



Addressing Health Equity through Health and Housing Partnerships

May 2019



NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

ABOUT CSH

CSH is the national champion for supportive housing, demonstrating its potential to improve the lives of very vulnerable individuals and families by helping communities create over 335,000 real homes for people who desperately need them. CSH funding, expertise and advocacy have provided \$1 billion in direct loans and grants for supportive housing across the country. Building on nearly 30 years of success developing multi and cross-sector partnerships, CSH engages broader systems to fully invest in solutions that drive equity, help people thrive, and harness data to generate concrete and sustainable results. By aligning affordable housing with services and other sectors, CSH helps communities move away from crisis, optimize their public resources, and ensure a better future for everyone. Visit us at csh.org.

ABOUT NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL

The National Health Care for the Homeless Council is a network of doctors, nurses, social workers, consumers, and advocates who share the mission to eliminate homelessness. Since 1986 we have been the leading organization to call for comprehensive health care and secure housing for all. We produce leading research in the field and provide the highest level of training and resources related to care for persons experiencing homelessness. We collaborate with government agencies and private institutions in order to solve complex problems associated with homelessness. Additionally, we provide support to publicly funded health centers and Health Care for the Homeless programs in all 50 states. Visit nhchc.org to learn more.

This resource is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$450,000 with 0% of the total NCA project financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government. For more information, please visit HRSA.gov.

TABLE OF CONTENTS

I. Introduction.....	1
II. Disparities and Inequities.....	1
III. Recommendations for Health and Housing Providers to Address Inequity at an Agency Level	4
Make Equity a Priority	4
Leadership, Staffing, and Training	4
Data	6
IV. Recommendations around Health and Housing Partnerships to Address Inequity.....	9
Coordination	9
Team-Based, Patient/Tenant-Centered Care	10
Co-location.....	100
Teaming on Wellness Groups/Activities.....	11
Tailor Interventions	12
System Efforts	13

GOAL OF THIS PUBLICATION

- Provide background information on health disparities, particularly for people of color, and the goal of health equity, with a focus on people who are experiencing or have experienced homelessness;
- Explore how health centers and supportive housing providers, both of which target underserved populations and operate with holistic, client-centered approach to care, are uniquely positioned to advance health equity;
- Offer suggestions for how health centers and supportive housing providers can work together and on their own to identify and address disparities and advance health equity.

While this paper will focus specifically on the roles of health centers and supportive housing providers, many suggestions can be generalized to other organizations in the health and housing fields, and there are roles for many other types of health and housing partners to play in advancing health equity.

I. INTRODUCTION

Health equity describes the ability of all people to access care and achieve good health without regard to race, income, neighborhood or community, housing status, or other characteristics.ⁱ Health inequalities are defined by the [World Health Organization](#) as the differences in health status or in the distribution of health determinants between different population groups.ⁱⁱ Many systemic forces,

Health centers deliver comprehensive primary and preventive care services to underserved and vulnerable populations.

Supportive housing providers offer affordable housing with services to help people with complex challenges.

historic and current, including discrimination, racism, classism, and sexism, drive inequities in health and other areas. Most significantly, institutional racism and segregation produce unequal access to opportunities for education, employment, and wealth in the form of homeownership, leading to devastating gaps in social determinants of health (e.g. socioeconomic status, access to health care, housing stability, etc.) which have driven and continue to reinforce significant health disparities.ⁱⁱⁱ

Health centers and supportive housing providers are uniquely positioned to make an impact on reducing health disparities because people of color are overrepresented in their often overlapping target populations.^{iv} In addition, both serve people who are currently experiencing or have experienced homelessness, and therefore are likelier to experience poor health. These factors position providers to positively impact the health of a particularly medically vulnerable population of patients/tenants who have the odds for good health stacked against them. Although health centers and supportive housing providers cannot address all the factors that drive health inequity, they can take steps to identify and address inequity and work to ensure that race and other factors do not limit their patients'/tenants' ability to live full, healthy lives.

II. DISPARITIES AND INEQUITIES

HEALTH. Researchers and health care professionals have long recognized that in America, people of color, particularly people who are Black or African American, American Indian or Alaska Native, and Hispanic/Latinx, experience higher rates of many chronic health conditions and poorer health outcomes, particularly in terms of disease mortality rates, than people who are White. Findings have shown that these racial disparities persist even when controlling for socioeconomic factors.^v Figure 1 below provides a sample of prevalence rates and health outcomes that illustrate clear racial disparities. Most significant to note is that people who are Black fare worse than those who are White in every category.

Fig. 1: Selected prevalence rates and health outcomes by race.

	White, non-Hispanic	Black, non-Hispanic	Hispanic	American Indian/Alaska Native
Life expectancy at birth, 2014 ^{vi}	79 years	75.6 years	Not provided	Not provided
Age-adj. prevalence of diabetes (≥25yrs), 2015 ^{vii}	8.1%	13.1%	12.2%	20.9
Age-adj. death rate/100,000 from diabetes, 2014 ^{viii}	18.6	37.3	25.1	31.3
Age-adj. prev. hypertension, (≥18yrs), 2007-10 ^{ix}	28.6%	41.3%	27.7%	Not provided
Age-adjusted death rates per 100,000 from persons with coronary heart disease & stroke ^x	117.1	141.3	86.5	92
Estimated rate of HIV infection diagnoses per 100,000 population, (adults≥18 years), 2010 ^{xi}	9.1	84	30.9	13.5
Age-adj. death rate/100,000 from HIV, 2014 ^{xii}	0.9	8.3	2.0	1.2

Fig. 1 data pulled from multiple sources; see endnotes on each category for citations.

