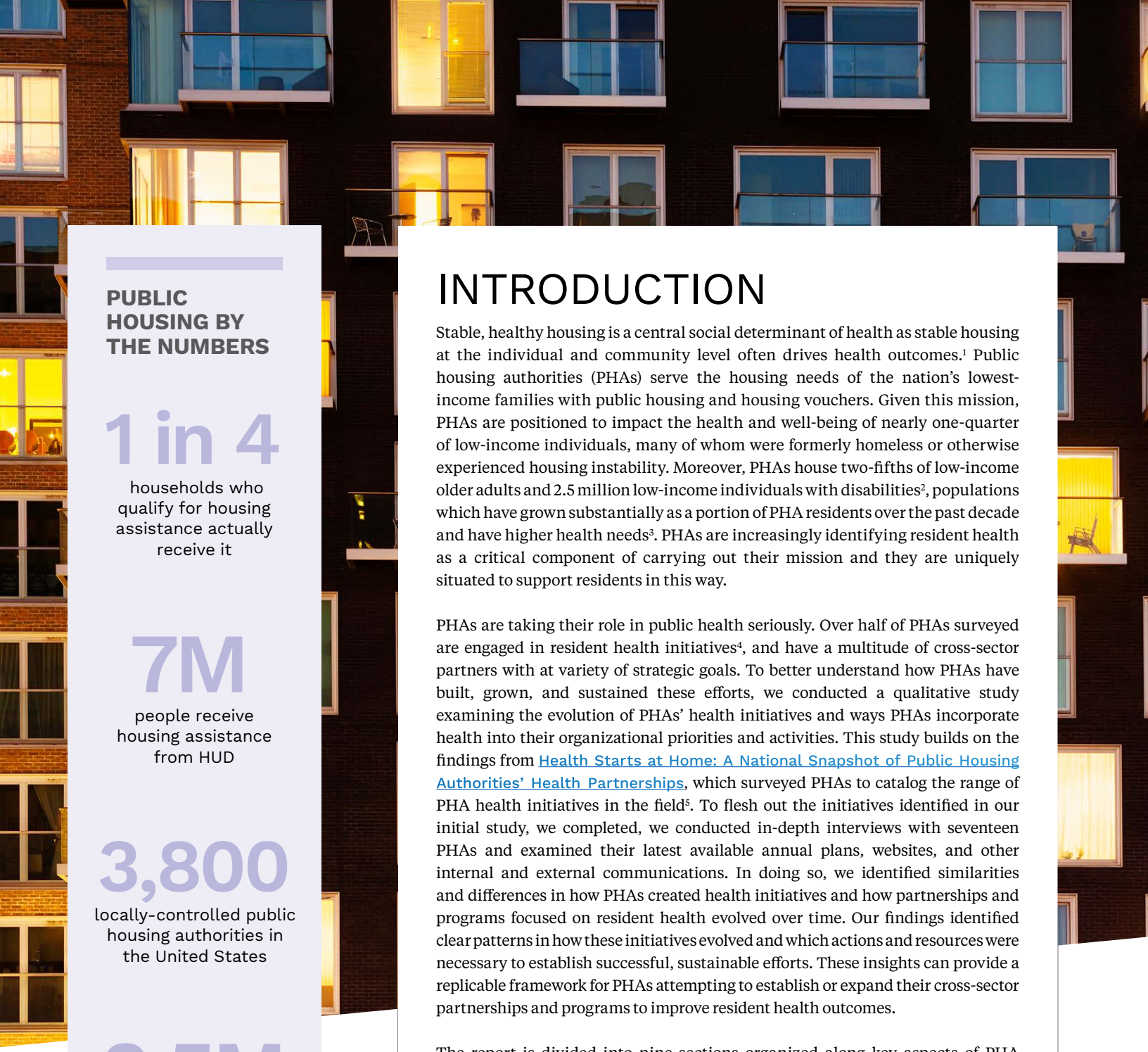
Strategize, Start, Sustain

The Evolution of PHA Health Initiatives

CLPHA PAHRC℠

2020



PUBLIC HOUSING BY THE NUMBERS

1 in 4

households who qualify for housing assistance actually receive it

7M

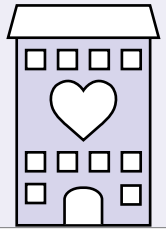
people receive housing assistance from HUD

3,800

locally-controlled public housing authorities in the United States

3.5M

housing units PHAs manage nationwide



INTRODUCTION

Stable, healthy housing is a central social determinant of health as stable housing at the individual and community level often drives health outcomes.[1] Public housing authorities (PHAs) serve the housing needs of the nation's lowest-income families with public housing and housing vouchers. Given this mission, PHAs are positioned to impact the health and well-being of nearly one-quarter of low-income individuals, many of whom were formerly homeless or otherwise experienced housing instability. Moreover, PHAs house two-fifths of low-income older adults and 2.5 million low-income individuals with disabilities[2], populations which have grown substantially as a portion of PHA residents over the past decade and have higher health needs[3]. PHAs are increasingly identifying resident health as a critical component of carrying out their mission and they are uniquely situated to support residents in this way.

PHAs are taking their role in public health seriously. Over half of PHAs surveyed are engaged in resident health initiatives[4], and have a multitude of cross-sector partners with at variety of strategic goals. To better understand how PHAs have built, grown, and sustained these efforts, we conducted a qualitative study examining the evolution of PHAs' health initiatives and ways PHAs incorporate health into their organizational priorities and activities. This study builds on the findings from Health Starts at Home: A National Snapshot of Public Housing Authorities' Health Partnerships, which surveyed PHAs to catalog the range of PHA health initiatives in the field[5]. To flesh out the initiatives identified in our initial study, we completed, we conducted in-depth interviews with seventeen PHAs and examined their latest available annual plans, websites, and other internal and external communications. In doing so, we identified similarities and differences in how PHAs created health initiatives and how partnerships and programs focused on resident health evolved over time. Our findings identified clear patterns in how these initiatives evolved and which actions and resources were necessary to establish successful, sustainable efforts. These insights can provide a replicable framework for PHAs attempting to establish or expand their cross-sector partnerships and programs to improve resident health outcomes.

The report is divided into nine sections organized along key aspects of PHA health initiative development. It concludes with lessons learned for PHAs looking to start or grow their current resident health initiatives.

I. Beginning PHA Health Initiatives
II. Evolution of Health Partnerships
III. Evolution of Organizational Structure
IV. How PHAs Leverage Funding and Resources
V. Sustaining Initiatives
VI. Overcoming Challenges
VII. Barriers to Health Initiatives
VIII. Future Health Initiative Goals
IX. Lessons Learned: How to Start Health Initiatives

Method

To understand the evolution of PHA health partnerships and initiatives, we conducted semi-structured interviews with seventeen PHAs. The PHAs were selected by size, region, and the presence of an internal health initiative[6], which was determined from our 2018 survey on PHA health initiatives and partnerships[7]. Based on that survey, thirteen of these PHAs were originally thought to have ongoing health initiatives and four no ongoing initiatives. However, after interviewing the PHAs, we found that fifteen PHAs had active initiatives and only two did not. With regard to geographic location, four PHAs were located in the Southeast, four in the Midwest, five in the West, and four in the Northeast, based on the U.S. Census Bureau's four regions[8]. Ten PHAs we interviewed are considered large, 2 medium, and 5 small, based on collapsing the ten size categories developed by the U.S. Department of Housing and Urban Development (HUD)[9].

