Home & Healthy for Good
A Statewide Housing First Program

Progress Report
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Prepared by

Massachusetts Housing and Shelter Alliance
PO Box 120070
Boston, MA 02112
phone: 617.367.6447 • fax: 617.367.5709 • email: info@mhsa.net
www.mhsa.net

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 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.[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
- 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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[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

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[5] 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.[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]

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[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. Tolomicsenko 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. Kasprow 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. Kasprow 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.[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 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.

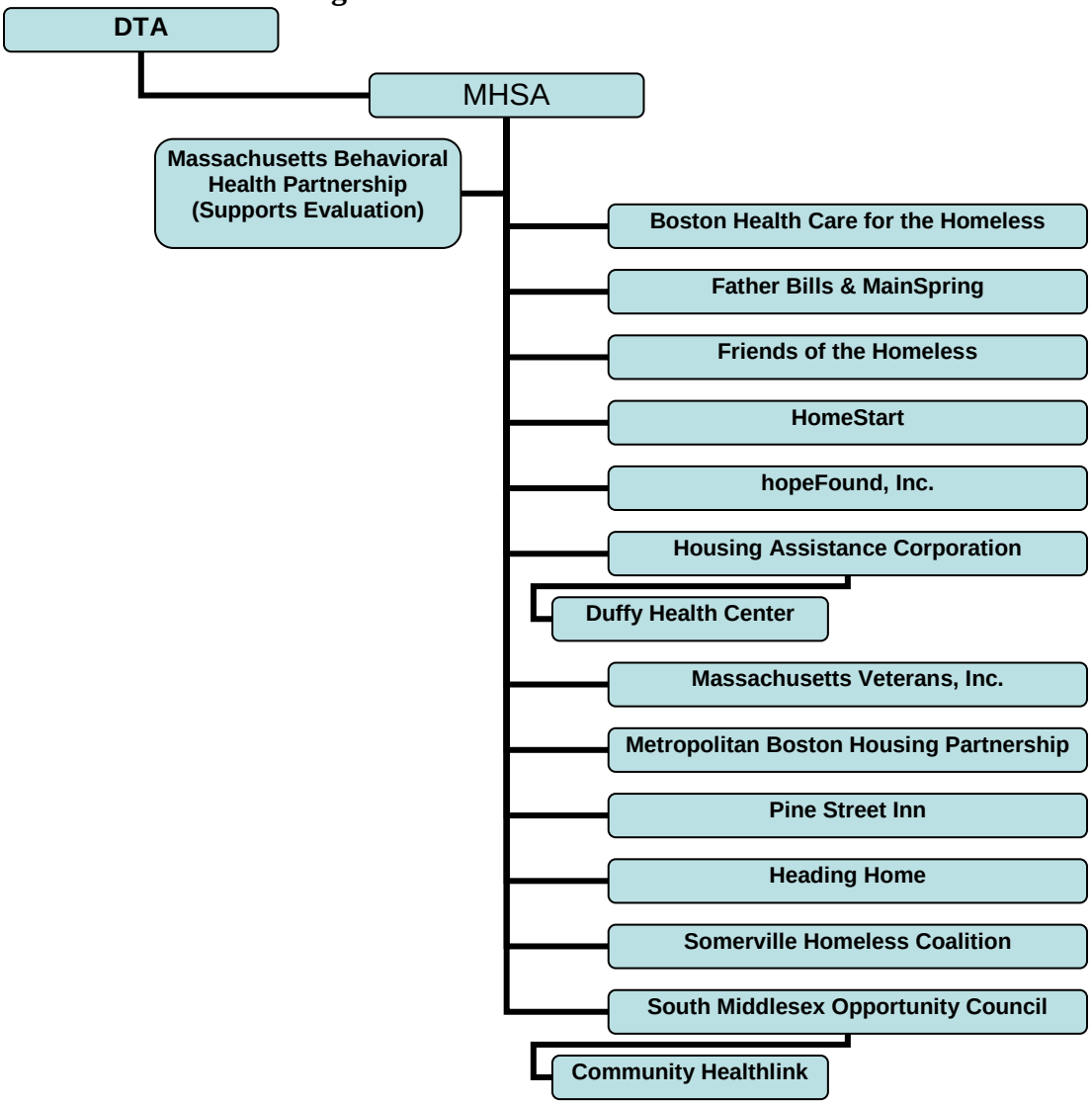
Furthermore, the Legislature requested that an evaluation of this pilot program be performed, with a focus on the cost per participant and projected cost-savings in state-funded programs. This report describes the implementation of *Home & Healthy for Good* and updated findings from the evaluation of the program as of March 2009.

