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Cross-Sector Partnerships to Improve Health and Housing Outcomes: Resource Guide

Throughout the country, health systems and governmental agencies are partnering with social service providers and other cross-sector organizations to address the social determinants of health impacting their communities. Capitalizing on this national momentum, the Centers for Disease Control and Prevention (CDC), the U.S. Department of Housing and Urban Development (HUD), and the Association of State and Territorial Health Officials (ASTHO) brought together public, private, and nonprofit leaders on Nov. 29-30, 2016 to explore how they could work together to improve health and housing outcomes. This convening identified existing partnership, financing, and data-sharing approaches for cross-sector partnerships among healthcare, housing providers, and other sectors that improve health and housing outcomes. This resource guide synthesizes the lessons learned from the 2016 convening and provides public health leaders with strategies to build effective partnerships.

Housing and Health 101

Affordable, safe, and stable housing has a considerable impact on an individual's health and well-being[1], including the ability to manage chronic diseases, maintain personal hygiene, access education and employment, engage with others in the community, and safely avoid environmental and health hazards. Housing is also an important source of protection against interpersonal and environmental threats. In summary, housing stability contributes to improved physical health as well as improved psychosocial outcomes.[2] The following aspects of housing can have a direct impact on health:

- **Affordability of housing and utilities**[3] – A lack of affordable housing and utilities can directly contribute to stress, depression, and anxiety, and can prevent an individual from preventing and managing existing physical and behavioral health issues.[4] Seventy-one percent of extremely low-income households spend more than half their income on rent and utilities,[5] which limits their ability to buy nutritious food, heating and cooling systems, and needed medications.[6] Individuals and families unable to afford housing are also at a distinct risk of homelessness, which severely impacts their ability to prevent and manage chronic diseases, behavioral health issues, and infections. Maintaining good nutrition, personal hygiene, and sleep habits also becomes a struggle. Individuals experiencing homelessness face illness at three to six times the rate of housed individuals and are three to four times more likely to die than the general population.[7]

- **Quality and safety of available housing**[8] – Conditions like asthma can be exacerbated or triggered by poor ventilation, damp housing conditions, and the presence of pests common in unsafe or poorly maintained living conditions. Poor living conditions are also associated with neurological development problems, lead poisoning, heart disease, and developmental delays among children.[9]

- **Access to transitional housing and/or supportive housing**[10] – Transitional housing is temporary housing that can include supportive services to bolster health outcomes related to mental health

conditions and substance use disorder, as well as co-occurring physical health needs. Transitional housing offers a safe and supportive environment for residents to build a community network, receive treatment for health issues, and overcome trauma.[11]

- **Neighborhood conditions**[12] – Neighborhood conditions can lead to or exacerbate exposure to physical injuries, respiratory infections, obesity, addiction, chronic disease, and unhealthy behaviors. Substandard neighborhood conditions include a lack of safe places to play and exercise, poor air quality, lack of access to nutritious foods, predatory lending businesses, crime, and advertisements promoting tobacco and alcohol use.[13] A neighborhood's social and economic conditions—for example, its availability of affordable housing, employment, transportation, and other key resources— inherently influence an individual's ability to support a healthy lifestyle.[14]

Housing can impact health outcomes for all individuals. However, the following populations experience the most dramatic impacts on their health due to a lack of affordable, quality housing:

- **Homeless populations**[15] – Individuals experiencing homelessness generally have high rates of chronic behavioral and physical health needs (including higher rates of infectious disease), and their extreme housing instability presents challenges accessing preventive services and establishing relationships with healthcare providers. For these reasons, people impacted by housing instability are also disproportionately high healthcare service utilizers, and are five times more likely to be admitted to hospitals than non-homeless individuals.[16] Housing instability can also contribute to an increase in use of high-cost services, such as utilizing emergency departments for health conditions or illnesses that could be handled in ambulatory or primary care settings.[17]

