

Healthcare Transformation Collaboratives Cover Sheet



1. Collaboration Name: Flexible Housing Pool (FHP) Collaborative

2. Name of Lead Entity: Center for Housing and Health

3. List All Collaboration Members:

- Center for Housing and Health
- AMITA Saints Mary and Elizabeth Medical Center
- Cook County Health
- University of Illinois Hospital and Health Sciences System
- Rush University Medical Center
- Sinai Health System
- South Shore Hospital
- Christian Community Health Center
- Heartland Alliance Health
- Mile Square Health Center
- Renaissance Social Services
- Corporation for Supportive Housing
- Deborah's Place
- Housing Forward
- Illinois Public Health Institute
- La Casa Norte
- Medical Home Network
- Thresholds
- The Night Ministry
- Unity Parenting and Counseling
- Sinai Urban Health Institute
- CountyCare Health Plan
- Meridian Health

4. Proposed Coverage Area: South and West Sides of Chicago

5. Area of Focus: Housing and healthcare systems integration.

With the assistance from the Healthcare Transformation funding opportunity, the FHP Collaborative will undertake activities that expand upon the existing Flexible Housing Pool program model to achieve the following outcomes: 1) enhance health navigation and communication for FHP participants; 2) increase behavioral health services available to FHP participants in community settings; and 3) develop new referral pipelines between hospitals and health care entities and the FHP program.

6. Total Budget Requested: \$25,722,860 requested; total project budget with match funds is \$31,616,150.

Project Description

0. Start Here - Eligibility Screen

Does your collaboration include multiple, external, entities?

☐ **Yes**

Can any of the entities in your collaboration bill Medicaid?

☐ **Yes**

1. Participating Entities

Contact Information for Collaborating Entities

1. What is the name of the lead entity of your collaborative?

Center for Housing and Health

2. Please provide primary contact information, secondary contact information, and the Tax ID # of each entity in your collaborative. Please list the lead entity in the top row.

EntityName	Tax ID # (xx-xxxxxx)	Primary Contact	Position	Secondary Contact	Secondary Contact Position
Center for Housing and Health	26-4287202	Peter Toepfer	Executive Director	Sydney Gosik	Senior Program Development Specialist
Cook County Health	36-6006541	Kathy Chan	Director of Policy	Chante Gamby	Interim Director of Housing
University of Illinois Hospital & Health Sciences System	37-600051	Stephen Brown	Director, Preventive Emergency Medicine	Rani Morrison	Chief Diversity and Community Health Equity Officer
Sinai Health System	36-3166895	Helen Margellos-Anast	President, Sinai Urban Health Institute	Stacy Ignoffo	Director, Community Health Improvement
South Shore Hospital	36-1799520	Leslie Rogers	Assistant Administrator	Tim Caveney	President
Christian Community Health Center	36-3799834	Kenneth Burnett	Chief Executive Officer	Lee Madigan	Development Manager
Heartland Alliance Health	36-3775696	Ed Stellan	Executive Director	Joan Liautaud	Chief Clinical Officer
Renaissance Social Services, Inc.	36-3900116	Michael Banghart	Executive Director	Erica Ernst	Clinical Director
Rush University Medical Center	36-2174823	Robyn Golden	Associate Vice President of Social Work and Community Health	Eugenia Olison	Program Manager-Center for Health and Homelessness
Meridian Health Plan	36-3382973	Felicia Spivack	Vice President of	Chelsea Dikowski	Senior Manager, Data Analytics and

			Compliance		Reporting
Corporation for Supportive Housing	13-3600232	Julie Nelson	Associate Director	Angela Brooks	Director
CountyCare Health Plan	36-6006541	Andrea McGlynn	Director of Clinical Services	Asron Galeener	Interim Chief Executive Officer
AMITA Health Saints Mary and Elizabeth Medical Center •	36-2235165	Kevin Ahrens	Regional Director of Operations-Behavioral Health Service Line	Dan Rakoski	Director of Nursing-Behavioral Health
Medical Home Network	80-0445929	Leana Lopez	Senior Director of Behavioral Health and Community Programs	Cheryl Lulias	Chief Executive Officer
La Casa Norte	36-4041525	Jose Munoz	Executive Director	Shannon Jackson	Director of Programs

3. Please confirm that you have entered the required information for each entity in the table above, including secondary contact information and Tax ID #.

☒ I confirm

4. Please upload the most recent IRS Form 990 (including Schedule H, if applicable) for all participants in the collaboration. (Note: These 990s will all have to be compiled into a single PDF file.)

Participating Entities

1. Are there any primary or preventative care providers in your collaborative?

☒ Yes

1A. Please enter the names of entities that provide primary or preventative care in your collaborative.

- Heartland Alliance Health
- Sinai Health Systems
- Rush University Medical Center
- Cook County Health
- University of Illinois Hospital and Health Sciences System
- Christian Community Health Center
- South Shore Hospital

2. Are there any specialty care providers in your collaborative?

☒ Yes

2A. Please enter the names of entities that provide specialty care in your collaborative.

- Sinai Health Systems
- Rush University Medical Center
- AMITA Health Saints Mary and Elizabeth Medical Center
- Cook County Health
- University of Illinois Hospital and Health Sciences System
- Christian Community Health Center

3. Are there any hospital services providers in your collaborative?

☒ Yes

☐ No

3A. Please enter the name of the first entity that provides hospital services in your collaborative.

1. Sinai Health Systems

3B. Which MCO networks does this hospital participate in?

Blue Cross Blue Shield Community Health
Plan

CountyCare Health Plan (Cook County only)

- IlliniCare Health
- Meridian Health Plan (Former Youth in Care
Only)

Molina Healthcare

3C. Are there any other hospital providers in your collaborative?

☒ Yes

3D. Please give the name of your second hospital provider here.

2. Rush University Medical Center

3E. Which MCO networks does this hospital participate in?

CountyCare Health Plan (Cook County only)

Meridian Health Plan (Former Youth in Care
Only)

3F. Are there any other hospital providers in your collaborative?

☒ Yes

3G. Please give the name of your third hospital provider here.

3. Cook County Health

3H. Which MCO networks does this hospital participate in?

CountyCare Health Plan (Cook County only)

3I. Are there any other hospital providers in your collaborative?

☒ Yes

3J. Please give the name of your fourth hospital provider here.

4. University of Illinois Hospital and Health

Sciences System

3K. Which MCO networks does this hospital participate in?

Blue Cross Blue Shield Community Health
Plan

CountyCare Health Plan (Cook County only)

IlliniCare Health

Meridian Health Plan (Former Youth in Care Only)

Molina Healthcare

3L. Are there any other hospital providers in your collaborative?

☒ Yes

3M. Please give the name of your fifth hospital provider here.

5. South Shore Hospital

3N. Which MCO networks does this hospital participate in?

- Blue Cross Blue Shield Community Health Plan

CountyCare Health Plan (Cook County only)

IlliniCare Health

Meridian Health Plan (Former Youth in Care Only)

Molina Healthcare

3O. If there are any other hospitals in your collaborative, please list them all here, together with a list of MCO networks which each participates in.

4. Are there any mental health providers in your collaborative?

☒ Yes

4A. Please enter the names of entities that provide mental health services in your collaborative.

1. Heartland Alliance Health
2. Sinai Health Systems
3. Unity Parenting and Counseling Inc.
4. Rush University Medical Center
5. AMITA Health Saints Mary and Elizabeth Medical Center
6. Cook County Health
7. Thresholds
8. Renaissance Social Services Inc.
9. University of Illinois Hospital and Health Sciences System
10. Christian Community Health Center

5. Are there any substance use disorder services providers in your collaborative?

☒ Yes

5A. Please enter the names of entities that provide substance abuse disorder services in your collaborative.

1. Center for Housing and Health
2. Heartland Alliance Health
3. Sinai Health Systems
4. Rush University Medical Center
5. AMITA Health Saints Mary and Elizabeth Medical Center
6. Deborah's Place
7. Cook County Health

8. Thresholds
9. Renaissance Social Services Inc.
10. University of Illinois Hospital and Health Sciences System
11. Christian Community Health Center
12. South Shore Hospital

6. Are there any social determinants of health services providers in your collaborative?

☒ Yes

6A. Please enter the names of entities that provide social determinants of health services in your collaborative.

1. Center for Housing and Health
2. Heartland Alliance Health
3. Sinai Health Systems
4. Medical Home Network
5. Unity Parenting and Counseling
6. Rush University Medical Center
7. AMITA Health Saints Mary and Elizabeth Medical Center
8. Cook County Health
9. Thresholds
10. Renaissance Social Services Inc.
11. University of Illinois Hospital and Health Sciences System
12. Christian Community Health Center
13. South Shore Hospital

7. Are there any safety net or critical access hospitals in your collaborative?

☒ Yes

7A. Please list the names of the safety net and/or critical access hospitals in your collaborative.

1. Sinai Health System
2. AMITA Health Saints Mary and Elizabeth Medical Center
3. Cook County Health
4. South Shore Hospital

8. Are there any entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that are majorly controlled and managed by minorities?

☒ Yes

8A. Please list the names of the entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that are majorly controlled and managed by minorities.

1. AMITA Health Saints Mary and Elizabeth Medical Center
2. Christian Community Health Center
3. La Casa Norte
4. South Shore Hospital

9. Please list the Medicaid-eligible billers (firms that can bill Medicaid for services) in your collaborative, and the Medicaid ID for each.

Heartland Alliance Health (Medicaid ID: 363775696020)

Sinai Health System (Medicaid IDs: 361509000001, 362170133001, 362179802001)

Rush University Medical Center (Medicaid ID: 140119)

AMITA Health Saints Mary and Elizabeth Medical Center (Medicaid ID: 362235165018)

Cook County Health (Medicaid ID: 366006541020)

Renaissance Social Services Inc. (Medicaid ID: 000015006)

South Shore Hospital (Medicaid ID: 51204952001)

10. Below are high-level descriptions of project types that appeared in the Transformation funding statute. Check any that apply to your project; if none apply, please provide a brief description of what kind of entities comprise your collaboration. (This question is informational only and will not affect your eligibility).

- ☐ Hospital plus Other Provider Partnerships in Distressed Areas to Address Health Disparities (led By Critical Area Hospitals, Safety Net Hospitals or other hospitals in distressed communities)

2. Project Description

Brief Project Description

- 1. Provide an official name for your collaboration. NOTE: Please ensure that this name matches the name given in the "Application Name" field in the Project Information form at the beginning of the application.

Flexible Housing Pool (FHP) Collaborative

- 2. Provide a one to two sentence summary of your collaboration's overall goals.

With the assistance from the Healthcare Transformation funding opportunity, the FHP Collaborative will undertake activities that expand upon the existing FHP program model to achieve the following outcomes: 1) enhance health navigation and communication for FHP participants; 2) increase behavioral health services available to FHP participants in community settings; and 3) develop new referral pipelines between hospitals and health care entities and the FHP program.

Detailed Project Description

Provide your narrative here:

Executive Summary

The Flexible Housing Pool Collaborative will improve health outcomes and housing stability for individuals experiencing homelessness on Chicago's West and South Sides. Housing is a key social determinant of health; research consistently shows that individuals experiencing homelessness have poorer health outcomes than the general population and tend to depend on costly emergency health services to receive care.¹ Chicago's housing and healthcare sectors remain largely siloed from each other, creating significant barriers for individuals experiencing homelessness to effectively access services. Furthermore, maintaining continuity of care can be challenging, as these individuals must also navigate a fragmented system of primary care, mental health, and substance use treatment, as well as housing resources. Each of these systems maintain their own eligibility, intake, and discharge policies and philosophies of care; the disconnect between these systems often results in people experiencing homelessness not receiving the connection to supportive resources they need to reach and maintain housing stability or improve their health conditions.

Positioning an evidence-based Permanent Supportive Housing program at the center of healthcare delivery is a transformational solution to improving health outcomes and disparities. The partners of the Flexible Housing Pool Collaborative are pleased to present this proposal to further integrate the housing and healthcare systems on Chicago's West and South Sides.

The Flexible Housing Pool Collaborative will build upon the existing and highly successful Flexible Housing Pool program model. The Flexible Housing Pool (FHP) program is unique from traditional Permanent Supportive Housing programs because of its novel funding structure and user engagement. The funding structure of the Flexible Housing Pool (FHP) leverages cross-sector investments from regional leaders in the housing and healthcare sectors to increase supportive housing resources across Chicago. FHP retains the original investor commitments from public, private, and healthcare entities that total \$9.6 Million annually and over \$23 million total. This diversified funding structure

¹ American Hospital Association, 2017

between public and private sectors ensures the program's sustainability and is the basis through which shared goals for ending homelessness between the housing and healthcare sectors are developed and implemented.

Also unique to the Flexible Housing Pool is its user engagement. FHP is committed to incorporating participant choice within each aspect of the program. The housing process begins by working with each participant to identify the community area where they would prefer to live and any unit accommodations that would best suit them and their household. The FHP program then secures apartments in the private market to house participants, where each household then signs their own lease. After signing the lease, households contribute 30% of their income toward monthly rent. This model of centering client choice contributes to increased housing stability.

The FHP program also engages its participants and ensures community feedback by gathering their direct input to inform the design of services and program implementation. The program seeks input from FHP participants through the Lived Experience Advisory Committee, the FHP Governance Council, and client satisfaction surveys. The Governance Council has written bi-laws stating that one-third of the Council's voting power is dedicated to FHP participants and currently has three representatives.

The Flexible Housing Pool program has successfully housed over 500 participants since launching in 2019, and of those participants 96.6% remain stably housed. The Flexible Housing Pool Healthcare Transformation Collaborative seeks to utilize the current FHP program structure and expand its operations to have a greater impact on the housing and healthcare systems. This Collaborative provides hospital systems, managed care providers, healthcare providers and community-based agencies with an avenue to address housing and employment as key social determinants of health. This proposal represents a five-year plan to achieve the following: 1) expand systems collaboration between the housing and healthcare sectors to increase care coordination; 2) increase the capacity for and connection to behavioral health services within community settings to improve behavioral health outcomes; and 3) provide stable, affordable housing with supportive services to 250 new households through the existing county-wide Flexible Housing Pool program. With those aims, this Collaborative will support the existing FHP partnership to: 1) further reach the population of patients experiencing homelessness on Chicago's South and West Sides; 2) improve behavioral health outcomes and reduce crisis system utilization for behavioral health services; 3) increase resources available within the housing system; and 4) enhance the overall sustainability of the FHP program by engaging new hospital and healthcare partners.

The model of this collaborative is distinguished from current practices in the following ways:

- It centers the recognition that housing is health care and addresses the inefficiencies between the housing and health care systems, which ultimately ensures people experiencing homelessness are identified and connected to housing and the necessary services needed to maintain permanent housing.
- It serves as an avenue to test a variety of housing and health interventions, such as tenancy and pre-tenancy supports, which are currently only partially covered or not at all covered by Medicaid.
- It provides a framework for healthcare providers to address the social determinants of health by screening patients for housing and support needs beyond traditional methods.
- It addresses the high need for behavioral health services among those experiencing homelessness in Chicago by increasing access to community-based psychiatric and behavioral health services on the South and West Sides of Chicago.
- It develops partnerships with Safety Net Hospitals to implement a system for identifying patients experiencing homelessness subsequently connecting them to housing and supportive services, including clinical behavioral health services.
- It aims to reduce healthcare utilization rates among the homeless population, therefore reducing the disproportionate burden of serving the population experiencing homelessness on Safety Net Hospitals.
- It builds on an existing evidence-based housing methodologies centered on participant choice, and the usage of effective, community-engaged Governance Structure on which members of the priority population maintain one-third of voting power.
- It realizes that care coordination and care management are most effective when the healthcare system has a process to identify and refer those experiencing homelessness to a permanent supportive housing program.
- It creates employment opportunities for members of the target population to serve in a peer-support capacity as Community Health Workers, while acknowledging the training and compensation needs to retain these workers.

- It addresses the prominent racial and health disparities within the population of people experiencing homelessness and combats the historical patterns of housing segregation within Chicago and Cook County.
- It provides a solution to address homelessness and improve health outcomes at the intersection of housing, health care, substance use treatment, and behavioral health.
- It addresses the impact COVID-19 has on housing security and healthcare delivery across metropolitan Chicago.

Flexible Housing Pool Background

The Permanent Supportive Housing (PSH) model addresses homelessness by combining low-barrier, affordable housing without a time limit with supportive services to help individuals and families lead more affirming and stabilized lives. The Center for Housing and Health (CHH) has extensive experience leading PSH programs which deliver a safe and stable homes.

The FHP program model goes beyond traditional PSH models because agencies from the healthcare sector are essential partners and are involved in programmatic decision-making and service coordination. The FHP coordinates the housing and healthcare systems to reach marginalized homeless individuals with complex health care needs. The FHP service delivery model leverages cross-sector investments which increase supportive housing resources across Cook County; with the intention of fully integrating the housing and healthcare systems, improving health outcomes, and to reduce overall costs. The core values of FHP are racial equity, Housing First², authentic lived experience collaboration, and positive youth development. FHP incorporates these core values into its program design and implementation.

The Flexible Housing Pool rapidly houses, offers wraparound services, and provides linkages to health services for participants who are experiencing homelessness and interact with multiple crisis systems. Center for Housing and Health staff connect participants to a housing unit of their choice and coordinate their access to wraparound supportive services. Additionally, participants are provided best-fit case management services through a network of social service agencies. Case managers use motivational interviewing techniques to help clients address barriers to accessing appropriate care (i.e., primary instead of emergency care or behavioral and mental health care), provide resources and referrals to obtain employment and income, and work with the participant to establish individualized goals around housing stability and improved health outcomes. The Center for Housing and Health subcontracts with the following agencies to provide direct supportive services: Christian Community Health Center, Deborah's Place, Housing Forward, Heartland Human Care Services, La Casa Norte, Renaissance Social Services, The Night Ministry, Thresholds, and Unity Parenting and Counseling.

The funding for the Flexible Housing Pool program combines public and private investments to create a diversified and sustainable structure. FHP investors represent regional leaders in public housing, health care delivery, managed care and care coordination, and private foundations focused on impacting population health outcomes. Coordinating these sectors through shared housing and health goals creates systems level impacts and serves as a model for how the sectors can work together to end homelessness in Chicago. The following entities from the housing and healthcare sectors invest in the Flexible Housing Pool to directly support rental subsidies and services: City of Chicago, Chicago Housing Authority, Chicago Department of Housing, Blue Cross Blue Shield of Illinois, Cook County Health, CountyCare, Advocate Aurora Health, UI Health, Meridian, and Medical Home Network. Other contributors to the FHP include the Cook County Housing Authority, Polk Bros. Foundation, Chicago Community Trust, Northern Trust, and the J.B. and M.K. Pritzker Foundation.

A major asset to the program is the partnerships and investments secured from the Managed Care and Accountable Care Organizations. CountyCare and Meridian Health, Medicaid Managed Care Organizations (MCO), and Medical Home Network, an Accountable Care Organization (ACO), have executed agreements as investors in the FHP. These three entities use their billing and health services data to first identify individuals experiencing homelessness who are also high utilizers of health care services and then subsequently refer them to the FHP program in order to be connected to housing and case management services. Having these care-based agencies as partners furthers the FHP program's ability to implement care coordination across the partnership. These partners work with FHP program staff to coordinate care for the FHP participants they refer, and this can serve as a model for implementing care

² Housing First - National Alliance to End Homelessness

coordination with additional FHP healthcare investors. The result of this coordination will reduce costs for healthcare partners while improving the health outcomes of FHP participants.

Since the program launched in 2019, the Flexible Housing Pool program continues to gain new healthcare partners and implement various phases of coordinated expansion to increase the number of individuals and populations served. To date, FHP has housed 504 participants in 375 households which includes single adults, youth ages 18-24, and families with dependent children. Of all FHP participants who have moved into permanent housing, 96.6% remain stably housed. This high housing stability rate among FHP participants is a significant accomplishment because the majority of FHP households (60%) are living with a behavioral health condition.

Funding through this Healthcare Transformation opportunity will fuel the Flexible Housing Pool's growth and demonstrate that utilizing housing as a solution for improving the social determinants of health transforms the healthcare delivery system and improves outcomes for populations with numerous barriers to care. Over the next two years, the FHP program aims to reach 1,000 households served. The vision of the project is to have every Medicaid MCO and every hospital in Cook County participating in the Flexible Housing Pool, where it is recognized and used as the essential resource for people experiencing homelessness who have complex health needs and are regular visitors to hospitals. This vision would ensure safety net and under-resourced hospitals have direct access to a life-saving option for their patients as well as a fully coordinated system of care.

The Flexible Housing Pool houses and provides services to two cohorts of participants: an adult and a youth (participants ages 18-24) cohort. Participants are referred to the FHP program in a variety of ways based on the FHP cohort they qualify for:

Adults experiencing homelessness are referred to FHP through the following referral sources:

- Advocate Aurora Health
- Cook County Health
- CountyCare
- Medical Home Network
- Meridian Health
- UI Health

Youth experiencing homelessness are referred to FHP through the following referral sources:

- Cook County Health
- CountyCare
- Cermak Health Services (health provider with the Cook County Jail)
- Service Coordination and Navigation (SCaN) (a project funded by the City of Chicago engaging with youth living in communities with high rates of violence.)
- Chicago Continuum of Care's Coordinated Entry System

Once participants are enrolled in FHP, they are matched with a case manager from one of the direct supportive service entities listed above. A CHH Housing Specialist works with each participant to determine in which community area of Chicago they would like to live and what are the desired housing accommodations and preferences. They then offer different apartment options to the participant and accompany them until the lease is signed. FHP seeks to honor each participant's choice of community-area and housing unit. The FHP program staff includes Landlord Engagement Specialists that seek out and form relationships with landlords across Chicago and Cook County to maintain a large and diverse portfolio of housing units available to FHP participants. During the housing process, participants begin working with their case manager to address housing and other goals. As the administrator of FHP, the Center for Housing and Health maintains partnerships with direct service agencies best-fit for serving each cohort of FHP participants.

Flexible Housing Pool Collaborative Overview

The Flexible Housing Pool has proven to be an effective program model for reaching people experiencing homelessness in Chicago and Cook County who have unmet health needs and by aiding them in becoming stably housed and maintaining their housing stability through supportive services. At its current growth rate, the FHP program is aiming to reach 1000 households in the next two years. This is significant; according to the 2021 Chicago

Point-In-Time Count, there are 4,477 residents experiencing homelessness.³ In effect, the FHP program is seeking to reduce the homeless population in Chicago by nearly 25%. The Center for Housing and Health, along with FHP partners, recognize that while this program is not the only solution to ending homelessness in Chicago; it is, however, a model that offers a unique funding and partnership structure. As such, the coordination between the housing and healthcare systems creates the momentum needed to get the whole healthcare community involved in effectively addressing homelessness.

The Flexible Housing Pool Collaborative will build upon and expand the existing Flexible Housing Pool program. The Collaborative aims to build and deepen additional relationships with Safety Net Hospitals on Chicago's South and West Sides to identify and connect people experiencing homelessness to essential housing and supportive services, thus allowing for sustainable and improved health outcomes. Developing these partnerships will further bridge the housing and health care systems to ensure robust care coordination for FHP participants. This Collaborative will also serve as a means for Safety Net Hospitals to reduce the disproportionate burden of serving people experiencing homelessness and behavioral health challenges. Providing people with stable housing and access to the services they need to remain housed and reach health goals reduces their rates of utilization.

The FHP Collaborative will identify individuals experiencing homelessness in healthcare settings, connect them to care, and ensure they are supported with the resources needed to remain stable. This methodology is based on the understanding that when people experiencing homelessness have their social determinants of health met, they are better able to manage their conditions without using crisis systems and to improve their overall health outcomes.

Flexible Housing Pool Collaborative's Goals and Outcomes

With the assistance from the Healthcare Transformation funding opportunity, the FHP Collaborative will undertake activities that expand upon the existing FHP program model to achieve the following outcomes: 1) develop new referral pipelines between hospitals and healthcare entities and the FHP program; 2) increase behavioral health services available to FHP participants in community settings; and 3) enhance health navigation and communication for FHP participants.

Developing New FHP Referral Structures

The FHP Collaborative will implement systematic processes for screening and identifying individuals experiencing homelessness within hospitals and other health care settings. Treatment providers must be knowledgeable about and help clients identify available housing resources to best serve patients and ensure their ability to manage their conditions and treatments.⁴ The FHP Collaborative anticipates that the process for identifying patients experiencing homelessness will vary among the hospital and health care partners. The Collaborative will discuss and pilot various methods of identification as part of the proposed planning phase of the funding period. By adding additional hospital partners to the FHP program, through the FHP Collaborative, and by implementing processes to identify patients experiencing homelessness, the FHP program will expand referral sources for the program. With improved patient identification processes and an increase in referral partners, the FHP program will have a significant impact on addressing homelessness on Chicago's South and West Sides.

Increasing Behavioral Health Services for FHP Participants

The FHP Collaborative will increase behavioral health services available to FHP participants within community-based settings. FHP Collaborative's partner, Renaissance Social Services Inc (RSSI), will hire staff to create a comprehensive Community Support Team (CST) dedicated to providing behavioral health services to FHP tenants. CST is an evidence-based practice shown to help people living with severe and persistent mental illness manage their conditions and improve functioning in community-based settings. Through FHP data monitoring to date, program staff have determined that 48% of households would benefit from Community Support Team services. Currently, less than one quarter of FHP participants are adequately connected to behavioral health services, primarily due to system-level access barriers, including the serious mental health workforce shortage. The lack of access to adequate clinical care creates challenges in providing the appropriate level of care to individuals with high behavioral health acuity.

The Healthcare Transformation funding would support the CST start-up period; during which Renaissance Social Services, Inc. will hire the team, begin service provision, and work towards reaching full caseload capacity. The

³ [Homelessness Infographic 2021 \(chicago.gov\)](https://www.chicago.gov/homelessness-infographic-2021)

⁴ [Behavioral Health Services for People Who are Homeless \(samhsa.gov\)](https://www.samhsa.gov/behavioral-health-services-for-people-who-are-homeless)

anticipated full caseload capacity for the CST team is 150 FHP participants. Alternative funding for this start-up period is essential, as Medicaid funding alone will not fully cover the operational costs of developing this team. Sustainability for the CST, after the Collaborative funding period has ended, will be achieved by billing Medicaid for CST services.

The Flexible Housing Pool Collaborative will also support increasing the capacity for psychiatry services available to FHP participants. Psychiatric services will be offered to FHP participants in community-based settings through two Collaborative partner agencies: Christian Community Health Center and Heartland Alliance Health. These two agencies currently provide psychiatric services. However, in order to serve the growing number of FHP participants hiring additional psychiatric professionals is necessary. The FHP Collaborative will support hiring either Psychiatric Advanced Practices Nurses (APN) or Doctors of Psychiatry to serve participants. The FHP Collaborative anticipates that about 150 FHP participants will engage in

In addition to implementing the CST and increasing psychiatry capacity, the Flexible Housing Pool Collaborative will utilize the Center for Housing and Health's Connection to Harm Reduction program. Many FHP participants are experiencing both homelessness and substance use disorders in a vicious cycle of instability. The Connection to Harm Reduction program is an effective model for connecting clients in permanent supportive housing to harm reduction methods and treatment for substance use disorders. The program's three Harm Reduction Counselors provide in-home counseling to participants and facilitates referrals to clinical treatment. The program also provides trainings to community-based service providers about harm reduction and distributes Naloxone, the opioid reversal drug.

Implementing these expanded behavioral health services will lead to a reduction in the number of behavioral health hospitalizations and follow-up care appointments leading to improvements in FHP participants' health outcomes.

Enhancing Health Navigation and Communication for FHP Participants

The FHP Collaborative will greatly enhance the FHP program service coordination by implementing a robust communication process and service coordination between housing services, supportive services, and health care services. Individuals experiencing homelessness are often forced to navigate a fragmented system of housing services, supportive services, and health care services. The disconnect between these systems, including the lack of coordination between multiple provider agencies, results in a lack of continuity of care and consequently poor housing stability and health outcomes. Increasing navigation and coordination through this Collaborative will ensure that FHP participants have access to all supporting services to maintain housing stability, continuity of care, and enhanced health outcomes.

In addition to increasing care coordination through communication and service coordination, this Collaborative will also explore and analyze methodologies utilized to develop peer support service providers trained as Community Health Workers. In Partnership with Sinai Urban Health Institute and Christian Community Health Center, the Collaborative will seek to hire and train FHP participants to serve the program as Community Health Workers. The addition of Community Health Workers to the FHP program will be beneficial as it would serve as a means of gainful employment for FHP participants and facilitate improving FHP participants' linkage services. According to the National Institutes of Health, the known outcomes of Community Health Worker services include: improved access to health care services for the populations they serve; better understanding between target populations and the health and social service system; and reduced need for emergency and specialty services.⁵ Sinai Urban Health Institute has gained national recognition for its unique implementation of the Community Health Worker model and will bring the model and training curriculum to this Collaborative. The Collaborative will account for the current challenges to retention among Community Health Worker positions, especially in the COVID-19 workforce landscape, by incorporating training, benefits, and the necessary compensation required to be retained.

