

Center for Urban Research & Learning (CURL)
Loyola University Chicago

Evaluation of the Medicaid Supportive Housing Program

Christine George, Ph.D.

Julie Hilvers, M.A.

Andrew Greenia, B.A.

Bill Byrnes, M.A.

Executive Summary

Evaluation of the Medicaid Supportive Housing Program

February 2014

**Submitted to
AIDS Foundation of Chicago**

**Prepared by
Loyola University Chicago Center for Urban Research and Learning (CURL)**

**Christine George, Ph.D.
Julie Hilvers, M.A.
Andrew Greenia, B.A.
Bill Byrnes, M.A.**

INTRODUCTION

The Medicaid Supportive Housing Program (MSHP) is a pilot initiative and represents a partnership between the AIDS Foundation of Chicago (AFC), Heartland Human Care Services (HHCS) and Heartland Health Outreach (HHO). The MSHP is a low-demand, housing first permanent supportive housing program, which serves individuals who are “high users”¹ of Medicaid and have at least two chronic health illnesses. Initiated in April of 2012, the two primary goals of the MSHP pilot program are to: improve health outcomes for program participants and reduce Medicaid healthcare spending.

AFC asked Loyola University Chicago’s Center for Urban Research and Learning (CURL) to conduct a process evaluation of the Medicaid Supportive Housing Program. This process evaluation was conducted in partnership with Health Disability Advocates (HDA), which has conducted an outcome evaluation to document Medicaid costs among program participants pre- and post-enrollment in the MSHP. The primary objectives of the process evaluation are to:

- 1) Examine the development and implementation of the MSHP;
- 2) Examine participants’ interactions with case managers and experiences with other components of the MSHP;
- 3) Assess program participants’ health and treatment “careers,” and help-seeking behaviors before and after enrolling in the MSHP; and
- 4) Explore case management practices between case managers who have and do not have direct access to a participant health information database.²

METHODOLOGY AND DATA SOURCES

Using a mixed methodological approach, multiple data collection procedures inform the data presented in this report. This is a preliminary study with limited resources and small sample sizes. The multiple types of data and participant informant groups (i.e., stakeholders, case managers, and program participants), however, allow us to draw initial assessments of the process and limited outcomes associated with the MSHP program. Methods included interviews and focus groups with program participants, interviews with stakeholders, a focus group with case managers, and a review of two administrative data sources: case notes and six-month participant assessment data. The team reviewed a random sample of case notes from 14 MSHP participants, representing assistance case managers provided during participants’ first 26 weeks in the program. The team also analyzed participant health data collected through AFC’s intake, six-month, and 12-month reassessment tools.

¹ See Appendix A in Final Technical Report for 2011 Medicaid Decile Expense Chart.

² Initially, this research question aimed at exploring case management practices with and without care coordination. Delays in the implementation of the Together4Health (T4H) required modifications in this research question. (See Appendix C in Final Technical Report for further information about T4H.)

DEVELOPMENT OF THE MEDICAID SUPPORTIVE HOUSING PROGRAM

Since 2003, homeless housing and health providers in Chicago have worked in collaboration to provide supportive permanent housing to chronically ill individuals who were homeless. AFC facilitates this partnership. Beginning with the Chicago Housing for Health Partnership (CHHP) in 2003 – an experimentally-designed demonstration project – these housing programs have examined the outcomes of utilizing a housing first strategy with this population. CHHP demonstrated that providing permanent supportive housing to chronically ill individuals who were homeless reduced hospital, emergency room, and nursing home visits. Providing housing not only improved health outcomes of these individuals, but also reduced medical costs (<http://www.aidschicago.org/housing-home/chhp>). The CHHP experiment led to a permanent CHHP program in 2008 with an expansion of provider partners and 180 permanent supportive housing subsidies. By 2010 its successor, the Chicago Samaritan Supportive Housing Project, was in place (<http://www.aidschicago.org/being-a-good-samaritan>) with 195 permanent supportive housing units.

