

Camden County Homeless Trust Fund Advisory Committee

Meeting Minutes

August 6, 2020

Opening

The regular meeting of the Camden County Homeless Trust Fund Advisory Committee was called to order at 9 am on August 6, 2020 via conference call

Present

Anthony Bianco, Holly Cass, Gino Lewis, Sharrae Morman, Patti Harris, Rob Page, Rob Jakubowski, Kevin Hickey, Laura Buckley, Dominic Vesper Sr, Susan Catando, Diana Cooper-Vanderlip & Kathleen Noonan (Camden Coalition)

Agenda

-The agenda was emailed to all participants

Financials

-Bianco reported that the current unencumbered balance of the Homelessness Trust Fund is \$318,217.28. The fund gets replenished at a rate of approximately \$15,000/month. Although this may decline during pandemic

New Business

Camden Coalition of Health Care Providers \$45,150.07- Kathleen Noonan (see attached request)

Gino suggested they look for long term solution with legislative assistance

Motion to approve by – Gino Lewis 2nd-Dominic Vesper Sr

(Votes attached)

Kevin asked that Anthony explain HTF request for funding process

-requests for funding are submitted to Anthony or Rob upon their review of qualifications of the provider it is submitted to Freeholder Rodriguez for support at the Freeholder level once approved he next step is to refer to HTF advisory board for final vote

Homelessness Initiative Update -Rob Jakubowski

1. We provide a shelter for homeless with COVID from April through June. We housed 40 people with the highest capacity at one time reaching 12. Due to lack of need, we scaled down from a motel to a shelter at VOA to ending the program. In anticipation of need, we are looking to re-create the partnership at the VOA shelter.

2. Point in time is being released soon. We had reviewed earlier drafts and not some errors, at our request those errors were corrected.

3. Earlier this year, using ESG funds we engaged with SCUCS to create a Housing Navigator position that is developing a list of available properties that could be available for formerly homeless. They also connect with landlords to be a resource with this population. The Navigator is available for agencies and clients to access the data base.

We also engaged with Camden Coalition to promote My Resource Pal. This is an online data base of resources. Camden coalition has been training more agencies to claim their listings and to begin to use the referral functions to connect clients to services within the network.

4. We worked on clearing an encampment recently. We were able to connect 20 people to services and shelter with at least one going to long term treatment. We learned a lot from the process should we need to do this again.

In the process we met several homeless outreach volunteers who have been working with this community for years. We will be meeting with them soon to learn more from them and to see how we can collaborate to end homelessness.

Adjournment

Meeting was adjourned at approximately 10:00 am.

Motion by-Gino Lewis 2nd-Sue Catando

Next meeting October 1, 2020 9:am Conference Call

MEETING SIGN-IN SHEET

Homeless Trust Fund Advisory Board	8/6/20
Facilitator: Anthony Bianco	Conference Call

Name	Present	Vote
Anthony Bianco	X	YES
Carmen Rodriguez		
Carol Bakey		
Christine Hentisz		
Diana Cooper -Vanderlip	X	ABSTAIN
Dominic Vesper Sr.	X	YES
Gino Lewis	X	YES
Holly Cass	X	
Joan Quinton		
Jordan Thomas		
Kevin Hickey	X	NO
Laura Buckley	X	ABSTAIN
Patti Harris	X	
Rob Jakubowski	X	
Robert Page	X	YES
Sharrae Morman	X	YES
Shirley Butler		
Susan Catando	X	YES