[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.

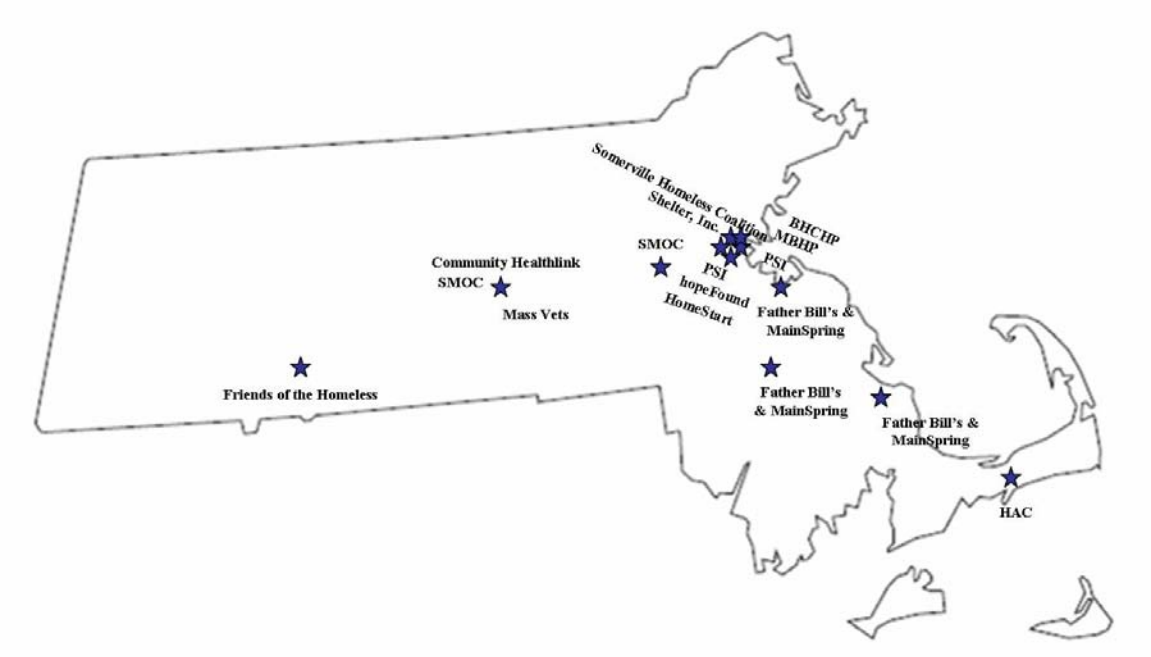
Implementation

MHSA and DTA generated a contract that outlined the technical aspects of *Home & Healthy for Good* for this fiscal year. Twelve homeless service providers across the state continue 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



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. Participants are also asked to sign MassHealth's Permission to Share Information form so that Medicaid claims data can figure into the analysis. 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. MassHealth analysts review billing claims data for those participants who have Medicaid eligibility in the year before and the year after moving into housing. 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* has been 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.

Outcomes

Total Participants
As of February 23, 2009, **357** formerly chronically homeless people have been housed in the *Home & Healthy for Good* (HHG) program.

Residential Stability
Out of a total of 357 participants, **217** people have remained housed in the *Home & Healthy for Good* program, **8** people have died while participating in the program, and **74** people have moved on to other permanent housing, resulting in a residential stability rate of **84%.** The following list categorizes participants who moved out of HHG housing:

Returned to homelessness	30 people
Lost to follow up	16 people
Incarcerated	9 people
Moved on to other permanent housing (remaining housed)	74 people

Tenants who remain housed have been in the program for an average of **1.8 years** as of March 2009. Tenants who exited the program left after an average of 7.8 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 **58%** of the housing in this program. The remaining **42%** of homes are scattered-site housing (individual apartments scattered throughout neighborhoods).

Former Street Dwellers
Street dwellers, defined as people who were staying predominantly outside prior to moving into housing (as opposed to staying in shelters), account for **30%** of participants in this program.