  Health systems and other organizations have been able to reduce healthcare costs among chronically homeless populations by 38-72 percent by using a Housing First model, which helps connect individuals with permanent and stable housing and then provides other social and medical services as necessary.[18] For example, researchers in Portland, Oregon, analyzed Medicaid claims data among beneficiaries in affordable housing properties and found that there was a direct correlation between moving into affordable housing and spending less on healthcare. The average member spent 12 percent less on healthcare, which equates to $48 savings per month. Housing stability and affordability contributed to a 20 percent increase in primary care visits and an 18 percent decrease in emergency room use.[19]

- **Children** – Children living in unstable or temporary housing are exposed to environmental asthma and allergy triggers more so than those living in permanent housing. Treating asthma costs the United States $56 billion per year and improving housing standards could be an effective preventative measure to reduce the prevalence of asthma and other allergens.[20] Housing instability has a profound impact on children's safety and developmental health as well. One recent study by Boston Medical Center found that children aged four and under in housing-unstable households had a 20 percent increased risk of hospitalization and 25 percent increased risk of developmental delays.[21]

- **Aging populations** – Senior citizens often experience higher costs for healthcare as they age, and therefore face uncertain futures when making decisions about remaining in their own homes or paying for medication or healthcare services. The demand for home- and community-based services will increase as more individuals age into Medicare. Since these same services can play a role in

preventing or delaying the onset of chronic illnesses, healthcare systems can avoid or minimize the high cost of disease treatment and high-cost assisted living and nursing care facilities by helping individuals safely stay in their homes and neighborhoods.[22]

- **Low-income families and under-resourced communities** – Housing is often the single greatest expense for families: The U.S. Department of Labor Bureau of Labor Statistics reports that in 2017 families spent an average of 27 percent of their income before taxes on housing.[23] For individuals and families already struggling financially, housing affordability, neighborhood safety, and the availability of community resources can directly affect the ability to maintain steady employment, pursue education, and access essential resources.

- **Individuals living with HIV/AIDS –** Housing status is powerfully linked with the risk for HIV exposure and transmission, as well as with care and health difficulties for persons living with HIV/AIDS. There is also a strong connection between HIV status and poverty. According to the CDC, HIV prevalence in urban poverty areas are inversely related to annual household income.[24] In addition, research indicates that 40-70 percent of all persons living with HIV in the United States experience homelessness or housing instability at some point following their diagnosis.[25] Consistent research findings support efforts to increase housing stability as an effective structural intervention to improve HIV treatment effectiveness and outcomes. For example, Ryan White HIV/AIDS Program clients with unstable housing situations have lower rates of viral suppression compared to clients with stable or temporary housing. In 2016, 72 percent of individuals in unstable housing displayed viral suppression, versus 82 percent of individuals in stable housing.[26]

- **Racial and ethnic minority groups –** Communities of color are impacted by the legacy of racist social and housing policies, which continue to result in de facto segregation in almost all cities.[27] Research has found that racial segregation directly contributes to health disparities. Highly segregated communities have lower housing quality, higher poverty, and relatively poor job and educational opportunities, all of which lead to a disproportionate burden of stress, preventable disease, death, and disability.[28,29] Efforts to improve health and housing must address the social contexts and institutional barriers that perpetuate these inequities. For example, there are an estimated four million instances of housing discrimination each year in the rental market, illustrating the high barrier for individuals wanting to move between neighborhoods.[30] In addition, a practice known as "redlining", in which banks define desirable locations to invest and often deny mortgages or loans to less affluent neighborhoods, has historically targeted communities of color and created disparities in mortgage lending and home ownership among Black Americans.[31]

Elements of Strong Partnerships

At the 2016 government agency convening, participants identified common strategies and windows of opportunity for health agencies to pursue new housing partnerships. The following section offers an overview of these promising practices, and additional resources are available to put recommendations into action.

Standardizing Language and Vision Across Partners

Different sectors (e.g., public and private sectors; housing, healthcare, and public health sectors) often use different terminology and have different priorities for an issue, which can make partnership efforts difficult.

For example, the housing and real estate sectors operate along much longer timelines and invest for periods longer than the typical public health grant cycle.[32]

Further, public and private health insurers may not see the financial benefits of housing interventions since those cost savings may appear in other sectors as patients move between insurance providers. Lastly, these partners may all approach the concept of "population health" differently.

