Network Expansion Track Meeting

December 8, 2022

Introductions

- Please let us know who is here by sharing via chat:
  - Your Name
  - Organization

- It's also helpful to update your name in Zoom to include your name, organization, and state
  - To change how your name appears in Zoom:
    - Go to "Participants" list and select the icon with 3 dots to the right of your name
    - Select "Rename"
    - Enter your name and organization and select "Change"

Agenda

- Role of Community Care Hubs to enable successful health and housing initiatives
  - Kelly Cronin and Lori Gerhard, ACL
- Accessing and using Community Health Needs Assessment Data to identify housing needs
  - Charisse Walcott, CDC
- Community Care Hub Insight and Experience
  - Jennifer Raymond, AgeSpan

Logistics

- Recordings and Meeting Material
  - NLC meetings will be recorded and shared with NLC participants via email. Meeting material will be posted to the NLC technical assistance page
- Sound
  - Please keep yourself on mute unless speaking.
- Use the Raise Hand function to engage
  - To raise your hand, click on the “Reactions” box and then click “Raise Hand.” You can also lower your hand by following the same process.
  - Please provide your name and organization when speaking
- Closed Captioning
  - A live transcript of the meeting is available. To turn on closed captioning click on the upward arrow next to Live Transcript and select “Captions.” The Captions option may also be available under the icon labeled “More.”

Health and Housing Partnerships & Opportunities

National Learning Curriculum Community Care Hubs (CCH) 12/8/2022 (2-3 pm ET)

Housing and Services
Resource Center

Objectives for This Segment

- Collectively Identify Housing Related Technical Assistance Needs
- Discover Potential Housing Partnership Opportunities
- Highlight a Few Resources

Housing and Services Resource Center

A partnership between

Email us at: HSRC@acl.hhs.gov

acl.gov/HousingAndServices #HousingResources

1st Menti Poll Question

- Please go to http://www.menti.com/
- Enter the code: 8278 8343
- Select ‘Join a Presentation’ and respond to our first question. You can submit multiple responses to the same question. Here’s the first question:
  - What is the name of your organization?

Menti Question 2: What is/are your target population(s) for housing? (check all that apply)

a. Persons with disability (serious mental illness, physical disabilities, or intellectual/developmental disabilities)
b. Older adults
c. People experiencing homelessness or at-risk of homelessness
d. People transitioning out of institutions
e. People seeking housing stability

Menti Question 3: How long has your Community Care Hub been addressing housing needs?

a. Less than 1 year
b. 1-3 years
c. More than 3 years
d. We are not currently addressing housing needs

Issues Around Health and Housing

- Affordability
  - For every **100** extremely low-income renter households, there are **only 37** affordable and available homes
- Accessibility
  - **< 1%** U.S. housing stock is wheelchair-accessible
  - **< 5%** can accommodate individuals with moderate mobility disabilities
- Housing Stability
  - Housing retention – Limited awareness, access, and availability of community services
  - **80% of admissions into nursing homes are from hospital stays**; short-term admissions often turn into long-term nursing home stays
  - Each year, **nearly 900,000** individuals fall into homelessness
  - **48.5%** who used homeless shelters over the course of a year report having a disability, and **23%** are older adults

Menti Question 4: How is your Community Care Hub addressing housing needs? (check all that apply)

a. Housing navigation
b. Use of housing vouchers
c. Eviction prevention
d. Accessible housing
e. Developing new housing through partnerships
f. Addressing homelessness
g. Transitioning people out of institutions
h. Other
i. My Community Care Hub is not addressing housing needs

Importance of Collaboration and Partnerships

- When we work together to align and leverage our work to coordinate affordable, accessible housing with increased access to health and home and community-based services, we create the infrastructure to fully meet the needs of the people we serve.

- Community Care Hubs can create a culture of collaboration – so that it becomes the way we work and eventually is naturally occurring. Through CCH's we can break out of our silos and build a culture of collaboration and partnership.

- ***"Partnerships don't just happen, however. They need "connective tissue" – an infrastructure supporting frequent and systemic level collaborations – to help form the partnership and hold it together over time."***

[Building connective tissue for effective housing-health initiatives (brookings.edu)](https://www.brookings.edu)

Figure 1

Section 1115 Waivers with Provisions Related to Social Determinants of Health (SDOH), as of 11/2/2022

Status of Section 1115 SDOH Provisions:

Approved (15 states) | Approved & Pending (3 states) | Pending (5 states)

NOTE: Through Section 1115 authority, states can test approaches for addressing the SDOH of Medicaid enrollees, including the use of federal matching funds to test SDOH-related services and supports in ways that promote Medicaid program objectives. For more information on approved and pending SDOH provisions across states, see SDOH table of KFF's waiver tracker.

