



# Health Care for the Homeless: A Vision of Health for All

Prepared by Josephine Ensign  
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# Executive Summary

## Background and Purpose

The overall purpose of this report is to reconstruct the history of the Health Care for the Homeless (HCH) movement in order to understand where the movement came from and how it developed; to assess its strengths and challenges; to discuss its future within the contemporary U.S. health care landscape; and to offer recommendations for moving forward. The focus is on the historical roots of the National Health Care for the Homeless Program and the National Health Care for the Homeless Council (NHCHC), as represented through the oral histories of long-time workers (Pioneers) of the program, as well as through various written summaries and reports.

HCH began as a national demonstration program of the Robert Wood Johnson (RWJ) Foundation and the Pew Memorial Trust in 1985, was replicated and expanded in the 1987 McKinney Act, and, as of the most recently available data (2015), serves over 890,000 people experiencing homelessness each year through 295 federally-funded health centers. Through the Health Center Consolidation Act of 1996, HCH became part of a larger set of programs addressing access to care through a network of safety-net, community-directed care providers.

Over the past three decades, the National HCH Council has successfully gathered the interests of health care professionals, researchers, advocates, and people without homes into a respected, coherent, and principled movement that insists upon quality care and the human right to housing and health care. Little documentation of this remarkable health care justice movement exists. Many of the long-time leaders of HCH are retiring and transitioning to other endeavors, and these Pioneers seek a means to gather for future leaders their collective experience and insights, even as the health care environment changes rapidly and new homelessness and health care interventions emerge.

## Methods

In conjunction with the annual National Health Care for the Homeless Conference and Policy Symposium held in Portland, Oregon, from May 31-June 3, 2016, the National HCH Council and conference organizers planned a special four-hour session, “HCH Pioneers Explore the Past and Address the Future of HCH.” This conference session was planned as an interactive session with consecutive panels of long-time leaders in HCH discussing the following: 1) the vision and values of the HCH movement with its balanced commitments to direct service, policy advocacy, consumer involvement, and ending homelessness; 2) the evolution and development of the HCH model of health care, including what factors contributed to the changes, and how the HCH model fits within the current health care environment; 3) the impact of HCH in terms of improved health of the homeless population, influence on other social justice movements, and influence on the U.S. health care system; and 4) ongoing and future work of HCH, such as the changing role of HCH within the rapidly evolving health care environment, the work of HCH to end and prevent homelessness, and the mandate for HCH leaders moving forward.

Leading up to the HCH Pioneers session, John Lozier, executive director of the National HCH Council, drafted a historical timeline of the HCH movement with dates of key events, people, reports, and federal legislation affecting HCH. This timeline was circulated to the long-time HCH leaders ahead of the Pioneers Session for people to make additions, and then copies of the amended timeline were circulated at the tables at the session for participants to review and amend.

Between the panel presentations, two table discussions and large-group feedback time periods were scheduled, with each table having an HCH Pioneer long-time leader as the small group facilitator. Forms were provided at each table for participants to record their thoughts on each of the four session content discussion areas, and people were asked to include their names, phone, and e-mail addresses for possible follow-up clarification or elaboration of their notes. Due to time constraints, with panelists exceeding their scheduled time allotments, only one of the table discussions was accomplished. Out of a total of 140 session participants and 12 tables, we received a total of eight completed forms, two of which were from table discussion summaries. One of the individual forms was from a person who read his responses to the group during the large-group feedback time; therefore, it was duplicative information.

The Pioneers Session was audio-recorded, with panelists and the people using the microphone during the large group feedback captured on the recording. The Pioneers Session assigned Recorder, Josephine Ensign, took hand-written notes during the session, focusing on recording nonverbal cues of the speakers and audience members during the session, as well as other observations in order to add contextual information to the audio-recording and participant written forms. After the Pioneers Session, Ensign listened to the audio-recording of the session, read the participant forms, and wrote expanded field notes of the session. Drafts of these expanded field notes were shared with John Lozier and Barbara DiPietro, who directs the policy and advocacy activities for the National HCH Council, for their changes and additions.

## Overview of Findings

The HCH movement did not develop within a vacuum, but rather grew out of other social justice and health care movements in the U.S. in the 1960s and 1970s. HCH has direct ties with the organizers and policy makers involved in the Community Health Center (CHC) movement. Key figures in the CHC movement were directly influenced by the World Health Organization's community-based primary care model. Therefore, a deep understanding of the historical roots and trajectory of CHC is essential for reconstructing the history of HCH. Teasing out the impediments and differences between the mission, values, and activities of HCH vis-à-vis CHC programs would be a fruitful future endeavor. These challenges were highlighted throughout the Pioneers Session by various long-time workers in the HCH movement. Representative statements for this include: 1) "When we became a Federally Qualified Health Center (FQHC) and CHC, we had a big job of convincing our staff we hadn't lost our mission," and 2) "There's little recognition of HCH within—we don't always look like our brothers and sisters within the community health world."

It is interesting to note that the roots of the CHC movement were mainly within a Southern rural, impoverished community that lacked any organized health care services, while the roots of HCH were within a large metropolitan, mission-focused hospital system. Also, the CHC movement has garnered considerable bipartisan support over the past 20 years, while subpopulation-focused programs like HCH have also grown, but mainly from being folded into the CHC funding stream.

There was considerable discussion of the role of HCH within the rapidly changing U.S. health care system. Pioneers pointed out that there was a growing chasm of opportunity and experience between HCH programs in Medicaid expansion states versus those in non-Medicaid expansion states. Many speakers highlighted key aspects of HCH that have now been adopted by the larger health care system: 1) team-based care models; 2) provision of comprehensive, wrap-around health services; 3) development of medical respite; 4) outreach programs aimed at reducing unnecessary ED visits and hospitalizations; 5) emphasis on the message that housing is health care; 6) patient-centered medical homes; and, 7) inclusion of motivational interviewing and trauma-informed care.

One speaker pointed to relatively recent published studies opining that, “evidence of eliminating HCH services ... didn’t make a difference [to federal supporters] ... Doing the good work that you do is 100% optional, and I don’t think that should be our future.” Another long-time HCH worker and health policy researcher stated, “The challenge is how the HCH model should be changed to fit the new system with its emphasis on health care outcomes, of proving that what we do makes a difference.” He followed this with, “We’re in a position of saying, ‘Well, what are the outcomes that are appropriate for this population?’” And he advocated for the inclusion of housing, employment, and social services, “things that aren’t getting discussed very much when we talk about outcomes in health care.”

Points of difference that emerged in the Pioneers Session had to do with whether or not ending homelessness was an explicit goal of the HCH movement from the beginning. Several of the speakers from the original RWJ-Pew HCH demonstration program spoke of being dismayed that 30 years later they still have a job and that the U.S. still has the problem of homelessness. Other speakers responded to this by pointing out that the original RWJ-Pew HCH Program mandate was to help change the overall health care system so that it would be more responsive to the needs of vulnerable populations, including those experiencing homelessness—and that while HCH has done a good job with that, there is still considerable work to be done. Related to this was a thread throughout the discussion of the role of HCH in continuing to advocate for a single-payer health care system, with Pioneers pointing to the fact that such a health care justice perspective had been an original part of the HCH mission and policy work.

## Recommendations

- One of the main recommendations is for the HCH Council to establish an improved and sustainable internal system for tracking and documenting the history of the HCH movement. One possibility is to partner with *CHronicles: The Community Health Center Story*, a multi-

media website of historical documents, photographs, videotaped oral histories, and written histories related to the Community Health Center movement, which is inclusive of Community, Migrant, Homeless, and Public Housing Health Centers (<http://www.chchronicles.org>). This website is a special project of the RCHN Community Health Foundation, the Geiger Gibson Program in Community Health Policy at the Milken Institute School of Public Health and Health Services at The George Washington University, and the National Association of Community Health Centers. It is dedicated to highlighting and recording the contributions made by community health centers across the country in delivering high-quality and comprehensive primary health care services. The site showcases contributed narratives, photographs, data, and other materials to advance an understanding and awareness of the vital role that community health centers play in the American health care system. CHroniCles celebrates the distinctive history of the health center movement, and the significant role community health centers fulfill in the lives of millions across the country. By contributing to this site, the National HCH Council would also add the unique history and perspective of the HCH movement within this “living history” website.

- With HCH membership growing and broadening to become inclusive of a CHC focus, dilution of the vision and mission and the sense of community the National HCH Council helped nurture is a potential unintended outcome. Therefore, part of the essential work of the National HCH Council is to find ways to address this threat, looking towards models of doing this well in terms of scaling up while maintaining the mission focus.
- The National HCH Council should consider finding the resources in order to conduct a meaningful, cost-effective, and anonymous survey of NHCHC members to find out additional important information, such as political leanings, whether or not people living in non-Medicaid expansion states are feeling alienated from the work of the Council, and what members find most valuable—as well as what is missing—from the work of the National HCH Council and the overall HCH movement.
- Besides the HCH Pioneers Session and this history report, which is meant as an internal document for the National HCH Council and its members, additional ways should be explored to share key findings more broadly. For instance, in terms of increasing the possibility for the HCH movement and Council to influence the future trajectory of the U.S. health care system, scholarly articles could be written for key health policy journals such as *Health Affairs*.
- While the HCH Pioneers Session and the work of gathering and synthesizing additional historical documents in the report are important steps, the National HCH Council should heed the advice of one of the Pioneers Session speakers who recommends a retreat in order to ask a “compendium of questions ... to ask ourselves the hard questions of what we aren’t doing well, where we need to change.” Finding a way to have these critical conversations, inclusive of not only the long-time Pioneers of the HCH movement, but also of newer members and those who have opposing ideological viewpoints, is essential for the healthy future of the HCH movement.

