With special thanks

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

Leadership partners
Letter from the Leadership Council Chair

To my Fellow Plan Stakeholders,

We are very grateful to all the members of the Leadership Council of our Chicago and Cook County Housing for Health (H2) Strategic Plan: 2017-2019, for their organizations that continue to support and guide our implementation activities, and for all of you. This Chicago Area collaboration between our housing and healthcare sectors, which in most places unfortunately are often siloed and without coordination and integration, is providing incredible opportunities to end homelessness and improve health outcomes among members of its various populations. Our Strategic Plan offers our community a blueprint with clear and measurable benchmarks for achieving realistic goals in the service of those with the experience of homelessness. Our Plan’s vision and mission call for long-term stable housing with high quality integrated healthcare services. It does so for all individuals and families with the experience of homelessness and living with health challenges. Our vision and mission are indeed extremely important today, especially within the context of our present social and political realities.

Our Leadership Council calls on all stakeholders who share our vision and mission to support our planning and implementation efforts. As we await our political leadership to determine the future of healthcare reform and Medicaid-funded services in our nation, we need your support and advocacy more than ever. We are actively pursuing and implementing our three strategic priorities and 25 SMART Goals. We will do all we can together to end homelessness and improve health outcomes for some of the most vulnerable individuals and families in our communities.

We welcome and encourage your continued participation with our Plan implementation efforts. We are so grateful for your involvement. If you have not been involved as of this date, we welcome your future participation and support.

With much gratitude,

Ed Stellon, Executive Director
Heartland Health Outreach
Chair, Leadership Council
Chicago and Cook County Housing for Health (H2) Strategic Plan: 2017-2019
Brief History of the Chicago and Cook County H2 Plans and Executive Summary of the H2 Strategic Plan: 2017-2019

In February 2015, officials from the National Office of the U.S. Department of Housing and Urban Development (HUD) approached Chicago Area leaders in the homeless services and healthcare sectors about HUD’s “Housing and Health (H2)” Project. The Obama Administration was requesting a select number of HUD-funded Homeless Continuums of Care to work closely with federal and state funded healthcare service systems to: (a) increase access to healthcare for homeless populations; (b) improve their health outcomes; and (c) decrease unnecessary costs to the healthcare sector. HUD’s H2 Project was also supported and sponsored by the U.S. Department of Health and Human Services (HHS), and especially its HRSA and SAMHSA Divisions.HUD officials were offering our two Area Continuums in the City of Chicago and Suburban Cook County technical assistance services (TA) to prepare an H2 Action Plan for 2016 to support the achievement of these objectives.

Chicago and Cook County has a long history of serving homeless populations, especially those suffering with chronic illnesses and other disabilities, through a variety of integrated housing and health services. The Cook County Health and Hospital System (CCHHS) has served these populations for decades at its County hospitals and clinics. Heartland Health Outreach (HHO) established its Federally Qualified Health Center (FQHC) for the Homeless in the 1980s; and it continues to provide both stable housing and medical and behavioral health services with thousands of persons experiencing homelessness. Thresholds has done the same, especially serving those with severe and persistent mental illnesses (SMI). The Corporation for Supportive Housing (CSH) has worked closely over the years with a number of Chicago Area housing providers to create thousands of supportive housing units for homeless populations disabled by chronic illnesses or other major challenges. The AIDS Foundation of Chicago (AFC) and its Center for Housing and Health (CHH) have served homeless populations living with HIV or AIDS or other chronic medical conditions through a variety of housing and health services. Between 2003 and 2008, AFC helped lead the nation in showing the cost benefits of supportive housing through its Chicago Housing for Health Partnership Research Study (CHHP), which published its findings in the Journal of the American Medical Association in 2009. The above examples are a few of a number of others.

Because of its multi-year history in offering homeless populations integrated housing and health services and because Cook County had added thousands of those living in homelessness to the State Medicaid Program through the Affordable Care Act’s (ACA) Expansion Project in 2014, HUD chose Chicago and Cook County to be the first major U.S. metropolitan area to prepare and implement an H2 Plan. The two lead organizations for preparing and adopting an H2 Plan, which worked closely with the HUD T.A. Provider – “Homebase,” were All Chicago and AFC’s Center for Housing and Health.

Also in 2014, when CCHHS was leading the major effort to enroll thousands of low-income residents of Chicago and Cook County into the State’s Medicaid Expansion Programs, the Michael Reese Health Trust (MRHT) and Polk Bros. Foundation (Polk) sponsored a Supportive Housing and Medicaid Chicago Area Summit in March. AFC’s Center for Housing and Health facilitated the summit bringing together for a day of dialogue and initial planning key public and private sectors leaders in the supportive housing and Medicaid-funded systems of healthcare. Among the participants were Director Julie Hamos of the State Medicaid Office (IDHFS), Secretary Michele Sadler of the Illinois Department of Human Services (IDHS), Steven Glass from CCHHS, Commissioner Bechara Suchair from the Chicago Department of Public Health, Karen Batia from HHO and Together for Health, Mark Ishaug from Thresholds, a number of area leaders from Medicaid Managed Care (MCO) and Coordinated Care Entities (CCE), representatives from Chicago’s Lived Experience Commission (experience with homelessness), the CEOs of a dozen of Chicago’s largest supportive housing organizations, and private foundation representatives. The Summit with over 60 participants marked the beginning of a two-year period of much consultation and planning that eventually resulted in the 2016 Chicago and Cook County Housing for Health (H2) Action Plan.

In July 2015 and with the help of HUD’s TA Providers, many of the same area leaders of homeless and healthcare services who had participated in the Summit met for two days to begin preparing the 2016 H2 Action Plan. Planning workgroups were established immediately following the July meetings. MRHT and Polk sponsored a second Summit on October 19, during which the first draft of the proposed Action Plan was reviewed with other concerns and
challenges addressed. By late November of that year the proposed Action Plan was ready for approval. HHO, CSH, and CHH then convened the first meeting of the official Leadership Council of the Chicago and Cook County Housing for Health Plan on December 10, 2015. At that meeting Leadership Council members, guided by the advice and support of national representatives of HUD, SAMHSA, and the U.S. Interagency Council on Homelessness (USIACH) who were present at the gathering, approved the 2016 Action Plan. The Executive Directors of the Plan’s Lead Agencies at that time, namely HHO, CSH, and CHH, made it clear that part of the 2016 Action Plan was to prepare a longer and more detailed three-year strategic plan that would begin in January 2017.

Throughout 2016, a number of stakeholders participated in the implementation of the H² Action Plan. Implementation workgroups met monthly. During those meetings, much needed interaction, coordination, and strategizing occurred among members of the various sectors involved: Medicaid MCOs, supportive housing Providers, Lived Experience Council members, hospital and health system administrators, public officials from State, County, and City government, and a number of other Plan contributors and advocates. During the last six months of 2016, workgroup participants also focused on the preparation of the three-year H² Strategic Plan.

The Plan’s Leadership Council met twice that year - once in April to review an report on plan implementation activities and give feedback, and a second time in late November to receive a report on the H² 2016 Action Plan implementation results and to approve the new three-year Strategic Plan. At the meeting, Ed Stellon was elected as the first Chair of the Plan’s Leadership Council.

The Chicago and Cook County 2017-2019 Housing for Health (H²) Strategic Plan clearly identifies its Vision and Mission with a very specific Target Population. The Plan calls for long-term stable housing with integrated and quality healthcare services for all homeless populations who are living with health challenges. Its Strategic Priorities are geared for those who experience homelessness, or have experienced it and are now housed, in accordance with the HHS/HRSA homeless definition.

