Housing and Health Partnerships: Putting Theory Into Practice

Kevin Lombardi MD, MPH
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The National Center for Health in Public Housing

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- All participants muted upon entry
- Engage in chat
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email

National Center for Health in Public Housing (NCHPH)

- The National Center for Health in Public Housing (NCHPH) is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09734, a National Training and Technical Assistance Partner (NTTAP) for $2,006,400 and is 100% financed by this grant. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
- The mission of the National Center for Health in Public Housing (NCHPH) is to strengthen the capacity of federally funded Public Housing Primary Care (PHPC) health centers and other health center grantees by providing training and a range of technical assistance.

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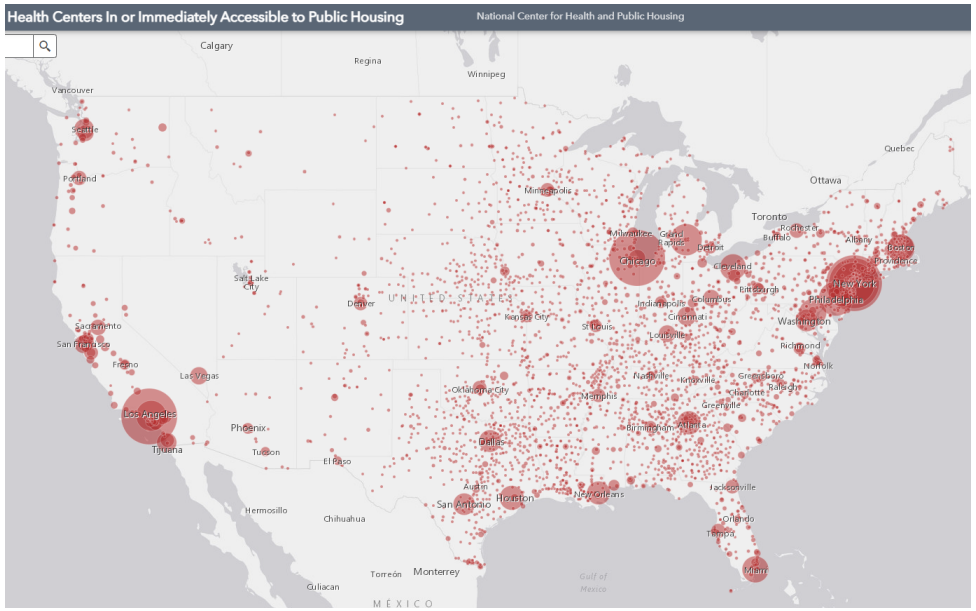
Health Centers Close to Public Housing

- 1,373 Federally Qualified Health Centers (FQHC) = **30 million patients**
- 458 FQHCs In or Immediately Accessible to Public Housing = **5.7 million patients**
- 108 Public Housing Primary Care (PHPC) = **911,683 patients**

Source: 2021 Health Center Data



Source: Health Centers in or Immediately Accessible to Public Housing Map

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Public Housing Demographics

1.5 Million Residents

2 Persons Per Household

38% Disabled

52% White

91% Low Income

43% African-American

26% Latinx

19% Elderly

36% Children

32% Female Headed Households with Children

[2022 HUD Resident Characteristics]

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Session content objectives

Through an examination of the literature and engagement in case studies we will review the following:

1. Review evidence-supported frameworks for implementing health and housing partnerships.
2. Perform an overview of methodologies for practical health/housing partnerships.
3. Take a practical view of the limitations and challenges in health/housing partnerships.

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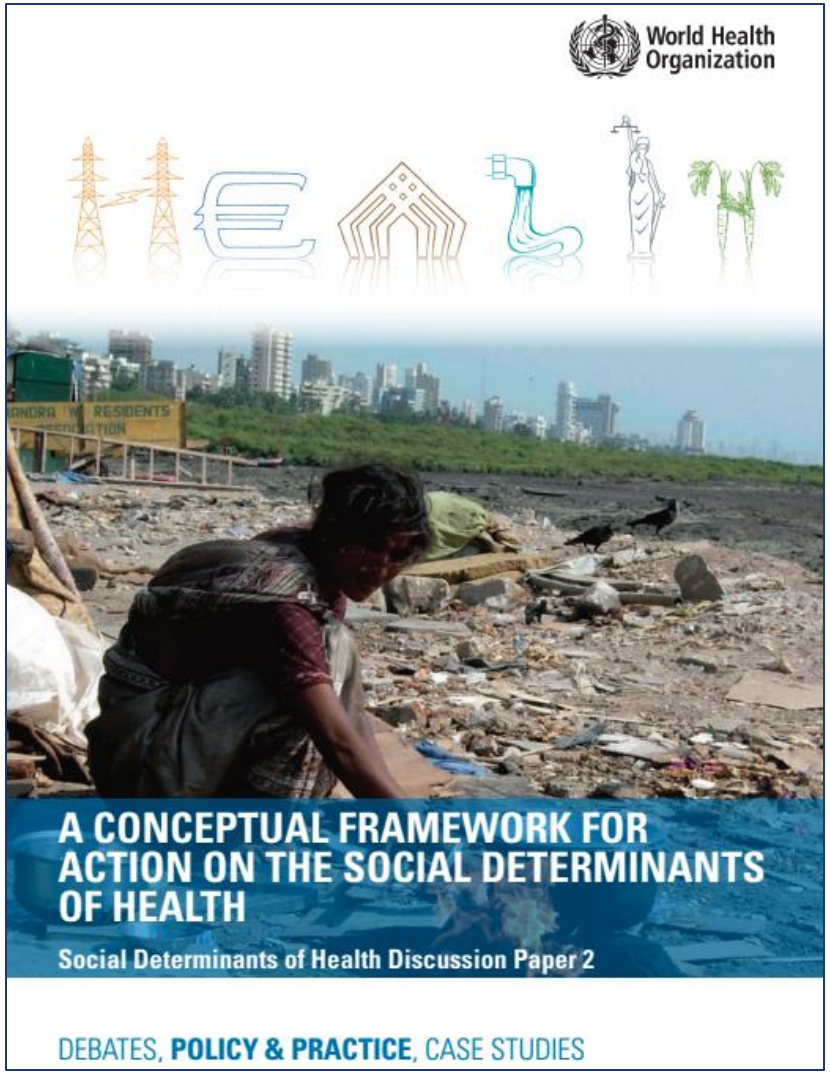
The SDOH: Conceptual Overview

Link to resource: [Healthy People 2030]

WHO Conceptual Framework



Human Rights → Policy Choices → More equitable outcomes

Link to Resource: [WHO Conceptual Framework]

