

REPORT ON THE RECOMMENDATIONS OF THE SYSTEMS CHANGE COLLABORATIVE TO IMPROVE THE HEALTH OF PEOPLE EXPERIENCING HOMELESSNESS



Photo: Guests and providers at Hotel 166 'shield housing', 2020

Systems Change Collaborative to Improve the Health of People Experiencing Homelessness

Convened by the Chicago Department of Public Health (CDPH)

Facilitated by the Illinois Public Health Institute (IPHI), with support from
Wilburn Strategic Solutions and High Ground Partners

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Thank you to the members of the Systems Change Collaborative that shared invaluable expertise throughout the Collaborative. Their thoughtful engagement developed the recommendations presented in this report.

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TABLE OF CONTENTS

Executive Summary	4
Background	6
The Systems Change Collaborative Project	7
Landscape Assessment	8
Systems Change Collaborative Meetings	8
Recommendations	10
Care Integration	10
#1 Maintain, Evaluate, and Expand the Shelter-Based Care Program	10
#2 Refine and Benchmark Standards of Care for Shelter-Based Care, and Incorporate into DFSS Shelter, Continuum of Care Program Model and CDPH Shelter-Based Care Team Expectations	11
#3 Increase Access and Support for Substance Use Disorders	12
State and Federal Advocacy	13
#4 Advocate for Additional Flexibility for Healthcare Reimbursement Mechanisms in Medicaid	13
#5 Advocate for Medicaid Funding for Tenancy Supports	14
#6 Increase Medical Respite Beds	15
Homeless Service Systems	16
#7 Expand Non-congregate Shelter, Stabilization Housing, and Low-barrier Shelter Programs	16
#8 Increase Accessible Emergency Shelter Options and Improve Processes to Ensure Individuals with Disabilities are Directed to Appropriate Shelter	17
#9 Increase Trauma Training and Support for Shelter and Housing Staff	18
#10 Expand Case Conferencing within the CoC to Include Care Coordinators and Healthcare Teams	19
#11 Increase the Role People with Lived Expertise Have in Decision Making about Homeless Services, Programs, and Policies	20
Data Systems	21
#12 Establish a Community Information Exchange (CIE) as a Data Bridge between Healthcare and Homeless Service Providers	21
#13 Design and Implement a Health/Healthcare Checklist in HMIS for People Leaving Shelter to Permanent Housing	22
#14 Create a New Process to Ensure People Experiencing Homelessness Have Disability Status Captured in HMIS by Medical Professionals	23
System Funding and Sustainability	24
#15 Streamline Reporting Requirements Between Funders	24
#16 Increase Pay Equity Among Homeless Service Staff, Raise Rates, and Support Employment Opportunities for People with Lived Expertise in the Sector	25
Progress and Anticipated Movement for Recommendations	26
References	30
Appendix: Landscape Assessment	33

EXECUTIVE SUMMARY

The Chicago Department of Public Health (CDPH) convened a group of service providers and community-based organizations to form a Systems Change Collaborative to Improve the Health of People Experiencing Homelessness throughout 2022, with planning activities beginning in August 2021. CDPH worked with the Illinois Public Health Institute (IPHI), Wilburn Strategic Solutions, and High Ground Partners to conduct a landscape assessment, convene a planning committee, and hold six System Change Collaborative meetings. The Systems Change Collaborative is an initiative within Healthy Chicago 2025, Chicago's five-year community health improvement plan, and is part of efforts to build ongoing systems to advance racial equity in the aftermath of the COVID-19 pandemic. The project was launched in conjunction with CDPH's increased investment in . helter-Based Care Teams and holistic health supports for people experiencing homelessness.

The purpose of the group was to develop system-level recommendations to improve health for Chicagoans experiencing homelessness in partnership with cross-sector experts and people with lived expertise, focusing on recommendations which CDPH and City partners could have a role in implementing. Initially identified opportunities included expanding access to high-quality, comprehensive care for people experiencing homelessness and those transitioning into housing by benchmarking standards of care, disseminating best practices, identifying common needs, and advocating collectively for policy and system changes. The Collaborative had 30 members representing people with lived expertise, homeless service providers and representatives from the Chicago Continuum of Care (CoC), healthcare and behavioral health professionals who provide care for people experiencing homelessness, and policy and advocacy organizations with expertise for specific populations (including people with disabilities, immigrants and refugees, LGBTQ+, youth and families). Within the meetings, experts in the field provided a presentation regarding the background of each topic, and there was a facilitated discussion with participants about opportunities for overcoming challenges and making system improvements.

The Systems Change Collaborative identified 16 key recommendations to support health, equity, and well-being for people experiencing homelessness in Chicago:

CARE INTEGRATION

1. Maintain, evaluate, and expand shelter-based care model
2. Refine and benchmark standards for shelter-based care, and incorporate into shelter/CoC standards
3. Increase access and support for substance use disorder treatment, including medication assisted treatment (MAT), Narcan knowledge and training, overdose follow-up, and drop-in services

STATE AND FEDERAL ADVOCACY

4. Advocate for additional flexibility for healthcare reimbursement mechanisms in Medicaid [i.e., loaded rates or per member per month (PMPM), not fee-for-service]
5. Advocate for Medicaid funding for tenancy supports
6. Increase medical respite beds

HOMELESS SERVICE SYSTEMS

7. Expand non-congregate shelter, stabilization housing, and low-barrier shelter programs
8. Increase accessible emergency shelter options and improve processes to ensure individuals with disabilities are directed to appropriate shelter
9. Increase trauma training and support for shelter/housing continuum staff
10. Expand case conferencing within the CoC to include MCO/care coordinators and healthcare teams
11. Increase the role people with lived expertise have in decision making about homeless services, programs, and policies [Roles could include serving as community RFP reviewers, consultants when new programs or policies related to homelessness are being developed and city priorities are being shaped.]

DATA SYSTEMS

12. Establish a Community Information Exchange (CIE) as a data bridge between healthcare and homeless service providers
13. Design and implement a Health/Healthcare Checklist in HMIS for people leaving shelter to permanent housing
14. Create a new process to ensure people experiencing homelessness have disability status captured in HMIS by medical professionals

SYSTEM FUNDING AND SUSTAINABILITY

15. Streamline reporting requirements between funders, and support foundation partners to conduct advocacy and public funder education on behalf of funding sectors and align funders on best practices
16. Increase pay equity among homeless service staff, raise rates, and support employment opportunities for people with lived expertise in the sector

This report presents the 16 recommendations developed by the Collaborative. In 2023, CDPH plans to work with partners to move forward the recommendations laid out in this report.

BACKGROUND

LOCAL CONTEXT

In 2020, approximately 16,026 Chicago residents experienced literal homelessness (those staying in shelters or residing in places not meant for human habitation) at some point in the year (Carlson et al., 2022). An additional 49,585 Chicagoans were unstably doubled up in the homes of others. Importantly, homelessness is an extremely disproportionate experience by race – in Chicago, approximately 75.9% of residents experiencing literal homelessness are Black, while only 29.2% of Chicagoans overall are Black (CCH, 2020). These disparities are rooted in the legacy and current reality of systemic racism. Therefore, any effective homelessness prevention and response strategy must center racial equity.

16,026

Chicago residents experiencing literal homelessness* at some point in 2020

* Those staying in shelters or residing in places not meant for human habitation

49,585

Additional Chicago residents unstably doubled up in homes of others

75.9%

of Chicago residents experiencing literal homelessness are Black.

29.2%

of Chicago residents are Black

Homelessness is also detrimental to individual health – disability and chronic health conditions are both risk factors for homelessness and aggravated by homelessness – poor health increases individuals' risk of homelessness and experiencing homelessness often produces rapid declines in health. In 2016, adults with disabilities were about four times more likely to be experiencing sheltered homelessness nationally than adults without a disability (Silverbush et al., 2017). A 2013 study of Boston Healthcare for the Homeless patients found that average life expectancy for a person without stable housing is 27.3 years less than the average housed person (Choucair and Watts) (Baggett TP). Those between the ages of 25 and 44 experiencing homelessness face an all-cause mortality risk that is 8.9 times higher than the general population; it is 4.5 times higher for those 45 to 64 (Choucair and Watts) (Baggett TP).

In 2016, adults with disabilities are about

4x

more likely to experience sheltered homelessness nationally than adults without a disability.

Source: Silverbush et al., 2017

Average life expectancy is

27.3 years less

for person without stable housing than for the average housed person.

Source: Choucair and Watts, Baggett TP, Boston Healthcare for the Homeless, 2013

Those between ages of 25 and 44 experiencing homelessness face an all-cause mortality risk

8.9x higher than general population

For those from 45 to 64, the risk is

4.5x higher than general population

In Chicago, many organizations and systems serve people experiencing homelessness and would need to be involved in implementing these recommendations. The **Chicago Department of Family and Support Services** (DFSS) is the primary City department providing and funding direct homeless services, including a network of shelters, street outreach and rapid re-housing. Many other City Departments and Sister Agencies have a role in serving people experiencing homelessness, including the **Chicago Department of Housing** (DOH), which develops affordable housing, and the Department of Streets and Sanitation (DSS), which participates in encampments cleanings with DFSS. The **Chicago Continuum of Care** (CoC) is an important HUD-mandated membership organization working together to prevent and end homelessness locally and to coordinate the work of homeless service providers as well as funders and other system partners throughout Chicago. **All Chicago** is a nonprofit which provides system-level staffing support for the CoC and manages the HMIS information system, the Coordinated Entry System and the CoC's annual NOFO application to HUD. Among other relevant direct service and systems leadership roles, the **Chicago Department of Public Health** (CDPH) provides public health guidance to shelters and funds two Federal Qualified Health Centers to provide holistic primary care, including behavioral health care and substance use service to shelters. These providers, called Lead Coordinating Organizations (LCOs) or Shelter-Based Service Teams, are **Lawndale Christian Health Center** (LCHC) and **Heartland Alliance Health** (HAH). Of course, in addition to these City and close partner entities, a large group of homeless service, supportive housing, healthcare, advocacy, other organizations and leaders with lived expertise of homelessness serve Chicagoans experiencing homelessness.

