Key Questions to Embedding a Health Equity Lens: The Case of Cook County's Flexible Housing Pool

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Background

Increasingly, healthcare organizations, health plans, and state Medicaid agencies are recognizing the role broader social issues (e.g. housing affordability and homelessness) have on community health. Within Cook County, Illinois, nearly 9,000 people are without a stable house each night. Lack of housing diminishes an individual's ability to achieve optimal health and has significant societal impacts. People experiencing homelessness have more difficulty obtaining primary care, often relying on high-cost emergency department visits and inpatient stays.

The risk of homelessness, however, is not borne equally by all racial groups. In Cook County, those experiencing homelessness are overwhelmingly Black men. This results from differential access to resources and exposure to risks in numerous domains, such as education, jobs, and nutrition.

Explicit racialized federal and local policies both reflected and reinforced cultural practices. Highways were sited to "contain" Black communities and within those communities, federal policies promoting redlining prevented Black families from accessing home loans. Between 1930-1960, the Federal Housing Administration (FHA) introduced new housing programs including the G.I. bill, administered through the states, which enabled first time home ownership for returning WWII veterans. However, during this time less than 1% of the FHA loans were directed to Black families. Contract buying caused Black families to lose huge investments in equity even if one payment was delayed. Though such policies have since been changed, Black families have not recouped the generational loss of wealth and still experience discrimination in access to home loans.

Advancing Health Equity: Leading Care, Payment, and Systems Transformation (AHE), a national program supported by the Robert Wood Johnson Foundation, is identifying and implementing strategies to reduce and eliminate disparities in health and health care by aligning payment reform and quality improvement efforts. The program is based at the University of Chicago and conducted in partnership with two non-profit, nonpartisan organizations—the Institute for Medicaid Innovation and the Center for Health Care Strategies. AHE brings together key stakeholders—state Medicaid agencies, Medicaid managed care organizations (MCOs), and clinical partners—to pursue payment innovations that support health equity. Together the partners determine effective ways to align payment and care delivery system reform to achieve health equity. Participating teams include Delaware, Illinois, Maine, New Jersey, Pennsylvania, Tennessee, and Washington State. Each team is designing and implementing an intervention tailored to their specific organization and settings.

From 2012 to 2018, for example, Chase bank loaned almost 9 times more in a single majority-white neighborhood in Chicago than it did in all of the city's majority-Black neighborhoods combined. Bank of America lent 29 times more money in white neighborhoods than Black neighborhoods in Chicago. Undervaluation of Black-owned homes, discrimination by source of income, and racial steering all reinforce these patterns of segregation and disinvestment in predominantly Black neighborhoods. Racism in other domains, in addition to the housing sector, combine to reduce access to power and resources that lead to a higher likelihood of homelessness.

Health outcomes and residential zip codes are therefore profoundly linked. Residents of previously-redlined neighborhoods in Chicago, such as Englewood, have a life expectancy of 60 years, 30 years shorter than the life expectancy in Streeterville, a predominantly white, wealthy neighborhood just 9 miles away. Chronic condition heat maps further illustrate how racialized housing and environmental policies lead to health disparities. For example, people in disinvested neighborhoods have higher rates of asthma, diabetes, hypertension, obesity, and other chronic diseases. While the AHE Illinois Learning Collaborative (LC) team won't directly address these structural factors, they seek to work at the intersection of the housing and health sector and recognize the importance of acknowledging this context in the design of their program.

An Overview of the AHE Illinois Learning Collaborative Team

The Illinois LC team is comprised of four organizations including: (1) Cook County Health (CCH), a safety-net provider serving more than 300,000 patients per year through two hospitals, 15 community health centers, correctional healthcare services, a comprehensive medical home for patients with HIV/AIDS, and the Cook County Department of Public Health and Medicare and Medicaid health plans; (2) CountyCare, a division of CCH and Cook County's largest Medicaid Managed Care Organization (MCO); (3) Access Community Health Network (ACCESS), a large federally qualified health center in Cook County, and (4) the Illinois Department of Healthcare and Family Services (HFS), the Medicaid program for Illinois. CCH has developed, invested, and participated in a range of housing-focused initiatives. One of them, the Flexible Housing Pool (FHP), is the focus of the Illinois team's AHE initiative. The FHP provides permanent supportive housing for people experiencing homelessness and seeks to improve individuals' health outcomes and reduce healthcare system costs. The FHP was developed in collaboration with Cook County Health and the City of Chicago and is funded by various sectors and stakeholders including local health plans, governmental agencies, and foundations.

In 2020, during the local peak of COVID-19 pandemic, HFS pivoted its annual quality pay-for-performance program toward a Community Reinvestment fund to encourage MCOs to invest in resources that address the social determinants of health. As a result, CountyCare invested $5 million into the FHP. The investment aims to house 66 CountyCare members and their families for 3 years (2021 to 2024). The release of the pay-for-performance withhold presented the team with a unique opportunity to use Medicaid dollars to directly fund housing, something Medicaid traditionally does not fund.

The Illinois LC team's investment serves two groups: (1) CountyCare members experiencing homelessness and severe mental illness (SMI) and/or substance use disorder (SUD) and (2) families with children. Given the impact of racism described above, the FHP will predominantly serve Black Chicagoans, even though FHP participants will not be determined based upon race. Most of the population that will be served have complex health needs and are inadequately served by our current housing and health systems. The goal of this program is to demonstrate that housing can both improve health and create savings by reducing the use of inpatient and emergency department services for needs that can be more effectively met through community-based services.

Embedding an Equity Lens

The Illinois LC team is integrating an equity lens into their initiative. The team does this by (1) acknowledging the historical context leading to homelessness and (2) attempting to identify and dismantle racial bias that can easily and unintentionally continue. Below, we describe three questions the team has explored in their efforts to build a service that honors the full personhood of its clients. The questions do not always have clear answers or resolutions, but they raise important conversations and bring intentionality into each component of the initiative.

