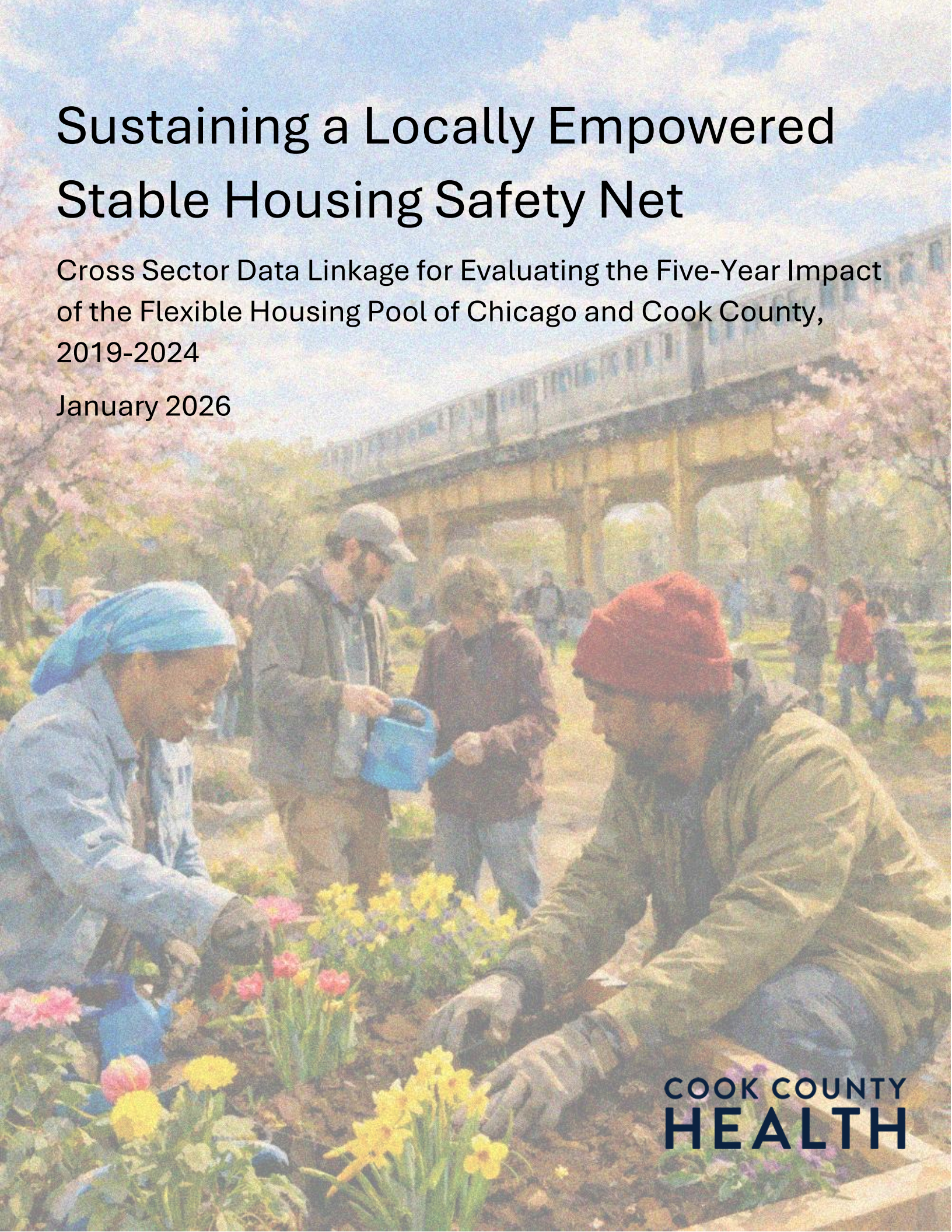
Sustaining a Locally Empowered Stable Housing Safety Net

Cross Sector Data Linkage for Evaluating the Five-Year Impact of the Flexible Housing Pool of Chicago and Cook County, 2019-2024

January 2026



COOK COUNTY HEALTH

Prepared by:

Keiki Hinami, Kruti Doshi, William Trick
Health Research and Solutions Unit, Center for Health Equity & Innovation, Cook County Health

Presented to the Funders and Leadership of the Flexible Housing Pool of Chicago and Cook County:

I. Introduction

The recent increase in homelessness in the United States reflects a systemic breakdown in our collective ability to engage residents in economic, social, and civic life.[1] While rising housing costs and an insufficient supply of affordable housing remain the dominant structural drivers of housing insecurity, health-related factors play a critical and often underappreciated role. National estimates indicate that health conditions may precipitate homelessness for approximately 60 percent of people who experience it.[2] Chronic illnesses, physical and behavioral health disabilities, and medical debt undermine stable employment and income, leaving individuals unable to meet rental obligations. The intersection of health vulnerability and housing instability therefore demands coordinated, system-level solutions rather than siloed interventions.

The Flexible Housing Pool of Chicago and Cook County (FHP) represents one such cross-sector solution. By aligning housing resources with health and supportive services, the program offers a cost-effective approach to stabilizing individuals with complex needs while reducing reliance on high-cost crisis systems. Rather than treating housing and health as separate policy domains, the FHP operationalizes the premise that stable housing is a prerequisite for improved health and more efficient public spending.

This report is intended for policymakers seeking rigorous evidence on the health impacts and fiscal implications of a fully scaled supportive housing model. It examines the benefits and costs associated with the FHP from 2019 through 2024. The purpose is not to debate whether urban and suburban homelessness warrants intervention, but to assess the extent to which health and related outcomes improve when individuals receive stable housing paired with appropriate services—and whether those improvements are achieved at costs society may reasonably elect to bear.

Established in 2018, the FHP was designed to expand the capacity of the regional housing safety net for individuals with chronic conditions and high utilization of crisis-oriented public systems, including hospital-based care, jail, emergency shelters, homeless outreach services, and emergency responders. The program brought together local government agencies, healthcare organizations, charitable foundations, and community-based housing and service providers to coordinate resources, reduce fragmentation, and improve outcomes for individuals with the most acute needs.

II. Summary of Evaluation Findings

- The Flexible Housing Pool (FHP) is a cost-effective intervention, as given by an incremental cost-effectiveness ratio (ICER) of **$47,330 per quality-adjusted life year (QALY) gained**, consistent with commonly accepted thresholds of high value innovations in health economics.
- Reductions in crisis-system utilization generate an estimated **$14,492 in annual cost offsets per household**, recouping roughly half of the per-household housing investment. At current scale, the FHP produces over $11 million in cost offsets annually.
- From 2019 through 2024, FHP provided supportive housing to **1,750 individuals across 998 households** and achieved a **12-month housing retention rate of 92%**.
- FHP participants experienced a **97% reduction in emergency shelter utilization** and a **72% reduction in street outreach encounters** across the Chicago and suburban Cook County Continua of Care.
- Annualized reductions included a **46% decrease in 911 emergency medical service activations** and a **32% decrease in Chicago Police Department calls for service**, sustained each year through five years of housing provision.
- In the first year following housing placement, participants demonstrated a **91% reduction in emergency department visits** and an **89% reduction in inpatient hospital days**, with sustained low rate of avoidable hospital utilization observed over five years.
- Cook County Jail registrations declined among participants by **81% in the first year post-housing**, with reductions maintained over five years.
- Over five years, FHP participants experienced an **absolute reduction in all-cause mortality of 0.9 percentage points relative to controls**, corresponding to **one life saved for every 111 individuals housed**.

III. Program Design and Governance

A. Funding Model and Governance Structure

The FHP was designed in part to address the "wrong-pocket problem", in which the broad social benefits of supportive housing – such as reduced street homelessness, health care utilization, and incarceration – accrue to multiple public systems, while the direct costs of housing subsidies are historically borne disproportionately by the housing services sector. FHP establishes a shared financing mechanism through a public escrow account into which health care organizations, managed care entities, government agencies, philanthropic foundations, and private-sector partners contribute. These funds are used to finance rental subsidies and case management services for enrolled clients.

