The Chicago Housing for Health Partnership: A program model for homeless adults with chronic medical conditions

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ABSTRACT

Homeless adults with chronic medical conditions are reported to use high medical and social service use. Despite this high use, this subgroup has poor health outcome and high mortality rates and is costly to treat. Lack of stable housing is a factor that contributes to their difficulties in disease management. Yet, supportive housing interventions for the homeless have targeted primarily homeless adults with severe mental illness and co-occurring substance use disorder. This paper describes a “Housing First” intervention model targeted specifically to homeless adults with chronic medical illnesses. A randomized clinical trial evaluating the effectiveness of intervention found it to be effective in reducing hospitalizations and emergency room visits. In this paper, we provide an overview of the Housing First model followed by a description of model’s development, its intervention components and implementation. This intervention model is that supports the benefits of providing housing support for chronically ill homeless adults and has significant policy implications.
INTRODUCTION

It is well documented that homeless adults have higher rates of medical illnesses than the general population. Rates of chronic medical problems reported among homeless adults range from 31 to 46% (Robertson & Cousineau, 1986, Burt et al, 1999; Zerger, 2002). Prevalence rates of specific chronic medical conditions vary. High prevalence rates of HIV (Burt et al 1999), hypertension (Luder, et al, 1990; Roper & Boyer, 1987), and latent TB infection (Zolopa, et al, 1994; McAdam et al, 1990) have been consistently reported.

Research by Hwang, et al (1998) found that the presence of chronic medical conditions increases the risk of death among homeless. Homelessness among adults with HIV/AIDS was also associated with higher mortality rates (Lieb, et al, 2002). It’s has been reported that homelessness adults living with HIV/AIDS may have a lower likelihood of receiving prophylaxis for opportunistic infections and receiving highly active antiretroviral therapy than the general HIV population (Bangsberg et al, 1997; Moss et al. 2004). It has been suggested that the absence of adequate and stable housing increases the difficult in the management of chronic medical conditions is difficult.

In addition to poor health outcomes and high mortality rates, this subpopulation homeless individuals also high use of Adults living with HIV/AIDS who are homeless are reported to have higher rates of emergency department use and high hospital admissions (Smith et al, 2004; Masson et al, 2004). The multiple problems that this population experience creates barriers in accessing ongoing medical care and social service support. As a result, the overall cost to society is high.
Despite the documented poor health outcomes and high use of medical and social service use among homeless adults with chronic medical illness, there is limited intervention research that focuses specifically on this vulnerable population. The research conducted to date has mixed results. Only two studies have been conducted that show positive health outcomes and reduced health service associated with using housing and case management interventions (Culhane, et al, 2002; Tsembris, 2004). There is an absence of published literature on permanent housing interventions for homeless adults suffering from chronic medical illnesses nor is there empirical research evaluating effectiveness.

To address this gap, a multi-disciplinary group of health care, respite care, and housing providers came together to develop the first supportive housing intervention specifically targeted to homeless adults with chronic medical conditions. The intervention entitled, The Chicago Housing for Health Partnership (CHHP), is modeled after a “Housing First” approach. This approach has been used successfully with homeless individuals with severe mental illness. Our model uses the same basic approach but aims to reduce health service costs for chronically ill homeless adults. Since the model has never been tested on subpopulation, a rigorous outcome evaluation of the model was conducted. The evaluation, which used a randomized controlled trial design, found the model to be effective in reducing hospitalizations and emergency room visits comparing those randomized to the CHHP program to “usual care” as the comparison group (Sadowski, Kee, VanderwWeele and Buchanan, 2009).
This paper (1) provides an overview of the Housing First approach; (2) describes the development of the CHHP program model; 3) identifies the core program elements of the intervention and 4) discusses its implementation.

Housing First Model

Our the past 25 years there has been increased interest in the use of permanent supportive Housing models as an option to assist homeless individual to access housing support. In 1987, congress passed the McKinney-Veto act is designed to offer a variety of housing options to help “promote the provision of supportive housing to homeless individual to help them to live as independent as possible. Programs developed were also required that programs developed assist with accessing appropriate supportive services (McKinney-Veto act, 1997). As a results, different models of supportive permanent housing models emerged including the development of the “Housing First” model.

