

# A Primary Care Primer on Housing Insecurity in Children

## First Steps: Improving Child Health and Housing



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# Contributors and Partners

- Access Community Health Network
- Advocate Medical Group
- AIDS Foundation of Chicago
- Ann and Robert H. Lurie Children's Hospital of Chicago
- Catholic Charities
- Center for Housing and Health
- Chicago House
- Christian Community Health Center
- Cook County Health
- Corporation for Supportive Housing
- Esperanza Health Center
- Facing Forward to End Homelessness
- Friend Family Health Center
- Heartland Alliance Health
- Housing Opportunities for Women (HOW Inc)
- Illinois Association of Medicaid Health Plans
- Inspiration Corporation
- La Casa Norte
- Logan Square Health Center of Cook County
- Loyola University Medical Center
- Memorial Health System of Central Illinois
- New Moms
- Northwestern Children's Practice
- The Ounce of Prevention Fund
- Primo Center for Women and Children
- Rush University Medical Center
- Sinai Urban Health Institute
- University of Chicago Comer Children's Hospital
- WellCare Health Plans Inc.



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# Primer Learning Objectives

- Become familiar with definitions and scope of homeless and housing insecurity in Chicago
- Learn how to sensitively address housing insecurity in patients
- Develop understanding of clinical guidelines related to housing insecure population
- Become familiar with screening tools and referral resources for children and families experiencing housing insecurity



# Presentation Outline

- 1) Overview of Chicago Housing System
- 2) Practice Site and Physician Cultural Sensitivity
- 3) Patient Communication and Identification of Risk
- 4) Clinical Guidelines
- 5) Referral Options and Tool



# Overview of the Chicago Housing System

Johnna Lowe, MNA  
Corporation for Supportive  
Housing

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# Learning Objectives

- Gain a basic understanding of how homelessness is defined in the Chicago housing system and the scope of the problem
- Discover the foundational role structural racism plays in shaping Chicago housing policy

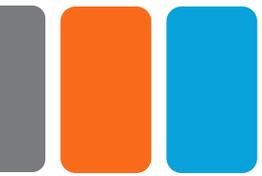




# Section Topics



- Federal Definitions of Homelessness
- Scale and Scope in Chicago
- Structural Racism and Impact
- Chicago's Housing Interventions and Resources



# Federal Program Definitions of Homelessness



# Housing Insecurity

- Multiple definitions for various federal programs
- No unified definition, like food insecurity
  - Housing instability
  - Literal homelessness





# HUD definitions

## Categories 1 and 4 are eligible for HUD Homeless Dollars

### 1. Literally Homeless

- Individuals who **do not have a permanent nighttime residence**. It could include someone who stays at a **shelter, on the street, or any place not meant for people to sleep**

### 4. Domestic Violence

- Any individual or family who is **attempting to flee domestic violence**, has no other residence, and has no means of accessing housing.

## Categories 2 and 3 are eligible for federal mainstream entitlement funding

### 2. Imminent Risk (Housing Insecure)

- Those who are at **risk of losing their home** within 14 days of asking for housing assistance. They have not identified where they will go next and lack the resources to access housing.

### 3. Other considerations

- **Unaccompanied youth** under 25 years of age, or **families with children and youth**, living doubled up for economic reasons, or awaiting foster care placement



# Education for Homeless Children and Youth Program

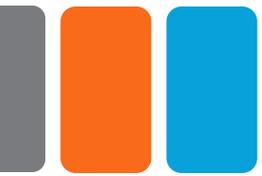
Children/youth

- lack a fixed, regular, and nighttime residence

or

- ha[ve] a primary nighttime residence that is
  - a supervised or publicly operated shelter designed to provide temporary living accommodations
  - an institution that provides a temporary residence for individuals intended to be institutionalized including welfare hotels, congregate shelters, and transitional housing for the mentally ill or
  - a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings





# Scale and Scope in Chicago



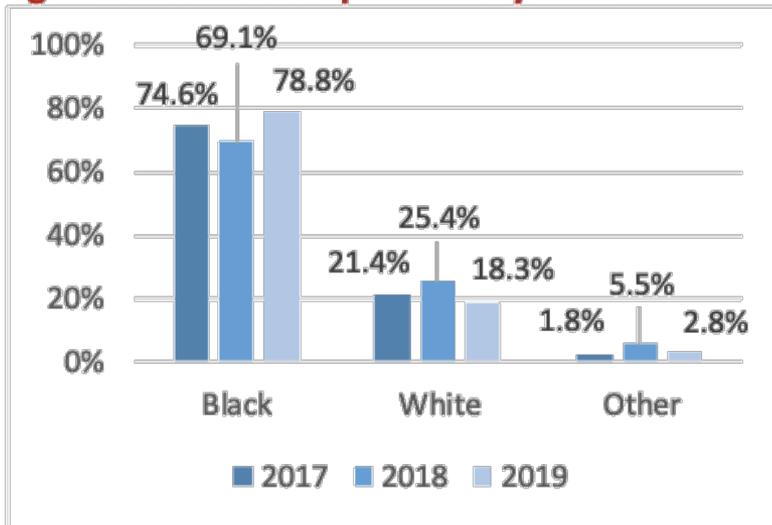
# The State of Homelessness

	Number of Individuals
Illinois	10,643
Chicago	5,290
Families in Shelters	559
No. of Individuals in families	1,996

2019 Point in Time Count

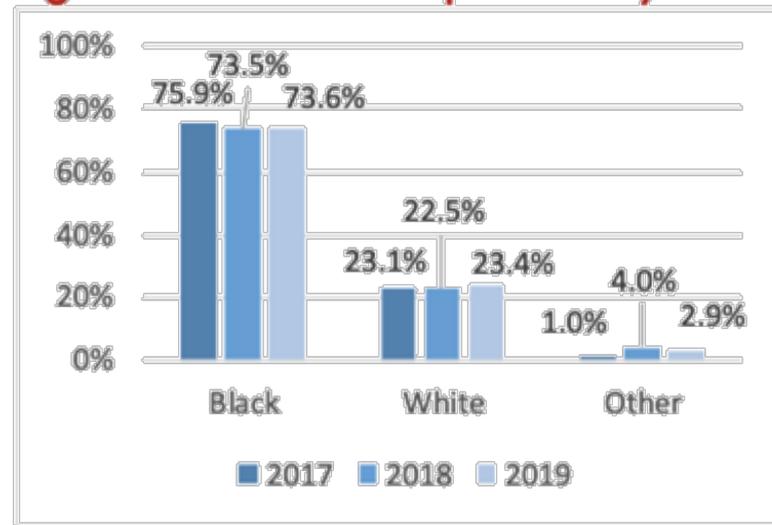
# Homelessness by Race

**Fig. 14: Sheltered Population by Race**



Source: 2017 - 2019 PIT Counts

**Fig. 15: Unsheltered Population by Race**

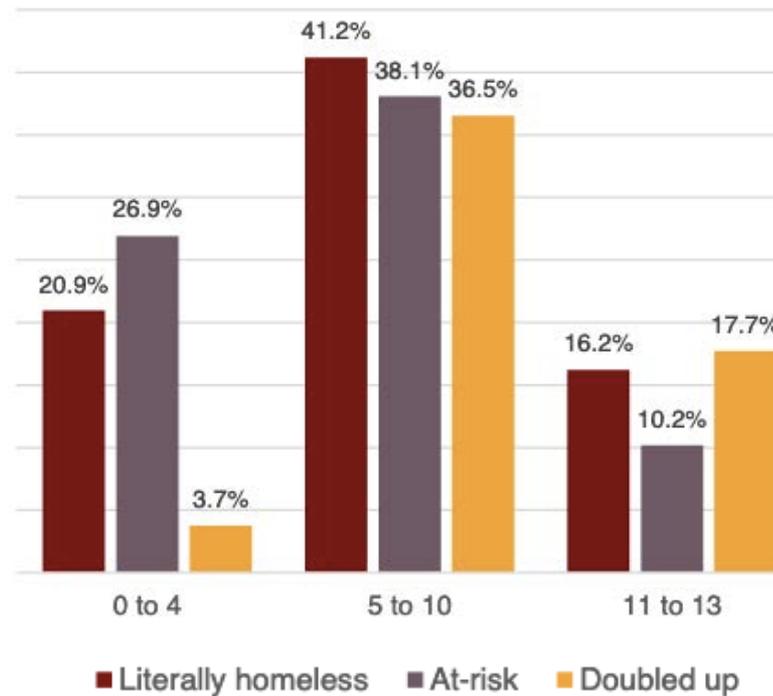


Source: 2017 - 2019 PIT Counts



# Homelessness by Age

Distribution of child age in families experiencing or at-risk of homelessness:  
CPS data from SY 2016–2017

