



Hospitals & Housing First for Chronically Homeless

Housing First

Hospitals & Community Partnerships for the Chronically Homeless

By getting the chronically homeless people into permanent housing first and providing them with basic services, their outcomes are dramatically improved and the model saves the community funds.



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Stakeholder Health: Insights from New Systems of Health



Stakeholder Health **Insights from New Systems of Health**

Editors: Teresa F. Cutts and James R. Cochrane

Developed with Support from the Robert Wood Johnson Foundation

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Housing First

Hospitals & Communities Partner
for the Chronically Homeless

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Hospitals, Housing First partnerships spread across the nation

By Tom Peterson

One day in 1967 John van Hengel saw a mother of 10 rummaging for food behind a Phoenix, Arizona, grocery store. Wanting to help people like her, he found a way to get to hungry people the food that could no longer be sold. In doing this, he started St. Mary's, the world's first food bank. The model he created worked and others copied it. A decade later food banks had spread to 18 cities. They proliferated in the 1980s

in response to the need created by deep cuts in the social safety net. Today the largest network, Feeding America, serves 46 million people a year through food banks in more than 200 cities.

Like food banks (or libraries, dog parks, or hospitals) many community institutions we now take for granted started somewhere as an idea — a response to a need — that became a physical reality. And because they **solved a need in one community they soon spread**.

Now, a new model called **Housing First** or **Permanent Supportive Housing** is spreading from city to city. Like the food banks, this model has its pioneers, beginning in the late eighties and early nineties by people like Tanya Tull in Los Angeles and Sam Tsemberis in New York City. And like the food banks, because the model is proving in city after city to work, it's rapidly growing.

The basic idea is that by getting the chronically homeless people into permanent housing first and providing them with basic services, their outcomes are dramatically improved and the model saves the community funds. Housing approaches are not all the same. In some communities the housing units are scattered throughout the community while in others units in one building.

Permanent supportive housing

In dozens of cities — such as Orlando, Charlotte, Denver, Chicago and San Francisco — hospitals are joining with others to

develop permanent supportive homes. This approach appears to have the greatest impact. It usually means placing individuals in efficiency apartments and connecting them with wrap-around supportive services. The National Alliance to End Homelessness calls this a proven effective alternative “in reducing chronic homelessness, as well as public health care costs.”

Here's a small sampling:

✓ **Augusta, Georgia**

The VA hospital and nonprofits in Augusta are currently retrofitting three historic buildings to create 98 units for homeless veterans and their families. The center is on a bus route, within walking distance of a grocery store and the hospital. Homeless veterans coordinator Mary Cunningham told the **Augusta Chronicle** “A lot of low-income veterans don't have transportation so anywhere in a city like Augusta where you can step outside your door and be able to catch the bus is an asset.” She anticipates that the program will also create “a good sense of community.”

✓ **Austin, Texas**

Community First Village has the feel of an upscale KOA campground in the Texas Hill Country. Eight miles east of downtown (and just outside the city limits, avoiding NIMBY issues) it's a 27-acre master-planned community. The Village expects by year's end to place around 200 chronic homeless people in 120 micro-homes, 20 “canvas-sided cottages” and 100 RVs.

To get the right people at the right growth rate the group is intentionally going slow. The Village also bought the property next door where they hope to house an additional 350 people.



While the homes don't have running water, they have microwaves and small refrigerators and all are near community kitchens, restrooms and showers.

Besides the houses, the Village has many amenities: a city bus stop, WiFi, places to worship and gather. An artistically decorated coop is a nicer shelter for chickens than many of the residents have known in recent years. There are walking trails, a small market sells food and crafts made by residents and free weekly movies at an outdoor theatre. Go out on a Saturday and you'll see dozens of volunteers — from church groups to Eagle Scouts — working alongside residents on a new house or in community gardens.

Through partnerships with local organizations, the Village offers on-site full-time behavioral health case managers and primary healthcare services, as well as support for hospice and respite care.

✓ Chicago

Recognizing that seven of its top 10 recurring patients were chronically homeless people the University of Illinois Hospital in Chicago is testing a Housing First program for 20 individuals. The hospital's Stephen Brown **told SJNN Chicago** that these patients were "very, very expensive. Their health care costs are five to 15 times what the average patient costs... They're both sick and they're also accessing the ER for what we call secondary gain — it's warm, they can get a sandwich, they're there to sleep during the night."

✓ Utah

Lloyd Pendleton, director of Utah's Homeless Task Force, learned about Housing First when he heard Sam Tsembiris at a conference in 2003. A conservative, Pendleton was impressed by reports of cost savings from the approach. So he left the conference and decided to try it back home. "As I flew out and we flew through the clouds, I can remember looking out at the clouds and saying, Lloyd, if there's any state in the Union that can accomplish this, it's the state of Utah," **Pendleton told NPR**.

They started with a pilot, housing 17 chronically homeless people. After 22 months they were all still in their homes. "So political people became believers because it worked in Salt Lake City," Pendleton said in the report. "That then gave us the courage, the moral impetus, the political will to go forth and build that hundred units, the next year, 84 units, the next

year, 201 units, the next year, 110 units and then another 59 units.”