Public health leaders and other stakeholders may consider using "translators" that can help partners bridge language and cultural divides. Translators may come from a backbone entity or an intermediary group, or they may be someone who has worked in multiple sectors.

Strategies to Build Effective Partnerships (Fig. 1)

Questions to consider:

1. What acronyms or lingo does my team use that may be specific to our field?
2. For which populations (e.g., geographic, demographic, patient populations) is my partner responsible? Which populations are impacting my partner's spending and resource allocation?
3. Is there someone either on my team or at my partner organization with a background in another sector who could provide background or terminology assistance?
4. What financial, political, social, or other limitations does my partner organization have that I may not?
5. Have I discussed the prioritization of resources with my partner organization on this project?

Case Example: *The Role of the Partnership Manager and Bridge-Builder in Oregon* – "It Takes a Neighborhood"—A Kaiser Permanente Northwest-funded Oregon initiative—led to the creation of the role of the Health Instigator. This full-time employee, funded by Kaiser Permanente, served as a "partnership manager" and worked to break through barriers and enhance the breadth and depth of community partnerships.

Tool: *Maximizing Public Health Partnerships with Medicaid to Improve Health* – ASTHO and the National Association of Medicaid Directors, with support from the de Beaumont Foundation, designed materials to improve the basic understanding of Medicaid and public health to facilitate collaboration. Tools include primers on how Medicaid and public health leaders can leverage mechanisms in Medicaid-managed care and health homes to support population health goals.

Tool: *Housing and Health Care: A Toolkit for Building Partnerships* – The LeadingAge Center for Housing Plus Services developed a toolkit focusing on housing interventions that support aging populations. The toolkit includes resources on how to explain the value of such partnerships to housing providers, such as how collaborations with health entities can support residents and maintain a well-managed property.

Setting Mutually Agreeable and Realistic Expectations and Goals

Take steps to understand the social, political, and economic context of the community where the intervention will take place, and then develop solutions based on existing evidence that correlates to the targeted population. Also, consider how your project team will engage community members in decision-making processes, and develop a plan to collect input on community health and housing priorities.

Formulate a project plan that outlines concrete action steps to be taken, and account for potential disruptions to the timeline. If no action steps are taken within a reasonable timeframe, partners may lose trust, interest, and traction. For example, if affordable housing developments encounter delays during the planning phase, investors may be unwilling to wait for these processes to be resolved and may move on to other investment opportunities. Further, some states and communities have achieved significant reductions in homelessness by establishing ambitious housing placement goals (or "surges").[33]

Finally, ensure that the project's goal aligns with the community's needs and investors' interests. This strategic planning allows investors and other partners to share a vision and understand their roles even if there are delays. Further mitigate risk by developing a cadre of leaders and decision makers who will convene at least quarterly and engage in discussions to address challenges and ensure project sustainability.

Questions to consider:

1. Have I articulated my priorities to my partner organization about this project?
2. Do I know what my partner organization's priorities are for this project?
3. What values do I and my partner organization share that could help shape the vision of our project?
4. How does this project align with any of my organization's plans, my partner organization's plans, or my state's strategic plans?
5. Has my partner organization shared their perception of what potential pitfalls this project might encounter?
6. How often will I be meeting or otherwise checking in with my partner on this project?
7. Have we set short-term and intermediate goals for the completion of this project?
8. Have we clearly delegated time-bound tasks to the appropriate individuals or teams?
9. What resources could I proactively line up now in case I need to draw upon them during the project's execution?

Case Example: *Housing the First 100, Orlando, FL* **–** In the Orland Housing First Initiative, "Housing the First 100," a collaborative group of healthcare providers, local law enforcement, and other government agencies provided case management, peer support, and housing connections to high-cost homeless populations that were frequent hospital utilizers. The collaborative prioritized building community buy-in in the early stages of planning, and they have collectively determined priority populations using a vulnerability index.

