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Housing as a Hub for Health, Community Services, and Upward Mobility

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Executive Summary and Recommendations

Housing is increasingly understood to be an important determinant of success in life, affecting health, access to education, and the opportunity for upward mobility. The condition and location of a family's home can affect such things as respiratory health and "toxic stress" among children, which can affect individuals throughout their lives. Indeed, the availability or otherwise of good social services, positive social networks, and job opportunities can determine whether a family achieves the American Dream.

Recognition of the importance of housing as a "hub" for well-being has caused analysts, policymakers, and community activists to explore the potential for housing-based initiatives to foster good health and economic mobility. To assist in this effort, we assembled an advisory group of housing analysts and practitioners from across the country to investigate the role of housing as a hub. The meetings and conversations with this group helped us to identify the potential of housing as a hub, the policy and other challenges limiting that potential, and to develop a set of recommendations to deal with these challenges and achieve the full potential of housing-based strategies to enhance the lives of Americans. The appendix lists the advisory group members. The authors of the report, not the advisory group members, are entirely responsible for the recommendations and discussion in this report.

The report first explores the way in which housing can affect the lives and success of individuals, and how the effect varies for different segments of the population.

The report then investigates the obstacles to housing functioning as a hub, from the difficulties of developing good data on the impact of housing-based strategies to shortcomings in the business models available for these strategies. The inadequate supply of affordable housing is of

course a constant limitation on the potential for housing to function as a hub.

Finally, we lay out a set of recommendations designed to strengthen the role of housing as a social determinant for health and success. These recommendations, summarized below, address ways in which housing can be a crucial part of inter-sector partnerships, such as with the health system and social services. They also identify steps that can be carried out at all levels of the federal system, and by nongovernmental institutions.

Recommendations

Recommendation 1: Improve data collection, sharing, and evaluation

Housing-based hubs and other community collaborations are hampered by their capacity to develop and share data, as well as weaknesses in techniques for measuring effectiveness. Several steps would help ameliorate these obstacles.

- Communities, including the housers and other institutions within them, should make greater use of data techniques to develop maps of assets and identify patterns of social and health challenges.
- Nonprofit organizations and government agencies at all levels should improve their procedures for sharing of housing, health, education and other data.
- Jurisdictions should assist in building data hubs and improve the capacity of small organizations to assemble and analyze data.

- Public and private bodies should develop better techniques to measure “social return on investment” (SROI) and to evaluate initiatives, and to use improved measures to determine the broad savings that can be achieved from intersector collaboration and partnerships. Public and private funders should use tiered grants to align funding approaches with the stage of development of promising initiatives.

Recommendation 2: Improve budgetary coordination and funding experimentation

Maximizing the return on investments in housing-based initiatives requires flexible budgeting, as well as planning and coordination across agencies. This requires political leadership at the federal, state, city, and local levels.

- The federal government, states, counties and cities should create bodies to link decision-makers from multiple agencies and coordinate planning, budget strategies, and investments.
- States should establish versions of Maryland’s county-level Local Management Boards (LMBs), or the Healthy Communities Hub model, to act as funding intermediaries to braid or blend together public and private funds to support local inter-sector collaboration.
- The federal government, and states, should make greater use of waivers and pilots to foster hubs and partnerships, including widening the statutory authority for program budgets to be used in different sectors. Among other steps, Congress should authorize multi-agency pooling of money to permit housing-based pilots, modeled on Performance Partnership Pilots (P3).

Recommendation 3: Experiment with different models to organize and manage housing-based services

Establishing and operating multisector programs within a hub puts great responsibilities on the management staff. Depending on the community and the stage of development of the housing hub, different models of management to link home and services might be most appropriate. Policymakers can take steps to support each of these models:

- In addition to Congress providing more funding for elderly housing, HUD should expand its supportive services demonstration pilots for elderly households, which cover the cost of a full-time enhanced service coordinator and nurses.
- Housing organizations, professional schools, and government should address credentialing and training to create stronger professional coordinator teams in housing.
- States and local governments should support the growth of “villages” based on the senior village model, experimenting with this model for a range of populations. Philanthropy should also support such models.
- Public Housing Authorities and other subsidized housers serving low-income residents should explore a variety of ways to deliver social services to residents.

Recommendation 4: Strengthen housing-health partnerships

Several hospital systems have undertaken significant housing-health partnerships. Some could be described as responses to financial

“sticks,” such as using housing initiatives to comply with community benefit requirements on nonprofit hospitals. Others are “good citizen” philanthropic examples of the hospital assisting its local community. A challenge is to structure partnerships that constitute a true business case for a health system. Certain steps could help strengthen that case, alongside other steps that refine the current requirements on health systems.

- Counties and cities should explore partnerships with hospitals, clinics and insurers to reduce the societal costs of homelessness and share part of the cost savings with the health system.
- With the support of states and local government, hubs should make greater use of community benefit investments by hospitals and financial, such as those encouraged by the Community Health Needs Assessment (CHNA) and the Community Reinvestment Act (CRA). They should also explore innovative forms of private funding and public-private financing, such as social impact bonds (SIBs).
- Congress should enact changes in the Medicaid statute to permit Medicaid funds to be used for room and board and direct housing capital costs when proposals seek to achieve measurable improvements in health.
- The federal government should expand housing-health partnerships for the elderly and disabled, including the Money Follows the Person initiative and Home and Community-Based Service waivers.
- The federal government should encourage a range of housing-health partnerships, including through an expanded Accountable Health Community Model and improved guidance for nonprofit hospitals’ community benefit requirement.
- Medicaid should aggressively and creatively use Home and Community-Based Service (HCBS) waivers to add flexibility and permit approaches that help people with chronic conditions to be established in housing, using their housing as a hub and reducing health costs.
- Drawing from the experience of 1115 waivers in Medicaid, and the potential for Medicare Advantage plans to address the broader factors affecting seniors’ health, Congress should grant Medicare broader authority to conduct pilots and grant waivers to allow Medicare to experiment with more housing partnerships.
- States and communities should experiment with a place-based District Nurse program to link home-based individuals with a network of health services and other supports.
- Public and private housing managers should explore the use of clinics based in housing projects, modeled on school-based health centers, as well as telemedicine.
- The federal government and states should build on the flexibility of Medicaid managed care organizations (MCOs) to combine medical services with other services, including housing, to improve health and reduce direct medical costs.

Housing and Community Well-Being

There is a growing recognition that, for people and neighborhoods to be healthy and successful, different sectors must work together and that investments in one sector can bring dividends in others. In health care, for instance, the increasing focus on “social determinants of health” stems from the understanding that the trajectory of a person’s health status is heavily influenced by such factors as housing, social conditions, and poverty.¹ Effective collaborations between health and other sectors have the capacity to address these factors and improve community health and well-being.² These collaborations are also important to achieving success in other areas, such as educational attainment and future economic stability.³ The University of California, San Francisco, maintains a searchable library of articles and reports focusing specifically on the impact of social determinants on health.⁴

Successful collaboration across sectors requires the existence of supportive policies and practices. In most cases, if not all, it also requires an organization or anchor institution—often referred to as a “hub”—to serve as the focal point and facilitator of inter-sector collaboration and to bring together a range of services, connecting them with the community’s population. Such hubs can be a familiar local institution—such as a church,

school, or hospital, housing authority, or community organization—or even a larger institution such as a university.⁵ There may be several hubs in a neighborhood, with different functions and perhaps partnering with each other. Along with providing services, some hubs contribute significantly to economic stability and help build the social capital of the community.⁶

In an earlier publication, we explored how schools and hospitals can function as hubs.⁷ We looked at the potential of those institutions to advance the health and economic mobility of neighborhood residents. We also identified challenges that impede the ability of these institutions to fulfill their potential as hubs, and we recommended policy changes to address those challenges.

In this report, we examine the role of housing as a hub.

Housing is often discussed as a negative determinant of health, educational success, and other crucial elements of success in life; the focus is on the effect of housing deficiencies. However, it is important to recognize, as we do in this report, the variety of ways in which housing and housing-based strategies can be a powerful and positive influence, especially for vulnerable populations.⁸

¹ Harry J. Heiman and Samantha Artiga, “Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity,” Kaiser Family Foundation, November 4, 2015, <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>; and Elizabeth H. Bradley, Benjamin R. Elkins, Jeph Herrin, and Brian Elbel, “Health and Social Services Expenditures: Associations with Health Outcomes,” *BMJ Quality & Safety*, 20, no. 10 (October 2011): 826–31.

² Vivian L. Towe et al., “Cross-Sector Collaborations and Partnerships: Essential Ingredients to Help Shape Health and Well-Being,” *Health Affairs* 35, no. 11 (November 2016): 1964–69, <http://content.healthaffairs.org/content/35/11/1964.abstract>; and Alina Schnake-Mahl and Sarah Norman, “Building Healthy Places: How Are Community Development Organizations Contributing?,” *Cities & Health* 1, no. 1 (2017), 47–58.

³ Olga Acosta Price, “School-Centered Approaches to Improve Community Health: Lessons from School-Based Health Centers,” *Brookings Institution*, July 13, 2016, <https://www.brookings.edu/research/school-centered-approaches-to-improve-community-health-lessons-from-school-based-health-centers/>; and Gerry Veenstra et al., “Who You Know, Where You Live: Social Capital, Neighborhood and Health,” *Social Science & Medicine* 60, no. 12 (June 2005): 2799–818.

⁴ SIREN (Social Interventions Research & Evaluation Network), Evidence Library, The University of California, San Francisco, <https://sirenetwork.ucsf.edu/tools/evidence-library>.

⁵ I. Harkavy, “Engaging Urban Universities as Anchor Institutions for Health Equity,” *American Journal of Public Health* 106, no. 12 (December 2016): 2155–457.

⁶ Julia Freeland, Michael B. Horn, and Stuart M. Butler, “Schools as Community Hubs: Integrating Support Services to Drive Educational Outcomes,” *Brookings Institution*, September 28, 2015, <https://www.brookings.edu/research/schools-as-community-hubs-integrating-support-services-to-drive-educational-outcomes/>.

⁷ Stuart M. Butler and Carmen Diaz, “Hospitals and Schools as Hubs for Building Healthy Communities,” *Brookings Institution*, December 5, 2016, <https://www.brookings.edu/research/hospitals-and-schools-as-hubs-for-building-healthy-communities/>.

⁸ Ehren Dohler et al., “Supportive Housing Helps Vulnerable People Live and Thrive in the Community,” *Center on Budget and Policy Priorities*, May 31, 2016, <https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community>.

With housing-based initiatives, in which people are helped in their own homes and communities, it is generally easier to develop trust and relationships, such as using community networks to informally “credential” outside service providers. There are also many advantages to a “place-based” approach based on where people live—bringing services to the household rather than the household to services. Housing is where people “are.” Thus, housing and more specifically the home can be the most practical and efficient location at which to provide certain health care and other services and to help shape positive patterns of behavior. The practical benefits of housing as a hub are generally useful, particularly when age, disability, or transportation gaps make it difficult people to obtain services and support elsewhere.

Looking at housing-based initiatives in this way is in some ways a modern version of the early settlement houses, which built multi-service communities to improve lives. In our approach, we expand upon that early model.

Beyond housing providers focused on supplying services to individual buildings, it is important to recognize that some housing providers and managers (or “housers”) are also critically important community development organizations, with impacts on the broader neighborhood, city, or region. Housers can be large public housing authorities. They can be private property owners and nonprofit organizations that manage several buildings. For the purposes of this paper, we consider the broad range of organizations that manage or connect homes in a community.

The Housing Affordability Problem

For modest-income individuals and families, housing cannot function as a hub or partner for providing services to individuals and families unless those families have access to affordable housing. An adequate supply of affordable housing is a necessary condition for the success of the strategies we recommend in this report.

Regrettably, access to affordable housing has become a sharply increasing problem for families in America, and the availability of affordable housing has become a severe limitation for using housing-based strategies to help address the many needs of moderate- and lower-income families. As the Urban Institute points out, finding and accessing reasonably priced rental housing is increasingly a challenge in many neighborhoods, with the problem more acute in some regions than others.⁹ The Urban researchers note that shortages of adequate, affordable housing tend to occur more in urban and metropolitan areas than in rural towns or counties; they attribute this to the higher concentration of poverty in urban and metropolitan cities and higher construction costs.

The problem of supply is at the level of a crisis. According to the National Low Income Housing Coalition (NLIHC), there are now only 35 affordable and available units for every 100 extremely low-income households in need of affordable housing.¹⁰ In its most recent report on the gaps in affordable housing supply, the NLIHC also notes that despite efforts to increase the number of affordable housing units in the private market, many existing units are actually occupied by those with higher incomes, decreasing the

⁹ Liza Getsinger et al., “The Housing Affordability Gap for Extremely Low-Income Renters in 2014,” Urban Institute, April 28, 2017, <https://www.urban.org/research/publication/housing-affordability-gap-extremely-low-income-renters-2014>.

¹⁰ National Low Income Housing Coalition, “The Gap: A Shortage of Affordable Homes,” March 2017, <http://nlihc.org/research/gap-report>.

number of affordable units available to low-income households.¹¹

Many factors affect the supply of affordable housing. As employment patterns and transportation facilities change, for instance, some neighborhoods become far more desirable, which causes property prices and rents to rise, pricing many families out of the market. Some jurisdictions respond to such “gentrification” with regulatory steps to influence development, such as inclusionary zoning, as they seek to retain affordable units while allowing neighborhood residents to benefit from improved amenities.¹²

Such local efforts help slow the disappearance of affordable housing. Unfortunately, there has been a significant reduction in federal assistance for modest- and lower-income families seeking housing, with cuts in recent years in public housing, vouchers, and other support programs.¹³ In addition to reductions in direct spending, tax-related subsidies to developers of low-income housing have also come under threat. Versions of the 2017 congressional tax reform legislation, for instance, would have sharply reduced the Low-Income Housing Tax Credit, which provides tax credits to private investors. Fortunately, that cut was not included in the final legislation.

This report focuses specifically on ways in which existing affordable housing can function as a hub. The discussion of which policies would increase the supply of affordable housing and how to pay

for such policies is beyond the scope of this report. Nevertheless, we emphasize that the ability of housing to achieve its potential as a hub for a range of important services will be undermined if the crisis of supply is not addressed.

Housing and Health

We have learned that there is a strong relationship between substandard housing conditions and health, due to the effects of physical housing conditions and other issues that arise with housing instability or social factors in the community. Housing conditions are a major social determinant of health.¹⁴ Many respiratory ailments, for example, are connected directly to housing conditions.¹⁵ Studies also indicate that housing segregation is among the factors related to racial disparities in health.¹⁶ People of color also disproportionately live in neighborhoods with high levels of low-quality housing.¹⁷ Many jurisdictions have responded by launching housing-based initiatives to address health problems. For instance, in Massachusetts, the Boston Housing Authority and Boston Public Health Commission have successfully introduced asthma and other indoor environmental improvement initiatives. These include the Boston Asthma Home Visit Collaborative, which aims to reduce asthma triggers and days missed from school,¹⁸ and the Health Public Housing

¹¹ National Low Income Housing Coalition, “The Gap.”

¹² Jonathan Grabinsky and Stuart M. Butler, “The Anti-Poverty Case for ‘Smart’ Gentrification, Part 2,” Brookings Institution, February 11, 2015, <https://www.brookings.edu/blog/social-mobility-memos/2015/02/11/the-anti-poverty-case-for-smart-gentrification-part-2/>.

¹³ Center on Budget and Policy Priorities, “Chart Book: Cuts in Federal Assistance Have Exacerbated Families’ Struggles to Afford Housing,” April 12, 2016, <https://www.cbpp.org/research/housing/chart-book-cuts-in-federal-assistance-have-exacerbated-families-struggles-to-afford/>.

¹⁴ Stuart M. Butler, Dayna Bowen Matthew, and Marcela Cabello, “Re-balancing Medical and Social Spending to Promote Health: Increasing State Flexibility to Improve Health Through Housing,” Brookings Institution, February 15, 2017, <https://www.brookings.edu/blog/up-front/2017/02/15/re-balancing-medical-and-social-spending-to-promote-health-increasing-state-flexibility-to-improve-health-through-housing/>; and Lauren A. Taylor et al., “Leveraging the Social Determinants of Health: What Works?,” Blue Cross Blue Shield of Massachusetts Foundation, June 2015, <https://bluecrossmafoundation.org/publication/leveraging-social-determinants-health-what-works/>.

¹⁵ C.-G. Bornehag, J. Sundell, and T. Sigsgaard, “Dampness in Buildings and Health (DHB): Report from an Ongoing Epidemiological Investigation on the Association Between Indoor Environmental Factors and Health Effects Among Children in Sweden,” *Indoor Air* 14, no. 7 (August 2004): 59–66.

¹⁶ National Academies of Sciences, Engineering, and Medicine, *Communities in Action: Pathways to Health Equity* (Washington, DC: National Academies Press, 2017), <https://doi.org/10.17226/24624>.

¹⁷ Schnake-Mahl and Norman, “Building Healthy Places.”

¹⁸ Boston Public Health Commission, “Boston Asthma Home Visit Collaborative,” retrieved October 18, 2017, <http://www.bphc.org/whatwedo/healthy-homes-environment/asthma/Pages/Boston-Asthma-Home-Visit-Collaborative.aspx>.

Initiative, which seeks to reduce health hazards that are linked to asthma.¹⁹

Toxic Stress. The social dynamics within communities also play a crucial role in the physical and mental health of individuals. For example, studies on “toxic stress” among children indicate that highly stressful neighborhood conditions—such as the accumulated effects of living in areas of highly concentrated poverty with inadequate access to supports such as healthy foods, safe streets, and good schools—can lead not only to short-term behavioral and mental health issues, but also, in severe cases, to long-term damage to a child’s brain development and health condition.²⁰ Recognizing this, many researchers and practitioners now address a variety of health, education, and social problems experienced by young individuals through a “multigenerational” approach—a strategy that includes parents or guardians in addition to the children in the home setting.²¹ A focus on housing can improve results in several areas in which home conditions are a factor, such as education, juvenile justice, successful aging, job stabilization, and social cohesion.²² In Akron, Ohio, for instance, the local housing authority partners with other agencies and service providers in the county to improve physical and mental health development and opportunities for children, working comprehensively to tackle toxic stress and reduce its long-term effects on health, well-being, and opportunity.²³

This appreciation of the connection between housing and health has led to a number of recent policy changes in both the private and public sectors.²⁴ For instance, Foundation Communities, a nonprofit houser in Austin, Texas, has taken a holistic approach to promoting health and well-being in its multifamily rental communities, implementing smoke-free policies, organizing wellness activities and classes, and creating walking paths and community gardens.²⁵ In addition, some hospitals, health foundations, and health insurance plans see investment in housing for low-income and elderly households as also an investment in health. Strategies to improve the health and conditions of individuals with disabilities and homeless Americans now include a greater emphasis on home and community-based services and more integration of Medicaid and housing dollars.

¹⁹ Boston Housing Authority, “Healthy Homes Initiatives: Healthy Public Housing Initiative,” <https://www.bostonhousing.org/en/Departments/Planning-and-Real-Estate-Development/Healthy-Homes.aspx>.

²⁰ Harvard University, Center on the Developing Child, “Toxic Stress,” <http://developingchild.harvard.edu/science/key-concepts/toxic-stress/>.

²¹ Princeton University and Brookings Institution, “Helping Parents, Helping Children: Two-Generation Mechanisms,” *Future of Children* 24, no. 1 (Spring 2014).

²² Maya Brennan, “The Impacts of Affordable Housing on Education: A Research Summary,” Center for Housing Policy, May 2011, http://www.nchh.org/Portals/0/HHFF_Impacts_of_Affordable_Housing.pdf; Darla Bardine et al., “Addressing the Intersections of Juvenile Justice Involvement and Youth Homelessness: Principles for Change,” Coalition for Juvenile Justice, 2017, <http://juvjustice.org/sites/default/files/ckfinder/files/FINAL%20Principles%20-%20ns%20final.pdf>; Joint Center for Housing Studies of Harvard University, “Housing America’s Older Adults: Meeting the Needs of an Aging Population,” 2014, http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/jchs-housing_america_older_adults_2014.pdf; Elizabeth Cove et al., “Can Escaping from Poor Neighborhoods Increase Employment and Earnings?,” Urban Institute, March 2008, <https://www.urban.org/research/publication/can-escaping-poor-neighborhoods-increase-employment-and-earnings>; and Kath Hulse and Wendy Stone, “Housing, Housing Assistance and Social Cohesion,” Australian Housing and Urban Research Institute, September 2006, <https://www.ahuri.edu.au/research/position-papers/91>.

²³ First Things First, “The Early Childhood Effect’ School Readiness Summit,” October 25, 2016, <http://seisummit.org/wp-content/uploads/2016/10/2016-School-Readiness-Summit-Program.pdf>.

²⁴ Corianne Scally et al., “Emerging Strategies for Integrating Health and Housing,” Urban Institute, July 2017, <https://www.urban.org/research/publication/emerging-strategies-integrating-health-and-housing>.

²⁵ Schnake-Mahl and Norman, “Building Healthy Places.”

WHAT IS TOXIC STRESS?

Researchers at Harvard University's Center on the Developing Child have developed a scale of stress responses, indicating different forms and levels of stress, and the short- and long-term effects of each type.²⁶

The most common type of stress is the brief and normal response associated with "fight or flight," including rapid increases in heart rate, breath, and stress hormone levels.²⁷ This is an evolutionary response to sudden and *immediate* threats, such as an oncoming car. After such an episodic stress response, the body quickly returns to normal levels without permanent harmful effects.

In contrast, when stress is constant and unrelenting and no buffers mitigate its effects, it becomes toxic. Individuals who lack adequate buffers, such as emotional support from family or the community, often experience its toxic effects.²⁸ The body's response to this form of stress results in a more constant and heightened state of alert. Individuals subjected to toxic stress remain at this elevated level of response.²⁹ For them, the accumulated stressors resulting from living in neighborhoods of concentrated poverty with inadequate resources, high crime or unsafe housing, economic adversity or uncertainty, and emotional or physical abuse can result in prolonged and damaging mental stress.

The alarming feature of toxic stress is how these exposures can permanently and seriously harm the health and well-being of children growing up in highly stressful environments. For instance, neurological studies have shown that repeated and prolonged exposure to stress harms the capacity of a child's brain to develop key neural connections essential to learning and executive function.³⁰ Learning and behavioral disorders are also common.³¹ Thus, toxic stress can profoundly interfere with the capacity for success in school and career, leaving children at a permanent disadvantage through life.³²

Housing and the Wider Community

Providing services through a housing-based hub can also have a ripple effect by serving a community that is wider than the residents living immediately nearby. A clinic or daycare center in a public housing project that is available to others in a community, for instance, can help support and strengthen the whole neighborhood.³³ In Denver, Colorado, when the housing authority redeveloped nearly 900 mixed-income units in the Mariposa and Sun Valley neighborhoods, it adopted a health and quality of life-focus and sought to improve access and connectivity to jobs, education, and nutritional resources, emphasizing steps to improve community engagement and social cohesion.³⁴ Some housing providers have created opportunities to employ residents in a community. For example, the Columbia Housing Authority in Columbia, South Carolina, invested in a much-needed neighborhood grocery store employing roughly 25 members of the community.³⁵ Building up multifamily housing as a hub in such ways can reach and benefit residents living in single-family homes. Even the skillful design and innovative use of common areas, where people can easily connect—referred to as "third places"—can have

²⁶ Harvard University, "Toxic Stress."