The Housing First model was designed to address the needs of homeless adults with serious mental illness (Tsemberis, 1999). It was developed in response to the recognized limitations of other housing models. The model was developed by Pathways to Housing in New York City in 1992, based on the premise that housing is a basic human right. The underlying theoretical foundation places an emphasis on consumer choice, access to supportive services and the use of harm reduction approaches (Tsemberis, 1999). The Housing First model does not require treatment or sobriety as a condition for entering or retaining permanent housing.

The distinguishing features of this model include: 1) direct or nearly direct placement in permanent housing; 2) access to supportive services without required participation in treatment to retain housing; 3) outreach to engage and offer housing to
homeless adults; 4) use of low demand approach to accommodate client level of readiness and address their high risk behaviors so that relapse will not result in loss of housing; and 5) ongoing case management to hold housing even if clients temporarily leave program housing (HUD, 2007). A growing body of research supporting the models effectiveness has emerged.

Tsemberis, Gulcur and Nakae (2004) found that the individuals receiving the intervention condition were housed quicker, remained stably housed and reported higher perceived consumer choice in comparison to participants in traditional sobriety based housing programs. Use of substance abuse treatment services was also significantly higher than the comparison group. However, no differences in substance use or psychiatric symptoms were found. A recent exploratory study commissioned by the Department of Housing and Urban Development evaluated 3 distinct programs using the Housing First model and found that they positively impacted housing stability (HUD, 2007).

Other recent studies have shown benefits to society Kidder et al ( ) found that providing housing to HIV+ homeless can reduce incidence of risky sexual behavior which can impact the risk of HIV transmission. Also, a study evaluating the association of a “Housing First” intervention for chronically homeless individuals with severe alcohol problems found significant cost savings and reductions in alcohol use for housed individuals over the course of the year (Larimer, Malone, Garner, et al, 2009) This promising research helped motivate

DEVELOPMENT OF THE CHHP PROGRAM MODEL
In the 2002, housing advocates, administrators, providers, consumers and researchers in the field developed and conceptualized the CHHP model. The group was guided by input from multiple sources. The principles outlined in the Chicago 10-Year Plan to End Homelessness (Chicago Continuum of Care, 2002) also were considered. The Chicago plan promotes a “Housing First” approach model for ending homelessness. A literature review conducted by the staff of the National Health Care for the Homeless Council, found no similar permanent supportive housing interventions or research studies that targeted homeless adults with chronic medical conditions. The developers of the CHHP model were also inspired by the experiences of local area respite care providers at Interfaith House, a specialized shelter and respite program on Chicago’s Westside, and Finally, Findings from the New York/New York Study that described significant cost savings when homeless adults with chronic mental illness were placed in permanent supportive housing units. (Culhane et al 2001).

From 2002 to 2007, CHHP served as a community based collaboration between 15 healthcare and housing providers (3 hospitals, 3 respite program providers, and 9 providers of permanent supportive housing) in the Chicago area. Leadership from these organizations formed the oversight committee for the project. These organizations have decades of experience providing services to homeless people with chronic medical illnesses and had recognized the need for research on the effectiveness of permanent supportive housing and intensive case management among this population.

The partnership succeeded in securing over $4.5 million in funding over a 4-year period from the U.S. Department of Housing and Urban Development (HUD) through its Supportive Housing Program (SHP) and its Housing Opportunities for People with AIDS
Special Projects of National Significance (HOPWA/SPNS). The HUD funding covered most of the needed rental subsidies and intensive case management services, as well as a portion of the costs for the management information system for the project. Support from private foundations provided the funds needed to fund the outcome evaluation.