The governance structure reflects the program's cross-sector design. Contributing funders, along with key stakeholder bodies – including the Lived Experience Advisory Committee who are FHP program participants – hold voting rights within the program's governance framework. This participatory model promotes transparency, shared accountability, and responsiveness to sector-specific concerns. The diversity of institutional perspectives represented in leadership enables the program to adapt to emerging policy, fiscal, and operational challenges.

In addition to core escrow-based financing, FHP secured competitive grant funding to support targeted subpopulations, including (1) individuals released from Illinois state prisons and (2) individuals and families experiencing unsheltered homelessness in Cook County. The program's success in securing these grants reflects acknowledgement by funders of the demonstrated service quality and measurable outcomes, which are examined in subsequent sections of this report.

B. Racial Equity

Racial disparities in homelessness within Cook County are pronounced. Black or African American residents constitute approximately 23 percent of the County's population but represent 56 percent of individuals experiencing homelessness. Among families experiencing homelessness, racial disproportionality is even more acute: approximately 90 percent of these households identify as Black (excluding newly arrived migrants).[3]

These disparities are rooted in longstanding structural inequities, including discriminatory mortgage lending and insurance practices, racially restrictive covenants, concentrated disinvestment in segregated neighborhoods, and persistent discrimination within rental markets.

FHP incorporates racial equity as a core programmatic principle. By prioritizing client choice in housing placement and reducing structural barriers to access, the program seeks to promote economic and racial integration as a necessary condition for long-term regional stability and shared prosperity.

C. Supportive Services

FHP provides comprehensive case management structured around two primary domains:

1. **Tenancy Support.** Clients receive assistance securing and maintaining housing, including connection to public benefits and traditional housing subsidies when available. Case managers also mediate relationships with landlords and address tenancy-related challenges to reduce the risk of eviction.
2. **Care Coordination.** Clients are linked to medical, behavioral health, and substance use treatment services. Care coordination emphasizes continuity of care, engagement with primary and specialty providers, and stabilization of health conditions that may otherwise threaten housing retention.

Although support services in these domains may be provided by a single case manager, care coordination is often offered through Medicaid Managed Care organizations whose staff perform telephonic and in-person outreach to members of Medicaid plans.

D. Scattered Site Rental Model

As detailed in a previous evaluation report,[4] the FHP utilizes a scattered-site rental model with no geographic restrictions on placement within Cook County for escrow-supported participants. Housing units are secured through proactive identification of available rental properties and sustained landlord engagement. Consistent with a housing choice framework, client preferences regarding neighborhood and unit location are accommodated whenever feasible, subject to market availability and program parameters.

IV. Service Cohorts and Eligibility

FHP operates under a Housing First framework, which recognizes stable housing as a foundational determinant of health and recovery. Consistent with this evidence-based approach[5], the program removes traditional preconditions for housing placement, such as employment, insurance status, or demonstrated behavioral health stability. The program prioritizes housing retention and makes concerted efforts to maintain placement even when landlord relationships, tenancy challenges, or neighborhood conflicts require reassignment. Due to the distinct priorities of funding partners, FHP serves four primary service cohorts.

A. Adult Cohort (Launched 2019)

The original and largest cohort consists primarily of adults identified through persistent utilization of regional crisis systems. Persistent utilization was defined as high use of hospital emergency departments or Cook County Jail over two consecutive years.

This eligibility criterion captured many individuals meeting U.S. Department of Housing and Urban Development (HUD) definition of chronic homelessness, as well as individuals exhibiting similar vulnerability profiles—disproportionately Black or African American men with elevated risk of substance use disorders and serious mental illness—who did not meet the strict federal definition but nonetheless demonstrated high acuity and system involvement.

B. Youth Cohort (Launched 2022)

Launched in 2022, the Youth Cohort was developed in alignment with the City of Chicago's goal of reducing youth homelessness. Eligibility includes individuals aged 16 to 24 with either a history of detention in Cook County Jail, or as participants in the City's Service Coordination and Navigation (SCaN) program, which pairs youth at elevated risk of violence involvement with navigators to support long-term stability and self-sufficiency.

A substantial proportion of participants in this cohort are heads of household with minor dependents, underscoring the intergenerational implications of youth housing instability. Heads of household participants of this cohort are assessed at age 25 for eligibility into the Adult cohort, or graduate out of FHP after stabilization. A separate qualitative report detailed the natural progression of their experience in the FHP.[6]

C. Reentry Cohort (Launched 2023)

Beginning in 2023, the Illinois Criminal Justice Information Authority (ICJIA) initiated annual contributions to support housing for individuals released from the Illinois Department of Corrections. The Reentry Cohort focuses on mitigating the well-documented relationship between housing instability and recidivism, with the goal of promoting community reintegration and reducing reliance on correctional systems.

D. Healthy Futures Cohort (Launched 2024)

Through the Healthy Futures sub-program, FHP secured HUD funding to provide housing to individuals and families whose primary nighttime residence is a location not intended for human habitation. Eligibility criteria include documented high hospital utilization and the presence of a qualifying disability.

This cohort targets individuals experiencing the most acute forms of housing deprivation and health vulnerability, with the objective of stabilizing both housing status and medical utilization patterns.

V. Evaluation Data and Methods

As described in the Early Impact Evaluation Report[7], we employed privacy-preserving record linkage (PPRL) methods to integrate person-level records across multiple administrative systems while maintaining strict data security and confidentiality standards. These techniques enabled cross-sector analytic linkage without direct exchange of personally identifiable information.[8]

Following linkage, the analytic dataset was fully de-identified by an honest broker, Medical Research Analytics and Informatics Alliance (MRAIA), in accordance with HIPAA Safe Harbor standards. All direct identifiers were removed prior to analysis. Contributing data sources for the date range between 2016 and 2024 are summarized in **Table 1**.

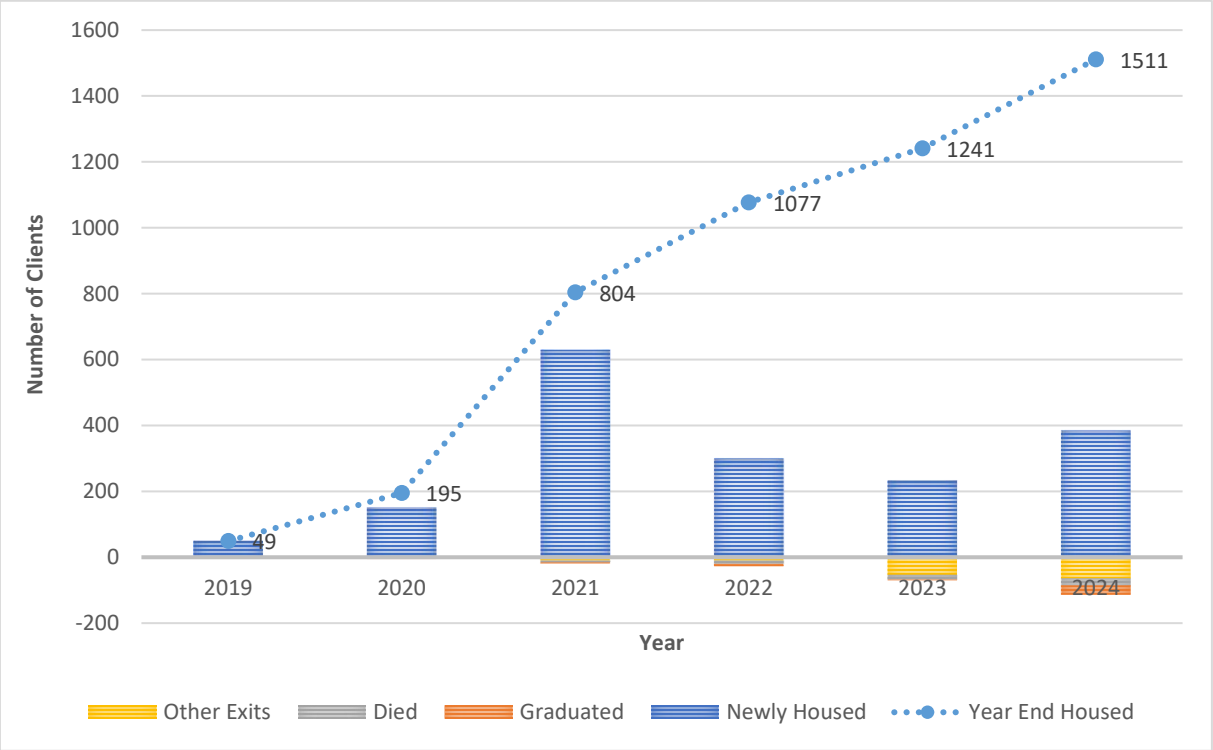
Table 1. Data Contributions to the Analytic Dataset