SOURCE: KFF Section 1115 Waiver Tracker • PNG

Housing Partnership Opportunities

- State Medicaid Agency: Money Follows the Person Demonstration and Supplemental Services; American Rescue Plan Section 9817 Plans, Medicaid Waivers (1115,1915), State Plan Services
- State Housing Finance Agency
- Local Public Housing Agencies: Emergency Housing Vouchers & Mainstream Housing Vouchers & Housing Choice Vouchers
- HUD Homelessness Continuums of Care
- House America
- State Assistive Technology Act programs—AT that enables accessibility and greater independence
- Emergency Rental Assistance Programs

Menti Question 5: What funding streams do you currently access to support housing and housing related services? (Select all that apply)

a. Health care contracts (Medicare Advantage, Medicaid Managed Care, etc.)
b. Money Follows the Person (Medicaid Supplemental Services/payment for housing supports)
c. HUD vouchers or HUD grants (such as Continuum of Care but not limited to CoCs)
d. US Department of Veterans Affairs programs (home modification, assistive technology, and prosthetics, HUD/VASH Vouchers, etc.)
e. Home modifications funding
f. Medicaid waivers
g. American Rescue Plan Funding
h. Older Americans Act Funding
i. Rehabilitation Act funding
j. SAMHSA Funding
k. Assistive Technology and/or Durable Medical Equipment provided or funded through Medicaid waivers, Medicaid State Plan services, Employment services (DOL/ Dept of Ed, RSA, Voc. Rehab), Older Americans Act, private insurance
l. State funded housing assistance programs

Menti Question 6: What are the top 3 areas you would like to focus on over the next 12 months? (Select up to 3)

a. Housing navigation
b. Use of housing vouchers
c. Eviction prevention
d. Accessible housing
e. Developing new housing through partnerships
f. Addressing homelessness
g. Transitioning people out of institutions
h. Other

Contact Information

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ADDITIONAL HSRC AND OTHER RESOURCES

HSRC Webinars

- Ending Homelessness—Developing Partnerships between Homelessness Systems Continuums of Care (CoC) and the Disability, Aging and Health Sectors
- Working Together to Empower Community Inclusion with Health/Housing/Independent-Living Partnerships
- Addressing Housing Accessibility through Cross-Sector Partnerships: A Closer Look at Home Modification Collaborations at Work
- Building and Sustaining Home Modification Collaborations: Strategies for Your Community
- Expanded Opportunities with Federal Funding for Housing and Services
- State and Local Partnerships for Housing Stability
- To view these webinars: visit the HSRC website at: https://acl.gov/HousingAndServices/Whats-New?j=1685948&sfmc_sub=174195509&l=7615_HTML&u=37869275&mid=515008575&jb=0 and open prior events.

Additional Resources

- Emergency Housing Voucher Dashboard: https://www.hud.gov/program_offices/public_indian_housing/ehv/dashboard
- Housing Choice Voucher Dashboard: https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/dashboard
- Housing and Services Resource Center website: https://acl.gov/HousingAndServices
- ACL Care Transitions website: https://acl.gov/caretransitions
- CMS Money Follows the Person website: https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html
- CMS Money Follows the Person Supplemental Services Information: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/mfp-supplemental-services-notice.pdf

More Partnership Opportunities

- Housing and Homelessness:
  - United States Interagency Council on Homelessness
- Transportation System and Sector
  - Coordinating Council on Access and Mobility
  - National Center for Mobility Management
  - Transit Planning 4 All
  - National Aging & Disability Transportation Center
  - ADA Participation Action Research Consortium
  - National Transportation Accessibility Center
- Commit To Connect Nationwide Network of Champions
- Direct Care Worker Resource Center

Community Health (Needs) Assessment and Improvement Planning: Leveraging Connections to Address Housing Needs

Charisse J. Walcott

Public Health Advisor

Center for State, Tribal, Local, and Territorial Support (CSTLTS)

