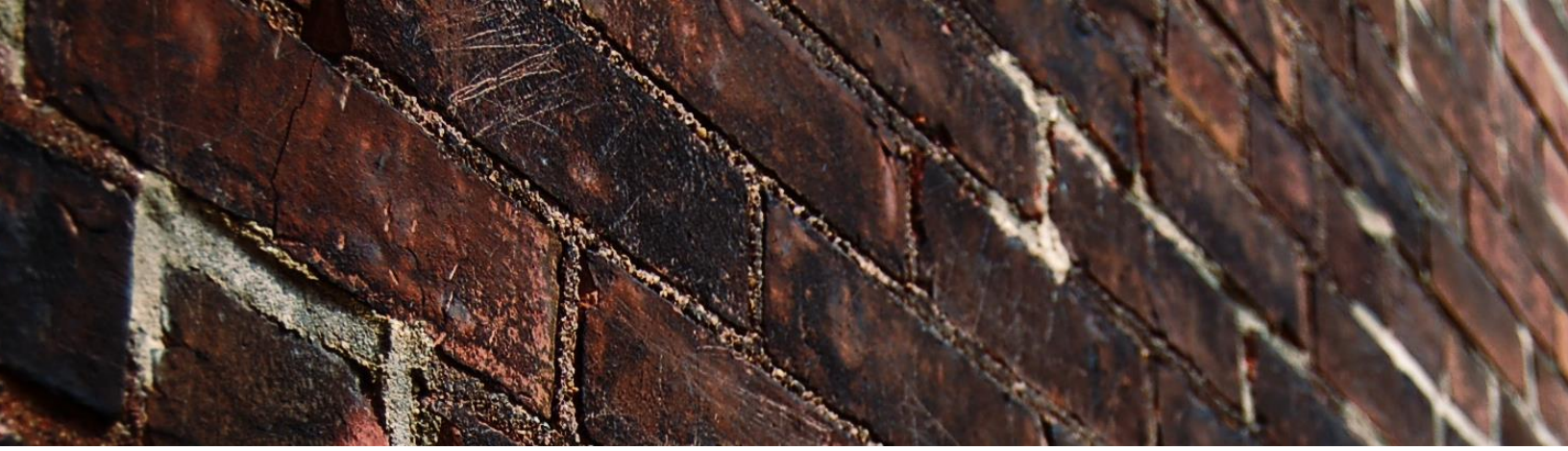


Housing is Healthcare

Housing Medically Vulnerable People without Homes during the COVID-19 Pandemic

Executive Summary

When the novel coronavirus (SARS-CoV-2) began community spread across the world with no vaccine to stop it, the medical advice was simple: wash hands, keep distance, and stay home. Housing is a place for hygiene, self-quarantine, isolation, and recovery. As such, it is harder for people without homes to protect or care for themselves. To make matters worse, unhoused people are more likely to have chronic medical issues[1] that put them at higher risk for serious illness or death from the coronavirus.[2] Furthermore, Black citizens in St. Louis—who are at higher risk from the virus—make up a disproportionate number of people without homes and face more housing discrimination.[3, 4] So what do we do?

We find a way to house people, because housing is healthcare.[5]

That said, housing those who are chronically ill and homeless is more than finding them four walls; it requires offering ongoing support. This project will provide comprehensive services—including bridge housing, long-term housing, ongoing social support, and mobile healthcare—to the 100 people living without homes who are at greatest risk of severe or deadly illness. It will also provide safe haven and housing-focused case management to 650 additional people. The project increases the capacity for rapid housing in St. Louis, which is vital and currently nearly stagnant due to limited outreach, healthcare, housing, and supportive services and strained by the coronavirus.

This initiative draws on a multidisciplinary team from nonprofit and for-profit organizations in the human service, shelter, healthcare, affordable housing and academic sectors in St. Louis, Missouri. In addition to years of advocacy and organizing related to these issues, the members of this group have been involved in a wide spectrum of COVID-19 response efforts. We have seen how system-level failures have impacted people we know on the street and have built a solution that is rapid, coordinated, and holistic. The project will identify, engage, accompany, and house St. Louis's most vulnerable people without homes, many of whom have been living in tents or shelters for years as they sit on waiting lists for programs that provide housing or healthcare. Housing them now matters.

