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

Preliminary Report
February 2007

"Disciple: Man on the Bench,"oil painting by George Bard, 1986

Submitted by
Massachusetts Housing and Shelter Alliance

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About MHSA

The Massachusetts Housing and Shelter Alliance 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 solutions to move people out of crisis to permanence.

MHSA membership includes 88 organizations serving homeless individuals across the state. These agencies have created over 250 programs which 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"

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, and 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 the shelter system 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 concerns 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 are 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 patients from 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 abuse
- Cognitive impairments seen in patients 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

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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. NEJM 1994; 331: 304-309.

[3] Hwang SW, Orav EJ, O'Connell JJ, Lebow JM, Brennan TA. Causes of Death in Homeless Adults in Boston. Ann Internal Med 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.nhcho.org

- 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 in homeless patients.

The Health Care Costs of Chronic Homelessness

Chronically homeless people, defined 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 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 living unsheltered on the streets chronically.[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.

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'

[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. Am J 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.

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 in several cities in recent years, including San Francisco, New York City, and Philadelphia. Outcome data has been reported in chronically homeless people with severe mental illness who were housed using this model in New York City between 1989 -1997.[7] This landmark study showed that a supportive housing first intervention in more than 4,600 people resulted in 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 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 130 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 would 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 the preliminary findings from the evaluation of the program as of February 2007.

[7] 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. Am J Community Psychol 1998; 26 (2): 207-232.

Implementation

MHSA generated a contract with DTA on September 20, 2006 that outlined the technical aspects of the program. A Housing First Coordinator was hired by MHSA 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**
- 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**

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 February 2007, 70 formerly homeless people have been housed and MHSA anticipates the enrollment of the final 60 participants this spring.

Evaluation of Outcomes

In order to ethically conduct research and measure outcomes, including those related to protected health information, participants are asked to sign HIPAA-compliant consent forms. 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 attempting to obtain participants' claims data from MassHealth, and we await access to this data in coming months. Researchers at the Center for Mental Health Services Research, University of Massachusetts Medical School assist with the data analysis.

Preliminary Data

As of February 2007, 70 people have been housed through HHG. The following data applies to 67 participants from whom informed consent and interview data have been obtained.

Demographics of Participants

Gender	
Male	66%
Female	34%

Age	Years
Average Age	40
Youngest	19
Oldest	61

Race	
American Indian	3%
African American	17%
White	78%
Unknown	2%

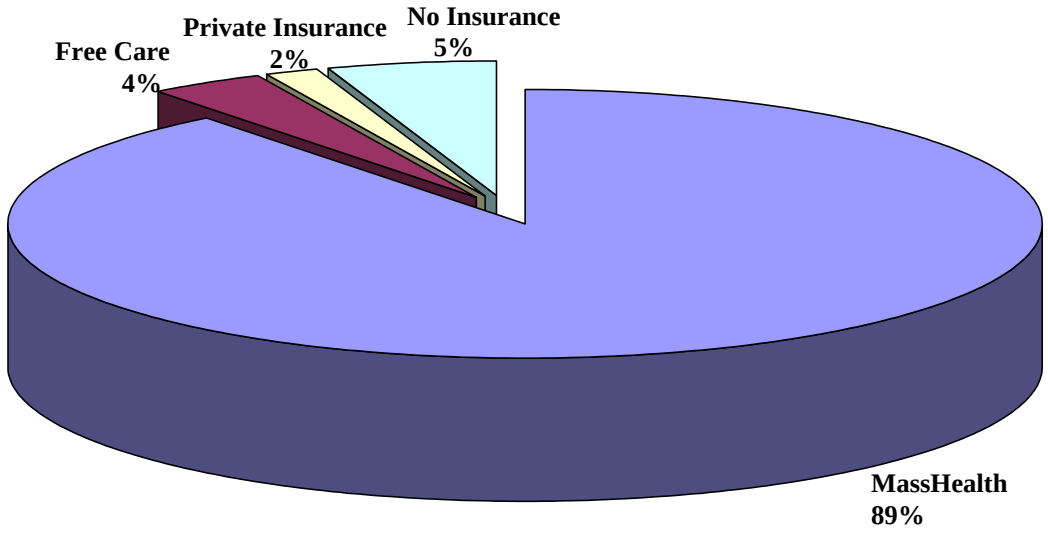
Ethnicity	
Hispanic	7%
Non-Hispanic	93%

Length of Homelessness

The average length of participants' homelessness prior to placement in housing is just under **four years** (3.75) with the longest length of homelessness being 33 years.