The three Strategic Priorities call for increasing the “capacity” of both the supportive housing and healthcare sectors by thousands of new housing units with well-integrated and quality healthcare services. The Chicago Area already has some “best-practices” examples of such.

Supportive housing units, but many more are needed if our City and County are to end homelessness and improve health outcomes for the Plan’s Target Population. The Priorities also call for more and strengthened “partnerships and joint projects” between the two sectors. The University of Illinois Health and Hospital System (UI Health) Housing Project with Chicago’s Better Health Through Housing Collaborative and its joint project with All Chicago for hospital and HMIS data integration provide excellent examples of such partnerships. Much more needs to be learned about systems integration through projects like these.

Finally, each of the 25 SMART Goals in the Plan is organized under one of the three Strategic Priorities for the sake of monitoring and Plan implementation activity. However, as the Mission Statement clearly outlines, all 25 SMART Goals will need to focus on data sharing and integration efforts, cross-training between the sectors, service coordination and integration projects, and increased capacity for housing and serving some of the most vulnerable residents of our communities.

Plan implementation activities began in January and February of this year after a short recess by participating Plan leadership and stakeholder during the December holiday period. Three workgroups have been organized and are meeting bi-monthly; and 25 SMART Goal subgroups are working on a weekly basis to implement the Plan by following clear outlines and identified benchmarks for each of the 25 Goals.

The Center for Housing and Health, which continues to receive support from MRHT and Polk, is staffing the Plan implementation work and activity. The Center will issue a quarterly reports beginning April of this year, which will update all stakeholders on the progress of Plan implementation.

Chicago Area Housing and Health Leadership is extremely grateful for all the support and guidance that has been provided to make this H² Strategic Plan a reality, especially as it makes use of a very realistic and achievable approach to implementation.
Endnotes

1. The Health Resources Services Administration (HRSA) funds many community clinics serving homeless populations, and the Substance Abuse and Mental Health Services Administration (SAMHSA) also supports a variety of projects with them.

2. The official roster of the Plan’s Leadership Council follows this History and Executive Summary.

3. Jennifer Ho, Senior Advisor to the HUD Secretary, represented HUD, Richard S. Cho, Deputy Director, represented IACH, and Jayme S. Marshall, Branch Chief of Homeless Programs, represented SAMHSA.

4. See the approved H2 2016 Action Plan in the Appendix Section.

5. During the summer of 2016, All Chicago and the Cook County Suburban Alliance to End Homelessness were added to the Plan’s Team of Lead Agencies.

6. See list of hundreds of participating stakeholders for both the H2 Action and Strategic Plans in the document immediately following the 2017-2019 Strategic Plan.

7. See the PowerPoint presentation of the report in the Appendix Section.

8. See both HUD and HRSA definitions of homelessness for a comparison of similarities and differences in the Appendix Section.

9. See brief project description with initial results in the Appendix Section.

10. SMART: Specific, Measurable, Achievable, Realistic, and with Time benchmarks.

11. See Appendix Section for document identifying each of the SMART Goals with its subgroup members and clearly measurable benchmarks.
Leadership Council Members – March 2017

Supportive Housing and Health Care Providers and Advocates
Carl Wolf, Executive Director, Respond Now, cwolf@respondnow.org
Cheryl Potts, Executive Director, Alexian Brothers, Housing and Health Alliance, cheryl.potts@alexian.net
Ed Stellon, Executive Director, Heartland Health Outreach, estellon@heartlandalliance.org
Katie Tuten, Program Manager, Program Development, Catholic Charities, ktuten@catholiccharities.net
Lynda Schueler, Executive Director, Housing Forward, lschueler@housingforward.org
Mark Angelini, President and CEO, Mercy Housing, mangelini@mercyhousing.org
Mark Ishaug, Chief Executive Officer, Thresholds, mark.ishaug@thresholds.org
Michael Banghart, Executive Director, Renaissance Social Services, mbanghart@rssichicago.org

Managed Care Entities Leadership
Beth Gasaway, Clinical Manager, Case Management, IlliniCare Health Plan, Bgasaway@illinicare.com
Bruce Himelstein, Senior Medical Director, BCBS of Illinois, Bruce_Himelstein@bcbsil.com
Emily Cassidy, Program Director, Molina Healthcare of Illinois, Emily.Cassidy@MolinaHealthcare.com
Heather Scalia, Director of Community Engagement, Humana, hscalial@humana.com
Sam Olds Frey, Executive Director, Illinois Association of Medicaid Health Plans, samoldsltc@gmail.com
Steven Glass, Executive Director, Managed Care, Cook County Health & Hospitals System, sglass@cookcountyhhs.org

Lived Experience Advocates
Connie Bacon, Lived Experience Commission, conniebacon@rocketmail.com
Richard Rowe, Lived Experience Commission and Heartland Health Outreach, RRowe@heartlandalliance.org

City of Chicago Officials
Annissa Lambirth-Garrett, Executive Director, Chicago Low-Income Housing Trust Fund, Annissa.Lambirth-Garrett@cityofchicago.org
Julie Morita, Commissioner, Chicago Department of Public Health, Julie.Morita@cityofchicago.org
Lisa Morrison Butler, Commissioner, City of Chicago Department of Family & Support Services, Lisa.Morrison_Butler@cityofchicago.org
Mary Howard, Deputy Chief Housing Officer, Resident Services, Chicago Housing Authority, mhoward@thecha.org

Cook County Officials
Dominic Tocci, Cook County Department of Planning and Development, Dominic.Tocci@cookcountyil.gov
Doug Elwell, Deputy CEO of Strategy and Finance, Cook County Health and Hospitals System, delwell@cookcountyhhs.org
Kathy Chan, Director of Policy, Cook County Health and Hospital System, kchan5@cookcountyhhs.org
Richard Monocchio, Executive Director, Housing Authority of Cook County

State of Illinois Officials
Avijit Ghosh, CEO, UIC Hospital and Clinics, ghosha@uillinois.edu
Felicia Norwood, Healthcare and Family Services Director, Illinois Department of Healthcare and Family Services, felicia.norwood@illinois.gov
James Dimas, Illinois Department of Human Services Secretary, james.t.dimas@illinois.gov
Lore Baker, Statewide Housing Coordinator for Long Term Care Reform, IDHS, Secretary’s Office, lore.baker@illinois.gov
**Federal Agency Officials**
Catherine Peterson, Midwest Regional Office, US Department of Housing and Urban Development, catherine.s.peterson@hud.gov
Jeff Coady, Regional Administrator, Substance Abuse and Mental Health Services Administration, jeffrey.coady@samhsa.hhs.gov
Ronald Fought, Associate Director for Patient Care Service/Nurse Executive, Jesse Brown VA Medical Center, Ronald.Fought@va.gov

**System Level Organizations**
Betsy Benito, Executive Director, Corporation for Supportive Housing, Chicago, betsy.benito@csh.org
Consuela Brown, Vice President for Programs, All Chicago, cbrown@allchicago.org
Dan Rabbitt, Health Advocacy Specialist, Heartland Alliance, drabbitt@heartlandalliance.org
Jennifer Hill, Executive Director, Alliance to End Homelessness in Suburban Cook County, jennifer@suburbancook.org
Pamela Rodriguez, President & CEO, Treatment Alternatives for Safe Communities, prodriguez@tasc.org
Pete Toepfer, Associate Vice President of Housing, AIDS Foundation of Chicago/Executive Director, Center for Housing & Health, ptoepfer@aidschicago.org, ptoepfer@housingforhealth.org
William Trick, Director, Collaborative Research Unit, CCHHS, WTrick@cookcountyhhs.org