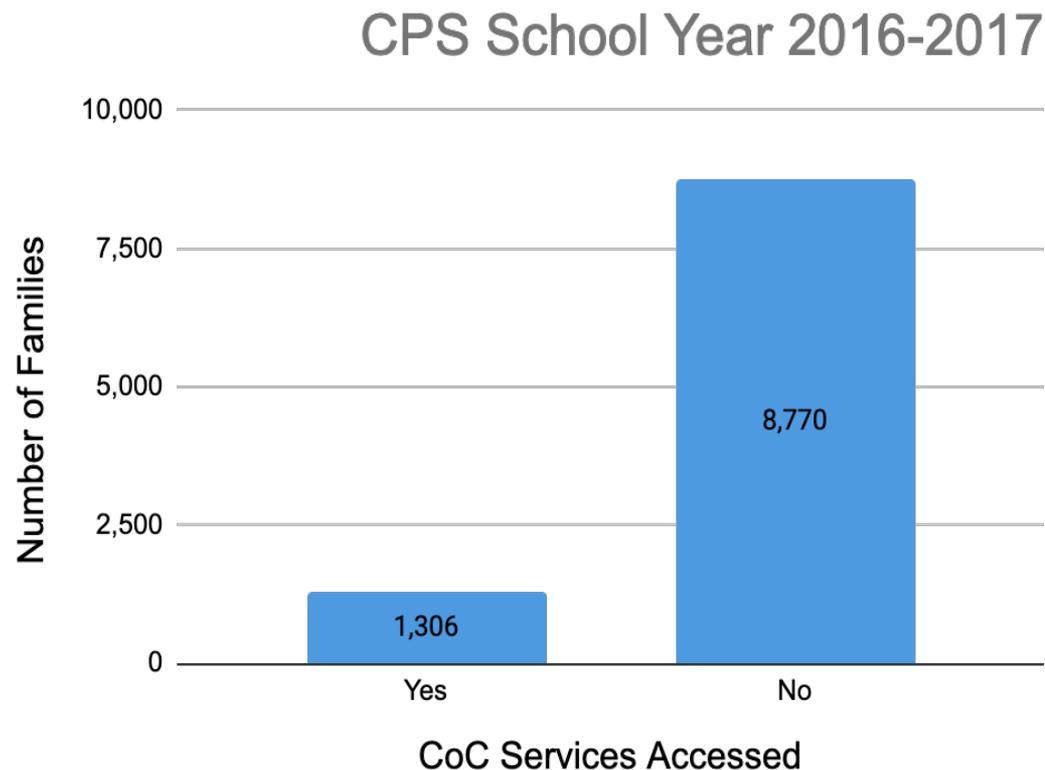


Limitations

Source: HMIS and CPS data. \*3,588 children in families accessing CoC services while experiencing literal homelessness as of August 21, 2017 in HMIS or categorized as literally homeless in CPS data in SY 2016–17



# Ending Family Homelessness Report



Approximately **10,076 families** experiencing housing insecurity under McKinney-Vento Act definition in Chicago Public Schools (CPS)



# Structural Racism and Impact



# Historical Context Timeline



- Slavery ends in 1865 with the 13<sup>th</sup> amendment
- 1930s – Institutionally segregated public housing
- Systemic redlining prohibiting sale or resale of homes to African-Americans by the Federal Housing Authority
- 1970s – Laws and policies set to impose barriers and inaccessibility based on race
- U.S. public housing program replaced by Section 8 program



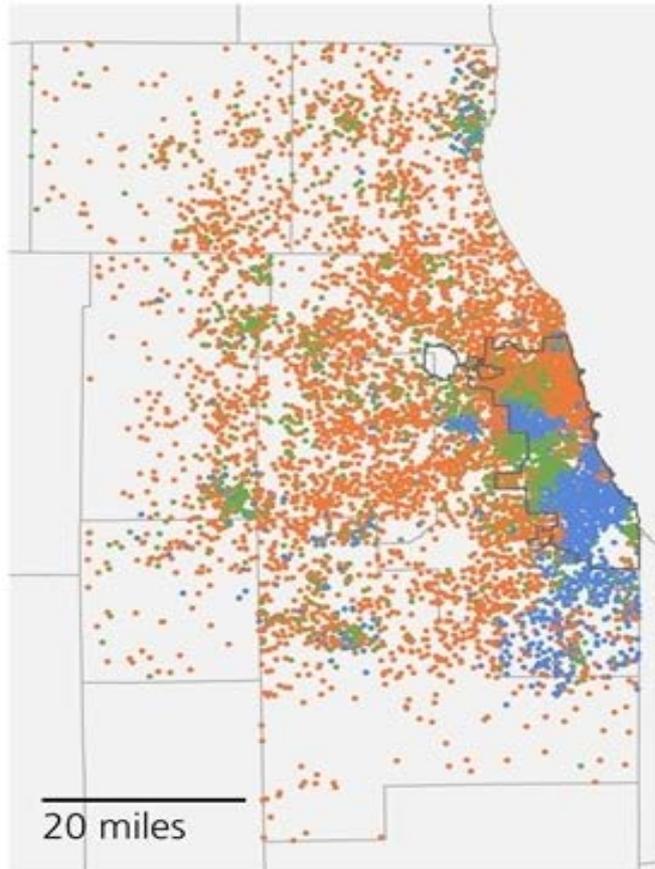
# Historical Context Timeline



- Deinstitutionalization of mental health services (JFK Community Mental Health Act)
- 1980s – \$140B in domestic cuts to HUD, unemployment, disability, food stamps, welfare
- War on drugs & crack cocaine epidemic disproportionately affected black and Latino communities
- Generational poverty in the African-American community
- People of color comprise disproportionate share of US homeless population



# Chicago Racial Segregation

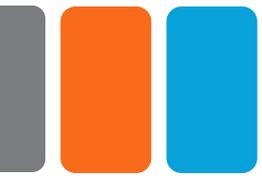


These maps illustrate where white, African American and Latino people live in the Chicago region. Each dot represents 1,000 people.

1 dot = 1,000 people  
Population: 8,505,977

- White (52.2%)
- African American (17.0%)
- Latino (22.4%)

Source: Map by MPC, based on Urban Institute map and analysis of 2011-2015 American Community Survey (ACS) five-year estimates



# Chicago's Housing Interventions and Resources



# Chicago's Housing Interventions and Resources

- Covered in the final section
  - Crisis Services
  - Rapid Re-housing (RRH)
  - Prevention
  - Supportive Housing
  - Affordable Housing
  - ICAAP Housing Referral Tool





# Next Presentation Section

- 1) Overview of Chicago Housing System
- 2) **Practice Site and Physician Cultural Sensitivity**
- 3) Patient Communication and Identification of Risk
- 4) Clinical Guidelines
- 5) Referral Options and Tool



# Practice Site and Physician Cultural Sensitivity

Markeita Moore, MD FAAP  
Advocate Children's Medical  
Group

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# Learning Objectives

- Identify steps needed to create a welcoming health care practice site
- Apply physician and provider cultural sensitivity for housing insecure population





# Why is Cultural Sensitivity Needed for the Housing Insecure Population?



- Ensures care is unbiased
- Aids in creating trust
- Leads to ideal health outcomes