Health Insurance

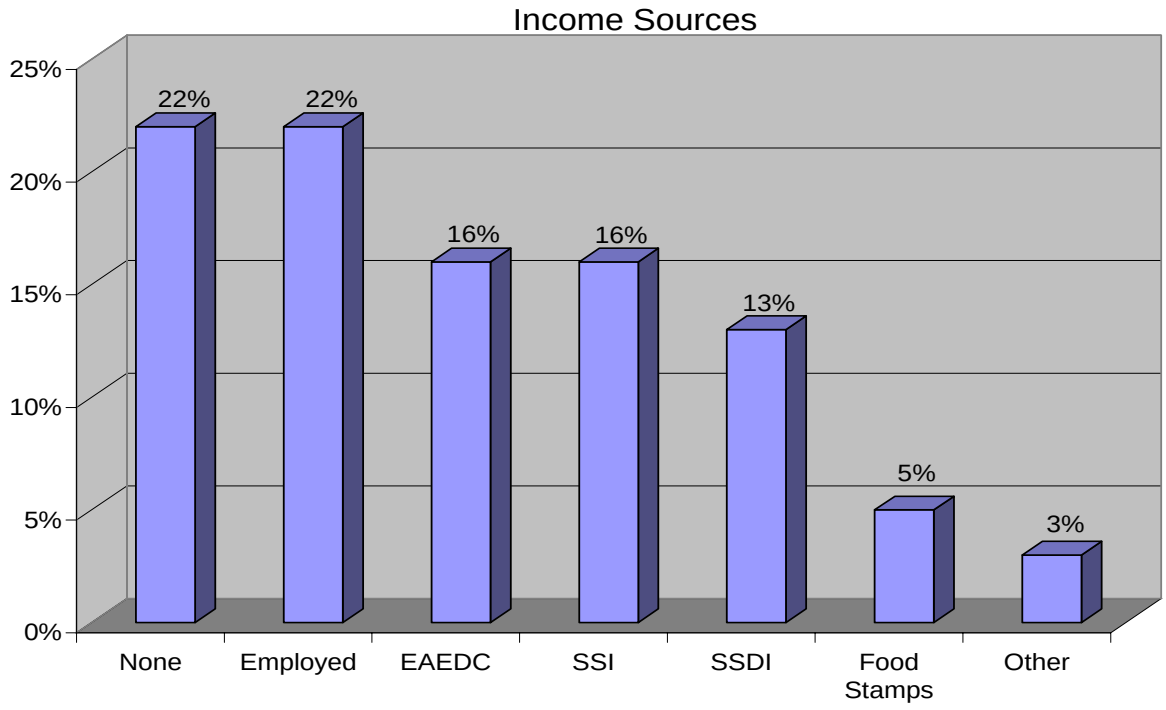
The following chart shows the percentage of participants with various types of health insurance coverage.



Disabilities
HHG for good participants suffer disabilities of the following types.