Camden Coalition of Healthcare Providers

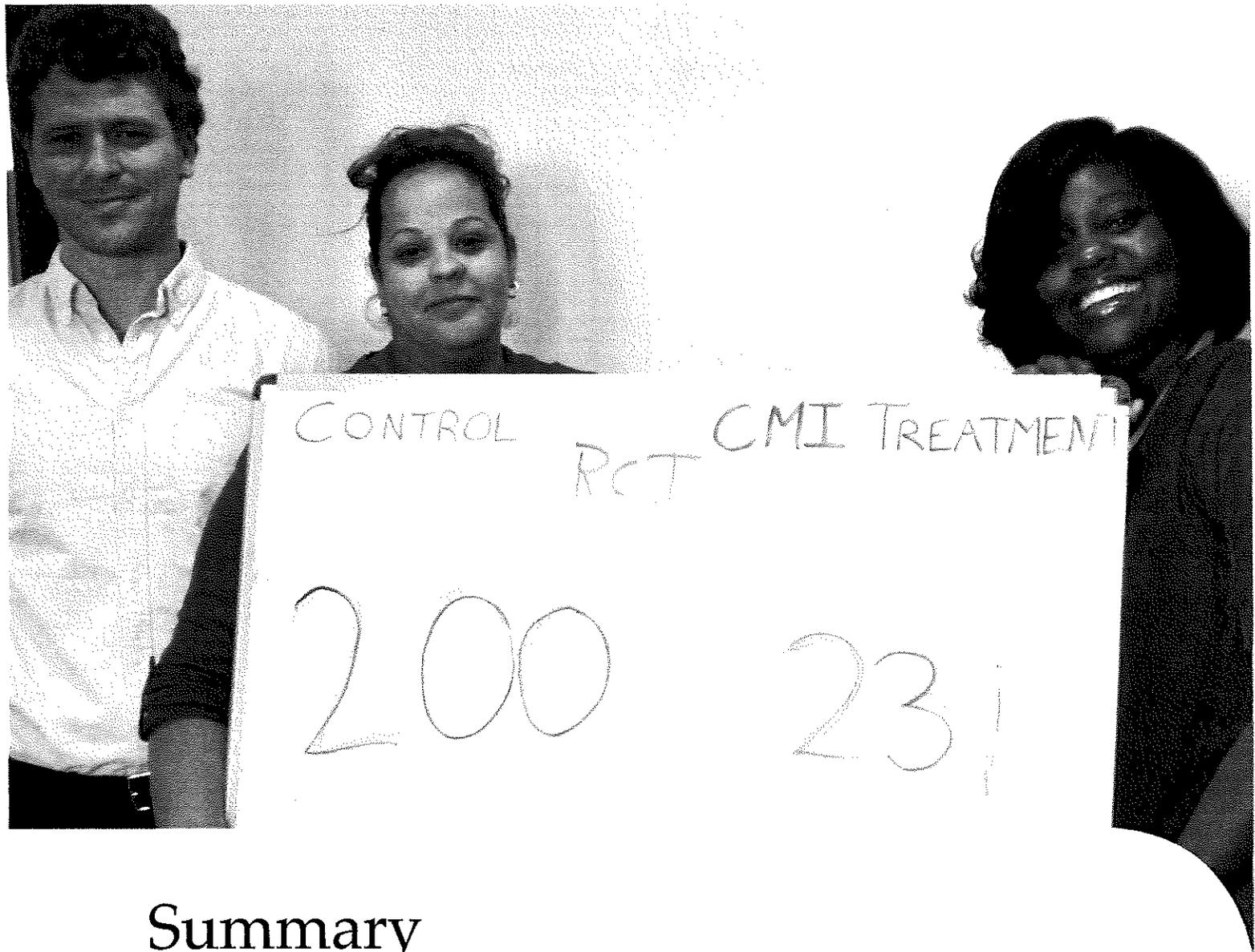
Funding Source Name : " Camden County - Homeless Trust Fund"

	Per Month	3 Month
	Direct Care Team	Direct Care Team
Salary Expense	\$ 11,666.68	\$ 35,000.05
Fringe	\$ 3,383.34	\$ 10,150.02
Total Direct Cost	\$ 15,050.02	\$ 45,150.07
Indirect Cost	\$ -	\$ -
Total Cost	\$ 15,050.02	\$ 45,150.07



Results and lessons from the Camden Coalition's randomized controlled trial

Aaron Truchil, Dawn Wiest, and Teagan Kuruna
January 2020



Summary

The Camden Core Model is the Camden Coalition of Healthcare Providers' signature care management intervention. As a learning organization, we iterate on the model in light of the challenges we encounter and continually evaluate our impact. From 2014-2017, we partnered with researchers affiliated with J-PAL North America to conduct a randomized controlled trial that would help us learn more about how our model affects patients' hospital readmissions.

The study found no difference between the treatment and control groups on hospital readmissions within 180 days, but did find a statistically significant rise in the number of participants receiving food assistance (SNAP benefits). The study also illuminated lessons for the Camden Coalition and the field of complex care, such as areas of future research, the value of identifying holistic outcome measures for complex care, and the necessity of increased upstream investment in the social determinants of health. This brief provides context for complex care and care delivery in Camden, NJ; the study itself; and implications for the Camden Coalition and other organizations.

Across the nation, the emerging field of complex care is learning how to best serve people with complex health and social needs.

Public health and other government agencies, health systems, medical and behavioral health providers, social service organizations, and others are working together to figure out which interventions work best for their communities.

The Camden Coalition of Healthcare Providers is one of these organizations. Over the past 15 years, we have worked with thousands of people in South Jersey facing the most complex medical and social challenges using a core set of practices emerging from the field of complex care. In addition to living with chronic medical conditions, many of our patients confront burdens resulting from a lifetime of racism and inequity. Their medical and behavioral health co-morbidities are often layered atop unemployment, poverty, homelessness, and incarceration, all of which threaten their health and well-being. Our patients experience stigma and lack of social support, and carry with them past trauma and negative interactions with systems and organizations. Institutions and agencies struggle to address these histories. Furthermore, the services our patients require, and the data collected about those services, are separated into disconnected systems. Individuals with complex needs encounter multiple fragmented and siloed systems resulting

What is complex care?

Complex care addresses the needs of people who experience a combination of medical, behavioral health, and social challenges that result in extreme patterns of healthcare utilization and cost. Complex care works at the personal and systemic levels, coordinating care for individuals while reshaping ecosystems of services and healthcare. It is person-centered, equitable, cross-sector, team-based, and data-driven.¹

in uncoordinated, duplicative, and inefficient care from which they do not derive lasting benefit.¹

Throughout the RCT study period of 2014 through 2017, and now, our understanding of patients' desires and needs has deepened. As a result, the Camden Core Model has evolved. For example, we can now bridge patients' medical, behavioral health, and social needs because of our more intense focus on strengthening services in our region. We have added a Housing First program and a Medical-Legal Partnership, advocated on behalf of easier access to medications for addiction treatment (MAT) for Medicaid beneficiaries,² and supported a new addiction medicine clinic at Cooper University Health Care. We also ran the 7-Day Pledge from 2014-2019, which helped patients leaving the hospital see their primary care providers within seven days of discharge.³



About the Camden Core Model

The heart of our work is the Camden Core Model, our signature care management intervention.⁴

Following the principles of trauma-informed care and harm reduction, our goal is to empower patients with the skills and support they need to avoid preventable hospital use and improve their well-being.