**Foundation Representatives**
Anna Lee, Program Officer, Chicago Community Trust, alee@cct.org
Debbie Reznick, Senior Program Officer, Polk Bros. Foundation, dreznick@polkbrosfdn.org
Gayla Brockman, President and CEO, Michael Reese Health Trust, gbrockman@healthtrust.net
William Koll, Senior Officer, McCormick Foundation, bkoll@mccormickfoundation.org

**Consultant**
Arturo V. Bendixen, abendixen2020@gmail.com
H² Strategic Plan: 2017-2019

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

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

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

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

**Strategic Priorities**

**Strategic Priority #1 – Increase the housing inventory serving homeless populations**
**IMPACT**: Stable housing for thousands experiencing homelessness in the streets, parks, and shelters of our City and County

**Strategic Priority #2 – Increase the quantity and quality of services resulting in optimal health outcomes**
**IMPACT**: Improved health outcomes among the homeless populations

**Strategic Priority #3 – Strengthen and expand partnerships between the housing and Healthcare Systems**
**IMPACT**: Increased access to and participation in housing and healthcare by homeless populations
SMART goals under strategic priorities

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

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

Goal 1.1 - By July 2017, end Veteran’s homelessness in Chicago reaching a “functional zero” target and with at least 75% of housed residents accessing all needed health services through the VA Health System or mainstream health partners

Goal 1.2 - By August 2017, complete with at least five area hospitals and healthcare systems a feasibility study of the possible conversion of their unused properties into recuperative care (respite) housing programs and short-term or long-term housing units

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

Goal 1.4 – By December 2017, complete a feasibility study for the development in Chicago and Cook County of at least three new supportive housing project-based buildings together with a health impact assessment

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

Goal 1.6 – By December 2019, have at least three fully functioning and sustainable “moving on” projects in Chicago and Cook County serving at least 500 annually

Goal 1.7 – By December 2019, make use of healthcare sources and the Medicaid benefit of “pre-tenancy and tenancy services” for service dollars to increase the supportive housing inventory by 2,000 new units

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

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

**IMPACT:** Improved health outcomes among the homeless populations

Goal 2.1 - By July 2017, implement a strategy with at least two FQHCs or safety net health providers to increase the integration of at least two health clinics with supportive housing programs

Goal 2.2 - By July 2017, develop and implement a communication strategy for a Medicaid reimbursable higher rate for mental health and substance use treatment, expanded eligible populations, and increased eligible settings for service delivery

Goal 2.3 - By November 2017, provide at least 10 cross-training sessions for service providers in both homeless service and healthcare entities

Goal 2.4 - By December 2017, inform and support the State’s credentialing standards, medical necessity criteria,
utilization management policies and rules for claims submission for the Medicaid Tenancy Supports Benefit for supportive housing providers

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

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

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

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

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

Goal 3.1 - By July 2017, establish an HIV/AIDS housing cascade that identifies health outcomes of HIV housing program residents and describes program models with correlated HIV-health outcomes

Goal 3.2 - By July 2017, assign care coordinators from at least three Medicaid Managed Care Organizations (MCO) to specifically serve all their own insured members living in at least five project-based supportive housing buildings or shelters

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

Goal 3.4 - By July 2017, provide accurate information through HMIS to at least five healthcare entities on the aggregated numbers of the homeless and formerly homeless in their data bases

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

Goal 3.6 - By December 2017, have identifiable data via a new consent form for 70% of HMIS participants that includes their Medicaid Recipient Identity Number (RIN) and MCO membership

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

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

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

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

*See Appendix section for a description of the proposed project
Participating Stakeholders with the Chicago and Cook County Housing for Health (H2) Plans from 2015 to 2017

Supportive Housing and Health Providers and Advocates
1. Carl Wolf, Executive Director, Respond Now
2. Catherine Lothspeich, Alexian Brothers Housing and Health Alliance
3. Cheryl Potts, Executive Director, Alexian Brothers, Housing and Health Alliance
4. David Esposito, VP for Housing, Thresholds
5. Debbie Pavick, Senior Vice President, Thresholds
6. Ed Stellon, Executive Director, Heartland Health Outreach
7. Felix Matlock, Mercy Housing
8. Frank Lowe, Respond Now
9. John Mayes, Trilogy
10. Judith Gethner, Executive Director, IL Partners in Human Services
11. Judy Perloff, Chicago House
12. Kathleen Kelleghan, Heartland Health Outreach
13. Kathy Booton Wilson, Deborah’s Place
14. Kathy Kerney, Thresholds
15. Katie Tuten, Program Manager, Program Development, Catholic Charities
16. Lynda Schueler, Executive Director, Housing Forward
17. Mark Angelini, President and CEO, Mercy Housing
18. Mark Ishaug, Chief Executive Officer, Thresholds
19. Mary Kay Gilbert, Heartland Health Outreach
20. Michael Banghart, Executive Director, Renaissance Social Services
21. Randi Tolliver, Heartland Health Outreach

Managed Care Entities Leadership
1. Beth Gasaway, Clinical Manager, Case Management, IlliniCare Health Plan
2. Bruce Himelstein, Medical Director, Aetna Better Health
3. Christie Hahn, Aetna Better Health- IL
4. Craig Rose, Clinical Supervisor, Aetna Better Health- IL
5. Debra Day, Director of Community Relations, Care Management, Aetna Better Health- IL
6. Ellen Dooley, Family Health Network
7. Emily Cassidy, Program Director, Molina Healthcare of Illinois
8. Enrique Salgado, WellCare Health Plans
9. Florodeluna Pasia, Case Management, Community Connector, Molina
10. Heather Scalia, Director, Community Engagement, Humana
11. Hetal Patel, IlliniCare
12. Karen Brach, Vice President of Medicaid, Blue Cross Blue Shield of Illinois
13. Katie Stephens, Housing Specialist, Molina
14. Lena Liberto, Humana
15. Lindsey Artola, IlliniCare
16. Lisa Wiseman, Humana
17. Lori Jones, Next Level
18. Lynn Stroiber, IlliniCare
19. Marcy Elamin, CountyCare
20. Matthew Stockov, Senior Data and Analytics Consultant, Aetna Better Health- IL
21. Michael Kidonakis, IlliniCare
22. Robert Hilliard, Jr., Harmony Health Plan
23. Ross Collins, Aetna
24. Sam Olds Frey, Executive Director, Illinois Association of Medicaid Health Plans
25. Steven Glass, Executive Director, Managed Care, Cook County Health & Hospitals System

Lived Experience Advocates
1. Becki Martello, Lived Experience Commission
2. Chris O’Hara, Lived Experience Commission
3. Connie Bacon, Lived Experience Commission
4. Richard Rowe, Lived Experience Commission and Heartland Health Outreach