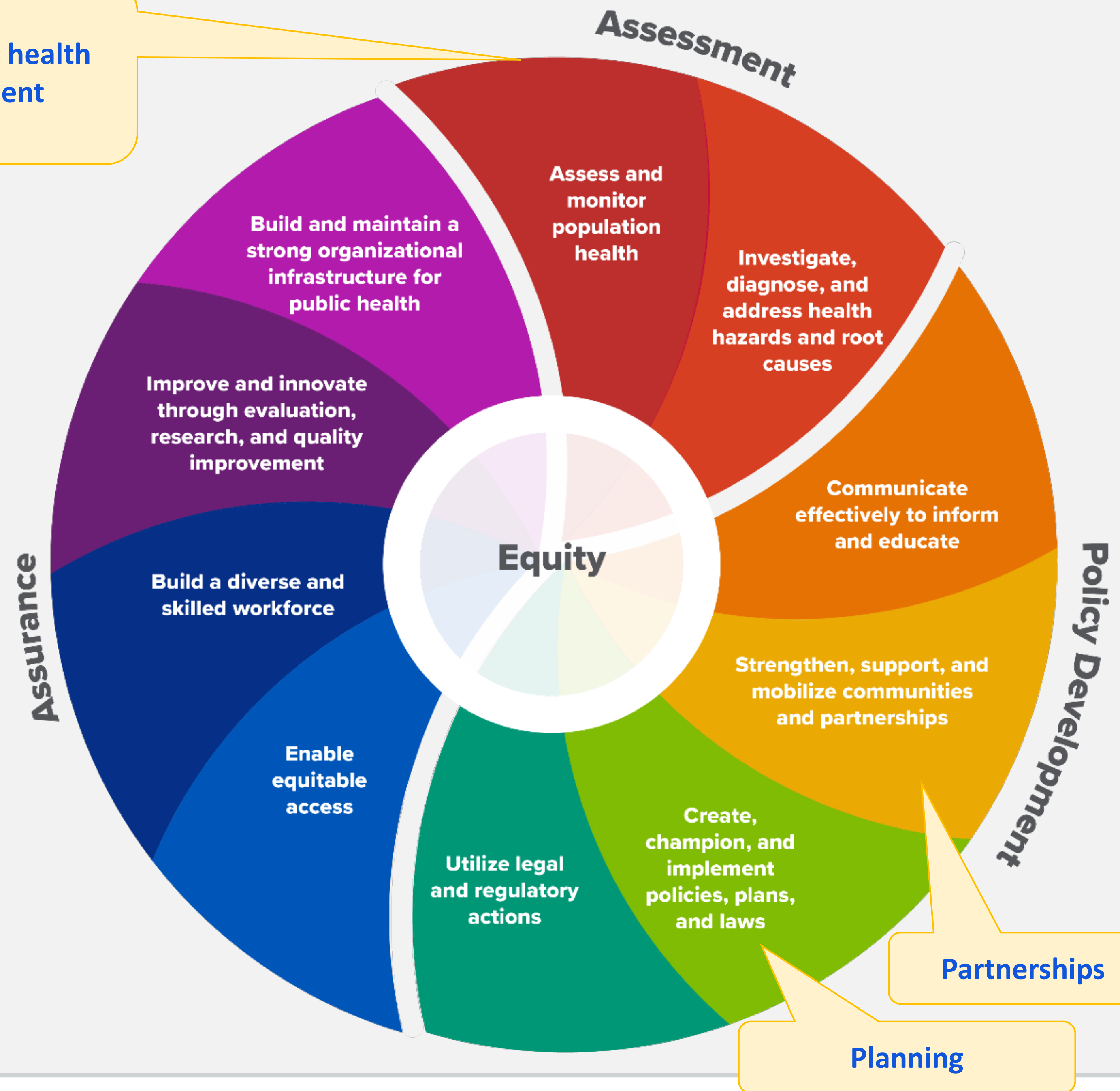
Centers for Disease Control and Prevention (CDC)

December 8, 2022

THE 10 ESSENTIAL PUBLIC HEALTH SERVICES

To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve equity, the Essential Public Health Services actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression. Everyone should have a fair and just opportunity to achieve optimal health and well-being.



Policy and Requirement-Related Community Health Assessment & Improvement Plan Drivers

- Community benefit requirements for not-for-profit hospitals
- Health departments
  - National voluntary accreditation for state, tribal, local, and territorial health departments (through the Public Health Accreditation Board)
  - State-specific requirements for health departments to conduct health assessment or develop health improvement plans
- Grant requirements or grant-related activities
- Comprehensive planning efforts led by other local partners

Community Health Assessment and Improvement Planning Processes and Models Have Similar Steps

Mobilizing for Action through Planning and Partnerships (MAPP)

Association for Community Health Improvement (ACHI) Community Health Assessment Toolkit

Common Steps

- Prepare and organize
- Engage the community
- Develop a goal or vision
- Conduct community health assessment(s)
- Prioritize health issues
- Develop community health improvement plan
- Implement community health improvement plan
- Evaluate and monitor outcomes

Principles to Consider for the Implementation of a Community Health Needs Assessment Process

- **Multi-sector collaborations** that support shared ownership of all phases of community health improvement
- Proactive, broad, and diverse **community partnership**
- Broad **definition of community**
- Maximum **transparency** to improve community engagement and accountability
- Use of **evidence-based interventions** and innovative practices with evaluation
- Evaluation to inform a **continuous improvement** process
- Use of the **highest quality data** pooled from and shared among diverse public and private sources

http://nnphi.org/CMSuploads/PrinciplesToConsiderForTheImplementationOfACHNAProcess_GWU_20130604.pdf

Housing-Related Measures in County Health Rankings Model

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

- Severe housing problems
  - Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities
- Homeownership
  - Percentage of owner-occupied housing units
- Severe housing cost burden
  - Percentage of households that spend 50% or more of their household income on housing
- Air pollution-particulate matter
  - Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)
- Drinking water violations
  - Indicator of the presence of health-related drinking water violations

https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/physical-environment/housing-and-transit

