

***Home and Healthy for Good:
A Statewide Pilot Housing First Program***

***Updated Report
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Prepared by
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Background

Massachusetts has reacted to homelessness with an emergency response for more than 20 years. While this emergency response has saved lives, it has not provided a permanent solution for people without housing. It has done little to decrease the number of individuals entering the front doors of homeless shelters, which remain in a constant state of overflow.

The state has constructed a massive infrastructure for temporarily combating the symptoms of homelessness, and shelters have become an accepted residential response for an entire segment of poor people. But sheltering has done little to actually reduce homelessness. According to data collected by the Massachusetts Housing and Shelter Alliance (MHSA), state-funded shelters have been over capacity every month for eight consecutive years.¹

Homelessness as a Public Health Issue

A lack of stable housing is associated with significant health concerns and consequently homeless people have disproportionately poor health. The most compelling evidence of this link between homelessness and serious health problems is the high rate of premature death in homeless populations. It has been well documented that mortality rates in homeless individuals in American cities are approximately 3.5 - 5.0 times higher than the general population, with death occurring prematurely at an average age of 47 years.^{2,3} Leading causes of death in homeless adults in Boston in 1997 were homicide (ages 18 - 24), AIDS (ages 25 - 44), and heart disease and cancer (ages 45 - 64).

Several fundamental issues that directly affect the health of homeless persons include:⁴

- Lack of stable housing prevents resting and healing during illness
- Increased potential for theft of medications
- Lack of privacy for dressing changes or medication administration
- Need for food and shelter take precedence over medical appointments
- Mental illness and addiction issues directly impact chronic medical illnesses
- Higher risk for physical and sexual violence (including homicide)
- Cognitive impairments seen in people with severe head injury, chronic substance abuse, or developmental disabilities are common
- Risk of communicable diseases, including respiratory infections, infestations, and skin diseases, is increased in shelter settings
- Medical care is often not sought until illnesses are advanced
- Lack of transportation is a primary obstacle to medical care
- Constant stress that homeless people experience negatively impacts illness
- Social supports, on which people usually depend during hard times, are often extremely limited

¹ Massachusetts Housing and Shelter Alliance. Nightly Census of State Funded Shelters. August 2006.

² Hibbs JR, Benner L, Klugman L, Spencer R, Macchia I, Mellinger AK, Fife D. Mortality in a Cohort of Homeless Adults in Philadelphia. *New England Journal of Medicine* 1994; 331: 304-309.

³ Hwang SW, Orav EJ, O'Connell JJ, Lebow JM, Brennan TA. Causes of Death in Homeless Adults in Boston. *Annals of Internal Medicine* 1997; 126 (8): 625-628.

⁴ Bonin E, Brehore T, Kline S, Misgen M, Post P, Strehlow AJ, Yungman J. Adapting Your Practice: General Recommendations for the Care of Homeless Patients. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc., 2004. www.nhchc.org

The Health Care Costs of Chronic Homelessness

Chronically homeless people, defined by the federal government as those who have experienced repeated or extended stays of a year or more on the street or in temporary shelter and have a disability, constitute about **ten percent** of the homeless population⁵ and **consume more than half** of homeless resources. This subset of people suffers from extraordinarily complex medical, mental, and addiction disabilities that are virtually impossible to manage in the unstable setting of homelessness. Medical illnesses frequently seen in this population include hypertension, cirrhosis, HIV infection, diabetes, skin diseases, osteoarthritis, frostbite, and immersion foot.

