RWJF-PEW HCHP Report

BJS 8/2013

**PROCESS**:

Besides for the Fleishman case-study—which only cited a few sources, several of them with no-longer active web-links—I did not have an obvious starting point to track down sources. I turned to the RWJF and Pew, in the hopes that they had made public an evaluation or retrospective on the program, but there was little available (some of this might be because the RWJF, which has a strong committed to the public evaluation of their programs, have not yet put much of their material from the ’80s online); the RWJF Anthology did point me in the direction of *Under the Safety Net*, the most comprehensive source on the topic. I turned to research databases next, including Lexis and JSTOR, and then to Google. I was able to turn up some useful material through the latter. I also contacted representatives from RWJF and Pew to ask about possible sources, and had some discussions with each; the Pew representative was able to send me a copy of the relevant article in *Trust* magazine. Finally, I had a useful discussion with John Lozier, the executive director of the National Health Care for the Homeless Council, who was quite active in the HCH program, and who provided me with some important historical background and with some suggestions of contacts for future research.

**SOURCES**:

Unlike the situation with the other case studies that I examined, there were few sources that specifically addressed the effectiveness or impact of HCHP (this made clear the significance in the institutional emphasis PWJF placed on making evaluations public in the 1990s). Instead, there were small sections in broader works that were relevant. I’ll highlight a few here. The case study in the Fleishman book gives a good overview of the program, and briefly addresses both its outcomes and impact. The most comprehensive treatment is in a 1990 book of articles on the HCH program, Under the Safety Net: *the Health and Social Welfare of the Homeless in the United States*. The book was edited by the physician who directed the national program, and many of the contributors had a hand in implementing it. The book covers many different aspects of the challenges of implementation, but does not say much about the process by which the federal government took over the program. Clues on this topic are offered in a 2000 article in *Trust*, Pew’s journal, and a 1992 article in *FoundationNews*. The discussion of the program in the RWJF *Anthology*, which had been so helpful on the foundation’s anti-tobacco programs, is limited, and focused much more on a subsequent program targeted to homeless families. There are also several articles that chronicle the experiences of the specific urban coalitions that received RWJF-PEW funding, especially several on the program in Boston, that provide some good details.

**IMPACT**:

The discussion of the impact of the HCHP in the sources is relatively straightforward, though it is important to note that there are two ways of understanding the impact of the RWJF-Pew program as a demonstration project. In December 1983, the two foundations, spurred by a recognition of how little was being done to address the problem, issued a call for proposals for programs that addressed the health care of the homeless. They ultimately spent $25 million supporting programs in nineteen cities, over the course of four years. In many of those cities, the RWJF-Pew call for proposals served as the spur to create new coalitions and organizations to address the health care of the homeless; according to a tabulation in *Under the Safety Net*, of the nineteen governing coalitions that emerged to administer the HCHP, 3 represented new coalitions for the homeless and 11 were new coalitions for health care for the homeless (only in 5 of 19 cities did the coalition that administered the program exist before the grant call). So in many respects, the foundations played a large hand in sparking the development of key organizational infrastructure to address the health care of the homeless; perhaps just as significantly, the program bolstered the idea that such a project was even feasible, and that the homeless could effectively be reached to receive medical treatment. Finally, a related outcome of the program, that also had long-term impact was that large data set that emerged from it, represented one of the first, and certainly the most comprehensive, studies of the health of the homeless. The data demonstrated both the serious health and developmental problems faced by the homeless (whether or not these problems were much worse than those faced by poor men and women who had a home seems to be open to debate) as well as the fact that that young families—consisting mostly of single women with two to three children—made up the fastest-growing segment of the homeless population. These findings influence many subsequent programs to address the condition of homelessness.

There was also a significant legislative impact. In the summer of 1987, Congress passed and the president signed the Stewart B. McKinney Homeless Assistance Act, which, among many other things, extended the HCH program to 108 cities. According to several sources, the section of the act that addressed health care for the homeless was lifted almost verbatim from the RWJF-Pew call for proposals. The Fleishman case-study also claims that the U.S. Department of Health and Human Services, which now oversees government funding of the HCHP, asserts on its website that “[t]he HCH Program was modeled after [the] successful four-year demonstration program operated in nineteen cities by the Robert Wood Johnson Foundation and the Pew Charitable Trust.” (The link in the citations did not work, however, and I was not able to find this quote online).