The Collaborative will utilize the Federally Qualified Health Center partners as hubs for physical and psychiatric care on both the South and West Sides of the city. Implementing two destinations for these healthcare services is crucial for FHP participants to access services because the FHP program model provides scattered housing units across the city based on participant choice. As such, the Collaborative is aiming to ensure every participant has geographic access to healthcare services. Heartland Alliance Health's James Wood Clinic, located in Haymarket Center, will serve as the health hub for the West Side. Christian Community Health Center's main health center will serve as the health hub on the South Side. Both of these partners are proficient in serving people experiencing homelessness and will be able to

⁵ [Role of Community Health Workers, NHLBI, NIH](#)

coordinate back to the Collaborative about further healthcare needs of the FHP participants they serve. Having this system of care coordination can ensure that FHP participants are connected to any specialty care services with the Collaborative's hospital partners. This model will improve health outcomes and reduce utilization rates among FHP participants.

FHP Collaborative Proposed Activities

To reach the three aforementioned aims, the FHP Collaborative's general approach and strategies consist of five components:

1. Identifying Patients Experiencing Homelessness

The FHP Collaborative will work with hospital partners to develop a systematic process to identify patients experiencing homelessness. The processes for patient identification that the Collaborative will consider is as follows:

- - Hospital staff, including clinical, social work staff and community health workers, identify people experiencing homelessness through interactions with the patient as they receive services.
 - Implementing a standardized screening that evaluates patient's social determinants of health, including housing and homelessness status.
 - Utilizing the clinical observation code (Z59) recorded through Electronic Health Records to produce a list of patients that have indicated they experience homelessness.

2. Increasing Behavioral Health Services

The FHP Collaborative will expand behavioral health services provided to participants through developing a CST, increasing psychiatric capacity, and facilitating connections to substance use treatment. To implement these services, the Collaborative will complete the following:

- During the proposed planning phase, Renaissance Social Services Inc (RSSI) will hire staff to create two comprehensive Community Support Teams (CST) dedicated to providing behavioral health services to FHP tenants. The Community Support Team will conduct weekly in-home and community-based services including intake, assessment, therapeutic treatment, recovery support, and case management.
 - The staff to be hired on each CST team include:
 - One CST team lead
 - One peer recovery support specialist
 - Three clinical case managers
- During year one of the project, Christian Community Health Center and Heartland Alliance Health will hire additional Psychiatric professionals to serve FHP participants.
- Throughout the duration of the project, FHP participants in need of substance use treatment will be referred to the Center for Housing and Health's Connection to Harm Reduction program.

3. Care Coordination

The Flexible Housing Pool Collaborative will improve care coordination by increasing communication between Center housing staff, case management staff, behavioral health staff, and health care providers. The aim of this work is to fully implement multidisciplinary team-based care for FHP participants. Providers include outreach workers, housing navigators, tenancy support case managers, community health workers, primary and specialty care providers, and behavioral health providers.

The FHP Collaborative will implement care coordination in the following ways:

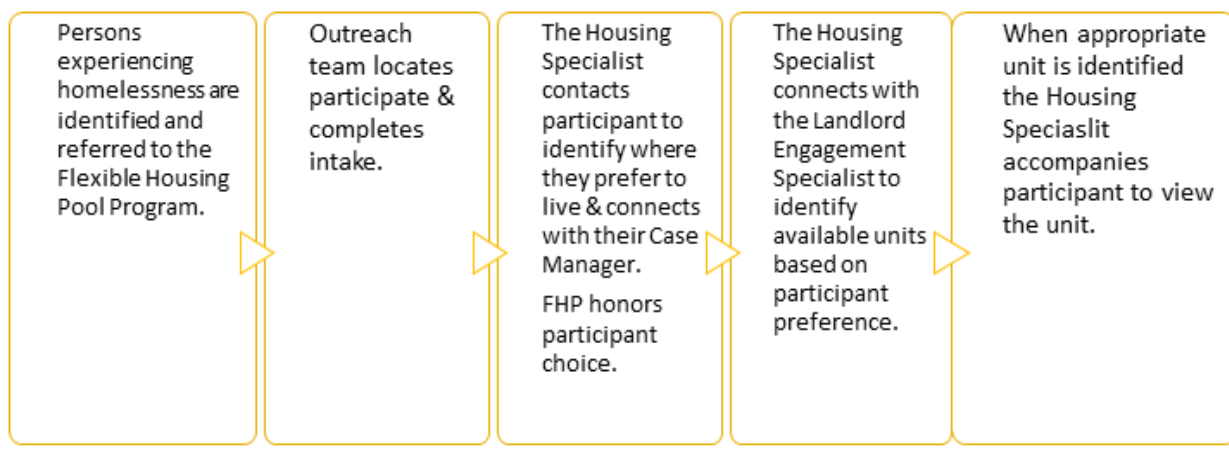
- The Collaborative will facilitate hiring and training Community Health Workers to serve FHP participants.
 - The Collaborative expects the Community Health Workers to be hired at Sinai Health Systems and Christian Community Health Center.
- All participating agencies will attend monthly Collaborative meetings to discuss and refine communication processes regarding FHP tenant's access to and utilization of services.
- Direct service staff from Collaborative agencies will attend the monthly FHP Systems Integration Team (SIT) meetings pertaining to the FHP tenants they serve.
 - SIT meetings bring together staff from the referral hospital, care managers, tenancy support case managers, and CHH housing coordination staff to discuss challenges specific to FHP tenants and how to overcome them.

- Strengthening communication channels between direct service staff at all partnering agencies.

4. Housing Patients Experiencing Homelessness

The Flexible Housing Pool Collaborative aims to house 250 participants experiencing homelessness during the funding period. Housing participants through the program includes housing navigation services to find the best-fit unit, covering the cost of leasing applications, security deposits, background-checks, and move-in fees. Once participants have located and signed a lease for a unit of their choice, an on-going rental subsidy is provided. (section continued on page 12).

The housing navigation process for FHP participants is described in the chart below:



The FHP program also maintains a robust Client Assistance Fund to support participants as they complete the housing navigation process, move into their unit, and thereafter. FHP participants are offered transportation assistance, furniture and necessary household items for their unit, cell phones, and food assistance.

5. Connection to Supportive Services

All FHP participants are connected to a case manager at a partnering agency, based on their individual or family needs. Case managers provide the following services to support the FHP tenant to maintain their housing ability and develop goals around their health and well-being:

- Two face-to-face home visits and three collateral case management contracts per month to all new heads of household enrolled in the program for the first six months after securing a permanent housing placement.
- One face-to-face home visit and two collateral case management contacts per month to heads of households after they have reached six months in housing.
- Complete a baseline FHP Intake Assessment with all household members to assess needs and inform the goal setting process.
- Complete a FHP Reassessment with all household members for every six months they remain in the program.
- Establish an Individualized Service Plan (ISP) within seven days of intake into the program which will then be re-evaluated and updated every six months.
- Assist all eligible heads of households with applying for public benefits within 30 days of housing.
- Provide referrals to programs based on participant need, such as employment services, substance use and harm reduction services, or other behavioral health services.

Resources the Flexible Housing Pool Collaborative Will Leverage

As previously described, the Flexible Housing Pool Collaborative will build on the existing Flexible Housing Pool Program. As such, below is a list of the resources that will be leveraged to enhance the work of the Collaborative:

- **The Flexible Housing Pool supervisory staff:** CHH's Flexible Housing Pool team consists of 12 employees; each staff member plays a role in guaranteeing all participants enrolled in the FHP program become housed,

are connected to supportive services, and maintain their housing stability. FHP managers are responsible for the day-to-day oversight of the project.

- **Outreach staff:** CHH subcontracts with four community-based agencies who provide outreach services including: locating and engaging with individuals experiencing homelessness who have been referred to the FHP program. These subcontracts support three full-time outreach workers and an additional five outreach workers to be used on an as-needed basis.
- **Substance use and harm reduction services:** CHH operates a substance use and harm reduction program funded by the Illinois Department of Human Services called Connection to Harm Reduction. The program includes three Harm Reduction Counselors who provide in-home substance use counseling, make linkage to medication assisted therapy, refer to outpatient and inpatient substance use treatment providers, make referrals to additional harm reduction services, distribute Naloxone (the opioid reversal drug), and facilitate of harm reduction trainings. The program services 100 people per year and all FHP participants in need of substance use and harm reduction services can be referred to this program.

Outcomes and HFS Quality Metrics

In order to demonstrate the impact of an integrated healthcare and housing project, the Flexible Housing Pool Collaborative will measure HFS Quality Metrics, access to care metrics and nationally accepted housing stability metrics for people experiencing homelessness. For condition-specific behavioral health metrics, the Collaborative will use the metrics HFS requires Medicaid MCOs to report and seeks to perform at the 75th percentile nationally. The Collaborative proposes to achieve the following outcomes for the 250 households in the project:

Adult Behavioral Health

- Follow-up after hospitalization for mental illness within 7 days – 39%
- Follow-up after hospitalization for mental illness within 30 days – 62%
- Follow-up after Emergency Department visit for alcohol and other drug abuse or dependence within 7 days – 19%
- Follow-up after Emergency Department visit for alcohol and other drug abuse or dependence within 30 days – 29%
- Pharmacotherapy for Opioid Use Disorder (POD) – 20%

Health Equity & Preventative Care

- Decrease emergency department visits by 25%
- Decrease inpatient hospitalization days by 25%
- Participants will meet with a primary care physician at least once per year – 50%

Household Housing Stability

- Households will remain stably housed for 12-months or longer – 80%
- Households will remain stably housed for 24-months or longer – 65%

As a cross-system project with multiple sector stakeholders, the Collaborative Research Unit (CRU) of Cook County Health was selected to be the independent evaluator for FHP. The approach of the CRU is to evaluate the immediate project and build a sustainable infrastructure (including data structures, relationships, and protocols), which allows for evaluation long-term once CRU's role is complete. In addition to building sustainable structures, CRU aims to assess individuals with specific conditions experiencing medical management that is influenced by receiving safe and secure housing, as well as determining the overall cost-effectiveness of permanent supportive housing in improving health outcomes. The CRU infrastructure will be used to conduct ongoing data analysis, though they will not serve as the formal evaluators for the Collaborative project.

A major aim of the FHP Collaborative is to improve care coordination for FHP participants. To coordinate this type of care, MCO Collaborative partners will share data on FHP participant healthcare utilization. FHP Collaborative partners Meridian and CountyCare currently manage care for about 85% of FHP enrollees. These two partners have committed to tracking the outcomes and, through the Collaborative, implementing ways to improve the care outcomes for participants.

Data for this evaluation will be provided by a variety of sources, including Chicago and Suburban Cook HMIS systems, Cook County Health, IL Department of Public Health, Chicago Department of Family and Support Services, IL Department of Correction, and Regional Healthcare Organizations. CRU will work with a specific organization who specializes in combining variant data sets into a cohesive and comprehensive data management structure. CRU

will ensure that data collection protects client privacy and protected health information. To examine the main health and cost outcomes, CRU will compare outcomes of those individuals who have been housed within FHP for one year and a matched control group (individuals drawn from County Care who have similar characteristics of those housed through FHP).

CHH's role in the evaluation will be not only to support CRU, but to be a main source of data for the process evaluation. CHH will provide information around supportive service provision and tenancy supports as well as housing quality and landlord engagement. CHH will also be instrumental in the interpretation of the results, specifically those around retention in housing and the interplay between individual risk factors, service provision, and the return to homelessness. Ongoing reports and final results will be shared with the FHP Governing Council to best understand the impact of the program and the results of system investments. CHH will closely review reports from CRU to help inform program delivery and adjust program implementation as needed.

To monitor the program's progress towards outcomes, the Center for Housing and Health has built five monitoring dashboards, specific to the Flexible Housing Pool (FHP) program. These dashboards allow program staff to view and analyze progress towards overall goals of FHP as well as identify areas of necessary improvement. These dashboards also simplify financial reporting for the program, which is an integral process-improvement especially as the project continues to evolve and expand. Access to the necessary dashboards is shared with FHP partner agencies to ensure that progress of the program can be viewed amongst all agencies. The following is a summary of the five dashboards and their functionality:

1. The Flexible Housing Pool Monitoring Dashboard: provides real-time tracking of client-data: referrals, enrollments, housing status of enrolled participants, time-to-housing for each participant, and the housing location of each participant. This dashboard is reviewed weekly by each member of the FHP team.
2. Quarterly Performance Dashboard: displays the target number of participants to be housed per quarter and tracks progress in real-time. Each Housing Specialist can view progress towards their quarterly goal; program leadership can provide support as needed. This dashboard is reviewed weekly by each member of the FHP team.
3. FHP Governance Dashboard: provides an overview of all participants housed in the program from the program's inception to current date and displays the following data points: time-to-housing, housing stability rates across the program, participant demographics, and housing location of all participants. FHP leadership reviews this dashboard regularly and shares with the FHP Governance Council Members at the quarterly FHP Governance Meetings.
4. Participant-Level Progression to Housing Dashboard: tracks each FHP participant's path to housing and indicates the housing needs to program staff as well as informs the program's housing processes. This dashboard is reviewed weekly by each member of the FHP team.
5. Disbursement Report Dashboard: tracks each participant who becomes housed over the bi-monthly reporting period, their leasing information, the rental payments made on behalf of each participant, and all Client Assistance Fund charges (including items such as move-in costs, rental applications, background checks, furniture, food, medication, transportation, and utilities).

The proposed expansions to the FHP program funded through this opportunity align with HFS's mission to improving lives by addressing social and structural determinants of health. This proposal aligns with three of HFS's Quality Pillars: 1) improve behavioral health services and supports for adults, 2) focus on health equity, and 3) serve more people in the settings of their choice. The FHP Collaborative will improve the integration of physical and behavioral health services for FHP participants by increasing the capacity for these services and by implementing care coordination amongst the Collaborative partners. This will improve care coordination and access to care for individuals with alcohol and or substance use disorders. All Collaborative activities will be rooted in equity, connecting the most underserved and disproportionately represented populations experiencing homelessness in community-based settings. The Collaborative will increase the percentage of people receiving community-based programming to maximize the health and independence of the individual. Aligning with these pillars and HFS's vision for healthcare improvement will result in the best outcomes for participants as these activities will better integrate the housing and healthcare system to provide the best care for individuals experiencing homelessness.

Flexible Housing Pool Collaborative Governance Structure

Each agency participating in the Flexible Housing Pool Collaborative will be held accountable for achieving progress towards the shared goals and outcomes. The Collaborative will meet on a monthly basis to discuss the project's

operations, successes, challenges, and progress. At the start of the Collaborative, each partner's roll will be well-defined. The group will establish which agencies are responsible for completing the activities outlined by the Collaborative and determine the benchmarks each agency should achieve towards each outcome. All Collaborative partners have committed to sending a representative to each monthly meeting, as documented in the Memorandums of Understanding.⁶

The Center for Housing and Health will develop a performance outcomes dashboard for the Collaborative that will track progress towards the stated goals and outcomes. Each partner participating in the Collaborative will have access to the performance dashboard, and it will be shared and discussed at Collaborative meetings. CHH will be the lead agency responsible for the Collaborative's quality management. CHH has a robust Quality Management Plan and Quality Management team to ensure that continuous quality improvement is accomplished through a community-guided, coordinated approach to compliance with federal, state, and local regulations and funding source guidelines. The mission of CHH's Quality Management Plan is to deliver the highest quality care and housing to vulnerable populations by: 1) establishing highest standards of services 2) conducting regular ongoing monitoring of performance measures and outcomes data, 3) implementing continuous quality improvement strategies driven by quality assurance and/or community feedback 4) evaluating quality assurance processes to continually evaluate program appropriateness, efficiency, and effectiveness of services within the system. This plan also incorporates the utilization of data and measurable outcomes to combat racial inequities across the housing and healthcare systems. To do this, the Quality Management team utilizes a community accountability framework to guide continuous improvement initiatives aimed at addressing immediate community needs and providing the highest quality of services.

The Flexible Housing Collaborative will utilize the existing Flexible Housing Pool governance structure. The FHP Governing Council meets quarterly to make decisions regarding the strategic direction of the program. The FHP Governing Council includes representatives from the Lived Experience Advisory Committee; each FHP investor (Chicago Department of Family and Support Services, County Care, Advocate Aurora Health, Meridian Health, Medical Home Network, University of Illinois Hospital and Health Systems, and the Blue Cross Blue Shield Foundation); the Chicago Continuum of Care lead agencies (All Chicago and Suburban Alliance to End Homelessness); the Chicago Department of Housing; the Corporation for Supportive Housing; and the Chicago Coalition for the Homeless. The responsibilities of the FHP Governance Council members include: regularly attending quarterly governance meetings, reviewing meeting materials in advance, completing onboarding webinars and readings, and remain informed of FHP progress via communication with implementation leads within their organization. Each agency investing in the FHP program and representatives from the Lived Experience Advisory Committee maintain voting seats on the Council, and each non-investing agency serves as an advisory member to the Council.

The FHP Governance Council is led by a Chair and Vice-Chair. The Chair serves a one-year term with the election occurring in January of each calendar year. The Chair is responsible for informing the meeting agenda, facilitating the quarterly governance meeting, and maintaining information on FHP progress from the Implementation Leads within each FHP organization. The Vice-Chair serves a one-year term with the election occurring in January of each calendar year. Once the Vice-Chair has served their one-year term, they can move into the Chair role if so desired. The Vice-Chair is responsible for learning the responsibilities of the Chair and filling the role of the Chair if/when they are unable to attend the meeting in addition to maintaining familiarity with the meeting goals and agenda.

The decision-making process for the FHP Governance Council follows Robert's Rules of Order for procedural processes and decision-making.⁷ A quorum must be present for any decision making to occur; no decision making may occur without representation from the Lived Experience Advisory Committee. A quorum is defined as two-thirds of the Council. In order to center and prioritize the leadership, contributions, and experience of individuals with lived experience, the FHP Governance Council retains proportionate lived experience representation. Representatives from the Lived Experience Advisory Committee hold one-third of the voting power among the FHP Governance Council. To operationalize this, if current lived experience representation drops below 33% of the Voting Governance Council members, an additional seat will be added.

Invitations to the FHP governance council intentionally prioritize representation from underrepresented groups. The demographics considered include: race, ethnicity, gender identify, orientation, age and disability. Demographics for

⁶ See attached Memorandums of Understanding in the Participating Agencies section of the application.

⁷ Please see attachment outlining Robert's Rules of Order.

Governance Council members are collected anonymously (with an option to decline) and are reported, in aggregate, twice a year in Governance Council reporting. Demographics of Governance Council voting members, Governance Council advisory members (non-voting), and LEAC members are reported on in separate categories.

As mentioned above, the Center for Housing and Health has developed a data monitoring dashboard to present at each quarterly Governance meeting. The FHP Governance Dashboard provides an overview of all participants housed in the program from the program's inception to the current date and informs discussion about the program's progress and future direction. This dashboard displays the following data points: time-to-housing, housing stability rates across the program, participant demographics, and housing location of all participants.

Given the expansive nature of FHP, six sub-committees have been established to ensure strategic program growth. In addition to the Lived Experience Advisory and Governance Committees mentioned above, FHP convenes Leadership, Racial Equity, Evaluation, and Sustainability Committees. It is crucial that all committees work in alignment with each other; thus, CHH actively participates on each committee and coordinates the implementation of recommendations formed in each. This robust participation also ensures continuous communication among stakeholders, which helps to facilitate relationship building between current and emergent strategic partners.

Commitment to Racial Equity

Chicago is one of the most racially segregated cities in the United States. In 2019 the Black population living in Chicago totaled 768,524 people; the majority (80%) of these Black residents live in just 23 of the 77 community areas of Chicago.⁸ Long histories of political and economic exclusion have led to the geographic isolation of the Black population from other racial groups in the city. This includes inequitable local government policies, racist practices such as red lining, contract sales, real estate covenants, and racialized violence.⁹ Exclusionary policies and practices continue today through restrictive health care delivery, unjust policing and sentencing, community divestment, and political exclusion. This system hinders Black economic and social progress and is the root cause of inequities disproportionately affecting the lives of Black Chicagoans.

The Chicago Department of Public Health (CDPH) generated many reports describing racial inequities among the Black population, especially focused on the South and West Sides of the city. These reports show that the communities comprised of at least 80% Black population are the same areas with high levels of economic hardship, lower per capita income, and higher severe housing cost burden. Reports also show several social factors disproportionately impacting the Black population. The rate of opioid-related overdose deaths among the Black population in Chicago is more than three times the rate among the non-Black population. Additionally, the incarcerated Black population is at much higher rates than the non-Black population. Black people account for 84% of Chicagoans who are incarcerated in Illinois prisons. Furthermore, reports show that almost half of all disconnected youth in Chicago, individuals aged 20-24 not enrolled in school nor employed, are Black.

The impact of the social and economic environment experienced by the Black population in Chicago contributes to the health inequities reported for this population. The current life expectancy among the Black population in Chicago is more than nine years lower than that of non-Blacks. This gap in life expectancy is driven by five main causes of death (disproportionately higher in Chicago's Black population): chronic disease, homicide, infant mortality, HIV and other infections, and opioid overdose. In addition to these causes of death, Black Chicagoans report experiencing more serious psychological distress in their everyday life as compared to non- Blacks.¹⁰

Parallel to, and intertwined with, the health inequities among Chicago's Black population, this population also experiences higher rates of housing instability and homelessness. Despite making up about one-third of Chicago's total population, Black and African Americans are overrepresented in the population experiencing homelessness. In 2021, 73% of the total 4,447 people identified as experiencing homelessness are Black or African American.¹¹

Homelessness in Chicago impacts individuals of all ages and family structures, and the disproportionate impact of homelessness on the Black population is seen throughout the subpopulations of families and youth. In 2021, 383 families with children were identified as experiencing homelessness and 75% of the heads of household among those

⁸ CDPH_BlackHealth7c_DIGITAL.pdf (chicago.gov)

⁹ State of Racial Justice in Chicago – A Tale of Three Cities (stateofracialjusticechicago.com)

¹⁰ CDPH_BlackHealth7c_DIGITAL.pdf (chicago.gov)

¹¹ Microsoft Word - 2021 PIT ReportFINAL (chicago.gov)

families are Black females. The total number of unaccompanied youths experiencing homelessness in 2021 was 213, and 80% of those youth are Black.¹²

In Chicago, homelessness is a racial equity issue. As such, racial equity is a core value of the Flexible Housing Pool program. FHP incorporates racial equity into the program model in a variety of ways. Firstly, by securing a broad portfolio of units across the city and honoring each participant's choice of which community area they would prefer to live, this ensures that participants can access a housing unit in the community area best suited to them, regardless of their income or social status. Secondly, the FHP program maintains a Racial Equity Workgroup to provide guidance on how to best represent and serve the priority population. Finally, the FHP Governing Council includes members from the Lived Experience Advisory Committee who are People of Color from the priority population providing guidance for program operations.

The Flexible Housing Pool promotes racial equity through the following commitments:

- Inclusiveness: Including people of color and people with lived experience of homelessness in the development of policies and governance of the program.
- Distribution: Addressing root causes of inequities by distributing housing resources in a manner that reflects the racial composition of the population being served.
- Selection: Ensuring access to housing, as a human right, is not restricted based on racial identity and providing the opportunity for participants to live in neighborhoods that are not disproportionately impacted by economic hardship or other inequities.
- Outcomes: Producing outcomes, with regards to health and housing stability, that cannot be reliably predicted based on one's racial identity.
- Evaluation: Documenting equitable racial impacts through data collection and evaluation, examining the role of race in the experience of FHP participants, and conducting a Racial Equity Impact Analysis.
- Collaboration: Aligning with other organizations and local efforts working to promote equity.

Furthermore, the Center for Housing and Health is currently working on racial desegregation initiatives with the Chicago Department of Housing to counter the historical patterns of housing segregation in Chicago. This work uses Flexible Housing Pool data to inform strategies. FHP leadership work alongside the Chicago Housing Authority and the Chicago Low Income Housing Trust Fund to provide a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis of the homeless system and develop a strategy to address the racial segregation in housing. Together, the three agencies mapped units provided to tenants across the city to recognize utilization patterns and further inform desegregation efforts.

The FHP Collaborative is dedicated to furthering initiatives to address the systematic challenges of racial equity within the housing system. The FHP Collaborative will build off the foundation of the Advancing Health Equity Learning Collaborative, funded by the Robert Wood Johnson Foundation to investigate innovations in Medicaid payment that promote equity. The team in Cook County was made up of representatives from HFS, CountyCare Health Plan, Cook County Health, and Access Community Health Network. The housing and healthcare systems have a deep history of racist policies that have enforced segregation and discrimination. The group's efforts consider the macro and micro policies that created and maintain the racial disparities seen today in their homeless population, focusing their efforts at the intersection of the health and housing systems.

The Illinois Advancing Health Equity team is focusing their efforts on Cook County's Flexible Housing Pool (FHP). In 2020, during the peak of COVID-19, HFS pivoted its annual quality pay for performance program toward a Community Reinvestment fund to encourage MCOs to invest in resources that address the social determinants of health. As a result, CountyCare invested \$5 million into the FHP. Their team decided to target the investment to serve individuals with mental illness and/or substance use disorder and families with children. The investment provided tenancy support, rent and associated housing costs for 66 members for three years. The goal of this program was to demonstrate that providing housing as a basic human right can both improve health and create savings by reducing the use of inpatient and emergency department services for needs that can be more effectively met through community-based services. The initial investment is a kickstart to a potentially sustainable payment innovation. CountyCare has joined the growing group of public and private investors in FHP; as the pool of investors grows, the FHP has the potential to support more residents of Cook County.

¹² Microsoft Word - 2021 PIT ReportFINAL (chicago.gov)

The Advancing Health Equity team integrated a racial justice lens into each program component. For example, due to the long history of discrimination and segregation, Black men are overrepresented in Cook County's homeless population, and the team is taking steps to ensure that members of the initiative's Lived Experience Advisory Committee (LEAC) reflect the demographics of those experiencing homelessness in Cook County.

Problem Statement

Homelessness in the United States

Across the United States, the number of people experiencing homelessness continues to increase. In 2020, about 580,000 people experienced homelessness in the United States, which is a 2% increase from 2019. This is the fourth consecutive year that homelessness has increased nationwide. Even more alarming is the number of individuals with chronic patterns of homelessness, defined as having experienced homelessness for at least a year while struggling with a disabling condition, increased by 15% between 2019 and 2020.¹³

Homelessness impacts the most vulnerable populations. Individuals experiencing homelessness have significantly higher rates of neurocognitive defects, severe traumatic brain injury, suicidality, substance use, and mental health disorders.¹⁴ At a minimum estimate, 25% of people experiencing homelessness have a serious mental health disorder and 45% have type of mental health disorder. People experiencing homelessness are also at high risk of overdose from substance use.¹⁵ According to the Substance Abuse and Mental Health Services Administration, 38% of people experiencing homelessness are dependent on alcohol and 26% used other drugs.¹⁶ Many of these individuals living with mental health conditions also have complex physical health conditions. Homeless adult individuals have increased rates of chronic medical conditions when compared to the general population, with adults experiencing chronic homelessness more likely to experience medical complications resulting from lack of regular medical care and lack of adequate housing.¹⁷

Many individuals experiencing homelessness cycle through crisis systems, such as hospitals and jails, simply to receive basic emergency care. Successive studies have shown that people without housing have higher healthcare utilization including more frequency emergency room visits, hospitalizations, and higher readmission rates.¹⁸ However, this cycle of crisis-seeking care lacks the coordinated primary and behavioral health services necessary to improve health outcomes, which ultimately results in high costs for the healthcare system. Hospitals have reported an increase in costs associated with in-patient admissions for the homeless population.¹⁹ Individuals experiencing homelessness are five times more likely than housed individuals to be admitted to inpatient hospital units and stay in the hospital for up to four days longer, at a cost of \$2,000 to \$4,000 a day.²⁰ Yet, the care they receive is not sufficient to address their chronic health conditions.

Crisis systems generally lack the ability to connect people experiencing homelessness to the housing resources needed to reach stability, however, providing housing for people experiencing homelessness is a proven way to prevent the exacerbation of substance use, mental illness, and other chronic conditions.

Homelessness in Chicago

Homelessness remains prevalent in the City of Chicago. The 2021 Chicago Point-In-Time Count identified 4,477 residents experiencing homelessness.²¹ However, the total number of people experiencing homelessness is thought to be higher because of the limitations placed on the Point-In-Time count due to COVID-19. The City of Chicago states that the 2021 Point-In-Time Counts are not comparable to past years due to methodology changes and unique

¹³ [2020 AHAR: Part 1 - PIT Estimates of Homelessness in the U.S. | HUD USER](#)

¹⁴ [Case Study: University of Illinois Hospital & Health Sciences System's Better Health Through Housing Program | AHA News](#)

¹⁵ [Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health \(samhsa.gov\)](#)

¹⁶ Microsoft Word - Substance Abuse and Homelessness.docx (nationalhomeless.org)

¹⁷ [Effect of a Housing Program on Hospital Use | Research | Supportive Housing Network of New York \(shnny.org\)](#)

¹⁸ [Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness | The National Academies Press \(nap.edu\)](#)

¹⁹ [Hospital care and costs for homeless people \(nih.gov\)](#)

²⁰ [Social Determinants of Health Series: Housing and the Role of Hospitals | AHA](#)

²¹ [Homelessness Infographic 2021 \(chicago.gov\)](#)

circumstances of COVID-19. As such, the Collaborative analyzed the 2020 Point-In-Time counts to form the proposed project.

