
# CLINICALLY-FOCUSED HOUSING NAVIGATION: SUPPORTING CONSUMER CHOICE IN A COORDINATED ENTRY SYSTEM

Presenter: Andrea Dakin

Co-Authors: Nora Bouacha and Nick Starkey

200 W MONROE ST. | SUITE 1150 | CHICAGO, IL 60606-5075 | TEL 312-922-2322 | FAX 312-922-2916 | AIDSCHICAGO.ORG

# AGENDA

Introduction and Background

Road to Health and Housing Program Design

Initial Results and Implications

Next Steps and Discussion

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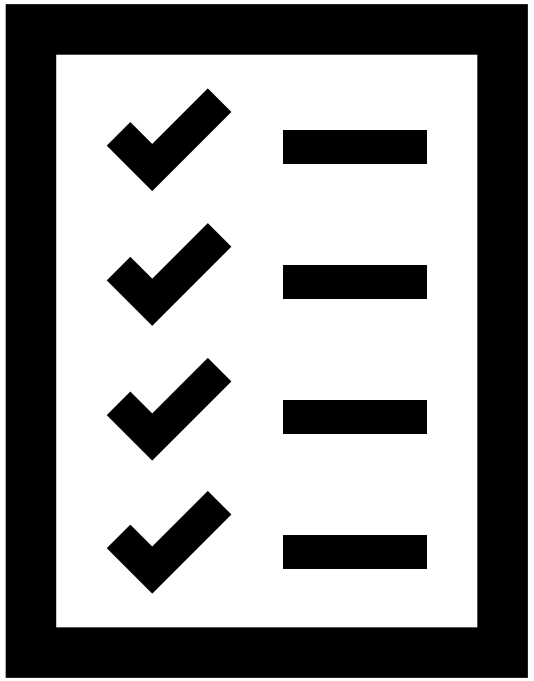
# SUMMARY

The Road to Health and Housing (R2H) program is a clinically-focused housing navigation program designed to facilitate movement into permanent supportive housing for adults experiencing homelessness with serious mental illness (SMI) and co-occurring disorders (COD).

This presentation will:

1) Describe the program and outline data from the mid-term evaluation; and
2) Identify and discuss the role of a Coordinated Entry System and impact on consumer choice.

# LEARNING OBJECTIVES



1. Describe the role of a clinically-focused housing navigation program for homeless individuals with SMI and COD within a Housing First Coordinated Entry System (CES).
2. Analyze the impact of the R2H Program on client interaction with the CES and on housing outcomes based upon comparative data of R2H clients to general CES enrollees.
3. Identify ways in which the Housing First principle of consumer choice can be supported and elevated within a Coordinated Entry System.

# POSITIONALITY AND BACKGROUND

- Started a case manager in the DV field
- Now oversee new program development, and research and evaluation at AIDS Foundation Chicago
- Current interest: social determinants of health; movement from homelessness to housing; understanding strategies and processes to support EBI implementation within CBOs
- Positionality: White, straight, middle-class, able-bodied, cisgender woman
- Have not experienced homelessness

# CHICAGO, IL, USA

- Largest city in the Midwest, located on Lake Michigan
- Population of approx. 2.7 million people
- 17.3% live in poverty
- 33% White, 29% Black, 29% Latino/a/x
- History of political, institutional, and individual racism resulted in highly racially segregated city
- White neighborhood wealth increasing; Black neighborhoods wealth decreasing

