Permanent Supportive Housing:  
A Solution-Driven Model  

January 2015 Home & Healthy for Good Progress Report

Prepared by:  
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About the Massachusetts Housing and Shelter Alliance

The Massachusetts Housing and Shelter Alliance (MHSA) is a nonprofit public policy advocacy organization with the singular mission of ending homelessness in Massachusetts.

Founded in 1988, MHSA represents 100 community-based agencies statewide. MHSA works with these member organizations to educate the public about homelessness and solutions that will end it; advocate for the strategic use of resources based on research and best practices; advance innovative, cost-effective solutions to homelessness; and form partnerships with government, private philanthropy, business leaders and service providers to ensure that homelessness does not become a permanent part of the social landscape.
Massachusetts has reacted to unaccompanied adult homelessness with an emergency response system for more than 25 years. While this has saved lives, it has done little to decrease the number of individuals utilizing homeless shelters and has created a costly disincentive to actually solve — rather than manage — the problem of chronic homelessness. Given the constant need for homeless services, the Commonwealth has constructed a massive infrastructure for temporarily combating the symptoms of homelessness without addressing the root of the problem itself: a lack of permanent, stable housing for the most vulnerable citizens of the state. The emergency shelter system has proven to be inadequate in addressing homelessness, both in the client outcomes it produces and its overall cost-effectiveness. Quite simply, the emergency shelter system was built to manage, rather than end, the homeless epidemic that developed throughout the 1980s.

A lack of stable housing is associated with significant health concerns, and it results in disproportionately poor health among individuals experiencing homelessness. The most compelling evidence of this link is the high rate of premature death in homeless populations.

**Housing First: A Low-Threshold Model for Success**

Now an increasingly recognized best practice, the Housing First model continues to represent a paradigm shift in addressing the costly social problem of chronic homelessness. Tenants live in leased, independent apartments or shared living arrangements that are integrated into the community. Tenants have access to a broad range of comprehensive community-based services, including medical and mental health care, substance abuse treatment, case management, vocational training and life skills training. The use of these services, however, is not a condition of ongoing tenancy. Housing First represents a shift toward “low-threshold” housing, which is focused on the development of formerly homeless persons as “good tenants” as opposed to “good clients.” The low-threshold housing model recognizes that a person’s disabilities may limit them from entering the traditional, linear service delivery system, which often entails complex clinical-based service plans, compliance-based housing placements and the acknowledgment on the part of the tenant to accept certain labels and diagnoses. By removing the barriers to housing, individuals are given an opportunity to deal with the complex health and life issues they face as tenants, rather than as clients of a prescribed system of care.

**Creating a Housing First Initiative in Massachusetts**

As a result of mounting evidence from around the country that Housing First is a cost-effective model that decreases 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 the Massachusetts Housing and Shelter Alliance (MHSA) through the Department of Transitional Assistance to operate the *Home & Healthy for Good* (HHG) program. Funding for HHG was increased to $1.2 million in FY08. On July 1, 2009, HHG and other homeless programs funded by the state were moved to the Department of Housing and Community Development (DHCD) under line item 7004-0104. In FY13 and FY 14, the funding for HHG was increased, resulting in the current funding level of $1.8 million. The state allocation for HHG is flexible so that the funding can go to supportive services, housing or both.
Quick facts about HHG tenants:

- **813 people** have been housed through HHG since the program began in 2006.
- **27 percent** of HHG tenants were street dwellers before entering the program, meaning they were living primarily outside.
- **65 percent** of HHG tenants come from shelters.

HHG tenants reported using emergency shelter more than **70,000 times** in the **6 months** before they entered permanent housing.

Average length of homelessness prior to entering HHG is **5 years**.

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**Home & Healthy for Good: Population Served**

*Home & Healthy for Good* serves chronically homeless adults. A chronically homeless person is defined by the federal government as “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years.” This population constitutes about 10 percent of the homeless population yet consumes more than half of homeless resources. This subset of people suffers from complex medical, mental and addiction disabilities that are virtually impossible to manage in the unstable setting of homelessness. Housing provides individuals with stability, which allows them to address the complex issues and disabilities that affect them.

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**Home & Healthy for Good: Implementation**

In FY15, MHSA entered into a contract with DHCD to continue to administer the HHG program across the state. Seventeen homeless service providers now participate in the program as agencies subcontracted by MHSA.

