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Rationing Housing: How Technologies, Providers, and Definitions of Homelessness Sort and Stratify by Health

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Rationing Housing: How Technologies, Providers, and Definitions of Homelessness Sort and Stratify by Health

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Rationing Housing: How Technologies, Providers, and Definitions of Homelessness Sort and Stratify by Health

Tessa M. Napoles

ABSTRACT

When there is not enough housing for all who need it, housing agencies must triage and prioritize who receives assistance, and who is left out. In this dissertation, I explore how people in the social and healthcare safety net are sorted and stratified by technologies, service providers, and definition of need. I focus on the increasing incorporation of illness into definitions of housing need and vulnerability and how biomedical logics have emerged as central to systems that prioritize people experiencing housing insecurity, homelessness, and poverty.

My findings are drawn from 17 months of fieldwork conducted between June 2021 and October 2022. I conducted over 100 hours of ethnographic observation and 79 one-on-one interviews, including 50 interviews with frontline and mid-level service providers and leadership staff and 29 interviews with clients experiencing housing insecurity or homelessness.

In my first set of findings, I provide a brief social history of the understandings of homelessness and the incorporation of health and illness as central components and operationalizations of homeless need and vulnerability. I argue that while conceptions of homelessness—and specifically the return of health and illness criteria—seek to identify some of the most vulnerable people experiencing homelessness and match them to housing, such definitions stratify and ration scarce housing resources in ways that create new tiers of housing need and vulnerability and generate additional forms of exclusion. Second, I explore an unexamined mechanism in the sorting and stratifying of housing opportunities: the assemblage of CE technology with its service provider users. I show how service providers have limited but important levels of discretion in the use of algorithmic systems that prioritize households experiencing homelessness into housing. Findings center around the CE system technology and underscore the importance of service provider advocacy and the ways they negotiate housing assessment and prioritization especially for households experiencing homelessness and living with a disability. Lastly, I examine the discursive work of on-the-ground service providers to show how biomedical norms and standards shape definitions of need, vulnerability, and deservingness and ultimately, housing receipt. I reveal how service providers work to fit clients to housing by constructing them as disabled or medically in need of housing. Service provider decision-making processes reveal how biomedical norms and standards shape definitions of need and vulnerability and deservingness and ultimately, housing receipt.

By investigating the processes involved in the adjudication of who should be prioritized for housing within housing rationing systems, I provide a clearer evidence base for housing and healthcare safety net institutions and policymakers to understand how social institutions both reproduce and mitigate housing inequality. Such evidence suggests how we might strengthen our ability to implement fair and equitable processes along which housing assistance is rationed and allocated in the context of housing scarcity. This research contributes to scholarly understandings of the social construction of deservingness, boundary and classification work, and technological rationalization and quantification.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER ONE: INTRODUCTION

> *Until there's more funding to end homelessness,*
> *communities must figure out how to prioritize and allocate*
> *limited resources, especially access to housing.*
> (National Alliance to End Homelessness 2022b)

For the past two decades, incomes have not kept pace with soaring housing costs, the supply of affordable housing continues to fall woefully short, and federal and state housing assistance across the spectrum from emergency shelter (Streeter 2022) to housing subsidies (Scally et al. 2018) has not expanded to meet the growing need (Joint Center for Housing Studies 2020). The confluence of housing unaffordability and scarcity creates a precarious situation for both rent-burdened[1] and low-income populations who are at higher risk of homelessness as well as those who are already experiencing homelessness.

While many regions in the U.S. suffer from shortages of affordable housing, California's housing crisis is particularly acute. In the U.S., close to 600,000 people experienced homelessness on a single night in 2022, one-third of whom live in California (U.S. Department of Housing and Urban Development 2023).[2] Two-thirds of people experiencing homelessness in California live unsheltered, defined as living in a place not meant for human habitation such as tents, vehicles, or on the street (U.S. Department of Housing and Urban Development 2023).[3] Over the past several years, the rates of homelessness in California have continued to increase (U.S. Department of Housing and Urban Development 2023; Finnigan 2023). Unhoused Californians are primarily single adults; however, almost 94,000 people experiencing

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[1] Nearly half of all Californians—including over 60 percent of renters—report that housing costs are a financial strain (Johnson et al. 2020). One in five renters spend more than 50 percent of their income on rent (Kimberlin 2017).

[2] Over 180,000 people experience homelessness daily in California. This estimate is likely an undercount because many of the state's Continuums of Care (CoCs), coalitions of nonprofit and government entities that help address homelessness, did not count their unsheltered homeless populations in 2023 (Mejia & Perez 2024).

[3] Unsheltered homelessness includes abandoned buildings, bus or train stations, camping grounds, garage, shed, or other location outside of a housing structure (U.S. Department of Housing and Urban Development 2017b).

homelessness (34 percent) are families with children (California Interagency Council on Homelessness 2022). Black Californians are also disproportionately represented in the unhoused population: they are less than 6 percent of the state's population but comprise almost 1 in 3 unhoused people (27.7%) (California Interagency Council on Homelessness 2022). Stark racial and ethnic disparities in California's homelessness rates continued to grow during the pandemic (Finnigan 2023).

While the causes of California's housing crisis are complex and multifactorial, the lack of affordable housing, stagnant incomes, and systemic racism drive homelessness (Kushel et al 2023; National Alliance to End Homelessness 2023). In 2023, California had only 24 units of affordable housing available for every 100 extremely low-income renter households (National Low Income Housing Coalition 2024).[4] Given the current scarcity of housing, institutions and agencies have increasingly needed to engage in processes of triage, prioritization and ultimately, differentiation and classification to make choices about who should receive housing-related resources and assistance (Moore 2016; Eubanks 2018; McCabe 2020; Rita et al. 2022).

These processes of triage and classification effectively construct social definitions of who is understood to be 'housing insecure' or 'homeless,' and become central sites for the contestation of these definitions.[5] In research, service provision, and policy, the terms 'housing insecurity' and 'homelessness' are widely used and variably defined. 'Housing insecurity' refers broadly to several dimensions of housing problems people may experience, including affordability, quality, safety, and loss of housing. While the federal definition of homelessness

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[4] Extremely low income is defined as incomes at or below either the federal poverty guideline or 30% of the area median income, whichever is greater.

[5] While my dissertation explored various aspects of housing insecurity and its relationship to health, my empirical chapters mostly trace service providers who worked with households experiencing or at risk of homelessness.

has steadily incorporated more categories and sub-populations, including households[6] still housed but at imminent *risk* of homelessness, 'homelessness' is often functionally defined as its narrowest interpretation: literal homelessness.[7] In contrast to much of the existing scholarship on housing insecurity that focuses primarily on discrete events and episodes (e.g., an eviction) and static states (e.g., homeless), I conceptualize housing insecurity and homelessness as a dynamic *process* and *trajectory*, and center the ongoing social construction of these categories as objects of inquiry. That is, I align my work with scholarship that examines processes of prioritization, the boundary work that is involved in the development of social categories of deservingness, and the consequences of which social categories are deemed deserving of state attention and resources, including housing (Rosen 2014; Eubanks 2018; McCabe 2020; Shiff 2021).

My empirical stance therefore leads me to interrogate how determinations of housing need and allocation of housing resources are understood and implemented on the ground. U.S. housing policy is largely federal, but localities have discretion and flexibility in how they implement homeless response systems. The federal government through its regulatory agency, the U.S. Department of Housing and Urban Development (HUD), institutionalizes who is defined as homeless as well as who is most in need or vulnerable, and therefore deserving, of homeless assistance. At the same time, local agencies that are responsible for the coordination and management of housing and homelessness services, and the providers who work within them, have discretion in how they understand, interpret, and implement such categories of

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[6] I use HUD's definition of household which is "any configuration of persons in crisis, whatever their age or number (adults, youth, or children; singles or couples, with or without children)." Therefore, I use individuals and households synonymously. Families or households with more than one person have access to CE if the head of the household is eligible and meets criteria for access to CE (U.S. Department of Housing and Urban Development 2017c:6).

[7] Literal homelessness can encompass street homelessness, temporary housing (such as homeless shelters), living in dwellings not meant for human habitation (like a car), and institutional stays (such as an acute medical facility, inpatient substance use treatment center, or jail) (U.S. Department of Housing and Urban Development 2024b).

deservingness.

I argue that who is prioritized for housing is not determined by straightforward, uncontested assessments of need or vulnerability; instead, questions of definition necessarily and principally require the adjudication of who—among those defined as homeless—is defined as most in need, most vulnerable, and/or most at risk (Rita et al. 2022). As I show in subsequent chapters, there are multiple *invisible cuts* to the population of people who need housing. As Foucault (1977:154) noted, "Knowledge is not made for understanding; it is made for cutting." I aim to surface the seemingly mundane and invisible ways in which a population of people is cut into different categories—deserving and not deserving—and the boundary work involved in its construction, activation, and implementation.

Within this larger context, I focus specifically on the increasing incorporation of illness into definitions of housing need and vulnerability. On its face, this growing imbrication of housing and health makes sense: Housing insecurity and homelessness remain both causes and consequences of illness and central components of the relationship between poverty and poor health. Rent-burdened individuals and families have less money to spend on health and wellness, and simultaneously, are more likely to face eviction and homelessness which further threatens their health (California Budget & Policy Center 2019). This reality has been severely exacerbated by the COVID-19 pandemic and its economic fallout (Ong 2020; Rodriguez et al. 2022). It seems straightforward, therefore, that biomedical criteria, logics and knowledge systems, and providers have emerged as central to the sorting and stratifying of people experiencing housing insecurity, homelessness, and poverty.

Yet the expansion of biomedicine within housing institutions is not inevitable but rather part of larger shifts in social welfare. Alongside the heightened attention and interest in integrating social care[8] into the delivery of healthcare (National Academies of Sciences, Engineering, and Medicine 2019), there is an increasing integration and co-location of health, housing, and social services (Sandel and Desmond 2017). A growing national trend among hospitals and healthcare systems seeks to "prescribe" housing for health (Kelleher et al. 2018). Critically, these initiatives are reorganizing frontline housing services such that service providers' work to surface and identify biomedically informed definitions of illness and disability constitute newly important parts of the process of addressing housing insecurity and allocating scarce housing resources.

Accordingly, there is a critical need to trace how people experiencing housing insecurity, homelessness, and poverty receive housing in the social and healthcare safety net are sorted and stratified by health status in ways that shape their housing trajectories, and how such processes produce housing precarity as an unfolding experience that itself has critical consequences for health. What roles do health and biomedical logics play in sorting and stratifying clients in ways that shape their housing trajectories? How do healthcare, housing, and social service agencies, and the gatekeepers of housing within them, interpret and implement housing definitions, policies, and processes? Do they agree with the categories? Rewrite them? Resist them? How is need and vulnerability defined, and by whom? How are these definitions understood, taken up, and implemented? Based on these definitions, who is prioritized for scarce housing resources? And what do definitions and their operationalizations tell us about who should get housing first? Examining these fundamental sociological questions would help explain how social institutions collectively affect individuals experiencing poverty, housing insecurity, and illness.

The overall objective of this dissertation is to understand how interpersonal, organizational, and

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[8] Social care is defined as "services that address health-related social risk factors and social needs" (National Academies of Sciences, Engineering, and Medicine 2019).

structural processes sort and stratify clients in ways that shape their housing and health trajectories. I sought to address three related aims: (1) understand how health and illness shape and are shaped by experiences and trajectories of housing insecurity and poverty; (2) describe the interactions, processes, and organizational arrangements of housing assistance provided through the housing and healthcare safety net for people experiencing illness and social marginalization; and (3) identify and analyze interpersonal, organizational, and structural processes that sort and stratify clients in ways that shape their housing and illness trajectories. By investigating the processes involved in the adjudication of who should be prioritized for housing within housing rationing systems, I provide a clearer evidence base for housing and healthcare safety net institutions and policymakers to understand how social institutions both reproduce and mitigate housing inequality. Such evidence suggests how we might strengthen our ability to implement fair and equitable processes along which housing benefits are rationed in the context of housing scarcity.

In what follows, I first trace the origins of definitions of housing insecurity and homelessness and separately, definitions of illness and disability which, together, have informed conceptions of housing need and vulnerability for permanent supportive housing (PSH)[9] through Coordinated Entry (CE)[10] and separately, non-congregate shelter during the COVID-19 pandemic through California's Project Roomkey program.[11] I then review the theoretical literature on biopower and biological citizenship and street-level bureaucracy, outline my

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[9] PSH is deeply affordable housing units that are targeted to people at risk of or experiencing homelessness, and that include the provision of mental health and other supportive services.

[10] Coordinated Entry (CE) or a Coordinated Entry System (CES) is considered the "front door" and central organizing feature of the homelessness response system in most CoCs. Each CoC is federally mandated to establish a CE system whose purpose is to assess the needs of households experiencing homelessness, identify the most vulnerable households through prioritization, and connect them to housing and services (U.S. Department of Housing and Urban Development 2015a, U.S. Department of Housing and Urban Development 2017b).

[11] Project Roomkey, established in March 2020 as part of the state response to the COVID-19 pandemic, provided non-congregate shelter options, such as hotels and motels, for people experiencing homelessness.

methodology and methods, and finally, provide an overview of the three empirical dissertation chapters.

BACKGROUND

Definitions of Housing Insecurity and Homelessness

The development of housing insecurity as a construct can be traced back to the U.S. Housing Act of 1949, where housing was presented as critical for “the general welfare and security of the Nation and the health and living standards of its people” (U.S. Congress 1987). The language of the housing act acknowledged that housing transcends the material infrastructure that serves as protection from the elements and further, housing, or its absence, is interrelated with physical, psychological, and social well-being (U.S. Congress 1987; Shaw 2004). Since 1949, definitions of housing (in)security and its surrogate terms[12], such as housing (in)stability[13], have tended toward defining the construct in terms of the dimensions used to measure it (U.S. Department of Housing and Urban Development 2020). For example, in 1969, the U.S. Department of Health and Human Services (HHS) defined housing insecurity using five dimensions (HHS 1969) (see **Table 1-1**). Yet, in their overview of the evolution of the concept and measurement of housing insecurity, Cox and colleagues (2019) show that policymakers, practitioners, and researchers often leverage just three dimensions of housing insecurity, namely, affordability, stability, and homelessness. The authors propose an operational definition of housing insecurity that includes seven dimensions—housing stability, housing affordability,

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[12] Housing insecurity is frequently used interchangeably with several surrogate terms, including housing instability, housing insufficiency, housing satisfaction, housing hardship, shelter hardship, housing stress, risk of homelessness, churning movers, residential mobility, residential displacement, hyper-mobility, residential transience, housing quality hardship, and poverty-related hypermobility.

[13] Some of the surrogate terms for housing insecurity are also individual dimensions that compose the definition of housing insecurity, including housing affordability, housing stability, housing safety, and housing quality.

housing quality, housing safety, neighborhood safety, neighborhood quality, and homelessness—based on the universal food insecurity measure and definition from the U.S. Food Security Survey Module. In addition to the conceptual similarities to food insecurity, proponents point to the "success of [the] term" in mobilizing resources and developing a vast research and policy agenda since the food insecurity measure was established in 1995 (Cox et al. 2017:12). More recently, HUD advanced a standardized set of questions to measure the continuum of housing insecurity based on three dimensions—lack of affordability, lack of stable occupancy, and lack of safety and decency—for use in the American Housing Survey, the nation's most comprehensive housing survey (U.S. Department of Housing and Urban Development 2020).[14]

TABLE 1-1: Dimensions of Housing (In)security

Housing instability (Office of the Assistant Secretary for Planning and Evaluation, 1969)	**Housing instability** (U.S. Department of Health and Human Services 1998)	**Adequate housing** (Office of the United Nations High Commissioner for Human Rights 2009)	**Housing insecurity** (Cox et al. 2019)	**Housing insecurity** (U.S. Department of Housing and Urban Development 2020)
Affordability Quality Neighborhood stability Overcrowding Homelessness	Cost Quality Neighborhood Overcrowding Homelessness	Affordability Habitability Availability of services, materials, facilities, and infrastructure Location Local security of tenure Accessibility Cultural adequacy	Housing affordability Housing quality Neighborhood quality Homelessness Housing safety Neighborhood safety Housing stability	Affordability Safety and decency Stable occupancy

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[14] While the HUD definition (2022) includes fewer dimensions than previous efforts to define housing insecurity, the dimensions seek to encompass the same scope as the HHS and UN definitions with the exception of neighborhood quality and stability (U.S. Department of Housing and Urban Development 2022).

Like housing insecurity, homelessness is a heterogenous concept that has grown to encompass increasingly more categories and sub-populations. HUD defines homelessness[15] in narrow ways. The federal definition of homelessness comprises four categories: literal homeless, imminent risk of homelessness, homeless under other federal statutes, and fleeing/attempting to flee domestic violence (**Table 1-2**).[16] While the federal definition of homelessness has steadily incorporated more categories and sub-populations, including households still housed but at imminent *risk* of homelessness, homelessness often functions as its narrowest interpretation: literal or street homelessness. *Literal homelessness* can encompass street homelessness, temporary housing (such as homeless shelters), living in dwellings not meant for human habitation (like a car), and institutional stays (such as an acute medical facility, inpatient substance use treatment center, or jail) (U.S. Department of Housing and Urban Development 2024b). Narrow conceptions of homelessness are not an accident nor oversight: they provide seemingly rational criteria on which the state and the homeless services industry can limit the scope of program and policy interventions (Williams 2005; Willse 2015). HUD's annual Point in Time (PIT) count, which is critical for the allocation of federal funds to Continuums of Care (CoCs),[17] excludes experiences of hidden homelessness—for example, "doubled-up" with

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[15] While homelessness is not included as its own domain, HUD's definition of housing insecurity includes the "proportion of persons in the household who are living there temporarily because they have nowhere else to go" as a sub-dimension of stable occupancy (U.S. Department of Housing and Urban Development 2022:xvii).

[16] With the 2009 HEARTH Act—the first and only major reauthorization of the McKinney-Vento Homeless Assistance Act, which is the largest source of funding for homeless assistance programs—federal definitions of homelessness were expanded to include people at imminent risk of homelessness (U.S. Department of Housing and Urban Development 2009; Leopold 2019). In 2013, individuals and families fleeing or attempting to flee domestic violence were another group for which homeless assistance was expanded (U.S. Department of Housing and Urban Development 2013).

[17] Continuums of Care (CoC) are defined by HUD and include "representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons" (U.S. Department of Housing and Urban Development 2017b). California is divided into 44 CoCs.

family,[18] couch surfing, staying in a motel/hotel,[19] or institutionalized in hospitals or incarcerated[20] (Metcalf 2021, National Law Center on Homelessness & Poverty 2017). In this way, the system and structure of funding, infrastructure, and oversight are built upon narrow understandings of homelessness, excluding groups of people experiencing homelessness and frustrating the purpose of the CoC program.

The three main categories of homelessness are important as they designate who has access to the county's homelessness response system and which resources and interventions are available to each household by category (see Table 1-2 column 3). Category 1 is eligible for all of HUD's interventions except prevention.[21] Category 2 is not eligible for street outreach[22] and permanent housing, such as rapid rehousing (RRH)[23] and PSH. Category 4 eligible for all interventions including supportive services[24] and shelter[25] (U.S. Department of Housing and Urban Development 2017c; U.S. Department of Housing and Urban Development 2024a). All

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[18] "Doubled-up" is defined as a person or family temporarily living with someone else without any property interest in the home (e.g., as co-renter or owner) (Metcalf 2021). Individuals and households who are living doubled-up are excluded from the federal definition of homelessness unless they will lose housing in the next 14 days.

[19] Individuals and households who are living in hotels/motels for more than 7 days if the stay is paid by the household, relatives, or friends, are not considered homeless. However, if the hotel/motel is paid by the government or charity, the household is considered homeless.

[20] Individuals who are staying in institutional living settings, such as an acute medical facility, inpatient substance use or mental health treatment, hospital, or jail, for more than 90 days and individuals staying in sober living or a board and care facility are excluded from HUD's definition of homeless.

[21] According to HUD, prevention services can include "housing relocation and stabilization services as well as short- and medium-term rental assistance to prevent an individual or family from becoming homeless" (U.S. Department of Housing and Urban Development 2024c).

[22] Street outreach generally consists of "engagement, case management, emergency health and mental health services, and transportation" and is "designed to meet the immediate needs of people experiencing homelessness in *unsheltered* locations by connecting them with emergency shelter, housing, or critical services, and providing them with urgent, non-facility-based care" (U.S. Department of Housing and Urban Development 2024e).

[23] HUD defines rapid rehousing (RRH) as "permanent housing that provides short-term (up to three months) and medium-term (4-24 months) tenant-based rental assistance and supportive services to households experiencing homelessness" (U.S. Department of Housing and Urban Development 2024d).

[24] Supportive services "help program participants obtain and maintain housing." Some examples include moving costs, case management, employment assistance, legal services, substance use treatment services, and utility deposits (U.S. Department of Housing and Urban Development 2024f).

[25] Emergency shelter, or shelter, is defined as "any facility, the primary purpose of which is to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless" (U.S. Department of Housing and Urban Development n.d.).

three categories are eligible for transition housing (TH).[26] Importantly, meeting a HUD-defined category does not necessarily mean that an individual or family will receive HUD homeless assistance as prioritization is a locally driven process as discussed in further detail in other chapters. In general, when a household secures permanent housing, they are no longer considered homeless.[27]

The housing and services available to people experiencing or at risk of homelessness are coordinated by CoCs, regional or local planning bodies responsible for the coordination and management of homelessness response systems (U.S. Department of Housing and Urban Development 2017b). Each CoC is federally mandated to establish a CE system whose purpose is to assess the needs of households experiencing homelessness, identify the most vulnerable households through prioritization, and connect them to housing and services (U.S. Department of Housing and Urban Development 2015a).[28] Communities often do not have or do not allocate the resources necessary to provide housing to every household experiencing homelessness; thus, the introduction of CE systems in 2012 sought to centralize homeless services and allocated housing based on vulnerability and need. Below, I thus summarize the literature that explores conceptions of health that are increasingly being incorporated into definitions of housing need and vulnerability.

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[26] Transitional Housing (TH) is "housing primarily designed to serve deinstitutionalized homeless individuals and other homeless individuals with mental or physical disabilities and homeless families with children" with the purpose of "facilitating the movement of homeless individuals and families to permanent housing within a reasonable amount of time (usually 24 months)" (U.S. Department of Housing and Urban Development n.d.).

[27] While individuals in HUD-funded TH continue to meet the definition of literal homeless (Category 1), they are not considered chronically homeless and are therefore ineligible for PSH projects or programs that are restricted to serving chronically homeless individuals. Households who are receiving RRH are able to maintain their homeless status, including literal and chronic homelessness, and are therefore eligible for PSH.

[28] Programs and projects that receive funding from the HUD CoC Program and the Emergency Solutions Grant (ESG) Program as well as state- (e.g., Homekey) and county-level programs are required to use the Homeless Management Information System (HMIS) and participate in CE.

TABLE 1-2: HUD Categories of Homelessness

Category	**Definition**	**Eligible Interventions**[29]
Category 1: **Literal Homeless**	Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: 1. Has a primary nighttime residence that is a public or private place not meant for human habitation; or 2. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or 3. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.	Street outreach Supportive services Shelter TH RRH PSH
Category 2: **Imminent Risk of Homelessness**	An individual or family who will imminently lose their primary nighttime residence, provided that: 1. Residence will be lost within 14 days of the date of application for homeless assistance; 2. No subsequent residence has been identified; and 3. The individual or family lacks the resources or support networks needed to obtain other permanent housing. Note: Includes individuals and families who are within 14 days of losing their housing, including housing they own, rent, are sharing with others, or are living in without paying rent.	Prevention Supportive services Shelter TH
Category 4: **Fleeing/Attempting to Flee Domestic Violence**	Any individual or family who: 1. Is fleeing, or is attempting to flee, domestic violence[30]; 2. Has no other residence; and 3. Lacks the resources or support networks to obtain other permanent housing	Prevention Street outreach Supportive services Shelter TH RRH PSH

Note: There are no California projects that serve people who qualify as experiencing homelessness under Category 3 (California Department of Housing and Community Development 2022a). Therefore, I do not describe or address this Category in this dissertation.

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[29] Homeless response systems, or CE, do not provide low-income housing rentals (which households can apply to through city and county housing lottery programs), affordable housing, Public Housing, and Housing Choice Vouchers (formerly known as Section 8).

[30] Domestic Violence (DV) includes dating violence, sexual assault, stalking, and other dangerous or life-threatening conditions that relate to violence against the individual or family member that either takes place in, or him or her afraid to return to, their primary nighttime residence (including human trafficking) (U.S. Department of Housing and Urban Development n.d.).

Housing and Health and Definitions of Chronic Homelessness and Disability

Science & Research - A vast body of scholarship connects health outcomes to high-cost housing, conditions inside the home, and the social, environmental, and neighborhood contexts of where people live (Gibson et al. 2011; Taylor 2018). People experiencing homelessness in particular have higher rates of premature mortality compared to the rest of the population and an increased prevalence of infectious diseases, mental health disorders, substance misuse, and experiences of violence (Fazel, Geddes, and Kushel 2014). Almost half (45%) of all people experiencing homelessness in California report a disabling condition (California Health Care Foundation 2022). A *disability*, or disabling condition, is defined by HUD as a "diagnosable" substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder (PTSD), cognitive impairment from brain injury, and/or a chronic physical illness or disability such as HIV/AIDS (U.S. Department of Housing and Urban Development 2015b). Chronic homelessness—defined as homelessness for at least a year, or repeatedly, while living with a disability (U.S. Department of Housing and Urban Development n.d.)—in California has increased by 78 percent between 2018 and 2022 (Colletti 2023).

Housing interventions can improve health outcomes. Specifically, the permanent supportive housing (PSH) model—deeply affordable housing units that are targeted to people at risk of or experiencing homelessness, and that include the provision of mental health and other supportive services—promotes housing stability and reduces acute healthcare utilization costs by following the Housing First approach where people are provided with housing first and then offered supportive services[31] (Dennis, Locke, and Khadduri 2007; Mares and Rosenheck 2011;

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[31] Permanent supportive housing (PSH) supportive services range from mental health and substance use to support with personal development and financial well-being (U.S. Department of Housing and Urban Development n.d.).

Leff et al. 2009). Even among people facing significant barriers to housing, PSH has been instrumental to the work of ending chronic homelessness (National Academies of Sciences, Engineering, and Medicine 2018). Likewise, rent assistance has been shown to improve food security and nutrition, improve mental and overall health, and reduce the risk of healthcare hardship. Temporary financial assistance reduces costs as well as mortality and suicidal ideation (Nelson et al. 2024).

Systems & Service Provision - Recent evidence shows that the healthcare system has an important role in connecting patients to housing, thereby improving their health (Bailey 2020; Kelleher et al. 2018; Sandel and Desmond 2017). Leading health and housing scholars like Sandel and Desmond (2017) have called on hospitals and health systems to play a larger role in addressing the housing crisis and the health problems that arise from inadequate housing. To address increasing housing costs and inefficient healthcare spending, there is an increasing integration and co-location of health, housing, and social services (Kelleher et al. 2018; Sandel and Desmond 2017). Specifically, there is an increased attention and interest in integrating social care, defined as "services that address health-related social risk factors and social needs," into the delivery of healthcare has ranged from light-touch assistance (e.g., referring patients to homeless service providers) to healthcare organizations investing in and partnering with community-based social care organizations in order to improve health outcomes and address unmet social needs (National Academies of Sciences, Engineering, and Medicine 2019). A growing national trend among hospitals and healthcare systems screens patients for social needs (Browne et al. 2021; Freibott et al. 2021) and "prescribes" housing—as well as food and transportation—for health (Kelleher et al. 2018; Swartz 2018). New housing-as-health initiatives seek to invest in supportive housing models to reduce healthcare utilization among individuals experiencing chronic homelessness and residential insecurity—where the “neighborhood as patient” suffers from a “syndrome” of housing insecurity, poverty, and residential segregation and the provision of housing acts as a “drug prescription” or “vaccine” (Sandel 2016:1; Sandel and Desmond 2017:2291; Yen et al. 2018:1). New initiatives involve hospitals and healthcare institutions using their land and investment portfolios to make investments in housing from subsidizing rent to directly owning and operating units (Hacke and Deane 2017; Truong 2019); Medicaid and managed care organizations (MCOs) paying for housing-related services like eviction prevention and tenants right training (Katch 2020; Wachino 2015); and community-based service providers, local public health departments, and MCOs partnering with housing providers to improve public and affordable housing properties or provide home-based healthcare (Bailey 2020; Spillman et al. 2016). Projects are underway across the country (Bailey 2020; Katch 2020). Healthcare institutions are also reorganizing frontline care and implementing new care models to include housing specialists, navigators, case managers and other staff to identify and address housing insecurity in the context of clinical care (National Academies of Sciences, Engineering, and Medicine 2019).

