HOUSING FIRST IMPLEMENTATION BRIEF

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The current Administration set a bold and ambitious goal to end chronic and Veteran homelessness by 2015.[1] To accomplish this mission, the U.S. Department of Veterans Affairs (VA) launched a comprehensive, evidence-based, data- and outcome-driven strategy supported by significant local and federal partnerships and a considerable financial commitment. VA has transformed its service model to be more "person-centered" and focused on solutions—including collaborative community-based treatment and supportive services—to prevent and end Veteran homelessness. This approach has greatly increased access to healthcare, benefits, employment services, and permanent housing solutions for Veterans who are homeless or at risk.[2]

Initial results of this transformation are promising: between 2010 and 2013, the number of Veterans experiencing homelessness on a single night in January decreased by 24% (76,329 to 57,849).[3] This significant reduction in homelessness among Veterans is particularly notable as this progress has occurred during one of the worst recessions our country has faced, characterized by an affordable housing crisis and approximately 46.5 million people living in poverty.[4]

THE HOUSING FIRST MODEL

A primary example of VA's transformation is its decision to adopt, as national policy, a Housing First approach for its homeless programs. Housing First is a low-barrier, supportive housing model that emphasizes permanent supportive housing to end homelessness.[5] This approach provides individuals who are experiencing homelessness—particularly those who have been homeless for prolonged periods and have disabling conditions such as schizophrenia, bipolar disorder, recurrent major depression, post-traumatic stress disorder (PTSD), and addictive disorders—with permanent housing as quickly as possible and supportive services as needed. The Housing First approach provides housing without prerequisites for abstinence, psychiatric stability, or completion of treatment programs.[6]

Instead, the Housing First approach provides permanent housing as the *initial* service, followed by other supports based on the individual's needs and preferences. However, Housing First is not housing only; the model has a significant clinical service component: community-based clinical case management teams provide 24-hour, 7-days-a-week access to services including crisis intervention, financial management, landlord and family mediation, employment, community reintegration, and access to mental health, primary care, and addictions treatment.[7]

VA'S HOUSING FIRST PILOT

Before Housing First was declared official VA policy, the VA National Center on Homelessness Among Veterans (NCHAV) implemented an initiative to evaluate the approach within the context of VA and to advance the implementation and early adoption of the model within VA's supported housing program, HUD-VASH. HUD-VASH is a joint effort between the U.S. Department of Housing

and Urban Development (HUD) and VA in which HUD supplies housing assistance through its Housing Choice Voucher program while VA provides case management and supportive services through its healthcare system.

In coordination with the Homeless Program Office, NCHAV identified 14 VA medical centers (VAMCs) to participate in a Housing First pilot and provided them with 50–75 additional HUD-VASH vouchers (for a total of 700 vouchers nationally) and enhanced funding for more intensive case management services. This included financial support for a social worker, a nurse case manager, a peer specialist, and a part-time prescriber (e.g., physician assistant, nurse practitioner, or psychiatrist). Medical centers could either use existing or new staff to provide supportive services or contract with a local agency.

To support the adoption of the model, staff from NCHAV and Pathways to Housing—the agency that pioneered the Housing First approach—provided special training and technical assistance, including monthly conference calls, site visits, and assessment of each program's fidelity to the Housing First model. The following VAMCs participated in the Housing First pilot (* indicates those that contracted their supportive services):

Bedford/Boston, MA*
Chicago, IL
Dallas, TX
New York Harbor Healthcare System & Bronx, NY*
Detroit, MI
Greater Los Angeles Healthcare System
Philadelphia, PA*
New Orleans, LA
San Francisco, CA*
Washington, DC*
Portland, OR
Syracuse, NY
Bay Pines, FL
Denver, CO

EVALUATION OF THE HOUSING FIRST PILOT

To monitor implementation of the Housing First approach at the VAMCs identified above, case managers, either from VA or a contracted agency, collected data for Veterans who were admitted to HUD-VASH using VA Homeless Programs' standard reporting procedures. These data were reported at the time of referral and admission to HUD-VASH, during the housing process, and when the Veteran exited the program, if applicable. Specific measures include the following:

- Demographics: age, gender, ethnicity, marital status, military information, homeless status, treatment needs
- Process times: dates when Veterans were referred and admitted to HUD-VASH, received the Housing Choice Voucher, and moved into permanent housing
- Housing status 12 months after admission into housing

In addition, the NCHAV accessed data from Veterans' VA medical records, which included mental health and substance use disorder diagnoses as well as inpatient and outpatient mental health,

substance use, primary, and emergency care encounters for the 12 months prior to and following the Veteran's admission to the program. The primary outcomes of interest for this pilot project are:

- Time to placement in permanent supported housing
- Rates of housing retention
- Change in emergency care and inpatient hospitalizations during the 12 months following Veterans' admission to HUD-VASH

Demographic Characteristics

Approximately 700 Veterans experiencing homelessness at 14 VAMCs were engaged in the Housing First pilot. The overwhelming majority of these Veterans were single males (91%) of which 48% were divorced or separated. The majority of these Veterans served in the Vietnam and post-Vietnam eras. Equal proportions of the Housing First participants were black and Caucasian and more than two-thirds were between the ages of 45 and 64 years. Approximately 94% of Veterans who were admitted to the program met criteria for chronic homelessness (i.e., homeless continuously for a year or more, or four or more episodes of homelessness in the past three years). These Veterans also had significant disabilities: 78% presented with an active or prior diagnosis of a mental health or addiction condition. (See Figure 1.)

The demographic characteristics of the Veterans who participated in the Housing First pilot indicate that the early adopters of this approach were able to house the most "hard-to-engage," disenfranchised Veterans.

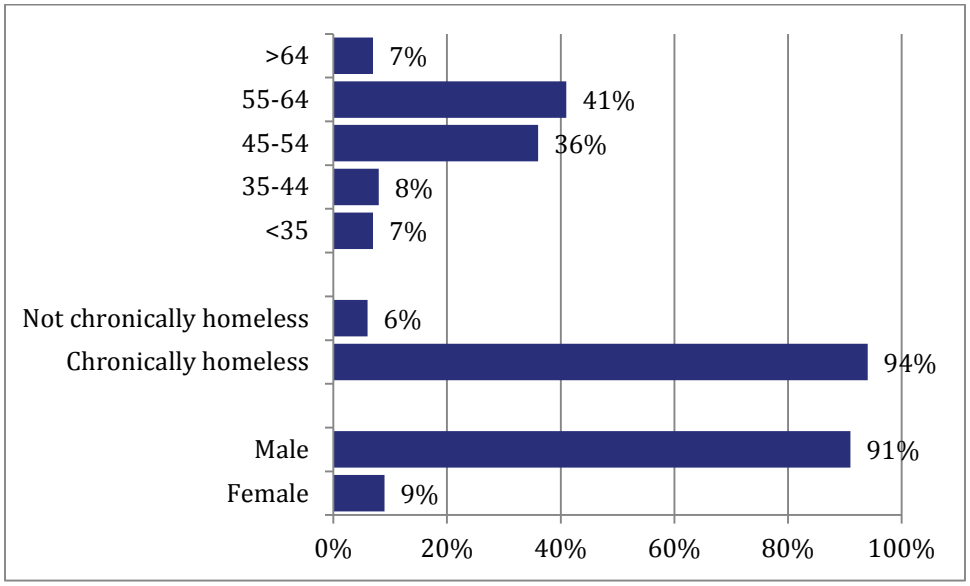

Figure 1. Demographics of Veterans Served in 14-Site Housing First Pilot

Time to Placement in HUD-VASH

On average, it took Veterans engaged in the Housing First approach 136 days to move into permanent housing following admission to the program. Possible factors that can explain this protracted time period include lack of financial resources for move-in costs and security deposits, as well as negative credit histories among the chronically homeless Veterans. These are common

barriers that make housing placement more difficult and increase the time that a Veteran remains homeless.