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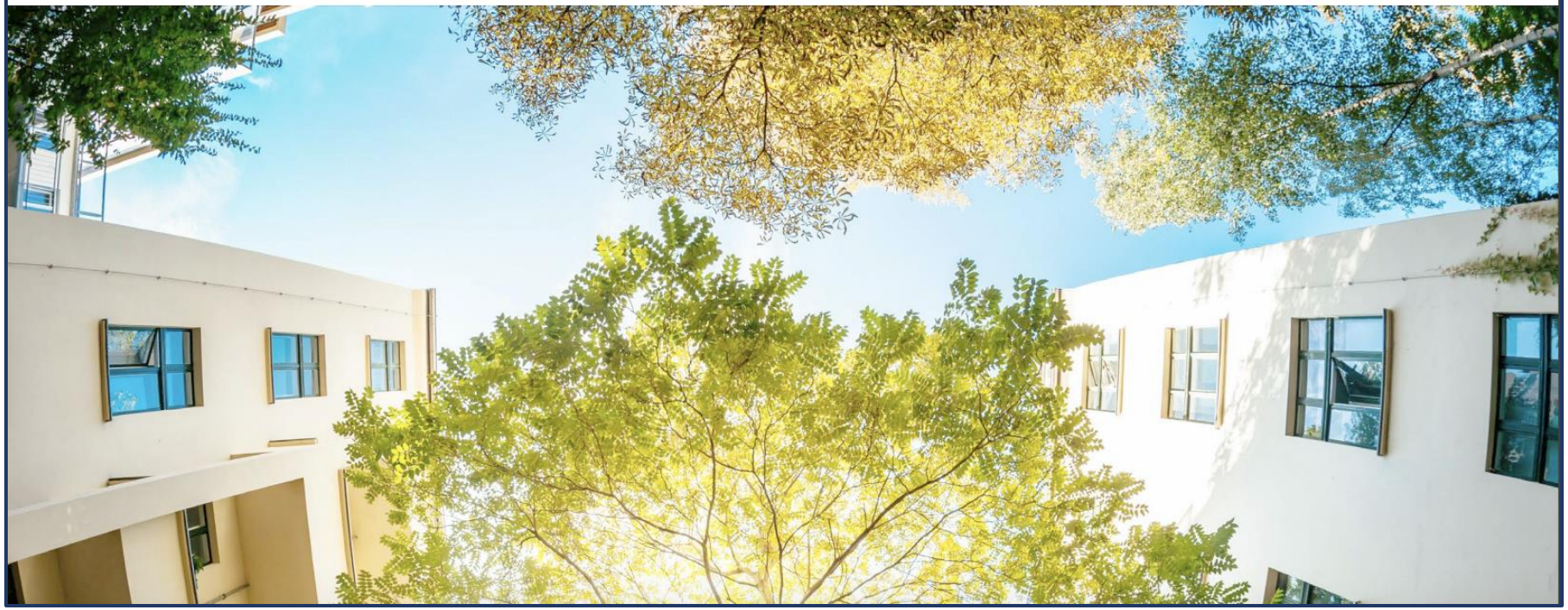
HEALTHY TOGETHER

A Toolkit for Health Center Collaborations with HUD-Assisted Housing and Community-Based Organizations



Link to Resource: [Healthy Together]

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Case study :

Mrs. Torres is a 67 year-old female with a PMH significant for T2DM, CKD stage I and hypertension. She presents at her primary care office for her annual wellness examination and to receive refills for her prescriptions. She denies any acute health issues.

At intake, vitals and an SDOH screener are performed per facility protocol.

<u>The results are as follows:</u>

HR: 82 bpm

BP: 140/86

R: 22 per min.

<u>Results from her previous exam 6 months ago are as follows:</u>

HR: 62 bpm

BP: 120/78

RR: 18 per minute

The intake nurse indicates that Mrs. Torres appears diaphoretic and nervous.

Case study :

Mrs. Torres' SDOH Screener displays the following results:

Appendix

WellRx Questionnaire

DOB **11/30/56** Male___ Female X

WellRx Questions

---

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?

_____ Yes X No

2. Are you homeless or worried that you might be in the future?

X Yes _____ No

3. Do you have trouble paying for your utilities (gas, electricity, phone)?

X Yes _____ No

4. Do you have trouble finding or paying for a ride?

X Yes _____ No

5. Do you need daycare, or better daycare, for your kids?

_____ Yes X No

Case study :

Mrs. Torres' SDOH Screener displays the following results:

6. Are you unemployed or without regular income?
_____ Yes
X No

7. Do you need help finding a better job?
_____ Yes
X No

8. Do you need help getting more education?
_____ Yes
X No

9. Are you concerned about someone in your home using drugs or alcohol?
_____ Yes
X No

10. Do you feel unsafe in your daily life?
_____ Yes
X No

11. Is anyone in your home threatening or abusing you?
_____ Yes
X No

Case study:

In the examination room Mrs. Torres is seen by a NP who reviews her vitals, recent lab results and performs a physical examination.

<u>Laboratory results indicate the following:</u>

Sodium: **149 mmol/L** (136-145)
Potassium: **3.7 mEq/L** (3.5-5.2)
BUN: **24 mg/dl** (5-20)
Crt: **145 mg/dL** (61.9-114.9
Phos: **3.7 mg/dL** (1.12-1.45)

Mrs. Torres's physical examination was unremarkable save some mild shaking and nervousness.

Case study:

When interviewed regarding her SDOH screener, Mrs. Torres mentions the following.

- She lives at home with her husband and adult daughter.
- She is the only source of income. Her hours were cut by 20% 6 months ago.
- Since then, her family has lived on savings, which are now gone.
- Her family has struggled to meet rent. She was evicted once in her early 30s. She is overwhelmed by fear that this could happen again.

Mrs. Torres is examined for and diagnosed with Generalized Anxiety Disorder (GAD) and Major Depressive Disorder (MDD) during her visit. She is started on Citalopram, an SSRI antidepressant. She is networked to social services, who schedule a consult with her for next week.

Please Consider the following Questions:

1. How are Mrs. Torres' non-medical challenges impacting her chronic diseases (T2DM, CKD I)?

2. What type of services could be helpful in supporting Mrs. Torres?

3. How should these services be delivered?

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_____ Yes ___X___ No

2. Are you homeless or worried that you might be in the future?

___X___ Yes _____ No

3. Do you have trouble paying for your utilities (gas, electricity, phone)?

___X___ Yes _____ No

4. Do you have trouble finding or paying for a ride?

___X___ Yes _____ No

5. Do you need daycare, or better daycare, for your kids?

_____ Yes ___X___ No

Case study :

Mrs. Torres' SDOH Screener displays the following results:

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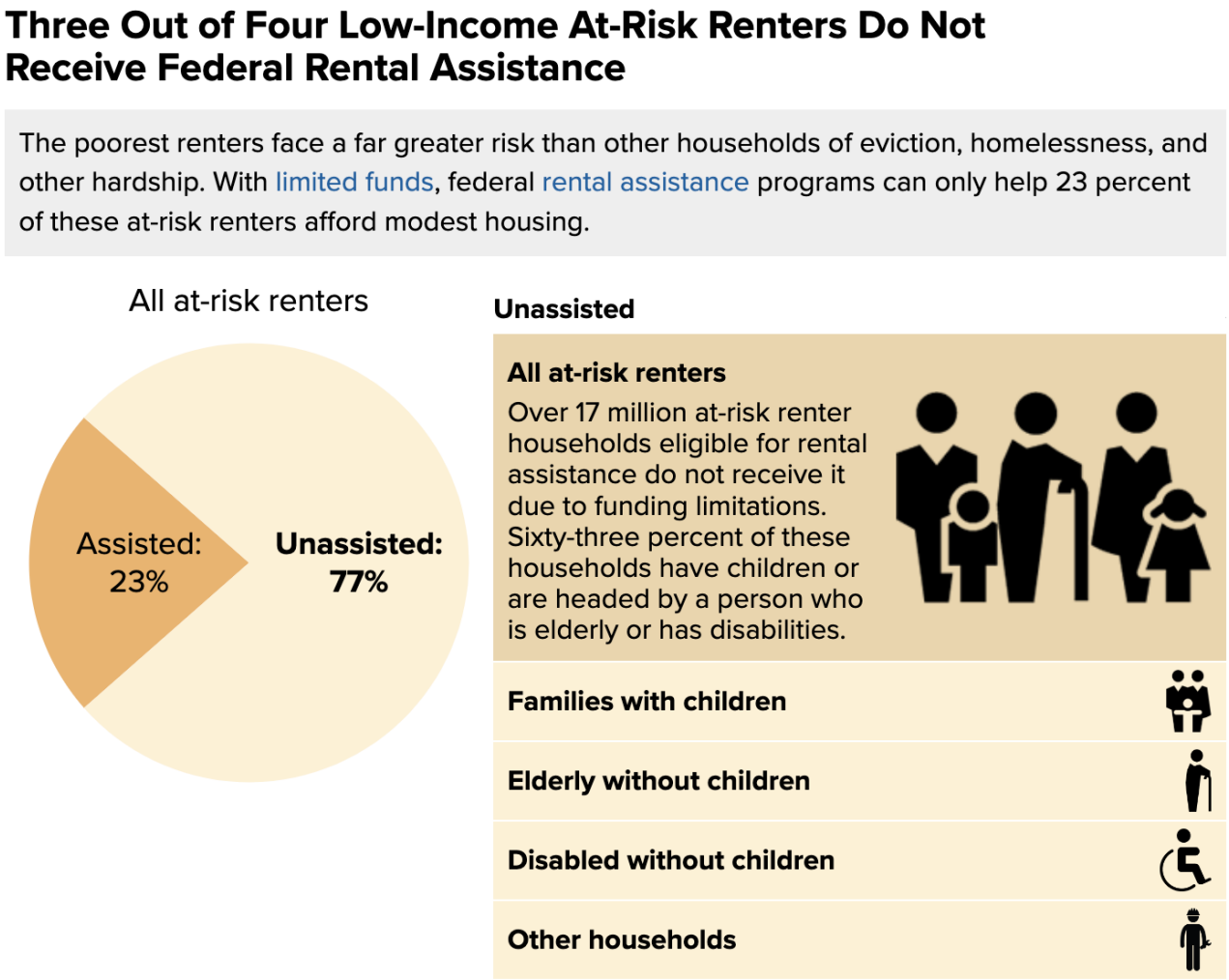
Health and Housing: Evidence