Today men and women who may have spent decades on the streets may live their own apartment in a former Holiday Inn. They pay either one-third of their monthly income or \$50, whichever is more. In 2005 the state of Utah set a goal to house all of its chronically homeless people by 2015. By 2015 they had reduced that population by 91 percent, from 2,000 to 200. (There are still 14,000 non-chronic homeless in the state.)

Read more in [Fast Company](#), [The Washington Post](#), [Mother Jones](#), and [NPR](#).

✓ Charlotte, NC

The [Housing Works](#) program in Charlotte offers several home options chronically homeless: “at Moore Place, an 85-unit apartment building..., in Scattered Site apartments (90 units), and in MeckFUSE, a partnership with Mecklenburg County providing an additional 45 community-based apartments.” Its partners include Novant Health and Salisbury VA Medical Center.



Evidence-based results

Hospitals engaging in housing first initiatives are no longer stabbing in the dark. The spread of health system/permanent supportive housing programs follows mounting evidence of their success. A recent article in [Hospitals & Health Networks](#):

A growing body of research, in fact, suggests that the benefits of housing programs for the health care system might be substantial. Researchers at Yale University’s Global Health Leadership Institute evaluated and summarized the results of several studies in the area in their report “[Leveraging the Social Determinants of Health: What Works?](#)”

- A “housing first” program in Seattle found that the median per person, per month cost of incarceration, emergency medical services, hospital-based medical services, detoxification and other publicly funded programs fell from \$4,066 to \$958 after 12 months in housing. This added up to annual net savings — after accounting for housing costs — of \$29,388 per person compared with a control group.
- A Massachusetts initiative that targeted homeless people with serious mental illness reduced the average number of hospital days per client from 102 to seven within two years after housing placement. That reduced hospital costs by about \$18 million per year overall.

- *A Los Angeles program that serves homeless patients with the highest public services and hospital costs documented that every \$1 invested in housing and support reduced public and hospital costs by \$2 the following year and \$6 in subsequent years.*

Hospitals Housing First Combo: A wheel that may not need to be reinvented

Health systems run the data from their electronic medical records. They notice the disproportionate number of visits from people whose addresses are homeless shelters and services. The frequent visits indicate that health needs may not be met. The costs raise the question of effectiveness.

Sometimes the wheel you need has already been invented. Sometimes what's needed in your town is what's working in a town down the road. Just borrow the proven idea and adjust it to fit your particular needs.

Photos: Austin, T. Peterson; Charlotte, Urban Ministry Center.

Hospitals & Housing First: Q&A with Mike Griffin and Larry James

Mike Griffin is Vice President of Advocacy and Public Policy for *Adventist Health System*. He recently served as Public Affairs and providing public affairs leadership to Florida Hospital and the Florida Division of the Adventist Health System.

Larry James is the CEO of *CitySquare* in Dallas. He has provided guidance and leadership since he joined there in 1994. He's a social entrepreneur and a committed public servant to the communities of East and South Dallas.

Both have deep experience in developing permanent supportive housing programs for chronically homeless people in their communities. This interview is adapted from a Stakeholder Health webinar that was held on April 4, 2017.

Interview by Tom Peterson



Stakeholder: The idea of housing first or permanent supportive housing is getting chronically homeless people into permanent housing first and then providing them with basic services. This has dramatically improved people's situations and has, by the way, saved community funds. Hospitals in dozens of cities are joining others to develop permanent supportive housing. Mike, can you tell us what Florida Hospital did in Orlando?

Griffin: In Orlando, we had a homeless crisis. You really have to look at a tri-county area: Orange County, where Or-

lando is; Seminole County, which is suburban and fairly affluent; and Osceola County, which is far less affluent than Orange County. So, it's a mixed community when it comes to income levels. And it's a service industry community.



Homelessness spiked after the recession in 2008 and reached a crisis here in 2012 or 2013. Our community had no coordinated sense of how to attack the problem. A Commission to End Homelessness was created — later called the Homeless Commission because ending homelessness is tough. It was made up of community movers and shakers, including our CFO.

We went to look at what they had done in Houston and Salt Lake City. The community was convinced after the Houston visit that housing first was the way to go, that we had to stop thinking about homeless services as a way to provide the homeless a sandwich or a roof over their head for a night and to look at actually providing them housing.

Our CFO, Eddie Solar, also looked at it from the standpoint of the utilization issue. Florida [Hospital] has a large percentage of uninsured people, and the highest and most expensive users of the system were the chronic homeless. He looked at it from the standpoint of, first, what's right for the community. Second, we're a faith-based organization, an arm of the Adventist Church. Our mission is to extend the healing ministry

of Christ into the community and, obviously, if we can solve this chronic health issue, the community will be healthier.

There was also the factor: the cost of the emergency room, the cost surrounding treating a chronic homeless person with, maybe, a chronic disease, an addiction, or schizophrenia. The cost of treating them in an emergency room is so much more expensive than just treating a twisted ankle or a kid who gets injured in a soccer game. There are all kinds of wrap-around services, psych evaluations, transport to a safe facility to house them until they get better.

