HEALTH AND HOUSING SERIES

NATIONAL HOUSING CONFERENCE

Promising Health and Housing Collaborations

by The National Housing Conference | July 2019

A prominent and growing body of research shows that health outcomes improve for people who have access to housing.[1,2] At the most basic level, people experiencing homelessness are better able to manage chronic diseases like diabetes and AIDS when properly housed. Better management of chronic diseases leads to a reduction in the net cost of medical care. Living in unaffordable housing requires budget tradeoffs that can compromise medical care. When paying the rent requires delaying the filling of a needed prescription, the long-term cost is compounded. Hospitals and taxpayers pay the ultimate financial price for the failure to manage acute and chronic care effectively.

Against this backdrop, healthcare organizations are increasingly looking for ways to reduce medical claims and affordable housing stands out as ripe for investment. The opportunities for partnership and investment are as deep as the demand for affordable housing. This report highlights three exemplary cases of health and housing collaboration to build and maintain affordable housing. The report also discusses challenges to this collaborative work and potential solutions.

Funded by a grant from the Kresge Foundation, the National Housing Conference (NHC) convened a series of health and housing working group meetings to bring together practitioners from both the nonprofit and for-profit affordable housing sphere with health care organizations. The objective was to explore practical and actionable ways that housing developers can work together with health systems and managed care organizations to build new affordable housing units while reducing unreimbursed medical costs in high-cost populations. Over the course of nine months, the group worked to identify the necessary next steps in order to foster more direct investment by health organizations in affordable housing, while identifying challenges that continue to require mitigating strategies.

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Featured Partnerships

Portland, Oregon Housing is Health Initiative

Tennessee Creating Homes Initiative

Massachusetts Housing and Health Pilot Program

Program Profiles

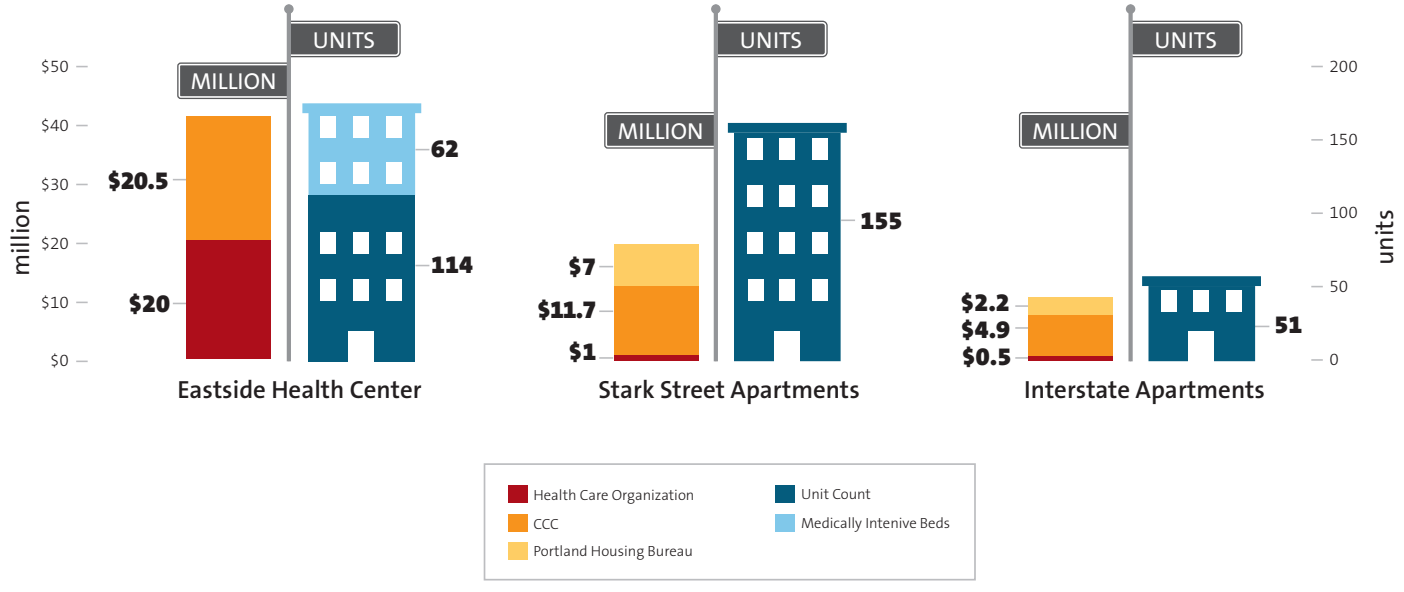
The following examples, drawn from conversations with working group members, illustrate the wide variety of partnerships between health and housing organizations. While they have overlapping goals and characteristics, each has a unique history that shapes how they developed. One thread that runs through all the partnerships is the significant amount of time it takes to develop relationships. Oftentimes, these partnerships start with small collaborations, like data-sharing agreements, and over the course of many years of working together develop into financial alliances. Building trust and learning to effectively communicate across industries is an important element of implementing similar programs. Successful projects often bring together partners from various government agencies, nonprofit and for-profit housing providers as well as healthcare organizations like hospitals and health insurers. No single entity can tackle the challenges around health and housing alone but through their shared strengths and resources, progress is being made.