²⁷ Harvard Medical School, "Understanding the Stress Response," March 2011, <https://www.health.harvard.edu/staying-healthy/understanding-the-stress-response>.

²⁸ Hillary A. Franke, "Toxic Stress: Effects, Prevention and Treatment," *Children* 1, no. 3 (2014): 390–402, <http://www.mdpi.com/2227-9067/1/3/390>.

²⁹ Harvard University, "Toxic Stress."

³⁰ J. J. Radley et al., "Chronic Behavioral Stress Induces Apical Dendritic Reorganization in Pyramidal Neurons of the Medial Prefrontal Cortex," *Neuroscience* 125, no. 1 (2004): 1–6.

³¹ Jack P. Shonkoff and Andrew S. Garner, "The Lifelong Effects of Early Childhood Adversity and Toxic Stress," *Pediatrics* 129, no. 1 (December 2011): e232–e246, <http://pediatrics.aappublications.org/content/129/1/e232>.

³² Harvard University, Center on the Developing Child, "The Science of Early Childhood Development," 2007, <https://developingchild.harvard.edu/resources/inbrief-science-of-eecd/>.

³³ Janet Viveiros, "Bringing Health Care Home for Low-Income Older Adults: A Profile of the Richmond Health and Wellness Program at Dominion Place in Richmond, Virginia," National Building Museum, October 2014, http://media.wix.com/ugd/19cfbe_78b5b2939771455a82464b1a90a57c12.pdf.

³⁴ Erin Christensen et al., "The Mariposa Healthy Living Initiative," Denver Housing Authority, October 2012, <http://www.denverhousing.org/development/Mariposa/Documents/Mariposa%20Healthy%20Living%20Initiative%202012.pdf>.

³⁵ Sarah Ellis, "Save-A-Lot Grocery Store Coming to Columbia's Celia Saxon Neighborhood," *State* (Columbia, SC), December 18, 2014, <http://www.thestate.com/news/business/article13928030.html>.

a broad and positive impact.³⁶ In Chicago, third places like libraries have been used to create innovative interagency partnerships. In this case, the Chicago Housing Authority and Chicago Public Library have come together to create three co-located housing and library developments throughout the city to strengthen neighborhoods and enrich the lives of its residents.³⁷

Place-Based Incubators and Launchpads. The ripple effect can be complex and work in multiple directions, leading some analysts to stress the importance of “place-conscious” approaches, with broader definitions of the area involved, as a refinement of the “place-based” model.³⁸ These analysts agree with the importance of place-based housing approaches, but point out that not all household services and support needs will be met from within their immediate community (for example, tertiary medical care or potential job opportunities), so we must usually link neighborhood residents to some broader city and regional services and opportunities. It is important, therefore, to see housing-based strategies as part of a horizontal approach to helping households, with many of the connected services being outside the community. Housing-based service models are more than housing programs; they must be seen as integral parts of the health care and long-term care systems.

Moreover, a housing-based strategy can build up the strength of the community so that community becomes a strong and positive “incubator” for residents to become more successful and prosper over time in their neighborhoods. Similarly, the goal may be for elderly residents to remain in their community as their needs change. But housing may sometimes be seen as a place-conscious approach that functions more as a

“launchpad” strategy, helping to provide the education, training, and other services needed to support families and individuals as they gain the necessary human and social capital to move elsewhere to improve their condition, as Americans have always been prone to do.³⁹ This approach is also a partial response to the limited supply of affordable housing, in that the housing and supports help families, especially children, move over time into the economic mainstream, reducing their future need for assisted housing and eventually freeing up the units for others. In either case, the approach is commonly known as “housing as a platform,” in which housing is combined with resources and services to support families and individuals in achieving success as their needs change.⁴⁰

Varieties of Housing Hubs

Housing can function as a hub in a variety of ways, but there are four main models. In these models, we can also think of different types of services. Some services are delivered by a health or social worker to homes to address an individual’s needs, such as elderly care or mental health services. Other services or amenities might be made available to everyone in a building, such as a resident service coordinator. Others might be co-located on site and available to some residents and perhaps some outsiders, such as a day care center or a clinic.

Houser-Operated

Services can be an integral component of a community, organized by a public housing authority, nonprofit housing provider, or private-

³⁶ Stuart M. Butler and Carmen Diaz, “‘Third Places’ as Community Builders,” Brookings Institution, September 14, 2016, <https://www.brookings.edu/blog/up-front/2016/09/14/third-places-as-community-builders/>.

³⁷ Fran Spielman, “Emanuel to break ground on three library-housing partnerships,” *The Chicago Sun-Times*, January, 26, 2018, <https://chicago.suntimes.com/news/emanuel-to-break-ground-on-three-library-housing-partnerships/>.

³⁸ Margery Austin Turner, “A Place-Conscious Approach Can Strengthen Integrated Strategies in Poor Neighborhoods,” Brookings Institution, August 10, 2015, <https://www.brookings.edu/research/a-place-conscious-approach-can-strengthen-integrated-strategies-in-poor-neighborhoods/>.

³⁹ Claudia J. Coulton, Brett Theodos, and Margery Austin Turner, “Family Mobility and Neighborhood Change: New Evidence and Implications for Community Initiatives,” Urban Institute, November 1, 2009, <https://www.urban.org/research/publication/family-mobility-and-neighborhood-change>.

⁴⁰ Maya Brennan and Martha M. Galvez, “Housing as a Platform: Strengthening the Foundation for Well-Being,” Urban Institute, September 2017, https://www.urban.org/research/publication/housing-platform/view/full_report.

sector owner or manager. In this case, housing itself serves as the anchor institution or organizing platform and the housing manager—the “houser”—organizes and brings together a range of health and social services and economic opportunities for residents and community members. Nurses, community health workers, and social workers usually play an important role. One example is Mercy Housing, a nonprofit organization operating in 41 states, which develops and manages affordable housing for a variety of populations and organizes a wide range of health, social services, and other services for residents.⁴¹ Erickson Living, for example, operates its own Erickson Health Medical Group, which provides on-site nurses and physicians working exclusively at Erickson Living properties in 11 states throughout the country.⁴²

Full Integration

Some houser-operated models not only assemble services but also partner with a health system and social services in an integrated manner. For example, Support and Services at Home (SASH) coordinates services provided by social services agencies and health providers for older Vermonters who choose to live independently at home.⁴³ In this way, SASH has integrated housers into the health care delivery system statewide. Thus, it could be called a “houser-health integration” or “full integration” model.

Intermediaries

Services are provided in a housing setting but arranged through an intermediary, so that the intermediary—not the houser—is the primary organizer of services to residents. For instance, Housing with Services coordinates health and social services for over 1,400 residents of 11 affordable housing properties in Portland, Oregon.⁴⁴ In another example, the first pay-for-success (PFS) model, which focuses primarily on homelessness and supportive housing, uses the Massachusetts Alliance for Supportive Housing as an intermediary between the Commonwealth of Massachusetts, service providers, and investors.⁴⁵ In another variant of the intermediary/housing theme, senior villages in Washington, DC, and several other cities use a mix of volunteers and paid staff to provide social activities, a range of home-based services, and links to medical services to elderly residents living in their own homes.⁴⁶ Senior villages are funded mainly by dues from residents.

Co-located

In some cases, housing-based services may be physically co-located with another houser, which organizes and coordinates services, such as a health care facility where the health center serves housing residents but also other patients. In these cases, a hospital or other medically licensed facility (such as a health clinic) is located on-site or nearby, operated separately but in partnership. One such model is the partnership in Washington, DC, between Pathways to Housing DC and Unity Health Care, the District’s largest federally qualified health center (FQHC). As a

⁴¹ Mercy Housing, “About Mercy Housing,” <https://www.mercyhousing.org/about>.

⁴² Erickson Living, <https://www.ericksonliving.com>.

⁴³ Support and Services at Home, <http://sashvt.org/>.

⁴⁴ Paula Carder et al., “Housing with Services,” executive summary, Portland State University, Institute on Aging, October 2016, <http://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Housing%20with%20Services%20Evaluation%20-%20Executive%20Summary%20and%20Report.pdf>.

⁴⁵ Massachusetts Housing & Shelter Alliance, “Pay for Success,” retrieved October 18, 2017, <http://www.mhsa.net/PFS>; and Massachusetts Housing & Shelter Alliance, “Pay for Success: 2017 Fact Sheet,” retrieved October 18, 2017, <http://www.mhsa.net/sites/default/files/PFS%20Fact%20Sheet%20November%202017.pdf>.

⁴⁶ Stuart M. Butler and Carmen Diaz, “How ‘Villages’ Help Seniors Age at Home,” Brookings Institution, October 19, 2015, <https://www.brookings.edu/blog/health360/2015/10/19/how-villages-help-seniors-age-at-home/>.

housing provider, Pathways to Housing DC, practices the “housing first” model and began to further integrate health services with Unity Health Care, the on-site walk-in clinic, and other community partners.⁴⁷ Another model is the NewCourtland LIFE Center in Philadelphia, Pennsylvania, featuring 42 one-bedroom apartments with a preference for seniors and co-located with the LIFE Center, which provides health and supportive services allowing residents to live independently for as long as possible.⁴⁸

Even as we encourage using housing as a hub to promote health, it is important to acknowledge that many housing organizations are already engaging in explicit strategies to improve well-being. For example, a recent survey of NeighborWorks organizations indicated that 57 percent had implemented strategies to increase access to healthy food, 46 percent promoted physical fitness opportunities, and 55 percent were using community engagement to promote health and well-being.⁴⁹ Moreover, the huser-operated and co-located models refer specifically to the provision of services to renters, not homeowners. The intermediary model, however, is also well suited to reaching low-income homeowners in areas where the cost of owning is low and homeownership among lower-income families is common, such as in parts of Detroit and many rural areas.

Housing as a Factor for Different Populations

Some multifamily buildings are homes primarily for populations with particular service needs—

such as the elderly, very low-income families, or immigrants—while others have a mix. Even in single-family homes made up of several generations, the service needs can vary widely, such as those with young children and headed by aging grandparents.

Consider the function of housing-based strategies and the issues involved for certain populations, keeping in mind that these are not mutually exclusive populations:

Children

In considering the well-being of children, we must try to measure outcomes longitudinally over many years to determine which factors affect their well-being, for good or bad, over the course of their lives. Research shows that housing stability and housing quality significantly affect a child’s long-term health and well-being.⁵⁰ Research at Johns Hopkins University and elsewhere indicates the relationships between housing, school attendance, and costs.⁵¹ Homelessness and housing stability have been shown to greatly affect a child’s near-term growth and long-term development, and they can have long-lasting effects on health, education and other social outcomes later in life.⁵²

Studies have also shown that higher degrees of housing instability are associated with higher degrees of household stress, in particular maternal stress, resulting in greater levels of toxic

⁴⁷ Pathways to Housing DC, “Integrated Health,” <https://www.pathwaystohousingdc.org/integrated-health>.

⁴⁸ Corporation for Supportive Housing, “NewCourtland LIFE Center, Philadelphia, PA,” 2016, <http://www.csh.org/wp-content/uploads/2016/10/Project-Profile-NewCourtland-Final.pdf>; and NewCourtland Senior Services, “NewCourtland Announces Northeast Expansion with the Acquisition of Saint Bartholomew Property,” June 15, 2016, <http://www.newcourtland.org/press-releases/232-st-barts-press-release>.

⁴⁹ Schnake-Mahl and Norman, “Building Healthy Places.”

⁵⁰ Megan Sandel, Richard Sheward, and Lisa Sturtevant, “Compounding Stress: The Timing and Duration Effects of Homelessness on Children’s Health,” Center for Housing Policy and Children’s HealthWatch, June 2015, http://docs.wixstatic.com/ugd/19cfbe_07b13c8e56a14337a316e2e991aa0bf7.pdf.

⁵¹ Johns Hopkins University, Hopkins Population Center, “Housing Effects on Children’s Development,” <http://popcenter.jhu.edu/projects/housing-effects-on-childrens-development/>.

⁵² Gary W. Evans et al., “The Role of Chaos in Poverty and Children’s Socioemotional Adjustment,” *Psychological Science* 16, no. 7 (July 2005): 560–65.

stress for children.⁵³ In addition to the importance of housing stability, housing quality and the living environment are also linked to children's outcomes.⁵⁴ One concern is the degree to which children are exposed to housing-related environmental stressors, which, if chronic and in the absence of supportive buffers, can reach the level of "toxic stress," significantly affecting long-term education achievement and other outcomes.⁵⁵

Policymakers thus need to recognize that a variety of housing-related factors can affect children in different ways. For example, emotional and mental problems may result from housing instability (marked by frequent moves or lack of safe, stable, and affordable housing) and overcrowding.⁵⁶ Housing quality, such as mold and lead-free environments, are equally important for child health outcomes. Asthma may be caused by airborne contagions that often are prevalent in substandard housing.⁵⁷ Research indicates that perceived safety and overall neighborhood quality also profoundly influence a child's stress response systems as well as physical health and well-being.⁵⁸

Concerns about housing and children's outcomes have prompted many jurisdictions to see housing as a tool for improving the long-term well-being of children. For instance, Foundation Communities, a nonprofit affordable housing provider based in North Texas affiliated with NeighborWorks America, developed a holistic effort to promote

health and well-being in its multifamily rental communities. The NeighborWorks organization installed walking paths and community gardens, organized health and wellness classes, implemented smoke-free policies, and integrated wellness activities into after-school programs. Among other evaluation efforts, Foundation Communities collaborated with the University of Texas to evaluate its physical activity programming, demonstrating measurable improvements in physical activity levels among participating children.⁵⁹

In Nevada, for instance, the state's children's cabinet—an interagency planning group dedicated to children's issues—focused on housing stability and launched two housing initiatives focused on at-risk youth in early 2017.⁶⁰ Their Center for Aspiring Youth provides housing for 12- to 17-year-olds coupled with services and counseling for youth and their families. The cabinet also launched the Cottage of Change, intended for young adults ages 18 to 24 who are homeless and have either aged out of foster care or need emergency or transitional housing. The program couples housing needs with relevant mental and behavioral health resources. Youth aging out of foster care are also a growing concern that is driving federal targeted vouchers extending the age at which foster care youth can remain eligible. In Vancouver, Washington, the public school district and housing authorities have coordinated efforts to target vouchers for homeless students.⁶¹ The housing authority for

⁵³ Rebekah Levine Coley et al., "Relations Between Housing Characteristics and the Well-Being of Low-Income Children and Adolescents," *Developmental Psychology* 49, no. 9 (September 2013): 1775–89.

⁵⁴ Coley et al., "Relations Between Housing Characteristics."

⁵⁵ Judith Yates, and Vivienne Milligan, "Housing Affordability: A 21st Century Problem," Australian Housing and Urban Research Institute, September 2007, <https://www.ahuri.edu.au/research/final-reports/105>.

⁵⁶ Claudia D. Solari and Robert D. Mare, "Housing Crowding Effects on Children's Wellbeing," *Social Science Research* 41, no. 2 (March 2012): 464–76, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3805127/>.

⁵⁷ World Health Organization, "Causes of Asthma," <http://www.who.int/respiratory/asthma/causes/en/>; Marion Hulin, Denis Caillaud, and I. Annesi-Maesano, "Indoor Air Pollution and Childhood Asthma: Variations Between Urban and Rural Areas," *Indoor Air* 20, no. 6 (December 2010): 502–14; and James Krieger, "Home Is Where the Triggers Are: Increasing Asthma Control by Improving the Home Environment," *Pediatric Allergy, Immunology, And Pulmonology* 23, no. 2 (August 2010): 139–45.

⁵⁸ Jennifer Northridge et al., "The Role of Housing Type and Housing Quality in Urban Children with Asthma," *Journal of Urban Health* 87, no. 2 (March 2010): 211–24; and Gary W. Evans, "Child Development and the Physical Environment," *Annual Review of Psychology* 57, no. 1 (2006): 423–51.

⁵⁹ Schnake-Mahl and Norman, "Building Healthy Places."

⁶⁰ Children's Cabinet, "Grand Opening of Center for Aspiring Youth and Cottage of Change," February 1, 2017, <http://www.childrenscabinet.org/grand-opening-center-aspiring-youth-cottage-change/>.

⁶¹ Martha M. Galvez and Jasmine Simington, "Housing and Education Partnerships: A Case Study of Vancouver, Washington," Urban Institute, April 9, 2015, <https://www.urban.org/research/publication/housing-and-education-partnerships-case-study-vancouver-washington>.

Tacoma, Washington, also has targeted vouchers toward homeless community college students.⁶²

Homeless or Housing Insecure Individuals

Among the specific needs of homeless, formerly homeless, or housing insecure populations, housing itself is of course the immediate necessity for improving both health and economic outcomes. On the other hand, housing insecurity or housing instability refers to difficulty paying rent, using over half of one's income to cover housing expenses, moving frequently due to overcrowding, or other factors affecting one's ability to secure housing.⁶³ As defined by the Department of Housing and Urban Development (HUD), those who are chronically homeless have qualifying disabilities and have been homeless either for a year or for at least four or more occasions totaling 12 months over three years.⁶⁴

Housing First. It was once a common view that the ill health and other common problems of people who were homeless or housing insecure needed to be addressed before they could be permanently housed. Today, the prevailing view is that tackling their housing needs first is a necessary condition for successfully dealing with the underlying problems that often helped trigger chronic homelessness. While the idea of addressing housing needs before tackling these underlying problems has its critics, mounting evidence seems to support the approach.⁶⁵ The Housing First⁶⁶ approach focuses on providing

immediate, safe, and affordable housing without requiring its residents to adhere to preconditions such as employment or sobriety before gaining access to stable housing. Rather, this model stabilizes patients in a housing setting, making it much easier for them to obtain services that are made readily available to residents and built into the supportive housing framework.

This approach sees housing as critical to the goals of improving general health, well-being, and self-sufficiency of these vulnerable Americans, while reducing their reliance on emergency department visits and hospitalizations. Using housing as a stabilizer for other outcomes has demonstrated results in such places as Portland, Oregon, where formerly homeless individuals have experienced both improved self-reported health outcomes and increased access to higher quality care that is more effective. Such supportive housing is the foundation for success in providing for behavioral and mental health, health care access, substance abuse services, and social support.⁶⁷

A review of rigorous evaluations programs shows substantial reductions in health care and criminal justice costs, although the cost of the housing investment often is not completely offset.⁶⁸ Some critics of the Housing First model argue that the approach should focus more on addressing alcohol or substance abuse. To be most successful, these supports do need to be incorporated into the housing intervention model—whether the services are coordinated or delivered by the housing provider, an intermediary, or a separate entity—and must

⁶² Tacoma Housing Authority, "Community Colleges and Student Housing Insecurity: New Strategies for Student Success," September 30, 2015, <https://www.tacomahousing.net/content/news-updates/articles/community-colleges-and-student-housing-insecurity-new-strategies-for>.

⁶³ Margot B. Kushel et al., "Housing Instability and Food Insecurity as Barriers to Health Care Among Low-Income Americans," *Journal of General Internal Medicine* 21, no. 1 (January 2006): 71–77.

⁶⁴ U.S. Department of Housing and Urban Development, "Flowchart of HUD's Definition of Chronic Homelessness," 2016, <https://www.hudexchange.info/resources/documents/Flowchart-of-HUDs-Definition-of-Chronic-Homelessness.pdf>.

⁶⁵ David Trilling, "Chronic Homelessness and the Housing First Program: Research Review of How Programs Have Worked," Journalist's Resource, August 26, 2016, <https://journalistsresource.org/studies/society/housing/chronic-homeless-housing-first-research>.

⁶⁶ National Alliance to End Homelessness, "Housing First," April 20, 2016, <https://endhomelessness.org/resource/housing-first/>.

⁶⁷ Flora Arabo et al., "Housing as Health Care: A Road Map for States," National Governors Association Center for Best Practices, September 2016, <https://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/housing-as-health-care-road-map.html>.

⁶⁸ Angela Ly and Eric Latimer, "Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature," *Canadian Journal of Psychiatry* 60, no. 11 (November 2015): 475–87, <http://journals.sagepub.com/doi/abs/10.1177/070674371506001103>.

correspond to the often complex care needs of the population. But it is also important to strike a careful balance: too many requirements on homeless individuals to accept services as a condition of receiving housing discourage some from accepting the housing. For this reason, the Permanent Supportive Housing program offers, but does not require participation in a range of services.⁶⁹

Very Low-Income Households

Housing is often also a key to addressing the many problems of low-income individuals. There is an increasing understanding that “place” and housing-based strategies are critical for helping low-income households improve their health and economic mobility.⁷⁰ Because households may comprise children, adults, and seniors and these generations interact and influence each other, the needs of low-income families may require approaches that are multigenerational and tailored to the specific community conditions.

Low-income working adults, for instance, typically require support services that include strong educational and job readiness skill development, as well as health and social services. These services are critical for improving job security and lay the foundation for greater upward mobility. With rents rising faster than wages in so many communities, steps to improve job and career growth are crucial.⁷¹ But that is often only possible when other housing-based family support services are available. Thus, some low-income housing providers, such as the

Watsonville Affordable Housing Development in Sacramento, California, have included childcare in their menu of housing amenities.⁷² This reflects research showing that childcare is a key leveler in economic mobility,⁷³ allowing low-income parents to not be burdened by the ever-increasing costs of childcare and instead focus on their job security, career development, or broader economic mobility. In that same vein, the San Antonio Housing Authority saw that a major barrier to gains in the area’s workforce programs was limited access to childcare.⁷⁴ Through the U.S. Department of Education’s Promise Neighborhoods Initiative, the housing authority was able to make childcare center referrals for families, but when the demand required more services, the authority partnered with United Way to create a sustainable childcare network of certified and trained families and community members, who were ready and on call if a family member had, for instance, a last-minute job interview and needed childcare quickly. Many affordable housing providers also offer robust financial planning and coaching, giving individuals and families tools to independently manage their budgets.⁷⁵

Beyond the immediate, multiple needs of households, communitywide services, such as transportation, need to be considered in the context of housing. A 2014 HUD report found that, for low-income households, transportation consumes a considerable portion of their household income, so linking good transportation with affordable housing increases disposable income as well as improving access to

⁶⁹ U.S. Department of Housing and Urban Development, “Supportive Housing Program,” retrieved January 8, 2018, <https://www.hud.gov/hudprograms/supportive-housing>.

⁷⁰ Turner, “A Place-Conscious Approach Can Strengthen Integrated Strategies in Poor Neighborhoods.”

⁷¹ Margery Austin Turner and G. Thomas Kingsley, “Federal Programs for Addressing Low-Income Housing Needs: A Policy Primer,” Urban Institute, December 2008, <https://www.urban.org/sites/default/files/publication/32191/411798-Federal-Programs-for-Addressing-Low-Income-Housing-Needs.PDF>.

⁷² Institute for Local Government, “Watsonville Affordable Housing Development Provides Families Access to Childcare and Transit,” April 10, 2009, <http://www.ca-ilg.org/sustainability-case-story/watsonville-affordable-housing-development-provides-families-access>.

⁷³ Tarjei Havnes and Magne Mogstad, “Is Universal Child Care Leveling the Playing Field?,” *Journal of Public Economics* 127 (July 2015): 100–14, <http://faculty.smu.edu/milimete/classes/eco7377/papers/havnes%20mogstad%202015.pdf>.

⁷⁴ Abra Lyons-Warren and Amber-Lee Leslie, “Two-Generation Strategies in Public Housing: Promoting Success for the Whole Family,” Council of Large Public Housing Authorities, July 2017, <https://www.housingis.org/resource/7966>.