So we opted to work with the Homeless Commission to establish the Homeless Impact Fund, and Florida Hospital donated \$6 million. It was originally scheduled to be \$2 million a year for three years, but we thought we could get more bang for our buck if we could park that money with an organization here called the Central Florida Foundation. They invest the money so it grows while we're spending it on the services.

The agreement was, the first year we would allow some of that money to go to infrastructure. but we made it clear that we're not in the housing business, we're in the health care business. So, we wanted to bulk of the money to go toward case managers. If you try to do this, it will evolve over time. The original plan was to get the people into housing and then provide them with case managers to take care of their health care needs, make sure their rent is getting paid, and dealing with any kind of issues that these folks may have.

The problem was, we couldn't get them housed fast enough. So, we altered the dynamic a little bit – now those case managers actually get out into the community, into the woods, and underneath the overpasses where these folks are and they start to case manage them from that point. That way we can help get them into the system faster.

There are a lot of layers to this that we can get into – governance, you know, it was like peeling an onion and we're only a third of the way through the onion. You have to deal with the governance structure, you have to deal with trying to get others to buy into the housing first strategy, which is difficult.

Stakeholder: Larry, could you tell us first, what is City Square? Then tell us about your experience in providing permanent supportive housing and how health systems connect with you.

James: City Square is a broad-based human and community development corporation. We're a faith-based non-profit. We work in several areas and housing is one of those. Really, our bread and butter is not homeless folks but rather working poor. Every year tens of thousands of them cross through our various doorways because they don't earn enough, even though they work hard to make life work for them and their families.



So the homeless population is a tiny percentage of our overall reach. We work in areas of hunger relief, prevention, and nutrition. We have a health clinic in one of our lowest income neighborhoods. We do a lot of employment training initiatives and have a public interest law firm that represents low-income people.

We've developed about 1,500 units of workforce housing beyond the 650 units of housing that we have for the homeless. We have a big AmeriCorps grant – we have 300 AmeriCorps members in the summer, 80 year-round. We work with the Department of Agriculture, here in Texas, to do the after-school and summer food program. So, we're doing a lot of different things and we, increasingly, are drawn into the homeless space.

By July 1, we will have over 650 units of permanent supportive housing that all employ the housing first strategy. In Dallas, during the administration of George W. Bush, the Inter-agency Council on Homelessness was established and President Bush set a goal to end chronic homelessness by 2016. We haven't done that, but every major community that was involved, including Dallas, has developed a continuum of care.

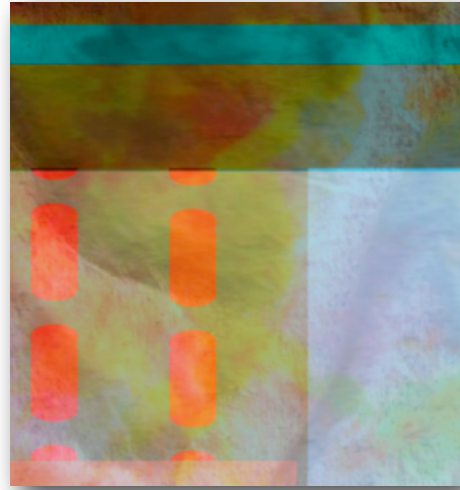
Through the continuum, HUD mediates about \$17 million to Dallas annually and the Metro Dallas Homeless Alliance is the organization that handles the contracts with HUD. We receive about \$3 million a year from HUD to fund our process and our product delivery, and that's those apartments. We are leasing apartments now. We actually built new apartments or ret-

rofitted existing structures to create new apartments.

Our most ambitious project to date opened in 2010. We turned a 15-story downtown office tower that had been vacant for 20 years, at the edge of the Arts District, into 200 units of housing using low-income housing tax credits. One hundred were set aside for formerly homeless persons and 100 for people who earn less than \$30,000 a year. In addition, we have retail and office space there and six condos that we sold at market rate. So, City Walk is an interesting enterprise. It's mixed-use, mixed income and it's right downtown. It's been a successful project and, again, we used housing first.

The project that relates most to our conversation today is The Cottages project that we completed late last year, right across from my office. We have 50 small homes – 400 square-foot houses – that each contains a bedroom scaled to queen-sized furniture, a kitchen, a private bath, a living room, and a big front porch that's turned into a big group of five or six other porches that make the housing development really architecturally and structurally designed to encourage community development. So far, it's been really successful.

That project was convened by the W.W. Caruth, Jr. Foundation that came to us eight years ago and said, "We want to work on a public safety initiative around housing." So, we



pulled together a coalition that included City Square, City Square Housing, Metro Dallas Homeless Alliance, and Metro-Care (our mental health provider in the county). Another partner, UT Southwestern Medical School, is doing the data analysis and measurement.

We also had a partner in Dallas County, especially Dallas County Criminal Justice. Because of HIPAA problems, we didn't have the same ability to engage our public hospital as we had to engage our public jail. On the backside of the public jail engagement, we were able to get into some of the Parkland [Hospital] data. But we identified the 300 most expensive homeless persons to Dallas County. Not counting city expenses or non-profit expenses, just the cost to the county through the public health system, the public mental health system, and the jail, we determined that these 300 individuals each cost Dallas County over \$40,000 to stay outside on the streets.