The 2020 Chicago Point-In-Time Count identified 5,390 residents experiencing homelessness.²² This was a total increase of 2% in the homeless population compared to 2019. In 2020, the number of unsheltered individuals increased by 21% from the previous year, meaning that more individuals are faced with living on the street or other locations not meant for human habitation.

Similar to the homeless population in the United States, Black and African American individuals are overrepresented. Despite making up about one-third of the city of Chicago’s total population, Black and African American individuals make up 77% of the homeless population. This overrepresentation has remained consistent since 2017. Furthermore, approximately 75% of the heads of household in the 506 families with children identified as experiencing homelessness are Black females. Of the families with children experiencing homelessness, about 25% of households are headed by parenting youth ages 18-24. These parenting youth heads of household are overwhelmingly female and Black. The total number of unaccompanied youths in 2020, individuals aged 24 and younger, increased by 16% and were also majority Black (77%). This consistent disproportionate representation of the Black population among individuals experiencing homelessness make this a racial equity issue in addition to a human rights issue.

A contributing factor to the on-going challenge of homelessness in Chicago is the lack of available affordable housing. In its 2020 report, titled: “The Gap: A Shortage of Affordable Homes,” the National Low Income Housing Coalition found that the Chicago metropolitan area had a deficit of 229,192 affordable and available units for persons with extremely low income, making housing inaccessible to many members of the Chicago community.

CHH’s focus population are households experiencing homelessness in Chicago and Cook County, who are also living with health conditions. Many highly vulnerable individuals experiencing homelessness (particularly those experiencing long-term transience, living with a disabling health condition, or recently released from jail or prison) may lack identification, a stable source of income, and/or access to mainstream benefits. Collectively, these factors impact an individual’s ability to obtain and maintain stable housing. Recognizing that housing is healthcare, CHH connects these individuals to permanent housing and provides services that support them to maintain housing stability.

FHP is open to all eligible individuals and families regardless of sexual orientation, gender identity, domestic violence history, or marital status. Of the clients who chose to identify demographic characteristics, 47% identify as female, 42% identify as male, and 1% identified as gender non-binary. Two percent of FHP participants identify as transgender in addition to the categories above. Seventy-five percent of participants identify as African American, 6% identify as white, 8% identify as Latinx, 2% identify as multi-racial, 1% identify as American Indian/Alaska Native, 1% identify as Asian, and 7% identify as another race or declined to provide the information. All clients participating in the program are users of multiple crisis systems, with many adults having at least one disabling condition, such as chronic health conditions, mental illness, substance use issues, physical disabilities, developmental disabilities, and HIV/AIDS. Overall, CHH’s programs are intentionally designed to address the needs of individuals experiencing homelessness who also have complex health conditions.

Community Service Area

The Collaborative’s community service areas include the zip codes listed below. These zip codes were identified by analyzing the service areas of the FHP Collaborative’s healthcare partners, service providers, and current FHP tenancy data. Since the Flexible Housing Pool Collaborative will house participants according to their community area of choice, the service area zip codes may expand.

The Collaborative will service the following neighborhoods on Chicago’s West Side:

West Chicago Zip Codes		
60623	60624	60644
60612	60651	60639
60302	60608	60622

And, the Collaborative will service the following neighborhoods on Chicago’s South Side:

²² 2020 PIT Report_vFinal.pdf (chicago.gov)

South Chicago Zip Codes		
60617	60649	60637
60619	60620	60621
60636	60615	60653
60628		

Project Timeline

The Flexible Housing Pool Collaborative requests funding for a total of five years.

Year 1: By the end of year one, the FHP Collaborative will achieve the following:

- Complete a planning period that will last between 12 to 18 months. The planning period will accomplish the following through monthly Collaborative meetings:
 - Develop procedures for patient identification at each of the safety net hospitals within the collaborative;
 - Define the specific roles community health workers hold within the FHP program both at hospitals and housing partners to establish best-practices;
 - Create and test communication channels between the Collaborative agencies to implement robust care coordination.
- Hire the following types of positions to fulfill Collaborative aims:
 - Care Coordination staff positions at healthcare partner facilities;
 - Behavioral health staff including the Community Support Team staff and Psychiatric staff
 - FHP housing and case management staff
- House 50 new FHP households and provide them with on-going rental subsidies and tenancy supports.
- Implement behavioral health services for FHP participants.
- Utilize communication channels developed by the Collaborative to implement care coordination for FHP participants.

Year 2: By the end of year two, the FHP Collaborative will achieve the following:

- Develop and implement processes for Safety net hospital and Federally Qualified Health Center partners to refer patients experiencing homelessness to FHP.
- House an additional 200 households for a total of 250 households housed through the FHP Collaborative, and provide on-going rental subsidies and tenancy supports.
- Hire and train Community Health Workers to serve FHP participants.
- Provide on-going behavioral health services for FHP participants.
- Utilize communication channels developed by the Collaborative to implement care coordination for FHP participants.

Years three-five of the FHP Collaborative will be focused on maintaining the processes and services implemented in years one and two.

Year 3:

- Provide on-going rental subsidies and tenancy supports for 250 households housed through the FHP Collaborative.
- Provide on-going behavioral health services for FHP participants.
- Provide on-going Community Health Worker services to FHP participants.
- Utilize communication channels developed by the Collaborative to implement care coordination for FHP participants.

Year 4:

- Provide on-going rental subsidies and tenancy supports for 250 households housed through the FHP Collaborative.
- Provide on-going behavioral health services for FHP participants.
- Provide on-going Community Health Worker services to FHP participants.

- Utilize communication channels developed by the Collaborative to implement care coordination for FHP participants.

Year 5:

- Provide on-going rental subsidies and tenancy supports for 250 households housed through the FHP Collaborative.
- Provide on-going behavioral health services for FHP participants.
- Provide on-going Community Health Worker services to FHP participants.
- Utilize communication channels developed by the Collaborative to implement care coordination for FHP participants.
- Implement sustainability initiatives.

Community Input

Effectively addressing homelessness on Chicago's South and West Sides requires input from people experiencing homelessness, awareness among the health care system, and consensus-building to best-serve the population. The strength of this Collaborative is that it includes strong partnerships across sectors, public and private investors, and provides the opportunity to expand those partnerships.

The FHP program engages its participants by gathering their direct input to inform the design of services and program implementation. The program seeks input from FHP participants through the Lived Experience Advisory Committee, the FHP Governance Board Council, and client satisfaction surveys. The Center for Housing and Health's (CHH) Lived Experience Advisory Committee (LEAC) meets on a monthly basis to provide feedback to program leadership regarding service needs and implementation. Participants attending LEAC meetings are provided financial compensation for their time and input. The FHP program maintains a Governance Council with written bi-laws stating that one-third of the Board Council's voting power is dedicated to FHP participants. Currently, four FHP participants hold a voting seat on the program's Governing Council. And, in order to gather feedback from all FHP participants, CHH distributes and collects an annual client satisfaction survey. The survey evaluates participants overall satisfaction with the program, their housing units, and the supportive services they receive. CHH believes that participant input is crucial for implementing a successful and sustainable FHP program. If funded, CHH will engage with LEAC members to gather input regarding the Collaboratives activities and best practices to implementing them in the FHP program.

In addition to CHH's efforts to incorporate community input into the Collaborative activities, Collaborative partners gather and incorporate community input into their programming and service delivery. The Board of Directors for each of the Federally Qualified Health Center partners includes patients as the majority of Board members. Additionally, the hospital partners conduct community engagement through a variety of initiatives that can help inform the Collaborative's activities. Furthermore, all of the health system partners also conduct Community Health Needs Assessments every three-five years which gather data and community input to inform healthcare delivery.

Budget

Funding for the Flexible Housing Pool Collaborative is an opportunity to meet the tremendous need for providing housing and healthcare services to those experiencing homelessness in Chicago. With this funding, the FHP program will be enhanced greatly. Not only will FHP participants become connected to the behavioral health services they need, but the program model will have a dramatic impact on ending homelessness in Chicago.

The Collaborative used HFS's budget template to develop the budget. The total budget request is \$25,722,860.

Revenues

Private philanthropy has provided substantial support to the Flexible Housing Pool to date. Specifically, the Polk Bros. Foundation, J.B. and M.K. Pritzker Family Foundation, Michael Reese Foundation, and the Chicago Community Trust currently support the FHP. The Collaborative estimates this support will continue over the 5-year grant term at \$250,000 annually or \$1,250,000 total.

Medicaid revenue included in the spreadsheet is based on encounters at the Federally Qualified Health Centers (FQHC) and by the two Community Support Teams (CST). The project used an average FQHC encounter rate of \$145 per encounter. During the Year one and Year two funding periods, the number of patients and encounters steadily increases. Year one included 50 patients with one encounter each for a total of \$7,250. Year two included 250 patients

with two encounters each for a total of \$72,500. Years three, four and five included 250 patients with four encounters each for a total of \$145,000 annually. Total FQHC Medicaid revenue is \$514,750.

Each of the two Community Support Team (CST) can serve 76 participants at full capacity, for a total of 152 participants. Renaissance estimates providing \$4,012.79 in Medicaid billable services per participant enrolled per year. In year one, the expectation is that 76 participants will be enrolled for three months each for a total of \$76,243. Year two includes 152 participants enrolled for a total of 7.5 months each for a total of \$381,215. Years three, four and five included 152 participants enrolled for 12 months each for a total of \$609,944 annually. Total CST Medicaid revenue is \$2,287,290.

Overall Medicaid revenue from both FQHC and CST sources for the project is \$2,802,040.

The Collaborative's Funds will be coming from four sources:

- 1) Center for Housing and Health will provide in-kind support by leveraging the organization's Connection to Harm Reduction program based on up to 40 participants enrolled at a point in time.
- 2) Center for Housing and Health staff time for day-to-day project management of the FHP.
- 3) Renaissance Social Services will leverage staff time for their mobile outreach team.
- 4) CountyCare Health Plan will leverage care management resources.

Total Collaborative's Funds are \$1,841,250 in salary and fringe.

Hospital and health system collaborative partners will certainly generate additional Medicaid revenue based on services provided to FHP patients. However, with far too many unknown factors in the type and frequency of services for the participants, these revenues were not included.

Additional in-kind donations valued at thousands of dollars will be provided by organizational leadership staff who participate in Collaborative planning, meetings and Governing Council.

Budget Justification

The Healthcare Transformation funds will build upon the existing infrastructure of the Flexible Housing Pool. HTC funding will allow the Collaborative to serve an additional 250 households who will receive the current suite of services offered by the FHP, which includes mobile street outreach, housing location, a rental subsidy, move-in expenses, ongoing tenancy support, and transportation assistance. Yet, the HTC funds address existing gaps in the current project and provide critical enhancements to the existing model to ensure the clinical, psychiatric, and other behavioral needs of FHP participants are met in order further the efforts of focusing on health outcomes. In addition to service access, this will only effectively occur through more comprehensive communication strategies, health systems navigation for participants, enhanced capacity and Collaborative-wide coordination.

Behavioral Health Staffing Expenses

Community Support Team Members, Renaissance Social Services

FTEs: 10

- Team Lead - 2.0 FTE
- Peer Recovery Specialist – 2.0 FTE
- Clinical Case Manager – 6.0 FTE

CST is an evidence-based practice shown to help people living with severe and persistent mental illness manage their conditions and improve functioning in community settings. The teams would conduct weekly in-home and community-based services, including intake, assessment, therapeutic treatment, recovery support and case management for 152 participants. The HTC funding would support the start-up period in Years 1 and 2 while the two CST teams reach full capacity for their caseloads during which Medicaid funding would not fully cover the operational costs. The total startup costs to launch the two teams will be \$236,000. In Years 3-5, Medicaid billing would cover the full cost of the two teams.

Increased Psychiatric Capacity – Christian Community Health Center, Heartland Alliance Health

- 1.0 FTE Advanced Practice Nurse (APN)
- Enhancement payments for Psychiatry

In order to ensure participants can access psychiatry services necessary to manage their mental illness, the Collaborative proposes to increase psychiatry capacity on both the West and South Sides of Chicago. An additional APN will be hired at Christian Community Health Center and directly connect with the CST teams. HTC funds will support the equivalent of \$60,000 annually (prorated in Year one) for a total \$255,000. Also, Heartland Alliance Health will receive psychiatric enhancement payments to cover the full costs of delivering psychiatric services for a total of \$127,500.

Direct Client Support

All participants in the FHP Collaborative will receive a rental subsidy, utility assistance, move in assistance, transportation and food assistance and furniture. Transportation and food assistance address two other major Social Determinant of Health both before and after a household reaches housing. The rental subsidy and move in costs have a higher rate in Year one (\$1,700/household) to account for the need for security deposits as well as temporary units, such as motel or hotel rooms, while households search for a permanent apartment as well as. 50 households will reach housing in Year one and 250 households will be housed by the end of Year Two. Both Years one and two show a prorated number of months of assistance to account for the time it will take for locate program participants and assist them with the housing search. Rental assistance and utility assistance continue for households while they remain enrolled in the program. Ongoing rental assistance is calculated at an average \$1,200/month based on fair market rent rates in the Chicago Metropolitan Area. Total direct client support for the project is \$14,042,500.

Housing Tenancy Support Services

FTEs: 10

Christian Community Health Center, Center for Housing and Health, Deborah's Place, Housing Forward, La Casa Norte, The Night Ministry, Thresholds, Unity Parenting and Counseling

- Housing Specialist - 2
- Housing Tenancy Support Case Managers – 5
- Landlord Engagement Specialist - 3

The housing tenancy support team is responsible for helping each household find, secure and maintain their housing. The Housing Specialist accompany participants on the housing search and then disengages after move-in. The Housing Tenancy Support Case Managers maintain the primary relationship with participants, serve as their advocate and liaison and go to their home at least once per month. The Landlord Engagement Specialists serve as the primary contacts to the many private market landlords with whom the project builds relationships and rents apartments for the program. Housing Specialist and Tenancy Support Case Manager case ratios are 1:20, while the Landlord Engagement Specialist case ratio is 1:85. Participants who have CST services do not also receive tenancy support case management because this is handled by the CST team. The average salary and fringe cost per FTE is \$68,600. The number of staff supported and months hired is prorated for Year one and Year two during ramp up.

Community Health Workers

FTEs: 7

Sinai Health System, Christian Community Health Center

- Community Health Workers (CHWs): 6.
- CHW Supervisor: 1.0

Community Health Workers will facilitate improving FHP participants' linkage services, navigating the health care system and promoting wellness. They will maintain a case ratio of 1:40 at a point in time. The average salary and fringe cost per FTE is \$61,000. The number of staff supported and months hired is prorated for Year one and Year two during ramp up.

Workforce Development

FTEs: 1

Sinai Urban Health Institute

- Training Manager: 1.0

The training manager will be responsible for leading the CHW training curriculum for interested FHP residents. The manager will also help link trainees to real-time employment opportunities in the workforce through a well-established network. The manager will also build the capacity of other collaborative partners to develop CHW models with a standard of excellence. The annual salary and fringe for this position is \$104,000.

Care Coordination

FTEs: 3

- Care Coordinators

Christian Community Health Center, Heartland Alliance Health

These staff at the FQHC partner sites will be responsible for communicating back to the rest of the care team about the ongoing physical and behavioral health care needs of project participants. They will be licensed clinical staff based on the expected acuity of the FHP participants.

Collaborative Staff Expenses

FTEs: 4

Center for Housing and Health

- Director, Health Care Transformation
- Grants and Finance Manager
- Housing Stabilization Specialist
- Data Services Manager

These staff will be responsible for convening the Collaborative, maintaining coordination and ensuring smooth operations for the project. All will be dedicated full time to the project. They will provide fiscal management of the Collaborative partners, manage accountability for project outcomes and regularly provide data to all Collaborative partners.

Safety Net Hospital Capacity Building

Each safety net hospital will receive \$20,000 annually to support the infrastructure and capacity needs in identifying and connecting patients who are homeless to the FHP Collaborative.

Technical Assistance

The Corporation for Supportive Housing will provide technical assistance and training at the rate of \$20,000 annually to FHP Collaborative partners around national best practices and innovations related to the intersection of housing and healthcare.

Christian Community Health Center is the Medicaid provider designated to receive the HFS directed payments on behalf of the Collaborative. The directed payments, minus the amount remaining with Christian Community Health Center for the budgeted work and fiscal administration fee, will be sent to the Center for Housing and Health to distribute among the Collaborative partners as agreed. Christian Community Health Center will be provided an administration fee of approximately 1% of each year's total budgeted amount.

Sustainability Plan

The sustainability plan for the Collaborative is based on 1) reinvestment of cost savings 2) accessing other mainstream resources 3) HFS authorizing CMS-covered Medicaid services.

By focusing on Medicaid beneficiaries who use multiple systems of care and have high utilization, the opportunity for cost savings is significant through the FHP Collaboration. Improving participant wellness and health outcomes while decreasing costly utilization of crisis services achieves multiple aims. Redirecting cost savings into the project (or similar projects) that achieve cost savings will enable the project to continue beyond the grant period and serve additional participants.

The largest single cost of the project is the ongoing rental subsidies for participants to ensure they can afford their homes. While resources for rental subsidies are limited across the region at any given time, the Flexible Housing Pool is designed to help participants eventually access other housing resources. These may include options such as affordable Senior Housing, the Statewide Referral Network units or vouchers through local Housing Authorities. Over time, most FHP participants would not need the rental subsidy amounts paid from the FHP.

Additionally, participants in the Workforce Development component of the Collaborative (as well as other employment options) will increase their own income, which in turn will decrease the amount needed from the of rental subsidy. With households contributing 30% of their income toward rent every month, higher income levels shift more responsibility onto the household and away from the program. Ideally some households will secure an income high enough to cover the full amount of their monthly rent in a private market apartment. Additionally, some participants will graduate or “Move On” from the program altogether during the course of the grant because they have met their goals and no longer need the housing tenancy services or rental subsidy.

Finally, a number of the expenses listed in the budget are Medicaid-eligible under federal CMS regulations. However, key roles such as Community Health Workers and housing tenancy support workers still have barriers in being billed under current Illinois Medicaid regulations. This project can serve as a demonstration for these services and moving toward full implementation of Medicaid billing in the future. Other states around the country such as Minnesota, Massachusetts and Rhode Island have already implemented a number of model changes to ensure housing tenancy supports can be effectively covered by Medicaid and deployed in the community. Last, it will be important to ensure that reimbursement rates sufficiently cover the cost of psychiatry services delivered to Medicaid beneficiaries. Providers often operate at a loss when delivering these critical services. The current access challenges for psychiatry could be improved by having more comprehensive reimbursement to cover the full cost of delivering these services.

Key Acronyms:

FHP: Flexible Housing Pool

PSH: Permanent Supportive Housing

CST: Community Support Team

3. Governance Structure

Structure and Processes

1. Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated and priorities set?

Each agency participating in the Flexible Housing Pool Collaborative will be held accountable for achieving progress towards the shared goals and outcomes. The Collaborative will meet on a monthly basis to discuss the project’s operations, successes, challenges, and progress. At the start of the Collaborative, each partner’s roll will be well-defined. The group will establish which agencies are responsible for completing the activities outlined by the Collaborative and determine the benchmarks each agency should achieve towards each outcome. All Collaborative partners have committed to sending a representative to each monthly meeting, as documented in the Memorandums of Understanding.

The Center for Housing and Health will develop a performance outcomes dashboard for the Collaborative that will track progress towards the stated goals and outcomes. Each partner participating in the Collaborative will have access to the performance dashboard, and it will be shared and discussed at Collaborative meetings. CHH will be the lead agency responsible for the

Collaborative's quality management. CHH has a robust Quality Management Plan and Quality Management team to ensure that continuous quality improvement is accomplished through a community-guided, coordinated approach to compliance with federal, state, and local regulations and funding source guidelines. The mission of CHH's Quality Management Plan is to deliver the highest quality care and housing to vulnerable populations by: 1) establishing highest standards of services 2) conducting regular ongoing monitoring of performance measures and outcomes data, 3) implementing continuous quality improvement strategies driven by quality assurance and/or community feedback 4) evaluating quality assurance processes to continually evaluate program appropriateness, efficiency, and effectiveness of services within the system. This plan also incorporates the utilization of data and measurable outcomes to combat racial inequities across the housing and healthcare systems. To do this, the Quality Management team utilizes a community accountability framework to guide continuous improvement initiatives aimed at addressing immediate community needs and providing the highest quality of services.

The Flexible Housing Collaborative will utilize the existing Flexible Housing Pool governance structure. The FHP Governing Council meets quarterly to make decisions regarding the strategic direction of the program. The FHP Governing Council includes representatives from the Lived Experience Advisory Committee; each FHP investor (Chicago Department of Family and Support Services, County Care, Advocate Aurora Health, Meridian Health, Medical Home Network, University of Illinois Hospital and Health Systems, and the Blue Cross Blue Shield Foundation); the Chicago Continuum of Care lead agencies (All Chicago and Suburban Alliance to End Homelessness); the Chicago Department of Housing; the Corporation for Supportive Housing; and the Chicago Coalition for the Homeless. The responsibilities of the FHP Governance Council members include: regularly attending quarterly governance meetings, reviewing meeting materials in advance, completing onboarding webinars and readings, and remain informed of FHP progress via communication with implementation leads within their organization. Each agency investing in the FHP program and representatives from the Lived Experience Advisory Committee maintain voting seats on the Council, and each non-investing agency serves as an advisory member to the Council.

The FHP Governance Council is led by a Chair and Vice-Chair. The Chair serves a one-year term with the election occurring in January of each calendar year. The Chair is responsible for informing the meeting agenda, facilitating the quarterly governance meeting, and maintaining information on FHP progress from the Implementation Leads within each FHP organization. The Vice-Chair serves a one-year term with the election occurring in January of each calendar year. Once the Vice-Chair has served their one-year term, they can move into the Chair role if so desired. The Vice-Chair is responsible for learning the responsibilities of the Chair and filling the role of the Chair if/when they are unable to attend the meeting in addition to maintaining familiarity with the meeting goals and agenda.

The decision-making process for the FHP Governance Council follows Robert's Rules of Order for procedural processes and decision-making. A quorum must be present for any decision making to occur; no decision making may occur without representation from the Lived Experience Advisory Committee. A quorum is defined as two-thirds of the Council. In order to center and prioritize the leadership, contributions, and experience of individuals with lived experience, the FHP Governance Council retains proportionate lived experience representation. Representatives from the Lived Experience Advisory Committee hold one-third of the voting power among the FHP Governance Council. To operationalize this, if current lived experience representation drops below 33% of the Voting Governance Council members, an additional seat will be added.

Invitations to the FHP governance council intentionally prioritize representation from underrepresented groups. The demographics considered include: race, ethnicity, gender identify, orientation, age and disability. Demographics for Governance Council members are collected anonymously (with an option to decline) and are reported, in aggregate, twice a year in Governance Council reporting. Demographics of Governance Council voting members, Governance Council advisory members (non-voting), and LEAC members are reported on in separate categories.

As mentioned above, the Center for Housing and Health has developed a data monitoring dashboard

to present at each quarterly Governance meeting. The FHP Governance Dashboard provides an overview of all participants housed in the program from the program's inception to the current date and informs discussion about the program's progress and future direction. This dashboard displays the following data points: time-to-housing, housing stability rates across the program, participant demographics, and housing location of all participants.

Given the expansive nature of FHP, six sub-committees have been established to ensure strategic program growth. In addition to the Lived Experience Advisory and Governance Committees mentioned above, FHP convenes Leadership, Racial Equity, Evaluation, and Sustainability Committees. It is crucial that all committees work in alignment with each other; thus, CHH actively participates on each committee and coordinates the implementation of recommendations formed in each. This robust participation also ensures continuous communication among stakeholders, which helps to facilitate relationship building between current and emergent strategic partners.

Accountability

1. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally, and with extensive participation from each participating entity? What methods will be used to enforce policy and procedure adherence?

Each agency participating in the Flexible Housing Pool Collaborative will be held accountable for achieving progress towards the shared goals and outcomes. The Collaborative will meet on a monthly basis to discuss the project's operations, successes, challenges, and progress. At the start of the Collaborative, each partner's role will be well-defined. The group will establish which agencies are responsible for completing the activities outlined by the Collaborative and determine the benchmarks each agency should achieve towards each outcome. All Collaborative partners have committed to sending a representative to each monthly meeting, as documented in the Memorandums of Understanding attached to this proposal.

In order to demonstrate the impact of an integrated healthcare and housing project, the Flexible Housing Pool Collaborative will measure HFS Quality Metrics, access to care metrics and nationally accepted housing stability metrics for people experiencing homelessness. For condition-specific behavioral health metrics, the Collaborative will use the metrics HFS requires Medicaid MCOs to report and seeks to perform at the 75th percentile nationally. The Collaborative proposes to achieve the following outcomes for the 250 households in the project:

Adult Behavioral Health

- Follow-up after hospitalization for mental illness within 7 days- 39%
- Follow-up after hospitalization for mental illness within 30 days- 62%
- Follow-up after Emergency Department visit for alcohol and other drug abuse or dependence within 7 days- 19%
- Follow-up after Emergency Department visit for alcohol and other drug use or dependence within 30 days – 29%
- Pharmacotherapy for Opioid Use Disorder (POD)- 20%

Health Equity & Preventive Care

- Decrease Emergency Department visits by 25%
- Decrease inpatient hospitalization days by 25%
- Participants will meet with a primary care physician at least once per year-50%

Household Housing Stability

- Households will remain stably housed for 12 months or longer- 80%
- Households will remain stably housed for 24 months or longer- 65%

As a cross-system project with multiple sector stakeholders, the Collaborative Research Unit (CRU) of Cook County Health was selected to be the independent evaluator for FHP. The approach of the CRU is to evaluate the immediate project and build a sustainable infrastructure (including data structures, relationships, and protocols), which allows for evaluation long-term once CRU's role is complete. In addition to building sustainable structures, CRU aims to assess individuals with specific conditions experiencing medical management that is influenced by receiving safe and secure housing, as well as determining

the overall cost-effectiveness of permanent supportive housing in improving health outcomes. The CRU infrastructure will be used to conduct ongoing data analysis, though they will not serve as the formal evaluators for the Collaborative project.

A major aim of the FHP Collaborative is to improve care coordination for FHP participants. To coordinate this type of care, MCO Collaborative partners will share data on FHP participant healthcare utilization. FHP Collaborative partners Meridian and CountyCare currently manage care for about 85% of FHP enrollees. These two partners have committed to tracking the outcomes and, through the Collaborative, implementing ways to improve the care outcomes for participants.

Data for this evaluation will be provided by a variety of sources, including Chicago and Suburban Cook HMIS systems, Cook County Health, Illinois Department of Public Health, Chicago Department of Family and Support Services, Illinois Department of Correction, and Regional healthcare organizations. CRU will work with a specific organization who specializes in combining variant data sets into a cohesive and comprehensive data management structure. CRU will ensure that data collection protects client privacy and protected health information. To examine the main health and cost outcomes, CRU will compare outcomes of those individuals who have been housed within FHP for one year and a matched control group (individuals drawn from County Care who have similar characteristics of those housed through FHP).

CHH's role in the evaluation will be not only to support CRU, but to be a main source of data for the process evaluation. CHH will provide information around supportive service provision and tenancy supports as well as housing quality and landlord engagement. CHH will also be instrumental in the interpretation of the results, specifically those around retention in housing and the interplay between individual risk factors, service provision, and the return to homelessness. Ongoing reports and final results will be shared with the FHP Governing Council to best understand the impact of the program and the results of system investments. CHH will closely review reports from CRU to help inform program delivery and adjust program implementation as needed.

To monitor the program's progress towards outcomes, the Center for Housing and Health has built five monitoring dashboards, specific to the Flexible Housing Pool (FHP) program. These dashboards allow program staff to view and analyze progress towards overall goals of FHP as well as identify areas of necessary improvement. These dashboards also simplify financial reporting for the program, which is an integral process-improvement especially as the project continues to evolve and expand. Access to the necessary dashboards is shared with FHP partner agencies to ensure that progress of the program can be viewed amongst all agencies. The following is a summary of the five dashboards and their functionality:

- The Flexible Housing Pool Monitoring Dashboard: provides real-time tracking of client-data: referrals, enrollments, housing status of enrolled participants, time-to-housing for each participant, and the housing location of each participant. This dashboard is reviewed weekly by each member of the FHP team.
- Quarterly Performance Dashboard: displays the target number of participants to be housed per quarter and tracks progress in real-time. Each Housing Specialist can view progress towards their quarterly goal; program leadership can provide support as needed. This dashboard is reviewed weekly by each member of the FHP team.
- FHP Governance Dashboard: provides an overview of all participants housed in the program from the program's inception to current date and displays the following data points: time-to-housing, housing stability rates across the program, participant demographics, and housing location of all participants. FHP leadership reviews this dashboard regularly and shares with the FHP Governance Council Members at the quarterly FHP Governance Meetings.
- Participant-Level Progression to Housing Dashboard: tracks each FHP participant's path to housing and indicates the housing needs to program staff as well as informs the program's housing processes. This dashboard is reviewed weekly by each member of the FHP team.

- **Disbursement Report Dashboard:** tracks each participant who becomes housed over the bi-monthly reporting period, their leasing information, the rental payments made on behalf of each participant, and all Client Assistance Fund charges (including items such as move-in costs, rental applications, background checks, furniture, food, medication, transportation, and utilities).