Many people experiencing homelessness reside in shelters, which are often congregate environments with many individuals sharing one room and bathroom, posing particular risk for infectious diseases. Recognizing the disproportionately vulnerable health of this population and the high COVID-19 transmission risk of congregate environments, in early 2020 during the onset of the COVID-19 pandemic CDPH, DFSS, and a broad range of external partners – including healthcare providers, homeless services and housing providers, advocates, and public health organizations – mobilized to foster system and policy changes to prioritize the health and well-being of people experiencing homelessness. These collaborations resulted in an array of initiatives aimed at preventing the spread of COVID-19 within this population, including support for shelters and encampments to adopt infection control guidance, rapid response to COVID-19 outbreaks, shielding housing to protect high-risk individuals, medical respite facilities for people who need a safe space to isolate and recover from COVID-19, and an Expedited Housing Initiative that dramatically increased the local availability of rapid re-housing (a housing program model).

The Systems Change Collaborative was developed during this time of increased collaboration and investment during and after the COVID-19 pandemic. While early COVID-19 was a time of immense collaboration to improve systems serving Chicagoans experiencing homelessness, it also laid bare a need for continued system improvements in areas such as real time data access, accessible and relevant public health training and information for homeless service providers, and shelter and other homeless service spaces that minimized risk of disease transmission. The Collaborative was created in response to this need to foster continued investments and systemic improvements to serve the health of people experiencing homelessness in Chicago, in tandem with increased investments in housing and homelessness prevention.

CDPH also understands and uplifts that the best public health intervention for individuals experiencing homelessness is housing and that housing is healthcare. CDPH views investments such as the Shelter-Based Care Program and other recommendations throughout this report as critical services which seek to support the health of people experiencing homelessness while affordable and supportive housing systems, policymakers, behavioral health providers and others pursue structural changes to ultimately prevent and end homelessness.

THE SYSTEMS CHANGE COLLABORATIVE PROJECT

The Chicago Department of Public Health (CDPH) began working on the Systems Change Collaborative to Improve the Health of People Experiencing Homelessness in August 2021. CDPH worked with the Illinois Public Health Institute (IPHI), Wilburn Strategic Solutions, and High Ground Partners throughout 2022 to conduct a landscape assessment, convene a planning committee, and hold six System Change Collaborative meetings to develop system recommendations in partnership with cross-sector experts to support improved health and well-being for people experiencing homelessness in Chicago.

This report presents 16 recommendations that were developed by the Collaborative. In 2023, CDPH plans to work with system partners to begin to advance the recommendations laid out in this report. As described within the recommendations, implementation of the recommendations will require participation by many partners in various capacities.

In order to accomplish the goals of the Collaborative, CDPH and IPHI worked closely with a planning committee which included the Department of Family and Support Services (DFSS), Shelter-Based Care Teams (Lawndale Christian Health Center and Heartland Alliance Health), All Chicago, homeless service providers, and people with lived expertise. Based on the findings of the Landscape Assessment (see more about the Landscape Assessment in the Appendix), the planning committee decided to organize the Collaborative's meetings around these policy and systems topics:



All topics sought to include a focus on cross-cutting topics of partner engagement, data systems, and racial equity.

LANDSCAPE ASSESSMENT

The Systems Change Collaborative sought to build on and not duplicate the existing efforts of organizations throughout Chicago. Therefore, IPHI worked with CDPH on an initial landscape assessment in Summer and Fall of 2021 to understand the local landscape of assets, health needs, and health-related services that are available to people experiencing homelessness in Chicago.

For the landscape assessment, CDPH and IPHI conducted key informant interviews, discussions with people with lived expertise, reviewed best practices, and leveraged existing data and information. IPHI and Wilburn Strategic Solutions interviewed 34 individuals representing shelters, healthcare, mental health and substance use, outreach, advocacy groups, city and state agencies, people with lived expertise, and more. People with lived expertise were compensated for their time and input for the interview and throughout the Collaborative.

Appendix A provides the full report of the key issues and topics raised by key informants in the landscape assessment.

SYSTEMS CHANGE COLLABORATIVE MEETINGS

CDPH convened over 30 partners as members of the Systems Change Collaborative including:

- people with lived expertise;
- homeless service providers and representatives from the Chicago Continuum of Care;
- healthcare and behavioral health professionals who provide care for people experiencing homelessness; and
- policy and advocacy organizations with a focus on specific populations.

The Systems Change Collaborative met a total of six times in 2022, with each meeting held on a different system topic. Within the meetings, experts in the field provided a presentation regarding the background of each topic, and there was a facilitated discussion with participants about opportunities for overcoming challenges and making system improvements.

MEETINGS

Meeting #1 – March 2, 2022 – Standards of Care

- Presentation –
 - Standards for Shelter-Based Health Care – Mary Tornabene, Heartland Alliance Health, Tom Huggett, Lawndale Christian Health Center

Meeting #2 – April 6, 2022 – Approaches to Health in Shelters

- Presentations –
 - Shelter System Overview and Priorities for Improvement – Christine Riley & Kimberly Howard, Chicago Department of Family and Support Services (DFSS)
 - Franciscan Outreach – Luwana Johnson, Franciscan Outreach

Meeting #3 – May 25, 2022 – Housing Models and Health Care Continuity

- Presentations –
 - Chicago’s Housing Interventions Addressing Homeless Populations – Johnna Lowe, Corporation for Supportive Housing (CSH)
 - Innovation and Lessons Learned in Providing Wrap-Around Services – Laura Bass, Facing Forward to End Homelessness
 - Flexible Housing Pool – Pete Toepfer, Center for Housing and Health, Chante’ Gamby, Cook County Health

Meeting #4 – July 12, 2022 – Sustainable Funding Models

- Presentation –
 - Intro to Chicago Funders Together – Emily Krisciunas, Chicago Funders Together to End Homelessness

Meeting #5 – October 12, 2022 – Workforce Development

- Presentation –
 - More Essential Than Ever Research and Advocacy – Lauren Wright, Illinois Partners for Human Service

Meeting #6 – November 9, 2022 – Review of Draft Recommendations and Feedback



Photo: Person receiving vaccination at shelter-based event

RECOMMENDATIONS



Photo: Group photo of members from Heartland Alliance Health.s Vaccination Team at Hotel Julian, 2021

CARE INTEGRATION

#1 Maintain, Evaluate, and Expand the Shelter-Based Care Program

The Shelter-Based Care Program (also referred to as the LCO program) is a program funded by CDPH and launched in October 2020 to regularly bring primary healthcare, behavioral healthcare, and critical infection prevention and control services in Chicago shelter through FQHC partners. In 2021 and 2022, the program provided 28,037 care encounters, including 19,381 primary care visits.

What problem does this recommendation solve?

Expands on the shelter-based care program that has proven valuable over the last 2 years as both providing increased access to care for a particularly vulnerable population and been an important public health partner during a myriad of public health events. For example, one study of homeless shelters in 7 US urban areas found shelters with medical services available were less likely to have very high COVID-19 infection (Self et al., 2021).

Alignment with Other Plans and Initiatives

- Illinois State Plan to Prevent and End Homelessness

Key Populations

- People with substance use disorders and/or complex behavioral and physical health conditions living in shelters or unsheltered
- People interacting with the criminal-legal system, homeless services AND emergency medical services
- People living unsheltered

Roles for CDPH and Partners

- Continued role for CDPH as funder and facilitator of healthcare provider relationships with shelter system
- DFSS- continued coordination with shelter system
- Shelter and street outreach providers

Racial Equity Considerations

Actors, partners and stakeholders working to implement this recommendation should consider the Racial Equity considerations that align the populations, systems involved and goals.

#2 Refine and Benchmark Standards of Care for Shelter-Based Care, and Incorporate into DFSS Shelter, Continuum of Care Program Model and CDPH Shelter-Based Care Team Expectations

Standards of care, similar to best practices, are a framework for providing consistency in expectations and a mechanism for accountability based on scientific evidence and expert consensus. Standards may be developed for specific settings, such as here with standards of care specific to healthcare in shelter settings. Initial standards have been developed by local healthcare for the homeless leaders (see [CHRRGE report on Standards for Shelter-Based Health Care](#)). The Standards provide guidance on discharge and transition of people experiencing homelessness from medical facilities to shelters, the expansion of care beyond primary care to include behavioral, psychiatric and substance use disorder services, increased provider education, accountability and support. The Collaborative recommends adopting these standards throughout local systems and continuing to refine them.

What problem does this solve?

Standards of care provide consistency in expectations (such as composition of healthcare in shelter to emphasize behavioral health in healthcare) and a mechanism for accountability. Formalizes best practice approaches defined by healthcare and homeless service providers.

