



Maternal and Infant Health: HUD Partnerships at Local and State Levels

Tuesday, November 7, 2023 @ 4 pm ET



Homebase



Panelists



**Adrienne Babbitt,
MA**
Maternal Health
Charter Lead



Mindy Mitchell
Homebase



Bob Burns, MPA
Director



Jason Amirhadji, JD
Neighborhood &
Community
Investment Specialist



And who are you?

- State agency
- Medical provider
- Local government
- Federal government
- Policy
- Nonprofit
- Other



Lessons Learned from the HUD MOTHER Initiative



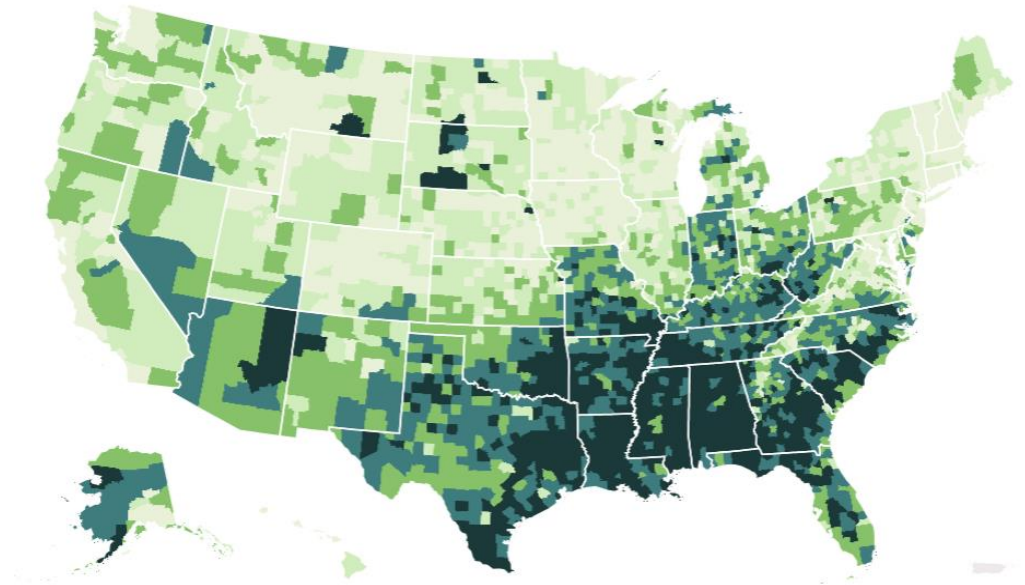
Mindy Mitchell
Directing Attorney

What is MOTHER?

Improve access to maternal health services in 5-8 communities through action plans developed in partnership with and supported by a HUD-funded TA provider ([Homebase](#)) in partnership with EnVision Centers and key stakeholders.

- **Who:** Mothers/infants/children in communities of color with poor maternal and infant health outcomes.
- **What:** Action plans to strategically address community defined gaps in maternal and infant health services for HUD assisted housing sites.
- **Where:** Birmingham AL, Jackson MS, East Harlem NY, Tulsa OK, Houston TX, and St. Louis, MO
- **When:** FY23 & FY24

Maternal Outcomes Through Housing Environments Reimagined



Maternal Vulnerability

- Very High
- High
- Moderate
- Low
- Very Low

MOTHER

Maternal Outcomes Through Housing
Environments Reimagined (MOTHER)

To help improve access to maternal health
services through:

- Listening sessions with moms
- Community feedback and info-sharing
tables
- Action planning and TA support to build
maternal health partnerships
- Newsletters/info-sharing
- Community of Practice



**Advice for
a New
Mom**

Lessons Learned (so far!)



Establishing trust.

- Being “real” (and being allowed to be).
- Showing up.
- Showing up again.
- And again.
- Good customer service.



Listening to moms.

- AND the community.
- Over and over.
- Building trust.
- Incorporating their feedback, into practice and policy.
- But not fetishizing “lived expertise.”
- Rewarding input and participation.



Flexibility.

- Centering moms and the community (not HUD).
- Being real.
- Showing up.
- Keep showing up.
- Not just moms.
- Not just medical (but definitely gotta have medical).



Good customer service.