The proposed expansions to the FHP program funded through this opportunity align with HFS's mission to improving lives by addressing social and structural determinants of health. This proposal aligns with three of HFS's Quality Pillars: 1) improve behavioral health services and supports for adults, 2) focus on health equity, and 3) serve more people in the settings of their choice. The FHP Collaborative will improve the integration of physical and behavioral health services for FHP participants by increasing the capacity for these services and by implementing care coordination amongst the Collaborative partners. This will improve care coordination and access to care for individuals with alcohol and or substance use disorders. All Collaborative activities will be rooted in equity, connecting the most underserved and disproportionately represented populations experiencing homelessness in community-based settings. The Collaborative will increase the percentage of people receiving community-based programming to maximize the health and independence of the individual. Aligning with these pillars and HFS's vision for healthcare improvement will result in the best outcomes for participants as these activities will better integrate the housing and healthcare system to provide the best care for individuals experiencing homelessness.

New Legal Entity

2. Will a new umbrella legal entity be created as a result of your collaboration?

☐ No

Payments and Administration of Funds

3. How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's intended purpose? If the plan is to use a fiscal intermediary, please specify.

Christian Community Health Center will be receiving the funds directly and then transferring the funds to the Center for Housing and Health (CHH) to serve as the primary fiscal administrator. Agencies in the Collaborative will voucher CHH for the funding amount they are subcontracted for.

The Center for Housing and Health has managed a wide range of housing assistance and supportive housing programs for more than 10 years and thus has extensive expertise in providing fiscal and administrative oversight. CHH's Chief Financial Officer (CFO) is a Certified Public Accountant with more than 20 years of experience in the social services sector. The CFO oversees a Finance and Contracts Department staffed by experienced, highly skilled individuals with a very low turnover rate. CHH has a financial management system that provides timely, current, and complete disclosure of financial information in accordance with Generally Accepted Accounting Principles.

Racial Equity

High-Level Narrative

A fundamental focus of healthcare transformation is racial equity. Please provide a high level description of how the design of your proposal incorporates racial equity. (Greater detail will be requested in the questions below.)

Chicago is one of the most racially segregated cities in the United States. In 2019 the Black population living in Chicago totaled 768,524 people; the majority (80%) of these Black residents live in just 23 of the 77 community areas of Chicago.²³ Long histories of political and economic exclusion have led to the geographic isolation of the Black population from other racial groups in the city. This includes inequitable local government policies, racist practices such as red lining, contract sales, real estate covenants, and racialized violence.²⁴ Exclusionary policies and practices continue today through restrictive health care delivery, unjust policing and sentencing, community divestment, and political exclusion. This system hinders Black economic and social progress and is the root cause of inequities disproportionately affecting the lives of Black Chicagoans.

The Chicago Department of Public Health (CDPH) generated many reports describing racial inequities among the Black population, especially focused on the South and West Sides of the city. These reports show that the communities comprised of at least 80% Black population are the same areas with high levels of economic hardship, lower per capita income, and higher severe housing cost burden. Reports also show several social factors disproportionately impacting the Black population. The rate of opioid-related overdose deaths among the Black population in Chicago is more than three times the rate among the non-Black population. Additionally, the incarcerated Black population is at much higher rates than the non-Black population. Black people account for 84% of Chicagoans who are incarcerated in Illinois prisons. Furthermore, reports show that almost half of all disconnected youth in Chicago, individuals aged 20-24 not enrolled in school nor employed, are Black.

The impact of the social and economic environment experienced by the Black population in Chicago contributes to the health inequities reported for this population. The current life expectancy among the Black population in Chicago is more than nine years lower than that of non-Blacks. This gap in life expectancy is driven by five main causes of death (disproportionately higher in Chicago's Black population): chronic disease, homicide, infant mortality, HIV and other infections, and opioid overdose. In addition to these causes of death, Black Chicagoans report experiencing more serious psychological distress in their everyday life as compared to non- Blacks.²⁵

²³ CDPH_BlackHealth7c_DIGITAL.pdf (chicago.gov)

²⁴ State of Racial Justice in Chicago – A Tale of Three Cities (stateofracialjusticechicago.com)

²⁵ CDPH_BlackHealth7c_DIGITAL.pdf (chicago.gov)

Parallel to, and intertwined with, the health inequities among Chicago's Black population, this population also experiences higher rates of housing instability and homelessness. Despite making up about one-third of Chicago's total population, Black and African Americans are overrepresented in the population experiencing homelessness. In 2021, 73% of the total 4,447 people identified as experiencing homelessness are Black or African American.²⁶

Homelessness in Chicago impacts individuals of all ages and family structures, and the disproportionate impact of homelessness on the Black population is seen throughout the subpopulations of families and youth. In 2021, 383 families with children were identified as experiencing homelessness and 75% of the heads of household among those families are Black females. The total number of unaccompanied youths experiencing homelessness in 2021 was 213, and 80% of those youth are Black.²⁷

In Chicago, homelessness is a racial equity issue. As such, racial equity is a core value of the Flexible Housing Pool program. FHP incorporates racial equity into the program model in a variety of ways. Firstly, by securing a broad portfolio of units across the city and honoring each participant's choice of which community area they would prefer to live, this ensures that participants can access a housing unit in the community area best suited to them, regardless of their income or social status. Secondly, the FHP program maintains a Racial Equity Workgroup to provide guidance on how to best represent and serve the priority population. Finally, the FHP Governing Council includes members from the Lived Experience Advisory Committee who are People of Color from the priority population providing guidance for program operations. The Flexible Housing Pool promotes racial equity through the following commitments:

- Inclusion: Including people of color and people with lived experience of homelessness in the development of policies and governance of the program.
- Distribution: Addressing root causes of inequities by distributing housing resources in a manner that reflects the racial composition of the population being served.
- Selection: Ensuring access to housing, as a human right, is not restricted based on racial identity and providing the opportunity for participants to live in neighborhoods that are not disproportionately impacted by economic hardship or other inequities.
- Outcomes: Producing outcomes, with regards to health and housing stability, that cannot be reliably predicted based on one's racial identity.
- Evaluation: Documenting equitable racial impacts through data collection and evaluation, examining the role of race in the experience of FHP participants, and conducting a Racial Equity Impact Analysis.
- Collaboration: Aligning with other organizations and local efforts working to promote equity.

Furthermore, the Center for Housing and Health is currently working on racial desegregation initiatives with the Chicago Department of Housing to counter the historical patterns of housing segregation in Chicago. This work uses Flexible Housing Pool data to inform strategies. FHP leadership work alongside the Chicago Housing Authority and the Chicago Low Income Housing Trust Fund to provide a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis of the homeless system and develop a strategy to address the racial segregation in housing. Together, the three agencies mapped units provided to tenants across the city to recognize utilization patterns and further inform desegregation efforts.

The FHP Collaborative is dedicated to furthering initiatives to address the systematic challenges of racial equity within the housing system. The FHP Collaborative will build off the foundation of the Advancing Health Equity Learning Collaborative, funded by the Robert Wood Johnson Foundation to investigate innovations in Medicaid payment that promote equity. The team in Cook County was made up of representatives from HFS, CountyCare Health Plan, Cook County Health, and Access Community Health Network. The housing and healthcare systems have a deep history of racist policies that have enforced segregation and discrimination. The group's efforts consider the macro and micro policies that created and maintain the racial disparities seen today in their homeless population, focusing their efforts at the intersection of the health and housing systems.

²⁶ Microsoft Word - 2021 PIT ReportFINAL (chicago.gov)

²⁷ Microsoft Word - 2021 PIT ReportFINAL (chicago.gov)

The Illinois Advancing Health Equity team is focusing their efforts on Cook County's Flexible Housing Pool (FHP). In 2020, during the peak of COVID-19, HFS pivoted its annual quality pay for performance program toward a Community Reinvestment fund to encourage MCOs to invest in resources that address the social determinants of health. As a result, CountyCare invested \$5 million into the FHP. Their team decided to target the investment to serve individuals with mental illness and/or substance use disorder and families with children. The investment provided tenancy support, rent and associated housing costs for 66 members for three years. The goal of this program was to demonstrate that providing housing as a basic human right can both improve health and create savings by reducing the use of inpatient and emergency department services for needs that can be more effectively met through community-based services. The initial investment is a kickstart to a potentially sustainable payment innovation. CountyCare has joined the growing group of public and private investors in FHP; as the pool of investors grows, the FHP has the potential to support more residents of Cook County.

The Advancing Health Equity team integrated a racial justice lens into each program component. For example, due to the long history of discrimination and segregation, Black men are overrepresented in Cook County's homeless population, and the team is taking steps to ensure that members of the initiative's Lived Experience Advisory Committee (LEAC) reflect the demographics of those experiencing homelessness in Cook County.

Racial Equity Impact Assessment Questions

2. Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?

Chicago is one of the most racially segregated cities in the United States. In 2019 the Black population living in Chicago totaled 768,524 people; the majority (80%) of these Black residents live in just 23 of the 77 community areas of Chicago.²⁸ Long histories of political and economic exclusion have led to the geographic isolation of the Black population from other racial groups in the city. This includes inequitable local government policies, racist practices such as red lining, contract sales, real estate covenants, and racialized violence.²⁹ Exclusionary policies and practices continue today through restrictive health care delivery, unjust policing and sentencing, community divestment, and political exclusion. This system hinders Black economic and social progress and is the root cause of inequities disproportionately affecting the lives of Black Chicagoans.

The Chicago Department of Public Health (CDPH) generated many reports describing racial inequities among the Black population, especially focused on the South and West Sides of the city. These reports show that the communities comprised of at least 80% Black population are the same areas with high levels of economic hardship, lower per capita income, and higher severe housing cost burden. Reports also show several social factors disproportionately impacting the Black population. The rate of opioid-related overdose deaths among the Black population in Chicago is more than three times the rate among the non-Black population. Additionally, the incarcerated Black population is at much higher rates than the non-Black population. Black people account for 84% of Chicagoans who are incarcerated in Illinois prisons. Furthermore, reports show that almost half of all disconnected youth in Chicago, individuals aged 20-24 not enrolled in school nor employed, are Black.

The impact of the social and economic environment experienced by the Black population in Chicago contributes to the health inequities reported for this population. The current life expectancy among the Black population in Chicago is more than nine years lower than that of non-Blacks. This gap in life expectancy is driven by five main causes of death (disproportionately higher in Chicago's Black population): chronic disease, homicide, infant mortality, HIV and other infections, and opioid overdose. In addition to these causes of death, Black Chicagoans report experiencing more serious psychological distress in their everyday life as compared to non- Blacks.³⁰

²⁸ CDPH_BlackHealth7c_DIGITAL.pdf (chicago.gov)

²⁹ State of Racial Justice in Chicago – A Tale of Three Cities (stateofracialjusticechicago.com)

³⁰ CDPH_BlackHealth7c_DIGITAL.pdf (chicago.gov)

Parallel to, and intertwined with, the health inequities among Chicago's Black population, this population also experiences higher rates of housing instability and homelessness. Despite making up about one-third of Chicago's total population, Black and African Americans are overrepresented in the population experiencing homelessness. In 2021, 73% of the total 4,447 people identified as experiencing homelessness are Black or African American.³¹

Homelessness in Chicago impacts individuals of all ages and family structures, and the disproportionate impact of homelessness on the Black population is seen throughout the subpopulations of families and youth. In 2021, 383 families with children were identified as experiencing homelessness and 75% of the heads of household among those families are Black females. The total number of unaccompanied youths experiencing homelessness in 2021 was 213, and 80% of those youth are Black.³²

3. Have stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities — been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged?

Effectively addressing homelessness on Chicago's South and West Sides requires input from people experiencing homelessness, awareness among the health care system, and consensus-building to best-serve the population. The strength of this Collaborative is that it includes strong partnerships across sectors, public and private investors, and provides the opportunity to expand those partnerships.

The FHP program engages its participants, of which the majority identify as Black or African American, by gathering their direct input to inform the design of services and program implementation. The program seeks input from FHP participants through the Lived Experience Advisory Committee, the FHP Governance Board Council, and client satisfaction surveys. The Center for Housing and Health's (CHH) Lived Experience Advisory Committee (LEAC) meets on a monthly basis to provide feedback to program leadership regarding service needs and implementation. Participants attending LEAC meetings are provided financial compensation for their time and input. The FHP program maintains a Governance Council with written bylaws stating that one-third of the Board Council's voting power is dedicated to FHP participants. Currently, four FHP participants hold a voting seat on the program's Governing Council. And, in order to gather feedback from all FHP participants, CHH distributes and collects an annual client satisfaction survey. The survey evaluates participants overall satisfaction with the program, their housing units, and the supportive services they receive. CHH believes that participant input is crucial for implementing a successful and sustainable FHP program. If funded, CHH will engage with LEAC members to gather input regarding the Collaborative's activities and best-practices to implementing them in the FHP program.

4. Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

The racial group most disadvantaged by the issues this proposal seeks to address is Black and African American Chicagoans.

Homelessness remains prevalent in the City of Chicago. The 2021 Chicago Point-In-Time Count identified 4,477 residents experiencing homelessness.²¹ However, the total number of people experiencing homelessness is thought to be higher because of the limitations placed on the Point-In-Time count due to COVID-19. The City of Chicago states that the 2021 Point-In-Time Counts are not comparable to past years due to methodology changes and unique circumstances of COVID-19. As such, the Collaborative analyzed the 2020 Point-In-Time counts to form the proposed project.

The 2020 Chicago Point-In-Time Count identified 5,390 residents experiencing homelessness.²² This was a total increase of 2% in the homeless population compared to 2019. In 2020, the number of unsheltered individuals increased by 21% from the previous year, meaning that more individuals are faced with living on the street or other locations not meant for human habitation.

³¹ Microsoft Word - 2021 PIT ReportFINAL (chicago.gov)

³² Microsoft Word - 2021 PIT ReportFINAL (chicago.gov)

Similar to the homeless population in the United States, Black and African American individuals are overrepresented. Despite making up about one-third of the city of Chicago's total population, Black and African American individuals make up 77% of the homeless population. This overrepresentation has remained consistent since 2017. Furthermore, approximately 75% of the heads of household in the 506 families with children identified as experiencing homelessness are Black females. Of the families with children experiencing homelessness, about 25% of households are headed by parenting youth ages 18-24. These parenting youth heads of household are overwhelmingly female and Black. The total number of unaccompanied youths in 2020, individuals aged 24 and younger, increased by 16% and were also majority Black (77%). This consistent disproportionate representation of the Black population among individuals experiencing homelessness make this a racial equity issue in addition to a human rights issue.

A contributing factor to the on-going challenge of homelessness in Chicago is the lack of available affordable housing. In its 2020 report, titled: "The Gap: A Shortage of Affordable Homes," the National Low Income Housing Coalition found that the Chicago metropolitan area had a deficit of 229,192 affordable and available units for persons with extremely low income, making housing inaccessible to many members of the Chicago community.

CHH's focus population are households experiencing homelessness in Chicago and Cook County, who are also living with health conditions. Many highly vulnerable individuals experiencing homelessness (particularly those experiencing long-term transience, living with a disabling health condition, or recently released from jail or prison) may lack identification, a stable source of income, and/or access to mainstream benefits. Collectively, these factors impact an individual's ability to obtain and maintain stable housing. Recognizing that housing is healthcare, CHH connects these individuals to permanent housing and provides services that support them to maintain housing stability.

FHP is open to all eligible individuals and families regardless of sexual orientation, gender identity, domestic violence history, or marital status. Of the clients who chose to identify demographic characteristics, 47% identify as female, 42% identify as male, and 1% identified as gender non-binary. Two percent of FHP participants identify as transgender in addition to the categories above. Seventy-five percent of participants identify as African American, 6% identify as white, 8% identify as Latinx, 2% identify as multi-racial, 1% identify as American Indian/Alaska Native, 1% identify as Asian, and 7% identify as another race or declined to provide the information. All clients participating in the program are users of multiple crisis systems, with many adults having at least one disabling condition, such as chronic health conditions, mental illness, substance use issues, physical disabilities, developmental disabilities, and HIV/AIDS. Overall, CHH's programs are intentionally designed to address the needs of individuals experiencing homelessness who also have complex health conditions.

5. What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

Chicago is one of the most racially segregated cities in the United States. In 2019 the Black population living in Chicago totaled 768,524 people; the majority (80%) of these Black residents live in just 23 of the 77 community areas of Chicago.⁸ Long histories of political and economic exclusion have led to the geographic isolation of the Black population from other racial groups in the city. This includes inequitable local government policies, racist practices such as red lining, contract sales, real estate covenants, and racialized violence.⁹ Exclusionary policies and practices continue today through restrictive health care delivery, unjust policing and sentencing, community divestment, and political exclusion. This system hinders Black economic and social progress and is the root cause of inequities disproportionately affecting the lives of Black Chicagoans.

These inequities are persistent and not narrowing.

The FHP Collaborative aims to reduce homelessness among the Black and African American population of Chicago, and participate in racial desegregations initiatives across the City.

6. What does the proposal seek to accomplish? Will it reduce disparities or discrimination?

In Chicago, homelessness is a racial equity issue. As such, racial equity is a core value of the Flexible Housing Pool program. FHP incorporates racial equity into the program model in a variety of ways. Firstly, by securing a broad portfolio of units across the city and honoring each participant's choice of which community area they would prefer to live, this ensures that participants can access a housing unit in the community area best suited to them, regardless of their income or social status. Secondly, the FHP program maintains a Racial Equity Workgroup to provide guidance on how to best represent and serve the priority population. Finally, the FHP Governing Council includes members from the Lived Experience Advisory Committee who are People of Color from the priority population providing guidance for program operations. The Flexible Housing Pool promotes racial equity through the following commitments:

- **Inclusiveness:** Including people of color and people with lived experience of homelessness in the development of policies and governance of the program.
- **Distribution:** Addressing root causes of inequities by distributing housing resources in a manner that reflects the racial composition of the population being served.
- **Selection:** Ensuring access to housing, as a human right, is not restricted based on racial identity and providing the opportunity for participants to live in neighborhoods that are not disproportionately impacted by economic hardship or other inequities.
- **Outcomes:** Producing outcomes, with regards to health and housing stability, that cannot be reliably predicted based on one's racial identity.
- **Evaluation:** Documenting equitable racial impacts through data collection and evaluation, examining the role of race in the experience of FHP participants, and conducting a Racial Equity Impact Analysis.
- **Collaboration:** Aligning with other organizations and local efforts working to promote equity.

Furthermore, the Center for Housing and Health is currently working on racial desegregation initiatives with the Chicago Department of Housing to counter the historical patterns of housing segregation in Chicago. This work uses Flexible Housing Pool data to inform strategies. FHP leadership work alongside the Chicago Housing Authority and the Chicago Low Income Housing Trust Fund to provide a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis of the homeless system and develop a strategy to address the racial segregation in housing. Together, the three agencies mapped units provided to tenants across the city to recognize utilization patterns and further inform desegregation efforts.

The FHP Collaborative is dedicated to furthering initiatives to address the systematic challenges of racial equity within the housing system. The FHP Collaborative will build off the foundation of the Advancing Health Equity Learning Collaborative, funded by the Robert Wood Johnson Foundation to investigate innovations in Medicaid payment that promote equity. The team in Cook County was made up of representatives from HFS, CountyCare Health Plan, Cook County Health, and Access Community Health Network. The housing and healthcare systems have a deep history of racist policies that have enforced segregation and discrimination. The group's efforts consider the macro and micro policies that created and maintain the racial disparities seen today in their homeless population, focusing their efforts at the intersection of the health and housing systems.

The Illinois Advancing Health Equity team is focusing their efforts on Cook County's Flexible Housing Pool (FHP). In 2020, during the peak of COVID-19, HFS pivoted its annual quality pay for performance program toward a Community Reinvestment fund to encourage MCOs to invest in resources that address the social determinants of health. As a result, CountyCare invested \$5 million into the FHP. Their team decided to target the investment to serve individuals with mental illness and/or substance use disorder and families with children. The investment provided tenancy support, rent and associated housing costs for 66 members for three years. The goal of this program was to demonstrate that providing housing as a basic human right can both improve health and create savings by reducing the use of inpatient and emergency department services for needs that can be more effectively met through community-based services. The initial investment is a kickstart to a potentially sustainable payment innovation. CountyCare has joined the growing group of public and private investors in FHP; as the pool of investors grows, the FHP has the potential to support more residents of Cook County.

The Advancing Health Equity team integrated a racial justice lens into each program component. For example, due to the long history of discrimination and segregation, Black men are overrepresented in Cook County's homeless population, and the team is taking steps to ensure that members of the initiative's Lived Experience Advisory Committee (LEAC) reflect the demographics of those experiencing homelessness in Cook County.

7. What are negative or unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized?

One of the unforeseen consequences for equity as a result of this proposal is the clustering of majority Black FHP participants in specific community areas of Chicago. Since the program utilizes a model that provides rental subsidies for units of the public market and clients are given a choice of the community area they prefer to live, patterns of housing segregation may persist. However, the Flexible Housing Pool Collaborative aims to secure housing units across the city so that FHP participants have a wide variety of choice when it comes to housing placement.

CHH's focus population are households experiencing homelessness in Chicago and Cook County, who are also living with health conditions. Many highly vulnerable individuals experiencing homelessness (particularly those experiencing long-term transience, living with a disabling health condition, or recently released from jail or prison) may lack identification, a stable source of income, and/or access to mainstream benefits. Collectively, these factors impact an individual's ability to obtain and maintain stable housing. Recognizing that housing is healthcare, CHH connects these individuals to permanent housing and provides services that support them to maintain housing stability.

FHP is open to all eligible individuals and families regardless of sexual orientation, gender identity, domestic violence history, or marital status. Of the clients who chose to identify demographic characteristics, 47% identify as female, 42% identify as male, and 1% identified as gender non-binary. Two percent of FHP participants identify as transgender in addition to the categories above. Seventy-five percent of participants identify as African American, 6% identify as white, 8% identify as Latinx, 2% identify as multi-racial, 1% identify as American Indian/Alaska Native, 1% identify as Asian, and 7% identify as another race or declined to provide the information. All clients participating in the program are users of multiple crisis systems, with many adults having at least one disabling condition, such as chronic health conditions, mental illness, substance use issues, physical disabilities, developmental disabilities, and HIV/AIDS. Overall, CHH's programs are intentionally designed to address the needs of individuals experiencing homelessness who also have complex health conditions.

8. Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

The best way to reduce the racial disparities within the homeless population and advance racial equity is to provide robust permanent supportive housing programs to individuals experiencing homelessness. Housing stability provides the platform from which individuals can reach their health and personal goals.

The Flexible Housing Pool promotes racial equity through the following commitments:

- Inclusion: Including people of color and people with lived experience of homelessness in the development of policies and governance of the program.
- Distribution: Addressing root causes of inequities by distributing housing resources in a manner that reflects the racial composition of the population being served.
- Selection: Ensuring access to housing, as a human right, is not restricted based on racial identity and providing the opportunity for participants to live in neighborhoods that are not disproportionately impacted by economic hardship or other inequities.
- Outcomes: Producing outcomes, with regards to health and housing stability, that cannot be reliably predicted based on one's racial identity.

- Evaluation: Documenting equitable racial impacts through data collection and evaluation, examining the role of race in the experience of FHP participants, and conducting a Racial Equity Impact Analysis.
- Collaboration: Aligning with other organizations and local efforts working to promote equity.

9. Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

The Flexible Housing Pool Collaborative will build upon the existing and highly successful Flexible Housing Pool program model. The Flexible Housing Pool (FHP) program is unique from traditional Permanent Supportive Housing programs because of its novel funding structure and user engagement.

The funding structure of the Flexible Housing Pool (FHP) leverages cross-sector investments from regional leaders in the housing and healthcare sectors to increase supportive housing resources across Chicago. FHP retains the original investor commitments from public, private, and healthcare entities that total \$9.6 Million annually and over \$23 million total. This diversified funding structure between public and private sectors ensures the program's sustainability and is the basis through which shared goals for ending homelessness between the housing and healthcare sectors are developed and implemented.

Also unique to the Flexible Housing Pool is its user engagement. FHP is committed to incorporating participant choice within each aspect of the program. The housing process begins by working with each participant to identify the community area where they would prefer to live and any unit accommodations that would best suit them and their household. The FHP program then secures apartments in the private market to house participants, where each household then signs their own lease. After signing the lease, households contribute 30% of their income toward monthly rent. This model of centering client choice contributes to increased housing stability.

The FHP program also engages its participants and ensures community feedback by gathering their direct input to inform the design of services and program implementation. The program seeks input from FHP participants through the Lived Experience Advisory Committee, the FHP Governance Council, and client satisfaction surveys. The Governance Council has written bi-laws stating that one-third of the Council's voting power is dedicated to FHP participants and currently has three representatives.

The funding for the Flexible Housing Pool program combines public and private investments to create a diversified and sustainable structure. FHP investors represent regional leaders in public housing, health care delivery, managed care and care coordination, and private foundations focused on impacting population health outcomes. Coordinating these sectors through shared housing and health goals creates systems level impacts and serves as a model for how the sectors can work together to end homelessness in Chicago. The following entities from the housing and healthcare sectors invest in the Flexible Housing Pool to directly support rental subsidies and services: City of Chicago, Chicago Housing Authority, Chicago Department of Housing, Blue Cross Blue Shield of Illinois, Cook County Health, CountyCare, Advocate Aurora Health, UI Health, Meridian, and Medical Home Network. Other contributors to the FHP include the Cook County Housing Authority, Polk Bros. Foundation, Chicago Community Trust, Northern Trust, and the J.B. and M.K. Pritzker Foundation.

A major asset to the program is the partnerships and investments secured from the Managed Care and Accountable Care Organizations. CountyCare and Meridian Health, Medicaid Managed Care Organizations (MCO), and Medical Home Network, an Accountable Care Organization (ACO), have executed agreements as investors in the FHP. These three entities use their billing and health services data to first identify individuals experiencing homelessness who are also high utilizers of healthcare services and then subsequently refer them to the FHP program in order to be connected to housing and case management services. Having these care-based agencies as partners furthers the FHP program's ability to implement care coordination across the partnership. These partners work with FHP program staff to coordinate care for the

FHP participants they refer, and this can serve as a model for implementing care coordination with additional FHP health care investors. The result of this coordination will reduce costs for health care partners while improving the health outcomes of FHP participants.

As a cross-system project with multiple sector stakeholders, the Collaborative Research Unit (CRU) of Cook County Health was selected to be the independent evaluator for FHP. The approach of the CRU is to evaluate the immediate project and build a sustainable infrastructure (including data structures, relationships, and protocols), which allows for evaluation long-term once CRU's role is complete. In addition to building sustainable structures, CRU aims to assess individuals with specific conditions experiencing medical management that is influenced by receiving safe and secure housing, as well as determining the overall cost-effectiveness of permanent supportive housing in improving health outcomes. The CRU infrastructure will be used to conduct ongoing data analysis, though they will not serve as the formal evaluators for the Collaborative project.

A major aim of the FHP Collaborative is to improve care coordination for FHP participants. To coordinate this type of care, MCO Collaborative partners will share data on FHP participant healthcare utilization. FHP Collaborative partners Meridian and CountyCare currently manage care for about 85% of FHP enrollees. These two partners have committed to tracking the outcomes and, through the Collaborative, implementing ways to improve the care outcomes for participants. Data for this evaluation will be provided by a variety of sources, including Chicago and Suburban Cook HMIS systems, Cook County Health, IL Department of Public Health, Chicago Department of Family and Support Services, IL Department of Correction, and Regional Healthcare Organizations. CRU will work with a specific organization who specializes in combining variant data sets into a cohesive and comprehensive data management structure. CRU will ensure that data collection protects client privacy and protected health information. To examine the main health and cost outcomes, CRU will compare outcomes of those individuals who have been housed within FHP for one year and a matched control group (individuals drawn from County Care who have similar characteristics of those housed through FHP).

CHH's role in the evaluation will be not only to support CRU, but to be a main source of data for the process evaluation. CHH will provide information around supportive service provision and tenancy supports as well as housing quality and landlord engagement. CHH will also be instrumental in the interpretation of the results, specifically those around retention in housing and the interplay between individual risk factors, service provision, and the return to homelessness. Ongoing reports and final results will be shared with the FHP Governing Council to best understand the impact of the program and the results of system investments. CHH will closely review reports from CRU to help inform program delivery and adjust program implementation as needed.

To monitor the program's progress towards outcomes, the Center for Housing and Health has built five monitoring dashboards, specific to the Flexible Housing Pool (FHP) program. These dashboards allow program staff to view and analyze progress towards overall goals of FHP as well as identify areas of necessary improvement. These dashboards also simplify financial reporting for the program, which is an integral process-improvement especially as the project continues to evolve and expand. Access to the necessary dashboards is shared with FHP partner agencies to ensure that progress of the program can be viewed amongst all agencies. The following is a summary of the five dashboards and their functionality:

- **The Flexible Housing Pool Monitoring Dashboard:** provides real-time tracking of client-data: referrals, enrollments, housing status of enrolled participants, time-to-housing for each participant, and the housing location of each participant. This dashboard is reviewed weekly by each member of the FHP team.
- **Quarterly Performance Dashboard:** displays the target number of participants to be housed per quarter and tracks progress in real-time. Each Housing Specialist can view progress towards their quarterly goal; program leadership can provide support as needed. This dashboard is reviewed weekly by each member of the FHP team.
- **FHP Governance Dashboard:** provides an overview of all participants housed in the program from the program's inception to current date and displays the following data points: time-to-housing, housing stability rates across the program, participant demographics, and housing location of all participants. FHP leadership reviews this dashboard regularly and shares with the FHP Governance Council Members at the

quarterly FHP Governance Meetings.

