Connecting Fractured Lives to a Fragmented System: Process Evaluation Report Chicago Housing for Health Partnership

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A Process Evaluation of the Chicago Housing for Health Partnership

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ABSTRACT

This is a report of the findings from a process evaluation of the Chicago Housing for Health Partnership. The Chicago Housing for Health Partnership (CHHP), a Housing First and Harm Reduction model, creates a new comprehensive system of health care, housing and supportive services with a partnership of 3 hospitals, 1 temporary health care facility and 10 temporary and permanent housing agencies.

In this study, the researchers conducted a process evaluation of the housing program using a multi-method approach, which involved qualitative interviews, focus groups, document analysis, and observations. The multiple research methods allowed us to examine the CHHP system at three different levels (the administrative level, the service provision level, and the client level).

CHHP was established in 2002 by a diverse group of health care, respite or interim housing and permanent housing providers and serves chronically medically ill homeless adults who have been recently hospitalized. We base our conclusions upon a year long study of the CHHP system and its participants and stakeholders including agency heads, program directors, case managers, consumers, and CHHP/lead agency staff.

One of the key findings in this report is the importance of the duality of the CHHP structure. We found that key strengths of this project were its strong coordination and leadership from the lead agency and its success in harnessing the expertise and skills of the diverse partner agencies. This created a flexible system of allocating resources, solving problems, and serving clients.

This report begins with a brief overview of the CHHP model and our research methodology. Then we will describe findings in seven key areas, followed by our analysis of the strengths and challenges of the CHHP model and our recommendations.

INTRODUCTION

This report contains the detailed findings of the process evaluation of the Chicago Housing for Health Partnership (CHHP) service delivery system. CHHP was established, in 2002, by a diverse group of health care, respite, and housing providers. Its stated primary goals have been to better serve the needs of homeless individuals with chronic medical conditions through the building of an innovative model of service integration between these three groups of service providers and rigorous testing of the model with the ultimate goal of informing national homeless policy. The CHHP program serves chronically medically ill homeless adults who have been hospitalized in one of three (originally four) partner hospitals in Chicago. To be eligible, the consumer must have had no stable housing for the month prior to hospitalization and have at least one chronic medical condition that normally increased the morbidity and mortality among homeless individuals or the general population. Eligible consumers were randomly assigned to either the "intervention" group, who received the CHHP program services, or a control group, who received standard care. The partnership designed and initiated a three year demonstration with this experimental design to test the model and its outcomes.

This process evaluation is intended to both inform the strategic planning of CHHP partners as they move from a demonstration project to an institutional system in Chicago, and to inform advocates and policy makers of the key strengths and challenges encountered in implementing this model. We base our conclusions upon a yearlong study of the CHHP system and its participants and stakeholders including agency heads, program directors, case managers, consumers, and CHHP/lead agency staff.

Among the findings, the key hallmarks of this project were that of an innovative system model and a strong fidelity to a housing first model. We have found that both these approaches have been successful from the perspective of the clients, the street level service providers, and the participating agencies. However, there are some unique challenges, which will be explored in this report, due to the collaboration of diverse agencies and maintenance of fidelity to the model.

A convergence of factors: the development of CHHP

Three factors converged into the formation of the CHHP project: the experiences of service providers at Interfaith House, which serves chronically ill homeless men and women; ground breaking research in New York on the cost savings and benefits of permanent supportive housing for the homeless; and the development of Chicago's Ten Year Plan to End Homelessness.

Interfaith House provides shelter and care giving for homeless individuals while they recover from medical illness and injuries. Interfaith House staff saw that clients who couldn't be permanently housed did not do well, relapsed, were hospitalized, and often returned to Interfaith. On the other hand, they also observed that those who were placed in permanent housing were often able to maintain their health and were rarely likely to "recycle" through the system.

These observations mirrored the findings of the ground breaking research of the "New York, New York" study by Dennis Culhane et al., which looked at homeless individuals with severe mental illnesses, and which found that clients who were placed in supportive permanent housing had better outcomes and dramatically reduced use of emergency health and other costly public services (2000).

At the same time, homeless service providers, public officials and funders were reassessing the strategies and structures of the homeless system that developed in the past twenty-five years in the United States. In Chicago, this reassessment led to non-profit and public sectors developing the "Chicago 10 year Plan to End Homelessness" in 2000. This plan intends to shift the focus of the homeless system from primarily providing emergency and transitional services for the homeless, to one whose main focus is the Housing First strategy that provides immediate permanent housing and supportive services for individuals who are homeless.

In January, 2002 Arturo Valdivia Bendixen, the Executive Director of Interfaith House, convened the first meeting of the Chicago Housing for Health Partnership (CHHP). The founding group included nine homeless housing providers, three hospitals, the Michael Reese Foundation and the AIDS Foundation of Chicago. They initiated a model of homeless service integration new to Chicago, if not the nation. CHHP is a unique blending of homeless housing, supportive services, and health services into a unified system. Also, it is the first research study in the nation to evaluate whether providing stable housing and intensive case management services to chronically medically ill homeless individuals will improve their health and their utilization of health services.

METHODOLOGY

It is important to note that one of the major strengths of the CHHP program is that it contained (by design) two separate evaluation components. In addition to the organizational or process evaluation contained in this report, the evaluation of the medical outcomes of the CHHP program participants is currently being conducted by the Collaborative Research Unit (CRU) of the Cook County Bureau of Health. CRU researchers are tracking intervention group clients

(those that received CHHP services) as well as control group members (those who received regular care) to assess the impact of CHHP services on clients.

Research Questions

Our evaluation focuses on the process of CHHP, with a special interest in the duplication of the CHHP system in other locations. Our research was guided by the following overarching questions:

1. How does the CHHP program work as a system?
2. What are the strengths and challenges as it is designed?
3. What are the outside influences that affect the system?
4. Could this be a model for other homeless programs or inter-agency collaborations?

These questions were developed in conjunction with CHHP staff located at the AIDS Foundation of Chicago, CHHP's lead agency.

Research Methods

In this study, we employed a multi-method approach, which involved qualitative interviews, focus groups, document analysis, and observations. Specifically, we conducted three focus groups with a total of 29 clients[1] and one focus group with the CHHP case managers. We interviewed 13 executive directors and 17 program supervisors of CHHP partner agencies, as well as the current CHHP director, current CHHP coordinator, the former CHHP coordinator, and a representative from one funding agency. We also attended and observed two months of weekly Systems Integration Team (SIT) meetings.

[1] This was approximately half of the clients who were engaged in the CHHP at the time. Clients self-selected to be in the groups, and although no one was turned away, obviously this selection limited our findings since individuals who were difficult to engage, or had dropped out of the program are not represented. The CRU research component has been individually tracking and meeting with clients and has been successful in keeping clients engaged in the research even if they were not currently engaged in CHHP. This research may become an additional source of information on clients' perspectives on program implementation and process when it is completed.

This research documents and analyzes the system in a way that is objective and external in perspective. As we were able to highlight, CHHP is best conceptually analyzed and experienced by individuals at three different levels: street level (clients and case managers), agency level (case managers and partner agencies), and lead agency level (agencies and key lead agency staff). Our research methods allowed us to visualize the CHHP system at these levels and to understand how CHHP works as a flexible learning system. It was important to capture data at all three levels of the CHHP process including the administrative level, the service provision level, and the client level. The triangulation of methods increased the validity of our findings as well as gave us richer data for analysis.

CHHP MODEL

Diversity of Clients and Complexity of Service System

Two contextual factors that framed the CHHP model are important to understanding its design and challenges: the tremendous diversity of the chronically ill homeless individuals and the fragmentation of the system of social service agencies, medical providers, and housing programs.

Tremendous diversity among clients

At the heart of what makes the CHHP model both challenging and necessary is the tremendous diversity among the chronically ill homeless.

Specifically, the 216 CHHP clients are diverse in a number of different ways:

- *Medically:* Because of eligibility requirements, all clients in the CHHP program have a chronic illness, with several clients having more than one medical diagnosis concurrently—as many as thirteen according to CHHP database information. The diagnoses include HIV/AIDS (35%); hypertension (34%),

congestive heart failure (16%), asthma (15%), diabetes (10%), cancer (5%) and seizure disorders (4%).

- *Racially/Ethnically:* The majority of the clients in the intervention group are African American/Black (79%) with 7% Hispanic/Latino, 7% White, and 7% of "Other" races or ethnicities.
- *Gender:* Approximately three-quarters (74%) of the CHHP clients are male, one-quarter (25%) are female, and there is 1 (1%) trans-gendered participant.[2]
- *Age*: The ages range from 21 to 82, with the majority of clients (62%) falling into the 41-60 category. The median age is 47 years.
- *Personal circumstances:*
    - Approximately 70% of the participants are considered to be experiencing, "long-term homelessness" (HUD), while 30% are classified as short-term homeless.[3]
    - The overwhelming majority of clients had a history of substance abuse, with 70% being formally assessed with long-term history, but 86% being estimated, by staff, as having a long-term substance abuse history.
    - Similarly, about one-third of clients (31%) were formally assessed as having mental illness, but staff estimated closer to 45% of clients had long-term mental illness.

[2] The gender imbalance in this study can be partly accounted for by the CHHP requirement that participants not be the custodial parent or guardian of minor children.

[3] HUD, HHS and VA define a chronically homeless person as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years. Federal Register, Vol. 68, No. 80, Friday, April 25, 2003, Notices, 21598.

Service System Complexity

In addition to the complicated and diverse needs of the target population, the housing provider industry in Chicago is relatively fractured. For example, an on-going project of the Chicago Alliance to End Homelessness (formerly the Partnership to End Homelessness) has identified over 300 homelessness-oriented programs provided by 95 non-profit private and public agencies ranging in size and organizational complexity throughout Chicago. In addition, social service agencies and hospitals are relatively isolated from one another, acting as distinct and separate systems, with different goals and professional cultures. This detachment makes coordination of services between hospitals and housing providers difficult. Social service agencies serving the homeless also have varying levels of understanding and past cooperative experiences with each other. They often find themselves in competition with one another over scarce funding and other resources.