Several federal, state, and local initiatives seek to support continued integration of social care into the healthcare delivery system. At the state level, California Advancing and Innovating MediCal (CalAIM), a multiyear care delivery and payment reform initiative, seeks to transform the state’s Medicaid program, known as MediCal. Led by the California Department of Health Care Services (DHCS), the goal of CalAIM is to enhance population health, expand access to coordinated whole person care, and improve outcomes for individuals living with the most complex needs by addressing health-related social needs, or social care. CalAIM builds on previous waiver programs Whole Person Care and the Health Homes, both of which ended in

2021. Two key components of CalAIM are Enhanced Care Management (ECM) and Community Supports which are designed to support individuals with complex health and social needs. ECM is a required benefit that seeks to coordinate the health and social services of individuals with complex needs through care management. Case managers assess the needs and goals of enrollees and with their providers, develop a plan to connect them to clinical and social services. DHCS has designated several populations of focus, including individuals and families experiencing homelessness. MediCal managed care plans (MCPs) have the option to provide 14 Community Supports which are services or settings that provide less costly alternatives to, for example, hospitalizations, nursing facility care, and emergency department use. These services or settings, which are reimbursed by MediCal, include housing supports, short-term recovery supports (e.g., medical respite), and independent living supports (e.g., medically tailored meals). Housing supports include housing transition navigation services to help enrollees find and obtain housing, housing deposits to assist a household in securing a home, and housing tenancy and sustaining services to assist households with staying in their housing. A core aspect of the Community Supports benefit is developing partnerships between MCPs and community-based organizations (CBOs), including housing and homeless service providers and community health organizations specializing in care management, who can address health-related social needs at a local level. Rather than expecting MCPs and healthcare systems to become experts in housing and homelessness, CalAIM incentivizes the healthcare sector to contract with CBOs who are already providing community-based homeless outreach and housing support services.

THEORETICAL FRAMEWORKS

Biopower and Biological Citizenship in Action: The Healthcare System as a Site of Intervention in Housing Insecurity

The increasing imbrication of housing and health generally, and the healthcare system as a critical site for the intervention in housing insecurity are ideal terrain for a critical application of Foucault's conception of biopower. Foucault (1978) refers to biopower as a post-Enlightenment form of power that has waxed as the absolute power of sovereign monarchs has waned. Biopower is a bipolar form of power characterized both by the disciplinary "anatamo-politics" that subjugates human bodies and the regulatory "biopolitics" that controls populations (Foucault 1978:139-140). While sovereign power is symbolized through "the old power of death" (e.g., the guillotine), biopower represents the "administration of bodies and the calculated management of life" (1978:139-40). In other words, biopower both subjugates bodies *and* controls populations; the two forms of power are inextricable. Unlike the overt and centralized sovereign power, biopower is both "polymorphous" and polyvalent: it is dispersed, materializing and operating at the "capillary" level through an infinite number of smaller moments of power, moving through vessels, pervading and flowing through every level of society and subject-positions (Foucault 1978:11, 84). Critical to Foucault's re-conception and reconfiguration of power is that power is productive (positive), not merely repressive (negative). Power is productive in that it creates and constitutes identities through the creation, classification, and distribution of new forms of sexuality, perversion, and criminality (Foucault 1977; Foucault 1978). Biopower provides a lens in which to understand how the housing-as-health movement has both the capacity to promote health and wellbeing through hospital and healthcare system investment in housing on one end (regulatory pole of biopower), and to pathologize and subsequently surveil, intervene, and reform the aberrant homeless/unstably housed and ill individual on the other (disciplinary pole of biopower).

At first glance, hospital and healthcare system investment in housing might appear to be just one more instantiation of biopower in contemporary life—yet another intervention that seeks "to foster life or disallow it to the point of death" (Foucault 1978:138). However, Foucault might argue that these new housing as health partnerships and programs should not be mistaken for egalitarian initiatives or the liberation of formerly abandoned and marginalized populations. Instead, the production (positive power) of new programs and professional identities exist to manage costs and transform illness and disease into productive parts of neoliberal economies. In other words, in a social welfare state context, illness and unproductivity would need to be intervened upon, reduced, and eliminated while in the contemporary neoliberal context, poor health and unproductivity become sites for economic investment (Willse 2015). Rather than "disallow it to the point of death," people experiencing homelessness/housing insecurity and/or illness are moved into housing operated by hospitals and health systems to protect and secure their health (Foucault 1978:138). Newly integrated housing-health industries serve the economy directly through the reduction of healthcare costs and the production of service and knowledge industries and indirectly through the investment in labor. This may help explain why some populations (e.g., homeless, "super-utilizers") become the targets of new housing-as-health initiatives while others do not (e.g., those considered more stably housed in an SRO, shelter, or doubled up with family). Therefore, it raises important questions about who (or what) benefits from these initiatives, and in what ways; what is expected or required of those who participate; and who is left out. While some individuals experiencing housing insecurity and/or chronic illness will benefit from these interventions, perhaps those who have the largest gains are those who have always already profited from neoliberal economies including the housing developers and hospital administrators themselves.

Another critical concept that borrows from and extends Foucault's ideas about biopower is the notion of biological citizenship. Like biopower, biological citizenship is based on the premise that the control and management of life is one of the major targets of governance. Here, citizenship does not equate to legal citizenship but rather to its more sociocultural forms that link social benefits to constructions of obligation and responsibility (Petryna 2002; Rose and Novas 2006). Scholars of poverty have shown how the receipt of cash benefits necessitates new responsibilities and subjectivities (Hansen et al. 2014; Korteweg 2003). That is, those who study stratification have long noted that social and legal benefits are coupled with notions of obligations, belonging, inclusion and exclusion, and deservedness. The concept of biological citizenship describes new forms of belonging and subjectivity based on biological traits, and whether and how these traits can make demands on the state and social institutions for resources and care. Like biopower, biological citizenship has both a productive power—creating new forms of belonging, identities, communities, and expertise based on biological claims—and a disciplining and differentiating capacity that may produce new social inequalities and reinforce biomedical dominance. Scholars have applied biological citizenship to addiction and substance use, HIV/AIDS, genetics and disability, and race and immigration (Mulligan 2017). However, no scholarship has applied biological citizenship to examine how newly required responsibilities upon receipt of shelter may be unequally structured for the poor, housing insecure, and chronically ill, adding to the labor of poverty.

The concepts of biopower and biological citizenship raise speculative but important questions about the fields of housing and health and the processes of distinguishing, differentiating, and classifying. What biomedical definitions of illness (e.g., HIV-positive, at least two chronic illnesses) are leveraged, and by whom, to designate individuals as un/deserving of housing? What claims do individuals experiencing housing insecurity (or frontline housing workers on their behalf) leverage to secure housing? Which claims do gatekeepers consider legitimate and why? Is the provision of housing for the chronically ill understood by the state as a way to preserve and manage the collective health of the population? Does this differ for different groups? How does the COVID-19 pandemic impact these dynamics given the heightened risks of homelessness and lack of shelter?

Gatekeepers of Housing and The Intersectional Impacts of Poverty and Health on Housing Insecurity

The framework of street-level bureaucracy helps to theorize how social institutions shape inequality and specifically, sort and stratify individuals experiencing housing insecurity and homelessness according to poverty and health status.[32] Street-level bureaucracy theory (Lipsky [1980] 2010) recognizes that individual actors function as policy decision-makers due to their positioning embedded within large public bureaucracies. This line of scholarship places social workers, police officers, teachers and other frontline workers in organizational contexts where their relationships with their supervisors, managers, peers, and clients shape, and are shaped by, their everyday mundane decisions and actions. Scholars working in this tradition argue that we must move beyond the false dichotomy between street-level discretion and rule-based implementation in order to focus on how discretion is embedded in routines, practices,

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[32] I recognize the critical role of race and gender in housing prioritization and receipt. As discussed in Chapter 5, the analysis of the intersectional impacts of race, gender, and health on housing insecurity will continue after the publication of my dissertation.

ideologies, and rule-based systems. The space where housing benefits and punishments[33] are defined, negotiated, and contested in the social safety net is the point of contact between the state and individual, or frontline worker and citizen-client (Soss 2000); thus, street-level bureaucracy theory helps to understand these negotiations.

Scholars have historically focused on the policies and practices of certain institutions such as the state (Rothstein 2017) and real estate agencies (Taylor 2019) and their impact on racial and housing inequality. Those who study poverty and residential mobility have long been interested in how the choices of low-income individuals and families—and the structural barriers that constrain them—create high-poverty neighborhoods that reproduce social and economic isolation as well as racial residential segregation (Sampson 2012). In particular, scholars have shown the critical role of landlords in selecting tenants "out" (Desmond 2012) or "in" (Rosen 2014), sorting them into different kinds and quality of housing and different neighborhoods. Further, in federal assistance programs, caseworkers use discretion in their decisions about when and how to impose sanctions, or financial penalties, for client failure to comply with rules and regulations[34] (Fording et al. 2013). While scholarship has focused on public housing prioritization, and the gatekeeping processes within it (for example, see Rita et al. 2022), less scholarship has focused on the prioritization processes in the CE system and further, in Project Roomkey housing.

Extending this scholarship, I more fully explore how the housing experiences of the

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[33] As discussed in Chapter 4, the rights and duties of biological citizenship are defined, negotiated and contested here as well.

[34] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) abolished the main cash assistance program for low-income families, Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance for Needy Families (TANF). The TANF program included certain policy measures to help achieve the goals of welfare reform, and President Bill Clinton's promise to "end welfare as we know it," such as time limits, work requirements, and sanctions (benefits reduced or eliminated) for failure to comply with TANF rules.

urban poor are shaped by the intermediary forces of organizational and institutional gatekeepers, specifically frontline housing workers. I examine how intersections of poverty and health status suffuse the inner workings and the on-the-ground activities that comprise these processes of housing eligibility determination, screening, rationing, and application. I describe the interactions, processes, and organizational arrangements of the various institutions, and the everyday work and decision-making of frontline housing workers within them, that do this sorting and stratifying work. Given their discretion in the day-to-day governing of housing assistance, frontline housing workers and other gatekeepers of housing translate institutional policies and rules and implement them as on-the-ground routines, and in doing so, effectively "rewrite" them. I therefore argue that frontline housing workers are street-level bureaucrats who are both embedded in and constrained by larger systems, institutions, and relationships, but also have agency to interpret policies, make decisions, and respond to their clients. Street-level bureaucracy theory raises speculative but important questions about the role of frontline housing workers in housing receipt through the healthcare safety net. How do frontline housing workers conceptualize who is considered un/deserving of housing? Do the frontline housing workers act and see themselves as agents of the state? Do frontline housing workers have agency to reproduce or contest hegemonic discourses or do they lack power in a system where they, too, are constrained by their institutional mandates and hierarchies?

Algorithms of Discretion and Oppression and the Quantification of Everyday Life

I bring the above literature together with scholarship on algorithms of discretion and oppression and the quantification of everyday life. While I dive into much greater depth on critical analyses of algorithms and quantification in Chapter 3, here I note several key arguments that integrate these literatures with the above frameworks that are central to my dissertation. First, healthcare and housing institutions are increasingly relying on algorithms—or rules written into software—to solve social problems such as assess tenant risk (Kiviat 2023), sort and criminalize people experiencing homelessness (Eubanks 2018), and target patients for "high-risk" care management programs in order to reduce costs associated with acute healthcare utilization. The ubiquitous use of algorithms has made housing assessment, prioritization, and allocations tools seem neutral and rational. However, algorithms are not simply inanimate material background of social life and instead, like all technology, algorithms bear the mark of their social origins and the actors who create them. In other words, algorithms never work on their own or act on their own accord, but rather, are assemblages of the data they depend on and the users who use them.

Indeed, works in Science and Technology Studies (STS) and the sociology of science have long questioned the lack of attention to the technological and material aspects of social life (Airoldi 2021). STS theorists have shown that both material objects (e.g., technology) and humans are agential 'actants', or sources of action in networks of relations (Latour 2005). Technologies never work on their own or act on their own accord, but rather, are assemblages (Latour 1987) of the data they depend on, the algorithms they use, and the users who must make the technology work. As Noble (2018) and others have argued, algorithms do not neutrally mirror reality and instead, the socio-technical arrangements of algorithms amplify and reify the biases and discriminations of algorithmic systems.

Second, quantification has never been more central to contemporary society. The transformation of information into numerical data has created an indicator and audit culture where numerical data as a form of knowledge and as a basis for decision making is highly valued (Merry 2016). In an indicator culture, for example, individuals are a "calculable thing" that can be regulated and controlled (Maturo and Moretti 2018:9). As STS scholars have argued, social and political practices and choices have resulted in the seeming neutrality and objectivity of numbers despite their social construction. I analyze the significant role that *disability classifications* (Fourcade and Healy 2013) play in the sorting and stratifying of people experiencing homelessness to show how schemes of quantification operate to reproduce inequality.

METHODOLOGY AND METHODS

> *This newer approach [to social constructionism] … raised a very challenging question: "What are the social processes that account for why some get classified in a category and others do not, even though both are engaged in the same or similar behavior?" … [It] asks the investigator to look at the social patterns in the discretions and strategies of sorting, naming, and classifying.*
>
> (Troy Duster, 2005 American Sociological Association annual address)

Methodology

Given high levels of precarity, involuntary residential mobility, and homelessness in populations who suffer from poverty and chronic illness, the sociology of housing must move beyond the "actual home or apartment" (Pattillo 2013) and trace how people's interactions with institutional actors within geographic, economic, and political contexts shape their housing (and health) trajectories. An understanding of the normative order that structures interactions within organizations and institutions that provide housing assistance helps to conceive of how micro-level relations both manifest from and accrete up to macro-structural forces.

I conducted a relational ethnography, which scholars offer as an alternative to ethnographies of bounded places (e.g., neighborhoods) or groups (e.g., people experiencing homelessness) (Desmond 2014a; Pattillo 2007). Instead, a relational praxis calls for a commitment to tracing "configurations of relations" and investigating processes involving different actors and institutions (Desmond 2014a). This dissertation pursued a relational and processual ethnographic object of study: the process of sorting and stratifying individuals by poverty and health status in ways that shape their housing and illness trajectories. While the process of sorting and stratifying inherently involves multiple actors and settings, I took the processes themselves as the fundamental units of analysis. Therefore, this study drew on ethnographic observations and in-depth interviews with people experiencing housing insecurity and homelessness and service providers in a county in California. I followed service providers and their clients over time in order to trace how service provider-client dyads act as "tied fates," actors bound together in mutual meaning-making, cooperation, and struggle in the process of securing housing (Desmond 2014a).

I take a county in California, Juniper County,[35] as a case study. Findings are drawn from over 100 hours of ethnographic observation and 79 one-on-one interviews, including 50 interviews with frontline and mid-level service providers and leadership staff at housing and healthcare institutions and organizations and 29 interviews with clients experiencing housing insecurity or homelessness.

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[35] All sites, organizations, institutions, locations, and individuals have been anonymized with pseudonyms.

Community Partnership and Collaboration

As part of my research approach, I sought to partner and collaborate with people providing care and services to people experiencing housing insecurity, homelessness, and living with chronic illness in Juniper County. Beyond bridging a gap between the academic and research communities in which I am a part of, it was important to me to build my dissertation upon collaborative partnerships in order to foster trust and create more equitable and effective research. I partnered with two main organizations in Juniper County: Housing is Healthcare, an intensive case management program based at a safety net healthcare system, and Housing Families, a non-profit affordable housing organization.[36] While the research questions for this project emerged from my time as a researcher on other studies alongside conversations with my dissertation committee, my community partners were involved in important parts of the research process, including serving as key informants, giving feedback on interview guides and adding questions that were meaningful and salient to them, providing input on data collection processes such as recruiting participants, and helping to interpret some of the findings. I was transparent about the aims and goals of my project and met with members of each organization, both leadership staff as well as service providers whom I shadowed, frequently about the purpose of, and preliminary findings that emerged from, my research.

Housing is Healthcare - In June of 2021, I learned that the case management program I had supported on another project sought to develop a pilot program called Housing is Healthcare (HiH), a project aimed to support housing stability for medically vulnerable healthcare safety net patients. HiH added frontline housing workers such as housing navigators and housing

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[36] All sites, organizations, institutions, locations, and individuals have been anonymized with pseudonyms.

community health workers (CHWs) to the team-based model of care.[37] HiH liaised with community partners to support patients with referrals to shelter, interim housing, and permanent housing as well as directly assisted patients with care coordination and housing problem solving. In exchange for access to ethnographic observations of the day-to-day work of HiH team members as well as assistance with service provider and patient recruitment, I helped HiH service providers and leadership staff develop the Housing is Healthcare Collaboration Project, a community-based research partnership between the parent case management program, myself, scholars at UCSF, and undergraduate students. The goal of the partnership was to gather rich, mixed methods data to improve patient, provider, and staff experiences and to train students—and each other—in conducting community-based mixed methods research. Our collaboration was generously supported by the UCSF Center for Community Engagement (CCE) Partnership Grant, the National Science Foundation, my department, Social & Behavioral Sciences (SBS), at UCSF, and the health system (anonymized here for confidentiality) in which I conducted my research. Our work was presented to both the health system on December 13, 2022, and the UCSF CCE Council Meeting on November 30, 2023.

Our collaboration included five concurrent projects. First, with a grant from CCE, we provided HiH funds to serve up 40 patients with emergency housing funds, which included housing deposits, transportation for appointments and meetings related to housing security, and fees for replacement documents needed for housing, such as birth certificates. The grant also

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[37] Frontline housing service providers are often social workers, health coaches, or CHWs and, as such, may provide services like housing navigation, health education, coordination of appointments and transportation, and linkages to food, housing, and employment assistance. While patients may be enrolled in team-based care due to their "overuse" of the healthcare services (usually measured by frequency of emergency department visits and hospitalizations), the root of their complex medical issues are often social issues, including housing and food insecurity, limited social support, unemployment, and distrust in the healthcare system. Frontline housing service providers, then, are critical staff members of team-based healthcare.

supported up to 25 welcome home baskets, which included items like basic kitchen, bedding, and other basic furnishings and grocery items. Second, I supported the development and implementation of a survey of CHWs for a larger project on the history and work of CHWs in the healthcare safety net. Third, our collaboration participated in several workshops with community- and academic-based experts on different topic areas that were important to our collaboration, including community-based participatory research and photovoice. Fourth, as part of my dissertation, I conducted interviews with, and observed, healthcare providers and staff and patients enrolled in HiH (as well as other healthcare and housing organizations in Juniper County) to learn more about the important role healthcare institutions were playing in housing work—everything from educating healthcare providers on eviction protections to referring patients to transitional or permanent housing.

Finally, from 2021-23, I served as a research mentor to four students of color as part of two undergraduate research programs. I trained each student in qualitative research methods and ethics, including the complex work of not only generating real-world data that reflects the messiness of participants' experiences and social practices but also conducting respectful qualitative research with historically marginalized individuals. In addition to discussing fieldwork challenges and emerging themes, weekly team meetings addressed power dynamics between interviewer and participant and how to attend to reflexivity in research. It was important for me to hire and train people of color to help conduct the client interviews as I recognize that my positionality as a relatively young, able-bodied, white woman working on a graduate degree and who has not experienced homelessness or housing insecurity placed me in a privileged position in relation to my client-participants. The students used their experiences with housing insecurity and chronic illness to establish some common ground with the participants as a way to build rapport.

Data Collection

Housing Rationing Systems: Two Cases

My research traced the increasing use of biomedical definitions of illness and disability to define who is prioritized for housing. My dissertation focused on two housing rationing systems[38]—defined as the collection of institutions, agencies, and service providers involved in the processes of determining who receives scarce housing—that use health and illness as eligibility to access housing programs and services: the HUD-funded, county-implemented CE system and Project Roomkey, California's non-congregate COVID-19 emergency shelter. I use CE and Project Roomkey as two cases that illustrate the often-hidden ways that conceptions of housing need and vulnerability sort and stratify homeless assistance. **Table 1-3** outlines the health-related eligibility criteria for each system/program.

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[38] I use "housing priority systems," "housing allocation systems," and "housing rationing systems" interchangeably.

TABLE 1-3: Health-related Eligibility Criteria for CE and Project Roomkey

Coordinated Entry (CE) System	Project Roomkey
People experiencing chronic homelessness are prioritized for PSH in CE.[39] Individuals need to be living with a disability to meet the chronically homeless definition (U.S. Department of Housing and Urban Development 2015). A disability is defined as one or more of the following: 1. Physical, mental or emotional impairment, including impairment caused by alcohol or drug abuse, post-traumatic stress disorder, brain injury or a chronic physical illness that: ○ Is expected to be long-continuing or of indefinite duration; and ○ Substantially impedes the person's ability to live independently; and ○ Could be improved by more suitable housing. 2. Developmental disability[40]	Project Roomkey residents needed to meet the following criteria (California Department of Social Services 2020): Populations specifically eligible for FEMA reimbursement include: ● Individuals who test positive for COVID-19 that do not require hospitalization, but need isolation or quarantine (including those exiting from hospitals); ● Individuals who have been exposed to COVID-19 (as documented by a state or local public health official, or medical health professional) that do not require hospitalization, but need isolation or quarantine; and ● Individuals who are asymptomatic, but are at "high-risk," such as people over 65 or who have certain underlying health conditions (respiratory, compromised immunities, chronic disease), and who require Emergency non-congregate shelter (NCS) as a social distancing measure.

Fieldwork

For 17 months from June 2021 to October 2022, I conducted fieldwork at two main sites in Juniper County, California: Housing is Healthcare and Housing Families. I conducted ethnographic fieldwork over 63 days at both main sites as well as three other locations, including a Project Roomkey turned Homekey site, permanent supportive housing (PSH) residence, and street health outreach team. Conducting fieldwork at two main sites provided me with a baseline

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[39] In addition to prioritizing people experiencing CH, the CE process prioritizes people who are more likely to need some form of assistance to end their homelessness or who are more vulnerable to the effects of homelessness. When considering how to prioritize people for housing and homelessness assistance, HUD has asked communities to use the following health-related guidelines: Significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing; High utilization of crisis or emergency services, including emergency rooms, jails, and psychiatric facilities, to meet basic needs; Vulnerability to illness or death (U.S. Department of Housing and Urban Development 2015a).

[40] As defined in Section 102 of the Developmental Disability Assistance and Bill of Rights Act of 2000 (United States Congress 2000).

familiarity through which I was able to form connections with service providers and clients and interpret much of what I heard and saw related to the processes of assessing, prioritizing, and matching clients to housing. It also provided me with the opportunity to compare day-to-day housing work and processes at a traditional housing organization and a healthcare safety net setting.

I recruited service providers who worked specifically in housing and healthcare organizations and institutions though many service provider participants provided a wide range of social services. To gain a comprehensive sense of the day-to-day work of service providers, I shadowed 41 service providers[41] and 24 of their clients[42] to observe the complex bureaucratic and interactional work and negotiations that contribute to sorting and stratifying processes in housing. Of the 41 service providers, I followed 10 closely for over a year, including 6 individuals at Housing is Healthcare and 4 individuals at Housing Families. I spent approximately 100 hours with these 10 individuals, 6 of whom were also interviewed, observing them and meeting with them 4 to 31 times each. I observed service providers' interactions with their clients and client families, caregivers, and social networks; colleagues within and outside of their organization/institution; supervisors and leadership staff within their organization/institution; and landlords, rental housing providers, and property managers. I observed their day-to-day work and processes, including outreach; housing and healthcare assessments; case/care planning meetings; phone conversations with clients, colleagues, and landlords/property managers; and paperwork, charting, and documentation. Such observations

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[41] Service providers are defined as individuals who work for a governmental or nongovernmental public service program that offers information, benefits, resources, services and/or referral around basic human needs, including food security, housing and homelessness, healthcare, and welfare.

[42] In this chapter and dissertation, I use the term "client" broadly to include any individual, or head of household, experiencing homelessness or housing insecurity and working with a service provider to secure housing, including those described as "patients" primarily by providers of housing services working in the healthcare safety net.

helped capture their caseload, workflow, approaches to communication, problem-solving, and decision-making. These informal interactions provided opportunities to discuss open-ended topics related to their work as well as to observe and hear about if, how, and where their clients were housed. My observations were particularly attuned to how providers build trust, conduct assessments, make referrals, help clients find and secure housing and sustain tenancy, and educate, empower, and build relationships with clients.

In addition to following human actors—whose bodies, behaviors, and deservingness are being acted upon (clients) and who construct visions of deservingness (service providers and housing gatekeepers)—my research also attended to non-human (material) actors that accompany and purport to characterize and sort client bodies (Clarke 2005; Latour 2005). Non-human actors in the process of proving deservingness include technology like Coordinated Entry (CE) and forms that establish "document readiness." Following non-human actors helped elucidate the sorting and stratifying work of human actors, and their consequences, more clearly. Whenever possible, I recorded observations in handwritten fieldnotes. Detailed fieldnotes recorded what happened, who was present, and what was said as well as the setting, context, anecdotes and observations, language used, topics and tone of conversation, and how phenomena observed related to previous observations. Some interactions were audio recorded with approval from all individuals present, such as case conferences and in-person meetings with clients where all relevant details could not be feasibly handwritten. All recordings were professionally transcribed. After each day in the field, I spent several hours typing up the handwritten fieldnotes.

Service Provider Interviews

I also conducted interviews with 50 service providers (**Table 1-4**) at 14 different organizations in Juniper County. Five were housing and homelessness organizations, two healthcare clinics and systems, three healthcare organizations working specifically with people experiencing homelessness, and six city and county offices and departments. Most organizations worked with all types of households experiencing homelessness while one organization focused on families.

Ten service providers worked at Housing is Healthcare and five from Housing Families. Frontline staff included the following roles: care/case manager, case/care coordinator, community health (outreach) worker, housing navigator, intake coordinator, mental healthcare provider (e.g., LCSW), primary care provider (e.g., family nurse practitioner), and wellness coach. Mid-level staff were defined as positions that manage programs and/or staff and include the following roles: coordinator (e.g. nursing, outreach), program director, program manager, and program supervisor. All mid-level staff had frequent and direct interactions with clients. The sampling strategy for the service provider sample aimed to incorporate as much heterogeneity as possible, including by position, role, location, race/ethnicity, and gender. I recruited a portion of the service provider sample through contacts I made in my ethnographic work. I also recruited individuals through cold emails and snowball sampling. If an individual expressed interest, I described my research as a study about their day-to-day work and how housing assistance is provided through the health and social safety net.

The gender and racial/ethnic representation in my interview sample by role is similar to the demographic composition of service providers in the county in which the research was conducted and state of California. Frontline service providers were predominantly women of color (69%) while most mid-level and leadership staff were white women (43%).

In-person interviews conducted off-site were not sanctioned by UCSF until July 30, 2021, due to the COVID-19 pandemic. Interviews prior to July 30, 2021, were conducted on Zoom or by phone. Participants who participated in the study after July 30, 2021, were given the option to participate in an interview in-person, by phone, or by Zoom. Phone and zoom participants were consented through electronic (signed) consent with DocuSign. Twenty-four (48%) interviews were conducted by Zoom, 14 by phone, and 12 in person.

Interviews explored day-to-day work; relationships with clients; processes for assessing and prioritizing clients into housing; processes and challenges of assisting clients with securing housing and sustaining tenancy; managing caseload; and COVID-19 experiences. In each interview, a set of predetermined domains was always covered, although the exact wording and order as well as additional topics followed the flow of conversation. Interviews lasted between 35 and 89 minutes, the average was 57 minutes. Interviewees were asked to fill out a short demographic form at the end of each interview by email.

All participants were provided with a $30 gift card for their time and participation. To protect the identity of participants, all names, locations, sites, and organizations/agencies are pseudonyms. The UCSF Institutional Review Boards and study sites approved all study procedures.

TABLE 1-4: Descriptive Statistics for Service Provider Sample (n = 50)

Characteristic	**N (%)**
Gender	
Female	39 (78%)
Male	10 (20%)
Non-Binary	1 (2%)
Age	39 [22-65]
Person of Color	29 (58%)
Role	
Frontline Service Provider (e.g., housing navigator)	29 (58%)
Mid-level Service Provider (e.g., program manager)	18 (36%)
Leadership Staff (e.g., executive director)	3 (6%)
Years Worked in Field	10.4 [0.5-40]
Housing Status	
Homeless Ever	9 (19%)
Housing Insecure Ever	20 (42%)
Currently Housing Insecure	4 (8%)

Notes: Two of the 50 participants did not fill out the demographic form and therefore, demographic data (except for gender and race/ethnicity, which was discussed in the respective interviews) is not available.

Client Interviews

I followed participants enrolled in Housing is Healthcare (HiH). Participants were recruited through patient lists and at the recommendation of healthcare providers at HiH. Over 8 months (April 2022 - November 2022), three Research Assistants and I conducted 26 in-person interviews. Another three interviews—for a total of 29 interviews—were conducted with clients at Housing Families (HF), a non-profit affordable housing organization. Fieldwork was more extensive at HF which allowed for more informal and longitudinal interviews with clients there.

Client eligibility criteria included: 18 years of age or older, English-speaking, extremely low-income as defined by the U.S. Department of Housing and Urban Development for Juniper County, and individuals seeking housing and/or working with a frontline housing worker. I used purposive sampling to include a diversity and range of participants based on race/ethnicity, gender, age, health status, and residence within Juniper County.

Clients were recruited in-person, during observations of frontline housing workers, where I provided clients with the IRB-approved Study Information Sheet for Observations.[43] Additional individuals were recruited by phone from patient lists and directly from frontline housing workers who passed along the IRB-approved Consent Form. Individuals who were interested in participating could directly contact me or approve me to contact them.

Interviews were conducted in English, lasted about 30 minutes, and took place in hospitals, clinics, public spaces (e.g., park), and participant homes, hotel rooms, and encampments. Interviews explored the following domains: current living situation and health conditions; experiences managing illness while housing insecure; meanings of housing security and stability; relationships with frontline housing workers and housing assistance; and experiences with securing and/or sustaining housing.

All interviews were digitally recorded with consent and audio recordings of each interview were professionally transcribed. All participants were provided a $30 e-gift card. The Research Assistants and I iteratively memoed after each interview which allowed me to move

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[43] Individuals who were interested in participating in the study could provide verbal consent for me to observe them at that time or contact me later with the contact information provided on the Study Information Sheet for Observations.

between data collection, coding of the data, emerging patterns, and further data collection. Emerging themes were discussed in weekly team meetings with the Research Assistants.

