**Program Brief: Camden City's Housing First Program For Patients With Complex Health And Social Needs**
**August 2017**

*The incoming administration should invest in the Housing First model as an effective health care intervention for individuals with complex health and social needs by developing a coordinated statewide approach to providing sustainable, low barrier supportive housing for homeless individuals experiencing high utilization of the healthcare system. To date, the preliminary findings from Camden City's Housing First Pilot Program demonstrate a 60 percent reduction in health care utilization per days at risk after patients receive housing.*

## Executive Summary

- Housing First is proving to be a powerful health care intervention. By prioritizing housing for patients with complex health and social needs, the next gubernatorial administration in New Jersey (NJ) has an opportunity to dramatically improve the health and wellbeing of some of our most vulnerable citizens. In so doing, the Medicaid system will also realize increased efficiencies and savings.
- Patients who experience chronic homelessness[*] and complex health and social needs[†] often suffer disproportionately from mental health and substance use disorders; rely heavily on emergency and inpatient services; incur the greatest expense in the health care system; and receive disjointed, fragmented care that is ineffective.[1]
- Evidence-based, the Housing First model of care offers housing and support services to patients who experience chronic homelessness and complex health and social needs. Grounded in the belief that housing is a right, the model provides housing with few barriers to entry.[3]
- To date, the preliminary findings from Camden City's Housing First Pilot Program demonstrate a 60 percent reduction in unnecessary health care utilization per days at risk after medically and socially complex patients receive housing. These early results underscore the importance of creating statewide Housing First.[3]
- NJ may be able to reduce health care utilization and costs for patients with the greatest need. To meet this end, it is imperative that the next administrativion continue to support Camden City's Housing First Pilot Program, as well as statewide Housing First policies and programs for patients with complex health and social needs.

[*] Chronic homelessness: someone who has experienced homelessness for a year or longer, or who has experienced at least four episodes of homelessness in the last three years (must be a cumulative of 12 months), and has a disability. A family with an adult member who meets this description would also be considered chronically homeless.[4]

[†] Patients with complex health and social needs: a relatively small patient population for whom the current health system is ill-equipped to meet the myriad of interrelated medical, behavioral, and social challenges they may face including those often considered 'non-medical' such as addiction, housing, hunger, and mental health. They often experience poorer outcomes despite extreme patterns of hospitalization or emergency care.[3]

## I. Introduction

The next gubernatorial administration in NJ has an opportunity to improve care quality and health outcomes for some of the most vulnerable citizens, as well as increase efficiencies and savings across the Medicaid system, by prioritizing housing for individuals with complex health and social needs. To date, the preliminary findings from Camden City's Housing First Pilot Program demonstrate a 60 percent reduction in unnecessary health care utilization per days at risk after patients with complex health and social needs receive housing. These early results underscore the importance of creating statewide Housing First policies and programs. Given the uncertainty at the federal level and limited state and Medicaid resources, programs like Housing First become all the more compelling.

This paper will address the connection between health and housing for patients with complex health and social needs and highlight Camden City's Housing First Pilot Program as an innovative, evidence-based health care intervention. Addressing some of the extant challenges to implementation and scalability, this paper offers preliminary recommendations to developing a statewide Housing First program for patients with complex health and social needs.

## II. The Problem: The Cost of Homelessness

Individuals at-risk for homelessness or considered chronically homeless often struggle with medical and social complexities. Absent permanent housing, they grapple with how to manage their health and health care and rely heavily on multiple systems to meet basic needs. Hospitalization and incarceration become their default systems of care. The United States Interagency Council on Homelessness reports that this misuse of emergency services and the jail is expensive, costing between $30,000 and $50,000 per person each year.[6] In addition, this patient population frequently falls into the one percent of Medicaid beneficiaries that account for 30 percent of Medicaid spending. A report by Rutgers Center for State Health Policy also found that 86 percent of these patients suffer from behavioral health diagnoses, including substance use disorders.[7]

