



*Permanent Supportive Housing:
A Solution that Works*

Progress Report
March 2012

Background

Introduction

Massachusetts has reacted to 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 the problem at hand. Given the constant need for homeless services, the Commonwealth has constructed a massive infrastructure for temporarily combating the symptoms of homelessness. The emergency shelter system has proven to be inadequate in addressing homelessness, both in the client outcomes it produces and the cost effectiveness of those outcomes. Quite simply, the emergency shelter system was built to manage, rather than end, the homeless epidemic that developed throughout the 1980s.

Population Served by *Home & Healthy for Good*

The *Home & Healthy for Good* program serves individual 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 population¹ and 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 is the stabilizing factor that can allow individuals to address the more complex issues that have inhibited their stability and independence.

Housing First: A Low-Threshold Model for Success

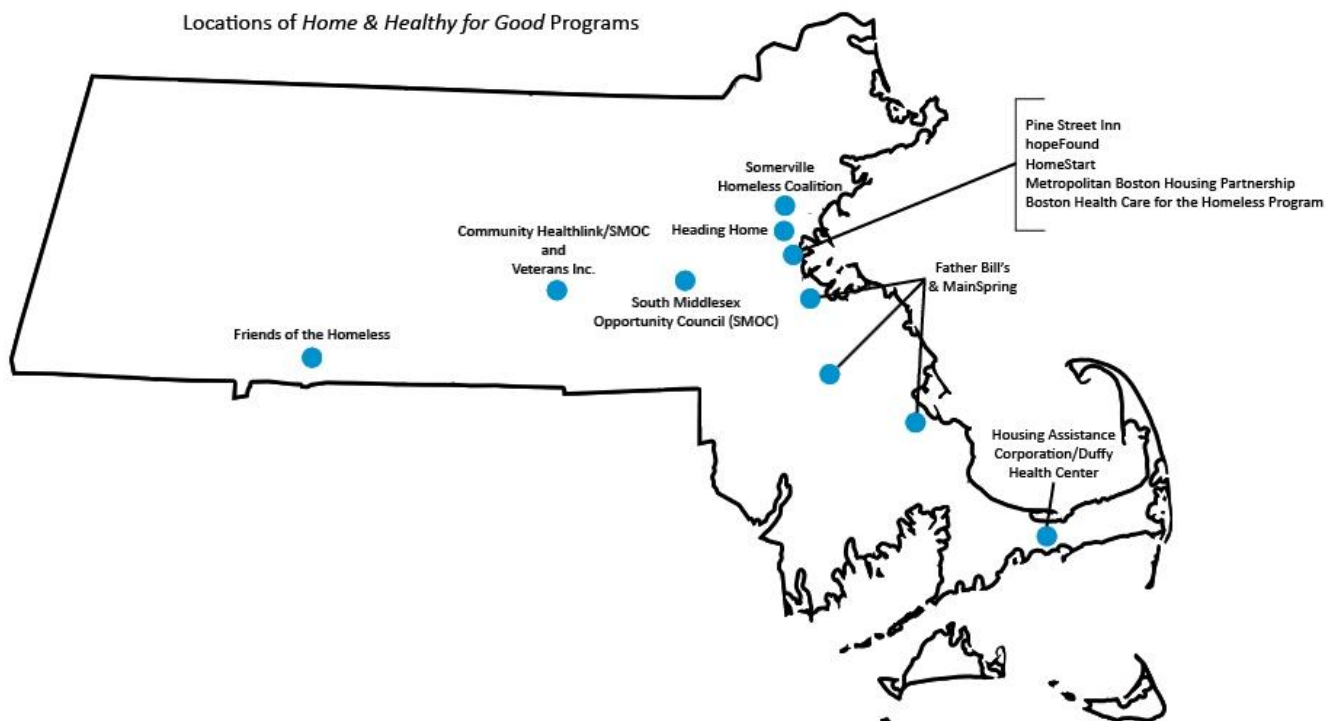
Housing First represents a paradigm shift in addressing the costly social problem of homelessness. Tenants live in leased, independent apartments or congregate-based homes that are integrated into the community. Tenants have access to a broad range of comprehensive community-based services, including medical and mental health care, substance abuse treatment, case management, vocational training, and life skills. 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.” Unlike the traditional, linear service delivery system, low-threshold housing is a model that recognizes that a person’s disabilities may limit them from entering housing contingent upon complex clinical-based service plans, compliance-based housing or the acknowledgment of certain labels or diagnoses. By removing the barriers to housing, individuals are given an opportunity to deal with the more complex issues they face as tenants, rather than clients of a prescribed system of care.

¹ 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.

Home & Healthy for Good History and Implementation

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 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, *Home & Healthy for Good* and other homeless programs funded by the state were moved to the Department of Housing and Community Development (DHCD) under line item 7004-0104. The state allocation for *Home & Healthy for Good* is flexible so that the funding can go to services or housing, or both, to best utilize leveraged funding to serve the population.

