

Homeless
VA

Facsimile Cover Sheet

**Department of Veterans Affairs
Coordinator
VA Homeless Programs**

To: Mary Smith, Associate Director

Fax No: 202.456.7431

From: Pete Dougherty

✓done
Put in Pete
Dougherty's
changes
on Saturday
10-03-98

**Fax No: 202-273-9472
Voice No: 202-273-5774**

Transmitting this cover page plus (8) pages.

**Comments: Mary -- hope you can read my chicken scratch.
If you have any questions please call. If you'd like to send me
the copy with the corrections, I promise to review ASAP. Sorry
for the delay.**

DRAFT

This is a very rough draft of an initiative that we received from the VA to address more fully the needs of homeless veterans. According to the Federal Plan to Break the Cycle of Homelessness, there are as many as 600,000 homeless persons on any given night. The National Coalition of Homeless Veterans estimates that there are 275,000 homeless veterans on any given night. They estimate that there would be double that number over the course of a year. This initiative would reach 50,000 additional veterans per year for a total of -----

\$184.5 mil
over 3 years

I. FEDERAL PROGRAMS TO ADDRESS HOMELESSNESS

The McKinney Act, which was enacted in 1987, is the major federal legislation addressing homelessness. McKinney funding for targeted homeless assistance has increased dramatically, from \$490 million in FY 1987 to ----- in FY 1998. The McKinney Act grant assistance programs fund activities that provide homeless men, women, and children, with emergency food and shelter, surplus goods and property, transitional housing, some supportive housing, primary health-care services, mental health care, alcohol and drug abuse treatment, education, and job training. HUD currently administers nearly 70 percent check of the McKinney Act funds, or spends approximately \$1 billion on homelessness per year (OMB).

The total VA budget for Homeless is \$90 million per year check. There are three major VA programs that work with the homeless:

1. Grant per diem. This program gives grants to community-based organizations to acquire transitional beds. In FY 94 through FY 97, 101 grants were awarded to 84 non-profit or state or local government agencies in 36 states. There is \$5 million per year for new grants. Pays up to \$16/day for ongoing operational costs.
2. Homeless Chronically Mentally Ill Veterans Program. The HCMI program places homeless veterans needing more intensive treatment into one of its roughly 125 - 200 contracted community-based facilities. The program serves over 19,000 - 20,000 homeless veterans per year, with over 3,000 receiving residential treatment. The average cost per day is \$38.
3. Domiciliary Care. Treatment takes place in approximately 1500 dedicated beds at VA medical center domiciliaries.

SPECIFIC PROPOSAL FROM VETERANS AFFAIRS

A. Increase Funding for VA's Homeless Grant and Per Diem Program

Background

This program allows for the provision of grants and per diem payments to assist public and non-profit organizations establish and operate new supportive housing and service centers for homeless veterans. Since the first round of funding in 1994, the VA has awarded 101 grants to 84 community agencies in 36 states and the District of Columbia. Total VA funding for these projects was over \$21 million, or approximately \$5 million annually. When these projects are completed, approximately 1,700 new community-based beds will be available for homeless veterans. With the current round of funding that number is expected to grow to 2,200 beds in the future.

1. Increase funding for new grants by \$7 million. This additional \$7 million, added to the \$5 million already funded by the VA for a total of \$12 million, would create approximately 1000-5000 new beds annually with services for homeless veterans. *at least 75% of the beds would be for VA-eligible persons. veterans*
2. Increase per diem funding by \$7 million. This funding is for ongoing operations, and it subsidizes providers, paying no more than one-half of their operating costs. Currently, approximately ~~5,500~~ *3,200* veterans receive services from existing programs. ~~Check: [it costs approximately \$6,000 per year to pay per diem to service providers on an annualized basis. This would pay for approximately 2,250 different veterans receiving care from VA. Check 2250 x 6000 = 13,500,000]~~ *paid for by VA 5,000 with new grant fund cab* Within 2 years, more 10,000 homeless veterans annually could be completing treatment in VA quality-approved community setting operated by nonprofit entities, Native American tribes, or state and local governments. *3.2 million*
3. Provide \$5 million in new per diem funding. P.L. 102-590 that created the Homeless Grant and Per Diem Program did not require an entity to receive a grant in order to be eligible for per diem; however, VA, by regulation and in an attempt to protect its grant investment, has limited per diem to programs that receive a grant. This would help to pay for care of approximately 2000 veterans in non-grantee, yet VA-approved, community-based programs.

Part A summary: \$24 million in funding (\$19 million if existing \$5 million not counted) for treatment and services for more than 5,000 veterans annually with service provided in community-based settings.

B. Increase Funding for Dedicated Staff and Contract Care Dollars at Each VA Medical Center.

Background

There are approximately ~~121~~ *150* VA Medical Centers across the country. At ~~81~~ *64* of these centers, there are dedicated staff with contract dollars to buy services from community service providers for homeless veterans. At those sites approximately ~~75~~ *4,500* veterans are serviced at each site for an approximate total of ~~4,500~~ *4,500* veterans. At 10 additional medical centers there are dedicated staff

without contract care money.

- 150/0000
250
30000000
10,200
1. Increase funding by \$27 million so that each of the approximately 471 VA Medical Centers in the country will have dedicated staff and contract dollars to address the needs of homeless veterans. If this proposal is initiated with an average of 1.5 FTE per site for a cost of \$100,000 annually and contract care dollars for residential contract care and transportation for a cost of \$150,000 per site annually, there would be, for the first time, a comprehensive nationwide system to address the needs of homeless veterans by having dedicated staff at each VA Medical Center. Costs are approximately \$250,000 annually per site. Check (This would allow as many as 6,000 new veterans to be treated in community residential settings. A total of up to 12,000 homeless veterans could be treated annually under this program by expanding the existing program) New: Dedicated staff at all VA Medical Centers would mean that more than 100,000 veterans could be seen and interviewed by VA clinicians in outreach activities over a three-year period. The additional staff (150 FTE) would, on average spend half their time on outreach activities thereby seeing an additional 10,200 veterans each year or more than 30,000 veterans over a three-year period.
- 4,000
8,000

- 1,000
2. Provide \$2 million in new funding for Homeless Women Veterans Programs. These funds would be used to develop up to 20 new programs for outreach, case management, and to provide residential care for homeless women veterans. Less than 3 percent of veterans treated under current programs are women. Special programs are needed because current offerings are male dominated making many women veterans uncomfortable, particularly considering a high rate of sexual trauma among women veterans. These programs would be largely contracted community care. The Department of Veterans Affairs estimates that up to 1,000 women veterans could be served under this initiative. Over a three year period 500 annually and 1,500

- OK
2000
3. Provide \$2 million in new funding for Compensated Work Therapy. VA's medical care program offers Compensated Work Therapy (CWT) to help homeless veterans become gainfully employed. This program offers many veterans with significant barriers to employment, particularly homelessness, with job readiness experiences. At present, this program helps approximately 3,500 check veterans annually to be able to move directly into competitive work in the community, and helps another 10,000 who need additional skills development and training. This program ties very closely with a number of programs at the Department of Labor to help veterans gain employment. The VA estimates that an additional \$2 million could help more than 2,000 veterans by expanding ten sites and program augmentations of CWT sites. Check if this is 20 or just 10? creating new programs
at 10 additional sites
10 new sites

Part B summary: \$31 million in funding to provide a VA continuum of care for all check the word "all" veterans, including some hard-to-reach rural and women veterans with an estimated 9,000 new veterans being assisted.

13,200 annually

C. Collaboration to Provide Care and Services Needed by Homeless Veterans.

1. Increase funding by \$10 million for the Homeless Veterans Reintegration Program (HVRP). The Department of Labor's Homeless Veterans Reintegration Program (HVRP) provides grants to community-based, nonprofit organizations that work directly with homeless veterans. Currently, this program receives \$2.5 million and has 23 operating sites. The VA estimates that an increase of funding of \$10 million for a total of \$12.5 million would permit grants to be awarded to one or more projects in approximately 37 states. The VA estimates that with an additional \$10 million would allow up to 100 grantees to be funded and that up to 45,000 veterans could be served with up to 30,000 placed back on the employment rolls, over a three-year period. *7,000 more jobs* *30,000 veterans served, 21,000 placed back* *10,000 annually*
2. Provide an additional \$2.5 million for Stand Downs. At almost 100 sites across the country each year, community-sponsored events called "Stand Downs" bring homeless veterans together with community-based service providers; state and local government service providers; VA health care and benefits staff; and many others prepared to assist homeless veterans and their families with housing, health care, employment, legal matters, education, transportation, and other barriers preventing them from reintegrating into the social mainstream. The VA estimates that, with an additional \$2.5 million, more than 100 sites would be able to conduct these one-stop service delivery programs for homeless veterans. A three-year study of 227 events showed that more than 80,000 veterans and their family members were assisted by these events. The VA proposes that these additional funds could be used to help between 25,000 and 50,000 veterans attend "Millennium Stand Downs," which is a White House project (involving Dena Wood and John Hanson) with a goal of ensuring that all veterans will have safe lodging and will be able to secure treatment at the Millennium. The VA estimates that over a three-year period, ~~between 50,000 and 100,000 veterans~~ could be engaged in first-step recovery activities. *35,000 veterans a year and over 100,000*
3. Fund an additional \$0.5 million to provide excess property to homeless veterans. The VA, along with the General Services Administration and the Department of Defense, provide excess property each year to homeless veterans. Primarily, this program provides clothing such as boots, hats, coats, pants, shirts, and other excess military personal clothing items. However, sleeping bags, blankets and other items are sometimes available as well. A current inventory lists over 220 items with a total value of more than \$11 million. This Hammer Award-winning program has distributed more than \$35 million of property to homeless veterans during the last four years. The VA proposes a new initiative to add donated civilian clothing, furniture, and equipment to assist thousands of homeless veterans and community-based homeless veterans service providers. The VA estimates that an additional \$0.5 million could secure additional warehouse space and pay for shipping costs associated with this initiative and could help approximately 25,000 to 50,000 veterans. The VA estimates that approximately 70,000 to 125,000 veterans would be assisted by this initiative over a three-year period. *40,000 per year and*

4. **Fund an additional \$0.5 million for the North East Program and Evaluation Center.** The North East Program and Evaluation Center (NEPEC) reviews, monitors, and evaluates VA's homeless programs. With all the additional programs and sites suggested under this initiative, additional funding would be needed to ensure a quality review with reliable information. According to the VA, NEPEC's high-quality standards of review are unmatched under any existing home program in the country and is the best protection in order to ensure that the highest quality evaluation is conducted.

Part C summary: \$3.5 million in funding for VA and \$10 million for the Department of Labor for job training and services for more than 115,000 homeless veterans annually. While some of these veterans may be duplicated, it would certainly represent the largest commitment ever made to improve the lives of homeless veterans.

D. Improvement of HUD's McKinney Act Funding Sources for Veterans.

Background:

Veteran-specific HUD McKinney Act funded projects are disproportionately under funded, and many projects claiming to be veterans' projects are not really targeted to veterans. After HUD's last round of funding, the VA contacted each of the projects listed by HUD as veteran-targeted or veteran-specific and found that many were not targeted or designed to serve veterans. According to information supplied by HUD, more than \$21 million was earmarked for "veteran" projects; however, VA discovered that more than \$9.5 million was not available for veterans. In its assessment, the VA excluded projects where less than one-third of their clients would be veterans. In fact, the VA found that many of the projects stated that no veterans or less than ten percent of the population to be served were expected to be veterans.

1. **Veteran representation on HUD's local planning boards.** Veterans Service Organizations believe that there is a strong need to have veterans' advocates at the local level because there is no existing mechanism to assist veterans at the national level to ensure that the needs of homeless veterans are addressed.
2. **Require HUD to use the "CHALENG for Veterans" Report.** For more than four years, VA has conducted meetings with strong participation from the veterans community in order to examine the services available locally for homeless veterans, identify the unmet needs of homeless veterans, and develop local action plans to address those unmet needs. This meeting and report called "CHALENG for Veterans" occurs at each VA medical center across the country and contains local resource information and a "veterans community view" of the unmet needs of veterans in the area. The overall information is folded into a national report. The VA proposes to require HUD and its local planning process to use the "CHALENG for Veterans" report to ensure that the needs of homeless veterans will be met under HUD's local continuum of care plans. As with any reporting system, the weight each community would give to this information would vary; however,

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the VA believes that it is imperative that this information be available.

3. **Provide an additional \$4 million to HUD-VASH.** In this joint Supported Housing program with the Department of Housing and Urban Development, VA staff at 35 VA Medical Centers provide ongoing case management and other needed assistance to homeless veterans in permanent housing supported by nearly 2,000 specially-designed HUD rental assistance vouchers. Long-term housing has been identified as one of the top unmet needs of veterans for several years in the CHALLENGE report. Each VA employee, usually a social worker, manages approximately 30 voucher recipients. The VA estimates that up to 500 HUD Section 8 vouchers are expected to expire in the near future. The VA proposes that all current vouchers for veterans should be held and that more vouchers should be offered for seriously mentally and physically ill homeless veterans. The VA recommends that thirty additional sites be added and that 1,800 vouchers be added. The VA estimates that an additional \$4 million will permit approximately 1,800 veterans to gain long-term housing which will reduce their dependence on the VA health care system. [HUD costs associated with this proposal have not been estimated.]
4. **Americorps.** Military service and civilian volunteer service are highly compatible under the Corporation for National Service's "Collaboration for Homeless Veterans." LA VETS is a National Direct grantee from the Corporation and operates a highly effective program with approximately 90 full-time members. Approximately 40 percent of those members are veterans and many of those veterans have been homeless. The VA estimates that a near tripling of full-time members to 250 nationwide would mean operating programs in at least 20 states and providing outreach and coordinating community resources with VA health care for at least 50,000 homeless veterans. (Cost to Corporation for National Service ~~is~~ estimated to be \$2-3 million per year)

Part D summary: \$4 million in funding to provide long-term housing for approximately 1,800 veterans.

FINAL COSTS/SUMMARY

This proposal would constitute the single largest investment into breaking the cycle of homelessness among veterans. This proposal seeks to increase residential alternatives, community-based contracted care, job preparation activities, stand down activities, the distribution of clothing, and long-term housing. This proposal is estimated to positively impact 100,000 to 150,000 veterans annually. Additional funding for the VA would be \$60.5 million and additional funding for the Department of Labor's Homeless Veterans Reintegration Program (HVRP) would be \$10 million. HUD's Section 8 costs are not contained in this estimate. [There appears to be a significant effort to increase section 8 long-term housing alternatives and this would simply urge a portion of those new vouchers to be dedicated under this effort. Additional resources in the amount of \$5 million per year for the next two years would be needed. After three years, the increased funding could be reduced to the present level if projections of services

are achieved.]

The VA estimates that if 40,000 veterans are returned to work by the third year of this initiative and that each veteran earns \$1,000 per month, the economy will be enriched with \$480 million in paid wages and, that assuming an overall tax rate of 15 percent, there will be \$72 million in additional tax revenues.

**Estimate of Vetans Impacted by Program Area
Over a Three-Year Period**

	Existing and New <i>over 3 year period</i>	New Only <i>over 3 year period</i>
Outreach	100,000 60,000	40,000 30,000 ~~30,000~~
Stand Downs	105,000 60,000	37,000
Clothing Distribution		
Contract Care	31,000 9,000	12,000 19,000 ~~20,000~~
Per Diem	42,000 10,000	30,000 21,000
CWT	40,000	6,000 ~~5,000~~ ~~6,000~~
HVRP	45,000 5,000	50,000 25,000
Americorps	25,000 10,000	15,000 15,000
TOTAL	388,000 194,000	430,000 156,000

77
12
79
2
110
116
25
141
15
156

*46 Totaled
350,000*

	Year 1	Year 2	Year 3
Outreach and Community Contract Clinical Care	27	27	27
New Grants	12	12	12
Per Diem for Grantees	7	7	7
Per Diem for Non-Grantees	5	5	5
Compensated Work Therapy	2	2	2
Stand Downs	2.5	2.5	2.5
Excess Property Distribution	0.5	0.5	0.5

Program Monitoring	0.5	0.5	0.5
Ongoing Efforts (increase costs)		5	10
TOTAL Per Year	56.5	61.5	66.5
Additional Funding - Other Agency Collaborations			
HUD-VASH	1	2	3
HVRP	10	10	10
TOTAL Per Year	(11)	(12)	(13)
- Corp for Nat'l Service	3	(3)	(3)
	14	15	16

Facsimile Cover Sheet

US Department of Veterans Affairs

To: Thomas L. Freedman - Mary L. Smith &
David Hochshield

Fax No: 456-~~833~~ 7431

From: Peter H. Dougherty
Director, Homeless Veteran Programs (075D)
US Department. of Veterans Affairs
810 Vermont Avenue, NW,
Washington, DC 20420
Fax No: 202-273-9472
Voice No: 202-273-5774

Transmitting this cover page plus (5) page(s).

Comments: Here is a modified plan that looks to addressing the unmet needs of homeless veterans. It is a very balanced plan that I think you will find if approved would do create a real opportunity to end homelessness among our nation's veterans.

VA
Homeless
(aw) What have
I filed
this under?

Completing the Promise Breaking the Cycle of Homelessness for America's Veterans

Increase Outreach to Homeless Veterans:

- 1. Outreach** - Dedicated staff at all VA Medical Centers would mean that more than 100,000 veterans would be seen and interviewed by VA clinicians in outreach activities over a three year term. The additional staff (150 FTEE) would, on average, spend half their time on outreach activities thereby seeing an additional 10,200 additional veterans each year or more than 30,000 veterans over the three year demonstration.
- 2. Stand Downs** - at as many as 100 sites across the country each year there are events that bring homeless veterans together with community based and state and local government service providers. VA health care and benefits staff and a host of others prepared to assist them and their families with housing, health care, employment, legal, education, transportation or other barriers preventing them from reintegrating back into the social mainstream. We estimate that these events with modest financial support could support these one-stop service delivery programs for homeless veterans. There is a targeted White House project to assure that all veterans at the Millennium will have a safe places to go to and will have be able to secure treatment as we enter the new millennium. This initiative could be targeted to that effort. Between 25,000 and 50,000 veterans could attend these Millennium Stand Downs. Over the three year period between 50,000 and 100,000 veterans could be engaged in first step recovery activities.
- 3. Excess military and civilian clothing** - VA, with GSA and DoD assistance, provides excess property to veterans who are homeless. Generally this consists of boots, hat, coats, pants, shirts and other excess military personal clothing items. Sometimes sleeping bags, blankets and other items are also available. A current inventory lists over 220 items is being distributed to community events [such as stand downs, community-based veteran homeless service providers, to Vet Centers and other VA targeted homeless programs] This Hammer Award winning program has distributed more than \$35 million of property to homeless veterans during the past four years. A significant new initiative to add donated civilian clothing (much more appropriate for veterans attempting to return to work) and donated furniture and equipment could assist thousands of homeless veterans and community based homeless veterans service providers. 70,000 - 125,000 veterans would be assisted by this initiative over a three year period.

Increase community based residential care and services:

- 1. 31,000 veterans could be housed over three years in high quality community based settings** By having 150 additional FTEE each VA medical center would, for the first time have dedicated staff with community based contract money available including \$2 million for demonstration sites for new women veterans. These new dollars could ensure that more than 19,000 additional veterans are provided residential care over three years.
- 2. Nearly 20,000 veterans additional could be serviced over three years by community based programs** by increasing per diem by \$7 million for new grantees, providing \$5 million for non grant recipients and using \$2.5 million in new funds in years two and three. Average cost per veterans is estimated to be \$1440
- 3. The psychological break to being homeless among veterans is to be gainfully employed.** VA offers Compensated Work Therapy (CWT) to address this need. This program offers many veterans with significant barriers to employment, particularly homelessness, with job readiness, job hardening, experiences. At present this medical care program results in some veterans being able to move directly into competitive work in the community (approximately 3,500 annually) with nearly 10,000 who need additional skills development and training. An additional \$2.0 million annually would allow ten significant new program activations and ten significant program augmentations of CWT sites and expand programs that could place more formerly homeless veterans in competitive employment. **More than 6,000 veterans could benefit from this initiative over three years.**

Collaboration with others

The missing (Federal) links to help homeless veterans.

- 1. HVRP - the Homeless Veterans Reintegration Program** (administered and funded by DOL VETS) provides small grants to community based non-profit organizations who work directly with homeless veterans. Currently this program receives \$2.5 million and has 22 operating sites. If funding is provided in the amount of \$12.5 million, (an increase of \$10.0 million) we believe one or more projects could be awarded in 3/4's (37) of the states. (Up to 100 grantees could be funded - **up to 45,000 veterans could be served with up to 30,000 placed back on to employment rolls** over the three year period.

2. **Veteran representation on HUD's local planning boards.** There is a strong need to have a veterans advocate at the local level since there is no existing mechanism to assist veterans at the national level to ensure that the needs of homeless veterans are addressed locally.
3. VA has, for more than 4 years, conducted meetings with strong participation from the veterans community to looking into the services available locally for homeless veterans (catalogue/list the current resources), identify the unmet needs and develop local action plans to address those unmet needs. This meeting and report (called "CHALENG for Veterans") occurs at each VA medical center across the country and is filled with local resource information and unmet needs of veterans in that area. A targeted way to get that information to HUD's local planning process should be initiated. **IF HUD used the "CHALENG for Veterans" Report it would significantly ensure that the needs of homeless veterans are being looked at in the local continuum of care plans.** As with any reporting system, the weight each community would give to this information may vary, however, it is important for this information to be considered.
4. **HUD-VASH** - Long term housing has been identified as one of the top unmet needs of veterans for several years in our CHALENG report. Each VA employees [generally a social worker] case manages approximately 30 voucher recipients. A number, believed to be up to 500 HUD Section 8 vouchers are expected to expire in the near future. All current vouchers for veterans should be held and more vouchers should be offered for seriously mentally and physically ill veterans who have been homeless. If thirty additional sites were added to the present list and 1,800 future vouchers would be added, there would be a total annual VA staff investment of \$4.0 million, **1,800 veterans would have long-term housing** which will reduce their dependence on VA health care system. [HUD costs associated with this proposal are unknown.)
5. **AmeriCorps** -- Military service and civilian voluntary service are found to be highly compatible under the Corporation of National Service's "Collaboration for Homeless Veterans." LA VETS is a National Direct grantee from the Corporation and operates a highly effective program with approximately 90 full-time members. Approximately 40% of those members are veterans and many of those veterans have formerly been homeless. A near tripling of full-time members to 250 (nationwide) could mean operating programs in at least 20 states and provide outreach and coordinating community resources with VA health care for at least 50,000 veterans who are homeless.