⁷⁵ Corporation for Enterprise Development, “Incorporating Asset Building Strategies into Neighborhood Revitalization,” webinar slides, May 10, 2012, <https://www.hud.gov/sites/documents/ASSETBLDGSTRATEGIES.PDF>.

employment opportunities.⁷⁶ For example, in Denver, Colorado, local affordable housing developers partnered with Enterprise Community Partners to create the Denver Regional Transit-Oriented Development Fund, an initiative that provides loans to affordable housing developers to purchase land near current and planned transportation routes.⁷⁷ That enables developers to purchase land before transit lines are constructed and land prices soar.

Such initiatives recognize the inherent dilemma in improving transportation and other basic services in a community: the result is often that housing values and thus rents start to rise, making neighborhoods less affordable. Thus, a complicating aspect of improving housing-based services can be that other strategies need to be in place to help residents stay in their housing and communities if housing costs increase, in addition to enabling many of the residents who take advantage of new services to move into more opportunity-rich neighborhoods.⁷⁸

The Elderly

Housing-based approaches for the elderly require delicately balancing three important needs:

Stability and Reliability. There needs to be a commitment to maintaining stable and reliable housing of choice for seniors as they age by arranging physical accommodations. Many adults prefer to live in their own homes for as long

as possible, whether rented or owned, in familiar neighborhoods and communities. And many low-income older adults choose to age in their homes only because they lack affordable alternatives to move into either nursing homes or assisted living facilities. Thus, “aging in place” accommodations are important for maintaining continuity and stability for seniors as their medical and other needs increase. Being able to continue living in a familiar community not only allows for gradual adjustments to home-based supports, but also gives the residents ease of mind by maintaining independence and control of their lives. Home modifications are often vital to perceived independence as well as health and can be as simple as adding a handrail to a set of stairs, providing safer carpeting, or making more complex adaptations, such as switching a bathtub out for a walk-in shower.⁷⁹ In Baltimore, Maryland, the CAPABLE program (Community Aging in Place, Advancing Better Living for Elders) sends nurses, handymen, and occupational therapists into older adults’ homes to identify and help with home modifications based not only on what the health teams assess need to be done, but primarily based on what the residents themselves identify to successfully live independently.⁸⁰ The individualized CAPABLE approach was found to not only save health care costs, but also improve health outcomes, particularly in mental health and depression.⁸¹

Changing Needs. The second need is the availability of services that support and permit the changing needs of a person to be met. From the

⁷⁶ U.S. Department of Housing and Urban Development, Office of Policy Development and Research, “Creating Connected Communities: A Guidebook for Improving Transportation Connections for Low- and Moderate-Income Households in Small and Mid-Sized Cities,” April 2014, https://www.huduser.gov/portal/publications/commdev/connecting_communities.html.

⁷⁷ Enterprise Community Partners, “Denver Regional Transit-Oriented Development Fund,” <https://www.enterprisecommunity.org/financing-and-development/community-loan-fund/denver-regional-tod-fund/>.

⁷⁸ Leonard S. Rubinowitz and James E. Rosenbaum, *Crossing the Class and Color Lines: From Public Housing to White Suburbia* (Chicago: University of Chicago Press, 2000); and Jens Ludwig et al., “Neighborhood Effects on the Long-Term Well-Being of Low-Income Adults,” *Science* 337, no. 6101 (September 21, 2012): 1505–10.

⁷⁹ Emily Salomon, “Home Modifications to Promote Independent Living,” American Association of Retired Persons, March 2010, <http://www.aarp.org/home-garden/housing/info-03-2010/fs168.html>; and William C. Mann et al., “Effectiveness of Assistive Technology and Environmental Interventions in Maintaining Independence and Reducing Home Care Costs for the Frail Elderly: A Randomized Controlled Trial,” *Archives of Family Medicine* 8, no. 3 (May–June 1999): 210–17, <https://www.ncbi.nlm.nih.gov/pubmed/10333815>.

⁸⁰ Lisa Watts, “CAPABLE Program Team Helps Baltimore’s Elderly Stay in Homes,” *Johns Hopkins Magazine*, Summer 2014, <https://hub.jhu.edu/magazine/2014/summer/capable-aging-in-place/>.

⁸¹ Sarah L. Szanton et al., “Community Aging in Place, Advancing Better Living for Elders (CAPABLE): A Bio-Behavioral-Environmental Intervention to Improve Function and Health-Related Quality of Life in Disabled, Older Adults,” *Journal of the American Geriatrics Society* 59, no. 12 (December 2011), 2314–20.

perspective of fostering independence, services that help an individual with activities of daily living (ADLs) or Instrumental activities of daily living (IADLs) are crucial to ensuring that an older person receives the help and support they need to age in their housing of choice. ADLs and IADLs could range from walking, dressing, and showering to cooking, shopping, and managing finances or transportation.⁸²

Isolation. The final need to be considered is the provision of services that meet social and community needs to combat isolation and separation from society through social interactions, wellness programming, classes, volunteering, and more. Solitude often undermines mental and emotional health. For those choosing to either live alone or remain in their current housing, it is important to combine access to supports with social interactions. Delivering that combination can be accomplished through such approaches as the Senior Villages model⁸³ and through other social groups, including religious communities and neighborhood organizations.

In thinking about housing-based strategies for seniors, it is also important to consider the very different conditions involved in residing in urban, suburban, and rural areas. Older adults living in rural areas often have limited transportation options. Interaction and socializing, as well as using medical and social services, can be very difficult, sometimes even forcing residents to leave their communities to gain adequate access to services.⁸⁴ While older adults might be skeptical of technology and privacy,⁸⁵ housers such as Avesta Housing, based in Portland, Maine, have created telemedicine rooms for

residents, of which roughly half are seniors, to connect them with health experts and nurses from their home.⁸⁶ Early in the planning process, Avesta partnered with local York Hospital, ensuring that its telemedicine room and services were HIPAA-compliant and implemented correctly. Avesta also partnered with MaineHealth, a nonprofit provider network, to coordinate monthly in-person nurse visits, using the designated telemedicine room for in-person services as well. While still too early to assess results, feedback has been overwhelmingly positive, Avesta continues to work to make services and care more accessible for its residents.

Disabled Adults

Housing strategies for people with disabilities require policymakers and providers to consider the typically differing needs of younger adults and older people with physical disabilities. It also requires attention to the varying needs of those with cognitive or mental disabilities. The U.S. Supreme Court's 1999 *Olmstead* decision, regarding discrimination against people with mental disabilities, has done much to shape the way states are funding and structuring housing, including HUD's Section 811 rental assistance program for the disabled. In thinking about housing, it is thus necessary to think far beyond just ramps and stair lifts.⁸⁷

Younger Disabled. For the younger disabled, there is a push to move away from institutionalization, seeking instead to provide

⁸² Centers for Medicare and Medicaid Services, "Medicare Current Beneficiary Survey (MCBS)," Appendix B, 2008, https://www.cms.gov/research-statistics-data-and-systems/research/mcbs/downloads/2008_appendix_b.pdf.

⁸³ Village to Village Network, "Village Model," http://www.vtvnetwork.org/content.aspx?page_id=22&club_id=691012&module_id=248578.

⁸⁴ Housing Assistance Council, *Rural Voices*, Winter 2011/2012, http://www.ruralhome.org/storage/documents/rv_winter2011-12.pdf.

⁸⁵ Miha Cimperman et al., "Older Adults' Perceptions of Home Telehealth Services," *Telemedicine Journal and e-Health* 19(10), 786–790, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3787386/>.

⁸⁶ Pam Bailey, "Technology + Housing = More Accessible Health Care," NeighborWorks America, December 2, 2016, <http://www.neighborworks.org/Blog/2016/Technology-housing-accessible-health-care>.

⁸⁷ Kim Borowicz and Hillary Coustan, "It's More than Ramps: Housing Accessibility for People with Disabilities," *Public Interest Law Reporter* 16, no. 2 (Spring 2011): 183–96, <https://lawecommons.luc.edu/pilr/vol16/iss2/19/>.

supports in a community setting.⁸⁸ Rather than institutionalize, which for decades was the typical approach, it is now understood that living independently with community supports, not in isolation, is important for quality of life and greater economic and social independence.⁸⁹ But generally, it is expensive to house adults with disabilities, in terms of both physical accommodations for those with physical disabilities and delivering services in a dispersed setting.

These considerations have led to the exploration of different models that can improve well-being in an affordable way. Money Follows the Person (MFP) is one demonstration, which makes it easier for states to transition individuals with chronic conditions or disabilities from long-term care institutions back into community and home settings.⁹⁰ Some 43 states and the District of Columbia have participated in MFP.⁹¹ A 2017 Mathematica evaluation report found that average monthly per beneficiary expenditures after transitioning to home or community settings decreased by \$1,783 for younger adults with physical disabilities and \$4,013 for individuals with intellectual disabilities.⁹² The report also found an improvement in satisfaction on many fronts, with 92 percent of participants reporting satisfaction with their living arrangements and only 8 percent still reporting an unmet service need.⁹³ Regrettably, funding for MFP expired in September 2016, and Congress has yet to reauthorize the program,⁹⁴ though a bill to renew

MFP was introduced in the Senate in December 2017.⁹⁵

Seniors. For the older disabled, there are widely accepted benefits for both aging in place and assisted living strategies. However, for individuals with disabilities, there is less agreement on whether providing housing-based services is more desirable than institutional care. Many younger adults with disabilities live in nursing homes because the current system infrastructure is not sufficiently integrated to meet their needs. For those individuals and others in assisted living, it is important to make sure that creating supportive housing communities does not actually end up segregating those adults from the rest of the community, making specialized care harder to deliver. It also important to note that the primary caregivers are often aging family members, so providing home-based services that also support the caregiver can be vital.

Immigrant, Cultural, and Racial and Ethnic Groups

Culturally relevant and appropriate housing strategies and trusted neighborhood-based services are very important when addressing the needs of most ethnic or immigrant communities. It is important to appreciate that a lack of trust in institutions outside the community, as well as government agencies, is common and can make immigrants fearful of using available services. To be successful, therefore, services must build trust, and community members must be included

⁸⁸ Sandra L. Friedman and Miriam A. Kalichman, "Out-of-Home Placement for Children and Adolescents with Disabilities," *Pediatrics* 134, no. 4 (October 2014): 836–46.

⁸⁹ Wendy Pentland et al., "Community Integration for Persons with Disabilities: Working Together to Make It Happen," *Canadian Journal of Occupational Therapy* 59, no. 3 (August 1992): 127–31, <https://www.ncbi.nlm.nih.gov/pubmed/10171084>.

⁹⁰ Centers for Medicare and Medicaid Services, "Money Follows the Person," retrieved January 8, 2018, <https://www.medicare.gov/medicaid/ltss/money-follows-the-person/index.html>.

⁹¹ Henry J. Kaiser Family Foundation, "Money Follows the Person Demonstration," <https://www.kff.org/search/?s=Money+Follows+the+Person+Demonstrations&fs=search>.

⁹² Carol V. Irvin et al., "Money Follows the Person 2015 Annual Evaluation Report," Mathematica Policy Research, May 11, 2017, <https://www.mathematica-mpr.com/our-publications-and-findings/publications/money-follows-the-person-2015-annual-evaluation-report>.

⁹³ Irvin et al., "Money Follows the Person 2015 Annual Evaluation Report."

⁹⁴ Julia Zur, MaryBeth Musumeci, and Rachel Garfield, "Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals," Henry J. Kaiser Family Foundation, June 29, 2017, <https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/>.

⁹⁵ Ensuring Medicaid Provides Opportunities for Widespread Equity, Resources, and Care Act" or the "EMPOWER Care Act, S. 2227, 115th Congress Cong. (December 13, 2017), <https://www.congress.gov/bill/115th-congress/senate-bill/2227>.

in planning processes and outreach.⁹⁶ Recognizing this, the Siloam Family Health Center in Nashville, Tennessee, takes steps to customize its approach to the city's immigrant communities. Siloam's refugee and immigrant patients come from 80 countries and speak 70 languages.⁹⁷ Siloam uses teams of health workers who have not only language familiarity, but also understand the cultural and social norms of the populations being served and even come from the same communities. Siloam also engages patients who are no longer in need of their services, providing opportunities for them to serve as medical interpreters and volunteers for others at the Siloam Health Center.⁹⁸

Services arranged around assisted housing can often be an important gateway to successful integration of immigrant and refugee families, making housing authorities one of their first points of contact. As an example, the Seattle and King Housing Authorities work closely with immigrant and refugee service agency coalitions to help with housing applications.⁹⁹ They have also taken steps to develop and embed cultural competencies in their operations staff and programs. This reinforces the work coming out of their newly created Immigrant and Refugee Commission,¹⁰⁰ which partners with faith

organizations, service agencies, and community organizations to ensure that the needs of its diverse immigrant and refugee population are met.¹⁰¹

Many aging-in-place models allow for culturally relevant outreach and programming flexibility. Initial versions of the Program of All-Inclusive Care for the Elderly (PACE), for instance, were shaped by the experiences of Asian and Italian families in 1970s San Francisco who were seeking aging and eldercare services beyond what was then available in traditional American nursing homes.¹⁰² The ability to age in familiar communities surrounded by family and close social circles appealed to these immigrant populations by allowing the elderly populations to maintain their cultural and social roots.

These cultural, ethnic, and community dimensions must be appreciated and addressed in order to build trust and effective partnerships. A culturally sensitive, relevant, and appropriate approach with meaningful and intentional collaboration is critical to success.

⁹⁶ Eva Marie Stahl and Bridget Clementi, "Building a Culture of Health Through Authentic Engagement," *CitiesSpeak*, August 28, 2017, <https://cityspeak.org/2017/08/28/building-a-culture-of-health-through-authentic-engagement/>.

⁹⁷ Siloam Health, "Community Partners," <https://siloamhealth.org/community-partners>.

⁹⁸ Siloam Family Health Center, "Annual Report," 2015, <https://siloamhealth.org/annual-report>.

⁹⁹ Seattle Housing Authority, "Citizenship and Immigration," <https://www.seattlehousing.org/supportive-services/resources/citizenship-and-immigration>.

¹⁰⁰ Seattle Immigrant and Refugee Commission, "About Us," <https://www.seattle.gov/immigrant-and-refugee-commission>.

¹⁰¹ King County, WA, "Immigrant and Refugee Task Force Report and Recommendations," February 27, 2017, <http://www.kingcounty.gov/elected/executive/equity-social-justice/Immigrant-and-Refugee/Immigrant-Refugee-TaskForce.aspx>.

¹⁰² Sarah Varney, "Private Equity Pursues Profits in Keeping the Elderly at Home," *New York Times*, August 20, 2016, <https://www.nytimes.com/2016/08/21/business/as-the-for-profit-world-moves-into-an-elder-care-program-some-worry.html>.

Requirements and Challenges for Housing as a Hub

As part of a Brookings Institution project supported by the Robert Wood Johnson Foundation, we interviewed a range of individuals engaged in efforts to improve collaboration across the housing sector, and we have studied several institutions. In a series of meetings and phone calls, we also brought together experts and practitioners to form an advisory group to explore the role of housing as a hub, the challenges faced, and policy steps that could improve their effectiveness.

In this report, we cannot examine all the factors and policies that affect the potential of housing as a hub. As we noted earlier, the factors affecting the supply and affordability of housing, which in turn affect the capacity of housing in certain neighborhoods to be a bridge to other services, are many and complicated. These factors involve many financial factors, government budgetary decisions, and economic issues that are beyond the scope of this report. Achieving an adequate supply of affordable housing is critical; it is difficult or impossible to have a housing-based approach to the issues facing vulnerable families if they do not even have access to affordable housing. But in this report, we do not delve into the larger issue of housing supply.

We instead focus on a review of the potential for linkages between housing and the major services needed to secure household and community well-being—such as health, social services and education—when sufficient affordable housing is available in a community. We explore the requirements for housing to play its full potential role as a hub for community well-being and the challenges that often impede that potential. These challenges face a range of attempts to collaborate across sectors and are not unique to housing.

We have arranged these challenges into three broad clusters.

Cluster 1: Data Collection and Measurement of Value

There are at least five reasons why good data are essential for effective collaboration and successful partnerships.

First, good data are necessary to provide an accurate **picture of the strengths and weaknesses and the needs of the community and its residents**. Using data to construct an accurate picture of the population, conditions, and institutions of a community can also give clues to ways of forming partnerships and identifying hubs to help strengthen the community. Such a “map” of the community can identify co-located issues, such as pockets of high crime and poor housing or health, and suggest possible hubs and partnerships to tackle these issues.

Second, collaboration between organizations and sectors to address the service needs of individuals requires **compatible data systems that can share information**. Data sharing is the lubricant of collaboration.

Third, the capacity to develop and analyze data about clients and performance is essential for an organization **to identify and report on its activities and to improve its operations, including those interventions that have the greatest likelihood of success**. Fortunately, some sectors are beginning to analyze data to identify patterns that lead to customized interventions to address problems concentrated in certain populations. The medical “hotspotting” approach, pioneered by such organizations as

the Camden Coalition,¹⁰³ is a good example.¹⁰⁴ In the health care area and as schools try to identify the reasons some children face difficulties, using data to identify home and community problem patterns is increasingly recognized as important. This has led some hospitals to develop housing partnerships. For example, Massachusetts General Hospital collected data about people frequently coming to the emergency room and found that 228 emergency room department patients lived in three buildings near the hospital. They created partnerships between the hospital and those three buildings, all housing providers for low-income older or disabled adults, where the hospital funds on-site services in the building, including a nurse.¹⁰⁵

Fourth, **good data collection and analysis** are necessary to evaluate ventures for public and private funders. Evaluation is crucial for identifying the activities of an organization that are most effective, and good data and effective techniques are needed to measure the broader social return on investment (SROI) and guide future investment strategies. In some cases, identifying impact over time is challenging, especially since some interventions take years for the savings and benefits to become evident.

And fifth, in the case of collaborative efforts across sectors with multiple impacts across the sectors, **good SROI techniques are crucial for achieving the optimal level of investment.** Only with good SROI analysis is it possible to pinpoint ways that an investment in one part of an interconnected structure of services and benefits, or value, can lead to value elsewhere. In turn, without that analysis, there is likely to be suboptimal total investment, with fewer and less efficient benefits and value to households and

communities than a better-informed and organized structure of investment could achieve. Inadequate SROI data exacerbate the “wrong pocket” problem, in which an investment cost is incurred by one organization or sector but another organization or sector is a “free rider,” enjoying much or most of the benefit but not contributing to the cost. (See below, in Cluster 2, for budget consequences)

Unfortunately, while the collection and analysis of data used to plan for and evaluate cross-sector partnerships are improving, significant challenges need to be addressed.

Mapping the Community. In recent years, there have been important steps forward in developing the data needed to assess conditions in neighborhoods and the needs of their residents. For instance, the National Neighborhood Indicators Partnership (NNIP),¹⁰⁶ a collaboration of the Urban Institute and dozens of local partners, promotes a model to build up data on neighborhood conditions and help community stakeholders use the data for program planning and policymaking. Nevertheless, most community initiatives lack access to such crucial basic information.

Data Sharing. Collaborative efforts are often frustrated by obstacles to sharing information and gaining access to necessary data. For instance, data often are not collected by government agencies in standardized ways, making it difficult to properly match multiple records on any individual to keep them consistent. Agencies are often reluctant to share data. Sometimes that reluctance is due to technical obstacles in public or private organizations, with systems that make it labor-intensive to access, document, and share

¹⁰³ Camden Coalition of Healthcare Providers, “Better Health Care at Lower Cost in Camden, NJ,” <https://www.camdenhealth.org/>.

¹⁰⁴ Atul Gawande, “The Hot Spotters,” *New Yorker*, January 24, 2011, <https://www.newyorker.com/magazine/2011/01/24/the-hot-spotters>.

¹⁰⁵ Joan Quinlan, “Massachusetts General Hospital and Housing,” Massachusetts General Hospital, Center for Community Health Improvement, December 7, 2017, <https://bluecrossmafoundation.org/sites/default/files/download/related/Massachusetts%20Panel%20-%20Joan%20Quinlan%20at%20Massachusetts%20General%20Hospital.pdf>.

¹⁰⁶ National Neighborhood Indicators Partnership, “NNIP Concept,” <https://www.neighborhoodindicators.org/about-nnip-concept>; and Stuart M. Butler and Jonathan Grabiner, “The Building Neighborhood Data to Inform Policy: A Q&A with Kathryn Pettit, Director of the National Neighborhood Indicators Partnership (NNIP),” Brookings Institution, December 29, 2015, <https://www.brookings.edu/blog/up-front/2015/12/29/building-neighborhood-data-to-inform-policy-a-qa-with-kathryn-pettit-director-of-the-national-neighborhood-indicators-partnership-annip/>.

data. In addition, there are often legitimate concerns about federal privacy requirements, such as Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) requirements. While there are many ways to comply with these requirements, especially under HIPAA, uncertainty often inhibits sharing among government agencies as well as private-sector organizations. As part of their *HousingIs* initiative, the Council of Large Public Housing Authorities (CLPHA) has created several data-sharing agreement templates to help housing and education sectors and organizations better collaborate and share data.¹⁰⁷ These templates allow flexibility and are being used by housing authorities, school districts, and third-party education entities across the country. CLPHA hopes to focus on adding a health sector data-sharing template in the coming year.¹⁰⁸

Capacity Issues and Evaluation. Supporting direct services rather than the “overhead” of data collection is always more attractive to funders. For smaller and innovative organizations addressing community needs, the result is often that they lack adequate data or analysis capacity to improve their operations.¹⁰⁹ Lack of funding for the planning, time, and technology needed for relevant data collection also means effective organizations or partnerships are unable to undertake the rigorous evaluations generally needed to be eligible for funding for expanded activities.¹¹⁰ This is especially problematic for projects and organizations spanning multiple sectors, where many data sets are involved or where the impact of an intervention (for instance, addressing children’s behavioral health) may

take several years to measure definitively and requires tracking individuals after they have left the organization’s program.

Return on Investment. The problem of data capacity is compounded by the limitations of current tools to measure the full impact of initiatives involving multiple sectors. A community-based initiative to address the mental health needs of children will have measurable potential health impacts and cost savings in the future. But it will also likely have beneficial effects on the child’s success in school and even in the workplace. To calculate a true SROI, these non-health impacts need to be factored in, which is technically difficult and expensive.¹¹¹ Unfortunately, our ability to measure these broader impacts is still quite limited, making it harder to make the case for funding and impeding progress toward collaboration.

Cluster 2: Budget and Payment Systems That Do Not Align with Creating Effective Housing Hubs

Effective collaboration requires the ability to align budgeted funds to reach a common objective involving different sectors. It also requires payment systems for relevant programs to provide the flexibility needed to permit spending in each program to contribute to a common approach. In addition, evaluations that will guide future budgets must reflect the broad impact on multiple sectors and budgets of an investment in one sector.

¹⁰⁷ Council of Large Public Housing Authorities, “Aligning Education and Housing: Data Sharing Agreement Template,” *Housing Is*, May 1, 2016, <https://www.housingis.org/resource/7806>.

¹⁰⁸ Council of Large Public Housing Authorities, “Making Data Sharing Agreements Work (CLPHA’s 2017 Affordable Housing & Education Summit),” *Housing Is*, July 19, 2017, <https://www.housingis.org/resource/7976>.

¹⁰⁹ Stuart M. Butler and Jonathan Grabinsky, “Data and Measurement Issues Surrounding ‘Hub’ Models: The Case of Briya/Mary’s Center,” Brookings Institution, August 13, 2015, <https://www.brookings.edu/opinions/data-and-measurement-issues-surrounding-hub-models-the-case-of-briyamarys-center/>.