We use real-time data to identify eligible patients, through the Camden Coalition Health Information Exchange, using criteria that identify significant medical and social complexity, such as extensiveness of past hospital use, presence of chronic medical illnesses, behavioral health comorbidities, and

housing instability. Then, we meet patients in-person, usually at the hospital bedside, to invite them to enroll in the intervention.

An interprofessional team of nurses, social workers, and community health workers visits participants in the community after hospital discharge, helps reconcile their medications, accompanies them to doctor's visits and other appointments, and links them to social and legal services. We co-construct a care plan with each patient and focus on helping them meet the goals that they set for themselves, which often leads to increased self-efficacy, stronger relationships with providers, and connection with a supportive social network.⁵

The randomized controlled trial

In 2014, we embarked on a randomized controlled trial (RCT)⁶ with researchers affiliated with J-PAL North America, a research center based at the Massachusetts Institute of Technology, to evaluate the effect of the

Camden Core Model in reducing patient readmissions.

While the model was still evolving to fully meet the needs of our patients, we had an opportunity to partner with a renowned research group and knew the results would contribute important

evidence to the growing body of research around complex care.

The research question we asked was: “At 180 days after a hospital discharge, do patients enrolled in the Camden Core Model experience a lower rate of hospital readmissions when compared to similar patients not enrolled in the intervention?”

Methods

Study recruitment took place at Cooper University Health Care and Lourdes Health System in Camden, New Jersey after patients eligible for the study were identified. In total, 800 individuals were enrolled in the study and half were randomized into the treatment group. To be eligible for the study, patients had to meet the following criteria:

- At least two inpatient admissions within the 6-month period inclusive of the hospital admission identified in the Camden Coalition Health Information Exchange;
- Two or more chronic medical conditions; and
- At least two of the following: five or more active outpatient medications, difficulty accessing services, lack of social support, a mental health comorbidity, active drug use, or homelessness.

Patients were excluded if they were uninsured, cognitively impaired, an oncology patient, or if their admission was for a surgical procedure for an acute problem, mental health care (with no comorbid physical health conditions), or complications of a progressive chronic disease with limited treatments.

J-PAL North America researchers

conducted the analysis using hospital discharge data from a regional hospital claims database that the Camden Coalition’s data team developed. These data were supplemented with data from the Camden Coalition Health Information Exchange, Camden Coalition staff records, New Jersey state administrative data, and the National Death Index. After integrating these data sets, analysts performed multivariate, linear regression analysis to compare 180-day readmission rates for the intervention and control groups.

The study population

One-half of the patients included in the RCT were women; 40 percent were under age 55, and 30 percent were over age 65. Slightly more than half — 55 percent — were non-Hispanic African American, 30 percent were Hispanic, and 15 percent were non-Hispanic white. The patients in the study had high rates of hospital use, nearly twice the rate of patients in other care management and care transition programs that have been evaluated with RCTs. Moreover, in the six months prior to the study, the hospitalization rate for RCT patients was 18 times higher than the general adult population in Camden.

Our triage process led to the enrollment of a highly complex patient population, as shown by the following characteristics of the study population:

- Almost the entire population (95 percent) was not employed at time of enrollment;
- 40% were diagnosed with substance abuse during the index admission;
- Three out of four patients were single, divorced or widowed;

- One-half had less than a high school degree;
- About 60% reported needing help with mobility; and
- 48% had Medicare as their primary payer, and 45% had Medicaid as their primary payer.

Outcomes

When 180-day readmission rates were compared, J-PAL analysts found that patients enrolled in the control and intervention groups readmitted to the hospital at similar rates and concluded that the intervention had no significant impact on the 180-day readmission rate. The 180-day readmission rate was 61.7% in the control group and 62.3% in the intervention group.

JPAL analysts also compared intervention and control patients on their participation in social services 6 months after hospital discharge using New Jersey state administrative data. The analysts found that while participation in TANF (i.e., Temporary Assistance for Needy Families) and General Assistance did not change significantly with the intervention, participation in SNAP (i.e., Supplemental Nutrition Assistance Program) was nine percent higher for patients enrolled in the intervention compared to patients in the control group. This finding lends evidence for the success of Camden Coalition staff in increasing patients' access to community resources to support their health and well-being.

Limitations of the study

All research has limitations, and these must be considered before drawing conclusions from the results. As outlined

in the study itself, the limitations for our evaluation include:

- The sample size was not large enough to analyze effects on specific sub-groups of patients, where there could be differential impacts. For example, patients housed through our Housing First program might have different outcomes than similar patients who were enrolled in the study but had not been placed in permanent housing during the study program;
- The data collected did not capture information that would allow for evaluation of potential non-tangible benefits of the intervention such as improved relationships with providers;
- The data collected do not allow comparison of participation in outpatient care; for example, whether patients in the intervention group see a primary care provider more regularly than patients in the control group;
- The study does not consider how a changing standard of care in Camden over the study period affected all patients in the region. For example, during the study period, multiple other care management programs emerged, and the Camden Coalition led a citywide campaign to connect Medicaid patients to primary care within 7 days of discharge. Similarly, the Affordable Care Act enabled Medicaid expansion in New Jersey during the study period, and the study does not take into account the changing insurance coverage landscape.

