With special thanks

We are very grateful for the generous support of the Chicago Community Trust, the Michael Reese Health Trust and the Polk Bros. Foundation that makes it possible for Center for Housing and Health to staff all the work of preparing and implementing our Chicago and Cook County Housing for Health (H2) Strategic Plan: 2017-2019.

Leadership partners
Chicago and Cook County Housing for Health

[approved by the Leadership Council: November 30, 2016]
[amended by the Leadership Council: December 4, 2017]

TARGET POPULATION

Anyone with the experience of homelessness, as defined by HHS-HRSA, in the City of Chicago and Cook County, whether housed or still homeless, and living with a health condition

PROPOSED VISION

By 2020, persons with the experience of homelessness and living with health conditions in Chicago and Cook County will have access to housing and sustainable and coordinated services through integrated housing and healthcare systems.

PROPOSED MISSION

Improve health outcomes and housing stability for those with the experience of homelessness by coordinating and integrating our housing and healthcare systems through:

- Increasing supportive housing units serving our homeless populations
- Maximizing services and housing resources resulting in optimal health outcomes
- Data systems with capacity to share and integrate data
- Cross-trainings and coordination among our service systems

PROPOSED STRATEGIC PRIORITIES

Strategic Priority #1 – Increase the housing inventory serving homeless populations

IMPACT: Stable housing for thousands experiencing homelessness in the streets, parks, and shelters of our City and County
Strategic Priority #2 – Increase the quantity and quality of services resulting in optimal health outcomes

IMPACT: Improved health outcomes among the homeless populations

Strategic Priority #3 – Strengthen and expand partnerships between the housing and Healthcare Systems

IMPACT: Increased access to and participation in housing and healthcare by homeless populations

"SMART" GOALS UNDER STRATEGIC PRIORITIES

Strategic Priority #1 – Increase the housing inventory serving homeless populations

IMPACT: Stable housing for thousands experiencing homelessness in the streets, parks, and shelters of our City and County

Goal 1.1 - By December 2018, end Veteran's chronic homelessness in Chicago by reaching a "functional zero" target

Goal 1.2 - By December 2017, at least five hospital and healthcare systems make a commitment to invest in recuperative care (respite) housing programs and short-term or long-term housing units

Goal 1.3 - By December 2017, establish at least one flexible rental subsidy pool funded through healthcare dollars to complement existing sources of housing rental subsidies

Goal 1.4 – By July 2019, inform City of Chicago and State of Illinois Qualified Allocation Plans (QAP) for tax credits to include health impact reviews

Goal 1.5 - By September 2018, support the Continuums of Care in Chicago and Suburban Cook County to apply for new HUD Bonus Projects for homeless populations and regularly recapture unused HUD Homeless funds and repurpose them for new supportive housing units

Goal 1.6 – By December 2019, have at least three fully functioning and sustainable “moving on” projects in Chicago and Cook County with the capacity to serve at least 500 people
Goal 1.7 – By December 2019, make use of healthcare sources and the Medicaid benefit of “pre-tenancy and tenancy services” for service dollars to increase the supportive housing inventory by 2,000 new units

Goal 1.8 – By December 2019, support homeless populations, living with health conditions and not eligible for supportive housing, to access at least 500 low-income housing units

Strategic Priority #2 – Increase the quantity and quality of services resulting in optimal health outcomes

IMPACT: Improved health outcomes among the homeless populations

Goal 2.1 - By July 2018, implement a strategy with at least two FQHCs or safety net health providers to increase the integration of at least two health clinics with supportive housing programs

Goal 2.2 - By December 2018, develop and implement a communication strategy for a Medicaid reimbursable higher rate for mental health and substance use treatment, expanded eligible populations, and increased eligible settings for service delivery

Goal 2.3 - By December 2018, provide at least 10 cross-training sessions for service providers in both homeless services and healthcare entities

Goal 2.4 - By December 2018, inform and support the State’s credentialing standards, medical necessity criteria, utilization management policies and rules for claims submission for the Medicaid Tenancy Supports Benefit for supportive housing providers

Goal 2.5 – By December 2018, reduce the loss of Medicaid eligibility by 50% through a streamlined redetermination process and at least 10 trainings for homeless service and healthcare workers