Portland, Oregon Housing is Health Initiative.

The Housing is Health Initiative in Portland, Oregon is led by Central City Concern (CCC). CCC brought together six healthcare organizations (Adventist Health Portland, CareOregon, Kaiser Permanente Northwest, Providence Health & Services–Oregon, Legacy Health and the Oregon Health and Science University) to pool resources to build affordable housing. Together, the healthcare organizations invested $21.5 million in three different affordable housing developments, each of which serves a specific and unique population. In total, the $21.5 million will help fund 382 new units of housing, which are further described in Figure 1.

By bringing local healthcare organizations together to invest collaboratively, CCC was able to mitigate concerns of health insurers and hospitals that investments would need to target their members and frequent patients in order for them to see a return on their investment. Of the six groups, five represent the major local hospitals and one is a health insurance provider. All of the hospitals receive community benefit credit, as required by the Affordable Care Act and discussed later in this brief, for their investments. Rachel Solotaroff, president and CEO of CCC, said of the initiative, "if we're not all in, then this won't work. There was a bit of healthy competition to get everyone to participate."

Figure 1



Stark Street Apartments in Portland

Courtesy of Ankrom Moisan

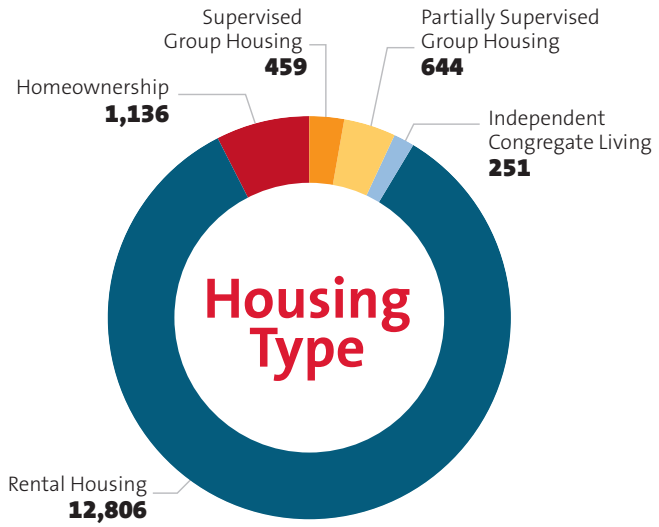
No single entity can tackle the challenges around **health** and **housing alone.**

To build support for this approach, CCC's then-CEO Ed Blackburn went on a boardroom "road show" to describe the importance of affordable housing and develop mission buy-in. CCC also recruited representatives from healthcare organizations to serve on their own board of directors. Of the 16 members of CCC's current board of directors, four are from healthcare organizations, including the chair. These board members would be able to advocate within their own organizations for partnership and investment in CCC. This kind of buy-in at the leadership level was critical to launching the investment partnership.

CCC has purchased a significant amount of land throughout Portland over its nearly 40-year history. When presenting proposals to the investor group, CCC's combination of pre-purchased land and shovel-ready projects helped to solidify the proposals. Many healthcare players are new to affordable housing and may not care to learn the complexities of tax credit financing and architecture. Having CCC take a leadership role in these areas allowed the healthcare organizations to focus on the health needs of the residents and design a well-thought-out health clinic.

Moving forward, the healthcare organizations will meet quarterly to discuss project updates. They have also partnered with the Center for Outcomes Research and Evaluation (CORE) to conduct a program evaluation. In addition to designing the health clinic, the group is designing medically intensive respite and palliative care beds at the Eastside Health Center. If this initial investment proves to be successful, it will help lay the groundwork for future investments both in Portland and around the country.