The resources allocated through HHG allow the following organizations to provide housing and supportive services:

- Action Inc. (Gloucester)
- AIDS Action Committee/Youth on Fire (Cambridge)*
- Boston Health Care for the Homeless Program (Boston)
- Boston Public Health Commission (Boston)
- DIAL/SELF Youth & Community Services (Greenfield)*
- Father Bill’s & MainSpring (Quincy, Brockton, Plymouth)
- Friends of the Homeless and Mental Health Association
- Heading Home (Cambridge)
- HomeStart (Boston)
- Housing Assistance Corporation/Duffy Health Center (Cape Cod)
- Justice Resource Institute (Boston)*
- Mental Health Association (Springfield)
- Metropolitan Boston Housing Partnership (Boston)
- Pine Street Inn (Boston)
- Somerville Homeless Coalition (Somerville)
- South Middlesex Opportunity Council/Community Healthlink (Framingham/Worcester)
- Veterans Inc. (Worcester)

*Provider for LGBTQ Pilot Program (page 6)
DATA COLLECTION

As a condition of HHG’s state funding, MHSA creates and files this report on the effectiveness of the HHG program, specifically in terms of cost-effectiveness and quality of life outcomes. HHG tenants are asked to consider participating in this research study when they first enter housing; refusal to participate in the research study component of HHG does not affect an individual’s access to housing or supportive services. In order to conduct this research ethically, informed consent is obtained from those individuals who agree to participate and participants are asked to sign MassHealth’s Permission to Share Information form so that Medicaid claims data may be analyzed in order to make cost savings estimates.

All data in this report is the product of MHSA’s research unless cited otherwise.

To measure the effectiveness of HHG, community support workers conduct interviews with tenants upon entry into housing and at approximately one-month intervals thereafter. The interviews are then submitted to MHSA and entered into a database. Since the fall of 2006, HHG community support workers and program managers have submitted more than 12,500 interviews to MHSA to create the current data set, which is used as the basis for this report.

Follow-up Interviews

During each monthly interview, community support workers ask about the tenant’s current source(s) of income; the tenant’s health insurance coverage; whether or not the tenant has received medical care of any kind in the time since the previous interview; whether or not the tenant has spent any time in an emergency room, hospital, detox facility, emergency shelter or prison since the previous interview (and if so, how much time); the tenant’s substance abuse status; the tenant’s level of satisfaction with general quality of life, health and type of housing (responses to these questions are ranked on a scale from “very dissatisfied” to “very satisfied”); and how the tenant’s life has improved since entering housing (answers range from “no improvement” to “much improvement”). Tenants have the option of refusing to answer any interview questions that they would prefer not to answer. As interviews are completed, case and program managers submit them to MHSA, at which point MHSA staff enter the data directly into an electronic database. This database is then used to create an estimated cost-benefit analysis, comparing pre- and post-housing emergency service usage, as well as to identify changes in life satisfaction and overall health.

External Data Analysis

MassHealth (Medicaid) analysts reviewed billing claims data in March 2009 for 96 HHG participants who had Medicaid eligibility in both the year before and the year after moving into housing. MassHealth provided MHSA with actual Medicaid costs for these participants, which serve as the basis for cost savings estimates. Even though this Medicaid claims data is based on a portion of the entire HHG cohort, it is used in place of previously collected self-reported data because it is the most accurate assessment of costs. Total Medicaid costs reported in this document include any medical service that was paid for by MassHealth, including inpatient and outpatient medical care, transportation to medical visits, ambulance rides, pharmacy needs and dental care.
Most HHG participants are white, non-Hispanic, aged 31-50, and come from the state’s emergency shelter system. **By definition, all chronically homeless individuals have some sort of disabling condition**, which may include mental health, substance abuse and physical health issues; nearly half of all HHG participants suffer from more than one disability.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Female</th>
<th>Male</th>
<th>Transgender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22%</td>
<td>78%</td>
<td>&lt;1%</td>
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**The majority of HHG tenants are between 31 and 61 years old; this is to be expected given the high proportion of middle-aged people in the nationwide homeless population.**

<table>
<thead>
<tr>
<th>Age</th>
<th>31-50</th>
<th>51-61</th>
<th>18-30</th>
<th>62+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>52%</td>
<td>33%</td>
<td>9%</td>
<td>6%</td>
</tr>
</tbody>
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While women make up a much smaller percentage than men of the total number of HHG tenants, they also make up a smaller proportion of the overall homeless population.
Hispanic origin is counted as an ethnicity rather than as a race in accordance with the U.S. Census Bureau’s definitions of race and ethnicity. Middle-aged white males are the most common demographic category among chronically homeless individuals. Minority groups are over-represented in Massachusetts’ homeless population compared to the general statewide population.

Subpopulation Highlights

**Young Adults**
In FY14, MHSA launched a pilot program specifically targeting homeless young adults between the ages of 18 and 24 who identify as LGBTQ. This pilot provides up to 32 units of housing in the Boston, Cambridge, and Greenfield areas.

**Veterans**
*Home & Healthy for Good* has provided housing to 159 veterans since it began, which represents 20 percent of the total number of people served by HHG. As Massachusetts moves toward implementation of its new plan for ending veteran homelessness, various service planning and grantmaking bodies have identified HHG as a model for housing homeless veterans.
The vast majority of HHG clients — and homeless individuals in general — are enrolled in MassHealth, Massachusetts’ Medicaid program. Most HHG clients remain on MassHealth for the duration of their participation in the program.