City of Chicago, Cook County, State of Illinois Officials
1. Avijit Ghosh, CEO, UIC Hospital and Clinics
2. Alisa Rodriguez, City of Chicago
3. Anne Posner, Director of Health Equity & Strategic Partnerships, Chicago Department of Public Health
4. Annissa Lambirth-Garrett, Executive Director, Chicago Low-Income Housing Trust Fund
5. Brenda Hampton, State of Illinois IDHS/DMH
6. Bryan Zises, Illinois Housing Development Authority
7. Chris Denes, City of Chicago
8. Craig Conover, Medical Research Analytics and Informatics Alliance (MRAIA)
9. Dave Skora, City of Chicago
10. Deborah Grant, IDPH
11. Dominic Tocci, Cook County Department of Planning and Development
12. Doug Elwell, Deputy CEO of Strategy and Finance, Cook County Health and Hospitals System
13. Elizabeth Weiss, State of Illinois
14. Ellie Montgomery, County Jail
15. Errick Christian, Cook County Health and Hospitals System
17. Gladys Taylor, Illinois Department of Correction
18. James Dimas, Illinois Department of Human Services Secretary
19. James Parker, State of Illinois HFS
20. Jamie Ewing, State of Illinois Department of Human Services
21. Jane Hornstein, Cook County Planning and Development
22. Jennifer Fabbrinini, Chicago Public Schools
23. Joe Hollendonner, Chicago Department of Public Health
24. John Jay Shannon, Cook County Health & Hospitals System
25. Julie Morita, Commissioner, Chicago Department of Public Health
26. Kathy Chan, Director of Policy, Cook County Health and Hospital System
27. Kellie Gage, DASA
28. Lisa Morrison Butler, Commissioner, City of Chicago Department of Family & Support Services
29. Lora McCurdy, State of Illinois HFS
30. Lore Baker, Statewide Housing Coordinator for Long Term Care Reform, IDHS, Secretary’s Office
31. Mary Howard, Deputy Chief Housing Officer, Resident Services, Chicago Housing Authority
32. Mary Sajdak, Cook County Health and Hospitals System
33. Megan Toth, Public Health Program Director, Medical Research Analytics and Informatics Alliance
34. Nik Prachand, Director of Epidemiology, Chicago Department of Public Health
35. Pam Ward, Illinois Department of Corrections
36. Richard Monocchio, Executive Director, Housing Authority of Cook County
37. Rick Wilk, Health Resources and Services Administration
38. Robert Mendonsa, Healthcare and Family Services
39. Stephanie Davis, UI Health
40. Stephen Brown, Director of Preventive Emergency Medicine, University of Illinois Hospital and Health Sciences System
41. William Trick, Cook County Health and Hospitals System

**Federal Agency Officials**
1. Antonio Riley, Midwest Regional Administrator, US Department of Housing and Urban Development
2. Catherine Peterson, US Department of Housing and Urban Development
3. Jeff Coady, Regional Administrator, Substance Abuse and Mental Health Services Administration
4. Jennifer Ho, US Department of Housing and Urban Development
5. Nora Lally, US Department of Housing and Urban Development
6. Tamara Cox, Health Resources and Services Administration

**System-Level Organizations**
1. Aaron Eldridge, Supportive Housing Providers Association
2. Andrew Hamilton, Alliance of Chicago
3. Angie Miller, AIDS Foundation of Chicago
4. Arturo Bendixen, Center for Housing and Health
5. Bethany Manerd-Moody, Suburban Alliance
6. Betsy Benito, Executive Director, Corporation for Supportive Housing, Chicago
7. Consuela Brown, Vice President for Programs, All Chicago
8. Dan Rabbitt, Health Advocacy Specialist, Heartland Alliance
9. Dave Thomas, All Chicago
10. Fred Rachman, Alliance of Chicago
11. Jennifer Hill, Executive Director, Alliance to End Homelessness in Suburban Cook County
12. Jessie Beebe, AIDS Foundation of Chicago/Center for Housing and Health
13. John Fallon, CSH
14. Julie Nelson, CSH
15. Lisa Mayse-Lillig, All Chicago
16. Lia Daniels, Illinois Hospital Association
17. Madeline Shea, AIDS Foundation of Chicago
18. Mary Lynn Clarke, Illinois Hospital Association
19. Michael Bach, Supportive Housing Providers Association
20. Padma Thangaraj, All Chicago
21. Pamela Rodriguez, President & CEO, Treatment Alternatives for Safe Communities
22. Pankaja (P.J.) Desai, Alliance of Chicago
23. Peggy Troyer, Suburban Alliance
24. Pete Toepfer, Associate Vice President of Housing, AIDS Foundation of Chicago/Executive Director, Center for Housing & Health
25. Renae Alvarez, Policy Analyst, the Center for Long Term Care Reform, Health & Medicine Policy Research Group (HMPRG)
26. Rich Sciortino, Brinshore Developers
27. Sharon Post, Health & Medicine Policy Research Group (HMPRG)
28. Stephanie Sideman, CSH
29. Svetlana Zhemebeyeva, Center for Housing and Health
Foundation Representatives

1. Anna Lee, Program Officer, Chicago Community Trust
2. Brandon Thorne, Chicago Community Trust
3. Debbie Reznick, Senior Program Officer, Polk Bros. Foundation
4. Denis Pierce, Pierce Family Foundation
5. Elizabeth Lee, Michael Reese Health Trust
6. Gayla Brockman, President and CEO, Michael Reese Health Trust
7. William Koll, Senior Officer, McCormick Foundation

Note: Our list is most likely missing a number of other stakeholders and planning and implementation contributors. We ask in advance our apologies if we have left out your name due to record keeping challenges. We will be happy to add the missing names as we update the ONLINE version on a monthly basis.
SMART goals

**S**omewhat specific
**M**easurable
**A**chievable
**R**ealistic
**T**ime limits
SMART Goals with Benchmarks for 2017

[March 2017 Update]

Goal 1.1 - By July 2017, end Veteran's homelessness in Chicago reaching a "functional zero" target and with at least 75% of housed residents accessing all needed health services through the VA Health System or mainstream health partners

Operationalizing Benchmarks:

- Throughout 2017, CSH continues to coordinate all organizations collaborating to end Veteran Homelessness and issues monthly reports on the progress toward a “functional zero” goal
- Throughout 2017, CSH and together with All Chicago continue to manage the ONE LIST that tracks homelessness and housing for homeless veterans in Chicago
- By July 2017, CSH and its partner organizations bring down the number of days for accessing PSH to 90 days for veterans experiencing homelessness
- By July 2017, Chicago ends Veteran's chronic homelessness reaching a "functional zero" target, including the remaining 144 individuals who are homeless
- By December 2017, Chicago end Veteran's homelessness reaching a "functional zero" target and with at least 75% of housed residents accessing all needed health services through the VA Health System or mainstream health partners

Goal 1.2 - By August 2017, complete with at least five area hospitals and healthcare systems a feasibility study of the possible conversion of their unused properties into recuperative care (respite) housing programs and short-term or long-term housing units

Operationalizing Benchmarks:

- By April 2017, HDA and with the support of CDPH and CHH issue a brief report on how their Hospital Collaborative plans to help fund supportive housing for their patients experiencing homelessness
- By June 2017, The McCormick Foundation makes a final decision regarding their support of the Hospital Collaborative and its Housing Project
• By August 2017, the HDA issues the results of a feasibility study for the possible conversion of their unused properties into recuperative care (respite) housing programs and short-term or long-term housing units.

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

Operationalizing Benchmarks:
• By June 2017, convene at least 3 group education sessions on the flexible rental subsidy pool concept with at a minimum the CDPH Hospital Collaborative, government funders, and private foundations.
• By June 2017 and following the CSH National Conference, CSH Illinois office issues a short summary report on (a) what is being learned from existing Flexible Rental Subsidy Pools around the country, and (b) an initial strategy for establishing one for Chicago and Cook County.
• By July 2017, CSH convenes a meeting with area foundations and other possible grantmakers and presents the 2017 Chicago Strategy for a Flexible Rental Subsidy Pool.
• By October 2017, secure commitments from funders on contributions to a Flexible Rental Subsidy Pool.
• By October 2017, establish an advisory body with governance and operating structures.
• By December 2017, identify a body to administer the flexible rental subsidy pool.