HOMELESSNESS. As with health outcomes, there are wide racial disparities in housing status, with people of color being disproportionately represented among those experiencing homelessness, as illustrated in Fig. 2. Most significant to note is that 40.6% of all persons experiencing homelessness are Black/African American, despite making up just 12.7% of the US population.^{xv} People identifying as Hispanic/Latinx, American Indian and Alaska Native, Native Hawaiian or Other Pacific Islander, and of multiple races are also overrepresented in the system.

People experiencing homelessness are at significantly greater risk of poor health than those who are stably housed, suffering from high rates of chronic conditions such as diabetes, asthma, HIV/AIDS, co-occurring mental health and substance use, and hypertension.^{xvi} The experience of homelessness can both lead to health issues and exacerbate or make it challenging to manage existing ones.^{xvii} For example, people who are unstably housed have higher rates of uncontrolled diabetes leading to emergency department visits and inpatient care.^{xviii} This reality is unsurprising, given that lack of a safe and stable home presents challenges such as: difficulty accessing primary and preventive care services; a lack of healthy food and a place to store and prepare it; lack of a secure place to store and administer insulin and to do regular glucose testing; and an inability to access a safe place to carry out orders for bed rest because shelters are usually closed during the day.^{xix}

Fig. 2: Overrepresentation of people of color experiencing homelessness.

	% of Total US Population ^{xiii}	% of all People Experiencing Homelessness ^{xiv}
Ethnicity		
Non-Hispanic	81.9%	78.4%
Hispanic	18.1%	21.6%
Race		
White	72.3%	47.1%
African American	12.7%	40.6%
American Indian or Alaska Native	0.8%	3.0%

Fig. 2 data pulled from multiple sources; see endnotes on each category for citations.

OTHER INTERSECTIONS. For many clients served by health centers and supportive housing providers, race/ethnicity, experience of homelessness, disabilities, poverty, histories of living in unstable or substandard housing, and other factors intersect, leading to complex, compounded disparities.

- Individuals with **disabilities** are less likely to receive recommended preventive care services and are at higher risk for poor health outcomes than individuals without disabilities.^{xx} In 2017, about half of people experiencing sheltered homelessness had a disability, which is more than 2.5 times the rate of disability in the US generally.^{xxi} Individuals in supportive housing are extremely likely to have a disability, based on the eligibility requirements for most programs. The high prevalence of disabilities among people experiencing homelessness may account for some of the health disparities seen for people experiencing homelessness generally, but it is also likely that having a disability amplifies the impact that experiencing homelessness has on health.
- **Socioeconomic status** is another factor that drives health disparities and can amplify other factors that drive poor health outcomes for the most vulnerable people. Like homelessness, chronic poverty increases the risks of diabetes, HIV/AIDS, hypertension, respiratory diseases such as asthma, and co-occurring mental health and substance use issues, among others.^{xxii}
- **Living in substandard housing** is a risk factor for poor health that many extremely low-income health center patients and people experiencing homelessness may currently face, or something they have dealt with in the past, whether as adults or children. According to data from the United States Census Bureau's American Housing Survey 2017, people who are Black, Hispanic/Latinx, and Native American experience higher rates of living in 'moderately inadequate' and 'severely inadequate' housing than people who are White.^{xxiii} Inadequate housing has been linked to a number of health problems including housing-associated asthma and allergies, lead poisoning, and mental health issues.^{xxiv}

For those whose circumstances place them at the mercy of multiple intersecting factors that drive health disparities, such as people of color with disabilities who are experiencing homelessness and/or intergenerational poverty, overcoming so many barriers to good health can be incredibly challenging. Health centers and supportive housing providers, whose robust services and holistic approaches are built to help people with complex needs, are uniquely positioned to help in this situation. Their services and supports can also help end intergenerational cycles of disadvantage by providing targeted interventions that help people change the trajectories of their lives and health, and go on to thrive, bringing future generations with them.^{xxv}

III. RECOMMENDATIONS FOR HEALTH AND HOUSING PROVIDERS TO ADDRESS INEQUITY AT AN AGENCY LEVEL

Health centers and supportive housing providers are already playing an important role in addressing the health of vulnerable populations by delivering interventions and services that are proven to help reduce barriers to care and improve health. In order to push further and ensure that they are actively identifying disparities and working towards health equity, providers can begin by making changes within their own organizations and programs.

MAKE EQUITY A PRIORITY

Organizations that recognize how important it is for all people to be able to live healthy, thriving lives regardless of race, ethnicity, socioeconomic status, or other characteristics, can prioritize these values by making an explicit organizational commitment to equity. This can involve steps such as including equity work, goals, and measures of success in the strategic plan, raising funds and developing partnerships to build the capacity to do equity-focused work, and building an understanding and culture of equity. For more information on how organizations can make equity a priority, see the [Institute for Healthcare Improvement's](#) guide: [Achieving Health Equity: A Guide for Health Care Organizations](#).^{xxvi}

LEADERSHIP, STAFFING, AND TRAINING

An organizational commitment to advancing equity starts with staff, the backbone of both health centers and supportive housing providers. Diversity in leadership and staffing, comprehensive training, and cross-sector (health-housing) positions are a few of the key areas for organizations to consider as they work to advance health equity.