¹¹⁰ Stuart M. Butler, “Why Capital Markets Are Tough for Scrappy Non-Profits,” Brookings Institution, August 23, 2016, <https://www.brookings.edu/opinions/why-capital-markets-are-tough-for-scrappy-non-profits/>.

¹¹¹ Robin Arnold-Williams et al., “Measuring Total Investments in Health: Promoting Dialogue and Carving a Path Forward,” Leavitt Partners, 2016, http://leavittpartners.com/wp-content/uploads/2016/10/Full-Report_Total-Spend-on-Health_10.17.2016-FINAL-1.pdf.

Regrettably, this is not the common practice of government budgeting, which hampers collaborative strategies such as using one institution as the hub for a range of services. As noted above, obstacles to the data sharing and the evaluation techniques are part of the problem. The tendency of agencies at all levels to plan independently is another problem. To be sure, there have been promising steps to reduce these bureaucratic walls. For instance, most states now have some form of “children’s cabinet”¹¹² designed to coordinate programs and budget planning on children’s issues; while these vary in effectiveness, they are a step forward. In addition, some federal agencies—notably the Department of Health and Human Services (HHS), HUD, and the Department of Education (DOE)—have a track record of joint planning. For instance, HUD and HHS have partnered in designing coordinated housing, health, and long-term services and supports for low-income elderly adults.¹¹³ HUD, the Department of Labor, and the Department of Veterans Affairs also launched a joint program to address veteran homelessness.¹¹⁴ And HUD and the Department of Justice developed an interagency to reduce homelessness among former inmates reentering communities.¹¹⁵

Wrong Pocket Problem. Bureaucratic inertia in coordinating budgets is compounded, however, by the pervasive “wrong pocket” problem. This refers to the situation in which the program or agency making the investment in an activity is not the one that incurs the primary benefit or savings. Thus, while a budget investment, for example, in improving the condition and safety of housing for the elderly may lead to significant reductions in health spending in federal and state programs, those savings do not accrue to the housing

budget. Meanwhile, switching housing budget money to an objective where the benefit accrues to another sector means shifting resources from other purposes where there might be a clear impact that serves the housing department’s own goals. Thus, understandably, this wrong pocket problem discourages the cooperation needed for efficient collaboration in a hub strategy.

Even when there is a strong measure of budget cooperation, the rules governing payments—including statutory requirements—can prevent money in a program from being used in ways that enhance the overall objective of the corporation. In some cases, restrictions on, for example, health programs using funds in another sector, such as housing, can undercut savings or improvements in the health sector itself. Indeed, a general problem of this kind is that health care spending and most social services are tied to individuals, while much housing support is tied to buildings. As a result, there tends to be very limited funding available to provide services for the nonhousing needs of building residents, such as a resident service coordinator, and resources that are available usually must be funded out of housing dollars.

Waivers. It is true that some federal agencies and programs have used the discretion they have to address some of these obstacles. For instance, the so-called Section 1115 waiver authority permits the HHS secretary to waive certain provisions of health and welfare programs, including Medicaid, to allow states to undertake experimental, pilot, or demonstration projects that could enhance the objectives of Medicaid. Using this discretion, HHS secretaries in several administrations have allowed Medicaid funds to be used in novel ways that ultimately reduce

¹¹² Forum for Youth Investment, “Children’s Cabinet Network,” <http://forumfyi.org/childrens-cabinet-network-0>.

¹¹³ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “Design of a Demonstration of Coordinated Housing, Health and Long-Term Care Services and Supports for Low-Income Older Adults,” May 11, 2011, <https://aspe.hhs.gov/report/design-demonstration-coordinated-housing-health-and-long-term-care-services-and-supports-low-income-older-adults>.

¹¹⁴ U.S. Department of Housing and Urban Development, Office of Policy Development and Research, “Veterans Homelessness Prevention Demonstration Evaluation: Final Report,” November 2015, <https://www.huduser.gov/portal/publications/homeless/veterans-homelessness-prevention-report.html>.

¹¹⁵ U.S. Department of Housing and Urban Development, “FY 2015 Pay for Success Permanent Supportive Housing Demonstration Program NOFA,” October 15, 2015, https://www.hud.gov/program_offices/administration/grants/fundsavail/nofa2015/pfspshdemo.

health costs, for instance, housing improvements aimed at reducing accidents involving the elderly or providing additional social services for low-income families. In addition, federal law permits states to obtain federal waivers to provide certain long-term care services in their homes and communities rather than in an institutional setting. In this way, health programs can sometimes support housing-based activities that pay off in reduced medical expenses. Furthermore, many managed care plans, such as Medicaid managed care organizations with capitated payments covering their enrollees, are able and increasingly willing to fund certain nonmedical services, including some housing support, when this helps to reduce the direct medical costs of their plan members.

Nevertheless, there are statutory limits to this flexibility. For instance, Medicaid funds cannot be used for room and board or the direct capital costs of supportive housing, even when that might reduce institutional nursing home care costs for Medicaid. Moreover, there is often a mismatch between income eligibility for Medicaid and for housing assistance, making it harder to use housing support in conjunction with Medicaid. Medicare funding permits even less flexibility in funding nonmedical services. Moreover, use of Medicaid waivers only encourages health investments in other sectors when there is a projected beneficial impact in the health program itself; it does not encourage investment in a health initiative when the benefit may be in other sectors, such as improving school graduation rates.

Integrating Funding. Inflexibility further up the funding “supply chain” is compounded by the challenges of integrating funds from multiple sources at the community level. For hub initiatives to be most efficient, they would blend money from different sources for a general activity, such as organizing an array of supportive

services for an elderly resident. But that can be difficult or impossible. Public and even major private funders typically have different spending restrictions on using their funds, different eligibility criteria for recipients, and different requirements for tracking and reporting on funds. For smaller hub ventures, the management time and resources needed to handle these requirements can be overwhelming, making it difficult to handle the variety of funding sources needed to be effective.¹¹⁶

Cluster 3: Business Model Challenges

In addition to the need to align budgets and payment systems, the growth of housing as hubs also requires the “business model” of housers—indeed any institution considering a role as a hub—to enable collaboration. That is not always easy. Organizations in communities tend to specialize: Housers are housers; schools are schools—although there are exceptions. For instance, the CLPHA has helped build and sustain cross-sector partnerships in several cities. But in general, there is often an aversion to potential “mission creep,” even though the principle of collaboration is widely espoused.

There are several reasons for this.

Skill Gaps. One reason is that engaging in housing-based partnerships, including when a houser decides to organize services on site, requires complex technical and adaptive learning skills. This is not a unique problem for housing as a hub; it poses similar problems for schools and hospitals.¹¹⁷ Other institutions resolve the challenge of building a staff with the necessary skills by turning to an intermediary to bring in

¹¹⁶ Butler, “Why Capital Markets Are Tough for Scrappy Non-Profits.”

¹¹⁷ Butler and Diaz, “Hospitals and Schools as Hubs for Building Healthy Communities.”

those skills.¹¹⁸ In education, for example, community schools build an in-house team to address a range of services to assist students.¹¹⁹ But other schools turn to intermediaries. Communities in Schools—a nonprofit organization that funds specialists to work in schools—is an example of such an intermediary approach.¹²⁰

But even bringing in an intermediary, to add to a houser's skills and permit partnerships to enhance housing-based services, still poses risks and costs to the houser that may seem hard to justify. For instance, relying on an outside expert or “community quarterback” carries the risk of the expertise disappearing at some point in the future. The chief financial officer often has difficulty seeing the rationale for accepting a new cost if the potential benefits appear outside the normal functions of housing, such as improving the behavioral health and academic success of children in the housing units. Without some ability for the houser to identify and capture some of the value added or the savings, it is often difficult to justify an investment. This example of the wrong pocket problem requires thinking about other organizational arrangements, in which a group of organizations can collectively make investment decisions—and recoup and allocate savings.

Legal Worries. Furthermore, providing on-site services can also pose regulatory and legal concerns. For instance, there may be privacy concerns about what information can be shared between service providers working with the same clients. Moreover, if medical and other services are provided on site, the houser may worry about legal liability exposure due to actions of nonhousing staff.

Fair housing rules can also complicate the picture. Some nonprofit hospital systems have invested in housing in certain neighborhoods, seeing this as part of their community mission rather than a business decision related to providing in-home medical services more efficiently for their patients or plan enrollees. If they were to reserve their housing units for only their customers (such as individuals with chronic illness who need frequent medical services or elderly individuals enrolled in their Medicare Advantage plan), many housers fear they would run afoul of fair housing antidiscrimination rules. Even though appropriate legal advice would enable housers to avoid most concerns, disparate-impact claims are always a worry. Thus, hospital-housing partnerships tend to work only from a business perspective if there happens to be a “natural” concentration of patients or enrollees living in the community, such as when one hospital plan is dominant in the area. Yet there are some exceptions to that general pattern. For instance, PACE-housing partnerships avoid fair housing concerns. In some pilots, a hospital uses its own funds to place homeless high-utilizing patients in affordable housing, such as the University of Illinois (UIC) Hospital has in partnership with the Center for Housing and Health throughout Chicago. The UIC Hospital invested nearly \$250,000 to house 25 high-utilizing patients and provide case managers to help with service referrals.¹²¹ Not only has UIC seen positive health outcomes, but health care costs for its first 15 patients have decreased by 42 percent in the first year.¹²² Some

¹¹⁸ Stuart M. Butler and Prabhjot Singh, “Intermediaries in Integrated Approaches to Health and Economic Mobility,” Brookings Institution, November 30, 2015, <https://www.brookings.edu/research/intermediaries-in-integrated-approaches-to-health-and-economic-mobility/>.

¹¹⁹ Reuben Jacobson, “Community Schools: A Place-Based Approach to Education and Neighborhood Change,” Brookings Institution, November 18, 2016, <https://www.brookings.edu/research/community-schools-a-place-based-approach-to-education-and-neighborhood-change/>.

¹²⁰ Communities in Schools, “Our Model,” <https://www.communitiesinschools.org/our-model/#collaborative-partners>.

¹²¹ Ray Cavanaugh, “Chicago Hospital Tries to Improve Health of ER ‘Super-Utilizers’—with Housing,” *Chicago Tribune*, September 2, 2016, <http://www.chicagotribune.com/lifestyles/health/sc-hospital-homeless-patients-health-0914-20160902-story.html>.

¹²² Miles Bryan, “A Hospital Offers Frequent ER Patients An Out—Free Housing,” NPR, June 29, 2016, <http://www.npr.org/sections/health-shots/2016/06/29/482994000/a-hospital-offers-frequent-er-patients-an-out-free-housing>.

hospitals have also paid for respite bed for discharged homeless patients.¹²³

Trust. Trust is an additional issue complicating the business model of partnerships. While focusing services on a person in their home is often an efficient way to deliver those services, the home is also the private domain of the resident. Hence, there can be a privacy-convenience tension when services are provided

on site. Many residents prefer distance from a landlord knowing their personal business, unless the houser is a trusted institution in the community.

¹²³ Steven Ross Johnson, "Shelter for Convalescence: Hospitals Link with Respite Programs to Aid Homeless Patients Through Recovery," *Modern Healthcare*, March 22, 2014, <http://www.modernhealthcare.com/article/20140322/MAGAZINE/303229937>.

Recommendations

Recommendation 1: Improve Data Collection, Sharing, and Evaluation

As noted above, housing-based hubs and other community collaborations are hampered by their capacity to develop and share data, as well as weaknesses in techniques for measuring effectiveness. Several steps would help ameliorate these obstacles.

Communities, Including The Housers And Other Institutions In Them, Should Make Greater Use Of Data Techniques To Map Assets And Identify Patterns Of Social And Health Challenges.

In addition to collecting and sharing data to coordinate and customize services for individual households, hubs and other local organizations need detailed health, education, and other data to assess the strengths and weaknesses of the community and to plan their work. This type of information does not involve public release of personal identifiers, and so does not trigger privacy concerns, but it is very important in developing strategy.

Organizations and Data Tools. As noted earlier, there are examples of efforts to make such data more generally available and usable. Projects such as the National Neighborhood Indicators Partnership¹²⁴ and KIDS COUNT¹²⁵ are examples of nonprofit organizations that provide data and assistance to communities to help

develop local capacity and use community information to plan initiatives. Software programs can help health care, educational, and other organizations concerned with strengthening their community, such as hospitals preparing community health needs assessments (CHNA). For instance, Lyon's Community Benefit Inventory for Social Accountability software is widely used by organizations, such as the Catholic Health Association and LeadingAge.¹²⁶

Philanthropy has been very helpful in supporting the launch of such data mapping projects. Some governmental jurisdictions have also played a strong role, such as in Charlotte, North Carolina. But this capacity needs to be developed in far more communities and will need more public and private support.

Using Local Institutions. Existing requirements on certain institutions to analyze their communities could be used to fund and organize data mapping. For instance, nonprofit hospitals are required as a condition of their tax exemption to institute "community benefit" programs, undertake a periodic CHNA of their community, and design a plan to address those needs.¹²⁷ Bexar County, Texas, is an example of a community that has used the CHNA in this way.¹²⁸ Bexar's Health Collaborative brings together a wide range of organizations in addition to its hospitals, such as the YMCA and others committed to better health, and uses the hospitals' CHNA as a detailed map of health conditions and behaviors.¹²⁹ Improving the algorithms in software programs to refine their ability to show accurate SROI measurements will

¹²⁴ National Neighborhood Indicators Partnership, <https://www.neighborhoodindicators.org/>.

¹²⁵ Kids Count, Data Center, Annie E. Casey Foundation, <http://datacenter.kidscount.org/>.

¹²⁶ Lyon Software, "About Us," <http://lyonsoftware.com/community-benefit/about-us/>.

¹²⁷ Sara Rosenbaum, "Hospitals as Community Hubs: Integrating Community Benefit Spending, Community Health Needs Assessment, and Community Health Improvement," Brookings Institution, March 9, 2016, <https://www.brookings.edu/research/hospitals-as-community-hubs-integrating-community-benefit-spending-community-health-needs-assessment-and-community-health-improvement/>.

¹²⁸ Health Collaborative, <http://healthcollaborative.net/>.

¹²⁹ Health Collaborative, "2016 Bexar County Community Health Needs Assessment Report," August 23, 2016, <http://healthcollaborative.net/wp-content/uploads/reports/chna-2016.pdf>.

be an important advance in measuring the impact of collaborative partnerships.

The Internal Revenue Service (IRS) provides guidance to hospitals on activities that comply with the CHNA requirement and could do more to encourage use of the CHNA for cross-sector collaboration. Too often, hospitals and communities are unsure which activities meet CHNA requirements. Thus, the IRS should indicate in that guidance that developing maps of capacities and challenges for communities to use for health and other social objectives meets its requirements.¹³⁰

In addition, the 2015 Every Student Succeeds Act (ESSA) requires state and district “report cards” on a wide range of educational metrics, but also patterns of chronic absenteeism and other patterns often related to local community or housing conditions.¹³¹ That requirement, somewhat like the CHNA, could encourage local jurisdictions to focus on assembling and making available community data.

Housers. Some nonprofit and public housing providers are also taking steps to build a much more complete health, educational, and socioeconomic picture of their residents. For instance, the District of Columbia Housing Authority asked the Urban Institute to conduct a community needs assessment of residence in its family properties.¹³² More housing authorities should undertake such assessments to build a picture of the strengths and needs of their residents. Such analyses—which would include reviews of economic stability, health conditions, nutrition and obesity, education, and family benefit receipts—would provide a benchmark for measuring and evaluating housing-based service

interventions. This could be conducted in collaboration with housing authorities, nonprofit housing organizations, universities, public health departments, and research centers. Denver, Portland, and Cambridge are already using this approach.

Nonprofit Organizations And Government Agencies At All Levels Should Improve Their Procedures For Sharing Housing, Health, Education, And Other Data.

Improving the sharing of personalized data among agencies and organizations requires action on several fronts.

Privacy. Dealing with deeper issues is more complicated. Addressing HIPAA and FERPA privacy issues requires several steps. But while the underlying statutes need to be reviewed, the laws are often not as restrictive as many organizations believe, so concerns about sharing can often be addressed through training and better education. The federal government can help by providing more guidance, such as by making greater use of the DOE’s Privacy Technical Assistance Center.¹³³ The HHS Office of the National Coordinator for Health Information Technology (ONC)¹³⁴ provides guidance to help organizations avoid legal minefields. The ONC can help design safe harbors and better consent requirements that can make it easier for collaboration that involves patient information.

Sharing Within Government and Among Nongovernment Organizations. Government at all levels should also provide guidance and assistance to departments on sharing information

¹³⁰ Sara Rosenbaum et al., “Improving Community Health Through Hospital Community Benefit Spending: Charting a Path to Reform,” George Washington University, Milken Institute School of Public Health, <https://publichealth.gwu.edu/sites/default/files/downloads/research/Improving%20Community%20Health%20through%20Hospital%20Community%20Benefit%20Spending%20Release.pdf>.

¹³¹ Education Trust, “The Every Student Succeeds Act: What’s in It? What Does It Mean for Equity?,” January 2016, <https://edtrust.org/wp-content/uploads/2014/09/What-is-in-ESSA-Public-Reporting.pdf>.

¹³² Urban Institute, “Impact 5000: Serving Children in Public Housing in DC,” January 18, 2017, https://www.urban.org/sites/default/files/presentation_of_findings_-_susan_popkin_-_impact_5000.pdf.

¹³³ U.S. Department of Education, “Student Privacy 101: Student Privacy at the U.S. Department of Education,” <https://studentprivacy.ed.gov/>.

¹³⁴ U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, <https://www.healthit.gov/>.

and encourage such sharing. While federal laws tend to attract the most attention, some states have more stringent protections. In Massachusetts, for instance, data collected by homeless providers through the federally mandated Homeless Management Information System cannot easily be integrated with state agency systems.

Some relatively simple steps can make a big difference. For instance, organizations trying to secure housing and support services for homeless and at-risk individuals can find it extremely time-consuming to obtain the necessary documentation and complete various applications from different agencies. The city of Boston has sought to solve this by holding occasional events designed to connect homeless individuals with housing and services by bringing together all necessary parties under one roof at one time.

The federal government, as well as states and local governments, needs to address several data obstacles that make it difficult for agencies to share data. For instance, the Department of Housing and Urban Development is hampered in fostering some housing-based initiatives because HUD does not have easy access to health claims data. Moreover, HUD has different data systems, which can make cooperation difficult. Often interoperability issues are among the technical problems that make sharing difficult. But governance questions—such as how transfers are managed and privacy assured—are also a challenge for agency officials. Uncertainty and concerns about accountability lead to officials becoming reluctant to share information.

Guidance and Training. Governments and private organizations need to invest in developing training and written guidance for employees on how to maintain and share potentially sensitive data. Fortunately, several organizations and branches of government are focused on these issues. Examples include HHS's Medicaid Information Technology Architecture, which is designed to foster integrated IT and data sharing across the Medicaid program and to address governance issues.¹³⁵ The Administration for Children and Families is also focused on improving interoperability.¹³⁶ Meanwhile, the federal government has been helping more broadly through the National Information Exchange Model, which is designed to promote efficient information exchange across a broad range of public and private organizations throughout the country.¹³⁷ And the National Governors Association has been working with states to harmonize state laws and policies for the use and sharing of information.¹³⁸

Some jurisdictions are models of responsible data sharing. Allegheny County, Pennsylvania, with Pittsburgh at its center, is such a model.¹³⁹ County officials brought in outside experts to help them better understand the laws and regulations affecting data. This led to improved data-sharing agreements and other steps. The county also created a data warehouse that integrates client data from multiple agencies, and it has developed protocols to provide access to this data to clients themselves as well as their service providers.¹⁴⁰

Such government-sponsored efforts are being supplemented by nongovernmental institutions that provide training and other assistance to both the public and nonprofit sectors. For example, the

¹³⁵ Centers for Medicare and Medicaid Services, "Medicaid Information Technology Architecture (MITA)," <https://www.medicaid.gov/medicaid/data-and-systems/mita/index.html>.

¹³⁶ U.S. Department of Health and Human Services, Administration for Children and Families, "Interoperability," October 4, 2017, <http://www.acf.hhs.gov/about/interoperability>.

¹³⁷ National Information Exchange Model, "About NIEM," <https://www.niem.gov/about-niem>.

¹³⁸ National Governors Association, "Data, Privacy and Interoperability," <https://www.nga.org/cms/center/issues/health/data-privacy-interoperability>.

¹³⁹ Allegheny County Department of Human Services, "Allegheny County Analytics," <https://www.alleghenycountyanalytics.us/>.

¹⁴⁰ Andrew Feldman, "Linking Data to Improve Human Services While Working Within Privacy Laws: An Interview with Erin Dalton and Brian Bell, Allegheny County Department of Human Services," Gov Innovator podcast, July 10, 2017, http://govinnovator.com/allegheny_county/.

Strategic Data Project at Harvard¹⁴¹ and the University of Pennsylvania’s Actionable Intelligence for Social Policy Project¹⁴² assist local levels of government and private institutions in constructing and managing integrated data systems. In its assistance to communities, NNIP provides online guides covering data-sharing agreements and other issues.¹⁴³ Meanwhile, the Robert Wood Johnson Foundation is among the foundations providing such help. Among other steps, the foundation launched a Data Help Improvement across Sectors for Health project to improve the collection and sharing of data across sectors to address community health needs.¹⁴⁴

Jurisdictions should assist in building data hubs and improve the capacity of small organizations to assemble and analyze data.

The federal government, states, counties, and cities should also accelerate steps to establish forms of “data warehouses” as a tool to make well-monitored data available to organizations. There has been significant progress in doing this with health data thanks to the increasing array of health information exchanges (HIEs) around the country. Many hospitals are part of HIEs or house them, and many HIEs include local clinics that provide a range of services beyond health care, including social services and education. Some cities are also taking steps to build on the HIE network to strengthen local services, such as Dallas through its use of the Information Exchange Portal.¹⁴⁵

State and local governments could widen the use of the HIE network and the capacity and skills of the exchanges by funding and supporting the addition of other data—such as education, juvenile justice, and social services—to HIE hubs. The funding of such wider data services by nonprofit hospitals could also be considered part of their community service obligations to meet IRS requirements for tax exemption.

Using Intermediaries. State and local governments and philanthropy should also explore using community intermediaries, or “backbone” organizations, as data intermediaries in communities. As described below, organizations such as the Family League of Baltimore are usually better positioned to collect, analyze, and appropriately share personalized data and other information than small organizations at the local level. But developing such an enhanced data capability imposes a heavy cost on organizations and, especially if they take over the data responsibilities of smaller, local organizations, is an addition to overhead that is not normally covered by foundation grants or government contracts. Public and private funders thus need to consider the broader benefits of building such data intermediaries and be open to funding their activities and so helping to build this critical data infrastructure.

Building Capacity. In addition, public and private funders should pay greater attention to building the data capacities of smaller organizations in the community.¹⁴⁶ Local service providers generally find it far more difficult to obtain support for data collection and analysis than for direct services.

¹⁴¹ Harvard University, Center for Education Policy Research, “Strategic Data Project,” <http://sdp.cepr.harvard.edu/>.

¹⁴² University of Pennsylvania, “Actionable Intelligence for Social Policy,” <http://www.aisp.upenn.edu/>.

