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# Evaluation of the Medicaid Supportive Housing Program

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**Final Technical Report**

**Evaluation of the Medicaid Supportive Housing Program**

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**Prepared by  
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## INTRODUCTION

This report details activities presents results from a process evaluation of the Medicaid Supportive Housing Program. 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 of Medicaid (i.e. in the top sixth decile of Medicaid Expense Charts) and have at least two chronic health illnesses. (See Appendix A for 2011 Medicaid Decile Expense Chart.) Initiated in April of 2012, the primary goals of the MSHP pilot program are twofold: to improve health outcomes for program participants and to reduce Medicaid healthcare spending.

The MSHP pilot has 48 permanent supportive housing units and is staffed by three intensive case managers from HHO and HHCS. MSHP was designed to utilize a “care coordination” model of case management. Health-housing care coordination is a primary component of the pilot and aims to facilitate the sharing of electronic records and cooperation among housing, social service, and physical and mental healthcare providers. MSHP program clients will be invited to enroll in the Together4Health (T4H) Care Coordination Entity (CCE) or one of the other CCEs serving metropolitan Chicago. T4H and the other CCEs, also known as “health homes,” were developed as part of the Obama Administration’s Affordable Care Act.

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 were to:

- 1) Examine the development and implementation of the MSHP;
- 2) Assess program participant’s health and treatment “careers,” and help-seeking behaviors before and after enrolling in the MSHP;
- 3) Examine participant’s interactions with case managers and experiences with other components of 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.<sup>1</sup>

## 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

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<sup>1</sup> 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.)

sizes. The multiple types of data and 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. These data collection procedures carried out as part of this evaluation included interviews, focus groups, a review of a sample of case notes, and analysis of participant assessment data collected at six-month intervals. All relevant data collection instruments are included in Appendix B.

### Interviews

The research team conducted interviews with six stakeholders of the MSHP, including staff from the AFC, HHCS, and HHO partner agencies. The stakeholders were selected based on their role in the development and leadership role in the implementation of the project.

In addition, the research team conducted 13 interviews with participants of the program, about half of whom have HIV/AIDS. The 13 individuals were randomly selected from the current participants in the Medicaid Supportive Housing Program. The open-ended interview questions asked participants about their health-seeking behavior before and after entry into the program. One key component of the analysis was to discern any difference in health-seeking behavior of individuals with HIV/AIDS due to the additional health services available to them. The interviews were “blind,” as the researcher did not know the health status of the interviewee, unless the individual disclosed their health status. After all interviews were completed and the data had been entered into a database (no personal identifying information; names replaced with a unique ID number), AFC informed the researchers as to the HIV/AIDS status for each ID number.

### Focus Groups

The research team conducted one focus group with randomly selected case managers from each housing program in the MSHP. In addition, two participant focus groups were conducted. One focus group (Focus Group A) consisted of four individuals who were both housed at HHO and also received their healthcare at the HHO clinic. The second focus group (Focus Group B) was comprised of six participants who were not *both* receiving housing and healthcare from HHO. Thus, these individuals were housed at either HHO or HHCS and were receiving healthcare at various sites throughout Chicago.

### Review of Case Notes

In addition, the research team reviewed a random sample of case notes from 14 MSHP participants. (See Appendix D for detailed case note information for each of the 14 participants.) These data represent assistance case managers provided during the first 26 weeks participants were in the program. An instrument was developed to allow a researcher to “interview” each case record and quantify the case notes. An intern from AFC, trained by CURL researchers and supervised by AFC, reviewed 14 randomly selected case notes files of participants for the first six months in the program.

The case notes contain a record of each meeting, interaction or attempted interaction between the case manager and participant. Through each case notes record, the case manager records

information including the amount of time spent with the participant, location of service, type of service (i.e., referral screening, continued case management), “care action” topics addressed during the session (e.g., adherence to medical appointments, benefits, and housing), and problems experienced by the individual.

#### Analysis of Administrative Database

Lastly, we present here analyses of administrative data extracted from the AFC Client Track database. When participants first enter the MSHP (or any AFC permanent supportive housing program), their case managers complete an Intake Assessment with them. The Intake Assessment is designed to gather information including demographics, income, prior residence, and substance use, as well as health and any existing medical conditions. In addition, the case manager administers a reassessment tool with each participant in six-month intervals to measure changes in substance use and health and medical conditions. Finally, case managers administer an Exit Assessment when participants are exiting their supportive housing program in order to document information including exit destination and reason for departure. Case managers enter all data into AFC’s centralized Client Track database. The interview participants’ self-reports of improved health status are demonstrated in the preliminary analyses of the Client Track data.

The data were analyzed using SPSS, utilizing analysis of frequencies and means. These findings primarily demonstrate participants’ behaviors, and, to a lesser extent, attitudes about their health and well-being over time. Results from this set of longitudinal data track participants’ behavioral and attitudinal information over the course of 12 months (from Intake through their first year in the housing program). For the analysis of each item, only cases where the respondent answered the particular question at Intake, six-month, and 12-month Reassessments were included. Because of missing data, the sample size is every small for some of the variables analyzed and must be interpreted with caution. While on one hand administrative data such as this presents an opportunity to track program participants’ health indicators and behaviors over time, the missing data endemic in such data (and we have a very small program size to begin with) limits robust findings.

### **THE DEVELOPMENT AND STRUCTURE OF THE MEDICAID SUPPORTIVE HOUSING PROGRAM**

#### **Impetuses for the Medicaid Supportive Housing Program**

Below is a brief description of the key milestones and factors that stakeholders and case managers identified pertaining to the development and structure of the MSHP. The MSHP evolved as a result of multiple factors, which are discussed below.

#### Chicago Housing for Health Partnership

The first was a pilot study, the Chicago Housing for Health Partnership (CHHP), which was conducted by AFC in partnership with a number of permanent supportive housing programs and hospitals in Chicago beginning in 2003. A study of the CHHP program showed that housing individuals who were homeless and chronically ill reduced hospital, emergency room, and nursing home visits. Providing housing, therefore, not only improved health outcomes of these

individuals but reduced medical costs (<http://www.aidschicago.org/housing-home/chhp>). In 2007, the CHHP experiment led to a permanent citywide collaboration comprised of 15 healthcare, housing, and social service agencies.

### Samaritan Supportive Housing Project

The Chicago Samaritan Supportive Housing Project, one result of the CHHP study, represents a partnership of over two dozen health, housing, and homeless service providers (<http://www.aidschicago.org/being-a-good-samaritan>). The Samaritan Project, which began in early 2010, subsidizes 195 permanent supportive housing units. MSHP stakeholders outlined how the CHHP study, and later the Samaritan Project, were instrumental in laying the foundation for the MSHP, especially the housing aspect of the project.

### Federal Inter-Departmental Collaborations and Discussions

Another component that led to the creation of the MSHP occurred in the mid-2000s when officials from the U.S. Department of Housing and Urban Development (HUD) called for a meeting in New York that included a HUD official, an official from the U.S. Department of Health and Human Services (HHS), Medicaid directors from a few states and several representatives of supportive housing organizations (including Arturo Bendixen from AFC). The purpose of the meeting was to determine what role Medicaid could have in supportive housing programs since research (such as the CHHP study) had shown that permanent supportive housing reduces medical costs and therefore could potentially save Medicaid money. This spurred the HUD Housing Opportunities for Persons with AIDS (HOPWA) office to contact AFC directly to see if any kind of supportive housing could be provided for those who were high users of Medicaid and HIV positive.

### State and Federal Medicaid Initiatives

In 2008 State Medicaid and Public Health officials from Illinois, California, and New York, and officials from AFC all met in Chicago. From that meeting, AFC established connections with Illinois State Medicaid officials who were very interested in the supportive housing work for which AFC was involved. Illinois Medicaid provided AFC a contact that would assist the organization in acquiring information to determine who was eligible for a supportive housing project that would target the highest users of Medicaid in the state who were homeless. The data would also serve as baseline information to differentiate health costs before and after being housed. In return, AFC would provide Medicaid with results and qualitative data, such as clients' experiences of improved health outcomes.

This second meeting and AFC's newly developed relationship with Illinois Medicaid Office coincided with Barack Obama's first election in 2008 and federal healthcare reform. One MSHP stakeholder explained: *"One of the things that...the Obama Administration has done is really pushed the silo entities of the federal government - HHS, HUD, the VA - to try to collaborate a lot more. So the first Obama budget had money 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."*

Although the 4,000 HUD subsidies were cut from the final version of the budget, AFC and Illinois 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. This program would provide eligible individuals with permanent supportive housing as well as Coordinated Care (also known as managed care), through Together4Health (T4H) or another CCE in metropolitan Chicago. T4H is a newly formed Coordinated Care Entity (CCE) or “health home,” which consists of a total of 34 member entities including hospitals, primary care providers, behavioral health providers, supportive housing, and system-level organizations.

### **Development of Medicaid Supportive Housing Program**

In order to develop the Medicaid pilot program, AFC sought existing supportive housing partners to provide not only housing, but also seasoned case managers. It was also the desire of AFC to have one agency that has a medical facility because they have access to Medicaid and Medicaid information and one that was not. AFC was able to find “*cousin*” agencies that fit the bill. From the Heartland Alliance, both Heartland Health Outreach (HHO) and Heartland Human Care Services (HHCS) agreed to participate. HHO is the Federally Qualified Health Center (FQHC) for the Homeless in Chicago. One MSHP stakeholder described the two agencies as being model partners and ideal for the collaboration necessary for the MSHP. These agencies selected experienced case managers to work with MSHP clients.

In order to identify potential participants for the pilot, MSHP stakeholders including AFC staff as well as HHO and HHCS case managers recruited participants 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 the healthcare costs of these relatively small number of individuals consumes over one half of the Medicaid funding in the state of Illinois. 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 were attributed to hospitalizations and emergency room visits.

Initially, the MSHP outreach team recruited broadly, obtaining Medicaid release forms from individuals who were homeless and “*go to the hospital all the time,*” but Medicaid billing data show they were not high users. In response, the outreach team began utilizing a more targeted outreach approach. They worked with the HHO medical clinic and primary care staff providing services in various shelters to identify individuals who were sick and hospitalized frequently, and thus likely high users of Medicaid.

## Components of the Medicaid Supportive Housing Program Model

### Structure

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. An MSHP stakeholder explained that the Oversight Committee sets day-to-day program policies pertaining to harm reduction, frequency of visits with case managers, and carries out some data recording. 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 that of the CHHP and Samaritan projects.

### Agreements

Agreements for the project essentially follow standard contracts for supportive housing units as issued by HUD. AFC acts as the intermediary fiscal organization and provides program coordination and oversight. AFC sub-contracted HHO and HHCS to provide case managers, housing and other services. These sub-contracts require that the case manager to participant ratio needs to be no higher than 1:16 and that the case managers see participants at least once a month. All of these regulations are in line with all of AFC’s permanent supportive housing programs., AFC also reviews the case notes and Client Track reports, which case managers complete regularly to track the implementation fidelity and challenges to the delivery model.

Agreements (whether explicit or implicit) between AFC and the Illinois’ Medicaid Office will allow for a cost-benefit outcome analysis of this project. Due to the relationship that was established between these two stakeholders years ago, a system was established by which AFC submits required forms (i.e. data request and releases) to a staff contact at the state Medicaid office with data and information on the Medicaid uses of each person in the program. This allows AFC to track user data over time. AFC reports directly to the Illinois State Medicaid Office with the results of their analysis of those participants enrolled in the MSHP who have agreed to release of information.

### Interactions

The MSHP program consists of primary interactions among the aforementioned levels. The SIT Team meets every two weeks. *“[W]e follow that same model of coming together and talking about the different challenges and successes and using that group brainstorm to troubleshoot and for support and just to say, ‘you know, this is hard work and you’re doing a good job’ and to come up with new ideas of ways to do things,”* one MSHP stakeholder explained. In addition to the support and advice case managers receive during the SIT meetings, 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. When the MSHP was in its early stages, the Oversight Committee met more frequently – usually on a monthly basis. The

executive directors then meet biannually to discuss more comprehensive findings and results as reported by AFC. The systemic interval interactions also follow the preceding model of the CHHP and Samaritan Projects.

In terms of interactions between participants and case managers, in this program's case management model 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 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**

### **Recruitment**

For the implementation of the MSHP, 48 housing units were acquired and swiftly filled by eligible participants. As discussed above, potential MSHP participants were recruited through Chicago-area healthcare and service providers. A total of approximately 300 individuals signed a Medicaid release form. Of these, about 80 individuals qualified for the study based on Illinois' Medicaid determining they were in the top sixth decile. Among the 80 eligible participants, 48 were enrolled in the MSHP housing beginning in April of 2012. One MSHP stakeholder explained that none of the 80 eligible participants were turned away from the program. Rather, among the eligible 80 participants, 30 did not re-connect with the program after signing the Medicaid release form. Since the beginning of the MSHP in April of 2012, 59 people have been housed. The discrepancy between program participants and available units is attributed to the fact that a small number of people have either passed away or left the program. Therefore, the housing component of the MSHP is going according to plan.

### **Characteristics of Participants**

Among the MSHP participant population<sup>2</sup>, 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; 5.6% reported a Hispanic ethnic background. At the intake assessment, nearly half (45.3%) of respondents reported that they were HIV positive, while 54.7% reported that they did not have HIV.

### **Care Coordination**

In addition to the housing component, care coordination was a primary element in the MSHP pilot model. Initially, it was planned that the MSHP pilot would coordinate with the Together4Health (T4H) Care Coordination Entity (CCE). Delays in the implementation of T4H required modifications in this process evaluation of the MSHP. Rather than exploring case management practices with and without care coordination – the original fourth research question guiding this evaluation – we explored the experiences of case managers at HHO whose participants receive both housing and health services. We compared case management

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<sup>2</sup> These data presented here represent data entered into Client Track as of July of 2013.

practices at HHO to those at HHCS, where case managers do not have direct access to a database containing their participant' medical information. As discussed further below, HHO case managers have access to HHO's Centricity database, thus are equipped to provide integrated housing and healthcare. (See Appendix C for further discussion of Together4Health.)

## HOW DOES THE MEDICAID SUPPORTIVE HOUSING SYSTEM WORK?

### Process of Getting into the Medicaid Supportive Housing Program

Among the 13 individuals who completed a participant interview, 10 had been housed in the MSHP for at least one year. Likewise, among the focus group participants, the majority had been housed for a year or more, with only one participant housed for a shorter length of time.

People were sheltered in a variety of circumstances prior to entering the MSHP. Among those that interviewed or participated in a focus group, the most predominant circumstance was either an emergency shelter or an interim housing program. A few had previously been in nursing homes, one leaving to avoid the nursing home becoming the payee for her Supplemental Security Income (SSI). A few others were on the street, or had recently entered drug/alcohol treatment facility after being on the streets, but a couple more resided with relatives or friends, one living on a cold and rat-infested porch at her sister's house.

The ways in which these participants were informed about the MSHP also varied. Some learned of the program through their existing case manager with Heartland or another agency, while others were informed through an outreach worker on the street. Others met someone from Heartland doing outreach at the shelter, clinic, or treatment center from where they were receiving services. 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 were satisfied with the process of getting housing, describing it as a "*smooth*" process. Some participants related that their case manager helped them to "*adapt*" and get "*established.*" Their respective case managers assisted all participants in locating a suitable apartment, and some mentioned receiving furniture, a "*starter kit*" including pots and pans, and help moving possessions into their new apartment. Most participants looked at only a few units before settling on an apartment. However, one participant explained that it was difficult to find an affordable apartment in close proximity to 24/7 public transit in an area of the city in which she was comfortable residing. Other participants expressed concerns about their neighborhoods; some described the area as violent and dangerous and one individual had harmful relationships in their current neighborhood and wanted to move.

## Interactions between Case Managers and Participants

### Overview

According to MSHP stakeholders and participants, the case managers are a “*very strong*” and “*vital*” component of the pilot. HHO and HHCS hired seasoned case managers with experience working with the MSHP population, and in terms of qualifications, case managers have at least a bachelor’s degree and approximately three years of experience. Case managers provide a wide array of supportive services while setting goals including managing healthcare, housing, finances, and education opportunities. Overall, the sentiments of case managers, participants, and stakeholders in the MSHP were largely affirming of one another while also pinpointing key challenges in the program’s implementation.

### Goal-Setting

Case managers identified their role, overall, as to “*help the participant help themselves.*” They saw the means to do this was to assist participants in identifying and achieving personal growth goals. Case managers described working with the participants to develop individualized treatment plans when they first enter the program and then updating these plans on a bi-annual basis. They described facilitating the development by the participant of six-month goals in three areas of four areas: health, housing, and income or professional development. One case manager described how harm reduction techniques are used – including motivational interviewing – to help participants to explore their thoughts about these areas, establish goals, and help them to move forward in achieving them.