Alignment with Other Plans and Initiatives

- Shelter-Based Care Teams
- National Healthcare for the Homeless Council
- CHRRGE

Key Populations

- Standards should seek to serve the needs of diverse groups within the population of people experiencing homelessness in Chicago
- People with lived expertise (PWLE) must be involved in refining and implementing

Roles for CDPH and Partners

- Leadership by CDPH, Shelter-Based Care Teams (LCOs) and their behavioral healthcare partners, and DFSS
 - Leadership on implementing must include PWLE
 - Engage other providers of care in shelters
 - Opportunities to expand to other sites of care in future
-

Racial Equity Considerations

Standards of care should explicitly acknowledge and include strategies to address structural racism and bias within the healthcare system.

#3 Increase Access and Support for Substance Use Disorder Treatment

Substance use disorder (SUD), which can include addiction, is a medical diagnosis that describes the mental, behavioral, and physical symptoms caused by the use of alcohol, tobacco, and other drugs. This recommendation calls for continued increases in investment in substance use services and resources that are accessible to people experiencing homelessness and staff working with them, including medication assisted treatment (MAT), Narcan and other training, and overdose follow-up services.

The need for these services is high. In 2021, 1,428 Chicagoans died of an opioid related overdose, the highest number ever recorded in the city.

What problem does this solve?

Increase availability, access, and connectivity to services for Opioid Use Disorder and other substance use disorders.

Alignment with Other Plans and Initiatives

- City initiative for stabilization housing program, building on Hotel 166 program during COVID
- Roadmap Initiative
- Flexible Housing Pool
- CoC SARD line of action
- CHHRGE
- DFSS 2023-24 expansion of non-congregate and low-barrier shelter

Key Populations

- People with substance use disorders and/or complex behavioral and physical health conditions living in shelter or unsheltered
- People interacting with the criminal-legal system, homeless services AND emergency medical services
- People living unsheltered

Roles for CDPH and Partners

- Leadership by CDPH Behavioral Health Bureau, DFSS, and CoC
-

Racial Equity Considerations

Address large disparities in mortality from opioids for Black Chicagoans and inequities in criminalization of substance use.

STATE AND FEDERAL ADVOCACY

#4 Advocate for Additional Flexibility for Healthcare Reimbursement Mechanisms in Medicaid (i.e., Loaded Rates or Per Member Per Month [PMPM])

This recommendation encourages the state to allow loaded rate or per member per month billing models for healthcare for people experiencing homelessness, rather than the typical fee-for-service model which incentivizes efficiencies which are very difficult to achieve in a shelter-based care setting. The State of Illinois would need to seek a Medicaid waiver to allow this billing model, and housing and healthcare partners across Illinois have encouraged the Department of Healthcare and Family Services (HFS) to include piloting PMPM payment in the waiver that is currently being considered.

More flexible healthcare reimbursement mechanisms within Medicaid such as per member per month (PMPM) fees and value-based payments for specific populations like people experiencing homelessness allow for coverage of more intensive care management and outreach and care coordination as well as more flexibility and innovation in the types of providers that can be part of reimbursable care (Rockville, 2014).



Photo: Guest receiving person-centered care on-site

What problem does this solve?

Support development of care teams and systems of care that provide medical, behavioral health, medication supports, and wrap-around services tailored to people experiencing homelessness and other co-occurring conditions.

Alignment with Other Plans and Initiatives

- Medicaid Advisory Committee (MAC) for Illinois, specifically the Health Equity and Quality Care Subcommittee and the Public Education Subcommittee
- Roadmap Initiative
- Medicaid MCOs, as they are interested in moving towards more value-based contracts

Key Populations

- People receiving health insurance coverage through Medicaid
- People with disabilities

Roles for CDPH and Partners

- Medicaid changes led by Illinois HFS, the Medicaid Advisory Committee (MAC), and MCOs
- Advocacy opportunity for CDPH and local partners
- City coordination with county, state and federal government.

Racial Equity Considerations

Enable providers to sustain flexible healthcare services that can meet people experiencing homelessness where they are. Improved healthcare access and quality for PEH is a racial equity issue as homelessness is disproportionately experienced by Black Chicagoans.

#5 Advocate for Medicaid Funding for Tenancy Supports

Supportive services play a critical role in supporting people experiencing homelessness in transitioning into housing and thriving in housing. Many affordable and supportive housing providers struggle to fund supportive services at desired levels, reducing the level and type of services provided and the competitiveness of wages. To address these and other health-related social needs, some states have services for people experiencing homelessness in their Medicaid Section 1115 waivers which can allow Medicaid funding for some aspects of housing tenancy supports, including home healthcare. As of November 2022, [Arizona](#), [Arkansas](#), [Massachusetts](#) and [Oregon](#) had Section 1115 Health-Related Social Needs (HRSN) waivers, and 18 additional states had pending Section 1115 legislation. In the Home Illinois plan, the State of Illinois has prioritized a strategy to request authorization from Medicaid to create a housing tenancy support benefit.

What problem does this solve?

Maximize Medicaid funding for housing-first models of care and support better integration of health and housing services for people transitioning from homelessness to housing.

Alignment with Other Plans and Initiatives

- Illinois State Plan to Prevent and End Homelessness
- HFS and partners working on state waivers including 1115 and/or state plan amendment
- Medicaid Advisory Committee (MAC) for Illinois
- Prior Housing for Health (H2) plan for Chicago and Cook County
- Flexible Housing Pool
- CoC SARD line of action
- Medicaid MCOs, including the State's negotiation of contracts
- Schools of Public Health
 - to obtain research that demonstrates the financial case for housing is healthcare

Key Populations

- People receiving health insurance coverage through Medicaid
- People who will benefit from housing as a healthcare intervention
- People with disabilities
- People with behavioral health conditions
- Young people transitioning from the foster care system

Roles for CDPH and Partners

- Medicaid changes led by Illinois HFS, the Medicaid Advisory Committee (MAC), and MCOs
- Advocacy opportunity for CDPH and local partners
- City coordination with county, state and federal government

Racial Equity Considerations

As pilot programs roll out, monitor demographics of who is benefitting from the program and make adjustments to ensure Black Illinoisans and other people of color are being served at rates proportional to representation among people experiencing homelessness.

#6 Increase Medical Respite Beds

Medical respite is a model of short-term residential and post-acute medical care for patients experiencing homelessness who are too ill or frail to recover from a physical illness while living in a shelter or on the streets, but who are not sick enough to be in a hospital. As highlighted in the State of Illinois' [Home Illinois Plan to Prevent and End Homelessness](#), Chicago and Cook County need additional medical respite beds, and two of the biggest barriers to increasing beds and capacity is lack of coverage to pay for medical respite as well as insufficient housing resources for discharge. There is also a need for additional medical respite services for people with behavioral health care needs (mental health and/or substance use disorders).

During the COVID-19 pandemic, the Chicago Department of Public Health (CDPH), like many other jurisdictions, provided isolation space in hotels for people experiencing homelessness living in congregate settings to recover from COVID-19 or to be protected from COVID-19 given an individuals health vulnerabilities. While not all strictly speaking medical respite, many of these programs underscored the value of medical respite models to homeless response systems. See examples including [Hotel 166](#) in Chicago, [Project Roomkey in California](#), and a [San Francisco study](#) regarding care of 346 people experiencing homelessness in hotels during COVID-19.

What problem does this solve?

Medical respite can keep people out of nursing homes and reduce extended or repeated inpatient hospital stays. For homeless service systems, medical respite allows an appropriate place for people to go whose medical needs cannot be met in shelter.

Alignment with Other Plans and Initiatives

- Illinois State Plan to Prevent and End Homelessness
- Cook County Health goal
- NIMRC (National Institute for Medical Respite Care)

Key Populations

- People with complex medical issues
- People with disabilities
- People experiencing homelessness who are being discharged from the hospital

Roles for CDPH and Partners

- Convening medical respite partners, in coordination with DFSS and state
- Partnering with the State, existing respite providers, healthcare payors, and other system partners

Racial Equity Considerations

Prioritize addressing health conditions and health inequities that impact Black, Latinx, Indigenous and people of color in Chicago and Illinois.

HOMELESS SERVICE SYSTEMS

#7 Expand Non-congregate Shelter, Stabilization Housing, and Low-barrier Shelter Programs

Non-congregate shelter is shelter in an environment where large groups of people are not sharing sleeping areas and bathrooms. Non-congregate is generally thought of as four or fewer individuals sharing sleeping and bathroom space, however a range of less-congregate configurations may make sense for individual facilities. Large congregate facilities pose an increased risk for rapid transmission of communicable diseases, including COVID-19 in comparison to facilities with less congregate configurations (Ghinai et al., 2020). Immediately pre-COVID, one-third of all shelter beds in the City-funded shelter systems are in shared rooms with over 20 people and shared bathrooms. For the single adult population, over 80% of beds are in shared rooms with over 20 people and shared bathrooms.

Low-barrier shelter is generally a shelter model that implements low-barrier strategies and practices, including removing curfews, accommodating pets, and accommodating couples and other groups staying together. DFSS's shelter network currently includes one low-barrier shelter operated by Franciscan Outreach.

Stabilization housing is a new model to Chicago, which CDPH is seeking to launch. This model is designed to address the health needs of people experiencing homelessness cycling chronically through Chicago's emergency and criminal-legal systems. The program will centralize medical and behavioral health care on-site, together with intensive case management, social and recovery services, and trauma-informed, community-centered wellness supports. This intensive, coordinated care seeks to disrupt high utilization of emergency services and improve health outcomes through high-quality, short-term, non-congregate housing (intended for up to six months) and services.



Photo: Dr. Thomas Huggett with a guest at Hotel 166, 2021

What problem does this solve?