The sources offer less detailed information about the process of transference from a foundation-supported to a federally-supported program, although a narrative can be constructed by piecing together references in a few of the sources. In 1986, representatives from the RWJF spoke before a Congressional subcommittee on the program, which, according to the *FoundationNews* article, began the process that resulted in the McKinney Act. According to that article, two Congressional staffers served on the HCHP’s national advisory committee, and helped to serve as liaisons. Finally, in conversation, John Lozier, executive director of the National Health Care for the Homeless Council, recalled that Congressman Henry Waxman was invited to speak at one of the annual meetings that Pew hosted for the program, and was one of its main champions on the Hill. It is worth mentioning as well that, although the HCHP was clearly intended to function as a demonstration program, according to the program’s national director, Philip Brickner, there did not seem to be an initial plan for the federal government to pick up the model; this seems to have occurred somewhat serendipitously. But more research needs to be done on this.

Finally, the sources do seem to exhibit a range of attitudes toward the *humanitarian* impact of the program. Some of them offer it effusive praise, while others point out its limits, both in terms of the small amount of money committed, both by the foundations and then by the government, to address the health of the homeless, relative to the problem itself; as well as to the need for more systemic change to address the roots of the problem of homelessness itself (see the Vladeck article for this critique).

**OTHER ACTORS**:

The sources do not offer much in terms of explaining the involvement of other non-foundation actors in the HCHP. A few articles refer to precursor programs in various cities (see, for instance, Vladeck), but do not offer any information on them and suggest that none of them were robust enough to create the model for a national health care for the homeless program. The RWJF leadership was apparently struck by how few organizations were addressing the problem, and it was the relative barrenness of the landscape that led them to fund the demonstration program.

The HCHP program was co-sponsored with the US Conference of Mayors, and several mayors took a leading role in promoting the program, especially to Congress. The sources do not offer any evidence that the Conference would have been able to promote the program without RWJF-Pew funding, but it is also clear that the Conference was an essential ally in getting the federal government to embrace the program.

Besides a few scattered references, there is also little information about individuals within Congress or federal and state governments that might have been working on a similar program at the same time. My sense is that they were galvanized by the RWJF-Pew program, and would not have likely embraced the issue without the prompting of the foundation-sponsored program, but there is not much evidence either way.

**NEXT STEPS**:

There are several potentially productive avenues for future research. The main one would be to work out in greater detail the mechanism of the HCHP’s transfer to a federally-funded program. In this case, the next step would probably be some journalistic reporting. It is clear that the person that could best answer the question is Philip Brickner, a physician at New York’s St. Vincent Hospital who directed the national HCHP. I have his email, though he is in his mid 80s, and I am not entirely sure how responsive he would be to inquiries. It might also be worthwhile to contact the two staffers mentioned as the liaisons between the two foundations and Congress, one of whom has left Congress but has continued to work in the field of homelessness. There are also a few more sources that I did not yet consult that might help filling in some details, such as the transcript of the hearing of the Subcommittee on Health and the Environment at which representatives from the RWJF spoke on the HCHP.

It might be worthwhile as well to look at RWJF’s Homeless Families Program, which the foundation initiated in 1990 (based on many of the lessons learned in HCHP) and which led to a partnership with HUD.

SOURCES:

**HOMELESS ORGANIZATION REPORTS**:

• National Coalition for the Homeless, McKinney-Vento Act, Fact Sheet #18

<http://www.nationalhomeless.org/publications/facts/McKinney.pdf>

• Michael Cousineau, Eve Wittenberg, Joshua Pollatsek, “A Study of the Health Care for the Homeless Program: Final Report/Executive Summary,” National Clearinghouse for Primary Care information, 1995.

<http://archive.org/stream/studyofhealthcar00cous#page/21/mode/2up>

**RWJF/PEW/PARTICIPANT SOURCES**:

• RWJF Annual Report – 1987 [I was not able to obtain 1985, 1986]

• James D. Wright, *Address Unknown: The Homeless in America* (1989)

• James D. Wright, “Methodological Issues in Evaluating the National Health Care of the Homeless Program,” in *Evaluating Programs for the Homeless*, *New Directions for Program Evaluation*, no. 52 (Winter 1991), 61-73

• Information from General Accounting Office on analysis of HCHP for Subcomittee on Housing and Urban Affairs, Senate Committee on Banking, Housing and Urban Affairs, 1994

<http://www.gao.gov/assets/90/83920.pdf>

• Debra J. Rog and Majorie Gutman, “The Homeless Family Program: A Summary of Key Findings,” from RWJF Anthology, *To Improve Health and Health Care*, 1997

<http://www.rwjf.org/content/dam/web-assets/1997/01/the-homeless-families-program>

• Marshall A Ledger, “Stopping By,” *Trust*, January 2000.

