Connecting Fractured Lives to a Fragmented System:

A Process Evaluation of the Chicago Housing for Health Partnership

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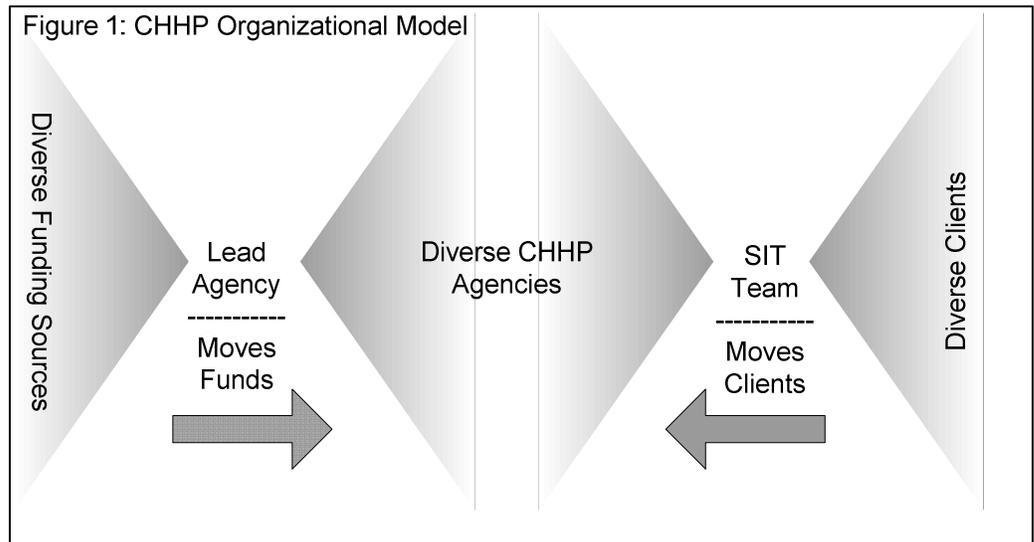
Introduction

This is a report of the evaluation of the Chicago Housing for Health Partnership (CHHP). CHHP was established in 2002 by a diverse group of health care, respite and housing providers. Its primary goal has been to better serve the needs of homeless individuals with chronic medical conditions through the building of an innovative model of service integration. In addition, CHHP's model includes rigorous testing of the system with the ultimate goal of informing national homeless policy. The partnership designed and initiated a three year demonstration project with an experimental design to test the model's impact on client heath and a cost benefit analysis of client's use of the health care system. Under this design, half of eligible participants were randomly assigned to a "control" group which received usual care. The other half, the "intervention group," received CHHP services. The Collaborative Research Unit (CRU) of the Cook Bureau of Health is conducting the outcome evaluation.

CHHP also wanted to document and evaluate the implementation of its model of service integration. CHHP, through its lead agency, the Aids Foundation of Chicago, commissioned Loyola University Chicago's Center for Urban Research and Learning (CURL) to conduct this collaborative research project. This process evaluation analyzes the key strengths and challenges encountered in implement-

ing the CHHP system. It is intended to both inform the strategic planning of CHHP partners as they move from an experimental demonstration project to more of an institutional system and to inform housing advocates and policy makers. It is primarily based on the perspectives and reports of key stakeholders including agency heads, program directors, case managers, consumers, and CHHP/lead agency staff collected through interviews, observations and focus groups conducted by the CURL researchers.

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.

Figure 1: CHHP Organizational Model

Diverse Funding Sources

Lead Agency

Moves Funds

Diverse CHHP Agencies

SIT Team

Moves Clients

Diverse Clients

The CHHP Model

A key function of CHHP is systems building. A chronically medically ill homeless individual has to negotiate multiple systems to secure health care, shelter and other necessary services. CHHP aims to provide a seamless system, in which the hospitalized individual moves from discharge planning to respite care to permanent housing. CHHP's mission of housing the chronically medically ill homeless is accomplished through two overarching processes: coordination of intensive case management and co-ordination of resources for providers. These proc-esses are translated into two key structures: the sys-tems integration team (SIT) and CHHP's governance model which combines a strong lead agency with a collaboration partnership model.

In short, CHHP works by funneling both funds and clients into centralized structures and then redis-tributes them to the partnering agencies. Figure 1 is a visual representation of these processes.

Lead Agency/Collaboration Model

CHHP is a synthesis of a collaborative partnership model and a lead agency model. The CHHP director and CHHP coordinator at the Aids Foundation of Chicago exercise a great deal of coordination and direction of the partnership while, at the same time, agencies give input into the program through a gov-ernance board and an oversight committee.

Under this model, the lead agency gathers funds from a variety of funding sources, including federal HUD grants and private foundation grants, and con-solidates/coordinates those funds at the AIDS Foun-dation of Chicago (AFC, the lead agency). The AFC then distributes the funds to the CHHP collaborative agencies. In addition, the lead agency assisted part-ner agencies in applying for their own funding

streams for CHHP services.