Program Monitoring and Evaluation

1. Monitoring and evaluation of VA's homeless programs has been rigorous since its inception more than ten years ago. With all the additional programs and sites suggested and to ensure a quality review with reliable information that is both understandable and comparable to existing program monitoring an additional \$0.5 million annually for the North East Program and Evaluation Center (NEPEC) is needed. NEPEC's high quality standards of review are unmatched under any existing homeless program system in the country and is the best protection to ensuring that the highest quality evaluation is conducted.

FINAL COSTS/SUMMARY:

Impact on Lives

Over 3 years, more than 250,000 veterans will be seen, provided clinical care, including contract residential care and care provided under per diem, job preparation and job referral. Tens of thousands will, as a result of this increase intervention, be healthier and happier thereby reducing out nation's health care costs appreciably.

If 40,000 veterans are returned to work, by year three and make \$1,000 per month, the economy will be enriched with \$480 million in paid wages and even at an overall tax contribution of 15%, a contribution of \$72 million in the total tax revenues could be achieved.

Estimate of Veterans Impacted by Program Area Over a Three Years Period

	Existing and New	New Only
Outreach	100,000	30,000
Stand Downs	105,000	37,000
Clothing Distribution		19,000
Contract Care	31,000	30,000
Per Diem	42,000	9,000
CWT	40,000	30,000
HVRP	45,000	15,000
AmeriCorps	25,000	
TOTAL	388,000	170,000

6/22

	Year 1	Year 2	Year 3
Outreach and Community Contract Clinical Care	27	27	27
New Grants	12	12	12
Per Diem for Grantees	7	7	7
Per Diem for Non-Grantees	5	5	5
Compensated Work Therapy	2	2	2
Stand Downs	2.5	2.5	2.5
Excess Property Distribution	0.5	0.5	0.5
Program Monitoring	0.5	0.5	0.5
Ongoing efforts		5	10
TOTAL by YEAR	66.5	61.5	66.5
ADD'L Funding - Other Agency Collaborations			
HUD-VASH (VA costs only)	1	2	3
HVRP	10	10	10
TOTAL by YEAR	11	12	13

December 11, 1998

MEMORANDUM TO THE PRESIDENT AND THE VICE PRESIDENT

From: Craig T. Smith
Subject: Weekly Political Report

ARKANSAS

Prosecutors announced December 9 that they will not file negligent homicide charges against state Senator Bill Llewellyn (D) following a November 30 automobile accident that killed a pedestrian. Llewellyn still faces charges on driving while intoxicated, leaving the scene of an accident, and refusing to submit to a blood-alcohol test.

COLORADO

A bitter contest is underway for the position of chairman of the Colorado Democratic Party, with AFL-CIO-backed Tim Knaus running against incumbent Phil Perington and former DNC committeeman Chris Gates. Colorado AFL-CIO President Bob Green, a long-time foe of Perington, has recently criticized Perington for conducting conversations on right-to-work legislation with incoming Governor Bill Owens (R).

CONNECTICUT

A State Superior Court Judge issued a temporary injunction December 9 barring Connecticut Democrats from voting this month on the re-election of embattled state Democratic Party Chair Ed Marcus. Marcus supporters argued that moving the election from January to December violated party bylaws.

FLORIDA

Florida Democratic Party Vice Chairman John Ausman convened a meeting of 150 party activists December 5 to discuss future strategies. Ausman scheduled the meeting for a day on which State Party Chairman Mitch Ceasar was out of state attending a meeting of all state party chairs in Las Vegas. The meeting was also attended by state Insurance Commissioner Bill Nelson (D), who has sought the support of the White House for his efforts to get elected officials more involved in the operations of the state party, and by potential 2000 Democratic presidential hopeful Senator Paul Wellstone (D).

GEORGIA

Kennesaw State University political science professor Christina Jeffrey (R), who was hired and fired as U.S. House historian by former U.S. House Speaker Newt Gingrich (R) in 1995, announced she will seek the 6th House district seat being vacated by Gingrich. She joins five other announced candidates in the race: Gingrich-backed state School Board Chairman Johnny Isakson (R), pharmacist Bruce Hatfield (R) and '98 state Labor Commissioner nominee John Frank Collins (R). The announced Democrats include former Gingrich challengers Tony Center ('92) and Gary Phelphey ('98).

GUAM

The Federal Court in Guam last night ordered a new election in the gubernatorial race in two weeks. It found that the Gutierrez ticket did not get the requisite 50% plus one vote. Governor Carl Gutierrez (D) will appeal to the 9th Circuit Court.

ILLINOIS

A day before he officially announced his intention to run for re-election in 2000, Chicago Mayor Richard Daley (D) on Monday, December 7, submitted nominating petitions with 207,000 signatures, more than eight times the number required to get on the ballot. Mayor Daley reportedly enters the race with \$3 million and at least 5,000 volunteers.

Appearing with Mayor Daley at the formal announcement Tuesday was Rev. Clay Evans, a close ally of the Rev. Jesse Jackson. Rev. Jackson has previously said that he supports "in principle" the candidacy of Daley's challenger, Rep. Bobby Rush (D-1). Mayor Daley also received an endorsement Wednesday from Alderwoman Madeline Haithcock (D), who is African American.

MARYLAND

Baltimore School Board member Carl Stokes (D) and perennial candidate Robert Kaufman (D) this week announced their candidacies for the Democratic nomination in the Baltimore mayor's race. They joined City Register of Wills Mary Connelly (D), the only other announced candidate in the race.

MASSACHUSETTS

Governor Paul Cellucci (R) is moving to take over the operation of the state Republican Party organization and met with state party chair Jean Inman on December 8 to inform her that he is seeking her resignation. Cellucci is said to be planning to replace the party's entire staff and to install a key member of his staff, John Brockelman, as executive director. He is also encouraging current executive director Marc DeCoursey to run for his former seat in the state Senate.

MISSISSIPPI

On December 7, retiring Rep. Mike Parker (R-04) officially launched his bid for governor with a statewide swing and a TV ad campaign touting his business experience and support for public education. He joins announced candidates: MS Attorney General Mike Moore (D), former MS Lieutenant Governor Eddie Briggs (R), Crystal Springs Mayor Dan Gibson (R), and state Rep. Charlie Williams (R). State Lt. Governor Ronnie Musgrove (D) is a prospective candidate. Incumbent Governor Kirk Fordice (R) is term limited.

MISSOURI

Governor Mel Carnahan (D) formally announced December 11 that he is challenging Senator John Ashcroft (R) for his seat in 2000. Governor Carnahan made the announcement at a fundraiser which raised more than \$5000,000 for the race. Ashcroft is expected to announce January 5 if he intends to run for the 2000 Republican presidential nomination.

MONTANA

On December 8, Secretary of State Mike Cooney (D) became the first announced candidate in the 2000 gubernatorial race. Other Democrats expected to jump in are state Auditor Mark

O'Keefe (D) and Attorney General Joe Mazurek (D). Incumbent Governor Marc Racicot (R) is term-limited.

NEVADA

In the 1998 U.S. Senate race, Rep. John Ensign (R) officially conceded defeat to Senator Harry Reid (D) on December 9 after preliminary recount results in Washoe County indicated that he could not win.

NEW YORK

Attorney General Dennis Vacco (R) continues legal efforts to question the results of his November election race against Eliot Spitzer (D). This week he sought -- and was refused -- a court order to have New York City police officers verify the registration of tens of thousands of New Yorkers who may have been eligible to vote. A byproduct of Vacco's efforts is that until the matter is settled, the State Board of Elections cannot certify the results from other races in the state, including the re-election of Governor George Pataki (R). If Pataki's election is not certified by January 1, state Senate Majority Leader Joe Bruno (R) could end up as acting governor until the matter is resolved. The State Board of Elections is set to meet on December 15 to certify race results.

Rep. Michael Forbes (R-NY-1) took heat this week from fellow Republicans when it was revealed that he contributed \$1,000 each this year to the campaigns of Reps. Bill Pascrell (D-NJ-8) and Loretta Sanchez (D-CA-46).

TEXAS

Rep. Ralph Hall (D-TX-3); one of only a handful of Democrats who have publicly announced their intention to vote in favor of the President's impeachment, was elected chairman of the Board of Directors of the Free Congress Foundation.

WEST VIRGINIA

On December 8, former Governor Gaston Caperton (D) announced that he would not be a candidate for the Democratic gubernatorial nomination in 2000. Jim Lees is so far the only candidate in the race, though Rep. Bob Wise (D-2) is expected to announce in early January. Other frequently mentioned potential candidates are state House Speaker Bob Kiss (D), Senate President Earl Ray Tomblin (D), and state Treasurer John Perdue (D). Incumbent Governor Cecil Underwood (R) is expected to run for re-election.

WISCONSIN

Post-election finance reports released this week show that Rep. Mark Neumann (R) outspent Senator Russ Feingold (D) by more than \$370,000 in the 1998 Senate race. Senator Feingold raised \$4,068,000 during 1997 and 1998, just \$254,000 more than he had spent until the final weeks of the campaign. Feingold's cash on hand as of November 23 was \$750,881.

2000 PRESIDENTIAL RACE

New Hampshire Governor Jeanne Shaheen (D) is asking potential candidates in the 2000 presidential campaign to sign a pledge of respect for New Hampshire's first in the nation primary. Vice President Gore was the first to sign the pledge, and has been joined by Rep. John Kasich (R-OH-12), former Senator Bill Bradley (D-NJ), Senator John Ashcroft (R-MO), and

former Vice President Dan Quayle (R).

Former Senator Bill Bradley announced December 4 the formation of a presidential exploratory committee. Alluding to his previous basketball career, Bradley said that he never showed up for training camp without the intention of playing in the regular season.

Senator Bob Kerrey (D-NE) is expected to make an announcement Sunday, December 13, regarding his intentions for 2000.

REPUBLICAN NATIONAL COMMITTEE

Michigan RNC member Chuck Yob (R) dropped out of the race for Republican Party chair on December 8 and pledged his support to incumbent RNC Chairman Jim Nicholson. Nicholson now has 42 of the 83 endorsements he needs to retain the post. Nicholson's only remaining challenger is Florida GOP Chair Tom Slade.

CAMPAIGN FINANCE

The Federal Election Commission on December 10 officially rejected the recommendation of its auditors that the Clinton/Gore and Dole/Kemp campaigns would have to repay millions of dollars in taxpayer matching funds from the 1996 campaign. The FEC also ruled that issue ads used by both parties in the campaign were not illegal since they did not explicitly ask people to vote for a candidate.

LABOR

On December 6, James P. Hoffa declared victory in the race for president of the Teamsters union, 41 years after his father was elected to the same post. Hoffa pledges that the union will take a more bi-partisan approach to politics than the previous leadership, and called for an end to federal oversight of the organization.

1998 AFRICAN AMERICAN VOTE

A Joint Center for Political and Economic Studies report entitled *The Black Vote in '98* shows that the overall African American vote in 1998 declined slightly from 1994 partly due to the significant drop in turnout in the five most populous states: California, Texas, New York, Florida and Pennsylvania. Despite declines, black turnout in 1998 was strategically effective in certain areas where turnout increased sharply and significantly influenced the outcome of key races. Nationally, the black vote in U.S. House races was 89% Democratic and 11% Republican. It also showed black women voting more Democratic than black men (92% for women versus 84% for men). The 1998 black vote was more female (60% women, 40% men) than in 1996, where the vote was equally divided.

THE WEEK AHEAD

The Vice President will travel to Pease, New Hampshire on Thursday, December 17, for a ribbon-cutting ceremony at the Pease International Trade Port. Later in the day, the **Vice President** will attend a Clean Water event in Manchester.

cc:

The First Lady
John Podesta
Steve Richetti
Doug Sosnik
Ann Lewis
Joe Lockhart
Mickey Ibarra
Paul Begala
Melanne Verveer
Ron Klain
Stacie Spector
Monica Dixon

Mrs. Gore
Maria Echaveste
Karen Tramontano
Minyon Moore
Bruce Reed
Larry Stein
Thurgood Marshall, Jr.
Sidney Blumenthal
Audrey Haynes
Maurice Daniel
Marsha Scott

MEMORANDUM

TO: BRUCE REED, ELENA KAGAN
FROM: TOM FREEDMAN, MARY L. SMITH
RE: HOMELESSNESS
DATE: JULY 20, 1998

DRAFT

We have developed an initiative that addresses more fully the needs of homeless veterans. According to the Federal Plan to Break the Cycle of Homelessness, there are as many as 600,000 homeless persons on any given night. The National Coalition of Homeless Veterans estimates that there are 275,000 homeless veterans on any given night. They estimate that there would be double that number over the course of a year. This initiative would reach _____ additional veterans per year for a total of -----.

I. FEDERAL PROGRAMS TO ADDRESS HOMELESSNESS

The McKinney Act, which was enacted in 1987, is the major federal legislation addressing homelessness. McKinney funding for targeted homeless assistance has increased dramatically, from \$490 million in FY 1987 to _____ in FY 1998. The McKinney Act grant assistance programs fund activities that provide homeless men, women, and children, with emergency food and shelter, surplus goods and property, transitional housing, some supportive housing, primary health-care services, mental health care, alcohol and drug abuse treatment, education, and job training. HUD currently administers nearly 70 percent **check** of the McKinney Act funds, or spends approximately \$1 billion on homelessness per year (OMB).

The total VA budget for Homeless is \$90 million per year **check**. There are three major VA programs that work with the homeless:

1. Grant per diem. This program gives grants to community-based organizations to acquire transitional beds. In FY 94 through FY 97, 101 grants were awarded to 84 non-profit or state or local government agencies in 36 states. There is \$5 million per year for new grants. Pays up to \$16/day for ongoing operational costs.
2. Homeless Chronically Mentally Ill Veterans Program. The HCMI program places homeless veterans needing more intensive treatment into one of its roughly 125 contracted community-based facilities. The program serves over 19,000 homeless veterans per year, with over 3,000 receiving residential treatment. The average cost per day is \$38.

3. Domiciliary Care. Treatment takes place in approximately 1500 dedicated beds at VA medical center domiciliaries.

SPECIFIC PROPOSAL FROM VETERANS AFFAIRS

A. Increase Funding for VA's Homeless Grant and Per Diem Program

Background

This program allows for the provision of grants and per diem payments to assist public and non-profit organizations establish and operate new supportive housing and service centers for homeless veterans. Since the first round of funding in 1994, the VA has awarded 101 grants to 84 community agencies in 36 states and the District of Columbia. Total VA funding for these projects was over \$21 million, or approximately \$5 million annually. When these projects are completed, approximately 1,700 new community-based beds will be available for homeless veterans. With the current round of funding that number is expected to grow to 2,200 beds in the future.

1. **Increase funding for new grants by \$7 million.** This additional \$7 million, added to the \$5 million already funded by the VA for a total of \$12 million, would create approximately 1000-5000 new beds annually with services for homeless veterans. 75% of the beds would be for VA-eligible persons.
2. **Increase per diem funding by \$7 million.** This funding is for ongoing operations, and it subsidizes providers, paying no more than one-half of their operating costs. Currently, approximately 5,500 veterans receive services from existing programs. **Check:** [It costs approximately \$6,000 per year to pay per diem to service providers on an annualized basis. This would pay for approximately 2,250 different veterans receiving care from VA. **Check $2250 \times 6000 = 13,500,000$**] Within 2 years, more 10,000 homeless veterans annually could be completing treatment in VA quality-approved community setting operated by nonprofit entities, Native American tribes, or state and local governments.
3. **Provide \$5 million in new per diem funding.** P.L. 102-590 that created the Homeless Grant and Per Diem Program did not require an entity to receive a grant in order to be eligible for per diem; however, VA, by regulation and in an attempt to protect its grant investment, has limited per diem to programs that receive a grant. This would help to pay for care of approximately 2000 veterans in non-grantee, yet VA-approved, community-based programs.

Part A summary: \$24 million in funding (\$19 million if existing \$5 million not counted) for treatment and services for more than 5,000 veterans annually with service provided in community-based settings.

B. Increase Funding for Dedicated Staff and Contract Care Dollars at Each VA Medical Center.

Background

There are approximately 171 VA Medical Centers across the country. At 61 of these centers, there are dedicated staff with contract dollars to buy services from community service providers for homeless veterans. At those sites approximately 75 veterans are serviced at each site for an approximate total of 4,500 veterans. At 10 additional medical centers there are dedicated staff without contract care money.

1. **Increase funding by \$25 million so that each of the approximately 171 VA Medical Centers in the country will have dedicated staff and contract dollars to address the needs of homeless veterans.** If this proposal is initiated with an average of 1.5 FTE per site for a cost of \$100,000 annually and contract care dollars for residential contract care and transportation for a cost of \$150,000 per site annually, there would be, for the first time, a comprehensive nationwide system to address the needs of homeless veterans by having dedicated staff at each VA Medical Center. Costs are approximately \$250,000 annually per site. This would allow as many as 6,000 new veterans to be treated in community residential settings. A total of up to 12,000 homeless veterans could be treated annually under this program by expanding the existing program.
2. **Provide \$2 million in new funding for Homeless Women Veterans Programs.** These funds would be used to develop up to 20 new programs for outreach, case management, and to provide residential care for homeless women veterans. Less than 3 percent of veterans treated under current programs are women. Special programs are needed because current offerings are male dominated making many women veterans uncomfortable, particularly considering a high rate of sexual trauma among women veterans. These programs would be largely contracted community care. The Department of Veterans Affairs estimates that up to 1,000 women veterans could be served under this initiative.
3. **Provide \$2 million in new funding for Compensated Work Therapy.** VA's medical care program offers Compensated Work Therapy (CWT) to help homeless veterans become gainfully employed. This program offers many veterans with significant barriers to employment, particularly homelessness, with job readiness experiences. At present, this program helps approximately 3,500 **check** veterans annually to be able to move directly into competitive work in the community, and helps another 10,000 who need additional skills development and training. This program ties very closely with a number of programs at the Department of Labor to help veterans gain employment. The VA estimates that an additional \$2 million could help more than 2,000 veterans by expanding ten sites and ten program augmentations of CWT sites. **Check if this is 20 or just 10?**

Part B summary: \$29 million in funding to provide a VA continuum of care for all **check the word “all”** veterans, including some hard-to-reach rural and women veterans with an estimated 9,000 new veterans being assisted.

C. Collaboration to Provide Care and Services Needed by Homeless Veterans.

- 1. Increase funding by \$10 million for the Homeless Veterans Reintegration Program (HVRP).** The Department of Labor's Homeless Veterans Reintegration Program (HVRP) provides grants to community-based, nonprofit organizations that work directly with homeless veterans. Currently, this program receives \$2.5 million and has 2 operating sites. The VA estimates that an increase of funding of \$10 million for a total of \$12.5 million would permit grants to be awarded to one or more projects in approximately 37 states. The VA estimates that with an additional \$10 million would allow up to 100 grantees to be funded and that 15,000 veterans could be served with up to 10,000 placed back on the employment rolls.
- 2. Provide an additional \$2.5 million for Stand Downs.** At more than 70 sites across the country each year, community-sponsored events called “Stand Downs” bring homeless veterans together with community-based service providers; state and local government service providers; VA health care and benefits staff; and many others prepared to assist homeless veterans and their families with housing, health care, employment, legal matters, education, transportation, and other barriers preventing them from reintegrating into the social mainstream. The VA estimates that, with an additional \$2.5 million, more than 100 sites would be able to conduct these one-stop service delivery programs for homeless veterans. A three-year study of 227 events showed that more than 80,000 veterans and their family members were assisted by these events. The VA proposes that these additional funds could be used to help more than 50,000 veterans attend “Millennium Stand Downs,” which is a White House project (involving Dena Wood and John Hanson) with a goal of ensuring that all veterans will have safe lodging and will be able to secure treatment at the Millennium.
- 3. Fund an additional \$0.5 million to provide excess property to homeless veterans.** The VA, along with the General Services Administration and the Department of Defense, provide excess property each year to homeless veterans. Primarily, this program provides clothing such as boots, hats, coats, pants, shirts, and other excess military personal clothing items. However, sleeping bags, blankets and other items are sometimes available as well. A current inventory lists over 220 items with a total value of more than \$11 million. This Hammer Award-winning program has distributed more than \$35 million of property to homeless veterans during the last four years. The VA proposes a new initiative to add donated civilian clothing, furniture, and equipment to assist thousands of homeless veterans and community-based homeless veterans service providers. The VA estimates that an additional \$0.5 million could secure additional warehouse space and pay for shipping costs associated with this initiative and could help

approximately 25,000 to 50,000 veterans.

4. **Fund an additional \$0.5 million for the North East Program and Evaluation Center.** The North East Program and Evaluation Center (NEPEC) reviews, monitors, and evaluates VA's homeless programs. With all the additional programs and sites suggested under this initiative, additional funding would be needed to ensure a quality review with reliable information. According to the VA, NEPEC's high-quality standards of review are unmatched under any existing home program in the country and is the best protection in order to ensure that the highest quality evaluation is conducted.

Part C summary: \$3.5 million in funding for VA and \$10 million for the Department of Labor for job training and services for more than 115,000 homeless veterans annually. While some of these veterans may be duplicated, it would certainly represent the largest commitment ever made to improve the lives of homeless veterans.

D. Improvement of HUD's McKinney Act Funding Sources for Veterans.

Background:

Veteran-specific HUD McKinney Act funded projects are disproportionately under funded, and many projects claiming to be veterans' projects are not really targeted to veterans. After HUD's last round of funding, the VA contacted each of the projects listed by HUD as veteran-targeted or veteran-specific and found that many were not targeted or designed to serve veterans. According to information supplied by HUD, more than \$21 million was earmarked for "veteran" projects; however, VA discovered that more than \$9.5 million was not available for veterans. In its assessment, the VA excluded projects where less than one-third of their clients would be veterans. In fact, the VA found that many of the projects stated that no veterans or less than ten percent of the population to be served were expected to be veterans.

1. **Veteran representation on HUD's local planning boards.** Veterans Service Organizations believe that there is a strong need to have veterans' advocates at the local level because there is no existing mechanism to assist veterans at the national level to ensure that the needs of homeless veterans are addressed.
2. **Require HUD to use the "CHALENG for Veterans" Report.** For more than four years, VA has conducted meetings with strong participation from the veterans community in order to examine the services available locally for homeless veterans, identify the unmet needs of homeless veterans, and develop local action plans to address those unmet needs. This meeting and report called "CHALENG for Veterans" occurs at each VA medical center across the country and contains local resource information and a "veterans community view" of the unmet needs of veterans in the area. The overall information is folded into a national report. The VA proposes to require HUD and its local planning process to use the "CHALENG for Veterans" report to ensure that the needs of homeless

veterans will be met under HUD's local continuum of care plans. As with any reporting system, the weight each community would give to this information would vary; however, the VA believes that it is imperative that this information be available.