We spoke with PHA staff by phone from fall 2019 through early spring 2020. Interviews generally lasted one hour. Participants were led through a series of questions about their health initiatives, ranging from their partners and strategic goals to the ways in which their resident health activities have evolved over time. PHA interviewees included executives, strategic planning directors, resident services leadership, and frontline resident services staff. Few PHAs had staff specifically dedicated to health initiatives, but many noted that specific staff members had resident health initiatives included in their job responsibilities. Respondents often participated on the call in groups. Interview notes were coded for common themes. We also examined PHA websites to find relevant documents like strategic plans, annual plans, and mission statements as well as documented service offerings.

FIG. 1: **Sample Distribution by Size and Region**

	SMALL	MEDIUM	LARGE
NORTHEAST	**2**	**1**	**1**
MIDWEST	**1**	**0**	**3**
SOUTH	**0**	**1**	**3**
WEST	**2**	**0**	**3**

About *Housing Is*

CLPHA's *Housing Is* Initiative helps establish, broaden, and deepen efforts to align affordable housing, education, and health systems to produce positive, long-term results. We are building a future where systems work together to improve life outcomes for low-income people. **Learn more at HousingIs.org.**

I. BEGINNING PHA HEALTH INITIATIVES

Fifteen of the PHAs interviewed had resident health initiatives in place. While the type of programs offered varied widely among PHAs, there were similarities among how their initiatives started. The most commonly reported catalyst for health initiatives was resident feedback (12), followed by an outside organization voicing residents' needs (10), a new funding opportunity (7), a community-wide initiative (7), a leadership connection to the health sector (6), and new staff from an external industry bringing a new perspective (4). All PHAs who reported having resident health initiatives were engaged in multiple health-related efforts that were catalyzed by a combination of these factors.

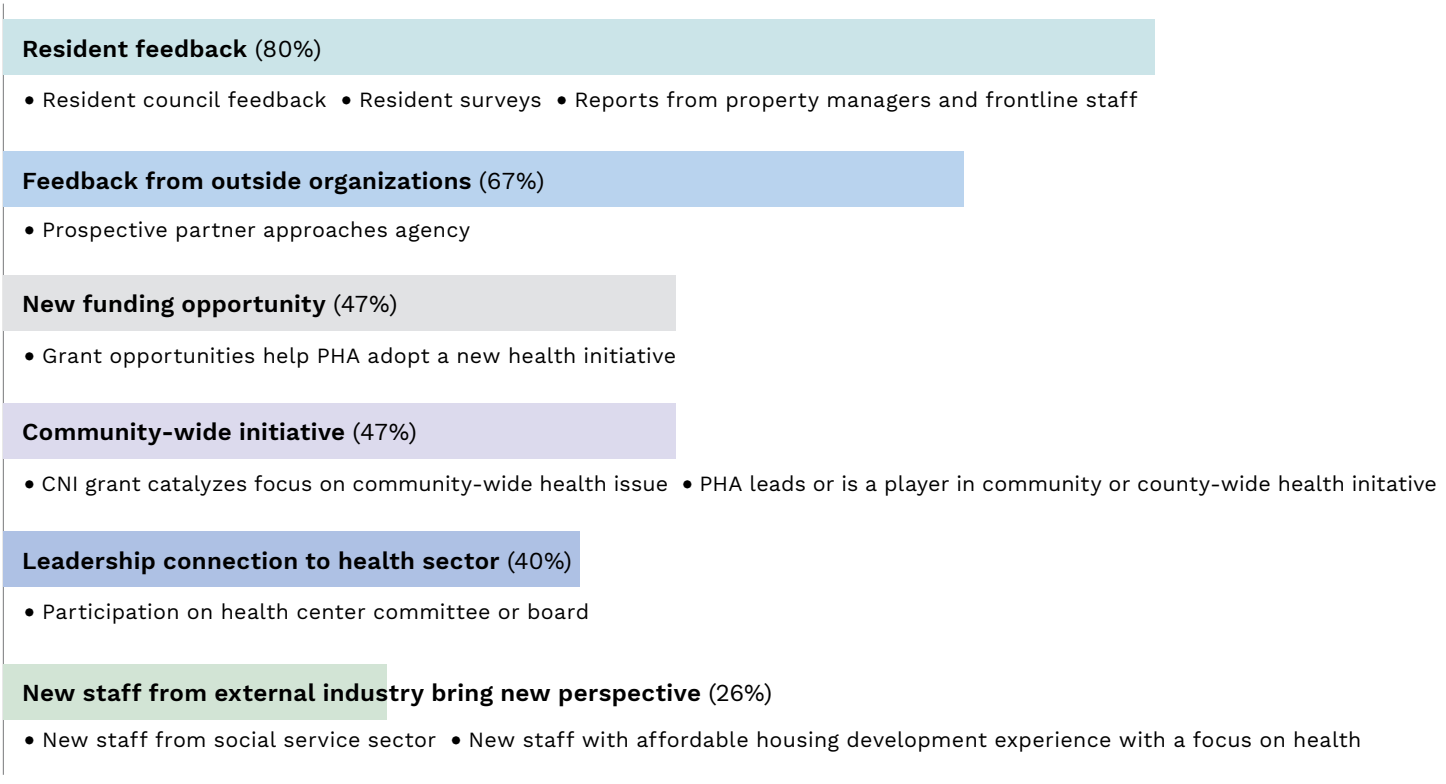
Resident Feedback

Most frequently, health initiatives began in response to residents voicing a need for a service. Twelve PHAs with health initiatives reported that at least one of their health initiatives resulted from resident feedback. PHAs gathered input from residents in a variety of ways, including feedback from resident counsels, resident surveys, and reports from property managers and frontline staff. Many agencies reported using this feedback to convince a prospective or current partner to offer a new program to meet the health needs of their residents. For instance, one agency partnered with a Medicaid health plan (UnitedHealthcare) to create a community health assessment tool to learn about challenges and identify needs of residents living within specific properties. Feedback from these assessments uncovered the diversity of languages spoken by residents and their overwhelming interest for wellness support, which the PHA was able to incorporate into a future grant application.

Feedback from Outside Organizations

Ten agencies reported that outside organizations were the impetus of their health initiatives. Most housing authorities

FIG. 2: **HOW DID HEALTH INITIATIVES BEGIN?**



reported that they were approached by prospective partners about offering health programming to their residents, such as educational seminars, flu shot clinics, or nutrition assistance. Generally, interviewees recalled that these organizations approached their housing authority because the organizations serve the same clients or want to replicate a program implemented by one of their peers. For instance, a PHA invited a local health clinic visited by many of their residents to a community fair. After becoming acquainted with the housing authority, the regional health center that operated the clinic approached the PHA about developing a formal partnership. This partnership resulted in the establishment of a shuttle route to health clinics, services addressing the mental health of unsheltered families, an onsite health clinic, and an evaluation of the impact of smoke free policies implemented by the agency. However, not all of these pitches resulted in a partnership, as many agencies reported informally factoring in the needs of the residents, the perceived value the program would offer, and the organization's reputation in the community before deciding whether to move forward. In one case, a housing authority declined a partnership with a well-respected medical provider in the community based on resident feedback that the partner was not providing the services they most needed. Beyond being approached by prospective partners, one agency also reported that they were encouraged to start a health initiative after attending a conference that discussed the value of intersectional health partnerships.

