

The Status of Homeless Women in Massachusetts: Are We Adequately Addressing the Social Determinants of Their Health?

**A White Paper from Health Care Without
Walls**

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Table of Contents

Executive Summary

Background

How Homeless Persons are Counted

Access to Health Care

Housing Insecurity: Shelters for Women

Personal Safety & Trauma

Transportation

Food Security

Summary and Recommendations

References

Executive Summary

Massachusetts has a proud public health heritage and a long history of caring for homeless persons. Two of the country’s earliest shelters for men (Pine Street Inn) and women (Rosie’s Place) were established in Massachusetts. The federal Health Care for the Homeless Program was launched as a Robert Wood Johnson demonstration project in 1985, with Boston as one of its initial sites. And yet the number of homeless women ¹ in Massachusetts appears to be on the rise. They are showing up in larger numbers in social service agencies, hospitals, day shelters, overnight shelters, and in requests for housing. Because poverty and poor health go hand in hand, it’s important to know the facts and the causes of this rise in order to address the public health implications and consequences, not only to be able to provide help to the individuals who are affected, but also because failure to address the problem affects the overall costs of providing medical care to this population. This comes at a time when Medicaid consumes nearly 25% of the state budget (1).

We are focusing on women because women come to homelessness through different paths than men. Domestic violence is the number one cause of homelessness among all women (2). Early studies on homeless women reported that nearly 90% of homeless women have experienced physical or sexual trauma (3). This is especially true for women veterans (4). Women’s unique biology influences the kinds of medical conditions and circumstances they face such as pregnancy, gynecological issues, breast health, menopause, and osteoporosis, among others. Sexual trauma puts them at risk of sexually-transmitted infections, which require close monitoring. But homeless women are not as visible to the public as homeless men because they spend their days in less public venues. There remains a public perception that society wouldn’t “allow” thousands of women to be homeless. But our combined experience runs counter to that perception. Two of the authors of this paper (RHM and JLR) have over 70 years’ combined experience providing medical care to women experiencing homelessness and housing insecurity². Based on our direct observations, and input from Boston’s women’s shelters, state and city housing agencies, health centers, and hospital social workers, the number of homeless women appears to be on the rise and the demand for services for homeless women in Massachusetts is exceeding current resources. But we need accurate data,

¹For the purposes of this paper and the data cited in this paper, the word “woman” most often refers to cis-gender women, though many of the barriers we discuss are difficulties experienced by anyone who identifies as a woman.

² Housing insecurity means being doubled up illegally, facing eviction, couch-surfing or any situation where one’s housing is financially precarious.

and that means re-visiting how we define and measure homelessness in women. This has consequences for their health and the cost of their care.

Between homelessness and housing insecurity, there is still no guarantee that one can access or receive adequate health care. Massachusetts has not yet figured out how to address the cultural context of homelessness in a seamless integrated manner as part of community care. Most of the women we have cared for do not wish to be labeled “homeless” or to receive segregated care. They want their caregivers to understand and address what their lives are like and the barriers they face. In addition to housing status, other factors have a strong correlation to health status: one’s mental capacity, whether one has health insurance coverage and transportation to medical appointments; whether one’s environment is clean, hygienic, and safe from threats of physical harm; whether one has access to nutritious food and the ability to pay for it; and finally, whether one has a reliable support system. By “support system” we mean persons or agencies that can help one understand and navigate the complex applications, rules and regulations that are required to receive the most basic survival needs. These conditions, under which one lives, are called the “social determinants of health”. Failure to address the social determinants of health for homeless persons will result in more costly care in the long run.

Our research into the numbers of homeless women in Massachusetts revealed that gender breakdown has been left out of the annual homeless census report since 2008. Many women who are virtually homeless are less likely to describe themselves as such, may opt to stay out of shelters and therefore are not counted under the current census criteria. These women are missing out on programs and services that address the more visible homeless.

Without an accurate count of women experiencing homelessness and dire poverty, and without an approach that accurately measures the needs of homeless women and the gaps in resources they currently face, Massachusetts faces a growing public health crisis. In 2018, the population of homeless women reported by the agencies and programs that see them every day includes pregnant women, women heads of households, women veterans and women in their 90’s. Massachusetts needs to look at how women and women-identified persons become homeless, what happens to them once they are homeless, and whether and how their social determinants of health are being addressed: what housing and shelter options are available to them, how safe they are, how they get food and whether it is healthy and of sufficient quantity, how and where they get health care, their transportation options, who follows and monitors them. We also need to know what efforts are in place to prevent women and women-identified persons from becoming homeless and to prevent them from returning to homelessness once they become housed.

The objectives of this White Paper are:

- (1) To provide a deeper understanding of the actual on-the-ground realities for homeless, housing insecure and destitute women in Massachusetts and to ask what happens to these women when there are gaps in the availability of key Social Determinants of Health?
- (2) To recommend the establishment of a Commission on Homeless Women. The Commission will bring together key players across multiple sectors in government, housing and shelter, women's health, trauma-informed care, health equity, policy researchers, and city planners. These stakeholders will be committed to accurately counting the number of women who are homeless or housing insecure and to developing a comprehensive, multi-disciplinary approach towards truly addressing homelessness amongst women in Massachusetts over the next ten years. The ultimate objective, of course, is to eliminate homelessness for this population.
- (3) To advocate for a more realistic definition of homelessness that includes the lived experience of women and to revise the census methodology to include those definitions.
- (4) To recommend that the state recognize the high prevalence of trauma that pervades the lives of homeless women and adopt an inclusive trauma-informed approach at all social service and health care intersection points.
- (5) To recommend access to free transportation on the T for homeless persons.
- (6) To expand programs that recognize that food is part of health.
- (7) To encourage policy makers to support and expand innovative programs that integrate the social, gender, behavioral, physical, and practical needs of the homeless with health care across all hospitals, health centers, shelters and community programs, and held together by a state-wide communications network. The components exist. The task ahead is to recognize and bring all the voices to the table, not just the loudest and most visible.

This White Paper will review homeless census methodology in Massachusetts and describe several key Social Determinants of Health with respect to what is available to homeless women in Massachusetts and what is, in fact, the on-the-ground reality from our combined perspective and the input from stakeholders. The paper is organized into seven sections, punctuated by subsections called "View from the ground." The quotes we include are the voices of the women themselves. At the end, we provide our Summary and Recommendations.

BACKGROUND

Women become homeless through various pathways: domestic violence, job loss, financial crisis (in older women this is often precipitated by under insurance or no insurance for a medical crisis), physical and mental disability, and substance use disorders. Overall, the number one reason women become homeless is from domestic violence (2), and yet the number of domestic violence beds is smaller than the number of homeless women. So, homeless women must figure out how to use the shelter system, or patch together temporary solutions such as couch-surfing. The options for a single woman head of household, or a pregnant woman, or a woman who is all alone are not all the same. It is scary and overwhelming to lose everything and to try and figure out what to do. We see women who have worked, raised families, paid their taxes, and become homeless standing in line for breakfast at a shelter and they are in shock. Women who become homeless must find food, places where they can feel safe, and figure out where and how to get medical care. Women thrive when they can form reliable relationships. Homelessness means competing for attention, space, resources and protection. Relationships can be fragmented and mercurial. It is isolating and lonely.