3. **Provide an additional \$4 million to HUD-VASH.** In this joint Supported Housing program with the Department of Housing and Urban Development, VA staff at 35 VA Medical Centers provide ongoing case management and other needed assistance to homeless veterans in permanent housing supported by nearly 2,000 specially-designed HUD rental assistance vouchers. Long-term housing has been identified as one of the top unmet needs of veterans for several years in the CHALENG report. Each VA employee, usually a social worker, manages approximately 30 voucher recipients. The VA estimates that up to 500 HUD Section 8 vouchers are expected to expire in the near future. The VA proposes that all current vouchers for veterans should be held and that more vouchers should be offered for seriously mentally and physically ill homeless veterans. The VA recommends that thirty additional sites be added and that 1,800 vouchers be added. The VA estimates that an additional \$4 million will permit approximately 1,800 veterans to gain long-term housing which will reduce their dependence on the VA health care system. [HUD costs associated with this proposal have not be estimated.]

Part D summary: \$4 million in funding to provide long-term housing for approximately 1,800 veterans.

FINAL COSTS/SUMMARY

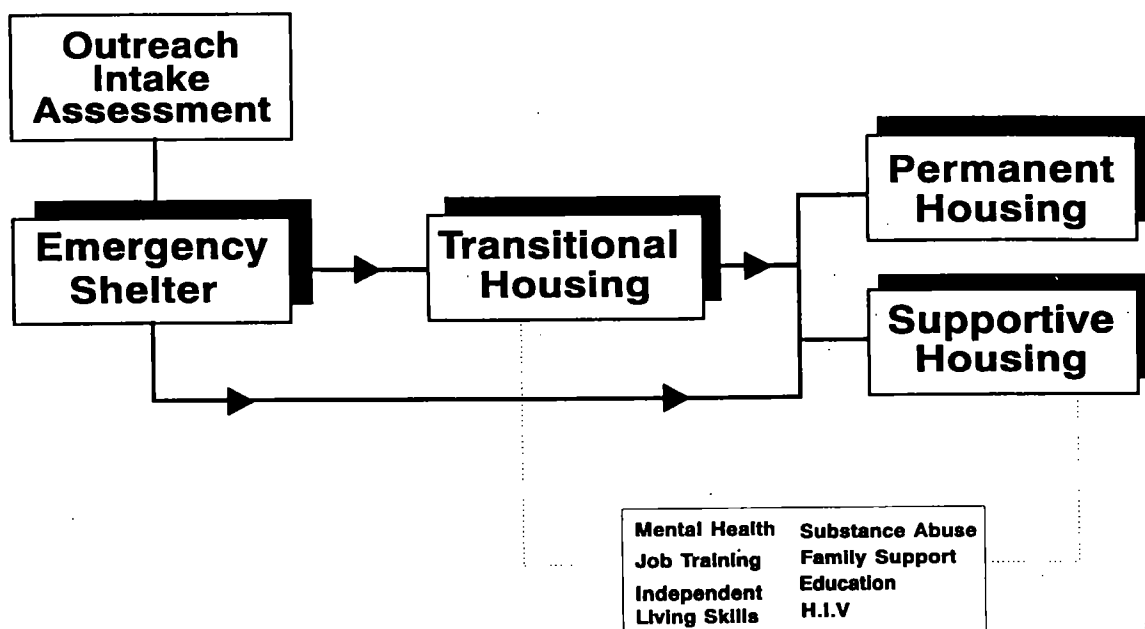
This proposal would constitute the single largest investment into breaking the cycle of homelessness among veterans. This proposal seeks to increase residential alternatives, community-based contracted care, job preparation activities, stand down activities, the distribution of clothing, and long-term housing. This proposal is estimated to positively impact 100,000 to 150,000 veterans annually. Additional funding for the VA would be \$60.5 million and additional funding for the Department of Labor's Homeless Veterans Reintegration Program (HVRP) would be \$10 million. HUD's Section 8 costs are not contained in this estimate. [There appears to be a significant effort to increase section 8 long-term housing alternatives and this would simply urge a portion of those new voucher to be dedicated under this effort. Additional resources in the amount of \$5 million per year for the next two years would be needed. After three years, the increased funding could be reduced to the present level if projections of services are achieved.]

where necessary, with the result being to target the added resources of the mainstream programs to the most needy.

This comprehensive approach to homelessness should be instituted and coordinated by localities. They are best suited to assess community needs and coordinate funding so that each stage of the continuum of care (emergency, transitional, or permanent, with services as required) can be linked with other points along the continuum. Unlike not-for-profit providers, the locality can view the entire system in the jurisdiction to ensure that transitions from each stage can be smooth. Unlike the Federal government, the locality is intimately familiar with the needs of its neighborhoods. In non-metropolitan areas, because of the unique configuration of resources and service delivery as well as the nature of homelessness itself, it is expected that state and county governments will be primarily responsible for the development of the continuum of care. The strategy designed on the local level should provide the basis for Federal participation.

Under this rationalized system, not-for-profits would be able to devote time to what they do best: providing and delivering services. The experience of the past decade has shown that not-for-profits are generally more effective than local government at quickly and efficiently siting, constructing, and operating housing and supportive facilities for homeless people. With the government providing resources, not-for-profits could provide the services.

Continuum of Care



As illustrated in the flow chart above, a continuum of care begins with a point of entry in which the needs of a homeless individual or family are assessed: In most communities, the intake and assessment component is performed by an emergency shelter or through a separate assessment center. To reach and engage homeless persons living on the street, the homeless service system should include a strong outreach component.

Once a needs assessment is completed, the person/family may be referred to permanent housing or to transitional housing where supportive services are provided to prepare them for independent living. For example, a homeless person with a substance abuse problem may be referred to a transitional rehabilitation program before being assisted with permanent housing. Some individuals, particularly persons with chronic disabilities, may require ongoing supportive services once they move into permanent housing. The goal of the comprehensive homeless service system is to ensure that homeless individuals and families move from homelessness to self-sufficiency, housing, and independent living.

To begin moving toward the recommended streamlining of the McKinney grant programs, HUD is currently working toward a restructuring of its McKinney programs. This proposal would rely on a single plan to establish and implement a continuum of care presented by the community to HUD for a single source of funding. The plan process would include participation by not-for-profits, homeless and formerly homeless people, and other interested community members. The program would be structured in such a way that if a comprehensive and acceptable plan is not submitted to HUD, service providers could then appeal to a HUD competitive process for assistance. During the past year, HUD has worked with localities in developing the continuum of care strategy through the Innovative Homeless Initiative Program. In early 1993, Secretary Cisneros

MEMORANDUM

TO: Mary Smith, Tom Freedman
FROM: David Hochschild
DATE: June 3, 1998
RE: Homeless legislation

This memo is based on information in the GAO report on Homelessness Prevention, the GAO report on the McKinney Act, the American Affordable Housing Institute's study on preventing homelessness, the VA's Homeless Veterans fact sheet and the VA's proposal for a three year initiative

Characteristics of America's homeless population at-large:

- one third of all homeless people suffer from severe mental illness
- 35-45% suffer from chronic alcohol problems
- 10-20% have problems with drugs other than alcohol
- 20-30% are families, often single mothers with kids
- more than half are people of color
- total number is between 600,000 - 750,000

Characteristics of homeless veterans:

- the mean age of homeless veterans is 44.5
- 98% are male
- 45% suffer from mental illness
- 73% are dependent on alcohol or drugs
- 85% have either a substance abuse or a psychiatric problem
- 50% are Vietnam vets (the number of homeless Vietnam vets is greater than the number of servicemen who died during that war)
- total number is 250,000 (although up to 500,000 may become homeless for a period at some point during the course of the year)

Conclusions that can be drawn from the studies and fact sheets

- *Three main causes of homelessness: the decline in the affordable rental housing stock, decline of earnings for unskilled labor and the release of mental patients from state hospitals.* In the 1970's and 1980's, both the number of affordable rental units and the earnings for unskilled labor declined, leaving poor people with less buying power and fewer options for housing. In addition, state hospitals began to reduce the number of mentally ill people that they cared for. Only half of the planned federal community mental health centers that were intended to absorb the mental patients were built, leaving many people who suffered from severe mental illness with no place to go.

- *The need exceeds the funding.* There is a consensus among homeless service providers that the funding to combat homelessness is insufficient to deal with the problem. A GAO study of FEMA's homeless assistance providers showed that for every 100 requests for rent and mortgage assistance that are met, 130 eligible requests had to be denied.
- *Newly homeless people are not the main problem.* 70% of all newly homeless people find housing on their own within a year, most in the first few months after becoming homeless. Those who have been homeless for more than a year are likely to remain homeless the longest. Veterans are disproportionately represented among this group.
- *The McKinney Act was a good start but it has not done enough.* The McKinney Act, which provides funds to local service providers (\$4.2 billion from '87 to '92), has helped leverage more funds to fight homelessness by legitimizing more providers in the eyes of foundations. But the act also frustrated some, who complain that it has not given them funding to sustain or expand programs that were already successful but did not meet the criteria of being a food, shelter or long-term housing program (such as substance abuse treatment and mental health care).
- *For the homeless who have problems other than unemployment, the most successful programs have these three goals:* (1) all addicts should become drug-free. (2) All mentally ill people should be using regular medication. (3) All drug-addicted or otherwise troubled heads of families should be enrolled in life skills classes.

Profiles of successful locally based homelessness prevention programs

Connecticut's Rent Bank/Eviction Prevention Program:

Started nine years ago to prevent homelessness in New Haven, this program mediates disputes between landlords and tenants. For those cases which cannot be resolved purely through mediation, the Rent Bank pays up to two months rent to fill the gap between what the tenant can afford and what the landlord needs. In FY 1990, funds were \$1.2 million for mediation and \$2 million for the Rent Bank.

Maryland's Rental Allowance Program (RAP):

Beginning in 1986, RAP has modest monthly rent subsidies (the average is \$175/mo.) for up to a year to homeless families and those who are on the verge of becoming homeless. It is a short term assistance program intended to return families to long-term self-sufficiency. 80-85% of RAP households appeared to attain at least housing self-sufficiency by the conclusion of their 12 months of assistance. The FY 1991 budget was \$2,000,000.

New Jersey's Homelessness Prevention Program (HPP):

HPP provides one-time emergency financial assistance to residents who are at risk of becoming homeless through eviction or foreclosure. Recipients are expected to repay the state within five years (New Jersey has the second worst rental housing crisis in the nation - over 150,000 eviction proceeding initiated each year). In order to receive the aid, recipients must demonstrate that they will be able to afford their present housing once the HPP assistance has brought them current. FY

1991 budget was \$4.8 million. 69% of those aided by HPP were able to avoid eviction.

St. Louis Homeless Services Network:

St. Louis integrated all services offered to homeless and at-risk people by creating a resource center that included relocation assistance, help with back rent, landlord intervention, counseling, shelter referral and other support services. This is one of the country's most effective models of an integrated continuum of care for homeless or those at risk of homelessness.

Summary of Proposed Expansion of VA's Homeless Services

- *Community-based services.* The VA is asking for \$24 million in new funding for treatment and services at community-based providers. This would create an additional 1000-1500 beds for homeless veterans and would double (from 5,000 to 10,000) the number of vets receiving community based treatment services annually.
- *VA Medical Center services.* The VA's proposed funding increase to \$29 million would give every VA medical center in the country the funds to care for homeless veterans. There are currently 61 VA medical centers that provide services for homeless veterans and 10 that do not. This package also includes special funding for employment training and for homeless women veterans outreach. This funding would boost the number of homeless veterans served annually from 40,000 to 80,000 and allow every veteran who wants help to get it.
- *Long-term housing.* \$4 million for long-term section 8 housing vouchers for 1,800 vets.
- *Miscellaneous projects.* \$3.5 million for stand-downs, distribution of excess military clothing, and program evaluation.

TOTAL BUDGET: \$60.5 million

TOTAL # VETERANS IMPACTED: 100,000 - 150,000

and District of Columbia Mayor Sharon Pratt Kelly formed one such partnership called the D.C. Initiative. The D.C. Initiative partnership has included participation by many Federal members agencies of the ICH, local government agencies, not-for-profits, homeless persons, and others in developing a homeless service system in the District of Columbia.

Implementation of this continuum-of-care model with HUD McKinney funds reorganized into the proposed HUD program as a "one-stop shop" would help move the existing panoply of homeless assistance programs with diverse rules and requirements toward a single coordinated approach to dealing with homelessness. It would focus the efforts of the Federal government, states, localities and not-for-profits on the tasks at which each excels. We should also immediately explore further consolidation and reorganization across Federal departments, including consolidation with mainstream programs, where appropriate.

VA's recent restructuring of its direct-care homeless assistance programs provides an effective complement to this proposed restructuring of the McKinney grant programs. By developing and supporting expanded partnerships with local public and nonprofit providers, including veterans service organizations, VA is already working nationwide to create comprehensive continuums of care tailored to complement local efforts to meet the most pressing needs of homeless veterans. Communities applying for McKinney Act grant funding should include coordination with VA's homelessness activities in the development of their overall continuum of care plans. By working with VA, local providers can make the best use of all available community resources to develop a comprehensive system of effective care and rehabilitation for both homeless veterans and non-veterans, alike.

However, a reorganization of current programs would still represent an emergency measure, intended to deal with the current crisis of homelessness. Eventually, these emergency measures need to be replaced by mainstream programs that deal with long-term community development. Localities would be expected to anticipate in the development of their continuum-of-care strategies the gradual phasing-out of all McKinney programs and their replacement by mainstream social service, human, and community development programs that deal with the underlying issues of economic opportunity and affordable housing.

Performance-based contracting. In accordance with the principles of "reinventing government," we must move beyond process to product by rewarding results rather than process. Through the new partnerships with governments and not-for-profits, Federal assistance will provide incentives for innovation and initiative among providers. The goal is not to fund bureaucracies but to help people move into permanent living arrangements. While much of the provider's work cannot be measured strictly by the number of people

placed, it should be one of the indices of success. Further, it will be expected that results are evidenced as the continuum of care and other necessary systems are put into place.

B. Double the HUD McKinney Homeless Assistance Budget

There is a widely recognized need for increased funding. With the new, more effective organization of programs and restructured relationships, substantial new resources are a worthwhile investment. HUD's McKinney budget for FY 1994 totaled \$823 million, 61 percent of the entire Federal McKinney homeless assistance funding. This amount represents a 42 percent increase from the 1993 funding level for HUD McKinney programs. We have recommended a doubling of the HUD homeless assistance budget to \$1.7 billion and an increase of the overall targeted Federal homeless assistance budget to \$2.15 billion. While the economic pressures are severe, this Federal commitment would signal a new priority and direction. The funds, while assisting more individuals directly, could catalyze a geometric increase by prompting better coordination and efficiencies on the local level. This large appropriation request includes 15,000 additional Section 8 vouchers to provide rental assistance to homeless households annually for five years. The funds would be used to help and enable communities to serve persons who are homeless through a continuum-of-care system with placement into permanent housing as the goal for all served. These recommendations have been accepted by President Clinton and are included in the FY 1995 budget proposal.

HUD is also exploring innovative financing techniques in partnership with the Federal National Mortgage Association (Fannie Mae). These initiatives would enhance HUD's ability to leverage Federal resources for McKinney homeless assistance projects. For example, Fannie Mae could purchase mortgages or bonds backed by McKinney funds, Section 8, or other Federally granted obligations and thereby make available additional capital for project development. Such initiatives will increase the development capacity at the local level for transitional and permanent housing. Fannie Mae is exploring financing techniques to help spur development of low and moderate income housing in areas that would need it to provide the continuum of care.

C. Make Mental Health Services Work for the Poor

The most visible and needy of the homeless population are the men and women with serious, persistent mental illnesses. They are among the most vulnerable and poorly served groups in our nation. Provision of adequate mental health treatment services ranked as a high priority need in the Federal Plan survey. In addition to their mental illness, many face problems of substance abuse, physical illness and the adverse consequences of poverty. They often have lost contact with their families, friends, or

other forms of support that might guide them through difficult times. This group suffers most on the street and contributes to the public's sense of "compassion frustration." The solution does not want for experience or knowledge, but for funding. In truth, there is no consistent mental health system for the very poor.

As reviewed earlier, a decade of hard-won experience has taught us how to reach even the most disaffiliated living on the street, and we have learned a great deal about working with homeless persons with mental illness. Outreach, combined with the availability of drop-in centers, safe havens (low-demand, non-threatening housing alternatives), and other transitional facilities have helped persuade some to leave the streets and begin the difficult return to a stable life in their communities. Recent innovations have made significant progress toward effective community-based treatment. Permanent, affordable housing with support services and supervision also is a proven and economical element critical to successful rehabilitation. Various demonstration programs have shown that supportive housing is not only a feasible alternative to more restrictive settings but an effective homelessness prevention measure as well. Linking housing with mental health treatment and other services is necessary to provide persons with mental illnesses with the support needed to maintain housing, as well as ensure that homeless persons moving back to permanent housing are able to adjust to new demands.

Clearly, more can—and must—be done to move beyond demonstration projects and isolated instances of effective community systems to a national solution. We must expand access to an integrated continuum of care much further.

Primary responsibility for the operation and financing of mental health services has been and will continue to be with the states.⁸ A few states and communities have made significant progress, and others can learn from them. The Federal government can and will help, but only states, and the cities and communities within them, can establish the necessary integrated systems of care and housing.

To direct resources to this difficult-to-serve population, states and communities must be convinced that the cost of providing mental health and housing services is minimal compared to the cost of not serving this population. *This is the true cost.* Studies in Minnesota and Washington State found that the hidden annual financial burdens (\$19,000 and \$22,000 per capita respectively) that acutely and chronically ill homeless people place on mainstream public support systems exceeds the cost of treating them outright for their illnesses (Nuener and Schultz, 1985; Troyer-Merkel, 1986). Preliminary results from an HHS/NIAAA-funded longitudinal study currently underway in Washington State suggest the costs may be even higher. The costs associated with the cycle of homeless individuals

⁸VA also provides mental health care to eligible veterans at over 150 VA medical centers nationwide.

going from the street to shelters to jail or hospitals and back to the street must be recognized.

We will focus our efforts on working with states and communities to develop integrated systems of support services and housing. We will accomplish this by developing incentives, requirements, and ways to assist them to address effectively the needs of mentally ill persons who are homeless or at risk for becoming homeless.

In this effort, we will explore ways to link currently required state mental health plans (which must include a component for outreach and services for homeless people with serious mental illness), health plans under the proposed Health Security Act, the plan required under the PATH program, the plan for the substance abuse block grant, and the comprehensive plan that will be required by HUD. The continuum-of-care plan should require the coordination of these programs for receipt of McKinney and other HUD funds. These plans and programs they relate to must be coordinated and address treatment, support services, and housing for persons with mental illness, especially those who are homeless and those who suffer from both mental illness and substance abuse disorders. We will also explore various alternative ways to help focus state mental health efforts on the most needy, including more targeting of Federal funds, tighter planning requirements, technical assistance, etc.

In this effort to develop more integrated systems of housing and services:

- For a more widespread effort, we will use as building blocks HHS's ACCESS Initiative, which made grants in 1993 to help selected communities in nine states move to integrated systems of care and housing, along with elements of VA's several programs that assist homeless veterans with mental illness.
- HHS, VA, and HUD will work with state and local governmental health, mental health, and housing agencies to coordinate Federal assistance and to undertake actions to enhance state and community support through the development of a continuum of care that integrates housing and services. In doing so, states and communities will be encouraged to do the following:
 - Effectively target mental health and housing resources to the most needy, such as homeless persons with mental illnesses or dual diagnoses.
 - Work closely with other key providers of services, including substance abuse treatment providers and providers in VA's mental health-care system.
 - Utilize the experience of the few states and communities that have developed integrated systems and of some Federal programs, including

HHS demonstration programs and VA's Health Care for Homeless Veterans (HCHV) program.

- Link mental health and substance abuse treatment activities.
 - Collaborate with local public and private housing providers and developers to establish joint initiatives and to encourage the development of affordable Single Room Occupancy housing, in particular.
 - Consider the unique and severe needs of homeless children with developmental disabilities and serious emotional disturbances.
- States and localities must review and strengthen discharge and aftercare planning strategies to ensure appropriate linkages with housing and community-based care in order to ensure that supports necessary to avoid subsequent homelessness are in place. The Federal agencies will work with them on this.
 - HUD, HHS, VA, and DOJ will establish a discharge planning working group to identify effective discharge-planning strategies for hospitals and community-based treatment facilities as well as ensure continuity of care and explore options for Federal, state, and local incentives to encourage Federally funded hospitals, prisons, nursing homes, community-based housing providers, and other institutions to develop necessary linkages to avoid discharging people who do not have a place to live.
 - Although a recent GAO report found that VA discharge planning staff are doing a good job given existing resource levels, VA recognizes the need to expand their efforts in this area. VA will work with the discharge planning group and others to develop new strategies to address these problems—including the development of new partnerships with other public and private agencies and organizations.
 - HUD will analyze the successes of some communities at developing SRO housing and will also identify ways to create incentives for private developers to reinvest in this type of housing and to develop linkages with support services.
 - Relevant Federal agencies will assess how their mainstream programs are serving this population and identify ways to improve access and linkages, similar to the outreach efforts underway for the SSI program.

Health-care reform also will play a significant role in this effort. The President's Health Security Act will finance a benefits package that must be provided without exclusions for prior existing condition exclusions or life-time limits. It is also the only

major health-care reform proposal that explicitly continues VA's mental health care efforts. The availability under the Act of less restrictive, nonresidential treatment services such as partial hospitalization will encourage and support more community-based treatment, a weak link in the current treatment system.

In addition, the Act requires that states develop comprehensive health plans, including a mental health component. It provides funding for development of community-based care systems. The provision of a comprehensive benefits package will allow states, as they develop their plans, to accelerate the development of comprehensive community-based mental health (and substance abuse) services linked with housing. The availability of loans and grants for community-based ambulatory clinics and residential treatment centers will help reach the goal of community-based care. Further, the Act makes available resources to fund services that will ensure that such actions as outreach and/or transportation are integrated into communities' plans.

D. Make Substance Abuse Services Work for the Poor

Addressing the needs of homeless persons with substance abuse problems is at least as important and challenging a task as addressing the needs of homeless mentally ill persons. Recent estimates suggest that as many as 2.5 million drug users could benefit from treatment. Most are addicted to cocaine, especially crack cocaine, often in combination with other illegal drugs and alcohol. We do not know the number of homeless that are drug- or alcohol-addicted, but studies suggest that 40 percent of the homeless have alcohol problems. An additional 15 to 20 percent have problems with drugs (HHS, 1992).

