Implementing Housing First in VA's HUD-VASH Program: Research Insights

The **H-SOLVE study** (VA HSR&D) **PI: Stefan G. Kertesz, Birmingham VA Medical Center**

Ending Veteran Homelessness: A Transformational Effort

In 2009, with over 75,000 Veterans homeless each night, VA announced its intention to end Veteran homelessness. By 2016, Veteran homelessness had fallen 48%.

Critical to this effort has been the expansion of HUD-VASH, a program that combines rental vouchers from the US Department of Housing and Urban Development (HUD) with client selection and support from Veterans Health Administration (VHA) staff. As of late 2016, the program had accommodated over 94,000 Veterans.

The program expansion also featured a formal decision by VA to adopt Housing First, an approach that removes traditional treatment-related preconditions for housing, prioritizes allocation of vouchers to the most vulnerable (and challenging) clients, and promises long-term support for recovery in housing. See the blue box on page 2 for more information.

Since 2012, our team has studied VA's efforts to implement Housing First. We held two expert panels, conducted over 170 in-person interviews, and analyzed client selection for HUD-VASH.

Our work identifies strengths and challenges and reveals where and how senior leaders and middle-managers can make a difference.

This white paper summarizes our findings with links to published manuscripts. Views expressed here are those of the authors and not the positions of any federal agency.

HUD-VASH
VA Supportive Housing

National Impact of Our Study

The New York Times

"Cities with tight housing markets need a very substantial amount of work, both in terms of front-line staff and organizational leadership, put toward recruiting landlords and even rehabbing buildings," Dr. Kertesz said by email. "It means a major organizational undertaking with all pistons firing."

Homeless Find a Champion in Canada's Medicine Hat
(New York Times, February 27, 2017)

The NEW ENGLAND JOURNAL of MEDICINE

"We believe that Housing First, coupled with efforts to prevent more people from becoming homeless, represents the best possible expression of what Abraham Lincoln characterized as "the better angels of our nature.""

Permanent Supportive Housing for Homeless People - Reframing the Debate
(New Engl J Med December 1, 2016)

What is Housing First?

Housing First (HF) is an *evidence-based approach* to providing permanent supportive housing for Veterans. HF has been *mandated* to guide HUD-VASH practice (Undersecretary William Schoenhard, October 12, 2012)

Key principles are:

(a) housing is permanent,

(b) removal of preconditions based on completing particular treatments or sobriety,

(c) strong clinical support for recovery after housing is achieved,

(d) prioritization of the most vulnerable clients.

Source: Annual Homeless Assessment Report to Congress (2009)

How Was This Research Conducted?

Multiple sources helped us create a rich understanding of how Housing First was implemented:

1. We held expert panels with VA homeless program leaders and experts in Housing First and housing policy. From this we developed a **fidelity tool** to assess HUD-VASH programs' adherence to Housing First.
2. We recruited eight VAMCs across the country, aiming for regional, size, and rental market diversity. At each VAMC site, we **interviewed** leadership, program managers, front-line staff, and community partners to gain multiple perspectives.
3. From this, we created **detailed narratives** for each HUD-VASH program and calculated **fidelity scores** (0-4) for both Housing First implementation and elements of organizational change. We developed insight into common barriers and facilitators, with close attention to how leaders acted.
4. Our team returned to four sites for **in-depth observation** of case management practices. These observations allowed us to see how case managers responded to the needs of Veterans experiencing homelessness both during and after housing placement.
5. Finally, ongoing **quantitative analyses** seek to understand the degree to which these 8 VAMCs prioritized medically and socially vulnerable Veterans for HUD-VASH.

How Do Leaders Make Housing First Happen?

Transforming practice (and expanding care) across a large organization is not simple, especially when the goal is ambitious, idealistic, and subject to a wide range of challenges. For VA HUD -VASH, challenges included hiring and retention of supportive services staff, complex and unfamiliar community-based partners (e.g., cities, housing authorities), and tight rental markets. Across eight sites, the degree of success in implementing Housing First correlated strongly with how well leaders and managers took actions reflecting six key features of organizational transformation.

