Impacts of Housing Instability on the Health of Vulnerable Populations

The National Center for Health in Public Housing

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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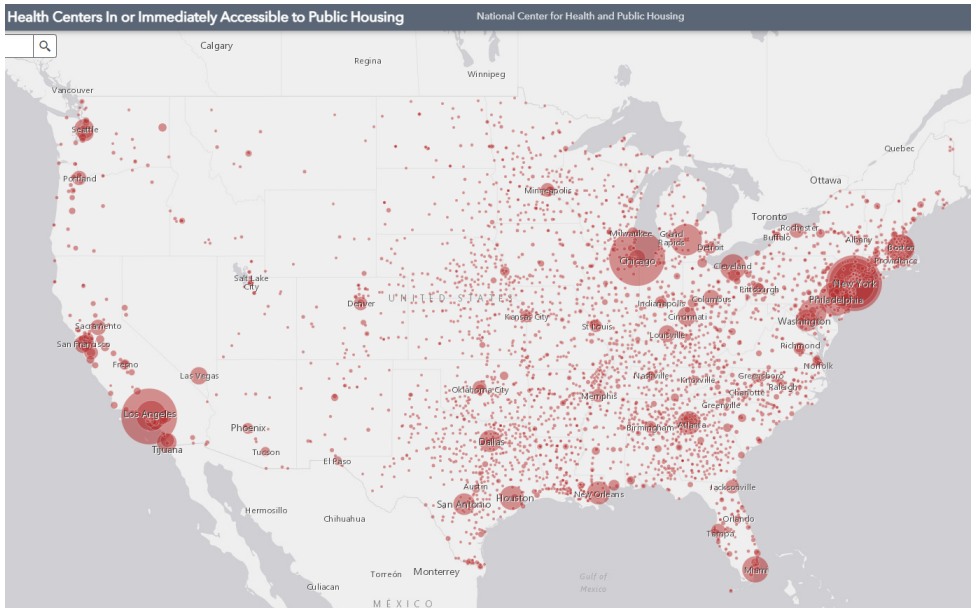
Health Centers Close to Public Housing

- 1,370 Federally Qualified Health Centers (FQHC) = **30.5 million patients**
- 483 FQHCs In or Immediately Accessible to Public Housing = **6.1 million patients**
- 107 Public Housing Primary Care (PHPC) = **935,823 patients**

Source: 2022 Health Center Data



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

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Today's Speakers

Kevin Lombardi MD, MPH
Manager of Policy, Research, and Health Promotion

Fide Pineda Sandoval, CHES
Manager of Training & Technical Assistance

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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

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Impacts of Housing Instability on the Health of Vulnerable Populations

This session will include the following material (overview):

1: Review data and scholarship which describes the clinical and non-clinical challenges faced by HUD-assisted families and residents of public housing.

2: Describe how health centers and PHA's can utilize Community Health Workers (CHWs) to support HUD-assisted families and residents of public housing.

3: Examine case studies that elucidate the impact of addiction, chronic disease and social marginalization on vulnerable patients.

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This session is designed to illicit discussion, process sharing and support between colleagues. The session framework will reflect these priorities. The – Discussion – Support – Assistance model describes NCHPHs approach to Training and Technical Assistance

Discussion

- Two discussion questions are integrated into the session material.
- Participants are asked to please write or type their response and to be open to share.

Support

- Participants include a range of clinical and non-clinical professionals from FQHC's, PHPCs and PHAs around the country.
- This interdisciplinary support can be an asset to better understanding the challenges your organization is facing.