In FY12, MHSA entered into a contract with DHCD to continue to administer the HHG program across the Commonwealth. Twelve homeless service providers across the state continue to participate in the program as agencies subcontracted by MHSA. These organizations provide either housing or supportive services, or both. Housing may be scattered-site apartments or congregate living situations and is combined with intensive in-home services by case managers or clinicians in the following geographic locations:



Data Collection

In order to ethically conduct research and measure cost and quality of life outcomes in a vulnerable population, HHG participants are asked to consider enrollment in the research study and informed consent is obtained from those who agree. Participants sign MassHealth's Permission to Share Information form so that Medicaid claims data may be analyzed. Refusal to participate in the research study does not preclude participation in HHG.

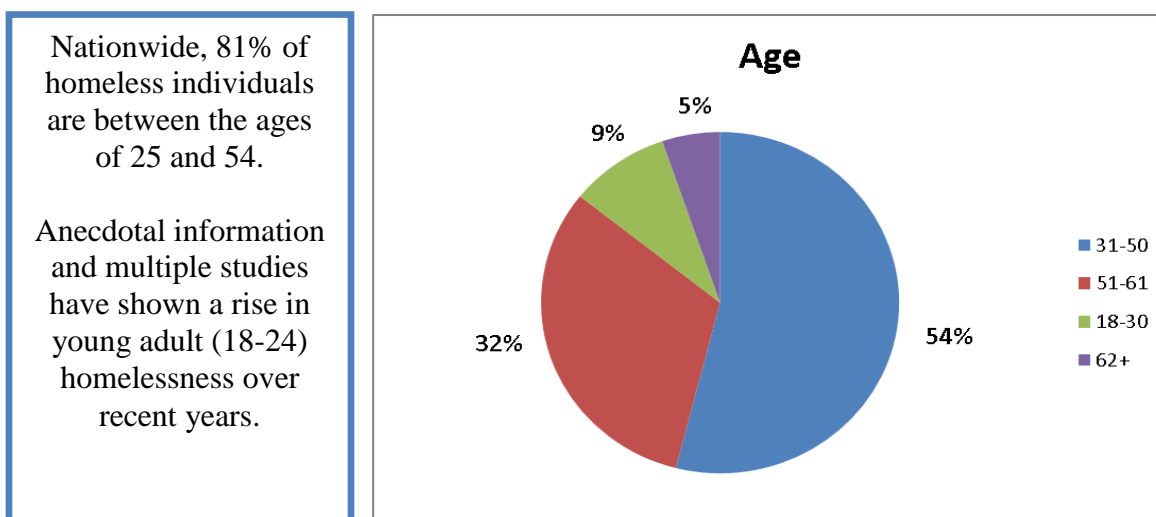
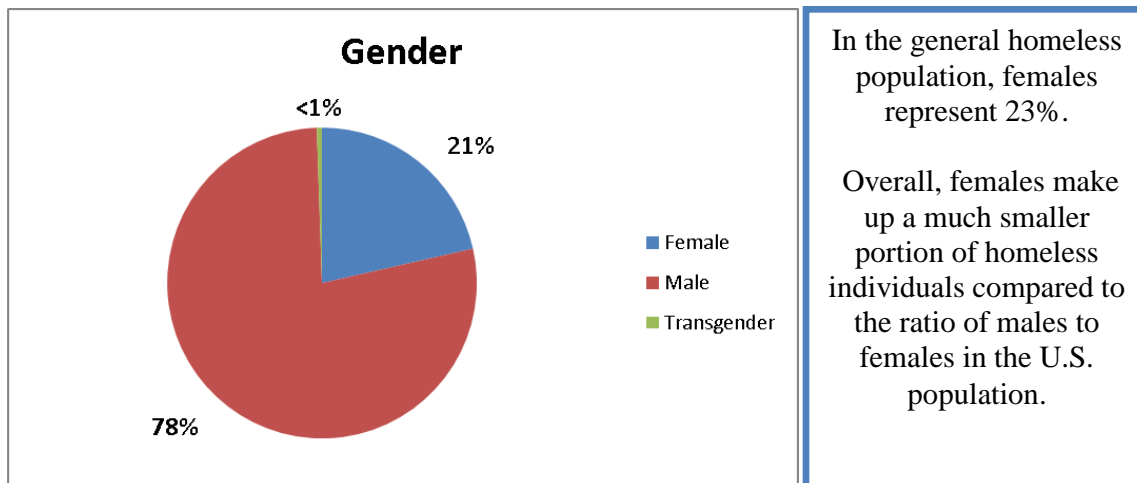
Case managers interview tenants who agree to participate in the research study upon entry into housing and at one-month intervals thereafter. The interviews are submitted to MHSa and entered into a database. Since the fall of 2006, **HHG case and program managers have submitted, and MHSa has entered, 8,378** interviews to create the current data set. Interview questions cover the following:

- Demographic information
 - Age
 - Gender
 - Race
 - Ethnicity
 - Veteran Status
- Length homelessness prior to housing
- Typical sleeping arrangements prior to housing
- Quality of life
 - Satisfaction with life in general
 - Satisfaction with health
 - Satisfaction with housing
- Nature of substance use
- Nature of disabling conditions
- Health insurance status
- Sources of income
- Self-reported medical service usage
- Self-reported public service usage (detox, jails, shelters, etc.)