• James O’Connell, “Boston HealthCare for the homeless: A Success Story,” *Virtual Mentor*, vol. 11 (January 2009)

<http://virtualmentor.ama-assn.org/2009/01/mnar2-0901.html>

• James O’Connell, et al, “The Boston Health Care for the Homeless Program: A Public Health Framework,” *American Journal of Public Health*, (August 2010)

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2901289/>

**SECONDARY SOURCES**:

• Philip W. Brickner, ed. et al, *Under the Safety Net: the Health and Social Welfare of the Homeless in the United States* (1990) [Brickner was the director of the national program, but many of the authors in the book were not directly involved in implementing the program]

• Bruce C. Vladeck, “Health Care for the Homeless: A Political Parable for Our Times,” *Journal of Health Politics, Policy and Law* (Summer 1990)

<http://www.ncbi.nlm.nih.gov/pubmed/2212527>

• Lea Agnew, “Three for the Money,” *FoundationNews*, vol. 33 (1992)

• Kenneth Kusmer, *Down & Out, on the Road: the Homeless in American History* (2002)

• Scott Kohler, Case 58: The Health Care for the Homeless Program, in Joel Fleishman, et. al. eds., *Casebook for the Foundation: A Great American Secret* (2007)

<http://cspcs.sanford.duke.edu/sites/default/files/descriptive/health_care_for_the_homeless.pdf>

**BACKGROUND:**

• Historical background is the crisis produced by rising number of homeless in 80s.

• On Dec 12, 1983, RWJF/Pew announced a joint multi-million dollar grant initiative, the Health Care for the Homeless Program (HCHP). “The announcement embarked the foundations upon a five-year experiment in community coalition building and health care innovation.” Reflects RWJF’s past history of supporting major, multi-state national programs, as well as demonstration programs. [*Under the Safety Net*]

• The origins of the program. First began at RWJF in July 1982; at first, homelessness not considered within RWJF’s purview because the foundation only addressed health care issues, but foundation staff struck by how little done on the problem, and began to view it in relation to health. Design a national competitive grant program.

RWJF staff came to believe that community-wide coordination was critical to addressing the problem. “Therefore, they decided to accept only one grant application per city and to require applicant coalitions to be citywide, include both public and private agencies, and have the support of the mayor (60).”

“In keeping with practices in a variety of other national health care programs, the foundation opted not to administer the program directly. Rather, they turned to the Dept. of Community Medicine at New York’s St. Vincent Hospital and Medical Center,” which had operated a variety of health programs for the homeless since 1969.

“Eligibility for funding was limited to the nation’s fifty-one largest cities in the Untied State and San Juan, PR. Each grant applicant had to develop an overall strategy for delivering health and other services to as many homeless persons as possible, with a minimum of fifteen hundred per year to be served. A citywide coalition, including representatives of public, voluntary, and religious groups, would have to design and implement the project. The intent was to create a leadership structure in each city. As such coalitions strengthened, it was hoped that they would become a stable structure for addressing the health and related needs of the homeless beyond the four-year grant period (60).

“The Request for Proposals required each local program to establish locations where care could be given on an ongoing basis to as large a population of homeless people as possible. Core service teams of physicians, nurses, and social workers were suggested….Finally, the RFP embodied the foundations’ belief that in addition to the need to provide direct health care, local programs must advance programs, such as welfare, housing, and job training, on an ongoing basis,” so each coalition included representatives from welfare and housing agencies.

“Because the RWJF/Pew funding was limited to four years, the RFPs required each city to develop a specific plan for continuing the program after the grant ended. A principal outcome of the requirement was to encourage coalitions to attempt to mainstream the homeless into existing reimbursements programs (e.g. Medicaid), and delivery systems.”

