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The Road Forward:

Framework for a Population Health Approach to Health and Housing Partnerships

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Prologue: COVID-19 and Housing

When we set out to examine the state of partnerships and collaboration to address health and housing in New York City, we were already aware of the unprecedented extent of needs. Housing is inextricably linked to health, but affordable housing in New York is less available and more costly than ever before. We are living in uniquely challenging times and face an ongoing housing crisis.

The arrival and persistence of the COVID-19 pandemic and the toll it has taken on vulnerable populations—especially people of color, individuals who are living in crowded housing, and those who are unhoused—has added to the urgency of the housing crisis that already existed.

The work described in this report was done before the emergence of COVID-19. While this work does not address specific models for housing during the pandemic, the framework presented here maps pathways for collaboration between health, housing, and other sectors. Existing collaborations have proven critical for addressing the immediate COVID emergency in the short term. Over the longer term, such collaborations can drive innovation that will inform policy and programmatic change and can help define the future of health and housing in New York.

Executive Summary

The inextricable link between an individual's health, future disease burden, and housing is well documented in the literature.[1] Many different kinds of housing needs and housing-related traumatic experiences may affect health. These include a lack of affordable housing; a lack of stable housing; environmental conditions in housing that lead to illness, injury, or displacement; homelessness; and difficulty navigating housing programs, which can delay or prevent access to needed housing supports. The numbers in New York City are daunting:

- Housing affordability: 45% of New York City rental households pay 30% of their income toward rent, and nearly 30% are severely rent burdened (paying more than 50% of income toward rent). Most burdened of all are low-wage and extremely low-wage workers, some of whom pay nearly 75% of their income toward rent.[2,3]
- Housing quality: More than 11% of all New York City housing has three or more maintenance defects. Among rental properties, that proportion is nearly 15%.[4]
- Housing availability: Since 2009 New York City's population grew by 500,000, but only 100,000 new housing units came to market.

Stakeholders universally agree on the importance of addressing housing needs that can affect health. However, the absence of a unifying, useable framework—coupled with disparate financial incentives in the health and housing sectors—raises concerns about the potential for developing collective solutions at scale. In 2019, as part of its work with the New York City Population Health Improvement Program (NYC-PHIP), United Hospital Fund (UHF) led an initiative to better understand health and housing interdependencies and advance a viable framework. The process included a review of health and housing data, key informant interviews, a targeted literature review, and a thought leaders roundtable event.

At the end of the day, health care providers and policymakers must recognize the importance of housing to individual and community-level health when designing interventions, policies, and regulations. Similarly, housing policymakers and providers must consider how to foster healthier communities. Historically, New York's early and significant investment in robust housing was intended to provide people a place to live or to offer them an alternative to institutional care. Today there is a new and important purpose for housing: improving health outcomes. The Health and Housing Framework presented in this paper addresses this new goal and suggests the need to operate in three overlapping and equally critical areas for action: 1) Grass-Roots Neighborhood Action; 2) Community-wide Health and Housing Partnerships; and 3) Collective Health and Housing Public Policy, Regulation, and Funding Action. A population health framework inclusive of these areas shares principles, interconnectedness, and accountability. While the framework explicitly focuses on building health and housing partnerships that will identify housing priorities and actions to improve health outcomes, it is reasonable to hope that the framework can support and align with broader, housing-only efforts (e.g., expanded affordable housing development) that also enhance population health.

Critical Areas for Health and Housing Action

Grass-Roots Neighborhood Action

Health and housing are inherently local. Population health strategies build on community assets, networks, partners, and priorities. Faith communities, businesses, and community leaders bring relevance and significant resources to health and housing solutions.

Potential Actions

Gather local stakeholders to prioritize community needs, map their resources, and respond in contextually relevant ways.

Community-Wide Health and Housing Partnerships

Consortia comprised of health care, public health, and housing organizations working ideally at the borough-wide level, form connections between health and housing public policy and neighborhood-led efforts. While consortia should reflect community needs and capacities, there are defining characteristics for success: facilitation by a neutral convener; operation at a scale that is both efficient and influential; data-informed intervention development; and supporting collaboration and coordination of efforts.

Potential Actions

Use data and borough-based expertise and service providers to spot a health and housing trend early, identify a solution, and target resources to intervene.

Collective Health and Housing Public Policy, Regulation, and Funding Action

To promote sustainable population health improvement, neighborhood and consortia activities must inform broader policy changes that support activities at the intersection of health and housing. This will require a collective health and housing public policy, regulation, and funding action to collaborate on assessing and rethinking payment models and service eligibility across programs and sectors. A working group of stakeholders and policymakers would be well positioned to scale population health strategies through health and housing policy adjustments and funding flexibility, with ease of access to services and health outcomes as core performance metrics. While regulatory reform would achieve scale more quickly, even small wins in this area could generate improvement in health outcomes and government return on investment.

