

***Home & Healthy for Good***  
**A Statewide Pilot Housing First Program**

***Progress Report***  
***July 2008***



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.<sup>1</sup>

### 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 poor health 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 times higher than the general population, with death occurring prematurely at an average age of 47 years.<sup>2,3</sup> 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:<sup>4</sup>

- 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
- 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 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 are often extremely limited

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<sup>1</sup> Massachusetts Housing and Shelter Alliance. Nightly Census of State Funded Shelters. August 2006.

<sup>2</sup> 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.

<sup>3</sup> 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.

<sup>4</sup> 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](http://www.nhchc.org)

## 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 population<sup>5</sup> 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 (BHCHP) has catalogued some of the medical needs and costs associated with chronically living unsheltered on the streets.<sup>6</sup> 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.<sup>7,8,9,10,11,12,13,14</sup>

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<sup>5</sup> 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.

<sup>6</sup> 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.

<sup>7</sup> 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.

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

<sup>9</sup> 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.

<sup>10</sup> 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.

<sup>11</sup> 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.

<sup>12</sup> 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.

<sup>13</sup> 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.

<sup>14</sup> 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 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-based 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, 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. Outcome data has been reported on chronically homeless people with severe mental illness who were housed using a Housing First strategy in New York City between 1989 -1997.<sup>15</sup> 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 population.

## ***Home & 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 & Healthy for Good* (HHG). Funding for this program was increased to \$1.2 million in FY08, and has been level funded at \$1.2 million for FY09. This resource is 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. This report describes the implementation of *Home & Healthy for Good* and updated findings from the evaluation of the program as of July 2008.

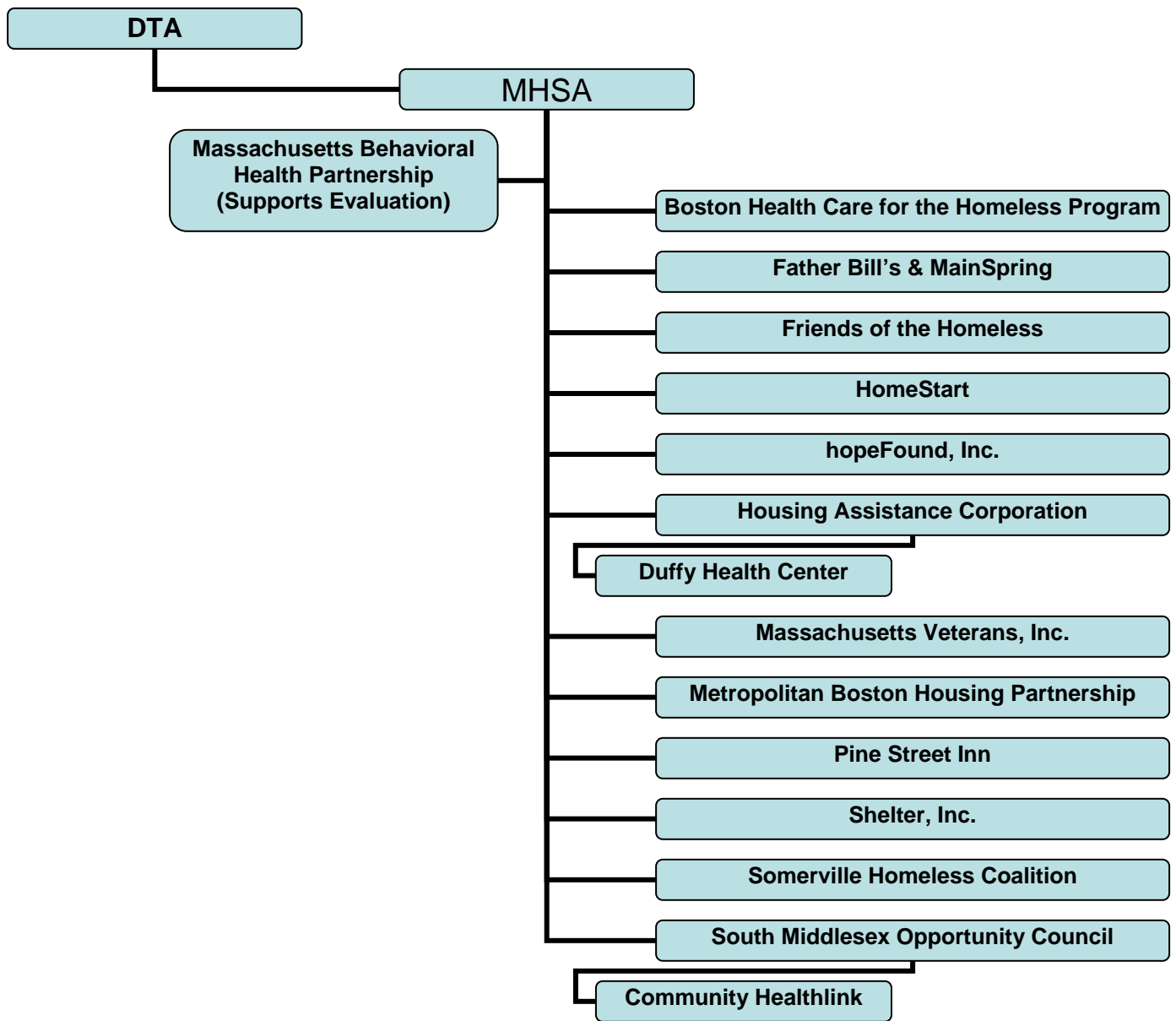
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<sup>15</sup> Culhane DP, Metraux S, Hadley T. Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*. 13(1): 107-163. 2002.

