Empowerment through Research for People Experiencing Homelessness

Priority Patient-Centered Comparative Effectiveness Research Questions for People Experiencing Homelessness

Prepared by Howard Padwa, Ph.D., Carissa Loya, B.A., Ronald Joshua Williams, M.A., Roya Ijadi-Maghsoodi, M.D., Madelyn Cooper, B.A., Benjamin Henwood, Ph.D., Randall Kuhn, Ph.D., Ricky Bluthenthal, Ph.D., Ena Fenderson, Elvin Galarza, Anthony Haynes, Dennis King, Emily Martiniuk, Sonny Mendoza, Theodore Patton, Suzette Shaw, Reba Stevens, & Lillian Gelberg M.D.

Background

Over 653,000 people experienced homelessness (PEH) in the United States (U.S.) in 2023, a 12 percent increase from 2020 levels. Over 143,000 of them experienced chronic homelessness, having been continuously homeless for at least one year or having had experienced four or more episodes of homelessness totaling at least 12 months in the previous 3 years.[1]

Beyond its socio-economic and humanitarian dimensions, homelessness is a health emergency. The harsh living conditions and acute stresses of homelessness accelerate aging, leading PEH to experience geriatric conditions and medical complications more typical of individuals 10-20 years older.[2] PEH are also at increased risk for behavioral health disorders including depression, anxiety, psychotic disorders, and substance use conditions, and they have significantly elevated prevalence of infectious disease than housed populations.[3] High levels of morbidity are compounded by the fact that PEH face significant barriers to accessing health care, and on the rare occasions they do access it, they receive services that are insufficient and/or of poor quality.[4] The combination of extreme need and insufficient treatment has dire consequences; on average, PEH die approximately 20 years earlier than their housed counterparts.[5]

The crisis of homelessness and health has spurred action, leading to the investment of hundreds of millions of dollars from the National Institutes of Health (NIH), the Department of Veterans Affairs (DVA), the Patient-Centered Outcomes Research Institute (PCORI), and other funders. These resources aim to contribute to research on how to improve healthcare and health outcomes for PEH.[6] As in other areas of medicine, researchers studying PEH have begun engaging individuals who have lived experience as partners in their work.[7] Individuals who are affected by complex social, health, and public health issues (such as homelessness) have unique insights that

---

[1] de Sousa T, Andrichik A, Presterea E, Rush K, Tano C, Wheeler M. *2023 Annual Homeless Assessment Report: Part 1 - PIT Estimates of Homelessness in the U.S. | HUD USER*. U.S. Department of Housing and Urban Development.; 2023. Accessed December 21, 2023. https://www.huduser.gov/portal/datasets/ahar/2023-ahar-part-1-pit-estimates-of-homelessness-in-the-us.html

[2] Adams, J., Rosenheck, R., Gee, L., Seibyl, C. L., & Kushel, M. (2007). Hospitalized younger: a comparison of a national sample of homeless and housed inpatient veterans. *Journal of health care for the poor and underserved*, *18*(1), 173-184; Brown, R. T., Kiely, D. K., Bharel, M., & Mitchell, S. L. (2012). Geriatric syndromes in older homeless adults. *Journal of general internal medicine*, *27*, 16-22.

[3] Richards J, Kuhn R. Unsheltered Homelessness and Health: A Literature Review. *AJPM Focus*. 2023;2(1):100043. doi:10.1016/j.focus.2022.100043

[4] Buccieri, K. (2020). Homeless patients associate clinician bias with suboptimal care for mental illness, addictions, and chronic pain. *Journal of Primary Care and Community Health*, *11*, 1–7. https:// doi.org/10.1177/2150132720910289; Jones, A. L., Haussman, L. R., Haas, G. L., Mor, M. K., Cashy, J. P., Schaefer, J. H., & Gordon, A. J. (2017). A national evaluation of homeless and non-homeless veterans' experiences with primary care. *Psychological Services*, *14*(2), 174–183. https://doi.org/10.1037/ser0000116

[5] Meyer BD, Wyse A, Bosma H. *Life and Death at the Margins of Society: The Mortality of the U.S. Homeless Population*. Becker Friedman Institute for Economics at the University of Chicago; 2015. Accessed January 11, 2024. https://bfi.uchicago.edu/insight/research-summary/the-mortality-of-the-us-homeless-population/

[6] Padwa, H., Henwood, B. F., Ijadi-Maghsoodi, R., Tran-Smith, B., Darby, A., Bluthenthal, R., ... & Gelberg, L. (2023). Bringing Lived Experience to Research on Health and Homelessness: Perspectives of Researchers and Lived Experience Partners. *Community Mental Health Journal*, 1-8.