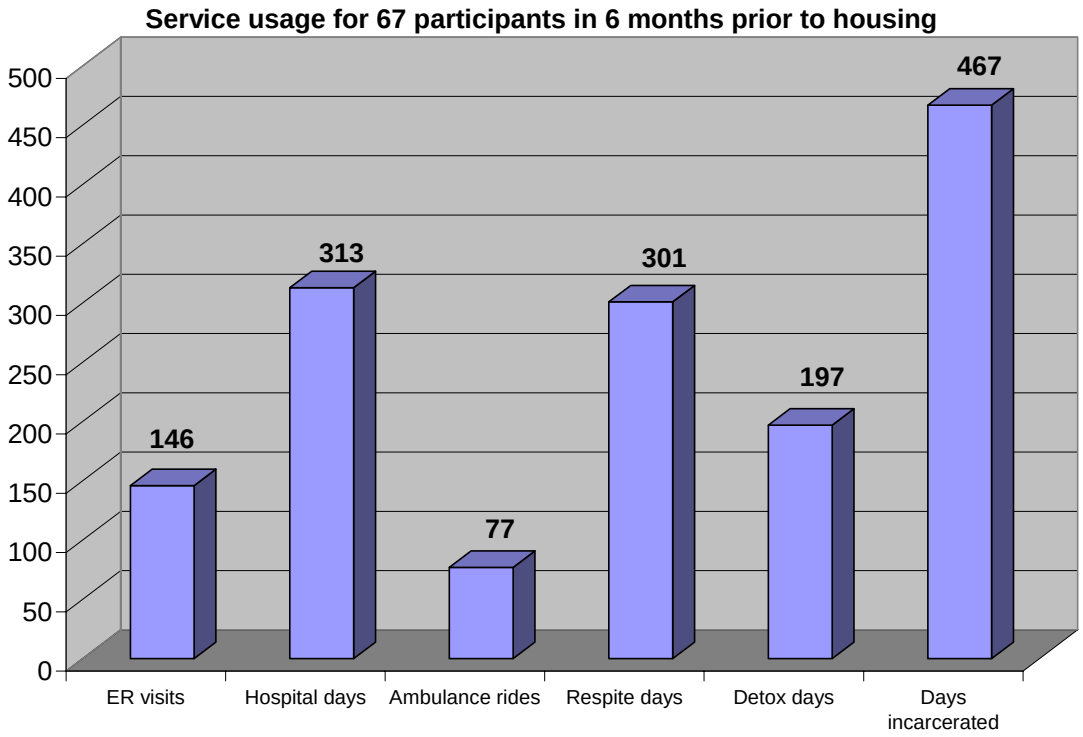
Disability	Percent
Medical	47%
Mental	69%
Addiction	8%
Co-morbidities	39%

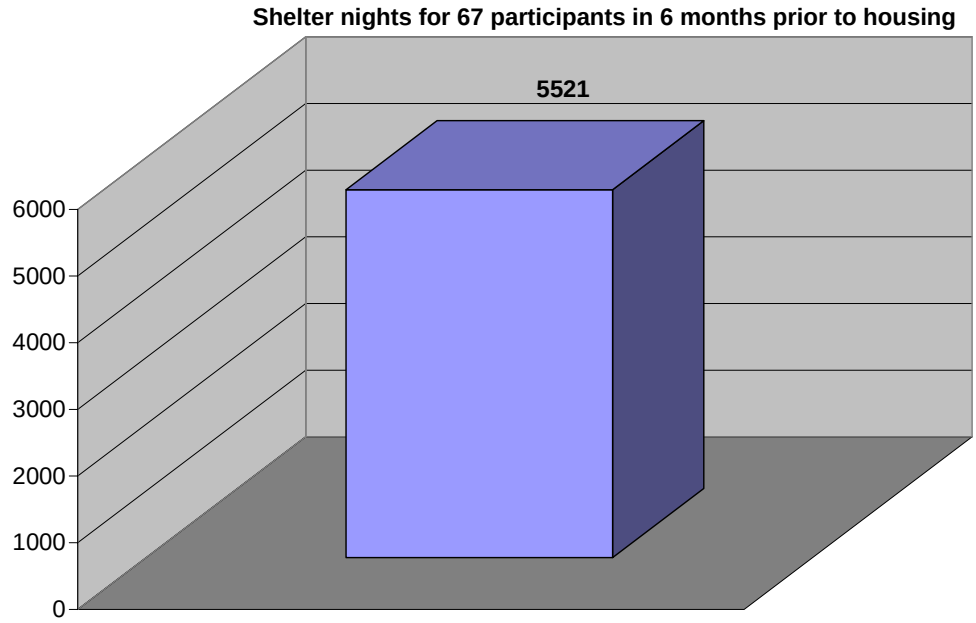
Income sources
The following chart illustrates the percentage of participants with various sources of income.



Service Usage Prior to Housing

The following two graphs depict the use of services and shelter in the **six months prior to entry into the program for 67 participants**. (Follow up data post housing placement is presented on subsequent pages.)

