

U.S. Department of Health and Human Services: Strategic Action Plan on Homelessness



**U.S. Department of Health and Human Services
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Report from
the Secretary's Work Group
on Ending Chronic Homelessness

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**U.S. Department of Health and Human Services:
Strategic Action Plan on Homelessness**

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U.S. Department of Health and Human Services: Strategic Action Plan on Homelessness

EXECUTIVE SUMMARY

Each year, approximately one percent of the U.S. population, some 2-3 million individuals, experiences a night of homelessness that puts them in contact with a homeless assistance provider, and at least 800,000 people are homeless in the United States on any given night. The population who experiences homelessness is a heterogeneous group, and includes single individuals, families with children, and unaccompanied runaway and homeless youth. While interventions to interrupt and end homelessness may vary across groups, ending homelessness permanently requires housing combined with the types of services supported by programs operated by the U.S. Department of Health and Human Services (HHS).

HHS is the United States government's principal agency for protecting the health of all Americans and supporting the delivery of essential human services, especially for those who are least able to help themselves. As such, the delivery of treatment and services to persons experiencing homelessness is included in the activities of the Department, both in five programs specifically targeted to homeless individuals and in fourteen non-targeted, or mainstream, service delivery programs. The coordination of these services, both within the Department, as well as with our Federal partners who provide housing and complementary service programs, is a critical component of achieving the goal of preventing and ending homelessness.

The U.S. Department of Health and Human Services has developed the *Strategic Action Plan on Homelessness* to outline a set of goals and strategies that will guide the Department's activities related to homelessness over the next several years. This strategic action plan serves as the next iteration of the strategic action plan released in 2003, *Ending Chronic Homelessness: Strategies for Action*, which outlined the Department's strategy for contributing to the Administration goal of ending chronic homelessness. The intent of this new plan is to refine the goals and strategies of the 2003 Plan to reflect the changing set of challenges and priorities four years after the development of the first plan.

- Goal 1: Prevent episodes of homelessness within the HHS clientele, including individuals and families
- Goal 2: Help eligible, homeless individuals and families receive health and social services
- Goal 3: Empower our state and community partners to improve their response to individuals and families experiencing homelessness
- Goal 4: Develop an approach to track Departmental progress in preventing, reducing, and ending homelessness for HHS clientele

U.S. Department of Health and Human Services: Strategic Action Plan on Homelessness

Strategic Action Plan Framework

Goal 1: Prevent episodes of homelessness within the HHS clientele, including individuals and families

- Strategy 1.1 Identify risk and protective factors to prevent episodes of homelessness for at-risk populations
- Strategy 1.2 Identify risk and protective factors to prevent chronic homelessness among persons who are already homeless
- Strategy 1.3 Develop, test, disseminate, and promote the use of evidence-based homelessness prevention and early intervention programs and strategies

Goal 2: Help eligible, homeless individuals and families receive health and social services

- Strategy 2.1 Strengthen outreach and engagement activities
- Strategy 2.2 Improve the eligibility review process
- Strategy 2.3 Explore ways to maintain program eligibility
- Strategy 2.4 Examine the operation of HHS programs, particularly mainstream programs that serve both homeless and non-homeless persons, to improve the provision of services to persons experiencing homelessness
- Strategy 2.5 Foster coordination across HHS to address the multiple problems of individuals and families experiencing homelessness
- Strategy 2.6 Explore opportunities with federal partners to develop joint initiatives related to homelessness, including chronic homelessness and homelessness as a result of a disaster

Goal 3: Empower our state and community partners to improve their response to individuals and families experiencing homelessness

- Strategy 3.1 Work with states and territories to effectively implement Homeless Policy Academy Action Plans
- Strategy 3.2 Work with governors, county officials, mayors, and tribal organizations to maintain a policy focus on homelessness, including homelessness as a result of a disaster
- Strategy 3.3 Examine options to expand flexibility in paying for services that respond to the needs of persons with multiple problems
- Strategy 3.4 Encourage states and localities to coordinate services and housing

Strategy 3.5 Develop, disseminate and utilize toolkits and blueprints to strengthen outreach, enrollment, and service delivery

Strategy 3.6 Provide training and technical assistance on homelessness, including chronic homelessness, to mainstream service providers at the state and community level

Goal 4: Develop an approach to track Departmental progress in preventing, reducing, and ending homelessness for HHS clientele

Strategy 4.1 Inventory data relevant to homelessness currently collected in HHS targeted and mainstream programs; including program participants' housing status

Strategy 4.2 Develop an approach for establishing baseline data on the number of homeless individuals and families served in HHS programs

Strategy 4.3 Explore a strategy to track improved access to HHS mainstream and targeted programs for persons experiencing homelessness, including individuals experiencing chronic homelessness

Strategy 4.4 Coordinate HHS data activities with other federal data activities related to homelessness

Chapter 1

Overview of the Strategic Action Plan

Introduction

Each year, approximately one percent of the U.S. population, some 2-3 million individuals, experiences a night of homelessness that puts them in contact with a homeless assistance provider, and at least 800,000 people are homeless in the United States on any given night (Burt et al 2001). Persons experiencing homelessness can benefit from the types of services supported by the programs offered by the U.S. Department of Health and Human Services (HHS). Among this population, there are several key subgroups, including:

- *Chronically Homeless.* Of the 2-3 million persons who experience homelessness annually, ten percent have been identified as *chronically homeless* due to their protracted spells of homelessness and the duration of their homelessness history. On any given night, this group will represent almost half of those who are homeless (Kuhn & Culhane 1998; Metraux et al. 2001). This subgroup has been identified as the long-term, or chronically homeless. HHS, the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Veterans Affairs (VA) and the U.S. Interagency Council on Homelessness (USICH) have agreed on the following definition of chronically homeless: “An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or has had at least four episodes of homelessness in the past three years.”
- *Homeless Families.* Data from the National Survey of Homeless Assistance Providers and Clients estimates that in 1998, families comprised 34 percent of the homeless population; 23 percent were children and 11 percent were adults in homeless families (Burt et al 1999). In a given year, this means 420,000 families, including 924,000 children, experience homelessness in the United States. For the purposes of this Plan, a homeless family is defined as one or two adults accompanied by at least one minor child who are either not housed or who have had recent periods during which they lacked housing.
- *At-Risk Individuals.* There are a number of other types of individuals who may be at-risk for becoming homeless or chronically homeless. For example, the annual prevalence of homelessness among adolescents is estimated at between 5.0 and 7.6 percent among youth aged 12 to 17, and evidence suggests that adolescents are the single age group most at risk for experiencing homelessness (Ringwalt, et al 1998; Robertson & Toro 1998). For the purposes of this Plan, homeless youth are defined as persons between the ages of 16-24 who do not have familial support and are unaccompanied – living in shelters or on the street. Other vulnerable groups at-risk of homelessness include individuals with disabilities, immigrants, persons leaving institutions (e.g., incarceration, inpatient care for psychiatric or chronic medical conditions), youth aging out of foster care, frail elderly, persons experiencing abuse, and disaster victims.

HHS and Homelessness

The Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and supporting the delivery of essential human services, especially for those who are least able to help themselves. The Department is the largest grant-making agency in the federal government, and the Medicare program alone is the nation's largest health insurer (<http://www.hhs.gov/about/whatwedo.html>). The programs and activities sponsored by the Department are administered by eleven operating divisions that work closely with state, local, and tribal governments. Many HHS-funded services are provided at the local level by state, county or tribal agencies, or through private sector and community and faith-based grantees.

HHS' work in the area of homelessness fits well with the Department's mission and priorities. The principals that form the philosophical underpinnings of the Secretary's 500 Day Plan are applicable to persons experiencing homelessness, particularly the first principal which reads "care for the truly needy, foster self-reliance" (<http://www.hhs.gov/500DayPlan/>). Additionally, the Department seeks to further the President's New Freedom Initiative to promote participation by all Americans with disabilities, including mental disabilities in their communities. One of the goals in the report of the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (<http://www.mentalhealthcommission.gov/reports/FinalReport/FullReport.html>) outlines the need for stable housing as a requirement for enabling individuals and families with mental illness to fully participate in their treatment and their communities. The Department's focus on homelessness is consistent with this recommendation.

Ending homelessness requires housing combined with the types of services supported by HHS programs. The delivery of treatment and services to persons experiencing homelessness are included in the activities of the Department, both in five programs specifically targeted to homeless individuals and in fourteen non-targeted, or mainstream, service delivery programs (see Table 1 below). The *targeted programs* are much smaller in scope, but are designed specifically for individuals or families who are experiencing homelessness. *Mainstream programs* are designed to serve those who meet a set of eligibility criteria, which is often established by individual states, but are generally for use in serving low-income populations. Very often, persons experiencing homelessness may be eligible for services funded through these programs. Because the resources available for the mainstream programs are so much greater than the resources available for the targeted homeless programs, HHS has actively pursued an approach of increasing access to mainstream services for persons experiencing homelessness.

Table 1. HHS Programs Relevant to Persons Experiencing Homelessness

Targeted Homeless Programs	Total Program Budget FY 2006 (millions)
Grants for the Benefit of Homeless Individuals (Treatment for Homeless)	\$ 44.0
Health Care for the Homeless	151.4
Projects for Assistance in Transition from Homelessness (PATH)	54.2
Programs for Runaway and Homeless Youth	102.8
Title V/Surplus Property*	-----
Mainstream Programs	
Access to Recovery	98.2
Child Support Enforcement Program	4,206.5
Community Mental Health Services Block Grant	428.0
Community Services Block Grant	630.0
Community Health Centers	1,785.0
Family Violence Prevention and Services Grant Program	127.6
Head Start	6,782.1
Maternal and Child Health Services Block Grant	692.5
Medicaid	180,625.0
Ryan White CARE Act	2,036.3
Social Services Block Grant	1,700.0
State Children's Health Insurance Program	5,451.0
Substance Abuse Prevention and Treatment Block Grant	1,757.4
Temporary Assistance for Needy Families	17,059.0

** The Title V/Surplus Property program involves the transfer of surplus federal property from HHS to a homeless assistance provider, and the program does not have a line item budget.*

HHS Response to Homelessness: 2001-2006

An Environment for Change. In 2001, the Secretaries of HHS and HUD met and committed to a collaboration that capitalized on the expertise of HHS in service delivery and the expertise of HUD in housing. A leading concern was for the services funded by HHS to be more accessible to eligible homeless persons residing in HUD-funded housing. Subsequently, HHS, HUD and VA explored goals and activities of mutual interest and concluded that collaboration was best achieved by adopting a specific and targeted focus on the issue of long term and repeated homelessness. Concurrently, in 2002, the Administration revitalized the U.S. Interagency Council on Homelessness (USICH) to coordinate the federal response to homelessness across twenty federal departments and agencies, and to create a national partnership at every level of government and the private sector, with the goal of reducing and ending homelessness across the nation. The final development of major significance came in the release of the Administration's

budget for fiscal year 2003, where President George W. Bush officially endorsed ending chronic homelessness as a goal of his Administration.

The Secretary’s Work Group on Ending Chronic Homelessness. In support of the articulated Administration goal of ending chronic homelessness, senior leadership within HHS established a Departmental work group in 2002 and tasked the group with developing a strategic action plan that would articulate a comprehensive approach for enabling the Department to better serve individuals experiencing chronic homelessness. This work group, entitled the *Secretary’s Work Group on Ending Chronic Homelessness*, comprises senior leadership from seven operating divisions and numerous staff divisions within the Office of the Secretary and has expanded to encompass more offices as the Work Group has matured (see Figure 1).

Figure 1. Members of the Secretary’s Work Group on Ending Chronic Homelessness	
Immediate Office of the Secretary	Center for Faith-Based and Community Initiatives
Administration for Children and Families	Office on Disability
Administration on Aging	Office of the Assistant Secretary for Resources and Technology
Centers for Medicare and Medicaid Services	Office of the Assistant Secretary for Legislation
Health Resources and Services Administration	Office of the Assistant Secretary for Planning and Evaluation
National Institutes of Health	Office of Intergovernmental Affairs
Substance Abuse and Mental Health Services Administration	Office of the General Counsel
Program Support Center	

In early 2002, the Secretary’s Work Group on Ending Chronic Homelessness was charged with designing a plan to:

- improve access to treatments and services;
- improve coordination across these services;
- identify strategies to prevent additional episodes of chronic homelessness; and
- itemize accountability and evaluation processes.

The strategic action plan developed by the Work Group, entitled *Ending Chronic Homelessness: Strategies for Action* (<http://aspe.hhs.gov/hsp/homelessness/strategies03/index.htm>), was released in 2003. The purpose of the 2003 Plan was to define the chronically homeless population and itemize the service needs of the population; analyze the response of HHS mainstream assistance programs to these needs; specify outcomes and objectives that would improve the response of mainstream programs to the chronically homeless population; and offer actions the agencies could take that would improve access to and coordination of services. The 2003 Plan has served as the framework for developing and implementing activities across the

Department related to chronic homelessness. The general premise of the strategic action plan posits that homelessness is a complex social problem, and ending chronic homelessness requires housing combined with the types of services supported by the programs funded and operated by HHS. The goals outlined within the strategic action plan provided a course of action for the Department to follow in order to improve access to needed health and social services for individuals experiencing chronic homelessness, empower states to improve their response to individuals experiencing chronic homelessness, and to prevent future episodes of homelessness within HHS clientele.

From its inception to the present time, the Secretary's Work Group has met regularly in order to discuss policy issues related to chronic homelessness, as well as homelessness among families and youth, review progress, and report about key activities occurring in the various operating divisions. The Work Group has developed an activities tracking matrix, which allows agencies to chart homeless-related activities under the specific goals and strategies outlined in the Plan noted above. The matrix provides Work Group members with a way to measure progress towards achieving these goals and strategies and also provides a simple measure of the level of activity within each key area of focus.

Since 2003, the Department has worked in partnership with the states, other federal Departments, and the U.S. Interagency Council on Homelessness to advance the goals outlined in the strategic action plan. As the plan approached its third anniversary, the Work Group collectively reviewed the Department's progress towards achieving the goals outlined in the plan, and has concluded that significant progress has been made towards certain goals and strategies, where other goals and strategies needed additional focus. Furthermore, though the 2003 Strategic Action Plan focuses solely on the chronically homeless population, the scope of work and focus of the Work Group was actually much broader, and includes activities that focus on homeless families with children, as well as homeless youth. The Work Group concluded that the Department would benefit from a new plan that would provide a framework for future efforts. The intent of this revision is not to usurp or replace the original strategic action plan, but rather to refine the goals and strategies to reflect the changing set of challenges and priorities three years after the development of the first plan.

Key Events Shaping Strategic Action Plan Revision

Between 2001 and 2006, several key events and activities guided the development of the 2007 Plan. First, HHS partnered with HUD, VA, ICH, the U.S. Department of Labor (DOL), and the U.S. Department of Education (ED) to fund nine *Homeless Policy Academies* that were designed to bring together state-level program administrators and homeless service providers in order to develop state-specific action plans designed to increase access to mainstream resources for persons experiencing homelessness. Five Policy Academies focused on chronic homelessness, and in response to demand, the remaining four Academies focused on homeless families with children. To date, every state (including the District of Columbia) and U.S. Territory has attended a Homeless Policy Academy. HHS, along with our federal partners, has provided significant technical assistance resources to these jurisdictions to assist them in the implementation of their Policy Academy action plans over the past several years.