Source	Description	Observations
Center for Housing and Health	Individuals referred to FHP including those eventually housed in the program. Demographic characteristics, relationship between heads of household and their dependents. All deaths while participating in the program.	2857
Cook County Health	Annual counts of emergency department visits, inpatient days, jail registrations, and ICD10 diagnoses, recorded in the health system's electronic health record (including Cermak Health Services of Cook County Jail) or in CountyCare (CCH's Medicaid Health Plan) claims.	374,808
All Chicago	Annual counts of emergency shelter, street outreach, or stable housing services for individuals as recorded in the Homelessness Management Information System of the Chicago Continuum of Care.	62,885
Alliance to End Homelessness in Suburban Cook County	Annual counts of emergency shelter, street outreach, or stable housing services for individuals as recorded in the Homelessness Management Information System of the Suburban Cook Continuum of Care.	4121
Cook County Medical Examiner	All forensically evaluated cases of death in Cook County.	26,900
Chicago Fire Department	Annual counts of 911 Emergency Medical Services under select categories of medical, mental health, and substance-related encounters for individuals by calendar year.	1,060,327
Chicago Police Department	Annual counts of 911 Police Services and descriptive encounter categories for individuals by calendar year.	260,209
Illinois Department of Public Health	Counts of emergency department visits and inpatient days incurred in any hospital operating in Cook County for the denominator population comprising distinct observations from the Center for Housing and Health, All Chicago, and the Alliance to End Homelessness in Suburban Cook County. List of primary and secondary ICD10 associated with encounters by calendar year.	724,256

VI. Enrollment and Retention

From calendar year (CY) 2019 through CY2024, the FHP placed 1,750 individuals across 998 households into stable housing. Program exits were classified into three categories: (1) graduation, defined as transition to alternative housing subsidies or resolution of homelessness through sufficient earned or non-housing income; (2) death; and (3) other exits, including absconding or self-directed departure from the program. After accounting for all forms of attrition, 1,511 individuals in 770 households remained actively housed through FHP as of the end of CY2024 (**Figure 1**).

Figure 1. Annual Enrollment and Exit from FHP, CY2019–CY2024



Housing retention was calculated at 6-, 12-, and 24-month intervals for the overall service population and separately for each programmatic cohort. For each retention interval, the denominator included only those individuals whose placement date allowed them to be observed for the full duration of the retention window (**Table 2**). This approach avoids downward bias that would result from including clients with insufficient follow-up time.

Table 2. Housing Retention Rates by Cohort and Duration

	Adult	Youth	Reentry	Healthy Futures	All
6 months	98%	100%	86%	93%	98%
12 months	92%	99%	47%	88%	92%
24 months	78%	93%	6%	NA	82%

VII. Participant Characteristics

Demographic characteristics are presented separately for heads of household (**Table 3**) and dependents (**Table 4**), each stratified by FHP service cohort.

Table 3. Demographic Characteristics of Heads of Household, by Cohort

Cohort Category, N	**Adult**	**Youth**	**Reentry**	**Healthy Futures**	**All**
	555	358	49	36	998
Age Category, %					
<16	1%	17%	2%	0%	7%
16-24	14%	83%	27%	14%	29%
25-34	20%	0%	16%	33%	13%
34-44	19%	0%	24%	22%	13%
45-54	28%	0%	24%	14%	17%
55+	18%	0%	6%	17%	11%
Sex Category, %					
Female	35%	58%	0%	0%	41%
Male	50%	36%	57%	8%	44%
Other or Unknown	15%	6%	43%	92%	16%
Race Ethnicity Category, %					
Black/AA	68%	84%	55%	58%	73%
Latinx	12%	11%	8%	3%	11%
White	10%	1%	18%	6%	7%
Other	10%	5%	18%	33%	9%
Any Mental or Behavioral Health Disorder, %	83%	61%	63%	28%	72%
Schizophrenia, %	30%	8%	59%	8%	23%
Depressive Disorder, %	53%	26%	37%	17%	41%
Bipolar Disorder, %	30%	13%	35%	8%	23%
Suicidal Ideation, %	30%	16%	37%	8%	25%
Opioid Disorder, %	45%	12%	24%	6%	30%
Stimulant Disorder, %	36%	3%	24%	6%	22%

Seventy-three percent of heads of household identified as Black or African American, reflecting the disproportionate representation of racial minorities among people experiencing homelessness (PEH) in the region. Age category was defined as strata of standardized age on a reference date of January 1, 2018, regardless of the client's age during program participation. The Adult Cohort comprised older participants relative to the Youth and Reentry cohorts, consistent with eligibility criteria tied to prolonged crisis-system utilization.

Sex category distribution varied by cohort. While the predominance of men in the Adult and Reentry cohorts mirrors regional patterns of homelessness, women represented a comparatively larger share of heads of household in FHP than among the broader population receiving homeless

services across the region's two Continuums of Care (CoCs) between 2018 and 2024 (41 percent in FHP versus 37 percent in CoCs).

Among heads of household, mental and behavioral health conditions were found in 83% of adult, 61% of youth, 63% of Health Futures, and 28% of the reentry cohort. Serious mental illness, defined as function impairing mental health disorders like schizophrenia and bipolar disease (affecting only about 4% of US adults) were highly prevalent in the served population. Similarly, substance use disorders were identified in nearly half of heads of household.

Table 4. Demographic Characteristics of Dependents, by Cohort

Cohort Category, N	**Adult**	**Youth**	**Reentry**	**Healthy Futures**	**All**
	343	440	0	13	796
Age Category, %					
<16	84%	92%	0%	85%	88%
16-24	6%	6%	0%	0%	6%
25-34	2%	<1%	0%	0%	1%
34-44	2%	1%	0%	0%	1%
45-54	3%	1%	0%	0%	2%
55+	3%	1%	0%	15%	2%
Sex Category, %					
Female	50%	42%	0%	38%	46%
Male	48%	45%	0%	62%	47%
Other or Unknown	1%	13%	0%	0%	8%
Race Ethnicity Category, %					
Black/AA	46%	60%	0%	38%	54%
Latinx	16%	19%	0%	15%	18%
White	1%	0%	0%	0%	<1%
Other	36%	21%	0%	46%	28%
Any Mental or Behavioral Health Disorder, %	17%	12%	0%	2%	14%
Schizophrenia, %	2%	2%	0%	0%	2%
Depressive Disorder, %	7%	3%	0%	0%	5%
Bipolar Diisorder, %	3%	1%	0%	0%	25
Suicidal Ideation, %	4%	3%	0%	0%	3%
Opioid Disorder, %	3%	2%	0%	0%	2%
Stimulant Disorder, %	3%	<1%	0%	0%	2%