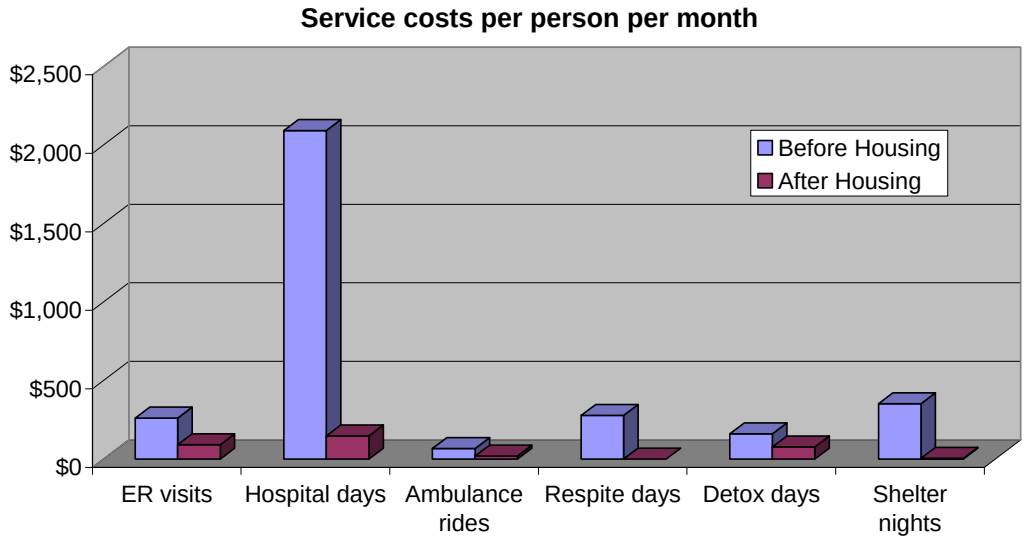




Cost of Services Before and After Housing

The preliminary comparison of service costs in the months prior to housing versus after housing is based on follow up data that is complete for **36 of the HHG participants**. In the six months prior to housing, this group accounted for **88** emergency room visits, **251** days in inpatient care, and **2,377** nights in emergency shelter. In the one month following housing, the group of 36 accounted for **seven** emergency room visits, **four** hospital days, and **eight** nights in shelter. While this data is too limited to draw any broad conclusions, MHSA anticipates continued declines in medical and other service usage as the program continues and additional follow up data is collected.

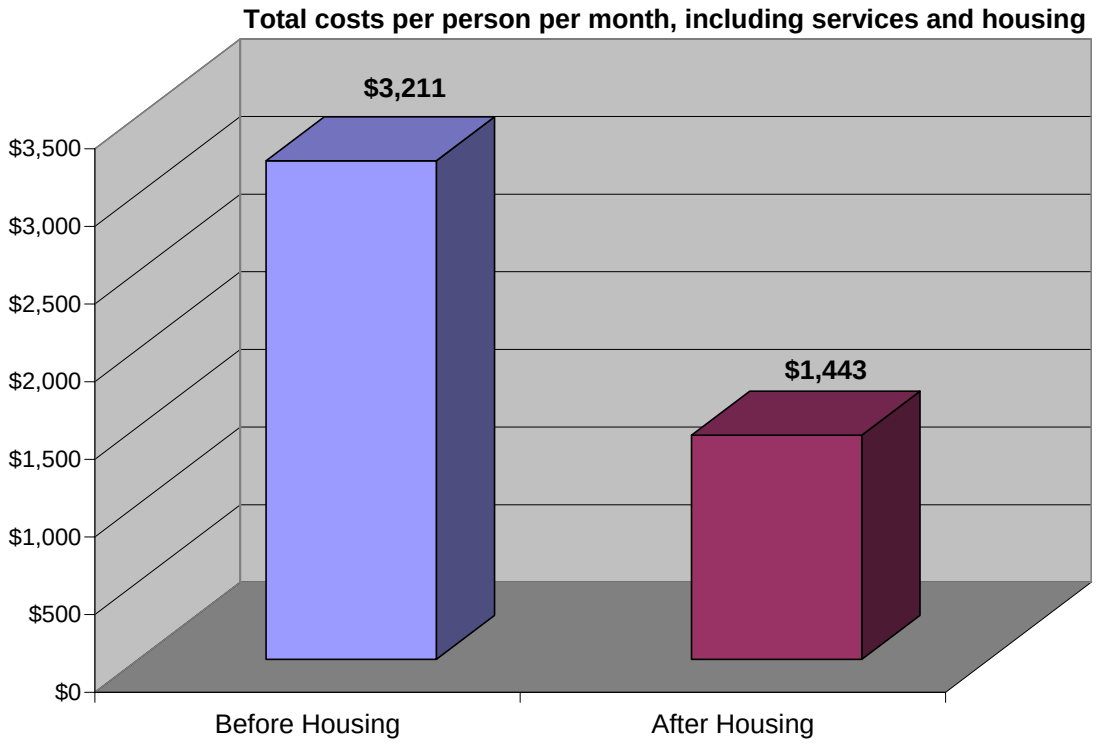
MHSA has made conservative estimates of the costs associated with various services. Based on the Blue Cross Blue Shield Medical Cost Estimator, the average **emergency room** visit in 2004 in Massachusetts was $640.[8] The Blue Cross Blue Shield of South Carolina Cost Estimator quotes an average cost of **hospital admissions** of $1,800 per day in 2005.[9] The cost of **ambulance rides** was estimated to be $230 based on the Massachusetts Division of Health Care Finance and Policy (114.3 CMR 27.03). An average day in **respite** at the Barbara McInnis House is $400 according to the Boston Health Care for the Homeless Program. An estimation of the costs associated with one day in **detox** is $198 according to the Massachusetts Department of Public Health's Bureau of Substance Abuse Services. Finally, the average cost to the state of a night in a Massachusetts homeless **shelter** for one person is $32 according to the Department of Transitional Assistance. We are continuing to analyze the costs associated with **prison or jail** time and this component was therefore not included in the projected cost savings. The following chart shows the estimated costs per person per month in several different service areas prior to and after placement in housing.



