



Housing & Healthcare: Community Partnerships

Introductions

- Christine Kahl, Phoenix Community Development Services
- Sara Runyon, The Center For Prevention of Abuse
- Nicole Wilson, Home For All Continuum of Care and Heart of Illinois United Way
- Sara Torres, Illinois Housing Development Authority

Session Objectives

- Provide an overview of the Housing and Healthcare pathways model
- Provide examples of local initiatives and successes
- Identify leveraged resources
- Showcase Housing + Healthcare innovations

Housing Is Healthcare

- Housing = social determinant of health
- Four pathways connecting housing and health



- Selected housing interventions for low-income people:
 - improve health outcomes
 - decrease health care costs

Housing is the Solution

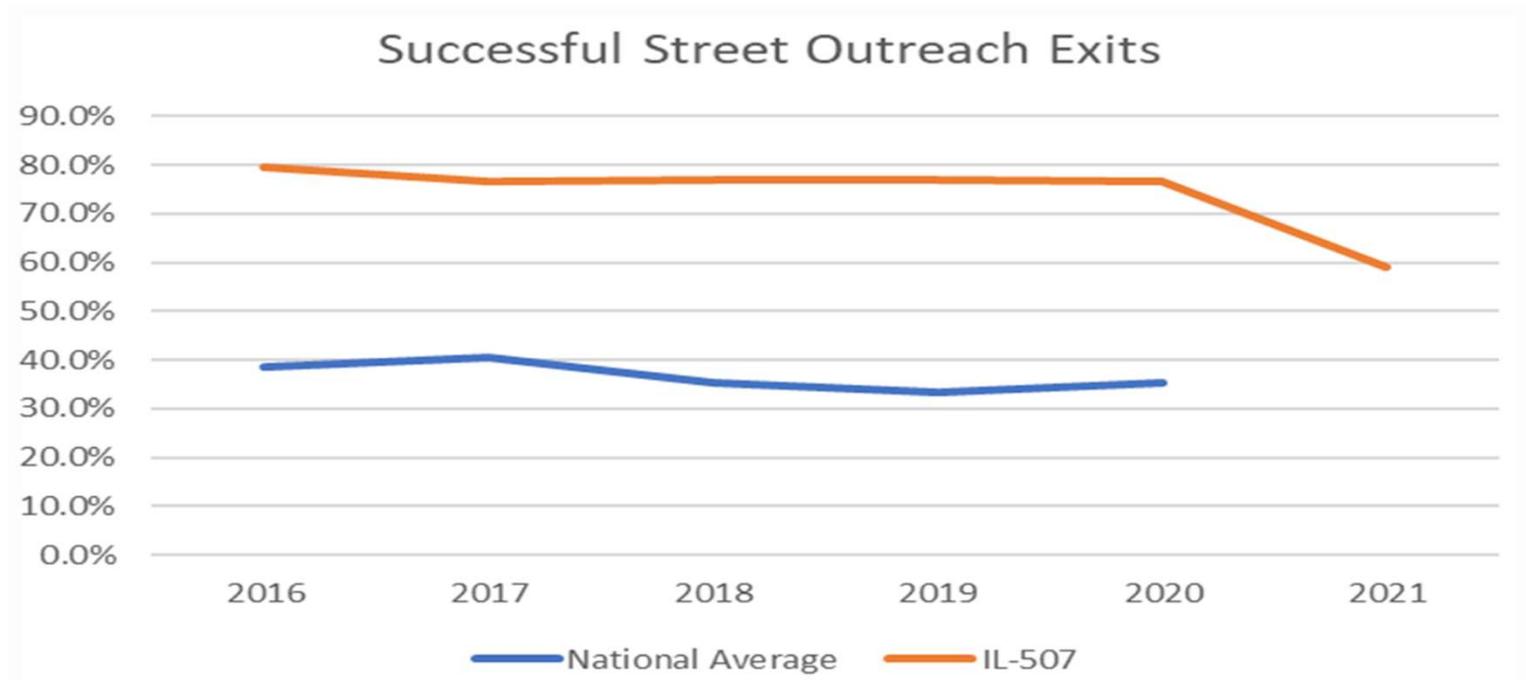
- **Cost Effective**
 - Housing First cost studies – reduces hospital visits, admissions, and duration of hospital stays and overall public system spending
 - Up to \$29,000/person/year savings after accounting for housing costs
- **Health outcomes improve**
 - Increase use of outpatient primary care
 - Decrease use of emergency departments
 - Positive improvements in primary health measures, psychological measures and incidence of domestic violence