# Cultural Sensitivity– Staffing

- Diversity & Inclusion:
  - Incorporate staff that resembles the population being served, speak same language(s)
  - Assign staff to perform ongoing competency training
- Adapt services and atmosphere to meet culturally unique needs
  - Staff to help patient navigate healthcare system
  - Staff to maintain current pamphlets/resource information in waiting area/exam rooms for:
    - transportation services
    - local food shelters
    - assistance programs
    - prescription mailing programs
    - employment opportunities
    - heating and cooling sites





# Cultural Sensitivity– Scheduling

- Give priority for scheduling
- If phone access is limited, inform patient to walk in first thing in the morning
- If there is a no walk-in policy, retain morning and evening same day slots
- When possible, accommodate all children within a housing insecure family on the same day



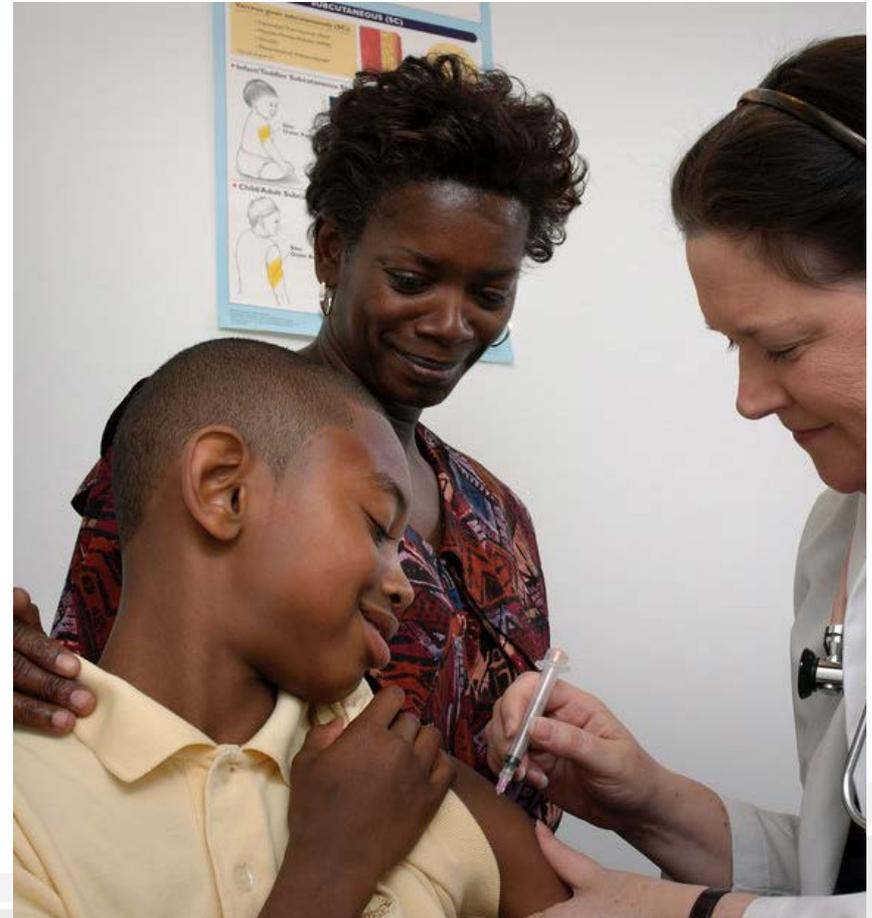
# Cultural Sensitivity– Physicians and Providers



- Treat each visit like it's the last
- Ask and screen for social determinants
  - Assess housing situation
  - Address factors that inhibit attending appointments
- Create a bond/trust through effective communication
  - Understand range of health literacy
  - Don't make assumptions for/about
  - Emphasize their strengths, resilience
  - Maintain empathy, trauma responsive care

# Cultural Sensitivity– Physicians and Providers

- Recognize communication may be limited
- Know when to report to child welfare
- Create resource sheet
- Understand their housing situation then develop a treatment plan
  - Decrease barriers to treatment/compliance and follow-up plans
  - If medication is needed, aim for simplest plan, less doses, shortest course
  - For acceptable cases, allow a phone follow-up instead of an in-office visit





# AAP Recommendations

- Facilitate enrollment of eligible children in Medicaid
- Become familiar with management of chronic diseases in homeless populations
- Optimize health visits to provide comprehensive, preventive care
- Connect families to community resources
- Identify the underlying causes of homelessness
- Assist in development of shelter-based care





# Summary

- Cultural sensitivity is key to providing unbiased care
- Culturally sensitive care allows housing insecure patients to feel welcomed and understood, creating a trust
- Achieving cultural sensitivity is a constant process that requires empathy and concrete policy-level action



# Implementation in Practice

- ✓ Institute ongoing competency training for staff
- ✓ Compile a list of resources to distribute to patients
- ✓ Promote flexible scheduling as a priority for children and families experiencing housing insecurity
- ✓ Implement trauma responsive care
- ✓ Designate staff for follow-up and navigation



# Trauma Responsive Care Resource

AAP Trauma Toolbox for  
Primary Care





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# Patient Communication and Identification of Risk

Barbara Bayldon, MD

Medical Director, Primary Care  
Section

Lurie Children's Hospital

Illinois Chapter

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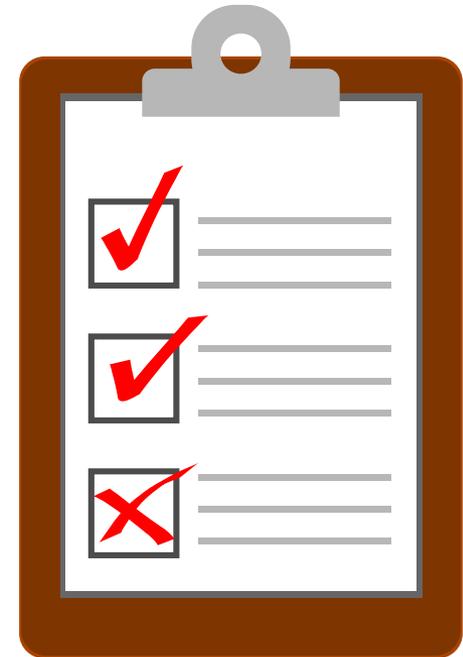
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## Learning Objectives

- Develop the skills to sensitively and effectively identify patient/families who have housing insecurity
- Support medical home family centered communication for children and families facing housing insecurity





# Section Outline

- How to Screen in a Culturally Sensitive Way
- Specific Screening Methods
- Communication Barriers
- Follow-up





# How to Screen in a Culturally Sensitive Way

# Principles of Screening Families with Housing Insecurity

The American Academy of Pediatrics Endorses Screening—AAP Committee on the Psychosocial Aspects of Child and Family Health 2012, 2016

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Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

POLICY STATEMENT

Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health

Within this highly variable and multi-dimensional context, the AAP and others have encouraged pediatric providers to develop a screening schedule that uses age-appropriate, standardized tools to identify risk factors that are highly prevalent or relevant to their particular practice setting.<sup>29,66,67</sup>



# Identifying Barriers in a Culturally Sensitive Way

- Understand Barriers to Disclosure
  - “Are you homeless?” does not effectively identify homelessness
  - Stigma, shame, fear of being treated poorly
  - Parents may worry about DCFS
  - Street address could belong to a friend, relative, shelter, or church, or be a previous residence
- Low Health Literacy– Poverty is a risk factor
  - Both oral and written communication should be at 5–6<sup>th</sup> grade level
  - Ensure understanding, use TEACH BACK
  - Family may wish to have a support, i.e. case manager with them or other staff member

# Identifying Barriers in a Culturally Sensitive Way

- Be aware of possibly recreating feelings of traditional institutional judgement in patients
- Explain why asking
  - You have a sincere concern and you wish to support them
  - Pediatricians cover all parts of life because they can all affect child health
  - Normalize by saying we ask everyone
- What will you do with the information?
  - "We want to help you be the best parent and have the healthiest family you can"
  - "We wish to support families who have life stresses and we can link you to resources"





# Implementing Screening for Housing Insecurity

- Decisions on implementation
  - Will you do face to face, on paper/electronically, or both – different people prefer different formats
  - Who will ask in clinic and when – you can tailor to your clinic workflow but make sure the people are trained
  - How will you ensure confidentiality
  - How frequently will you ask – one size does not fit all





# Implementing Screening for Housing Insecurity

- Be prepared to respond

**VIEWPOINT**

## Avoiding the Unintended Consequences of Screening for Social Determinants of Health

**Arvin Garg, MD, MPH**  
Department of Pediatrics, Boston University School of Medicine, Boston Medical Center, Boston, Massachusetts.