Case Example: *Connecticut's 100-Day Campaign to End Homelessness* – In 2015, Connecticut's lieutenant governor launched a 100-day effort across four communities to tackle homelessness. The state engaged with the Rapid Results Institute, as well as charitable foundations, housing authorities, hospitals, the Veterans Administration, state Department of Mental Health and Addiction Services, and the Connecticut Coalition to End Homelessness. Partners met and agreed on a goal to house 75 percent of the chronically homeless population within a 100-day period. A clearly defined process was used among partners to:

1. conduct outreach using an assessment tool to prioritize individuals.
2. collect necessary documentation to move individuals into housing.
3. compile a list of available housing options.
4. match people with housing opportunities.

Tool: Prevention Institute Collaboration Multiplier **–** The Prevention Institute's interactive framework can be used to analyze collaborative efforts across the field. It is designed to guide an organization to better understand which partners it needs and how to engage them. The Collaboration Multiplier can help lay the foundation for shared understanding and common ground between partners.

Understanding the Range of Financing Options

State health agencies, health systems, and other organizations are using a broad range of financing options to support housing improvement projects and other initiatives to increase access to housing and social services. Partners should be aware of options and innovations happening across other states. Partners should also be mindful of how other sectors may have different budget cycles, spending restrictions, and reporting requirements. A sample of financing mechanisms that have supported cross-sector partnerships include the following:

- *Direct investments from hospitals and health systems, possibly in alignment with community benefit dollars*. An example of this is comes from Portland, Oregon, where five hospitals and a nonprofit health plan are donating more than $20 million to help build nearly 400 housing units for homeless and low-income individuals.[34]

- *Blending and braiding public dollars.* Combining multiple funding streams (e.g., across public health and social service agencies) is an option to diversify funding and build programmatic resilience.[35]

- *Use of Low-Income Housing Tax Credits (LIHTC)*. Created by the Tax Reform Act of 1986, the LIHTC program gives State and local LIHTC-allocating agencies the equivalent of nearly $8 billion in annual budget authority to issue tax credits for the acquisition, rehabilitation, or new construction of rental housing targeted to lower-income households.[36]

- *Medicaid innovations that invest in housing-related services and/or screening for the social determinants of health.* Efforts like the CMS Accountable Health Communities (AHC)[37] initiative can be used creatively to support housing programs. In addition, Medicaid Section 1115 waivers are being used to provide supportive services, including housing service navigation, for individuals who have behavioral health needs or are experiencing homelessness.[38]

- *Managed care organization contracts that include housing-related services*. An example is Mercy Maricopa, a nonprofit healthcare plan in Phoenix, Arizona, that manages behavioral healthcare for Medicaid-eligible adults and children. The services provided to Medicaid-eligible residents by Mercy Maricopa serve as the match required for HUD housing vouchers; in addition, some state-only Medicaid funds are used to acquire and/or subsidize housing for these individuals. In combination, these resources allow Medicaid members to receive individualized services in the community of their choice, ensuring that HUD funds are focused on expanding housing opportunities.[39]

- *Reinvesting savings created by supportive housing to increase the supply of rental assistance*. Massachusetts, for instance, funds supportive housing for about 1,300 households. At least 34 states have at least one program that provides housing assistance to low-income people, which often are used for supportive housing.[40]

- *Money Follows the Person (MFP) demonstration projects*. As of December 2016, over 75,151 people with chronic conditions and disabilities have transitioned from institutions back into the community through MFP programs. The Affordable Care Act of 2010 strengthened and expanded the MFP program, allowing more states to apply. There are currently 43 states and the District of Columbia participating in the demonstration.[41]

Questions to consider:

1. Are we aware of state and federal funding cycles, application processes, and/or reporting requirements?
2. Am I engaged with my partners in the state Medicaid agency? If so, what data or evidence do I need to collect before I meet with them (e.g., return on investment data)?
3. What existing projects are underway in my state? Is there an AHC bridge organization grantee in our state, and are we in contact with them? Is there an MFP demonstration in our state?