With an extreme level of disability, these individuals are among the highest-end utilizers of our state's health care systems. Recently collected data from clinicians at Boston Health Care for the Homeless Program has catalogued some of the medical needs and costs associated with chronically living unsheltered on the streets.⁶ Over a five year period, a cohort of **119 street dwellers** accounted for an astounding **18,384** emergency room visits and **871** medical hospitalizations. The average annual health care cost for individuals living on the street was **\$28,436**, compared to **\$6,056** for individuals in the cohort who obtained housing. A growing body of evidence in the mental and public health literature shows dramatic improvement in health outcomes, residential stability, and cost to society when homeless people receive supportive medical and case management services while living in permanent, affordable housing units.^{7,8,9,10,11,12,13,14}

⁵ Kuhn R, Culhane DP. Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization: Results from the Analysis of Administrative Data. *American Journal of Community Psychol* 1998; 26 (2): 207-232.

⁶ O'Connell JJ, Swain S. Rough Sleepers: A Five Year Prospective Study in Boston, 1999-2003. Presentation, Tenth Annual Ending Homelessness Conference, Massachusetts Housing and Shelter Alliance, Waltham, MA 2005.

⁷ Padgett DK, Gulcur L, Tsemberis S. Housing first services for people who are homeless with co-occurring serious mental illness and substance abuse. *Research on Social Work Practice*. 16(1): 74-83. Jan 2006.

⁸ Siegal CE, et al. Tenant Outcomes in Supported Housing and Community Residences in NYC. *Psychiatric Services*. 57(7): 982-993. July 2006.

⁹ Martinez TE, Burt MR. Impact of Permanent Supportive Housing on the Use of Acute Care Health Service by Homeless Adults. *Psychiatric Services*. 57(7): 992-999. July 2006.

¹⁰ Tsemberis S, Gulcur L, Nakae M. Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*. 94(4): 651-656. April 2004.

¹¹ Seidman LJ, Schutt RK, Caplan B, Tolomiesenko GS, Turner WM, Goldfinger S. The effect of housing interventions on neuropsychological functioning among homeless persons with mental illness. *Psychiatric Services*. 54(6): 905-8. Jun 2003.

¹² Rosenheck R, Kaspro W, Frisman L, Liu-Mares W. Cost-effectiveness of supported housing for homeless persons with mental illness. *Archives of General Psychiatry*. 60: 940-51. Sept 2003.

¹³ McHugo GJ, Bebout RR, Harris M, Cleghorn S, Herring G, Xie H, Becker D, Drake RE. A randomized controlled trial of integrated versus parallel housing services for homeless adults with severe mental illness. *Schizophrenia Bulletin*. 30(4): 969-82. 2004.

¹⁴ Mares AS, Kaspro WJ, Rosenheck RA. Outcomes of supported housing for homeless veterans with psychiatric and substance abuse problems. *Mental Health Services Research*. 6(4): 199-211. Dec 2004.

Housing First

“Housing First” represents a significant paradigm shift in addressing the costly phenomenon of homelessness. This strategy demonstrates impressive outcomes when people are supported in a permanent, housed environment, rather than targeted for intensive services in shelters or streets. Tenants live in leased, independent apartments or congregate-living homes that are integrated into the community and they continue to have access to a broad range of comprehensive services, including medical and mental health care, substance abuse treatment programs, case management, vocational training, and life skills. The use of these services, however, is not necessarily a condition of ongoing tenancy. Housing First represents a shift toward “low-threshold” housing, which focuses on the development of formerly homeless persons as “good tenants” as opposed to “good clients.” It is a change in the service delivery model that recognizes that many persons’ disabilities limit them from entering housing contingent upon complex service plans, compliance-based housing, or the acknowledgment of certain labels or diagnoses.

This model has been implemented with success in several cities in recent years, including San Francisco, New York City, and Philadelphia. In one study, outcome data has been reported on chronically homeless people with severe mental illness who were housed using this model in New York City between 1989 -1997.¹⁵ This landmark study showed that a supportive Housing First intervention for more than 4,600 people resulted in dramatically lower rates of emergency public service usage and their associated costs. Following placement in supportive housing, homeless people in this study experienced fewer and shorter psychiatric hospitalizations, a **35% decrease** in the need for medical and mental health services and a **38% reduction** in costly jail use. Furthermore, costs of the housing units, subsidized mostly by the state and federal governments, were offset by savings in governmental spending on health services for this mentally ill, homeless population.

