

A close-up photograph of a person's hand holding a large set of keys. The hand is positioned in front of a dark, textured wooden door. The keys are attached to a green plastic ring and include a large white key, a blue keychain, and several silver keys. The person is wearing a blue long-sleeved shirt. The background is slightly blurred, showing the texture of the door and a portion of the person's face on the right side.

Project 25:

Housing the Most Frequent Users of Public Services among the Homeless

Fermanian Business & Economic Institute at PLNU

actionable

April 2015

economics

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Letter to the Reader

April 2015

Point Loma Nazarene University's (PLNU) Fermanian Business & Economic Institute (FBEI) has been actively engaged in providing consulting services to numerous individuals, for profit and non-profit businesses, government agencies, and organizations throughout the region, as well as nationally, and internationally since 2010. In addition to being the Economic Forecasting Unit for California State Treasurer John Chiang, other long standing partners and clients include, but are not limited to, San Diego Military Advisory Council (SDMAC), The Jacobs & Cushman San Diego Food Bank, San Diego Zoo Global, Semptra Energy, Chain Link Fence Manufacturer's Institute (CLFMI), The Corky McMillin Companies, National Association for Business Economics (NABE), Equinox, and San Diego Workforce Partnership.

In the following report, *Project 25: Housing the Most Frequent Users of Public Services among the Homeless*, we focus on individuals who were among the most frequent users of public services in the San Diego metropolitan area and assess the results of providing housing and other services in an effort to reduce their use and costs of public services.

We would like to thank our friends at Father Joe's Villages, St. Vincent de Paul for providing data sources useful in gathering accurate and timely information to include in our research, analysis, and recommendations for this report.

We appreciate the opportunity to present this study to individuals, firms, government officials, and decision makers at all levels. Our desire is that the results of our work will have a positive impact at the local level and can be used to support and validate future programs and resources used to reduce the number of homeless in our community.



Cathy L. Gallagher

Executive Director

Fermanian Business & Economic Institute

Point Loma Nazarene University

About The Authors

Executive Editor:

Cathy L. Gallagher – *Executive Director, Fermanian Business & Economic Institute*

Ms. Gallagher has extensive business experience as owner, manager, and operator of several small businesses on the east coast before joining PLNU 11 years ago. In her current role she is responsible for overall leadership of the Institute, planning and implementation of all strategic initiatives, business development, and client relations. She works closely with for-profit and non-profit businesses, organizations, and individuals, nationally and internationally, to develop collaborative, strategic, and mutually beneficial partnerships furthering objectives and bringing actionable results.

Ms. Gallagher provided editorial leadership, overall project management, and quality control to the Project 25 study.

Primary Author:

Dr. Lynn Reaser, Ph.D. – *Chief Economist, Fermanian Business & Economic Institute*

Dr. Reaser has an extensive background in finance and banking as the former Chief Economist for the Investment Strategies Group of Bank of America, and as a Chief Economist for Barnett Bank and Wells Fargo prior to that. In her role at the Institute, she provides actionable economic counsel to PLNU and its stakeholders, as well as to the overall business community. She leads the economic research team of the Institute and is highly proficient at analyzing economic data, modeling, and forecasting, with special attention given to providing clear and concise recommendations for the reader. Reaser is a leading spokesperson for the university, conducting interviews with newspapers, magazines, television, radio, wire services, and the internet on a variety of topics related to the economy. She speaks at national and international conferences and forecasting events throughout the year. Reaser currently serves as the Chief Economist for California State Treasurer, John Chiang's Council of Economic Advisors.

Dr. Reaser provided oversight of the Project 25 study and was the lead author of the report.

Contributors:

Dieter Mauerman, MBA – *Business & Economic Research Associate, Fermanian Business & Economic Institute*

Mr. Mauerman has worked as a business & economic research associate at the Institute for 5 years. His responsibilities include conducting field research, data acquisition and analysis, and creating exhibits and presentations for client projects and studies. He was awarded a certificate in economic measurement from the National Association for Business Economics in 2010. Mauerman manages and directs individual and groups of MBA student researchers who assist with studies and projects for the Institute.

Mr. Mauerman provided oversight of data collection and research for the Project 25 study, and was responsible for all exhibits included in the report.

Acknowledgements:

Laura Yoccabell-Dibble, MBA – *Assistant Director, Fermanian Business & Economic Institute*

Ms. Yoccabell-Dibble brings a strong background in management, events, operations, and marketing to her position at the Institute. She is responsible for marketing and communication efforts for the Institute as well as planning, management, and execution of all events. Additionally she manages the independent contractors and student assistants who assist with studies and projects for the Institute.

Ms. Yoccabell-Dibble provided scheduling, instruction, and management to student assistants involved in the project.

Erica Manthe – *MBA Researcher*. Ms. Manthe assisted with research and data collection for the study.

FBEI Student Researchers:

Claire Bakken

Anna Heinz

Jesse Oleson

Kristin Beeman

Laura Meng

Kristen Raney

Jake DeSaegher

We would like to thank everyone at Made By Grizzly who supported in the creative direction of this publication.

The Fermanian Business & Economic Institute

The **Fermanian Business & Economic Institute** (FBEI) is a strategic unit of the Fermanian School of Business at Point Loma Nazarene University (PLNU) that specializes in expert business and economic consulting, modeling, forecasting, studies, research, commentary, speeches, business plans, and related services to firms, organizations, and individuals nationally and internationally. The FBEI also provides the San Diego region with economic forecasting events, business and economic roundtables, and special projects.

Through our partnerships and in our work with clients, the FBEI represents the academic standards of the university by maintaining a clear, unbiased approach and has a reputation for authoritative and expertise regarding issues of business, economics, and policy facing our region. In addition to being the Economic Forecasting Unit for California State Treasurer John Chiang, our clients include, San Diego Military Advisory Council (SDMAC), Building Industry Association (BIA) San Diego, Chain Link Fence Manufacturer's Institute (CLFMI), National Association for Business Economics (NABE), Sempra Energy, The Jacob's & Cushman San Diego Food Bank, San Diego Zoo Global, and The Corky McMillin Companies.

Acknowledgments

Project 25 would not have been possible without the leadership of the United Way of San Diego County. The United Way not only provided the majority of the funding for the program but brought a wide variety of partners to the table to ensure its success. In addition to the United Way, the County of San Diego and the City of San Diego provided extensive resources to the program and were excellent partners throughout the pilot.

In addition to the partners above, the following is a list of all of the partners throughout San Diego County that provided data on individuals enrolled in Project 25 over the 3-year pilot. A huge thanks to each of these partners for their willingness to provide the data which made this study possible.

- ALPHA PROJECT
- ALVARADO HOSPITAL
- ALVARADO PARKWAY INSTITUTE
- AMERICAN MEDICAL RESPONSE
- CATHOLIC CHARITIES
- COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES
- KAISER FOUNDATION HOSPITAL
- PALOMAR HEALTH
- PARADISE VALLEY/BAYVIEW HOSPITAL
- PROMISE HOSPITAL
- RURAL METRO CORPORATION
- SALVATION ARMY
- SAN DIEGO COUNTY OFFICE OF THE PUBLIC DEFENDER
- SAN DIEGO COUNTY SHERIFF'S DEPARTMENT
- SCRIPPS HEALTH
- SHARP HEALTHCARE
- TRI-CITY MEDICAL CENTER
- UCSD MEDICAL CENTER
- VA MEDICAL CENTER
- VETERANS VILLAGE OF SAN DIEGO



Executive Summary

Project 25 was designed to determine if the provision of permanent housing with intensive individualized support, coupled with an identified, “Medical Home,” could significantly reduce the use and cost of various public programs by their most frequent homeless users in the San Diego metropolitan area.

The pilot program was funded by United Way over a three-year period, 2011-13. St. Vincent de Paul Village (SVdPV) was the lead agency and partnered with Telecare Corporation, under contract from the County of San Diego, to provide a full array of health and other services. The San Diego Housing Commission provided the majority of the housing resources. The assistance of 32 data providers of various public services offered one of the most comprehensive data sets so far employed for this type of study. The results are impressive.

- Project 25 focused on homeless individuals who were the most frequent users of public services, including emergency rooms, hospitals, jails, and ambulances.
- The program followed the approach of Housing First, which is based on the premise that individuals need to be placed in affordable, permanent housing as quickly as possible and then offered a comprehensive set of services. This contrasts with the more traditional approach of providing rehabilitative services while the person is living in a temporary housing situation, such as an emergency shelter or transitional housing.
- The 28 individuals analyzed in this report all were enrolled in the program and housed in their own apartments by the end of 2011. Their use of various public health and other services was tracked during 2012 and 2013 and compared with the usage of 2010 prior to program enrollment.
- The individuals studied ranged in age from 22 to 61, with a median age of 47. Five were Veterans. All of the individuals studied had some form of mental illness, a serious physical disability, and/or a diagnosable substance abuse disorder. Many had all three.
- Using administrative data matched across multiple systems ensured that those selected for the project were the most frequent users of public services and incurred the highest costs community wide. Also, it ensured that those targeted were most in need.

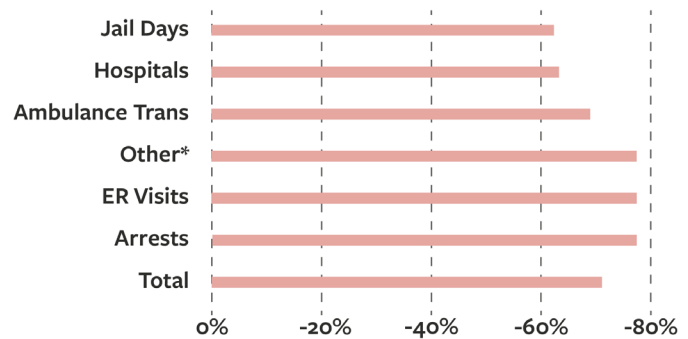
- In the base year 2010, the expenses of all public services used by the 28 individuals totaled approximately \$3.5 million. In the first full year of participation, 2012 saw these costs cut by more than half, or 56%, to \$1.5 million. In 2013, there was a significant 25% further reduction to \$1.1 million. The program thus showed a dramatic reduction of 67% in total costs comparing the base year of 2010 to 2013.
- The expense of all major categories, including ambulance transportation, emergency room visits, hospitalizations, arrests, and days in jail, all fell by more than 60% to nearly 80%. Compared with a pre-program cost of nearly \$111,000 per person in 2010 while living on the streets, the median expense in 2013 was only about one-tenth of that amount at less than \$12,000 after placed in permanent housing with a complete set of services.
- Similar to dollar expenses, utilization of various services, such as the number of ambulance rides, emergency room visits, hospitalizations, arrests, and days in jail, also fell by 60% to 80% between the base year and 2013.
- Subtracting the costs to operate the Project 25 program from the reduction in extrapolated public outlays for hospital and other services yielded a net savings of approximately \$1.6 million in 2012 and \$2.1 million in 2013. The net return on dollars spent for Project 25 was a dramatic 207% in 2012 and 262% in 2013.
- In addition to significant decreases in public costs and service utilization, Project 25 also helped people become more independent, including helping them secure their own income. At the time of enrollment in 2011, only 11 or 39% of the 28-member Project 25 sample was receiving a monthly income. By the end of 2013, that number had nearly doubled to 20, or 71%, of the total. Either Social Security or Supplemental Security Income (SSI) remained the source of income for all of the individuals. Having their own income allowed Project 25 participants to contribute to their rent and other bills and purchase items of their own choosing.
- Of the 36 total number of individuals enrolled in Project 25 during 2011, all but three are still in the program. (Three have passed away from natural causes.) The 33 Project 25 individuals all were housed in their own apartments, have acquired health care insurance, and are receiving necessary health care on an ongoing basis.
- At the end of the pilot period, although all individuals demonstrated a dramatic decrease in both utilization and costs of public services, a third of the participants still required supportive services to maintain their housing stability and continue their improved quality of life. This intense level of support may be required indefinitely. Another third “graduated” from the program and is utilizing a reduced level of services. The final third is anticipated to graduate after some additional time of receiving intensive support.
- The experience of Project 25 provided important lessons for the expansion of this program and other ventures. These include the importance of selecting the appropriate home for each individual, establishing a close relationship between the landlord and the program, maintaining a high level of individualized support, using a client centered approach to substance abuse treatment that may include both abstinence and Harm Reduction philosophies, and having strong coordination with a comprehensive medical home.
- To build on the success of Project 25 and prove the viability of its approach, the program needs to be extended in time and expanded with additional participants under a stable source of funding. A better understanding needs to be obtained on the path of public service usage and program costs over time, whether economies of scale can be achieved, the cost effectiveness of in-home versus off-site health care and other services, and how to manage caseloads more efficiently.
- The implementation of the Affordable Care Act (ACA) and the California expansion of Medicaid to individuals who have earnings that are less than 133% of the Federal Poverty Level, significantly impacted the payer responsibility for costly health services such as emergency room visits and hospital admissions. The implications of this are far reaching from the perspective of more easily establishing a medical home for participants and for program sustainability. Further analysis is needed of other sectors that have a financial stake in addressing frequent users of public services, such as hospitals, the County, and the City, since these entities realize cost

savings as a result of the Project 25 intervention and thus may have an interest in investing those savings in future efforts. The implementation of the Affordable Care Act (ACA) also necessitates a new analysis to better understand the discrepancy between hospital costs and reimbursement rates. Subtracting the costs of the Project 25 program from the reduction in extrapolated public outlays for hospital and other services yielded a net savings of approximately \$1.6 million in 2012 and \$2.1 million in 2013. The net return on dollars spent for Project 25 was a dramatic 207% in 2012 and 262% in 2013.