Local Initiatives – High Utilizers

- Driven by PPD Analyst – anecdotal connections between homeless population, jail, ambulance, and ERS
- Determination of stakeholders, criteria, who to focus on first
- Data sharing – HIPAA
- Implementation
- Successes
 - 61 identified in HMIS – 58 located – 57 in PSH within 30 days (more than 60% new PSH placements + existing identified PSH residents)
 - Healthcare cost savings
 - Still tracking initial cohort – 6 years of data

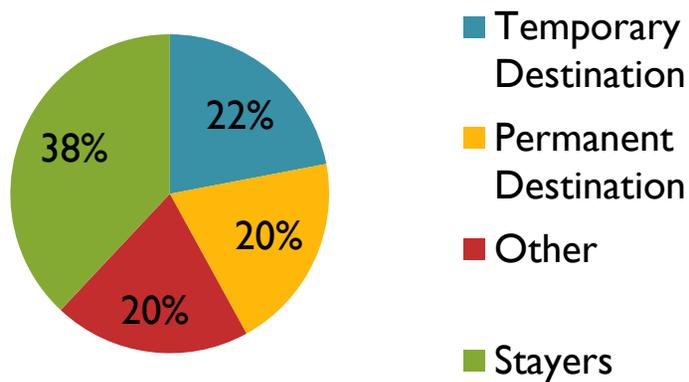
Local Initiatives – Street Outreach + Rapid Re-Housing (RRH)

- PATH Street Outreach and Rapid Re-Housing (RRH) = almost 50% are chronically homeless

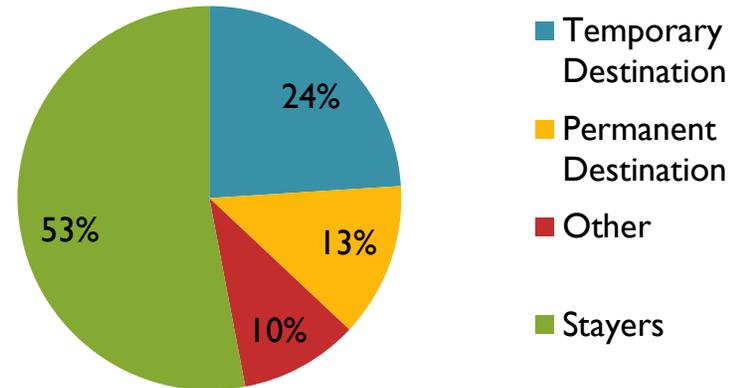


SO Exits – Temporary vs. Permanent

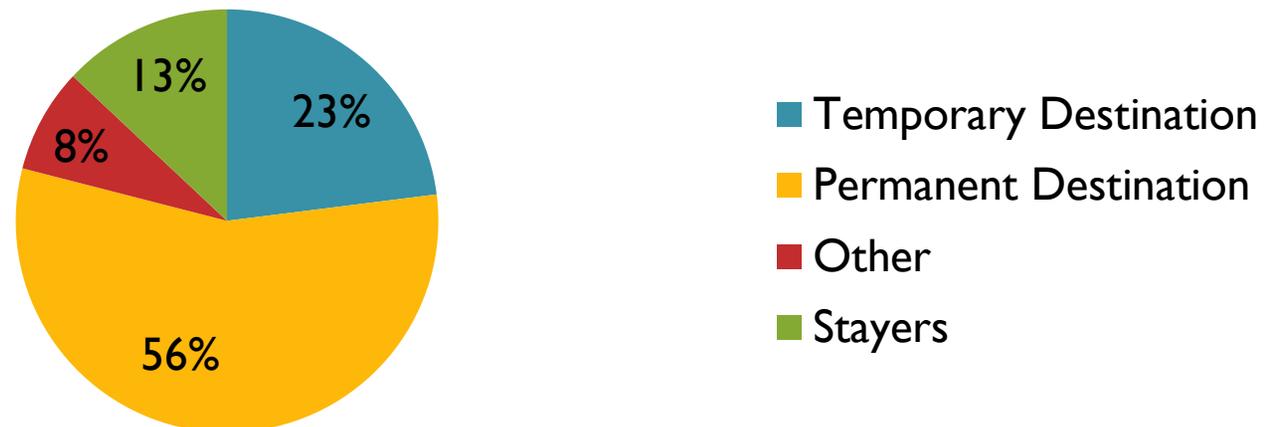
Street Outreach Exits - National



Street Outreach Exits - State



Street Outreach Exits - Phoenix CDS (IL-507)