[7] Ibid.; Fletcher, E. H., Gabriellan, S., Brown, L., Gough, J. C., Ijadi-Maghsoodi, R., Kolofonos, I., Nazinyan, M., Orellana, E., & Wells, K. (2022). Lessons learned by collaborating with structurally vulnerable veterans via a Veterans Engagement Group. Journal of General Internal Medicine, 37(S1), 109–112. https://doi.org/10.1007/ s11606-021-07075-y; Franco, A., Meldrum, J., & Ngairuiya, C. (2021). Identifying homeless population needs in the emergency department using communitybased participatory research. BMC Health Research, 21(428), https://doi.org/10.1186/s12913-021-06426-z; Kiser, T., Hulton, L. (2018). Addressing health care needs in the homeless population: A new approach using participatory action research. SAGE Open, 8(3), https://doi.org/10.1177/215824401878975

can be used to ensure that studies (a) ask questions related to outcomes that matter to patients, and (b) produce answers that are relevant for the challenges that patients face.[8] Bringing the lived experience to research related to homelessness is particularly important since many of the problems PEH endure—high levels of violence,[9] frequent adversarial interactions with law enforcement,[10] and limited access to basic amenities like shelter and restrooms[11]—are so profound that they are difficult to fathom for those who have not experienced them. By centering the voices and perspectives of people with lived experience in research on healthcare and homelessness, the field may be able to generate solutions to critical questions about how to improve health and well-being for PEH—solutions that so far, have remained elusive.

By centering the voices and perspectives of people with lived experience in research on healthcare and homelessness, the field may be able to generate solutions to critical questions about how to improve health and well-being for PEH—solutions that so far, have remained elusive.

In 2022, PCORI funded *Resources to Empower Persons Experiencing homelessness in Comparative Trials—Project RESPECT* to help bring the perspectives of PEH to research on homelessness and health. Project RESPECT assembled a team of researchers, healthcare providers, homeless service providers, and eleven individuals who have personally experienced chronic homelessness to accomplish several tasks,[12] including the development of three priority questions for patient-centered comparative effectiveness research on homelessness and health. For further detail on Project RESPECT and its functioning, see the group's *Guide to Engaging People with Lived Experience as Stakeholders in Patient-Centered Comparative Effectiveness Research*.[13] Through a process that was driven by the perspectives and priorities of PEH themselves, Project RESPECT has generated a list of research topics that we believe can generate actionable knowledge that will improve the health and well-being of PEH. This report provides an overview of the steps used to create this list, and the list itself.

---

[8] Guerrero Ramirez, G., Bradley, K., Amos, L., Jean-Baptiste, D., Ruggiero, R., Marki, Y…Benton, A. (2023). *What Is Lived Experience?* U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Retrieved from https://aspe.hhs.gov/lived-experience February 22, 2024

[9] Ellsworth, J. T. (2019). Street crime victimization among homeless adults: A review of the literature. *Victims & Offenders*, *14*(1), 96-118.

[10] Robinson, T. (2019). No right to rest: Police enforcement patterns and quality of life consequences of the criminalization of homelessness. *Urban affairs review*, *55*(1), 41-73.

[11] Swayne, M. R., Calzo, J. P., Felner, J. K., & Welsh Carroll, M. (2023). Developing evidence for building sanitation justice: A multi methods approach to understanding public restroom quantity, quality, accessibility, and user experiences. *Plos one*, *18*(7), e0288525; Sommer, M., Gruer, C., Smith, R. C., Maroko, A., & Hopper, K. (2020). Menstruation and homelessness: Challenges faced living in shelters and on the street in New York City. *Health & Place*, *66*, 102431.

[12] *Resources to Empower Persons Experiencing homelessness in Comparative Trials (RESPECT).* Retrieved from https://www.pcori.org/research-results/2021/resources-empower-persons-experiencing-homelessness-comparative-trials-respect February 23, 2024.