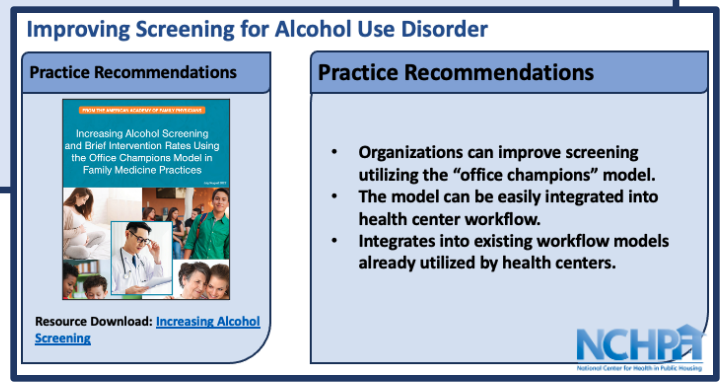
Assistance

- Discussion session format is designed to illicit the main themes in the learning objectives and are related to the resources and recommendations reviewed in this session

NCHPH presentations are designed to be utilized as external resources by FQHCs PHPCs and PHAs these can be freely circulated to partners and colleagues as needed.

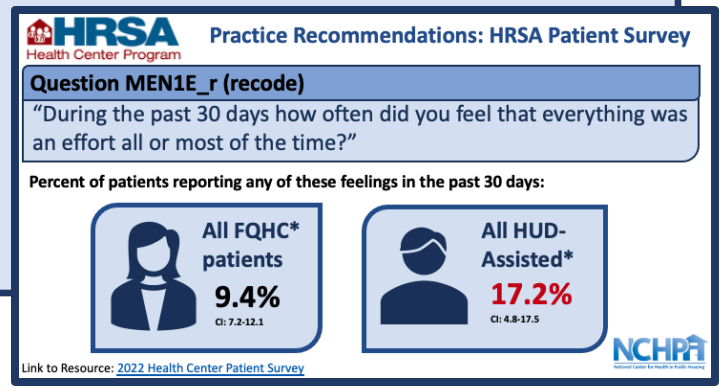
Research and Clinical Resources

- Cited resource links are located at the bottom right of the slides.
- Resources are publicly available and can shared internally or externally.
- Cited research is investigated and validated during a structured review process.



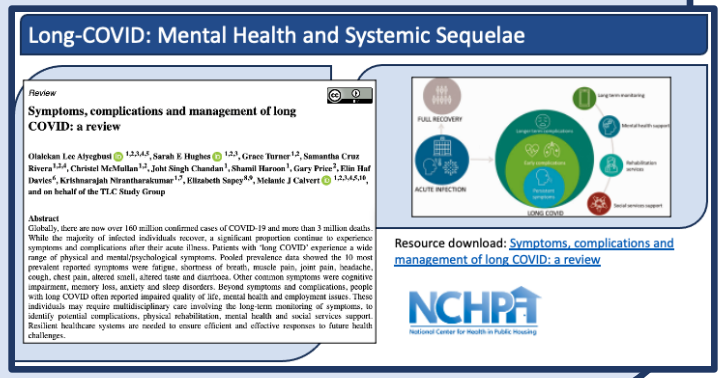
Guidance and Recommendations

- Recommendations are based on NCHPH internal research or validated external research.
- Practice recommendations presented are reviewed and validated by the NCHPH team.



Support and Consultation Resources

- NCHPH staff members and SMEs are available to FQHCs, PHPCs, PHAs and partner organization for consulting and advising services.