Housing-Related Objectives in HP 2030

Healthy People 2030
ODPHP | Office of Disease Prevention and Health Promotion

- Housing instability
  - Proportion of persons living in poverty (SDOH-01)
  - Employment rates in working-age people (SDOH-02)
  - Proportion of families that spend more than 30 % of income on housing (SDOH-04)

    https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability
- Quality of housing
  - Proportion of homes that have an entrance without steps (DH-04)
  - Blood lead levels in children aged 1 to 5 years (EH-04)
  - Proportion of people whose water systems have the recommended amount of fluoride (OH-11)
  - Proportion of smoke-free homes (TU-18)

    https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/quality-housing
- Environmental conditions
  - Proportion of people whose water supply meets Safe Drinking Water Act regulations (EH-03)
  - Number of days people are exposed to unhealthy air (EH-01)

    https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/environmental-conditions

2019 Ohio State Health Assessment- Physical Environment

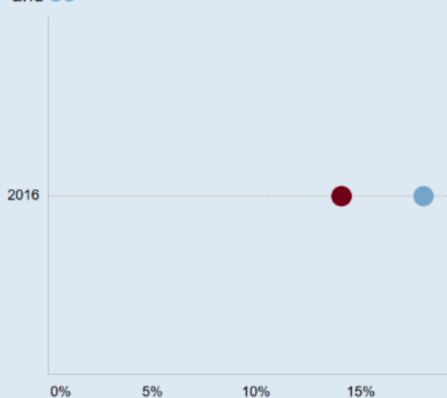
Ohio State Health Assessment | Physical Environment

Suggested Citation

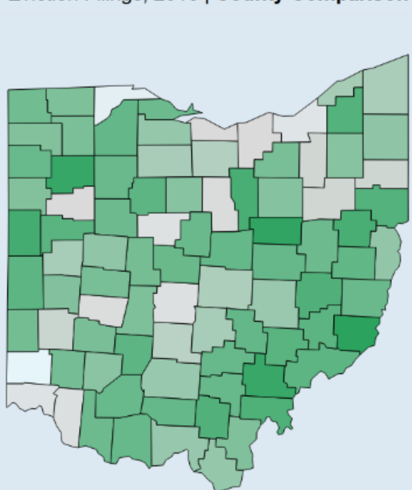
	Total Population	Access to Exercise Opportunities	Residential Segregation: Non-White/W..	Eviction Filings
Ohio	11,799,448	84%	58	67.5

Housing, Built Environment and Physical Activity Access

Severe Housing Problems | Comparison of Ohio and US



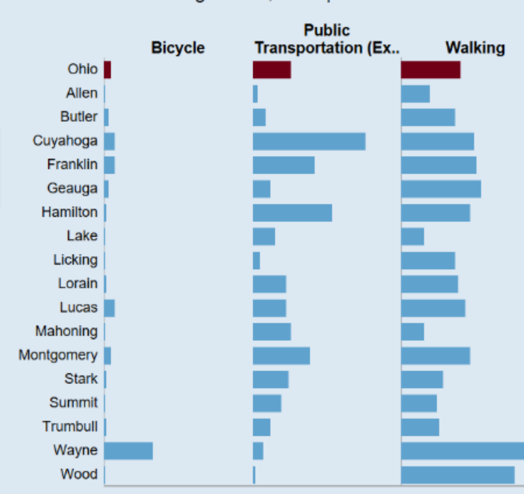
Eviction Filings, 2016 | County Comparison



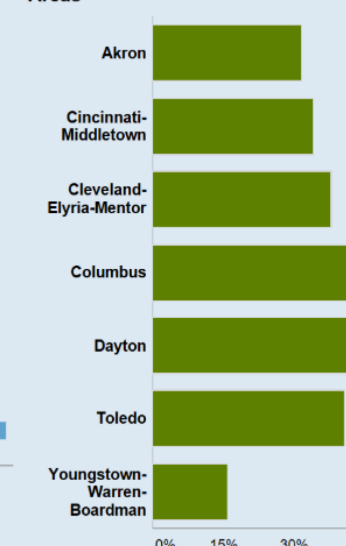
Best to Worst

Home Ownership, 2014-2018 | Ohio

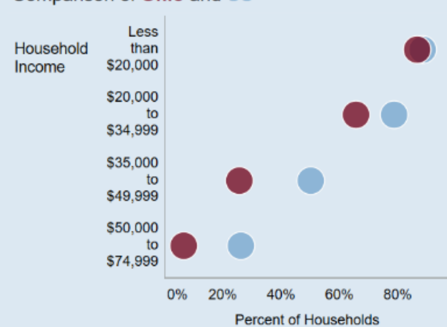
Alternative Commuting Modes, 2019 | Ohio Metro Counties