- The experience of Project 25 provided important lessons for the expansion of this program and other ventures. These included the importance of selecting the appropriate home for each individual, establishing a close relationship between the tenant and the landlord, maintaining intensive case management, phasing in abstinence programs, and establishing a “one-stop” venue for delivering a variety of health and social services.
- To build on the success of Project 25 and prove the viability of its approach, the program needs to be extended in time and expanded with additional participants under a stable source of funding. Better understanding needs to be obtained on the path of public service usage and program costs over time, whether economies of scale can be achieved, the cost effectiveness of in-home versus off-site health care and other services, and how to manage caseloads more efficiently.

Project 25’s Impact on Public Service Expenses

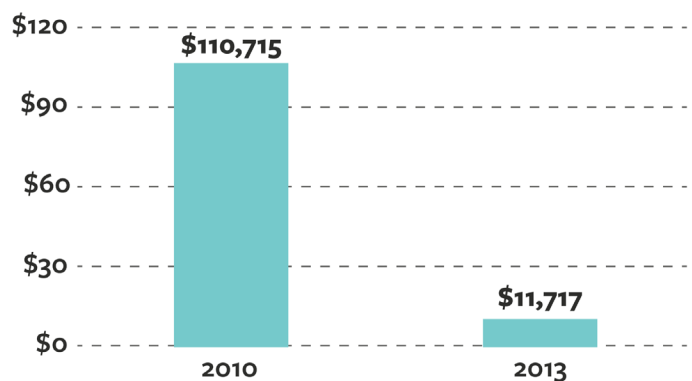
2010 BASE TO 2013



*Includes: Crisis House, detox centers, homeless shelters, legal assistance, Psychiatric Emergency Response Team

Median Expense Per User

THOUSANDS OF DOLLARS



Net Return from Project 25

PERCENT

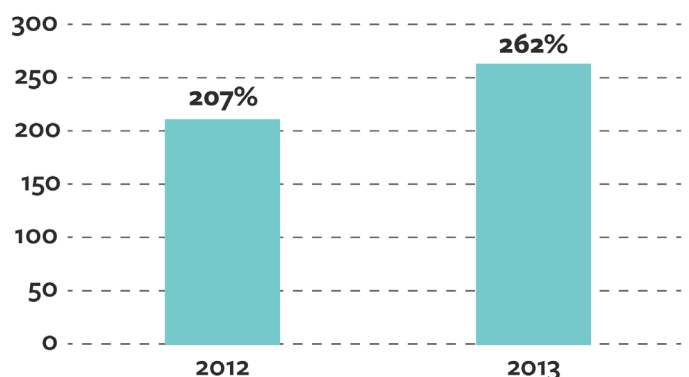


Table of Contents

i. STUDY PURPOSE	01	x. CONCLUSIONS AND NEXT STEPS	13-14
ii. HOMELESSNESS IN SAN DIEGO	01	xi. BIBLIOGRAPHY	15-16
iii. OTHER STUDIES	02	xii. APPENDIX: Literature Review	17-26
iv. HOUSING FIRST	02		
v. THE PROJECT 25 PROGRAM	02-04		
vi. DEMOGRAPHICS OF THE PARTICIPANTS	04-05		
vii. RESULTS	05-12		
viii. INCOME EFFECTS OF PROJECT 25	12-13		
ix. CURRENT STATUS OF PROJECT 25'S PARTICIPANTS	13		

Index of Exhibits

04 *Exhibit 1*
DEMOGRAPHICS

Demographics EXHIBIT 1

	Male	Female	
Gender	85%	14%	
Race	Black / African American	White	American Indian / Alaska Native
	68%	26%	4%
Ethnicity	Hispanic	Non-Hispanic	
	2%	98%	

	Yes	No
Victims	95%	81%
Disabling Condition	100%	6%
Mental Health Issues	89%	1%
Substance Abuse	84%	1%
Victims of Domestic Violence	1%	8%

04 *Exhibit 2*
AGE, EDUCATION,
AND INCOME

Age, Education, and Income EXHIBIT 2

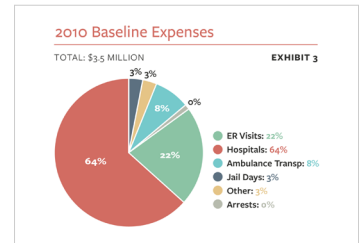
Age Distribution	20 - 29	30 - 39	40 - 49	50 - 59	60+
(No. of people)	2	1	12	10	1

Level of Education Completed	Less than 10 years	High School Diploma or GED	High School 10 years
(No. of people)	7	14	5

Income	Income	No Income
(percent)	29%	6%

Level of Income	\$0 - \$500	\$500 - \$1000	\$1000 - \$2000	\$2000 - \$5000
(No. of people)	17	8	2	1

05 *Exhibit 3*
2010 BASELINE EXPENSES



05 *Exhibit 4*
PROJECT 25 FINANCIAL
RESULTS

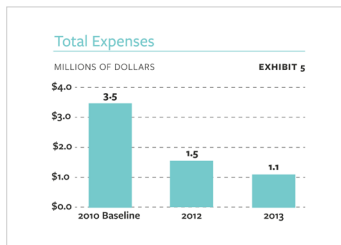
Project 25 Financial Results EXHIBIT 4

DOLLARS

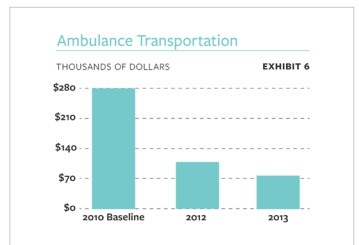
Category	Item	2010	2012	2013
Arrests	Arrests	1000	1000	1000
Ambulance Transportation	Ambulance	1000	1000	1000
Emergency Room Visits	Emergency Room	1000	1000	1000
Hospital	Hospital	1000	1000	1000
Jail Days	Jail Days	1000	1000	1000
Other	Other	1000	1000	1000
Total	Total	1000	1000	1000

*Includes: Crisis House, detox centers, homeless shelters, legal assistance, Psychiatric Emergency Response Team

06 *Exhibit 5*
TOTAL EXPENSES



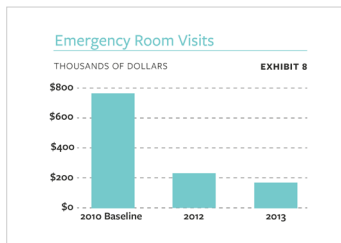
06 *Exhibit 6*
AMBULANCE
TRANSPORTATION



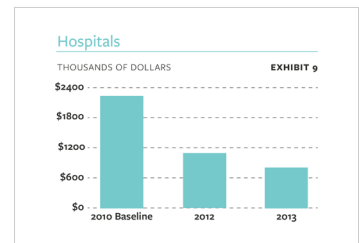
07 *Exhibit 7*
ARRESTS



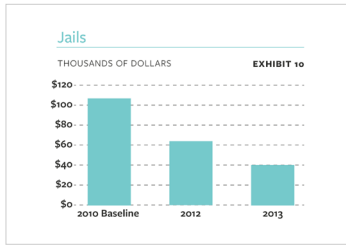
07 *Exhibit 8*
EMERGENCY ROOM VISITS



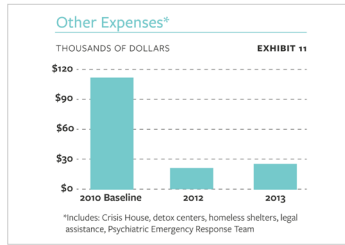
08 *Exhibit 9*
HOSPITALS



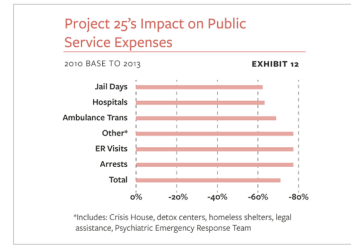
08 **Exhibit 10**
JAILS



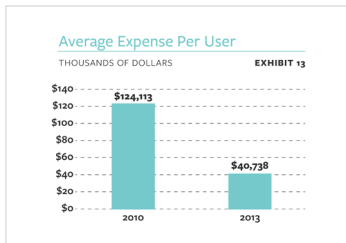
09 **Exhibit 11**
OTHER EXPENSES



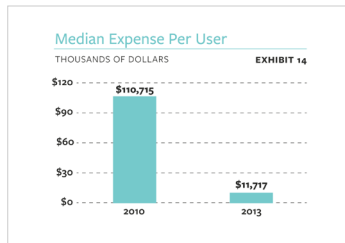
09 **Exhibit 12**
PROJECT 25's IMPACT ON PUBLIC SERVICE EXPENSES



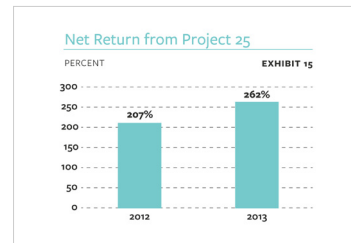
10 **Exhibit 13**
AVERAGE EXPENSE PER USER



10 **Exhibit 14**
MEDIAN EXPENSE PER USER



11 **Exhibit 15**
NET RETURN FROM PROJECT 25



11 **Exhibit 16**
PROJECT 25 RESULTS IN CONSTANT DOLLARS

Category	2010	2012	2013	% Change 2010-2012	% Change 2010-2013
Arrests	100	100	100	0%	0%
Emergency Response	100	100	100	0%	0%
ER Visits	100	100	100	0%	0%
Hospital Days	100	100	100	0%	0%
Hospitalizations	100	100	100	0%	0%
Jail Days	100	100	100	0%	0%
Other	100	100	100	0%	0%
Total	100	100	100	0%	0%
Transportation	100	100	100	0%	0%
Transportation Expenses	100	100	100	0%	0%
Other	100	100	100	0%	0%
Average net savings	100	100	100	0%	0%
Other	100	100	100	0%	0%

*Includes: Crisis House, detox centers, homeless shelters, legal assistance, Psychiatric Emergency Response Team

12 **Exhibit 17**
PROJECT 25's IMPACT ON TOTAL PUBLIC SERVICE USAGE

Category	2010	2012	2013	% Change 2010-2012	% Change 2010-2013
Hospitalizations	100	100	100	0%	0%
Hospital Days	100	100	100	0%	0%
ER Visits	100	100	100	0%	0%
Arrests	100	100	100	0%	0%
Jail Days	100	100	100	0%	0%
Ambulance Miles	100	100	100	0%	0%
Other	100	100	100	0%	0%

*Includes: Crisis House, detox centers, homeless shelters, legal assistance, Psychiatric Emergency Response Team

12 **Exhibit 18**
PROJECT 25's IMPACT ON AVERAGE PUBLIC SERVICE USAGE

Category	2010	2012	2013	% Change 2010-2012	% Change 2010-2013
Hospitalizations	100	100	100	0%	0%
Hospital Days	100	100	100	0%	0%
ER Visits	100	100	100	0%	0%
Arrests	100	100	100	0%	0%
Jail Days	100	100	100	0%	0%
Ambulance Miles	100	100	100	0%	0%
Other	100	100	100	0%	0%

*Includes: Crisis House, detox centers, homeless shelters, legal assistance, Psychiatric Emergency Response Team

PROJECT 25:

Housing the Most Frequent Users of Public Services Among the Homeless

i. Study Purpose

The purpose of Project 25 is to investigate whether providing permanent housing with intensive individualized support, coupled with an identified, “Medical Home,” can realize a significant reduction in the use and cost of public services. This study focuses on those individuals who were among the most frequent users of public services in the San Diego metropolitan area, such as emergency rooms, jails, and hospitals. It was based on the “Housing First” approach, which embraces the concept that secure housing is the first step and essential to stabilizing the personal and financial lives of individuals.

ii. Homelessness in San Diego

Based on the most recent reports from the United States Department of Housing and Urban Development (HUD), San Diego has the fifth largest homeless population in the nation and is only surpassed by the metropolitan areas of New York City, Los Angeles, Las Vegas, and Seattle. In 2014 there were 8,506 homeless people living in San Diego County, with almost half unsheltered. These individuals lived in the streets, in their vehicles, in hand-built structures, or in other places not meant

for human habitation. About 14% of the homeless lived in emergency shelters, with the remainder residing in some form of transitional housing.