Potential Actions

Engage a multidisciplinary, stakeholder working group to streamline and modernize health and housing policy to support population health goals.

Background

New York City is facing a housing and homelessness crisis. Record-setting numbers of individuals used the homeless shelter system in 2019, while placements in supportive housing reached a 14-year low.[5] More than a quarter of City residents (and growing for the lowest-income New Yorkers) face a severe rent burden, due in large part to a lack of affordable housing stock—45% of New York City rental households pay 30% of their income toward rent, and nearly 30% are severely rent burdened, paying more than 50%.[6] Some low-wage and extremely low-wage workers (those in households with incomes between $10,000 and $20,000 annually) pay nearly 75% of their income toward rent.[7] At the same time, many New Yorkers live in low-quality housing. More than 11% of all New York City housing has three or more maintenance defects, and among rental properties that proportion is nearly 15%.[8] In addition, relatively few new housing units are available. Since 2009, New York City's population grew by 500,000, but only 100,000 new housing units came to market.[9] Currently, the ratio of eligible households that are very- or extremely low-income to affordable housing units is just over two to one.[10]

Both homelessness and housing insecurity are known to have detrimental effects on health outcomes. Individuals who are chronically homeless are susceptible to higher rates of chronic disease and present with more advanced conditions at a younger age than non-homeless individuals.[11] Housing-insecure individuals and those who live in substandard housing also have increased morbidity and mortality rates due to both chronic and infectious disease—as well as higher risks for mental health effects, such as anxiety—that result from their housing status.[12] These effects add to more general socioeconomic stressors that hinder health and drive health disparities.[13,14]

There is increasing recognition in the field that the intersection of both individual and population level health with housing needs plays an outsize role in the ability of both sectors to best meet the needs of City residents. There is also a growing impetus to address these needs because of their effect on health care expenditures. Health care stakeholders—including the Medicaid program, commercial insurers, and health care provider systems—are paying closer attention to the effect of housing needs on health care utilization and costs, often as part of broader efforts to address a range of social needs that drive up to 40% of health outcomes.[15,16] Current interventions in health and housing are concentrated around housing instability, safety, quality, affordability, and neighborhood characteristics and conditions, particularly regarding health care outcomes and health care system utilization and costs.[17,18]

Using a partnership model to address some of the causes and symptoms of the housing crisis presents a unique opportunity for public, private, and nonprofit sectors to work together to improve both the health and housing status the most vulnerable New Yorkers. In addition to the 62,000 individuals experiencing homelessness,[19] children, older adults, low-income families, individuals living with HIV/AIDS, and racial and ethnic minorities are all more susceptible to the negative health outcomes caused by housing instability.[20] Given the various population segments affected, there are opportunities for interventions

at multiple levels to address these issues and eventually inform policy development around health and housing.

Cross-sector initiatives and investment in health and housing interventions are appearing in New York City and State and the rest of the nation with increasing frequency. Medical respite programs,[21] supportive housing development and placement programs,[22] and home environment and defect maintenance initiatives have all begun to produce outcomes and become models for similar initiatives that could spread to more locations across the city and state.[23]

Health and Housing Partnerships in New York City: Current Context

In October 2019, UHF undertook a broad environmental scan of health and housing initiative strategies around New York City. After a series of key informant interviews, a targeted review of relevant literature, and an exploration of City data on health and housing indicators, UHF convened a roundtable of health and housing stakeholders from across New York City to discuss current efforts and future opportunities. The conversation revealed key components, challenges, and opportunities for successful health and housing collaborations. Stakeholders agreed that the process of community assessment and engagement must be equitable and must also identify and mobilize existing assets within the community (i.e. an "assets-based approach). Participants also emphasized the importance of recognizing resource imbalances between health care, housing, and human services stakeholders. Simply put, contributors did not feel that health care and housing were equal partners in terms of resources, investment, and reimbursement. Stakeholders also indicated that new models for distributing resources, with lower thresholds for funding, were necessary to enable community-based organizations to engage with patients and clients. Participants longed for "whatever it takes money" in the form of unrestricted funds to resolve immediate issues in the populations they serve.

