plan to end homelessness nationwide. In the Federal Strategic Plan, the Obama administration set goals to end chronic and veteran homelessness by 2015 and family, youth, and child homelessness by 2020. HUD's data have been crucial in setting these targets, tracking progress toward accomplishing those goals, and determining which partners and interventions are most effective in reaching these targets. (See "Tackling Veteran Homelessness With HUDStat," p. 1).

Other agencies recognize the value of these data sources in achieving their objectives. In addition to jointly enumerating veteran homelessness with HUD each year through the PIT count, the U.S. Department of Veterans Affairs is beginning to adopt HMIS. For instance, the new Supportive Services for Veteran Families program requires grantees to participate in HMIS. Similarly, Projects for Assistance in Transition From Homelessness (PATH), the U.S. Department of Health and Human Services' formula grant program, is implementing HMIS for its grantees; PATH serves individuals with severe mental illness who are homeless or at risk of homelessness. As is the case with PATH, HMIS is useful not only for people who are homeless but also those who are at risk of homelessness. Congress directed that grantees of the $1.5 billion HPRP program, which primarily served persons at risk of homelessness, must participate in HMIS. As of March 31, 2012, HPRP has served more than 1.3 million clients. By including those at risk of homelessness who then received prevention assistance in HMIS counts, communities can learn whether these persons become homeless over time.

Looking to the Future

Although HUD has made great strides in its data collection efforts, there is more to learn and do. The recently enacted Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act is pushing HUD to improve data collection at the community level. The HEARTH Act requires more critical analysis of recidivism and the nature of those experiencing homelessness for the first time. HUD will continue to encourage communities to analyze projects based on performance. Although a number of communities are using their data to evaluate performance and make critical decisions, HUD desires to instill that approach in all of its providers, resulting in effective projects that meet the needs of each community. HUD will continue to improve its data collection process to help the agency and its partners prevent and end homelessness in the United States. EM

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Linking Housing and Health Care Works for Chronically Homeless Persons

Highlights

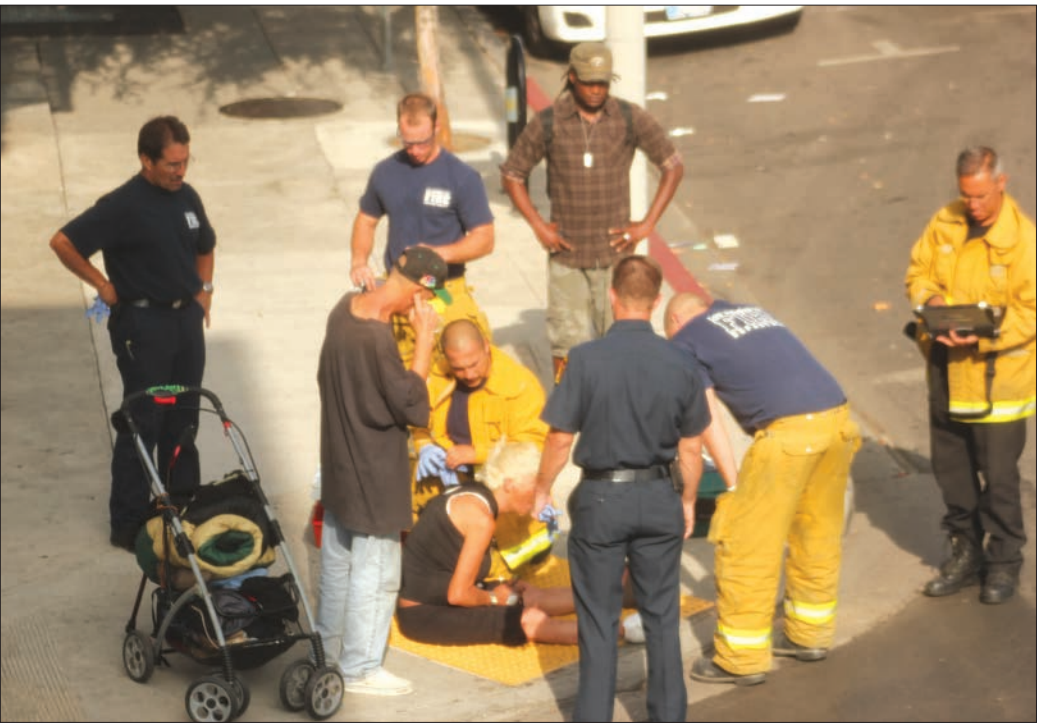
- Evidence shows that housing has a major effect on health and that stable housing can significantly improve health outcomes for chronically homeless individuals.
- Programs around the country, including in Boston and New York City, use a Vulnerability Index to assess and prioritize the housing and health-care needs of homeless individuals.
- The Chicago Housing for Health Partnership has tested an approach that combines housing with intensive case management services; this approach has yielded greater housing stability and fewer hospital visits for chronically homeless patients.