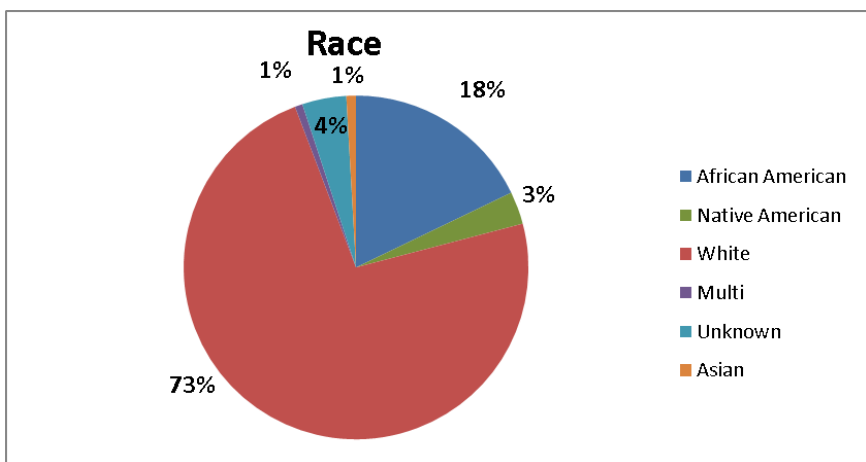
MassHealth (Medicaid) analysts reviewed billing claims data in March 2009 for those 96 participants who had Medicaid eligibility in the year before and the year after moving into housing.

Demographics and Population Served

Home & Healthy for Good participants represent a broad spectrum of demographics. As you can see, the majority of HHG participants are white, non-Hispanic, aged 31-50, and come from the state's emergency shelter system. It is worth noting that nearly half of all entrants suffer from more than one disability, including mental health, substance abuse and physical health issues.

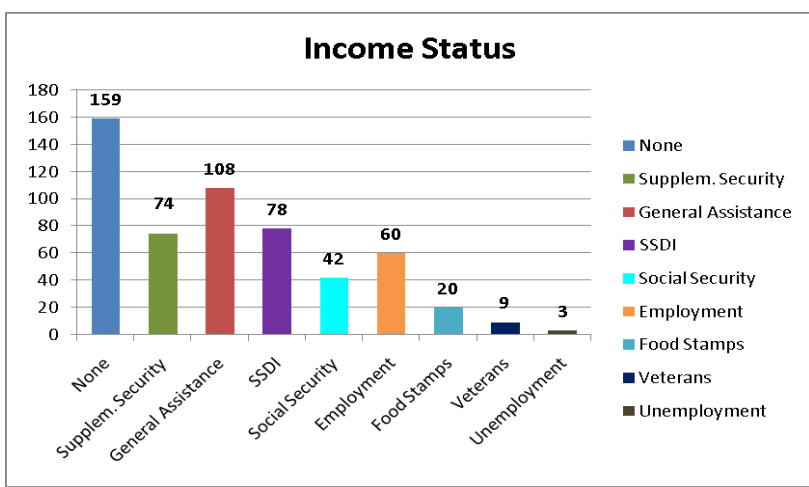
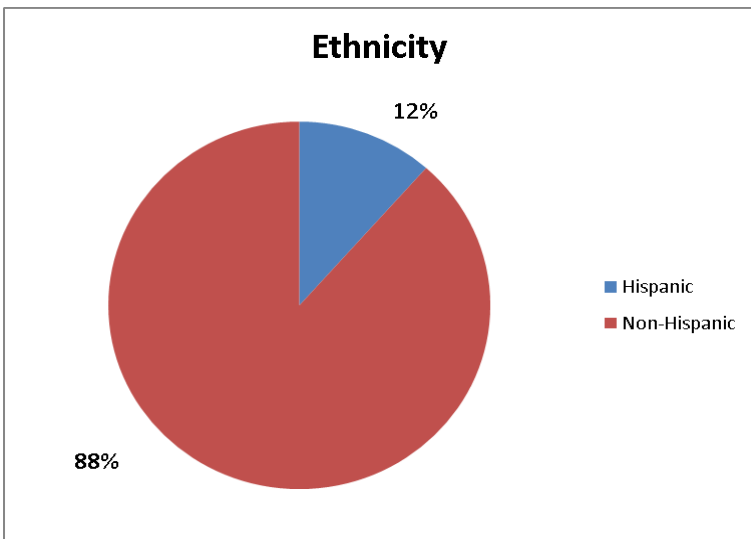


Demographics and Population Served



While the African American community is over-represented in the homeless population, numerous studies have shown that middle-aged white males are the most common demographic among chronically homeless individuals.

