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

Tuesday, November 7, 2023 @ 4 pm ET
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
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
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

<table>
<thead>
<tr>
<th>Education</th>
<th>Digital Inclusion</th>
<th>Employment/Financial Empowerment</th>
<th>Special Populations</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Education</td>
<td>Department of Education</td>
<td>Department of Labor</td>
<td>Department of Justice</td>
<td>Department of Health and Human Services (HHS)</td>
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<tr>
<td>Department of Energy</td>
<td>Corporation for National Community Service</td>
<td>Consumer Financial Protection Bureau</td>
<td>Federal Interagency Reentry Council</td>
<td>Office of Minority Health (OMH)</td>
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<tr>
<td>Federal Aviation Administration</td>
<td>United States Department of Agriculture</td>
<td>Department of Treasury</td>
<td>Federal Interagency Working Group on Youth Programs</td>
<td>Interdepartmental Health Equity Collaborative (IHEC)</td>
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<tr>
<td>Intergovernmental Policy Council on Child Development &amp; Academic Success</td>
<td>National Telecommunications and Information Workgroup</td>
<td>Small Business Association</td>
<td>Coordinating Council on Juvenile Justice and Delinquency Prevention</td>
<td>National Center for Health in Public Housing (NCHPH)</td>
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<td></td>
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<td>Federal Deposit Insurance Corporation</td>
<td>White House Initiative on Historically Black Colleges and Universities</td>
<td>Health Resources &amp; Services Administration (HRSA)</td>
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<td>U.S. Interagency Council on Economic Mobility</td>
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<td>Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
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<td>Workforce Development Intergovernmental Policy Council</td>
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PHA Investments

- 700+ PHAs served by CSS
- 40+ Tribes
- Dozens of nonprofits & resident associations
# Community & Supportive Services Programs

## Funded Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Services</th>
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</thead>
<tbody>
<tr>
<td><strong>ROSS</strong></td>
<td>- Funds Service Coordinators to:</td>
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<tr>
<td></td>
<td>- Provide case coaching</td>
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<td></td>
<td>- Assess resident needs</td>
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<tr>
<td></td>
<td>- Build partnerships</td>
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<tr>
<td></td>
<td>- Coordinate services with local providers</td>
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<tr>
<td><strong>FSS</strong></td>
<td>- Increases earned income through:</td>
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<td></td>
<td>- Long-term motivational coaching</td>
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<td></td>
<td>- Partner-provided services, supports, and job training</td>
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<td></td>
<td>- Family escrow account</td>
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<tr>
<td><strong>Jobs Plus</strong></td>
<td>- Transformative, intensive 4-year investment with:</td>
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<tr>
<td></td>
<td>- Coaching &amp; Supportive Services</td>
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<tr>
<td></td>
<td>- Community Supports for Work</td>
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<tr>
<td></td>
<td>- Jobs Plus Earned Income Disregard</td>
</tr>
<tr>
<td><strong>ConnectHome</strong></td>
<td>- Narrows digital divide with:</td>
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<tr>
<td></td>
<td>- Connectivity</td>
</tr>
<tr>
<td></td>
<td>- Devices</td>
</tr>
<tr>
<td></td>
<td>- Training</td>
</tr>
<tr>
<td></td>
<td>- Opportunities</td>
</tr>
<tr>
<td></td>
<td>- Collaboration with FPM, PD&amp;R</td>
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<tr>
<td><strong>HUD Strong Families</strong></td>
<td>- Reaches 3,300+ PHAs</td>
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<tr>
<td></td>
<td>- Core pillars:</td>
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<tr>
<td></td>
<td>- Health</td>
</tr>
<tr>
<td></td>
<td>- Education</td>
</tr>
<tr>
<td></td>
<td>- Economic Empowerment</td>
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<td></td>
<td>- Delivers regular:</td>
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<td>- Newsletters</td>
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<td></td>
<td>- Webinars</td>
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<td>- HSF Virtual Office Hours</td>
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## Unfunded Programs

<table>
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<th>Services</th>
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<td><strong>Jobs Plus</strong></td>
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<td><strong>ConnectHome</strong></td>
<td>- Collaboration with FPM, PD&amp;R</td>
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</table>
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
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
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
Adults in HUD-assisted housing have higher rates of chronic health conditions and are greater utilizers of health care than the general population.

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

Source: Helms VE, 2017
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:

Reasons for Partnership: Primary Care, Health Issue or Crisis

- Align agendas, goals, messaging
- Reduce and eliminate barriers
- Integrated approach to delivering services
- Share Resources

FQHCs  Residents  PHAs
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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