Local Initiatives – Interim Shelter

- **Interim Shelter collaboration since 2017**
 - 50% of exiting shelter residents who received additional services through the OSF partnership exited to permanent housing
 - Compared to only 6% of the total shelter population exited to permanent housing
 - Since January 2020, 92% of those who have received additional services through the OSF partnership and exited to permanent housing have not re-presented as homeless within 24 months as tracked through HMIS

Local Initiatives - HOWIE

- All-season Mobile Hygiene Vehicle, named HOWIE
- Launched in 2021 at the height of the COVID pandemic
- Collaborative partnership with CoC and HOIUW
- Provides access year round to showers and laundry services
- Another highly visible outreach tool used in our progressive engagement strategies
- Intake and assessment services are available concurrently



Other Local Initiatives

- Telligen project – added CNA to outreach team to focus on health needs
- Meridian project – allowed MCO to locate missing high utilizing members; introduced health acuity needs assessment
- Neighborhood Investment – Richland, North Valley, Community Garden

Local Partnerships

- Learning Collaborations - nursing students, medical students
- Positive Health Solutions – HOPWA and LGBTQI+ services
- FQHC partnerships – co-pays waived – higher HRSA rate
- OSF street medicine – Dr. Stapel
- JOLT harm reduction

Other Local Partnerships

- U.S. Department of Veterans Administration- GPD, HCHV, HUD-VASH, SSVF
- OSF/FQHC (Heartland) – Medicaid innovation grant
- Law Enforcement/Behavioral Health Co-Response Pilot

Innovation – Health Café

- Designed to:
 - improve access to healthcare,
 - decrease disparities,
 - decrease high utilization of publicly-funded services, and
 - improve outcomes for such a vulnerable population as those dealing with housing instability and homelessness.
- Leverages trust residents have with their housing provider
- Dignity and respect

Innovation – Health Café

- On-site service model - comprehensive collaboration of several community healthcare providers and stakeholders
- Embedded in large PSH project with 2 largest shelters and 6 other PSH projects within 1 mile radius
- Brings together medical and behavioral health services professionals
- Staffed primarily by specialized community health workers (OSF/Heartland's Medicaid Innovation Grant)

Health Café Services

- Primary healthcare
- Digital access to specialty care
- Mental health and substance abuse counseling
- Medication-assisted treatment
- Specialized care for LGBTQI+ persons
- Wellness education
- Basic health exams
- Screening for cancer and other chronic health conditions
- Chronic health condition (i.e. high blood pressure, diabetes) management
- Sexual Healthcare
- Vaccine clinics
- Exercise and self-care programs
- Personal hygiene care
- Community health navigators and care coordinators
- Benefits enrollment

Health Café – Learning Incubator

- Host learning center that creates an opportunity to facilitate a learning environment that advances the goals of healthcare access and equity in a community-based setting
- Community health rotation for students from multiple disciplines:
 - Medical students/interns
 - Nursing
 - Social workers
 - Physical Therapy and Occupational Therapy
- Research opportunities

Leveraged Resources

- Medicaid billing across the system
- Philanthropic
 - Heart of IL United Way – CoC lead agency, matching funds, new initiatives, 211 information/referral
 - Foundations/Fraternal Organizations
 - Key supporters of supplies for Street Outreach and household goods for consumers
 - Faith Communities
 - Direct financial supports for housing (rent, security deposits, utilities)



Healthy Housing, Healthy Communities Partnerships Grant (H3C)