The complexity of health and housing issues and the multi-stakeholder systems that help address these needs reinforce the need for "whatever it takes" funding. It also underscores the notion that a one-size-fits all approach to health and housing collaborations may not be the best approach. Rather than creating and following a single rubric for addressing health and housing issues in the community, partnerships could benefit from guidance on framing, tracking, evaluating, and communicating their efforts in order to strengthen their own self-advocacy and empowerment. Such a framework is consistent with assets-based community development strategies that help local initiatives:

- Facilitate asset mapping and service and resource gap analysis
- Foster network development between community service providers
- Invite input from a range of community members, working toward equitable representation
- Build consensus to amplify messages and develop community power

Roundtable participants spoke of the value of several health and housing collaborations in New York City. These multi-stakeholder initiatives work to identify and respond to a range of issues around housing instability and quality by convening networks of providers and offering training and technical assistance to partner organizations. For example, the Bronx Health and Housing Consortium, established in 2011, has worked to streamline client access to health care, housing, and medical respite (see sidebar). In 2017 it expanded its operation to Brooklyn, helping to establish the Brooklyn Health and Housing Consortium, led by NYU Langone Health, which works on addressing housing instability and health status issues among its patients. Programs like those administered by the consortia seek to improve client and patient services by training staff, sharing information and resources, and advocating for community-wide improvements in the management of their clients and patients.[24]

Bronx Health and Housing Consortium

Established in 2011, the Bronx Health and Housing Consortium works to streamline client access to health care and housing. The Consortium convenes a network of over 70 member organizations, including hospitals, health homes, community-based organizations, managed care plans, and government agencies. Acting as a neutral convener and facilitator, the Consortium provides members with services like research and advocacy, training and technical assistance, and facilitation of cross-sector collaboration. In 2017, with support from NYU Langone Health's Community Service Plan, the Consortium began a planning process to spread its health and housing partnership model to Brooklyn.

The Bronx and Brooklyn consortia have collectively trained over 500 health and housing stakeholders on various topics, such as eviction prevention, permanent supportive housing, and homeless services and referrals. The consortia have also facilitated intensive interagency case conferences to improve coordination between emergency departments, supportive housing providers, homeless services and social services.

Notable activities of the Bronx Consortium include research and advocacy work like the Hospital Homeless Count, a census of unsheltered homeless individuals in hospital emergency departments; the development of a Medical Respite model and regulatory framework for consideration by New York State; and the Bronx Frequent Users of System Engagement project (see sidebar on following page). Among its training and technical assistance activities is the facilitation of housing marketplaces for care coordinators and hospital social workers to meet and conference with housing providers on eligibility requirements, referrals, and potential placements for their patients and clients.

In general, initiatives billed by health care entities as focusing on the social determinants of health may be better described as targeted programs focused on individual-level, health-related social needs for specific sub-populations of their patients. These efforts often lack the means to aggregate and communicate the outcomes of the various initiatives across a geographic area, making it difficult to assess effectiveness and impact and promote broader spread. Borough-based partnership models, such as health and housing consortia, can be helpful actors in organizing a crowded field of individually run programs and initiatives. Roundtable participants underscored the value of the consortia approach as providing important functions like neutral convening, strategic planning, and outcome aggregation (details in accompanying sidebars). Such partnerships, potentially building on existing efforts described in the accompanying examples, could translate many stakeholders' interventions on health-related social needs into broader population health strategies that also inform needed policy change.

Health and Housing Collaboration Barriers

Several evergreen challenges complicate neighborhood and borough-wide efforts to address health and housing in New York City. First and foremost, the general lack of adequate affordable housing is a serious barrier to housing more vulnerable New Yorkers. Second, eligibility criteria and program requirements for the myriad State and City housing programs are confusing at best and opaque at worst, frustrating stakeholders who struggle to efficiently connect patients and clients with the most appropriate housing, services, and supports. Third, numerous affordable housing programs have barriers to entry that exclude many individuals experiencing homelessness, increasing their risk for chronic homelessness. Fourth, the significant underinvestment in the human services sector (i.e. low wages, low operating margins, reliance on ever-decreasing government contracts) has likely contributed to the ongoing confusion experienced by referring entities; this confusion stems in part from a churn in the workforce and disruptions caused by the frequent onboarding and training of new employees.

Bronx Frequent Users System Engagement (FUSE)

The Bronx FUSE initiative, led by the Corporation for Supportive Housing, the Bronx Health and Housing Consortium, and the Bronx RHIO (Regional Health Information Organization) works to better understand the complex needs among high utilizers of health systems, especially individuals experiencing homelessness. Matching Medicaid claims data, Department of Homeless Services data, and other health care utilization data, Bronx FUSE conducts cross-system analyses to engage stakeholders like managed care organizations and community-based social services providers in partnerships that prioritize cases for intervention. The goal is to reduce service utilization and cost of care by providing supportive housing and services to very vulnerable people.