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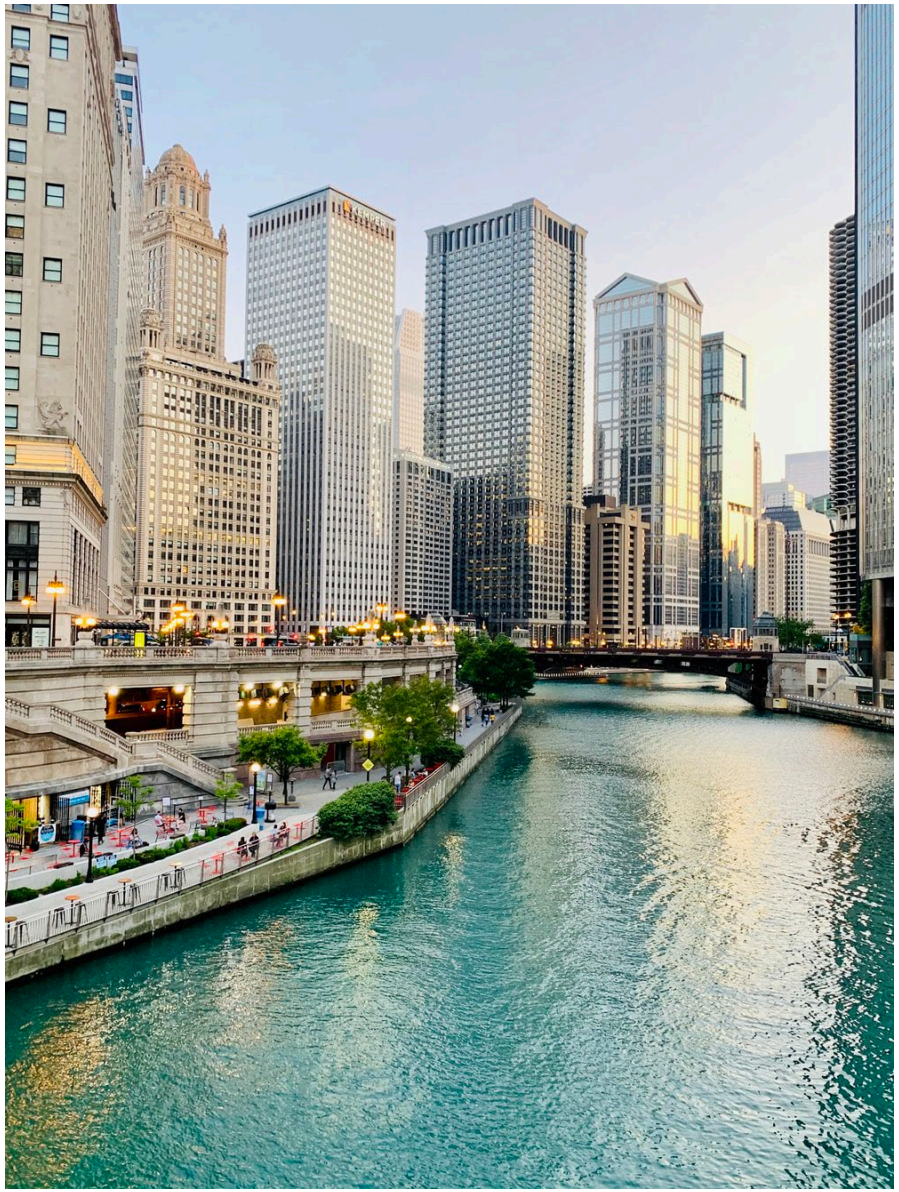
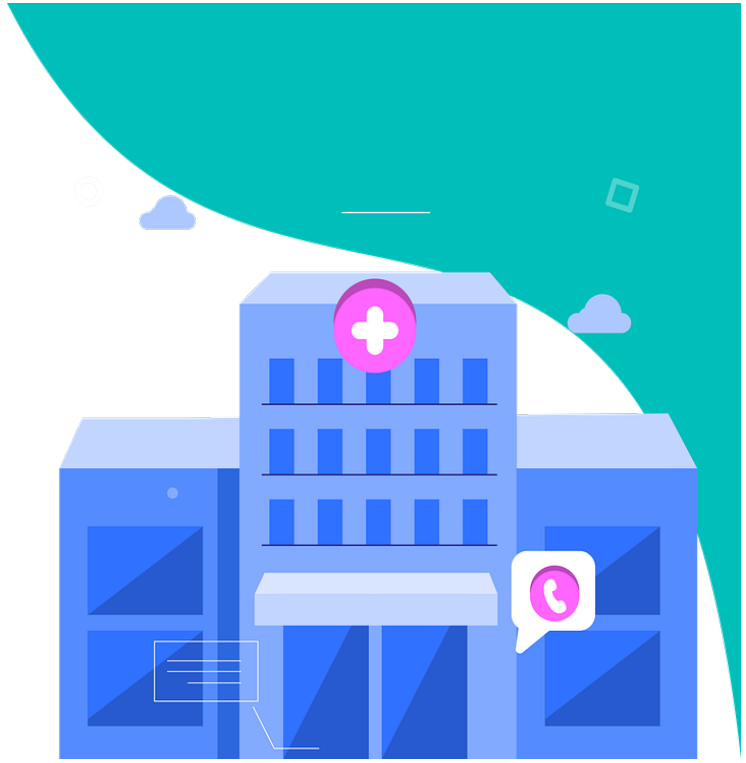


# AIDS FOUNDATION CHICAGO

- Located in Chicago, serving HIV-positive individuals and those vulnerable to HIV in the 8-county area through a partnership model
- Medical Case Management and other HIV services: more than 5,000 served per year
- Housing: provide more than 600 units of permanent supportive housing, close to 500 households served with long-term rental subsidies, almost 500 households receive emergency financial assistance
- Partner with academic institutions on research studies
- Community trainings on emergent topics
- Lead, co-lead, and participate on local, state, and national coalitions focused on HIV health care and other critical topics