New Funding Opportunity

New funding opportunities were another common catalyst for health initiatives, reported by seven PHAs. These funding opportunities were mainly in the form of local, federal, and corporate grants. For instance, numerous PHAs mentioned that they were able to hire service coordinators after securing a ROSS grant or implement a new program targeting a community need using funding received from a local foundation. However, many of these programs are tailored to match the funding opportunities available to them. One agency stated that their programming generally 'follows the funding' and often reflects the goals of local foundations.

Community-wide Initiative

Seven agencies noted that their health initiatives began in response to a community-wide health initiative. These community health initiatives are more common among county-wide housing authorities and generally focus on specific negative health outcomes impacting the region. For example, one PHA partnered with their county to create a behavioral health campus to reduce unnecessary hospitalizations. Additionally, four agencies reported that their focus on community-wide health initiatives was catalyzed by a Choice Neighborhoods grant. One of these agencies reported that a Choice Neighborhoods grant enabled the agency to engage with numerous health partners in the community to promote food access and reduce infant mortality.

The most commonly reported catalyst for health initiatives was resident feedback, followed by an outside organization voicing residents' needs, a new funding opportunity, a community-wide initiative, a leadership connection to the health sector, and new staff from an external industry bringing a new perspective.

Leadership Connection to Health Sector

Six PHAs reported that a connection to the health sector on their leadership team catalyzed a health initiative at their agency. In all cases, these connections were from a member of the leadership team participating on the committee or board of an organization focused on health, such as a local hospital, foundation, or community council. For instance, one Executive Director volunteered for the allocation process at United Way which allowed the housing authority to meet and explore prospective partners in the community. Another housing authority whose Executive Director was on a committee of a local hospital emphasized that cultivating a relationship at the highest level was key to strengthening their partnership with the hospital.

New Staff Bring New Perspectives

Finally, four PHAs stated that new staff from external industries, such as social work, community development, and healthcare, ignited their health initiatives. Some agencies, particularly Moving to Work (MTW) agencies, are attracting staff from the social service or affordable development housing development sector as are other housing authorities that have a long history of health initiatives. These new perspectives propelled the agency to adopt a new approach to serving residents. For instance, two housing authorities hired a new Executive Director that had experience managing an agency with a strong resident services program, which drove the agencies to ramp up their resident service programs.

II. EVOLUTION OF HEALTH PARTNERSHIPS

Partnership can have a variety of meanings for PHAs and their collaborators, from knowing who to call when support is needed to complex, long-standing relationships with shared funding and accountability. In our study, we observed PHAs actively pursuing opportunities with health partners to build programs to benefit residents while also managing the inherent challenges associated with external partners. Factors such as staff turnover, changes in leadership, and unreliability of dedicated funding can pose significant threats to established cross-sector collaborations. Several factors help weather these challenges: Strategic planning and outcome evaluation focused on resident health, deep collaboration activities, such as data sharing, and PHA leadership in cross-sector collaborations.

Deepening Partner Investments

Most often, PHAs mentioned that their partnerships had become more significant as they invested more time or funds into the project. Ten PHAs noted that they had provided funds to shared programs, assigned staff to manage partnerships, or engaged in more frequent and strategic conversations with partners. For example, one agency reported that their leadership team meets with partners regularly and stated that these meetings help raise the profile of the partnership, demonstrate their commitment, and propel the partnership forward. Another agency mentioned that they were able to provide onsite services to residents by paying some of their partners a fee. Many agencies reported deepening their partnerships by demonstrating strong results and significant participation in initial health initiatives.

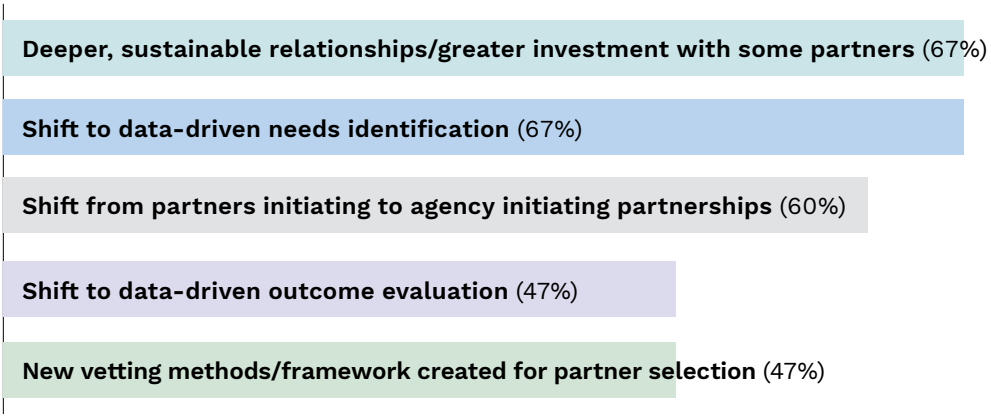
Shift to Data-Driven Needs Identification

Ten PHAs also mentioned that they had moved towards a data-driven, systematic approach to identifying resident needs from a more organic approach, in which needs became apparent through resident contact or through incidents occurring at the PHA. Data were gathered from one-time or annual resident surveys, needs assessments, census information, or other systematic methods. One PHA serving residents county-wide noted that collecting data on resident needs successfully positioned them to make the case to their partners to expand health services offered to residents outside of their central city.

Shift to Agency Initiating Partnerships

Another commonly reported trajectory, noted by nine PHAs, was taking a larger role in initiating partnerships to advance PHA health initiatives and strategy. PHAs reported numerous catalysts that led them to initiate health partnerships including achieving goals set in a new strategic plan, new leadership, relationships formed from mutual involvement on city-wide committees, and unmet resident needs. One agency mentioned that they led a health convening to reach out to the broader community and foster new health partnerships. PHAs may be better positioned to initiate health partnerships if their city or county fosters collaboration across agencies. One PHA interviewed noted that they initiate health partnerships through relationships established in the intra-agency council in their county. By initiating partnerships, agencies are better positioned to select partners and provide services that directly meet residents' needs.

FIG. 3: **HOW DID HEALTH PARTNERSHIPS EVOLVE?**



Shift to Data-Driven Outcome Evaluation

Seven PHAs noted that they had moved from measuring inputs and outputs, such as participation or number of classes offered, to evaluating partnerships based on outcomes related to their strategic goals. Many agencies mentioned that they partnered with a local university to perform an evaluation of specific health initiatives led by the PHA. Agencies with completed evaluations reported using these findings to improve their health programs. Additionally, one agency reported that they are partnering with their local health department to develop a leadership and governance structure to access and share data to make strategic decisions across their sectors to determine which strategies to pursue. Another agency discussed adopting a new framework that prioritizes partnerships that contribute to positive health outcomes. As part of this new framework, the agency emphasized the importance of developing research partnerships to evaluate why residents are participating in programs and what was achieved from their participation.