## III. What is Housing First?

Widely used and evidence-based, Housing First provides permanent housing and support services to individuals facing long-term housing challenges. Housing First is based on the belief that all people experiencing homelessness can achieve medical and social stability in permanent housing. By definition, Housing First programs have very few barriers to entry, which is different from traditional housing programs that have pre-requisites. Preconditions, such as sobriety, are shown to impede housing stability.[14] The Substance Abuse and Mental Health Services Administration (SAMSHA) defines seven key elements as essential to high fidelity Housing First. The following fidelity scale for Housing First was created under the influence of federal policies and regulations, consumer preference data, and research:

1. Choice of Housing: To the extent possible, people should be able to choose the

type of housing they prefer. Some research shows that people have better outcomes when living in housing that meets their expressed preferences.

2. Separation of Housing and Services: Property management and case management functions are separate and distinct. Ideally, housing units and services are provided by separate entities.

3. Decent, Safe and Affordable Housing: Housing is considered affordable when tenants pay no more than 30 percent of their income toward rent plus basic utilities. Housing is considered safe and decent if the unit meets U.S. Department of Housing and Urban Development (HUD) Housing Quality Standards.

4. Integration: Federal law and the Olmstead Supreme Court decision support the need for permanent housing and support services to be provided in integrated settings. Such settings may be scattered-site housing or housing in which units are available to people who do not have disabilities or histories of homelessness.

5. Rights of Tenancy: Tenants must have a lease that is in compliance with local landlord/tenant law.

6. Access to Housing: Access to housing should not be denied based on requirements that prospective tenants be "ready" for housing.

7. Flexible, Voluntary Services: High fidelity Housing First requires that consumers/tenants are the primary authors of their treatment plans, and that the services that they chose under these plans are consumer-driven and chosen from a flexible "menu."[8]

Housing First is widely recognized by experts and government agencies as a successful intervention for patients who rely heavily on the emergency room and inpatient wards. HUD, SAMHSA, and the Rutgers University Biomedical and Health Sciences Working Group on Medicaid High Users describe Housing First as a solution to end chronic homelessness, decrease unnecessary health care utilization, and support habits that lead to recovery for individuals suffering from substance use disorders.

## IV. National Data to Support Housing First

Developed in 1992 by Dr. Sam Tsemberis in New York, Housing First has been replicated across the country and supported by a history of strong evidence.[9] Housing First programs range from programs that focus broadly on chronically homeless individuals to those that focus on specific patient populations, as denoted below:

- *In Los Angeles in 2011, the "10th Decile Project" was implemented and targets the top ten percent of homeless patients experiencing super utilization of the health care system. They have found that a typical 10th Decile patient costs over $70,000 annually when*

*homeless, but after obtaining housing, saves public systems over 71 percent in spending.*[10]

- *In Utah, the state implemented a Housing First program in 2006. After nine years, the state decreased the number of chronically homeless individuals by 72 percent. "Utah found that giving people supportive housing cost the system about half as much as leaving the homeless to live on the street."*[11]
- *In Denver, Colorado, the city found that emergency department costs decreased by 73 percent for previously homeless individuals after enrolling in a Housing First program. In addition, during the first two years of the program (2003-2005), the city saved $17,858 per Housing First beneficiary.*[11]
- *In New York City, homeless individuals with severe mental illness cost an average of $40,449 a year in emergency department, shelter, and other public system expenses. After these individuals enrolled in a Housing First-like program, they cost approximately $16,282 less per year (study conducted between 1989-1997).*[11]

## V. Lessons from Camden City's Housing First Pilot

In November 2015, the Camden City's Housing First Pilot Program was launched in response to the significant rates of homelessness and substance use disorders facing patients with complex health and social needs. This Housing First program is operated by the Camden Coalition of Healthcare Providers (Camden Coalition), along with Volunteers of America Delaware Valley, South Jersey Behavioral Health Resources (SJBHR), St. Joseph's Carpenters Society and OAKS Integrated Care. Housing is provided through 50 Project Based Section 8 vouchers from the New Jersey Department of Community Affairs (DCA) in the form of a 15-year commitment. A key component of the program is the intensive, high-touch, in-home case management and care coordination that helps participants retain their housing and stay active in the program. These support services are critical to a person's success in the program.