**CONCEPTUAL FRAMEWORK**

CHHP is grounded in a “Housing First/Low Demand” approach. The underlying assumption that drives the model is that placement in supportive permanent housing combined with a fully integrated medical and social service case management system will improve housing stability, improves health outcomes and reduce service costs for this population. The model is designed to be highly responsive to the diverse needs and preferences of its target population, and intensive case management services and to flexibly address existing gaps in the continuum of care by building housing and service capacity where it is most required.

The four primary intervention components of the model are: 1) Placement in permanent supportive housing; 2) Systems level integration and coordination using a lead agency and programs level integration and coordination activities (a multi-agency collaboration model); 3) intensive case management using a Systems Integration Team approach (hospitals, respite programs and supportive housing); and 4) Provision of ongoing intensive case management services.

*Placement into CHHP Supportive Housing*

Access to and placement into stable housing as quickly as possible is the central component of the CHHP model. Permanent supportive housing is defined as long term housing with wrap around supportive services provided by CHHP Stage 3 case managers.
working for a partner housing agency. Four types of Stage 3 supportive housing units are made available: scattered site/sobriety based; scattered site/ harm reduction; project based/harm reduction and group living/sobriety based. Specific placement sites include group living arrangements; scattered-site apartments units; single room occupancy (SRO) units; specialized housing for women; housing for persons with HIV/AIDS; and housing for individuals with mental illness/substance abuse are available.

The model also anticipates that permanent housing would not be immediately available after discharge from the hospital, so it includes the availability of short term interim housing. Interim housing was defined by the Chicago Continuum of Care in 2002 as a form of transitional housing that provides immediate short-term housing and serves as a portal to permanent housing services. As a goal, interim housing participants were to stay in those facilities no longer than 120 days. The CHHP interim housing programs were also to provide a number of medical supports and psychosocial services.

Systems and Programs Integration and Coordination

The formation and maintenance of CHHP integrated and coordinated systems of care is designed to facilitate primarily access to permanent supportive housing in a shorter time and within an expedited process, especially when compared to the traditional Chicago housing placement. Research, provider and consumer experience in 2002 suggested that the homeless population discharged from area hospitals were most likely to face a fragmented service system. A number of providers were not able to respond to clients’ needs due to system level barriers including lack of opportunities to collaborate or coordinate care and case managers having to manage unrealistic high client caseloads. To be effective, health care, shelter and housing providers needed to develop or piece
together a formal system of referrals and service collaboration with one another. The CHHP model aimed to provide the needed mechanisms to reduce these systemic barriers providers and consumers were encountering.

The CHHP model was designed to integrate and coordinate systems at two levels of agency leadership: the executive and program directors levels. The two levels of intervention activities were to involve CHHP governance and program oversight collaborative activities and structures.

Governance activities were defined as those aimed at maintaining communication, collaboration and coordination among CHHP agencies and institutions. This included a number of structured CHHP gatherings: annual peer reviews, quarterly governance council meetings, and convening a monthly consumer committee. Program oversight activities were defined as those occurring at the program directors’ level to ensure that agencies were agreeing on needed common practices, following the implementation protocols and meeting all required contractual obligations. This included monthly oversight meetings, annual site agency visits by CHHP staff and ongoing interagency communications.

Systems Integration Team (SIT)

In the Chicago homeless care system in 2002, housing and support services were often scattered and fragmented across distinct agencies, and case managers were often expected to assist clients to access and navigate services across agencies and systems of care. To better facilitate the delivery of housing and case management services to the CHHP intervention homeless population, CHHP developed a systems integration model for the delivery of intensive case management services.
The model adopted a team approach to providing intensive case management services. The decision to use a team model was informed by research suggesting that a team approach has a number of advantages over individual case managers working alone. Teams make better use of resources, overcome fragmentation and promote improved individualized care; teams arrive at more complete patient profiles and engender feedback and mutual support (The National Health Care for the Homeless Council, 2001).

Participants were to be matched with agency based case managers at each stage of the CHHP service continuum: hospitals, respite care programs, and permanent supportive housing. The System Integration Team (SIT) was designed to consist of three specialized intensive case management sub-teams: Stage 1 was a hospital care sub-team; Stage 2 was a respite care / interim housing team; and Stage 3 was a permanent supportive housing sub-team (See figure 1). Each SIT case manager is to maintain an average caseload of 10 participants at any one time. Together as an SIT, the case managers were to jointly case conference approximately 30-40 of their clients during their weekly meetings under the guidance of a full time CHHP coordinator.