New Vetting Methods

Seven PHAs described a conscious shift in partnership vetting from accepting services from partners as they were offered to strategically seeking or and vetting partners that would meet a set of pre-determined resident health outcomes. For instance, one agency reported that they engage in a three-step screening process to evaluate whether the prospective partner would be a good fit before inviting them to work with the PHA. This shift was often paired with a move from mostly partner-initiated to PHA-initiated partnerships. Agencies frequently expressed a desire to grow beyond one-off programs and develop deeper long-term sustainable partnerships that closely align with resident's needs. One agency reported that they work with residents to evaluate prospective partnerships based on the partner, what they are bringing to residents, whether it is a respected organization, and the long-term sustainability of the partnership.

Linear Partnership Evolution

Many agencies mentioned that their partnership evolved in a linear direction. Some reported that their partnership continually grew as the relationship strengthened. For instance, one agency mentioned that their partnership with the local university started with the nursing students performing clinicals and screenings with residents and grew to include additional programs provided by the pharmacy and nutrition departments of the school. Meanwhile, other agencies reported that simply maintaining existing partnerships is a success, particularly as funding ends. For example, one PHA mentioned that they use grant funding to pilot new programs. If the program is successful, they use their affiliate non-profit to raise funds to maintain the programs once the grant ends. However, securing new funding to replace expiring grants can be a challenge as seven PHAs noted that their partnerships had dissolved when funding ended.

Nonlinear Partnership Evolution

However, the evolution of these relationships is not static, where partnerships simply improve, maintain, or decline. While many agencies saw partnership growth, which was linear in nature, others talked about having to consciously reinvigorate existing relationships, secure new funding to maintain the partnership, or even consider prioritizing some partners over others. For instance, one agency mentioned that they hired two resident service coordinators who enabled them to improve their partnerships and expand their services, however when the coordinators left, they struggled to replace them and their programs fell to the wayside during the transition. Another agency reported that the type and level of on-site health and support services provided to residents fluctuated as their amount and source of grant funding changed. Many PHAs thought of these shifts in terms of opportunities to have a greater impact and challenges to growth.

III. EVOLUTION OF ORGANIZATIONAL STRUCTURE

As PHAs implemented health partnerships and began to see health as a key component of resident well-being, many experienced shifts in their organizational structure aimed at increasing the sustainability of these efforts. PHAs shifted organizational goals to incorporate health, made personnel changes to focus on health activities, and made other organizational changes. Most PHAs implemented two or more of these changes and the types of changes they implemented varied by PHA size.

Changes to Organizational Goals

PHAs commonly made changes to their organizational goals to focus on resident health and well-being. The most common organizational goal change was adding health outcomes to the agency's strategic plan. Twelve agencies reported taking this step. Eleven agencies mention resident service outcomes, more broadly, in their latest annual plan available on their website. Ten agencies added health or resident well-being directly to the mission statement of the agency. Nine agencies adopted health outcomes as central to their resident services philosophy. These changes allowed agencies to prioritize resident health as an organizational outcome and instill this as an organizational value.

Personnel Changes

Agencies also made personnel changes to help them improve resident health outcomes and meet their new resident health goals. Hiring staff or earmarking funding towards staffing health initiatives was the most common personnel change, reported by all fifteen PHAs with health initiatives. Most of these agencies mentioned hiring a full-time resident coordinator or adding more full-time coordinators to help oversee health activities and partnerships. Another common organizational change mentioned frequently by respondents was to move the department overseeing resident services closer to the executive division in the agency's organizational structure. For example, seven agencies moved the resident service department or the department that oversaw health activities directly under the Executive Director. In some cases, resident service directors became part of the senior management or the executive management team. Other agencies included oversight of resident services as the function of a Director of Innovation or Planning to keep services flexible and forward-thinking. Goals of improving resident health and quality of life were also integrated into staff training and the daily duties of frontline staff across the agency. Five agencies discussed cross-training all staff to provide feedback on resident health to the resident services staff or including resident outcomes in staff performance goals.

FIG. 4: **HOW DID THE ORGANIZATIONAL STRUCTURE OF THE AGENCY EVOLVE?**

Changes to Organizational Goals	Personnel Changes	Other Organizational Changes
• Health outcomes added to strategic plan of agency (**12**) • Health outcomes added to agency mission (**10**) • Health central to resident services philosophy (**9**)	• Staff/funding dedicated to specific strategic outcomes including health (**15**) • Positions overseeing health/resident outcomes promoted to senior staff/EMT in agency structure (**7**) • Mission/strategy integrated across positions and part of job performance (**5**)	• New nonprofit arm created to manage health programming and grant activities (**7**)

Other Organizational Changes

Other organizational changes were also noted. For example, seven agencies created a new nonprofit organization or utilized a current nonprofit tied to the agency to facilitate their health activities. This move allowed the agency to apply for and accept grants more easily. One agency mentioned that they created a new affiliate nonprofit focused on raising funds for resident services, which was separate from their other nonprofit focused on affordable housing development, since funding for development overshadowed resident services funds and confused donors about the level of need.

Differences by Size

In general, smaller agencies were more likely to note utilizing frontline staff across the agency to gather resident feedback and reach out to residents about their health needs. Some small agencies also provided stipends to residents to fill coordinator-like roles. Resident coordinators organized events, reached out to potential partners, and spoke with other residents to encourage participation. Larger agencies with resident services departments were better positioned to promote the department in the organizational structure, hire more resident services staff, or utilize a nonprofit arm to conduct health activities.

IV. HOW PHAs LEVERAGE FUNDING AND RESOURCES

For decades, PHAs have been chronically under-funded by the federal government. Despite this, PHAs have been judicious and creative with limited financial resources in order to meet their important obligations and also engage in innovative cross-sector projects. PHAs often build on existing funding streams and programs by engaging external partners to benefit residents.

Most PHAs with health initiatives rely on partnerships[10]. Partners can provide in-kind resources such as staffing and supplies for activities that are mutually beneficial to them, the PHA, and residents involved. Occasionally these partners can provide direct funding. PHAs are also tapped by community-based organizations to fulfill grant obligations, provide resources to populations and individuals in need, and otherwise bridge the gap between sectors. Agencies with more proactive partnership goals (i.e. forging new relationships rather than relying on requests from others) can position themselves as advantageous collaborators to these organizations by articulating the importance of having a major affordable housing provider at the table.

PHAs in the study discussed how they fund their health programs through a combination of HUD programs and external sources provided by states, counties, philanthropic foundations, and their partners. Figure 5 includes a list of programs agencies leverage for health-housing collaborations. While PHAs receive a vast majority of their funding from the federal government, they can sometimes use additional monies at the local/state level.

Agencies can position themselves as advantageous collaborators by articulating the importance of having a major affordable housing provider at the table.

HUD Funds

HUD funds and programs play an important role supporting PHA health initiatives. ROSS was the most commonly cited health initiative funding source provided by HUD, reported by eight PHAs. These agencies mentioned that ROSS funding enabled them to hire service coordinators, which facilitated partnerships and provided assistance to help elderly and disabled residents age in place. Four agencies also reported that funding from Choice Neighborhoods Initiative (CNI) enabled them to support communitywide health needs and survey residents. For instance, one agency reported that they used funding from the CNI grant to convene residents and community stakeholders to come up with a strategy to address infant mortality and low food access in one of their neighborhoods. Five agencies interviewed also reported using their capital and operating funds to start health initiatives or hire staff to facilitate them. Three PHAs also emphasized that the MTW program positioned them to expand their health initiatives by encouraging them to research resident outcomes, reframing the culture, and providing funding flexibility, which allowed them to more easily hire staff and fund programs supporting health initiatives.