Nationally, the findings from the CHHP program and from other similar programs throughout the country were communicated by a group of advocates, including AFC, to officials from the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Health and Human Services (HHS), and Medicaid directors from a few states through meetings and conferences. Attempts to build on the findings from CHHP and other programs were facilitated by the efforts of the first Obama administration to push the main governmental homeless entities – HHS, HUD and the Veteran’s Administration – to collaborate. These efforts resulted in a proposal for 4,000 HUD subsidies to be used for people on Medicaid with additional SAMHSA (Substance Abuse Mental Health Services Administration) dollars to help pay for services that Medicaid would not pay in the first Obama budget.

Although the 4,000 HUD subsidies were cut from the final version of the budget, AFC and Illinois State Medicaid continued their work. AFC applied for and received HUD funding to develop a local pilot program that targeted “high users” of Medicaid, meaning those in the top deciles of Medicaid Expense Charts. Thus, the Medicaid Supportive Housing Program was developed.

AFC partnered with the Heartland Alliance to develop the MSHP. Two main components of Heartland, Heartland Health Outreach (HHO) and Heartland Human Care Services (HHCS) were able to provide key aspects of the program: housing, seasoned case managers (with at least a bachelor’s degree and approximately three years of experience) and a Federally Qualified Health Center (FQHC) which served homeless individuals. Potential participants for the pilot were recruited at shelters, treatment programs, hospitals, and other housing and healthcare providers. Illinois State Medicaid provided data for all individuals who signed Medicaid releases in order to determine which individuals were “high users” of Medicaid and therefore, eligible to enroll in the MSHP. The MSHP targeted “high users” because serving the cost of providing the health needs of these relatively small number of individuals consumes half of Medicaid funding

in the state. For example, in 2011 Illinois had 3,200,000 enrollees in Medicaid who spent a total of \$13 billion that year. Less than 100,000 enrollees, or 3% of the 3.2 million, spent half the funds or \$6.5 billion (Bendixen, Draft - T4H Summary, not dated). A majority of these “high users” expenses are attributed to hospitalizations and emergency room visits.

STRUCTURE OF THE MEDICAID SUPPORTIVE HOUSING PROGRAM

Organizationally the structure of the MSHP consists of three levels. The first of these levels is the System Integration Team (SIT), which is made up of the three case managers, one from HHCS and two from HHO, and is facilitated by AFC’s Housing Manager. The next level is the Oversight Committee, which is comprised of the HHCS and HHO program directors and supervisors that oversee the case managers. The third level is comprised of the executive directors of the agencies and facilitated by AFC’s Vice President for Housing Partnerships. This organizational structure was modeled after the CHHP and Samaritan Housing projects.

AFC acts as the intermediary fiscal organization and provides program coordination and oversight. HHO and HHCS provide case managers, 48 housing units, and other supportive services. The delivery model stipulates that the case manager-to-participant ratio is not higher than 1:16 and the case managers see participants at least once a month. AFC reviews the case notes and the six-month assessments (recorded in the Client Track database) to track the implementation fidelity and challenges to the delivery model.

The MSHP program consists of primary interactions among the aforementioned levels. The SIT Team meets every two weeks. HHO and HHCS supervisors meet with their respective case managers at least on a bi-weekly basis, providing administrative oversight and clinical supervision. The Oversight Committee meets every six weeks to review data and discuss policies and procedures. The executive directors then meet biannually to discuss more comprehensive findings and results as reported by AFC.

In terms of interactions between participants and case managers, the case managers focus more on health and healthcare than typical case managers in other supportive housing programs. Case managers are meant to work closely with the participants’ healthcare provider(s), and when possible, are privy to their medical records and information. This is atypical of housing case managers in other established permanent supportive housing programs.

