

**A PRELIMINARY REVIEW OF LITERATURE
CHRONIC MEDICAL ILLNESS AND HOMELESS INDIVIDUALS**

PREPARED FOR:

**INTERFAITH HOUSE
MINI-CONTINUUM OF CARE FOR
CHRONICALLY MEDICALLY ILL HOMELESS ADULTS:
PHASE ONE PLANNING GRANT**

BY:

**SUZANNE ZERGER
NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL
P.O BOX 60427
NASHVILLE, TN 37206-0427**

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INTRODUCTION

The Interfaith House of Chicago, Illinois, is involved in phase one of a planning grant to develop a collaborative “mini-continuum” that will focus on prioritizing services and housing placement for chronically medically ill homeless adults. To assist them in this phase of planning, the Interfaith House has contracted with the National Health Care for the Homeless Council to compile relevant resources which address the relationship between chronic medical conditions and homelessness. This paper summarizes these sources, which include published research and evaluations as well as “renegade” sources. Because this is a “preliminary” literature review, the paper provides an introductory assessment of the general topics covered in the available resources, their primary message(s), and access to additional resources which may be useful. A special attempt was made to focus on any available cost-benefit analyses of services, particularly housing, provided for homeless persons with chronic medical illness.

The Problem in Context: Chronic Medical Illness in the United States

This section of the report briefly summarizes the prevalence and costs associated with chronic medical illness in the United States on the whole; this provides an important context to subsequent discussions involving the impact of housing status on health. Throughout this report, chronic medical illness or condition will be defined broadly as *a condition [which] lasts a year or longer, limits what one can do and may require ongoing care*. This definition, as well as many of the statistics in this section, are taken from the National Chronic Care Consortium (NCCC) website (www.ncccconline.org).

Prevalence of Chronic Medical Illness in the U.S.

The prevalence and associated costs of chronic medical illness have increased dramatically in the United States and are projected to continue its alarming growth rate in the foreseeable future. In 2000, more than 125 million Americans had at least one chronic condition; 60 million had more than one chronic condition. Projections indicate that by the year 2020, 25% of the American population will be living with multiple chronic conditions. Several factors may account for this dramatic increase in chronic conditions, including the aging of the baby boomers, advances in medical science which have extended our life span and left more people vulnerable to chronic conditions related to aging, and a general increase in asthma and diabetes. (NCCC website 2002)

A recent study indicates the most prevalent conditions for adults in the U.S. include upper respiratory infections, hypertension, nontraumatic chronic joint disorders, diabetes, disorders of lipid metabolism, and asthma. For children, upper respiratory disease, asthma, blindness/vision defects, lower respiratory disease, and mental conditions are most frequently reported. (Hwang et.al. 2001)

Facts About Chronic Illness in the United States

- People with chronic illnesses – such as Alzheimer’s disease, heart disease, diabetes, and chronic obstructive pulmonary disease – represent the highest-cost and fastest-growing service group in healthcare;
- More than one in every three Americans is at risk of having a chronic condition limit daily activities;
- Ninety percent of morbidity and 80 percent of deaths are related to chronic conditions;
- The chronically ill consume the majority of medical services, accounting for 96 percent of home care visits, 83 percent of prescription drug use, 80 percent of hospital days, and 66 percent of physician visits;
- Nearly 70 percent of the nation’s personal healthcare expenditures are for chronic care; and,
- Approximately 40 percent of direct healthcare costs for the chronically ill are financed by the public sector, while only 20 percent of acute care costs are publicly funded.

(NCCC website 2002)

Costs Associated with Chronic Illness

Persons with different chronic conditions face common problems, including very high costs that are often not covered by insurance, and a complex health care system that it is difficult to use. Both private insurance plans and government programs are not easy to navigate. Costs associated with the care of chronic conditions include:

- Direct costs paid by third parties, including private insurers, Medicare and Medicaid, and costs paid by other types of payers;
- Out-of-pocket costs directly related to professional care and prescription medications paid by patients and their families;
- Related costs not covered by any program, such as for home modifications, supplies and equipment, respite care; and
- Economic costs such as income lost because of illness, early death, or caregiving.

(NCCC website 2002)

It is noteworthy that the mean-average out-of-pocket spending is generally higher for persons who are uninsured than for those with health insurance. Despite this discrepancy, uninsured persons are less likely to see a health care provider than are persons who have insurance. A recent study assessing data from the 1996 Medical Expenditure Panel Survey concluded that *“among chronically ill persons the uninsured had the highest out-of-pocket spending and were five times less likely to see a medical provider in a given year. Further research is necessary to clarify the relationship between insurance status, out-of-pocket spending, and access to care among persons with chronic conditions.”* (Hwang W et.al. 2001)

The annual medical expenditures for a person with a chronic condition is \$6,032, or approximately five times expenditures for a person without a chronic condition; this is expected to double by 2050. Nationally, by 2030, cost expenditures for direct costs of medical services for people with chronic conditions are expected to be \$798 billion.

The current health care system excels at responding to immediate medical needs such as accidents and severe injury and sudden bouts of illness. American health care is less expert at providing ongoing care to people with chronic conditions and improving their day-to-day lives. (NCCC website 2002)

HOUSING STATUS AND HEALTH

The homeless population is diverse and ever-changing.¹ To speak generally about health status or prevalence of disease in the “homeless population” as if it were otherwise is misleading and can mask critical differences among specific subpopulations. For example, demographic characteristics such as gender, age, race, and the time spent homeless can all affect one’s health status. That said, the situation of being homeless – without adequate shelter – has an independent impact on an individual’s ability to prevent or avoid certain health problems and on the ability to attend to and manage one’s health. This section of the paper explores some of the general impacts housing status has on one’s health and some common barriers to care associated with homelessness.

The Impact of Housing Status

The relationship between housing status and prevalence of chronic medical illness among homeless persons is a double-edged sword. Homelessness creates health problems; it also simultaneously makes health care more difficult to obtain. (Scharer et.al. 1990; Song et.al. 2000; Stronks et.al. 1998) A document titled “Homelessness, Health, and Human Needs” from the Institute of Medicine describes the relationship between homelessness and health succinctly: “*there are three different types of interactions: 1) Some health problems precede and causally contribute to homelessness, 2) others are consequences of homelessness, and 3) homelessness complicates the treatment of many illness. Of course, certain diseases and treatments cut across these patterns and may occur in all three categories.*” (Institute of Medicine 1988, p.39) Two conditions - mental illness and substance abuse – are particularly prevalent in the homeless population and might well fall into all three of these categories. They are also chronic medical conditions according to our definition. However, given the limited scope of this paper mental illness and substance abuse will be discussed here only as contributing factors to other chronic diseases. Their importance should not be downplayed, however, particularly when developing interventions to improve homeless persons’ overall health status.

The following statement by a physician who has worked with homeless persons for many years raises some of the key factors affecting prevalence of chronic physical illness:

The medical disorders of the homeless are common illnesses, magnified by disordered living conditions, exposure to extremes of heat and cold, lack of protection from rain and snow, bizarre sleeping accommodations, and overcrowding in shelters. The stress of street life, psychiatric disorders, and sociopathic behavior patterns obstruct medical intervention and contributes to the chronicity of disease. (Brickner et.al. 1986, p.405)

To briefly recapitulate just some of the factors associated with homelessness which can contribute to the existence or seriousness of chronic disease among homeless individuals:

¹ The operational definition of homelessness is adapted from the Stewart B. McKinney Homeless Assistance Act (P.L. 100-77 enacted in July 1987). Homeless persons are defined as individuals age 18 or older who spent the previous night in one of the following situations: 1) In a public or private shelter, or 2) “On the streets” (i.e., in a public or private place not designed for, or ordinarily used as, regular sleeping accommodations for humans. These include, for example, public or abandoned buildings, vehicles, or places out-of-doors like parks, streets, bus terminals, airports, under bridges or overpasses, or any other public or private space not designed for shelter.) As a caveat, however, the studies reported in this report have used a variety of definitions for “homeless,” not all of which are consistent with the one presented here.

- life-style factors, such as alcohol or drug use and tobacco use, contribute to chronic illness – for example, hypertension is twice as common among heavy drinkers than among nondrinkers;
- the exposure to environmental elements such as extreme temperatures and lack of protection from rain, snow, and sun;
- nutritional deficiencies resulting in part from lack of choice in foods (e.g. in food lines, shelters, garbage) (see Drake 1992 and Luder et.al. 1990); and,
- victimization of crime and violence.

Conversely, chronic illness itself can limit a person's ability to work and lead to impoverishment and even homelessness; a history of inadequate access to health services, especially preventive care, can also contribute to these results. (Fleischman et.al. 1992) Chronic problems among homeless persons often go unrecognized, and even when detected, compliance problems result in unabated progression of the disease, disability, morbidity and premature death.

The time spent homeless is also directly correlated to perceptions of poor health. Studies have consistently demonstrated that homeless persons are much more apt to report their health as fair or poor than are housed persons (Fischer et.al. 1986; Ropers et.al. 1987; Robertson et.al. 1986; Gelberg et.al. 1990b; Trevena 2001), a rate which increases with time spent homeless. (White et.al. 1997; North et.al. 1998) Poor health certainly plays a role in preventing some homeless persons from escaping their predicament; for example, one-quarter of homeless adults report their poor health has prevented them from working or going to school. (Robertson et.al. 1986) Similarly, homeless parents have consistently rated their children's health as fair or poor much more frequently than housed parents. (Wood 1989; Weinreb et.al. 1998; Hu 1989; Miller et.al.1988; Parker 1991; Menke et.al. 1997)

Barriers to Health Care Caused by Homelessness

Dr. Lillian Gelberg's review of the literature resulted in the following summary categories to describe common barriers homeless persons experience when trying to access health care. (Gelberg 1996)

- Financial barriers and problems in satisfying eligibility requirements for health insurance;
- Lack of transportation to medical facilities;
- Competing needs – basic needs for food, shelter, and income take precedence over health care;
- Psychological distress and disabling mental illness – least able to obtain services while most in need (for example, many are disconnected from supportive social networks – Kroll et.al.1986);
- Social conditions of street life affect compliance with medical care (see discussion below);
- Personal avoidance of authorities (for example, bad experiences with authorities in the past, undocumented immigrants fear medical providers will call immigration authorities; homeless women with children may fear child protective service workers, drug abusers or ex-convicts may fear the police);
- Lack of facilities to adequately treat them;
- Health care facilities designed for the poor or for emergency treatment are not set up to care for homeless persons;
- The medical profession itself is perceived as a barrier;
- Lack of adequate discharge planning (see Gantt et.al. 1999); and,
- Lack of recuperative services for homeless patients.