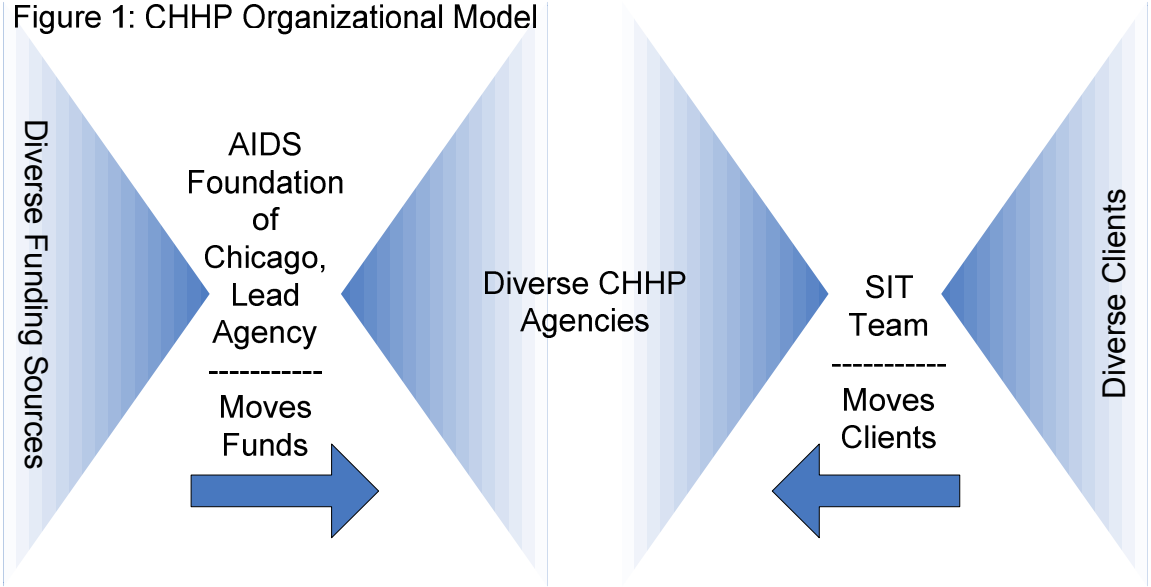
CHHP encompasses this complexity. As of June 2006, CHHP included a total of 17 agencies including three hospitals, three interim housing agencies, and 11 permanent housing agencies. The hospitals involved in CHHP include a Veterans Administration hospital, a public hospital, and a private hospital. The interim housing agencies consisted of an emergency, overnight shelter; a harm-reduction based transitional housing program; and a medically-oriented interim housing facility. The permanent housing agencies were a mix of scattered site and agency based housing. Some of the agencies only worked with HIV/AIDS clients, while others only worked with women or substance abusers. The agencies served clients across the city of Chicago and some of the near suburbs.

Two Key Structures of CHHP System

A key function of CHHP is its systems building approach to housing the chronically ill. An ill homeless individual has to negotiate multiple systems to secure health care, shelter and needed services. CHHP aims to provide a seamless system, in which the hospitalized individual moves directly from discharge planning to respite care to permanent housing. We were able to discern in our evaluation that CHHP's mission of housing the chronically medically ill homeless is accomplished through two overarching processes: the coordination of intensive case management and the coordination of provider resources. These processes are translated into two key structures: the systems integration team (SIT) and the lead agency model.

In short, we found that CHHP works by funneling both funds and clients into centralized structures and then redistributes them to the partnering agencies. Figure 1 is our visual representation of these processes.

Figure 1: CHHP Organizational Model



Lead Agency/Collaboration Model

CHHP is a synthesis of a collaborative partnership model and a lead agency model, as evidenced in the way the CHHP system was created. The founding health and homeless provider agencies that envisioned CHHP jointly worked on developing the CHHP model. The governing board oversees the policy of the project and is highly involved in CHHP. At the same time, the CHHP staff is responsible for a great deal of coordination of the program and is housed at the AIDS Foundation of Chicago (AFC).

Funding Coordination and Distribution

Under the CHHP model, the lead agency structure gathers (or facilitates a partner's gathering) funds from a variety of funding sources, including federal HUD grants and private foundation grants, and consolidates/coordinates many of those funds at the AIDS Foundation of Chicago. The AIDS Foundation then distributes the funds to the CHHP collaborative agencies. This model of funding allows the CHHP partnership a significant amount of flexibility in how they distribute funds and what kinds of agencies they bring on board. While some grants have many restrictions (i.e., HUD and HOPWA[4]) other grants are relatively open-ended (i.e., Michael Reese Health Trust). Having a lead agency model, with the direct service agencies as subcontractors, allows money to be used within a grant's guidelines, but also allows more flexibility in the overall system. It also provides a simplified, timely, and responsive billing system for the agencies. In addition, the lead agency provides the following:

[4] HOPWA is Housing Opportunities for People With Aids, established and managed by HUD's office of HIV/AIDS Housing. HOPWA makes grants to local communities, States, and nonprofit organizations for projects that benefit low income persons medically diagnosed with HIV/AIDS and their families. www.hud.gov.

- Funding over-sight and coordination, such as integration of public and private funding, coordination, and combining of different housing options for clients;
- Facilitating and staffing CHHP governance groups;
- Development of new resources.

Governance and Coordination

Since CHHP consists of 17 partner agencies, the partnership relies on a series of meetings at multiple levels in order to coordinate the involvement and funding of so many organizations. All these meetings were well attended, with an average of 90% of the agencies in attendance. These meetings and a series of periodic individual meetings between the CHHP program director and partner agencies weave a strong pattern of interactions that create a strong system grid.

The Systems Integration Team (SIT)

Whereas the Lead Agency/Collaboration Model works at facilitating the relationships between organizations in CHHP, the SIT Model is the actual process of moving clients through the system.

The SIT model works to move diverse clients into housing with appropriate agencies. There are three stages to the SIT model:

- Stage 1 is the recruitment stage and takes place at the hospital level. Hospital patients who are identified as homeless are approached by a CHHP case manager to determine their eligibility.
- Stage 2, agencies are temporary housing locations for clients while the CHHP case managers determine the next appropriate placement in Stage 3. During this phase,

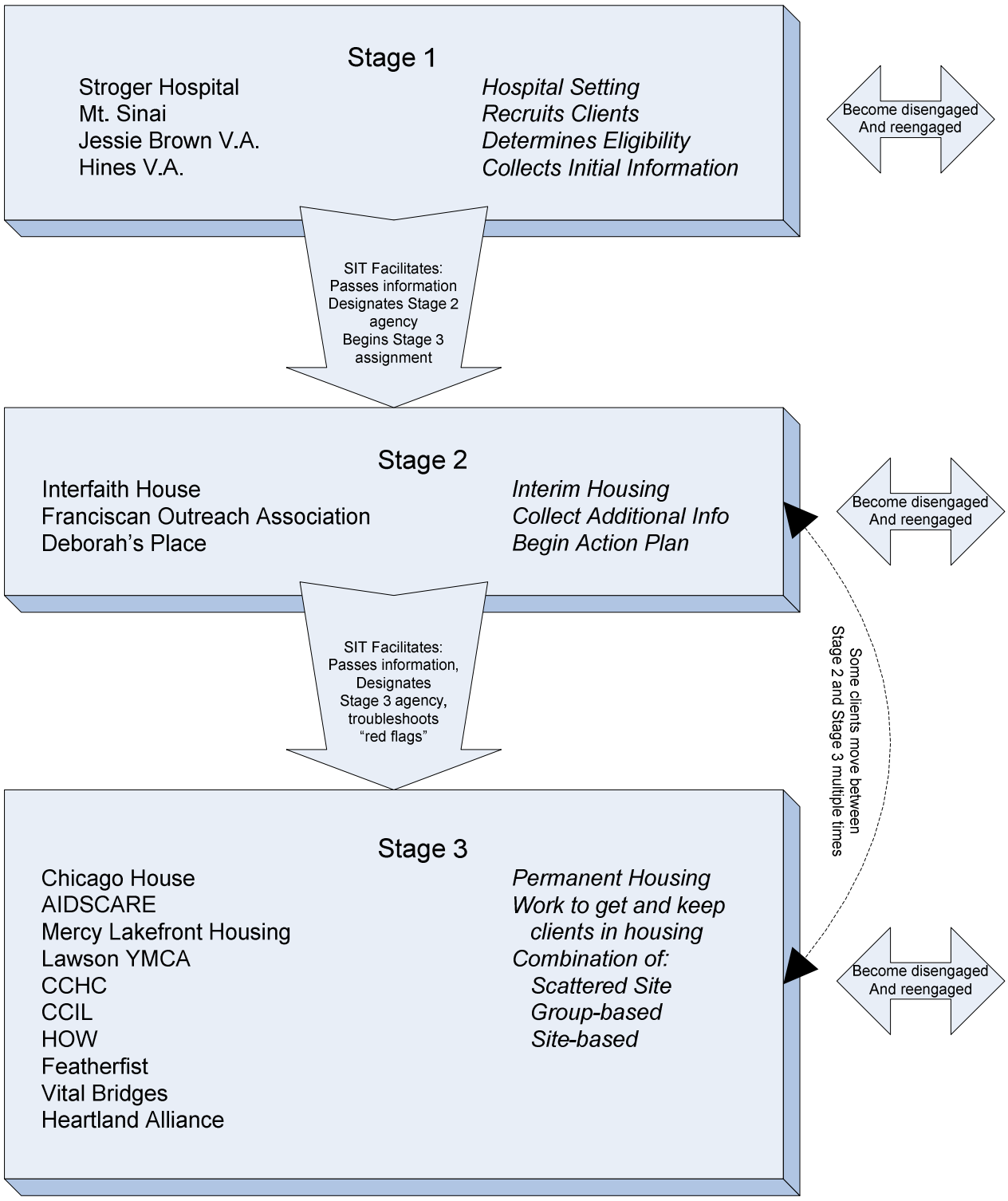
case managers also work to get client identification and paperwork in order, begin applications for SSI or other outside programs and help stabilize patients.

- At Stage 3, clients receive a permanent housing placement in a scattered-site, private apartment or in an agency-based building.

Figure 2 presents our vision representation of this system.

SIT Service Model:

Three Stages of Services, Facilitated by SIT team



Although the basic model assumes linear progression, many clients move through the model in non-linear paths. Some may stay at multiple Stage 2 or Stage 3 agencies. Some disengage from the CHHP system and are at large for long periods of time before re-engaging. Some go through multiple iterations of disengagement and re-engagement at different levels of the system.

A standardized management coordinated across agencies and sectors

The complexity of client career paths, as evidenced in Figure 2, has been recognized by the CHHP designers and partners and therefore there has been a tremendous investment in the case management approach. An intensive and common case management approach accompanies the SIT model. CHHP provides support services that assist clients from hospital discharge to obtaining housing and then provides assistance as needed to the permanently housed clients. Key to the provision of these services is the CHHP case manager. While CHHP case managers are employees of the partner agencies, the CHHP case managers' pay, work description, and training is standardized across agencies. In addition, they are required to coordinate their work with the CCHP coordinator, use a common data system, attend weekly staff meetings, and participate in periodic training sessions. Among the features of the CHHP Intensive Case Management approach are:

- Low client-staff (10:1) ratios;
- Developing rapport and trust with clients;
- Flexible services offered on an as-needed basis and client participation in the treatment process;
- Identification, acknowledgement, and support of clients' strengths in managing their health and housing;
- Innovative, individualized approaches to providing housing and services;
- Aggressive outreach, recruitment, and follow-up;
- Interventions offered in non-traditional settings, including clients' homes and neighborhoods; and
- Provision of crisis intervention with clients, as needed.

The weekly staff meetings, Systems Integration Team (SIT), are key. Each Thursday, all CHHP case managers from partner agencies meet with the CHHP coordinator to find the most appropriate housing placement for clients, work through roadblocks, and deal with "red flags" (clients who are difficult to place or are having difficulty maintaining their housing or engagement with the program).