IMPLEMENTATION OF THE MEDICAID SUPPORTIVE HOUSING PROGRAM

The housing component of the MSHP went fairly smoothly. During the recruitment process 300 individuals signed a Medicaid release form. Of these, about 80 individuals were identified by

Illinois State Medicaid as being in the top sixth cost decile, thus qualified for the study based on Illinois' Medicaid determination. Of those 80, 48 were enrolled in the MSHP housing beginning in April of 2012. Among the MSHP participant population,³ about one-third (33.3%) of respondents were female and two-thirds (66.7%) were male. The majority (84.6%) of respondents reported a racial identity of black/African American, while 15.4% identified as white; out of 54 respondents who answered the question, 5.6% reported a Hispanic ethnic background. At the time of intake, nearly half (45.3%) of respondents reported that they were HIV positive, while 54.7% reported that they did not have HIV. Other chronic illnesses included cancer, diabetes, and cardiac related issues. Many of the MSHP participants were identified originally from the 100,000 Homes Campaign, ranking high on the Vulnerability Index.⁴

Recruitment and Getting Housed

Participants described the process of entering the MSHP and becoming housed as “smooth” and efficient.

- Active outreach on the street, emergency shelters, treatment centers or clinics along with connections through case managers were key to recruiting individuals for the program.
- Among those who were eligible, most were housed within one month. The amount of time between learning about the MSHP program and becoming housed ranged from two weeks to four months, while most were housed in one month.
- Most participants reported looking at a few apartments before making their decision. Some found it hard to find an apartment in the HUD-mandated price range that were in a convenient location (e.g. close proximity to health care providers) and most importantly, in a safe neighborhood.
 - The selection of housing in “safe neighborhoods” (i.e. North Side) has become limited.
- Participants described the process of becoming housed as “smooth,” with case managers assisting every step of the way – from finding an apartment to getting “starter kits” of pots and pans and other necessities.
- Case managers and their supervisors mentioned that participants, particularly those who have never been housed before, are challenging. They enter housing without skills – from procedural to social – necessary for maintaining housing.

Case Managers: Supporting Stable Housing and Health

The supportive services case managers provide participants are key aspects of the program.

³ These data presented here represent data entered into Client Track as of July of 2013.

⁴ The Vulnerability Index was utilized by the national 100,000 Homes Campaign. Developed by Boston's Healthcare for the Homeless Organization, the Index is a tool for identifying and prioritizing the most chronic and the most vulnerable among the homeless for housing “according to the fragility of their health.” <http://100khomes.org/sites/default/files/About%20the%20Vulnerability%20Index.pdf>

The “When” and “Where” of Case Management

- Case managers provide a wide array of supportive services, while also assisting participants with setting goals related to managing healthcare, housing, finances, and education opportunities.
- Overall, case managers, participants, and stakeholders revealed that contact between case managers and participants is one of the most influential facets of the program.
- Case managers identify their role, overall, as to “*help the participant help themselves.*”
- Harm reduction techniques are used – including motivational interviewing – to help program participants explore their thoughts about housing and health, establish goals, and help them to move forward in achieving them.
- Case managers and participants meet at least twice a month during the first six months of the program, though the frequency of meetings typically tapers off to once per month after the first six months, at minimum. The review of case notes demonstrated that the number of contacts during the participants’ first six months in the program ranged from 20 to 40.
 - Two-thirds of meetings take place at the participants’ homes with most of the remainder being in a case managers’ office.
- Besides meetings, frequent phone calls and messaging occurs for follow-up and rescheduling, resulting in 40% of all contacts between case managers and participants.

The “What” of Case Management

Housing

- As demonstrated through the review of case notes, housing and housing-related issues (9% of the total issues noted) were an ongoing issue noted by both case managers and participants (see Table 1). The research team reviewed case notes from the sample of participants’ first six months in the program. The case notes showed that participants experienced such problems throughout their first six months in the program. In addition, stakeholders and case managers identified that for many participants, housing problems continued beyond this six-month period.
- Participants and case managers alike described unresponsive landlords who were delayed in making repairs, as well as some landlords who neglected concerns about safety and security of buildings. Case managers also explained some participants are “*stigmatized*” from landlords and were often unfairly targeted about building problems.
- Some participants wanted case managers to increase their advocacy around housing. For example, participants described threatening and disruptive people in the halls and other safety concerns in their building. They were frustrated that their case manager was unable to get them out of their lease in these situations.
- A small but essential portion of case manager activities, as noted in the case notes records were direct contact with landlords. Issues include participants not paying their required portion of the rent, excessive noise from guests, altercations with neighbors, and substance use in their unit. Case managers explained in the focus groups that they

intervene with these issues not only to solve the immediate issue but to maintain the relationship with the landlord.