Demographics

Participant Characteristics	No.	(%)
Total	357	(100)
Gender		
Male	268	(75)
Female	87	(24)
Transgender	2	(1)
Age		
18-30	26	(7)
31-50	189	(53)
51-61	113	(32)
62+	22	(6)
Unknown	7	(2)
Average	—	
Ethnicity		
Hispanic	39	(11)
Non-Hispanic	318	(89)
Race		
American Indian	9	(3)
Asian	5	(1)
African American	57	(16)
White	269	(75)
Unknown	17	(5)
Income Sources reported		
Supplem. Security	54	(15)
SSDI	59	(17)
Social Security	29	(8)
General Assistance	67	(19)
Veterans Benefits	7	(2)
Employment	38	(11)
Medicaid	2	(1)
Food Stamps	5	(1)
Other	11	(3)
None	92	(26)
Health Insurance		
Private Insurance	6	(2)
Medicare	37	(10)
MassHealth	295	(83)
Veterans	17	(5)
Commonwlth Care	6	(2)
Free Care	9	(3)
No Insurance	13	(4)
Disability		
Medical	202	(57)
Mental	224	(63)
Active Substance Abuse	77	(22)
Multiple Disabilities	167	(47)
Served in Military	72	(20)
Average Length of Homelessness	5.5 years	

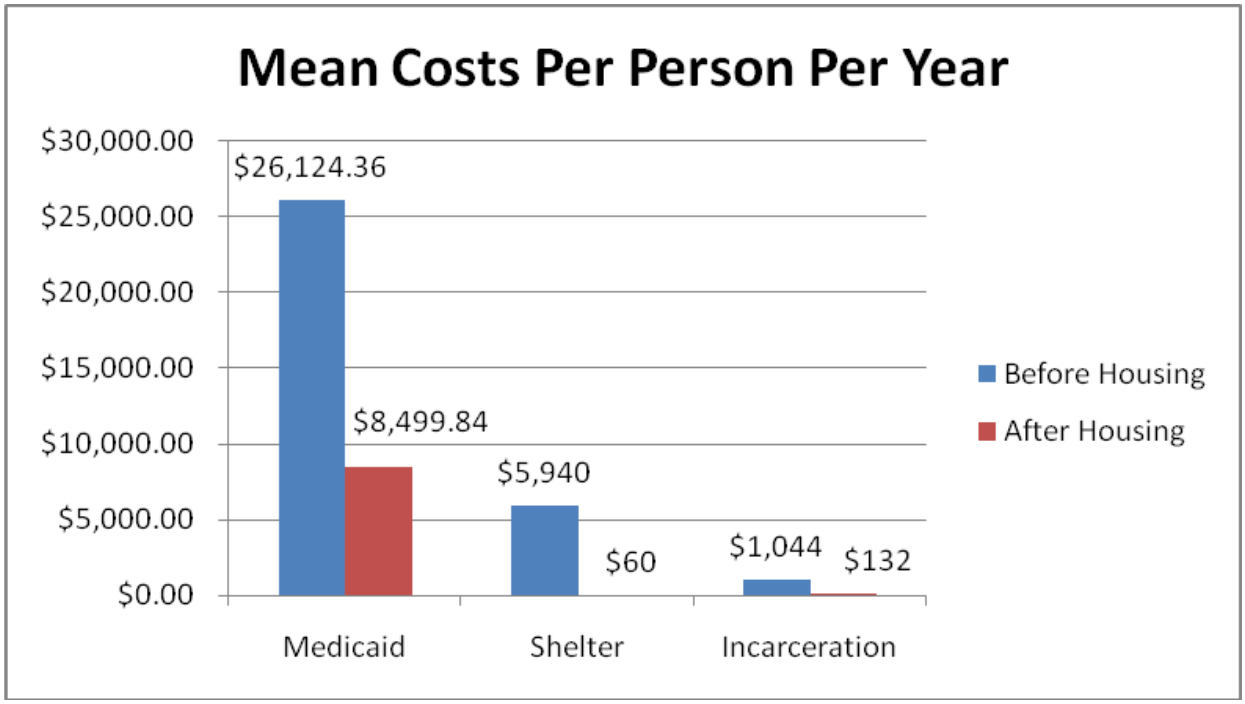
Research Sample
Of 357 participants in HHG, **87%** (312 people) have given written, informed consent to participate in the research project. With the exception of the Medicaid costs (see below), the data reported below was obtained through monthly interviews of this group of 312 research subjects. As of March 2009, each tenant has been interviewed an average of 9.7 times to inform this report.