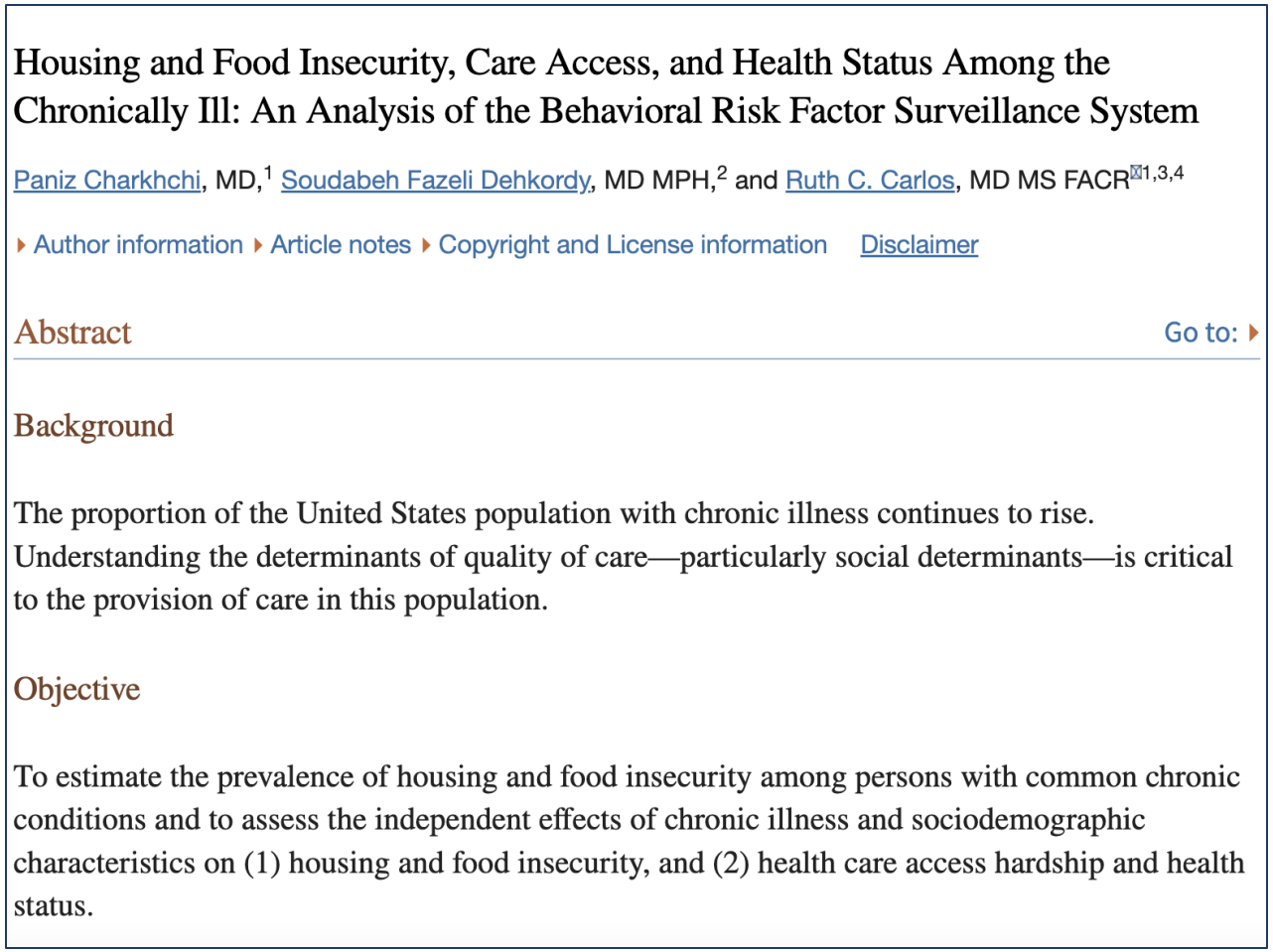


[Link to Resource]

Key takeaways:

- Access to safe, affordable housing is a major contributor to the SDOH.
- Poor access to these resources can have a particularly for those experiencing chronic disease states.
- Supporting access to housing has a strong measurable impact on health outcomes.

Health and Housing: Evidence



Housing and Food Insecurity, Care Access, and Health Status Among the Chronically Ill: An Analysis of the Behavioral Risk Factor Surveillance System

Paniz Charkhchi, MD,[1] Soudabeh Fazeli Dehkordy, MD MPH,[2] and Ruth C. Carlos, MD MS FACR[1,3,4]

Author information · Article notes · Copyright and License information Disclaimer

Abstract Go to:

Background

The proportion of the United States population with chronic illness continues to rise. Understanding the determinants of quality of care—particularly social determinants—is critical to the provision of care in this population.

Objective

To estimate the prevalence of housing and food insecurity among persons with common chronic conditions and to assess the independent effects of chronic illness and sociodemographic characteristics on (1) housing and food insecurity, and (2) health care access hardship and health status.

Key takeaways:

- 36.71% of the chronically ill experience housing insecurity.
- The presence of cardiovascular or lung disease increases the likelihood of experiencing housing insecurity by 69%.
- The presence of cardiovascular or lung disease increases the likelihood of experiencing housing insecurity by 75%.