# PROGRAM BACKGROUND

Road to Health and Housing (R2H) program launched in October 2018

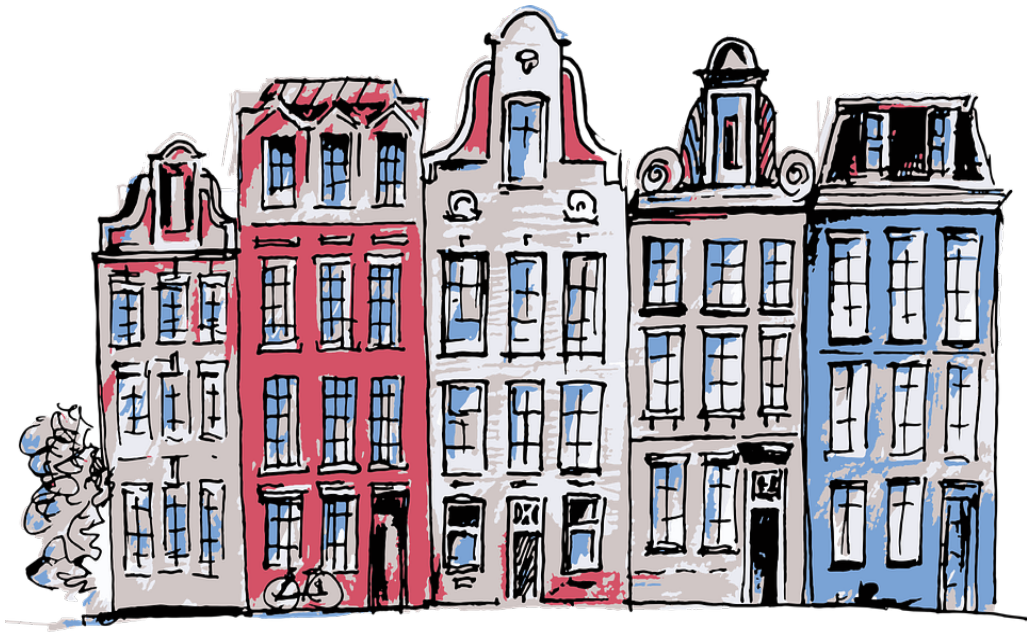


- Why did AFC feel a clinically-focused housing navigation program was needed?
  - Chicago Continuum of Care (CoC) had identified system navigation as a significant service gap
  - Within the Coordinated Entry System (CES):
    - 40% [2,529] of assessed individuals identified a mental health issue as a disabling condition
    - 13% [843] identified co-occurring disorder issues
  - In 2018, only 14% of individuals "matched" to housing through CES successfully reached housing

# HOMELESSNESS IN CHICAGO

## The 2020 Chicago Point-in-Time Count found:

- 3,668 individuals, not living in families, (2,161 sheltered/1,507 unsheltered) were experiencing homelessness
- Between 25% and 50% of individuals are experiencing chronic homelessness
- Almost 30% were receiving or felt that they would benefit from mental health services
- Almost 41% were receiving or felt that they would benefit from substance use services



# HOMELESSNESS IN CHICAGO

## The Chicago Coalition for the Homeless

Reports that in 2020:

- 65,611 people experienced homelessness – sheltered, unsheltered, and temporarily living with others
- 75.6% were temporarily living with others
- 16,009 people were either sheltered or unsheltered
- More than 20,000 utilized some aspect of the homeless system

# COORDINATED ENTRY SYSTEM

- Skilled assessors complete a Housing Assessment which places individuals on the Coordinated Entry System
- Housing providers receive a “match” when they have an available unit – matches influenced by current system priorities
- Households are then housed with the housing provider
  - Housing Navigation launched in 2019 to assist with this process
- Ineligible or not located households remain on the CES to be rematched
- In 2021, there were 9364 people on the CES – of those, 1028 were new to the homeless system
- In 2021, 2221 entered permanent supportive housing programs

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# PURPOSE AND STRATEGIES

**Overall goal:**

Increase the availability and ensure coordination of integrated behavioral health, primary health, housing and supportive services to improve physical health, behavioral health, and housing stability for homeless adults with SMI and COD in the city of Chicago.

- Provision of clinically-focused housing navigation with ongoing support
- Provision of evidence-based mental health and substance use interventions, integrated with primary care
- Infrastructure development to improve cross-sectors integration and service coordination

# R2H PROGRAM OVERVIEW


Matched to PSH provider via CES
Identified as having mental health and/or substance use disorder

Outreach and engagement
Screen and assess
Refer and link
Schedule and attend appointments
Housing navigation
Re-engagement
Coordination
Benefits referral or enrollment

Work with all housing providers in the system to which individuals are matched

Project partner Heartland Alliance Health provides primary care, psychiatry, behavioral health services, and dental services

Project partner Legal Council for Health Justice files legal appeals for financial benefits (SSI/SSD)



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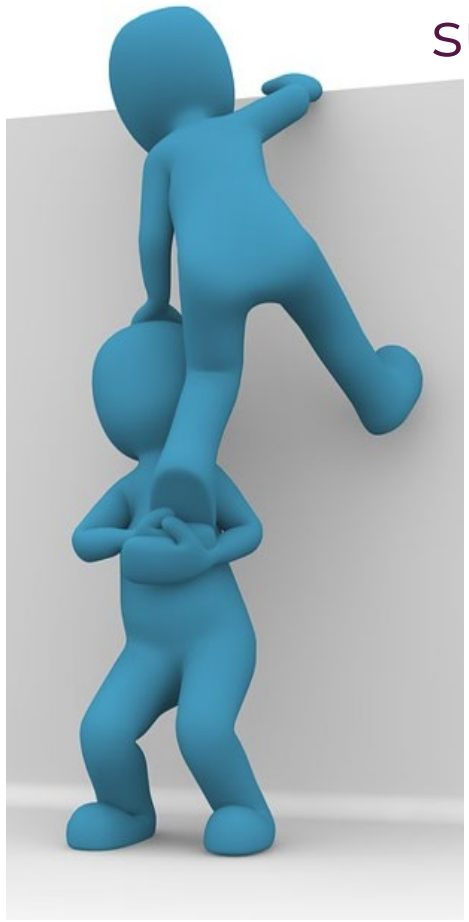
# R2H PROGRAM OVERVIEW



## Clients experiencing SMI and COD needs benefit from extra support and services to move through the housing system

- Provide clients with stable, consistent, trauma informed housing and health navigation services
  - Previous negative experiences working independently to navigate complex housing and medical
  - Negative views of the system or processes (i.e. removed from other waitlists or bounced from provider to provider)
- Re-establish trust through advocacy and empowerment, providing clients a voice in healthcare and housing
  - Provides additional support, reminders, advocacy, and transportation coordination to promote maintained medical engagement and re-engagement