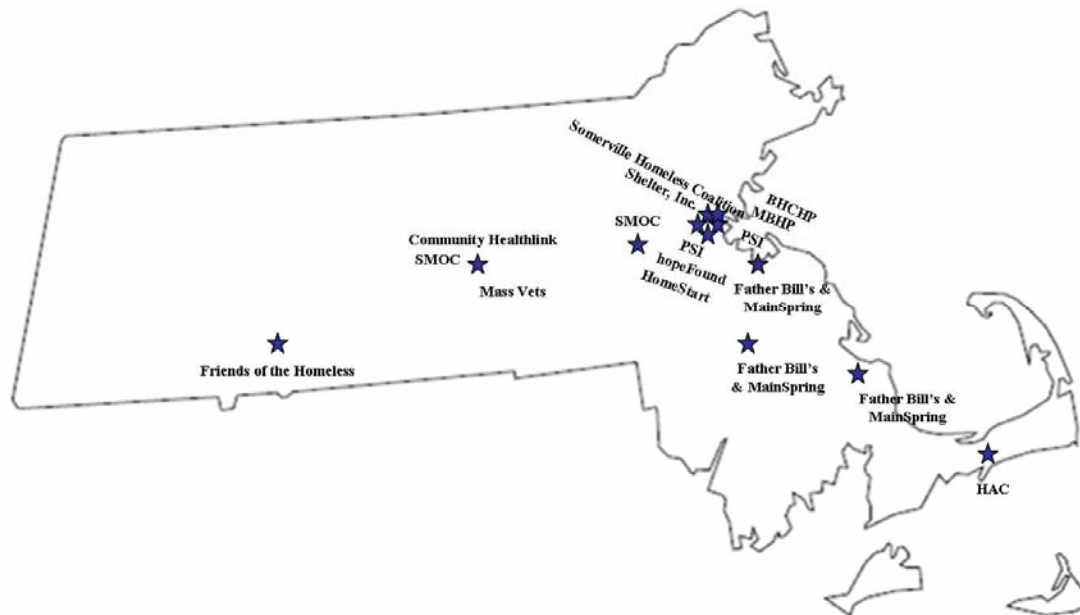
## Implementation

MHSA and DTA generated a contract on October 30, 2007 that outlined the technical aspects of *Home & Healthy for Good* for this fiscal year. Twelve homeless service providers across the state agreed to participate in the program as agencies subcontracted by MHSA. These organizations, listed in the right hand column under MHSA in the schematic below, provide either housing or in-home services, or in some cases both. Housing may be scattered-site apartments or congregate-based. Intensive in-home services are provided by case managers or in some cases medical clinicians.