Many of the barriers in the list above are self-explanatory. Given our topic of chronic medical conditions, however, it is important to reiterate that the situation of homelessness can have a deleterious effect on an individual's ability to adhere or comply with treatment requirements, resulting in serious consequences. (see text box below for examples) A body of research has examined some of the reasons and consequences for nonadherence in treatment for HIV (see Song 1999 for a review of research on reasons for nonadherence to HIV/AIDS medications; Bamberger et.al. 2000; O'Leary et.al. 2000; Friedland et.al. 1999; Hsu et.al. 2001); barriers to diabetes management (Hwang et.al. 2000b; Brickner et.al. 1986; Martinez-Weber 1987; Fleischman et.al.1992; Harris et.al. 2000); epilepsy (Jaffe 1995) and hypertension management (Michael et.al 1988; Child et.al. 1998; Kinchen et.al. 1991; Brickner et.al. 1973) The homeless persons' inability to adhere with treatment can raise complications for medical providers. One article examines ethical conflicts raised among hospital staff when faced with a homeless person with HIV/AIDS exhibiting nonadherent behavior to treatment; the article raises important issues about the scope of patient autonomy, and about institutional altruism vs. institutional self-interest. (Bosek et.al. 1999)

Barriers to Treatment Adherence

Treatment for HIV/AIDS: *"Persons typically must take 2-15 pills at a time, 2 to 3 times a day. Some of the medications require refrigeration, which may not be available to the homeless poor. Most homeless persons do not have food available to them on a consistent schedule. Therefore, they may have difficulty adhering to instructions to take medications only on an empty stomach or with food. Lack of a safe place to store medications may be an issue for some. In addition, many urban poor live with drug, alcohol, or mental health problems, which can interfere with taking medications as prescribed."* (Bamberger et.al. 2000, p. 699)

Treatment for Diabetes: *"Diabetes mellitus may be used as an example of the problems faced in treating a serious illness in a homeless person. The patient may need a controlled diet, regular injections of insulin, and monitoring of blood sugar levels. Shelters offer adequate food but no special diets. Insulin, if I can be obtained on a regular basis by a homeless person, must be refrigerated to maintain its potency, a requirement almost impossible to fulfill. Syringes, and even the alcohol swabs used to cleanse an injection site, are subject to theft for their street value. These patients face the risk of immediate and long-term complications of diabetes. If diabetic coma is somehow avoided, the likelihood is that the vascular consequences of the disease will occur in 10 to 20 years, leaving the patient subject to a stroke, amputation, or blindness, and becoming a permanent and expensive ward of the state."* (Brickner et.al. 1986, p. 407)

PREVALENCE OF CHRONIC MEDICAL ILLNESS AMONG HOMELESS PERSONS

A handful of attempts have been made to assess the prevalence of chronic disease among national samples of homeless persons; more typically, prevalence studies have been conducted in central cities and/or are disease-specific.

Homeless Adults

National Samples

Among homeless adults served by the 19-city Robert Wood Johnson homeless health care project, clinic staff reported that 31% of clients had been diagnosed with one or more chronic physical disorders. Among those clients seen in the clinics more than once, 40% had at least one chronic disease. The most common chronic diseases diagnosed among homeless adults included: hypertension and heart disease, peripheral vascular disease, chronic obstructive pulmonary disease, diabetes, dental problems, and neurological disorders. (Fleischman et.al. 1992, Wright 1987)

In a national study relying on self-reported data by homeless clients receiving services in an assistance programs, 46% reported having one or more chronic health conditions. Homeless clients with alcohol, drug, or mental health problems were even more likely to report one or more chronic health conditions (53%) than those without these problems (33%). Study authors note that these numbers may well underestimate actual prevalence because the survey only asked clients about a limited number of conditions, clients may be reluctant to report certain conditions, and some may be unaware that they have certain conditions (such as hypertension) unless they had been examined recently by a primary health care provider. One of the strengths of this study is its inclusion of suburban and urban fringe areas and rural areas as well as central cities. The most common conditions reported by these homeless clients included arthritis, rheumatism, or joint problems (24%), high blood pressure (15%), problem walking, lost limb or other handicap (14%). Others included anemia (8%), problems with liver (7%), diabetes (5%), heart disease (5%), HIV positive (3%), cancer (2%), and AIDS (1%). An additional 20% checked “other” on the survey. (Burt et.al. 1999)

Again, while these studies have limitations and are not generalizable to all homeless persons in the country, the message is consistently clear that homeless persons suffer disproportionately from chronic medical conditions. Though specific numbers and percentages are complicated by definitional problems and the transience of the homeless population, overall rates of prevalence seem to range from one-third to one-half of the homeless population, compared with less than one-quarter of the housed population. The following regional studies also bear this discrepancy out on various subsamples of the homeless population using a variety of methodologies.

Regional Samples

Evidence of contagious disease in the homeless population can be seen in outbreaks of infection that have occurred in various regions across the country— meningococcal disease in skid rows of the Northwest, pneumococcal pneumonia in a Boston shelter, TB in shelters in Boston, Cincinnati, and Columbus, and Idiphtheria in an Omaha mission and in Seattle’s skid row. (Gelberg 1996 p. 277) In addition, some regions have conducted studies which specifically examine prevalence of various chronic conditions among their homeless populations to better understand how to serve them.

Hennepin County, Minnesota

Researchers surveyed 68 homeless adults in eight urban emergency shelters and found “*impressive rates of mental illness, alcoholism, minor criminality, and chronic medical and dental problems.*” (Kroll et.al. 1986)

New York City, NY

This study assessed etiology, prevalence and treatment of physical disorders among aging (50 years and older) homeless men. The sample of 195 non-street dwellers (residents of flophouse and apartments) and 86 street dwellers on the Bowery scored worse than an aged-matched sample on opiratory, gastrointestinal, edema, hearing, hypertension, and ambulatory scales. (Cohen et.al. 1988)

Los Angeles County, California

Using physical exam data and lay interviewers, researchers examined a subgroup (n=363) of a larger probability sample of homeless adults in Los Angeles County. They found high blood pressure, poor vision, peripheral vascular diseases of the feet and legs, and significant skin conditions to be prevalent. (Kleinman et.al. 1996)

Comparing the health status of older (50-78 yrs) and younger (18-49) homeless adults in two beach communities in Los Angeles, researchers found the older adults more likely to report a chronic disease

(69% vs. 49%). They also observed greater prevalence of high blood pressure (42% versus 22%), elevated creatinine (11% versus 2%), and elevated cholesterol (57% versus 36%). Older adults were less likely to have a toothache (3% versus 30%), report psychotic symptoms (25% versus 42%), and to be illegal drug users (15% versus 55%). The authors conclude that, although chronologically younger, the constellation of health and functional problems of older homeless adults resemble those of geriatric persons in the general population. (Gelberg et.al. 1990a).

Another study examined the effects of homelessness on elderly Native Americans living in Los Angeles County in 1987-1989 (n=335). The researchers compared the 16 percent of their sample who were homeless with domiciled older Native Americans and found the former self-reported higher rates of physical and mental health problems, including hypertension, shortness of breath, diabetes, chest pains, alcoholism, depression, sadness, and loneliness. Of homeless elders who reported usual habitat, all those aged 60 or more years lived on the street year-round; in contrast, 30% of those aged 60 years or less at least occasionally rented rooms for shelter. (Kramer et.al. 1996).

San Francisco, California

Researchers assessed self-reports of physical health among a representative sample of homeless persons in San Francisco (n=2,780). Because they compared their data to the National Health Interview Survey (NHIS), a table from the study is presented below. The table shows the highest standardized morbidity ratios for asthma; that is, there are twice the number of homeless persons reporting asthma, in younger as well as older adults, as would be expected using NHIS rates. Also evident are higher rates of arthritis, high blood pressure and diabetes in those aged 18-44 years as compared to adults in the NHIS.

| RATES OF SELF-REPORTED HEALTH CONDITIONS FROM THE NATIONAL HEALTH INTERVIEW SURVEY, 1990 AND EXCESS MORBIDITY AMONG HOMELESS PERSONS, SAN FRANCISCO, 1990-1993 | | | |
|---|-----------------------|---------------------------------------|---------------|
| Condition | NHIS Rate/1000 | Standard Morbidity Ratio (SMR) | 95% CI |
| Asthma | | | |
| Age 18-44 | 35.2 | 2.39 | 2.06-2.75 |
| Age 45-64 | 38.6 | 2.07 | 1.51-2.73 |
| Arthritis | | | |
| Age 18-44 | 47.9 | 1.84 | 1.59-2.11 |
| Age 45-64 | 249.1 | 1.01 | 0.85-1.18 |
| High Blood Pressure | | | |
| Age 18-44 | 55.7 | 1.66 | 1.44-1.90 |
| Age 45-64 | 218.3 | 1.01 | 0.84-1.20 |
| Diabetes | | | |
| Age 18-44 | 10.1 | 1.63 | 1.14-2.20 |
| Age 45-64 | 50.4 | 0.94 | 0.61-1.33 |
| Bronchitis/emphysema | | | |
| Age 18-44 | 41.5 | 1.06 | 0.86-1.28 |
| Age 45-64 | 57.4 | 1.55 | 1.15-2.02 |
| Heart Disease | | | |
| Age 18-44 | 38.1 | 0.64 | 0.48-0.82 |
| Age 45-64 | 118.7 | 0.75 | 0.56-0.98 |
| Kidney Disease | | | |
| Age 18-44 | 11.3 | 0.77 | 0.46-1.15 |
| Age 45-64 | 19.6 | 0.93 | 0.44-1.59 |