Another key effort extending into the states is the work of the ICH to encourage the development of *State Interagency Councils on Homelessness* as well as *state and local ten-year planning processes to end chronic homelessness*. As part of the Council's strategy to create intergovernmental partnerships to end homelessness, Governors of 53 states and territories have taken steps to create a state-level ICH, while over 280 Mayors and County Executives have initiated a ten-year planning process. Currently, many of the states and Territories are leveraging the support and infrastructure of the ICH and the Homeless Policy Academies to strengthen and coordinate their State Interagency Councils on Homelessness, Homeless Policy Academy teams and state and local planning processes that may already be institutionalized through HUD's Continuum of Care process.

A cornerstone effort of the increased focus on chronic homelessness was the development of the *Collaborative Initiative to Help End Chronic Homelessness*, also known as the Chronic Homelessness Initiative (CHI), an innovative demonstration project coordinated by the ICH and jointly funded by HUD, HHS (SAMHSA and HRSA) and the VA. Recognizing that homelessness is an issue that cuts across various agencies in the federal government, this unique effort across the Department offered permanent housing and supportive service funding through a consolidated application process. Successful applicants described an integrated and comprehensive community strategy to use funding sources, including mainstream service resources, to move chronically homeless individuals from the streets and emergency shelters into stable housing. Once housed, the residents would be able to access the range of services needed to promote and maintain greater self-sufficiency. The CHI is important because it operationalizes many of the key goals and strategies outlined in both the original and revised strategic action plans; for example, use of interagency partnerships on both local and federal levels, increasing the effectiveness of integrated systems of care, and the use of mainstream resources. In October 2003, 11 grantees received funding for three years, FY 2003-2005. HHS funding totaled \$30 million for the three-year period.

Another key event that influenced the Secretary's Work Group was *Hurricane Katrina*, which occurred in August 2005. A special meeting of the Secretary's Work Group was held in September 2005 on this topic. At this meeting, a literature review compiled for the meeting was used to guide discussion pertaining to: the key players during the hurricane; housing and health issues; the impact on the historically homeless; and data pertaining to and lessons learned from previous disasters. Furthermore, agency representatives at the meeting described their experiences providing concrete assistance during Hurricane Katrina. Lessons learned from this disaster have led the Department to carefully consider how HHS should prepare for and respond to homelessness and human service needs in future disasters, and how the structure of the Work Group might be used as a tool for future natural disasters.

Finally, one of the original charges to the Work Group was to "itemize accountability and evaluation processes." This called for establishing *monitoring and evaluation benchmarks* pertaining to chronic homelessness. However, the absence of data to inform the Department about a baseline suggested considerable developmental work would be needed before empirical benchmarks could be established. Over the past several years, the ability to demonstrate results towards ending and reducing homelessness in a quantitative fashion has increased, and thus, where the original plan included a recommendation for this work, a more focused effort to

develop data and performance measurements will be critical to documenting future success and is a key component to the revised strategic action plan.

HHS 2007 Homelessness Strategic Action Plan

Purpose of Plan. The purpose of the 2007 Plan is to provide the Department with a vision for the future in the form of a formal statement that addresses how individuals, youth, and families experiencing homelessness can be better served through the coordinated administration of Departmental resources. This Plan allows the Secretary to highlight the accomplishments that have been achieved over the past several years, as well as to chart a course for future activities for the Department that builds on the current efforts. The revised Plan covers a five-year time frame, from FY 2007-FY 2012.

Audience for the Plan. The 2007 Plan has both internal and external audiences and thus may be utilized in various ways. The internal audience consists of the HHS operating and staff divisions that have approved the Plan and agreed to implement it as is appropriate to their respective agency/division. For example, the Plan may impact HHS agencies' strategic and performance plans, program activities, training, data collection/performance measurement, and/or budgets.

The external audience will be wide-ranging, including HHS grantees and other providers of homeless assistance services, participants of the state Homeless Policy Academies, the developers of state/local 10-year plans to end homelessness, participants of HUD's Continuum of Care process, advocacy/interest groups, Congress/legislative branch, states, researchers, federal partners, and the U.S. Interagency Council on Homelessness.

Approach Used In Developing the 2007 Plan. In order to develop the 2007 Plan, a Strategic Action Plan Subcommittee was formed, consisting of representatives from the various agencies participating in the Secretary's Work Group. This subcommittee, working in close partnership with the entire Work Group, utilized an iterative process to review recent accomplishments and to develop recommendations for the goals and strategies to be the framework of the 2007 Plan. Throughout the development of the revised goals and strategies, as well as the narrative text of the 2007 Plan, the subcommittee reported to the full Work Group and revised the plan based on the feedback of the full Work Group. The 2007 Plan was circulated throughout the HHS operating and staff division heads prior to being finalized by the Department and made public.

Major Plan Revisions. As a result of the above process, the following major changes for the 2007 Plan were incorporated:

- *Families/At-Risk Individuals.* The scope of the Plan was broadened to incorporate families with children and individuals at-risk of homelessness, particularly youth, while maintaining a continued commitment to ending chronic homelessness. By including a broader range of populations in the Plan, the Department is acknowledging that effectively preventing chronic homelessness requires the two-pronged strategy of ending the homelessness cycle for those who are already homeless, and the prevention of new episodes of homelessness for those who are currently housed, but who are at risk of

becoming homeless. The significant work related to addressing homelessness for families and individuals is on-going and is critical to our mission as a Department.

- *Federal Agency Collaboration.* Homelessness is a complex social problem that will require solutions to be developed in partnership, not simply across HHS, but across the multiple federal agencies that dedicate resources towards ending homelessness, as well as our state and local partners. In recognition of the critical nature of these partnerships, specific strategies were added to the Plan to encourage intradepartmental and interdepartmental coordination and collaboration with other federal agencies who operate housing and service programs that complement HHS programs;
- *Policy Academy Follow-up.* To date, every state (including the District of Columbia) and U.S. Territory has attended a Homeless Policy Academy and is working to implement a state Action Plan intended to improve access to mainstream health and human services and employment opportunities that are coordinated with housing for persons who are experiencing homelessness. Strategies in the 2007 Plan were revised to reflect the second phase of the Homeless Policy Academies, including providing technical assistance to the states and territories around effective implementation of their Action Plans and sustaining their momentum in addressing homelessness in their jurisdictions;
- *Primary Prevention.* A new strategy was added to the Plan that emphasizes preventing first-time homelessness for at-risk populations;
- *Data/M Measurement.* A new and separate goal about data and measurement, as well as strategies that address the issue of developing a homelessness data infrastructure within HHS pertaining to targeted and mainstream programs, was added to the Plan.
- *Disasters.* A new strategy was added specifically referring to working with federal, state, local partners and tribal organizations around policies pertaining to addressing homelessness in the context of a disaster.

Measuring Work Group Outcomes. The Secretary's Work Group will continue to meet regularly. Prior to each of these meetings, the operating and staff divisions that participate in the Work Group will be asked to update the activities tracking matrix. This matrix includes key activities that the agencies are implementing related to homelessness and is organized by the goals and strategies outlined in the strategic action plan. Each activity listed in the matrix includes information about the activity, its timeframe, and its outcome or expected outcome. The matrix can then be used as an analytical tool to examine the Department's progress related to the activities by goal or strategy, as well as by agency. Each updated matrix is distributed to those attending the Secretary's Work Group meetings. In addition, participating agencies report orally on their key activities at each meeting; meeting minutes are recorded and sent to participants.

The chapters that follow provide further elaboration on various aspects of the 2007 Plan. Chapter two will outline the 2007 Strategic Action Plan in detail, providing examples of activities that might be undertaken in support of the goals and strategies proposed in the Plan. Chapter three highlights what is new in the plan and the rationale for expanding the existing goals and strategies established in 2003. The fourth chapter provides an overview of progress made by the Department towards achieving the goals outlined in the 2003 Plan. Finally, a series

of appendices provide supporting information to the strategic action plan. Appendix A provides an overview of the HHS programs that may serve persons currently experiencing, or at risk of, homelessness. A list of departmental homelessness web resources and research reports relevant to homelessness are included as Appendix B. Additional appendices provide a list of commonly used acronyms (Appendix C), a membership list of the Secretary's Work Group, including the staff list of the Strategic Action Plan Subcommittee (Appendix D), and finally, a crosswalk of the goals and strategies included in the 2003 and 2007 Plans (Appendix E).

Chapter 2

The Strategic Action Plan in Detail

This chapter delineates all the goals and strategies identified in the 2007 Strategic Action Plan. The chapter also provides, under each strategy, a few examples of possible activities the Department could implement in order to fulfill a given strategy. It is assumed throughout this document that no strategies, or activities, will be implemented without seeking and attaining all relevant legislative and/or regulatory changes needed to ensure that all programs within HHS continue to operate within their given authority and mission. It is also assumed that, to the extent the strategies seek to impose any requirements on applicants as conditions of given awards, before doing so, programs will confirm that their authorizing authority and program/administrative regulations permit such imposition of conditions. It is further assumed that no proposals will be implemented without resolving any inherent budget implications.

The goals, strategies, and examples of activities are as follows:

GOAL 1: PREVENT EPISODES OF HOMELESSNESS WITHIN THE HHS CLIENTELE, INCLUDING INDIVIDUALS AND FAMILIES

Strategy 1.1 Identify risk and protective factors to prevent episodes of homelessness for at-risk populations

Examples of Activities:

- Identify and promote the use of effective, evidence-based homelessness prevention interventions, such as discharge, release, or transition planning; intensive case management; access to protection orders, legal assistance and safety planning for victims of abuse; landlord mediation, and family strengthening, along with organizational and cross-organizational level strategies.
- Promote organizational development and horizontal coordination between agencies such as housing, HIV/AIDS services/prevention, mental health and substance abuse treatment and prevention, and criminal justice to provide integrated comprehensive services to prevent homelessness.
- Examine how HHS agencies can synthesize, sponsor, or conduct epidemiological, intervention, and health services research on risk and protective factors for homelessness and identify preventive interventions that could be provided in health care and human services settings that are effective at preventing at-risk persons from entering a pattern of residential and personal instability that may result in homelessness.
- Encourage states and communities to experiment with various approaches to creating a coordinated, comprehensive approach to addressing homelessness prevention (e.g. establish an infrastructure that supports prevention activities,

allows flexibility in the use of funds, and fosters the development of systematic relationships between providers and across systems of care).

Strategy 1.2 Identify risk and protective factors to prevent chronic homelessness among persons who are already homeless

Examples of Activities:

- Review and synthesize the published and non-published literature to identify risk factors associated with chronic homelessness and protective factors that reduce the risk for chronic homelessness.
- Examine how HHS can sponsor or conduct epidemiological, intervention, and health services research on risk and protective factors for chronic homelessness and to identify preventive interventions that could be provided in health care and human services settings that are effective at preventing currently homeless individuals from becoming chronically homeless.
- Develop targeted interventions preventing chronic homelessness specifically for use in HHS programs that are serving currently homeless persons, such as PATH, Treatment for Homeless grantees, and Health Care for the Homeless programs.

Strategy 1.3 Develop, test, disseminate, and promote the use of evidence-based homelessness prevention and early intervention programs and strategies

Examples of Activities:

- Sponsor, synthesize, or conduct research and evaluation on interventions that focus on primary, secondary, and tertiary homeless prevention strategies and health treatment regimens, as well as the organization, effectiveness, and cost of such preventive interventions.
- Identify and develop workforce development strategies and program incentives that foster the adoption and implementation of evidence-based homelessness prevention programs and practices.
- Promote the availability of technical assistance and training documents on services and policy issues related to homelessness prevention via internet access, distribution at relevant meetings, and other settings offering instruction on the issue of homelessness, such as SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) and other listings of effective program models.

GOAL 2: HELP ELIGIBLE, HOMELESS INDIVIDUALS AND FAMILIES RECEIVE HEALTH AND SOCIAL SERVICES
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Strategy 2.1 Strengthen outreach and engagement activities*Examples of Activities:*

- Encourage mainstream programs that support outreach and case management to identify individuals and families experiencing homelessness as potentially eligible candidates for these services.
- Identify and promote innovative outreach and engagement activities successfully operating in existing programs, such as mobile health clinics, outreach workers who function as case managers, and innovative clinic-based programs that operate through the Health Care for the Homeless Program and the PATH program.
- Support empirical studies and demonstration projects that develop and test the effectiveness of outreach and engagement strategies for various populations.

Strategy 2.2 Improve the eligibility review process*Examples of Activities:*

- Develop tools for providers that simplify or streamline the eligibility review process, similar to the Health Resources and Services Administration (HRSA)-funded publication entitled *Documenting Disability: Simple Strategies for Medical Providers*, which provides a partnership tool for the Social Security Administration's Homeless Outreach Projects and Evaluation (HOPE) program, focused on assisting eligible, chronically homeless individuals in applying for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits.
- Promote the inclusion of homeless assistance programs among the entities conducting eligibility and enrollment functions for mainstream programs.

Strategy 2.3 Explore ways to maintain program eligibility*Examples of Activities:*

- Explore state practices related to policies designed to suspend, rather than terminate, Medicaid eligibility for individuals who are institutionalized so that the eligibility process does not need to be initiated over again upon release.

Strategy 2.4 Examine the operation of HHS programs, particularly mainstream programs that serve both homeless and non-homeless persons, to improve the provision of services to persons experiencing homelessness

Examples of Activities:

- Inventory mainstream HHS programs, identifying barriers to access for persons experiencing homelessness, and propose strategies to reduce and eliminate these barriers to services.
- Identify regulatory barriers and other challenges faced by states as they implement their Homeless Policy Academy state action plans to increase access to mainstream resources.

Strategy 2.5 Foster coordination across HHS to address the multiple problems of individuals and families experiencing homelessness

Examples of Activities:

- Continue to use the regularly scheduled meetings of the Secretary's Work Group on Ending Chronic Homelessness as a means to promote collaboration and coordination across the Department and develop joint activities and approaches to addressing various aspects of homelessness.
- Work with HHS program agencies to ensure that the Department's disaster planning efforts address the special needs of the elderly, individuals with disabilities, and other vulnerable populations affected by disasters. Where feasible and appropriate in HHS programs, identify ways to mitigate the long-term impact of homelessness as a result of disasters.
- Develop initiatives which can enable NIH research to be linked to pilot projects and programs within HHS to establish the effectiveness of such projects and programs and expand the evidence-base on what works.

Strategy 2.6 Explore opportunities with federal partners to develop joint initiatives related to homelessness, including chronic homelessness and homelessness as a result of a disaster

Examples of Activities:

- Promote joint initiatives through interagency cooperative agreements, pooled funding for special projects or evaluations of mutual interest or benefit.
- Jointly develop policy or program guidance to assure consistency with other Departments' policies and statutory and programmatic definitions, and/or consider joint issuance of key policy or programmatic guidance, especially where

such issuance has the potential of having a significant impact on another Department's clients and/or grantees.

GOAL 3: EMPOWER OUR STATE AND COMMUNITY PARTNERS TO IMPROVE THEIR RESPONSE TO INDIVIDUALS AND FAMILIES EXPERIENCING HOMELESSNESS

Strategy 3.1 Work with states and territories to effectively implement Homeless Policy Academy Action Plans

Examples of Activities:

- Encourage federal agencies to incorporate language into their program funding guidance that authorizes applicants to use HHS and other federal funds to create and/or support programmatic strategies that formulate an integrated safety net for poor and disabled individuals and families, where appropriate. Language should also include a requirement that provides for the ability to evaluate the effectiveness of the coordinated efforts.
- Support state grantees to seek appropriate HHS funds to support the implementation of their Policy Academy action plans to address homelessness.
- Support state efforts to expand Policy Academy Action Plans to address the needs of HHS clientele including homeless families and individuals at risk of homelessness, particularly youth and victims of abuse.