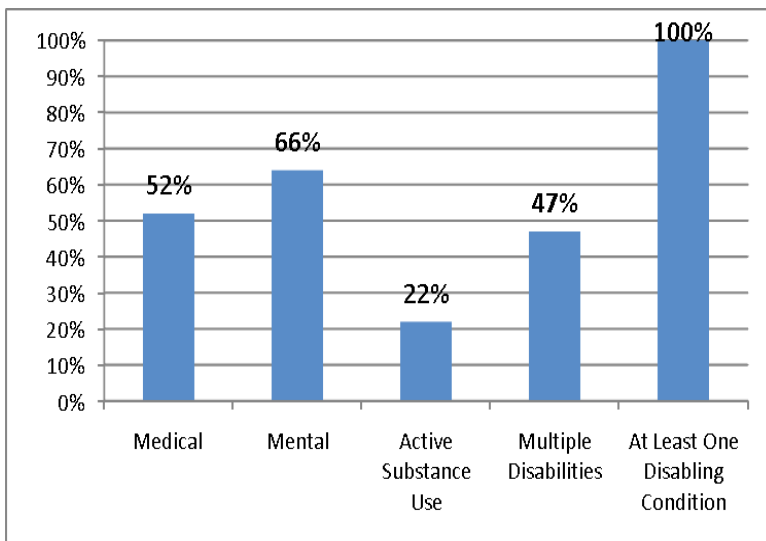
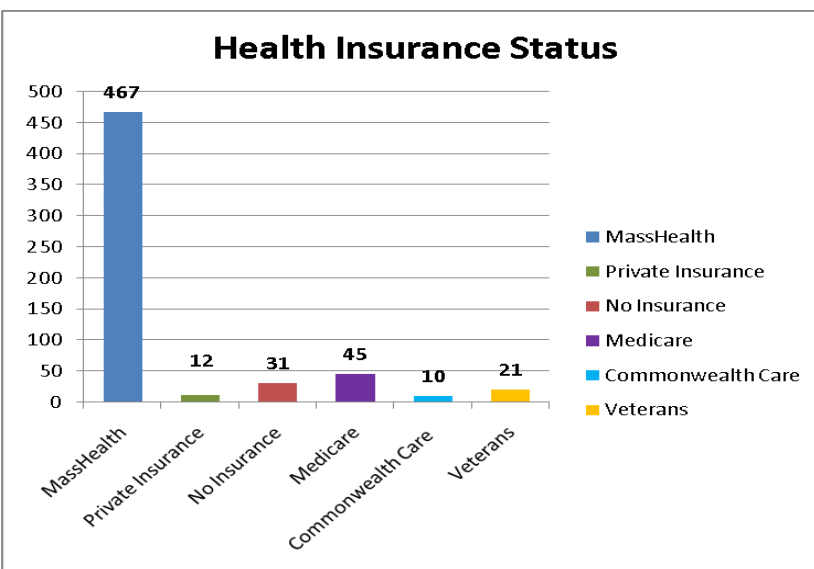
Defining ethnicity is an ongoing issue while collecting demographic data on HHG tenants. MHSA has seen several interviews where either the ethnicity or the racial identity was noted instead of both, assuming that the two are mutually exclusive.



More participants responded that they had zero income at entry than any other income category. An analysis of those who exited the program showed that 47% of those participants who left HHG did so with increased income from when they entered.

Demographics and Population Served

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.



By definition, all chronically homeless individuals have a disabling condition. Those with more than one diagnosis are considered dual-diagnosed and can present some of the biggest challenges when it comes to service delivery models.

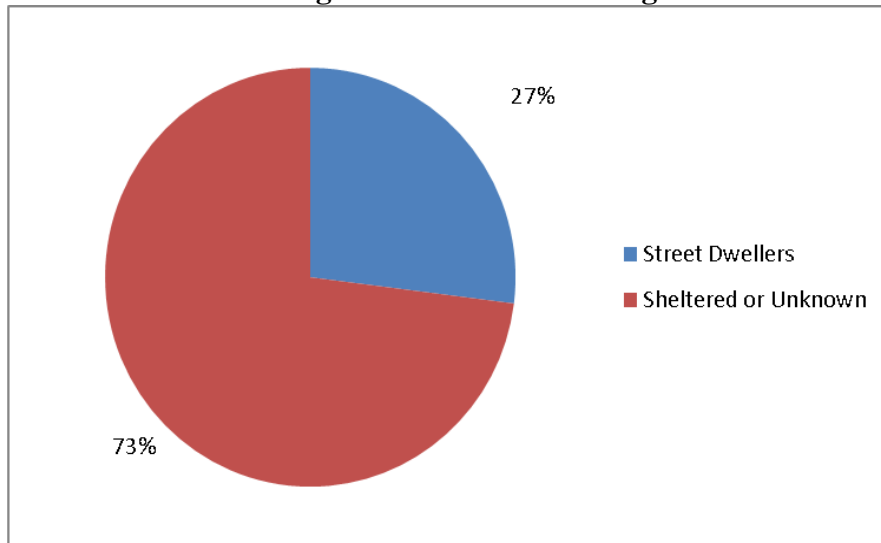
Whether living on the streets or in the shelter system, Chronically Homeless Individuals have few opportunities to tackle some of the most significant and challenging barriers they face.

Housing Placement and Retention

As of February 15, 2012, 555 formerly chronically homeless people have been housed in the *Home & Healthy for Good* program.