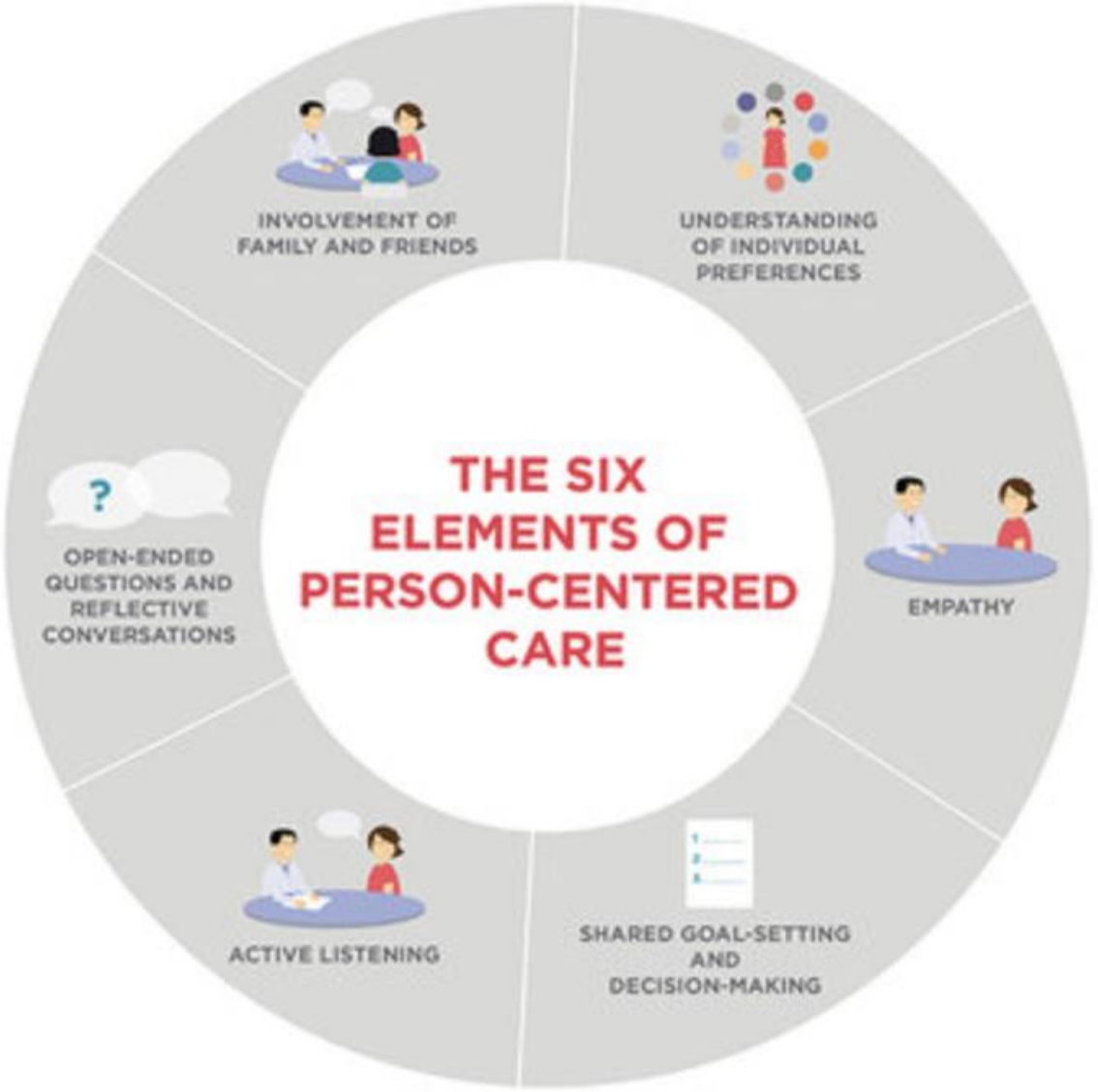
Link to Resource

Health and Housing: Evidence

Key takeaways:

- Access to safe, affordable housing is a major contributor to the SDOH.
- Poor access to these resources has an outsized impact on individuals experiencing chronic disease states.
- Supporting access to housing has a strong measurable impact on health outcomes.

Link to Resource



Six elements of Person-Centered Care

1. Involvement of Family and Friends.
2. Understanding of individual preferences.
3. Empathy.
4. Shared goal-setting and decision-making.
5. Active listening.
6. Open-ended questions and reflective conversations.

Link to Resource: [Ida Institute]

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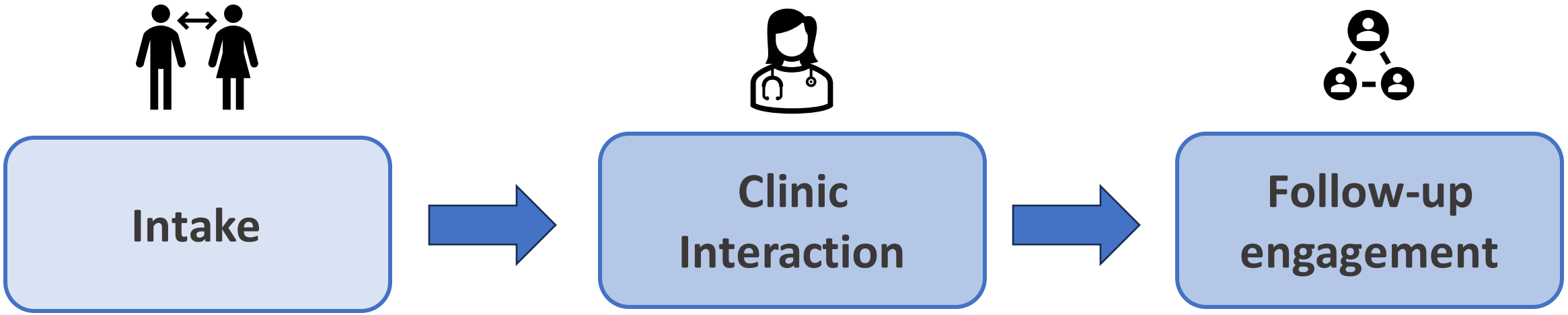
Screening for housing access: Outpatient framework



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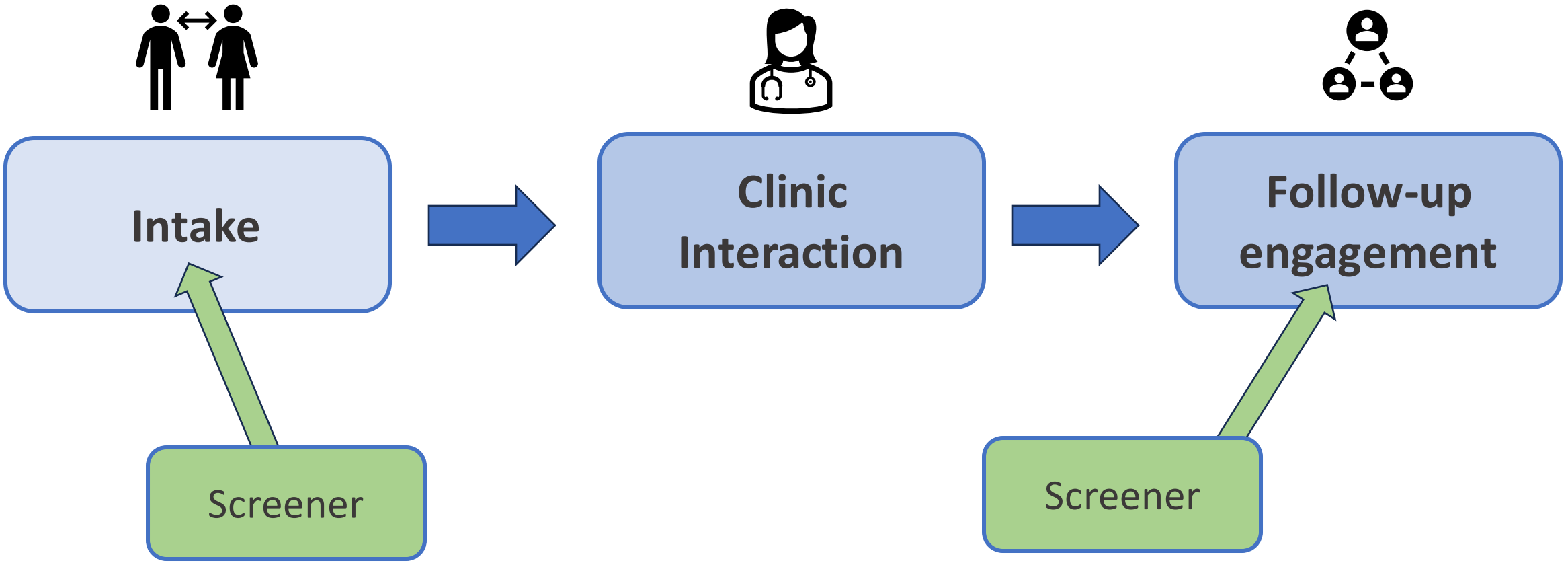