[8] Hhttp://www.bluecrossma.com/common/en_US/pdfs/SampleMedicalCosts.pdfH

[9] Hhttp://www.bluechoicesc.com/Internet/chca/chc/imglib.nsf/Files/medical+cost+estimator.pdf/$FILE/medical%20cost%20estimator.pdfH

The average monthly cost for all services combined per person prior to housing was $3,211, compared to $339 after placement in housing. Taking into account the average cost of HHG of $1,104 per person (which includes both housing and in-home case management), tenants are costing approximately $1,443 per month after moving into housing, for a **savings to the state of $1,768 per person per month**.



Our projected annual cost-savings to the Commonwealth per housed person is $21,216.

Budget

HHG has been funded under the Massachusetts state budget FY07 line item 4406-3010 in the amount of $600,000, which has been used to pay for a portion of the housing and services needed to implement the program. The funds from this line item have allowed provider agencies to **leverage $1,014,712** in federal, other state, or private resources. The total annual cost for housing and supportive case management services for this program is $1,695,480, or an **average annual cost of $13,246 per participant.**

In some cases, the state funds for HHG are used to pay for supportive services while leveraging housing resources, and in other instances, HHG funds support housing costs while service dollars have been leveraged. Leveraged federal resources total $595,694; other state resources leveraged total $297,359 (including funds from DMH, MRVP vouchers, DTA, and funds through the Medicaid/CSPECH program administered by the Massachusetts Behavioral Health Partnership); private grants total $116,659; and tenant rent accounts for $5,000.

The current amount of $600,000 in this year's state budget will fund approximately 130 units of housing plus services through June 30, 2007. Because of administrative issues and the governor's 9C cuts to the budget, which temporarily included HHG, the program could not be implemented until three to six months into the current fiscal year. Therefore, the current amount of capacity for HHG is based upon 6-9 months of operation. **To maintain its current capacity for FY08, MHSA estimates it would cost $900,000.**

Tenants' Stories

1: Daniel's apartment in Mattapan.

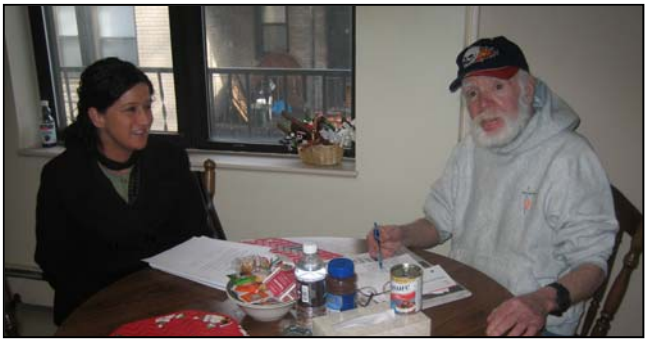
Daniel[10] (Boston)

A 61-year-old man from South Boston, Daniel moved into an independent apartment in Mattapan in December, after more than 20 years living outside on the streets.