Analysis

While a relational ethnography studies processes—events, actions, and relations—as they unfold, constructivist grounded theory analysis is also distinguished by its iterative nature (Charmaz 2014; Corbin and Strauss 2008). Procedurally, this meant I collected data and analyzed it concurrently. For this analysis, audio recordings of each interview were professionally transcribed, and all service provider interview transcripts were coded using Dedoose software.

In the tradition of constructivist grounded theory, I continuously developed codes and sub-codes during data collection by drawing from interview guide items and frequent data review (Charmaz 2014). Additional sensitizing concepts served as preliminary codes included those that emerged from the overarching goals of this dissertation. This included codes that tagged and traced the interpersonal, organizational, and structural processes that sort and stratify clients into different housing situations and how individuals navigate these processes and the safety net system more broadly. Safety net institutions provide care and support to vulnerable individuals regardless of their ability to pay (Institute of Medicine 2000); yet often, safety net institutions are the source and (re)production of social harms. Thus, I was particularly attuned to the following during data collection and analysis and later, created codes and sub-codes to capture these processual phenomena: (a) Entry points: where and how clients initially get access to any one institution; (b) Pathways: how individuals and families navigate each institution; (c) Institutional barriers: where people get stuck, and what they do when they get stuck; (d)

Connectors: how frontline housing workers coordinate services within and across institutions; (e) Differential experiences based on demographics: how experiences with entry points, pathways, barriers, and connectors differ based on how one is categorized in the institution (e.g., mother, veteran, homeless), who is prioritized, how, and why; (f) Definitions of progress and success: who secures housing and what it means to "successfully" navigate the health and social safety net. I will also be attuned to inductive phenomena while in the field.

The list of 106 deductive and inductive codes and sub-codes were compiled into an iterative codebook. Dedoose queries of these codes were periodically run to enable identification of emerging themes and initial substantive analysis of the data. I used the same codebook across data sources—with supplemental codes that were unique to specific data sources—to enable triangulation of data on similar phenomena across all data sources. For example, phenomena related to the processes of adjudicating and allocating housing benefits emerged in both interviews and observation; by using the same subset of codes across both data sources, I was able to analyze interview data alongside data from observations.

I wrote analytic memos to identify findings as they emerged from the data which, in turn, were used to fine-tune interview guide questions, guide future data collection and sampling, attend to new hunches, and eventually build larger classes of codes. These larger classes of codes, or categories, were broader than the specific codes that stay close to the data in the sense that they captured heterogeneity and range within a given piece of the data. Memos and their respective excerpts were organized into several emerging themes documents which systematically outlined the patterns that emerged from the interview data.

OVERVIEW OF DISSERTATION CHAPTERS

In my first set of findings, Chapter 2, I explore the social construction of housing need and vulnerability and the implications for who is prioritized for housing. I provide a brief social history of the understandings of homelessness and the incorporation of health and illness as central components and operationalizations of homeless need and vulnerability. I argue that the history of federal homelessness policy from the 1980s onward, through to the emergence of the Coordinated Entry (CE) system in 2012 and the COVID-19 pandemic, herald a new era in understandings of homelessness, one that highlights a formidable return to medicalized notions of housing need. While conceptions of homelessness—and specifically the return of health and illness criteria—seek to identify some of the most vulnerable people experiencing homelessness and match them to housing, I argue that such definitions stratify and ration scarce housing resources in ways that create new tiers of housing need and vulnerability and generate additional forms of exclusion. Specifically, these definitions legitimate and promote medicalized and individualized notions of need, prevent many individuals from accessing much-needed resources based on narrow eligibility criteria, and further, turn our focus away from structural- and community-level solutions. Taken together, this chapter underscores that conceptions of vulnerability and need are not static nor fixed.

The third chapter explores an unexamined mechanism in the sorting and stratifying of housing opportunities: the assemblage of CE technology with its service provider users. I show how service providers have limited but important levels of discretion in the use of algorithmic systems that prioritize households experiencing homelessness into housing. Findings center around the CE system technology and underscore the importance of service provider advocacy and the ways they negotiate housing assessment and prioritization especially for households experiencing homelessness and living with a disability. I describe the specific discretionary strategies service providers use—contextualizing, defining and normalizing, coaching and probing, and adjusting—to achieve what they understand to be more accurate assessments of housing need. Each of these strategies constitute interactional processes and actions on and with the CE technology that make the system 'work' to render it to be less problematic and more trustworthy. The very work that service providers feel they must do for CE to prioritize their clients properly for the housing they need shows the stakes of algorithmic outcomes. Taken together, Chapter 3 underscores the importance of service provider advocacy and the ways they negotiate housing assessment and prioritization especially for households experiencing homelessness and living with a disability.

In my fourth chapter, I examine the discursive work of on-the-ground service providers to show how biomedical norms and standards shape definitions of need, vulnerability, and deservingness and ultimately, housing receipt. I reveal how service providers work to fit clients to housing by constructing them as disabled or medically in need of housing. Service provider decision-making processes reveal how biomedical norms and standards shape definitions of need and vulnerability and deservingness and ultimately, housing receipt. While Chapter 3 outlined the ways in which service providers challenged formal, narrow criteria and dysfunctional technology, Chapter 4 shows how service providers constructed biomedical versions of their clients, reinforcing and implicitly legitimizing biomedicine as the appropriate system to determine housing worthiness. Together, Chapters 3 and 4 show that clients who manage to be prioritized and matched to housing tend to receive assistance from service providers who advocate for their clients and engage in various "tactics of classification" (Rita et al 2022), such as defining and normalizing disability and fitting clients to housing by constructing them as disabled or medically in need of housing. I show how service providers interpret official definitions of need and vulnerability and attempt to turn them into usable categories that prioritized households for housing.

Taken together, my empirical chapters show how technologies, service providers, and definitions of need and vulnerability sort and stratify people experiencing housing insecurity and homelessness by health status, illness, and disability.

CHAPTER TWO: THE RETURN OF MEDICALIZED NOTIONS OF HOUSING NEED: TOP-DOWN AND BOTTOM-UP VIEWS OF HOUSING PRIORITIZATION CLASSIFICATIONS

INTRODUCTION

A critical understanding of the social construction of housing need and vulnerability and the implications for who is prioritized for housing remains conceptually undertheorized. The ways housing need and vulnerability are defined, interpreted, and operationalized have distinctive and consequential effects for how households experiencing homelessness and illness are understood, measured, and managed, including who is excluded from housing prioritization processes and placements. In this chapter, I provide a brief social history of the understandings of homelessness and the incorporation of health and illness as central components and operationalizations of homeless need and vulnerability. I argue that the history of federal homelessness policy from the 1980s onward, through to the emergence of the Coordinated Entry (CE) system[1] in 2012 and the COVID-19 pandemic, herald a new era in understandings of homelessness, one that highlights a formidable return to medicalized notions of housing need.

I then describe how service providers understand and view these shifts in deservingness in their everyday work and in the lives of their clients. In general, service providers could see why health and illness came to have renewed importance for housing prioritization; however, they argued this surface logic belied a deep irrationality: namely, some clients in dire need of

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[1] Coordinated Entry (CE) or a Coordinated Entry System (CES) is considered the "front door" and central organizing feature of the homelessness response system in most communities, or Continuums of Care (CoCs). Each CoC is federally mandated to establish a CE system whose purpose is to assess the needs of households experiencing homelessness, identify the most vulnerable households through prioritization, and connect them to housing and services (U.S. Department of Housing and Urban Development 2015a, U.S. Department of Housing and Urban Development 2017b).

housing were sorted out by strict eligibility criteria or were allocated housing only when they were so sick that they passed away right before or just after the receipt of housing. In their appraisals of the irrationality of housing criteria, service providers underscored two critical points: one, the way in which we define and operationalize homelessness is essentially a rationing system, and two, the system cannot be anything but that, given housing is a scarce resource.

While conceptions of homelessness—and specifically the return of health and illness criteria—seek to identify some of the most vulnerable people experiencing homelessness and match them to housing, I argue that such definitions stratify and ration scarce housing resources in ways that create new tiers of housing need and vulnerability and generate additional forms of exclusion. Specifically, these definitions legitimate and promote medicalized and individualized notions of need, prevent many individuals from accessing much-needed resources based on narrow eligibility criteria, and further, turn our focus away from structural- and community-level solutions.

Taken together, this chapter underscores that conceptions of vulnerability and need are not static nor fixed. Indeed, the spaces where housing prioritization is determined, negotiated, and contested are innumerable. While this chapter centers on how *definitions* sort, later chapters focus on the point of contact between technology and its users, and interactions among the state, service providers, and citizen-clients. In this way, this chapter highlights the origins of housing prioritization classifications and how definitions of housing need and vulnerability are contested, while later chapters show how service providers interpret and activate these categories of deservingness through resistance and acceptance.

THE ORIGINS OF HEALTH AND ILLNESS AS CRITICAL DOMAINS OPERATIONALIZING HOUSING NEED: A SOCIAL HISTORY

The origins of health and illness as central components and operationalizations of homeless need and vulnerability can be traced back to the 1980's when, to reduce the rising levels of homelessness, federal homelessness policy focused on the treatment of the most visible forms of homelessness specifically, people living with serious mental illness and/or substance use. Later efforts sought to categorize and describe this group as chronically homeless. After a temporary transition towards a more nuanced understanding homelessness as a structural issue with social and economic causes due to the 2008 housing crisis, my data show that current understandings of homelessness, and therefore the housing rationing systems that operationalize its constructions, increasingly prioritize and favor individualized and medicalized notions of need.

The Reagan Era: Homelessness as a Healthcare Issue

The origins of health and illness as central components and operationalizations of homeless need and vulnerability can be traced back to the 1980's (Jones 2015; National Academies of Sciences, Engineering, and Medicine 2018; Metcalf 2021). This era was characterized by significant cuts in federal government funding for the U.S. Department of Housing and Urban Development (HUD) and other safety net programs, paired with the Reagan administration's resistance to acknowledge homelessness as a national crisis, the closure of state-run mental hospitals, and a major recession. This confluence of events led to the shift in understandings of 'the homeless' from single, white, older disabled men on welfare and social security living in cheap hotels or single room occupancy (SROs) units in urban centers, to the more visible people living on the street with substance use and/or serious mental illness (SMI) (National Academies of Sciences, Engineering, and Medicine 2018).[2] Cuts to Supplemental Security Income (SSI) in the late 1980's also made it more challenging to qualify for disability benefits and the subsequent loss of income pushed many people living with mental illness into homelessness (National Academies of Sciences, Engineering, and Medicine 2018; Collin and Barry 1987).

The high level of visibility of people living on the street with SMI and/or substance use, while only a third of all people experiencing homelessness (Jones 2015), "perpetuated the understanding of homelessness as primarily a healthcare issue" (Metcalf 2021:338). In 1982, the National Institute of Mental Health (NIMH) launched a seminal program to investigate mental illness and substance use among people experiencing homelessness, the only research conducted at the time on homelessness. As Jones (2015) argues, the NIMH research program set the mold for a generation of research and policy characterizing homelessness as an individual and cultural problem rather than a structural problem of the social safety net. More specifically, researchers and policymakers alike disproportionately focused on the individual pathology of populations experiencing homelessness, as interest in understanding those *not* living with SMI, substance use, or a disability dwindled.

This individualization embedded within homelessness research of that time significantly impacted the federal policy response to homelessness, skewing its focus to the most physically and mentally disabled minority of the homelessness population. The "theme" of federal homelessness policy during the 1980s, therefore, was that the treatment of SMI and/or substance use was the pathway to reducing the rising levels of homelessness that had resulted from

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[2] The latter group tended to be younger (the average age of homelessness in 1985 was thirty-five) and now included more people of color, families, and children.

deinstitutionalization (Metcalf 2021:339). The Reagan administration's opposition to funding social science research, too, meant that very few studies explored the relationship between homelessness and social, economic, and structural factors such as poverty, housing, employment, and social services (Jones 2015).

Chronic Homelessness

By the 1990s, second- and third-generation studies sought to characterize the various subgroups experiencing homelessness, including families, children, and people living in rural areas. Of particular importance, Culhane and Kuhn (1998) developed a typology of homelessness derived from three mutually exclusive patterns of shelter utilization: Transient or *crisis* homelessness was defined as a single, brief episode of homelessness precipitated by a catastrophic event and typically resolved within 6 months. Second, *episodic* homelessness was characterized by short but frequent stays in shelters and other institutions. And third, *chronic* homelessness was defined as long periods of homelessness and the presence of a disability. Studies subsequently showed that the chronically homeless group consumed disproportionate amounts of emergency room services, policing, and other public resources (Jones 2015). Culhane's typology and later studies using it to compare service utilization rates thus laid the groundwork for a focus on *chronic* homelessness as the most significant and intransigent group and pattern of homelessness.

This focus further institutionalized increasing attention to disability and health conditions more generally in housing categorizations and interventions and created a subpopulation to be managed due to its economic impact. Later, HUD published a definition of chronic homelessness to describe people who have experienced homelessness for at least a year, or repeatedly, while living with a disabling condition such as a serious mental illness, substance use disorder, or physical disability (U.S. Department of Housing and Urban Development 2009). Indeed, Willse (2015) traces the growing attention to the "chronically homeless" as a costly group who drains healthcare and housing systems and therefore, requires intervention. In other words, "the problem of chronic homelessness [became] a problem of inefficient use of resources" (Willse 2015:158).

The addition of medical criteria to definitions of homelessness made the sorting of people into housing seemingly more rational and economistic by aiming to specify who was most costly. Questions that assessed and ranked health and disability issues would seek to identify and prioritize "super-utilizers"—people living with multiple chronic conditions compounded by complex social needs, who frequently use acute care services—for housing, improving individual health and ostensibly lessening the burden on the healthcare safety net (Mann 2013; Blumenthal et al. 2016; Cohen 2017). Importantly, the creation and articulation of the chronically homeless groups dictated who received what CoC resources: while households experiencing *crisis* homelessness are provided emergency shelter, transitional housing, or rapid rehousing (RRH), households experiencing *chronic* homelessness are prioritized and referred to permanent supportive housing (PSH).[3]

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[3] PSH, the gold standard for housing people experiencing chronic homelessness—defined as people who have experienced homelessness for at least a year, or repeatedly, while living with a disability—pairs ongoing rental assistance with supportive services such as case management, substance use programs and mental health treatment. While homelessness and disability are the baseline criteria to be matched to PSH, access to a PSH unit ultimately depends on several other factors including household characteristics and whether the household is eligible for specific funding streams. Nonetheless, definitions of homelessness and disability are the principal gatekeeping criteria to access PSH.

The 2008 Housing Crisis: A Temporary Transition Towards Understanding Homelessness as a Structural Issue

Metcalf (2021) argues that understandings of homelessness and its causes have evolved from an exclusionary focus on healthcare starting in the 1980’s to a more nuanced understanding that also includes social and economic causes. As a result of the housing crisis of 2008, where 8.7 million people lost their jobs and 10 million people lost their homes (Pew Research Center 2010), the federal government reauthorized and expanded the McKinney-Vento Homeless Assistance Act (the first and only major piece of legislation to provide federal funding for homeless programs; also established the first statutory definition of homelessness) through the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009. The HEARTH Act was a fundamental shift in the federal government’s approach to homelessness in at least two ways.

First, it enshrined Housing First principles and programming into federal legislation. Housing First is an evidence-based approach that prioritizes providing permanent housing to people experiencing homelessness, guided by the belief that “people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues” (National Alliance to End Homelessness 2022a). Housing First also seeks to promote client choice in housing selection and participation in supportive services, with the understanding that client choice enhances the odds of people remaining housed. The HEARTH Act thus signified a radical break from the prior “housing readiness” model that assumed only some people were prepared for housing and that others must first accept mandatory treatment (Tsemberis, Gilcur, and Nakae 2004; Willse 2015).

Second, the HEARTH Act expanded the definition of homelessness to include people at imminent risk of homelessness, previously homeless people temporarily in institutional settings, unaccompanied youth and families with persistent housing instability, and people fleeing or attempting to flee domestic violence (Leopold 2019). This definitional expansion was important as most of the individuals and families affected by the 2008 housing crisis may not have qualified for services under the former, narrower definition as they were not yet literally homeless.[4] Metcalf argues that these fundamental shifts at the federal level signaled the recognition of the "complexity of homelessness" and a transition "away from solutions rooted only in healthcare to those addressing the economic and social systemic issues that also drive the issue" (Metcalf 2021:345).

The Return of Medicalized Notions of Housing Need

Yet while homelessness may be increasingly understood as a structural problem with complex social and economic drivers, my data show that current understandings of homelessness, and therefore the housing rationing systems that operationalize its constructions, increasingly prioritize and favor individualized and medicalized notions of need. As I describe below and in subsequent chapters, individuals who have health conditions that could be defined as disabled, who have conditions and characteristics that could be easily translated into medical diagnoses of special interest to housing allocation systems, and who are visibly compromised, are prioritized for scarce housing resources. In particular, the arrival of the CE system and later,

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[4] Leopold (2019) notes that while this new, expanded definition had the potential to increase access to homelessness programs, "it is unlikely that it had much effect because it was not associated with the creation of new programs or an increase in funding for existing programs." But Metcalf (2021) does argue that rapid rehousing, "one of the most significant interventions within the Housing First approach" (2021:344), made sense for individuals and families whose homelessness was caused by social and economic factors such as unemployment, lack of affordable housing, and having an eviction on their record: "People in this situation, with some help, are able to achieve housing stability more quickly compared to someone with an untreated drug addiction or other mental illness, who might not be able to immediately enter independent housing" (2021:345).

the COVID-19 pandemic signal a new era in understandings of homelessness, one that emphasizes a formidable return to medicalized notions of housing need but not necessarily more housing. This shift is characterized by two main factors: first, the development and subsequent ubiquitous deployment of the VI-SPDAT within CE systems led to health, illness, and disability domains to have a larger impact on priority scores; and second, the COVID-19 pandemic ushered in a new wave of individualized metrics of health need for people experiencing homelessness based on public health *risk* through Project Roomkey.[5] Both cases reveal that housing prioritization systems continue to perpetuate false notions that homelessness is rooted in individual pathology.

The Coordinated Entry (CE) Era: Elevating Health & Illness Domains through the VI-SPDAT

In 2012, the introduction of CE—a computerized homeless response system used to assess, prioritize, and match households to housing in a CoC or community—sought to shift communities from a first-come, first-served model of homeless services to a centralized system based on vulnerability and need. HUD requires communities to establish a CE system using a standardized tool to prioritize services. One of the main purposes of CE is to ensure that people with the most severe service needs and levels of vulnerability are prioritized for housing and homeless assistance. In many ways, CE represents the result of ongoing efforts since the 1990s to identify, with greater precision and refinement (now in automated, algorithmic ways, as I

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[5] Project Roomkey, established in March 2020 as part of the state response to the COVID-19 pandemic, provided non-congregate shelter options, such as hotels and motels, for people experiencing homelessness (California Department of Social Services 2022). Homekey supported CoCs to acquire these and other properties for conversion into interim and permanent housing for people experiencing homelessness (California Department of Housing and Community Development 2022b).

explore in Chapter 3), those subpopulations deemed most in need of housing. As described above, these include people experiencing *chronic* homelessness, per the HUD policy for PSH eligibility (U.S. Department of Housing and Urban Development 2015a), and thus, by definition, individuals also need to be living with a disability. In addition to prioritizing people experiencing chronic homelessness, the CE process seeks to prioritize people who are more likely to need some form of assistance to end their homelessness or who are more vulnerable to the effects of homelessness. In practice, therefore, HUD has asked communities to use *health-related* guidelines when considering how to prioritize people for housing and homelessness assistance. As **Table 2-1** shows, these include: significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing; high utilization of crisis or emergency services, including emergency rooms, jails, and psychiatric facilities, to meet basic needs; and/or vulnerability to illness or death.

HUD acknowledges that "like the untested predictive value of existing assessment tools, no single scoring or other prioritization method has been proven to reliably predict what housing and supportive services project(s) will end homelessness for a specific person" (U.S. Department of Housing and Urban Development 2017c:41). However, homelessness response systems have largely used the VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance Tool) to assess, prioritize, and match households to housing (National Alliance to End Homelessness 2022c).[6] The VI-SPDAT was created in 2013 when the Community Solutions' VI (Vulnerability Index) tool was merged with the OrgCode's SPDAT (Service Prioritization

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[6] OrgCode Consulting discontinued the VI-SPDAT at the end of 2020 (OrgCode Consulting, Inc. 2020). OrgCode expressed concern that communities relied solely on the VI-SPDAT to make resource allocation decisions—a problematic practice given evidence that it contributes to disparities by race, gender, and age and therefore, inequitable access to housing (Wilkey et al. 2019, Cronley 2020)—rather than using it as one component in a process to inform/guide decisions on program placement (OrgCode Consulting, Inc. 2020). Nonetheless, the VI-SPDAT continues to be one of the most widely used tools among CoCs to prioritize housing services.

Decision Assistance Tool) Prescreen tool (National Alliance to End Homelessness 2022c).

TABLE 2-1: HUD Definitions of Chronically Homeless, Disability, and CE Priority Categories

Chronic Homelessness (U.S. Department of Housing and Urban Development)	A ‘‘chronically homeless’’ individual is defined to mean ● A homeless individual with a disability as defined in section 401(9) of the McKinney-Vento Assistance Act (42 U.S.C. 11360(9)), who: ○ Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter, and ○ Has been homeless and living as described for at least 12 months* or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described. ● An individual who has been residing in an institutional care facility for less, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria of this definition before entering that facility; or ● A family with an adult head of household (or, if there is no adult in the family, a minor head of household) who meets all of the criteria of this definition, including a family whose composition has fluctuated while the head of household has been homeless.
Disability (U.S. Department of Housing and Urban Development 2009)	The term “homeless individual with a disability” means an individual who is homeless, as defined in section 103, and has a disability that: 1. a. is expected to be long-continuing or of indefinite duration; b. substantially impedes the individual's ability to live independently; c. could be improved by the provision of more suitable housing conditions; and d. is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post traumatic stress disorder, or brain injury;[7] 2. is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or 3. is the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency for acquired immunodeficiency syndrome.
CE Priority Categories (U.S. Department of Housing and Urban Development 2015b)	In addition to prioritizing people experiencing chronic homelessness, the coordinated entry process prioritizes people who are more likely to need some form of assistance to end their homelessness or who are more vulnerable to the effects of homelessness. When considering how to prioritize people for housing and homelessness assistance, communities can use the following: ● Significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing; ● High utilization of crisis or emergency services, including emergency rooms, jails, and psychiatric facilities, to meet basic needs ● The extent to which people, especially youth and children, are unsheltered ● Vulnerability to illness or death ● Risk of continued homelessness ● Vulnerability to victimization, including physical assault or engaging in trafficking or sex work

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[7] The statutory (versus regulatory) definition of chronic homelessness also requires that “the individual or family has a head of household with a diagnosable substance use disorder, serious mental illness, developmental disability, posttraumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability.”

The VI-SPDAT tool “highlights areas of higher acuity” through the assessment of the health and social needs of individuals experiencing homelessness. Points allocated are based on four domains: history of housing and homelessness, risk, socialization and daily functions, and wellness (see **Table 2-2**) (OrgCode Consulting Inc. and Community Solutions n.d.). The Wellness domain inquires about physical health, mental health and substance use, medications, and experiences with abuse and trauma. The physical health domain asks specific questions about the presence of chronic health issues (liver, kidney, stomach, lungs or heart as well as HIV/AIDS), physical disabilities that would limit living independently, care-avoidance when feeling sick, and pregnancy. Respondents are also asked if they have ever had to leave a place of residence because of their physical health. The substance use domain asks two questions about whether alcohol or drug use has impacted, or will impact, one’s ability to stay housed. The mental health domain similarly asks if a mental health issue, head injury, or learning disability, developmental disability, or other impairment has impacted, or will impact, one’s ability to stay housed or live independently. Respondents who have physical, mental, *and* substance use issues are considered tri-morbid and allocated an extra point. Two questions inquire about one’s refusal to take medications and not taking medications as prescribed or selling medications. The final section asks one question about whether the respondent feels like their current period of homelessness was caused by an experience of emotional, physical, psychological, sexual, or other type of abuse or trauma. Out of the total points a respondent can receive on the VI-SPDAT, over one-third (6 out of 17 or 35%) come from assessments of wellness.[8]

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[8] If a respondent receives 0 to 3 points, “no housing intervention” is recommended; scores of 4 to 7 receive an assessment for Rapid Rehousing; and scores of 8 or more are assessed for Permanent Support Housing (PSH) or other Housing First interventions (OrgCode Consulting Inc. and Community Solutions n.d.).

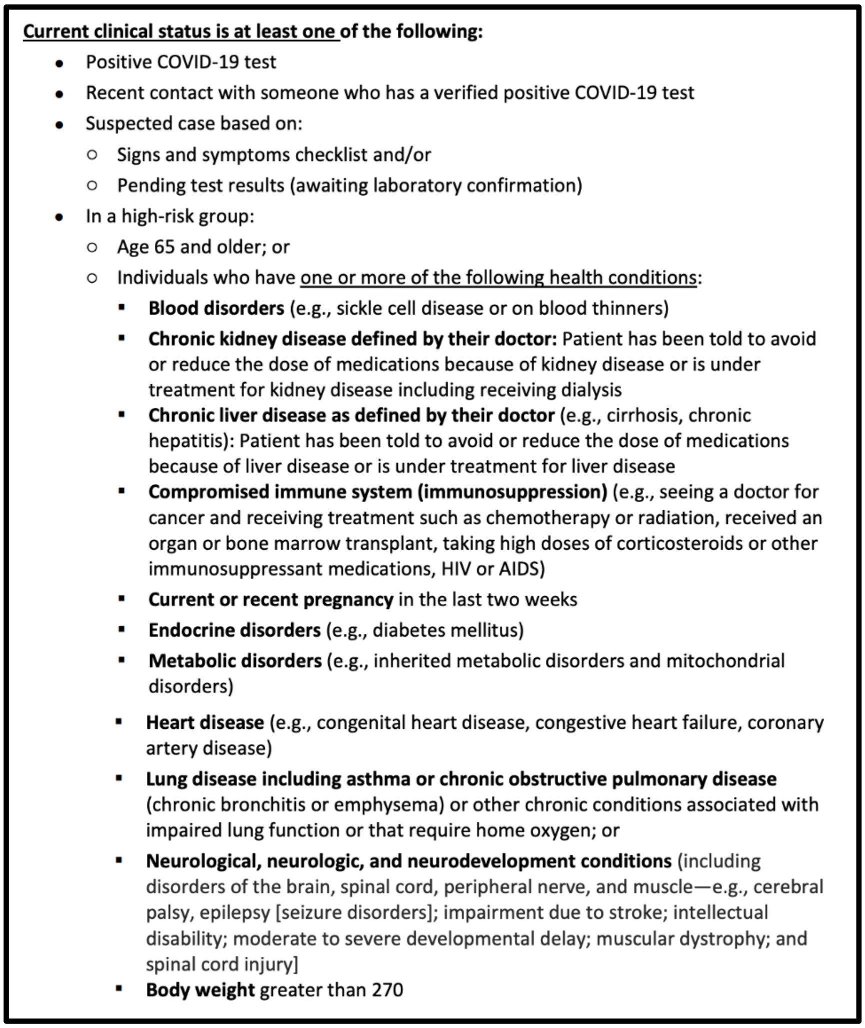
TABLE 2-2: Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) Domains

Domain	**Sub-domains**	**Points Allocated**
Age	60 years of age or older	1
History of housing and homelessness	Location slept (e.g., shelter, outdoors); length of time since lived in permanent stable housing; number of times homeless in past three years	2
Risks	Emergency service use (e.g., hospital, mental health crisis); risk of harm to self or others; legal issues; risk of exploitation	4
Socialization & Daily Functioning	Money management; daily activity; self-care; social relationships	4
Wellness	Physical health; mental health; substance use; medications; abuse and trauma	6

The COVID-19 Pandemic: Individualized Metrics of Risk and Narrow Interpretations of Medicalized Need

A second key factor that ushered in a renewed emphasis on health in housing assessment was the COVID-19 pandemic. The Centers for Disease Control (CDC) and the Federal Emergency Management Agency (FEMA) provided emergency housing during the pandemic for those who met certain criteria (California Department of Social Services 2020). Clients needed to be living with specific illnesses based on public health guidance and risk of COVID-19 including contracting or being exposed to COVID-19, or underlying health conditions, such as respiratory issues, compromised immunities, or chronic disease.

However, as **Figure 2-1** shows, in practice, the criteria were not so straightforward, with a lengthy list of possible conditions whose documentation and veracity required burdensome and bureaucratic processes (California Department of Social Services 2020:12). FEMA's narrow eligibility criteria proved to be a significant challenge for local officials and homeless service providers. As the next section will show, the strict eligibility criteria prevented individuals from accessing much-needed resources and complicated the process of moving people into hotels. Determining who was eligible was confusing; outreach and eligibility workers spent extra time attempting to find specific people from the sorted lists of eligible individuals which passed up others who were in need and more readily available (National Low Income Housing Coalition 2020).