The Systems Integration Team (SIT)

The Systems Integration Team (SIT) consists of case managers from the three stages of care (hospital, interim housing and permanent housing) and the CHHP coordinator. The SIT works together to move diverse clients from hospital discharge into housing with appropriate agencies (see Appendix A):

Stage one 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 eligibil-ity.[1]

Stage two agencies are temporary housing loca-tions for clients while they await an opening and placement in stage three. 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 clients.

At **stage three**, clients receive a permanent hous-ing placement in a scattered-site, private apart-ment or in an agency-based building.

CHHP case managers from all partner agencies meet weekly to review CHHP client service needs and progress, contact each other between meetings and maintain common data and record keeping. One important feature of the SIT is that CHHP case man-agers are employees of partner agencies (rather than the lead agency or CHHP). In contrast, the CHHP coordinator (who is in charge of overall client track-ing) is employed by the lead agency.

Intensive Case Management

CHHP provides support services that assist clients from hospital discharge to obtaining stable housing and then provides assistance as needed to the perma-

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[1] Eligibility criteria included having no stable source of housing for the last month and having at least one chronic medical condition that normally increases mortality and morbidity among homeless individuals or the general population.

nently housed clients. Key to the provision of these services is the CHHP case manager. The CHHP case management model operates with an intensive case management approach, including a low client-staff (10:1) ratio, individualized approaches to housing and service provision, and interventions offered in non-traditional settings, such as clients' homes or neighborhoods.

Housing First and Harm Reduction

According to the Housing First model the underlying causes of homelessness can be best addressed once a individual is housed. Given that goal, a significant portion of the housing that is available should be designated as harm reduction, that is, the housing should not require abstinence of substance abusers before they are permanently housed.

Methodology

We began by asking the following questions:

- How does the CHHP program work as a system?

- What are the strengths and challenges as it is designed?

- What are the outside influences that affect the system?

- Could this be a model for other homeless programs or inter-agency collaborations?

In order to answer these questions, we employed a multi-method approach, which involved personal interviews, focus groups, document analysis and observations and which took place at three key levels: street level (clients and case managers), agency level (case managers and partner agencies), and lead agency level (agencies and key lead agency staff). Specifically, we conducted

Client Characteristics*

Medical conditions:

HIV/AIDS	35%
Hypertension	34%
Congestive Heart Failure	16%
Asthma	15%
Diabetes	10%
Cancer	5%
Seizure Disorders	4%

Racial/ethnic groups:

African American/Black	79%
Hispanic/Latino	7%
White	7%
Other race or ethnicities	7%

Gender:

Male	74%
Female	25%
Transgendered	1%

Age:

Range	21-82
Median age	47

*Data accurate as of March 1, 2006.

three focus groups with a total of 29 clients 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 SIT meetings.

Findings

Our findings fit into seven key areas: the SIT model, intensive case management, impact of CHHP on the clients, capacity expansion, harm reduction, lead agency/collaboration model, and unexpected/outside influences.

The SIT Model

There is a high level of teamwork and coordination between CHHP case managers from the partner agencies.

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.

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 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 pro-

"Just being able to get emotional support and understanding from the people around the table on an informal basis since we're all going through the same program together and trying to get the same thing to work has been really valuable to me."
- CHHP case manager

fessional 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.

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.

The CHHP coordinator role is 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.

The computerized record keeping system plays an important role in information and data exchange on clients, but it is not sufficient.

Tensions over data coordination existed throughout the CHHP collaboration. A computer program called FACTORS was made available to all agencies to capture data about CHHP clients, however it was unreliable and agencies often lost data due to program crashes. FACTORS was then made available as a web-based system, but not all agencies could effectively access it. One agency even had to send their case manager to the AFC to enter data. According to CHHP administrators, many of these issues have been resolved, although resolving them took a significant amount of time and effort. Agencies were also frustrated with the data management because case managers often had to fill out two separate systems of paperwork: one to satisfy agency needs and one for CHHP.

Having hospitals as recruitment facilities is important to the overall model.

CHHP staff reported that recruiting at the hospital resulted in a wider breadth of clients than is normally seen in respite transitional housing. Clients identified the value of connecting to services and case-management within the hospital. The stage one case managers brought an important public health perspective into CHHP which reinforced the Housing First model.

Intensive Case-management
There is a great deal of complexity in and diversity of client engagement patterns.
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, 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.

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. When clients miss appointments, or when they cannot be reached for long periods of time, this slows the process. One case manager expressed concern about a particular Stage 3 agency requiring three separate interviews, and stated, "There's so many hoops, you have to have your state ID, you have to have your social security card, you have to have your birth certificate…."

Many clients became disengaged several times before moving into stable housing. Others moved back and forth between stage two and stage three agencies, sometimes several times. In some cases,

clients go through up to ten different iterations of engagement, sometimes ending in them being black-listed 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. 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.