Expands the models of shelter and services available to meet the needs of people experiencing homelessness, particularly people with complex combinations of substance use, behavioral health and physical health conditions (stabilization housing) and people living on the streets or in encampments (low-barrier shelter).

Alignment with Other Plans and Initiatives

- City initiative for stabilization housing program, building on Hotel 166 program during COVID
- Roadmap Initiative
- Flexible Housing Pool
- CoC SARD line of action
- CHHRGE
- DFSS 2023-24 expansion of non-congregate and low-barrier shelter

Key Populations

- People with substance use disorders and/or complex behavioral and physical health conditions living in shelter or unsheltered
- People interacting with the criminal-legal system, homeless services AND emergency medical services
- People living unsheltered

Roles for CDPH and Partners

- Non-congregate shelter and low-barrier shelter: lead from DFSS and CoC
- Stabilization housing: lead from CDPH

Racial Equity Considerations

Actors, partners and stakeholders working to implement this recommendation should consider the racial equity considerations that align the populations, systems involved and goals.

#8 Increase Accessible Emergency Shelter Options and Improve Processes to Ensure Individuals with Disabilities are Directed to Appropriate Shelter

Physically accessible and ADA-compliant shelters are important to ensure access to this safety net service. There are two main challenges in ensuring accessibility: availability of shelter across the system, and capital funding (i.e., building maintenance and improvements funding beyond per person, per night rates).

DFSS funds approximately 3,000 shelter beds through delegate agency partners which operate near or at capacity on any given day, particularly in winter months. When the system is near full, there is very limited opportunity to put shelter seekers at sites best situated to meet their needs.

Additionally, many shelters are not well designed to ensure accessibility. Capital funding is needed to increase the accessibility of these sites and is not reliably available.

What problem does this solve?

Increasing the accessibility of existing sites or dedicated non-congregate space coupled with a physical accessibility placement policy would help with hospital discharge and general placement processes, as well as ensure equal access to shelter.

Alignment with Other Plans and Initiatives

- Illinois Plan to End Homelessness (reference to Centers for Independent Living to provide TA and support to homeless sites on accessibility);
- DFSS requires reasonable accommodation plans and 504 ADA compliance

Key Populations

- People with physical disabilities- temporary or permanent

Roles for CDPH and Partners

- DFSS to lead process improvements along with delegates
 - CDPH to support and champion
 - Coordinate with MOPD community advisors and key organizations representing people with disabilities such as Access Living
-

Racial Equity Considerations

Report and track data on racial/ethnic demographics of people with disabilities and (as available) data on people with disabilities experiencing homelessness.

#9 Increase Trauma Training and Support for Shelter and Housing Staff

Trauma-informed care is a framework and practice which generally involves five key elements: SAMHSA's 4 Rs and a 5th-R (resilience) is included in CDPH's definition after identified as equally important by local community members. These "5 Rs" are realizing the prevalence of trauma; recognizing how trauma affects all individuals, communities, organizations, and systems; responding by putting this knowledge into practice; resisting re-traumatization; and restoring resilience by supporting healing for all (SAMHSA, 2014).

This framework can be particularly important in spaces working with people experiencing homelessness, who are disproportionately impacted by past and ongoing traumas. Collaborative members lifted up Heartland Alliance Health's trainings for homeless services staff through the Midwest Harm Reduction Institute as one helpful resource.

What problem does this solve?

Ensuring homeless service provider staff, healthcare staff, and other providers that interact with people experiencing homelessness have the training and supports needed to provide trauma-informed care

Alignment with Other Plans and Initiatives

- Trauma-Informed City
- CHHRGE
- Trauma-informed Hospitals Collaborative and ACES Response Collaborative
- Heartland Alliance training

Key Populations

- People experiencing homelessness, both in shelter and unsheltered
- People impacted by trauma
- People with mental health conditions

Roles for CDPH and Partners

- CoC provide trauma-informed training to CoC organizations and the homeless services sector
- Leadership by CDPH
- Shelter-Based Care teams – providers with expertise in trauma-informed training
- DFSS champion and promote training

Racial Equity Considerations

Report and track data on racial/ethnic demographics of people with disabilities and (as available) data on people with disabilities experiencing homelessness.

#10 Expand Case Conferencing within the CoC to Include Care Coordinators and Healthcare Teams

Case conferencing, or system integration meetings, occur when multiple individuals working with a population, such as housing case managers and housing navigators, get together to promote communication in order to provide the best services to clients. While not relevant to all CoC clients, some case conferencing/systems integration meetings do currently happen within the local Continuum of Care, especially for individuals near housing or special populations, such as veterans.

What problem does this solve?

Improved coordination with healthcare providers in these contexts could breakdown silos and promote improved outcomes, such as shorter time to housing.

Alignment with Other Plans and Initiatives

- Systems Integration Team (SIT) forums
- Flexible Housing Pool

Key Populations

- People with complex medical issues
- People who will benefit from housing as a healthcare intervention
- People receiving services from multiple systems

Roles for CDPH and Partners

- CDPH to support shelter care teams in initiating integration into Systems Integration Team (SIT) forums where appropriate
 - Shelter care teams to participate in SIT/case conferencing where appropriate
-

Racial Equity Considerations

Actors, partners and stakeholders working to implement this recommendation should consider the RE considerations that align the populations, systems involved and goals.

#11 Increase the Role People with Lived Expertise Have in Decision Making about Homeless Services, Programs, and Policies

People who have experienced homelessness are an indispensable voice in decision making on relevant programs and policies. Partners of the Systems Change Collaborative recommend exercising cultural competence and awareness, and person-centered strategies when engaging with people with lived expertise of homelessness or housing insecurity. For example, meeting in less formal settings, flexibility on how input is being received and providing food to guests when formal settings are deemed appropriate or necessary, [these examples are not exhaustive](#).

Opportunities for people with lived expertise to inform and participate in decision making include serving as community RFP reviewers, consultants when new programs or policies related to homelessness are being developed and city priorities are being shaped and routinizing collection and integration of ongoing feedback from participants in programs serving people experiencing homelessness. Members of the Systems Change Collaborative recommended that City Departments have structures for direct engagement with people with lived expertise to inform City programs and decisions, through a consumer advisory board or other structure that builds on existing groups. Collaborative members recommended that new and expanded roles for people with lived expertise build on rather than duplicate existing bodies such as the CoC Lived Experience Commission and Youth Action Board and the Flexible Housing Pool lived experience advisory council.



Photo: CDPH Commissioner Dr. Allison Arwady with a guest at a shelter-based Vaccination Event

What problem does this solve?

Uplifts the voice and expertise of consumers to inform key policy, practice, and funding decisions.

Alignment with Other Plans and Initiatives

- Coordinate with existing tables led by people with lived expertise (continuum of care, Housing Opportunities for Persons with AIDS (HOPWA), Flexible Housing Pool, etc.)
- Must consider what should the role of this council be, how to coordinate across multiple departments, and how to not duplicate or burden consumers

Key Populations

- Diverse representation of age groups- any newly established Community Advisory Board should represent the racial/ethnic demographics of residents experiencing homelessness
- Include representation of groups with complex health coordination and management

Roles for CDPH and Partners

- For CDPH this is a coordination activity and needs further definition. First step would be to initiate planning and coordination around PWLE involvement in consultation with DFSS and CoC/All Chicago and in consultation with other leadership groups of people with lived expertise to define roles, create advisory process, and define what would be in scope

Racial Equity Considerations

Methods to center the voices of people with lived expertise and have community-driven decisions can change racist structures/policies/practices and promote equity.

DATA SYSTEMS

#12 Establish a Community Information Exchange (CIE) as a Data Bridge between Healthcare and Homeless Service Providers

A Community Information Exchange (CIE) is a platform that provides “care coordination tools that bring together providers and data from the health and social services sectors.” Such a system could allow increased coordination of services between multiple providers and sectors, for example homeless service providers and medical providers.

In Chicago, the new 211 system presents an opportunity for designing and building a Community Information Exchange (CIE). The CIE will need to connect directly with the existing HMIS system to ensure data integration across sectors and to avoid any duplication of data entry processes. The 211 and CIE system design in Chicago also presents an opportunity to address needed system improvements for the 311 shelter placement system.

What problem does this solve?

People experiencing homelessness have their data and information siloed across multiple systems and there are few integrated services that work efficiently with data from different service providers, thus reducing the quality of services people experiencing homelessness receive.

Alignment with Other Plans and Initiatives

- New 211 and exploration of Community Information Exchange (CIE) – Chicago and Cook County priorities
- CoC priorities
- Former Housing and Health (H2) plan

Key Populations

- People receiving services from multiple systems
- Medical and homeless service providers

Roles for CDPH and Partners

- Convening, strategic leadership in coordination with Cook County
- Leveraging new 211 system and collaborative leadership structure
- CoC, HMIS users and healthcare providers must be involved in planning and implementation

Racial Equity Considerations

Actors, partners and stakeholders working to implement this recommendation should consider the RE considerations that align the populations, systems involved and goals.

#13 Design and Implement a Health/Healthcare Checklist in HMIS for People Leaving Shelter to Permanent Housing

Homeless Management Information System (HMIS) is a data system that the U.S. Department of Housing and Urban Development (HUD) requires every Continuum of Care (CoC) uses. HMIS is a database that collects and organizes specific data on people experiencing homelessness and the housing and homeless services that they receive. Collecting standardized data helps us better understand homelessness and allows us to measure progress towards specific goals. Since 2012, All Chicago has been elected by Chicago's Continuum of Care to administer Chicago's HMIS (Data Analytics, 2020).

