

Initial Results of the CHHP Project

March 2008

Innovative “Housing First” Program Improves Quality of Life, Reduces Hospital, Emergency Room, and Nursing Home Visits of Homeless Individuals with Chronic Medical Illnesses

BALTIMORE – Underscoring the idea that housing is healthcare, initial study findings from the Chicago Housing for Health Partnership (CHHP) – an innovative program that provides housing to homeless individuals living with HIV/AIDS and other chronic illnesses – were presented March 6 by CHHP researchers and staff at the National Housing and HIV/AIDS Summit in Baltimore. Project researchers and directors will finalize and publish the full study later this year.

Led by the AIDS Foundation of Chicago (AFC), CHHP is the first “hospital-to-housing” effort of its kind in the nation. CHHP identifies chronically ill homeless individuals at hospitals, moves them to permanent supportive housing, and provides them with intensive case management services so that they can maintain their health and secure long-term housing stability.

CHHP (pronounced “chip”) is a response to the reality that too often hospitals in American cities discharge their homeless patients to overnight shelters or other inadequate places which cannot meet their healthcare needs. The CHHP method of service delivery provides the nation with an effective model for assisting this segment of the homeless population and saving taxpayer dollars.

In the summer of 2007, CHHP evolved from a four-year research and demonstration project (2003- 2007) to a permanent citywide collaboration between 15 healthcare, housing, and social service agencies. The program addresses the fact that 1 of every 3 inpatients (32.4 percent) at Chicago’s Cook County Hospital was homeless or at high risk for homelessness during a study period in 2006. To date, CHHP provides 180 permanent housing subsidies for homeless individuals discharged from three area hospitals. These hospitals serve a large percentage of the Chicago homeless population.

During the 18-month research phase for each participant, researchers used a randomized control trial design to study the number of hospital, emergency room, and nursing home visits incurred by two groups: individuals who received CHHP supportive housing versus those who received “usual care” – a piecemeal system of emergency shelters, family and recovery programs. The information was used to track health outcomes and assess how much in medical expenses could be saved through stable housing and increasing access to primary care rather than relying on costly hospital visits and nursing home stays.

The Intervention Group participants had high rates of long-term substance abuse (86 percent), mental illness (46 percent), and medical issues such as HIV/AIDS (34 percent) and hypertension (33 percent), as well as a number of other chronic medical illnesses such as diabetes and cancer.

Initial findings were presented March 6, 2008 at the National Housing and HIV/AIDS Summit in Baltimore. During the spring and early summer of 2008, project researchers and directors will finalize the study results and publish them in scientific journals. They will also generate a final cost analysis of the outcomes.

Below is a summary of the key highlights and preliminary cost estimates that were presented at the Summit:

- Despite high rates of mental illness, substance use and other factors thought to affect individuals' ability to remain stably housed, a very high percent of clients in the Intervention Group remained stably housed over their 18-month study period when compared to the usual care participants.
- The housed group used almost half as many nursing home days as their usual care counterparts and were nearly two times less likely to be hospitalized or use an emergency room.
- An annual average of \$12,000 was spent per housed client to provide a permanent supportive housing unit in a highly coordinated system of care.
- Preliminary cost estimates show that annual medical expenses for housed clients were at least \$900,000 less than their usual care counterparts, after subtracting the annual expense of providing the CHHP supportive housing intervention.

The CHHP model differs from traditional emergency shelter or transitional housing approaches in that the primary focus is on helping individuals quickly access and sustain housing, where needed services are provided best. Such "housing first" and "low demand" programs are less expensive than the cost of habitual shelter stays and emergency medical services often required by chronically ill homeless people.

These promising findings will help AIDS and housing advocates seek social service and housing reform so that low-income people with serious health conditions receive more rational housing options that improve their health. Over the months to come, AFC will lead an advocacy effort and campaign to disseminate the findings and translate them into policy initiatives.

More than 180 CHHP participants who remained engaged with their CHHP case managers received intensive care and support after their discharge from participating hospitals.

Darrell, a former day laborer with a 36-year history of alcohol abuse, received supportive housing through CHHP in 2004 after a referral from the county hospital, the John Stroger Medical Center Hospital. His medical diagnoses included congestive heart failure, a nodule on his lung, and a work-related hand injury. He had been homeless for three years, occasionally staying with his sister or between two city shelters.

When Darrell realized that he could no longer work or pay for a place to live, he contemplated taking all his medicine at one time. But instead, CHHP helped Darrell get to Interfaith House, a shelter that provides short-term housing for injured or ill homeless people. Counselors there helped him get social security benefits and move him into permanent supportive housing as quickly as possible.

Today, Darrell has remained stably housed for almost 4 years. His health has stabilized and his use of unnecessary and costly medical expenses is a thing of the past. Darrell's housing stability and support services allow him to get needed rest and proper nutrition, access outpatient care on a regular basis, and remain adherent to his medicine regimens and medical appointments.

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