Experiencing homelessness exacerbates health problems and the ability to access appropriate care. Residential instability and insecurity, including doubling up and overcrowding, creates substantial risks to child health, development, and educational outcomes.[1] Housing instability and living in lower socioeconomic neighborhoods can lead to significant stress, mental health problems, obesity, and diabetes.[2] A growing body of evidence demonstrates the positive impact of stable housing on such outcomes. In response to this increasingly clear and compelling picture, the HUD Strategic Plan for fiscal years 2010–2015 included a goal to "utilize housing as a platform for improving quality of life." Recent research provides particularly strong evidence supporting the role of housing in improving outcomes for chronically homeless individuals. This article will highlight the evidence by describing three communitywide approaches to addressing chronic homelessness in Boston, New York City, and Chicago.

Chronic Homelessness

Although definitions vary, chronically homeless individuals generally have lengthy histories of homelessness and struggle with disabilities and disabling health conditions.[3] This population experiences high rates of serious mental illness, substance abuse, and chronic physical illness, with these conditions often co-occurring. The mortality rate for chronically homeless persons is four to nine times higher than that for the general population.[4]

Homelessness impedes access to health care and the ability to stay healthy, such as eating well, getting enough sleep, taking medication regularly, and caring for injuries. Socially isolated, many chronically homeless individuals receive little or no health care and no continuity of care. Addressing the intensive health needs of these vulnerable individuals with emergency, acute care interventions are extremely costly and have not proven to be effective. Without intervention, chronically homeless individuals who struggle with serious primary and behavioral health issues continue to cycle intermittently from the street through shelters, emergency rooms, and prisons — and then back to the street again.



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Reliance on emergency health care for meeting needs of homeless persons is less effective and more expensive than housing and individualized support services.

As intractable as the problem seems, evidence suggests that the right tools and approaches can reduce chronic homelessness. In many cases, permanent supportive housing programs — in particular, those that follow the "housing first" model — are successful in moving chronically homeless individuals off the streets and into stable housing. Perhaps equally compelling to communities battling chronic homelessness is the cost effectiveness of the strategy. Cycling chronically homeless individuals through expensive public systems carries a steep economic cost. Providing shelter or supportive housing costs less and results in savings, compared with other interventions. For example, the typical daily per capita charge for shelter ($28) and affordable supportive housing ($31) are much less than the cost of hospital inpatient

Jill Roncarati and Jason Sousa of BHCHP help Peter Pettibone, formerly homeless, move in to his new apartment.

treatment ($1,940), an emergency room visit ($905), a psychiatric hospital intervention ($604), or detoxification ($256).[5]

Around the country, practitioners and researchers from the housing and healthcare communities are discovering and applying evidence-based interventions toward ending chronic homelessness. In Boston, a healthcare organization learns directly about the needs of chronically homeless patients from the patients themselves — and puts those lessons into practice. These lessons have proven relevant in New York City and beyond. In Chicago, a coalition of homeless service providers used their collective experience and resources to design and empirically test an intervention that contributed to understanding what works to improve the health and well-being of medically vulnerable and chronically homeless persons, while also improving resource allocation.

Without intervention, chronically homeless persons cycle from the street through shelters, emergency rooms, and prisons — and back to the street.

In Boston: Integrated Primary Care + Housing

Physician Assistant Jill Roncarati, a member of the Boston Health Care for the Homeless Program's Street Team, is intimately familiar with the living conditions and needs of chronically homeless individuals. "My patients," Roncarati says, "are people who live on the streets, on park benches, under bridges, and in back alleyways." Health problems are caused and exacerbated by homelessness, which is why Roncarati and her colleagues not only take health care to their patients, but also are committed to helping them become housed. "We assist them with the difficult transition from the streets to a home, continuing to provide health care and mental health support as they contend with the challenges of living independently," she says.

The Boston Health Care for the Homeless Program (BHCHP) combines medical care in the shelters and on the street with care provided by teaching hospitals and neighborhood health centers. Its mission is to make the highest-quality health care accessible

Boston Health Care for the Homeless Program

to Boston's homeless population.[6] The program's clinical services began nearly 30 years ago with a 3-year Health Care for the Homeless demonstration project grant from the Robert Wood Johnson Foundation and the Pew Charitable Trusts. Dr. James O'Connell, president and founder of BHCHP, recounts that during the initial grant period, the group operated 3 hospital clinics and 14 clinics in adult and family shelters; established the first medical respite program in the country, with 25 beds that provided temporary care and time to heal; initiated street services with a physician and an overnight van for taking around-the-clock health services to those sleeping on the streets; and created a multidisciplinary, multicultural HIV team to offer primary and specialty care to the city's homeless population. After Congress passed the Stewart B. McKinney Homeless Assistance Act in 1987, BHCHP became a federally qualified health center funded by the Health Resources and Services Administration's Bureau of Primary Health Care. Over time, the program has evolved as a public healthcare model that focuses on prevention, treatment, and continuity of care.[7]

Today, BHCHP annually treats more than 11,000 homeless individuals who use homeless shelters, eat at soup kitchens, sleep on the streets, or work on the backstretch and sleep in the stables and barns of Boston's Suffolk Downs racetrack. Close collaboration among doctors, physician assistants, nurses, nurse practitioners, and case managers offers primary care that enables a patient to move more easily from the street to a clinic, hospital, or respite care, and ultimately to housing. Specialty care, including dental, mental health, and psychiatric services, are also integrated with the primary care service model.