Link to Resource: NCHPH

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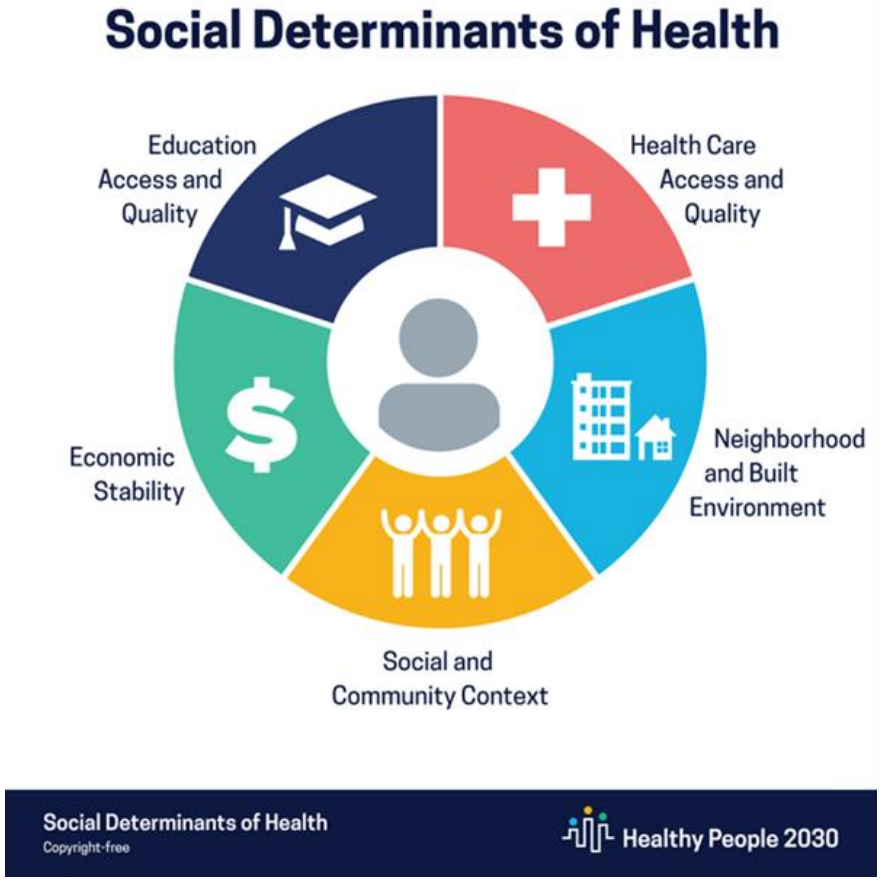
Learning Collaborative Session 3

Please take a moment to type your response to the following:

Where are you joining us from?

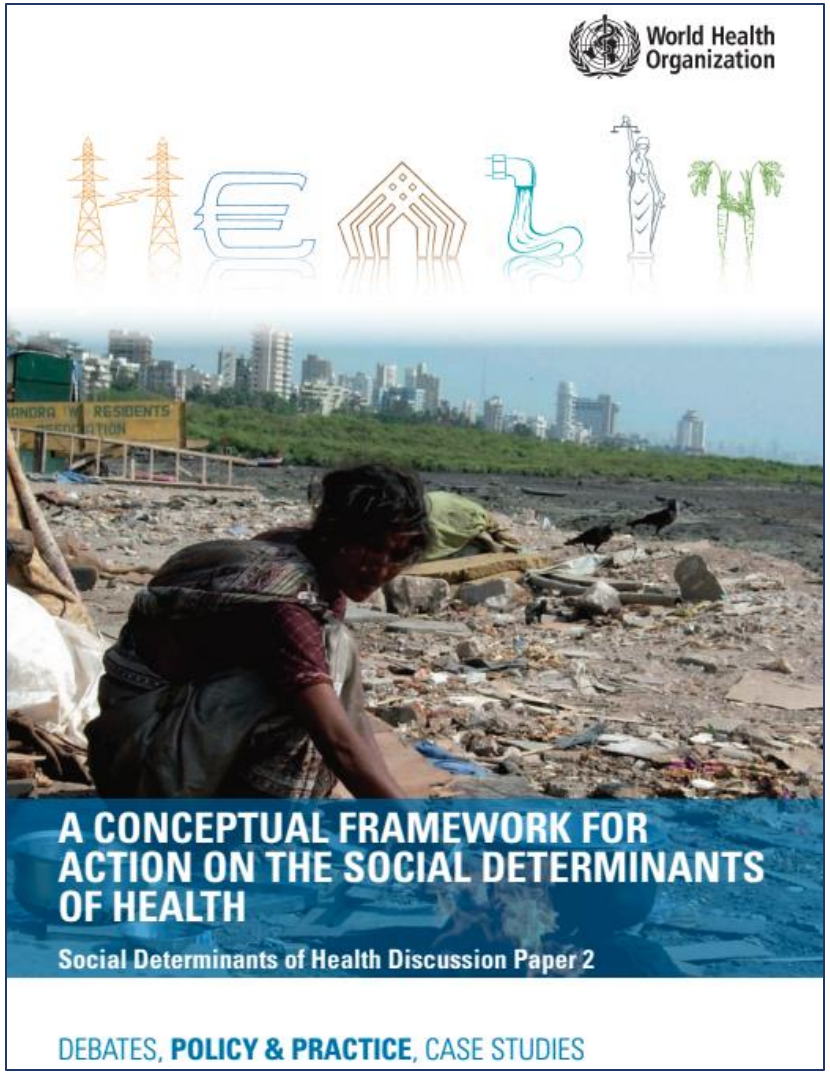
What is your role at your organization?