Getting and keeping clients placed is a major challenge
While there are undoubtedly challenges involved in *placing* clients in permanent housing, what sometimes may be even 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, common client conditions jeopardized their ability to keep permanent housing. These conditions included a history of substance abuse or active use, ongoing mental illness, disruptive or violent behavior, and allowing unauthorized people to stay at the apartment.

A final note on the issue of the tremendous diversity of CHHP clients is that their situations are not static. Just like anyone else, and perhaps even more so, the lives of CHHP clients change. One

"It's easy...to become lonely when you've been in shelters and rehab facilities for a year. You can become lonely and depressed quickly, but my case manager sees me every week, and I go to AA and recovery meetings every week... and I think the intensity of the services is really valuable."
— CHHP client

client talked about how since joining the CHHP program, she has gotten married. She expressed concern that the program has not worked 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 in his life. The client allowed his wife to move in, but then he passed away, leaving the agency to figure out what to do with the woman (not a CHHP client) who was living in the apartment. CHHP policies should take such life-changes into account.

Clients' reports of their interaction with CHHP reflect the effectiveness of the intensive case management approach.
The CHHP model employs a very intensive model of case management. Client comments demonstrate the effectiveness of this approach. Clients see case managers as advocates who are dependable and responsive. Many echoed the statement made by one client who said that "they practice what they preach." Clients also said that they valued the fact that case managers "kept their word." Many of the permanently housed clients' stories of success present the case manager as a "life coach" helping these clients strategize, with personal interactions being tailored to each individual. All reported that case managers were supportive and respectful.

Impact of CHHP on Clients
In listening to the clients talk about their experiences

with CHHP, it is clear that overall they see it as a very positive program:

CHHP is viewed as a program that provides respite.
In focus groups, clients provided numerous examples of the value of being more able to cope, of not worrying, of the housing being a place from which to move forward and/or to find refuge and privacy. All clients offered examples including social, emotional and economic support. As 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.

Clients valued this opportunity to let go of some of their day-to-day housing and shelter concerns so that they could concentrate on their own health and well-being.

CHHP is seen as successful in providing resources
Almost unanimously the response was that CHHP made it easier to get connected with a multitude of services. The ease of connecting to a variety of resources was seen as a benefit of the CHHP program. For example, clients explained that case managers would find other services for them and in some cases even make appointments or arrange transportation for them. One client commented, "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."

CHHP provides a strong sense of belonging.
There was camaraderie between clients that was also seen 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 to us, with CHHPs 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. Clients identify with and receive an identity from CHHP. They talk about being a "CHHP" person. Many said they wanted CHHP to be its own program. In fact one client stated "I wish CHHPs [sic] would go nationwide." Other clients nodded their heads and expressed agreement.

Clients present CHHP as a transformational experience.
Clients talked about being valued and empowered through CHHP. Many gave examples of the respectful manner in which case workers interact with them. CHHP combines autonomy and respect to the individual with support and help. Through CHHP, clients became more future-oriented. 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. Another talked about being able to house his children, another about being sober, another about controlling his temper. One client saw CHHP as an

opportunity to serve as a positive role model,

> 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...

Being a part of CHHP changed the way clients thought of themselves.

Clients see some room for improvement.

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 including more geographic diversity in housing, with some clients wanting to be near family or friends. Other clients mentioned needing assistance with providing furnishing for scattered site apartments. 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. Another area in need of improvement was that clients expressed the need for more second stage options.

Capacity Expansion Needs

There was limited inclusion of non-English speakers in CHHP.

While the model included provisions for English and Spanish-speaking clients, there were fewer Spanish speakers eligible for the program than originally expected for reasons that remain unclear. However, there were other language groups who could not participate in CHHP despite their eligibility and need. For example, CRU data showed that there were five Polish-speaking clients who could not participate in the CHHP project because of language barriers. In addition, hospitals may have not actively recruited patients from other language groups because of the lack of translation services.

Capacity could not easily meet demand at Stage 2 Respite Housing.

Many clients were not housed in Stage 2, but instead utilized other alternatives, such as staying with relatives or friends. Some of this was due to personal preferences of clients. For others, stage two facilities didn't meet their particular needs.

Almost unanimously, clients expressed discomfort in staying in emergency shelters that did not have a 24-hour residency option. While the one respite care facility received very favorable comments from clients, case managers and administrators, it was difficult to house all clients who needed respite care at that facility. In particular, a lack of harm reduction slots at stage two leads to the need for alternative arrangements for substance users. This can be problematic especially for those substance users whose health is significantly compromised.

In addition, the most commonly utilized Stage 2 agencies have limited beds specifically for women. There are also unique concerns for women's sense of safety and comfort, particularly for those women who have a history of sexual assault. While one stage two agency is exclusively for women and CHHP clients are given priority on their waiting list, the low turnover rate of that agency severely limited availability. Since 25% of CHHP clients are women, the lack of women-oriented options is problematic.

At Stage 3, available housing options do not always match client profiles.