### Schematic of Involved Agencies



## Geographic Locations of Programs



### Case Management Support

MHSA sponsored a half-day seminar for involved case managers on October 24, 2007 titled, “Harm Reduction and Motivational Interviewing in the Setting of Housing First.” Approximately 60 case managers from across the state attended the seminar, which was presented by Mark Kinzly, a harm reduction expert from Yale University. MHSA also holds regular meetings with case managers to obtain frontline input and discuss troubleshooting.

### 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 HHG.

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. Internal Review Board approval has been granted by the Center for Mental Health Services Research, University of Massachusetts Medical School and researchers from that institution assist with data analysis.

The research component of *Home & Healthy for Good* is funded in large part by a grant from the Massachusetts Behavioral Health Partnership, an organization that has been instrumental in promoting a Housing First approach for chronic homelessness in Massachusetts.

## Preliminary Results

### Total Participants

As of June 16, 2008, **281** people have been housed in the *Home & Healthy for Good* program.

### Residential Stability

Out of a total of 281 participants, **180** people have remained housed in the *Home & Healthy for Good* program, **5** people have died while in HHG housing, and **49** people have moved on to other permanent housing, resulting in a residential stability rate of **83%**. The following list categorizes participants who moved out of HHG housing:

Assumed return to homelessness	28 people
Lost to follow up	10 people
Incarcerated	9 people
Moved on to other permanent housing (remaining housed)	49 people

Tenants who remain housed have been in the program for an average of 11.5 months as of July 2008. Tenants who exited the program left after an average of 6 months.

### Type of Housing

Congregate housing, in which each tenant has a private bedroom and shares bathroom, kitchen, and laundry space with housemates, accounts for 56% of the housing in this program. The remaining 44% of homes are scattered-site housing (individual apartments scattered throughout neighborhoods).

### Research Sample

Of 281 participants in HHG, **85%** (239 people) have given written, informed consent to participate in the research project. The preliminary research data reported below was obtained through monthly interviews of this group of 239 research subjects. As of June 2008, each participating tenant has been interviewed an average of 7 times to inform this report.

## Demographics

<b>Participant Characteristics</b>		
	<b>No.</b>	<b>(%)</b>
<b>Total</b>	281	(100)
<b>Gender</b>		
Male	211	(74)
Female	68	(25)
Transgender	2	(1)
<b>Age</b>		
18-30	23	(8)
31-50	144	(51)
51-61	90	(32)
62+	17	(6)
Unknown	7	(2)
Average	49	
<b>Ethnicity</b>		
Hispanic	31	(11)
Non-Hispanic	247	(89)
<b>Race</b>		
American Indian	4	(1)
Asian	3	(1)
African American	44	(16)
White	216	(77)
Unknown	14	(5)
<b>Income Sources reported</b>		
Supplem. Security	47	(17)
SSDI	44	(16)
Social Security	15	(5)
General Assistance	55	(20)
Veterans Benefits	2	(1)
Employment	29	(10)
Medicaid	2	(1)
Food Stamps	5	(2)
Other	11	(4)
None	75	(27)
<b>Health Insurance</b>		
Private Insurance	5	(2)
Medicare	24	(9)
MassHealth	237	(84)
Veterans	14	(5)
Commonwlth Care	3	(1)
Free Care	9	(3)
No Insurance	11	(4)
<b>Disability</b>		
Medical	154	(55)
Mental	180	(64)
Active Substance Abuse	53	(19)
Multiple Disabilities	116	(41)
<b>Served in Military</b>	47	(17)
<b>Average Length of Homelessness</b>		
	5.62 years	

### **Services Before and After Housing**

In the six months prior to entering housing, **239 participants** accounted for **504** emergency room visits, **1,065** days in inpatient care, and **21,309** nights in emergency shelter. The use of these services decreased substantially following participation in HHG. MHSA has made conservative estimates of the costs associated with these and other services. Our cost estimates are based on the following:

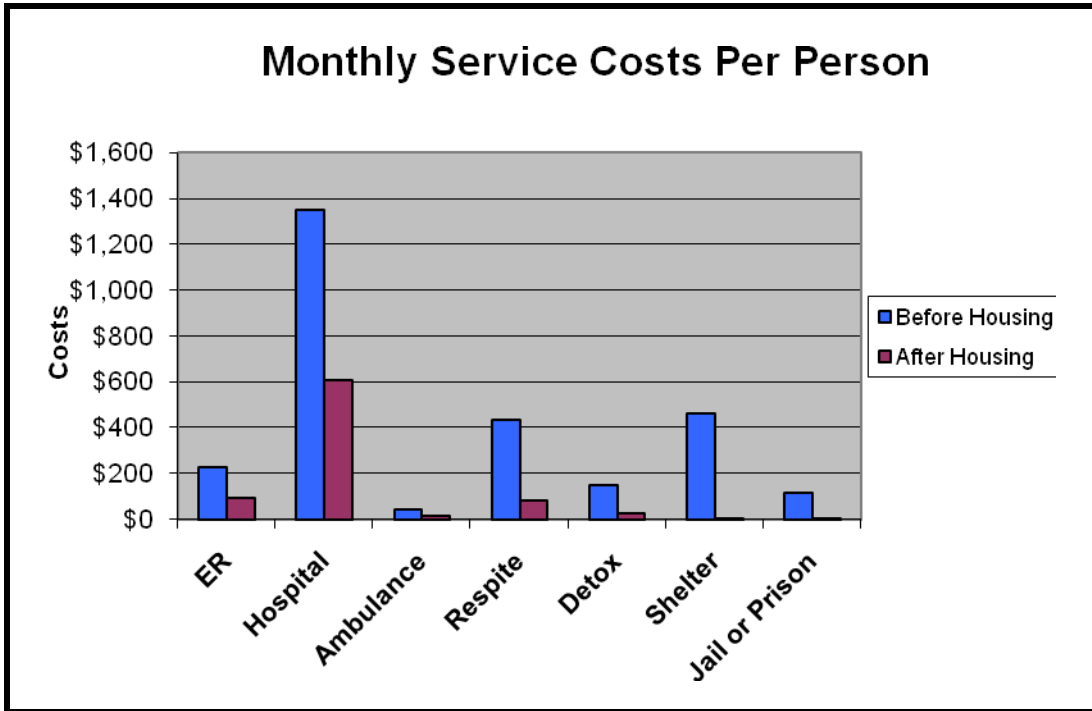
- **Emergency Room:** Based on the Blue Cross Blue Shield Medical Cost Estimator, the average emergency room visit in 2004 in Massachusetts was \$640<sup>16</sup>
- **Hospitalization:** The Massachusetts Hospital Association quotes an average cost of an inpatient day in a Massachusetts hospital as \$1,895 per day in 2006
- **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

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<sup>16</sup>[http://www.bluecrossma.com/common/en\\_US/pdfs/SampleMedicalCosts.pdf](http://www.bluecrossma.com/common/en_US/pdfs/SampleMedicalCosts.pdf)