- In addition, there is a need for a larger-scale, more comprehensive research-based report on the history, development, impact, and potential future for the HCH program. In order to avoid potential or perceived bias, such a report would best originate from outside the NHCHC. Perhaps the Institute of Medicine would consider a report in follow-up to their 1988 report *Homelessness, Health, and Human Needs*.<sup>1,2</sup>

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<sup>1</sup> Institute of Medicine (U. S.). Committee on Health Care for Homeless People, *Homelessness, Health, and Human Needs* (Washington, D.C.: National Academy Press, 1988).

<sup>2</sup> As of Summer 2016, the National Academies of Sciences, Engineering, and Medicine’s Science and Technology for Sustainability (STS) Program and the Board on Population and Public Health Practice are beginning a new study on “Housing, Health, and Homelessness: Evaluating the Evidence.” The study will evaluate interventions and policy options for addressing urban homelessness, particularly permanent supportive housing programs. Specifically, the study will address the fundamental question: to what extent have permanent supportive housing programs improved health outcomes and affected health care costs in people experiencing homelessness? To address this question, the committee will take into consideration any variation in outcomes for different subsets of homeless populations, including people experiencing chronic homelessness and people identified as high-utilizers of health care services, as well as the variation in outcomes related to different housing configurations and approaches to service delivery and financing associated with permanent supportive housing.

## Introduction

This report is a synthesis of findings gathered from a variety of sources. Background books, journal articles, and reports were consulted for information on the roots and development of the national Health Care for the Homeless (HCH) movement, including an annotated timeline created by the National Health Care for the Homeless Council (NHCHC). The principal source is the proceedings of an “HCH Pioneers” Special Session held in conjunction with the annual National Health Care for the Homeless Conference and Policy Symposium held in Portland, Oregon, from May 31-June 3, 2016. The four-hour session was titled, “HCH Pioneers Explore the Past and Address the Future of HCH.” This was planned as an interactive event with consecutive panels of long-time leaders in HCH discussing the following: 1) the vision and values of the HCH movement with its balanced commitments to direct service, policy advocacy, consumer involvement, and ending homelessness; 2) the evolution and development of the HCH model of health care, including what factors contributed to the changes, and how the HCH model fits within the current health care environment; 3) the impact of HCH in terms of improved health of the homeless population, influence on other social justice movements, and influence on the U.S. health care system; and, 4) ongoing and future work of HCH, such as the changing role of HCH within the rapidly evolving health care environment, the work of HCH to end and prevent homelessness, and the mandate for HCH leaders moving forward.

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## Part One: Vision and Values

Homelessness aggravates all other ills, and the toll that it exacts on health is especially severe ... This year, we have taken a historic step. Through the efforts of a coalition of advocates in behalf of the homeless, concerned citizens, public officials, and lawmakers in both the House and the Senate, the 100<sup>th</sup> Congress passed a bill that inaugurates a new national effort against homelessness. Passed into law this past summer, the bill provides an unprecedented \$97 million for temporary shelter and for health care and other services. But this legislation is only the beginning. Its significance lies in the implied commitment to find a solution to this American tragedy, to turn away from indifference and towards community, and to build a more just society and a stronger nation.<sup>3</sup>

Senator Edward M. Kennedy wrote these words 30 years ago in the Preface to James D. Wright and Eleanor Weber's *Homelessness and Health*, the first official report on research findings from the Robert Wood Johnson Foundation and Pew Memorial Trust-funded national Health Care for the Homeless demonstration program.<sup>4</sup> From the beginning of the Health Care for the Homeless (HCH) movement in the U.S., the overall vision has been to provide compassionate and quality primary health care to people experiencing homelessness.

From its beginnings as a foundation-funded demonstration program, HCH has been distinguished from many other homeless programs by its balanced commitments to direct service, policy advocacy, consumer involvement, and ending homelessness. The key questions posed to the presenters and participants of this section of the HCH Pioneers Session were: How was this balance established and maintained? What was the original vision for the work, and were the values applied throughout the projects?

The National Health Care for the Homeless program is often referred to as the HCH movement. When asked about this terminology, John Lozier, replied: "*Movement* is an admittedly nebulous term, often not subject to clear definition. In our case, I'd say we are a contributing part of a social movement toward health equity, away from historic health care injustice, toward a rights-based framework for the financing and delivery of health care that includes attention to the social determinants of health." (Personal communication, July 11, 2016)

The HCH movement is situated within larger national efforts to provide accessible, affordable, and quality community-based primary health care to people. Many of these earlier models of community-based care were founded by public health nurses, such as Lillian Wald, who in 1893 began providing outreach nursing services to impoverished immigrants in New York City's Lower East Side.<sup>5</sup> Wald's work grew into the Henry Street Settlement House and the Visiting Nurse Service of New York City. In 1925, nurse midwife Mary Breckinridge established another

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<sup>3</sup> James D. Wright and Eleanor Weber, *Homelessness and Health* (Mcgraw-Hill, 1988). pp. vii-viii.

<sup>4</sup> Ibid.

<sup>5</sup> Lillian D. Wald, *Lillian D. Wald, Progressive Activist* (New York: Feminist Press at the City University of New York, 1989).

pioneering model of community-based care, the Frontier Nursing Service in rural Appalachia, in which outreach nurses provided obstetric, primary care, and health education to impoverished and geographically isolated women and families.<sup>6</sup> Both of these nurse-led, community-based health programs used the model of nurses providing the primary health care, with physicians reserved for follow-up services on a referral basis. As physician and health policy experts Thomas S. Bodenheimer and Kevin Grumbach state, “Both the urban and rural models of community health centers waned during the middle years of this century. Public health nursing declined in prestige as hospitals became the center of activity for nursing education and practice. A team model of nurses working in collaboration with physicians withered under a system of hierarchical professional roles.”<sup>7</sup>

Bodenheimer and Grumbach point out that “the community health center model was revived in 1965, when the federal Office of Economic Opportunity, the agency created to implement the ‘War on Poverty,’ initiated its program of community health centers. The program’s goals included the combining of comprehensive medical care and public health to improve the health status of defined low-income communities, the building of multidisciplinary teams to provide health services, and participation in the governance of the health centers by community members.”<sup>8</sup>

The first two community health centers to be funded were located in a public housing project in Boston and in an impoverished, rural African-American community in the Mississippi Delta. Both sought to combine clinical health care services with public health outreach and advocacy services to support the social determinants of health, including affordable housing, safe drinking water (in the rural area), and community gardens. They trained and supported community residents to become outreach workers. As research and demonstration programs, they were able to show a reduction of hospitalization and emergency department use, and improved community health status in the populations they served.<sup>9</sup> As physician-founder of the community health centers H. Jack Geiger states:

The grant reflected a conclusion that the existing system of charity care, emergency departments, fragmented outpatient departments, and separate public health clinics and programs, north and south alike, had failed adequately to serve the primary care needs of the nation’s poor and sick populations—especially communities of color—and that a new kind of institution, located in such communities and directly responsive to their needs, was required.<sup>10</sup>

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<sup>6</sup> Thomas Bodenheimer and Kevin Grumbach, “Understanding Health Policy: A Clinical Approach, 6e | AccessPharmacy | McGraw-Hill Medical,” 2012, <http://accesspharmacy.mhmedical.com.offcampus.lib.washington.edu/book.aspx?bookid=394>.

<sup>7</sup> Ibid. p. 61.

<sup>8</sup> Ibid. p. 62.

<sup>9</sup> H. Jack Geiger, “The First Community Health Centers: A Model of Enduring Value,” *Journal of Ambulatory Care Management Community Health Centers* 28, no. 4 (December 2005): 313–20.

<sup>10</sup> Ibid. p. 314.

Based on broad bipartisan support of the CHC model as an essential component of the U.S. safety-net health care system, the federal government has invested in a new period of expansion of community health centers. These health centers are critical access points for the health care system reforms enacted in the Affordable Care Act of 2010. As of the most recently available data (2015), there are more than 1,370 health centers in the U.S. serving over 24 million people.<sup>11</sup>

Also stemming from the 1960s civil rights and counter-culture movements, came the development of grassroots community Free Clinics, such as the Haight-Asbury Clinic in San Francisco which opened in the summer of 1967. As physician-founder of this clinic David E. Smith and his colleagues write in a 1971 “manual” of Free Clinic medical care:

Community health care clinics, or “free clinics” as they are called, were not created as novel community experiments, demonstration projects, or even as pilot programs, nor were they the result of social dilettantism by social reformers. They emerged out of acute need and sheer desperation. They were also not part of what Selznick has called “a broad, conscious social vision,” but were established ad hoc, to cope with an epidemic of youthful drug abuse and the health problems which accompany it.<sup>12</sup>

They go on to point out that the Free Clinics which opened in cities around the U.S. in the 1960s and 1970s, were largely anti-establishment, volunteer-run, and consumer-driven. “The word ‘free’ is meant to mean more than no charge per patient visit. It also means no red tape about forms or papers ... The term ‘free’ also means ‘free’ of conventional labeling and value systems.”<sup>13</sup>

Many Free Clinics from this time period either closed or merged with existing CHCs, but others—including the Haight-Ashbury Free Clinic in San Francisco and the Fan Free Clinic in Richmond, Virginia, are still in operation. Faith-based Free Clinics also exist as part of the safety-net health care system. These clinics have a focus on “poverty medicine,” and they tend to be concentrated in the Southern Bible Belt region.<sup>14</sup> There have also been Free Clinics and outreach health care service programs associated with academic medical centers; these are typically university-sponsored or student-run clinics in impoverished urban areas.<sup>15</sup>

It is within this health care and societal context that the HCH movement developed in the mid-1980s, in response to the health needs of the burgeoning number of visibly homeless “street

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<sup>11</sup> NACHC, “Research and Data,” NACHC, accessed August 27, 2016, <http://nachc.org/research-and-data/>.

<sup>12</sup> David E. Smith et al., *The Free Clinic: A Community Approach to Health Care and Drug Abuse.*, ed. David E. Smith (Beloit, Wis, Stash Press, 1971). p. x.

<sup>13</sup> Ibid. p. xv.