* SMR (standardized morbidity ratio) is calculated as the observed number among homeless persons divided by the number expected in the homeless using NHIS rates. (White et.al. 1997, p. 278)

Disease-Specific Prevalence

HIV/AIDS

Numerous studies have focused on prevalence of HIV among the homeless population; some of these are presented in the summary table below. This table also illustrates the point made earlier: the homeless population is diverse, so to generalize about the prevalence of this and other diseases among homeless persons is to mask important facts. For example, as noted in Smereck’s study, persons living on the street are at much higher risk for HIV/AIDS, as are certain age groups (20-29 years) and certain racial and ethnic groups (Hispanics and blacks). (see also Lee et.al. 2000)

| Selected Studies of HIV Prevalence in the Homeless Population | | | |
|--|---|-------------------|------------------------------|
| Location | Sample | Prevalence | Study Author and Year |
| San Francisco, CA | Homeless adults | 9% | Zolopa et.al. 1994 |
| Los Angeles, CA | African American homeless women | 1.3% | Nyamathi 1992 |
| New York City, NY | Homeless psychiatric patients in a men’s shelter | 19% | Susser 1993 |
| New York City, NY | Homeless men visiting a shelter clinic | 62% | Torres 1990 |
| New York City, NY | Shelter clinic for runaway and homeless adolescents | 5% | Stricof 1991 |
| Ann Arbor, MI | Out-of-treatment injection drug users and crack cocaine users (total) | 11.2% | Smereck 1998 |
| | <i>On-the-street – total</i> | <i>19%</i> | |
| | <i>On-the-street – Hispanic males</i> | <i>29%</i> | |
| | <i>On-the-street – Hispanic females</i> | <i>32%</i> | |
| | <i>On-the-street black females</i> | <i>38%</i> | |
| Toronto, Ontario | Street youth | 2.2% | DeMatteo 1999 |

The rate of AIDS mortality in the U.S. has generally been slower for women than for men; for example, although AIDS mortality declined 23% in the U.S. from 1995 to 1996, the decline was 25% for men and 10% for women. Therefore, a number of recent efforts have focused on women at risk for HIV. These studies provide a greater understanding of women’s experiences and elements to consider in prevention efforts. (Shor-Posner et.al. 2000, Stein et.al. 2000, Nyamathi et.al. 2000, Logan et.al. 1998; Logan et.al. 2000; Metsch et.al. 1998; Weinreb et.al. 1998) For example, the following excerpt from a case study illustrates how homelessness can affect women – and their physical health – differently.

The fact that Bobbie had no home strongly increased her HIV risk. On many occasions, she felt compelled to acquiesce to sex in return for a place to spend the night. Under these circumstances, Bobbie found it impossible to insist on condom use. After being beaten one night, when sleeping in an abandoned building, Bobbie began to exchange sex for protection from violence as well. (O’Leary et.al. 2000, p. S70)

Respiratory Disease and Tuberculosis

The prevalence of TB infection among homeless adults ranges from 32% in San Francisco (Zolopa et.al. 1994) to 43% in New York. (McAdam et.al. 1990) Numerous studies have illustrated the relationship between poverty and homelessness and respiratory disease (Bor et.al. 1991, Chin et.al. 1998); a recent study documents diabetes as a risk factor for tuberculosis. (Bashar et.al. 2001) Numerous studies have also demonstrated the critical role homeless shelters play in the transmission of tuberculosis. (Stead 1989; Barnes et.al. 1999)

“Now that tuberculosis is well controlled in most segments of our society, it is all too often forgotten as a disease that still plagues its less fortunate members.” (Stead 1989)

Peripheral Vascular Disease

Prevalence of peripheral vascular disease - including chronic edema, lower extremity cellulitis, and phlebitis – all of which frequently derive from venous or arterial insufficiency – are 10-15 times higher among homeless persons than in the general population. (Fleischman et.al. 1992, Wright et.al. 1987, Brickner 1973)

Hypertension

Hypertension also has higher prevalence among homeless persons than among those who are housed. Wright found abnormally high blood pressure in one-quarter to one-third of his sample of clients (1987); Luder and colleagues (1990) found 39% of their sample of shelter-users had hypertension; Ropers and Boyer (1987) found 39% reported a history of hypertension; and Kellogg (1985) found prevalence of hypertension in 60% of a sample of older residents of SRO facilities.

Other Conditions

Prevalence studies are less common for other diseases homeless persons suffer from disproportionately, such as seizure disorders (Ropers and Boyer 1987), and chronic obstructive pulmonary disease. (RWJ study referenced in Fleischman et.al. 1992)

Mortality

One researcher recently reviewed the MEDLINE database for references covering the past 5 decades to determine physical and mental status in homeless people. He concluded that *“homeless persons suffer frequently from physical health problems like tuberculosis, asthma, bronchitis, HIV infection, and as a consequence, they run an increased risk for premature mortality.”* (Martens 2001) Indeed, given the higher disease prevalence among homeless persons, the harshness of their environment and lifestyle conditions, and extremely limited access to appropriate health care services, it is not surprising that rates of mortality are three to four times higher in the homeless population than they are in the general population. (Gelberg 1996) Following is a brief summary of some of the studies which have tried to better understand homeless health issues by assessing the causes of their mortality.

Boston, Massachusetts

These researchers found the causes of mortality of the homeless population in Boston varied widely by age category. Homicide was the leading cause of death among men who were 18 to 24 years of age (mortality rate ratio 4:1). AIDS was the major cause of death in men (mortality rate ratio 2:0) and women (mortality rate ratio 5:0) who were 25 to 44 years of age. Heart disease and cancer were the leading causes of death in persons who were 45 to 64 years of age. (Hwang et.al. 1997)

New York City, New York

This study used data from a representative sample of shelter residents surveyed in 1987 and matched it against national mortality records for 1987 through 1994. The study concluded that age-adjusted death rates of homeless men and women were four times those of the general US population and two to three times those of the general population of New York City. Among homeless men, prior use of injectable drugs, incarceration, and chronic homelessness increased the likelihood of death. The authors recommend that *“Interventions must address not only the health conditions of the homeless but also the societal conditions that perpetuate homelessness.”* (Barrow et.al. 1999)

Atlanta, Georgia

Examining data on a small study of eighteen homeless persons in Atlanta, researchers found formal, medical documentation of significant alcohol-related morbidity was shown in 50% of those who died homeless. Other common medical problems included seizure disorders, hypertension, pneumonia, chronic pulmonary disease, and non-lethal trauma. (Hanzlick et.al. 1989)

Homeless Children

Less is known about the prevalence of chronic disease among homeless children on a national level. Again, however, numerous studies have focused on prevalence of specific chronic problems among homeless children, or are location-specific. Following are samples of some of these studies and their findings:

- Health care screenings done in a St. Louis clinic found that chronic health problems, such as asthma and anemia and deficits in growth and development, were among the top 10 diagnoses of the homeless children. Less serious problems like colds and lice were more prevalent, however. (Stretch et.al. 1990)
- Another study examined homeless families and children and concluded that the children have a higher prevalence than the general population of all categories of illness, including acute illnesses such as colds, fevers, and diarrhea; chronic health problems such as epilepsy and asthma; developmental delay; and behavior and mental health problems. (Wood 1989)
- Yet another study of New York City shelters found that at least 38% of homeless children in the city's shelters have asthma, more than six times the national rate. The same study found otitis media rates 50 percent higher than in the general population. (Redlener 1999)
- One recent study of children using a school-based health center found homeless children have multiple health problems much more frequently than do housed children. (Berti 2001)
- A study in Baltimore, Maryland, found the most common youth-identified health problems included STDs, HIV/AIDS, pregnancy, depression, drug use and injuries; these correlated well with more objective health status data for the same youth. The youth also spoke of environmental safety threats of violence and victimization by adults, as well as racism and sexism in their lives. (Ensign et.al. 1998)

Additional studies have noted higher rates of lead toxicity in homeless children; (Alpertstein 1988; Parker et.al. 1991; Fierman 1993); obesity and malnutrition (Miller 1988; Wood 1990; Alpertstein 1988 – Fierman 1993 found evidence of stunting); asthma (Berti et.al. 2001; Wood 1990; Weinreb et.al. 1998; Parker 1991); and infectious diseases such as diarrhea (Wood 1990), lice and scabies. (Murata et.al. 1992, Wright 1987)

SERVICE UTILIZATION

Homeless persons have extremely limited access to health care services of any kind. It has been well-documented that homeless clients are much more likely to use the most costly health services, such as emergency departments and walk-in clinics, due to this limited access to better alternatives. (O'Connell 1999; Salit et.al. 1998; Diamond et.al. 1994; Weinreb et.al. 1998; Smith et.al. 2000; Melchior et.al. 2001; Mason et.al. 1992) These studies and others have also repeatedly documented the gross unmet service needs in this population.

Hospitals remain a major component of the health care system for homeless adults and children with chronic medical illnesses; palliative and respite care is virtually nonexistent for this population. (Vogel 1991; Gelberg 1996) Clearly this results in non-essential usage of hospital services. For example, in a rigorous study of homeless and low-income patients in New York public hospitals, Salit and colleagues found nearly half of homeless medical hospitalizations were for conditions related to their living

conditions and therefore preventable (respiratory disorders, skin infections, parasites/infections, and trauma).