### Meeting Frequency

Case managers reported that the frequency of their meetings with participants varies based on the individual’s length of time in the program, as well as their specific needs. Case managers estimated that they met with their participants at least twice a month during the first six months of the program, though the frequency of meetings typically tapered off to once per month after the first six months, at minimum. Among the participants, they described meeting with their case manager between one and four times per month, and these meetings typically occurred at the participants’ homes, yet some participants met at the HHO Resource Room or their case manager’s office.

These estimations by the case managers and participants were echoed in the reviewed case notes. For example, among the 14 random case records reviewed, we found a range of contact between the case managers and participants during the first six months of being in the MSHP. The number of contacts ranged from 20 to 40. Approximately 1/5 of the time scheduled appointments were missed and were rescheduled. The contacts took place in a number of settings including home visits (33%) the case manager’s office (18%), and phone calls (42%). Approximately 5% of contacts involved a third party, such as a landlord. The reasons for the visit varied; they included assessments, case management, follow-up, or the case manager leaving messages and trying to connect. Rarely did a week go by without a point of contact.

Case managers and their supervisors expressed that these case management meetings are critical, and that, ideally, they could occur more frequently. Overall, case managers, participants, and stakeholders revealed these points of contact between case managers and participants as one of the most influential facets of the program.

## Housing

An overwhelming benefit of the program, participants reported, is the stable housing. One person related, *“The best part is having shelter - my housing. When you have an apartment, everything else falls in line from there.”* Participants feel a sense of security knowing the rent will be paid through the program, and some mentioned that the portion they are required to pay is affordable.

Besides harm reduction techniques, the case managers utilize Housing First approaches in their work with MSHP participants. We make *“sure that the [participants] understand that housing is a first goal,”* one case manager related. Adhering to a harm reduction approach, case managers connect participants to resources and develop goal-setting strategies.

When participants first enter the MSHP, their case manager assists them in locating an apartment, and for most participants case managers also assisted in obtaining furniture and other household items for their apartments. One case manager helped a participant secure a personal assistant (PA) who assists with cleaning, cooking, laundry, and other household activities. According to several MSHP stakeholders, case managers dedicate a great deal of time addressing housing issues with participants. One stakeholder related: *“I mean it is one thing to get someone housed, but keeping them housed is an ongoing process, not with everybody.”*

The reviewed case notes illustrate this process. Housing and housing-related issues were a consistent issue in which case managers and participants interacted during the six months for which files were reviewed. Among the 14 reviewed cases, nine seem to have fairly stable housing circumstances, although not without some problems, and among the remaining five individuals, housing stability problems were an ongoing major challenge. Looking at individuals who had housing stability problems, we see a varying combination of issues:

- Re-hospitalization, death of a family member, falling behind in rent, beginning to hear voices again.
- Hospitalized after mugging when phone and wallet stolen, late on rent, case manager can't contact client, phone disconnected, front door does not lock properly, heat is not working so participant using oven.
- Participant informed landlord would be late with rent, therapist report participant *“not doing well,”* outstanding electric bill and electric shut off, damaged CTA card, participant suspected of using substances, participant has not paid rent in four months, participant is hospitalized.
- Participant's phone not working and need to schedule housing inspection, participant has relapsed and is in hospital, participant reports housing has bed bugs and roaches and threw out furniture (calls health department); CTA pass stolen, participant

intoxicated, participant phone is disconnected again, participant goes to AA; recurring problem with bedbugs, participant intoxicated again.

- Working on housing location, housing resources education, participant has not moved in new apartment, case manager trying to locate participant, participant moved out of apartment without notifying landlord or case manager, hospitalized for mental illness, participants' refrigerator and stove stolen, food stamps have stopped, abusing substances.

Looking at participants with the most stable circumstances, we still see that in some cases they and their case managers were still addressing housing-related issues:

- Housing location and housing resources education, housing inspection, apartment is flooded and participant late in rent, stolen CTA card, issues with plumbing in the house.
- Housing location and housing resource education, housing inspection, case manager having problems contacting participant, landlord reported complaints from other tenants about noise, participant missing appointments.
- Before move the shelter had bed bugs, housing location and resources assistance, participant had anxiety after moving; landlord reported tenancy problems, a leak in the bathroom.
- No housing related problems indicated but continued housing resource education noted.
- No housing problems indicated but continued housing resource education noted.
- No housing problems indicated.

### Healthcare Management

As the main objectives of the MSHP are to improve health outcomes for program participants and to reduce Medicaid billing, case managers help participants to navigate and negotiate the healthcare system. In the case notes review, we find that 50% of the issues case managers noted were health-related (see Table 1).

Over one-fourth of the health-related issues pertained to appointment and medication adherence. Case managers and stakeholders described that one of the program's primary strategies is connecting program participants to primary health care providers and medication. Case managers connect people to primary care physicians, accompany them to appointments, go to a pharmacy to help them get prescription refills, and advocate for the individual if they are not getting the refills they need. In some cases, the case manager will help to negotiate the relationship between the participant and the physician or health program, as according to one stakeholder, *"they know their client the best, a lot of times, out of anybody"*

Case managers reported assisting individuals to adhere to their medications as prescribed and maintain their physical and mental health. They also described inquiring with participants about

whether they are taking their prescriptions. However, one case manager explained that because they do not have daily contact with participants, they are not able to ensure participants adhere to their medications. In addition, case managers explained that participants' substance use often interferes with medication adherence. One case manager's explanation below shows the consistency and perseverance needed.

*I have a participant and she self-disclosed that whenever ... actively using, she just doesn't take any of her HIV medications and she's been actively using since like January of 2011. ... I had tried a combination of "before you pick up the drugs can you just take your medication?" And that wasn't working, and ... she disclosed: "Every time I have to take this medication, I'm reminded of the asshole who gave me HIV." ...Then little by little we got her to go to the doctor. We were gonna go back in two weeks to get the results and she didn't show up ... then we get the Medicaid spending breakdown again and she ... she hasn't been taking her medication ... having that information I was then able to go back and have this conversation with her like, "here's what we're trying to do, you're doing it, but in this case that's not what we want..."and still trying to just figure out a way that's gonna make her want to go and take the medication... .*

*So I had another participant. She got mugged and hit over the head with a tire iron, and that just set her into such a bad depression that she stopped taking her medication, but she's really adherent to her medical appointments. She had gone and got her blood work done, and in just the three weeks she had stopped taking her medication. We saw her CD4 level drop by 200, and so she was able to like have that tangible proof in front of her that like, "better get on this again," now that pulls her out of her depression and like, "I need to get back on track to improve my health." She has a number of other conditions that could worsen quickly if she were to stop taking her medication. It varies from person to person and so, I think those are the most concrete examples of how wildly medication adherence will vary among the population we're working with.*

### Accessing and Managing Economic Resources

In addition to assistance maintaining health and housing, case managers reported striving to connect participants to income and benefits resources including food stamps and SSI. Beyond these primary areas, case managers reported assisting participants to meet their individual needs. These include assistance with furniture, employment, education and vocational training, transportation, immigration assistance, and other legal support.

Money management is another area in which case managers assist. One participant mentioned that her case manager helped her to develop a budget sheet. Another participant explained that he applied for HHO to become his payee, yet Social Security denied the request. For another participant, in contrast, HHO is his payee. Other participants also mentioned this assistance with developing a budget as well as setting up a credit union account and auto bill payment for rent. As participants envision more financial stability, case managers are ensuring that they set future-oriented goals to become self-sustainable through the housing first model.

Case managers have also provided employment and educational assistance. For example, one participant had discussed obtaining his GED with his case manager, and another received information about vocational training. Still, another participant hoped for even more assistance and information regarding employment and volunteer opportunities. In some cases, case managers have provided information about education opportunities including programs and classes, such as computer classes.

Case managers have also helped participants apply for SNAP and connect to food pantries as well as receive transportation assistance through CTA passes and reduced fare cards. In addition, case managers have provided information regarding YMCAs and other gyms, and with one individual, a case manager even helped their diabetic participant work closely with a dietician to purchase and consume foods that are appropriate for his medical condition.

Through the review of the case notes, we see that 10% of the action items noted between participants and case managers were benefit-related, money management (9%), transportation (6%) and education and employment (3%). Interestingly, the participants in their interviews did not identify assistance with social services as an area which increased with their entry into the program.

### Social and Emotional Support

In addition to the resources and assistance case managers provided, participants described their appreciation that their case manager is someone they can talk to. All participants shared that their relationships with case managers were crucial to their positive experiences in the program. They discussed the quality of support they received and that their ability to discuss anything with their case managers. Some participants described having a strong bond with their case manager, describing them as a friend or like family.

While a great deal of that emotional and social support is part of the process of the interaction and harder to quantify, it is instructive that in the case records review we found that 5% of the case manager and participant interactions were identified as being about explicit emotional support: and a small percentage of interactions (0.7%) were crisis interventions (8 interactions).

**Table 1. Assistance Case Managers Provide to Medicaid Supportive Housing Program Participants<sup>1</sup>**

Care Action Categories	Percentage
<b>Health-Related</b>	<b>50.4%</b>
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%
<b>Benefits Assistance (advocacy, application, maintenance)</b>	<b>10.4%</b>
<b>Money Management</b>	<b>9.0%</b>
<b>Housing (location, resource education, problem-solving)</b>	<b>7.1%</b>
<b>Transportation</b>	<b>5.7%</b>
<b>Emotional Support</b>	<b>5.3%</b>
<b>Food and Nutrition</b>	<b>3.5%</b>
<b>Other</b>	<b>3.2%</b>
<b>Discuss Change in Level of Care</b>	<b>2.2%</b>
<b>Employment</b>	<b>1.6%</b>
<b>Education</b>	<b>0.9%</b>
<b>Crisis Intervention (including domestic violence)</b>	<b>0.7%</b>

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

## THE IMPACT OF DIFFERENTIAL ACCESS BY CASE MANAGERS TO PARTICIPANT MEDICAL INFORMATION

### Case Management with “Quasi” Coordinated Care

Due to the delays with implementing T4H, we were unable to compare the experiences of case management with and without care coordination. However, one AFC staff member explained that case managers are able to do “quasi” coordinated care. Case managers from HHO are better equipped to provide integrated housing and healthcare case management – a coordinated care approach – to participants because they have access to the HHO Centricity database. This database is utilized by healthcare providers at the HHO clinics to enter patient health information. Among those MSHP participants who are both housed through HHO and receive care at an HHO clinic, their case manager is able to view information in the database to monitor their health. The database contains information about medical appointments including scheduled appointments and whether the participant attended an appointment. Further, the database also indicates the medications prescribed for each participant, as well as whether a

new prescription/refill has been picked up. This information helps facilitate conversations between the case manager and the MSHP participant about the participants' health. Also, the HHO case managers are able to remind the participant about appointments and medications. Likewise, the HHO case managers are able to schedule medical appointments at the HHO clinic for participants via the Centricity database. In addition, the case managers are able to "easily" obtain a medical report for each participant every six months, which is a requirement of the MSHP.

The case manager from HHCS, in contrast, does not have access to the Centricity database, thus is neither able to view the aforementioned health information nor schedule medical appointments for their MSHP participants. Recalling a conversation with the HHCS case manager, one AFC staff member explained: "... when I talked to the case manager at Heartland Health she said, 'The number one thing that would improve my job is if I had access to Centricity' but she does the best she can with what [information] she has." The HHCS case manager explained that the level of care coordination she is able to provide is dependent on the individual participant. The HHCS case manager proactively asks participants about scheduled appointments and prescribed medications, however some participants do not accurately recall this information. Thus, this case manager is not always able to make appointment reminder calls or check-in to ensure they are taking their medications as prescribed. In addition, although the participants for whom she provides case management have signed a release of information form, one major challenge is that the medical providers typically do not respond to her requests for information. The HHCS case manager explained: "In that regard it has been really difficult to even really have a full understanding of what my participants health issues are, because I am getting it from them, and they are not the best historians of their own medical appointments or [I have] to just wait until someone [medical provider] decides to respond to me. So, it's frustrating."

Similarly, the HHO case managers related that they experience challenges with obtaining health information and medical reports for participants who do not receive their healthcare at the HHO clinic.

### **Participant Experiences**

Case managers provide varying levels of assistance with managing their healthcare, participants explained. Participants who are both housed and receive healthcare at HHO discussed a greater level of assistance from their case manager in managing their health care relative to those participants were housed at either HHO or HHCS and receiving healthcare from different sites. Members of housed and receiving healthcare at HHO related that their case managers often make their medical appointments, set up referrals, and call to remind them about appointments. This is not surprising given that the case managers at HHO have access to the HHO Centricity database.

### **Educating Participants about Care Coordination**

During the period prior to the implementation of T4H in January of 2014, an AFC staff member met with the MSHP participants to discuss their healthcare experiences and to educate them

about care coordination. AFC issued a series of progress reports in July, September, and December of 2013 documenting information gathered during those meetings. Reporting on the meetings with the nearly three-fourths of participants with whom she had already met as of October of 2013, she reported: *“Everybody loves the care coordination aspect of it [Together4Health]. They say things like, ‘I wish this would have been put in place a long time ago, I can really see how this would benefit me, this seems like a great idea,’ they kind of see the effectiveness, I think, really quickly.”*

Through her meetings with MSHP participants, the AFC staff member characterized those participants engaged in care compared to those not engaged in care. Many of those who are engaged *“have a very supportive, caring, and almost family-like relationship with their provider.”* This AFC staff member continued:

*...their engagement depends on a supportive relationship and someone they feel listens to them, cares for them, and has their best interest at heart. They describe their providers as like family members to me, “I love this person, they have cared for me when I was homeless.” It is a very intimate close relationship, and that is where I see people going to their appointments, taking their medication, listening to what their doctor tells them to do because...they have that supportive relationship.*

Relationships with healthcare providers also affect those participants not engaged in their care. This AFC staff member explained that those participants who are not treated well at the clinic or feel that their healthcare provider does not listen or understand them are likely to not be engaged in their care. Participants experience both individual and systemic barriers to accessing and engaging in care, specifically: financial issues, organizational barriers, negative relationships with providers, substance abuse, mental health issues, and family issues.

## **CHANGES IN HEALTH-SEEKING BEHAVIOR**

In assessing the effectiveness of this program with participants, we interviewed participants to see how their healthcare experiences had changed after enrolling in the MSHP. Interview data suggest that MSHP has afforded participants across the board positive benefits in managing their healthcare. When directly asked if there was any change in their health status, participants reported that they felt a significant positive change in their health status. One participant said that their health issues have become *“100% better.”* While participants without HIV reported larger improvements than participants with HIV due to their less consistent healthcare access prior to MSHP, all participants overwhelmingly hope for the continuation and expansion of this program.

### **Healthcare Management**

Before the program, all program participants had Medicaid. A majority of participants without HIV stated that the ER was their most consistent form of healthcare managements as their frequency of visits ranged from every other week to once a month. While participants with HIV

saw the ER as an option, they overwhelmingly managed their healthcare by seeing regular physicians at the Stroger Hospital's HIV/AIDS clinic, the CORE Center, and other locations. It is clear that participants without HIV had much more reliance on the ER for their basic needs than participants with HIV.

After beginning the MSHP program, it is not surprising that those without HIV showed a stronger contrast in before and after preventative care and use of primary care physicians. The ER was only mentioned by one participant with HIV for the reason that she may have taken too many pills or the pills were interfering with her other medication. Since being in the program, responses ranged for participants from seeking primary care physicians at locations including the CORE Center, Heartland Health Outreach, and the Family Health Clinic.

### **Types of Providers**

Before participating in the program, individuals without HIV said that they mostly saw doctors at the ER with a small amount having seen psychologists, nurse practitioners, and diabetes physicians. Conversely, most participants with HIV stated that they had already been seeing specialists or some kind of regular doctor with responses ranging from optometrist to diabetes physician to primary care doctor and other specialists. Overall, participants with HIV, and the one cancer survivor who had been connected through a Medicaid program for individuals with breast cancer, had more knowledge and access to specialized doctors than the other program participants.

After entering the program, the responses of many participants revealed that they had been beginning to see new primary doctors at various healthcare centers and facilities. 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. While participants without HIV had begun to see new doctors and primary care physicians, participants with HIV overwhelmingly stated that they were simply continuing to see their regular doctors and specialists, primarily at the CORE Center.

### **Frequency of Seeking Services/Treatment**

Before participating in the program, individuals without HIV made frequent visits to the ER ranging from every other week to once every few months. While three participants also met with a primary doctor or specialist, most individuals without HIV reported primarily going to the ER and only seeking treatment when absolutely necessary. Conversely, all individuals with HIV received treatment with a primary doctor or specialist ranging from once a month to once every three months. While three participants with HIV did report seeking treatment at the ER as well, they did so on an irregular basis and for reasons including depression, problem with medication, bipolar disorder, pneumonia, and seizures.

After beginning the program, individuals without HIV reported that they were no longer receiving treatment at the ER but instead sought services from primary care doctors and specialists ranging from twice per month to once every two months. All participants with HIV shared that they continued receiving treatment from their primary care physicians and

specialists ranging from one per month to once every two months. In the case of three participant with HIV who had been seeking treatment at the ER, two also no longer sought treatment at the ER once the program began. The one use by the other individual was for an adverse drug interaction/overdose. Table 2 below 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.