<sup>14</sup> Gregory Weiss, *Grassroots Medicine: The Story of America’s Free Health Clinics* (Lanham, Md.: Rowman & Littlefield Publishers, 2006).

<sup>15</sup> Smith et al., *The Free Clinic*.

people” throughout the country. Much has been written on what has come to be termed the phenomenon of “new homelessness,” characterized by the rapid increase in numbers and visibility of people on the city streets, and the changing demographics of people we have come to call “homeless.”<sup>16,17</sup> As anthropologist Kim Hopper writes in his book *Reckoning With Homelessness*, “By the end of the 1970s, increasingly frequent public outcry, press coverage, and a growing advocacy movement signaled that homelessness was an urgent issue demanding attention and redress.”<sup>18</sup> Hopper, along with urban studies researchers at MIT Donald Schön and Martin Rein have pointed out, “homeless” was a convenient umbrella term to describe a range of people experiencing the extremes of disaffiliation and ruptured social ties. In an important policy frame analysis case study of Massachusetts in the 1980s, Schön and Rein observe that, “The very naming of the phenomenon of homelessness reflected a political struggle ... The scandal of homelessness looked as though it could harness a new politics of compassion and shame—compassion for the plight of the dispossessed and shame at the inhumanity of national and local policies toward them. Homelessness, in sum, had political appeal.”<sup>19</sup>

In December 1983, the Robert Wood Johnson Foundation and the Pew Charitable Trusts, with the support of the U.S. Conference of Mayors, announced a joint \$25 million five-year program to fund a new initiative, the Health Care for the Homeless Program. Dr. Philip Brickner, Chair of the Department of Community Medicine at St. Vincent’s Hospital in New York City, was chosen to direct the program on behalf of the foundations. Through a competitive process, 19 initial demonstration projects across the U.S. were funded.<sup>20,21</sup>

Based on the experiences of St. Vincent’s hospital, in 1985 Dr. Brickner published a manual “to serve as a guide for physicians, nurses, social workers, shelter staff members, and program managers who work with the homeless.”<sup>22</sup> This manual included chapters on clinical care topics such as chronic disease management, infectious disease management, approaches to the treatment of both mental health and alcoholism, team-based care, and ways to help patients without homes access Medicaid, Medicare, and public assistance benefits. It also included a chapter, “Working with Hospitals,” which included a description of early hospital discharge

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<sup>16</sup> Peter H. Rossi, “The Old Homeless and the New Homelessness in Historical Perspective,” *American Psychologist* 45, no. 8 (1991): 954–59.

<sup>17</sup> Barrett A. Lee, Kimberly A. Tyler, and James D. Wright, “The New Homelessness Revisited,” *Annual Review of Sociology* 36 (2010): 501–21, doi:10.1146/annurev-soc-070308-115940.

<sup>18</sup> Kim Hopper, *Reckoning with Homelessness*, Anthropology of Contemporary Issues (Ithaca, NY: Cornell University Press, 2003). p. 61.

<sup>19</sup> Donald A. Schön, *Frame Reflection: Toward the Resolution of Intractable Policy Controversies* (New York: Basic Books, 1994). pp. 132-133.

<sup>20</sup> Philip Brickner et al., “Under the Safety Net | W. W. Norton & Company,” 1990, <http://books.wwnorton.com/books/Under-the-Safety-Net/>.

<sup>21</sup> Joel L. Fleishman, *Casebook for the Foundation: A Great American Secret*, 1st ed. (New York, NY: Public Affairs, 2007).

<sup>22</sup> Philip W. Brickner et al., eds., *Health Care of Homeless People* (New York, NY: Springer Publishing Company, 1985). p. xi.

planning for patients without homes, as well as the establishment of alternatives to hospital stays through what came to be termed medical respite care.

For this section of the HCH Pioneers session, two nurses from the original RWJ/Pew HCH demonstration program spoke of their experiences. Barbara Conanan, currently program director of the NYU Lutheran Family Health Centers, spoke of the early roots of the St. Vincent's Hospital and Medical Center, Department of Community Medicine-affiliated clinic in a men's shelter in the Bowery where several St Vincent's Hospital physicians worked in a "clinic (that) was really barbed wire." St Vincent's had operated such health programs specifically for the homeless since 1969: Dr. Brickner was the lead author of a 1972 *Annals of Internal Medicine* article about this clinic titled "A Clinic for Male Derelicts in a Welfare Hotel Project."<sup>23</sup>

Barbara Conanan had been working at the same men's shelter with Project Renewal, a substance abuse program, and she stated, "I witnessed that care. Meeting people where they're at." She started working with Dr. Brickner at St Vincent's Hospital in August 1981, and in 1983 Dr. Brickner asked her to become the manager of the outreach shelter. Then "RWJ showed up" to observe how they did their HCH program. "We were figuring it out as we went along. Just do it and if it doesn't work one way, try it a different way."

The 50 most populous U.S. cities were eligible to apply for demonstration program grants. Out of those, 45 were selected for visits by RWJ teams consisting of a physician/nurse/social worker and a RWJ foundation person. They used the teamwork model from St Vincent's Hospital. They aimed for continuity—so that the same teams would try to visit the same cities over the four years of the demonstration program—so that they could see evolution of the projects. Barbara developed relationships with people at these sites over those years while the RWJ people focused on evaluating specifics of the different demonstration programs.

In follow-up communications with John Lozier about this part of the HCH history, he noted that "the Foundations originally intended to fund 18 cities – 14 by RWJF and 4 by Pew. A 19<sup>th</sup> (Newark) was added by Princeton-based RWJF in response to the concern of the Governor of New Jersey. All 19 were funded at once." Lozier went on to add, "As to the McKinney Act, the issue at hand was whether the health title would simply expand funding for existing CHCs or create a dedicated funding stream. Dr. Brickner advocated with Senator Kennedy for the latter, resulting in a new Section 340 of the Public Health Service Act, created through the Stewart B McKinney Homeless Assistance Act." Lozier also remembers that the first use of "Health Care for the Homeless" came from the announcement of the RWJF/Pew/USCOM Demonstration program and that the term then carried over into the federal program. Other sources state that the section of the McKinney Act that addressed Health Care for the Homeless was adapted from the RWJF-Pew call for proposals.<sup>24</sup>

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<sup>23</sup> Philip W. Brickner et al., "A Clinic for Male Derelicts in a Welfare Hotel Project," *Annals of Internal Medicine* 77, no. 4 (October 1, 1972): 565–69, doi:10.7326/0003-4819-77-4-565.

<sup>24</sup> Fleishman, *Casebook for the Foundation*.

Conanan stated that she had recently found and re-read a case study of the RWJF and the beginning of HCH. “They said they wanted to:

- 1) Demonstrate new ways to deliver health care and social services to homeless people,
- 2) Develop better ways to link people with public benefits, and
- 3) Encourage community agencies and organizations to work together to solve problems. “In parentheses they added ‘of homeless.’ I found it interesting that they didn’t say ‘end homelessness’ but rather ‘to solve the problems of homelessness.’”

She went on to say, “The vehicle for this was to create coalitions—coalitions as the driving force for how services were going to be provided in that locality. What was emphasized was that each area had its own politics, its own way of delivering services, and therefore each city should make that decision on their own. They also said this would be an opportunity for learning that could lead to action. That was interesting and surprised me: they said ‘making a difference for homeless people they serve.’ That was something that touched my heartstrings. One other driving force was that each program had to find a way to sustain themselves within two years.”

The other speaker in this section of the HCH Pioneers session was Sharon Brammer, a nurse practitioner from Birmingham, Alabama.

We were the smallest of the original 19 RWJ HCH demonstration sites. We had six employees. ... We came. We met. Not a one of us in that room knew what to do. We didn’t even know how to begin. We didn’t know how to run a clinic. Then I thought: maybe it would be a smart idea to ask a homeless person what worked. I took a stethoscope and a blood pressure cuff and went out into the parks and asked the consumers, “What would work for you?” What kind of access would help you get access to care? They said, “Well, you’ve gotta come when we’re here, when the shelters close in the morning.” So we started doing clinics at 5:30 in the morning. “We have to eat, so you can come at the soup kitchen time.” So we would have clinic at the soup kitchen, and then in the afternoon when they came to get a bed. The bottom line was to find what worked for them, because obviously something had not been working. We had clinics in shelters, then a mobile health unit. We found we needed a central clinic. It grew from there. Really, the only thing the grant asked us to do was to demonstrate new ways to deliver health care and social services to the homeless people. Demonstrate better ways to link services and people together and to link community services. But it did not give us a manual of how to do it. At that time there was no Council (NHCHC). There were none of the wonderful publications that we have now and that those 400 new people (the number of first-time attendees at the 2016 conference) can have access to now. That’s how we evolved over the 30 years. ... It still bothers me that 30 years later I still have a job. I’m really sorry about that.

John Lozier adds, “The way I recall it being expressed was that they simply wanted to demonstrate that ‘homeless people’ could be effectively engaged in care, contrary to the prevailing opinion.” This is echoed in Wright and Weber’s research report on the RWJ-Pew HCH demonstration program:

What has been learned in the Johnson-Pew program that would be of use in implementing the health care provisions of the McKinney Act? Apparently, the most obvious and important lesson has already been learned: namely, that it is indeed possible to engage the nation's homeless population in a professional system of health care. It is useful to stress that before the existence of the Johnson-Pew HCH program, this was *not at all obvious*. The homeless, it was frequently said, were too hostile towards institutions, too suspicious and disaffiliated, too hard to locate, and too noncompliant to assist in any substantial way. ... What the Johnson-Pew program has demonstrated, first and foremost, is that *something* can indeed be done to alleviate the health problems of many homeless people. What Congress has decided is that it is time to get on with the task.<sup>25</sup> (p. 153)

Indeed, by the end of the RWJ-Pew-funded HCH demonstration program, close to 100,000 clients without homes were seen in HCH clinics for a total of 300,000 visits.<sup>26</sup>

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<sup>25</sup> James D. Wright, *Homelessness and Health* (Washington, D.C.: McGraw-Hill's Healthcare Information Center, 1987).