In the new Cottages project, we took 50 of those people and housed them in our Cottages. We were able to care for them, provide them with fine housing and great community engagement for less than \$15,000 a year. So, the economics make an awful lot of sense. To live in the Cottages, you have to be chronically homeless, disabled with some presenting mental health issue, and you have to have been in jail. So, we're not screening people out, we're screening people in. And so far, so good.

Stakeholder: HUD estimates that nationally the typical chronically homeless person will cost the community— with jails, hospitals, and so on — about \$40,000 a year. By providing housing and support, that drops to \$16,000 a year. So it's better provide the support. But this is not for every homeless person in your community. Can you both that is address this?

James: Metro Dallas Homeless Alliance has developed a Vulnerability Index and, through the HMIS Data System, when an apartment opens up and a person is identified, if they meet the criteria and if they are the most vulnerable on the list at the time they get plugged into housing first. So, we've improved our processes greatly over the last several years. We've had a struggle because, just like in Florida originally as you described it, the original emphasis was all on service providers only and no one was doing much with housing. We were settling for shelter beds and calling that housing. HUD frowns on that and, actually, it doesn't get us what we need in our communities.

Griffin: That's a good point. And to understand how to get someone into a home, you have to understand how the bureaucracy works. The Vulnerability Index – the process is called VI-SPIDAT – is how they determine how at-risk somebody is, and that puts them on the priority list. So, we didn't just write a check and walk away, we got involved in trying to reform the system. When we looked at the VI-SPIDAT questions we discovered that, at least the form they were using here, didn't take into account health care issues. There wasn't a question like, "Have you been in the emergency room or the

hospital in the last six months?" or "Have you been in jail in the last six months?" We changed the VI-SPIDAT to make it reflective of not just their time on the street, but what kind of services they were utilizing.

Then, there were a lot of social service agencies that were not on the HMIS [Homeless Management Information System]. So, remember that first bit of money that we said could be used for infrastructure? We included computer systems, so we upgraded a lot of social service agencies' computer systems. The key was going to a coordinated data entry system.

Before, if you went to homeless services Center A, they owned you and it was very siloed. Now it's coordinated so if you go to social services Agency A, your data is shared with the other agencies. It dramatically made the pipeline bigger; we could get more people through faster. We don't invest in causes; we invest in outcomes.

We're a faith-based organization, and a lot of our faith-based partners initially had issues with the housing first concept. Particularly barriers to entry: "Will you promise not to have a beer? Will you promise not to do drugs? Will you promise..." These folks just won't do that. So, the option is you let them stay out on the streets and continue to care for them or you break down those barriers to entry and get them into a situa-



tion where they can be cared for. That's a difficult conversation to have.

James: It is a difficult conversation. We were in Seattle years ago at the 1811 Eastlake Project, which is one of the leading housing first “wet” housing developments, if you will. There were groups of folks from five Texas cities and the Director told us their policy: if someone had a problem with alcohol, so long as they didn't bring it into the common areas and corrupt the community, that failure wasn't fatal. We were dumbfounded by that and the guy said, “I'll give you a fact and then I'll ask you a question. Maybe this will help you. The fact is, I'm saving King County \$X million a year by having these people in my buildings. And my question is, would you rather have these folks in my building dealing with their problems there or do you want them back out on the street again?”

Sometimes we're too good for our own good. So, in our housing if you fail at alcohol, for example, failure's not fatal – 98 percent of alcoholics in America are already housed, right? Why do we make some poor shmuck on the street go through more than we do ourselves dealing with our own problems?

Griffin: That's exactly right. We have a scattered housing system here, so we find apartments wherever they are. When we announced our gift, one of the local TV affiliates went out and did a man-on-the-street kind of interview and just kind of stopped people on the street and said, “Florida Hospital's paying to put, basically crazy, homeless people into apartments. Are you going to feel safe having somebody in your apartment



that may have a mental disorder or be an alcoholic or a drug abuser?” I called the reporter and said, “Do you live in an apartment downtown?” She said, “Yes.” I said, “Well, do you know if your neighbors next to you or above you have an alcohol problem? He might be driving a Porsche but he could be addicted to any kind of drugs, he could be an alcoholic. You don't know who your neighbors are.” It's really just a way of looking at it in a different frame.

Stakeholder: Mike, have you all been doing this long enough so that you can point to electronic medical records data in terms of, this is working and here's how we know it?

Griffin: Yes, what we know is that Orlando is one of the first communities to reduce its veterans' homelessness. We targeted veterans first. Part of the reason for that is, frankly, kind of a marketing effort to try to get people to better understand the system, the conditions of the homeless, and who they are. We reduced veterans' homelessness by 100 percent. The latest check is that there are no longer any homeless veterans in Orlando, in our service area.

In addition to that, we house 398 people. What we work off of internally is what we call the “Frequent Flyers List.” We started with 100. We also asked our competitor, Orlando Health across town, to develop their list. It was 100 frequent flyers – the ones who had come into our emergency room

more than any others. The number one guy on the list had consumed almost \$2 million of health care in a year. He had done, I think, 19 or 20 ED visits in a span of eight or nine months. Looking at the people we housed, at the point we did that check, we had invested about \$1.8 million and had reduced the utilization of people who had consumed \$2.9 million of services. That's just our little world. That doesn't include the impacts of reduction of cost to the jail, the emergency responders, or the police.

