December 8, 2021

Anthony Love
Interim Executive Director
U.S. Interagency Council on Homelessness
Federal Center SW, 409 Third Street, SW, Suite 310
Washington, DC 20024

RE: Input on the Federal Strategic Plan to End Homelessness

Dear Mr. Love:

Thank you for the opportunity to provide input on the U.S. Interagency Council on Homelessness' (USICH) Federal Strategic Plan to Prevent and End Homelessness.

The National Health Care for the Homeless Council is a membership organization representing [Health Care for the Homeless](#) (HCH) health centers and other organizations providing health care to people experiencing homelessness (PEH). Our members offer a wide range of services to include comprehensive primary care, mental health and addiction treatment, medical respite care, supportive services in housing, case management, outreach, and health education, regardless of an individual's insurance status or ability to pay. Nationally, 299 HCH programs serve over 900,000 patients in 2,000+ locations across the country. We work every day to help our patients access health care, housing, and other services so they can meet their basic needs and escape homelessness.
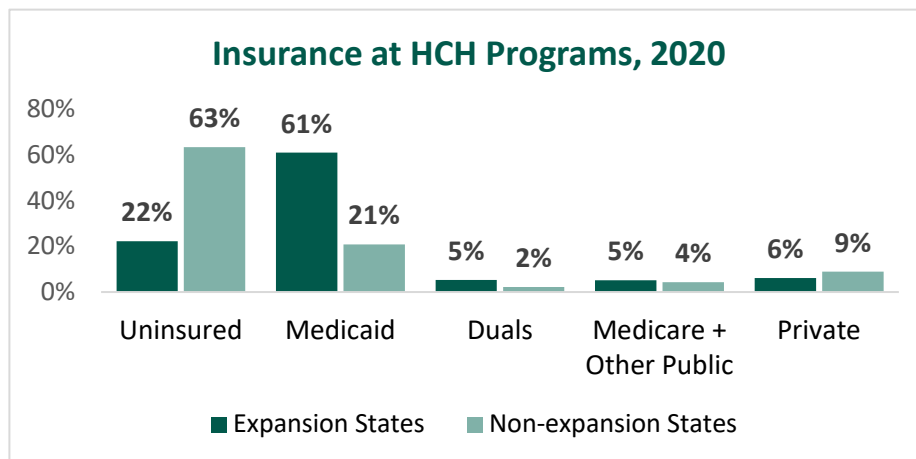
On November 29th staff members at NHCHC and a cohort of our membership representing our clinical, consumer, and policy leadership participated in a listening session with your staff at the USICH. The commentary provided in this letter reflects the feedback shared at the listening session, and adds some additional issues.

What should the federal government's top priorities be?

- **Understanding housing as health care.** The HCH community has long-known that poor health causes homelessness, and that the traumatic experience of

homelessness exacerbates existing health conditions, causes new ones to develop, and contributes to premature mortality. Permanent housing offers the stability needed to seek care, receive services, and gain health and wellness. It serves as the very foundation for health, and remains one of the most effective clinical interventions we can offer our patients as health care providers. For this reason, more Health Care for the Homeless programs have been investing in housing— either as service providers in supportive housing programs and/or as leaders of capital projects. Housing is a core social determinant of health, and is the reason we have been asserting "housing is health care" for over 30 years. Increasing the supply of affordable, accessible, and high-quality housing is critical to preventing and ending homelessness.

- **Providing comprehensive and affordable health coverage to all.** Providing health coverage to everyone by expanding both Medicaid and Medicare coverage (as well as the services these programs provide) is greatly needed and long-overdue. Insurance coverage for PEH varies widely (see graph below). While many PEH are *eligible* for Medicaid in states that expanded coverage, onerous insurance requirements make *obtaining and retaining* coverage more difficult. About two-thirds of PEH are uninsured in states that did not expand Medicaid. Recently proposed expansions in Congress—such as lowering the Medicare eligibility age to 60—would benefit the nearly 80,000 patients between the ages of 60-64 in the HCH community. Providing a coverage option for people in the 12 states that did not expand Medicaid would improve access to care for 120,000 patients in the HCH community who currently remain uninsured. Finally, there needs to be a concerted effort to offer coverage and care to people who are undocumented, or otherwise ineligible for existing programs. These expansions would be a positive step towards addressing many inequities of the health care system, however gaps and inefficiencies in the system would still remain. Ultimately, the federal government should support reforming our health system to one that is more equitable and easier to manage through a "Medicare for All" approach.