Bronx FUSE's targeting of homeless high-utilizers—combined with the intensive, cross-system collaboration required to manage this high-cost, high-need population—is intended to demonstrate this approach's potential to develop value-based partnerships. This initiative is also an example of the kind of data sharing and data transparency challenges that can hinder a partnership's ability to address health-related social needs throughout the health care and human services systems. At the same time, it clearly identifies these issues and, in so doing, helps make the case for new and revised policies around cross-sector information sharing that could promote collaborative and cost-effective models of care.

Roundtable participants and key informants also suggested that misaligned expectations of services and benefits were major contributors to the complexity of, and confusion in, health and housing initiatives. Health care providers expressed a lack of understanding of the various programs in housing and human services. Indeed, housing and human services providers agreed that health care providers are often unclear on the eligibility criteria, the timeline from referral to service delivery, the scope of services provided by the organization administering the program, and their capacity to take on more referrals. Stakeholders noted that gaps between expectations and reality contributed to inappropriate or inefficient referrals as well as frustration between the health care providers making referrals and the social service providers receiving them.

Increased attention to social determinants of health has also increased the demand for social needs services, often provided by human services agencies and community-based organizations. Chronic underfunding of human services raises concerns about the capacity to absorb the increased demand for referrals and provide needed services. Furthermore,

data transparency and data-sharing limitations between health care and human services organizations introduce costly barriers to case conferencing and client information sharing, making the closure of referral feedback loops challenging.

Stakeholders made several recommendations to address the complexity of health and housing initiatives and some of the persistent problems that strain their already limited resources, such as:

- Development of mutual definitions of populations and their needs to reflect changes in the service delivery and payment/financing systems
- Standardization of screening and referral processes to ensure providers in a related service area are operating under the same assumptions
- Inventory and organization of existing community assets to assess and identify gaps in services
- Development of methods for health care and housing providers to case conference and collectively advocate for high-risk patients and clients
- Development of best practices for the retention of institutional knowledge around health and housing initiatives and referral processes to help limit delays caused by employee churn
- Development of an advocacy agenda to amplify stakeholders' voices on evidence and outcomes to influence policymakers
- Investment in the development of a universal policy around data sharing and transparency between health care and human services organizations that receive referrals for intervention services

> "A patient in Camden, New Jersey's coalition hot-spotting initiative told a nurse that one thing would keep him out of the hospital: housing."
>
> Gorenstein D and Walker L. January 8, 2020. Reduce Health Costs by Nurturing the Sickest? A Much-Touted Idea Disappoints. *Kaiser Health News*. https://khn.org/news/lower-health-care-costs-by-helping-the-sickest-a-much-touted-idea-disappoints/

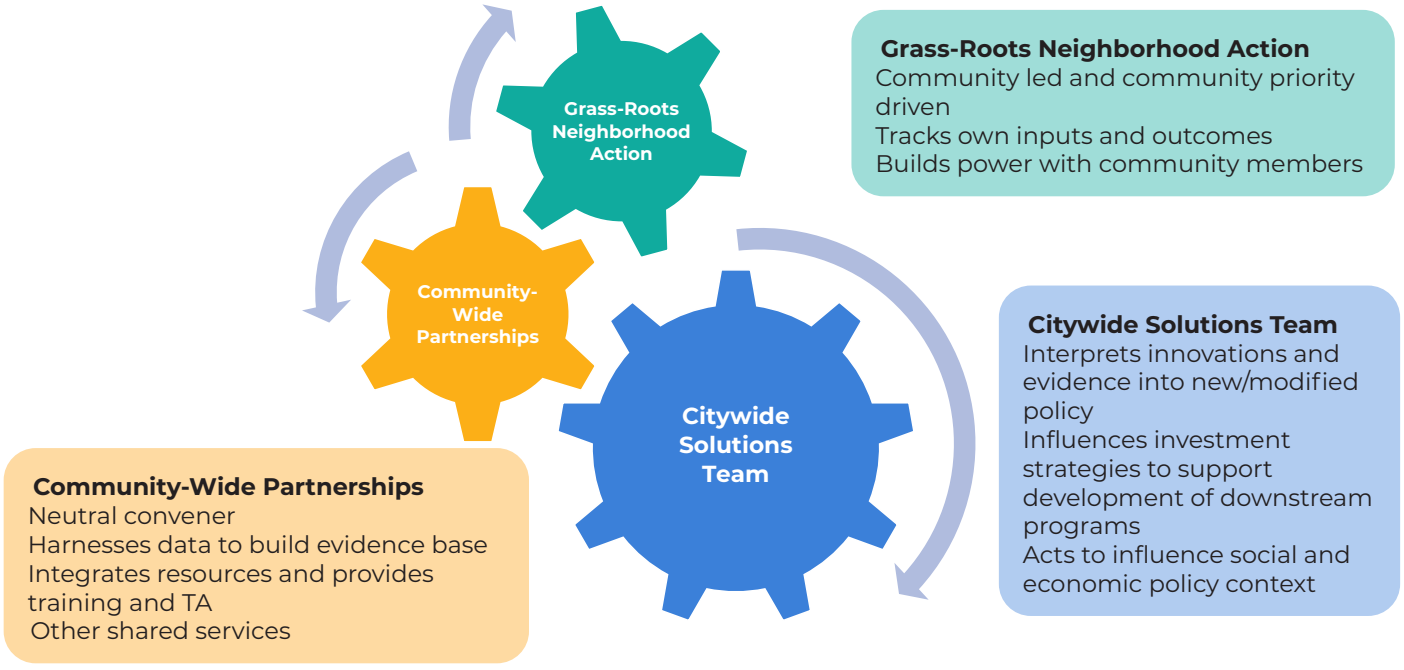
Participants in UHF's roundtable on health and housing acknowledged the work of government, health care and housing providers, and communities to reduce the number of homeless individuals, increase affordable housing, and pursue innovations with medical respite, among other housing efforts directly tied to improvement in health outcomes. From actions that would make optimal use of current resources as quickly as possible to disruptive innovations that are necessary to modernize the approach to health and housing, their feedback and suggestions inform a powerful vision for what could be.