Massachusetts policy makers and stakeholders have had a long history of prioritizing housing and homelessness as a public policy issue. Beginning in the early 1980s Massachusetts documented a substantial rise in the number of all homeless individuals (5). In 1983, while a member of the Boston City Council, Raymond Flynn sponsored legislation that created the Emergency Shelter Commission (ESC), which was charged with providing shelter for Boston's homeless population. Thirty-four years ago the ESC began conducting its annual Homeless Census. The first count was conducted by six individuals over the course of two weeks; only the homeless population on the street was counted. Later, homeless persons in shelter beds were added. When Raymond Flynn became Mayor (1984-1993), the issue of homelessness was a major public health and safety concern in the city of Boston. Governor Michael Dukakis (1983-1991) established the Massachusetts Comprehensive Policy Approach to Homelessness which included efforts at prevention, emergency services, support services and permanent housing (5,6,7). In 2001, the ESC added homeless persons at medical respite, detox, and mental health facilities to the census as well as veteran status and any role of domestic violence in precipitating the homelessness (8). Mayor Thomas Menino launched several initiatives to end homelessness including the Boston Homelessness Prevention Clearinghouse and Bringing Boston Home (9,10). Mayor Walsh has committed to ending chronic and veterans homelessness (11). More recently, Massachusetts Governor Charlie Baker convened the Interagency Council on Housing and Homelessness, which is implementing its recommendations related to homeless youth and the disabled (12).

According to the 1983 Boston Census of the Homeless (7), there were 2,056 men, 573 women and 138 children under the age of 18, a total of 2767 homeless individual in the city of Boston. Women represented 28% of the total. The total number of reported homeless persons decreased over the years, and the percent of women in the annual census remained about 25% from 1984 through 2008, when gender breakdown inexplicably ceased to be reported (7,8,13).

Then, despite multiple programs and interventions at both the public and private levels over the years, and a committed state legislature, statewide homelessness in MA grew, fueled and exacerbated by the Great Recession. By 2017 there were about 17,500 homeless individuals in MA which included about 6,200 single adults and 11,300 family members. Among the families, about 3,600 families with children including pregnant women were placed in Massachusetts Emergency Assistance (EA) shelter programs (13). During the 2016-2017 school year, over 21,000 homeless children were enrolled in MA public schools (14). Thousands of families were placed in state-subsidized motel and hotel rooms with only a microwave for cooking meals. The 75% increase in family homelessness between 2007 and 2017 has been attributed to the Great Recession, a lack of affordable housing and cuts in federal funding for public housing (15). That trend has started to reverse with concerted efforts to prevent homelessness through the RAFT and HomeBASE rental voucher programs under Governor Baker.

Family homelessness and homelessness in women is primarily caused by poverty among single female heads of household who are not able to earn a living wage if they are the sole caretaker and/or their education and training have been limited. Too often, women are escaping the experiences of physical and sexual violence, all of this exacerbated by a chronic under-supply of affordable housing.

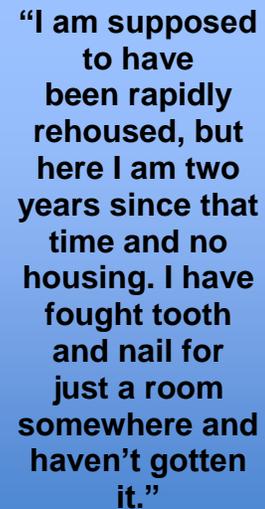
At \$11/hour minimum wage in MA, even a family of 3 with one adult working full-time earns only \$22,880 annually which is far from a living wage. The Federal Poverty Level for a family of 3 in 2017 was \$25,520. There are education and work requirements for rental programs and subsidized child care, but those are out of reach for single mothers with limited education or skills training and a child or children with health problems or disabilities, which has been found to be more prevalent among homeless women because of the high prevalence of premature births (16). In addition, government entitlements are often not enough to make ends meet. These families are forced to constantly juggle their resources at the expense of basic needs such as food, clothing, transportation and medical care.

Social Determinants of Health - Housing

Homelessness and housing insecurity are recognized as examples of Social Determinants of Health (SDH)--conditions which affect the health and well-being of individuals or whole populations.

The World Health Organization (WHO) defines Social Determinants of Health as “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies, development agendas, cultural and social norms, social policies, and political systems that stem from the social determinants of health and result in stark differences in health and health outcomes (17).”

The degree to which Social Determinants of Health are un-addressed or under-addressed for women who are homeless in Massachusetts is at the root of a public health crisis which, if left unchanged, will only add to the human and societal cost of care.



“I am supposed to have been rapidly rehoused, but here I am two years since that time and no housing. I have fought tooth and nail for just a room somewhere and haven’t gotten it.”

Impact of homelessness on health care costs:

There have been successes in lowering the number of veterans and chronically homeless following the implementation of the comprehensive policy changes in Boston Mayor Walsh’s Action Plan to End Veteran and Chronic Homelessness in Boston: 2015-2018 through Homes for the Brave and Boston’s Way Home (11) and Governor Charlie Baker’s establishment of the Interagency Council on Housing and Homelessness (12). But the problem of homelessness remains for women, who are less visible to the public. The cost to society is enormous in terms of poor pregnancy outcomes at the earlier end of the life span and the treatment cost of chronic diseases among elderly homeless women at the later end as detailed below.

We all pay the price when the safety net is stretched so thin that vulnerable populations miss out on multiple Social Determinants of Health. The long-term effects on subsequent generations add to the cost. Precious dollars are spent on crisis care and management instead of prevention, and that leads to stigmatization and resentment by those who must shoulder the burden of additional costs. Recent studies show that addressing and attending to Social Determinants of Health can reduce overall healthcare spending (18,19).

How Homeless Persons are Counted

How homelessness is defined affects how and whether everyone who is actually experiencing homelessness are counted. Circumstances have changed since the original federal definition in 1985. Women experiencing homelessness in MA opt for different choices than men do when they don't have secure housing, and those choices are not included in the MA census. For that reason, homeless women in MA are mostly invisible when the census numbers are used to shape resource allocation.

According to the National Health Care for the Homeless Council, the definition of homelessness is: “an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (eg, shelter) that provide temporary living accommodations, and an individual who is a resident in transitional housing (20).”

The original federal HUD definition of homelessness was: “an individual who lacks a fixed, regular, and adequate nighttime residence.” In 2012, the definition was changed to include 4 categories:

- “People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they resided for up to 90 days, and were in shelter or a place not meant for human habitation immediately prior to entering that institution.
- “People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled up situation, within 14 days and lack resources or support networks to remain in housing. [HUD requires specific documentation for this category].
- “Families with children or unaccompanied youth who are unstably housed and likely to continue in that state. It applies to families...who have not had a lease or ownership interest in a housing unit in the last 60 or more days, have had two or more moves in the last 60 days, and who are likely to continue to be unstably housed because of disability or multiple barriers to employment.
- “People who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing (21).”