Housing Retention

Of the 700 homeless Veterans admitted to HUD-VASH utilizing a Housing First approach, 84% (585) are still living in permanent housing, with varying lengths of stay. Among the 115 Veterans who have left the program, 37% (43) moved to a more independent living arrangement; 20% (23) discharged to an institutional setting, including hospital, nursing home, or prison; 30% (34) relapsed into homeless or were lost to care; and 13% (15) died, the majority from natural causes.

Further evaluation is needed to better understand negative exits as well as deaths during the program, especially given the medical complexity of the Veterans served by Housing First. In addition, the role that addictive behaviors play in both negative discharges and causes of death should be assessed. Finally, the program would benefit from a deeper understanding of how healthcare and supportive services can advance permanent housing while properly addressing the special needs of Veterans with serious mental illness and dual diagnoses of mental illness and substance use disorders as well as those who are aging or medically fragile. Future research must focus on why interventions do not work for certain populations and what is required to make housing and healthcare more attainable and sustainable for all Veterans.

Services Utilization Prior to and After Program Admission

Using data from Veterans' medical records, utilization of emergency room and inpatient care services was compared during the 12 months prior to and following admission to HUD-VASH. For the 622 Veterans for whom there was complete data, the number of emergency room visits decreased by 27% (1,243 to 905) and acute inpatient hospitalizations decreased by 33% (456 to 307). Remarkably, the average length of stay for a hospitalization decreased from 17 days to 5 days and the total number of hospital bed days declined by 71% (10,443 to 3,043).[8] (See Figures 2 and 3.)

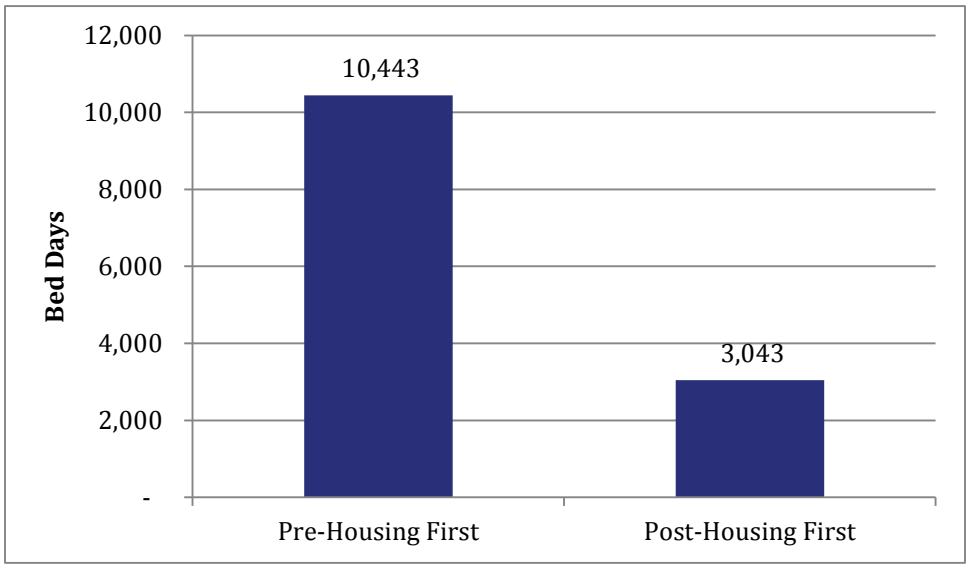

Figure 2. Total Bed Days During the 12 Months Prior to and Following Admmission to Housing First