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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Emotional Wellbeing and Housing Status: 2022 HRSA Health Center Patient Survey

n (weighted) = 27,224,243

Symptoms reported in past 12 months	All other Housing (%)	95% CI	All HUD-assisted* (%)	95% CI	*p*	Public Housing (%)	95% CI	*p*
Any feelings of worthlessness				13.7-30.1		26.1	15.0-41.4	0.046
Any feelings that everything is			43.1	32.4-54.6	0.009	40.7	27.5-55.4	0.13
Feeling everything is an effort of the time			17.2	10.9-23	0.012	9.4	4.8-17.5	0.86
Any feelings of hopelessness			24.1	16.1	0.17	29.5	17.5-45.4	0.06
Feeling hopeless most or all of the time			5.4		0.4	5.4	1.7-15.5	0.58
Any feelings of restlessness or fidgeting	34.3	29.6-39.4	4		067	41.3	27.6-56.6	0.35
Any feelings of nervousness	39.12	34.3-44.1	4		07	39.5	26.9-53.7	0.9
Feeling nervous all or most of the time	8.3	6.3-10.9	10.9		0.28	12.7	6.3-24.0	0.24
Any feelings of extreme sadness	29.1	25.2-33.3	41.1	31.6-51.3	0.013	44.6	30.1-60.1	0.034

95% Confidence Interval (95% range of real possibility)

P – value (statistical significance)

** Includes Section 8 Voucher, Housing Choice Voucher, Project-based Section 8 and other HUD PH programs*

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Any feelings of hopelessness	18.3	15.2-21.7	24.1	16.1-34.5	0.17	29.5	17.5-45.4	0.06
Feeling hopeless most or all of the time	3.8	2.6-5.6	5.4	2.5-11.2	0.4	5.4	1.7-15.5	0.58
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All patients (reference group)

All HUD-assisted (comparison group 1)

Public housing only (comparison group 2)

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Practice Recommendations: HRSA Patient Survey

Question MEN1B_r (recode)

"During the past 30 days how often did you feel that everything was an effort"

Percent of patients reporting any feelings of nervousness in the past 30 days:

All FQHC* patients

29.8%

CI: 25.4-34.5

All HUD-Assisted*

43.1%

CI: 32.4-54.6

Link to Resource: [2022 Health Center Patient Survey]

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Practice Recommendations: HRSA Patient Survey

Question MEN1E_r (recode)

"During the past 30 days how often did you feel that everything was an effort all or most of the time?"

Percent of patients reporting any of these feelings in the past 30 days:

All FQHC* patients

9.4%

CI: 7.2-12.1

All HUD-Assisted*

17.2%

CI: 4.8-17.5

Link to Resource: 2022 Health Center Patient Survey

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Practice Recommendations: HRSA Patient Survey

Question MEN1a (recode)

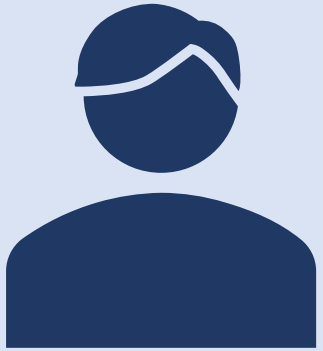
"During the past 30 days, how often did you feel so sad that nothing could cheer you up?