What problem does this solve?

Promote continuity of care as people move across the homeless services system into housing and start to have data and information about the extent to which people are connected to care.

Key Populations

- Individuals and families with complex healthcare needs
- People with behavioral health conditions

Roles for CDPH and Partners

- CDPH can work with CoC/DFSS and shelter-based care teams (LCOs). Will require coordination among a number of system partners
-

Racial Equity Considerations

Potential to facilitate equitable access to healthcare services as households transition to permanent housing.

#14 Create a New Process to Ensure People Experiencing Homelessness Have Disability Status Captured in HMIS by Medical Professionals

Homeless Management Information System (HMIS) is a data system that the U.S. Department of Housing and Urban Development (HUD) requires every Continuum of Care (CoC) uses. HMIS is a database that collects and organizes specific data on people experiencing homelessness and the housing and homeless services that they receive. Collecting standardized data helps us better understand homelessness and allows us to measure progress towards specific goals. Since 2012, All Chicago has been elected by Chicago's Continuum of Care to administer Chicago's HMIS (Data Analytics, 2020).

Many permanent housing programs in Chicago, as in many other localities, require an individual qualifies as chronically homeless in order to be prioritized for housing. Chronic homelessness is a HUD-defined category that requires certain lengths of time experiencing homelessness AND a disabling condition. This information is drawn from Coordinated Entry Assessments within HMIS when housing matches are being made. Therefore, it is important that disability status is captured accurately in HMIS and that medical professionals working with people experiencing homelessness have an opportunity to inform that status within HMIS. There is not currently a systemic process to facilitate this communication.

What problem does this solve?

Address the issue of people not being able to establish their chronic homeless status and coordinated entry priority if disability status is not accurately reflected in HMIS by establishing a systematic way to ensure people have disability status documented.

Key Populations

- People with disabilities that are less apparent to non-clinical staff and who are not self-identifying during CES assessment

Roles for CDPH and Partners

- CDPH could work with CoC and healthcare providers to implement a pilot funding a group of healthcare systems that would commit to training providers, providing disability documentation and liaising with homeless system providers
 - Other system partners like CSH and Center for Housing and Health have expertise to leverage
 - Information should be available to both homeless service and medical partners
-

Racial Equity Considerations

Address structural barriers to accessing healthcare documentation for Black Chicagoans, LGBTQ+ Chicagoans, and other groups overrepresented in people experiencing homelessness that face structural barriers to quality care.

SYSTEM FUNDING AND SUSTAINABILITY

#15 Streamline Reporting Requirements Between Funders

Collaborative members lifted up the many streams of funding, both public and private, that homeless service providers and healthcare for the homeless providers often have and the administrative burden imposed. Members suggest looking for ways to streamline reporting requirements between funders and supporting foundation partners in conducting advocacy and public funder education on behalf of funding sectors to align funders around best practices.

What problem does this solve?

Program sustainability is impacted by requirements, bureaucracy, and paperwork. Staff time is pulled toward reporting and billing requirements and away from individual care/services.

Alignment with Other Plans and Initiatives

- Funders Together to End Homelessness
- CoC/Service Providers Commission
- Illinois Partners for Human Service

Key Populations

- Direct service providers
- Philanthropy

Roles for CDPH and Partners

- CDPH coordinate with DFSS and other public sector partners to engage with Funders Together to End Homelessness and other private funders
 - Engage delegate agencies and other funded partners in designing efficient systems and processes
 - Funders across government and philanthropy can partner to visit and lift up innovations and best practices from homeless service providers
-

Racial Equity Considerations

Intentionally prioritizing needs of smaller organizations and organizations led by people of color in designing systems and processes. Identifying structural inequities in funding and developing funding streams focused on addressing these.

#16 Increase Pay Equity Among Homeless Service Staff, Raise Rates, and Support Employment Opportunities for People with Lived Expertise in the Sector

The human services sector, including homeless services, struggles to provide adequate wages due in part to failures for reimbursement rates to meet Consumer Price Index increases since at least FY2000 (Fakhoury et al., 2021). Pay equity and increased funding allows for better and more consistent care for guests with complex medical and social needs and allows for better training and retention among homeless service staff (Illinois Partners for Human Service, 2021).

What problem does this solve?

Homeless service organizations are able to retain staff longer when pay is competitive and the quality of services is improved when staff is retained and when individuals with lived expertise are on staff.

Alignment with Other Plans and Initiatives

- Changes in pay and contracts during COVID
- Ongoing DFSS efforts to increase pay equity across delegates
- Illinois Partners for Human Service

Key Populations

- Staff within the homeless service sector and homeless
- People experiencing homelessness interested in career support and peer support staff opportunities

Roles for CDPH and Partners

- Lead role for DFSS and other funders (private and public)
 - Lead role for CoC and individual homeless services organizations to support employment opportunities for people with lived expertise
-

Racial Equity Considerations

Promoting more equitable funding across organizations and across neighborhoods increases equitable access. Racially and geographically equitable funding is an issue across the nonprofit sector.

PROGRESS AND ANTICIPATED MOVEMENT FOR RECOMMENDATIONS

This report documents priority recommendations of the Systems Change Collaborative with high potential to positively impact the health of Chicagoans experiencing homelessness. Many of these recommendations have strong alignment with goals of other partners, such as the Chicago Department of Family and Support Services, the Chicago Continuum of Care, and the State of Illinois in addition to the Chicago Department of Public Health. Recognizing that progress on these recommendations requires action from many different partners, the table below summarizes relevant progress that has been since the Collaborative started meeting and next steps that are expected in 2023. CDPH plans to update this table periodically to track progress on recommendations.

Recommendation	Current Status , as of March 2023
1. Shelter-Based Care: Maintain, Evaluate, and Expand the Shelter-Based Care Model	CDPH continues to fund the Shelter-Based Care (or LCO) program. In early 2023, this program was integrated into CDPH's Behavioral Health Bureau. Within this Bureau, an increased emphasis on behavioral health including substance use services and continuity with the rest of the CDPH Behavioral Health portfolio is being supported. In March 2023, the LCO contracts were extended through December 31, 2023 with an additional \$3,877,616 in funding. Northwestern University's EDIT program also completed an evaluation of the Shelter-Based Care Teams in Feb 2023, which supported the value of the program as well as many of the opportunities for continued growth highlighted by the Collaborative.
2. Refine and benchmark Standards of Care for Shelter-Based Care , and Incorporate into Shelter/CoC Standards	In 2023, CDPH will work with existing Shelter-Based Care partners to continue to build out the standards and will consider incorporating them into future shelter-based care RFPs.

Recommendation	Current Status, as of March 2023
<p>3. Increase access and support for substance use disorder treatment, including medication assisted treatment (MAT), Narcan knowledge and training, overdose follow-up, and drop-in services</p>	<p>In 2022, CDPH launched several programs designed to increase access to opioid use disorder treatment and harm reduction resources. These programs were designed particularly with the needs of individuals with barriers to accessing traditional models of service in mind, including people experiencing homelessness.</p> <p>The MAR NOW program is a hotline which connects individuals seeking medication assisted treatment or other opioid use treatment to immediate care. The hotline is staffed 24/7. Through MAR NOW, individuals are connected to a provider and able to start medication-assisted treatment the same day they call, with facilitation to ongoing care.</p> <p>MAR NOW has connected 275 people across Illinois to methadone, buprenorphine, or naltrexone since program launch in May 2022.</p> <ul style="list-style-type: none"> • 99% of callers calling for buprenorphine via home induction picked up their prescription. • 95% of callers calling for buprenorphine in-person attended their first appointment. • 76% of callers calling for methadone attended their first appointment. <p>CDPH also continued to build out partnerships to increase low-barrier access to harm reduction supplies, such as fentanyl test kits and Narcan. CDPH has provided trainings to shelter staff on administering Narcan and made Narcan available to the public at all 81 Chicago Public Library branches. Since Jan 2022, 4,851 Narcan kits have been distributed to the public at Chicago Public Libraries. In addition, since March 2022, CDPH clinics have distributed 334 Narcan kits, 321 Fentanyl test kits. CDPH has also made Narcan and Fentanyl test kits available at 11 bars, clubs, music venues or businesses since December 2022 and continues to expand this initiative.</p> <p>CDPH began working with Cook County Sheriff's Office in 2022 to ensure that everyone leaving Cook County Jail has access to Narcan, fentanyl test kits, and education on opioid overdose prevention. This partnership also funds several new reentry care managers within CCSO to help connect people leaving the jail to substance use disorder and mental health care.</p> <p>Additionally, CDPH expects to receive approximately \$78 million from opioid epidemic settlement funds and will utilize these funds to continue building these and other crucial efforts to expand low-barrier access to harm reduction and MAT. For more on plans for settlement funds, see https://www.chicago.gov/city/en/depts/cdph/provdrs/behavioral_health/news/2023/march/city-of-chicago-announces-new-initiatives-to-combat-the-opioid-e.html.</p>