Home and Healthy for Good

As a result of mounting evidence from around the country that Housing First is cost-effective and decreases the incidence of chronic homelessness, the Massachusetts Legislature passed line-item 4406-3010 in the FY07 state budget to fund a statewide pilot Housing First program for chronically homeless individuals. The state allocated \$600,000 to MHSA through the Department of Transitional Assistance (DTA) to operate the program, known as *Home and Healthy for Good* (HHG). This resource is to be used to fund a portion of the service *or* housing components for program participants, with the expectation that federal or other state resources will be leveraged to finance additional needed service or facilities funds.

Furthermore, the Legislature requested that an evaluation of this pilot program be performed, with a focus on the cost per participant and projected cost-savings in state-funded programs. The following report describes the implementation of *Home and Healthy for Good* and updated findings from the evaluation of the program as of June 2007.

¹⁵ Culhane DP, Metraux S, Hadley T. Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*. 13(1): 107-163. 2002.

Implementation

MHSA generated a contract with DTA on September 20, 2006 that outlined the technical aspects of *Home and Healthy for Good*. MHSA hired a Housing First Coordinator to coordinate the program. The following homeless service providers across the state agreed to participate in the program as provider agencies subcontracted by MHSA:

- South Middlesex Opportunity Council (SMOC), **Framingham** with Community Healthlink in **Worcester**
- Shelter, Inc., **Cambridge**
- Pine Street Inn (PSI), **Boston and Brookline**
- Metropolitan Boston Housing Partnership (MBHP), **Boston**
- Quincy Interfaith Sheltering Coalition (QISC), **Quincy, Brockton, and Plymouth**
- Housing Assistance Cooperation (HAC), **Cape Cod**
- Friends of the Homeless (FOH), **Springfield**
- Massachusetts Veterans, Inc., **Worcester**

The first tenants were housed in late September 2006. Funding and implementation were temporarily put on hold when line item 4406-3010 was cut as part of the Governor's 9C action in November. Funding of this line item was restored in late November and implementation of the program resumed. As of June 2007, 155 formerly homeless people have been housed.

Data Collection

In order to ethically conduct research and measure outcomes in a vulnerable population, participants are asked to consider enrollment in the research study and informed consent is obtained from those who agree. It is important to note that refusal to participate in the research study does not preclude participation in the Housing First program.

Case managers interview tenants who agree to contribute to the research study upon entry into housing and at one-month intervals thereafter. Interview questions pertain to demographic information, quality of life, nature of disabilities, health insurance, sources of income, and self-reported medical and other service usage. MHSA is in the process of also obtaining participants' claims data from MassHealth. Researchers at the Center for Mental Health Services Research, University of Massachusetts Medical School assist with the data analysis.

Preliminary Results

Total Participants

As of June 1, 2007, **155** people have been housed in the Home and Healthy for Good program.

Residential Stability

Out of a total of 155 participants, **133** people have remained housed, resulting in a residential stability rate of **85.8%**. The following chart shows the reasons participants moved out of HHG housing:

Unable to sustain tenancy	17 people
Incarcerated	3 people
Deceased	2 people
Moved on to other permanent housing (remaining housed)	8 people