Percent of patients reporting these feelings in the past 30 days:

All FQHC* patients

29.1%

CI: 25.2-33.3



All HUD-Assisted*

41.1%

CI: 31.6-51.3

Link to Resource: [2022 Health Center Patient Survey]

Program Interventions and Development for Service Delivery

Become a partner: Research indicates that utilizing CHW-based coaching and navigation resources can provide the comprehensive SDOH

Know your environment: Housing instability necessitates a comprehensive. Research indicates that improving partnerships with social support organizations is key to improving service delivery.

Focus on Cultural Competency and diversity: Patients are more likely to accept help when it is advertised and provided in a culturally competent manner.

There are a variety of measures that facilities and providers can utilize to support patients with housing instability

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The use of SDOH Screening tools: Application

When planning implementation of a new screener:

1. Examine organization structure and workflow.
2. Identify key patient care interactions.
3. Consider data collection.
4. Consider workflow integration.
5. Consider screener design.

When planning revision of an existing screener:

1. Examine organization structure and workflow.
2. Examine locations where SDOH data is collected.
3. Examine impact of SDOH screener on workflow and patient care

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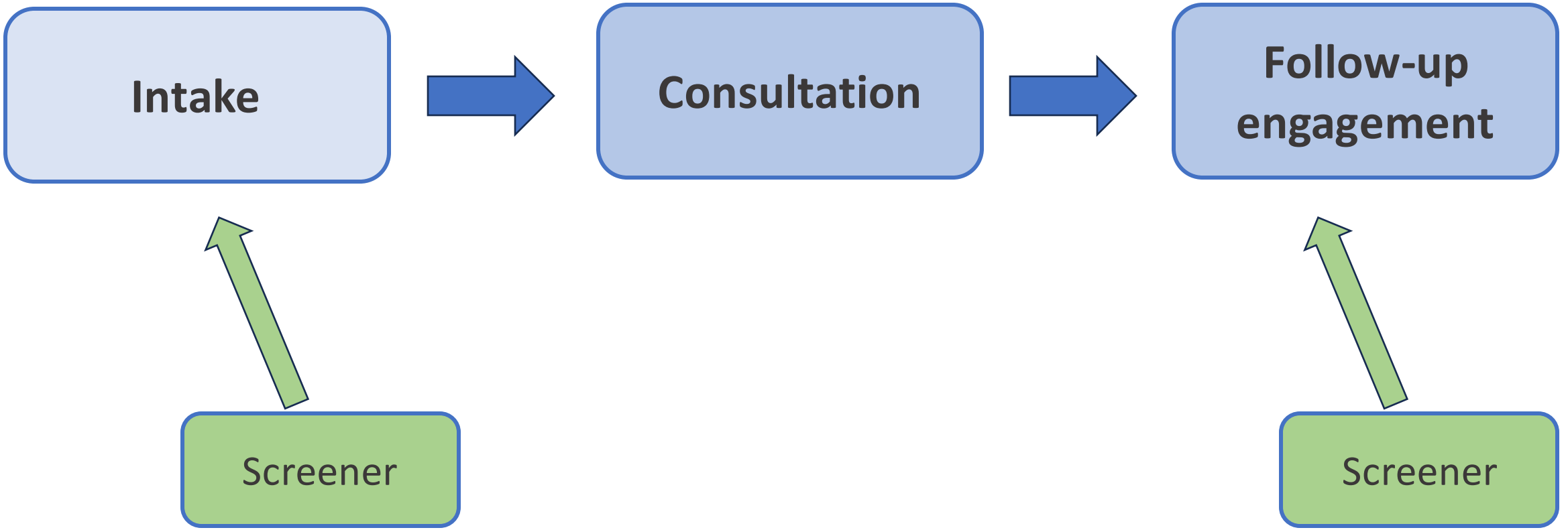

Model 1: Integration of CHW and Social-Services into inpatient workflow.

CHW performs standardized SDOH assessment

- Assessment performed using standardized tool.
- Tool results added to patient's file or entered directly into EHR.
- Patient educated regarding resources and access.