Goal 1.4 – By December 2017, complete a feasibility study for the development in Chicago and Cook County of at least three new supportive housing project-based buildings together with a health impact assessment.

Operationalizing Benchmarks:
• By April 2017, CSH and the Suburban Alliance agree on how their two agencies will pursue the feasibility study with health impact assessments.
• By June 2017, CSH and the Suburban Alliance convene the partner agencies who will participate in the feasibility study, including those who will assist with resources.
• By September 2017, all preparations for the feasibility study with health impact assessments are completed.
• By December 2017, complete a feasibility study for the development in Chicago and Cook County of at least three new supportive housing project-based buildings together with a health impact assessment.

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

Operationalizing Benchmarks:
STRATEGIC PLAN: 2017-2019

- By April 2017, All Chicago and the Suburban Alliance identify the approximate month(s) when HUD may release new opportunities the funding availability for new Bonus Projects
- By May 2017, All Chicago and the Suburban Alliance identify the 2017 process to recapture unused HUD Homeless funds and repurpose them for new supportive housing units
- By May 2017, the SMART Goal 1.5 Subgroup meets to determine a strategy for supporting and coordinating applications for new HUD Bonus projects to serve the Plan’s Target population and
- By May 2017, the SMART Goal 1.5 Subgroup meets to determine a strategy for advocating for as many unused and recaptured HUD dollars to be used for the Plan’s Target Population
- By September 2017, the SMART Goal 1.5 Subgroup supports the implementation of both strategies

Goal 1.6 – By December 2019, have at least three fully functioning and sustainable “moving on” projects in Chicago and Cook County serving at least 500 annually

Operationalizing Benchmarks:
- Throughout 2017, CSH continue to advocate with CHA to support CSH’s “Moving On Pilot” in Chicago; and the Suburban Alliance will continue to support HACC with a similar Pilot in Cook County, which is called FLOW.
- By July 2017, the Suburban Alliance monitors the possibility of using 85 HACC vouchers in 2017 for the FLOW Program (see Note #1 below)
- By December 2017, CSH and Suburban Alliance to End Homelessness conduct 5 training sessions for Chicago and Cook County's PSH providers on how to promote the moving-on culture among their PSH residents.
- By December 2017, CSH and Suburban Alliance to End Homelessness conduct 3 informational sessions for Chicago and Cook County's PSH providers about how their Property Rental Assistance Program (PRA) residents, who no longer need intensive services, can move on to affordable housing opportunities in the community by utilizing CHA and HACC Housing Choice Vouchers.
- By December 2017, CSH facilitates a process with 54 CHA vouchers for 2017 (see Note #2 below) with PSH agencies in Chicago applying for them for their “moving on” residents

Notes:
1. There is a projected 15% cut to HUD's budget this year and HACC put the FLOW voucher on hold because they might use them for people who are already utilizing HACC vouchers so they do not lose their housing.
2. Beginning in 2017, all CHA project-based voucher tenants, including those in supportive housing, will have the ability to request a tenant-based voucher after one-year of tenancy and meeting other federal rules.
Goal 1.7 – By December 2019, make use of healthcare sources and the Medicaid benefit of “pre-tenancy and tenancy services” for service dollars to increase the supportive housing inventory by 2,000 new units

Operationalizing Benchmarks:
- By July 2017, CasaYSalud finishes a survey of all new PSH units for the Plan’s target population being created in 2017 in Chicago and Suburban Cook County
- By September 2017, CSH and CHH estimate how many new PSH units for the Plan’s target population may be created with the support of the Medicaid Tenancy Services dollars beyond 2017
- By December 2017, CasaYSalud tallies the number of new PSH units for the Plan’s target population created in 2017 in Chicago and Suburban Cook County
- By December 2017, CSH and CHH identify and secure funding for at least 200 new PSH units through the braiding of housing rental subsidies and Medicaid “Pre-tenancy and Tenancy Service” dollars for those living with persistent and severe mental illness and/or long-term substance use

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

Operationalizing Benchmarks:
- By July 2017, CHH consults with CCHHS staff regarding their plan to fund housing units for jail inmates leaving the County Jail
- By July 2017, CHH consults with HDA and CDPH staff regarding their plan to fund housing units through their Hospital Collaborative
- By August 2017, CHH consults with other area organizations regarding possible funding opportunities for low-income housing units for members of the target population who are not eligible for supportive housing
- By December 2017, CHH issues a short report on a possible strategy to begin the funding of 500 low-income housing units by December 2019

Goal 2.1 - By July 2017, implement a strategy with at least two FQHCs or safety net health providers to increase the integration of at least two health clinics with supportive housing programs

Operationalizing Benchmarks:
- By May 2017, HHO executes sharing agreements for the Health Neighborhood Program with four Permanent Supportive Housing providers and begins their integration of participant care with Heartland Health Outreach
- By June 2017, HHO completes implementation of the Health Neighborhood Program with three Permanent Supportive Housing providers and fully integrates the care of mutual participants
• By June 2017, HHO executes a sharing agreement for the Health Neighborhood Program with one additional Permanent Supportive Housing provider and begins its integration of participant care with Heartland Health Outreach
• By July 2017, HHO completes implementation of the Health Neighborhood Program with the two remaining Permanent Supportive Housing providers and fully integrates the care of mutual participants, for a total of five PSH providers

Goal 2.2 - By July 2017, develop and implement a communication strategy for a Medicaid reimbursable higher rate for mental health and substance use treatment, expanded eligible populations, and increased eligible settings for service delivery

Operationalizing Benchmarks:
• By April 2017, the Goal 2.2 Subgroup Members begin collaborating with other mental health and SUD groups in the work to retain the recent Medicaid add-on payment for Rule 132 services
• By May 2017, Subgroup Members collect needed secondary research to demonstrate the return on investment thanks to increased access to MH/SUD treatment, with a special focus on the Plan’s target population
• By June 2017, Subgroup Members join other advocates to identify and engage key public officials on the need for enhanced reimbursement and eligibility criteria for MH/SUD, with a special focus on the Plan’s target population
• By June 2017, Subgroup Members join other advocates and submit comments to JCAR on the revision of Rule 132, now to be named Rule 160
• By July 2017, Subgroup Members collaborate with HFS on the design of the Integrated Health Homes and the design of the tenancy supports program, both pending federal approval

Goal 2.3 - By November 2017, provide at least 10 cross-training sessions for service providers in both homeless service and healthcare entities

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

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

Operationalizing Benchmarks for 2017:
• By March 31, CasaYSalud will determine the various groupings and their numbers of case managers and other service workers (e.g. outreach workers) who will need to be trained by December 2019
• By March 31, CHH staff will prepare a list of required competencies to meet the needs of our target populations in regards to SMART Goals 2.5, 2.7, and 3.6 (HMIS new consent forms with RINs)
• By April 20, the HFH Services Workgroup with approve the required competencies for the trainings
• By April 30, CHH staff will provide two training opportunities for All Chicago and Suburban Alliance HMIS trainers on how RINs can be identified by members of the target populations with the support of their outreach and case workers
• By April 30, CasaYSalud will support Thresholds and HHO staff to identify how many of their own trainings will be held in 2017 and how many of their workers (serving the target population) will be trained by them on the required competencies
• By May 1, CHH staff will publicize the 2017 schedule for at least two trainings for “agency trainers” or other agency leaders to support them with their own staff in achieving the required competencies
• By May 1, CHH staff will publicize the 2017 schedule for at least four trainings for case and outreach workers that support them to achieve the required competencies
• By the summer, the State of Illinois will activate the ABE Portal “Manage My Case”
• By the fall, CHH will sponsor at least three training for MCO workers and hospital staff on the approved competencies that support the SMART Goals
• By November, CasaYSalud will support CHH staff with an evaluation of the 2017 trainings and their impact on worker competencies and with recommendations for 2018 benchmarks
• By November, S.H.O.P. Study leadership will provide a report on a list of health services provided by the 22 participating PSH agencies