Implications for the Camden Coalition

In light of these limitations and the Camden Coalition's dedication to continuous quality improvement, we are pursuing additional analyses with the RCT data set to learn more about our patients' needs, and will continue to improve our model based on what we learn.

We are expanding our ongoing partnership with J-PAL to include the Rutgers Center for State Health Policy. This new collaboration will allow us to integrate Medicaid enrollment and claims data to study the effect of the Camden Core Model on non-hospital healthcare utilization outcomes among Medicaid patients enrolled in the RCT. We will compare intervention and control patients on outcomes including (but not limited to) utilization of primary and specialty care; participation in home-based services; medication prescription patterns; and stability of Medicaid enrollment.

Our internal data and quality improvement team is also analyzing the RCT data to understand how readmission outcomes varied by characteristics of the intervention (e.g., timing of enrollment, number of hours our care teams spent working with patients) and by clinical and demographic characteristics of patients (e.g., age, chronic disease profile, behavioral health co-morbidities). The results from this work will help us refine our triage criteria, intervention milestones, and our approach to working with specific subgroups of patients. Importantly, as we learn more about the intricacies of the barriers that our patients face, we will continue to build capacity in our community to address the multifaceted needs of the individuals and families we serve.

Implications for the field of complex care

Success in complex care will not be accomplished by a single health system, community-based organization, or social service agency.

Communities must come together to collectively build complex care ecosystems in which siloed and fragmented services and organizations collaborate deeply to address people's needs. The need to iterate on our own model showed us the importance of being flexible, partnering across sectors, and rooting our intervention in our patients' and community's unique needs. In light of this, our National Center for Complex Health and Social Needs was established to inspire, connect, and support the evolving community of complex care practitioners and leaders.

To do the hard work of complex care, we have to think beyond traditional return on investment models, both in terms of the financial and the non-financial investments that our field should make and the returns that we should expect.

In the case of people with complex needs who are accessing multiple sectors, measures of success and the model for calculating return on investment needs to be complex and nuanced. The Camden Coalition remains deeply invested in improving the lives the vulnerable populations who rely on us to iterate on our work based on what we learn and co-designing interventions that address well-being.

Complex health and social needs are a consequence of systematic underinvestment in upstream solutions. Increased spending on education, mental health care, job training, and other preventive and protective civil society investments could support economic mobility and minimize significant trauma. While it is essential to serve people whose needs are not being met right now, investment in economic and social opportunity is key to preventing future complexity. These results send a powerful message to community and policymakers: short-term healthcare interventions alone cannot remedy lifetimes of complexity.

Acknowledgments

This study was possible through the hard work and dedication of many people. The Camden Coalition thanks each of the study participants for agreeing to be part of this research; Camden Coalition staff, especially Audrey Hendricks, Mary Pelak, and Marisol Velazquez; the study authors and researchers associated with J-PAL North America; Cooper University Health Care, Jefferson Health, and Virtua Health; the Camden Coalition Board of Trustees; and the Camden Coalition member organizations.

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Camden Coalition
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The National Center
for Complex Health & Social Needs

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About the Camden Coalition

We are a multidisciplinary nonprofit working to improve care for people with complex health and social needs in Camden, NJ, and across the country. The Camden Coalition works to advance the field of **complex care** by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and wellbeing. Supported by a robust data infrastructure, cross-sector convening, and shared learning, our community-based programs deliver better care to the most vulnerable individuals **in Camden and regionally**.

Through our **National Center for Complex Health and Social Needs** (National Center), the Camden Coalition's local work also informs our goal of building the field of complex care **across the country**. Launched in 2016, the National Center exists to inspire people to join the complex care community, connect complex care practitioners with each other, and support the field with tools and resources that move the field of complex care forward.



Assessing the relationship between housing and health among medically complex, chronically homeless individuals experiencing frequent hospital use in the United States

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Funding information

Corporal Michael J. Crescenz Veterans Affairs Medical Center

Abstract

In the United States and abroad, health systems have begun to address housing insecurity through programs that adhere to the Housing First model. The model provides permanent supportive housing without disqualification due to current mental health problems or substance use, along with optional case management services. This study used qualitative methods to explore how housing stability affected chronic disease management and social and community relationships among individuals with complex health and social needs and patterns of high hospital utilisation who were housed as part of a scattered-site Housing First program in a mid-size city in the northeastern United States. 26 individual, semi-structured interviews were conducted with Housing First clients in their homes or day program sites between March and July 2017. Interviews were digitally recorded and transcripts were analysed using a qualitative descriptive methodology until thematic saturation was reached. Findings suggest that housing provided the physical location to manage the logistical aspects of care for these clients, and an environment where they were better able to focus on their health and wellness. Study participants reported less frequent use of emergency services and more regular interaction with primary care providers. Additionally, case managers' role in connecting clients to behavioural health services removed barriers to care that clients had previously faced. Housing also facilitated reconnection with family and friends whose relationships with participants had become strained or distant. Changes to physical and social communities sometimes resulted in experiences of stigmatisation and exclusion, especially for clients who moved to areas with less racial and socioeconomic diversity, but participation in the program promoted an increased sense of safety and security for many clients.