CHHP clients are housed in permanent housing on average within 76 days. As is the case during Stage 2, there are many challenges faced by clients and

agencies in finding that housing. CHHP agencies face many challenges in finding an appropriate match between housing that is available at a specific time and the needs of the client. For example, an agency may only have the funding to provide placement for clients who are HIV positive, making it more difficult at times to find a Stage 3 agency for someone who is *not* HIV positive. Also, some CHHP clients are sex offenders, which limits where these clients can be legally placed. This has become an increasing problem because of new Illinois legislation that was effective this past year (as discussed later). In addition, client substance use statuses and needs differ. While some clients respond better to scattered-site housing, others are more appropriately matched with a program-based facility. Also, physical and mental health needs differ. For example, some facilities are not ideal for people with limited mobility. Finally, clients may have a strong preference to live on the Southside, when housing is only available on the North side at that time. Geographic preferences may be based on racial or ethnic group, location of family or friends, or familiarity.

Harm Reduction

Harm reduction is integral to a housing first model.

Initially, CHHP included limited options for substance users, but as the pilot progressed, it became apparent that the vast majority of clients needed some form of harm reduction program. In order to adhere to a housing first model, in which clients are housed regardless of their other circumstances, there must be adequate harm reduction units available in the CHHP system.

There were varying agency responses to and experi-

ences with harm reduction.

For those who already employed harm reduction principles in their agency, CHHP was a chance to expand their work and share their expertise with other agencies. For other agencies, it was an opportunity to expand into different housing options and funding streams. For example, some agencies had never worked with harm reduction before and, while harm reduction housing was challenging, they found that their diversified capacity helped them better serve clients and may eventually make them more eligible for new funding opportunities.

Related to these varying responses and experiences there are different understandings of harm reduction among partner agencies. Our interviews with executive directors and program managers, and program staff indicated that there were many different ways of talking about harm reduction. Some 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. Others see harm reduction as a series of case management tools (system of change, motivational interviewing) that they can use in many ways and the issue of substance use is secondary or not mentioned at all. For example, one agency program manager said that he had started using motivational interviewing as a management technique with his staff. In some cases, staff explicitly used the harm reduction tools to motivate clients to become clean and sober.

These differences in perception of the harm reduction model become especially apparent when staff members describe success stories from their agency:

- Some program managers defined success as clients who had been permanently housed for a long

time;

- Sometimes success explicitly meant housing someone for a long time *while they were using alcohol and drugs*;

- Sometimes success was measured by "small changes" such as building trusting relationships;

- For other program managers, even under the harm reduction model, success was clients becoming clean or sober.

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.

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.

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.

Lead Agency/ Collaborative Partnership Model
CHHP prospered because there were dedicated and skilled individuals who combined professional expertise, advocacy and relationship development.

Leadership was crucial on many levels. Key leaders helped garner funding, built relationships and guided the collaboration on key decisions. Without this

commitment, a collaborative agency partnership will not work. For example, one agency director said, "In the person of [the CHHP director], it has been perfect. [He] has been an incredible leader on that partnership. He's very knowledgeable, I don't think it would have gotten as far as quickly or accomplished what it has accomplished with out him."

CHHP combines the centrality of a lead agency with the diverse resources and expertise of the partnership agencies.

This duality was important to the success of the model because it provided balance within the governance of CHHP. Because the lead agency was able to control most of the grants for the CHHP program, funding could adapt to changing situations with agencies and clients. For example, in order to serve more clients with substance abuse needs, the AFC could divert funds from sobriety-based programs to harm reduction based programs quickly. In addition, the diversity of agencies was a true asset to the program, as one program manager commented, "There's been some good relationship ties. There's been a very deep and rich resource bank with the CHHP program. … We survive by sharing our resources." Some agencies had expertise in specific areas, such as harm reduction. Staff at one agency said, "We lend ourselves more to helping out other agencies where they can piggyback

"You need one point of contact. One source of information. I don't think we'd be in the same position in terms of even getting funding. They have great relationships with foundations... It's possible that we could have gotten that on our own, but I think the AFC's relationships with them were crucial."

- Agency staff

off of what we do being that we're harm reduction and they aren't [necessarily]." One of her colleagues also mentioned, "We have already worked with two of the other agencies. One has come out and shadowed us on our home visits because of that they expanded into to doing harm reduction." In this way, agencies were able to benefit from others' expertise.

CHHP is very flexible.

On a number of different levels, CHHP's approach to implementation and operations has been very flexible. During the implementation of the pilot it became clear that more harm reduction housing was needed. Agencies with harm reduction programs were able to increase their involvement while other agencies initiated harm reduction programs for the first time. In a three year period, the percent of harm reduction housing available through CHHP went from 25% to almost 85% of total housing units. In addition, public and private resources were shifted between partners to match funding parameters, program needs and maintain model fidelity. For example, HUD funding was only available for case management at the homeless/housing partner agencies. Funding from private sources was utilized to cover the outreach and recruitment work of hospital case managers. At the street level, a client who could not be successfully housed with one agency could easily be moved to another agency to better address that client's circumstances and needs.