Recommendation	Current Status, as of March 2023
<p>4. Advocate for additional flexibility for healthcare reimbursement mechanisms in Medicaid (i.e., Loaded Rate/Per Member Per Month [PMPM], not fee-for-service.)</p>	<p>No updates at this time.</p>
<p>5. Tenancy supports: Advocate for Medicaid funding for tenancy supports</p>	<p>The State of Illinois is moving forward with implementation of the Home Illinois plan which includes a commitment from the Department of Healthcare and Family Services (HFS) to “Request authorization from Medicaid to create a housing tenancy support and medical respite benefit.” HFS is expecting to take action on this priority in 2023.</p>
<p>6. Medical respite: Advocate for Medicaid-eligibility for medical respite at the state level and Position Chicago in collaboration with Cook County to quickly add medical respite beds to the system when Medicaid eligible</p>	<p>The State of Illinois is moving forward with implementation of the Home Illinois plan which includes a commitment from the Department of Healthcare and Family Services (HFS) to “Request authorization from Medicaid to create a housing tenancy support and medical respite benefit.” HFS is expecting to take action on this priority in 2023. IDHS has also funded 11 communities across Illinois in 2023, including several in Chicago and Cook County, for capacity building grants to plan for new or expanded medical respite services.</p>

Recommendation	Current Status, as of March 2023
<p>7. Expand non-congregate shelter, stabilization housing, and low-barrier shelter programs</p>	<p>Exciting progress has been made on these initiatives in alignment with the Chicago Recovery Plan.</p> <p>Non-congregate shelter: Through a partnership between the Department of Family and Support Services and the Department of Housing, the City is making funding available to increase the number of shelter beds that are not in congregate spaces. In September 2022, DOH released an RFP to fund the acquisition and rehabilitation of non-congregate shelter spaces. Approximately \$30 million will be distributed through this RFP. 5 grantee finalists were selected, who are now working with DOH toward individual closings.</p> <p>Additionally, in February 2023, DFSS released a Homeless Services Shelter Infrastructure Initiative RFQ. This RFQ will fund shelter providers in need of repairs and/or renovations that will significantly improve the quality of existing shelter facilities, restore beds lost due to COVID-19 and shelter “decompression”, and increase accessibility and non-congregate spaces for clients.</p> <p>Stabilization housing: CDPH will release an RFP for a Stabilization Housing program operator in Q2 2023 and DOH will be supporting site acquisition in collaboration with CDPH. The stabilization housing pilot program will create up to 40 non-congregate units for persons cycling through emergency rooms, jail, 911 services, and the shelter system. The space will stabilize an estimated 120 residents per year by providing shelter, integrated physical and behavioral health services, discharge planning and linkage to housing.</p> <p>Additionally, in February 2023, the Chicago Continuum of Care was awarded an additional \$60 million in funds through a Special NOFO process for projects designed to house and otherwise serve people experiencing homelessness. Through this award, a triage housing program was awarded \$2.5 million. The program model, similar to stabilization housing, is new to the Chicago CoC.</p> <p>Low-barrier shelter: DFSS is seeking opportunities to support an additional low-barrier shelter and support existing delegates in lowering barriers.</p>
<p>8. Increase accessible emergency shelter options and improve processes to ensure individuals with disabilities are directed to appropriate shelter</p>	<p>In recognition of the need highlighted by this recommendation, DOH and DFSS are prioritizing accessibility in the significant shelter investments outlined in Recommendation #7. Accessibility is being prioritized in all rehabilitations or acquisitions funded under these two initiatives, to which \$50 million has been dedicated.</p>

Recommendation	Current Status, as of March 2023
<p>9. Increase trauma training and support for shelter/housing continuum staff</p>	<p>CDPH Behavioral Health updates: Heartland Alliance Health and Lawndale Christian Health Center will provide Harm Reduction trainings. Heartland Alliance Health will be incorporating trauma trainings into their Shelter-Based Care work. CDPH is currently working with Center of Immigrant Health and Trilogy Behavioral Health to develop training cohorts to build capacity to understand mental health signs and symptoms, impact of trauma, and mental health first aid. Developments will be solidified, and trainings will be deployed across shelters with consultative follow up to support shelter staff in consolidation of learnings.</p> <p>Additionally, DFSS includes a trauma-informed programmatic approach in shelter and other homeless services RFPs as a program requirement and will continue to do so going forward.</p>
<p>10. Expand case conferencing within the CoC to include care coordinators and healthcare teams</p>	<p>No updates at this time.</p>
<p>11. Increase the role people with lived expertise have in decision-making about homeless services, programs, and policies</p>	<p>CDPH and DFSS are looking for opportunities to increase the role of people with lived expertise in decision making. DFSS has also adjusted the department's RFP and evaluation criteria recently to encourage increased roles for people with lived expertise in the program and policy design of delegate agencies.</p> <p>Additionally, in 2023, the Continuum of Care, the collaboration of the City, is beginning a 2-year TA opportunity with the US Interagency Council on Homeless and the White House that aims to reduce unsheltered homelessness. One focus of this partnership will be increasing the role of people with lived expertise in decision making.</p>
<p>12. Community Information Exchange: Establish a Community Information Exchange (CIE) as a data bridge between healthcare and homeless service providers</p>	<p>In early 2023, CDPH applied for CDC grant funding to fund a CIE planning initiative with a use case focused on people experiencing homelessness. The final award decision is shortly forthcoming. CDPH anticipates funding a year-long project to work through design of a CIE and CIE use case and lay the groundwork for necessary legal, technology and other resources to launch a CIE. CDPH will include people with lived expertise as compensated team members.</p>
<p>13. Design and implement a Health/Healthcare Checklist in HMIS for people leaving shelter to permanent housing</p>	<p>In 2022, the Chicago Continuum of Care worked to clarify HMIS decision making and role and responsibilities. This culminated in a new HMIS Memorandum of Understanding being approved by the CoC in December 2022 and adopted by the CoC membership at the All Members meeting in January 2023. As part of the new MOU, an HMIS Committee with responsibilities documented in the MOU has been launched and is meeting monthly. This groundwork has set the stage for increased HMIS improvements looking forward.</p>

Recommendation	Current Status , as of March 2023
14. Create a new process to ensure people experiencing homelessness have disability status captured in HMIS by medical professionals	See relevant update for Recommendation 13 above.
15. Streamline reporting requirements between funders , and support foundation partners to conduct advocacy and public funder education on behalf of funding sectors and align funders on best practices	In the State of Illinois' Home Illinois plan, IDHS set a goal of reviewing reporting requirements within their homeless services bureau to identify opportunities to implement reporting efficiencies with HUD homeless standardized reports. Such changes at the state level would, if enacted, would allow Chicago to streamline reporting requirements of homeless service providers locally.
16. Increase pay equity among homeless service staff, raise rates, and support employment opportunities for people with lived expertise in the sector	In fiscal year 2022, DFSS dedicated an additional \$1.5 million per year to raise the minimum shelter reimbursement rate per bed night in order to reach a more equitable baseline. In turn, service providers were able to raise direct service staff salaries. DFSS plans to maintain and where possible increase rates going forward- the 2023 City budget provided an additional \$3.7 million to raise the minimum shelter reimbursement rate per bed night and \$1 million to raise street outreach program frontline staff rates.

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APPENDIX: LANDSCAPE ASSESSMENT

Appendix: Landscape Assessment Report, April 2022

Chicago Department of Public Health's (CDPH)

Systems Change Collaborative to Improve the Health of People Experiencing Homelessness

Introduction and Goal of the Landscape Assessment

The Illinois Public Health Institute (IPHI) began to support CDPH's work on the Systems Change Collaborative to improve the health of people experiencing homelessness in Chicago in August of 2021. The Collaborative will focus on the following to expand access to high quality, comprehensive care for people experiencing homelessness and those transitioning into housing:

- benchmarking standards of care
- disseminating best practices
- identifying common needs
- advocating collectively for policy and system changes

Since the Collaborative plans to build on the existing efforts of partners throughout the city, it was important to complete a Landscape Assessment to provide a foundation for the project. The goal of the Landscape Assessment was to understand the local landscape of assets, health needs, and health-related services that are available to people experiencing homelessness in Chicago. The information collection methods included:

- key informant interviews with service providers and other key partners
- discussions with people with lived experience and expertise
- review of publicly-available data
- review of existing conditions data and information collected by the Chicago Department of Public Health, the Lead Coordination Organizations (LCOs), and the Chicago Department of Family and Support Services (DFSS) throughout the pandemic
- review of local and national best practices

Given the time urgency of this project, and the limited capacity on the part of all partners, IPHI leveraged existing data and information for the Landscape Assessment to be able to focus this project's partner engagement and data collection on collaborative problem-solving and system strategy development.

Partnership Analysis and Interviewees

With partner engagement being a cross-cutting approach for this project, the project's launch included discussing what organizations and individuals were key partners for this project. We determined that, in order to accomplish the set goals, it will be important to work closely with CDPH, DFSS, the Local Coordinating Organizations (Lawndale Christian Health Center and Heartland Alliance Health), people with lived experience of homelessness, and others with aligned work during this phase of the project.