45 eligible cities submitted full grant applications. After selecting 5, RWJF-Pew increase funding, to 19 cities, $25 million. Some cities opt for permanent clinics specializing in health services for the homeless, others created mobile or outreach programs. Some coalitions became directly involved in service delivery while others contracted with existing providers. Some targeted homeless in shelters, others through soup kitchens. [*Under the Safety Net*]

• “Pew and RWJF committed a total of $25 million over five years to create the Health Care for the Homeless Program (HCHP). The initiative started out in five cities, but had expanded to nineteen by the time the foundations’ involvement ended. The national program was overseen, for both RWJF and Pew, by Dr. Philip Brickner, but each regional HCH office had the flexibility to determine which combination of tactics would be most effective in connecting the homeless to local healthcare systems. In Philadelphia, for example, HCHP linked hospitals to homeless shelters, allowing the homeless to receive both inpatient care and outpatient “respite” care. In New York, on the other hand, the program focused on offering health care services at soup kitchens. All HCH programs emphasized “aggressive street outreach” in targeting the homeless.” [Fleishman]

• Initially addresses lack of health care services for homeless in five cities. “Birmingham, Ala. had no network of care; HCHP helped create ties with local hospitals, so that the homeless could get inpatient services, and then ‘respite care,’ for discharged patients still too sick to care for themselves. In NYC, the program focused on medical care at soup kitchens. In Philly and San Francisco primary medical care was a focus. In San Antonio, Texas, plans to help the homeless were behind schedule, so HCHP helped build a shelter and establish a job development center. Eventually 19 cities took part in the program, which was always tuned to local needs (13).” [Ledger, *Trust*]

• “Like many other social-actions programs, HCH did not have clear program goals articulated from the outset. The major aim was to do something about the shocking increase in homelessness in the large cities. The foundation brochure announcing the program noted the lack of access to primary health care among the homeless population. The intention was clearly to address this need, but just how the need was to be addressed, and how progress was to be monitored, was left more or less unstated.

“There was one specific numerical goal that the evaluation was designed to track: each of the projects was to provide services to at least 1,500 homeless people each year. But even here there was a fundamental (and apparently intentional) ambiguity: whether one client seen ten times during the year was supposed to add *one* or *ten* toward this numerical goal was not clarified, at least not in the beginning.

“Most of the remaining program goals were equally vague. The projects were to achieve ‘continuity of care,” ‘coordination of services,’ and ‘effective case management.’ None of these goals was stated with sufficient clarity to suggest a specific operationalization of progress toward it. In essence, the projects were given money and told to do good for homeless and destitute people who needed health care.” [Wright, 1991]

• “Under this program, thousands of homeless people received health services, assessments, and referrals through primary care clinics located in shelters. The simple premise of the program was to make health care accessible to homeless people by locating it where they congregate and by tailoring the care to their special needs. The program accomplished its goal of demonstrating the feasibility and the acceptability of health clinics for homeless persons, and it became the template for the hundreds of clinics supported in many cities under the 1987 Stewart B. McKinney Act—the nation's landmark legislation in homelessness.” [RWJF Anthology]

• “The Johnson-Pew program required that each city’s program be governed by a broadly based public/private sector coalition; that the services supported have a strong outreach component; and that social services, especially those having to do with ensuring homeless people receipt of entitlement benefits for which they were eligible, have a major place in all programs.”

“Most of the work of the Johnson-Pew health care providers involves routine primary care with a part emphasis on psychiatric and substance abuse counseling, screening for infectious diseases, and…an especially heavy emphasis on social services, esp those having to do with entitlements.”[Vladeck]

**OUTCOMES/ IMPACT**

**•** Between the start up of the program and the end of data collection in December 1987, nearly 100,000 homeless were seen in HCH clinics a total of 300,000 times [*Under the Safety Net*]

**•** “Btw 1984 and 1988, the $25 million program served over 85,000 people in 19 cities, sending doctors, nurses and social workers into shelters and soup kitchens across the country.” [FoundationNews]

**•** The program was fundamentally a demonstration project, premised on its own limits. Aimed to service at least 1,500 homeless in 19 cities, total of around 114K, and at $25 million, then expenditure per client of around $200. “But even at the design stage there was no good reason to believe that it would be a large enough sum to have major discernible impacts on the health status of the homeless population in the nineteen project cities (63).” [Brickner, in *Under the Safety Net*]

**•** “The nineteen pilot programs reached hundreds of thousands of homeless people, many of whom had previously been receiving virtually no medical attention. Between 1985 and 1988, the foundations proved (1) that America’s homeless were, on average, far more susceptible to health problems than average citizens, and (2) that the homeless can be reached by emphasizing outreach and offering targeted, flexible services in locations [such as shelters] where homeless people can be found.” [Fleishman]

• “The experiences of the HCH projects demonstrated conclusively that it is indeed possible to engage the nation’s homeless population in a professional system of health care.