# CHALLENGES WORKING WITHIN CES

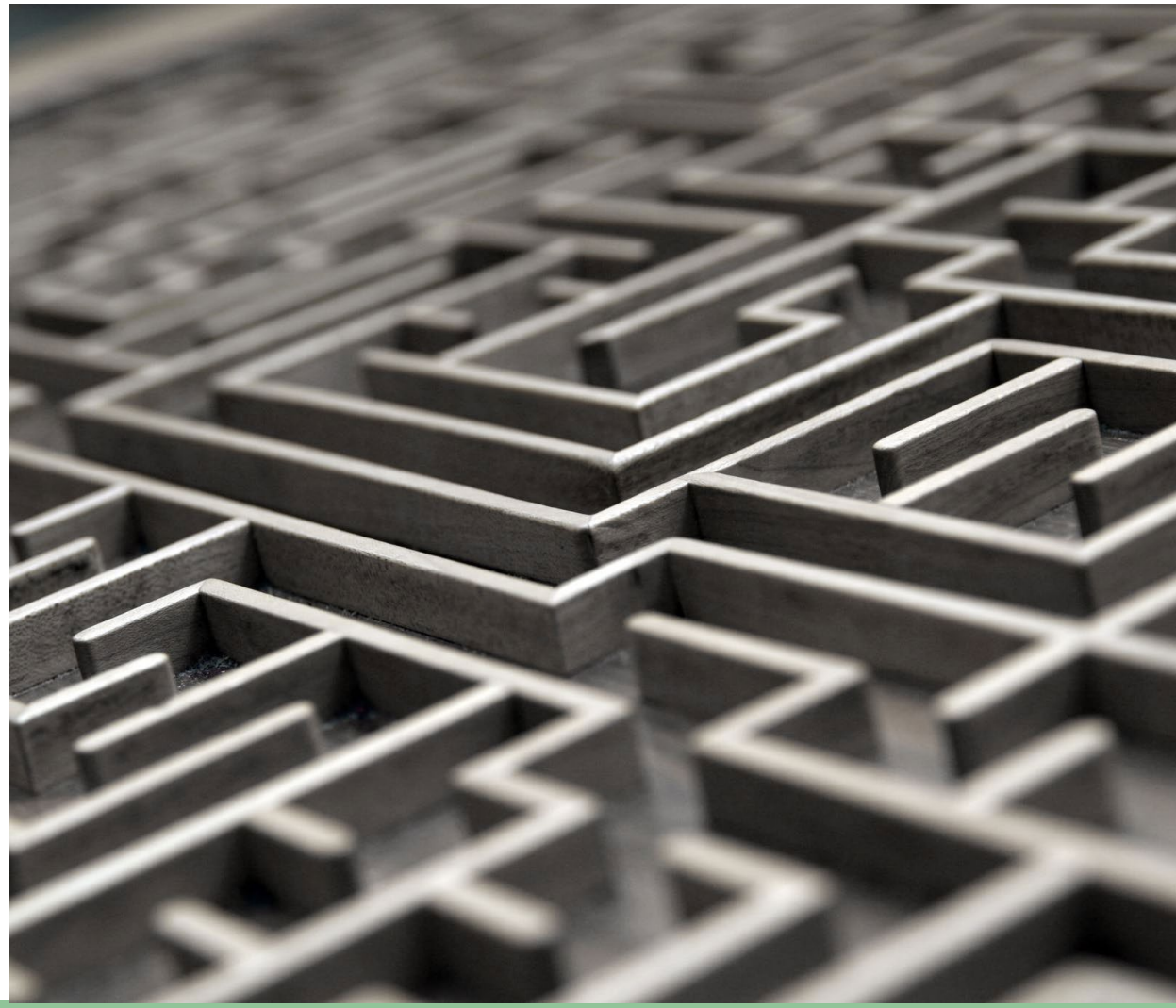
**Non-alignment with CES population prioritization**

- At program launch: youth
- Shifted to length of time homeless

**Changes in CES process flow inadvertently excluded R2H**

- During Spring/Summer 2020, priority given to individuals connected to outreach, drop-in, emergency shelter providers or official CES system navigation

**Variability among housing provider responsiveness**



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# UNDERLYING HOUSING ASSUMPTIONS

1. **Clinically focused housing navigation will expedite the movement from homelessness into housing (i.e. take less time)**