KEYWORDS

addiction, chronic illness, complex interventions, housing, mental health, social and health services

4 | INTRODUCTION

For most individuals who are homeless in the United States, housing instability is temporary. However, a small subset of individuals are “chronically homeless,” defined by the Department of Housing and Urban Development as experiencing homelessness for 1 year or longer, or having had at least four episodes totalling 12 months of homelessness in the past 3 years (United States Department of Housing & Urban Development, 2014). Compared to the general population, individuals experiencing chronic homelessness have higher mortality rates, higher healthcare costs and acute care utilisation, higher rates of substance use disorders and mental health problems, and lower rates of engagement with supportive services (Kirst, Zerger, Misir, Hwang, & Stergiopoulos, 2014; Quinn, Dickson-Gomez, Nowicki, Johnson, & Bendixen, 2018; Roncarari et al., 2018). This subset of the population also experiences high rates of uncontrolled chronic diseases compared to the general population, as lack of stable housing makes detection, treatment and management of chronic illness nearly impossible (Brown, Kiely, Bharel, & Mitchell, 2012; Lebrun-Harris et al., 2013; Pribish, Khalil, Mhaskar, Woodard, & Mirza, 2019).

Health systems are increasingly investing in programs that address housing insecurity and other social drivers of health (Kuehn, 2019; Onie, Lavizzo-Mourey, Lee, Marks, & Perla, 2018; Wright, Vartanian, Royal, & Matson, 2016). One strategy health systems in the United States and abroad have adopted to address the health consequences of housing insecurity is investment in programs that adhere to the Housing First model, which provides permanent supportive housing without disqualification due to current mental health problems or substance use, along with optional case management services (American Hospital Association, 2017; Tsemberis, Gulcur, & Nakae, 2004).

Evidence for the positive impact of Housing First on the health of individuals who have experienced chronic homelessness has grown over the years. Research has found associations between housing placement and decreased hospital utilisation (Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003; Hwang et al., 2011; Ly & Latimer, 2015; Montgomery, Hill, Kane, & Culhane, 2013; Russolillo, Patterson, McCandless, Moniruzzaman, & Somers, 2014), decreased substance use (Collins et al., 2012; Padgett, Stanhope, Henwood, & Stefancic, 2011), and decreased psychiatric symptom burden (Aubry, Nelson, & Tsemberis, 2015; Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005). Improvements in self-reported quality of life, help-seeking and life satisfaction are also identified as benefits of participation in programs adhering to Housing First principles (Parsell, Ten Have, Denton, & Walter, 2018; Urbanoski et al., 2017). However, for some, the initial positive impact of Housing First participation on quality of life may attenuate over time (Urbanoski et al., 2017). Furthermore, the health outcomes of Housing First participants vary by the quality and consistency of the housing received (Sylvestre et al., 2018).

There are few studies of how individuals with complex medical conditions who are chronically homeless experience interaction

What is known about the topic

- Housing First programs are associated with decreased substance use and improved mental health.
- For formerly homeless individuals, the sense of security resulting from housing stability improves feelings of efficacy over health and other aspects of life.
- Evidence for the effect of Housing First programs on healthcare service use is inconclusive.

What this paper adds

- Housing facilitates stability and security, improving management of health conditions for formerly homeless individuals with significant medical needs.
- Case managers play a critical role in connecting Housing First clients to services and help mitigate feelings of isolation.
- Housing facilitates re-connection with friends and family, but clients in scattered-site programs can experience stigmatisation and a lack of social integration.

with the healthcare system and management of their health conditions following housing (Buchanan, Kee, Sadowski, & Garcia, 2009; Henwood et al., 2013; Sylvestre et al., 2018). We address this gap by exploring how housing stability affected chronic disease management and social and community relationships among participants in a Housing First program operated as part of a care management intervention for individuals with complex medical needs and comorbid behavioural health diagnoses. Understanding the perspectives of Housing First participants with complex medical needs provides insight critical to improving the health of populations experiencing chronic homelessness.

2 | METHODS

2.1 | Design

For this descriptive qualitative study, we conducted in-depth, semi-structured interviews with 26 individuals enrolled in a Housing First program as part of an intensive care management program. Digital recordings of interviews were transcribed verbatim, entered into NVivo 11 (QSR International) software for coding and analysed using a qualitative descriptive methodology (Colorafi & Evans, 2016).

2.2 | Setting

In 2007, a non-profit healthcare organisation (“the organisation”) in a mid-size city in the northeastern United States began providing a community-based care management intervention for patients with significant social and medical complexity and frequent hospitalisation. When data revealed limited success reducing hospital use for patients

experiencing chronic homelessness, the organisation launched a Housing First program in November 2015 for individuals enrolled in the care management intervention who also met the Housing and Urban Development definition of chronic homelessness. A state agency provided 50 project-based housing vouchers and seed funding to support the program. Although the program was closely aligned with Housing First principles, there were some preconditions in that the state required that clients apply for the project-based voucher, which impeded immediate access to housing upon eligibility. Once approved, clients were given a choice of apartments and were placed in scattered-site housing throughout two counties in the state. Landlords entered into a master lease with an outside organisation contracted by the lead organisation; optional case management services were also provided by an outside organisation.