We think it's been very successful. When you look at the actual health care cost, though, you have to understand there's another side to it. These people will be getting health care for the first time. We've had about half a dozen go into alcohol rehab, which we pay for. We had one patient have a stroke. If

he would have had a stroke in the woods, he would have died. But he was in an apartment complex and we're taking care of him.

So, on the one hand you're dealing with their daily health needs but you have to understand this is a very sick population. So, if you're looking

strictly to reduce the overall health care costs, for some cases you might not actually see that for individual patients. You get them in there and you find out, not only are they mentally ill but they have cancer. So, that's the other side of the issue.

Stakeholder: Why would any community not do this?

Griffin: For us it was the challenge of the existing infrastructure – getting 31 different agencies to work together was challenging. Some didn't want to work with us, so we no longer support them. That's tough love. You sit across the table from a partner you've been partnering with for 70 years and you tell them, "We can no longer partner with you."

There's also the sense that people can pull themselves up by the bootstraps. Everyone loves a good Horatio Alger rags-to-riches story. You just have to realize that these folks will never be able to do that. They're critically ill. If you can, it's gravy. You have to look at it as God's work. These people need your help and what they need is some kind of sustainability.

We've identified folks who are not suitable for living in an apartment and we're struggling to find somewhere where we can place them. The key is having a community consensus that this is important. That happened in the community with our mayor and this homeless commission.

Again, we take a regional approach in Southern Florida. We got all of the organizations and communities together. We have hospitals in all three counties, so we're a player on the business side, on the Chamber of Commerce side, as well as the health care side. We just made the case that this will save everyone money over time and, second, that this will have to be a regional approach and we'll have to use a risk-based system. So, where the crisis is worse is where we need to start. Once we got everybody on board with that, it made things a lot easier.

Stakeholder: And from your perspective, Larry?

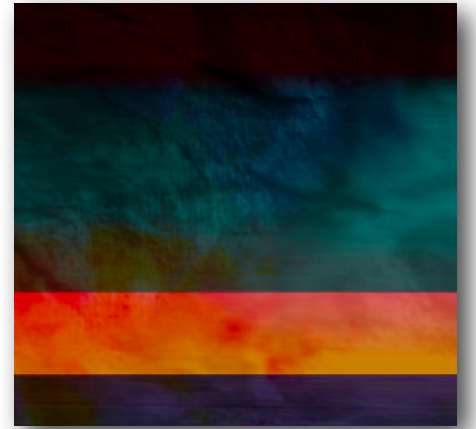
James: There's a bias in Dallas against the very poor. We seldom make adequate connections between our hyperventilated churchy spirituality and the plight of the people under the bridge. It comes down to money and to where in the world do I site these projects I'm building. That's been an amazing revelation to us, is to how small people can actually be. We try to peg most of our argument and most of our advocacy to the sheer economic reality that is undeniable.

Early on, in 2008 or 2009, we got enough funds from HUD to provide 55 apartments. And we provided those out of north Dallas in an apartment complex that probably had 500 units. We had a team leader in an office there who worked with the population. We determined that these 55 men and women spent 17 times more in the year before they entered housing than during the year that they completed housing. That was startling to us.

I was out there one day and six men in the program approached me. They said, "Larry, we owe you an apology. We didn't believe you when you explained housing first to us. Now we know you're serious and we're going to get to stay here. We just wanted to let you know that we've organized a crime watch because, you know what, there's drugs on this property."

People will do well if they get the opportunity to level out their lives. The church needs to understand a deeper kind of spirituality and commitment to justice. I tell churches, "If it weren't

for the salvation thing, we probably wouldn't like Jesus too much because he would hang out with these people. They would be regarded as friends and potential disciples for the world revolution that he had in mind." We need to re-investigate our theology because that's a big problem.



Stakeholder: If you're in a health system, why wouldn't you want to a convener for this conversation?

James: Somebody's got to do the work; it takes effort. It's a priority for us because it's part of our mission. We could make a better selling case for taking Medicaid dollars to cover services to folks in housing and have a better public health outcome than we currently have.

Gary Gunderson (Secretary of Stakeholder Health): Right now most hospitals are not being asked to play a creative role in these kinds of issues. I think that's going to be changing quite radically, given the examples here and in other places around the country. But we haven't viewed it as our expertise, and the homeless networks have not thought of hospitals as integral to the solution other than that we can write a check. Mike, you might comment on that.

Griffin: I just got promoted to a new job, so I'm now corporate. And what we're doing is bringing together into close connection our government relations efforts, our community efforts, and our policy efforts. What really has to happen is,

there has to be some sense of political awareness and you've got to get people to understand that the government infrastructure has to be a partner in this.

As I've said, we're not in the housing business, that's not our area of expertise. But we build hospitals and we do business with construction companies all the time that also build apartment complexes. So we have these business connections, we have these political connections, and of course, we're a faith-based organization, so we work closely with the faith-based community.