- *Sharing client information.* The case managers at all stages share client's records and work as an integrated team to move clients from stage to stage (see Figure 2, SIT Service Model). Also during the meeting, case managers share information about clients, including their challenging experiences and receive social and informational support from other case managers. Meetings last approximately three hours. Occasionally, case managers also bring household items and other living necessities (including referral information for other programs) to be distributed to clients as needed.
- *Working as a team and joint problem solving.* During weekly SIT meetings, case managers work as a team to move clients through the three stages and into permanent housing. We found that these meetings were invaluable because case managers had the opportunity to give each other advice on how to handle troublesome situations and where to find needed resources. They shared knowledge of recent contacts (and sightings) of clients in different stages of engagement as well as successful client outcomes and benchmarks. Together, they discussed (and argued about) various approaches to providing services to clients, developing a common outlook based on the different perspectives, and strategies of their particular agencies or sectors (public health vs. homeless

services, etc.) while recognizing differences in agency and sector approaches.

- *Strong identification and connections.* There is a high degree of attendance at all weekly meetings, although there is some variation that seems to reflect the degree to which the agency has actively engaged CHHP clients. An unanticipated consequence of these intense meetings was that case managers displayed a high degree of comfort with and knowledge of each other, which provided a sense of teamwork and identity with the project. They were very much at ease with each other, often sharing casual as well as professional interchanges. Many had a high degree of knowledge of each others' agencies, sometimes stemming from the fact that when vacancies did occur in a CHHP position in one agency or another, they were often filled by a CHHP case manager from another agency.[5]
- *Building a common system.* The SIT meetings are crucial to help disperse information on diverse services to all agencies. These weekly meetings of case managers from all of the participating agencies seem to help to keep everyone focused and moving toward the goals of the overall program. The SIT meetings also help with identifying the best agency for clients and expediting clients' movement between agencies. Case managers from one organization said that the SIT meetings helped them get to know more about clients before they actually entered their organization because other case managers had worked with them and could tell them about their challenges, goals, etc. For example, during one SIT meeting, we observed, two case managers discussed the challenges of a client who was moving from one stage three agency to another:

[5] This awareness of the activities of the different agencies has also lead to a number of case managers applying for and accepting jobs at other CHHP agencies.

> CM1 started talking about one of her "red flag" clients. CM2 also knew this client, so they talked about her together. Client is bi-polar and was crying a lot. She's not with her boyfriend anymore and is very depressed. CM1 was going to take her to a food shelf this week because she was using again and had lost weight and didn't have any food in the house. CM2's agency was taking her as a referral. CM2 seemed sad to hear that the client was so depressed, but happy that she wasn't with her boyfriend any longer (seemed like boyfriend was bad influence).

This kind of discussion about client's lives, fears, and relationships could easily get lost in official records or brief reports, but the SIT meetings allow organizations to share crucial, detailed information with each other. Case managers can ask additional questions and get a better sense of clients' diverse experiences and needs through talking with others who have worked with the clients intensively.

- *Resource Sharing.* In addition, SIT meetings help diverse organizations to share their resources and experiences with other agencies outside of CHHP. In one meeting, a case manager told the group about an agency that was helping his client prepare for an SSI hearing.

> A client had an SSI hearing (appealing to receive SSI) and was working with [people from an outside agency] who were providing a team of case managers and a lawyer to try to get SSI benefits for the client. CM1 didn't seem to think it was likely that the client would get SSI benefits. There was some discussion about [the outside agency]. The CHHP coordinator hadn't heard of them. CM2 and CM3 mentioned two other groups that did similar advocacy for SSI applicants.

In this example, case managers shared resources that could help their clients get additional services outside of CHHP. In the next SIT meeting, the case manager who had been working with the outside agency reported that they had really "dropped the ball" on his client's case. In this case, case managers got much more detailed information from each other than they would from a simple list of referrals; they also got an assessment of the service based on their colleague's experience.

- *SIT meeting valued by stakeholders.* Stakeholders at all levels of the CHHP partnership highly valued the weekly SIT meetings. The weekly SIT meetings were time and labor intensive. However, case managers often cited the importance of the weekly SIT meeting. They underscored the importance of the emotional and professional support that they received at the meetings, and how valuable the exchange of information was to carrying on their day-to-day work. One case manager stated, "it's really important that we exist as a team and that we have these meetings…I mean the clients are really individualized through this process, or we see them as individuals, and so there's a continuity of care." Most of the partner agency administrators (executive directors and immediate supervisors) identified the value of the weekly meetings, while simultaneously lamenting the time demands it entailed for their case managers.

Coordination of the SIT

The CHHP coordinator role is also vital to the success of the model. We found the CHHP coordinator's function combines equal parts administrative coordination, professional mentoring and consultation, and facilitation of interchanges between case managers. The CHHP coordinator works closely on the development of each client's engagement with CHHP, tracking their progress, problem solving, and consulting with case managers as needed between CHHP meetings. The tracking of clients is largely facilitated by personal data keeping and communication with case managers. There is an extremely complex level of coordination conducted to track all the varying permutations of engagement and needs of CHHP clients and this role is essential in helping the model work effectively especially without an effective computerized record keeping system.

Clients' Evaluation of SIT Model

Clients are basically positive about the SIT model when they know about it but there may be some feelings of privacy invasion. One client said during a focus group that it was a mistake to think of a case manager as a friend:

> Do you know that every time you feel like that, every time you share something like that it's discussed around a round table…When I thought of my case manager as being my friend, and I let my guard down, and I didn't know that simple things I was saying to her were being discussed around a round table.

In response to this, other clients mentioned that they did not mind being discussed at the SIT meeting because they had "nothing to hide" or because the case managers were discussing them to help them better. While clients generally recognized the importance of the SIT meeting, they may also appreciate more communication about what goes on during the meetings and what type of information is discussed.

In summary, the SIT meetings are a crucial element of the CHHP process and are integral to its success as a model. Client movements between stages are discussed in detail and arranged at these weekly SIT meetings. A significant allocation of resources is required to maintain the effectiveness of CHHP, including the allocation of time for a three hour long meeting every Thursday. Because the CHHP client population is diverse, it is more useful to be able to offer a variety of services through diverse agencies. Each agency also has its own network of outside services that they can refer clients to. However, there are challenges in this diversity because the CHHP system must balance the benefits of working with diverse agencies with the difficulty of getting everyone on the same page, moving in the same direction, and dealing with all of the information.

BUILDING A HOUSE FIRST MODEL

In addition to our analysis and synthesis of the way in which the CHHP system works, there are several other key findings related to the programmatic challenges in maintaining a "Housing First Model." These challenges primarily related to 1) a Harm Reduction approach and 2) the intensive case management.

Housing First and Harm Reduction Principles

The CHHP model is rooted in the Housing First principle. A key goal of CHHP was to demonstrate the cost and service benefits of the Housing First programmatic strategy that provides permanent housing for a homeless individual as the first, rather than the last step in addressing the underlying issues and causes of homelessness for that individual.

The original CHHP model in the pilot study, however, did not include provisions that a significant portion of the housing would be harm reduction; that is housing that does not require abstinence of substance abusers before they are permanently housed. Harm reduction is a set of practical strategies that reduces negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself (Harm Reduction Coalition, 2006).

However, the data in the pilot study and input of the case managers changed this. Case managers reported that at least 80% of the CHHP intervention group participants had substance use histories and were actively engaged in the use of either alcohol or illegal substances. To them and to the CHHP founders, this demonstrated a significant need for increased harm reduction units. After the pilot study ended in 2003, the project design and research design were

gradually adjusted in order to accommodate more active substance users than originally planned for.

According to CHHP director and founder, Arturo Valdivia-Bendixen, in the two years after the pilot project "… more housing agency partners who specialized in harm reduction, such as CCHC, Heartland Alliance and HOW were brought into the CHHP program." In addition, several abstinence-only agencies began implementing harm reduction practices and shifted housing units into the harm reduction model. The CHHP housing data indicate that the total number of harm reduction based units grew gradually and steadily:

Availability of Stable Housing Units for CHHP: 2003-2005

Type of Housing	**2002**	**2004**	**2006**
Scattered Site /Sobriety Based	20	8	0
Scattered Site /Harm Reduction	20	48	87
Project Based / Harm Reduction	0	29	30
Group Living / Sobriety Based	40	37	21
Total CHHP Units	80	122	138

Source: Year 3 (July 1, 2005-June 30, 2006) Report

This adjustment and move toward harm reduction demonstrates the benefits of first creating a pilot study and then moving to a demonstration project. The inclusion of harm

reduction units within the CHHP program also highlights the positive features of CHHP's flexible service and organizational model.

Varying Perspectives on Harm Reduction and Agency Implementation

Street-level Perspectives

The topic of harm reduction arose continually throughout our research and at all levels of stakeholders. Clients and case managers reported that harm reduction facilitates and enhances clients' compliance with CHHP and positive interactions with case managers. For the clients, questions about harm reduction elicited a very positive response. Three larger themes emerged from their responses. A harm reduction philosophy: 1) alleviated their constant fear of being kicked out of the program; 2) increased their ability to cope with life circumstances; and 3) allowed them to be honest with their case managers about their substance use, which made for more meaningful and directive help. One client had the following to say about the harm reduction model:

> My case manager [said], 'I don't want you to be concerned about it; I want you to be open and honest. Because that program [AA] is based on honesty. If you get in any trouble, or even if you want to drink or want drugs let me know. It's not going to cause despair or angst between us. You're not going to lose your housing over it.' … And it did give me the peace of mind to know that if I should relapse or fail I would not be put on the street for it, and that information was given to me day one.

Case managers reported that harm reduction allows flexibility in working with clients. Whereas in non-harm reduction agencies or programs a client may have to leave if they 'break the rules,' case managers reported that within CHHP agencies there was more 'leeway.'

Agency Level Perspectives

Staff, generally, acknowledged that administering and maintaining a harm reduction program was challenging. The push for harm reduction created tensions both within agencies

and amongst their clients. Case managers reported tensions between their agencies' philosophy/rules and CHHP's focus on harm reduction. Program managers reported that the harm reduction model requires more training and different training of existing case managers and the hiring of more specialized case workers.

Many administrators and case managers from scattered site agencies reported that harm reduction clients "burn through apartments" which can negatively impact the agency's relationship with those landlords for any kind of housing. Some administrators wanted help and resources from the CHHP program or the AIDS Foundation to identify and work with landlords over harm reduction clients.

Clients, case managers, and administrators all reported difficulty in having harm reduction units in group based living situations, whether shelters or residential shared living agencies, because relapse is "contagious" and therefore can negatively impact other clients who may be trying to maintain sobriety. At the agency level, we have identified three major issues concerning the implementation of the harm reduction philosophy: 1) differing interpretations of what harm reduction involves, 2) differing operationalizations of success, and 3) the relevance of landlord burnout now and in the future for the success of CHHP.

- *Differing Interpretations of Harm Reduction at the Agency Level*. In our interviews with executive directors and program managers, they talked about harm reduction in many different ways. Some seem to equate harm reduction with a system of care that does not pass judgment on those who are not clean and sober and does not necessarily push clients to become clean and sober. For example, the program manager from one agency said, "We've adapted that model for all of our programs. When we got involved with CHHP it was an easy

move as opposed to other agencies that hadn't done that yet. Like no barriers to entry and working with active substance users and the issues that go along with that."