Massachusetts counts its homeless population through an Annual “Point-in Time” (PIT) Census directed by the federal Department of Housing and Urban Development (HUD). This count is conducted in major urban areas across the country and takes place on the same day each year.

One can also gauge the demand for shelter through indirect methods. The Massachusetts Department of Housing and Community Development (DHCD) issues an annual report on met/unmet requests for emergency housing and shelter.

According to HUD, in 2017, 39% of all homeless individuals nationwide (554,000) were female (21).

“I am still realizing how little I have in the form of ‘clout’ to make people hear me, and being transgender makes it that much harder. It is harder to speak to policemen for help, it is harder to go to formal help-seeking systems. It’s harder to seek health care that is appropriate.”

The PIT method informs federal and state resource allocations, but there are major limitations to this methodology. It reflects only one point in time, so it cannot fully capture the depth of homelessness. In Massachusetts, it involves counting either individuals identified on the street at the time of the count or those “using shelter beds or residing in transitional housing programs.” Massachusetts does NOT count individuals who are doubled up, couch-surfing, staying in hotels or in unsafe domestic situations – many of whom are women. While many women move into the shelter system during the winter, many also move into these doubled up situations. As a result, the number of adult homeless women is under-counted. Failure to identify the true prevalence of homelessness among women results in inadequate resources, which in turn, affects morbidity and mortality of this population.

Another limitation is that HUD allows each Continuum of Care (CoC), the entities responsible for conducting local surveys to assess homelessness, to use a random sampling approach to generate the necessary demographic data, such as gender and race (22,23). In addition, Boston and Massachusetts currently do not report the breakdown of adult homeless persons by gender or gender identity (21,24) even though the numbers are collected. The authors could not find any reports on the number of trans persons experiencing homelessness in Massachusetts.

View from the Ground:

There is a clear and increasing need for additional services for homeless women, which is evidenced by the nonprofit organizations in the community dedicated to caring for them. For example, from 2012 to 2016, the number of women aged 60+ seen in the clinics operated by the non-profit free care program, Health Care Without Walls (HCWW) increased by 44%. In 2017, HCWW cared for six women over 90 years old. That number jumped to 10 in 2018. From 2013 to 2017, the Boston Health Care for the Homeless Program documented a 66% increase in the number of women over aged 60 seen in their outpatient programs. At the Women’s Lunch

Place, a day shelter in Boston for homeless and impoverished women, the number of resource center visits almost doubled and the number of meals served increased from 71,000 to nearly 105,000 from 2013 to 2017. At Rosie's Place, an overnight shelter and day program for homeless and impoverished women in Boston, the number of meals served increased from 80,000 to 104,000 during that same time period. Woods-Mullen Shelter, one of a handful of female-only shelters operated by the City of Boston, regularly exceeds its capacity by 10-15% (25).

In the last quarter of the 2017 fiscal year (FY17) for which there is data, the main reasons families in MA sought emergency assistance (EA) shelter were:

- Domestic violence (13%)
- Health and safety concerns (57%), of which
 - 63% cited irregular housing
 - 25% cited their living situation was not meant for human habitation
 - 6% cited violent conduct (26)

These near-homeless families would not be included in the PIT method unless they had already been placed in a shelter at the time of the census. These numbers represent only those who have made it to the Department of Housing and Community Development (DHCD) to ask for help. However, many newly homeless individuals do not know where to start to apply for housing. Individuals and families who are doubled-up, couch-surfing, and not part of an apartment lease, might not declare themselves homeless, but in effect, they are homeless--they are without safe, reliable housing.

On the health care side, "homeless" status is captured inconsistently in health centers and hospitals across Massachusetts. Lacking this information impacts discharge planning, treatment and therapeutic options.

Access to Health Care

Because homeless individuals receive care in multiple locations, the care is discontinuous and inaccessible to all the involved caregivers. Electronic medical record systems are siloed into their parent institutions and don't communicate to each other. This leads to test duplication and additional charges which could be prevented if all the electronic record systems "talked" to each other. Community day service agencies where most of the homeless spend their days, are locations where the homeless can access walk-in health care, mental health counseling, referrals to detox, housing applications and food banks, amongst other services that impact the social determinants of health--but those services are not yet formally part of the health care delivery or payment system. Ideally, any future effort to reduce fragmentation, duplication, unnecessary costs, and improve continuity and communication should include all the major hospitals and health centers as well as the community agency "touch-down" places where homeless individuals go.

Being homeless increases the risk of poor health and chronic diseases (27). A review of the literature showed that homeless women aged 18-44 living in urban areas were estimated to be more than 10 times more likely to die than women in the general population. The major causes of death for homeless individuals in Boston from 1988 to 2003 were overdose, cancer, and heart disease (27). Given their environment and limitations to engaging in regular, preventative health care, homeless individuals are disproportionately high utilizers of expensive forms of health care, such as emergency rooms and hospitals (27).

Adults with chronic disease require a safe place to rest, social support, regular monitoring, dietary control and medication management. Hypertension and diabetes are among the top two medical conditions documented and treated in homeless women using shelter clinics. Both conditions are risk factors for cardiovascular and cerebrovascular emergencies if left untreated.

Homeless persons who do not have a regular source of primary care are more likely to use Emergency Departments (29) because they are low-barrier and accessible at all hours. Because women's biology is different from men, women rely on primary and gynecological care throughout their lives, which adds to the importance of having a Primary Care Provider (PCP). Due to the high prevalence of trauma in their lives, homeless women need sources of medical care that are trained in trauma-informed approaches and that are in locations where they can feel safe.

"I lost complete trust in the medical system." "When you go to the hospital and they find out that you are homeless, you do get different treatment."

The national Health Care for the Homeless Program, which started in 1985, has created hundreds of clinics in multiple states to treat the homeless and is funded through the federal

Health Resources and Services Bureau of Primary Health Care. Since it was introduced in MA in 2006, universal health insurance has been associated with a greater use of ambulatory/primary care services by homeless persons. The Housing First model, which emphasizes housing followed by wrap-around support services for homeless persons, has provided an opportunity for a greater continuity of care to a population that previously fell through the cracks (30). All of these steps have made a difference for the homeless of MA, but there is more work to be done in identifying, locating and counting homeless women and meeting their unique health needs.

Applications for MassHealth, DTA, SSI/SSDI, and SNAP can all be done online through the same portal, the Health and Social Services' Virtual Gateway. However, the application process is complicated and requires help from a social worker or case manager plus multiple forms of identification and proof of financial status. Homeless persons who speak another language, are illiterate, cognitively impaired, mentally ill, or lack computer skills are unable to complete the lengthy application process and are at risk of missing out unless someone sits down with them, and that takes trust on the part of the applicant.