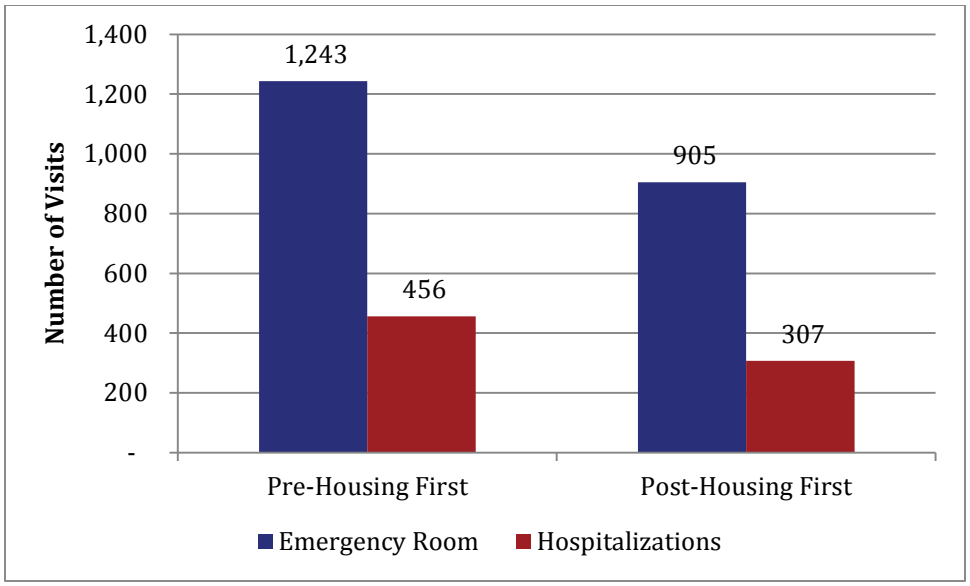

Figure 3. Total Emergency Room Visits and Hospitalizations During the 12 Months Prior to and Following Admission to Housing First

Decreases in acute healthcare services led to significant reductions in healthcare costs: overall there was a 32% reduction in total direct VA healthcare costs and, specifically, the utilization of more intensive inpatient cost decreased by 54%. This suggests that this population, who often present with trauma, difficulties managing chronic disease, mental illness, addictions, and deferred or delayed medical needs are engaging in ambulatory care services, which is promoting reductions in emergency and acute care.[9] (See Table 1.)

Table 1. VHA Healthcare Cost (12 months pre- and post-admission), N=622

	Mean Cost Pre-Admission	Mean Cost Post-Admission	Percent Change
Inpatient			
Mental Health	$4,270.63	$2,407.91	
Substance Abuse	$3,164.34	$1,587.38	
Other (Medical)	$6,375.94	$2,311.59	
Total Inpatient	*$13,810.91*	*$6,306.88*	**-54.3%**
Outpatient			
Mental Health	$2,229.28	$2,037.81	
Substance Abuse	$1,209.07	$1,019.00	
Other (Medical)	$6,222.82	$6,677.56	
Total Outpatient	*$9,661.17*	*$9,734.37*	**0.8%**
Total	$23,472.08	$16,041.25	**-31.7%**
Data source: Veterans Health Administration (VHA) Decision Support System (DSS)			

DISCUSSION

Findings from this early implementation initiative demonstrate that Housing First is both a clinically effective and fiscally efficient model of permanent supported housing that can be implemented successfully in VA Homeless Programs. This evaluation is most notable in how the Housing First model was associated with reductions in acute hospital utilization while increasing ambulatory-based engagement.

The findings presented here are consistent with other studies that demonstrate Housing First's effectiveness at accessing and maintaining permanent supported housing for single adults, particularly those who have experienced chronic homelessness and have a mental health disability.[10] These findings also support prior studies that have demonstrated the efficacy of permanent supported housing in reducing rates of homelessness and associated healthcare utilization, particularly emergency care and inpatient hospitalizations.[11] Notwithstanding these positive findings, more rigorous research is needed to further evaluate the effectiveness of the model with homeless individuals who are experiencing both substance abuse and mental health issues that complicate the engagement and retention process.

A limitation of this report is that its study of cost only included cost incurred by the VAMC. For a more complete understanding of the cost savings, external data sources to assess other community costs—Medicare, justice, shelter—are needed, making it possible to evaluate the full return on investment for communities that are implementing Housing First. Additional areas of inquiry include the question of whether housing provides a foundation for healthy behaviors that increase compliance with healthcare and, ultimately, improve quality of life as well as determining the right dose and duration of case management and supports to help individuals achieve and sustain permanent housing. VA and NCHAV are in an ideal position to conduct such studies and to further evaluate the long-term implications (i.e., 36 months or greater) of the Housing First approach on housing stability, healthcare costs, and improved quality of life for chronically homeless Veterans.

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