[13] *Resources to Empower Persons Experiencing homelessness in Comparative Trials (RESPECT).* Retrieved from https://www.pcori.org/research-results/2021/resources-empower-persons-experiencing-homelessness-comparative-trials-respect February 23, 2024.

The report includes:

- A description of the group's process for developing its patient-centered research agenda.
- The three key group recommendations to advance future patient-centered research on homelessness.

Methods: Developing a Patient-Centered Research Agenda on Health and Homelessness Driven by the Priorities of PEH

Project RESPECT convened fourteen ninety-minute meetings with the group's lived experience partners and other researchers via Zoom from 2022 through 2024 to develop a patient-centered research agenda related to health and homelessness. Members of the group with lived experience also corresponded with members of the Project RESPECT team (researchers from the University of California, Los Angeles) by email and telephone throughout the project period. Throughout this process, Project RESPECT undertook many activities and had many in-depth discussions about their lived experience and their understanding of how services need to be improved to make meaningful differences for PEH's health. For more details on this process, see Project RESPECT's *Guide to Engaging People with Lived Experience as Stakeholders in Patient-Centered Comparative Effectiveness Research*.[14]

Phase One – The SEED Method

Originally, Project RESPECT planned to use the *Stakeholder Engagement in Question Development and Prioritization (SEED) Method* developed by a research team from Virginia Commonwealth University[15] to guide groups in developing patient-centered conceptual models and research questions. Initial Project RESPECT meetings that used the SEED Method provided venues for group members to share their lived experiences, discuss their perspectives on what "patient-centered outcomes" for PEH may be, and identify shortcomings of existing service systems. However, practical restraints—particularly the fact that Project RESPECT was meeting via Zoom and that meetings were only ninety minutes—made it difficult to accomplish key steps in the SEED Method process, particularly those related to patient-centered research question development.

---

[14] Ibid.

[15] Zimmerman, E., Cook, S. (2017). *The SEED Method Toolkit: Overview and Summary.* Retrieved from https://societyhealth.vcu.edu/media/society-health/pdf/SEEDMethodToolkitBrochure.pdf; Zimmerman, E. B., Rafie, C. L., Moser, D. E., Hargrove, A., Noe, T., & Mills, C. A. (2020). Participatory action planning to address the opioid crisis in a rural Virginia community using the SEED Method. *Journal of Participatory Research Methods*, *1*(1); Rafie, C. L., Zimmerman, E. B., Moser, D. E., Cook, S., & Zarghami, F. (2019). A lung cancer research agenda that reflects the diverse perspectives of community stakeholders: process and outcomes of the SEED method. *Research Involvement and Engagement*, *5*, 1-12; Zimmerman, E. B., Cook, S. K., Haley, A. D., Woolf, S. H., Price, S. K., & Team, T. E. R. (2017). A patient and provider research agenda on diabetes and hypertension management. *American Journal of Preventive Medicine*, *53*(1), 123-129.

Phase Two – Individualized Conversations

After realizing that the group was not accomplishing its goals using the SEED method, the RESPECT team shifted course, moving from large group discussions to one-on-one conversations with each lived experience group member. In these conversations, the RESPECT team asked group members to share their personal stories about how their health and well-being improved as they transitioned through and out of homelessness. Interview facilitators focused on having lived experience group members identify: (1) when in their minds they felt that their health and well-being were improving (however they defined it); and (2) the things that they believed helped their situation improve.

The team analyzed notes from interviews, and classified "how/when you felt things were improving" as patient-centered outcomes, and the "things that helped" as potential mediators. Before finalizing this list, they consulted with lived experience stakeholders in a group meeting to verify that these classifications were correct and concorded with their experiences g. See Table 1 below for an overview of these findings.