- Participant-Level Progression to Housing Dashboard: tracks each FHP participant's path to housing and indicates the housing needs to program staff as well as informs the program's housing processes. This dashboard is reviewed weekly by each member of the FHP team.
- Disbursement Report Dashboard: tracks each participant who becomes housed over the bi-monthly reporting period, their leasing information, the rental payments made on behalf of each participant, and all Client Assistance Fund charges (including items such as move-in costs, rental applications, background checks, furniture, food, medication, transportation, and utilities).

10. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

In order to demonstrate the impact of an integrated healthcare and housing project, the Flexible Housing Pool Collaborative will measure HFS Quality Metrics, access to care metrics and nationally accepted housing stability metrics for people experiencing homelessness. For condition-specific behavioral health metrics, the Collaborative will use the metrics HFS requires Medicaid MCOs to report and seeks to perform at the 75th percentile nationally. The Collaborative proposes to achieve the following outcomes for the 250 households in the project:

Adult Behavioral Health

- Follow-up after hospitalization for mental illness within 7 days – 39%
- Follow-up after hospitalization for mental illness within 30 days – 62%
- Follow-up after Emergency Department visit for alcohol and other drug abuse or dependence within 7 days – 19%
- Follow-up after Emergency Department visit for alcohol and other drug abuse or dependence within 30 days – 29%
- Pharmacotherapy for Opioid Use Disorder (POD) – 20%

Health Equity & Preventative Care

- Decrease emergency department visits by 25%
- Decrease inpatient hospitalization days by 25%
- Participants will meet with a primary care physician at least once per year – 50%

Household Housing Stability

- Households will remain stably housed for 12-months or longer – 80%
- Households will remain stably housed for 24-months or longer – 65%

The proposed expansions to the FHP program funded through this opportunity align with HFS's mission to improving lives by addressing social and structural determinants of health. This proposal aligns with three of HFS's Quality Pillars: 1) improve behavioral health services and supports for adults, 2) focus on health equity, and 3) serve more people in the settings of their choice. The FHP Collaborative will improve the integration of physical and behavioral health services for FHP participants by increasing the capacity for these services and by implementing care coordination amongst the Collaborative partners. This will improve care coordination and access to care for individuals with alcohol and or substance use disorders. All Collaborative activities will be rooted in equity, connecting the most underserved and disproportionately represented populations experiencing homelessness in community-based settings. The Collaborative will increase the percentage of people receiving community-based programming to maximize the health and independence of the individual. Aligning with these pillars and HFS's vision for healthcare improvement will result in the best outcomes for participants as these activities will better integrate the housing and healthcare system to provide the best care for individuals experiencing homelessness.

4. Community Input

Service Area of the Proposed Intervention

1. Identify your service area in general terms (e.g., "West Chicago", "East St. Louis Metro Area", "Southeastern Illinois").

South and West Sides of Chicago

2. Please select all Illinois counties that are in your service area.

Select counties: Cook County

3. Please list all zip codes in your service area, separated by commas.

60623, 60624, 60644, 60612, 60651, 60639, 60302, 60608, 60622, 60617, 60649, 60637, 60619, 60620, 60621, 60636, 60615, 60653, 60628

Community Input

1. Describe the process you have followed to seek input from your community and what community needs it highlighted.

Effectively addressing homelessness on Chicago's South and West Sides requires input from people experiencing homelessness, awareness among the health care system, and consensus-building to best-serve the population. The strength of this Collaborative is that it includes strong partnerships across sectors, public and private investors, and provides the opportunity to expand those partnerships.

The FHP program engages its participants by gathering their direct input to inform the design of services and program implementation. The program seeks input from FHP participants through the Lived Experience Advisory Committee, the FHP Governance Board Council, and client satisfaction surveys. The Center for Housing and Health's (CHH) Lived Experience Advisory Committee (LEAC) meets on a monthly basis to provide feedback to program leadership regarding service needs and implementation. Participants attending LEAC meetings are provided financial compensation for their time and input. The FHP program maintains a Governance Council with written bi-laws stating that one-third of the Board Council's voting power is dedicated to FHP participants. Currently, four FHP participants hold a voting seat on the program's Governing Council. And, in order to gather feedback from all FHP participants, CHH distributes and collects an annual client satisfaction survey. The survey evaluates participants overall satisfaction with the program, their housing units, and the supportive services they receive. CHH believes that participant input is crucial for implementing a successful and sustainable FHP program. If funded, CHH will engage with LEAC members to gather input regarding the Collaboratives activities and best practices to implementing them in the FHP program.

In addition to CHH's efforts to incorporate community input into the Collaborative activities, Collaborative partners gather and incorporate community input into their programming and service delivery. The Board of Directors for each of the Federally Qualified Health Center partners includes patients as the majority of Board members. Additionally, the hospital partners conduct community engagement through a variety of initiatives that can help inform the Collaborative's activities. Furthermore, all of the health system partners also conduct Community Health Needs Assessments every three-five years which gather data and community input to inform healthcare delivery.

Input from Elected Officials

1. Did your collaborative consult elected officials as you developed your proposal?

☐ No

5. Data Support

Note on the importance of data in proposal design:

It is imperative that applicants use data to design the proposed work. HFS is seeking applications that are "data-first." This means that applicants used data to determine health needs and designed and targeted the proposed work to meet those needs.

Examples of relevant data include, but are not limited to, data from the [community data reports](#) produced by UIC, data analysis of healthcare utilization data, qualitative and quantitative surveys, literary reviews, etc.

1. Describe the data used to design your proposal and the methodology of collection.

Please refer to all data references provided in the full proposal document attached to Form 2 in addition to the Flexible Housing Pool Governance Board document attached in the Appendix.

7. Health Equity and Outcomes

1. Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes.

Homelessness in the United States

Across the United States, the number of people experiencing homelessness continues to increase. In 2020, about 580,000 people experienced homelessness in the United States, which is a 2% increase from 2019. This is the fourth consecutive year that homelessness has increased nationwide. Even more alarming is the number of individuals with chronic patterns of homelessness, defined as having experienced homelessness for at least a year while struggling with a disabling condition, increased by 15% between 2019 and 2020.³³

Homelessness impacts the most vulnerable populations. Individuals experiencing homelessness have significantly higher rates of neurocognitive defects, severe traumatic brain injury, suicidality, substance use, and mental health disorders.³⁴ At a minimum estimate, 25% of people experiencing homelessness have a serious mental health disorder and 45% have type of mental health disorder. People experiencing homelessness are also at high risk of overdose from substance use.³⁵ According to the Substance Abuse and Mental Health Services Administration, 38% of people experiencing homelessness are dependent on alcohol and 26% used other drugs.³⁶ Many of these individuals living with mental health conditions also have complex physical health conditions. Homeless adult individuals have increased rates of chronic medical conditions when compared to the general population, with adults experiencing chronic homelessness more likely to experience medical complications resulting from lack of regular medical care and lack of adequate housing.³⁷

Many individuals experiencing homelessness cycle through crisis systems, such as hospitals and jails, simply to receive basic emergency care. Successive studies have shown that people without housing have higher healthcare utilization including more frequency emergency room visits, hospitalizations, and higher readmission rates.³⁸ However, this cycle of crisis-seeking care lacks the coordinated primary and behavioral health services necessary to improve health outcomes, which ultimately results in high costs for the healthcare system. Hospitals have reported an increase in costs associated with in-patient admissions for the homeless population.³⁹ Individuals experiencing homelessness are five times more likely than housed individuals to be admitted to inpatient hospital units and stay in the hospital for up to four days longer, at a cost of \$2,000 to \$4,000 a day.⁴⁰ Yet, the care they receive is not sufficient to address their chronic health conditions.

Homelessness in Chicago

Homelessness remains prevalent in the City of Chicago. The 2021 Chicago Point-In-Time Count identified

³³ [2020 AHAR: Part 1 - PIT Estimates of Homelessness in the U.S. | HUD USER](#)

³⁴ [Case Study: University of Illinois Hospital & Health Sciences System's Better Health Through Housing Program | AHA News](#)

³⁵ [Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health \(samhsa.gov\)](#)

³⁶ Microsoft Word - Substance Abuse and Homelessness.docx (nationalhomeless.org)

³⁷ [Effect of a Housing Program on Hospital Use | Research | Supportive Housing Network of New York \(shnny.org\)](#)

³⁸ [Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness | The National Academies Press \(nap.edu\)](#)

³⁹ [Hospital care and costs for homeless people \(nih.gov\)](#)

⁴⁰ [Social Determinants of Health Series: Housing and the Role of Hospitals | AHA](#)

4,477 residents experiencing homelessness.⁴¹ However, the total number of people experiencing homelessness is thought to be higher because of the limitations placed on the Point-In-Time count due to COVID-19. The City of Chicago states that the 2021 Point-In-Time Counts are not comparable to past years due to methodology changes and unique circumstances of COVID-19. As such, the Collaborative analyzed the 2020 Point-In-Time counts to form the proposed project.

The 2020 Chicago Point-In-Time Count identified 5,390 residents experiencing homelessness.⁴² This was a total increase of 2% in the homeless population compared to 2019. In 2020, the number of unsheltered individuals increased by 21% from the previous year, meaning that more individuals are faced with living on the street or other locations not meant for human habitation.

Similar to the homeless population in the United States, Black and African American individuals are overrepresented. Despite making up about one-third of the city of Chicago's total population, Black and African American individuals make up 77% of the homeless population. This overrepresentation has remained consistent since 2017. Furthermore, approximately 75% of the heads of household in the 506 families with children identified as experiencing homelessness are Black females. Of the families with children experiencing homelessness, about 25% of households are headed by parenting youth ages 18-24. These parenting youth heads of household are overwhelmingly female and Black. The total number of unaccompanied youths in 2020, individuals aged 24 and younger, increased by 16% and were also majority Black (77%). This consistent disproportionate representation of the Black population among individuals experiencing homelessness make this a racial equity issue in addition to a human rights issue.

A contributing factor to the on-going challenge of homelessness in Chicago is the lack of available affordable housing. In its 2020 report, titled: "The Gap: A Shortage of Affordable Homes," the National Low Income Housing Coalition found that the Chicago metropolitan area had a deficit of 229,192 affordable and available units for persons with extremely low income, making housing inaccessible to many members of the Chicago community.

CHH's focus population are households experiencing homelessness in Chicago and Cook County, who are also living with health conditions. Many highly vulnerable individuals experiencing homelessness (particularly those experiencing long-term transience, living with a disabling health condition, or recently released from jail or prison) may lack identification, a stable source of income, and/or access to mainstream benefits. Collectively, these factors impact an individual's ability to obtain and maintain stable housing. Recognizing that housing is healthcare, CHH connects these individuals to permanent housing and provides services that support them to maintain housing stability.

FHP is open to all eligible individuals and families regardless of sexual orientation, gender identity, domestic violence history, or marital status. Of the clients who chose to identify demographic characteristics, 47% identify as female, 42% identify as male, and 1% identified as gender non-binary. Two percent of FHP participants identify as transgender in addition to the categories above. Seventy-five percent of participants identify as African American, 6% identify as white, 8% identify as Latinx, 2% identify as multi-racial, 1% identify as American Indian/Alaska Native, 1% identify as Asian, and 7% identify as another race or declined to provide the information. All clients participating in the program are users of multiple crisis systems, with many adults having at least one disabling condition, such as chronic health conditions, mental illness, substance use issues, physical disabilities, developmental disabilities, and HIV/AIDS. Overall, CHH's programs are intentionally designed to address the needs of individuals experiencing homelessness who also have complex health conditions.

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

Flexible Housing Pool Collaborative's Goals and Outcomes

With the assistance from the Healthcare Transformation funding opportunity, the FHP Collaborative will undertake activities that expand upon the existing FHP program model to achieve the following outcomes: 1) develop new referral pipelines between hospitals and healthcare entities and the FHP program; 2) increase behavioral health

⁴¹ [Homelessness Infographic 2021 \(chicago.gov\)](https://www.chicago.gov/homelessness-infographic-2021)

⁴² 2020 PIT Report_vFinal.pdf (chicago.gov)

services available to FHP participants in community settings; and 3) enhance health navigation and communication for FHP participants.

Developing New FHP Referral Structures

The FHP Collaborative will implement systematic processes for screening and identifying individuals experiencing homelessness within hospitals and other health care settings. Treatment providers must be knowledgeable about and help clients identify available housing resources to best serve patients and ensure their ability to manage their conditions and treatments.⁴³ The FHP Collaborative anticipates that the process for identifying patients experiencing homelessness will vary among the hospital and health care partners. The Collaborative will discuss and pilot various methods of identification as part of the proposed planning phase of the funding period. By adding additional hospital partners to the FHP program, through the FHP Collaborative, and by implementing processes to identify patients experiencing homelessness, the FHP program will expand referral sources for the program. With improved patient identification processes and an increase in referral partners, the FHP program will have a significant impact on addressing homelessness on Chicago's South and West Sides.

Increasing Behavioral Health Services for FHP Participants

The FHP Collaborative will increase behavioral health services available to FHP participants within community-based settings. FHP Collaborative's partner, Renaissance Social Services Inc (RSSI), will hire staff to create a comprehensive Community Support Team (CST) dedicated to providing behavioral health services to FHP tenants. CST is an evidence-based practice shown to help people living with severe and persistent mental illness manage their conditions and improve functioning in community-based settings. Through FHP data monitoring to date, program staff have determined that 48% of households would benefit from Community Support Team services. Currently, less than one quarter of FHP participants are adequately connected to behavioral health services, primarily due to system-level access barriers, including the serious mental health workforce shortage. The lack of access to adequate clinical care creates challenges in providing the appropriate level of care to individuals with high behavioral health acuity.

The Healthcare Transformation funding would support the CST start-up period; during which Renaissance Social Services, Inc. will hire the team, begin service provision, and work towards reaching full caseload capacity. The anticipated full caseload capacity for the CST team is 150 FHP participants. Alternative funding for this start-up period is essential, as Medicaid funding alone will not fully cover the operational costs of developing this team. Sustainability for the CST, after the Collaborative funding period has ended, will be achieved by billing Medicaid for CST services.

The Flexible Housing Pool Collaborative will also support increasing the capacity for psychiatry services available to FHP participants. Psychiatric services will be offered to FHP participants in community-based settings through two Collaborative partner agencies: Christian Community Health Center and Heartland Alliance Health. These two agencies currently provide psychiatric services. However, in order to serve the growing number of FHP participants hiring additional psychiatric professionals is necessary. The FHP Collaborative will support hiring either Psychiatric Advanced Practices Nurses (APN) or Doctors of Psychiatry to serve participants. The FHP Collaborative anticipates that about 150 FHP participants will engage in

In addition to implementing the CST and increasing psychiatry capacity, the Flexible Housing Pool Collaborative will utilize the Center for Housing and Health's Connection to Harm Reduction program. Many FHP participants are experiencing both homelessness and substance use disorders in a vicious cycle of instability. The Connection to Harm Reduction program is an effective model for connecting clients in permanent supportive housing to harm reduction methods and treatment for substance use disorders. The program's three Harm Reduction Counselors provide in-home counseling to participants and facilitates referrals to clinical treatment. The program also provides trainings to community-based service providers about harm reduction and distributes Naloxone, the opioid reversal drug.

Implementing these expanded behavioral health services will lead to a reduction in the number of behavioral health hospitalizations and follow-up care appointments leading to improvements in FHP participants' health outcomes.

Enhancing Health Navigation and Communication for FHP Participants

The FHP Collaborative will greatly enhance the FHP program service coordination by implementing a robust communication process and service coordination between housing services, supportive services, and health care services. Individuals experiencing homelessness are often forced to navigate a fragmented system of housing services, supportive services, and health care services. The disconnect between these systems, including the lack of

⁴³ [Behavioral Health Services for People Who are Homeless \(samhsa.gov\)](https://www.samhsa.gov/behavioral-health-services-for-people-who-are-homeless)

coordination between multiple provider agencies, results in a lack of continuity of care and consequently poor housing stability and health outcomes. Increasing navigation and coordination through this Collaborative will ensure that FHP participants have access to all supporting services to maintain housing stability, continuity of care, and enhanced health outcomes.

In addition to increasing care coordination through communication and service coordination, this Collaborative will also explore and analyze methodologies utilized to develop peer support service providers trained as Community Health Workers. In Partnership with Sinai Urban Health Institute and Christian Community Health Center, the Collaborative will seek to hire and train FHP participants to serve the program as Community Health Workers. The addition of Community Health Workers to the FHP program will be beneficial as it would serve as a means of gainful employment for FHP participants and facilitate improving FHP participants' linkage services. According to the National Institutes of Health, the known outcomes of Community Health Worker services include: improved access to health care services for the populations they serve; better understanding between target populations and the health and social service system; and reduced need for emergency and specialty services.⁴⁴ Sinai Urban Health Institute has gained national recognition for its unique implementation of the Community Health Worker model and will bring the model and training curriculum to this Collaborative. The Collaborative will account for the current challenges to retention among Community Health Worker positions, especially in the COVID-19 workforce landscape, by incorporating training, benefits, and the necessary compensation required to be retained.

The Collaborative will utilize the Federally Qualified Health Center partners as hubs for physical and psychiatric care on both the South and West Sides of the city. Implementing two destinations for these healthcare services is crucial for FHP participants to access services because the FHP program model provides scattered housing units across the city based on participant choice. As such, the Collaborative is aiming to ensure every participant has geographic access to healthcare services. Heartland Alliance Health's James Wood Clinic, located in Haymarket Center, will serve as the health hub for the West Side. Christian Community Health Center's main health center will serve as the health hub on the South Side. Both of these partners are proficient in serving people experiencing homelessness and will be able to coordinate back to the Collaborative about further healthcare needs of the FHP participants they serve. Having this system of care coordination can ensure that FHP participants are connected to any specialty care services with the Collaborative's hospital partners. This model will improve health outcomes and reduce utilization rates among FHP participants.

FHP Collaborative Proposed Activities

To reach the three aforementioned aims, the FHP Collaborative's general approach and strategies consist of five components:

4. Identifying Patients Experiencing Homelessness

The FHP Collaborative will work with hospital partners to develop a systematic process to identify patients experiencing homelessness. The processes for patient identification that the Collaborative will consider is as follows:

- Hospital staff, including clinical, social work staff and community health workers, identify people experiencing homelessness through interactions with the patient as they receive services.
- Implementing a standardized screening that evaluates patient's social determinants of health, including housing and homelessness status.
- Utilizing the clinical observation code (Z59) recorded through Electronic Health Records to produce a list of patients that have indicated they experience homelessness.

5. Increasing Behavioral Health Services

The FHP Collaborative will expand behavioral health services provided to participants through developing a CST, increasing psychiatric capacity, and facilitating connections to substance use treatment. To implement these services, the Collaborative will complete the following:

- During the proposed planning phase, Renaissance Social Services Inc (RSSI) will hire staff to create two comprehensive Community Support Teams (CST) dedicated to providing behavioral health services to FHP tenants. The Community Support Team will conduct weekly in-home and community-based services including intake, assessment, therapeutic treatment, recovery support, and case management.
 - The staff to be hired on each CST team include:
 - One CST team lead

⁴⁴ [Role of Community Health Workers, NHLBI, NIH](#)

- One peer recovery support specialist
- Three clinical case managers
- During year one of the project, Christian Community Health Center and Heartland Alliance Health will hire additional Psychiatric professionals to serve FHP participants.
- Throughout the duration of the project, FHP participants in need of substance use treatment will be referred to the Center for Housing and Health's Connection to Harm Reduction program.

6. Care Coordination

The Flexible Housing Pool Collaborative will improve care coordination by increasing communication between Center housing staff, case management staff, behavioral health staff, and health care providers. The aim of this work is to fully implement multidisciplinary team-based care for FHP participants. Providers include outreach workers, housing navigators, tenancy support case managers, community health workers, primary and specialty care providers, and behavioral health providers.

The FHP Collaborative will implement care coordination in the following ways:

- The Collaborative will facilitate hiring and training Community Health Workers to serve FHP participants.
 - The Collaborative expects the Community Health Workers to be hired at Sinai Health Systems and Christian Community Health Center.
- All participating agencies will attend monthly Collaborative meetings to discuss and refine communication processes regarding FHP tenant's access to and utilization of services.
- Direct service staff from Collaborative agencies will attend the monthly FHP Systems Integration Team (SIT) meetings pertaining to the FHP tenants they serve.
 - SIT meetings bring together staff from the referral hospital, care managers, tenancy support case managers, and CHH housing coordination staff to discuss challenges specific to FHP tenants and how to overcome them.
- Strengthening communication channels between direct service staff at all partnering agencies.

4. Housing Patients Experiencing Homelessness

The Flexible Housing Pool Collaborative aims to house 250 participants experiencing homelessness during the funding period. Housing participants through the program includes housing navigation services to find the best-fit unit, covering the cost of leasing applications, security deposits, background-checks, and move-in fees. Once participants have located and signed a lease for a unit of their choice, an on-going rental subsidy is provided. (section continued on page 12).

The housing navigation process for FHP participants is described in the chart below:



The FHP program also maintains a robust Client Assistance Fund to support participants as they complete the housing navigation process, move into their unit, and thereafter. FHP participants are offered transportation assistance, furniture and necessary household items for their unit, cell phones, and food assistance.

5. Connection to Supportive Services

All FHP participants are connected to a case manager at a partnering agency, based on their individual or family needs. Case managers provide the following services to support the FHP tenant to maintain their housing ability and develop goals around their health and well-being:

- Two face-to-face home visits and three collateral case management contracts per month to all new heads of household enrolled in the program for the first six months after securing a permanent housing placement.
- One face-to-face home visit and two collateral case management contacts per month to heads of households after they have reached six months in housing.
- Complete a baseline FHP Intake Assessment with all household members to assess needs and inform the goal setting process.
- Complete a FHP Reassessment with all household members for every six months they remain in the program.
- Establish an Individualized Service Plan (ISP) within seven days of intake into the program which will then be re-evaluated and updated every six months.
- Assist all eligible heads of households with applying for public benefits within 30 days of housing.
- Provide referrals to programs based on participant need, such as employment services, substance use and harm reduction services, or other behavioral health services.

3. Why will the activities you propose lead to the impact you intend to have?

Please see the references in the full proposal attached to Form 2 and in the text below that provide evidence as to why the activities proposed below will lead to the intended impact.

Developing New FHP Referral Structures

The FHP Collaborative will implement systematic processes for screening and identifying individuals experiencing homelessness within hospitals and other health care settings. Treatment providers must be knowledgeable about and help clients identify available housing resources to best serve patients and ensure their ability to manage their conditions and treatments.⁴⁵ The FHP Collaborative anticipates that the process for identifying patients experiencing homelessness will vary among the hospital and health care partners. The Collaborative will discuss and pilot various methods of identification as part of the proposed planning phase of the funding period. By adding additional hospital partners to the FHP program, through the FHP Collaborative, and by implementing processes to identify patients experiencing homelessness, the FHP program will expand referral sources for the program. With improved patient identification processes and an increase in referral partners, the FHP program will have a significant impact on addressing homelessness on Chicago's South and West Sides.

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The FHP Collaborative will increase behavioral health services available to FHP participants within community-based settings. FHP Collaborative's partner, Renaissance Social Services Inc (RSSI), will hire staff to create a comprehensive Community Support Team (CST) dedicated to providing behavioral health services to FHP tenants. CST is an evidence-based practice shown to help people living with severe and persistent mental illness manage their conditions and improve functioning in community-based settings. Through FHP data monitoring to date, program staff have determined that 48% of households would benefit from Community Support Team services. Currently, less than one quarter of FHP participants are adequately connected to behavioral health services, primarily due to system-level access barriers, including the serious mental health workforce shortage. The lack of access to adequate clinical care creates challenges in providing the appropriate level of care to individuals with high behavioral health acuity.

The Healthcare Transformation funding would support the CST start-up period; during which Renaissance Social Services, Inc. will hire the team, begin service provision, and work towards reaching full caseload capacity. The anticipated full caseload capacity for the CST team is 150 FHP participants. Alternative funding for this start-up period is essential, as Medicaid funding alone will not fully cover the operational costs of developing this team. Sustainability for the CST, after the Collaborative funding period has ended, will be achieved by billing Medicaid for CST services.

The Flexible Housing Pool Collaborative will also support increasing the capacity for psychiatry services available to FHP participants. Psychiatric services will be offered to FHP participants in community-based settings through two

⁴⁵ [Behavioral Health Services for People Who are Homeless \(samhsa.gov\)](https://www.samhsa.gov/behavioral-health-services-for-people-who-are-homeless)

Collaborative partner agencies: Christian Community Health Center and Heartland Alliance Health. These two agencies currently provide psychiatric services. However, in order to serve the growing number of FHP participants hiring additional psychiatric professionals is necessary. The FHP Collaborative will support hiring either Psychiatric Advanced Practices Nurses (APN) or Doctors of Psychiatry to serve participants. The FHP Collaborative anticipates that about 150 FHP participants will engage in

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The FHP Collaborative will greatly enhance the FHP program service coordination by implementing a robust communication process and service coordination between housing services, supportive services, and health care services. Individuals experiencing homelessness are often forced to navigate a fragmented system of housing services, supportive services, and health care services. The disconnect between these systems, including the lack of coordination between multiple provider agencies, results in a lack of continuity of care and consequently poor housing stability and health outcomes. Increasing navigation and coordination through this Collaborative will ensure that FHP participants have access to all supporting services to maintain housing stability, continuity of care, and enhanced health outcomes.

In addition to increasing care coordination through communication and service coordination, this Collaborative will also explore and analyze methodologies utilized to develop peer support service providers trained as Community Health Workers. In Partnership with Sinai Urban Health Institute and Christian Community Health Center, the Collaborative will seek to hire and train FHP participants to serve the program as Community Health Workers. The addition of Community Health Workers to the FHP program will be beneficial as it would serve as a means of gainful employment for FHP participants and facilitate improving FHP participants' linkage services. According to the National Institutes of Health, the known outcomes of Community Health Worker services include: improved access to health care services for the populations they serve; better understanding between target populations and the health and social service system; and reduced need for emergency and specialty services.⁴⁶ Sinai Urban Health Institute has gained national recognition for its unique implementation of the Community Health Worker model and will bring the model and training curriculum to this Collaborative. The Collaborative will account for the current challenges to retention among Community Health Worker positions, especially in the COVID-19 workforce landscape, by incorporating training, benefits, and the necessary compensation required to be retained.

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Center for Housing and Health

8. Access to Care

⁴⁶ [Role of Community Health Workers, NHLBI, NIH](#)

1. Name the specific obstacles or barriers to healthcare access you are targeting in your service area. Describe the causes of these obstacles that your project specifically seeks to address and explain why you have chosen to address these causes.

Chicago's housing and healthcare sectors remain largely siloed from each other, creating significant barriers for individuals experiencing homelessness to effectively access services. Furthermore, maintaining continuity of care can be challenging, as these individuals must also navigate a fragmented system of primary care, mental health, and substance use treatment, as well as housing resources. Each of these systems maintain their own eligibility, intake, and discharge policies and philosophies of care; the disconnect between these systems often results in people experiencing homelessness not receiving the connection to supportive resources they need to reach and maintain housing stability or improve their health conditions.

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

Flexible Housing Pool Collaborative's Goals and Outcomes

With the assistance from the Healthcare Transformation funding opportunity, the FHP Collaborative will undertake activities that expand upon the existing FHP program model to achieve the following outcomes: 1) develop new referral pipelines between hospitals and healthcare entities and the FHP program; 2) increase behavioral health services available to FHP participants in community settings; and 3) enhance health navigation and communication for FHP participants.

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The FHP Collaborative will implement systematic processes for screening and identifying individuals experiencing homelessness within hospitals and other health care settings. Treatment providers must be knowledgeable about and help clients identify available housing resources to best serve patients and ensure their ability to manage their conditions and treatments.⁴⁷ The FHP Collaborative anticipates that the process for identifying patients experiencing homelessness will vary among the hospital and health care partners. The Collaborative will discuss and pilot various methods of identification as part of the proposed planning phase of the funding period. By adding additional hospital partners to the FHP program, through the FHP Collaborative, and by implementing processes to identify patients experiencing homelessness, the FHP program will expand referral sources for the program. With improved patient identification processes and an increase in referral partners, the FHP program will have a significant impact on addressing homelessness on Chicago's South and West Sides.

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Sustainability for the CST, after the Collaborative funding period has ended, will be achieved by billing Medicaid for CST services.

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The Collaborative will utilize the Federally Qualified Health Center partners as hubs for physical and psychiatric care on both the South and West Sides of the city. Implementing two destinations for these healthcare services is crucial for FHP participants to access services because the FHP program model provides scattered housing units across the city based on participant choice. As such, the Collaborative is aiming to ensure every participant has geographic access to healthcare services. Heartland Alliance Health's James Wood Clinic, located in Haymarket Center, will serve as the health hub for the West Side. Christian Community Health Center's main health center will serve as the health hub on the South Side. Both of these partners are proficient in serving people experiencing homelessness and will be able to coordinate back to the Collaborative about further healthcare needs of the FHP participants they serve. Having this

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system of care coordination can ensure that FHP participants are connected to any specialty care services with the Collaborative's hospital partners. This model will improve health outcomes and reduce utilization rates among FHP participants.