Physician makes referrals, integrates results into care

- Using form data, physician integrates data into patient care.
- Physician approves referral to social services.

Patient seen by social services

- Patient consulted regarding available resources they qualify for.
- Patient assisted in resource application process.

Link: To Publication

Case Study: Continuity of Care to Support Behavioral Health

Intake

- *Relationship building Screening*
- *Networking.*

Goal Setting

- *Goals set during SDOH Screening.*

Follow-up engagement

- *Keeping focus on goals.*
- *Encouragement and networking.*

Navigation

- *Relationship building, Screening*
- *Networking.*

Coaching

- *Relationship building Screening*
- *Goal achievement.*

Case Closure

- *Closure when all goals are achieved.*

Case Study: Supporting Patients with Housing Instability

Mr. Rossi is a 57 year-old man who presents for a wellness exam. He has a past medical history of T2DM, and hypertension. The patient has a behavioral health history of Major Depressive Disorder (MDD), post-traumatic stress disorder (PTSD) Generalized Anxiety Disorder (GAD) and Tobacco Use Disorder (remission for 1 years as of 2018). Mr. Rossi is a combat veteran –with a history of adverse combat experience in 2007). Your health center has a large veteran population and is in the suburban area of a medium-sized city. Mr. Rossi identifies as white and Italian-American and a practicing Roman Catholic.

The patient undergoes a standard intake, including vitals and an SDOH screener. The results are as follows:

BP: 178/98
HR: 92
RR: 18

A review of Mr. Rossi' medical records indicates the following:

Vitals (2018):
BP: 138/98
HR: 60
RR: 18

HbA1c: 7.0
Drug Screen: Pan-negative

Prescribed Medications: Metformin, Chlorothiazide, Citalopram (Celexa)

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The results of Mr. Rossi' SDOH screener reveal the following:

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

National Center for Health in Public Housing

_____ 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?

_____ Yes ☑ No

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

National Center for Health in Public Housing

Case Study: Supporting Patients with Housing Instability

Mr. Rossi is treated by his provider, who is also a combat veteran. Upon physical examination Mr. Rossi is noted to be withdrawn and to exhibit closed body language. His responses are terse, and he seems irritated. His physical examination is positive for 1+ pitting edema and darkened skin around his neck and groin area. New results are positive for an HbA1c of 8.2

When Questioned Regarding the Results of His SDOH Screener Mr. Rossi Reveals the following:

1. Mr. Rossi worked as a welder until 3 months ago when he was laid off. He has 2 months of unemployment available.
2. He is behind on his utilities and his Truck is unreliable. He uses uber and walks for transportation.
3. Mr. Rossi reports more frequent "panic attacks" in the past six months (3 x per week vs 1x per month one year ago)
4. Mr. Rossi is single and does not have any family in the area.
5. Mr. Rossi receives a 20% disability payment from the US Army every. Month.
6. Mr. Rossi has been taking a half dose of his prescription medications because he can no longer afford the medication.

Mr. Rossi is asked if he is interested in treatment for his behavioral health conditions or SDOH issues (including housing instability) but avoids answering the question. When questioned **he notes that he prefers to deal with his private life by himself. When asked why he notes that in the past he has had difficulty connecting with his providers and that he felt judged.**

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Addressing Learning Objective 3

Case Study: Supporting Patients with Disabilities

Please take a moment to write or type your response to the following:

What is your assessment of Mr. Rossi' clinical condition? Is it getting worse or better? Why?

How could a patient like Mr. Rossi be encouraged to seek supportive services?

Case Study: Supporting Patients with Housing Instability

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☑ Yes ☐ No

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☑ Yes ☐ No

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☑ Yes ☐ No

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☑ Yes ☐ No

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

☐ Yes ☑ No

Link: To Resource

National Center for Health in Public Housing

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Link: To Resource

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5. Mr. Rossi receives a 20% disability payment from the US Army every month.
6. Mr. Rossi has been taking a half dose of his prescription medications because he can no longer afford the medication.