<sup>26</sup> Philip W. Brickner et al., *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States* (New York, NY: W. W. Norton & Company, 1990).

## Part Two: Evolution of the Model of Care

HCH was first characterized as outreach-oriented primary care delivered by physician-nurse-social worker teams. The key questions posed to the presenters and participants of the HCH Pioneers Session in this section were: How has the HCH model of care changed in the past 30 years? What factors have contributed to the changes over time (e.g., McKinney Act; Health Center Consolidation Act; Affordable Care Act; managed care; new treatment options)? How does the HCH model fit with the current health care environment?

In this section of the HCH Pioneers session, Dr. Jim O’Connell, from the Boston HCH Program, responded to Brammer’s comment about how she is sorry that after 30 years of this work she still has a job. He stated:

We had a different response in Boston which I kind of still hold onto. The Foundation (RWJ-Pew) made it really clear to us that we should be a catalyst within the mainstream and that we should be out of a job within four years. But not because homelessness would go away, but because the world would respond appropriately. So I want to keep thinking—we do have jobs, but our job is still to change that damn system so that homeless people get taken care of. We’re always going to have the need to take care of people who are in really vulnerable spots.

O’Connell described the fall of 1984 in Boston, when,

88 people formed a coalition—a fierce homeless coalition—and they confronted the mayor. It was an issue of social justice and not charity. They were sick of charity. Advocates said: 1) we couldn’t use volunteers because it smacked of charity, 2) we couldn’t use students because they said students are coming out and practicing on them and then going on with their careers, 3) we couldn’t do research because at the time it looked like “blame the victim” type of research, and 4) we couldn’t do mental health services.

He added that this was after deinstitutionalization, which his colleague Bob Taube always reminds us was a good idea, but the necessary community-based services weren’t provided. O’Connell added that at the time in Boston the shelters were amassing a legal suit against the Department of Mental Health because of their lack of adequate community-based mental health services.

In Boston, they looked at St Vincent’s Hospital as a model program. O’Connell states, “It was the only model at the time. It was a remarkable model of nurses working with doctors. By the way, it was appropriate that the first panel (for the Pioneers session) was all nurses. It was very much based in the hospital but going out and doing services in the community. Homeless folk told us they wanted it to be hospital-based so if they got sick, we’d take care of them.” Their model



evolved, providing services in soup kitchens, in detox units, and out on the street. “Then the challenge was how to provide continuity of care.”

O’Connell spoke of how wide and variable the conditions were in terms of responding to local-area needs surrounding health and homelessness. “We were dealing with pressures from the mayors and coalitions, while working within some guidelines of the Foundation. The *richness* of the thing was how wide and varied it was, and I think the *challenge* was how wide and varied it was and how do you come up with good models of care.”

It is interesting to note that the only numerical goal that the HCH demonstration projects were asked to meet was to provide services to at least 1,500 people without homes each year. The funders did not stipulate whether or not this was to be an unduplicated count. The original HCH program goals have been characterized as vague, and included continuity of care, coordination of services, and effective case management, without specific operationalized definitions of what these were or of how to measure progress towards these goals.<sup>27</sup> However, early in the administration of the federal HCH program by the Health Resources and Services Administration, HCH-funded programs were required to delineate and document specific primary care problems to address, along with goals, measurable objectives, and method/action steps.<sup>28</sup>

Vince Keane spoke next in this section of the Pioneers session. He said the real pioneer from Washington, D.C., who was in the room was Dr. Janelle Goetcheus. He pointed out that he came into work with HCH when it was already established, in 1990 in Washington, D.C. Dr. Goetcheus and her team believed that “you go where the people were.” He spoke of CCNV (Community for Creative Nonviolence), which was and still is one of the largest shelters in the country. Mitch Snyder ran it “to the extent that anyone ran it. Mitch was the biggest opponent of us coming to the shelter. He believed it was institutionalization of health care delivery. He thought anyone who made money from health care was impure—he saw it as exploitation.” Snyder also insisted that volunteer doctors and universities “love to work with homeless people because they could experiment on them. It took time to earn their [CCNV’s] trust and approval. 30 years later the shelter [with an HCH clinic] is still there. There are 1,000 people currently living in the shelter. Success was developing that collaboration.”

Before Keane worked at HCH he worked at the NACHC (National Association of Community Health Centers) with Freda Mitchem who ran the homeless portfolio before the Council took it over.<sup>29</sup> “She believed in the concept, but it didn’t quite fit at that time under the NACHC

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<sup>27</sup> James D. Wright, “Methodological Issues in Evaluating the National Health Care for the Homeless Program,” *New Directions for Program Evaluation* 1991, no. 52 (December 1, 1991): 61–73, doi:10.1002/ev.1594.

<sup>28</sup> Copy of Primary Health Care Section of HCH Grant Proposal from The Daily Planet, Richmond, VA, 1989. Document in personal files of Josephine Ensign.

<sup>29</sup> HRSA has contracted with a succession of nongovernmental organizations to provide technical assistance, conferences, education, training and resources for its HCH grantees, including NACHC, John Snow, Inc., Policy Research Associates (PRA), and, for the last two decades, the National Health Care for the Homeless Council.

umbrella. It wasn't a right fit at that time with FQHCs." Keane states that the technical assistance grant went to the National HCH Council instead. He was asked to be the CEO of HCH and "then John took over the contract."

The Washington, D.C., HCH Project eventually took over for a faltering Community Health Center and became a CHC, Unity Health Care. Keane reports that the agency encountered challenges in "assuring our existing homeless staff we hadn't lost our mission. We expanded over the years and became a full-fledged CHC." Keane sees advantages to being a FQHC, especially in terms of being able to provide dental and mental health services. They've also expanded their services into the prison system. He spoke of the importance of a team-based approach and creativity within the 19 (original HCH) sites, which were based on the same principles, but were operationally different. The main guiding principles were "1) commitment, and 2) continuity of care. Plus, an integration of mental health/substance abuse/oral health."

In conclusion he had this to say:

I think it's ironic that 25-30 years later, that massive movement towards team-based health care delivery. That massive movement towards patient-centered medical homes. Where did this start? I think the health care system can learn from this. ... Homeless health care programs were the ones that set the roots in which that was established. I'm excited that it's happening now and I think we in HCH should be talking to people in the health care delivery system because I think they have much to learn about this model of 30 years ago.

Jean Hochron served as the HRSA point person for the HCH program in its formative years and beyond. She spoke of three phases of the HCH lifecycle from the federal perspective:

- 1) The early years, 1987-1995
  - Separate legislative authority— under Section 340 of the Public Health Service Act.
  - Relatively small cohort of grantees with very limited growth: 119 grantees, including the original 19.
  - Funding uncertainties from year to year. "How can we provide continuity of care if we can't count on funding?"
  - Little recognition as participants in the Community Health Center Movement.
  - Early development of HCH professional standards.
- 2) Consolidation and growth, 1996-2002
  - Passage of the Health Center Consolidation Act of 1996. Congressional authority changed from Section 340 of the Public Health Services Act to Section 330(h), with 'h' as in homeless.
  - HCH becomes part of a larger set of programs addressing access to care.

- Consolidated program expectations. She sat on a panel to decide this and would say, “Excuse me, that won’t work for the homeless programs.” Waiver for 51% consumer involvement<sup>30</sup>—“they hated us because we had the easy way out, because we didn’t have to have 51% consumers on our board.”
- Emergence of the Council as a source of training, technical assistance, and community-building—“which didn’t come under the previous contractors like NACHC and Freda and John Snow—they did a wonderful job of education but not community-building. It was the Council that brought us together as a family.”
- The Council published *Organizing Health Care Services for Homeless People* (1997, 2001) by Marsha McMurray-Avila, “the book—the HCH bible.”
- The HCH Clinicians’ Network was started during that time.
- The first national meeting of Medical Respite providers, in Chicago in 2000; the Medical Respite Providers Network later merged into NHCHC.
- The National Consumer Advisory Board was organized soon afterwards.
- Expanded numbers of grantees and people served.

### 3) The past 10 years or so

- In 2004-2005, much more significant consolidation with the FQHC world occurred.
- Finding our place in measurement and standards, including quality metrics.
- Developing partnerships “or at least misery loves company with other special interest groups and National Cooperative Agreement<sup>31</sup> entities.”

### What’s changed?

- 1) HCH has always lived in two worlds, the two families of health and housing. “We’re now moving much more towards our health care family ... population health, migrant health, etc. Now we see HRSA and HUD and VA and SAMHSA all holding hands.” Hochron is somewhat skeptical, but she thinks they’re making progress.
- 2) HCH used to get pressure for “getting off easy” in regards to program expectations, but that is no longer the case.
- 3) Early HCH programs used to struggle to get funding for outreach, enabling services, behavioral health, and oral health. “We’ve moved a tremendous way in that area.”

### What’s not changed:

- 1) The challenge of training/enlightening federal officials and their representatives, program officers, OSV (Operational Site Visits, HRSA’s current oversight for grantees) team members, policy staff, and grant reviewers.

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<sup>30</sup> Community Health Centers are required to have Boards of Directors comprised of 51% consumers of the health centers’ services. The legislation allows stand-alone HCH grantees to use alternate mechanisms for consumer input into agency governance.

<sup>31</sup> National Cooperative Agreements are the funding mechanism HRSA uses to contract with providers of training and technical assistance for health centers.

- 2) Funding and programmatic silos and stovepipes, which tend to support discrete activities rather than addressing the whole person and the whole system. “We still have to chase funding in many different directions.”
- 3) We’re still seeing the same systemic challenges that created HCH—we cannot end it and are unable to prevent it [homelessness].

Hochron concluded:

There’s little recognition of HCH within community health. We don’t always look like our brothers and sisters in the community health world. But let’s not forget a few other things that have not changed and that are quite remarkable:

- The commitment of thousands of people to this work continues.
- The community created by the Council has just gotten better and better.
- Our impact hasn’t changed. There are many people whom we have touched and healed and helped into recovery and into housing.
- The leaders and advocates we’ve created among administrators, clinicians, consumers, and at least one fed.