FHP Collaborative Proposed Activities

To reach the three aforementioned aims, the FHP Collaborative's general approach and strategies consist of five components:

7. Identifying Patients Experiencing Homelessness

The FHP Collaborative will work with hospital partners to develop a systematic process to identify patients experiencing homelessness. The processes for patient identification that the Collaborative will consider is as follows:

- Hospital staff, including clinical, social work staff and community health workers, identify people experiencing homelessness through interactions with the patient as they receive services.
- Implementing a standardized screening that evaluates patient's social determinants of health, including housing and homelessness status.
- Utilizing the clinical observation code (Z59) recorded through Electronic Health Records to produce a list of patients that have indicated they experience homelessness.

8. Increasing Behavioral Health Services

The FHP Collaborative will expand behavioral health services provided to participants through developing a CST, increasing psychiatric capacity, and facilitating connections to substance use treatment. To implement these services, the Collaborative will complete the following:

- During the proposed planning phase, Renaissance Social Services Inc (RSSI) will hire staff to create two comprehensive Community Support Teams (CST) dedicated to providing behavioral health services to FHP tenants. The Community Support Team will conduct weekly in-home and community-based services including intake, assessment, therapeutic treatment, recovery support, and case management.
 - The staff to be hired on each CST team include:
 - One CST team lead
 - One peer recovery support specialist
 - Three clinical case managers
- During year one of the project, Christian Community Health Center and Heartland Alliance Health will hire additional Psychiatric professionals to serve FHP participants.
- Throughout the duration of the project, FHP participants in need of substance use treatment will be referred to the Center for Housing and Health's Connection to Harm Reduction program.

9. Care Coordination

The Flexible Housing Pool Collaborative will improve care coordination by increasing communication between Center housing staff, case management staff, behavioral health staff, and health care providers. The aim of this work is to fully implement multidisciplinary team-based care for FHP participants. Providers include outreach workers, housing navigators, tenancy support case managers, community health workers, primary and specialty care providers, and behavioral health providers.

The FHP Collaborative will implement care coordination in the following ways:

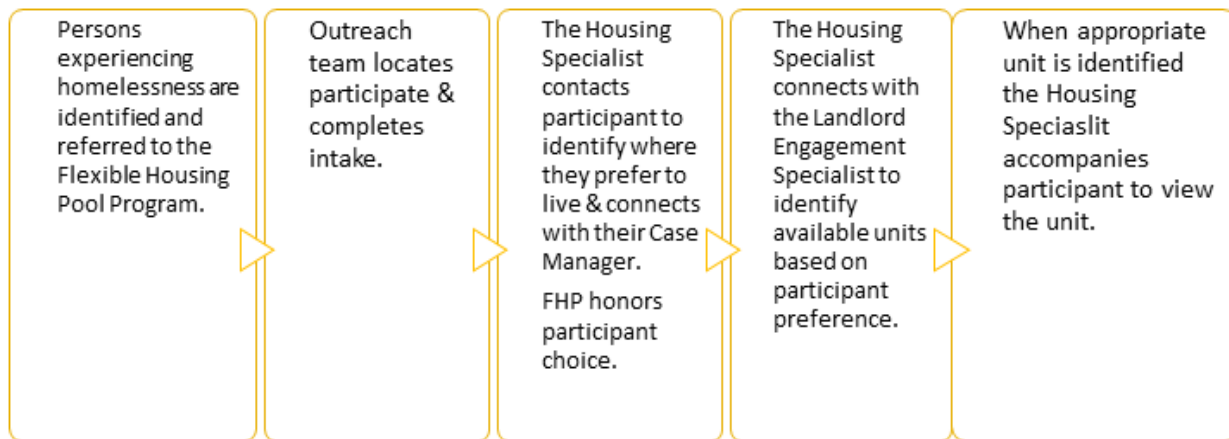
- The Collaborative will facilitate hiring and training Community Health Workers to serve FHP participants.
 - The Collaborative expects the Community Health Workers to be hired at Sinai Health Systems and Christian Community Health Center.
- All participating agencies will attend monthly Collaborative meetings to discuss and refine communication processes regarding FHP tenant's access to and utilization of services.
- Direct service staff from Collaborative agencies will attend the monthly FHP Systems Integration Team (SIT) meetings pertaining to the FHP tenants they serve.
 - SIT meetings bring together staff from the referral hospital, care managers, tenancy support case managers, and CHH housing coordination staff to discuss challenges specific to FHP tenants and how to overcome them.

- Strengthening communication channels between direct service staff at all partnering agencies.

4. Housing Patients Experiencing Homelessness

The Flexible Housing Pool Collaborative aims to house 250 participants experiencing homelessness during the funding period. Housing participants through the program includes housing navigation services to find the best-fit unit, covering the cost of leasing applications, security deposits, background-checks, and move-in fees. Once participants have located and signed a lease for a unit of their choice, an on-going rental subsidy is provided. (section continued on page 12).

The housing navigation process for FHP participants is described in the chart below:



The FHP program also maintains a robust Client Assistance Fund to support participants as they complete the housing navigation process, move into their unit, and thereafter. FHP participants are offered transportation assistance, furniture and necessary household items for their unit, cell phones, and food assistance.

5. Connection to Supportive Services

All FHP participants are connected to a case manager at a partnering agency, based on their individual or family needs. Case managers provide the following services to support the FHP tenant to maintain their housing ability and develop goals around their health and well-being:

- Two face-to-face home visits and three collateral case management contracts per month to all new heads of household enrolled in the program for the first six months after securing a permanent housing placement.
- One face-to-face home visit and two collateral case management contacts per month to heads of households after they have reached six months in housing.
- Complete a baseline FHP Intake Assessment with all household members to assess needs and inform the goal setting process.
- Complete a FHP Reassessment with all household members for every six months they remain in the program.
- Establish an Individualized Service Plan (ISP) within seven days of intake into the program which will then be re-evaluated and updated every six months.
- Assist all eligible heads of households with applying for public benefits within 30 days of housing.
- Provide referrals to programs based on participant need, such as employment services, substance use and harm reduction services, or other behavioral health services.

Outcomes and HFS Quality Metrics

In order to demonstrate the impact of an integrated healthcare and housing project, the Flexible Housing Pool Collaborative will measure HFS Quality Metrics, access to care metrics and nationally accepted housing stability metrics for people experiencing homelessness. For condition-specific behavioral health metrics, the Collaborative will

use the metrics HFS requires Medicaid MCOs to report and seeks to perform at the 75th percentile nationally. The Collaborative proposes to achieve the following outcomes for the 250 households in the project:

Adult Behavioral Health

- Follow-up after hospitalization for mental illness within 7 days – 39%
- Follow-up after hospitalization for mental illness within 30 days – 62%
- Follow-up after Emergency Department visit for alcohol and other drug abuse or dependence within 7 days – 19%
- Follow-up after Emergency Department visit for alcohol and other drug abuse or dependence within 30 days – 29%
- Pharmacotherapy for Opioid Use Disorder (POD) – 20%

Health Equity & Preventative Care

- Decrease emergency department visits by 25%
- Decrease inpatient hospitalization days by 25%
- Participants will meet with a primary care physician at least once per year – 50%

Household Housing Stability

- Households will remain stably housed for 12-months or longer – 80%
- Households will remain stably housed for 24-months or longer – 65%

As a cross-system project with multiple sector stakeholders, the Collaborative Research Unit (CRU) of Cook County Health was selected to be the independent evaluator for FHP. The approach of the CRU is to evaluate the immediate project and build a sustainable infrastructure (including data structures, relationships, and protocols), which allows for evaluation long-term once CRU's role is complete. In addition to building sustainable structures, CRU aims to assess individuals with specific conditions experiencing medical management that is influenced by receiving safe and secure housing, as well as determining the overall cost-effectiveness of permanent supportive housing in improving health outcomes. The CRU infrastructure will be used to conduct ongoing data analysis, though they will not serve as the formal evaluators for the Collaborative project.

A major aim of the FHP Collaborative is to improve care coordination for FHP participants. To coordinate this type of care, MCO Collaborative partners will share data on FHP participant healthcare utilization. FHP Collaborative partners Meridian and CountyCare currently manage care for about 85% of FHP enrollees. These two partners have committed to tracking the outcomes and, through the Collaborative, implementing ways to improve the care outcomes for participants.

Data for this evaluation will be provided by a variety of sources, including Chicago and Suburban Cook HMIS systems, Cook County Health, IL Department of Public Health, Chicago Department of Family and Support Services, IL Department of Correction, and Regional Healthcare Organizations. CRU will work with a specific organization who specializes in combining variant data sets into a cohesive and comprehensive data management structure. CRU will ensure that data collection protects client privacy and protected health information. To examine the main health and cost outcomes, CRU will compare outcomes of those individuals who have been housed within FHP for one year and a matched control group (individuals drawn from County Care who have similar characteristics of those housed through FHP).

CHH's role in the evaluation will be not only to support CRU, but to be a main source of data for the process evaluation. CHH will provide information around supportive service provision and tenancy supports as well as housing quality and landlord engagement. CHH will also be instrumental in the interpretation of the results, specifically those around retention in housing and the interplay between individual risk factors, service provision, and the return to homelessness. Ongoing reports and final results will be shared with the FHP Governing Council to best understand the impact of the program and the results of system investments. CHH will closely review reports from CRU to help inform program delivery and adjust program implementation as needed.

To monitor the program's progress towards outcomes, the Center for Housing and Health has built five monitoring dashboards, specific to the Flexible Housing Pool (FHP) program. These dashboards allow program staff to view and analyze progress towards overall goals of FHP as well as identify areas of necessary improvement. These dashboards also simplify financial reporting for the program, which is an integral process-improvement especially as the project continues to evolve and expand. Access to the necessary dashboards is shared with FHP partner agencies to ensure that

progress of the program can be viewed amongst all agencies. The following is a summary of the five dashboards and their functionality:

6. The Flexible Housing Pool Monitoring Dashboard: provides real-time tracking of client-data: referrals, enrollments, housing status of enrolled participants, time-to-housing for each participant, and the housing location of each participant. This dashboard is reviewed weekly by each member of the FHP team.
7. Quarterly Performance Dashboard: displays the target number of participants to be housed per quarter and tracks progress in real-time. Each Housing Specialist can view progress towards their quarterly goal; program leadership can provide support as needed. This dashboard is reviewed weekly by each member of the FHP team.
8. FHP Governance Dashboard: provides an overview of all participants housed in the program from the program's inception to current date and displays the following data points: time-to-housing, housing stability rates across the program, participant demographics, and housing location of all participants. FHP leadership reviews this dashboard regularly and shares with the FHP Governance Council Members at the quarterly FHP Governance Meetings.
9. Participant-Level Progression to Housing Dashboard: tracks each FHP participant's path to housing and indicates the housing needs to program staff as well as informs the program's housing processes. This dashboard is reviewed weekly by each member of the FHP team.
10. Disbursement Report Dashboard: tracks each participant who becomes housed over the bi-monthly reporting period, their leasing information, the rental payments made on behalf of each participant, and all Client Assistance Fund charges (including items such as move-in costs, rental applications, background checks, furniture, food, medication, transportation, and utilities).

The proposed expansions to the FHP program funded through this opportunity align with HFS's mission to improving lives by addressing social and structural determinants of health. This proposal aligns with three of HFS's Quality Pillars: 1) improve behavioral health services and supports for adults, 2) focus on health equity, and 3) serve more people in the settings of their choice. The FHP Collaborative will improve the integration of physical and behavioral health services for FHP participants by increasing the capacity for these services and by implementing care coordination amongst the Collaborative partners. This will improve care coordination and access to care for individuals with alcohol and or substance use disorders. All Collaborative activities will be rooted in equity, connecting the most underserved and disproportionately represented populations experiencing homelessness in community-based settings. The Collaborative will increase the percentage of people receiving community-based programming to maximize the health and independence of the individual. Aligning with these pillars and HFS's vision for healthcare improvement will result in the best outcomes for participants as these activities will better integrate the housing and healthcare system to provide the best care for individuals experiencing homelessness.

3. Why will the activities you propose lead to the impact you intend to have?

Please see the full proposal attached to Form 2 providing evidence and references supporting why the proposed activities will lead to the intended impact.

1. Name the specific social determinants of health you are targeting in your service area. Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes.

The Permanent Supportive Housing (PSH) model addresses homelessness by combining low-barrier, affordable housing without a time limit with supportive services to help individuals and families lead more affirming and stabilized lives. The Center for Housing and Health (CHH) has extensive experience leading PSH programs which deliver a safe and stable homes.

The FHP program model goes beyond traditional PSH models because agencies from the healthcare sector are essential partners and are involved in programmatic decision-making and service coordination. The FHP coordinates the housing and healthcare systems to reach marginalized homeless individuals with complex health care needs. The FHP service delivery model leverages cross-sector investments which increase supportive housing resources across Cook County; with the intention of fully integrating the housing and healthcare systems, improving health outcomes, and to reduce overall costs. The core values of FHP are racial equity, Housing First⁴⁹, authentic lived experience collaboration, and positive youth development. FHP incorporates these core values into its program design and implementation.

The Flexible Housing Pool rapidly houses, offers wraparound services, and provides linkages to health services for participants who are experiencing homelessness and interact with multiple crisis systems. Center for Housing and Health staff connect participants to a housing unit of their choice and coordinate their access to wraparound supportive services. Additionally, participants are provided best-fit case management services through a network of social service agencies. Case managers use motivational interviewing techniques to help clients address barriers to accessing appropriate care (i.e., primary instead of emergency care or behavioral and mental health care), provide resources and referrals to obtain employment and income, and work with the participant to establish individualized goals around housing stability and improved health outcomes. The Center for Housing and Health subcontracts with the following agencies to provide direct supportive services: Christian Community Health Center, Deborah's Place, Housing Forward, Heartland Human Care Services, La Casa Norte, Renaissance Social Services, The Night Ministry, Thresholds, and Unity Parenting and Counseling.

The funding for the Flexible Housing Pool program combines public and private investments to create a diversified and sustainable structure. FHP investors represent regional leaders in public housing, health care delivery, managed care and care coordination, and private foundations focused on impacting population health outcomes. Coordinating these sectors through shared housing and health goals creates systems level impacts and serves as a model for how the sectors can work together to end homelessness in Chicago. The following entities from the housing and healthcare sectors invest in the Flexible Housing Pool to directly support rental subsidies and services: City of Chicago, Chicago Housing Authority, Chicago Department of Housing, Blue Cross Blue Shield of Illinois, Cook County Health, CountyCare, Advocate Aurora Health, UI Health, Meridian, and Medical Home Network. Other contributors to the FHP include the Cook County Housing Authority, Polk Bros. Foundation, Chicago Community Trust, Northern Trust, and the J.B. and M.K. Pritzker Foundation.

A major asset to the program is the partnerships and investments secured from the Managed Care and Accountable Care Organizations. CountyCare and Meridian Health, Medicaid Managed Care Organizations (MCO), and Medical Home Network, an Accountable Care Organization (ACO), have executed agreements as investors in the FHP. These three entities use their billing and health services data to first identify individuals experiencing homelessness who are also high utilizers of health care services and then subsequently refer them to the FHP program in order to be connected to housing and case management services. Having these care-based agencies as partners furthers the FHP program's ability to implement care coordination across the partnership. These partners work with FHP program staff to coordinate care for the FHP participants they refer, and this can serve as a model for implementing care coordination with additional FHP healthcare investors. The result of this coordination will reduce costs for healthcare partners while improving the health outcomes of FHP participants.

Since the program launched in 2019, the Flexible Housing Pool program continues to gain new healthcare partners and implement various phases of coordinated expansion to increase the number of individuals and populations served. To date, FHP has housed 504 participants in 375 households which includes single adults, youth ages 18-24, and families with dependent children. Of all FHP participants who have moved into permanent housing, 96.6% remain stably

⁴⁹ Housing First - National Alliance to End Homelessness

housed. This high housing stability rate among FHP participants is a significant accomplishment because the majority of FHP households (60%) are living with a behavioral health condition.

Funding through this Healthcare Transformation opportunity will fuel the Flexible Housing Pool's growth and demonstrate that utilizing housing as a solution for improving the social determinants of health transforms the healthcare delivery system and improves outcomes for populations with numerous barriers to care. Over the next two years, the FHP program aims to reach 1,000 households served. The vision of the project is to have every Medicaid MCO and every hospital in Cook County participating in the Flexible Housing Pool, where it is recognized and used as the essential resource for people experiencing homelessness who have complex health needs and are regular visitors to hospitals. This vision would ensure safety net and under-resourced hospitals have direct access to a life-saving option for their patients as well as a fully coordinated system of care.

The Flexible Housing Pool Collaborative will build upon and expand the existing Flexible Housing Pool program. The Collaborative aims to build and deepen additional relationships with Safety Net Hospitals on Chicago's South and West Sides to identify and connect people experiencing homelessness to essential housing and supportive services, thus allowing for sustainable and improved health outcomes. Developing these partnerships will further bridge the housing and health care systems to ensure robust care coordination for FHP participants. This Collaborative will also serve as a means for Safety Net Hospitals to reduce the disproportionate burden of serving people experiencing homelessness and behavioral health challenges. Providing people with stable housing and access to the services they need to remain housed and reach health goals reduces their rates of utilization.

The FHP Collaborative will identify individuals experiencing homelessness in healthcare settings, connect them to care, and ensure they are supported with the resources needed to remain stable. This methodology is based on the understanding that when people experiencing homelessness have their social determinants of health met, they are better able to manage their conditions without using crisis systems and to improve their overall health outcomes.

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

The Flexible Housing Pool has proven to be an effective program model for reaching people experiencing homelessness in Chicago and Cook County who have unmet health needs and by aiding them in becoming stably housed and maintaining their housing stability through supportive services. At its current growth rate, the FHP program is aiming to reach 1000 households in the next two years. This is significant; according to the 2021 Chicago Point-In-Time Count, there are 4,477 residents experiencing homelessness.⁵⁰ In effect, the FHP program is seeking to reduce the homeless population in Chicago by nearly 25%. The Center for Housing and Health, along with FHP partners, recognize that while this program is not the only solution to ending homelessness in Chicago; it is, however, a model that offers a unique funding and partnership structure. As such, the coordination between the housing and healthcare systems creates the momentum needed to get the whole healthcare community involved in effectively addressing homelessness.

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⁵⁰ [Homelessness Infographic 2021 \(chicago.gov\)](https://www.chicago.gov/homelessness-infographic-2021)

overall health outcomes.

Flexible Housing Pool Collaborative's Goals and Outcomes

With the assistance from the Healthcare Transformation funding opportunity, the FHP Collaborative will undertake activities that expand upon the existing FHP program model to achieve the following outcomes: 1) develop new referral pipelines between hospitals and healthcare entities and the FHP program; 2) increase behavioral health services available to FHP participants in community settings; and 3) enhance health navigation and communication for FHP participants.

Developing New FHP Referral Structures

The FHP Collaborative will implement systematic processes for screening and identifying individuals experiencing homelessness within hospitals and other health care settings. Treatment providers must be knowledgeable about and help clients identify available housing resources to best serve patients and ensure their ability to manage their conditions and treatments.⁵¹ The FHP Collaborative anticipates that the process for identifying patients experiencing homelessness will vary among the hospital and health care partners. The Collaborative will discuss and pilot various methods of identification as part of the proposed planning phase of the funding period. By adding additional hospital partners to the FHP program, through the FHP Collaborative, and by implementing processes to identify patients experiencing homelessness, the FHP program will expand referral sources for the program. With improved patient identification processes and an increase in referral partners, the FHP program will have a significant impact on addressing homelessness on Chicago's South and West Sides.

Increasing Behavioral Health Services for FHP Participants

The FHP Collaborative will increase behavioral health services available to FHP participants within community-based settings. FHP Collaborative's partner, Renaissance Social Services Inc (RSSI), will hire staff to create a comprehensive Community Support Team (CST) dedicated to providing behavioral health services to FHP tenants. CST is an evidence-based practice shown to help people living with severe and persistent mental illness manage their conditions and improve functioning in community-based settings. Through FHP data monitoring to date, program staff have determined that 48% of households would benefit from Community Support Team services. Currently, less than one quarter of FHP participants are adequately connected to behavioral health services, primarily due to system-level access barriers, including the serious mental health workforce shortage. The lack of access to adequate clinical care creates challenges in providing the appropriate level of care to individuals with high behavioral health acuity.

The Healthcare Transformation funding would support the CST start-up period; during which Renaissance Social Services, Inc. will hire the team, begin service provision, and work towards reaching full caseload capacity. The anticipated full caseload capacity for the CST team is 150 FHP participants. Alternative funding for this start-up period is essential, as Medicaid funding alone will not fully cover the operational costs of developing this team. Sustainability for the CST, after the Collaborative funding period has ended, will be achieved by billing Medicaid for CST services.

The Flexible Housing Pool Collaborative will also support increasing the capacity for psychiatry services available to FHP participants. Psychiatric services will be offered to FHP participants in community-based settings through two Collaborative partner agencies: Christian Community Health Center and Heartland Alliance Health. These two agencies currently provide psychiatric services. However, in order to serve the growing number of FHP participants hiring additional psychiatric professionals is necessary. The FHP Collaborative will support hiring either Psychiatric Advanced Practices Nurses (APN) or Doctors of Psychiatry to serve participants. The FHP Collaborative anticipates that about 150 FHP participants will engage in

In addition to implementing the CST and increasing psychiatry capacity, the Flexible Housing Pool Collaborative will utilize the Center for Housing and Health's Connection to Harm Reduction program. Many FHP participants are experiencing both homelessness and substance use disorders in a vicious cycle of instability. The Connection to Harm Reduction program is an effective model for connecting clients in permanent supportive housing to harm reduction methods and treatment for substance use disorders. The program's three Harm Reduction Counselors provide in-home

⁵¹ [Behavioral Health Services for People Who are Homeless \(samhsa.gov\)](https://www.samhsa.gov/behavioral-health-services-for-people-who-are-homeless)

counseling to participants and facilitates referrals to clinical treatment. The program also provides trainings to community-based service providers about harm reduction and distributes Naloxone, the opioid reversal drug.

Implementing these expanded behavioral health services will lead to a reduction in the number of behavioral health hospitalizations and follow-up care appointments leading to improvements in FHP participants' health outcomes.

Enhancing Health Navigation and Communication for FHP Participants

The FHP Collaborative will greatly enhance the FHP program service coordination by implementing a robust communication process and service coordination between housing services, supportive services, and health care services. Individuals experiencing homelessness are often forced to navigate a fragmented system of housing services, supportive services, and health care services. The disconnect between these systems, including the lack of coordination between multiple provider agencies, results in a lack of continuity of care and consequently poor housing stability and health outcomes. Increasing navigation and coordination through this Collaborative will ensure that FHP participants have access to all supporting services to maintain housing stability, continuity of care, and enhanced health outcomes.

In addition to increasing care coordination through communication and service coordination, this Collaborative will also explore and analyze methodologies utilized to develop peer support service providers trained as Community Health Workers. In Partnership with Sinai Urban Health Institute and Christian Community Health Center, the Collaborative will seek to hire and train FHP participants to serve the program as Community Health Workers. The addition of Community Health Workers to the FHP program will be beneficial as it would serve as a means of gainful employment for FHP participants and facilitate improving FHP participants' linkage services. According to the National Institutes of Health, the known outcomes of Community Health Worker services include: improved access to health care services for the populations they serve; better understanding between target populations and the health and social service system; and reduced need for emergency and specialty services.⁵² Sinai Urban Health Institute has gained national recognition for its unique implementation of the Community Health Worker model and will bring the model and training curriculum to this Collaborative. The Collaborative will account for the current challenges to retention among Community Health Worker positions, especially in the COVID-19 workforce landscape, by incorporating training, benefits, and the necessary compensation required to be retained.

The Collaborative will utilize the Federally Qualified Health Center partners as hubs for physical and psychiatric care on both the South and West Sides of the city. Implementing two destinations for these healthcare services is crucial for FHP participants to access services because the FHP program model provides scattered housing units across the city based on participant choice. As such, the Collaborative is aiming to ensure every participant has geographic access to healthcare services. Heartland Alliance Health's James Wood Clinic, located in Haymarket Center, will serve as the health hub for the West Side. Christian Community Health Center's main health center will serve as the health hub on the South Side. Both of these partners are proficient in serving people experiencing homelessness and will be able to coordinate back to the Collaborative about further healthcare needs of the FHP participants they serve. Having this system of care coordination can ensure that FHP participants are connected to any specialty care services with the Collaborative's hospital partners. This model will improve health outcomes and reduce utilization rates among FHP participants.

FHP Collaborative Proposed Activities

To reach the three aforementioned aims, the FHP Collaborative's general approach and strategies consist of five components:

10. Identifying Patients Experiencing Homelessness

The FHP Collaborative will work with hospital partners to develop a systematic process to identify patients experiencing homelessness. The processes for patient identification that the Collaborative will consider is as follows:

- Hospital staff, including clinical, social work staff and community health workers, identify people experiencing homelessness through interactions with the patient as they receive services.
- Implementing a standardized screening that evaluates patient's social determinants of health, including housing and homelessness status.

⁵² [Role of Community Health Workers, NHLBI, NIH](#)

- Utilizing the clinical observation code (Z59) recorded through Electronic Health Records to produce a list of patients that have indicated they experience homelessness.

11. Increasing Behavioral Health Services

The FHP Collaborative will expand behavioral health services provided to participants through developing a CST, increasing psychiatric capacity, and facilitating connections to substance use treatment. To implement these services, the Collaborative will complete the following:

- During the proposed planning phase, Renaissance Social Services Inc (RSSI) will hire staff to create two comprehensive Community Support Teams (CST) dedicated to providing behavioral health services to FHP tenants. The Community Support Team will conduct weekly in-home and community-based services including intake, assessment, therapeutic treatment, recovery support, and case management.
 - The staff to be hired on each CST team include:
 - One CST team lead
 - One peer recovery support specialist
 - Three clinical case managers
- During year one of the project, Christian Community Health Center and Heartland Alliance Health will hire additional Psychiatric professionals to serve FHP participants.
- Throughout the duration of the project, FHP participants in need of substance use treatment will be referred to the Center for Housing and Health's Connection to Harm Reduction program.

12. Care Coordination

The Flexible Housing Pool Collaborative will improve care coordination by increasing communication between Center housing staff, case management staff, behavioral health staff, and health care providers. The aim of this work is to fully implement multidisciplinary team-based care for FHP participants. Providers include outreach workers, housing navigators, tenancy support case managers, community health workers, primary and specialty care providers, and behavioral health providers.

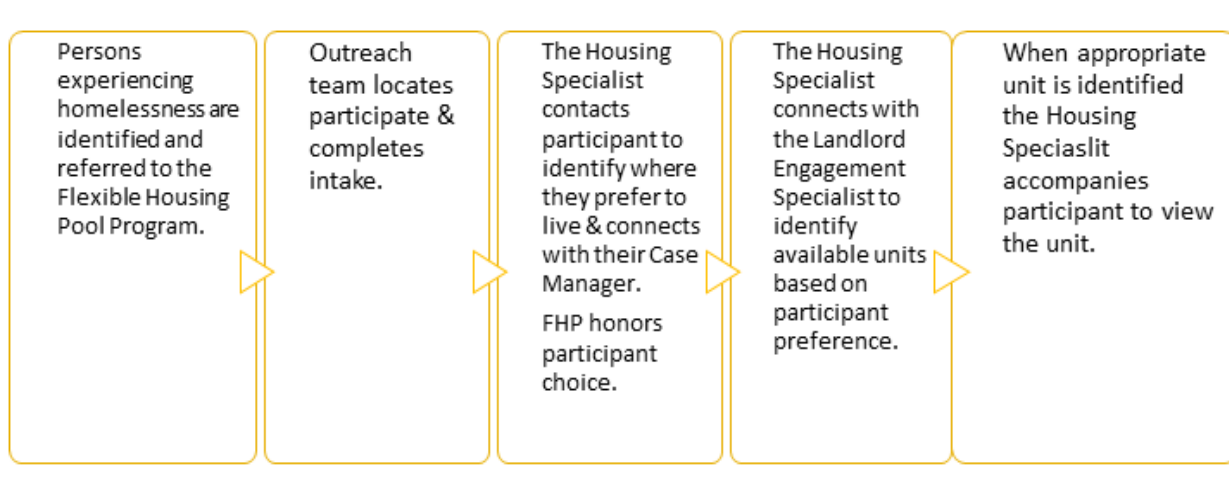
The FHP Collaborative will implement care coordination in the following ways:

- The Collaborative will facilitate hiring and training Community Health Workers to serve FHP participants.
 - The Collaborative expects the Community Health Workers to be hired at Sinai Health Systems and Christian Community Health Center.
- All participating agencies will attend monthly Collaborative meetings to discuss and refine communication processes regarding FHP tenant's access to and utilization of services.
- Direct service staff from Collaborative agencies will attend the monthly FHP Systems Integration Team (SIT) meetings pertaining to the FHP tenants they serve.
 - SIT meetings bring together staff from the referral hospital, care managers, tenancy support case managers, and CHH housing coordination staff to discuss challenges specific to FHP tenants and how to overcome them.
- Strengthening communication channels between direct service staff at all partnering agencies.

