

Cook County Health Supports Policies

Research shows that housing homeless individuals decreases emergency room visits by nearly 61 percent and health care costs by 59 percent. Investing in strategies to house individuals and families while providing them access to preventive health care is a strategy that will reap enormous benefits for society as a whole. We have only scratched the surface.

As health care providers learn to better incorporate the evaluation of social determinants of health into routine practice, we must work with policymakers to advocate for policy initiatives that:

1. Increase funding for supportive and affordable housing recognizing the link between health and housing

2. Promote cross-system data sharing and coordination between health care and homeless services systems.
3. Reduce barriers for individuals and families who may have additional challenges obtaining and remaining in stable housing, including those in the justice system and those living with mental illness or substance use disorders.
4. Increase access to the full continuum of housing and services options, including, but not limited to, street and shelter outreach, prevention, medical respite and permanent supportive housing.

Our Work Continues

From 2003-2007, Cook County Health Collaborative Research Unit's Dr. Laura Sadowski led a foundational research project studying the health impacts of housing and health interventions. It demonstrated a positive correlation between housing and health management of homeless adults.¹²

More than a decade later, our work continues.

Special thanks to:

All Chicago
Alliance to End Homelessness in Suburban Cook County
BEDS Plus
The Boulevard
Center for Housing and Health
Chicago Community Trust
Chicago Department of Family & Support Services
Chicago Department of Public Health
Chicago Housing Authority
Corporation for Supportive Housing

As we continue to make progress, Cook County Health is grateful for the partnerships that have developed out of a mutual desire to address the connection between affordable housing and healthy living. Cook County Health looks forward to continuing our relationship, as well as developing new connections as we all try to improve the lives of the residents of Cook County.

Deborah's Place
Housing Authority of Cook County
Housing Forward
Illinois Department of Human Services, Division of Substance Use Prevention and Recovery
Illinois Housing Development Authority
Illinois Public Health Institute
J.B. and M.K. Pritzker Family Foundation
Renaissance Social Services Inc.
South Suburban PADS
Thresholds

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¹ "Homeless Populations at High Risk to Develop Cardiovascular Disease," American College of Cardiology, May 2018, <https://www.acc.org/about-acc/press-releases/2018/05/29/10/08/homeless-populations-at-high-risk-to-develop-cardiovascular-disease>

² "Unstable Housing and Diabetes-related Emergency Department visits," American Diabetes Association, May 2018, <http://care.diabetesjournals.org/content/41/5/933>

³ "Asthma and Adaptive Functioning Among Homeless Kindergarten-aged Children in Emergency Housing," Journal of Healthcare for the Poor and Underserved, May 2014, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4498570/>

⁴ Serious Mental Illness and Homelessness, <https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3629-serious-mental-illness-and-homelessness>

⁵ National Coalition for the Homeless, <https://www.nationalhomeless.org/factsheets/addiction.pdf>

⁶ All Chicago, <https://allchicago.org/dashboard-to-end-homelessness>

⁷ All Chicago's Homeless Management Information System, <https://allchicago.org/HMIS>

⁸ "The Business Case For Ending Homelessness," American Health and Drug Benefits, February 2012, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4046466/>

⁹ Chicago Coordinated Entry System connects people facing homelessness to housing. <https://www.csh.org/chicagoces/>

¹⁰ January 31, 2018

¹¹ Cook County Health is one of the largest public health care systems in the U.S. with an international reputation for medical research and training. The system operates two hospitals; a network of community health centers including four regional outpatient centers; a state- and nationally-certified public health department; Correctional Health Services; and CountyCare, one of the largest Medicaid managed care plans in Cook County. CountyCare is a Medicaid managed care health plan owned and operated by Cook County Health. Approximately 75 percent of CountyCare members receive care outside the Cook County Health system.

¹² "Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults," https://shny.org/uploads/CHHP_randomized_trial.pdf

HOUSING IS HEALTH

Homelessness and Housing Instability

Homeless patients face multiple challenges in accessing health care and stabilizing their health conditions. Without access to safe, stable and affordable housing, individuals and families can struggle to achieve optimal health.

Homeless individuals have an increased risk of hypertension¹, diabetes², asthma³, mental health problems⁴ and substance use disorders⁵. This is due, in part, to homelessness creating significant challenges to making and getting to medical appointments and maintaining medication regimens.