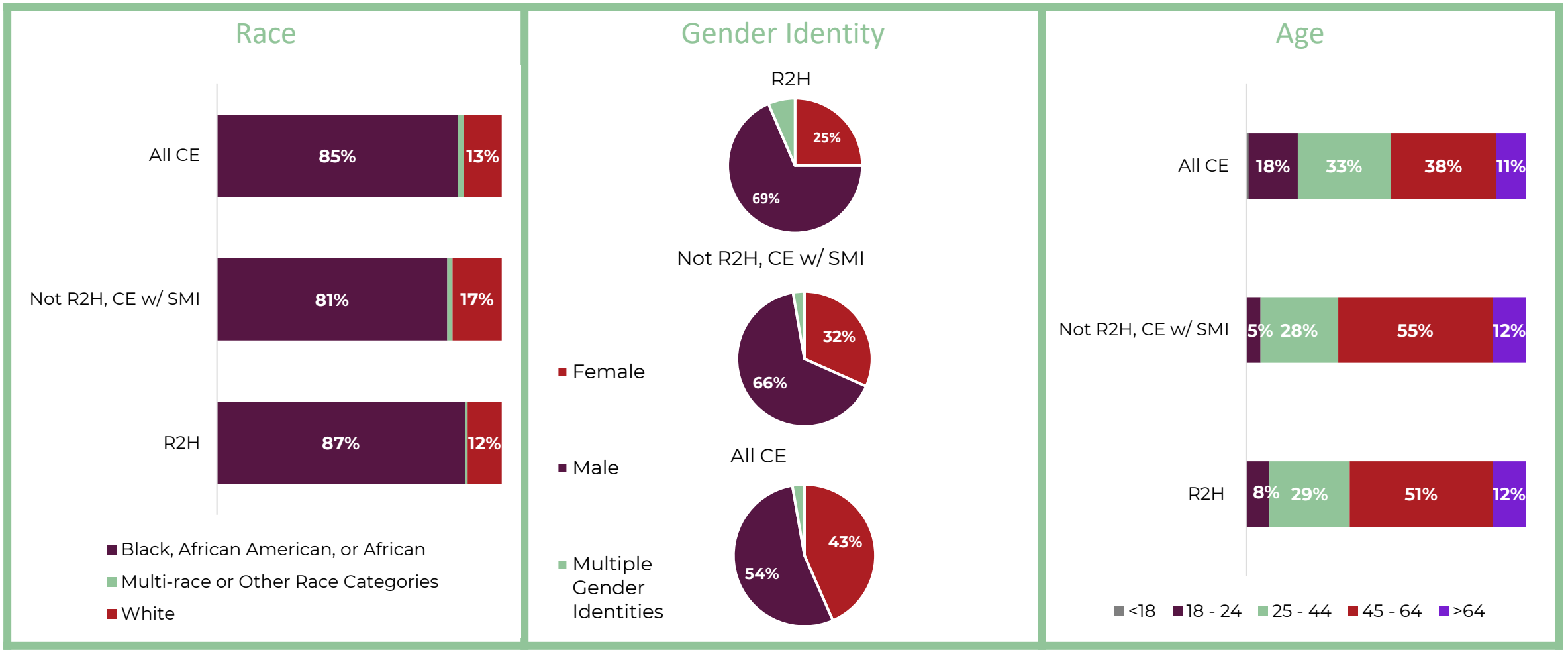
2. **Clinically focused housing navigation will require fewer rematches (as R2H staff will assist clients with obtaining required documentation and facilitate communication between the provider and the matched individual)**

3. **Clients who are already linked to mental health and substance use services at housing entry will retain housing longer**

# EVALUATION

- To understand the impact of R2H, we requested comparison data from the Homeless Management Information System
- Requested and received R2H data, along with comparison data for individuals with SMI not enrolled in R2H and general CES population
- All included individuals were matched to housing through CES
- Dates: Years 1-3 of the program; 10/1/18 to 9/30/21
- Groups:
  - R2H: 216
  - Comparison group: 2845
  - All CES enrollees: 7608