4. Housing Patients Experiencing Homelessness

The Flexible Housing Pool Collaborative aims to house 250 participants experiencing homelessness during the funding period. Housing participants through the program includes housing navigation services to find the best-fit unit, covering the cost of leasing applications, security deposits, background-checks, and move-in fees. Once participants have located and signed a lease for a unit of their choice, an on-going rental subsidy is provided. (section continued on page 12).

The housing navigation process for FHP participants is described in the chart below:



The FHP program also maintains a robust Client Assistance Fund to support participants as they complete the housing navigation process, move into their unit, and thereafter. FHP participants are offered transportation assistance, furniture and necessary household items for their unit, cell phones, and food assistance.

5. Connection to Supportive Services

All FHP participants are connected to a case manager at a partnering agency, based on their individual or family needs. Case managers provide the following services to support the FHP tenant to maintain their housing ability and develop goals around their health and well-being:

- Two face-to-face home visits and three collateral case management contracts per month to all new heads of household enrolled in the program for the first six months after securing a permanent housing placement.
- One face-to-face home visit and two collateral case management contacts per month to heads of households after they have reached six months in housing.
- Complete a baseline FHP Intake Assessment with all household members to assess needs and inform the goal setting process.
- Complete a FHP Reassessment with all household members for every six months they remain in the program.
- Establish an Individualized Service Plan (ISP) within seven days of intake into the program which will then be re-evaluated and updated every six months.
- Assist all eligible heads of households with applying for public benefits within 30 days of housing.
- Provide referrals to programs based on participant need, such as employment services, substance use and harm reduction services, or other behavioral health services.

3. Why will the activities you propose lead to the impact you intend to have?

Please see the full proposal attached to Form 2 providing references to evidence explaining why the activities proposed will lead to the intended impact.

10. Care Integration and Coordination

1. Describe how your proposal improves the integration, efficiency, and coordination of care across provider types and levels of care.

A major asset to the program is the partnerships and investments secured from the Managed Care and Accountable Care Organizations. CountyCare and Meridian Health, Medicaid Managed Care Organizations (MCO), and Medical Home Network, an Accountable Care Organization (ACO), have executed agreements as investors in the FHP. These three entities use their billing and health services data to first identify

individuals experiencing homelessness who are also high utilizers of health care services and then subsequently refer them to the FHP program in order to be connected to housing and case management services. Having these care-based agencies as partners furthers the FHP program's ability to implement care coordination across the partnership. These partners work with FHP program staff to coordinate care for the FHP participants they refer, and this can serve as a model for implementing care coordination with additional FHP healthcare investors. The result of this coordination will reduce costs for healthcare partners while improving the health outcomes of FHP participants.

Enhancing Health Navigation and Communication for FHP Participants

The FHP Collaborative will greatly enhance the FHP program service coordination by implementing a robust communication process and service coordination between housing services, supportive services, and health care services. Individuals experiencing homelessness are often forced to navigate a fragmented system of housing services, supportive services, and health care services. The disconnect between these systems, including the lack of coordination between multiple provider agencies, results in a lack of continuity of care and consequently poor housing stability and health outcomes. Increasing navigation and coordination through this Collaborative will ensure that FHP participants have access to all supporting services to maintain housing stability, continuity of care, and enhanced health outcomes.

In addition to increasing care coordination through communication and service coordination, this Collaborative will also explore and analyze methodologies utilized to develop peer support service providers trained as Community Health Workers. In Partnership with Sinai Urban Health Institute and Christian Community Health Center, the Collaborative will seek to hire and train FHP participants to serve the program as Community Health Workers. The addition of Community Health Workers to the FHP program will be beneficial as it would serve as a means of gainful employment for FHP participants and facilitate improving FHP participants' linkage services. According to the National Institutes of Health, the known outcomes of Community Health Worker services include: improved access to health care services for the populations they serve; better understanding between target populations and the health and social service system; and reduced need for emergency and specialty services.⁵³ Sinai Urban Health Institute has gained national recognition for its unique implementation of the Community Health Worker model and will bring the model and training curriculum to this Collaborative. The Collaborative will account for the current challenges to retention among Community Health Worker positions, especially in the COVID-19 workforce landscape, by incorporating training, benefits, and the necessary compensation required to be retained.

The Collaborative will utilize the Federally Qualified Health Center partners as hubs for physical and psychiatric care on both the South and West Sides of the city. Implementing two destinations for these healthcare services is crucial for FHP participants to access services because the FHP program model provides scattered housing units across the city based on participant choice. As such, the Collaborative is aiming to ensure every participant has geographic access to healthcare services. Heartland Alliance Health's James Wood Clinic, located in Haymarket Center, will serve as the health hub for the West Side. Christian Community Health Center's main health center will serve as the health hub on the South Side. Both of these partners are proficient in serving people experiencing homelessness and will be able to coordinate back to the Collaborative about further healthcare needs of the FHP participants they serve. Having this system of care coordination can ensure that FHP participants are connected to any specialty care services with the Collaborative's hospital partners. This model will improve health outcomes and reduce utilization rates among FHP participants.

13. Care Coordination

The Flexible Housing Pool Collaborative will improve care coordination by increasing communication between Center housing staff, case management staff, behavioral health staff, and health care providers. The aim of this work is to fully implement multidisciplinary team-based care for FHP participants. Providers include outreach workers, housing navigators, tenancy support case managers, community health workers, primary and specialty care providers, and behavioral health providers.

The FHP Collaborative will implement care coordination in the following ways:

⁵³ [Role of Community Health Workers, NHLBI, NIH](#)

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- All participating agencies will attend monthly Collaborative meetings to discuss and refine communication processes regarding FHP tenant's access to and utilization of services.
- Direct service staff from Collaborative agencies will attend the monthly FHP Systems Integration Team (SIT) meetings pertaining to the FHP tenants they serve.
 - SIT meetings bring together staff from the referral hospital, care managers, tenancy support case managers, and CHH housing coordination staff to discuss challenges specific to FHP tenants and how to overcome them.
- Strengthening communication channels between direct service staff at all partnering agencies.

2. Do you plan to hire community health workers or care coordinators as part of your intervention?

☒ Yes

2A. Please submit care coordination caseload numbers and cost per caseload (stratified by risk, if applicable).

The FHP Collaborative plans to hire three community health workers to provide care coordination for FHP participants. The care coordination caseload ratio will be 1:83. The care coordination cost is \$776 per participant per year.

3. Are there any managed care organizations in your collaborative?

☒ Yes

3A. Please list the names of the managed care organizations in your collaborative.

CountyCare Health Plan
Meridian Health

11. Minority Participation

1. Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise Program (BEP) and/or not-for-profit entities majorly controlled and managed by minorities that will be used on the project as subcontractors or equity partners.

List entities here:

1. AMITA Health Saints Mary and Elizabeth Medical Center
2. Christian Community Health Center
3. La Casa Norte
4. South Shore Hospital

2. Please describe the respective role of each of the entities listed above, and specify whether they will have a role only during the implementation of your proposal or if they will have a role in the ongoing operation of your transformed delivery system.

AMITA Health Saints Mary and Elizabeth Medical Center: Safety net hospital that will be identifying patients experiencing homelessness. Role during implementation and ongoing role in operations.

Christian Community Health Center: FQHC responsible for primary physical healthcare to FHP participants, psychiatric care, and tenancy supports. Role during implementation and ongoing role in operations.

La Casa Norte: Tenancy support for FHP participants. Role during implementation and ongoing role in operations.

South Shore Hospital: Safety net hospital that will be identifying patients experiencing homelessness. Role during implementation and ongoing role in operations.

12. Jobs

Existing Employees

1. For collaborating providers, please provide data on the number of existing employees delineated by job category, including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these job levels.

All of the healthcare provider positions for this Collaborative will be new hired for each participating agency should this proposal be funded.

New Employment Opportunities

2. Please estimate the number of new employees that will be hired over the duration of your proposal.

36

3. Describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve.

Behavioral Health Staffing Expenses

Community Support Team Members, Renaissance Social Services

FTEs: 10

- Team Lead - 2.0 FTE
- Peer Recovery Specialist – 2.0 FTE
- Clinical Case Manager – 6.0 FTE

CST is an evidence-based practice shown to help people living with severe and persistent mental illness manage their conditions and improve functioning in community settings. The teams would conduct weekly in-home and community-based services, including intake, assessment, therapeutic treatment, recovery support and case management for 152 participants. The HTC funding would support the start-up period in Years 1 and 2 while the two CST teams reach full capacity for their caseloads during which Medicaid funding would not fully cover the operational costs. The total startup costs to launch the two teams will be \$236,000. In Years 3-5, Medicaid billing would cover the full cost of the two teams.

Increased Psychiatric Capacity – Christian Community Health Center, Heartland Alliance Health

- 1.0 FTE Advanced Practice Nurse (APN)
- Enhancement payments for Psychiatry

In order to ensure participants can access psychiatry services necessary to manage their mental illness, the Collaborative proposes to increase psychiatry capacity on both the West and South Sides of Chicago. An additional APN will be hired at Christian Community Health Center and directly connect with the CST teams. HTC funds will support the equivalent of \$60,000 annually (prorated in Year one) for a total \$255,000. Also, Heartland Alliance Health will receive psychiatric enhancement payments to cover the full costs of delivering psychiatric services for a total of \$127,500.

Direct Client Support

All participants in the FHP Collaborative will receive a rental subsidy, utility assistance, move in assistance, transportation and food assistance and furniture. Transportation and food assistance address two other major Social Determinant of Health both before and after a household reaches housing. The rental subsidy and move in costs have a higher rate in Year one (\$1,700/household) to account for the need for security deposits as well as temporary units, such as motel or hotel rooms, while households search for a permanent apartment as well as. 50 households will reach housing in Year one and 250 households will be housed by the end of Year Two. Both Years one and two show a prorated number of months of assistance to account for the time it will take for locate program participants and assist

them with the housing search. Rental assistance and utility assistance continue for households while they remain enrolled in the program. Ongoing rental assistance is calculated at an average \$1,200/month based on fair market rent rates in the Chicago Metropolitan Area. Total direct client support for the project is \$14,042,500.

Housing Tenancy Support Services

FTEs: 10

Christian Community Health Center, Center for Housing and Health, Deborah's Place, Housing Forward, La Casa Norte, The Night Ministry, Thresholds, Unity Parenting and Counseling

- Housing Specialist - 2
- Housing Tenancy Support Case Managers – 5
- Landlord Engagement Specialist - 3

The housing tenancy support team is responsible for helping each household find, secure and maintain their housing. The Housing Specialist accompany participants on the housing search and then disengages after move-in. The Housing Tenancy Support Case Managers maintain the primary relationship with participants, serve as their advocate and liaison and go to their home at least once per month. The Landlord Engagement Specialists serve as the primary contacts to the many private market landlords with whom the project builds relationships and rents apartments for the program. Housing Specialist and Tenancy Support Case Manager case ratios are 1:20, while the Landlord Engagement Specialist case ratio is 1:85. Participants who have CST services do not also receive tenancy support case management because this is handled by the CST team. The average salary and fringe cost per FTE is \$68,600. The number of staff supported and months hired is prorated for Year one and Year two during ramp up.

Community Health Workers

FTEs: 7

Sinai Health System, Christian Community Health Center

- Community Health Workers (CHWs): 6.
- CHW Supervisor: 1.0

Community Health Workers will facilitate improving FHP participants' linkage services, navigating the health care system and promoting wellness. They will maintain a case ratio of 1:40 at a point in time. The average salary and fringe cost per FTE is \$61,000. The number of staff supported and months hired is prorated for Year one and Year two during ramp up.

Workforce Development

FTEs: 1

Sinai Urban Health Institute

- Training Manager: 1.0

The training manager will be responsible for leading the CHW training curriculum for interested FHP residents. The manager will also help link trainees to real-time employment opportunities in the workforce through a well-established network. The manager will also build the capacity of other collaborative partners to develop CHW models with a standard of excellence. The annual salary and fringe for this position is \$104,000.

Care Coordination

FTEs: 3

- Care Coordinators

Christian Community Health Center, Heartland Alliance Health

These staff at the FQHC partner sites will be responsible for communicating back to the rest of the care team about the ongoing physical and behavioral health care needs of project participants. They will be licensed clinical staff based on the expected acuity of the FHP participants.

Collaborative Staff Expenses

FTEs: 4

Center for Housing and Health

- Director, Health Care Transformation
- Grants and Finance Manager
- Housing Stabilization Specialist
- Data Services Manager

These staff will be responsible for convening the Collaborative, maintaining coordination and ensuring smooth operations for the project. All will be dedicated full time to the project. They will provide fiscal management of the Collaborative partners, manage accountability for project outcomes and regularly provide data to all Collaborative partners.

4. Please describe any planned activities for workforce development in the project.

This Collaborative will also explore and analyze methodologies utilized to develop peer support service providers trained as Community Health Workers. In Partnership with Sinai Urban Health Institute and Christian Community Health Center, the Collaborative will seek to hire and train FHP participants to serve the program as Community Health Workers. The addition of Community Health Workers to the FHP program will be beneficial as it would serve as a means of gainful employment for FHP participants and facilitate improving FHP participants' linkage services. According to the National Institutes of Health, the known outcomes of Community Health Worker services include: improved access to health care services for the populations they serve; better understanding between target populations and the health and social service system; and reduced need for emergency and specialty services.⁵⁴ Sinai Urban Health Institute has gained national recognition for its unique implementation of the Community Health Worker model and will bring the model and training curriculum to this Collaborative. The Collaborative will account for the current challenges to retention among Community Health Worker positions, especially in the COVID-19 workforce landscape, by incorporating training, benefits, and the necessary compensation required to be retained.

The FHP Collaborative will facilitate hiring and training Community Health Workers to serve FHP participants. The Collaborative expects the Community Health Workers to be hired at Sinai Health Systems and Christian Community Health Center.

13. Quality Metrics

1. Tell us how your proposal aligns with the pillars and the overall vision for improvement in the Department's Quality Strategy.

The proposed expansions to the FHP program funded through this opportunity align with HFS's mission to improving lives by addressing social and structural determinants of health. This proposal aligns with three of HFS's Quality Pillars: 1) improve behavioral health services and supports for adults, 2) focus on health equity, and 3) serve more people in the settings of their choice. The FHP Collaborative will improve the integration of physical and behavioral health services for FHP participants by increasing the capacity for these services and by implementing care coordination amongst the Collaborative partners. This will improve care coordination and access to care for individuals with alcohol and or substance use disorders. All Collaborative activities will be rooted in equity, connecting the most underserved and disproportionately represented populations experiencing homelessness in community-based settings. The Collaborative will increase the percentage of people receiving community-based programming to maximize the health and independence of the individual. Aligning with these pillars and HFS's vision for healthcare improvement will result in the best outcomes for participants as these activities will better integrate the housing and healthcare system to provide the best care for individuals experiencing homelessness.

2. Does your proposal align with any of the following Pillars of Improvement?

⁵⁴ [Role of Community Health Workers, NHLBI, NIH](#)

2A. Maternal and Child Health?

☒ No

2B. Adult Behavioral Health?

☒ Yes

Adult Behavioral Health

Follow-up after hospitalization for mental illness within 7 days – 39%

Follow-up after hospitalization for mental illness within 30 days – 62%

Follow-up after Emergency Department visit for alcohol and other drug abuse or dependence within 7 days – 19%

Follow-up after Emergency Department visit for alcohol and other drug abuse or dependence within 30 days – 29%

Pharmacotherapy for Opioid Use Disorder (POD) – 20%

2C. Child Behavioral Health?

☒ No

2D. Equity?

☒ Yes

Health Equity & Preventative Care

Decrease emergency department visits by 25%

Decrease inpatient hospitalization days by 25%

Participants will meet with a primary care physician at least once per year – 50%

All Collaborative activities will be rooted in equity, connecting the most underserved and disproportionately represented populations experiencing homelessness in community-based settings.

2E. Community-Based Services and Supports?

☒ Yes

☐ No

The Collaborative will increase the percentage of people receiving community-based programming to maximize the health and independence of the individual.

Adult Behavioral Health

Follow-up after hospitalization for mental illness within 7 days – 39%

Follow-up after hospitalization for mental illness within 30 days – 62%

Follow-up after Emergency Department visit for alcohol and other drug abuse or dependence within 7 days – 19%

Follow-up after Emergency Department visit for alcohol and other drug abuse or dependence within 30 days – 29%

Pharmacotherapy for Opioid Use Disorder (POD) – 20%

Health Equity & Preventative Care

Decrease emergency department visits by 25%

Decrease inpatient hospitalization days by 25%

Participants will meet with a primary care physician at least once per year – 50%

Household Housing Stability

Households will remain stably housed for 12-months or longer – 80%

Households will remain stably housed for 24-months or longer – 65%

3. Will you be using any metrics not found in the quality strategy?

☐ No

14. Milestones

For all activities described in your proposal, please provide a calendar of milestones to show progress (e.g., when IT will be purchased, when IT will be operative, when construction projects will begin and end, when people will be hired, etc.) The timeline should be in months from award.

The Flexible Housing Pool Collaborative requests funding for a total of five years.

Year 1: By the end of year one, the FHP Collaborative will achieve the following:

- Complete a planning period that will last between 12 to 18 months. The planning period will accomplish the following through monthly Collaborative meetings:
 - Develop procedures for patient identification at each of the safety net hospitals within the collaborative;
 - Define the specific roles community health workers hold within the FHP program both at hospitals and housing partners to establish best-practices;
 - Create and test communication channels between the Collaborative agencies to implement robust care coordination.
- Hire the following types of positions to fulfill Collaborative aims:
 - Care Coordination staff positions at healthcare partner facilities;
 - Behavioral health staff including the Community Support Team staff and Psychiatric staff
 - FHP housing and case management staff
- House 50 new FHP households and provide them with on-going rental subsidies and tenancy supports.
- Implement behavioral health services for FHP participants.
- Utilize communication channels developed by the Collaborative to implement care coordination for FHP participants.

Year 2: By the end of year two, the FHP Collaborative will achieve the following:

- Develop and implement processes for Safety net hospital and Federally Qualified Health Center partners to refer patients experiencing homelessness to FHP.
- House an additional 200 households for a total of 250 households housed through the FHP Collaborative, and provide on-going rental subsidies and tenancy supports.
- Hire and train Community Health Workers to serve FHP participants.
- Provide on-going behavioral health services for FHP participants.
- Utilize communication channels developed by the Collaborative to implement care coordination for FHP participants.

Years three-five of the FHP Collaborative will be focused on maintaining the processes and services implemented in years one and two.

Year 3:

- Provide on-going rental subsidies and tenancy supports for 250 households housed through the FHP Collaborative.
- Provide on-going behavioral health services for FHP participants.
- Provide on-going Community Health Worker services to FHP participants.
- Utilize communication channels developed by the Collaborative to implement care coordination for FHP participants.

Year 4:

- Provide on-going rental subsidies and tenancy supports for 250 households housed through the FHP Collaborative.
- Provide on-going behavioral health services for FHP participants.
- Provide on-going Community Health Worker services to FHP participants.

- Utilize communication channels developed by the Collaborative to implement care coordination for FHP participants.

Year 5:

- Provide on-going rental subsidies and tenancy supports for 250 households housed through the FHP Collaborative.
- Provide on-going behavioral health services for FHP participants.
- Provide on-going Community Health Worker services to FHP participants.
- Utilize communication channels developed by the Collaborative to implement care coordination for FHP participants.
- Implement sustainability initiatives.
-
-

15. Budget

1. Number of Individuals Served

Year 1 Individuals Served
50

Year 2 Individuals Served
250

Year 3 Individuals Served
250

Year 4 Individuals Served
250

Year 5 Individuals Served
250

Year 6 Individuals Served
250+

2. Alternative Payment Methodologies

Outline any alternative payment methodologies that your proposal might utilize for receiving reimbursement for services from MCOs.

A major asset to the program is the partnerships and investments secured from the Managed Care and Accountable Care Organizations. CountyCare and Meridian Health, Medicaid Managed Care Organizations (MCO), and Medical Home Network, an Accountable Care Organization (ACO), have executed agreements as investors in the FHP. These three entities use their billing and health services data to first identify individuals experiencing homelessness who are also high utilizers of health care services and then subsequently refer them to the FHP program in order to be connected to housing and case management services. Having these care-based agencies as partners furthers the FHP program's ability to implement care coordination across the partnership. These partners work with FHP program staff to coordinate care for the FHP participants they refer, and this can serve as a model for implementing care coordination with additional FHP healthcare investors. The result of this coordination will reduce costs for healthcare partners while improving the health outcomes of FHP participants.

The Illinois Advancing Health Equity team is focusing their efforts on Cook County's Flexible Housing Pool (FHP). In 2020, during the peak of COVID-19, HFS pivoted its annual quality pay for performance program toward a Community Reinvestment fund to encourage MCOs to invest in resources that address the social determinants of health. As a result, CountyCare invested \$5 million into the FHP. Their team decided to target the investment to serve individuals with mental illness and/or substance use disorder and families with children. The investment provided tenancy support, rent and associated housing costs for 66 members for three years. The goal of this program was to demonstrate that providing housing as a basic human right can both improve health and create savings by reducing the use of inpatient and emergency department services for needs that can be more effectively met through community-based services. The initial investment is a kickstart to a potentially sustainable payment innovation. CountyCare has joined the growing group of public and private investors in FHP; as the pool of investors grows, the FHP has the potential to support more residents of Cook County.

16. Sustainability

Provide your narrative here:

The sustainability plan for the Collaborative is based on 1) reinvestment of cost savings 2) accessing other mainstream resources 3) HFS authorizing CMS-covered Medicaid services.

By focusing on Medicaid beneficiaries who use multiple systems of care and have high utilization, the opportunity for cost savings is significant through the FHP Collaboration. Improving participant wellness and health outcomes while decreasing costly utilization of crisis services achieves multiple aims. Redirecting cost savings into the project (or similar projects) that achieve cost savings will enable the project to continue beyond the grant period and serve additional participants.

The largest single cost of the project is the ongoing rental subsidies for participants to ensure they can afford their homes. While resources for rental subsidies are limited across the region at any given time, the Flexible Housing Pool is designed to help participants eventually access other housing resources. These may include options such as affordable Senior Housing, the Statewide Referral Network units or vouchers through local Housing Authorities. Over time, most FHP participants would not need the rental subsidy amounts paid from the FHP.

Additionally, participants in the Workforce Development component of the Collaborative (as well as other employment options) will increase their own income, which in turn will decrease the amount needed from the of rental subsidy. With households contributing 30% of their income toward rent every month, higher income levels shift more responsibility onto the household and away from the program. Ideally some households will secure an income high enough to cover the full amount of their monthly rent in a private market apartment. Additionally, some participants will graduate or “Move On” from the program altogether during the course of the grant because they have met their goals and no longer need the housing tenancy services or rental subsidy.

Finally, a number of the expenses listed in the budget are Medicaid-eligible under federal CMS regulations. However, key roles such as Community Health Workers and housing tenancy support workers still have barriers in being billed under current Illinois Medicaid regulations. This project can serve as a demonstration for these services and moving toward full implementation of Medicaid billing in the future. Other states around the country such as Minnesota, Massachusetts and Rhode Island have already implemented a number of model changes to ensure housing tenancy supports can be effectively covered by Medicaid and deployed in the community. Last, it will be important to ensure that reimbursement rates sufficiently cover the cost of psychiatry services delivered to Medicaid beneficiaries. Providers often operate at a loss when delivering these critical services. The current access challenges for psychiatry could be improved by having more comprehensive reimbursement to cover the full cost of delivering these services.

**Memorandum of Understanding
between
Center for Housing and Health
and
Medical Home Network**

A. Background

The purpose of this Memorandum of Understanding (“MOU”) is to memorialize plans for a collaborative relationship between the Center for Housing and Health (“CHH”) and MHNU Corporation, an Illinois not-for-profit corporation d/b/a Medical Home Network (“Medical Home Network” or “MHN”). CHH and MHN are entering into this MOU to support CHH’s application for funding from the State of Illinois Department of Healthcare and Family Services (“DHFS”) Healthcare Transformation Collaborative (the “HTC Program”). The CHH initiative to be supported with any funding awarded from the HTC Program is hereafter called “The Flexible Housing Pool Collaborative”.

CHH’s mission is to honor every person’s right to a home and health care by bridging the housing and health care systems to improve the lives of Chicagoans experiencing homelessness. The mission of Medical Home Network is to improve healthcare delivery for vulnerable populations, empowering primary care practices to improve quality of care, improve patient experiences, and reduce medical costs.

Based upon these shared goals, CHH and MHN have agreed to enter into a collaboration in which CHH will be the lead agent and MHN will be a subcontractor supporting Flexible Housing Pool collaborative initiatives funded by the HTC Program. Building on the successes of an existing integrated healthcare and permanent supportive housing initiative that CHH and MHN support in Cook County, the Flexible Housing Pool Collaborative will increase behavioral health services in clinical and community settings to improve health outcomes for people experiencing homelessness. CHH and MHN anticipate that this collaborative will, if fully funded by the HTC Program, serve 250 households and operate for a period of five years.

B. Agreement

This MOU represents a set of agreed-upon, non-binding principles to be used as a framework for negotiating the terms and conditions of a definitive agreement between CHH and Medical Home Network, as described below. This MOU is effective upon signature of both parties and, unless otherwise terminated pursuant to Section D hereto, shall terminate immediately if CHH is notified that it has not been awarded funding under the HTC Program. If CHH is awarded funding under the HTC Program, this MOU will terminate upon CHH and Medical Home Network’s execution of a written services agreement that memorializes in further detail each party’s roles and responsibilities with respect to the HTC Program and the Flexible Housing Pool Collaborative (the “Definitive Agreement”).

C. Scopes of Services

CHH anticipates that it will, subject to the mutually agreed upon terms and conditions of any Definitive Agreement, provide the following services for the Flexible Housing Pool Collaborative if funding is granted by the HTC Program:

1. Provide all overall project leadership, coordination, and administration needed to operationalize the Flexible Housing Pool Collaborative in accordance with HTC Program rules and award agreements;
2. Coordinate referrals of participants to the Flexible Housing Pool Collaborative;
3. Provide Flexible Housing Pool Collaborative participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, health care services including behavioral health services, employment and education services, income, etc.;
4. Facilitate the compliant exchange of patient information for eligible individuals and organizations via the MHNConnect platform;
5. Communicate with Flexible Housing Pool Collaborative participants, including MHN, regarding participant housing stability and health outcomes; and
6. Prepare and deliver to DHFS all reports required under HTC Program rules and award agreements.

Medical Home Network anticipates that it will, subject to the mutually agreed upon terms and conditions of any Definitive Agreement, provide the following services for the Flexible Housing Pool Collaborative if funding is granted by the HTC Program:

1. Become familiar with the Flexible Housing Pool Collaborative's goals, objectives, and procedures;
2. Facilitate the compliant exchange of patient information for eligible individuals and organizations via the MHNConnect platform;
3. Identify MHN ACO, MoreCare, or other appropriate patients who are candidates for services and support provided by the Flexible Housing Pool Collaborative;
4. Communicate to CHH regarding overall care and health care service utilization for MHN ACO, MoreCare or other patients managed by MHN who are receiving support and services from the Flexible Housing Pool Collaborative in a manner and with a frequency to be mutually agreed in the Definitive Agreement;
5. Provide care management and care coordination for patients in populations managed by MHN who are receiving services and support from the Flexible Housing Pool Collaborative; and
6. Participate in Flexible Housing Pool Collaborative meetings on a mutually agreed upon schedule.

D. General Agreements

The parties agree to exchange relevant information about patients who are being considered for, or who participate in, the Flexible Housing Pool Collaborative initiatives, providing that the party releasing the information has obtained appropriate consent from the patient. The parties agree to maintain the appropriate degree of confidentiality concerning patient information and agree to comply with all federal, state, and local laws regarding confidentiality

of patient information including, but not limited to, the Health Insurance Portability and Accountability Act. Referrals of patients to the Flexible Housing Pool Collaborative will be considered by each party without regard to the patient's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

During the term of this MOU, the parties are each free to enter into other memoranda of understanding and/or contractual arrangements with other parties with regard to matters other than those related to their services to each other for the Flexible Housing Pool Collaborative.

Each party is an independent entity and is not an agent, servant, or employee of the other party. Neither party is granted any right to create any obligation or responsibility or make representations, express or implied, on behalf of or in the name of the other party or to bind the other party in any manner whatsoever. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. Unless otherwise terminated pursuant to Section B hereto, this MOU may be terminated at any time by either party upon written notice. This MOU may be amended as necessary by a writing duly executed by the parties.

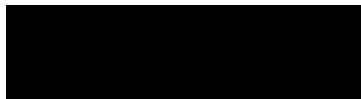
This MOU summarizes the non-binding principles and framework for negotiation of terms and conditions of a proposed services agreement. This MOU is not intended to constitute a complete framework of such terms and conditions nor a legally binding agreement between the parties. The specific terms and conditions governing the proposed services agreement are subject to additional refinement as well as approval by the parties' respective Board of Directors.



12AE32526DCF09D0D3FF24F6E9E7DC05 contractworks.

Cheryl Lulias
Date 11/17/2021

President & CEO
MHNU Corporation d/b/a
Medical Home Network



BDB27B7EC594A204885FD9E0F2BF6091 contractworks.