### **How Access/Manage Medication**

Overall, prior to entering the MSHP, individuals who described having a 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. Most of those individuals reported receiving assistance managing medications from social workers, personal assistants, and specialized programs such as the CORE Center or Interfaith House. The other individuals mostly responded by saying that a doctor helped them manage their medication by distributing it to them when at the hospital or ER. For example, one participant said that the ER would give him 10 pills and then he would go to the doctor at Cook County Hospital, at 7:00 am, where first 10 people could see the doctor, and if he was the 11<sup>th</sup> in line, he had to go to the ER again where he would get one day's pills at the ER and then go back the next day.

After beginning the program, most responses from participants indicated stable, continuous access to medications, with self-management as well as some 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' adherence to medication, scheduling doctor appointments, and providing general support and assistance.

### **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. If the participants did state that they had someone to help, that person was usually a friend or family member. In two cases, doctors provided some direction but they were ultimately forced to take care of their situation 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. While some participants reported that case managers reinforced current regimens and schedules, others reported that case managers had promoted new ideas or ways of approach difficulties. For example, one participant said that their case managers suggested Weight Watchers and provided information for the participant to look into it further. Another who had not done any self-care related to his diabetes reported starting to address problems before they reached the stage of toe amputation (as it had prior to the program). The few participants that did not mention their case manager said that their significant other or other program providers (e.g. nurse advocate) were helpful in navigating the healthcare system.

**Table 2. Location and Frequency of Health Care Services Before and After Enrolling in MSHP (N=13)<sup>3</sup>**

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

<sup>3</sup> 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.

### Connection to Social Service

Before the program, all except two participants stated that they had SSI or an Illinois Link Card.<sup>4</sup> In the cases of the two exceptions, one was unsure if they had received food stamps and the other shared that the CORE Center helped them get on disability.

After beginning the program, few participants reported changes in their connection to social services. In one case the cancer-surviving participant said that her food stamps were decreased when she became housed at Heartland and her case manager was working on that issue. In another case a participant with HIV said that their case manager linked him to skills trainings, trade schools, and additional social service resources.

### CHANGES IN HEALTH STATUS AND BEHAVIOR

The following section discusses the ways in which participants' health status have changed after entering the MSHP. In addition to reporting information participants shared during interviews, we report preliminary health data collected through the Client Track database.

Participants described many ways in which stable housing has helped them to improve their health. One participant even said, *"It's changed my whole life. I'm a different person."* Participants related that they can manage their health conditions better with the stability of housing, versus when they were homeless, they were not able to keep medical appointments or take medication as prescribed. Some participants mentioned having lower blood pressure and increased T-cells.

Individuals with conditions including high cholesterol, heart disease, and diabetes related stable housing has enabled them to improve their diets as they are now able to eat regularly and attempted to eat more nutritious foods. In addition, stable housing enables people to check their blood sugar regularly. Further benefits participants described include not using drugs or drinking, and living in an apartment separate from negative relationships and influences. In addition, simply being housed allowed for better health while not being exposed to harmful elements including rodents and extreme weather. Some 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.

In addition, participants described how permanent housing had substantially improved their mental wellbeing. For example, participants described reduced stress and increased drive and motivation. Many participants feel happier, with one participant relating that she is now able to invite family over to visit, activities which *"keeps joy in life."*

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<sup>4</sup> This does not reflect information reported in the case notes, as case managers reported assisting participants apply for these benefits.

### **Intake and Re-Assessment Tool Health Data**

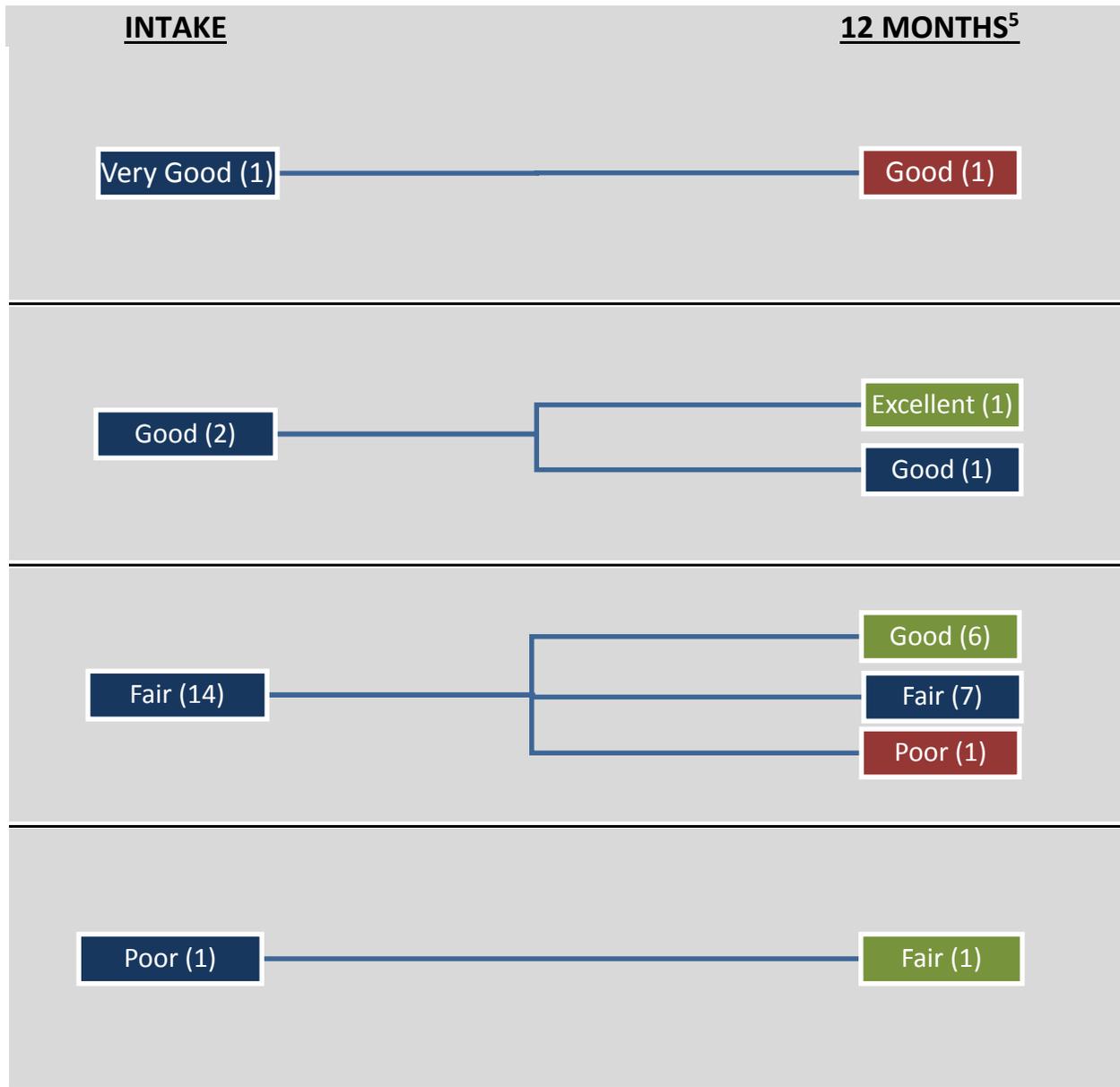
The following section presents results from preliminary descriptive analyses of select health and well-being data collected through the Intake and Reassessment tools.

This data provides an interesting picture of the changes in health status and adherence to medications among participants of the MSHP. Albeit, because of the very small sample size, these results should be seen as tentative and exploratory. Overall, we see an improvement in participants' reports of general health, including a reduction in physical and emotional problems interfering with their social activities. We also see that participants reported not being as restricted in activities due to their physical health. Likewise, among various indicators of psychiatric medication adherence, we largely see an improvement or no change (thus stability).

## General Health

In general, would you say your health is...

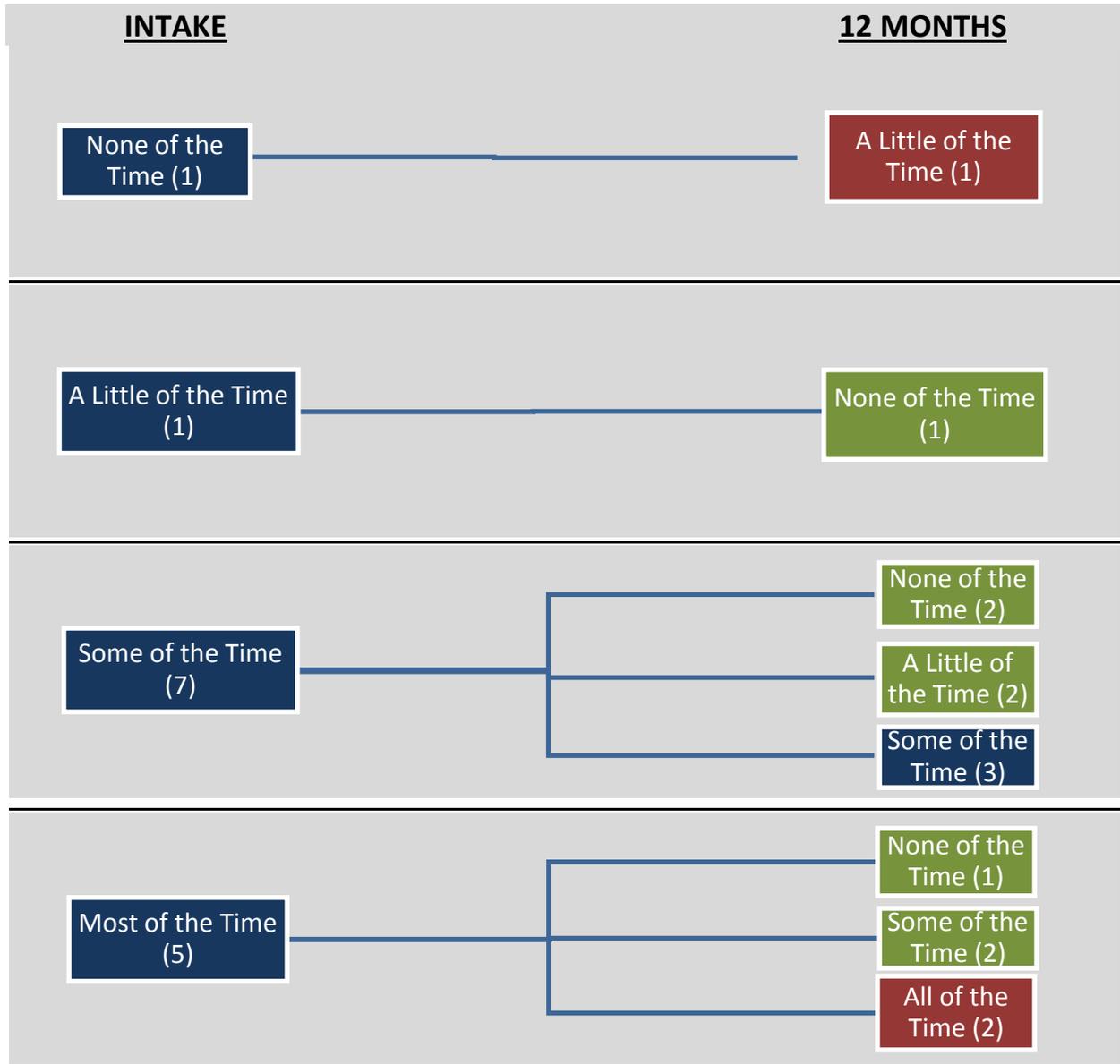
Respondents rated their health on a scale of 1 to 5, where 1 is “excellent” and 5 is “poor.” A total of 18 respondents answered this question at intake, at 6 months, and at 12 months. Of them, 8 (44.4%) reported no change in their general health status; 2 (11.1%) reported a decline in their general health status; and 8 (44.5%) reported an improvement in their general health status.



<sup>5</sup> Participant answers at the 12-month re-assessment are color-coded in all of the diagrams included in this section. When a respondent’s answer at the 12-month reassessment matches their intake response, it is coded in blue. Responses which denote an improvement are coded in green and responses which denote a decline or worsening are coded in red.

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

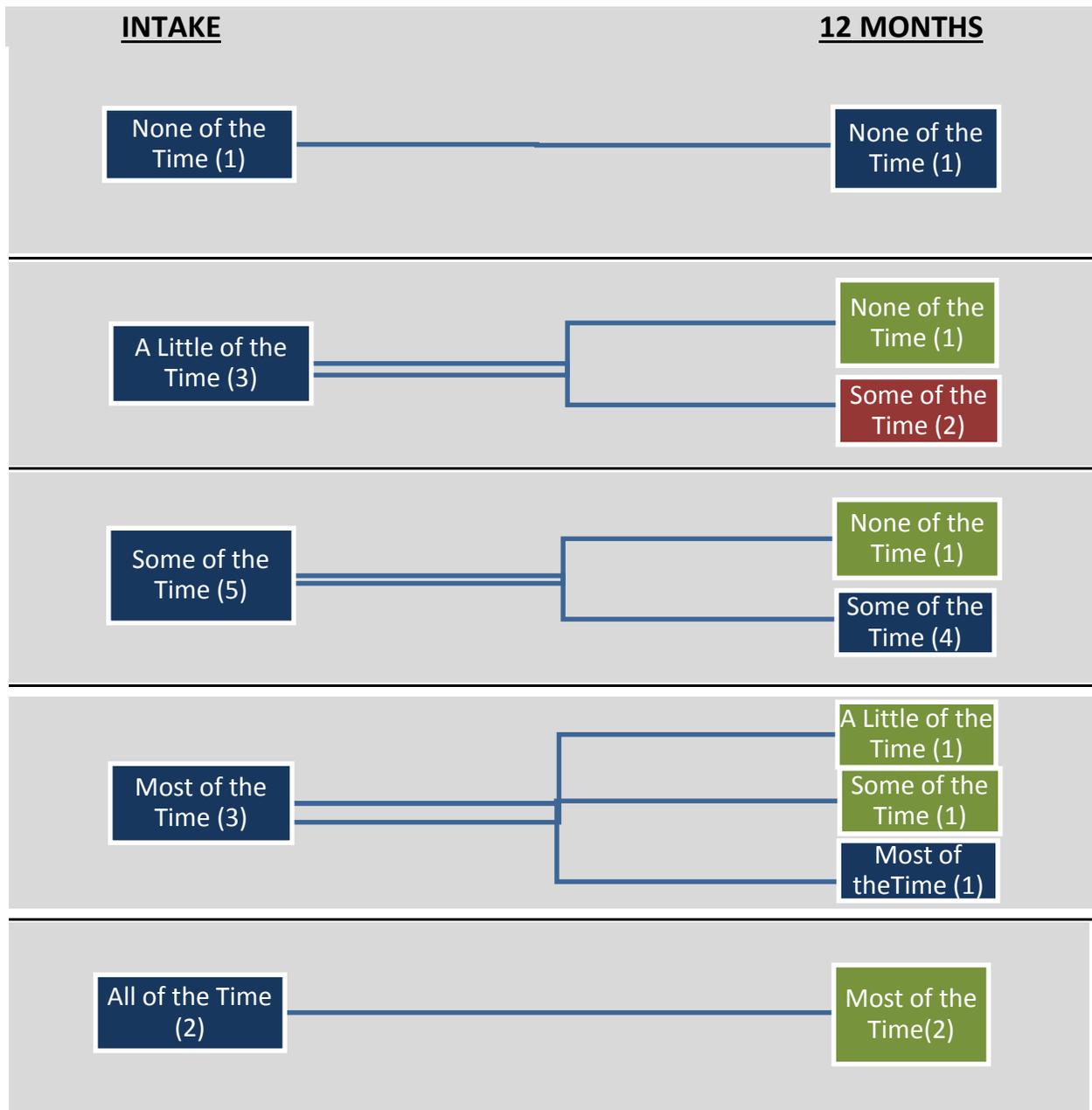
Respondents rated this item on a scale of 1 to 5, where 1 is “all the time” and 5 is “none of the time.” Of the 14 respondents who answered this question at intake, at 6 months, and at 12 months, 3 (21.4%) reported no change in how much their physical or emotional problems interfered with their social activities; 8 (57.1%) reported a decrease in how much their physical or emotional problems interfered with their social activities; and 3 (21.4%) reported an increase in how much their physical or emotional problems interfered with their social activities.