“It is useful to stress that before the existence of the HCH program, this was *not at all obvious*. The homeless, it was frequently said, were too hostile toward institutions, too suspicious and disaffiliated, too hard to locate, and too noncompliant to help very much. This, to be sure, is no doubt true of a sizeable fraction, but it is not true of them all. What the HCH program demonstrated, first and foremost, was that *something* could indeed be done to alleviate the health problems of many homeless people.” [Wright 1989]

**•** “It represents yet another example of a foundation initiative that almost certainly led to federal legislation. The careful record-keeping and self-evaluation done over the course of the program allowed homeless advocates to make a persuasive case to Congress in support of federal assistance for the homeless. In 1987, Congress passed the Stewart B. McKinney Homeless Assistance Act, “the first federal attempt to address the problems of homeless people.” Included in the McKinney Act was the authorization of a governmental Health Care for the Homeless Program, which picked up right where the foundations were leaving off.” [Fleishman]

• “It is widely known and understood that the model for this federal program was the national HCHP. For the health care portion of the [McKinney] act, the text was drawn from the original RWJF-Pew Request for Proposals of 1984. The nineteen program sites were well prepared by experience and background to apply for McKinney Act grants, and all were successful (392).” [Greene, in *Under the Safety Net*]

• “The health provisions of the McKinney Act were explicitly designed to support the Johnson-Pew programs, along with new programs developed in accordance with the Johnson-Pew model (312).” [Vladeck]

• “The sections of the bill dealing with healthcare were “adopted nearly verbatim” from the two foundations’ HCHP research materials. In fact, the U.S. Department of Health and Human Services, which now oversees government funding of the HCHP, asserts on its website that ‘[t]he HCH Program was modeled after [the] successful four-year demonstration program operated in nineteen cities by the Robert Wood Johnson Foundation and the Pew Charitable Trust.’ The foundations’ HCH Program probably did not cause the McKinney Act, but it certainly helped to shape it, and indeed made possible its effectiveness in providing health care. In particular, it illuminated the need for a health care appropriation to be included in the bill, and showed the government a proven way to attack effectively the problem at hand.” [Fleishman]

• Mechanism: “In March 1985, four months after the program’s inception, [RW] Johnson’s staff members testified on the issue at a House Subcommittee on Housing and Community Development hearing. The testimony began a process that culminated with the Stuart H. McKinney Homeless Assistance Act. Then-director of the Public Health Service, Harold Dane, termed the joint foundation effort ‘the national model for providing health care to the homeless.’

“‘When we started the [HHC] project,’ says its director, NYC physician Philip W. Brickner, ‘I had no idea that it would lead to federal legislation. But when it did, the Johnson/Pew program was subsumed into the health care part of the McKinney Act.’ Either serendipitously or by design, both the AIDS and homeless initiatives had influential friends in the halls of Congress. Timothy Westmoreland, counsel to the House Subcommittee on Health and the Environment, and Andreas Schneider, an aide to Rep. Henry Waxman (D-CA), served as members of the national advisory committee of the IDS Health Services Program and Health Care for the Homeless.” [FoundationNews]

**•** “Beyond giving health care to hundreds of thousands of homeless people, the program, through matching grants, encouraged city wife efforts to address the full range of problems facing the homeless.

“Even more, HCHP’s meticulous records and reports explained how to develop and conduct such programs. They were persuasive when Congress passed the Steward B. McKinney Homeless Assistance Act in 1987, the first federal attempt to address the problems of homeless people. As [program director Dr. Philip] Brickner recalls, the HCHP research materials were adopted nearly verbatim into the health-care provisions of the act, which ‘almost seamlessly’ came into being as HCHP ended.” [Ledger, *Trust*]

• “As the RWJF health care for the homeless program neared completion in 1987, the

Stewart B. McKinney Homeless Assistance Act, public law 100–77, included [Boston] HCHP and the 18 other pilot projects in a national Health Care for the Homeless program funded by HRSA’s Bureau of Primary Health Care under section 340 of the Public Health Service Act. This program, now organized and funded as part of the Consolidated Health Centers Act, serves more than 700000 homeless persons annually through 205 projects in every state and the District of Columbia, Puerto Rico, and the US Virgin Islands.” [O’Connell, 2010]