- Almost all participants remained continually housed. In the review of the case notes, 64% of those were in a stably housed situation.

Healthcare Management

- Through the case notes review, we found that 50% of the issues case managers noted were health-related, with over one-fourth of those pertaining to appointment and medication adherence.
- The differences in care coordination were evident when contrasting between reports by participants who received housing and medical care by HHO and those in non-coordinated situations. Those who were both housed and received healthcare at HHO discussed a greater level of assistance from their case manager in managing their health care relative to those housed at either HHO or HHCS and receiving healthcare from different sites. Those with “quasi” care coordination related that their case managers often make their medical appointments, set up referrals, and call to remind them about appointments.
 - Case managers reported difficulty in getting timely and or complete information needed to assist with medical management when they had to rely on phone calling providers and getting reports from participants.

Stabilizing Resources

- The review of case notes demonstrated that 10% of the action items noted between participants and case managers were benefit-related, money management (9%), and transportation (6%), and education and employment (3%).

Social and Emotional Support

- All participants shared that their relationships with case managers were crucial to their positive experiences in the program. Some participants described having a strong bond with their case manager, describing them as a friend or like family.
- Participants expressed concerns about staffing changes with their case managers. They had anxiety about the uncertainty of who would be their new case manager and how the transition would go.

Some Challenges with Case Management

- Participants shared that while case managers provide much support and are working hard, some do not seem to have access to a sufficient amount of resources that could provide optimal help. There appear to be limits of what case managers can do, and some participants desired for their current case manager to advocate more. Further, some participants felt somewhat stuck, not aware of the course of action when they perceived the case manager was not effective (e.g. contacting Heartland supervisor).
- Case managers and their supervisors felt that because these meetings are so important, they would ideally like to meet with the participants even more. They pointed to some

cases in which the participants were very disorganized in which they thought a more aggressive case management model, based on the ACT model (Assertive Community Treatment) would be appropriate.

Table 1. Assistance Case Managers Provide to Medicaid Supportive Housing Program Participants¹

Care Action Categories	Percentage
Health-Related	50.4%
Physical Healthcare	12.1%
SBIRT – Brief Intervention for Substance Abuse and Mental Health	10.7%
Adherence to Medication/Medication Readiness	7.8%
Adherence to Medical/Mental Health Appointments	5.4%
<i>Both</i> Mental Health and Substance Use	5.1%
Mental Health	4.8%
HIV-Related	2.8%
Refer to GPRA/Access to Wellness Services	1.1%
Substance Use	0.6%
Benefits Assistance (advocacy, application, maintenance)	10.4%
Money Management	9.0%
Housing (location, resource education, problem-solving)	7.1%
Transportation	5.7%
Emotional Support	5.3%
Food and Nutrition	3.5%
Other	3.2%
Discuss Change in Level of Care	2.2%
Employment	1.6%
Education	0.9%
Crisis Intervention (including domestic violence)	0.7%

¹ Data represent case notes information for a random sample of 14 participants. These data represent assistance provided during the first 26 weeks participants were in the program.

IMPACT OF THE PROGRAM ON PARTICIPANTS’ HEALTH, BEHAVIOR, AND OUTLOOK

During interviews and focus groups, participants discussed the substantial impact of being housed. At the most basic level, they described that stable housing resulted in their better health because they were no longer exposed to harmful elements including rodents and extreme weather. They also described that they were now able to take care of such basic, daily tasks of resting better, preparing meals, as well as personal hygiene practices including showering and changing clothes regularly. Individuals with conditions including high cholesterol, heart disease, and diabetes related stable housing has enabled them to improve their diets as they were able to eat regularly and attempted to eat more nutritious foods. Many

participants feel happier, with one participant relating that she was now able to invite family over to visit, activities which *“keeps joy in life.”*