Therefore, the IPHI and Wilburn Strategic Solutions teams interviewed 34 individuals representing shelters, primary care, outreach, advocacy groups, city and state agencies, people with lived expertise, and more. People with lived expertise were compensated for their time and input for the interview. After identifying the key partners to interview, we cross walked their organization and name with the key policy and systems issue

areas (Data and Technology, Standards of Care, Continuity of Care, Sustainable Funding Models, Housing and Shelter Models, and Workforce Development) to organize which questions to ask during the interviews and analyze any gaps in our assessment. The following are the organizations that we interviewed:

1. All Chicago
2. Alliance Chicago
3. Center for Housing & Health
4. Chicago Department of Public Health, Behavioral Health
5. Chicago Homelessness and Health Response Group for Equity (CHHRGE)
6. Cook County Health
7. Corporation for Supportive Housing (CSH)
8. Chicago Department of Family and Support Services (DFSS)
9. Funders Together to End Homelessness
10. Heartland Alliance Health (including mobile health and substance use teams)
11. Housing Action Illinois
12. Illinois Department of Human Services (IDHS)
13. Lawndale Christian Health Center
14. Matthew House
15. The Night Ministry
16. Renaissance Social Services
17. Thresholds

Key Policy and System Issues

During the first part of the key informant interviews, individuals were asked to analyze the list of key policy and systems issues and let us know if anything should be changed or added to the list. Many interviewees agreed with the list being a good high-level summary of the issues that persist. In addition, several interviewees mentioned key approaches that should be highlighted throughout the project, including communication; advocacy; coordination; and racial equity, specifically addressing structural racism and trust between people experiencing homelessness and healthcare providers. Other considerations included policies and funding related to increased prevention for the homeless system, preparation for another pandemic, and the importance to emphasize housing and shelter as separate issues. Workforce development pertaining to both people with lived experience of homelessness and shelter providers was also mentioned several times and was added to the list of policy and systems-level issues during the second round of interviews to reflect these statements.

We then asked the interviewees to name any collaborative tables that currently exist and discuss any of the key policy and system issues that we are focusing on. The list of collaboratives is in the table below.

- CoCs (Chicago/Suburban)
- Bring Chicago Home
- CHHRGE
- Chicago Coalition for the Homeless
- Chicago MAT Collaborative

- Chicago CoC System Analysis and Resource Development team
- CoC Affinity Groups
- CES System Integration Meetings
- COCHI - Collaborative on Child Homelessness Illinois
- DFSS Meetings - Youth Homelessness
- Expedited Housing Initiative
- Flexible Housing Pool
- Funders Together to End Homelessness (national and Chicago affiliate)
- Illinois Housing Roundtable
- Michael Reese Health Trust Roundtable
- National and local medical respite convenings
- Pride Action Tank Roundtable
- PSH Medical Workgroup
- Road Map Initiative
- Sinai Urban Health Institute - Housing/Community Health Advisory Council
- Supportive Housing Providers Association of IL (SHPA)
- Urban Labs convening on data dashboard
- West Side Opioid Task Force
- Illinois Interagency Task Force on Homelessness and council
- Treatment not Trauma
- CDPH Health Equity Zones
- Chicago Metropolitan Agency on Planning (CMAP)
- Chicago Council on Mental Health Equity (CCMHE)
- Illinois Collaboration on Youth (ICOY)

Next, we asked the interviewees a series of questions related to the policy and systems issue categories we had marked for them previously. The results of the key informant discussions are below.

Data and Technology

Interviewees were asked to share thoughts on the technology infrastructure needed to support care delivery and information sharing across settings of care.

Overall, key informants highlighted the importance of creating a real-time shared platform that is accessible to consumers, responsive, and able to communicate with other systems. Systems must be responsive and set up to communicate with each other whenever possible to avoid duplication and to better support individuals involved in multiple care systems. They also identified the need for a forum to share best practices, communicate around data sharing and integration, define problems and opportunities, and break down silos. Several people mentioned that they felt the City should be involved in this effort and work to establish standards or guidance, and partnerships with the right organizations. We also heard that just identifying who has need and creating data systems to link data across systems will not solve the bigger, root problem, but it will certainly help.

Here are more detailed notes from the discussions:

- There is a need for an integrated, real-time shared platform for multiple systems; this will not solve the problem but will support efforts.
- One key issue that was presented during the interviews is that the HMIS is siloed to housing providers. Clinical providers cannot look to see if their patient is active in the HMIS system and vice versa.
- It was recommended that these two systems, as well as others, such as the justice system, should be integrated. Partners from each system could come together to discuss what information would be useful, while also engaging people with lived expertise and practicing empathy and humility to understand the perspective of individuals needing help. People with lived expertise could also help to alert us to where good intentions in making data available might actually create unintended vulnerabilities.
- It will be important to address and dismantle the structural racism that influences many of these barriers and issues.
- Articulate use cases and communicate the need for data sharing and integration, and what are best systems/approaches to accomplish
- It is difficult to obtain and/or share medical records and history for patients.
- It's a challenge to support partner organizations when sharing client-level information since it is difficult to share medical history between systems.
- For example, it is very difficult from the perspective of FQHCs to share data with any healthcare or housing partners.
- Some interviewees have considered solutions like data-sharing agreements between organizations to ease the burden. The agreements begin with discussions around patients' healthcare needs, HIPAA regulations, referrals, and appointment follow-up.
- It would be helpful for the city to provide resources, funding, standards, and best practices as well as establish key partnerships to resolve issues and prevent data duplication.
- For best practices, it was mentioned that it would be great if templates and/or roadmaps on how to achieve systems change around data and technology could be shared. The best practices could come from other cities and regions in the country. The City could support that engages best practices and what successful practices and agreements could look like/be structured.
- A neutral party might be needed in the conversations so that vendors and businesses are not driving the need.
- The City could continue funding the HMIS.
- Provide a clear explanation of how the data being pulled is going to benefit the person whose data will be shared.
- Think about how the programs can be held accountable to each other and not in separate spheres.
- Take a holistic view; if we all agree that homelessness is a problem that has tremendous economic and social cost to us as a city, we should figure out how to be more creative about using our resources in a more organized way.
- It is important to have the right partners at the table.

- It will be important to have key partners at the table with the capacity to move the system. The City could partner with Cook County and the State to actualize some of the recommended solutions to bring about systems change.
- There have been a few examples of how healthcare systems have come together and collected pieces of data consistently to identify opportunity areas, like using standardized surveillance and mandated reporting to monitor chronic diseases. This could be applied to healthcare and homelessness services.
- One pilot used a data platform/ technology called Capricorn to create a data join between the HMIS system and a medical database. The technology allowed for a way to identify the same patient in multiple databases in a deidentified way. This would highlight whether they were receiving certain housing services and what their experience was like in the healthcare institution. The findings were that there was not as much overlap between people identified in the HMIS system and people identified in the institution. This was a hint of what the impact of stable housing was.
- Much of the responses in the interviews pointed to the question of how could housing be more integrated with other parts of the system.
- Input from people with lived expertise and system users is crucial.
- Community co-lead design is essential for policy and system-level change because those most impacted should be involved in developing solutions for the future. Co-designing with the community will lead us to innovative approaches to push us past default practices that may continue to propel systemic inequities.
- We need to understand the problem, what the constraints are, who is going to buy into it, and who will work with it.
- Before you move too quickly with a technology solution, you first need to understand the problem you will have to solve, what the constraints are, who is going to buy into it, and who will work with it.
- If everyone agreed that they all thought this information was important and all were committed to making it available and using it and collecting it in a way where it could populate whatever infrastructure, it won't be a problem to find a technology.
- A common language and set of terms/standards is needed.
- Accurately portray what the contribution of various services are to items that are major costs to payers (create opportunity for them to realize the need for adjusting their investments)
- If we could more accurately portray what the contribution of the various services are to things that are appearing as major costs to payers, then there might be an opportunity for them to realize the need for adjusting their investments.
- We're probably spending much more money in total than if we became more efficient and spent it well.
- A comprehensive pilot that tracks the data and expenditures across the system could lead to us engaging with the people with money in a different way.
- Implement a more consumer-centric approach where part of the goal is to make sure the consumer provides and understands consent, has easier access to their own data, and can assemble the information themselves.

Standards of Care

For this section, interviewees were asked to share thoughts on strategies to disseminate and implement the healthcare for the homeless standards of care, including infection control, the integration of primary and behavioral health, and coordination between outpatient and inpatient care settings.

Many of the individuals that were interviewed were not too familiar with the Standards for Shelter-Based Health Care document that was authored by Mary Tornabene and Dr. Thomas Huggett in 2020, or the Healthcare for the Homeless standards, but several individuals had thoughts about what would be beneficial to include in these documents and where the standards could be implemented.

Overall, interviewees stated that we should identify ways to expand to other sites of care when implementing the standards, such as other Federally Qualified Health Centers (FQHCs), hospitals, ambulatory sites, and homeless service providers. All standards should be aligned in some way and incorporate best practices for behavioral health, transportation, malpractice, prenatal care, oral health, working with specific populations, and utilizing students and volunteers. Several people also mentioned that our system could do a better job at educating people experiencing homelessness and those transitioning to housing on healthcare and benefit selections, and that that should be a standard practice as well. Moreover, there is a need to create an implementation and evaluation plan for standards of care.

Here are detailed notes from the discussions:

- The standards should be expanded to hospitals and other ambulatory and FQHC sites.
- Increase direct engagement of homeless service providers with standards.
- Develop an implementation plan, evaluation plan, and metrics for deployment of the standards.
- Build out standards for the following topics: behavioral health, transportation and accessibility, malpractice, students/volunteers, specific populations, prenatal care, and oral health.
- Be consistent with providing support for selecting benefits and providers and understanding insurance processes, changes, and enrollment.

Care Continuity

Several interviewees were asked to share thoughts on interventions that promote care continuity as people move across the homeless system and into housing.

Overall, most individuals emphasized that we must acknowledge that housing is a healthcare issue that needs greater resources. There is not enough housing, so even if the system's processes improve, the issue will not be resolved if we don't have housing to put people in. Placing people into housing should be prioritized so that we can focus on other aspects of the continuity of care.