In a recent *American Journal of Public Health* review article, the authors summarize the development of the HCH model of care and emphasize key elements of the HCH model: 1) outreach and engagement, including the development of patient tracking methods<sup>32</sup>; 2) community collaborations to provide HCH patients with a variety of social and health benefits and services; 3) case-management; 4) medical respite care; and 5) consumer involvement and patient-driven care.<sup>33</sup>

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<sup>32</sup> The Boston HCH Program was an early innovator of electronic medical records, used to maintain continuity in caring for a highly mobile population.

<sup>33</sup> Cheryl Zlotnick, Suzanne Zerger, and Phyllis B. Wolfe, “Health Care for the Homeless: What We Have Learned in the Past 30 Years and What’s Next,” *American Journal of Public Health* 103, no. 2 (December 2013): S199–205.

## Part Three: Impact

HCH still exists as a distinct service within health centers and other service systems. The key questions posed to the presenters and participants of the HCH Pioneers Session were: How has HCH interacted with mainstream service providers such as hospitals, other health centers, behavioral health providers, public health departments, Medicaid and other payers, and health profession schools? Has HCH affected other justice movements, and if so, how? Has HCH improved the health of the homeless population as a whole? If yes, how? If not, why not?

John Parvensky, executive director of the Colorado Coalition for the Homeless, spoke of his 30 years of work with the Coalition. “We started out in places that weren’t designed to provide medical care, some that were barely habitable. We didn’t think we’d have to create institutions of care.” He showed “before and after” photos of the Stout Street Clinic and spoke of how they had started with a staff of six people and they now employ 600 staff members, and of the challenges of “how to keep the philosophy of service, that culture of client-centeredness” with that sort of expansion. He worked with Mitch Snyder and others who advocated for McKinney funding for HCH and showed photos of Comic Relief<sup>34</sup> and Robin Williams. “Health care as a right, not as a privilege, is what we’ve had from the beginning.”

As the movement has gone along we’ve been able to make the facilities more dignified, more appropriate, more trauma-informed.” Parvensky referred to Jean Hochron’s statement years ago that “she hates what they did, she hates what Baltimore did in building a new clinic, she hates what Boston did, and I agree. We didn’t think when we started out that we’d need to establish institutions that would last beyond a few years in order to address the issue. But we came to terms with, in dealing with Health Care for the Homeless, you’re not dealing with a person who just doesn’t happen to have a safe place to be tonight, but the underlying conditions that led people in and out of homelessness, and their ongoing needs.

When advocacy wasn’t enough, we figured out how to do it ourselves—including housing.” Two years ago they were able to build a freestanding clinic using lessons learned across the country—integrated care in one building and with 78 housing units above them. They now have 2,000 housing units dedicated for families without homes, which include onsite health care services. “We’re still struggling with how to bring the HCH model into the Housing First model when people don’t necessarily want you there. The advocacy piece is central to the Council role.

Parvensky concluded by stating, “The road ahead is darker than I’d hoped for 30 years ago. I’m more discouraged. The level of acuity of the issues we’re seeing keeps increasing. The availability of housing—as much as we’ve been able to create—keeps dwindling. We have our work cut out

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<sup>34</sup> Comic Relief was a series of 8 HBO telethons starting in 1986 that raised funds for the member agencies of the National Health Care for the Homeless Council.

for us. And unless we continue that advocacy focus while demonstrating that what we do makes a difference, makes an impact, we're not going to be successful."

Ed Blackburn, executive director of Central City Concern (CCC) in Portland, Oregon, spoke of how CCC is not typical of most HCH programs, since they started out as a housing agency back in 1980. "We had many SRO hotels. They were being torn down in the 1980s and street homelessness was rising. They were pretty horrible places actually. The city formed a coalition to save some of these. They went into these places with baseball bats and took them back from drug dealers and occupied them, stabilized the buildings, and brought homeless people back in. The things that we did to survive and to develop, we'd never do now. There's something about going through the struggle in the early days—you did it because of incredible dedication, vision of people, risk-taking, but also this creativity—it had to be endless. You had to really figure out from one crisis to the next."

Blackburn also stated that, "Going into the health care business almost put us out of business. We hired people in recovery to help. We now have 850 employees and half self-identify as being in recovery from addictions or mental health." He spoke of the importance of working with anti-poverty programs. "Continue to serve people in homelessness while working to end homelessness. People know now that when you get people into better housing, they get better."

CCC partners with Oregon Health Sciences University, offering medical school rotations, and with 16 other health science programs. They are currently working with the largest managed-care agency in Oregon, Health Share of Oregon. Because they came into this from the housing perspective first, they've been working on ending homelessness from the very beginning.

This advocacy thing and this political thing is really a strength we have in the history of HCH. We can't give it up. I think we need to be more active on the ending homelessness front as we continue to serve people in homelessness—because that's where the hope is. That's where the advocacy needs to be. We know that people get better when they get housing at a higher rate. There's real hero work going on for people on the streets and in the shelters. And I have no doubt that just the compassion and the human contact, but also the clinical skills are resulting in better outcomes for people. But if we can get people into housing it's going to get better yet... This (NHCHC) is a terrific advocacy organization. There's more passion in this organization than almost any other we belong to.

Bobby Watts, executive director of Care for the Homeless in New York City, spoke next. "We did not want to become an institution; we did not want to become an organization that continues on." He spoke of the ongoing tension between wanting to keep specialized homeless services versus mainstreaming, and the importance of changing the health care system and FQHCs to help them be more effective at serving homeless populations. He's come around to wanting to do both, but he tends now to work more on mainstreaming changes. "Health Care for the Homeless is a distinct service, a specialized service, serving a distinct population with specialized needs. To what extent should we continue to enhance our specialization, or should we try to make sure that homeless people are served by the mainstream health center?" Mr. Watts has

come to the conclusion that HCH should do both. He also spoke of joint programs between hospitals and HCH programs, especially programs trying to address the problem of patients with frequent emergency department visits, and also medical respite which was “innovated as a model through HCH.” He pointed out that mainstream health care systems are seeing the need for this through the ACA as a way to decrease unnecessary hospitalizations and repeat emergency department visits. Watts concluded with:

“Are we improving the health of the homeless?” is a perverse question. It is like asking, “Are we improving the health of people in human trafficking?” I don’t know if we’re improving the health of the homeless population as a whole. The big thing is SDH (social determinants of health). Until we can make a difference in SDH, including housing, we can’t really make a dent in their health. We’ve come a long ways. We’ve helped to move the health care system. But we have unfinished work to do. It’s good to reflect on the past, how we’ve moved the needle. But we need to focus on people trapped in homelessness and how to end their captivity.

Heidi Nelson, chief executive officer of Duffy Health Center on Cape Cod, spoke of how Duffy was funded in the second wave of HCH in the early 2000s. She talked of seeing herself as “a mainstream provider, a hospital administrator” and that she found herself working in a setting where “everyone was a doctor or nurse or social worker or had gone to seminary but decided not to be a minister—or had been a priest—they all had a grassrootsy feel.” She highlighted the fact that “HCH is at the nexus of many, many programs and systems: mental health, substances, homelessness, HIV/AIDS, housing, refugee, veterans. There are so many different meetings and it is so important to be at all these tables.” She also spoke of the Treatment for Homeless Persons (THP) grant through SAMHSA. “We started that program—the National HCH Council—started it.” In terms of teaching the mainstream how to care for homeless people, she said it is “‘Pie in the sky’ thinking we’d teach them and then we wouldn’t need to teach them anymore—it isn’t true. We try to bring them into the big house of HCH. We need to stand up and say ‘you aren’t doing it right, but in a really nice way.’”

At the conclusion of the panel presentation for this section of the HCH Pioneers session, John Lozier stated that “something we have not spoken to, perhaps just lip service, is the role of consumers in our work. That’s an important piece I don’t want us to overlook.” Then he opened it up for anyone in the room to speak.

Mark Rabiner, formerly with Dr. Brickner’s Department of Community Medicine at St. Vincent’s Hospital, talked about the evolution of the model of care. “The HCH model, which is outreach-oriented primary care delivered by teams, is not really a health care model. And I think that is one of the factors of what we do in Health Care for the Homeless. We have this utopia of what we want, but we tend to forget that we have to fit within the reality of what health care is. The vision is health care for everyone. And the value is excellent care given with dignity and compassion.”

Michael Cousineau, a professor at the USC Krech School of Medicine and the founding director of Homeless Healthcare-Los Angeles, addressed the changes in our health care system, including the focus on the patient-centered medical home. “There’s a lot of money being made on things we’ve been doing for 30 years.” The challenge to the group is “how the HCH model should be changed to fit into the new system with its emphasis on health care outcomes, of proving that what we do is making a difference. We’re not going to be exempted from this. But I think we’re in a position of saying, ‘Well, what are the outcomes that are appropriate for this population?’ I think we have to be in the front of that argument as advocates to try to put that argument forward—it’s got to include housing, social services, employment—things that aren’t getting discussed very much when we talk about outcomes in health care.” In a follow-up conversation I had with Cousineau, he spoke of how the HCH program was supposed to have a beginning and an end. “I feel like we’re still putting Band-Aids on this problem—I’ve never seen it this bad.” He also pointed out that the St. Vincent’s HCH model that Brickner and others started was very much hospital-based care and outreach, while the HCH model developed in L.A. and some other cities was more community-based.

Marion Scott, former director of the HCH project of the Harris County, Texas, Hospital District, spoke of the creative and innovative use of resources and the importance of networking:

What we had back then—it was remarkable what we did with what we had. Early on we talked about rescuing and fixing—that is what we did. Availability does not equal accessibility for homeless people. We’ve moved now to empowering consumers and liberating providers—that allows them to do what they need to do to provide the total health care—including the social determinants of health to provide a continuum of care. The challenges of moving from silo to team-based care. There are still challenges, but we can see improvements that come perhaps from the HCH model. Continuum of care and care coordination has become important. Networking is a strength of HCH. There’s always been that element. We can call someone across the country—tell these stories from one program to another. We use the HCH central expertise. The importance of mentors, supportive family members in a way for our work, has to continue, that spirit has to continue, telling stories from one program to the other, and using available HCH expertise is going to be important as new programs begin to evolve and operate.