CHANGES IN HEALTH-SEEKING BEHAVIOR

Through the participant interviews we focused on learning how individuals' healthcare experiences had changed after enrolling in the MSHP. Overall we found a pattern of a significant positive change in the participants' reported health-seeking behavior. Participants without HIV/AIDS reported larger improvements than participants with HIV/AIDS due to their less consistent healthcare access prior to MSHP.⁵

Healthcare Management

- The vast majority of participants without HIV stated that the ER was their most consistent form of healthcare management before they entered the program. Their frequency of visits to the ER ranged from every other week to once a month. This was less true of those with HIV, as while participants with HIV saw the ER as an option, they already managed their healthcare by seeing regular physicians at Stroger Hospital's HIV/AIDS clinic, CORE Center, and other health facilities.
- All those without regular care prior to MSHP reported connecting to preventative care and the use of primary care physicians and various health centers after entering the program.
- Several stated the ER was still an option, but a great emphasis had been placed on seeing a regular doctor at health centers such as Heartland or Family Health Center.
- The participants reported that the frequency of emergency room visits or hospitalizations decreased, although those who previously were without primary care physicians often increased their number of medical visits, typically for issues that they would ignore until it became an emergency prior to entering the MSHP.

Table 2 provides a snapshot of the location and frequency of healthcare services before and after enrolling in the MSHP for each of the 13 MSHP interview participants.

Medication Management

- Overall, prior to entering the MSHP, the only individuals who reported having stable and continuous access to medication were those who had been diagnosed with HIV/AIDS as well as the one individual in the special program for individuals with breast cancer.
- After beginning the program, most participants described stable, continuous access to medication. For the most part, participants self-managed their medications, and also described check-ins with case managers and regular physicians. For some participants, case managers seemed to play a very large role in checking up on participants'

⁵ Since almost half of the participants had been diagnosed with HIV/AIDS and were likely to have had a primary care provider and been provided with a medication regime prior to being housed we conducted a stratified sample of those with and without a diagnosis of HIV/AIDS.

adherence to medication, scheduling doctor appointments, and providing general support and assistance.

Table 2. Location and Frequency of Health Care Services Before and After Enrolling in MSHP (N=13)⁶

	Before	After
Client 1	West Suburban Hospital ER [every other week] / Primary Care Provider	Primary Care Provider (followed doctor to new clinic) [once per month]
Client 2	St. Mary's Hospital ER [once per month] / Psychologist	Heartland Health Outreach [once per month]
Client 3	Stroger Hospital ER [rarely] / Heartland Health Outreach	PCC Clinic (Family Health Clinic) [two times per month]
Client 4	Heartland Clinic [once every 1-2 months]	Heartland Clinic [once every 1-3 months]
Client 5	Salvation Army Van / Stroger Hospital ER [twice per month]	Heartland Health Outreach / Primary Care Provider [once per month] / St. Mary's Hospital (psychiatry & therapy sessions) [once every two months]
Client 6	Mercy Family Clinic / Medicaid IBCCP Program / Oncologist at Rush Hospital	Medicaid IBCCP Program / Oncologist at Rush Hospital
Client 7	CORE Center / ER [rarely]	CORE Center
Client 8	Health Clinic [once per month] / ER	Heartland Health Outreach [once every two months]
Client 9	CORE Center [every three months]	CORE Center [every three months]
Client 10	Howard Brown [once per month]	Howard Brown [once per month]
Client 11	Provident Hospital [once per month] / ER	Provident Hospital [once per month] / ER
Client 12	CORE Center [every three months]	CORE Center [every three months]
Client 13	CORE Center [once per month]	CORE Center [once per month]

⁶ The last 7 individuals in the un-shaded boxes were HIV+ or with AIDS. As you can see, in all but one case, these individuals had a primary care provider when they entered the MSHP and continued with that provider.

Assistance Navigating Healthcare System

- Before the program, most participants reported having no one to help them navigate the healthcare system and had to take care of it themselves.
- After beginning the program, it was clear that participants relied heavily on the work of the case managers. Case managers were said to have provided health literature, suggested counseling, visited the hospital, and kept track of appointments and medications.

Connection to Benefits and Social Services

- After beginning the program, few participants interviewed reported changes in their connection to benefits and social services. This is in contrast to the case notes review that identified 10% of the contacts being related to benefit assistance.