Although there have been demonstration projects and VA programs focusing on this population, more can and should be done, as documented by the large number of respondents to our survey who have identified this as a priority issue.

Little has been done to address the needs of the significant number—sometimes estimated at half of the substance-abusing homeless population—with co-occurring mental health and substance abuse disorders. This population is often shuttled ineffectively between the mental health and substance abuse treatment systems.

The following ongoing or planned actions should be implemented to address some of these problems, at least in part:

- The Health Security Act includes some coverage for inpatient treatment, intensive treatment in nonresidential community settings, and outpatient treatment for substance abuse. This important coverage will provide needed financing for

treatment, and also free up resources from existing treatment programs to refocus on providing services for hard-to-reach populations, including the homeless.

- Along with passage of the Administration's Crime Bill in 1994, we recommend approval of the President's FY 1995 budget proposal to appropriate \$355 million for an initiative to reduce hard-core substance abuse. This funding, coupled with anticipated resources from the Crime Bill, will allow an additional 140,000 hard-core users to receive treatment. Currently, the nation's drug treatment system has the capacity to treat roughly 1.4 million drug users, about 1.1 million fewer than the total in need of treatment. Due to the severity of need, this funding is part of a long-term strategy to help the treatment system expand the delivery of services and reduce the gap between need and demand for treatment.

We need to build on these actions to ensure that the treatment system, related support services, and housing are linked and focused on the problems outlined above:

- It must be ensured that the approximately \$5.4 billion the Federal government provides to states and communities for drug abuse prevention and treatment is coordinated and targeted effectively to serve hard-core users and difficult-to-reach populations such as the homeless.
- Agencies will work with states and communities to develop effective treatment systems linked with housing and other community-based rehabilitative services and assistance. Special attention will be focused on innovative approaches to help people stay in treatment, as well as on education, training, and employment programs that support transition to community living. As part of this systems development, the Federal government will work creatively to accomplish the following:
 - Ensure that providers of treatment and care address the needs of homeless people with co-occurring disorders regardless of their point of entry: substance abuse or mental health.
 - Integrate treatment for persons with severe addictions into primary and managed health-care systems.
- Finally, the Federal government should work with providers of service and treatment to increase knowledge of the substance abusing population—those who abuse alcohol, drugs, or both—and effective treatment intervention strategies. Because of the diversity within this population, a variety of approaches are necessary. VA should continue to inform homeless service organizations that VA can provide substance abuse treatment to eligible veterans.

E. Provide Assistance for Persons with TB and AIDS

Housing is critical for people infected with tuberculosis (TB), HIV/AIDS, or both. The TB and HIV/AIDS epidemics have produced a special need for housing for people with these diseases. In large metropolitan areas, it is estimated that 25 to 40 percent of the persons with active TB are homeless or are in imminent danger of homelessness due to their illness, lack of income or other resources, and weak support systems (NYC Office on AIDS Policy, 1994). In addition, some persons infected with HIV may face an increased and unnecessary risk of TB infection as a result of unsafe living conditions. Moreover, up to 50 percent of new TB patients are also HIV infected.

We believe that the only successful approach to controlling the TB epidemic is to assure that proper curative and preventive therapy is provided to all those with active TB disease and TB infection. High priority must be given to the prevention and control of TB among homeless people by detection, evaluation, and follow-up services to those homeless people with current symptoms of active TB. Those diagnosed with TB should complete an appropriate course of treatment. The provision of housing and a wide range of services to homeless patients is key to ensuring the completion of TB treatment for disease and infection.

We recommend that programs for people with TB and/or HIV/AIDS be established and existing programs changed to provide the following:

- Community-based client assessment to ensure early identification of patients infected with these diseases.
- A range of permanent housing options for homeless patients, including respite-care scattered-site housing.
- Intensive supportive services to this population, including Directly Observed Therapy (DOT) when needed, case management, access to primary health care, substance abuse treatment, mental health services, social services, TB support services, and crisis intervention.

We recommend that funding for the identification and detection of TB and the treatment of AIDS be expanded, consistent with the levels in the President's FY 1995 budget, and that states and communities give some priority in existing and new funding to homeless persons with TB and AIDS. President Clinton's FY 1995 budget includes an increase of \$34 million in funding for TB and an additional \$388 million government-wide for AIDS treatment, including an increase of \$93 million for the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act which would provide health care

services for persons infected with HIV. These increases should receive the support of Congress. In addition, states should utilize a newly authorized optional Medicaid benefit for certain low-income people with TB that includes basic primary care services, prescription drugs, and DOT.

Housing has become a fundamental component in providing a continuum of care for this population. This continuum is founded on two principles: if at all possible, maintain individuals and families within their own homes, and secure housing for those who need it. People with HIV/AIDS at nearly all socioeconomic levels may face special housing problems related to the following:

- Discrimination on the basis of their serostatus.
- Progressive illness requiring improved or different living facilities.
- The severe strain that HIV/AIDS places on employment abilities and financial resources.

Additionally, histories of chronic substance abuse, homelessness, and increased risk of illnesses such as tuberculosis challenge standard responses to the housing shortage. The need is not just for bricks and mortar anymore, especially for special needs populations, such as those with TB and HIV/AIDS, who require health care and supportive services.

We recommend the following strategies to increase housing placement:

- Use of short-term rental payments, in emergency situations for persons with HIV/AIDS and/or TB to prevent homelessness and to reduce the risks of exposure to opportunistic diseases by minimizing the use of emergency congregate facilities.
- Expansion of subsidized rent programs, such as Section 8, with an emphasis on tenant-based vouchers.
- Broadened availability of supportive services (this should be included in a community's HUD continuum-of-care plan) that focus on preventing homelessness and maintaining permanent housing.
- Maintenance of categorical funding streams for special needs populations, such as Housing Opportunities for Persons with AIDS (HOPWA).

F. Continue Earned Income Tax Credit and Remove Barriers To Its Use

Currently, low-income workers can claim the EITC when filing their tax returns at the end of the year. In addition, workers with children have their choice of obtaining a portion of the credit in advance upon filing their income tax returns. Certain barriers to claiming the EITC in advance should be removed. In recent years, fewer than one percent of EITC claimants have received the credit through advance payments in their paychecks. The reasons for the low utilization rate are not fully known. A recent GAO study found that many low-income taxpayers were unaware that they could claim the credit in advance. To remedy this problem, the IRS has begun an intensive effort to educate and encourage employers to help deliver advanced EITC payments in workers' paychecks.

While many EITC recipients may prefer to receive the credit as a lump-sum payment, others could benefit from receiving the credit in more regular intervals throughout the year. Many workers may find it difficult to meet their monthly rent payments with only the promise of a credit at the end of the year. To improve assistance to the working poor and provide an additional vehicle to prevent homelessness, workers could receive the credit as they earn wages and thus realize the direct link between work efforts and the EITC.

The Administration should consider allowing states to propose to the Secretary of the Treasury a demonstration project which would make advance payments of the EITC to eligible residents through a State agency. Approval by the Secretary of the Treasury of states' proposals would be required in all cases.

Allowing states the option to provide advance payments of the EITC through other agencies (e.g., the offices that also provide housing assistance or food stamp benefits) may resolve many of the problems with the current system. A state could choose to target information about the EITC to the working poor or to the homeless. Individuals could have a choice of receiving the credit from a neutral third-party, without fear of the consequences of notifying their employers of their eligibility for the EITC. Moreover, they could receive assistance in determining the appropriate amount of the EITC to claim in advance. The amount of the credit available in advance could also be increased in state programs.

These overarching recommendations will enable us to address the crisis of current homelessness. If accepted, these actions would serve as short-term and intermediate steps to the larger issue of homelessness prevention. Once mainstream programs perform their logical role of homeless prevention through program effectiveness and efficiencies, the targeted McKinney homeless assistance program could be phased out.

2. Long-term Structural Measures

The reasons for the persistence of poverty in America are no secret. They have been documented in report after report over the past 25 years. Poverty grinds on because decent jobs remain scarce, housing costs have soared, income maintenance programs have contracted, family structure has changed, drug use has increased, widespread alienation at the margins continues, and because racism persists, in often unobtrusive forms. If anything, the effects of poverty have become even more pernicious as the distance between the poor and those better off has grown. What little progress had been made was checked in recent times by twelve years of neglect. Sometimes the facts speak for themselves. Disinvestment, reduced funding, loud ideological attacks and quiet inaction have all taken their toll. While homeless people are perhaps the most visible of this population, they are unfortunately not alone, as millions more hang precariously close to a similar fate, but for a meager wage and the help of friends and families.

The necessary long-term response to homelessness and poverty is both apparent and complex. We need to provide more decent opportunities for work, job training that leads somewhere, necessary social services, better education, and affordable housing—and do all of this as components of comprehensive community planning and economic development. Admittedly, achieving this will not be easy, nor will it be done painlessly or in short order. While we may lack all the resources to *solve* the problem right away, we know to build upon what has been learned.

The Clinton Administration has already made significant strides in these directions. It has moved to integrate economic, physical, and human development through creation of the empowerment zone/enterprise community program to build partnerships for economic opportunity and sustainable community. Other steps include: reforming the Community Reinvestment Act; enacting legislation to establish community development financial institutions to insure investments in needy areas; significantly strengthening the Earned Income Tax Credit to make work pay; expanding funding and enhancing quality of Head Start to provide a helping hand early in life; enhancing technical assistance and access to employment and training services through the Job Training Partnership Act service delivery system; and initiating comprehensive welfare and health-care reform. Still other steps are underway to develop enhanced tools for economic development in communities and to move localities toward a comprehensive planning and application process for receipt of their HUD-administered community development, affordable housing, and homeless assistance funds.

While the Administration has taken some bold steps on this long-term agenda, we can do more to provide an equitable housing system that assists the very poor and those at risk of becoming homeless, and to provide an economic and human development system that effectively addresses those in need. Specific recommendations are:

A. Increase Housing Subsidies and Fight Discrimination

Housing affordability. During the 1980s, households with worst-case needs for assistance increased much more quickly than did assistance slots. By 1991, only 25 percent of eligible very low-income renters received rental assistance, whereas 40 percent—plus those literally homeless—had problems that conferred priority for admission to assistance. Unmet priority needs for assistance were more frequent and had grown most rapidly among eligible single individuals and families with children (HUD 1991). As this Plan has emphasized, the number of homeless persons on the streets and in the shelters is fed by a stream of poor persons who are precariously housed, particularly single adults and female-headed households. Long-term efforts to reduce and prevent homelessness cannot succeed unless measures to provide housing assistance to those who are literally homeless are complemented by structural changes that effectively reduce the probability of becoming homeless in the first place.

To increase the availability of affordable housing—the issue ranked number one in the Federal Plan survey—we have recommended increasing HUD's housing assistance budget to begin to make up for past budget cuts and to enable homeless people and those precariously housed to access permanent housing. HUD's budget is noticeable in the spectrum of Federal departments for its rate of decline during the 1980s. Although the numbers of households assisted continued to increase in the 1980s largely as a result of the Carter Administration investments, the rate of increase dropped from more than 250,000 households annually in the Carter years to less than 100,000 annually in the 1980s. Amazingly, if the HUD budget had increased at the rate of inflation since its 1980 level, budget authority in 1994 would have been \$65 billion; HUD's 1994 appropriation was \$26 billion. There can be no doubt that the HUD budget reductions of the 1980s contributed to the current homelessness problem. We should begin on the long road to providing affordable housing by increasing the HUD overall budget by nearly two billion dollars in 1995. This includes a doubling of the HUD assistance programs for the homeless. We recommend enactment of President Clinton's 1995 budget proposal, which includes the increased budget recommendations for HUD and FmHA mentioned here.

Recognizing the needs of rural communities, the President's budget request increases FmHA's Section 521 rental assistance budget by more than \$77 million to alleviate rent burden in FmHA-subsidized rental housing in rural areas. Rental assistance enables tenants to hold their rent to 30 percent or less of their income. FmHA's budget for rental assistance has not kept pace as the need for it has increased. At present, in FmHA subsidized rental housing, there are more than 80,000 families paying more than 30 percent of their income for rent. In addition, there are more than 22,000 vacant units that could house more than 60,000 people, if they were made affordable with rental assistance.

But housing alone is not enough. If we are to improve the self-sufficiency of residents of public and assisted housing, we must improve the services available to them. To do so, we must improve the nexus between the programs of the Departments of Labor, Education, Health and Human Services, and the Veterans Administration and public and assisted housing. Currently, there are useful programs, such as Family Self-Sufficiency, that could do more if better coordinated with state and local providers. Most residents of public housing do not receive adequate services to address their problems. If we improve the self-sufficiency of residents of public and assisted housing, we will increase turnover in those units and, in effect, increase the supply of affordable housing and reduce the number of persons forced to move into the streets.

Fighting discrimination. To ensure that permanent housing—both housing providing supportive services and traditional low-income housing—can be freely sited, we must aggressively enforce Federal fair housing laws. The Federal Fair Housing Act, which is enforced by HUD and the Department of Justice, prohibits discrimination in access to housing on the basis of race, color, religion, sex, familial status, national origin and handicap. The Department of Justice (DOJ) also enforces the Americans with Disabilities Act and the Rehabilitation Act of 1973, which prohibit discrimination in public accommodations and other services that may affect homeless persons. These statutes, for example, protect homeless persons from discrimination based on real or perceived disabilities. The statutes define mental impairment, such as mental illness and mental retardation, as disabilities. The statutes also protect persons who have a history of alcohol and drug abuse from discrimination as long as they do not currently use illegal substances.

HUD and DOJ must vigorously enforce the housing rights of all persons, including the homeless and those who seek to provide housing and other services for the homeless. An example of the effectiveness of this action is the Clinton Administration's pursuit of a lawsuit brought by the United States against the City of Philadelphia when the City refused to grant the zoning accommodation necessary to allow the construction of a SRO designed for homeless persons with disabilities. The District Court ruled in the United States' favor and against the City's efforts to block the project; the case is currently on appeal. In addition, the work that DOJ and HUD have done in Vidor, Texas is a positive example of what can and should be done. Specifically, the Departments will do the following:

- Continue to adopt proactive measures to increase the investigation and litigation of fair housing violations. DOJ's Fair Housing Testing Program will be expanded to uncover and document discriminatory housing practices by conducting systematic testing investigations in the rental markets of more than a dozen metropolitan areas. DOJ has authorized the hiring of more staff to augment its fair housing enforcement activities.

- Build upon current enforcement of the Americans with Disabilities Act to prohibit discrimination in public accommodations and other places and services that may affect homeless persons.
- Continue to challenge cities that refuse to permit group homes for persons who are mentally ill, mentally retarded, or former substance abusers. Some cities selectively enforce zoning restrictions to appease neighborhood efforts to exclude residences for such persons—the so called Not-In-My-Backyard (NIMBY) syndrome.

B. Low-Income Housing Tax Incentives

This report has pointed out that the number of homeless persons on the street and in the shelters is constantly being fed by a stream of poor persons who are precariously housed. Until this problem is adequately addressed, we will not solve the problem of homelessness (see "Structural Remedies" herein). In 1989, more than five million renter households had worst-case needs—38 percent of eligible very low-income renters. In that year, 72 percent of rental households with worst case needs lived in adequate, uncrowded housing, with rent burdens exceeding 50 percent of their income as their only housing problem (HUD, 1992). Thus, severe rent burdens were by far the dominant problem, with substandard housing much less common. Unmet priority needs for assistance were more frequent among eligible single individuals and families with children than among elderly households. Of the very poor facing extreme housing burdens, it is the single adults and female-headed households that most often end up on the street. Often they have other compounding problems contributing to their homelessness state, but lack of means to pay for shelter dominates other causes for most homeless persons.

There are several ways of addressing this huge pool of persons who are entering the stream of homelessness. One way is to increase the housing subsidies: an increased HUD budget as recommended above. A second way is to use the tax system. The mortgage interest deduction has long provided housing subsidies, as have the low-income housing tax credit and mortgage revenue bonds.

Our long-term efforts should examine ways that these benefits could be extended to lower income people through rental and home ownership incentives. Special attention should be taken to explore the development of programs that could be coordinated with existing tax incentives.

C. Strengthen Integrated Economic and Human Development

An essential element of any long-term strategy to reduce poverty and homelessness is the creation of jobs, particularly those that are accessible to poor residents of center-city areas where most of the homeless are concentrated. Job creation should be part of a broader community development strategy tied into development of human capital and improved delivery of services.

The Administration has already taken a number of initiatives to create jobs and integrate economic, physical, and human development through the creation of empowerment zones and enterprise communities. Related efforts include the Community Reinvestment Act reform, legislation to establish community development financial institutions to ensure investments in distressed areas, and significantly strengthening the earned income tax credit to make work pay.

Further, steps have been taken to streamline and coordinate existing economic and community development programs to better integrate economic and human development efforts. To effect real meaningful change through holistic strategies, HUD has begun to consolidate the planning, application, and reporting requirements of its housing and community development formula programs. This consolidation allows communities to identify their housing and community development needs, develop priorities and appropriately allocate scarce resources in a comprehensive and more intelligent framework.

Reform is needed in America's elementary and secondary schools in order to meet the demands of our future high skills-high wage economy. The Goals 2000: Educate America Act will stimulate school-based reforms aimed at providing all students the chance to reach challenging academic and occupational skills standards. Furthermore, the School to Work Opportunities Act will improve the linkage between school and work for those U.S. students who do complete college.

Finally we must embrace lifelong learning opportunities, including strengthening JOBS, programs for dislocated workers, and other employment and training programs. All are closely linked to job creation. We accomplish little to reduce poverty and homelessness if (a) we create jobs in distressed areas and those for whom the jobs are intended are not adequately prepared to take advantage of these resources, or (b) we provide education and training and there is no employment available. Job creation is closely linked with welfare reform. One cannot succeed without the other.

Social contract. At the same time, we must learn the lessons of failed policies of the past: rights must be balanced with responsibilities. Our goal is to help individuals and families to help themselves and provide them with the opportunity to better themselves.

Government is not and cannot be a substitute for the family or individual will. This new social contract is mutual.

3. Cross-cutting Agency Action Steps

A. Implement Proposed Reforms in the Nation's Health Care System

We recommend that Congress enact the Administration's proposed Health Security Act, which would significantly contribute to reducing homelessness and preventing future homelessness:

- First, the Health Security Act would provide a comprehensive standardized benefits package. This guarantee of health-care services will apply to all persons, including the homeless and those most at-risk of future homelessness. The lack of access to adequate health care or the failure to obtain it are themselves proximate causes of homelessness. Reform of the health-care system and the increased access to health care that will follow from it will help stabilize the lives of homeless people and those most at risk of becoming homeless. Important aspects of the new system will be new protection against the financial consequences of catastrophic illnesses that can lead to homelessness.
- Beyond that, the Health Security Act would expand the capacity and assist in development of qualified community health plans and community health networks that would improve access to health services for medically underserved populations, including large numbers of homeless persons and those at risk of homelessness.
- HHS would also make funds available for services to help hard-to-reach populations, such as homeless persons, access health care. Such services would include transportation, community and patient outreach, patient education, and translation.
- The proposed Health Security Act includes such mental health benefits as inpatient care in a psychiatric or general hospital or residential treatment program; intensive nonresidential care in facilities, such as partial hospitalization, day treatment, or psychiatric rehabilitation programs; and outpatient care that includes medication management, treatment, and prescription drugs.
- The Health Security Act also contains significant substance abuse treatment benefits, including residential care, intensive day treatment in nonresidential settings, and outpatient care.

- Under the Health Security Act, the VA will remain an independent health care provider and will offer low-income veterans (which would include the homeless) and those with service-connected health problems the same broad range of mental health-care services that they receive today, which are more generous than those offered in the comprehensive benefits packages.
- As a general matter, by simplifying responsibility for the financing of care, the proposed reforms in the financing of health care will free up the existing network of service providers to focus their resources on getting hard-to-reach populations such as the homeless into needed medical care, helping them manage that care, and providing essential auxiliary services to increase the chances of moving them to more stable lives.
- Finally, with all Americans insured for a comprehensive package of basic health-care benefits, states will be better able to develop integrated systems of care for those persons who need help in accessing health care, many of whom are homeless or at risk of becoming so.

B. Reform the Welfare System to Reward Work

We are excited by the possibilities of the Administration's plan for welfare reform. Such reform could have a dramatic affect on the lives of homeless families and could provide the supports necessary to avert homelessness for other low-income families.

AFDC is a primary source of income for the majority of homeless families. A 1992 HHS Office of Inspector General study reported that almost 70 percent of all families interviewed in family shelters were receiving AFDC benefits. In some cities the percentages are even higher. For example, the New York City Human Resources Administration reported that 95 percent of homeless families were receiving AFDC at the time of shelter intake (Culhane, 1993).

Reform of the welfare system could build on the Family Support Act and the recent expansion of the Earned Income Tax Credit and incorporate the following four aspects:

- Promote parental responsibility to ensure that both parents are held responsible for the support of their children by strengthening child support enforcement so that noncustodial parents provide support to their children and by taking steps to help reduce the rate of out-of-wedlock births.

- Reward people who go to work by making work pay—that is, by ensuring that people who move from welfare to work have the tax credits, health care, and child care they need to support their families adequately through work;
- Promote work and self-support by providing access to education and training for parents, making cash assistance a transitional, time-limited program and expecting adults to work once the time limit is reached.
- Reinvent government assistance to reduce administrative bureaucracy, combat fraud and abuse, and give greater state flexibility within a system that has a clear focus on work.

This focus on work, with the availability of an improved support system that includes universal health care, could help prevent families on AFDC from becoming homeless and could help homeless families, the vast majority of whom receive AFDC, to move from poverty toward self-sufficiency.

C. Improve Access to Mainstream Programs

The Federal government will spend slightly over \$200 billion in FY 1995 through programs in just five departments (HHS, HUD, Labor, USDA and Education) to address the needs of low-income individuals and families. Clearly we must make these mainstream programs more accessible to homeless individuals and families and more effective in preventing homelessness among those who are at risk of becoming homeless. Rather than institutionalizing a separate support system for the homeless population, we should ensure that the existing service system is able to address the needs of homeless individuals and families.

Therefore, we recommend that the Interagency Council on the Homeless and its member agencies do the following:

- Identify the principal mainstream programs in the areas of health, mental health, substance abuse treatment, income assistance, social services, housing, and education and employment training that are critical to preventing homelessness and helping homeless individuals and families make the transition from homelessness.
- Conduct a systematic assessment of how effectively sets of these programs serve the homeless population and persons at risk of homelessness, identify how to make the programs more accessible to the homeless population, and determine how to improve these programs so that they better prevent homelessness.