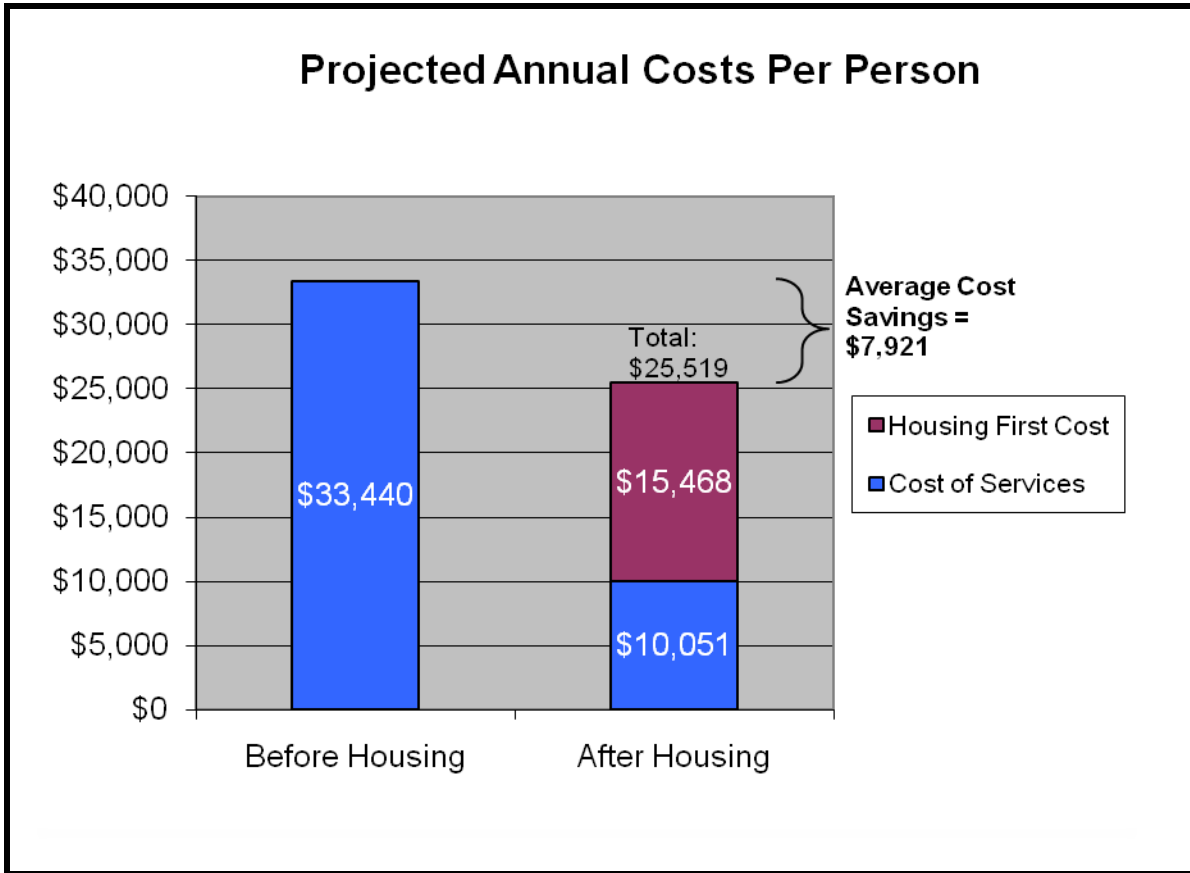
### Monthly Service Costs Decrease After Housing

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



### Total Projected Annual Costs

In summary, the chart below depicts the estimated total costs of all the above measured services (ER visits, hospital days, ambulance use, respite days, detox days, shelter nights, and days incarcerated) that were used by each person in the year prior to and the year after housing (in blue), along with the costs of operating this program, including housing and in-home services (in burgundy).



**Therefore, our projected annual cost-savings to the Commonwealth per housed tenant is \$7,921.**

## Summary and Recommendations

The *Home & Healthy for Good* pilot program was included in the FY07 and FY08 state budgets to measure the effectiveness of a Housing First model for chronically homeless individuals. 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 & 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 and more effective than managing their homelessness and health problems on the street or in shelter. Preliminary results show a trend towards tremendous savings in health care costs, especially hospitalizations, when chronically homeless individuals are placed into housing with services. Tenancy retention rates and improved health outcomes point to Housing First as an effective intervention for chronically homeless individuals.

Ultimately, ending homelessness in Massachusetts will require more than one housing model, one line item or focusing on one target population. A long-term strategy to end homelessness will require a serious evaluation of how the state uses its resources and bold action on the part of the Massachusetts Interagency Council on Homelessness and Housing and lawmakers. 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 & Healthy for Good* will play a critical role in influencing policy as the state moves toward permanent solutions to end homelessness, as outlined in the recent report put forth by the Massachusetts Commission to End Homelessness.

## **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 & 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, 2008, 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..... \$1,200,000”