Current clinical status is at least one of the following:

- Positive COVID-19 test
- Recent contact with someone who has a verified positive COVID-19 test
- Suspected case based on:
  - Signs and symptoms checklist and/or
  - Pending test results (awaiting laboratory confirmation)
- In a high-risk group:
  - Age 65 and older; or
  - Individuals who have one or more of the following health conditions:
    - **Blood disorders** (e.g., sickle cell disease or on blood thinners)
    - **Chronic kidney disease defined by their doctor:** Patient has been told to avoid or reduce the dose of medications because of kidney disease or is under treatment for kidney disease including receiving dialysis
    - **Chronic liver disease as defined by their doctor** (e.g., cirrhosis, chronic hepatitis): Patient has been told to avoid or reduce the dose of medications because of liver disease or is under treatment for liver disease
    - **Compromised immune system (immunosuppression)** (e.g., seeing a doctor for cancer and receiving treatment such as chemotherapy or radiation, received an organ or bone marrow transplant, taking high doses of corticosteroids or other immunosuppressant medications, HIV or AIDS)
    - **Current or recent pregnancy** in the last two weeks
    - **Endocrine disorders** (e.g., diabetes mellitus)
    - **Metabolic disorders** (e.g., inherited metabolic disorders and mitochondrial disorders)
    - **Heart disease** (e.g., congenital heart disease, congestive heart failure, coronary artery disease)
    - **Lung disease including asthma or chronic obstructive pulmonary disease** (chronic bronchitis or emphysema) or other chronic conditions associated with impaired lung function or that require home oxygen; or
    - **Neurological, neurologic, and neurodevelopment conditions** (including disorders of the brain, spinal cord, peripheral nerve, and muscle—e.g., cerebral palsy, epilepsy [seizure disorders]; impairment due to stroke; intellectual disability; moderate to severe developmental delay; muscular dystrophy; and spinal cord injury]
    - **Body weight** greater than 270

FIGURE 2-1: Medical-Clinical Eligibility to Access Project Roomkey

SURFACE RATIONALITY: SERVICE PROVIDER OPINIONS ABOUT LINKING HOUSING VULNERABILITY TO HEALTH

> *There was this…stratification within the homeless population as to who we could house and who we couldn't, which I really struggled with…it's hard to accept a 30-year-old with asthma over a 63-year-old with a traumatic brain injury and an amputation. That's the situation we were in…Those can be death-producing conditions, but they don't put you at increased risk of death in COVID.*
>
> -Project Roomkey Medical Director

Above, I traced the social history of the incorporation of health and illness into current understandings of homelessness, from the 1980s to the present. Here, I turn to how service providers understand and view these shifts in deservingness in their everyday work and in the lives of their clients. Service providers could see why health and illness came to be important for housing prioritization; however, they argued that this surface logic belied deeper irrationality that passed over some of their clients in dire need of housing, or that allocated housing to them only when they were so sick that they passed away right before or right after the receipt of housing. In this way, service providers revealed the critical point that housing is a sorting and stratifying system that rations a scarce resource with acute consequences.

Service Provider Understandings of the Origins of Health in Assessing Housing Need

Service providers had various understanding about why health and illness domains came to play a larger role in housing eligibility and prioritization. They acknowledged that on its face, prioritizing people living with illness and disability for scarce housing resources made sense. Sonia, a psychosocial services manager, shared that the incorporation of disability criteria didn’t always drive housing placements, but this shift translated into “really important progress in terms of prioritizing people's medical needs." Terrence, a program supervisor, shared that he and his healthcare management team[9] called for Juniper County to add a "medical complexity component" to their CE assessment:

> When I got here 10 years ago, housing was not in the state that it is today…the landscape changed so drastically and fast around us…Originally, there was not a medical complexity component to coordinated entry, so doing things like going to the directors and the executives, the C-suite folks at these respective [county] programs and saying, "Look at our patient population. Look at what they suffer from. Why aren't these people prioritized [for housing]? It's one thing to be homeless, but it's another thing to be chronically ill with all of these issues and homeless."...We were really showing people [at the county] the numbers. For example, I had a patient that had about $4.5 million in ambulance utilization over a year.

Terrence thus leveraged the economic costs of ill health as a commonsense justification to mobilize resources for a specific population of people experiencing complex health and social issues. Nina, a housing social worker working in the healthcare safety net, also pointed to the origins of a construction of housing need and vulnerability based on medical criteria using an economic lens. She highlighted how the motivation for adding medical criteria to housing prioritization systems was not only about meeting patient needs but saving the system money:

> I think the reason why they're doing that [prioritizing the medically vulnerable for housing], it has to do with the cost of healthcare…The managed care programs have driven it where they don't want to pay out. So, they say, "Okay, well, housing is here for the most vulnerable because then they'll stay out of the EDs. They'll stay out of the hospitals if they're housed."

These perspectives mirrored the larger national discourse about why including illness in housing assessment and prioritization made sense: it saves money. However, Nina makes an added critique that the cost savings in fact accrue not necessarily to society, taxpayers, or individual patients, but instead, to insurers.

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[9] Care management programs offer intensive case management and support for patients with complex medical and social needs.

How Medicalized Notions of Housing Need Generates New Forms of Exclusion

Service providers supporting women and families attempting to flee domestic violence in particular were outspoken about how their clients were deprioritized for much-needed housing within the CE system due to the emphasis on illness and specifically, disability. For this reason, a vocal minority of service providers did not support the medical complexity components of CE. Eden, an executive director of a housing organization, explained that while housing organizations were initially included in the county-level redesign process of CE:

> When they developed the [CE] assessment tool to prioritize people I was there saying, "Okay, families need to be prioritized. It looks like you're prioritizing length of homelessness and medical issues. That leaves out families." And the people who were in charge at that point were like, "Well, there already is enough family resources and we need to focus on single people."...Well, in the end, the system didn't work because it prioritized people who were sick on the street…and it left out survivors of domestic violence and families…Healthcare took over the whole system of Coordinated Entry.

More generally, service providers critiqued "eligibility criteria [that] are really specific to certain diagnoses" when the conditions of their patients were "unique" and "complex" and did not fit neatly into the health and illness classifications that helped to determine housing eligibility. Further, the landscape of housing programs for people experiencing homelessness and living with health issues, while designed to serve distinct and specialized needs, resulted in fractured spaces of care by eligibility criteria. Project Roomkey hotels, respites, and skilled nursing facilities (SNF)—three types of facilities that provide varying levels of housing and medical care for people experiencing homelessness[10]—operate strict medical criteria for housing

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[10] While respites are short-term residential care that offer people experiencing homelessness a safe place to recover while accessing medical care and other supportive services (Stevens 2023), SNFs provide 24-hour skilled nursing care and rehabilitative services (California Department of Aging n.d.). SNF residents are generally chronically ill or recuperating from an illness or surgery and need regular nursing care and other health related services but do not need to be experiencing homelessness to qualify. Respites require the resident to be "independent," usually measured by activities of daily living, or ADLs, including the ability to bathe, dress, groom, and eat independently. Many people experiencing homelessness cycle from street to hospital to SNF to respite.

placement. For example, respites do not accept clients who are not fully independent or need support with activities of daily living because they do not provide 24-hour care. SNFs only accept individuals who need consistent nursing care and usually offer only a limited number of beds to people experiencing homelessness (California Department of Aging n.d.; National Institute for Medical Respite Care 2022). Eligibility criteria across housing programs was neither comprehensive nor exhaustive and therefore resulted in certain key groups of vulnerable people falling through the cracks.[11] Victoria, a medical director of a Project Roomkey hotel, described a kind of serial strike-out phenomenon based on what seemed like overly minute exclusion criteria for the hotel she managed:

> So, you can't be admitted if you need ADL [activities of daily living] support. You can't be admitted if you're in a wheelchair. You can't be admitted if you have cognitive decline, or you have a behavioral health problem that requires some intervention occasionally. Or you can't be admitted if you've got a substance abuse disorder. And so there's all these barriers set up to entry…There's no end goal in that cycle where people get stuck between hospitalization and skilled nursing facilities and the street.

While on the surface these guidelines and criteria make sense—"to protect human life and to minimize the strain on the healthcare system capacity during the COVID-19 pandemic" (California Department of Social Services 2020:12)—service providers like Victoria pointed to the kinds of clients who end up overlooked:

> We had to turn away a ton of people because we could only house the ones that CDC said were at an increased risk of COVID…There's so many people that we didn't get housed…like [those with] traumatic brain injury, which is like a fairly common thing that you would expect [with] any kind of time in homelessness. Or you have a substance abuse disorder…People who have traumatic brain injuries shouldn't be on the street … I don't think anyone's going to argue that that's not the case. But we couldn't house them in this program. Or like any kind of trauma, any kind of trauma from—so like wounds, that's another one where people have really awful wounds that they can't get healed because they're in a wheelchair and they live in a tent, and they need wound care, and

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[11] In Chapter 4, I discuss how the siloed landscape of diagnosis-dependent housing, while tailored to provide targeted levels of care based on specific medically defined criteria and needs, resulted in fragmented systems of care and residential instability for some clients.

> they need to be dry, and they need to have clean clothes. You know, those can be death-producing conditions, but they don't put you at increased risk of death in COVID, technically. So, there was this… stratification within the homeless population as to who we could house and who we couldn't, which I really struggled with. I mean, I would like to house everybody… It's hard to accept a 30-year-old with asthma over a 63-year-old with a traumatic brain injury and an amputation. That's the situation we were in.

Service providers understood the logic behind the eligibility criteria for emergency COVID housing, where people living with conditions like obesity, diabetes, lung issues, and chronic obstructive pulmonary disease were at higher risk of contracting and developing complications of COVID-19. For example, Nick, a behavioral health social worker, could see that it made sense to prioritize a client with congestive heart failure (CHF) for Project Roomkey housing: they would be more vulnerable to COVID-19, and additionally, if they were on Lasix (a diuretic commonly prescribed to treat fluid retention in CHF), they would need access to a bathroom and consistent coordination and access to food and medication. In contrast, he said, "Schizophrenia didn't qualify you to get into the [Project Roomkey] hotels in the same way that like a recent stroke and heart failure would…To my knowledge, schizophrenia on its own doesn't put you at higher risk of dying of COVID." But as he thought further, "perhaps [schizophrenia] does [put you at higher risk] because you don't wear your mask, or don't understand what's going on in that regard, and obviously serious mental illness leads to chronic health conditions." The scatter-plot rationality of medical criteria for Project Roomkey hotels thus put providers in moral quandaries. When I asked Nick how he felt about the Project Roomkey inclusion/exclusion criteria, he took a long pause before answering, "It's really hard to know." Service providers expressed frustration and sadness in turning people away from housing, their hands tied by seemingly arbitrary conceptions of who was worthy of housing.

Selma, a housing navigator, shared that merely living in an encampment did not provide her client access to Project Roomkey housing. While living in an encampment satisfied the criteria of “living in a precarious living situation,” it was not until her client developed a chronic health condition on the “Clinical Criteria” list a whole year into the pandemic that she was able to refer her client to a Project Roomkey hotel and secure them a housing placement. But had Selma’s client been offered housing earlier, they may not have developed the chronic health condition in the first place.

“Dying in Limbo”

Service providers argued that an emphasis on illness and disability in definitions of housing need, while important for the prioritization of clients who are currently very sick and vulnerable, was operationalized in ways that did not come soon enough nor were sensitive enough to identify those who need housing now to avoid death in the near to midterm. In other words, the criteria were predicated on a sense of emergency, imminence, and visibility, obscuring the greater pool of individuals who needed housing. Multiple providers pointed out that a system set up to save the greatest amount of costs by prioritizing the highest-acuity clients meant that some clients passed away right before or just after they moved into permanent housing. Alysia, a street medicine social worker, shared her experience:

> I understand the thought process, trying to house the sickest of the sick people. However, I have had a lot of people die before they get their housing. They get a match, we've got the documents in, we're just waiting to hear back from the apartment complex and they die before that process is finished. And I've also had people who will get housed, a few weeks or months later they will die. And I think that that is something that isn't said. But it's part of the, you get someone housed with the idea that they're going to die in a few months.

Another service provider, Ryan, a housing program manager, shared a similar sentiment:

> We're plucking people right off the top of who are the most vulnerable, which I'm hoping that is the best way of doing this but noticed that some people die right before they get housed. We just had a client, they just got linked to [permanent supportive housing for

> seniors], which is a new property that keeps getting postponed. They got matched to this unit to move in and they just passed away…They're linked to the unit, but they died right before. I've seen that happen multiple times, it's so close to getting them off the streets and something like that happens.

Relatedly, Eden, a housing director, relayed that the phenomenon of clients dying soon after being housed was a product of their vulnerability of living on the street and a definition of need that was too blunt to catch those at imminent risk of death.

> I think that the pandemic really [shined] a light on the vulnerability of homeless folks on the street…When we put all those people from the street from [city] into housing many of them die within six months, many of them.

These situations led some providers to wrestle with their own quasi-economic analyses, not just from the perspective of paying for housing to potentially save on healthcare, but also weighing the return on housing someone in terms of longevity. Zach, a housing outreach case manager, shared:

> I don't think there's an easy answer. Is a 55-year-old who's been homeless for 30 years, are they more deserving? Are they likelier to cost the system more?…It's a philosophical question. If you can put a 30-year-old and save them from 25 years of misery, do you do that or do you want to try to let someone die if they're 50 years old and they've been homeless for a long time, they're probably not going to live to be 70.

Many service provider participants felt very torn by the prospect of prioritizing some clients over others, and that they should not be put in a position of choosing one client over another for housing. Diane, a nurse coordinator working with a street health team, summarized:

> I think it's really difficult to actually rank people as who is in need the most. I understand the need for some way to just filter out the less chronically homeless, the more acute homeless, the younger patients. But in the same way, I don't think those people are less deserving of housing. So, that's hard.

Susan, a housing attorney and navigator, agreed:

> The problem is that we have a very limited resource and there is this big, administrative process to try to figure out how to distribute it to the most vulnerable people first. It is not

> a random process. They have an algorithm, and they try to prioritize people who are elders or people who have really, really severe conditions. I don't know. I mean everybody deserves housing. I think we are in an emergency and maybe it does make sense to prioritize people who are, for a lack of a less horrible way to say it, who are the most at risk of dying on the street, people with really serious chronic illnesses, people who are elders…I guess it does make sense to distribute it that way, but it's awful when I have to tell people.

Ultimately, service providers like Sonia, a psychosocial services manager, stressed that while health and illness criteria are valuable metrics, medicalized notions of need do not help to solve the enduring question of who is most deserving:

> I mean, it's such a tricky question… it's this like, Sophie's Choice situation of having to even prioritize people. And it's a horrible situation to be in…Yes, I think healthcare, health diagnoses, health utilization is very valuable information to help inform prioritization for housing… it's an imperfect solution to an impossible situation.

Ben, a housing program manager, questioned what the prioritization criteria communicated to people experiencing homelessness and the risks some may take to be placed in housing:

> It's like if you don't have a serious chronic illness but you become homeless, does that mean you're not worthy and we don't care about you? Do you do something to harm yourself such that you do have a chronic, serious, long-term illness such that you do then qualify for housing services?...It feels like yes, maybe a short-term solution now to help support people who are living outdoors and who are really sick get housing, but that also doesn't necessarily get us out of the way housing is prioritized right now where those folks should probably already be prioritized on the [CE assessment].

Service providers argued that a model of housing that prioritized those who were *already* sick was inherently a reactive one, moving our gaze away from preventative approaches to homelessness. Doris, a community health outreach worker, commented,

> I feel like a lot of the focus is on acute situations. Like, "Hey, this person is sick right now. They're really, really sick. And they really need a place"…We certainly need to find housing now to prevent them from getting worse.

But as they pointed out, this was "focusing on the...burning fires instead of preventing the fires from happening in the first place." An alternative could be to "think[] upstream, like, "Hey, eventually this person might, or will get sick or they're not going to get better," right?... focus more on the upstream like prevention."

An even more fundamental critique providers articulated was the constructed nature of the problem: the scarcity of affordable housing was not inevitable. Thus, housing medically vulnerable people was only a short-term solution; truly long-term solutions should focus on increasing the supply of housing, as Allison, a housing program manager, described:

> I feel not good about making an assessment or judging [who is deserving of housing] in a sense. We're in the system of completely fabricated scarcity. If the government just cut the military budget a little bit, we wouldn't have any of these things. So, I get really hung up on feeling frustrated about the system and I would hate to be one of the people in the county [who] has to make a decision about how to do the [CE] assessment because you're just rationing insanely scarce resources for a human rights crisis. I have no idea how anyone makes it. I don't love the [CE] assessment, but I also don't blame [it]. It's such a terrible system.

Sonia notes that, in the absence of housing as an entitlement, service providers will continue to operate in the context of scarcity.

> It's such a messed up setup. Everyone deserves safe and affordable housing, and we are operating in such a space of scarcity … we shouldn't even be in this circumstance…So it's kind of an impossible situation.

Across the board, service providers pointed to how the supply of affordable housing continues to fall woefully short of need. As Ben shared:

> My worry is that if we focus on things, by depoliticizing the need for affordable housing on a broader scale, what kind of message do we send … To me this all goes into supply of affordable housing units and that, to me, seems to be like the huge bottleneck here, is that there is just not enough supply to meet demand and what are the tactics that we need to do to increase supply.

Despite these deep and fundamental misgivings about the very system in which they had to work, at the end of the day, service providers acknowledged that they were a part of this housing sorting and stratifying system. In the next chapters, I explore how they did this work, and the ways in which they sought flexibility and resisted categories of prioritization with *technology* (Chapter 3) or reinforced biomedical criteria as the appropriate and legitimate sorting mechanisms to determine housing worthiness through *discursive* work (Chapter 4).

CONCLUSION

In this chapter, I provided a brief social history of the understandings of homelessness and the incorporation of health and illness as central components and operationalizations of homeless need and vulnerability. I argue that the emergence of the Coordinated Entry (CE) system in 2012 and the COVID-19 pandemic herald a new era in understandings of homelessness, one that highlights a formidable return to medicalized notions of housing need. I also described how service providers understood this shift in deservingness. While service providers could see why health and illness came to have renewed importance for housing prioritization, they argued the surface logic belied a deep irrationality: namely, some clients in dire need of housing were sorted out by strict eligibility criteria or were allocated housing only when they were so sick that they passed away right before or just after the receipt of housing.

Diffuse and confusing constructions of deservingness coupled with narrow operationalizations of housing need and vulnerability had several high-stakes, even life-and-death consequences. First, households that did not meet and retain the coveted homelessness status necessary to access the services system—because they moved in and out of complex, mutable, and heterogeneous states of homelessness—were turned away with an implicit message that their situation needed to become more dire to access, and be deserving of, housing and services. Second, these processes render invisible the social, political and economic circumstances in which individuals who experience housing insecurity are situated. When narrow categories of housing insecurity and homelessness become naturalized in programs, policy, and processes, they obscure the cumulative and life-course effects of racialized, gendered, and classed housing (and health) histories. Divorcing housing insecurity and homelessness, as individual characteristics, from the conditions that shape the provision of and access to housing displaces a focus from the *structural* conditions of housing that produce vulnerability, suffering, and illness to a singular focus on *individuals* who experience housing insecurity themselves. This process also displaces attention to singular, static events. In this way, households experiencing homelessness who do not meet narrow operationalizations are sorted at the outset. I will show in subsequent chapters how households are further sorted in ways that shape their housing and health trajectories.

CHAPTER THREE: SURFACING DISABILITY IN TECHNOLOGIES OF COORDINATED ENTRY

INTRODUCTION

The housing and services available to people experiencing or at risk of homelessness are coordinated by Continuums of Care (CoCs), regional or local planning bodies responsible for the coordination and management of homelessness response systems (U.S. Department of Housing and Urban Development 2017b).[1] Each CoC is federally mandated to establish a Coordinated Entry (CE) system[2] whose purpose is to assess the needs of households[3] experiencing homelessness, identify the most vulnerable households through prioritization, and connect them to housing and services (U.S. Department of Housing and Urban Development 2015a).[4] Communities often do not have or do not allocate the resources necessary to provide housing to every household experiencing homelessness; thus, the introduction of CE systems in 2012 sought to centralize homeless services and allocated housing based on vulnerability and need.

In the last chapter, I described how conceptions of housing need and vulnerability sort and stratify access to housing. I argued that while definitions of homelessness—and specifically

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[1] Continuums of Care (CoC) are defined by the U.S. Department of Housing and Urban Development (HUD) and include "representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons" (U.S. Department of Housing and Urban Development 2017b). California is divided into 44 CoCs.

[2] CE is also referred to as CES or Coordinated Entry System.

[3] I use HUD's definition of household which is "any configuration of persons in crisis, whatever their age or number (adults, youth, or children; singles or couples, with or without children)." Therefore, in this paper, I use individuals and households synonymously. Families or households with more than one person have access to CE if the head of the household is eligible and meets criteria for access to CE (U.S. Department of Housing and Urban Development 2017c:6).

[4] Programs and projects that receive funding from the HUD CoC Program and the Emergency Solutions Grant (ESG) Program as well as state- (e.g., Homekey) and county-level programs are required to participate in CE and use the Homeless Management Information System (HMIS), the County-wide data system used for all CE activities.

the return of health and illness criteria—seek to identify some of the most vulnerable people experiencing homelessness and match them to housing, such definitions stratify and ration scarce housing resources in ways that create new tiers of housing need and vulnerability and generate additional forms of exclusion. In this chapter, I turn my focus to the CE technology and its service provider[5] users. While CE is considered the "front door" and central organizing feature of the homelessness response system in most CoCs, including Juniper County,[6] research on how CE works to sort people experiencing homelessness and allocate housing is understudied (Ecker et al 2022). I contribute to filling this gap by considering the CE system and the service providers who use it as an assemblage of human and non-human actors (Latour 1987) and trace how, in its efforts to prioritize housing to those who ostensibly need it most, this assemblage incentivizes the demonstration of disability. In what follows, I first review the literature on algorithms of discretion and oppression, street-level bureaucracy theory, and the quantification and classification of everyday life, and then present my findings.

Much has been written about how the growing availability of individual-level data and individual assessments of risk, characteristics of the neoliberal era, which have helped fuel the quantification of everyday life (Mennicken and Espeland 2019). With big data, both government and private institutions create complex and often opaque technologies based on algorithms, or rules written into software, to predict behavior and based on these predictions individuals are offered different prices, services, and terms to maximize profit or control (Kiviat 2019). Institutions have long used personal records of people's pasts to make risk calculations or

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[5] I define service provider as an individual who works for a governmental or nongovernmental public service program that offers information, benefits, resources, services and/or referral around a host of basic human needs, including food security, housing and homelessness, healthcare, and welfare. As described in more detail in the methods, I recruited service providers who worked in housing and healthcare organizations and institutions though many service providers I observed and interviewed provided a wide range of social services.

[6] A pseudonym for a county in California where I conducted my research. See Chapter 1 for a detailed description of my methods.

assessments, and increasingly do so with algorithms. Algorithms are often proprietary, challenging our ability to fully understand and assess them.

The U.S. credit market, access to education, funding of public policies, and financial and healthcare algorithms classify individuals and produce decisions based on indicators, rankings, and numerical thresholds. According to Fourcade and Healy (2013), scoring technologies work to split and sort people into "classification situations," or *artificially* generated positions in market technologies (e.g., credit market), which structure life chances. They argue that society is becoming a "world of scores rather than classes" where individuals who do not possess the desired personal, financial, social or political score may suffer punishment and exclusion (Fourcade & Healy 2013:568). In this way, numbers are given great authority and power.

There is mounting scholarship that the quantification of everyday life and specifically data-fed algorithms allocate costs, opportunities, and burdens of a given market in ways that result in stratification and social inequalities; that is, algorithms privilege whiteness and (re)produce racial, gender, and health disparities (Barocas et al 2016; Noble 2018; Benjamin 2019; Obermeyer et al. 2019; Kiviat 2023). Indeed, algorithms shape high-stakes, institutional decisions from who gets hired or admitted to school to who should (or will) go to jail or receive scarce public benefits (Datta 2015; Angwin 2016; Noble 2018; Benjamin 2019). In the U.S., healthcare organizations and payers use algorithms to target "high-risk" patients for care management programs to reduce costs associated with acute healthcare utilization and improve health through better care coordination (Hong et al 2014; McCall et al 2010; Hsu et al 2017). In their analysis of a nationwide commercial prediction algorithm used to identify and help patients with complex needs, Obermeyer and colleagues (2019) find evidence of racial bias resulting in a significant reduction in Black patients identified for extra care compared to white patients.

In housing, and specifically tenant screening, landlords and property managers have long assessed tenant risk by consulting credit reports, criminal records, and eviction histories using rule-based algorithms paired with more traditional methods of judgment. Kiviat (2023), in interviews with landlords, property managers, and executives at real estate and tenant screening companies, shows how algorithms shape the way landlords make exceptions for bad background checks, arguing that "algorithms do not erase discretion, only relocate it." Similarly, Eubanks (2018:178) reminds us that "digital tools are embedded in old systems of power and privilege" and behind every algorithm is human input and decision making.[7]

A growing body of work finds that CE technology broadly, and their assessment tools and algorithmic prioritization processes specifically, contribute to disparities by race, gender, and age and therefore, inequitable access to housing (Wilkey et al. 2019; Cronley 2020). Several studies have examined the widely used tool for CE assessment, the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT), and how it triages households to housing and other supportive services (OrgCode Consulting Inc. and Community Solutions n.d.). Because the VI-SPDAT has been the most widely used tool among CoCs to prioritize housing services, communities have needed to confront both empirical and ethical questions about what should count as risk, who should get services first, and who should receive what (Shinn and Richard 2022). Wilkey and colleagues (2019) find that white individuals and families have statistically higher mean prioritization scores for permanent supportive housing (PSH) than their BIPOC counterparts. Likewise, Cronley (2020) finds that white women scored consistently higher on vulnerability in the VI-SPDAT compared to all men and Black women despite both

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[7] Less scholarship points to how algorithms might reduce inequities. However, Robinson (2022) shows how a community of patients, clinicians, scientists, public officials, and advocates collaborated to build a new transplant matching algorithm—a system to offer donated kidneys to patients from the U.S. national waiting list—in a more inclusive, accountable way.

Black and white women reporting similarly higher odds of experiencing homelessness due to a history of trauma and abuse. Similar concerns about the racial biases of the VI-SPDAT have been expressed among Indigenous people and Indigenous service agencies in Canada (Bomberry et al. 2020) and disparities based on age have also been observed: one study found that younger white men were disproportionately prioritized for housing referrals using the VI-SPDAT (U.S. Department of Housing and Urban Development 2021a). Two additional studies find that, while the VI-SPDAT may be an important tool for communities working to end homelessness, high VI-SPDAT scores do not always equate with vulnerability or need; both studies conclude that further testing and development of the VI-SPDAT is necessary (Brown et al 2018; Balagot et al 2019). Ultimately, these concerns led the creators of the VI-SPDAT to discontinue its use at the end of 2020 (OrgCode Consulting, Inc. 2020). But because HUD does not endorse a specific assessment tool or approach (U.S. Department of Housing and Urban Development 2017c:30) and each community continues to have flexibility in how they collect and document need and implement their prioritization system, many continue to use the VI-SPDAT. Within most CE systems, people who are experiencing chronic homelessness—defined as homelessness for at least a year, or repeatedly, while living with a disability—are prioritized for housing. In other words, households with the longest histories of homelessness and the highest barriers to housing, including disability, have the highest priority for housing resources.

In this chapter, I explore an unexamined mechanism in the sorting and stratifying of housing opportunities: the assemblage of the CE technology with its service provider users. Specifically, I highlight how service providers implement specific strategies in conjunction with their use of the CE system to *surface disability* for clients[8] and especially for households who may feel stigmatized for sharing sensitive experiences, histories, and diagnoses. Notably, and especially pertinent to this chapter's findings, studies find that the reliability and validity of any CE technology (including the VI-SPDAT) are likely contingent on service provider training, implementation, and administration as well as client "reluctance to respond accurately to the measure" (Brown et al 2018:115). Specifically, Balagot and colleagues (2019) report that clients who knew their case manager upon enrollment in CE were more likely to establish eligibility than those who did not know their case manager.

This research underscores the importance of frontline service providers in the CE process and comports with extensive sociological work that examines how policy regimes are implemented by frontline workers and other gatekeepers within and outside social institutions (Lipsky [1980] 2010, Soss 2000). Such scholarship shows how frontline workers have discretion in their decisions about when and how to impose sanctions, or financial penalties, for client failure to comply with federal assistance program rules and regulations[9] (Korteweg 2003; Schram et al. 2009; Fording et al. 2013; Pavetti 2018). Street-level bureaucracy theory (Lipsky [1980] 2010) recognizes that individual actors function as policy decision-makers due to their positioning embedded within large public bureaucracies. This line of scholarship places social workers, police officers, teachers and other frontline workers in organizational contexts where

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[8] In this chapter and dissertation, I use the term "client" broadly to include any individual, or head of household, experiencing homelessness or housing insecurity and working with a service provider to secure housing, including those described as "patients" primarily by providers of housing services working in the healthcare safety net.

[9] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) abolished the main cash assistance program for low-income families, Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance for Needy Families (TANF). The TANF program included certain policy measures to help achieve the goals of welfare reform, and President Bill Clinton's promise to "end welfare as we know it," such as time limits, work requirements, and sanctions (benefits reduced or eliminated) for failure to comply with TANF rules.

their relationships with their supervisors, managers, peers, and clients shape, and are shaped by, their everyday mundane decisions and actions.

Likewise, scholars of poverty and inequality have shown the critical role of landlords and other supply-side actors as gatekeepers in selecting tenants “in” (Rosen 2014) or “out” (Pager and Shepherd 2008; Desmond 2012; Desmond 2016; Mallory and Sears 2016; Korver-Glen 2018; Sullivan 2018; Garboden and Rosen 2019), sorting them into different kinds and quality of housing and different neighborhoods. Further research describes the importance of “intermediaries”—actors situated between housing agencies and clients such as caseworkers and social service providers—to interpret and activate categories of deservingness on behalf of clients (Rita et al. 2022). Indeed, the space where benefits and punishments are defined, negotiated, and contested in the social safety net is the point of contact between the state and individual, or frontline worker and citizen-client (Soss 2000). Therefore, it is critical to present the understandings, experiences, and actions of service providers who actually use CE for housing prioritization.