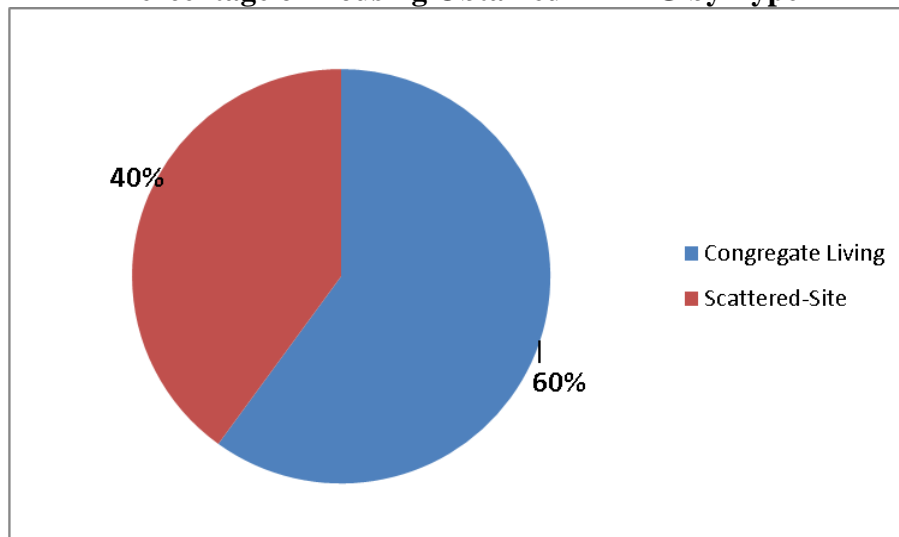
Street dwellers, people who were living predominantly outside prior to moving into housing account for 27% of participants in this program.

Living Situations Pre-Housing



Congregate housing, where each tenant has a private bedroom and shared bathroom, kitchen and laundry space with housemates, accounts for 60% of the housing into which tenants are placed. The remaining 40% of homes are scattered-site housing.

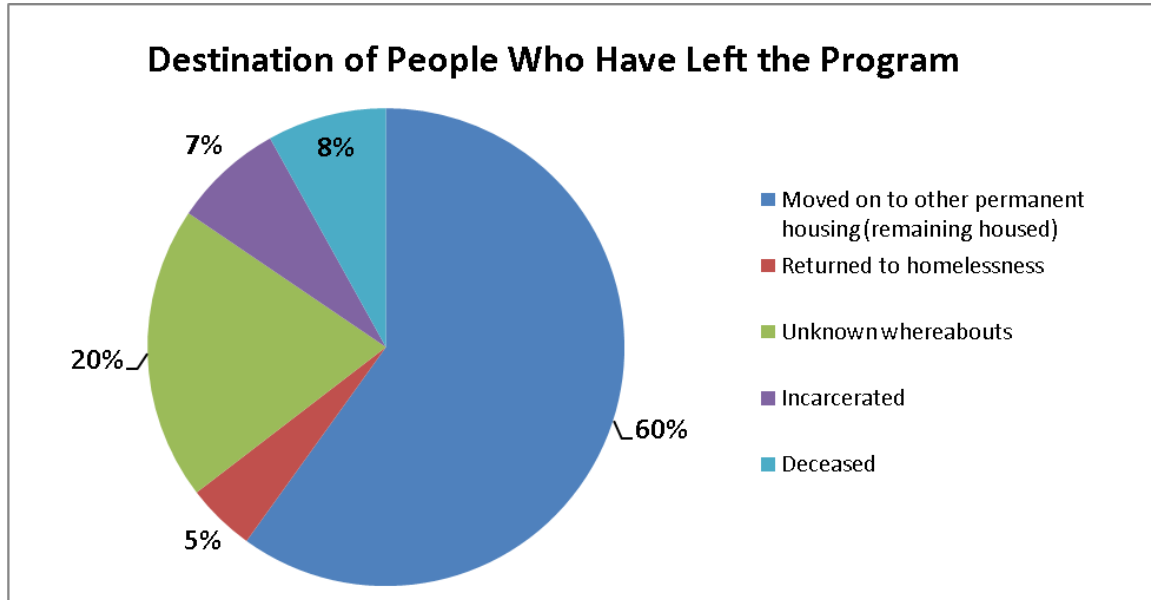
Percentage of Housing Obtained in HHG by Type