(a) **Impetus for change** came mostly from national leadership, who declared goals and secured funds. Local VAMC leaders varied in the degree of reinforcing the national goal to end Veteran homelessness;

(b) **Commitment** at some study sites included VAMC Directors volunteering at service events, and one shadowing a social worker for an afternoon of case management. Another high-impact form of commitment at some sites lay in the selection of strong, homeless-knowledgeable clinical managers;

(c) **Successful vertical alignment** and

(d) **Horizontal integration of effort** came from work groups that cut across service lines, assuring communication up and down chain-of-command. To a striking degree, success depended on mid-level managers who varied greatly in their ability to explain challenges up and down the chain (alignment) and across service lines (integration). High-performing sites also coordinated with non-VA agencies (like Police or the local Public Housing Authority), often because upper management encouraged strong working relationships with governmental and non-governmental partners;

(e) **Staff engagement** partly reflected core emotional commitment, but it also reflected the degree to which they felt supported (see example at right);

(f) **Sustainability,** particularly staff retention, remained a concern in part because of uncertainty regarding long-term funding decisions for the program that ultimately depend on Congress.

What do VA Leaders and Staff Say?

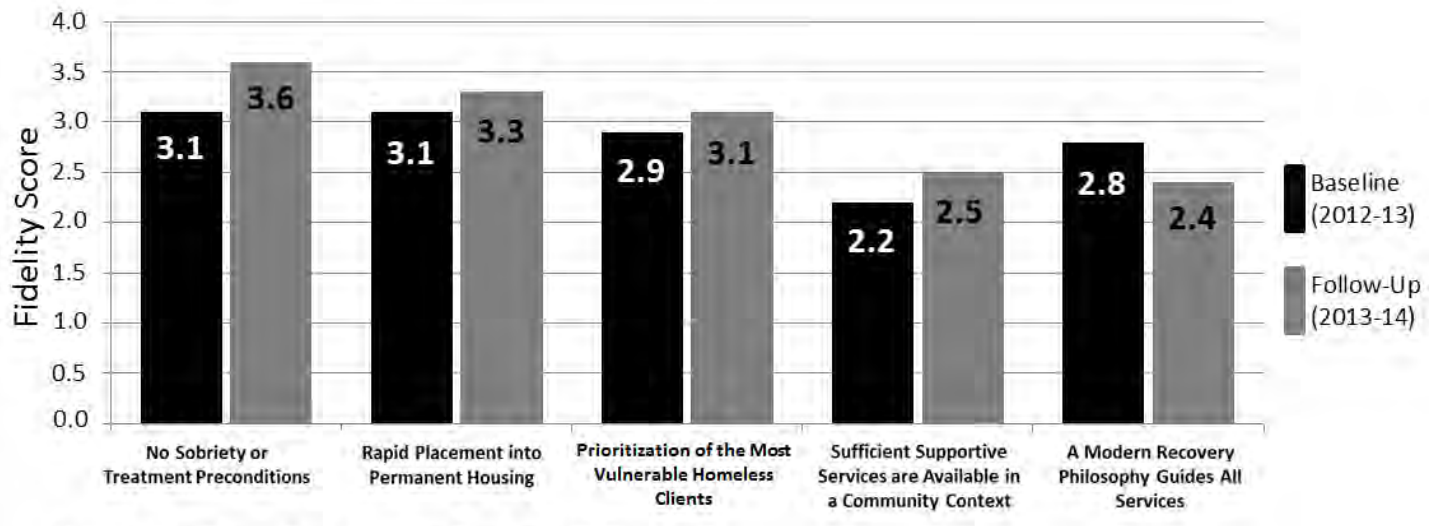
Leadership Commitment: "There are some things I can make happen by virtue of my position: hiring, getting resources in the facility. It gets difficult, dicey sometimes. I meet weekly with (Chief of Mental Health) to remove any barriers in her way" **(Quote from VAMC Director).**

