

HEALING HANDS



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The Relationship between Housing and Health Care

In America, homelessness exists for many reasons—among them: an enormous disparity between the number of low rent housing units that are available and those that are needed; poverty often exacerbated by overwhelming health care costs; and substance-related disorders and mental illness linked to severe disability, which can disrupt family connections and isolate individuals. The following articles describe housing models that have successfully achieved client housing retention along with better health outcomes, and discuss how clinicians and others can advocate for solutions to these social problems.

In 2001, **Joseph O'Neill, MD**, then associate administrator of HRSA's HIV/AIDS Bureau, recognized the need for a progressive and comprehensive definition of health care, saying that government, and indeed our society, tended to accept a paradigm that "pits medical care and pharmaceuticals against social and support services . . . [and] denigrates housing, case management, and support services that are absolutely critical to helping people maintain their health." Realizing the economics of scarce resources, his agency issued *Housing Is Health Care*—a guidance on the Ryan White CARE Act housing policy—to assure the most flexibility consistent with the legislation because: "It is ridiculous to give \$20,000 in medical prescriptions to someone who is forced to live under a bridge." Since 2001, the insight that housing is health care has gained widespread commonsense acceptance, which is well supported by data calling for housing-based community support for homeless people as an integral part of comprehensive care.^{2,3,4}

The National Health Care for the Homeless Council represents 104 organizational and over a thousand individual members nationwide, including members of the Health Care for the Homeless Clinicians' Network. The Council has long understood that stable, sanitary housing is central to effective health care.⁴ Indeed, homelessness causes medical problems, greatly exacerbates existing illness, and seriously complicates treatments. People without homes are exposed to the elements, violence on the streets, diseases that are rampant in overcrowded shelters, and debilitating effects of poor diet and lack of rest. A person experiencing homelessness is three to four times more likely to die prematurely than his or her housed counterparts.²

"Secure housing and effective health care are necessary for human survival," says **Marion Scott, MSN, RN**, Council president. "They are fundamental human rights that have not yet been attained in this country."

Barbara DiPietro, PhD, the Council's new director of policy adds, "Everything we do as clinicians is more of an uphill battle if our clients

are sleeping on the street or in unstable housing. And this applies to every aspect of health—nutrition, chronic and communicable disease, victimization, behavioral health, appointment adherence, medication storage and compliance, you name it—just the sheer stress of homelessness complicates healing and health care."

"Housing helps stabilize existing health conditions, and prevents other health conditions from developing. At the same time, housing serves as a base for stabilizing other aspects of life such as employment and family relationships. Stability is the key here; homelessness is marked by constant change without foundations to support work or school," DiPietro says. "It's especially frustrating that our system seems to facilitate sliding into homelessness while making it really tough to get out. Hence, a complex issue is compounded because policies related to housing, income, benefits, and health care make it much more difficult—especially in the current economy—to maintain independent living."

AFFORDABLE HOUSING IN AMERICA There is a direct relationship between contemporary homelessness and the decline of federally funded affordable housing. Between 1976 and 1983, the U.S. Department of Housing and Urban Development (HUD) budget authority shrank from \$83 billion to \$18 billion (in 2004 constant dollars), and has since languished below \$35 billion.²

As funding for affordable rental housing has decreased, very low-income renters have increased from 10.7 million households in 1978 to 16.3 million in 2005. The drastic lack of federal investment in affordable housing unsurprisingly places greater numbers of low-income households at risk of homelessness. Today, 9 million extremely low-income renter households compete for 6.2 million affordable rental homes.² Given the economic downturn of 2008, the imbalance is likely to grow.

Today more than 60 percent of extremely low-income households spend over 30 percent of their income on housing, exceeding HUD's

affordability standard. Three-and-a-half million people experience homelessness each year—the most visible symptom of our affordable housing crisis. When a person working full-time must earn an hourly wage of \$17.32 to rent an average two-bedroom apartment with a Fair Market Rent of \$900 per month, it is no wonder that the onset of serious illness or disability added to this struggle can easily result in homelessness.⁵ Two-thirds of all personal bankruptcies are attributed to medical expenses.⁶

HOUSING SOLUTIONS A healthy variety of housing philosophies and approaches exists. Key concepts in three current interventions being studied follow.