There was also a lot of confusion from interviewees around registration, prioritization, coordination, and how someone is placed into housing with the Coordinated Entry System, but we did learn that there are resources on the Center for Supportive Housing and All Chicago websites that explain some of this. In addition, we heard many concerns about the prioritization tool or process needing to be reviewed and

revamped to be more equitable. Overall, many people don't really understand the processes if they're not working with them on a daily basis. People felt that the system is so process-heavy and that it has to be doing more harm than good to the people that need the resources.

Another theme that emerged from the conversations is that care coordination and case management processes should be reviewed and streamlined to better identify, track, and mutually support people experiencing homelessness. Clients need more supportive services during their transition to housing. Every client has unique needs that determine how they interact with healthcare systems; the system needs to be intentionally aware and responsive to this. People mentioned that they do not know what happens from a healthcare aspect once someone is housed, and people that have experienced this also noted that they would have liked more support that was tailored to their unique needs and situation. When someone shows up to a shelter or is transitioned into housing, there is a need for an easier way for care teams to take someone into their care system or find a way to make sure that that patient can stay connected to their same care team.

Along the path to housing in this system, it is important for all environments to be welcoming, consistently supportive, and adaptive so that all people experiencing homelessness receive the best service possible.

Here are more detailed notes from the discussions:

- There is not enough housing and resources for those experiencing homelessness – this is a healthcare issue as well as a housing issue.
- There was very limited knowledge of entire process for care coordination and care continuity for those transitioning to housing.
- There was also very high variability of knowledge around registration and prioritization processes for the Coordinated Entry System outside of those that work with it.
- The system needs to improve communication around processes, limitations regarding hours of service, and services for participants with high-needs (for both Coordinated Entry and housing placement).
- Shelter-Based Care Teams must have an easier way for them to take someone into their care system; if someone is going to go to another clinic, then warm connection should be made.
- The prioritization tool may not be equitable.
- The current system is process heavy, which is harmful to the people that the system is trying to support.
- The ability to find people must be significantly improved to increase efficiency.
- Some people experiencing homelessness may not be recognized by a hospital if they are not experiencing extreme homelessness or identifying themselves due to vulnerabilities that they perceive with sharing.
- Some people experiencing homelessness refuse to go to the emergency room because they cannot bring their belongings, they cannot leave their partner, or they are scared to go through withdrawal if they are using substances. There should also be a strategy for high-utilizers.
- Case management should be streamlined across the system; there is no consistency with resources that are shared or training for the professionals.

- More supportive services are needed during the transition to housing.
- It is important to have a supportive and welcoming environment for people that are experiencing homelessness, especially for those that are sick.
- In order to support care continuity for the patient, there needs to be more access to transportation services for appointments and any technology needed for the patient to use these services, such as a cell phone.
- The definition of homelessness can be a barrier to some trying to get help and support.
- The 311 website could be used more effectively to help with homelessness.
- Make sure clinicians/healthcare providers are at the table.

Sustainable Funding Models

A few interviewees answered questions around how sustainable funding models (Medicaid reimbursement, etc.) could be used to facilitate the provision of care in shelters and encampments, medical respite/stabilization, and as people move into permanent housing.

The overall theme that emerged from the interviews is that policies need to be created to increase funding at different levels of the government to address healthcare for people experiencing homelessness, such as more funding for behavioral health (including counseling and therapy), housing (including tenancy and pre-tenancy services), workforce and staff expansion, outreach services, case management, and nursing. Many interviewees noted the potential that Medicaid could have in supporting transitions to housing, but that currently there are limited options for Medicaid billing and reimbursement. This could be resolved with a focus on leveraging innovative policy to increase Medicaid reimbursement and cover as many of these services as possible. All funding, even dollars outside of Medicaid, should be flexible and adjustable based on needs to create sustainability for those providing support to people experiencing homelessness.

The most effective and cost-saving strategies that were noted for sustainable funding are to prevent people from experiencing homelessness and to just pay for housing as a system improvement since this may be the cheaper and most effective route.

Here are more detailed notes from the discussions:

- All policy levers must be coordinated to bring together funding at different levels of government with innovative care delivery models by healthcare (including behavioral health) and increased funding for housing.
- There is a need for funding for all topics, including workforce and staff expansion (nursing, outreach, psychiatrists, peer support, etc.).
- Several services have no (or limited) options for billing and reimbursement from Medicaid, which creates the need for outside funding.
- Look more in depth at innovative policy and reimbursement opportunities related to team-based care, outreach and engagement work, coverage of some specific services (like nursing in shelters), expanded behavioral health services, case management, and housing tenancy supports.
- Prevention is a totally different strategy that needs more thought.

- Movement to encourage Medicaid to support the transitioning people from homelessness into housing was great; the 1115 waiver part got approved, but then nothing happened with it.
- If there was a way to figure out how to make the numbers (funding) work, that would make a big difference.
- It is probably much cheaper to just pay for housing.
- Understand where inefficiencies are in the system, and then right-size funding.
- There is a need for flexibility in funding for outreach and people who are living on the streets.

Housing Models

As stated previously, we received the suggestion to emphasize both housing models and shelter models separately. Therefore, the results will be summarized separately. This section summarizes thoughts on optimal housing models to improve the health of people experiencing homelessness.

Once again, there is not enough housing, so there is a need for much more resources and funding for this issue. Overall, interviewees stated that there needs to be a focus on providing a wider range of affordable housing models that are safe, supportive, welcoming, easy to navigate, well-funded, and low-barrier. The housing should also be well-resourced, including having the ability to provide quality support services such as mental health and substance use services. Clients have unique needs and past experiences that should be considered when they are housed – not every environment is the perfect environment for some. The neighborhoods should have a safe area to walk, access to healthy foods, laundry, and any other services necessary to have a healthy lifestyle.

This also points to the need for relationships with case managers, landlords, and building managers to be streamlined. For instance, case managers should be trained to match the needs of each individual to different housing models and neighborhoods.

Intentionally working to end and prevent generational homelessness should also be a focus when discussing housing models.

Here are more detailed notes from the discussions:

- Optimal housing models need to be the focus, making sure there is increased resources and funding for housing, including permanent supportive housing.
- Bring awareness to the flow/ process map showing how people navigate the systems to access housing; this would be helpful to understand to continue strategizing.
- Models should be low-barrier and welcome guests as they are.
- Pick a place that fits the clients' needs, such as for people that have serious mental illnesses and/or experience substance use.
- The needs are also based on how long someone has been experiencing homelessness.
- Supportive housing is not the solution for everyone so we need to invest in a wider range of affordable housing models and solutions so that folks can have options that meet their needs.

- Case managers are able to understand each person and know what they need and want; this can be leveraged for system improvements.
- Housing models should have quality supportive services attached to them, including recovery and stabilization housing.
- Relationships with landlords and building managers need to be streamlined.
- There needs to be more focus on families and youth experiencing homelessness, which will help with ending generational homelessness.
- Being involved with the justice system is a barrier to getting help.

Shelter Models

Partners were then asked to share their thoughts on optimal shelter models, including changes to the physical footprint of shelters to provide health outcomes.

First, we need to address the inequities in shelter resources and capacity. Multiple interviewees noted the inequitable differences in shelters based on geographic locations, with funding being noted as a direct influence of this. Ultimately, more funding must be shifted to affordable housing.

Interviewees also mentioned that shelter models should be low-barrier and welcome guests as they are, especially for specific populations, like those that are unsheltered, LGBTQ+, specifically trans people of color, undocumented, families, youth, re-entry, and those experiencing acute homelessness. All of these populations need tailored care and support.

Respite care must be seen and developed more as a bridge between shelters and housing.

Here are more detailed notes from the discussions:

- There are inequities in shelter resources (including funding) and capacity on the South Side of the City.
- Models for shelters should be low-barrier and welcome guests as they are.
- The rules at shelters are too stringent for guests.
- Limited business hours and/or curfews are barriers for people that have to work, especially those that work non-traditional hours.
- The more money being spent on shelters means less money being spent on housing.
- The development of medical respite is needed as a bridge.
- People experiencing homelessness that are unsheltered, transgender, transgender people of color, undocumented, etc. need more attention and resources.
- More shelters need to accommodate families.
- There should be more focus on the re-entry and acute populations, and a need to be more flexible with them.

Workforce Development

Lastly, some interviewees were asked questions about workforce development, including coordination support, professional development for shelter staff, and expanding outreach and engagement. Workforce development for both people with lived expertise and providers emerged as a theme throughout the interviews. In both domains, the workforce and staff must continuously be developed and expanded, including care coordination, case management, community health workers, and outreach and engagement workers, and wages must be livable and competitive.

To go even further, professional development must consistently be offered to fuel sustainability as well. Job training and opportunities for career development should be prioritized for individuals with lived expertise and shelter staff.

Here are more detailed notes from the discussions:

- Silos across sectors must be broken down so that care can be effectively supported and coordinated.
- For staffing, it is very important to expand the outreach and engagement workforce - care coordinators, case managers, community health workers, outreach workers, etc.
- Coordination support is needed for new and existing work; this was mentioned by partners both in homeless services and healthcare.
- Professional development for shelter staff is needed to create equitable career pathways.
- There are opportunities for workforce development across sectors/silos to improve systems of care and continuity of care.
- There should be livable wages and cost of living increases; it is not okay to fight poverty with poverty.
- There is a need for more formal training and job opportunities for people with lived expertise, including a ladder for improvement. Structural changes need to be made to allow career opportunities for people with lived expertise, including those that have involvement with the justice system (especially from crimes of homelessness).
- Provide more training and onboarding that is focused on emotional intelligence and being judgment-free.