A number of studies have also documented increased hospitalization rates and emergency department visits specifically for homeless children. (Alperstein et.al. 1988; Weinreb et.al. 1998; Parker et.al. 1991) A report on homeless children in New York City's shelter system found only nine percent of those with asthma were on proper medication; nearly half of them had made at least one trip to the hospital emergency room for care; and the majority - 61% - of 2-3 year olds had not received proper immunization. (Redlener 1999) Other studies have also noted a delay and lack of up-to-date immunizations for homeless children. (Berti et.al. 2001, Menke et.al. 1997, Fierman et.al. 1993, Miller 1988, Alperstein 1988)

Hospitalization Costs

Using hospital services is not only more costly for the homeless individual forced to rely on them, but these services are also not designed to serve their needs. Two research studies have rigorously assessed hospitalization costs associated with homeless persons' service use. In 1995, Rosenheck and colleagues undertook a study examining health service use and related costs among homeless veterans. The results from their national survey of more than 9,000 veterans hospitalized in acute mental health care units of veterans' hospitals indicated that over one-third (35%) of the clients were homeless upon admission and, that the cost of care for a homeless veteran was \$3,196 higher than for one with a home.

Salit's study, mentioned above, assessed nearly 19,000 homeless admissions to the New York public hospital system and found:

- homeless patients stayed an average of 4.1 days -- or 36% -- longer than low-income patients with homes and cost an average of \$2,414 more per admission;
- psychiatric patients accounted for 57% of extra hospital days among the homeless;
- a third of homeless psychiatric patients stayed an average stay of 84 days - the extra cost per admission was \$17,500;
- the total preventable costs associated with homelessness for the New York City public hospital system are \$100 million per year.

Costs Of A Non-System Of Care

Other systems, in addition to hospitals, frequently end up "serving" the homeless population as well, resulting in more preventable costs. A few studies have attempted to estimate actual costs to several other systems (criminal, welfare, health) in serving the most difficult-to-serve homeless individuals. These provide an important context for understanding cost-effectiveness of alternative approaches.

- Researchers in San Antonio, Texas, selected twenty-one of the most severely impaired persons they could find (e.g. presented substantial risk of potential violence to self or others; arrested frequently on misdemeanor charges due to chemical use). They concluded that almost three-quarters of a million dollars were spent providing services to these 21 men in the two and one-half years that were documented. Approximately three-quarters of those costs were for the criminal justice system (typically for public intoxication). Health care constituted the next largest expense – the men used emergency rooms and walk-in services most frequently, but greatest expenses were for inpatient care (usually trauma-related). Health costs totaled \$125,126 and included outpatient care (73 visits -

\$4,007), emergency care (135 visits - \$14,708) and inpatient care (14 admissions - \$106,411). The study authors described their reaction to their findings:

Although the amount of money spent on the care of this small sample of men is quite large, it is the way in which it is spent that is the most telling. Thirteen thousand dollars a year is a lot of money to spend to enable each of these men to maintain a marginal, often dangerous, lifestyle. For example, one of these men at the age of 67 spent about two nights a month during the study period sleeping in the county hospital emergency room. He would arrive in the early evening complaining of an ache or a pain. The appropriate tests were run and he was usually discharged in the morning, having spent the night and received a meal. In that the tests and evaluations were consistently negative, a much less expensive room and board alternative could have been found than one provided through an already stressed metropolitan area emergency room. ...Interventions must address the range of problems and deficits experienced by this group of people. Housing and income support are essential..."(Diamond 1994, p. 24)

- A British Columbia, Canada, study reviewed outcomes of an innovative collaboration among mental health, substance abuse treatment, corrections, forensic and social and housing agencies devised to address the service needs of hard-to-serve homeless persons. The collaboration was titled the “multi-service network (MSN).” The authors commissioned a cost study of ten of the “most difficult” of the 154 MSN clients. The cost study found an average annual cost of \$17,805 to justice, welfare and health service systems spent in up to five years prior to the clients’ involvement in MSN, compared with approximately \$14,285 on average after the intervention. (Buckley et.al. 1992) The authors concluded about this small subgroup that “*Multi-problem, service resistant individuals in every metropolitan community consume extraordinary amounts of human service at great cost to publicly-funded agencies with less than satisfactory benefit to the individual.*” (Buckley et.al. 1992)
- Wall and his colleagues estimated the 1996 “social costs” associated with untreated opioid dependence in Toronto, Ontario. Their sample consisted of 114 daily opiate users not currently in or seeking treatment for their addiction; the majority (51.8%) were living in a shelter, rooming house or on the street. The researchers calculated the associated costs at \$5.086 million or \$13,100 per person (Canadian dollars); these totals included crime victimization (44.6%), law enforcement (42.4%), productivity losses (7.0%) and health care utilization (6.1%). The \$311,000 cost of health care derived from opioid dependence arose from use of hospitals, emergency departments, outpatient departments, medical care, ambulance services, substance abuse treatment, and prescription pharmaceuticals. (Wall et.al. 2000)
- The Corporation for Supportive Housing reports that supportive housing generally costs \$10,000-12,000 per person per year. This compares with costs, also for a one-year period, for a prison cell (\$47,000), a homeless shelter (\$25,000), or a mental health institution (\$160,000). (CSH website 2002) The same website gives an example of costs associated with the “Cycle of Homelessness” – following an individual through various systems including shelters, psychiatric hospitals and detox centers, concluding that costs associated with the individual living in homelessness totaled \$50,000, compared with \$10-12,000 for supportive housing.

INTERVENTIONS TO IMPROVE HEALTH STATUS

Disease Prevention and Harm Reduction

The most comprehensive response to the lack of health care for homeless persons has been the establishment of the Health Care for the Homeless (HCH) Program, the only federal program “*with the sole responsibility of addressing the critical primary health care needs of homeless individuals.*” (HCH Grantee Profiles 2000, p.4) The HCH Program, made possible through the enactment of the Stewart B. McKinney Homeless Assistance Act - Public Law 100-77 in 1987, currently consists of a network of 137 HCH projects, serving 500,000 different individuals each year in every state, the District of Columbia and Puerto Rico. The projects provide a wide range of services, either directly or through linkages within their communities, to these individuals to address their multiple and complex needs. (See Wright 1987 for an early description of program configurations and client characteristics.) In addition to primary health care, for example, these services generally include substance abuse and mental health, oral health, outreach for the difficult-to-reach, and case management to address housing and employment needs. These projects have developed many innovative approaches to serving individuals who often do not succeed in more “traditional” systems of care. For example, many providers have incorporated “harm reduction” activities into their systems of care; activities designed to reduce or manage the damage done by substance abuse without requiring complete abstinence.

Outside of the HCH Program, numerous communities have implemented various programs or approaches to encourage adherence to medications. For example, studies have shown some success in offering antiretroviral therapy and supervised TB therapy in prisons and community programs. (Friedland et.al. 1999; Marco et.al. 1998; Lopez-Zetina et.al. 2001; Culhane et.al. 2001) (see examples below) The types and predictors of risky behaviors among youth, as well as the need for education (Wagner et.al. 2001; Booth et.al. 1999; Clatts et.al. 1998; Clatts et.al. 1999; Morse et.al. 1998; De Rosa et.al. 2001; Huba et.al. 2000) are also well-documented, and two such innovative programs have been developed with some success in Seattle (Tenner et.al. 1998) and in Boston. (Woods et.al. 1998) Other effective disease prevention approaches described in the research literature on the homeless population include health screening clinics (Macnee et.al. 1996; see also Long et.al. 1998 for an assessment of attitudes toward cancer screening), pharmacist-managed diabetes care program in a free medical clinic (Davidson et.al. 2000), culturally competent HIV/AIDS education program for impoverished African American women (Nyamathi et.al. 1999), the co-location of dental services with HIV/AIDS care at community organizations (Zabos 2001), and urban outpost nursing (Hilton et.al. 2001), and even music therapy. (Mramor 2001)

Following are just two examples of prevention-oriented programs, included here because they identified their associated costs.

- The Action Point Adherence Project is a storefront, drop-in, locally funded medication adherence program to help the HIV-positive urban poor adhere to highly active antiretroviral medications and benefit from advances in HIV treatment. The Project was conceived through a community planning process and is funded by the city and county of San Francisco. A variety of adherence support services are provided, including a \$10 cash incentive dispensed weekly to clients who use services at least once a week; after 1 month of enrollment, clients are given a pager that receives e-mail messages via the Internet to remind them when to take their medications. When Action Point is not available, needle exchange and urgent care medical services are provided in the same facility. Staff includes two RNs, each specializing in HIV care; two case managers; a reception/site coordinator; a quarter-time acupuncturist; and a quarter-time pharmacist. In addition to adherence case management, services include nursing care and assessment, medication storage and dispensing,

acupuncture, and referrals for mental health and substance use treatment and housing support. Costs for a year of services is estimated at \$4250 per client, which authors suggest is approximately the same as the yearly cost of a single protease inhibitor. And, five months after opening, many clients had improved their living conditions and laboratory markers of significant viral suppression. The program is undergoing a federally-funded evaluation to determine whether it improves adherence and benefits for clients in terms of life expectancy and quality of life. (Bamberger et.al. 2000)

- Another study compared the incremental cost effectiveness of three different strategies for administering a pneumococcal immunization program. The researchers found that directly administering the vaccine at the clinic was least costly (\$595) and it significantly reduced the episodes of pneumococcal disease. Other strategies included supplying a prescription (\$702) and not vaccinating (\$714). The first strategy prevented 269 and 299 additional cases of pneumococcal disease and resulted in a cost savings of \$535,000 and \$595,000 in direct medical costs when compared to strategies 2 and 3 respectively. *“Were a consistent effort at direct clinic delivery of vaccine to street involved people with HIV made, this analysis predicts that costs involved in supplying the vaccine would be more than recouped in savings attributed to lower costs for managing acute disease.”* (Marra et.al. 2000, p.339)

Supportive Housing Solutions

Providing adequate housing, however, is the best prevention and is also the most logical, cost-efficient initial step in addressing the health care needs of homeless persons. The literature on homeless persons with AIDS in particular has established the need for housing if health status is to be improved; typical is the conclusion Bonuck drew in a recent article: *“With the advent of protease inhibitor therapy, stable and adequate housing has become especially critical for persons with HIV/AIDS.”* Placing the issue in our current political context, Bonuck goes on to say that *“public assistance ‘reforms’ are likely to exacerbate their housing needs, and may ultimately compromise the potential benefits of treatment.”* (Bonuck 2001; see also Goldfinger et.al. 1998)