TABLE 1
Findings from Personal Stories of Lived Experience Project RESPECT Members

Patient-Centered Outcomes	*Mediators*
I started viewing things positively	Getting connected to resources and benefits
I was sleeping better	Going to classes and activities
I felt seen and heard	Gaining control of my finances
My basic needs were being met	Having a provider who listened to my needs
I was thriving, not just surviving	Getting education about my mental health
I felt more connected to reality	Getting connected to church
I was not using alcohol/drugs	Getting transportation
I trusted others	Getting furniture
I felt I was working towards a future	Being given everyday supplies
I felt financial stability	Getting help with housing/benefits paperwork
I felt capable	Getting help with housing/benefits bureaucracy
I was making my own decisions	Help managing conflicts with other tenants
I had sense of belonging	Having a positive relationship with staff
I had a sense of accomplishment	Enrollment in a jobs program/employment help
I was grateful	Good program management
I felt peace	Providers who followed through on promises
I was happy	Living in a safe environment
I started expressing myself more through art	Having providers who empowered me
I felt I had skills	Continuity of medical/mental health care
I had privacy	Getting mental health care
I felt joy	Getting substance use disorder treatment
I was getting along with others	Getting connected to a 12-step group
I felt motivated	Going to groups in my housing program
I felt mentally healthy	Mindfulness activities
I felt optimistic	Feeling accepted

I felt a sense of control	Developing life skills
I felt physically safe	Being given choice
I felt courageous	Getting money
I was being nice to other people	Getting housing immediately
I felt physically healthy	Outdoor activity
	Exercise
	Providers who did not blame/dehumanize me

Phase Three – Creating a Conceptual Model

The RESPECT team then consolidated these lists into five overarching patient-centered outcomes and overarching six moderators that were related to these outcomes in PEH's stories. Prior to finalizing this list, the RESPECT team verified its accuracy with Project RESPECT's lived experience stakeholders. See Tables 2 and 3 below.

TABLE 2
Patient-Centered Outcomes for PEH

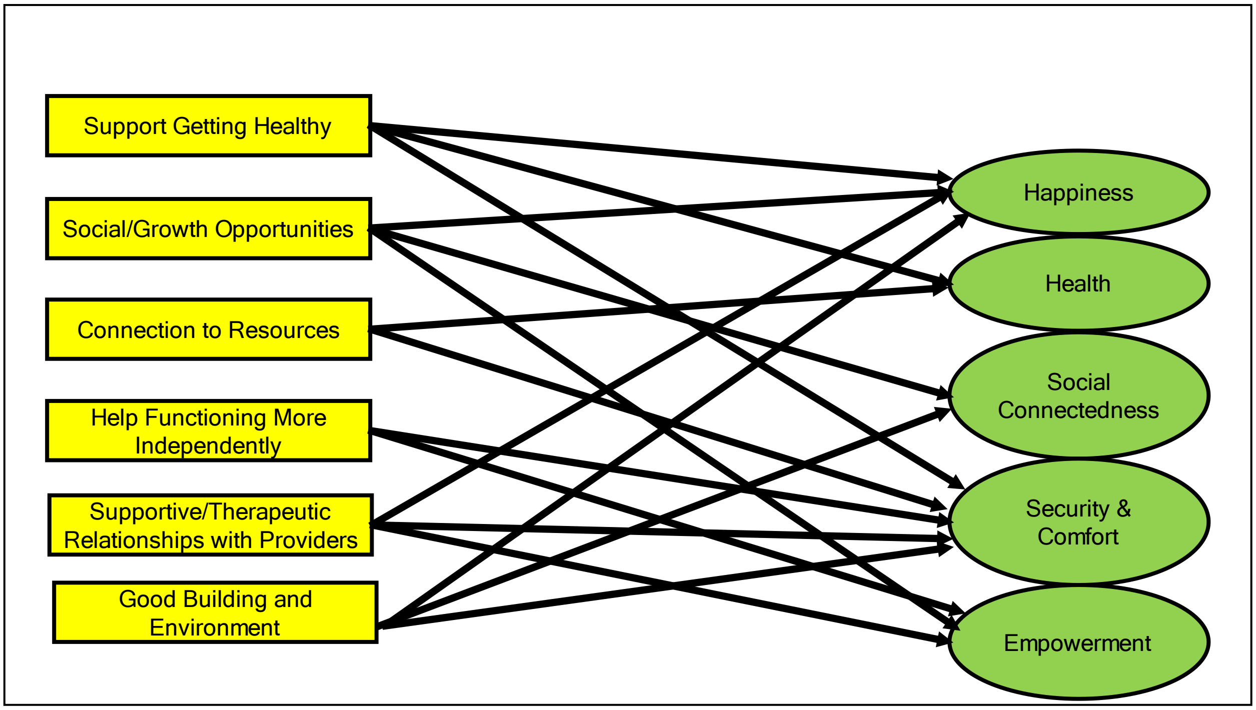
Category	Improvement Mentioned in Interviews
Happiness	I started viewing things positively, I was thriving not just surviving, I was grateful, I felt peace, I was happy, I felt joy, I felt optimistic
Health	I was sleeping better, I was more connected to reality, I was not using alcohol/drugs, I felt mentally healthy, I felt physically healthy
Social Connectedness	I felt seen and heard, I trusted others, I had a sense of belonging, I was getting along with others, I was being nice to other people
Security and Comfort	My basic needs were being met, I felt financial stability, I had privacy, I felt physically safe
Empowerment	I felt I was working towards a future, I felt capable, I was making my own decisions, I had a sense of accomplishment, I started expressing myself more through art, I felt I had skills, I felt motivated, I felt a sense of control, I felt courageous