- Unconditional positive regard.
- Showing up (again and again and again).
- Listening.
- Space and grace.
- Flexibility (and permission to be flexible).
- SERVICE: What do you need? How can I/we give you that?*



**Top three
things needed
before giving
birth:**



Connecting with HUD's People People on the Ground



Jason Amirhadji, JD
Neighborhood & Community
Investment Specialist

Community & Supportive Services (CSS)



Mission: To support the work of **partners** and PHAs in **reducing barriers** and **improving access** to opportunities for communities, families, and residents to improve their **quality of life**.



Interagency Partnerships

Education

- Department of Education
- Department of Energy
- Federal Aviation Administration
- **Intergovernmental Policy Council on Child Development & Academic Success**

Digital Inclusion

- Department of Education
- Corporation for National Community Service
- United States Department of Agriculture
- **National Telecommunications and Information Workgroup**

Employment/Financial Empowerment

- Department of Labor
- Consumer Financial Protection Bureau
- Department of Treasury
- Small Business Association
- Federal Deposit Insurance Corporation
- **U.S. Interagency Council on Economic Mobility**
- **Workforce Development Intergovernmental Policy Council**

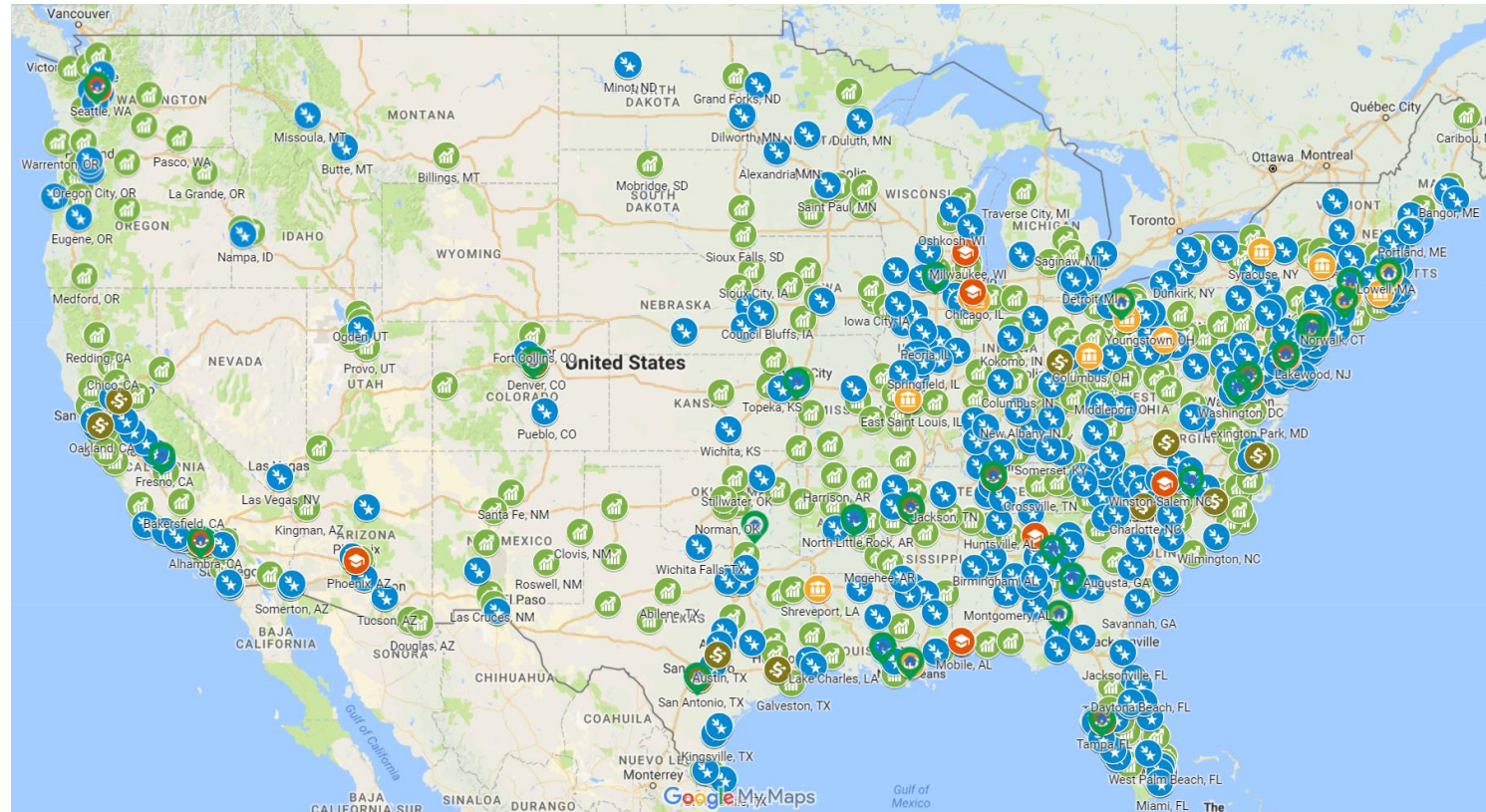
Special Populations

- Department of Justice
- Federal Interagency Reentry Council
- Federal Interagency Working Group on Youth Programs
- Coordinating Council on Juvenile Justice and Delinquency Prevention
- White House Initiative on Historically Black Colleges and Universities

Health

- Department of Health and Human Services (HHS)
- Office of Minority Health (OMH)
- Interdepartmental Health Equity Collaborative (IHEC)
- National Center for Health in Public Housing (NCHPH)
- Health Resources & Services Administration (HRSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

PHA Investments



-  FSS
-  Jobs Plus