In the face of all these barriers, there are new care models that utilize trained, outpatient Community Health Workers (CHWs) who are outreach workers who connect vulnerable persons to social services and the health care system. CHWs take into account the high prevalence of complex physical and behavioral health issues among the homeless female population, including the role of persistent trauma from street violence which can cause Post Traumatic Stress Disorder. CHWs operate as the "human passport" between inpatient and outpatient care, between what goes on in the physicians' offices and hospitals/health centers, and what the individual is actually trying to manage in "real life." CHWs work intensively with their clients and report back to the mainstream providers, thus closing important gaps in care, care coordination and communications. CHWs are being utilized as a bridge to outpatient services by hospitals, as a link to community services by Community Health Centers, and as members of mobile field teams that operate within the community itself, going directly to their clients in the shelters, subsidized apartments, streets or cars.

The use of Community Health Workers among vulnerable populations is essential. The Robert Wood Johnson Foundation (RWJF) Diabetes Initiative 2002-2009 which was implemented in 14 ethnically and economically diverse community health centers who employed CHWs as integral members of the diabetes self-management teams experienced quality improvement in diabetes care (31).

Medicaid is now looking at innovative partnerships between health centers/providers and community-based organizations (CBOs) (32). In these models, payments are made from the Medicaid Accountable Care Organizations (ACOs) to Community-Based Organizations whose interventions can impact the quality of health care as evidenced by clinical metrics. These models offer hope if they include the common locations in the community where homeless women feel safe, receive basic social services and that have access to low-barrier medical services.

View from the ground:

The same SDH that impact the factors associated with health care access and utilization impact a homeless woman's ability to traverse the complex health care system. Homeless women will opt out of planned and preventive care when basic survival depends on going to day shelters and social service agencies to meet those needs. Having an insurance (Medicaid) card and a PCP don't guarantee that these women know how to navigate or connect to the health care system, even to the federally funded homeless clinics. Mental illness, disability, fear, cognitive dysfunction, intoxication, shame and feeling overwhelmed get in the way. Homeless women who are undocumented lack access to comprehensive health insurance and health care, and yet they have the same medical conditions which require monitoring and management that insured women have. Being homeless makes follow-up and notification about abnormal test results challenging because most shelters have a limited length of stay and not all women carry a cell phone or keep the same number. Without money for transportation, these women can't travel to their appointments. Staying in a shelter where bed assignments are done in the afternoon or sleeping outside or doubled up in an unsafe neighborhood means late-day appointments are less desirable. The majority of homeless women opt to not use the women's shelters if they are perceived as unsafe from perpetrators of street violence. For the same reason, many homeless women avoid the clinics that the homeless men use. In a study conducted by Women of Means (later: Health Care Without Walls), homeless women selected academic health center and community health center clinics in the majority of cases, not always revealing to their PCPs that they were homeless (33) out of feelings of shame.

Compounding Challenges: Pregnancy

Two important medical conditions that affect pregnancy outcomes are food insecurity and the constant stress, fear and uncertainty from homelessness: gestational diabetes mellitus and hypertension in pregnancy. Gestational diabetes mellitus (GDM), a form of diabetes only seen during pregnancy, has a prevalence of 5.4% among Latina women and 3.9% among African-American women (34). Latina women are 2.5 times more likely than African American women of childbearing age to develop GDM. GDM can lead to poor pregnancy outcomes including fetal demise and adult onset diabetes later in life for the pregnant woman. Hypertension in

pregnancy can lead to heart attacks, strokes and pre-eclampsia, necessitating emergency interventions to save both the mother and her baby. Babies born prematurely due to hypertension, diabetes or other serious medical conditions require neonatal intensive care services which are expensive and not fully covered by Medicaid, leaving the hospitals with the burden of making up the costs. The state further picks up the cost if the homeless women are placed in shelters outside the city, or lack transportation and therefore are unable to visit their babies in the NICU. They risk losing those babies to foster care.

Most pregnant women in the state of Massachusetts are insured through Mass Health only for the duration of the pregnancy and up to 6 weeks postpartum. After that, it is up to the recipient to reapply for insurance and identify a PCP. Homeless women who have just delivered are overwhelmed with finding safe housing and taking care of their babies with limited resources. Locating a PCP and signing up for care is an additional burden. The transition from Antepartum /Postpartum care to a PCP should be seamless and would be cost-effective.

Housing Insecurity: Shelters for Women

The shelter system in Massachusetts is complex. There are shelters for **single adults**, which can be single gender or mixed gender, **pregnant women and families**, and survivors of **domestic violence**. Some shelters are government owned and operated, while others are established by nonprofit organizations. As a result, there is great variability in what resources are offered at each shelter and how the shelters are accessed.

Churches and private individuals were the first to create rooms and spaces for homeless women in MA. Kip Tiernan opened Rosie's Place in 1974 after observing that women were dressing up as men to get services. In December of 1984 a new year-round 50-bed unit for homeless women opened at the Long Island Shelter; but Long Island Shelter was closed in 2014 when the bridge to the island was deemed unsafe. Pine Street Inn added the Women's Inn in 1992. In 1977, Casa Myrna Vazquez (now: Casa Myrna) opened the first domestic violence shelters for women in Boston. Others have followed. Woods Mullen converted from a mixed-gender to a women's only shelter in 2015 following the closure of the Long Island Shelter. The men from Long Island and Woods-Mullen shelters were moved into a new Men's shelter on Southampton St.

“My abusers are within the shelter systems themselves and nobody has taken any action to remove me from the shelter system. I started to press charges then quickly realized I would have been at risk for retaliation. So like most women who have been sexually assaulted, I quickly stopped the process of pressing charges.”

A. Shelters for Single/Unaccompanied Adults:

Shelters for single adults are for persons over 21 who do not have children with them. There are “day” shelters that are places where one can congregate for meals and social services during daytime hours, and “overnight” shelters where homeless persons can sleep. Some overnight shelters also provide daytime social services. Shelters are not licensed to provide health care unless they have a contract with an outside health care agency or if they themselves have secured a Department of Public Health Clinic License and hire the staff to provide clinical services. Overnight shelters have varying rules that govern whether a person can stay in the shelter throughout the day, whether a person will be guaranteed a bed each night, and what the maximum length of stay is. No two shelters are alike.

A typical day for a single adult homeless woman is having to leave the overnight shelter with her personal portable belongings in the morning. She may have stored a few possessions in a small locker at the shelter or rented a storage unit if she can afford it. She can move to a day

shelter or “soup kitchen”, which offers social services and meals, or to a public space. In the afternoon, she must wait in line outside the shelter at a specified time in order to be guaranteed a bed for the night; these waiting areas can be mixed or single gendered depending on the shelter. There is generally no priority given for older age or infirmity. If she is not granted a bed or has reached the maximum length of stay at that shelter, her options are to sleep on the streets, attempt to find temporary housing with friends or family, or go to an emergency department. A homeless person can be “barred” for a specified length of time (determined by the infraction and the shelter) if they break the rules or pose a threat to the safety of others. Barred persons can try to find another shelter or take their chances outside. An individual can be barred from all the shelters in certain circumstances, no matter the age or medical conditions. Short of threatening behavior, shelters are rough places where bullying, harassment, rough behavior, arguments, stealing and uncontrolled emotions are commonplace.