## Physical Health

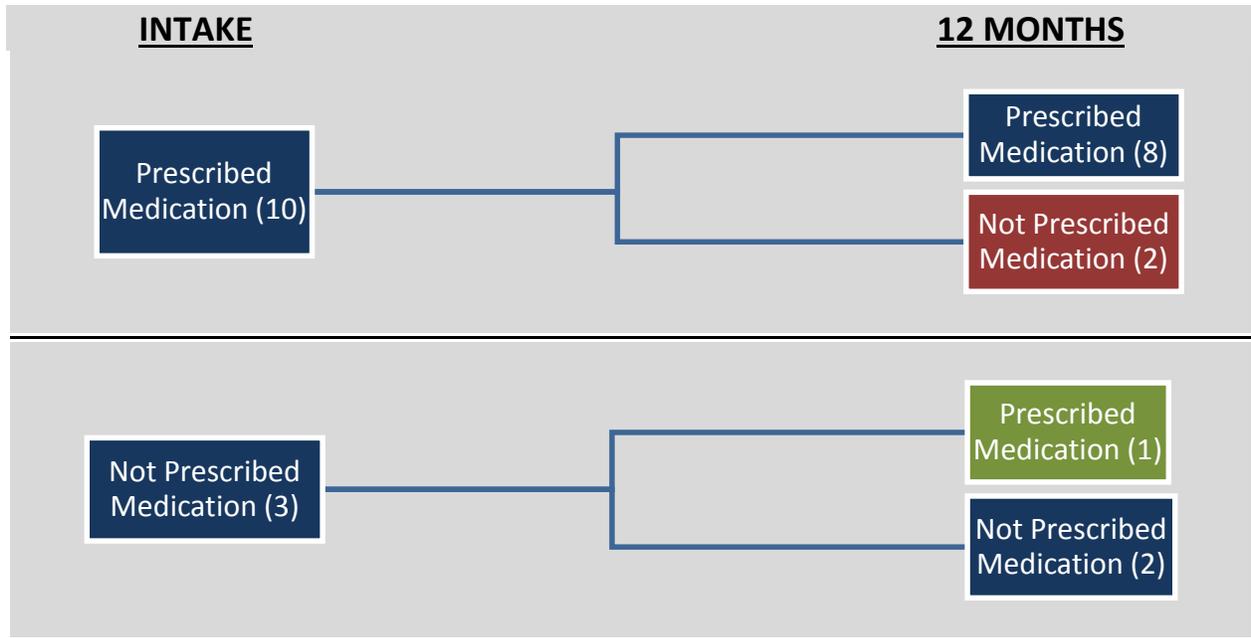
During the last 4 weeks, have you accomplished less than you would like as a result of your physical health?

Respondents rated this item on a scale of 1 to 5, where 1 is “all the time” and 5 is “none of the time.” Of the 14 respondents who answered this question at intake, 6 months and 12 months, 6 (42.9%) reported no change in how much they have accomplished; 6 (42.9%) reported that their physical health was less of an impact on how much they accomplish (thus, an improvement); and 2 (14.3%) reported that their physical health caused them to accomplish less.



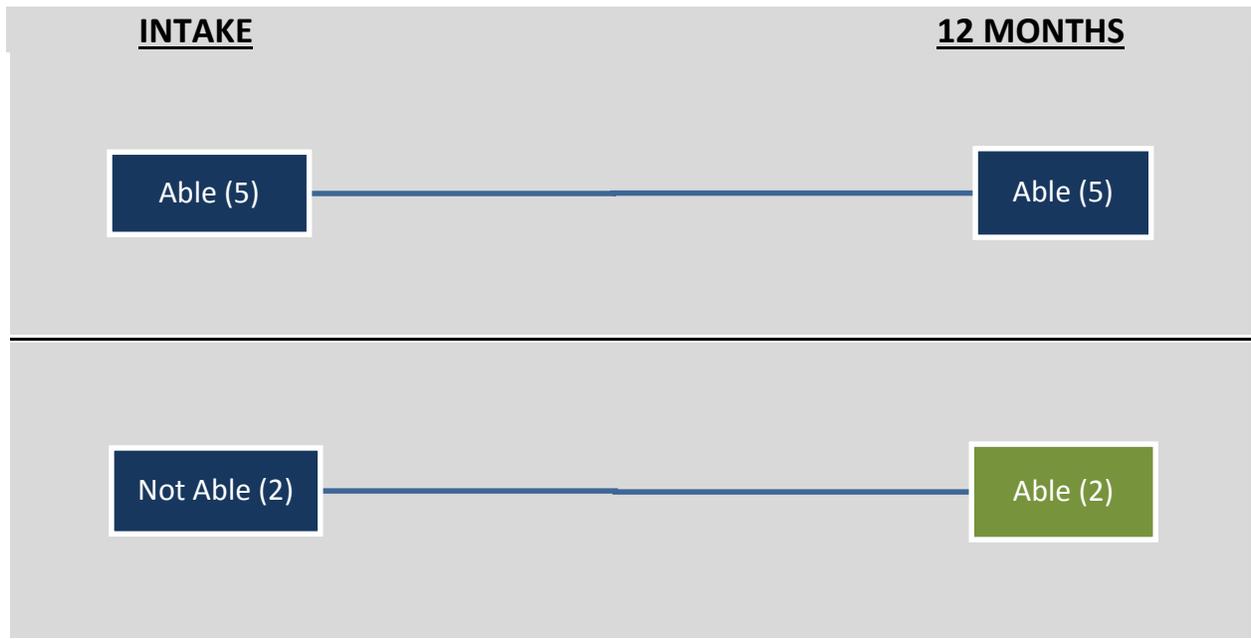
Are you currently being prescribed medication for your chronic medical condition(s) (not including HIV or psychiatric medications)?

A total of 13 respondents answered this question at intake, at 6 months, and at 12 months. Of the 13 respondents, 10 (76.9%) reported no change in whether they were currently being prescribed medication for their chronic medical conditions; 2 (15.4%) reported that they had gone from being prescribed medication to not being prescribed medication; and 1 (7.7%) reported that they had gone from not being prescribed medication to being prescribed medication.



Have you been able to follow through on the prescription?

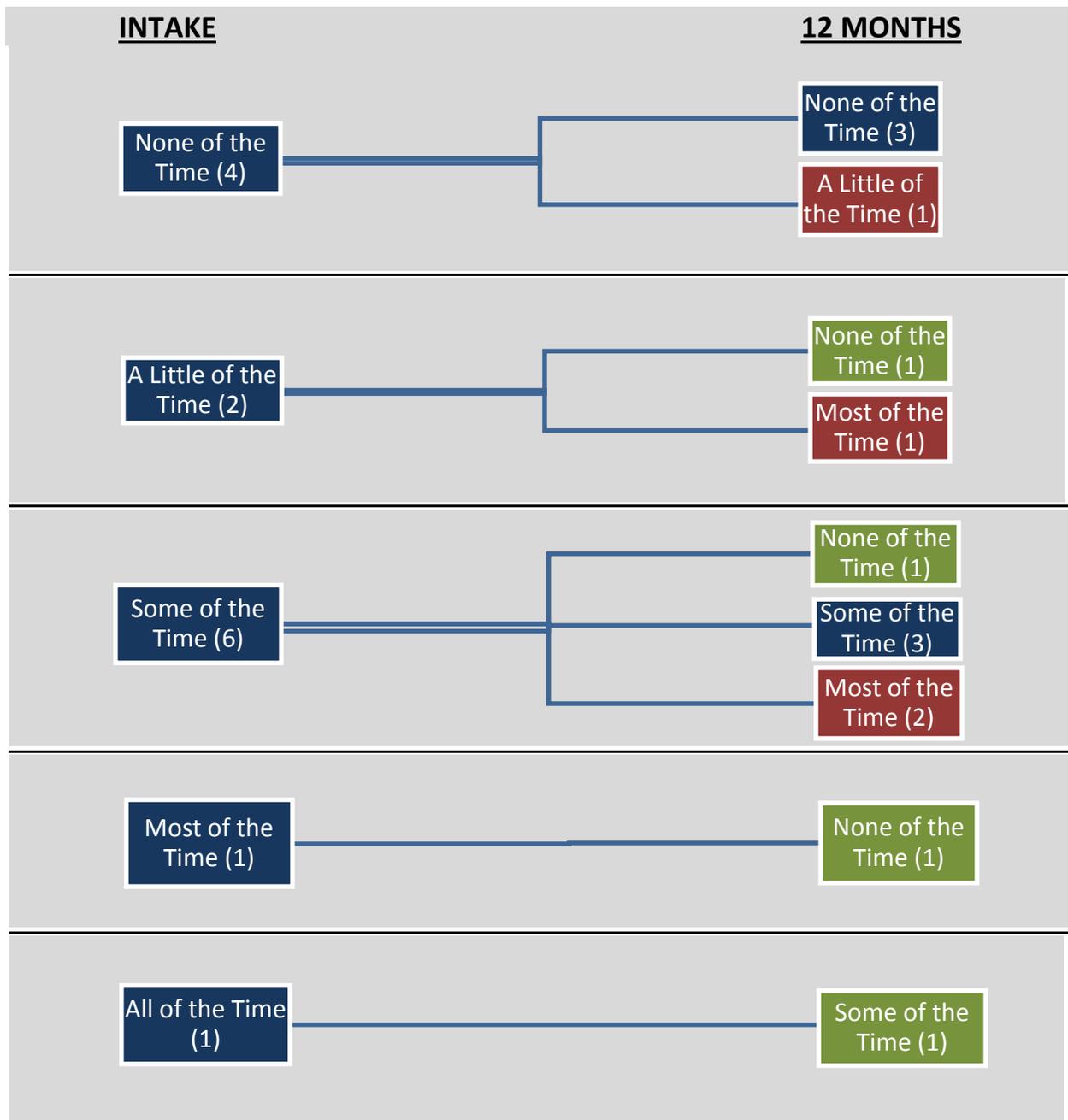
A total of 7 respondents answered this question at intake, at 6 months, and at 12 months. Of the 7 respondents, 5 (71.4%) reported no change in whether they were able to follow through on their prescription; 2 (28.6%) reported that they had gone from not being able to follow through to being able to follow through.



## Mental Health

During the past 4 weeks, have you accomplished less than you would like as a result of any emotional problems (such as feeling depressed or anxious)?

Respondents rated this item on a scale of 1 to 5, where 1 is “all the time” and 5 is “none of the time.” Of the 14 respondents who answered this question at intake, 6 months and 12 months, 6 (42.9%) reported no change in how much they accomplished; 4 (28.6%) reported that their mental health was less of an impact on how much they accomplish (thus, an improvement) and 4 (28.6%) reported that their mental health caused them to accomplish less.

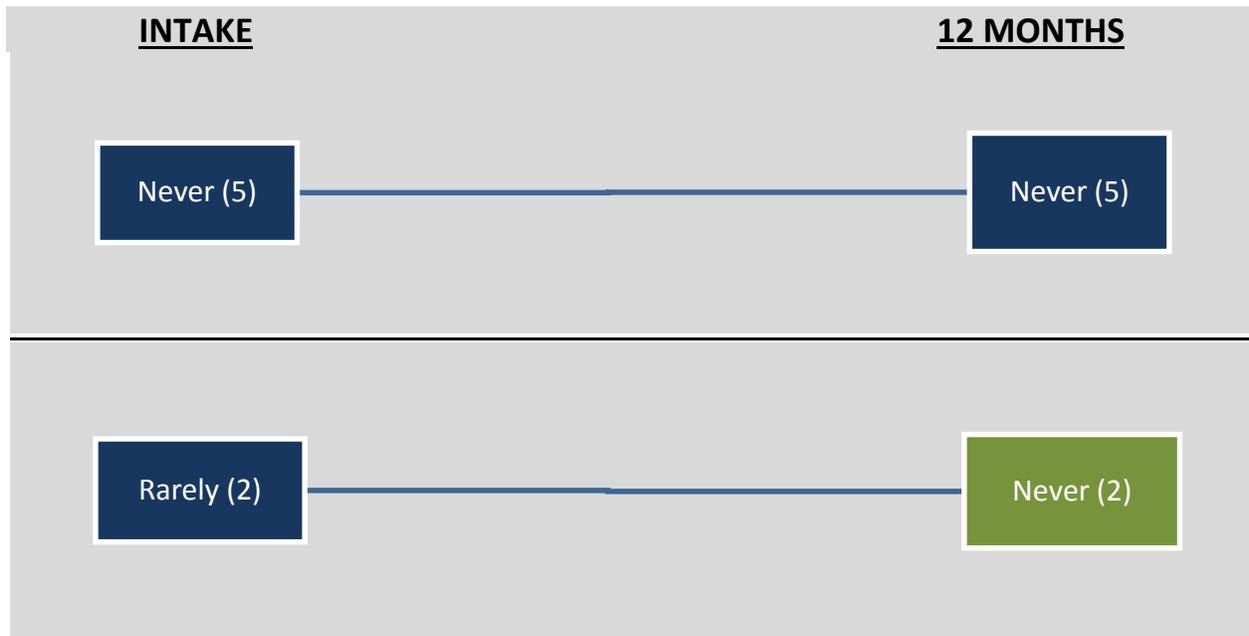


Are you currently being prescribed medication for your psychiatric condition?

A total of 14 respondents answered this question at intake, at 6 months, and at 12 months. Of the 14 respondents, all 14 (100%) reported no change in whether they had been prescribed medication for a psychiatric condition. 7 (50%) respondents who answered “no” at intake also answered “no” at 12 months. 7 (50%) respondents who answered “yes” at intake also answered “yes” at 12 months.

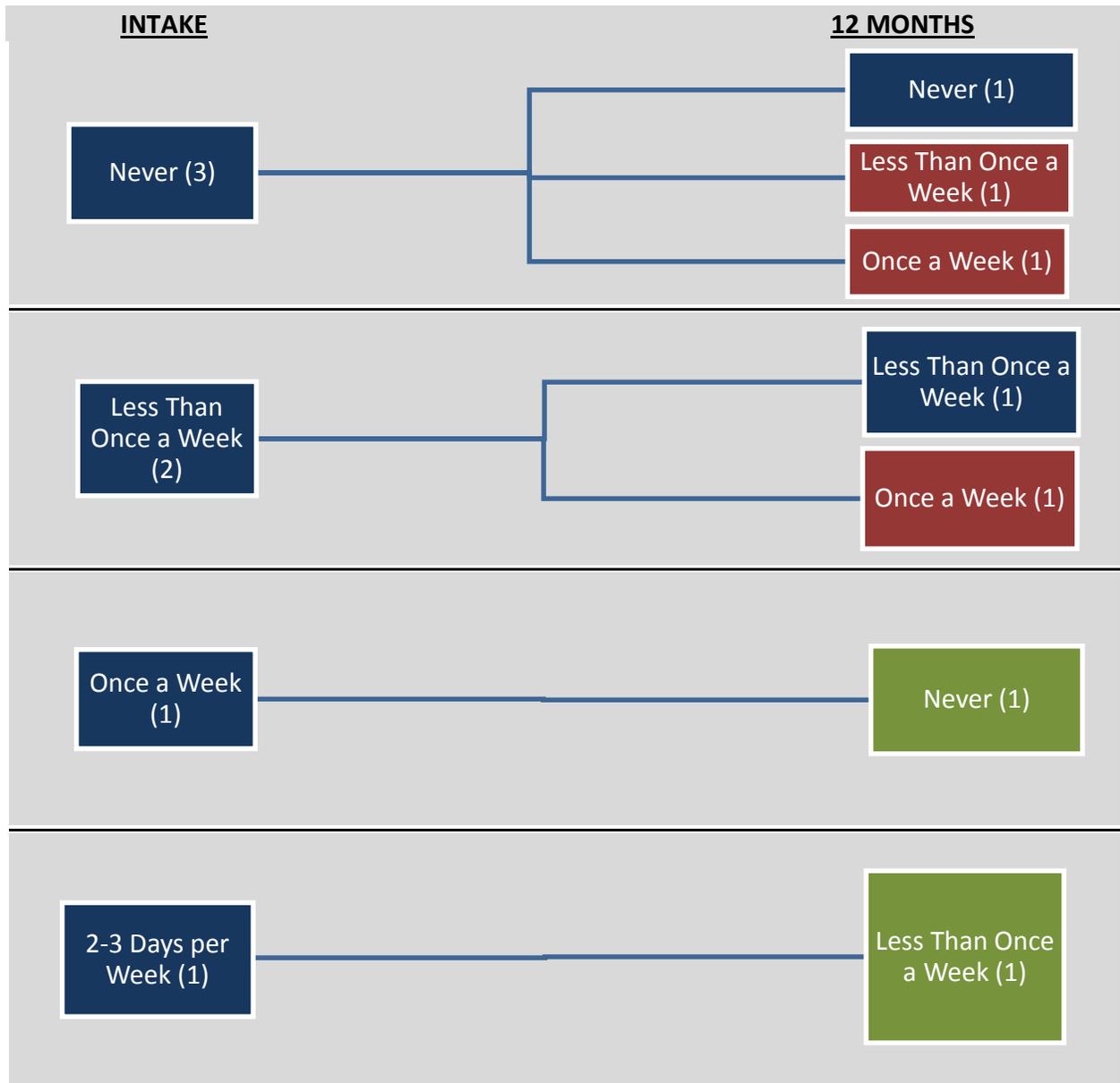
How often do you feel that you have difficulty taking your psychiatric medications on time? By “on time” we mean no more than two hours before or two hours after the time your doctor told you to take it.