Approximately three-fifths of the homeless in 2014 were in the City of San Diego, with the rest dispersed throughout the rest of the County. Veterans accounted for about 20% of homeless adults in San Diego County in 2014. About 36% of homeless adults were afflicted with severe mental illness, while 19% were considered chronic drug abusers. Approximately 22% of the total homeless adult population in San Diego County were victims of domestic violence.

iii. Other Studies

A number of programs and studies have been conducted in recent years examining the impact of housing on the usage of various public services. Most have shown significant reductions in emergency room use, hospitalizations, and other public costs. Others have also investigated the impact on ambulance, jail, and shelter expenses. However, studies have differed in a number of ways, including what kind of housing and other services were provided as well as the types of data that were collected. For example, some studies have analyzed only Medicaid costs, while others have been limited by the number of service providers who would provide data. The expense of program usage in many cases has also been distorted by the collection of hospital bills (charges) as opposed to the actual costs of service providers.

A summary of some of these studies, together with a synopsis of several articles on the subject is included in the Appendix at the end of this report.

iv. Housing First

Housing First approaches the problems of the chronically homeless (those with lengthy homeless histories and a disabling health condition) with the premise that individuals need to be placed in affordable, permanent housing as quickly as possible and then offered a comprehensive set of services. This contrasts with the more traditional

approach where people were provided rehabilitative services first and then moved into permanent housing only at some future time when deemed appropriate.

The more traditional approach, long supported by HUD, is transitional housing. Transitional housing programs focus on addressing issues that have caused an individual's homelessness and preparing the individual to live independently. The challenge with this strategy is that many chronically homeless individuals require long-term supportive services in order to sustain housing and function within society. As a result, they end up occupying space in shelters and transitional housing programs that could be more effectively utilized by other less chronically homeless people.

The Housing First strategy works from the concept that stable and permanent housing is a precondition for helping the most seriously afflicted homeless receive and benefit from a holistic approach entailing a wide range of medical, financial, and social services. Project 25 embraces this approach.

v. The Project 25 Program

Project 25 was designed to determine if the provision of secure permanent housing, combined with intensive individualized case management and a comprehensive offering of primary and behavioral health care, could significantly reduce the use and cost of various public programs by their most frequent homeless users. The three-year pilot program was funded by the United Way and the County of San Diego with the San Diego Housing Commission providing the majority of the housing resources. St. Vincent de Paul Village (SVdPV) was the lead agency and provided services to half of the individuals in the study, managed the housing resources for most of the individuals, and was responsible for the collection of data throughout the project. Telecare Corporation, under contract with the County of San Diego, provided services for the other half of individuals and supplied housing resources to some of these individuals.

A total of 36 individuals were enrolled in the program over the study period of 2011-2012. Two deceased in 2013 due to natural causes and one was not enrolled in the program until the end of 2012. A total of 28 individuals were both enrolled in the program and placed in permanent housing by the beginning of 2012 and remained in the program through 2013. Because of the focus on assessing the impact of providing housing security, this was the sample analyzed in this report.

SVdPV was responsible for data collection and partnered with 32 data providers. These included 22 hospitals along with shelters, ambulance service providers, and San Diego County's Health and Human Services Agency (HHSA), Sheriff's Department, and Public Defender. Data on actual costs incurred by hospitals and other service providers, as opposed to posted charges, was collected and used in the analysis.

Data on the use of various public services, including the cost and incidence of ambulance transportation, arrests, emergency room (ER) visits, and hospitalizations, was collected for the base year of 2010. Quarterly data was then collected for 2011 through 2013 to assess the impact of Project 25. Because of quarterly variations, this study analyzes the two full calendar years of 2012 and 2013 after all 28 individuals were housed in their own apartments.

Selection of the Participants

Project 25 selected homeless individuals who were the most frequent users of public services, including emergency rooms, hospitals, jails, and ambulances. Participants had to have utilized two of the three service categories below:

- **Jails**
- **Emergency rooms, ambulances, hospitalization**
- **County behavioral health services**

From a list of 71 names ranked by costs, the top users were selected to be part of the Project 25 study.

Program Services

Individuals enrolled in the program were given the option to use temporary housing at SVdPV or hotel rooms paid for by the County of San Diego rather than living on the street while permanent housing was arranged. Most individuals then received housing through a subsidy provided by the San Diego Housing Commission while some were provided with permanent housing through funds from the Mental Health Services Act (MHSA). Individuals earning income paid 30% of their earnings for rent.

Individuals were then provided with various services depending on their individual needs. Telecare Corporation, under contract from the County of San Diego, worked with 14 of the 28 people analyzed in this report who were initially identified as having a severe and persistent mental illness. SVdPV focused on the other 14 who, although they had mental illness, primarily suffered from severe substance abuse disorders and cognitive limitations.

Services provided included medical, dental, and psychological care, medication management and delivery, drug and alcohol abuse treatment including a Harm Reduction approach, landlord mediation, disability benefits advocacy using a local approach based on the national SSI/SSDI Outreach Access and Recovery (SOAR) model, flexible payee programs to help manage money and ensure that rent and other bills were paid, and general life skills coaching. It is the intensity of these services that is important to note. Some individuals were seen in the beginning of the program as many as 4-5 times per week. There was decreasing intensity over the course of the project, but visits by supportive services staff never were less than one visit a week.

Medical Home

Most of the preventative health care was delivered through the SVdPV clinic. The clinic is onsite at SVdPV and provides both primary care and psychiatric care. All individuals in the program managed by SVdPV used the clinic as their medical home while only a handful of the individuals with Telecare used it for their care. Telecare did have a psychiatrist as a part of its model to assist with mental health care, while individuals needing primary care were treated in a variety of other clinic settings, including a mobile clinic that was stationed outside of the Telecare offices on certain days of the week.

Housing

The San Diego Housing Commission (SDHC) provided the program with 25 sponsor-based subsidies through its Moving to Work designation by HUD. The subsidies were similar to traditional tenant-based vouchers such as Section 8 in that the individual had to direct 30% of his or her income towards rent if the individual had income. Project 25 was allowed the flexibility to design the subsidy program to fit the needs of homeless frequent users. The subsidies could be used in any unit within the City of San Diego as long as the landlord was willing to accept the voucher and the rent was under a certain limit. SVdPV managed the subsidies for all of its individuals as well as 10 of the individuals enrolled in the Telecare program. The other individuals with Telecare who did not receive a sponsor-based subsidy were housed using housing funds through the Mental Health Services Act (MHSA).

A scattered site model was used, meaning that individuals were housed throughout the City and integrated into the community

as opposed to having a single site or congregated housing. Although a good portion of the individuals lived in housing throughout the community, several of the individuals were also housed in affordable housing buildings operated by SVDPV.

vi. Demographics of the Participants

The basic demographics of the 28 participants studied in Project 25 are summarized in *Exhibits 1 and 2*.

The preponderance of the 28 individuals was male, with only four, or 14%, of them female. Twenty-two were white, five were black, and one was Native American. Two of the total were Hispanic. The individuals studied ranged in age from 22 to 61. The median age was 47. Five of the total group were Veterans.

All of the individuals had some form of physical disability or mental illness. All but three, or 89%, suffered from mental illness. All but three (not the same three) of the total also had problems of substance abuse. Every individual in the program was afflicted either with mental illness or substance abuse. Three of the individuals, or 11%, were victims of domestic violence.

Nearly 60%, or 16, of the group reported that they had a high school diploma or equivalent GED (successfully passing the General Educational Development test). Another five had received more than twelve years of education (college or vocational training). The remaining seven

reported less than twelve years of school.

Approximately three-fifths of the individuals enrolled in the program during 2011 had no income. The others received all of their earnings from the Social Security Administration. Four of those individuals had worked enough in the past to earn credits based on their contributions. Their monthly checks due because they had become disabled were higher than average and ranged from \$912 a month to \$1,700 a month. Most of the Project 25 participants with earnings at entry into the program

Demographics

EXHIBIT 1

	Male	Female	
Gender	86%	14%	
	Black / African	White	American Indian / Alaska Native
Race	18%	78%	4%
	Hispanic	Non-Hispanic	
Ethnicity	7%	93%	

	Yes	No
Veterans	18%	82%
Disabling Condition	100%	0%
Mental Health Illness	89%	11%
Substance Abuse	89%	11%
Victim of Domestic Violence	11%	89%

Age, Education, and Income

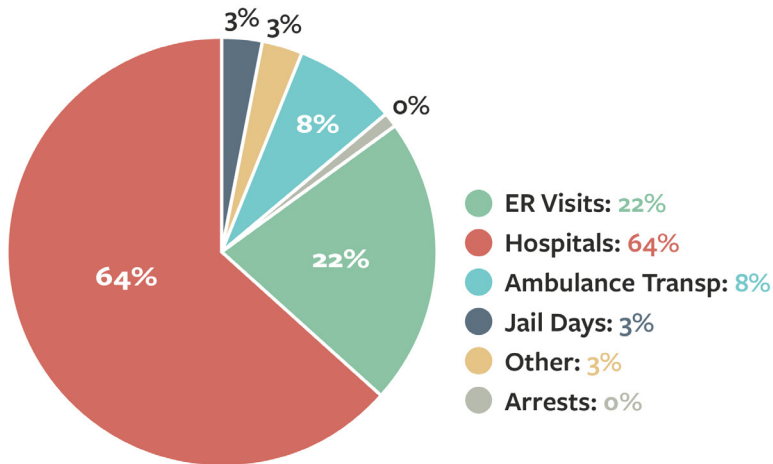
EXHIBIT 2

Age Distribution	20 - 29	30 - 39	40 - 49	50 - 59	60+
(no. of people)	3	1	13	10	1
Level of Education Completed	Less than 12 years	High School Diploma or GED	High School 12 years		
(no. of people)	7	16	5		
Income	Income	No Income			
(percent)	39%	61%			
Level of Income	\$0 - \$500	\$500 - \$1000	\$1000 - \$1500	\$1500 - \$2000	
(no. of people)	17	8	2	1	

2010 Baseline Expenses

TOTAL: \$3.5 MILLION

EXHIBIT 3



collected Supplemental Security Income (SSI), which is designed to assist disabled, blind, or aged individuals with little or no income. Their monthly incomes were all in the range of \$800 to \$900.

vii. Results

The results of Project 25 are impressive. In the base year 2010, the expenses of all public services used by the 28 individuals totaled approximately \$3.5 million. Hospitalization accounted over three-fifths of the total at \$2.2 million. (See *Exhibit 3.*)

In the first full year of participation, 2012 saw these costs cut by more than half, or 56%, to \$1.5 million. In 2013, there was a further reduction of 25% to \$1.1 million. The program thus showed a dramatic reduction of 67% in total costs comparing the base year of 2010 to 2013. The expense of all major categories, including ambulance transportation, arrests, ER visits, hospitalization, and jail time, all fell by more than 60% to nearly 80%. (See *Exhibits 4-12.*)

The average expense per person fell from over \$124,000 in 2010 to about \$41,000 in 2013. The drop in the median expense was even more dramatic. Compared with a starting point of nearly \$111,000 in 2010, the median expense in 2013 was only about one-tenth of that amount at less than \$12,000. (See *Exhibits 13-14.*)

A better picture of the true savings from Project 25 is obtained by extrapolating what the expense of various services would have been without the program's intervention. Assuming that expenses