View from the Ground--Single/Unaccompanied Adult Women:

There are limited options for individual adult women, especially for those seeking single gender shelters out of concern for their safety (see section on *Personal Safety & Trauma*). These authors could not find a report of the exact number of shelter beds for individual adult women in Massachusetts. There are far fewer shelters for women than for men in Massachusetts and the majority of women’s shelters are located in Boston. Nevertheless, shelters for women exist in all counties as homelessness among women is a state-wide problem. In October 2014, the 450-bed emergency shelter for adult men and women on Long Island closed emergently because of an unsafe bridge that led to the island from the mainland. In response, the Woods Mullen Shelter was converted from a mixed gender shelter to a women-only shelter, and the new Southampton Street Shelter for men was built. The Women’s Inn at Pine Street Inn is a 120-bed shelter in Boston that fills nightly, though between 125-140 women line up each day. The Woods-Mullen Shelter, one of a handful of female-only shelters in Boston, houses over 240 women nightly, though they only have 220 beds. It is located in a high-crime area where an underlying cause of violence stems from substance use.

Not all hospital care coordinators know how the shelter system works. It is not unusual for a woman to be discharged from a hospital and sent by cab or even ambulance to a woman’s shelter without advance notice. Shelters are not licensed to manage IVs, wound care, immobile persons or persons who are unable to perform personal hygiene. This results in the patient being “bounced back” to the hospital’s Emergency Room for re-admission and more appropriate placement. When shelters reach capacity, the overflow clients are required to sleep on mats on the floor or on furniture or cots in the lobby. The Shattuck shelter, previously a mixed gender shelter, closed its beds for women in September 2016.

The opioid epidemic has added to the urgency of lack of shelter beds and housing for women. There are very few emergency shelter beds for women in locations that are free of men or of active drug and alcohol users.

B. Shelters for Pregnant Women & Families:

Families who become homeless must apply for emergency housing through a housing agency or directly at the Department of Housing and Community Development (DHCD). A review of the past 5 years of reports from DHCD, shows that there are more requests for shelter than there are beds.

In the Summer of 2014, over 50% of families in emergency assistance (EA) shelters lived in hotels and motels. When these hotels and motels were closed, families were relocated to sites scattered across Massachusetts.

Children experiencing homelessness have more frequent episodes of illness and visits to the emergency room and twice the rate of emotional and behavioral problems as housed children. Homeless children struggle with hunger at twice the rate as other children. Chronic food insecurity leads to higher rates of obesity and diabetes. Because of the frequent educational disruptions from unpredictable housing placement, these children are four times more likely to show delayed development and exhibit twice the rate of learning disabilities³.

Homeless women that have high-risk pregnancies must obtain care at tertiary care centers in Boston. However, due to the housing shortage in Metro Boston, they can be placed up to 50 miles away from their health care providers, with no or limited ability to travel to their medical appointments, their children’s schools or pediatricians. Many homeless families have established jobs, schools, and communities in one area, but are placed at shelter sites far from their workplaces and support systems.

Applicants for family shelter must bring a photo ID (license, EBT card, work ID, passport), each person’s birth certificate, social security card, a letter from their current landlord stating their eviction date, recent lease, a list of all the places they have lived with dates and reasons for leaving

within the past 7 years, any medical letters that testify to the presence of serious medical

³ Bassuk, EL, DeCandia, CJ, Beach, CA, Berman, F. America’s Youngest Outcasts: A Report Card on Child Homelessness. The National Center on Family Homelessness, November 2014.

conditions (must be dated within the previous 30 days), and last month's pay stubs for starters. If denied, which happens often because applicants usually do not know these rules ahead of time, they have 30 days to gather the materials and try again.

View from the Ground--Pregnant Women and Families:

Pregnant women who are homeless often stay on someone's couch ("doubled up") but have to leave once the baby is born. These doubled up situations put the renter at risk because it violates the occupancy rules for subsidized apartments. DHCD staff require letters from the landlord and the renter stating that the pregnant woman is not on the lease, and to conduct site visits to certify the conditions. The state's "right to shelter" law guarantees shelter to families through the Massachusetts Emergency Assistance (EA) Shelters. But they are caught in a Catch-22: DHCD will no longer grant emergency family shelter to every woman who is pregnant. Pregnant women in the Bridges to Moms Program operated by Health Care Without walls have been turned away and asked to return when she has the baby because "without the baby, she is not a family." This has meant that women with newborns as young as 48 hours old or just released from the NICU are required to sit in the DHCD office for entire days, waiting for shelter placement. For women whose babies are in the NICU, this means the mother is in housing limbo until her baby is released from the hospital, and even then, she is forced to spend the day at DHCD waiting her turn, trying to care for an infant, who often has serious medical conditions due to prematurity. In desperation, some of these families have spent a night in an Emergency Room in order to qualify for emergency shelter under the "right to shelter" law which defines a homeless family as one that has spent at least one night in a location that is not meant for human habitation (35).

C. Shelters for Women Fleeing Domestic Violence:

On the night of the 2018 Boston census, 153 persons belonging to 66 families were in domestic violence shelters or transitional housing. In Boston, since 1999, over 90% of homeless women cared for by Health Care Without Walls have reported physical, sexual, psychological or emotional trauma, many with experiences starting in childhood and occurring throughout their lives, including during pregnancy and into their 90's. The majority of domestic violence shelters or safe houses are renovated homes with individual rooms for women with families. The families live in a single room and share common facilities. There are rules in place to protect the safety of all the residents. In most cases, the buildings are located in safe areas and the residents are protected from trauma-inducing events or exposure. Massachusetts has 57 domestic violence programs and shelters located in 34 different cities. Shelters for single women, by comparison, are for hundreds of individuals, are more often in urban areas, and are close to high crime neighborhoods or near shelters for hundreds of men. Shelter staff can

monitor behavior within the walls of the shelter up to a point but they have no control over what happens outside their doors.

Women seeking emergency safe housing can go to an Emergency Department or call the Massachusetts Safe Link hotline number (operated by Casa Myrna). Unaccompanied women fleeing domestic violence can enter the single adult shelter system, or apply for emergency shelter through DHCD. Every effort is made to prioritize and find safe housing for these individuals and families but the number of requests often exceeds supply.

View from the Ground--Women Fleeing Domestic Violence:

Violence and trauma are intricately part of the lives of women who are homeless in MA. The majority of women who experience trauma are not sheltered in a DV program--they are out on the street or trying to get by in the shelter system. The Boston Public Health Commission has instituted a program called "Front Door Triage" which aims to document all the needs including the personal safety status of persons entering the shelters but it is not universally employed yet. City-wide, there is no regular screening for personal safety in Boston's women's shelters despite the recommendation of experts in trauma-informed care, and the neighborhoods around the main women's shelters are crime-ridden and in some cases, where drug deals take place even during the daytime. Women who utilize the women's shelters consistently report verbal harassment, physical abuse, theft and bullying by other shelter guests.