Eighty-eight percent of dependents housed through FHP were children under age 16, underscoring the substantial number of families served. Household size ranged from 1 to 9 individuals. Although the fiscal return on investment associated with mitigating homelessness among children is difficult to quantify precisely, existing longitudinal research suggests that the developmental, educational, and health benefits of stable housing during childhood are both substantial and durable into adulthood.[9]

Table 5. Age Distribution of Analytic Cohorts by Minimum Years Housed

	Age Category				
	<18	**18-44**	**45-64**	**65**	**All**
Minimum Years Housed, n					
0	684	711	321	34	1750
1	679	707	303	34	1723
2	666	645	263	30	1604
3	514	491	172	15	1192
4	441	406	110	3	960
5	338	247	85	3	673

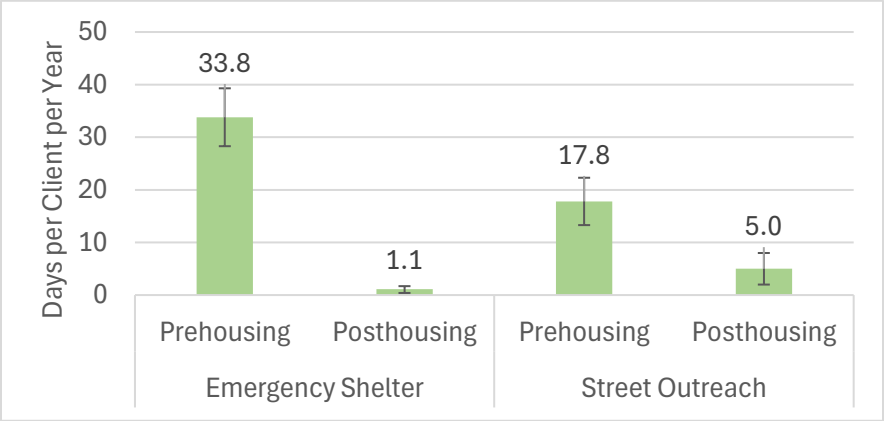
The scale of placements over the five-year study period provided an opportunity to assess potential "dose-response" effects associated with longer durations of housing stability. For analytic purposes, the calendar year in which a household was first placed into housing was defined as Year 0. Crisis-system utilization was measured for up to two years prior to placement (Years -2 and -1) and for as many as five years following placement (Years +1 through +5). Analyses of post-placement outcomes were limited to nested sub-cohorts with sufficient follow-up time to be observed for each interval. Age distributions for these cohorts are shown in **Table 5**. The use of standardized client age on a static reference date (January 1, 2018) underestimates age in longer-housed cohorts. However, as the table demonstrates, age groups are broadly represented across cohorts defined by minimum years housed. This consistency suggests that differences in crisis-system utilization observed (in Sections IX and X) across cohorts primarily reflect the cumulative effects of sustained housing stability rather than changes in the demographic composition of the service population.

VIII. Emergency Shelter and Outreach

In the two calendar years preceding housing placement, FHP participants utilized emergency shelter services for an average of 33.8 days per year and received street outreach services for an average of 17.8 days per year.

Beginning in the first calendar year following placement into stable housing, utilization of these services declined markedly. Emergency shelter use decreased by 97 percent on an annualized basis, and street outreach utilization declined by 72 percent (**Figure 2**).

Figure 2. Change in Average Annual Homeless Service Utilization across Chicago and Suburban Cook County



These reductions are consistent with the program's central hypothesis: that provision of stable housing substantially diminishes reliance on homelessness-response infrastructure and crisis-oriented services.

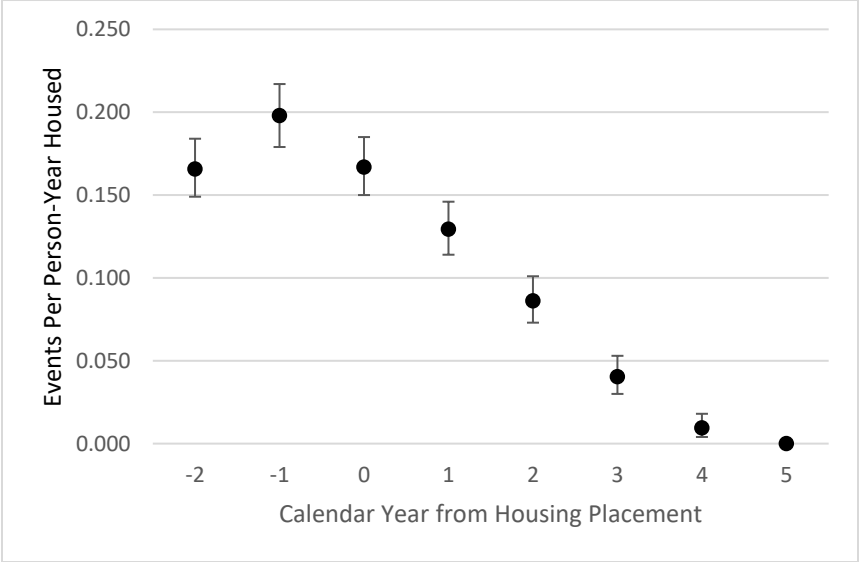
IX. Health System Utilization

A. Emergency Medical Services (EMS)

Through data linkage with the Chicago Fire Department, we tracked utilization of Emergency Medical Services (EMS) across the City of Chicago for individuals housed through FHP.

Figure 3 presents the average annualized per-person rate of EMS encounters for all housed clients, indexed to the calendar year of housing placement (Year 0). In the two years preceding and including Year 0, participants averaged approximately 0.17 EMS activations per person per year. Beginning in Year 1 following housing placement, EMS utilization declined substantially, with an average 46 percent reduction in activation rates sustained through Year 4 among cohorts with sufficient follow-up. No EMS activations were observed among individuals in the Year 5 follow-up cohort.

Figure 3. Annualized EMS Encounters per Person, Relative to Year of Housing Placement



The Chicago Fire Department classifies EMS encounters by service description. For analytic clarity, we consolidated encounter types into three categories: (1) medical, (2) mental health–related, and (3) substance-related encounters. Across all age strata, significant reductions were observed in annual EMS activation rates following housing placement (**Figures 4, 5, and 6**). These declines were consistent across encounter categories, indicating broad-based stabilization rather than reductions confined to a single clinical domain.

Figure 4. Change in Medical EMS Encounter Rate (per person-year) by Age Category

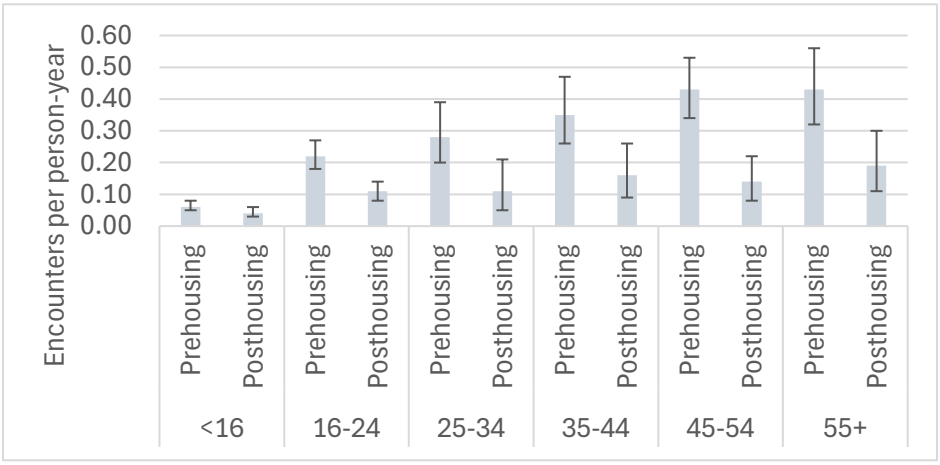


Figure 5. Change in Mental Health EMS Encounter Rate (per person-year) by Age Category