Tool: *CMS Informational Bulletin: Coverage of Housing-related Activities and Services for Individuals with Disabilities* – CMS shared an information bulletin to clarify the circumstances under which Medicaid reimburses for certain housing-related activities, with the goal of promoting community integration for individuals with disabilities, older adults needing long-term services, and those experiencing chronic homelessness.

Tool: *State and Federal Healthy Housing Financing Initiatives* – While not exhaustive, ASTHO compiled a collection of several place-based initiatives that can finance residential and community health improvement projects.

Tool: *Strategies to Strengthen Health and Housing Partnerships through Medicaid to Improve Health Care for Individuals Experiencing Homelessness* – The National Academy for State Health Policy (NASHP) created an issue brief that outlines a variety of federal authorities and delivery systems that can be used to increase access to supportive housing services. NASHP has also compiled a collection of additional resources for state policymakers, including a case example on Louisiana's permanent supportive housing program, which is administered jointly by the state Medicaid agency and housing authority.

Data Gathering, Storing, and Sharing

Construction of data infrastructure can be a labor-intensive and lengthy process. Barriers to data sharing may also arise from concerns about proprietary information or processes for linking data. Therefore, it is important to determine the party or parties responsible for developing, implementing, and maintaining data infrastructure early in the planning process. Establish a formal data sharing agreement that can be presented within a memorandum of understanding (MOU) in consultation with the appropriate legal experts that outlines the responsibilities of each party and the process through which data will be shared. An MOU also allows for all parties to mutually agree upon the purpose and goals for data collection to ensure data will be actionable.

The presence of strong leaders can also help support the development of cross-sector partnerships and overcome data sharing challenges. Leaders may have the capacity to directly influence resource allocation and development, particularly around data infrastructure. Leaders can also bring diverse partners together and build the support necessary to spur action.

Questions to consider:

1. Does my organization have a comprehensive information technology/data strategy? How does this initiative fit (or not) with my partner organization's strategic objectives?
2. How will my partner organization and I handle sensitive information?
3. Who is responsible for developing and maintaining the infrastructure for data-sharing?
4. What kind of information will we collect, and what do we want to do with it during and/or after the completion of the project?

Case Example: *Washington State Data Sharing through the Accountable Communities of Health* – Public health agencies in Seattle and King County, Washington, are linking housing data with Medicaid claims records to paint a more complete picture of health and healthcare utilization among public housing residents. The agencies will engage in bi-directional exchange of de-identified data with the goal of preventing chronic disease and reducing health inequities.

Case Example: *Data-Sharing Ending Chronic Homelessness in Maine* – Maine developed a Statewide Homeless Council through state legislation. The council included the Housing Authority, the Department of Health and Human Services, the Department of Corrections, the Bureau of Veterans' Services, and regional assemblies. The council used cross-sector data to identify individuals who were chronically homeless or at risk of becoming chronically homeless and targeted community-based resources to those individuals. Between 2013-2015, Maine showed a 53 percent decrease in the number of single adults staying at shelters for over 180 cumulative days.

Tool: *Sources for Data on Social Determinants of Health* – CDC has compiled a collection of data sources that can illustrate the social determinants of health at the national, state, and county or city levels.

Conclusion

Housing plays an important role in disease prevention and health equity.[42] State and territorial health agencies can use limited resources most effectively by investing in evidence-based, upstream prevention strategies that improve the health of the full community, such as place-based innovations that address housing.[43] However, governmental public health cannot achieve population health alone, and a broad range of partners, including communities, are needed to address social determinants of health and create vibrant and healthy neighborhoods. For example, public health leaders can employ place-based community assessments of factors that influence health and wellbeing and subsequently address those identified needs through community-driven interventions.

As cross-sector partnerships emerge at the local and state levels, common themes are emerging around the need to build a business case that is attractive to different payers and investors, as well as to address the priorities and practical realities of partners. In addition, early practices indicate that there are benefits to engaging high-level leadership in spearheading partnerships and facilitating data-sharing between sectors and partners. Federal and state agencies are also coming forward to build a supportive environment where new innovations can blossom. Cross-sector partnerships are capable of blending unique perspectives, expertise, and community relationships, and offer a promising path forward towards improved population health.

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