Innovative community-based nonprofits in the mid-eighties pioneered “supportive housing” programs to respond to the crisis of homelessness by combining housing with the health and social service supports necessary for individuals with a wide variety of needs and preferences to stabilize their lives. Several major supportive housing initiatives have been implemented in the U.S. over the past few decades; the largest of these have been made possible with the support of the federal government through the Stewart B. McKinney Homeless Assistance Act and led by the U.S. Department of Housing and Urban Development (HUD). (Rog et.al. 1998, p.11-6 ff.) Since 1994, HUD has utilized the “Continuum of Care” approach in its homeless programs, an approach intended to help communities plan and implement housing resources to assist homeless individuals transition out of homelessness and reconnect with the community. The Continuum of Care includes three key housing programs: Supportive Housing Program (SHP), Shelter Plus Care (S+C), and Section 8 Moderate Rehabilitation Assistance Single Room Occupancy (SROs). All fund housing operating expenses, and, although all are encouraged to provide access to supportive services, only SHP receives funding for services. Another major initiative worth noting is the Housing Opportunities for Persons with AIDS (HOPWA) program administered by HUD; funds can be used for housing and a wide range of services to provide for low-income persons and their families, including homeless individuals and families, currently living with HIV/AIDs. (Rog et.al. 1998)

Foundations such as Robert Wood Johnson and the Ford Foundation have also joined with HUD in fostering housing initiatives designed to curb homelessness and to study their outcomes. In 1991 the Corporation for Supportive Housing (CSH), a national nonprofit intermediary, was established to improve the quantity and quality of supporting housing for persons who are homeless or are at risk of being homeless. Currently, there are more than 11,000 units of supportive housing in New York City, and more

than 7,000 additional units nationwide – specifically for homeless persons with chronic conditions which often include mental illness, substance abuse, AIDS or other debilitating health problems. (See Appendix A for a description of some of these innovative housing programs).

The following table summarizes some of the lessons learned from a review of published research on the residential stability of homeless individuals and families.

What Have We Learned About Reconnecting Homeless People to Housing?

- Once in housing – generally with supports – the majority stay housed
- Rental subsidies improve residential stability
- Providing housing is often not enough, other assistance can help
- Provide housing first, before tackling other issues
- A range of options may be needed to meet a range of needs and preferences

(Rog et.al. 1998, p. 11-8)

Effectiveness of Supportive Housing Initiatives

This section of the report reviews key findings from some of the evaluation studies which have attempted to systematically quantify client outcomes and cost-benefits associated with housing interventions for homeless persons.

Evaluations of National Demonstration Programs

All of the federally-sponsored supportive housing initiatives have included an evaluation component to determine client outcomes and cost-benefits of the various programs. Brief descriptions of the initiatives are included here, as well as key findings from the respective evaluations.

National Evaluation of the Supportive Housing Demonstration Program (SHP)

The SHP consisted of two separate initiatives, the Transitional Housing program offering services to help families move toward stability, and the Permanent Housing component which offered long-term housing for “disabled individuals.”

In 1992, the Transitional Housing projects were serving over 10,000 households, many of which were one or two-parent families with children. Half came to the program from the shelters or the streets, while others were living independently or doubled-up, or had been in hospitals or treatment facilities. Typical services provided in these projects included money management, housing location services, household management, prevocational training, and vocational counseling. The evaluation, conducted by HUD’s Office of Policy Development and Research, found:

- 70% of families who completed the program moved to stable housing, compared with 33% of those who left the program early;
- employment among participants had doubled; and,
- receipt of most kinds of public assistance had declined.

The clients in the Permanent Housing component included 56% suffering from chronic mental illness and 31% who were developmentally disabled. Many of the participants had histories of residential instability.

These projects supported over 1,600 housing units; typical services included money management, household management counseling, and medication monitoring. Case management services were seen as crucial to the success of this program. This initiative also met with success, as nearly 70% of these participants remained in program housing for at least a year, and half of those who left the program entered other stable housing situations. Modest increases in employment were also made.

National Evaluation of the Shelter Plus Care Program (S+C)

This HUD program provided grants to public agencies for projects that would offer participants a variety of housing choices coupled with supportive services “*to fashion residential environments that range from highly supportive to independent living.*” The hard-to-serve clients included, during the program’s first two years, 34% with severe mental illness, 33% with chronic substance abuse problems, 8% with AIDS, and 25% with multiple disabilities. The evaluation’s key findings, taken from HUD’s periodical *Recent Research Results* (December 1997), included:

- More than half of participants reported improved physical and mental health, ability to care for themselves, and social and familial ties. For most, improvements usually occurred within three months, though for participants with multiple disabilities, substantial improvements appeared only after 2 years. This progress was reflected in fewer encounters with emergency room services, inpatient hospital care, substance abuse treatment centers, and jails.
- The average income of participants rose and employment increased by 10 percent. Case managers estimate that one-third of participants may eventually be capable of gainful employment.
- The administrative costs of securing, coordinating, and tracking the delivery of supportive services proved to be much higher than initially anticipated. Grantees called for greater administrative and programmatic flexibility in using Shelter Plus Care.

National Evaluation of the Housing Opportunities for Persons with AIDS Program (HOPWA)

The evaluation of this initiative was made available in January 2001 through HUD. It examines how the housing needs of persons with HIV/AIDS are being met through the HOPWA initiative, what barriers exist to addressing those needs; and how coordination with other programs, such as health care and supportive services, was managed within a community strategy.

Making a Difference: Report of the McKinney Research Demonstration Program for Homeless Mentally Ill Adults

This study was a five-site, four-year, 896-person survey which assessed the “*success of providing flexible support services combined with permanent housing to homeless people with severe mental illness, individuals "often seen as unreachable and difficult to serve."*” Results, released by the U.S. Department of Health and Human Services in 1994, included a retention/success rate of 83.5% and decreases in public service usage as well as health improvements. Specifically, they found:

- In San Diego, inpatient days were reduced by 49%;
- in Baltimore, inpatient costs were lowered by 52%;
- in Boston, annual per person inpatient costs were reduced by \$3,800;

- decrease in emergency room visits by 50%;
- decrease in incarcerations by 50%; and
- decrease in symptoms of schizophrenia and depression.

Evaluations of State Supportive Housing Initiatives

New York/New York Agreement to House Homeless Mentally Ill Individuals

This agreement, signed by representatives of the city and state governments in 1990, represented an attempt to alleviate the enormous increase in demand New York City was experiencing on its emergency shelter and psychiatric treatment services. With over 50 nonprofits in all five boroughs of NYC, the state and city governments created 3,615 units of service-enriched housing for homeless mentally ill individuals over a nine-year period. The Agreement funded construction of 3,092 units of both permanent and transitional housing with different levels of clinical and social services.

A cost study of the NY/NY Agreement represents one of the most comprehensive studies on the effects of homelessness and service-enriched housing on mentally ill individuals' use of publicly funded services. Researchers tracked 4,679 homeless individuals with psychiatric disabilities who were placed into housing by the Agreement. Following are the key findings taken verbatim from the report:

- A homeless mentally ill person in New York City uses an average of \$40,449 of publicly funded services over the course of a year (*Note: all figures are stated in 1999 dollars*).
- Once placed into service-enriched housing, a homeless mentally ill individual reduces his or her use of publicly funded services by an average of \$12,145 per year.
- Accounting for the natural turnover that occurs as some of the residents move out of service-enriched housing, these service reduction savings translate into \$16,282 per year for each unit of housing constructed.
- The reduction in service use pays for 95% of the costs of building, operating and providing services in supportive housing, and 90% of the costs of all types of service-enriched housing in New York City.

Examining the service reductions in detail, the study also found that:

- \$14,413 of the service reduction savings resulted from a 33% decrease in the use of medical and mental health services directly attributable to service-enriched housing.
- Much of these savings resulted from NY/NY residents' experiencing fewer and shorter hospitalizations in state psychiatric centers, with the average individual's hospital use declining 49% for every housing unit constructed.
- On average, shelter use decreased by over 60%, saving an additional \$3,779 a year for each housing unit constructed.
- The cost of supportive housing, the most common model of NY/NY housing, was considerably less than that of other models created by the initiative, requiring an annual outlay of just \$995 per unit.

Connecticut Supportive Housing Demonstration Program

The Statewide Connecticut Demonstration Program created nearly 300 units of supportive housing in nine developments across the state. This evaluation, commissioned by the Corporation for Supportive Housing, was prepared by Arthur Anderson of the Center for Mental Health Policy and Services Research at the University of Pennsylvania Health System in January 2001. The evaluation assessed whether stable housing reduced the need for expensive health and social services over time, enhanced the quality of life for its residents, and allowed residents to attend to their employment and vocational needs. In addition, the study evaluated the financial stability of the projects participating in the Program over a three-year period. Some of the key findings include a dramatic decrease in the use of costly services. (Findings repeated from CSP website 2002)

Comparing medical data over six months for participants twelve months prior to moving into supportive housing and eighteen months after:

- Tenants' use of Medicaid-funded mental health and substance abuse services declined an average of 43% per person;
- Tenants' use of nursing home services dropped by 79%.

In terms of economic impact of the Demonstration Program on state and local economies and found:

- The projects' development had an overall total impact (direct and indirect) of \$70.7 million
- The projects' development had an overall total fiscal benefit of \$1.5 million
- The Demonstration Program's annual post-development benefit totaled \$2.9 million
- The Program's annual fiscal benefit totaled of \$261,900

Minnesota Supportive Housing Demonstration Program

A systematic evaluation of this statewide Supportive Housing Demonstration Program, conducted by Wilder Research Center, has been completed but was not available at this printing.