TABLE 3
Patient-Centered Outcomes for PEH - Mediators

Category	Improvement Mentioned in Interviews
Support Getting Healthy	Getting education about my mental health, Continuity of medical and mental health care, Getting mental health care, Getting substance use disorder treatment, Getting connected to a 12-step group, Mindfulness activities, Exercise
Social/Growth Opportunities	Going to classes and activities, Getting connected to church, Going to groups in my housing program, Feeling accepted, Outdoor activity
Connection to Resources and Materials	Getting connected to resources and benefits, Getting transportation, Getting furniture, Being given everyday supplies, Getting help with housing/benefits paperwork, Getting help with housing/benefits bureaucracy, Getting money, Getting housing immediately
Help Functioning More Independently	Gaining control of my finances, Enrollment in a job program/employment help, Having providers who empowered me, Developing life skills, Being given choice
Supportive/Therapeutic Relationships with Providers	Having a provider who listened to my needs, Having a positive relationship with staff, Providers who followed through on promises, Providers who did not blame/dehumanize me
Good Buildings and Living Environment	Help managing conflicts with other tenants, Good program management, Living in a safe environment

Using these outcomes and mediators, the RESPECT team then created a conceptual model of patient-centered outcomes for PEH. See Figure 1.

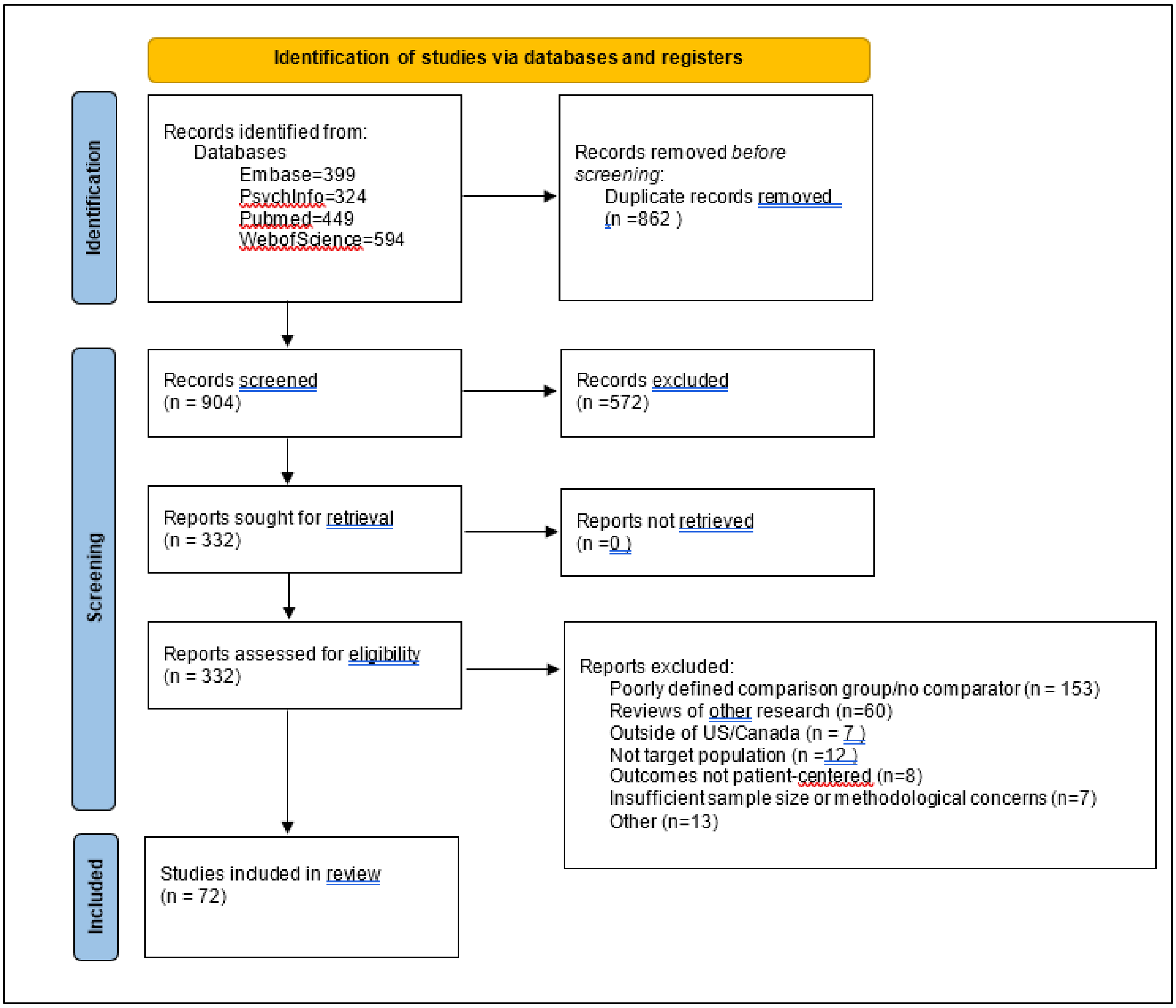
FIGURE 1
Patient-Centered Outcomes and Moderators for PEH