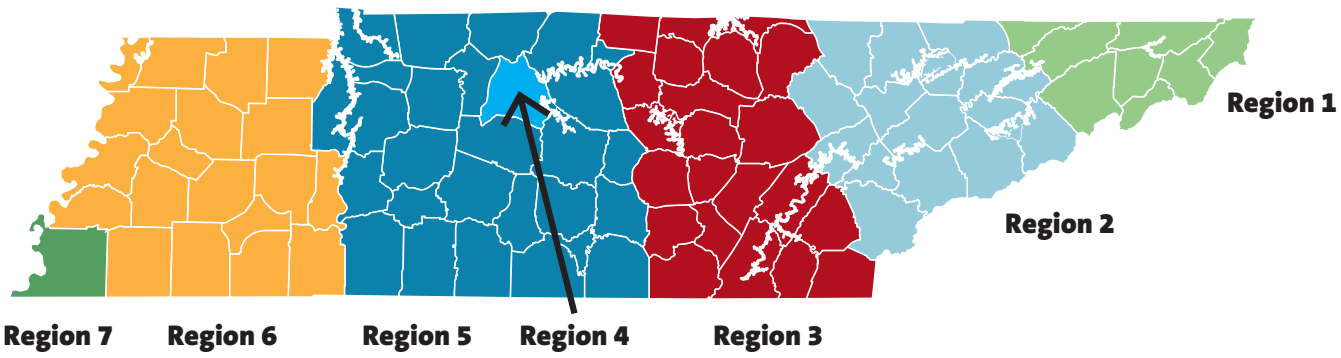
Figure 2



Tennessee Creating Homes Initiative. The Creating Homes Initiative (CHI) is led by the Tennessee Department of Mental Health and Substance Abuse Services. The Tennessee Department of Mental Health and Substance Abuse Services employs seven regional housing facilitators across the state who each are responsible for developing 600 – 700 new housing opportunities each year in their region. The regional housing facilitators are experts in grant writing and affordable housing development. From 2001 to 2016, they have developed 15,296 new affordable housing opportunities. The types of housing range from independent living options to more supervised settings, with the majority of the housing being independent living options under rental and homeownership as described in Figure 2. The housing is owned and operated by local agencies, usually mental health service providers or affordable housing agencies. Impressively, the number of psychiatric hospitalization days in the year post-move-in has dropped by an average of 87 percent compared to the prior year.

CHI launched in 2000 and soon thereafter, President George W. Bush's New Freedom Commission on Mental Health found that "the lack of decent, safe, affordable, and integrated housing is one of the most significant barriers to full participation in community life for people with mental illnesses" and "housing is, perhaps, the first line of treatment for people with serious mental illness."[3] This spotlight on the role of housing in the treatment of people with mental illnesses empowered the Tennessee Department of Mental Health and Substance Abuse Services to continue CHI and expand permanent supportive housing opportunities.

CHI benefited from strong leadership that advocated for funding and guided it through the early years. The state initially allocated $2.5 million to fund four regional housing facilitators at the Tennessee Department of Mental Health and Substance Abuse Services. The Tennessee Housing Development Authority then put $2 million towards the initiative. The initiative has enjoyed continued support despite new governors and leadership changes across the various agencies. The funding to build and operate the housing comes from a wide variety of sources including grants from the Tennessee Department of Mental Health and Substance Abuse Services, grants from the Affordable Housing Program run by the Federal Home Loan Banks, HUD programs, Tennessee Housing Development Agency programs, U.S. Department of Agriculture rental assistance programs, the Low Income Housing Tax Credit and donations.



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Massachusetts Housing and Health Pilot Program. While this pilot has yet to formally launch, it nonetheless offers a promising example of a collaboration that can help more seniors age in place. LeadingAge Massachusetts and the Long-Term Quality Alliance (LTQA) are designing a pilot project that will bring together housing providers and health plans to deliver coordinated services and supports to residents of affordable senior housing communities in Massachusetts. This statewide initiative pools the funding from health insurers in the Senior Care Options program and Program of All-Inclusive Care for the Elderly to for pay on-site service providers in affordable housing. By funding enhanced resident service coordinators and wellness nurses, the health insurers hope to reduce hospitalizations and emergency department visits as well as delay institutionalization. These on-site service providers will be able to regularly check in with residents and coordinate medical care with both providers and the healthcare plans. The pilot will launch in five to seven affordable housing buildings that serve seniors with the goal of expanding to additional buildings if the original pilot sites prove successful. This pilot is intended to exclusively serve seniors and allow them to age in place for as long as possible before entering a nursing home or skilled nursing facility.