Insurance at HCH Programs, 2020

	Uninsured	Medicaid	Duals	Medicare + Other Public	Private
Expansion States	22%	61%	5%	5%	6%
Non-expansion States	63%	21%	2%	4%	9%

■ Expansion States   ■ Non-expansion States

- **Expanding Medical Respite Care in all communities.** There is a critical need for medical respite care (MRC), which offers acute and post-acute medical care for PEH who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital. MRC reduces hospital lengths of stay and re-admissions, bridges the gap between a hospital and a home, and improves health outcomes. Community responses to COVID-19, often in the form of delivering services to PEH in non-congregate Isolation and Quarantine settings as well as protective housing, was an adapted use of the MRC model of care. Yet, MRC programs do not have a dedicated funding source in most communities and would benefit from the sustainability available through Medicaid.

- **Championing the expansion of harm reduction-based substance use disorder treatment.** Consistent with the HCH approach to care, harm reduction strategies offer a lower barrier, more holistic approach to providing health care services. To reduce the catastrophic level of overdose deaths, a stronger federal response to harm reduction approaches is critically needed. While the Biden Administration recently announced that harm reduction is a core part of its overdose prevention strategy, more needs to be done to promote Medication-Assisted Treatment and remove federal (and local) barriers to syringe services programs. Further, the Biden Administration has not endorsed Supervised Consumption Sites, but now has the opportunity to do so given developments in New York City.

- **Bringing to scale the services needed for supportive housing.** Supportive housing projects continue to be "pilot" programs that are individually negotiated, operate at a small "demonstration" scale, and are only approved for several years at a time, which makes sustainability and planning more difficult. It is beyond time to systematize how services and housing are combined, such as incorporating service formulas along with housing vouchers.

- **Penalizing localities for criminalizing homelessness.** The criminalization of PEH has a direct impact on health and well-being. Arrests (or the threat of arrest) and constant police harassment only serve to compound an individual's trauma and make it much more difficult for service providers to deliver needed care and build trust with vulnerable people (see more below on encampment sweeps). The federal government must prioritize penalizing localities that criminalize homelessness, as opposed to just releasing guidelines and recommendations that have no enforcement mechanism and are routinely ignored by local officials.

- **Prioritizing permanent housing and improving shelters:** While the focus of our comments remains on health care—we must emphasize the ongoing, critical need to prioritize permanent housing for PEH. At the same time, we also recognize the need to improve shelter experiences as part of a crisis response system so they offer more dignity. An important component of an effective shelter is the connection to services, to include health care. Promoting shelter standards of care (such as the

model in Chicago) would improve shelter services and engage more vulnerable people in care.

What are the biggest barriers in your community?

- **The pervasiveness of encampment sweeps.** Encampment sweeps have a harmful impact on health outcomes and the provision of health care/support services. Sweeps of encampments and other efforts to "move people along" result in a loss of medications, identification papers, and medical equipment and often sever trust between the patient and provider. Clinicians in the HCH Community report that after an encampment is swept, they are unable to locate those patients they were regularly treating, which causes dangerous and unnecessary interruptions in care. Often, these HCH clinicians are providing vital care to vulnerable people who will not otherwise seek help but who desperately need medical and behavioral health attention.

- **Complicated health care systems that are difficult for patients and providers to navigate**. Lack of access to appropriate medical care and benefits make it extremely difficult to provide timely and adequate care to PEH. Just a few of these limitations include:

  - Complicated insurance-based systems with eligibility re-determinations, high "churn," and little continuity of care
  - Inadequate provider networks and reimbursements
  - Lack of high-quality, residential behavioral health care
  - Lack of admission to appropriate levels of care
  - Burdensome administrative delays in care, such as prior authorizations
  - Inadequate benefits, such as lack of dental care
  - Approaches such as "pay for performance" and "value-based care" that don't translate well for high-need patient populations

  As mentioned previously, a Medicare-for-All health care system would eliminate most, if not all, of these challenges.

- **Lack of integrated health care and homeless services systems.** Limitations of the "coordinated entry" process and the lack of health care information in the housing determination process delay permanent housing opportunities and leave many waiting years for housing opportunities. In addition, information sharing between HMIS systems, public health systems, and health care systems is usually quite difficult.

- **Stigma and vast public misunderstanding of the causes and solutions to homelessness.** The pervasive myth that people chose to be homeless is toxic, and

makes it difficult to engage policymakers in social justice reforms. Communities instead focus on "quick fixes" (encampment sweeps) instead of the solutions we know will end homelessness (permanent housing coupled with appropriate services). There is a broad need to decrease stereotypes and educate the public (especially policymakers) about the solutions truly needed to build a sufficient supply of affordable housing and end homelessness.