Housing Readiness: A stepwise linear approach to care with an expectation that clients need to achieve behavioral stability, often evidenced by sobriety, in order to enter permanent housing. Treatment for substance-related or nonaddictive disorders is offered within a continuum of care spanning emergency shelters to transitional housing, or stabilization programs, which may include the goal of future permanent individual or group housing.⁷

Housing First: A low demand approach to care that gives priority to housing placement as a first and necessary step in addressing a person's homelessness. In the purest applications of the housing first philosophy, there are no requirements that clients participate in treatment or be in any particular phase of recovery. Residents have access to a range of health and social services designed to promote housing stability and well-being. They must comply with standard lease requirements governing rent payment, safety, and behavior.⁸⁻¹⁰

Permanent Supportive Housing (PSH): A cost-effective combination of permanent, affordable housing with services that help people live more stable, productive lives.¹¹ Depending on the severity of a resident's needs, services may be provided on- or off-site. Visiting interdisciplinary care teams or integrated primary and behavioral health care clinics enhanced by strong case management and life skills training promote long-term stability, recovery, and improved patient health.⁹⁻¹²

HUD'S COMMITMENT HUD-sponsored research has found the Housing First approach to be responsive to the housing needs of chronically homeless individuals with mental illness and often co-occurring substance-related disorders. In a review of three Housing First programs—Downtown Emergency Service Center, Seattle; Pathways to Housing, New York City; and Reaching Out and Engaging to Achieve Consumer Health, San Diego—all achieved housing stability and housing tenure. Some clients required transitional or temporary placements and some had periods of instability. In this review, short-term stability in a

“Across the country, the federal government, states, and communities have made a commitment to the goal of ending chronic homelessness. In so doing, a wide range of housing and service strategies tailored to the needs of people experiencing chronic homelessness have been developed... It will take a more substantial investment in research on homelessness to demonstrate with precision the efficacy of some of these promising practices, and to answer important questions about what works best for whom.”

—Caton, Wilkins, and Anderson, 2007¹²



From left: Vivian welcomes a visitor into her new apartment. The Plymouth on Stewart building in Seattle. (Photos courtesy of Plymouth Housing Group)

Photo Credits: Doug Plummer (L), William Wright (R).

healthy, safe environment was a positive outcome although there were very few identifiable changes in client behaviors over 12 months. Overall, program and policy implications offer a framework for future research in the continued debate about the effectiveness of this approach.^{7-10, 13,14}

HOUSING SUCCESS Cities nationwide have experienced success with assorted housing care models. There are caveats: housing readiness approaches show better results in helping to change and end addiction behaviors but often have lower housing retention rates; housing first programs do not show changes in addiction behaviors but show much better housing retention.⁷⁻¹⁰ In many communities, program design varies enough to make comparisons difficult. Across the board, however, supportive housing practices for individuals and families make a major difference in quality of life, treatment success for comorbid conditions, family relationships, and cost of services.

PSH models in New York, San Francisco, Los Angeles, Berkeley, Denver, Portland, Oregon, and rural Maine have continually shown positive results for clients often accompanied by reductions in service use that offset much or all of housing costs.^{10-12,15-17}

In Seattle, the Plymouth Housing Group developed a Housing First project—Begin at Home—at the Plymouth on Stewart (PST) building. Program Manager **Michael Quinn** says, “Our program protocol offers direct placement in permanent housing from the streets with no sobriety or readiness requirements to begin or remain in housing.” As in other programs, services are voluntary, intensive, and easily accessible with a focus on harm reduction, relapse prevention, and recovery from mental illness, substance use, and medical conditions. Behaviors needed to manage responsibilities of being in housing are also promoted. Quinn continues, “Tenants hold their lease and have the full rights and obligations of tenancy with eviction considered a last resort. Units may be held for up to 90 days during a tenant absence.”