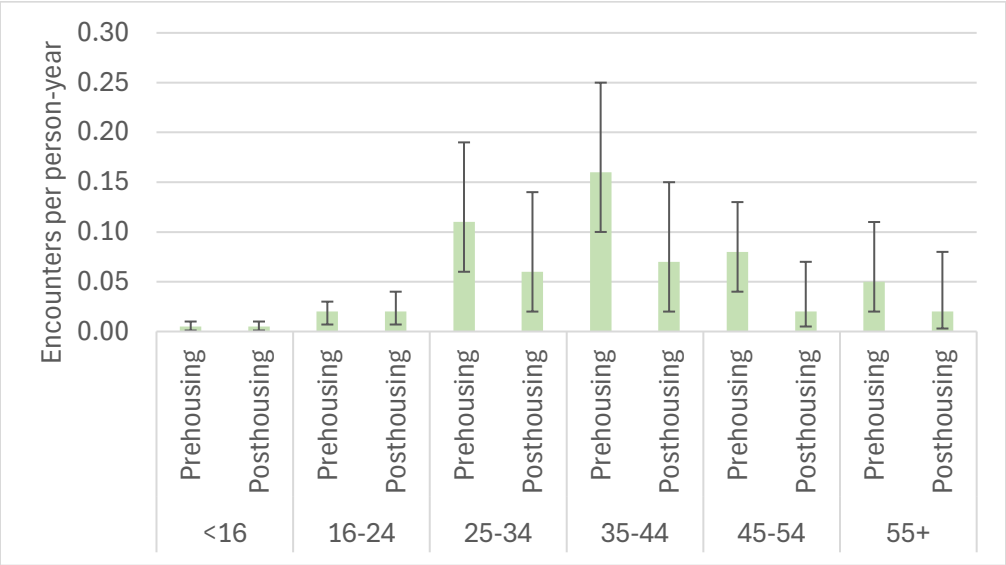
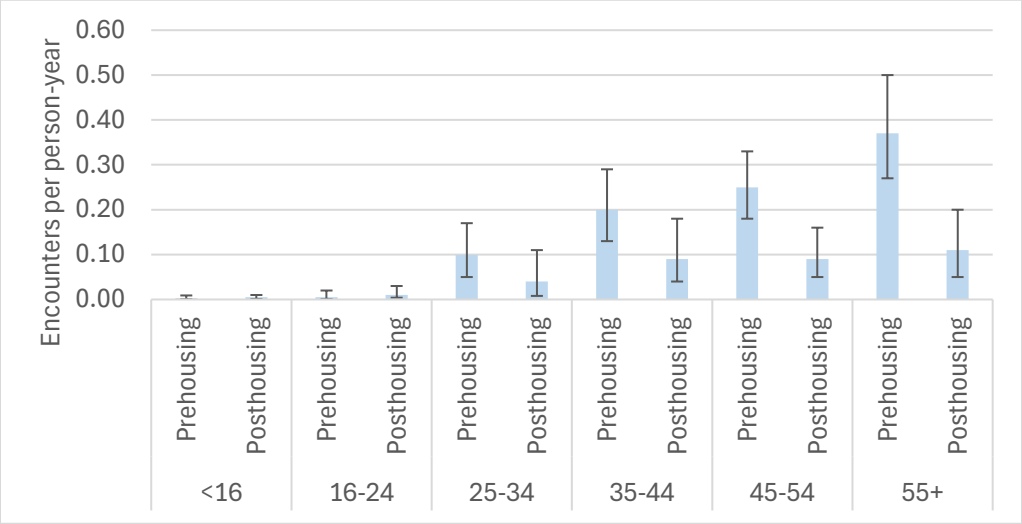


Figure 6. Change in Substance Related EMS Encounter Rate (per person-year) by Age Category

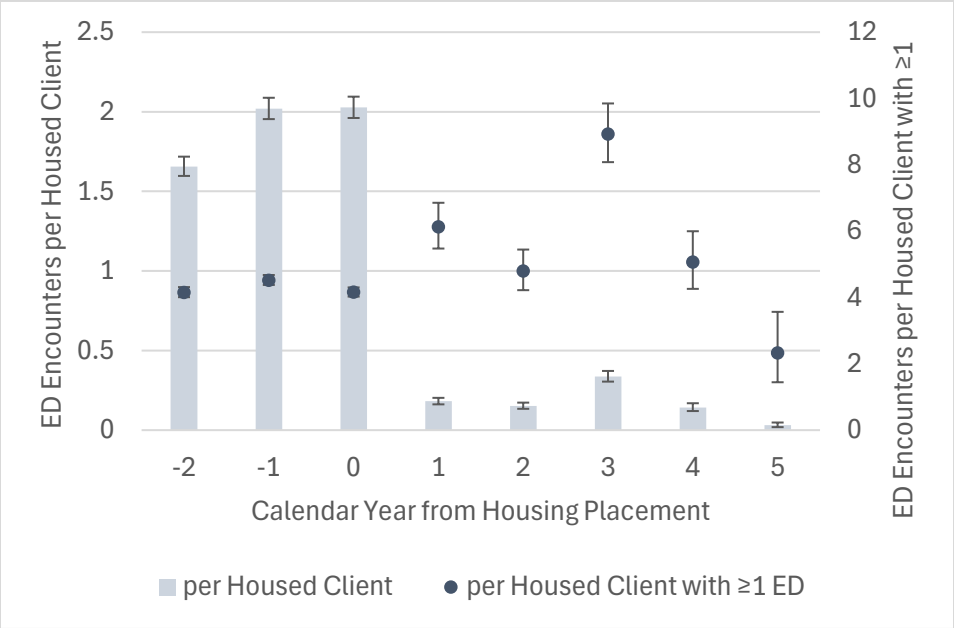


B. Emergency Department (ED) Visits and Hospitalizations

Through data linkage with the Illinois Department of Public Health, we obtained records of emergency department (ED) visits and inpatient hospital days across all hospitals in Cook County.

Figure 7 displays average annualized per-person ED visits for FHP participants, indexed to the year they were housed (Year 0). In the two years prior to and including Year 0, participants averaged up to approximately two ED visits per year. Beginning in Year 1 following housing placement, ED utilization declined sharply, with a 91 percent reduction relative to the pre-housing baseline. This reduction was sustained across analytic cohorts with up to five years of follow-up.