Project 25 Financial Results

DOLLARS

EXHIBIT 4

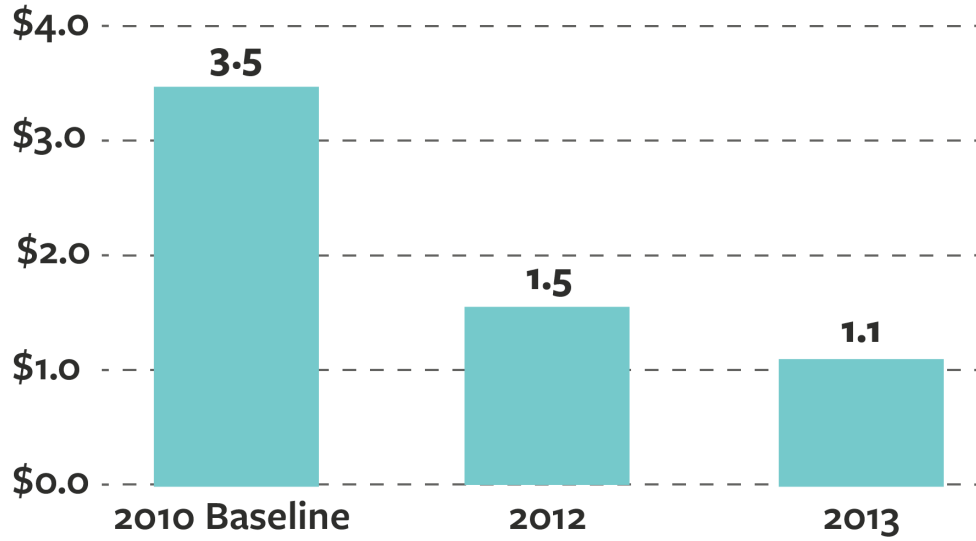
28 member group	Dollars			Percent Change		
	Baseline	2012	2013	Base to 2012	2012 to 2013	Base to 2013
Expenses						
Ambulance Transportation	\$279,576	\$122,647	\$90,182	-56%	-26%	-67.7%
Arrests	\$12,300	\$3,750	\$2,700	-70%	-28%	-78%
ER Visits	\$750,977	\$225,661	\$164,919	-70%	-27%	-78%
Hospitals	\$2,214,060	\$1,092,019	\$818,306	-51%	-25%	-63%
Jail Days	\$105,901	\$61,787	\$39,715	-42%	-36%	-62%
Other*	\$112,361	\$21,549	\$24,840	-81%	15%	-78%
Total	\$3,475,174	\$1,527,414	\$1,140,662	-56%	-25%	-67%
Program Costs		\$754,294	\$790,202		5%	
Avg expense per person	\$124,113	\$54,550	\$40,738	-56%	-25%	-67%
Median expense per person	\$110,715	\$26,364	\$11,717	-76%	-56%	-89%
Extrapolated baseline expenses	\$3,475,174	\$3,840,962	\$4,002,410			
Total program expenses		\$1,527,414	\$1,140,662			
Total program costs		\$754,294	\$790,202			
Net savings		\$1,559,254	\$2,071,547			
Average net savings		\$55,688	\$73,984			
Net return		207%	262%			

*Includes: Crisis House, detox centers, homeless shelters, legal assistance, Psychiatric Emergency Response Team

Total Expenses

MILLIONS OF DOLLARS

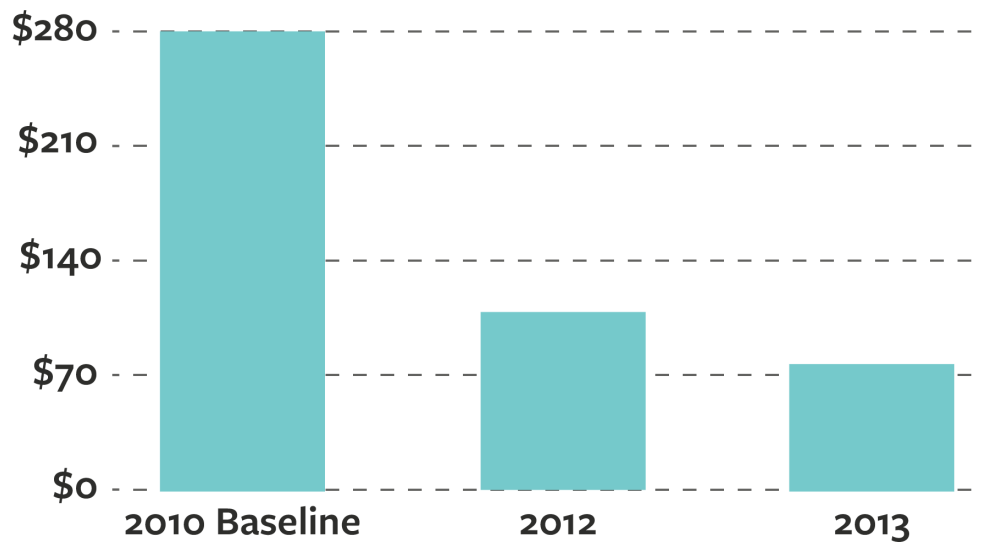
EXHIBIT 5



Ambulance Transportation

THOUSANDS OF DOLLARS

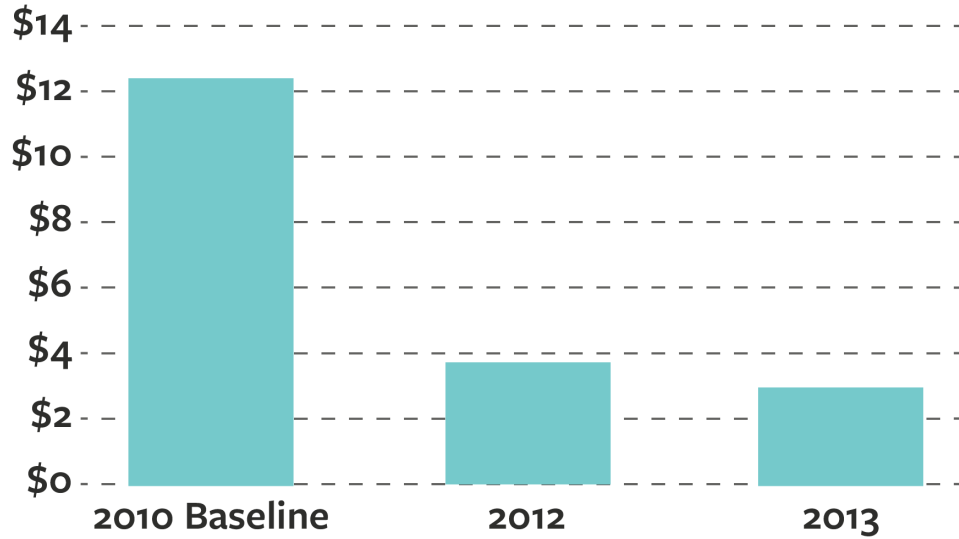
EXHIBIT 6



Arrests

THOUSANDS OF DOLLARS

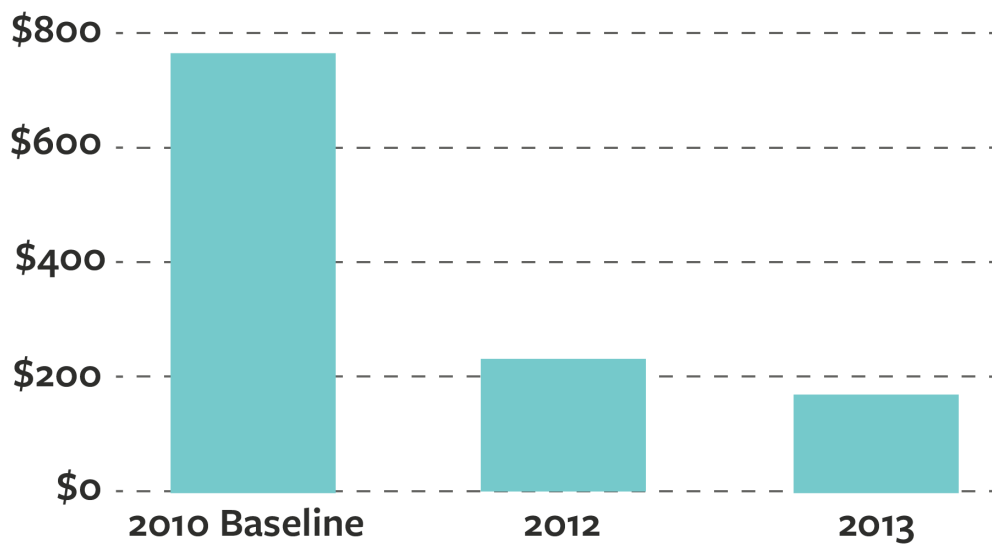
EXHIBIT 7



Emergency Room Visits

THOUSANDS OF DOLLARS

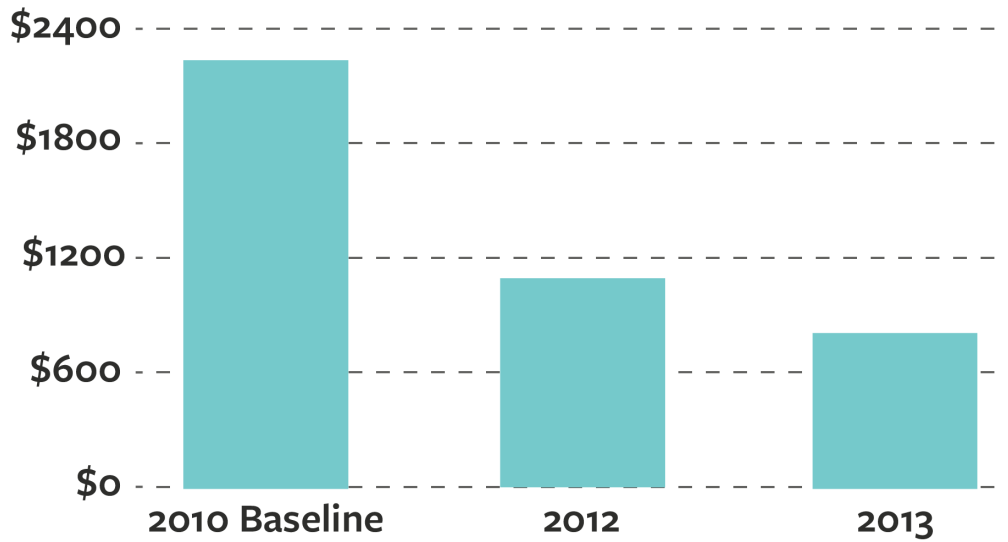
EXHIBIT 8



Hospitals

THOUSANDS OF DOLLARS

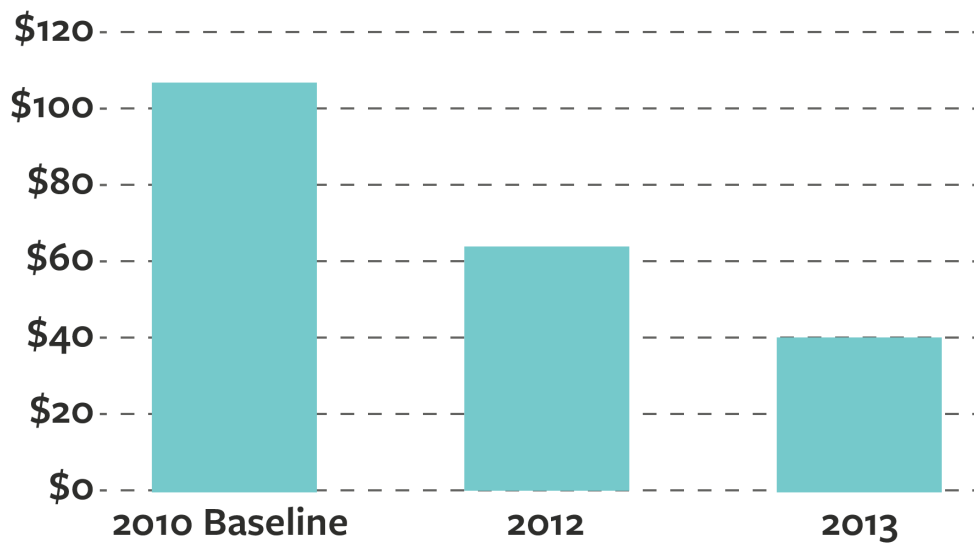
EXHIBIT 9



Jails

THOUSANDS OF DOLLARS

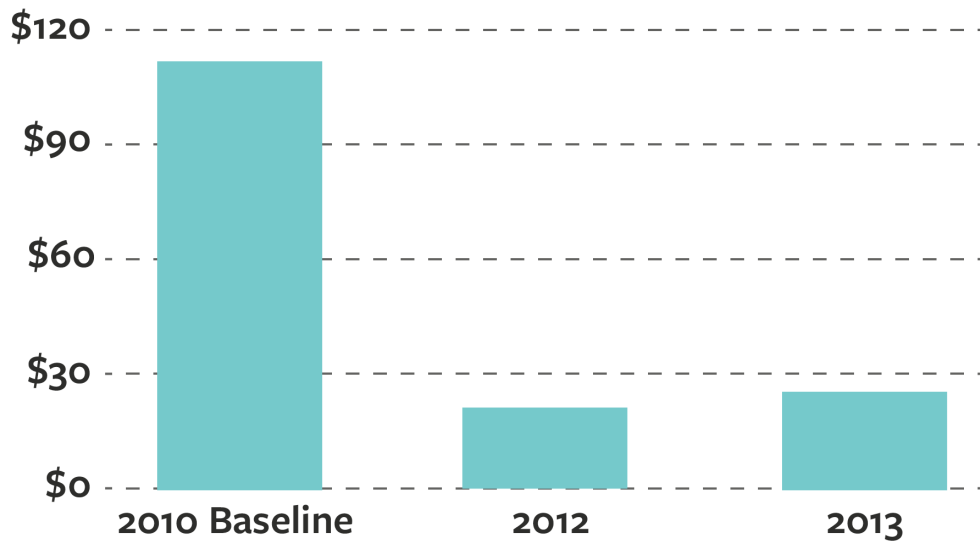
EXHIBIT 10



Other Expenses*

THOUSANDS OF DOLLARS

EXHIBIT 11

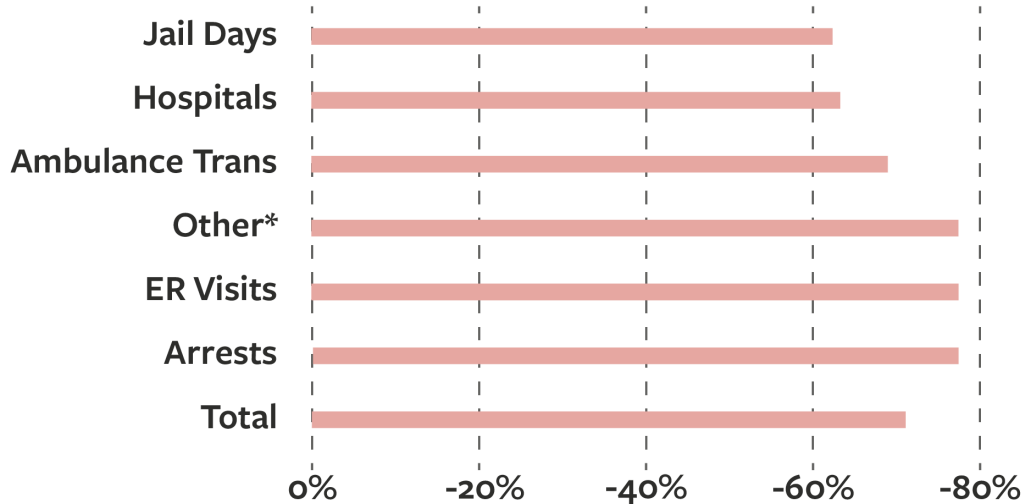


*Includes: Crisis House, detox centers, homeless shelters, legal assistance, Psychiatric Emergency Response Team