Strategy 3.2 Work with governors, county officials, mayors, and tribal organizations to maintain a policy focus on homelessness, including homelessness as a result of a disaster

Examples of Activities:

- Encourage national intergovernmental organizations to hold sessions with a homelessness policy focus at their annual and/or winter meetings (e.g., U.S. Conference of Mayors, National Association of Counties, National Conference of State Legislatures, National Governors Association, National Council of State Governments, National Association of State Mental Health Program Directors, etc.).
- Share information with the national intergovernmental organizations that can be used in their newsletters and other communications with their members (e.g., through a homelessness clearinghouse website that provides links not only to relevant HHS programs but also to state and local activities that could serve as “best practice” models).

Strategy 3.3 Examine options to expand flexibility in paying for services that respond to the needs of persons with multiple problems

Examples of Activities:

- Investigate regulatory barriers faced by grantees utilizing HHS funding that impede the ability of grantees to provide timely, comprehensive services to families and individuals experiencing homelessness. Examine options for reducing identified regulatory barriers.
- Identify “lessons learned” from the jointly funded Chronic Homeless Initiative (CHI) pilot program which allowed for pooled funds from mainstream programs and targeted homeless programs to create a collaborative and comprehensive approach to addressing the problems of homelessness.
- Develop and distribute a primer that will help explain what medical, behavioral health, and support services that would benefit individuals who are homeless can be reimbursed by Medicaid.

Strategy 3.4 Encourage states and localities to coordinate services and housing

Examples of Activities:

- Encourage states and communities to establish approaches, such as partnerships, to create a coordinated, comprehensive system of services to address homelessness, including chronic homelessness. Such approaches include establishing an infrastructure that forges systemic relationships among providers for effective client referral and treatment, more effective leveraging of fiscal and human resources, cross-system training, and increased focus on sustainability of activities.
- Encourage applicants’ use of grant funds to support community infrastructure development efforts, including expenses for staff associated with partnership activities, incentive funds, and other funding mechanisms that can support infrastructure development efforts.
- Where feasible, encourage Federal agencies to develop policy or guidance language encouraging states and communities to address the needs of their homeless residents by coordinating services and housing in a comprehensive way.

Strategy 3.5 Develop, disseminate and utilize toolkits and blueprints to strengthen outreach, enrollment, and service delivery

Examples of Activities:

- Continue interagency collaborations between HHS program agencies to develop tools that are designed for use by both homeless service providers as well as individuals who are homeless.

- Complete, disseminate, and promote the use of toolkits developed by agencies (e.g., SAMHSA’s Treatment Improvement Protocol (TIP) #42 *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Assertive Community Treatment and Integrated Dual Disorders Treatment, and Permanent Supportive Housing).

Strategy 3.6 Provide training and technical assistance on homelessness, including chronic homelessness, to mainstream service providers at the state and community level

Examples of Activities:

- Continue to maintain jointly-funded collaborations to support state and community partners to implement their homeless Policy Academy action plans (e.g., SOAR Training Initiative, jointly funded HRSA Policy Academy contract, jointly funded SAMHSA Policy Academy Technical Assistance contract, jointly funded ACF Homeless Families Policy Academies).
- Utilize national meetings of HHS grantees to highlight promising practices and other information to help states implement their action plans through workshops, discussion sessions and transfer peer-to-peer learning to mainstream providers.

<p>GOAL 4: DEVELOP AN APPROACH TO TRACK DEPARTMENTAL PROGRESS IN PREVENTING, REDUCING, AND ENDING HOMELESSNESS FOR HHS CLIENTELE</p>

Strategy 4.1 Inventory data relevant to homelessness currently collected in HHS targeted and mainstream programs; including program participants’ housing status

Examples of Activities:

- Inventory and compile the data currently collected within the Department relevant to homelessness; domains may include: OPDIV, title of data source; population included; method of data collection; web link to the data source (or directly to data that are publicly available), and strengths and limitations, among others.
- Review data elements relevant to homelessness and housing status currently collected across HHS programs in order to identify opportunities to compare data across programs, gaps in data collection, as well opportunities to link data across administrative systems.

Strategy 4.2 Develop an approach for establishing baseline data on the number of homeless individuals and families served in HHS programs

Examples of Activities:

- Support a research project to begin the exploration of available data that could be used to identify the number of homeless persons currently accessing HHS

mainstream programs by investigating which states currently collect housing status data from applicants of Medicaid and Temporary Assistance for Needy Families (TANF), the two largest HHS mainstream programs that may serve individuals or families experiencing homelessness.

- Explore the feasibility of collecting data regarding the housing status or program participants of HHS mainstream service programs.

Strategy 4.3 Explore a strategy to track improved access to HHS mainstream and targeted programs for persons experiencing homelessness, including individuals experiencing chronic homelessness

Examples of Activities:

- Partner with all HHS agencies that support homeless programs and identify incentives and standard policy language that requires recipients of federal funds to document attempts at improved access to mainstream target programs.
- Collaborate with states and local entities to support efforts to document homelessness and share data with HHS as agreed to by partners. Ensure that any agreements developed are feasible and that the response burden does not exceed that which is deemed reasonable and negotiable by all parties.

Strategy 4.4 Coordinate HHS data activities with other federal data activities related to homelessness

Examples of Activities:

- Generate an inventory of all data elements utilized by various agencies in order to establish similarities and differences within each respective system. Compare HHS inventory with the inventory of other Federal agencies, such as HUD.
- Monitor the development of HUD's Homeless Management Information Systems (HMIS) and seek opportunities to partner with HUD and local Continuums of Care on future research initiatives utilizing HMIS data, while maintaining the confidentiality of personally identifying information about individuals served by domestic violence programs.
- Disseminate the findings and results of HHS data collection efforts with Federal partners and collaborate on efforts to improve data quality on homelessness.

Chapter 3

What's New in the Strategic Action Plan

Introduction

The primary purpose for the development of the 2007 Strategic Action Plan is to refine the goals and strategies outlined in the 2003 Strategic Action Plan in order to reflect the progress that has been made, and has not been made, in the four years since the development of the initial HHS strategic action plan on homelessness. There are two new elements that represent the greatest departure from the 2003 Strategic Action Plan and deserve to be highlighted for their magnitude and breadth. First, the Department has broadened the scope of the plan to address issues faced by a clientele that encompasses not only chronically homeless individuals, but also homeless families with children and runaway and homeless youth. Second, the Department has added a new goal that focuses exclusively on issues of data and measurement; specifically, the Department's ability to document progress in preventing, reducing, and ending homelessness for the HHS clientele. This new goal related to data and measurement includes strategies that seek to identify what types of data are needed to measure progress in addressing homelessness, as well as methods by which to obtain this data. It is important to note that while these new goals and strategies will broaden the focus of the Department's activities related to ending and reducing homelessness, it is not the intention of the Department to retreat from the initial 2003 commitment to help end chronic homelessness. Rather, the expanded scope will reflect the work related to addressing homelessness for families and children, as well as youth, which is already ongoing and critical to the mission of the Department of Health and Human Services, *in addition to* the Departmental priority to end chronic homelessness.

This chapter will summarize how the two major changes have been incorporated into the framework of the strategic action plan, and will provide the rationale for the expansion of the plan in these two new directions. In addition, this chapter will briefly discuss the other changes made to the strategic action plan that, while not as prominent in the goals-and-strategies framework as the two major changes mentioned above, are significant and warrant highlighting.

Broadening the Plan to Incorporate a Focus on Homeless Families with Children and Youth

The Change

When the Secretary established the Secretary's Work Group on Ending Chronic Homelessness in 2002, the Work Group was to report recommendations for a Department-wide approach that would contribute to the Administration's goal of ending chronic homelessness and improve the Department's ability to assist persons experiencing chronic homelessness. As the title of the 2003 Strategic Action Plan indicates (*Ending Chronic Homelessness: Strategies for Action*) the focus of the Work Group was on chronic homelessness. For the last three years, however, the Work Group has actively tracked the efforts of numerous components of HHS to improve access to treatment and services for all eligible groups, including chronically homeless individuals, homeless families with children, and homeless youth. While chronic homelessness has remained

a priority, the Department has also engaged in other homelessness related activities that affect families with children and youth, who make up a substantial portion of the HHS clientele.

The goals and strategies from the 2003 Strategic Action Plan framework specifically focused on chronic homelessness. For example, the language in Goals 1 and 2 used the terms *chronically homeless* and *chronic homelessness*, and the same two terms were also used throughout the different strategies under all three goals. In order to accurately capture the clientele served by all homelessness-relevant HHS programs, the Work Group decided that the plan would have to be broader in scope. Therefore, the goals and strategies were edited to include families and youth, where applicable. In general, phrases such as “chronically homeless individuals” were substituted by “homeless individuals and families” so as to be inclusive of families and children experiencing homelessness, while still including *individuals* experiencing homelessness, whether chronic or episodic. However, in order to maintain chronic homelessness as a priority, the Work Group highlights chronic homelessness in a few different strategies in the new framework. Additionally, the new Goal 4 (which will be discussed in more detail below) also takes a broader approach and applies to the whole of the HHS clientele, including individuals and families.

The Rationale

Evidence of the growing number of homeless families supports the expanded scope of the Department’s strategic action plan to include homeless families with children. Findings from the research literature show that families are a significant subgroup that warrants specific attention and interventions that may differ from those that are successful in serving homeless individuals.

According to the 1996 National Survey of Homeless Assistance Providers and Clients, 34 percent of all persons using homeless services were members of a homeless family (Burt et al 1999), though more recent studies (Shinn, et. al 1998) estimate that families make up roughly 40 percent of those who become homeless. The U.S. Conference of Mayors Hunger and Homelessness Survey of 23 cities (2006), report that requests for shelter from homeless families increased by 5% over the previous year, with 59% of the 23 cities reporting an increase. For the purposes of this strategic action plan, a homeless family is defined as one or two adults accompanied by at least one minor child who are either not housed or who have had periods during some recent time period during which they lacked housing. A significant body of research documents the broad array of negative health and mental health outcomes experienced by both children and their mothers in association with episodes of homelessness.

Current research indicates that homeless families are more similar to poor housed families than to single homeless individuals (Burt, et al 1999; Bassuk et al 1996). Several studies have compared housed and non-housed low-income families in an effort to document what characteristics or contextual factors influence a low-income family’s probability of experiencing homelessness. While these studies each examine the experiences of homeless families in only one city, and therefore are not nationally representative, the studies report similar results. In general, researchers have found that heads of homeless families have higher rates of victimization, mental illness, and substance abuse along with weaker social networks, less robust employment histories, and lower incomes than the heads of housed low-income families (Bassuk et al 1996; Bassuk et al 1997; Shinn et al 1998). Additionally, homeless heads of household tend

to be younger and tend to have younger children than their housed counterparts (Shinn et al 1998; Webb et al 2003).

In considering which families might be at greatest risk for homelessness, one must consider individual characteristics that might indicate a higher chance of experiencing homelessness, such as substance abuse or mental illness; family factors, such as the presence of violence in the home; as well as contextual factors, such as a lack of affordable housing in the community. Other issues related to the causes and consequences of family homelessness, such as a family's interaction with the child welfare or foster care systems, may be important as the dynamics of children and their parent(s) while they move through the shelter system may not be the same (Park et al 2004). Fifty-five percent of the cities participating in the 2006 Hunger and Homelessness Survey report that families may have to separate in order to be sheltered (U.S. Conference of Mayors 2006). Many studies have documented a large number of single homeless individuals, primarily women, who are parents but are no longer residing with their children (Burt et al 1999). A number of other studies indicate that housing instability in childhood appears to be associated with adolescent homelessness, suggesting that housing stabilization for homeless or poorly housed families may contribute to the prevention of chronic homelessness (Robertson et al 1999; Park et al 2004).

Runaway and homeless youth, defined in the Runaway and Homeless Youth Act as "individuals who are not more than 21 years of age...for whom it is not possible to live in a safe environment with a relative and who have no other safe alternative living arrangement," may have different needs than homeless youth who are still connected to their families due to runaway and homeless youth's lack of adult supervision during a homeless episode. Other youth who may be at-risk of homelessness include youth who are aging out of foster care or exiting the juvenile justice system (Farrow et al 1992). After reviewing the range of estimates of the number of homeless youth, Robertson and Toro concluded that youth under the age of 18 may be at higher risk for homelessness than adults (1999).

A focus on homeless youth not only fits with the mission of the Department, but also provides an additional opportunity to advance the goal of preventing chronic homelessness among adults. Research indicates that "the problems that homeless individuals experience as adults have very clear analogs in their childhoods" (Koegel et al 1995), and individuals who experience homelessness and other forms of residential instability are at higher risk of becoming homeless as an adult. Developing effective intervention strategies to prevent homelessness among youth and rapidly re-house those who may become homeless during adolescence may provide an additional strategy to reduce the risk of adult homelessness.

HHS operates a wide range of programs that may be accessed by homeless families with children and runaway and homeless youth. The following is a list of HHS programs (both targeted and mainstream) that provide services to homeless families:

Figure 2. HHS Programs That May Provide Services to Homeless Families and Homeless Youth

Targeted Programs:

- Health Care for the Homeless (HRSA)
- Programs for Runaway and Homeless Youth (ACF)

Mainstream Programs:

- Community Mental Health Services Block Grant Program (SAMHSA)
- Community Health Centers (HRSA)
- Community Services Block Grant (ACF)
- Family Violence Prevention and Service Grants (ACF)
- Head Start (ACF)
- Medicaid (CMS)
- Social Services Block Grant (ACF)
- State Children's Health Insurance Program (CMS)
- Substance Abuse Prevention and Treatment Block Grant (SAMHSA)
- Temporary Assistance for Needy Families (ACF)
- Title V Maternal and Child Health Services Block Grant (HRSA)

Expanding the scope of the strategic action plan to encompass family and youth homelessness will formalize the Department's already ongoing efforts to assist homeless families with children and youth, as well as tie the work of the Department's agencies closely to the Secretary's goals and objectives for the Department as a whole.

Adding a New Goal Focusing On Data and Performance Measurement

The Change

The 2003 Strategic Action Plan devoted one strategy (Strategy 2.9) to data and measurement issues, which read as follows: "Develop an approach for baseline data, performance measurement, and the measurement of reduced chronic homelessness within HHS." While this is an important strategy, a single strategy alone cannot encompass the many data and measurement issues related to homelessness that have been raised within the Department over the past three years. For example, Strategy 2.9 did not address how the Department would measure progress in improving the access to mainstream services for eligible homeless clients. It also did not address how HHS data activities would be coordinated with other federal department's important data activities related to homelessness, such as the creation and utilization of HUD's Homeless Management Information System (HMIS). Therefore, an entirely new goal that contains four separate strategies and focuses exclusively on homelessness data issues and how they relate to tracking Departmental success in addressing the problem of homelessness for the HHS clientele was added to the 2007 Plan.

The new goal (Goal 4) was established to develop an approach to track Departmental progress in preventing, reducing, and ending homelessness for HHS clientele. Strategy 4.1 encourages the Department to inventory homelessness related data that is currently collected in HHS targeted and mainstream programs, including the housing status of participants. Strategy 4.2 promotes the development of an approach for establishing baseline data on the number of homeless individuals and families served in HHS programs, whereas Strategy 4.3 relates to developing a strategy by which to track improved access to HHS mainstream and targeted programs for persons experiencing homelessness. The final strategy identifies collaboration with other Federal departments as a critical component of the Department's homelessness data activities.