The Road Forward: Framework for a Population Health Approach to Health and Housing Partnerships

Building on the lessons from the research and discussions described above, we propose the creation of a unifying and feasible health and housing collaboration framework as well as recommendations for action. Many of the concepts in the proposed framework derive directly from a series of exercises conducted during the roundtable to elicit a vision for the future and immediate next steps for getting there.

A successful health and housing framework must deliver results at scale. The three operational areas outlined below are rooted in research and recommendations from roundtable participants. The three areas for action—Grass-Roots Neighborhood Action; Community-wide Health and Housing Partnerships; and Collective Health and Housing Public Policy, Regulation, and Funding Action—harness unique skill sets by clarifying roles, acknowledge interdependence versus hierarchy, and help maximize capacity. Inefficiency and poor outcomes are common in complex systems that lack a clarity in roles. Each action area in the health and housing framework defines clearly articulated roles, which will contribute to increased access to safe and affordable housing. The framework also recognizes that all action areas are mutually reliant on one another and that it is unlikely any one can be successful without coordinating and sharing information with the others. By identifying shared services, recognizing grass-roots resources, and focusing public investment, the framework challenges current thinking on the capacity required to activate change at scale.

Three Interdependent Areas for Action



Area 1: Grass-Roots Neighborhood Action

All health care is local, and housing is by its very nature local. Locally controlled and operated initiatives and partnerships are adept at identifying their community's assets, needs, and priorities. These may include any number of business, faith-based, and community leaders. Grass-roots action often occurs at drop-in centers, food pantries, settlement houses, and supportive housing providers. Local organizations and their activities are typically mission driven, making the inclusion of local leaders in the governance and operation of the local stakeholder network critical. Convening grass-roots neighborhood action networks with locally led governance strategies helps ensure continuous engagement with those individuals and organizations with firsthand knowledge of the neighborhood's conditions and priorities, and ongoing service gaps and educational needs. To the extent possible, grass-roots neighborhood action networks should coordinate with existing coalitions on health and housing, as well as engage with the New York City Department of Health and Mental Hygiene's Neighborhood Health Action Centers. These centers help connect community programs and services and create spaces for community groups to work and coordinate neighborhood health improvement strategies.

By leveraging existing expertise, services, and training capacity, grass-roots networks can reduce duplication of effort and optimize efficiency in environments that are often underfinanced or otherwise resource poor. The roles of grass-roots neighborhood action networks include community mobilization; conducting community asset mapping, service inventories, and needs assessments; responding quickly to low-cost/high-return needs (e.g., providing a meal and a blanket); and engagement of credible messengers. Action at this level could be a launching pad for local health and housing consortia, providing insight into the resources available within the community, leveraging existing expertise, and streamlining available services to maximize efficiency and fill in any gaps. Such community-participatory models have proven to be effective in assessing and prioritizing the needs of a community, helping to improve neighborhood safety, cleanliness, and, in some cases, traffic. These efforts could easily expand to encompass health and housing improvements, which would help make the case for broader adoption and influence policy development.