Goal 2.6 - By December 2019, issue a report with criteria for optimizing placement into the fourteen types of supportive housing programs through the Chicago “Supportive Housing: Optimizing Placement (S.H.O.P.) Research Study”

Goal 2.7 – By December 2019, train at least 75% of all housing case managers to support their homeless populations in accessing healthcare and optimizing their health outcomes

Goal 2.8 - By September 2017, develop model contract language for HFS for Medicaid MCOs that will serve homeless populations in 2018
Strategic Priority #3 – Strengthen and expand partnerships between the housing and Healthcare Systems

IMPACT: Increased access to and participation in housing and healthcare by homeless populations

Goal 3.1 - By July 2018, use established HIV/AIDS housing cascades to identify health outcomes of HIV housing program residents by program type

Goal 3.2 - By October 2018, assign care coordinators from at least three Medicaid Managed Care Organizations (MCO) to specifically serve all their own insured members living in at least five project-based supportive housing buildings or shelters

Goal 3.3 - By July 2017, develop the University of Illinois Health (UI Health) and Chicago Homeless Management Information System (HMIS) community action plan to generate shared and integrated data on those served in common

Goal 3.4 - By July 2018, provide accurate information through HMIS to at least three healthcare entities on the aggregated numbers of the homeless and formerly homeless in their databases.

Goal 3.5 – By December 2017, merge de-identified HMIS data with “CAPriCORN” clinical data to characterize patterns of health services use and diagnoses of homeless populations

Goal 3.6 - By July 2018, have identifiable data via a new consent form for 70% of HMIS participants that supports the inclusion of their Medicaid Recipient Identity Number (RIN) and MCO membership

Goal 3.7 – By June 2018, have five housing and healthcare partnerships actively and regularly sharing HMIS identifiable data that includes Medicaid RIN information

Goal 3.8 - By June 2018, develop and implement a service-high-user targeting tool with Medicaid MCOs for identifying and serving insured members needing PSH

Goal 3.9 - By December 2018, implement a section of “Coordinated Entry in Chicago and Suburban Cook County” that includes hospital, MCO, and other health care utilization data to identify high users with multiple chronic health conditions

Goal 3.10 – By December 2019, building upon the “CAPriCORN / HMIS Data Merger Project,” establish a system capacity to alert healthcare entities and case workers in real time of highly vulnerable and/or high users of healthcare services
Leadership Council Members – June 2018

Supportive Housing and Health Care Providers
1. Cheryl Potts, Executive Director, Alexian Brothers Housing and Health Alliance, cheryl.potts@alexian.net
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Chicago and Cook County Housing for Health Strategic Plan: 2017-2019

“H² Plan”

4. Mary Howard, Deputy Chief Housing Officer, Resident Services, Chicago Housing Authority, mhoward@thecha.org

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4. Richard Monocchio, Executive Director, Housing Authority of Cook County, rmonocchio@thehacc.org

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3. James Dimas, Illinois Department of Human Services Secretary, james.t.dimas@illinois.gov
4. Lore Baker, Statewide Housing Coordinator for Long Term Care Reform, IDHS, Secretary's Office, lore.baker@illinois.gov

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3. Jesse Brown VA Medical Center - TBD

System Level Organizations
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3. Dan Rabbitt, Health Advocacy Specialist, Heartland Alliance, drabbitt@heartlandalliance.org
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THE CHICAGO AND COOK COUNTY HOUSING FOR HEALTH STRATEGIC PLAN
2017-2019

Leadership Council

- Provides overall oversight and direction for Plan
- Consists of key leaders from housing providers and advocates, people with lived experience, State, County, and City government, hospital and health systems, managed care, foundations, and other stakeholders.
- Meets biannually

Three Implementation Workgroups:

Increasing Capacity
Services Coordination and Integration
Data Sharing and Integration

- Meet every two months
- Focus on the implementation of 26 SMART Goals and developing benchmarks

TARGET POPULATION

Anyone with the experience of homelessness, as defined by HHS-HRSA, in the City of Chicago and Cook County, whether housed or still homeless, and living with a health condition.

VISION

By 2020, persons with the experience of homelessness and living with health conditions in Chicago and Cook County will have access to housing and sustainable and coordinated services through integrated housing and health care systems.