Outcome Data

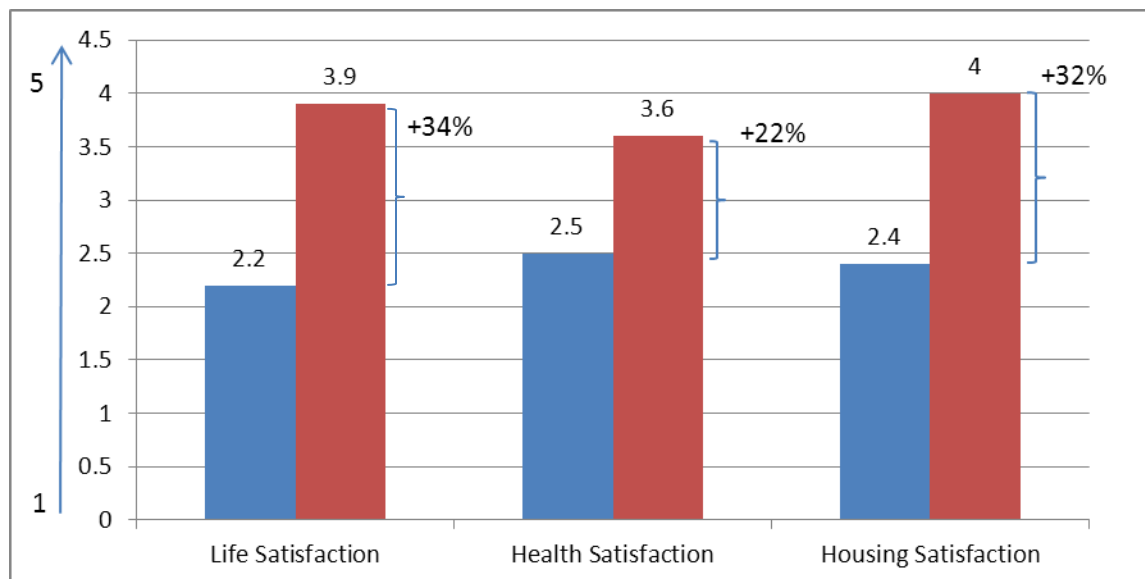
Residential Stability

Of the 555 participants enrolled as of February 2012, the following figures represent where those clients currently reside, demonstrating a housing retention rate of 82%:



Quality of Life Improvements

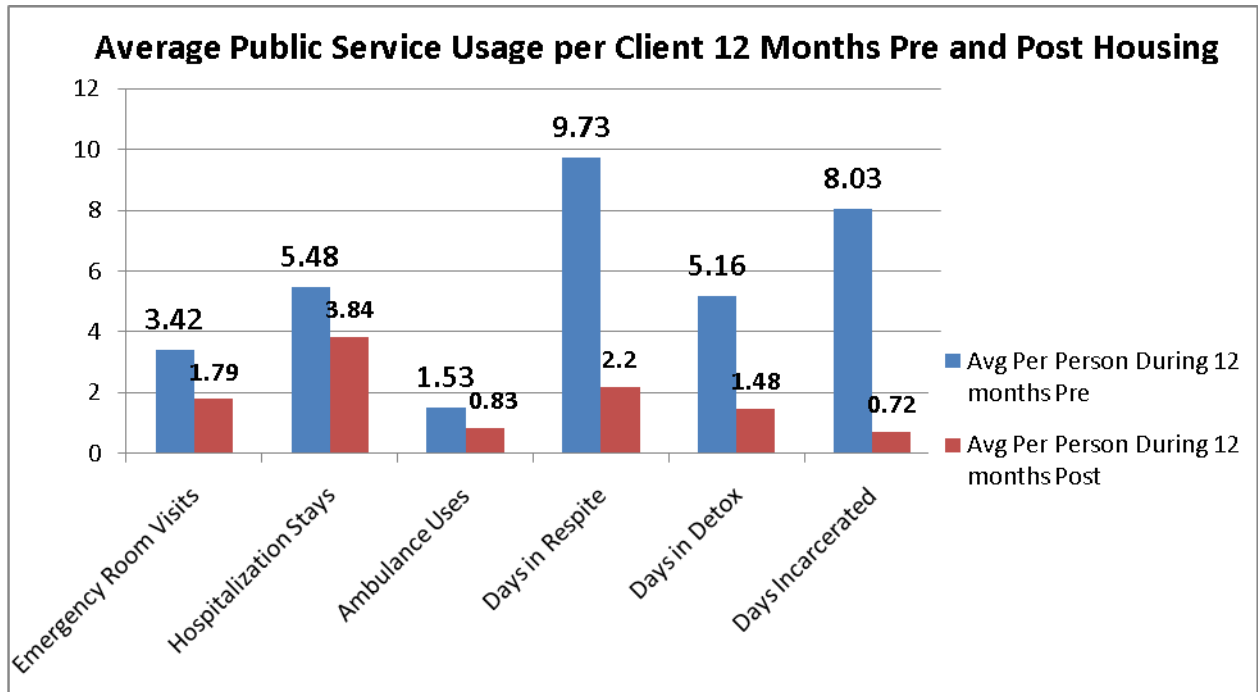
We have also witnessed a significant positive link between permanent housing and a client's housing, health and overall life satisfaction. Between the time immediately prior to entering housing and follow-up interviews conducted six months after entering the program, participants self-reported demonstrable increases in their satisfaction across all three metrics. The chart below demonstrates this link.



Outcome Data

Reductions in Public Emergency System Usage

As demonstrated in the charts below, client self-reported emergency usage decreases dramatically in just the first 6 months of housing.