Therefore, they opt for alternatives to shelters: sleeping outside, staying temporarily with housed persons ("doubled up"), couch surfing, or forming temporary alliances to share a room and expenses, a situation which in many cases breaks down and may lead to further abuse.

Permanent Housing:

The City of Boston has invested millions in programs to prevent and manage the growing homeless population. Mayor Menino recognized the rising homeless problem and reduced the numbers through multiple efforts including the Bringing Boston Home program. Mayor Walsh has fully committed to eradicating chronic and veterans' homelessness. These efforts are commendable and have made a difference. And yet, permanent and safe housing remains elusive to thousands in the Commonwealth. There are several different government-funded voucher programs that are available. Homeless women who are under sixty years of age and do not have a disability have access to the Massachusetts Rental Voucher Program (MRVP). Pregnant women and low-income families can also access HomeBASE, Residential Assistance for Families in Transition (RAFT), Housing Choice Vouchers (Section 8) and Public Housing. These programs offer hope for homeless and low-income women and are facilitated by case managers from housing and social service agencies.

View from the Ground--Permanent Housing:

Massachusetts has approximately 90,000 units of state and federally assisted public housing and several rental assistance programs. Despite these resources, women and families remain in shelters or in doubled-up situations for years awaiting placement. The rental assistance programs are time-limited and require that the recipients become self-supporting. This is extremely challenging due to the lack of jobs that can pay a living wage. When the family fails, they return to homelessness, and they lose eligibility for another voucher for a period of time.

The state housing programs release reports on the numbers of subsidized rental vouchers that are given out each year. The number of requests for vouchers exceeds the supply. In 2018, Federal Section 8 vouchers were being given to individuals who filed their applications as far back as 2007. As pointed out by Chris Norris, Executive Director of Metro Boston Housing, despite the City's laudable commitment to expanding affordable housing, the stock of housing for impoverished elderly and disabled is not yet meeting demand (36).

In summary: women's shelters in metro Boston report that daily requests for shelter outnumber available beds and services. The current stock of affordable housing is consistently not reaching all of the state's low income population. Massachusetts has not eliminated homelessness for women since it started counting them in 1983. Violence against women persists and is a daily occurrence. The existing array of services is not filling all the necessary gaps. Pregnant women are living in cars. Families are broken up because the available stock doesn't include enough multi-bedroom options. Teenage boys are separated from their mothers because they are felt to be a risk for potentially aggressive behavior. Women in their 80s are sleeping outside or on a shelter floor.

Personal Safety & Trauma

Hhealth, trauma, and homelessness are intimately connected. The pathways to homelessness are different for women and men. Women most often become homeless as a result of violent victimization, especially if it is by an intimate partner (37). In a study of shelter residents who were survivors of domestic violence, over 50% of women returned to a past abusive relationship for economic reasons (38).

“I have been through a lot [on the streets]. I have been raped, I have been bricked, I have been stabbed... They have done everything to me except basically take my life. It is terrible. Nobody should have to live in the street. Not even a dog lives in the street. It’s just inhumane.”

In Massachusetts, nearly 1 in 2 women (housed and non-housed) experience sexual violence victimization other than rape and nearly 1 in 3 experienced rape, physical violence, and/or stalking by an intimate partner (39). However, after women become homeless, they are more likely to experience violence from those who are not their intimate partners. There is currently no statewide program that is tracking the degree of violence against women in Massachusetts shelters or on the streets.

Trauma has long lasting impacts on health. It is thought that trauma causes physiologic changes to the body’s response to stress. Children who have experienced trauma have worse health outcomes as adults (40). Survivors of trauma also often forgo important preventative measures like breast and cervical cancer screenings (41). Survivors may turn to illicit substances to self-medicate the symptoms of post-traumatic stress disorder (PTSD) such as anxiety, sleep disorders, depression and hyper-vigilance.

View from the Ground:

Many homeless women report having experienced trauma before they became homeless, and the psychological damage from trauma contributed to their becoming homeless. The cycle persists when homelessness itself leads to further trauma. Homeless women report that on the streets they are held at knifepoint or gunpoint, robbed of their limited belongings, forced to consume illicit substances, and/or trafficked. Women using Boston shelters have even reported being raped in the immediate vicinity of the shelters. The fear is constant and unrelenting.

As a result of their trauma histories, many women limit their exposure to or avoid spaces that are dominated by men, particularly homeless men who are the perpetrators of violence in the majority of cases. That is not always a possibility. Circumstances often force women to be in

unsafe spaces because avoidance would be detrimental to their health or leave them even more unsafe (i.e. avoiding shelters that have mixed gender waiting areas, forgoing treatment at facilities with shared elevators). These experiences are triggering and re-traumatizing. In most shelters, there is limited screening for a history of violence and when women are screened, it is only for intimate partner violence. The depth and frequency of the trauma that homeless women experience on a nearly daily basis from non-intimate partner violence is undocumented and underreported.

Transportation

Accessing transportation services is critical to accessing health care, but an undue burden is placed on individuals and families living in poverty. One study showed that impoverished individuals spent over 15% of their income on transportation costs (42).

There are a variety of programs that offer transportation assistance in Massachusetts, but eligibility varies and programs are decentralized. According to the MBTA, homelessness itself does not qualify an individual for transportation assistance. The application for a “T Pass” is not HIPAA-protected: it requires divulging private and personal medical information to MBTA staff who are not clinically-trained, and the approval process can take more than 3 months, during which time the applicant has no transportation to medical care and must beg for spare change or forfeit a basic life-sustaining need to pay for the transport, and there is no guarantee that the Pass will be issued. Even with the Pass, the fare is often reduced, not entirely free. It is no wonder that medical appointments are missed. This highlights the importance and value of having medical professionals embedded in the community at the social service intersection points where these women can be seen and monitored regularly.

From the shelter where she was placed: “It was almost a 2-hour commute and that was early in the morning, but every day it is about 4 to 4.5 hours. And it is expensive. I spent \$400 a week on transportation alone, never-mind food.”

Groups that do qualify for transportation assistance include senior citizens, veterans, and individuals with a medical disability documented by a healthcare provider. The RIDE, the Massachusetts Bay Transportation Authority’s (MBTA) door-to-door, shared ride paratransit service, offers transportation for people with disabilities. Rides are not free. Fares are determined by the location of the destination and whether changes are made to the reservation. Through the Access Pass, seniors, veterans, and individuals with disabilities may be eligible for reduced fares. Reduced fares are not based on income. The MBTA and some medical centers have launched pilot programs with Uber, Lyft and Curb. Currently they require advance planning, organization and a cell phone.