Project 25's Impact on Public Service Expenses

2010 BASE TO 2013

EXHIBIT 12

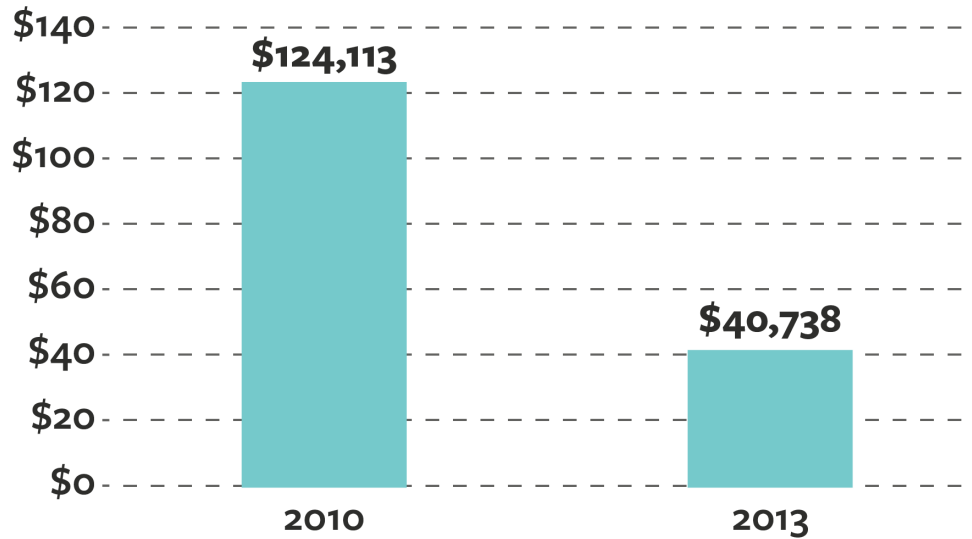


*Includes: Crisis House, detox centers, homeless shelters, legal assistance, Psychiatric Emergency Response Team

Average Expense Per User

THOUSANDS OF DOLLARS

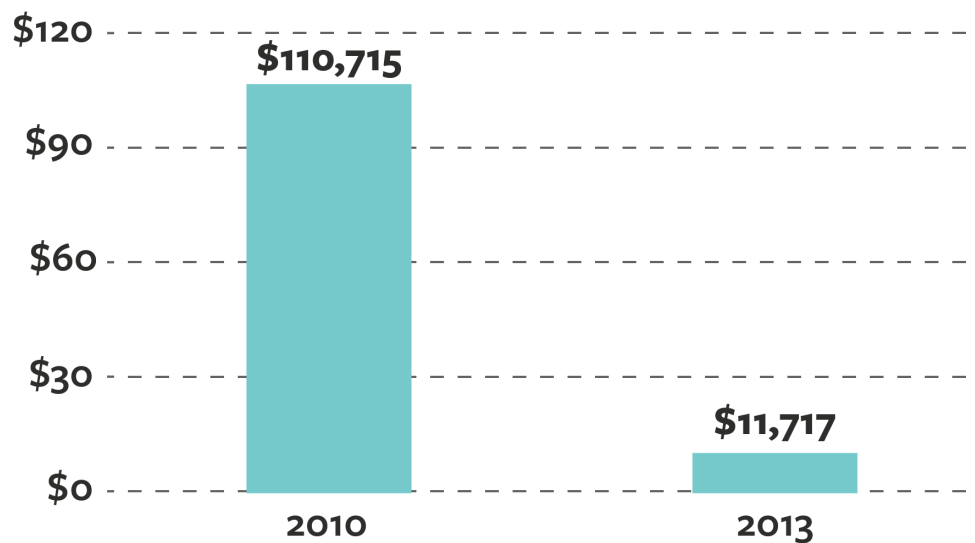
EXHIBIT 13



Median Expense Per User

THOUSANDS OF DOLLARS

EXHIBIT 14



only kept pace with inflation and exhibited no change in usage intensity, the total in 2013 would have climbed to \$4.0 million. (Health-related expenses were adjusted using the Consumer Price Index for hospital services; other expenses were adjusted using the Personal Consumption Expenditures Price Index.) The costs of the Project 25 program was also taken into account to determine the net savings realized. These costs encompassed both the provision of housing and all of the various services provided the program's participants.

Subtracting the cost of the Project 25 program from the reduction in extrapolated public outlays for hospital and other services yielded a net savings of approximately \$1.6 million in 2012 and \$2.1 million in 2013. The net return on dollars spent for Project 25 was a dramatic 207% in 2012 and 262% in 2013. **(See Exhibit 15.)**

Adjusting all data for inflation between 2010 and 2013 yields even somewhat larger favorable results. The expense of total spending for various public services plunged by 72% between 2010 and 2013 (compared with 67% before inflation adjustment). The average expense in 2013 dollars fell from about \$143,000 in 2010 to \$41,000 in 2013, while the median expense plunged from approximately \$128,000 to about \$12,000 three years later. **(See Exhibit 16.)**

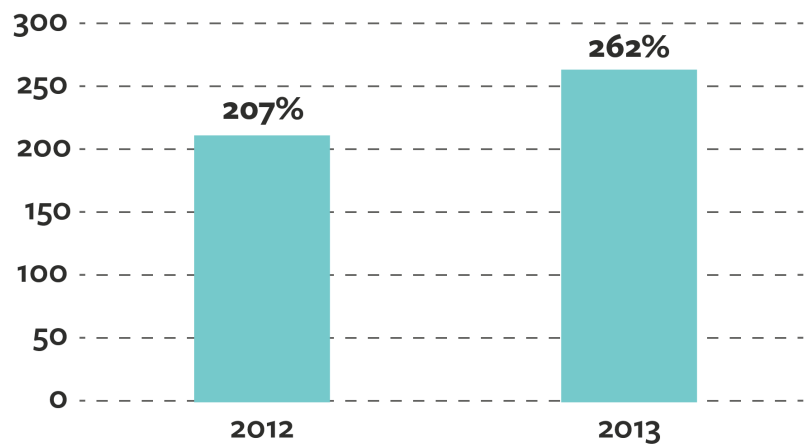
Usage rates

The usage rate of various public services fell sharply between 2010, the base period, and 2012-13 when the 28 individuals were situated in stable and permanent housing. In 2010, the average number of hospitalizations for medical or psychiatric care was 10, while the average amount of time spent in hospitals averaged 46 days. Ambulance rides averaged 22 that year per individual studied and ER visits

Net Return from Project 25

PERCENT

EXHIBIT 15



Project 25 Results in Constant Dollars

CONSTANT DOLLARS

EXHIBIT 16

28 member group	Constant 2013 Dollars			Percent Change		
	Baseline	2012	2013	Base to 2012	2012 to 2013	Base to 2013
Expenses						
Ambulance Transportation	\$295,204	\$124,119	\$90,182	-58%	-27.3%	-69%
Arrests	\$12,988	\$3,795	\$2,700	-71%	-29%	-79%
ER Visits	\$877,291	\$236,245	\$164,919	-73%	-30%	-81%
Hospitals	\$2,586,465	\$1,143,235	\$818,306	-56%	-28%	-68%
Jail Days	\$111,821	\$62,528	\$39,715	-44%	-36%	-64%
Other*	\$118,842	\$21,808	\$24,840	-82%	14%	-79%
Total	\$4,002,410	\$1,591,730	\$1,140,662	-60%	-28%	-72%
Program Costs		\$763,346	\$790,202		4%	
Avg expense per person	\$142,943	\$56,847	\$40,738	-60%	-28%	-72%
Median expense per person	\$127,512	\$27,475	\$11,717	-78%	-57%	-91%
Extrapolated baseline expenses	\$4,002,410	\$4,002,527	\$4,002,410			
Total program expenses		\$1,591,730	\$1,140,662			
Total program costs		\$763,346	\$790,202			
Net savings		\$1,647,451	\$2,071,547			
Average net savings		\$58,838	\$73,984			
Net return		216%	262%			

*Includes: Crisis House, detox centers, homeless shelters, legal assistance, Psychiatric Emergency Response Team

averaged 42. There were a total of 82 arrests in 2010, while the average individual spent 28 days in jail. Usage of other services (including Crisis House, detox centers, homeless shelters, legal assistance, and Psychiatric Emergency Response or PERT) totaled 151 for the 28-member group.

After the first full year of the program, usage of all of these services generally

dropped between 60% and 70%. Further declines generally in the range of 30% to 50% followed in 2013. Only two categories experienced increases in 2013. The number of hospital days rose because of the illness of one individual, while the frequency of public defender time (shown as a part of “Other”) also increased since Project 25 worked with the Public Defender’s Office to have those arrested released to Project 25 with specific conditions in lieu of custody time.

Between 2010 and 2013, all categories of public services exhibited notable reductions. The average number of hospitalizations per year dropped from 10 to 2, or 80%. The average number of days spent in the hospital fell from 46 to 17, a decrease of 63%.

Ambulance rides averaged 5 per individual in 2013, less than one-fourth the 2010 figure. Emergency room visits fell to an average of 13 during the year from 42 in 2010, a cut of 76%. The total number of arrests across the group plummeted from 82 to 18, or 78%, while the average amount of jail time was cut almost in third from 28 days to 10 days. The total usage of all other services was pared by nearly a third from over 150 to less than 100. (See Exhibits 17-18.)

Project 25’s Impact on Total Public Service Usage

NUMBER

EXHIBIT 17

	2010 base	2012	Change from base to 2012 (numeric)	Change from base to 2012 (percent)	2013	Change from 2012 to 2013 (numeric)	Change from 2012 to 2013 (percent)	Change from base to 2013 (numeric)	Change from base to 2013 (percent)
Hospitalizations	289	112	-177	-61%	47	-65	-58%	-242	-84%
Hospital Days	1301	399	-902	-69%	488	89	22%	-813	-62%
ER Visits	1171	367	-804	-69%	278	-89	-24%	-893	-76%
Arrests	82	28	-54	-66%	18	-10	-36%	-64	-78%
Jail Days	773	565	-208	-27%	285	-280	-50%	-488	-63%
Ambulance Rides	620	219	-401	-65%	147	-72	-33%	-473	-76%
Other*	151	79	-72	-48%	96	17	22%	-55	-36%

*Includes: Crisis House, detox centers, homeless shelters, legal assistance, Psychiatric Emergency Response Team

Project 25’s Impact on Average Public Service Usage

NUMBER

EXHIBIT 18

	2010 base	2012	Change from base to 2012 (numeric)	Change from base to 2012 (percent)	2013	Change from 2012 to 2013 (numeric)	Change from 2012 to 2013 (percent)	Change from base to 2013 (numeric)	Change from base to 2013 (percent)
Hospitalizations	10	4	-6	-60%	2	-2	-50%	-8	-80%
Hospital Days	46	14	-32	-70%	17	3	21%	-29	-63%
ER Visits	42	13	-29	-69%	10	-3	-23%	-32	-76%
Arrests	3	1	-2	-67%	1	0	0%	-2	-67%
Jail Days	28	20	-8	-29%	10	-10	-50%	-18	-64%
Ambulance Rides	22	8	-14	-64%	5	-3	-38%	-17	-77%
Other*	5	3	-2	-40%	3	0	0%	-2	-40%

*Includes: Crisis House, detox centers, homeless shelters, legal assistance, Psychiatric Emergency Response Team

viii. Income Effects of Project 25

One of the most significant effects of Project 25 took place on the income side. At the time of enrollment in 2011, only 11 or 39% of the 28-member Project 25 sample was receiving a monthly income. By the end

of 2013, that number had nearly doubled to 20, or 71%, of the total due to the program utilizing the national SOAR model. Either Social Security or SSI remained the source of income for all of the individuals and was secured as information about eligibility was disseminated and explained to all of the Project 25 participants.