Figure 7. Annualized Emergency Department Visits per Person, Relative to Year of Housing Placement



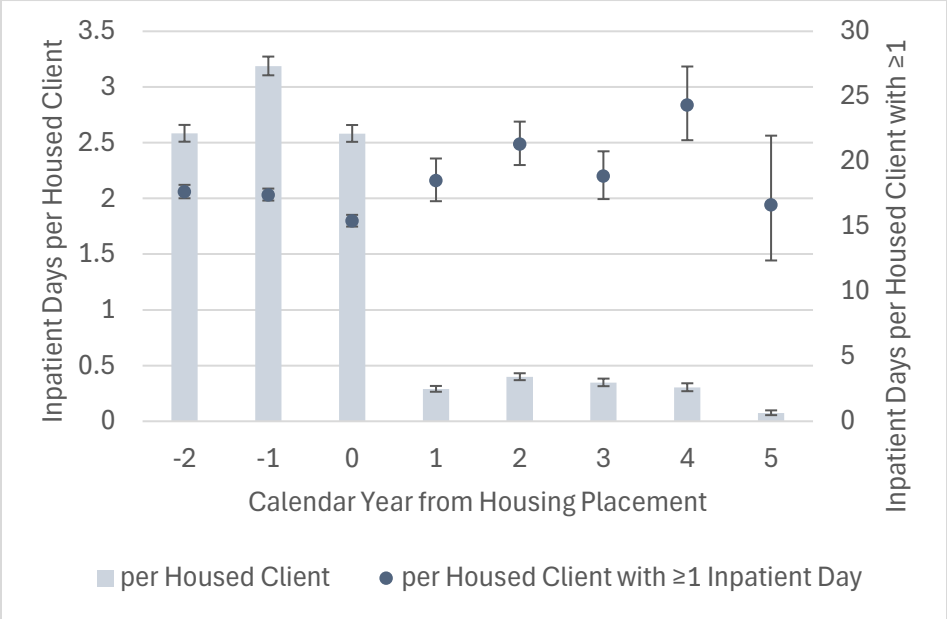
The observed stepwise and sustained reduction in ED utilization was not mirrored in secular trends among comparison cohorts, supporting the inference that the decline is attributable, at least in part, to housing stabilization. Markers within **Figure 7** indicate average annual ED visit counts among individuals with at least one visit in a given year. Utilization intensity among ED users remained relatively stable, ranging between two and nine visits annually. The absence of a monotonic decline in per-user intensity suggests that reductions were driven primarily by fewer individuals requiring avoidable emergency care, rather than diminished access for those with ongoing clinical need.

Figure 8 presents average annualized inpatient days per person, indexed to Year 0. Participants averaged approximately three inpatient days per year in the two years preceding and including housing placement. In Year 1 following placement, inpatient utilization declined by 89 percent relative to baseline and remained substantially lower across cohorts with up to five years of stable housing.

As with ED visits, the reduction in inpatient utilization was stepwise and sustained. Among individuals with at least one hospitalization in a given year, average inpatient days ranged between approximately 15 and 24, without evidence of a consistent downward trend in per-user intensity.

This pattern indicates that reductions were primarily attributable to fewer hospitalizations overall, rather than restricted access to inpatient care among medically complex individuals.

Figure 8. Annualized Inpatient Days per Person, Relative to Year of Housing Placement



Collectively, these findings support the conclusion that stable housing is associated with substantial and durable reductions in high-cost acute healthcare utilization, consistent with the program's underlying theory of change.

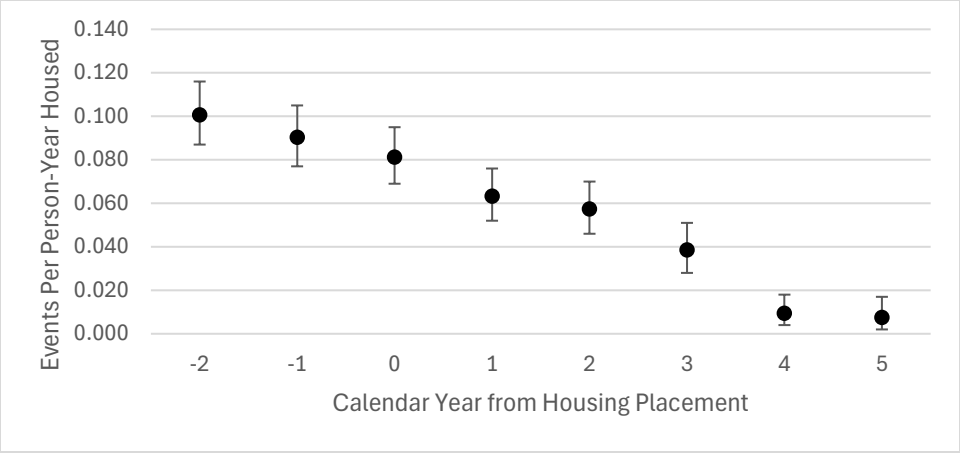
X. Law Enforcement and Jail Involvement

A. Chicago Police Department Encounters

Through data linkage with the Chicago Police Department (CPD), we tracked 911-initiated police service encounters across the City of Chicago for individuals housed through FHP.

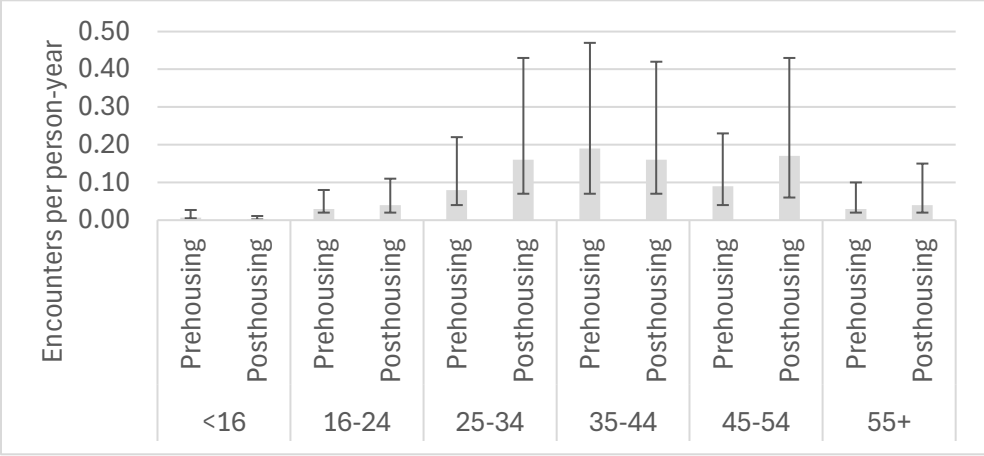
Figure 9 presents the average annualized per-person rate of CPD encounters, indexed to the calendar year of housing placement (Year 0). In the two years preceding and including Year 0, participants averaged approximately 0.10 police encounters per person per year. Following housing placement, the encounter rate declined by an average of 32 percent for each additional year of stable housing. Among cohorts with four and five years of follow-up, the annualized encounter rate approached zero.

Figure 9. Annualized CPD Encounters per Person, Relative to Year of Housing Placement



Reductions were observed across most offense categories, with the largest declines occurring in drug-related violations, warrant arrests, and larceny–theft incidents. Notably, mental health–related CPD encounters did not demonstrate statistically significant reductions (**Figure 10**), suggesting that while housing stabilization reduced many forms of law enforcement contact, behavioral health–related crises may require complementary clinical interventions beyond housing alone.

Figure 10. Change in CPD Mental Health Encounter Rate by Age Category, encounter per person-year



B. Jail Registrations

Through data linkage with Cermak Health Services of Cook County Health, we tracked registrations at Cook County Jail for all individuals housed in FHP.

Figure 11 displays the average annualized per-person jail registration rate, indexed to the year clients were placed into housing (Year 0). In the two years preceding and including housing placement, participants averaged approximately 0.18 jail registrations per person per year. In the first year following housing placement, jail registrations declined by 81 percent relative to baseline. This reduction was sustained across analytic cohorts with up to five years of stable housing.

Figure 11. Annualized Jail Registrations per Person, Relative to Year of Housing Placement

The magnitude and persistence of the decline were not observed in secular trends among comparison cohorts (i.e., individuals experiencing homelessness with similar characteristics but for whom a housing unit was not provided), supporting the inference that the reduction is plausibly attributable to housing stabilization. Among individuals with at least one registration in a given year, the average number of registrations was approximately one event annually. The observed decline in both overall incidence and per-user intensity over time suggests that stable housing reduces immediate exposure to incarceration risk for many participants and may further attenuate that risk with sustained housing duration.

Collectively, these findings indicate that stable housing is associated with substantial reductions in law enforcement contact and jail involvement, consistent with the program's theory that housing stability mitigates crisis-driven system utilization across multiple public sectors.