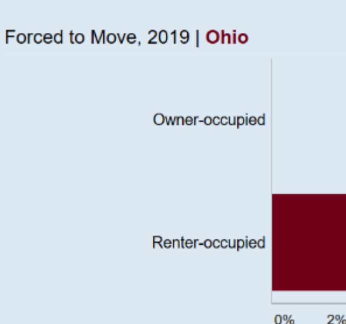
Job Access Rate, 2010 | Ohio Metro Areas



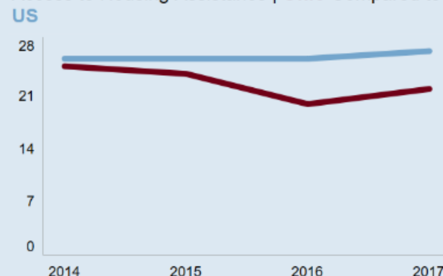
Severe Housing Burden for Renters, 2019 | Comparison of Ohio and US



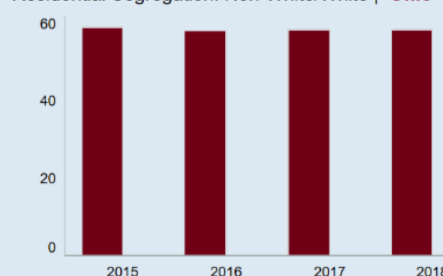
Forced to Move, 2019 | Ohio



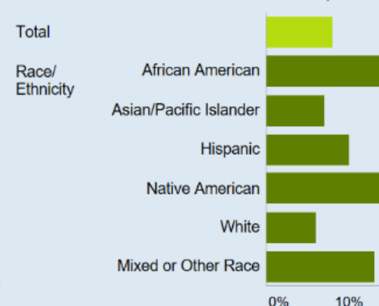
Access to Housing Assistance | Ohio Compared to US



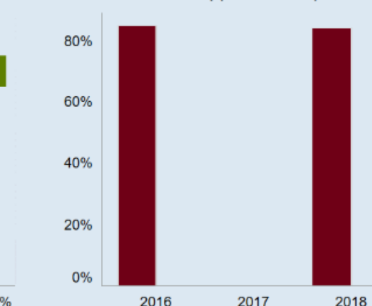
Residential Segregation: Non-White/White | Ohio



Households Without a Vehicle, 2019 | Ohio



Access to Exercise Opportunities | Ohio



https://odh.ohio.gov/explore-data-and-stats/interactive-applications/2019-online-state-health-assessment

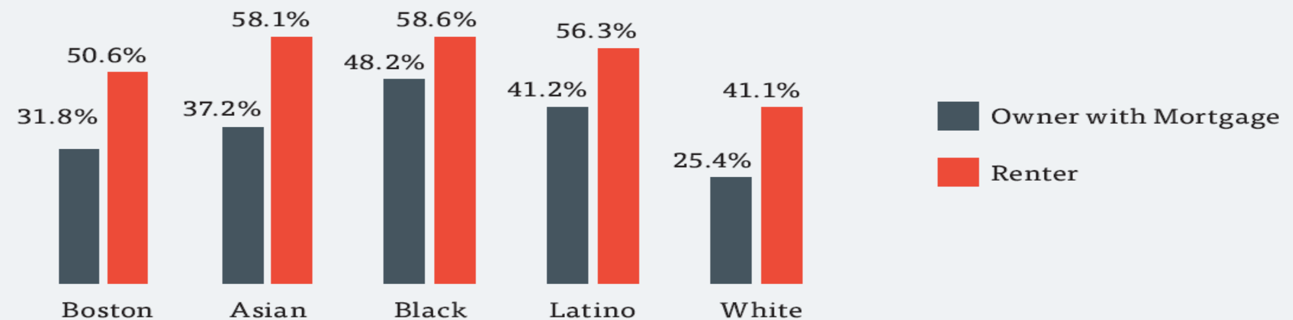
Massachusetts General Hospital 2019 CHNA-Housing

Improving health: The Boston CHNA Priorities

Housing

Boston is known for its high cost of housing. CHNA participants across neighborhoods consistently stated that the rising cost of housing in Boston is a major day-to-day concern and leaves few resources for other needs. The cost of a single-family home rose by 48% between 2011-2016. Among renters, Blacks, Latinos, and Asians are significantly more likely to spend 30% or more of their income on housing compared to all Boston renters. The availability of affordable housing has dropped considerably between 1996-2016. More than 39% of all new housing permits in 1996 were affordable, compared to only 18% in 2016. Almost 20% of CHNA survey respondents (19.5%) reported trouble paying their rent or mortgage. For some groups the rate was much higher, including respondents who were Black (29.4%), Latino (27.1%), Non-binary/transgender (42.3%), those with some college or a certificate program (34.2%), LGBTQ individuals (24%), and the parent of a child under age 18 (23.7%).