Only a hospital, or maybe a university, operates in all of those spaces. That gives us the opportunity to be the convener. One of our partners owns a transitional housing apartment complex and they didn't feel comfortable with that and said, "We want to give this to you." We said, "Hold on, we're a hospital." So we did a state-wide search and identified a company called Ability Housing that builds and renovates communities based on the housing first concept. So, we took that property and leased it to Ability Housing for \$1 a year. And we helped raise some money to renovate the facility. Hopefully, after a couple of years, we're going to deed that property over to them. Those are the kind of things that you have to be prepared to do if you want to solve the problem.

It's a tough sell because in most instances you're not dealing with homeless families with kids and moms. They really are an invisible population. People equate the guys begging on the street corners with the homeless. Even those people are not

necessarily who we're helping. We're helping people who are deep off the grid. That's kind of a challenge you face when you try to get people excited about this work.

Gunderson: Reverend James, what's harder in this issue of housing, the spirituality or the technicalities?

James: Personally, I've made peace with the spirituality, as weird as mine may be to some people, that drives me and takes care of my soul. So the technicalities can be maddening and yet motivating, as well, because there's a way to figure things out. The technicalities are challenging and they're different in each project. Leasing is different than owning. The Healthy Community Collaborative Fund that the State of Texas makes available is a completely different kind of approach. So we tailor our work to meet their funding criteria



but it's the same population. Rapid re-housing is different from a grant from HUD for the continuum of care. We just keep working that,

And we're having luck inviting church folks into the mix and just getting to know people. That's back to overcoming stigma, which Mike addressed. If you just get to know each

other, it's not so frightening because we're all the same, we've just had different life experiences. As we say around here, "Everybody's rich and everybody's poor, just in different ways." We've got to humanize this challenge to make progress.

Griffin: On the faith side, we've got a 150-year tradition with Adventist Health to encourage whole-person health – body, mind, and spirit, nutrition, the importance of rest. This company treats its employees that way, so it's ingrained in our culture. The challenge for me has been on the faith side. Everybody agrees that our mission is to extend the healing ministry of Christ, but how do you do that? Is it a free clinic or is it recognizing that there are social determinants of health? What we've built around this is the concept that housing is healing, that if someone has a roof over their head, they're on the road towards being a healthier person.

We also focus on food insecurity – food as medicine – because there are people living in food deserts that don't have access to nutritious, healthy fruits and vegetables and non-processed meat. That's health care. Finally, access to care; you've got to get your health care outside of the walls of a building and into the community where people are.

To me, the bigger challenge hasn't been firing people up on the faith side. It's been trying to redefine what our advocacy strategy is. Do we target a diabetes program in a community where they have higher rates of diabetes or do we try to find out how we can provide access to good food and quality housing in those areas because that feeds the whole systemic illness? We're still trying to figure this stuff out ourselves.

Housing First Pioneers: Tanya Tull and Sam Tsemberis

Housing First began when people asked: What if something else worked better?

By Tom Peterson

“The world changes according to the way people see it, and if you can alter, even by a millimeter, the way people look at reality, then you can change the world.” — James Baldwin

In the early 1980s, during the Reagan administration, a homelessness epidemic suddenly hit a scale not seen since the Great Depression. Many thought the problem was temporary, so the response was an emergency response: night shelters and soup kitchens, with much of the energy coming from the faith communities. The problem didn't go away; in the following decades, the challenge of homelessness has seemed to intractable. But a few people began looking at it differently.



Tanya Tull — going beyond shelter

Tanya Tull sees things others miss. And then she creates based on what she sees. She has not only founded five nonprofits but she also began the “housing first” movement. This rapidly growing movement has its roots with Tull in the late-eighties in Los Angeles and with Sam Tsemberis the early nineties in New York City.

While in her early twenties — and after three months of receiving welfare — Tull became a social worker. She soon found herself working for a time in the Skid Row area of Los Angeles. She left that work to pursue a few other activities for a while.

Then in 1979 she read a news article about hundreds of children living in the same Skid Row hotels she had known a decade earlier. She shifted her energy to found “Para Los Niños” to help those children. Later she founded an organization for housing in the area. And in 1988, she started “A Community of Friends” to create affordable housing in partnership with mental health agencies that provided services to the residents.



Knowing that shelters were not the long-term answer, Tull later founded Beyond Shelter to help homeless families find permanent housing. The idea was to place families in homes, and then provide the supportive services they needed to become self-sufficient. Beyond Shelter has gone on to develop affordable housing in low-income neighborhoods, along with support services for the residents. Tull’s approach is credited with helping thousands of families in Los Angeles County get permanent housing, and her institute has trained more than 1,000 people in the housing first model.

Sam Tsemberis — pathways to housing

Around this time, as Sam Tsemberis wondered about the homeless people he passed as walked to work at Bellevue Hospital in New York City. Tsemberis, too, became obsessed with the challenge and after a while he left Bellevue to become a street outreach worker. He knew the system for dealing with chronically homeless people was broken; before they could be

rewarded with housing, people first had to deal with their addictions, mental illness and other challenges. It didn’t work.