Participant Characteristics		
	No.	(%)
Total	95	(100)
Gender		
Male	73	(77)
Female	20	(21)
Transgender	2	(2)
Age		
18-30	10	(11)
31-50	45	(47)
51-61	34	(36)
62+	4	(4)
Unknown	2	(2)
Average	44.7	
Ethnicity		
Hispanic	14	(15)
Non-Hispanic	79	(83)
Unknown	2	(2)
Race		
American Indian	4	(4)
Asian	2	(2)
African American	15	(16)
White	69	(73)
Unknown	5	(5)
Income Sources reported		
Supplem. Security	27	(28)
SSDI	17	(18)
Social Security	4	(4)
General Assistance	15	(16)
Veterans Benefits	1	(1)
Employment	7	(7)
Medicaid	1	(1)
Food Stamps	3	(3)
Other	2	(2)
None	22	(23)
Health Insurance		
Private Insurance	1	(1)
Medicare	6	(6)
MassHealth	79	(83)
Free Care	3	(3)
No Insurance	6	(6)
Disability		
Medical	53	(56)
Mental	62	(65)
Active Substance Abuse	19	(20)
Multiple Disabilities	46	(48)
Served in Military	12	(13)
Average Length of Homelessness		
	6.47	years

Demographics

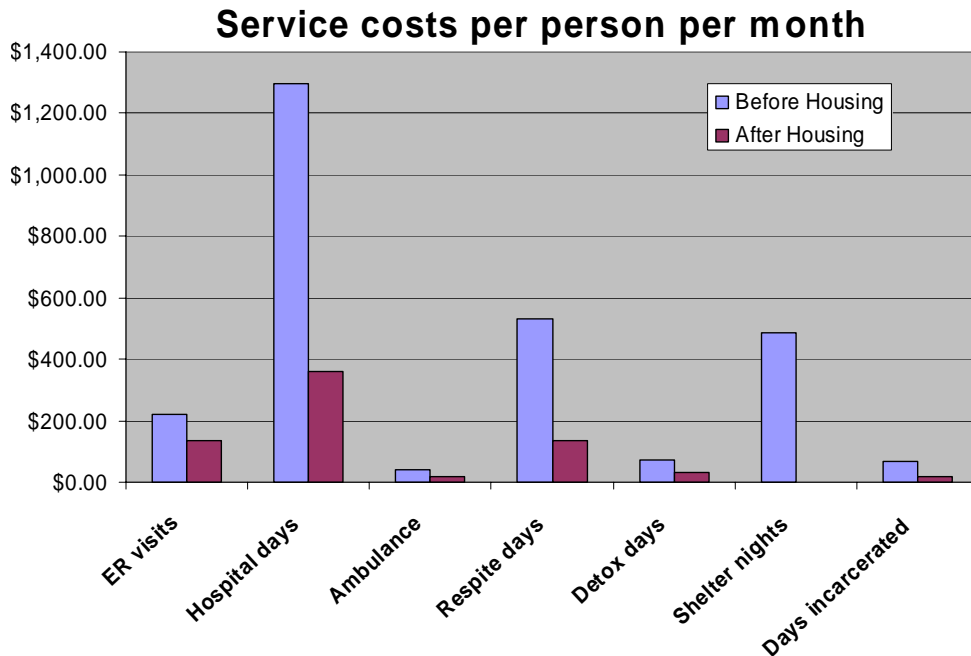
The following data applies to 95 of 155 participants from whom informed consent and interview data have been obtained. This data is based on an average of 2.5 follow-up interviews per person that have been collected as of June 2007.

Cost of Services Before and After Housing

In the six months prior to entering housing, **95 participants** accounted for **198** emergency room visits, **411** days in inpatient care, and **8,692** nights in emergency shelter. The use of these services decreased substantially following participation in HHG. MHSAs has made conservative estimates of the costs associated with these and other services. Our cost estimates are based on the following:

- **Emergency Room:** Based on the Blue Cross Blue Shield Medical Cost Estimator, the average emergency room visit in 2004 in Massachusetts was \$640¹⁶
- **Hospitalization:** The Blue Cross Blue Shield of South Carolina Cost Estimator quotes an average cost of hospital admissions of \$1,800 per day in 2005¹⁷
- **Ambulance:** The Massachusetts Division of Health Care Finance and Policy (114.3 CMR 27.03) estimates the cost of an ambulance ride to be \$230
- **Respite:** Boston Health Care for the Homeless Program estimates an average day in respite at the Barbara McInnis House to cost \$400
- **Detoxification:** The Massachusetts Department of Public Health's Bureau of Substance Abuse Services estimates the costs associated with one day in detox to be \$198
- **Shelter:** According to the Department of Transitional Assistance, the average cost to the state of a night in a Massachusetts homeless shelter for one person is \$32
- **Incarceration:** Former Lt. Governor Healey estimates the costs associated with prison or jail time to be \$118 per day