Principal points of contact with their patients are made on the street and at homeless shelters by teams of clinicians. Nearly every homeless shelter in the city hosts a clinic, as do three of the hospitals. Clinicians are able to access patients' medical records electronically.[8] BHCHP also runs a 104-bed care facility that provides respite and recuperative services for patients who need to heal, receive treatment for diseases such as pneumonia and cancer, be monitored for conditions like blood sugar levels or trench foot, or even prepare for a colonoscopy. Roncarati says this option for respite care is a critical piece of providing health care for homeless, chronically ill individuals: "I couldn't treat my patients successfully without it."

HomeStart, a nonprofit that links homeless people to housing opportunities and resources, is one of several housing agencies to which BHCHP refers patients. Because all of BHCHP's patients are both chronically homeless and chronically ill, those who have been homeless for the longest time are given priority for referrals. Through its Housing First initiative, HomeStart makes housing vouchers available to these referrals and provides stabilization services. A BHCHP team member accompanies and introduces a patient to HomeStart and assists with applying for services, securing income, and ensuring transportation access for patients. HomeStart helps patients equip their new home, shop, and otherwise get stabilized. BHCHP follows up with house calls to ensure continuity of health care and preserve patient-doctor relationships. With more patients being housed, Roncarati notes a change in the flow of care: "It cuts down on the number of people we can see. The team has to prioritize to determine who needs the next visit. Our staffers talk a lot, stay in touch by phone with patients, and try to stay flexible to get medical and health care to those needing it the most."

Identifying Those Most at Risk

The health care program's work and experience with chronically homeless persons also generate research that has helped shape its own approach and inform other service providers. Motivated by high morbidity and mortality rates among the homeless during the 1990s, medical researchers affiliated with the program began to study the medical records of BHCHP clients to identify factors other than homelessness that were associated with death.[9] The research of Stephen Hwang, James O'Connell, and their medical colleagues established that chronic health conditions put homeless persons at significantly heightened risk for dying on the street.[10] Their studies showed that being chronically homeless for six months or more and having one or more of the following markers signaled a high chance of premature death without housing and adequate support:

- Hospitalization, emergency room visits, or admissions to respite care in the past year;
- aged 60 or older;
- cirrhosis, end-stage liver disease, or renal failure;
- history of frostbite, immersion foot, or hypothermia;

J. B. Rutagarama

Personal connections forged with people who need stable housing help change perceptions about homelessness.

- HIV-positive or AIDS; and
- Tri-morbidity, or co-occurring psychiatric, substance abuse, and chronic medical conditions.[11]

These markers formed the basis of what later became known as the Vulnerability Index, a tool used to assess and prioritize the healthcare and housing needs of chronically homeless persons. With these health conditions, BHCHP's medical researchers learned that even aggressive clinical intervention and 24 hours a day, 7 days a week followup with a chronically homeless cohort could not prevent untimely deaths. Their findings indicated the need for safe places to heal, which respite care and stable housing with intensive support services can provide. Such housing led to lower readmission rates and fewer deaths. For example, individuals who were discharged from a hospital to a homeless respite program were 50 percent less likely to be readmitted within 90 days compared with individuals who were discharged to the shelter system.[12,13]

"Clearly," O'Connell concludes, "Housing as an intervention, has been nothing less than life-saving for people on the street." Once vulnerable individuals move into stable housing, they have the basis for improving their health; at this stage supportive services become particularly crucial. "Although housing is absolutely necessary, it's not always sufficient," states O'Connell, explaining that skills necessary for living on the street, which are often finely tuned, do not necessarily transfer to a stable housing situation. Patients with multiple and chronic health needs often find navigating a complex and fragmented healthcare system overwhelming, making wraparound supportive services an essential component of linking health care and housing.

In New York City: Taking the Vulnerability Index to Scale

In the 1990s, while BHCHP was working out effective strategies in Boston, a nonprofit organization in New York City called Common Ground discovered that the same homeless individuals they were helping to house frequently experienced health crises and hospitalizations. It became apparent to Rosanne Haggerty, then Common Ground's director, that the healthcare and homeless assistance systems were separately assisting many of the same homeless individuals and not making much progress in either area. It seemed evident that the two systems needed to coordinate their services. Haggerty explains, "We were trying to figure out how to put together an objective and appropriate triage that focused on resources, filled gaps in service, and dealt directly with the serious health issues," when her team found the answer in

CONTINUED ON PAGE 22

Combating Family Homelessness

Individuals in families accounted for 37 percent of the nation's total homeless population on a single night in January 2011.[1] Public, private, and philanthropic organizations are working to identify and adopt effective responses to family homelessness. In the state of Washington, the Bill and Melinda Gates Foundation collaborates with a range of organizations to create a comprehensive, coordinated response to family homelessness backed by a reliable funding stream. New York City focuses on prevention and rapid re-housing to reduce homelessness among families. And in a multiyear comparative study that ends in 2014, HUD is comparing the effects of four different housing and services interventions on family homelessness.