CHANGES IN HEALTH STATUS AND BEHAVIOR

During the interviews and focus groups, participants described their health changing for the better after being in the program. One participant even said, *“It’s changed my whole life. I’m a different person.”*

A descriptive analysis of select health and well-being data of all the MSHP participants collected through the Intake and Reassessment tools demonstrates some health changes between the intake and one-year re-assessment. We restricted our analysis of each measurement to individuals who answered the assessment questions at both periods of time⁷.

Change in General Health Status

- 44% reported no change in their general health status; 11% reported a decline in their general health status;
- 45% reported an improvement in their general health status.

Impact of Physical and Emotional Health on Social Activities

- 21% reported no change in how much their physical or emotional problems interfered with their social activities;
- 57% reported that their physical or emotional problems interfered less with their social activities;
- 21% reported an increase in how much their physical or emotional problems interfered with their social activities.

⁷ Because of missing data this has limited our sample size in many questions and the findings can only be seen as exploratory.

Impact of Physical Health on Ability to Accomplish What They Wanted

- 43% reported no change in how much their physical health impacted how much they have accomplished;
- 43% reported that their physical health was less of an impact on how much they accomplished (thus, an improvement);
- 14% reported that their physical health caused them to accomplish less.

Impact of Emotional Problems on Ability to Accomplish What They Wanted

- 43% reported no change in how much their mental health impacted how much they have accomplished;
- 29% reported that their mental health was less of an impact on how much they accomplished (thus, an improvement);
- 29% reported that their mental health caused them to accomplish less.

Medication Adherence

- 71% reported that they continued to adhere to the recommended procedure for taking medication for their chronic medical condition (physical); 28 % reported that they had gone from not adhering to adhering.
- 71% also reported that they had no difficulty in taking their psychiatric medication on time; and 29 % reported less difficulty in taking their medication on time.

DISCUSSION

These evaluation findings provide us with an overall positive picture of the Medicaid Supportive Housing Program process. Most participants reported substantial improvement in their health. They also reported a strong, positive view of the program in general and case managers in particular. These findings definitely point to the importance of the “support” component of this permanent supportive housing initiative. Along with having stable housing – a home – case management is an essential aspect of the program, both in facilitating the stability of housing, supporting people in organizing their lives and improving their health maintenance. In the section below, first we will discuss the strengths of the model and its implementation and then reference the challenges identified by the respondent and possible refinements to the program.

Relationship with Case Manager

The MSHP program model emphasizes participant choice and responsibility, with very consistent and accessible support from case managers. Starting from the housing location process – which participants found efficient and smooth – a working relationship develops between the participant and case manager. It is consumer-centered, with the participant making the decisions. The case manager role here was to facilitate finding housing locations, trouble-shooting, and assisting with move-in.

We see the working relationship between participant and case manager initiated during the housing location and move-in process continuing to develop and refine itself to each particular case after the move-in. Participants and case managers described, and the case notes reflected a process of relationship-building, based on each participants needs. The core activities and support were health-related, from appointment and medication adherence to nutrition counseling. Yet organizing the issues of everyday living, from achieving some economic stability through assistance with benefits and money management to the ever present issues of housing stability were consistent issues that participants and case managers continued to address. The data show that some participants are fairly organized and independent, with others requiring continuing and frequent assistance. While the relationship is very task-oriented, the participants valued a congenial inter-personal relationship with their case managers.

Program Impact on Health Behavior and Status

We can only draw limited conclusions about changes in participants' health behaviors and health status outcomes because the data reviewed through this evaluation was based on participant self-report.⁸ Despite these limitations, however, all indications point to a positive improvement.

Data show that participants without a primary care home attain one after enrolling in the program. Participants reported less reliance on emergency room visits and hospitalization, improved access to medications, and medication adherence. In addition, most reported improvement in their general health. As such, participants reported being less restricted by physical and mental health problems in the functions of their everyday activities.