¹⁴³ National Neighborhood Indicators Partnership, “NNIP Lessons on Local Data Sharing,” February 14, 2016, <https://www.neighborhoodindicators.org/library/guides/nnip-lessons-local-data-sharing>; Leah Hendey, “Using Integrated Data to Improve Communities: Lessons from a Cross-Site Project,” National Neighborhood Indicators Partnership, April 2016, <https://www.urban.org/research/publication/using-integrated-data-improve-communities-lessons-cross-site-project>; National Neighborhood Indicators Partnership, “Expanding Training on Data and Technology to Improve Communities,” April 2016–August 2017, <https://www.neighborhoodindicators.org/activities/projects/expanding-training-data-and-technology-improve-communities>; and National Neighborhood Indicators Partnership, “Data and Tech Training Catalog,” <https://www.neighborhoodindicators.org/data-tech/training>.

¹⁴⁴ Data Across Sectors for Health, “About DASH,” <http://dashconnect.org/about-dash/>.

¹⁴⁵ Dallas Information Exchange Portal, <http://iep.pccipieces.org>.

¹⁴⁶ Kathryn L. S. Pettit and Maia Woluchem, “Empowering the Public and Nonprofit Sectors with Data and Technology,” National Neighborhood Indicators Partnership, June 2017, <https://www.neighborhoodindicators.org/library/catalog/empowering-public-and-nonprofit-sectors-data-and-technology>.

But the lack of data capabilities makes it harder for them to assess their performance and modify operations, as well as to provide the performance data required by funders.

Public and private bodies should develop better techniques to measure SROI and evaluate initiatives, and they should use improved measures to determine the broad savings that can be achieved from intersector collaboration and partnerships. Public and private funders should use tiered grants to align funding approaches with the stage of development of promising initiatives.

As noted earlier, a challenge to gaining financial and policy support for collaborative initiatives is the limitation of existing techniques and research results for demonstrating impact. Good measurement of the multisector impacts of initiatives is necessary to persuade policymakers to take the political risk of altering budget allocations to support cross-sector initiatives; it is also needed to provide public and private funders with the justification they need to reallocate grants between sectors to finance new ventures. Even in such areas as social determinants of health, where there is general openness to improving health by investing in nonmedical interventions, solid SROI evidence is often thin.

Improving the Measurement of Multisector Impacts. A significant part of the problem is the

need to refine techniques to measure multisector impacts. For instance, a growing body of research indicates a causal link between certain housing conditions, such as mold, and health impacts, such as respiratory ailments,¹⁴⁷ and on housing and neighborhood conditions as a factor in children's readiness for learning.¹⁴⁸ But drawing a more complete picture and justifying investments in housing-based initiatives to address other conditions—such as education problems, behavioral issues, and low workforce participation—requires much stronger and broader SROI research. Important work has been launched to develop better SROI techniques, such as at Chapin Hall (University of Chicago) and the American Public Human Services Association (APHSA),¹⁴⁹ and for some cross-sector organizations, such as community schools.¹⁵⁰ Chapin Hall serves as a third party, data-sharing intermediary for housing and school districts.¹⁵¹ NeighborWorks America's Success Measures evaluation group has developed 68 new data collection tools to help housing, community development, and health organizations take a more intentional approach to measuring and evaluating health outcomes.¹⁵²

Some other countries, such as the United Kingdom,¹⁵³ are also refining SROI methodology to analyze public investments. In the United States, some state-based organizations are developing better analytical techniques for policymakers, such as the Washington State Institute for Public Policy¹⁵⁴ and EPISCenter in

¹⁴⁷ Butler et al., "Re-balancing Medical and Social Spending to Promote Health."

¹⁴⁸ Claudia Coulton et al., "Leveraging Integrated Data Systems to Examine the Effect of Housing and Neighborhood Conditions on Kindergarten Readiness," Case Western Reserve University, Center on Urban Poverty and Community Development, April 4, 2016, http://povertycenter.case.edu/wp-content/uploads/2016/04/Coulton_et_all_2016_Leveraging_Integrated_Data.pdf.

¹⁴⁹ American Public Human Services Association, "Social Return on Investment," May 2013, <http://www.aphsa.org/content/dam/aphsa/pdfs/Innovation%20Center/2013-05-Social-Return-on-Investment-Brief.pdf>.

¹⁵⁰ Laura Martinez, Cheryl D. Hayes, and Torey Silloway, "Measuring Social Return on Investment for Community Schools: A Practical Guide," Finance Project, 2013, http://www.nccs.org/sites/default/files/resource/NCCS_SROI_Guide.pdf.

¹⁵¹ Erika M. Kitzmiller, "IDS Case Study: Chapin Hall," University of Pennsylvania, Actionable Intelligence for Social Policy, August 2013, http://www.aisp.upenn.edu/wp-content/uploads/2015/08/ChapinHall_CaseStudy.pdf; and Julie Spielberger et al., "Connecting the Dots: Data Use in Afterschool Systems," Chapin Hall at the University of Chicago, April 2016, https://www.chapinhall.org/sites/default/files/Wallace_report_connecting%20dots.pdf.

¹⁵² Success Measures at NeighborWorks America, "Document Outcomes, Measure Impact, Inform Change," <http://www.successmeasures.org/>; and Jessica Mulcahy, "Measuring Health Outcomes: Success Measures Evaluation Tools for Community Development and Health," Success Measures at NeighborWorks America, 2017, http://www.successmeasures.org/sites/all/files/HealthPubTool_111917.pdf.

¹⁵³ Social Value UK, "A Guide to Social Return on Investment," January 2012, <http://www.socialvalueuk.org/resources/sroi-guide>.

¹⁵⁴ Washington State Institute for Public Policy, "Benefit-Cost Results," <http://www.wsipp.wa.gov/BenefitCost?topicId>.

Pennsylvania.¹⁵⁵ Others, such as the Low Income Investment Fund, have developed online tools to help show the broad financial impact of community investments.¹⁵⁶

These are all important developments, and they indicate the potential for designing tools to indicate the cross-sector effects of an investment in one sector. They also suggest that we could sharply improve the efficiency of social investments. But we are still well short of the needed capacity and range of tools. Far more public and private investment and greater academic focus are needed in the field of SROI techniques and use.

Evaluation. Public and private grant-making decisions for housing-based and other inter-sector collaborations should take into account the limitations of SROI analysis, as well as the general data challenges facing new and innovative hubs and partnerships. In an ideal world, such hubs would collect extensive data and arrange for rigorous evaluations of their work. But when they are small and relatively new, it is very difficult for them to do that—that is, requiring rigorous evaluation can slow innovation when organizations are going through their early trial-and-error phase of refining their operations and experimenting with approaches.

Matching funding strategies with the development phase of institutions and their capacity to collect data requires care. In particular, we need to be cautious about applying traditional, rigorous evaluation methodologies to these developing, inter-sector organizations. Their interconnectedness means, among other things, that it is difficult to isolate and measure the effect of one or more interventions in the way

normally done under randomized controlled trials and similar methodologies. Instead, evaluators should typically use a mixed-methods strategy, incorporating both quantitative and qualitative methodologies to take account of the multiple elements.¹⁵⁷

Addressing the issues associated with evaluating new and innovative organizations is made more urgent by the growing interest in evidence-based policymaking and funding by federal agencies and other sources of funding.¹⁵⁸ Fortunately, such organizations as the Bipartisan Policy Center and Project Evident¹⁵⁹ are exploring these issues, seeking to improve evaluation and accountability without inundating organizations with demands for extensive and expensive data. Meanwhile, public and private funders should be more inclined to use tiered grants.¹⁶⁰ Such grants include funding for evaluation, so that grantees can build up their data capabilities and become eligible in the future for grants requiring more rigorous assessment. Tiered grants incorporate so-called stage funding, where initial currents focus on support for untested but high-potential initiatives, with larger grants down the road for grants aimed at validation and then scaling-up activities. Currently, some federal agencies, including HHS and the Department of Labor, have been using tiered funding in such areas as teen pregnancy prevention, home visiting, and social innovation.

¹⁵⁵ Evidence-Based Prevention and Intervention Support Center, <http://www.episcenter.psu.edu/>.

¹⁵⁶ Low Income Investment Fund, "Social Impact Calculator," <https://www.liifund.org/calculator/>.

¹⁵⁷ Butler and Grabinsky, "Data and Measurement Issues Surrounding 'Hub' Models."

¹⁵⁸ Commission on Evidence-Based Policymaking, "The Promise of Evidence-Based Policymaking: Report of the Commission on Evidence-Based Policymaking," September 2017, <https://www.cep.gov/cep-final-report.html>; and Andrew Feldman, "Strengthening Results-Focused Government: Strategies to Build on Bipartisan Progress in Evidence-Based Policy," Brookings Institution, January 30, 2017, <https://www.brookings.edu/research/strengthening-results-focused-government-strategies-to-build-on-bipartisan-progress-in-evidence-based-policy/>.

¹⁵⁹ Project Evident, <https://www.projectevident.org/>.

¹⁶⁰ Andrew Feldman, and Ron Haskins, "Tiered-Evidence Grantmaking," Evidence-Based Policymaking Collaborative, September 9, 2016, <http://www.evidencecollaborative.org/toolkits/tiered-evidence-grantmaking>.

Recommendation 2: Improve Budgetary Coordination and Funding Experimentation

Coordination between agencies and flexible budgeting are among the keys for collaboration across sectors. But as discussed in the challenges to enabling housing to be an effective hub, such coordination flexibility is often missing. Agencies often do not coordinate their program planning and their budgets. Moreover, agencies in jurisdictions tend to focus on actions that affect their own budgets, and the jurisdiction often will not systematically identify how investments in one agency's programs would yield larger savings in another agency and for the entire jurisdiction. This example of the wrong pocket problem strongly discourages budget investments that benefit other sectors. And payment rules often make flexibility in budgeting extremely difficult.

In addition, government rules and requirements have the power to influence key investment decisions within communities by financial and nonprofit medical institutions, as well as encouraging creative forms of private capital to achieve social objectives.

To address these obstacles and opportunities, governments at every level of the federal system need to take steps to improve coordination flexibility and encourage funding innovations. This requires political leadership at the federal, state, city, and local levels.

The federal government, states, counties, and cities should create bodies to link decision makers from multiple agencies and to coordinate planning, budget strategies, and investments.

At every level of government, officials in many of the agencies that should be coordinating budgets and planning together literally do not talk to each other. For housing to realize its potential as a hub, institutions must be allowed to use government funds flexibly and creatively. To improve the environment for hubs to function in this way, government agencies need to better coordinate their activities to reach shared goals. For that to happen, leaders in government must foster a culture of cross-agency collaboration and experiment with bodies designed to improve coordination of planning and budgets, but also ensure results. The experience of such bodies shows that leadership is critical for success—the effectiveness and staying power of such interagency depends on the forceful and continuous support of the chief executive presiding over the agencies.

Joint Planning: Federal, State, and Local.

There have been some effective examples at the federal level. During the Reagan Administration, the White House launched a series of “cabinet councils” to focus multiagency action on its priorities, such as economic recovery. At the state level, many states have created “children’s cabinets” to bring together top officials from different agencies to coordinate services and budgets.¹⁶¹ In Virginia, several different departments responsible for different funding streams for high-risk children were given authority under statute to pool funds that are now managed by an interagency council.¹⁶²

¹⁶¹ Forum for Youth Investment, “Children’s Cabinet Network.”

¹⁶² Trust for America’s Health, “Blueprint for a Healthier America 2016: Policy Priorities for the Next Administration and Congress,” November 2016, <http://healthyamericans.org/report/129/>; Maryland’s Local Management Boards, “Making a Difference for Children and Families, 1990–2010,” 2011, http://communitypartnerships.info/wp-content/uploads/2014/05/MD_LMB_Jan_2011.pdf; and Amy Clary and Trish Riley, “Pooling and Braiding Funds for Health-Related Social Needs: Lessons from Virginia’s Children’s Services Act,” National Academy for State Health Policy, June 2016, <http://nashp.org/pooling-and-braiding-funds-for-health-related-social-needs-lessons-from-virginias-childrens-services-act/>.

There are some promising examples of cross-agency collaboration. At the federal level, HHS and HUD have developed joint pilot programs in such areas as elderly housing. In one innovative partnership, HUD and HHS linked HUD tenant data with Medicare and Medicaid data, creating the first such dataset of its kind.¹⁶³ A review for HHS conducted by the Lewin Group found that such partnerships are crucial for effective research on how to help low-income aging populations live and age independently, and housing–health care partnerships can not only improve health outcomes but also lower medical costs.¹⁶⁴ In some cases, a congressional statute has been the spur for such cooperation. For instance, the 1987 McKinney Homeless Assistance Act created the Interagency Council on the Homeless (now named the US Interagency Council on Homelessness) in the executive branch to promote cooperation within the federal government and with state and local governments.¹⁶⁵

Cities and Counties. Many local jurisdictions have been exploring better ways to link housing with other services. For instance, the National League of Cities assembled a “Mayors’ Institute” to review lessons from cities on promoting healthy housing.¹⁶⁶ Meanwhile, the city of Boston recently decided to speed up the linking of homeless individuals to affordable housing and services. To do this, Boston has held a series of one-day “housing surges” that bring together all necessary parties under one roof at one time. A housing surge is different from a “fair,” where people learn about resources for which they may be eligible. A “housing surge” not only provides

this information, but also actually enrolls individuals in supportive service programs and makes housing offers on site at the event, allowing attendees to leave with an address and support services the very same day. Boston found that the first event took a great deal of agency coordination and leadership, but with experience, it became easier and cultivated ongoing housing and service partnerships among local agencies. From the county perspective, Broward County in Florida has a child welfare interagency council that was the impetus for their participation in a federal pilot exploring the role of supportive housing and integration of services in reducing child welfare involvement for vulnerable families.¹⁶⁷

Creating Interagency Councils. Drawing on the experience of cabinet councils, children’s cabinets, and existing interagency collaboration, the federal government should establish interagency councils to encourage the creation of housing hubs and other partnerships to foster inter-sector cooperation. To assure strong agency support, these councils should include senior officials from such departments as HUD and HHS. The councils should engage in joint planning and budget requests to encourage local collaboration.

States should establish similar councils to foster interagency coordination, modeled on children’s cabinets, to foster the creation and funding of housing-based hubs and other hubs. Even when states strengthen interagency cooperation, there are intricate procedural steps and planning multiple steps to ensure state plans fit the

¹⁶³ U.S. Department of Housing and Urban Development, “HUD and HHS Announce Successful Test to Match Housing and Health Data to Better Understand the Needs of HUD-Assisted Households,” June 12, 2014, <https://archives.hud.gov/news/2014/pr14-070.cfm>.

¹⁶⁴ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “Picture of Housing and Health: Medicare and Medicaid Use Among Older Adults in HUD-Assisted Housing,” March 1, 2014, <https://aspe.hhs.gov/basic-report/picture-housing-and-health-medicare-and-medicaid-use-among-older-adults-hud-assisted-housing>.

¹⁶⁵ U.S. Interagency Council on Homelessness, “U.S. Interagency Council on Homelessness Historical Overview,” 2010, https://www.usich.gov/resources/uploads/asset_library/USICH_History_final.pdf.

¹⁶⁶ National League of Cities, “City-Level Models to Advance Healthy Housing: Lessons from NLC’s Mayors’ Institute on Housing, Hazards and Health,” 2017, <http://nlc.org/sites/default/files/users/user75/FINAL-Healthy%20Housing.pdf>.

¹⁶⁷ Martha R. Burt, Maeve E. Gearing, and Marla McDaniel, “Evolution in Programs Offering Supportive Housing to Child Welfare–Involved Families Services Integration and Systems Change at the Half-Way Point,” Urban Institute, March 2016, <https://www.urban.org/research/publication/evolution-programs-offering-supportive-housing-child-welfare-involved-families-services-integration-and-systems-change-half-way-point>.

requirements of federal programs. Fortunately, the National Governors Association's Center for Best Practices provides guidance to help states to navigate the coordination of health care and housing.¹⁶⁸

Wrong Pockets, Public Goods, and Optimal Investments. An objective of such collaboration and planning should be to devise budgetary arrangements to address the wrong pocket problem, leading to a more optimal level of investment when multiple sectors and departments are involved. A possible arrangement might include treating a collection of programs in different sectors more like a public good, with investment decisions separated from the agencies involved. Another might be to identify or create financial intermediaries that could manage certain funds and invest strategically (see the next recommendation).

Local Leadership

When Louisville Mayor Greg Fischer first took office, he laid out a multiyear strategic plan outlining ways in which to invest in neighborhoods, specifically innovative housing initiatives.¹⁶⁹ Fischer has since been a driving force for coordinating with local agencies and community partners. The plan created the Louisville Creating Affordable Residences for Economic Success (Louisville CARES) program, which gives developers financial incentives to support existing and create new affordable housing units. The plan also provides innovative mechanisms to provide financial assistance to homeowners, homebuyers, and renters whether they desire to remain in their current housing or seek new housing. The mayor has continued to lead these financial innovations, while leveraging community organizations and nonprofits to partner with agencies such as the greater Kentucky Housing Corporation to assist those at risk of foreclosure.

This work also addresses health, education, safety, and community engagement. In fact, the Robert Wood Johnson Foundation recognized the city of Louisville as one of their 2016 Culture of Health Prize Winners for the city's collaboration, dedication to data-driven decision-making, and shared commitment to those same innovative health and mobility efforts.¹⁷⁰ Specifically highlighted was Mayor Fischer's commitment to making Louisville a "city of compassion" and his leadership in bridging community members, local government departments, community members or organizations, and the private sector, with the greater goals of helping the most vulnerable residents while also spurring economic growth and providing financial security and stability for the city.

This type of leadership can be seen in many cities around the country. As our Brookings colleagues have explained,¹⁷¹ mayors throughout the country are in unique positions to not only engage community partners, but also take charge in pushing innovation forward and be at the forefront of continued collaborations and change.

¹⁶⁸ Arabo, "Housing as Health Care."

¹⁶⁹ City of Louisville, Kentucky, "Strategic Plan," 2012, <https://louisvilleky.gov/government/mayor-greg-fischer/strategic-plan>.

¹⁷⁰ Robert Wood Johnson Foundation, "Louisville, Kentucky: 2016 RWJF Culture of Health Prize Winner," 2016, <https://www.rwjf.org/en/library/features/culture-of-health-prize/2016-winner-louisville-ky.html#college-advancement>.

¹⁷¹ Julie Wagner et al., "Advancing a New Wave of Urban Competitiveness: the Role of Mayors in the Rise of Innovation Districts," Brookings Institution, June 2017, <https://www.brookings.edu/research/advancing-a-new-wave-of-urban-competitiveness/>.

States should establish versions of Maryland’s county-level Local Management Boards (LMBs) or the Healthy Communities Hub model to act as funding intermediaries to braid or blend together public and private funds to support local inter-sector collaboration.

Funding is always one of the many challenges faced by creative new partnerships at the local level. Securing public and private support is difficult enough when an initiative is confined to one sector, such as health or housing. That problem is multiplied for initiatives that seek to coordinate a range of activities involving multiple sectors, such as housing-based partnerships providing multiple services. While waivers and block grants provide states with a degree of flexibility,¹⁷² states generally find it difficult to mix funding streams for collaborative cross-sector ventures.

Creating Financial Intermediaries. Maryland has taken steps to reduce this problem by creating through statute county-level bodies that can braid or blend funds from state and private sources and federal funds flowing through the state.¹⁷³ These Local Management Boards can be government bodies or nonprofit organizations.¹⁷⁴ The LMBs contract with local organizations, which become grantees of the LMBs. Hence, these local initiatives can gain access to a wide range of resources, with the LMB held accountable for the use of funds. In this way, the local grantees can receive funds from multiple sources without shouldering the full burden of applying and reporting to each funder. The Family League of Baltimore is a good example of an LMB; the league is a nonprofit organization that focuses on enabling Baltimore

children to be healthy, succeed in their education, and transition to the workforce.¹⁷⁵

States could establish LMBs with a focus on housing-based strategies, as well as other goals. The LMB’s role in housing initiatives could include braiding and blending funds from Medicaid, the Community Development Block Grant and other HUD programs, and such private funds as resources from financial institutions required under the Community Reinvestment Act and the local benefit investments required of nonprofit hospitals.¹⁷⁶

The nonprofit Trust for America’s Health (TFAH) and the financial services firm Deloitte have designed a model of a financing intermediary with a health care focus, like the LMB, which they call a Healthy Communities Funding Hub.¹⁷⁷ In keeping with the general concept of a hub, this intermediary would help facilitate the organization of health services in a community by blending and braiding money from multiple sources. The hub would provide fiduciary oversight and management to coordinate multiple funding sources. It would also act as a trusted intermediary and raise and prioritize funds.

Maryland’s experience suggests there are important factors in an LMB’s success, reflected in the Deloitte/TFAH proposal. One is that it has the capacity and technical ability to manage a range of funds and to report on their use. That means the intermediary must be able to obtain and process the necessary data and, in practice, carry out reporting functions that would be beyond the capability of many of their grantees receiving money from multiple funders. This means the LMB itself must have the necessary financial support to carry out these “back office” functions on behalf of their grantees. Another

¹⁷² Amy Clary and NASHP staff, “Learn How States Can Blend, Braid, and Use Block Grant Funds to Promote Public Health,” National Academy for State Health Policy, December 12, 2017, <https://nashp.org/learn-how-states-can-blend-braid-and-use-block-grant-funds-to-promote-public-health/>.

¹⁷³ “Blending” refers to the practice of integrating funds from a range of sources where the money is not identified and tracked according to the original source. When money is “braided,” the original source is tracked by each source.

¹⁷⁴ Maryland’s Local Management Boards, “Making a Difference for Children and Families, 1990–2010.”

¹⁷⁵ Family League of Baltimore, <http://familyleague.org/>.

¹⁷⁶ Rosenbaum, “Hospitals as Community Hubs.”

¹⁷⁷ Jitinder Kohli and Anne De Biasi, “Supporting Healthy Communities,” Deloitte Center for Government Insights, August 2, 2017, <https://dupress.deloitte.com/dup-us-en/industry/health-care/building-and-funding-healthy-communities.html>.

important factor is a successful LMB must possess the trust of both the community projects and higher levels of government. That likely requires such financial intermediaries to have roots in the community—as Family League of Baltimore does. To give outside funders more confidence, Deloitte/TFAH recommend a certification process, indicating financial skills, sound governance, and strong stakeholder support.

The federal government and states should make greater use of waivers and pilots to foster hubs and partnerships, including widening the statutory authority for program budgets to be used in different sectors. Among other steps, Congress should authorize multiagency pooling of money to permit housing-based pilots, modeled on Performance Partnership Pilots (P3).

Federal agencies have the authority to grant waivers in several programs, giving states and local governments the flexibility to undertake a variety of experiments and to ease limitations on the use of federal funds. For example, Section 1115 of the Social Security Act gives the HHS secretary authority to approve “experimental pilot, or demonstration projects” that promote the broad objectives of Medicaid.¹⁷⁸ Section 1115 waivers have been important in launching many important initiatives that allow Medicaid funds to improve the health of the elderly by funding housing-related health needs. For example, New York and Oregon have used Section 1115 waivers to provide supportive housing services for their most complex and vulnerable Medicaid populations.¹⁷⁹ HHS has also launched the

Accountable Health Community Model, a demonstration program designed to align health care with other community services in chosen communities.¹⁸⁰ Meanwhile, DOE operates Promise Neighborhoods, a pilot program that allows money to be used in specific communities in a wide variety of ways for innovative community-based initiatives to improve prospects for children and youth.¹⁸¹

States also can issue waivers that allow state-controlled funds to be used for creative partnerships across sectors. Many states, including Virginia, have begun piloting innovative ways to fund such cross-sector partnership models.¹⁸²

Waivers and pilot programs have proved to be crucial tools to allow more flexible use of government funds across sectors to pursue such overall objectives as improved health, education, and economic development. However, they must operate within the constraints of statutes. Unfortunately, as we have learned more about social determinants of health and similar multisector factors affecting other goals, such as school success, statutory limitations have become more evident. For instance, health practitioners and researchers increasingly recognize the importance of safe and stable housing for the health care needs of the elderly, disabled, and chronically ill. While existing waiver authority allows some federal health funds to be used to promote health by addressing housing needs, federal Medicaid money may not be used for room and board, even when doing so potentially would lead to significant future Medicaid savings (See the recommendation on Medicaid below).