In 2000, the Gates Foundation launched its Sound Families Initiative with $40 million to create service-supported, transitional housing for families that were homeless or at risk of becoming homeless. By 2007, the initiative had funded 1,445 supportive housing units in the target areas of King, Snohomish, and Pierce Counties, which together contain more than 60 percent of the state's homeless population. Nearly 70 percent of the homeless families that received assistance through the initiative obtained permanent housing, and 48 percent improved their economic stability. The initiative also became the impetus for the Washington Families Fund (WFF), a public-private partnership created by the state legislature in 2004 to be a dependable, long-term funding stream for supportive housing programs serving homeless families with children. As of December 2010, WFF had awarded more than $17 million to programs that aided 1,286 families in 19 counties.[2]

Despite these efforts, family homelessness in Washington continues to grow rapidly, so the Gates Foundation is pursuing a new approach to reducing family homelessness in the state. This five-pronged strategy features early intervention to prevent at-risk families from becoming homeless, coordinated access to services for homeless families, rapid re-housing, tailored programs that address each family's unique needs, and education and job training programs that provide homeless families with a path to economic self-sufficiency. In 2009, King, Snohomish, and Pierce Counties began demonstration projects to test homelessness interventions based on this strategy. With support from WFF and the Gates Foundation, these counties are creating a comprehensive and coordinated response to family homelessness.[3] Pierce County has already implemented a centralized intake and referral system, a single point of access for at-risk and homeless families that connects them to needed services.[4]

Prevention and rapid re-housing are key to New York City's efforts to reduce family homelessness, at the center of which is the city's award-winning Homebase program. Homebase offers case management services and financial assistance to the city's vulnerable population to prevent homelessness, minimize stays in homeless shelters, and prevent repeated shelter stays. Families that are homeless or at risk of becoming homeless are referred to one of 13 neighborhood-based Homebase centers. Each family is assigned a case manager who helps avert the immediate housing crisis and also creates a long-term housing stability plan tailored to the family's unique needs. Through community partnerships, Homebase provides financial assistance, housing mediation assistance, financial counseling, legal services, job training, and aftercare services for families leaving shelters and deemed to be at risk of reentry. More than 90 percent of the 34,100 families and individuals served by the Homebase program since its inception in 2004 did not enter the shelter system.[5]

A multiyear study sponsored by HUD looks to fill gaps that remain in understanding the best ways to prevent and end homelessness among families. More than 2,300 families in participating communities have been randomly assigned to one of four designated housing and services interventions: permanent housing subsidy; transitional housing with supportive services for up to 24 months; temporary rental assistance in private-market housing; or usual care, which represents assistance that people would normally access on their own from shelters. Families are tracked every three months and will complete a followup interview 18 months after being assigned an intervention. Preliminary analysis on the followup data will be available in early 2013, with longer-term results reported in 2013 and 2014.

[1] U.S. Department of Housing and Urban Development. 2011. "The 2011 Point-in-Time Estimates of Homelessness: Supplement to the Annual Homeless Assessment Report," 3.

[2] The Northwest Institute for Children and Families, University of Washington School of Social Work. 2007. "Evaluation of the Sound Families Initiative: Final Findings Summary — A Closer Look at Families' Lives During and After Supportive Transitional Housing," Bill and Melinda Gates Foundation, 1–2; "Grantmaking and Evaluation," Building Changes (**www.buildingchanges.org/our-work/grantmaking-and-evaluation**). Accessed 4 April 2012.

[3] "Washington Families Fund Launches New Strategy to Prevent and End Family Homelessness," Bill and Melinda Gates Foundation (**www.gatesfoundation.org/press-releases/Pages/memorandum-of-understanding-ending-homelessness-090319.aspx**). Accessed 4 April 2012.

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[5] "Homebase," New York City Department of Homeless Services (**www.nyc.gov/html/dhs/html/atrisk/homebase.shtml**). Accessed 5 April 2012; New York City Department of Homeless Services. 2011. "Federal Stimulus Funds Help Department of Homeless Services Assist More Than 100,000 Individuals," press release, 12 September.

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the research of James O'Connell and his colleagues from the BHCHP. The markers the Boston researchers had identified for determining those most in need of both health care and stable, supportive housing — now coined the Vulnerability Index by Common Ground — "is so intuitively logical," says Haggerty.

Common Ground applied the Vulnerability Index in an initiative to reduce chronic street homelessness in Times Square and surrounding blocks. Using the index to assess and prioritize the need for housing and services, the Street to Home initiative not only took medical, psychiatric, and housing placement services to homeless individuals on the street, but also made housing placements directly, bypassing traditional city shelter intake.[14] Common Ground's surveys found that persons experiencing homelessness were averse not to housing, but rather to shelters. "Shelters were, in their minds, associated with broken promises and a number of barriers to housing, like admission criteria that appeared to screen out those most in need of services with requirements such as six months of sobriety and having original copies of government identification documents that were difficult to access. The barriers were profound — impossible for overwhelmed, bereft persons in compromised states of health to deal with," reports Haggerty.

Becky Kanis

A homeless woman is interviewed by a 100,000 Homes Campaign volunteer.