Mission

Improve health outcomes and housing stability for those with the experience of homelessness by coordinating and integrating the housing and health care systems through:

- Increasing supportive housing units serving homeless populations
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- Data systems with capacity to share and integrate data
- Cross-trainings and coordination among our service systems

THREE STRATEGIC PRIORITIES

Strategic Priority #1 – Increase the housing inventory serving homeless populations

Strategic Priority #2 – Increase the quantity and quality of services resulting in optimal health outcomes

Strategic Priority #3 – Strengthen and expand partnerships between the housing and Healthcare Systems

Lead Agencies:

- Center for Housing & Health
- CSH
- all Chicago
- Housing Forward
- Alliance to End Homelessness

- Plan initiation and development
- Preparation for Leadership Council meetings
- Center for Housing and Health prepares quarterly reports for community stakeholders.

Funders:

- MRHT, Polk Bros., and CCT fund Center for Housing and Health for infrastructure support related to Plan staffing, implementation, and monitoring.
Mission
Improve health outcomes and housing stability for those with the experience of homelessness by coordinating and integrating our housing and healthcare systems.

Increasing the number of housing units serving homeless populations

Data Sharing and Integration Workgroup
Data systems with capacity to share and integrate data between sectors

Services Coordination and Integration Workgroup
Maximizing services and housing resources resulting in optimal health outcomes

Cross-trainings and coordination among our service systems

Increasing Capacity Workgroup

Workgroup Highlight
CAPriCORN/HMIS merger
Chicago Area Patient Centered Research Network (CAPriCORN) and Homeless Management Information System (HMIS) merger project will identify homeless patients across Chicago’s major academic medical institutions and a number of Federally Qualified Health Centers with the objective of identifying patterns of health services use and for certain comorbidities.

Workgroup Highlight
Flexible Housing Pool
The City of Chicago provided seed funding for a new service delivery model to increase supportive housing resources across Cook County through cross sector investments for frequent users of public systems who are homeless. The initial cohort referred will have complex medical needs, behavioral health conditions and involvement with the criminal justice system.