External Funds

Funding from external sources, such as state and local governments, philanthropy, and partner organizations, are integral catalysts to creating and sustaining PHA health initiatives. Funding or in-kind support from partners was the most common health initiative funding source, reported by thirteen PHAs. Most of this support was provided through in-kind services, but one PHA mentioned that their partner provided funding to them to support resident services.

FIG. 5: **FUNDING SOURCES TO START HEALTH INITIATIVES**

	SOURCE	ABOUT	HOW IT'S USED	PHAs LEVERAGING FUNDING
HUD Funds	**Resident Opportunities & Self-Sufficiency (ROSS)**	Competitive grant awarded to PHAs with public housing explicitly to hire service coordinators to help elderly and disabled residents	• Facilitate resident service partnerships • Hire service coordinators	**8**
HUD Funds	**Operating Fund & Capital Funds**	Funds awarded to PHAs to operate and maintain public housing	• Make accessibility improvements • Facilitate resident services • Award building event stipends	**6**
HUD Funds	**Choice Neighborhoods Initiative**	Competitive grants awarded to local leaders to invest in distressed neighborhoods with HUD-assisted housing	• Establish community-wide health partnerships • Administer resident surveys	**4**
HUD Funds	**Moving to Work (MTW)**	A demonstration program that provides PHAs with funding and regulatory flexibilities to design programs to boost resident self sufficiency	• Funding flexibility • Ease partnership and program development • Catalyze change in organizational structure	**3**
External Funds	**Partner Funding**	In-kind services or funding provided by a partner organization	• Support health programs meeting partner's mission	**13**
External Funds	**Philanthropy**	Funds awarded by a nonprofit or corporate foundation	• Support health programs meeting foundation's funding priorities	**10**
External Funds	**State and Local Funding**	Funding provided by the state or city government to support a local health program	• Support health programs addressing a local need (ex: assisted living services, infant mortality, and mental health support)	**4**
External Funds	**Program of All-Inclusive Care for the Elderly (PACE)**	Funding provided by Centers for Medicare and Medicaid Services to provide comprehensive medical and social services for frail elderly	• Support health programs for frail elderly support)	**2**

PHAs partnered with a wide variety of organizations to provide health services, including universities, insurers, local healthcare providers, foodbanks, local health departments, and more.

Philanthropy can be a powerful funder of new, innovative ideas that need initial investments to bring them to life. Ten PHAs mentioned that their health initiatives were funded by a philanthropic foundation, eight of which were funded by local foundations. PHAs reported using philanthropic funds to create an aging mastery program, develop a health dashboard, rehabilitate older adult's homes while they are on the waiting list, expand resident bike access, and more. However, these agencies reported that their grants were temporary and many described difficulty locating new funding sources to continue providing these services once the grant ends. Additionally, the scope of these grants can be narrow and might not perfectly align with resident needs or wants.

Funding from the state can take pressure off of PHAs to provide services that would typically be above and beyond. Four PHAs reported that funding from state and local programs supported their health initiatives. This funding supported specific state, city or county-wide initiatives facilitated by the PHA or provided a tax break to support a health initiative. For example, state and local agencies provided funding to PHAs to facilitate a peer support program, assisted living services, a home modification program, and general resident health services.

V. SUSTAINING INITIATIVES

PHAs reported sustaining health programs and partnerships by securing continued funding, making changes to their organizational structure to institutionalize health initiatives, and deepening partner relationships to integrate goals. Many of these efforts were implemented in combination with one another.

Securing Continued Funding

Securing external funding or in-kind services is critical to ensuring health initiative sustainability for PHAs. All fifteen PHAs with health initiatives with whom we spoke relied on their partners to fund or provide some in-kind health programming or services to their residents. PHAs noted that their partners provided funding or direct services because the two organizations had shared clients or it was part of the partner's mission to serve clients with characteristics matching the PHA's residents. Health partnerships were reported between a variety of organizations, including hospitals, health clinics, Boys and Girls Clubs, local departments of health, universities, food banks, and local nonprofits focused on health. PHAs also described that in exchange for allowing their residents to participate in the partners programs, there were clear expectations that the partner would continue these services long-term to limit disruption to their residents. The formality of these expectations varied by PHA, with some requiring memoranda of understanding (MOUs) with partners, and others communicating this expectation verbally. Circumstances that necessitated more formal relationships with partners varied by PHA as did partnership expectations.

Another common mode of obtaining continued funding was through existing HUD programs like ROSS or FSS to support the work of resident service coordinators or to provide funding for program activities. Eleven PHAs depended on HUD programs like FSS or ROSS for continued funding or their MTW funding flexibility. Six PHAs built ongoing funding into their operating budgets to sustain programs. Two PHAs noted that they earmark funds in their operating budget for successful initiatives when grant funding expires, but many PHAs have limited operating budgets to absorb the operating cost of health initiatives as congress continues to underfund housing authorities, resulting in a $26 billion capital needs backlog. As a result, two PHAs reported creatively funding their health initiatives in their operating budget using revenue from their non-public housing inventory. Additionally, seven PHAs tapped into state or local programs that provide health funding. For example, a state health insurance system covered programing for several PHAs. Fewer PHAs were able to obtain long-term philanthropic grant funding, with only four PHAs noting that they received ongoing grant funding to support their programs. PHAs that had obtained previous grants often noted that the funding was for a limited time and it was difficult to sustain the program over time.