Question 1: What is the historical and social context of the health equity issue?

"*My hope for our team, and really for the State of Illinois, is that there will be payment reform to address not only the behavioral or the medical challenges our population has but also the social determinants of health, the food insecurities, the housing insecurities, the lack of a living wage, the employment opportunities, that so much impact their lives and their qualities of life.*" Ann Lundy RN, BSN, MBA, Chief Operating Officer, ACCESS Community Health Network

The Illinois LC Team joined the AHE initiative with a strong foundation in the historical and social landscape leading to inequitable outcomes that Black Americans experience in health and housing. Consequently, the AHE project fits their established culture of equity, and is one of many equity-focused initiatives that the health system and its partners have launched to increase health access, reduce health disparity, and ensure respectful and high quality service to its members.

Project members have redesigned their governance structure and protocols to promote equity and member agency. The change to the FHP governance structure described below (see question 2) is one such example. The FHP has also acknowledged the impact of federal housing vouchers on exacerbating and enforcing segregation (due to the value of the vouchers and the willingness of landlords to accept them). They are considering how their own housing investments can be modified to encourage permanent housing opportunities in communities with more resources, amenities and racial diversity.

The health plan and its State and provider partners also place a high importance on the provision of wraparound services through care coordination. The health plan screens members for social risk factors not traditionally tackled by health systems, such as the availability of food, work, housing, transportation, and education, as well as exposure to unsafe conditions in the home or community. HFS prioritizes care coordination in its oversight, and the health plan has promoted the location of care coordination in provider offices. This allows members to receive, whole person care from team members who are cognizant of their lived experience in Cook County's political and community contexts. Care coordinators often visit homes or meet members in places of the member's own choosing and, along with other care team members, are typically from the communities being served. Lastly, all staff are expected to be culturally competent.

Question 2: How do we ensure that those being served hold positions of power and are key decision-makers?

"*We actually talked with some members that had lived-experience of homelessness… their perspective really helped us get an insight into what it means to be homeless, you know? We all think we know what it means, but really talking with them and meeting with them and spending time with them, I think, allowed us to see that.*" An Illinois LC Team Member

The Illinois LC team and FHP have been intentional to ensure people with lived-experience with homelessness are part of the FHP's governing board and advisory councils. The FHP created proactive member partnership structures, to center their insights from the outset rather than asking them to respond to plans after they were drafted. For example, the FHP's Lived Experience Advisory Council (LEAC) is composed of people with chronic health conditions who were formerly homeless and are currently in supportive housing. The LEAC meets monthly to advise and inform the FHP and has already provided valuable insight. The LEAC is recruiting more Black men to ensure its membership represents members served by the FHP.

In addition, the FHP reconsidered the balance of power on its governance board. The governance board is made up of leaders across the agencies invested in the FHP and includes a few members with lived experience. However, the perspectives of those with lived experience can easily be stifled or passed over when they only comprise a small percentage of the governance board membership. Recognizing this, the governance board had a series of difficult conversations to determine if the board composition needed more people with lived experience, as weighed against the value of having members without lived experience who have connections to municipal-, county-, and state-level resources, and power structures. After many meetings, deep reflection, and discussion, the FHP decided to increase governance membership of people with lived experience to forty percent.

Question 3: What are the best ways to assess the outcomes of an equity-focused initiative?

The Illinois LC team will conduct a two-part evaluation of their AHE initiative. First, they will evaluate the impact of a housing first policy on health outcomes and member experience. Second, because CountyCare is a publically funded system, which is only one area under Cook County Health, they have the opportunity to account for potential societal benefits (e.g. reduced incarceration or ED utilization). The team will evaluate if CountyCare captures enough of this societal benefit to permit continued financial investment into the FHP. The team is considering how to shift from an emphasis on ROI and cost-benefit analysis to emphasizing measures of quality of life, self-rated health, and health outcomes to decide if the program should be sustained from the health plan's perspective. The team is also balancing measures that are of interest to leadership, potential investors, or others who may support the sustainability and future investments to the FHP.

Alongside their evaluation, the team is asking bigger questions about their role in addressing housing. For example, is CountyCare the best lead organization of this initiative, or are there local community-based organizations that may be better situated to serve the 66 individuals and families? There may be other organizations or entities that have stronger trust and relationships with potential FHP participants or may be more likely to see a financial return. Questions like this exemplify the Illinois LC team's intentionality to operationalize equity. The team's ability to think beyond traditional measures and interrogate their role has provided space to center equity in their evaluation efforts and expand traditional notions of how to evaluate equity-focused care transformation and payment transformations.

Conclusion

It is important to note the internal equity environment and work that concurrently happening within the partnering organizations on the Illinois team's success. For example, since CCH's founding, it has prioritized the care of historically marginalized communities. Included among CCH's institutions is the first Black-owned hospital in the county, which was started in the late 19th century to address health disparities. Furthermore, people of color comprise the majority of CCH's leadership; that leadership team continues to embed equity into its strategic plan. CCH also invests in workforce development, participates in neighborhood reinvestment, advocates for equitable public polices, and participates in minority-owned/ women-owned business enterprise (MBE/WBE) vendor programs. Given the size of CCH and its span, these internal equity efforts can have positive ripple effects across Cook County.

Furthermore, the AHE initiative provided a unique opportunity for the four partnering organizations to learn from one another and leverage their resources. The discussions that resulted from each of the questions above helped to not only advance their AHE initiative in the most equitable way, but also build the knowledge and consciousness of all team members, supporting a culture of equity within and across the partnering organizations. ■