Respondents rated this item on a scale of 1 to 5, where 1 is “all the time” and 5 is “none of the time.” A total of 7 respondents answered this question at intake, at 6 months, and at 12 months. Of the 7 respondents, 5 (71.4%) reported no change in how often they feel they have difficulty taking their psychiatric medications on time, and 2 (28.6%) reported a decrease in how often they feel they have difficulty taking their psychiatric medications on time.



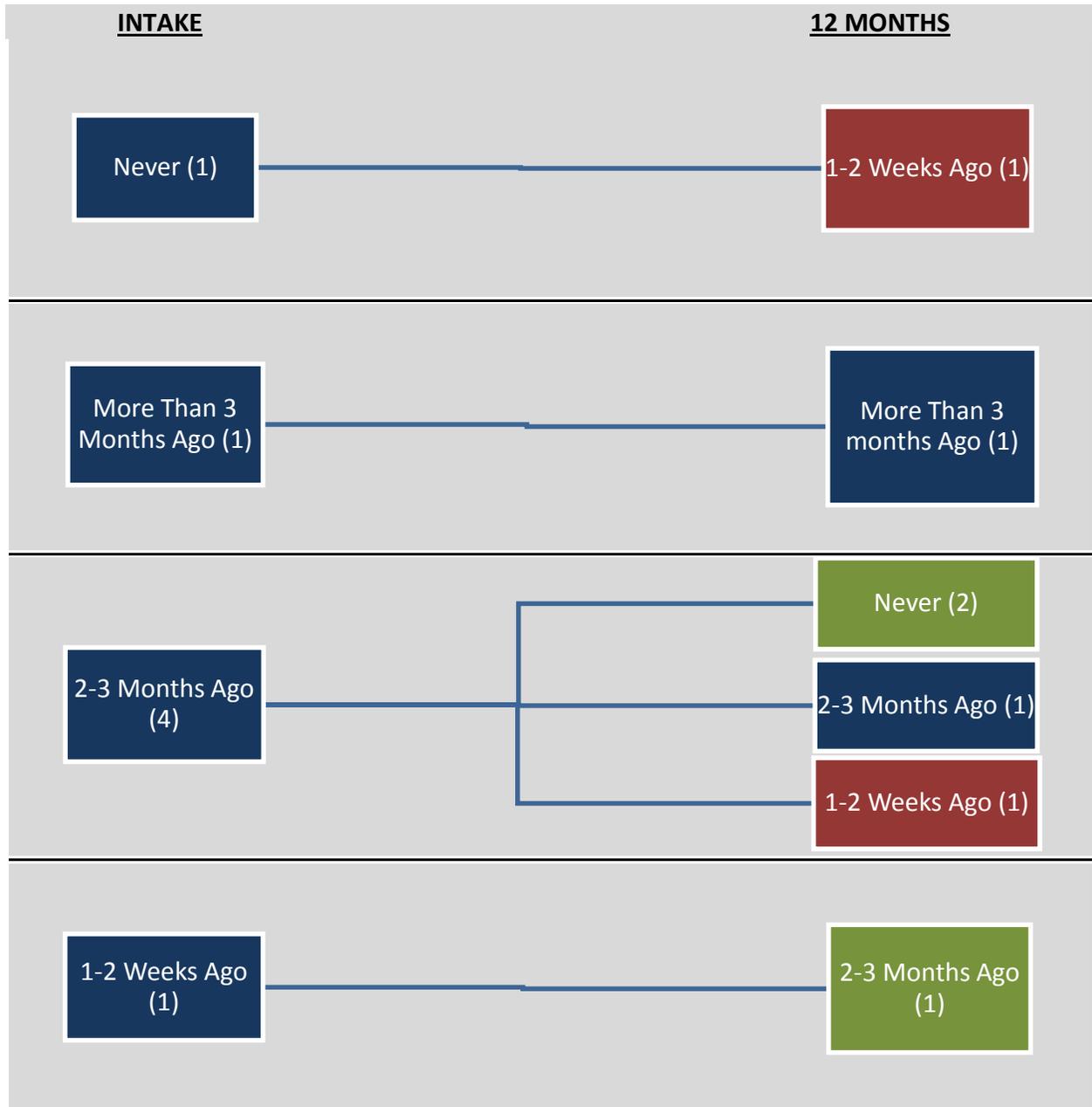
On average, how many days per week would you say that you missed at least one dose of your psychiatric medications?

A total of 7 respondents answered this question at intake, at 6 months, and at 12 months. Of the 7 respondents, 2 (28.6%) reported no change in how many day per week they missed at least one dose of psychiatric medication; 2 (28.6%) reported a decrease in how many day per week they missed at least one dose of psychiatric medication; and 3 (42.9%) reported an increase in how many day per week they missed at least one dose of psychiatric medication.



When was the last time you missed at least one dose of your psychiatric medications?

Respondents answered this item using a scale of 1 to 5, where 1 is “within the past week” and 5 is “more than 3 months ago.” A total of 7 respondents answered this question at intake, at 6 months, and at 12 months. Of the 7 respondents, 2 (28.6%) reported no change in the last time they missed at least one dose of psychiatric medication; 3 (42.9%) reported an improvement in the last time they missed at least one dose of psychiatric medication (increase in time); 2 (28.6%) reported a decline in the last time they missed at least one dose of psychiatric medication (decrease in time).



## CHALLENGES WITH THE MEDICAID SUPPORTIVE HOUSING PROGRAM

While participants, stakeholders, and case managers described the MSHP positively overall, some discussed a range of challenges related to landlords and housing, the vulnerability of the participant population, and concerns about case management transitions.

### Housing and Landlord Challenges

Some participants expressed that they felt lonely and isolated residing in their apartments, as they were used to being around other people when residing in nursing homes, shelter programs, or on the street. A few individuals mentioned that the HHO Resource Center helped them to connect with others.

In addition, 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 that participants are “*stigmatized*” from landlords because they are in a housing program and that participants are often unfairly targeted about problems in the building.

In addition to these challenges with landlords, case managers often intervene when participants are not lease compliant. Such issues include participants not paying their required portion of the rent, excessive noise from guests, altercations with neighbors, and substance use in their unit. Participants and case managers discussed that case managers intervene with landlord-tenant issues both to assist the participant to ensure the landlord made necessary repairs and address issues to building security. Further, case managers explained that they intervene in landlord-tenant issues to maintain the relationship with the landlord.

Several case managers and MSHP stakeholders explained how 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 – is extremely limited. Due to the decreased Fair Market Rent amounts, there is a small area on the North Side, which one case manager characterized as the “*projects*,” in which some MSHP participants reside. She explained: “*Everyone in the building is receiving a subsidy, everyone in the building is recovering, everyone is still using, everyone is dealing, everyone knows everyone.*” Further, this case manager related that this housing is of substandard quality and that the landlords accepted subsidies because households paying market rents would not accept the poor housing quality. In addition, this case manager expressed that she was not able to house anyone in the North Side in the year 2013.

Due to the limited housing options on North Side many participants locate apartments on Chicago’s South and West Sides. Because the majority of HHCS and HHO offices and clinics are located on the North Side, this leads to long travel times for participants to attend health clinic appointments and case managers for case management home visits.

### Current Challenges Meeting Healthcare Needs

Most participants reported no current challenges in meeting healthcare needs. However,, many participants mentioned 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, and 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 great need for childcare assistance so patients can attend their medical appointments.

### Vulnerable Participant Population

In addition to these challenges with healthcare, several stakeholders and case managers discussed characteristics of the MSHP population, particularly their vulnerability. One HHCS stakeholder explained that many of the MSHP participants were identified originally from the Chicago 100,000 Homes Campaign, ranking high on the Vulnerability Index.<sup>6</sup> Several MSHP stakeholders related the challenges of case managers having caseloads comprised primarily of vulnerable individuals.

One stakeholder explained that while the Heartland programs and case managers are well-experienced working with individuals with multiple barriers including mental health and substance use, when these issues are coupled with participants also being high users of Medicaid the results are very challenging. When a new combination of changes is combined with the fact that many participants were previously on the street prior to becoming housed the situation can become very difficult. One stakeholder described that this: “...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].

Another stakeholder wondered if a number of participants admitted into the MSHP program were not ready for independent housing. One case manager related that the greatest number of housing challenges arise with those participants who were chronically homeless and living on the streets for long periods of time. This case manager explained:

*We are housing people who have never lived independently before, who have never been a lease holder, and all the sudden it's, “Here's a lease, pay your rent, meet with me twice a month, have at it!” with really no skill building to be a good neighbor, pay your rent on time, contact the landlord when there is a problem. Everything becomes a crisis...So what I find a lot of kind of what the job entails to is starting to then develop those skills*

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<sup>6</sup> 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>

*in someone who may be in their late 40s early 50s and for the first time in their life is having to really be a good neighbor or be a lease holder. And then facing the consequences of the landlord when it doesn't go well.*

The case managers expressed some concern that most of their time was spent helping participants with housing and other such logistics, leaving little time to focus on health, as is a main intention of the project. While this was clearly an issue with some individuals in the case reviews, it was not true of the majority of the participants. Fifty percent of the overall activities over 6 months in the case review were health related.

However, there is no question that main challenge of the program, is providing appropriate level of support to meet the needs of the most vulnerable MSHP participants. Case managers expressed concern about the MSHP not being supportive enough for the program's most vulnerable and challenged participants. Some individuals, one case manager related, would benefit from almost daily support from a case worker. Further, this case manager explained that for some program participants, they request some supports which are not consistent with the harm reduction approach, such as voluntary drug testing.

Some stakeholders suggested that the program may need to provide different levels of support based on a participant's individual needs. A few stakeholders 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. One stakeholder mentioned that such an intensive staffing model might be beneficial especially for those participants not ready for independent housing. Another stakeholder related that many individuals with both mental health and substance use disorders need more intensive case management. One stakeholder considered whether it may be advantageous to establish screening criteria to identify those individuals who are not ready for independent housing, thus needing more intense support.

#### **Limited Income**

Discussing another aspect of vulnerability, a few stakeholders also discussed participants' limited financial resources. Stakeholders explained that most participants have very limited incomes, while some do not have any income beyond food stamps. The MSHP participant population has been impacted by cuts in General Assistance benefits and food stamps, and, these economic factors challenge participants' ability to get to medical appointments and other life necessities. In addition, as a result of limited income sources and limited experience with independent housing, some participants do not pay their required portion of the rent to the landlord when it is due. 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.

#### **Case Management**

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. Participants have a great deal of trust in their case manager and were anxious about opening up to a new person and establishing a new relationship. Further, several were frustrated about a perceived learning curve for new case managers becoming familiar with resources and procedures.

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. For example, if there are disruptive people in the halls or safety concerns in the building, Heartland and the case manager are unable to get the participant out of the lease. 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).

As mentioned previously, stakeholders were unanimous about the vital role of the case managers for the MSHP. Varying case management approaches were also discussed among stakeholders. One stakeholder recommended that a *“therapeutic”* or *“clinical”* approach is advantageous compared to a *“task-oriented”* approach. Further, one stakeholder related that because the case managers are *“essential in so many of the health outcomes”* targeted in the MSHP, these individuals should be better compensated to reflect their *“vital”* role in the program.

## 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. As such, 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.

## APPENDICES

**Appendix A: 2011 Medicaid Decile Expense Chart**

DECILE	CLIENTS	CUM.	% TOTAL	CUM. %	EXPENSE	CUM. %	PMPM	AVERAGE
								ANNUAL
ONE	4,745	4,745	0.15%	0.15%	\$1,156,826,700	10.00%	\$20,316	\$243,799
TWO	11,463	16,208	0.36%	0.50%	\$1,156,826,700	20.00%	\$8,410	\$100,918
THREE	19,519	35,727	0.61%	1.11%	\$1,156,826,700	30.00%	\$4,939	\$59,267
FOUR	26,467	62,194	0.82%	1.93%	\$1,156,826,700	40.00%	\$3,642	\$43,708
FIVE	36,156	98,350	1.12%	3.06%	\$1,156,826,700	50.00%	\$2,666	\$31,995
SIX	53,548	151,898	1.67%	4.72%	\$1,156,826,700	60.00%	\$1,800	\$21,604
SEVEN	94,289	246,187	2.93%	7.66%	\$1,156,826,700	70.00%	\$1,022	\$12,269
EIGHT	178,132	424,319	5.54%	13.20%	\$1,156,826,700	80.00%	\$541	\$6,494
NINE	420,324	844,643	13.07%	26.27%	\$1,156,826,700	90.00%	\$229	\$2,752
TEN	2,371,037	3,215,680	73.73%	100.00%	\$1,156,826,700	100.00%	\$41	\$488
<b>TOTAL</b>	<b>3,215,680</b>		<b>100.00%</b>		<b>\$11,568,267,000</b>			
	Columns "A"		Columns "B"		Column "C"	Col "D"	Columns "E"	

**Explanation of Medicaid Decile Chart -**

1. Column A / Bottom Row: Total number of Medicaid enrollees for the year
2. Column C / Bottom Row: Total funds paid out by Medicaid for all enrollees for the year
3. Column C / All Rows: Total funds divided into 10 equal amounts or DECILES
4. Column A / All Rows: Enrollees assigned to each decile based on individual Medicaid expense
5. Column E / All Rows: Average expense per enrollee paid out by Medicaid

**Note 1: 4,745 enrollees or 0.15% spend \$1.1 billion**

**Note 2: 98,350 enrollees or 3.1% spend half the funds (\$6.5 billion)**

Source: Chart provided by the AIDS Foundation of Chicago

## Appendix B: Data Collection Instruments

### Stakeholder Interview Schedule

*[Aims of this interview are to explore how the MSHP was developed, the structure of the program, including agreements and interactions between program stakeholders and collaborators.]*

- Who were the main stakeholders and motivators of the Medicaid Supportive Housing Program?
  - How was the need for the MSH identified by key stakeholders?
- What is the structure, agreements, interactions between various stakeholders of the MSHP?
- How has the MSHP program developed?
  - Program partners, stakeholders, and staff?
  - What were their respective roles?
- Implementation of the MSHP...
  - What is your role?
  - How do you fit into the program delivery/administrative model?
    - Who do you supervise?
    - Who supervises you/who do you report to for this program?
  - How are decisions made?
  - What is the role of the case managers in the program model?
    - How often do they meet with clients?
  - Is the program going according to plan?
    - If yes, how?
    - If no, what has happened?
  - What modifications, if any, have been made to the implementation?
    - Timing?
    - Procedures?
  - What barriers and/or facilitators have affected the implementation of care coordination/case management model for the MSHP?

## Case Manager Focus Group Schedule

*[Focus group to include the three case managers for the MSHP program to explore how the MSHP system works, how case management interacts with clients, successes and challenges, and in particular, how case management works with care coordination.]*

- As case managers, how does the MSHP system work? (probe: coordinated care and interactions with clients' medical providers, access to information about client medical history, motivational interviewing, linkage to other social services and community supports, use of centrality database.)
- What type of interactions do you have with MSHP clients? Probes:
  - Types of meetings; frequency of meetings
  - What occurs during meetings
  - Medication management
  - Arranging doctor visits
  - Arranging transportation
  - Use of motivational interviewing and stages of change to help draw people out and into treatment
  - Linkage to other social services such as entitlements, LINK, SSI
  - Activities related to linkage to employment such as setting employment goals, vocational goals, linkage to job training or employment
  - Housing: maintaining housing, helping adjusting to housing, housekeeping, cooking, cleaning, shopping
  - Money management, document management, keeping medical and business documentation
  - Other social services or community supports
- What are the most important functions of the case manager in the MSHP? (probe: individualized plan and model)
- What are your experiences working with clients health care
- What challenges experience with the MSHP program and clients?
  - 100,000 clients, so the most vulnerable – how has that been a problem?
  - Clients that need extra support? What types of support?
  - Harm reduction outcomes: usage, type of substance (lethal, legal)
  - Adherence to medications; to doctor's visits; ER usage; attendance at group therapy and addiction meetings.
  - Client drop-outs/no shows
- What are your experiences working with healthcare providers?
  - Challenges with healthcare providers? (probe: medical records)
- What are your experiences finding housing for clients?
  - Housing stability
  - Issues with fair rent value/location in which clients want to reside
  - Landlords

- Any other problems?
- Where do you receive support/assistance for working through client problems? Other problems

(probe: peers, SIT meetings, supervisors)

- What successes experience with the MSHP program and clients?
  - Harm reduction outcomes: Lowering usage, switching to something less lethal, more legal.
  - Increased adherence to medications; to doctor's visits; reduced ER usage; attendance at group therapy and addiction meetings.
  - Increased self-care, higher reported health status

## Program Participant Interview Schedule

*[Aims of this interview are to explore health and helpseeking behavior before and after entering the MSHP.]*

When did you begin in your current housing program at Heartland, the Medicaid Supportive Housing Program?

What was the process of getting into the program? (probe: where were you staying before you got into Heartland housing? how did you find out about program? How long did it take to get into the program? How long did it take to find an apartment? Any challenges finding apartment?)