PST serves a population with these demographic characteristics: 75 percent men, 77 percent Caucasian, age range of 29 to 62 years, average 41 months homeless, 74 percent with mental health conditions, 68 percent with substance-related disorders, and 53 percent with other disabilities. One of eleven buildings serving a diverse, multiethnic, multiracial, and multicultural tenant community of 1,500, this site had 91 percent of participants housed after the first year. All buildings have retail components and staffing 24 hours a day, seven days a week.¹⁸

Other Housing First projects in Chicago, Hyannis, and Santa Cruz County, California, have shown improved physical and mental health outcomes, increased housing retention rates, client attention to health care needs and participation in individual and group counseling, reduction in emergency department (ED) use along with substantial cost savings.^{11,19} Denver's 16th Street Housing First Program uses assertive community treatment (ACT) teams in which professionals trained in social work, rehabilitation, nursing, and psychiatry provide case management, initial and ongoing assessments, psychiatric services, employment and housing assistance, family support and education, substance abuse services, and other services and supports critical to an individual's ability to live successfully in the community. The Denver program also showed decreased ED and hospital use, increased independent living and housing stability, retention in treatment, participant and family satisfaction, reduced psychiatric symptoms, and improved quality of life.²⁰

Evidence-based treatments in more traditional linear approaches have been successful in addiction recovery while less successful in assuring long-term housing after treatment, in part because treatment teams rarely control long-term housing resources.^{7,21} However, housing during treatment is critical. "You can't accomplish treatment without secure residential support," says **Stefan G. Kertesz, MD, MSc**, of the University of Alabama at Birmingham and the Birmingham VA Medical Center. "Addiction recovery activities remain central to escaping homelessness for many," Kertesz continues. "We know this in part from anecdotes, but also from decades of treatment research documenting a significant percentage of addiction treatment-seekers who enter rehabilitation programs and ultimately get clean and find jobs and housing." He cautions that community supports after treatment are key: "A good

number of people in recovery still need supportive housing for a long enough period to stabilize their lives and earn the money necessary to pay first and last month rents and security deposits. Communities like my own often have failed to meet this need."

Funding for supportive housing, especially Housing First, can be politically challenging in some communities. "In small, conservative Southern cities with patterns of lower social spending, financial arguments for a housing program that spends \$12,000 per client yearly don't always resonate," Kertesz continues. "Jefferson County, Alabama, has extreme financial problems and recently laid off 30 percent of its workforce. When road maintenance stops and clinics close, discussion becomes especially difficult. Similar distress is being felt in many communities today."

"Well-designed programs with good resources can succeed. Seattle offers a superb program for heavy drinkers, but the upfront resources need to be met in order for such a program to work," Kertesz adds. "Whether illicit drugs fit readily into Housing First is unclear, in part because the issue is less studied but also because communities will resist ongoing cocaine use in a housing program." For clients who are trying to get clean, nearby distribution of cocaine, heroin, or methamphetamine can be a problem.^{7,15}

Given these constraints, Kertesz sees hope in faith communities. "Faith communities are the number one form of social capital in towns like Birmingham, where religious and business leaders are building a 140-bed work-rehabilitation program called Changed Lives Christian Center. We are even looking at how to add Housing First to the same campus." ■

Using Advocacy to Achieve Housing Policy Solutions

The Council's advocacy agenda focuses on the federal level, and policy statements specific to homelessness are updated annually. The 2009 Policy Statement on Housing and Homelessness recommends that legislators:

- Provide dedicated sources of funding for the National Housing Trust Fund to build, preserve, and rehabilitate 1.5 million units of housing affordable to low-income people over the next ten years.
- Preserve and increase current publicly assisted housing. Fund all Section 8 housing vouchers currently in use, and provide additional funding for 200,000 new vouchers a year.
- Restore the requirement for a one-to-one replacement of low-income housing units to increase the availability of affordable housing.
- Assure access to affordable housing with a full range of supportive services for people experiencing homelessness.
- Support public and private initiatives that keep people from becoming homeless.

"The National Council has done a great job of creating venues for clinicians, consumers, researchers, respite care providers, and the broad range of HCH and similar health centers across the country who serve homeless clients," says **Barbara DiPietro, PhD**. "Each of these groups brings policy priorities that they are trying to achieve to the table. My goal is to link these efforts so that we can be most effective with a unified Council voice when working externally, as well as be coordinated internally so that all benefit from each other's clinical practice and experience. In addition, each HCH project has a solid voice within its own local community to advocate for and advance systems changes that benefit our clients. Working steadily in an integrated way at multiple levels like this, we can and will achieve our goals of quality, affordable, universal health care; sufficient incomes and supports; and decent, affordable and accessible housing for all people."