Medicaid Costs
Actual Medicaid costs pre-housing and post-housing were obtained from MassHealth for the first **96** HHG participants. The Medicaid analysis is limited to these 96 participants because these are the participants who have been in housing long enough so that medical claims data are complete for an entire year after moving into housing. Total Medicaid costs reported below include any medical service that was paid for by MassHealth, including inpatient and outpatient medical care, transportation to medical visits, ambulance rides, pharmacy, dental care, etc.

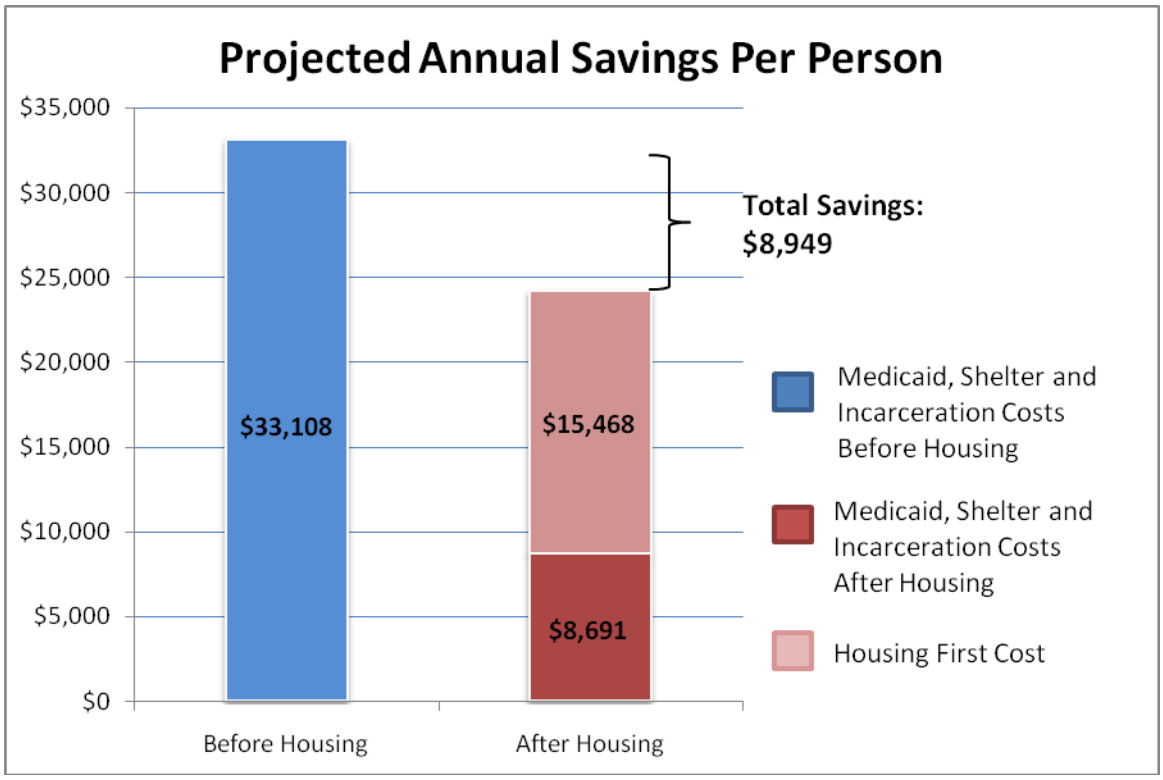
Shelter and Incarceration Costs
MHSA has made conservative estimates of the costs of shelter and incarceration in the year prior to housing compared to the year after housing for HHG participants. These estimates are based on the following:

- **Shelter**: According to the Department of Transitional Assistance, the average cost to the state of a night in a Massachusetts homeless shelter for one individual is $32
- **Incarceration**: Former Lt. Governor Healey estimates the costs associated with prison or jail time to be $118 per day

Projected Annual Costs Per Person



Projected Annual Savings



This chart depicts the estimated total costs of all the above measured services (Medicaid, shelter, incarceration) per person per year in the year prior to and the year after housing (in), along with the costs of operating this program, including housing and in-home services (in pink).

Therefore, our projected annual cost-savings to the Commonwealth per housed tenant is $8,948.52.