Goal 2.4 - By December 2017, inform and support the State’s credentialing standards, medical necessity criteria, utilization management policies and rules for claims submission for the Medicaid Tenancy Supports Benefit for supportive housing providers

Operationalizing Benchmarks in 2017:
• By April 30, 2017, CSH proposes policy recommendations on the contractual relationship between SH providers and health plans. Standards to be determine include target population, billing structure, claims submissions expectations medical necessity criteria for the benefit and utilization management processes and schedules.
• By April 30, 2017, CSH provides draft service definitions of roles of tenancy support services and credentialing standards for services in SH
• By May 31, 2017, a team of CSH and CHH staff train SH providers in documentation requirements, and determine how many existing SH tenants will be eligible for waiver services for tenancy supports based on eligible populations and encourage providers to take the CSH Dimensions of Quality Self-Assessment
• By June 30, 2017, CSH helps lead the establishment of a case rate payment structure (PM/PM) that reflects true costs of housing tenancy services for people with MI and SA
• By July 31, 2017, CSH assists SH providers statewide with aligning activities in SH programs with the waiver and help determine the need for Administrative Services Organization support, third-party providers or other funding mechanisms for non-Waiver services
• By December 31, 2017, the State provides training for participating SH providers (i.e. CSH Medicaid Academy) to prepare for implementation of the benefit
• By December 31, 2017, the State will provide training for Managed Care Organizations to prepare for implementation of the benefit
• By December 31, 2017, CSH establishes credentialing standards, medical necessity criteria, utilization management policies and rules for claims submission for the Medicaid Tenancy Supports Benefit in the 1115 Waiver that are accessible and flexible for supportive housing providers

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

Operationalizing Benchmarks in 2017:
• By July 2017, CHH recruits at least 850 of the 1,000 PSH residents to participate in the research study
• By July 2017, AFC research teams complete 100% of scheduled follow-up interviews
• By October 2017, CHH recruit the last remaining 150 PSH residents to participate in the research study
• By December 2017, AFC completes 100% of scheduled follow-up interviews
• By December 2017, complete the cost study portion of the research study
• By December 2017, the Medical College of Wisconsin and CasaYSalud begin the Medicaid data portion of the research study

Goal 3.1 - By July 2017, establish an HIV/AIDS housing cascade that identifies health outcomes of HIV housing program residents and describes program models with correlated HIV-health outcomes

Operationalizing Benchmarks in 2017:
• By March 2017, CDPH establishes a plan to generate the HOPWA cascade for Chicago on an annual basis and develop a strategy to create cascades for each CDPH funded HOPWA service category
• By October 2017, AFC and CDPH agree on the methodology for an HIV/AIDS housing cascade that identifies health outcomes of HIV housing program residents and describes program models with their correlated HIV-health outcomes
• By March 2018, CDPH generates HOPWA cascades by program type for Chicago with their correlated HIV-health outcomes
Goal 3.2 - By July 2017, assign care coordinators from at least three Medicaid Managed Care Organizations (MCO) to specifically serve all their own insured members living in at least five project-based supportive housing buildings or shelters

Operationazing Benchmarks in 2017:
- By March 2017, CHH staff contact all MCO representatives working with the H² Plan and invite to participate in the project
- By April 2017, CHH staff convene a meeting with all interested MCO representatives to review project objectives and the commitment required
- By May 2017, CHH share the list of addresses of all PSH Project-based buildings or homeless shelters, whose addresses are in the public record, with MCOs committed to the project
- By July 2017, at least three Medicaid MCOs assign their care coordinators to specifically serve all their own insured members living in at least five project-based supportive housing buildings or shelters

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

Operationalizing Benchmarks in 2017:
- By May 2017, All Chicago and UIC Hospital finalize a Community Action Plan to generate shared and integrated data on those served in common by UI Health and the Chicano HMIS (Academy Health Grant)
- By June 2017, All Chicago and UI Health finalize a portal with the Chicago HMIS
- By July 2017, All Chicago and UI Health demonstrate a portal with the HMIS-All Chicago / UI Health Academy Health Grant

Goal 3.4 - By July 2017, provide accurate information through HMIS to at least five healthcare entities on the aggregated numbers of the homeless and formerly homeless in their data bases

Operationalizing Benchmarks: in 2017
- By May 2017, All Chicago, the Suburban Alliance, and CDPH complete the data sharing project between HIV-surveillance and the HMIS Databases to determine the number of homeless individuals living with HIV or AIDS in Chicago and Suburban Cook County
- By July 2017, Chicago and the Suburban Alliance complete the ABT/HUD--funded project between the HMIS and Medicaid Databases in order to track Medicaid enrollment and expenditures for two years prior to and two years following a placement of the homeless in permanent supportive housing
- By July 2017, All Chicago and/or the Suburban Alliance identify at least three other data sharing projects by HMIS Databases with healthcare entities to determine the
aggregated numbers of the homeless and formerly homeless in the healthcare databases

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

**Operationazing Benchmarks in 2017:**

- **By May 2017,** participating CAPriCORN hospital and healthcare systems identify the prevalence of individuals recognized as meeting the HUD definition, the HRSA definition, and both definitions of homelessness
- **By June 2017,** CAPriCORN participating health institutions describe issues which contribute to the complexity of reporting on the homeless status of their patients
- **By July 2017,** HMIS, HHO, and CAPriCORN encrypted data is shared to achieve the following two benchmarks
- **By August 2017,** CAPriCORN leadership describes frequently occurring key diagnoses and combinations of conditions (comorbidities) to specify areas of focus and inform the development of targeted programming, interventions, and outreach
- **By September 2017,** CAPriCORN leadership characterizes health care utilization by homeless status in the CAPriCORN participating health institutions in order to understand mean use and determine the implications of utilization findings

**Goal 3.6 - By December 2017, have identifiable data via a new consent form for 70% of HMIS participants that includes their Medicaid Recipient Identity Number (RIN) and MCO membership**

**Operationa**lizing Benchmarks in 2017:

- **By May 2017,** All Chicago and the Suburban Alliance train all HMIS data collection and entry staff on the updated (fall 2016) HMIS consent form
- **By December 2017,** All Chicago and the Suburban Alliance administer the updated HMIS consent form with at least 80% of active participants in the Chicago and Suburban Cook County
- **By December 2017,** All Chicago and the Suburban Alliance have identifiable data for 70% of HMIS participants that includes their Medicaid RIN and Medicaid MCO

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

**Operationa**lizing Benchmarks in 2017:

- **By December 2017** and after reviewing and evaluating the success of the 2017 HMIS Data Sharing Project (Goal 3.4), prepare the 2018 benchmarks for this SMART Goal
Goal 3.8 - By June 2018, develop and implement a service-high-user targeting tool with Medicaid MCOs for identifying and serving insured members needing PSH