- Monitor ongoing programs and conduct impact evaluations to identify outcomes and ways to forge more effective linkages between targeted and mainstream programs, including consolidations.

This effort should build on planned reforms, such as health-care and welfare reform, and reforms that have already been undertaken by Federal agencies to help make mainstream programs more accessible:

- A joint VA and HHS Social Security Administration (SSA) pilot outreach initiative has succeeded in increasing the number of seriously mentally ill homeless veterans who apply for and receive regular VA and SSA benefits. SSA and VA personnel are working in several communities to improve claims processing for this hard-to-reach population. In other cities, SSA and VA's Health Care for the Homeless Veterans grantees are working together to increase referrals, recruit representative payees, and provide follow-up case management to ensure that veterans complete the SSI application process. In addition, SSA is providing information to VA teams serving VA's seriously mentally ill homeless population about the ways workers can facilitate applications for SSI.
- The Administration proposes to increase access to mainstream employment services for homeless persons and enhance services delivered by job training programs administered the Department of Labor (DOL). Many of the activities currently funded under the Job Training for the Homeless Demonstration Program, which was created by the McKinney Act in 1987, will be supported by a revamped JTPA. JTPA now encourages local programs to target services to the extremely disadvantaged, including the homeless. In FY 1994, DOL will provide technical assistance and enhanced service delivery to select JTPA Service Delivery Areas (SDAs) that will serve a greater number of homeless persons and offer them a wider range of services. These SDAs may use service providers as sub-grantees, including grantees currently funded by the Job Training for the Homeless Demonstration Program, to provide homeless persons with employment and training services, supportive services and housing through partnerships with housing agencies.
- The Administration's efforts to expand and improve the Head Start program will allow the program to reach more low-income families and provide valuable early childhood development and other services to support these families before homelessness occurs. In addition, HHS is working to improve the accessibility of homeless families to Head Start programs.
 - As part of the expansion of Head Start, in FY 1994, the Department is requiring Head Start grantees to base expansion on careful assessments of

community needs and explore the possibility of coordination with other community programs, including shelters for homeless families.

- The recently authorized Family Support and Preservation Program will provide funding to states to expand services to families in crisis or at risk of crisis due to abuse or other problems, providing another type of early intervention services that will help to avert the downward spiral that often leads to homelessness.
- HUD will make additional Section 8 housing vouchers available to homeless individuals and families. For FY 1995, HUD is proposing to award more than \$514 million in Section 8 vouchers to provide rental assistance to 15,000 homeless households annually for five years.
- Recent changes to the Food Stamp Program authorized by the Mickey Leland Childhood Hunger Relief Act of 1993 will play a role in preventing homelessness. Low-income individuals and families will no longer have to choose between paying rent and buying food. The 1993 legislation changes the treatment of housing costs in the Food Stamp program by eliminating the cap on shelter costs. As a result, additional food assistance will be provided to households facing very high shelter costs relative to their income. This act also simplified the definition of a household, thus enabling adult siblings or children living with parents, under some circumstances, to be counted as separate households and receive food stamps.
- FmHA is undertaking a number of actions to make its programs more accessible to currently and formerly homeless individuals, as well as to nonprofit organizations that provide housing and other services to homeless individuals. This includes such as offering special sale items and long-term leases to nonprofit organizations and public bodies to provide transitional housing for the homeless from FmHA's single family inventory property and setting aside funds to support the use of FmHA-financed Domestic Farm Labor Housing during the off-season to serve the homeless .
- To design and administer effective programs, we need accurate information on the causes of homelessness and characteristics of the homeless and at-risk populations. While there is research on the population with chronic disabilities, there is less information on the number and characteristics of those experiencing crisis poverty. The research that has been reviewed in preparation of this report is most revealing. The Federal government through its member agencies should review and explore the most recent data and its findings.
- We must continue special efforts to educate and encourage states, cities and not-for-profit organizations about the potential use of CDBG, HOME, HOPWA

(Housing for Persons with AIDS), acquired properties and other mainstream HUD program resources to assist homeless people.

- We also should improve the Title V Surplus Federal Property Program. As many military bases will be closing in the coming years, the National Law Center on Homelessness and Poverty, *Beyond McKinney*, and the US Conference of Mayors have recommended that HUD strengthen implementation of the program to encourage non-profit organizations and cities to use the program. In addition, the development of housing for homeless individuals and families will be easier if vacant land is included in the program.
- We must continue to support family intervention and prevention models that support the development of family and life skills such as Head Start, Even Start, Healthy Start, Operation Fatherhood, Family Support and Preservation and the Family Self-Sufficiency program. Also we should work with states to remove obstacles for participation for homeless families.

D. Strengthen Mechanisms for Interagency Coordination at the Federal and Local Levels

All Federal efforts proposed in the Plan require the cooperation within and among the Federal agencies working on homelessness as well as between the Federal government and state, local, private, and voluntary efforts to assist homeless individuals and families. Such coordination is a major component of this Plan and is essential to the success of Federally sponsored efforts.

- Through the Interagency Council on the Homeless and agencies' technical assistance contracts, disseminate information about successful programs, including how communities have developed their continuum of care. Provide technical assistance on program and system developments.
- To improve coordination and reduce fragmentation of programs, evaluate the "value-added" by targeted programs. HHS is pursuing the consolidation of three runaway and homeless youth programs, multiple mental health research demonstration authorities, including one targeted to homeless persons, and the consolidation of the Emergency Community Services program with Community Service Block Grant program.
- Through the Interagency Council on the Homeless, sponsor two meetings a year with Governor-appointed State Homeless Contacts and McKinney and non-McKinney Homeless Assistance Program Managers to encourage state and local

coordination and the development of integrated approaches to addressing homelessness.

- Through the Interagency Council on the Homeless, develop an advisory committee of homeless persons.
- Update and develop new handbooks for McKinney Act Programs to provide comprehensive guidance to states, localities, and not-for-profits on eligible activities, grant management strategies, fiscal and accounting requirements, and outcome measurements.
- Through the Interagency Council on the Homeless, develop and disseminate a publication that describes all Federal homeless assistance programs and exemplary program models nationwide.
- Through the Corporation for National Service, develop AmeriCorps programs and other volunteer efforts to augment government and non-profit efforts to respond to homelessness.
- As the states have done, encourage local governments to establish both a single point of contact regarding their homelessness programs and an interagency or interdepartmental council to promote coordination among their homelessness programs.
- Continue to hold local, regional, and national conferences and other events—such as the HUD/ICH Interactive Forums and the VA National summit on Homelessness Among Veterans and the HHS/HUD national conference on integrating housing and services for the mentally ill—to share information, increase coordination of efforts, and develop new partnerships.
- Increase Federal support to locally based Stand Downs for Homeless Veterans in order to increase community awareness of homelessness among veterans and to bring together new resources from local governments, providers, businesses, and others both to support the Stand Downs and for future collaborative efforts.
- Increase outreach to veterans service organizations and other nontraditional homeless providers to encourage and support their participation in the national effort to break the cycle of homelessness.

Closing

This Plan has provided a straightforward assessment of homelessness, its present context, and recent efforts to ameliorate it. Clearly, long-term solutions will require us to grapple with social and economic issues that have persisted for decades. The Clinton Administration has already embarked on a road towards that goal. Recommendations made here to study amending the tax code to address the problem of excessive rent burdens for the poor, a significant increase in housing subsidies, and a more comprehensive mental health system for the indigent will further our progress. Additional measures include an overhaul of the Federal program response, restructuring of Federal, state and not-for-profit roles, and a major commitment of resources to McKinney Act funding. None of this will be easy. But given the alternative—a deepening morass of half-measures and hesitancy—it is both possible and necessary.

The Plan also appreciates that the ultimate factor is the existence of the political will to end homelessness. Recent press reports suggest "compassion fatigue." We disagree. A deep public concern exists for those less fortunate, however, failed government attempts of the past have raised public hopes, only to be dashed. Government must demonstrate not only a commitment to make a difference but the ability to succeed. That is the present challenge. Met successfully, public confidence can be restored, and the political will can develop to address the long-term conditions.

Appendix A

List of Interactive Forum Cities

San Francisco
Baltimore
Chicago
Seattle
Miami
Denver
Memphis
St. Paul
Phoenix
Boston
Atlanta
New Orleans
Columbus
Los Angeles
Dallas
St. Louis
New York

Appendix B

Sample Questionnaire

FEDERAL PLAN QUESTIONNAIRE

Name/Organization/Address (optional)

Describe the geographical category and type of organization you represent.

Geographical Category

- ☐ Large metropolitan area
- ☐ Moderate to medium area
- ☐ Rural area
- ☐ Other

Type of Organization

- ☐ Service provider
- ☐ Advocacy organization
- ☐ City/county government
- ☐ State government
- ☐ Federal government
- ☐ Other

Part I: Recommendations to Break the Existing Cycle of Homelessness and Prevent Future Homelessness

(1) My recommendations for improving, streamlining and/or consolidating existing programs designed to assist homeless individuals and/or families are as follows:

(2) My recommendations for redirecting existing funding streams in order to strengthen linkages between housing, support, and education services are as follows:

(3) My recommendations for promoting coordination and cooperation among grantees, local housing and support service providers, school districts and advocates for homeless individuals are as follows:

(4) My recommendations for encouraging and supporting creative approaches and cost-effective local efforts to break the cycle of existing homelessness and prevent future homelessness, including tying current homeless assistance programs to permanent housing assistance, local housing affordability strategies, or employment opportunities are as follows:

Part II: Ranking of Issues to be Addressed in the Federal Plan

In FY90 and FY91, staff of the Interagency Council on the Homeless conducted monitoring and evaluation meetings with focus groups in 47 States. Listed below are the issues most commonly raised during those meetings. Please review, list issues that you think should be addressed in addition to those listed and indicate, on a scale of 1 to 5, with 1 being highest priority and 5 being lowest priority, your preference for addressing in the Federal Plan.

- ☐ Shortage of affordable housing options (accessibility, availability, suitability, problems posed by NIMBY).
- ☐ Needs of working poor (jobs, sufficient income, health care, child care, transportation).
- ☐ Need for adequate mental health treatment programs and more effective discharge policies by hospitals, prisons, the military, and mental institutions.
- ☐ Lack of adequate, appropriate treatment/aftercare programs for persons suffering from substance abuse, including single parents with minor children.
- ☐ Concern over increasing numbers of homeless families.
- ☐ Need for increased emphasis on preventing homelessness.
- ☐ Lack of attention to issues related to rural homelessness, particularly transportation needs.
- ☐ Need for increased emphasis on meeting the needs of homeless children and youth, particularly young males who cannot access traditional family shelters, adult shelters, or foster care.
- ☐ Insufficient health care services coupled with increase of seriousness of health problems such as AIDS.
- ☐ Inadequacy of State support, lack of overall anti-poverty policies.
- ☐ Concerns over increasing homelessness among migrant workers/illegal aliens.
- ☐ Need for transitional housing or supportive services for ex-offenders, parolees.
- ☐ Inadequacy of services for victims of domestic violence and concern over increased incidence of domestic violence.
- ☐ Declining public support for homeless programs.
- ☐ Need for affordable child care for single-parent families.

- Need for prevention/early diagnosis/outreach to veterans suffering from post-traumatic stress disorder (PTSD).

Please list and rank any additional concerns, issues you wish to see addressed:

— _____
— _____
— _____
— _____

If you have any other recommendations, please attach additional sheets.

Thank you for your participation. By December 20, 1993, please return your completed form to:

Federal Plan
U.S. Department of Housing and Urban Development
451 7th Street, S.W., Suite 7274
Washington, D.C., 22410

If your mailing label is incorrect, please include changes or corrections with your completed form.

HOMELESS PROVIDERS SURVEY

1) SIMPLIFIED/IMPROVED GRANT PROCESS

- 1A One funding source, one application, single stream funding for shelter and services
- 1B One grant to each locality for all homeless shelter and/or homeless services
- 1C Decrease regulations and paperwork on all levels so more funds go to service delivery
- 1D Long-range national housing policy
- 1E Provide for more flexible, realistic and innovative programs
- 1F Evaluate like communities for competitive programs
- 1G Bypass city government; fund service providers directly
- 1H Require collaboration among providers
- 1I Critique program results, reward cooperation and coordination, make recipients accountable
- 1J Provide technical assistance on grant application

2) LOCAL COORDINATION

- 2A Coordinated, multi-agency, community plan for each locality
- 2B One provider center for all homeless shelter and/or services
- 2C Citizen review boards including homeless
- 2D State Office for the Homeless with regional offices
- 2E Set standards and accountability levels for providers
- 2F Mechanism for coordination and communication among providers
- 2G States and cities work in conjunction with non-profits

3) IMPROVED DELIVERY OF SERVICES

- 3A Case management
- 3B Social services should be provided at shelters
- 3C Provide transportation to easily accessible services
- 3D Services open on weekends and after 5:00 pm
- 3E Locate services near housing
- 3F Use schools and other mainstream programs to teach life-skills
- 3G Require client commitment
- 3H Long term programs rather than temporary shelters
- 3I Focus on prevention, i.e., intervention with landlords, provide emergency rental assistance
- 3J Information systems and dissemination of information on housing stock, innovative programs
- 3K Staff development for service providers

4) SOCIAL SERVICES SUPPORT

- 4A Substance abuse
- 4B Battered women and children
- 4C Child care

Special Article

HOSPITALIZATION COSTS ASSOCIATED WITH HOMELESSNESS
IN NEW YORK CITY

SHARON A. SALIT, M.A., EVELYN M. KUHN, PH.D., ARTHUR J. HARTZ, M.D., PH.D., JADE M. VU, M.P.H.,
AND ANDREW L. MOSSO, B.A.

ABSTRACT

Background Homelessness is believed to be a cause of health problems and high medical costs, but data supporting this association have been difficult to obtain. We compared lengths of stay and reasons for hospital admission among homeless and other low-income persons in New York City to estimate the hospitalization costs associated with homelessness.

Methods We obtained hospital-discharge data on 18,864 admissions of homeless adults to New York City's public general hospitals (excluding admissions for childbirth) and 383,986 nonmaternity admissions of other low-income adults to all general hospitals in New York City during 1992 and 1993. The differences in length of stay were adjusted for diagnosis-related group, principal diagnosis, selected co-existing illnesses, and demographic characteristics.

Results Of the admissions of homeless people, 51.5 percent were for treatment of substance abuse or mental illness, as compared with 22.8 percent for the other low-income patients, and another 19.7 percent of the admissions of homeless people were for trauma, respiratory disorders, skin disorders, and infectious diseases (excluding the acquired immunodeficiency syndrome [AIDS]), many of which are potentially preventable medical conditions. For the homeless, 80.6 percent of the admissions involved either a principal or a secondary diagnosis of substance abuse or mental illness — roughly twice the rates for the other patients. The homeless patients stayed 4.1 days, or 36 percent, longer per admission on average than the other patients, even after adjustments were made for differences in the rates of substance abuse and mental illness and other clinical and demographic characteristics. The costs of the additional days per discharge averaged \$4,094 for psychiatric patients, \$3,370 for patients with AIDS, and \$2,414 for all types of patients.

Conclusions Homelessness is associated with substantial excess costs per hospital stay in New York City. Decisions to fund housing and supportive services for the homeless should take into account the potential of these services to reduce the high costs of hospitalization in this population. (N Engl J Med 1998;338:1734-40.)

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SINCE the early 1980s, homelessness has been an intractable problem in the nation's largest cities. Some observers trace the growth of homelessness largely to the social policies of the 1970s, including the deinstitutionalization of the mentally ill and the dismantling of government-sponsored housing and social-services programs for the poor.¹⁻³ In more recent years, questions have been raised about whether the many public resources used by homeless persons are ultimately more costly than housing and other services that could prevent homelessness. Because data on the social costs associated with homelessness have been difficult to obtain, however, policy makers have not been able to evaluate these issues fully.

Numerous investigators have documented high rates of illness and mortality among homeless persons.⁴⁻⁸ Most studies, however, have relied on self-reported data from shelter residents^{5,6,9,10} or administrative data on users of services, usually clinic patients,^{8,11,12} who may not be typical of general homeless populations. The authors of a 1994 study of mortality among homeless persons in Philadelphia⁴ were the first to gain access to the clinical records of a large sample of a defined homeless population.

Our study was undertaken in response to the growth in the number of homeless patients in New York City's public hospitals since the late 1980s and to reports that many of these patients were spending long periods in hospitals awaiting placement in public housing or community-treatment programs, which are in short supply in the city. We obtained discharge data on nearly 19,000 admissions of homeless patients and compared their diagnoses and lengths of stay with those of other low-income persons in New York City to estimate the hospitalization costs that may be associated with homelessness itself. Comparisons of the lengths of stay were adjusted for the se-

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verity of illness, coexisting illnesses prevalent among the homeless (substance abuse, mental illness, and infection with the human immunodeficiency virus [HIV]), and demographic characteristics.

METHODS

Study Design and Sources of Information

We compared homeless patients discharged from New York City's public general hospitals with two other groups of low-income patients: public-hospital patients not identified as homeless (referred to here as public-hospital patients) and patients covered by Medicaid who were discharged from private general hospitals (referred to here as private-hospital patients) in New York City. Homeless patients were compared with other low-income patients to adjust for the effects of poverty on hospitalization costs.^{13,14} Two comparison groups were chosen so as to represent a range of low-income patients. The public hospitals are known to treat the most disadvantaged of the city's poor, many of whom may live in conditions not materially different from those of the homeless. By contrast, a smaller proportion of private-hospital Medicaid patients would be expected to be homeless or marginally housed.

We obtained hospital-discharge data on 354,494 adults (people more than 17 years of age) admitted to the public hospitals during 1992 and 1993 from the New York City Health and Hospitals Corporation. Hospital-discharge data on 184,726 adult Medicaid recipients admitted to private hospitals in New York City during 1992 were obtained from the New York Statewide Planning and Reporting Cooperative System.

Identifying Homeless People in Hospital Data Bases

Homeless people were identified in the public hospitals' data bases from patient-address information. Patients whose addresses were recorded by hospital staff as "homeless," "undomiciled," or "shelter" were included, as were patients whose addresses matched an address of 1 of the city's 43 public homeless shelters (privately operated shelters, which provided 5000 of the city's 29,000 beds for homeless families and single adults during the study period, were not included). These methods identified 19,355 discharges of homeless adults during 1992 and 1993. About 60 percent were identified by hospital coding and 40 percent by matches with shelter addresses. To verify the reliability of our methods and findings, we reviewed them with hospital staff. We discovered during the course of the study that many homeless women who gave birth were placed in special housing that was not included on the public-shelter list. For this reason and because a large proportion of patients in the comparison groups were admitted for childbirth, we excluded maternity discharges from the study. With the exclusion of maternity patients, our final data set included discharges of 18,864 homeless patients, 244,345 public-hospital patients, and 139,641 private-hospital patients. We had no means of identifying homeless patients at private hospitals, so this comparison group included some homeless persons, although the public hospitals are believed to treat most hospitalized homeless persons in the city.

Unit of Analysis

We were required to use the hospital discharge, instead of the individual patient, as the unit of analysis, because patient identifiers were not available for private-hospital patients. However, we were concerned that if readmission rates varied significantly according to patient group, the use of discharge data alone could bias the results. Since we had patient identifiers for public-hospital patients, we were able to examine this issue. We found that homeless patients had higher readmission rates than other public-hospital patients (for readmissions within the public-hospital system), but the demographic and clinical characteristics of public-hospital patients were similar whether our analysis was based on

patients or on discharges, suggesting that our results would not be sensitive to the unit of analysis.

Statistical Analysis

Length of Stay

We compared the mean lengths of stay for homeless, public-hospital, and private-hospital patients after adjusting for the patients' characteristics (diagnosis-related group [DRG], principal diagnosis, coexisting illnesses, and demographic characteristics) using analysis of covariance (SAS program PROC GLM^{15,16}). In a preliminary analysis, we found that the effects of the DRG, principal diagnosis, and coexisting illnesses on the length of stay were not additive. For this reason, we subdivided the DRGs on the basis of a three-digit code from the *International Classification of Diseases, 9th Revision* (ICD-9) for principal diagnosis and the presence or absence of a coexisting diagnosis of serious mental illness, the variables that most affected the length of stay. Serious mental illness included ICD-9 codes 295.00 through 298.99 (psychoses), 290.00 through 290.99, 293.00 through 294.99, 318.10, and 318.20 (organic brain diseases), and 301.00 through 301.99 (personality disorders). After we excluded the patients in the DRG subgroups with fewer than two homeless patients, there were 1350 DRG subgroups included in the analysis, and we conducted the analysis at the DRG-subgroup level of detail.

We also adjusted differences in the length of stay for two additional coexisting illnesses common among homeless patients: substance abuse and HIV infection. Substance abuse included ICD-9 codes 291.00 through 292.99 (alcohol and drug psychosis) and 303.00 through 305.99 (alcohol and drug dependency and abuse, excluding code 305.10 [tobacco abuse]). HIV infection included ICD-9 codes 042.00 through 044.99. Adjustments were also made for demographic characteristics (age, sex, race, and insurance payer).

Discharges were excluded from the analysis of the length of stay if they did not fall into any of the 1350 DRG subgroups described above. This criterion excluded discharges of 991 homeless patients, 40,781 public-hospital patients, and 21,682 private-hospital patients from the analysis. Discharges were also excluded if the patients' stays were terminated for reasons unrelated to the need for treatment (i.e., death, transfer to another hospital, or discharge against medical advice). Transfers and discharges against medical advice were excluded because the lengths of stay for the patients involved did not reflect the care that was medically necessary. Deaths were excluded so that patients with the most severe illnesses would not be counted as having had shorter stays. These exclusions removed from the analysis an additional 4183 discharges of homeless patients (355 deaths, 345 transfers, and 3483 discharges against medical advice), 42,167 discharges of public-hospital patients (11,453 deaths, 5828 transfers, and 24,886 discharges against medical advice), and 23,486 discharges of private-hospital patients (5151 deaths, 1500 transfers, and 16,835 discharges against medical advice). The final analysis of the length of stay included discharges of 13,690 homeless patients, 161,397 public-hospital patients, and 94,473 private-hospital patients.

Nearly two thirds of the 69,836 discharges involving terminated stays were discharges against medical advice. The high rate of such discharges among low-income patients in New York City is reported to be related in part to substance abuse — an explanation consistent with our finding that 56 percent of the discharges against medical advice among all the patient groups in our data set involved principal or secondary diagnoses of substance abuse, as compared with 31 percent of the other discharges. Discharges against medical advice are also reported to be associated with high readmission rates. Therefore, had we included these discharges, the differences in length of stay between the homeless patients and the other patients might have been reduced, although some of this reduction might have been offset by higher readmission rates among patients discharged against medical advice.