Communities successful in housing vulnerable homeless persons engage an array of stakeholders united around a shared goal.

Common Ground helped people gain access to permanent housing with the right supportive services to fit their needs. As a result, more than 90 percent of those placed in permanent housing remained housed after 12 months. Between 2005 and 2007, homelessness in Times Square declined by 87 percent and by 43 percent in the targeted surrounding 230 blocks. "The very powerful message was that systems needed to change, to eliminate the barriers that homeless individuals were experiencing," Haggerty points out.

Vulnerability Index Instrumental in Systems Change

A new organization headed by Haggerty, Community Solutions, is taking this systems-change strategy and the Vulnerability Index to the national level with the 100,000 Homes Campaign. The campaign's goal is to engage communities nationwide in the cause of permanently housing the nation's most vulnerable and long-term homeless individuals by July 2014. The 100,000 Homes Campaign started in 2008 with a few pilot communities whose successes and best practices were built into a model that could be used (or replicated) by other communities wishing to end homelessness in their community. As of May 2012, 124 participating communities had housed 13,928 chronically homeless people and raised $174,000 for move-in kits featuring basic items, such as eating and cooking utensils, needed to begin housekeeping.[15]

Becky Kanis, Community Solutions' director of innovations and the 100,000 Homes Campaign, reports that the organization has learned significant lessons as the campaign has matured. One of the insights gained during the campaign's first 18 months is the importance of building a strong local team that will drive sustainable changes in housing systems. The communities that are finding success in the campaign have engaged an array of stakeholders united around a shared goal of reducing chronic homelessness in a particular geographic area.[16] Community Solutions has also learned that using the Vulnerability Index changes perceptions about homelessness. When local volunteers survey homeless individuals in the early morning hours to learn their names, take their photographs, and identify

their health problems, there is a secondary benefit beyond assessing the need for services. The personal connections forged with people who are ill and need a place to live motivate volunteers to make a difference on behalf of these vulnerable individuals. Haggerty observes that this personal connection is essential to the campaign because "with [this] change in perceptions, changes in political will and systems tend to follow."

Kanis also notes that localities have eliminated numerous administrative and bureaucratic barriers to improve or speed up access to housing assistance and services for chronically homeless and vulnerable people. When Kanis helps a local campaign map out and analyze an existing housing system, she often finds practices and beliefs that are pervasive but no longer necessary. Local campaigns are advised that lining up the supply of housing and getting people into housing with supportive services as rapidly as possible means negotiating for housing resources en masse and eliminating all but the most essential elements of the housing application.[17] Some local campaigns have made significant progress in shaving days off the time it takes to house people, such as in Washington DC, where housing placements are achieved in an average of 30 days, compared with 6 to 9 months elsewhere. Eight communities are surpassing the campaign's benchmark of housing 2.5 percent of their documented vulnerable chronically homeless population each month, whereas others have rates as low as 0.1 percent, Kanis reports.

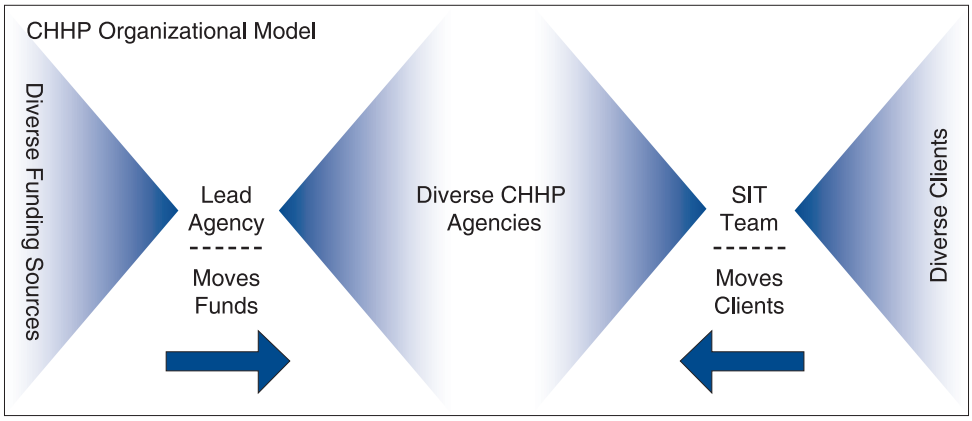
Once vulnerable individuals move into stable housing, they have a platform for improving their health. The campaign recognizes, however, that until housing and healthcare systems are better integrated, formerly homeless persons will require a lot of assistance to navigate them. Catherine Craig, director of health integration at Community Solutions, helps localities build community partnerships that can bridge healthcare and housing services. This is possible, says Craig, with care coordination built around improving a vulnerable individual's health. Craig explains that multiple health needs "are not in and of themselves complex challenges; the complexity arises when the tasks of making connections among multiple care providers and linking each intervention to the individual's overall care plan fall in the lap of the individual. Without effective partnering or support, the challenge of navigating multiple care systems is really daunting."[18]

In Chicago: Collaborating To Test an Intervention

In the late 1990s, at the same time that Common Ground was finding that coordinated intervention from the housing and healthcare systems was an effective strategy to reduce chronic homelessness, homeless service providers in Chicago were seeing positive results from a similar approach of linking permanent housing to services. At the time, Arturo Bendixen was the executive director of Interfaith House, a nonprofit that offers residential support and health services to homeless adults with chronic illnesses. Bendixen recalls that "the chronic homeless who went to permanent housing didn't return to our program still homeless. We saw people stabilize and come back to say 'thank you.'"