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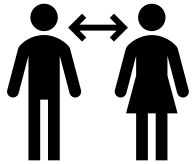
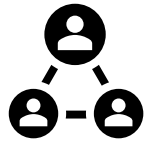
Screening for housing access: Inpatient framework



Standardized SDOH assessment

Physician makes referrals, integrates results into care



Patient seen by social services. Continuum planning.

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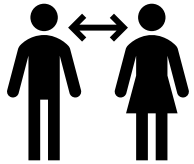
Screening for housing access: Inpatient framework



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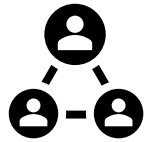

Patient seen by social services. Continuum planning.

Screener

Identify housing access issues with other SDOH concerns

Screener

Navigation to resources, coaching and continuum planning

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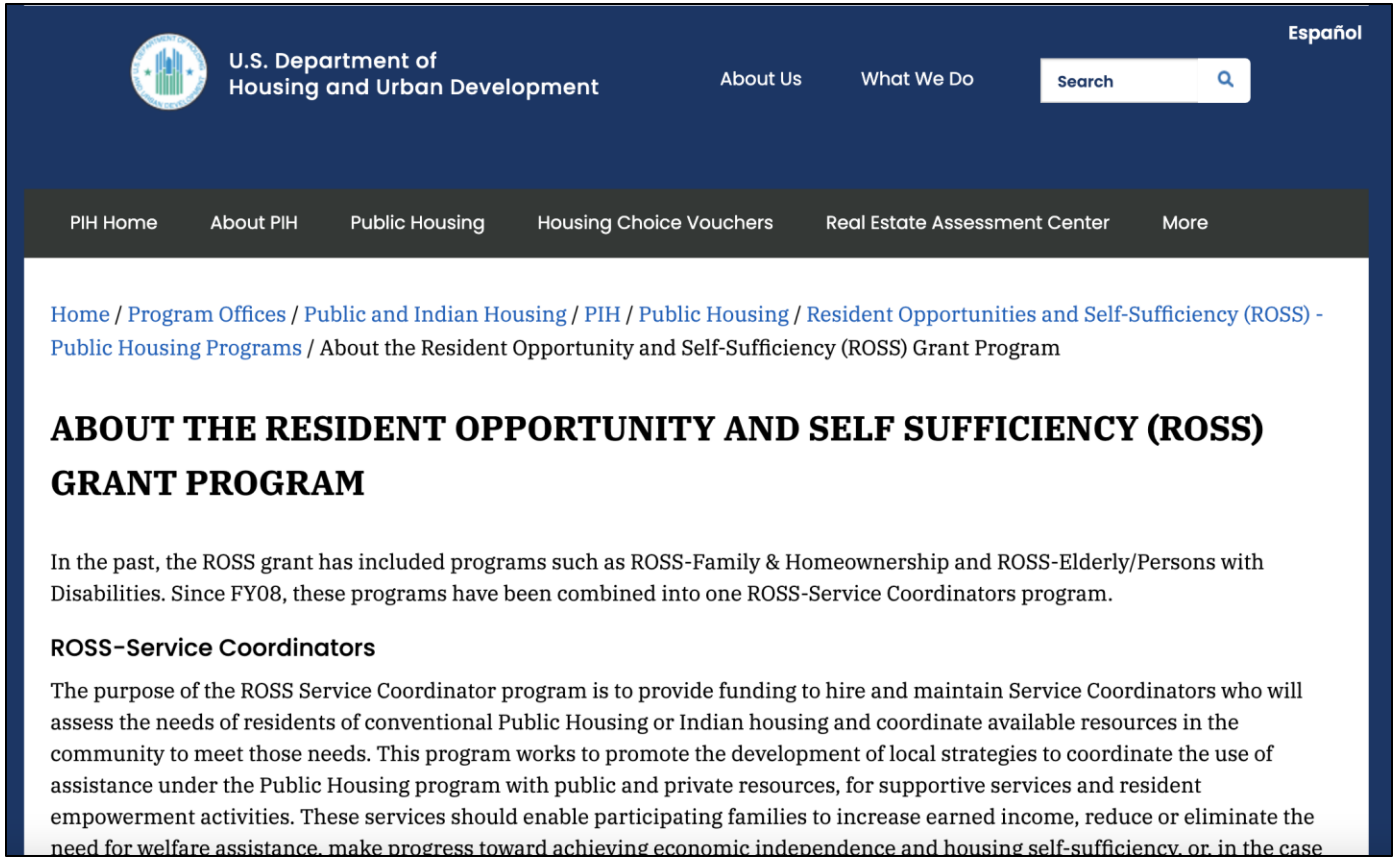
Promising practices for support housing access

1. Support HUD voucher recipients through strengthening partnerships with local property owners.
2. Form partnerships with local/regional ROSS-SC grant recipients.
3. Strengthen relationships with your local housing administration.
4. Support staff knowledge of the SDOH and their implications on your population.
5. Increase your understanding of community housing stock and limitations.
6. Support the expansion and development of CHW and related staff.

Link to Resource

Partnership Opportunities: ROSS-SC Grant Recipients



ROSS-SC Supports the following services:

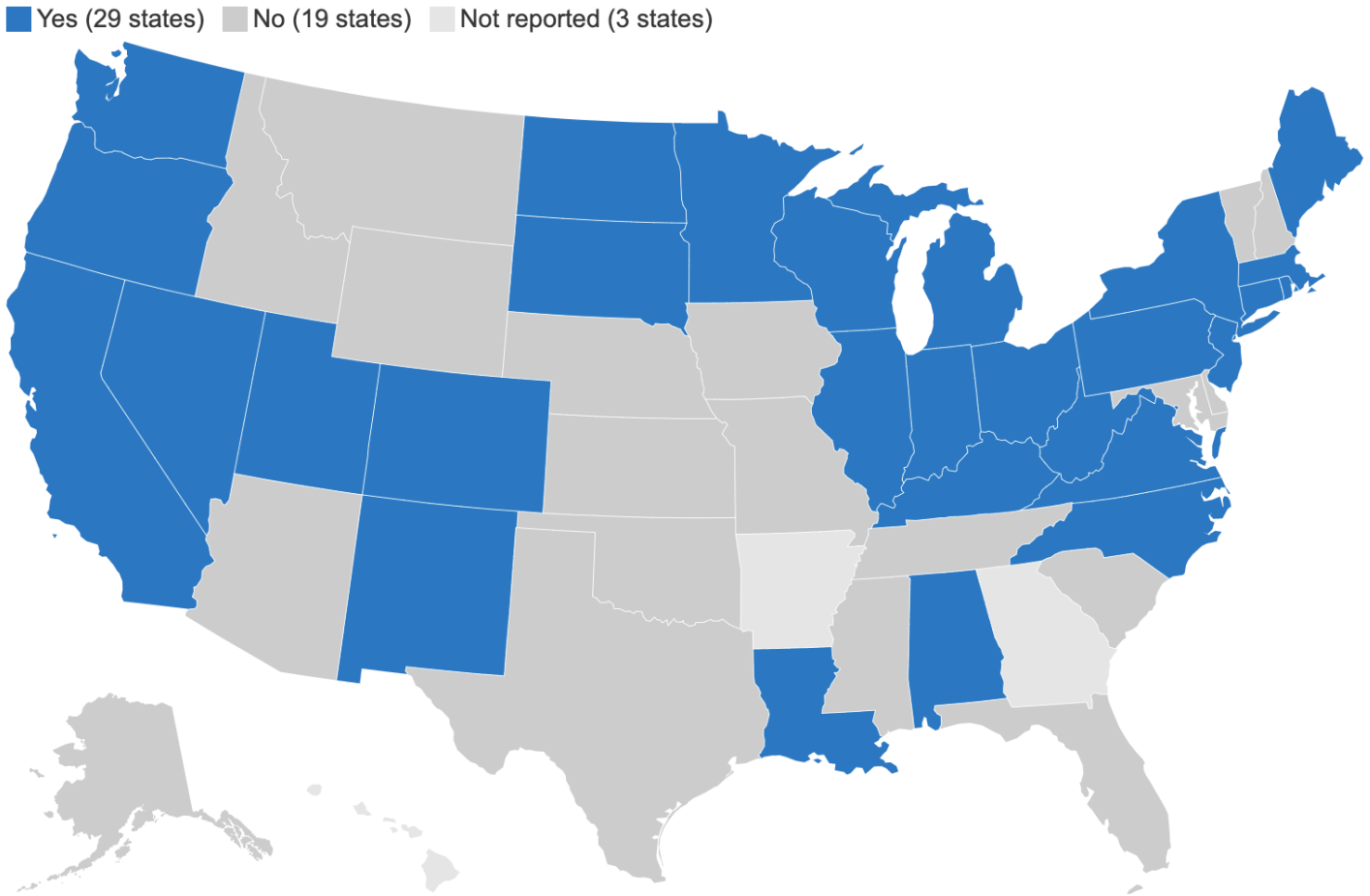
1. Resident Needs Assessments.
2. Coordination and Service Delivery.
3. Case Management/Coaching.
4. Resident Engagement.
5. Evaluation.
6. Reporting.

Link to resource: ROSS-SC grant program

Resource Download: ROSS Grant Recipient List

Figure 1

States that Allow Medicaid Payment for Services Provided by Community Health Workers (CHWs) as of July 1, 2022



NOTE: Arkansas, Georgia and Hawaii did not provide responses to this question.
SOURCE: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2022. • PNG

KFF

Link to Resource: KF Report

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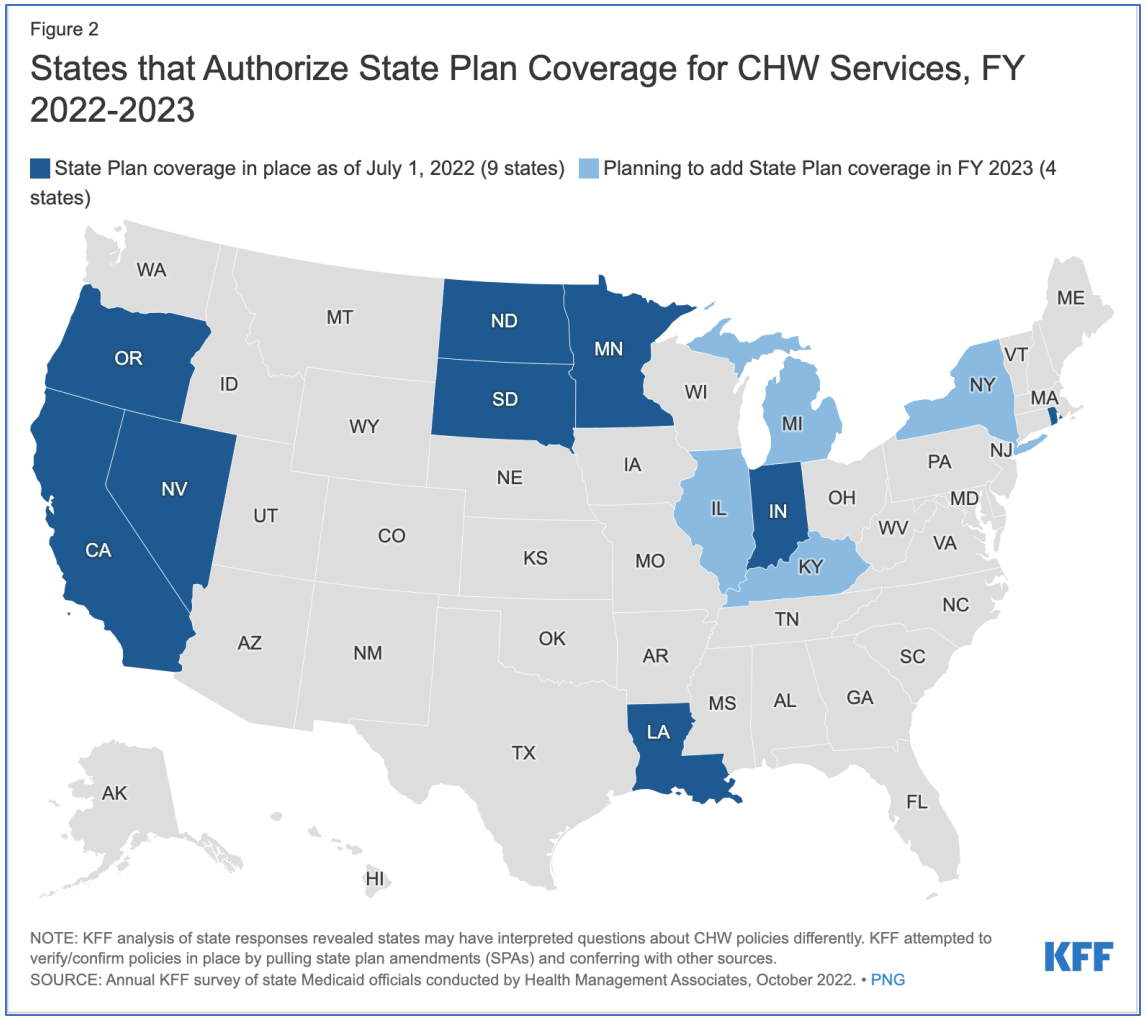
Funding CHW Staff:



Key takeaways:

- Nine states have authorized CHW funding through their state insurance plans for specific services.
- Four states (CA, LA, NV, RI) initiated this coverage in 2022.
- Four additional states (IL, KY, MI, NY) will begin implementing coverage in 2023.

Link to Resource: [KF Report]

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FY23 Omnibus Budget Bill (passed)

Sec. 1616. (1) By September 30 of the current fiscal year, **the department shall seek federal authority to formally enroll and recognize community health workers as providers and to utilize Medicaid matching funds for community health worker services, including the potential of leveraging of a Medicaid state plan amendment, waiver authorities, or other means to secure financing for community health worker services.** The appropriate federal approval must allow for community health worker services on a **statewide** basis and must not be a limited geography waiver. The authority should allow the application of community health worker services statewide and maximize their utility by providing financing that includes fee-for-service reimbursement, value-based payment, or a combination of both fee-for-service reimbursement and value-based payment for all services commensurate to their scope of training and abilities as provided by evidence-based research and programs.