MassHealth offers transportation assistance to and from medical appointments through the Provider Request for Transportation form (PT-1). Individuals who receive approval are assigned a transportation broker who can arrange rides, which must be scheduled in advance and the

ride may be shared with other passengers. Individuals will incur a fee for certain types of rides, including transportation by wheelchair vans and nonemergency ambulances.

View from the Ground:

Homeless women have high-risk pregnancies that require care from maternal-fetal medicine physicians. In Massachusetts, these women often require care from providers located in Boston. However, they are placed in shelters that are two to three hour commutes from Boston through public transportation. When women cannot make their prenatal care appointments, their health and their child's health suffers.

Although MassHealth can reimburse transportation costs related to medical care, homeless women do not have the income flexibility to wait for reimbursements. Ride services such as PT-1 need to be scheduled in advance, therefore travel for non-emergent, but urgent care is delayed until an emergency prompts calling an ambulance. In addition, the PT-1 service is established with a specific "home" address once MA Health has approved it. For women who flee that address or who are evicted, it takes time to change the address submitted for the PT-1. Services that incorporate ride sharing can be challenging for individuals with mental illness and survivors of trauma who often fear enclosed spaces with strangers.

Food Security

“Food insecurity” refers to limited access to nutritionally adequate foods and “food insufficiency” refers to inadequate quantity of food intake. Homeless women experience both and both can affect health outcomes (43, 44). Pregnancy and chronic conditions like diabetes, heart disease, and hypertension are directly affected by diet. Women often sacrifice food for their children or choose to buy food over medications, and may forgo medical care until later stages of illness. According to data from the Health Care for the Homeless User Survey, chronically homeless and traumatically victimized individuals were more likely to have food insufficiency. This insufficiency was associated with a higher likelihood of hospitalization (45).

“I only get food stamps and TAFDC through DTA. It’s not enough... once the food is gone, the food is gone.”

The United States Department of Agriculture (USDA) runs several food and nutrition programs. SNAP (previously known as food stamps) provides a monthly food source for low-income individuals and families. Eligibility requirements for SNAP involve a host of calculations based on income and monthly expenses. As it exists now, non-disabled recipients must work or be in an educational or training program at least 20 hours per week. The benefit is delivered through an Electronic Benefit Transfer (EBT) card, and can be used at farmer’s markets. The Women, Infants, and Children (WIC) Nutrition Program provides healthy foods, nutrition education, and breastfeeding support for eligible families from pregnancy until the child is 3 years old.

View from the Ground:

Although many day programs in recent years have introduced healthy food alternatives for their homeless clients, the risk of being hungry means that many homeless women opt for high-fat, high-carbohydrate “comfort foods” from the shelters and soup kitchens. Homelessness means not having a refrigerator or storage for fresh foods. Homeless women with diabetes controlled by insulin do not have a refrigerator to store their insulin. Applying for SNAP is complicated and many families report that the monthly allotment is insufficient. In addition, persons who are undocumented are ineligible for SNAP. Pregnant women with small children end up foregoing eating or trying to get by on cereal and snacks, putting their health and the health of their fetus at risk, in order to use SNAP for their children. When these pregnant moms opt to feed their hungry children instead of themselves, their fetuses stop growing.

While all pregnant women are entitled to WIC, both citizens and non-citizens, WIC does not cover special formulas for babies with special dietary needs.

Summary and Recommendations

Massachusetts has a proud public health heritage and it is to those values that the authors have focused this paper.

From our perspective in the trenches and with input from stakeholders in the community, homelessness is rising among women in Massachusetts despite millions of dollars and the commitment of our civic leaders. Yet, the majority of homeless women are invisible to the public. In our work, which is within the homeless community, we are seeing rising numbers of pregnant women and women over 60 who are experiencing homelessness and the despair and frustration that go with feeling shut out and ignored. Their numbers are under-reported. The impact of this fact is a public health crisis that will only get worse and will cost taxpayers millions if it is not addressed. The solution is not simply offering a shelter bed and a cup of soup. Homelessness is complicated. Women come to it differently and respond to it differently than men. Understanding and addressing this critical social determinant of health matters. There has never been a comprehensive study of homelessness in women in MA or a coalition whose single mission was to tackle this problem. The goal of this paper was to shine light on this problem and pave the way for creating solutions.

Massachusetts can do better, and we must.

We recommend the following:

1. Establish a Massachusetts Commission on Homeless Women whose primary purpose would be to accurately study the incidence and prevalence of homelessness amongst the women of MA and assess the gaps in safety net services. We believe its mission should be to:
 - Determine the best method for obtaining an accurate count of homeless and precariously housed women in Massachusetts.
 - Conduct a community needs assessment for homeless women and review current allocations of resources.
 - Hold listening events across Massachusetts to gather data on the numbers of women who are homeless and marginally housed and the gap in availability of resources.
 - Assess barriers to accessing care following housing placement, particularly for pregnant women and women with complex health care needs.

- Connect programs currently addressing social determinants of health for homeless women.
 - Assess the specific needs of transgender women.
2. Revise the methodology for counting the number of homeless women in order to allocate the appropriate amount of resources. This may require re-defining how we define “homelessness” to include the many temporary living situations that women choose that are illegal and unsustainable, but which have made them invisible.
 3. Revise the definition of homelessness to include situations where women are doubled-up, couch-surfing or staying in an unsafe situation and incorporate the screening for these situations in health center and hospital intakes and patient registration.
 4. Create more “safe spaces” for homeless women to spend their days, away from trauma-inducing locations such as areas of high crime and drug activity.
 5. While the state takes action to reduce overall homelessness among women, build a new state-of-the art shelter for homeless women that incorporates trauma-informed principles and addresses the rising numbers of older women. Include rooms for both cis- and transgender women. This shelter needs to be accessible by public transportation and offer gender-specific support services.
 6. Conduct a feasibility study on a city-wide HIPAA-protected communication system for tracking the care, care coordination, and SDH interventions provided by all the health care providers as well as the many smaller community agencies that are doing impactful work.
 7. Expand Boston’s Housing Surges, “events where representatives from government and nonprofit agencies gather in one place to efficiently assist homeless people to connect with housing and supportive services (45). In particular, we recommend:
 - Review eligibility requirements and consider expanding them to include women and families who experience violence and irregular housing, given that this population is particularly vulnerable and will not meet the standard definition of chronic homelessness.
 - Tailor support services to the needs of women.
 8. Utilize a universal trauma-informed approach and initiate screening and follow-up.

Ensure that all agencies utilize a trauma-informed approach to all interactions with homeless individuals. In particular, staff working directly with homeless women should receive training in this approach and incorporate a long-term care plan for each woman and woman-identified person that maximizes safety. Gather feedback on the extent to which the Front Door Triage Program is being utilized to its full extent.

9. Expand Access to Transportation.

Allow all homeless women free access on the T.

10. Promote Food Security.

At a minimum, maintain current funding levels for SNAP, WIC, and the National School Lunch Program until a cost-of-living analysis can be conducted, and adjust accordingly, particularly as the minimum wage is increased. Streamline the application process for all agencies responsible for feeding vulnerable persons.