**Thinking back to before you were in your program**, typically how did you manage your healthcare?

- Where did you go for services/treatment/appointments?
- What types of providers did you see? (e.g. nurse, primary care physician, etc.) Did you have a regular doctor? Did you see any other types of doctors?
- How often did you go for services? (ask about any doctors/ER, etc. that they mention)
- How did you access your medication
  - Any assistance with managing medication?
- Anyone to help you navigate/access the healthcare system – help you figure out what doctors to go to?
- Information and support in managing health?
- Connection to social service? (e.g. LINK, SSI)
- Did you have health insurance/Medicaid?

Next, we have questions about access and experiences with healthcare since you started in your current program at Heartland

- Since starting in your current program, what has changed with how you manage your health care?
  - Probes:
    - Places go for treatment/types of providers
    - Type of provider/service
    - How often go to treatment/appointments
- Where do you go for services/treatment/appointments?
- What types of providers do you see? (e.g. nurse, primary care physician, etc.)
- How often do you go for services/treatment/appointments?
- How do you access your medication?
- Do you receive any assistance...
  - Managing medication
  - Navigating healthcare system
  - Linking social service (e.g. LINK, SSI)
- Does your case manager provide any assistance/talk to you about your health?

- Case manager assist with services like LINK, SSI, etc.
- Information and support in managing health?
- How has your health changed since starting in the program?

In addition to Medicaid, do you have any additional health insurance?

Next, we would like to know how your current program works for you overall.

- What are the best aspects of your program? (e.g. assistance from case manager)
- What challenges with your program do you experience?
- Any current challenges with meeting your healthcare needs?

What else would you like to share about your experiences with your program?

This is considered a harm reduction program. Are you familiar with Harm Reduction? (e.g. Not required to be clean/not abstinence-based) How has harm reduction philosophy impacted your health?

## Program Participant Focus Group Schedule

*[Aims of this focus group are to explore clients' interactions with case management and other components of the MSHP program, to understand what aspects work well for them, and what challenges they may experience.]*

To start off, we'd like to ask you some questions about when you started living at the Medicaid Supportive Housing Program...

How long have you been living in the Medicaid Supportive Housing Program?

What was the process of getting into the program? (probe: how did you find out about program? How long did it take? Any challenges?)

Next, we'd like to ask you about meetings with your MSHP case manager.

- What types of meetings do you have?
- How often?
- What occurs during meetings?

What types of assistance and resources does your case manager provide?

- Medication management
- Arranging doctor visits
- Arranging transportation
- Linkage to other social services such as entitlements, LINK, SSI
- Activities related to linkage to employment such as setting employment goals, vocational goals, linkage to job training or employment
- Housing: maintaining housing, helping adjusting to housing, housekeeping, cooking, cleaning, shopping
- Money management, document management, keeping medical and business documentation
- Other social services or community supports

Last, we'd like to understand how case management and other aspects of the MSHP are working out.

- In thinking about your case manager...
  - What aspects are working well for you?
  - What challenges do you experience?
- In thinking about other aspects of the MSHP program...
  - What aspects of the program are working well for you?
  - What challenges do you experience?
- Are you experiencing any challenges with meeting your healthcare needs?
- In addition to Medicaid, do you have any additional health insurance?

**Client ID**

**Case Manager**

**Access to Wellness**

**Client Housed with AFC before Medicaid program? (1=yes; 0=no)**

**Location of Service**

- Time Spent (in hour units – example: .5) (1=yes; 0=no)
- Client's Home (1=yes; 0=no)
- Case Manager Office (1=yes; 0=no)
- Phone (1=yes; 0=no)
- Third Party (1=yes; 0=no)
- Other (Specify) (1=yes; 0=no)
- Missed Appointment (0=no; 1=Client Missed Appt.; 2=Case Manager Cancelled; 3=Mutual Agreement between Case Manager and Client)

**Type**

- Referral Screening (1=yes; 0=no)
- Continued Case Management (1=yes; 0=no)
- Follow Up (1=yes; 0=no)

**Case Manager "Care Action" Topic**

- Adherence to Medical Appts. (1=yes; 0=no)
- Adherence to Mental Health Appts. (1=yes; 0=no)
- Benefits Advocacy (1=yes; 0=no)
- Benefits Application (1=yes; 0=no)
- Benefits Maintenance (1=yes; 0=no)
- Care Coordination (ex. Jessie discussing Together4Health CCE) (1=yes; 0=no)
- Crisis Intervention (Includes Domestic Violence) (1=yes; 0=no)
- Education Issues (1=yes; 0=no)
- Employment (1=yes; 0=no)
- Money Management (1=yes; 0=no)
- English as 2<sup>nd</sup> Language (1=yes; 0=no)
- Emotional Support (1=yes; 0=no)
- HIV Disclosure Issues (1=yes; 0=no)
- Discrimination/Stigma (1=yes; 0=no)
- Discuss Change in Level of Care (1=yes; 0=no)
- Food and Nutrition Issues (1=yes; 0=no)
- HIV Partner Counseling & Referral (1=yes; 0=no)
- HIV Prevention with Positives (1=yes; 0=no)
- HIV/AIDS Education (1=yes; 0=no)
- Housing Location (1=yes; 0=no)
- Housing Resource Education (1=yes; 0=no)
- Housing Problem-Solving (Specify) (1=yes; 0=no)
- Medication Adherence (1=yes; 0=no)
- Medication Readiness (1=yes; 0=no)

Mental Healthcare (0=None; 1=Mental Health; 2=Substance Abuse; 3=BOTH MH & SA)

Physical Healthcare (1=yes; 0=no)

Planning to Transfer Self Care (1=yes; 0=no)

Refer to GPRA/Access to Wellness Services (1=yes; 0=no)

Repeated Referral (If Case Manager Repeats Service Info Already Provided) (1=yes; 0=no)

Transportation Issues (1=yes; 0=no)

SBIRT – Brief Intervention (For Substance Abuse and Mental Health) (1=yes; 0=no)

Other (Specify)

**Client's Report of Activities**

Doctor Visit (Scheduling or Attending Appts.) (1=yes; 0=no)

Psychiatrist Visit (1=yes; 0=no)

Emergency Room Visit (1=yes; 0=no)

In-Patient Hospital Visit (1=yes; 0=no)

Therapist Visit (1=yes; 0=no)

Employment (1=yes; 0=no)

Benefits (e.g. Link, SSI) (1=yes; 0=no)

**Problems Experiencing**

Problem One (Specify)

Problem Two (Specify)

Problem Three (Specify)

## Appendix C: Discussion of Together4Health

The Together4Health (T4H) Care Coordination Entity (CCE) is a 34-member initiative comprised of Chicago-area hospitals, primary care and behavioral health agencies, supportive housing programs, and system-level organizations. According to MSHP stakeholders, the T4H member organizations will share electronic records and collaborate to coordinate client's healthcare. Medicaid will pay the T4H member organizations based on meeting 33 health outcomes. This differs from Medicaid's typical "fee for service" reimbursement model (Bendixen, Draft - T4H Summary). According to MSHP stakeholders, the care coordination model reflects a shift from "volume-based" to "value-based" outcomes. The CCE model will allow staff from the 34 member organizations of T4H to communicate for the purposes of obtaining improved health care and overall improved outcomes for clients. This model is intended to address the current fragmented nature of the health care system. One HHO stakeholder explained: *"That's the whole goal of Together for Health, so the providers will be clustered in hubs and they will be forced on a weekly basis to talk about the problems face-to-face and then there will be Together for Health staff behind the scenes making those phone calls, making the connections between providers asking: 'why is it that releases of information go to you... you don't respond to them?'"* This HHO stakeholder continued to explain that the federal HIPPA Privacy regulations (Health Insurance Portability and Accountability Act) constrain the degree to which providers will be able to access information outside their own system.

It was originally planned that MSHP participants would opt in to T4H. Later, however, it was determined that all eligible individuals will be automatically enrolled into CCEs, unless an individual opts out. In addition, an initial plan of MSHP was that all housing clients would receive healthcare at HHO. However, a number of participants enrolled in the MSHP program are HIV positive and already received HIV treatment from the CORE Center or other healthcare providers. Thus, because these individuals had existing primary care providers, the MSHP was not going to require these participants to disrupt their existing care and transfer to HHO, unless they wished to.

T4H was incorporated in November of 2012 and the initial meeting of the member organizations took place in January of 2013. The CCE began enrolling participants in January of 2014. According to MSHP stakeholders, this timeline for enrollment is one and a half years later than was originally planned, as T4H was originally intended to be operational when MSHP began enrolling participants. This delay is due to a combination of factors, namely a delay in the initial Request for Proposals by Illinois State Medicaid for CCEs, which then delayed the contracts and finalizations necessary to enroll participants in T4H. In addition, the process of all 34 member entities signing the contract has resulted in further delays as some members are requesting language modifications. Though this delay was unexpected, it has not adversely impacted stakeholders, as all participants are still being housed and results will still indicate the impact of high-users being housed compared to their formerly unstable housing situations. One MSHP stakeholder sees this delay as a potential advantage in terms of data collection because the results from the first year will show the impact of high-users being housed and when the enrollment for T4H begins, the data will show the impact of both care coordination and housing

for high users of Medicaid. Also, these data could potentially be powerful in demonstrating the impact that both housing and care coordination have in reducing medical costs and therefore, Medicaid expenses and improving health outcomes.

**Appendix D: Case Note Information for Sample of 14 Participants**

Case 1	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
<b>Where</b>	Clients home(2)	CM Office (1)	Phone (1) Third Party(1) Other-Voicemail (1)	Client's Home (1) Home & Third Party (1) Third Party (1) Phone (4) Other-Fax/E-Mail (2)	Client's Home (1) Case Manager's Office (1) Phone (2)	Client's Home (3) Phone (3)
<b>What?</b>	Referral Screening (1) CCM (1)	Follow Up (1)	Follow Up (1) Client Missed Appt.- Voicemail (1) Not Stated (1)	CCM (6) Mutual Missed Appt. (2) Client Missed Appt. (1)	CCM (3) Follow Up (1)	CCM (5) Client Rescheduled(1)
<b>Types of issues</b>	Benefits Advocacy (1) Benefits application (1) Benefits Maintenance(1) Housing Location (1) Housing Resource Education (1) Transportation Issues(1)	Benefits Maintenance (1) Mental Healthcare (1) Physical Healthcare (1)	Other (2)- Discussed Housing Inspection & Case Transferred to Catholic Charities	Intervention (1) Employment(1) Money Management(3) Emotional Support (2) Housing Problem Solving (2) Food & Nutrition Issues(1) Mental Healthcare (1) Physical Healthcare (1) Other (2) (Rescheduled Appt./ Following up on Scheduled appt.)	Adherence to Medical Appts. (1) Employment Issues(1) Emotional Support (1) Food & Nutrition Issues (1) Medication Adherence (2) Mental Health Issues (1) Transportation Issues (1)	Food & Nutrition Issues (1) Housing Problem Solving (1) Medication Adherence (2) Mental Healthcare (1) Physical Healthcare (1) Other (3)-Client Called HRS for Walgreens/ Target Giftcards, Provided PP with Donations, Reminder of Schedule Health visit
<b>Client report of Activities</b>	Not Reported	Not Reported	Not Reported	Doctor's Visit (1) Psychiatrist Visit (1)	Doctor's Visit (2) Therapist Visit (1)	Not Reported
<b>Problems</b>	Not Reported	Not Reported	Not Reported	Client late on his rent Flooding in Apt.	Stolen CTA Card	Issues with Plumbing at Home

<b>Case 2</b>	<b>Month 1</b>	<b>Month 2</b>	<b>Month 3</b>	<b>Month 4</b>	<b>Month 5</b>	<b>Month 6</b>
<b>Where?</b>	CM Office (2) Client's Home (1)	Client's Home(1) Phone (1) Other (2) (LL's Office & LL/Care Team)	Client's Home (6)	Client's Home(1) hone& Third Party (1)-LL Phone, Third Party, & Other (1)-Voicemail 3 <sup>rd</sup> Parties (1)- Community Support Team Other(2) (LL/ Reported to HRS that really heavy traffichad been coming to Client's apt., HRS contacts LL)	CM Office (1) Client's Home (3) Client's Home & Third Party (1)- Community Support Team	CM Office & Third Party-CST Worker(1) Client's Home (2)
<b>What?</b>	CCM (3)	CCM (2) Client Missed Appt. (2)	CCM (2) Client Missed Appt. (4)	CCM (3) Missed Appt. (1) Not Stated (2)	CCM (1) Client Missed appts. (4)	CCM (2) Follow Up (1)
<b>Types of Issues</b>	Adherence to Medical Appts.(1) Adherence to Mental Health Appts. (1) Benefits Advocacy (1) Money Management (2) Emotional Support (3) HIV/Disclosure Issues (1) Discrimination/Stig ma (2) Discuss Change in Level of Care (1) Housing Location (2) Housing Resource Education (2) Mental Health/Substance abuse (1) Physical Healthcare(2)	Adherence to Mental Health Appts. (1) Benefits Advocacy (1) Money Management (3) Emotional Support (1) Housing Resource Education (1) Discuss change in Level of Care (1) Mental HealthCare (2) Physical Healthcare (1) Transportation Issues (1) Other (1)-LL Consultation	Emotional Support (2) Discrimination & Stigma (1) Discuss Change in Level of Care (2) Housing Resource Education (1) Mental Health/ Substance Abuse (2) - 1MH/1MH+SA Physical Healthcare(2) SBIRT(2) Other (1)- (Adherence to HRS Appts.)	Money Management (1) Discuss Change in Level of Care (1) Housing Location (1) Housing Resource Education (2) Housing Problem Solving (1) Mental Healthcare (1) SBIRT (1) Other (2) (outreach to PP's disengaged to care/ Lifeskills)	Discuss Change in Level of Care (1) Mental Health/Subst ance Abuse (1) Physical Healthcare(1) Transportatio n Issues(1) SBIRT(1) Other(1)- Empowerme nt Counseling	Adherence to Medical appts. (2) Benefits Advocacy (1) Benefits Maintenance (1) Money Management (3) HIV Disclosure Issues (1) Discuss Change in Level of Care (1) Housing Location (2) Housing Resource Education (1) Transportation Issues (2) Mental Health/Substan

	Transportation Issues (3) SBIRT (2) Other (2) (Empowerment Counseling/Legal Issues & Official Move in Day)					ce Abuse (2)-1 MH/1 MH+SA Physical Healthcare (1) SBIRT (2) Other (2) Moving into new Apt./Lifeskills
<b>Client Report of Activities</b>	Psychiatrist (1)					Doctor's Visit (1) Psychiatrist Visit (1)
<b>Problems</b>		Client has Missed Last Two Appts. LL has not seen PP PP Still needs to give LL money order for rent	Client Has Begun Abusing Alcohol Adherence to HRS Appts. Client Appt. Adherence HRO appt. Adherence	Lots of Traffic Coming to PP's Apt. 2 Adherence to HRO Appts. Heavy Traffic in/out apt. Community support team will attempt to meet pp at home Disclosing issues Attempted to contact LL in regards to client's outstanding rent and problematic behavior	PP's adherence to HRO appts. Unable to find Client Unable to contact PP Client disengaged with TX Losing Current Housing	

Case 3	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
<b>Where?</b>	CM Office (3) Phone (1) Other (2)- Location not Stated	CM Office (2) Phone (7)	CM Office (1) CMO & Third Party (1) Client's Home (2) Phone (2)- Voicemail Other(2)- Location not stated/Sister-in-law's Apt.	Client's Home & CM Office (1) Phone (2) Other(1)- Sister in law's Home	Client's Home (1) Phone(1)	Client's Home (1) Client's Home & Phone (1) Phone (3)
<b>What?</b>	CCM (5) Follow Up (1)	Referral Screening/C CM (1) CCM (4) Follow Up (3) Follow Up- Client Missed Appt. (1)	CCM (5) Follow Up (2) Client Missed Appt. (1)	CCM (4)	Follow Up (2)	CCM (1) Follow Up (4)
<b>Types of Issues</b>	Benefits Application (2) Benefits Maintenance (1) Money Management (4) Housing Location (1) Medication Adherence (3) Medication Readiness (3) Mental Healthcare/Substance Abuse(3)- 3MH+SA Physical Healthcare (4) Repeated Referral (1) SBIRT (3) Other (3)-Initial Meeting/Housing Process/ LL Consultation	Benefits Advocacy (1) Benefits Maintenance (2) Money Management (5) Housing Problem-Solving(1) Medication Adherence(3) Medication Readiness (3) Mental Health/Substance Abuse (3)- 1MH/1MH+SA	Benefits Advocacy (2) Benefits Application (2) Benefits Maintenance (4) Money Management (4) Emotional Support(1) Housing Problem Solving (1) Medication Adherence(2) Medication Readiness(2) Mental Health/Substance Abuse (3)- 3MH+SA Physical Healthcare ((4) Transportation Issues(1) SBIRT (3)	Benefits Advocacy (2) Benefits Maintenance (2) Money Management (4) Emotional Support (2) Medication Adherence (2) Medication Readiness (2) Mental Health/ Substance Abuse (2)-2 MH+SA Physical Healthcare(1) SBIRT (2) Other (1)- LL Consultation	Benefits Advocacy (2) Benefits Maintenance (2) Money Management (1) Other (2)- LL Consultation	Benefits Advocacy(2) Benefits Maintenance(3) Money Management (4) Medication Adherence(1) Medication Readiness (1) Mental Health/Substance Abuse(1)- 1MH+SA Physical Healthcare (1) SBIRT(1)