The Rationale

In order to measure progress in preventing, reducing, and ending homelessness, the Department needs to have data systems and performance measures at its disposal. It has been the Department's experience that it does not yet have an established data approach by which to track its success in addressing homelessness. The Work Group believes that devoting an entire goal and set of objectives to data and performance measures related to homelessness will aid in the process of measuring the success of the strategic action plan. There is a growing desire within the federal government to focus on results and to measure success by documenting progress. This perspective can be seen within different HHS operating divisions' strategic plans. For example, the Health Resources and Services Administration (HRSA) strategic plan for fiscal years 2005-2010 (<http://www.hrsa.gov/about/strategicplan.htm>) discusses how the agency measures its progress by monitoring a variety of performance measures that are linked to the goals and objectives set out in the strategic plan. In addition to performance measures, the HRSA strategic plan also discusses the need to assess results, program effectiveness, and strategies. Likewise, there should be a Department-wide approach to measuring the effectiveness of the homeless assistance programs, and of the Department's strategic action plan. This new focus on data and measurement issues may also assist HHS homelessness programs with future Program Assessment Rating Tool (PART) reviews.

Furthermore, the Department has been pursuing a strategy over the past several years of increasing access to mainstream resources for eligible homeless individuals and families. In the 2003 Strategic Action Plan the Work Group outlined sixteen strategies to reduce chronic homelessness, one of which was to "improve the transition of clients from homeless-specific programs to mainstream service providers." A cornerstone activity under this strategy has been the development and implementation of nine Homeless Policy Academies that were designed to bring together state-level program administrators and homeless service providers in order to develop state-specific action plans designed to increase access to mainstream resources for persons experiencing homelessness. However, the key policy question, "Has HHS been successful at improving access to mainstream service programs?" cannot yet be answered because no baseline data are available. At the federal level, most mainstream programs are not required to collect data related to the number of homeless clients served. This lack of baseline information about the number of homeless individuals and families served in HHS mainstream programs makes it difficult, if not impossible, for HHS to document improvements in access.

There are a number of challenges in developing this kind of baseline data, particularly due to the fact that homelessness is a dynamic state; a person may be homeless today but housed tomorrow, thus causing fluidity in the number of program participants experiencing homelessness at any given point in time. However, further exploration is warranted to improve the Department's ability to develop measures related to increasing access to mainstream resources for persons experiencing homelessness. It is also important to highlight that these data development efforts are likely to be fruitless if they are not coordinated with our federal partners. As such, Strategy 4.4 emphasizes the importance of coordinating homelessness data activities within HHS with relevant data activities in other federal agencies and Cabinet-level departments such as HUD, VA, DOL, and the USICH. Thus, while the Department will develop its own data strategies internally, it will be paramount to also coordinate our efforts and integrate data across multiple Federal departments.

Additional Changes to the Plan

While the two major revisions discussed in detail above represent the most substantial changes to the plan, other smaller, yet significant changes have been made within the revised goals and strategies of the 2007 Plan. These changes address the following issues:

- At-Risk Individuals and Primary Prevention
- Federal Agency Collaboration
- Policy Academy Follow-up
- Disasters

In addition to broadening the plan to address homelessness experienced by families with children, the new plan also incorporates *populations who are at-risk of homelessness*. Vulnerable groups who may be at-risk of homelessness include individuals with disabilities, immigrants, persons leaving institutions (e.g., incarceration- including juvenile detention facilities, inpatient care for psychiatric or chronic medical conditions), youth aging out of foster care, frail elderly, persons experiencing abuse, and disaster victims. By including the at-risk population in the Plan, the Department is acknowledging those who may be on the verge of becoming homeless and who could become the next generation of chronically homeless individuals. Specifically, Strategy 3.1 in the new plan highlights the importance of identifying risk and protective factors to prevent episodes of homelessness for at-risk populations. This new strategy was added to the Plan to emphasize the importance of preventing first-time homelessness for at-risk populations (i.e. *primary prevention*). The inclusion of at-risk populations further acknowledges that effectively preventing chronic homelessness requires the two-pronged strategy of ending the homeless cycle for those who are already homeless, and the prevention of new episodes of homelessness for those who are currently housed, but who are at risk of becoming homeless.

The plan also contains new language and specific strategies about *federal agency collaboration* to encourage *intradepartmental* and *interdepartmental* coordination and collaboration across the federal government. Federal collaboration was included in Goal 4 as a specific strategy for data activities, but a separate strategy was added to Goal 1 in order to encourage federal partnership

across all Departmental activities related to homelessness. Strategy 1.6 reads as follows: “Explore opportunities with federal partners to develop joint initiatives related to homelessness and improve communication on programmatic goals, policies, and issues related to homelessness.”

Strategies in the plan were also revised to reflect the second phase of the Homeless Policy Academies. This *Policy Academy follow-up* includes providing technical assistance to the states and territories around effective implementation of their Action Plans and sustaining their momentum in addressing homelessness in their respective states and territories. In general, the strategies under Goal 2 (to empower our state and community partners to improve their response to individuals and families experiencing homelessness) are related to this second phase of the Homeless Policy Academies.

Finally, *disasters* are considered as an issue relevant to homelessness, given the devastation caused by Hurricanes Katrina and Rita, and the consequences to those who lost their homes and those who already were homeless before the catastrophe. To this end, a new strategy in the Plan specifically refers to working with state, local and tribal organizations around policies pertaining to homelessness, including addressing homelessness as a result of disasters, the needs of homeless persons before/during/and after a disaster, and ways to assist the new population of temporarily homeless persons due to a disaster.

Chapter 4

Progress Made Since 2003

Introduction

The strategic action plan developed in 2003 has served as the framework for developing and implementing activities across the Department related to chronic homelessness. The general premise of the strategic action plan posits that homelessness is a complex social problem, and ending chronic homelessness requires housing combined with the types of services supported by the programs funded and operated by HHS. The goals outlined within the strategic action plan provided a course of action for the Department to follow in order to improve access to needed health and social services for individuals experiencing chronic homelessness, empower states to improve their response to individuals experiencing chronic homelessness, and to prevent future episodes of homelessness within HHS clientele. Since 2003, the Department has worked in partnership with the states, other federal Departments, and the U.S. Interagency Council on Homelessness to advance the goals outlined in the strategic action plan.

In considering the direction of the 2007 Strategic Action Plan, two documents in particular were reviewed carefully: the final report of the National Learning Meeting and the activities matrix of the Secretary's Work Group. The National Learning Meeting, held in October of 2005, was the capstone meeting of the first seven Homeless Policy Academies. Representatives of fifty-four states and U.S. territories joined federal agency partners, public and private organizations addressing homelessness, and technical assistance providers to showcase innovative approaches that states and territories are implementing, exchange peer-to-peer technical assistance, and renew the states and territories commitment to fully implementing their Homeless Policy Academy action plans. The recommendations of the states and territories were captured in the final report of the meeting and were considered carefully when developing the revised goals and strategies of the 2007 Plan. The second document that was reviewed was the activities matrix developed by the Secretary's Work Group on Ending Chronic Homelessness. The matrix provides the means by which the agencies and staff divisions within the Department track progress towards achieving the goals outlined in the Plan. By reviewing the activities matrix, the Department can identify where opportunities to move forward exist.

There are two key areas in which the Department can track its progress since 2003: 1) the programs that serve persons experiencing homelessness and 2) the range of research and programmatic activities that have been undertaken since 2003.

HHS Programs That Serve Individuals, Youth, and Families Experiencing Homelessness

HHS operates a range of programs that may serve individuals and families experiencing homelessness. The relevant programs are divided into two categories: *targeted* homeless assistance programs, which are specifically designed to serve individuals and families who are homeless, and *mainstream* programs, which are designed to meet broader goals, such as alleviating poverty or providing health care to low-income persons. The budgets of the targeted homeless programs have experienced growth since 2003 (see Table 1), but improving access to

mainstream programs remains critical to increasing the Department’s capacity to serve this population.

Often times, individuals or families who are homeless are eligible for, or can access, services provided through mainstream programs. The combined total budget of the targeted homeless assistance programs is less than one percent of the combined total budget of the mainstream programs that individuals or families who are homeless may access (see Table 2). Additionally, utilization of the mainstream programs not only represents a significant funding stream, but also greatly expands the capacity of the Department to provide the necessary services to persons experiencing homelessness. However, barriers to accessing mainstream programs often hinder the engagement of some persons experiencing homelessness (such as a lack of a permanent, fixed address), and a lack of knowledge about engaging persons experiencing homelessness commonly exists within the broader mainstream service provider community. In order to improve the accessibility and take advantage of the funding and capacity available within the mainstream programs, the Department has engaged in a range of strategies to increase access to mainstream resources for persons experiencing homelessness.

Table 2. HHS Budget Growth- Targeted Homelessness Programs FY 2003-FY2006
(all values in millions)

	FY 2003	FY 2004	FY 2005	FY 2006
TARGETED PROGRAMS				
Grants for the Benefit of Homeless Individuals	\$29.7	\$33.2	\$36.0	\$44.0*
Health Care for the Homeless	\$121.7	\$135.7	\$145.8	\$151.4
Projects for Assistance in Transition from Homelessness (PATH)	\$43.1	\$49.8	\$54.8	\$54.2
Programs for Runaway and Homeless Youth	\$105.4	\$104.7	\$103.9	\$102.8
Title V/ Surplus Property**	---	---	---	---

Note: Table reports funding only for targeted homeless programs and does not include funding for research (NIH, OASPE, SAMHSA, HRSA, ACF); *Includes \$4 million in one-time CMHS funds to support competitively-awarded supplements for chronic homelessness; ** The Title V/Surplus Property program involves the transfer of surplus federal property from HHS to a homeless assistance provider, and the program does not have a line item budget.

Table 3. HHS Budget Growth- Mainstream Programs FY 2003-FY 2006
(all values in millions)

	FY 2003	FY 2004	FY 2005	FY 2006
MAINSTREAM PROGRAMS				
Access to Recovery	---	---	\$99	\$98
Child Support Enforcement Program	\$4,063.1	\$4,004.2	\$4,093.5	\$4,206.5
Community Mental Health Services Block Grant	\$437	\$435	\$433	\$429
Community Services Block Grant	\$646	\$642	\$637	\$630
Community Health Centers	\$1,505	\$1,617	\$1,735	\$1,782
Family Violence Prevention and Services Grant Program	\$129.0	\$128.6	\$128.9	\$127.6
Head Start	\$6,667	\$6,775	\$6,843	\$6,786
Maternal & Child Health Services Block Grant	\$731	\$730	\$724	\$693
Medicaid	\$160,693	\$176,231	\$181,780	\$180,625
Ryan White CARE Act	\$2,018	\$2,045	\$2,073	\$2,063
Social Services Block Grant	\$1,700	\$1,700	\$1,700	\$1,700
State Children's Health Insurance Program	\$4,355	\$4,607	\$5,129	\$5,451
Substance Abuse Prevention and Treatment Block Grant	\$1,754	\$1,779	\$1,776	\$1,759
Temporary Assistance for Needy Families	\$17,009	\$17,209	\$17,881	\$17,059

Key Research and Programmatic Activities Between 2003 - 2006

Between 2003 and 2007, the Department made significant progress towards the goals identified in the 2003 Plan. Reviewing key research and programmatic activities accomplished under each of the three original goals of the strategic action plan provide an opportunity to measure the progress of the Department in a quantitative manner and provide context for the revisions that are ultimately laid forth in the 2007 Strategic Action Plan.

2003 Strategic Action Plan Goal 1: Help eligible, chronically homeless individuals receive health and social services

The objective of goal one was to expand the capacity of HHS programs to assist persons experiencing chronic homelessness. Many HHS programs lack the funding to serve individuals

with multiple, complex needs. If the funding is available, effective service delivery interventions may not be applied when working with this population. The activities developed to meet this goal centered on strengthening outreach and engagement activities, improving the eligibility review process, exploring way to maintain program eligibility, and improving the transition of clients from targeted homeless programs to mainstream service providers.

- ***Collaborative Initiative to Help End Chronic Homelessness:*** Between 2003 and 2005, HHS partnered with the HUD, VA, and USICH to sponsor the Collaborative Initiative to Help End Chronic Homelessness. Funds from HHS' Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA), are helping to support eleven communities that are working to integrate housing and treatment services for disabled persons who have experienced long-term and repeated homelessness. HHS contributed \$10 million to the initial \$35 million in funding in 2003, and an additional \$10 million each in both fiscal years 2004 and 2005 for these projects. An additional \$1 million has been made available within HHS in order to provide technical assistance to the grantees. An evaluation of the initiative is also being sponsored by HHS, HUD, and VA; with HHS contributing a total of \$600,000 towards the evaluation project.
- ***Supplemental Security Income and Social Security Disability Insurance Outreach, Access and Recovery (SOAR):*** In 2003, SAMHSA, in consultation with the Social Security Administration, published a volume entitled: *Stepping Stones to Recovery, A Case Manager's Manual for Assisting Adults who are Homeless, with Social Security Disability and Supplemental Security Income Applications*. This volume is designed to provide an overview of the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs, and to provide frontline caseworkers with the tools to assist persons experiencing homelessness to apply for SSA disability programs.
- ***Supplemental Security Income and Social Security Disability Insurance Outreach, Access and Recovery (SOAR) Technical Assistance Initiative:*** This training initiative utilizes SAMHSA's *Stepping Stones for Recovery* curriculum, with the goal of providing states and local community providers with the tools to implement a specific set of action steps that will lead to increased access to SSA disability benefits for people who are chronically homeless. Participating states receive in-state facilitation to devise a plan that identifies the staff, training, and interagency coordination needed to increase such access, learn how to use the curriculum and receive follow-up technical assistance, including training for two or more trainers per state to create on-going local training capacity. SOAR training has been funded through the pooled resources of the funders of the Homeless Policy Academies: HHS, HUD, DOL, and VA. Since 2005, 25 states have participated in the SOAR training initiative.
- ***Documenting Disability: Simple Strategies for Medical Providers:*** HRSA sponsored the development of this manual, which is a guide to documenting medical impairments in support of applications for the Social Security Administration's disability benefits programs. It is primarily for health care providers in the United States serving individuals with disabilities who are homeless or marginally housed. The purpose of the manual is to inform clinicians about SSA's disability criteria and to explain how they can expedite the disability determination process. By understanding the process of applying for SSA disability benefits and the requirements for providing evidence in support of a disability claim, providers can do so more efficiently and effectively.