Operationalizing Benchmarks in 2017:
- By July 2017, All Chicago and UIC Hospital demonstrate a portal with the Chicago HMIS and UI Health databases through the Academy Health Grant Project
- By September 2017, CasaYSalud support interested stakeholders begin a sustainability plan and process for fully integrating HMIS into Cerner Electronic Medical records
- By March 2018, UI Health develops the service-high-user targeting tool with Medicaid MCOs for identifying and serving insured members needing PSH
- By June 2018, CHH and UI Health implement a service-high-user targeting tool with Medicaid MCOs for identifying and serving insured members needing PSH

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

Operationalizing Benchmarks:
- By April 30, 2017, CHH introduces SMART Goal benchmarks at the Chicago CoC Coordinated Entry Committee
- By May 31, 2017, CHH agrees with the Suburban Alliance how SMART Goal benchmarks will be implemented in its Coordinated Entry activity
- By June 30, 2017, CHH finalizes with the Chicago CoC Coordinated Entry Committee how SMART Goal benchmarks will be implemented
- By December 31, 2017, CHH leadership, in conjunction with the Suburban Alliance and All Chicago, will facilitate data and data sharing procedures for identifying high users of health care services
- By December 2018, a team of CSH and CHH staff support homeless outreach, skilled navigation and assessment, homeless shelters, and bridge housing programs to locate and engage at least 50% of MCO homeless members and re-connect them with health care services while waiting for housing
- By December 2018, a team of CSH, All Chicago, and CHH staff give access to at least five health system providers to Coordinated Entry Systems in Chicago and Cook County that include coordinated outreach and bridge housing serving at least 2,000 individuals and families annually

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

Operationalizing Benchmarks in 2017:
- By December 2017 and after reviewing and evaluating the success of the 2017 CAPriCORN Project (Goal 3.5), prepare the 2018 benchmarks for this SMART Goal
Legal Definitions of Homelessness

Required for Eligibility to Receive Services Funded by HUD and HRSA

Health Services Resource Administration (HRSA) Definition of Homeless

Health centers funded by the U.S. Department of Health and Human Services (HHS) use the following definition of homelessness:

A homeless individual is defined in section 330(h)(4)(A) as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing." A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. [Section 330 of the Public Health Service Act (42 U.S.C., 254b)]

An individual may be considered to be homeless if that person is "doubled up," a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness. (HRSA/Bureau of Primary Health Care, Program Assistance Letter 1999-12, Health Care for the Homeless Principles of Practice)

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U.S. Department of Housing and Urban Development (HUD) Definition of Homeless

Programs funded by HUD use a different, more limited definition of homelessness.²

For example, an individual or family are considered literally homeless³ only when they reside in one of the places described below:

- In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, bus or train station, airport, or camping ground, etc.;
- In an emergency shelter or transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals;
- In any of the above places but is spending a limited time (up to 90 consecutive days) in a hospital or other institution.

The following do NOT meet the HUD definition of Homeless:

- Persons living in housing, even though they are paying an excessive amount for their housing, the housing is substandard and in need of repair, or the housing is crowded.
- Persons who couch-surf and live with relatives or friends because they do not have any other housing options
- Persons staying in a motel, including a pay-by-the-week motels if they pay for their rent out-of-pocket
- Persons living in a Board and Care, Adult Congregate Living Facility, or similar place.

Most Permanent Supportive Housing (PSH) programs funded by HUD can only serve homeless clients that meet the aforementioned requirements in addition to other qualifying conditions (e.g. disability and length of homelessness).

² Found in the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (P.L. 111-22, Section 1003)
³ Category 1 of the HUD Homeless Definition. Please see the full definition at https://www.hudexchange.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf
**Simplified Table for Easy Reference**

[Always Refer to Official Definitions]

*HUD funds mostly housing and HRSA healthcare services*

<table>
<thead>
<tr>
<th>LOCATION OF PERSONS</th>
<th>HUD</th>
<th>HRSA</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living in the streets or other places not meant for human habitation</td>
<td>X</td>
<td>X</td>
<td>Examples: under bridges, abandoned buildings, cars, Lower Wacker Drive,…</td>
</tr>
<tr>
<td>Living in homeless emergency shelters</td>
<td>X</td>
<td>X</td>
<td>Most are overnight shelters for only night time use</td>
</tr>
<tr>
<td>In temporary housing for street or shelter homeless populations</td>
<td>X</td>
<td>X</td>
<td>Many called Interim or Transitional Housing serving homeless populations</td>
</tr>
<tr>
<td>Street or shelter homeless persons inpatient in a hospital or other institution for less than 90 days</td>
<td>X</td>
<td>X</td>
<td>Staying more than 90 days does not impact HRSA eligibility for homeless services</td>
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<tr>
<td>Fleeing Domestic Violence with no resources for new housing</td>
<td>X</td>
<td>X</td>
<td>DV is not specifically mentioned in HRSA definition but implied in list of definitions</td>
</tr>
<tr>
<td>Couch-surfing or living with a friend or relative</td>
<td>X</td>
<td></td>
<td>Commonly known as “doubled-up” and eligible person has no ownership of or makes rental payments for the housing unit</td>
</tr>
<tr>
<td>In a treatment institution or jail/prison for more than 90 days and being discharged with no resources for housing</td>
<td></td>
<td>X</td>
<td>HUD does not consider these persons eligible for HUD-funded housing</td>
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<tr>
<td>Living in an SRO (single residency occupancy) or a PSH (permanent supportive housing) unit</td>
<td></td>
<td>X</td>
<td>HUD eligibility for some funded services requires the SRO or PSH resident to have met the HUD Homeless definition before being housed</td>
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The Chicago / Cook County Housing for Health Action Plan

December 10, 2015

Part of HUD’s H2 National Initiative: The H2 Initiative provides communities with TA designed to ensure effective coordination linkages between housing and healthcare services to maximize care coverage and increase access to comprehensive health care and supportive services that can be coordinated with housing.

Time period for Plan: January 1 to December 31, 2016

Target Population for Plan: Anyone with the experience of homelessness, as defined by HHS/HRSA, in the City of Chicago and Cook County, whether housed or still homeless, and living with a health condition

STRATEGIC PRIORITY #1: Integrate Homeless and Healthcare Databases

Goal 1.1: By February 2016, establish and begin to implement data sharing policies and procedures between the Chicago HMIS and Suburban HMIS Databases

Goal 1.2: By October 2016, both HMIS Database administrators will develop and begin using new consent forms for enrollment or re-enrollment into HMIS that will allow the sharing of limited but pertinent client information with health care plans and hospital systems

Goal 1.3: By September 2016, provide participating MCOs and hospital and clinic systems with a list of addresses of all project-based supportive housing programs for formerly homeless

Goal 1.4: By October 2016, identify the number of individuals and families and their Medicaid MCO insurers, who are receiving health services at clinics collocated in permanent supportive housing sites
Goal 1.5: By November 2016, collaborate with the Chicago HMIS / UIC Hospital Pilot Project to develop a community action plan to generate prevalence data of homelessness and housing instability among UIC Health System utilizers and to identify the number of patients at UIC Hospital who are at-risk of homelessness or homeless

Goal 1.6: By November 2016, support UI Health to generate recommendations to hospitals and health systems for identifying homelessness in the Electronic Health Records (EHR)

Goal 1.7: By September 2016, establish a process and begin using it to match data in the Chicago and Suburban Cook County HMIS Databases with State Medicaid data of insured members in the top five deciles of expense

Goal 1.8: By October 2016, apply the established process to match HMIS data with data in at least two Medicaid MCO databases to determine how many of their members experience homelessness

Goal 1.9: By December 2016, identify patterns of Medicaid usage for at-risk homeless and chronically homeless patients