This type of experiential feedback prompted a group of 15 healthcare, respite, and housing providers who served persons experiencing homelessness to come together informally as the Chicago Housing for Health Partnership (CHHP). In 2002, they developed a service delivery model and secured funds to test how well linking health care with housing could address the needs of homeless persons with chronic medical conditions. The model was derived from the collective knowledge and experiences of coalition members who served the homeless population in

Stable housing can enable chronic homeless individuals to stay off the street and improve their health.



Christine George, Anne Figert, Jennifer Nargang Chernega, and Sarah Stawiski, "Connecting Fractured Lives in a Fragmented System: A Process Evaluation of the Chicago Housing for Health Partnership, Loyola University Center for Urban Research and Learning, 2007, 10.

Chicago. Bendixen, now vice president for Housing Partnerships at the AIDS Foundation of Chicago, notes: "Many of these providers had witnessed the role that stable housing could play in enabling chronic homeless individuals to stay off the street and to improve their situations. The partners shared a client-centered orientation and a belief that when homeless individuals with chronic medical conditions are able to focus energy on healing and maintaining their health, rather than straining to find a place to sleep each night, their health is likely to improve."[19]

The coalition carried out a six-month pilot study and subsequent research demonstration project from 2003 to 2007. The demonstration project, funded locally with major contributions from private foundations, was led by the AIDS Foundation of Chicago with Bendixen coordinating the project. Bendixen describes the CHHP model as one characterized by multiagency collaboration and the integration of health, shelter, and housing systems; integrated services that moved ill and homeless persons directly from hospital settings to housing; and intensive case management and "wraparound" supportive services.

Demonstrating an Integrated Health + Housing Model

The coalition partner organizations that designed the model also carried out the demonstration project. The partners funneled funds and client referrals into a centralized process, and then redistributed them to participating agencies for housing and support services. A Systems Integration Team (SIT) consisted of case managers from hospital care, interim housing services, and permanent housing providers. The SIT and CHHP coordinator reviewed client service needs weekly, maintained continuous contact, and kept common records. Caseloads were kept small at a 10:1 ratio, and social workers had direct access to available housing, thereby facilitating an individualized approach to providing housing and services.

A Loyola University process evaluation team found three advantages to the coordinated approach; it reduced duplication of services, drew on the experiences of existing agencies, and negated competition among the partners for funds. Also important was the "strong coordination and leadership from the lead agency [the AIDS Foundation of Chicago] and its success in harnessing the expertise and skills of the diverse partner agencies. This created a flexible system of allocating resources, solving problems, and serving clients."[20]

> When chronically ill and homeless persons can focus on healing and taking care of themselves, their health is likely to improve.

For the 2003–2007 demonstration, patients hospitalized in a public teaching hospital or a private, nonprofit hospital in the city were referred to the CHHP project by social workers. The patients were adults with chronic illness(es), had a history of at least one hospitalization, and had been homeless for an average of 30 months. These patients were randomly assigned to either an "intervention" group or a "usual care" group. At the point of discharge from the hospital, those in the intervention group were offered immediate interim housing followed by placement in long-term housing. Intensive case management support was available onsite in the hospital, in interim housing, and in permanent stable housing. Usual care clients, as the control group, received customary discharge planning services from hospital social workers.

Doctors from the Collaborative Research Unit of the Cook County Bureau of Health Services independently evaluated the effectiveness of the demonstration for improving the health and well-being of homeless adults with chronic medical illnesses. David Buchanan, presently chief medical officer at the community-based Erie Family Health Center in Chicago and one of the principal investigators in the research, points out that "CHHP was one of the first models to be proven effective with a gold standard research design. That has helped physicians, health policy staff, and healthcare administrators take housing seriously."[21]

In 2009, the *Journal of the American Medical Association* published the study in which Buchanan and his colleagues found the demonstration model to be an effective healthcare strategy for vulnerable chronic homeless populations. Compared with the control group that received only discharge planning services, the intervention group that

was placed in housing with wraparound intensive case management services accrued 29 percent fewer hospital days, 24 percent fewer emergency department visits, and 50 percent fewer nursing home days. Nearly 75 percent of the intervention group remained stably housed for the entire 18-month follow-up period compared with only 15 percent of the control group.[22] An analysis of the cost effectiveness of the demonstration model revealed that, compared with those who received usual care, those who had received housing and intensive case management services yielded an average annual cost savings of $6,307 per person.[23]