**Screening for social determinants** of health, which are the health-related social circumstances (eg, food insecurity and inadequate or unstable housing) in which people live and work, has gained momentum as evidenced by the recent Centers for Medicare & Medicaid Services innovation initiative of \$157 million toward creation of accountable health communities.<sup>1</sup> Funding

ment) requires effective care coordination and cross-sector collaboration. The relatively few exemplary, evidence-based models (eg, WE CARE, Health Leads, Project DULCE, Safe Environment for Every Kid, Help Me Grow) that use such strategies are limited in scope and reach and must be expanded to address the needs of diverse patient populations.<sup>6</sup>

*“Screening for any condition in isolation without the capacity to ensure referral and linkage to appropriate treatment is ineffective and, arguably, unethical.” Garg, 2016*

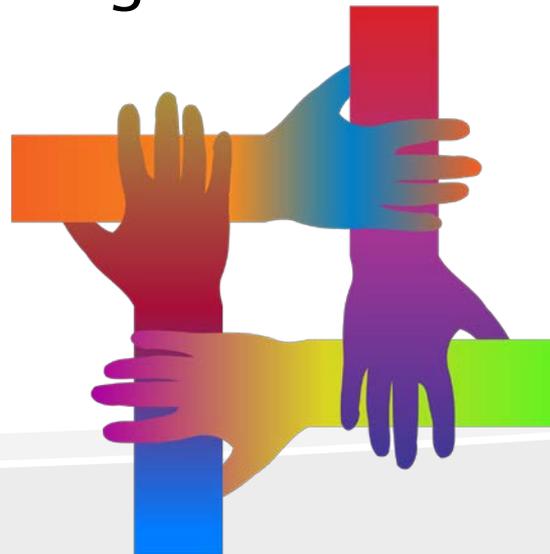
- Empathetic listening can be a response in and of itself



# Implementing Screening for Housing Insecurity

## A Team Effort

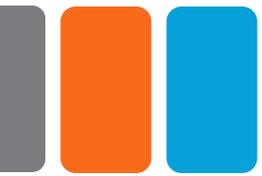
- In the clinic: nurse, medical assistant, front desk, and if you have social service support – all can have a role
- In the community: schools, legal, government and nonprofit agencies – need to all play a role





# Resources for Referrals

- Housing Resources – depending on whether it is a crisis and if family is homeless
  - Coordinated Entry System can be posted in waiting or provided by a social worker
  - Specific groups may have access to particular programs– Victims of Domestic Violence, Veterans
- Other Resources
  - <https://www.cityofchicago.org/city/en/progs/health/svcs.html>
  - Create a list of community resources: e.g. CPS, Legal, Public Aid, Child Find, Mental health



# Specific Screening Methods



# Specific Screens for Housing Insecurity

- Sandel et al, Pediatrics 2018
  - “During the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?”
  - “In the past 12 months, how many places has the child lived?”
- Current Homelessness
  - “What type of housing does the child live in?”
- History of Homelessness
  - “Since the child was born, has she or he ever been homeless or lived in a shelter?”





# Centers for Medicare & Medicaid Services 2017

- What is your housing situation today?
  - I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
  - I have housing today, but I am worried about losing housing in the future.
  - I have housing
- WE CARE– “Do you think you are at risk of becoming homeless?” (Garg, 2007)



# PRAPARE– National Association of Community Health Centers

- a. What is your housing situation today?
  - I have housing
  - I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
  - I choose not to answer this question
- b. Are you worried about losing your housing?
  - Yes
  - No
  - I choose not to answer this question
- c. What address do you live at? (include street and zip code)
  - Street:
  - City, State, Zip code:



# Communication Barriers



# Communication Barriers

- Understand barriers to communication/ follow-up
  - Fear
  - Moving around
  - Lack of access to phone
  - Competing needs and shelter restrictions
  - Lack of experience with prior continuity of care or health system in general

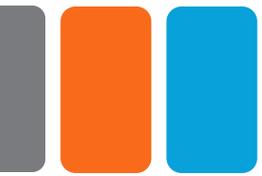




# Communication Barriers

- Ask address and phone information at every visit– contacts may change
- Phone: extra number
- Secondary Contact: “who is the person who always knows where you are or you can reach out to when in trouble?” – this could be a family member, case manager, school, mental health provider
- Text or e-mail: only non-HIPPA information
- Portal use
- Mail: “where is the place that you can always receive mail?”





# Follow-up



# Follow-up

- Check on transportation barriers
- Be flexible with appointment times – family focused scheduling
- Engage in outreach – consider going to shelters





# Summary

- Help families by screening for housing insecurity in a culturally sensitive and unbiased way and offer interventions
- Use specific screens which allow one to assess for different levels of housing insecurity
- Communicate with and follow-up of patients with housing insecurity with enhanced efforts to make sure they are can be reached and they are able to access services



# Implementation in Practice

- ✓ Create a process for assessing and identifying families for risk of housing insecurity
- ✓ Promote flexibility in scheduling as a priority for children and families experiencing housing insecurity
- ✓ Explore all possible avenues of communication with families with housing insecurity



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# Clinical Guidelines

Barbara Bayldon, MD

Medical Director, Primary Care  
Section

Lurie Children's Hospital

Illinois Chapter

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# Learning Objectives

- Develop understanding of clinical topics to be considered due to impact of housing insecurity on families with young children
- Develop skills in specific clinical guidelines of care and best practice for delivery of that care for families with housing insecurity





# Section Outline

- Clinical Impact of Housing Insecurity
  - Physiologic
  - Brain Health
  - Social
- Best Practices for Clinical Encounters





# Clinical Impact of Housing Insecurity

Physiologic Health

Brain Health

Social Health

# Clinical Impact of Housing Insecurity – Physiologic Health



- Altered Nutrition – under or inappropriate nutrition
- Increases risk of infectious disease
  - Otitis media, respiratory, diarrhea, scabies, lice
  - Tuberculosis
- Increased dental caries risk
- Decreased stability of chronic disease such as asthma
- Increased risk of accidents



# Clinical Impact of Housing Insecurity – Brain Health

- Increased prevalence of developmental delay
- Increased risk of behavior and mood problems
- Increased parental/guardian stress and depression may affect attachment with child, engagement and parenting





# Clinical Impact of Housing Insecurity – Social Health

- Social environment and support disruption
- Academic disruption
- Benefits disruption
- Transportation barriers
- Risk of underlying social circumstances including domestic violence and drug/substance abuse





# Best Practices for Clinical Encounters



# Best Practices for Clinical Encounters

- History
  - General history – medical care
  - Eating behaviors and patterns, food security and barriers to healthy diet
  - Sleep hygiene and safety
  - Dental hygiene and prior history of appointments and barriers to appointments





# Best Practices for Clinical Encounters

- History
  - Address safety in housing–safeguarding and supervision
  - Screen for infection– exposure to infectious individuals and GI and respiratory symptoms, rashes specifically
  - Assess understanding of adherence to management and barriers to adherence for patients with chronic conditions



# Best Practices for Clinical Encounters

- History
  - Full developmental assessment
    - Observation
    - Use formal tools such as Ages and Stages (ASQ)
  - Socio-Emotional Assessment
    - Such as PEDS  $\geq$  2 yrs
  - Daycare/school history and interruptions
  - Family history- parental depression, disability, drug use/abuse and past sexual and physical abuse