To eliminate the effects of extreme outliers on comparisons of

the length of stay, we truncated hospital stays at 150 days (i.e., stays over 150 days were considered to be 150 days long). The differences in these truncated stays were used to estimate the costs associated with homelessness. Even with stays truncated at 150 days, it was possible that longer stays by homeless patients could have been caused by a few outliers. To reduce the effect of outliers further, we also analyzed the data with stays truncated at 60 days.

Costs

Data on the costs and charges for individual public-hospital patients were not available. Therefore, we used two sources of information to estimate costs per day for homeless patients: (1) the actual cost per day according to the major medical service (i.e., medicine and surgery, psychiatry, treatment for the acquired immunodeficiency syndrome (AIDS), or alcohol or drug detoxification) as listed in the public hospitals' 1994 *Medicare Institutional Cost Reports*, adjusted for inflation to 1997, and (2) the intensity weights of the cost per day according to DRG (i.e., the relative cost per day for each DRG) from New York State's hospital-payment system. For a given medical service, the cost per day for the homeless patients was obtained by multiplying the cost per day for public-hospital patients by the ratio of the average DRG-weighted cost for homeless patients to the average DRG-weighted cost for all public patients.

In calculating the cost of additional days per hospital stay that were associated with homelessness, we made three assumptions that gave us lower bounds for these cost estimates. First, we conservatively assumed that all additional days occurred at the end of long stays and valued these days at 60 percent of the average per diem cost, the marginal payment rate for such additional days under the federal Medicare and New York State hospital-payment systems during the study period. Second, we applied the 60 percent marginal-cost rate to the average costs per day, which already included the reduced cost effects of long stays by outliers. Finally, we excluded the number of days over 150 per stay, since the cost of care for these days might have been less than 60 percent of the cost of usual care.

RESULTS

Characteristics of the Homeless Patients

As shown in Table 1, the demographic characteristics of the homeless patients differed significantly from those of the comparison groups. The homeless patients were far more likely to be male, black, and middle-aged. They also were more likely to be covered by Medicaid and less likely to be uninsured than the other public-hospital patients.

The reasons for hospitalization also differed in the homeless and the comparison groups. Most strikingly, 51.5 percent of the admissions of homeless patients were for treatment of substance abuse or mental illness, as compared with 18.4 percent for the public-hospital patients and 27.2 percent for the private-hospital patients (Table 2). Admissions for substance abuse were substantially higher in the private hospitals, because the public-hospital system provides proportionately less inpatient substance-abuse treatment in the city.

Because substance abuse and mental illness accounted for such a large share of the discharges of homeless patients, we excluded these cases to compare the proportions of discharges for other clinical categories among the three groups of patients. Among

TABLE 1. PATIENTS' CHARACTERISTICS.*

CHARACTERISTIC	HOMELESS PATIENTS (N=18,864)	PUBLIC-HOSPITAL PATIENTS (N=244,345)	PRIVATE-HOSPITAL PATIENTS (N=139,641)
percentage of discharges			
Sex			
Male	81.7	52.2	51.2
Female	18.3	47.8	48.8
Age (yr)			
18-34	34.0	31.6	33.6
35-54	53.6	35.6	42.6
55-64	8.3	12.4	13.3
>64	4.1	20.4	10.5
Race or ethnic group			
Black	56.2	42.8	40.3
Hispanic	20.5	34.4	20.1
White	21.2	16.7	22.3
Other	2.1	6.1	17.3
Insurance payer			
Medicare	6.4	19.4	0
Medicaid	80.4	51.5	100
Commercial	1.0	7.0	0
Uninsured	4.6	13.2	0
Other	7.6	8.9	0

*Maternity-related discharges have been excluded. $P < 0.001$ for the differences between the homeless patients and each of the other two groups.

TABLE 2. DISCHARGES ACCORDING TO PRINCIPAL DIAGNOSIS.*

PRINCIPAL-DIAGNOSIS CATEGORY	HOMELESS PATIENTS (N=18,864)	PUBLIC-HOSPITAL PATIENTS (N=244,345)	PRIVATE-HOSPITAL PATIENTS (N=139,641)
percentage of discharges			
Substance abuse	28.5	9.2	22.2
Mental illness	23.0	9.2	5.0
Subtotal	51.5	18.4	27.2
	(N=9149)	(N=199,427)	(N=101,646)
Other†			
Respiratory system	17.2	12.4	13.3
AIDS	16.6	6.3	11.2
Trauma	12.9	12.9	5.4
Skin	8.4	4.0	3.7
Circulatory system	8.4	16.7	16.6
Digestive system	5.8	7.5	8.1
Nervous system	5.4	5.6	6.3
Endocrine or metabolic system	3.6	3.6	4.4
Kidney or urinary tract	3.2	4.7	5.3
Liver or pancreas	2.9	3.6	4.9
Musculoskeletal system	2.8	2.5	3.4
Female reproductive system	2.3	8.6	6.6
Infections or parasites	2.2	1.3	1.5
Ears, nose, and throat	2.2	2.1	1.6
Blood or immunologic system	1.3	1.4	2.5
Neoplasms	0.5	1.1	2.5
Other	4.3	5.7	2.7

*The principal-diagnosis categories represent the primary reasons for hospital admissions and are mutually exclusive. Maternity-related discharges have been excluded. $P < 0.001$ for the differences between the homeless patients and each of the other two groups.

†Percentages for the diagnoses are of all diagnoses other than substance abuse or mental illness.

the remaining 48.5 percent of the discharges of homeless patients, a disproportionate number of patients were admitted for respiratory disorders, trauma, skin disorders, and infections (excluding AIDS-related infections) or parasitic diseases — medical conditions for which hospitalization is often preventable. The homeless patients had proportionately fewer admissions for circulatory, digestive, kidney or urinary, and hepatic or pancreatic disorders.

The homeless patients also had significantly higher rates of coexisting substance abuse, mental illness, and AIDS. As shown in Table 3, the homeless patients were two to three times as likely to have coexisting substance abuse and two to three times as likely to have coexisting mental illness as the comparison groups. Of the discharges of homeless patients, 80.6 percent had a principal or coexisting diagnosis of substance abuse or mental illness — roughly twice the rate for the comparison groups. Substance abuse was the leading problem among the homeless patients, reported for 71.4 percent of the discharges.

To determine to what extent the differences in principal diagnoses between the homeless and the housed patients were due to the large numbers of homeless patients with coexisting substance abuse or psychiatric conditions, we recalculated the percentage of discharges according to clinical category after adjusting for these illnesses. As shown in Table 4, for all of the main clinical categories (except AIDS) for which the homeless patients had significantly larger percentages of discharges, the differences between the homeless patients and the other patients persisted after adjustment for coexisting substance abuse. For trauma patients without coexisting substance abuse, the relative differences between groups increased, but for those with coexisting substance abuse the differences between groups decreased.

TABLE 3. DISCHARGES WITH SELECTED COEXISTING ILLNESSES.*

VARIABLE	HOMELESS PATIENTS (N=18,864)	PUBLIC- HOSPITAL PATIENTS (N=244,345)	PRIVATE- HOSPITAL PATIENTS (N=139,641)
	percentage of discharges		
Coexisting illness†			
Substance abuse	42.9	18.7	16.1
Mental illness	7.4	3.2	2.3
AIDS	6.4	2.8	4.8
Principal or coexisting diagnosis‡			
Substance abuse	71.4	27.9	38.3
Mental illness	30.3	12.4	7.3
Substance abuse or mental illness	80.6	33.4	41.3
AIDS	14.5	8.0	12.9

*P<0.001 for the differences between the homeless patients and each of the other two groups.

†Discharges of patients with a principal diagnosis of any of these conditions have been excluded.

‡Discharges of patients with the condition present as a principal or coexisting diagnosis have been included.

Lengths of Stay

Table 5 shows the adjusted mean lengths of stay (truncated at 150 days) according to broad DRG categories. The homeless patients stayed, on average, 5.1 days (49 percent) longer than the private-hospital patients, 3.1 days (25 percent) longer than the public-hospital patients, and 4.1 days (36 percent) longer than the two comparison groups combined. The differences were greatest for mental illness, AIDS, and surgery.

We performed two analyses to evaluate whether a majority of the homeless patients had longer stays or a small percentage of the patients had very long

TABLE 4. DISCHARGES ACCORDING TO SELECTED CLINICAL CATEGORIES FOR PATIENTS WITH AND THOSE WITHOUT COEXISTING SUBSTANCE ABUSE.*

PRINCIPAL-DIAGNOSIS CATEGORY	PATIENTS WITHOUT COEXISTING SUBSTANCE ABUSE			PATIENTS WITH COEXISTING SUBSTANCE ABUSE		
	HOMELESS PATIENTS (N=3659)	PUBLIC- HOSPITAL PATIENTS (N=162,716)	PRIVATE- HOSPITAL PATIENTS (N=81,946)	HOMELESS PATIENTS (N=4556)	PUBLIC- HOSPITAL PATIENTS (N=30,637)	PRIVATE- HOSPITAL PATIENTS (N=17,419)
Respiratory system	16.7	11.9	13.2	17.6	14.6	13.5
AIDS	9.3	3.4	7.4	22.2	20.5	28.1
Trauma	15.3	12.9	5.1	11.5	13.5	6.3
Skin	7.7	4.0	3.4	9.2	3.9	4.5

*Clinical categories for which homeless patients had a significantly greater percentage of discharges than the comparison groups have been included. Discharges of patients with principal diagnoses of mental illness or substance abuse and those with a secondary diagnosis of mental illness have been excluded. P<0.001 for the differences between the homeless patients and each of the other two groups.

**TABLE 5. ADJUSTED MEAN LENGTH OF HOSPITAL STAY
ACCORDING TO PRINCIPAL-DIAGNOSIS CATEGORY.***

PRINCIPAL-DIAGNOSIS CATEGORY	HOMELESS PATIENTS (N=13,690)	PUBLIC- HOSPITAL PATIENTS (N=161,397)	PRIVATE- HOSPITAL PATIENTS (N=94,473)	DIFFERENCE BETWEEN HOMELESS AND PUBLIC-HOSPITAL PATIENTS	DIFFERENCE BETWEEN HOMELESS AND PRIVATE-HOSPITAL PATIENTS
length of stay (days)					
All categories	15.6	12.5	10.5	3.1	5.1
Mental illness	36.2	29.9	21.3	6.4	14.9
AIDS	25.4	20.1	19.4	5.3	6.0
Surgery	17.0	11.5	9.9	5.5	7.1
Trauma	6.7	5.7	4.9	1.0†	1.8‡
Medicine	10.7	9.1	8.8	1.6	1.9
Substance abuse	9.2	9.3	6.8	-0.1§	2.4

*Differences in the lengths of stay were adjusted for diagnosis-related group, principal diagnosis, selected coexisting illnesses, and demographic characteristics. Deaths, discharges against medical advice, and transfers were excluded. Discharges were grouped according to principal-diagnosis categories, which are mutually exclusive. Stays longer than 150 days were counted as lasting 150 days. $P < 0.001$ for all differences between the homeless patients and each of the other two groups, unless otherwise noted.

† $P < 0.05$ for the difference in the mean length of stay.

‡ $P < 0.01$ for the difference in the mean length of stay.

§The difference in the mean length of stay was not significant.

stays. We first reduced the effects of long stays by truncating the length of stay at 60 days. Even after this adjustment, the mean length of stay for the homeless patients was still 3.4 days more than for the private-hospital patients and 1.8 days more than for the public-hospital patients. Therefore, long stays (60 to 150 days) among the homeless did not account for most of the differences in length of stay. Second, we compared median lengths of stay (unadjusted for covariates) for the six principal diagnoses with the highest volume of discharges among the homeless: schizophrenia (36 days for the homeless patients, 29 days for the public-hospital patients, and 21 days for the private-hospital patients), affective psychoses (28, 23, and 17 days), HIV-related tuberculosis (26, 20, and 20 days), HIV-related pneumonia (11, 10, and 12 days), fractures of the face (9, 6, and 5 days), and hernia procedures (3, 2, and 2 days). These differences further suggested that longer stays among the homeless were not due to a small percentage of outliers.

Although a higher percentage of the homeless patients had stays longer than 60 days (8.3 percent, as compared with 3.1 percent of the public-hospital patients and 1.5 percent of the private-hospital patients), two thirds were psychiatric patients, as compared with about one third of the comparison groups. An additional 9 percent of the homeless patients discharged after long stays had AIDS, so mental illness and AIDS accounted for nearly three quarters of the long stays among the homeless. Of the patients with

long stays, just 1.1 percent of the homeless patients, 0.4 percent of the public-hospital patients, and 0.1 percent of the private-hospital patients had stays longer than 150 days.

Cost of Additional Days per Discharge

We found that the differences in the length of stay between the homeless and the housed patients in 1997 dollars (averaging the private-hospital and public-hospital stays) cost \$4,094 per discharge of a psychiatric patient, \$3,370 per discharge of a patient with AIDS, and \$2,414 per discharge for all causes (excluding substance abuse, for which the homeless patients' stays were only negligibly longer than those of the comparison groups).

DISCUSSION

We found major differences in the causes of hospitalization and lengths of stay between homeless people and other low-income people in New York City. The vast majority of hospitalized homeless people had principal or coexisting diagnoses of substance abuse or mental illness, and nearly three quarters were hospitalized for conditions for which hospitalization is often preventable, including substance abuse, mental illness, respiratory disorders, trauma, skin disorders, and infectious diseases other than AIDS. The homeless patients stayed an average of 4.1 days per hospital stay, or 36 percent, longer than the other patients — a difference that was not explained by adjustments for poverty, severity of ill-

ness, coexisting illnesses, or demographic characteristics. Most of the additional days of hospitalization were accounted for by the patients with psychiatric disorders or AIDS (57 percent and 12 percent, respectively). The average cost of additional days per discharge (\$2,414) among the homeless nearly equaled the annual public-assistance rent allowance for a single person in New York City (\$2,580).¹⁷

Our statistical analysis could not account for many unmeasurable differences between homeless and housed patients that might explain some of the clinical and length-of-stay variations we found. However, our findings were consistent with reports by public-hospital staff that longer stays among homeless patients are primarily due to a lack of housing. The leading cause of long stays cited by hospital staff was placement problems among homeless psychiatric patients. The public hospitals have been under a court order since 1991 to place all such patients in supportive housing at the time of discharge. However, because of a shortage of supportive housing in the city and the continued downsizing of state psychiatric hospitals, this process can be delayed for months. City officials report that there are just 110 vacancies to accommodate an estimated 200 additional people who become eligible for these apartments every month.¹⁸

Efforts are also made to place other homeless patients in housing or shelters, but such placement is difficult because of overcrowding in the adult shelters¹⁸ and chronic shortages of low-rent housing in the city. City officials estimate that 100,000 of 145,000 rooms in low-rent rooming houses were lost in the city from the late 1970s through the mid-1980s.¹⁹ As a result, some homeless patients are kept in hospitals until beds in shelters become available, especially during the winter months when shelters are often filled to capacity.

Physicians also reported delaying the discharge of homeless patients who required follow-up care, knowing that these patients' access to ambulatory care and clean environments or their compliance with treatment might be limited. Our finding that the number of excess days was particularly high for homeless patients who underwent surgery was consistent with these reports. Finally, physicians indicated that they lower the threshold for admission for homeless patients whose medical conditions are likely to worsen if they remain in shelters or on the streets. Our finding that homeless people were hospitalized disproportionately often for such conditions as respiratory and skin disorders, trauma, and infectious or parasitic diseases that often can be treated on an outpatient basis agree with these reports.

Several interventions should be considered to reduce the high hospital costs associated with homelessness. One strategy would be to increase the supply of supportive housing for the homeless mentally ill, a group that accounted for the majority of the

excess hospital days among homeless patients. As we mentioned, the discharge of these patients can be delayed for months because of the lack of housing. We found that a third of the homeless psychiatric patients had hospital stays that ran more than a month longer than the two weeks generally required to stabilize an acutely psychotic patient. These patients stayed an average of 84 days and accounted for 69 percent of all the days of hospitalization for psychiatric reasons among the homeless patients. Better access to supportive housing for these patients could reduce hospital stays by as many as 70 days per admission. Seventy days in a general-hospital psychiatric unit, even at a rate of \$250 per day for subacute care, costs \$17,500, whereas a unit of supportive housing with social services for an entire year costs \$12,500 in New York City.¹⁹

The development of more low-cost housing in the city might also reduce hospital stays, especially among patients undergoing surgery, who are currently kept in the hospital for follow-up care, and patients admitted for medical conditions that can be treated in ambulatory settings. Finally, treatment programs for substance abuse, or at least interventions to reduce the health risks associated with substance abuse, are services critically needed by New York City's homeless that could help reduce hospitalization.

Investment in housing and other services for the homeless will require a major allocation of public resources. Yet, as our study suggests, given the current costs of homelessness borne by the health care system and probably also by other social institutions, these services may represent a more cost-effective as well as a more humane approach to the problem of homelessness.

Supported by a grant from the United Hospital Fund of New York.

We are indebted to Jan Blustein, M.D., Ph.D., Howard Bloom, Ph.D., and Stuart Kirk, D.S.W., for their thoughtful comments on the manuscript; to Dennis Culhane, Ph.D., for his expertise regarding New York City's homeless population; to David Schwartz, M.D., for consultation on the medical problems of homeless persons; to Pai Tao Wu Chen for assistance with data analysis; and to the many staff members of New York City's public hospitals who assisted us with the study.

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California Red-Legged Frog

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An important question is what the physician should do in the case of an infant who has undergone electrocardiography and whose QTc is greater than 440 msec. Genetic testing is still a research tool and not clinically helpful in most cases. Measurements of the QTc may vary among different observers, depending on whether U waves are included in the measurement, the magnitude of sinus arrhythmia, and the choice of which cycle to use for the measurement. Consequently, it is uncertain whether all such patients should receive beta-blocker therapy, the treatment of choice for the long-QT syndrome. If there are other findings on the electrocardiogram, such as T-wave alternans or ventricular arrhythmia, it seems prudent to consider this option seriously. Certainly when the QTc approaches 470 to 500 msec, as was the case in 3 of the 12 infants who died suddenly in the study by Schwartz et al.,⁴ many physicians would initiate therapy. It has been our experience, however, that there are many infants whose QTc measures in the range of 450 to 460 msec. Rather than begin therapy in such cases, we repeat the electrocardiography at two to three weeks of age and, if the results are normal, again at two to three months of age. Since most cases of SIDS occur after this time, this approach seems reasonable.

In terms of screening infants in the future, the development of a more useful tool that can be used in the physician's office and can measure the QTc, rather than a full electrocardiogram, would be welcome. Abnormalities of the QT interval identified in this way could then be evaluated more formally by a pediatric cardiologist, thus optimizing the use of resources.

Schwartz and colleagues are to be commended for conducting this forward-thinking, long-term prospective study (involving nearly 20 years of data) of a tragic disorder. Over time, their work will almost certainly help to improve the outcome of infants at risk.

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THE HOMELESS AND THE PUBLIC HOUSEHOLD

ROBERT Frost once described home as "the place where, when you have to go there, /They have to take you in."¹ This is precisely what the homeless lack: not only a home of their own but also a claim on anyone else — kin, community, or government — to take them in and give them a home. Chronic illness, physical as well as mental, commonly accompanies homelessness and may have contributed to it in the first place. Often, however, it is only when the homeless become acutely ill that they are able to make a large claim on resources from a system that must take them in. And of course that claim falls immediately on hospitals and ultimately on the public purse, or as political economists sometimes aptly refer to it, the "public household."

Elsewhere in this issue of the *Journal*, Salit et al. report that hospital stays for the homeless in New York City cost far more than stays for other patients and suggest that this added burden be taken into account when policies for housing and supportive services are developed.² The phenomenon the authors identify follows a familiar pattern. Failure to deal with a social problem "upstream" (lack of housing, education, health insurance, substance-abuse prevention) leads to added costs for resources "downstream" (police, prisons, hospital care). The downstream institutions are not only expensive, but also poorly equipped to deal with the underlying social problems. Many people conclude, therefore, that preemptively attacking the problems upstream would be both more efficient and more effective, but the pattern stubbornly persists. In the case at hand, we continue paying to put the homeless in hospital beds while not providing them with ordinary beds of their own.

This result seems irrational, even tragic, but the failure to do more earlier is not due simply to shortsightedness. In tracing the genesis of any complex social problem, there are usually several factors to consider, and each one presents its own difficulties. The causes of homelessness involve changes in labor and housing markets, mental health policy, and social behavior. Since the 1970s, housing costs have risen more rapidly than the incomes of the least skilled workers, and although the number of subsidized housing units has increased, it falls far short of demand. The deinstitutionalization of the mentally ill (without adequate provision of community care) and the use of addictive drugs, notably "crack" cocaine, have also contributed to the increase in the homeless population. The decline in marriage rates has exposed more poor people to the risk of homelessness when they are unable to meet the costs of housing individually.³

None of these sources of homelessness has a cheap and obvious solution. Upstream interventions might be more affordable if they could be directed exclusively to people who end up in trouble downstream, but often the number of people at risk is much larger than the number who are affected. (This is where the metaphor breaks down; streams are usually narrower the further up one goes.) For example, the number of people who are eligible for subsidized housing because their incomes are low far exceeds the number who actually become homeless. Many of the poor live doubled up with relatives and roommates, although they are only an argument or an acute illness away from living on the streets. Subsidized housing for all these people would sharply reduce homelessness, but it would be very expensive.

It seems hard to believe, however, that the problem is intractable. After all, there was a time within living memory when homelessness hardly existed in the United States. As recently as the 1960s, the homeless population was extremely small, although we do not know exactly what its size was. But by 1987 about 500,000 to 600,000 Americans were homeless on any given night, according to a widely cited estimate⁴ (which one critic revised downward to 350,000).³ The National Law Center on Homelessness and Poverty estimates that there has been a 5 percent annual increase since 1987, but there is no consensus on the current figure. Most of the homeless are without homes for only short periods, and thus a far larger number of people experience a spell of homelessness over time. From 1988 to 1992, about 3 percent of the population of New York City used public shelters at some time.⁵

Although homelessness has increased greatly in recent decades, overall housing conditions in the United States have not declined. On the contrary, by any of the usual measures, such as the number of square feet per residence, housing has substantially

improved. Higher housing standards may, in fact, have indirectly contributed to homelessness. The low-grade, crowded dwellings that once provided homes to the very poor can no longer be built under current housing codes. Many communities do not want cheap housing in their backyards, and local zoning regulations often restrict the supply of cheap rental units by preventing houses from being subdivided. Given the current standards for living space and amenities, public subsidies support relatively fewer low-income housing units than they would under the standards that prevailed in the past.