(Insert Figure 1)

The SIT meetings also were to provide the opportunity to coordinate and integrate services across hospital, respite care / interim housing and supportive housing systems. Besides the weekly case conferencing of clients, the meetings were designed to provide the CHHP case managers with the opportunity of joint consultations, trainings and team
building activities. The SIT was also to continue to support and monitor the needs of the participants until the individual was able to become self-sufficient.

The first stage of service is to occur at the partner hospitals. The hospital sub-team consisted of CHHP case managers stationed at the three partner hospitals. Once eligibility would be established and the CHHP research team had assigned participants to the intervention group, the CHHP hospital case manager was to orient the participant about the SIT services. The hospital case manager would contact the Stage 2 case managers to expedite and coordinate the participant’s hospital discharge. The Stage 1 hospital case manager has responsibility to educate participants about disease progression and symptoms, as well as disease management techniques.

Upon arrival to Stage 2, participants begin to work with their new CHHP case manager who functions as their primary case manager while awaiting housing placement. The case manager had the responsibility to conduct a full psychosocial assessment and develop a personal service care plan based on participant needs. While in Stage 2 housing, the case manager would work with the client to find the needed supportive housing with the appropriate CHHP partner agency. Housing placement needs are to be identified and coordinated during SIT meetings.

Once a CHHP participant is placed in permanent supportive housing, a Stage 3 case manager would take over as the new primary case manager. The case manager was to work with the participant to refine and update the personal service care plan and psychosocial assessment on an ongoing basis. The CHHP case manager would work to support the participant to remain stably housed and move toward self-sufficiency. A key component in developing independent living skill is the requirement of tenants paying
their portion of the rental payments on a monthly basis. CHHP participants would be expected to pay no more of 30% of their income for rent and utilities. Finally, all participants were to be linked with primary and ancillary health care services. These services were to be provided through the CHHP project partners or ancillary services and participants’ medical status was to be monitored by their case manager.

*Provision of Intensive Case Management Services*

As mentioned in the previous section of the conceptual framework, intensive case management is to be provided across the intervention. A review of case management practice and research emphasized the importance of establishing and maintaining linkages to mainstream services (Morse, 2002). Case managers were to help participants to access mainstream resources and coordinate and adhere to their service plan. Specifically, they are to help participants negotiate the multiple and fragmented medical and social service systems and, if need be, serve as the primary advocate for the participant.

The case managers are to be their first and primary connection to needed supportive services. In order to strengthen and build a trusting relationship, intensive case managers maintain regular contact with CHHP participants with a minimum of two contacts per month. SIT case managers were to maintain a 10 to 1 ratio of participant to case manager throughout each stage of the CHHP project continuum. This low caseload would allow for the intensive case managers to have the necessary time to provide the high intensity case management services as well as to be available for participants in event of an emergency.
Finally, intensive case management service provision would use the program management information system to track and integrate service delivery across the partner agencies. At each stage, intensive case managers were to document the three types of case management service contacts: face to face, phone, and collateral. They were to document the following primary case management activities: assessments, planning linkage, monitoring, crisis intervention, participant advocacy and outreach.

**ASSESSMENT OF PROGRAM MODEL FIDELITY**

To supplement the formal outcome evaluation of the CHHP program model, a year long process evaluation of the CHHP model was conducted in 2006 (George, 2007). This qualitative process evaluation by the University of Loyola Center for Urban Research and Learning (CURL) used a multi-method approach that included key stakeholder interviews, focus groups, document analysis and observation. The evaluators identified and examined key program structures and processes across the different levels of the intervention. The key findings of the report highlighted the importance of the duality of CHHP structure. They were able to discern that the “CHHP mission is accomplished through the overarching processes: the coordination of the intensive case management and the coordination of provider resources. These processes are translated into two key structures: the system integration team (SIT) and the lead agency model” (George, 2007). The evaluation also found that key strengths of the project were its strong coordination and leadership from the lead agency and maximizing the expertise and skills of the partner agencies.