- ***Evaluation of Housing Approaches for Persons with Serious Mental Illnesses:*** SAMHSA sponsored a project to identify models of housing for adults with serious mental illnesses and co-occurring substance abuse disorders that may reduce homelessness and institutionalization and promote community living. The study evaluated a cross-site evaluation on six sites using a common data collection protocol and site-specific evaluations, with the goal of developing a supportive housing tool kit. The *Supportive Housing Implementation Resource Kit* is under development and will be piloted in 2007.
- ***Funding Health, Behavioral Health, and Support Services for Persons Who Are Homeless with Medicaid:*** CMS is developing a primer for policy makers and others who wish to understand what medical, behavioral health, and support services can be reimbursed by Medicaid that would benefit individuals who are homeless. This report will address an important knowledge gap identified by states, providers, consumers and consultants and is due to be published in 2007.
- ***Health Care for the Homeless/Community Mental Health Center Collaboration Project:*** Between 2002 and 2005, HRSA and SAMHSA funded a demonstration project to expand access to health and behavioral health services for homeless persons with psychiatric and substance use disorders. Twelve program sites funded with \$3.1 million annual funding. Additional funding was provided by SAMHSA and ASPE to support an evaluation of the demonstration project, and the final evaluation is expected in 2007.
- ***Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Abuse Disorders:*** In 2003, SAMHSA developed a report designed to help states and local communities develop integrated systems of care to address homelessness among people who have serious mental illnesses and/or co-occurring substance abuse disorders.
- ***How States Can Use SAMHSA Block Grants to Support Services for People Who are Homeless:*** In 2003, SAMHSA published a report to highlight efforts of many states to use the federal block grant funds for mental health and substance abuse services to provide more effective care for people who are homeless.
- ***Medicare Prescription Drug Coverage and Persons Experiencing Homelessness:*** In 2005/2006, the Centers for Medicare and Medicaid Services developed a flyer entitled “What do I need to know about Medicare prescription drug coverage to help my homeless clients?” and circulated the material widely to homeless assistance providers.
- ***Benefits for individuals leaving institutional settings:*** In 2004, HHS issued policy guidance to encourage states to “suspend” and not “terminate” Medicaid benefits while an individual is in an institutional setting.
- ***National Institutes of Health (NIH) Research Initiatives:*** Since 2002, the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) have jointly issued a program announcement to support research on homelessness and to develop further knowledge and evidence-based practices for treating and preventing the development of chronic homelessness in vulnerable populations. A number of research projects have been or are currently supported via this mechanism.

2003 Strategic Action Plan Goal 2: Empower our state and community partners to improve their response to people experiencing chronic homelessness

HHS is the largest grant-making agency in the federal government and the nation's largest health insurer. HHS administers more grant dollars than all other federal agencies combined and handles more than one billion insurance claims per year. These activities are administered by eleven Operating Divisions across the Department. The Operating Divisions work closely with state, local, and tribal governments, as many HHS-funded services are provided at the local level by state, county or tribal agencies, or through private sector and faith-based grantees. Much of the funding awarded by HHS is distributed in the form of block grants to states, allowing states to prioritize and direct the funding towards the needs they have prioritized, which may be different than their neighboring states. As such, it is critical that HHS works with states and community partners to empower them and provide the appropriate tools by which to improve their response to people experiencing chronic homelessness.

- ***Homeless Policy Academies:*** Between 2002 and 2005, HHS played a lead role in the development and implementation of nine Homeless Policy Academies designed to improve access to mainstream services for chronically homeless individuals and families with children experiencing homelessness. The Policy Academies were designed to bring together state-level program administrators and homeless service providers in order to develop state-specific action plans designed to increase access to mainstream resources for persons experiencing homelessness. To date *every state and U.S. Territory and the District of Columbia has participated in a Homeless Policy Academy*. Over the course of three years, nine Policy Academies have been sponsored by HHS, HUD, VA, DOL, Department of Education, Department of Justice, Department of Agriculture, and the U.S. Interagency Council on Homelessness.
- ***Follow-up Policy Academy Technical Assistance:*** Customized technical assistance for the states who have attended a Homeless Policy Academy is a critical component of the Policy Academy activity. Each state and territory has been provided with a technical assistance budget, and those funds can be used to support a range of technical assistance activities that enable the state to implement their action plans. Funds from multiple contracts have been woven together to provide this technical assistance, and HHS is partnering with the other sponsoring federal agencies to fund technical assistance to all state and territories developing and implementing state action plans that were initiated by attending a Homeless Policy Academy. Technical assistance has been delivered since 2003 and will continue into 2007.
- ***Learning Community Workgroups:*** In 2006, HHS partnered with other federal agencies to develop and implement a series of Learning Communities Workgroups, which were small meetings gathering representatives from ten to twelve states to focus on specific topic areas to help move states along in their implementation of their state plans drafted through the policy academy process. Four Learning Community Workgroups were held during 2006 on the following topics: youth homelessness, transition/discharge planning, employment, and data and performance measurement.
- ***FirstStep, a CD-ROM resource:*** HHS and HUD jointly developed and disseminated widely FirstStep, an easy-to-use, interactive tool for case managers, outreach workers and others working with people who are homeless. FirstStep, first released in October 2003, is a CD-ROM resource that staff can use to identify the health services and benefits needed by a

homeless person available through mainstream programs, and to determine how to go about accessing these services. Currently, CMS is making a series of refinements to the FirstStep product to address additional needs articulated by states and other constituents. The Social Security Administration, the Department of Agriculture, the Department of Labor, and the Department of Veterans Affairs also partnered with HHS and HUD to develop FirstStep.

- ***Participation of HHS Regional Offices in Regional Interagency Councils on Homelessness:*** All ten regions have established regional ICHs or other homelessness committees involving appropriate federal agencies. Several Regional ICHs are working with their states and communities in the development of ten-year plans for ending chronic homelessness. Other activities include technical assistance workshops for state and local homelessness program coordinators, conferences, resource directories, and working with local governments to identify barriers to accessing services.
- ***National Training Conference on Homelessness and Mental Illness:*** SAMHSA hosts a biennial national training conference addressing homelessness for people with mental illness and/or substance abuse disorders. The conference typically features three days of interactive workshops on housing, services, and cross-cutting issues, and is attended by roughly 800 clinicians, program officials, and policy makers.
- ***National Health Care for the Homeless Conference:*** HRSA sponsors an annual National Health Care for the Homeless (HCH) conference. These conferences, typically attended by 800-900 consumers, providers, and administrators, focus on the clinical, administrative, and policy challenges facing homeless persons and those that serve them. In addition to the main conference, there are supplemental all-day sessions on timely topic areas.
- ***National Returning Veterans Conference: The Road Home: National Behavioral Health Conference on Returning Veterans and Their Families:*** In March of 2006, SAMHSA sponsored a conference to give federal, state, and local public and private service providers evidence-based information and approaches that can help veterans and their families build resiliency to prevent and to treat mental health disorders (including Post-Traumatic Stress Disorders), substance abuse disorders, suicide, and/or co-occurring disorders.
- ***Symposium on Housing for Persons with Disabilities: Understanding Universal Design and Access Modification.*** In June 2004, the HHS Office on Disability partnered with CMS, HUD, Fannie Mae and North Carolina State University to host a Symposium on housing for persons with disabilities. The focus of this Symposium was on universal design and access modification for persons with disabilities; including those with physical, visual, hearing, cognitive, and mental disabilities. A webcast of the Symposium, as well as a webcast for a prior Symposium on home ownership are both available online at http://www.hhs.gov/od/archive_webcasts.html

2003 Strategic Action Plan Goal 3: Work to prevent new episodes of homelessness within the HHS clientele

Prevention activities are critical to any plan that seeks to end chronic homelessness. However, in order to prevent homelessness, we first need to understand effective prevention interventions. As such, HHS has sponsored research over the past several years to better understand what prevention models might be effective.

- ***Evaluability Assessment of Discharge Planning to Prevent Homelessness:*** ASPE sponsored an evaluability assessment of discharge planning in institutional and custodial settings, with a specific focus on whether discharge planning is a strategy that can prevent homelessness. The project included a literature review on discharge planning; a documentary analysis of selected exemplary programs, including site visits to identified programs; and a final report that summarizes key findings from the study, including possible evaluation design options. The final report was published September 2005 and available at: <http://aspe.hhs.gov/hsp/05/discharge-planning/index.htm>
- ***Characteristics and Dynamics of Homeless Families with Children:*** Recognizing that data on homeless families is not as robust as data available on single adults, ASPE is sponsoring a research project designed to identify opportunities and strategies to improve data about homeless families upon which future policy and program decisions may be based by investigating the availability of data with which to construct a typology of homeless families. A typology could foster a better understanding of these families' characteristics, service needs, interactions with human services systems, and the dynamics of their use of emergency shelter and other services and assistance. The final report from this project will be available in the spring of 2007.
- ***Evaluation of Chronic Homelessness Policy Academies:*** HRSA is partnering with SAMHSA/CMHS to co-fund an evaluation of the Chronic Homelessness Policy Academies, a multi-year project that was funded by HHS, HUD, VA, and DOL. The Homeless Policy Academies were designed to offer states an opportunity to bring together a team of policy-makers, providers, and program leaders to spend three days working on a strategic action plan to increase access to mainstream services for people experiencing chronic homelessness. Both a process evaluation and an outcome evaluation will document the process, assess the effectiveness of the Academies, and identify lessons learned from the Policy Academy activity for the 49 states and territories who attended a chronic homeless Academy. Final evaluation report is expected in late 2007.
- ***National Symposium on Homelessness Research:*** ASPE is partnering with HUD to sponsor a National Symposium on Homelessness Research. This project will oversee the commissioning of a series of synthesis papers, the organization of a symposium to present and discuss the papers, and the production of a final report featuring the papers commissioned for the project. Over the past decade, the landscape of homelessness research has evolved immensely; new models for housing and service delivery have emerged and cutting edge research has expanded our understanding of the various populations that experience homelessness. The findings presented through this project will serve to guide federal and state policymaking, to assist local practitioners in incorporating successful strategies into their programs, and to assist researchers to identify areas meriting future research. The Symposium will be held in 2007 and the volume of final papers will also be available in 2007.
- ***Homeless Families Program:*** SAMHSA funded a multi-site study of the effectiveness of services provided to homeless women and their children. Approximately 1600 women and their families received services under this program. The project was designed to document and evaluate the effectiveness of time-limited, intensive intervention strategies for providing treatment, housing, support, and family preservation services to homeless mothers with

psychiatric and/or substance use disorders who are caring for their dependent children. The study design involved a five-year, cross-site data collection and analysis program involving eight study sites. The project was begun in September of 1999 and data collection was concluded in September of 2006. A series of articles that report the study findings will be published in the *Journal of Community Psychology* in 2007.

- ***Promising Strategies to End Youth Homelessness:*** The Family and Youth Services Bureau within ACF, in consultation with the USICH, is conducting a study of "promising strategies to end youth homelessness" which responds to statutory requirements. The study will identify and assess a wide range of practices that show promise or carry evidence of effectiveness in helping young people find appropriate living situations, including those youth who have suffered from systemic failures, such as when child welfare and juvenile justice programs have been incapable of providing effective transitions to adult independence for youth in their care. Runaway and homeless youth served by FYSB are served in emergency situations and cases where returning home is not an option. The study is anticipated to be released in 2007.

References

- Bassuk, Ellen L., Buckner, John C., Weinreb, Linda F., Browne, Angela, et al. Homelessness in Female-Headed Families: Childhood and Adult Risk Protective Factors. *American Journal of Public Health*. 1997; 87(2): 241-248.
- Bassuk, Ellen L., Weinreb, Linda F., Buckner, John C., Browne, Angela; et al. The Characteristics and Needs of Sheltered Homeless and Low-Income Housed Mothers. *JAMA*. 1996; 276(8): 640-646.
- Burt, M., Aron, L.Y., Douglas, T., Valente, J., Lee, E., & Iwen, B. (Urban Institute) (1999). *Homelessness: Programs and the people they serve: Findings of the National Survey of Homeless Assistance Providers and Clients*: Technical report prepared for the Interagency Council on Homelessness. Washington, D.C.: The Council.
- Farrow, J.A., Deisher, R.W., Brown, R., Kulig, J.W., and Kipke, M.D. Health and health needs of homeless and runaway youth. A position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health*. 1992; 13(8): 717-726.
- Helping America's Homeless: Emergency Shelter or Affordable Housing? by Martha Burt, Laudan Y. Aron and Edgar Lee (with Jesse Valente); Washington, DC: The Urban Institute Press; 2001.
- Koegel, Paul, Elan Melamid, and M. Audrey Burnam. Childhood risk factors for homelessness among homeless adults. *American Journal for Public Health*. 1995; 85(12): 1642-1649.
- Kuhn R, Culhane DP. Applying cluster analysis to test a typology of homelessness by pattern of shelter utilization: results from the analysis of administrative data. *American Journal of Community Psychology*. 1998; 26(2): 207-232.
- Metraux, Stephen, Dennis P. Culhane, Stacy Raphael, Matthew White, Carol Pearson, Eric Hirsch, Patricia Ferrell, Steve Rice, Barbara Ritter, & J. Stephen Cleghorn. Assessing Homeless Population Size through the Use of Emergency and Transitional Shelter Services in 1998: Results from the Analysis of Administrative Data in Nine US Jurisdictions. *Public Health Reports*. 2001; 116: 344-352.
- Park, Jung Min, Metraux, Stephen, Brodbar, Gabriel, and Culhane, Dennis P., Child welfare involvement among children in homeless families. *Child Welfare*. 2004; 83(5): 423-436.
- Ringwalt, C.L., Greene, J.M., Robertson, M; McPheeters. (1998). The prevalence of homelessness among adolescents in the United States. *American Journal of Public Health*. 1998; 88(9): 1325-1329.
- Robertson, M.J., & Toro, P.A 1999. Homeless Youth: Research, Intervention, and Policy. *Practical Lessons: The 1998 National Symposium on Homelessness Research*. Washington DC. U.S. Departments of Housing and Urban Development and Health and Human Services.

Shinn, Marybeth, Weitzman, Beth C., Stojanovic, Daniela, Knickman, James R., et al. Predictors of Homelessness Among Families in New York City: From Shelter Request to Housing Stability. *American Journal of Public Health*; 1998; 88(11): 1651-1657.

United States Conference of Mayors. A Status Report on Hunger and Homelessness in America's Cities: A 23-City Survey, December 2006, available on-line at: <http://www.mayors.org/uscm/hungersurvey/2006/report06.pdf>.

Webb, David A., Culhane, Jennifer, Metraux, Stephen, Robbins, Jessica, and Culhane, Dennis. Prevalence of episodic homelessness among adult childbearing women in Philadelphia, PA. *American Journal of Public Health*. 2003; 93(11): 1895-1896.

Appendix A: Overview of Programs Operated by the U.S. Department of Health and Human Services That May Serve Persons Experiencing Homelessness

HHS identifies 18 targeted and non-targeted programs as relevant to serving eligible homeless persons. The *targeted programs* are much smaller in scope, but are designed specifically for individuals or families who are experiencing homelessness. *Mainstream programs* are designed to serve those who meet a set of eligibility criteria that is often established by the states, but generally address provision of services to low-income populations. Very often, persons experiencing homelessness may be eligible for services funded through these programs. These programs are located in five of the organizational components of HHS and their role in serving persons experiencing homelessness are detailed in this Appendix.

HHS Targeted Homelessness Programs

Grants for the Benefit of Homeless Individuals (GBHI) (also referred to as Treatment for Homeless)

The Grants for the Benefit of Homeless Individuals (GBHI) program enables communities to expand and strengthen their treatment services for homeless individuals with substance abuse disorders, mental illness, or with co-occurring substance abuse disorders and mental illness. Eligible applicants are community-based public and private nonprofit entities. Since the inception of the Treatment for Homeless program, over 10,000 persons have received grant-supported services. As of October 2006, there were 91 active GBHI grants.

Programs and activities include: (1) substance abuse treatment; (2) mental health services; (3) immediate entry to treatment; (4) wrap-around services; (5) outreach services; (6) screening and diagnostic treatment services; (7) staff training; (8) case management services; (9) supportive and supervisory services in outpatient and residential settings; and (10) referrals for primary health services, job training, educational services, and relevant housing services.