# Best Practices for Clinical Encounters

- Social History
  - Family structure and supports and domestic violence, parental drug/substance use challenges
  - Prior housing
  - Interruptions in care
  - Employment as appropriate
  - Transportation and communication issues
  - Interrupted benefits– SNAP, WIC, TANF, legal
  - Consider screening for Adverse Childhood Experiences



# Best Practices for Clinical Encounters

- Physical
  - Document and address either weight for length  $< 2$  yrs or BMI  $\geq 2$  yrs and Head Circumference
  - BP  $\geq 3$  yrs or at younger age if risk factors
  - Focused observation on behavior and development in clinic setting
  - Dental exam and application of fluoride varnish
  - Careful evaluation for infectious disease or infestation
  - Careful dermatologic exam





# Best Practices for Clinical Encounters

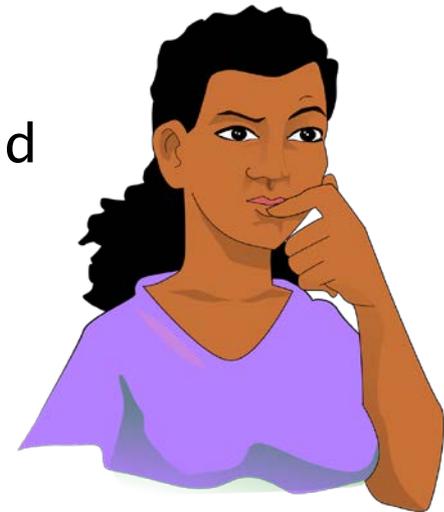
- Screening
  - CBC or hemoglobin or ferritin, lead (until 7 yrs)
  - Tuberculosis screening
    - If  $\geq 2$  yrs AND able to obtain enough blood Quantiferon gold
    - If  $< 2$  years PPD
  - Determine which developmental, socio-emotional screens you wish to use eg. ASQ, M-CHAT at 18 and 24 months
  - Check vaccine records and ICARE for gaps in immunization
  - Screens for specific conditions such as Asthma Control Test



# Clinical Management

Consider constraints to manage effectively

- Access to refrigeration and storage
- Electrical access
- Access to facilities e.g., bathrooms and kitchens
- Privacy
- Change in living situation
- Barriers to communication





# Best Practices for Clinical Encounters

- Resources and supports
  - Supporting resilience
    - Reach Out and Read
    - 7C's of resilience (competence, confidence, coping, connectedness, character, contribution, control)
    - Parenting Programs– Nurturing Parenting, Triple P, The Incredible Years
  - Supporting developmental/behavioral problems
    - Connect to Early Intervention
    - For housing insecure, ODLSS Child Find Centers may work better than an in-home evaluation
- Covid-19 considerations: state by state allowances for OT. Specific facility allowances for OT. Call site.  
<https://www.aota.org/~media/Corporate/Files/Practice/Manage/Occupational-Therapy-Telehealth-Decision-Guide.pdf>



# Best Practices for Clinical Encounters

- Concrete community resources – if in a shelter, these may be supplied there
  - Medicaid
  - Benefits assistance
  - Transportation
  - Legal
- Daycare/School– CPS Students in Temporary Living Situations Program (STLS)





# Model of Care Delivery

- Optimize acute care visits to best resolve patient concerns and provide comprehensive care when possible
- Identify underlying causes of homelessness and help facilitate connection to appropriate resources
- Partner with families to develop care plans that acknowledge barriers posed by homelessness– e.g., transportation, communication

AAP, Pediatrics, 2013



# Coding and Adjusting for Care of Housing Insecure

- ICD-10-CM code for homelessness – [Z59.0](#)
- In EHR or medical record
  - No fixed address– to designate that homeless
  - Flag EHR for frequent users to address whether homeless



# Summary

- Housing Insecurity places families at increased risk for poor outcomes
- Children with Housing Insecurity need to be screened for specific issues associated with housing in physiologic, mental health and social realms
- Management needs to account for challenges and frequently requires community partnership



# Implementation in Practice

- ✓ Create a template to support the clinical encounter for children with housing insecurity
- ✓ Adjust management to incorporate challenges faced by families with housing insecurity (flexible scheduling, medicines that do not need refrigeration)
- ✓ Compile lists of resources by topic to distribute to patients
- ✓ Help Medicaid enrollment to increase access to care



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# Referral Options and Tool

Johnna Lowe, MNA

Corporation for Supportive Housing

Referral Tool

Stephanie Liou, MD, Resident

University of Chicago

Illinois Chapter

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# Learning Objectives

- Increase basic understanding of the Chicago housing system and how to access it
  - Crisis Systems
  - Coordinated Entry
  - Affordable Housing
  - Supportive Housing
- Effectively utilize the housing referral tool in order to assist families with needed referrals



# Section Outline

- Housing System Summary
- Housing Interventions
- Referrals and Resources
- Case Studies