-  ROSS
-  Project SOAR
-  JRAP
-  ConnectHome

- **700+ PHAs served by CSS**
- **40+ Tribes**
- **Dozens of nonprofits & resident associations**

Community & Supportive Services Programs

Funded Programs

ROSS

- Funds Service Coordinators to:
 - Provide case coaching
 - Assess resident needs
 - Build partnerships
 - Coordinate services with local providers

FSS

- Increases earned income through:
 - Long-term motivational coaching
 - Partner-provided services, supports, and job training
 - Family escrow account

Jobs Plus

- Transformative, intensive 4-year investment with:
 - Coaching & Supportive Services
 - Community Supports for Work
 - Jobs Plus Earned Income Disregard

Unfunded Programs

ConnectHome

- Narrows digital divide with:
 - Connectivity
 - Devices
 - Training
 - Opportunities
- Collaboration with FPM, PD&R
- Nonprofit partner: Education-SuperHighway

HUD Strong Families

- Reaches 3,300+ PHAs
- Core pillars:
 - Health
 - Education
 - Economic Empowerment
- Delivers regular:
 - Newsletters
 - Webinars
 - HSF Virtual Office Hours

Community Health Worker PATH Activities



- COVID-19 education, testing and vaccination
 - Partnership with local businesses
 - Creative incentives
 - Mask design contest
 - Contact tracing
- Addressing Social Determinants of Health
 - Transportation
 - Digital access/scheduling virtual appointments
 - Violence prevention
- Health support
 - Well child checks
 - Resources for pregnant women dealing with substance abuse
 - Health self-monitoring
 - Mental health courses
- Doula training

Public Housing & Health Care Partnership



Bob Burns, MPA
Director

National Center for Health in Public Housing

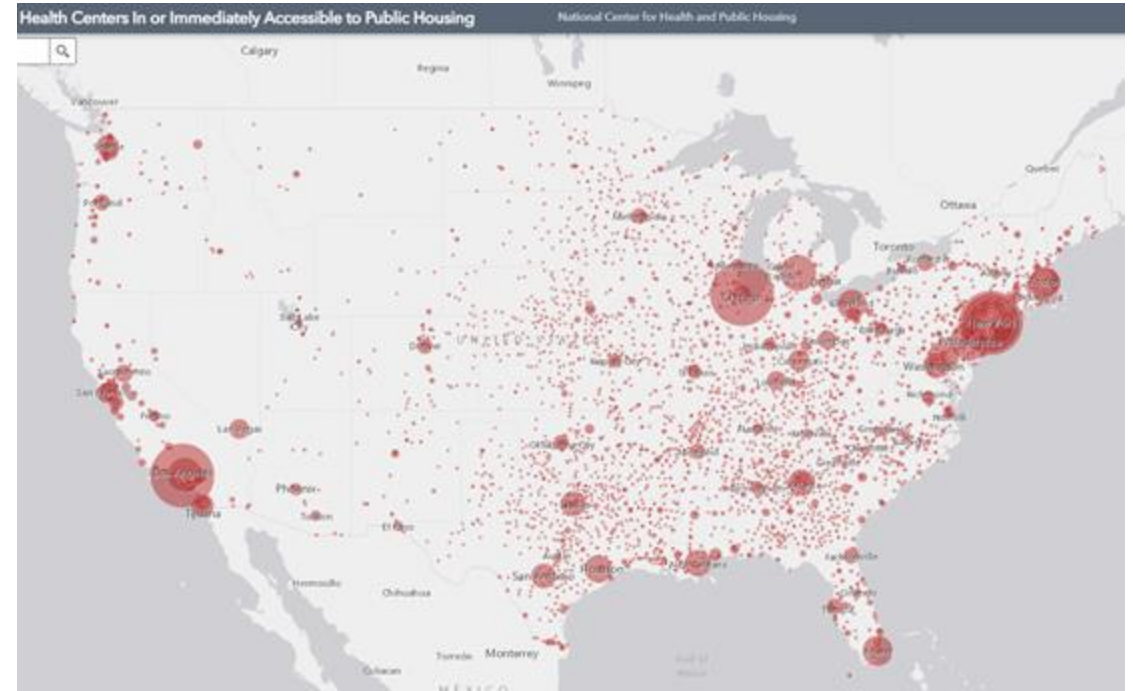
- The National Center for Health in Public Housing (NCHPH) is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09734, a National Training and Technical Assistance Partner (NTTAP) for \$668,800 and is 100% financed by this grant. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.