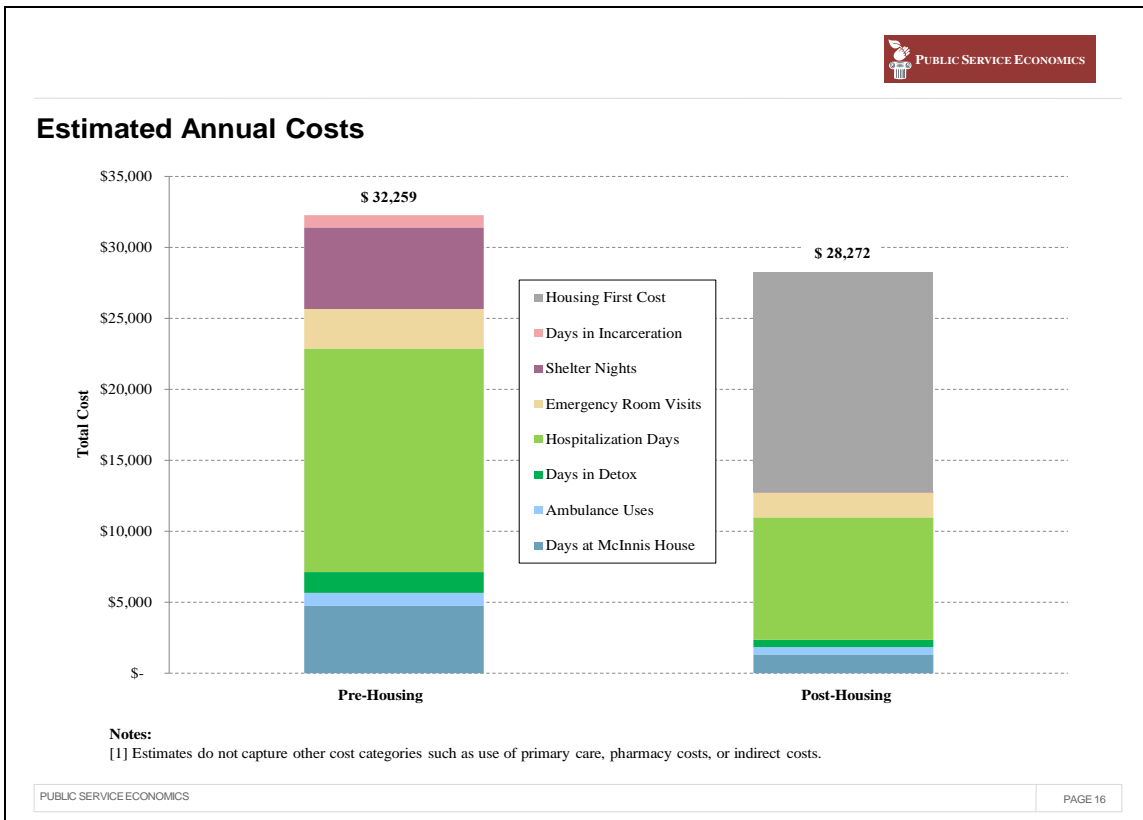


The 555 people housed in *Home & Healthy for Good* reported using emergency shelters **50,367 times in the six month period before entering housing.**

Outside Analysis of Self-Reported Data: *Public Service Economics*

MHSA recently received a grant from the Corporation for Supportive Housing to perform an in-depth study of the differences in effectiveness of various service delivery models on client outcomes and tenancy success in the *Home & Healthy for Good* program. Through this grant, MHSA teamed up with Root Cause and Public Service Economics who used self-reported client data and publicly available cost averages to further analyze the pre- and post-housing per client costs of HHG. Public Service Economics' cost analysis supports MHSA's ongoing conclusions, showing a post-housing savings of roughly \$4,000. Data in the chart below is derived from client-reported public resource usage. The service usage costs demonstrated here are considered to be a conservative estimate given that the data used to determine the savings for each cost type does not represent the true nature of serving chronically homeless individuals with public resources.

Cost Category	2010 Cost Estimate
Ambulance transportation (per trip)	\$544.76
Stay at emergency shelter (per day)	\$32.00
Stay in prison (per day)	\$71.64
Stay at hospital (per day)	\$2,327.33
Stay at McInnis House (per day)	\$400.00
Stay at detoxification center (per day)	\$198.00
Emergency Room visit (per visit)	\$769.45



Cost Savings

Research Sample

Due to the expiration of the original consent form, a new form was created and signed by 276 participants. With the exception of the Medicaid costs (see below), the data reported below was obtained through monthly interviews of this group of 276 research subjects. As of February 2012, each tenant was interviewed an average of over 13 times.

