Housing First: A Solution to Urban Homelessness

Kelsey L. Capron; Lara C. Weinstein, MD

Pathways to Housing PA; Dept. of Family and Community Medicine at Thomas Jefferson University

Homelessness in the United States

- 630,000 homeless in the US in 2012, thousands in Philadelphia
- **Over 3% of the US population** has been homeless during the past 5 years
- Homeless = no stable residence
  - Temporary shelters, unsheltered locations (the street, transit stations, parked cars), etc.
- High rates of **legal issues, substance abuse/dependency, & lack of stable employment**
  - Severe mental illness = overrepresented & linked to severe health disparities
- Higher risk for all-cause **mortality** (primarily due to injuries, overdose, CV disease)
  - Mortality rates **3-4x higher** than the general population
  - Chronic & acute **mental & physical health** conditions
    - HIV, tuberculosis, hypertension, diabetes mellitus, Hepatitis C
  - **Life expectancy: 42-52 years** for the chronically homeless
- Disproportionately low numbers / low quality of social supports
- **The current "continuum of care" model:**
  - Outreach → treatment → transitional housing → permanent supportive housing
  - Perceived by the homeless as a **series of hurdles**, often not possible to overcome
- **No empiric support in favor of the practice of requiring individuals to participate in psychiatric treatment or to maintain sobriety before being housed**

Poor health is a risk factor for homelessness, and homelessness is a risk factor for increased health needs.

Impact on the US Healthcare System

- **Competing priorities** may prevent the homeless population from seeking out or accessing primary & preventative healthcare
  - **Basic subsistence** (staying safe, eating, finding a place to sleep)
  - Competing needs can result in a **"so what" attitude towards their own health**
- **Internal vs. external factors**; depression, lack of motivation to change habitual patterns, the difficulties of navigating our complex health system, etc.

→ Delays in pursuing needed health care often lead to a **deterioration in health status**

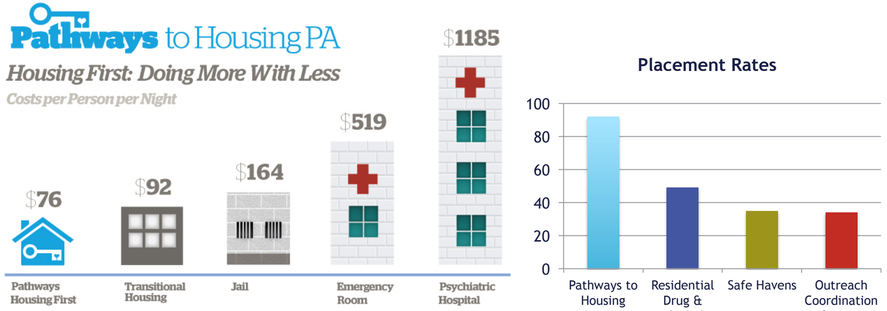
  - Usually results in a need to implement **more expensive** forms of health care delivery in order to treat these patients' more advanced conditions
- Homeless = **more intensive users of health services** than the general population
  - Emergency department use, overall hospital use, psychiatric hospitalization
    - **ED use: 3x higher** (only available safety net to many of the chronically homeless)
    - **Hospitalization: 4-5x higher**
- Great burden of acute & chronic disease + homelessness-associated socioeconomic deprivation = intensive utilization of the healthcare system (especially emergency medical services)
- Homeless **high-intensity users** of health services drive these trends

Homelessness is the individual characteristic that is most predictive of emergency department use

The Housing First Model

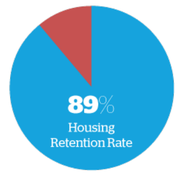
- End homelessness by providing a patient-centered, medical home for patients with a history of **homelessness & co-occurring serious mental illness and addiction**
- **Choice** (of housing options), **Availability** (immediate access to housing), **Affordability** (rent supplements/subsidies), **Permanence & Commitment** to re-house (should a client lose housing for any reason), and **Separation of treatment & support** (use of mental health services and substance abuse treatment is voluntary)
  - No "housing readiness" expectations or prerequisites (**harm reduction**)
  - **Housing = a basic right**
- Effective interventions/support = individually tailored to fit the stage/needs of each individual
  - Apartment + treatment + support + access to specific resources
- **Housing First has been shown to successfully end homelessness** for people with a serious mental illness by offering immediate access to permanent housing options as well as intensive community-based interdisciplinary support teams
  - Permanent housing, community-based supports, integrated person-centered health home, effective local public health monitoring system
    - Pilot programs in the US & Canada: great success → ~900 US cities/counties
    - Reduces homelessness, increases housing stability, decreases criminal activity, decreases number of visits to the ED & detox center, & increases the number of nonemergency (primary care) clinic visits
- *Example*: Seattle Housing First program targeted homeless individuals with severe alcohol issues
  - Reduced costs from $4066/person/month to $1492/person/month after 6 months, & to $958/person/month after 12 months

    → **Collective reduction in costs by more than $4 million for 95 individuals**



Pathways to Housing PA

- Philadelphia's Housing First model, 2008-present (modeled after New York City's success)
- Partnered with Thomas Jefferson University & Hospital
- Has engaged & housed hundreds of formerly homeless people in Philadelphia
  - **89% five-year housing retention rate** for the chronically homeless (compared to 30-50% in the city's more traditional housing & treatment programs)
  - Targets those who experience chronic homelessness, mental illness, substance dependence & addiction, and HIV/AIDS
- **Interdisciplinary support teams**: a family/community medicine physician, social workers, a nurse, a psychiatrist, a peer specialist, a vocational specialist, & a drug/alcohol counselor



High-Intensity Healthcare Users

- The **relative risk of frequent use of health services = 4.5x higher** among the homeless
- ED use among the homeless = 2 visits per person-year
- ED use among the homeless high-intensity users = 12.1 visits per person-year
  - **10% of the overall homeless population → 60% of the ED visits**
- Higher economic costs, emergency department overcrowding, poorer patient outcomes, treatment delays, stigmatization of frequent users, & lower quality of care
  - At a single institution, costs for homeless high-intensity users alone = $5 million/year
- Despite frequent interaction with the many acute care systems that target these populations, their **complex medical & mental healthcare needs are not being met** (shelters, hospitals, mental health services, drug & alcohol treatment services, the criminal justice system, welfare)
- The **social determinants of health** play a major role in the homeless population

- <u>Ways to reduce ED visits by the homeless:</u>
  - More comprehensive planning of discharges
  - Referral/transportation to an effective social safety net program
    - Many EDs were found to provide a **social services consult and/or discharge plan that addressed homelessness in 4% of homeless frequent users**
  - ***Address the issue of homelessness itself***
  - ***Emphasize community-oriented prevention of illness & disability***

We need a social ecology approach, with collaborations between the traditional medical system, mental health supports, economic development, housing, and access to healthy & affordable food.

Pathways to Housing Population Research

- Compile retrospective & current data on usage of emergency health services by Pathways to Housing PA participants, particularly high-intensity healthcare users
  - Describe trends in emergency health care utilization by this formerly homeless population → identify common health needs & issues

- Behavioral Model of Health Services Utilization for Vulnerable Populations
  - Explain usage of health services, define determinants of health care use, identify particular challenges faced in the context of a vulnerable population
  - Determinants:
    - Predisposing factors (demographics or social structural attributes)
    - Enabling factors (personal, family, or community resources)
    - Need factors (symptoms or health conditions that precipitate a health service use)

"Assessing Emergency Department Utilization of Pathways to Housing Participants"