REFERENCES

1. [Http://www.massbudget.org/health_care.php](http://www.massbudget.org/health_care.php).
2. [Https://www.acf.hhs.gov/fysb/resource/dv-homelessness-stats-2016](https://www.acf.hhs.gov/fysb/resource/dv-homelessness-stats-2016).
3. Browne, A. Responding to the Needs of Low Income and Homeless Women Who are Survivors of Family Violence. *Journal of American Medical Women's Association* 53(2):57-64, 1998.
4. Homelessness and Trauma in the Lives of Women Veterans. From: The National Center on Family Homelessness. Fact Sheet November 2013.
5. Kaufman, N: Homelessness: A Comprehensive Policy Approach, *J Urban and Social Change Review*, 17: 21-26, Winter 1984.
6. Argeriou, M. Homelessness in Massachusetts: Perception, Policy, and Progress, *New England Journal of Public Policy*: Vol. 8: Issue 1, Article 40, 1992.
7. Making Room: Comprehensive Policy for the Homeless City of Boston Mayor Raymond L. Flynn December 1986. <https://archive.org/stream/makingroomcompre00flyn#page/n1>
8. Homelessness in the City of Boston, Winter 2008-2009, Annual Census Report, December 15, 2008.
9. [Https://www.cityofboston.gov/oldnews/Default.aspx?id=3197](https://www.cityofboston.gov/oldnews/Default.aspx?id=3197).
10. [Https://www.cityofboston.gov/news/Default.aspx?id=6335](https://www.cityofboston.gov/news/Default.aspx?id=6335).
11. An Action Plan to End Veteran and Chronic Homelessness in Boston: 2015-2018, City of Boston Mayor's Office, 2015.
12. [Https://www.mass.gov/orgs/interagency-council-on-housing-and-homelessness](https://www.mass.gov/orgs/interagency-council-on-housing-and-homelessness).
13. Boston Homeless Census Reports <https://www.boston.gov/departments/neighborhood-development/annual-homeless-census>.
14. MA Coalition for the Homeless website: <https://www.mahomeless.org/about-us/basic-facts>.

15. Shuster, L and Vance A. Three Causes of Boston's Decade-Long Rise in Homelessness...And recent Signs of Progress. www.bostonindicators.org/article-pages/2017/may/homelessness-and-progress-in-boston.
16. <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.html>.
17. WHO website: https://www.who.int/social_determinants/sdh_definition/en.
18. Larimer, ME et al. Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems. *JAMA* 301 (13): 1349-1357, 2009. Doi: 10.1001/jama.2009.414.
19. Flaming, D, Lee, S, Burns, P, Sumner, G. Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients. Report from the Economic Roundtable and the Corporation for Supportive Housing, 2013.
20. www.nhchc.org/faq/official-definition-homelessness.
21. <https://endhomelessness.org/resource/changes-in-the-hud-definition-of-homeless>.
22. Annual Homeless Report to Congress, December 2017.
23. Department of Housing and Urban Development Point-in-Time Count Methodology Guide, 2014.
24. City of Boston 38th Annual Homeless Census, January 2018.
25. Personal communications between Health Care Without Walls and the referenced agencies.
26. Department of Housing and Community Development Emergency Assistance Program Fiscal Year 2017 Fourth Quarterly Report, August 2017.
27. Cheung AM, Hwang SW. Risk of Death Among Homeless Women: A Cohort Study and Review of the Literature. *CMAJ* 170(8):1243-7, Apr 13, 2004. PubMed PMID: 15078846; PubMed Central PMCID: PMC385354.
28. Ku, BS, et al. The Urban Homeless: Super-Users of the Emergency Department. *Pop Health Manag* 17(6): 366-71, Dec 2014. Doi: 10.1089/pop.2013.0118. Pubmed PMID: 24865472).

29. Kushel MB, Vittinghoff, E, Haas, JS. Factors Associated With the Health Care Utilization of Homeless Persons. *JAMA* 10: Vol 285, 2000-2006, 2001.
30. Koh, HK, O'Connell, JJ. Improving Health Care for Homeless People. *JAMA*, 316 (24)2586-7, 2016.
31. Liebman J & Heffernan D. Quality Improvement in Diabetes Care Using Community Health Workers. *Clinical Diabetes* 26(2), 75-76, 2008.
32. Using Medicaid Levers to Support Health Care Partnerships with Community-Based Organizations. In: Partnership for Healthy Outcomes, a collaboration between Nonprofit Finance Fund, Center for Health Care Strategies and the Alliance for Strong Families and Communities. Fact Sheet October 2017.
33. Blazey-Martin, D, Williams, K, Means, RH. Who Cares for Poor and Homeless Women in Boston? A Study of Primary Care Sources. Presented at the APHA Annual Meeting, November 9, 2009.
34. Kieffer EC et al. Obesity and Gestational Diabetes Among African-American Women and Latinas in Detroit: Implications for Disparities in Women's Health. *J Am Med Womens Assoc* 56 (4): 181-187, 196, Fall 2001. <https://www.ncbi.nlm.nih.gov/pubmed/11759788>.
35. Stewart, AM et al. Pediatric Emergency Department Visits for Homelessness After Shelter Eligibility Policy Change. *Pediatrics* 142(5): November 2018:e20181224.
36. Norris, C. Testimony of Metro Housing/Boston to Boston City Council Committee on Housing and Community Development, August 7, 2018.
37. Broll R, Huey L. "Every Time I Try to Get Out, I Get Pushed Back" (1): The Role of Violent Victimization in Women's Experience of Multiple Episodes of Homelessness. *J Interpers Violence*. May 1, 2017. Doi:10.1177/0886260517708405.
38. Pavao J, et al. Intimate Partner Violence and Housing Instability. *Am J Prev Med* 32(2):143-6, Feb 2007. PubMed PMID: 17234488.
39. Center for Disease Control and Prevention (2010). "National Intimate Partner and Sexual Violence Survey." Available at <https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf>.

40. Felitti VJ et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med.*14(4):245-58, May 1998. PubMed PMID: 9635069.
41. Farley, M., Golding, JM, Minkoff, JR. Is a History of Trauma Associated With a Reduced Likelihood of Cervical Cancer Screening? *J Fam Pract.* 51:10, 827-831, October 2002.
42. The Pew Charitable Trusts. "Household Expenditures and Income." Issue Brief, March 30, 2016.
43. Seligman et al. Exhaustion of Food Benefits at Month's End and Hospital Admissions or Hypoglycemia. *Health Affairs*, 33 (1), Jan 2014.
44. <https://www.childrenshealthwatch.org>. December 2012
45. Baggett, TP et al. Food Insufficiency and Health Services Utilization in a National Sample of Homeless Adults. *J Gen Intern Med.* 26(6):627-34, June 2011. doi: 10.1007/s11606-011-1638-4. PubMed PMID: 21279455.
46. Boston's Way Home: Year One. 2016.