2.3 | Study recruitment and interviews

The study was conducted in 2017 in two counties in the southern region of the state and is based on interviews with clients who were housed as part of the organisation's Housing First program. The study team recruited clients who had moved into permanent housing via telephone. At times, program staff asked clients during home visits if they would be open to study recruitment and shared that information with the study team. Each participant provided informed consent and received a \$25 USD gift card for their participation. In-depth, semi-structured interviews were conducted ($n = 26$) by research staff in participants' homes or day program sites between March and July 2017. On rare occasions program staff also attended the interviews to comply with the program's safety policy of requiring two individuals at a home visit. Clients were not interviewed if they appeared to be under the influence of substances or became verbally or physically aggressive to staff. The interviews were digitally recorded and lasted approximately 1 hr. Participants were asked about their previous experiences with housing instability; management of their physical, mental and behavioural health prior to and following housing placement; and their familial, social and community relationships prior to and following housing placement.

2.4 | Ethical considerations

Written and verbal information about the study was given to participants and written informed consent was obtained. Participants were informed that participation was voluntary, that they could withdraw their participation at any time, that refusal to participate or end the interview prematurely would not affect the services they received or their status in the program, and that their names would not be linked to their responses. The Institutional Review Board at a large research university in the United States approved this study.

2.5 | Data analysis

The authors developed a codebook through open coding of several transcripts, and the research team met regularly to discuss the coding

process, emerging patterns in the data and to resolve any discrepancies in the application of codes. Coding was done by three authors, and 20% of interviews were double coded to ensure consistency with an IRR kappa of ≥ 0.6 for each of the coding nodes. Domains relevant to the interview guide and objectives of this paper were organised using a template analysis approach (King, 1998). Members of the research team used the template to organise common categories of responses across transcripts, outlier responses and exemplar quotes. Once thematic saturation was reached, no new interviews were scheduled.

Data on demographics, health status and health system utilisation of clients were collected from a case management database and the organisation's Health Information Exchange by select care team staff.

3 | FINDINGS

3.1 | Characteristics of the sample

Among 50 clients participating in the Housing First program, 30 clients were approached to participate in interviews. Of these, two declined to participate, one was dropped due to scheduling difficulties and one was not interviewed because of evidence of alcohol use during the visit and aggressive behaviour towards staff. No additional clients were contacted because saturation was reached after 26 interviews. Interviewees ranged in age from 32 to 80, with an average age of 52 at the time of the interview. All 26 study participants had at least one chronic medical illness and at least one mental health condition; 14 had a recent history of substance abuse, dependence or a substance use disorder. The most prevalent chronic medical illnesses were hypertension and chronic obstructive pulmonary disease. Major depressive disorder, schizoaffective disorder, generalised anxiety disorder and post-traumatic stress disorder were the most common mental health conditions. Fourteen participants had four or more emergency department visits in the year prior to program entry; seven had four or more hospitalisations in the year prior to program entry. Table 1 displays information about interview participants' clinical and demographic characteristics.

3.2 | Interview results

Four central themes emerged from the analysis. First, receiving housing and additional services through the Housing First program reduced stress and improved participants' sense of security and stability. Second, with stability, participants experienced better management of chronic health conditions, including feeling greater self-efficacy in addressing substance use and dependence. Third, the optional case management offered through the program provided support and navigation through the health system. Finally, housing constancy led to an improved sense of social connectedness, which case managers contributed to as well.

Underlying these themes was the importance of establishing ontological security, the feeling of well-being that arises from a sense of constancy in one's social and material environment, which, in turn, provides a secure platform for identity development and

TABLE 1 Key informant characteristics (n = 26)

Characteristic	No. of clients (%)
Gender	
Male	14 (54)
Female	11 (42)
Transsexual	1 (4)
Age, years	
30s	4 (15)
40s	3 (12)
50s	15 (58)
60s	3 (12)
80s	1 (4)
Number of chronic medical conditions	
Up to 2	9 (35)
3	8 (30)
4+	9 (35)
At least 1 substance use disorder	14 (54)
At least 1 mental health condition	26 (100)
Number of emergency department visits in year prior to program entry	
Up to 3	12 (46)
4-7	7 (27)
10-15	3 (12)
16+	4 (15)
Number of hospitalisations in year prior to program entry	
Up to 2	13 (50)
3	6 (23)
4-5	3 (12)
6+	4 (15)

self-actualisation (Giddens, 1990). Participants consistently reflected on their increased sense of security as critical to an improved sense of physical and mental health.

3.2.4 | Housing stability led to lower stress and a greater sense of security

Participants often described improved physical and emotional stability following housing – and drew explicit connections between housing stability and their health. In particular, individuals highlighted regularly taking part in routine home activities, like cooking, cleaning and relaxing, which had been challenging or impossible during periods of homelessness, that now provided a symbol of stability:

I wasn't used to having a home to be in. I used to get up and go out on the streets and hang out. Now it's nice just coming home relaxing. I can cook and watch TV. I don't have to worry about nothing.

(Participant 19)

Many described feelings of decreased stress:

I don't have the stress that I had before living out there. And I feel I don't have to worry like I used to. I don't have to worry about eating. I have a place to live which is great. And physically and mentally. I haven't been to the hospital since I moved in here. And I used to be in the hospital a lot before I did move in here.

(Participant 6)

Participants reported that feeling unsafe was a significant stressor prior to being housed. Many were concerned about acts of violence, and drug use and trade where they previously lived:

It's not safe. You don't wanna be where people – there's gunshots every night. I mean it's terrible. And oh, right in front of our house they were selling drugs. I'm like that's not good for – you know what I mean? It's just not a safe place.