Mr. Rossi is asked if he is interested in treatment for his behavioral health conditions or SDOH issues (including housing instability) but avoids answering the question. When questioned **he notes that he prefers to deal with his private life by himself. When asked why he notes that in the past he has had difficulty connecting with his providers and that he felt judged.**

National Center for Health in Public Housing

Case Study: Supporting Patients with Housing Instability

Mr. Rossi is contacted by a staff member that works for your facility. He initially refuses assistance. The CHW offers the following resources, which lead to Mr. Rossi agreeing to an initial consultation.

1. Consultation via Telehealth

2. A community-based, veteran CHW

Mr. Rossi meets his CHW via the facility telehealth mobile application. In the beginning of his appointment Mr. Rossi has a short introductory session with his CHW, who uses the following techniques to make Mr. Rossi more comfortable during his visit.

Link to resources: Health Assessment Interview Techniques

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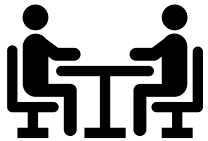
Case Study: Supporting Patients with Housing Instability

Mr. Rossi' CHW utilizes the following techniques to facilitate his interview.

Active listening: Fully comprehending the client response through verbal and nonverbal cues, including client emotional state. Complete concentration on the client

Adaptive questioning: Starting with general questions, then becoming more specific.



Nonverbal communication: Staying in-tune with client posture and body language.

Link to resources: [Health Assessment Interview Techniques]

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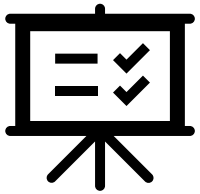
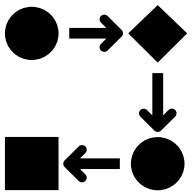
Case Study: Supporting Patients with Housing Instability

Mr. Rossi's CHW utilizes the following techniques to facilitate his interview (continued)



Empathy, validation, reassurance: Telling the client that their emotions are reasonable

Partnering and summarization: Playing a coach-like role with the patient, talking-back the patient responses to ensure they are and feel understood.



Transitions and empowerment: Letting the client know what steps are next can help to lower provider and client anxiety.

Link to resources: Health Assessment Interview Techniques

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Case Study: Supporting Patients with Housing Instability

During consultation Mr. Rossi' CHW utilizes the Framework of the SDOH to determine facility resources to meet his needs:

Education Access and Quality:

- *Veteran's vocational training program.*

Health Care Access:

- *Free transportation to health center via facility van service. Appointment reminders via facility appointment mobile application and text.*
- *Medications paid by VA benefits.*

Neighborhood and Built Environment:

- *Utilities vouchers provided from a local community-based organization.*
- *Social worker contacts utilities for discontinuation support.*
- *Medical-legal assistance for eviction support*

Link to resources: Jobs Plus Initiative

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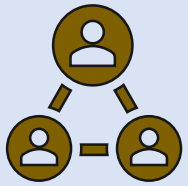
Case Study: Supporting Patients with Housing Instability

During consultation Mr. Rossi' CHW utilizes the Framework of the SDOH to determine facility resources to meet his needs:

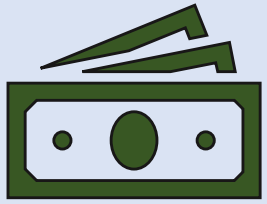
Social and Community Context:



- *Local veteran social group.*
- *Tobacco cessation literature and resource pamphlets.*
- *Regular (bi-monthly) tobacco cessation check-ins*

Economic Stability:

- *Training and support services through facility Jobs Plus Site.*
- *Veterans peer-support group at local church.*



Link to resources: [Jobs Plus Initiative]

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Addressing Learning Objective 3

Case Study: Supporting Patients with Housing Instability

Please take a moment to write or type your response to the following:

What programs or interventions would you recommend for Mr. Rossi?

What is a program mor service at your institution that would be helpful in supporting Mr. Rossi' SDOH needs?

Q&A Session

Complete our Post Evaluation Survey

National Center for Health in Public Housing

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Thank you!