Each night in Cook County, nearly 9,000 people are living on the streets or in a shelter⁶. **Cook County Health provides health services to 83 percent of the single adult homeless population in Chicago**, as identified through a data match between Cook

County Health records and the Chicago Homeless Management Information System (HMIS)⁷.

The impact of homelessness and housing instability on health care organizations is clear. Homeless individuals make more frequent use of emergency departments, have longer stays when admitted and have higher rates of readmission, all of which lead to increased health care costs. According to a 2012 study, **homeless people visit the emergency department an average of five times annually, with each visit costing \$3,700**. On average, homeless people then spend three nights per visit in the hospital, which can cost more than \$9,000.⁸

Across the country, health care organizations are looking at alternative means to help these at-risk populations.



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Cook County Health Is Committed

As part of its mission to address health care equality across the county, Cook County Health has developed and invested in a number of efforts to identify and address the housing insecurity of some of our patients. One in five CountyCare members has identified as needing help with housing.

Homeless shelters were one of the first locations where new CountyCare members were enrolled. Medicaid connects individuals with a primary care provider, a critical first step in improving the health of these patients and ultimately reducing costs.

To address this situation, Cook County Health has:

- Trained community health workers in the Chicago Coordinated Entry System⁹ to assess and prioritize patients for housing assistance.
- Created a Housing Department within our Integrated Care Department that works internally and with community partners to create target housing opportunities for unstably housed patients.
- Developed relationships with two local Housing and Urban Development (HUD) continuums of care – All Chicago and the Alliance to End Homelessness in

suburban Cook County – to better align and link our relevant data systems and more efficiently connect vulnerable individuals with housing resources.

In addition, Cook County Health has partnered with several local organizations to match patients with available housing opportunities.

- **Housing Forward Wellness Initiative Network:** Connects CountyCare members with supportive housing and case management services in west and south suburban Cook County.
- **Illinois Housing Development Authority Rental Housing Support Program:** Links unstably housed patients to housing in suburban Cook County.
- **The Boulevard:** Provides medical respite care for homeless patients exiting an in-patient hospitalization.

Cook County Health holds board seats on the Chicago and Suburban Cook Continuums of Care, participates actively in the Chicago and Cook County Housing for Health (H2) Initiative and is a member on the Chicago Area Patient Outcomes Research Network (CAPriCORN), which is focused on improving health care quality, outcomes and equity.

Cook County Research: Serving Patients Experiencing Homelessness

As a member of the Cook County Health’s utilization management committee, Dr. Lauren Smith, Chair of the Division of Observation & Quality, Department of Emergency Medicine, is tasked with looking at ways to effectively and efficiently provide care for patients in the emergency department.

Dr. Smith and medical residents in the Cook County emergency department began looking at frequent users of the emergency department, many of whom were homeless or have unstable housing. Frequent users of the emergency department were described as individuals who made 4-19 visits per year, while super users were individuals who made more than 20 visits in a year.

From January 1-December 31, 2017, Cook County Health had 63 patients who qualified as “super users” and 3,696 who qualified as “frequent users.” **The super users combined for 1,844 encounters in the emergency department (1.8 percent of all Cook County Health patient emergency department encounters) while frequent users totaled 21,071 encounters (20.88 percent).**

A high proportion of both patient groups presented with psychiatric or substance-related issues.

The emergency department now identifies those patients as frequent or super users of the emergency department, and this triggers an emergency department social worker to intervene and refer for possible intervention or case management.

“A lack of housing is a huge social determinant,” Dr. Smith said. “When you’re homeless, your priority isn’t making a doctor’s appointment or refilling medication, it’s surviving. At a time when health care costs are rising, we need to find out what we can do to make sure someone who doesn’t need to be in the emergency room, doesn’t present there for needs that can be met elsewhere. We need to ensure they are getting the right care, at the right time and at the right place.”

Dr. Smith and her team presented their findings at the 2018 annual conference of the National Center for Complex Health and Social Needs.