The lead agency in CHHP was not a provider agency and, therefore, did not add to the competition over resources.

Social service provision is dominated by the need for funds. Agencies often find themselves competing with each other over limited funding sources. CHHP seeks to work with agencies strategically, rather than competitively, to find and direct funding. Since AFC was not a provider agency, it was able to more efficiently administrate the program.

Diverse Incentives for Participating

Organizational leaders cited a diverse set of incentives to participate in the program. These included:

Fills a Service Gap at the Hospital Level

For the hospitals within the partnership, the CHHP program fills a significant service gap. As one hospital staff person said, "It has also made me more aware of the programs, and resources that are out there. We had always been interested in them but we didn't have the resources to access them, now we have been able to access." Another hospital administrator said, "[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." 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. CHHP helped them help their patients.

Expands Organizational Capacity

Increased organizational capacity was seen as a key advantage to agency participation in the CHHP pro-

gram. CHHP helps agencies increase their capacity along many variables including services, client populations, organizational knowledge, and funding.

Increased Services

Organizations were able to explore new programming opportunities such as scattered site housing and harm reduction programs. Others said that they had improved their referral relationships and increased their referral and resource databases through CHHP. Additionally, partnering 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.

Diversify Client Populations

Another way to increase organizational capacity is to broaden the range of clients served. CHHP expanded client bases and 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. 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.

Expanding Organizational Knowledge

Many cited the trainings for CHHP case managers as an important source of new information for their agency. Heads of agencies appreciated learning new techniques for serving clients. Some agencies indicated they wanted even more training for case managers.

Expanding Funding

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. Other organizations cited the direct funding they received from CHHP for a case manager or other costs as beneficial. Still others cited the increased visibility for other funding opportunities as being a key motivator for participation.

Allows engagement in Leadership Roles

Some 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. One agency program manager said, "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."

Facilitates participation in a research project

The design of CHHP as a research project was appealing to many agencies as well. 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. Organizations said that the more information they had about programmatic outcomes, the better they could serve clients and create better programs. In addition, they cited the project as a way that their work would have a voice in the national policy discussions on homelessness.

Organizational Tensions

As in any partnership, especially those with diverse partners, there are tensions within the CHHP system. While the case managers were generally positive and excited about the CHHP program, the executive directors and program managers in particular mentioned a variety of tensions that arose throughout the research project including issues of funding, clashing organizational cultures and problems with data coordination. These concerns included:

Funding Concerns

Several organizations indicated that funding for ancillary services would help them serve more CHHP clients and help them provide more complete services. CHHP clients within certain agencies felt this lack of funding and also in talks with each other, identified the inequality of resources between agencies. 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 agency reported that if CHHP offered them additional units, they wouldn't be able to take them on without some kind of administrative compensation.

Organizational Culture Clashes

While most organizations reported that CHHP fit well into their existing programs, some indicated that their organizational culture clashed with the CHHP model or with the AFC as the lead agency. For example, under the public health philosophy that guided the hospitals in CHHP, all clients need to be served regardless of their status or substance use. A clinical social work model is traditionally more restrictive and involves criteria that clients must meet

in order to be served by a particular agency. We noticed this especially amongst the case managers in SIT meetings. Hospital case managers were often frustrated by the slow pace of getting clients into housing or exasperated by agency criteria that clients had to meet.

Differing project implementation between first stage hospitals

There were three hospitals partners: Jesse Brown Veteran Administration (VA) Hospital, Cook County's Stroger Hospital, and Mt. Sinai (a private hospital). Jesse Brown had more challenges implementing the project than the other two hospitals. This resulted in much lower client participation in the project. Some of the difference in participation can be attributed the length of the VA's Institutional Review Board process (administered by the University of Illinois at Chicago), which delayed both the pilot and the full project. However, more pertinent were the organization of the Jesse Brown VA's social service system and the lack of funding to provide an in-house CHHP case manager who could become an integral part of the CHHP system. In contrast, the other two hospitals each had a dedicated case manager. At both Stroger Hospital and Mt Sinai, there is one centralized social service department responsible for all homeless (as well as other) patients. At Jesse Brown, a number of relatively autonomous

"We had the benefit of having some landlords, but we have been working with new landlords because of the growth of CHHP and they have a tough time working with the, let's call it the CHHP activity [drug activity]."

- Agency staff

social service departments serve different categories of VA patients. In addition, private funds were not available to underwrite the cost of a federal employee to recruit CHHP clients at the VA. Rather, the Stroger case manager conducted outreach at the Jesse Brown VA, but did not have the connections or authority of in-house staff to work within its complicated social service system.

Unexpected and Outside Influences

We found three influences that were either unexpected at the onset of the pilot project or that originated outside of CHHP.

The target population for CHHP included many more substance users than initially expected leading to a greater need for harm reduction.