Failing to house them will endanger their lives. It will also cost St. Louis dearly. Over the next two years, leaving the most medically vulnerable 100 people unhoused and not caring for 650 people of moderate medical need will cost the health, human service, and public safety infrastructure roughly $35 million in emergency healthcare, inefficient shelter programs, law enforcement interactions, and downstream system effects. Providing services without housing is akin to giving someone socks with no shoes. It might seem cheaper, but in the long run, the hardship of walking without shoes repeatedly destroys the socks and ultimately costs more. This is always true, but it is made more extreme as the pandemic increases the burden on systems and cost of care.

Funding this project will reduce the chance of death from COVID-19. It will also cost roughly 80% less than the alternative: $7.5 to operate for two years ($5 million for the first year and $2.5 million per additional year). By addressing the racial and economic injustices connected to housing and healthcare, we can create the necessary conditions for human dignity and flourishing. It will also lead to a roughly 40% reduction in chronic homelessness in St. Louis. The Start Small Foundation can create the opportunity for significant growth in program capacity in the St. Louis area, long-term cost savings for various sectors, and meaningful improvement in people's lives.

Problem

This St. Louis-based project will house the 100 most medically vulnerable people without homes and support 650 others at moderate risk from COVID-19. This group is imperiled by poverty, age, race, and health and is trying to survive in a system with limited capacity and an ineffective pandemic response.

Elevated Health Risk

People without homes are at greater risk from COVID-19 due to various factors, including:

- limited ability to self-quarantine, social distance, isolate, recover, or maintain hygiene.
- increased likelihood of high-risk health conditions—such as diabetes, heart disease, and immunocompromising conditions—and limited access to quality care.
- racial inequality, as Black people in St. Louis both have higher risks for COVID-19 due to inequitable care and a disproportionate likelihood of being homeless (three times more likely than white people, accounting for 77% of the homeless population.)

Limited Existing Capacity

St. Louis lacks various structures required to house people quickly. St. Louis has:

- no low-barrier shelter or safe haven centers and half the shelter beds required.[6]
- over 600 homeless people on the list for housing and only a few openings in permanent supportive housing per month.[7]
- racial inequity regarding housing due to years of disinvestment in Black communities.[8]
- programs whose support is fractured and impersonal and require people to move between 6 to 10 organizations as part of their rehousing plan.
- restrictive funding sources that create barriers for effective solutions.

Ineffective COVID-19 Responses

While nonprofit organizations have creatively mobilized their programs in response to the pandemic, the City of St. Louis has lacked an effective, long-term response. The city has:

- defied CDC guidelines[9] and displaced people living in encampments,[10] which puts them at further risk.
- created short-term shelters at a recreation center and hotel/motels that offer no long-term utility and have underfunded supportive services.[11]

Taken together, these system-level problems pose real dangers to people who struggle to survive every day. Nonprofits and City employees say they want to help, but the follow-through is too often too slow to be trusted. For medically vulnerable people without homes, the prospect of becoming housed in the midst of a pandemic and economic downturn is hard to imagine.

Solution

The Housing is Healthcare Project will house and support the 100 most medically vulnerable people without homes in St. Louis within the next nine months. It does this by creating a comprehensive program that addresses all the needs of the program participants within a single project. This allows them to move quickly through the logistical and psychological process required to become housed. It also allows 650 additional people to access a safe haven and housing-focused case management over the course of two years (housing roughly 100 more people). There are four project elements.

Accompaniment Staff

Accompaniment service staff will journey alongside participants—from outreach to case manager to housing support—instead of passing clients between staff or organizations. In addition to removing time-consuming and redundant processes, this creates opportunity for humanizing relationships that build valuable trust. Our plan will use a cohort model that will move all 100 people through the steps of housing at roughly the same time (while also creating capacity to serve many more people).

Initial Aid (Bridge Housing and Safe Haven)

Bridge housing will provide a temporary place to stay in a hotel/motel while permanent housing is developed or found. This allows people to be immediately protected from the pandemic while also beginning the transition into housing. A **safe haven** drop-in center that operates 24/7 will provide showers, laundry, a mailing address, meals, and access to resources and support. It will serve as the logistical and social center of the project. The safe haven will be able to provide immediate support and housing-focused case management for not only the cohort of 100 but also 650 additional people.