# Housing System Summary



# Local Interventions and Crisis Systems

Goals: Short term and immediate needs for safety and stabilization

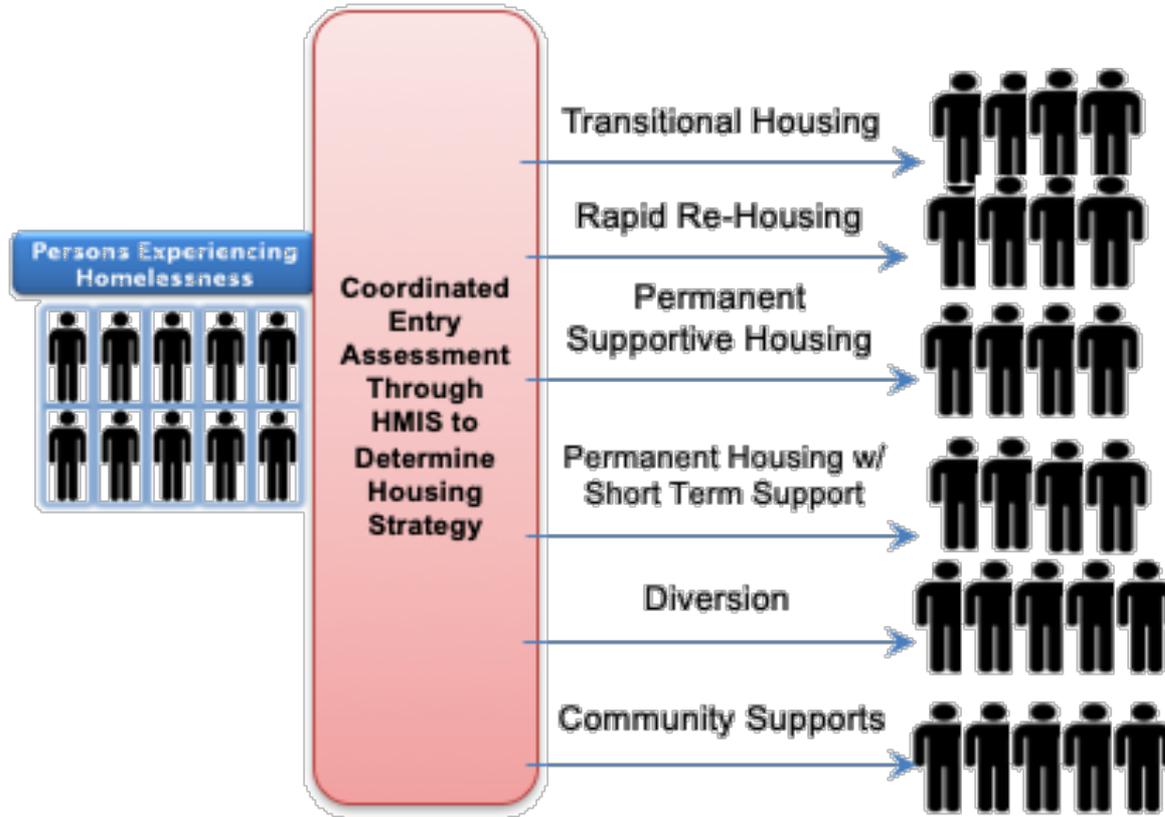
Shelters

Domestic Violence Hotline

Human Trafficking Hotline

Homeless Prevention Call Center

# Chicago's Path to Housing





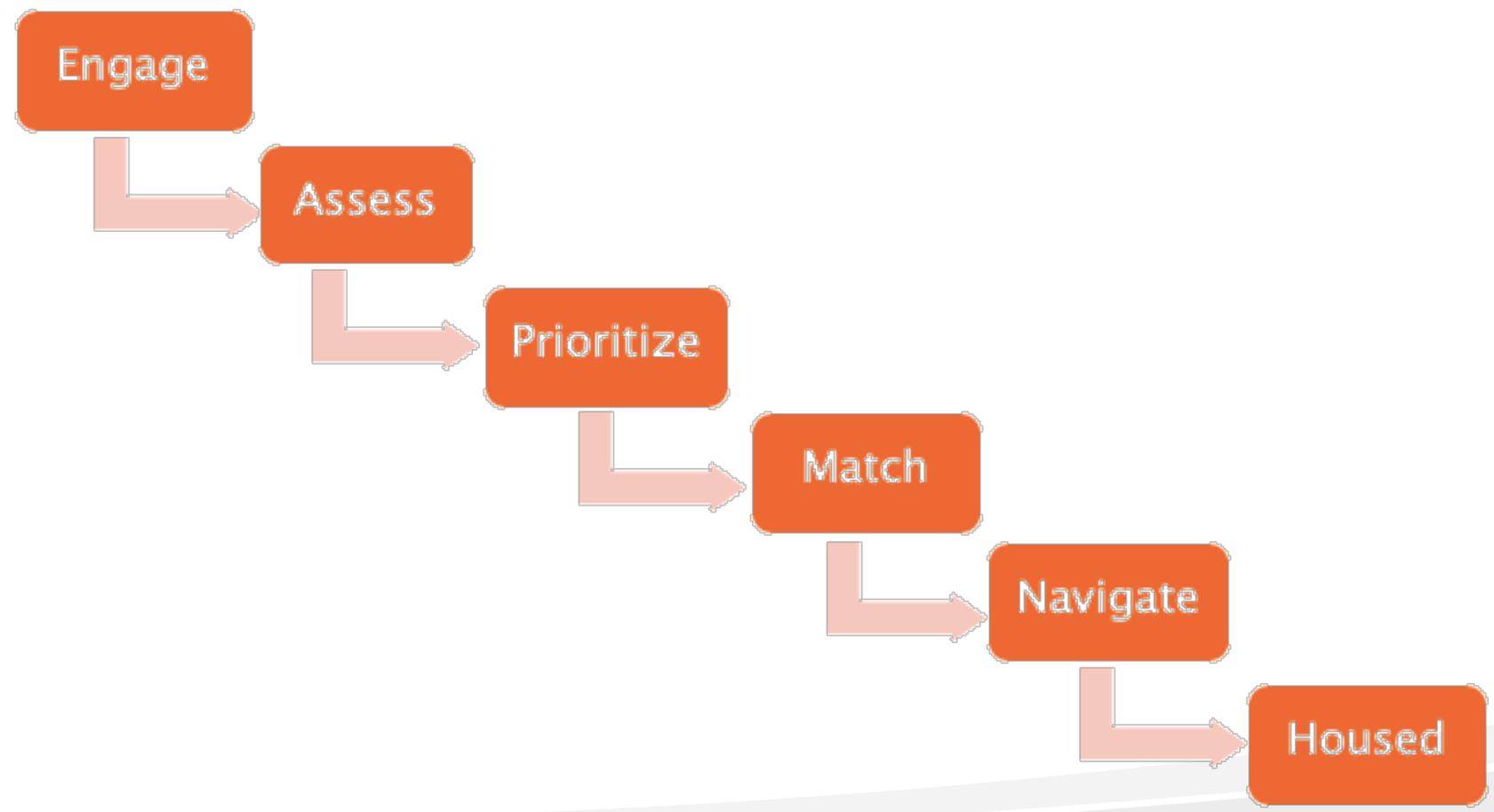
# Coordinated Entry

- Vision: a community response to ending homelessness
  - Coordinated Entry tries to get the most vulnerable individuals into the limited housing resources available
  - Most vulnerable individuals: people with complex challenges and barriers, persons or children with a disability
  - Individuals must complete an assessment to get connected to housing resources





# Coordinated Entry Process





# Housing Interventions



# Housing Interventions

- Prevention
  - Prevents homelessness by paying past due rent, mortgages, utility bills, or other financial needs
- Rapid Re-Housing (RRH)
  - Rapid housing intervention with time limited rental assistance, support for housing identification, move-in, and case management





# Housing Interventions

- Subsidized affordable: subsidy attached, ensuring affordable (30% of income)
- Just because someone meets criteria doesn't mean they will get it
- Need is greater than supply
  - 35 affordable and available homes per 100 who need it
  - 75% of extremely low-income renters without a subsidy pay 50% of income on rent/utilities



# Housing Interventions

- Supportive Housing
  - Affordable housing paired with supportive services to assist individuals in achieving goals, maintaining stability
  - A household member must have a disability
  - Housing with a subsidy attached, long term affordability
  - Chicago unmet need: 4,200 units



# Referrals and Resources



# Health Care Providers Without Care Coordination/Referral Support

## Homeless: Chicago or Cook County

- If patient/parent reports homelessness, provide patient with Text to Connect Flyer
  - Distribute flyer or text 773-786-9916
  - Directs patients to locations for housing assessments in the coordinated entry system
- Homeless Prevention and Diversion
  - Call 311 and ask for Short Term Help to be screened for homelessness prevention resources (rental assistance, etc. to define short term help)



**TEXT TO CONNECT**  
IF YOU ARE EXPERIENCING HOMELESSNESS  
HELP IS A TEXT AWAY

**TEXT *CONNECT***  
**TO 773-786-9916**  
**FOR ASSISTANCE**



YOU WILL RECEIVE A BRIEF SURVEY TO ASSESS WHICH  
REFERRALS WILL BE THE MOST HELPFUL FOR YOU

If you can't text but have access to the internet,  
visit our website at  
[www.connectmenow.org](http://www.connectmenow.org)