# R2H PROGRAM COMPARISON: CLIENT PROFILE



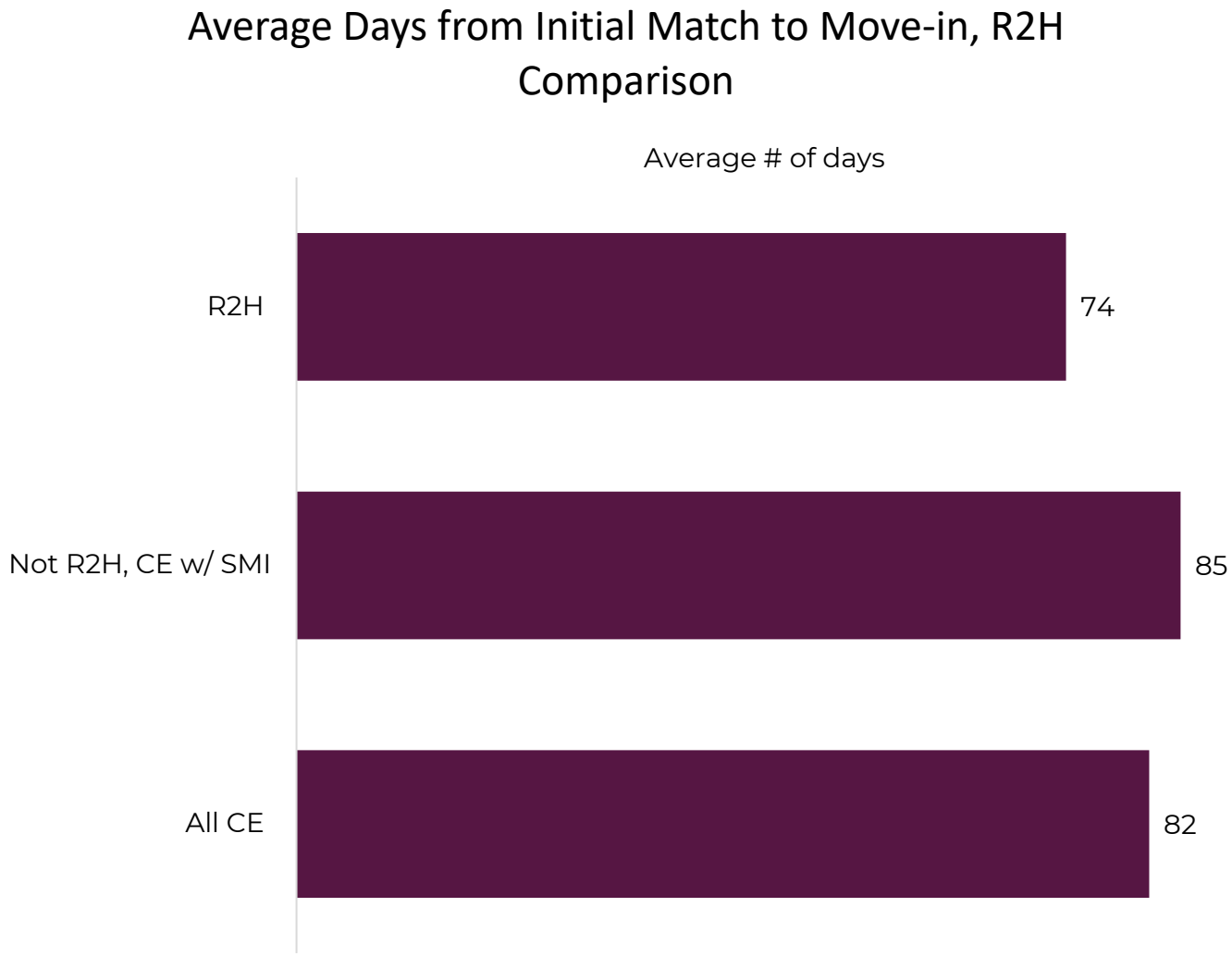

Note: R2H N=216; Comparison Group N=2,845; All Coordinated Entry N=7,608

# ASSUMPTION #1

Clinically-focused housing navigation will expedite the movement from homelessness into housing.

# R2H PROGRAM COMPARISON: TIME TO MOVE-IN

R2H clients moved into housing 11 days earlier than comparable, non-R2H CE enrollees with a match