Although incomes remained modest, typically amounting to the SSI payment of \$877 per month, the psychological and social impacts should not be understated. The receipt of a monthly check has been a major source of empowerment for these individuals, giving them greater control over their lives. It gives them the ability and the responsibility to make choices, setting the platform for them to need and want to understand budgeting and financial planning. The monthly paycheck surely is also a major force boosting self-esteem and confidence.

ix. Current Status of Project 25's Participants

Of the 36 total individuals enrolled in Project 25 during 2011-12 (including the eight not including in this report's analysis), all but three are still in the program. (Three have passed away from natural causes.) The 33 Project 25 individuals all were housed in their own apartments, have acquired health insurance, and are receiving necessary preventative health care through a community clinic rather than constantly accessing emergency care.

Although 21 of the Project 25 participants have been forced to move at least once because of behavioral issues, all but two have been successful in their second unit. Efforts are under way to secure new housing for these two individuals. Although the pilot period ended, all participants retain their housing vouchers and thus are able to maintain their housing units indefinitely. SVdPV and Telecare are still providing services for those enrolled, but both programs have already graduated certain individuals to a reduced level of support, are preparing others for graduation, and planning for those who may need a more intensive level of care for an extended period of time.

x. Conclusions and Next Steps

Providing chronically homeless and frequent users of public resources with stable and secure housing, combined with a comprehensive and unified set of health and social services, can yield a dramatic reduction in the use and expense of various public services. This has been the conclusion of Project 25 as it engaged the participation of some of the most frequent users of hospitals, emergency rooms, ambulances, and jails in San Diego County.

While caution is warranted in inferring too much from the small sample of individuals covered in the Project and in this report, the results are encouraging and compelling. They also give weight to the Housing First approach, which emphasizes that the chronically homeless can be treated cost effectively after they have been situated in more permanent homes. However, cost savings may differ significantly if those targeted for the intervention are not identified as frequent users of public services. Providing housing and services to the chronically homeless is the right thing to do but from an economic perspective the cost savings realized by Project 25 may not be the same as other efforts addressing chronic homelessness.

Conclusions

The experience of Project 25 provided some important lessons on the keys to success in helping chronically homeless frequent users:

- Time and care must be devoted to finding the appropriate housing for each individual. The first home may not even be successful, but the second typically is.
- A close relationship between the landlord and the program must be established.
- Intensive case management is essential. High intensity of contact is needed early in the program and can decrease as time goes on. Flexibility and a willingness to “do whatever it takes” are also key in providing services to this population. Lastly, staff may need to redefine what success looks like with this population and understand that even things that may seem insignificant to service staff

traditionally can be huge steps forward with this subpopulation.

- Abstinence may not be a realistic first step but can follow after a progression through safer and reduced alcohol consumption. Programs working with homeless frequent users must utilize different approaches to substance abuse treatment, such as Harm Reduction, since some may not be ready or may not ever become sober and free of addiction.
- To effectively deliver health care, case managers must be closely involved. They need to communicate with the doctors, insure that appointments are made, transport patients to and from the medical facility, and sit with the patient during the appointment.

Next Steps

Project 25 yielded dramatic net public savings, but the study was only funded through 2013 and the comparable sample only encompassed 28 individuals. In light of the ongoing problem of homelessness, particularly in San Diego, several recommendations can be made::

1. The program needs to be extended for a number of years to see how these individuals progress. Will their use of public services continue to decline, plateau, or eventually again rise? Will they be able to be successful even with less support? A stable source of funding needs to be established for the program. Medi-Cal Managed Care companies, hospitals, and other County providers of public services could share the cost in proportion to the savings they realize.
2. The program needs to be extended to larger numbers of chronically homeless, first reaching out to other of the most intense users of ambulances, ERs, hospitals, and other public services.
3. Break-even points need to be determined. How many chronically homeless can be accommodated in the program before the net savings are eliminated? Are there any economies of scale that can be achieved? Alternatively, are there diseconomies of scale?
4. As a larger part of the homeless population is brought into the program, the group needs to be analyzed in terms of specific problems and treatment solutions. Do the success rates and net costs of treating individuals differ significantly depending on their specific problem area (e.g., physical health, substance abuse, mental health, victim of domestic violence)?
5. More studies and analysis need to be conducted to determine the optimal models of wrap-around services to be provided to newly housed individuals. What are the cost and benefits of various programs, including those providing intensive case management? Do certain groups (e.g., those with more mental illness) do better with more one-on-one attention than others?

6. Expanding the program to large numbers of chronically homeless could be extremely costly given the importance of intense individual case management indicated in this study. Ways to manage cases effectively, but more efficiently, using advances in technology need to be developed.
7. Analysis of the costs and benefits of in-home versus off-site provision of various services needs to be evaluated.
8. Social Impact Bonds or Pay for Success models could offer a creative and accountable way to provide up-front capital to pay for programs like Project 25 that have demonstrated success in decreasing costs
9. Further studies and analysis are also needed to more definitively determine how much of the favorable results from Project 25 are due to the provision of permanent housing as opposed to the impact of intensive case management and a unified provision of services. Ideally, the cost and benefits of a program providing the same services in temporary versus permanent housing would be compared.

On balance, the evidence from Project 25 is impressive in demonstrating the potential for effectively helping individuals who are among the most problem afflicted in our population, while also substantially reducing their cost burden on society.

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x. Literature Review

Other Studies

Service Use and Cost for Persons Experiencing Chronic Homelessness in Philadelphia: A Population Based-Study

by Stephen R. Poulin, MSW, PhD, Marcella Maguire, PhD, Stephen Metraux, PhD, Dennis P. Culhane, PhD.

November 2010

This study examined service use by chronically homeless individuals in Philadelphia, Pennsylvania over three years between 2000 and 2002. Data was taken from the City of Philadelphia's Office of Supportive Housing (OSH), the Bethesda Project, and the Outreach Coordinating Center (OCC). 2,703 persons exhibited chronic homelessness between 2000 and 2003. Of this total, 2,434 (90%) met the criterion for shelter use only, 151 (5.6%) met the criterion for outreach services only, and 118 (4.4%) met both sets of chronicity criteria. The heaviest user of services accounted for 60% of the total cost incurred, with an average annual cost of \$22,372 per person. On average, a person who was chronically homeless used \$7,455 per year in publicly funded behavioral health, corrections, and homeless services, which totaled approximately \$20 million annually for the chronically homeless population of Philadelphia. Most of this cost was from psychiatric care and jail time. 81% of the persons in the highest quintile had a diagnosis of serious mental illness and 83% in the lowest quintile had a history of substance abuse without a diagnosis of

mental illness. In conclusion, a supportive housing model for people with serious mental illness and chronic homelessness was associated with substantial cost offsets because the use of care services decreased in an environment of housing stability and ongoing support services. But, persons with substance abuse issues and no history of mental health treatment used relatively fewer and less costly services. Cost neutrality for these persons may require less service intensive programs and smaller subsidies.

Ill, Itinerant, and Insured: The Top 20 Users of Emergency Departments in Baltimore City

by Barbara Y DiPietro, Dana Kindermann, and Stephen M. Schenkel

2010

A retrospective study based on a review of administrative records from three emergency departments (ED) within two miles of each other was completed in 2005. The study focused on finding commonalities of the 20 most frequent users of emergency services in Baltimore City. The top 20 users made 2,079 visits in 2005, accounting for 1.3% of the total users of ED. The average age was 48, median age 51. The majority of visits were triaged as moderate or high acuity. The five most frequent diagnoses were limb pain, lack of housing, altered consciousness, infection with HIV, and nausea/vomiting. The most common chronic illnesses were hypertension, HIV infection, diabetes, and alcohol abuse. The most common characteristic of these top 20 users was homelessness, with 18 having contact with homeless services agencies during the year.

The Cost of Homelessness and the Net Benefit of Homelessness Programs: A National Study

by Kaylene Zaretsky, Paul Flatau

December 2013

The study examined programs in inner city and metropolitan and major regions in New South Wales, Victoria, Southern Australia, and Western Australia from 2010 to 2012. The study sought to show that clients of specialist homelessness services were heavy users of non-homelessness services such as health, justice, and welfare services compared to the average Australian population. If the use of these services could be reduced to the non-homeless population levels then government could save an estimated \$29,450 per client/year at 2010-11 levels. Two surveys were conducted: a longitudinal Client Survey, which comprised of a Baseline and Follow-up survey of clients of homeless services and an Agency Survey of agencies and associated services delivering homeless programs whose clients participated in the Base Line Survey. The Follow-up survey was conducted 12 months after the completion of the initial survey and it had a 30% completion rate. This report showed that 81% of respondents considered the support received as very important. Positive outcomes were reported such as more stable accommodations, improvement in health care access, improvement in stable income source, improved social relationships, and an overall improvement in satisfaction with life. The only area where all clients reported minimal change was in relation to employment and financial circumstances.

Overall, the surveyed homeless individuals using non-homeless services were very diverse in terms of their government cost impact. Not all homeless interventions created immediate cost savings. Some interventions created cost in the short term. Nevertheless, on the whole, net savings were generated even in the short term and good outcomes for the vast majority of clients were experienced.

Health Care Utilization of Chronic Inebriates

by Lisa Thornquist, PhD, Michelle Biros, MS, MD, Robert Olander, MA, Steven Sterner, MD

April 2002

Chronic Inebriates accounted for 5.6% of all yearly emergency departments (ED) visits at the Hennepin County Medical Center (HCMC) in Minneapolis, Minnesota. Hennepin County developed three programs aimed at reducing emergency resource utilization. The study was a retrospective observational study of individuals enrolled in programs at the Glenwood Residence, Anishinabe Wakiagun Residence, and the Street Case Management Project in March 1999. The programs included an ethnic- and gender-specific supportive housing program and a program of intensive street case management that was in part patient developed. Glenwood and Anishinabe Wakiagun Residence offered single occupancy rooms. Glenwood did not allow drinking on site but provided a place for residents to “sleep off” intoxication. Glenwood had a doctor who regularly visited the facility to address minor medical issues. Glenwood actively worked to reduce ED visits by talking to residents about the inappropriateness of using ED for minor medical care. Anishinabe Wakiagun Residence allowed residents to drink in their rooms and have visitors, but they could not have guests and drink at the same time. The Street Case Management project began in 1996 with the goal of reducing inappropriate ED and detox services. 92 individuals were in the study. The median number of detox admissions declined from 10 per year to 1. The number of medical visits with the mention of alcohol or injury declined. The number of visits due to illness did not decline. The total median charges for hospital visits declined from \$9,297 to \$5,218 annually.

Impact of the San Diego Serial Inebriate Program on Use of Emergency Medical Resources

by James V. Dunford, MD, Edward M. Castillo, PhD, MPH, Theodore C. Chan, MD, Gary Vilke, MD, Peter Jensen, MD, Suzanne P. Lindsay, PhD, MSW, MPH

2006

A retrospective review of 529 individuals from 2000 to 2003 was completed to determine the impact of a treatment strategy called the San Diego Serial Inebriate Program on the use of emergency medical services (EMS) and emergency department (ED) and inpatient services by individuals repeatedly arrested for public intoxication. Judges offered individuals a 6-month outpatient treatment program in lieu of custody. Of the 529 individuals reviewed, treatment was offered to 268 and accepted by 156. The use of EMS, ED, and inpatient services declined by 50% for clients who chose treatment, resulting in an estimated decrease in total monthly

average charges of \$5,662 (EMS), \$12,006 (ED), and \$55,684 (inpatient).

The Effects of Respite Care for Homeless Patients: A Cohort Study

by David Buchanan, MD, Bruce Doblin, MD, MPH, Theophilus Sai, MD, Pablo Garcia, MD

July 2006

A study was conducted between October 1, 1998 and December 31, 2000 at Cook County Hospital, a 700-bed urban hospital, and Interfaith House, a 64 bed respite care provider in Chicago, Illinois. Homeless individuals suffer from high rates of physical and mental illness and experience mortality rates several times higher than the general population. The homeless are hospitalized more frequently than comparable adults. Homelessness may diminish the long-term effectiveness of the care once they are released from the hospital due to competing priorities (obtaining food, clothing, shelter) and from substance use, diverting attention from follow-up care, compliance with medication, and other physical instructions. While homeless shelter requires homeless people to vacate the premise during the day, respite services provided around-the-clock room and board to the homeless. Homeless individuals that entered into respite care after a hospital stay utilized less hospital care after discharge and cost less than individuals who followed the traditional path after discharge. When health services were analyzed for the 12-month period after hospital discharge, the respite care group utilized 58% fewer inpatient days and had a 49% reduction in hospital admissions. The average length of stay in respite care was 42 days, costing the respite care providers \$79 a day. Therefore, the average cost of respite per hospital-day avoided was \$706.