¹⁷⁸ Centers for Medicare and Medicaid Services, “About Section 1115 Demonstrations,” <https://www.medicare.gov/medicaid/section-1115-demo/about-1115/index.html>.

¹⁷⁹ Corporation for Supportive Housing, “Summary of State Actions: Medicaid and Housing Services,” January 2017, <http://www.csh.org/wp-content/uploads/2017/01/Summary-of-State-Action-Medicaid-and-Supportive-Housing-Services-2017-01.pdf>.

¹⁸⁰ Centers for Medicare and Medicaid Services, “Accountable Health Communities (AHC) Model Assistance and Alignment Tracks Participant Selection,” April 6, 2017, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-04-06.html>.

¹⁸¹ U.S. Department of Education, “Promise Neighborhoods,” July 27, 2017, <https://www2.ed.gov/programs/promiseneighborhoods/index.html>.

¹⁸² Clary and Riley, “Pooling and Braiding Funds for Health-Related Social Needs: Lessons from Virginia’s Children’s Services Act.”

Multiagency Pilots. To encourage interagency waivers and pilots, Congress should authorize multiple agencies to pilot housing hub initiatives that address social determinants of health and create other forms of community value, modeled on Performance Partnership Pilots.¹⁸³ The P3 program, launched by Congress in 2014, authorized HHS, DOE, and the Department of Labor to create pilots in which state and local jurisdictions can pool portions of money from several federal programs into a single blended stream to address the needs of disconnected youth. In late 2016, HUD joined the other P3 agencies with the goal of promoting budget flexibility to mitigate youth homelessness and housing instability. Congress should establish a similar experimental program to make it easier to establish and fund housing-based initiatives designed to address such goals as improved school readiness and reductions in homelessness among individuals with mental health problems.

Recommendation 3: Experiment with different models to organize and manage housing-based services

Establishing and operating multisector programs in a hub puts great responsibilities on the management staff. There are three broad management models.

In-House Management. A housing organization can build its own on-site staff to arrange services. An example of this would be elderly housing

facilities that assemble a wide range of services available in-house, including skilled nursing care. Erickson Living, mentioned earlier in this report, provides on-site medical care and services for its residents. Another example is the Leah Residence, a housing provider for homeless women in San Diego, California.¹⁸⁴ Owned by Catholic Charities, Leah provides a part-time service coordinator to residents along with access to the Rachel Women's Center (run by and co-located with Catholic Charities), which provides medical care, mental health services, and other resources to residents. Meanwhile, in a venture known as Housing Opportunities and Services Together (HOST), a group of housing authorities in four cities in conjunction with the Urban Institute is testing approaches to using housing as the platform for a variety of services, with the intent of applying the lessons to a wider network.¹⁸⁵

External Managers. The management of housing hubs can also be provided by an outside organization that manages a range of home-based services delivered through a network of housers. Examples include SASH and Park Eden, a senior housing provider run by the Cincinnati Metropolitan Housing Authority (CMHA) that partners with TriHealth Senior Link to provide care to residents. At the time, TriHealth was short on clinic space and approached CMHA offering to set up a care center and renovate the Park Eden space in exchange for free rent in a portion of the building's ground floor.¹⁸⁶ Both parties agreed, catalyzing similar partnerships between housing authorities and health care providers. It was only a few months before 30 Park Eden residents were enrolled in this PACE program.

¹⁸³ Interagency Working Group on Youth Programs, "Performance Partnership Pilots for Disconnected Youth (P3)," <http://youth.gov/youth-topics/reconnecting-youth/performance-partnership-pilots>.

¹⁸⁴ Corporation for Supportive Housing, "The Leah Residence, San Diego, CA: Permanent Housing for Homeless Persons with Special Needs," 2010, <http://www.csh.org/wp-content/uploads/2011/11/leahresidence.pdf>.

¹⁸⁵ Urban Institute, Metropolitan Housing and Communities Policy Center, "Housing Opportunities and Services Together," <https://www.urban.org/policy-centers/metropolitan-housing-and-communities-policy-center/projects/housing-opportunities-and-services-together>.

¹⁸⁶ Larry McNickle, "Keeping PACE with Seniors' Needs: Health Care Meets Housing in Symbiotic Partnerships," *Journal of Housing & Community Development* 61, no. 5 (September/October 2004): 24–29, http://pace.techriver.net/website/download.asp?id=3402&title=Health_Care_Meets_Housing_-_2004.

Intermediaries. Further along the spectrum are cases where an intermediary organization acts as a link between different sectors but focuses on addressing people's needs in their home communities and housing. One example is City Health Works, based in New York City, which seeks to bridge the gap between the doctor's office or hospital and the home setting for people with chronic illness.¹⁸⁷ City Health Works describes most clinicians as viewing the home as a largely unknown "black box," while it focuses on the realities of the home setting.

Depending on the community and the stage of development of the housing hub, different models of management to link home and services might be most appropriate. Policymakers can take steps to support each of these models.

WHAT IS SASH?

Support and Services at Home (SASH) is a statewide model in Vermont dedicated to helping seniors and disabled individuals safely remain in their homes.¹⁸⁸ Launched in 2011, SASH now operates at 140 affordable housing communities. SASH is an integration model led by housers that have formed partnerships with every hospital, area agency on aging, home health agency, and mental health agency in the state. The housers employ the coordinators. The statewide coordinator, a nonprofit houser, contracts with the state to improve coordination of care between medical homes and the 65 SASH partner agencies.¹⁸⁹

SASH is a partnership between a nonprofit developer, 21 other housers, hospitals, and home and community-based providers.¹⁹⁰ On-site nursing, care coordination, and social activities enable participants to remain in their homes and be actively connected to community and social networks. Because every 100 SASH participants have a wellness nurse team and SASH coordinator, participants have routine and regular needs assessments and have access to customized resources and coaching. Importantly, SASH participants give consent for their information to be shared among SASH service partners so that, when they need more supports, SASH coordinators and care providers can better coordinate and meet their needs.

Along with better health and overall wellness, the results of SASH are promising. A 2016 evaluation of SASH estimated a reduction in annual Medicare expenditure growth by \$1,536 per beneficiary per year.¹⁹¹ Originally part of Vermont's Medicare Multi-Payer Advanced Primary Care Practice demonstration,¹⁹² a demonstration undertaken by several states in conjunction with the Centers for Medicare and Medicaid Services (CMS), SASH is now funded through an all-payer model.¹⁹³ The demonstration pays for both the wellness nurse and SASH service coordinator. Other program costs are covered by state and federal sources, including Medicaid, the Department of Aging and Independent Living, the Department of Vermont Health Access, and other grants.

¹⁸⁷ City Health Works, "Ambassadors of Health," <http://cityhealthworks.com/>.

¹⁸⁸ Support and Services at Home, "Learn About SASH," <http://sashvt.org/learn/>.

¹⁸⁹ Support and Services at Home, "Learn About SASH."

¹⁹⁰ Howard Gleckman, "How Can Frail Seniors Who Live at Home Get Better Care?," *Forbes*, December 16, 2015, <https://www.forbes.com/sites/howardgleckman/2015/12/16/how-can-frail-seniors-who-live-at-home-get-better-care/#618f547e74a3>.

¹⁹¹ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Support and Services at Home (SASH) Evaluation: Second Annual Report," January 2016, <https://aspe.hhs.gov/basic-report/support-and-services-home-sash-evaluation-second-annual-report>.

¹⁹² RTI International and Urban Institute, "Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Final Report," June 2017, <https://downloads.cms.gov/files/cmmi/mapcp-finalevalrpt.pdf>; and Patient-Centered Primary Care Collaborative, "Vermont Blueprint for Health," February 2016, <https://www.pcpcc.org/initiative/vermont-blueprint-health>.

¹⁹³ Ena Backus et al., "The All-Payer Accountable Care Organization Model: An Opportunity for Vermont and an Exemplar for the Nation," *Health Affairs*, November 22, 2016, <http://www.healthaffairs.org/doi/10.1377/hblog20161122.057616/full/>.

In addition to Congress providing more funding for elderly housing, HUD should expand its supportive services demonstration pilots for elderly households, which cover the cost of a full-time enhanced service coordinator and nurses.

In January 2017, HUD announced that it was awarding \$15 million to test a new method allowing low-income seniors to age in place. Funded through the Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing, this demonstration will assess the effectiveness of coordinating enhanced support services with affordable senior housing.¹⁹⁴ All housing providers in the demonstration must have both a full-time enhanced service coordinator and a part-time wellness nurse on site to coordinate services and needs-based supports for residents to delay or avoid nursing facility care.¹⁹⁵

CMS also developed a PACE-like care model that mirrors PACE but focuses on younger disabled populations, as opposed to seniors. Tentatively named “Person Centered Community Care,” or P3C, this model attempts to use the same service coordination and supports integration used in the original PACE model to see if those elements could result in positive outcomes for other populations.¹⁹⁶

WHAT IS THE PACE PROGRAM?

Program of All-Inclusive Care for the Elderly (PACE) is a federal program for adults over the age of 55 and eligible for Medicare, although some states allow Medicaid beneficiaries to also have eligibility.¹⁹⁷ The goal of PACE is to help older adults who are eligible for nursing home care, but prefer and can remain in their homes, to age in their communities. In this unique model, the PACE providers create teams of health and social services professionals who provide coordinated care to participants. Although PACE does not provide housing services, it serves as an intermediary and coordinates and refers program participants, many of whom reside in affordable housing units, to appropriate services.¹⁹⁸ From the housing provider’s perspective, partnering with PACE allows delivery of much-needed services to residents without the burden of managing and delivering the actual services themselves. For participants, PACE eases the burden of travelling to receive services, as well as provides opportunities for interaction and socializing with others, mitigating isolation.

Housing organizations, professional schools, and government should address credentialing and training to create stronger professional coordinator teams in housing.

Although housing is both a place of residence and a center of community life, in general, housers have not created strong internal teams to develop strong connections between residents and service providers they may need. By contrast, the school system has experimented and developed numerous approaches to building teams around students to help them succeed academically.¹⁹⁹

Community schools are an example: typically public schools that go beyond having just a social worker or school nurse on staff and build an integrated team to partner with a range of

¹⁹⁴ U.S. Department of Housing and Urban Development, “HUD Announces \$15 Million to Test a New Approach to Help Low-Income Seniors Age in Place,” January 13, 2017, https://www.hud.gov/press/press_releases_media_advisories/2017/HUDNo_17-007.

¹⁹⁵ U.S. Department of Housing and Urban Development, “Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing,” September 18, 2015, <https://www.hud.gov/sites/documents/2015SSDEMO-NOFA.PDF>.

¹⁹⁶ LeadingAge New York, “CMS Seeking Comments on PACE-Like Models of Care,” <https://www.leadingage.org/providers/managed-long-term-care/new-models-of-care/cms-seeking-comments-on-pace-like-models-of-care/>.

¹⁹⁷ Centers for Medicare and Medicaid Services, “Program of All-Inclusive Care for the Elderly,” <https://www.medicare.gov/medicaid/tss/pace/index.html>.

¹⁹⁸ McNickle, “Keeping PACE with Seniors’ Needs.”

¹⁹⁹ Freeland, Horn, and Butler, “Schools as Community Hubs.”

institutions and specialists to help children.²⁰⁰ Some school districts, such as Cincinnati, Ohio, have built a strong network of community schools with well-trained teams.²⁰¹ The Cincinnati Public School system created partnerships in its school campuses, bringing community and social services to the school building in hopes of not only promoting academic excellence but also effectively engaging and partnering with its community members. Each of the participating schools, dubbed “Community Learning Centers (CLCs),” have a full-time resource coordinator who assesses the needs of a particular school, students, and greater community and serves as a bridge between services provided and community members.²⁰² A variant of this model is Communities in Schools, a national nonprofit network that embeds its own teams in public and charter schools.²⁰³ Cross-sector hiring has also been very effective for housing authorities engaged in education initiatives. Hiring an education expert not only helps residents, but also facilitates and sustains partnerships with school districts. As part of the Moving to Work demonstration,²⁰⁴ the Washington State Housing agencies in Seattle, King County, and Tacoma received funding from the Bill & Melinda Gates Foundation to hire education specialists.²⁰⁵

Resident Service Coordinators. Some housing ventures have also built teams to address the broader needs of residents. Mercy Housing, for example, is a national nonprofit organization that operates in 41 states and is engaged in the development, management, and financing of affordable housing for low-income people,

seniors, and people with special needs.²⁰⁶ It provides a broad range of services and programs. Mercy uses “resident service coordinators” to help residents deal with such issues as their health and financial stability and to help arrange after-school activities and link them to the resources and services needed.²⁰⁷ While a common intervention, financing is the key factor in being able to provide such a service.

Building a Cross-Sector Profession. A limitation on housing-based teams is that such coordinators generally acquire their skills on the job rather than obtaining the necessary background and technical knowledge in a variety of service sectors through professional training and credentialing. HUD-funded resident service coordinators are required to meet certain training and skill requirements.²⁰⁸ Besides the learning curve that imposes on most members of a housing team, the absence of professional credentials can impede reimbursement from programs for team services. For example, many states have not credentialed community health workers in housing settings to provide asthma medication to residents. On the other hand, there has been some progress in some areas, such as addressing environmental problems in housing. For instance, the Building Performance Institute and HUD have developed a “micro-credential” for inspecting and identifying environmental health hazards, potentially making Medicaid reimbursement possible for housing teams dealing with such hazards.

Federal and state agencies should work with housers to develop appropriate training and

²⁰⁰ Jacobson, “Community Schools.”

²⁰¹ Coalition for Community Schools at the Institute for Educational Leadership, “Community School Results,” <http://www.communityschools.org/results/results.aspx>.

²⁰² Cincinnati Public Schools, “CPS’ Community Learning Centers,” <https://www.cps-k12.org/community/clc>.

²⁰³ Communities in Schools, <https://www.communitiesinschools.org/>.

²⁰⁴ U.S. Department of Housing and Urban Development, “Moving to Work (MTW),” https://www.hud.gov/program_offices/public_indian_housing/programs/ph/mtw.

²⁰⁵ Seattle Housing Authority, “Moving to Work (MTW),” <https://www.seattlehousing.org/about-us/reports/moving-to-work-reports>; King County Housing Authority (King County, WA), “MTW Plans & Reports,” <https://www.kcha.org/news/mtw/>; and Tacoma Housing Authority, “2017 Moving to Work Plan,” August 8, 2008, <https://tacomahousing.net/sites/default/files/THA%202017%20MTW%20Plan%20FINAL%20DRAFT%202016-8-08.pdf>.

²⁰⁶ Mercy Housing, <https://www.mercyhousing.org/>.

²⁰⁷ Mercy Housing, Resident Services,” <https://www.mercyhousing.org/Resident-Services>.

²⁰⁸ U.S. Department of Housing and Urban Development, “Service Coordinator Training,” https://www.hud.gov/program_offices/housing/mfh/scp/scptraining.

credentialing for individuals to carry out a range of tasks as a housing coordinator. In addition, professional schools and colleges should explore the curriculum necessary for a rounded professional qualification for housing team leaders and members. There are examples of this in other fields. For example, the University of Virginia's Curry School of Education offers a major in youth and social innovation, which includes courses in a wide range of areas needed to help school students succeed, such as youth physical and emotional development, child protection services, and social policy.²⁰⁹ Graduates with this major are well positioned to lead school-based teams. Meanwhile, Washington University at St. Louis launched a dual master's degree in social work and public health.²¹⁰ The joint degree equips students with skills in a range of topics, such as public health, the built environment, social policy, and community dynamics, and it prepares them for management and team casework in such organizations as community schools and community health centers.

States and local governments should support the growth of “villages” based on the senior village model, experimenting with this model for a range of populations. Philanthropy should also support such models.

Villages are nonprofit membership organizations that use volunteers and some paid staff as intermediaries to empower older Americans to age in their own homes and neighborhoods by organizing a wide range of services and supports.²¹¹ In this way, villages can be a much

less expensive alternative to nursing homes and assisted living facilities for people. In the United States, there are now well over 200 villages in 45 states and the District of Columbia, linked together through the Village to Village Network.²¹²

Villages vary in type and sophistication. In some areas—such as Boston and the Washington, DC, metropolitan area—they have become an important form of housing hub using intermediaries.²¹³ Many are purely volunteer-operated, such as Bloomingdale Aging in Place in New York City.²¹⁴ Others, such as the Capitol Hill Village and several other villages in DC, combine volunteers with paid staff and membership dues collected from residents.²¹⁵ Paid-staff models are typically more active and sophisticated in their services. Some limit their activities to mainly social activities and such volunteer services as transportation, assistance with basic housing maintenance, shopping services, and referrals to medical and other professional help. But others have developed partnerships with health care and other service providers, including home visits by nurses and physicians.

Using village staff to develop connections with the health care system appears to be a promising future of this form of housing-based network. In addition to facilitating community-based care, some hospitals in Boston and the District of Columbia have experimented with villages as partners in their discharge planning. For instance, Newton Wellesley Hospital in Boston purchased short-term Newton Village memberships for some discharged Medicare patients to improve

²⁰⁹ University of Virginia, Curry School of Education, “Speech Communication Disorders Major,” <http://curry.virginia.edu/academics/degrees/bachelor-of-science-in-education/youth-social-innovation>.

²¹⁰ Washington University in St. Louis, Brown School, “Joint and Dual Degrees,” <https://brownschool.wustl.edu/Academics/Joint-and-Dual-Degrees/Pages/default.aspx>.

²¹¹ Butler and Diaz, “How ‘Villages’ Help Seniors Age at Home.”

²¹² Village to Village Network, <http://www.vtvnetwork.org/>.

²¹³ Washington Area Villages Exchange, “Villages in the Washington DC Metropolitan Area,” <http://wavevillages.org/index.php/about-us/our-villages>.

²¹⁴ Bloomingdale Aging in Place, <http://www.bloominplace.org/>.

²¹⁵ Capitol Hill Village, <http://www.capitolhillvillage.org/>.

their recovery and reduce readmissions—in turn reducing readmission penalties on the hospital.²¹⁶

Government Can Support Villages. Still, villages face challenges in forming and growing. The cost and complexity of starting an organization can be daunting, as can the capacity to levy dues. Financial capacity is a major concern, of course, in low-income neighborhoods, where limited resources are often combined with a higher level of needed services, so to make the approach viable at any scale in poorer areas would take outside funding. The Village to Village Network does provide technical assistance, and that can help at the start-up phase and for certain services. But to build up the model, some government jurisdictions have decided to invest in creating villages. For instance, the District of Columbia Office on Aging offers a competitive grant to help establish a village in its poorest wards and to provide training for staff and volunteers.²¹⁷ Massachusetts has used Community Development Block Grant funds to support villages. Partnerships with hospitals are still at the formative stage, and many hospitals remain unconvinced that investing in a partnership generates adequate returns.

States and local governments should experiment with a variety of ways to expand the village model of paid staff and volunteers to organize housing-based services in dispersed housing for individuals with needs, especially in lower-income communities. Governments can help with the start-up and training costs and can develop demonstration projects to test the model for populations in addition to the elderly, such as the disabled. In addition, local governments can

encourage nonprofit hospitals subject to community benefit requirements to explore partnerships with villages, such as linking staff and volunteer training with investments by the hospital. States and the federal government should also explore ways in which health and social service programs can partner with villages. Councils on Aging and Area Agencies on Aging can also play a help role.

Help from Foundations and Schools. Private philanthropy should also consider supporting village experiments, both working in parallel with local government and piloting such ideas as a housing equivalent of Health Leads.²¹⁸ Health Leads uses college volunteers who work with hospitals and physicians to link lower-income and vulnerable discharged patients with the full range of resources to which they are entitled, such as housing, food, and utility assistance.²¹⁹ In a similar manner, medical-legal partnerships within health organizations help organize supportive housing and other services for vulnerable patients.²²⁰ In a “housing leads” equivalent, college volunteers might work with villages or housers to identify services for which a resident is eligible, involve the resident, and monitor the services.

School districts and individual schools could also work closely with villages. In Rockville, Maryland, Link Generations has taken an intergenerational approach to connecting seniors with young people in their local communities by partnering with high schools. In addition to fulfilling young people’s desire for volunteer work, the program also helps the adolescents fulfill their school’s social service and academic requirements. Link Generations provides students with training on

²¹⁶ As a result provisions in the Affordable Care Act, hospitals serving Medicare patients face financial penalties if discharged patients with certain diagnoses are readmitted to a hospital with the same diagnosis within 30 days.

²¹⁷ District of Columbia, Office on Aging, “Notice of Funding Availability-FY 2018 Senior Villages Competitive Grant,” 2017, <https://dcoa.dc.gov/page/notice-funding-availability-fy-2018-senior-villages-competitive-grant>.

²¹⁸ Rebecca D. Onie et al., “Integrating Social Needs into Health Care: A Twenty-Year Case Study of Adaptation And Diffusion,” *Health Affairs*, 37, no. 2 (February, 2018): 240-247, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1113>.

²¹⁹ Health Leads, <https://healthleadsusa.org/>.

²²⁰ Marsha Regenstien, Jennifer Trott, and Alanna Williamson, “The State of the Medical-Legal Partnership Field: Findings from the 2016 National Center for Medical-Legal Partnership Surveys,” National Center for Medical-Legal Partnership, August 2017, <http://medical-legalpartnership.org/wp-content/uploads/2017/07/2016-MLP-Survey-Report.pdf>.

aging and designing social activities. Organizers identified independence as a common desire for both the elderly and youth, opening common ground for the two groups to learn from each other and engage socially in meaningful ways.²²¹

Public housing authorities and other subsidized housers serving low-income residents should explore a variety of ways to deliver social services to residents

Housing can be the platform for a range of social services needed for lower-income families to move up the economic ladder. In addition to stable housing, such families usually need a range of social services supports to advance, such as job training, financial counseling, and childcare. Housers can provide and coordinate such several services on site or through service coordinators functioning as intermediaries. However, in an example of the wrong pocket problem, housing authorities facing tight budget constraints do not typically receive adequate funding for such coordinators, even though there can be significant downstream savings in health care and other sectors.

Fortunately, some important initiatives are tackling this problem. For example, as noted earlier, in the HOST initiative, which grew out of Urban Institute research, the institute helps local housing authorities take a two-generational, place-based approach in using housing as a platform for intentional interventions that go beyond health and explore ways to use social services to improve families' social and economic futures.²²² By partnering housing agencies and nonprofit service providers, HOST is able not only to leverage resources to support families in its

four demonstration cities (Bangor, Maine; Chicago; Washington, DC; and Portland), but also to collect and share data and lessons across its growing network of partner housing authorities.