Area 2: Community-Wide Health and Housing Partnerships

Overcoming health and housing challenges requires organizations to collectively understand the need for and promise of neutral consortia that can act as the connection between grass-roots neighborhood action and governmental leadership. The consortia are not intended to infringe upon the autonomy of the many community-based organizations, health systems, housing providers and businesses who operate in each of the five boroughs. Rather, this neutral convener seeks to promote meaningful use of data across the borough, act as an innovation incubator, enhance coordination among existing resources, and reduce redundancy in the need for evaluation and data systems; it is also a borough-based leader in identifying and understanding community-level conditions affecting health and housing.

Previously noted promising efforts of the existing borough-level health and housing consortia suggest an expansion of this approach to other boroughs could provide the infrastructure and capacity necessary to deliver on projects that improve the lives of borough residents. These consortia may operate as conveners of multiple local partnerships, aggregating organizations, people, and resources for the mutual benefit of all the stakeholders (see "Consortia Governance Approaches," below). In addition to providing the organizational structure to identify community and stakeholder needs and develop projects to address those needs, the consortia itself, in some models, may be able to offer services to its participating members to help ensure project success. Collectively, borough-level consortia could share best practices and challenges, collaborate on region-wide strategies, and advocate for additional resources to the benefit of residents and organizations serving those residents across the region.

Critical capacities for borough-level health and housing consortia include:

1. **Neutrality.** Consortia must be managed in ways that are responsive to all stakeholder groups without privileging the needs of one group or stakeholder's agenda above any others.

2. **Dedicated staff.** To achieve the identified role for borough capacity building, a dedicated cadre of staff will be required.

3. **Programmatic, policy, and stakeholder knowledge.** Just as credible messengers and individuals with lived experience are critical to the governance and functioning of grass-roots initiatives, expertise in program operations and policy and regulatory issues—as well as knowledge of the stakeholder community—are important for the smooth functioning of consortia. Such expertise helps leaders achieve buy-in from members and other stakeholders in the programmatic and policy environment that the network will act in or attempt to influence. One strategy for reinforcing this expertise and credibility is to include, wherever possible, community members and recipients of services from stakeholder organizations as consortia advisors or as part of the governance structure.

Area 3: Collective Health and Housing Public Policy, Regulation, and Funding Action

The roundtable informing this report made clear that despite many dispersed convenings on various projects and bigger picture policy issues, there was no one consistent place for stakeholders to discuss and develop health and housing policy solutions. While the focus of UHF's effort is supporting more operational partnerships, the model described above could also support filling the gaps in collective opportunities to inform policy. This would not only enhance individual partnerships but create possibilities for addressing the underlying community conditions necessitating those partnerships in the first place. Regardless of how stakeholders continue to pursue health and housing partnerships on the ground, they will be developing experience that can and should inform policymaking

at the city and state level. Aggregating that experience and turning it into workable policy proposals could be done individually by the participants described in each level above but would likely be more effective if it were pursued through a shared approach. A team or workgroup addressing collective health and housing public policy, regulation, and funding action could be regularly convened to discuss shared opportunities and challenges. It could also develop ideas for policy, regulatory, or government operational changes necessary to make the most of opportunities and overcome obstacles. Given the unique health and housing needs in New York City, a citywide working group (hereafter Citywide Solutions Team or Team) likely makes the most sense, but that group could also coordinate with efforts across the state when priorities align.

There are numerous potential approaches for creating and supporting a collective health and housing policy, regulation, and funding action team. Three options seem most likely:

1. **Citywide Consortium.** If a citywide health and housing consortium emerges as described in the "Consortia Governance Apprroaches" sidebar, it could be a natural convener of a Citywide Solutions Team. The consortium would need to include individuals and organizations beyond its own members/participants on the Team. While the consortium might consider itself a neutral convener for purposes of Team deliberations, it would also be well positioned to champion policies developed by the Team and advocate with policymakers on issues the Team identified as important.

2. **Independent Convener.** There are several organizations across the city well known for their capacity to neutrally convene working groups and develop materials and policy prescriptions based on those discussions. While this model offers the benefit of a truly independent organization doing the convening, the convener would not necessarily be best positioned to advocate with policymakers.