Efforts to Align from top to bottom: ""I chair the homeless committee with [the Homeless Coordinator]. [She] is wonderful—really, really strong. We come to the table together and go over all the issues. Second issue—since most patients have mental health issues, I chair the Mental Health Council. Then, the Medical Center Director's meeting. We hear reports regularly, once a month." **(Quote from Chief of Staff)**

Engagement at Staff Level: "I have to tell you the truth—I've never been turned down. I know how to do it. I do all the footwork. I know everything they need, all the documents. I take them where they need to go to be connected to get the deposit, I do all of that. Usually I can help with furniture, if the kids need something special, I can get that done." **(Quote from Housing Specialist)**

What Aspects of Housing First Proved Most and Least Achievable?

Adoption of Housing First required doing many things right including changes in how staff selected Veterans to receive vouchers or how case managers delivered services after housing. Our qualitative narratives and scoring exercise looked at how VA met the Housing First requirements over time (i.e. "**fidelity**"). The figure summarizes how VA met the standards for delivering Housing First in five domains for the year prior and the year after Housing First was mandated .



No Sobriety or Treatment Preconditions: Adherence to this principle scored highest at follow-up. This reflects adjustments to the philosophy of VA housing programs as well as lowering barriers to housing people with substance use and mental health issues.

Rapid placement of the Most Vulnerable: We found moderate, but not high fidelity for "Rapid Placement into Permanent Housing" and "Prioritization of the Most Vulnerable Homeless Clients." Rapid placements were limited by the need to coordinate with community agencies, and by tight housing markets. High-fidelity sites addressed such issues by, for example, hiring Housing Specialists. Sites that had taken steps to prioritize chronically homeless veterans also received high fidelity scores. However, prioritizing persons with serious medical or mental illnesses received far less attention across all sites we visited.

Supportive Services: The lowest fidelity scores applied for "Sufficient Supportive Services Available" and "Modern Recovery Philosophy Guides All Services." Many staff reported large, high-acuity caseloads, and reported having insufficient time and resources to focus on client goal-setting or harm reduction. High-fidelity sites reorganized to form multidisciplinary or acuity-based care teams to leverage case manager expertise and to prevent burnout.

In sum, the goal of ending Veteran homelessness was honorable, ambitious, and helped huge numbers of persons out of homelessness. The Housing First mandate created impetus for success and a re-orientation of services. However, sustained commitment and resources will be necessary to maintain clients in housing long term and to strengthen Veteran-centered supportive services.

Innovative Approaches to Improve Fidelity

Facing challenges, some sites innovated. Many received guidance from national leadership, from the National Center on Homelessness Among Veterans, and from consulting agencies such as Community Solutions. Some sites cultivated landlords through Housing Fairs and similar high-profile campaigns. Others supported a Housing Specialist to maintain a database of rentable units, including landlords not requiring criminal record checks. Others installed VA staff in Public Housing Authority offices to offset the workload caused by a flood of Veteran clients. Because of challenging rental markets, more than one site took advantage of the opportunity to house multiple clients in a single building.

Several sites restructured case management. A few developed teams based on client acuity, with a high-acuity team allowing more generous case manager-to-client ratios. As Veterans stabilized, they moved to a low-acuity team. One site restructured shift assignments to permit a work week of 4 10-hour days, allowing more flexibility in client visits. Others co-located services (medical, housing, and mental health) in a one building, often with expanded hours of access. Such innovations emerged in programs where managers and service line chiefs were willing to challenge traditional practices, to learn from external partners, and where they had the full support of Medical Center leadership.

Opening the Black Box Of Housing First:

Ethnographic Examination Of Case Management

To better understand case management, we directly observed work at four VA medical centers. Two experienced ethnographers shadowed six case managers (three social workers and three nurses), observing 16 attempted client contacts, 13 completed client interactions, and three team meetings.