Several groups in New Jersey implement Housing First programs for chronically homeless individuals, including the Greater Trenton Behavioral Healthcare (GTBH) in Mercer County; Bergen County Housing, Health and Human Services Center; and the United Way of Hudson County. The Camden City's Housing First Pilot Program has learned extensively from these other programs, specifically GTBH.[12]

### a. Camden City's Housing First Model

The Camden Coalition uses the Camden Health Information Exchange (HIE) to identify and enroll eligible patients (based on high health care utilization, chronic medical conditions, and social vulnerabilities) into our 30-90 day intervention. If enrollees qualify as chronically homeless, they are then screened for eligibility for the Housing First program; patients must demonstrate a history of both chronic homelessness and excessive health care utilization to be considered for the program. Patients are housed approximately six months after they are deemed eligible. The Camden Coalition hosts monthly Learning Collaborative meetings for front-line providers to encourage collaboration, advance the mission of the program, and share learnings.

**Camden City's Housing First Pilot Program update as of April 7, 2017:**

- 50 patients approved for DCA vouchers to date
- 41 patients have secured a housing unit to date (submitted an RFT)
- 39 patients housed to date

**Patient demographics:**

Of the 50 people who have been DCA approved:

- Predominantly English speaking
- About half male, half female
- Average age is 53
- Racial makeup is 62 percent Black, 22 percent White, ten percent Latino, six percent other
- At least 82 percent have a substance use disorder diagnosis, of those at least 48 percent have an opioid related diagnosis (both consistently under-diagnosed)
- At least 73 percent have a mental health diagnosis (also under-diagnosed)
- At least 65 percent have co-occurring mental health and substance use disorder diagnoses
- All have at least one chronic illness

**b. Program Evaluation and Preliminary Findings**

The Camden Coalition is conducting a pilot evaluation of the Housing First Pilot Program to monitor the progress of beneficiaries. In addition, this pilot evaluation serves as the foundation for a long-term program evaluation. The pilot evaluation compiles ongoing records of hospital utilization; jail stays; housing evaluation appointments; tenant/landlord interactions; and rent payment timeliness. These data allow for a comprehensive and continuous assessment of each Housing First patient. The evaluation also calculates the average number of emergency department visits and hospital admissions, per day, both before and after the Housing First intervention. This allows us to see the reduction in hospital utilization by individual and across the entire group. This evaluation measures the impact of the Housing First program on health care savings, non-health care savings, and the improvement in quality of life for program beneficiaries.

***To date, the preliminary findings of the cohort show a 60 percent reduction in inpatient and emergency room utilization per days at risk.*** In addition, local data reveals that over 65 percent of the initial Housing First cohort has had criminal justice encounters over the past five years (e.g., arrests, stays at the jail). The high costs of incarceration and recidivism are well documented. This is believed to mean that the Housing First program reduces the cost of homelessness beyond unnecessary hospitalizations, by avoiding incarceration, as well.

For a more comprehensive evaluation, to assess the multi-public system impact of Camden City's Housing First Pilot Program, the Integrated Population Health Data (iPHD) Project (PL 2015, Ch. 193), which establishes a process to integrate health and administrative data, presents an excellent opportunity. NJ has the opportunity to become a leader in the country in conducting rich analysis around its Housing First programs and

measuring impact not only on our health care system but also criminal justice and social service systems. The iPHD Project creates a streamlined and cost-effective process to understand the impact these programs have on the consumers' health and housing outcomes. The iPHD Project's governance board has been activated as of January 2017 and meets quarterly.

