Systems Change Collaborative
Meeting #3
1:30 pm – 3:00 pm

Welcome

The third Systems Change Collaborative meeting was kicked off by Colleen Mahoney, a Senior Policy Analyst at the Chicago Department of Public Health. Colleen began by re-orienting everyone with the purpose of this Collaborative.

The Systems Change Collaborative is convened by the Chicago Department of Public Health and hosted with the Illinois Public Health Institute and Wilburn Strategic Solutions. The Collaborative was built to bring together stakeholders and allies to look at expanding high quality and comprehensive care for people experiencing homelessness and those transitioning into housing through a focus on the following:

i. Benchmarking standards of care
ii. Disseminating best practices
iii. Identifying common needs
iv. Advocating collectively for policy and system changes

The COVID-19 pandemic has shown how closely systems worked than ever before and the convening of this collaborative is to continue this momentum and increase collaboration between homeless services and advocates, public health, and healthcare communities in order to improve health equity for Chicagoans experiencing homelessness.

Colleen reviewed the meeting's agenda and meeting objectives, timeline, and group norms.

Mission Moment

Sydney Edmond, from the Illinois Public Health Institute led the group through a Mission Moment. This segment is a grounding effort that is part of every meeting. It is a tool for members to reconnect with the work about to begin, the people being served, and to build collaborations between partners.

In this activity, Sydney asked the group to reflect on the prompt: *When you think of the intersection of housing and health, what is the first thing that comes to mind from a philosophical or personal place?* Participants responded with thoughts and reflections, noting ideas like independence, personal autonomy, choice, equity, dignity and human rights, community, home, accessible, seamless, and stable.

Housing Models – Level-Setting

Housing Interventions and Addressing Homeless Populations – Corporation for Supportive Housing

In this presentation our partner from Corporation for Supportive Housing (CSH), Johnna Lowe, Senior Program Manager, provided an overview on Chicago's Housing Interventions and Addressing Homeless Populations. CSH uses a coordinated entry system that is part of their continuum of care. This system is a best practice according to HUD. Partners who are part of the coordinated entry system are working together in a cohesive way to support people experiencing homelessness with the goal of going directly to them to provide services. Prioritization is also an important component of the coordinated care system. This process allows people who require complex care but face many barriers to be seen sooner by providers.

To join the coordinated care system, households and participants must complete an assessment. These assessments are distributed throughout the city in various ways.

Within the coordinated entry process, there are six key steps:

I. Engage
II. Assess

III. Prioritize
IV. Match
V. Navigate
VI. Housed

There are several homeless-targeted housing interventions that CSH maintains, including:

I. Supportive Housing—affordable housing paired with supportive services to assist individuals in achieving goals and maintaining stability
II. Rapid Re-Housing—intervention where participant experiencing homelessness is moved into stable housing as quickly as possible through identification, rental, and move-in assistance, and case management
III. Prevention—assist people with housing to prevent them from becoming homeless by paying for past due rent, mortgages, utility bills, or other financial needs
IV. Diversion—approaches household or individual to help them look at the situation they are facing from a strength-based approach, understanding there may be people in their network who could support them

CSH defines supportive housing as being held up by property and housing management, housing, supportive services, and the project's relation to the community. Community buy-in for projects is important, including buy-in for permit subsidies. CSH aims to also support clients in finding stability beyond housing in their lives, ensuring services provided are flexible. They believe people in households are experts in their lives which is part of CSH's tenant-centered approach.

Supportive housing has two models, one where all housing in a building is designated as supportive (single site) and one where housing units are spread across multiple co-located buildings (scattered sites).

CSH collects and analyzes statistics on supportive housing, finding that 80% of the time, supportive housing tenants maintain housing for at least a year. There is also a demonstrated decrease on the utilization by clients of other systems, such as a healthcare or criminal justice systems. Supportive housing tenants also more often choose to participate in services even when they are not a requirement for tenancy.

Following Johnna's presentation, participants engaged in a question-and-answer portion with her. Questions posed to Johnna can be appreciated in the meeting recording.

Flexible Housing Pool – Center for Housing and Health, Cook County Health

The next presentation was provided Pete Toepfer, Executive Director of the Center for Housing and Health, who is the administrator for the Chicago and Cook County Flexible Housing Pool. He was joined by his colleague Chante Gamby, the Housing Director at Cook County Health.

The primary vision for the flexible housing pool is that all Cook County residents who experience homelessness and interact with public crisis systems will have a stable home and access to the healthcare they need. This model is based on a similar model in LA County that was responsible for breaking the cycle of homelessness and improved health outcomes for individuals and families experiencing homelessness.