(Participant 9)

Choosing housing outside of areas where participants witnessed and/or experienced violence allowed for an increased sense of security and safety:

And when [they] showed me this place, I liked it. And my brother lives down the street, so it's a little peaceful, like more help. It was a new beginning. And all the old stuff I didn't have to worry about. It's peace and quiet.

(Participant 10)

3.2.2 | Housing stability improved health management and reduced reliance on hospital-based care

Following successful housing placement, participants described increased engagement in managing their medical conditions, and improvement in their health. Many participants associated this improvement with the resolution of stressors from their prior living situations. Housing also provided a structure that facilitated better chronic disease management from a logistical standpoint:

It's easier to stay on top of you taking your medicine when you have a good environment like this. It's not being homeless where you gotta go hide your medicine. Then you gotta go get it. Then you gotta get – the bathroom's 400 yards away. And it's crazy. This here's stable.

(Participant 22)

Other participants noted that stable housing provided a place to receive reliable home-based services:

Having a home health aide is the only reason I'm doing okay. Having a home makes having an aide possible. I never had one before my current housing. Before living here and having an aide, I was managing my health conditions by myself.

(Participant 4)

Participants also described decreased barriers to keeping appointments with primary care and other healthcare providers following housing placement, related to improved coordination of transportation, among other factors:

I don't have to be stuck out there, not being able to wash myself to go to the doctors or stuff like that. I can just get up and go or call my mom or call for transportation. I'm back on stable ground now with that.

(Participant 23)

Notably, participants reported less delayed care-seeking following housing placement, whereas prior to housing they would often wait to seek help for worsening health status, necessitating the use of emergency services:

I just would go to the hospital emergency room. And I usually waited until it was really, really, really bad. [...] They told me they believed if I would've stayed one more day out that I probably would've died in my sleep because my lungs were so full of fluid.

(Participant 14)

Some participants emphasised how housing had not only decreased their use of emergency services but contributed to an overall improvement in their sense of health:

Ever since I moved in here, I haven't been in the hospital once. Now that's a blessing. Going from being in the hospital in 2015, 28 times from January until August, and then getting housing November of 2015 and moving here. And still today, [I] haven't been in the hospital.

(Participant 8)

However, the decrease in hospital use was not uniform across all participants. Some participants described continued hospitalisations at rates similar to before housing, as well as continued exacerbations of chronic health conditions. These participants noted conditions such as severe chronic obstructive pulmonary disease and complications due to intravenous drug use, including soft tissue infections and osteomyelitis, as contributing to continued hospitalisations.

For individuals with substance use disorders, particularly alcohol and opioid use disorders, housing was critical for engaging in treatment and sustaining recovery. A key factor for many of these

participants was moving away from environments that provided temptations to use:

So then it was much easier [...] when I left [the city] I was pleading. I'm like [Case Manager], you gotta find me something because I can't live here. There's too many drugs. I'm relapsing.

(Participant 9)

I'm not out there with crazy people. I'm not doing the drugs anymore. I'm not drinking no more. So I'm at peace.

(Participant 12)

Participants expressed increased ability and willingness to engage in treatment for substance use disorders, describing improved outlook and well-being:

I had a drug problem, I will admit. But by the grace of God, I'm kind of 30 days clean [...] and I want to be 30 more days because I'm – but basically [the Case Managers] helped me to like start off in life, seemed like. Pick me up, dust me off and pointed me the way that I should have been going all along.

(Participant 4)

3.2.3 | Case managers' role in helping clients overcome barriers to health is multifaceted

Case management played a critical role in participants' improved feelings of stability and security, and their ability to manage health conditions. Support ranged from informal communication, such as checking to see how someone was doing, to formal actions, such as facilitating rent and utility bill payments. Case managers also provided direct care coordination, including accompanying clients to appointments:

They keep in contact with the nurse here. So they keep me up to date with all my appointments and everything. So it's been a pleasure being with that group, as far as the health is concerned, seeing the doctors and making sure I'm getting all the things I need

(Participant 18)

Participants described ways case managers helped them overcome barriers to obtaining medications and appointments, which clients had not been able to address themselves before program enrolment:

When I got out of the hospital, I didn't have any meds and they said go to your primary care; they'll refill them. I went to my primary care and she goes we don't refill prescriptions from other doctors. And

I'm like what am I supposed to do? Find a psychiatrist. ... there's a four-week waiting list. Well, I can't wait four weeks for my meds. So [Case Manager] made a suggestion let's try to get you a new primary care.

(Participant 9)

Well, I got a Medicaid card. They [Case Managers] helped me with that –to get that, so I don't have to pay out of pocket for my medications. Because I used to pay a lot of money for my medications. So I don't have to do that no more.

(Participant 12)

Case management was also integral to addressing non-medical issues that influenced participant access to care, such as coordinating transportation, securing nutritional support and/or assisting with justice system interactions:

Well, he [the Case Manager] helped me find NA meetings to go to around here and – he helped me with that. He helped me get a bus pass so I can get to the doctor so I don't have to pay for the bus. Stuff like that.

(Participant 6)

She [the Case Manager] came with me to the court in Riverton last month, and because she was there the judge was super lenient. He gave me a free public defender. They ended up dropping the charges.

(Participant 2)

3.2.4 | Housing constancy improved social connectedness, but not necessarily social integration

Prior to housing, participants described social isolation, and rarely could identify a person to call in case of an emergency. Participants spoke of physical housing placement as relieving that sense of isolation:

But I used to feel really lonely when I first moved in. Now it's like solitude. To me, there's a difference. Solitude is where you feel good and relaxed.