XI. Cost Offsets

Using imputed costs for services we calculated an estimate for cost offsets associated with the reductions in crisis services attributable to the FHP. **Table 6** lists the estimated cost of crisis service utilization from a societal perspective.

Table 6. Imputed Costs of Crisis System Utilization

Service	Description Detail	Unit Cost	Source
Emergency Department Visit	Treat-and-release emergency department visits in the United States in 2021 for Medicaid patients	$600	https://hcup-us.ahrq.gov/reports/statbriefs/sb311-ED-visit-costs-2021.pdf
Inpatient Hospital Day	True economic cost to a regional hospital estimated	$2,939	https://www.rush.edu/patients-visitors/billing/cost-care
Stay in Cook County Jail	Average estimated total cost per detainee at $143 per detainee per day x 8 days	$1,150	https://cookcountysheriffil.gov/new-law-reduces-length-stay-non-violent-cook-county-jail-individuals-in-custody/
Emergency Shelter daily rate	Low-end contracted shelter bed rate	$30	https://www.chicago.gov/city/en/sites/texas-new-arrivals/home/rfp.html
911 ambulance transport in Chicago	Public sector service cost	$1,500	https://www.bettergov.org/2014/04/09/no-more-free-ride
911 police dispatch in Chicago	Public sector service cost	$60	Blackstone EA et al. Burglary reduction and improved police performance through private alarm response. International Review of Law and Economics (2020); Vol 63; September.

The unit cost estimates presented in the table above are intentionally conservative and likely understate true costs from a societal perspective, thereby establishing a lower bound for the cost offsets attributable to the FHP. Based on observed utilization patterns in emergency departments, inpatient hospitalizations, and jail stays, we assume that the reductions realized in the first year of program participation persist at similar levels in each subsequent year. For 911 dispatch services, cost offsets were calculated separately using the average annual reduction in utilization rates. To further reinforce the conservative nature of these estimates, several relevant cost components were excluded from the analysis, including costs associated with arrest processing, post-detention legal proceedings, and outpatient pharmacy utilization, among others.

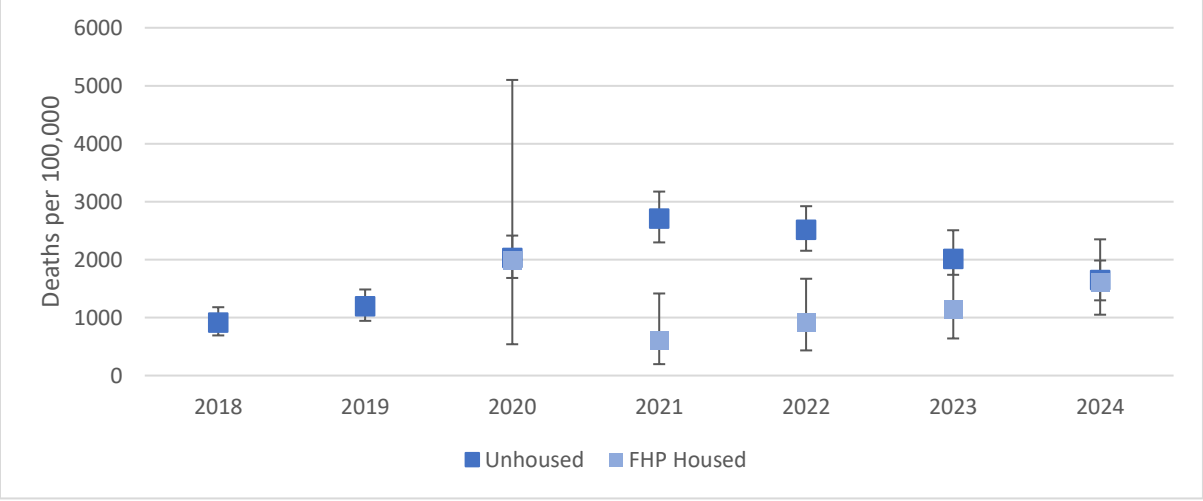
Under these assumptions, the analysis yields an estimated annual cost offset of $14,492 per household attributable to reductions in crisis service utilization.

XII. Mortality

By joining with data from the Cook County Medical Examiner, we captured all forensically investigated deaths among PEH in Cook County between 2018 and 2024. Although the Medical Examiner historically investigates just under half of all deaths in Cook County, deaths among the population of PEH are strongly associated with circumstances that trigger medical examiner's evaluation for the detailed cause of death. Using this systematic death record, we calculated crude annual mortality among a reference population of people age 16 or greater in literal homelessness defined by the population utilizing emergency shelters or street outreach services across the housing Continua of Care of Chicago or Suburban Cook County, and whose homelessness during each calendar year was confirmed by the assignment of an ICD10 code for homelessness during any hospital encounter in that year. **Figure 12** illustrates the increase in mortality among the reference population, peaking in 2021 at 2632 all cause deaths per 100,000 before declining, thereafter. The majority of deaths (61%) were related to illicit substances. The decline in mortality in this at-risk population in recent years is corroborated in other authoritative epidemiological data, but the exact reasons remain unclear.

In comparison, all deaths among clients of FHP were completely captured by service providers. FHP clients' crude all-cause mortality in 2020 was nearly identical to that of the reference population. However, even as unhoused peers suffered a further rise in mortality in the subsequent years, the rate among FHP clients remained statistically similar at a 5-year average of 1250 deaths per 100,000. Fifty-five percent of these deaths were also related to substance causes. In 2024, mortality among the unhoused cohorts declined to converge with the FHP population's level of risk.

Figure 12. Crude Annual Mortality among FHP Housed Population vs Unhoused Controls (age 16 and older)



The absolute mortality reduction in 2021 was 1-2% and 0.9% across the five-year period between 2019 and 2024; this means that the number needed to house in order to prevent 1 death was 111. Implicit from this figure is the protective effect of supportive stable housing during a period of increased environmental hazards, particularly unpredictable potency opioids in the illicit drug supply.

XIII. Cost-Effectiveness

We calculated the estimated incremental cost effectiveness ratio (ICER) by assuming an increase in the quality of life among participants of the FHP compared to the counterfactual in which these clients remain homeless.

$$ICER = \frac{Programmatic\ cost}{QALY\ housed - QALY\ homeless}$$

In order to estimate a plausible change in the quality of life from supportive housing, we generalized values derived for people with opioid use disorder, as one of the most prevalent conditions in the served population. Taken from a recent study that synthesized cross-sectional national surveys in the US, we assumed a utility multiplier of 0.434 for co-occurring homelessness and substance use disorder.[10] Assuming that clients housed in the FHP will experience resolution of homelessness and opportunities to engage in treatment for opioid use disorder, we assumed a utility multiplier of 0.599 for patients with substance use disorder receiving treatment.[11] We calculated the difference in quality adjusted life year (QALY) by taking the difference of the total person-years served in FHP multiplied by each of the QALY of the reference conditions. For cost, we assumed a societal perspective by taking a uniform bundled per-household cost in 2024 US dollars and subtracting the cost offset obtained from a reduction in the crisis system before multiplying the number of household-years served in FHP:

$$Programmatic\ Cost = (\$30{,}000\ per\ year - \$14{,}500\ cost\ offset\ per\ year)\ x\ household years$$

The estimated ICER came out to **$47,330 per QALY saved**. This figure meets a conservative definition of cost effectiveness (below the $50,000 per QALY gained) and thereby society's typical willingness to pay for innovations that save lives and improve quality of life.

XIV. Conclusion and Policy Recommendations

The Flexible Housing Pool of Chicago and Cook County represents a mature example of a locally financed supportive housing model capable of producing measurable improvements in health outcomes and reductions in crisis-system utilization. Over five years of implementation, the program demonstrated sustained reductions in emergency shelter use, healthcare utilization, emergency response activation, and jail involvement while maintaining high rates of housing retention.