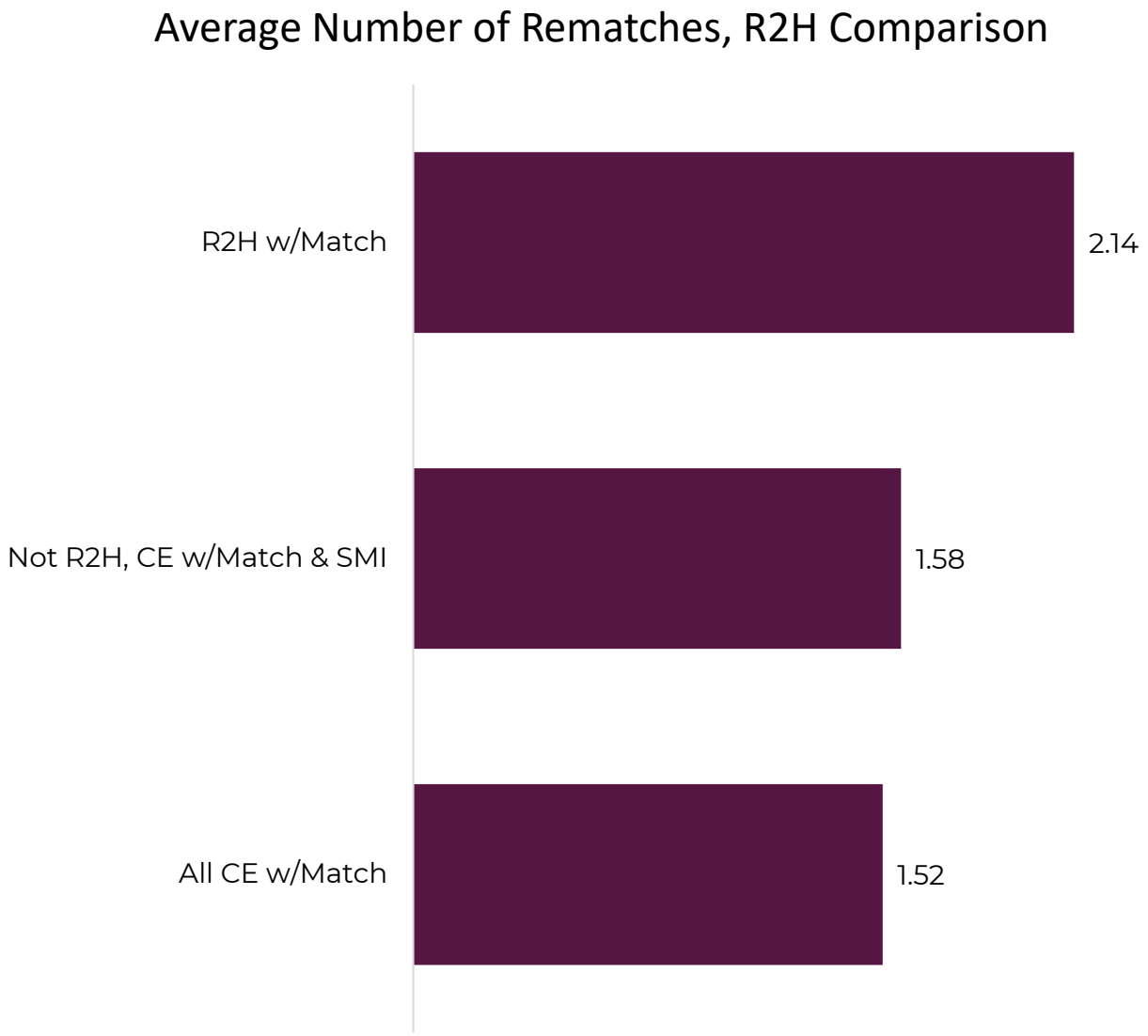

Note: R2H N=216; Comparison Group N=2,845; All Coordinated Entry N=7,608

## ASSUMPTION #2

# Clinically focused housing navigation will require fewer rematches.

# R2H PROGRAM COMPARISON: MATCH AND REMATCH

R2H clients rematched more frequently than comparable CE enrollees with a match



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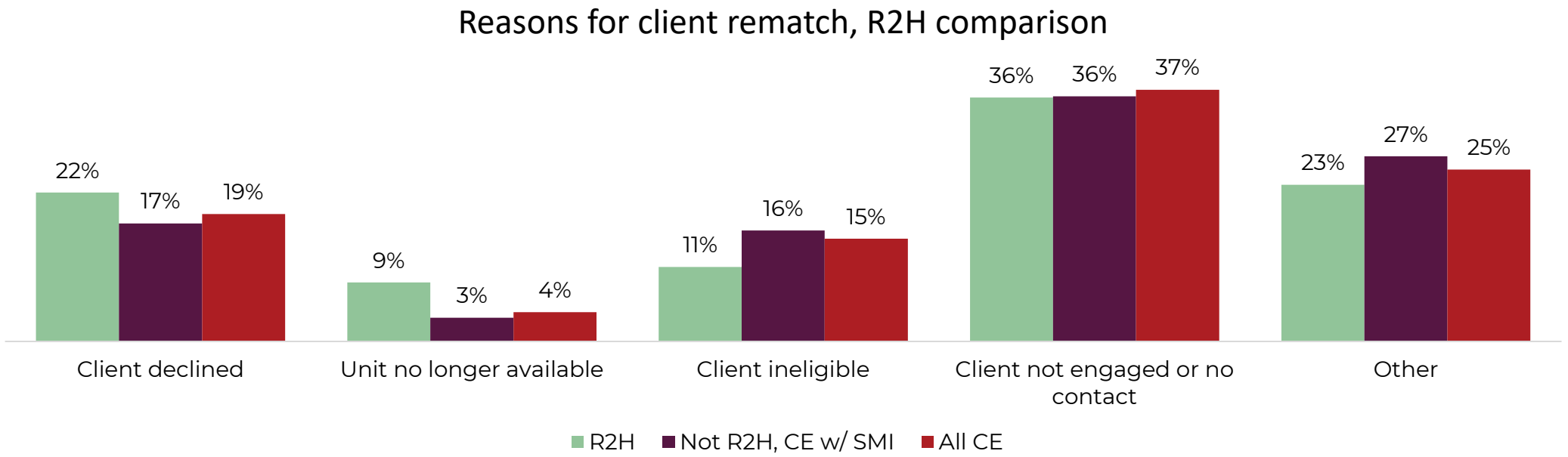
# R2H PROGRAM COMPARISON: MATCH AND REMATCH

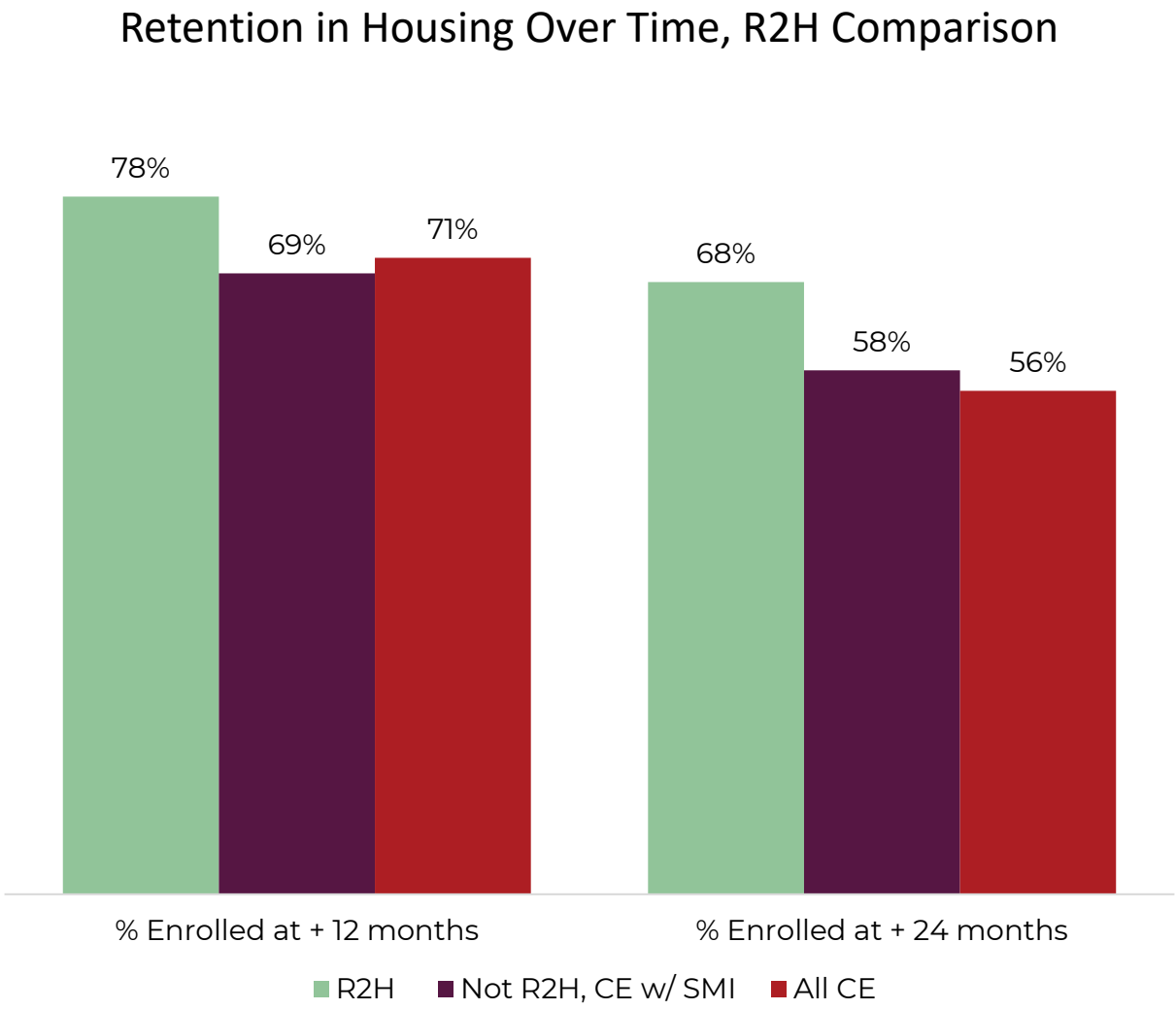
## R2H clients were more likely to decline their original match and ask to be rematched, and less likely to be ineligible for housing