Others seem to see harm reduction as a series of case management techniques (system of change, motivational interviewing) and the issue of substance use is secondary or not mentioned at all. For example, this program manager discusses harm reduction in terms of the motivational interviewing technique:

> It really requires a very committed focus on its effectiveness. It took the HIP program, once we understood it, we were supposed to learn this motivational interviewing and we all came from different models so we had to put that aside and look at what we were going to do and focus on embracing it. It's not necessarily the same in larger agencies and I think the conflict comes from the top. The executive director has to use motivational interviewing if the janitor is supposed to use it. It has to be consistent throughout the agency. My staff lives and breathes it because I live and breathe it. It becomes difficult only in terms of how committed to it. Then, there's the philosophical challenges when people talk about harm reduction as opposed to abstinence, it takes some education. (So, do you see tension with in an agency between people who have adopted the harm reduction model and those who haven't?) What I do observe is maybe not the opportunities to use it and people tend to use what's available or what's comfortable. What I can't see is how they may be thinking of how they might use motivational interviewing or harm reduction with each client. It's really a process at all levels.

In some cases, agency staff seemed to use these tools to motivate clients to become clean and sober. For example, a program manager from one agency said, "We're working with where the client is we're just here to educate them on how to reduce certain things and to inform them about how their decisions may be harmful to them, but not to stop them from doing things."

- *What does success mean?* Differences in perception of the model become especially apparent when staff described success stories from their agency. The different perceptions of what success entails is indicative of what they see as the goals of the program. Who do they see as successful clients vs. unsuccessful clients? Some program managers

defined success as clients who had been permanently housed for a long time: "You know, we have had some luck getting some people into treatment. No single success stories stands out. The biggest success is that 8 of our participants have lived here for over a year, and several for over 2 years."

Sometimes, success explicitly meant housing someone for a long time *while they were using alcohol and drugs*: "Since I've been doing CHHP since 2004, I started out with 8 participants, those 8 participants are still successfully housed 18 months later and they are still active substance users. They are linked to health services and 2 are working now."

For other program managers, even under the harm reduction model, success was helping clients become clean or sober. When asked if their program had any success stories in terms of the harm reduction model, one program manager said:

> I believe that a couple of clients are continuing to be successful in the way that they're working with their recovery and in their housing and their medical care. In terms of them actually identifying that this is an issue and to deal with it and address it and get the resources to really deal with it. We have others that are still having challenges and we're still trying to help and inform and assist, but there are some that have really maintained their sobriety through that.

Another program manager from a different program replied to the same question by saying, "You know, we have had some luck getting some people into treatment. No single success story stands out." For some programs, sobriety is linked to other successes, such as health or improved family relationships as is evident in the following quote: "One gentleman that I can think of actually started doing better. (What do you mean got better?) He got a girlfriend, got a lot better, isn't smelling like alcohol, better able to walk, going to hospital less."

Some organizations indicated that they had adopted a harm reduction model that allowed for alcohol and drug consumption, but they worried about the effect of this model on the clients and if it was really helping them:

> Also with harm reduction I sort of wonder if, how do I phrase this, you have clients becoming dependent knowing that the voucher is going to be paid for and, this is a question, I don't know the outcome, but what are we doing to the client. My big thing is, I tell my case managers, clients are not to become dependent on us, so are we creating so much of a dependency for the client when it comes to housing.

Including agencies with diverse perceptions of the harm reduction model poses problems for the CHHP program in terms of making sure that agencies are "speaking the same language" when talking about harm reduction and other programmatic issues. At the same time, having agencies that can offer a range of harm reduction services, from those that emphasize sobriety to those that place no substance use expectations on clients, works positively to serve the needs of a diverse client population.

- *Landlord Burnout.* Related to the implementation of harm reduction principles is the important issue of landlord burnout. Many of the agency staff, in our study, mentioned landlord burnout as a significant hurdle to housing CHHP clients, especially those who were active substance users. During SIT meetings, case managers often related stories of clients who had been evicted for using or trafficking drugs out of their apartments, damaging their apartments, or having unauthorized guests living in units with them. The loss of housing for individual clients is frustrating for case managers because they must find new housing for the most difficult-to-house clients (who now have an eviction on their record, further damaging their ability to rent). Evicted CHHP clients also hurt established agency relationships with landlords. One agency told us that a CHHP client had been housed with a landlord who they had worked with several times and whose relationship they valued for many of their housing programs. This CHHP client was eventually evicted from the building (for unknown reasons) and the landlord severed ties with the agency, effectively blocking them from placing any of

their clients with him. Thus, CHHP clients' relationships with landlords can have agency-wide effects. Another example is provided from an Executive Director of a Stage 3 agency:

> We have one landlord who we have 30 or 40 units with, and over one CHHP client he was just really just about ready to dump all of them. And then you have to get into a really deep conversation with that person. And explain, this is what we're trying to do and this is the reasoning behind it. And, in the end, that person wasn't housed, but I think that it deepened our relationship with that landlord. We've also had neighbors who have gone to our funders [to complain]. [They looked up the unit on the public register and followed it back to us and then found our list of funders and complained]. But this is what we do. It's an independent living program and that's how we're trying to do it.

Some agency staff expressed a desire for the AFC (as the lead agency) to help them find landlords to work with CHHP clients or frustration that AFC had not already done this. Without a collaboration-wide bank of landlords to work with, CHHP case managers are put into another, potentially conflicting role. In addition to the intensive case management they provide for CHHP clients, case managers at many agencies are responsible for developing their own scattered site housing. This can mean finding eligible, willing landlords, negotiating the application process and rental agreements, and helping landlords deal with issues long after clients have moved into an apartment. In one case, a client moved into an apartment and his ex-wife eventually joined him. The client died, leaving the wife in the apartment, but because she was not a CHHP client, she did not receive a subsidy and could not afford to stay in the apartment. The landlord contacted the agency and it took them months of working together to get the woman out of the apartment, losing the landlord a significant amount of money and damaging their relationship in the process.

When asked what an ideal housing program would look like, one case manager said that he would have a battery of twenty to thirty case managers whose only job would be to find housing. Clearly, finding private landlords is a critical part of the CHHP program and needs to be addressed. As CHHP moves into a permanent program, it may benefit agencies to receive

more assistance or training in recruiting and retaining landlords. Landlord burnout is certainly a challenge of implementing the harm reduction model and needs to be addressed. By hiring and intensively training "housing locators," CHHP could reduce some of the burden of finding housing that is currently placed on the case managers.

Investment in Case Management

We found that the concerted effort, CHHP has placed in intensive case management, was a crucial component of its Housing First strategy. As discussed already in this report, CHHP has made a solid investment in case management. In fact, the case manager/client relationship is at the center of the CHHP model. This investment is absolutely necessary, as evidenced by the complexity and diversity of clients' circumstances and career paths throughout the three stages. Apart from the diversity in clients' medical diagnoses, demographic characteristics, and life circumstance there is also tremendous diversity in the "career path" of clients. In other words, how clients move through the stages and their experiences once they attain "permanent" housing varies significantly. The diverse experiences of CHHP clients demonstrate many of the challenges faced by clients and by the agencies that serve them in trying to house the chronically ill homeless and hence demonstrate the need for intensive case management.

Engagement Pattern Complexity

There is a great deal of complexity in and diversity of client engagement patterns throughout the various stages of the CHHP model. Client diversity impacts how clients get into the program, move through the stages, and their experiences once they attain permanent housing. This demonstrates many of the challenges faced by clients and by the agencies that serve them in

trying to house the chronically ill homeless and illustrates the need for an intensive one on one case management approach.

For example, as of June 2006, of the 111 clients permanently housed by CHHP, 81% did not go through the intended track (Stage 1 to Stage 2 to Stage 3) and 23% were disengaged at some point during the process. Many clients became disengaged several times before moving into stable housing. Others moved back and forth between Stage 2 and Stage 3 agencies (sometimes several times). In some cases, clients go through up to ten different iterations of engagement, sometimes ending in them being blacklisted by landlords, sometimes ending in them finding permanent housing.

The CHHP coordinator has used a coding scheme with 17 different codes to try to capture some of the complexity and diversity of client situations (see appendix for condensed display of this system). Some clients are asked to leave because they cannot meet the sobriety regulations of a particular housing facility; some have to be re-hospitalized throughout the stages; and others are lost-to-contact for various reasons. This complexity can be particularly challenging once clients move out of the hospitals into Stage 2 interim housing.

Stage 2: Figuring out the best place for "temporary" housing

Once the client is discharged from the hospital, CHHP is designed such that clients go immediately to a "Stage 2" agency, where in most cases they are housed "temporarily" and receive intensive case management. There were three Stage 2 agencies, although the overwhelming majority of clients were sent to two of the three agencies.

- *Different experiences based on Stage 2 Placement.* Clients were asked during focus groups to describe their experiences during Stage 2. Some described their experiences at

Franciscan Outreach, an overnight temporary housing shelter, early on in the program. A common complaint was that there initially were not any daytime services and everyone had to leave the shelter and take a bus to Interfaith House (a different Stage 2 provider) during the day. While clients were eventually able to stay at Franciscan during the day, structure and programs were still limited. As one case manager points out, it is not supportive to have drug users sitting around being idle all day with nothing to do. This also created tensions and problems for Franciscan Shelter. Other clients described their experiences at Interfaith House. Comments about Interfaith were generally positive, although there were some concerns raised by interviewees that it was difficult to get enough clients into Interfaith House upon leaving the hospital. Some clients choose not to stay at a Stage 2 agency. Some stayed with family members and others stayed on the streets. Clients' needs during Stage 2 will impact where they are placed and what options are available.

- *Different needs based on gender.* An example of different alternatives based on personal characteristics is that there are different Stage 2 needs based on gender. Both of the most commonly utilized Stage 2 agencies, Franciscan and Interfaith, have very limited beds specifically for women. Apart from space limitations, there are also unique concerns for women's sense of safety and comfort, particularly for those women who may have been sexually assaulted. While Deborah's Place (the other Stage 2 facility for women only) is a great option, there has been considerable difficulty in getting women from CHHP placed there due to lack of turnover and other limited options for homeless women in Chicago.

- *Challenges in keeping clients engaged.* Even when an appropriate placement is found, Stage 2 agencies report some difficulty in keeping clients engaged. Some clients may decide to leave their Stage 2 agency and find alternative living arrangements, and this can make it difficult for case managers to continue to track them. Others may be asked to leave because they cannot meet the sobriety regulations. Some clients have to be re-hospitalized during this stage.

Stage 3: Getting them in, keeping them in

As is the case during Stage 2, there are many challenges faced by clients and agencies alike during Stage 3. One of the goals for clients during Stage 2 is to locate a placement for permanent housing through one of the Stage 3 agencies. We highlight five key challenges to finding and maintaining permanent client housing in this report: 1) time and frustration, 2) limited placement options, 3) client engagement challenges, 4) changing needs of clients, and 5) more stringent sex offender legislation.