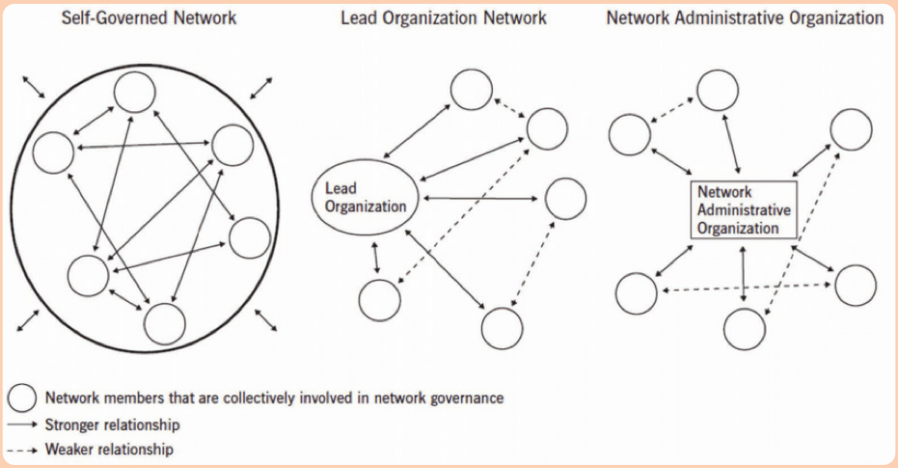
3. **City Government.** New York City government agencies have a long history of convening working groups, and multiple agencies are already actively engaged at the intersection of health and housing in the City. A single agency or a collaboration of agencies could convene a Citywide Solutions Team, but that approach could come with both benefits and limitations. A City-convened Team might be able to tackle some administrative issues without additional policy development and advocacy. However, the City might be unable to facilitate a neutral conversation about its own policies and operations and might be more or less interested than Team members in pursuing specific policy changes at the state level. Regardless, there are likely City officials that should be included on the Team however it is convened.

Both housing and health policy are complex and often seem intractable, but they can be advanced with a combination of expertise, explanation of on-the-ground conditions, and support from stakeholder organizations and the community. A Citywide Solutions Team would ultimately need to define its own charge and actions, but there are numerous possibilities for the type of work the group could undertake. Efforts by the Team must

Consortia Governance Approaches

There are three basic governance structures that could be used to support a consortium, each suited to different organizational demands.

Self-governed/shared governance. These consortia tend to be small, with decision-making spread across the membership and driven by consensus among organizations with similar needs and interests. Technical assistance and other management functions are not critical parts of the governance functions, which may limit the depth and breadth of projects possible in a self/shared governance health and housing consortium.



Lead Organization. Consortia with lead organizations have moderate numbers of members with various goals, with some occasionally already functioning in partnerships. A primary function of the lead organization in this governance structure is the convening and facilitation of the consortia. Decision-making is centralized in the administrative functions that the lead organization provides to or on behalf of the other member organizations. Lead organizations often emerge from central entities with more access to resources or more frequent exposure to the issue being addressed; the issue may relate, for example, to clients or patients served by large social services or health care organizations. As a result, lead organization governance structures may occasionally be challenged by questions of power imbalance or neutrality among its network members.[25]

Consortia Administrator. The consortia administrator model provides significant administrative, facilitative, and technical assistance functions to members of the community. Decisions are made centrally and brokered by the administrator, who acts as a neutral party. Administrative and facilitative functions include contract and business development, resource sharing and education, data aggregation and evaluation, communication, strategy development, and policy advocacy.

Nationwide, community-level efforts that bring together health care and other sectors to improve the health and socioeconomic conditions of specific geographies are proliferating. These models unite community members with the organizations serving their communities and foster collaboration around specific issues or broader community health improvement. Lessons from these efforts suggest that one strong organization should serve as a backbone, offering accountability to its participating stakeholders and the community as a whole as well as providing the core infrastructure and support to projects and partnerships at both the community-wide level and in sub-geographies of the community. In New York City, it might be feasible and even advisable to develop a citywide consortium using the administrator model which could be comprised of multiple community- or borough-level consortia that could be organized under any of the three governance models.

Figure source: Network governance archetypes, adapted from Provan and Kenis (2007) in Popp et al., 2015.

be informed by, and inform, work at the borough and grass-roots levels. This will enable the Citywide Solutions Team to work in two broad modalities: 1) refining access to and services within the health and housing systems; 2) and influencing overarching health and housing policy, which can address root causes of housing insecurity and poor health outcomes, such as housing affordability. The Team could develop policy proposals ranging from streamlining existing administrative requirements to big, new programs that might require substantial City or State investment.

While developing these policy ideas, it is likely that the Citywide Solutions Team would identify interim operational improvements for existing efforts that could be feasible and helpful even in the absence of policy change. Once the policy is developed, the Team convener or its individual members or downstream partnership participants may be asked to advocate for the policy. A Citywide Solutions Team could also consider supporting the underlying efforts of a citywide consortium and lower-level partnerships by developing collaborative proposals for philanthropic or government support of ongoing health and housing efforts in the community.