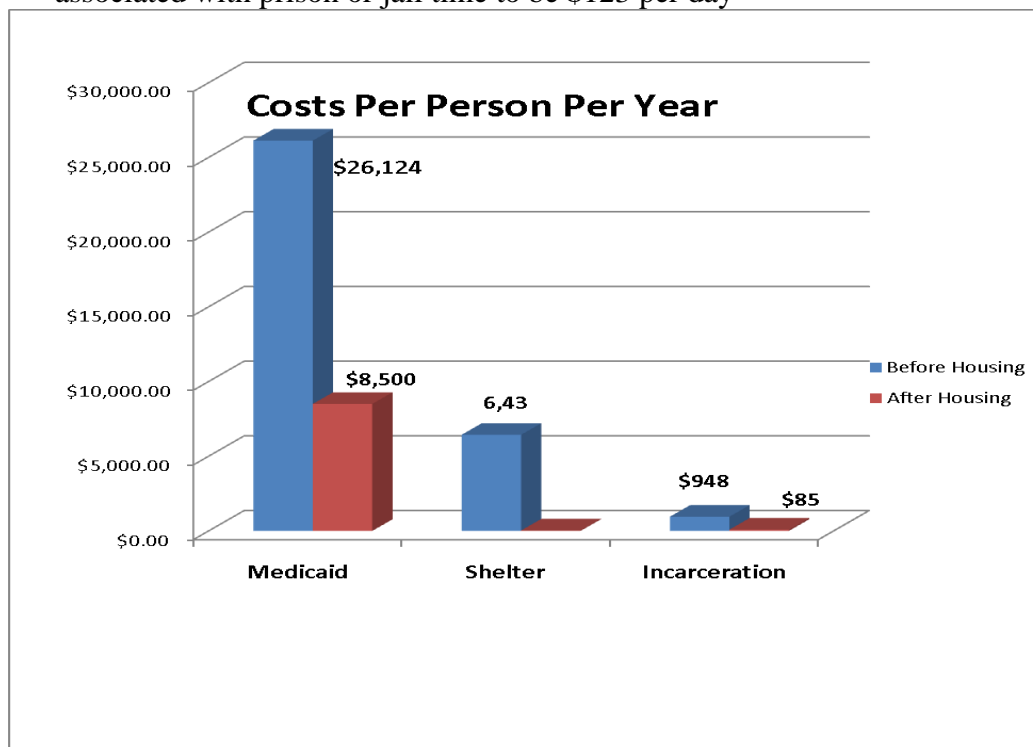
Medicaid Costs

Actual Medicaid costs pre-housing and post-housing were obtained in March 2009 from MassHealth for the first 96 HHG participants. The Medicaid analysis is limited to these 96 participants because they have been in housing long enough 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. We have chosen to use this Medicaid claims data, even though it is from only a portion of the entire HHG cohort, instead of previously collected self-reported data because it is the most accurate assessment of costs.

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:

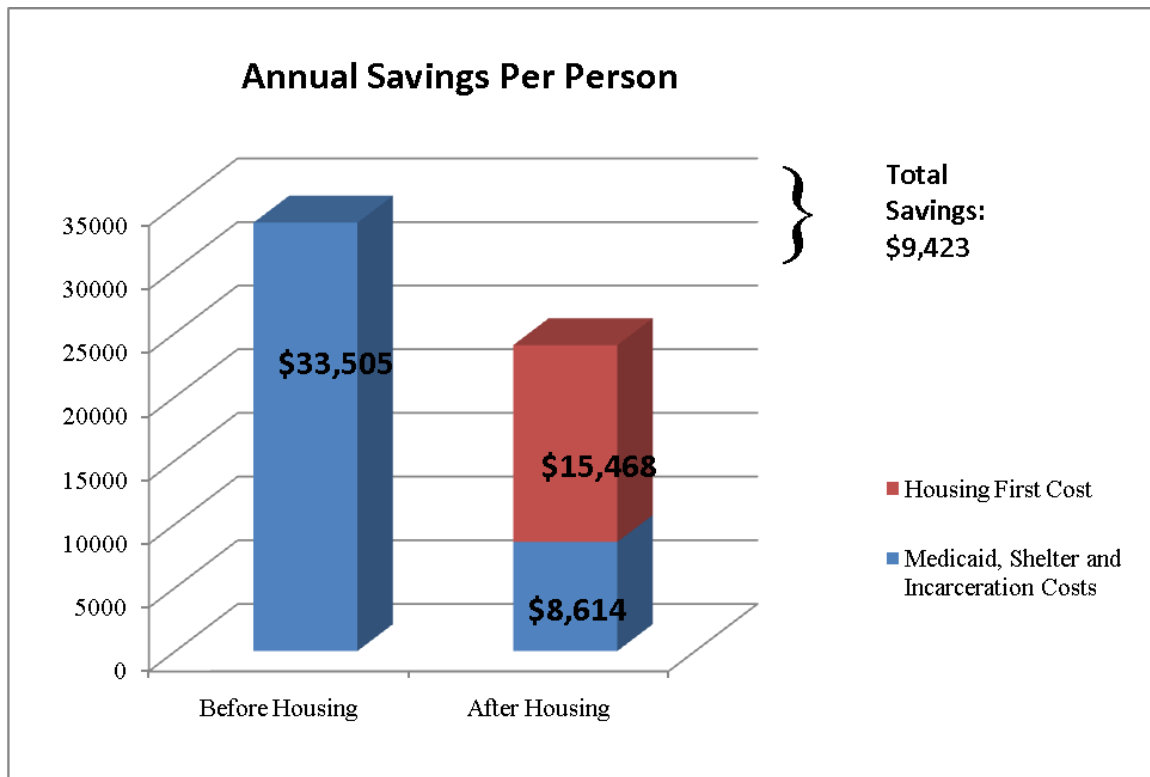
- **Shelter:** According to the Department of Transitional Assistance, the average cost to the state of a night in a Massachusetts homeless shelter for one individual is \$32
- **Incarceration:** Massachusetts Department of Correction estimated the costs associated with prison or jail time to be \$123 per day



Annual Costs Per Person

A Cost Effective Solution

The chart below 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 blue), along with the costs of operating this program, including housing and in-home services (in red).



The Massachusetts Housing and Shelter Alliance estimates an annual cost-savings to the Commonwealth of **\$9,423 per housed tenant.**

Summary

Through *Home & Healthy for Good*, MHSA continues to demonstrate 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. 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 a very 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 Housing and Homelessness, the Administration 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.