"Currently, one of our top advocacy priorities is to educate policymakers about

the impact of health reform legislation on individuals experiencing homelessness," DiPietro adds. "It's surprising, but many lawmakers think that Medicaid already covers all low-income people and they need to be reminded about the link between poor health and homelessness. So while the health reform debate is centrally about health care, we must also continue to emphasize that a good health care system is a key component to preventing and ameliorating homelessness."

CLINICIANS AS ADVOCATES **Bob Donovan, MD**, medical director of the Cincinnati Health Care for the Homeless Program contends, "Clinicians working in homeless health care are the experts in the field—in all its breadth and depth—due to the scope of our day-to-day experiences and the knowledge base gathered by the HCH Clinicians' Network. We are well-positioned to be influential advocates on many levels."

"We need to influence policy in order to establish power, reach a larger audience, frame the discussion, set the agenda, and engage in the realities of the American political system," states **Andie Martinez, MPP**, associate director for special populations at the California Primary Care Association. "We accomplish our goal by working with politicians and their staffs. We need to remember that politicians are accountable to diverse groups that include their constituents, political party, spoken or pledged ideology, donors, and lobbyists. They want the message delivered in a short and sweet format that is solution-oriented with winnable strategies." Martinez advises:²²

- Policymakers are not the ones living the realities, so your vantage point is critical to creation of good policy
- Political authority is based on one's length of term in office, close friends and allies, rank, and memberships on committees and coalitions
- Policy is fluid and lags behind reality
- Various levels of government and groups have different agendas
- Public mood and sentiment need to work with you
- Few items get on the agenda and most legislation dies

Marc Wetherhorn, MBA, national advocacy director with the National Association of Community Health Centers, concurs and encourages advocating the enactment or defeat of pending or proposed federal, state, or local legislation because "more than 75 percent of a health center's budget is determined by federal, state, and local governments' decisions." It is important for health centers to communicate directly with an official's office and urge support or opposition to a specific piece of legislation or referendum as well as encourage grassroots lobbying by urging others to communicate with an official. Both are critical to making an impact. There are limits, however, to what nonprofits can do.²²

- Never use any federal funds to lobby or for lobbyist registration; advocacy work must be paid for with private funds
- Keep lobbying expenses below 5 percent of your organization's time and effort
- Do not support or oppose candidates for elective office (although you may personally)
- Do not endorse or oppose a candidate—implicitly or explicitly—or contribute money, time, or facilities to a candidate
- Do not coordinate activities with a candidate

BALTIMORE'S HOUSING PROGRESS

Vice President for External Affairs **Kevin Lindamood, MSW**, at Health Care for the Homeless, Inc., in Baltimore, remembers when the mayor wanted to clean up the downtown in 2005 and ordered the police to clear out a park where homeless people had built a campsite. "We contacted the administration and said, 'You can arrest these folks but when they come out of jail they will be harder to help.' So working together, resources were found to house the 28 people living in the park. HCH provided intensive case management and today 85 percent of those individuals are still housed and off the street."

In November 2006, Mayor-Designate Sheila Dixon launched a ten-year planning process to end homelessness in Baltimore overseen by the Civic Leadership Council. HCH was at the table and the resulting plan seeks to accomplish its goal by 2018. Lindamood continues, "We had worked with Mayor Dixon when she was a councilperson and established a level of rapport and trust. We are excited about this call to action that links public, private, and community stakeholders in the challenge of addressing homelessness and making sure it becomes rare and brief."

HCH received SAMHSA grant funding in 2007 to establish an ACT team that offers a greater range of services to clients in supported scattered site housing, 24 hours a day, 365 days a year. The ACT team developed a vulnerability scale to help meet client needs and continues to show an 85 percent rate of housing retention. "Over the last ten years," Lindamood continues, "we've seen a paradigm shift from housing readiness to housing first solutions. Currently, we have about 100 people in some kind of housing first model, and at the end of three years, 500 people will be placed. Despite the economic downturn, there have been resources. Like Pathways to Housing in New York, once we find landlords they tend to have multiple sites

and apartments and are glad to be assured that the rent will be paid and they will have help with their tenants. Clearly, there is not enough housing, but when there is, we see that positive, stable housing improves health."