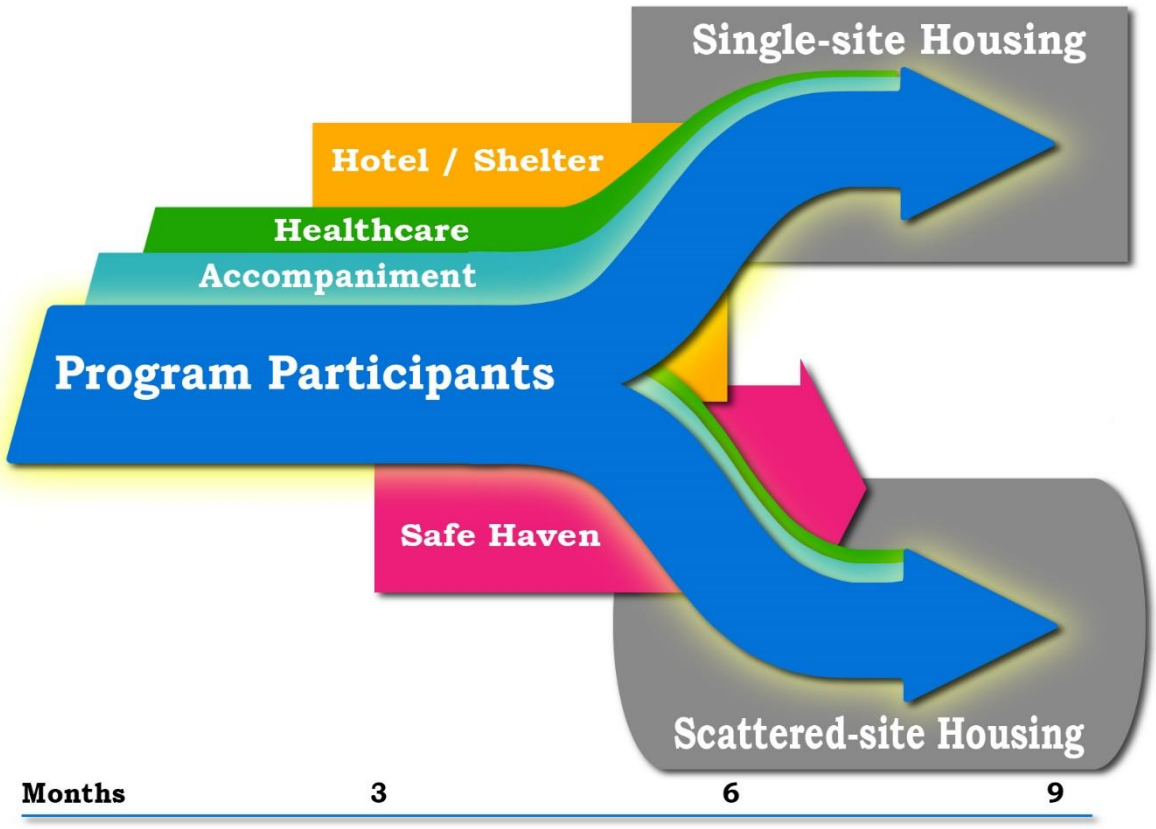
Healthcare

Mobile and telehealth healthcare will provide substance use disorder treatment, wound care, primary care, and medicine, as well as cover incidental costs. This will be coordinated by a medical doctor who is a member of the design team with established, trusted relationships with unhoused people in encampments.

Supported Housing

Scattered-site housing capacity will be created through landlord engagement and offering rent and utility support for 50 units. This type of housing is ideal for people who need moderate, ongoing support and can be made available quickly. **Single-site housing** will be provided through a 50-apartment unit complex. This style of housing offers greater on-site supports and other needed accommodations. While property acquisition is typically a long process, potential for-sale complexes have already been toured and vetted. By providing both scattered and single-site housing, the project can meet the unique needs of each individual and family served and break down barriers so that unhoused persons may access the things they need, deserve, and choose. The program will directly house 100 people. Through ongoing connections with low income housing/rental assistance programs and engagement through the safe haven and accompaniment staff, we aim to house an additional 100 people over the two years.