Watching the never-ending stream of homeless people cycling from the street to treatment programs and hospitals and then back to the street, in 1992 Tsemberis gathered a small group to listen to the people they served. This led them to an approach similar to the one discovered by Tanya Tull: get the person into safe housing and then work with them on their other issues.

“We began taking people from the streets into an apartment of their own... nothing fancy but the privacy and dignity of being able to live not in a crowded shelter setting,” he told a TEDx audience. “There, they could cook and eat what they wanted, watch television, do what they wanted. Have dignity.”

As clinicians, “we had put aside our own beliefs about what was clinically possible for someone who has serious mental illness,” such as schizophrenia or bi-polar illness. “It turns out that our clinical expertise was discordant with what people wanted.”



Their approach had two parts: First, the group helped people find an apartment (with a rental stipend allowing the person to pay a landlord) and, second, they offered wrap-around service teams that would visit them in their homes. This helped with observation and helped the residents avoid going from one agency after another. “It seems, in hind sight, so simple

that somebody who had to walk to the church program to get breakfast and then find a place where they could use the bathroom during the day and then walk another two miles to go to the shelter at night would do so much better in an apartment where the kitchen, bathroom and bedroom were all in one place. They had those survival skills all along, they just weren't as evident to us."

A proven model

As the early results began to be known, others tried the controversial model. Terrence McCoy writes in the Washington Post:

Success beget success. Several years later, the federal government tested the model on 734 homeless across 11 cities, finding the model dramatically reduced levels of addiction as well as shrank health related costs by half. "Adults who have experienced chronic homelessness may be successfully housed and can maintain their housing," the report declared...

Homelessness has long seemed one of the most intractable of social problems. For decades, the number of homeless from New York City to San Francisco surged — and so did the costs. At one point around the turn of the millennium, New York was spending an annual \$40,500 on every homeless person with mental issues. Then came Tsemberis, who around that same time unfurled a model so simple children could grasp it, so cost-effective fiscal hawks loved it, so socially progressive liberals praised it.

Today, Tsemberis is the CEO of Pathways to Housing, the organization he founded in 1993. His model has been replicated in more than 40 U.S. cities and is spreading internationally as well. The organization boasts that after three years, "85 percent of those people are still in their apartments, which is the highest success rate of any housing model that has been created."

Besides saving taxpayers money, another side effect of permanent supportive housing for the chronic homeless is that it opens up the capacity of the shelters, feeding programs and other services there to help those who homeless temporarily.

"The mere formulation of a problem is far more essential than its solution, which may be merely a matter of mathematical or experimental skills," said Albert Einstein. "To raise new questions, new possibilities, to regard old problems from a new angle requires creative imagination and marks real advances in science."



Permanant Supportive Housing and Healthcare Resources



Compiled by Tom Peterson

In an article titled, “**Nationwide, Homelessness Plunged Under Obama,**” *The Atlantic* points to the great gains as

seen in the HUD data: “Between 2007 and 2016, the number of people living on the streets, in encampments, or otherwise outside the shelter system, has plunged dramatically—a drop-off of 31 percent.”

The most important figures fall in the 2010–2016 range, since that span serves as a measure of the federal government’s homelessness strategy. The feds can’t take all the credit, of course: Housing First and Rapid Re-Housing are policy concepts that started at the city and community level, before the Obama administration adopted them as federal law. The work to fight homelessness is first and foremost the work of local government. But federal support... has helped more communities adopt and expand housing-first strategies.

“While the results in the report are encouraging,” the article continues, “they raise the question: Will President-elect Trump continue the Obama administration’s efforts to stop homelessness?”

No matter how that question gets answered, health systems across the nation are increasingly becoming key players in the Housing First movement. And they are finding a plethora of resources, as well as organizations with decades of experience that will help them navigate the complexities of setting up and managing successful programs.

Organizations

Corporation for Supportive Housing

Founded in 1991, CSH is a “collaborative and pragmatic community partner as well as an influential advocate for supportive housing.” It’s involved in programs in 300 cities nationwide and has offices in more than a dozen states. Its offerings are wide ranging, including the **Supportive Housing Training Center** that “provides a combination of webinars and on-the-ground assistance to health centers to foster and expand health center coordination and collaboration with key partners. The goal is to streamline service delivery and improve healthcare outcomes for extremely low-income individuals who frequently use emergency rooms, hospitals, and nursing homes, have housing instability, and lack a connection to primary and preventive care services.”

National Alliance to End Homelessness

Founded in the mid-eighties, the Alliance “analyzes policy and develops pragmatic, cost-effective policy solutions” around homelessness. The Alliance board includes members such as Judy Woodruff, Mike Lowry, Henry Cisneros. They offer workshops on a variety of subjects, including **Rapid Re-Housing**.

