# SHELTER: Strengthening Health through Housing Education, Linkages, & Training to Empower Residents

**Cohort:**
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**Location:**
New York, New York

**Focus Areas:**
Built Environment/Housing/Planning

## Background

### SHELTER: Strengthening Health through Housing Education, Linkages & Training to Empower Residents

Housing Insecurity (HI) has been defined as inextricably linked to poor physical and mental health. Moreover, low-income minority families are disproportionately affected, partly due to housing discrimination and racial segregation. HI is prevalent in many communities served by Northwell Health in New York City, the 14th largest clinically-integrated health care system in the US and serves >8 million people, with the majority residing in Queens and Nassau. Queens is the most diverse county in the country, with 46% immigrants and no racial/ethnic majority. Half of the population are limited English proficient and 22% are uninsured. In Nassau, county-level health data completely masks major health disparities of severely underserved communities.

Two of our most vulnerable communities in the Northwell Health catchment area are Jamaica, Queens and Hempstead, Nassau. These "vulnerable communities" have higher rates of asthma, type 2 diabetes hospitalizations, and late prenatal care, with a 20% uninsured rate.

Community needs assessments included forums with community residents who repeatedly reported lack of smoke-free, stable and affordable housing, difficulties in managing chronic illnesses and frequent exacerbations of respiratory and cardiovascular illness due to substandard housing. Health providers reported high levels of housing instability, a major obstacle to care coordination, leading to high no-show rates. Housing vouchers were inadequate to cover costs. Current local emergency housing programs have waitlists and inadequate numbers of housing units. In our communities, HI has led to a trifecta of poor access, low use of preventive care and suboptimal chronic disease management, resulting in poor health.

## Wicked Problem Description

> "Poor housing is always associated with high rates of morbidity and mortality, yet housing generally is not high on the list of societal needs and governmental priorities." -Robert E. Novick, Environmental Health in Rural and Urban Development and Housing, World Health Organization.

Housing remains one of the most profound social determinants of health (SDH). The wicked problem of HI is growing, affecting 40 million Americans, and includes families affected by unstable, unaffordable and/ or overcrowded housing, poor housing quality/safety and/or homelessness. Housing-related health hazards and injuries, poverty due to high housing costs and impaired access to care are some of the pathways through which HI leads to poor health.

## Project Strategies

Through a collaboration between the 3rd largest health system in NY, Northwell Health, and local community based organizations (CBOs), we propose a multi-level approach (patient, community, health workforce) to address the wicked problem of HI in two communities in Queens and Nassau counties, with major health disparities and pervasive HI.

### Goal 1

At the patient level, we will expand SDH screening across 4 clinical practices that serve our communities, provide resources and follow-up for patients with adverse SDH. Those with HI, and eligible for the Northwell Medicaid Health Home (MHH), a care coordination program for at-risk patients with chronic conditions, will also receive "SHELTER services" (home safety assessment/education, financial counseling, housing repair and legal aid) provided by CBO partners.

## Goal 2

At the community-level, community campaigns will be accomplished through creation of community "Collaboratives", with local CBOs, health centers, legal aid agencies, housing authorities and community residents.

## Goal 3

To strengthen the health workforce, we will employ a skill-based curriculum focused on care of vulnerable populations (VPs), to improve SDH knowledge, referral and resource navigation.

# Outcomes

### Goal 1 Outcomes

*Improve access and care by addressing HI and other adverse SDH.*

Short-term outcomes include site-specific SDH screening tool, a screening/referral protocol for each clinical site, completed screening for 90% of target patients and site-specific patient databases outlining demographic, health and SDH data. Intermediate outcomes include referring all eligible patients with positive screens to Northwell MHH, providing SHELTER services for at least 75% of MHH- enrolled patients with HI that reside in Hempstead and Jamaica. By project end, a sustainability plan for SHELTER services will be implemented, 50% of our eligible patients will have elimination of at least one HI domain (affordability, quality, instability, homelessness).

### Goal 2 Outcomes

*Develop SHELTER Collaboratives to engage communities in planning and implementation of projects to address housing insecurity.*

Short-term outcomes include stakeholder buy-in and engagement from identified community partners, two firmly established SHELTER Collaboratives and initiation of our community education campaign. Intermediate outcomes include ongoing quarterly meetings with the Collaboratives and one community-informed Culture of Health based project, designed and implemented by Hempstead and Jamaica community members. By the end of the project, there will be a sustainability plan for continued community education and Culture of Health projects.

### Goal 3 Outcomes

*Strengthen health provider capacity to address SDH through delivery of SDH curriculum.*

Short-term outcomes include finalizing curricula and a basic needs assessment of learners' current knowledge, attitudes and skills of the proposed content. Intermediate outcome is 80% of learners completing the curriculum. By the end of this project, learners will have increased awareness of health impacts of SDH,

increased knowledge on available resources and skills on addressing SDH, particularly HI.

## Timeline

We will begin strategic planning for implementation of Goals 1 and 2 from October 2017- March 2018; Implementation of goals 1 and 2 will begin from March 2018; Implementation of goal 3 will begin in March 2019. The evaluation period of project outcomes is anticipated to commence in September 2019.

## Partnerships

Multiple partners will be engaged throughout the implementation of this project. In order to deliver "SHELTER services:" to families with identified HI, we will partner with Northwell Health Medicaid Health Home, a care coordination program for at-risk patients with chronic conditions. Guiding the development of SHELTER Collaboratives, we will work with community-based organization partners: 1) United Way Long Island (UWLI), one of the largest social service agencies serving Nassau with a dedicated healthy housing initiatives department and 2) The Child Center of New York (CCNY), a non-profit organization dedicated to improving the lives of children and families, with over 70 programs focused in the areas of youth development, behavioral health, early childhood, home visitation and family support.

## Evaluation Strategies

- Pre and post data will be collected for the patients identified and determined eligible for SHELTER services, specifically, type of chronic medical conditions, ER utilization and compliance with primary care.
- We will track the number of referrals, resources utilized and patients enrolled.
- As a surrogate measure to health outcomes, patient satisfaction and perception of health will be collected pre and post project.
- We will ensure number of participants in the collaborative who attend meetings, in addition to success of the proposed projects.
- We will measure community penetration of the community education campaign, measured by social media (e.g., retweets, Facebook likes, local media coverage).
- We will use the validated, Relationships in Community Groups Trust Scale (RCG-TS), to measure changes in community trust and engagement
- We will track the total number of learners participating in the curriculum and partaking in the training.
- We will utilize a pre-post survey of learner knowledge, attitudes and skills around being SDH advocates will be completed