High-minded, low-budget public policy thus seems to have had a role in creating homelessness. Should we be surprised that more people are unable to find an affordable place to live after governmental policies raise housing standards and restrict the private supply of cheap apartments while real earnings are stagnant and housing subsidies reach only a minority of the poor? Or that more people in psychological distress are on the streets after states have emptied mental hospitals without funding alternative community services? In regard to both housing and mental health, the comfortable have not been willing to pay the costs of policy, and the homeless have ended up paying the price.

If people with very low incomes are to afford homes, either their incomes must be higher or housing must be cheaper. Increases in the minimum wage and higher wage subsidies, such as earned-income tax credits, help raise more of the poor to self-sufficiency. Increased subsidies for low-income housing or reduced regulation can make housing cheaper or cheap housing more available. The remedy does not have to be a single magic bullet. And the government itself need not be in the business of building or providing the homeless a place to live; private nonprofit organizations have been some of the most effective suppliers of low-income housing. But governmental action to raise incomes or reduce costs is necessary to narrow the housing-affordability gap. Unfortunately, some policies that have been adopted recently, notably time limits on welfare benefits, may contribute to future increases in homelessness even if only a minority of the former recipients of public aid are unable to find work.

Failing the necessary upstream policies, the health care system will be left with the extra burden of the homeless. No one approves of this result, but whether the public and its representatives disapprove strongly enough to prevent it is another matter. Health care professionals can perform a great service by helping to mobilize that disapproval to put the public household in better order.

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- 4D Transportation
- 4E Mental health
- 4F Health
- 4G Education
- 4H Life skills counseling
- 4I Job training and job placement
- 4J More jobs

5) INCREASED FUNDING TO PROGRAMS AND/OR DIRECTLY TO HOMELESS

- 5A Welfare reform
- 5B Federal tax credits
- 5C Additional funding to rural areas
- 5D Redirection not issue, just more funds
- 5E Increase funding for services to the mentally ill
- 5F Increase minimum wage

6) HOUSING

- 6A Build more affordable housing, low-income housing
- 6B Use closed military bases, plants, and public facilities
- 6C Use vacant HUD project units
- 6D Site managers at public housing projects
- 6E Transitional housing
- 6F Provide counseling so formerly homeless do not return to streets
- 6G SRO preservation and production
- 6H Get foreclosed and abandoned homes to low-income people through public/private partnerships and non-profits

7) DEFINING THE CLIENT

- 7A Families
- 7B Children
- 7C Youth
- 7D Single adult males
- 7E Single adult females
- 7F Those at risk of becoming homeless
- 7G Formerly homeless

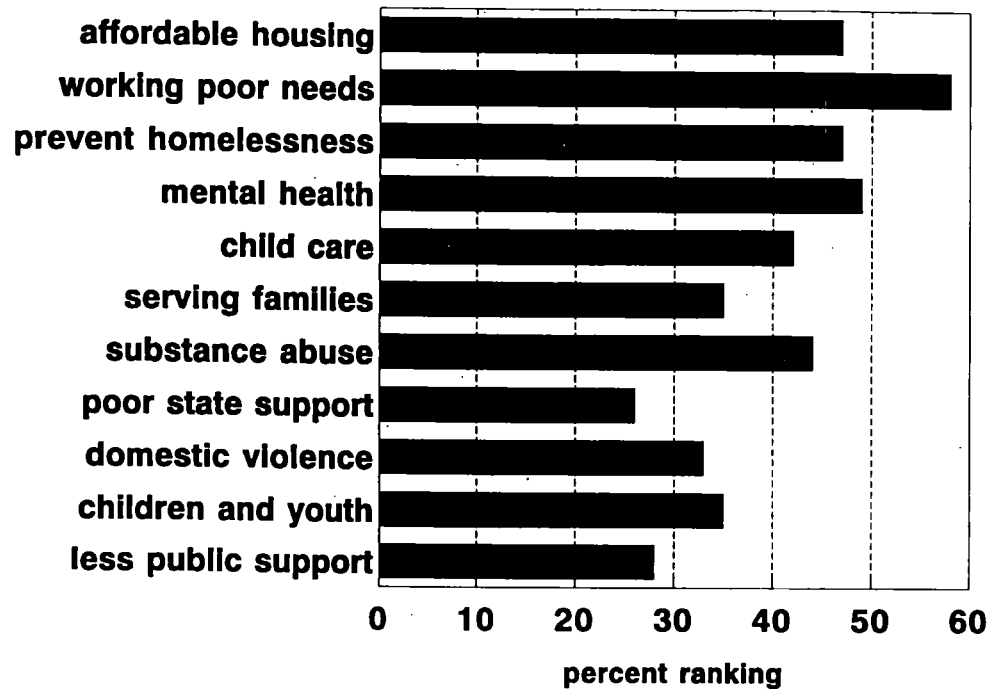
8) INNOVATIVE PROGRAMS/IDEAS/INSIGHTS

Appendix C

Additional Bar Graphs

PRIORITY HOMELESS ISSUES FROM FEDERAL GOVERNMENT

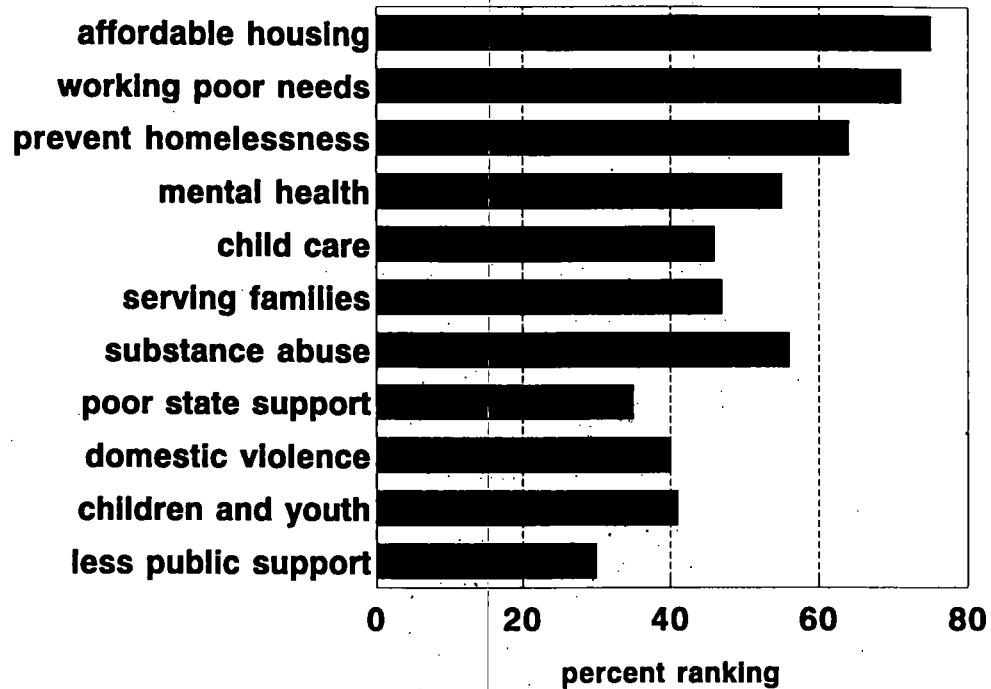
Top Issues ranked 1st or 2nd priority



SOURCE: 1993 HUD national survey (N=43)

PRIORITY HOMELESS ISSUES FROM CITY/COUNTY GOVERNMENT

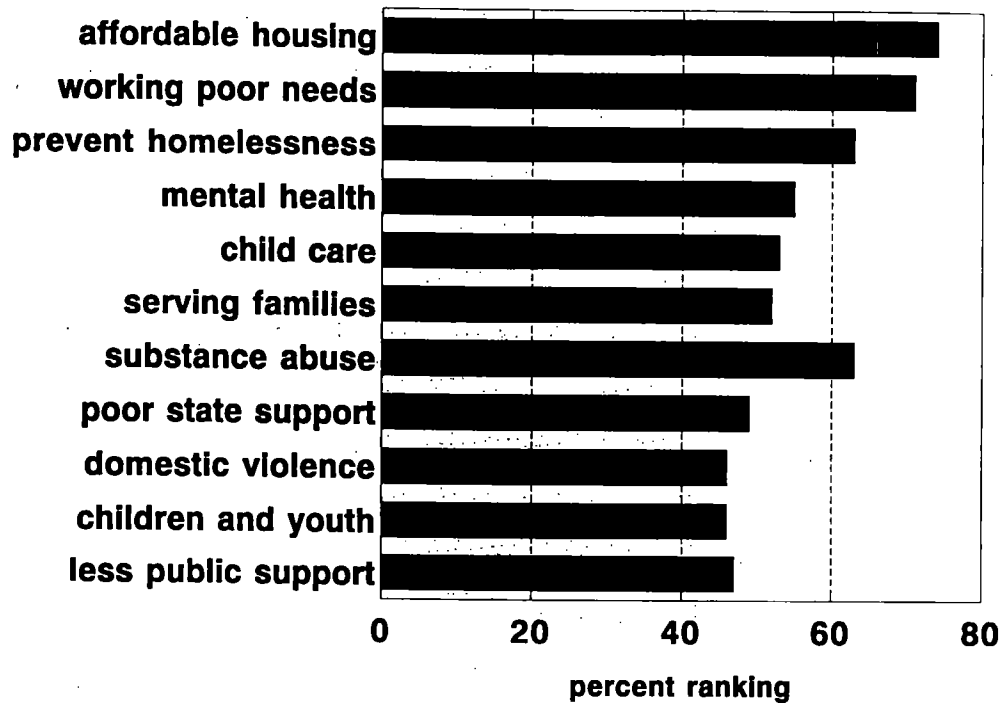
Top Issues ranked 1st or 2nd priority



SOURCE: 1993 HUD national survey (N=241)

PRIORITY HOMELESS ISSUES FROM LARGE METRO AREAS

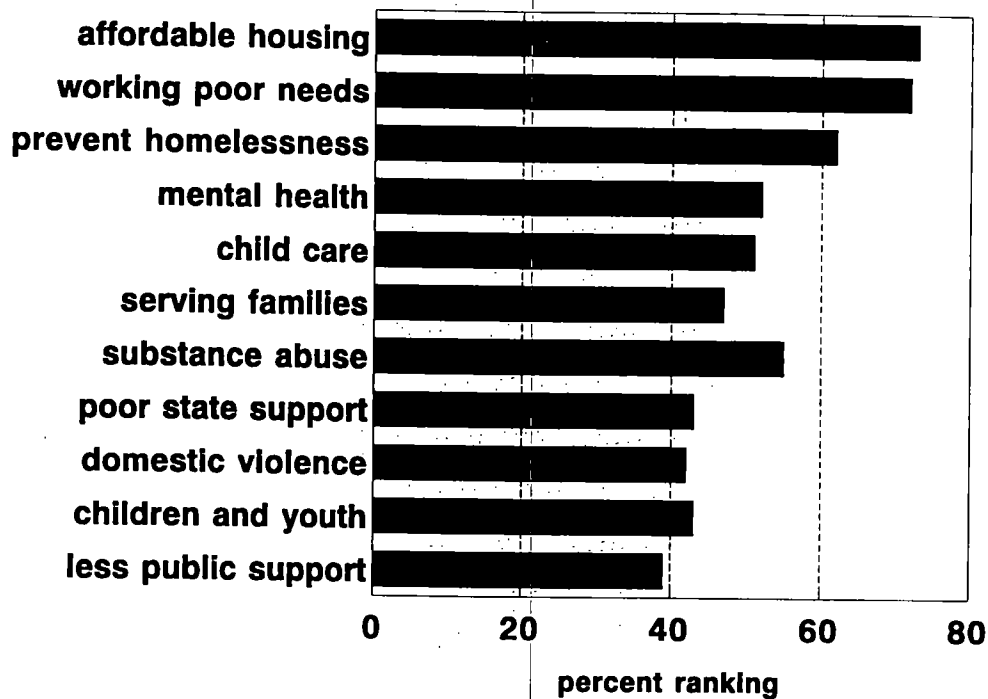
Top Issues ranked 1st or 2nd priority



SOURCE: 1993 HUD national survey (N=688)

PRIORITY HOMELESS ISSUES FROM MODERATELY SIZED AREAS

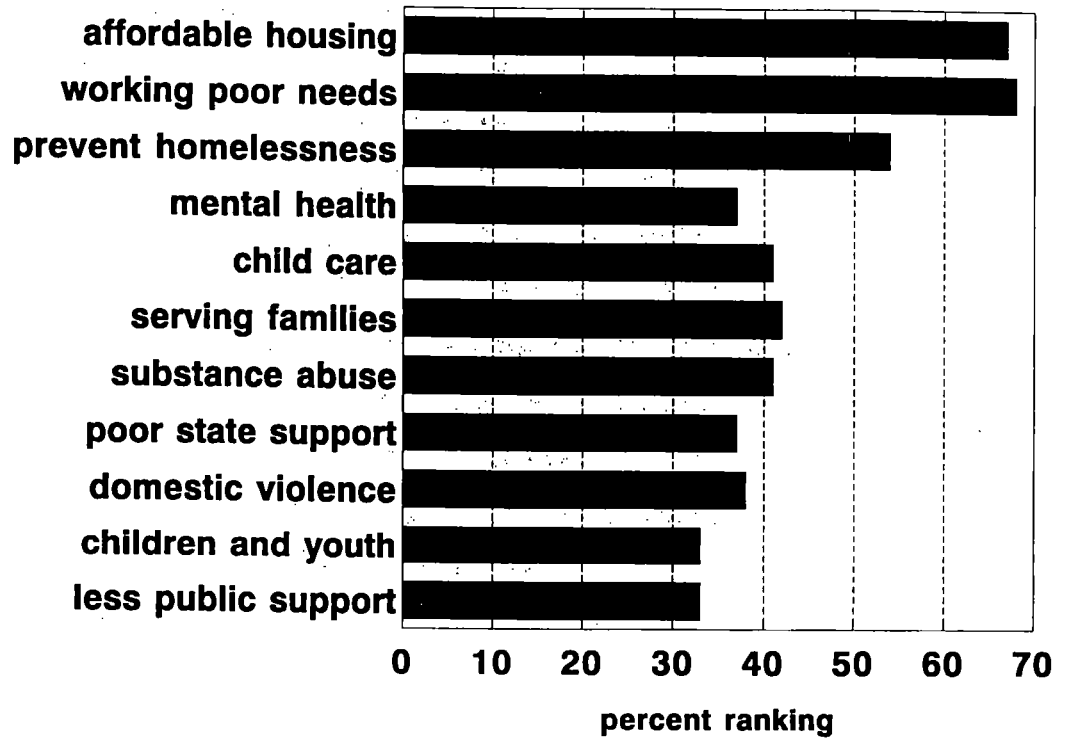
Top Issues ranked 1st or 2nd priority



SOURCE: 1993 HUD national survey (N=656)

PRIORITY HOMELESS ISSUES FROM RURAL AREAS

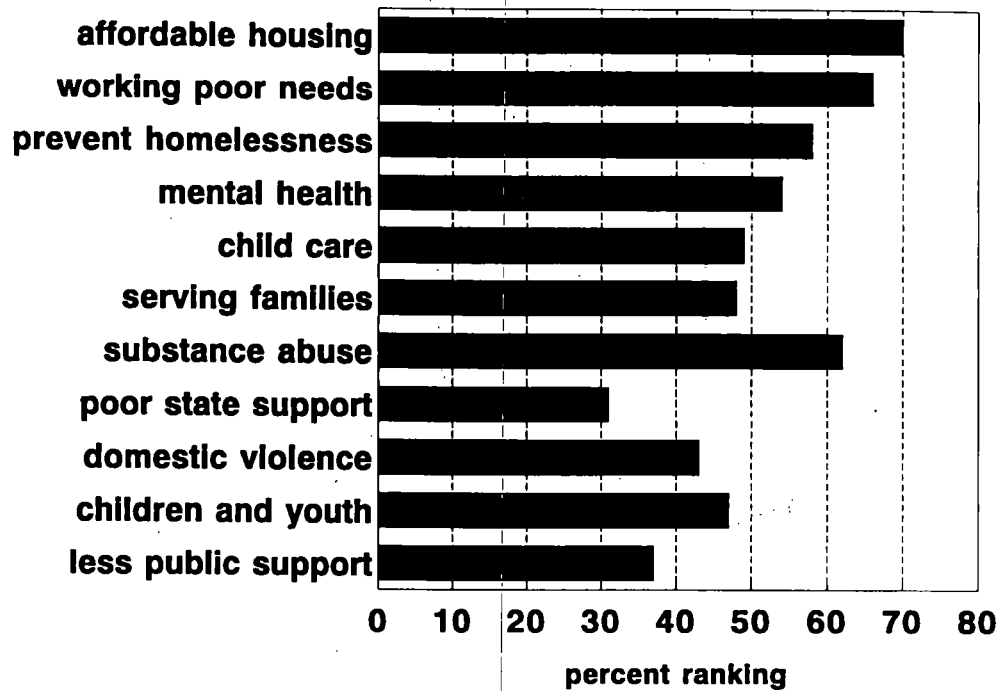
Top Issues ranked 1st or 2nd priority



SOURCE: 1993 HUD national survey (N=434)

PRIORITY HOMELESS ISSUES FROM STATE GOVERNMENTS

Top Issues ranked 1st or 2nd priority



SOURCE: 1993 HUD national survey (N=102)

Appendix D

Consultants and Advocacy Organizations

Consultants and Advocacy Organizations

The Interagency Council on the Homeless would like to thank the following individuals for their contributions to the development of this Plan. Acknowledgment in the list below does not imply endorsement of this Plan.

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Hank 55

✓ Health

✓ Non-profits

✓ 101 - grants &

① \$5 million / grant 16 per cost
\$15,000 per yr.

② - 71 med. centers

HCM 1.

Substance abuse

③ 1300 - 1500 - don't coal

\$90 m. 11.

40,000

250,000

→ Grants
→
\$45 mill.
w/rote gk of hank (55)



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

Homeless -
GW

DRAFT

STATEMENT OF ADMINISTRATION

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH

H.R. 3039 - Veterans Transitional Housing Opportunities Act of 1998 (Stump (R) AZ and 12 cosponsors)

H.R. 3039 would authorize VA to guarantee up to 15 loans, totaling as much as \$100 million, for non-profit organizations to construct or rehabilitate multifamily transitional housing projects for homeless veterans.

The Administration is deeply concerned about the plight of homeless veterans. The Administration supports the goal of H.R. 3039 to increase the availability of transitional housing for homeless veterans. In fact, the President's FY 1999 Budget expands funding for homeless assistance, including a significant increase in funding for McKinney Act programs, which provide assistance to homeless veterans.

While the Administration has a number of concerns with H.R. 3039, the Administration is particularly concerned about: (1) how the bill's proposed loan program would be structured and implemented because the loan guarantee program in H.R. 3039 does not conform with the fundamental principles of Federal credit management; and (2) VA has no previous experience administering multi-family housing loan guarantees or guaranteeing debt incurred by non-profit organizations; therefore, H.R. 3039 would necessitate the establishment of a new office within VA to implement the program.

The Administration looks forward to working with the Congress to determine whether existing VA programs can be used and/or enhanced to meet the transitional housing needs of homeless veterans.

Pay-As-You-Go Scoring

H.R. 3039 would affect direct spending; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act (OBRA) of 1990. OMB's preliminary scoring estimate of this bill indicates that it would increase direct spending by approximately \$3 million in FY 1999 and \$48 million during FYs 1999-2003. The bill does not contain offsets for this increased spending. Therefore, if the bill were enacted and the FY 1999 costs were not offset during the remainder of this session of Congress, the bill's deficit effects could contribute to a sequester of mandatory programs.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
LEGISLATIVE AFFAIRS

10/1/85

PHONE: 395-4790 / FAX: 395-3729

TO: Mary Smith

59136

DATE: 5-15

FROM:

___ CHUCK KIEFFER

___ CHUCK KONIGSBERG

___ LISA KOUNTOUPES

✓
___ KATE DONOVAN

___ NANCY BRANDEL

Comments: Attached are two draft SAPs for
your clearance:

① HR 3603

② HR 3039

Please call me on Monday @ 5-9136 w/ clearance/
comments.

FAX #: 6-8581

PAGES: 6

PHONE NUMBER: 6-7732

(includes cover page)

Thanks!

- On House Suspensions calendar for Tues.

DRAFT - NOT FOR RELEASE

May 15, 1998
(House)

H.R. 3603 - A Bill to Authorize Major Medical Facility Projects and Major Medical Facility Leases for the Department of Veterans for Fiscal Year 1999, and for other purposes
(Stump (R) AZ and 7 cosponsors)

The Administration does not object to House passage of H.R. 3603, but will work in the Senate to:

- Address the Administration's concerns about the additional, unrequested authorization of appropriations included in the bill. H.R. 3603 would authorize nearly \$140 million in projects not requested in the President's FY 1999 Budget.
- Increase the threshold amount for determining what constitutes a Department of Veterans Affairs (VA) major medical facility lease. The Administration is pleased that H.R. 3603 would increase the threshold for designating a parking facility project as a major medical facility project from \$3 million to \$4 million, but also favors an increase from \$300,000 to \$1 million in the threshold defining a VA major medical facility lease.

* * * * *

(Do Not Distribute Outside Executive Office of the President)

This Statement of Administration Policy was developed by the Legislative Reference Division (Elmore) in consultation with VAPD (Keenan/ Dennis). The Department of Veterans Affairs (Anderson) concurred with the position, and the Department of Defense had no comment. The NSD (Devine), GC (Damus), and White House LA (Maldon) did not respond.

OMB/LA Clearance: _____

Background on H.R. 3603

H.R. 3603 would authorize appropriations for construction projects and leases for VA medical facilities for FY 1999. The bill includes five construction projects, totaling \$139.6 million, that were not included in the President's FY 1999 Budget.

H.R. 3603 was introduced on March 31, 1998, and reported by the House Veterans' Affairs Committee on April 22, 1998. To date, the Administration has not taken a position on H.R. 3603.

Summary of H.R. 3603

H.R. 3603 would authorize appropriations of \$205.3 million for ten major construction projects and \$8.5 million for three facility leases. It also would increase the threshold for the designation of certain projects as "major" medical facilities.