% Housing Units Where 30% or More of Income Spent on Monthly Housing Costs by Housing Tenure, by Boston and Race/Ethnicity, 2017

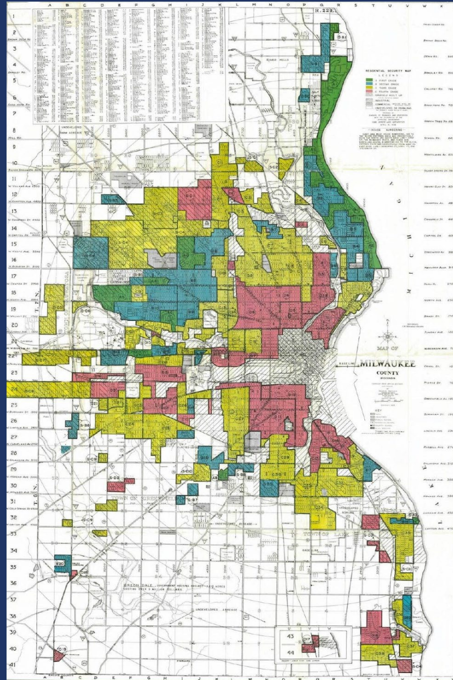


DATA SOURCE: U.S. Census, American Community Survey 1-Year Estimates, 2017

https://www.massgeneral.org/assets/mgh/pdf/community-health/cchi/20191016-chna-report.pdf

City of Milwaukee Health Department 2022 Community Health Assessment-Built Environment

Community Health Assessment 2022

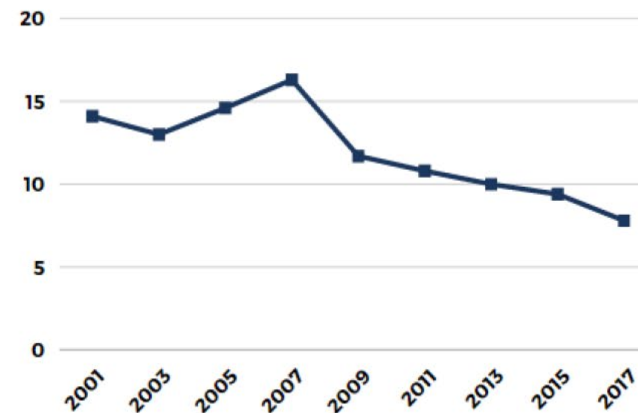


CITY OF MILWAUKEE
HEALTH DEPARTMENT

Built Environment: Housing

Continued

Air Quality - Historical Air Quality - PM2.5: Annual Average Concentration (Monitor + Modeled Data)



Renters spend 30% or more of their income on rent — 53%

Households have at least one of the following severe housing problems (overcrowding, lack of kitchen or plumbing facilties or severe cost burden) — 24%

Data Source: Wisconsin Enviromental Public health Tracking Program (DHS)

https://city.milwaukee.gov/Health/Reports-and-Publications/MAPP-Community-Health-Assessment

2019 Kaiser Foundation Hospital and Alameda County Health Department CHNA-Housing and Homelessness

COMMUNITY HEALTH NEED

OAKLAND

Housing & Homelessness

What's the issue?

The U.S. Department of Housing and Urban Development defines housing as affordable when it costs no more than 30% of a household's annual income. Spending more than that makes a household less able to afford other necessities, such as food, clothing, transportation, and medical care.[1] The physical condition of a home, its neighborhood, and the cost of rent or mortgage are strongly associated with the health, well-being, educational achievement, and economic success of those who live inside.[2]

Poor health can lead to homelessness, and homelessness can lead to poor health.[3] People without a home experience more health care issues, suffer from preventable illnesses at a greater rate, require longer hospital stays, and have a greater risk of premature death than their peers with a home.[4] The average life expectancy for someone who lacks permanent housing is at least 25 years less than that of the average U.S. resident.[5]

What does the data show?

In the KFH-Oakland service area, housing concerns are prevalent. Most statistics on housing appear to meet benchmarks, but geographic and ethnicity data suggest that some communities disproportionately experience housing challenges. Poor housing quality—evidence of leaks, mold, and pests—is associated with childhood asthma

continued >>

Households With Housing Problems

Walnut Creek

Lafayette

Oakland

Legend:

more than 54.7

54.7 to 50.2

50.2 to 45.6

45.6 to 41

41 to 36.4

36.4 or less

Percent (lower value is better)

Housing problems include at least one of the following: Housing unit lacks complete kitchen facilities; housing unit lacks complete plumbing facilities; housing unit is overcrowded (>1 person per room); or household is cost-burdened (housing costs represent >30% of monthly income). / SOURCE: U.S. Census Bureau, American Community Survey, 2012–2016.

The median rent for a two-bedroom apartment in Alameda County is $2,595.[6]

KEY DISCOVERY

2 in 5 households in the KFH-Oakland service area are cost-burdened, spending more than 30% of their income on rent or mortgage.[7]

What is the issue?

- Secondary Data
  - US Dept of Housing and Urban Development-User Datasets (Affordable Housing)

What do the data show?