The pilot began in January of 2016 when LeadingAge convened a housing and health task force that brought together over 75 stakeholders for a day-long conversation. During the meeting, participants discussed several comparative housing and health models and decided to work to build their own. The initial pilot design work is funded through a grant from the West Health Policy Center, which has allowed them to build out several working groups to think through on-site staffing, case management integration with existing service providers and measurement to track the success of the program. LeadingAge Massachusetts and the LTQA are partnering with UMass Boston to conduct a comprehensive study on the cost and health outcomes of the pilot program.

Regulatory Considerations

Under the Affordable Care Act, tax-exempt hospitals are required to conduct community health needs assessments (CHNA) and develop implementation plans every three years in order to maintain their tax-exempt status. Through the CHNA process, hospitals work with stakeholders to identify the health needs of the communities they serve and then develop plans to address those needs.[4] The Rush University Medical Center (Rush) in Chicago recently announced its role in a partnership with a group of Chicago health care institutions, residents, civic leaders and nonprofit partners like the Local Initiatives Support Corporation, aimed at closing the 16-year gap in life expectancy between people living in Chicago's Loop and in some of the city's West

Side neighborhoods.[5] Over a three-year period, Rush will invest $6 million to expand housing, job development efforts, access to healthy food and hire community health workers. Rush's investment in this collaborative effort will satisfy some portion of their community health benefit requirement. Many hospitals also reimburse themselves for uncompensated medical care through their community benefit requirements.

RTI International and the Milken Institute School of Public Health at The George Washington University recently launched the Community Benefit Insight web tool, which aggregates community benefit data for tax-exempt hospitals.[6] Before the site launched in December of 2017, each hospital's CHNA was submitted to the Internal Revenue Service (IRS) and posted on their individual websites, but not aggregated anywhere. The new website allows users to search for tax-exempt hospitals to see their total community benefit spending and how the community benefit is spent.[7] The web portal also provides links to their CHNA and shows when hospitals will be required to conduct their next CHNA. This gives interested housing practitioners the opportunity to easily access hospitals CHNAs and connect with appropriate parties at the hospital. Hospitals can use their community benefit dollars towards the financing of affordable housing, but affordable housing must be first identified as a community health need. It is imperative for affordable housing providers and advocates to be at the table when CHNAs are being conducted in order to raise the importance of affordable housing on health outcomes.

The U.S. Department of the Treasury recently issued a report on modernizing the Community Reinvestment Act (CRA).[8] Under CRA, banks are required to make investments in underserved communities. There may be an opportunity for harmonization between banks' CRA requirements and tax-exempt hospitals' CHNA requirements that could direct significant capital towards the financing of affordable housing. As Treasury and the relevant bank regulators undertake CRA reform, they should work with their counterparts at IRS to ensure that CRA and community benefit investments can work together. Banks and hospitals serving the same community should be able to work together to identify and ultimately serve community needs.

The U.S. Department of the Treasury and the IRS are in the process of developing rules and regulations for Opportunity Zones. The Opportunity Zone program was codified into law in the Tax Cuts and Jobs Act of 2017. Governors designated Opportunity Zones in their states by selecting low-income and low-income-contiguous census tracts. Investors in Opportunity Zones are able to temporarily defer their capital gains and ultimately eliminate their tax exposure. There is potential for CRA, community benefit and Opportunity Zone investments to all flow to the same geographic area, perhaps even the same affordable housing development.

Challenges and Potential Strategies for Mitigation

Beyond High-Need Populations. Much of the body of research in this area is focused on people with significant medical and housing needs who, when able to access affordable housing and appropriate medical care, have dramatically reduced medical spending. These cost studies present clear justification for using healthcare dollars to fund affordable housing. Beyond this high-needs group, there is an even larger population that will see less dramatic returns on investment, or long-term returns on investment that are difficult to track. Nonetheless, investments in the housing needs of families with children and less medically complicated populations are still worthwhile investments. Research has shown that children living in homes that were remediated for lead paint needed less special education services and had increased earnings over their lifetime compared with the control group.[9]