Health Centers Close to Public Housing

- **1,370 Federally Qualified Health Centers (FQHC) = 30.5 million patients**
- **483 FQHCs In or Immediately Accessible to Public Housing = 6.1 million patients**
- **107 Public Housing Primary Care (PHPC) = 935,823 patients**

Source: [2022 Health Center Data](#)



Source: [Health Centers in or Immediately Accessible to Public Housing Map](#)

Public Housing Demographics



1.5 Million
Residents



2 Persons
Per Household



38% Disabled



52% White



91% Low
Income



43% African-
American



26% Latinx



19% Elderly



36% Children



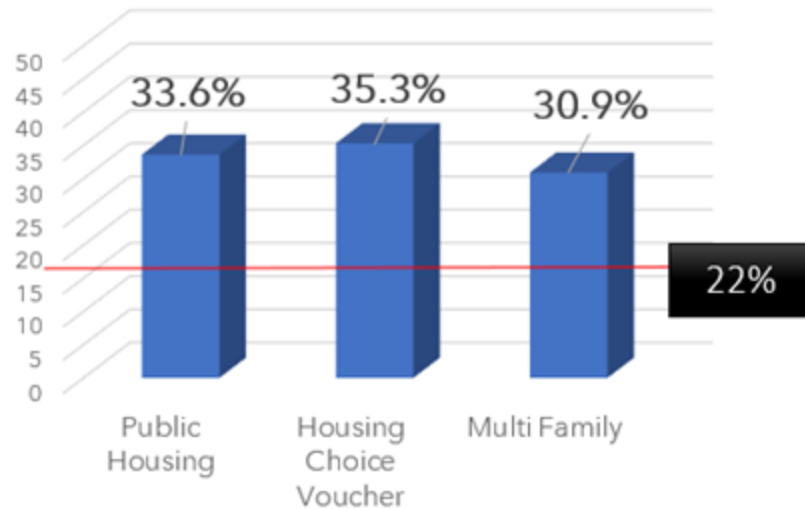
32% Female Headed
Households with
Children

Source: 2022 HUD Resident Characteristics Report

A Health Picture of Hud-Assisted Adults (2006-2012)

Adults in HUD-assisted housing have higher rates of chronic health conditions and are greater utilizers of health care than the general population.