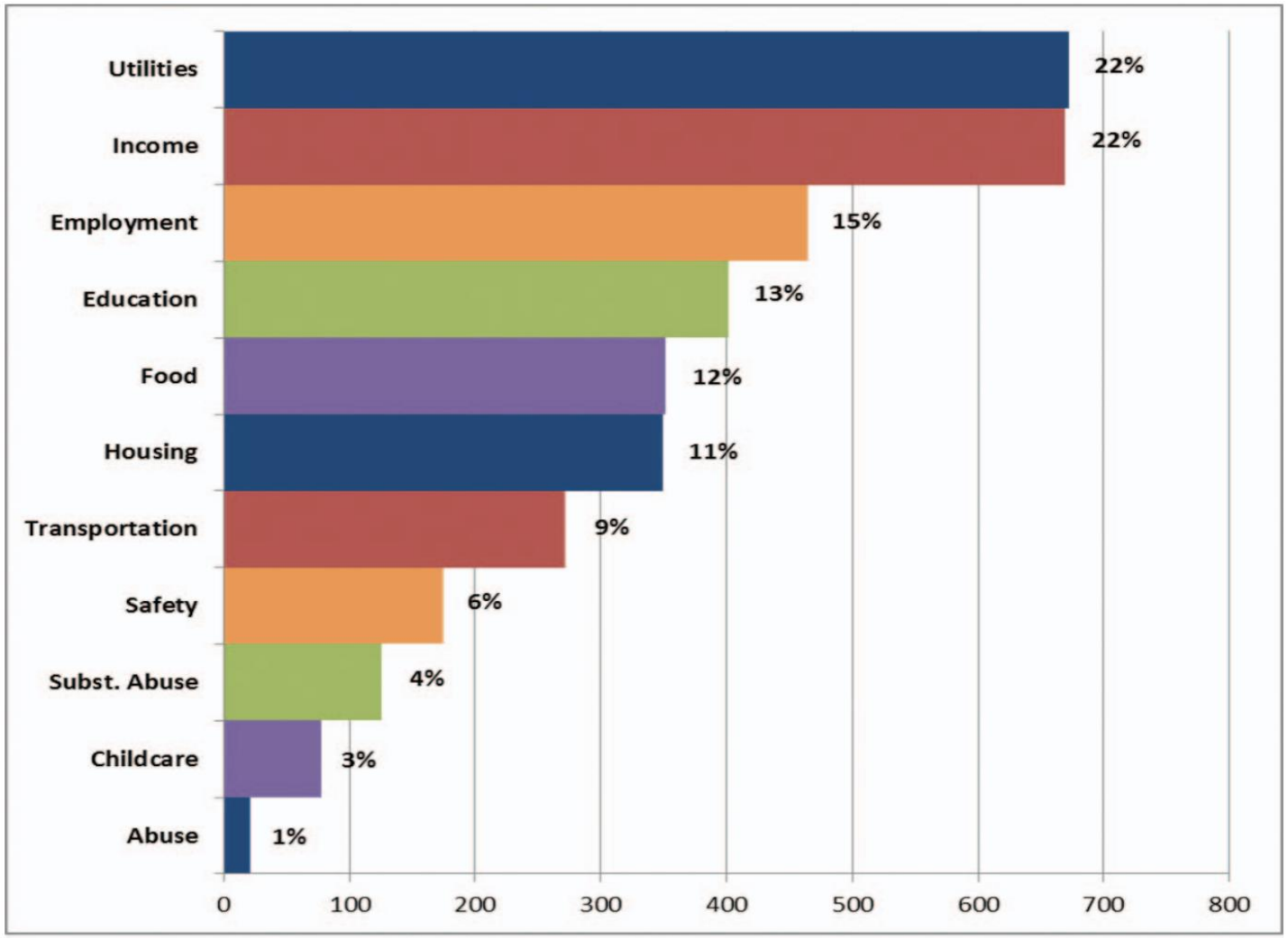
(2) By September 30 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office on the progress of meeting the requirements in subsection (1).

Link: To Resource

WellRx Pilot, University of New Mexico

[Link: To Publication]

WellRx Pilot, University of New Mexico



Institutional interest in SDOH policies

Grant to develop SDOH screening tool

Creation of screening tool using 11 domains

Integration with Community Health Workers (CHWs)

Tool Pilot with social services screening

[Link: To Publication]

Appendix

WellRx Questionnaire

DOB_____ Male___ Female _____

WellRx Questions

---

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?

_____ Yes _____ No

2. Are you homeless or worried that you might be in the future?

_____ Yes _____ No

3. Do you have trouble paying for your utilities (gas, electricity, phone)?

_____ Yes _____ No

4. Do you have trouble finding or paying for a ride?

_____ Yes _____ No

5. Do you need daycare, or better daycare, for your kids?

_____ Yes _____ No

Link: To Resource

_____ Yes _____ No

6. Are you unemployed or without regular income?

_____ Yes _____ No

7. Do you need help finding a better job?

_____ Yes _____ No

8. Do you need help getting more education?

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9. Are you concerned about someone in your home using drugs or alcohol?