Stephen Kertesz, a physician formerly of Boston, now from Birmingham, pointed out that the VA has embraced the HCH group wisdom with their H-PACTs (Homeless Patient Aligned Care Teams). He also spoke of legislative threats to the future of HCH. “The 1996 consolidation legislation of community health clinics doesn’t include specific wording protecting homeless services. In 330(h) there is no mandated care for the homeless.” He’s watched the dismantling of homeless health care services in Birmingham, and he’s witnessed firsthand the effects of that on the care of people without homes. “Doing the good work that you do is 100% optional. And I don’t think that that should be our future.” In a follow-up e-mail and telephone conversation that I had with him, Kertesz addressed the problems that have recently surfaced in terms of the Birmingham HCH. He wrote:



Once you read what we have experienced in Birmingham (and the lessons I derived from talking with several people who have observed the HCH program over decades), you'll see that I feel like homeless persons are at high risk of being abandoned by the very grant-funded program intended to help them. Whether HCH grantees truly seek to serve homeless people by tailoring their service model and maximizing care options for people who are homeless, or whether they minimize exposure to the population by providing them with poorly-resourced care, is simply a matter of conscience of the agency.

In my telephone conversation with him, Kertesz voiced a concern that people feel that there is no longer any problem to fix, that “the bad man is gone,” and that no one is acknowledging that there are serious systemic issues in terms of oversight of HCH programs, and that quality, compassionate Health Care for the Homeless is being eroded. The other thing that he mentioned towards the end of our conversation was that the people who tend to be in the inner circle of the NHCHC can tend to reinforce the status quo of interests and direction of the Council, which serves to alienate many other people who work within HCH across the country.

Travis Baggett, a physician from Boston HCH Program, stated, “Our understanding of addiction was much different 30-40 years ago than it is now. We saw it as more of a character problem when we started out. Now there’s an evolution in our understanding of the biological realities of addiction. We’ve been at the forefront of this—we can be leaders of the move to integrate addiction services into what we do.”

Since no one in the Pioneers session specifically spoke to the role of consumers in the work of HCH, I sought out additional input from consumers who participated in the HCH Conference and Policy Symposium. From a conversation I had with Willie J. Mackey, CAB<sup>35</sup> member from Palo Alto, CA, he said, “Be sure to tell people that homeless folk need jobs, employment with regular health insurance—not just public assistance—that makes you lazy and it eats your self-esteem away. All these people [sweeping his hands towards the registration table and some of the Council members standing around] mean well. They’re compassionate people, but it’s all ‘over there at a distance, and I don’t really want to know or listen to what it’s like to be homeless.’”

Art Rios, from Portland, Oregon, who received a Consumer Advocate Award, said in his acceptance speech, “Some of the biggest support I have is from the other CAB members. He read a powerful poem, “Hello, My Name is Homeless,” that he wrote. I contacted him after the conference to ask if he would be willing to send me the full poem and to allow me to include it in this report, and he agreed. Here is the full text of the poem:

Hello my name is Homeless  
by Art Rios, Sr.

How did I get this name? it could be from many reasons

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<sup>35</sup> A CAB is a Consumer Advisory Board, a mechanism that numerous HCH grantees use to provide consumer input into agency governance.

Addiction, mental illness, poverty, poor education, medical problems, criminal history,  
lost wages, lost job  
Hello my name is Homeless  
No shower, no food stamps, no money, no shelter, no blankets, no self respect for my  
self, because I can do better.  
Hello my name is Homeless  
But I will sleep on the sidewalk tonight because I know I have the power to get up  
tomorrow and do it all over again.  
Hello my name is Homeless.

In a conversation I had with Amy Grassetto, a consumer from Worcester, she applauded the work of John Lozier and the Council in working towards inclusiveness of consumers in leadership roles. She states, "Over the 12 years I've been involved, I've seen that grow in importance steadily and from everything I hear from the different committees, it seems to be a strong focus. There was a time that there were no consumers on Council Committees or on the Council's Board of Directors. That has completely changed." She also pointed to NCAB involvement in research, such as a recent study on violence published in a journal.<sup>36</sup>

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<sup>36</sup> Molly Meinbresse et al., "Exploring the Experiences of Violence Among Individuals Who Are Homeless Using a Consumer-Led Approach," *Violence and Victims* 29, no. 1 (February 1, 2014): 122–36, doi:10.1891/0886-6708.VV-D-12-00069.

## Part Four: Ongoing Work

Homelessness is likely to persist for the foreseeable future, and people without homes will need health care. The key questions posed to the presenters and participants of the HCH Pioneers Session were: In an era of expanding health insurance coverage and the broader adoption of evidence-based practices such as integrated, trauma-informed care teams, what is the ongoing role for HCH projects? How must the HCH model evolve? How can HCH help prevent and end homelessness? What is the mandate for HCH leaders moving forward?

Kevin Lindamood, president and CEO of Baltimore HCH, started off this section of the Pioneers Session by remembering when he started work there as a Jesuit Volunteer in 1993. “I got to work with this rather interesting guy named Jeff Singer. Jeff wrote the *HCH Mobilizer*, and in the faxed versions he embedded secret messages.” Lindamood left to go to graduate school and work in Detroit, and by the time he came back to Baltimore Jeff Singer had become the CEO, “which meant he could no longer be the Council’s policy person, which is what I think he secretly wanted to still be.” Bernie Sanders was a speaker at the National HCH Conference that year. “We were debating who gets money, who doesn’t get money from Comic Relief. Debating membership. Debating an anti-Iraq War resolution—the link between military spending and homelessness.”

Lindamood went on to say:

You find your next chapter in what you’ve already written. There are seeds in our history for what our future is and needs to be. In terms of the evolution of our systems, our goal was to put ourselves out of business—to train other health care providers to take care of our patients. That hasn’t happened. We’re not really influencing those around us. We’ve developed really good systems to treat people who are currently experiencing homelessness. One of the seeds I’ve seen came from Father Vince Keane—my spiritual advisor—and Dr. Goetchus—who’s at Unity, ahead of many of us in HCH programs who decided to take what was good about that model and incorporate a broader network of CHCs that are serving people who are vulnerable, people who are low income, people on the margins who may experience homelessness. As Bob Taube told me when we were doing our strategic planning back in 2012, we’ve become less concerned about whether or not someone arbitrarily had a place to stay last night—we’re concerned with people on the edge, people on the margins. That becomes controversial because we’re concerned we’re going to lose our focus on the most vulnerable. But I think in our future we need to be wrestling with that: how do we improve systems of care for vulnerable people? And use that to influence broader systems and not maintain this homeless-only focus when we know that homelessness is just a symptom of a far broader problem.

He concluded by stating that there are three questions to ask moving forward:

- 1) How do we build sustainable organizations? Preparing for evolving payment models? This is a critical phase as our country wrestles with this;

2) How do we build sustainable organizations that can advance deeper justice work and shape the communities around us? The importance of a living wage for our workers. Investing in our people in the long-term, so that they themselves don't experience homelessness. The importance of consumers in deep and meaningful ways—to benefit from actual lived experiences;

3) How is the policy environment we live and work in limiting us from doing the policy work we need to do? No one is acknowledging that the contemporary homelessness problem came from disinvestment in housing resources. We're living in a toxic policy environment. How might the policy environment that we're living in, that sustains us, that gives us the resources to do our work, how might that very environment be limiting our work in advocacy for the policy environment we need?

I think we need to reject the narrative that as a country we are ending homelessness. It's a narrative that many of us might be participating in. It's a narrative that we're hearing from a lot of our partners, from federal funders—but we have to reject that narrative, because we simply know it's not accurate. I applaud HUD for finally recognizing 30 years later that housing is the solution to homelessness. We have to acknowledge that it is the disinvestment in housing that caused modern-day homelessness in the first place, and homelessness is still going to be created as fast as we can stop it.

Jenny Metzler, executive director of Albuquerque HCH, spoke of how 1995 was her first HCH conference. “I cut my teeth on your stories, and I offer them up to new people. The big, righteous, smart embrace that is the National HCH Council. There's a compendium of questions we need to ask. And how do we have these critical conversations? We need to ask ourselves the hard questions of what we aren't doing well. Where we need to change. What we've done well. The inclusion of consumers, such as through the CAB leadership, but ways to bring us together even better.” Metzler went on to say, “We're shaped by the health care environment. We can—and have also helped shape the health care environment. We've been a resource for the ACA. Do we shape the landscape, do we become the landscape? Did we want to just sit back and wait for them to fail? To say, ‘I told you so’? That's an indulgent setup to re-traumatize consumers. We've invited ourselves to the planning tables. We know we're a resource. There's strength in that identity. Pick whatever social justice issue you care about—HCH touches on it.”

Barbara DiPietro, Senior Director of Policy for both the Council and Baltimore HCH, spoke next and pointed out that she has been working with HCH for seven years, but worked 10 years before that on homeless policy. She was “drawn in by the big personalities in the cold State House—people like Kevin Lindamood and Jeff Singer. We're at the crossroads of so many systems. I'm aware of how many allies we have. All these people we've touched by our values and clear dedication to our work.” She spoke of the Medicaid work, of finding new partners through that, through health reform, which is “incremental change and not getting us where we need to go perhaps but people with power, influence, and money—they also get it now—like housing is health care—we're not the only ones saying that anymore.” She is encouraged by the new partners in the work “who really want to get it. They're looking for creative ways within a

really complicated system, to get there. That's a leverage point, and I'm excited about these new relationships."