Peter Toepfer
Date 11/18/2021

Executive Director
Center for Housing and Health

**Memorandum of Understanding
between
Center for Housing and Health
and
Christian Community Health Center**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and Christian Community Health Center for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of Christian Community Health is to provide high-quality primary healthcare and related services to the community regardless of the ability to pay; to provide services in a manner which demonstrates, in word and deed, the love of Jesus Christ.

A. Term of Agreement

Based upon shared goals, CHH and Christian Community Health Center have agreed to enter into a collaboration in which CHH shall be the lead agent and Christian Community Health a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with Christian Community Health Center.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

Christian Community Health agrees to provide the following services:

1. Provide primary care to patients to approximately 125 (estimate) patients over the five-year grant period;
2. Provide psychiatric care to Flexible Housing Pool patients.
3. Share health outcomes for patients enrolled in the Flexible Housing Pool;
4. Coordinate with the Center for Housing and Health, CST teams, tenancy support organizations and hospitals to ensure continuity of care for patients through semi-monthly Systems Integration Team meetings and informal communication between staff across the collaborative;
5. Provide housing tenancy case management services to at least 45 households.
6. Case managers will provide at least two face-to-face home visits and three collateral case management contacts per month to all new heads of household enrolled in the program for their first six months after housing;
7. Case managers will assist all eligible heads of household with applying for public benefits, including food stamps, within 30 days of housing;
8. Participate in on-going Flexible Housing Pool Collaborative-wide meetings.

C. General Agreements

Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.

[Redacted Signature]
Kenneth Burnett
Chief Executive Officer
Christian Community Health Center

Date

6/2021

[Redacted Signature]
Peter Toepler
Executive Director
Center for Housing and Health

Date

**Memorandum of Understanding
between
Center for Housing and Health
and
Corporation for Supportive Housing**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and the Corporation for Supportive Housing for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of the Corporation for Supportive Housing is to advance solutions that use housing as a platform for services to improve the lives of the most vulnerable people, maximize public resources and build healthy communities.

A. Term of Agreement

Based upon shared goals, CHH and the Corporation for Supportive Housing have agreed to enter into a collaboration in which CHH shall be the lead agent and the Corporation for Supportive Housing a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with the Corporation for Supportive Housing.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

The Corporation for Supportive Housing agrees to provide the following services:

- 1. Provide training and technical assistance to Flexible Housing Pool Collaborative partners;
- 2. Convene and facilitate Flexible Housing Pool Collaborative meetings and workgroups;
- 3. Provide staffing to the Flexible Housing Pool Governance Board.

C. General Agreements

Each party agrees to become familiar with each other’s programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client’s race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.

	11/16/2021 12:42 PM PST	
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Angela Brooks
Director
Corporation for Supportive Housing

Date

Peter Toepfer
Executive Director
Center for Housing and Health

Date

**Memorandum of Understanding
between
Center for Housing and Health
and
Deborah's Place**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and Deborah's Place for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called "The Flexible Housing Pool Collaborative."

CHH's mission is to honor every person's right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of Deborah's Place is to open doors of opportunity for women who are homeless in Chicago through supportive housing and services as a key to healing, achieving goals, and moving on from the experience of homelessness.

A. Term of Agreement

Based upon shared goals, CHH and Deborah's Place have agreed to enter into a collaboration in which CHH shall be the lead agent and Deborah's Place a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with Deborah's Place.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

Deborah's Place agrees to provide the following services:

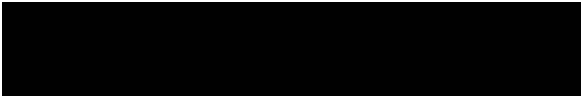
1. Case management services will be provided for at least 30 female-identified unduplicated Flexible Housing Pool participants;
2. Case managers will provide at least two face-to-face home visits and three collateral case management contacts per month to all new heads of household enrolled in the program for their first six months after housing;
3. Case managers will assist all eligible heads of household with applying for public benefits, including food stamps, within 30 days of housing;
4. Participate in on-going Flexible Housing Pool Collaborative meetings.

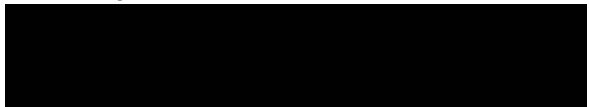
C. General Agreements

Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.


Katharine Booton Wilson 11-18-21
Chief Strategy Officer
Deborah's Place


Peter Toepfer Date
Executive Director
Center for Housing and Health

**Memorandum of Understanding
between
Center for Housing and Health
and
Cook County Health**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and Cook County Health for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of Cook County Health is to deliver integrated health services with dignity and respect regardless of a patient’s ability to pay; create partnerships with health providers and communities to enhance the health of the public; and advocate for policies that promote the physical, mental and social well-being of the people of Cook County.

A. Term of Agreement

Based upon shared goals, CHH and Cook County Health have agreed to enter into a collaboration in which CHH shall be the lead agent and Cook County Health a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with Cook County Health.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

Cook County Health agrees to provide the following services:

1. Identify patients experiencing homelessness;
2. Refer patients to the Flexible Housing Pool Collaborative;
3. Communicate regularly regarding patient follow-up and access to health care services;
4. Participate in on-going Flexible Housing Pool Collaborative meetings.

C. General Agreements

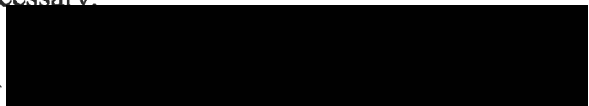
Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.


Israel Rocha
CEO
Cook County Health

Date


Peter Toepfer
Executive Director
Center for Housing and Health

Date

**Memorandum of Understanding
between
Center for Housing and Health
and
CountyCare Health Plan**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and CountyCare Health Plan for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of CountyCare as a public, provider-led health plan that is part of Cook County Health, is to improve our members’ lives by partnering with communities, supporting a vibrant safety-net, advancing health equity, and empowering providers to deliver integrated, member-centered health care.

A. Term of Agreement

Based upon shared goals, CHH and CountyCare Health Plan have agreed to enter into a collaboration in which CHH shall be the lead agent and CountyCare Health Plan a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with CountyCare Health Plan.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

CountyCare Health Plan agrees to provide the following services:

1. Communicate regarding overall care and utilization for the Flexible Housing Pool Participants insured by the Managed Care Organization;
2. Provide care coordination for Flexible Housing Pool participants enrolled in CountyCare;
3. Participate in on-going Flexible Housing Pool Collaborative meetings.

C. General Agreements

Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

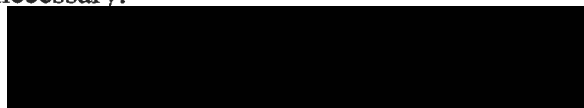
The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.



Israel Rocha, Jr
CEO
Cook County Health

Date



Peter Toepfer
Executive Director
Center for Housing and Health

Date

**Memorandum of Understanding
between
Center for Housing and Health
and
Heartland Alliance Health**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and Heartland Alliance Health for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of Heartland Alliance Health is to advance human rights and champion human dignity by providing services and promoting solutions to achieve a more just global society.

A. Term of Agreement

Based upon shared goals, CHH and Heartland Alliance Health have agreed to enter into a collaboration in which CHH shall be the lead agent and Heartland Alliance Health a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with Heartland Alliance Health.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

Heartland Alliance Health agrees to provide the following services:

1. Provide primary care to approximately 125 (estimate) patients over the five-year grant period;
2. Provide psychiatric care to Flexible Housing Pool patients enrolled with the Renaissance Social Services' Community Support (CST) Team;
3. Share health outcomes for patients enrolled in the Flexible Housing Pool;
4. Coordinate with the Center for Housing and Health, CST teams, tenancy support organizations and hospitals to ensure continuity of care for patients through semi-monthly Systems Integration Team meetings and informal communication between staff across the collaborative;
5. Participate in on-going Flexible Housing Pool Collaborative-wide meetings.

C. General Agreements

Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.


Ed Stellan
Executive Directors
Heartland Alliance Health

Date


Peter Toepfer
Executive Director
Center for Housing and Health

Date

**Memorandum of Understanding
between
Center for Housing and Health
and
Housing Forward**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and Housing Forward for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of Housing Forward is to transition people from housing crisis to housing stability.

A. Term of Agreement

Based upon shared goals, CHH and Housing Forward have agreed to enter into a collaboration in which CHH shall be the lead agent and Housing Forward a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with Housing Forward.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

Housing Forward agrees to provide the following services:

1. Case management services will be provided for at least 15 unduplicated homeless households enrolled in the Flexible Housing Pool;
2. Case managers will provide at least two face-to-face home visits and three collateral case management contacts per month to all new heads of household enrolled in the program for their first six months after housing;
3. Case managers will assist all eligible heads of household with applying for public benefits, including food stamps, within 30 days of housing;
4. Participate in on-going Flexible Housing Pool Collaborative meetings.

C. General Agreements

Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.

Lynda Schueler
Executive Director
Housing Forward

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Peter Toepfer Date
Executive Director
Center for Housing and Health

**Memorandum of Understanding
between
Center for Housing and Health
and
Illinois Public Health Institute**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and the Illinois Public Health Institute for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of the Illinois Public Health Institute is to mobilize stakeholders, catalyze partnerships and lead action to improve public health systems to maximize health, health equity and quality of life for people and communities.

A. Term of Agreement

Based upon shared goals, CHH and the Illinois Public Health Institute have agreed to enter into a collaboration in which CHH shall be the lead agent and the Illinois Public Health Institute a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with the Illinois Public Health Institute.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

The Illinois Public Health Institute agrees to provide the following services:

1. Provide training and technical assistance to Flexible Housing Pool Collaborative partners;
2. Participate in on-going Flexible Housing Pool Collaborative meetings.

C. General Agreements

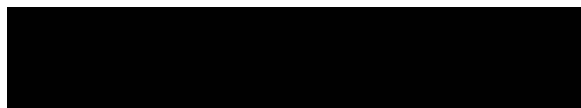
Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.



Elissa Bassler November 17, 2021
CEO
Illinois Public Health Institute



Peter Toepfer Date
Executive Director
Center for Housing and Health

**Memorandum of Understanding
between
Center for Housing and Health
and
La Casa Norte**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and La Casa Norte for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of La Casa Norte is to serve youth and families confronting homelessness by providing access to stable housing and deliver comprehensive services that act as a catalyst to transform lives and communities.

A. Term of Agreement

Based upon shared goals, CHH and La Casa Norte have agreed to enter into a collaboration in which CHH shall be the lead agent and La Casa Norte a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with La Casa Norte.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

La Casa Norte agrees to provide the following services:

1. Case management services will be provided for at least 15 unduplicated homeless youth households ages 18-24 enrolled in the Flexible Housing Pool;
2. Case managers will provide at least two face-to-face home visits and three collateral case management contacts per month to all new heads of household enrolled in the program for their first six months after housing;
3. Case managers will assist all eligible heads of household with applying for public benefits, including food stamps, within 30 days of housing;
4. Participate in on-going Flexible Housing Pool Collaborative meetings.

C. General Agreements

Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.



Jose Munoz Date 11/17/2021
Executive Director
La Casa Norte



Peter Toepfer Date
Executive Director
Center for Housing and Health

**Memorandum of Understanding
between
Center for Housing and Health
and
Renaissance Social Services**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and Renaissance Social Services for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of Renaissance Social Services is to change the lives of individuals and families in Chicago by supporting communities and the people who live within them with quality affordable housing, behavioral healthcare, outreach, homeless prevention, compassionate support services and a purposeful focus on racial equity, we provide the opportunity for stability and wellness.

A. Term of Agreement

Based upon shared goals, CHH and Renaissance Social Services have agreed to enter into a collaboration in which CHH shall be the lead agent and Renaissance Social Services a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with Renaissance Social Services.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

Renaissance Social Services agrees to provide the following services:

1. Provide Community Support Team (CST) services to 150 participants in the Flexible Housing Pool referred for behavioral health services
2. Conduct outreach services to 100% of potential participants assigned by the Center for Housing and Health;
3. Participate in on-going Flexible Housing Pool Collaborative meetings.

C. General Agreements

Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

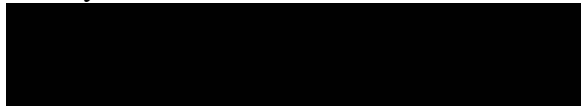
The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.



Michael Banghart
Executive Director
Renaissance Social Services

Date



Peter Toepfer
Executive Director
Center for Housing and Health

Date

**Memorandum of Understanding
between
Center for Housing and Health
and
Sinai Health System**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and Sinai Health System for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of Sinai Health System is to improve the health of the individuals and communities they serve.

A. Term of Agreement

Based upon shared goals, CHH and Sinai Health System have agreed to enter into a collaboration in which CHH shall be the lead agent and Sinai Health System a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with Sinai Health System.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

Sinai Health System agrees to provide the following services:

1. Identify patients experiencing homelessness;
2. Refer patients to the Flexible Housing Pool Collaborative;
3. Provide healthcare navigation to Flexible Housing Pool participants through community health workers;
4. Provide workforce development opportunities for Flexible Housing Pool participants to prepare for employment within the healthcare field;
5. Provide training sessions to the Flexible Housing Pool Collaborative agencies on the role and curriculum standards for Community Health Workers;
6. Communicate regularly regarding patient follow-up and access to health care services;
7. Participate in on-going Flexible Housing Pool Collaborative meetings.

C. General Agreements

Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

Each party shall maintain, throughout the term of this MOU, professional liability insurance on behalf of itself and its employees with limits of not less than \$1 million per occurrence and \$3 million in the annual aggregate. Each Party shall provide workers' compensation coverage for its respective employees in accordance with state law.

The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each Party

Notices:

All notices required or permitted under this Agreement shall be sent by U.S. mail or commercial courier delivery to the receiving party at its address as specified below, or at such other address as the party may designate to the other in writing from time to time. Any such notice mailed via U.S. mail shall be effective three (3) days after it has been sent by certified mail, return receipt requested, postage prepaid. Notices may be delivered electronically only with written acknowledgment of receipt by the other Party, effective upon such acknowledgement of receipt.

For Sinai Health System:

Sinai Health System
Attention: General Counsel

1500 S. Fairfield Avenue
Chicago Illinois 60608

For CHH:

Center for Housing and Health
Attention: Peter Toepfer
200 West Monroe St., Suite 1150
Chicago, IL 60606

Each Party shall comply with all relevant applicable Ordinances, Federal and State statutes, rules and regulations (collectively, "Laws").

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.



Karen Teitelbaum
President & CEO
Sinai Health System

Date

Chicago,
org, c=US
0:36 -0600



Peter Toepfer
Executive Director
Center for Housing and Health

Date

**Memorandum of Understanding
between
Center for Housing and Health
and
South Shore Hospital**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and South Shore Hospital for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of South Shore Hospital is to provide the safest, highest quality healthcare experience possible to patients and their families.

A. Term of Agreement

Based upon shared goals, CHH and South Shore Hospital have agreed to enter into a collaboration in which CHH shall be the lead agent and South Shore Hospital a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with South Shore Hospital.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative (the Flexible Housing Pool program), the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with a housing placement services, a rental subsidy and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.
4. Communicate regarding participant housing stability and health outcomes.

South Shore Hospital agrees to provide the following services:

1. Identify patients experiencing homelessness;
2. Refer patients to the Flexible Housing Pool Collaborative;
3. Communicate regularly regarding patient follow-up and access to health care services;
4. Participate in on-going Flexible Housing Pool Collaborative meetings.

C. General Agreements

Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.


Leslie Rogers
Assistant Administrator
South Shore Hospital

Date


Peter Toepfer
Executive Director
Center for Housing and Health

Date

**Memorandum of Understanding
between
Center for Housing and Health
and
The Night Ministry**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and The Night Ministry for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of The Night Ministry is to provide housing, health care, outreach, spiritual care, and social services to adults and youth who struggle with homelessness, poverty, and loneliness.

A. Term of Agreement

Based upon shared goals, CHH and The Night Ministry have agreed to enter into a collaboration in which CHH shall be the lead agent and The Night Ministry a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with The Night Ministry.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

The Night Ministry agrees to provide the following services:

1. Case management services will be provided for at least 15 unduplicated homeless youth households ages 18-24 enrolled in the Flexible Housing Pool;
2. Case managers will provide at least two face-to-face home visits and three collateral case management contacts per month to all new heads of household enrolled in the program for their first six months after housing;
3. Case managers will assist all eligible heads of household with applying for public benefits, including food stamps, within 30 days of housing;
4. Participate in on-going Flexible Housing Pool Collaborative meetings.

C. General Agreements

Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

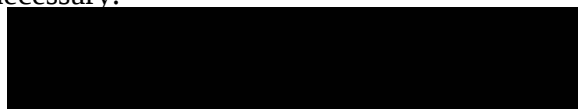
The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.



Erin Ryan
Senior Vice President
The Night Ministry

Date



Peter Toepfer
Executive Director
Center for Housing and Health

Date

**Memorandum of Understanding
between
Center for Housing and Health
and
University of Illinois Hospital & Health Sciences System**

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and the University of Illinois Hospital & Health Sciences System (hereafter called “UI Health”) for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of UI Health to advance healthcare to improve the health of our patients and communities, promote health equity and develop the next generations of healthcare leaders.

A. Term of Agreement

Based upon shared goals, CHH and UI Health have agreed to enter into a collaboration in which CHH shall be the lead agent and UI Health a partner for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal collaborative agreement with UI Health.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

UI Health agrees to provide the following services:

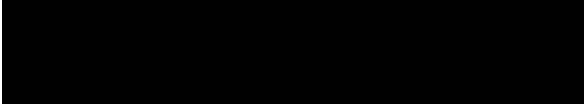
1. Identify patients experiencing homelessness;
2. Refer patients to the Flexible Housing Pool Collaborative;
3. Communicate regularly regarding patient follow-up and access to health care services;
4. Participate in on-going Flexible Housing Pool Collaborative meetings.

C. General Agreements

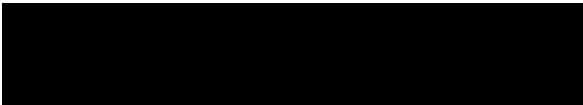
Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.



Dr. Robert Barish Date
Vice Chancellor for Health Affairs
UI Health



Peter Toepfer Date
Executive Director
Center for Housing and Health

Memorandum of Understanding
between
Center for Housing and Health
and
Unity Parenting and Counseling, Inc.

The purpose of this Memorandum of Understanding (MOU) is to formalize the relationship between the Center for Housing and Health (CHH) and Unity Parenting and Counseling, Inc. for the purpose of the State of Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative application hereafter called “The Flexible Housing Pool Collaborative.”

CHH’s mission is to honor every person’s right to a home and health care, by bridging the housing and health care systems, to improve the lives of Chicagoans experiencing homelessness. The mission of Unity Parenting and Counseling, Inc. is to make life better, meaningful and rewarding for young people and families from disadvantaged backgrounds.

A. Term of Agreement

Based upon shared goals, CHH and Unity Parenting and Counseling, Inc. have agreed to enter into a collaboration in which CHH shall be the lead agent and Unity Parenting and Counseling, Inc. a subcontractor for the purposes of the Healthcare Transformation Collaborative. If awarded, the Flexible Housing Pool Collaborative will operate for five years.

This agreement is effective upon signature of both parties and shall terminate if CHH is denied funding under the Healthcare Transformation Collaborative. Should CHH be awarded grant funding under the Healthcare Transformation Collaborative, it shall execute a formal subcontract with Unity Parenting and Counseling, Inc.

B. Scopes of Services

Building on the existing integrated healthcare and permanent supportive housing collaborative, the Flexible Housing Pool Collaborative will increase behavioral health services within clinical and community settings to improve health outcomes for people experiencing homelessness. This collaborative will serve 250 households.

CHH agrees to provide the following services:

1. Provide overall project leadership and coordination;
2. Coordinate referrals of participants to the Flexible Housing Pool program;
3. Provide participants with housing placement services and a rental subsidy, and connect participants to supportive services such as tenancy support, behavioral health services, employment and education services, income, etc.;
4. Communicate regarding participant housing stability and health outcomes.

Unity Parenting and Counseling, Inc. agrees to provide the following services:

1. Case management services will be provided for at least 15 unduplicated homeless youth households ages 18-24 enrolled in the Flexible Housing Pool;
2. Case managers will provide at least two face-to-face home visits and three collateral case management contacts per month to all new heads of household enrolled in the program for their first six months after housing;
3. Case managers will assist all eligible heads of household with applying for public benefits, including food stamps, within 30 days of housing;
4. Participate in on-going Flexible Housing Pool Collaborative meetings.

C. General Agreements

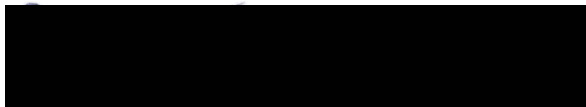
Each party agrees to become familiar with each other's programs, goals, objectives, and procedures. Referrals to the project will be considered by each facility without regard to the client's race, creed, gender identity/expression, sexual orientation, marital status, education, social background, political affiliations, or nation or origin.

The parties to this agreement agree to exchange information about mutual clients, providing that the party releasing the information has obtained consent from the client. The parties agree to maintain the appropriate degree of confidentiality concerning client information and agree to comply with all federal, state, and local laws regarding confidentiality of patient information including, but not limited to, the *Health Insurance Portability and Accountability Act* (HIPAA).

Each party is an independent agency and is not an agent, servant, or employee of the other party. Neither party assumes any liability for the actions or inactions of the other. This MOU is not exclusive. This agreement may be terminated at any time by either party upon written notice and may be updated and revised as necessary.


Flora Koppel
President/CEO
Unity Parenting and Counseling, Inc.

Date


Peter Toepfer
Executive Director
Center for Housing and Health

Date

November 17, 2021

Peter Toepfer, Executive Director
Center for Housing and Health
200 W. Monroe Street, Suite 1150
Chicago, Illinois 60606

RE: Support for the Flexible Housing Pool Collaborative

Dear Mr. Toepfer:

On behalf of AMITA Health Saints Mary and Elizabeth Medical Center, it is my pleasure to submit this letter of support on behalf of the Center for Housing and Health's application to Illinois Department of Healthcare and Family Services for their Healthcare Transformation Collaborative proposal.

For more than 130 years, AMITA Health Saints Mary and Elizabeth has provided compassionate, award-winning care to the city's West Town communities. We are one of the City of Chicago's and the State's largest safety net hospital. Our medical campus consists of a 495-bed medical center which provides comprehensive services including primary care, cancer care, behavioral health, neurology and neurosurgery, orthopedics and rehab, cardiovascular services, imaging, midwifery and obstetrics, emergency services, surgery and more. Magnet-recognized by the American Nursing Credentialing Center, we rank in the top seven percent of all U.S. hospitals for nursing excellence. We are Leapfrog Group grade 'A' for 8 ½ years straight.

In our work, we often encounter and re-encounter patients experiencing homelessness who have multiple chronic conditions that are difficult to manage and improve without a stable home. As such, we support the Center for Housing and Health's mission to honor every person's right to a home and health care by bridging the two systems to improve the lives of Chicagoans experiencing homelessness.

Based upon our shared goals to best serve the Chicago community, AMITA Health Saints Mary and Elizabeth Medical Center supports the Center for Housing and Health's proposal to form the Flexible Housing Pool Healthcare Transformation Collaborative. We believe that this Collaborative will serve to connect Chicago's housing and healthcare system and improve health outcomes for those experiencing homelessness. We support the ever-increasing need for both inpatient and outpatient behavioral health services for patients experiencing homelessness. We will assist with identifying patients experiencing homelessness, and support care coordination for any patients we refer to the Flexible Housing Pool program.

AMITA Health
Saints Mary and Elizabeth
Medical Center Chicago
2233 W. Division St. &
1431 N. Claremont Ave.
Chicago, IL 60657

312.770.2000

[AMITAhealth.org](https://www.AMITAhealth.org)

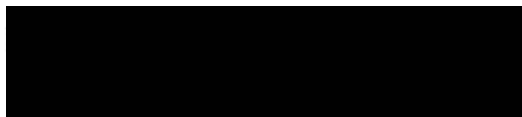


SAINTS MARY AND ELIZABETH MEDICAL CENTER
CHICAGO

Considering the Center for Housing and Health's on-going success housing participants through the Flexible Housing Pool program and forming new partnerships to support the program within the healthcare field, we believe the impact of this patient and systems-level program will continue to grow.

We strongly support the Center for Housing and Health's application for continued growth of the Flexible Housing Pool through the proposed Flexible Housing Pool Collaborative. If you have any questions, please do not hesitate to contact me.

Sincerely,



Robert Dahl
President & CEO
AMITA Health Saints Mary and Elizabeth Medical Center

AMITA Health
Saints Mary and Elizabeth
Medical Center Chicago
2233 W. Division St. &
1431 N. Claremont Ave.
Chicago, IL 60657

312.770.2000

AMITAhealth.org

Social Work and Community Health

Johnston R. Bowman Health Center
710 S. Paulina St.
Suite 438
Chicago, IL 60612

Tel: 800.757.0202
Fax: 312.942.6116
www.rush.edu/swch

Department of Social Work

College of Health Sciences, Rush University
710 S. Paulina St.
Suite 438
Chicago, IL 60612



Rush University Medical Center

November 17, 2021

Peter Toepfer
Center for Housing and Health
200 West Monroe St., Suite 1150
Chicago, IL 60606

To Whom It May Concern,

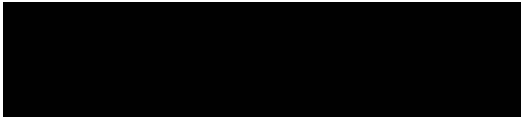
We are pleased to write a letter of support for the Center for Housing and Health's (CHH) proposal to Healthcare and Family Services (HFS), for The Flexible Housing Pool Collaborative, to directly improve the health and housing stability of people experiencing homelessness on the south and west sides of Chicago.

Rush is an academic medical center with a bold mission to transform healthcare by improving the health of the individuals and diverse communities we serves through the integration of outstanding patient care, education, research, and community partnerships. Furthermore, Rush has maintained a history of commitment to the community. Our health equity strategy builds on a community engagement and collaboration model that recognizes structural and social determinants of health and identifies opportunities to partner with other organizations whose goals of dismantling injustices that contribute to poor health outcomes and promoting health equity align.

As a demonstration of our health equity framework, Rush has established the Center for Health and Homelessness, which serves as the administrative and organizational support to the Chicago Homelessness and Health Response Group for Equity (CHHRGE) coalition, in which CHH is a partner. As part of this coalition, Rush and CHH work collectively to identify and address the barriers that negatively affect the access to services, and the overall health and well-being of people experiencing homelessness. CHH and Rush will continue to expand our collaboration by focusing on the physical and mental health and social care needs across different sectors through CHHRGE. CHHRGE is utilizing its collective resources and expertise, to both develop a mental health safety net and enhance social action supports through its advocacy committee.

We are eager to join and support the Center for Housing and Health, in their efforts to further integrate these systems – with the aim of significantly demonstrating the impact of The Flexible Housing Pool Collaborative and its resources, for people experiencing homelessness. We believe this Healthcare Transformation Plan, will have lasting implications related to optimizing best practices, reliable supports and services for people experiencing homelessness.

Sincerely,



Robyn Golden
Associate Vice President of Social Work and Community Health



November 18, 2021

Peter Toepfer, Executive Director
Center for Housing and Health
200 W. Monroe Street, Suite 1150
Chicago, Illinois 60606

Dear Mr. Toepfer:

On behalf of Thresholds, it is my pleasure to submit this letter of support on behalf of the Center for Housing and Health's application to Illinois Department of Healthcare and Family Services for their Healthcare Transformation Collaborative proposal.

Founded in 1959, Thresholds has been providing community mental health and supportive housing services for over 60 years. Most individuals that we serve have been diagnosed with a serious mental illness. Diagnoses include schizophrenia, bipolar disorder, major depression, and severe post-traumatic stress disorder. This also includes individuals who are experiencing substance use conditions – either coexisting with their mental illness or on its own. At the time of initial service, 90% of our clients are unemployed and living well below the National Poverty Level, and approximately half have co-occurring substance use conditions, and most have at least one advanced physical health problems such as diabetes and heart disease.

In our work, we often encounter and re-encounter patients experiencing homelessness who have multiple chronic conditions that are difficult to manage and improve without a stable home. As such, we support the Center for Housing and Health's mission to honor every person's right to a home and health care by bridging the two systems to improve the lives of Chicagoans experiencing homelessness.

Based upon our shared goals to best serve the Chicago community, Thresholds supports the Center for Housing and Health's proposal to form the Flexible Housing Pool Healthcare Transformation Collaborative. We believe that this Collaborative will serve as a way to connect Chicago's housing and healthcare system and improve health outcomes for those experiencing homelessness. We support increasing behavioral health services for patients experiencing homelessness, will assist with identifying patients experiencing homelessness, and support care coordination for any patients we refer to the Flexible Housing Pool program.

Considering the Center for Housing and Health's on-going success housing participants through the Flexible Housing Pool program and forming new partnerships to support the program within the healthcare field, we believe the impact of this patient and systems-level program will continue to grow. We strongly support the Center for Housing and Health's application for continued growth of the Flexible Housing Pool through the proposed Flexible Housing Pool Collaborative. If you have any questions, please do not hesitate to contact me.

Sincerely,

A black rectangular box redacting the signature of Nadia Underhill.

Nadia Underhill
Vice-President, Housing and Real Estate