Workgroup Highlight
Health Neighborhood Demonstration Project
Heartland Alliance Health designed and initiated the Health Neighborhood Demonstration Project to help Permanent Supportive Housing programs share in Medicaid dollars without going through the cumbersome and expensive process of becoming a Medicaid biller. The model seeks to demonstrate that this deep integration between a traditional health care provider and Permanent Supportive Housing programs will results in improved health outcomes, an improved participant experience, and lower health costs for Health Neighborhood participants.
<table>
<thead>
<tr>
<th>Project Title</th>
<th>HIV/AIDS Surveillance Data Project</th>
<th>Medicaid/HMIS Project</th>
<th>CAPriCORN/HMIS Project</th>
<th>UIC Hospital/HMIS Project</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short description</strong></td>
<td>The project will identify an unduplicated count of individuals who have experienced homelessness or are homeless and living with HIV or AIDS in both Chicago’s and Suburban Cook County’s HMIS Databases</td>
<td>The project will identify Medicaid expenditures for individuals who have experienced homelessness or are homeless for two years prior to and two years following a placement in PSH.</td>
<td>CAPriCORN project will identify homeless patients who received care at participating CAPriCORN institutions with the objective of identifying patterns of health services use across institutions and for certain comorbidities.</td>
<td>UIC Hospital received an AcademyHealth grant to design a Community Action Plan (CAP) that will lead to the bi-directional flow of data between the HMIS and EMR systems.</td>
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<tr>
<td><strong>Agencies involved</strong></td>
<td>All Chicago, Suburban Alliance, CDPH</td>
<td>All Chicago, Abt Associates, HFS</td>
<td>All Chicago, Suburban Alliance to End Homelessness, CAPriCORN, Medical Research Analytics and Informatics Alliance (MRAIA)</td>
<td>All Chicago, the University of Illinois at Chicago department of emergency medicine</td>
</tr>
<tr>
<td><strong>Data systems</strong></td>
<td>Chicago HMIS, Suburban Cook HMIS, CDPH HIV Surveillance Data</td>
<td>Chicago and Suburban Cook HMIS, DuPage, Medicaid</td>
<td>Chicago and Suburban Cook County HMIS, CAPriCORN (Rush, University of Chicago, AllianceChicago, CCHHS, and Northwestern)</td>
<td>Chicago HMIS, UIC Hospital EPIC system</td>
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<tr>
<td><strong>Methodology</strong></td>
<td>Both Chicago and Suburban Cook County HMIS use a common encryption formula for anyone in their databases who is either living in the streets or shelters or who has already been housed. CDPH, using the same encryption code, will apply it to the data of those living with HIV or AIDS in Chicago and Cook County. All three sets of the encrypted datasets will be sent to a trusted broker entity, which does not have access to the encryption formula. The trusted broker agency in this project is the CDPH Epidemiology Department because HIV/AIDS Surveillance Data is highly confidential and cannot leave CDPH.</td>
<td>HMIS will send Abt an identifiable HMIS dataset, from which Abt can create a “finder’s file” of identifiers for the individuals in the matching project. Then, under a two-way Data Usage Agreement between Abt and the Medicaid agency, Abt will provide a finder’s file to the Medicaid agency, and the Medicaid agency will filter the desired Medicaid service utilization data and provide a client-level limited Medicaid data set back to Abt for merging with the clients’ HMIS data.</td>
<td>CAPriCORN institutions use a designated, secure data hub which allows for data linkage across the participating healthcare institutions for research purposes. Both HMIS will send de-identified data for a 12 month period to the trusted broker, MRAIA. De-identification will be performed using CAPriCORN project software, which can be installed for use by HMIS staff. There will be no re-identification of individuals.</td>
<td>UIC Hospital will cross-reference patients in the hospital’s medical records with the database of Chicago HMIS.</td>
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<tr>
<td><strong>Funding</strong></td>
<td>None</td>
<td>HUD</td>
<td>CCT grant of $25k</td>
<td>$100,000 AcademyHealth grant</td>
</tr>
<tr>
<td><strong>Goal of initiative</strong></td>
<td>The information from this project can help set priorities and allocate resources in the most effective way, especially since Chicago is expecting to see an expansion of HIV housing resources in the coming months.</td>
<td>Increase funding/reallocate resources, prove that placing high users of Medicaid experiencing homelessness into permanent housing reduces Medicaid expenditures.</td>
<td>Since a large number of homeless in HMIS have likely received services in CAPriCORN institutions, this set of data could be analyzed to identify health characteristics of the homeless population and, ultimately, engage health systems to provide permanent housing for individuals with chronic medical conditions</td>
<td>Improve care coordination -to develop a way to embed a patient’s housing status into the electronic medical record so patient basic health information could be shared with housing professionals when HMIS clients access healthcare facilities.</td>
</tr>
<tr>
<td>Timeframe / Current Phase</td>
<td>Suburban Cook HMIS needs to send a data use agreement to CDPH Epidemiology Department and the project will be implemented by July 2018</td>
<td>Work in progress, All Chicago sent the data-sharing agreement to the State and they are awaiting their response on the next steps.</td>
<td>Chicago &amp; Suburban Cook HMIS sent hashed data to MRAIA in the end of March. The data analysis is in progress and preliminary findings will be presented at the Data Workgroup meeting in May.</td>
<td>Recommendations were issued in 2017 to fulfill AcademyHealth grant’s requirements. However, it’s an ongoing project and UIC Hospital needs to resign their data sharing agreement with HMIS to continue working on the project.</td>
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1 The Chicago Area Patient-Centered Outcomes Research Network (CAPriCORN) is a partnership of research institutions, clinicians, patients and patient advocates. The CAPriCORN mission is to develop, test, and implement policies and programs that will improve health care quality, health outcomes, and health equity for the richly diverse populations of the metropolitan Chicago region and beyond. CAPriCORN is funded by the Patient-Centered Outcomes Research Institute and is led by the Chicago Community Trust. Participating healthcare delivery institutions include: AllianceChicago, Ann & Robert H. Lurie Children's Hospital of Chicago, Cook County Health and Hospitals Systems, Loyola University Chicago/Loyola University Health System, NorthShore University HealthSystem, Northwestern University- Rush University Medical Center, University of Chicago Medicine, University of Illinois Hospital and Health Sciences System / University of Illinois at Chicago, and Veterans Affairs Medical Centers (Hines, Jesse Brown).