DiPietro went on to acknowledge that "we're still working within a toxic policy environment. At the local, state, and federal levels, there's a disinvestment in housing and social support." She advocates the use of motivational interviewing in policy work, and for "expanding our allies—bring them in because they may be heard with a different ear. ... The 51% solution<sup>37</sup> is a core of who we are." She also asked, "How do we keep our values within the changing environment?" and addressed how people working within HCH never thought of themselves as mainstream. "We were scrappy, into bending rules and not asking for permission." She also asked, "What does becoming mainstream mean? We wanted Medicaid expansion—it's a good thing. We got what we wanted, although not for everyone. We wanted to get our patients off the street and get them in the mainstream. There's billing and coding—boring stuff—playing by the mainstream rules. And when we're asked to demonstrate the value of what we do, we're indignant that we have to do outcomes data and evaluation. ... We know what we do works. The challenge is proving it through the data. ... We have love and compassion. That's an envy to a lot of folks. We can leverage that value and respect."

She went on to call attention to the reality of people living and working within non-Medicaid expansion states. "How do we continue to support each other? I worry about the continuity of our community because we forget that not everyone is working with new resources. There are 19 states that still haven't said 'yes' to Medicaid. How do we continue to support each other to get to a 'yes' there—so that we continue to work on an equal platform?"

Gary Cobb, a Community Outreach Coordinator for Central City Concern in Portland, Oregon, was the last panelist to speak. He talked about his work with the "quad morbidity of TBI (traumatic brain injury), addictions, mental illness, and 'houselessness.'" He spoke of the importance of charting, of documenting TBI. He saw hospital charts of patients with "drug seeker" and "gang banger" written on them, and how stigmatizing these terms are, and that they are labels that follow patients and negatively impact their health care. "We can be instruments in how charting happens in large systems. Teams should have peer providers." Portland's teams consist of peer providers, mental health professionals, addiction specialists, nurses, and housing/employment/benefits specialists. "It sounds like a big team, but it's important to have these wraparound types of support teams." He concluded by stating that, "Care needs to happen in a very non-judgmental way." He developed this through motivational interviewing techniques and trauma-informed care training, as well as "reflecting on my own experience. How to provide trauma-informed care and establish boundaries—there's a fine line there, but it can be done."

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<sup>37</sup> The 51% solution is a stated intention of the NHCHC to devote 51% of its advocacy efforts to addressing systemic causes of homelessness, rather than bolstering services that address the effects of homelessness.

## Conclusion

As Kevin Lindamood stated, “You find your next chapter in what you’ve already written. There are seeds in our history for what our future is and needs to be. In terms of the evolution of our systems, our goal was to put ourselves out of business—to train other health care providers to take care of our patients. That hasn’t happened.”

The HCH movement did not develop within a vacuum, but rather grew out of other social justice and health care movements in the U.S. in the 1960s and 1970s. HCH has direct ties with the organizers and policymakers involved in the CHC movement. Key figures in the CHC movement were directly influenced by the World Health Organization’s community-based primary care model. Teasing out the specific tensions and differences between the mission, values, and activities of HCH vis-à-vis CHC would be a fruitful future endeavor.

It is interesting to note that the roots of the CHC movement were mainly within a Southern rural, impoverished community that lacked any organized health care services, while the roots of HCH were within a large metropolitan, mission-focused hospital system. Also, the CHC movement has garnered considerable bipartisan support over the past 20 years, while sub-population focused programs like HCH have also grown, but mainly from being folded into the CHC model of care.

There was considerable discussion of the role of HCH within the rapidly changing U.S. health care system. Pioneers pointed out that there was a growing chasm of opportunity and experience between HCH programs in Medicaid expansion states versus those in non-Medicaid expansion states. Many speakers highlighted key aspects of HCH that have now been adopted by the larger health care system: 1) team-based care models; 2) provision of comprehensive, wraparound health services; 3) development of medical hospice; 4) outreach programs aimed at reducing unnecessary ED visits and hospitalizations; 5) emphasis on the message that housing is health care; 6) patient-centered medical homes; and, 7) inclusion of motivational interviewing and trauma-informed care.

Points of difference that emerged in the Pioneers Session had to do with whether or not ending homelessness was an explicit goal of the HCH movement from the beginning. Several of the speakers from the original RWJ-Pew HCH demonstration program spoke of being dismayed that 30 years later they still have a job and that the U.S. still has the problem of homelessness. Other speakers responded to this by pointing out that the original RWJ-Pew HCH Program mandate was to help change the overall health care system so that it would be more responsive to the needs of vulnerable populations, including those experiencing homelessness—and that while HCH has done a good job with that, there is still considerable work to be done. Related to this was a thread throughout the discussion of the role of HCH in continuing to advocate for a single-payer health care system, with Pioneers pointing to the fact that such a health care justice perspective had been an original part of the HCH mission and policy work. As Wright and Weber wrote in their *Homelessness and Health* report 30 years ago, “Better access to health care for homeless Americans is only the first step in what one hopes will be a renewed national commitment to quality health care for all, even for the poorest among us.”<sup>38</sup> (p. 159)

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<sup>38</sup> Wright and Weber, *Homelessness and Health*.

## Appendix: Timeline

This timeline presents highlights and historical notes relevant to the development of Health Care for the Homeless (HCH) in the United States, most particularly those of the National HCH Council. It is incomplete: *readers are encouraged to send corrections or additions to [executivedirector@nhchc.org](mailto:executivedirector@nhchc.org).*

The “Council President” column indicates years in which individuals’ presidencies ended. The “Sample and Notable Publications” column indicates authors for items that were *not* published by the National HCH Council; we are grateful to the many authors who have advanced the work of the Council. Most of these items, with appropriate credits, can be found at [www.nhchc.org](http://www.nhchc.org).

Year	Key Developments	National HCH Conference	Council President	Sample and Notable Publications
1983	RWJF/Pew/USCOM issue HCH Demonstration Program Call for Proposals			
1984	19 Demonstration program grantees announced; Program Office is St. Vincent’s Hospital. (NYC) Department of Community Medicine, Philip Brickner, MD, Director			
1985	RWJF Program Meeting in Washington, D.C., results in creation of Project Directors’ Council		Hope Gleicher/ John Lozier	Brickner, <i>The Health Care of Homeless People</i>
1986	Comic Relief first televent, chooses HCH as “designated recipient”; adds four cities to original 19  RWJF Program meeting in Los Angeles, CA  Early Homeless Persons’ Memorial Day events		Hope Gleicher/ John Lozier	
1987	Stewart B. McKinney Homeless Assistance Act replicates demonstration program  RWJF Program meeting in Nashville, TN			
1988	119 original McKinney Act grants by HRSA  RWJF final Program meeting in San Antonio, TX  Project Directors Council becomes National HCH Council			Institute of Medicine, <i>Homelessness, Health and Human Needs</i>

1989	St. Vincent's Hospital HCH project becomes 24th Comic Relief recipient	1st National HCH Conference, organized by Natl. Assn. of Community Health Centers, Washington, D.C.		Wright, <i>Address Unknown: The Homeless in America</i>
1990	John Lozier hired as first Council staff person			Brickner, <i>Under the Safety Net: The Health and Social Welfare of the Homeless in the United States</i>
1991	First National HCH Council membership meeting (YMCA of the Rockies, Estes Park, CO) adopts Statement of Mission & Principles  Polly Bullock hired as second Council staff person  Council incorporates as 501(c)(3) in Tennessee			O'Connell and Groth, eds., <i>The Manual of Common Communicable Diseases in Shelters</i>
1992	Membership Standards adopted  Membership meeting in Napa Valley, CA	Washington, D.C., Louie Anderson entertains	Joan Haynes/ Michael Cousineau	Wood, <i>Delivering Health Care to Homeless Persons</i>  <i>Tuberculosis 101</i>
1993	HRSA contracts with the Council to survey HCH clinicians regarding their support needs  Council contracts with HCH Baltimore for HCH Mobilization Project  Wayne Anderson joins staff as Deputy Director	San Jose, CA, organized by John Snow Inc.  First Policy Symposium is attached to Conference	Susan Neibacher	<i>HCH Mobilizer</i> first issue  <i>Combating Tuberculosis &amp; Homelessness</i>  <i>Health Care and Homelessness: The Policy Context</i> (Symposium proceedings)
1994	HCH Clinicians' Network (CN) organized by Council with HRSA support.  Brenda Proffitt hired as CN Project Director.  CN Steering Committee first meeting, Boston, MA	Nashville, TN	Marsha McMurray-Avila	<i>'Tis a Gift to be Simple: Homelessness, Health Care Reform and the Single Payer Solution</i>



1995	<p>Council contracts with National Coalition for the Homeless (NCH) for Health Policy Analyst</p> <p>CN Statements of Mission &amp; Principles</p>		<p>Lisa Thomas</p>	<p><i>A Bitter Pill: Welfare Reform &amp; the Health of Homeless People</i></p> <p><i>Triage Guidelines</i></p> <p><i>Homelessness, Violence and Public Health</i></p>
1996	<p>Health Center Consolidation Act</p> <p>Tipper Gore funds Mental Health Outreach Fund; Council makes grants to 4 projects</p> <p>Governing Membership meeting: Port Townsend WA</p> <p>Council and CN agree to continue as one organization</p> <p>First CN Membership meeting</p> <p>CN awards program established</p>		<p>Vincent Keane</p>	<p><i>Gore, Picture This</i></p> <p><i>Sample Safety Guidelines in Homeless Health Services Programs</i></p>
1997	<p>Council appoints 2 HCH Ombudspersons to Bureau of Primary Health Care</p> <p>HCH101 training established</p> <p>CN representatives join Council Board of Directors</p> <p>nhchc.org website launched</p>		<p>Heidi Nelson</p>	<p><i>Organizing Health Services for Homeless People</i></p> <p><i>Determining Disability: Simple Strategies for Clinicians</i></p> <p><i>Healing Hands</i> first issue (February)</p>