DIVERSITY IN LEADERSHIP AND STAFF. Too often the demographics of organizations largely serving people of color, people experiencing homelessness, people living with disabilities, LGBTQ people, people who speak languages other than English, and other marginalized groups are not reflective of the people that they serve. While often unnoticeable to staff, this incongruence can be intimidating and alienating to patients/tenants, and can also result in organizations, programs, and staff that are unresponsive to the needs of the people they serve. The continued impact of racism, classism, sexism, and other forms of structural oppression make it necessary for organizations to actively seek out individuals from underrepresented groups, including people with lived experience, in order to ensure that the demographics of their organization reflect the diversity of the community they serve. Such efforts will be most effective when they focus on hiring for positions throughout the organization – including peer workers, other frontline staff, supervisors, program managers, executives, and the Board of Directors. In order to ensure that representation spreads though all

levels of the organization, efforts should go beyond recruiting to include targeted mentoring, capacity building, and opportunities for advancement to ensure that people from underrepresented groups, especially people of color and those with lived experience, can grow into all positions, including those of leadership.

STAFF TRAINING. Providing regular, ongoing staff training is an important way for both health and housing providers to build their capacity to engage, serve, and improve outcomes for patients/tenants. Some critical areas for training that can help advance health equity are:

- **Cultural humility.** Staff in both health centers and housing agencies can improve their ability to build trusting relationships with patients/tenants and advance equity by operating with cultural humility - an approach that assumes an individualized and context-based nature of culture, pushes practitioners to recognize and challenge power imbalances, and holds institutions accountable for encouraging the practice.^{xxvii} Practicing cultural humility involves an ongoing process of self-reflection and examination and working to understand oneself and others, recognizing the fluid nature of culture and the way that cultures combine to include values and beliefs.^{xxviii} The results of cultural humility include mutual empowerment, respect, and partnership, all of which can make a significant impact not only in improving care and outcomes at the individual level, but also helping to advance equity at the systems level.^{xxix}
- **Implicit bias.** [Project Implicit](#) defines implicit bias as attitudes and stereotypes that influence judgment, decision, making, and behavior in ways that are outside of conscious awareness and/or control;^{xxx} it is a serious barrier that must be addressed in order to reduce racial disparities in health outcomes and advance health equity. The [Institute for Healthcare Improvement](#) has developed a number of recommendations for how health care providers can reduce implicit bias, including education and training, reframing techniques, and increasing opportunities for contact with individuals from different groups.^{xxxi} Almost all of the recommendations are applicable to housing providers as well as health providers. For both groups, training and education around identifying and addressing implicit bias can ultimately improve access to care and outcomes for all patients/tenants by:
 - Equipping organizational leaders with the understanding and tools they need to reduce or eliminate implicit bias that impacts hiring and promotion processes, program design, and internal policies and structures.
 - Helping staff that work with clients to reduce implicit bias in individual reactions by helping them become aware of the bias and consequently modify their responses.
- **Intersection of race, homelessness, and health.** As discussed in the introduction, racial disparities in health outcomes are exacerbated by homelessness, poverty, and housing instability. Specific training to help leaders and staff understand the intersection of race, homelessness, poverty, substandard housing, and poor health outcomes is critical. When organizational leaders understand the multitude of systemic barriers to good health that people of color, especially those who have experienced homelessness, have faced throughout their lives, they are better able to develop comprehensive strategies and programs that can reduce barriers and improve health. For front-line workers such training

can help staff understand the range of factors that have impacted their patient/tenant's health and work more effectively with them to improve their outcomes. In Syracuse, for example, the Continuum of Care has incorporated front-line staff training on trauma-informed care with an anti-racism focus to improve the ability of those who work with people at risk of or currently experiencing homelessness to engage and effectively serve their clients.^{xxxii}

Organizations should keep in mind that the topics above are not ones that can be covered in a single staff workshop – training is most effective when it is ongoing, revisited through supervision and peer discussion, and supported by the creation of relevant policies and procedures that enable staff to operate and interact with clients in accordance with the concepts in the trainings.

CROSS-SECTOR POSITIONS. As funding is available, organizations may consider adding positions that cross boundaries. Hiring staff with expertise in health to supportive housing agencies can greatly increase the capacity of the organization to identify the health needs of their tenants, provide appropriate services and supports, and develop effective partnerships with health providers to ensure that tenant needs are fully met. When funding does not provide for designated staffing positions, strong cross-sector partnerships can provide a bridge between services. For example, both supportive housing organizations and health centers have found success with hiring community health workers to engage residents, connect them to services, and help them improve their health. One example is [Health Care for the Homeless Houston](#), which integrated community health workers into their care team to align physical and behavioral health with social needs. These peer workers played a vital role in helping individuals with high utilization of health care and crisis services transition into housing and improve health outcomes. For more information on this project, see the profile: [Integrated Health for the Chronically Homeless](#).^{xxxiii}

COMMUNITY HEALTH WORKERS

Community health workers (CHW) are frontline public health workers who help people in their own communities access high-quality, culturally competent services.

For more, see: <https://www.apha.org/apha-communities/member-sections/community-health-workers>

DATA

The first step to gaining a better understanding of racial disparities and how to address them is for both health and housing providers to ensure that they are tracking the right measures and **breaking data down by race and ethnicity** to understand differences in service utilization and outcomes.