		Physical Healthcare (4) GPRA/Access to Wellness Services(1) Transportation Issues (2) SBIRT (3) Other (3)-LL Consultation	Other(2)- Appt. Reminder/LL Consultation			
<b>Client's Report of Activities</b>	Doctor's Visit (1) Benefits (3)-LL Consultation	Doctor's Visit (2) In-Patient hospital Visit (2) Benefits (2)	Benefits (2)			Psychiatrist Visit (1) Emergency Room Visit (1) Benefits (2)
<b>Problems</b>	Client Spent all of SSI	Client has not paid rent due to being hospitalized Client in hospital for seizure and still needs to pay rent Client reports she lost \$400 of SSI	Family Member Died Unable to pay rent	Behind on Rent		Began hearing voices, went to the ER Lost Apt. Key

Case 4	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
<b>Where?</b>	Client's Home +Phone+Third Party (1) Other (2)-Community/Letter	CM Office (2) Phone-Voicemails (5) Third Party (2)-Email/Landlord Phone+Third Party (1)-Client's Father	CM Office (1)Client's Home (2) Phone (2) Third Party & Other (1)-email/LL Other (1)-Letter	CM Office (1) Phone-voicemail (6) Third Party (1)	Client's Home (1) Phone (4) Third Party & Other (1)-Email/LL Other (1)-Letter	CM Office(1) Phone (1) Third Party(1)-LL Third Party & Other (1)-Email LL Other (1)-Letter
<b>What?</b>	CCM (2) Follow Up (1)	Referral Screening (2) CCM (2)	CCM (1) Follow Up (4)	CCM (4) Follow Up (1) Not Stated (3)	CCM (7)	CCM (4) CCM-CM Cancelled (1)
<b>Types of Issues</b>	Money Management (1) Housing Location (1) Housing Resource Edu. (1) Housing Problem-Solving (1) Other(2)-LL Consultation	Adherence to Medical Appts. (1) Benefits Advocacy (1) Intervention (1) Money Management(3) Emotional Support (1) Housing Resource Edu. (1) Housing Problem-Solving (1)- Will pay portion of rent Food & Nutrition Issues (1) Mental Health/ Substance Abuse (2)- 1 MH & 1MH+SA Physical Healthcare (3) SBIRT (1) Other (3)-Oral Healthcare/2 LL Consultation	Adherence to Medical Appts. (1) Benefits Maintenance(1) Money Management (2) Housing Problem-Solving (1)- Contacted LL Mental Health/ Substance Abuse (1)- 1MH Physical Healthcare(2) GPRA/Access to Wellness Services (1) SBIRT (1) Other (3)- LL Consultation	Benefits Maintenance(2) Money Management(2) Housing Resource Edu.(2) Physical Healthcare(1) Repeated Referrals(5) Other(2)- Received food voucher from AFC/PP reported receiving furniture	Education Issues (1) Employment (1) Housing Location (1) Housing Problem-solving (2)-LL Consultation Mental Health/Substance Abuse (1)-1MH SBIRT (1) Other(2)- Scheduled appt/Confirmed appt.	Physical Healthcare (1) Transportation Issues (1) Other (2)- Repairs made to PP's home/LL Consultation
<b>Client's Report</b>		Doctor's Visit (2) ER Visit (1)	Doctor's Visit (1)	Doctor's Visit (1) Benefits (1)		

of Activities			In-Patient Hospital Visit (1) Benefits (1)			
<b>Problems</b>	Lost Money Order for Rent	Client was Mugged, Lost Phone, wallet, and money Hospitalized due to mugging Client late on rent, unable to contact client Unable to reach Client or his emergency contact Left father a message for client to contact HRS	Unable to contact client Client's rent is late Issues with front door	Client's Phone is Disconnected Phone is disconnected HRS received letter that she sent to client, it was marked undeliverable People drinking in vacant unit near client Front door does not lock properly Heat is not working, using oven		Received letter that mail was undeliverable to client Client's phone not in service Client late on October's rent

Case 5	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
<b>Where?</b>	CM Office (1) Phone (2)- Voicemail	Client's Home (1) Phone- Voicemail(4)	Phone (1) Other (1)- Letter	CCM (1) Phone (2) Third Party (2)-LL, Client's Mother Other (2)- Hospital, Voicemail	Client's Home/CM Office/Third Party-LL/Other- Furniture Store (1) Phone & Third Party-LL (1) Phone (3) Other (1)- Client Mother's Home Other & Third Party (1)- Mother's apt. w/ mother	CM Office (1) Phone- Voicemail (4)
<b>What?</b>	Referral Screening (1) CCM (2)	CCM (2) Follow Up (2) Client Missed Appt. (1)	CCM (2) Follow up- Client Missed Appt. (1)  Client Missed Appt. (2)	CCM (3) Follow Ups (3) Client Missed Appt. (1)	CCM (2) Follow Up (5) Follow Up- Missed Appt.(2) Client Missed Appt. (3)	Referral Screening (1) CCM (2) Follow Up (1) Follow Up- Client Missed Appt (1)
<b>Types of Issues</b>	Housing Location (3) Other (2)- LL Consultation	Housing Location (2) Housing Problem Solving (1) Other (2)- LL consultation, Signed Lease/ Follow up on new apt.	Housing Resource Education (1)	Benefits Application (1) Benefits Advocacy (1) Money Management(1) Food & Nutrition Issues(1) Medication Adherence(1) Mental Health/ Substance Abuse (2)-1MH/1MH+SA Physical Healthcare (2) Transportation Issues(1) SBIRT (2) Other (1)- Regarding Client's Furniture	Benefits Advocacy (4) Benefits Application(1) Benefits Maintenance (4) Money Management (2) Housing Location (1) Housing Problem- solving(1)-Break- in Medication Adherence (1) Medication Readiness(1) Mental Health/Substance Abuse (2)- 1MH/1MH+SA	Money Management (1) Emotional support (1) Housing Location(3) Medication Adherence(1) Medication Readiness(1) Mental Health/ Substance Abuse (1)- 1MH+SA Physical Healthcare (1) SBIRT (1) Other(2)-LL Consultation

					Physical Healthcare(3) SBIRT (3) Other(1)-Housing Inspection	
<b>Client's Report of Activities</b>				Psychiatrist Visit(1) In-patient Hospital Visit (1)	Psychiatrist Visit (1)	Benefits (1)
<b>Problems</b>		Client not moved into new apt yet. HHO attempted to contact family	Letter regarding unable to contact client	Not able to make contact with client Client has moved out of apt. without notifying LL or HRS Hospitalized for mental illness	Client's Stove/ Refrigerator Stolen	Abusing Substances, Food stamps Have stopped

Case 6	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
<b>Where?</b>	Client's Home (2) CM Office (2) Phone (1)	CM Office's (1) Phone (2)	Client's Home (4) Phone (6)	Client's Home (1) Client's Home & Third Party-LL (1) Client's Home & Phone (1) Phone-voicemail (2)	Phone-Voicemail (1)	Client's Home (2) CM Office(2) Phone (3) Client's Home/Phone/ Third Party-close Friend (1) Phone/Third Part-Close Friend (1) Not Stated (1)
<b>What?</b>	Referral Screening (1) CCM (3) Follow Up (1)	CCM (2) Follow Up (1)	Follow Up (8) Client Missed Appts. (2)	CCM (2) CCM-Client Missed Apt. (3)  Client Missed Appt. (1)	Follow Up (1)	CCM (4) Follow Up (2) CCM-Client Missed Appt. (2)
<b>Types of Issues</b>	Adherence to MH Appts. (3) Benefits Advocacy (2) Care Coordination (1) Employment (1) Money Management (3) Emotional Support (3) HIV Disclosure Issues (2) Discrimination/Stigma (2) Discuss change in level of care (3) HIV Prevention with Positives (3) Housing Location (2) Housing Resource Edu. (4)	Adherence to MH Appts.(1) Money Management (1) Emotional Support (2) HIV Disclosure Issues (1) Discrimination/Stigma (1) Discuss Change in Level of care (2) HIV Prevention w/ Positives (2) Medication Adherence (1) Mental Health/Substance Abuse (1)- 1MH Physical Healthcare (3) Transportation Issues(2) SBIRT (2)	Adherence to MH Appts. (2) Emotional Support (2) HIV Disclosure Issues (2) Discrimination/Stigma (4) HIV Partner Counseling & Referral (2) Mental Health/Substance Abuse (1)- 1 MH Other (5) Attempted to Schedule/Contact	Adherence to MH Appts. (1) Emotional Support (1) Other (2)- LL Consultation/HRS Appointment adherence		Adherence to Medical Appts. (1) Adherence to Mental Health Appts. (5) Benefits Application (1) Money Management (1) Emotional Support (2) HIV Disclosure Issues (3) Discrimination /Stigma (1) Discuss Change in Level of Care (2) HIV Prevention w/ Positives (4)

	Medication Adherence (1) Mental Health/Substance Abuse (4)- 1 MH/ 3 MH+SA Physical Healthcare (4) GRPA/ Access to Wellness Services (1) Transportation Issues (2) SBIRT (3) Other (4)- Legal Issues, Lifeskills/ Empowerment Counseling, Housing Inspection	Other (1)- Lifeskills/empowerment Counseling				Mental Health/Substance Abuse (4)- 1 MH/ 3 MH+SA Physical Healthcare (3) Transportation Issues (2) SBIRT(4) Other (6)- Lifeskills/Empowerment Counseling, Consulted with close friend of client, appt. Confirmation
<b>Client's Report of Activities</b>	Doctor's Visit (2) Psychiatrist Visit (1)	Doctor's Visit (1) Psychiatrist Visit (1)	Psychiatrist Visit (2)			Doctor's Visit (2) Psychiatrist Visit (1)
<b>Problems</b>			Continues to be unable to contact and schedule	Client was not home, HRS spoke with LL. LL stated there have been complaints from other tenants regarding loud noises in client's apt. Argument in Client's apt, Client did not disclose who Unable to contact Client	Unable to contact Client	Client No showed for appt Client missed GPRA appt. Issues with receiving services from various facilities

<b>Case 7</b>	<b>Month 1</b>	<b>Month 2</b>	<b>Month 3</b>	<b>Month 4</b>	<b>Month 5</b>	<b>Month 6</b>
<b>Where?</b>	Client's Home/ Phone (1) CM Office (1) Phone (1) Other-Out in Community (1) Did not specify location (1)	CM Office (1) Phone- Voicemail (3)	Phone (4) Location Not Stated (1)	Client's Home (1) CM Office (1) Phone (2) Client's Home/Phone (1)	Client's Home (1) CM Office(2) Phone- Voicemail (3)	Client's Home (3)
<b>What?</b>	CCM (3) Follow Up (2)	CCM (2) Follow Up (2)	Referral Screening (2) Follow Up (1) Follow Up - Client Missed Appt. (1) CCM- Mutual agreement between CM/client (1)	CCM (2) Follow Up (1) CCM-Client Missed Appt. (1) Follow Up - Mutual agreement between CM/Client (1)	CCM (2) Follow Up (2) N/A-Client Missed Appt. (1)	CCM (2) Follow Up- Client Missed Appt. (1)
<b>Types of Issues</b>	Benefits Advocacy (2) Benefits Maintenance(2) Money Management (1) Emotional Support (2) Housing Location(1) Housing Resource Edu.(1) Physical Healthcare (1) SBIRT(1) Other (2)-LL Consultation	Benefits Application (1) Benefits Maintenance(2) Money Management(1) Physical Healthcare(2) Repeated Referrals(2) Other(1)- Scheduled appt.	Benefits Maintenance (1) Food & Nutrition Issues (1) Medication Readiness (1) Physical Healthcare (4) Other (1)- rescheduled appt. Client Out of town	Employment (1) Money Management (2) Food & Nutrition Issues (2) Medication Adherence (2) Medication Readiness (1) Physical Healthcare (2) Repeated Referrals(1) Transportation Issues(2) Other- Rescheduled Appt. (2)	Money Management (2) Emotional Support ((1) Food & Nutrition Issues (1) Medication Adherence (2) Medication Readiness(2) Physical Healthcare(2) Transportation issues(1) Other- Attempted to contact (1)	Benefits Maintenance(2) Education Issues (1) Money Management (1) Emotional Support(1) Medication Adherence(2) Medication Readiness (2) Mental Health/Substance Abuse (1)-1SA Physical Healthcare (2) Transportation issues (2) SBIRT(1)
<b>Client's Report of Activities</b>			Doctor's Visit (3)	Doctors Appt (1)	Doctor's Visit(3)	Doctor's Visit (1)

					In-Patient hospital Visit(1)	
<b>Problems</b>			Missed Appt. with medical provider		Hospitalized for chest pain	Lost CTA Card

<b>Case 8</b>	<b>Month 1</b>	<b>Month 2</b>	<b>Month 3</b>	<b>Month 4</b>	<b>Month 5</b>	<b>Month 6</b>
<b>Where?</b>	Client's Home (1) Phone (1) Location Not Stated (1)	Client's Home (1) Phone (2)	Client's Home (1) CM Office(1) Phone(1) Location Not Stated (1)	Client's Home (2) Phone (2)	CM Office (1) Phone- Voicemail(1)	Client's Home (2) Phone (1)
<b>What?</b>	CCM- Client Missed appt. (1) Not Stated (2)	CCM (1) Follow Up (1) Not Stated (1)	CCM (1) Follow Up (1) Not Stated (2)	CCM (2) Follow Up (2)	CCM(1) Not Stated (1)	CCM (1) Follow Up (1) Not Stated (1)
<b>Types of Issues</b>	Adherence to MH Appts. (1) Benefits Advocacy (1) Benefits Application (1) Benefits Maintenance (1) Emotional Support (3) Money Management (1) Food & Nutrition Issues (1) Housing Location(1) Housing Resource Edu. (2) Mental Health/Substance Abuse(2)-2MH Physical Healthcare(1) Transportation Issues(1) SBIRT(2)	Adherence to Medical Appts. (1) Adherence to Mental Health Appts. (2) Benefits Advocacy(3) Benefits Application(3) Emotional Support(2) Money Management(1) Food & Nutrition Issues(3) Housing Resource Edu.(1) Mental Health/Substance Abuse(2)-1MH/1MH+SA Physical Healthcare(3) Other(2)-Lifeskills/Empowerment Counseling	Benefits Advocacy (2) Benefits Application(1) Benefits Maintenance (1) Money Management(2) Emotional Support (2) HIV Disclosure Issues (1) Discrimination/Stigma(1) Food & nutrition issues (1) Mental Health/Substance Abuse(3)-1MH/2MH+SA Physical Healthcare(4) Transportation issues (1) SBIRT (3) Other (3)-Lifeskills/Empowerment Training	Adherence to MH Appts. (4) Benefits Advocacy (1) Benefits Maintenance (1) Education Issues (1) Money Management(1) Emotional Support (1) HIV Disclosure Issues(2) Discrimination/Stigma(1) Food & Nutrition Issues (1) Housing Resource Edu. (1) Medication Adherence (1) Mental Health Care/Substance Abuse (2)- 1 MH/1 MH+SA Physical Healthcare (3) Transportation issues(1) SBIRT (2) Other (3)-Integrated Assessments, Lifeskills/Empowerment Training, Legal issues	Adherence to MH Appts. (1) Money Management (1) HIV Disclosure Issues(1) Medication Adherence(1) Physical Healthcare(1) Other (2)- Attempted to schedule, Lifeskills/Empowerment	Adherence to MH Appts. (1) Benefits Maintenance(1) Money Management(2) HIV Disclosure Issues(1) Food & Nutrition Issues(2) Mental Health/Substance Abuse(2)-2MH+SA Physical Healthcare(2) Transportation Issues (1) SBIRT(2) Other(3)-Lifeskills/Empower

	Other (3)-LL Consultation, Lifeskills/Empo werment Counseling					ment Training, Confirmat ion of Appointm ent
<b>Client's Report of Activities</b>	Benefits(1)	Doctor's Visit (1) Benefits (2)	Doctor's Visit (1) Benefits (1)	Doctor's Visit (1)	Doctor's Visit (1)	Doctor's Visit (2) Benefits (2)
<b>Problems</b>						