RURAL ISSUES At the Coalition on Homelessness and Housing in Ohio (COHHIO), **Jonda Clemings, MEd, LSW**, rural housing program coordinator, knows how important education is when building grassroots teams. COHHIO has provided a voice for the underrepresented for over 30 years, with its mission of ending homelessness and promoting affordable housing.

COHHIO is involved in advocacy and education for housing assistance services including homeless prevention, emergency shelters, transitional housing, and permanent affordable housing with linkages to supportive services as needed. They operate on Margaret Mead's principle that one should never doubt that a small group of thoughtful, committed people can change the world because it is the only thing that ever has. "At COHHIO, we believe that everybody should have a home and we advocate on behalf of those who do not," Clemings says. "We help hundreds of housing organizations and homeless service providers pursue their missions, and assist through public policy advocacy, training and technical assistance, capacity building, research, public education, tenant outreach, youth empowerment programs, housing preservation, and a Rural Advisory Council."

Clemings adds, "The Ohio Housing Finance Agency gives tax credits to the elderly, homeless, and disabled, but funding often favors urban programs. In the rural setting, we need a different model to fund development of projects with six to eight units, which don't benefit from economies of scale. COHHIO advocates for more equitable funding set-asides in rural areas. The end result must ensure that all Ohioans—especially those with low-income and special needs—have safe, decent, fair, affordable housing of their choosing."

According to Clemings: "We need flexible policy that makes sense. HUD has really thought out a program that gives folks just enough help based on best practices instead of caps. It [the HEARTH Act, *see below*] allows us to cover transportation, teach folks how to budget, or pay a \$350 security deposit for an

NEW TO ADVOCACY? TRY THESE TIPS

- Know your community: attend public meetings and become involved in faith-based and neighborhood organizations
 - Build a network with like-minded people and launch coalitions
 - Read and listen to local media; visit government and community websites
 - Strategize to use networks and coalitions effectively
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TEN STEPS FOR EFFECTIVE ADVOCACY

1. Be an involved citizen. Act at the local level to influence systems change related to homelessness and poverty. After all, most politics are local.
2. Know the issues and be prepared. You don't have to be an expert, but know why your issue matters, which organizations or individuals share your viewpoint, and the steps to advance your issue.
3. Include local representatives in your outreach and governance so that they learn about the challenges you and your clients face, and how you might better respond through flexible support. These contacts may help later as they gain higher office.
4. Be aware of local, state, and national legislation that affects poverty, homelessness, housing, and health care.
5. Identify policy issues from your caseload (e.g., housing for medically fragile individuals) and use examples from your clinical experience to personalize the issue for decision makers.
6. Know the solution you want to champion and the best audience to receive your message. Sometimes you need to start by educating the community.
7. Subscribe to free policy-focused e-newsletters such as the Council's *HCH Mobilizer* and *On the Hill*. Follow recommendations for action right when your involvement can make a critical difference.
8. Take advantage of suggested wording in action alerts in your emails, letters, or calls. Personalize your message and ask for something specific.
9. Learn when your congresspersons will be in their home offices and visit them. Contact them when they are in Washington, and ask others to do the same. As a constituent, you have a powerful voice. Follow-up the meeting with a thank you note.
10. Thank your elected officials for every positive vote and successful piece of legislation; they will remember!

apartment rather than keep a mother and three children in a shelter at \$2,200. Rural communities are challenging the system because we serve large geographic areas with less than 100,000 people, high poverty rates, less educational attainment, and more agricultural and extractive industries. We are striving to provide cost-effective housing support that better meets people's needs."