- *Placement takes time.* Even in the ideal case where a perfect match is found between client and placement, there are still additional obstacles in getting them housed in a timely manner. One main point that case managers, program managers and executive directors made was that keeping clients engaged is not easy. In order to be ready to move into a place, the client has to be able to make appointments, get paperwork together, and so forth. One case manager stated, "We don't have enough housing and we don't have enough specific (types of) housing."

When clients miss appointments, or when they cannot be reached for long periods of time, this slows the process. In order to get through all of these "hoops," it may take some persistence on the part of the clients which is sometimes difficult to come by. Another related issue is that during these interviews, clients are expected to tell the truth which sometimes does not happen. Some agencies are unable to house a client because they were not truthful during their intake interview.

As one case manager pointed out, "I know the frustration of a client that is waiting to be housed, waiting to be housed and waiting to be housed…" There appears to be a capacity problem in itself, but it also appears that this may be compounded by the diversity of CHHP's clients.

There are also placement issues related to clients' varied physical and mental health needs. The fact that many of CHHP's clients have both physical and mental heath issues further complicates their situations. CHHP case managers are aware of a similar project underway in New York and, during the focus group, some indicated that the program in New York was able to find housing for clients more quickly (www.csh.org, 2001). However, one case manager pointed out that a key difference is that the clients in the New York study had primarily *mental illness*, but not necessarily co-morbidity *with medical illness*. Again, the diverse range of needs presents additional challenges for the CHHP clients.

- *Clients' Options are Sometimes Limited.* Because the CHHP clients and their needs are so diverse, this creates several organizational strains. One issue is that certain Stage 3 agencies have restrictions on the type of clients that they can accept. For example, an agency may only have the funding to provide placement for clients who are HIV positive. Therefore, it

may be more difficult at times to find a Stage 3 agency for someone who is *not* HIV positive. Another similar issue that makes Stage 3 placement difficult at times is that some of the CHHP clients are sex offenders, which means that there are limitations on where these clients are placed.

Another big issue is that there are different placement needs based on substance-abuse history and current use. While most of the agencies that are involved in the CHHP program follow a "harm-reduction" model, there are still so few beds that clients can sometimes "fall through the cracks." Some clients respond better to scattered-site housing and the freedom associated with living on their own, as well as the fact that they are not clumped together with other drug users. Others, however, need more structure, and are more appropriately matched with a program-based facility.

Apart from placement issues revolving around eligibility and client "needs," it is also important to recognize that clients also have their own set of *preferences* in where they are placed. The most common example that came up from focus groups was the issue of location. For example, a client may have a strong preference to live on the Southside when, at the time, housing is only available on the north side of the city. Clients talked about having family members, friends, or even doctors in a certain part of town that they wanted to be near. In other cases, clients wished to be removed from a particular environment that had led to a destructive lifestyle in the past.

- *Client engagement challenges.* While there are undoubtedly challenges involved in *placing* clients in permanent housing, what sometimes may even be more concerning are the obstacles in *keeping* clients housed. Again, the diversity of clients and their needs adds to the

difficulty in keeping them housed. For example, as previously discussed, the majority of clients have a history of substance abuse, and many of these clients are still actively using. Also, several of the clients have ongoing mental illness and they may or may not be compliant with their treatment plans. This can create problems if there is awareness of the substance abuse by neighbors or the landlord, or if it leads to disruptive behavior on site. As an executive director of a Stage 3 agency put it, "Living in an apartment building with landlords that we are really trying to negotiate with to keep people there, when people are going to continue to use and do it openly, it becomes very difficult for landlords to want to keep you there."

Related to active substance abuse, mental health issues, or anything else, problems in client behavior sometimes results in being evicted from their housing. For example, program staff reported that violent behavior had resulted in some clients being removed from their housing. Another example was a client that was discussed for several weeks during SIT meetings who was allowing multiple people to stay at her apartment with her. Her neighbors, as well as the landlord had complained to the CHHP case manager on several occasions and she had been warned that she was not to allow people to use her apartment as a hotel, or she could be asked to leave.

All of the problems discussed thus far in keeping clients housed: active substance abuse, non-compliance with lease agreements, and unacceptable behavior, lead to tension arising between the landlord and the Stage 3 agency. After a client has been housed and has had to be removed from that housing because of any of the aforementioned reasons, the landlord may become reluctant to rent to other CHHP clients in the future. In this way, the difficulties of Stage 3 become cyclical: the more difficulties in keeping clients housed leads to more difficulties in placing clients. One of the administrators at a Stage 3 agency also expressed concern about

this, "every time we have a crises it damages our credibility. The housing provider must be a part of the equation, he has to be taken care of…if not, our word becomes tainted."

It is important to note, however, that all of these problems are ubiquitous when working with the homeless population and are certainly not unique to CHHP clients. However, several of the case managers were quick to point out that CHHP clients were better off than non-CHHP clients. For example, one stated, "there are some clients that fall through the cracks in CHHP, but a lot less clients fall through the cracks in CHHP than if they were out on their own, and trying to navigate the system on their own." One Stage 3 agency currently has an outreach component where they are trying to follow-up with clients that have been disengaged for years, which would likely not happen anywhere else.

Some of the advantages for CHHP clients include the waiting period being shorter, and the fact that case managers can provide everything from clothing to transportation to help with cashing checks and paying bills. This is helpful in keeping clients housed. Another advantage that clients in the CHHP program have is that there is more leeway, and agencies are sometimes able to bend the rules for them. And, in the case when a client must be removed from a housing situation, there are other CHHP agencies to choose from that may better suit the needs of the client. One case manager emphasized this point by saying that the clients "don't get dropped back out in the street…which is usually what happens."

- *Clients' Diverse Needs Ever-changing.* Just like anyone else, and perhaps even more so, the lives of CHHP clients change. One client talked about how since joining the CHHP program, she has gotten married. She expressed concern that the program is not designed to help her husband, who is undergoing treatment for cancer. An administrator from a Stage 3 agency

discussed a similar situation of changing circumstances about a client whose wife re-appeared. The client allowed his wife to move in, but then he passed away, and CHHP had to figure out what to do with the woman who was living in the apartment. Change is something that may further complicate the already very difficult challenge of meeting all clients' diverse needs. However, change also offers hope. For example, one client talked about looking to the future, and indicating that eventually he would like to find a larger apartment because he hoped to not be alone forever.

- *Sex Offender Legislation.* As of January 1, 2006, the sex offender registration act in Illinois was amended to restrict child sex offenders from living within 500 feet of a school, a playground, or a facility providing programs or services exclusively directly toward persons under 18 years of age. In addition, a sex offender cannot reside in the same apartment or condominium building as another convicted sex offender (State of Illinois, 2006). These restrictions significantly limit the available spaces for CHHP clients who are registered sex offenders. This has put strain on agencies and case workers because they have fewer options available for their clients.

The sex offender issue came up at every SIT meeting we attended. Case managers found it very difficult to house sex offenders because of the new law and there was a perception that there were more sex offenders entering the CHHP system because the law had made it illegal for them to stay in their homes. The law seems to be especially tricky to navigate because even if a location is found that complies with the distance restrictions and has a landlord who is willing to house the clients, CHHP can only place one sex offender in that location.

At one SIT meeting, the CHHP coordinator said that there were communities willing to take sex offenders, but the law is so restrictive that they cannot be housed. However, it does seem that many landlords may not be willing to rent to sex offenders and some organizations cannot or will not serve them (some because they also house women or children). Also, some case managers discussed in the SIT meetings that they were conflicted about whether or not to disclose that their clients were registered sex offenders to potential landlords. On the one hand, they felt obligated to protect the confidentiality of the clients. However, by not disclosing this information upfront, they may just be wasting time and money if landlords find out about offenses themselves. Further, there is an overall concern about "burning bridges" with landlords, and therefore honesty may be better for relationship-building.

If the number of sex offenders entering CHHP increases, as perceived by the case managers and CHHP coordinator, after the research project phase ends, this population will need specific attention. CHHP may consider entering into advocacy or lobbying activities in order to change sex offender restrictions and ease the housing process for them. CHHP has already begun to address this by offering training to case managers on the new legislation, demonstrating its ability to learn and change in response to external factors.

Clearly, with the variety of challenges that arise throughout stage two and stage three there is a need for the case managers to be well trained, committed, and able to work as a team to help these clients through the process. The case manager's role is vital to the process.

PARTICIPANTS' PERSPECTIVES: KEY ISSUES OF CLIENTS, PROGRAM STAFF AND ADMINSTRATORS

In this section of the report, we highlight the data we collected at the three different levels of CHHP: the street level (clients and case management), agency level (case managers

and partner agencies), and lead agency level (agencies and key lead agency staff) and conclude with thoughts about the ownership of CHHP expressed and felt by participants across these three levels.

Clients

As indicated in this report, the CHHP model employs a very intensive model of case management. Client comments demonstrate the effectiveness of this approach. Client reports of their interaction with CHHP reflect the effectiveness of the intensive case management approach. Our evaluation covers four main findings about their case management by the clients: 1) Client assessments of case managers; 2) the nature of the case manager/client interaction; 3) what CHHP means to the clients; and 4) client critiques of CHHP.

Overall positive assessment of case managers

Clients talked about the case management component of the CHHP program very favorably. Starting at Stage 1, clients appreciated the strong, directed case management staff. For example, a client talked about his experience at Stroger, "the people at Stroger…they would not let me leave…worked very hard to provide what I needed to talked to people a CHHP...they wanted to put me into Interfaith House…I did get there." Something that sets the CHHP program apart is the consistency of the case manager. One client recalled their CHHP case manager even came to see him while in drug treatment. The clients identified 4 characteristics that they appreciated in their case managers: advocacy, dependability/responsiveness, life coaching and support.

Clients see the case managers as advocates

Clients talked about how the case managers helped them find placements that were the best option for them. As one client put it, the case manager "made sure I got into the *best* housing program." Another commented that it helps to have the case management. When asked why, he responded: "Because you can sit right there and your case manager will make an appointment and you won't have to go by yourself. They will help make an appointment with whatever doctor you want to see. And if you're too sick or something, they will provide help with how to get there, and back."

Clients see case managers as dependable and reliable

A very common sentiment that was expressed by clients was that their case manager was dependable and reliable. When a case manager said they would do something, the clients knew that they meant it. One client said, "They stood up to whatever they said they would do…whatever I asked, they were there for me." Another said that, "They practice what they preach." The fact that case managers kept their word was valued by clients.

Clients value case managers

Clients also valued the fact that case managers were responsive to their needs. One client recalled:

> What's good about CHHP (snapping fingers) they move they respond to you they call when they say they are going to call, they act quick you know what I'm saying you don't have to keep on calling them bugging them what's this what's that they call and explain it to you and sometimes when you don't have transportation they will get transportation for you to get around and stuff like that.

Clients see case manager as a coach

The case manager was often seen as a coach for clients. Case managers push for planning and goal setting. The use of motivational interviewing is common, which is often used in conjunction with implementing the harm reduction model…"They teach you to have a plan for whatever you do…restructuring my life to save me, be concerned about me, and I can still be concerned about others. It's teaching a form of responsibility for those who want that…" Case managers encourage their clients to set and achieve their goals.