FOR HEALTH CENTERS. In order to more holistically understand the needs of their patients, identify disparities among their population served, and identify areas of opportunity to advance health equity, health centers can incorporate the following data-based strategies:

- **Screen for homelessness, housing instability, and other social determinants of health.** Once needs have been identified, staff can work to identify individuals experiencing housing crises and other social determinants of health needs, and connect them to appropriate resources and services. Resources to help health centers understand how to screen for social determinants of health, including housing status and stability, include:
 - [The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences \(PRAPARE\) Implementation and Action Toolkit](#)^{xxxiv}
 - [Strategies for Using PRAPARE and Other Tools to Address Homelessness: Quick Guide and Recommendations](#).^{xxxv}
 - [How 6 Organizations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care: An Overview](#)^{xxxvi}
 - [Ask & Code: Documenting Homelessness Throughout the Health Care System](#)^{xxxvii}
- **Compare patient demographics to the community.** Health centers can compare the demographics of the patients they serve to those of the community as a whole to ensure that they are reaching all segments of the population. If there are significant differences, they may consider how to increase access for underserved populations, such as extending operating hours, siting facilities in underserved neighborhoods, providing linguistically-inclusive forms and interpreters, and partnering with schools, community groups, and religious organizations to increase awareness of the health center's offerings.^{xxxviii}
- **Identify disparities within specific health conditions.** By reviewing Uniform Data System (UDS) equity tables, health centers can identify disparities within specific health conditions, including reviewing key indicators around diabetes and hypertension through an equity lens. This review can help health centers identify specific disparities to address, develop targeted interventions or program modifications, and monitor progress.
- **Review Electronic Health Record (EHR) data.** A review of EHR data can help a health center identify disparities based on selected demographics. This information can be used to: highlight service gaps and where initiatives can be created or modified to reduce disparities; how services might be adapted to address the needs of certain populations; and where training is needed to ensure that tenants receive effective care and achieve healthy outcomes regardless of race or other factors.
- **Collect qualitative data.** Once health centers have completed an initial equity-focused review of their data, they can develop ways to collect and analyze qualitative data with an equity lens. Where there are significant disparities, information from focus groups, key stakeholder interviews, and client surveys can provide useful feedback that can be used to modify services and processes to eliminate disparity-driving barriers. Possible questions to patients include: what concerns, if any, they have about their health; what support, resources, and services they think they need to be able to live a healthy life; and how can the health center can support them in achieving good health? The health center's consumer

ADDITIONAL RESOURCES

For information on what health and housing providers can track together, see **Health Outcomes & Data Measures: A Quick Guide for Health Center & Housing**, Partnerships, available at:

<https://www.csh.org/resources/health-outcomes-data-measures-a-quick-guide-for-health-center-housing-partnerships/>

advisory board or consumer representatives on their board of directors are a good starting place to gather initial qualitative feedback from patients.^{xxxix}

FOR SUPPORTIVE HOUSING PROVIDERS. To identify disparities and areas of opportunity to advance health equity, supportive housing providers can incorporate the following data-based strategies:

- **Use health-related data to identify considerations for services.** Although supportive housing providers do not track health data on the level that health centers do, if they are federally-funded (as most are) they collect several common data elements (CDEs) that are relevant to strategizing around improving tenant health. Knowing whether or not tenants are connected to health insurance, for example, is a good starting place for understanding if they have the basic tools for accessing care, and what services to engage them with. Other elements may include if tenants have a chronic health condition, mental health problems, and substance use.
- **Compare tenant demographics to the community.** Supportive housing providers can compare the demographics of the tenants they serve to those of people experiencing homelessness in their community, and the demographics of the group of people being prioritized for supportive housing (if the CoC is able to provide this information). If there are significant differences, providers can consider reviewing eligibility criteria, interview processes/policies, intake staff training, and other factors to ensure that the organization is providing equitable access. Housing is in itself an extremely critical factor in health management and outcomes, so ensuring equitable access to each housing program is an important step in helping to reduce health disparities. Beyond looking at their own data, providers can take part in or even help lead cross-community data collection/analysis efforts to help the community better understand disparities and how to address them. For more details on how to get involved in such systems-level data work, see the “System Efforts” section below.
- **Break down service utilization data.** When possible, providers can benefit from looking at the demographics of clients who engage in each of the agency’s services. Looking at utilization data by demographics can help providers understand if there are differences in service uptake that suggest a need to modify services, processes, staff training, or take other steps to more effectively engage and meet the needs of all tenants and better support their health.
- **Collect qualitative data.** In addition to reviewing program-level data, providers may consider developing ways to collect and analyze qualitative data with an equity lens. Information from focus groups, key stakeholder interviews, and resident surveys can provide useful feedback. By looking at these data from many lenses, including race/ethnicity, language, gender, etc., supportive housing providers may be able to identify ways to reduce gaps in access to service, work with health partners to ensure that they are tailoring interventions and services to unique population needs, and equitably provide tenants with the care, resources, and tools for good health.

IV. RECOMMENDATIONS AROUND HEALTH AND HOUSING PARTNERSHIPS TO ADDRESS INEQUITY

Health centers and supportive housing providers can have the greatest impact on health outcomes of shared clients and advancing health equity in their community by working together at multiple levels. Such partnerships are strongest when built around common goals, a shared understanding of the critical role each partner plays in improving the health and well-being of shared clients, and concrete strategies for improving care and outcomes. Key strategies include:

COORDINATION

Coordination between health centers and supportive housing agencies around health equity will be most effective when it includes the development, implementation, and monitoring of an overall strategy for working together to identify disparities and opportunities to work together to improve health and housing outcomes for shared clients. Frontline staff should be able to be able to make appropriate, direct referrals when needs are identified. Strategies for developing effective partnerships to coordinate services include:

- **Formalize the partnership.** Memoranda of Understanding (MOU) or other written agreements are critical for partnerships with deep collaboration, serving to codify responsibilities and expectations for partners and formalize the relationships. These agreements may include: processes around referrals for services, expectations around rotating services (such as visits by a Nurse Practitioner), protections for client data, and plans for ongoing coordination. For more information and sample documents, see the strategic guidance document linked in the textbox above.
- **Cross-train staff.** Health centers and supportive housing providers can improve coordination and working relationships among frontline staff by providing cross-training. Such training will aim to help health and housing staff understand the shared goal of improving the whole health of their shared patient/tenant, how to speak each other's languages, and how each other's programs work. For maximum effect, training will cover the delimitation of roles and responsibilities. This multi-level training will enable staff to work more effectively with their counterparts in the other system, leading to better outcomes for shared clients.
- **Ensure that social determinants of health are a part of the conversation.** When assessing and monitoring the needs of patients/tenants, both health centers and supportive housing