_____ Yes _____ No

10. Do you feel unsafe in your daily life?

_____ Yes _____ No

11. Is anyone in your home threatening or abusing you?

_____ Yes _____ No

Link: To Resource

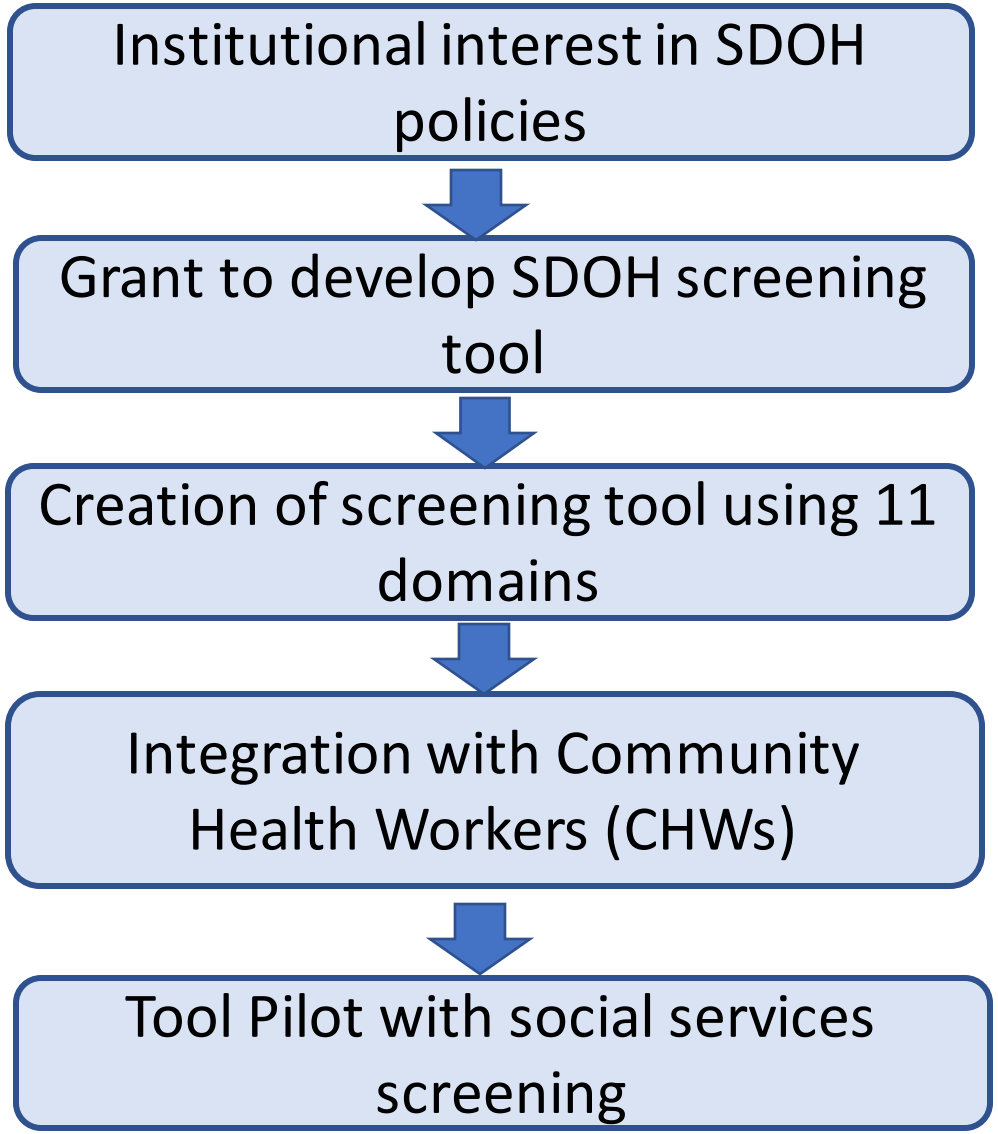
Discussion Question

Please take a moment to consider the following:

Your health center is considering altering an existing SDOH screener to improve information regarding housing access in your community.

This effort is in the context of an ongoing partnership between an FQHC and Housing Administration.

Which questions would you add to the screener to better assess housing access in your community?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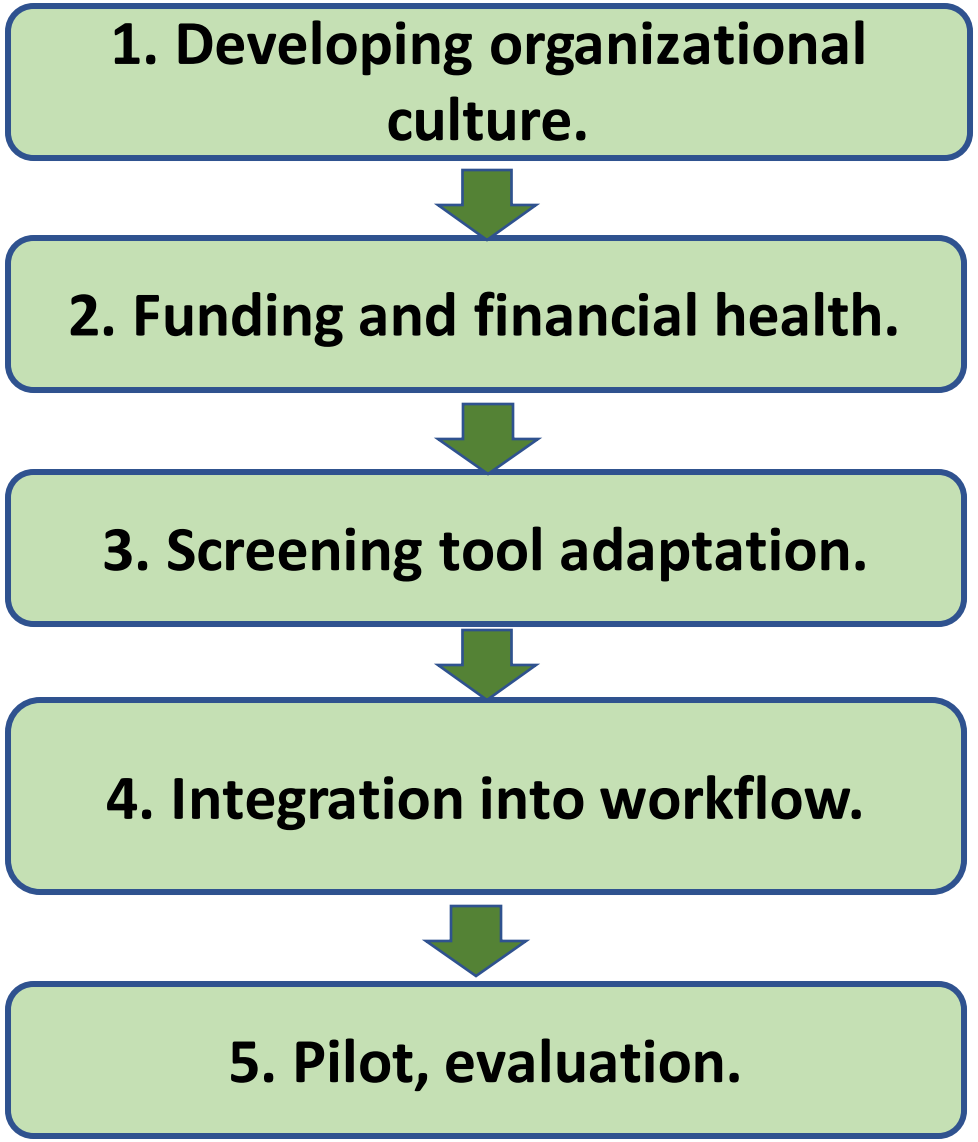
1. Developing organizational culture.
2. Funding and financial health.
3. Screening tool adaptation.
4. Integration into workflow.
5. Pilot, evaluation.

BRIEF | OCTOBER 2017

CHCS Center for Health Care Strategies, Inc.

Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations

By Caitlin Thomas-Henkel and Meryl Schulman, Center for Health Care Strategies

IN BRIEF

With the recognition that social determinants of health (SDOH) can account for up to 40 percent of individual health outcomes,[1] particularly among low-income populations, their providers are increasingly focused on strategies to address patients' unmet social needs (e.g., food insecurity, housing, transportation, etc.). This brief examines how organizations participating in *Transforming Complex Care* (*TCC*), a multi-site national initiative funded by the Robert Wood Johnson Foundation, are assessing and addressing SDOH for populations with complex needs. It reviews key considerations for organizations seeking to use SDOH data to improve patient care, including: (1) selecting and implementing SDOH assessment tools; (2) collecting patient-level information related to SDOH; (3) creating workflows to track and address patient needs; and (4) identifying social service resources and tracking referrals.

Compared to other industrialized nations, the United States spends much less on social services, and much more on health care.[2] This is true despite evidence that social determinants of health (SDOH) — including income, educational attainment, employment status, and access to food and housing — affect an array of health outcomes,[3] particularly among low-income populations.[4] Individuals with unmet social needs are more likely to be frequent emergency department (ED) users, have repeat 'no-shows' to medical appointments, and have poorer glycemic and cholesterol control than those able to meet their needs.[5]

[Link: To Publication]

Takeaways:

Screening tools should be adapted to meet the following:

- Capacity to address specific SDOH needs.
- Availability of local resources and referral networks.
- Ease of use within clinical setting (workflow).
- Ability of tool to capture needs the organization can realistically address.

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Q&A Session

Upcoming Webinars

- **Lead Screening and Housing Partnerships: Leveraging resources to improve population health**
  - Tuesday, June 27th, 2023 at 1:00 pm EDT
  - Registration link: https://us06web.zoom.us/webinar/register/WN_2ZA9vcA5TuKuhQJmkDqIdA

- **Community Health Worker (CHW) Workforce Development: Methodologies for CHW use in addressing the SDOH in vulnerable populations**
  - Wednesday, June 28th, 2023 at 1:00 pm EDT
  - Registration link: https://us06web.zoom.us/webinar/register/WN_B-hMEFzLQ5uq91Yh2JJE7g

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Complete our Post Evaluation Survey

https://www.surveymonkey.com/r/YXCMWR5

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Thank you!