Today Ohio is experiencing close to 12 percent unemployment. The lack of qualitative and quantitative knowledge about the needs of rural homeless individuals and the causes of their homelessness has prevented providers and policymakers from adequately addressing the problem.²³ The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, signed into law May 20, 2009, allows rural communities new guideline options that offer more flexibility and assistance with capacity building.²⁴ The act promotes rapid rehousing by adding:

- An incentive for communities to develop rapid rehousing programs for homeless families
- Selection criteria that reward communities that reduce family homelessness
- An emergency solutions program that helps rehouse families who are doubled up or in other precarious situations before they ever become homeless

- A requirement that at least 10 percent of funding be used for permanent housing for homeless families
- A federal goal that no family should be homeless for more than 30 days

ON THE NATIONAL FRONT The Council belongs to several coalitions that advocate for national change in the provision of health care and housing to homeless people. In 2008 after an eight-year campaign, President Bush signed the American Housing Rescue and Foreclosure Prevention Act (H.R. 3221) establishing a National Housing Trust Fund (NHTF). Since the passage of that legislation, advocates have worked to secure a dedicated source of funding.

The National Low Income Housing Coalition published an open letter to Congress and the current administration in April 2009. It examined the need for affordable housing for people with the lowest incomes and highlighted the significance of a major investment in federally funded affordable housing for the U.S., particularly in light of the current economic crisis. Two initiatives were specifically called for in the fiscal year 2010 budget and appropriations process:

- Dedicated sources of funding for the NHTF sufficient to produce or preserve 1.5 million homes affordable to people with extremely low income, over the next ten years.

- New housing choice vouchers: 200,000 each year for ten years.

On May 8, 2009, HUD Secretary Shaun Donovan announced HUD's budget for FY10. The gross budget authority proposed for HUD for FY10 is \$46.344 billion, a 10.8 percent increase over the \$41.833 billion for FY09. It includes measures to substantially increase funding for Section 8 tenant-based rental vouchers; increase funding for, and fully fund, the Community Development Block Grant program; and contribute \$1 billion towards the NHTF. This announcement is important to homeless health care providers and consumers because it describes the Section 8 voucher program as the most effective and quickest tool to help the lowest-income families and increase effective funding by \$1.8 billion.

The Obama Administration is showing a commitment to many of the priorities that the Council and its partners have long advocated. "These initiatives and funding plans will tend to reduce—but will not end—the great health disparities that so severely disadvantage homeless people," says Council President **Marion Scott, MSN, RN**. "Much remains to be done." ■

SOURCES & RESOURCES

1. U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. (2001). *Housing is health care—Housing and the CARE Act* (DHHS Publication No. HAB Policy 99-02). Washington, DC: U.S. Government Printing Office. Retrieved from <http://hab.hrsa.gov/tools/guidance/housing.htm>
2. National Health Care for the Homeless Council. (2009). 2009 Policy statement on housing and homelessness. Nashville, TN: Author. Retrieved from <http://www.nhchc.org/Advocacy/PolicyPapers/2009/2009HCHPolicyStatements052209.pdf>
3. Lozier, J. (2007). *Housing is health care*. Nashville, TN: National Health Care for the Homeless Council. Retrieved from <http://www.nhchc.org/Publications/HousingIsHealthCare.pdf>
4. National Health Care for the Homeless Council. (2009). *The nexus of health reform, housing & homelessness: Recommendations for the Obama Administration*. Nashville, TN: Author. Retrieved from <http://www.nhchc.org/HealthReformRecsNHCHC010809.pdf>