1. Construction Authorization. H.R. 3603 would authorize appropriations for the following projects at VA medical centers in the cities listed below:

- Clinical consolidation and seismic corrections -- Long Beach, CA
- Seismic corrections -- San Juan, Puerto Rico
- Outpatient clinic projects -- Auburn, CA, and Merced, CA
- Parking structure -- Denver, CO
- Outpatient clinic expansion -- Washington, DC
- Construction and seismic corrections -- Palo Alto (Menlo Park), CA
- Ambulatory care improvements -- Cleveland (Wade Park), OH
- Ambulatory care addition -- Tucson, AZ
- Psychiatric care addition -- Dallas, TX

The last five projects listed (for Washington, DC; Palo Alto (Menlo Park), CA; Cleveland (Wade Park), OH; Tucson, AZ; and Dallas, TX) were not included in the President's FY 1999 Budget. *A total of \$139.6 million is authorized for these five projects.*

2. Leases. H.R. 3603 would authorize appropriations of \$8.5 million for medical facility leases of satellite outpatient clinics in Baton Rouge, LA; Daytona Beach, FL; and Oakland Park, FL. All of these leases were included in the President's FY 1999 Budget.
3. "Major" Threshold Increase. H.R. 3603 would increase the threshold for treatment of a parking facility project as a "major" medical facility project. The threshold would be increased from \$3 million to \$4 million. This increase was included in the President's FY 1999 Budget.

Pay-As-You-Go Scoring

According to VAPD (Keenan), H.R. 3603 would not affect direct spending or receipts; therefore, it is not subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act (OBRA) of 1990. CBO concurs.

LEGISLATIVE REFERENCE DIVISION DRAFT

May 15, 1998 - 4:45 p.m.

May 15, 1998
(House)

H.R. 3039 - Veterans Transitional Housing Opportunities Act of 1998
(Stump (R) AZ and 12 cosponsors)

The Administration is deeply concerned about the plight of homeless veterans and supports the goal of H.R. 3039 to increase the availability of transitional housing for homeless veterans. The President's FY 1999 Budget expands funding for homeless assistance, including a significant increase in funding for McKinney Act programs, which provide assistance to homeless veterans.

H.R. 3039 would authorize VA to guarantee up to 15 loans, totaling as much as \$100 million, for non-profit organizations to construct or rehabilitate multifamily transitional housing projects for homeless veterans. The Administration is particularly concerned about how the bill's proposed loan program would be structured and implemented. The loan guarantee program in H.R. 3039 does not conform with the fundamental principles of Federal credit management. In addition, VA has no previous experience administering multi-family housing loan guarantees or guaranteeing debt incurred by non-profit organizations. H.R. 3039, therefore, would necessitate the establishment of a new office within VA to implement the program.

Instead of the new loan guaranty program proposed in H.R. 3039, the Administration is prepared to work with the Congress to determine whether existing VA programs can be used and/or enhanced to meet the transitional housing needs of homeless veterans.

Pay-As-You-Go Scoring

H.R. 3039 would affect direct spending; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act (OBRA) of 1990. OMB's preliminary scoring estimate of this bill indicates that it would increase direct spending by approximately \$3 million in FY 1999 and \$48 million during FYs 1999-2003. The bill does not contain offsets for this increased spending. Therefore, if the bill were enacted and the FY 1999 costs were not offset during the remainder of this session of Congress, the bill's deficit effects could contribute to a sequester of mandatory programs.

* * * * *

(Do Not Distribute Outside Executive Office of the President.)

This Statement of Administration Policy was developed by the Legislative Reference Division (Elmore) in consultation with VAPD (Zavada, Lehr, Dennis), HTF (Meredith), BRD (Sullivan, Stigile, McAllister), GC (Rettman) and VA (Cohn). The Departments of Housing and Urban Development (Moran), Labor (Taylor), Defense (Raezer), and Justice (Jones), and NSD (Devine), HD (Rowe), TCJS (Haas), and OIRA (Eydt) had either no objection to, or no comment on, the position.

White House LA (Maldon) and the Departments of Health and Human Services, and Treasury did not respond to the request for views on this SAP.

OMB/LA clearance: _____.

H.R. 3039 was introduced on November 13, 1997. On March 11th, the House Veterans' Affairs Committee amended H.R. 3039 and ordered it reported. The Committee report was filed on March 17th.

Administration Position to Date

At a February 24th hearing on H.R. 3039, VA supported the goal of increasing the availability of transitional housing for homeless veterans, but stated that the Administration could not support the bill as introduced. VA questioned whether a loan guaranty program is the best alternative to achieve the bill's goal and how such a program would be structured and implemented. VA also stated that the National Service Life Insurance (NSLI) program was not an appropriate or viable funding offset for the new loan guaranty program. (As reported, H.R. 3039 no longer includes the NSLI as a funding offset or any other offset.)

In an April 20th letter to Rep. Quinn (R-NY), OMB Deputy Director Lew expressed the Administration's concern about the plight of homeless veterans, but noted the Administration's concerns about H.R. 3039.

Background on VA's Position

Since the February 24th testimony, VA (Sec. West) has indicated a preference to support the bill. VA decided not to answer a question posed by Rep. Quinn (R-NY) at the hearing regarding what funding offsets VA would support instead of the NSLI fund provision. VA's decision not to respond was due, in large part, to OMB's insistence that the answer not identify offsets for the bill, since the Administration does not support the bill. Despite VA's desire to support the bill, VA was involved in drafting this Statement of Administration Policy and agrees with it.

Summary of H.R. 3039

H.R. 3039 would seek to expand the supply of transitional housing for homeless veterans by authorizing the Secretary to guarantee loans for the construction, rehabilitation, or refinancing of multifamily transitional housing projects for homeless veterans. To achieve this goal, the bill would authorize VA to guarantee up to 15 loans with a maximum aggregate value of \$100 million. VA could not guarantee more than five loans in the first three years of the program. The bill would authorize the Secretary to guarantee loans notwithstanding any requirement elsewhere in law for prior appropriations for such purpose. Up to 100 percent of the loan amount could be guaranteed.

H.R. 3039 would require certain standards of personal responsibility from the facilities' residents. They would be required to seek and obtain employment and maintain sobriety. The project would be required to enforce sobriety standards and provide supportive services, including job counseling. Additionally, residents would be expected to pay a reasonable fee for their residence.

H.R. 3039 includes several requirements to assure repayment of loans. The maximum loan amount for a project could not exceed the lesser of the amount generally approved for projects of similar nature and risk or 90 percent of the project's total cost. In addition, the loans would have to be of sound value, secured, and subject to terms and conditions that the Secretary considers reasonable in comparison to projects of similar size, location, population, and services provided. The bill also would provide that the Secretary take necessary steps to obtain repayment on defaulted loans.

Pay-As-You-Go Scoring

According to VAPD (Lehr, Dennis) and BASD (Sullivan, Stigile), H.R. 3039 is subject to the pay-as-you-go (paygo) requirement of the Omnibus Budget Reconciliation Act (OBRA) of 1990 because it would increase direct spending. OMB's preliminary scoring estimate of this bill indicates that it would increase direct spending by approximately \$3 million in FY 1999 and a total of \$48 million during FYs 1999-2003. The bill does not contain offsets for this increased spending. Therefore, if the bill were enacted and the FY 1999 costs were not offset during the remainder of this session of Congress, the bill's deficit effects could contribute to a sequester of mandatory programs.

CBO's final report on H.R. 3039 estimates paygo costs of about \$6 million over the same period (FYs 1999-2003) and a total of \$10 million over the period FYs 1999-2005, the span of the proposed loan program. (CBO's estimate uses the Small Business Administration's (SBA) micro-lending program as a proxy. OMB's estimate, on the other hand, uses the Department of Agriculture's Section 515 multifamily housing direct loan program, which OMB argues is a better proxy because its characteristics are much more similar to those of the proposed loan program than are the SBA program.)

LEGISLATIVE REFERENCE DIVISION DRAFT

May 15, 1998 - 5:55 p.m.

MEMORANDUM

TO: BRUCE REED, ELENA KAGAN
FROM: TOM FREEDMAN, MARY L. SMITH
RE: HOMELESSNESS
DATE: JUNE 23, 1998

I have added budget figures at the end.

I. BACKGROUND

- Fred Karnas is the head of the Interagency Council (708-1506).
- George Ferguson (708-1418 or 708-0614 x4517) to get draft of surveys.

II. STATISTICS

- There are about 250,000 to 350,000 homeless persons on a given night. (OMB).
- The Federal Plan states that on any given night there are as many as 600,000 homeless persons. (Burt and Cohen, 1989).
- OMB states that 4 out of 5 single homeless men are veterans. The Federal Plan states that approximately 30 to 45 percent of the entire adult male homeless population are veterans. Fred Karnas estimates that one-third of all homeless persons are veterans.
- The National Coalition of Homeless Veterans estimates that there are 275,000 homeless veterans on any given night. They estimate that there would be double that number over the course of a year.
- The National Coalition of Homeless Veterans estimates that the VA served 30,000 homeless veterans in 1997. VA says they serve 40,000 per year.
- 50 percent of the homeless population have substance abuse problems (Fred Karnas).
- One-fourth to one-third have a mental health problem (Fred Karnas).
- Dennis Culhane has the best studies.
 - 80% cycle through pretty quickly
 - 10% have a longer cycling

--10% substance abuse and are chronically on the street

- The LA Vets program (which is a community-based organization) saved the local VA \$12- \$14 million.
- The Maryland Homeless Veterans program in Baltimore is also a good program.

III. GOVERNMENT

- The McKinney Act is the major legislation addressing homelessness. There is \$700 million for competitions.
- HUD spends \$1 billion on homelessness per year (OMB).
- Total VA budget for Homeless is \$90 million per year (Peter Dougherty).
- There are three major VA programs that work with homeless.
Grant per diem. This program gives grants to community-based organizations to acquire transitional beds. In FY 94 through FY 97, 101 grants were awarded to 84 non-profit or state or local government agencies in 36 states. There is \$5 million per year for new grants. Pays up to \$16/day for ongoing operational costs.
Homeless Chronically Mentally Ill Veterans Program. The HCMI program places homeless veterans needing more intensive treatment into one of its roughly 125 contracted community-based facilities. The program serves over 19,000 homeless veterans per year, with over 3,000 receiving residential treatment. The average cost per day is \$38.
Domiciliary Care. Treatment takes place in approximately 1500 dedicated beds at VA medical center domiciliaries.
- Homeless Veteran Reintegration Program at the Department of Labor. \$10 million per year. This program gives money for employment programs.
- There are 56 VA facilities that serve homeless veterans (National Coalition).
- VA says there are 172 VA Medical Centers, and that 71 sites provide health care for homeless. At least 70 sites don't have domiciliary program (geographical that would be one-half of the country). Peter Dougherty estimates that they would need about \$45 million to cover most of country.
- Rep. Lazio's bill, which passed in the House, would revamp the McKinney Act. HUD has dropped support for this bill (OMB).

- Rep. Marcia Kaptur (D-OH) is looking at the mental health aspects of homelessness (Fred Karnas).
- H.R. 3039. Sponsored by Stump and Lane Evans. This bill is a \$100 million loan guarantee program. It would only fund 15 sites. See Bruce Long at OMB.

IV. UPCOMING DATES

- May 1998. Draft of the national survey of clients. Marty Burke at Urban Institute will write it.
- Fall 1998. Provider survey, to be released later in summer.
- Fall 1998. The Interagency Council is going to lay out research and prepare a best practices report.
- November 1998. The Interagency Council is planning on putting on a conference (Fred Karnas).

V. RECOMMENDATIONS

- **Tracking:** we need to track the homeless population. There is an ANCHOR database system being developed by University of Pennsylvania's Dennis Culhane (sp). Recommended by OMB. The National Coalition suggests that providers ask whether someone is a veteran on their intake forms.
- **Better coordination -- make mainstream programs more available.**
- **Link housing vouchers to case management.** Recommended by OMB.
- **The VA is not held accountable on outcome.** The National Coalition believes that the VA only counts numbers served, not the number who no longer are homeless. Peter Dougherty from the VA disputes this -- he says they have great tracking statistics.
- **Put more money in VA programs.** In this order (1) grants per diem (because it is only a subsidy so you get more bang for your buck (2) health care and (3) domiciliaries.
- **HUD grants should put veterans as a consideration in issuing grant.** (Peter Dougherty from VA).

SPECIFIC PROPOSALS

I. PROPOSAL FROM VA

A. Increase Funding for VA's Homeless Grant and Per Diem Program

Background

This program allows for the provision of grants and per diem payments to assist public and non-profit organizations establish and operate new supportive housing and service centers for homeless veterans. Since the first round of funding in 1994, the VA has awarded 101 grants to 84 community agencies in 36 states and the District of Columbia. Total VA funding for these projects was over \$21 million, or approximately \$5 million annually. When these projects are completed, approximately 1,700 new community-based beds will be available for homeless veterans. With the current round of funding that number is expected to grow to 2,200 beds in the future.

1. **Increase funding for new grants by \$7 million.** This additional \$7 million, added to the \$5 million already funded by the VA for a total of \$12 million, would create approximately 1000-5000 new beds annually with services for homeless veterans. 75% of the beds would be for VA-eligible persons.
2. **Increase per diem funding by \$7 million.** This funding is for ongoing operations, and it subsidizes providers, paying no more than one-half of their operating costs. Currently, approximately 5,500 veterans receive services from existing programs. **Check:** [It costs approximately \$6,000 per year to pay per diem to service providers on an annualized basis. This would pay for approximately 2,250 different veterans receiving care from VA. **Check $2250 \times 6000 = 13,500,000$**] Within 2 years, more 10,000 homeless veterans annually could be completing treatment in VA quality-approved community setting operated by nonprofit entities, Native American tribes, or state and local governments.
3. **Provide \$5 million in new per diem funding.** P.L. 102-590 that created the Homeless Grant and Per Diem Program did not require an entity to receive a grant in order to be eligible for per diem; however, VA, by regulation and in an attempt to protect its grant investment, has limited per diem to programs that receive a grant. This would help to pay for care of approximately 2000 veterans in non-grantee, yet VA-approved, community-based programs.

Part A summary: \$24 million in funding (\$19 million if existing \$5 million not counted) for treatment and services for more than 5,000 veterans annually with service provided in community-based settings.

B. Increase Funding for Dedicated Staff and Contract Care Dollars at Each VA Medical Center.

Background

There are approximately 171 VA Medical Centers across the country. At 61 of these centers, there are dedicated staff with contract dollars to buy services from community service providers for homeless veterans. At those sites approximately 75 veterans are serviced at each site for an approximate total of 4,500 veterans. At 10 additional medical centers there are dedicated staff without contract care money.

1. **Increase funding by \$25 million so that each of the approximately 171 VA Medical Centers in the country will have dedicated staff and contract dollars to address the needs of homeless veterans.** If this proposal is initiated with an average of 1.5 FTE per site for a cost of \$100,000 annually and contract care dollars for residential contract care and transportation for a cost of \$150,000 per site annually, there would be, for the first time, a comprehensive nationwide system to address the needs of homeless veterans by having dedicated staff at each VA Medical Center. Costs are approximately \$250,000 annually per site. This would allow as many as 6,000 new veterans to be treated in community residential settings. A total of up to 12,000 homeless veterans could be treated annually under this program by expanding the existing program.
2. **Provide \$2 million in new funding for Homeless Women Veterans Programs.** These funds would be used to develop up to 20 new programs for outreach, case management, and to provide residential care for homeless women veterans. Less than 3 percent of veterans treated under current programs are women. Special programs are needed because current offerings are male dominated making many women veterans uncomfortable, particularly considering a high rate of sexual trauma among women veterans. These programs would be largely contracted community care. The Department of Veterans Affairs estimates that up to 1,000 women veterans could be served under this initiative.
3. **Provide \$2 million in new funding for Compensated Work Therapy.** VA's medical care program offers Compensated Work Therapy (CWT) to help homeless veterans become gainfully employed. This program offers many veterans with significant barriers to employment, particularly homelessness, with job readiness experiences. At present, this program helps approximately 3,500 **check** veterans annually to be able to move directly into competitive work in the community, and helps another 10,000 who need additional skills development and training. This program ties very closely with a number of programs at the Department of Labor to help veterans gain employment. The VA estimates that an additional \$2 million could help more than 2,000 veterans by expanding ten sites and ten program augmentations of CWT sites. **Check if this is 20 or just 10?**

Part B summary: \$29 million in funding to provide a VA continuum of care for all **check the word "all"** veterans, including some hard-to-reach rural and women veterans with an estimated 9,000 new veterans being assisted.

C. Collaboration to Provide Care and Services Needed by Homeless Veterans.

1. **Increase funding by \$10 million for the Homeless Veterans Reintegration Program (HVRP).** The Department of Labor's Homeless Veterans Reintegration Program (HVRP) provides grants to community-based, nonprofit organizations that work directly with homeless veterans. Currently, this program receives \$2.5 million and has 2 operating sites. The VA estimates that an increase of funding of \$10 million for a total of \$12.5 million would permit grants to be awarded to one or more projects in approximately 37 states. The VA estimates that with an additional \$10 million would allow up to 100 grantees to be funded and that 15,000 veterans could be served with up to 10,000 placed back on the employment rolls.
2. **Provide an additional \$2.5 million for Stand Downs.** At more than 70 sites across the country each year, community-sponsored events called "Stand Downs" bring homeless veterans together with community-based service providers; state and local government service providers; VA health care and benefits staff; and many others prepared to assist homeless veterans and their families with housing, health care, employment, legal matters, education, transportation, and other barriers preventing them from reintegrating into the social mainstream. The VA estimates that, with an additional \$2.5 million, more than 100 sites would be able to conduct these one-stop service delivery programs for homeless veterans. A three-year study of 227 events showed that more than 80,000 veterans and their family members were assisted by these events. The VA proposes that these additional funds could be used to help more than 50,000 veterans attend "Millennium Stand Downs," which is a White House project (involving Dena Wood and John Hanson) with a goal of ensuring that all veterans will have safe lodging and will be able to secure treatment at the Millennium.
3. **Fund an additional \$0.5 million to provide excess property to homeless veterans.** The VA, along with the General Services Administration and the Department of Defense, provide excess property each year to homeless veterans. Primarily, this program provides clothing such as boots, hats, coats, pants, shirts, and other excess military personal clothing items. However, sleeping bags, blankets and other items are sometimes available as well. A current inventory lists over 220 items with a total value of more than \$11 million. This Hammer Award-winning program has distributed more than \$35 million of property to homeless veterans during the last four years. The VA proposes a new initiative to add donated civilian clothing, furniture, and equipment to assist thousands of homeless veterans and community-based homeless veterans service providers. The VA estimates that an additional \$0.5 million could secure additional warehouse space and pay for shipping costs associated with this initiative and could help approximately 25,000 to 50,000 veterans.
4. **Fund an additional \$0.5 million for the North East Program and Evaluation Center.** The North East Program and Evaluation Center (NEPEC) reviews, monitors, and evaluates VA's homeless programs. With all the additional programs and sites suggested under this initiative, additional funding would be needed to ensure a quality review with

reliable information. According to the VA, NEPEC's high-quality standards of review are unmatched under any existing home program in the country and is the best protection in order to ensure that the highest quality evaluation is conducted.

Part C summary: \$3.5 million in funding for VA and \$10 million for the Department of Labor for job training and services for more than 115,000 homeless veterans annually. While some of these veterans may be duplicated, it would certainly represent the largest commitment ever made to improve the lives of homeless veterans.

D. Improvement of HUD's McKinney Act Funding Sources for Veterans.

Background:

Veteran-specific HUD McKinney Act funded projects are disproportionately under funded, and many projects claiming to be veterans' projects are not really targeted to veterans. After HUD's last round of funding, the VA contacted each of the projects listed by HUD as veteran-targeted or veteran-specific and found that many were not targeted or designed to serve veterans. According to information supplied by HUD, more than \$21 million was earmarked for "veteran" projects; however, VA discovered that more than \$9.5 million was not available for veterans. In its assessment, the VA excluded projects where less than one-third of their clients would be veterans. In fact, the VA found that many of the projects stated that no veterans or less than ten percent of the population to be served were expected to be veterans.

1. **Veteran representation on HUD's local planning boards.** Veterans Service Organizations believe that there is a strong need to have veterans' advocates at the local level because there is no existing mechanism to assist veterans at the national level to ensure that the needs of homeless veterans are addressed.
2. **Require HUD to use the "CHALENG for Veterans" Report.** For more than four years, VA has conducted meetings with strong participation from the veterans community in order to examine the services available locally for homeless veterans, identify the unmet needs of homeless veterans, and develop local action plans to address those unmet needs. This meeting and report called "CHALENG for Veterans" occurs at each VA medical center across the country and contains local resource information and a "veterans community view" of the unmet needs of veterans in the area. The overall information is folded into a national report. The VA proposes to require HUD and its local planning process to use the "CHALENG for Veterans" report to ensure that the needs of homeless veterans will be met under HUD's local continuum of care plans. As with any reporting system, the weight each community would give to this information would vary; however, the VA believes that it is imperative that this information be available.
3. **Provide an additional \$4 million to HUD-VASH.** In this joint Supported Housing program with the Department of Housing and Urban Development, VA staff at 35 VA

Medical Centers provide ongoing case management and other needed assistance to homeless veterans in permanent housing supported by nearly 2,000 specially-designed HUD rental assistance vouchers. Long-term housing has been identified as one of the top unmet needs of veterans for several years in the CHALENG report. Each VA employee, usually a social worker, manages approximately 30 voucher recipients. The VA estimates that up to 500 HUD Section 8 vouchers are expected to expire in the near future. The VA proposes that all current vouchers for veterans should be held and that more vouchers should be offered for seriously mentally and physically ill homeless veterans. The VA recommends that thirty additional sites be added and that 1,800 vouchers be added. The VA estimates that an additional \$4 million will permit approximately 1,800 veterans to gain long-term housing which will reduce their dependence on the VA health care system. [HUD costs associated with this proposal have not be estimated.]

Part D summary: \$4 million in funding to provide long-term housing for approximately 1,800 veterans.

FINAL COSTS/SUMMARY

This proposal would constitute the single largest investment into breaking the cycle of homelessness among veterans. This proposal seeks to increase residential alternatives, community-based contracted care, job preparation activities, stand down activities, the distribution of clothing, and long-term housing. This proposal is estimated to positively impact 100,000 to 150,000 veterans annually. Additional funding for the VA would be \$60.5 million and additional funding for the Department of Labor's Homeless Veterans Reintegration Program (HVRP) would be \$10 million. HUD's Section 8 costs are not contained in this estimate. [There appears to be a significant effort to increase section 8 long-term housing alternatives and this would simply urge a portion of those new voucher to be dedicated under this effort. Additional resources in the amount of \$5 million per year for the next two years would be needed. After three years, the increased funding could be reduced to the present level if projections of services are achieved.]