Case 9	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
<b>Where?</b>	CM Office (1) Phone (4) Other (1)- Community Phone & Third Party -LL(1) Client's Home & Third Party-LL (1) Location not Stated (1)	Not stated (2)	Client's Home (1) Phone (2)	Client's Home (1) CM Office (1)	Phone- voicemail (1)	Client's Home (2) Client's Home/Third Party-Client's Friend in Building (1) Phone (4) Location Not Stated (1)
<b>What?</b>	CCM (3) Follow Up (4) Not Stated (1)	Follow Up (1) Not stated (1)	CCM (1) Follow Up (2)	CCM (2)	Not Stated (1)	Referral Screening (1) CCM (2) Follow Up (3) Client Missed Appt. (1) Not Stated (1)
<b>Types of Issues</b>	Adherence to MH Appts. (3) Benefits Advocacy (7) Money management(7) Emotional Support (1) HIV Disclosure Issues (1) Discrimination/Stigma(1) Food/Nutrition Issues(2) Housing Location (3) Housing Resource Edu. (8) Medication Adherence(2) Mental Health/Substance Abuse (4)- 2MH/2MH+SA	Adherence to MH Appts. (1) Money Management (1) Medication Adherence(1) Mental Health/Substan ce Abuse (2)- 2MH Physical Healthcare (2) SBIRT(1) Other(1)- Lifeskills/Empo werment Counseling	Money Management (2) Emotional Support(1) Housing Problem- Solving (1) Mental Health/Substa nce Abuse (1)- 1 MH Physical Healthcare(1) Other (3)- Lifeskills/Emp owerment, LL Consultation	Adherence to MH Appts.(2) Benefits Advocacy(1) Education Issues(1) Employment( 1) Money Management( 1) Emotional Support(1) HIV Disclosure Issues(1) Discriminatio n/Stigma(1) Food/Nutritio n Issues(1) Housing Resource Edu.(1) Medication Adherence(1)		Adherence to MH Appts. (6) Money Management( 1) Emotional Support(1) HIV Disclosure Issues (2) Discriminatio n/Stigma(1) Discuss Change in Level of Care(3) Food & Nutrition Issues(1) Housing Problem Solving(1)-LL Consultation Mental Health/Substa

	Physical Healthcare (5) Transportation Issues (3) SBIRT(5) Other (7)-Legal issues, Lifeskills/Empowerment Counseling, LL Consultation, Move-in			Mental Health/Substance Abuse(2)-1MH/1MH+SA Physical Healthcare(2) Transportation Issues(1) SBIRT (2) Other(2)-Lifeskills/Empowerment Counseling, Integrated assessment		nce Abuse (5)-4 Mh/1MH+SA Physical Healthcare(5) Transportation Issues(2) SBIRT (4) Other (5)-Lifeskills/Empowerment Counseling
<b>Client's Report of Activities</b>		Doctor's Visit (1) Psychiatrist (1)	Doctor's Visit (1)			Doctor's Visit (4) Psychiatrist visit(3) Benefits (1)
<b>Problems</b>	Concerned with current shelter's bug infestation Anxiety after moving		LL Reports Tenancy Problems Attempted to contact client			Sprung a leak in the bathroom

Case 9Types not mentioned in many

Case 10	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
<b>Where?</b>	Client's Home (1) CM Office (1) Location not stated (1)	CM Office (1) Phone (1) Location not stated (1)	Location not stated (1)	Client's Home (2) Phone(1)	Client's home (3)	Client's Home (3) Client's Home/Phone(1)
<b>What?</b>	CCM (2) Follow Up (1)	CCM (1) Follow Up (2)	Follow Up (1)	CCM (1) Follow Up(1) Not stated (1)	CCM (2) Missed Appt.- Follow Up (1)	CCM (2) CCM-Client Missed Appt.(1) Follow Up (1)
<b>Types of Issues</b>	Benefits Advocacy (1) Benefits Application (1) Benefits Maintenance(1) Money Management (1) Housing Location (1) Housing Resource Edu. (1) Other (3)- LL Consultation, AFC Paperwork/Signed Lease	Benefits Advocacy (1) Benefits Application (1) Care Coordination(1) Emotional Support(1) Housing Location(1) Medication Adherence(1) Mental Health/Substance Abuse(2)- 2MH Physical Healthcare(2) GPRA/Access to Wellness Services(1) SBIRT(2) Other(1)- Medical Paperwork/LL Consultation	Food & Nutrition Issues (1) Mental Health/Substance Abuse(1)- 1MH+SA SBIRT(1)	Food & Nutrition Issues(1) Medication Adherence(2) Medication Readiness(1) Mental Healthcare\Substance Abuse(2)-2MH Physical Healthcare(3) Repeated Referral (1) SBIRT (2)	Money Management (2) Food & Nutrition Issues(1) Medication Adherence (2) Medication Readiness (2) Mental health/Substance Abuse (2)- 1MH/1MH+SA Physical Healthcare(2) SBIRT (2)	Money Management (2) Emotional Support (2) Food & Nutrient Issues (1) Medication Adherence (3) Medication Readiness (3) Mental Health/Substance Abuse (3)-3 MH Physical Healthcare(3) GPRA/Access to Wellness Services (1) SBIRT(3) Other (2)- Attempted to contact, scheduled appt
<b>Client's Report of Activities</b>				Doctor's Visit (2)	Doctor's Visit (2) Psychiatrist Visit (1)	

<b>Problems</b>			Needed food, given knowledge on local food pantry	Missed PCP Appointment due to feeling too ill Feeling ill		
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<b>Case 11</b>	<b>Month 1</b>	<b>Month 2</b>	<b>Month 3</b>	<b>Month 4</b>	<b>Month 5</b>	<b>Month 6</b>
<b>Where?</b>	CM Office (2) Phone-Voicemail (3)	Phone-Voicemail (3) Third Party(2)-LL, Aunt Other(1)-Letter	Phone/Third Party-Client's Therapist (1) Other-Letter (1)	Client's Home (1) Phone (5) Phone/Third Party (3)-Therapist, LL, Unknown man answers client's phone Third Party Third Party (2)-Pete from AFC	Phone (1) Phone/Third Party (1)-LL Other(1)-Letter	CM Office(1) Phone (5) Phone/Third Party (1)-LL Location not stated (1)
<b>What?</b>	CCM(1) Follow Up (4)	CCM (1) Follow Up (4) Not stated (1)	CCM (1) Follow Up (1)	Referral Screening-Client Missed appt. (1) CCM (6) Follow Up (4)	Referral Screening (1) Follow up (2)	CCM (3) Follow Up (5)
<b>Types of Issues</b>	Adherence to MH appts.(1) Food & Nutrition Issues (1) Other (5)-Attempted to contactx4, Children Services, Scheduled next appt.	Money Management (1) Transportation Issues (1) Other(6)-Informative letter about attempted contacts, Attempted Contact, discussed not being able to contact client, scheduled appts./informative VM of new HRS	Mental Health/Substance Abuse(1)- 1 MH SBIRT (1) Other(1)-Informative letter about CTA policy	Intervention (4) Money Management (5) Housing Resource Edu.(1) Mental Health/Substance Abuse (2)-1MH/1MH+SA Physical Healthcare(2) Repeated Referral(2) Transportation Issues (2) SBIRT (3) Other (6)-Unable to contact, appt. reminder,	Money Management(1) Mental Health/Substance Abuse (1)-1SA SBIRT(2) Other (3)-Attempt to contact/unable to make contact, LL Consultation-Rental Payment Solution, Referral sources sent to client for substance abuse	Adherence to MH Appts. (1) Intervention (2) Money Management(4) Emotional Support(1) Medical Adherence(1) Medical Readiness (1) Mental Health/Substance Abuse (4)-4 MH+SA Physical Healthcare (1) Transportation Issues (4) SBIRT(4)

				children's services/housing inspection, attempted to contactx3		Other (7)-Client received she received referral letter, Encouragement to go to TX, Client will be going to detox/TX-LL consultation, LL consultationx3, Called to schedule appt.
<b>Client's Report of Activities</b>	Doctor's Visit (1)			Doctor's Visit (2) Psychiatrist Visit (1)		Doctor's Visit (1) Psychiatrist Visit (3) In-Patient Hospital Visit (4)
<b>Problems</b>	Phone is shut off	LL-Reported client informed she would be late with the rent Unable to contact client Unable to contact PP	Therapist Reported client is not "doing well"	Outstanding electric bill Notice of Electricity being shut off HRS suspects client is using substances, possible electricity shut off, damaged CTA card Ineligible for emergency services Client has not paid rent in 4 months, outstanding electric bill, unable to contact client Unable to contact client		Lost weight due to using, lost CTA card, reports being depressed. Not allowed to return to Lutheran Social Services without Mental Health Medication

Case 11

Case 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
<b>Where?</b>	Client's Home (2) CM Office (1) Phone (2) Other (2)- Letter	Client's Home (1) CM Office (1) Phone/Other-E-mail (1) Third Party (1) Other-Not Stated (1)	CM Office (2) Phone (2)	Client's Home (1) Phone (1)	Client's Home (1) Phone (5)	Client's Home (1) Phone (6) Other- Letter (1)
<b>What?</b>	CCM (5) CCM-Client Missed Appt. (1) Follow Up- Mutual missed appt by CM/Client (1)	Referral Screening (1) CCM (3) Follow Up (1)	CCM (1) CCM- Client Missed appt. (1) Follow Up- Client Missed appt. (1) Client Missed Appt. (1)	CCM (1) Follow Up (1)	CCM (1) CCM-Missed Appt. (1) Follow up (3) Follow up- Missed appt. (1)	CCM (2) Follow Up (5) Mutual Missed appt CM/Client. (1)
<b>Types of Issues</b>	Adherence to MH Appts. (1) Benefits Advocacy(1) Benefits Application(1) Benefits Maintenance(1) Money Management(1) Medication Adherence (1) Mental Health/Substance Abuse(2)-2SA Physical Healthcare(2) Repeated Referral(1) Transportation Issues(2) SBIRT(2) Other(5)- Schedule appt.	Adherence to MH appts. (1) Benefits Maintenance (1) Housing Problem Solving (1)-Lock broken on front door Medication Adherence(2) Medication Readiness (2) Mental Health/ Substance Abuse(5)- 1MH/2SA/2MA+SA Physical Healthcare (1) Repeated Referral(1) Transportation Issues (1) SBIRT(5)	Adherence to MH Appts. (1) Money Management (1) Physical Healthcare Other(4)- 3 Attempted Contacts/ Housing Inspection	Adherence to MH Appts. (1) HIV/AIDS Education (1) Medication Adherence(1) Mental Health/Substance Abuse(1)-1SA Physical Healthcare(1) Transportation Issues (2) SBIRT (2) Other(2)- Rescheduled Appt. Client has started attending AA	Housing Location(1) Physical Healthcare (1) SBIRT (1) Other(5)-LL Consultation , 4 Attempted contacts	Housing Location (1) Housing Resource Edu. (1) Medication Adherence(1) Medication Readiness (1) Mental Health/Substance Abuse (1)-1SA Physical Healthcare(3) SBIRT(1) Other(6)- Attempted to contact, information on tenant training, LL consultation x 2, attempted to schedule,

	to meet, attempted to contact, informed client about CTA policy, scheduled appt., housing inspection	Other(2)- LL Consultation				rescheduled appt.
<b>Client's Report of Activities</b>	Benefits (1)	In Patient Hospital Visit (1)		Doctor's Visit (1)	Doctor's Visit (1)	Doctor's Visit (2)
<b>Problems</b>	Phone not working correctly	Client has Relapsed "unwanted" visitors have been entering her building Lost keys to front door, taking painkillers for a toothache, refuse to go to a dentist	Client called Health Department on LL. Stated the building had bed bugs/roaches . Threw away her furniture.	Someone stole client's CTA Pass	Client was intoxicated	Client's phone is disconnected Client's phone is shut off x2 Issues with Bedbugs Client Appears to be intoxicated

<b>Case 13</b>	<b>Month 1</b>	<b>Month 2</b>	<b>Month 3</b>	<b>Month 4</b>	<b>Month 5</b>	<b>Month 6</b>
<b>Where?</b>	Client's Home 4) CM Office (2) Phone (1)	Phone (2) Location Not stated (1)	Client's Home (1) CM Office (1) Phone (1)	Client's Home (1) CM Office (1) Phone (2)	CM Office (1)	Client's Home (2) Phone (1)
<b>What?</b>	CCM (7)	CCM (2) Not stated (1)	CCM (1) Follow Up (1) Not Stated (1)	CCM (2) Follow Up (2)	Follow Up (1)	CCM (2) Follow Up (1)
<b>Types of Issues</b>	Adherence to MH Appts.(2) Benefits Advocacy (2) Benefits Application (3) Education Issues(1) Employment(1) Money Management(3) Emotional Support(3) HIV Disclosure Issues(3) Discrimination/S tigma(1) Discuss Change in Level of Care(2) Food & Nutrition Issues(2) Housing Location(2) Housing Resource Edu.(4) Medication Adherence(1) Mental Health/Substanc e Abuse (4)- 4MH+SA	Adherence to MH Appts. (1) Money Management (2) Emotional Support(1) Discuss change in level of care (1) Mental Health/Subst ance Abuse (2)-2MH+SA SBIRT (2) Other (2)- Lifeskills/Em powerment Counseling, Client reported relapsing	Adherence to MH Appts. (1) Benefits Advocacy (1) Benefits Application (1) Education issues (2) Employment (2) Money Management(1) Emotional Support(2) Discrimination/St igma(1) Discuss change in level of care (1) Food & Nutrition Issues(1) Housing Resource Edu. (1) Medication Adherence(1) Mental Health/Substanc e Abuse(3)- 3MH+SA Physical Healthcare(2) Transportation Issues (1) SBIRT(3)	Adherence to MH Appts.(1) Education Issues (1) Employment (3) Money Management(3) Emotional Support (3) Medication Adherence(1) Mental Health/Substanc e Abuse(4)- 4MH+SA Physical Healthcare(2) Transportation issues(2) SBIRT(4) Other (3)- Lifeskills/Empow erment x3	Employment (1) Money Management (1) Discuss change in level of care (1) Mental Health/Substanc e abuse (1)- 1MH+SA Physical Healthcare (1) SBIRT (1) Other(1)- Completed Treatment Plan	Adherence to MH appts. (2) Benefits Maintenance (1) Education Issues (1) Employment (2) Money Management (2) Emotional Support (2) HIV Disclosure Issues (1) Discrimination /Stigma (1) Food & Nutrition Issues (2) Housing Resource Edu. (1) Medication Adherence (1) Mental Health/Substa nce Abuse (3)- 3 MH+SA Physical Healthcare (2)

	Physical Healthcare (4) Transportation Issues(3) SBIRT(4) Other(5)-Legal Issues, Lifeskills/Empowerment Counseling, Harm Reduction, Housing Inspection-LL Consultation		Other (3)- Lifeskills/Empowerment, Integrated assessment, legal issues			Transportation Issues (2) SBIRT (3) Other (1)-Legal Issues
<b>Client's Report of Activities</b>	Psychiatrist Visit (1) Benefits (2)	In-Patient Hospital Visit (2)	In-Patient Hospital Visit (1)			Doctor's Visit (1) Psychiatrist Visit (2)
<b>Problems</b>		Reported being depressed for being in rehab over his birthday				

<b>Case 14</b>	<b>Month 1</b>	<b>Month 2</b>	<b>Month 3</b>	<b>Month 4</b>	<b>Month 5</b>	<b>Month 6</b>
<b>Where?</b>	Client's Home (1) CM Office (1) Location not stated (1)	Location not Stated (2)	Client's Home (2) CM Office (1) Location not Stated (2)	Client's Home (3) Location Not stated (1)	Client's Home (1) Client's Home & CM Office (1) Location Not stated (1)	Client's Home (3)
<b>What?</b>	CCM (3)	CCM (2)	CCM (3) Follow up (1) Not Stated (1)	CCM (2) Follow Up (1) Not Stated (1)	CCM (2) Not Stated (1)	CCM (3)
<b>Types of Issues</b>	Benefits Advocacy (2) Benefits Application (1) Benefits Maintenance (2) Housing Location (1) Other (2)- Housing Inspection, LL Consultation	Benefits Advocacy(1) Benefits Application (1) Benefits Maintenance (1) Other (1)- Attempted to Contact	Benefits Advocacy (1) Benefits Application(2) Benefits Maintenance(3) Emotional Support(1) Food & Nutrition Issues (2) Physical Healthcare(3) Transportation Issues(3) Other (1)- Rescheduled Appt.	Benefits Advocacy (1) Benefits Application (1) Care Coordination (1) Food & Nutrition Issues (1) Medication Adherence (1) Physical Healthcare(2) GPRA/Access to Wellness services (1) SBIRT(1) Other (1)- Attempted Contact	Benefits Advocacy (2) Benefits Application (2) Benefits Maintenance ((1) Food & Nutrition Issues(1) Medication Adherence (2) Medication Readiness (1) Physical Healthcare (2) Transportation Issues (1)	Benefits Maintenance (1) Emotional Support (2) Mediation Adherence(2) Medication Readiness(3) Mental Health/Substance Abuse(1)- 1MH Physical Healthcare(2) Transportation Issues(3) SBIRT (2)
<b>Client's Report of Activities</b>			Doctor's Visit (1)	Doctor's Visit (2)	Doctor's Visit (1) Benefits (1)	
<b>Problems</b>				Pain in her ankle, reported no ID Feet are swelling	Reporting Pain in her ankle	Pain in Ankles and Legs