**c. Patient Story highlights**

Camden City's Housing First Pilot Program is still in its early stages. Although the data is not complete yet, the following brief patient stories illustrate how the program has impacted the lives of some of the beneficiaries.

**Peter** has chronic asthma and experienced homelessness for two years. He moved into his own unit in November 2015. During those two years, Peter had $643,000 in hospital charges and $62,000 in receipts (over 9 percent) as a result of 19 emergency department (ED) visits and 15 admissions (the majority of these encounters were uncompensated charity care). Since moving into his own place, and receiving services from SJBHR 15 months ago, he has been hospitalized only once for a planned procedure and has represented the Housing First Pilot Program on PBS NewsHour.[‡]

**Sandra** has experienced homelessness on-and-off for 30 years. She had a startling 101 ED visits and 17 admissions in the two years' prior moving into permanent supportive housing, which equates to an estimated $618,000 in charges and an estimated $110,000 in receipts (17.8 percent). Although she has only been housed for six and a half months, her only hospital use in that time was one emergency department visit. Sandra has experienced a 94 percent reduction in hospital use, including more consecutive hospital-free days than she has had at any point in the last 24 months.

## VI. Challenges

The Camden Coalition has worked closely with DCA to mitigate some of the barriers to the development and implementation of Camden City's Housing First Pilot Program. Many obstacles, however, drastically impede the potential for Housing First programs in NJ to grow and better serve chronically homeless, complex and costly patients. Below are some of the most significant challenges:

- Lack of housing stock: A widespread problem in NJ, the housing deficit gravely impacts patients with complex health and social needs, including those eligible for Housing First. There is a shortage of available, affordable one and two bedroom apartments, as well as handicap accessible apartments, for Housing First beneficiaries. In addition, many patients are prevented from obtaining the few available units as landlords set arbitrary rules regarding criminal backgrounds and forgiveness.

[‡] We are monitoring hospital utilization for the five Camden area hospitals.

- Landlords: Successful Housing First programs need willing and engaged landlords, who can often be resistant to engage in the program. For example, many landlords espouse arbitrary standards and procedures regarding criminal background checks that are not required by law. These standards and procedures complicate and delay the housing process, as many beneficiaries are subject to multiple criminal background checks. Many landlords also lack awareness about the profitability of offering apartments to Housing First beneficiaries and assume that this program will come with a financial loss. Finally, stigma around the beneficiaries plays a pernicious role, preventing landlords from wanting to house these individuals.
- Lack of funding for support services: The scope of the current targeted case management benefit is too narrow, often excluding Housing First patients and providing low reimbursements to providers. Proper funding and reimbursement is pivotal to hiring and affording patients with quality support services. These quality support services are an essential feature of the Housing First program and patients' maintaining a high retention rate.
- Lack a robust assessment of number of chronically homeless individuals: The point-in-time (PIT) count, which is used to capture the number of homeless individuals in a designated geographic area is limited and subjective. [§]

## VII. Preliminary recommendations

It is incumbent upon the next administration to support statewide Housing First policies and programs. Specifically, we urge the next administration to:

- Invest upfront, catalytic funding to help create housing stock and affordable housing opportunities as well as ensure Housing First providers have the capital needed to provide quality support services for participants.
- Commit to reinvesting generated savings to scale successful supportive housing programs across the state.
- Take full advantage of the services identified by the Centers for Medicare and Medicaid Services that can be covered under Medicaid to build a robust Medicaid Supportive Housing benefit package.
- Articulate a definition of high fidelity Housing First that includes SAMSHA's fidelity scale, which outlines seven key elements; 1) choice of housing; 2) separation of housing and services; 3) decent, safe, and affordable housing, 4) integration in the community; 5) rights of tenancy; 6) access to all housing options; and 7) flexible, voluntary services.
- Ensure that programs are 'low barrier' by expanding eligibility definitions and target the most vulnerable and costly patients for permanent supportive housing interventions.