Data Privacy. Health data privacy for residents is a significant concern and many affordable housing providers are hesitant to collect and store such data due to Health Insurance Portability and Accountability Act (HIPAA) requirements. HIPAA's privacy rule covers the use and disclosure of protected health information (PHI) by an organization. Several healthcare organizations in the working group suggested that it would be beneficial for housing organizations to track PHI data in order to demonstrate improved health outcomes, thereby justifying the investment made by health care organizations. However, becoming a HIPAA-compliant organization requires significant upfront investment and ongoing training to remain compliant. Furthermore, many housing providers felt it was an inappropriate role for them to play; most landlords do not track the health outcomes of their residents. Housing providers already track a significant amount of data that may be useful to healthcare organizations and there are groups

better equipped to track the health data, potentially even the healthcare organizations themselves. If affordable housing providers are able to provide resident move-in dates, a health insurer could conduct its own cost study analysis to compare the pre- and post-move-in healthcare claims data. Beyond just cost measures, insurers could also track the type of care to see if individuals who are stably housed are seeking appropriate services. For example, their data may indicate a reduced number of emergency room visits and increased primary care visits. Housing providers have an important role to play in data collection but becoming HIPAA compliant and tracking sensitive health data may not be the most appropriate role for them. Through cross-sector partnerships health and housing organizations can leverage each other's strengths to achieve the same outcome.

Olmstead. The June 22, 1999, decision of the United States Supreme Court in Olmstead v. L.C. ruled that under Title II of the Americans with Disabilities Act, "States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."[10] For housing providers, the essential question is whether or not a housing complex that serves only, or even primarily, people with disabilities is compliant with Title II of the ADA as interpreted in the Olmstead decision. Olmstead need not be a bar to providing community treatment of such individuals. As Justice Kennedy noted in his concurring opinion, "For a substantial minority [of mental health patients] ... deinstitutionalization has been a psychiatric *Titanic*. Their lives are virtually devoid of 'dignity' or 'integrity of body, mind and spirit.' 'Self determination' often means merely the person has a choice of soup kitchens. The 'least restrictive setting' frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies."[11]

Through potentially reduced claims, health insurers have a financial interest in ensuring that their members with the most complex health needs are able to access affordable housing. If healthcare insurers were to finance and build housing for only their members with the most complex health care needs, some fear that they may run afoul of the Olmstead decision. Others believe this is an overzealous reading of Olmstead that is not supported by the actual opinion. It is true, regardless, that if federal funds like the Low Income Housing Tax Credit were used to help finance the development or to support ongoing rent subsidies, health providers and insurers may be unable to restrict the housing to just their members and would need to allow people who are on waiting lists for vouchers to access units. Alternatively, health providers and insurers could separate funding of designated units to achieve a community development project that was integrated with the broader community while not violating the Fair Housing Act or specific requirements of other federal subsidies or tax expenditures.

Enrollment Churn. Health insurance organizations have real concerns about members switching health insurers. Several health insurance organizations in the working group expressed a willingness to make upfront investments in order to reduce claims spending over the long term. However, they have concerns about their member switching to another health insurer, making it hard to internally justify the initial investment. As described earlier in this brief, the Massachusetts Housing and Health Pilot Program was able to curtail this concern by bringing together the major senior health insurers to make a joint investment. The collaboration gave health insurers the comfort of knowing that their members would be served in spite of the churn of member enrollment.

Conclusion

NHC will continue to research and develop strategies to make it easier for healthcare organizations and housing providers to work together. Oftentimes, these partners have the same goals but are unaware of each other's efforts or are unsure how to connect. The program profiles in this report can serve as guideposts as communities work to develop similar partnerships. Each profile demonstrates an increased awareness among health professionals that housing is an important social determinant of health and healthcare organizations have an important role to play. As housing providers look to implement similar models in their communities, one easy first step is to look up the local tax-exempt hospital's CHNA. Its CHNA will illuminate how much the hospital has thought about housing as a social determinant of health and serve as a useful benchmark to guide initial conversations. Together, health care and housing organizations can meaningfully impact the health of residents to both reduce expenditures and produce better outcomes.

Endnotes

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4. Viveiros, Janet and Lisa Sturtevant. *The Role of Anchor Institutions in Restoring Neighborhoods: Health Institutions as a Catalyst for Affordable Housing and Community Development*. The National Housing Conference. Washington, DC: March 2016.

5. Rush University Medical Center. *West Side United Shares Plans to Address Health Disparities in Nine Chicago Communities.* Chicago, IL: February 27, 2018.

6. Available at: www.communitybenefitinsight.org

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10. Olmstead v. L.C. No. 98-536. Justice Ginsberg writing for the majority, p. 22.

11. Olmstead v L.C. No. 98-536. Justice Kennedy quoting from Torrey, *supra*, p. 11.

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