After his mother died when he was 10, Daniel lived at the Home for Little Wanderers until age 17. He was deployed to Vietnam upon entering the Marine Corps at age 17, where he was wounded in combat and exposed to Agent Orange. After his time in the military, he worked as a cab driver and insurance salesman. Daniel became an alcoholic in adulthood and his relationships with his wife and children suffered. He began living outside on the streets of South Boston more than 20 years ago. His only social support in recent years came from a long term girlfriend who died of pancreatic cancer five years ago. In the year prior to moving into housing, Daniel required inpatient medical hospitalization and respite at the Barbara McInnis House several times for a myriad of complicated medical problems.

2: The kitchen.

Daniel was housed in an apartment in Mattapan in December 2007. An intensive case manager from Pine Street Inn helps him adjust to life in a new apartment. Within the first two months in a home, his alcohol use has almost completely subsided and he has reconnected with old friends. As a result of a stable living environment, he is able to treat his emphysema, hypothyroidism, and chronic knee and back pain for the first time. He recently learned how to make French toast, enjoys a cup of coffee that he brews himself every morning, and has been bowling in his neighborhood.



3: Daniel's case manager pays a visit.

[10] Tenants' names have been changed to respect their privacy. Written consent was given by tenants to use their pictures and stories in this report.

Chris[11] (Plymouth)

Having battled depression and anxiety for several years, Chris turned to prescription narcotics as a way to self-medicate. His depression and addiction led to difficulty sustaining his job as a painter. Relationships with his family members suffered. He was eventually thrown out of the Plymouth home that he shared with his girlfriend and their children.

1: The van Chris lived in for four years.

2: Chris' new bedroom.

Homeless at the age of 34 years, he lived for the next four years out of his van, sometimes staying outside, on the beach, or in halfway houses or shelters. Scratch tickets that had been thrown away by other people were his only source of income. Chris entered detox centers about ten times per year and frequented emergency rooms during this period of his life. He was hospitalized for severe depression with suicidal thoughts. He felt embarrassed to see his family.

During a recent shelter stay, homeless service providers offered Chris housing and he moved out of his van and into an apartment in Plymouth in February 2007 after four years of homelessness. For the first time, he is being linked to mainstream services including psychiatric care and he is applying for disability benefits. He is successfully being treated with methadone maintenance therapy and hopes to have access to suboxone therapy soon. **"I have a secure feeling and a home base," Chris states.** On a recent visit to his father's house he was relieved that he didn't have to ask to stay overnight and he feels hopeful that this next year will bring further stability to his life.

3: Chris in his kitchen.

[11] Tenants' names have been changed to respect their privacy. Written consent was given by tenants to use their pictures and stories in this report.

Brian, Keith, Frank, and Tom[12] (Framingham)

These four men have moved into a congregate-living house in Framingham after a collective 19 years of homelessness. Each has his own bedroom and they share a kitchen, living room, and bathrooms. Frank has picked up the guitar again and is hoping to find work as a mechanic. Brian is learning to putt golf in his bedroom and is applying for work as a driver.

1: Congregate-living home in Framingham.

2: Brian and Keith in the kitchen.

3: Frank plays his guitar.

4: Tom helps his case manager on his swing.

[12] Tenants' names have been changed to respect their privacy. Written consent was given by tenants to use their pictures and stories in this report.

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 outlined in this report are already showing tremendous savings in health care costs when chronically homeless individuals are placed into housing. Initial retention rates and improved health outcomes also point to housing first as an effective intervention for chronically homeless individuals.

Home and Healthy for Good was funded at $600,000 in Fiscal Year 2007. Taking into account that implementing the program required time to complete contracts with DTA and subcontractors, MHSA aims to place 130 individuals into housing by Spring 2007. Therefore, the current capacity for HHG is based upon 6-9 months of operation.

To maintain its current capacity of 130 units 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 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 will require a serious evaluation of how the state uses its resources and will require bold actions on behalf 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). This 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.