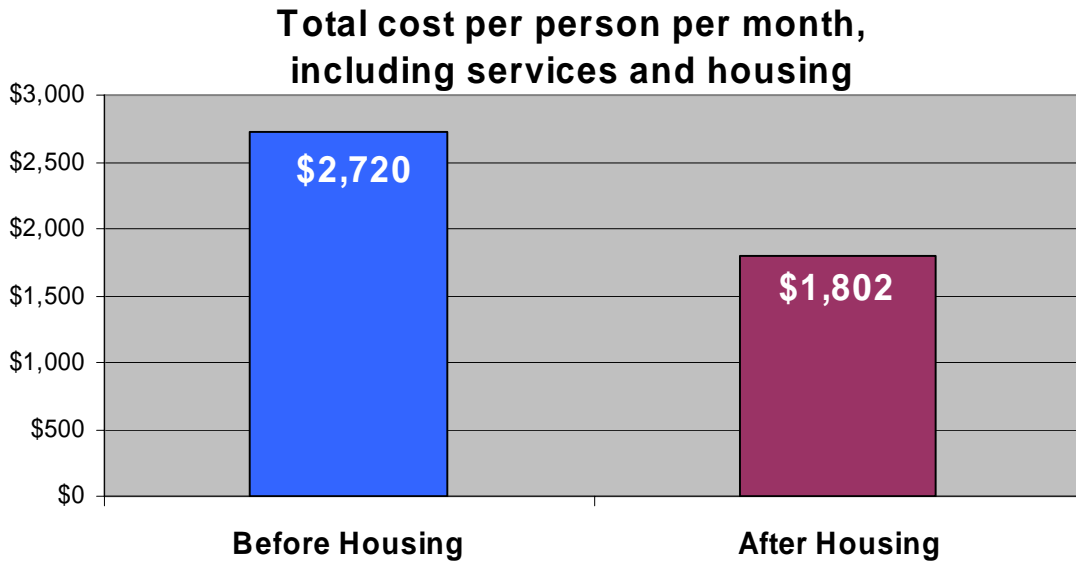
The following chart shows the estimated costs per person per month in several different service areas prior to and after placement in housing.



¹⁶http://www.bluecrossma.com/common/en_US/pdfs/SampleMedicalCosts.pdf

¹⁷[http://www.bluechoicesc.com/Internet/chca/chc/imglib.nsf/Files/medical+cost+estimator.pdf/\\$FILE/medical%20cost%20estimator.pdf](http://www.bluechoicesc.com/Internet/chca/chc/imglib.nsf/Files/medical+cost+estimator.pdf/$FILE/medical%20cost%20estimator.pdf)

The average monthly cost for all services combined per person prior to housing was \$2,720, compared to \$698 after placement in housing. Taking into account the monthly average cost of HHG of \$1,104 per person (which includes both housing and intensive case management), tenants are costing approximately \$1,802 per month after moving into housing, for a **savings to the state of \$918 per person per month.**



Therefore, our projected annual cost-savings to the Commonwealth per housed tenant is \$11,016.

Summary and Recommendations

The *Home and Healthy for Good* pilot program was included in the FY07 state budget to measure the effectiveness of a Housing First model for chronically homeless individuals with severe health problems. For more than 20 years, this segment of the homeless population has received emergency care while living on the street or in shelter – locations that greatly limit the effectiveness of any treatment clinicians can provide.