Findings highlighted challenges in implementing Housing First. First, case management requires not just attention to clients' needs, but responding to the challenge of providing services across broad geographic areas. Large caseloads increased the need to plan time efficiently visiting clients clustered together in the same area. Second, case management requires consideration of a variety of practical and clinical issues, including medication management and medical issues, mechanics of housing placement and retention, and mental health (especially suicide prevention). Although case managers reported prevalent substance abuse, we observed only one client-case manager interaction focused on substance use suggesting that case managers accustomed to abstinence-contingent interventions simply lack the training or confidence to address substance use from a harm reduction perspective. Third, although Housing First emphasizes team-based care, most work involved individual, independent case managers brokering supportive services for their clients. Multiple challenges made team-based care difficult. For example, in one location, inadequate space existed in a central location for team meetings, meaning that a morning team meeting was held in a hospital waiting area—requiring the members to discuss clients without providing identifying information.

Were Vulnerable Veterans Prioritized for Housing?

Our analysis looked at all 15,675 applicants at the eight selected HUD-VASH programs for FY2011-12 (pre-Housing First) and for FY2013-14 (post-Housing First). When we compared accepted and not accepted HUD-VASH applicants, chronically homeless clients were clearly prioritized. This tendency increased over time.

Housing First includes a commitment to prioritizing the most vulnerable. ***Chronically homeless veterans were prioritized, but there was far less attention to prioritizing those with other vulnerabilities.***

There was some prioritization of women and persons with custody of children. **Surprisingly, there was almost no evidence of prioritization of persons with other vulnerabilities such as alcohol or drug use disorders, medical problems, or high hospital use.**

Our analyses suggest that persons with complex medical and psychiatric needs proved to be more challenging customers. Intense pressure to quickly lease up allocated vouchers may have discouraged prioritization of people who could not comply rapidly with the complex requirements of the HUD-VASH program. We believe continued effort should go into identifying resources, supports, and incentives necessary to assure that veterans with high service requirements are appropriately moved to supportive housing.

Going Deeper

Kertesz et al. Making Housing First Happen: Organizational Leadership in VA's Expansion of Permanent Supportive Housing. ***J Gen Intern Med.*** 2014 .

Austin et al. VA's Expansion of Supportive Housing: Successes and Challenges on the Path Toward Housing First. ***Psychiatric Services.*** 2014.

Kertesz et al. Housing First and the Risk of Failure: A Comment on Westermeyer & Lee (2013). ***J Nerv Ment Dis.*** 2015

Kertesz et al. Permanent Supportive Housing for Homeless People — Reframing the Debate. ***N Engl J Med.*** 2016.

Kertesz et al. Housing first on a large scale: Fidelity strengths and challenges in the VA's HUD-VASH program. ***Psychological Services.*** 2017.

Housing First: A Case of Overreaching? Homelessness Policy and Practice in the US forum. (Video)

Copies of scientific manuscripts are available for VA leaders from Dr. Stefan Kertesz . Stefan.Kertesz@va.gov

Essential VA guidance on Housing First is available the National Center on Homelessness Among Veterans, including a set of video modules well worth viewing.

Overall Implications

Housing First gained prominence because of data showing this approach helped people escape homelessness. When VA adopted Housing First for its HUD-VASH program, it became the largest entity in the world to take this approach. Our VA HSR&D-funded study shows that Housing First is a complex undertaking requiring a distinct focus on care and the complex requirements of implementing a program that is both a social intervention and a clinical undertaking. Our research highlights key successes and challenges that affected VA, which likely apply across many agencies and communities.

We found that organizational leaders, including leaders of VA Medical Centers, often played a transformational role in conveying support for the initiative, breaking logjams, and helping VA and non-VA professionals work across traditional organizational silos. However, this initiative faced challenges in assuring adequate clinical supports for this crisis-prone clientele. Because VA benefits from a higher level of clinical investment than many community agencies, it is reasonable to expect this issue will prove even more difficult for community agencies where clinical funding is poor. Some clinicians and lukewarm allies often point to intermittent failed placements to discredit the Housing First approach. Our data suggest that innovative implementation, coupled with support from senior leaders and adequate clinical investment, can overcome reservations and advance a compelling social good.