- Secondary Data
  - US Census Bureau-American Community Survey (Households with Housing Problems)

What does the community say?

- Primary data
  - Focus groups, surveys (Housing quality, safety, and affordability are issues)

Ethnic Disparities: Homelessness in Alameda County

Group	Percent
Asian	2%
Naitve American	3%
Multi-Ethnic	15%
Latinx (Any Race)	17%
White	30%
Black	49%

Percentage total exceeds 100% due to people choosing multiple ethnicities. / SOURCES: Applied Survey Research, Alameda County Homeless Census and Survey, 2017, and U.S. Department of Housing and Urban Development, PIT Estimates of Homelessness in the U.S., 2014 and 2017.

and asthma-related emergency room visits. There were 4,093 asthma-related emergency room visits for Black children per 100,000 in the City of Oakland, which is nearly four times that of Latinx—and 10 times that of White and Asian—kids.[8]

What does the community say?

Residents and local experts in the KFH-Oakland service area (who recently participated in a community health needs assessment) sponsored by Kaiser Permanente) identified safe, healthy housing as a top priority. Of particular concern was the effect of rent increases on single parents and low- and/or fixed-income households. Participants strongly linked housing and mental health, indicating that the stress of maintaining housing negatively affects families. They also connected housing issues and physical health, noting that some people in recent years have spent less on food and medical care because of increases in housing costs. The prevalence of jobs yet shortage of new housing units was called out in focus groups as a major driver of the housing crisis. Concerns were also expressed about the health of people experiencing homelessness, who are at greater risk of poor health outcomes than others. Experts cited a lack of strong tenant protections (and a lack of knowledge about the protections that exist) to keep renters from being displaced.

"Housing [quality] is an issue as well. If you've got multiple families living in one apartment and more and more rentals, then they're at the kind of whim of the landlord in terms of how to go about making changes to [address] indoor air quality, mold, or rats."
—COMMUNITY EXPERT

SOURCES

[1] U.S. Department of Housing and Urban Development. (2018). *Affordable Housing.*

[2] Pew Trusts/Partnership for America's Economic Success. (2008). *The Hidden Costs of the Housing Crisis.* See also: The California Endowment. (2015). *Zip Code or Genetic Code: Which Is a Better Predictor of Health?*

[3] National Health Care for the Homeless Council. (2011). *Care for the Homeless: Comprehensive Services to Meet Complex Needs.*

[4] O'Connell, J.J. (2005). *Premature Mortality in Homeless Populations: A Review of the Literature.* Nashville, TN. National Health Care for the Homeless Council.

[5] National Coalition for the Homeless. (2009). *Health Care and Homelessness.*

[6] Zilpy.com (2018).

[7] U.S. Census Bureau, American Community Survey. (2012–2016).

[8] City of Oakland. *Equity Indicators Report.* (2018).

Read the complete 2019 Community Health Needs Assessment report at www.kp.org/chna

KAISER PERMANENTE. actionable insights

https://about.kaiserpermanente.org/content/dam/internet/kp/comms/import/uploads/2019/09/Oakland-CHNA-2019.pdf

Housing, Food, and Economic Security in State Health Assessments (ASTHO 2022 Environmental Scan)

- **Social determinants of health is a priority area in 49% of state health assessments (SHA) and plans.**
- **Economic and Work Environment, e.g., poverty, unemployment, was identified as a focus area in 25% of SHAs and plans and housing and homelessness in 20% of plans.**
- **To support housing, food, and economic security, states are taking action to increase access to and linkage with employment opportunities by:**
  - Focusing on vulnerable populations, e.g., formerly incarcerated people, people experiencing homelessness, and people living with mental or physical disabilities
  - Coordinating housing and housing supportive service training across systems to help individuals identify and transition into the best living option to support their needs
  - Developing community-based, family-centered services to increase access to and linkage with childcare, economic supports, weekly groceries, affordable housing options, and other support systems

https://www.astho.org/globalassets/pdf/environmental-scan.pdf

Opportunities for Engagement in CH(N)A Activities

- Review most recent CHNA, state SHA, community health assessments (CHA) or plan documents
- Reach out to hospital or health department SHA and CHA coordinators to introduce your program and explore potential alignments
- Get involved with ongoing state and local health assessment and implementation planning efforts
- Invite health department and hospital SHA/CHA/CHNA partners and staff to your meetings to initiate new ways to inform, share, collaborate, and/or co-develop plans