Through *Home and Healthy for Good*, MHSA is working to test the hypothesis that providing housing and services to chronically homeless individuals through a Housing First model is less costly than managing their homelessness and health problems on the street or in shelter. Preliminary results are showing a trend towards tremendous savings in health care costs, especially hospitalizations, when chronically homeless individuals are placed into housing with services. Initial tenancy retention rates and improved health outcomes point to Housing First as an effective intervention for chronically homeless individuals.

To maintain its current capacity for FY 2008, MHSA estimates it would require \$900,000 in state funding. **MHSA supports doubling the size of *Home and Healthy for Good*, funding Line Item 4406-3010 at \$1.8 million.** With this amount of funding, HHG could continue to reduce the number of chronically homeless individuals – and the costs related to their homelessness – on a scale that will allow the state to more accurately measure the effectiveness of a Housing First approach.

Ending homelessness will require more than one housing model, one line item or focusing on one target population. A long-term strategy to end homelessness in Massachusetts will require a serious evaluation of how the state uses its resources and will require bold actions on the part of lawmakers. Some of this work has already begun with the formation of the Commission to End Homelessness established by Chapter 2 of the Resolves of 2006 (approved October 26, 2006). An evaluation of homelessness spending must be based on empirical data, informed by results from innovative housing models, and premised on the fact that resources are scarce and must be strategically targeted. The results of *Home and Healthy for Good* will play a critical role in influencing policy as the state moves toward permanent solutions to end homelessness.

Testimonials

“For too long I think we’ve relied heavily on shelter. Simply allowing people to remain on the street is going to eventually cost the taxpayers more money. It means more visits to the emergency room.”

- **Ed Sanders-Bey,**
Assistant Commissioner for Policy and Program Management, Massachusetts
Department of Transitional Assistance

“From a business perspective and the perspective of many of the businesses in the chamber of commerce, they want to see a program that’s working, not a program that’s growing with bad results, but a program that actually works and helps solve a problem.”

- **Peter Forman, President,**
South Shore Chamber of Commerce

“By taking the locus of health care away from the emergency room and into primary care settings, we’re seeing to it that they’re really going to be much healthier.”

- **Bill Fisher, Ph.D., Professor of Psychiatry,**
University of Massachusetts Medical School

“The shelter really didn’t have the facilities for someone to recuperate. People don’t realize what it is not to have a home and having different medical issues going on. I don’t know what I’d have done. I don’t know if I’d still be alive.”

- **Lois Spencer, Housing First Tenant**

About MHSA

The Massachusetts Housing and Shelter Alliance (MHSA) is a public policy advocacy organization with the singular mission of ending homelessness in the Commonwealth. Founded in 1988 by a dedicated group of “first responders” working with unsheltered adults in Greater Boston, MHSA initiates innovative solutions to move people out of crisis and into permanence.

MHSA membership includes 88 organizations serving homeless individuals across the state. These agencies have created more than 250 programs that provide permanent housing; transitional programs; emergency shelter; outreach, assessment, and treatment programs; health services; day programs; employment and housing placement programs; economic development opportunities; and homeless self-advocacy.

4406-3010 Legislative Language

4406-3010

“For a grant to the Home and Healthy for Good pilot program operated by the Massachusetts Housing and Shelter Alliance for the purpose of reducing the incidence of chronic homelessness in the commonwealth; provided, that the Massachusetts Housing and Shelter Alliance shall be solely responsible for the administration of this program; provided further, that the Massachusetts Housing and Shelter Alliance shall file a report with the clerks of the house, the commissioner of the department of transitional assistance and senate, and the chairpersons of the house and senate committees on ways and means no later than March 1, 2007, detailing the implementation of this program; and provided further, that the report shall include information on the number of people served, the average cost per participant, the demographics of those served, whether participants have previously received government services and any projected cost-savings in other state funded programs..... \$600,000”