A separate study of a subgroup of patients enrolled in CHHP also demonstrated that stable housing plus intensive case management services improved the health and survival rates of persons with HIV/AIDS. This disease was selected from 15 chronic illnesses that made patients eligible for CHHP because homelessness makes it almost impossible to maintain the medical and healthcare regimen HIV-positive individuals need. The positive effect of the housing plus services intervention for this challenging group was evident. Buchanan and his colleagues found that 55 percent of the intervention group had relatively healthy immune systems after a year, in contrast to 34 percent of the usual care control group.[24] The impact of such research is now reflected in the Center for Disease Control's recommended protocol of continuous care and permanent housing for those with HIV/AIDS and in the National HIV/AIDS Strategy for the United States, which declares, "Access to housing is an important precursor to getting many people into a stable treatment regimen. Individuals living with HIV who lack stable housing are more likely to delay HIV care, have poorer access to regular care, are less likely to receive optimal antiretroviral therapy, and are less likely to adhere to therapy."[25]

Overall, "the CHHP demonstration established that housing plus intensive care management is an effective healthcare strategy for vulnerable homeless populations and that such intervention saves money," says Buchanan. Drawing on his research and experience in working on the health problems of these populations, Buchanan notes some additional lessons to highlight. One is that "for housing to be a successful intervention, it is important to identify the right patients or clients for these interventions. We found patients in the hospital, which testified to the fact that there was something badly wrong. We wouldn't find the same health impact or cost outcomes with patients who were less sick."

> Health and housing systems must eliminate barriers to serving the very individuals for whom they exist.

Resonating with Haggerty's emphasis on the need for systems change, Buchanan points to barriers created by both the housing and health systems. "One flaw we've learned about in the housing system is that housing programs often find the least sick people to house," Buchanan says. There are barriers to getting into housing programs, "like having to show up on three different occasions to complete an application, when showing up at all is a major achievement. Lots of these programs do great work," Buchanan observes, "but they are not targeting the people most likely to benefit from the resources available." To illustrate similar barriers in the health system, Buchanan points out that homeless patients are often unable to see a doctor when they need one and cannot make or keep appointments. "Of course, that doesn't work and patients end up in the ER, which is not set up to provide primary care."

A final, and crucial, takeaway that Buchanan emphasizes is the importance of respite care. "It's an essential piece that CHHP had in its design prior to placement in permanent housing. In any case with the homeless, it needs to be there when a discharged patient has nothing in the way of family or a support system — even if the person is a formerly homeless individual who had been stably housed prior to hospitalization."

Since the CHHP project ended in 2007, Bendixen reports that the tested model and its principles — collaboration, systems (health, shelter, and stable housing) integration, services integration, hospital-to-housing for the seriously ill, and supportive housing plus intensive case management — have been adapted by a number of programs in Chicago that serve vulnerable homeless individuals. These include Hospital-to-Housing, a Medicaid Supportive Housing program, and the Samaritan Housing Program. The model is also consistent with participation in the local Chicago 100,000 Homes Campaign, which promotes system and services integration, collaboration, and the housing first model.

Housing as a Platform To Improve Health

Evidence clearly shows how vital the provision of stable housing is to addressing the health needs of the chronically homeless population and moving them toward an improved quality of life. The initiatives and commitments to reducing chronic homelessness reviewed in this article have been shaped empirically, through experience and research. Lessons learned along the way in Boston, New York, and Chicago — and now spreading to localities across the nation — have produced powerful insights into how to end chronic homelessness and better use available resources. Boston's Health Care for the Homeless Program found that the health

conditions suffered by chronically homeless people impede their ability to obtain and retain housing. Stable housing in combination with health care and services is essential to improving health and ending chronic homelessness. New York's Common Ground learned that to effectively meet the housing needs of chronically homeless persons, partnerships between health and services systems were necessary. Common Ground also demonstrated how research outcomes could be used to implement reform, thus targeting scarce resources to better serve the needs of sick and vulnerable homeless individuals. In Chicago, the CHHP project established that a strategy that married health care with stable housing was not only the most successful in improving health, but also resulted in significant cost savings.

An integral aspect of the lessons learned in Boston, New York, and Chicago is the importance of collaboration and the integration of disparate systems, programs, and organizations to focus on particular needs. Those interviewed from the front lines of the battle against chronic homelessness emphasize the need for systems reform and integration. They challenge systems to reexamine their priorities and to eliminate barriers to serving the very individuals for whom they exist. As organizations succeed in getting homeless, sick, and vulnerable individuals off the street and into housing, the need to work together in teams and as partners to help stabilize these individuals will become even more critical. O'Connell reports that "the necessary support is very, very intense" and foresees that there is still much to learn about how to sustain this success over time. "Housing first is absolutely the right thing to do and it's the cost effective thing to do," he says. "Now its success depends on how well we can do it." **EM**

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[5] U.S. Interagency Council on Homelessness. 2010. *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*. Washington, DC.

[6] Respite refers to the provision of temporary care for a patient who requires specialized or intensive care or supervision that is normally provided by his or her family at home, but the homeless (or recently housed) have no such support system.

[7] James J. O'Connell, Sarah C. Oppenheimer, Christine M. Judge, Robert L. Taube, Bonnie B. Blanchfield, Stacy E. Swain, and Howard K. Koh. 2010. "The Boston Health Care for the Homeless Program: A Public Health Framework," *American Journal of Public Health* 100, no.8: 1400–8.