Housing Data-Related Resources for SHA and CH(N)A

- Robert Wood Johnson Foundation: Better Data for Better Health
- Child Opportunity Index: Child Opportunity Index (COI)
- CDC and Robert Wood Johnson Foundation: PLACES-Local Data for Better Health
- County Health Rankings & Roadmaps: County Health Rankings-Physical Environment-Housing and Transit
- NORC: Rural Health Mapping Tool and Prosperity Index
- US Department of Housing and Urban Development: US Dept of Housing and Urban Development-User Datasets
- US Census Bureau: US Census Bureau-American Community Survey
- CDC/ATSDR Social Vulnerability Index: CDC/ATSDR SVI
- CDC and US Department of Health and Human Services Office of Minority Health: CDC/OMH Minority Health SVI
- CDC/National Center for Environmental Health: National Environmental Public Health Tracking
- National Equity Atlas: National Equity Atlas-Data and Indicators
- Community Commons: Community Health Needs Assessment-Resources for Sourcing Secondary Data
- Big Cities Health Coalition: Big Cities Health Data
- Healthy People 2030: Healthy People 2030-Housing Instability

Selected CH(N)A Tools, Resources, and Guidance

- **CDC webpages –Community Assessment and Planning**
  - CDC - Home - Community Health Assessment - STLT Gateway
  - Community Health Improvement Navigator - CDC
  - Community Health Assessment and Group Evaluation (CHANGE) Tool | DNPAO | CDC

- **Other Selected Resources**
  - Association of State and Territorial Health Officials (ASTHO)
    - ASTHO Public Health Assessment
    - ASTHO State Health Improvement Plan Guidance and Resources
    - ASTHO 2022 Environmental Scan
  - National Association of County and City Health Officials (NACCHO):
    - NACCHO Community Health Assessment and Improvement Planning Resources
  - Association for Community Health Improvement: Community Health Assessment Toolkit | ACHI (healthycommunities.org)
  - National Center for Healthy Housing: Hospital Community Benefits | NCHH
  - County Health Rankings & Roadmaps: County Health Rankings and Roadmaps Take Action To Improve Health Cycle
  - National Academies of Sciences: Action Collaborative on Bridging Public Health, Health Care, and Community | National Academies
  - Public Health Accreditation Board: www.phaboard.org

Thank you!

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1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Integrating Health and Housing Supports

December 8, 2022

Our Role in the Aging Network

- One of the largest AAA in Massachusetts, serving 28 cities and towns (and hundreds of communities within them)
- Serve over 45,000 older adults annually
- 450+ employees and 450+ volunteers
- Contracts with managed care, ACO, other health care entities, and public housing for case management, navigation, care and service coordination, evidence based-programs, and SDOH services
- Home of Statewide contracting network for evidence-based programs (Healthy Living Center of Excellence)

AgeSpan

Core housing services

- SDOH screening
  - At risk for homelessness?
  - Food Insecure?
  - Transportation and other access issues?
  - Income insecurity?
  - Social isolation and loneliness?
- Resident Service Coordinators
  - Connection to AAA services
  - Community resource navigation
  - Assistance with benefit enrollment
  - Food access
  - Social Connectedness

Housing and Services Resource Center Case Study: AgeSpan and Partners Bring Housing and Services Together

Housing Support Services

- Pre-tenancy Counseling
- Housing Search
- Housing Applications and Benefit Enrollment
- Rent payments
- Eviction/Legal
- Home Modifications and Household needs
- Wellness Nurse
- Hoarding and Cluttering

AgeSpan

Blending and Braiding

Public housing contracts

Private housing contracts

Local Philanthropy

OAA Title III

Federal grants (ACL, CDC)

State Contracts

Housing Supports

Health Care contracts (ACO 1115 waiver)

AgeSpan

Case Study: Johanna D.

- 36 y/o female
- Hispanic/Latino (Bilingual)
- Did not finish high school
- Employed part-time
- Health Need Based Criteria: Behavior Health (depression/anxiety)
  - Depression/anxiety/bi-polar disorder
  - Lost custody of her children a year ago (termination of parental rights/adoption risk)
- Risk factors:
  - Experiencing homelessness
  - At risk for homelessness
  - At risk for nutritional deficiency

Drivers of Health Care Utilization

Behavior Health Needs

- Collaboration with MVACO to address self-harm threats
- Referral to BH CP to address current BH needs
- Participation in evidence-based programs to enhance behavior change and activation (Healthy IDEAS and CDSMP)
- Wellness checks: Meal delivery and law enforcement

Poverty / Economic Stability

- Medically Tailored /Home Delivered meals
- Consults with RD
- SNAP benefits
- Emergency grocery assistance

Neighborhood and built environment

- Housing application assistance
- Transportation to collect/drop off information needed for housing application
- Digital access/Laptop to access court date for child custody

Accessing Health Care

- Case conference with MVACO
- Transportation

Upcoming Events

- Expansion track meetings:
  - January 12 – Financing Strategies to Enable Housing Stability
  - February 9 – Cross-sector Partnerships: Addressing Homelessness and Engaging Health Care Partners
- Peer group dialogue opportunities:
  - January 26 and February 23
- Reminders:
  - Learning goals
  - Survey re: housing and care transitions

Thank you!

Please contact

CommunityCareHubs@acl.hhs.gov

with any questions.