County Targeted Response to Housing Instability: Chicago & Cook County Flexible Housing Pool

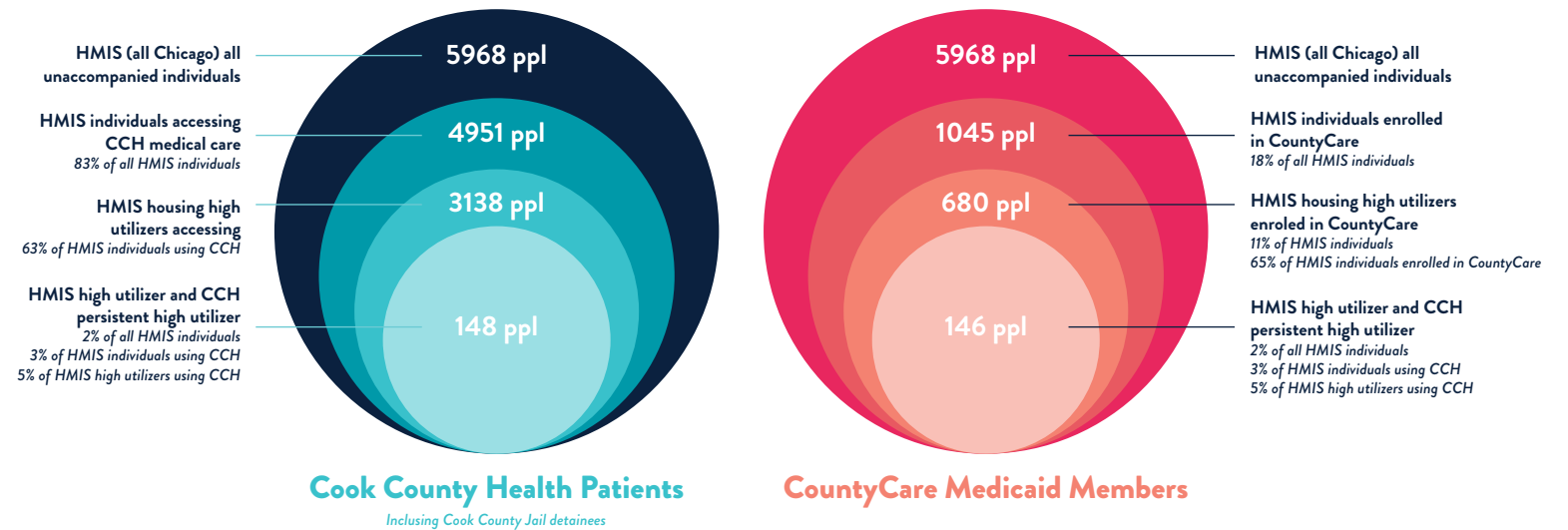
Cook County Health is a lead partner in the Chicago & Cook County Flexible Housing Pool, a partnership between Cook County Health, the City of Chicago and committed partners, with the goal of rapidly housing vulnerable homeless individuals and connecting them with supportive services.

As part of the program, Cook County Health identifies and refers participants through data from Cook County Health

and Cook County Jail medical records and CountyCare claims, focusing on high utilizers of hospital and jail services.

The graphic below shows the data on a point in time¹⁰ to show how the information is cross referenced to determine the targeted populations.

Housing & Medical Care Data Match, 2018



Profile: Aloyce Hill Not Just Surviving, But Thriving

After facing devastating adversities and obstacles in her life, Aloyce Hill soon became overwhelmed by the circumstances, impacting her ability to keep doctor’s appointments, maintain proper nutrition and take needed medication.

She moved in with a friend, but when her friend’s living situation changed, Ms. Hill soon found herself facing potential homelessness.

That’s when she met advocates from Cook County Health. They recognized the dire situation and the potential impact it could have on Ms. Hill’s health.

After meeting with a Cook County Health care coordinator, Ms. Hill was identified for a one-bedroom apartment set up by Housing Forward, a housing partner of Cook County Health in the western suburbs. She moved in on December 3, 2018.

The new apartment, provided through the Illinois Housing Development Authority Rental Housing Support Program, has given Ms. Hill a fresh start. She takes a yoga and Zumba class at the library and continues her study of Nichiren Buddhism. She is now working on finding peace within herself through better physical and mental health.

“I’m not just surviving today,” Ms. Hill said. “I’m thriving.”