Most residents of publicly assisted housing qualify for a range of health and social services. When these services are coordinated, the results are invariably better. As noted earlier, achieving coordination can be a challenge, both financially and because of limitations in the skills of housing staff—although HUD does provide grants to fund service coordinators through the Service Coordinator in Multifamily Housing grant program.²²³

Some affordable housing providers have developed partnerships to serve residents. Foundation Communities in Austin, Texas, provides residents with a wide range of services and access to community health workers. Foundation Communities collaborates with such partners as the Central Texas Food Bank, the City of Austin Health Department, Austin's local health foundation, St. David's Foundation, and other key community organizations.²²⁴ Partnering with external experts and organizations facilitates on-site services and programming and allows Foundation Communities to build connections with community members. Especially when seeking to create and implement resident-focused programming, housing providers should explore engaging community organizations in this way and regularly soliciting feedback from residents and partners to improve coordination and provide higher-quality services.²²⁵

Employment. Housing providers concerned with seeing their residents succeed in these areas can help provide employment and job skills

²²¹ Link Generations, <http://linkgenerations.org/>.

²²² Urban Institute, "Housing Opportunities and Services Together."

²²³ U.S. Department of Housing and Urban Development, "HUD's Service Coordinator in Multifamily Housing Program Resource Guide (Draft)," October 2017, <https://www.hudexchange.info/resource/5631/huds-service-coordinator-in-multifamily-housing-program-resource-guide/>.

²²⁴ Ruth Gourevitch, "How an Affordable Housing Developer Improved Austin's Health Outcomes," Urban Institute, July 20, 2017, <https://www.urban.org/urban-wire/how-affordable-housing-developer-improved-austins-health-outcomes>.

²²⁵ Scally et al., "Emerging Strategies for Integrating Health and Housing."

opportunities for its residents. For instance, housers can create partnerships with local employers or employment agencies and even deliver in-house training and coaching with the help of intermediaries such as Seedco.²²⁶ HUD's Family Self-Sufficiency Program is another employment and savings incentive program that helps low-income families with Section 8 vouchers or living in public housing pursue their employment or savings goals.²²⁷ In addition, HUD's Jobs Plus Initiative Grant Program²²⁸ offers job placement and training opportunities to residents in public housing and has been found to be successful in short- and long-term earnings gains.²²⁹ Still, housing staff need to be knowledgeable about income limits and other benefits issues that may affect residents' eligibility.²³⁰

Financial Literacy. Other services housing providers can offer are financial stability counseling and wealth-building education strategies to residents. Asset building—whether through savings, bank accounts, or good credit—is a powerful influence in financial stability and intergenerational economic and social mobility.²³¹ HUD has partnered with several nonprofit organizations, such as the Corporation for Enterprise Development (now known as Prosperity Now) and the Consumer Financial Protection Bureau, to build on its own programs.²³²

Housing providers can also follow such examples as the Tacoma Housing Authority (THA) in Tacoma, Washington, which provides asset-building tools and financial literacy education for its residents. THA partners with local financial education providers, community organizations, and tax preparation and counseling resources.²³³ THA also works with the local public schools to create children's savings accounts for residents of one of its most diverse housing communities. When a child of the residence enrolls in kindergarten, THA creates an account with an initial deposit of \$50 and provides annual matching of up to \$400 of family contributions through middle school and \$700 matching through high school.²³⁴

Child and Family Services. Housing agencies and local housing providers can also improve coordination with child and family service agencies to help prevent children and their families from experiencing housing instability or homelessness. Children experiencing homelessness often end up needing much higher levels of child or family services and are more likely to need foster care.²³⁵ Moreover, research from Chapin Hall at the University of Chicago suggests that children in foster care have an

²²⁶ Seedco, "How We Work," <https://www.seedco.org/how-we-work>.

²²⁷ U.S. Department of Housing and Urban Development, "Family Self-Sufficiency (FSS) Program," https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/fss.

²²⁸ U.S. Department of Housing and Urban Development, "FY 2017 Jobs Plus Initiative Grant Program," https://www.hud.gov/program_offices/spm/gmomgmt/grantsinfo/fundingopps/fy17jobsplus.

²²⁹ James A. Riccio, "Sustained Earnings Gains for Residents in a Public Housing Jobs Program," MDRC, January 2010, <https://www.mdrc.org/publication/sustained-earnings-gains-residents-public-housing-jobs-program>; and U.S. Department of Housing and Urban Development, "HUD Awards More Than \$14 Million to Help Low-Income Public Housing Residents Secure Higher Paying Jobs," September 27, 2016, <https://archives.hud.gov/news/2016/pr16-143.cfm>.

²³⁰ Corporation for Supportive Housing, "Employment Services in Supportive Housing," August 2013, http://www.csh.org/wp-content/uploads/2013/09/EmpSrvcs_F.pdf.

²³¹ Julia B. Isaacs, Isabel V. Sawhill, and Ron Haskins, "Getting Ahead or Losing Ground: Economic Mobility in America," Brookings Institution, February 2008, <https://www.brookings.edu/research/getting-ahead-or-losing-ground-economic-mobility-in-america/>.

²³² U.S. Department of Housing and Urban Development, "Resources for Community and Supportive Services," https://www.hud.gov/program_offices/public_indian_housing/programs/ph/hope6/css/resources.

²³³ Corporation for Enterprise Development, "Incorporating Asset Building Strategies."

²³⁴ Tacoma Housing Authority, "THA's Children's Savings Account Program," <https://www.tacomahousing.net/children%E2%80%99s-savings-account-program>.

²³⁵ Jung Min Park et al., "Child Welfare Involvement Among Children in Homeless Families," *Child Welfare* 83, no. 5 (October 2004): 423–36, http://repository.upenn.edu/cgi/viewcontent.cgi?article=1022&context=spp_papers.

increased risk of becoming homeless in adulthood.²³⁶

To improve the delivery of targeted housing-based interventions, such interventions as HUD's Family Unification Program should be modified and improved to better coordinate between public housing authorities and child and family service agencies.²³⁷ The HUD-Veterans Affairs Supportive Housing voucher program (HUD-VASH) could be an interagency model operation for HUD and HHS to combine resources to help local public housing authorities and child welfare or family services to serve children and families.²³⁸

Recommendation 4: Strengthen Housing-Health Partnerships

Several hospital systems have undertaken significant housing-health partnerships.²³⁹ In Baltimore, Maryland, for instance, Bon Secours Hospital provides affordable housing to the community and its patients.²⁴⁰ In the late 1980s, Bon Secours began developing senior living units, eventually focusing more on its neighboring community through a partnership with Enterprise, an organization focused on affordable housing and community development. Bon Secours provides on-site service coordinators who connect residents to medical and well-being services provided by Bon Secours Hospital, provides training and screenings, and connects

residents to other services in the community.²⁴¹ The service coordinators were originally funded by a HUD grant, but have now become permanent fixtures in the Bon Secours annual budget.²⁴² Bon Secours now owns over 720 units, all previously vacant properties, which continue to serve low- and moderate-income families, seniors, and individuals with disabilities.²⁴³

Meanwhile, Washington Adventist Hospital (WAH), near the nation's capital, has developed several housing-related partnerships with Montgomery County, Maryland. One such partnership is with Montgomery County Fire and Rescue Service, in which Fire and Rescue conducts home safety checks developed by the hospital in low-income housing communities and then shares its findings with the hospital.²⁴⁴ WAH is then able to coordinate resources to modify and correct the identified issues. In another collaboration with the county, WAH provides continuous nursing services to a pilot program to provide short-term housing for homeless men who have been discharged from the hospital—with the aim of reducing the likelihood of readmissions and assisting the men to return to normal life.

These and other housing-health partnerships display certain patterns. Some could be described as responses to financial “sticks,” such as using housing initiatives to reduce readmission penalties or to comply with community benefit requirements on nonprofit hospitals. Others are “good citizen” philanthropic examples of the hospital assisting its local community, such as

²³⁶ Chapin Hall at the University of Chicago, “Predictors of Homelessness During the Transition from Foster Care to Adulthood,”

<http://www.chapinhall.org/research/inside/predictors-homelessness-during-transition-foster-care-adulthood>.

²³⁷ Child Welfare and Supportive Housing Resource Center, “Beyond the Family Unification Program (FUP): Partnerships Between Public Child Welfare Agencies and Public Housing Agencies to Stably House Vulnerable Child Welfare-Involved Families,” *Notes from the Field* 1, no. 2 (April 1, 2015): 1–6. <http://www.csh.org/wp-content/uploads/2015/05/Notes-from-Field-PHAs.pdf>.

²³⁸ U.S. Department of Veterans Affairs, “HUD-VASH Eligibility Criteria,” January 13, 2017, https://www.va.gov/homeless/hud-vash_eligibility.asp.

²³⁹ Pauline Bartolone, “Hospitals Invest in Housing for Homeless to Reduce ER Visits,” *Healthcare Finance*, October 18, 2017, <http://www.healthcarefinancenews.com/news/hospitals-invest-housing-homeless-reduce-er-visits>.

²⁴⁰ Bon Secours, “Family Housing,” <https://bonsecours.com/baltimore/community-commitment/housing/family-housing>.

²⁴¹ Robert Wood Johnson Foundation, “A Hospital Helps Revitalize the Community Outside Its Walls: Q&A with George Kleb and Christine Madigan,” *Culture of Health*, March 25, 2014, https://www.rwjf.org/en/culture-of-health/2014/03/a_hospital_helpsrev.html.

²⁴² Robert Wood Johnson Foundation, “A Hospital Helps Revitalize the Community Outside Its Walls.”

²⁴³ Bon Secours, “Bon Secours Housing,” <https://bonsecours.com/baltimore/community-commitment/housing>.

²⁴⁴ Stuart M. Butler, Jonathan Grabinsky, and Domitilla Masi, “Hospitals as Hubs to Create Healthy Communities: Lessons from Washington Adventist Hospital,” Brookings Institution, September 2015, <https://www.brookings.edu/research/hospitals-as-hubs-to-create-healthy-communities-lessons-from-washington-adventist-hospital/>.

Dignity Health's financial support for families attempting to retain their homes during the Great Recession—when banks and other mortgage lenders were unable to provide relief.

More challenging, however, is structuring partnerships that constitute a more traditional business case for a health system, since an effective partnership will generally reduce health costs and so reduce revenue to the health system. But that business case can sometimes be achieved by recognizing the broader benefits of the partnership and sharing that benefit with the health system. Certain steps could help strengthen that case alongside other steps that refine the current requirements on health systems.

Counties and cities should explore partnerships with hospitals, clinics, and insurers to reduce the societal costs of homelessness and share part of the cost savings with the health system.

Some counties and other jurisdictions recognize the health-related causes and multisector costs of certain chronic problems, such as homelessness, and so are structuring partnerships designed to save the jurisdiction money while improving the condition of individuals. Montgomery County's experiment with Washington Adventist is an example. One jurisdiction that has strongly encouraged such partnerships is Los Angeles County in California. The 10th Decile Project, which links medical institutions and housing in the county, is an example. The project stemmed from the nonprofit Corporation for Supportive Housing's (CSH) Frequent Users Systems Engagement (FUSE) pilot, connecting hospitals

to housing providers and targeting the highest-cost, highest-need individuals.²⁴⁵

Originally, the financial model was made possible thanks to philanthropy. However, CSH was able to expand its the FUSE pilots after receiving a five-year federal Social Innovation Fund award, which also helped the county to expand and scale up the project.²⁴⁶ The public-private partnership of 20 hospitals, nine Homeless Service Providers (some also mental health providers), nine FQHC providers, and other service providers is organized into nine geographically organized teams to identify patients in the area who are homeless and account for the top 10 percent highest-cost and highest-need patients.²⁴⁷ Using hospital data in a triage tool developed by the Economic Roundtable,²⁴⁸ the partnering hospitals and clinics are able to assess and identify those patients with the highest costs and highest need. These costs could include anything from medical or hospital costs to mental health costs to costs associated with jail and detention. Through the 10th Decile Project collaborative networks, hospitals, and clinics are then able to design a system of support to match these identified individuals with housing and other relevant and appropriate resources.

As noted above, in the discussion of budgeting reforms, the key to such ventures gaining public encouragement and financial support is for jurisdictions to use SROI data to identify the cross-sector and cross-agency savings or benefits that can result from partnerships across sectors and how the jurisdiction itself can on balance save money and/or achieve greater impact.

²⁴⁵ Corporation for Supportive Housing, "The 10th Decile Project: Impressive Early Outcomes in Los Angeles," September 25, 2013, <http://www.csh.org/2013/09/the-10th-decile-project-impressive-early-outcomes-in-los-angeles/>.

²⁴⁶ Economic Roundtable, "10th Decile Project to House High Need Homeless," <https://economicrt.org/current-projects/10th-decile-project-to-house-high-need-homeless/>.

²⁴⁷ Partnership HealthPlan of California, "Improving the Health of Homeless Populations Through Innovation and Collaboration," December 16, 2016, http://www.partnershiphp.org/Providers/Quality/Documents/Strategic%20Initiatives%202016/Improving%20the%20Health%20of%20Homeless%20Populations%20Through%20Innovation%20and%20Collaboration_REVISED_FINAL%20Agenda.pdf.

²⁴⁸ Economic Roundtable, "Screening Tool for Calculating Likelihood of Generating 10th Decile Costs," version 2a, http://economicrt.org/wp-content/uploads/2015/03/ERT_Triage_Tool_v1-v2.xlsx.

With the support of states and local government, hubs should make greater use of community benefit investments by hospitals and financial, such as those encouraged by the CHNA and the Community Reinvestment Act (CRA). They should also explore innovative forms of private funding and public-private financing, such as social impact bonds (SIBs).

In addition to greater flexibility in the use of public funds, housing-based partnerships and hubs can make use of a growing variety of private-sector sources of investment.

Housing-based services have long been financed with the assistance of nonprofit organizations specializing in community investment, often in partnership with hospitals and other large enterprises. Enterprise Community Partners is an example. Enterprise partnered with Bob Secours Health System in Baltimore, providing almost \$100 million in financing for a joint initiative to provide more than 800 affordable housing units.²⁴⁹ Working with Sinai-Grace Hospital in Detroit, Enterprise also brought together finance and local partners to provide housing and services.²⁵⁰

In many cases, health systems help finance housing and other services because neighborhood development is part of their mission. As the Urban Institute noted in a 2017 report on strategies for integrating health and housing, such mission-driven health system investing was spearheaded by the Catholic hospital systems, including Bon Secours in Baltimore and Dignity Health in the western states.²⁵¹

Some systems also see the potential for saving money by doing good. The health insurer UnitedHealthcare, for instance, invested in affordable housing units in Texas to stabilize the lives of many of its poorer enrollees with the aim of reducing expensive emergency room visits. UnitedHealthcare includes housing navigator staff as part of its care teams and has partnered with homeless providers in Texas to help homeless members find housing by paying an incentive fee to the homeless providers once the person is in housing.²⁵² Meanwhile, in Georgia, the Amerigroup managed care system, in conjunction with Mercy Housing, is piloting the use of telemedicine services to improve resident access to health services. The service is available to all residents, but because approximately 30 percent of the property's residents are Amerigroup beneficiaries, there is a strong business case for the partnership.²⁵³

CRA and CHNA. For many years, private investment in community housing initiatives has been encouraged by government requirements. Thanks in part to the 1977 Community Reinvestment Act, commercial banks and other financial institutions, for example, have been required to increase lending in low-income communities in which they are chartered. Meanwhile, with the US Treasury's financial backing, community development financial institutions provide important long-term support to community ventures, including housing-based initiatives.

In addition, hospitals increasingly recognize the importance of their local investment as an anchor

²⁴⁹ Enterprise Community Partners, "Cross-Sector Partnerships to Advance Health," 2017, <https://www.enterprisecommunity.org/sites/default/files/media-library/solutions-and-innovation/health-and-housing/cross-sector-partnerships-to-advance-health-bon-secours-balt.pdf>.

²⁵⁰ Enterprise Community Partners, "Cross-Sector Partnerships to Advance Health."

²⁵¹ Scally et al., "Emerging Strategies for Integrating Health and Housing."

²⁵² Edgar Walters, "To Reduce Health Costs, Insurer Spends on Housing for Homeless," *Texas Tribune*, September 21, 2015, <https://www.texastribune.org/2015/09/21/save-health-costs-one-company-tries-spending-housi/>.

²⁵³ Stewards of Affordable Housing for the Future, "The Path to Partnership: Lessons Learned in the Pursuit of Joint Initiatives Between Affordable Housing Providers and Medicaid Managed Care Programs," April 25, 2017, <https://www.sahfnet.org/media-center/news/path-partnership>.

function in their communities.²⁵⁴ This pattern has been encouraged by federal requirements on nonprofit hospitals to indicate their commitment to community benefit as a condition of their tax-free status, including provisions in the Affordable Care Act that require nonprofits to conduct a CHNA. The CHNA is a periodic review of the health needs in the community, followed by a plan to address them. The result has been more investment by hospitals in a range of activities that promote health, including housing-based services.

Boosting Crossover Investment. The federal government could encourage investment in housing-based hubs through more coordination of the CRA and CHNA requirements on institutions. A problem today is that institutions face different rules and guidance under each federal requirement. Many hospitals are also uncertain whether they will receive credit for some of their more innovative community activities. Moreover, there is little encouragement for “crossover” investments by hospitals and financial institutions. For instance, it is generally difficult for hospitals to obtain community benefit credit for economic activities or for financial institutions to obtain CRA credits for health promotion and prevention. For instance, the Dignity Health system increased its housing investments by providing financial assistance to families to help them remain in their homes during the Great Recession, when financial institutions were cutting back on loans and mortgages. But Dignity was unable to claim CRA credits for this assistance.

The federal government could encourage crossover and more hospital investment in housing-based initiatives by providing clearer guidance and by being more flexible about the range of activities that comply with the CRA and

CHNA requirements. For example, partnerships with other nonprofits and government entities can often advance community health needs and remedies. The IRS should give clear guidance and assistance to hospitals on how to develop such partnerships in ways that meet their obligations. The IRS should highlight that housing-based initiatives providing a range of services would fit the requirements. IRS guidance should also emphasize the appropriateness of using a broad definition of community health improvement that covers nonclinical activities aimed at general community health and social determinants of health. A helpful step would be to establish a working group from HHS and other departments, such as HUD, Treasury, and the DOE to collect research and case examples for the guidance. In addition, the IRS should consider revising its current policy regarding “directly offsetting revenue” to permit hospitals to report as community benefit expenditures the restricted grants they receive and thereby further their community health objectives through investments in housing and other services.

SIBs. Another source of investment with great promise stems from the growing interest in “pay-for-success” strategies, in which the public sector contracts with private investors, typically through financial instruments known as SIBs.²⁵⁵ In a SIB contract, private investors finance a public-private partnership to a specific goal, such as a reduction in recidivism among released prison inmates or reducing homelessness. The payment to the investors depends on the success or otherwise of the venture. Thus, PFS strategies have two broad benefits for initiatives, including housing-based partnerships. The first is that the partnership can finance start-up and capital requirements from a flexible private investor, rather than compete for money from public programs or even philanthropy. This can often

²⁵⁴ Tyler Norris and Ted Howard, “Can Hospitals Heal America’s Communities?,” Democracy Collaborative, December 2015, https://democracycollaborative.org/content/can-hospitals-heal-americas-communities-0?mc_cid=fa5da54d58&mc_eid=c2de728e1a.

²⁵⁵ Urban Institute, “Pay for Success,” <http://pfs.urban.org/>; and Ian Galloway, “Using Pay-for-Success to Increase Investment in the Nonmedical Determinants of Health,” *Health Affairs* 33, no. 11 (November 2014), 1897–904, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.0741>.

allow pilots of creative ventures. The second is that, if the initiative can attract the funds, the investor carries the ultimate financial risk if the initiative is unsuccessful.

The experience with SIBs is still only over a short period and still debated.²⁵⁶ But SIBs are a key financing feature of many interesting projects that seek to build supportive services around a housing base, and many variants of the PFS model are being piloted or are planned.

One example of the role SIBs can play in housing-based partnerships is a senior housing venture being launched in Massachusetts by LeadingAge and the Long Term Quality Alliance, in cooperation with the West Health Policy Center. The venture will bring multiple senior affordable housing organizations together with the health plans that enroll their residents to pool resources to provide in-residence care teams that connect with residents as an extension of the plans' care teams. The venture will include a careful evaluation of the net health savings to the health plans associated with enhanced supports to both residents and caregivers and may use part of the projected savings as the return for a PFS investor.

Congress should amend the Medicaid statute to permit use of Medicaid funds for room and board and direct housing capital costs when proposals seek to achieve measurable improvements in health.

As noted earlier, the federal government has taken important steps to use waivers under Section 1115 of the Social Security Act to permit

use of Medicaid funds for state innovations and pilots involving housing where the goal is to enhance the effectiveness of Medicaid's health goals. But there are statutory limits on using Section 1115 waivers for housing, in particular for room and board and direct capital costs.²⁵⁷ The only exception is under Medicaid's 1915(c) and 1915(i) Home and Community Based Services (HCBS) waivers, which permit "temporary short-term out of home respite services and for unrelated live-in caregivers" so long as the person receiving care does not live in housing owned by the caregiver or owned/leased by the provider of waiver services.²⁵⁸

To address these constraints on payment and budget flexibility, Congress should ease the restrictions on using Medicaid for housing needs in cases where research suggests that there may be savings to the Medicaid program or significant improvements in the health of beneficiaries would accrue. Broader permission to use Medicaid in this way should be added to the Section 1115 waiver process.

The federal government should expand housing-health partnerships for the elderly and disabled, including the MFP initiative and HCBS waivers.

As the Bipartisan Policy Center (BPC) has pointed out, Washington can help encourage state and local agencies to coordinate housing and health care for the elderly in a variety of ways.²⁵⁹ BPC urges such steps as launching more pilots to coordinate health care and long-term supports and services for Medicare beneficiaries in publicly assisted housing, expanding and making permanent the Home

²⁵⁶ Emily Gustafsson-Wright, Sophie Gardiner, and Vidya Putcha, "The Potential and Limitations of Impact Bonds: Lessons from the First Five Years of Experience Worldwide," Brookings Institution, July 2015, <https://www.brookings.edu/research/the-potential-and-limitations-of-impact-bonds-lessons-from-the-first-five-years-of-experience-worldwide/>.

²⁵⁷ Vikki Wachino, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities," Centers for Medicare and Medicaid Services, June 26, 2015, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>.

²⁵⁸ Wachino, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities."

²⁵⁹ Bipartisan Policy Center, "Healthy Aging Begins at Home," May 2016, <http://bipartisanpolicy.org/wp-content/uploads/2016/05/BPC-Healthy-Aging.pdf>.

Demonstration program, and extending the Money Follows the Person (MFP) initiative. In a 2017 study mentioned earlier in this report, transitioning older adults from nursing homes to home or community settings decreased average monthly per beneficiary expenditures by \$1,783.²⁶⁰ Initiatives such as MFP and the Balancing Incentives Program have now expired, but Congress should reauthorize such programs, especially as state MFP directors are facing the choice of ending such programs or continuing them without funding support.²⁶¹

The federal government should also make maximum use of Medicaid's Managed Care 1915(b) and 1915(c) HCBS waivers. This would allow communities to make greater use of social workers and other professionals to provide home-based care for discharged and elderly patients, thus making it more likely they can remain in their homes—as most prefer—rather than moving into expensive nursing homes or assisted living facilities.²⁶² Existing HCBS waiver authorities need to be streamlined and expanded.²⁶³

Efforts should also focus on preventative measures for “pre-Medicaid” populations who might be at risk of prematurely moving into a nursing facility.²⁶⁴ Vermont's Choices for Care model focuses on three eligibility groups with moderate, high, and highest needs.²⁶⁵ Admission into the moderate-needs program does not require Medicaid eligibility and offers a smaller, preventative package of services including case management, homemaker services, and adult day services to delay the need for nursing home

levels of care. At the end of 2017, the Center for Health Care Strategies and Manatt Health released a toolkit providing strategies for states to further strengthen and incorporate home- and community-based services and supports.²⁶⁶

The federal government should encourage a range of housing-health partnerships, including through an expanded Accountable Health Community Model and improved guidance for nonprofit hospitals' community benefit requirement.