(Participant 9)

Some attributed the shift from loneliness to solitude to the increased trust they had in their case managers, including the reliability of case managers in being present during times of need:

I mean, they don't know me. They never seen me. They never met me before. And for them to pursue me the way that they did, it was mind-blowing [...]

Because I believed as an addict that nobody cared for me and no one cares about me.

(Participant 16)

Others found the constancy provided by housing as important for reconnecting with friends and family. For those with active substance use, participants described rebuilding relationships with family and friends who they had lost touch with due to their disorder, while distancing themselves from individuals who had triggered their substance use. In some cases, participants directly attributed their improved health to reestablished relationships:

My health is much better. My children help me – help me to remind me about my pills, make sure I take them because it's three times a day [...]. It's just been great because I didn't have that contact with them before[...] We're much closer now.

(Participant 11)

Participants voiced feelings of improved connectedness despite living in an unfamiliar environment that was sometimes geographically more distant from friends and family. Overall, the housing placement experience was discussed as positive; however, participants rarely provided descriptions of social integration, such as attending community events or participating in local religious groups. Some participants living in new neighbourhoods described feeling out of place or stigmatised for reasons such as being of significantly different age or of different racial/ethnic identities compared to neighbours:

For a person like me, I need to be in a nice, quiet neighbourhood, a quiet location. I don't feel unsafe, but people look at me and expect the worst right away. All they see when they look at anyone is a thug.

(Participant 4)

A few participants discussed having supportive relationships with neighbours or other members of the local community, but only if those individuals were family, friends known previously, or other clients receiving services from the organisation.

4 | DISCUSSION

Previous studies suggest that the sense of security resulting from housing stability improves feelings of efficacy over other aspects of life, including health, and that housing draws evidence of ontological security into sharp relief (Tsemberis et al., 2004; Woodhall-Melnik et al., 2017). Our findings advance knowledge of how housing facilitates stability and improves management of health conditions for chronically homeless individuals with significant medical complexity. In the United States, chronic diseases comprise seven of the top 10 causes of death and are major drivers of healthcare costs, accounting for over 75 percent of this

country's aggregate healthcare spending and 83 cents per dollar of Medicaid spending (Johnson, Hayes, Brown, Hoo, & Ethier, 2014; Kent, 2018). Among the Housing First clients interviewed for our study, housing provided the physical location for managing the logistical aspects of their care, and an environment where they were better able to focus on their health and wellness. Study participants often described less frequent use of emergency services and more regular interaction with primary care following housing placement. Those who experienced increased physical, social and emotional stability with housing also more readily engaged in treatment for substance use disorders. Our findings also suggest that certain populations may be more likely to experience decreased care utilisation and cost, depending upon type and severity of their health concerns.

Similar to other studies, participation in case management emerged as critical to addressing clients' health needs (Clifasefi, Collins, Torres, Grazioli, & Mackelprang, 2016; Kernan, Sylvestre, Aubry, Distrasio, & Schutz, 2019). Case managers' role in connecting clients to services removed barriers to care that clients had previously found difficult or impossible to overcome, and support from case managers in addressing transportation coordination, food insecurity and criminal justice system involvement was vital. While service participation is voluntary within the Housing First paradigm, research suggests the essential role of case management and other supportive services in improving residents' likelihood of success and stability in permanent housing (Gilmer, Stefancic, Henwood, & Ettner, 2015; Henwood et al., 2018; Quinn et al., 2018).

Changes to physical and social communities as a result of the scattered-site housing program sometimes resulted in experiences of stigmatisation and exclusion, as has been found in other studies (Watson, Fossey, & Harvey, 2019; Vanos, Felton, Tsemberis, & Frye, 2007). Although scattered-site housing has been associated with longer housing retention, research shows an advantage of single-site housing in improving sense of community and increasing the quality of social networks among program participants (Montgomery et al., 2019). Participants in our study infrequently reported involvement in community activities, yet rarely reported feelings of loneliness. Indeed, case management service coordinators played a significant role in mitigating feelings of isolation by providing regular, dependable sources of contact. Housing also facilitated reconnection with family and friends whose relationships with participants had become strained or distant, often related to substance use or the nature of being unstably housed. These relationships were essential sources of support as participants sought to overcome barriers to health that seemed insurmountable prior to housing placement.

5 | METHODOLOGICAL CONSIDERATIONS

Our findings are based on a sample of clients in a single Housing First program. Participant responses may have been influenced by social desirability, although this potential bias was minimised by

establishing rapport, ensuring confidentiality, asking open-ended questions and encouraging participants to provide examples. The team ensured the trustworthiness of the data by using well-established thematic analysis techniques, including investigator triangulation of the data for interviews and analysis, member checking during interviews, peer debriefing and creation of a clear audit trail (Guba & Lincoln, 1989; Nowell, Norris, White, & Moules, 2017).

6 | CONCLUSIONS

The transition to housing provides constancy and stability for chronically homeless individuals with medical complexity and frequent hospital use. These elements enable self-management and treatment of health conditions, and help reestablish social relationships. Given the key role that case managers play in the experience of Housing First clients, case management quality may affect social connectedness and health outcomes for specific groups of patients, particularly those with multiple chronic conditions and substance use disorders.

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