5. National Low Income Housing Coalition. (2009). *Out of reach 2007–2008*. Washington, DC: Author. Retrieved from <http://www.nlihc.org/oor/oor2008>
6. Himmelstein, D. U., Thorne, D., Warren, E., & Woolhandler, S. (2009). Medical bankruptcy in the United States, 2007: results of a national study. *American Journal of Medicine*, 122(8), 741–746.
7. Kertesz, S. G., Crouch, K., Milby, J. B., Cusimano, R. E., & Schumacher, J. E. Housing first for homeless persons with active addiction: are we overreaching? *The Milbank Quarterly*, 87(2), 495–534.
8. Pearson, C. L., Locke, G., Montgomery, A. E., & Buron, L. (2007). *The applicability of housing first models to homeless persons with serious mental illness*. Report prepared for U.S. Department of Housing and Urban Development, Office of Policy Development and Research. Walter R. McDonald & Associates, Inc., & Abt Associates Inc.
9. Locke, G., Khadduri, J., & O'Hara, A. (2007). *Housing models*. Paper presented at the 2007 National Symposium on Homelessness Research, Washington, DC. Retrieved from <http://aspe.hhs.gov/hsp/homelessness/symposium07>
10. Post, P. A. (2008). *Defining and funding the support in permanent supportive housing: Recommendations of health care centers serving homeless people*. Washington, DC: Corporation for Supportive Housing.
11. Goyer, C., Sippi, C., & Wilkins, C. (2009). *Housing is health care: Supportive housing for homeless people with complex health problems*. Paper presented at the National Health Care for the Homeless Conference and Policy Symposium, Washington, DC. Retrieved from <http://www.nhchc.org/2009conference/workshops/W90.html>
12. Caton, C. L. M., Wilkins, C., & Anderson, J. (2007). *People who experience long-term homelessness: Characteristics and interventions*. Paper presented at the 2007 National Symposium on Homelessness Research, Washington, DC. Retrieved from <http://aspe.hhs.gov/hsp/homelessness/symposium07>
13. Larimer, M. E., Malone, D. K., Garner, M. D., Atkins, D. C., Burlingham, B., Lonczak, H. S., et al. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *Journal of the American Medical Association*, 301(13), 1349–1357.
14. Stefancic, A., & Tsemberis, S. (2007). Housing first for long-term shelter dwellers with psychiatric disabilities in a suburban county: a four-year study of housing access and retention. *The Journal of Primary Prevention*, 28, 265–279.
15. Post, R., & Post, P. (2008). *Permanent supportive housing services: Lessons learned and promising practices*. Paper presented at the National Health Care for the Homeless Conference and Policy Symposium, Phoenix, AZ. Retrieved from <http://www.nhchc.org/2008conference/workshops/51.html>
16. Brousseau, R. T. (2009). Grant Watch Report: Addressing homelessness among people with mental illnesses: a model of long-term philanthropic effectiveness. *Health Affairs*, 28(3), 907–911.
17. Mondello, M., Bradley, J., McLaughlin, T. C., & Shore, N. (2009). *Cost of rural homelessness: Rural permanent supportive housing cost analysis*. Washington, DC: Corporation for Supportive Housing and the Maine Department of Health and Human Services.
18. Quinn, M. (2009). *Beyond the porch: Engaging medically vulnerable high-utilizers into housing*. Paper presented at the National Health Care for the Homeless Conference and Policy Symposium, Washington, DC. Retrieved from <http://www.nhchc.org/2009conference/workshops/W64.html>
19. Sadowski, L. S., Kee, R. A., VanderWeele, T. J., & Buchanan, D. (2009). Effects of a housing and case management program on emergency department visits and hospitalizations: a randomized trial. *Journal of the American Medical Association*, 301(17), 1771–1778.
20. Hardy, E., & Genter, K. (2009). *Successful use of ACT and harm reduction in a housing first program*. Paper presented at the National Health Care for the Homeless Conference and Policy Symposium, Washington, DC. Retrieved from <http://www.nhchc.org/2009conference/workshops/W105.html>
21. Kertesz, S. G., & Weiner, S. J. (2009). Housing the chronically homeless: high hopes, complex realities. *Journal of the American Medical Association*, 301(17), 1822–1824.
22. Martinez, A., & Wetherhorn, M. (2009). *How to create the change you want through advocacy and lobbying*. Paper presented at the National Health Care for the Homeless Conference and Policy Symposium, Washington, DC. Retrieved from <http://www.nhchc.org/2009conference/workshops/W15.html>
23. Clemings, J. (2009). *Housing and homelessness initiatives in rural America*. Paper presented at the National Health Care for the Homeless Conference and Policy Symposium, Washington, DC. Retrieved from <http://www.nhchc.org/2009conference/workshops/W02.html>
24. National Alliance to End Homelessness. (2009). *Legislative updates: McKinney-Vento reauthorization*. Washington, DC: Author. Retrieved from http://www.endhomelessness.org/section/policy/legislature/mckinney_vento

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