[8] BHCHP created the first electronic medical record system for a homeless population in 1996 to coordinate care across hospital and shelter clinics.

[9] Stephen W. Hwang, E. John Orav, James J. O'Connell, Joan M. Lebow, and Troyen A. Brennan. 1997. "Causes of Death in Homeless Adults in Boston," *Annals of Internal Medicine* 126, no.8: 625–8.

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[17] Community Solutions. 2010. *The 100,000 Homes Campaign Playbook: A Toolkit for Finding and Housing Vulnerable People*. New York, NY.

[18] Communication with Catherine Craig, March 2012.

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Additional Resources

- "A Critical Review of the Literature Regarding Homelessness among Veterans" (2011), by Howard Balshem et al., identifies risk factors for homelessness among veterans including factors related to military service and incarceration. **www.hsrd.research.va.gov**

- *Prevalence and Risk of Homelessness Among US Veterans: A Multisite Investigation* (2011), by Jamison Fargo et al., analyzes HMIS and American Community Survey data from seven jurisdictions to assess the prevalence and relative risk for homelessness among veterans by race, sex, age, and poverty status. **works.bepress.com/dennis_culhane/107/**

- "Cost-effectiveness of Supported Housing for Homeless Persons with Mental Illness" (2003), by Robert Rosenheck et al., studies the cost impact of three interventions for mentally ill homeless veterans: housing vouchers with intensive case management, case management only, and standard VA care. **archpsyc.ama-assn.org/**

- "Understanding the Experience of Military Families and Their Returning War Fighters: Military Literature and Resource Review" (2010), prepared by The National Center on Family Homelessness, offers a military literature review of key issues raised by recent wars and the impact of adverse experiences that lead to PTSD, TBI, substance abuse, unemployment, and homelessness. **www.familyhomelessness.org**

- "Family Permanent Support Housing: Preliminary Research on Family Characteristics, Program Models, and Outcomes" (2006), by Ellen L. Bassuk et al., examines the findings from three sets of evaluation studies of family permanent supportive housing programs. **www.usich.gov**

- "Developing Community Employment Pathways: For Homeless Job Seekers in King County & Washington State" (2007), prepared by the Taking Health Care Home Initiative, describes how nearly 60 community stakeholders from employment, housing and homelessness, mental health, and chemical addiction treatment systems mapped and analyzed the current landscape of employment services for homeless people living in Washington State, with a focus on King County. **www.buildingchanges.org**

- "Final Findings Report: A Comprehensive Evaluation of the Sound Families Initiative" (2008), prepared by the Northwest Institute for Children and Families, measures the effectiveness of service-enriched housing in helping homeless families achieve stability and gathers data on families' experiences of being homeless, their progress toward self-sufficiency, and their quality of life after leaving transitional housing. **www.buildingchanges.org/our-work/grantmaking-and-evaluation/303-sound-families-evaluation-reports**

- "Costs Associated with First-Time Homeless for Families and Individuals" (2010), by Brooke Spellman et al., measures costs associated with first-time homeless families and individuals incurred by homeless and mainstream service delivery systems in six study communities. **www.huduser.org/portal/publications/povsoc/cost_homelessness.html**

- "America's Youngest Outcasts: State Report Card on Child Homelessness" (2009), prepared by The National Center on Family Homelessness, documents the extent of child homelessness, child well-being, risk for child homelessness and policy, and planning efforts for each state. **www.homelesschildrenamerica.org/findings.php**

- "Supportive Housing Approaches in the Collaborative Initiative to Help End Chronic Homelessness (CICH)" (2010), by Marilyn Kresky-Wolff et al., examines qualitative data on how the projects used U.S. Department of Housing and Urban Development funding and three housing approaches (scattered units, congregate/clustered, or a combination) for rapid placement of clients. **www.ncbi.nlm.nih.gov/pubmed/**

- "State of Homelessness in America" (2011), prepared by the National Alliance to End Homelessness, analyzes the effect the recession has had on homelessness and how it has contributed to an increased risk of homelessness for many Americans. **www.endhomelessness.org/content/article/detail/3668**

- "Collaborative Initiative to Help End Chronic Homelessness: Introduction" (2009), by Lawrence D. Rickards et al., provides background on chronic homelessness, describes the federal collaboration to comprehensively address chronic homelessness, and introduces findings and lessons learned from participating communities in addressing chronic homelessness. **www.ncbi.nlm.nih.gov/pubmed/19337841**

- "State of Homelessness in America, A Research Report on Homelessness" (2011), by M. William Sermons and Peter Witte, provides an in-depth examination of homeless counts, economic indications, demographic drivers, and changes at the state and national level. **www.ncdsv.org/publications_housing.html**

- "Best practices in affordable housing: Knoxville, Tennessee: Minvilla Manor Historic Rehabilitation" (2012), describes the rehabilitation of an historic building to provide permanent supportive housing for chronically homeless individuals in Knoxville, Tennessee. **www.huduser.org/portal/bestpractices/study_06122012_1.html**

For additional resources archive, go to . **www.huduser.org/portal/periodicals/em/additional_resources_2012.html**.

Evidence Matters

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