Funds may not be used to: (1) pay for housing (other than residential substance abuse treatment and/or residential mental health programs); (2) carry out syringe exchange programs; and (3) pay for pharmacologies for HIV antiretroviral therapy, STDs, TB and hepatitis B and C services.

Health Care for the Homeless (HCH)

<http://bphc.hrsa.gov/hchirc/>

The purpose of the Health Care for the Homeless (HCH) program operated by the Health Resources and Services Administration (HRSA) is to provide primary health care, substance abuse treatment, emergency care with referrals to hospitals for in-patient care services and/or other needed services, and outreach services to assist difficult-to-reach homeless persons in accessing care, and provide assistance in establishing eligibility for entitlement programs and housing.

Eligible grant recipients include private nonprofit and public entities. Eligible recipients of services include persons who are literally homeless, as well as those who are living in transitional housing arrangements. Services provided include primary health care, substance abuse, mental health, and oral health services; extensive outreach and engagement; extensive

case management services; and assistance with accessing public benefits, housing, job training, etc. HCH works within guidelines for the Community Health Center (Health Center) program. Health centers serve all residents in their catchment area, regardless of ability to pay. Health Centers serve homeless individuals as appropriate, therefore, Centers located in communities that do not have HCH programs may serve persons who are homeless. Approximately 650,000 persons are served annually by HCH program grantees.

Projects for Assistance in Transition from Homelessness (PATH)

<http://www.pathprogram.samhsa.gov/>

PATH is a formula grant program operated by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide financial assistance to states to support services for homeless individuals who have serious mental illness or serious mental illness and substance abuse. The formula allots funds on the basis of the population living in urbanized areas of the state, compared to the population living in urbanized areas of the entire United States, except that no state receives less than \$300,000 (\$50,000 for territories). States must agree to make available nonfederal contributions equal to not less than \$1 (in cash or in kind) for each \$3 of Federal funds provided in such grant. Territories have no matching requirements. Not more than 20 percent of the payment may be expended for housing services.

Eligible programs and activities include: (1) outreach services; (2) screening and diagnostic treatment services; (3) habilitation and rehabilitation services; (4) community mental health services; (5) alcohol or drug treatment services; (6) staff training; (7) case management services; (8) supportive and supervisory services in residential settings; (9) referrals for primary health services, job training, educational services, and relevant housing services; and (10) a prescribed set of housing services.

According to the latest available data, state-funded community based agencies used FY 2003 allocations to provide PATH eligible services to 86,000 enrolled persons. Persons served were among the most severely disabled. Thirty-six percent of clients had schizophrenia and other psychotic disorders; 59% of persons served had a co-occurring substance use disorder in addition to a serious mental illness; and almost 69% of clients served were living on the street or in emergency shelters.

Programs for Runaway and Homeless Youth (RHY)

The Administration for Children and Families (ACF) funds 669 public, community and faith-based programs through three grant programs that serve the runaway and homeless youth population. Ninety percent of grant dollars awarded are used for preventive activities, and/or housing activities for youth who are at-risk of experiencing homelessness or are already in a homeless situation, and ten percent of funds are used for support services.

Eligible applicants for the Basic Center and Transitional Living Programs are states, units of local government, a combination of units of local government, and public or private nonprofit agencies, organizations or institutions. Federally recognized Indian Tribes, Indian Tribes that are not federally recognized and urban Indian organizations are also eligible. Eligible applicants for

the Street Outreach Program include any private, nonprofit agency, non-federally recognized Indian Tribes and urban Indian organizations.

Basic Center Program

The purpose of the Basic Center Program is to establish or strengthen locally-controlled, community and faith-based programs that address the immediate needs of runaway and homeless youth and their families. Basic Centers provide youth with temporary emergency shelter, food, clothing, and referrals for health care. Other types of assistance provided to youth and their families may include individual, group, and family counseling; recreation programs; and aftercare services for youth once they leave the shelter. Grants can also be used for outreach activities targeting youth who may need assistance. Basic Centers seek to reunite young people with their families when possible, or to locate appropriate alternative placements.

Transitional Living Program

The purpose of the Transitional Living Program is to provide shelter, skills training, and support services to youth, ages 16 through 21, who are homeless, for a continuous period, generally not exceeding 18 months. Youth who have not reached the age of 18 years during an 18 month stay may remain in the program for an additional 180 days or until their 18th birthday, whichever comes first.

Youth are provided with stable, safe living accommodations and services that help them develop the skills necessary to move to independence. Living accommodations may be host family homes, group homes, including maternity group homes, or “supervised apartments.” Skills training and support services provided include: basic life-skills and interpersonal skill building; educational opportunities (vocational and GED preparation); job placement; career counseling; and mental health, substance abuse, and physical health care services.

Street Outreach Program

The purpose of the Street Outreach Program is to provide educational and prevention services to runaway, homeless and street youth who have been subject to, or are at risk of, sexual exploitation or abuse. The program works to establish and build relationships between street youth and program outreach staff in order to help youth leave the streets. Support services that will assist the youth in moving and adjusting to a safe and appropriate alternative living arrangement include: treatment, counseling, information and referral services, individual assessment, crisis intervention, and follow up support. Street outreach programs must have access to local emergency shelter space that is an appropriate placement for young people and that can be made available for youth willing to come in off the streets.

Title V Surplus Property Program

<http://www.psc.gov/aos/federalprop/titleV.html>

Title V of the McKinney-Vento Homeless Assistance Act (Title V), authorizes the Secretary of Health and Human Services to make suitable federal properties categorized as excess or surplus

available to representatives of persons experiencing homelessness as a permissible use in the protection of public health. The purpose of the program is to provide federal surplus land and buildings to organizations which serve the needs of the homeless. Eligible applicants are states and their political subdivisions and instrumentalities, and tax-supported and nonprofit institutions, which provide a broad array of services to the homeless. Eligible activities include emergency and transitional housing and related services; substance abuse and mental health programs for homeless individuals; homeless ex-offender aftercare programs and miscellaneous other supportive homeless services. A policy change that took effect in September of 2006 expands the allowable uses of surplus real property to include permanent supportive housing. Currently, there are 80 active properties on which numerous services are provided to homeless individuals and/or families. There are approximately 3,000 transitional housing beds and 800+ emergency housing beds being successfully operated by homeless assistance providers receiving properties pursuant to Title V of the McKinney-Vento Homeless Assistance Act.

HHS Mainstream Programs

Access to Recovery (ATR)

<http://atr.samhsa.gov/>

Access to Recovery (ATR), operated by the Substance Abuse and Mental Health Services Administration (SAMHSA) and established in 2003, supports a grantee-run voucher program for substance abuse clinical treatment and recovery support services built on the following three principles: consumer choice, outcome oriented, and increased capacity. ATR is a competitive grant program, and selected ATR Grantees have designed their approach and targeted efforts to areas of greatest need, areas with a high degree of readiness, and to specific populations, including adolescents. Critically, grantees are using the new funds to supplement, not supplant current funding and are building on existing programs. The goal of the program is to expand clinical treatment and recovery support services to reach those in need.

Child Support Enforcement Program

<http://www.acf.hhs.gov/programs/cse/>

The mission of the child support enforcement program is to assure that assistance in obtaining support (both financial and medical) is available to children through locating parents, establishing paternity and support obligations, and enforcing those obligations. The program is a federal/state/tribal/local partnership to help families by promoting family self-sufficiency and child well-being. All States and territories run a child support enforcement program, usually in the human services department, department of revenue, or the State Attorney General's office, often with the help of prosecuting attorneys, district attorneys, other law enforcement agencies and officials of family or domestic relations courts. Native American Tribes, too, can operate culturally appropriate child support programs with Federal funding. Families seeking government child support services must apply directly through their state/local agency or one of the tribes running the program. Services are available to a parent with custody of a child whose other parent is living outside the home, and services are available automatically for families receiving assistance under the Temporary Assistance for Needy Families (TANF) program.

The child support program in each state can be a helpful resource to families consisting of single custodial parents with children, since a reason for the homelessness may be non-payment of child support. In addition, child support programs can help homeless noncustodial parents, through outreach, address any outstanding child support issues (perhaps helping them with the order modification process) and connecting them with organizations that can help them with basic skills, such as how to seek and maintain employment, and understand issues surrounding court and child support agency processes.

Community Mental Health Services Block Grant (CMHSBG)

<http://www.mentalhealth.samhsa.gov/publications/allpubs/KEN95-0022/>

The Community Mental Health Services Block Grant (CMHSBG), operated by the Substance Abuse and Mental Health Services Administration (SAMHSA), is a formula grant to states and territories for providing mental health services to people with serious mental illnesses. The formula for determining the federal allocations of funds to the states is determined by Congress. The funds are intended to improve access to community-based health care delivery systems for adults with serious mental illnesses and children with serious emotional disturbances. States design a services delivery plan that addresses the unique needs of the state's populations. Mental health plans must respond to federal criteria that include: 1) a comprehensive community based mental health system with a description of health and mental health services, rehabilitation services, employment services, housing services, educational services, substance abuse services, medical and dental care; 2) mental health system data and epidemiology estimates of incidence and prevalence in the state of serious mental illness among adults and serious emotional disturbance among children; 3) services for children with serious emotional disturbance provided in an integrated system of care; 4) targeted services to rural and homeless populations with a description of state's outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas; and 5) management systems for financial resources, staffing and training for mental health providers, and training of providers of emergency health services. CMHSBG funds are used to carry out the plan, evaluate programs and services carried out under the plan, and for planning, administration and educational activities that relate to providing services under the plan. Block grant funds are used by each state as they determine their needs; therefore, the program does not require states to report on expenditures related to homelessness.

Community Services Block Grant (CSBG)

<http://www.acf.hhs.gov/programs/ocs/csbg/>

The purpose of the Community Services Block Grant (CSBG) operated by the Administration for Children and Families (ACF) is to provide services and activities to reduce poverty, including services to address employment, education, better use of available income, housing assistance, nutrition, energy, emergency services, health, and substance abuse needs. Funds are allocated by formula to 50 states and the District of Columbia, Puerto Rico, Guam, American Samoa, the Virgin Islands, the Northern Marianas, and state and federally-recognized Indian tribes. Funds are used by states to support a network of local community action agencies, federally and state recognized Indian tribes and tribal organizations, migrant and seasonal farm worker organizations, or private/public community-based organizations to provide a range of services and activities to assist low-income individuals, and families, including the homeless, to alleviate

the causes and conditions of poverty. As a flexible block grant awarded to states and U.S. Territories, CSBG does not collect specific data on amounts expended on homelessness.

Community Health Centers (CHC)

<http://bphc.hrsa.gov/chc/>

The Community Health Centers, operated by the Health Resources and Services Administration (HRSA), provide health services to underserved populations. This includes people who face barriers in accessing services because they have difficulty paying for services, have language or cultural differences, or because there is an insufficient number of health professionals/resources available in their community. Health Centers provide health care services as described in statute and regulation. They provide basic preventive and primary health care services. Health Centers also provide services that help ensure access to the primary care such as case management, outreach, transportation and interpretive services. Services are provided without regard for a person's ability to pay. Fees are discounted or adjusted based upon the patient's income and family size from current Federal Poverty Guidelines. All grantees must demonstrate that all persons will have access to the full range of required primary, preventive, enabling, and supplemental health services, including oral health care, mental health care and substance abuse services, either directly on-site or through established arrangements. In FY 2006, the entire Health Center program, including HCH, received \$1.785 billion (including funds for Tort Claims). Health Center reporting does not support an estimate of expenditures on homelessness outside of the HCH program.

Family Violence Prevention and Services Grant Program (FVPS)

<http://www.acf.hhs.gov/programs/fysb/content/familyviolence/programs.htm>

The purpose of the Family Violence Prevention and Services program, operated by the Administration for Children and Families, is to fund grants to state agencies, territories and Indian Tribes for the provision of shelter to victims of family violence and their dependents, and for related services, such as emergency transportation and child care. Grantees use additional resources to expand current service programs and to establish additional services in rural and underserved areas, on Native American reservations, and in Alaskan Native Villages. The program also supports technical assistance and training for local domestic violence programs and disseminates research and information through five resource centers.

Head Start

<http://www.acf.hhs.gov/programs/hsb/>

Head Start and Early Head Start are comprehensive child development programs operated by the Administration for Children and Families (ACF) that serve children from birth to age five, pregnant women, and their families. It is a child-focused program with the overall goal of increasing the school readiness of young children in low-income families. Head Start serves homeless families eligible for the program in areas such as nutrition, developmental, medical and dental screenings, immunizations, mental health and social services referrals, and transportation. Section 645 of the 1998 Head Start Act establishes income eligibility for participation in Head Start programs by reference to the official poverty line, adjusted annually in accordance with changes in the Consumer Price Index. Homeless families often fall within these guidelines. In

FY 2005, Head Start served approximately 20,000 homeless children and their families throughout the country at a cost of \$143,705,000.

Maternal and Child Health Services Block Grant (MCHBG)

<http://mchb.hrsa.gov/>

The Maternal and Child Health Services Block Grant (MCHBG), operated by the Health Resources and Services Administration (HRSA), has three components: formula block grants to 59 states and Territories, grants for Special Projects of Regional and National Significance, and Community Integrated Service Systems grants. It operates through a partnership with State Maternal and Child Health and Children with Special Health Care Needs programs. The Program supports direct care; core public health functions such as resource development, capacity and systems building; population-based functions such as public information and education, knowledge development, outreach and program linkage; technical assistance to communities; and provider training. Most services supported by MCH block grant funds fall within four areas: 1) Direct Health Care - Basic health care services are provided to individual clients generally on a one-on-one basis between health care professionals and patients in a clinic, office, or emergency room; 2) Enabling Services - These services help targeted populations in need to gain access to the care that is available to them. Types of services include transportation to care, translation services, respite care for family caregivers, and health education programs; 3) Population-based Services - Most of these services are preventive services that are available to everyone. Examples include immunizations, child injury prevention programs, lead poisoning prevention activities, and newborn screening programs; and 4) Infrastructure Building - These activities form the foundation of all MCH-funded services. Activities include: evaluation, monitoring, planning, policy development, quality assurance, training and research. Neither HRSA nor states collect financial data on how many of its program dollars support homeless mothers and children, nor does it collect program data that indicates how many homeless mothers and children are served by Title V.

Medicaid

<http://www.cms.hhs.gov/home/medicaid.asp>

Medicaid, operated by the Centers for Medicare and Medicaid Services (CMS), is a jointly funded, federal-state health insurance program for certain low-income and needy people. In FY 2005, Medicaid provided coverage to more than 44.7 million individuals including 21.7 children, the aged, blind and/or disabled, and people who are eligible to receive federally assisted income maintenance payment. Total expenditures for the Medicaid program in FY 2005 were \$182 billion, however, state Medicaid programs are not required to report to CMS on the homelessness or housing status of persons who receive health care supported with Medicaid funding; therefore, Medicaid data systems are not designed to produce estimates of expenditures on services provided to persons who are homeless.