Originally, the program design was based on experiences at Interfaith House, which is a sobriety-based interim housing facility. Because Interfaith House includes sobriety as a condition of housing, they were unfamiliar with the large proportion of substance users in the target population. The pilot, therefore, fulfilled its purpose by allowing the CHHP program to adapt to this unexpected reality.

Landlord burnout was a major obstacle to implementing a scattered site/harm reduction program.

Agency staff and directors repeatedly cited trouble recruiting and maintaining landlords as a key challenge of implementing the CHHP program. When

asked about her biggest challenges, one program manager said:

> Locating additional housing, and landlords. Every time we have crises it damages our credibility. The housing provider must be a part of the equation, he has to be taken care of, maintain the unit, make sure it's not damaged. If not, our word becomes tainted.

Another agency staff person told a story about working with one landlord with whom they'd had a long-standing relationship for their agency's non-CHHP clients. When a CHHP client was placed in one of the landlord's apartments, and continued using drugs, it created so many problems for the landlord that he refused to work with any of the agency's clients in the future. Thus, landlord burnout can have negative effects that reverberate through an agency, affecting CHHP and non-CHHP clients alike.

Sex offender legislation limits housing options for affected CHHP clients.

The sex offender registration act in Illinois was amended as of January 1, 2006, to restrict child sex offenders from living within 500 feet of a school, a playground, or a facility providing programs or services directly to persons less than 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. If the number of sex offenders entering CHHP increases, as perceived to be the case by the case managers and CHHP coordinator, this population will need specific attention after the research project phase ends.

Analysis and Recommendations

In this section we make recommendations which are based upon our findings about the CHHP model and collaboration. We recommend that any future CHHP program needs to consider the following issues:

Coordination of the CHHP system

Weekly meetings of agency staff from across a large city such as Chicago presents a sizable allocation of organizational resources. They are however, well invested. The weekly SIT meetings were essential to the success of CHHP. The SIT meetings helped the case managers do their job and ultimately helped clients in four ways:

1. *Identification with program* -- The case managers at SIT saw themselves as part of the CHHP team and, given the diversity of clients' housing and support service needs, working as a team is crucial for clients moving successfully through the CHHP program;

2. *Professional development and a common understanding of the CHHP mode* — Keeping everyone focused and moving toward the goals of the overall program is critical for the fidelity of the CHHP model in that there is a common CHHP practice;

3. *Emotional/job support* -- In the weekly SIT meetings, case managers 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;

4. *Smooth communication and feed-back both among case managers and between case managers and the larger CHHP system.* Not only does the weekly meeting prevent clients from "falling through the cracks" it also insures that

case managers' street level experiences are easily assessable and communicated to the larger CHHP system.

Continue and enhance coordination of the CHHP system.
Any future CHHP model should include frequent and regular SIT meetings.

The role of the SIT coordinator

The SIT coordinator plays a critical role in this system. The role includes experience with the homeless system; the skills and background to provide and facilitate peer mentoring relationships among case managers; and the ability to facilitate rather than command activities among case managers.

The centrality of the coordinator role in overseeing clients and their case management should be included in any future CHHP models.

Case management practices, staffing and resources

Client engagement in CHHP is complex. Keeping clients engaged in CHHP is not easy. In order to be ready to move into housing, the client has to be able to make appointments, get paperwork together, and so forth. Clients are diverse and they will have different levels of needs in keeping engaged. When clients miss appointments, or when they cannot be reached for long periods of time, this slows the process. All of the challenges are faced by the clients and case managers together. Without the intensive case management, these challenges may be insurmountable at times.

Keeping clients housed at Stage 3 is especially difficult. For example, all of the problems discussed

in keeping clients housed: active substance abuse, non-compliance with lease agreements, and unacceptable behavior, lead to tension arising between landlords and Stage 3 scattered site agencies. 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 or non-CHHP clients in the future. The difficulties of Stage 3 become cyclical: the more difficulties in keeping clients housed leads to more difficulties in placing clients. This requires negotiation and relationship building with landlords on the part of the case managers. It requires that the case managers are very aware of what is going on with their clients so they can prevent and troubleshoot these types of problems.

Continue intensive case management with the current low client-case manager ratios and flexible interactions.

Case managers need to be able to reduce the diverse day-to-day concerns of clients. Case managers often can provide everything from clothing to transportation to help with cashing checks and paying bills. This is helpful in keeping clients housed. Yet some clients seem to have more access to resources than others. Because CHHP participation is an identity marker for CHHP clients, they often discuss the program when they meet in groups. During these interactions, they realize the disparity in resources available to them.

The lead agency should coordinate and explore ways of enhancing resources that case managers need for their clients such as money for household items and day-to-day living expenses.

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System of client recruitment

Hospitals often have complex organizational forms. The different recruitment experiences between the Jesse Brown VA and the other hospitals in the program point to some of the challenges inherent in mobilizing the hospital system and connecting with homeless patients before their discharge from the hospital. A dedicated in-house system of client recruitment to CHHP is necessary at each first stage partner hospital.