Canon Kip Community House and the Lyric Hotel in California

The Corporation for Supportive Housing commissioned a study of these supportive housing programs' pre-occupancy and post-occupancy use of emergency rooms and inpatient care. Examining results of research conducted between 1996 and 2000 on the more than 250 clients living in these housing programs, the researcher found:

- 81% or 204 remained housed for at least one year;
- they experienced a 58% decrease in emergency room visits;
- 57% drop in the number of inpatient days; and
- 100% drop in use of residential mental health facilities.

SUMMARY

The prevalence and associated costs of chronic medical illness have increased dramatically in the United States and are expected to continue increasing at an alarming rate in the foreseeable future. Managing these illnesses is made especially difficult by the high costs often not covered by insurance, and the complexity of our health care system. Not having adequate housing greatly increases both the chance of getting a chronic medical illness and the ability to obtain and comply with treatment. This paper summarizes some of the research, published and unpublished, which has documented the disproportionately high prevalence of chronic disease among various subgroups of homeless adults and children throughout the country, as well as the barriers they encounter in acquiring and adhering to treatment.

Due to limited access to adequate health care services, homeless persons are much more likely to use the most costly health services, such as emergency departments and walk-in clinics. They are also more apt to be “served” by alternate systems, such as the criminal justice and welfare systems. Several studies have documented both the high costs of these services and their unsatisfactory responses to these individuals’ needs; all point to the need for more innovative interventions to fill this gap.

Communities and organizations throughout the country have worked to develop appropriate, cost-efficient interventions to improve the health status of homeless persons. Some of the approaches include the Health Care for the Homeless Program which provides primary health care and related services for homeless persons throughout the country, several prevention programs which strive to educate persons about risky behaviors and/or to reduce the risk of chronic medical illness by encouraging adherence to treatment. Many of these programs have documented impressive health and cost-benefit outcomes. Again, however, the situation of homelessness limits any substantive improvement to these individuals’ health status.

Since the mid-eighties, a number of innovative community-based nonprofits have responded to the crisis of homelessness by providing housing along with health and social service supports. Taken together, evaluations of some of these supportive housing demonstration programs provide compelling and consistent evidence that supportive housing programs for homeless persons are a cost-effective response to address needs of even some of the most difficult-to-serve homeless clients. Those programs which included administrative and funding flexibility to accommodate client preferences and effective collaboration proved most successful. Provision of adequate housing in itself will improve one’s health status, and all of these supportive housing program evaluations document reduction in costly health service usage, such as emergency room visits, inpatient days and residential mental health facilities, which also may indicate an overall improvement in health status. These studies do not, however, specifically assess the chronically medically ill homeless person; further research is needed to examine the health and cost-benefit outcomes of systems of care for this high-risk homeless population.

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APPENDIX A

SUPPORTIVE HOUSING PROGRAM DESCRIPTIONS

The following descriptions have been taken verbatim from the Common Ground or Corporation for Supportive Housing websites. These examples provide an indication of the diversity of services and housing models which have been designed to address the diverse needs of the homeless persons.

Medical Respite Center (Fall 2002)

Common Ground is creating a medical respite center for homeless individuals to offer recuperative care to those homeless individuals who regularly cycle in and out of the City's hospital, never getting well. The program will use the period of recover and healing to break the cycle of hospital recidivism and shelter use for these especially vulnerable individuals. The respite center will address the needs of homeless individuals who are ready to be discharged from the hospital, yet require additional medical care for complete recuperation. Length of stay will range from two weeks to six months, to allow patients to achieve medical recuperation, secure available benefits, and engage in the exploration of transitional or permanent housing alternatives. We anticipate better health and housing outcomes for these individuals at a far reduced public cost. Primary medical services will be provided on site through a partnership with Bellevue Medical Center. Necessary emergency care and specialty care will be provided by referring hospitals. Other services, designed to break destructive living patterns and promote overall health, will include:

- Group and individual counseling
- Linkages to housing and treatment programs
- Pastoral care
- Access to physical and occupational therapy, both on-site and off site
- Adjunctive care such as dental care and podiatric care
- Health and nutrition education
- Access to alternative medical treatments, including acupuncture and massage therapy
- Independent living skills training

Skills will be designed to assist residents to recover from or effectively manage their medical conditions and to use the period of recuperation to break from past living habits and move to greater stability.

Common Ground is now seeking a site for a 40-bed facility with a goal of being in operation in the fall of 2002. This program, based on successful programs in Washington, D.C., Boston and Chicago, will be the first of its kind in New York City.

FOYER PROGRAM (late 2002)

Common Ground moves into the work of homelessness prevention with its introduction of a new form of housing linked to employment for young adults (ages 18-24) who are "aging out" of foster and residential care, or who are homeless or at risk of homelessness. The Foyer Program, based on a successful European model, and designed to prevent homelessness by offering these young people a comprehensive transitional experience to independent adulthood. Participants will work over an 18-month to two-year period towards goals of permanent housing and stable employment with career skills by the time of graduation. These young people will live in a college dormitory-type setting and have access to employment, educational, mentoring and life-skills training programs. Long established in France, Ireland and England, Foyer programs have been effective in providing young people without connections to family with the supports and skills necessary to achieve self-sufficiency through a planned transition to adulthood -- reducing their vulnerability to homelessness, unemployment, poverty, substance abuse and violence. Common Ground's Foyer Program will be the first in this country and located in the Chelsea Residence on 24th Street. The 40-unit Foyer will share the building with 167 units of permanent supportive housing. The renovations will be done in two phases beginning in early 2002. The Foyer Program will open in late 2002.

FIRST STEP -NY (Fall 2002)

First Step reinvents the traditional "lodging house" form of housing, and will offer private, safe, clean and affordable short-term accommodations to individuals who are transitioning to housing, facing homelessness, or who have rejected or failed in other programs. Our First Step Unit is an 8' x 7' living space that accommodates a bed, a workspace, and storage. For \$7 a night, guests may come directly off the street and stay for up to 21 days. Services,

which will be optional, include linkages to housing and employment resources, medical help and substance abuse treatment. Lodging houses once existed by the dozens in New York and other cities, offering basic, inexpensive sleeping "cubicles" on a night-by-night basis. New York's Bowery alone had nearly 100 such modest hotels in the early part of the 20th century. The First Step concept builds on this once vital form of shelter for the poor. In shaping this approach to engaging the service wary sector of the homeless population, we went to the homeless themselves. Over 200 homeless men and women, plus many outreach staff working directly on the streets, participated in program and architectural design focus groups and interviews to create the First Step plan. To house this new initiative, Common Ground purchased The Andrews Hotel on 197 Bowery in Lower Manhattan in January 2002. Built in 1909, The Andrews was one of only three lodging houses still in operation. The 19,750 square foot six story building will be expanded with the addition of three partial floors. The renovations will be done in phases to accommodate the 95 men now living in the building who will remain as permanent tenants, and are scheduled to begin in the fall of 2002. When complete, The Andrews Hotel will provide 146 First Step housing units.

THE TIMES SQUARE IN NEW YORK CITY, NY (1991)

Established in 1991, The Times Square is a 652-unit supportive housing residence providing permanent housing and on-site supportive services to formerly homeless and low-income working single adults. It is designed to respond to the needs of individuals with serious health and mental health disabilities as well as unemployed and under-employed single adults. The Times Square is home to a mixed population: half low-income working people and half formerly homeless individuals - including the elderly, those with mental illness, those recovering from substance abuse and those living with HIV/AIDS. The Times Square is co-sponsored by Common Ground Community HDFC, Inc., a not-for-profit housing development organization which manages the residence and the Center for Urban Community Service, Inc., a not-for-profit mental health and social service organization which provides on-site services to the building's tenants. The Times Square provides tenants with access to a wide-array of opportunities ranging from social services to job training and employment services to educational opportunities.

Number of Units: 652

Total Development Cost: \$32,000,000

Reconstruction Completed: 1994

THE PRINCE GEORGE (1999)

The Prince George is the one of the largest permanent supportive housing residences in the United States, providing studio apartments and on-site supportive services for 416 low-income and formerly homeless individuals, including many with disabilities. The rehabilitated hotel features many attractive common areas used to host a wide range of events and activities and will soon included renovated commercial spaces that will provide employment opportunities for tenants and revenue to support job-training initiatives. At the Prince George, The Center for Urban Community Services (CUCS) seeks to maximize tenants' capacity for independence and residential stability by providing supportive services that are flexible and individualized to meet tenants' needs. Acceptance of services is not required as a condition of tenancy. *Tenant Profile:* The 416 single adult residents who live in The Prince George reflect the diverse mid-town Manhattan community surrounding the building. Low-income working people are neighbors with people who have histories of homelessness, psychiatric disabilities, histories of alcoholism and substance abuse, and HIV/AIDS. *Support Services:* The Prince George combines permanent affordable housing with a variety of on-site social services designed to keep people housed and stable. Social service offices are located in the penthouse and interspersed throughout the residential floors.

Number of units: 416

Total Development Cost: \$40,000,000

THE UPTOWN RESIDENCES

The Heights (1985)

The Heights is a five-floor walk-up located in a central shopping zone of Washington Heights. It provides housing to 55 low-income and formerly homeless individuals, including many who have psychiatric disabilities, HIV/AIDS, and histories of chemical dependency. All tenants have private bedrooms and share baths and kitchens. There is a large community kitchen located on the first floor and a kitchenette on each of the upper floors. A large community space is located on the first floor. The basement houses an additional community room and a laundry room, and each floor has a meeting room.

The Stella (1988)

The Stella is a five-floor walk-up located in a residential section of Washington Heights. It provides housing to 28 low-income and formerly homeless individuals, including many who have psychiatric disabilities, HIV/AIDS, and

histories of chemical dependency. All tenants have private bedrooms and share baths and kitchens on each floor. There is an entry lounge, a patio garden used seasonally for community events, and a laundry room in the basement.

The Delta (1989)

The Delta, a former hotel, is a five-floor elevator building located in the Sugar Hill area of West Harlem, near the Dance Theater of Harlem, the Harlem School of Arts, City College, and the Convent Avenue Baptist Church. It provides housing to 32 low-income and formerly homeless individuals, including many who have psychiatric disabilities, HIV/AIDS, and histories of drug and alcohol abuse. All tenants have either studio or one-bedroom apartments with private baths and kitchens. There are two large common rooms located on the first floor including a community kitchen that is used for community events.