Phase 4 – Literature Review

Starting with this conceptual model, the RESPECT team undertook an extensive literature review to identify existing research and research gaps to generate a roadmap for future patient-centered comparative effectiveness research related to health for PEH. In this review, the RESPECT team systematically reviewed PubMed, Embase, PsychInfo, and Web of Science, on these five patient-centered outcomes and homelessness to identify all relevant research published between 1989 and January 2024. The search yielded 1,769 research articles for potential inclusion in the literature review. After several phases, the group identified 72 articles that met criteria for inclusion in the review as comparative effectiveness research on patient-centered outcomes (happiness, health, social connectedness, security & comfort, empowerment) that were relevant for PEH (see Figure 2 below).

FIGURE 2
PROTOCOL FOR LITERATURE SEARCH
PATIENT-CENTERED OUTCOMES IDENTIFIED BY PROJECT RESPECT STAKEHOLDERS[16]



The Project RESPECT team reviewed these 72 comparative effectiveness research articles, and found the following:

1. The two most frequently researched types of interventions in comparative effectiveness research on health and homelessness were case management interventions (including intensive case management interventions that incorporated elements of behavioral health support, such as Assertive Community Treatment), and housing interventions (generally Permanent Supportive Housing using a Housing First approach). Other interventions included in comparative effectiveness research articles included behavior change interventions, traditional outpatient care for medical

---

[16] Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

or behavioral health disorders, education and job training, and medications to help manage mental health and substance use conditions. Frequently, studies compared combinations of several interventions with one another (e.g. Permanent Supportive Housing plus intensive case management vs. Permanent Supportive Housing plus regular case management).

2. The two patient-centered outcomes that were the focus of most comparative effectiveness research on health and homelessness were Security & Comfort (generally in the form of shelter or housing stability) and Health (symptom reduction, health-related functioning). There was little comparative effectiveness research focused on how to best achieve happiness, social connectedness, or empowerment for PEH.

Phase 5 – Stakeholder Feedback on Literature Review and Relevance to Real-World Problems Facing PEH

After completing the literature review, the Project RESPECT team presented findings to lived experience stakeholders and engaged them in a discussion of their implications for future research. While stakeholders agreed that the research gaps in the literature review—happiness, social connectedness, and empowerment—were noteworthy, they also expressed concern that simply recommending the development of research on how to achieve these three outcomes for PEH would be inappropriate for two reasons.