Note: R2H N=216; Comparison Group N=2,845; All Coordinated Entry N=7,608

# R2H PROGRAM COMPARISON: RETENTION IN HOUSING

R2H clients were more likely to be retained in housing 12 and 24 months after moving in



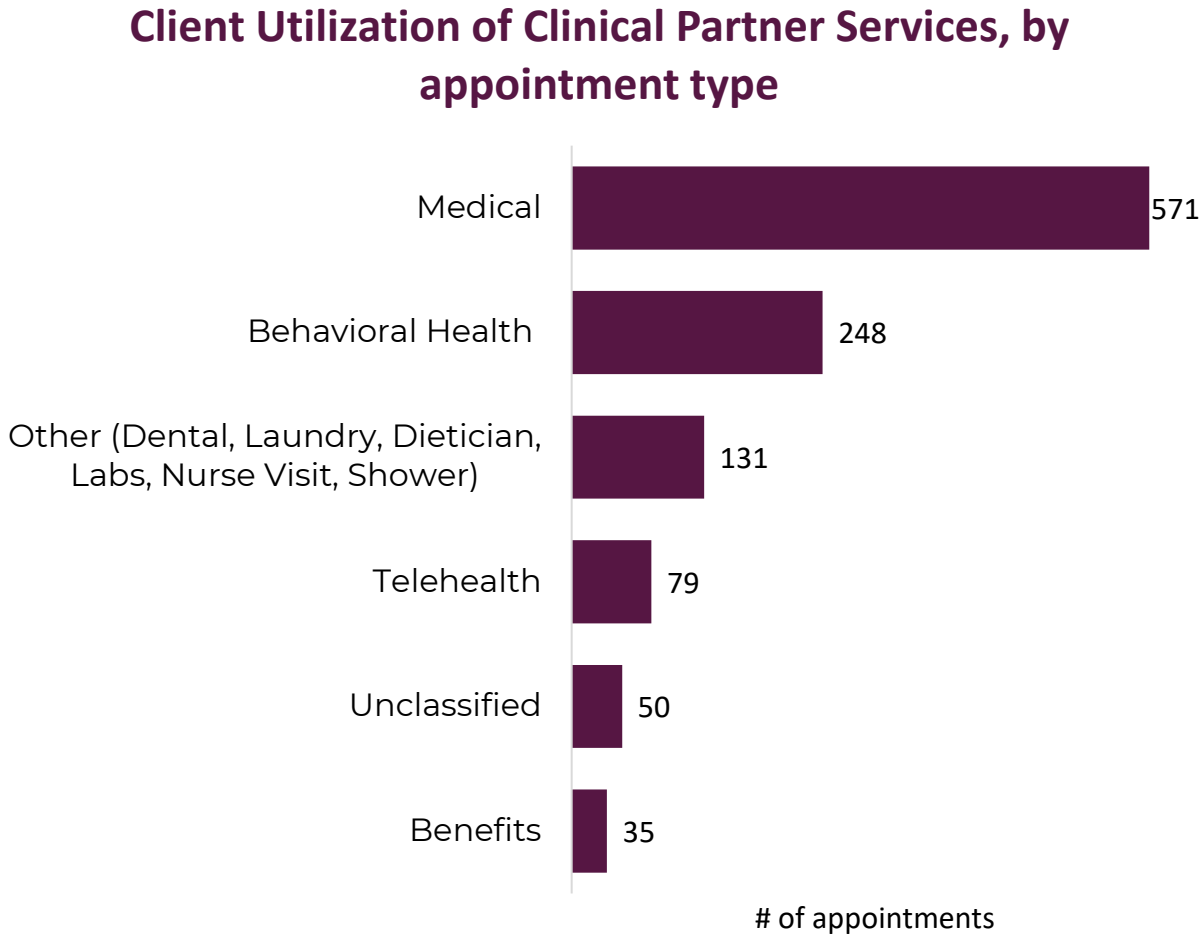

Note: R2H N=216; Comparison Group N=2,845; All Coordinated Entry N=7,608

## ASSUMPTION #3

# Clients who are already linked to mental health and substance use services at housing entry will retain housing longer.

# R2H PROGRAM OUTCOMES: SERVICE UTILIZATION

- R2H Clinical Partner indicated that 71 clients enrolled received health services at their site.
- Of the 1,114 appointments scheduled, 51% were for medical services and 22% were for behavioral health.



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# NEXT STEPS

- Continue program operations until funding exhausted
- Obtain 5-year Comparative Data in Fall 2023
- Qualitative interviews with former R2H participants:
  - Experience with R2H Program
  - Understanding of CES
  - Utilization of behavioral and physical health care services
- Review results with Coordinated Entry Steering Committee and Chicago CoC Lived Experience Commission
- Advocate for increased housing navigation services

# QUESTIONS?

# THANK YOU!

To learn more about this program, please contact:

- Andrea Dakin, PhD: Program Evaluator: ADakin@aidschicago.org
- Nora Bouacha, MPP, Senior Manager of Research and Evaluation: NBouacha@aidschicago.org
- Nick Starkey, Senior Clinical Engagement Specialist: NStarkey@aidschicago.org