Aligning health and housing systems to improve community health.

While social and economic determinants have a large impact on the health and well-being of families and individuals, the health care system has traditionally been disconnected from the human services systems designed to meet those needs. Despite growing recognition of the shared populations they serve and their interdependence in shaping outcomes, health care providers remain siloed from human services providers, including affordable housing providers.

The lack of system coordination and alignment leads to large gaps in service. Individuals with complex needs have trouble navigating these fragmented systems, which often results in receipt of insufficient levels of care and support. Uncoordinated and misaligned systems further traumatize vulnerable populations, increase health disparities, and produce negative outcomes such as increased emergency department utilization and cost.

Better connecting, coordinating, and aligning health and human services systems can more effectively and efficiently address both health and social needs. Achieving this goal requires understanding between the systems and significant collaboration for building integrated systems of care and support that serve vulnerable populations.

Aligning Health & Housing Systems Initiative.

UnitedHealthcare COMMUNITY & STATE | CLPHA Strengthening Neighborhoods. Improving Lives. | CSH

The Corporation for Supportive Housing (CSH), the Council of Large Public Housing Authorities (CLPHA), and UnitedHealthcare Community & State (UnitedHealthcare) have created the **Aligning Health & Housing Systems (AHHS) Project,** a multi-sector collaboration to improve the health outcomes of Medicaid beneficiaries served through managed health care and living in publicly-assisted housing. The AHHS Project, supported by the Robert Wood Johnson Foundation, will design and implement systems of care and interventions that align health and housing resources at the person, program, and population level.

The AHHS Project aims to move the national conversation around health and housing beyond the theoretical to concrete, replicable models and strategies that operationalize the vision of addressing social determinants of health. Learnings from the project will be disseminated broadly to encourage widespread adoption among health care and housing sector leaders and

aligned systems. A key, final goal of the project is to develop health plan-agnostic solutions that can be implemented and scaled by UnitedHealthcare and other Medicaid health plans, regardless of their health plan coverage.

The AHHS Project team partners believe that Managed Care and Public Housing Authorities are ideal partners, with similar scale and impact in local communities, to achieve this goal. Most importantly, the initiative will result in direct and concrete improvements in health and well-being for individuals, families, and communities.

Project Phases and Timeline

Aligning Health & Housing Systems Initiative: **Project Sites**

CSH, CLPHA and UnitedHealthcare identified 25 communities in 13 states where CLPHA had public housing authority (PHA) members and UnitedHealthcare was a Medicaid managed care plan. They assessed these communities by reviewing the strength of local leadership and sophistication in the health care policy environment, Medicaid contracting schedules and other relevant factors that distinguished communities from one another. This intensive review process resulted in the selection of five communities—Columbus and Akron, Ohio; Houston and Austin, Texas; and Seattle/King County, Washington—to receive resources and staffing support to facilitate the planning and development of local interventions, including an environmental scan of their community health needs.

The five communities are developing health initiatives that will leverage the capacity, resources, and expertise of CLPHA and its member public housing authorities; CSH; and, UnitedHealthcare and its state health plans. Within these initiatives, each community is developing a targeted health intervention(s) based on joint priorities, as well as a longer-term partnership grounded in data sharing activities. All partners are focused on strategies to improve health outcomes and reduce housing instability, address health disparities, and ensure efficient use of public sector funding. Each of the five community partnerships will create an integrated system that aligns health and housing systems and creates a policy roadmap for improving the health of Medicaid beneficiaries, which could improve health outcomes and equity, and lower avoidable costs over the long-term.

Project Site Highlights

Akron, Ohio:

Population of over **119,000**

Non-Hispanic white	**77.6%**
Non-Hispanic African American	**14.7%**
Asian	**3.3%**
Hispanic	**2.0%**
American Indian	**0.2%**

60% are between the ages of 19 and 64

Akron Metropolitan Housing Authority is the local PHA engaged in this project. This PHA manages or oversees housing for 19,200 individuals in over 9,300 households. **In Akron, UnitedHealthcare's Community Plan of Ohio manages the health care of over 28,400 individuals.**

15% percent of Summit County residents have fair or poor health with health behaviors related to:

- **Smoking**
- **Obesity**
- **Alcohol Use**

The Ohio State Department of Health identified **three priority areas to improve health outcomes in the state.** These priorities align with Summit County's Health Department priorities, which also include adolescent health and aging populations.

- **Mental Health and Addiction**
- **Chronic Disease**
- **Maternal/Infant Health**

Austin, Texas:

Population of over **950,000**

Non-Hispanic white	**49.3%**
Hispanic	**33.9%**
Non-Hispanic African American	**8%**
Asian	**3.3%**

68% are between the ages of 19 and 64

The Housing Authority of the City of Austin is the local PHA engaged in this project. The Housing Authority manages or oversees housing for 17,000 individuals in 7,800 households. **The UnitedHealthcare Community Plan of Texas provides health care coverage for almost 15,000 members in Travis County.**

Travis County ranks **50th in overall health outcomes and 57th for length of life across all 242 counties in Texas.** The City of Austin, according to the Centers for Disease Control and Prevention (CDC), has better than average U.S. health outcomes related to cancer, diabetes, asthma, high cholesterol, and overall physical and mental health. Austin also has lower than average U.S. statistics in all unhealthy behaviors with the exception of binge drinking. Travis County and the City of Austin have been focused on reducing chronic health conditions for residents by:

- **Increasing Healthy Behaviors**
- **Educating Residents**
- **Promoting Healthy Foods**
- **Expanding Access to Health Care**

Project Site Highlights

Columbus, Ohio:

Population of over **860,000**

Non-Hispanic white	**64.2%**
Non-Hispanic African American	**22.3%**
Hispanic	**5.3%**
Asian	**5.1%**
American Indian	**0.3%**

65% are between the ages of 19 and 64

Columbus Metropolitan Housing Authority is the local PHA engaged in this project. This PHA manages or oversees housing for 34,100 individuals in 14,500 households. **The UnitedHealthcare Community Plan of Ohio is responsible for managing the health care of over 28,200 individuals in Columbus/Franklin County.**

County Health Rankings report **16 percent** of Franklin County's residents have fair or poor health due to:

- **High Child Mortality Rates**
- **Sexually Transmitted Disease Infection Rates**
- **Rates of Alcohol Use**
- **Teen Pregnancy Rates**

Both the State of Ohio and Franklin County have identified three priority areas to improve health outcomes:

- **Mental Health and Addiction**
- **Chronic Disease**
- **Maternal/Infant Health**

Houston, Texas:

Population of over **2.3 million**

Hispanic	**42.4%**
Non-Hispanic white	**30.4%**
Non-Hispanic African American	**18.6%**

63% are between the ages of 19 and 64

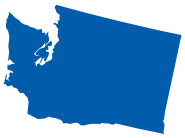
Houston Housing Authority is the local PHA engaged in this project. The Housing Authority manages or oversees housing for 53,600 individuals in 21,900 households. **In Houston/Harris County, the UnitedHealthcare Community Plan of Texas manages the health care of over 125,700 individuals.**

The overall population of Texas has an 18% fair or poor health ranking, which is the same as Harris County. Houston has slightly higher than U.S. average health outcomes in diabetes, overall physical health and mental health outcomes. In Houston, over 34% of adults are considered obese and notably over 30% of adults age 18-64 are uninsured, which is significantly higher than the U.S. average of 14.8%.

The City of Houston Department of Health and Human Services has set six health improvement priorities with measured outcomes focused on:

- **Access to Care**
- **Behavioral Health**
- **Childhood Obesity**
- **Chronic Disease**
- **Environmental Health**
- **HIV/Aids**

Project Site Highlights



Seattle, Washington:

Population of over **704,000**

Non-Hispanic white	**61.1%**
Asian	**17.4%**
Hispanic	**6.4%**
Non-Hispanic African American	**6.4%**
Asian	**1%**
Native Hawaiian/ Pacific Islander	**.9%**

68% are between the ages of 19 and 64.

King County Housing Authority and Seattle Housing Authority are the local PHAs engaged in this project. Together, the two PHAs manage or oversee housing for 65,000 individuals (King County: 36,600 and Seattle: 28,400) in 29,600 households (King County: 15,000 and Seattle: 14,600). **The UnitedHealthcare Community Plan of Washington provides health care coverage for over 73,000 individuals in Seattle/King County.**

King County is the first in length of life and second overall in health outcomes across the 39 counties in Washington State. King County has lower percentages and numbers on all health outcomes and health behaviors in comparison to Washington State and the U.S. The only health behaviors that are higher are alcohol consumption, HIV prevalence and sexually transmitted disease infections.

To improve health outcomes in King County, the Public Health Department and partners are focused on:

- **Support for Youth and Families**
- **Support for Older Adults**
- **Health Equity**
- **Social Determinants of Health**
- **Housing and Homelessness**
- **Access to Health Care**

Aligning Health & Housing Systems Initiative: **The Data**

After site selection, the second phase of the project is in data analytics. The three national partners and five community sites will share, match, and analyze data to identify opportunities to improve health outcomes at both the community and individual level. The insights from the data analytics effort will be used to identify population health trends and issues and develop health care strategies to better serve individuals who are public housing residents and health plan members.

To date, data sharing agreements (DSAs) have been developed and signed between the housing authorities and UnitedHealthcare. The DSAs allow PHAs to share data with UnitedHealthcare. UnitedHealthcare then matches the housing data with individual UnitedHealthcare Community Plan client data where a shared data set will be created.

The UnitedHealthcare Medical Economics team is leading the data analytics work and is including claims data and health information from late 2017 through late 2018 related to specific data elements—demographics, most common diagnoses, service utilization: providers and patterns of use, and costs—that were agreed to among the partners. All data will remain separate between each PHA so that the appropriate UnitedHealthcare local health plan can review the detailed analyses.

Moving Forward

In the project's next phase, joint priorities will be identified between housing authorities and their local UnitedHealthcare partners. The sites will develop community health intervention pilots related to a specific health challenge(s) identified from the data analysis. In addition, a roadmap for other PHAs and health plans will be created and communication protocols and collaborative best practices will be established to help create pathways to allow systems to work together to identify and address emergent health needs, track gaps in care, and support and reform policies to address these gaps.

The long-term commitment is a roadmap for collaboration that other housing authorities and health plans can follow. Learnings from these projects will be disseminated broadly to encourage widespread, effective adoption and scaling of these models and strategies to improve the health outcomes of Medicaid beneficiaries served through managed health care living in publicly-assisted housing. **The partners seek to deepen and sustain collaboration between major health and housing provider systems to scale data-driven community health interventions to larger numbers of individuals served by multiple systems.**

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