These findings support the central premise underlying the program: that stable housing, when paired with coordinated support services, functions as a high-value health and social intervention for individuals with complex needs. The estimated incremental cost-effectiveness ratio of $47,330 per quality-adjusted life year gained places the program within commonly accepted thresholds for high-value health interventions.

Importantly, the FHP addresses the longstanding "wrong-pocket problem" by aligning contributions from health systems, government agencies, and philanthropic partners into a coordinated financing structure. This shared-investment model allows multiple sectors to benefit from reductions in crisis-service utilization while distributing the cost of housing stabilization more equitably.

Nonprofit hospitals, by virtue of their tax-exempt status, are well positioned to deliver measurable community benefit through direct investment in the FHP. Such contributions represent a high-value strategy to alleviate emergency department congestion and reduced uncompensated hospital-based care – both of which are likely to intensify under anticipated reductions in HUD and Medicaid funding. By supporting FHP, hospitals can address upstream drivers of utilization while improving system efficiency and patient outcomes.

Beyond the healthcare sector, coordinated investment from transportation agencies, law enforcement, and the local business community should also be strongly considered. Each of these sectors bears downstream costs associated with housing instability and stands to benefit from reductions in homelessness. A cross-sector financing approach would advance a shared objective: strengthening regional resilience, improving public safety and economic productivity, and enabling the metropolitan area to respond more effectively to future shocks while addressing persistent system inefficiencies.

The policy environment in which the FHP operates remains uncertain. Proposed federal changes to Medicaid and housing assistance programs may reduce resources available to vulnerable populations while increasing demand for locally financed interventions. In this context, the FHP provides a practical model for regional resilience, demonstrating how local institutions can collectively strengthen the housing safety net even in periods of fiscal constraint.

XV. SWOT Analysis

Strengths

- Demonstrated cost-effectiveness with an ICER below commonly accepted thresholds for high-value health interventions.

- Durable reductions in crisis-system utilization across healthcare, public safety, and homelessness-response systems.
- High housing retention rates sustained across multiple cohorts.
- A legally structured pooled-funding mechanism that enables cross-sector investment and shared accountability.
- Flexible scatter-site housing model that accommodates participant choice and promotes geographic integration.
- Strong cross-sector data infrastructure enabling rigorous evaluation and continuous improvement.

Weaknesses

- Limited availability of higher-intensity supportive housing resources for participants with the most complex behavioral health and functional needs.
- Dependence on ongoing voluntary contributions from institutional funders.
- Administrative complexity associated with cross-sector governance and financing.

Opportunities

- Increased participation by managed care organizations seeking to reduce high-cost utilization.
- Potential investments from justice-focused services including Chicago Fire Department, Chicago Police Department, County Sheriff's Department, and the Illinois Criminal Justice Information Authority (ICJIA), as well as opioid settlement funding authorities.
- Development of tiered housing models to better serve individuals requiring intensive clinical support.
- Continued use of linked administrative data to guide program targeting and demonstrate return on investment.

Threats

- Potential federal reductions in HUD and Medicaid funding that may increase demand for locally financed housing interventions.
- Rising rental costs in Cook County that increase per-household subsidy requirements.
- Landlord market tightening that may reduce availability of scatter-site units.
- Economic downturns that may reduce philanthropic and institutional contributions.
- Policy changes affecting Medicaid managed care and health care provider participation in housing-related services.

XVI. References

1. *The 2024 Annual Homelessness Assessment Report (AHAR) to Congress. Part 1: Point-in-Time Estimates of Homelessness*. 2024:December. https://www.huduser.gov/portal/sites/default/files/pdf/2024-AHAR-Part-1.pdf
2. Soucy D, Hall A, Moses J. *State of Homelessness: 2025 Edition*. 2025. September 4. https://endhomelessness.org/state-of-homelessness/#report
3. *Annual Report on Homelessness - Progress on Implementing Nineteen Principles for Addressing Encampments*. 2025. July 17. https://www.chicago.gov/city/en/depts/fss/provdrs/emerg/news/2024/july/2025-annual-report-on-homelessness.html
4. Ward A, Leo M, Khayr Y, Hinami K. *Meeting the Challenge of Housing Low-and-No Income Residents across Chicago and its Suburbs: The Flexible Housing Pool of Chicago and Cook County*. June 2025.
5. National Academies of Sciences Engineering and Medicine (U.S.). Committee on an Evaluation of Permanent Supportive Housing Programs for Homeless Individuals. *Permanent supportive housing : evaluating the evidence for improving health outcomes among people experiencing chronic homelessness*. Consensus study report. The National Academies Press; 2018:xiv, 212 pages.
6. Leo M, Ward A, Hinami K, Khayr Y, George C. *At the Transition of Homelessness and a Self-Directed Future: Emerging Adults in the Flexible Housing Pool of Chicago and Cook County*. November 2024.
7. Hinami K, Doshi K, Trick WE. *Cross Sector Data Linkage for Evaluating the Flexbile Housing Pool of Chicago and Cook County, 2018-2021: Early Impact Evaluation*. 2023. January
8. Linkja. Accessed January 30, 2026. https://linkja.github.io/
9. Cutuli JJ, Desjardins CD, Herbers JE, et al. Academic achievement trajectories of homeless and highly mobile students: resilience in the context of chronic and acute risk. *Child Dev*. May-Jun 2013;84(3):841-57. doi:10.1111/cdev.12013
10. Rao IJ, Brandeau ML. Modeling Health and Economic Outcomes of Providing Stable Housing to Homeless Adults With OUD. *JAMA Netw Open*. Jun 2 2025;8(6):e2517103. doi:10.1001/jamanetworkopen.2025.17103
11. Rand K, Arnevik EA, Walderhaug E. Quality of life among patients seeking treatment for substance use disorder, as measured with the EQ-5D-3L. *J Patient Rep Outcomes*. Nov 9 2020;4(1):92. doi:10.1186/s41687-020-00247-0

XVII. Acknowledgements

This evaluation of the FHP was made possible with funding from the J.B. and M.K. Pritzker Family Foundation. The authors gratefully acknowledge Tameeka Christian for her guidance and support in her role as Program Officer.

The authors also wish to recognize the additional contributors to this report as listed below:

Michael Corcoran	**All Chicago**
Jennifer Hill	**Alliance to End Homelessness in Suburban Cook County**
Jeremy Heyboer	
Peggy Troyer	
Azalea Acuna	**Center for Housing and Health**
Charlie Pekarek	
Dave Thomas	
Joel Ritsema	
Liza Duschesneau	
Peter Toepfer	
Pierre Phanor	
Adam Walker	**City of Chicago**
Alexander Heaton	
Bruce Coffing	
Cameron Kinch	
Christine Riley	
Emile Jorgensen	
Evan Haim	
Golnar Teimouri	
Jaye Stapleton	
Kevin Barszcz	
Mark Kiely	
Matthew Richards	
Maura McCauley	
Megan Weston	
Nancy Cao	
Nik Prachand	
Sarah Richardson	
Alex Patino	**Cook County Health**
Ashley Huntington	
Chante Gamby	
Cindy San Miguel	

Kathy Chan Maurice Brown Paige Clincy Yvonne Collins	
Ponni Arunkumar	**Cook County Medical Examiner's Office**
Derrick Lyons Johnna Lowe Julie Nelson	**Corporation for Supportive Housing**
Anh-Thu Runez Dejan Jovanov	**Illinois Department of Public Health**
Ellen Holfels	**Medical Research Analytics and Informatics Alliance**
Luke Rasmussen	**Northwestern University**

Cook County Health's Health Research and Solutions Unit within the Center for Health Equity & Innovation is a team of clinicians and data scientists committed to building informatics infrastructure and performing analyses in the service of the people of Cook County.