The Edgecombe/Abraham (1989)

The Edgecombe, an elegant former mansion with a sweeping staircase, is listed in the Landmark Register of Historic Places. It is a three-floor walk-up building located in the Sugar Hill area of West Harlem, overlooking Jackie Robinson Park and Yankee Stadium. It provides housing to 21 formerly homeless individuals with psychiatric disabilities. All tenants have private bedrooms and most share bathrooms. There is a cozy lounge and community kitchen located on the first floor. A beautifully appointed flower, herb, and vegetable garden graces the land surrounding this magnificent mansion.

The Rio (1991)

The Rio is a five-floor elevator building located in a residential section of Washington Heights. It provides housing to 75 low-income and formerly homeless individuals, including many who have psychiatric disabilities, HIV/AIDS, and histories of drug or alcohol abuse. In addition, it provides housing to seven low-income families. All single tenants have studio apartments with private baths and kitchens, and all families have two bedroom apartments with full kitchens, baths, and living rooms. Common spaces include an entry lounge, a beautifully maintained roof deck garden, and a penthouse public meeting space and art gallery, exhibiting original art by tenants, community artists, and nationally recognized painters.

Chelsea Residence (undergoing renovation)

Following a two-phase renovation that will begin in January 2002, the renamed "Chelsea Residence" will offer 2076 units of supportive housing for single adults. The building will actually house two separate programs: the Foyer Program (described below) and 167 units of permanent supportive housing - 50% of the permanent apartments will be set aside for low income working people and 50% for individuals who have been homeless. Good Shepherd Services has assisted Common Ground in developing the support services plan for the Foyer. Support services for permanent tenants will be provided by CUCS, with funding provided by the New York City Department of Mental Health, the New York City Department of Homeless Services and the New York City Division of AIDS Services. Permanent tenants will have one or two year leases. Monthly rents have been designed to be within 30% of tenants' incomes.

APPENDIX B

ADDITIONAL RESOURCES: ORGANIZATIONS

The information on these organizations has been taken directly from the internet; web addresses from each site have been included for convenience.

CHRONIC HEALTH CONDITIONS

Partnership for Solutions

www.chronicnet.org

The Partnership, led by Johns Hopkins University and The Robert Wood Johnson Foundation, is a new initiative to improve the care and quality of life for the more than 125 million Americans with chronic health conditions. The Partnership is engaged in three major activities:

- conducting original research and identifying existing research that clarifies the nature of the problem;
- communicating these research findings to policymakers, business leaders, health professionals, advocates and others; and
- working to identify promising solutions to the problems faced by people with chronic health conditions.

National Chronic Care Consortium

www.ncccconline.org

The Consortium (NCCC) is a strategic alliance of leading nonprofit health plans and providers in the United States and Canada. The NCCC's mission is to change the delivery structures, administration, payment methods, and healthcare regulations that are fundamentally inconsistent with the nature of chronic illness.

Alzheimer's Association, Inc.

www.alz.org

With its national network of chapters, it is the largest national voluntary health organization committed to finding a cure for Alzheimer's disease and helping those affected by it.

American Academy of Pediatrics (AAP)

www.aap.org

AAP and its member pediatricians dedicate their efforts and resources to the health, safety and well-being of infants, children, adolescents and young adults.

American Diabetes Association

www.diabetes.org

The Association is the nation's leading nonprofit health organization providing diabetes research, information and advocacy.

American Geriatrics Society (AGS)

www.americangeriatrics.org

AGS is the premier professional organization of health care providers dedicated to improving the health and well-being of all older adults.

Family Voices

www.familyvoices.org

Family Voices is a national, grassroots network of over 40,000 families and friends, for sharing information concerning the health care of children with special health needs. Together, we share the expertise and experiences of families from around the country bringing the family perspective to policy discussions and decisions.

Johns Hopkins University

www.jhsph.edu

Founded in 1916 with a grant from the Rockefeller Foundation, the Johns Hopkins University School of Public Health has grown exponentially to become a leader in health research and education.

National Alliance for the Mentally Ill (NAMI)

www.nami.org

NAMI is a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses, including schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, and anxiety disorders.

National Health Council

www.nhcouncil.org

The National Health Council, a dynamic forum for policy development, is made up of member organizations that share the common goal of improving the health of all people, particularly those with chronic diseases and/or disabilities.

The Robert Wood Johnson Foundation

www.rwjf.org

The Foundation is the nation's largest philanthropy devoted exclusively to health and health care. It concentrates its grantmaking in three goal areas: to assure that all Americans have access to basic health care at reasonable cost; to improve care and support for people with chronic health conditions; and to reduce the personal, social, and economic harm caused by substance abuse.

SUPPORTIVE HOUSING FOR HOMELESS PERSONS

Corporation for Supportive Housing (CSH)

www.csh.org

Mission: CSH helps build a unique type of housing that lets homeless and disabled people connect to homes, health care, jobs, and the community.

Center for Urban Community Services

www.cucs.org

Mission: CUCS reduces homelessness, advances effective housing and service initiatives, and provides supportive services to people with mental illness, AIDS, histories of substance abuse, and other special needs.

Common Ground

www.commonground.org

Mission: Common Ground works to end homelessness through the creation of innovative programs designed to promote stability and independence for the individuals it serves. (sic)

The National Supportive Housing Technical Assistance Partnership

The Corporation for Supportive Housing (CSH) provides technical assistance to organizations across the country that are seeking to develop and operate supportive housing through the National Supportive Housing Technical Assistance Partnership.

The Partnership includes:

AIDS Housing of Washington is a national organization providing assistance to organizations involved with helping people with AIDS, including those developing supportive housing. AHW has culled the web for comprehensive information on these topics, including advocacy updates, a list of agencies involved in this work nationwide and funding sources.

Center for Urban Community Services is a New York-based organization that provides support services to over 1000 homeless men and women living with mental illness. In addition, CUCS provides trainings and technical assistance to organizations seeking to provide services to homeless disabled people living in supportive housing.

Technical Assistance Collaborative is a Boston-based national organization providing technical assistance to nonprofits and government agencies interested in developing supportive housing for people with special needs. T.A.C. also provides a Guide to Developing a Local Supported Housing Plan.

APPENDIX C
ADDITIONAL RESOURCES: REPORTS

The following are a few important studies related to homelessness and supportive housing. Many of these titles and descriptions are taken from the Corporation for Supportive Housing website (www.csh.org) where information about accessing the reports can also be found. Many of the studies reviewed in the final section of this report can be found at the CSH website or the HUD website. Many are available in pdf format and can be downloaded for free from the Internet.

New Financing Opportunity For Services In Supportive Housing For Homeless Families And Young Adults: TANF

Many states have available large sums of money in the form of a federal Temporary Assistance for Needy Families (TANF) block grant surplus and a potential shortfall in State Maintenance of Effort (MOE) expenditures. These funds are well-suited to fill the gap in financing for supportive housing for homeless families, those at risk of homelessness, and young adults who would otherwise become homeless. As we enter the fifth year of welfare reform, the time is ripe to implement family and young adult supportive housing initiatives. Many vulnerable families are approaching their time limit in the TANF program. Without intensive intervention, homeless families with special needs, in particular, are likely to exceed their time limit. Similarly, homeless youth and young adults aging out of foster care are likely to become the next generation of long-term welfare recipients, unless they receive affordable housing and an array of services designed to move them into the job market. This report sets forth a legal and policy analysis to support a model approach to using federal and state welfare funds to finance essential services for homeless families, families at risk of becoming homeless, homeless youth and young adults aging out of foster care, who face multiple barriers to stability and self-sufficiency.

Next Door -- a Concept Paper for Place-Based Employment Initiatives (1998)

Written by Juliane Dressner, Wendy Fleischer and Kay E. Sherwood

This report explored the applicability of place-based employment strategies tested in supportive housing to other buildings and neighborhoods in need of enhanced employment opportunities for local residents. Funded by the Rockefeller Foundation, the report explores transferring the lessons learned from a three-year supportive housing employment program to the neighborhoods 'next door.' At base are the lessons learned from CSH's three-year, three-city Next Step: Jobs initiative, funded by the Rockefeller Foundation and involving 21 local supportive housing providers. The paper hypothesizes that the strategies that enabled the formerly homeless and disabled tenants of supportive housing to find meaningful employment can be extended to people in the surrounding neighborhoods as well. A program model is proposed in addition to a literature review and extensive interviews with nonprofit providers across the country.

**The Monmouth County Supportive Housing Collaboration Two-Year Evaluation
Commissioned by CSH (February 2002)**

Written by Tony Proscio

This report concentrates on the process of improving interagency and intergovernmental cooperation for the purpose of creating long-term solutions to the housing and human service needs of residents with special needs in Monmouth County, New Jersey.

Family Matters: A Guide to Developing Family Supportive Housing (2001)

Written by Ellen Hart Shegos.

This manual is designed for service providers and housing developers who want to tackle the challenge of developing permanent supportive housing for chronically homeless families. This manual will provide information on the development process from project conception through construction and rent-up. It also discusses alternatives to new construction such as leased housing. It contains practical tools to guide decision making about housing models, picking partners, and service strategies.

Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing - National Edition (2001)

Commissioned by CSH.

Prepared by the Law Offices of Goldfarb and Lipman.

This manual offers some basic information about the laws that pertain to supportive housing and sets out ways to identify and think through issues so as to make better use of professional counsel. It also offers reasonable approaches to resolve common dilemmas.