Program Challenges

Both the housing system as well as the health and welfare system have been the sources of challenges with the effective implementation of the MSHP. These challenges are often beyond the ability of this program to directly address, but should be examined for possible policy advocacy. In addition, the program should consider implementing some modifications with the case management model to address challenges experienced by the most vulnerable program participants.

Housing Challenges

Besides housing challenges related to the experiences and behavior of individual participants, there are challenges with the subsidized housing system itself. Stakeholders and case managers reported that it has become increasingly difficult to identify landlords willing to accept participants in their units. A primary reason is that the HUD Fair Market Rate (FMR) for Cook County, Illinois has consistently decreased in the previous few fiscal years. As such, the availability of quality housing apartment units on the North Side – the region of the city in which most participants prefer to live – and the location of HHO clinics – is extremely limited.

⁸ Information gathered through interviews, focus groups and the intake re-assessment data is based on participant self-report.

Health and Welfare Challenges

Many participants in the focus groups and interviews identified the need for Medicaid to provide additional coverage for medications and dental care. Several participants explained that Medicaid only covers a limited number of their medications and does not cover all types of medications. Consequently, they are not able to pay the remaining cost due to their limited financial resources. A number of individuals mentioned they have limited resources for food due to cut in SNAP/food stamps. One individual with HIV mentioned there is a need for childcare assistance so patients can attend their medical appointments.

Case Management Model and the Most Vulnerable Population

While case managers working in the program are experienced working with individuals with multiple barriers including mental health and substance use, the participants in the MSHP can present a unique challenge. Mental health and substance use issues are often coupled with very poor health, along with the fact that many participants were on the street prior to becoming housed. Some stakeholders felt that a number of these individuals were not ready for independent living. One stakeholder described that this portion of the MSHP population *“was like this new type of clientele... Something as simple as appointment adherence with their case manager and communication and having the basic ability or desire to want to even minimally meet to even attempt to do any of these sorts of activities...”* [tends to be a challenge for the MSHP population].

In relation to another aspect of vulnerability, a few stakeholders discussed participants' limited financial resources and their limited ability to structure a budget to pay their rent on time. One stakeholder from HHCS recommended a payee system as a strategy to ensure that landlords would be paid the participants' portion of the rent when it is due.

Given the vulnerability of these participants, some stakeholders suggested that the program may need to provide different levels of support based on a participant's individual needs. A few considered whether an Assertive Community Treatment (ACT) outreach model or more intensive staffing would be appropriate for the most vulnerable participants and those experiencing crises. Another stakeholder recommended that a *“therapeutic”* or *“clinical”* approach could be advantageous compared to a *“task-oriented”* approach.

CONCLUSIONS AND RECOMMENDATIONS

The Medicaid Supportive Housing Program pilot is working well overall. In examining participant experiences with the MSHP, stable housing and the strong supportive services are equal factors in the effectiveness of the program. Clearly, the MSHP pilot should continue and be expanded.

Addressing the existing challenges experienced by program participants can strengthen the MSHP. Two of the challenges – the lack of accessible, affordable housing and limitations with Medicaid funding – are issues that the MSHP program itself cannot remedy, but these are areas

for advocacy and planning. First, the reliance on the market to provide affordable, quality housing is clearly limited. On a local level, the development of more affordable housing options should be discussed. On a national level, the limitation of the current computation of the HUD FMR amount needs to be addressed. Second, current Illinois State Medicaid regulations limit the coverage of certain medications and services including dental and vision care. Information about the healthcare problems that participants face due to these limitations should be shared. Discussions with state health policy advocates, health consumer groups, and policymakers working to improve the Illinois State Medicaid program would be a positive initial step.

Finally, stakeholders and case managers alike were eloquent in identifying limitations with the current case management model in addressing the most vulnerable and unstable participants. They explained that the combination of mental health and substance abuse issues combined with the fragile physical health of individuals with a long history of chronic homelessness creates a *“new type of clientele.”* We recommend that MSHP begin the process of reviewing and refining its current supportive service model – that is successful with the majority of the MSHP participants – to include new approaches. This could include screening to identify the most vulnerable individuals during the recruitment process and providing them with a more intensive and therapeutic case management approach.