Program Logic Model



Timeline

The project will begin with a fiscal agent, Horizon Housing, assembling and subcontracting to a set of human service delivery partners. Horizon Housing has experience operating safe haven spaces and develops, owns, and operates permanent supportive housing. We envision the elements of the project evolving over four phases. The following times are based on the vetting, tours, identification, and partnership discussion that the design team has already performed.

Program Phases

	Planning **1–2 months**	**Engagement** **3–6 months**	**Transition** **6–9 months**	**Housing** **9 months +**
Housing	Acquire/develop	Develop, begin housing	Continue housing people	House all participants
Safe Haven / Bridge Housing	Acquire/develop, identify partners	Open	Operate	Operate
Accompaniment	Hire and train staff	Outreach	Case management	Ongoing social support
Healthcare	Partner and train	Provide care	Provide care	Provide care

What is it Like to be a Participant?

Explaining the project using a person-centered narrative, we offer a portrait of a hypothetical participant. This illustrative fiction is based on the team's experience housing hundreds of people.

Michael is a 62-year-old Black man from St. Louis. He lived in Kansas City, somewhat housing insecure, for 20 years but returned home to help his sister care for their sick mother. After their mother died, Michael became homeless and has lived in and out of shelters for eight years. He likes community, has an independent soul, and now lives in an encampment with ten other people. Michael probably has a disabling condition but has never certified his disability. He has type 2 diabetes and hypertension, had tuberculosis in the past, and while never diagnosed, probably has alcohol use disorder. He doesn't have health insurance or a primary care physician. He visits the ER when he's sick and during extreme weather.

Michael is selected for the Housing is Healthcare program because of his health conditions and age. Two outreach workers—Sarah and Jordan—approach Michael and invite him into the program, saying that it includes shelter, healthcare, and housing. At first, he's hesitant to trust the promises made by the outreach workers, but as they continue to meet with him and invite him to visit the safe haven (to wash his clothes or use the bathroom when he is downtown), he decides that the program is legit and might be worth being involved in.

His path to housing isn't a straight line. He signs up for the program, but then questions his decision. He worries that he won't like the program or the other participants. Also, though he doesn't talk about it much, the prospect of being housed is connected to the loss of his mother and the conflict with his sister. Moving through this trauma is painful. He's used to doing his own thing in the encampment and worries about restrictive rules. But Sarah and Jordan do what good case managers do—they listen and support. They offer options and honor his right to choose. Where they can, they allay his fears. Where they can't, they are honest.

At first, Michael doesn't use the bridge housing or the offered medical care. But when he gets the flu, he quickly uses the mobile medical services and averts an ER visit. When the temperature drops one night in November, he decides that he's done being so cold. The voucher system is ready and waiting, and Sarah gets him in that night. For Michael, being in the hotel room is like a trial run for having his own apartment. He still goes to the day center to do laundry and connect with a few other friends who use it, but he gets comfortable with the daily shower, refrigerator, and bed.

Listening to the options described by his friends Sarah and Jordan, Michael decides that he'd like to be part of the single-site housing unit over the scattered site. He likes the idea that there will be community like his old camp. Sarah and Jordan help him move from the hotel room to his new place. The first few months, to be honest, are settling in—almost like hibernating. Just getting used to living inside takes time. But Jordan visits regularly, and Sarah texts him. Three months in, Michael gets involved in a few activities run by the case managers at the housing site. He also starts meeting with the doctor more regularly to get his diabetes and hypertension under control. He isn't ready to talk with the doctor about alcohol yet but knows that that time is coming soon.

Life isn't perfect. His back still hurts every day, which makes fulltime work in his field of construction daunting. But when the successive waves of the coronavirus hit, he has a place to be. He stays at home.

Program Goals and Outcomes

Housing is healthcare. As such, the primary goal of this project is the improved health and wellbeing of people at high risk for severe cases of COVID-19. We intend to:

- prevent death from COVID-19.
- reduce the number of emergency room visits and inpatient hospitalizations through preventive care by 50%.
- offer all program participants (and double) proactive healthcare engagements.
- increase sense of social wellbeing and mental health through program participant self-assessment or case manager assessment.
- prevent health issues from exposure to extreme weather.

Why Will It Work?