Recruitment at hospitals should be staffed by a hospital employee who can both mobilize the community within the hospital and be an integral part of the CHHP SIT system.

Client's permanent engagement in CHHP or "Once in CHHP, Always in CHHP?"

In speaking with clients, some expressed a belief that once they were admitted into the CHHP program, they could be in it forever. Other clients did not know how long they would be a part of it. There seems to be unclear communication to clients about their futures in CHHP. A related point is that there is no clear articulation regarding an exit strategy. If clients are eventually going to be moved out of the CHHP program, what is the process for this? If clients need to re-engage, how will this be done? How to handle an exit strategy is a very complicated question and one that has no easy answer.

CHHP should conduct analysis and planning to develop an engagement/exit model for 3ʳᵈ stage CHHP participants.
Subsequently, CHHP should communicate the extent and limitations of the program to clients.

Stage 2 and stage 3 capacity

Many agencies mentioned landlord burnout as a significant hurdle to housing CHHP clients, especially those who were active substance users. 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 and evicted CHHP clients also hurt established agency relationships with landlords. Some agency staff expressed a desire for the AFC to help them find landlords to work with CHHP clients.

CHHP should help agencies find and keep private landlords. Agencies may benefit from assistance or training in recruiting and retaining landlords. In addition, the project may consider establishing CHHP housing developers as part of the SIT team, who could either be housed at the lead agency or shared by partner agencies. CHHP could also consider offering workshops or trainings aimed at landlords to help them work with CHHP clients, perhaps boosting both landlord recruitment and retention.
It is crucial that CHHP keep a mix of harm reduction and sobriety-based options available for clients. As seen in the diversity of clients and their CHHP experiences, no single option works for all.

The Stage 2 interim housing options were not sufficient for clients.

Stage 2 housing options should be expanded by recruiting new interim housing agencies to the partnership as well as increasing capacity at current Stage 2 agencies.

There may be clients in the target population who have diverse language needs.

CHHP should assess the language needs of their target population and expand translation capabilities if necessary.

Harm reduction programs

Throughout this research project the issue of harm reduction was prevalent. Initially, the CHHP model had not anticipated such large numbers of substance abusers in their target population. Once it was determined that most CHHP clients needed a harm reduction model in order to be stably housed, CHHP responded to that need by adjusting its program and funding. Several CHHP organizations that had previously been sobriety-based rose to the task by exploring and adopting harm reduction programs. However, including agencies with diverse perceptions of the harm reduction model could pose problems for the more established 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, perhaps the overall model is flexible enough to include 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. This model could work positively to serve the needs of a diverse CHHP client population.

Provide more training and education about the value of harm reduction using client experiences.
CHHP should determine what is an acceptable range of philosophies for harm reduction, continue discussing and monitoring fidelity to the harm reduction model, and ensure that an accessi-

ble mix of housing, both harm reduction and abstinence, is available to meet the varying needs of clients.
Expand harm reduction housing slots while maintaining a mix of housing options.

People and leadership

The CHHP model prospered because there were dedicated and skilled individuals who combined professional expertise, advocacy and relationship development.

Especially given the volatility and fragility of funding for this population, the lead agency should continue providing strong, dedicated, active leadership, which is integral to maintaining and developing flexible partner agency involvement and funding strategies.
Continue lateral collaboration and governance structure.

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 directly to 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.

If the number of sex offenders entering CHHP increases, as perceived to be the case by the case

managers and CHHP coordinator, this population will need specific attention after the research project phase ends.

CHHP should consider various programmatic alternatives to address this problem, ranging from screening victims from aspects of the CHHP program to bringing in new partners who can house this population. In addition, CHHP may consider entering into advocacy or lobbying activities in order to change sex offender restrictions and ease the housing process for them.

The importance of a flexible learning model

By starting as an experimental model, CHHP has developed a learning culture, which can adapt and change to needs, as witnessed in the change to a stronger harm reduction approach and other modifications after the pilot project.

CHHP needs to continue its feedback and evaluation process. In particular, beyond identifying research questions needed in planning and policy, CHHP has to ensure that the data system in place easily and effectively captures information on clients' outcomes and engagement for future tracking and assessment.

The importance of the lead agency/collaboration approach

The duality of CHHP is one of its greatest strengths. By having a systems approach with a strong lead agency, resources are developed and coordinated, and clients can be served by the agency best able to meet their needs. At the same time, the strong governing role of agencies and the dual role of case managers (as both employees of their agencies as

well as linked to a common culture through the SIT) ensures the input and expertise of the agencies is put to its best use.

As CHHP moves beyond the demonstration project, it is important to provide opportunities for all partners to recommit, evaluate their participation, and envision the next steps for the partnership.