My findings are organized into two sections: First, I describe the Coordinated Entry (CE) system in Juniper County with specific attention as to how households are assessed, prioritized, and matched to housing. I describe two features of the CE system technology that sorted households in or out of housing, leading to substantial distrust in the system that service providers were required to use. Faced with a prioritization system that did not seem to work well, and in an effort to rectify some of the problematic features of CE, I show in the second section how service providers used their limited but important levels of discretion to work the CE system, with the explicit intent to align housing assessment, prioritization, and receipt in ways that better reflected their own evaluations of actual client need. Through the deployment of four distinct strategies, service providers leveraged the disability section of the CE assessment to ensure their clients, including those who were living with a disability but who were not classified as disabled, were not left out. I conclude by discussing the implications of these findings for service providers, clients, and technologies of prioritization.

DISTRUST OF CE TECHNOLOGY

Households that meet the U.S. Department of Housing and Urban Development (HUD) definition of literal homeless[10] have access to CE through certain access points[11] where they are administered an assessment of their needs, vulnerability, and preferences (U.S. Department of Housing and Urban Development 2017c:7). Assessments include questions about prior living situation, length of time homeless, household information (e.g., number and age of household members), income, health, disability, housing barriers (e.g., eviction, arrests and convictions), and exposure to, and risk of, violence.

Generally, portions of the assessments are weighted and assigned points which lead to a single score per assessment using a standard scoring method. In this way, the collection of very personal information is quantified and reduced to a single score. Based on the score, a

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[10] Literal homeless, or homeless, is defined by HUD as lacking a fixed, regular, and adequate nighttime residence. Literal homelessness includes places not meant for human habitation (e.g., street, car); publicly or privately operated temporary shelters or temporary housing (e.g., congregate shelters, transitional housing, subsidized hotels/motels); or institutions (e.g., jail, hospital, inpatient treatment center) where the individual has resided for 90 days or less and who met the definition of homeless prior to entering that institution. This definition of homelessness does not include people living "doubled up" with friends or family, or people paying to live in hotels/motels. However, the definition does include people living in vehicles, including trailers and RVs (U.S. Department of Housing and Urban Development 2017b).

[11] In Juniper County, households that meet the HUD definition of literal homeless have access to CE through certain access points which include Housing Resource Centers (HRC), physical sites that offer in-person and virtual CE services, as well as street health teams and some hospitals, mental health clinics, and schools. Juniper County also uses 2-1-1, a 24/7 call center that connects people with HRCs. Access point staff are trained and licensed to use the Homeless Management Information System (HMIS), the County-wide data system used for all CE activities.

household's level of vulnerability or need is ranked relative to other households (U.S. Department of Housing and Urban Development 2017c:40-41). However, HUD acknowledges that "like the untested predictive value of existing assessment tools, no single scoring or other prioritization method has been proven to reliably predict what housing and supportive services project(s) will end homelessness for a specific person" (U.S. Department of Housing and Urban Development 2017c:41).

Some CoCs maintain a single, centralized priority list of all households experiencing homelessness who have been assigned a score. Other CoCs maintain distinct queues by housing resource (e.g., shelter, rapid rehousing[12]) and/or population (e.g., families with children, people living with HIV/AIDS) that correspond to differences in housing inventory specific to the housing type or subpopulation. Each queue has a unique threshold based on current and anticipated housing inventory (supply), the estimated number of eligible households (demand), and the number of referrals that are typically needed to fill an opening. An assessment score above the threshold qualifies the household to be added to the respective queue and therefore, prioritized for housing in that queue.[13]

Communities have flexibility in how they implement their prioritization system, including the assessment tool used to collect information, document need, and prioritize households. While Juniper County uses a custom prioritization tool where questions are phrased, weighted, and scored differently than the VI-SPDAT, it serves the same function as the VI-SPDAT in that it uses an algorithm to assess individual-level vulnerability. The factors that

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[12] Rapid rehousing (RRH) is time-limited rental assistance and services (usually up to 24 months) (U.S. Department of Housing and Urban Development 2024d).

[13] Within a queue, subpopulations may have different threshold scores because resources of certain subpopulations (e.g., families with children, veterans, people living with HIV/AIDS) may be more plentiful relative to other groups. The County CoC adjusts thresholds based on increases or decreases in inventory as well as referrals.

establish an assessment score are shared on the county website—for example, individuals with higher healthcare service use and greater physical, mental, and behavioral healthcare needs are assigned more points. However, the exact weights assigned to each assessment question and the scoring method are not publicly available.[14] Nevertheless, the CE assessment tool used to prioritize households is designed to be "objective" and rational, as explained by Irene, a housing program director:

> The [CE assessment] is…designed to provide an objective way to prioritize people for housing resources and asks questions about disability, about housing barriers, about household makeup so that people can also be matched to the right type of resource, the right size of unit. That is the tool that's been used to prioritize people for housing.

After an assessment is conducted, Juniper County staff can immediately see a client's CE score. Households with scores below a given threshold are told that housing is unlikely and referred back to housing problem solving.[15] Households that score above the threshold are assigned to one of Juniper County's two queues: If a score is above the Assessment 1 threshold score, the household is added to Queue 1 for emergency shelter, transitional housing, or safe parking.[16] If a household scores above the higher Assessment 2 threshold score, they are added to Queue 2 for time-limited subsidized housing (such as RRH) or permanently subsidized housing.[17] The highest scoring Queue 2 households—those who have experienced homelessness

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[14] According to HUD, prioritization policies must be documented and publicly available in each CoC: "Prioritization must be based on a specific and definable set of criteria that are made publicly available through the CoC's written prioritization standards and that must be applied consistently throughout the CoC. CoCs should refer to the 2016 Prioritization Notice for detailed guidance on prioritizing in PSH projects…Written policies and procedures must include the process by which the CoC staff will make prioritization decisions for each project type (e.g., PSH, RRH) and the criteria used for prioritization decisions" (U.S. Department of Housing and Urban Development 2017c:40).

[15] Housing problem-solving is a strategy designed to divert households who have recently become homeless from entering the homelessness response system through alternative housing options, including returning to their previous housing, shared housing, or living with family.

[16] Safe parking programs are sanctioned areas where people use their own vehicles as housing. People living in their vehicles are categorized as unsheltered (California Interagency Council on Homelessness 2023).

[17] Within a queue, subpopulations may have different threshold scores because resources of certain subpopulations (e.g., families with children, veterans, people living with HIV/AIDS) may be more plentiful relative to other groups.

for at least one year, or repeatedly, where at least one member is living with a disability (chronic homelessness)—are referred to PSH, that is, permanent housing assistance (e.g., long-term leasing or rental assistance) paired with supportive services (U.S. Department of Housing and Urban Development 2017b).[18] The queues, or ordered lists of prioritized households, are then used to match[19] and refer[20] individuals to housing resources available through CE.

While service provider participants had limited understandings of how the algorithmic systems actually ranked those experiencing homelessness for housing, they understood the practical reality that CE needed to identify the most vulnerable households in Juniper County experiencing homelessness so they could be prioritized for housing and other supportive services However, there were two main features of CE that fundamentally undermined service provider and client trust in the system.

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[18] The permanent supportive housing (PSH) model—deeply affordable housing units that are targeted to people at risk of or experiencing homelessness, and that include the provision of mental health and other supportive services—promotes housing stability and reduces acute healthcare utilization costs by following the Housing First approach where people are provided with housing first and then offered supportive services (Dennis, Locke, and Khadduri 2007; Mares & Rosenheck 2011; Leff et al. 2009). Supportive services range from mental health and substance use to personal development and financial well-being. Even among people facing significant barriers to housing, PSH has been instrumental to the work of ending chronic homelessness (National Academies of Sciences, Engineering, and Medicine 2018; Reid 2023).

[19] Matching is the process of identifying one or more households who are eligible for a housing resource based on their eligibility and preferences and making a connection between the household and the entity managing the resource (e.g., shelter, housing program). Many housing programs have specific eligibility criteria for a household to qualify such as dedicated units for veterans, people living with serious mental illness or HIV, people experiencing chronic homelessness, or seniors. Likewise, households may have preferences about where they want to live (e.g., geographic). In order to match to a Queue 2 housing resource, households need to be "document ready" which means they have collected, with the help of service providers, a set of documents that "prove" their identity and eligibility for the housing resource available. To be matched to PSH, households need a government-issued photo ID, Social Security Card (or SSN verification), verification of literal or chronic homelessness, and verification of disability. A disabling condition must be verifiable by a licensed healthcare professional.

[20] A referral is the formal connection of a household that has matched to a housing resource to the entity managing the resource (e.g., housing operator). Typically, multiple households are matched to each opening so a match and referral does not guarantee that a household will be accepted by a housing operator or program. The service provider linked to the household has a time-limited period to respond to a match (e.g., 5 days for permanent housing) and separately, a referral (e.g., 10 days for permanent housing) and to ensure their client is document ready (though some service providers begin the document readiness process before a client is matched). If a household is matched, referred, document ready, and then accepted by a housing operator, the service provider can assist with move-in which may include securing move-in funds or coordinating a warm handoff to staff and services associated with the housing program.

Compulsory Disclosure of Sensitive and Stigmatizing Statuses

First, the CE system demanded clients' compulsory disclosure of sensitive and stigmatizing statuses and experiences leading to client distrust of the CE system. Again, providers understood the reality that the system assigned priority based on illness and disability (e.g., mental illness), institutional experiences (e.g., incarceration), or barriers to housing (e.g., eviction). The more a client revealed, the more points they would be allocated on their assessment, participants told me. However, because clients were understandably reluctant to self-report such stigmatizing information, providers worried that need for housing would be inaccurately assessed, and thus considered this aspect of the CE technology as a system flaw. In this way, the CE assessment failed to identify many of the vulnerabilities it was intended to capture. Sonia, a mental health social worker, explained,

> Is the information in there [CE file] even accurate? Because it all depends upon someone [client] being transparent and forthcoming about what's going on for them. And someone who's been judged, stigmatized, treated very poorly in the past for being poor, homeless, disabled, having a mental health diagnosis, having addiction, for any of those—people who have experienced the kind of treatment that those folks experience in our systems—it's really hard for them to then sit on the phone or sit in person with someone and be like, "Yep, I have an incarceration history. Yep. I have a serious mental illness. Yep, I have an addiction."

Service providers identified the apparent contradictory imperative for clients to be forthcoming about the details of their lives as a major limitation of CE. That is, providers observed that the CE technology was situated within, and was emblematic of, a larger institutional context that stigmatized and punished many of the behaviors and statuses that the CE assessment compelled clients to report. They pointed out that while the CE system rewarded the disclosure of sensitive and stigmatizing health, housing, and incarceration experiences and histories, in other settings—such as healthcare, legal, and institutions of family policing—clients would likely not be rewarded for such disclosures. Thus, the way CE demands compulsory disclosure is blind to the fact that clients have adverse experiences with disclosure and long histories of mistreatment at the hands of health and social service institutions. For example, as Zach, an outreach case manager explained, the disclosure of certain personal information in other settings and institutions may have negative repercussions.

> This was horrible from the jump, right? First time I meet you, I'm supposed to tell you I've got a drug abuse history, I'm mentally ill, and so many of our clients understand or are conditioned to understand that telling someone something that can be used against them, is not in their interest all the time. Doctors are going to use it against you. Now if you have a good rapport with your doctor, at some point you can figure out I can be honest with them, but generally none of us as humans wants to just start telling people our most personal things [the] first time I meet you.

In other words, clients who may have reason to distrust the healthcare system, may not disclose their substance use disorder during an assessment, or avoid seeking acute care services (e.g., emergency room visits, hospitalizations), would not be allocated additional points needed to be prioritized for housing. Zach continued:

> And so that's a flaw [of the CE system] because people wouldn't say they had a drug [issue]—or they wouldn't say they're mentally ill, and they [people administering CE assessments] would just base it on those points and people [clients] would get low scores.

While the service providers I shadowed attempted to repair their clients' experiences with an untrustworthy system, the CE assessment repeatedly undermined this fragile relationship-building work. For example, Irene, a housing program director, shared that while the questions on the CE assessment are meant to be administered as written, staff are trained to build trust with their clients during the pre-assessment phase and then coach them that the assessment is a safe space to disclose sensitive information.[21]

> The assessment is designed to be asked in the way that the questions are written, so that it's fair, but you're absolutely right that people are going to be more likely to disclose

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[21] HUD recommended that agencies administer the assessment in a private space, preferably a room with a door, or, if outside, away from others' earshot. HUD also recommended that agencies administering the CE assessment follow protocols to address the "psychological impacts caused by the assessment" and that those administering the tool should be trained to recognize signs of trauma or anxiety (U.S. Department of Housing and Urban Development 2015a:62).

> information if they have a little bit of trust…we also talk in the [CE] trainings about messaging, how to set the stage for an assessment, talking about who has access to the information, basically saying that, "This information can be used to connect you to certain resources, so the more you're comfortable disclosing, the more likely we are to be able to have the information we would need to connect you to certain resources."

Moreover, disclosures did not always lead to housing: even when clients could be persuaded to disclose sensitive and stigmatizing information, the majority of clients were not prioritized and matched to housing.[22] Such experiences deepened clients' distrust of the system.

Opaque and Irrational

A second problematic feature that led to service provider distrust was inconsistent and nonsensical scores and housing matches produced by the CE prioritization system that was ostensibly designed to be objective and rational. Providers frequently offered examples of clients who were high-risk and high-need yet were ranked low despite many barriers to housing. In other words, the housing and health situations of those who *were* prioritized through CE did not always materially differ from those who were *not* prioritized. Sierra, a nurse coordinator, shared how she cared for a patient at a respite who "checked every box" in the assessment but was nevertheless not prioritized for housing:

> [CE] doesn't seem to work… I don't understand that system. I don't get it…For instance, there was a guy that I had, street homeless for 15 years, legally blind, brittle diabetic [i.e., with hard-to-control diabetes], who was severely developmentally delayed, maybe seven or eight years old cognitively. When I got him in for his initial housing assessment, he ended up [low] on the list which doesn't make sense because he had every—oh, and he was an alcoholic—everything that you got points for or whatever, he had it in spades.

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[22] In California, only about 40 percent of people who access CE are actually matched to temporary or permanent housing (California Interagency Council on Homelessness 2023).

Another participant, Ryan, a housing program manager, shared about a senior client who had been homeless for over 20 years. Despite high vulnerability, this client never made it to the top of the CE list, passing away while awaiting housing.

> She was the oldest client I worked with…to me, she's extremely vulnerable. What happened in the system for her never to be housed? Then I have someone else who's in her twenties and she got permanent housing. I just don't know.

Participants acknowledged that much of the CE system, and specifically the algorithm that prioritized clients, lacked transparency. A housing navigator shared, "I wish I knew more about it [algorithm], I have no idea. It is like a mystery to me." Another said, "For the last…four years that I've been a part of this [CE] system, we've never really figured out how it works. [Those who have designed CE are] very—I would almost say—secretive on the process." "I feel like…in my position, it's not super transparent when somebody will get matched and when somebody won't get matched," another housing navigator shared.

Ryan, whose oldest client was never prioritized for housing while another in her twenties qualified for permanent housing, concluded, "I can't really have faith in that system." The inconsistent and nonsensical results paired with limited transparency undermined service provider trust in the system they were required to use. Ultimately, distrust in the system led service providers to question the integrity of the CE system and its constituent parts. As a housing community health worker, Iris, shared,

> Do I still believe the [CE] system works? No…I don't think there's much success in match rates because the way they score things, not even the people that do the coordinated entry assessment understand the scoring.

Finally, because of these challenges, service providers wondered whether alternatives to clients' self-report of their health and social conditions and experiences might not be more accurate and equitable. Irene talked aloud with me about pulling data directly from client healthcare records or alternatively, healthcare provider administration of CE assessments as opposed to frontline staff.

> Irene: …because [the CE assessment] is completed by non-healthcare professionals and it's based on self-report…it's not always a great proxy for acuity. So sometimes someone might have a really acute condition but not have any of the other things that would score in a Coordinated Entry assessment…We're not basing it on healthcare data, we're basing it on self-report…
> Tessa: What would that look like then? Having maybe healthcare providers doing the assessments and/or access to medical records of some sort?
> Irene: Yeah, I think more realistically would be [using]...healthcare data—having healthcare providers do the assessments. That doesn't feel like that would ever happen, so I don't know. I think having the ability to bring in more data.

This excerpt reveals service provider concern that, even if the CE assessment is rational and unbiased, feeding an algorithm poor-quality data will produce faulty assessments. In other words, not only is the CE system itself problematic, as outlined above, it is also compounded by bad and/or insufficient data fed into the system (that is, they worried that putting 'garbage in' would produce 'garbage out,' to borrow a common phrase used in computer science). My conversation with Irene highlights the sentiment, shared by other participants, that more accurate and comprehensive data might be gathered from healthcare professionals, than from clients who might reasonably withhold information that might be stigmatizing, especially given uncertainty and distrust around how it might be used.

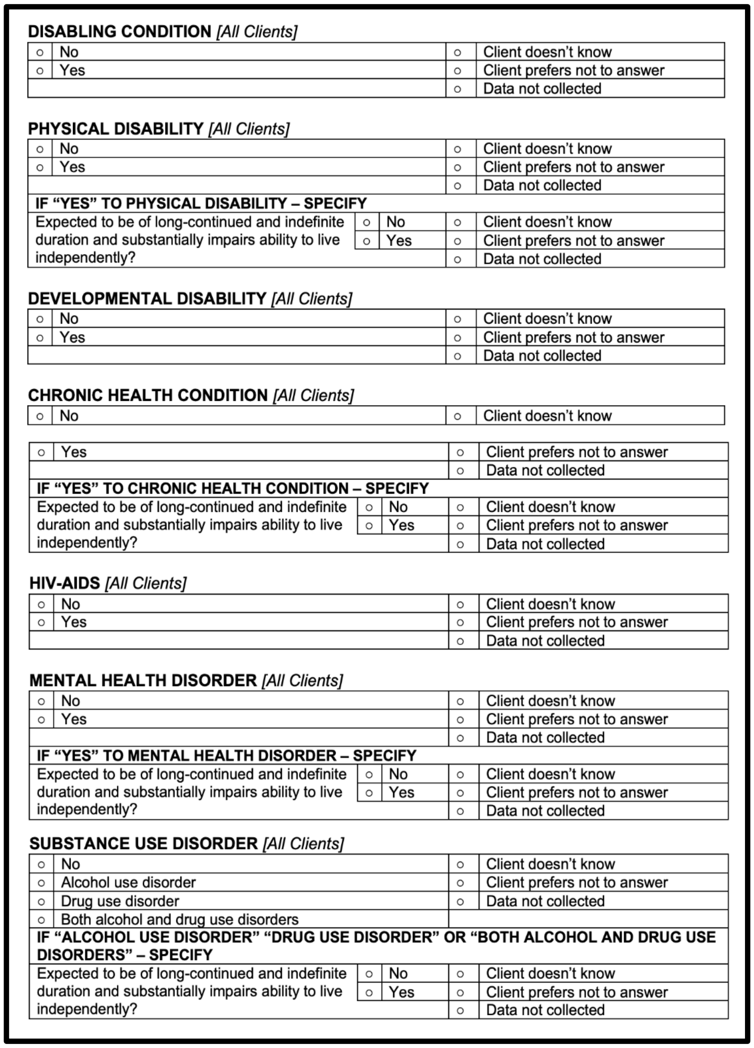
Irene yearned not only for more "objective" data (by changing who the assessment is administered by) but also better ways to measure complex domains like "acuity," or the severity of an individual's illness and the level of care or service they may need, and therefore the priority in which they should be seen or ranked in the CE system. The fact that the CE assessments are point-in-time evaluations, where a household's level of vulnerability and need for housing is assessed at a particular moment in time, means that it often fails to be sensitive enough to pick up even day-to-day changes in acuity. A household's situation may be vastly different six months, or even a week, later and likewise, one's health situation can deteriorate quickly. In Juniper County, a CE assessment was considered valid for 90 days for Queue 1 and 180 days for Queue 2 if the client's situation had not changed. After such time, or if the client's housing status or circumstances had changed (e.g., the client had to be hospitalized), service providers were recommended to update the assessment. Juniper County encouraged service providers to update client profiles as often as possible which required frontline workers to be in constant communication with their clients. Yet this was highly infeasible due to high caseloads, the COVID-19 pandemic, and clients who were often dealing with complex social and health situations and residential transience. Thus, what effectively were point-in-time assessments were unable to capture the ongoing precarity of someone's housing, resulting in households whose situations had deteriorated since they were last assessed not being appropriately prioritized for housing.

Irene's quote also conveys that healthcare professionals' evaluation of health (and even social) conditions are seen as more objective than an individual's own self-report of their diagnoses and experiences or knowledge of their body. Despite the onus on individual clients to disclose sensitive and stigmatizing conditions, experiences, and histories, disclosures were not necessarily sufficient to unlock housing opportunities and placements as detailed in the next section.

EXERCISING DISCRETION: STRATEGIES TO MAKE COORDINATED ENTRY WORK FOR CLIENTS LIVING WITH DISABILITIES

Faced with CE technology that demanded compulsory disclosure of personal information, produced inconsistent and nonsensical scores, lacked transparency, and ultimately cultivated distrust in the larger system, service providers exercised discretion to make CE work for their clients. That is, rather than understanding CE as a technology that operates on its own, I see CE as an assemblage that comprises a web of arrangements between the algorithm, service provider users, clients, and the larger housing infrastructure. In this way, clients were not simply subject to CE technology and its impacts; instead, service provider users became attuned to the ways client scores could be increased and asserted their agency in their use of CE to better optimize the priority scores for their clients.

Specifically, providers realized the disability section (**Figure 3-1**) of the CE assessment played an outsized role in how clients were prioritized for housing, and thus was one area where service providers felt they had some discretion and could impact their clients' prioritization for appropriate and timely housing allocation.



DISABLING CONDITION *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

PHYSICAL DISABILITY *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "YES" TO PHYSICAL DISABILITY – SPECIFY			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○ No	○	Client doesn't know
	○ Yes	○	Client prefers not to answer
		○	Data not collected

DEVELOPMENTAL DISABILITY *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

CHRONIC HEALTH CONDITION *[All Clients]*

○	No	○	Client doesn't know

○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○ No	○	Client doesn't know
	○ Yes	○	Client prefers not to answer
		○	Data not collected

HIV-AIDS *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

MENTAL HEALTH DISORDER *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "YES" TO MENTAL HEALTH DISORDER – SPECIFY			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○ No	○	Client doesn't know
	○ Yes	○	Client prefers not to answer
		○	Data not collected

SUBSTANCE USE DISORDER *[All Clients]*

○	No	○	Client doesn't know
○	Alcohol use disorder	○	Client prefers not to answer
○	Drug use disorder	○	Data not collected
○	Both alcohol and drug use disorders		
IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE DISORDERS" – SPECIFY			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○ No	○	Client doesn't know
	○ Yes	○	Client prefers not to answer
		○	Data not collected

FIGURE 3-1. Disability Section of CE Assessment

Marina, a street medicine social worker, explained: "the disability or mental health portion [of the CE assessment] I think is probably the most important part in figuring out where on the [CE priority] list they rank." As a housing program manager Nia explained:

> What I can tell you is that people that have disabilities, whether that be mental, physical, emotional, just whatever type of disability, a learning disability, maybe it's alcohol abuse, drug abuse—that would all fall under that [disability section]. They're going to be kind of shot to the top [of the CE ranking] because they're having higher barriers now.

When I sat with Carmen, a housing navigator, as she showed me the CE assessment she recently conducted with a client, she noted how each additional check mark in the disability section of the assessment, in her experience, translated into clients more quickly being prioritized for housing.

> This [disabilities section of the assessment] is where you get your [housing] resources. This is everything that determines where you are and what, how much you can get.…so if I put yes, yes, yes [pointing to the list of disability questions], they're going to skyrocket and then they'll change—their number [score] changes and then I'll get "bing! this person is qualified for permanent supportive housing." (Fieldnote 220408 4)

Service providers employed multiple strategies in conjunction with their use of the CE system to achieve what they understood to be more accurate assessments of housing need. First, they *contextualized* the importance of the CE assessment and situated client experiences in this light. Second, they *defined* and *normalized* disability. Third, they *coached* clients what to expect from the CE assessment to help clients avoid vague answers that may have downplayed their need or acuity and asked open-ended questions and follow-up *probes* to ensure question comprehension and make space for narrative responses. Fourth, they *adjusted* client files to reflect accurate histories, experiences, and diagnoses. Each of these strategies constituted interactional processes and actions on and with the CE technology that made the system 'work' and rendered it to be less problematic and more trustworthy.

Contextualizing Compulsory Disclosures

Service providers knew the CE system was designed to capture a list of problems or barriers, so it was to their client's advantage to reveal as many barriers as they had experienced. I define contextualizing here as the process of educating clients why CE is important and situating the assessment and their experiences in that light; this was one strategy service providers leveraged with an eye towards making the CE system work for their clients.

Service provider participants put the results of the assessment in context by educating clients living with a disability about how the assessment was connected to specific housing resources, including PSH. During fieldwork, I observed Carmen, a housing navigator share with her client, a single mother living with disabilities:

> This disability portion [of the CE assessment] is important too because we also have a program called permanent supportive housing based on your disability. You'll be eligible for a subsidized unit for the rest of your life…so that's why these questions are very important because even though we get help from this program [rapid rehousing (RRH)], there's a lot of other resources that you're eligible for [because you're living with a disability]. (Fieldnote 211006 2)

Importantly, service providers felt that contextualizing was critical to preempt and mitigate against clients' inclinations to withhold what they might view as stigmatizing information. That is, because the CE system compelled self-report of sensitive statuses and experiences, as described in the section above, providers felt that the CE technology could only 'work' if it was paired with their overt efforts to contextualize why such information was so important to disclose. Sophia, a behavioral health case manager, explained how completing a CE assessment was required to secure housing resources through the county and that the most important indicators of need/vulnerability were time spent homeless and the presence of medical conditions.

> Essentially, this is the only way someone's going to get…a permanent supportive housing voucher through the county. They have to do this [CE] assessment. So it breaks it down into different parts, where it's demographic information, the health stuff. Of course, there are ethnicity, veteran status, all that stuff. And then there's kind of subcategories…foster youth…seniors or any children in the household, people that have been incarcerated and have felonies, or even people that have evictions on their records…They call them "vulnerabilities"…you would think it was a negative thing as far as people asking these questions like, "Okay, how many times have you been arrested in the past year?" But we try to explain it that, in this sense, it kind of goes in their favor because it makes them more vulnerable to acquire stable housing.

Sophia underscores how the compulsory disclosure of "vulnerabilities" are often viewed by clients as "negative things"; therefore, service providers knew it was imperative to contextualize, or explain, to their client that it was in their interest to disclose their vulnerabilities for the purpose of garnering the "more vulnerable" status in CE to unlock "stable housing." Sonia, a mental health social worker, discussed how she contextualizes, or educates, her clients to understand that the CE assessment is not intuitive: the CE algorithm actually allocates points for the presence of stigmatized vulnerabilities.

Sonia also notes that if a service provider does not do the critical work of contextualizing, the client's CE file and assessment may not be "accurate" and require an "update":

> Okay, let's think about, who is this person [client]? What does their situation look like? Do they need to do a CES assessment or an update? Is the information in there [CE file] even accurate?...So sometimes what we'll do is, we'll make sure that their CES assessment is actually reflecting what's going on for them. And we'll do a lot of education with them around the fact that this system is actually designed to prioritize people who are the most vulnerable, and things like addiction, incarceration history, HIV diagnosis, those things are actually going to help you to get housing. We do education like that.

Service provider participants also contextualized by relaying to their clients that they need not identify with the story they tell. In other words, clients were told that they are not just what they self-report on the assessment, although those details were of particular interest to the CE system; instead, service providers saw their clients as full human beings, not simply a list of their stigmatized experiences. In this way, service providers distanced themselves from the CE system they were required to use. Owen, a homeless outreach coordinator, explained, "what I typically do is…to let them [client] know what to expect [of CE assessments], what it looks like, the kinds of questions they ask…there's a certain story they're listening for which focuses on problems …the [CE] system needs to know what your experience with that story is." But then the coordinator made sure to reassure clients that "this is only a limited story of who they are, but…you don't have to own that story…you don't have to own the labels that come out of that."

Defining and Normalizing Disability

Alongside contextualizing, defining and normalizing disability were strategies to work within the problematic and untrustworthy CE system. Service providers defined and normalized disability for their clients as a means to clarify and illustrate what disability is and create a safe and comfortable environment for clients to disclose their experiences. In so doing, service providers not only worked with the CE system, but also placed themselves between the CE technology and their client, protecting their client from the full impact of how CE assessment questions might alienate, further stigmatize, and re-inflict harm on their clients.

On several occasions shadowing Carmen, a housing navigator, I observed her define and normalize disability for her clients. She and other service providers I shadowed clarified to clients that a disability could be either physical or mental and encompassed far more common and expansive conditions beyond conventional notions and images of severe physical disability. In this excerpt from a fieldnote, Carmen *defines* disability by providing examples of less-stigmatized health conditions like asthma, then *normalizes* disability by relaying that living with a mental or physical health issue is a universal experience.