The success of this plan is based on three factors: evidence-based practices, having the right team, and the long-term financial efficiencies.

Evidence-Based Practices

This project is based on various evidence-based best practices to structure the programs regarding:

- selection of program participants (vulnerability assessment[12]).
- support of people with significant mental and behavioral health needs (assertive community treatment,[13] critical time intervention,[14] trauma informed care[15]).
- housing (housing first,[16] permanent supportive housing,[17] rapid rehousing,[18] housing drives[19]).
- healthcare (mobile street medicine,[20] telehealth[21]).

These practices have been developed in the field, tested through independent evaluation mechanisms, and have an established body of scholarly and practical tools for implementation. Our team has training, experience, and/or has performed original research on these high-impact practices.

The Team

This project was designed by the people required to successfully implement it. The design team includes ten people who have collectively worked with unhoused people for more than 150 years. Their work spans outreach, housing development, shelter, research, advocacy, church, medicine, and system development. We came together at the start of the pandemic because of our determination to find creative solutions to the specific danger it posed to unhoused people. The group includes:

- Teka Childress: Mental Health Outreach Worker and long-time advocate for unhoused people. She is the founder or co-founder of three organizations that have provided new models of community housing, both temporary and permanent, for unhoused persons.
- Shanna Nieweg: Executive director of Horizon Housing Development Co. and Horizon North Housing Inc. who has served as Chair of the Continuum of Care.
- Anthony D'Agostino: Executive director of St. Patrick Center, the largest homeless human services nonprofit in the region. Anthony has also founded an affordable housing nonprofit.

- Dr. LJ Punch: Surgeon at Barnes-Jewish Hospital and associate professor at Washington University. Founder of "The T," a community center that addresses urban public health concerns, including bullet injuries, homelessness, opiate use disorder, and COVID-19.
- Rev. Michael Robinson: Founder and pastor of Destiny Family Church and CEO of City Hope STL, which operates emergency weather shelter and expanded COVID-19 shelters.
- Toni Wade: CEO of the HomeQuest Group who specializes in transitional housing, sustainable skills training, recovery support, and teaching investment property ownership to underserved populations.
- Tammy Laws: Independent consultant who served as a member of St. Louis Continuum of Care for 15 years, including as past chair, chair, and coordinated entry chair, and has worked with women experiencing homelessness with persistent mental health issues.
- Cynthia Duffe: Executive director of Gateway Housing First who is a nonprofit facilitator, owner, and operator of permanent supportive housing for households impacted by disabilities and homelessness.
- Toni Wade: CEO of the HomeQuest Group who specializes in transitional housing, sustainable skills training, recovery support, and teaching investment property ownership to underserved populations.
- Timothy Huffman: Associate Professor at Saint Louis University and Board Member and Program Committee Co-Chair at St. Patrick Center who uses community-based participatory research methods on behalf of people without homes and human service nonprofits.

Program Efficiency: Roughly 80% Cost Reduction

Using best practices, the Housing as Healthcare project will improve various indicators of health and wellbeing—not the least of which is preventing preventable deaths. That said, it is also cost efficient relative to other approaches, namely, the non-strategic, non-integrated status quo.[22, 23] This program offers a substantial reduction in overall cost to deliver care and offers a **5:1 social return on investment**. This program efficiency is important for acquiring future funding from local funders.

Cost Efficiency

Item	Total Cost
Housing people	
1) Reduces use of human service and law enforcement systems[24]	$10.5 million
2) Reduces medical system costs for those housed[25] during the pandemic[26]	$6.9 million
3) Opens shelter capacity which reduces the ER use of up to 100 other people[27]	$7.4 million
Providing safe haven reduces medical and law enforcement costs.[28]	$10.2 million
Total Saved	**$35 million**

Ending Chronic Homelessness

This program focuses on the people at highest risk from the coronavirus pandemic. However, many of these people are also chronically homeless. As such, it will also meaningfully reduce St. Louis

chronic homelessness; we estimate by 40% overall. If we increased the program capacity to 250 and established ongoing program support, we could functionally end chronic homelessness in St. Louis. This would add an additional cost of roughly $4.5 million in the first year and $1.3 million in subsequent years.

