

Executive Summary

The **Better Health Through Housing** (BHH) program is a partnership between the University of Illinois Hospital & Health Sciences System (UI Health) and the Center for Housing and Health (CHH), a subsidiary of the Aids Foundation of Chicago. It is a demonstration pilot that is drawing attention to the nationally-validated **Housing First** model here in Chicago, with a goal of scaling and sustaining a permanent collective solution among healthcare, government, and housing agencies that will result in a dramatic reduction in the number of chronically homeless. Although the chronically homeless constitute 10-15% of the total homeless population, they account for 80-90% of public cost and utilization. **Housing First** programs throughout the country have demonstrated it costs society one-third to a half as much to provide supportive housing rather than allowing citizens to remain homeless.

Program Overview

UI Health pays CHH \$1,000 per patient per month once a patient has transitioned into permanent support. Housing stock comes from a cooperative of 28 supportive housing agencies that represent 150 one bedroom apartments scattered throughout the city as well as single room occupancy (SRO) studio units. This is a collaborative interdisciplinary model that includes hospital social workers, supportive housing case managers, street outreach workers, with CHH playing a project management and coordination role.

Outcomes & Lessons Learned

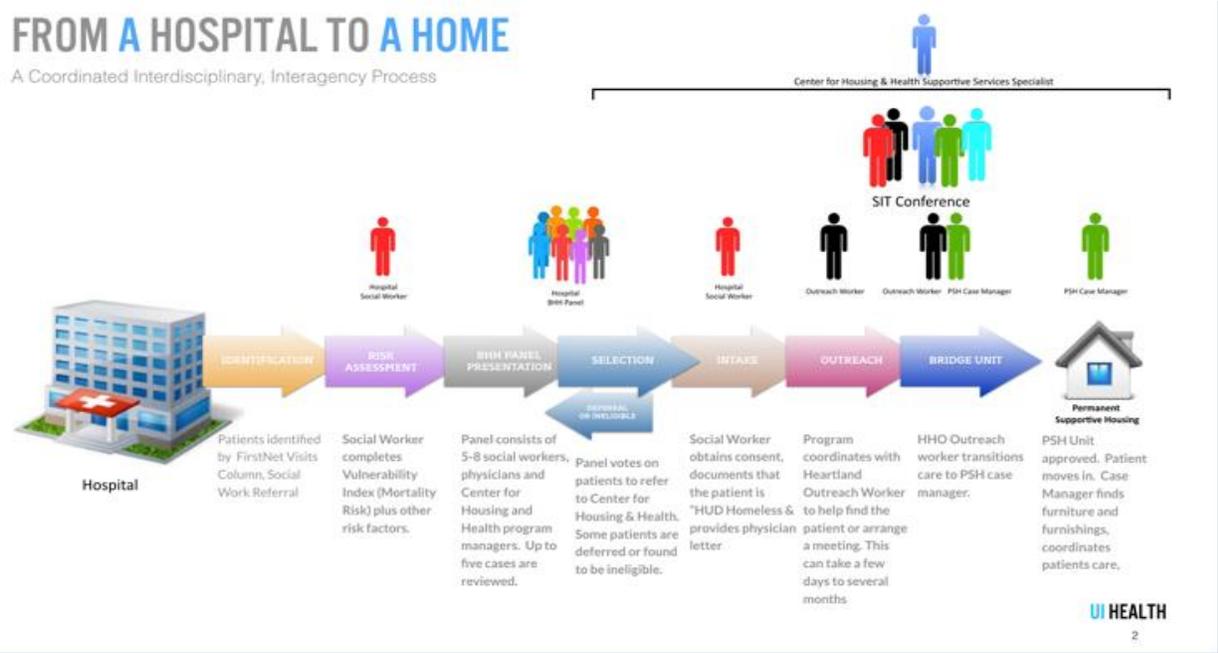
BHH has created a healthcare-to-housing model that has demonstrated a significant drop in healthcare costs (-21%).

A few of the many lessons learned through the pilot;

1. Homelessness is a *dangerous health condition*
 - a. The pilot has shown high mortality rates. Four of the 27 expired during the first year of the program and another is in hospice. The homeless in America have life expectancies that are 25 years less than the average American.
 - b. There are high rates of head and neck cancers, and traumatic brain injuries
2. The homeless are invisible in the healthcare system. When the program started, we had identified 48 individuals and their healthcare costs were 4.8 times higher than the average UI Health patient. We have now found over 1,325 patients (2008-2017) with 574 current patients who are experiencing homelessness or unstable housing.
3. The process for identification, selection, intake, outreach and transition to bridge unit and permanent supportive housing requires intensive care coordination among an interdisciplinary cross-agency care team. Team members include hospital social workers, psychiatrists, ED physicians, outreach workers, supportive case managers and project managers.

FROM A HOSPITAL TO A HOME

A Coordinated Interdisciplinary, Interagency Process



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<http://www.chicagobusiness.com/article/20160402/ISSUE01/304029992/this-program-could-lower-health-care-costs-in-chicago>

National Public Radio, All Things Considered (6/29/16)

<http://www.npr.org/sections/health-shots/2016/06/29/482994000/a-hospital-offers-frequent-er-patients-an-out-free-housing>