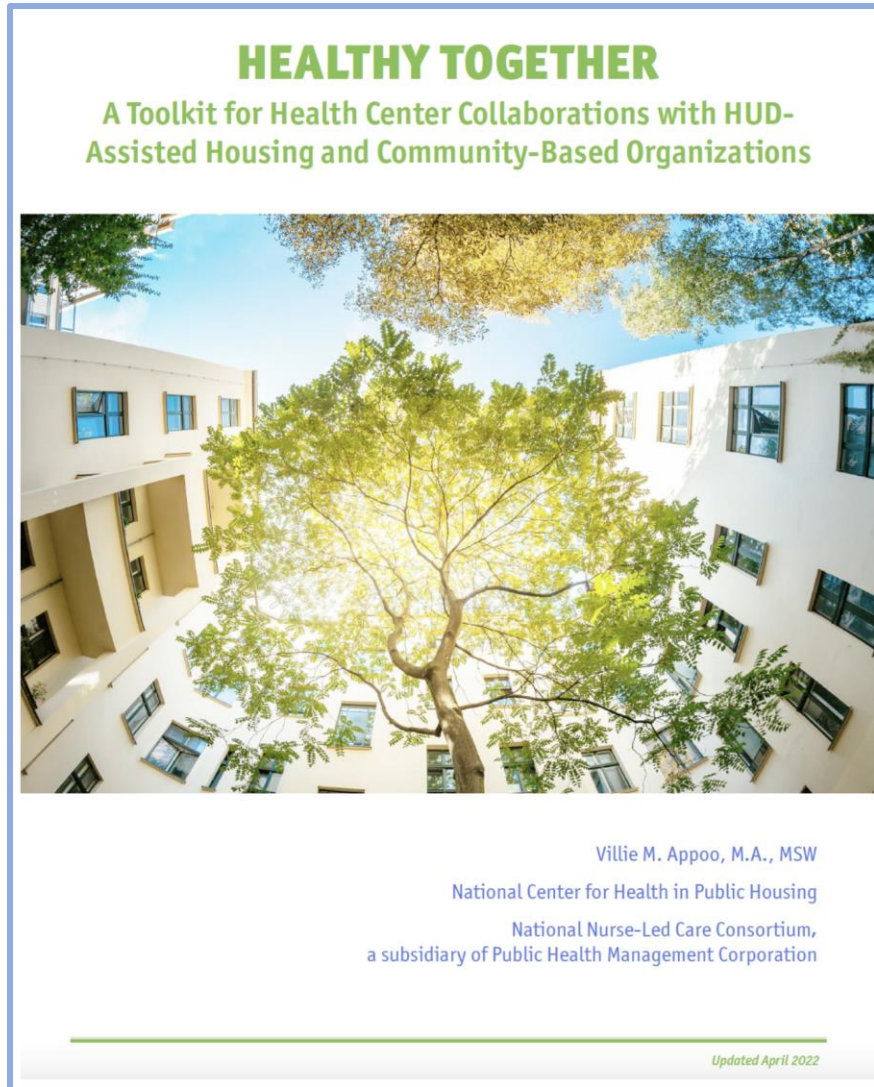
Adult Smokers with Housing Assistance



Source: Helms VE, 2017

	HUD-Assisted	Low-income renters	All Adults
Fair/Poor Health	35.8%	24%	13.8%
Overweight / Obese	71%	60%	64%
Disability	61%	42.8%	35.4%
Diabetes	17.6%	8.8%	9.5%
COPD	13.6%	8.4%	6.3%
Asthma	16.3%	13.5%	8.7%

Healthy Together: A Toolkit for Health Center Collaborations with HUD-Assisted Housing and Community-Based Organizations



This toolkit by NCHPH and NNCC provides information and resources for health center staff to partner and collaborate more effectively with their local housing authorities and with other providers serving residents of public housing and other low-income housing.

To view the toolkit, click on the link below:

<https://nchph.org/2022/05/healthy-together-a-toolkit-for-health-center-collaborations-with-hud-assisted-housing-and-community-based-organizations/>

Reasons for Partnership: Primary Care, Health Issue or Crisis



Lessons/Outcomes from Flu LEAD/COVID

- **30%** of vaccinated residents became patients of the Health Center

- Partner with PHA, DOH
- Get out from “behind the stethoscope”
 - Meet people where they are
 - Delivery
 - Curbside Services
 - Door to door vaccines
 - Virtually - Telemedicine
- Prioritize the Underserved with emphasis on elderly & disabled
- Trust v. Vaccine Hesitancy
- Mobile Units for Vaccination, Testing and transporting staff and patients



- Communication and Flexibility are Key
 - Clear, evidence-based messaging
 - Internal, with local PHA staff and residents
 - Multiple methods of contact and promotion (flyers, web, text messages, day of presence, virtual town halls, radio)
- Residents have competing priorities
 - Jobs, Childcare, etc.
- Visibility: be in front or main area
- Secure supplies of vaccine, tests, therapeutics, masks
- Augment Staffing: e.g., Student Nurses (need exposure to community health, and injection practice)
- Community Health Workers-Shared: Liaison, advocates, support services, communications between FQHCs, PHAs and residents/patients

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