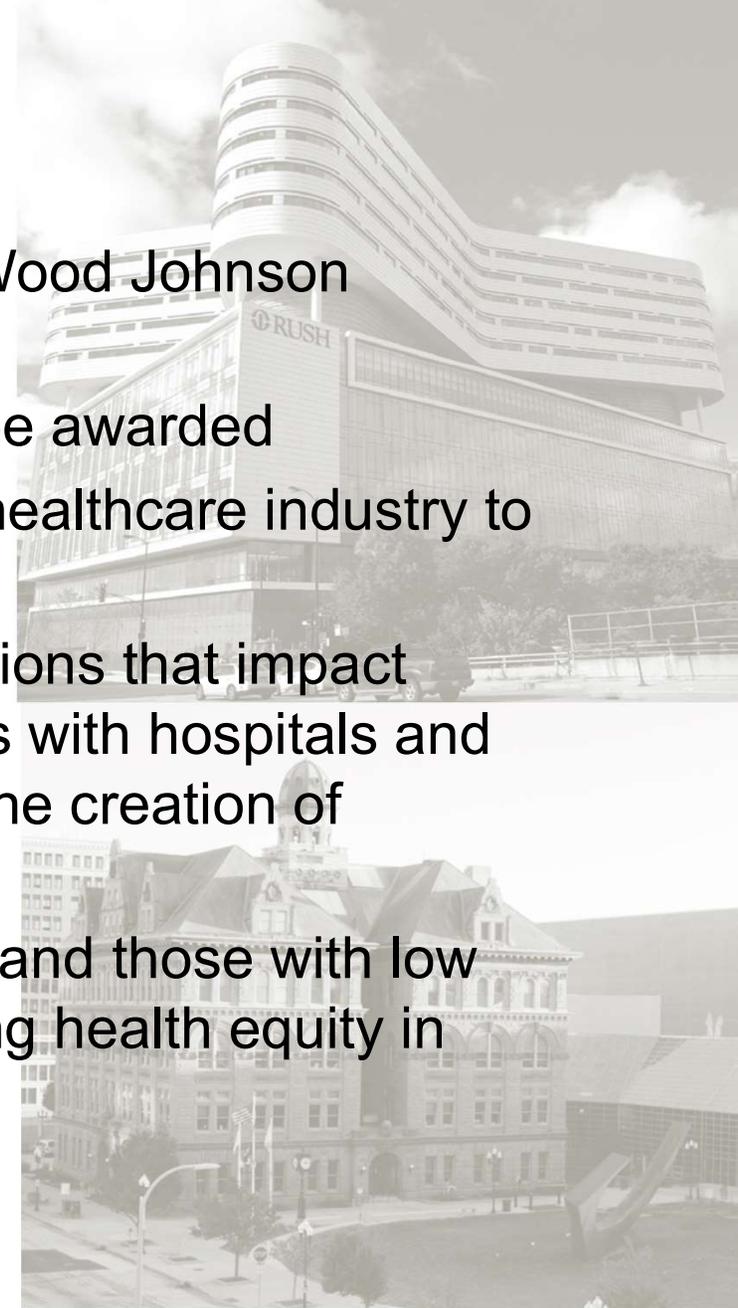
Sarah Torres, AICP, LEED AP

Planning and Research Specialist



About the H3C Grant

- Awarded on behalf of NCSHA/Robert Wood Johnson Foundation
- IHDA was one of 6 HFAs nationally to be awarded
- **Objective:** build partnerships with the healthcare industry to finance affordable housing
- Priority to address neighborhood conditions that impact health and racial equity via partnerships with hospitals and community organizations and through the creation of affordable housing
- Commitment to serving people of color and those with low and moderate incomes and to advancing health equity in the partnership with the HFA





What is IHDA's Commitment/Goal?

- Target markets: Peoria and western Cook County
- Target populations: could include homeless with chronic conditions or frequent utilizers of emergency rooms
- \$15 million in capital funds for two demonstration projects
- Develop a sustainable funding model with the healthcare industry to replicate in future funding rounds





How Can the Healthcare Industry Participate?

- Matching fund contributions
- Operational support
- Rental assistance
- Down-payment assistance
- Land or facility donations
- Service/staffing support





Where are we now?

- Engaging with developers to identify pipeline projects
- Identifying community health/housing priorities for healthcare industry in western Cook County and Peoria
- Engaging with elected officials
- Preparing for required community engagement components





What's Coming?

- February 2023: Healthcare industry/developer meet-up
- June 2023: RFA for health and housing projects
- August 2023: Applications due





QUESTIONS

References & Resources

- Housing and Health Pathways Figure adapted from Taylor 2018, Gibson et al. 2011, Sandel et al. 2018, Maqbool et al. 2015, and Braveman et al. 2011.
- “Housing and Health: An Overview of the Literature,” Health Affairs Health Policy Brief, June 7, 2018.
- “Housing is Health Care,” National Health Care for the Homeless Council brief.
<https://nhchc.org/>
- National Low Income Housing Coalition -
<https://nlihc.org/>

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