*Systems and Programs Integration and Coordination*
Throughout the development and implementation of the project, systems and programs level integration and coordination activities occurred consistently. At the macro systems level, four annual peer review meetings were held, as well as 17 quarterly governance council meetings in the 4-year project period. At the program level, 33 program oversight meetings were held; and each of the partner agencies were formally visited annually to assess grant compliance and technical assistance needs. Records indicate that meeting attendance by stakeholders at this level was consistently high, usually at 80% or more.

*Systems Integration Team*

The facilitation of the SIT meetings was another central intervention component that reflected a key process activity. The SIT also provided strong communication and coordination across the three stages of the intervention. The CHHP coordinator and case managers strongly adhered to this central component of the design. Over the intervention period, every year a total of at least 33 SIT meetings were held for a total of approximately 142 hours of care coordination. The SIT meetings also provided a forum to provide case supervision and formal training. Over the four year intervention period, SIT case managers received at least 72 hours of training on an annual basis. Finally, the SIT meetings allowed time for case managers from the CHHP agencies to build solid working relationships with one another.

*Placement into CHHP Supportive Housing*

The average number of housed days for all CHHP intervention participants during the 18-month study period (518 days) was 264 days or 51%. During the 18 months, 10% of the housed time (48 days) was spent in stage 2 respite/interim housing, and 41% (216
days) was spent in permanent supportive housing. The majority of intervention participants accessing permanent supportive remained housed. Intervention participants were placed in their permanent supportive housing units on average 71 days after being enrolled in the study at the hospital.

_Provision of Intensive Case Management Services_

Intervention participants received an average of 56 case management service encounters over the 18 month intervention period. Of those, 53% were face to face, 20% were phone and 27% were collateral encounters. Case managers maintained regular contact with the majority of intervention participants. Not surprisingly, case management service contacts were higher during the first 9 months of the intervention period then leveled off, but remained consistent over the intervention period. The bulk of the coordination activities occurred during the weekly SIT meetings.

CONCLUSIONS

The Chicago Housing for Health partnership was successful in developing a comprehensive system of health care, housing and supportive services. As a structural intervention, it targeted two key structural barriers (service systems fragmentation and housing) and also offered individualized client level support within a more coordinated delivery system than existing usual care practice. The intended systems, programs and providers level coordination and integration activities were adhered to throughout the intervention period. The majority of intervention participants received both housing and intensive case management services suggesting high program engagement and intervention exposure.
References


The Urban Institute. (2002). Preventing homelessness: meeting the challenge. Washington, DC.


FIGURE 1 SIT Model

CHICAGO HOUSING FOR HEALTH PARTNERSHIP SYSTEMS INTEGRATION TEAM MODEL

AIDS Foundation of Chicago (Lead Agency – Systems Coordinator)

CASE MANAGEMENT ACTIVITIES

STAGE 1 - HOSPITAL
- Participant identification and screening
- Intake
- Expedited hospital discharge
- Intensive case management begins
- Education on disease management

STAGE 2 – INTERIM HOUSING
- Psychosocial assessment
- Respite care services
- Intensive case management
- Housing First strategy implementation

STAGE 3 – SUPPORTIVE HOUSING
- Wrap-around, intensive case management services
- Rental assistance
- Skills training
- Linkages & referrals to health services
- Advocacy services

Hospital Sub-Team
Stroger Hospital • Mt. Sinai Hospital
West Side VA Hospital

Interim Housing Sub-Team
Interfaith House • Franciscan Shelter • Deborah’s Place

Stable Housing Sub-Team
AIDSCare • Chicago House • Chicago Christian Industrial League • Vital Bridges
Featherfist • Housing Opportunities for Women • Heartland Human Care Services
Mercy Lakefront Supportive Housing • Lawson YMCA
Christian Community Health Center

Intensive Case Management