Effects of a Housing and Case Management Program on Emergency Department Visits and Hospitalization Among Chronically Ill Homeless Adults

by Laura S Sadowski, MD, MPH, Romina Kee, MD, MPH, Tyler J VanderWeele, PhD, David Buchanan, MD, MS

May 2009

Homeless adults, especially with chronic medical illnesses, are frequent users of costly medical services, especially emergency department and hospital services. From September 2003 to May 2006, two randomized controlled trials were conducted at two primary hospital sites: a public teaching hospital and a private nonprofit hospital in Chicago, Illinois. Hospital workers referred patients who were at least 18 years old with at least one of the following medical illnesses: hypertension, diabetes, thromboembolic disease, renal failure, cirrhosis, congestive heart failure, myocardial infarction, atrial or ventricular arrhythmias, seizures, asthma, emphysema, cancer, gastrointestinal tract bleeding, chronic pancreatitis, and HIV. 201 participants randomized to the intervention group received case management services from the on-site intervention social worker, including plans for care to a respite facility. Each participant had contact with his/her on-site case manager at least biweekly. Case managers met weekly to coordinate housing, social services, and medical care needs of the participant. In the control group, 206 participants randomized to the usual care received the usual discharge planning services with no continued relationship after hospital discharge. Typically patients were provided transportation to a shelter. The study showed that 18 months after discharge 583 from the intervention group were hospitalized for a total of 2,635

hospital days and 743 from the usual care group were hospitalized for 3,500 days. There were 787 emergency care visits from the intervention group and 1,154 from the usual care group. Thus, from every 100 homeless adults offered intervention the expected benefits would be 49 fewer hospitalizations, 270 fewer hospital days, and 116 fewer emergency visits.

Hospital Discharge: Safe and Effective Models for People Experiencing Homelessness

by A. Aidala, W. McAllister, M. Yomogida, & M. Shubert

June 2013

In this study, ten hospitals were examined because they provided safe and effective hospital discharge protocol for people experiencing homelessness, which also provided an immense financial benefit for hospitals. Of the ten models reviewed, eight were comprised of staff-housing and/or discharge coordinators, outreach workers, and social care coordinators who were hired by hospitals to work on-site with patients experiencing homelessness. Two models utilized a strong partnership with a not-for-profit organization and had trained staff members from these organizations come to the hospital to work with patients experiencing homelessness to find housing, network, and coordinate services. The ten models in New York, Minneapolis, Chicago, and the United Kingdom demonstrated success in the following ways:

- All ten models noted an increased networking and improved care coordination for patients.
- All ten models noted a substantial decrease in the number of inadequate and unsafe hospital discharges of patients experiencing homelessness, which directly decreased re-admissions to hospitals.
- Seven of the ten models noted a noticeable reduction in the length of stay of patients experiencing homelessness.
- Five of the ten models noted a reduction in spending for hospital care and ER visits.
- Eight of the ten models offered tangible proof that the cost associated with hiring housing or discharge coordination is negligible when compared with the cost savings they provided to the hospital.
- The other two of the ten models illustrated the benefits that can be realized through hospital partnerships with not-for-profit organizations. The not-for-profit does the work of a housing or discharge coordinator at little or no cost to the hospital.

Frequent Users Service Enhancement ‘FUSE’ Initiative: New York City Fuse II Report

by Angela A Aidala, PhD, William McAllister, PhD, Maiko Yomogida, MA, Virginia Shubert, JD

2013

Housing instability/homelessness increases risk for incarceration and, conversely, incarceration increases the risk for homelessness. To address these risks, the Frequent Users Services Enhancement (FUSE) initiative was developed in collaboration with the Corporation for Supportive Housing; The New York City Departments of Homeless Services, Correction, Health and Mental Hygiene, and Housing Preservation and Development; The New York City Housing Authority; and ten non-profit providers of housing and services. FUSE provided supportive housing to roughly 200 individuals who were frequently cycling in and out of jails and homeless shelters. The FUSE model had three core elements: data driven problem solving, policy reform, and targeted housing and services. The study followed 60 individuals in the intervention group and 70 individuals who closely matched the intervention group to serve as the comparison group. The participants in both groups were followed for 24 months.

- At 12 months 91% of FUSE participants had permanent housing. At 24 months the percentage dropped to 86%. 28% of the control group had permanent housing at 12 months and the share increased to 42% at 24 months.
- After 24 months the FUSE participants spent 147 fewer days in shelters compared to the control group. The percentage of FUSE participants who used shelters during the 24 months was reduced by 70%.
- There was a 40% reduction in days incarcerated (19.2 fewer days) for the FUSE participants.
- Drug use for FUSE participants was reduced by half and alcohol use was decreased by one third.
- Crisis care use dropped for the FUSE participants to fewer than 1 ambulance ride (.67 mean) and 4.4 days hospital days. The comparison group had an average of 1.21 ambulance rides and 8.04 days in the hospital.
- Cost was reduced for the FUSE group. Cost for inpatient medical and behavioral services decreased by \$7,308. Cost for shelter and jail was reduced by \$8,372 in a 12 month period and by \$29,208 in 24 months, a 76% reduction. The control group also saw a decrease of 33%.

Frequent Users of Health Services Initiative: Final Evaluation Report

by Karen W. Linkins, PhD Jennifer J. Brya, MA, MPP Daniel W. Chandler, PhD

The Frequent Users of Health Services Initiative (Initiative) was a five-year, \$10 million project jointly funded by The California Endowment and the California HealthCare Foundation. The goal of the Initiative was to promote the development

and implementation of innovative, integrated approaches to addressing the comprehensive health and social service needs of frequent users of emergency departments. The evaluation approach involved three phases: 1) an assessment of the six grants funded during the planning phase, 2) a process evaluation that documented start-up and implementation experiences of the six implementation grants, and 3) an outcome evaluation that tracked interim and long-term outcomes achieved by the six implementation grants. The goal of this outcome evaluation was to examine the impact of the Initiative programs in three areas: 1) individual-level outcomes, 2) emergency department and inpatient hospital utilization and costs, and 3) organizational and community systems of care. This final report represented a summary of findings on the outcomes, accomplishments, and learnings of the Initiative over a three-year grant period. Overall, the programs yielded statistically significant reductions in emergency department (ED) utilization (30%) and hospital charges (17%) in the first year of enrollment. An analysis of clients with two years of data showed modest reductions in inpatient admissions and charges (17% and 14% respectively) and slight increases in cumulative inpatient days (+3%) in the first year of enrollment in the programs. However, second year post-enrollment reflected significant decreases in inpatient admissions (-64%), cumulative days (-62%) and charges (-69%) for all sites. Nearly half (45%) of the frequent user clients enrolled in the six programs were homeless at the time of enrollment. There is a high prevalence of homelessness in the frequent user population and evidence that housing is a critical factor in addressing the health concerns of this population. Overall, clients connected to permanent housing showed greater reductions in both ED use and charges compared to

those who remained homeless or in less stable housing arrangements (a 34% reduction compared to a 12% reduction in ED visits, a 32% reduction compared to a 2% reduction in ED charges).

Project 50: The Cost Effectiveness of the Permanent Supportive Housing Model in the Skid Row Section of Los Angeles County

by Halil Toros, Max Stevens, Manuel Moreno

June 2012

The purpose of this report was to provide the Los Angeles County Board of Supervisors with information on the cost effectiveness of Project 50, a program created by action of the Board and funded by the County's Homeless Prevention Initiative (HPI). Project 50 provided housing and integrated supportive services to the most vulnerable homeless adults previously living on the streets of Skid Row in downtown Los Angeles. Project 50 involved the work of 24 partnering agencies and organizations. For the bulk of the time, Project 50 participants were housed in four single room occupancy hotels located in the Skid Row area and owned and managed by the Skid Row Housing Trust.

The data indicated that the program group's average incarceration costs were slightly over \$10,000 two years before participants entered the program (year 1) and continued to increase to over \$12,000 during the year before entry (year 2). During the first post-program year (year 3), average incarceration costs dropped below \$9,000, and by the second post-program year (year 4) the average costs fell to below \$3,000. The number of incarcerated program group participants fell from 24 to 5 over two years. The yearly average days of incarceration per

participant also dropped from 31 days to 9 days.

The data show that average medical costs for the program group were over \$9,000 two years prior to entry into Project 50 (year 1) and then almost tripled, exceeding \$25,000 during the year prior to entry (year 2). However, over the first year after entry into the program (year 3), average health costs dropped significantly to just over \$8,200, and by the second post-program year (year 4) the average costs decreased by more than half to \$4,000. Mental health costs increased during the program. This could have been due to participants not receiving needed mental health treatment at the beginning of the program and receiving necessary treatment at the by the end. Costs for drug and alcohol treatment increased, and then fell as participants were entered into treatment programs and later no longer needed intense treatment.

The average costs per occupied housing dropped from \$40,758 during the second pre-program year (year 2) to \$25,285 during the first post-program year (year 3), and declined to below \$13,933 during the second post-program year (year 4). The pre-post comparison indicated that the service cost savings yielded through participation in Project 50 are \$15,473 per occupied unit during the first year of the program (year 3). These savings were estimated to increase by almost three times, exceeding \$42,000 by the end of the second year in the program (year 4). During the second year of the program, cost savings increased by 73.37 percent, from \$15,473 to \$26,825.

The analysis of Project 50's cost effectiveness presented in this report showed that the program yielded significant cost offsets through its method of providing housing and services to some of the most vulnerable homeless adults living on Skid Row. This was consistent with the general state of scholarly knowledge on permanent supportive housing. The total service cost savings generated by Project 50 over two years was \$3.284 million. Since the total cost of the program was \$3.045 million, another way to frame Project 50's cost effectiveness is that the program's surplus was \$238,700 over the break-even point.

Where We Sleep: The Cost when Homeless and Housed in Los Angeles

by Daniel Flaming, Michael Matsunaga and Patrick Burns, ECONOMIC ROUNDTABLE

November 2009

The central question investigated in this study is the public cost of people in supportive housing compared to similar people who are homeless. The study encompassed 10,193 homeless individuals in Los Angeles County, 9,186 who experienced homelessness while receiving General Relief public assistance and 1,007 who exited homeless by entering supportive housing. The typical public cost for residents in supportive housing is \$605 a month. The typical public cost for similar homeless persons is \$2,897, five-times greater than their counterparts who are housed. There were six general findings:

- Public costs go down when individuals are no longer homeless.
- Public costs for homeless individuals vary widely depending on their attributes.

- Public costs increase as homeless individuals grow older.
- 69 percent of the savings for supportive housing residents are in reduced costs for hospitals, emergency rooms, clinics, mental health, and public health.
- Higher levels of service for high-need individuals produce higher cost savings.
- One of the challenges in addressing homelessness is housing retention – keeping individuals who may well be socially isolated, mentally ill, and addicted from abandoning housing that has been provided for them.

Recommended solutions are to link housing strategies to cost savings, strengthen government-housing partnerships, leverage resources, improve retention rates for individuals in supportive housing, increase the supply of supportive housing, and produce information for developing comprehensive strategies and better outcomes.

Building a Better Economy: A Habitat For Humanity Economic Impact Study

by Paul Hendershot, MS, Erin Wood, MPA, Joseph Farmer BA

2010

Dallas Area Habitat for Humanity (DAHfH) generated millions of dollars of economic activity and supported hundreds of jobs. This study analyzed the economic impact DAHfH spending and partner households had on the region. Every dollar DAHfH spent generated \$3.18 of economic activity. From 2004-2009, DAHfH invested \$6.2 million in capital expenditures (building, land, and improvements). This spending generated \$10.2 million in economic activity and 61 jobs paying over \$3.7 million in wages. Spending by existing DAHfH households produced \$29.1 million in annual economic activity while maintaining 200 jobs in the region. In 2009, DAHfH operations generated \$33.5 million in economic activity, created 265 jobs and \$1.0 million in state and local taxes. Over the next five years, DAHfH expected to build over 550 additional homes. Once completed, these households would provide an additional, ongoing economic impact. The primary focus of DAHfH was the construction of new homes for households who would otherwise not have the opportunity to become homeowners. The current literature indicated that children raised in owned housing are far more likely to be well-adjusted and well-rounded members of society (Green & White, 1997). The four primary direct methods by which parental homeownership benefit children are:

- **Parenting practices:** Parents who own a home deliver an emotionally stable and more stimulating learning environment for their children, which significantly improves cognitive ability and diminishes behavioral problems.
- **Physical environment:** Owned homes tend to provide more space for physical activity and increased privacy.
- **Residential mobility:** Studies indicate that moving may disrupt the emotional development of a child. A lack of stability at home tends to harm a child's educational outcomes.