How can the federal government more effectively center racial equity and support equitable access at the local level?

- **Speak more explicitly about racism.** The over-representation of Black people (and other people of color, to include Latinx and Indigenous populations) in homeless populations is directly the result of intentional public policies and not due to individual failures. The federal government should take a much more aggressive stance to hold states and local jurisdictions accountable for housing discrimination and police abuses, and should actively advance and/or endorse reparations policies to impacted communities.

- **Speak more explicitly about housing and health care as human rights—for everyone.** The federal government should play a key role in promoting both housing and health care as human rights. It should also fine-tune its own messaging to carefully avoid a "worthy v. unworthy" narrative about who "deserves" housing or health care. Homelessness is unacceptable for anyone, and no "category" of homelessness should be prioritized over another (e.g., families v. individuals, veterans v. non-veterans, etc.).

- **Promote single-payer because it is the anti-racist choice.** To quote Dr. Ibram X. Kendi: *"Anti-racist policy is any measure that reduces racial inequity and creates racial equity. The Affordable Care Act reduced the gap in insurance rates which means the Affordable Care Act was an anti-racist way to go. Now when you compare single-payer to the Affordable Care Act, it is a different conversation. To not do single-payer is to maintain disparities in health insurance. **That makes the single-payer option the anti-racist policy."***

What lessons have you learned during the COVID pandemic about how housing, health, and supportive services systems can best respond?

- **The importance of Medical Respite Care (MRC) and access to non-congregate facilities.** As mentioned above, in response to COVID-19, many communities established Alternate Care Sites for people experiencing homelessness. Many of

these sites [mimic the existing model of MRC](#). HCH providers report seeing patients flourish in non-congregate settings due to the greater dignity, increased privacy, and access to services they offer. Some PEH understandably do not stay in shelters because they are chaotic and often unpleasant places. COVID-19 responses rapidly increased non-congregate spaces, which clearly illustrated how improvements in shelter and service provisions can better stabilize people with significant health care conditions.

- **The need to increase support for street medicine.** Providers in the HCH Community report great success with street medicine during the COVID-19 pandemic. Street medicine has been especially beneficial for patients living in encampments who often will not seek care due to a lack of trust with the medical system and/or limited mobility. Similar to MRC programs, widely variant Medicaid programs and administrative barriers often inhibit the ability to provide street medicine, yet it is a necessary and effective component of reaching PEH to provide care.

- **The need to significantly invest in public health.** The pandemic revealed the importance of a strong public health response during an emergency, and the value of our public health partners in leading effective solutions to protect PEH. Unfortunately, the pandemic also revealed the [significant disinvestment in public health](#) over the past decades, leaving some communities with little to no infrastructure to respond. The nation must rebuild its public health systems so that communities have the capacity, expertise, and resources needed to take proactive, effective actions in the face of health threats.

The HCH Community identified [five lessons learned during COVID-19](#): participate in community partnerships & engage trusted messengers, integrate health care & support services, provide virtual care/telehealth, advance racial equity, and advocate for change.

Is there anything else you wish to add?

- **Aging population.** Members of the HCH Community regularly raise concerns about the increase in the numbers of elderly seniors they see in clinics, shelters, and MRC programs. Older adults, especially those experiencing homelessness, have health issues that are often complicated by decades of trauma and a lack of proper care. Major reforms (such as those recommended in this letter) are needed immediately to ensure there is infrastructure to care for these individuals.

- **Homeless Mortality.** There is no national review or standardized data collection for homeless mortality, and thus it is difficult to better understand how homelessness is killing people. Some communities have developed their own local reviews of homeless mortality to determine how many people without homes are lost each

year, what caused these deaths, and what specific interventions can prevent additional deaths in the future. We know that people experiencing homelessness are likely overrepresented in opioid overdose deaths and COVID-19 deaths, yet the extent of the overrepresentation is not known. In 2020, NHCHC released a [Homeless Mortality Tool Kit](#), created by members of the [Homeless Mortality Data Workgroup](#). The USICH could help promote more systematic data collection on mortality and raise the issue of homeless deaths as a national crisis similar to the opioid epidemic (given that both are avoidable crises).

Preventing and ending homelessness will take major, structural policy changes at the federal and local level. Incremental changes will not achieve this goal. Thank you for the opportunity to submit feedback as you develop the next federal strategic plan to end homelessness. Please do not hesitate to reach out to us for more information on any of these topics. I can be reached at bdipietro@nhchc.org.

Sincerely,

Barbara DiPietro, Ph.D.
Senior Director of Policy