Recommendations

As described in this report, there are many examples of organizations and initiatives taking action at the grass-roots and community-wide levels. This work leverages local expertise, continuous community engagement, and capacity for training and resource sharing to make an impact on health and housing outcomes for constituents.

The recommendations that follow assume robust and growing action at the grass-roots and community-wide levels, and therefore focus on leveraging and supporting these efforts through a collective focus on policy, regulation, and funding to support health and housing improvements. Emergent grass-roots neighborhood action and community-wide health and housing partnerships should have a well-developed sense of their local organizations' resources, services, and capacity to deliver them. By conducting community asset mapping and needs assessments, grass-roots and community-wide partnerships can identify and engage many stakeholders and raise awareness about otherwise unrecognized resources. Guides like "What Housing Resources Exist for My Patients: A Guide for NYC Healthcare Providers"—while written primarily for an audience of health care practitioners—provide helpful framing on the key types of resources available, the categories of services they fall into, and directories of where and how to find such services. This information augments, but is not a substitution for, the expertise of local leaders. The *Community Data Snapshots* included in Appendix B of this report are examples of how health and housing indicators (identified in a needs assessment) and community resources (found through asset mapping) may be synthesized to plan community-specific strategy and action.

As noted above, there is a desire among health and housing stakeholders for a consistent opportunity to come together and develop policy solutions to address root causes of housing related health outcomes (such as housing affordability) and the underlying systemic challenges that create inequities in access to affordable housing (like persistent residential segregation). To that end, we recommend the creation of a Citywide Solutions Team to address shared opportunities and challenges, explore promising practices among existing health and housing partnerships, and develop ideas for policy, regulatory, or government operational change. Once established, the collective Citywide Solutions Team should pursue the following short-term and intermediate policy actions.

Near-Term Health and Housing Agenda

As an inaugural activity, the Citywide Solutions Team should focus on supporting and facilitating the implementation of the health and housing framework identified in this paper. Specifically, this would mean helping form, fund, and socialize the Grass-Roots – Neighborhood Action and Community-wide Health and Housing Partnerships. The Team should work to align and simplify access to current housing services and supports between hospitals, health providers, specialty care, community leaders, and housing services. This can be achieved through the creation of referral pathways and tools. Critical elements include incorporating all ages and specialties in housing pathways; aiming for a first-time referral to the optimal, available housing resource; and creating a tool for a real-time view of housing stock and current inventory by borough/region and housing type (market rate, affordable, transitional, homeless, population specific).

While expansion of affordable housing is critical, there are measures that could improve access to current housing. Adoption of a universal referral format and shared application systems would promote the goal of achieving a first-time referral to the optimal housing option. A universal application system would also improve data tracking, needs assessments, and the ability to hold parties accountable. As an analogue, individual City/State Agency patient prioritization algorithms have become exceptionally complex and at times contradictory. Looking at housing prioritization through a shared lens would promote population health and offer greater clarity to communities striving to improve health through greater access to housing. The Citywide Solutions Team should also, wherever and whenever possible, support actions to mitigate or remove barriers to housing through eligibility expansion and elimination of the ability to refuse housing to people with substance use disorder and criminal justice involvement.

Intermediate-Term Health and Housing Agenda

Harnessing data is essential to improving health outcomes through housing. The Citywide Solutions Team should seek inventive and cost-effective ways to identify priority health and housing actions through predictive analytics. It should also develop performance metrics for housing, housing support, and care management interventions that include outcomes focused on health improvements resulting from housing placement and supports. Working with grass-roots and borough colleagues, the Team should identify high-impact

health and housing regulatory relief priorities, with a defined implementation workplan of 12–24 months. The Team should consider policy and regulatory timing and opportunities to incorporate needed health and housing changes within both ongoing and future Medicaid redesign and waiver proposals and in the implementation of the Executive Order from Governor Cuomo for "Health in All Policies."

Conclusion

Taking a population health approach to solving daunting health and housing challenges is a difficult but worthwhile endeavor that has the potential to improve the health and quality of life for some of New York's most vulnerable residents. Successfully addressing interrelated health and housing needs will require true collaboration on multiple fronts: the health care and housing industries, providers of social services, and community members must all be at the table to plot a way forward that is sensitive to community needs and lets communities lead. Success will also require that health and housing are included in multiple ongoing policy discussions—especially any continuation work extending from the Medicaid Redesign Team II effort, given that the populations most in need of health-related housing supports are likely those enrolled in Medicaid. We hope this report and the proposed framework provide already dedicated stakeholders a clear path forward to enhanced collaboration in meeting the needs of New Yorkers.

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