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, experi-
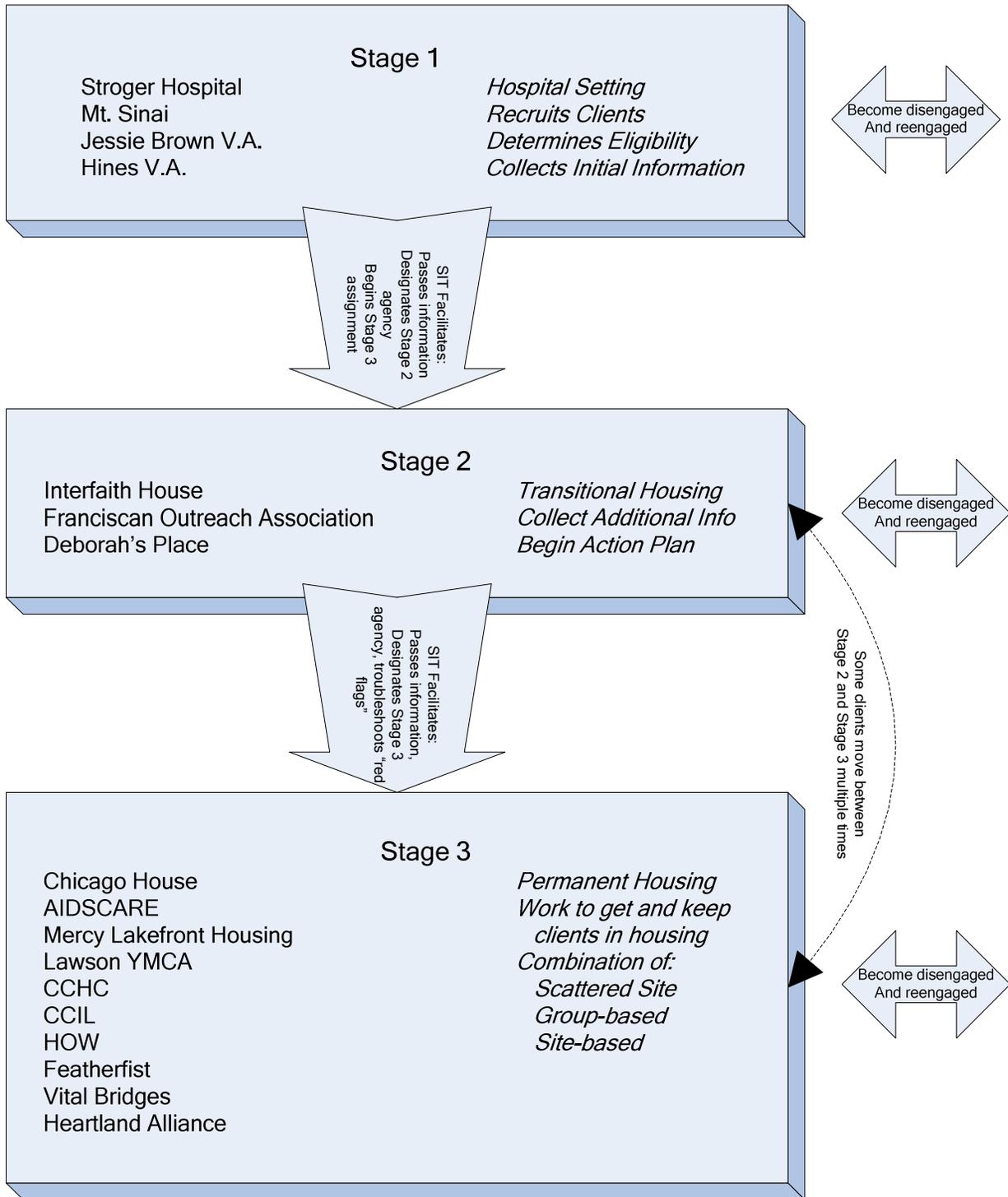
ences, and service options. The dual "nesting" of case managers in the agency (where they are employed) and in the SIT team is important to the quality and comprehensive delivery of services to the clients. In addition, communication between agencies and within CHHP occurs at the dynamic street level 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 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.

SIT Service Model:
Three Stages of Services, Facilitated by SIT team

Stage 1

Stroger Hospital
Mt. Sinai
Jessie Brown V.A.
Hines V.A.

Hospital Setting
Recruits Clients
Determines Eligibility
Collects Initial Information

Become disengaged
And reengaged

SIT Facilitates:
Passes information
Designates Stage 2
agency
Begins Stage 3
assignment

Stage 2

Interfaith House
Franciscan Outreach Association
Deborah's Place

Transitional Housing
Collect Additional Info
Begin Action Plan

Become disengaged
And reengaged

SIT Facilitates:
Passes information,
Designates Stage 3
agency, troubleshoots "red
flags"

Some clients move between
Stage 2 and Stage 3 multiple times

Stage 3

Chicago House
AIDSCARE
Mercy Lakefront Housing
Lawson YMCA
CCHC
CCIL
HOW
Featherfist
Vital Bridges
Heartland Alliance

Permanent Housing
Work to get and keep
* clients in housing*
Combination of:
* Scattered Site*
* Group-based*
* Site-based*

Become disengaged
And reengaged

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.