Keeping the Door Open to People with Drug Problems - Volumes I, II and III

Written by Wendy Fleischer, Juliane Dressner, Nina Herzog and Alison Hong

This three-part guide offers employment program managers and staff encouragement, strategies and tips for serving people with drug problems. The guide is divided into three volumes to make it easy to read for busy practitioners. Volume I is written with managers in mind. It focuses on the systems needed to train, manage and support staff in a program serving people with drug problems. For example, it includes ideas for establishing program rules and a system to refer clients to treatment. It also includes both the federal policy restrictions and funding sources for working with people with drug problems. Volume II is targeted to employment program staff. It covers basic information about drug addiction and treatment and offers tips for working with people including sample dialogues and forms. Volume III is focused on employment programs operating in public housing. It discusses the related housing policies and regulations and some of the challenges and opportunities provided by the public housing context. This section also lists relevant public funding streams.

A Description and History of The New York/New York Agreement to House Homeless Mentally Ill Individuals

Written by Ted Houghton

This document provides a description and history of the New York/New York Agreement to House Homeless Mentally Ill Individuals, signed in 1990 by the City and State of New York.

Homelessness in Urban America: A Review of the Literature

Written by Heidi Sommer

Prepared for Urban Homelessness and Public Policy Solutions:

A One-Day Conference held at the University of California, Berkeley on January 22, 2001

This report, prepared for a conference on Urban Homelessness, summarizes who is homeless, the causes of homelessness, and what this country has done to address it.

The Network: Health, Housing and Integrated Services: Best Practices and Lessons Learned.

Commissioned by CSH

Written by Gerald Lenoir

This report summarizes the principles, policies, procedures and practices used by housing and service providers that have proven to be effective in serving Health, Housing and Integrated Services tenants where they live.

Interim Housing for Long-Term Shelter Residents: A Study of the Kelly Hotel.

Written by Susan M. Barrow, Ph.D.

and Gloria M. Soto Rodriguez

Recent evidence that a subgroup of homeless individuals have become long-term residents of NYC shelters has spurred a search for new approaches to engage them in services and providing appropriate housing alternatives. The Kelly Hotel Transitional Living Community (TLC), developed by the Center for Urban Community Services (CUCS) with first year funding from the Corporation for Supportive Housing, is one pioneering effort to help mentally ill long-term shelter residents obtain housing. This report presents results of an evaluation describing the TLC model, its implementation by CUCS, and outcomes achieved by its initial group of residents.

Forming an Effective Supportive Housing Consortium; Providing Services in Supportive Housing; and Developing and Managing Supportive Housing

Commissioned by CSH

Written by Tony Proscio.

These three related guidebooks are for those interested in forming local consortia and developing supportive housing projects. Guidebook I discusses the formation and management of the supportive housing consortium. Guidebook II sets out the necessary building blocks for designing and organizing services in developments. Guidebook III provides information designing, financing, building, and managing housing for people who need ongoing services.

Landlord, Service Provider...and Employer: Hiring and Promoting Tenants at Lakefront SRO (2000)

Commissioned by CSH

Written by Tony Proscio and Ted Houghton.

This essay provides a close look at Lakefront SRO's program of in-house tenant employment as a guide for other supportive housing programs that either hire their own tenants or might want to do so. The lessons of **Landlord, Service Provider...and Employer** are also of potential interest to affordable housing programs whose tenants could become valuable employees given sufficient encouragement, training, and clear policies.

The Next Wave: Employing People with Multiple Barriers to Work: Policy Lessons from the Next Step: Jobs Initiative (2000)

Commissioned by CSH

Written by Wendy Fleischer and Key E. Sherwood.

The Next Step: Jobs Initiative tested the premise that a range of employment services targeted to supportive housing tenants can help them access employment. It used supportive housing as the focal point for deploying a range of services to address the multiple barriers to employment that tenants face. It also capitalizes on the residential stability and sense of community that supportive housing offers.

The Next Step: Jobs Initiative Cost-Effectiveness Analysis (1999)

Written by David A. Long with Heather Doyle and Jean M. Amendolia

The report constitutes early findings from a cost-effectiveness evaluation by Abt Associates of the *Next Step: Jobs* initiative, which provided targeted services aimed at increasing supportive housing tenants' employment opportunities. The report finds these services increased tenants' rates of employment and earned income as well as decreased tenants' dependence on entitlements when contrasted with a comparison group. The study also projects that these services will pay for themselves over a multi-year period.

Vocationalizing the Home Front: Promising Practices in Place-Based Employment (2000)

Commissioned by CSH

Written by Paul Parkhill.

Accessibility; inclusiveness; flexibility; coordinated, integrated approach to services; high quality, long-term employment; and linkages to private and public sectors are hallmarks of a new place-based strategy to help people with multiple barriers to work, find and keep employment. The 21 place-based employment programs featured in this report represent some of the most comprehensive and innovative approaches to employing persons who are homeless, former and current substance abusers, individuals with HIV/AIDS, those with physical and psychiatric disabilities and other challenges.

Under One Roof: Lessons Learned from Co-locating Overnight, Transitional and Permanent Housing at Deborah's Place II (1998)

Commissioned by CSH

Written by Tony Proscio.

This case study examines Deborah's Place II in Chicago which combines three levels of care and service at one site with the aim of allowing homeless single women with mental illness and other disabilities to move towards the greatest independence possible without losing the supports they need to remain stable. The evaluation describes successes and challenges associated with the model as developed by Deborah's Place, a nonprofit provider of housing and services for homeless women in Chicago.

Work in Progress 2: An Interim Report on Next Step: Jobs (1998)

Commissioned by CSH

Written by Tony Proscio.

Work in Progress 2 describes the early progress of [Next Step: Jobs](#) in helping supportive housing providers "vocalize" their residences--that is, to make working and the opportunity to work part of the daily routine and normal expectation of many, even most, residents. The report covers lessons learned from the first two years of the three year, three city Rockefeller-funded initiative.

A Time to Build Up (1998)

Commissioned by CSH

Written by Kitty Barnes.

A Time to Build Up is a narrative account of the lessons learned from the first two years of the three-year CSH New

York Capacity Building Program. Developed as a demonstration project, the Program's immediate aim is to help participating agencies build their organizational infrastructure so that they are better able to plan, develop, and maintain housing with services for people with special needs. The strategies developed through the program represent significant innovation in the area of capacity building.

Not a Solo Act: Creating Successful Partnerships to Develop and Operate Supportive Housing (1997)

Written by Sue Reynolds in collaboration with Lisa Hamburger of CSH.

Since the development and operation of supportive housing requires expertise in housing development, support service delivery and tenant-sensitive property management, nonprofit sponsors are rarely able to "go it alone." This how-to manual is a guide to creating successful collaborations between two or more organizations in order to effectively and efficiently fill these disparate roles. It provides worksheets and sample legal documents to help groups maximize their potential for success.

Closer to Home: An Evaluation of Interim Housing for Homeless Adults (1996)

Commissioned by CSH

Written by Susan M. Barrow, Ph.D. and Gloria Soto of the New York State Psychiatric Institute.

This evaluation examines low-demand interim housing programs, which were developed by nonprofits concerned about how to help homeless people living on the streets who are not yet ready to live in permanent housing. Funded by the Conrad N. Hilton Foundation, this 15-month study of six New York interim housing programs concludes that the model shows promise as a way of transitioning "street homeless" into permanent settings. The study tracked 113 service-resistant people who were placed in interim housing and found that 62% went on to permanent settings, as compared to 34% of the 50-person control group.

Design Manual for Service Enriched Single Room Occupancy Residences (1994)

Produced by Gran Sultan Associates in collaboration with CSH.

This manual was developed by the architectural firm Gran Sultan Associates in collaboration with CSH and the New York State Office of Mental Health to illustrate an adaptable prototype for Single Room Occupancy (SRO) residences for people with chronic mental illnesses. Included are eight prototype building designs, a layout for a central kitchen, recommendations on materials, finishes and building systems, and other information of interest to supportive housing providers, architects and funding agencies.

Employing the Formerly Homeless: Adding Employment to the Mix of Housing and Services (1994)

Commissioned by CSH

Written by Basil Whiting.

Funded by the Rockefeller Foundation, this report explores the advisability of implementing a national employment demonstration program for the tenants of supportive housing. The paper is based on a series of interviews with organizations engaged in housing, social service, and employment projects in New York City, the San Francisco Bay Area, Washington, D.C., Chicago, and Minneapolis/St. Paul, as well as a body of literature on programs aimed at alleviating the plight of homelessness.

See Also:

Homelessness: State and Local Efforts to Integrate and Evaluate Homeless Assistance Programs (June 1999)

www.gao.gov – report number RCED-99-178

Homelessness: Grant Applicants' Characteristics and Views on the Supportive Housing Program (August 12, 1999) www.gao.gov – report number RCED-99-239

Hospital-Hospice Partnerships in Palliative Care: Creating a Continuum of Service (December 2001)

A joint project of the National Hospice and Palliative Care Organization and the Center to Advance Palliative Care. This report describes the nine projects and "lessons learned" about developing these continua of service.

<http://www.capcmssm.org/>

Medical Respite Services for Homeless People: Practical Models (December 1999)

McMurray-Avila, M. National Health Care for the Homeless Council.

Organizing Health Services for Homeless People: A Practical Guide (2001)

McMurray-Avila, M. National Health Care for the Homeless Council.

Casualties of Complexity: Why Eligible Homeless People are Not Enrolled in Medicaid (May 2001)

Post, PA. National Health Care for the Homeless Council.

The Manual of Common Communicable Diseases in Shelters (1991)

O'Connell JJ, Groth J (eds.) Boston Health Care for the Homeless Program.

Videos

In Our Back Yard (1996)

Commissioned by CSH

Directed and produced by Lucas Platt.

This educational video is aimed at assisting nonprofit sponsors to explain supportive housing to members of the community, government representatives, funders and the media. It features projects and tenants in New York, Chicago and San Francisco and interviews a broad spectrum of supporters, including police, neighbors, merchants, politicians, tenants, and nonprofit providers. Included is Building Community Support for Supportive Housing, which includes fact sheets, sample flyers and tips on how to run community meetings to build support for new projects.

Miracle on 43rd Street (August 3, 1997 & December 26, 1999)

60 Minutes feature on supportive housing as embodied in the Times Square in New York City.