> Carmen: Do you have a disability? [pause]
> Client: [shakes her head 'No']
> Carmen: I'm going to explain a disability, because I knew you were going to do that.
> Client: I wanna know! I wanna know what that means. [laughs]
> Carmen: [laughs] So, a disability does not [just] mean handicapped or an amputee or anything like that; it's also mental health. It could be physical, it can be a health condition such as asthma, lupus. Do you have asthma? It's different things.
> Client: I have blood clots.
> Carmen: So you have chronic health conditions. So that falls under the line of disability.
> Client: Yeah.
> Carmen: Drug and alcohol abuse, you know, that's also a disability, things like that…So I know every time I say, "You know, this is good," everyone's like, "No." I say, "Hold on!"
> Client: Right, [that's] how we do.
> Carmen: We all have something, you know? And it's okay. Mental health, depression, anxiety, I think we all suffer from some form. (Fieldnote 211006)

Later in the session with her client, Carmen learned that her client was living with depression, anxiety, and PTSD from her time in the foster care system and the victim of physical and sexual violence from a former partner. Carmen shared with me that she tells her clients that everyone experiencing homelessness is living with stress, anxiety, depression, or another mental health issue. In fact, Carmen revealed to her clients that she herself is living with mental health issues and receives mental healthcare and therapy, so that they felt more comfortable sharing the health issues they may be living with. In this way, Carmen normalized disability. She told me:

> Mental illness, it's like the root of every client…the fear, the anxiety, the panic attacks, the trauma, that can be crippling and disabling. I tell them like I've been there, like depression, it doesn't mean you're crazy…nothing's wrong with you. I notice too in our culture that it's like a big no-no. “Therapy?” “I’m not crazy. I’m not talking to nobody.” Or even the fear of speaking. They think if you go to therapy, you're only speaking to a white person and they’re going to judge and things like that…“Just do it once and it’ll change your life.” The stigma and I really want to open that up so that people, I think that would help us a lot. (Fieldnote 211207)

Carmen acknowledged and highlighted that her clients, who are predominantly Black women, felt stigma disclosing their disabilities, in particular mental health issues. Carmen used her own lived experience as a Black woman to develop trust with her clients, normalize disability, and draw out their experiences.

> And then a lot of people, especially African American, they refuse. They're just like, “No, I'm not crazy”…we're assuming that they [client] understand the question. We can’t do that. I’m like, “Do you understand the question?” So I just say, “Have you ever dealt with this, or do you ever get overwhelmed on bills or just you can't make ends meet?” You know? And they’ll be like, “Yeah.” I’m like, “That’s mental health. That's just stress. I said, that’s all it is, this day to day stress.” I'm like, “We all have it.” And then they ease up like, “I have it.” They're like, “ok phew, you too.” So I try to give them my own lived experience, like get kind of open with them because I want them to know, like, “I understand, I've been in your shoes, so I’m not judging. I'm just trying to help you.” Because they always get, like, “Oh, you're judging.” I'm not judging. (Fieldnote 220408 2)

Coaching and Probing

Given a system of rewarding disclosures, many providers coached their clients to be “honest,” “forthcoming,” and “transparent” about their health, housing, and incarceration histories. Coaching went hand in hand with probing, the process of acknowledging that the closed-ended CE assessment questions were insufficient to capture a client’s holistic life history and therefore rewording questions to be more open-ended, and then following up these questions with specific probes. Coaching and probing were ways service providers diverged from the CE assessment ‘script’ where questions were meant to be administered as they were written. Such standardized questions and assessments were often thought to produce fair and equitable results. However, providers determined that the CE assessment’s scripted language did the opposite, leading to inaccurate and inappropriate assessments because the system neglected a larger institutional context that stigmatized and punished client histories and experiences. In doing so, it constrained disclosure of disability and vulnerability. As Zach describes, the coaching and probing strategies were critical to ensuring clients received as many points in the CE system as possible:

> So then you’d get providers coaching people to either be as honest as you can if you’ve ever had a drug problem, if that’s led to something, if you’ve ever felt sad you have depression, that sort of thing…I know people coach, providers will coach people because I hear that. And we would do the same thing…and that’s going to give you more points.

Zach, a homeless outreach case manager, coached his clients to be “reassessed” when they did not disclose certain health issues. He shared, “And we would do the same thing as far as telling someone you need to go get reassessed because you said you didn't have a drug problem and you do, and that's going to give you more points.”

The goal of coaching and probing was also to help a client avoid vague answers that may result in underreporting their need or minimizing their acuity. Carmen, a housing navigator, talked about how she broke down the CE disability questions into several follow up questions. If a client answered ‘no’ to the disability questions, she informed the client how important these questions were to accessing housing and then repeated the assessment with the client. Carmen did not assume her clients understood the disability questions so she rephrased them in a way that elicited a more fulsome history:

> Tessa: Seems like these [CE] assessments are just so important and building rapport with the client, right? For them to trust you, to put it in the system.
> Carmen: Yeah…because if they say, "no, no, no" [to the disability questions], I stop…I'm like, "Have you ever had an IEP [individualized education plan for people living with disabilities]? Have you ever had a learning disability?" Things like that. And then chronic health, I'm like, "Have you ever been diagnosed with asthma?"...So I kind of break it down and try to pull from them. And then I explain, "Okay, you've answered 'no' to all these questions. What you just did was put a huge barrier for yourself. I'm going to go over it again. And I want you just to think about anything that you ever encountered in your life medically...I can't assume they understand what I'm saying to them, you know, we can't make an assumption so I explain in layman's terms. "Have you ever did this, or have you ever dealt with this? You have a health condition." (Fieldnote 220408 2)

This provider, like many others, emphasized the crucial importance of knowing their clients for coaching and probing to be most effective. Understanding clients' histories and personalities allowed providers to redirect and follow-up on questions in ways that would elicit clearer and more granular information about disabilities. In some cases, CE assessments were conducted by service providers who did not have a strong relationship with a client. A homeless outreach coordinator argued there were "huge consequences" of how staff asked the CE assessment questions:

> Owen: Some people are really good. "So tell me a little bit about in school, like, did you struggle a little bit? You know, maybe you learned a little differently or you're in special ed or was it hard for you? Were you…fidgeting a lot? Was it harder for you to sit still? Did anyone ever get you support around that? Did you see someone to help you?" Yeah. So I think there [are] ways…you can say, "do you have a disability?" [And the client answers] "No."
> Tessa: Right. Right. And yeah, like those small things seem to have big consequences.
> Owen: Huge consequences. Even if you ask their homeless history, like you could ask the same person their homeless history. In your data, you can get five different answers…you can ask someone like, "How long have you been homeless?" "Oh I've been homeless two years." Well, like the last two years I've been homeless, but then before that, I could have been in jail…but actually you've really been homeless since you're like a young person and 20 years [homeless]. So it just depends on their understanding of what that [question] means. And the point differences are huge.

As Owen notes, it is critical for the assessor to have a relationship with the client who is being assessed: "it means someone's invested in you differently. And your housing and healthcare will have a different outcome" compared to an assessor who is "just checking boxes." Knowing what was at stake, Iris, a housing community outreach worker who worked in the healthcare system and who did not have access to conduct CE assessments, accompanied her clients to assessments to ensure her client's health issues and disabilities were properly documented in the CE assessment:

> Had I not been there, they probably wouldn't even done the coordinated entry assessment correctly…The times that I've gone, I've been able to get longer term shelter places for my patients. I make sure that it's done correctly. Because most of the time, if they [client] go on their own…sometimes it's like they can't comprehend [the CE assessment questions].

Kira, a clinical social worker, shared a similar sentiment about the CE assessment: "A lot of the times it also comes from how the patients are answering those questions. I feel like they don't do a good job in helping them answer the questions accurately." The framing of accuracy—whether a client is answering the CE assessment questions correctly—was a product of the discordance in knowledge between service providers and their clients about the weight given to disability experiences in the CE assessment as well as what the service providers knew about a client's health given their access to electronic health records compared to what clients disclosed and what was reported in an assessment. Like Iris, Kira did not conduct CE assessments but did have a deep understanding of the health and social circumstances of her patients which were not reflected in many CE assessments that she was able to view, but not adjust, in the CE system.

Adjusting

Adjusting is the process of making small changes to a client's file—with or without the knowledge of the client—to ensure it reflects accurate experiences, histories, and diagnoses. As I showed above, small changes to a client's file, such as adding a mental health diagnosis or clarifying their length of time homeless, often had substantial implications as to how clients were prioritized for housing. Service providers worked under the assumption that not all clients would disclose sensitive and stigmatized aspects of their lives during assessments, and service providers dealt with such vague and incomplete information by adjusting.

Service providers noted that a client's CE file, and corresponding CE assessment, may not reflect their reality. A mental health social worker shared, "We'll make sure that their CES assessment is actually reflecting what's going on for them." Similarly, a mental health outreach social worker discussed "adjusting" a client's CE file to include their client's mental health diagnosis which was reported in her healthcare record but not disclosed by the client during the CE assessment. Ensuring her client's CE file accurately classified her as living with a mental health issue would increase her CE score and at least hypothetically, prioritize her for housing. Thus, Tamika opted to adjust her client's file to reflect her history of mental illness.

> I recently had a client who I didn't see in the mental health [section of CE assessment] or any signs of mental health, but I did happen to be in her [medical] chart and there was—I was able to just go and adjust it [CE assessment]. I didn't ask her. I didn't say anything to her about it. I just go and adjust the score. It was because—I feel like the stigma behind mental health.

Service providers with access to the CE system could not directly change scores but they could update a client's profile and assessment answers. Tamika explained that adjustment work is tied to Juniper County's CE "threshold number." Individuals needed to receive a CE assessment score above the threshold, or cutoff, to be prioritized for permanent housing like PSH.[23]

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[23] In the case of the VI-SPDAT assessment tool, there is limited evidence for the cutoffs between housing options (Shinn and Richard 2021). While the VI-SPDAT was meant to help communities assess what type of housing assistance might best suit a person's needs, resource-strapped communities ended up using the tool to make decisions based on the outputs. In other words, the score was not meant to be the ultimate criteria for deciding whether a person should receive housing assistance. Due to the widespread misuse of the VI-SPDAT, the creators of the tool announced it would phase it out and no longer provide technical support to communities using the tool (see Chapter 2, note 7). Critics argue that algorithmic assessments are quick ways to eliminate individuals from housing eligibility under the guide of fairness and efficiency.

Knowing the threshold score, Tamika shared that she worked hard to bring her clients up and above that number.

> The [threshold] score is 80…The county really wants us to work with clients that are considered chronic and severe. What I do, I try my best is to get everybody to that 80, pulling out as much information, getting as much history, and explaining things to let people know what things mean.

During one day of fieldwork, I sat next to Carmen as she reviewed the CE assessment for one of her clients. She noted that the eligibility worker for her organization is "only gathering information that they [the client] tell us" implying that the data in the CE system may not contain the whole picture. I could see on the screen that all disabilities were checked "no." This included physical, developmental, chronic health, mental health, and substance use disabilities. Carmen therefore decided to invite her client to return to the office to redo the assessment and planned to coach and educate her about the importance of disclosing mental health disabilities. In re-administering the CE assessment to her client, Carmen was also doing the work of adjusting.

> Carmen: [Pointing to mental health question in CE assessment] She [client] definitely has this [mental health disability]. And I can't tell this to people [clients], but every time I've done an assessment, this is 'yes.' Anyone living outside has some kind of mental health [disability]. I mean, the depression, like how can you not? When you're just constantly worried? That's anxiety. Shucks. So what I'm going to do is change this assessment. I'm going to have her come in and ask her some more questions and explain to her why this is very important. Because even while she's waiting [for a domestic violence emergency housing voucher], she can get permanent supportive housing. This [disabilities section of the CE assessment] is where you get your [housing] resources. This is everything that determines where you are and what, how much you can get.
> Tessa: The disabilities?
> Carmen: Yes. Because they [people living with disabilities] take priority over regular clients. Now she would have sat [waiting]. If they just look at this [no disabilities checked in the assessment], she could sit just in idle for three to five years.
> Tessa: So she'd just be [living] in [a] shelter?
> Carmen: Yeah. Or if she denies it [shelter], then she'd just be on the street. That is, it's just like, uh.
> Tessa: And she has been waiting for over 10 years [already] it sounds like.
> Carmen: And that's what's sad. (Fieldnote 220408 4)

Other examples of adjustment were less direct. Owen, a homeless outreach coordinator who did not have access to administer CE assessments or make adjustments to client files but who could see the results of a CE assessment, helped adjust the CE files of his clients by writing letters to CE assessors to make sure his clients' files were not missing critical pieces of information that would help prioritize them in the CE system:

> Then I could be able to write a letter saying like, "Here's some additional information that they [client] didn't share at the time that would be important to add or they go to the hospital, they go to jail" like any time they did, that intentionally adds points…"This person went to jail. Can you make sure you add that information?" Because I knew that would give them more points. There are cutoffs.

In this way, advocacy and going the extra mile to make sure assessments reflected reality was key to the prioritization of households who, despite living with a disability, may have scored low on the CE assessment.

CONCLUSION

> One of the things that we have to recognize doing this work is that we are gatekeepers to resources that people need in order to sustain their lives, and housing is totally one of those. People don't get on the queue for affordable housing unless we are there to do the housing problem solving, to document that…and to do the CES assessment…So many systems that were designed, built, and maintained by folks who are upholding systems rooted in white supremacy. That is totally evident by the disproportionate impact of homelessness and chronic illness that you're seeing on the streets…we [service providers] did not make the decisions to create the systems the way that they are…the best that we can do is to do right by our patients, and that is to look for everything we possibly can to accurately document their health status, their length of homelessness, to do all the things we can do to get them to score as high as we can possibly get them to score on that vulnerability index [CE assessment] so that they're housed as quickly as possible.

In the above excerpt, Ben, a program manager for a street medicine team, shared how housing systems and technology like CE are rooted in systems of white supremacy that constrain frontline staff who use CE technology, even as they have some discretionary power as gatekeepers of housing. In reflecting on this, Ben powerfully synthesizes the raison d'etre of CE: because our society rations scarce and costly social goods, there must be a rationing system that claims to be legitimate and rational. Indeed, the CE system not only *rations* scarce resources but provides the *rationale* for using algorithms and technology to shrink the pool of individuals who need housing down to the number of housing units available—a classic example of shrinking the problem to fit the solution (Eubanks 2018; Bacalao 2021).

Like all technologies, CE bears the mark of its social origins and the actors who create them. Technologies never work on their own or act on their own accord, but rather, are assemblages of the data they depend on, the algorithms they use, and the users who must *make* the technology work. Accordingly, I find that service providers have limited but important levels of discretion in the use of algorithmic systems that prioritize households experiencing homelessness into housing. In this chapter, I underscored the importance of service provider advocacy and the ways they negotiate housing assessment and prioritization especially for clients experiencing homelessness and living with a disability. Service providers exercised discretion through various strategies—contextualizing, defining and normalizing, coaching and probing, and adjusting—with an eye towards working with the CE system to produce priorities for the types of housing service providers believed their clients needed, but did not trust the CE system to produce on its own. The commitment of service providers to prioritize their clients properly for the housing they so desperately need, but were not accurately assessed for, shows the stakes of algorithmic outcomes.

My findings provide context to the housing prioritization studies that show that algorithms can be complex and opaque, and further, privilege whiteness and (re)produce racial, gender, and health disparities (Barocas et al 2016; Noble 2018; Benjamin 2019; Obermeyer et al. 2019; Kiviat 2023). My data have important implications for housing assessment and prioritization tools that inquire about sensitive and stigmatizing health and disability statuses. While the documentation of illness and disability in client files can facilitate referral and linkages to healthcare, facilitating continuity of care, it also poses significant challenges for clients who have been penalized and punished for the disclosure of such statuses in other healthcare, legal, and institutions of family policing.

While much of the scholarship on street-level bureaucracy highlights the use and misuse of frontline discretion and judgment (e.g., Korteweg 2003; Pavetti 2018; Schram et al. 2009; Soss et al. 2011), my findings point to the ways in which service providers leverage their discretion to surface disability to ensure their clients are appropriately prioritized for housing. Given their discretion in the day-to-day governing of housing assessment and prioritization, service providers, as street-level bureaucrats and gatekeepers of housing, translate what they describe as opaque and nonsensical CE rules, procedures, and outcomes, and in doing so, effectively "rewrite" them.

My findings in this chapter build upon the work by Rita et al. (2022) who show how Housing Choice Voucher (HCV)[24] waitlist wait times were decreased not by a client's "*eligibility* for prioritization, but the *legibility* of their priority status" or how clients and their caseworkers worked to prove homelessness to state agencies (Rita et al. 2022:96; emphasis in original). The authors outline caseworker strategies including suggesting clients stay outdoors until their homelessness could be validated. In this way, the authors find that HCV waitlist prioritization criteria were not based on a basic assessment of need and instead, reflected issues

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[24] Housing Choice Voucher (HCV; formerly known as Section 8) is a federally funded, locally administered program which provides subsidies to very low-income households to afford housing in the private rental market.

of definition (of homelessness), legibility, and institutional social capital. While Rita et al. (2022) notes that "service providers may prioritize those who exhibit traditional forms of 'deservingness' or who perform sanctioned help-seeking behavior (Osborn 2019)," the service providers I shadowed ensured that those who were deemed to be disabled, but *not* in normalized, officially legible ways, were still prioritized for housing.

Likewise, building on the work of other scholars (Jones 2015; Metcalf 2021), and as discussed in more detail in Chapter 2, my data show that disability continues to be an important criterion to inform housing prioritization. While the collection of health, illness, and disability information is primarily used to inform PSH placements in CE systems, I find that an emphasis on chronic homelessness in the CE assessment tool may shape the nature and content of conversations between service providers and their clients particularly during assessments. Specifically, service providers may emphasize or give more attention to disability (than other aspects of a client's complex set of circumstances) in their conversations with clients, not only because they see that the CE assessment tool does not always capture and prioritize their clients living with a disability, but also because PSH (which requires a disability) is decidedly a more desirable placement than temporary housing or even other permanent housing options such as RRH.[25] Indeed, scholarship has shown how service providers may use their discretion to create unfair and inequitable realities for clients as they too have biases that may be reflected in how they coach and adjust files for some individuals and not others. While some service providers may go above and beyond to ensure CE assessments are accurate, others may simply read the

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[25] While rapid rehousing (RRH) is considered permanent housing, it is time-limited (usually up to 24 months) rental assistance and services. While, like PSH, it is offered without preconditions (such as employment, income, absence of criminal record, or sobriety), households are ultimately considered to be "self-sufficient" when the program ends. The idea is that by connecting individuals with a home, they will be in a better position to address other challenges such as securing employment (U.S. Department of Housing and Urban Development 2024d).

script or make minor efforts to ensure accurate scoring thus impacting client life-chances unequally. Further, there are issues of equity in the randomness in which clients are assigned to certain service providers. In this way, the CE system may be deliberately opaque in order to prevent service providers from coaching their clients and ostensibly manipulating the system.

Further, while service providers argued that health diagnoses and healthcare utilization are valuable information to inform prioritization for housing, they had a major and fundamental problem with the fact that the CE system reduced complex histories and experiences into a single score. The quantification and reduction of complex lives—and the seeming neutrality and objectivity of the score—was the basis for the strategies service providers undertook to work with the CE system. Relatedly, according to Fourcade and Healy (2013), scoring technologies work to split and sort people into "classification situations," or *artificially* generated positions in market technologies (e.g., credit market), which structure life-chances. They argue that society is becoming a "world of scores rather than classes," where individuals who do not possess the desired personal, financial, social or political score may suffer punishment and exclusion (Fourcade & Healy 2013:568).

My work therefore builds upon Fourcade and Healy's (2013) "classification situations" to argue that *disability classifications*, positions in the CE system based on the presence of a disability in the assessment, sort and structure clients into different life-chances. Specifically, clients living with a disability but not classified as disabled due to embedded inequities in CE technologies did not possess the score needed to be prioritized for housing. In this way, my findings move beyond Eubanks' (2018) conclusion that CE is a "surveillance system for sorting and criminalizing the poor" to one that also classifies, sorts, and stratifies by disability.

CHAPTER 4: BIOLOGICAL CITIZENSHIP IN ACTION: MEDICALIZING NEED AND VULNERABILITY IN HOUSING PRIORITIZATION

INTRODUCTION

In the last chapter, I highlighted how service providers challenged formal, narrow criteria and dysfunctional technology by exercising discretion through various strategies to produce housing prioritizations service providers believed their clients needed but did not trust the system to produce on its own. In this chapter, I examine the discursive work of on-the-ground service providers to show how biomedical norms and standards shape definitions of need, vulnerability, and deservingness and ultimately, housing receipt. While Chapter 3 revealed resistance and workarounds to the prioritization process, Chapter 4 shows moments of acceptance and legitimation of the medicalized categories of need used in housing prioritization.

While Coordinated Entry (CE)[1] is considered the "front door" to the homeless response system[2] in most Continuums of Care (CoCs),[3] including Juniper County, only about 40 percent of people who access CE in California are actually matched to temporary or permanent housing

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[1] The purpose of a Coordinated Entry (CE) system (also abbreviated as CES) is to assess the needs of households experiencing homelessness, identify the most vulnerable households through prioritization, and connect them to housing and services (U.S. Department of Housing and Urban Development 2015a).

[2] Programs that typically constitute a community's homeless response system include street outreach, emergency shelter, rapid re-housing (RRH), transitional housing (TH), and permanent supportive housing (PSH); these programs are recognized by HUD, a major funder of homeless response programs. Programs that receive funding from HUD as well as the State Homekey programs and county-level homelessness-specific funding are required to use the HMIS system and participate in CE. Juniper County also offered an array of temporary and permanent housing resources and support not managed by the CE system, including safe parking, tiny homes, non-congregate shelters such as Project Roomkey, single-room occupancy (SROs), project-based Section 8 housing, and tenant-based Housing Choice Vouchers.

[3] Continuums of Care (CoCs) are defined by HUD and include "representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons" (U.S. Department of Housing and Urban Development 2017b). California is divided into 44 CoCs.

through it (California Interagency Council on Homelessness 2023).[4] As discussed in Chapter 3, service providers found it challenging to align their clients' health conditions with program- and funding-specific eligibility criteria. Narrow operationalizations of need and vulnerability paired with limited housing and increasing levels of acuity left service providers with a subset of clients who were "never going to be prioritized for CE," as Sonia, a psychosocial services manager, put it:

> We have some other resources that we can help patients get into. And we usually try to push those on folks who we know, based on our knowledge of CES [Coordinated Entry System], they're never going to be prioritized for [housing]... and so it's fruitless to try to just keep telling them like, "Keep calling 211, keep doing the CES assessment." You're never going to actually get up to the top…So we have informed, transparent conversations with our patients around what the system of care looks like and what they're going to be eligible for or not eligible for, so that we can manage expectations and set realistic expectations for people.

For households experiencing homelessness and living with a chronic illness or disability who were not immediately prioritized for housing through CE, or did not meet housing program eligibility criteria, service providers worked to *fit clients to housing* by constructing them as disabled or medically in need of housing through various strategies. Systems of housing prioritization, and therefore service provider strategies, favored individuals who were medically legible and who had health conditions that could more easily be stretched to be categorized as disabled and/or visibly compromised. For those initially excluded from housing because narrow and strict medical eligibility criteria failed to include them, service providers often sought to

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[4] The Statewide Homelessness Assessment (California Interagency Council on Homelessness 2023) found that about 60% of people who accessed CE remained homeless (20%) or had an unknown destination (40%). The report notes that while it is impossible to know whether those with unknown destinations resolved their homelessness on their own (for example, by moving in with friends or family), the likelihood that they are still experiencing homelessness, or are at risk of returning to homelessness, is high. Unknown destinations were most common for people experiencing chronic homelessness and in street outreach programs. Thus, the majority of households experiencing homelessness who access CE remain homeless or their destination remains unknown. These numbers do not account for households who do not access the CE system in the first place.

assign meanings, interpretations, and weights to their illnesses and characterize them as disabled in ways that might earn them housing.

However, service providers often did not, or could not, undertake this work for all of their clients; instead, for the "right" client—a biomedicalizable client—seemingly immutable categories were flexible, bendable, and negotiated. Constrained by housing allocation systems that stratified clients by medicalized notions of need, service providers focused on those clients who had medical complexities and risks that could be highlighted, and in so doing, reinforced biomedical criteria as the appropriate and legitimate sorting mechanisms to determine housing worthiness. Service provider decision-making processes thus revealed how biomedical norms and standards shape definitions of need, vulnerability, and deservingness and ultimately, housing receipt. As the subsequent sections show, service providers attempted to fit their clients to housing by making them disabled. Together, service provider strategies underscore that health issues among people experiencing homelessness are complex, messy, and unpredictable; therefore, housing resources and services must accommodate the natural progression of illness trajectories. Specifically in this chapter, I aim to show how biomedical definitions of illness are leveraged, and by whom, to designate individuals as un/deserving of housing.

Biological citizenship is a useful theoretical foundation on which to explore the inclusion of health status in housing stratification processes. Like biopower (Foucault 1978), biological citizenship is based on the premise that the control and management of life is one of the major targets of governance. The concept of biological citizenship describes new forms of belonging and subjectivity based on biological traits, and whether and how these traits can make demands on the state and social institutions for resources and care (Petryna 2002; Rose and Novas 2006). Therefore, biological citizenship has both a productive power—creating new forms of belonging, identities, communities, and expertise based on biological claims—and a disciplining and differentiating capacity that may produce new social inequalities and reinforce biomedical dominance.

Scholars have used biological citizenship to better understand the governance of addiction and substance use, HIV/AIDS, genetics and disability, and race and immigration by the state (Mulligan 2017). However, no scholarship has applied biological citizenship to examine how newly required responsibilities upon receipt of shelter may be unequally structured for the poor, housing insecure, and chronically ill, adding to the labor of poverty. Yet, scholars of poverty have shown how the receipt of cash benefits necessitates new responsibilities and subjectivities (Hansen et al. 2014; Korteweg 2003). That is, social and legal benefits are coupled with notions of obligations, belonging, inclusion and exclusion, and deservedness. Thus, the concepts of biopower and biological citizenship raise important questions about the fields of housing and health and the processes of distinguishing, differentiating, and classifying. What biomedical definitions of illness (e.g., HIV-positive, at least two chronic illnesses), subjectivities, and biotechnologies are leveraged, and by whom, to designate individuals as un/deserving of housing? What claims do individuals experiencing homelessness, *or service providers on their behalf*, leverage to secure housing? Which claims do gatekeepers consider legitimate and why? In this chapter, I show how service providers take what appear to be official, written definitions of need, interpret, adjudicate, and activate such categories in their everyday mundane interactions with clients and in turn, produce and assign new meanings of the definitions, categories, and eligibility criteria themselves.

THE MAKING OF DISABLED CLIENTS

Specifically, service providers worked to *make clients disabled*; that is, they engaged in processes to render their clients, and represent their lives, in ways that fit them under the disabled category or within medical eligibility criteria. This “categorization work” (Schneider 2010) shows that medicalized notions of need are not clear cut and service providers must walk a fine line between resisting and working around medical criteria on the one hand, and on the other hand, using and implicitly legitimating medicalized categories of need because they are so consequential in who receives housing (or not). Service providers deployed four specific strategies to construct their clients as disabled: seeing and showing disability through medical compromise and complexity; justifying medical exceptions; escalating disability to rehouse clients in need of a higher level of residential care; and as a strategy of last resort, mobilizing social ties with medical professionals and housing gatekeepers. I show how each strategy maps onto biomedical constructions of housing deservingness and specific types of housing and institutional care (**Table 4-1**).

TABLE 4-1: Service Provider Strategies, Biomedical Constructions of Housing Deservingness, and Types of Housing and Institutional Care

Service Provider Strategies	Biomedical Constructions of Housing Deservingness	Types of Housing and Institutional Care
Seeing and showing disability	“Medically compromised” and “medically complex”	Homekey PSH for “medically fragile”
Justifying medical exceptions	“Medically exceptional”	Respite Tiny home Hospital/acute care
Escalating disability	“In need of a higher level of care”	Housing Choice Voucher (HCV)[5]
Mobilizing social ties with medical professionals and housing gatekeepers	Disability	Project Roomkey Transitional housing

While not all service providers seeking to place clients in a specific type of housing listed above (in the right column) used the strategy listed (in the left column), providers leveraged these strategies frequently enough and commented on the need to do so, that this became a notable part of the claims making that providers undertook as part of categorization work. That is, service providers worked to show how their clients met the spirit or intent to identify clients most in medical need of housing and found that this required them to negotiate narrowly constructed medical categories of vulnerability in multiple ways. Also, service providers used the biomedical terms listed in Table 4-1—“disabled,” “medically vulnerable,” “medically fragile,” “medically compromised,” and “medically complex”—interchangeably. I argue that service providers strategically conflated these terms; allowing labels to substitute in for each other was a strategy in and of itself to get their clients—who otherwise were not housed through CE—housed.

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[5] Housing Choice Voucher (HCV; formerly known as Section 8) is a federally funded, locally-administered program which provides subsidies to very low-income households to afford housing in the private rental market.

Seeing and Showing Disability through Medical Compromise and Complexity

Service providers argued that many of their clients who were not prioritized for PSH or recorded as disabled by the CE system (see Chapter 3) were just as in need of housing as individuals who were matched to housing through the CE system. In other words, the housing and health situations of those who *were* prioritized through CE did not always materially differ from those who were *not* prioritized. In order to address this tension and advocate for individuals who had "fallen through the cracks," some service providers constructed their clients as disabled by *seeing and showing their disability. Seeing disability* involved providers' favoring their own direct observations of clients' actual health conditions and needs for housing, often over electronic medical record (EMR) data. This frequently took the tack of constructing clients as "medically compromised" and/or "medically complex" as a pathway towards housing deservingness. Service providers knew from their hands-on experiences as medical and social service providers that EMR data on symptoms, diagnoses, and healthcare utilization did not always capture the level of compromise or complexity they witnessed in person. *Showing disability* involved making recommendations to housing gatekeepers about who was most sick and in need of housing based on seeing disability.