FIG. 6: **HOW DO PHAs SUSTAIN THESE PARTNERSHIPS?**

Securing Continued Funding

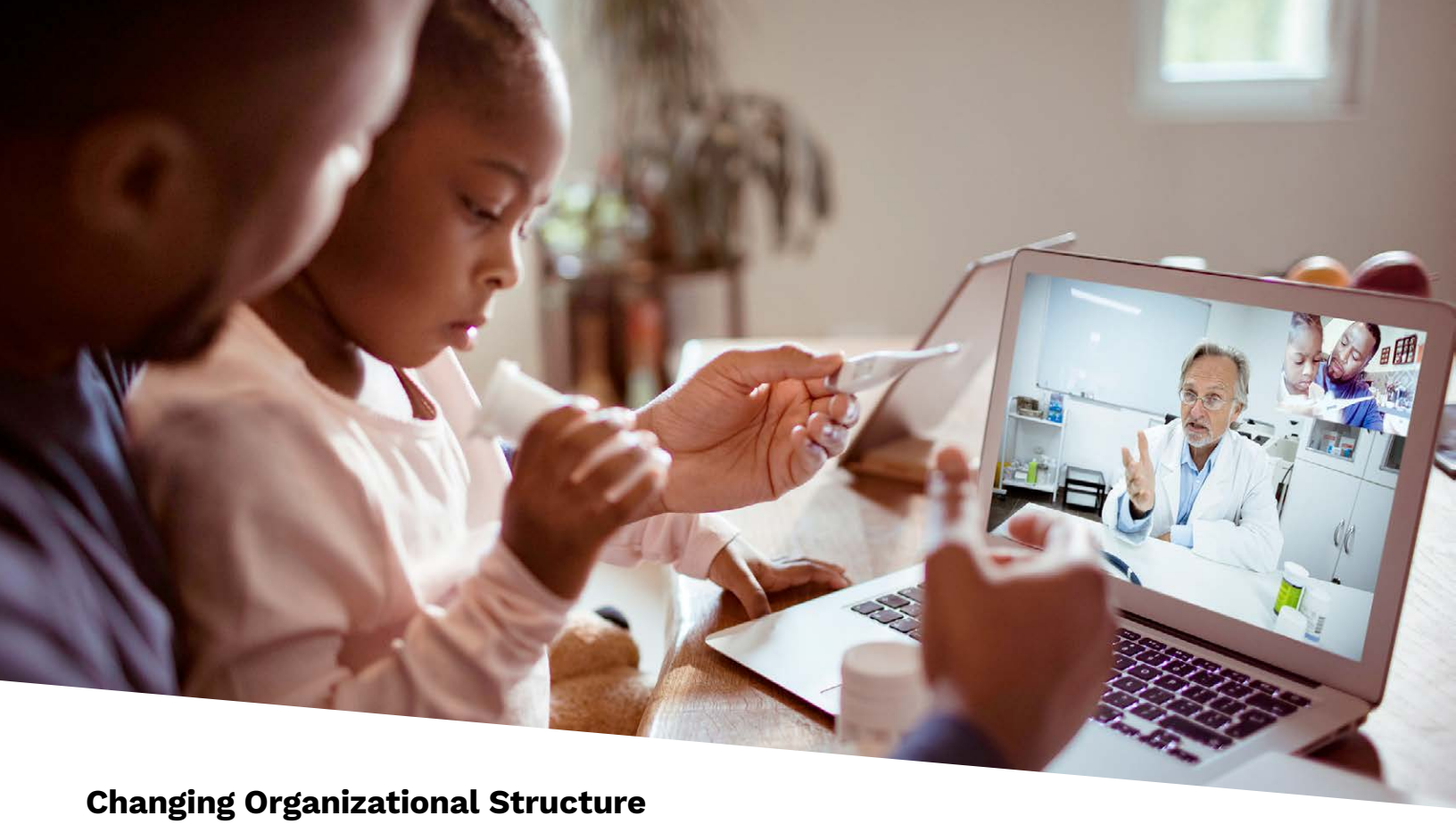
- Funding or in-kind services from partners (**15**)
- Continued funding from HUD program (**11**)
- Continued funding from state or local government (**7**)
- Built into PHA operating budget (**6**)
- Continued external funding through grants (**4**)

Changing Organizational Structure

- Built into PHA mission or strategic plan (**12**)
- Built into employee performance (**2**)

Strengthening Stakeholder Relationships

- Cultivating strong partner relationships (**11**)
- Creating staff buy-in and support (**9**)
- Increasing resident participation and leadership (**7**)



Changing Organizational Structure

Many PHAs were able to sustain their health programs by building these initiatives into their organizational structure and promoting these initiatives as organizational priorities. Nine agencies credited their ability to sustain resident health programs to raising health outcomes as a strategic priority in the strategic plan or the agency's mission. Once it was an agency goal, agency resources were diverted toward long-term support. Seven agencies promoted the division that oversees resident services or health services higher in the organization structure, often with the department head reporting directly to the executive. With their activities closer to the top of the organization, they received more visibility and support from executive management and were more readily seen as an agency priority. Two agencies also reported including goals related to health initiatives in employee performance evaluations.

Strengthening Stakeholder Relationships

Deepening relationships with stakeholders so that the partnership became integrated into both organizations was a key factor that that strengthened the sustainability of partnerships. For example, deepening partnerships meant providing a staff member, having regular meetings, pooling funding, or sharing data. Eleven PHAs depended on deepening partner relationships to sustain their programs. Most PHAs noted that effective and frequent communication with partners was a key factor in their most successful partnerships. Likewise, partnerships with similar missions and clients also seemed to grow with greater ease. Several PHAs noted that providing data-driven evidence of success to their partners to encourage their continued participation and funding was important in promoting sustainability and partnership growth.

PHAs also noted that they were able to sustain health services and programs by facilitating board, leadership, and staff support. Nine agencies noted that staff support was important to their ongoing resident health activities. Agencies interviewed reported fostering staff buy-in using top-down and horizontal approaches and secured staff buy-in a number of ways. Some agencies incorporated meeting resident health goals into employee performance reviews and worked to make them a part of employee culture. They also worked to hire staff who were a good fit with the new agency goals, with mission-oriented backgrounds and interest in innovation. Others described how the agency structure related to serving residents and sharing resident feedback was very horizontal, so that frontline staff in particular could provide important information to decision-makers. Likewise, decision-makers could help instill the importance of resident health for all staff.

Involving residents and incorporating resident feedback was also noted as an important step toward sustainability. Seven agencies reported that this effort was key to sustaining their health initiatives. For example, one small agency provided a stipend to residents to coordinate resident activities and gather resident feedback. Other agencies reported regular resident surveys and training staff to gather resident feedback about health needs. Resident trust and participation is essential for conducting successful resident services that can garner external support and provide evidence of success.

VI. OVERCOMING CHALLENGES

Despite the fact that many PHAs prioritize improving resident health, many face challenges when attempting to incorporate health into their programs. Barriers frequently reported by PHAs include insufficient or inconsistent access to funding (11), low resident participation rates (10), and challenging partner relationships (7). Other less frequently reported barriers include advanced resident needs (4), a lack of partners in the community (2), collecting resident feedback (2), and knowledge gaps related to HIPPA/data privacy (1).

Insufficient Funding

Funding was the most common challenge to expanding health initiatives, cited by eleven PHAs. These challenges included securing seed funding, maintaining long-term sustainable funding, and navigating the complexities of funding streams. While some resident service funds are included in PHA operating allotments, most activities need additional funds to meet the total cost of implementing the program. Most PHAs we spoke to mentioned that they needed to pool funds from a variety of sources, such as ROSS, FSS, CBDG, and partner grants, to fully support their health services. They noted that this piecemeal approach can put programs at risk if one significant source of funding becomes unavailable or the PHA becomes ineligible. For instance, one PHA noted that their funding to hire service coordinators through the ROSS program has diminished over the years as the PHA converts their public housing portfolio through the Rental Assistance Demonstration (RAD) program. It also makes supporting the program and reporting on the use of funds to partners and grantors more complex.

In some cases, PHA partners provide the funding for programs through a grant. PHAs in the study noted that communication with the grant-holding partner was important to ensure that the PHA could meet the requirements of the grant and that the residents would benefit from the outcomes. Depending on partner funding can also lead to a lack of consistency in the services provided, especially if the grant ends and cannot be renewed. PHAs noted that it is important for the programs to offer reliable and consistent benefits in order to attract residents and to keep them participating. In fact, some of the agencies located in more rural areas stated that they aren't large enough for private funding.