ADDITIONAL RESOURCES

For details on developing and strengthening partnerships, see: Health and Housing Partnerships: Strategic Guidance for Health Centers and Supportive Housing Providers, available at:

<https://www.csh.org/resources/health-and-housing-partnerships-strategic-guidance-for-health-centers-and-supportive-housing-providers/>

provider staff can work to incorporate discussions about health, housing, and other important factors that can pose barriers to health and well-being, into the conversation.

TEAM-BASED, PATIENT/TENANT-CENTERED CARE

A key strategy for building effective partnerships to address health disparities is to ensure that supportive housing and health center staff participate in, or at least coordinate with, each other's care teams to the extent possible and as permitted by the patient/tenant. In both the health and housing sector, team-based care is a common and effective strategy for ensuring that patients/tenants get the care they need. Team-based care allows providers to offer interventions that: are holistic and coordinated; address multiple layers of need; reduce duplication; and ensure that all providers working with a patient/tenant have an understanding of their broader needs, goals, and care/services plan. This care strategy also allows providers to closely monitor the outcomes of health, housing, and other interventions and services, and modify them as needed.

Such teams can help health, housing, and other service providers build on the relationships that other team members have with the patient/tenant in order to improve outcomes. For example:

- Pharmacists may be able to notify housing case managers to follow up with tenants when they have not filled important prescriptions.
- Community Health Workers may be able to build rapport with a patient/tenant, and may then be able to help other members of the team to deepen their engagement with them.
- A housing case manager may become a member of the tenant's patient-centered primary health care team, with their consent.

In many health center and housing partnerships, the cross-sector care team has regular case conferencing where the case managers, nurses, physicians, behavioral health providers, and other providers as applicable discuss shared patients/tenants to ensure continuity of care across systems.

CO-LOCATION

A critical step that supportive housing providers can take to improve the health of their tenants and advance health equity is to work with health centers to ensure that tenants are easily able to access health care, especially primary care and behavioral health services. Co-location is a particularly helpful strategy for lowering barriers to care for tenants who are medically fragile or struggling with other challenges, such as mental health or a physical disability, that make it difficult to travel to and access care in traditional settings. When planning for new or rehabilitation projects, supportive housing providers can consider opportunities to create space for health center partners. Possibilities range from co-location of a full-service health center site providing primary and behavioral health care in part of a supportive housing building or supportive services site, to creating a small space within a building's office suite where a doctor or Nurse Practitioner can provide services part-time. A more

flexible way of achieving the same goal is to partner with providers that can offer mobile clinics that make regular visits to supportive housing sites or other areas convenient for tenants. Health centers can utilize existing mobile services or apply for a change in scope to include housing sites or add mobile services into their approved work areas.^{xl}

PASEO VERDE

Paseo Verde is an example of a development that holistically addresses the housing and health needs of clients.

The complex provides co-located supportive housing and a Federally Qualified Health Center, along with a pharmacy, affordable housing, fitness and computer centers, and on-site services including child care and employment counseling.

For details, see:

<https://www.csh.org/resources/paseo-verde-2/>

TEAMING ON WELLNESS GROUPS/ACTIVITIES

Another way that health centers and supportive housing providers can work together to improve health is to work in partnership to develop collaborative, wellness-focused activities, services, and programs. Data that health and housing providers have gathered on disparities in outcomes for patients/tenants their programs and communities can help to drive targeting and tailoring of activities and programs to populations impacted by inequity. Possible topics include: racial and other disparities in health and the causes of inequity; nutrition and the role food can play in health; modeling healthy meal preparation; exercise classes; walking groups/challenges; and chronic disease self-management groups focused on the conditions where disparities are most apparent. Activities will be most effective for all participants when they are designed and delivered with cultural humility, and can take place either in supportive housing or on-site at health centers, in which case housing providers may coordinate transportation and scheduling to ensure accessibility for tenants. Health and housing providers may also consider activities such as providing pop-up services at each other's sites, such as periodic health fairs/screenings at supportive housing sites, and housing fairs at health centers.

ADDITIONAL RESOURCES

For more on health and housing partnership strategies, see: **Health and Housing Partnerships: Overview of Opportunities and Challenges for Health Centers**, available at:

<https://www.csh.org/resources/health-and-housing-partnerships-overview-of-opportunities-and-challenges-for-health-centers/>

TAILOR INTERVENTIONS

Both health centers and supportive housing providers by their nature operate using a patient/tenant-centered/driven approach, but when racial and other disparities in outcomes exist within their own programs, they need to consider what else they can do to tailor their interventions and services to produce equitable outcomes. Considerations may include:

- **Cultural context.** As discussed in the staff training section, cultural humility is key. Health centers need to ensure that the interventions they are providing make sense for the patients they are serving. Evidence-based practices, for example, have often not been developed in a way that is inclusive of multiple cultural contexts, which can make them unresponsive to the unique needs of diverse populations.^{xli} Health and housing providers and their patients/tenants stand to benefit from providers working to understand how effective the interventions that they use regularly are for different populations, and consider ways to adapt and make them more culturally-informed, when possible, to improve outcomes. One example of such an adaptation is work done by the Southwest Interdisciplinary Research Center (SIRC) to their Keepin'it REAL (KiR) school-based substance use prevention program. To better meet the needs of urban Native American youth in the community, who were demonstrating less positive outcomes than other groups, the researchers collaborated with local Native American adults and youth, community and school personnel, and Native American curriculum development experts in order to make the intervention more culturally relevant to the local youth population.^{xlii}
- **Health literacy.** Health centers can work to ensure that clinicians understand and are responsive to the varying levels of health literacy (the skills/abilities needed to function in the health care environment) among their patients. This is particularly important for addressing racial disparities in health, because studies have shown that people of color, particularly those who are Black, have lower health literacy than Whites, even when controlling for educational attainment, income, gender, and age.^{xliii} Strategies can include:
 - Reducing or eliminating use of jargon/technical terminology
 - Working to assess patient understanding of instructions and the care plan, and
 - Empowering patients to ask questions and clarify their understanding of the care plan.^{xliv}

Similarly, supportive housing providers can make efforts to ensure that conversations with tenants about their health and any health-related group activities/education are understandable and helpful for tenants regardless of their level of health literacy.

- **Harm reduction and Motivational Interviewing.** Harm reduction, which seeks to reduce the harm and risks of certain behaviors, and Motivational Interviewing, which supports people in making positive changes, are critically important approaches for health and housing providers to employ when working with patients/tenants to improve health. Clinicians and frontline staff will benefit from regular training and support through supervision on these approaches, and can use them in enhancing their work to help patients/tenants understand and address factors related to health outcomes, including alcohol and substance use, following their medication/treatment plan, diet, exercise, and risky behaviors such as needle-sharing and unsafe sex.

ADDITIONAL RESOURCES

For more on harm reduction and Motivational Interviewing, see the following National Health Care for the Homeless resources:

<https://www.nhchc.org/training-technical-assistance/online-courses/harm-reduction/>;
<https://www.nhchc.org/training-technical-assistance/online-courses/mi/>

SYSTEM EFFORTS

Health inequities are driven by far larger systems and forces than health centers and supportive housing providers have the capacity to address alone. To build on the progress that they can make individually and together, health centers and supportive housing providers can tap into, or help launch, larger systems efforts to identify and address inequity in their communities and beyond. Strategies that community partners working to identify disparities and advance health equity can pursue include:

ADDITIONAL RESOURCES

For more on data matching to identify the highest utilizers of crisis services, see: csh.org/fuse

- **Data-based community efforts to identify disparities.** Gaining a full picture of racial and other disparities in health and other outcomes in a given community necessitates the engagement of stakeholders from multiple sectors, all working together to determine which data sources to analyze, how to break down data by race, ethnicity, and other factors, and options for data integration/matching to help identify and target resources to the most vulnerable people.
 - The [Continuum of Care \(CoC\) Racial Equity Analysis Tool](#), available from the Department of Housing and Urban Development (HUD), is designed to help communities understand access to, and outcomes for, their system through a racial equity lens.^{xlv} Both health and housing providers can engage their local CoC around using this tool to better understand disparities among people experiencing sheltered and unsheltered homelessness in the community. **Data-matching efforts**, in which partners from a variety of systems, such as housing, health, and justice, allow communities to identify the people who are experiencing poor outcomes and are caught in a cycle of crisis services across multiple systems. Adding an equity lens to data matching efforts can help communities understand racial, ethnic, and

other disparities between these high utilizers and the community as a whole, as well as within the high utilizer group, which can inform strategic decisions about targeting resources and adapting outreach, service, health, housing, justice, child welfare and other interventions to advance equity. Health centers can get involved in data-matching efforts by working with partners from other systems to develop goals for data-sharing efforts and agreements to govern the actual matching.^{xlvi} Supportive housing providers can take part by encouraging the CoC to include high service utilization as a factor in the local coordinated entry system’s prioritization policy, and by working with community partners that have done data matches to understand how supportive housing services can best be tailored to help people who have been caught in a cycle of crisis utilization stabilize and thrive once in housing.

- **Qualitative data** are an important part of any data-driven effort to identify disparities and inform solutions to address them. *SPARC (Supporting Partnerships for Anti-Racist Communities)* is a groundbreaking national effort by the Center for Social Innovation around racial equity in the homelessness sector. The research activities in six communities that informed the [SPARC: Phase 1 Study Findings](#) report included qualitative data gathered through oral histories and focus groups, and recommended that such data be collected to help communities better understand the complex dynamics that drive the flow to and through the homeless system for people of color.^{xlvii} Health centers and supportive housing providers can both push community partners to incorporate qualitative data in equity-focused needs assessments and discussions, and work to ensure that patients/tenants have an opportunity to inform and influence community efforts to advance equity.
- **Community-wide planning, goal-setting, and coordination to improve health and advance equity.** Building equity into community-wide strategic plans, as well as the strategic plans of key systems such as public health, housing, and social services, can help cement commitments to equity, drive resources to these efforts, and coordinate work across multiple systems to advance equity. Innovative models and helpful resources that health and housing providers can work with community partners to explore and utilize when developing local strategies include:
 - **Health in All Policies (HiAP).** A strategy in which health is a consideration in decision making across a wide swath of sectors, such as housing, urban planning, public safety, and transportation, in addition to public health, HiAP is an example of an impactful cross-sector approach to addressing social determinants of health.^{xlviii} Health centers and supportive housing providers can work with their immediate community partners, such as the local Continuum of Care, and the health department, to engage other community stakeholders around the importance of considering health when developing public policies. Providers

ADDITIONAL RESOURCES

For more information on the Health in All Policies approach and communities that are implementing it, see:

<https://www.apha.org/topics-and-issues/health-in-all-policies>

- from both sectors can also offer data and anecdotes to illustrate the impact that various social determinants of health, which could be impacted by such health-conscious policies, have had on the outcomes for their clients.
- The [Build Healthy Places Network](#) offers tools, resources, and online discussion forums aimed at supporting the collaboration of health and community development sectors to improve outcomes for people in their communities.^{xix} Health centers and supportive housing providers are both positioned to lead or support efforts to bring community partners from multiple sectors, such as education, employment, transportation, in addition to health and housing, together to advance health equity using the tools and resources available through the Network. In particular, when developing strategies for cross-agency collaborations, health and housing providers and their community partners can utilize the Principles for Building Health and Prosperous Communities framework developed by the network, which include: 1) Collaborate with the community; 2) Embed equity; 3) Mobilize across sectors; 4) Increase prosperity to improve health; and 5) Commit over the long term.
 - [Racial Equity Tools](#) is an online repository of tools, resources, practices, and community examples to support groups working to achieve racial equity; it was developed and is maintained by the Center for Assessment and Policy Development, MP Associates, and World Trust Educational Services. Health and housing providers can explore the tools, which cover a wide variety of topics under each of the planning, implementation, and evaluation phases, to learn more about what they can do and how they might be able to with other partners in order to amplify their efforts to advance equity and improve health and other outcomes for their patients/tenants and people throughout the community.ⁱ

ⁱ http://www.who.int/topics/health_equity/en/; <https://www.apha.org/topics-and-issues/health-equity>;

ⁱⁱ <https://www.who.int/hia/about/glos/en/index1.html>

<https://www.hrsa.gov/sites/default/files/hrsa/health-equity/2017-HRSA-health-equity-report.pdf>

ⁱⁱⁱ Williams DR. Race, socioeconomic status and health—the added effects of racism and discrimination. *Ann N Y Acad. Sci.* 1999; 896:173-88; Healthy People 2020. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. “Social Determinants of Health” Available from: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

^{iv} Health Resources Services Administration. 2017 Health Center Program Grantee Data Table 3B – Demographic Characteristics. Available at:

<https://bphc.hrsa.gov/uds/datacenter.aspx?q=t3b&year=2017&state>; HUD. 2017 Annual Homeless Assessment Report (AHAR) to Congress, Part 2 – Estimates of Homelessness in the U.S. Oct. 2018, Section 7: 2017 One-year estimates of people in permanent supportive housing. Available at:

<https://www.hudexchange.info/resources/documents/2017-AHAR-Part-2-Section-7.pdf>

^v Colen, C. G. et al. “Racial disparities in health among nonpoor African Americans and Hispanics: The role of acute and chronic discrimination” *Social science & medicine* (1982) vol. 199 (2017): 167-180.

^{vi} Health Resources and Services Administration, Office of Health Equity. Health Equity Report 2017. ROCKVILLE, MARYLAND: U.S. Department of Health and Human Services; 2018. Available at:

<https://www.hrsa.gov/sites/default/files/hrsa/health-equity/2017-HRSA-health-equity-report.pdf>

^{vii} *ibid*

-
- viii National Center for Health Statistics. Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK367640/>
- ix Center for Disease Control. "CDC Health Disparities and Inequalities Report – United States, 2013" *Morbidity And Mortality Weekly Report: MMWR*. vol. 62 supplement 3 (2013): 1-187. Available at: <https://www.cdc.gov/mmwr/pdf/other/su6203.pdf>
- x *ibid*
- xi *ibid*
- xii National Center for Health Statistics. Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK367640/>
- xiii U.S. Department of Housing and Urban Development. 2017 Annual Homeless Assessment Report (AHAR) to Congress, Part 1 - PIT Estimates of Homelessness in the U.S. Oct. 2018. Available at: <https://www.hudexchange.info/resource/5639/2017-ahar-part-1-pit-estimates-of-homelessness-in-the-us/>
- xiv U.S. Census Bureau. ACS Demographic and Housing Estimates, 2017 American Community Survey 1-Year Estimates. Available at: <http://factfinder.census.gov>.
- xv U.S. Department of Housing and Urban Development. 2017 Annual Homeless Assessment Report (AHAR) to Congress, Part 1 - PIT Estimates of Homelessness in the U.S. Oct. 2018. Available at: <https://www.hudexchange.info/resource/5639/2017-ahar-part-1-pit-estimates-of-homelessness-in-the-us/>
- xvi U.S. Department of Housing and Urban Development. Connection Between Housing and Healthcare Needs: Growing Evidence Base for Housing as a Social Determinant of Health. February 2017. Available at: <https://www.hudexchange.info/programs/housing-healthcare/h2-toolkit/>
- xvii Stafford, Amanda and Lisa Wood. "Tackling Health Disparities for People Who Are Homeless? Start with Social Determinants" *International journal of environmental research and public health* vol. 14, 12 1535. 8 Dec. 2017, doi:10.3390/ijerph14121535
- xviii Berkowitz SA, et. al. "Unstable Housing and Diabetes-Related Emergency Department Visits and Hospitalization: A Nationally Representative Study of Safety-Net Clinic Patients" *Diabetes Care* 2018; 41(5):933-939. <https://doi.org/10.2337/dc17-1812>
- xix Brehove, T., et.al. *Adapting Your Practice: Treatment and Recommendations for Homeless People with Diabetes Mellitus*. 2007. Nashville: Health Care for the Homeless Clinicians' Network.
- xx Healthy People 2020. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. "Disability and Health" Available at: <https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health>
- xxi U.S. Department of Housing and Urban Development. 2017 Annual Homeless Assessment Report (AHAR) to Congress, Part 2 – Estimates of Homelessness in the U.S. Oct. 2018. Available at: <https://www.hudexchange.info/resource/5769/2017-ahar-part-2-estimates-of-homelessness-in-the-us/>
- xxii Price, J, et.al. "Poverty and Health Disparities: What Can Public Health Professionals Do?" 2018. *Health Promotion Practice*. 19. 14-18.
- xxiii Data available at: <https://www.census.gov/programs-surveys/ahs.html>
- xxiv Jacobs, David E. "Environmental health disparities in housing" *American journal of public health* vol. 101 Suppl 1, Suppl 1 (2011): S115-22.
- xxv UISCH. "Supporting Whole-Family Approaches to Housing Stability and Economic Mobility: The role of housing and homelessness providers." November 2018. Available at: https://www.usich.gov/resources/uploads/asset_library/Supporting_Whole_Family_Approaches_Housing.pdf
- xxvi Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)
- xxvii National Health Care for the Homeless Council. "Creating a Culture of Safety: A Guide for Health Centers" December 2017. Available at: <https://www.nhchc.org/2017/12/new-resource-a-quick-guide-to-creating-a-culture-of-safety-at-health-centers/>
- xxviii Yeager, Katherine A and Susan Bauer-Wu. "Cultural humility: essential foundation for clinical researchers" *Applied nursing research: ANR* vol. 26, 4 (2013): 251-6.
- xxix Foronda, Cynthia et al. "Cultural Humility: A Concept Analysis" *Journal of Transcultural Nursing*. (2015). 27. 10.1177/1043659615592677.
- xxx <https://www.projectimplicit.net/lectures.html>