The National Health Care for the Homeless Council

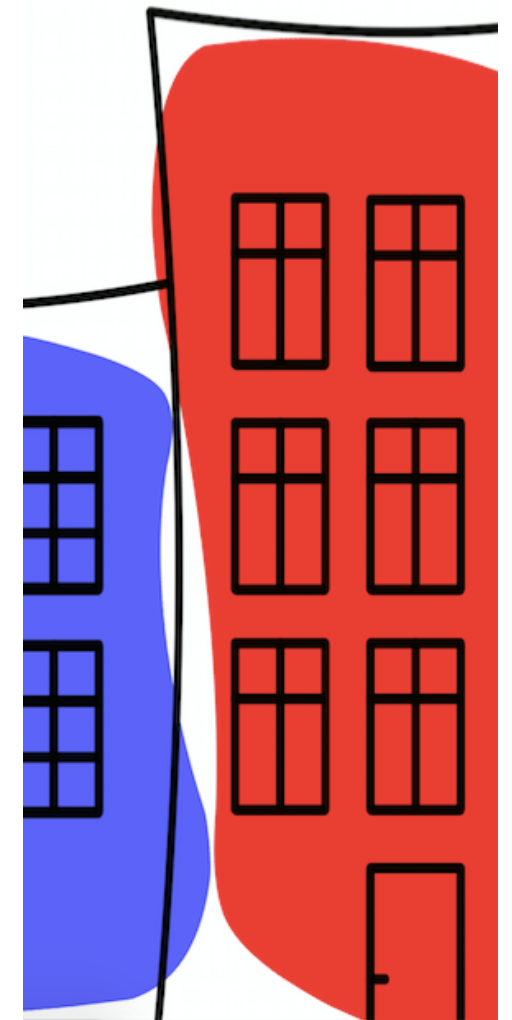
This “network of more than 10,000 doctors, nurses, social workers, patients, and advocates who share the mission to eliminate homelessness” offers a variety of resources including webinars, online and printed publications and an annual conference.

Pathways Housing First

Founded in 1992 by Sam Tsemberis, this organization’s website offers a variety of **helpful videos**.

100,000 Homes

This group wants to help you avoid reinventing the wheel. Among other helpful resources, 100,000 homes offers a treasure trove of dozens of technical helps, templates, how-to’s—from a “rental arrears flow chart” to a pdf on “Partnering with the VA and Accessing HUD-VASH.” They also have a “Peer Mentor Network” that helps communities in areas such as building the team, lining up housing, and helping people stay housed.



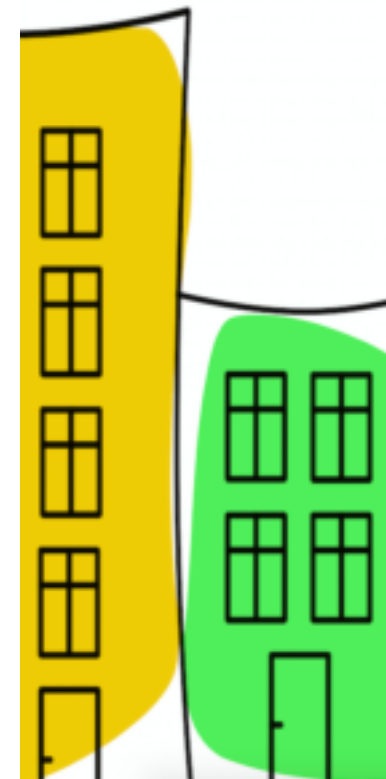
Resource: HHS Guide

HHS Permanent Supportive Housing Kit. Building Your Program: Permanent Supportive Housing. The Department of Health and Human Services has developed a thorough 133-page how-to to help communities develop permanent supportive housing, including the following:

- *Tips for Mental Health Authorities*
- *Tips for Agency Administrators and Program Leaders*
- *Sources of Funding*
- *Local and State Housing Plans*
- *Evaluating a Housing Market*
- *Phases of Housing Development*
- *With case studies looking at Housing Support Teams, and a few places the program took root, and samples of helpful documents like job descriptions and Memorandum of Understanding*

Helpful Articles

The Corporation for Supportive Housing's Press Room includes a great resource for news about permanent supportive housing. New articles are added almost daily and many of these focus on health systems involvement.



Why Hospitals Are Housing the Homeless? *Hospitals & Health Networks.*

When Housing Comes First, Hospitals Benefit, *Hospitals & Health Networks.*

Housing the First 100, an overview of an effort in Orlando that focused on Florida Hospital's top 100 users.

Overcoming NIMBY (Not In My Backyard) is one of the greatest challenges for those working in housing first.

Even when they agree to move forward, concern about crime and lower property values often make it hard for communities to agree on a place. The **Homeless Hub** has a number of resources connected to managing the challenges of NIMBY. Community Supportive Housing, or CSH, has an article showing (with links to studies) that **supportive housing can improve neighborhoods.**

What Works In The Fight Against Homelessness? An NPR story with great links.

Another NPR story about LA county, to expand to California, asks if Medicaid funds should be used for permanent supportive housing.

Impact of Permanent Supportive Housing on the Use of Acute Care Health Services by Homeless Adults

Permanent Supportive Housing: Assessing the Evidence, *Psychiatry Online*.

How Housing for the Chronically Homeless May Save Taxpayers Money, from Fox Business

Health care groups pledge \$21.5 million for housing, homeless help. Portland-area systems — Oregon Health and Science University, Adventist Health Portland, CareOregon, Kaiser Permanente Northwest, Legacy Health and Providence Health & Services Oregon — pitch in to build 382 units for supportive housing.

Linking Housing and Health Care Works for Chronically Homeless Persons, from HUD