Staffing Capacity

Funding shortfalls lead to staffing capacity issues, which was another challenge mentioned by PHAs. Many PHAs budgets run on razor thin margins; staff are often asked to do more with less and in turn, experience burnout. As a result, some PHAs reported that frontline staff pushed back regarding the inclusion of health initiatives as a goal, particularly during budget shortfalls. However, one PHA in particular attempted to realign their culture in order to overcome this barrier; they voiced their vision which included health, and brought in new staff to align with that vision. Other times, funding cuts eliminated resident services staff and the remaining staff did not have the capacity to take on additional responsibilities even if they were supportive of health initiatives. One interviewee noted that when funding cuts were made, the property managers of the PHA took on the role of service coordinators, which turned out to be less effective. In addition, it is challenging for PHA's located in rural areas to access needed health partner professionals. Rural areas often have limited access to specialists, which makes it more difficult to locate partners and connect the residents to healthcare.

FIG. 7: **BARRIERS IMPLEMENTING HEALTH INITIATIVES**

Common Barriers	• Insufficient funding (**11**) • Low resident participation (**10**) • Challenging partner relationships (**7**)
Less Common Barriers	• Advanced resident needs (**4**) • Lack of partners in community (**2**) • Collecting resident feedback (**2**) • HIPPA knowledge gaps (**1**)

Low Resident Participation

Another barrier mentioned by ten PHAs in this study was lack of resident participation, although the reason driving low resident participation varied across agencies. Residents may have limited mobility and find it difficult to attend certain types of health programming without modifications. Other PHAs, particularly those in rural areas, noted that resident sprawl and lack of transportation prevented them from boosting resident participation rates. Other housing agencies noted that it was difficult to spread the word about health programming offered to residents. Some housing authorities mentioned a language or cultural barriers as a deterrent to residents attending programming. Convincing residents to attend programs and commit to improving their health can also be challenging. Some residents may not accept their health status and might not see these programs as necessary. In response, one housing authority mentioned that they communicate the health benefits of

art, music, or cooking classes in their outreach. Others offer new on-trend programming that might be especially interesting to residents. Popular programs that have been implemented by PHAs have included yoga, foot care clinics, gardening classes, cooking classes, and more. However, each agency noted that some programs have had less success, and received little to no participation.

Challenging Partner Relationships

Lastly, another commonly reported challenge reported by seven PHAs was communication with partners. These challenges are driven primarily by misconceptions about how the partner operates, misaligned partnership goals, inadequate touch points, and differing expectations on the speed of results. One PHA mentioned that their prospective partners don't understand what they do and how they operate; a clinic that wanted to partner with them did not understand the concept of "waiting lists" and thought that the PHA could provide much more than they could. In addition, another PHA reported it was a challenge to find a partner that understands how culture impacts health. They also reported that they have conflicting goals with their partners completing health evaluations regarding when and how to complete the evaluation. Similarly, another agency reported that there were misconceptions between their partner on how quickly results were expected. Another PHA mentioned that sometimes partners would apply for grants and assume that the PHA would do things without asking. All of the aforementioned examples show that communication is key when it comes to forming a lasting partnership.

Less Common Challenges

Less frequently, PHAs also reported that advanced resident needs, a lack of community partners, collecting resident feedback, and understanding Health Insurance Portability and Accountability Act (HIPPA) regulations was a challenge. Four agencies noted that there is not a continuum of care in the community, which results in individuals with advanced health needs living at their properties that require more frequent support than the PHA can provide. Two PHAs, particularly those in more rural areas, also noted that their community doesn't have access to healthcare centers with whom to partner. Additionally, one PHA each reported that they have trouble administering health initiatives due to HIPPA knowledge gaps, high turnover rates, and difficulty collecting resident feedback.

VII. BARRIERS TO IMPLEMENTING HEALTH INITIATIVES

About half of PHAs surveyed in 2018 did not have any health-focused initiatives in place[11]. We spoke to two agencies that noted they did not have health programs of initiatives in place and they described a variety of reasons why this was the case.

Resident Needs Not Voiced

A primary reason reported for not engaging in health initiatives by both PHAs without health services was that their residents had not voiced a need for these services and that there were no apparent gaps in health-related services being provided by external organizations. Relatedly, these agencies voiced a lack of interest from the residents in programs they had created in the past, which made it hard to obtain resident feedback or make the case for external support.

Other Organizations are Meeting Need

Another primary reason for not offering health initiatives noted by both PHAs was that outside sources within the community were able to provide health-related activities to meet the needs their residents. For example, one agency noted a veterans association offered rides to many of their residents for medical appointments and other errands. The other agency reported that PHA staff offered the residents information booklets to connect them to local organizations that could meet their health and other needs, leaving residents to reach out to these various services if needed.

FIG. 7: **REASONS PHAS DON'T HAVE HEALTH INITIATIVES IN PLACE**

Resident need not voiced (**2**)	Other organizations are meeting need (**2**)	Lack of community resources (**1**)

Lack of Community Resources

Another reason voiced by one PHA not offering such services was a lack of health resources and partners in the area. This agency noted that the closest hospital was ten miles away, but most residents traveled over an hour to receive services.

VIII. FUTURE HEALTH INITIATIVE GOALS

Many PHAs interviewed were aspirational about strengthening their health initiatives. The most commonly reported reach goals expressed by PHAs to improve their health initiatives were to expand health partnerships and programs (12), followed by implement organizational changes (5), measure resident outcomes (5), boost program sustainability (5), and improve relationship with partners (5).

Expand Health Services and Partnerships

Twelve PHAs expressed a desire to expand health sector partnerships and programs in the future. New programs proposed by PHAs included expanding telemedicine access, healthy food access, and programs for domestic violence survivors, hiring community health workers, and co-locating properties with health services. Some of these proposed expansions were for brand new programs that residents have expressed interest for in their community, while others were proposals to bring back programs that were lost due to funding cuts.

FIG. 9: **FUTURE HEALTH INITIATIVE GOALS**

Expand Health Services and Partnerships (12)	• Develop new partnerships • Apply for new funding
Implement Organizational Changes (5)	• Adopt new leadership and governance structure • Create standalone resident services department • Develop strategic plan for health programs • Expand smoke-free policy • Develop strategic plan • Hire new staff member to facilitate partnerships
Measure Resident Outcomes (5)	• Adopt data sharing agreements • Perform program evaluations
Boost Program Sustainability (5)	• Identify long-term revenue sources
Improve Relationships with Partners (5)	• Additional touchpoints • Adopt performance based contracts • Survey partners • Adopt partnership evaluation • Collaborate on community health needs assessment with partners

Implement Organizational Changes

Five PHAs also reported that they aspired to implement organizational changes to support health initiatives, each proposing unique strategies. Organizational changes proposed by PHAs interviewed included establishing a new leadership and governance structure, creating a standalone resident services department, implementing performance based contracts, adopting a strategic plan for health initiatives and partnerships, expanding smoke free policies, and hiring a new staff member to facilitate partnerships.

Measure Resident Outcomes

Five PHAs also included measuring resident outcomes as a future health initiative goal. In all cases, these PHAs proposed specific programs they would like to evaluate at their agency. One PHA interviewed also mentioned that they would like to adopt a data sharing agreement to pursue this goal. Another interviewee mentioned that program evaluations will enable their agency to identify which pilot programs should be scaled up and make it easier to secure additional funding for successful programs.