The federal government has administrative tools to encourage the health sector to explore housing-based ownerships. For instance, the Accountable Health Communities Model (AHC), an initiative of the CMS's Innovation Center (CMMI), is intended to spur comprehensive screening for the health-related social needs of Medicare and Medicaid beneficiaries. In the AHCs, “bridge organizations will serve as hubs in their communities, forming and coordinating consortia” to develop partnerships with clinical delivery sites and coordinate with community service providers.²⁶⁷ While still at an early age, a concern is that the AHC is too restrictive in the initiatives it permits. Given the importance of housing in the health equation, CMMI should encourage housing organizations and housing-hospital partnerships to apply to be bridge organizations under the AHC.

As noted earlier, nonprofit hospitals are required to review health conditions in their communities

²⁶⁰ Irvin et al., “Money Follows the Person 2015 Annual Evaluation Report.”

²⁶¹ Molly O'Malley Watts, Erica L. Reaves, and MaryBeth Musumeci, “Money Follows the Person: A 2015 State Survey of Transitions, Services, and Costs,” Henry J. Kaiser Family Foundation, October 16, 2015, <https://www.kff.org/report-section/money-follows-the-person-a-2015-state-survey-of-transitions-services-and-costs-conclusion>.

²⁶² Susan C. Reinhard et al., “Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers,” AARP, Commonwealth Fund, and SCAN Foundation, 2014, http://longtermcorecard.org/~media/Microsite/Files/2014/Reinhard_LTSS_Scorecard_web_619v2_rev_04152016.pdf.

²⁶³ Bipartisan Policy Center, “Financing Long-Term Services and Supports: Seeking Bipartisan Solutions in Politically Challenging Times,” July 2017, <https://bipartisanpolicy.org/wp-content/uploads/2017/07/BPC-Health-Financing-Long-Term-Services-and-Supports.pdf>.

²⁶⁴ Richard Eisenberg, “How States Are Helping People Get Medicaid at Home,” *Forbes*, December 28, 2017, <https://www.forbes.com/sites/nextavenue/2017/12/28/how-states-are-helping-people-get-medicaid-at-home/>.

²⁶⁵ Vermont Agency of Human Services, “Choices for Care Training Module I, Program Overview (2017),” 2017, <http://asd.vermont.gov/sites/asd/files/documents/Choices%20for%20Care%20Training%20Module%20I%20Overview.pdf>.

²⁶⁶ Manatt Health and the Center for Health Care Strategies, “Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment: A Toolkit for States,” December 2017, <https://www.chcs.org/resource/strengthening-medicaid-long-term-services-supports-evolving-policy-environment-toolkit-states/>.

²⁶⁷ Centers for Medicare and Medicaid Services, “Accountable Health Communities (AHC).”

and develop plans to address concerns, especially through the CHNA requirement. The federal government should encourage localities to propose AHC models that make creative use of CHNA requirements, particularly models including community partners.

Medicaid should aggressively and creatively use HCBS waivers to add flexibility and permit approaches that help people with chronic conditions to be established in housing, using their housing as a hub and reducing health costs.

Following BPC recommendations to simplify and expand existing HCBS waivers, Medicaid should give more flexibility to states to encourage integrated home and community-based services and supports for beneficiaries.²⁶⁸

Many different housing-related services exist, most of which could be made more routinely eligible Medicaid services as part of an enhanced HCBS waiver. These could include *transition services*, which prepare a person to move from a facility into housing and include combining other services and supports. In addition, *housing search services* help a person seeking housing find appropriate housing, complete applications, mitigate such barriers as criminal records, and even negotiate directly with landlords. *Move-in assistance* helps tenants amass security and utility deposits, move belongings to the housing, furnish the apartment including purchasing of household goods, sign the lease, and set up any assistive technology and accessibility modifications. Once housing is secured and the tenant has successfully moved in, *tenancy-sustaining supports* help residents understand their rights and the responsibilities of tenancy,

including upkeep of the unit, paying rent, maintaining a relationship with the landlord, and general help with living skills, money management, etc.

Some states, such as Louisiana, have developed housing supports teams that have expertise in these areas.²⁶⁹ But a general problem facing states and localities is that Medicaid does not as clearly reimburse other services that might be available in a building for any resident such as resident service coordinators, wellness programming, and educational or social activities. That needs to be clarified; with the HCBS 2014 rules on choice in service providers, there are limitations to having on-site services tied to a building.²⁷⁰

Drawing from the experience of Section 1115 waivers in Medicaid and the potential for Medicare Advantage plans to address the broader factors affecting seniors' health, Congress should grant Medicare broader authority to conduct pilots and grant waivers to allow Medicare to experiment with more housing partnerships.

Medicaid has a relatively good track record in using federal Section 1115 waivers (initiated by states) and federally supported demonstration projects to test innovative approaches in which Medicaid funding can be used to support other services that are likely to help achieve the objectives of Medicaid. In addition, a series of experiments have been launched to provide a better array of services to seniors who are “dual eligible”—that is, eligible by age or disability for Medicare and by income for Medicaid.²⁷¹ Housing

²⁶⁸ Bipartisan Policy Center, “Financing Long-Term Services and Supports: Seeking Bipartisan Solutions in Politically Challenging Times.”

²⁶⁹ Valerie Canady, “Partnerships, Support Fuel Success of Creative Louisiana Housing Program,” *Mental Health Weekly*, March 3, 2012, <http://www.mentalhealthweeklynews.com/Article-Detail/partnerships-support-fuel-success-of-creative-louisiana-housing-program.aspx>.

²⁷⁰ Centers for Medicare and Medicaid Services, “Fact Sheet: Summary of Key Provisions of the Home and Community Based Services (HCBS) Settings Final Rule,” January 10, 2014, <https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-setting-fact-sheet.pdf>.

²⁷¹ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field,” August 2014, <https://aspe.hhs.gov/pdf-report/medicaid-and-permanent-supportive-housing-chronically-homeless-individuals-emerging-practices-field>.

has often been an important feature of these experiments.

Medicare has been less in the forefront of this type of service experimentation, in part because the statute does not provide for strong waivers such as Medicaid's Section 1115 and in part, because Medicare is a federal program and states have less incentive to push for innovations where the federal government would be the financial beneficiary.

Using the Flexibility of Medicare Advantage Plans. Medicare is largely untapped in its potential for using housing services and other nonmedical services to help achieve the objectives of the program. In addition, Medicare Advantage (MA) plans generally have yet to fully emulate Medicaid managed care organizations (MCOs) in exploring such approaches that are permitted by law. For instance, MA plans are not required to conduct health risk assessments associated with housing in their long-term services questions. They should do so to explore housing services as a means of reducing health costs and improving the quality of life for their elderly members.²⁷² A bigger problem has been the legal restrictions on Medicare, making it difficult or impossible for the program to pay for health-improving social services and housing support.

Fortunately, the February 2018, federal budget agreement opens up new possibilities for Medicare to pay for these services. Under the budget legislation, MA plans can now pay for non-medical services in their benefit packages, thanks to the inclusion of a bill known as the CHRONIC Act.²⁷³ Thanks to this legislation, MA plans could prove to be a viable and sustainable funding source for housing-based service models, particularly with federal incentives for payers to

include a certain percentage of low-income members in the pool in return for a more favorable risk adjustment in payments. In addition, MA plan managers should explore ways in which housing-based support services could enhance the general health of their plan members—as Medicaid MCOs are increasingly doing—and incorporate more of these services into their plans.

CMS should also pursue two housing-based service model payment methods: a place-based MA product and a multi-payer value-based payment method. MA plans should be incentivized to enroll groups of low-income seniors and individuals with a disability in affordable housing properties, following CMS's mission of providing patient-centered care and choice of care. CMS should also test a multi-payer approach to better evaluate and improve cost, care, and choice. Currently, 14 states are equipped to begin initial testing of both housing-based service model payment methods, and such demonstrations could be scaled if found to be effective.

Time for Medicaring. Many researchers and advocates for the elderly have argued for additional steps to integrate Medicare and social services to create more customized and comprehensive approaches to aging. This might be particularly beneficial for seniors with chronic conditions who would prefer to remain in their own homes. For example, the Altarum Institute argues for a comprehensive “Medicaring” approach through the integration of funding for long-term health and social and supportive services in health plans.²⁷⁴

Rule Changes. Modifications of federal rules could also help. The BPC notes that the Medicare can advance housing and health policy in several

²⁷² Allyson Schwartz and Anand Parekh, “Integrating Health Care and Housing to Promote Healthy Aging,” *Health Affairs*, May 23, 2016, <http://www.healthaffairs.org/doi/10.1377/hblog20160523.054972/full/>.

²⁷³ Howard Gleckman, “Today’s Massive Budget Deal Makes Big Medicare Changes,” <http://howardgleckman.com/2018/02/todays-massive-budget-deal-makes-big-medicare-changes/>.

²⁷⁴ Altarum Institute, “MediCaring Communities: Getting What We Want and Need in Frail Old Age at an Affordable Cost,” 2016, https://altarum.org/sites/default/files/uploaded-related-files/Center%20for%20Elder%20Care%20Advanced%20Inness_MediCaring_101116.pdf.

areas. These range from simply including housing-based questions in health risk assessments to more complex changes such as allowing MCOs to pay for home alterations.²⁷⁵ In the case of those dually eligible for Medicaid and Medicare, there should be increased focus on the nearly 1.3 million elderly participants currently living in public housing.²⁷⁶ CMS should undertake more demonstrations to coordinate health and long-term supports and services for Medicare beneficiaries living in public housing.

Increased Waiver Authority. In addition, drawing from the experience of Section 1115 waivers, Congress should give Medicare greater authority to work with states on housing-related strategies and other approaches to improve health for the elderly while reducing costs. With the new flexibility for Medicare to cover certain non-medical services, MA plans could become key institutions to coordinate housing services for beneficiaries in such waivers.

Since Medicare is a federal program, not a joint federal-state program like Medicaid, such a Medicare waiver authority would need to establish a budget arrangement to encourage states to request waivers involving Medicare. One way would be through a “shared savings” model, in which states would negotiate with the federal government on the degree to which Medicare’s projecting savings would be shared with the state to cover nonmedical service costs.²⁷⁷

States and communities should experiment with a place-based district nurse program to link home-based individuals with a network of health services and other supports.

The British National Health Service (NHS) makes extensive use of community-based and highly skilled nurses to coordinate the care of people discharged from hospitals and home-based patients with complex needs. These “district nurses” predate the NHS and link home-based patients with the health care system. They are senior nurses, who manage other nurses, prescribe medication, and provide a range of in-home services.²⁷⁸

Community-based nurses do exist in the United States, including school nurses and parish nurses, as well as lesser-skilled community health workers and grand aides.²⁷⁹ The Nurse-Family Partnership, created to assist first-time mothers, focuses on home-based services.²⁸⁰ The locally hired coaches of City Health Works in New York City²⁸¹ also work closely with families to improve health habits and help clients navigate the health and social service system.²⁸² Durham County, North Carolina, has developed a neighborhood nursing program as part of its public nursing program, in which nurses are located strategically in low-income neighborhoods, provide free in-home visits to the parents of newborns, and connect them with the community services they need.²⁸³ Meanwhile, in South Carolina, Nurse-Family Partnership (NFP),

²⁷⁵ Bipartisan Policy Center, “Healthy Aging Begins at Home.”

²⁷⁶ U.S. Department of Health and Human Services, “Picture of Housing and Health.”

²⁷⁷ Butler, Stuart, M., David Kendall, and Len Nichols, “Enlisting States as Partners in Health Care Cost Savings,” George Mason University, Center for Health Policy Research & Ethics, February 12, 2014, <https://chpre.org/wp-content/uploads/2014/09/Issue-Brief-1.pdf>.

²⁷⁸ National Health Service, “District Nurse,” <https://www.healthcareers.nhs.uk/explore-roles/nursing/district-nurse>. See also Stuart M. Butler and Carmen Diaz, “Nurses as Intermediaries in the Promotion of Community Health: Exploring Their Roles and Challenges,” Brookings Institution, September 21, 2017, <https://www.brookings.edu/research/nurses-as-intermediaries-in-the-promotion-of-community-health/>.

²⁷⁹ Grand-Aides USA, <http://www.grand-aides.com/>.

²⁸⁰ Nurse-Family Partnership, <https://www.nursefamilypartnership.org/>. See also Sabrina Tavernise, “Visiting Nurses, Helping Mothers on the Margins,” *New York Times*, March 8, 2015, <https://mobile.nytimes.com/2015/03/09/health/program-that-helps-new-mothers-learn-to-be-parents-faces-broader-test.html>.

²⁸¹ City Health Works, “Ambassadors of Health.”

²⁸² Joanne Kenen, “New York Borrows a Health Care Idea from Africa,” *Politico*, October 25, 2017, <https://www.politico.com/agenda/story/2017/10/25/primary-care-cost-saving-communication-000555>.

²⁸³ Durham County Network of Care for Behavioral Health, “Durham Connects Program,” July 31, 2017, http://durham.nc.networkofcare.org/mh/services/agency.aspx?pid=DurhamConnectsProgram_371_2_0.

a nonprofit organization, is engaged in a multiyear Medicaid waiver to explore the impact of providing a range of home-based services to mothers during pregnancy and the first two years of their child's life.²⁸⁴

Another example is Healthy Start in Housing (HSiH), an initiative between the Boston Housing Authority and the Boston Public Health Commission.²⁸⁵ Aimed at pregnant women or families with young children, HSiH identifies women or families who are either homeless or at risk of becoming homeless. Through the program, expectant mothers and families are given high priority on the housing waitlist and are paired with public health nurses and case managers for three years.²⁸⁶ These nurses and case managers meet monthly with clients in whatever setting they feel most comfortable, eventually in the clients' homes once they are placed in housing. The public health nurses assist and educate clients about tenant rights and other housing issues and with resources to improve birth outcomes and overall health and well-being.²⁸⁷ An initial evaluation from Boston University researchers found moderate improvements in mental health and instances of depression.²⁸⁸

Wellness nurses have become an important component of successful housing for the low-income elderly. In Vermont's SASH program, the nurses play a crucial role, working with on-site service coordinators, in organizing integrated health and social services and in promoting wellness education and prevention. HUD is currently funding a randomized control trial of such wellness nurse/service coordinator teams in

40 housing sites. The evaluation is being implemented by the Lewin Group, LeadingAge, and the National Center for Healthy Housing.²⁸⁹

²⁸⁴ Katherine Baicker et al., "The Impact of a Nurse Home Visiting Program on Maternal and Child Health Outcomes in the United States," Abdul Latif Jameel Poverty Action Lab, <https://www.povertyactionlab.org/evaluation/impact-nurse-home-visiting-program-maternal-and-child-health-outcomes-united-states>.

²⁸⁵ Boston Housing Authority, "Healthy Start in Housing Provides Housing and Services to Women with High Risk Pregnancies," December 16, 2014, <https://www.bostonhousing.org/en/BHA-Blog/December-2014/Healthy-Start-in-Housing-provides-housing-and-serv.aspx>.

²⁸⁶ Scally et al., "Emerging Strategies for Integrating Health and Housing."

²⁸⁷ Sandel, "Compounding Stress."

²⁸⁸ Charlotte Vieira et al., "Effects of Healthy Start in Housing on Maternal Mental Health Among High-Risk Pregnant Women Experiencing Homelessness," American Public Health Association, November 2, 2015, <https://apha.confex.com/apha/143am/webprogram/Paper318073.html>.

²⁸⁹ Geralyn Magan, "CFAR Will Help Implement HUD's Housing Plus Services Demonstration," LeadingAge, February 23, 2017, <https://www.leadingage.org/cfar/cfar-will-help-implement-hud%E2%80%99s-housing-plus-services-demonstration>.

BRITAIN'S DISTRICT NURSES

In the United Kingdom, the local district nurse is as much a central institution of the community as the local post office or church. The nurse is a crucial intermediary between the home-based patient and other critical institutions that are critical to a person's life and daily living.

Report author Stuart Butler well remembers the district nurse during his upbringing in the West Midlands of England in the 1950s and 1960s. At that time, his mother managed the sub-post office in the village. Throughout Britain, post offices handled a variety of transactions, including distributing pensions (Social Security) and taking deposits for the national post office savings bank, as well as mail services. Thus, the typical person in the community interacted with the post office frequently and regularly.

Butler recalls that almost every day the district nurse would literally bicycle over to the post office to check in with his mother and to see if someone who regularly came to the post office had been a “no show” or seemed to have a medical problem of some kind. If so, the nurse would bicycle to that person's home to make sure he or she was all right “and have a cup of tea” or deal with any problems. Moreover, the assistance would not be strictly medical; the district nurse would take the initiative to link the person with whatever service they needed to remain safe and healthy, including social services and even home repairs. Everyone knew the district nurse, who was the connector and the centerpiece of home-based health.

Public and private housing managers should explore using clinics based in housing projects, modeled on school-based health centers, as well as telemedicine.

Schools have become a very important platform for providing health services to young people. Not only do most schools have school nurses on site or available at some point during the school week, but a network of school-based health

centers provide a range of medical services to students in some schools.²⁹⁰ In some cases such as the Mary's Center-Briya charter school partnership in Washington, DC, a school and clinic are co-located, with the clinic delivering medical services to students and their parents and other households in the community.²⁹¹ These school-based community clinics take advantage of the foot traffic out of school to make it simple and easy for many families to access health services.

Housing, like schools, makes sense as a location for health services because co-located or embedded clinics can easily serve residents while having access to the broader community. Many multi-housing and senior housing developments that provide wellness centers for residents and some housers, such as Mercy Housing, have explored partnerships with a health provider (Amerigroup) to become a telemedicine site to significantly expand access to medical services for residents.²⁹² Meanwhile, students and staff from the schools of Medicine, Nursing, Pharmacy and Social Work at Virginia Commonwealth University operate interdisciplinary clinics in senior housing in Richmond.²⁹³

Still, housing-based health centers face challenges that will require more experimentation and the acquisition of experience if they are to become a common feature. Liability concerns are one issue—as they were with in-house school health clinics—and that discourages many private and public housers from pursuing on-site medical services, even when, as noted earlier, the concerns could be avoided with good legal advice. Scale is also important, with health providers concerned that there will be enough residents in a property and walk-ins from the

²⁹⁰ Acosta Price, “School-Centered Approaches to Improve Community Health.”

²⁹¹ Stuart M. Butler, Jonathan Grabinsky, and Domitilla Masi, “Using Schools and Clinics as Hubs to Create Healthy Communities: The Example of Briya/Mary's Center,” Brookings Institution, July 15, 2015, <https://www.brookings.edu/research/using-schools-and-clinics-as-hubs-to-create-healthy-communities-the-example-of-briyamarys-center/>. (Disclosure: Co-author Stuart Butler is a board member of Mary's Center, a nonprofit federally qualified health center.)

²⁹² Stewards of Affordable Housing for the Future, “The Path to Partnership.”

²⁹³ Virginia Commonwealth University, Center for Interprofessional Education and Collaborative Care, “The Richmond Health and Wellness Program,” May 1, 2015, <https://ipe.vcu.edu/clinical-programs/richmond-health-and-wellness-center/>.

community to make a clinic financially viable. In addition, there can be significant privacy issues. HIPAA compliance is one issue, but so is the desire of many residents to avoid their next-door neighbors having knowledge of their medical encounters. In both cases, telemedicine may prove to be a useful tool to facilitate the use of housing as a portal for health services.

Innovative housers and health providers seem ready to explore the possibilities of housing-based clinics, as schools did in the past, and seek solutions for the issues that must be addressed. As they do, housing-based health services could become an increasingly important component of the health care system.

The federal government and states should build on the flexibility of Medicaid MCOs to combine medical services with other services, including housing, to improve health and reduce direct medical costs.

Many state Medicaid programs already depend greatly on MCOs to provide services to their Medicaid enrollees. Depending on Medicaid provisions and Section 1115 waivers, managed care plans have significant potential to use nonmedical services that may reduce costs while improving outcomes by paying for some housing-related services that contribute to better health.²⁹⁴ With state approval, MCOs can also use their Medicaid revenue to cover health-improving services outside what has been considered Medicaid benefits.²⁹⁵ These services can include transportation and housing-based services. Because the Medicaid MCOs receive a capitated payment, they have an incentive to pay for

nonmedical services for beneficiaries that would not normally be covered by Medicaid if that results in savings to the MCO while improving the health of enrollees.

For example, the AmeriHealth and Trusted Medicaid MCOs have launched a pilot program with Mary's Center, an FQHC in the Washington, DC, area. Under the pilot, the MCOs contract with Mary's Center to provide home-based telemedicine services for high-cost MCO patients who have chronic conditions and are "disconnected" from the health system (often because of transportation, employment, or family constraints) and thus do not receive necessary regular checkups and care.²⁹⁶ Mary's Center, which adopts a multisector approach to its clients, uses home visitors in addition to telemedicine staff.²⁹⁷ Normally, Medicaid does not reimburse telemedicine services if the patient is relatively close to a medical facility. Under the pilot, the MCOs are testing whether the savings to them from home-based services for these patients are sufficient to warrant the MCO paying for unreimbursed telemedicine. In another example, the Camden Coalition Accountable Care Organization (ACO) in Camden, New Jersey, has pursued several different strategies to partner with two managed care providers to identify and establish a set of criteria and quality metrics for performance assessment.²⁹⁸ This was one of the first instances where an MCO could invest in housing and reap financial benefits, thereby making a better business case for the MCO. As the Camden Coalition continues to flourish, more support is needed from the state level to address the housing crises. However, there should also be caution: MCOs have the potential to limit the ACO's full potential.²⁹⁹

²⁹⁴ Julia Paradise and Donna Cohen Ross, "Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples," Henry J. Kaiser Family Foundation, January 27, 2017, <https://www.kff.org/report-section/linking-medicaid-and-supportive-housing-issue-brief/>.

²⁹⁵ U.S. Department of Health and Human Services, "Design of a Demonstration of Coordinated Housing."

²⁹⁶ Mary's Center, "Telemedicine: Mary's Center Brings Healthcare to Your Home," May 24, 2017, <http://www.maryscenter.org/blog/telemedicine>.

²⁹⁷ Butler, Grabinsky, and Masi, "Using Schools and Clinics as Hubs to Create Healthy Communities."

²⁹⁸ Camden Coalition of Healthcare Providers, "Camden Coalition Accountable Care Organization Gainsharing Plan," 2016, http://www.nj.gov/humanservices/dmahs/info/Camden_Coalition_of_Healthcare_Providers_Gainsharing_Plan.pdf.

²⁹⁹ Frank J. Thompson and Joel C. Cantor, "The New Jersey Medicaid Accountable Care Organization Demonstration: Lessons from the Implementation Process," Rutgers Center for State Health Policy, May 2016, <http://www.cshp.rutgers.edu/publications/the-new-jersey-medicaid-accountable-care-organization-demonstration-lessons-from-the-implementation-process>.

Appendix: Advisory Group

For this project, we assembled an advisory group of researchers, practitioners, policy experts, and specialists to suggest policy steps and review drafts of this report.

While the recommendations reflect suggestions raised in our various conversations and discussions, they are not a consensus of the advisory group, and the recommendations do not necessarily reflect the individual or institutional opinions of any advisory group participant.

The authors of this Brookings report, not the advisory group members, are entirely responsible for the recommendations and discussion in this document.

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