Clients see case manager as supportive and respectful

When clients talked about their case managers they often spoke about them being supportive and respectful. For example, one client mentioned that she appreciated being treated like an adult, "the attention, you know, not that we have to be babied or whatever." Another client talked about a very memorable experience where her case manager provided her support, "My case manager also went to the hospital with me, lumps were discovered on my breasts and I had put the appointment off numerous times, and the fact that she went with meant something to me, you know, moral support…" For some of these clients, the support and respect is a very meaningful part of their CHHP experience.

<u>Case managers individualized approach to each client</u>

Understanding that the CHHP clients have diverse needs requires that case managers take a unique approach for each client that they work with. No one plan will fit for every individual. One client was amazed at how well the CHHP program had worked for him, when previous programs were not for him because he requires more autonomy. He states, "I'm really grateful

for this program, truly grateful, it has helped me to straighten out and get on my own. Its hard being in crowds, in institutions and stuff, it bugs me. I like being alone." The CHHP program was able to find him placements that were in-line with his preferences, and therefore the program was a success.

- Another client talked about how it's not necessarily the best for every client to move through stage 2 as quickly as possible. Case managers "didn't push people to move from one stage to another before time." Case managers recognize that some clients need the safety net that is provided at Stage 2 for a longer period.
- While CHHP provide a great deal of support to clients, it also meets the needs of those clients who prefer less structure and more autonomy. CHHP deals well with difficult clients. One client talked about how in the past he had had a lot of problems with authority and that he wanted to be the one in control of his life. His experience with CHHP, however, was different in that he was shown how to get his own housing.
- Some of the clients in the CHHP program have been through a tremendous amount of adversity. For those clients who are struggling just to hang on, case managers acted as a preserver. One client states, "So personally it has helped me, been uplifting and encouraging to hold on, to be still, and like, um…She said hold on, I'm going to get you something, and they kept me encouraged the whole way…" The case managers were able to provide strength to clients to keep on going.

<u>Clients reported finding support and respite</u>

In addition to comments made directly about case managers, clients' comments about the CHHP program in general is also evidence of the effectiveness of the intensive case

management. It is a result of the personal connection that CHHP provides respite, is able to adapt to each individual's needs, and is seen as effective.

- One of the most apparent themes that emerged from listening to clients talk about their experiences with the CHHP program was that they felt that being in the CHHP program gave them relief from having to worry so much about things and to just be able to focus on getting better. They discussed receiving social and economic support, as well as day-to-day support.
- One client said, "You have a chance to sit down and get your mind together…When you're on the streets your mind is in two or three other places. With the CHHP program, you have the chance to actually sit down on a couch and think for awhile…You can relax and get well and be rested, and take care of your business at the same time."

<u>Client report easier to maneuver through social service system</u>

- Clients consistently remarked that they were impressed by the expediency in which they were placed in housing. One client said that they were, "Quick getting in housing compared to doing it on your own…"
- Other clients appreciated the continuity of services. When asked about what the best thing about CHHP was, one responded, "The continuity of services between the three stages. There are no gaps."
- The collaboration between the diverse agencies was also seen as an asset to clients. Clients were asked if the affiliation with the CHHP program made it in any way more difficult to get other services. Almost unanimously the response was that CHHP made it easier to get connected with a multitude of services. One client said, "What basically

really attracted me was that if you needed connections with if you needed mental counseling, mental health treatment, that if you needed testing for HIV if you hadn't already been diagnosed, (and) they help you get connections with diabetes clinics."

Many Clients valued the Harm Reduction Approach

There was overwhelmingly positive response from clients when asked about the harm-reduction model.

- One client spoke about how he is in Alcoholics Anonymous and how honesty is part of his recovery. With harm reduction he is able to be honest about his substance use and not worry that he will be removed from his housing.
- Another client spoke about how it was a useful model because you can get support when you need it most because you do not have to "stay away" when you're using.

Some Clients found limitations in housing

While there was enormous support and praise of the CHHP program expressed by the clients, there were some areas that were perceived to be in need of improvement.

- While most were satisfied with the ease in which they were able to get permanent housing, a couple of clients expressed that they wanted more help from case managers in finding housing, or that they were not able to get into housing soon enough.
- Related to this, some clients brought up the fact that there were limitations in finding housing. This may especially be a problem when the only housing available is group project housing for addicts trying to get clean.
- Some clients stated that there might be a need for more scattered site housing.

Confusion about permanence of CHHP housing

There seemed to be different understandings among clients about CHHP-related funding issues. For example, some clients perceived CHPP as permanent housing, and talked about how CHHP is "forever." These comments reflect in part the complicated reality of the subsidized housing system and the confusion that it engenders.

- One client compared CHHP to other programs which lose funding and said, "Their funds are being cut and I got a neighbor of mine who uh funds got reduced to $250 a month $250 every other month right he got a $600 month rent to pay you know I don't have that problem."
- While some think it is permanent, others are not sure about the future of CHHP.
- Another example of how clients' perceptions are unclear was seen when one client stated that there was not coordination with the Section 8 or CHA vouchers.

Quality and location of housing was problematic for some clients

Some clients expressed that they would like to see an improvement in the quality of the housing that is provided to them. Others expressed different preferences about where they would like to live. They felt that one part of CHHP that could be improved is to place them in the part of town that they want to be in.

- For example: "My problem with Maywood was, they put me in area that was full of drugs; drugs, shooting, stuff like that. I left that area; I packed up my stuff and left that place…"
- Another client complained that the quality of her apartment was poor and she'd like to live in place that was worth the money that CHHP had to pay for it.

- As one client described, "The bad part about my situation is, they sent me to a, they send us to different areas, Northside, Southside, Westside. They sent me to the Southside, and there's nothing available there."

Clients had very limited resources to furnish their housing or for transportation

One downside of the program that was brought up was that once a client moves into permanent housing, they have very limited resources.

- For example, sometimes they move into a totally empty apartment and do not even have the basics needed to prepare a meal in the kitchen.
- Also, there is not a lot of money left for them to get around on public transportation or for any other personal needs such as toiletries.
- Other clients said they would want CHHP vans that could help them with their transportation needs.

Clients felt uncomfortable in some 2nd stage placement

One issue came up in that at some of the Stage 2 facilities, participants felt that there was sometimes a clash between the cultures of CHHP and the agency where they were placed.

- One client said, "They have a limitation, because they (CHHP program) are guests, where I'm at, Franciscan house, so they don't have a lot of leeway to do things."
- There was also a sense that there was some tension that arose between CHHP and non-CHHP clients. It may stem from the fact that sometimes CHHP clients get extra privileges and others may resent this.
- Some clients implied that CHHP would be better off on it's own with comments such as, "I'd like to see them have their own building...I'm not saying they haven't helped

us enough, I'm just saying they could help us better with their own property." Despite these areas that may be in need of improvement, it is worth reiterating that comments about the CHHP program were overwhelmingly positive. In fact one client stated, "I wish CHHP would go nationwide." In response to this comment, other clients expressed agreement. It is evident that CHHP has made a positive and meaningful impact on the lives of many of the clients which it has served.

Agency Staff

Most agencies saw CHHP as "fitting into" their organizations relatively well. Even those organizations that had ideological differences with the CHHP model (usually in terms of harm reduction) saw their organizations and CHHP as compatible due to similar programming and populations served. In addition, they saw CHHP as expanding their capacity, or increasing the quality of their services.

Fitting in

Same mission

One way that CHHP "fit into" existing agencies was through programming that agencies perceived as similar to their own existing services. One executive director said of her agency's CHHP clients, "They receive the same services as our other clients. The only difference is that they receive a designated permanent housing placement." Many agencies also said that CHHP fit well with their existing missions and that working with CHHP was an expansion of the social good that they were accomplishing with those missions. Even when key parts of an agency's mission contradicted central tenets of CHHP ideology, agency staff still seemed to see CHHP as compatible with their organizations. An executive director from a sobriety-based agency

indicated that he saw his program and CHHP as being very similar. He said, "CHHP is what we do." When asked how his program was similar to or different from CHHP he said there were only a few differences: "Only a few things, like sobriety, but only a few things." The similarity between CHHP and existing programs improved the fit.

Same target populations

Another way that organizations perceived CHHP as fitting into their agency was through serving similar populations. Some organizations had client criteria that were relatively similar to CHHP's in that they worked to house a homeless population that was also chronically, medically ill. Others had more general client criteria, but saw the populations as similar. For example, this executive director describes his client base as being all people who are homeless, but also sees his population as being the same as CHHP's: "Our mission and our business plan if you want to call it that, is housing people that are homeless and providing supporting service to stay housed, and the CHHP clients are exactly the people we would like to provide services to."

Agencies Receive Diverse Benefits

When asked about the benefits of participating in the CHHP program, organizational leaders cited a diverse set of incentives from increasing organizational capacity to the opportunity to act in a leadership role. Thus, the diversity of agencies and the scope of the CHHP program is crucial to recruiting and retaining agencies for the partnership because no single benefit would appeal to all of the organizations.

Filling a Service Gap

For the hospitals within the partnership, the CHHP program seems to fill a significant service gap. While hospital staff tended to see their role as stabilizing clients and getting them

ready for the next stage of their care, they expressed serious concerns about where homeless patients would go after their release. Before CHHP, hospitals had few options in terms of referrals for homeless patients. One hospital administrator said:

> Well, [CHHP has] become a very valued piece of discharge planning for our homeless population. If we didn't have it I believe we'd go back to where we were pre-CHHP where most of our patients were going to shelters, even those who were too sick to go to shelters had substance abuse issues or Interfaith House was full, so they'd end up staying with us for months. Sometimes they'd end up being placed in the best place we could provide, which often meant just a plain old shelter.

Even if hospitals had programs to discharge patients to transitional housing to shelters, the ability to offer patients a path to permanent or stable housing was new and an important addition to their social work. Hospital staff recognized that stable and, eventually, permanent housing was much more appropriate for sick patients and were excited that they could provide that opportunity through CHHP. When asked about the benefits of participating in CHHP, one hospital administrator said:

> I would say, speaking on behalf of the social workers, that they are, they feel they can sleep much better at night knowing that our patients are discharged to a more medically appropriate environment. So many of our patients are so ill and to know that our patients are going to a shelter where they have to spend their days on the street really made them angry. So to know that half our patients are going to better housing than they would have normally is nice.

While hospitals may have been historically interested in tapping into housing programs in the community, they didn't have the resources or expertise to do so before CHHP. Most hospital staff that we interviewed said that they had benefited from the new relationships they had developed with the housing community and that their referral abilities had really increased. Some also indicated that having a case manager that focused exclusively on homelessness was a very valuable resource for both their clients and their other staff. Thus, CHHP has not only increased hospitals' level of service within the CHHP program, but is perhaps also increasing

their capacity to serve non-CHHP clients as well by increasing awareness of and relationships with outside resources.

