Background

In July 2002, a coalition of health care, respite care, and housing providers formed a unique partnership to improve continuity of care and outcomes for long-term homeless individuals with chronic medical health conditions. The **Chicago Housing for Health Partnership (CHHP)** works to identify chronically ill homeless individuals at hospitals, move them to permanent supportive housing as quickly as possible, and provide them with wrap-around intensive case management services so that they can focus their energies on maintaining their health and achieving housing stability.

CHHP Intervention

The CHHP Intervention consists of three stages:

Stage 1 – Expedited Hospital Discharge
During stage one, the hospital partners identify potential CHHP clients and conduct screening and intake procedures. If an individual meets the project requirements (history of long-term homelessness, chronic medical illness), he or she begins to receive integrated case management services from a hospital social worker, including health assessment and education on disease management. Once clients are discharged, they are either placed into stage two or three, depending on the availability of housing and their need for recuperative care.

Stage 2 – Respite Care/Interim Housing
During stage two, clients are moved from hospitals to a respite care/interim housing partner, where they stay until a permanent supportive housing unit becomes available and they complete their medical recovery period. Upon arrival, each client is assigned a stage two case manager. CHHP clients spend an average of 30 to 90 days in stage two, and meet with case managers weekly. While working to move participants into appropriate, stable housing, the case managers also conduct psychosocial assessments and develop a personal housing and service care plan based on the identified needs and goals of each client, with the goal of fostering self-sufficiency.

Stage 3 – Stable Housing
During stage three, CHHP clients are placed into stable, permanent supportive housing. Each client is assigned a stage three case manager, who uses client information gathered during the first two stages to continue working to refine and achieve personalized service plans. Specialized intensive case management services received may include access to medical care, assistance obtaining and maintaining public benefits, financial management, vocational skills development, employment opportunities, legal assistance, meal programs, and substance abuse/mental health treatment. Clients receive a formal assessment every six months, at which time their service plans are updated accordingly.

CHHP Systems Integration Team

The CHHP case managers from each stage and partner agency are known as the Systems Integration Team (SIT). Each SIT member has an individual caseload of ten or fewer clients. SIT case managers meet weekly to share information, track client progress, and leverage the collective expertise of the partners to identify health, housing, and supportive service resources and develop effective, ongoing housing and health service plans for each client. Information sharing is also facilitated through a

centralized Management Information System (MIS), which provides the SIT with access to integrated client data.

CHHP Governance Structure

Three collegial bodies guide CHHP's permanent model of service delivery:

The Governance Council
Comprised of the executive or division director from each partner organization as well as two CHHP clients, this Council is responsible for overall direction and assessment of the partnership and its goals. The Governance Council meets quarterly to review finances, set major policies, monitor the evaluation, and address challenges.

The Oversight Committee
The Oversight Committee consists of the program directors from CHHP organizations that provide direct healthcare or housing/shelter services. The committee meets bi-monthly to address challenges in service delivery, housing, and the management information system (MIS).

The AIDS Housing Advisory Council
The AIDS Housing Advisory Committee is a group of 12 individuals who participate in one of the supportive housing programs coordinated by the AIDS Foundation of Chicago, CHHP's lead partner. Two committee members are currently CHHP clients, and all have previously experienced homelessness. This group meets monthly to discuss issues of importance to homeless consumers and advises AFC on housing programs, policies, and procedures.

Housing First and Harm Reduction

CHHP's service delivery model is based on "housing first" and "harm reduction" philosophies.

Housing First
The National Alliance to End Homelessness defines "housing first" as an approach that differs from traditional emergency shelter or transitional housing approaches in that the immediate and primary focus is on helping individuals and families quickly access and sustain permanent housing, and then providing services as needed to promote housing stability and individual well-being. The CHHP leadership believes in this approach in that the underlying causes of homelessness are best addressed once a person is housed. Moreover, housing first programs are less expensive than the cost of habitual shelter stays and the emergency medical services often required by the chronically ill homeless.

Harm Reduction
The Harm Reduction Coalition defines harm reduction as "a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use, to abstinence." Harm reduction strategies accept that licit and illicit drug use is a reality of our society and works to minimize its harmful effects rather than simply ignore or condemn them. By adopting a harm reduction philosophy, CHHP allows consumers to receive housing and supportive services without a sobriety requirement, which is critical as many CHHP clients have long-term substance use histories. Once a person is housed, CHHP case managers work with the individual to lessen the harms of substance use through education, prevention, and treatment of addictions.

CHHP as a Permanent Model

Inspired by CHHP's positive client outcomes over the past four years, the CHHP leadership launched the CHHP Hospital to Housing Program in June 2007 as a permanent model of service delivery for the chronically ill homeless in Chicago.