1998	<p>Comic Relief 8, final televent</p> <p>Governing Membership meeting: Albuquerque, NM</p> <p>Council enters into Cooperative Agreement with HRSA</p> <p>Marsha McMurray-Avila hired; Albuquerque, NM, office of Council established</p> <p>ESG funding from Tennessee DHS establishes TennCare Shelter Enrollment program</p>	<p>St Louis, MO, Neibacher Address: Quentin Young</p>	<p>Jackie Gaines</p>	<p><i>Can Managed Care Work for Homeless People: Guidance for State Medicaid Programs</i></p> <p><i>Searching for the Right Fit: Homelessness and Medicaid Managed Care</i></p> <p><i>Healing Hands: Bridging the Gap: What We Know and Don't Know about Dual Diagnosis</i></p> <p><i>Comments on OSHA proposed standard on Occupational Exposure to Tuberculosis</i></p>
1999	<p>HRSA Program Assistance Letter 99-12: Principles of Practice—A Clinical Resource Guide for HCH Programs</p> <p>Congress creates SAMHSA Grants for the Benefit of Homeless Individuals (GBHI, now CABHI) in response to Council advocacy</p> <p>Governing Membership meeting: Snowbird, UT</p>	<p>Washington, D.C., Neibacher Address: Bernie Sanders</p>	<p>Barbara Conanan</p>	<p><i>Utilization &amp; Costs of Medical Services by Homeless Persons</i></p> <p><i>The Effects of SSI &amp; SSD Benefits Termination as seen in HCH Projects</i></p> <p><i>HIV/AIDS &amp; Homelessness: Recommendations for Clinical Practice &amp; Public Policy</i></p>
2000	<p>Governing Membership meeting: Sebasco Harbor, ME</p> <p>Respite Gathering: Chicago, IL</p>	<p>First HCH101 Pre-Conference Institute</p>	<p>John McKinney</p>	<p><i>Identifying and Responding to Domestic Violence Among Poor and Homeless Women</i></p>
2001	<p>Governing Membership meeting: Nashville, TN</p> <p>National Consumer Advisory Board organized</p> <p>Council participation in Health Disparities Collaboratives</p> <p>Respite Gathering: Boston, MA</p> <p>Jack Geiger, Clinicians' Network 6th Annual Meeting speaker</p>	<p>Washington, D.C.</p>	<p>John McKinney</p>	<p><i>Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled in Medicaid</i></p> <p><i>Healing Hands: Hard to Reach: Rural Homelessness and Health Care</i></p>

2002	Robin Williams fundraiser: Grand Ole Opry Museum	Chicago, IL	Sigrid Olson	<i>Adapting Your Practice: Treatment &amp; Recommendations for Homeless Patients with Diabetes Mellitus</i>  <i>Homeless Children: What Every Health Care Provider Should Know</i>
2003	Governing Membership meeting: San Antonio, TX	Washington, D.C., Neibacher Address: Ralph Nader	John Parvensky	<i>Social Support for Homeless Mothers: Implications for Best Practices and Program Design</i>  <i>Creating and Maintaining A Healthy Work Environment: A Resource Guide for Staff Retreats</i>
2004	Governing Membership meeting: Baltimore, MD  Respite Care Providers Network Becomes Individual Membership Group	New Orleans, LA	Barbara Conanan 2003-2004	<i>Adapting Your Practice: General Recommendations for the Care of Homeless Patients</i>  O'Connell, ed., <i>The Health Care of Homeless Persons: A Manual of Communicable Diseases and Common Problems in Shelters and on the Streets.</i>
2005	Governing Membership meeting: Austin, TX  Respite Care Directory, first edition	Washington, D.C., Neibacher Address: David Himmelstein	Jeff Singer	<i>Shelter Health: A Guide to Effective Practices</i>  <i>Premature Mortality in Homeless Populations: A Review of the Literature</i>
2006		Portland, OR	Jeff Singer	<i>Shelter Health: Essentials of Care for People Living in Shelter</i>  <i>A Research Agenda on Homelessness and Health</i>

2007	Governing Membership meeting: Washington, D.C., at Human Rights Campaign & Hotel Rouge  First Ellen Daily Consumer Advocate Award	Washington, D.C., Neibacher Address: FEANTSA President Robert Aldridge  Congressional briefing	Alan Ainsworth	<i>Documenting Disability: Simple Strategies for Medical Providers</i>  <i>Medical Respite Care for People without Stable Housing</i>
2008	Governing Membership meeting: Nashville, TX	Phoenix, AZ, Neibacher Address: Donna Smith Conference Keynotes: Craig Rennebohm, Lew Feldstein	Eddie Bonin	<i>Traumatic Brain Injury Among Homeless Persons: Etiology, Prevalence and Severity</i>  <i>Defining and Funding the Support in Permanent Supportive Housing</i>  <i>Enfranchising Homeless Clients: A Resource Guide to Voter Registration for Health Care for the Homeless Projects</i>
2009	Governing Membership meeting: Nashville, TN  Regional Training: Milwaukee, WI	Washington, D.C., Neibacher Address: Barney Frank Conference Keynotes: Mary Hurley, John Parvensky	Bob Taube	<i>Defining and Funding the Support in Permanent Supportive Housing</i>  <i>Disaster Planning for People Experiencing Homelessness</i>  <i>Discharge Planning: Exemplary Policies &amp; Practices</i>  <i>Foreclosure to Homelessness: The Forgotten Victims of the Subprime Crisis</i>

2010	<p><i>Opening Doors: Federal Strategic Plan to Prevent and End Homelessness</i></p> <p>Affordable Care Act</p> <p>Governing Membership meeting: Nashville, TN</p> <p>Regional Trainings: Houston, TX; Nashville, TN</p>	<p>San Francisco, CA, Neibacher Address: Jim O'Connell Conference Keynotes: Jim Macrae, Barbara Poppe, Kevin Lindamood</p>	Marion Scott	<p><i>Medicaid Expansion &amp; Health Center Investments: Key Factors, Challenges &amp; Recommendations for HCH Grantees</i></p> <p><i>Creating Healthier Communities: Chronic Disease Prevention Initiatives of Interest to Health Centers</i></p>
2011	<p>Governing Membership meeting: Nashville, TN</p> <p>Nashville fundraisers with Cowboy Jack Clement, Old Crow Medicine Show, et al.</p> <p>Regional Trainings: Albuquerque, NM; Boston, MA; Denver, CO; Detroit, MI</p>	<p>Washington, D.C., Neibacher Address: Linda Kaufman Conference Keynote: Don Berwick</p>	Tom Andrews	<p><i>Community Health Workers in Health Care for the Homeless: A Guide for Administrators</i></p> <p><i>Adapting Your Practice: Recommendations for the Care of Homeless Adults with Chronic Non-Malignant Pain</i></p>
2012	<p>Regional Trainings: Seattle, WA; Orlando, FL; Memphis, TN</p> <p>Region IX HCH Conference: San Diego, CA</p> <p>Council receives first round Health Care Innovation Award to study "Triple Aim" impact of Community Health Workers</p> <p>Governing Membership meeting: Nashville, TN</p>	<p>Kansas City, MO, Neibacher Address: Georges Benjamin</p>	Bob Donovan	<p><i>Pain Management Survey of Health Care for the Homeless Clinicians: Summary of Results</i></p> <p><i>Policy Advisory: Clarification of the 12-Month Rule</i></p> <p><i>Within Reach: Perspectives of Hard-to-Reach Consumers Experiencing Homelessness: Findings from a Consumer Participation Survey</i></p> <p><i>Improving Care Transitions for People Experiencing Homelessness</i></p>

2013	<p>Regional Trainings: Irvine, CA; Chicago, IL; Morristown, NJ; Houston, TX</p> <p>Governing Membership meeting: Nashville, TN</p>	<p>Washington, D.C., Neibacher Address: Bobby Watts Conference Keynotes: Jennifer Ho, Rachel Klein;</p>	Bobby Watts	<p><i>Homeless Children: What Every Health Care Provider Should Know</i></p> <p><i>Teaching Health Centers: A Resource Guide</i></p> <p><i>Supplemental Nutrition Assistance Program: Health Status, Homelessness and Hunger</i></p>
2014	<p>Council receives second Health Care Innovation Award to study “Triple Aim” impact of Medical Respite Care</p> <p>Governing Membership meeting: Nashville, TN</p> <p>Regional Training: Berkeley, CA</p>	<p>New Orleans, LA, Neibacher Address: Bechara Choucair Conference Keynotes: Shaun Donovan and Mark Horvath</p>	Jean Hochron	<p><i>Outreach &amp; Enrollment Quick Guide: Promising Strategies for Engaging the Homeless Population</i></p> <p><i>Adapting Your Practice: Treatment and Recommendations for the Care of Homeless Patients with Opioid Use Disorders</i></p> <p><i>Living and Working in the Coverage Gap: Homeless Health Care in States Yet to Expand Medicaid</i></p>
2015	<p>Governing Membership meeting: Nashville, TN</p> <p>Regional Trainings: New York City, NY; Philadelphia, PA</p>	<p>Washington, D.C., Neibacher Address: T.R. Reid Conference Keynote: Sylvia Burwell</p>	Nic Apostoleris	<p><i>Homeless Care Providers and Rapid HIV Testing</i></p> <p><i>National Homeless Persons' Memorial Day: Organizing Manual</i></p> <p><i>Health and Homelessness among Veterans: Development and Pilot of a Military History Screening Tool</i></p>

2016	Governing Membership meeting: Nashville, TN  Regional Training: Denver, CO; Louisville, KY	Portland, OR, Neibacher Address: Paul Harkaway Conference Keynote: David Satcher	Doreen Fadus	<i>How has the ACA Medicaid Expansion Affected Providers Serving the Homeless Population: Analysis of Coverage, Revenue, and Costs</i>  <i>Hospital Community Benefit Funds: Resources for the HCH Community</i>  <i>Medication-Assisted Treatment: Buprenorphine in the HCH Community</i>
2017			Kevin Lindamood	
2018			Jenny Metzler	

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