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Disability Status
By definition, all chronically homeless individuals have at least one disabling condition.
- 50 percent of HHG tenants have a medical disability
- 69 percent have a mental health disability
- 23 percent have a self-reported substance abuse disorder
- 48 percent of tenants are dual-diagnosed, meaning they deal with multiple disabilities

Health Insurance Status Upon Entering HHG

More participants responded that they had zero income at entry than any other income category. Once housed, case managers work with tenants to access all potential income streams, which include a range of cash benefits, food stamps, and employment opportunities.
HHG is an outcome-based model, and the program’s success is measured in a variety of ways. MHSA evaluates HHG by examining tenants’ self-reported quality of life, destination status and public service usage, as well as through cost savings analysis.

**Quality of Life and Tenant Satisfaction Outcomes**

Prior to entering HHG, most tenants indicated that they were “not satisfied” with their quality of life, health and housing; after being placed in housing, average opinion shifted to “satisfied” in all three categories mentioned.

As of December 2014, 98 percent of all responses indicated an improvement in tenants’ quality of life, with 55 percent of tenants indicating “much improvement” in their lives since entering housing and 43 percent indicating that their lives were “somewhat improved” as a result of entering HHG.

MHSA’s quality of life data is based on more than 12,500 follow-up interview responses that have been collected since HHG began.

Total number of people housed through HHG: 813

98% of all responses indicated an improvement in tenants’ quality of life

Over 12,500 follow-up interview responses have been collected since HHG began in 2006
Home & Healthy for Good has produced significant positive outcomes for participants, both during and after their enrollment in the program. Since HHG’s foundation in 2006, 813 chronically homeless adults have been placed into permanent housing with supportive services, which have been provided by 17 service agencies across the Commonwealth. Of those placed, 27 percent resided on the streets or in places not meant for human habitation and 66 percent resided in emergency shelters prior to obtaining housing. Fifty-eight percent of the 813 participants were placed into project-based, single room occupancy units while the remaining 42 percent obtained scattered-site, one-bedroom or studio apartments.

Of the 813 people who have enrolled in HHG over the past eight years, 252 individuals currently remain in the program while another 353 individuals have either moved into other living situations or died while in housing, as shown in the graph above. As demonstrated above, 68 percent of the total HHG population is either housed through HHG or resides in another type of permanent housing (31 percent of the total HHG population is still enrolled in the program and 37 percent of the total population served has exited to another form of permanent housing). An additional 6 percent of the population transitioned from HHG to long-term treatment care and 7 percent of all tenants housed over the eight-year period died while in housing, many from chronic health conditions. Remarkably, only 36 individuals — 4 percent of HHG participants — are known to have recidivated to homelessness after obtaining permanent housing. As the chart above shows, 10 percent of clients exited to an “unknown” destination, meaning that the agencies providing supportive services and housing for those individuals were unable to confirm the exiting participant’s destination.
As shown above, HHG participants’ self-reported emergency service usage decreases dramatically in the first 12 months of housing.

This decline in public service usage among previously high utilizers is indicative of the important physical and mental health stabilization process that occurs within the first several months that individuals are in housing. Once in housing, individuals are safer than they were on the streets or in shelter, experiencing fewer accidents and injuries that require immediate attention. With access to supportive services through HHG, formerly homeless individuals no longer need to rely on public emergency services as their primary sources of care. Instead, tenants are able to utilize mainstream systems of preventative and primary health care, better coordinate with mental health providers and maintain consistent permanent tenancy rather than using more costly public systems, such as emergency shelters and detox facilities.

The significance of this decrease in public service usage is twofold: it indicates an improvement in tenants’ health and quality of life as a result of housing, and it also shows that HHG results in major cost savings, allowing money that would be spent on expensive emergency care to be allocated in other ways (for housing, more comprehensive year-round care, etc.). This data shows that housing is a cost-effective, yet humane, solution to homelessness — one that brings stability to individuals’ lives, regardless of their health histories or personal challenges.
MHSA’s cost savings estimates indicate that HHG saves the Commonwealth **an annual $9,339 per housed tenant.**

The chart above depicts the estimated total costs of the measured services — Medicaid, shelter and incarceration — per person for the year prior to entering HHG, as well as the estimated costs of these services in the year after entering housing. The annual cost of operating HHG, including housing and in-home services, is shown in light blue.
SUMMARY

Through Home & Healthy for Good, MHSA continues to demonstrate that providing housing and supportive 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. Results show a trend toward tremendous savings in health care costs, especially hospitalizations, when chronically homeless individuals are placed into housing with services. Improvements in quality of life and overall health outcomes indicate that Housing First is 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 policymakers. 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 allocated. The results of Home & Healthy for Good will continue to play a critical role in influencing policy as the state moves toward permanent solutions to end homelessness.

“Housing gives you a lot more hope, a lot more ambition to move forward with your life.”
- HHG tenant

“Going to school is easier because you have a place where you can come home and study.”
- HHG tenant

“No one wants to be in the shelter ... shelter should be like a triage.”
- HHG tenant

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

Quick facts

813 people housed through HHG since it began

$9,339 annual savings per tenant for the Commonwealth

98% reported increase in quality of life

159 veterans housed through HHG since its inception

To learn more about MHSA, visit www.mhsa.net.
REFERENCES