Conclusion

The Housing as Healthcare project will address injustices connected to poverty, race, and healthcare that increase the dangers from COVID-19 by providing long-awaited access to permanent, safe, and affordable housing. The project will also create system efficiencies, add long-term capacity, and serve as a model for rapidly housing medically frail people in the St. Louis community and beyond. Despite the strong efficiencies created by doing so, the initial up-front investment is steep enough that it is hard to find capable local funders to support this comprehensive project amid the strain caused by the pandemic. By providing the initial startup costs, the Start Small foundation allows us to create the project and then leverage local funds to sustain and grow it.

The Start Small Foundation is uniquely positioned to help create a model of low-barrier housing that can work quickly and effectively with the consistent support teams necessary to help the unhoused both procure and maintain housing during the pandemic. We have long known that engagement and relationships are the best practice for housing transition. However, housing-oriented case management is often underfunded in housing projects. Simply put, funders, including the federal government, are more willing to fund costs related to rent or facilities than they are supportive services and the people who provide those services. In addition, funders often impose regulations that unintentionally create additional barriers for quickly and effectively housing someone struggling with health issues. Inadvertently, the manner by which housing is traditionally funded ignores a simple truth: that housing is a social determinant of health and that making sure that someone has safe housing can greatly reduce other more significant costs to a community if paired with the right support services.

The true value of this project is its integrated and comprehensive care strategy. Now, it is not an accident this holistic approach is required. People without homes in St. Louis have been systematically denied access to the bare necessities for human flourishing for years. On top of that, so-called solutions have been critically underfunded and, thus, have had low success rates. A gift from the Start Small Foundation would allow us to create a new model with the right partners, supportive services, and necessary housing options.

People need both socks and shoes. Socks with no shoes (services without housing) wears out the socks and leads to blisters. Inversely, if people have shoes with no socks, they will find the shoes are uncomfortable, and their sweat will damage the shoes. People need the shoe for its protective structure just as they need the sock for its supple, soft, and absorbent qualities. In the same way, if we want to protect people from the ravages of the virus, we must provide both the housing and the supportive social and health services. All too often, only one gets funded. Start Small can fund both.

We believe that now is the right time to act, that the Start Small Foundation is the right funder, and that this project is the right way to do it. Together, we can prevent preventable death while also contributing to long-term human and community flourishing.

Appendix 1: Budget

The full budget includes all four program elements: housing development, safe haven/hotels, staff, and healthcare.

Budget for Year 1	
Staffing Salaries and Wages	$1,137,966
Landlord Incentive Fund	$50,000
Leasing Support	$240,000
Operating Cost	$224,236
Hotel Vouchers	$376,000
Research	$35,000
Outreach Healthcare	$75,000
Primary and Behavioral Health	$200,000
Street Medical	$250,200
Capital Development Purchase	$2,200,000
Renovation Cost	$250,000
Total Expenditures	$5,338,402

Budget for Year 2+	
Staffing Salaries and Wages	$1,137,966
Landlord Incentive Fund	$50,000
Leasing Support	$480,000
Operating Cost	$349,236
Primary and Behavioral Health	$100,000
Street Medical	$250,200
Total Expenditures	$2,782,402

Budget Description

Staffing Salaries and Wages: Includes accompaniment staff, safe haven staff, landlord engagement staff, and management.
Landlord Incentive Fund: Created to reimburse landlords for damage done by tenants. Communities that have implemented these rarely need to use them, but it alleviates landlord anxiety.
Leasing Support: Rents paid to landlords.
Operating Cost: Includes costs of operating the 50-unit apartment building and safe haven, including maintenance and repairs, utilities, equipment, insurance, furnishings, and building security.
Hotel Vouchers: To sustain bridge housing at participating hotels.
Research: Evaluation of project using qualitative and quantitative assessment.
Outreach Healthcare: Includes transportation costs (bus tickets/Uber rides), clothes, food, prescriptions/copays, phones/phone minute, and other supplies of daily living that people need.
Primary and Behavioral Health: Includes high-cost healthcare not provided by street medicine.
Street Medical: Primary and behavioral healthcare, including substance use disorder treatment.
Capital Development Purchase: Acquisition or renting of 50-unit apartment complex and safe haven space.
Renovation Cost: For renovating safe haven space.

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