**•** “When the RWJF funded its national Health Care for the Homeless (HCH) demonstration program in 1985, it simultaneously contracted with the Social and Demographic Research Institute (SADRI) of the University of Massachusetts to undertake a four-year program of research on the health aspects of homelessness. The intent was primarily not to evaluate the HCH demonstration program; in fact, it was obvious even at the design stage that HCH was probably not evaluable in conventional “impact assessment” terms. The intent, rather, was to exploit the research opportunity provided by the existence of HCH to address a range of unanswered questions.” [Brickner in *Under the Safety Net*]

• “Additionally, evaluation of the Health Care for the Homeless Program led to the first large multicity dataset on the characteristics of homeless people and their health care needs. This study, along with others conducted at the time, helped establish the fact that young families—consisting mostly of single women with two to three children—made up a significant segment, and the fastest-growing one, of the homeless population. These studies also documented that members of homeless families were experiencing significant health problems, depression, and developmental delays….”

“Finally, data from the Health Care for the Homeless Program supported the contention of many researchers that a significant number of these children were at risk for long-term, if not permanent, developmental delay.” [RWJF Anthology]

**• “**Although no foundation demonstration program can solve a national problem, the nineteen-city twenty-five million Health Care for the Homeless Program is considered successful. Indeed, it established a whole field of endeavor for local health care providers and for the federal govt. Over four years HCHP clinicians provided primary care services, assessments, and referrals to more than two hundred thousand homeless persons. All nineteen cities found the motivation and financial resources to continue after foundation funding had ceased.” [Somers in *Under the Safety Net*]

**•** “To this day, the Johnson-Pew projects remain the backbone of the provision of health care to homeless people in much of the country (312).” [Vladeck]

• As an example of the Johnson-Pew request for proposals triggering the creation of healthcare for the homeless coalitions, see Boston’s HCHP. “In 1984, Boston mayor Raymond Flynn and Massachusetts governor Michael Dukakis convened a community coalition of more than 80 people representing shelters, homeless service agencies, hospitals, community health centers, nursing and medical schools, and state and city governments, as well as homeless persons and advocacy groups. The coalition conducted an extensive community needs assessment, identified gaps in existing health care services, and wrote a grant proposal for a 4-year RWJF pilot grant ($300000 annually). In 1985, Boston was 1 of 19 cities nationwide to receive this grant (subsequently matched by an additional $250000 annually from the state of Massachusetts).” [O’Connell, 2010]

The Boston coalition lasted well beyond the RWJF-Pew funding. As of 2009, the Boston HCHP has 17 doctors, 35 nurse practitioners, and 60 nurses, most of whom are full-time. “We have three hospital clinics and 75 clinics in shelters and community sites familiar to homeless people. We have a street team and a racetrack team, and we pretty much get ourselves to wherever homeless people are. Everyone is on the same electronic record, and all of the people we see outside are automatically patients of Boston Medical Center or MGH once we see them.” [O’Connell 2009]

**OTHER ACTORS:**

• “The [US Conference of Mayors] played a key role in providing information to Congress and the public that substantiated the need for such legislation. At numerous congressional hearings prior to the McKinney Act, members of the conference’s Task Force on Hunger and Homelessness testified on homelessness and on federal initiatives needed to address this growing problem. Through numerous reports, the conference documented the causes and magnitude of the problems of homelessness, hunger, and poverty in cities, how cities were responding to them, and what national responses were required (58).” The conference also worked on the implementation of the law after its passage. [Somers, in *Under the Safety Net*]

**NEXT STEPS**:

• “Growing recognition and evidence of the more complex needs of subgroups of the homeless [gained from the HCHP data], especially these [homeless] families, led to the development of the Homeless Families Program.”

“The Homeless Families Program, a joint effort of the Robert Wood Johnson Foundation and the Department of Housing and Urban Development, was the first large-scale response to the problem of family homelessness. Started in nine cities across the nation, it had two complementary goals: 1. To develop or restructure the systems of health, support services, and housing for families. 2. To develop a model of services-enriched housing for families who have multiple, complex problems. The ultimate goal of the Homeless Families Program was to improve the residential stability of families, promote greater use of services, and increase steps toward self-sufficiency. In addition, as a demonstration program the HFP integrated a major evaluation into the initiative at all sites. The evaluation was designed to learn more about the needs of families who struggle with homelessness and other problems, to learn how services and systems might be better organized and delivered to meet those needs, and to examine how housing might be delivered to promote stability and use of services as well as progress toward self-sufficiency.” [RWJF Anthology]