Ryan White CARE Act

<http://hab.hrsa.gov/history.htm>

The Ryan White CARE Act, operated by the Health Resources and Services Administration (HRSA), authorizes funding for the bulk of the agency's work on HIV/AIDS. Programs are funded through states, disproportionately impacted metropolitan areas, community health centers, dental schools, and health care programs that target women, infants, youth, and families. An increasing number of the people accessing HIV/AIDS services and housing have histories of homelessness, mental illness, and chemical dependency. The HRSA bureau responsible for administration of the CARE Act, the HIV/AIDS Bureau (HAB), has approached the issue of housing and healthcare access through housing policy development, direct service programs, service demonstrations, as well as in technical assistance and training activities to grantees. According to our CY 2004 CARE Act Data Report (CADR), of the 2,467 providers responding to the question whether they delivered services to special target populations, 1,184 providers indicated that they provided services to persons experiencing homelessness.

Types of housing assistance provided through the CARE Act:

- Housing referral services defined as assessment, search, placement, and advocacy services;
- Short-term or emergency housing defined as necessary to gain or maintain access to medical care;
- Housing services that include some type of medical or supportive service including, but not limited to residential substance treatment or mental health services, residential foster care, and assisted living residential services (does not include facilities classified as an institute of mental diseases under Medicaid);
- Housing services that do not provide direct medical or supportive services but are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment. Necessity of housing services for purposes of medical care must be certified or documented.

Social Services Block Grant

<http://www.acf.hhs.gov/progrms/ocs/ssbg/>

The Social Services Block Grant (SSBG) operated by the Administration for Children and Families (ACF) assists states in delivering social services directed toward the needs of children and adults. Funds are allocated to the states on the basis of population. SSBG funds support outcomes across the human service spectrum, and these outcomes are associated with strategic goals and objectives such as employment, child care, child welfare, adoptions, and youth services. The SSBG allows states flexibility in their use of funds for a range of services, depending on state and local priorities. The SSBG is based on two fundamental principles: (1) state and local governments and communities are best able to determine the needs of individuals to help them achieve self-sufficiency; and (2) social and economic needs are interrelated and must be met simultaneously. States have the flexibility to spend SSBG funds on a variety of services. Of these, services to promote self-sufficiency are the most relevant to homelessness. In FY 2004, the most recent data available, states reported spending \$111 million on self-sufficiency services, including education/training, employment services, family planning

services, independent/transitional living for adults, pregnancy and parenting, and substance abuse services. As a flexible block grant awarded to states and U.S. Territories, SSBG does not collect specific data on amounts expended on homelessness.

State Children's Health Insurance Program (SCHIP)

<http://www.cms.hhs.gov/home/schip.asp>

The State Children's Health Insurance Program, operated by the Centers for Medicare and Medicaid Services (CMS), is a partnership between the Federal and State Governments that provides health coverage to uninsured children whose families earn too much to qualify for Medicaid, but too little to afford private coverage. The federal government establishes general guidelines for the administration of SCHIP benefits. However, specific eligibility requirements to receive SCHIP benefits, as well as the type and scope of services provided, are determined by each state. Total expenditures for the SCHIP program in FY 2005 were \$5.129 billion, however, state SCHIP programs are not required to report to CMS on the homelessness or housing status of persons who receive health care supported with SCHIP funding; therefore, SCHIP data systems are not designed to produce estimates of expenditures on services provided to eligible homeless persons.

State Protection and Advocacy Agencies (P&As)

<http://www.acf.hhs.gov/programs/add/states/pnafactsheet.html>

The Administration for Children and Families oversees a program to support a Protection & Advocacy (P&A) System in each State, Territory, as well as a Native American Consortium, to protect and advocate for persons with developmental disabilities. All States, Territories, and a Native American Consortium (total of 57) are funded under the Protection & Advocacy for Individuals with Developmental Disabilities (PADD) program that requires the governor to designate a system in the State to empower, protect, and advocate on behalf of persons with developmental disabilities. The PADD program provides information and referral services and exercises legal, administrative and other remedies to resolve problems for individuals and groups of clients with developmental disabilities. The PADD program protects the legal and human rights of all persons with developmental disabilities. The amount of funding for the PADD program in an individual State is based on a formula that takes into account the population, the extent of need for services for persons with developmental disabilities, and the financial need of the State.

The PADD program in each State has a significant role in enhancing the quality of life of persons with developmental disabilities in every community. The PADD is mandated to:

- investigate incidents of abuse and neglect, follow up on reports of such incidents, and investigate if there is probable cause to believe that such incidents have occurred; and
- have access to all client records when given permission by the client or the client's representative authorization and have access records without permission when there is probable cause that abuse or neglect is involved

Substance Abuse Prevention and Treatment Block Grant (SAPTBG)

The Substance Abuse Prevention and Treatment Block Grant (SAPTBG), operated by the Substance Abuse and Mental Health Services Administration (SAMHSA), is a formula block grant to states to provide substance abuse treatment and prevention services to individuals in need. The formula grant is intended to provide maximum flexibility to states in determining allocations of the block grant to all populations within the states, dependent on state needs and priorities, including vulnerable and underserved populations such as the homeless and those at risk of homelessness. The authorizing legislation does not, however, specify homeless services and current policy does not encourage set-asides for specific populations. For FY 1999 (the only year for which a special analysis was compiled), the 40 participating states reported just over \$26 million SAPTBG funds were spent on alcohol and drug abuse services to homeless populations, approximately 1.64 percent of the Block Grant (Analysis by the National Association of State Alcohol and Drug Abuse Directors [NASADAD], 2002).

Temporary Assistance for Needy Families (TANF)

<http://www.acf.HHS.gov/programs/ofa/>

Temporary Assistance for Needy Families (TANF) is a block grant to states operated by the Administration for Children and Families (ACF). Title IV-A, section 404 of the Social Security Act (Act) allows states, Territories and federally recognized Indian Tribes to use Federal TANF funds in any manner that is reasonably calculated to accomplish a purpose of the TANF program. Section 401 of the Act sets forth the following four TANF purposes: (1) provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; (2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; (3) prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and (4) encourage the formation and maintenance of two-parent families.

Each state, territory, and participating Tribe decides the benefits it will provide and establishes the specific eligibility criteria that must be met to receive financial assistance payments and/or other types of TANF-funded benefits and services. TANF agencies provide a range of benefits to eligible families who are homeless or at-risk of becoming homeless. Common benefits and services provided to homeless families include: cash assistance for temporary shelter arrangements; assistance to obtain permanent housing; case management services; one-time cash payments; and vouchers for food, clothing, and household expenses. For at-risk families, common benefits include counseling, housing referrals, assistance for past due utility bills, and assistance for arrearages in rent or mortgage payments. As a flexible block grant to states, states are not required to report data related to homelessness.

Appendix B: U.S. Department of Health and Human Services Resources on Homelessness

HHS Web Resources Relevant to Homelessness

U.S. Department of Health and Human Services Homelessness Website:

<http://www.hhs.gov/homeless>

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Homelessness Website:

http://www.samhsa.gov/Matrix/matrix_homelessness.aspx

U.S. Department of Health and Human Services, Administration on Aging Homelessness Website:

<http://www.aoa.gov/prof/homelessness/homelessness.asp>

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services Homelessness Website:

<http://www.cms.hhs.gov/HomelessnessInitiative/>

Homelessness Policy Academy Website:

<http://www.hrsa.gov/homeless>

PATH Program Website:

<http://pathprogram.samhsa.gov/>

National Resource and Training Center on Homelessness and Mental Illness:

<http://www.nrchmi.samhsa.gov/>

FirstStep:

<http://www.cms.hhs.gov/apps/firststep/index.html>

National Communications System: The National Runaway Switchboard:

<http://www.acf.hhs.gov/programs/fysb/content/youthdivision/resources/nrsfactsheet.htm>

Runaway and Homeless Youth Management Information System:

<http://www.acf.hhs.gov/programs/fysb/content/youthdivision/resources/rhymfactsheet.htm>

Runaway and Homeless Youth Programs:

- Basic Center Program:
<http://www.acf.hhs.gov/programs/fysb/content/youthdivision/programs/bcpfactsheet.htm>
- Transitional Living Program:
<http://www.acf.hhs.gov/programs/fysb/content/youthdivision/programs/tlpfactsheet.htm>
- Street Outreach Program:
<http://www.acf.hhs.gov/programs/fysb/content/youthdivision/programs/sopfactsheet.htm>

Healthcare for the Homeless Information Resource Center:
<http://bphc.hrsa.gov/Hchirc/>

Title V Surplus Property Program:
<http://www.psc.gov/aos/federalprop/titleV.html>

Recent HHS Publications Relevant to Homelessness

National Symposium on Homelessness Research (ASPE & HUD)

This project will oversee the commissioning of a series of synthesis papers, the organization of a symposium to present and discuss the papers, and the production of a final report featuring the papers commissioned for the project. The findings presented through this project will serve to guide federal and state policymaking, to assist local practitioners in incorporating successful strategies into their programs, and to assist researchers to identify areas meriting future research. The final report, which will consist of a collection of 12 research papers, will be available in the summer of 2007.

Evaluation of Housing Approaches for Persons with Serious Mental Illnesses (SAMHSA)

SAMHSA sponsored a project to identify models of housing for adults with serious mental illnesses and co-occurring substance abuse disorders that may reduce homelessness and institutionalization and promote community living. The study evaluated a cross-site evaluation on six sites using a common data collection protocol and site-specific evaluations, with the goal of developing a supportive housing tool kit. The *Supportive Housing Implementation Resource Kit* is under development and will be piloted in 2007.

Evaluation of Chronic Homelessness Policy Academies (SAMHSA & HRSA)

HRSA is partnering with SAMHSA/CMHS to co-fund an evaluation of the Chronic Homelessness Policy Academies, a multi-year project that was funded by HHS, HUD, VA, and DOL. The Homeless Policy Academies were designed to offer states an opportunity to bring together a team of policy-makers, providers, and program leaders to spend three days working on a strategic action plan to increase access to mainstream services for people experiencing chronic homelessness. Both a process evaluation and an outcome evaluation will document the process, assess the effectiveness of the Academies, and identify lessons learned from the Policy Academy activity for the 49 states and territories who attended a chronic homeless Academy. Final evaluation report is due in late 2007.

Evaluation of the Health Care for the Homeless/Community Mental Health Center Collaboration Project (ASPE & SAMHSA)

ASPE and SAMHSA have supported a 3-year evaluation of a collaboration between Health Care for the Homeless programs and community mental health agencies. 12 grantees were selected with the goal of increasing the availability of mental health and primary care services for homeless persons with serious mental illnesses and explore new approaches to the provision of comprehensive integrated treatment to these consumers. Grants ended in 2005, and a draft evaluation report is currently under development and expected in 2007.

Characteristics and Dynamics of Homeless Families with Children (ASPE)

Recognizing that data on homeless families is not as robust as data available on single adults, this project aims to identify opportunities and strategies to improve data about homeless families upon which future policy and program decisions may be based by investigating the availability of data with which to construct a typology of homeless families. A typology could foster a better understanding of these families' characteristics, service needs, interactions with human services systems, and the dynamics of their use of emergency shelter and other services and assistance. The final report from this project will be available in the Spring of 2007.

Promising Strategies to End Youth Homelessness (ACF)

The Family and Youth Services Bureau within ACF, in consultation with the USICH, is conducting a study of "promising strategies to end youth homelessness" which responds to statutory requirements. The study will identify and assess a wide range of practices that show promise or carry evidence of effectiveness in helping young people find appropriate living situations, including those youth who have suffered from systemic failures, such as when child welfare and juvenile justice programs have been incapable of providing effective transitions to adult independence for youth in their care. Runaway and homeless youth served by FYSB are served in emergency situations and cases where returning home is not an option. The study is anticipated to be released in 2007.

Homeless Families Program (SAMHSA)

SAMHSA funded a multi-site study of the effectiveness of services provided to homeless women and their children. Approximately 1600 women and their families received services under this program. The project was designed to document and evaluate the effectiveness of time-limited, intensive intervention strategies for providing treatment, housing, support, and family preservation services to homeless mothers with psychiatric and/or substance use disorders who are caring for their dependent children. The study design involved a five-year, cross-site data collection and analysis program involving eight study sites. The project was begun in September of 1999 and data collection was concluded in September of 2006. A series of articles that report the study findings will be published in the *Journal of Community Psychology* in 2007.

Mental Health and Substance Abuse Services for Homeless, Runaway, and Thrown Away Youth (SAMHSA)

This project will examine the range of programs currently offering services to the population and determining the extent to which these programs adhere to best practices approaches. A total of 491 organizations operating 780 programs have been identified, and data on these programs will be compiled in a national directory of agencies providing services that will be web accessible.

Evaluation of the Collaborative Initiative to Help End Chronic Homelessness (ASPE)

ASPE is partnering with HUD and the VA to support an evaluation of the Collaborative Initiative to End Chronic Homelessness, a unique grant program funding 11 sites to develop a comprehensive and integrated community strategy to assist chronically homeless persons to move into stable housing and access a range of support services. Grant funding from HHS, VA, and HUD provides permanent housing, substance abuse and mental health services, primary care services, and case management services for enrolled clients. Evaluation will examine both client

and system-level outcomes, with data collection concluding in March 2007. A final report will be available in 2009.

An Evaluation of the Respite Pilot Initiative (HRSA)

In May 2000, HRSA funded ten Health Care for the Homeless grantees, for up to five years, to enhance their medical respite services for homeless persons. HRSA also supported a prospective evaluation to 1) document the differing models of respite care delivery being used, and 2) assess the effect of those respite services on the health of homeless persons. A common database was developed to collect client-level data from each of the pilot projects. These results will enable the HCH Program to determine the efficacy of respite services and in what configuration they are most appropriate. Final report was published in March 2006 and is available at:

<http://www.nhchc.org/Research/RespiteRpt0306.pdf>

The DASIS Report: Homeless Admissions to Substance Abuse Treatment: 2004 (SAMHSA)

A short report based on the SAMHSA's Drug and Alcohol Services Information System (DASIS), the primary source of national data on substance abuse treatment. According to SAMHSA's Treatment Episode Data Set (TEDS), more than 175,300 admissions to substance abuse treatment in 2004 were homeless at time of admission. The admissions who were homeless comprised 13% of all admissions for which living arrangements were recorded; an increase from 10% TEDS admissions reported to be homeless in 2000. Report is available at:

<http://oas.samhsa.gov/2k6/homeless/homeless.pdf>

Adapting Your Practice: Treatment and Recommendations for Homeless Patients with HIV/AIDS Pocket Guidebook (HRSA)

This condensed pocket guidebook on adapting clinical guidelines for homeless clients with HIV/AIDS was a project of the HIV/AIDS Bureau Homelessness and Housing Workgroup in revising the original manual, *Adapting Your Practice: Treatment and Recommendations for Homeless Patients with HIV/AIDS (2003)*, developed by the Health Care for the Homeless (HCH) Clinicians' Network. The authors were comprised of health and social service providers experienced in the care of homeless individuals with HIV/AIDS. This Advisory Committee developed recommendations of adaptations to clinical practice guidelines for homeless clients with HIV/AIDS. The desired purpose of this pocket handbook is to be utilized as a quick and essential resource tool for clinicians, peer workers, and social service providers in hopes that they will routinely adapt their services and foster better outcomes for homeless clients. The pocket guide was adopted in August 2006, and is available at:

<ftp://ftp.hrsa.gov/hab/adaptpractice.pdf>

Evaluability Assessment of Discharge Planning to Prevent Homelessness (ASPE)

Purpose of this study was to conduct an evaluability assessment of discharge planning in institutional and custodial settings, with a specific focus on whether discharge planning is a strategy that can prevent homelessness. Project included a literature review on discharge planning, the use of an expert panel, documentary analysis of selected exemplary programs, and site visits to exemplary programs. Final report published September 2005 and available at:

<http://aspe.hhs.gov/hsp/05/discharge-planning/index.htm>

Using Medicaid to Support Working Age Adults with Serious Mental Illness in the Community: A Handbook (ASPE)

The purpose of this primer is to describe the Medicaid program in the delivery of services to adults with serious mental illnesses; specifically, the primer explains how existing Medicaid options and waivers are used by states to finance a broad range of community services and supports for adults with serious mental illnesses, and to demonstrate what aspects of state-of-the-art community services and supports for this population are funded by Medicaid. The primer was published in 2005 and is available at: <http://aspe.hhs.gov/daltcp/Reports/handbook.pdf>

Stepping Stones to Recovery: A Case Managers Manual for Assisting Adults Who Are Homeless, with Social Security Disability and Supplemental Security Income Applications (SAMHSA)

Individuals who are homeless and have mental illnesses often face overwhelming challenges in obtaining disability benefits through the Social Security Administration (SSA). A complex application system, confusion over eligibility criteria, and lack of a fixed address can all create seemingly insurmountable hurdles. This manual was designed to assist case managers and other professionals in obtaining critical services for their clients. The report was published in 2005 and is available at: <http://www.prainc.com/SOAR/tools/manual/SteppingStonesMan.pdf>

Improving Medicaid Access for People Experiencing Chronic Homelessness: State Examples (CMS)

This technical assistance report developed in 2004 is designed to highlight several state initiatives that increase Medicaid access for people who are chronically homeless. Report available at:

<http://www.cms.hhs.gov/HomelessnessInitiative/Downloads/ImprovingMedicaidAccess.pdf>

The DASIS Report: Characteristics of Homeless Female Admissions to Substance Abuse Treatment: 2002 (SAMHSA)

A short report based on the SAMHSA's Drug and Alcohol Services Information System (DASIS), the primary source of national data on substance abuse treatment. The data in this report is from the Treatment Episode Data Set (TEDS) 2002 Supplemental Data Set on living arrangements of people admitted for substance abuse treatment. Report available at:

<http://oas.samhsa.gov/2k4/femHomeless/femHomeless.pdf>

How States Can Use SAMHSA Block Grants to Support Services for People Who Are Homeless (SAMHSA)

The Mental Health Block Grant provides funds to States to create comprehensive, community-based systems of mental health care. This report highlights efforts of many States to use Federal Block Grant funds for mental health and substance abuse services to provide more effective care for people who are homeless.

<http://www.nrchmi.samhsa.gov/pdfs/publications/BlockGrant.pdf>

Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders (SAMHSA)

This report was developed to disseminate state-of-the-art information about ending homelessness for people who have mental or addictive disorders. The Blueprint offers practical advice for how

to plan, organize, and sustain a comprehensive, integrated system of care designed to end homelessness. <http://www.nrchmi.samhsa.gov/pdfs/publications/Blueprint.pdf>

Achieving the Promise: Transforming Mental Health Care in America (SAMHSA)

In 2002, the President announced the creation of the New Freedom Commission on Mental Health and charged the Commission to study the mental health service delivery system, and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and participate fully in their communities. *Achieving the Promise* is the final report of the New Freedom Commission.

<http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html>

Adapting Your Practice: Treatment and Recommendations for Homeless Patients with HIV/AIDS (HRSA)

A clinical guidebook written by clinicians with extensive experience caring for individuals who are homeless and who routinely adapt their medical practice to foster better outcomes for these patients. This adaptation of clinical practice guidelines for homeless patients was developed by the Health Care for the Homeless Clinicians' Network with support from the HIV/AIDS Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. Guidebook published in 2003. Report is available at:

<http://www.nhchc.org/Publications/HIVguide52703.pdf>

Core Performance Indicators for Homeless-Serving Programs Administered by the U.S. Department of Health and Human Services (ASPE)

This report explores the feasibility of developing a core set of performance measures across four HHS programs that focus on service delivery to homeless persons. The report also explores the extent to which mainstream service-delivery programs supported by HHS, i.e., those not specifically targeted to homelessness, could generate performance measures on the extent to which homeless persons are served and with what effect.

<http://aspe.hhs.gov/hsp/homelessness/perf-ind03/report.pdf>

Ending Chronic Homelessness: Strategies for Action (HHS)

This document was developed in 2003 by the HHS Secretary's Work Group on Ending Chronic Homelessness to outline a series of goal and strategies that would align the Department's effort towards the goal of ending chronic homelessness.

<http://aspe.hhs.gov/hsp/homelessness/strategies03/index.htm>

1996 National Survey of Homeless Assistance Providers and Clients: A Comparison of Faith-Based and Secular Non-Profit Programs (ASPE)

This study examines data from NSHAPC to determine more thoroughly the role that faith-based programs play in the larger context of homeless assistance. The study has an explicit focus on comparing homeless assistance programs administered by faith-based versus secular non-profit service agencies. It provides a basic but comprehensive picture of the numbers and characteristics of the two types of homeless assistance programs.

<http://aspe.hhs.gov/hsp/homelessness/NSHAPC02/index.htm>

Housing is Health Care: A Guide to Implementing the HIV/AIDS Bureau (HAB) Ryan White CARE Act Housing Policy (HRSA)

The main purpose of the Guidebook is to provide guidance on funding of housing-related costs under the CARE Act. The Guide focuses on implementation of HAB Policy 99-02, as issued in 1999 by the Health Resources and Services Administration, HIV/AIDS Bureau, which administers the CARE Act. The publication was funded by the U.S. Department of Health and Human Services Health Resources and Services Administration, HIV/AIDS Bureau, with John Snow, Inc. and AIDS Housing of Washington. The guidebook was published in 2001 and can be found at: <ftp://ftp.hrsa.gov/hab/housingmanualjune.pdf>

National Institutes of Health

The NIH supports a wide range of studies involving homeless populations because of associations between homelessness and many adverse health conditions. In FY 2005, NIH is supporting more than 65 investigator-initiated studies with a primary focus on homelessness. These studies are concentrated primarily in five institutes: the National Institute on Drug Abuse (NIDA), the National Institute on Mental Health (NIMH), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Child Health and Development (NICHD), and the National Institute on Nursing Research (NINR). Research projects funded via an NIH grant are traditionally published in scientific journals. A full list of funded research can be found by searching <http://crisp.cit.nih.gov/>.

Appendix C: Acronym Glossary

The following is a list of acronyms used throughout this report and their meanings.

ADD- Administration on Developmental Disabilities

ACF – Administration for Children and Families

AHIC – American Health Information Community

AoA – Administration on Aging

ASL – Office of the Assistant Secretary for Legislation

ASPE – Office of the Assistant Secretary for Planning and Evaluation

ASRT – Office of the Assistant Secretary for Resources and Technology

ATR – Access to Recovery

CADR – CARE Act Data Report

CARE (*as in* Ryan White CARE Act) – Comprehensive AIDS Resources Emergency

CCHIT – Certification Commission for Healthcare Information Technology

CD-ROM – Compact Disc Read-Only Memory

CFBCI – Center for Faith-Based and Community Initiatives

CHC – Community Health Centers

CHI – Chronic Homelessness Initiative (*also referred to as the* Collaborative Initiative to Help End Chronic Homelessness)

CMHC- Community Mental Health Center

CMHS – Center for Mental Health Services

CMHSBG – Community Mental Health Services Block Grant

CMS – Centers for Medicare and Medicaid Services

CSBG – Community Services Block Grant

CY – Calendar Year

DD- Developmental Disability

DOL – U.S. Department of Labor

ED- U.S. Department of Education

EHR – Electronic Health Records

FTE – Full-Time Equivalent

FY – Fiscal Year

FYSB – Family and Youth Services Bureau

GBHI – Grants for the Benefit of Homeless Individuals (*also referred to as Treatment for Homeless*)

HAB – HIV/AIDS Bureau

HCH – Health Care for the Homeless

HHS – U.S. Department of Health and Human Services

HISPC – Health Information Security and Privacy Collaboration

HITSP – Health Information Technology Standards Panel

HIV/AIDS – Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome

HMIS – Homeless Management Information Systems

HOPE – Homeless Outreach Projects and Evaluation

HRSA – Health Resources and Services Administration

HUD – U.S. Department of Housing and Urban Development

ICH – U.S. Interagency Council on Homelessness

IGA – Office of Intergovernmental Affairs

IOS – Immediate Office of the Secretary

MCHBG – Maternal and Child Health Block Grant

MCHS – Maternal and Child Health Services

NIAAA – National Institute on Alcohol Abuse and Alcoholism

NIDA – National Institute on Drug Abuse

NIH – National Institutes of Health

NIMH – National Institute of Mental Health

NREPP – National Registry of Evidence-Based Programs and Practices

NSHAPC - National Survey of Homeless Assistance Providers and Clients

OASPE – *see* ASPE

OD – Office on Disability

OGC – Office of the General Counsel

OPDIV – Operating Division

P&A – Protection & Advocacy

PADD- Protection & Advocacy for Individuals with Developmental Disabilities

PART – Program Assessment Rating Tool

PATH – Projects for Assistance in Transition from Homelessness
PSC – Program Support Center
PTSD – Post-Traumatic Stress Disorder
RHY – Programs for Runaway and Homeless Youth
SAMHSA – Substance Abuse and Mental Health Services Administration
SAPTBG – Substance Abuse Prevention and Treatment Block Grant
SCHIP – State Children’s Health Insurance Program
SOAR – SSI and SSDI Outreach, Access and Recovery
SSA – U.S. Social Security Administration
SSBG – Social Services Block Grant
SSDI – Social Security Disability Insurance
SSI – Supplemental Security Income
STD – Sexually Transmitted Diseases
TANF – Temporary Assistance for Needy Families
TB – Tuberculosis
TIP – Treatment Improvement Protocol
USICH – *see* ICH
VA – U.S. Department of Veterans Affairs

Appendix D: Membership of the Secretary's Work Group on Ending Chronic Homelessness

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**Appendix E: Comparison of Goals and Strategies:
2003 Strategic Action Plan and 2007 Strategic Action Plan**

The purpose of this appendix is to demonstrate how the goals and strategies from the original strategic action plan evolved into the new, revised framework. The table below shows how each original goal and strategy was either reordered, reframed, renumbered, deleted, and/or unchanged, and which goals and strategies are entirely new to the plan (these actions can be found in the ‘Action’ column). In the ‘Goal/Strategy’ column each crossed-off section indicates language from the original plan that was either reframed or deleted altogether.

Action	Goal/Strategy
<i>Reframed and Reordered</i>	<p>Goal 3: Work to prevent new episodes of homelessness within the HHS clientele</p> <p>Goal 1: Prevent episodes of homelessness within the HHS clientele, including individuals and families</p>
<i>Reframed and Renumbered</i>	<p>Strategy 3.1 Identify risk and protective factors to prevent future episodes of chronic homelessness</p> <p>Strategy 1.1 Identify risk and protective factors to prevent episodes of homelessness for at-risk populations</p> <p>Strategy 1.2 Identify risk and protective factors to prevent chronic homelessness among persons who are already homeless</p>
<i>Reframed and Renumbered</i>	<p>Strategy 3.2 Promote the use of effective, evidence-based homelessness prevention interventions</p> <p>Strategy 1.3 Develop, test, disseminate, and promote the use of evidence-based homelessness prevention interventions</p>

Action	Goal/Strategy
<i>Reframed and Reordered</i>	<p>Goal 1: Help eligible, chronically homeless individuals receive health and social services</p> <p>Goal 2: Help eligible, homeless individuals and families receive health and social services</p>
<i>Renumbered</i>	Strategy 2.1 Strengthen outreach and engagement activities
<i>Renumbered</i>	Strategy 2.2 Improve the eligibility review process
<i>Renumbered</i>	Strategy 2.3 Explore ways to maintain program eligibility
<i>Reframed and Renumbered</i>	<p>Strategy 1.4 — Improve the transition of clients from homeless-specific programs to mainstream service providers</p> <p>Strategy 2.4 Examine the operation of HHS programs, particularly mainstream programs that serve both homeless and non-homeless persons, to improve the provision of services to persons experiencing homelessness</p>
<i>Reframed and Renumbered</i>	Strategy 2.5 Foster coordination across HHS to address the multiple problems of individuals and families experiencing homelessness
<i>New</i>	Strategy 2.6 Explore opportunities with federal partners to develop joint initiatives related to homelessness, including chronic homelessness and homelessness as a result of a disaster

Change	Goal/Strategy
<i>Reframed and Reordered</i>	<p>Goal 2: Empower our state and community partners to improve their response to people experiencing chronic homelessness</p> <p>Goal 3: Empower our state and community partners to improve their response to individuals and families experiencing homelessness</p>
<i>Reframed and Renumbered</i>	<p>Strategy 2.1 — Use state Policy Academies to help states develop specific action plans to respond to chronic homelessness</p> <p>Strategy 3.1 Work with states and territories to effectively implement Homeless Policy Academy Action Plans</p>
<i>New</i>	<p>Strategy 3.2 Work with governors, county officials, mayors, and tribal organizations to maintain a policy focus on homelessness, including homelessness as a result of disasters</p>
<i>Reframed and Renumbered</i>	<p>Strategy 2.2 — Permit flexibility in paying for services that respond to the needs of persons with multiple problems</p> <p>Strategy 3.3 Examine options to expand flexibility in paying for services that respond to the needs of persons with multiple problems</p>
<i>Reframed and Moved to Goal 2</i>	<p>Strategy 2.3 — Reward coordination across HHS assistance programs to address the multiple problems of chronically homeless people</p>
<i>Reframed and Renumbered</i>	<p>Strategy 2.4 — Provide incentives for states and localities to coordinate services and housing</p> <p>Strategy 3.4 Encourage states and localities to coordinate services and housing</p>

Change	Goal/Strategy
<i>Renumbered</i>	Strategy 3.5 Develop, disseminate and use toolkits and blueprints to strengthen outreach, enrollment, and service delivery
<i>Reframed and Renumbered</i>	<p>Strategy 2.6 Provide training and technical assistance on chronic homelessness to mainstream service providers</p> <p>Strategy 3.6 Provide training and technical assistance on homelessness, including chronic homelessness, to mainstream service providers at the state and community level</p>
<i>Deleted</i>	Strategy 2.7 Establish a formal program of training on chronic homelessness
<i>Deleted</i>	Strategy 2.8 Address chronic homelessness in the formulation of future HHS budgets or in priorities for using a portion of expanded resources
<i>Reframed (basis for new Goal 4 and Strategies 4.1 - 4.4)</i>	Strategy 2.9 Develop an approach for baseline data, performance measurement, and the measurement of reduced chronic homelessness within HHS
<i>Deleted</i>	Strategy 2.10 Establish an ongoing oversight body within HHS to direct and monitor the plan

Change	Goal/Strategy
<p><i>New (based on old Strategy 2.9)</i></p>	<p>Goal 4: Develop an approach to track Departmental progress in preventing, reducing, and ending homelessness for HHS clientele</p> <p>Strategy 4.1 Inventory data relevant to homelessness currently collected in HHS targeted and mainstream programs; including participant’s housing status</p> <p>Strategy 4.2 Develop an approach for establishing baseline data on the number of homeless individuals and families served in HHS programs</p> <p>Strategy 4.3 Explore a strategy by which to track improved access to HHS mainstream and targeted programs for persons experiencing homelessness, including individuals experiencing chronic homelessness</p> <p>Strategy 4.4 Coordinate HHS data activities with other federal data activities related to homelessness</p>