First, they pointed out that many homeless service providers claim to provide comprehensive, person-centered supports and services of the kind described in research literature (e.g. Permanent Supportive Housing, Housing First), but that they rarely implement them. Consequently, beyond studying what services to provide, it would be helpful to have research on how to deliver these services *well* and *consistently* in real-world settings.

Second, lived experience stakeholders expressed concern that by focusing on specific outcomes or aspects of service delivery, research risks oversimplifying the complexity of homelessness and helping PEH achieve stability in their lives. While services to help PEH can be beneficial, stakeholders maintained, the deprivations and dangers of homelessness are so great that they make other outcomes related to health and wellness difficult to achieve and nearly impossible to sustain. Stable, quality housing is not just part of "patient-centered outcomes" for PEH, but it is an essential precondition for the achievement of all other meaningful outcomes. Consequently, studying how to improve other outcomes while housing remains unstable is like researching how to best arrange deck chairs on the Titanic; it may answer questions, but the solutions will probably be inconsequential given the disastrous context. To really achieve patient-centered outcomes, homelessness

Studying how to improve other outcomes while housing remains unstable is like researching how to best arrange deck chairs on the Titanic; it may answer questions, but the solutions will probably be inconsequential given the disastrous context.

must be prevented whenever possible, and addressed immediately as soon as individuals become unhoused.

Results: Three Priority Patient-Centered Comparative Effectiveness Research Questions for People Experiencing Homelessness

Based on the results of the discussions, research, and analyses described above, Project RESPECT has determined that the following three areas should be the focus for future patient-centered comparative effectiveness on homelessness:

1. *How to produce patient-centered outcomes of happiness, social connectedness, and empowerment for PEH.* The majority of comparative effectiveness research on improving health for PEH focuses on two of the five patient-centered outcomes identified as patient-centered by the Project RESPECT group—housing and health. While achieving these outcomes is important for PEH, it is not sufficient. As the World Health Organization asserts in its Constitution, "health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[17] Yet the bulk of existing research on improving health for PEH focuses on the elimination of negative living conditions or mitigation of disease symptoms (i.e. achieving "absence of disease or infirmity"), advancing few answers to questions about how to promote "complete physical, mental, and social well-being." More research on how to achieve the social well-being outcomes of happiness, social connectedness, and empowerment for PEH is needed.

2. *How to implement interventions that improve patient-centered outcomes for PEH in real-world settings.* There is a strong research base for some interventions that can produce patient-centered outcomes, particularly for the Housing First model to improve outcomes related to security and comfort (mainly housing retention and avoiding returns to homelessness).[18] However, Housing First is often implemented as a "housing only" solution in practice, lacking the outreach and support services that are critical to the model's success.[19] Low fidelity implementation of Housing First decreases its effectiveness,[20] and many housing programs are poorly equipped to implement the model

---

[17] World Health Organization (2024). *Constitution.* Retrieved from https://www.who.int/about/accountability/governance/constitution February 26, 2024

[18] Woodhall-Melnik, J. R., & Dunn, J. R. (2016). A systematic review of outcomes associated with participation in Housing First programs. *Housing Studies*, *31*(3), 287-304; Baxter, A. J., Tweed, E. J., Katikireddi, S. V., & Thomson, H. (2019). Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. *J Epidemiol Community Health*, *73*(5), 379-387; Peng, Y., Hahn, R. A., Finnie, R. K., Cobb, J., Williams, S. P., Fielding, J. E., ... & Community Preventive Services Task Force. (2020). Permanent supportive housing with housing first to reduce homelessness and promote health among homeless populations with disability: a community guide systematic review. *Journal of Public Health Management and Practice*, *26*(5), 404-411.

[19] Discovery Institute (2022). *How Congress Can Reform Government's Misguided Homelessness Policies: Real Solutions for Mental Illness, Drug Addiction, and Crime Cannot be Found in Housing Subsidies Alone.* Report retrieved from https://fixhomelessness.org/2022/report/ February 24, 2024.