During fieldwork, I shadowed service providers who referred many of their medically vulnerable patients experiencing homelessness to the Sunrise Hotel,[6] a Homekey permanent supportive housing site, that provided on-site skilled nursing care,[7] in-home caregiving services, and medical and social case management for medically fragile residents. The Sunrise Hotel

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[6] Pseudonym

[7] Skilled care refers to skilled nursing or rehabilitation services, provided by licensed health professionals like nurses and physical therapists, ordered by a doctor. Skilled nursing care can be provided at home or in a facility such as a skilled nursing facility (SNF). SNFs generally provide 24-hour skilled nursing care, as well as related or rehabilitative services. "The typical resident is a person who is chronically ill or recuperating from an illness or surgery and needs regular nursing care and other health related services" (California Department of Aging n.d.; (Centers for Medicare & Medicaid Services 2016).

provides a good example of how service providers took up and deployed the strategies of seeing and showing disability. Homekey is an initiative born out of the COVID-19 response that funded permanent supportive housing (PSH)[8] for medically and socially vulnerable individuals experiencing homelessness. While Homekey sought to provide long-term housing assistance, it did not necessarily ensure residents could stay if their service and care needs changed. Yet the natural progression of chronic illness and the corresponding escalation of care needs often meant that individuals experiencing homelessness and living with complex chronic illness move through institutional placements and fragmented systems of care. For example, skilled nursing facilities (SNFs) may not be able to care for people who have psychiatric illness or substance use disorder, and shelters are not able to accommodate people who need support with ADLs; this leaves many individuals who are living with complex chronic conditions to cycle in and out of hospitals, nursing facilities, respites, and the street. Studies show that this churn results in poor quality of life, increased morbidity and mortality, medical and social destabilization, and restricted access to hospice/palliative care.

In an effort to create permanent supportive housing that allowed medically complex, formerly homeless individuals to age in place throughout their illness trajectory and to capture the individuals who did not qualify for PSH through other avenues, Juniper County reserved the Sunrise Hotel for a small group of high-need, medically fragile residents who were housed through Project Roomkey, a temporary state-funded program to quickly create housing for people experiencing homelessness in the wake of the COVID-19 pandemic. As the Co-Medical Director of the Sunrise Hotel told me, “At Sunrise in particular, the county was looking for a solution to avoid exiting some of our most fragile [Project] Roomkey residents to the streets if

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[8] Permanent Supportive Housing (PSH) is permanent housing assistance (e.g., long-term leasing or rental assistance) paired with supportive services (U.S. Department of Housing and Urban Development 2017b).

they didn't qualify for permanent supportive housing through other measures." The model acknowledged that medically compromised and frail individuals experience a natural and expected progression of chronic illness.[9] To meet them where they were in both their housing and illness trajectories, the Sunrise Hotel offered residents the full spectrum of outpatient care *onsite*, such as medical services, nursing care, and assistance with daily activities. Residents at the Sunrise Hotel could stay as their care needs changed over time unlike other Homekey or PSH units that required independence[10] or only provided minimal support with ADLs. To be eligible for the Sunrise Hotel, residents needed to be "medically fragile," defined by three criteria: functional compromise or major functional disability (e.g., using a wheelchair, blind), high acute care utilization (multiple hospital admissions or ED visits), and medically complex. Victoria, one of the co-medical directors of the Sunrise Hotel, shared with me that assessing medical fragility involved "selecting the people who had not just kidney disease but kidney failure, not just diabetes but uncontrolled diabetes, not just heart disease like hypertension but congestive heart failure…the sickest people." To determine whether individuals met these criteria, the medical directors and staff of the Sunrise Hotel could not rely on medical record data: because those experiencing homelessness tend to move frequently and often do not or cannot seek care when they need it, medical records data were considered to be "imperfect," according to the medical director. Instead, the medical directors opted to see Project Roomkey residents and evaluate them

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[9] As formerly homeless individuals living with chronic illness progress medically, they may require rehousing from a board and care home, which provides minimal assistance with activities of daily living like meal prep and bathing, to a skilled nursing facility (SNF), which provides 24-hour skilled nursing care.

[10] According to the HUD, permanent supportive housing is "permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently" (U.S. Department of Housing and Urban Development 2024g). The National Alliance to End Homelessness defines PSH as "Permanent supportive housing is an intervention that combines affordable housing assistance with voluntary support services to address the needs of chronically homeless people. The services are designed to build independent living and tenancy skills and connect people with community-based healthcare, treatment and employment services" (National Alliance to End Homelessness 2023).

in person. Seeing residents enabled providers to formulate more holistic, overall assessments of the degree to which clients were functionally and medically compromised, rather than depending solely on specific definitions of disability or medical fragility. As Victoria went on to explain:

> For our in-house referral process…it always involves going to actually see the person and kind of understand how compromised they actually were, how sick they actually were…So it was a pretty informal process in that we, [co-medical director] and I, would just sort of say, "Okay, this meets criteria" … then we would present [Project Roomkey residents who we considered compromised and complex] to the housing folks and just make our recommendation that if [the Project Roomkey resident] could move to the [Sunrise Hotel], we would be supportive of that…We can just kind of advocate for what we think is appropriate.

Victoria explained that while clients might not exactly tick off each criterion of the official definition of medically fragility set by the county, service providers, based on their direct observations, understood their clients to be too weak, frail, and “compromised” to be without permanent supportive housing.

Seeing and observing and therefore, having first-hand knowledge that a resident was indeed medically fragile and medically “compromised” was, in the case of the Sunrise Hotel, the preferred way of determining eligibility. This process ensured that medically fragile residents in need of housing were not overlooked again; many of them had not secured PSH through other measures, namely the county CE system. Seeing and observing in person and in real time was considered more reliable than an “imperfect” electronic record system with “missing” data. The medical directors even called upon service providers at other Project Roomkey hotels to find and refer individuals who met the medical eligibility criteria and who were missed by the medical record review[11]: “‘If there [are] people that we are missing…that you believe meet the criteria, let us know.’”

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[11] While Juniper County used a unique electronic record application to capture health and social issues, such as mental health diagnoses and homelessness, in one system for healthcare providers, care coordinators, and housing navigators alike, there were still challenges with access and up-to-date information.

The strategies of *seeing and showing disability* highlighted that while official, written eligibility criteria may exist, the ways in which clients were selected for some housing—in this case, a distinctive PSH model for medically fragile residents—was a subjective, flexible process that emphasized the in-person clinical assessment of a select group of service providers who advocated for specific clients by seeing disability among residents and then showing disability to housing gatekeepers who ultimately signed off on the referrals.

In another example of seeing disability, Gina, a health and wellness coach and case manager at a health center for people experiencing homelessness, shared an example of a client experiencing homelessness who needed temporary housing to recover from an upcoming surgery but who did not initially meet medical eligibility criteria for Project Roomkey housing:

> [One of my clients] had urinary incontinence and had a surgery coming up that would make her need a lot of support in a place to recuperate for a pretty long time, and also make her a little more susceptible with her immune system, and she just didn't qualify [for housing] based on all of those things…Usually the eligibility criteria are really specific to certain diagnoses that are also very high risk…but I also have patients with other conditions that can be pretty complex and also make them very high risk that aren't included in the few [diagnosis-specific eligibility criteria] listed that we're given to refer people in with.

Gina went on to describe how they resolved this:

> It can be challenging even for us, a medical clinic, to work without an organization and advocate for our patients who have unique situations and complex medical conditions and needs to get inside…But once we called and worked with the [housing] organization, they understood that she was someone who would be a good fit for the program.

In this way, Gina and other service providers constructed their clients' social and health situations as "more complex" than the oversimplified and strict categories of inclusion. Gina articulates how her client's health conditions could be improved with access to housing and likewise, how the absence of housing would make her client "susceptible," or at risk of further medical deterioration.

It is important to note that service providers felt the need to leverage the strategies of seeing and showing disability because their clients had actual, significant medical reasons to be housed. Seeing and showing disability offered service providers a way to temporarily contend with the structural problem of limited housing that was outside of their control. Providers leveraged legitimate biomedical categories of “functional compromise,” “functional disability,” “medical complexity,” and “medical fragility” in ways that they felt actually fulfilled the intended aims of the stipulated criteria. These two paired strategies of seeing and showing disability thus highlight a tension with service provider work: On one hand, there is an ad hoc and seemingly arbitrary nature of eyeballing clients and designating them as “compromised,” which secured these clients housing. On the other hand, service providers found the official definitions and lists of diagnoses to be overly rigid and hyper-narrow, believed in the accuracy of their holistic, in-person screening (particularly given how multifactorial and complicated medical complexity and fragility are to assess), and knew that medical records were fractured and incomplete. They therefore capitalized on the flexibility afforded to them within a dysfunctional system, to *see and show* the level of sickness not captured on paper or in an electronic database, and to secure their clients housing.

Justifying Medical Exceptions

In addition to seeing and showing disability, service providers also argued there were *medically* legitimate outliers to the acknowledged categorical boundaries. In other words, while service providers recognized that some of their clients did not fit technical, medical criteria, and in some cases official categories could not be stretched far enough to cover these clients, service providers still worked to show how their clients actually met the ‘spirit of the law.’ That is, they identified clients most in *medical* need of housing, who constituted justifiable medical exceptions to official criteria. In this way, service providers leaned into how the prioritization systems were structured, using biomedical criteria for illness and disability to make their case for qualifying specific clients for housing.

Iris, a housing community health outreach worker working in the healthcare safety net, shared how many of her new clients were more recently homeless due to a chronic health issue where long hospitalizations resulted in the loss of employment and housing. “I've noticed a lot of cancer patients lately have been having to live in their cars,” she shared. Iris discussed how she advocated for one such client, a woman with stage four colon cancer, to gain access to various types of diagnosis-dependent housing and care as her health deteriorated. While her client did not fit the official, written criteria for a tiny home[12] and she later had to “push” for her client to receive care at a hospital, Iris leveraged the strategy of justifying medical exceptions to argue her client was worthy of housing at both locations:

> No human being should be living in their car while they're fighting stage four colon cancer while getting chemotherapy and treatment, like radiation.…[I] got her into [a respite], was able to make an exception for her and got her into [a tiny home], which they usually only take [people from City]. But due to her health decreasing and the amount of pain she was in, she ended up in the hospital, we were able to push that. After being in [a tiny home] for very few weeks, she ended up at [hospital]. Unfortunately, she passed away. But although it wasn't what I wanted for her, at least she was able to spend her last days on earth…[in] her own space.

Iris’s client did not meet the criteria for the tiny home, which required residents to be previously living unhoused in a specific geographic jurisdiction, a restriction set by city or regional funding streams. Further, while Iris’s client fit the criteria for a congregate medical respite,[13] which

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[12] Tiny homes are small temporary shelters or permanent housing for people experiencing homelessness.

[13] Medical respites, also referred to as recuperative care, are generally intended for individuals experiencing homelessness who are too ill or frail to recover on the street, in shelter, or independent living, but not sick enough for a hospital setting (California Health Care Foundation 2023).

provided a bed while she received treatment, her client wished to have her own place in the last weeks of her life and therefore, Iris sought an exception on the grounds of her client's unique medical situation. Another part of her calculus for moving her client from respite care was to avoid the hospital near that facility where her client had previously received sub-par care, and instead provide her with access to a different hospital close to the tiny home. As Iris explained:

> [At the hospital near the respite] she was in ED for two days because there was no bed. And we had been requesting for pillows for her for two days and there wasn't any. So, when I went to visit her at [the hospital near the tiny home], she had all the pillows in the world. So at least I knew that she got more attention and at least her death was able to have support.

The narrow and strict categories of inclusion/exclusion for different types of housing from tiny homes and PSH to SNFs and medical respites did not always align with the complex, messy reality of unpredictable illness trajectories where people can meet criteria one day and not the next. This case also shows how service providers who knew their clients well were often attuned to their clients' unfolding illness trajectories and so worked to provide them with the level of care they needed. In some cases, this meant moving clients from one housing situation to another to match housing and care to a client's level of medical complexity at a particular point in time. Moving clients to new housing was also sometimes the only way service providers could fulfill client preferences for where they wanted to live while they underwent certain treatments, to be near social support or better care, or to have a better quality of life in the time they had remaining. Providers' desires to give their clients the appropriate level and quality of care they needed and deserved thus occasioned a significant amount of work. The siloed landscape of diagnosis-dependent housing, while tailored to provide targeted levels of care based on specific medically defined criteria and needs, resulted in fragmented systems of care and residential instability for some clients.

Escalating Disability

The passages thus far describe how service providers construct clients as disabled in order to end homelessness for some of their clients. Once clients were housed, service providers continued to construct their clients as in need of higher levels of care by *escalating disability* in order to prevent clients from losing their housing and returning to homelessness. In this way, service providers leveraged the high medical needs of their clients as both a solution to *and* as prevention of homelessness.

Clients living with physical, mental, and/or behavioral health conditions are at greater risk of eviction (Jaureguilorda et al. 2022), in part because living with a disability or multiple disabilities may make managing tasks like timely rent payment or communicating with landlords difficult. Behaviors such as substance use, psychotic breaks, unclean living spaces, and hoarding that are manifestations of health issues may jeopardize an individual's tenancy. Chris shared:

> I foresee a large number of our folks being evicted for all sorts of reasons. Hoarding is a big issue…It's very difficult to keep [a client] housed because of that, because it's a mental health issue. Hoarding is just one of those things that's really tough to treat.

Service providers described the herculean interpersonal work needed to maintain good relationships with landlords, housing operators, property managers, and neighbors to ensure clients sustained their tenancy. Chris continued:

> A typical [client], they probably go through five or six different types of housing before they figure out what works…the hard part actually isn't getting someone into housing, it's keeping them housed. That is the real dance, is keeping someone housed. [It] is a Herculean task for our [staff].

Service providers argued that it was an unrealistic expectation that individuals experiencing homelessness—in many cases, chronic homelessness—would be able to function in housing after being on the street without pairing housing with long-term, comprehensive health and social care and assistance. Eden, an executive director of an organization that provided housing and support services to families experiencing homelessness, argued that clients and their service providers needed access to flexible housing options.

> I think housing ends homelessness but it doesn't end suffering. So, as we move people off the streets and out of shelters into housing in huge numbers, I'm not feeling the plan for how that's going to be maintained. What if someone can't handle housing? What if they need a higher level of care? There's all these what ifs and I'm not seeing any discussion or any plans on having more mental health service available.…you do need back doors for folks when things don't work. They're being triggered in that [housing] environment or they're being destructive in that environment or their unit is too small or too big or they blew it or got threatened by somebody…Or they need higher level or lower level [of support/care]. We need that kind of flexibility to really make a true difference in people's lives…We'll have a percentage of cases that isn't working. So, what do we do?

What providers did is to escalate disability to preemptively rehouse their clients at risk of being displaced. It was common, for example, for clients who were already housed to "progress medically" and need greater support and services beyond what their current housing could provide. For clients who needed higher levels of social services or were at risk of eviction, some service providers preventatively rehoused their clients in order to avert displacement. Alana, a housing locator, shared an example of a client who "wasn't able to sustain his own unit on his own" and needed to be moved into assisted living where he would be provided with mental health support and care.

> I have rehoused people when need be. I would say sometimes that has to do with the fact that they need a higher level of care…I think these clients, they want to keep their housing. They don't want to go back to homelessness…Typically when it's not a good fit and they're breaching their lease or breaking their lease in ways, it's often not helpful for them to be in that kind of environment and they might need more support.

Alana made it clear that breaking the lease in some cases meant that a client needed more support than their current housing placement could offer. Alana characterized the process of rehousing clients as "walking away quietly." She explained the difficulty of securing housing with an eviction on a client's record, and therefore, the benefits of preventively moving, or rehousing, a client to avoid complications with landlords that might result in eviction. Another service provider, Jack, shared: "I just have like several really high-needs clients that are losing their units for other reasons…last year I rehoused several people that lost their lease." The strategy of rehousing clients underscored how clients cycle in and out of many housing situations before they find the "right match," resulting in great residential instability after homelessness.

Mobilizing Social Capital

When the above strategies failed, service providers resorted to leveraging their personal and professional connections to fit their clients to housing by making them disabled. This strategy involved *mobilizing social capital* to personally advocate for their clients and often hinged on the ability to make the case that their clients were in fact disabled enough and had medical reasons to be housed. Social capital is "the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition" (Bourdieu & Wacquant 1992:119). Social capital inheres in the power and resources (including the amount and types of capital, including economic, cultural, and symbolic) possessed by one's network. When service providers appealed to strategically positioned colleagues and used their connections to pursue goals on behalf of their clients, they were leveraging the social capital they had access to by virtue of their position within housing rationing systems. I found that service providers mobilized two kinds of social ties: relationships with medical professionals, and relationships with housing gatekeepers.

First, service providers who were not themselves clinicians often used their connections and relationships with medical professionals to convince housing gatekeepers that their client was in medical need of housing. The prioritization of people experiencing homelessness and living with an illness or disability—and the concomitant need to ascertain and document this—has given rise to the seemingly indispensable medical professional to prove and verify illness and disability (see, e.g., Willse 2015). It was rarely sufficient for a client to merely disclose or declare their illness or disability. Instead, clients were deemed sick and disabled by credentialed healthcare authority figures, that is, those who were physicians, nurse practitioners, social workers or therapists, depending on the specific health condition being documented. Sonia, a psychosocial services manager and social worker, noted that to access PSH through the CE system, clients needed to prove their disability:

> A big, big part of CES [Coordinated Entry System] is getting people what they call "document-ready," so assembling all these documents that are required for usually HUD or other funders…According to HUD, like the way that someone is considered chronically homeless and who's eligible for coordinated entry is someone who is disabled and homeless. In order to complete a disability verification, if it's a medical disability, you need to be an MD or an NP. And if it's a mental health disability or a cognitive disability or developmental disability, it can be a behavioral health clinician.

Kira, a clinic program supervisor and social worker, also explained:

> Say we're working on getting someone qualified for SSI benefits, so they can get an income to, eventually, get housing. The doctor is key in that aspect when we need to have a lot of medical verifications filled out to justify that they're disabled and they need Social Security. Same with any other type of disability benefits. Or, for Project Roomkey, there needs to be a specific medical verification form that's filled out by a physician. Same with respite programs, doctors have to attest to certain medical conditions…

It is important to note that this mobilization of social ties to medical providers was necessary because the system mandates that medicalized criteria like disability must be ascertained by credentialed clinicians. However, it is the service providers who are closest to their clients, who know of their complicated health status and medical vulnerability in deep and detailed ways, who are in fact often the ones with the requisite knowledge and expertise. They simply need the social capital, in the form of established relationships to medical professionals, to be able to act on that knowledge on behalf of their clients. Providers shared, for example, how they would coach clinicians on how to fill out the forms:

> I see coordinators, case managers, social workers coaching providers through what needs to be said and how to really fill out that paperwork. Oftentimes, in my past experience, I have just filled out that paperwork for the doctors and have them sign it.

In the case of Iris's client above, as a frontline worker, Iris required approval and sign off from her supervisor, a nurse care manager, but it was her detailed understanding of her client's health and end-of-life preferences that enabled her to direct her housing plan:

> I did all the groundwork and then it was up to me because we really have to push for this [tiny home option]. But it took [my] supervisor's word for it, because I don't have authority, I'm just a worker. So although I had that conversation with them [tiny home staff] and they were like, "Yeah, we're going to look into it," my supervisor did have to give some sort of [sign] of approval…even though it was my patient, my idea and my suggestion and my work.

Second, housing providers mobilized personal and professional connections to other housing providers located at key gatekeeping nodes within the system. For example, Diane, a nurse program coordinator working in a healthcare clinic, shared that most of her clients living on the street and in need of housing "stay on the [CE] queue for years" after they are administered a CE assessment: "For anyone who's like 50 years old, hypertension, substance use disorder, homeless for 15 years, that's you and everybody else. You're not going to be anywhere up on the [CE priority] list." The sentiment here was that while clients living with chronic health issues were in high need of housing, their medical issues were not acute enough, they were not at imminent risk of death, and they would only rise to the top if they became progressively worse and were appropriately reassessed as such. However, Diane acknowledged that she could, at times, leverage her connections and credentials to secure a spot for a subset of very high-need clients whom she personally advocated for: "If you email a sob story to the right person, you somehow can get someone in."

> I do think that the longer you're in this position…once you gain this type of seniority and you get your network, it's like you can just really streamline things…I guess it's good that there's some flexibility in the system. I don't agree that it should be fully a numbers game…They give you diagnostics, but everyone has asthma, COPD. At one point hypertension and smoking was on [the eligibility criteria list]. So it's like everyone. So, it's really hard to be the one to figure out who gets what.

Other scholars have found that frontline service providers may manage the emotional and physical demands of their jobs by using their discretion to help a subset of "likely to succeed" clients, a process known as "creaming" (Lipsky, [1980] 2010). However, I found limited evidence of traditional conceptions of creaming, which often describe how caseworkers are more willing to help clients who appear competent and motivated. In this case, while service providers may ration the resources they manage (or maintain connections to gatekeepers who do) by prioritizing some client cases over others, this was based on who was deemed most medically in need of housing among a pool of clients who all needed housing. In other words, while there may have been clients who were relatively more high-risk than others (acutely ill vs chronically ill), service providers relayed the sentiment that almost any person on their caseload could be chosen and rendered in ways that highlighted their medical need, thus prioritizing them for housing or said another way: all clients are deserving of housing.

Sometimes, the process of making clients disabled did not involve cherry-picking one client to advocate for as high-need and disabled; instead, blocks of housing would open up and, in these circumstances, service providers utilized their personal connections to both gather intel about when these openings might occur and create opportunities to place multiple clients in housing at one time. Nonetheless, providers still felt compelled to update their clients' conditions, and to be ready to show their disability, fragility, and medical risk:

> If you email someone on the right day, like today, then you get an email back saying, "We're going to reopen the [Project Roomkey] referrals in the next couple days." And it's like, "Oh, shit. Let me get my act together. Now I've got to update my list of all my highest-risk patients so that I'm ready to refer people as soon as that referral comes out."

While this strategy often worked to secure housing for clients, it came with the discomfort of cherry-picking some clients over others. Almost all the service providers I spoke to who had direct lines of access to secure housing for their clients—or who worked with staff who had this power—expressed great uneasiness about being a gatekeeper of housing or working around established protocols. Diane said,

> You also shouldn't have to [use your networks] in order to access the system that has been laid out to try to help people…It's really hard to try to be the decider. I think, for a lot of our staff, it feels like you are the decider…And it's hard to be like, "You're sick enough. You're not sick enough”... I don't want to be a gatekeeper.

At the same time, they wanted what was best for their clients. Marina, a housing and healthcare social worker, shared her conflicting feelings about taking advantage of an “under the table” connection at a transitional housing building that required clients to “meet medical eligibility to be referred.”

> [The units in the transitional housing building] filled up really quickly. And now they have a really long wait list. But they love [my colleague]. So they will call [my colleague] when they have an opening and ask [her] to refer people instead of going to the waitlist. So that ends up being useful for me, because [my colleague] will ask me, "Do you have any high priority people?" But on the other hand, it makes me so angry. Because what's the point of having a waitlist if you're just going to call [my colleague] and ask her to refer people? I was especially angry when I first found out because I had referred a man who was 85 years old with dementia. And I had had a whole email chain about him, because he's 85 with dementia and he's on the street!...And then I hear that [my colleague] is getting calls, asking about high priority patients.

Service providers argued that they could take any one person from their caseload and write a “sob story” about them; that is, most clients had bona fide and often heartbreaking illness trajectories that medically qualified them for housing. That service providers could mobilize their social capital with clinicians and housing gatekeepers to advocate for their clients was not, from the providers’ perspective, a legitimate way to make the system of housing prioritization ‘work,’ but instead a clear indictment of how broken the system in fact was.

CONCLUSION

While federal, state, and county governments institutionalize categories of need and eligibility for housing for people experiencing homelessness, localities and service providers have discretion and flexibility in how they interpret, determine, and implement these classifications. In this chapter, I show how service providers exercise agency and discretion in their understandings and use of categories of housing deservingness, by seeing and showing disability through medical compromise and complexity, justifying medical exceptions, escalating disability to rehouse clients in need of a higher level of residential care, and as a strategy of last resort, mobilizing their social capital. Systems of housing prioritization, and therefore service provider strategies, favored individuals who were medically legible and who had health conditions that could more easily be stretched to be categorized as disabled, and/or visibly compromised.

In these ways, deservingness is structured but not determined by the formalized definitions put forth by housing institutions. While service providers took issue with narrowly defined and operationalized measures of vulnerability, they also framed their clients' needs and histories in biomedical terms to work within the dysfunctional housing eligibility and prioritization systems on behalf of their clients. While the process of *making clients disabled* and leveraging constructions of disability (and concomitantly, conceptions of illness, risk, and medical complexity) to fit clients to housing reveals a paradox: On the one hand, it allowed service providers to highlight how the social and health situations of their clients are more complex than official definitions of need can capture. On the other hand, the process of documenting that need arguably re-flattened that complexity as service providers were constrained to asking clinicians to check boxes and provide closed-ended responses to verify disability. Thus, service providers' constructions of risk, medical complexity, and disability ultimately reinforced biomedical discourse as the appropriate and legitimate system to determine housing worthiness.

CHAPTER 5: CONCLUSION

ROOTS OF THE PROJECT

My dissertation emerges from my long-standing interests in social science research at the intersection of chronic health, housing insecurity, social networks, and the urban safety net. My work and scholarship are informed by several projects, and even more people.

A decade ago, I conducted an ethnography of a breast cancer patient navigation program at a safety net hospital in the San Francisco Bay Area for my master's thesis. This project oriented me towards the critical role frontline healthcare workers play in reducing healthcare disparities. The project solidified my interest in pursuing social science research using ethnographic methods. I saw first-hand how patient navigators provided not only language translation but also critically important emotional and informational support to historically underserved women seeking care in the healthcare safety net. I observed that patient navigators had a certain level of day-to-day discretion in how they provided care; yet they were simultaneously constrained by the confusion about their role in the context of team-based care. As a result, at times, patient navigators were reduced to medical interpreters, while at other times, they were pulled into tasks well beyond their scope of training. This fieldwork sensitized me to the structured social relations that frontline providers experience while at work, including relations with their colleagues, the people they serve, other members of the care team, and how these relations impact the care they provide.

Following the completion of my master's degree, I joined three UCSF-based research teams as a Research Analyst and was awarded the UC Berkeley Human Rights Center Fellowship to pursue independent research. As a Human Rights Fellow, I led and conducted a small study that documented through qualitative interviews with healthcare providers understandings of and experiences with time-limited breast cancer treatment for undocumented women in California. The research questions for the project emerged from my conversations with a community-based organization I was collaborating with. My findings revealed that when undocumented women chose to receive treatment, they risked deportation. Consequently, women who received treatment felt they were forced to choose between their health and the ability to stay in the U.S. Before I learned the theoretical concept of biological citizenship, I saw how social benefits were coupled with responsibilities, and in this case, life-altering consequences: the risk of deportation. This project helped orient me towards the importance of community-based research collaborations and the material consequences of public policy.

As a Research Analyst, I worked on a range of social and structural issues affecting the health of people living with chronic illness and learned to apply qualitative and quantitative methods to complex questions under the mentorship of leaders in their fields. On one project, I worked for over five years with a food assistance organization in the Bay Area. The community-based participatory research project examined how comprehensive, medically appropriate food support impacted the health outcomes of food- and housing-insecure individuals living with chronic health conditions. While everyone I interviewed for the study experienced food insecurity, what was most salient for people was their experiences with housing insecurity and homelessness. This was the first time I felt a calling to research the social-structural foundations of and solutions to housing insecurity and homelessness. Simply put, one cannot benefit from a bag of healthy groceries if you do not have a place to store, refrigerate, and cook the food.

Later, in my work on two interdisciplinary research teams, I collected preliminary data for my dissertation project. The studies explored how urban, healthcare safety net settings address the medical and social needs of patients living with multiple chronic illnesses. These projects showed me how health and illness shape and are shaped by experiences and trajectories of housing insecurity and poverty and further, provided the infrastructure upon which to gain entreé to one of my fieldwork sites.

As a witness to California's growing social and economic inequity, and the policies enabling and sustaining it, I have confronted both normative and empirical questions of power, privilege, and social exclusion in my everyday work and life. With roots in the Bay Area and a deep commitment to the community I grew up in, I have spent the last decade conducting research in Northern California's most contested and rapidly changing cities and neighborhoods. We live in a humanitarian crisis. Documented counts indicate there are over 180,000 people experiencing homelessness daily in California and this is likely an undercount. Many are children and families and people experiencing chronic illness and disability, showing the complete failure of our health and social safety net systems. I have seen how the policies that we enact to address homelessness are frequently punitive—they criminalize, individualize, pathologize, and demonize people who have been repeatedly failed and traumatized by multiple social institutions. This is inequitable and unacceptable. Clearing encampments and locking up people with mental health illnesses, for example, does not solve the underlying problems. Rather, such approaches add to the trauma, distrust, and poor outcomes for individuals and communities. I feel compelled to be a part of the research and the policy solutions that move away from blaming individuals for homelessness, poverty, and illness, that use sociological tools to redirect our gaze and efforts towards changing the social-structural and systemic origins of the crisis that continue to perpetuate and exacerbate homelessness in California. My positionality as a relatively young, able-bodied, white woman working on a graduate degree who has not experienced homelessness places me in a privileged position in relation to my client- and service provider-participants. Accordingly, I feel compelled to be involved in this crisis, to be an ally in this work, and to collaborate with, and take direction from, people with lived experience as well as the service providers who care for them. In the context of a rising tide of legislation reversing constitutional protections for people experiencing homelessness and emboldening jurisdictions seeking to criminalize homelessness, this work is of even greater importance.