-
- xxxix <http://www.ihl.org/communities/blogs/how-to-reduce-implicit-bias>
- xxxix <https://www.usich.gov/news/initiative-sparks-change-in-local-organizations-approach-to-racial-inequity-in-work-to-end-homelessness/>
- xxxix CSH. "Integrated Care for the Chronically Homeless" Available at: <https://www.csh.org/resources/integrated-care-for-the-chronically-homeless/>
- xxxix National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. "PRAPARE Implementation and Action Toolkit" 2016. Available at: <http://www.nachc.org/research-and-data/prapare/toolkit/>
- xxxix CSH, National Health Care for the Homeless Council. "Strategies for Using PRAPARE and Other Tools to Address Homelessness: Quick Guide and Recommendations." Available at: <https://www.nhchc.org/2018/11/new-quick-guide-examines-strategies-for-using-prapare-and-other-tools-to-address-homelessness/>
- xxxix LaForge, Kate et al. "How 6 Organizations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care: An Overview" *Journal of ambulatory care management* vol. 41, 1 (2017): 2-14.
- xxxix National Health Care for the Homeless Council. Ask and Code: Documenting Homelessness Throughout the Health Care System. Available at: <https://www.nhchc.org/2016/10/upcoming-webinar-ask-code-documenting-homelessness-throughout-the-health-care-system/>
- xxxix Andermann, Anne and CLEAR Collaboration. "Taking action on the social determinants of health in clinical practice: a framework for health professionals" *CMAJ: Canadian Medical Association journal* vol. 188, 17-18 (2016): E474-E483.
- xxxix National Health Care for the Homeless Council. Consumer Engagement in Governance. Available at: <https://www.nhchc.org/resources/consumer/consumer-engagement-in-governance/>
- xl Health Resources Services Administration. Scope of Project. 2018. Available at: <https://bphc.hrsa.gov/programrequirements/scope.html>
- xli Gone, Joseph P. "Reconciling Evidence-Based Practice and Cultural Competence in Mental Health Services: Introduction to a Special Issue." *Transcultural Psychiatry*, vol. 52, no. 2, Apr. 2015, pp. 139-149, doi: 10.1177/1363461514568239.
- xlii Marsiglia, Flavio F and Jamie M Booth. "Cultural Adaptation of Interventions in Real Practice Settings" *Research on social work practice* vol. 25, 4 (2014): 423-432.
- xliii Chaudhry, Sarwat I et al. "Racial disparities in health literacy and access to care among patients with heart failure" *Journal of cardiac failure* vol. 17, 2 (2010): 122-7; Rikard, R V et al. "Examining health literacy disparities in the United States: a third look at the National Assessment of Adult Literacy (NAAL)" *BMC public health* vol. 16, 1 975. 13 Sep. 2016, doi:10.1186/s12889-016-3621-9
- xliii Sudore, Rebecca L and Dean Schillinger. "Interventions to Improve Care for Patients with Limited Health Literacy" *Journal of clinical outcomes management: JCOM* vol. 16, 1 (2009): 20-29.
- xliii U.S. Department of Housing and Urban Development. New CoC Racial Equity Analysis Tool. 2019. Available at: <https://www.hudexchange.info/news/new-coc-racial-equity-analysis-tool/>
- xliii For more details on how health centers can get involved in data matching, see: <https://www.csh.org/resources/hud-policy-brief-on-data-matching-understanding-the-impact-and-potential-for-health-centers/>.
- xliii Center for Social Innovation. SPARC: Phase One Study Findings. March 2018. Available at: <https://center4si.com/sparc/>
- xliii Pepin, Dawn et al. "Collaborating for Health: Health in All Policies and the Law" *Journal of law, medicine & ethics: a journal of the American Society of Law, Medicine & Ethics* vol. 45, 1_suppl (2017): 60-64.
- xliii For more information, see: <https://buildhealthyplaces.org/>
- l *ibid*