Boost Program Sustainability

Identifying funding sources to maintain program sustainability is important to ensure the long-term success of health initiatives. Five PHAs interviewed aspired to incorporate sustainability into their health initiative goals. However, these agencies were still exploring actionable strategies to achieve this goal, suggesting that more resources are needed to support PHAs looking to sustain their programs long-term.

Improve Relationships with Partners

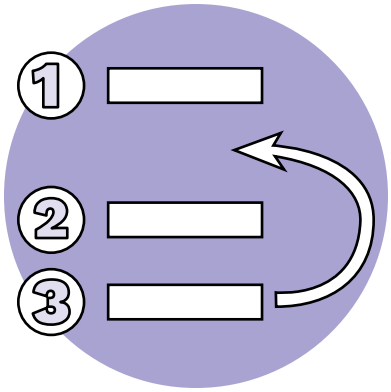
Five PHAs interviewed mentioned that they would like to improve their partner relations when asked about their future health initiatives, each proposing a variety strategies to pursue this goal. PHAs aspiring to improve their relationship with partners proposed increasing touchpoints with partnerships, surveying partners on their experience with the PHA, establishing a process to evaluate current and prospective partners, adopting performance based contracts, and collaborating with local hospitals to perform community health needs assessment to deepen partnerships.

IX. HOW TO START HEALTH INITIATIVES

These findings can inform plans for agencies that hope to start or grow health initiatives. The steps below provide guidance on what has worked for agencies in the study as well as existing research on partnerships and observations made by researchers in the course of their professional activities.

Define internal priorities regarding resident health.

- Collect feedback from residents and staff on health initiatives to pursue. Resident-centeredness is especially important to prioritize as PHAs with health initiatives have reported resident interest and participation as challenges to sustaining their activities.
- Incorporate health initiative goals into strategic plan.

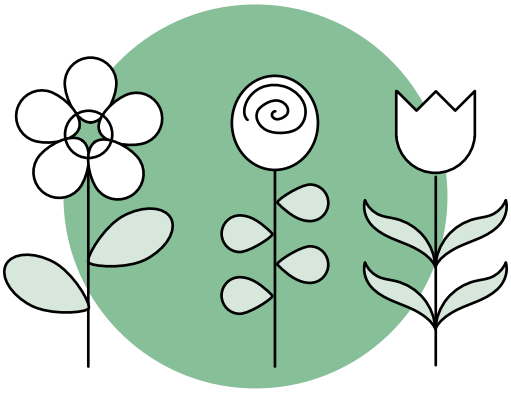


Prioritize steps in implementing strategic health plan.

- Accomplish "low-hanging fruit" and no-to-low-resource efforts early to achieve easy wins. (e.g. on-site flu shots, transportation to healthcare facilities)
- Pursue additional external funding/resources needed for additional work.
- Establish timeline and process for evaluating iterative progress.
- Incorporate strategic plan goals into employee job performance.

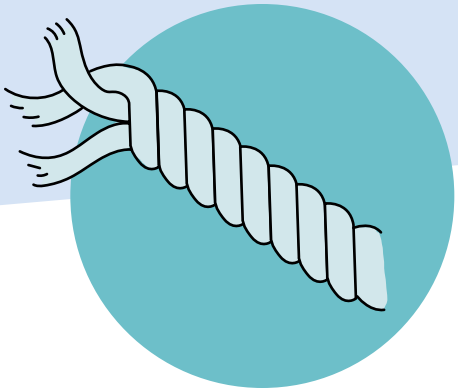
Secure internal buy-in and resources to pursue strategic priorities.

- Hire or designate a staff member to be responsible for managing health initiatives and partnerships.
- Place resident health responsibilities in the executive management team to provide more robust attention and resources.
- Train staff on new vision and strategic plan to pursue health initiatives.



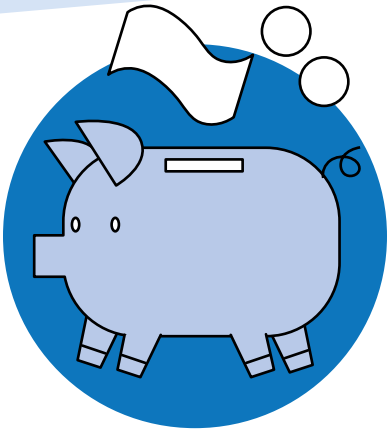
Cultivate new partners with an eye toward PHA strategic goals and sustainability.

- Establish a process to vet partners, involving residents in the process.
- Participate in local committees and boards to meet potential health partners.
- Leverage your staff's network to introduce your agency to prospective partners in your community.
- Demonstrate and measure overlapping goals between PHA and prospective partners to make the case for a partnership.
- Secure commitment across partner organizations (presenting as a united front).
- Propose small scale or one-time partnerships as a stepping stone to test the waters and build the relationship.



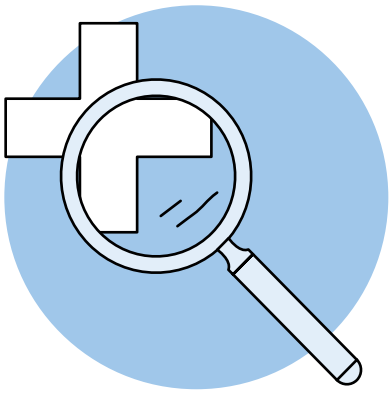
Strengthen communication between partners.

- Conduct cross-organizational learning/ training (new and existing partners).
- Establish a contingency plan to avoid interruptions/issues related to staff turnover).
- Establish a robust communication process, such as monthly check-ins.
- Identify roles and responsibilities for program implementation and evaluation.
- Communicate successes to build upon partnerships.
- Formalize strong partnerships with a Memorandum of Understanding (MOU) or contract.



Secure funding to create, sustain, or expand health initiatives.

- Reach out to local government to identify any tax breaks that can be leveraged.
- Establish an affiliate nonprofit to fundraise for health initiative efforts.
- Apply for grants from government agencies and public and private foundations to adopt new health initiatives.
- Provide support to partners applying for grant funds to be used to provide services at PHA properties.



Evaluate health initiatives to strengthen programs and partnerships.

- Partner with a local university or nonprofit to assist with an evaluation of the health initiative.
- Collect feedback from residents on the health initiative and partner.
- Provide data to partners on program participation to demonstrate impact wherever possible.
- Leverage the evaluation to strengthen the initiative, secure new funding, and/or expand the partnership
- Establish a 'phase out' plan for programs and partnerships that are not working.

Refine and expand partnership activities on an ongoing basis.

- Evaluate existing partners to identify successes, areas for improvement, and gaps in need.
- Identify needs to be met by additional partners.
- Phase out partners that do not meet core goals.
- Prioritize partners that can provide sustainable, tangible services to residents.

CONCLUSION

PHAs are important contributors to resident health and the health of our nation's most vulnerable low-income seniors, disabled individuals, and families. While they have been navigating health partnerships for some time, these relationships and the scope of the programs implemented have evolved over time. This study finds patterns in the evolution of PHA health partnerships over time and that these patterns are suggestive of how PHAs may start out and grow existing partnerships to achieve successful outcomes. Systematically assessing data on resident needs, establishing strategic resident health goals in core PHA operations, structuring partnerships for sustainability, making co-investments with partners, and evaluating program outcomes based on strategic goals have been identified by PHAs as key steps to produce sustainable and successful programs.

ENDNOTES

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