SUMMARY OF DISSERTATION FINDINGS

In the first empirical chapter, Chapter 2, I explored the social construction of housing need and vulnerability and the implications for who is prioritized for housing. I provided a brief social history of the understandings of homelessness and the incorporation of health and illness as central components and operationalizations of homeless need and vulnerability. I argued that the history of federal homelessness policy from the 1980s onward, through to the emergence of the Coordinated Entry (CE) system in 2012 and the COVID-19 pandemic, herald a new era in understandings of homelessness, one that highlights a formidable return to medicalized notions of housing need. While service providers could see why health and illness came to have renewed importance for housing prioritization, they argued this surface logic belied a deep irrationality: namely, some clients in dire need of housing were sorted out by strict eligibility criteria or were allocated housing only when they were so sick that they passed away right before or just after the receipt of housing.

While conceptions of homelessness—and specifically the return of health and illness criteria—seek to identify some of the most vulnerable people experiencing homelessness and match them to housing, I argue that such definitions stratify and ration scarce housing resources in ways that create new tiers of housing need and vulnerability and generate additional forms of exclusion. Specifically, these definitions legitimate and promote medicalized and individualized notions of need, prevent many individuals from accessing much-needed resources based on narrow eligibility criteria, and further, turn our focus away from structural- and community-level solutions. Taken together, this chapter underscores how conceptions of vulnerability and need have material and social consequences.

In Chapter 3, I explored an unexamined mechanism in the sorting and stratifying of housing opportunities: the assemblage of CE technology with its service provider users. Specifically, I highlighted how service providers implemented specific strategies in conjunction with their use of the CE system to *surface disability* for clients and especially for households who may feel stigmatized for sharing sensitive experiences, histories, and diagnoses. I argued that rather than being black boxes that take human inputs to produce algorithmic outputs, technologies like the CE system give service providers limited but important levels of discretion they can leverage to prioritize households experiencing homelessness into housing. Providers identified the disability section of the CE assessment as a key strategic lever to produce housing prioritizations they felt better reflected their own evaluations of actual client need.

I described the specific discretionary strategies service providers used—contextualizing, defining and normalizing, coaching and probing, and adjusting—to achieve what they understood to be more accurate assessments of housing need. First, they *contextualized* the importance of the CE assessment to preempt and mitigate against clients' inclinations to withhold what they might view as stigmatizing information and situated client experiences in this light. Second, to protect their clients from the full impact of how CE assessment questions might alienate, further stigmatize, and re-inflict harm on their clients, they *defined* disability as encompassing far more common and expansive conditions beyond conventional notions and images of severe physical disability and *normalized* disability by relaying that living with a mental or physical health issue is a universal experience. Third, they *coached* clients what to expect from the CE assessment to help clients avoid vague answers that may have downplayed their need or acuity and asked open-ended questions and follow-up *probes* to ensure question comprehension and make space for narrative responses to better capture a client's holistic life history. Fourth, they *adjusted* client files to reflect accurate histories, experiences, and diagnoses that might translate into higher CE scores and ultimately, housing receipt. Each of these strategies constituted interactional processes and actions on and with the CE technology that made the system 'work' and rendered it to be less problematic and more trustworthy. The very work that service providers felt they must do for CE to prioritize their clients properly for the housing they needed showed the stakes of algorithmic outcomes. Taken together, Chapter 3 underscored the importance of service provider advocacy and the ways they negotiate housing assessment and prioritization especially for households experiencing homelessness and living with a disability.

While Chapter 3 revealed resistance and workarounds to the prioritization process, Chapter 4 showed moments of acceptance and acknowledgement of the legitimacy of the medicalized categories of need used in housing prioritization. In Chapter 4, I examined the discursive work of on-the-ground service providers to show how biomedical norms and standards shape definitions of need, vulnerability, and deservingness and ultimately, housing receipt. Systems of housing prioritization, and therefore service provider strategies, favored individuals who were medically legible and who had health conditions that could more easily be stretched to be categorized as disabled and/or visibly compromised. For those initially excluded from housing because narrow and strict eligibility criteria failed to include them, service providers often sought to assign meanings, interpretations, and weights to their illnesses and characterize them as disabled in ways that might earn them housing.

Specifically, I showed how, for clients experiencing homelessness and living with a chronic illness or disability who were not immediately prioritized for housing through CE, or did not meet housing program eligibility criteria, service providers worked to *fit clients to housing* by constructing them as disabled or medically in need of housing through various strategies. Service providers deployed four specific strategies to construct their clients as disabled: seeing and showing disability; justifying medical exceptions; escalating disability; and personally advocating with social capital. First, *seeing disability* involved providers' favoring their own direct observations of clients' actual health conditions and needs for housing as electronic medical record data on symptoms, diagnoses, and healthcare utilization did not always capture the level of compromise or complexity they witnessed in person. *Showing disability* then involved making recommendations to housing gatekeepers about who was most sick and in need of housing based on seeing disability. These paired strategies of *seeing and showing disability* highlighted that while official, written eligibility criteria may exist, the ways in which clients were selected for some housing was a subjective, flexible process that emphasized the in-person clinical assessment of a select group of service providers who advocated for specific clients. Second, when clients did not fit technical, medical criteria, and in some cases official categories could not be stretched far enough to cover these clients, service providers worked to show how their clients actually met the 'spirit of the law'; that is, they identified clients most in medical need of housing, who constituted justifiable *medical exceptions* to official criteria. Third, once clients were housed, service providers continued to construct their clients as in need of higher levels of care by *escalating disability* to prevent clients from losing their housing and returning to homelessness. When the above strategies failed, service providers *mobilized their social capital* to personally advocate for their clients; leveraging personal and professional connections often hinged on the ability to make the case that their clients were in fact disabled enough and had medical reasons to be housed.

I showed how each strategy mapped onto biomedical constructions of housing deservingness and specific types of housing and institutional care. Constrained by housing allocation systems that stratified clients by medicalized notions of need, service providers focused on those clients who had medical complexities and risks that could be highlighted, and in so doing, reinforced biomedical criteria as the appropriate and legitimate sorting mechanisms to determine housing worthiness. Together, service provider strategies underscore that health issues among people experiencing homelessness are complex, messy, and unpredictable; therefore, housing resources and services must accommodate the natural progression of illness trajectories.

THEORETICAL CONTRIBUTIONS

Through the sociological study of the interpersonal, organizational, and structural processes that sort and stratify households experiencing housing insecurity and homelessness, this research contributes to scholarly understandings of the social construction of deservingness, boundary and classification work, and technological rationalization and quantification. These intertwining social actions were central to the dissertation’s focus on the sorting and stratifying processes that underlie the allocation of the scarce, valuable resource of housing.

First, this dissertation attends to what social categories are deemed deserving of state attention, how symbolic boundaries are drawn and sustained (Lamont and Fournier 1992), and how marginalized groups, particularly the poor, have been constructed as deserving or undeserving (Soss, Fording, and Schram 2011; Katz 2013). Deservingness—one of the most enduring narratives to classify people experiencing poverty and determine their worthiness of assistance—is defined in a myriad of ways. Philosophers have articulated different possibilities including the value of the service to individual and society (utilitarianism), the benefits that accrue a particular group or society (past-oriented reciprocity or future oriented instrumental value) or favoring individuals in the direst circumstances (prioritarianism) (Shinn and Ricard 2022). But these approaches are rarely wholly singular, and instead, often mix; however, all such approaches carry within them ideas about moral worth and shape decisions that allocate public resources, and direct attention, to some but not others. The binary framework of deservingness over-simplifies decisions about the distribution of resources despite complex realities (Watkins-Hayes and Kovalsky 2016). My research contributes to this scholarship through an examination of housing prioritization systems that seek to allocate scarce housing resources to those considered most in need or vulnerable of housing. While scholarship has traced the shift in federal homeless policy from prioritizing populations who are "housing ready" (a treatment first model) to the "hardest-to-house" (Housing First model), my dissertation reveals a new era of deservingness based on individualized and medicalized notions of need. In this era, deservingness is defined as individuals who had health conditions that could be defined as disabled, who had conditions and characteristics that could be easily translated into medical diagnoses of special interest to housing allocation systems, and who were visibly compromised.

Second, I contribute to scholarship on street-level bureaucracy theory to explore an unexamined mechanism in the sorting and stratifying of housing opportunities: the frontline service provider. While much of the scholarship on street-level bureaucracy highlights the use and misuse of frontline discretion and judgment (e.g., Korteweg 2003; Pavetti 2018; Schram et al. 2009; Soss et al. 2011), my findings point to the productive and beneficial ways in which service providers leverage their discretion to *surface disability* to ensure their clients who are living with a disability but who were not classified as disabled are prioritized for housing. Service providers are street-level bureaucrats who are both embedded in and constrained by larger homelessness response systems, the organizations in which they work, and their relationships with superiors and clients, but data show that service providers also have important, albeit limited, levels of agency to interpret policies and processes, make decisions, and respond to their clients. Given their discretion in the day-to-day governing of housing assessment and prioritization, service providers, as gatekeepers of housing, translate what they describe as opaque and nonsensical CE rules, procedures, and outcomes, and in doing so, effectively "rewrite" them. As they interpret and apply categories of need and deservingness in their everyday mundane interactions with clients, they in turn produce and assign new meanings of the definitions, categories, and eligibility criteria themselves.

Relatedly, I contribute to the scholarship that examines how social policies sort households with varying health status into different housing opportunities with various consequences (Rosen 2014; Eubanks 2018; McCabe 2020; Shiff 2021). Given the current scarcity of housing, institutions and agencies have increasingly needed to engage in processes of triage, prioritization and ultimately, differentiation and classification, to make choices about who should receive housing resources and assistance (Moore 2016; Eubanks 2018; McCabe 2020; Rita et al. 2022). My dissertation takes up health and illness as under-examined yet increasingly critical dimensions along which eligibility, screening, and selection for housing are determined and conducted. Specifically, my research shows how the stratification of individuals and households experiencing homelessness has been medicalized through the proliferation of notions of need that reinforce biomedical criteria as the appropriate and legitimate sorting mechanisms to determine housing worthiness. In this way, my work moves beyond Eubanks' (2018) conclusion that CE is a "surveillance system for sorting and criminalizing the poor," to one that also classifies, sorts, and stratifies by health status, illness, and disability.

Additionally, my project contributes to the study of health, disability, and illness as grounds to make claims for scarce and valuable housing resources. I take up the concept of biological citizenship, which describes new forms of belonging and subjectivity based on biological traits, and whether and how these traits can make demands on the state and social institutions for resources and care (Petryna 2002; Rose and Novas 2006), to show how biomedical definitions of need and vulnerability are leveraged by service providers on behalf of their clients to designate individuals as deserving of housing. In this way, as service providers come to understand the details of specific classification processes—for example, becoming attuned to the disability section of the CE assessment tool—they participate and facilitate processes that enact biological citizenship, by strategically aligning their clients with biomedicalized classification criteria, and ultimately housing receipt.

Further, my findings also extend the work that examines and critiques the technological rationalization of public service delivery (Eubanks 2018; Noble 2018; O'Neil 2016). The quantification and reduction of complex lives—and the seeming neutrality and objectivity of the CE score—was the basis for the strategies service providers undertook to work with the CE system, or rather, to make the CE system 'work.' My findings provide context to the housing prioritization studies that show that algorithms, or rules written into software, can be complex and opaque, and further, algorithms (re)produce existing social and health disparities (Barocas et al 2016; Noble 2018; Benjamin 2019; Obermeyer et al. 2019; Kiviat 2023). I take up Fourcade and Healy's (2013) "classification situations," in particular, to argue that *disability classifications*, or the ways in which the CE system orders households based on presence of a disability, and sort and structure them into different life-chances. Specifically, households living with a disability but not classified as disabled due to problematic CE features may be deprioritized for housing. The commitment of service providers to prioritize their clients properly for the housing they so desperately need, but were not accurately assessed for, shows the stakes of algorithmic outcomes. My data therefore have important implications for any assessment and prioritization tool that inquire about sensitive and stigmatizing health and disability statuses. In the context of studies that argue that the quantification and reduction of complex lives shrink social programs and exacerbate inequalities, these theoretical contributions are of paramount value.

STUDY LIMITATIONS

This research is based on a case study of a single county in California. While this allowed for an in-depth exploration of the processes of sorting and stratifying in Juniper County, the findings may not be generalizable to other regions or contexts with different demographics, policies, or levels of resource availability.

The COVID-19 pandemic created an extraordinary and atypical context, with widespread disruptions to social services, housing markets, and public health systems. The behaviors, policies, and practices observed during this period may not reflect the usual functionings of housing and healthcare systems. Consequently, some findings might be more reflective of pandemic-induced conditions. Many policies and interventions implemented during the pandemic, such as eviction moratoriums, emergency shelter programs like Project Roomkey, and expanded public health measures, were temporary. Therefore, this research may capture the effects of these short-term measures, which may not be applicable in a post-pandemic context.

The pandemic introduced fieldwork and data collection challenges, including difficulties in accessing certain populations, limitations on in-person interactions, and disruptions to planned fieldwork. These challenges led to a greater reliance on virtual interviews and fieldwork during the beginning of the study to comply with social distancing measures, resulting in fewer opportunities for direct observation and interaction. The pandemic increased service provider workload and stress, which may have impacted their willingness or ability to engage in interviews and longitudinal observations. People experiencing homelessness and housing insecurity were likely harder to reach due to shelter-in-place orders and the closure of public spaces. Client participants moved frequently, their phone numbers changed, or they lost contact with service providers which made it challenging to follow clients over time.

Although the study aimed to include a diverse range of participants, there are gaps in representation. Certain groups, such as non-English speakers, undocumented immigrants, and people living with severe mental health issues, are not included or are underrepresented. Further, a significant portion of the data reported here is derived from interviews with and fieldwork of service providers. Their views may not fully capture the experiences of clients.

The study’s focus on the interaction between service providers and technology (such as Coordinated Entry systems) may overlook other important factors influencing housing outcomes, such as policy changes, funding availability, or broader economic conditions.

And finally, although the study considered the intersectional impacts of poverty and health on housing insecurity, future research necessitates an analysis of other critical dimensions of identity and oppression such as race and gender.

IMPLICATIONS FOR HOUSING POLICY AND PROVISION

My dissertation has been motivated by the idea that understanding the nature, causes, and consequences of housing insecurity in the most structurally vulnerable populations will provide broad and nuanced insights into mechanisms of downward social mobility, poverty, and illness. Chronic disease and illness occur in complex interdependencies and are deeply rooted in poverty, racism, unemployment, social isolation, and housing insecurity. Through the identification of shortcomings in the health, housing, and social safety net, this research provides a clearer evidence base for social institutions and policymakers to make informed decisions and develop meaningful, upstream solutions that achieve positive change for individuals experiencing poverty, housing insecurity, and illness. Herein, I describe the implications for service providers and for housing provision and policy.

This dissertation shows how service providers' navigations of and resistance to the allocation technologies and systems they had to work with is rooted in the recognition that all the attention to definitions and boundaries of deservingness arise out of widespread unmet need and unjust distribution. In the absence of housing for all, service provider strategies to make their clients *legible* (Rita et al. 2022) does not reduce the overall number of people experiencing homelessness nor does it widen the supply of housing or pool of benefits; instead, they merely "rearrang[e] scarcity" (Rita et al. 2022:86). Providers understood this at an intuitive level and felt diminished by and disconnected from the system they had to work within. The work was arduous and further exacerbated by the COVID-19 pandemic. Ultimately, the anomie of service providers contributed to burnout and their exit from this work. In turn, provider turnover exacerbated client distrust and further delayed housing placements. Lipsky ([1980] 2010) suggests that street-level bureaucrats manage the emotional and physical demands of their jobs by using their discretion to help a subset of "likely to succeed" clients, a process known as "creaming." In the context of rationing scarce resources, and to manage emotionally draining and risky work, street-level workers may ration the resources they manage by prioritizing some client cases over others. While I do find that service providers in my study help clients surface disability (Chapter 3) and fit them to housing (Chapter 4), I found limited evidence of creaming. Further, I did not find that service providers relied on their discretion to claim small successes or redeem some satisfaction from challenging frontline work. Instead, service providers used their discretion to counteract narrow definitions of need and vulnerability and problematic technology in their everyday work. In other words, I do not think that service providers manipulated the CE system; instead, service providers deployed several strategies to supplement the CE system to make it work accurately and fairly.

While I highlight the challenges and critiques of housing prioritization processes and systems for clients and their service provider advocates, my findings should not be interpreted as support for doing away with the housing prioritization tools all together. As long as federal funding for social programs remains insufficient, communities will struggle to equitably ration and allocate the limited housing resources available to address housing insecurity and homelessness. Critics of CE take issue with the tool's generation of a vulnerability score, where only those above a threshold (based on housing supply and estimated demand[1]) are matched to housing placements, and instead have advocated for an approach to assessment that categorizes households by what *type* of housing they need (Bacalao 2021; Council on Homelessness San Francisco 2023). The former approach simply quantifies the available housing stock in a community, potentially reinforcing a scarcity-driven framework. In contrast, the latter approach enables communities to assess and understand the specific types and amounts of housing and assistance required to adequately support all households experiencing homelessness, fostering a more comprehensive and needs-based system.

Indeed, my findings revealed how clients may be inappropriately matched to certain types of housing and require higher levels of care and supportive services to support their high-acuity mental, behavioral, and physical health needs long-term and as they age in place. The siloed landscape of diagnosis-dependent housing, tailored to provide targeted levels of care based on specific medically defined criteria and needs, resulted in fragmented systems of care and residential instability for some clients. In this way, tying services to housing created unintended (yet predictable) consequences. As chronic illness waxes and wanes, and as individuals age, formerly homeless individuals experiencing illness and disability need varying levels of care and support. When support services vary by housing, and their need for these services is part of the eligibility criteria, individuals then need to change housing, adding to the vicious cycle of moving in and out of hospitals, nursing facilities, respites, and the street. While meeting clients where they are is a core part of ensuring equitable access to the support and

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[1] In Juniper County, there are two main queues. Each queue has a unique threshold based on current and anticipated housing inventory (supply), the estimated number of eligible households (demand), and the number of referrals that are typically needed to fill an opening. An assessment score above the threshold qualifies the household to be added to the respective queue and therefore, prioritized for housing in that queue. Within a queue, subpopulations may have different threshold scores because resources of certain subpopulations (e.g., families with children, veterans, people living with HIV/AIDS) may be more plentiful relative to other groups. The County CoC adjusts thresholds based on increases or decreases in inventory as well as referrals.

services they need, it too has unintended consequences of forcing people out. This then requires service providers to construct clients as disabled to fit them to housing using the strategies I identify in Chapter 4.

Access to onsite clinical staff and in-home support (found at some PSH sites, including the Sunrise Hotel as described in Chapter 4) may help residents living with chronic mental, physical, and/or substance use issues avoid eviction and displacement due to lease violations that stem from failing to maintain their living spaces. From a policy perspective, investing in innovative models that provide comprehensive health and social services and that are replicable and scalable will help improve health and housing outcomes for formerly homeless individuals experiencing illness and disability, such as reductions in evictions and acute care visits. My research therefore provides support for the innovative braiding of sustainable funding streams, such as Homekey paired with Medi-Cal waivers[2] and new offerings provided by CalAIM, the state's reform of Medicaid services, to realize the promise, and sustainability, of PSH (Reid 2023). In the context of the increasing imbrication of housing and healthcare systems, it is even more important to direct funds to expand the supply of affordable and permanent supportive housing as well as sustain investment in their day-to-day operating expenses to ensure high-quality services (Reid 2023).

More broadly, my findings underscore that a more capacious and empirically accurate way to define homelessness is to consider it as a process, not a place. In the U.S., the scholarship connecting poverty, housing insecurity, and illness focuses primarily on discrete events/episodes

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[2] Waiver programs could include Medi-Cal's Home and Community Based Alternatives (HCBA) program and the Assisted Living Waiver (ALW). HCBA provides care management services, including onsite health and personal care, to persons at risk of nursing home or institutional placement. The ALW program covers care needs equal to those of Medi-Cal-funded residents living and receiving care in nursing facilities and willing to live in an assisted living setting or in publicly funded senior and/or disabled housing as an alternative to a nursing facility. Long-term coverage of nursing home care is now under managed care plans (MCPs) rather than the state fee-for-service program; therefore, MCPs have a vested interest in supporting people to live outside nursing homes.

(e.g., an eviction) and static states (e.g., homelessness). In contrast, I propose that scholars of housing theorize housing insecurity as a *process*. Such an approach attends to the temporality yet durability of unequal structural conditions and is critical to understanding the role of health and illness in the experiences of housing insecurity, especially but not only among chronically ill individuals living in poverty. Conceptualizing housing insecurity as a process is central to elucidating both the broader power structures that precipitate housing insecurity in the first place and then maintain it, *and* the resulting health impacts that come not just from being unhoused per se but also from exposure to chronic risk, precarity, and instability (Bossarte et al. 2013; Graif et al. 2016; Leventhal and Brooks-Gunn 2003; Liu et al. 2014).

From a policy perspective, a more inclusive definition of homelessness, that better captures all those who are experiencing precarity, would provide a more comprehensive accounting of actual need (Chamberlain 1999; Williams 2005). Even official counts of homelessness exclude more hidden forms of homelessness—for example, those who are "doubled-up" with family, couch surfing, or institutionalized in hospitals or incarcerated (Metcalf 2021; National Law Center on Homelessness & Poverty 2017).[3] More accurate counts could help to galvanize (even if not necessarily to ensure) more resources that are directed towards housing, thereby changing the scarcity of housing.

My findings also raise important questions about the costs of reducing individuals to quantifiable characteristics: What would it look like to add community-level risk factors, such as neighborhood and exposure to violence, to housing prioritization tools and scoring to capture the

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[3] It is important to note that while undocumented individuals and exploited farm workers are often precariously housed and experience homelessness, they are not targeted at the outset by policies to end homelessness. In this way, my research shows that biomedicine provides the framework and tools to help society justify allocating housing to people living with illness and disability while many people who experience housing insecurity in a broader sense are not considered in need of housing resources and services at the outset.

structural contexts in which people are living? What if, instead of compelling people to report sensitive and stigmatizing statuses and using overly complex metrics to determine worth, we simply asked people experiencing homelessness what they needed? Both CE and Project Roomkey definitions of need and eligibility criteria reveal how our definitions of need and vulnerability are still not looking at the *structural* factors that produce risk.

FUTURE DIRECTIONS

My long-term goal is to study and lead scholarly research that furthers social-scientific knowledge to guide policy decision and remains rooted in a commitment to social justice. To this end, I plan to present the final analyses and its implications for housing and healthcare policy to my two research sites. These workshops will help facilitate a discussion as to how the findings can be translated into policy. I also plan to further disseminate this work into the publication of lay, policy, and sociological reports and papers.

One arm of future work will be to support innovative projects that bridge the housing and healthcare sectors, specifically initiatives to expand permanent supportive housing (PSH) in California through Medi-Cal.[4] My dissertation research revealed healthcare system challenges in forging partnerships with homeless services agencies through CalAIM, Medi-Cal's care delivery and payment reform initiative, and why healthcare providers and staff maintained, and in some cases expanded, the housing work they were responsible for despite state-level efforts to situate housing supports and services in the community. This highlights that without additional investments in the homeless services industry—including helping PSH providers leverage

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[4] Work in this area is underway at the Terner Center for Housing Innovation at UC Berkeley under Carolina Reid, PhD.

healthcare funding for housing—the promises of integrating housing-related social care into the delivery of healthcare and likewise, adequately funding and providing supportive and health services to residents in PSH units, will not be fully realized.

Another area of further analysis and future research is the exploration of the critical and intersectional role of race, gender, and health in housing prioritization and receipt. Specifically, preliminary data from my fieldwork and interviews show how housing prioritization processes might compound the racialization of people experiencing homelessness. Racialization occurs through processes of accumulation where state policies are elaborated by the mundane acts of many individuals at multiple levels of government over time (Soss et al. 2011). That is, racial disparities flow directly from social (e.g., housing, poverty, healthcare) institutions and organizations (Ray 2019), and also deeply depend on the actions of individual organizational actors that make up those institutions. In my data, as Carmen and other service providers highlighted, Black clients may "refuse" to answer CE questions about health and disability; "'I'm not crazy,'" some clients responded. Indeed, Black communities face significant stigma in discussing and disclosing mental health issues and experiences, in particular, a major factor in Black individuals not receiving mental healthcare (Keene, Cowan, and Baker 2015). Given that a quarter of individuals experiencing homelessness in California are Black (Young et al. 2024) over half of homeless families in the U.S. are Black (U.S. Department of Housing and Urban Development 2023), and many of the clients and service providers I interviewed and shadowed were Black, my analysis raises questions for future research about the role of stigma in the relationship between race and prioritization scores and housing receipt. While Juniper County materials claimed that, unlike the VI-SPDAT, use of their custom prioritization tool did not produce racial disparities, my work raises questions about the relationships among race, health, and technology and how they collectively and intersectionally influence organizational processes that may shape the larger racial order (Ray 2019). In particular, my findings raise the following questions: is the number of families experiencing chronic homelessness an undercount due to the requirement of clients to self-disclose sensitive and stigmatizing statues and experiences, including disability? Are CE systems, in turn, deprioritizing Black women experiencing homelessness, many of whom are single mothers, for housing? Indeed, emerging research finds that decreased discretion and increased automation of CE assessment tools may exclude certain subgroups with unique vulnerabilities and barriers to housing, such as single women and Black men (Brewer 2021).

Another future area of scholarship would attend to the increasing standardization and automation of housing processes and decisions. As frontline discretionary work increasingly comes under pressure in the age of artificial intelligence (AI) for its apparent subjectivity and arbitrariness, governments may seek to standardize processes of assessment, prioritization, matching, and case management or replace discretion completely with automation. My time with service providers suggest that discretion in the context of housing prioritization, as shown through their everyday strategies, is a product of skill, compassion, and flexibility, where service providers meet clients where they are at, respond to individual and situational contexts, create safe spaces for disclosure, and at critical junctions, even self-disclose their own health issues in order to draw out client experiences and normalize disability so that clients are appropriately prioritized for housing. In this way, discretion is an indispensable part of the everyday work of service providers and the process of making decisions (including the minutia of administering a CE assessment) cannot be reduced to a set of seemingly objective rules or closed-ended questions. Simply, algorithms cannot do human decision-making work. As put forward by scholars in other areas (e.g., Petersen et al. 2020 in frontline social work), I call for housing prioritization systems to better integrate discretion with technology rather than undermine one or the other to create a system that flexibility incorporates the benefits and promises of discretion and digitization. In the age of AI, where the use of algorithms is expanding at an unprecedented pace, the need for algorithmic literacy, transparency, and oversight is also paramount.

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There is a fundamental assumption that underlies this dissertation: housing is a scarce resource. On one hand, this is true: there is not enough housing to meet the overwhelming demand for it. On the other hand, scarcity discourse and arguments lend themselves to processes and tactics of prioritization, triage, differentiation, and classification and ultimately, narrow definitions of need and vulnerability to allocate seemingly limited resources to those defined as deserving, thus perpetuating a system of scarcity (see, e.g., Metcalf 2021). While the federal definition of homelessness has steadily incorporated more categories and sub-populations, these include classifications that can be narrowly interpreted. Narrow conceptions of homelessness are not an accident nor oversight as they tend to limit the scope of program and policy interventions by helping the state and homeless services industry regulate and manage access to apparently limited funding under the guise of seemingly rational criteria (Williams 2005; Willse 2015). While most of my service provider participants argued that prioritizing people with medical issues is important, the CE system did not reduce the number of people experiencing homelessness and further, housing prioritization systems will not “fix” homelessness. Instead, CE uses algorithmic technology to regulate who can access the community’s limited housing resources. Bacalao (2021) described this as “shrink[ing] the problem—not in the sense of reducing it, but in the sense of putting tens of thousands of unhoused people through a digital process of elimination until the number of people prioritized for housing more or less matches the amount of housing that happens to be available." In other words, the CE system continues to move people to the back of the queue until the system deems them homeless or sick *enough* to be worthy of housing assistance. Because immense housing need exists across a wide range of individuals and groups, any conception of need and vulnerability will be susceptible to criticism. As Rita and colleagues note (2022:100), "the primary policy failure rests not in the preference system…but in the material shortage that it is designed to manage." Or, as one service provider I interviewed put it, in the context of emergency housing provided during the pandemic, "If we had enough [emergency COVID] hotel rooms…we wouldn't have to have these more minute eligibility criteria because there would be enough for everybody."

Given this fundamental fact of scarcity, and high levels of precarity, involuntary residential mobility, and homelessness in populations who suffer from poverty and chronic illness, I argue that the sociology of housing must move beyond the "actual home or apartment" (Pattillo 2013) and instead trace how people's interactions with institutional actors within geographic, economic, and political contexts shape their housing and health trajectories. My project has aimed to do just that, and to contribute an understanding of the normative order that structures interactions within organizations and institutions that provide housing assistance. By showing how micro-level relations both manifest from and accrete up to macro-structural forces, and by theorizing process not place, my work extends the realm of dispossession of land and home to body and health, and asserts that the cyclical and processual deprivation of home has unfolding consequences for health.

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