Expanded Capacity

Many organizations cited increased organizational capacity as a key advantage to their participation in the CHHP program. Additionally, CHHP seems to help agencies increase their capacity along many variables including services, client populations, organizational knowledge, and funding.

- *Services*. By participating in CHHP, organizations are able to explore new programming opportunities. Some organizations said that CHHP allowed them to add scattered site housing to their programs. Others said that they had improved their referral relationships and increased their referral and resource databases through CHHP. Additionally, working with diverse agencies with a variety of criteria or programming allowed organizations to continue helping clients, even if they didn't work out in their own programs. The program manager from one organization said: "If someone isn't working out here, and really requires a higher level of care, we can talk to the CHHP people, we don't have to evict, we can get someone moved into the appropriate placement."

- *Client Populations.* Another way to increase organizational capacity is to broaden the range of clients served. One organization mentioned that CHHP had expanded their client base by connecting them with HIV negative clients: "as an agency we had no other

programs that work with non-[HIV] positive clients and that was new for us. That was a challenge getting them connected to services outside of the HIV realm."

Additionally, the CHHP program encouraged agencies to work with substance abusers through the harm reduction model and other clients who they may not have otherwise included in their programs. One agency staff person said that CHHP clients were different than her typical clients because they had even more challenges facing them (mental illness, physical illness and substance use). While organizations may find the experience of serving new client populations initially challenging, an expanded client base may eventually help open up new funding streams.

- *Organizational Knowledge.* Organizations also said that participating in CHHP had increased their organizational knowledge base. Many cited the trainings for CHHP case managers as an important source of new information for their agency. One program manager said, "Everything our case manager learns he brings it back to the whole organization." Especially in the area of harm reduction, agencies appreciated learning new techniques for serving clients. Some agencies indicated they wanted even more training for case managers.

- *Funding.* Of course, for many agencies, funding is a critical issue. Many program managers and executive directors cited funding benefits as a key reason to participate in the CHHP program and to stay engaged in CHHP. Some organizations cited the direct funding they received from CHHP for a case manager or other costs as beneficial: "It was nice to get a computer and to get some money. I thought that was valuable when I was a case manager and I know the current case manager finds it useful." Another program manager said, "For our

organization, being able to have a staff person dedicated to working with homeless patients [is beneficial]."

Other organizations cited the increased visibility for other funding opportunities as being a key motivator for participation: "I think being able to be identified in the partnership. Funders want to see you engaging in partnerships, so just being on the list as a partner was the most advantageous thing for us."

Leadership Roles

Some of the agencies saw CHHP as an opportunity to become a leader in the partnership and to inform other agencies of their work. This is an especially important benefit for small agencies in marginal communities who might otherwise not have the opportunity to network with large organizations or to take on leadership positions in collaborative partnerships. Staff from one Southside organization said:

> The collaborative benefit of CHHP has been very beneficial. CHHP is a huge project with a lot of partners doing a lot of things. It gave us the opportunity to tell other agencies about what we were doing. Sometimes on the south side we get forgotten but being able to sit at the table with the big agencies like the hospital and funders was a benefit.

A program manager from another organization indicated that his agency benefited from both being a teacher and a learner in the partnership:

> I think when it comes to, what benefits us is we do promote that we provide housing to homeless, the homeless population, what do we bring, our expertise to the table and on the other hand a willingness to learn and to grow.

Research Project

The design of CHHP as a research project was appealing to many agencies, as well. One agency staff person saw the research project as a way to push the organization in a more progressive direction:

> The two main things are one, participating in what we consider to be a very progressive approach to housing the homeless with chronic illnesses. To be able to be in a research project has been a stimulus to the agency to be more responsive and progressive.

Other agencies cited the ability to gather data at the same time that they were serving clients as an advantage. Many organizations were excited to see the final outcomes of the research project. One executive director said, "Obviously the fact that it was a research project was good because you learn about what you're doing." Organizations said that the more information they had about programmatic outcomes, the better they could serve clients and create better programs.

While the research project provided a large incentive to participate initially in CHHP, we and some of the agencies involved were concerned about what would happen to the collaboration when the research project ends. Will the organizations that saw research as a key benefit of the program realize enough other benefits to keep them highly invested in CHHP? How else could the program work to keep all agencies engaged and invested?

Lead Agency Level and Organizational tensions

As in any partnership, especially those with diverse partners, there are tensions within the CHHP system. At the third and final level of the CHHP design, executive directors and program

managers mentioned a variety of tensions that arose throughout the research project including issues of funding, clashing organizational cultures and problems with data coordination.

Funding Concerns

Several organizations indicated that funding for ancillary services would help them serve more CHHP clients and help them provide more complete services. The additional funding needs that they cited included administrative costs (administrative staff, fees for applications, etc.), as well as costs for furniture and other living necessities (beds, sheets, appliances, etc.). One organization said that without these funds they would not be able to take on significantly more clients despite their desire to expand this part of their services.

Organizational Culture Clashes

While most organizations reported that CHHP fit well into their existing programs, some indicated that their organizational culture clashed with CHHP or with the AFC as the lead agency. These organizational culture clashes were also relatively diverse. Some organizations were frustrated with what they perceived as a large number of meetings or an inordinate amount of time spent on process and planning. Other organizations felt that their programmatic decisions were at odds with the expectations of the AFC or CHHP. When asked about tensions in the program, one executive director said:

> … we are not as afraid to appropriately discharge people. And I mean appropriately, not just oh, they didn't do something, but after months of trying to work with someone and they're not willing to do what is necessary to be housed, they need to be let go. And I think sometimes AFC didn't get that. And our model is self-sufficiency, which is not about keeping homeless in housing; it's about helping homeless stay in housing by becoming self sufficient.

In addition, some agencies are coming from a public health model of service compared to a clinical social work model of service. Under the public health (hospital) model, all clients need

to be served regardless of their status, substance use, etc. While a clinical social work model is traditionally more restrictive and involves criteria that clients must meet in order to be served by an agency. We saw these organizational culture clashes in some of the SIT meetings where a hospital case manager would get frustrated with an agency because of their restrictions or inability to help a client.

Sometimes organizational restrictions were insurmountable. During the course of the study, we learned that Franciscan Outreach Association and CHHP chose to not renew their contract with one another. This occurred because Franciscan's lack of day programming and organizational set-up was not working out for CHHP clients.

Data Coordination Struggles

Finally, there were also tensions over data coordination within the CHHP collaboration. The FACTORS data system was a source of frustration at many levels because it was cumbersome and unreliable. Some organizations were never able to access the system so their case managers had to input data at the AFC offices, adding additional hurdles to their jobs and making data sharing difficult. Many organization staff also complained that, despite efforts to streamline paperwork, the CHHP intake and other forms were significantly different than their own, so their case managers had to fill out paperwork twice, doubling their paper-workload. In some cases, just getting forms from one organization to the appropriate person at another agency was difficult. The following incident occurred at a SIT meeting that we observed:

> CM1 wanted to move a client from Agency 1 into Agency 2, but there were problems with the application process. It sounded like she had faxed the application to Agency 2 almost a month before, but CM2 had just found it two days ago because it had been put in with the "regular" application process. CM2 asked that future applications for CHHP clients have CHHP written in big letters on them. CM1 said that she was transferring the client to an outside supportive housing program instead because he couldn't wait for the delay.

In this case, data coordination problems ended up deeply affecting a client and causing a referral to be made outside of the CHHP system. Streamlining these processes and improving computer systems would help alleviate tensions between agencies.

Flexibility and Transparency: A Solution to the Tensions

There were two key reasons why organizational tensions did not lead to a melt-down of the entire CHHP partnership system: flexibility in the system and transparency in decision-making processes.

The CHHP system proved its flexibility by its ability to adapt to the unexpectedly high number of substance users in its population by adopting a harm reduction philosophy, but the partnership was also flexible in other ways. As the needs of CHHP clients became clearer, the AFC was able to move funding around the partnership in order to provide the programs with the most in-demand housing with the most resources.

In other partnerships, this kind of funding diversion and reallocation may have increased competition between the agencies or added to organizational tensions. However, in CHHP, the decision-making processes were always incredibly transparent. The CHHP director was always careful to make decision-making processes open to the observation and critique of all of the partnership agencies. Also, decisions were made with clear, pre-determined criteria and always centered on the needs of clients and the best ways to serve them. Even when agencies left CHHP (either because funding was diverted into other programs or because they chose to cease participation in the project), it was on good terms. Indeed, former organizational members of CHHP were still invited to participate in planning and governance meetings in order to keep

them integrated into the system, even though they were not housing any CHHP clients or receiving CHHP funds.

Ownership

At every level, there was a sense of investment and ownership of the CHHP program. From the clients to the case managers to the agency heads it was evident that there was a real commitment to the program. This aspect of the program sets it apart from other experimental and multi-level projects.

Clients: CHHP provides a sense of belonging

Clients seemed to derive a strong sense of belonging from their affiliation with the CHHP program. There was camaraderie between clients, and also with the case managers. In fact, some clients even referred to it as a "family." For example, one client described her experiences by saying,

> It's like, uh, like a family setting that I get when I'm around them (yeah!), there's not that many of us who have a family setting when you can be with persons you've never met before in your life who have concern and are compassionate towards you…They try to teach us, to suggest us, with CHHP to be like a close-knit family, to be supportive of each other…

After this statement was made, other clients in the focus group expressed agreement. For some of these clients this may be the first experience in a long time that has allowed them to feel like they belonged somewhere.

Related to the idea that CHHP clients feel a sense of belonging from the program, it was also clear that their involvement with CHHP is strongly linked to their sense of identity. There appeared to be an "us" versus "them" mentality expressed during the focus groups. Clients perceived themselves to be different from non-CHHP clients. For example, some clients talked

about how there was perhaps resentment of CHHP-clients by non-CHHP clients because they had "special privileges," particularly at the Stage 2 facilities. In addition to the resentment that CHHP clients sometimes perceived as a result of being their own group, there was also a sense that CHHP clients felt in some ways superior to non-CHHP clients. For example, "CHHP people were encouraged to got to…be independent. But the people…not with CHHP hadn't even thought of getting a job. They didn't try to get independent." Another client said of the non-CHHP clients that "they were taking advantage of the system." It was clear from statements such as these that there was a sense of pride derived from their affiliation with the CHHP program.

For some of the clients, being involved in the CHHP program has resulted in profound personal change. One CHHP client talked about how he can go back to his old neighborhood and see his friends and they recognize a change in him. He says:

> You know I can go back to the old program, my friends see me, and they say what you doing, you are a totally different person, and I give them hope that they can change too. It's a whole different world out there; I just want to be an example for my friends. CHHP program changed me, I can change them too. I want to be an example for them. I show them it's the same me, I'm no different person, but I want them to see that they can change too.

There is a sense that this client, as well as others are not only changed but empowered as a result of CHHP. This is also evidenced by the fact that several of the CHHP clients are members on the Client Advisory Board. They are able to speak about their experiences and opinions and to be actively involved in shaping the CHHP program.