[§] The PIT is conducted one night each year during the end of January, when a group of volunteers count the number of sheltered and unsheltered homeless individuals in an area. However, many unsheltered homeless individuals are hard to find; sub-populations congregate in different areas; a cold night could grossly skew the count; sometimes volunteers are expected to count individuals as homeless based on the quality of their clothes, alone.[13]

- Create a robust evaluation of programmatic outcomes that leverages new legislation (PL 2015, Ch. 193), the iPHD Project, which establishes a process to integrate health and administrative data.
- Incorporate local, regional and/or statewide learning collaborations to ensure high quality implementation of Housing First programs and identify and address systemic barriers as they arise.
- Address the PIT count currently used to identify chronically homeless individuals in NJ. The PIT count should span multiple weeks and the appropriate tools, used by other states, should be employed to avoid duplication.
- Broaden the definition or eligibility for chronic homelessness so that additional individuals experiencing super medical utilization can benefit from Housing First services.

Endnotes

---

[1] National Alliance to End Homelessness. (2016). *Cost of Homelessness* [Fact Sheet]. Retrieved from http://www.endhomelessness.org/pages/cost_of_homelessness

[2] National Alliance to End Homelessness. (2016). *Fact Sheet: Housing First* [Fact Sheet]. Retrieved from http://www.endhomelessness.org/page/-/files/2016-04-26%20Housing%20First%20Fact%20Sheet.pdf

[3] Camden Coalition of Healthcare Providers. (2012). *Housing First in Camden Pilot Program* [Fact Sheet]. Retrieved from https://www.camdenhealth.org/housing-first-pilot-program/

[4] National Alliance to End Homelessness. (2016). *Chronic Homelessness* [Fact Sheet]. Retrieved from http://www.endhomelessness.org/pages/chronic_homelessness_overview

[5] McCarthy, D., Ryan, J., Klein, S. (2015). *Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis*, The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/care-high-need-high-cost-patients

[6] United States Interagency Council on Homelessness. (2017). *Ending Chronic Homelessness in 2017* [Fact Sheet]. Retrieved from https://www.usich.gov/resources/uploads/asset_library/Ending_Chronic_Homelessness_in_2017.pdf

[7] Rutgers Biomedical and Health Sciences. (2016). *Analysis and Recommendations for Medicaid High Utilizers in New Jersey.* Retrieved from http://www.cshp.rutgers.edu/Downloads/10890.pdf

[8] U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. (2010). *Evaluating Your Program, Permanent Supportive Housing.* Retrieved from https://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-05-EvaluatingYourProgram-PSH.pdf

[9] Pathways Housing First. (2017). Retrieved from https://www.pathwayshousingfirst.org/.

[10] CSH. (2015). 10th Decile Project. *Initiative Booklet.* Retrieved from http://www.csh.org/wp-content/uploads/2015/10/Frequent-User-Initiative-Profile-Booklet-10th-Decile-Project-Final.pdf

[11] Carrier, Scott. (2015, February 17). The Shockingly Simple, Surprisingly Cost-Effective Way to End Homelessness. *Mother Jones.* Retrieved from http://www.motherjones.com/politics/2015/02/housing-first-solution-to-homelessness-utah/

[12] New Jersey Coalition to End Homelessness. (2015). *Housing First*. Retrieved from http://www.njceh.org/housing-first

[13] U.S. Department of Housing and Urban Development. *PIT and HIC Guides, Tools, and Webinars.* Retrieved from https://www.hudexchange.info/programs/hdx/guides/pit-hic/#general-pit-guides-and-tools

[14] Ornelas, J., Martins, P., Zilhao, M., et al. (2014). Housing First: An Ecological Approach to Promoting Community Integration, *European Journal of Homelessness*, *8*, 29-56. Retrieved from http://housingfirstguide.eu/website/wp-content/uploads/2016/03/Housing-First-An-Ecological-Approach.pdf