Goal 1.10: By November 2016, explore the matching of HIV surveillance data with HIV housing data at the Chicago Department of Public Health to show the correlation between housing and improved health outcomes for HIV-positive populations

STRATEGIC PRIORITY #2: Improve Health Outcomes and Coordination between Homeless Services and Medicaid Managed Care

Goal 2.1: By October 2016, train at least 200 caseworkers on how to collaborate with MCE care coordinators to improve health care access and outcomes

Goal 2.2: By November 2016, educate at least 500 residents of supportive housing about their managed care services and how to access health care effectively

Goal 2.3: By December 2016, support 200 caseworkers to interact at least monthly with MCE care coordinators to improve outcomes and integrate care coordination

Goal 2.4: By August 2016, support the Illinois Association of Medicaid Health Plans (IAMHP) to establish a process for the adequate transition of their members experiencing homelessness from one health plan to another and for safeguarding their continued enrollment in Medicaid benefits
Goal 2.5: By August 2016, establish a 3-year strategy with FQHCs and safety net providers to increase the colocation of clinics with PSH programs and other similar integration practices

Goal 2.6: By April 2016, develop a proposal and pursue it with the State for appropriate Medicaid funding of mental health and substance use treatment services to increase community-based capacity to deliver services, expand eligible populations, and increase eligible settings for services delivery

Goal 2.7: By December 2016, enroll or reenroll at least 85% of the eligible population experiencing homelessness into Medicaid and other public benefits

Goal 2.8: By December 2016 and through a working group of the Illinois Supportive Housing Providers Association (SHPA) and the Illinois Association of Medicaid Health Plans (IAMHP), hold at least 8 meetings to improve communication and service connection between members and mutual customers

STRATEGIC PRIORITY #3: Increase Supportive Housing Capacity

Goal 3.1: By June 2016, using data from integrated homeless and health data systems, establish the number of new permanent housing (PH) subsidies/units needed over the next three years

Goal 3.2: By June 2016 and by using the high-user program pilot model with MCEs and hospitals, establish at least 4 opportunities to house at least 200 individuals experiencing homelessness

Goal 3.3: By June 2016, coordinate with Cook County officials to fund at least 500 new “PH subsides/units with support services” for individuals experiencing homelessness, using the model of a flexible rental subsidy pool as in the example of the Los Angeles County DHS Project

Goal 3.4: By September 2016, work with State Medicaid officials to fund supportive services in PH, in order to reallocate existing HUD homeless support service resources and create at least 500 additional housing units

Goal 3.5: By June 2016, expand strategies of “moving-on from PSH programs” to turn over and make available at least 150 existing housing units for individuals experiencing homelessness

Goal 3.6: By June 2016, expand the “Bridge Housing Program” and the “Illinois DMH Bridge Rental Subsidy Program,” each by 100 units, to help transition those experiencing homelessness into PH
The Chicago and Cook County
“Housing for Health”

Report Card
and
Implementation Highlights
Three Strategic Priorities with 24 ”SMART” Goals

- Achieved: 5
- Works in Progress: 17
- Not Achieved: 2
Plan Implementation Roles

• Monitoring, Reporting, Integrating
• Contributing to Implementation
• Leading Implementation
ACHIEVEMENTS - 2016

• Updated HMIS consent forms (1.2)
• Addresses of PSH Buildings (1.3)
• Identifying hospital high users (1.6)
ACHIEVEMENTS - 2016

• Cross-training 200 workers (2.1)
• At least 85% in Medicaid (2.7)
WORKS IN PROGRESS

• Common policies / protocols for both HMIS databases (1.1)
• Medicaid members served in co-located clinics (1.4)
• #s of Medicaid highest users – top five deciles (1.7)
• #s of highest users with Medicaid MCOs (1.8)
• Patterns of Medicaid use by chronically ill (1.9)
• Data sharing: HMIS and CDPH (1.10)
WORKS IN PROGRESS

• Educate 500 PSH residents on Managed Care (2.2)
• Support interaction between CMs and CCs (2.3)
• Increase Medicate rates for behavioral health (2.6)
• Create 1,000 new PSH units (3.3 / 3.4)
• Create 100 new “bridge units” (3.6)
NOT ACHIEVED

• Smooth transitions between MCOs (2.4)
• Support 8 Statewide meetings between SHPA and IAMHP for improving services (2.8)
Q&A

• TRANSITIONING into

• The Chicago and Cook County “Housing for Health” Strategic Plan: 2017-2019
CONCEPT: Use of the CAPriCORN data infrastructure to gain insights into health status and utilization of health care services among the Chicago area homeless populations

While homeless status is widely recognized to be a factor in poor health status and high costs of health care utilization, it is difficult to assemble comprehensive data. Fragmentation of health services and inconsistent documentation of homeless status in health records, as well as the fragmentation of health services and records characteristic of utilization patterns among homeless are contributing factors. These challenges are compounded in Chicago where there is no active health information exchange infrastructure to assemble health information around individuals across the variety of institutions and settings in which they receive care. The complexity and cost of addressing these problems in individual databases is formidable. Furthermore, there are challenges posed in protecting privacy rights of individuals.

There is opportunity to link three significant databases in Chicago in order to overcome many of these challenges to assembling health data on are homeless:

- The two Homeless Management Information Systems (HIMS) in Chicago and Suburban Cook County, which contain homelessness and housing information for a majority of Chicago area individuals with an experience of homelessness
- The Chicago Area Patient Centered Research Network (CAPriCORN), which is a data infrastructure that enables assembly of health information for individuals and populations across Chicago’s major academic medical institutions and a number of FQHCs. - source data includes electronic health records, and contemplates patient generated data, and other data such as insurance/claims data

CAPriCORN is one of 33 partner networks comprising PCORnet, a national initiative undertaken by the Patient Centered Outcomes Research Institute (PCORI) to increase the efficiency and economy of carry out large scale population research initiatives and analyses. Based in healthcare systems such as hospitals, integrated delivery systems, and federally qualified health centers, CAPriCORN is an unprecedented partnership of research institutions, clinicians, patients and patient advocates. Its mission is to develop, test, and implement policies and programs that will improve health care quality, health outcomes, and health equity for the richly diverse populations of the metropolitan Chicago region and beyond.

At the heart of the PCORnet initiative is the use of PopMed net, a technology that permits institutions to participate in collective group data queries while maintaining the integrity and sanctity of their data within their own infrastructures. By attaching PopMedNet to each participating institutions data repository, building a standardized data model around the national PCORnet data model, and employing a local patient matching solution, CAPriCORN has built capacity to carry out local data analyses on de-identified data across all the participating databases. CAPriCORN has also established requisite administrative infrastructure including templates for data use agreements, and IRB and a research planning and review committee.

We propose to connect the HMIS systems as a contributing data node in CAPriCORN to allow for distributed queries for the HMIS population against the CAPRICORN database. Linking this information between the two systems would allow for identification of homeless patients among records of the participating healthcare institutions. Since a large number of homeless in the HMIS systems have likely received services in these institutions, we expect a rich set of data that could be analyzed. As outlined above, queries can be done without exporting data from the HMIS system, and can be done with de-identified data and with attention to HIPAA requirements for protection of protected health information.

Building upon the underlying technology utilized by CAPriCORN and the collaborative/administrative infrastructure created would allow many questions of cost, data ownership, privacy protection and consistency across the system to be addressed

Secondary benefit will be the opportunity to more effectively identify homeless populations in research and analyses projects undertaken by CAPriCORN. Finally, this work in Chicago may have implications for the wider PCORnet collaboration nationally.