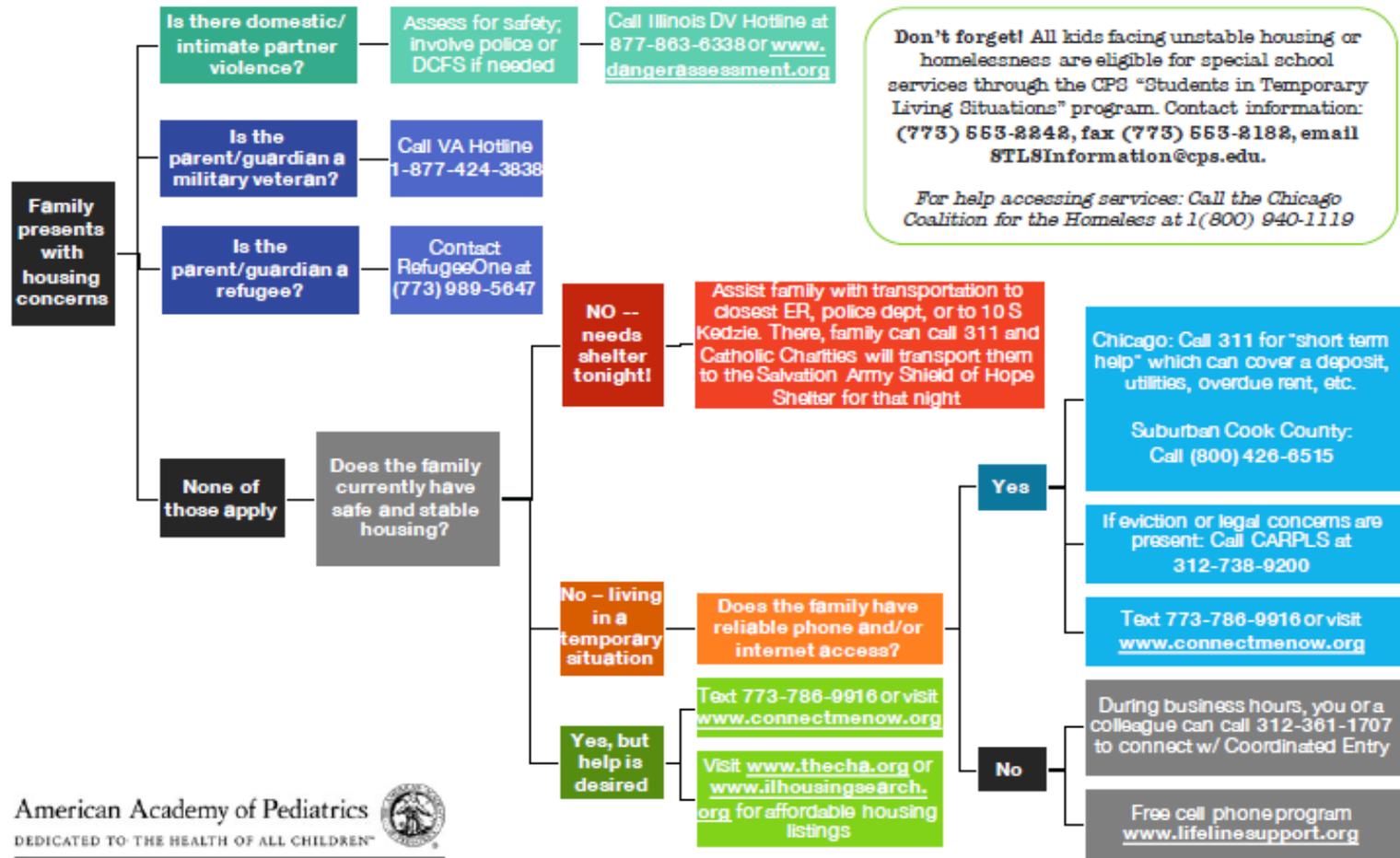




# Health Care Providers with Care Coordination/Referral Support

- Clinic staff can make additional referrals directly
- Requires
  - Staff and Time
  - 1-on-1 support for the family to understand household needs and situation to identify best referral
  - Best practice – critical referrals, call/initiate together before they leave or set time to return
  - Assess and address barriers the family faces in following up (phone access, internet, language)

# ICAAP Chicago/Cook County Housing Referral Tool for Physicians (2020)



American Academy of Pediatrics  
 DEDICATED TO THE HEALTH OF ALL CHILDREN™  
 Illinois Chapter

Tool created by Julie Nelson, Associate Director of the Corporation for Supportive Housing (CSH) and HY Stephanie Liou MD, Pediatric Resident at UChicago Medicine, for the ICAAP Committee on the Social Determinants of Health - Improving Child Health and Housing Work Group. Last Updated 2/13/2020. For more information, please contact Mary Ebner (melsner@illinoisap.com).



# Crisis Referral Resources

## Shelter

- Chicago
  - Salvation Army Shield of Hope, 924 N Christiana Ave
  - Call 311 from a police station, emergency room, or 10 S Kedzie (DFSS-funded service center) and Catholic Charities will provide transportation to Shield of Hope
- Suburban
  - Connect to appropriate resource based on location
  - <http://www.suburbancook.org/emergency>



# Crisis Referral Resources

## Safety

- Illinois Domestic Violence Hotline
  - 877-863-6338
- National Human Trafficking Hotline
  - 888-373-7888

## Refugee

- RefugeeOne
  - (773) 989-5647





# Veteran Referral Resources

- Veterans who are homeless or at imminent risk of becoming homeless
  - Call or visit local VA Medical Center or Community Resource and Referral Center
  - National helpline:  
1-877-4AID-VET  
(877-424-3838) to access VA services

**VA**

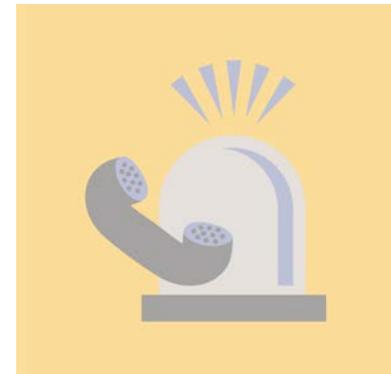


U.S. Department  
of Veterans Affairs



# Crisis Referral Resources

- Diversion Services
  - Short term resources to prevent homelessness, assistance with deposit, utilities, conflict mediation, connections to other resources
- Chicago
  - 311 and ask for Short Term Help
- Suburban Cook
  - 800-426-6515





# Coordinated Entry Referral – Chicago

- Chicago Call Center for Healthcare Providers
  - Staff must call with the patient: 312-361-1707, 8:30 am – 4:00 pm
- Families connecting to resources on their own
  - Text to Connect for housing assessment locations: 773-786-9916
- Eligibility assessed through call center, must currently reside
  - In a shelter
  - On the streets or a place not meant for human habitation – abandoned building, CTA, park, etc.
  - In an institution (hospital, jail, respite facility, nursing home, etc.) where they stayed for 90 days or less and resided in either of the above locations prior to institution
  - Fleeing domestic violence or human trafficking



# Coordinated Entry Referral – Cook County

- Suburban Cook Call Center
  - Family can call on their own: 877-426-6515, 8:30 am to 4:30 pm Monday – Friday
- Walk in Access Points
  - <http://myentrypoint.org/get-help/connect/#walk-in-center>
- Eligibility assessed through call center, currently residing:
  - In a shelter
  - On the streets or a place not meant for human habitation such as an abandoned building, CTA, a public park, etc.
  - In an institution (hospital, jail, respite facility, nursing home, etc.) where they stayed for 90 or less and who resided in either of the above locations before entering the institution
  - Fleeing domestic violence or human trafficking

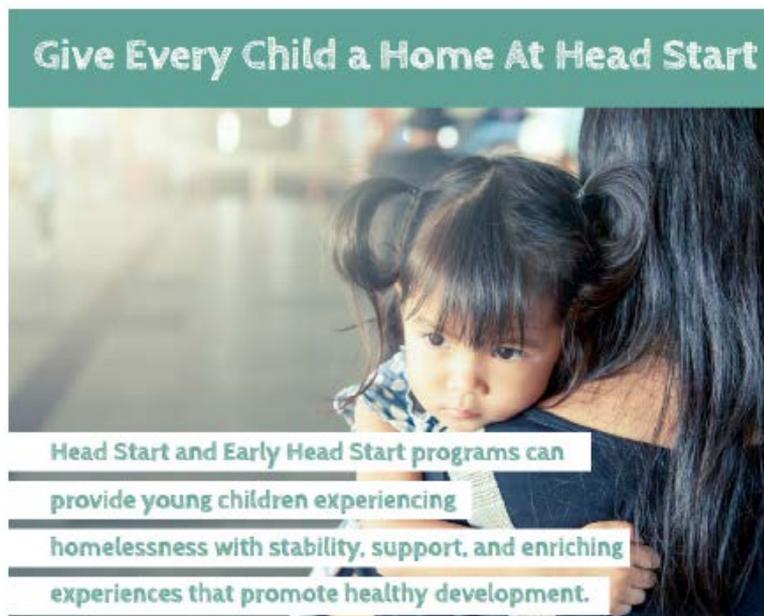


# Affordable Housing Resources

- Chicago Housing Authority
  - Homeless preference, wait times by property, apply online
  - <https://www.thecha.org/>
- Chicago Department of Planning and Development
  - Affordable Rental Housing Resource List
  - [https://www.chicago.gov/city/en/depts/dcd/supp\\_info/affordable\\_rentalhousingresourcelist.html](https://www.chicago.gov/city/en/depts/dcd/supp_info/affordable_rentalhousingresourcelist.html)
- Statewide Referral Network
  - Listing, search by zip, includes rent amount, can search by accessibility features
  - [www.ilhousingsearch.org](http://www.ilhousingsearch.org)