- **Wealth:** Owning a home provides financial stability for the household.

Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients

by Daniel Flaming, Susan Lee, Patrick Burns Gerald Sumner

September 2013

This study evaluates outcomes from April 2011 to May 2013 for 163 hospital patients screened by the 10th Decile Project in Los Angeles, which works with hospitals to identify the 10 percent of homeless patients with the highest public and hospital costs – the 10th decile – and provide immediate services for placing these individuals into permanent supportive housing. As of May 2013, 163 formerly chronically homeless individuals had been screened, 131 individuals were found to be in the 10th decile, 89 had been enrolled in the 10th Decile Project, 36 had moved into permanent supportive housing, 22 were still receiving frequent help to manage the process of stabilizing their lives, and 5 had been placed in other types of permanent housing. These interventions resulted in avoidance of significant public and hospital costs.

For the 10th decile patients studied in this evaluation who obtained housing, total annual average public and hospital costs per person are estimated to have decreased from \$63,808 when homeless to \$16,913 when housed – excluding housing subsidy costs. Total health care costs, including jail medical and mental health care, are estimated to have declined an average of 72 percent, from \$58,962 to \$16,474 per person. On an annual average, emergency room visits decreased 50 percent, hospital admissions decreased 71 percent, and inpatient days decreased 84 percent. The most difficult

problem facing the 10th Decile Project is lack of access to permanent supportive housing and extended delays in obtaining housing subsidy vouchers that enable patients to pay rent. Broad housing solutions are needed to increase the supply of permanent housing and reduce time waiting to get into that housing. The following actions are recommended:

- Make more existing project-based permanent supportive housing units available to 10th decile renters.
- Convert tenant-based Section 8 vouchers into project-based vouchers that will provide the financial backbone for converting existing rental complexes into project-based permanent supportive housing sites.
- Make 10th decile individuals a top priority for tenant-based housing subsidies.

Additional recommendations are: increasing the engagement rate, increasing the housing rate, and implementing system improvements in hospitals.

2014 San Diego Regional Homeless Profile

Summary Results from the San Diego Regional 2014 Point-In-Time Count

September 2014

On January 23rd, 2014 the 2014 San Diego Regional Homeless Point-In-Time Count was conducted. The count revealed a number of 8,506 homeless persons in all of San Diego County. 3,985 of these persons were unsheltered, in locations not meant for human habitation. 1,179 persons were in an emergency shelter, while 3,291 were staying in transitional housing and 51 located in a Safe Haven.

Emergency Housing provides temporary overnight housing, typically with a 90 day maximum stay. Transitional housing is a longer-term solution, providing shelter for up to two years and strives to transfer residents to a more stable and permanent housing option. Safe havens serve homeless people with severe mental illnesses and encourage clients to enter into a supportive service. 36% of homeless adults suffer from Severe Mental Illness and 19% are considered Chronic Substance Abusers. 20% of the homeless population is compiled of veterans, including sheltered and unsheltered.

According to the U.S. Census Bureau's estimate of 3.2 million San Diego Residents, 0.3% of the population was recorded homeless in January 2014. The total homeless population has decreased by 5.7% since 2011. It is estimated that 24% of homeless people are a member of a homeless family, including both adults and children. The purpose of this study was to obtain a snapshot of the homeless population on any given night. The three main components of the Point-in-Time Count are:

1. Sheltered Count on the same night as the Street Count--enumeration of the sheltered homeless persons.
2. The general street count between the hours of 4:00am-7:00am--enumeration of unsheltered homeless persons.
3. The unsheltered survey in the weeks following the general street count--extrapolates the general characteristics of the unsheltered homeless.

The data resulted in two distinct categories of homeless: sheltered and unsheltered. This study is important in determining funding for the necessary services to reduce the effects of homelessness in San Diego County.

The Ratio of Costs to Charges: How Good a Basis for Estimating Cost

by Michael Schwartz, David W. Young, Richard Siegrist

1995-1996

RVUs- Relative Value Units

RCCs-Ratio of Cost to Charges

DRG- Diagnosis-related Group

This study evaluates the accuracy of costs derived from the ratio of costs to charges (RCCs) using cost based on relative value units (RVUs) as the "gold standard." RCCs are used by health policy analysts and those making managerial decisions by using the ratio of cost to charges to adjust charges. Under the RVU approach, each item consumed in a department is assigned a value to reflect its relative costliness compared to the department's baseline cost. RCC estimated costs were compared to RVU estimated costs for three types of analysis: 1) estimating individual patient costs, 2) estimating average costs per DRG, and 3) comparing costs in a DRG in a particular hospital to the average costs of patients in that DRG in a group of hospitals. Data was collected on all patients discharged from seven hospitals. Data from six hospitals was

from the 1988 fiscal year and from the 1989 calendar from one hospital. Of the seven hospitals, two were from the West Coast, one in the Southwest, one in the Midwest, and three in New England. The study showed that RCCs were not a good basis for determining individual patient costs. However, when examining costs per DRG the RCC was a better estimate with costs within 10% of the average RVU calculated costs with patients in the same hospital. RCCs were even more reliable when comparing a DRG from one hospital to the average cost of patients in that DRG in a group of hospitals.

Articles

The Housing First Approach

by United States Interagency Council on Homelessness

November 2006

The goal of the Housing First Program is to offer permanent housing as quickly as possible for people experiencing homelessness. This is especially related to people who have long histories and co-occurring health challenges. Income, sobriety, and/or participation in treatment or other services are not required to receive housing. Housing First works to minimize barriers to “screen in” people with significant challenges who might be screened out of housing because of poor credit or prior evictions. Good relationships with landlords and good communication are key to a successful scattered site Housing First program. Services are flexible and individualized and service providers endeavor “do whatever it takes” to help the person or family find housing stability. In Seattle, the Downtown Emergency Service Center operates a site-based permanent supportive housing program (1811 Eastlake), using a housing approach for men and women with chronic alcohol addiction. Results demonstrated by the program include high rates of housing retention and stability in housing. Housing first programs for adults experiencing chronic homelessness have demonstrated substantial savings in public costs for hospital care, sobering centers, shelters, ambulance services, jails, and other services.

The Hot Spotters: Can We Lower Medical Costs by Giving the Neediest Patients Better Care?

by Atul Gawande

January 2011

Jeffrey Brenner began analyzing hospital data in Camden, New Jersey in 2002. He began to focus on the people whose medical care was the highest to see what could be done to help them. He believed that helping them would also lower health care costs. In 2007 Brenner began working one-on-one with patients to improve their health through frequent monitoring, home visits, and assistance obtaining the correct medicines. Over time he was able to expand his practice by hiring a nurse practitioner and a social worker by obtaining grant money. The article proceeds to share various success stories from his approach of giving the neediest patients the highest quality of care. In 2009, Brenner was able to measure long-term effects on

its 36 highest hospital utilizers, finding that there was a 40% reduction in hospital visits and a 56% reduction in hospital bills. The article continues on with an explanation of Atlantic City’s Special Care Center, a clinic created to address the health care issues with a casino workers’ union and of a hospital. The Care Center focuses on the workers with the highest medical expenses. The patients paid a flat fee for frequent interaction with the medical staff. Preliminary findings of a study comparing Special Care Center patients with a similar population of casino workers in Las Vegas showed a 25% drop in costs. These types of programs face obstacles due to Medicare laws, political resistance, and lobbyists from medical industries.

Frequent Users of Public Services: Ending the Institutional Circuit

by The Corporation for Supportive Housing

2009

The Corporation for Supportive Housing assembled leaders from the health, corrections, and housing fields for a National Frequent Users Forum. The goal was to strategize how to support innovative models of care and work models that were needed to change the health care system to better address the needs of “frequent users” of the health care system. Frequent users were defined as a small group of chronically homeless individuals whose health and mental health needs placed them at high risk of repeated, expensive, and avoidable engagement with corrections and crisis care systems. Frequent users often had overlapping mental and physical health problems that were not adequately addressed when they entered emergency care or correctional facilities, and they accounted for a disproportionate share of cost and time. Coordinating service

delivery of housing, addiction and health treatment, and reentry from prison was difficult because each sector focused only on their clients with very little interaction with other services. Participants of the forum agreed that collecting and analyzing data across systems was critical. A growing body of research showed that targeted interventions that employ cross-system strategies could interrupt repeated rounds of institutional and emergency care. Several of the core components of effective service strategies were:

- Assertive outreach and in-reach into institutions to establish trust, build relationships, create connections with providers.
- A concentrated “dose” of individual support after initial engagement.
- Access to affordable and supportive housing.
- Connection to a range of services and integrated care.
- Practical and sustained support to meet basic needs and respond to preferences and goals.
- Trauma-informed services that restore hope.
- Harm reduction and enhanced motivation to change harmful/risky behaviors.
- Forum participants agreed that access to safe, affordable, and appropriate housing is the most important element in successful programs.

The Cost of Homelessness: A Perspective from the United States

from the Selected Works of Dennis P. Culhane

January 2008

There are beliefs and evidence to support that the cost of permanently housing the homeless is cheaper per night than the cost of a shelter cot, hospital bed, or prison. These views have not always been accepted. Cost analysis efforts that came from local planning organizations throughout the U.S. had a substantial impact on policies at the national and local level, gathering resources for permanent housing solutions. Previously, the homeless were invisible in the health care system because healthcare payment systems did not identify if a hospital user was homeless. Research on service utilization of the homeless has begun to allow agencies to learn to what degree their clients are homeless and what service (or lack thereof) contributes to homelessness. The introduction of more integrated database research has given cities the ability to identify the cost of homelessness and the cost of intervention. Cities saw that there was a decrease in cost in services when homeless are given supported housing.

On the other hand, research has shown that not every study has shown that the homeless are costly services users. As research demonstrated in Texas, the mentally ill homeless utilized fewer services than the regular population through emergency care or insured services. There may well be substantial regional variations in the U.S. with regard to availability and accessibility of services. Since 2003, localities around the U.S. have seized on the concept of a “cost stud” of homelessness with an effort to end chronic homelessness. Many of these studies would not meet a scientific peer review standard due to their sampling limitation in focusing on the homeless with no control group, but the intent of the studies were not to produce academic research but to mobilize political will and local action. The research completed in the U.S. could be used in other countries that are struggling with homelessness.

The Real Cost of Homelessness: Can We Save Money by Doing the Right Thing?

by Gaetz, Stephen

2012

A 2012 article out of Canada looked at the issue of whether it was more cost effective to house people and/or prevent them from becoming homeless in the first place than to let people live in a state of homelessness, relying on emergency shelters and day programs. In 2007, the average cost of homelessness in Canada was \$4.5-\$6 billion for community organizations, government, and non-profit emergency services. People who were homeless for an extended period saw a decline in their physical and mental health. The homeless did not suffer from different illnesses as the regular population, but since there were higher barriers to accessing health services they had much higher chances to have various diseases, such as Hepatitis C, heart disease, cancer, asthma, and arthritis. The homeless relied on emergency services that were more costly than receiving regular services. In Canada, one of five prisoners was homeless when they were incarcerated and were in custody for a little over two months. Some research suggested that the average annual cost to house a male is \$106,583. Criminalizing homelessness cost Toronto Police Services over \$900,000 in the past 11 years while

only \$8,086 in fines were paid. Research showed that preventing homelessness by providing housing and health services is more cost effective.

Million Dollar Murray (Article from the New Yorker) www.gladwell.com

by Malcom Gladwell

February 2006

In 1998 Boston College Graduate, Dennis Culhane lived in a Philadelphia shelter for seven weeks as part of his research for his dissertation. He went back a few months later and was surprised to discover that none of the same people were in the shelter. Culhane put together a database to track who was coming in and out of the shelter. This research showed that homelessness did not have a normal distribution as previously thought. It had a power-law distribution, where all activity was not in the middle, but at one extreme. In this case, 80% of the homeless using the Philadelphia shelter were in and out quickly, with the common length of time being one day. 10% were episodic users, staying for three weeks at a time and returning periodically. The final 10% were chronically homeless, often living in shelters for years at a time. The chronically homeless used enormous sums of money in hospital care. Culhane saw that the money it would take to solve homelessness could be less than the money it took to ignore it. In 2002, President Bush appointed Philip Mangano as the director of the U.S. Interagency Council on Homelessness. Mangano traveled across the U.S., educating local governments on the real shape of homelessness. Mangano worked with Denver on their homeless problem and offered the homeless free apartments because the cost to the city of the apartment was less expensive than the cost of emergency and medical services. While this did not fix the problem, it was a way to contain the problem.





POINT LOMA
NAZARENE UNIVERSITY

(619) 849-2200

3900 Lomaland Drive, San Diego, CA 92106

pointloma.edu