Over the last few years, housing instability has emerged as an influential social determinant of health. Up to 50% of ER frequent utilizers experience homelessness, and homelessness has high comorbidities with behavioral and chronic health conditions. Typical systems do not address the connections between housing and health. Patients often are left to interact on their own with various systems. The goal of the Flexible Housing Pool is to meet patients where they are to provide care.

This project was developed to reduce ER and inpatient utilization, jail stays, emergency shelter days, crisis services, and gun violence, and increase housing stability, health outcomes, outpatient utilization, and the affordable housing market.

The Flexible Housing Pool includes investors from different sectors, including managed care, public systems, and healthcare systems. Private funders are also involved. This group of investors has set flexible housing commitments, resulting in $29 million committed to-date resulting in 700 people being housed. The program has strong retention outcomes, with 97% maintain permanent housing for at least one year. The retention outcomes are also consistent across racial demographics.

When patients are housed more quickly, they are more readily connected to outpatient services. This results in a positive impact on community health needs assessment and social determinants of health by reducing unnecessary crisis system use.

From a process standpoint, there are many partners involved in the flexible housing pool. The Center for Housing and Health works with landlords to ensure housing is available and coordinates with tenants and Outreach Specialists who get individuals and families connected to resources. Once individuals are housed, they are connected to Housing Case Managers who link them to public services, including healthcare, and ensure they can maintain housing.

Healthcare is involved in every step of the process, from outreach, to enrollment, to being housed. If any identified patients from Cook County Health arrive at Stroger or Cook County Jail, Cook County Health is immediately alerted, and outreach begins from the moment they are notified.

Cook County Health (CCH) also provides care coordination services. They provide intensive care coordination for CountyCare members, Flexible Housing Pool (FHP) Housing Coordinators participate in systems integration team meetings (SITs) to consult on healthcare needs, CCH serves as a healthcare resource for FHP housing staff, and they provide healthcare-based trainings for FHP staff.

Following the FHP team's presentation, participants engaged in a question-and-answer portion. Questions posed to presenters can be appreciated in the meeting recording.

Coordinated Entry System and Housing Navigation – Facing Forward to End Homelessness

Laura Bass, Deputy Director with Facing Forward to End Homelessness (FFEH), provided a presentation on their coordinated care and housing navigation systems. A person experiencing homelessness can become involved in Chicago's Coordinated Entry System online, by phone, or by in-person assessment with a partner.

Within coordinated entry, there aren't enough housing resources in the COC for everyone who does an assessment. Because not enough resources currently exist, a prioritization process must occur. The current prioritization plan was developed as a result of the pandemic. Individuals who are considered at higher risk for severe complications due to COVID are part of the priority work, though a new workgroup are meeting to set updated prioritization protocol.

When a participant is matched to housing, that is the first step of the process. Most programs require proof of literal homelessness, such as being in an emergency shelter, on the street, or in institutional settings. Providers are often asked to provide a letter stating the individual is facing insufficient housing. Many programs in the Continuum of Care provide housing to people experiencing chronic homelessness, particularly those who have a history of homelessness and where the head of household has disability. Many individuals will need support communicating with providers. Different housing providers, depending on funding, can be more or less flexible in accepting identification and other documentation from the individuals.

A form documenting disability must also be completed by providers, and HUD has laid out specific eligible disability types. A medical provider licensed by the State must agree via this form that an individual has met HUD's definition of a disability. People do not need disability benefits or be eligible for benefits to meet HUD criteria.

Housing navigation is a program model that supports and advocates for clients who have been matched to housing. Providers support with gathering documents, transportation, and communication with other housing providers. They also connect individuals to healthcare providers to obtain verification of disability. Navigators can also provide support to clients who are denied housing.

All housing programs operate differently, but generally, whenever it's possible, housing and healthcare providers should share contact information. When possible, it's also important to advocate for housing that is physically accessible to existing healthcare providers. It is also helpful to identify how healthcare providers and housing case managers can assist each other.

Following Laura's presentation, participants engaged in a question-and-answer portion with her. Questions posed to Laura can be appreciated in the meeting recording.

Breakout Discussion

Participants were split among breakout groups and provided the following questions to respond to on Jamboard:

1. What system improvements should be made to the transition from shelters or streets to housing, especially to support health care continuity?
2. What are best practices, key models, or innovations where investment should be increased in order to improve access to housing and supportive health services for people experiencing homelessness with vulnerable health? What are the needed steps to achieve that increase in investment?
3. How could care coordination be streamlined to support the health of people in supportive housing programs?

After about thirty-five minutes, the three groups reconvene to report on the discussions held in the breakout rooms.

Next Steps

Following the discussion, Sydney Edmonds asks the participants to fill out a short survey. The next meeting for the Systems Change Collaborative will meet next on July 12th on the topic of Sustainable Funding.