# Head Start and Early Head Start

- Eligibility:
  - Birth to 5, from families with low income, according to US Poverty Guidelines
  - Children in foster care, who are homeless, or receiving public assistance (TANF or SSI) regardless of income
- Prioritize families experiencing homelessness
- Case management for pregnant women
- [Early Head Start FAQ's](#)
- [Connecting to Head Start](#)





# School Program for Housing Insecure Students

- McKinney–Vento Homeless Assistance Act protects educational rights of children who are homeless
- Chicago Public Schools – Students in Temporary Living Situations (STLS)
  - Additional Services available, right to stay in their school
  - [https://cps.edu/Programs/Pathways\\_to\\_success/Pages/StudentsInTemporaryLivingSituations.aspx](https://cps.edu/Programs/Pathways_to_success/Pages/StudentsInTemporaryLivingSituations.aspx)
- Chicago Coalition for the Homeless – Law Project
  - Family may need legal advocacy – (800) 940–1119





# Free Cell Phone

- If you receive benefits from any of these programs:
  - Supplemental Nutrition Assistance Program (Food Stamps or SNAP)
  - Medicaid
  - Supplemental Security Income (SSI)
  - Federal Public Housing Assistance (Section 8)
  - Veterans Pension and Survivor's Benefit
  - Bureau of Indian Affairs General Assistance (BIA)
  - Tribally Administered TANF
  - Tribal Head Start
  - Food Distribution Program on Indian Reservations (FDPIR)
- May also qualify in Illinois if Household Income at/under 135% of the Federal Poverty Guidelines.
- <https://www.freegovernmentcellphones.net/states/illinois-government-cell-phone-providers>





# Legal Resources

- Coordinated Advice & Referral Program for Legal Services (CARPLS)
  - Throughout Cook County
  - Give legal advice, connect to legal counsel, or assist patient in getting connected to the most appropriate agency for their situation
  - Hotline – (312) 738-9200 (waiting time required)





# Expedited Disability Income Benefits

- Social Security Administration
  - Refer children with disability, parent with disability, or survivor's benefits
  - Referrals for legal or application assistance with Social Security applications
    - <https://www.illinoislegalaid.org/>
- Guidebook to share with patients
  - <https://www.illinoislegalaid.org/legal-information/disabilities-guidebook-social-security-disability-benefits>





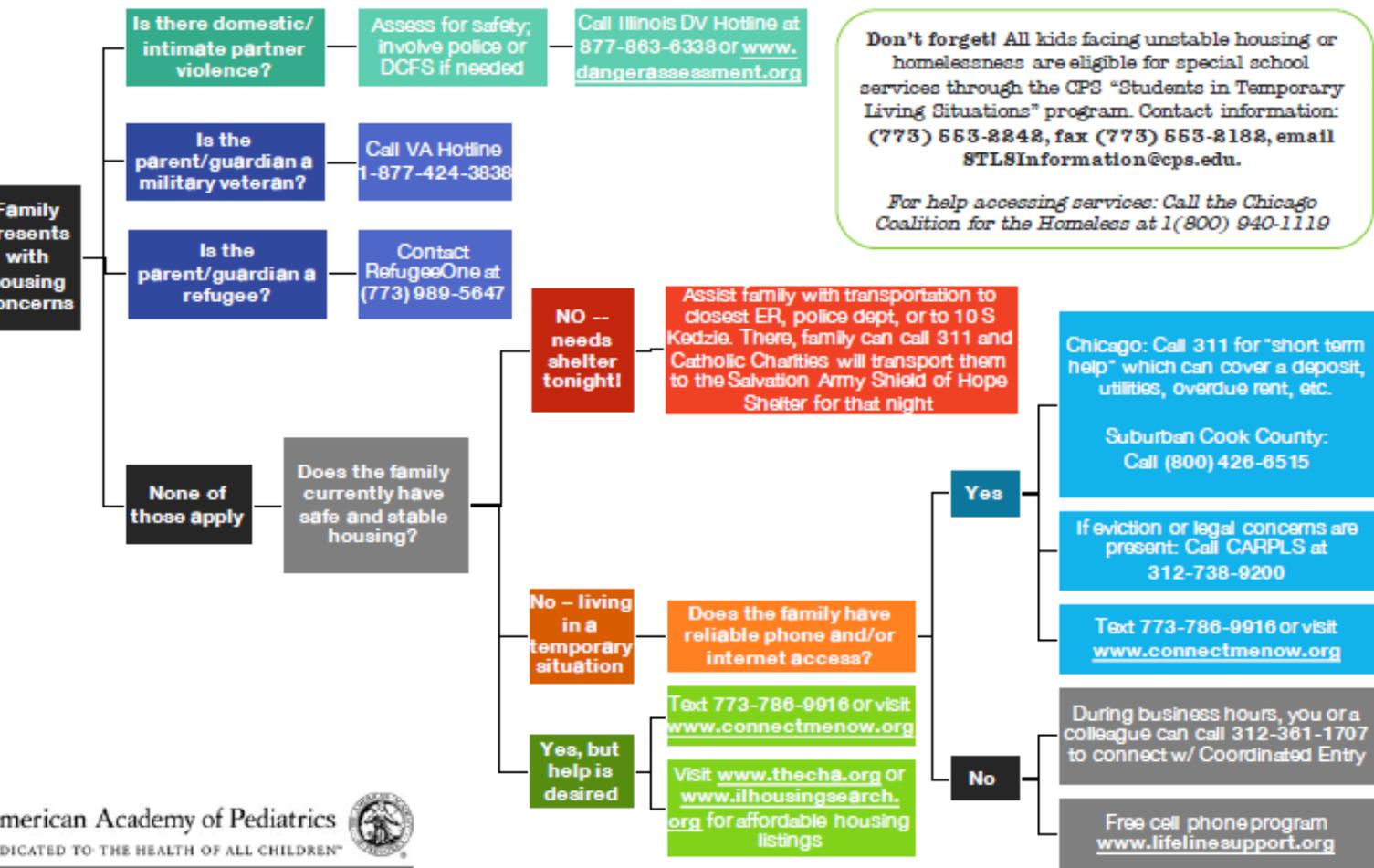
# Case Studies



# Case Study

- Ms. Johnson has brought her daughter Bianca in for her school physical. During Bianca's exam, Dr. Hasting conducts a social determinants of health screening.
- Ms. Johnson shares she and Bianca are in an unsafe living situation, and Ms. Johnson is experiencing intimate partner violence, and needs some support to leave. She doesn't have any family who can help her right now.
- What should Dr. Hasting do? What resource(s) can she share with the family?

# ICAAP Chicago/Cook County Housing Referral Tool for Physicians (2020)



**Don't forget!** All kids facing unstable housing or homelessness are eligible for special school services through the CPS "Students in Temporary Living Situations" program. Contact information: (773) 553-2242, fax (773) 553-2182, email [STLSInformation@cps.edu](mailto:STLSInformation@cps.edu).

*For help accessing services: Call the Chicago Coalition for the Homeless at 1(800) 940-1119*



# Summary of Resources

- Text to Connect flyer
- Physician Referral Tool
- 311
- Domestic Violence Hotline – (877) 863-6338
- Human Trafficking Hotline – (888) 373-7888
- Veterans Helpline – (877) 424-3838
- Chicago Housing Authority – <https://www.thecha.org/>
- Chicago Department of Planning and Development – [https://www.chicago.gov/city/en/depts/dcd/supp\\_info/affordable\\_rentalhousingresourcelist.html](https://www.chicago.gov/city/en/depts/dcd/supp_info/affordable_rentalhousingresourcelist.html)
- Free Cell Phone – <https://www.freegovernmentcellphones.net/states/illinois-government-cell-phone-providers>



# Implementation in Practice

- ✓ Determine practice capacity for assistance to patients
- ✓ Use screening tool flowchart
- ✓ Utilize and refer to resources described in presentation and available in resource section



# Implementation in Practice

- ✓ Implement screening and referral for housing insecurity
- ✓ Use physician referral tool (flowchart) to simplify referrals
- ✓ Utilize and refer to resources described in presentation and available in resource section



# Project Funding

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# Questions