[20] Gilmer, T. P., Stefancic, A., Katz, M. L., Sklar, M., Tsemberis, S., & Palinkas, L. A. (2014). Fidelity to the housing first model and effectiveness of permanent supported housing programs in California. *Psychiatric Services*, *65*(11), 1311-1317.

as intended.[21] Implementation science—the rigorous study of how interventions are executed in real-world settings and strategies to improve their uptake and quality—can help identify reasons for the gaps between science and practice in services for PEH, improve their application in real-world settings, and ultimately improve participant-level outcomes.[22] There are over 60 established implementation science frameworks that can be used to guide research on the implementation of interventions to improve outcomes for PEH, and the Society for Implementation Research Collaboration has established a repository of over 400 measures that can be used in implementation research.[23] Research on the comparative effectiveness of implementation strategies when applied to interventions for PEH, and hybrid studies that examine both effectiveness and implementation,[24] are needed to advance knowledge on how to improve patient-centered outcomes for PEH in the real world.

3. *Preventing homelessness.* Homelessness is so destabilizing and damaging that it is inherently incompatible with health and wellness. While research on how to improve patient-centered outcomes for those who fall into homelessness is important, the best way to improve patient-centered outcomes is to prevent homelessness in the first place. Research related to other serious public health problems has subfields that focus on developing and testing prevention measures designed to reduce risk for disease and disability.[25] Universal interventions (applicable to entire populations), selective interventions (targeting those at elevated risk), and indicated interventions (targeting those who are found to manifest specific risk factors or behaviors) akin to those developed to limit the incidence of infectious disease, cancer, and substance use disorders exist for homelessness. These include income assistance programs,[26] rental subsidies, eviction prevention programs, community-based services (short-term financial assistance, education/job placement assistance, benefits enrollment, child care assistance), comprehensive case management services (e.g. Critical Time Intervention),[27] and services designed to mitigate risk for particularly at-risk populations, such as individuals exiting the criminal justice system.[28] Research on the comparative effectiveness of homelessness

---

[21] Fenwick, K., Henwood, B., Lengnick-Hall, R., Stefancic, A., & Gilmer, T. (2019). Exploring variation in housing first implementation: the role of fit. *Human Service Organizations: Management, Leadership & Governance*, *43*(5), 392-406.

[22] Bauer, M. S., Damschroder, L., Hagedorn, H., Smith, J., & Kilbourne, A. M. (2015). An introduction to implementation science for the non-specialist. *BMC psychology*, *3*(1), 1-12.; Rapport, F., Clay-Williams, R., Churruca, K., Shih, P., Hogden, A., & Braithwaite, J. (2018). The struggle of translating science into action: foundational concepts of implementation science. *Journal of evaluation in clinical practice*, *24*(1), 117-126.

[23] Curran, G. M. (2020). Implementation science made too simple: a teaching tool. *Implementation Science Communications*, *1*(1), 1-3.

[24] Curran, G. M., Bauer, M., Mittman, B., Pyne, J. M., & Stetler, C. (2012). Effectiveness-implementation hybrid designs: combining elements of clinical effectiveness and implementation research to enhance public health impact. *Medical care*, *50*(3), 217.

[25] Mrazek, P. J., & Haggerty, R. J. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. National Academy Press.

[26] Evans, W. N., Sullivan, J. X., & Wallskog, M. (2016). The impact of homelessness prevention programs on homelessness. *Science*, *353*(6300), 694-699.

[27] Shinn, M., & Cohen, R. (2019). Homelessness prevention: A review of the literature. *Center for Evidence-Based Solutions to Homelessness. http://www. evidenceonhomelessness. com/wp.*

[28] Augustine, D., & Kushel, M. (2022). Community supervision, housing insecurity, and homelessness. *The ANNALS of the American Academy of Political and Social Science*, *701*(1), 152-171.

prevention interventions can help advance the ultimate patient-centered goal of research related to health and well-being for PEH: ending homelessness itself.

Conclusions and Next Steps

Through a collaboration of researchers, homeless service providers, and PEH, Project RESPECT developed three priority areas for patient-centered comparative effectiveness related to homelessness and health that was shaped by the perspectives of individuals with lived experience. Our hope is that funders will take these recommendations for future research to heart, and support research that can answer these questions, which we believe hold some of the keys to improving the health and well-being of PEH. Similarly, we hope that researchers and their community partners (including PEH stakeholders) will rise to the challenge of designing and implementing studies that can generate actionable evidence that will be of use to policymakers, administrators, service providers, and PEH themselves.

If you have questions about Project RESPECT or would like further information, please reach out to Dr. Howard Padwa at hpadwa@mednet.ucla.edu