<u>Case manager: Support and identification with program</u>

CHHP case managers formed strong connections to the CHHP program and to each other as a team. Case managers talked about liking the program because of the model. They see the

success of CHHP as motivational and feel like they are doing more for their clients because of the streamlined CHHP processes. Also, case managers said that they liked CHHP because they didn't have to punish clients for "breaking rules," something they had been expected to do in other programs or positions. With CHHP, they felt like they could continue working with clients or, at the very least, find a client a more appropriate agency within the system. Smaller caseloads allowed case managers to have more intensive interactions with clients. For example, one case manager said that he took his client to the currency exchange every payday to help him cash his check and pay his bills. Another said that he fills a client's pill case every week to help him remember to take his medications.

Case managers saw themselves as a team and working as a team was crucial for clients moving successfully through the CHHP program. One case manager said that a benefit CHHP clients experienced was that there was a "team that surrounds you that's going to guarantee that you're not homeless unless you choose to be homeless, pretty much." Another case manager said:

> I just think for the individual clients that it's really important that we exist as a team and that we have these meetings even though I know I dread them a lot and I think everybody else does too. But I mean the clients are really individualized through this process or we see them as individuals and so there's a continuity of care between, ok, if they relapse or go back into the hospital from a medical reason, you know, I can work directly with the stage three case manager or whatever. Or if I enroll somebody I send them to [another case manager] I might have one perception about, oh yea, they're fine, they're going to do great, you know. But then after they stay there for a month or two, you know, they really can make a better assessment in terms of what kind of care and what kind of housing that person might need. So I think that's something that's unique probably to CHHP and it's important.

The sense of being part of a team is clearly reinforced by the weekly SIT meetings. In these meetings, case managers get to work together to house clients, but also get to work through

emotional issues regarding their work, find support with others who understand their situation, and learn from each other's experiences.

Program and Executive Directors: Less contact

Program managers also recognized the SIT meetings as important sites of training and support for their case managers. However, program managers and executive directors did not meet as regularly with each other as the case managers did and their level of identification with the CHHP program reflected that relative lack of contact.

For many program and executive directors, CHHP was just one of several programs in their agency. The exception to this was those executive directors who were involved in the original planning and formation of the partnership. Among those executive directors, there is a strong sense of identification and pride. One executive director said of CHHP:

> Because I was in from the very beginning and the planning, I don't think I ever fully imagined what this could become because I hadn't ever done anything like this before. It's a wonderful group. I've never been involved with something this successful that we've built from the ground up.

CONCLUSION

The key hallmarks of this project are an innovative system model and a strong fidelity to a housing first model. We have found that both these approaches have been successful from the perspective of the clients, the street level service providers, and the participating agencies. However, the collaboration of diverse agencies and maintenance of fidelity to the model also present unique challenges which we have explored in this report.

The CHHP program was designed as collaboration between existing organizations and agencies as opposed to the creation of a new agency. At the same time, its goal was to go beyond traditional referral structures in which clients have to maneuver between different points, to a

comprehensive and effective system. We found that this model is beneficial for three main reasons: it reduces the likelihood of duplicating existing services; it draws on the historical experiences of existing agencies; and acts as a source of funding rather than increasing competition for funds.

Two key features promote the efficient function of this system: duality and flexibility. The lead agency aspect of its organization provides needed coordination of funding, resources, planning, and communications. The collaboration aspect between agencies provides a breadth of expertise, experiences, and service options. The dual "nesting" of case managers in the agency (where they are employed) and in the SIT team is important to the quality and comprehensive delivery of services to the clients. In addition, communication between agencies and within CHHP occurs at the dynamic street level of direct services as well as the administrative and governance level.

Flexibility has also been a hallmark of this project at all levels. When the pilot phase demonstrated the need for more harm reduction placements, the program was able to shift. The lead agency has been able to combine different funding sources and organizational resources to ensure housing of individuals with very diverse housing needs. The SIT case management system allows different approaches and services, again to the benefit of the diverse client base.

The CHHP system must be flexible in the face of continual environmental change. One example that was observed during the data collection period was CHHP's response to a new piece of sex offender legislation. Based on the new demands and restrictions relating to placement of clients who are registered sex offenders, CHHP had to learn how to adjust to this and how to prepare case managers to address these new challenges.

The experimental design of this demonstration project, which required fidelity to the housing first model, anchored this flexibility. As the project moves beyond a demonstration project, to a permanent system of service delivery to Chicago's homeless, CHHP must take special attention to address the complexities of serving this population with a housing first/harm reduction approach and maintain a strong commitment to housing first. The duality of the system model with its success in building a common approach and professional culture will be central to that effort.

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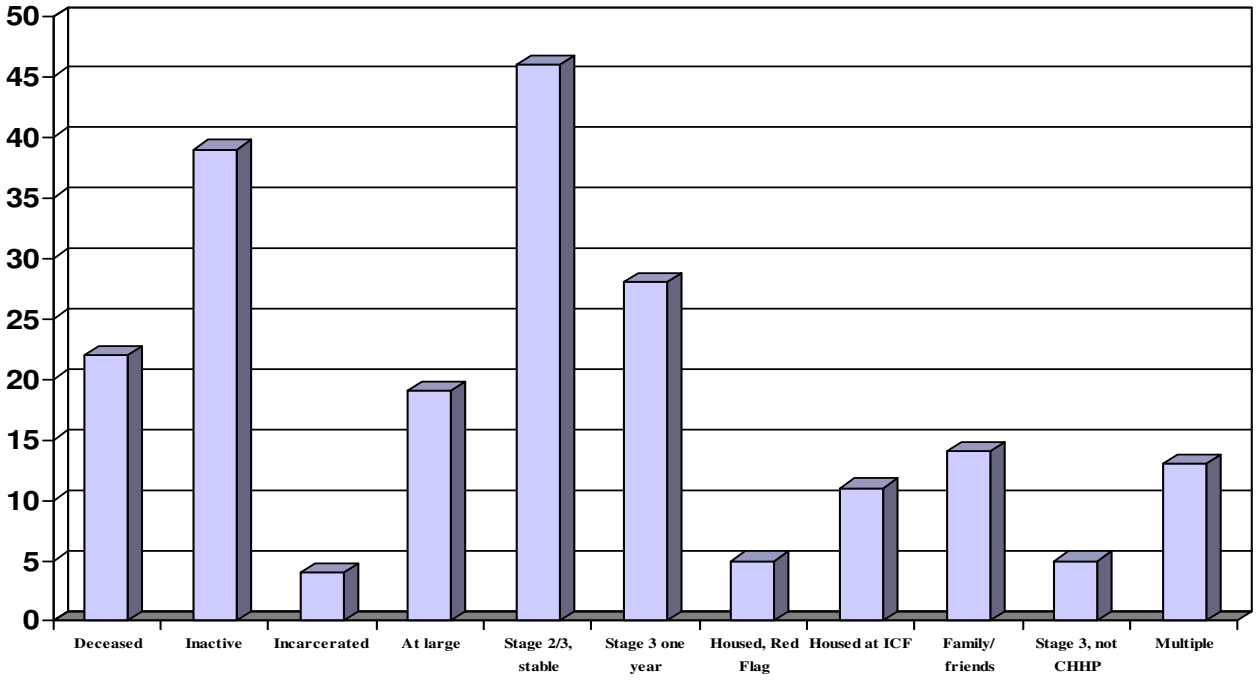
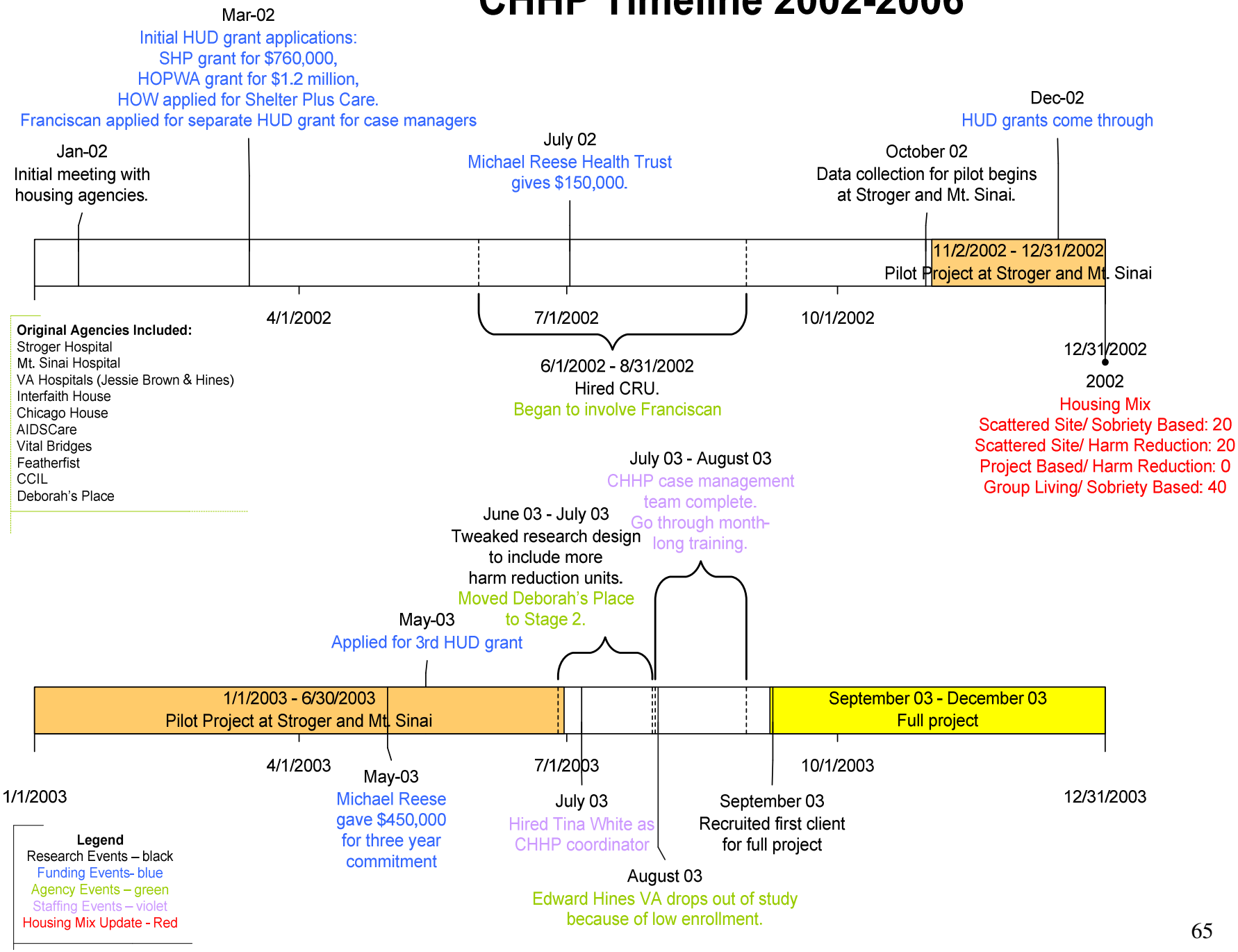
APPENDIX 1: CLIENT CODES



CHHP Timeline 2002-2006



CHHP Timeline 2002-2006